NATIONAL SELF-HARM REGISTRY IRELAND

ANNUAL REPORT 2024

NSRF
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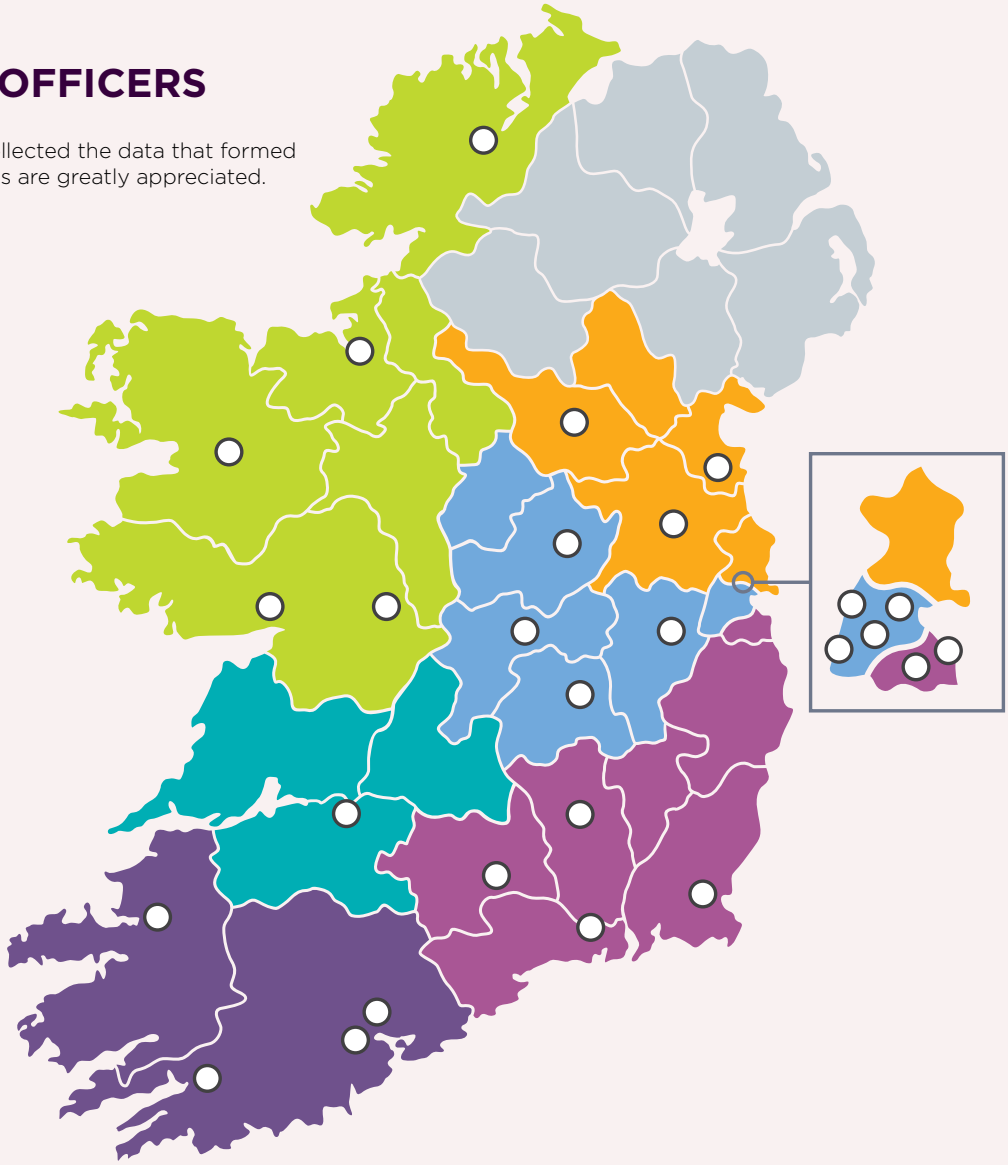
DATA REGISTRATION OFFICERS

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



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

National Self-Harm Registry Ireland team.

Foreword

The National Self-Harm Registry Ireland was established in 2000 by the National Suicide Research Foundation, working in collaboration with the School of Public Health, University College Cork. The Registry was set up at the request of the Department of Health and Children and is funded by the Health Service Executive's National Office for Suicide Prevention. It is the world's first national registry of cases of intentional self-harm presenting to hospital emergency departments and is recognised by the World Health Organization as a template for such surveillance systems.

This report relates to hospital-presenting self-harm in 2024. This represents a reduced time to publication compared to recent reports when the Registry was experiencing the combined effects of access restrictions due to the COVID-19 pandemic, data recording challenges due to the HSE cyberattack in 2021 and changing work practices associated with enhanced data protection regulations. I am especially grateful to our Data Registration Officers for their ongoing commitment and dedication and to the hospital staff for facilitating the operation of the Registry as we overcame these challenges. I would also like to thank the members of our Advisory Panel who have provided guidance on the operation of the Registry and on enhancing the level of public involvement with the Registry, the engagement between the Registry and mental health support groups and service providers, and the level of transparency of the Registry.

Connecting for Life, Ireland's National Suicide Reduction Strategy, operated for the ten-year period 2015-2024 and has been in its evaluation phase since 2024. A reduced rate of hospital-presenting self-harm was one of the two primary goals of *Connecting for Life*. The findings in this Report provide the first assessment of whether this was achieved. In-depth analysis of the trends over time are underway in collaboration with colleagues in the Department of Health. We are aware that work on a successor to *Connecting for Life* is at an advanced stage, which demonstrates the government's ongoing commitment to supporting suicide and self-harm prevention.

Emergency department services for hospital-presenting self-harm were greatly enhanced with the establishment, in 2016, of the National Clinical Programme for Self-Harm and Suicide Related Ideation. The Clinical Programme was updated in 2022 to include the Suicide Crisis Assessment Nurse Service, which aims to provide a timely response to appropriate requests for assessment of general practice patients in suicidal crisis. The Clinical Programme continues to progress towards full implementation and we look forward to continuing to work together towards our shared objectives.

Dr Paul Corcoran
Head of Research,
National Suicide Research Foundation, Cork.

Executive Summary

This is the twenty-second annual report from the National Self-Harm Registry Ireland. It is based on data collected on hospital presentations of self-harm in the Republic of Ireland in 2024. This year, the Registry reports on data from 27 hospitals: 25 Emergency Departments (EDs) including two in Children's Health Ireland hospitals, and two Model 2 hospitals. Data were not available for four hospitals in 2024. We estimated the number of presentations and people presenting to these hospitals using data from recent years to provide national estimates in 2024. All rate calculations presented in this report are based on those estimates.

Main findings

In 2024, the National Self-Harm Registry Ireland estimated that there was a total of 12,621 self-harm presentations made by 9,436 individuals. The estimated age-standardised rate of individuals presenting to hospital following self-harm in 2024 was 181 per 100,000. This is 5% lower than the rate in 2023, and 19% lower than the peak rate recorded by the Registry in 2010 (223 per 100,000). In 2024, the national female rate of self-harm was 201 per 100,000, 7% lower than 2023. The female rate in 2024 is the lowest rate recorded by the Registry for women. The rate in 2024 also marks a continuation of the decrease observed for women since 2021. The male rate of self-harm in 2024 was 163 per 100,000, 2% lower than the rate in 2023.

Connecting for Life, Ireland's National Suicide Reduction Strategy, operated for the ten-year period 2015–2024 and has been in its evaluation phase since 2024. A reduced rate of hospital-presenting self-harm was one of the two primary goals of *Connecting for Life*. The findings in this Report suggest that this was achieved. The rate in 2014, the year before *Connecting for Life* started, was 200 per 100,000 whereas we estimate that the rate in 2024 was 10% lower at 181 per 100,000. The estimated rate in 2024 suggests that there was a 7% reduction in the female rate of hospital-presenting self-harm, from 216 to 201 per 100,000, while the male rate reduced by 12% from 185 to 163 per 100,000.

As observed each year, the peak rate for women was in the 15–19-year-old age group at 652 per 100,000. The peak rate for men in 2024 was among 25–29-year-olds at 373 per 100,000. This is in contrast to the previous two years where the peak rate was among 20–24-year-olds and approximately 400 per 100,000. The rates in 2024 imply that one in every 153 girls in the 15–19-year age group, and one in every 268 men in the 25–29-year age group, presented to hospital with self-harm in 2024.

There were 651 presentations made by residents of homeless hostels/shelters and people of no fixed abode in 2024, accounting for approximately 6.2% of all presentations recorded by the Registry. This is comparable to the 6.9% reported in 2023.

Consistent with previous years, intentional drug overdose was the most common method of self-harm, involved in over three in five (61%) self-harm presentations in 2024. Minor tranquilisers were the most common drug type used, similar to previous years. Self-cutting was the other most common method, recorded in 30% of all presentations. Attempted hanging was involved in 8% of all self-harm presentations (12% for men, 5% for women). Attempted drowning was involved in 4% of presentations and, although rare as a method of self-harm, self-poisoning involving chemical substances was involved in 3% of presentations. Alcohol was involved in 32% of all presentations and was more often involved in male than female presentations (39% and 26% respectively). In general, the type of method used in self-harm was similar to recent years.

For 59% of presentations in 2024, the patient was assessed by a member of the mental health team in the presenting hospital (n = 5,050). For a further 6%, an assessment was arranged in the presenting hospital (n = 512). Most commonly, in 49% of presentations, individuals were discharged following treatment in the ED. For most of these individuals, four in five were provided with a recommended referral or follow-up appointment. In 14% of presentations, the individual left the ED before a next-care recommendation could be made. There was considerable variation in the recommendations for next care across health regions, particularly in relation to the proportion of patients admitted to the presenting hospital, leaving before a recommendation or receiving a mental health assessment. For example, inpatient care (irrespective of type and whether the patient refused) was recommended for as little as 17% and as much as 37% of adult presentations across the six health regions, while the proportion of adult patients who left before a recommendation could be made ranged from 12% to 21%. Similarly, the proportion of adults discharged following treatment in the ED ranged from 33% in HSE Dublin and North East to 61% in HSE South West. This observed difference is likely to be due to variation in the availability of resources and services, but it also indicates that assessment and management procedures for self-harm patients are likely to vary across the country.

In 2024, we gathered information on the current care for individuals presenting to hospital with self-harm. For a third of presentations (n = 3,520), it was noted that the individual was currently attending Mental

Health Services (public/private/voluntary). In a further 2% of presentations, the patient had previously been referred and was awaiting an appointment with Mental Health Services (*n* = 225). For 3% of presentations, individuals were attending counselling or addiction services. Individuals were engaged with homeless services in 2% of cases.

There was a similar proportion of presentations accounted for by repetition in 2024 as in 2023 (25% and 24%, respectively). Of the 7,940 self-harm patients who presented to hospital in 2024, 1,265 (16%) made at least one repeat presentation to hospital during the calendar year. Therefore, repetition continues to pose a major challenge to hospital staff and family members involved. The highest rate of repetition was reported in HSE South West (19%). In 2024, at least five self-harm presentations were made by 147 individuals. These patients account for 2% of all self-harm patients but their presentations represented 12% of all self-harm presentations. As in previous years, self-cutting was associated with an increased level of repetition whereby almost one in five individuals (18%) who used this method had a repeat presentation within the calendar year.

Above (left to right): Paweł Hursztyn, Shelly Chakraborty, Paul Corcoran, Mary Joyce, James Camien McGuiggan.

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2024 Statistics at a Glance

Presentations
12,621

Persons
9,436

2024 rate is 10% lower than the rate recorded in 2014

RATES:

181
per 100,000
1 in every 552
had a self-harm act

Men: 25-29 year-olds
1 in every 268

Women: 15-19 year-olds
1 in every 153

PEAK RATES WERE AMONG YOUNG PEOPLE

TIME:

Peak time
6–7pm

Almost half of presentations made between 6pm–2am (44%)

J F M A M J
J A S O N D

March saw most presentations
December saw the fewest

METHOD:

6 in every 10
involved **overdose**

Men

Women

1 in every 3
involved **alcohol**

3 in every 10
involved **self-cutting**

TREATMENT:

65% received a psychiatric assessment in the presenting hospital

74% received a follow-up recommendation after discharge

14% left ED before a recommendation was made

1 in 6
persons had a repeat attendance in 2024

Implications and Recommendations

The implications of the findings in this report and related recommendations are set out below and overleaf. Considering that patterns of self-harm exist over multiple years, some of the recommendations outlined here continue to be relevant over time.

Self-Harm in Children and Young People

Over the past twenty years of reporting from the National Self-Harm Registry Ireland, the highest rates of self-harm have consistently been observed in young people. The increased rates of self-harm among children aged 10–14 years in recent years also indicates that the age of onset of self-harm is decreasing. A recent scoping review which examined the age of onset of self-harm in children and adolescents across 42 studies further corroborates this observation.[1] This phenomenon has been reported in the UK, Australia and The Netherlands with an increasing trend of self-harm, as well as the use of highly lethal self-harm methods, in children aged 5-12 years and in particular, among boys.[2, 3] Evidence-based mental health programmes as well as appropriate referral and treatment options are crucial to address the needs of young people in the key transition stages between childhood and adolescence into adulthood.

