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Medically Serious Suicide Attempts in a national cohort of older people attending Emergency Departments with a suicidal crisis

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Abstract

Background

Internationally, there are higher rates of death by suicide among older adults, but self-harm is less common in this population. Medically Serious Suicide Attempts (MSSA) represent the most serious and potentially fatal self-harm presentations, but little is known about this in older people.

Aims

This study aimed to examine the characteristics associated with MSSA among older adults presenting to emergency departments (EDs).

Method

This study reports a cohort of people in Ireland presenting with suicide-related ideation and self-harm to EDs from 2018 to 2022. The data comes from database of the National Clinical Programme for Self-Harm and Suicide-related Ideation and includes 72,810 clinical presentations. The characteristics associated with MSSA were examined in those aged over 60.

Results

This study found that nearly twice as many episodes of self-harm in people aged over 60 years were graded “moderate” or "high” lethality, with one-fifth (20.3%, n=219) of attempts of those over 60 were rated as high lethality (11.6% under 60: $p<0.001$). People aged over 60 were more than twice as likely to require admission to a medical, surgical or critical care ward (n=943, 18.7%) compared with those under 60 (n=5711, 8.5%; $p<0.001$). The association between older age and high self-harm lethality remained significant after controlling for gender, ethnicity and substance use (Odds Ratio 1.23; CI: CI:1.157-1.305).

Conclusion

The higher proportion of MSSA amongst the older cohort, taken in the context of the higher suicide rates in this group, highlights the urgent need to understand better the variables associated with increased risk.

Introduction

Internationally, it is estimated that over 727,000 people die by suicide each year, with over 14 million episodes of self-harm annually. (WHO 2025; Moran et al. 2024) In the UK’s NICE guidelines, self-harm is defined as *“intentional self-poisoning or injury, irrespective of the apparent purpose”.* (NICE 2022) This includes acts which may or may not be associated with suicidal intent, and those with a degree of ambivalence. Self-harm as a key risk factor for suicide is a major public health concern. Self-harm is not necessarily associated with suicidal plans, and is associated with a range of functions and motivations. However, notwithstanding the range of motivations for the person involved, it is associated with death by

suicide, and is an important risk factor for suicide. (Bostwick et al. 2016; Carroll, Metcalfe, and Gunnell 2014)

Characteristics of severe self-harm

While self-harm and suicidal ideation may occur in people without a diagnosed mental illness, they have been described in association with many mental illnesses. The most common diagnosis among those who die by suicide is depression, encompassing depressive episodes and recurrent depressive disorder. (Bruce et al. 2004) Self-harm has been found to be one of the most reliable factors associated with future death by suicide: about 40% of those who die by suicide have records of previous attempts. (Cavanagh et al. 2003) It has been calculated that self-harm is associated with a greatly increased risk of suicide in the year following an attempt by a factor of 66. (Hawton, Zahl, and Weatherall 2003) However, not all acts of self-harm convey the same risk. If we view suicidality as a spectrum that ranges from passive death wish all the way to suicide, with suicidal ideation and mild/ moderate/ severe self-harm in between, and with high severity self-harm adjacent to suicide, high severity self-harm may have more in common with suicide than other types of suicidal presentations. (Giner et al. 2014; Mohan et al. 2020) Medically serious suicide attempts (MSSA) or medically serious self-harm are defined as self-harm that would have been fatal without access to emergency care and that subsequently required hospitalisation for more than 24 hours in critical care, or surgery under general anaesthesia. (Levi-Belz and Beautrais 2016) While there have been a small number of studies which have examined the characteristics of MSSA, none have examined this in older people.

Self-harm in older people

In almost all countries, self-harm is more frequently seen in young people and adolescents, while older adults have the highest suicide rate. Among older US-based men, the incidence is 48.7/100,000 (which is more than four-fold the age-adjusted rate in the US of 11.1/100,000) and is higher again, with a rate of 140 per 100,000 among older males in rural regions of China (Conwell and Thompson 2008). Likewise, the definition of "older people" can vary somewhat between countries. Studies from the US defines older people” as those aged 65 years and some Chinese studies set the cut-off at 60 years (Conwell and Thompson 2008). Rates of death by suicide increase with age past the age of 60; there is evidence that age has the opposite impact on rates of self-harm, with a lowering incidence over time. Hawton and Harriss examined the lifetime incidence of suicide related to self-harm, and reported a high ratio of self-harm to suicide (200:1) in those aged under 20 years, but this ratio was much lower in older adults (10:1 in those over 60 years) (Hawton and Harriss 2008). This phenomenon even applies to older people who died by suicide. In the context of both the elevated rate of suicide as a cause of death among older adults, and self-harm’s role as a key risk factor for suicide, identifying the characteristics of self-harm in this population is a clinical priority. Additionally, understanding the demographic and clinical factors associated with suicidal behaviours, along with patterns of engagement with services, is crucial for tailoring interventions and clinical services to meet their needs compassionately and effectively.

