National Registry of Deliberate Self Harm Ireland

NSRF

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Executive Summary and Recommendations

This is the eleventh 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 2012 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 2012, the Registry recorded 12,010 presentations to hospital due to deliberate self-harm nationally, involving 9,483 individuals. Taking the population into account, the age-standardised rate of individuals presenting to hospital following deliberate self-harm in 2012 was 211 per 100,000, a 2% decrease on the rate in 2011. This decrease follows a 4% decrease in the rate of persons presenting to hospital following deliberate self-harm in Ireland from 2010 to 2011. However, the rate in 2012 was still 12% higher than that in 2007.

In 2012, the national male rate of deliberate self-harm was 195 per 100,000, 5% lower than in 2011. The female rate of deliberate self-harm in 2012 was 228 per 100,000, 1% higher than in 2011. Despite the overall decrease in 2012, the male rate has increased by 20% since 2007 and the female rate has increased by 6% over the same period.

In 2012, the only significant changes in the rate of hospital-treated deliberate self-harm by age were among males aged 15-19 and females aged 35-39. The male rate for those aged 15-19 fell by 14% from 2011, from 430 to 368 per 100,000. The female rate for those aged 35-39 fell by 13%, from 279 to 243 per 100,000. Rates of self-harm in other age groups remained similar to 2011.

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 17% in 2012. The peak rate for women was in the 15-19 years age group, at 617 per 100,000, whereas the peak rate among men was in 20-24 year-olds at 533 per 100,000. These rates imply that one in every 162 girls in the age group 15-19 and one in every 188 men in the age group 20-24 presented to hospital in 2012 as a consequence of deliberate self-harm.

There was widespread variation in the male and female deliberate self-harm rate when examined by city/county of residence. The male rate varied from 107 per 100,000 for Galway County to 469 per 100,000 for Limerick City. The lowest and highest female rate was recorded for Monaghan and Limerick City residents at 141 and 528 per 100,000, respectively. Relative to the national rate, a high rate of deliberate self-harm was recorded for male and female city residents and for men living in Louth and Kerry and for women living in South Dublin, Wexford and Leitrim. In 2012, 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 almost twice the national rate and for women the rate of deliberate self-harm was 43% higher than the national rate.

Between 2011 and 2012, the national rate of hospital-treated deliberate self-harm decreased by 5% for men, while it increased by 1% for women. The most notable decreases among men were observed in Galway County (-26%), Cavan (-25%), Carlow (-24%), Limerick County (-23%) and Cork City (-20%), while increases were observed in Longford (+34%) and Leitrim (+46%). The female rate fell significantly in Carlow (-18%), Laois (-22%) and Cavan (-18%). Significant increases in the female rate of self-harm were observed in Limerick City (+27%), Leitrim (+65%) and Roscommon (+68%). The rate of self-harm among female Waterford City residents increased two-fold (+106%) in 2012 – from a rate of 166 per 100,000 in 2011 to 342 per 100,000 in 2012.

Despite a decrease in the number of presentations in 2012 from 2011, the proportion of acts accounted for by repetition in 2012 (21.0%) was higher than that in 2010 or 2011, and similar to the years 2003-2009 (range: 20.5-23.1%). This confirms that repetition continues to pose a major challenge to hospital staff and family members involved.

At least five deliberate self-harm presentations were made by 118 individuals in 2012, accounting

for just 1% of all deliberate self-harm patients in the year but 8% of all deliberate self-harm presentations recorded. 24 individuals made ten or more presentations in 2012, representing 3% of all presentations. Self-cutting was associated with an increased level of repetition. Almost one in five of those who used cutting as their main method of self-harm in their index act made at least one subsequent deliberate self-harm presentation in the calendar year compared to just over one in eight of those who took a drug overdose. Risk of repetition was greatest in the days and weeks following a deliberate 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 (14.3% vs. 14.6%), repetition rates by gender did vary by 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.

Drug overdose was the most common method of self-harm, involved in 69% of all acts registered in 2012, and more so in women (75%) than in men (62%). Minor tranquillisers, paracetamol-containing medicines and anti-depressants/mood stabilisers were involved in 41%, 28% and 22% of drug overdose acts. The number of deliberate self-harm presentations to hospital involving drug overdose in 2012 (8,284) represented a slight decrease on the numbers recorded in 2011 and 2010 (2%). This was also true when examined by type of drug. The exception was paracetamol-only medication, which saw a rise of 6% on the 2011 figures. This rise was due to female presentations (11% increase), while male presentations involving paracetamol fell by 2%. Most notably, there was a reduction in the number of self-harm presentations involving minor tranquilisers by 7% from 2011. This reduction was more prominent among cases of self-harm by men compared to women (11% and 4%, respectively).

Attempted hanging was involved in 7% of all deliberate self-harm presentations (10% for men and 3% for women). At 776, the number of presentations involving attempted hanging has increased significantly by 6% from 2011 (n=734). This is the greatest number of deliberate self-harm presentations involving hanging recorded by the Registry and is 75% higher than the number recorded in 2007 (n=444).

Cutting was the only other common method of self-harm, involved in 23% of all episodes and was significantly more common in men (26%) than women (21%). Unlike previous years, the treatment following self-cutting was similar for both women and men. 30% of presentations involving self-cutting required no treatment, 30% required steristrips, 21% received sutures, while 4% were referred for plastic surgery.

Alcohol was involved in 38% of all cases. While overall alcohol involvement decreased slightly from 2011, alcohol was significantly more often involved in male episodes of self-harm than female episodes (42% versus 36%, 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. In addition, the Registry identified an increased number of self-harm presentations to hospital associated with some public holidays.

Next care varied significantly by HSE hospitals group. The proportion of deliberate self-harm patients who left before a recommendation was made varied from 6% in the Southern Hospitals Group to 19% in the Dublin North East Hospitals Group. Inpatient care (irrespective of type and whether the patient refused) varied from 24% of the patients treated in North Eastern and 25% in Dublin North East to 58% in the South Eastern Hospitals Group. Overall, direct psychiatric and general admissions were almost equally common in Dublin South and Dublin North East whereas general admissions were far more common than direct psychiatric admissions in South Eastern, Mid-Western, Dublin/ Midlands and North Eastern Hospital Groups. 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.

RECOMMENDATIONS

Following successive increases in deliberate self-harm in Ireland during the period 2007-2010, the 2012 Annual Report of the National Registry of Deliberate Self Harm shows a second subsequent annual decrease. Considering the relatively small reduction, this should be interpreted with caution since it would be premature to conclude that this indicates a decreasing trend. The 2012 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.

Considering that the rate of self-harm in 2012 was still 12% 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; 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, the Health Research Board has provided funding to the NSRF for a three-year study, which will be conducted in collaboration with the UCC Department of Epidemiology and Public Health, and the Department of General Practice.

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; NICE, 2011)*. We would recommend this as an on-going priority of the National Mental Health Programme.

In 2012, an increase of 6% was observed in attempted hanging from 2011, and by 26% since 2010, in particular among men. In terms of next care, 8.3% of those who had engaged in attempted hanging left the hospital before receiving a recommendation. Considering the high risk of subsequent suicide among people using highly lethal methods of self-harm, suicide risk assessment combined with psychiatric and psychosocial assessment should therefore be incorporated in the standard care for self-harm patients presenting to hospital EDs. 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.

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).*

As in previous years, minor tranquillisers (benzodiazepines) were by far the most common type of medication involved in intentional acts of drug overdose, accounting for 3,353 presentations to hospital in 2012. The second and third most frequently used drugs in intentional drug overdoses were paracetamol containing medication and Selective Serotonin Reuptake Inhibitors (SSRIs)/mood stabilisers respectively. In January 2012, the National

Office for Suicide Prevention (NOSP) established a National Working Group on Restricting Access to Means with a priority on restricting access to minor tranquillisers. We would recommend that this working group continues to address access to minor tranquillisers and would review the implementation of the paracetamol legislation and prescribing patterns of SSRIs as additional priorities.

Based on a subsample of the Registry, we found that having a prescription of a minor tranquilliser increased the risk of using psychotropic drugs in intentional overdoses, and this risk increased with age *(Corcoran et al, 2013)*. Therefore, we would recommend:

- Careful monitoring of the use of medication by the prescribing health professionals, in particular among older people.
- Consideration of referral to complementary or alternative therapies for patients with anxiety disorders, such as cognitive-behavioural therapy.

Compared to 2011, a significant reduction was observed in the involvement of street drugs in intentional drug overdose acts which fell by 10% in 2012, which follows a 27% reduction in 2011. This reduction is likely to be associated with the ban on head shop drugs from August 2010 onwards. This finding would be in line with nationally and internationally consistent effects of strategies aimed at restricting access to means on reducing self-harm and suicide *(Arensman, 2010; Corcoran et al, 2010; O'Driscoll et al, 2009; Mann et al, 2005)*.

While 2012 saw a decrease in deliberate self-harm involving self-cutting (-8%), 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. The NOSP has also funded a pilot project in Cork and Kerry with the aim to implement and evaluate a brief CBT programme for self-harm patients presenting to EDs using a Train-The-Trainer model with potential for national implementation.

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 6% in the South Eastern Hospitals Group to 19% in the Dublin North East 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 – *O'Farrell et al* (under review). 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.

IMPLICATIONS

Information from the Registry on self-harm trends, 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 2013 and 2014 according to a stepped approach and prioritising hospitals according to the number of self-harm presentations.

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.

3. Implementation of guidelines for assessment and management of self-harm patients presenting to Irish Emergency Departments (2013-2014) – 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. 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.

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.

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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 Dr 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.
- Alcool 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 2012 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 census enumeration area 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.

Seen by
For general hospital treated cases, this indicates the different disciplines involved in the initial treatment of the presentation.

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 2012, deliberate self-harm data were collected from each HSE region in the Republic of Ireland (pop: 4,585,500).

There was complete coverage of all acute hospitals in the HSE Dublin/ Mid-Leinster Region (pop: 1,325,906) 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: 1,018,669). 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: 1,167,100) 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: 1,073,826) 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 2012 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. The emergency department of the South Infirmary Victoria University Hospital Cork closed in April 2012 and no cases of self-harm were recorded by the Registry for 2012.

In April of 2012 there was a change to the emergency department IT system in St. Michael's Hospital, Dun Laoghaire, which led to an under-recording of self-harm presentations to the hospital. Ongoing efforts are being made to rectify this situation.

POPULATION DATA

For 2012, 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 2012 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 2012. 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 2 cases of deliberate self-harm for which patient initials, gender or date of birth were unknown. These 2 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 2012.

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 $\mathbf{n \pm 2\sqrt{n}}$. For example, if 25 deliberate self-harm presentations are observed in a specific region in one year, then the 95% confidence interval will be $25 \pm 2\sqrt{25}$ or 15 to 35. Thus, the 95% confidence interval around a rate ranges from $\mathbf{(n - 2\sqrt{n}) / p}$ to $\mathbf{(n + 2\sqrt{n}) / p}$, 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 $\mathbf{rd - 2\sqrt{(n_1 / p_1^2 + n_2 / p_2^2)}}$ to $\mathbf{rd + 2\sqrt{(n_1 / p_1^2 + n_1 / p_1^2)}}$. If the rates were expressed per 100,000 population, then $\mathbf{2\sqrt{(n_1 / p_1^2 + n_2 / p_2^2)}}$ 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.

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National Registry of Deliberate Self Harm Ireland

DELIBERATE SELF-HARM IN THE REPUBLIC OF IRELAND

National Suicide Research Foundation

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Deliberate Self-Harm in the Republic of Ireland

I. Hospital Presentations

For the period from 1 January to 31 December 2012, the Registry recorded 12,010 deliberate self-harm presentations to hospital that were made by 9,483 individuals. Thus, the number of deliberate self-harm presentations was 2% lower than that in 2011 and the number of persons involved decreased by 4%. Table 1 summarises the changes in the number of presentations and persons since the Registry reached near national coverage in 2002.

The age-standardised rate of individuals presenting to hospital in the Republic of Ireland following deliberate self-harm in 2012 was 211 (95% Confidence Interval (CI): 207 to 216) per 100,000. This rate, which accounts for the changing age distribution of the population, represents a slight decrease of 2% on the equivalent rate of 215 (95% CI: 211 to 219) per 100,000 in 2011. This decrease follows a significant 4% decrease from 2010 to 2011. The incidence of deliberate self-harm in Ireland is examined in detail in Part II of this section of the Annual Report.

The numbers of deliberate 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 2012, 46% were made by men and 54% were made by women. Deliberate self-harm episodes were generally confined to the younger age groups. Just under half of all presentations (44%) were by people under 30 years of age and 85% of presentations were by people aged less than 50 years.

	Presentations		Persons	
Year	Number	% diff	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%

Table 1: Number of deliberate self-harm presentations and persons who presented in the Republic of Ireland in 2002-2012 (2002-2005 figures extrapolated to adjust for hospitals not contributing data).

In most age groups the number of deliberate self-harm acts by women exceeded the number by men. This was most pronounced in the 10-14 year age group where there were 2.9 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 34-39 year age group.

In line with 2011, 469 (4%) of all deliberate self-harm presentations were by residents of homeless hostels and people of no fixed abode and 89 (0.7%) were made by hospital inpatients.

DELIBERATE SELF-HARM BY HSE HOSPITALS GROUP

Based on provisional figures acquired from the HSE Business Intelligence Unit, deliberate self-harm accounted for 0.97% of total attendances to general emergency departments in the country. This percentage of attendances accounted for by deliberate self-harm varied by HSE hospitals group from 0.74% and 0.79% in the Dublin/ Midlands and West/ North Western, to 0.87% in the North Eastern and South Eastern, 1.03% in the Mid-Western, 1.12% in the Southern, 1.08% in the Dublin/ North East and 1.36% in the Dublin South.

The proportion of deliberate self-harm presentations treated in each hospitals group in 2012 ranged from 8% in the North Eastern and Mid-Western, to 11% in the South Eastern, 13% in the West/ North Western, 14% in the Southern and Dublin South, 15% in the Dublin/ Midlands and 17% in the Dublin/ North East.

The gender balance of recorded episodes in 2012 (at 46% men to 54% women) varied by hospitals group (Figure 1). Deliberate self-harm presentations by women outnumbered those by men in all but two of the eight hospitals groups. There were equal numbers of self-harm presentations by men and women in the North Eastern Hospitals Group and men accounted for a small majority of the cases treated in the Southern Hospitals Group.

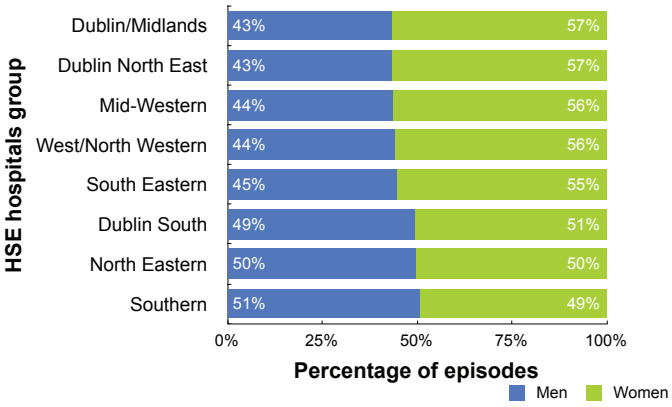


Figure 1: Gender balance of deliberate self-harm presentations by HSE hospitals group.