The Registry findings highlight the importance of the priorities outlined in the HSE's National Service Plan 2025 and the National Strategy to Reduce Suicide in Ireland, 2015-2024 *Connecting for Life* in relation to young people.[4, 5] The recently established HSE Child and Youth Mental Health Office further highlights a commitment to the reform of child and youth mental health services in Ireland.[6]

Recommendation 1: Services and resources should continue to be prioritised for children and adolescents through the expansion of child and adolescent mental health services (CAMHS) teams as outlined in the HSE Service Plan 2025.

Recommendation 2: Enhance the supports for children and adolescents with mental health difficulties or who are vulnerable to suicide by delivering early intervention and psychological support for young people at primary care level, as well as secondary care level including CAMHS. (*Connecting for Life*, Goal 3, Objective 3.3).

Recommendation 3: Strengthen the supports provided in primary and post primary schools aimed at enhancing children, adolescents and young people's mental health and wellbeing, including targeted support for students identified at risk of developing mental health difficulties (HSE Child and Youth Mental Health Office Action Plan 2024-2027: Theme 1, Action 4).

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[1] Wiggin, D., Ní Dhálaigh, D., McMahon, E., McNicholas, F., & Griffin, E. (2025). Age of onset of self-harm in children and adolescents: a scoping review. *Child and Adolescent Psychiatry and Mental Health, 19*(1), 128. **https://doi.org/10.1186/s13034-025-00982-6**

[2] Geulayov, G., Casey, D., Bale, L. et al. (2022). Self-harm in children 12 years and younger: characteristics and outcomes based on the Multicentre Study of Self-harm in England. *Soc Psychiatry Psychiatr Epidemiol* 57, 139–148. **https://doi.org/10.1007/s00127-021-02133-6**

[3] Torok, M., Burnett, A. C., McGillivray, L., Qian, J., Gan, D. Z., Baffsky, R., & Wong, Q. (2023). Self-harm in 5-to-24 year olds: Retrospective examination of hospital presentations to emergency departments in New South Wales, Australia, 2012 to 2020. *PLoS one, 18*(8), e0289877. **https://doi.org/10.1371/journal.pone.0289877**

[4] Health Service Executive (2025). National Service Plan 2025. Available at: **https://about.hse.ie/api/v2/download-file/file_based_publications/hSE-National-Service-Plan-2025.pdf/**

[5] Health Service Executive (2015). Connecting for Life: Ireland's National Strategy to Reduce Suicide 2015-2020. Available at: **https://www.hse.ie/eng/services/list/4/mental-health-services/nosp/preventionstrategy/connectingforlife.pdf**

[6] Health Service Executive (2023). HSE Child and Youth Mental Health Office Action Plan 2024-2027. Available at: **https://www.hse.ie/eng/services/list/4/mental-health-services/camhs/publications/hse-child-and-youth-mental-health-office-3-year-action-plan.pdf**

Clinical Management of Self-Harm

The proportion of patients that received a mental health assessment (or for whom an assessment was arranged) in the presenting hospital remains similar to recent years, yet it is higher than that reported in other countries. The reported variation across hospitals and health regions in the provision of mental health assessments and recommended next care underlines the importance of the implementation of a standardised and evidence-informed approach to the assessment and treatment of patients who present to hospital following self-harm. The National Clinical Programme for Self-Harm and Suicide-Related Ideation (NCPSHI) was introduced in Ireland between 2014 and 2017 and has been implemented in all 26 adult and one paediatric acute hospital ED. In 2022, the Clinical Programme was updated and provides a framework to improve services for all who self-harm or present with suicide-related ideation, regardless of where they present.[7]

The findings in the 2024 report indicate that there remains considerable variation in recommended next care across hospitals, and that on average, one in seven patients leave the ED without being seen by a clinician or without a next care recommendation. Research utilising Registry data which examined risk factors for individuals discharged from the ED without a mental health related referral found that those who were brought to hospital by ambulance, presented to hospital outside of 9 a.m. – 5 p.m., and who were admitted to an ED Medical Assessment Unit were most likely to not receive such a referral.[8]

Self-harm has also been identified as a risk factor for subsequent self-harm presentations and suicide.[9] The importance of safety planning and timely follow-up and referral in the period following presentation to hospital with self-harm has also been highlighted by Griffin and colleagues whereby the risk of suicide was found to be greatest in the days and weeks following a presentation to hospital.[10] Research has also found that physical and mental illness comorbidity is high among individuals with frequent self-harm episodes.[11] The type and intensity of the provision of care for individuals following an ED self-harm presentation is therefore an important consideration. Despite this, a study carried out with patients who had a high-risk self-harm presentation to hospital found that those with a history of self-harm and mental health service engagement were more likely to report dissatisfaction with the care provided.[12]

Recommendation 4: The delivery and implementation of the NCPSHI should continue to be supported in all hospitals nationally.

Recommendation 5: Safety planning and timely follow-up and referral in the period following presentation to hospital with self-harm should be prioritised.

Recommendation 6: Tailored assessment and treatment procedures for self-harm patients with frequent patterns of self-harm and those with high-risk self-harm should be implemented.

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[7] Health Service Executive (2022). National Clinical Programme for the Assessment and Management of Patients Presenting to the Emergency Department following Self-Harm. Available at: **https://www.hse.ie/eng/about/who/cspd/ncps/self-harm-suicide-related-ideation/moc/**

[8] Cully, G., Russell, V., Joyce, M., Corcoran, P., Daly, C., & Griffin, E. (2024). Discharged from the emergency department following hospital-presented self-harm: referral patterns and risk of repeated self-harm. *Irish Journal of Medical Science (1971-), 193*(5), 2443-2451. **https://doi.org/10.1007/s11845-024-03722-5**

[9] Carroll, R., Metcalfe, C., & Gunnell, D. (2014). Hospital presenting self-harm and risk of fatal and non-fatal repetition: systematic review and meta-analysis. *PloS one, 9*(2), e89944. **https://doi.org/10.1371/journal.pone.0089944**

[10] Griffin, E., Corcoran, P., Arensman, E., Kavalidou, K., Perry, I. J., & McMahon, E. M. (2023). Suicide risk following hospital attendance with self-harm: a national cohort study in Ireland. *Nature mental health, 1*(12), 982-989. **https://doi.org/10.1038/s44220-023-00153-6**

[11] Sadath, A., Troya, M. I., Nicholson, S., Cully, G., Leahy, D., Ramos Costa, A. P., ... & Arensman, E. (2023). Physical and mental illness comorbidity among individuals with frequent self-harm episodes: A mixed-methods study. *Frontiers in psychiatry, 14*, 1121313. **https://doi.org/10.3389/fpsyt.2023.1121313**

[12] Cully, G., Leahy, D., Shiely, F., & Arensman, E. (2022). Patients' experiences of engagement with healthcare services following a high-risk self-harm presentation to a hospital emergency department: a mixed methods study. *Archives of Suicide Research, 26*(1), 91-111. **https://doi.org/10.1080/13811118.2020.1779153**

Restricting Access to Means

Restricting access to means has been highlighted internationally as an effective strategy in reducing the incidence of self-harm or suicide.[13] An example of this is the positive impact shown for measures to reduce access to sites where people frequently engage in attempted or fatal drowning.[14] In Ireland, a best practice toolkit for preventing suicide in public places was launched in February 2025.[15] The toolkit recommends means restriction as part of a broader suicide prevention strategy. Initiatives to reduce access to means continue to be critical to reduce the incidence of self-harm in Ireland.

Intentional drug overdose (IDO) is the most common method of self-harm recorded by the Registry and paracetamol is one of the most common drug types used. In 2022, a campaign was launched in Ireland by the Paracetamol Working Group whereby new information packs were made available nationally to staff working in pharmacy and non-pharmacy retail settings. The objectives of the information campaign were to: 1) enhance the messaging around safe sales of paracetamol 2) support improved implementation of paracetamol sales regulations and 3) spotlight the importance of such regulations in the context of self-harm and suicide prevention efforts. The Working Group continues to expand its ongoing efforts to reduce paracetamol-related overdoses through ongoing evaluation and educational initiatives. Additional work in means restriction is also being carried out via the 'RESTRICT – REducing intentional overdose: a mixed methods STudy of means RestrICTion interventions' project which aims to reduce IDO by evaluating the impact and informing the implementation of means restriction interventions. The outcomes of this project will inform national policy, support the implementation of evidence informed health service delivery and advance understanding of intentional overdose. Measures to reduce access to methods of self-harm are aligned with *Connecting for Life*, Goal 6.

Recommendation 7: Actions set out in the best practice toolkit for preventing suicide in public places should be considered by relevant agencies (e.g. Local Authorities, Transport Infrastructure Ireland) and implemented through partnership and collaboration.

Recommendation 8: Findings from the work of the Paracetamol Working Group and projects like RESTRICT should be disseminated to relevant stakeholders to increase awareness and advance understanding in relation to IDO.

[13] Hawton, K., Knipe, D., & Pirkis, J. (2024). Restriction of access to means used for suicide. *The Lancet Public Health, 9*(10), e796-e801. **https://doi.org/10.1016/S2468-2667(24)00157-9**

[14] Pirkis, J., Spittal, M. J., Cox, G., Robinson, J., Cheung, Y. T. D., & Studdert, D. (2013). The effectiveness of structural interventions at suicide hotspots: a meta-analysis. *International Journal of Epidemiology, 42*(2), 541-548. **https://doi.org/10.1093/ije/dyt021**

[15] Health Service Executive (2025). Preventing suicide in public places. A best practice toolkit. Available at: **https://www.hse.ie/eng/services/list/4/mental-health-services/nosp/resources/preventing-suicide-public-places.pdf**

Self-Harm among Persons Experiencing Homelessness

In 2024, the proportion of self-harm presentations recorded by the Registry of persons experiencing homelessness/of no fixed abode was comparable to recent years including 2023. An increase had been observed in the years prior to 2020. This group of individuals is a particularly vulnerable population, at high risk of repetition and mortality from all causes.[16] In accordance with Goal 3, Action 3.1 of *Connecting for Life*, these findings underline the need for targeted suicide prevention interventions among this group. One such example is a peer-delivered intervention which was trialled in Scotland and England to reduce harm and improve the well-being of individuals who experience both homelessness and problem substance misuse, and was found to be feasible and acceptable.[17] However, a scoping review of suicide specific intervention programmes for people experiencing homelessness identified just three types of intervention that target this group.[18] That review highlights the lack of evidence-based supports for this group of individuals.

Recommendation 9: Further work to examine specific risk and protective factors associated with self-harm among persons experiencing homelessness and those of no fixed abode should be carried out.

Recommendation 10: Evidence-based supports and targeted suicide prevention interventions should be identified for this priority group.

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[16] Nilsson, S. F., Laursen, T. M., Erlangsen, A., Hawton, K., Nordentoft, M., & Fazel, S. (2025). Homelessness, psychiatric disorders, and risks of suicide and self-harm: a population-based cohort study. *The Lancet Public Health, 10*(7), e559-e567. **https://doi.org/10.1016/S2468-2667(25)00100-8**

[17] Parkes, T., Matheson, C., Carver, H. et al. (2022). Assessing the feasibility, acceptability and accessibility of a peer-delivered intervention to reduce harm and improve the well-being of people who experience homelessness with problem substance use: the SHARPS study. *Harm Reduct J* 19, 10. **https://doi.org/10.1186/s12954-021-00582-5**

[18] Murray, R. M., Conroy, E., Connolly, M., Stokes, D., Frazer, K., & Kroll, T. (2021). Scoping review: Suicide specific intervention programmes for people experiencing homelessness. *International journal of environmental research and public health, 18*(13), 6729. **https://doi.org/10.3390/ijerph18136729**

Surveillance of self-Harm and Suicide and Prioritising Data Collection

The National Self-Harm Registry Ireland is an example of a national system which can provide timely and relevant information to assess the impact of significant events such as public health emergencies on suicidal behaviour. During the COVID-19 pandemic, the Registry published periodic data briefings on the monthly number of self-harm presentations to a select number of hospitals during 2020 and 2021. The provision of timely and accurate self-harm data during public health emergencies are particularly important given that these data briefings were able to accurately determine no significant increase in self-harm rates during the early stages of the pandemic. The continued collection of data by the Registry over multiple years also facilitates the examination of trends over time. Examination of such trends highlighted an increase in self-harm in younger age groups up to and during the pandemic, as well as peaks for certain groups of individuals during recessionary times. Ongoing surveillance is important, and the publication of data and associated findings remains a priority for the Registry.

Recommendation 11: The continued monitoring of self-harm and suicide should be prioritised to inform suicide prevention activities as listed under Priority Area 2 in the recently launched Strategic Plan 2025-2030 from the National Suicide Research Foundation.[19]

Recommendation 12: The publication of data and associated findings from surveillance systems like the National Self-Harm Registry should be prioritised to enhance awareness and understanding of self-harm.