Exmainig the variables associated with high-lethality self-harm can help us better identify those at highest risk, including individuals who present with MSSA.

Objectives

This study aimed to identify the clinical and sociodemographic characteristics of older adults who present with higher severity self-harm, that meets the criteria for MSSA.

Methods

Design & setting

This cohort study is based on a national dataset collected and maintained by the Irish Health Service Executive's National Clinical Programme for Self-Harm and Suicide-related ideation (NCPSHI). Since 2010, the NCPSHI has ensured that all patients who present to the ED with suicidal ideation or self-harm receive a full biopsychosocial assessment promptly (HSE 2022). The NCPSHI has set the standards for both the biopsychosocial assessment and the following clinical management of people presenting to EDs with suicidal ideation or self-harm. The Clinical Nurse Specialists (CNSs) of the NCPSHI play a key role in coordinating data collection to monitor and evaluate programme outcomes, in addition to their clinical duties in performing clinical assessments. These data are anonymised upon entry into the NCPSHI electronic template, and this dataset includes all individuals seen in the ED, whether by CNSs and other members of the consultation-liaison psychiatry teams during working hours, or by on-call psychiatry clinicians outside core working hours (Hoare et al. 2024)

Participants

This study is based on the years 2018–2022, using a national dataset which comprises a complete five-year cohort of 72,810 presentations (HSE 2022). This data comprises anonymised information from Irish EDs serving adult patients. Data are de-identified at the point of submission and reflect the number of presentations and not the individuals presenting.

Variables & measurement

Sociodemographic information is collected as part of the biopsychosocial assessments. Since 2018, age groups have been recorded under the following brackets: <19, 20–29, 30–39, 40–49, 50–59 and > 60. Other sociodemographic information collected includes ethnic background (as defined and categorised by Ireland's Central Statistics Office), gender, employment status (collected since January 2020), and hospital. The dataset also includes clinical information regarding whether the individual presented with self-harm or ideation, lethality of self-harm act (since the beginning of 2020), details of suicidal thoughts (i.e. regarding suicide or self-harm), any substance use which may have contributed to

the presentation, if medical treatment was required (whether the person required medical/surgical/critical care admission for physical treatment of self-harm), and prior or current engagement with a mental health service (including if the individual is attending a statutory, voluntary or private service). In addition, the database holds information on the source of referral to the ED and on onward referral following assessment (including psychiatric admission and referral to a range of statutory services and voluntary agencies).

The NCPSHI requires that the following suicide prevention interventions are completed and recorded for each presentation. These include, in addition, the completion og a biopsychosocial assessment, an emergency safety plan, the collection of a collateral history and, where possible, next-of-kin engagement in the development of a discharge plan. A summary letter is sent to the individual's GP within one working day, and if appropriate, copied to the individual's mental health service. The database records bridging or follow-up calls (within 72 hours of assessment), another key evidence-based suicide prevention intervention.

Medical lethality: In this dataset, two measures were used to assess lethality: the lethality measure from the dataset (limited to years 2020–2022, a measure input by the clinical nurse specialist collecting the data at the site), and the need for medical admission as a proxy for medical seriousness or lethality: this latter group represents MMSA proper.

Power calculation

As this study was a full retrospective cohort study of a nationally provided service over five years, and included all presentations (n = 72,810); a power calculation was not required. Older people represented a smaller subgroup (n = 5,041).

Statistical Analysis

The data were input into SPSS and analysed to assess the characteristics of suicidality in the population aged over 60 years, using descriptive statistics, specifically chi-square tests. This study developed a multivariable model in order to explore the relationship between older age and MSSA, and controlled for confounding factors. We examined the relationship between MSSA and psychiatric admission using logistic regression and controlled for gender, year of presentation, co-occurring substance use, and medical admission. The significance level was set at 0.05.