ANNUAL CHANGE IN DELIBERATE SELF-HARM PRESENTATIONS TO HOSPITAL

While the national number of deliberate self-harm presentations to hospital in 2012 was 2% lower than that in 2011, there were some relatively large changes in the number of presentations at the level of the individual hospitals (Figures 2a and 2b). 15 general hospitals saw an increase in self-harm presentations between 2011 and 2012, while 20 general hospitals saw a decrease during the same period. Four general hospitals saw an increase of 25% or more in self-harm presentations between 2011 and 2012. Overall, the most pronounced changes were in small hospitals, where two hospitals saw decreases of more than 50%. This is the second significant annual decrease in self-harm presentations to St. John's Hospital, Limerick, while the decrease in St. Michael's Hospital, Dun Laoghaire is a consequence of the under-recording of self harm presentations 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.

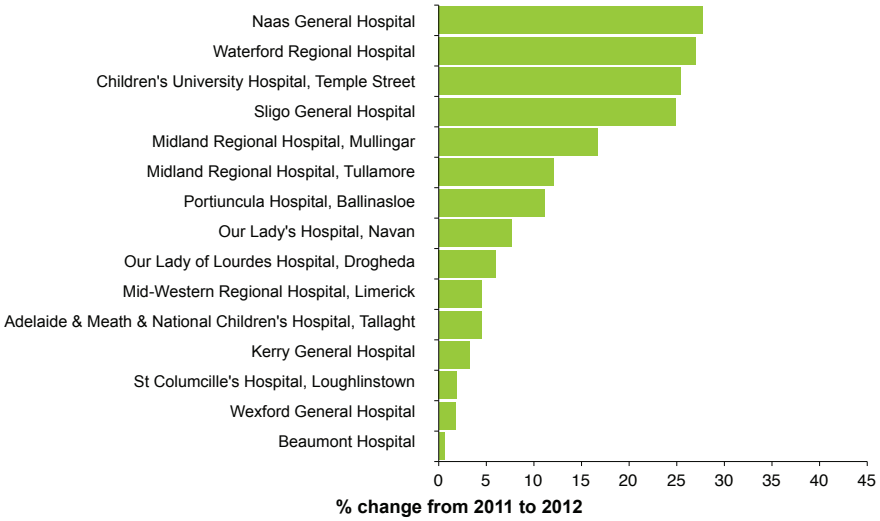


Figure 2a: Hospitals receiving more deliberate self-harm presentations in 2012.

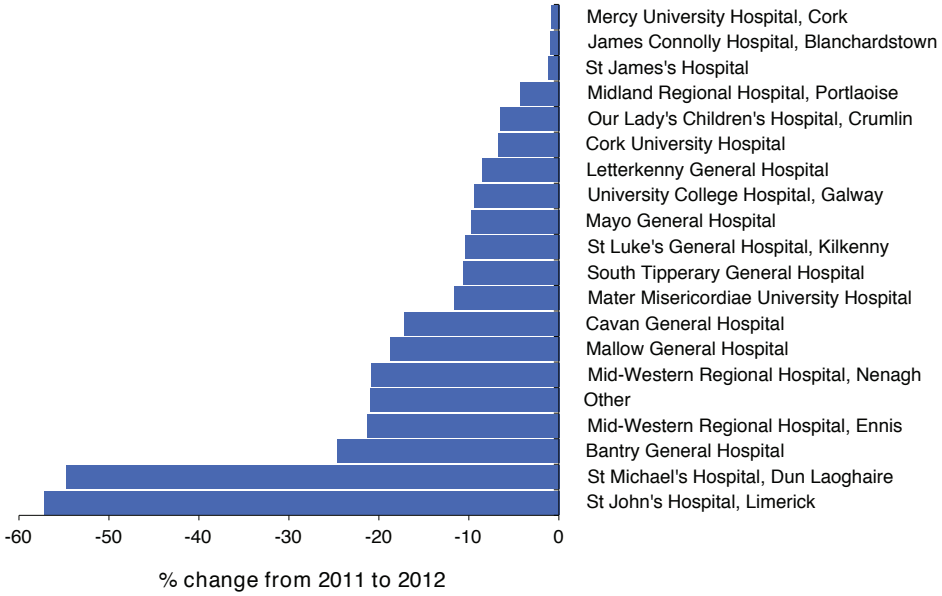


Figure 2b: Hospitals receiving fewer deliberate self-harm presentations in 2012.

VARIATION BY MONTH

The monthly average number of deliberate self-harm presentations to hospitals in 2012 was 1000. Figure 3 illustrates the percentage difference between observed and expected number of presentations, accounting for the number of days in each calendar month. In 2012, February and March saw more self-harm presentations than might be expected (15% and 10%, respectively). The fall in self-harm presentations in July and August of 2011 was not observed in 2012 and in fact there were more presentations than expected for these months (5% and 3%, respectively). The end of year fall in presentations was more pronounced in 2012 than in previous years. From September to December there were fewer presentations than would be expected, in particular for the month of December (-14%).

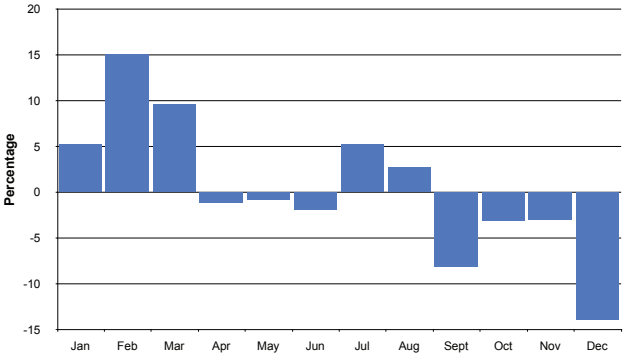


Figure 3: Percentage difference between the observed and expected number of deliberate self-harm presentations by month in 2012.

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total
Men	478	513	530	439	477	420	512	491	432	428	422	388	5530
Women	592	543	584	533	530	544	557	553	471	556	531	486	6480
Total	1070	1056	1114	972	1007	964	1069	1044	903	984	953	874	12010

Table 2: Number of deliberate self-harm presentations in 2012 by month for men and women.

VARIATION BY DAY

As in previous years, the number of deliberate self-harm presentations was highest on Mondays and Sundays. These days accounted for 32% 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 2012, there was an average of 33 deliberate self-harm presentations to hospital each day. There were six dates in the year on which 50 or more self-harm presentations were made, including: January 1st, New Year's Day (n=63) and October 1st, the day following the October Bank Holiday (n=50). The association between self-harm increases and public holidays has been a consistent pattern over many years.

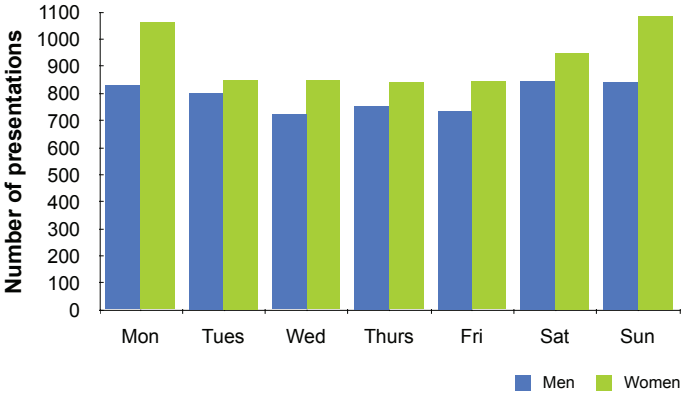


Figure 4: Number of presentations by weekday, 2012.

	Monday	Tuesday	Wed'day	Thursday	Friday	Saturday	Sunday	Total
Men	829	801	722	754	736	846	842	5530
	(15%)	(14.5%)	(13.1%)	(13.6%)	(13.3%)	(15.3%)	(15.2%)	(100%)
Women	1062	849	848	841	844	949	1087	6480
	(16.4%)	(13.1%)	(13.1%)	(13%)	(13%)	(14.6%)	(16.8%)	(100%)
Total	1891	1650	1570	1595	1580	1795	1929	12010
	(15.7%)	(13.7%)	(13.1%)	(13.3%)	(13.2%)	(14.9%)	(16.1%)	(100%)

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

Table 3: Deliberate self-harm presentations in 2012 by weekday.

VARIATION BY HOUR

As in previous years, there was a striking pattern in the number of deliberate 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 women was 10pm and for men was midnight. 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 19% of all presentations.

The majority of patients (53%) 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 45% for presentations between noon and 4pm to 68% for those who presented between midnight and 8am.

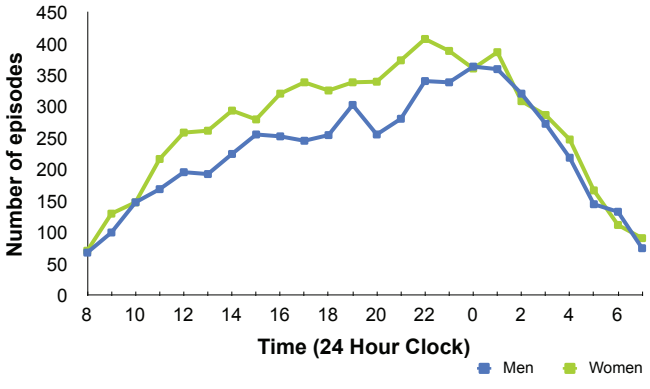


Figure 5: Number of presentations by time of attendance.

METHOD OF SELF-HARM

Almost three quarters (69%) of all deliberate 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 75% of female episodes. Alcohol was involved in 38% of all cases. Alcohol was significantly more often involved in male episodes of self-harm than female episodes (42% and 36%, respectively).

Cutting was the only other common method of self-harm, involved in 23% of all episodes. Cutting was significantly more common in men (26%) than in women (21%). In 86% of all cases involving self-cutting, the treatment received was recorded. 30% received steristrips or steribonds, 30% did not require any, 21% required sutures while 4% 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 deliberate self-harm presentations (10% for men and 3% for women). At 776, the number of presentations involving attempted hanging has increased significantly by 6% from 2011 (n=734). This is the greatest number of deliberate self-harm presentations involving hanging recorded by the Registry and is 75% higher than the number recorded in 2007 (n=444).

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 highest among males younger than 15 years, involving 26% of presentations. In 2011, the proportion of male cases of self-harm involving attempted hanging was similar across all age groups.

	Overdose	Alcohol	Poisoning	Hanging	Drowning	Cutting	Other	All
Men	3418	2303	148	573	208	1420	357	5530
	(61.8%)	(41.6%)	(2.7%)	(10.4%)	(3.8%)	(25.7%)	(6.5%)	(100%)
Women	4866	2307	116	203	141	1347	259	6480
	(75.1%)	(35.6%)	(1.8%)	(3.1%)	(2.2%)	(20.8%)	(4%)	(100%)
Total	8284	4610	264	776	349	2767	616	12010
	(69%)	(38.4%)	(2.2%)	(6.5%)	(2.9%)	(23%)	(5.1%)	(100%)

Table 4: Methods of self-harm involved in presentations to hospital in 2012.

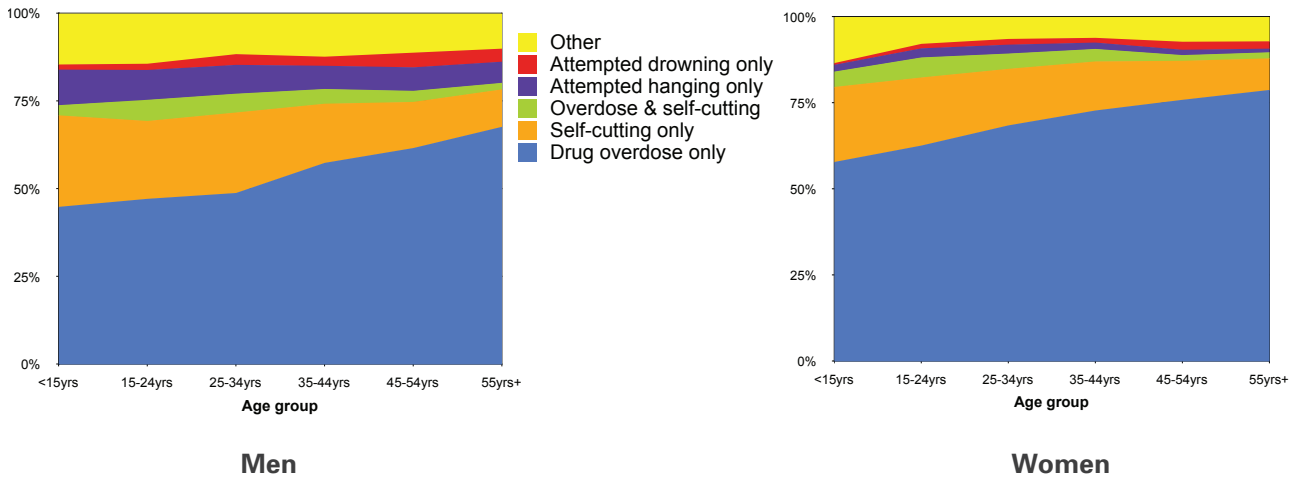


Figure 6. Method of self-harm used by gender and age group, 2012.

DRUGS USED IN OVERDOSE

The total number of tablets taken was known in 70% of all cases of drug overdose. On average, 30 tablets were taken in the episodes of deliberate 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: 32 vs. 28). Figure 7 illustrates the pattern of the number of tablets taken in drug overdose episodes for both genders. Half (50%) of the female episodes and 46% of the male episodes of overdose involved 10-29 tablets. At least 50 tablets were taken by 18% of men compared to 15% of women.

Figure 8 illustrates the frequency with which the most common types of drugs were used in overdose. 41% of all overdoses involved a minor tranquilliser and such a drug was used significantly more often by men than by women (43% and 39%, respectively) (see implication no. 4). A major tranquilliser was involved in 10% of overdoses. 44% of all female overdose acts and 34% of all male acts involved an analgesic drug. Paracetamol was the most common analgesic drug taken, being involved in some form in 28% of drug overdose acts. Paracetamol was used significantly more often by women (32%) than by men (22%). More than one in five acts (22%) 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 13% of overdose cases. Street drugs were involved in 9% 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 deliberate self-harm presentations to hospital involving drug overdose in 2012 (8,284) was a slight decrease on the number recorded in 2011 (-2%). This was also true when the number of presentations involving each of the drug types described here were examined. The exception was paracetamol-only medication, which saw a rise of 6% on 2011 figures. This rise was due to female presentations (11% increase), while male presentations involving paracetamol fell by 2%. Most notably, there was a reduction in the number of self-harm presentations involving minor tranquilisers by 7% from 2011. This reduction was more prominent among cases of self-harm by men compared to women (11% and 4%, respectively). The number of deliberate self-harm presentations to hospital involving street drugs fell a further 10% from 2011 (following a 27% decrease in 2011 from 2010) to 433, which is similar to the level recorded in 2007 (n=434).

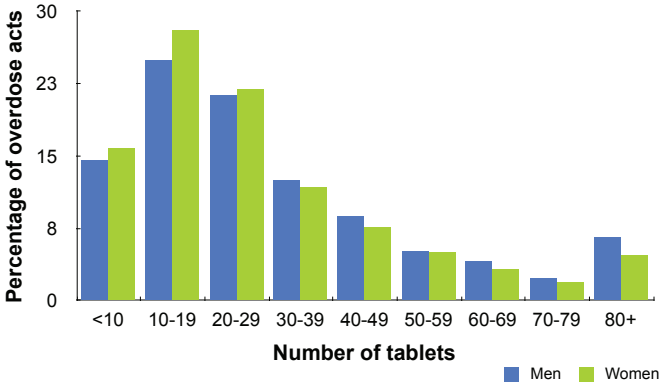


Figure 7: The pattern of the number of tablets taken in male and female acts of drug overdose.