[19] National Suicide Research Foundation (2025). Leading Research, Shaping Change National Suicide Research Foundation Strategic Plan 2025-2030. Available at: **https://www.nsrf.ie/wp-content/uploads/2021/04/NSRF-Strategic-Plan_digital.pdf**

Recent Publications from the Registry (2024–2025)

The Registry disseminates findings from the data we collect in various ways. One way in which data are disseminated is via peer-reviewed articles that are published in academic journals. Information on a selection of articles published from 2024 and 2025 is provided below.

Data were not available for four hospitals during the timeframe of this report. Area level information across Ireland is not presented in this report as a result. In previous years, where there was full hospital coverage in an area, the Registry reported on hospital self-harm presentations via Community Healthcare Organisation (CHO) Area Reports. CHO reports for previous years are available on our website:

www.nsrf.ie/registry/registry-annual-reports-interim-reports-and-cho-reports

With the introduction of six new HSE Health Regions in 2024, the Registry will report on hospital self-harm presentations according to these regions from 2024 onwards.

Recent Peer-reviewed Publications

Comparing times of self-harm presentations to hospital emergency departments in children, adolescents, young adults and adults: a national registry study 2007–2019

Purpose

The few studies that have explored self-harm presentation times at hospital emergency departments (EDs) – an important factor that can determine if a patient receives a mental health assessment – primarily focus on adult samples. This study examined the times of self-harm presentations to EDs, self-harm methods used, mental health assessments, and admission data across different age-groups.

Methods

Using data from the National Self-Harm Registry Ireland over a 13-year timeframe (2007–2019), this study compared times, days, seasons, methods of self-harm, and admission data for children (8–12 years), adolescents (13–17 years), young adults (18–25 years) and adults (>25 years).

Results

The majority of the 152,474 self-harm presentations (78.6%) for all ages occurred out-of-hours (outside the standard working hours or in-hours times of 09:00–17:00, Monday-Friday). The four hours before midnight had the highest proportions of self-harm presentations for adolescents (27.9%) and adults (23.1%), whereas the four hours after midnight had the highest proportion of self-harm presentations for young adults (22.9%). The 16:00-midnight timeframe had highest proportion of self-harm presentations in children (52.3%). Higher proportions of patients received a mental health assessment in-hours compared to out-of-hours among young adults (78.2% vs. 73.3%) and adults (76.1% vs. 72.0%). Self-harm presentations were lowest during summer months in children and adolescents.

Discussion

Hospitals should ensure that adequate resources are available for individuals presenting with self-harm, especially in the case of overcrowded EDs, and protocols need to be designed for those presenting with self-harm due to intoxication. In line with national policy, protocols for patients presenting during out-of-hours should be designed that can incorporate services from allied health multidisciplinary teams, social work, addiction services and counselling organisations. Given the lower rates of self-harm during school holidays for children and adolescents, the school environment must be considered in the context of mental health and self-harm public health prevention interventions.

Source: McEvoy, D., Joyce, M., Mongan, D., Clarke, M., & Codd, M. (2024). Comparing times of self-harm presentations to hospital emergency departments in children, adolescents, young adults and adults: a national registry study 2007–2019. *BMC psychiatry, 24*(1), 474. **https://doi.org/10.1186/s12888-024-05921-x**

Discharged from the emergency department following hospital-presented self-harm: referral patterns and risk of repeated self-harm

Background

Presentation to the emergency department (ED) with self-harm provides an important opportunity for intervention.

Aims

To investigate characteristics and self-harm repetition risk of those discharged from the ED without a referral for mental health–related aftercare.

Method

Data on consecutive self-harm presentations to EDs for the years 2013–2019 (n = 55,770) were obtained from the National Self-Harm Registry Ireland. Multilevel Poisson and Cox regression models were estimated.

Results

Half of the self-harm presenters were discharged from the ED (49.8%) and almost half of them did not receive a mental health–related referral (46.8%). Receipt of a psychosocial assessment was associated with a 50% reduced risk of non-referral (IRR 0.54; 95% CI 0.51–0.57). Non-referral was also less likely for young people (< 18 years), presentations involving attempted hanging, persons with previous self-harm presentations, and in the latter half of the study period (2017–2019 vs. 2013–2016), but was more likely for those brought by ambulance, presenting outside 9 am–5 pm and admitted to an ED medical assessment unit. Of those not referred, 19.3% had a repeat presentation within 12 months, compared to 22.4% of those referred. No difference in repetition risk between these two groups was evident in adjusted analyses. Self-harm history had the strongest association with repetition, with highest risk among individuals with four or more previous presentations (HR 9.30, 95% CI 8.14–10.62).

Conclusions

The findings underline the importance of assessing all individuals who present with self-harm and highlight the need for comprehensively resourced 24hr services providing mental health care in the ED.

Source: Cully, G., Russell, V., Joyce, M., Corcoran, P., Daly, C., & Griffin, E. (2024). Discharged from the emergency department following hospital-presented self-harm: referral patterns and risk of repeated self-harm. *Irish Journal of Medical Science (1971-), 193*(5), 2443–2451. **https://doi.org/10.1007/s11845-024-03722-5**

The burden of attempted hanging and drowning presenting to hospitals in Ireland between 2007 and 2019: a national registry-based study

Aim

To measure the impact of hospital-treated self-harm by hanging and drowning in Ireland in 2007–2019 and identify risk factors for these methods of self-harm.

Methods

Data on all self-harm presentations to Irish hospitals between 2007 and 2019 were obtained from the National Self-Harm Registry Ireland, a national self-harm surveillance system. Multinomial regression was used to explore factors associated with attempted hanging and drowning.

Findings

The age-standardised incidence rate of attempted hanging and drowning increased by 126% and 45%, respectively, between 2007 and 2019. The incidence of both methods was highest among young people aged 15–24 years. The odds of presenting to hospital for attempted hanging were highest in males (aOR 2.85, 95% CI 2.72–3.00), people experiencing homelessness (aOR 1.32, 95% CI 1.16–1.49) and individuals living in the capital, Dublin (aOR 1.23, 95% CI 1.17–1.29). The odds of presenting for attempted drowning were highest in males (aOR 1.68, 95% CI 1.58–1.78) and people experiencing homelessness (aOR 2.69, 95% CI 2.41–2.99).

Conclusion

The incidence of hospital-treated self-harm by hanging and drowning is increasing in Ireland and is highest among adolescents and young adults. Males and people experiencing homelessness may be at highest risk and warrant targeted preventive interventions.

Source: White, P., Corcoran, P., Griffin, E., Arensman, E., & Barrett, P. (2024). The burden of attempted hanging and drowning presenting to hospitals in Ireland between 2007 and 2019: a national registry-based study. *Social psychiatry and psychiatric epidemiology, 59*(2), 235–244. **https://doi.org/10.1007/s00127-023-02525-w**

Advancing early detection of suicide? A national study examining socio-demographic factors, antecedent stressors and long-term history of self-harm

Background

A range of factors including **mental disorders**, adverse events and history of self-harm are associated with suicide risk. Further examination is needed of the characteristics of suicides which occur without established risk factors, using national surveillance systems.

Methods

Data on all suicides in Ireland from 2015 to 2017 were drawn from the Irish Probable Suicide Deaths Study (IPSDS). Variables examined included socio-demographics, psychiatric history and precipitant stressors. Suicide data were linked with data on prior self-harm from the National Self-Harm Registry Ireland (NSHRI). Latent Class Analysis (LCA) was used to identify sub-groups of suicide cases.

Results

Of the 1809 individuals who died by suicide, 401 (22.2 %) had a history of hospital-treated self-harm. Four distinct profiles of suicides were identified. One group was marked by high levels of prior self-harm and **mental health** conditions. Two of the groups included few individuals with a history of self-harm but had notably high levels of mental health conditions. These two groups had relatively high levels of reported chronic pain or illness but differed in terms of socio-demographics. The final group, predominantly male, had markedly low levels of mental health conditions or self-harm but high levels of personal stressors and substance use.

Limitations

The use of coronial data may be limited by bias in the collecting of information from the deceased's family members.

Conclusions

A sub-group of suicide cases exists without any psychiatric or self-harm history but with salient occupational or health-related proximal stressors. Suicide prevention interventions should include occupational settings and should promote mental health literacy.

Source: McMahon, E. M., Cully, G., Corcoran, P., Arensman, E., & Griffin, E. (2024). Advancing early detection of suicide? A national study examining socio-demographic factors, antecedent stressors and long-term history of self-harm. *Journal of affective disorders, 350,* 372–378.
https://doi.org/10.1016/j.jad.2024.01.030

Hospital-presenting self-harm among older adults living in Ireland: a 13-year trend analysis from the National Self-Harm Registry Ireland

Aim

To examine trends in rates of self-harm among emergency department (ED) presenting older adults in Ireland over a 13-year period.

Methods

Design: Population-based study using data from the National Self-Harm Registry Ireland.
Setting: National hospital EDs.
Participants: Older adults aged 60 years and over presenting with self-harm to hospital EDs in Ireland between January 1, 2007 and December 31, 2019.
Measurements: ED self-harm presentations.

Findings

Between 2007 and 2019, there were 6931 presentations of self-harm in older adults. The average annual self-harm rate was 57.8 per 100,000 among older adults aged 60 years and over. Female rates were 1.1 times higher compared to their male counterparts (61.4 vs 53.9 per 100,000). Throughout the study time frame, females aged 60–69 years had the highest rates (88.1 per 100,000), while females aged 80 years and over had the lowest rates (18.7 per 100,000). Intentional drug overdose was the most commonly used method (75.5%), and alcohol was involved in 30.3% of presentations. Between the austerity and recession years (2007–2012), self-harm presentations were 7% higher compared to 2013–2019 (incidence rate ratio (IRR): 1.07 95% CI 1.02–1.13, p = 0.01).

Conclusion

Findings indicate that self-harm in older adults remains a concern with approximately 533 presentations per year in Ireland. While in younger age groups, females report higher rates of self-harm, this gender difference was reversed in the oldest age group (80 years and over), with higher rates of self-harm among males. Austerity/recession years (2007–2012) had significantly higher rates of self-harm compared to subsequent years.

Source: Troya, M.I., Griffin, E., Arensman, E., Cassidy, E., Mughal, F., Lonergan, C.N., O'Mahony, J., Lovejoy, S., Ward, M. & Corcoran, P. (2024) Hospital-presenting self-harm among older adults living in Ireland: a 13-year trend analysis from the National Self-Harm Registry Ireland. *International psychogeriatrics, 36*(5), 396–404.
https://doi.org/10.1017/S1041610223000856

Impact of the Registry at National and Global Level (2025)

Technical support for the establishment of self-harm surveillance systems at global level

- In 2025, the NSRF continued as a designated collaboration centre for surveillance and research in suicide prevention with the World Health Organisation (WHO).
- In April 2025, the NSRF hosted delegates from Wales at a National Self-Harm Registry Ireland meeting in Cork to continue to advise and provide further information about establishing a self-harm registry in North Wales.
- On May 27th 2025, the NSRF contributed updates on self-harm and suicide surveillance in Ireland at the WHO meeting involving all WHO Collaborating Centres working in the area of suicide and self-harm.
- In May, the UCC School of Public Health and NSRF co-hosted an annual conference with the HSE National Clinical Programme for Self-harm and Suicide related ideation, providing an opportunity to share research findings and clinical experiences of providing care for self-harm in emergency departments, with a focus on involving family members/supporters in care following self-harm. This project will co-produce an e-module for healthcare staff along with accessible information resources for family members, supporters and patients."
- The NSRF contributed multiple presentations based on the National Self-Harm Registry Ireland to the 33rd World Congress of the International Association for Suicide Prevention, June 10th-13th 2025.
- On September 25th 2025, Professor Ella Arensman presented 'Do National Suicide Prevention Strategies Work?' at the 55th Annual Scientific Conference for Suicide Prevention at Maison De La Chimie, Paris.
- In October 2025, Dr Paul Corcoran contributed to a Webinar by Mental Health Reform, Ireland on real-time self-harm and suicide surveillance systems in Ireland.

Technical support for the development, implementation and evaluation of national suicide prevention programmes

- Technical support in expanding and optimising a self-harm surveillance system in Wales was provided to a delegation from the School of Health Sciences, University of Bangor, Wales.
- World Health Organisation Collaborating Centre (WHOCC) staff completed an EU Horizon Health grant application on the implementation of evidence-based mental health promotion and suicide prevention programmes among refugees, involving members from the WHO Country Office in Kenya and UNHCR.

Above: Members of the NSRF team at the 33rd World Congress of the International Association for Suicide Prevention, 2025.

Methods

Background

The National Self-Harm Registry is operated by the National Suicide Research Foundation. The National Suicide Research Foundation was founded in November 1994 by the late Dr Michael J Kelleher and is governed by a Board of Directors. The National Suicide Research Foundation team is led by Dr Eve Griffin, Dr Paul Corcoran, Professor Ella Arensman and Dr Mary Joyce. Dr Paul Corcoran is also Head of the National Self-Harm Registry and Dr Mary Joyce is Manager of the National Self-Harm Registry.