Results

This NCPSHI database comprised presentations of all people presenting with suicidal ideation and self-harm to EDs across Ireland for the years 2018 to 2022. The majority of those presentations were from people under 60 years of age (n=67,603), with 5,041 presentations from those aged over 60 (see Table 1). The number of presentations to EDs increased significantly from 2018 to 2022 in both age groups

(over and under 60 years). However, the presentations of those aged over 60 years increased to a significantly higher degree (n = 1316, 26.1%) compared with those aged under 60 (n = 15351, 22.7%, p < 0.001).

Overall, the number of older people attending EDs nationally with self-harm increased from 409 presentations in 2018 to 439 in 2020 (107% of the 2018 attendance). In the aftermath of the COVID-19 pandemic, the numbers continued to increase, with 528 presentations in 2022, 129% of the 2018 presentations. The increase was more marked in men (an increase of 138%) than in women (an increase of 123%), as illustrated in Figure 1.

There were significant differences in self-harm proportions across age brackets. The highest proportions of self-harm were in the 20-29 age bracket (n=10,593, 29.7%, p<0.001), while the lowest proportions were in the group aged over 60 years (n=2,193, 6.1%, p<0.001).

White Irish was overwhelmingly the most common ethnicity among presentations in both the under-60s and over-60s, representing a greater proportion of the over-60s: 85.2% vs 91.9%, p < 0.001. In all age groups, the most common method of self-harm was drug overdose, and this formed a significantly greater proportion of the over-60 age group: (n=1,471) 30.2% compared with (n=17,619) 27.3% in the under-60s, p<0.001 (Table 1). Presentations from those aged under 60 had a higher prevalence of drug use, compared to those over 60, who had a higher prevalence of alcohol use only. A higher proportion of those over 60 years were currently attending a mental health service; n = 1828, 38.1%.

Table 1: Clinical characteristics of people aged >60years compared with those aged under 60

years

When the relationship between age and lethality was examined, two measures were used to assess lethality: the lethality measure from the dataset (limited to years 2020-2022) and the need for medical admission as a proxy for medical seriousness or lethality: this group representing MMSA proper. Lethality of attempt in the over 60s was significantly more likely to be rated as moderate or high compared with those under 60 years. Over one-fifth (20.7%, n=216) of self-harm in those over 60 was rated as being of high lethality, nearly double the proportion (11.8%; n=1761) in those under 60, p<0.001. People aged over 60 years were significantly more likely to be assessed on a medical or surgical ward or in the ICU (n=943, 18.7%) compared with the under-60-year cohort (n=5711, 8.5%; p<0.001). When we examined the relationship between the objective measure of lethality (need for admission for medical/ surgical treatment) with the subjective measure which was input into the database by the clinicians at the sites (only available for a portion of the sample), there were significant differences between the two groups on bivariate analysis, both in the group as a whole and in those aged over 65 years (table 2).

Table 2: Measures of lethality in the whole population and in those aged over 60 years

The patients aged 60 years and over were more likely to be admitted to a mental health inpatient unit (n=1152, 24.6%) compared with those aged under 60 (n=9799, 16.2%), p<0.001. The ratio of low to high

N (%)	Total (n=72,644)	<60 (n=67,603)	>60 (n=5,041)	P value (c^2)
Self-Harm Yes	35695 (51.5)	33502 (52)	2193 (45.1)	<0.001
No (suicide-related ideation)	33625 (48.5)	30952 (48)	2673 (54.9)	(86.5)
Type of Self Harm Cutting	8243 (11.9)	8006 (12.4)	237 (4.9)	<0.001
Attempted Drowning	811 (1.2)	739 (1.1)	72 (1.5)	(479.1)
Drug and Alcohol overdose	2052 (3)	1952 (3)	100 (2.1)	
Drug Overdose	19090 (27.5)	17619 (27.3)	1471 (30.2)	
Attempted Hanging	2126 (3.1)	2060 (3.2)	66 (1.4)	
Jumping from a height	329 (0.5)	309 (0.5)	20 (0.4)	
Shooting	21 (0)	18 (0)	<10	
Multiple methods	1172 (1.7)	1117 (1.7)	55 (1.1)	
Attempted suffocation	18 (0)	17 (0)	<10	
Other	1833 (2.6)	1665 (2.6)	168 (3.5)	
Substance Use Alcohol and Drugs	9318 (12.8)	9227 (13.6)	91 (1.8)	<0.001
Alcohol only	16114 (22.2)	14781 (21.9)	1333 (26.4)	(1068.1)
Drugs only	6352 (8.7)	6275 (9.3)	77 (1.5)	
No drugs or alcohol	40860 (56.2)	37320 (55.2)	3540 (70.2)	
Attending mental health team	42713 (63.4)	39743 (63.5)	2970 (61.9)	0.029
No/Unknown	24697 (36.6)	22869 (36.5)	1828 (38.1)	(4.8)
Yes				
Referred to ED by Mental health team	649 (0.9)	576 (0.9)	73 (1.5)	<0.001
General practitioner	8695 (12)	7984 (11.9)	711 (14.1)	(259.0)
Police	3959 (5.5)	3790 (5.6)	169 (3.4)	
Other	59022 (81.6)	54950 (81.6)	4072 (81)	
Assessment Location	58379 (80.4)	54633 (80.8)	3746 (74.3)	<0.001
ED	6654 (9.2)	5711 (8.5)	943 (18.7)	(627.4)