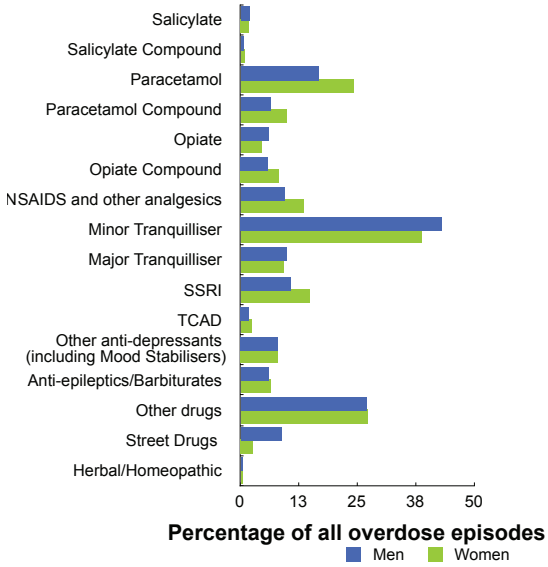


Figure 8: The variation in the type of drugs used.
Note: Some drugs (e.g. compounds containing paracetamol and an opiate) are counted in two categories.

RECOMMENDED NEXT CARE

Overall, in 12% of 2012 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 38% of cases, irrespective of whether general or psychiatric admission was intended and whether the patient refused or not. Of all deliberate self-harm cases, 28% resulted in admission to a ward of the treating hospital whereas 10% 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 3% of cases, the patient refused to allow him/herself to be admitted whether for general or psychiatric care. Most commonly, 48% of cases were discharged following treatment in the emergency department (see implication no. 3).

Next care recommendations in 2012 were broadly similar for men and women. Men more often left the emergency room before a recommendation was made (13% vs. 11%). Women were more often admitted to a ward of the treating hospital than men (30% vs. 25%), although psychiatric admission was more common among men than women (12% vs. 9%).

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 drowning and hanging and least common after 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, 59% 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.

	Overdose (n=8284)	Alcohol (n=4610)	Poisoning (n=264)	Hanging (n=776)	Drowning (n=349)	Cutting (n=2767)	Other (n=616)	All (n=12010)
General admission	34.0	28.9	31.4	18.0	15.5	13.1	16.4	27.6
Psychiatric admission	8.1	7.7	12.9	25.0	22.3	11.3	14.6	10.3
Patient would not allow admission	2.3	3.0	1.9	3.1	5.7	3.5	2.4	2.7
Left before recommendation	11.6	14.5	7.2	8.2	13.8	13.5	11.9	11.8
Not admitted	44.1	45.8	46.6	45.6	42.7	58.5	54.7	47.7

Table 5: Recommended next care in 2012 by methods of deliberate self-harm.

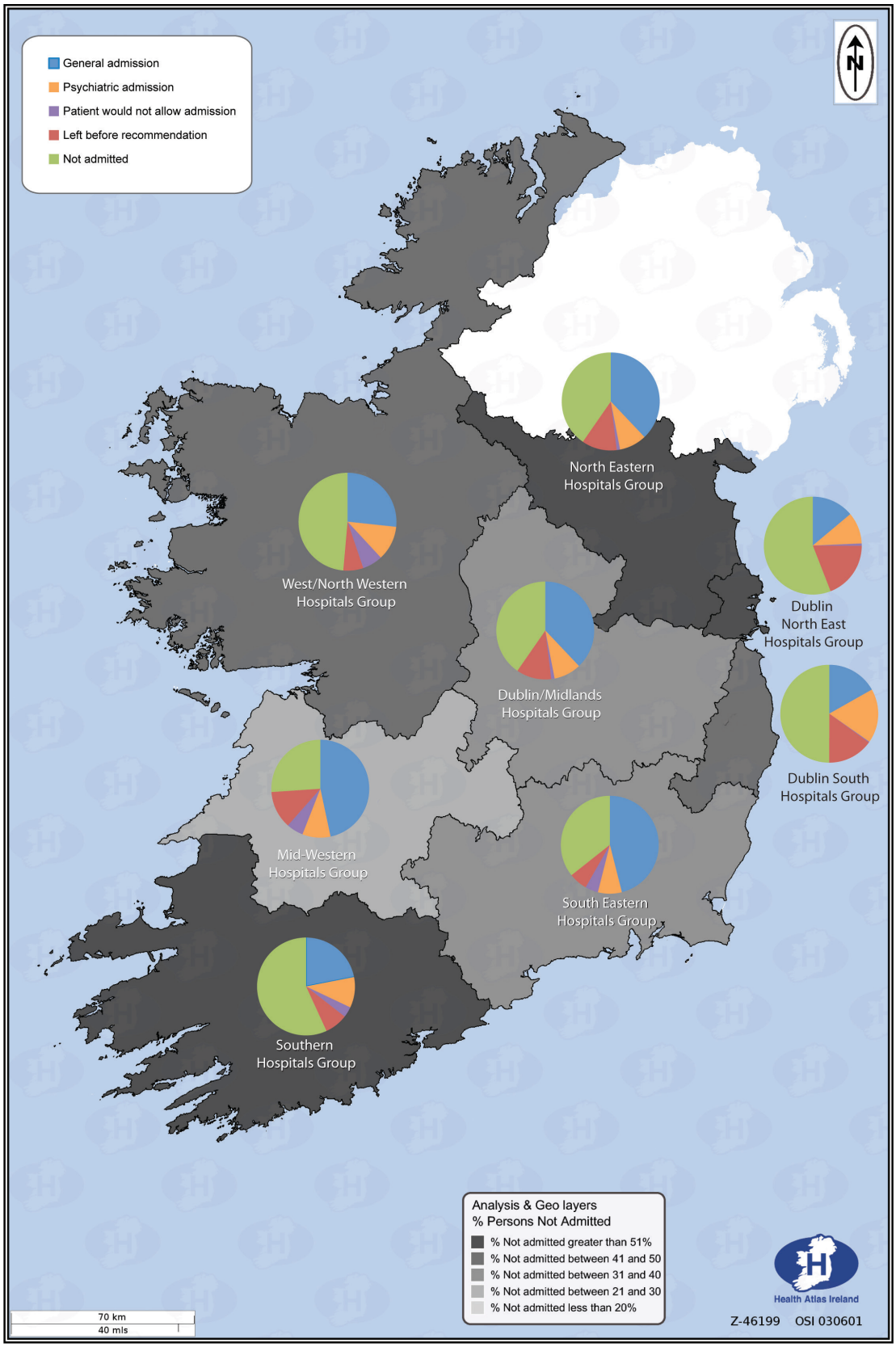
Next care varied significantly by HSE hospitals group (Table 6). A thematic map is also provided to illustrate this regional variation in next care in 2012. The proportion of deliberate self-harm patients who left before a recommendation was made varied from 6% in the South Eastern Hospitals Group to 19% in the Dublin North East Hospitals Group. Across the hospitals groups, inpatient care (irrespective of type and whether patient refused) was recommended for 24% of the patients treated in the North Eastern, 25% in the Dublin North East, 35% in the Dublin South, 36% in the Southern, 45% in the West/ North Western, 48% in the Dublin/ Midlands, 62% in the Mid-Western and 58% in the South Eastern Hospitals Group. As a corollary to this, the proportion of cases discharged following emergency treatment ranged from a low of 26% in the Mid-Western Hospitals Group to a high of 61% in the North Eastern Hospitals Group. The balance of general and psychiatric admissions directly after treatment in the emergency department differed significantly by hospitals group. Overall, direct psychiatric and general admissions were almost equally common in the Dublin South and the Dublin North East Hospitals Groups. In contrast, direct general admissions were far more common than direct psychiatric admissions in the South Eastern, the Mid-Western, the Dublin/ Midlands and the North Eastern Hospital Groups.

Appendix 2 details the recommended next care for deliberate 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	Dublin South	Dublin North East	North Eastern	South Eastern	Southern	Mid-Western	West/North Western	
	(n=1814)	(n=1623)	(n=2050)	(n=941)	(n=1298)	(n=1719)	(n=1003)	(n=1562)	(n=12010)
General admission	37.9%	16.8%	13.9%	21.8%	46.1%	21.9%	46.7%	26.7%	27.6%
Psychiatric admission	9%	17.9%	10.4%	2.6%	7.9%	10.1%	9.3%	11.5%	10.3%
Patient would not allow admission	1.1%	0.3%	0.8%	0.1%	4.3%	3.5%	5.6%	6.7%	2.7%
Left before recommendation	11.6%	15%	19%	14.2%	6.1%	7.6%	12.4%	6.6%	11.8%
Not admitted	40.3%	49.9%	55.9%	61.3%	35.7%	56.8%	26.1%	48.5%	47.7%

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

Table 6: Recommended next care in 2012 by HSE hospitals group.



Map 1: Recommended next care for deliberate self-harm patients in the Republic of Ireland 2012 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.

REPETITION OF DELIBERATE SELF-HARM

There were 9,483 individuals treated for 12,010 deliberate self-harm episodes in 2012. This implies that more than one in five (2,527, 21.0%) of the presentations in 2012 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%). Of the 9,483 deliberate self-harm patients treated in 2012, 1,374 (14.5%) made at least one repeat presentation to hospital during the calendar year. This proportion is within the range reported for the years 2003-2009 (13.8-16.4%) and higher than the proportion recorded in 2010 and 2011 (13.8% and 13.7%, respectively). At least five deliberate self-harm presentations were made by 118 individuals in 2012. They accounted for just 1.2% of all deliberate self-harm patients in the year but their presentations represented 7.9% of all deliberate self-harm presentations recorded.

The rate of repetition varied highly significantly with the method of self-harm involved in the deliberate 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 (19.4%) who used cutting as a method of self-harm in their index act made at least one subsequent deliberate self-harm presentation in the calendar year.

	Overdose	Alcohol Poisoning	Hanging	Drowning	Cutting	Other	All
Individuals treated	6686	3679	202	629	265	1981	495	9483
No. who repeated	907	521	31	77	30	385	85	1374
% who repeated	13.6%	14.2%	15.3%	12.2%	11.3%	19.4%	17.2%	14.5%

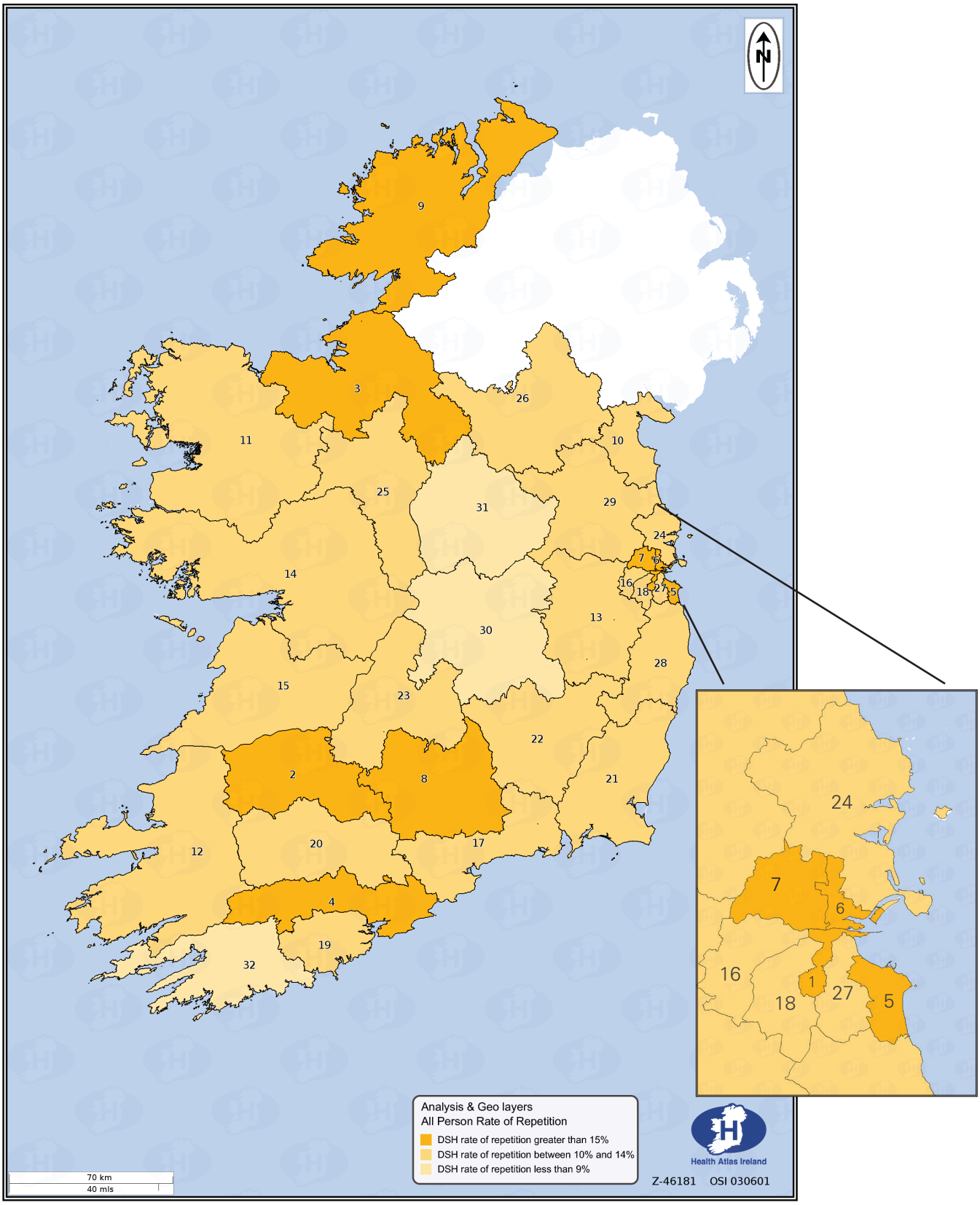
Table 7: Repeat presentation after index deliberate self-harm presentation in 2012 by methods of self-harm.

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. Among self-harm patients aged 65 years and over, the repetition rate has doubled from 5% in 2011 to 10% in 2012.

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	661	596	754	386	471	699	363	545	4378
Women	852	656	887	406	586	677	435	704	5105
Total	1513	1252	1641	792	1057	1376	798	1249	9483
Number who repeated									
Men	88	108	117	55	71	101	52	83	628
Women	110	110	140	46	80	104	85	111	746
Total	198	218	257	101	151	205	137	194	1374
Percentage who repeated									
Men	13.3%	18.1%	15.5%	14.2%	15.1%	14.4%	14.3%	15.2%	14.3%
Women	12.9%	16.8%	15.8%	11.3%	13.7%	15.4%	19.5%	15.8%	14.6%
Total	13.1%	17.4%	15.7%	12.8%	14.3%	14.9%	17.2%	15.5%	14.5%

Table 8: Repetition in 2012 by gender and HSE hospitals group



Map 2: Rate of repetition (within 1 year) in the Republic of Ireland 2012 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 2012, the thematic map (see page 14) 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 City, Limerick and Sligo/Leitrim/ West Cavan had the highest rates of repetition (20.6%, 18.0% and 17.5%, respectively). The lowest rates of repetition were seen in Laois/ Offaly, Longford/Westmeath and West Cork (9.2%, 9.0% and 7.5%, respectively).