Funding Statement

The National Self-Harm Registry Ireland is a national system which monitors the occurrence of hospital-presenting self-harm. It was established by the National Suicide Research Foundation at the request of the Department of Health and Children and is funded by the Health Service Executive's National Office for Suicide Prevention. This report has been commissioned by the National Office for Suicide Prevention.

Definition and Terminology

The Registry uses the following definition of 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 World Health Organisation/ 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 '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 intentional self-harm, as listed in the 10th Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10) codes of X60-X84, are included i.e., intentional 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 self-harm act are included.

Exclusion Criteria

The following cases are not considered to be self-harm:

- Accidental overdoses of medicinal or illegal drugs e.g., an individual who takes additional medication in the case of illness or used drugs for recreational purposes, without any intention to self-harm.
- Alcohol overdoses alone where there was no 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 data are continuously checked for consistency and accuracy. In addition, the Registry also undertakes a cross-checking process in which pairs of Data Registration Officers independently collect data from two hospitals for the same consecutive series of attendances to the ED. Cross-checking has not been conducted since the onset of the COVID-19 pandemic. Previous to that, results of the cross-checking process indicated there was a very high level of agreement between Data Registration Officers.

Data Recording

Since 2020, the Registry records data via a cloud-based clinical data management platform, Castor Electronic Data Capture (EDC), which meets all European Union standards related to secure data storage of health research data. Data are available in real-time as Data Registration Officers input data to this electronic system. The move to Castor EDC for the electronic processing of Registry data in 2020 was a positive and necessary update for several reasons including its modern design, user friendly interface, secure log-in, real-time access and ease of data upload. Castor EDC includes several features such as data monitoring, query function, comment option, progress bar for each data entry, and audit trails. These features have enhanced the way the Registry manages data and completes quality checks.

Patient identifiers are not recorded in Castor EDC. Instead, name, sex and date of birth are entered into a separate software programme to generate a unique ID code for each patient. The bespoke software programme was designed specifically for the Registry by Millennium Software. The generated ID code is then recorded in the Registry dataset via Castor EDC, while patient identifiers are not.

All Data Registration Officers receive ongoing training on the use of Castor EDC and the code generator software on a regular basis.

Data Items

A minimal dataset has been developed to determine the extent of 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 data processing system to avoid duplicate recording and to recognise repeat acts of self-harm by the same individual, it is impossible to identify an individual based on the data held in the Registry database.

Initials
Initial letters from the self-harm patient's name are recorded in an encrypted form via the code generator software so that a unique ID code can be assigned to each patient. Having a unique ID code for each patient ensures that repeat episodes are recognised and incidence rates based on persons rather than events can be calculated.

Sex
The sex of the patient 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 generate the unique ID code for patient, date of birth is used to calculate age.

Area of residence
Patient addresses are coded to the appropriate Small Area where applicable. Patients without a fixed or known address are coded as such.

Date and hour of attendance at hospital
The date of attendance and hour of attendance (in 24-hour format) is recorded.

Mode of arrival
Information is recorded about patients who were brought to hospital by Ambulance or other Emergency Services (e.g. An Garda Síochána). If a patient self-presented or was brought in by someone (e.g. family member), this information is recorded when known.

Method(s) of self-harm
The method(s) of self-harm are recorded according to the ICD-10 codes for intentional injury (X60-X84). The main methods are intentional 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., intentional overdose of medications and self-cutting. For acts involving self-cutting, the treatment received is recorded when known. Since 2020, further detail is also recorded on certain self-harm methods such as X70 (whether it was hanging, strangulation or suffocation) and X78 (further information on wounds).

Drugs taken
Where applicable, the name and quantity of the drugs taken are recorded.

Medical card status
Whether the individual presenting has a medical card or not is recorded.

Mental health assessment
Whether the individual presenting had an assessment by the psychiatric team in the presenting hospital is recorded.

Recommended next care
Recommended next care following treatment in the hospital ED is recorded.

Current care
Information on the current care of the patient and whether they are engaged with hospital/community-based services i.e. Mental Health Service supports, Addiction Services, Homeless Services etc. is recorded when known.

Confidentiality and Data Protection

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, the Irish Data Protection (Amendment) Act of 2003 and the General Data Protection Regulation (GDPR) 2018. All staff members are trained in GDPR and adhere to all GDPR guidelines when collecting and working on data. The names and addresses of patients are not recorded in the Registry database. Only anonymised data are released in aggregate form in reports. Individuals may request to access their information or to have their information withdrawn from the Registry at any time by contacting the Registry team. An enquiry can also be made via an online form on our website: **www.nsrf.ie/registry/**.

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 individual hospital and Health Service Executive (HSE) ethics committees. In 2020, the Registry received approval from the Health Research Consent Declaration Committee to continue the operation of the Registry utilising a waiver of consent.

Registry Coverage

In 2024, self-harm data were collected from 27 hospitals in the Republic of Ireland (pop: 5,380,300). The hospitals for which data are presented in this report are listed by HSE health region in the table on the following page.

Data were collected in three of the six acute hospitals in HSE Dublin and North East.

Data were collected in eight of the nine acute hospitals in HSE Dublin and Midlands. This includes two children's hospitals: Children's Health Ireland at Crumlin and Temple Street.

There was complete coverage of all acute hospitals in HSE Dublin and South East (five hospitals), HSE Mid West (one hospital), HSE South West (three hospitals), and HSE West and North West (five hospitals).

In 2013, a number of hospital EDs were re-designated as Model 2 status hospitals as part of the HSE's *Securing the Future of Smaller Hospitals* framework, with some of these hospitals closing their ED and others operating on reduced hours. The hospitals included in this report which continue to have their ED on reduced hours or provide an Urgent Care Centre as an alternative are: Bantry General Hospital and St. Michael's Hospital, Dún Laoghaire. These hospitals are referred to as Model 2 hospitals throughout this report.

In total, self-harm data were collected for the full calendar year of 2024 for 25 of the 29 EDs that operated in Ireland during this year. Data were also collected for the full calendar year for two Model 2 hospital EDs.

Population Data

For 2024, the Central Statistics Office population estimates were utilised. These estimates provide age-sex-specific population data for the country.

Calculation of Rates

In 2024, there were four hospitals in which data were unavailable. We estimated the number of presentations and people presenting to these hospitals using data from recent years. Data on hospital-presenting self-harm in 2024 were not available from three general hospitals and one Children's Health Ireland hospital. We used the following approach in order to estimate the national figures for hospital-presenting self-harm that would have been recorded for 2024 if these hospitals had contributed data. We reviewed several years of data from the three CHI hospital emergency departments, which determined that another CHI hospital had a similar number and profile of presentations. We calculated a weighting based on the number of self-harm presentations to both hospitals in 2023 and applied that weighting to the data from the hospital that contributed data in 2024. For the three general hospitals, we analysed the data from the most recent year when all three contributed data. We compared the number of self-harm presentations (and presenters) to general hospitals in that year when the three hospitals were included and when they were excluded. This was done by sex and five-year age group. Weightings were calculated based on these comparisons, which were applied to the data recorded from the contributing general hospitals in 2024.

Self-harm rates were calculated based on the number of persons who engaged in self-harm. Crude and age-specific rates per 100,000 population were calculated by dividing the number of persons who engaged in self-harm (n) by the relevant population figure (p) and multiplying the result by 100,000, i.e. $(n/p) \times 100{,}000$.

European age-standardised rates (EASR) 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 self-harm rather than differences in the composition of the populations. EASR were calculated as follows: for each five-year age group, the number of persons who engaged in 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, 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.

A small number of 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 2024.

A Note on Confidence Intervals

Confidence intervals provide us with a margin of error within which underlying rates may be presumed to fall on the basis of observed data. Confidence intervals assume that the event rate (n/p) is small and that the events are independent of one another. A 95% confidence interval for the number of events (n) is $n \pm 2\sqrt{n}$. For example, if 25 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 $(n - 2\sqrt{n})/p$ to $(n + 2\sqrt{n})/p$, 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 $rd - 2\sqrt{(n_1 / p_1^2 + n_2 / p_2^2)}$ to $rd + 2\sqrt{(n_1 / p_1^2 + n_2 / p_2^2)}$. If the rates were expressed per 100,000 population, then $2\sqrt{(n_1 / p_1^2 + n_2 / p_2^2)}$ 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.

HSE health region	Hospitals in the region
HSE Dublin and North East	Cavan Monaghan Hospital
	Our Lady of Lourdes Hospital, Drogheda
	Our Lady's Hospital, Navan
HSE Dublin and Midlands	Children's Health Ireland at Crumlin
	Children's Health Ireland at Temple Street
	Midland Regional Hospital Mullingar
	Midland Regional Hospital Portlaoise
	Midland Regional Hospital Tullamore
	Naas General Hospital
	St. James's Hospital
	Tallaght University Hospital
HSE Dublin and South East	St. Luke's General Hospital, Carlow Kilkenny
	St. Michael's Hospital, Dún Laoghaire
	Other
	Tipperary University Hospital
	University Hospital Waterford
	Wexford General Hospital
HSE Mid West	University Hospital Limerick
HSE South West	Bantry General Hospital
	Cork University Hospital
	Mercy University Hospital, Cork
	University Hospital Kerry
HSE West and North West	Letterkenny University Hospital
	Mayo University Hospital
	Portiuncula University Hospital
	Sligo University Hospital
	University Hospital Galway

SECTION I:
Hospital Presentations

Hospital-Presenting Self-Harm in the Republic of Ireland

For the period from 1 January to 31 December 2024, the Registry recorded 10,532 self-harm presentations to hospital that were made by 7,940 individuals. These figures do not include presentations to four hospitals as outlined earlier (see Methods). Adjusting for the absence of data from four hospitals, we estimate that there was a total of 12,621 self-harm presentations by 9,436 individuals. Thus, the number of self-harm presentations was similar to that recorded in 2023 while 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.

	Presentations		Persons	
Year	Number	% difference	Number	% difference
2002	10,537	–	8,421	–
2003	11,204	+6%	8,805	+5%
2004	11,092	–1%	8,610	–2%
2005	10,789	–3%	8,594	–<1%
2006	10,688	–1%	8,218	–4%
2007	11,084	+4%	8,598	+5%
2008	11,700	+6%	9,218	+7%
2009	11,966	+2%	9,493	+3%
2010	12,337	+3%	9,887	+4%
2011	12,216	–1%	9,834	–<1%
2012	12,010	–2%	9,483	–4%
2013	11,061	–8%	8,772	–8%
2014	11,126	+<1%	8,708	–<1%
2015	11,189	+1%	8,791	+1%
2016	11,445	+2%	8,876	+1%
2017	11,620	+2%	9,114	+3%
2018	12,588	+8%	9,785	+7%
2019	12,465	–1%	9,705	–1%
2020	12,590	+1%	9,585	–1%
2021	12,661	+1%	9,533	–<1%
2022	12,705	+<1%	9,748	+2%
2023	12,792	+<1%	9,786	+<1%
2024	12,621	–1%	9,436	–4%

Table 1: Number of self-harm presentations and persons who presented to hospital in the Republic of Ireland in 2002–2024 (2002–2005 and 2020–2024 figures extrapolated to adjust for hospitals not contributing data).

The age-standardised rate of individuals presenting to hospital in the Republic of Ireland following self-harm in 2024 was 181 per 100,000 (95% Confidence Interval (CI): 177–184). This was a decrease of 5% on the rate of 191 per 100,000 (95% CI: 188-195) in 2023. The incidence of self-harm in Ireland is examined in more detail in Section II of this report.

Of the recorded presentations in 2024, 44% were made by men and 56% were made by women. Self-harm presentations were higher among the younger age groups. Almost half of all presentations (49%) were by people under 30 years of age and 83% of presentations were by people aged less than 50 years. The number of self-harm presentations to hospitals in Ireland by age and sex are provided in Appendix A, Tables A1–A6.

In most age groups, the number of self-harm presentations by women exceeded the number by men. This was most pronounced in the 10–19-years age group where there were almost three times as many female presentations (1,849 for women vs 631 for men). The number of self-harm presentations by men was higher than the number by women in the 25-39 years age group (1,728 vs 1,450). In recent years, presentations by men were higher in the 35-44 years age group only, and only marginally so.

There were 1,085 presentations from non-household residents, accounting for 10% of all presentations. The number of self-harm presentations made by residents of homeless hostels and people of no fixed abode was 651, representing 6.2% of all presentations. This is a slight decrease from the 6.9% reported in 2023. Adolescents in Residential Care Units accounted for 168 (1.6%) presentations.

Self-Harm by HSE Health Region

Based on figures acquired from the HSE Business Information Unit, self-harm accounted for 0.78% of total attendances to the Emergency Departments of hospitals included in this report. The percentage of attendances accounted for by self-harm varied by HSE health region: from 0.67% in HSE Dublin and North East, 0.68% in HSE West and North West, 0.72% in HSE Dublin and South East and in HSE Dublin and Midlands to 0.91% in HSE Mid West and 1.2% in HSE South West.