Medical/Surgical/ICU	7589 (10.5)	7239 (10.7)	350 (6.9)	
Not assessed				
Reasons not assessed	5780 (76.2)	5537 (76.5)	243 (69.2)	<0.001
Left ED before assessment completed	65 (0.9)	55 (0.8)	10 (2.8)	(24.0)
RIP	1592 (21)	1503 (20.8)	89 (25.4)	
Transferred to another site	153 (2)	144 (2)	<10	
Not recorded				
Subsequent admission to psychiatry	54103 (83.2)	50565 (83.8)	3538 (75.4)	<0.001
No	10951 (16.8)	9799 (16.2)	1152 (24.6)	(215.7)
Yes				
Next referrals Specialist MHS	27245 (50.9)	25387 (50.7)	1858 (52.9)	0.11
Other	26331 (49.1)	24678 (49.3)	1653 (47.1)	(7036.7)
Time to admission/discharge	42416 (67.8)	39650 (68.2)	2766 (62.2)	<0.001
<6 hours	10321 (16.5)	9612 (16.5)	709 (15.9)	(138.9)
<9 hours	9819 (15.7)	8847 (15.2)	972 (21.9)	
>9 hours				
Consistent with the methodology of the National Clinical Programme for Self-Harm and Suicide-Related ideation and filed with less than 10 presentations is presented as <10.				

lethality self-harm was 4.4:1 in the under-60s and 1.9:1 in the over-60s, using the measure in the database, and the ratio of ED-treated to medically admitted was 9.6:1 in the under-60s and 3.9:1 in the over-60s.

On logistic regression, the association between older age and MSSA (using the proxy measure of admission to a medical/ surgical/ critical care bed) was statistically significant with an Odds Ratio (OR) of 1.32; CI:1.244-1.399). This remained significant after controlling for gender, ethnicity, attending mental health services and substance use. (OR 1.23; CI:1.157-1.305; p<0.001: see table 3). Female gender was similarly significantly associated with MSSA (OR 1.82; CI:1.763-1.878; p<0.001), as was active substance use (OR 0.7; CI:0.679-0.723; p<0.001).

Table 3: Logistic regression examining the relationship between higher lethality self-harm and age

		Total	Medically treated in ED	Admitted to a medical /surgical/ critical care ward	P value (c^2)
Lethality measure input by coder	**All**	N= 16,009	N= 13,209	N= 2800	
	Low	7,956 (49.7)	7356 (92.5)	600 (21.4)	<0.001
	Medium	6,076 (38)	4597 (75.7)	1479 (52.8)	(1236.8)
	High	1,977 (12.3)	1256 (63.5)	721 (25.8)	
	Over 60s	N= 1,043	N= 711	N= 332	
	Low	402 (38.6)	323 (45.5)	79 (23.8)	<0.001
	Medium	425 (40.7)	269 (37.8)	156 (47)	(49.2)
	High	216 (20.7)	119 (16.7)	97 (29.2)	

This table compares measures of lethality in the whole population and in those aged over 60 years for whom both measures of lethality are available, the measure inputted by the coder (2020-2022) and the proxy measure: need for medical treatment as an inpatient (n=16,009)