While overall the rate of repetition in one year was similar for men and women (14.3% vs. 14.6%), 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 Limerick (21% vs. 15%) and Sligo/ Leitrim/West Cavan (19% vs. 16%, respectively). In addition, in both North Cork and Clare, the rate of repetition for women was almost twice that for men (9% vs. 17%, and 9% vs. 18%, respectively). In Dublin South City, the male repetition rate was higher than the female rate (23% vs. 19%), however the female rate was still above the national average in this LHO. 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.

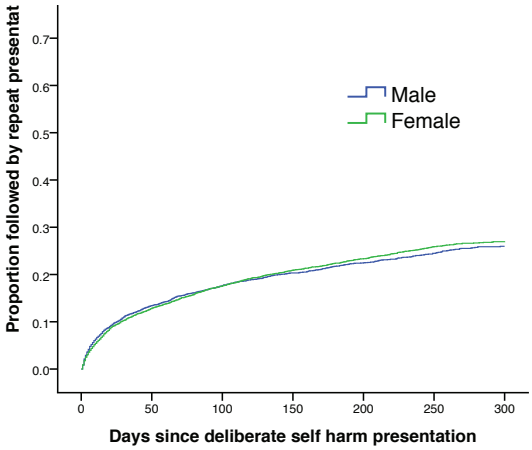
Appendix 3 details the repetition rate for male, female and all patients treated following deliberate self-harm in 2012. Caution should be taken in interpreting the repetition rates associated with the smaller hospitals as the calculations may be based on small numbers of patients.

Risk of repetition was greatest in the days and weeks following a deliberate self-harm presentation. A total of 9,203 deliberate self-harm presentations were made to hospital emergency departments in the first nine months of 2012. For 17.4% of these (n=1,603) there was a repeat self-harm presentation made within three months (91 days). This proportion varied significantly by HSE Hospitals Group: North Eastern (13.9%), Mid-Western (14.9%), Dublin/ Midlands (16.0%), South Eastern (16.2%), Southern (16.9%), West/ North Western (17.3%), Dublin North East (19.5%) and Dublin South (21.7%).

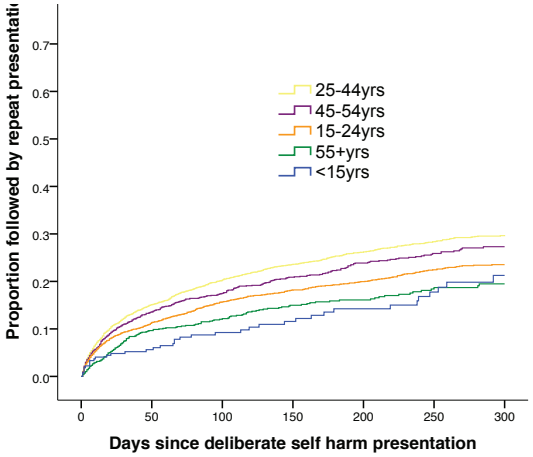
This proportion of self-harm presentations followed by a repeat presentation within three months was almost identical for men (17.3%) and women (17.6%) but did vary by age group. The proportion was lowest among those aged under 15 years (8.1%) and over 55 years (11.3%), compared with 15.8% among 15-24 year-olds, 20.0% among 25-44 year-olds and 17.4% 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 (10.5% following an attempted hanging, 15.4% following a drug overdose, 17.0% following an attempted drowning, 24.3% after an act of self-cutting only and 25.0% after an act involving drug overdose and self-cutting).

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 (13.0%), compared to 16.5% of those who were not admitted (16.5%), to 23.4% who would not allow admission, 23.9% who left before a recommendation and 24.6% who were admitted to a psychiatric ward.

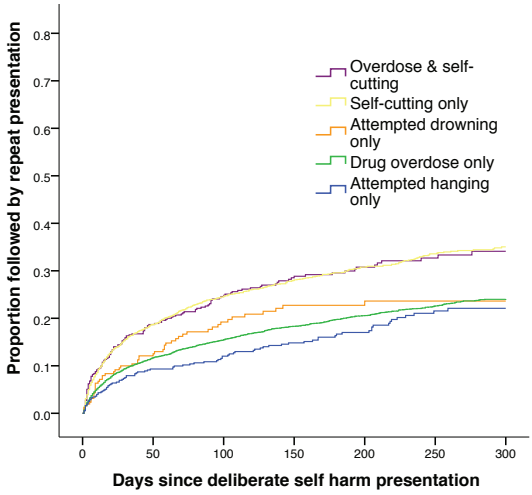
However, the factor having by far the strongest influence on likelihood of repetition was the number of self-harm presentations made to hospital. Just one in ten (11.0%) first presentations in January-September 2012 was followed by a repeat presentation in the next three months. This proportion was 30.8% following second presentations, 41.3% following third presentations, 63.2% following fourth presentations and 80.9% following fifth or subsequent presentations. The full pattern of repetition in 2012 is illustrated in Figure 9 by gender, age group, method of self-harm, recommended next care and number of self-harm presentations.



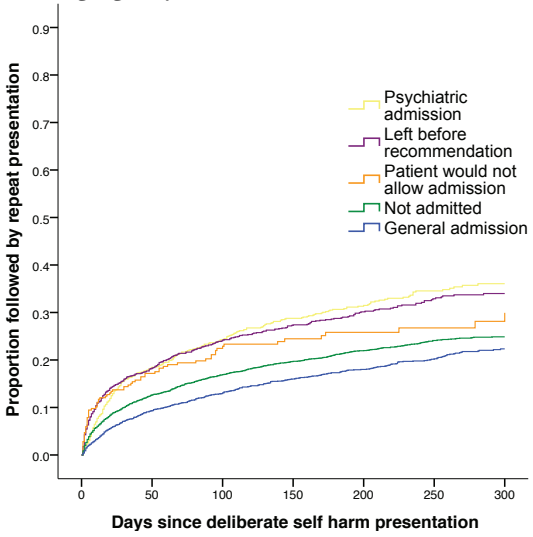
(a) Gender



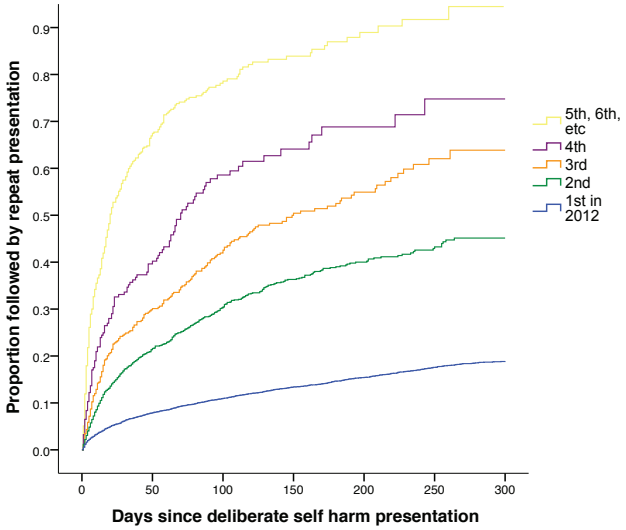
(b) Age group



(c) Method of self harm



(d) Recommended next care



(e) Number of self-harm presentation

Figure 9: Rate of repeated presentation to hospital following a deliberate self-harm presentation in 2012 by gender, age group, method of self-harm, recommended next care and by the number of the self-harm presentation.

II. Incidence Rates

For the period from 1 January to 31 December 2012, the Registry recorded 12,010 deliberate self-harm presentations to hospital that were made by 9,483 individuals. Based on these data, the Irish person-based crude and age-standardised rate of deliberate self-harm in 2012 was 207 (95% CI: 203 to 211) and 211 (95% CI: 207 to 216) per 100,000, respectively. Thus, the age-standardised rate in 2012, which accounts for the changing age distribution of the population, was 2% lower than the equivalent rate in 2011 (215 per 100,000). This decrease follows a 4% decrease in the annual Irish rate of persons presenting to hospital as a result of deliberate self-harm from 2010 to 2011. Despite two successive decreases the rate in 2012 was still 12% higher than in 2007, the year before the economic recession.

	Men		Women		All	
Year	Rate	% diff	Rate	% diff	Rate	% diff
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%

Table 9: Person-based European age-standardised rate (EASR) of deliberate self-harm in the Republic of Ireland in 2002-2012 (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 deliberate self-harm in 2012 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 deliberate self-harm for men and women in 2012 was 195 (95% CI: 189-201) and 228 (95% CI: 222-235) per 100,000, respectively. Thus, there was a significant 5% decrease in the male rate of deliberate self-harm, while the female rate increased by 1% from 2011 to 2012. Taking recent years into account, the male self-harm rate in 2012 was 20% higher than in 2007 whereas the female rate was just 6% higher.

The female rate of deliberate self-harm in 2012 was 17% 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 10-13% higher in 2009-2011.

There was a striking pattern in the incidence of deliberate self-harm when examined by age. The rate was highest among the young. At 617 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 2012 as a consequence of deliberate self-harm. The peak rate for men was 533 per 100,000 among 20-24 year-olds or one in every 188 men. The incidence of deliberate 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 300 per 100,000, across the 25 to 54 year age range.

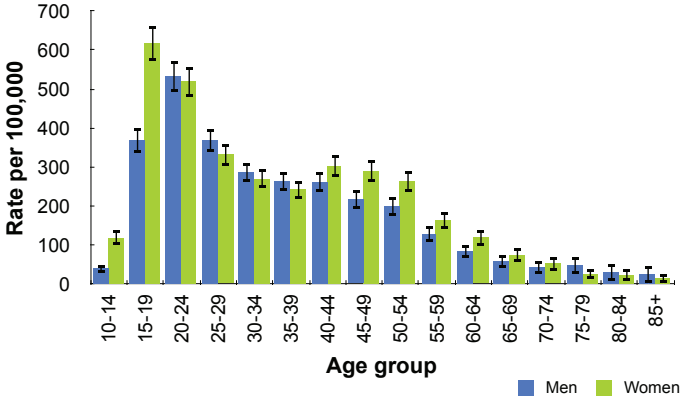
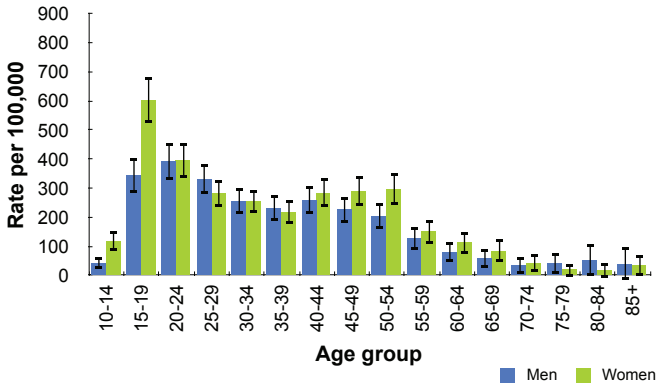


Figure 10: Person-based rate of deliberate self-harm in the Republic of Ireland in 2012 by age and gender.

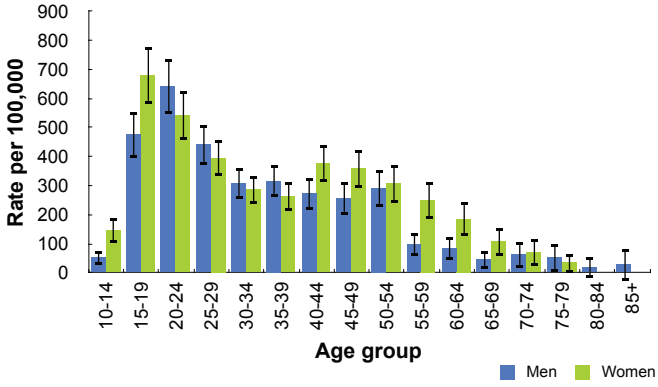
Gender differences in the incidence of deliberate self harm varied with age. The female rate was twice that of the male rate in 10-14 year-olds and 67% higher than the male rate in 15-19 year-olds. The female rate of deliberate self harm was again higher than the male rate across the 40-64 year age range. However, in 20-34 year-olds, the male rate was 11% higher than the female rate. Since 2009, the Registry has recorded a significantly higher rate of deliberate self harm in men in this age group compared to women.

In 2012, the only significant changes in the rate of hospital-treated deliberate self-harm by age were among males aged 15-19 and females aged 35-39. The male rate for those aged 15-19 fell by 14% from 2011, from 430 to 368 per 100,000. The female rate for those aged 35-39 fell by 13%, from 279 to 243 per 100,000. Rates of self-harm in other age groups remained similar to 2011.

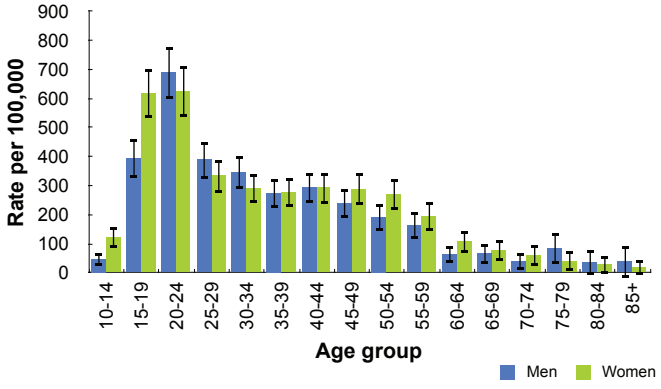
(a) HSE Dublin/ Mid-Leinster



(b) HSE Dublin/ North East



(c) HSE South



(d) HSE West

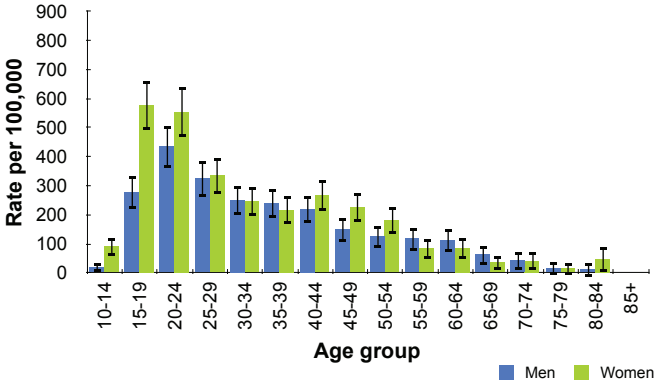


Figure 11: Person-based rate of deliberate self-harm in 2012 by residents of the four HSE regions by age and gender.

Figure 11 shows the incidence of deliberate 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 deliberate 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 South where the male and female self-harm rates among those aged 20-24 years were both higher.

Deliberate self-harm was rare in 10-14 year-olds, particularly for boys. However, the incidence of deliberate self-harm increased rapidly over a short age range. This is illustrated in greater detail in Figure 12. In 12-18 year-olds, the female rate of deliberate 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 21-year old men and 19 year-old women, with rates of 639 and 681 per 100,000, respectively.

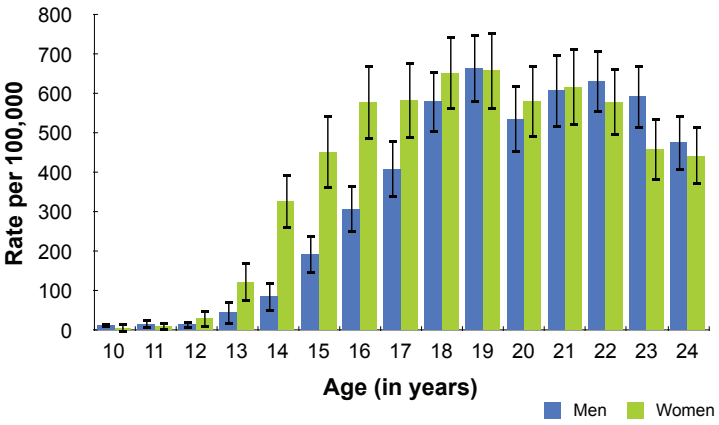


Figure 12: Person-based rate of deliberate self-harm in the Republic of Ireland in 2012 by single year of age for 10-24 year-olds.