In terms of the overall number of self-harm presentations (*n* = 10,532; 100%), the proportion accounted for by HSE health region ranged from 8% in the HSE Mid West and 9% in HSE Dublin and North East, to 17% in HSE West and North West, 20% in HSE South West, 21% in HSE Dublin and South East, and 26% in HSE Dublin and Midlands.

In 2024, the proportion of male to female self-harm presentations was 44% to 56% nationally. When examined at HSE health region level, the proportion of male to female self-harm presentations varied across the regions, though presentations by women outnumbered those by men in all of them (Figure 1).

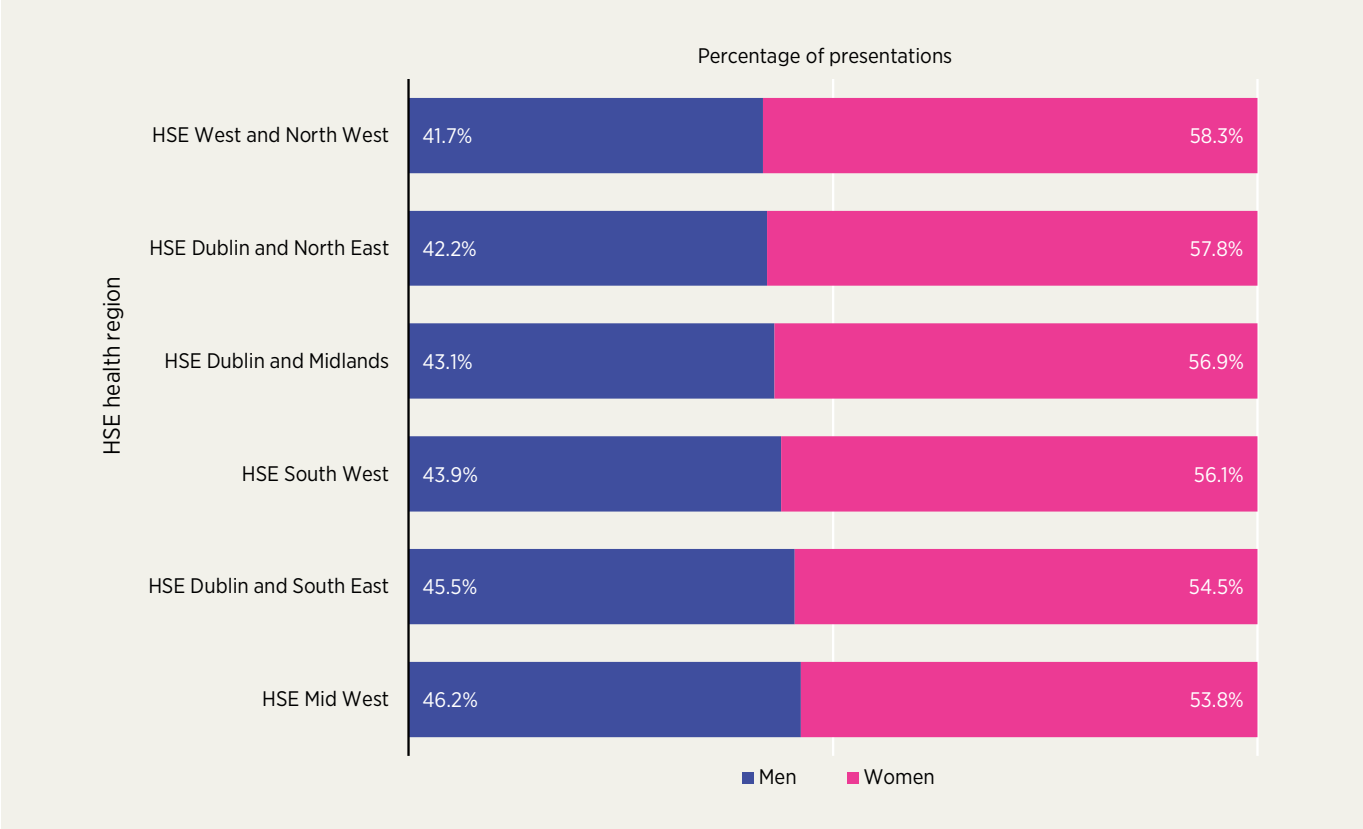

Figure 1: Proportion of male and female self-harm presentations by HSE health region, 2024.

Note: HSE Dublin and North East is missing data from three hospitals. HSE Dublin and Midlands is missing data from one hospital.

Annual Change in Self-Harm Presentations to Individual Hospitals

While the national number of self-harm hospital presentations in 2024 was similar to that recorded in 2023, there were some relatively large changes in the number of presentations at the level of individual hospitals. Eight hospitals saw an increase in self-harm presentations between 2023 and 2024 while 14 hospitals saw a decrease during the same time period (Figure 2). There was a <1% change in three hospitals.

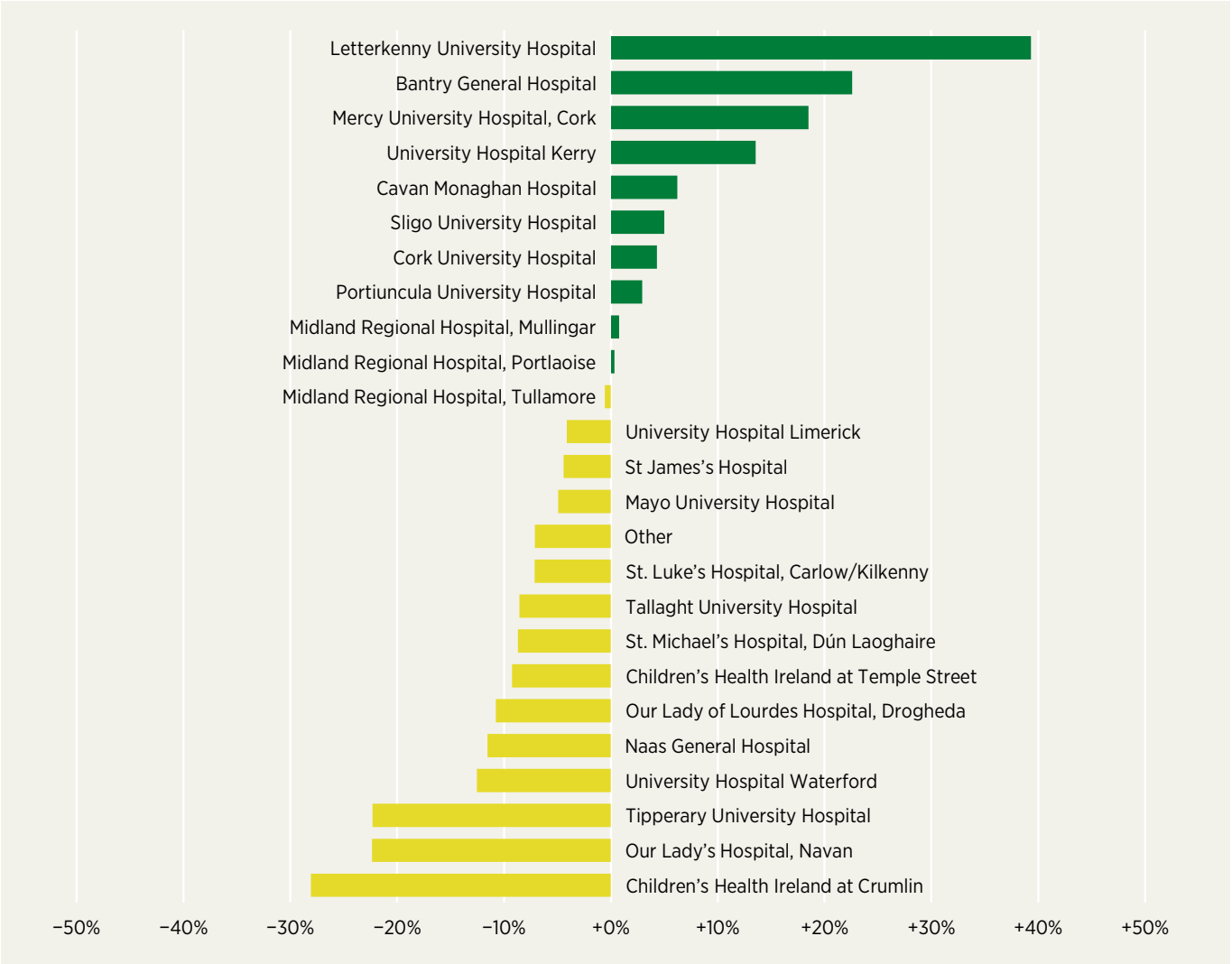

Figure 2: Percentage change in number of presentations to hospitals from 2023 to 2024.

Note: This figure excludes Wexford General Hospital for which an increase of 81% was recorded in 2024. In 2023, the ED was closed for five months which resulted in a lower number of presentations in that calendar year. The figure also excludes University Hospital Galway. Data for 2023 were not available for this hospital so a comparison across years was not possible.

Presentations by Time of Occurrence

Variation by Month

The monthly number of self-harm presentations to hospitals in 2024 is presented for men and women in Table 2.

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total
Men	396	356	431	361	373	390	420	406	393	398	365	312	4,601
Women	476	463	555	510	522	467	473	504	507	504	491	459	5,931
Total	872	819	986	871	895	857	893	910	900	902	856	771	10,532

Table 2: Number of self-harm presentations in 2024 by month for men and women.

The monthly average number of self-harm presentations to hospitals in 2024 was 878. Figure 3 illustrates the percentage difference between observed and expected number of presentations while accounting for the number of days in each calendar month.

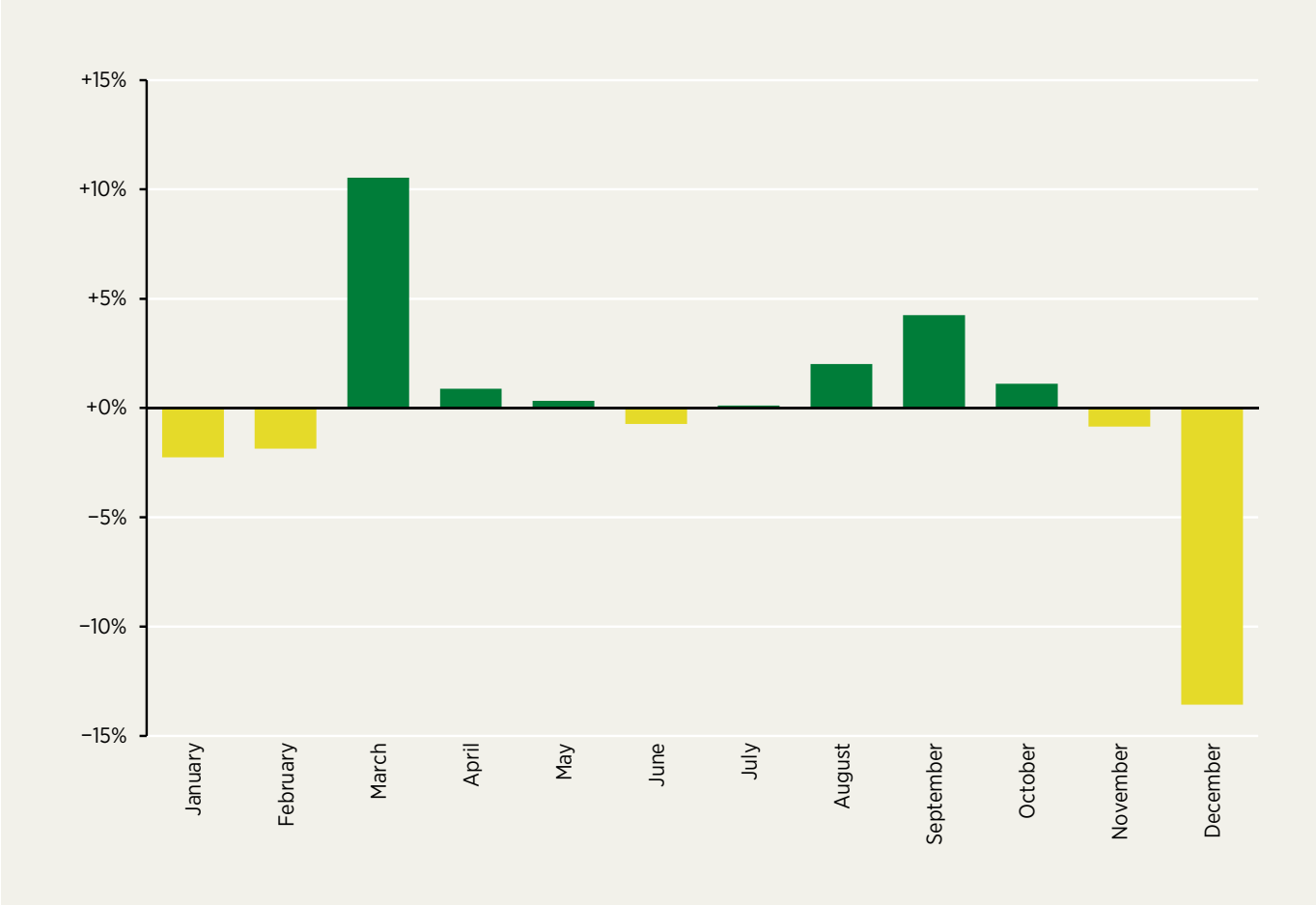

Figure 3: Percentage difference between observed and expected number of self-harm presentations by month in 2024.