	Odds Ratio	p-value	Confidence interval
Model 1			
Age (under v over 60 years)	1.32	<0.001	1.244-1.399
Model 2			
Age (under v over 60 years)	1.23	<0.001	1.157-1.305
Gender	1.82	<0.001	1.763-1.878
Ethnicity	1.08	0.005	1.022-1.129
Substance use	0.70	<0.001	0.679-0.723
Attending mental health services	0.83	0.206	0.948-1.012
Model 3 (over 65 years only)			
Gender	2.01	<0.001	1.791-2.264
Ethnicity	1.27	0.044	1.006-1.612
Substance use	0.79	<0.001	0.699-0.901
Attending mental health services	0.88	0.208	0.958-1.219
Models 1 and 2 show the relationship between higher lethality self-harm (dependent variable) and age; and Model 3 shows the variables associated with high lethality self-harm in those aged over 60 years			

When we ran this model in those aged over 60 years only (removing age as a variable, but retaining gender, ethnicity, attending mental health services and substance use), female gender was significantly associated with MSSA (OR 2.01; CI:1.791-2.264; p<0.001).

Discussion

Our results illustrate the significant differences in the older individuals who present to Irish EDs with MSSA or high lethality self-harm compared with younger people, where previously a paucity of data existed. This study reported a year-on-year increase in the number of older people attending the ED with self-harm between 2018 and 2022. It also found that people aged over 60 years attending EDs with self-harm and suicidal ideation represented a small population compared with younger people (6.1% of the total). However, self-harm episodes were significantly more likely to be graded “moderate” or "high” lethality. One-fifth of the self-harm in those over 60 years was rated as ‘high lethality’.

People aged over 60 years were more than twice as likely to require admission to a medical, surgical or critical care ward compared with those aged under 60. This may be seen as a proxy measure for medical lethality. Older age was strongly associated with medical admission on logistic regression after

controlling for other variables such as gender, age, ethnicity, substance use and previous attendance at mental health services.

Older people were significantly more likely to have pre-existing contact with mental health services or to have been referred to the ED by a health professional. In addition, older people were significantly more likely to require admission to a psychiatric ward, which indicates a higher degree of psychiatric illness in this population. This may also reflect barriers to access to services, for example, while all persons aged over 70 years have free primary healthcare, this is not the case for those aged under 70, where it is means-tested, which means that about 2/3 of people there have a cost associated with attending their primary healthcare provider.

These findings are consistent with the literature, which shows that older people are overrepresented among those admitted with more medically serious self-harm. This is an important population to identify, as there is evidence that people who experience medically serious self-harm have much in common with those who die by suicide. (Beautrais 2001) These findings are reflected in the proportion of presentations that require admission for medical or surgical treatment of their injuries, as well as in the nurse-rated lethality score. It is worth noting that critical care admission for any cause is associated with an elevated suicide risk. Fernando et al, in their study of 423,060 people who had required critical care admission, reported an increased rate of both suicide and self-harm, with hazard ratios of 1.15 and 1.22, respectively. (Fernando et al. 2021) While this study reported a lower mean age in those who had an episode of self-harm or suicide following a critical care admission, these outcomes were associated with higher rates of premorbid mental ill-health. However, this study did not specify whether any of the included patients had a critical care admission precipitated by an act of self-harm. (Fernando et al. 2021) Given that psychiatric admission within the past 3 months is associated with suicide rates up to 100 times the population rates, the subgroup of patients requiring critical care admission due to self-harm is likely to have significantly elevated suicide risk. (Meehan et al. 2006; Chung et al. 2017)

The ratio of low to high lethality of self-harm of 1.9:1 compared with in those aged under 60, where it is 4.4:1, suggests that, in general, episodes of self-harm in older people are more frequently associated with a higher level of medical lethality. While this study does not allow a direct comparison with suicide rates, the differing ratios in self-harm between those aged above and below 60 years suggest there is a difference in the function of self-harm in this population. These may be different points on a spectrum ranging from suicidal ideation through to death by suicide as conceptualised by Mohan et al. (Mohan et al. 2020). This reflects a similar pattern to that described by Hawton and Harriss, who reported a much higher ratio of self-harm to suicide, of 10:1 in individuals aged 60 years. (Hawton and Harriss 2008)

Although the database does not capture psychiatric diagnoses, the significantly higher proportions of older people requiring psychiatric admission may be seen to represent a greater burden of mental illness in this population. Di Lorenzo et al likewise reported that a greater proportion of retired persons required psychiatric hospitalisation for self-harm compared with other reasons for admission (4.7% v 3.9%). (Di Lorenzo et al. 2024) An Italian study of older people who accessed psychiatry admission for self-harm

reported that the majority (62.3%) had never had a previous admission, and 46.4% were not attending mental health services at the time of the self-harm, which precipitated the admission: higher than the 38.1% attending in this study. (Gramaglia et al. 2021)