VARIATION BY HSE REGION

The 17% higher incidence of deliberate self-harm for women compared to men varied by HSE region. The female rate of deliberate self-harm was significantly higher than the male rate in all HSE regions – by 10% in HSE South, 16% in Dublin/ North East, 20% in Dublin/ Mid-Leinster and 26% in HSE West.

In 2012, the incidence of male and female deliberate self-harm was significantly higher than the national rate in the HSE Dublin/ North East region (+17% for both men and women) and in the HSE South region for men (+13%; Table 10). The rate was significantly lower in the HSE Dublin/ Mid-Leinster region for both genders (-9% for men, -7% for women), and in the HSE West region (-18% for men, -12% for women).

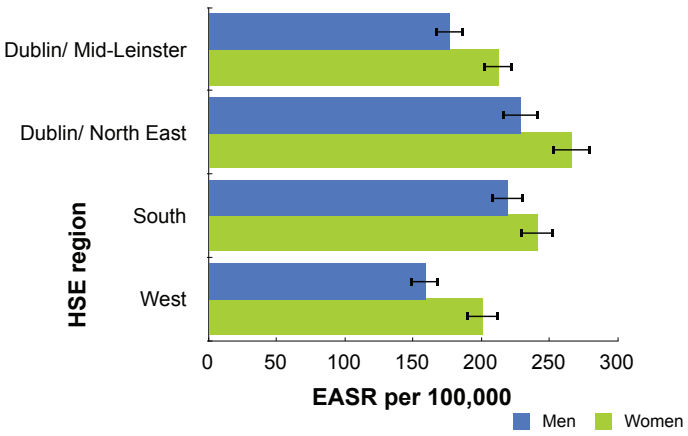


Figure 13: Person-based European age-standardised rate (EASR) of deliberate self-harm in the Republic of Ireland in 2012 by HSE region of residence and gender.

	Men					Women				
HSE Region	Rate	95% CI*	Rate difference**	95% CI***	% difference	Rate	95% CI*	Rate difference**	95% CI***	% difference
Dublin/ Mid-Leinster	**177.0**	**(+/-13)**	**-18**	**(+/-12)**	**-9.3**	**212.5**	**(+/-14)**	**-16**	**(+/-13)**	**-7.0**
Dublin/ North East	**228.8**	**(+/-12)**	**34**	**(+/-15)**	**17.3**	**266.2**	**(+/-13)**	**38**	**(+/-15)**	**16.5**
South	**219.5**	**(+/-11)**	**24**	**(+/-14)**	**12.5**	**241.3**	**(+/-12)**	**13**	**(+/-14)**	**5.6**
West	**159.2**	**(+/-10)**	**-36**	**(+/-12)**	**-18.4**	**201.1**	**(+/-11)**	**-27**	**(+/-13)**	**-12.0**
Ireland	**195.1**	**(+/-6)**				**228.4**	**(+/-6)**			

* 95% Confidence Interval for the HSE region deliberate self-harm rate.
** Rate difference = HSE region rate – national rate for men and women.
*** 95% Confidence Interval for deliberate self-harm rate difference.

Table 10: Person-based European age-standardised rate (EASR) of deliberate self-harm in the Republic of Ireland in 2012 by HSE region of residence and gender with comparison to the national rate.

HSE Region	Men 2012	Men 2011	Men Rate difference	Men 95% CI*	Men % difference	Women 2012	Women 2011	Women Rate difference	Women 95% CI*	Women % difference
Dublin/ Mid-Leinster	177.0	176.9	0	(+/-19)	0.0	212.5	214.8	-2	(+/-20)	-1.1
Dublin/ North East	228.8	224.0	5	(+/-18)	2.2	266.2	266.0	0	(+/-18)	0.1
South	219.5	248.0	-28	(+/-16)	-11.5	241.3	241.0	0	(+/-17)	0.1
West	159.2	179.0	-20	(+/-15)	-11.0	201.1	188.0	13	(+/-16)	6.9
Ireland	195.1	204.9	-10	(+/-8)	-4.8	228.42	225.9	3	(+/-9)	1.1

* 95% Confidence Interval for deliberate self harm rate difference.

Table 11: Person-based European age-standardised rate (EASR) of deliberate self-harm in the Republic of Ireland in 2012 and 2011 by HSE region of residence and gender.

The observed 1% increase in the national female rate of deliberate self-harm was primarily due to an increase of 7% in the HSE West region. The 5% decrease in the national male rate of deliberate self-harm was primarily due to decreases in the HSE South and West regions (-12% and -11%, respectively) (Table 11).

While the national rate of hospital-treated deliberate self-harm for males aged 15-19 years decreased by 14% in 2012, this pattern was due to changes in HSE South (-30%) and HSE West (-26%). The 13% reduction in the female rate of deliberate self-harm in those aged 35-39 years was also observed to varying degrees across the HSE regions. There was a decrease of just 3% in HSE South, 12% in Dublin/ Mid-Leinster, 17% in HSE West and 20% in HSE Dublin/ North East. The observed 4% decrease in the national female rate of deliberate self harm was primarily due to a 14% decrease in the HSE West region. The 3% decrease in the national male rate of deliberate self harm was observed in all but the HSE Dublin/ North East region (Table 11).

URBAN AND RURAL DISTRICT COMPARISON BY HSE REGION

Figure 14 illustrates the deliberate 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 deliberate self-harm was 320 per 100,000 for residents of urban districts which was more than twice (+109%) the incidence rate of 153 per 100,000 among residents of rural districts. In each HSE region, the incidence of deliberate self-harm was significantly higher in the urban district population. Compared to rural district populations, the deliberate self-harm rate was 103%, 124% and 187% higher in the urban district populations of the HSE regions of South, Dublin/ Mid-Leinster and West, respectively. The difference was far less pronounced in the HSE Dublin/ North East where the urban district population had a 26% higher rate.

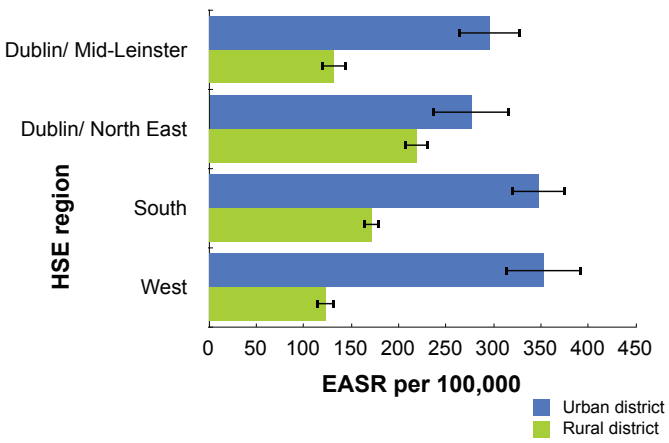


Figure 14: Person-based European age-standardised rate (EASR) of deliberate self-harm in 2011 for urban and rural district residents by HSE region.

RATE BY CITY AND COUNTY

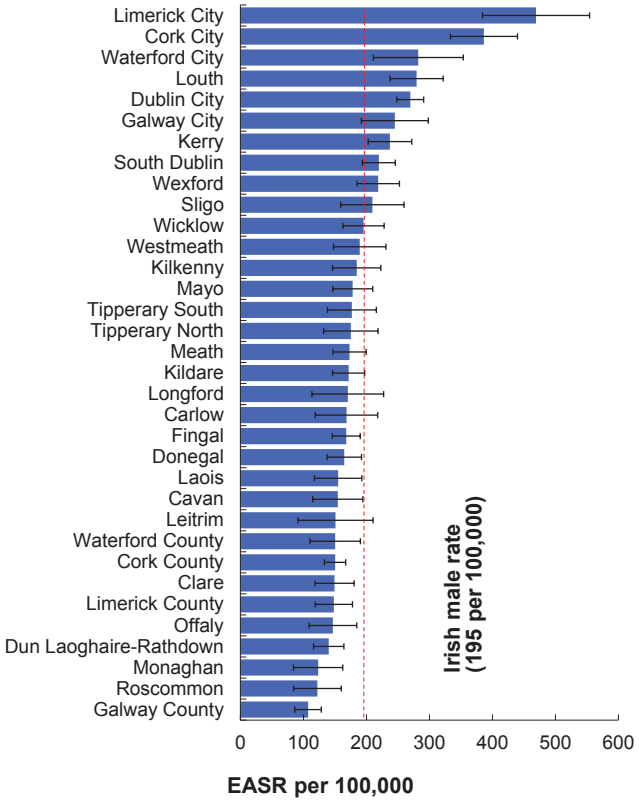


Figure 14a: Person-based European age-standardised rate (EASR) of deliberate self-harm in the Republic of Ireland in 2012 by city/county of residence for men.

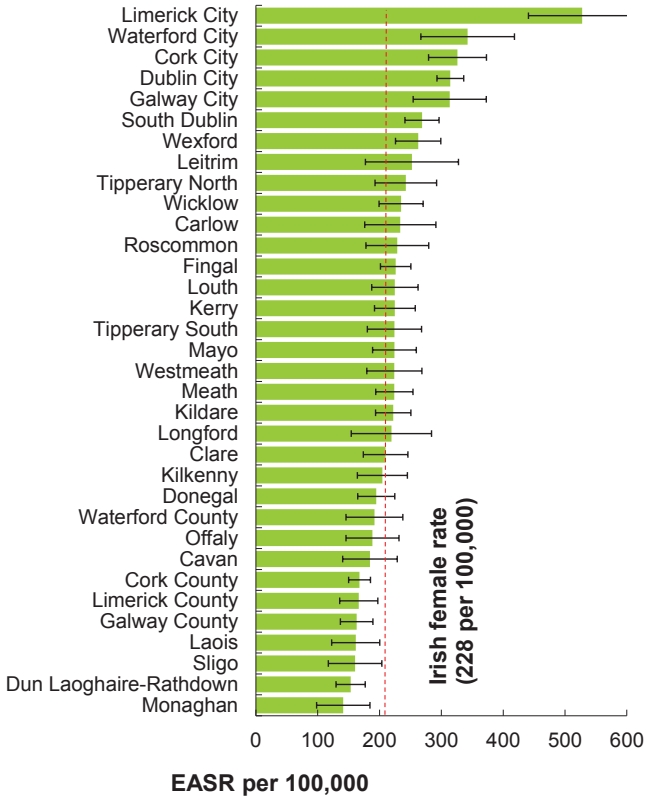


Figure 14b: Person-based European age-standardised rate (EASR) of deliberate self-harm in the Republic of Ireland in 2012 by city/county of residence for women.

There was widespread variation in the male and female deliberate self-harm rate when examined by city/county of residence. The male rate varied from 107 per 100,000 for Galway County to 469 per 100,000 for Limerick City. The lowest and highest female rate was recorded for Monaghan and Limerick City residents at 141 and 528 per 100,000, respectively. Relative to the national rate, a high rate of deliberate self-harm was recorded for male and female city residents and for men living in Louth and Kerry and for women living in South Dublin, Wexford and Leitrim. In 2012 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 almost twice the national average and the female rate was 43% higher than the national average.

At a national level, the female deliberate self-harm rate exceeded the male rate by 17%. The magnitude of this gender difference varied by city/county. The female rate far exceeded the male rate in Roscommon (+87%), Leitrim (+67%), Galway County (+52%) and Clare (+40%). The opposite pattern of a significantly higher male rate was observed in Sligo (-23%), Louth (-20%) and Cork City (-16%).

Between 2011 and 2012, the national rate of hospital-treated deliberate self-harm decreased by 5% for men, while it increased by 1% for women. The most notable decreases among men were observed in Galway County (-26%), Cavan (-25%), Carlow (-24%), Limerick County (-23%), Cork City (-20%) and county (-19%) and in Tipperary South (-19%), while increases were observed in Longford (+34%) and Leitrim (+46%). The female rate fell significantly in Carlow (-18%), Laois (-22%) and Cavan (-18%). Significant increases in the female rate of self-harm were observed in Limerick City (+27%), Leitrim (+65%) and Roscommon (+68%). The rate of self-harm among female Waterford City

residents increased two-fold (+106%) in 2012 – from a rate of 166 per 100,000 in 2011 to 342 per 100,000 in 2012.

There were significant year-to-year increases in the rate of hospital-treated deliberate self in Ireland since the advent of the economic recession in 2008. Despite the decrease in 2012, the overall rate has increased by 12% since 2007, from 188 to 211 per 100,000. The male rate has increased by 20% from 162 to 195 per 100,000 and the female rate has increased by 6% from 215 to 228 per 100,000. Figures 15a and 15b illustrate, for each county and city, the percentage change in the rate of hospital-treated self-harm from 2007 to 2012.

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

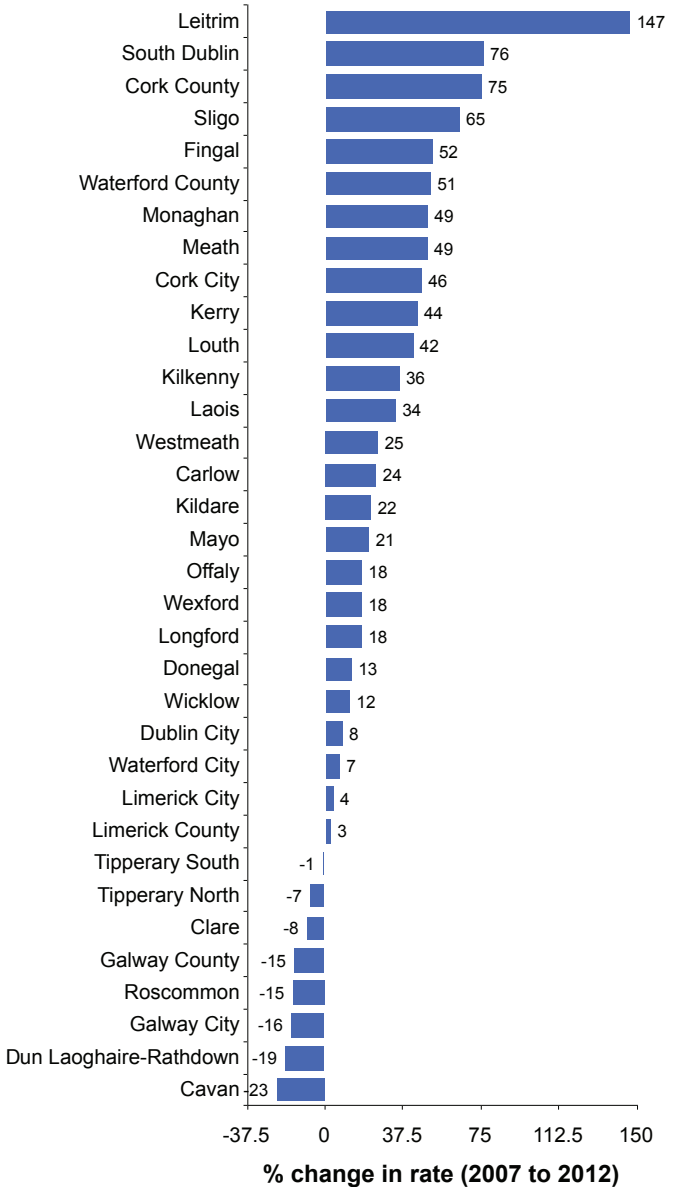


Figure 15a: Percentage change from 2007 to 2012 in the person-based European age-standardised rate of deliberate self-harm in the Republic of Ireland by city/county of residence for men.