The number of presentations was considerably higher than the monthly average in February 2024 (+11%). The number of self-harm presentations also exceeded expected levels in August, September and October. Similar to previous years, the number of self-harm presentations in December was considerably lower than expected (−14%).

Variation by day

The number and percentage of self-harm presentations to hospitals in 2024 is presented by weekday for men and women in Table 3. On average, each day would be expected to account for 14.3% of presentations.

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday	Expected
Men	686	651	634	691	658	614	667	657
	14.9%	14.1%	13.8%	15.0%	14.3%	13.3%	14.5%	14.3%
Women	940	893	825	819	834	724	896	847
	15.8%	15.1%	13.9%	13.8%	14.1%	12.2%	15.1%	14.3%
Total	1,626	1,544	1,459	1,510	1,492	1,338	1,563	1,505
	15.4%	14.7%	13.9%	14.3%	14.2%	12.7%	14.8%	14.3%

Table 3: Self-harm presentations in 2024 by day of the week for men and women.

The number of self-harm presentations was highest on Mondays, Tuesdays and Sundays. The variation in weekday presentations by men and women is visually presented in Figure 4. The number of presentations by day of the week was consistently higher for women.

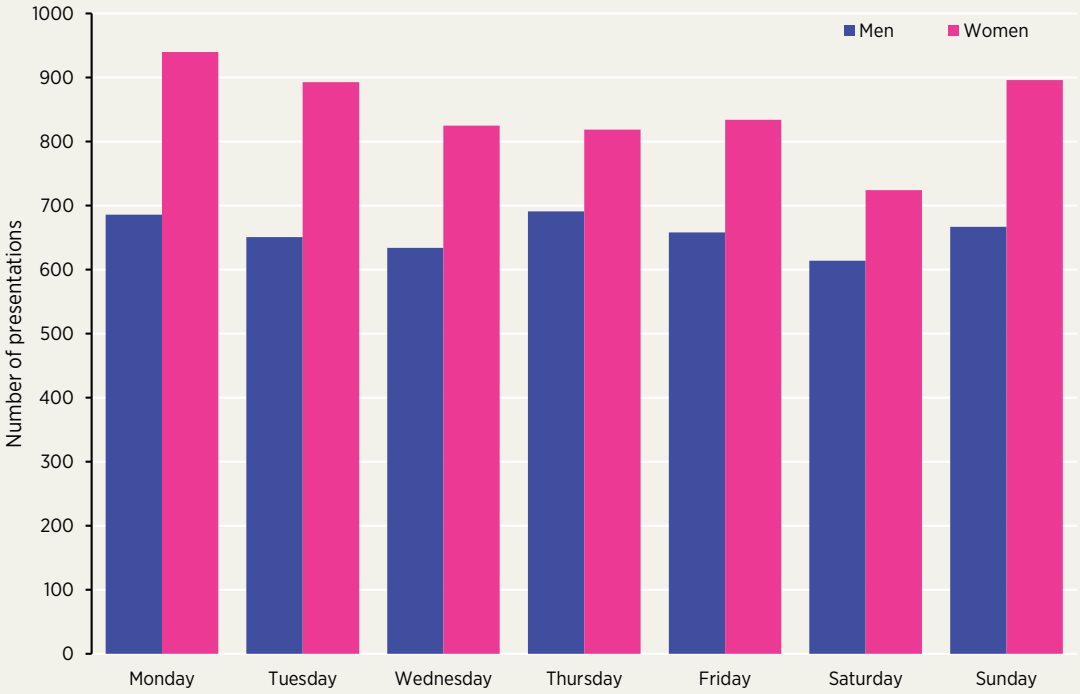

Figure 4: Number of self-harm presentations in 2024 by day of the week for men and women.

In 2024, there was an average of 29 self-harm presentations to hospital each day. Notably, there were eleven days in 2024 on which 40 or more self-harm presentations were made, including November 11th, which had the highest number of presentations (*n* = 44). Conversely, there were seventeen days in 2024 on which fewer than twenty self-harm presentations occurred, seven of which were in December (7th, 17th, 19th, 21st and 23rd–25th).

Variation by hour

The number of self-harm presentations to hospitals in 2024 is presented by time of attendance for men and women in Figure 5.

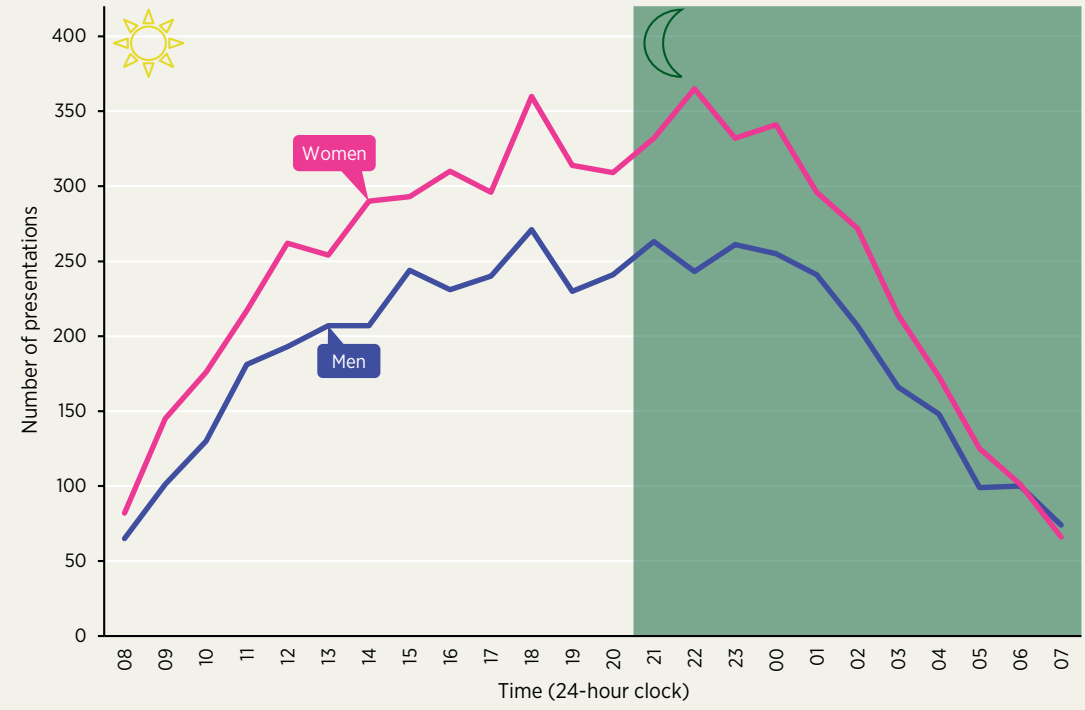

Figure 5: Number of self-harm presentations in 2024 by time of attendance for men and women.

As in previous years, there was a striking pattern in the number of self-harm presentations seen over the course of the day. The numbers for both men and women gradually increased over the course of the day. The peak time for men was 6–7 p.m. while it was 10–11 p.m. for women. Almost half of the total number of presentations (44%) were made during the eight-hour period from 6 p.m. to 2 a.m. This contrasts with the quietest eight-hour period of the day, 3–11 a.m., which accounted for 19% of presentations.

In 2024, 5,919 (56%) of all presentations involved a transfer to hospital by ambulance and a further 3% were brought to hospital by other emergency services such as An Garda Síochána. For 20% of presentations, individuals were brought to hospital (or accompanied) by someone (e.g., a family member or friend) and for 18% of presentations, individuals self-presented to the ED. The proportion of cases brought to an ED by ambulance or other emergency services varied over the course of the day from 48% of presentations between noon and 4 p.m., to 74% of presentations between 4 a.m. and 8 a.m.

Method of Self-Harm

The methods of self-harm[2] involved in presentations to hospital in 2024 are presented in Table 4.

	Intentional drug overdose	Alcohol	Self-poisoning	Attempted hanging	Attempted drowning	Self-cutting	Other
Men (*n* = 4,601)	2,727	1,812	121	530	197	1,308	478
	59.3%	39.4%	2.6%	11.5%	4.3%	28.4%	10.4%
Women (*n* = 5,931)	3,743	1,524	139	295	178	1,862	355
	63.1%	25.7%	2.3%	5.0%	3.0%	31.4%	6.0%
All (*n* = 10,532)	6,470	3,336	260	825	375	3,170	833
	61.4%	31.7%	2.5%	7.8%	3.6%	30.1%	7.9%

Table 4: Methods of self-harm involved in presentations to hospital in 2024 by sex.

In 2024, 61% of all self-harm presentations to hospitals in 2024 involved an intentional drug overdose (IDO). IDO was more commonly used as a method of self-harm by women than men, involved in 63% of female and 59% of male presentations. Alcohol was involved in 32% of presentations, and was more likely to be involved in male than female presentations (39% vs. 26% respectively).

Self-cutting was the only other common method of self-harm, involved in 30% of all presentations. Self-cutting presentations were more common among women (31%) than men (28%).

In 60% of all cases involving self-cutting, the treatment received was recorded. Of these, the majority either had their wound cleaned and/or dressed (20%) and a further 19% did not require any treatment. In 17% of presentations, the patient received steristrips, stitches or sutures, 1% had their wound glued and 2% were referred for plastic surgery. Among presentations where the treatment is known, men who engaged in self-cutting generally required more intensive treatment than women. 31% of male presentations resulted in the receipt of steristrips, stitches or stitches and 4% resulted in referral for plastic surgery compared to 26% and 2% respectively of female presentations. By contrast, 67% of self-cutting presentations by women required either no treatment or wound cleaning/dressing in comparison to 60% by men.

Attempted hanging was involved in 8% of self-harm presentations (12% for men and 5% for women). Attempted drowning was involved in 4% of presentations (*n* = 375) and self-poisoning was involved in 2% of presentations.

The greater involvement of IDO as a method of self-harm for women in 2024 is illustrated in figure 6. IDO also accounted for a higher proportion of self-harm presentations in the older age groups (68% among 45–54-year-olds and 69% among those aged over 55, compared to an average across all age groups of 61%), especially for women (73% among 45–54-year-olds and 74% among those aged over 55, compared to an average across all age groups of 63%). Conversely, self-cutting was less common among these age groups: 17% of presentations by men aged over 55 involved self-cutting as compared to an overall average of 28%, and 14% of presentations by women aged over 55 involved self-cutting as compared to an overall average of 31%. Self-cutting was the most common method of self-harm in boys aged under 15 years, involved in half of presentations. While IDO was the most common method among young women (involved in 59% of presentations by those aged 15–24), cutting was the most common method of self-harm for girls under 15 years, involved in over half (51%) of presentations.

[2]Some presentations involved multiple methods of self-harm so the sum of the percentages per row exceeds 100%.

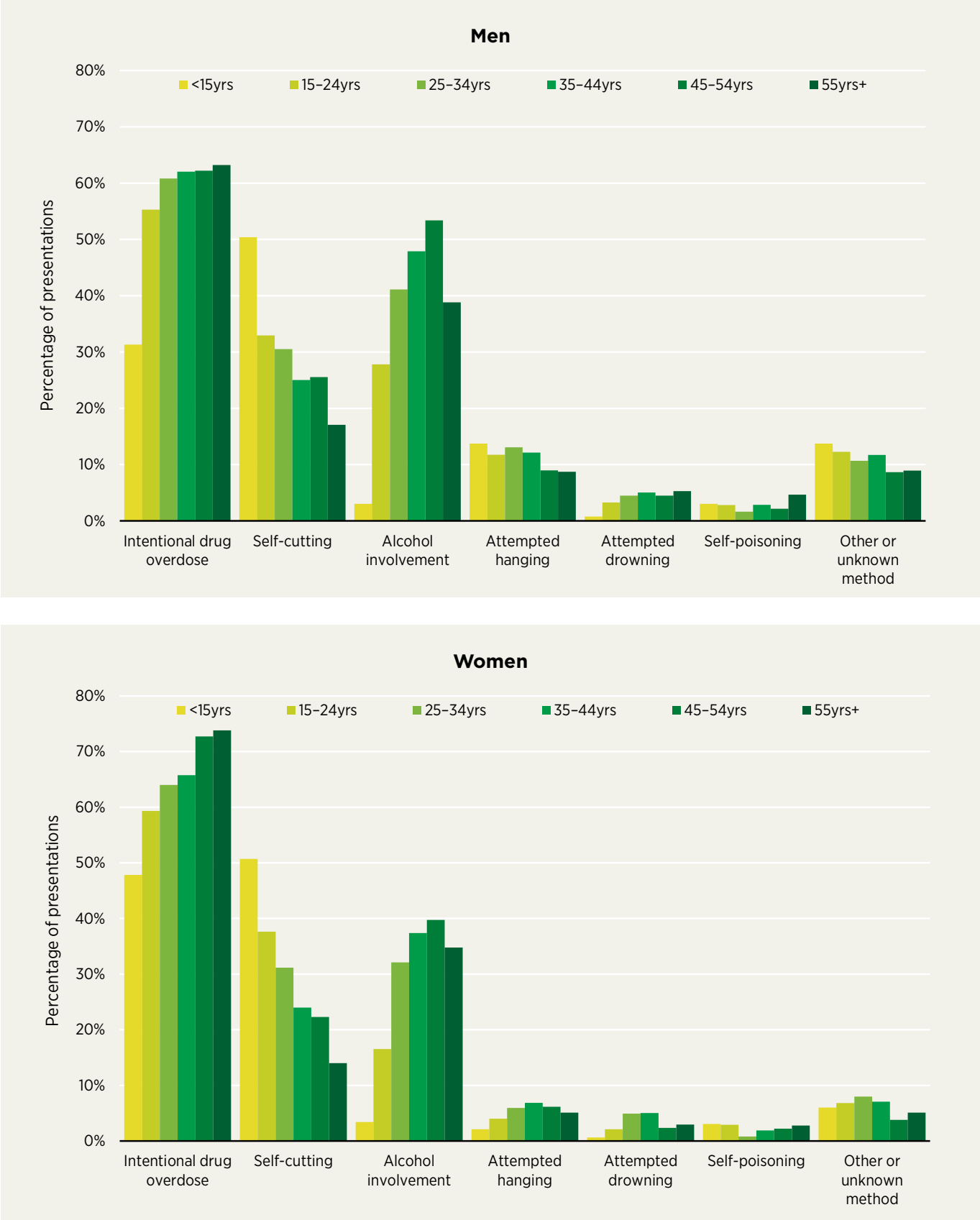

Figure 6: Method of self-harm used by men and women across age groups in 2024.