There is conflicting evidence from the literature regarding the impact of the COVID-19 pandemic on older people and medically serious self-harm, with the systematic review by Pathiranthna and colleagues reporting elevated rates in older people associated with pre-existing mental illness and financial difficulties identified as contributing factors. (Pathirathna et al. 2022) On the other hand, studies by Corbe and colleagues and by Beneria and colleagues reported that younger people were disproportionately affected by self-harm in France and Spain, respectively (Beneria et al. 2024; Corbé et al. 2023). Our study showed a steady increase in older people's attendance at EDs with self-harm and suicidal ideation pre-pandemic over the years 2018 - 2020. The numbers continued to increase further in the aftermath of the pandemic. This suggests unmet need in the community, and perhaps an increased willingness to seek help, unexpected in the context of the focus on "cocooning" older adults during this pandemic. Overall, these findings are consistent with the literature, suggesting that, in the midst of the pandemic, there was no major increase in presentations; however, this increase was more likely to occur after the initial crisis of the pandemic. (Steeg et al. 2022; McIntyre et al. 2021). One single-site study from Japan, which examined the medical lethality of patients presenting to an urban hospital, reported significantly elevated lethality among older men (Tsuchida et al. 2023). Our findings are consistent with those reported by Szucs et al, which found that medically serious self-harm was associated with older age. (Szücs et al. 2025) The high rates of critical care admissions for older adults are similarly surprising given the pressure on critical care beds in the pandemic. Cai et al reported in their systematic review that there was a significantly elevated suicide rate among older people (Cai et al. 2022). One systematic review, which examined high medical lethality self-harm in older people, did not find any significant association between severity of lethality and age or gender. (Barker, Oakes-Rogers, and Leddy 2022). The prevalence of higher lethality self-harm attempts in older people attending Irish EDs suggests an urgent need to identify and understand the characteristics of self-harm in this population. This information is key to developing treatments and responsive (even proactive) services that meet the specific needs of this high-risk group.

The impact of gender on medically serious self-harm suggests that women are more likely to require a medical admission for self-harm, which indicates that older women present with MSSA at twice the rate of men, despite having lower rates of suicide. This is consistent with existing evidence, which suggests that women have higher rates of more serious episodes of self-harm as they age. (Clements et al. 2025; Troya et al. 2019)

Strength and Limitations

The strengths of this paper include the utilisation of a national data source of a cohort presenting to EDs with suicidal ideation and /or self-harm to examine the characteristics of older adults. The comparison

between older and younger people who present with self-harm identified key differences in sociodemographic and clinical characteristics between the two groups.

The retrospective nature of the register is a limitation of the study. However, the population studied is a complete clinical sample. It is further limited in the presentation-based rather than individual-based nature of the dataset; therefore, repeated presentations of individuals are not captured. The lethality measure used for multivariable analysis, utilised the need for medical/surgical/ critical care admission as a proxy for a more direct method of assessing lethality. While this is an Irish national database, the findings are likely generalisable to other international settings where emergency care and all mental healthcare is free at the point of access.

Conclusions

Our results indicate significant differences in older people compared with younger people who attend the ED with suicidal ideation or high lethality self-harm. The higher prevalence of MSSA amongst the older cohort makes it a clinical priority to understand the variables associated with increased risk. The higher psychiatric admission rates identified in this cohort are important in resource allocation and service development.

There is a need for further work to better understand the characteristics, motivations and clinical needs of older adults who attend the ED with suicidal ideation or self-harm, especially MSSA. Specifically, further information regarding the medical lethality and the perceived lethality, along with details of the types of difficulties, especially mental illness, which precipitated the event, would greatly enhance our understanding of this population.

Declarations

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Ethics Considerations: The authors assert that all procedures contributing to this work comply with the ethical standards of the relevant national and institutional committees on human experimentation and with the Helsinki Declaration of 1975, as revised in 2013. All procedures involving human subjects/patients were approved by the Clinical Research Ethics Committee of University College Dublin LS-LR-22-167.