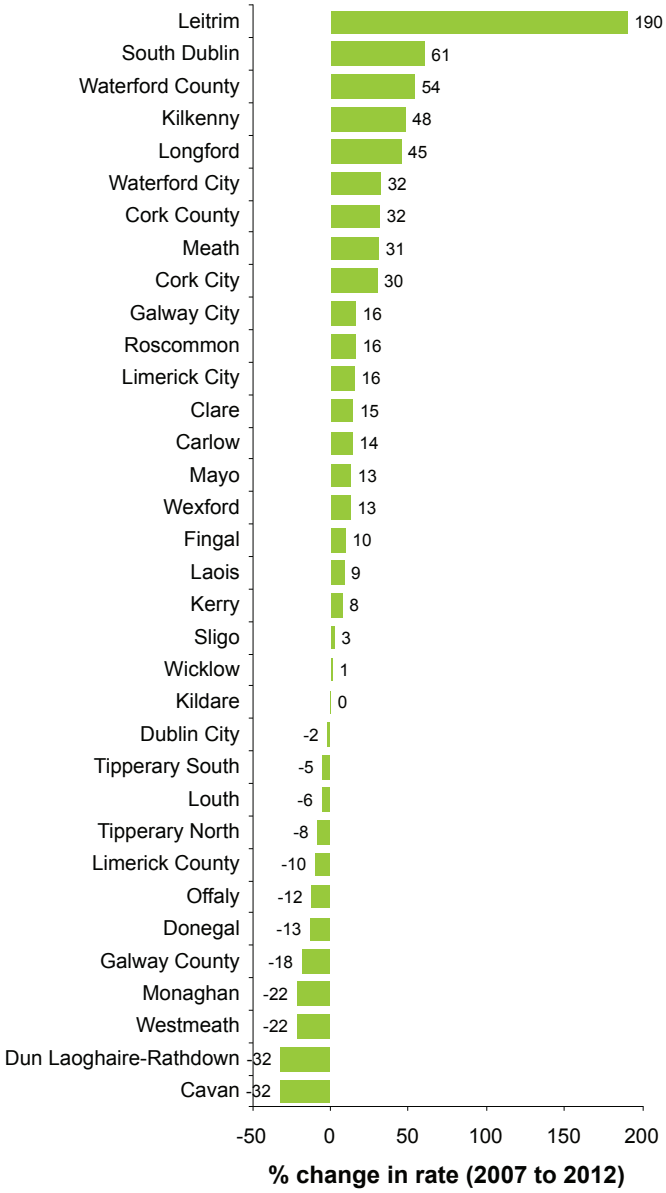


Figure 15b: Percentage change from 2007 to 2012 in the person-based European age-standardised rate of deliberate self-harm in the Republic of Ireland by city/county of residence for women.

RATE BY HSE LOCAL HEALTH OFFICE

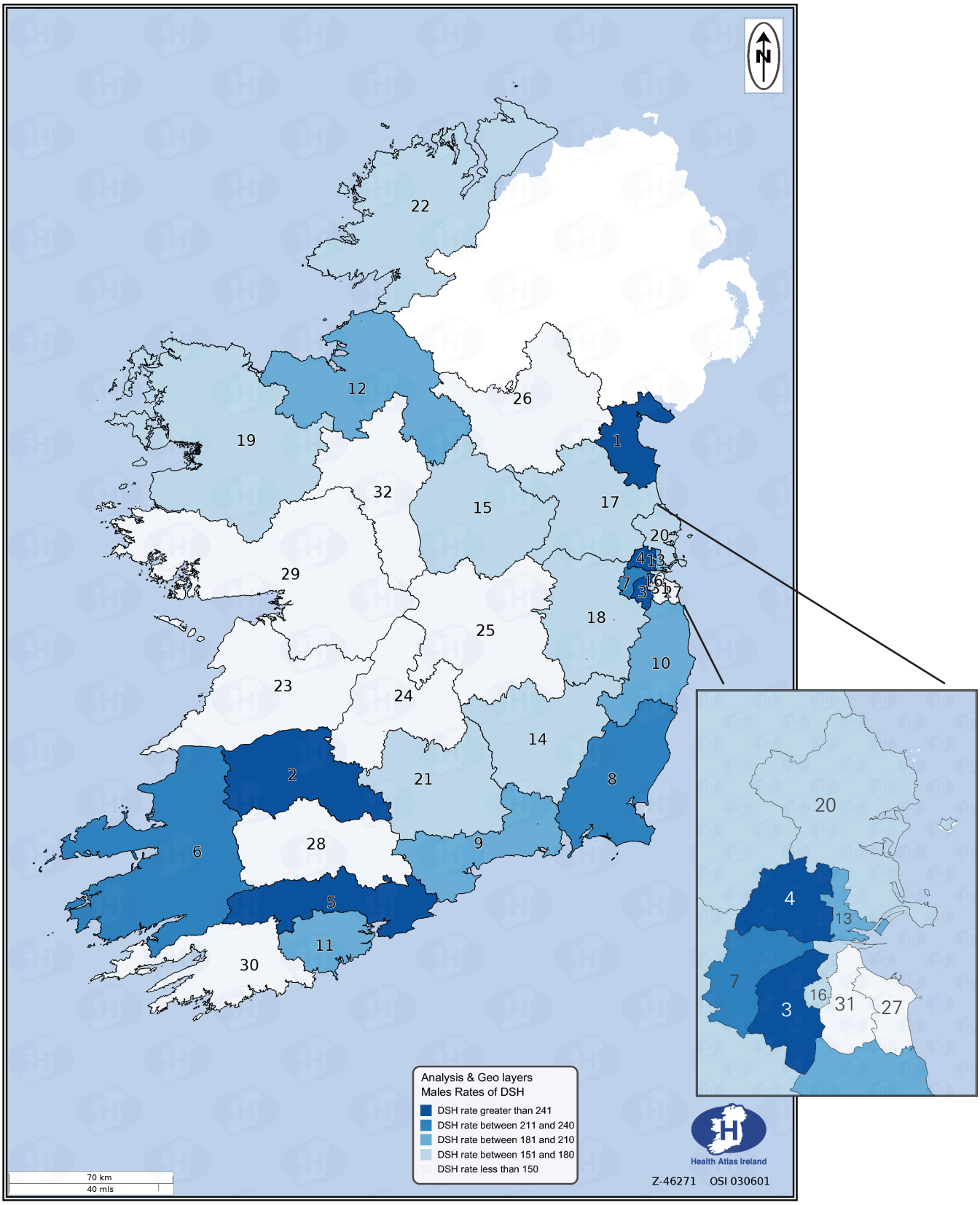
For 2012, Table 12 details the population (derived by the National Census 2011), number of men and women who presented to hospital as a result of deliberate self-harm and the incidence rate (age-adjusted to the European standard population) for each LHO area. Thematic maps are also provided to illustrate the variation in the male and female incidence of hospital-treated deliberate self-harm by LHO area.

There was approximately a threefold difference in the rate of deliberate self-harm when examined by LHO area. The rate for men ranged from 91 per 100,000 in Roscommon to 268 in Louth and for women ranged from 1123 per 100,000 in Dublin South East to 320 per 100,000 in Dublin West. The male rate exceeded 240 per 100,000 for Limerick, Dublin South West, Dublin North West and Cork North Lee. Four of the eight Dublin LHO areas (Dublin South West, Dublin West, Dublin North Central and Dublin North West) had the highest female rate of deliberate self-harm, along with Limerick, Cork North Lee, Wexford and Waterford.

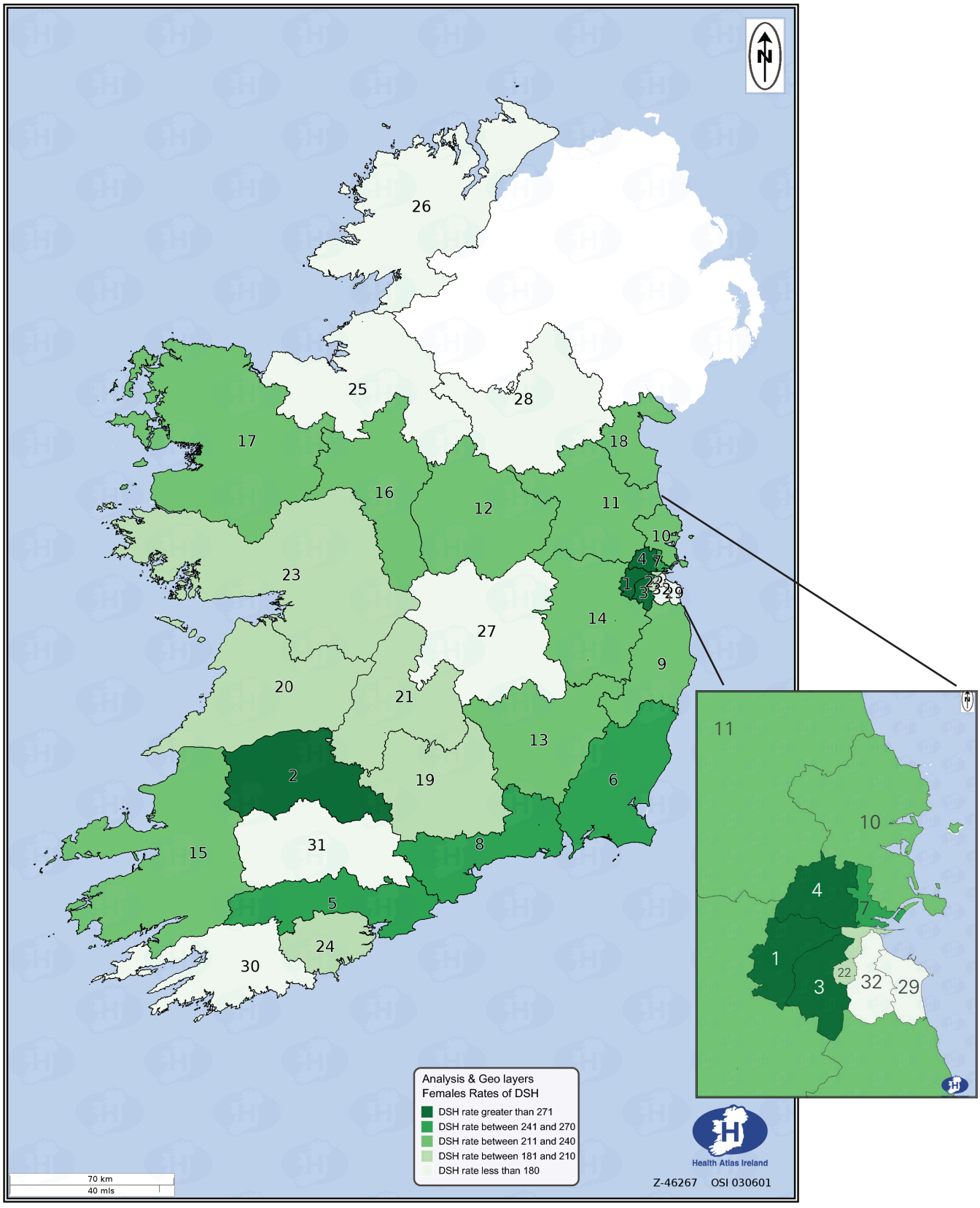
	HSE Region and LHO	Men				Women			
		Population*	Deliberate self harm			Population*	Deliberate self harm		
			Persons	Rate**	Rank		Persons	Rate**	Rank
DUBLIN MID LEINSTER	Dublin South City	69042	127	172	16	71143	150	191	22
	Dublin South East	57530	64	106	31	62502	77	123	32
	Dublin South West	75078	195	258	3	79393	219	286	3
	Dublin West	72067	166	221	7	74265	234	320	1
	Kildare/West Wicklow	113750	191	166	18	114660	251	221	14
	Laois/Offaly	79017	109	143	25	78229	131	175	27
	Longford/Westmeath	62432	109	177	15	62732	136	223	12
	Dun Laoghaire	62008	86	138	27	68555	103	153	29
	Wicklow	58450	109	194	10	60092	136	235	9
DUBLIN NORTH EAST	Cavan/Monaghan	66734	89	139	26	65639	102	159	28
	Dublin North	119057	196	163	20	125305	280	232	10
	Dublin North Central	66320	137	184	13	69059	183	257	7
	Dublin North West	98800	259	245	4	102945	284	281	4
	Louth	60763	160	267	1	62134	128	211	18
	Meath	91910	147	167	17	92225	199	226	11
SOUTH	Carlow/Kilkenny	65251	114	179	14	65064	140	222	13
	Cork North	44889	55	133	28	44642	54	132	31
	Cork North Lee	90708	221	243	5	91094	231	261	5
	Cork South Lee	93436	180	187	11	97733	180	182	24
	Cork West	28437	29	113	30	28093	38	146	30
	Kerry	72629	152	225	6	72873	145	221	15
	Tipperary South	47156	71	158	21	46980	94	210	19
	Waterford	63520	123	201	9	64287	154	252	8
	Wexford	71909	146	217	8	73411	180	260	6
WEST	Clare	58298	81	144	23	58898	108	196	20
	Donegal	80523	117	155	22	80614	135	178	26
	Galway	124758	158	124	29	125895	238	188	23
	Limerick	76749	204	262	2	77638	219	286	2
	Mayo	65420	100	164	19	65218	126	212	17
	Tipperary North/East Limerick	54406	79	144	24	53338	101	191	21
	Roscommon	32353	28	91	32	31712	61	213	16
	Sligo/Leitrim/West Cavan	49299	88	184	12	49185	83	179	25

* Population derived by the National Census 2006 ** Person-based European age-standardised rate per 100,000 population

Table 12: Deliberate self-harm in 2012 by HSE Local Health Office (LHO) area of residence and gender



Map 3: Person-based European age-standardised rate (EASR) of deliberate self-harm in the Republic of Ireland in 2012 by HSE Local Health Office area for men (Numbers indicate rank of rate from 1 for highest to 32 for lowest)



Map 4: Person-based European age-standardised rate (EASR) of deliberate self-harm in the Republic of Ireland in 2012 by HSE Local Health Office area for women (Numbers indicate rank of rate from 1 for highest to 32 for lowest)

Appendices

APPENDIX 1: HOSPITAL-TREATED EPISODES OF DELIBERATE SELF-HARM IN THE REPUBLIC OF IRELAND BY HSE REGION AND HOSPITALS GROUP, 2012