Drugs Used in Intentional Drug Overdoses

The total number of tablets taken was known for 69% of all presentations involving intentional drug overdose (IDO). On average, 29 tablets were taken in IDO presentations. More than half of IDO presentations (51%) involved fewer than 35 tablets, 46% involved 20 tablets or fewer and one quarter involved 11 tablets or fewer. On average, the number of tablets taken in IDO presentations was higher among men than women (mean: 31 vs. 27). Figure 7 illustrates the number of tablets taken in IDO presentations by sex. Over half of female IDO presentations (53%) and 45% of male presentations involved 10–29 tablets.

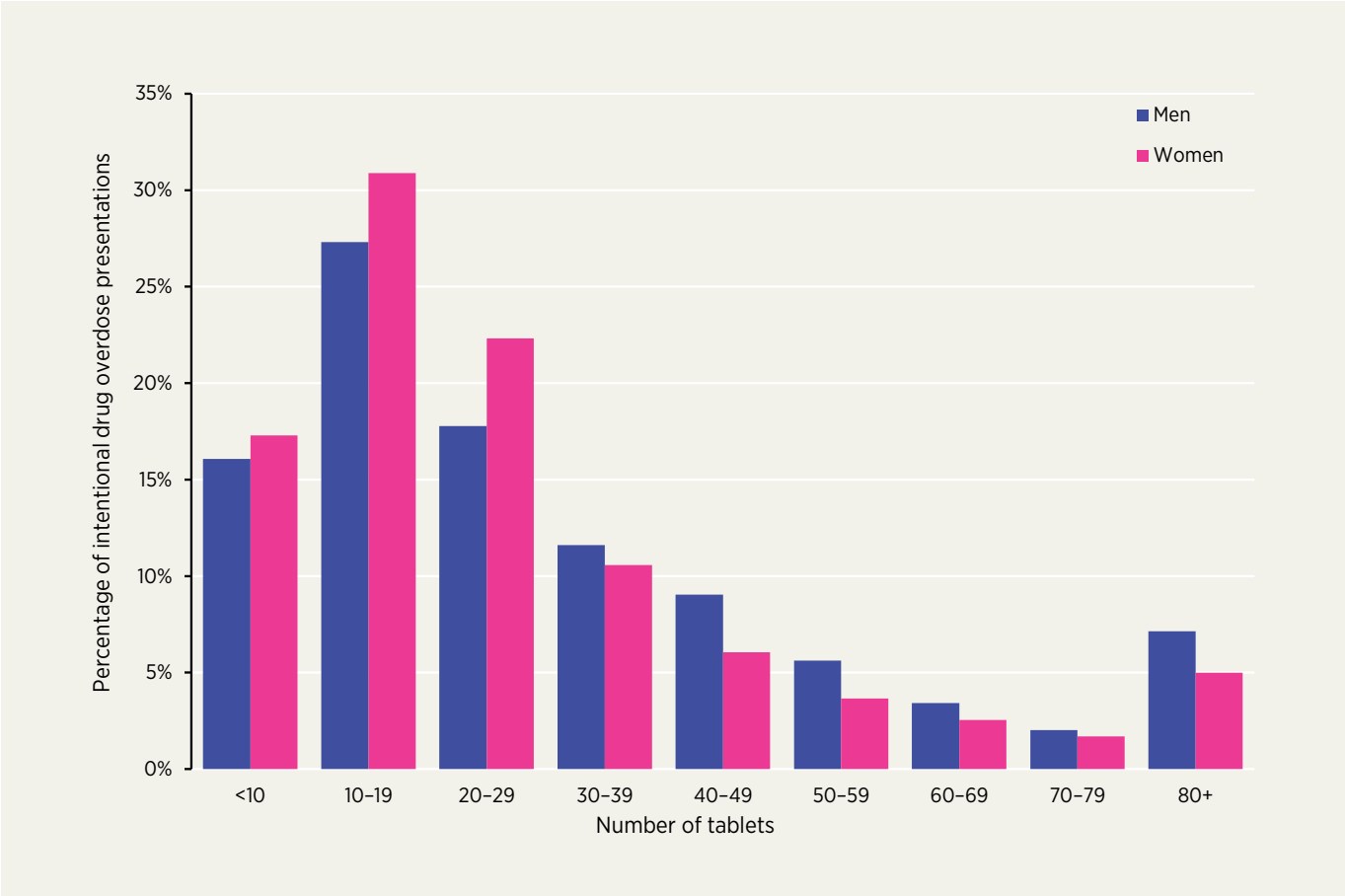

Figure 7: Number of tablets taken by men and women in intentional drug overdoses in 2024.

Figure 8 illustrates the frequency with which the most common drug types were used by men and women in IDO.

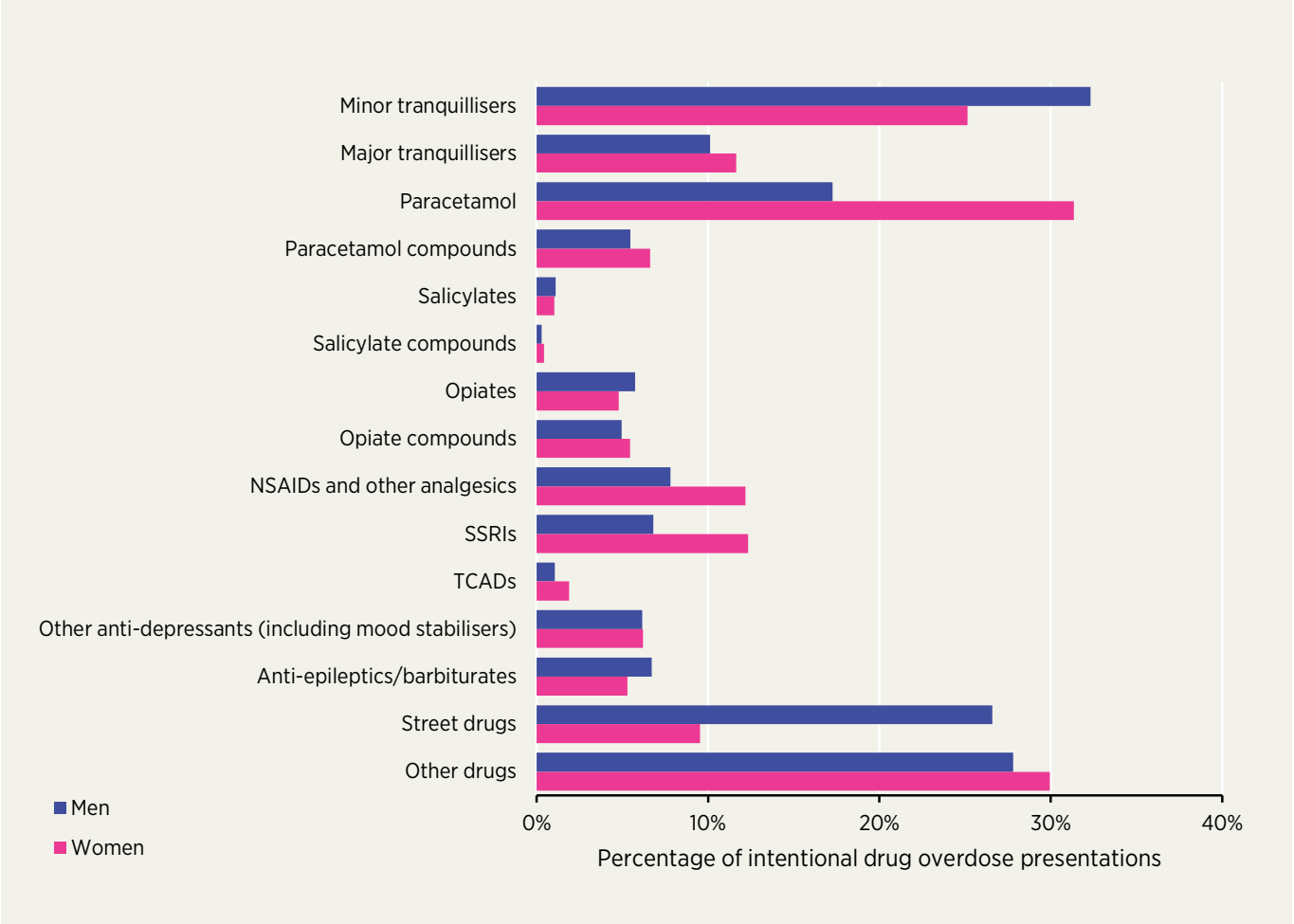

Figure 8: Types of drugs used by men and women in IDO presentations in 2024.

Note: Some drugs (e.g. compounds containing paracetamol and an opiate) are counted in two categories.

Just under three in ten IDO presentations (28%) involved a minor tranquilliser; these were more often used by men than women (32% vs. 25% respectively). A major tranquilliser was involved in 11% of overdoses. In total, 47% of female overdoses and about 32% of male overdoses involved an analgesic drug. Alongside minor tranquilisers, paracetamol- containing drugs were the most common drug taken, involved in 30% of IDOs, significantly more so by women (36%) than by men (21%). 17% of IDOs involved an anti-depressant or mood stabiliser. The group of anti-depressant drugs known as selective serotonin reuptake inhibitors (SSRIs) were present in 10% of IDOs. Illegal or street drugs were involved in 27% of male and 10% of female IDOs, and were the only drug used in 12% of male IDOs and 4% of female IDOs. Other prescribed drugs were taken in 29% of all IDOs.