Consent to participate: Not applicable. The authors assert that the anonymised registry was obtained from the National Clinical Programme for Self-Harm and Suicide-related Ideation, Health Service Executive, Ireland. As the data represent presentations, and not individuals, and were fully anonymised and collected as part of routine care, individual-level consent was not required, and the requirement for informed consent was waived by the Ethics Committee (Clinical Research Ethics Committee of University College Dublin LS-LR-22-167).

Consent for publication: Not applicable

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Figures

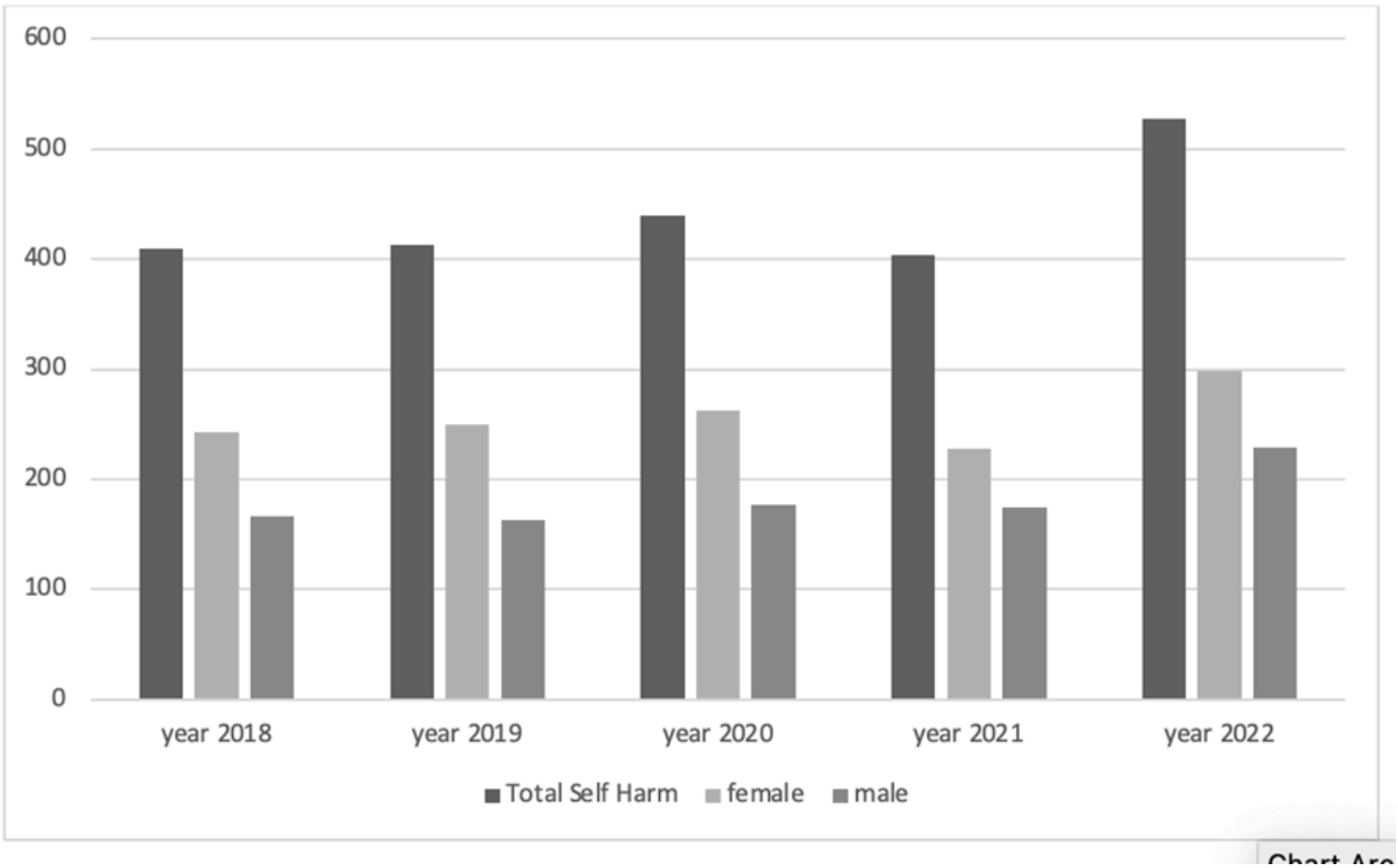


Figure 1

Presentations of people aged 60 and over with Self-Harm from 2018 to 2022, with gender breakdown