HSE Region	Dublin/ Mid-Leinster				Dublin/ North East				South				West				Republic of Ireland	
Hospitals Group	Dublin/ Midlands		Dublin South		Dublin North East		North Eastern		South Eastern		Southern		Mid-Western		West/ North Western			
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
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	0	0	0	0	0	0	<5	0	0	0	0	0	<5
10-14yrs	21	50	<5	<5	17	47	<5	15	8	20	10	28	5	7	<5	33	69	201
15-19yrs	116	172	54	112	102	147	52	63	71	102	96	150	50	91	85	169	626	1006
20-24yrs	101	114	112	128	145	152	83	45	102	108	173	142	62	101	123	131	901	921
25-29yrs	121	123	108	106	136	154	57	59	67	77	100	96	85	78	97	109	771	802
30-34yrs	107	101	108	106	128	126	58	55	78	107	99	63	54	65	70	85	702	708
35-39yrs	68	78	104	72	110	98	58	42	61	66	81	80	51	47	80	81	613	564
40-44yrs	97	114	99	73	93	138	58	58	63	70	98	74	44	57	74	94	626	678
45-49yrs	61	106	65	78	72	89	31	51	40	60	71	86	26	49	45	68	411	587
50-54yrs	44	82	75	66	78	66	43	29	34	50	52	65	20	30	34	57	380	445
55-59yrs	21	48	33	30	13	40	14	21	27	31	32	39	14	14	30	21	184	244
60-64yrs	12	22	21	26	14	38	7	15	11	14	13	14	20	18	20	12	118	159
65-69yrs	7	9	10	15	<5	25	5	6	10	7	10	13	<5	5	13	6	60	86
70-74yrs	5	9	<5	<5	<5	<5	<5	<5	<5	7	6	<5	<5	<5	<5	9	28	41
75-79yrs	<5	0	<5	<5	<5	<5	<5	<5	6	0	5	6	<5	<5	<5	<5	26	18
80-84yrs	<5	<5	<5	0	<5	0	0	0	0	0	<5	<5	0	<5	<5	<5	9	13
85yrs+	<5	0	<5	<5	<5	0	0	0	0	0	<5	<5	0	0	0	0	6	6
Total	*784*	*1030*	*799*	*824*	*922*	*1128*	*477*	*464*	*579*	*719*	*852*	*867*	*435*	*568*	*682*	*880*	*5530*	*6480*

APPENDIX 1A: HOSPITAL-TREATED EPISODES OF DELIBERATE SELF-HARM IN THE HSE DUBLIN/MIDLANDS HOSPITALS GROUP, 2012

	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	
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
<15yrs	9	22	<5	<5	<5	<5	<5	<5	<5	<5	6	19
15-19yrs	53	92	16	15	7	12	<5	7	32	32	<5	14
20-24yrs	39	38	11	6	15	21	8	16	28	33	0	0
25-34yrs	95	93	31	28	27	25	19	13	56	65	0	0
35-44yrs	60	72	22	31	12	16	11	16	60	57	0	0
45-54yrs	48	65	22	27	8	22	13	21	14	53	0	0
55-64yrs	14	19	<5	15	6	<5	<5	11	6	21	0	0
65yrs+	<5	10	<5	<5	<5	<5	<5	<5	5	<5	0	0
Total	*321*	*411*	*112*	*127*	*78*	*102*	*61*	*88*	*202*	*269*	*10*	*33*

APPENDIX 1B: HOSPITAL-TREATED EPISODES OF DELIBERATE SELF-HARM IN THE HSE DUBLIN SOUTH HOSPITALS GROUP, 2012

	St Columcille's Hospital, Loughlinstown		St James's Hospital		St Michael's Hospital, Dun Laoghaire		Other	
	Male	Female	Male	Female	Male	Female	Male	Female
<15yrs	0	<5	0	0	0	0	<5	0
15-19yrs	22	41	24	39	<5	0	7	32
20-24yrs	32	17	51	83	<5	0	27	28
25-34yrs	58	33	115	122	<5	<5	42	54
35-44yrs	41	44	126	67	0	<5	36	33
45-54yrs	25	37	79	62	<5	5	35	40
55-64yrs	13	16	19	22	<5	0	20	18
65yrs+	5	5	6	9	<5	0	5	12
Total	*196*	*194*	*420*	*404*	*10*	*9*	*173*	*217*

APPENDIX 1C: HOSPITAL-TREATED EPISODES OF DELIBERATE SELF-HARM IN THE HSE DUBLIN NORTH EAST HOSPITALS GROUP, 2012

	Beaumont Hospital		Children's University Hospital, Temple Street		James Connolly Hospital, Blanchardstown		Mater Misericordiae University Hospital	
	Male	Female	Male	Female	Male	Female	Male	Female
<15yrs	0	<5	16	45	<5	<5	0	0
15-19yrs	29	46	6	31	35	30	32	40
20-24yrs	34	42	0	<5	50	51	61	58
25-34yrs	64	89	0	0	83	88	117	103
35-44yrs	64	84	0	0	62	66	77	86
45-54yrs	31	61	0	0	42	43	77	51
55-64yrs	7	42	0	0	8	21	12	15
65yrs+	<5	14	0	0	<5	11	6	8
Total	*233*	*379*	*22*	*77*	*285*	*311*	*382*	*361*

APPENDIX 1D: HOSPITAL-TREATED EPISODES OF DELIBERATE SELF-HARM IN THE HSE NORTH EASTERN HOSPITALS GROUP, 2012

	Cavan General Hospital		Our Lady of Lourdes Hospital, Drogheda		Our Lady's Hospital, Navan	
	Male	Female	Male	Female	Male	Female
<15yrs	<5	6	<5	5	0	<5
15-19yrs	12	19	31	31	9	13
20-24yrs	8	<5	57	26	18	17
25-34yrs	31	20	64	67	20	27
35-44yrs	14	20	76	49	26	31
45-54yrs	21	15	35	42	18	23
55-64yrs	10	7	5	21	6	8
65yrs+	<5	<5	8	<5	<5	6
Total	*100*	*93*	*278*	*242*	*99*	*129*

APPENDIX 1E: HOSPITAL-TREATED EPISODES OF DELIBERATE SELF-HARM IN THE HSE SOUTH EASTERN HOSPITALS GROUP, 2012

	St Luke's General Hospital, Kilkenny		South Tipperary General Hospital		Waterford Regional Hospital		Wexford General Hospital	
	Male	Female	Male	Female	Male	Female	Male	Female
<15yrs	0	<5	<5	<5	<5	11	<5	6
15-19yrs	23	28	12	18	26	32	10	24
20-24yrs	25	19	15	20	38	37	24	32
25-34yrs	34	41	33	51	49	42	29	50
35-44yrs	23	36	18	22	43	39	40	39
45-54yrs	17	26	8	18	16	29	33	37
55-64yrs	15	13	11	7	5	7	7	18
65yrs+	<5	<5	<5	0	5	8	7	<5
Total	*141*	*168*	*100*	*137*	*186*	*205*	*152*	*209*

APPENDIX 1F: HOSPITAL-TREATED EPISODES OF DELIBERATE SELF-HARM IN THE HSE SOUTHERN HOSPITALS GROUP, 2012

	Bantry General Hospital		Cork University Hospital		Kerry General Hospital		Mallow General Hospital		Mercy University Hospital, Cork	
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
<15yrs	0	<5	6	17	<5	5	0	0	<5	6
15-19yrs	<5	<5	44	55	26	48	<5	<5	22	42
20-24yrs	<5	6	56	41	40	37	<5	<5	72	56
25-34yrs	<5	<5	73	53	51	24	<5	<5	67	78
35-44yrs	8	<5	57	51	45	31	8	<5	61	65
45-54yrs	<5	8	42	42	23	36	<5	5	52	60
55-64yrs	5	<5	18	15	6	10	<5	0	15	27
65yrs+	<5	<5	11	13	8	5	<5	<5	5	7
Total	*25*	*27*	*307*	*287*	*200*	*196*	*23*	*16*	*297*	*341*

APPENDIX 1G: HOSPITAL-TREATED EPISODES OF DELIBERATE SELF-HARM IN THE HSE MID-WESTERN HOSPITALS GROUP, 2012

	Mid-Western Regional Hospital, Ennis		Mid-Western Regional Hospital, Limerick		Mid-Western Regional Hospital, Nenagh		St John's Hospital, Limerick	
	Male	Female	Male	Female	Male	Female	Male	Female
<15yrs	0	<5	5	6	0	0	0	0
15-19yrs	<5	9	45	80	<5	<5	0	0
20-24yrs	<5	9	59	85	<5	5	0	<5
25-34yrs	14	13	119	122	5	6	<5	<5
35-44yrs	7	12	81	89	5	<5	<5	<5
45-54yrs	<5	8	42	69	<5	<5	<5	0
55-64yrs	<5	<5	29	25	<5	<5	<5	0
65yrs+	0	<5	<5	8	0	<5	0	0
Total	*29*	*56*	*384*	*484*	*16*	*22*	*6*	*6*

APPENDIX 1H: HOSPITAL-TREATED EPISODES OF DELIBERATE SELF-HARM IN THE HSE WEST/NORTH WESTERN HOSPITALS GROUP, 2012

	Letterkenny General Hospital		Mayo General Hospital		Portiuncula Hospital, Ballinasloe		Sligo General Hospital		University College Hospital, Galway	
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
<15yrs	<5	6	<5	6	0	<5	0	13	<5	6
15-19yrs	23	17	16	35	7	21	10	28	29	68
20-24yrs	29	25	24	29	8	10	23	23	39	44
25-34yrs	28	39	30	42	18	34	36	18	55	61
35-44yrs	35	36	27	39	16	18	29	40	47	42
45-54yrs	17	30	13	27	5	18	20	31	24	19
55-64yrs	8	<5	14	12	5	6	7	5	16	6
65yrs+	<5	0	7	<5	0	<5	<5	5	7	9
Total	*143*	*157*	*132*	*193*	*59*	*112*	*129*	*163*	*219*	*255*

APPENDIX 2A: RECOMMENDED NEXT CARE BY HOSPITAL IN THE HSE DUBLIN/ MIDLANDS HOSPITALS GROUP, 2012

	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
	(n=732)	(n=239)	(n=180)	(n=149)	(n=471)	(n=43)
General admission	34.4%	66.1%	48.9%	46.3%	17.8%	86%
Psychiatric admission	7.7%	7.5%	12.8%	13.4%	10%	0%
Patient would not allow admission	1.1%	0.4%	0%	0%	2.3%	0%
Left before recommendation	7.7%	10.5%	12.8%	9.4%	19.7%	0%
Not admitted	49.2%	15.5%	25.6%	30.9%	50.1%	14%

APPENDIX 2B: RECOMMENDED NEXT CARE BY HOSPITAL IN THE HSE DUBLIN SOUTH HOSPITALS GROUP, 2012

	St Columcille's Hospital, Loughlinstown	St James's Hospital	St Michael's Hospital, Dun Laoghaire	Other
	(n=390)	(n=824)	(n=19)	(n=390)
General admission	23.6%	14%	36.8%	15.1%
Psychiatric admission	13.8%	18.9%	15.8%	20%
Patient would not allow admission	0.5%	0.4%	0%	0%
Left before recommendation	13.6%	19.2%	5.3%	8.2%
Not admitted	48.5%	47.6%	42.1%	56.7%

APPENDIX 2C: RECOMMENDED NEXT CARE BY HOSPITAL IN THE HSE DUBLIN NORTH EAST HOSPITALS GROUP, 2012

	Beaumont Hospital	Children's University Hospital, Temple Street	James Connolly Hospital, Blanchardstown	Mater Misericordiae University Hospital
	(n=612)	(n=99)	(n=596)	(n=743)
General admission	11.1%	58.6%	10.4%	13.1%
Psychiatric admission	0.3%	0%	19.6%	12.8%
Patient would not allow admission	0.5%	0%	2.3%	0%
Left before recommendation	14.4%	1%	21.5%	23.1%
Not admitted	73.7%	40.4%	46.1%	51%

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 2D: RECOMMENDED NEXT CARE BY HOSPITAL IN THE HSE NORTH EASTERN HOSPITALS GROUP, 2012

	Cavan General Hospital	Our Lady of Lourdes Hospital, Drogheda	Our Lady's Hospital, Navan
	(n=193)	(n=520)	(n=228)
General admission	34.7%	12.7%	31.6%
Psychiatric admission	6.2%	0.4%	4.4%
Patient would not allow admission	0%	0.2%	0%
Left before recommendation	18.1%	13.5%	12.7%
Not admitted	40.9%	73.3%	51.3%

APPENDIX 2E: RECOMMENDED NEXT CARE BY HOSPITAL IN THE HSE SOUTH EASTERN HOSPITALS GROUP, 2012

	St Luke's General Hospital, Kilkenny	South Tipperary General Hospital	Waterford Regional Hospital	Wexford General Hospital
	(n=309)	(n=237)	(n=391)	(n=361)
General admission	61.2%	32.9%	24.6%	65.1%
Psychiatric admission	7.8%	7.2%	15.3%	0.3%
Patient would not allow admission	5.5%	2.5%	5.1%	3.6%
Left before recommendation	7.4%	3.8%	6.4%	6.1%
Not admitted	18.1%	53.6%	48.6%	24.9%

APPENDIX 2F: RECOMMENDED NEXT CARE BY HOSPITAL IN THE HSE SOUTHERN HOSPITALS GROUP, 2012

	Bantry General Hospital	Cork University Hospital	Kerry General Hospital	Mallow General Hospital	Mercy University Hospital, Cork
	(n=52)	(n=594)	(n=396)	(n=39)	(n=638)
General admission	38.5%	33.3%	23%	33.3%	8.6%
Psychiatric admission	13.5%	1.2%	23.7%	0%	10.3%
Patient would not allow admission	5.8%	2.4%	5.6%	0%	3.3%
Left before recommendation	1.9%	3.7%	7.1%	0%	12.5%
Not admitted	40.4%	59.4%	40.7%	66.7%	65.2%

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 2G: RECOMMENDED NEXT CARE BY HOSPITAL IN THE HSE MID-WESTERN HOSPITALS GROUP, 2012

	Mid-Western Regional Hospital, Ennis	Mid-Western Regional Hospital, Limerick	Mid-Western Regional Hospital, Nenagh	St John's Hospital, Limerick
	(n=85)	(n=868)	(n=38)	(n=12)
General admission	36.5%	46.3%	78.9%	41.7%
Psychiatric admission	30.6%	7.5%	5.3%	0%
Patient would not allow admission	3.5%	5.9%	2.6%	8.3%
Left before recommendation	5.9%	13.4%	2.6%	16.7%
Not admitted	23.5%	27%	10.5%	33.3%

APPENDIX 2H: RECOMMENDED NEXT CARE BY HOSPITAL IN THE HSE WEST/ NORTH WESTERN HOSPITALS GROUP, 2012

	Letterkenny General Hospital	Mayo General Hospital	Portiuncula Hospital, Ballinasloe	Sligo General Hospital	University College Hospital, Galway
	(n=300)	(n=325)	(n=171)	(n=292)	(n=474)
General admission	41%	21.8%	48.5%	24%	14.3%
Psychiatric admission	17.3%	12.6%	1.2%	6.5%	13.3%
Patient would not allow admission	2%	8.9%	5.3%	5.5%	9.5%
Left before recommendation	4.3%	8.9%	7%	1.4%	9.5%
Not admitted	34%	47.7%	37.4%	62.7%	53.4%

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 3A: REPETITION BY GENDER AND HOSPITAL FOR INDIVIDUALS TREATED IN THE HSE DUBLIN/MIDLANDS HOSPITALS GROUP, 2012

		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	260	98	67	55	177	8
	Women	349	118	83	80	203	32
	Total	*609*	*216*	*150*	*135*	*380*	*40*
Number who repeated	Men	45	11	7	4	20	2
	Women	55	10	9	8	31	1
	Total	*100*	*21*	*16*	*12*	*51*	*3*
Percentage who repeated	Men	17.3%	11.2%	10.4%	7.3%	11.3%	25%
	Women	15.8%	8.5%	10.8%	10%	15.3%	3.1%
	Total	*16.4%*	*9.7%*	*10.7%*	*8.9%*	*13.4%*	*7.5%*

APPENDIX 3B: REPETITION BY GENDER AND HOSPITAL FOR INDIVIDUALS TREATED IN THE HSE DUBLIN SOUTH HOSPITALS GROUP, 2012

		St Columcille's Hospital, Loughlinstown	St James's Hospital	St Michael's Hospital, Dun Laoghaire	Other
Number of individuals treated	Men	162	311	10	139
	Women	170	324	7	180
	Total	*332*	*635*	*17*	*319*
Number who repeated	Men	23	68	4	26
	Women	27	56	3	34
	Total	*50*	*124*	*7*	*60*
Percentage who repeated	Men	14.2%	21.9%	40%	18.7%
	Women	15.9%	17.3%	42.9%	18.9%
	Total	*15.1%*	*19.5%*	*41.2%*	*18.8%*

APPENDIX 3C: REPETITION BY GENDER AND HOSPITAL FOR INDIVIDUALS TREATED IN THE HSE DUBLIN NORTH EAST HOSPITALS GROUP, 2012

		Beaumont Hospital	Children's University Hospital, Temple Street	James Connolly Hospital,	Mater Misericordiae University Hospital
Number of individuals treated	Men	213	20	244	303
	Women	294	67	266	281
	Total	*507*	*87*	*510*	*584*
Number who repeated	Men	22	2	39	65
	Women	36	11	35	70
	Total	*58*	*13*	*74*	*135*
Percentage who repeated	Men	10.3%	10%	16%	21.5%
	Women	12.2%	16.4%	13.2%	24.9%
	Total	*11.4%*	*14.9%*	*14.5%*	*23.1%*

APPENDIX 3D: REPETITION BY GENDER AND HOSPITAL FOR INDIVIDUALS TREATED IN THE HSE NORTH EASTERN HOSPITALS GROUP, 2012

		Cavan General Hospital	Our Lady of Lourdes Hospital, Drogheda	Our Lady's Hospital, Navan
Number of individuals treated	Men	87	221	87
	Women	86	216	112
	Total	*173*	*437*	*199*
Number who repeated	Men	14	35	9
	Women	6	29	13
	Total	*20*	*64*	*22*
Percentage who repeated	Men	16.1%	15.8%	10.3%
	Women	7%	13.4%	11.6%
	Total	*11.6%*	*14.6%*	*11.1%*

APPENDIX 3E: REPETITION BY GENDER AND HOSPITAL FOR INDIVIDUALS TREATED IN THE HSE SOUTH EASTERN HOSPITALS GROUP, 2012

		St Luke's General Hospital, Kilkenny	South Tipperary General Hospital	Waterford Regional Hospital	Wexford General Hospital
Number of individuals treated	Men	113	81	158	128
	Women	149	101	179	164
	Total	*262*	*182*	*337*	*292*
Number who repeated	Men	20	14	25	16
	Women	18	18	24	25
	Total	*38*	*32*	*49*	*41*
Percentage who repeated	Men	17.7%	17.3%	15.8%	12.5%
	Women	12.1%	17.8%	13.4%	15.2%
	Total	*14.5%*	*17.6%*	*14.5%*	*14%*

APPENDIX 3F: REPETITION BY GENDER AND HOSPITAL FOR INDIVIDUALS TREATED IN THE HSE SOUTHERN HOSPITALS GROUP, 2012

		Bantry General Hospital	Cork University Hospital	Kerry General Hospital	Mallow General Hospital	Mercy University Hospital, Cork
Number of individuals treated	Men	23	271	161	22	239
	Women	23	250	152	15	253
	Total	*46*	*521*	*313*	*37*	*492*
Number who repeated	Men	2	27	24	3	48
	Women	1	39	24	2	44
	Total	*3*	*66*	*48*	*5*	*92*
Percentage who repeated	Men	8.7%	10%	14.9%	13.6%	20.1%
	Women	4.3%	15.6%	15.8%	13.3%	17.4%
	Total	*6.5%*	*12.7%*	*15.3%*	*13.5%*	*18.7%*

APPENDIX 3G: REPETITION BY GENDER AND HOSPITAL FOR INDIVIDUALS TREATED IN THE HSE MID-WESTERN HOSPITALS GROUP, 2012

		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	27	323	14	5
	Women	48	379	20	6
	Total	*75*	*702*	*34*	*11*
Number who repeated	Men	2	48	2	2
	Women	12	74	4	1
	Total	*14*	*122*	*6*	*3*
Percentage who repeated	Men	7.4%	14.9%	14.3%	40%
	Women	25%	19.5%	20%	16.7%
	Total	*18.7%*	*17.4%*	*17.6%*	*27.3%*

APPENDIX 3H: REPETITION BY GENDER AND HOSPITAL FOR INDIVIDUALS TREATED IN THE HSE WEST/ NORTH WESTERN HOSPITALS GROUP, 2012

		Letterkenny General Hospital	Mayo General Hospital	Portiuncula Hospital, Ballinasloe	Sligo General Hospital	University College Hospital, Galway
Number of individuals treated	Men	112	113	51	106	171
	Women	129	138	102	123	222
	Total	*241*	*251*	*153*	*229*	*393*
Number who repeated	Men	20	13	10	15	30
	Women	21	22	14	29	29
	Total	*41*	*35*	*24*	*44*	*59*
Percentage who repeated	Men	17.9%	11.5%	19.6%	14.2%	17.5%
	Women	16.3%	15.9%	13.7%	23.6%	13.1%
	Total	*17%*	*13.9%*	*15.7%*	*19.2%*	*15%*

APPENDIX 4: DELIBERATE SELF-HARM BY RESIDENTS OF THE REPUBLIC OF IRELAND, 2012

Age group	Men				Women			
	Population	Deliberate self harm			Population	Deliberate self harm		
		Persons	Rate	95% CI*		Persons	Rate	95% CI*
0-4yrs	186100	0	0	(+/-0)	178600	0	0	(+/-0)
5-9yrs	166000	0	0	(+/-0)	158800	1	1	(+/-1)
10-14yrs	156300	63	40	(+/-10)	149100	177	119	(+/-18)
15-19yrs	141400	521	368	(+/-32)	134500	830	617	(+/-43)
20-24yrs	138500	738	533	(+/-39)	139200	724	520	(+/-39)
25-29yrs	163500	605	370	(+/-30)	177600	590	332	(+/-27)
30-34yrs	191200	551	288	(+/-25)	201100	542	270	(+/-23)
35-39yrs	181500	479	264	(+/-24)	182900	444	243	(+/-23)
40-44yrs	168700	443	263	(+/-25)	167100	507	303	(+/-27)
45-49yrs	153100	332	217	(+/-24)	155000	449	290	(+/-27)
50-54yrs	138200	276	200	(+/-24)	140100	370	264	(+/-27)
55-59yrs	123600	159	129	(+/-20)	124400	205	165	(+/-23)
60-64yrs	109900	93	85	(+/-18)	109900	131	119	(+/-21)
65-69yrs	90700	53	58	(+/-16)	90900	68	75	(+/-18)
70-74yrs	64400	28	43	(+/-16)	68300	36	53	(+/-18)
75-79yrs	47700	23	48	(+/-20)	55900	15	27	(+/-14)
80-84yrs	29400	9	31	(+/-20)	41600	10	24	(+/-15)
85yrs+	19500	5	26	(+/-23)	41000	6	15	(+/-12)
*Total***	*2269700*	*4378*	*195*	*(+/-6)*	*2316000*	*5105*	*228*	*(+/-6)*

** 95% Confidence Interval.*

*** The total rates are European age-standardised rates per 100,000.*

APPENDIX 4A: DELIBERATE SELF-HARM BY RESIDENTS OF THE HSE DUBLIN/ MID-LEINSTER REGION, 2012

Age group	Men				Women			
	Population	Deliberate self harm			Population	Deliberate self harm		
		Persons	Rate	95% CI*		Persons	Rate	95% CI*
0-4yrs	54060	0	0	(+/-0)	51850	0	0	(+/-0)
5-9yrs	47088	0	0	(+/-0)	45359	0	0	(+/-0)
10-14yrs	44537	19	43	(+/-20)	42313	50	118	(+/-33)
15-19yrs	39170	135	345	(+/-59)	38455	232	603	(+/-79)
20-24yrs	40093	157	392	(+/-63)	43172	171	396	(+/-61)
25-29yrs	51751	171	330	(+/-51)	57012	161	282	(+/-45)
30-34yrs	59497	152	255	(+/-41)	62268	159	255	(+/-41)
35-39yrs	53089	123	232	(+/-42)	54456	119	219	(+/-40)
40-44yrs	48832	127	260	(+/-46)	48259	137	284	(+/-49)
45-49yrs	42900	97	226	(+/-46)	44478	129	290	(+/-51)
50-54yrs	39001	80	205	(+/-46)	40258	120	298	(+/-54)
55-59yrs	34283	44	128	(+/-39)	35867	54	151	(+/-41)
60-64yrs	30103	24	80	(+/-33)	30875	35	113	(+/-38)
65-69yrs	23937	14	58	(+/-31)	24753	21	85	(+/-37)
70-74yrs	16705	6	36	(+/-29)	18674	8	43	(+/-30)
75-79yrs	12428	5	40	(+/-36)	15246	3	20	(+/-23)
80-84yrs	7535	4	53	(+/-53)	11382	2	18	(+/-25)
85yrs+	5031	2	40	(+/-56)	11008	4	36	(+/-36)
*Total***	*650039*	*1160*	*177*	*(+/-10)*	*675686*	*1405*	*212*	*(+/-11)*

** 95% Confidence Interval.*

*** The total rates are European age-standardised rates per 100,000.*

APPENDIX 4B: DELIBERATE SELF-HARM BY RESIDENTS OF THE HSE DUBLIN/ NORTH EAST REGION, 2012

Age group	Men				Women			
	Population	Deliberate self harm			Population	Deliberate self harm		
		Persons	Rate	95% CI*		Persons	Rate	95% CI*
0-4yrs	44268	0	0	(+/-0)	42750	0	0	(+/-0)
5-9yrs	37780	0	0	(+/-0)	35703	0	0	(+/-0)
10-14yrs	33901	18	53	(+/-25)	32320	47	145	(+/-42)
15-19yrs	29873	142	475	(+/-80)	28073	191	680	(+/-98)
20-24yrs	30226	194	642	(+/-92)	31395	170	541	(+/-83)
25-29yrs	39288	173	440	(+/-67)	43305	171	395	(+/-60)
30-34yrs	46758	144	308	(+/-51)	49828	143	287	(+/-48)
35-39yrs	43374	137	316	(+/-54)	43675	115	263	(+/-49)
40-44yrs	38626	105	272	(+/-53)	38196	144	377	(+/-63)
45-49yrs	33412	85	254	(+/-55)	33718	121	359	(+/-65)
50-54yrs	28813	84	292	(+/-64)	29377	90	306	(+/-65)
55-59yrs	24597	24	98	(+/-40)	25180	63	250	(+/-63)
60-64yrs	21546	18	84	(+/-39)	22166	41	185	(+/-58)
65-69yrs	18007	8	44	(+/-31)	18760	20	107	(+/-48)
70-74yrs	12931	8	62	(+/-44)	14109	10	71	(+/-45)
75-79yrs	9375	5	53	(+/-48)	11756	4	34	(+/-34)
80-84yrs	5596	1	18	(+/-36)	8410	0	0	(+/-0)
85yrs+	3682	1	27	(+/-54)	7999	0	0	(+/-0)
*Total***	*502054*	*1147*	*229*	*(+/-13)*	*516721*	*1330*	*266*	*(+/-14)*

** 95% Confidence Interval.*

*** The total rates are European age-standardised rates per 100,000.*

APPENDIX 4C: DELIBERATE SELF-HARM BY RESIDENTS OF THE HSE SOUTH REGION, 2012

Age group	Men				Women			
	Population	Deliberate self harm			Population	Deliberate self harm		
		Persons	Rate	95% CI*		Persons	Rate	95% CI*
0-4yrs	45800	0	0	(+/-0)	43900	0	0	(+/-0)
5-9yrs	42000	0	0	(+/-0)	40500	1	2	(+/-5)
10-14yrs	40300	19	47	(+/-22)	38500	47	122	(+/-36)
15-19yrs	37000	146	395	(+/-65)	35600	220	618	(+/-83)
20-24yrs	35700	246	689	(+/-88)	34300	214	624	(+/-85)
25-29yrs	38500	150	390	(+/-64)	41100	137	333	(+/-57)
30-34yrs	45000	155	344	(+/-55)	47500	138	291	(+/-49)
35-39yrs	45200	124	274	(+/-49)	44500	123	276	(+/-50)
40-44yrs	42600	125	293	(+/-52)	42400	124	292	(+/-53)
45-49yrs	40500	96	237	(+/-48)	40300	116	288	(+/-53)
50-54yrs	36500	70	192	(+/-46)	36600	99	270	(+/-54)
55-59yrs	33100	54	163	(+/-44)	32200	62	193	(+/-49)
60-64yrs	29600	19	64	(+/-29)	28900	31	107	(+/-39)
65-69yrs	24600	16	65	(+/-33)	24600	19	77	(+/-35)
70-74yrs	17800	7	39	(+/-30)	18500	11	59	(+/-36)
75-79yrs	13100	11	84	(+/-51)	15100	6	40	(+/-32)
80-84yrs	8200	3	37	(+/-42)	11200	3	27	(+/-31)
85yrs+	5200	2	38	(+/-54)	10800	2	19	(+/-26)
*Total***	*580700*	*1243*	*220*	*(+/-12)*	*586500*	*1353*	*241*	*(+/-13)*

** 95% Confidence Interval.*

*** The total rates are European age-standardised rates per 100,000.*

APPENDIX 4D: DELIBERATE SELF-HARM BY RESIDENTS OF THE HSE WEST REGION, 2012

Age group	Men				Women			
	Population	Deliberate self harm			Population	Deliberate self harm		
		Persons	Rate	95% CI*		Persons	Rate	95% CI*
0-4yrs	41972	0	0	(+/-0)	40099	0	0	(+/-0)
5-9yrs	39132	0	0	(+/-0)	37238	0	0	(+/-0)
10-14yrs	37562	7	19	(+/-14)	35967	33	92	(+/-32)
15-19yrs	35357	98	277	(+/-56)	32372	187	578	(+/-84)
20-24yrs	32482	141	434	(+/-73)	30333	168	554	(+/-85)
25-29yrs	33961	110	324	(+/-62)	36182	121	334	(+/-61)
30-34yrs	39945	100	250	(+/-50)	41503	102	246	(+/-49)
35-39yrs	39836	95	238	(+/-49)	40269	87	216	(+/-46)
40-44yrs	38642	85	220	(+/-48)	38245	102	267	(+/-53)
45-49yrs	36288	54	149	(+/-41)	36505	82	225	(+/-50)
50-54yrs	33886	42	124	(+/-38)	33865	61	180	(+/-46)
55-59yrs	31620	37	117	(+/-38)	31153	26	83	(+/-33)
60-64yrs	28651	32	112	(+/-39)	27959	24	86	(+/-35)
65-69yrs	24156	15	62	(+/-32)	22786	8	35	(+/-25)
70-74yrs	16965	7	41	(+/-31)	17018	7	41	(+/-31)
75-79yrs	12797	2	16	(+/-22)	13799	2	14	(+/-20)
80-84yrs	8070	1	12	(+/-25)	10608	5	47	(+/-42)
85yrs+	5587	0	0	(+/-0)	11193	0	0	(+/-0)
*Total***	*536907*	*826*	*159*	*(+/-11)*	*537094*	*1015*	*201*	*(+/-12)*

** 95% Confidence Interval.*

*** The total rates are European age-standardised rates per 100,000.*

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