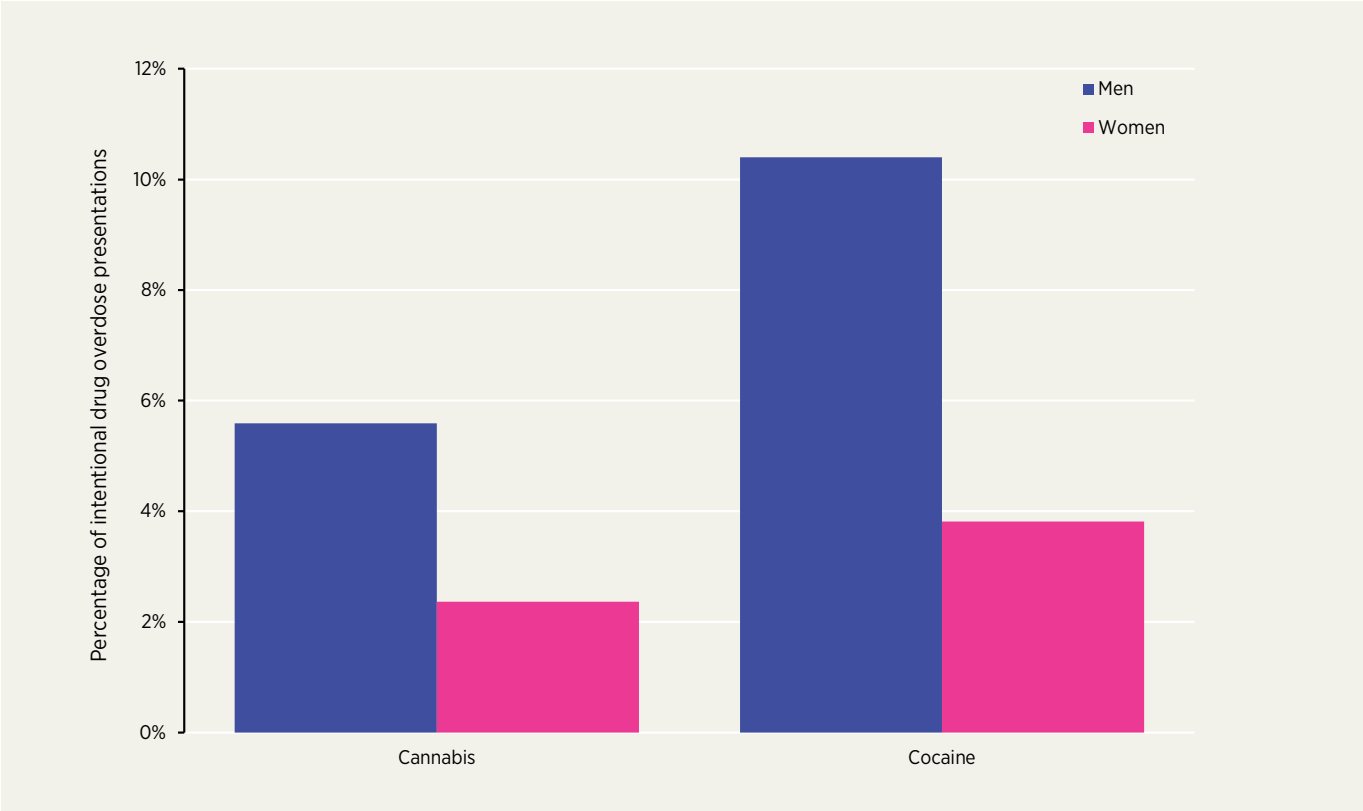

Figure 9: Cocaine and cannabis involvement in self-harm presentations in 2024.

From 2022, information has been recorded by the Registry about whether cocaine or cannabis was involved in self-harm presentations. Of all presentations in 2024 (*n* = 10,532), cocaine was involved in 7% of presentations while cannabis was involved in 4%. A greater proportion of men used cocaine and cannabis in comparison to women (11% vs. 4% for cocaine and 6% vs. 2% for cannabis). For both drugs, the majority (57–63%) of presentations by men and women were among those aged 20–34 years.

Recommended Next Care

In 2024, most commonly, in 49% of presentations, patients were discharged following treatment in the ED. An inpatient admission was the next care recommended for 31% of presentations after treatment in the ED. Inpatient admissions are classified as general medical admissions, psychiatric admissions and admissions to Intensive Care Units (ICUs), and are included even if the patient refused admission. Of all self-harm presentations, 23% resulted in an admission to a general ward in the treating hospital, 5% were admitted for psychiatric inpatient treatment and 2% were admitted to an ICU. It is not always recorded in the ED notes that a patient has been directly admitted to psychiatric inpatient care; in addition, some patients admitted to a general medical ward are subsequently admitted as psychiatric inpatients; therefore, direct psychiatric admission figures provided here may be underestimated. For 6% of presentations, the patient was transferred to another hospital or psychiatric unit, for 14% of presentations, the patient left the ED before a next care recommendation could be made, and for 1% of presentations, the patient refused to be admitted for general or psychiatric care.

Next care recommendations in 2024 were similar for men and women. However, men more frequently left the ED before a recommendation was made than women (16% vs. 12%). Conversely, women were more frequently admitted to a general ward of the treating hospital than men (25% vs. 21%).

The recommendations for next care also varied according to the method of self-harm (Table 5).

Approximately 30% of presentations involving intentional drug overdose and 28% of presentations involving self-poisoning were admitted for general inpatient care. For other methods of self-harm, general inpatient care was recommended for 11–21% of presentations. Given that 13% of presentations involving self-cutting resulted in a general inpatient admission, this may be an indication of the superficial nature of the injuries sustained in some cases. Of the presentations where the patient used self-cutting, 60% were discharged after receiving treatment in the ED.

The highly lethal self-harm methods of attempted hanging and attempted drowning were associated with a higher proportion of patients being admitted for psychiatric inpatient care directly from the ED (10% for each). Admission to an ICU was highest for presentations involving hanging (2%).

	Intentional drug overdose (*n* = 6,470)	Alcohol (*n* = 3,353)	Self-poisoning (*n* = 260)	Attempted hanging (*n* = 825)	Attempted drowning (*n* = 375)	Self-cutting (*n* = 3,170)	Other (*n* = 882)	All (*n* = 10,532)
General admission	30.0%	20.7%	28.5%	14.5%	10.7%	13.1%	13.9%	23.4%
Psychiatric admission	4.4%	3.6%	5.4%	10.2%	9.9%	4.6%	7.7%	5.2%
Admission ICU	2.0%	1.5%	1.9%	2.3%	0.5%	0.2%	0.9%	1.5%
Patient refused admission	1.1%	1.4%	1.2%	1.7%	1.3%	1.0%	1.1%	1.1%
Transferred to another hospital/ psychiatric unit/ psychiatric hospital	4.7%	5.0%	7.3%	12.6%	12.0%	5.6%	10.9%	5.8%
Left before recommendation	13.5%	18.8%	10.8%	9.8%	16.0%	14.9%	12.8%	13.7%
Discharged from ED	43.5%	48.3%	45.0%	48.1%	49.6%	60.2%	52.2%	48.7%

Table 5: Recommended next care by methods of self-harm in 2024.

Recommendations for next care also varied significantly by HSE health region (see Table 6). The proportion of self-harm presentations where the patient left before a recommendation was made varied from 12% in HSE South West to 21% in HSE Dublin and North East. Across the health regions, inpatient care (irrespective of type and whether the patient refused) was recommended for 17% of presentations in HSE Mid West, 24% of presentations in HSE South West, 29% of presentations in HSE Dublin and North East, 34% in HSE Dublin and South East, 36% in HSE Dublin and Midlands and 37% in HSE West and North West.

As a corollary to this, the proportion of cases discharged following emergency treatment ranged from 33% in HSE Dublin and North East to 61% in HSE South West. The balance of general and psychiatric admissions directly after treatment in the ED differed significantly by region. Direct general admissions were more common than direct psychiatric admissions across all regions.

	HSE Dublin and North East (*n* = 935)	HSE Dublin and Midlands (*n* = 2,745)	HSE Dublin and South East (*n* = 2,206)	HSE Mid West (*n* = 792)	HSE South West (*n* = 2,103)	HSE West and North West (*n* = 1,751)	Republic of Ireland (*n* = 10,532)
General admission	24.1%	30.1%	25.8%	10.6%	19.4%	20.2%	23.4%
Psychiatric admission	1.3%	4.6%	5.4%	4.2%	2.6%	11.5%	5.2%
Admission ICU	3.1%	0.7%	1.2%	1.0%	1.7%	2.3%	1.5%
Patient refused admission	0.2%	0.5%	1.0%	1.4%	0.4%	3.1%	1.1%
Transferred to another hospital/ psychiatric unit/ psychiatric hospital	16.7%	4.3%	8.1%	7.8%	1.7%	3.5%	5.8%
Left before recommendation	21.1%	13.6%	12.9%	14.9%	11.6%	13.0%	13.7%
Discharged from ED	33.2%	46.2%	45.2%	59.6%	60.8%	46.0%	48.7%

Table 6: Recommended next care in 2024 by HSE health region.

Note that it may not always be recorded in ED notes that a patient has been directly admitted to psychiatric inpatient care. As a result, the figures for direct psychiatric admission detailed in this table may be underestimates.

Note that HSE Dublin and North East is missing data from three hospitals, and that HSE Dublin and Midlands is missing data from one hospital.

The recommended next care after a self-harm presentation is provided by hospital in Appendix B, tables B1–B5. Within each health region, there were significant differences between the hospitals in their next-care recommendations.

In 2024, 14% of patients left the ED before a recommendation could be made. The funnel plot in figure 10 illustrates the percentage of presentations per hospital for which the patient left before a recommendation could be made. For almost three-quarters of hospitals (*n* = 17), the proportion was similar to the national rate. Six hospitals fell outside of the dashed lines, indicating that their rate is different to the national rate.

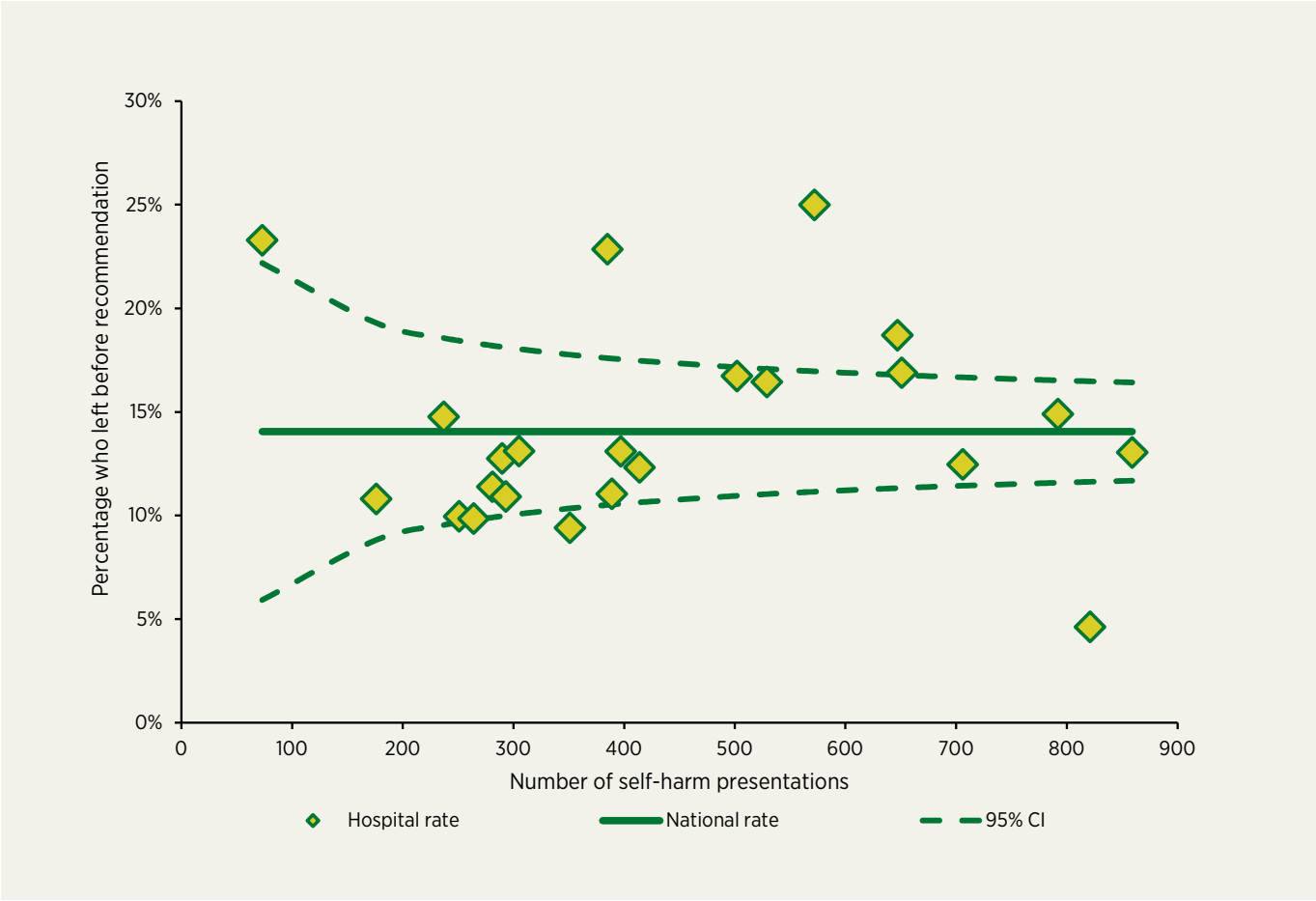

Figure 10: Funnel plot of the percentage of presentations in which the patient left before recommendation, by hospital, 2024.

Note: Due to small numbers, data for Children's Health Ireland hospitals and Model 2 hospitals have been excluded.

Current Care

Data were collected about the current care of individuals who presented to hospital with self-harm in 2024. For 33% of presentations (n = 3,520), it was noted that the patient was currently attending Mental Health Services. In a further 2% of presentations (n = 225), it was noted that the patient had previously been referred and was awaiting an appointment with Mental Health Services. For 3% of presentations (n = 361), individuals were attending addiction services while for 2% of presentations, individuals were engaged with homeless services (n = 225). For a large number of cases, however (43%; n = 4,484), information on current care was not documented.

Women were more likely than men to be engaged with Mental Health Services (63% vs 37%). Conversely, men were more likely than women to be attending addiction services (61% vs 39%) and homeless services (64% vs 36%).

Self-Harm Cases Discharged from Emergency Department

For presentations that resulted in the patient being discharged from the ED following treatment (*n* = 5,131), information on the type of follow-up care or referral offered is presented in Figure 11.

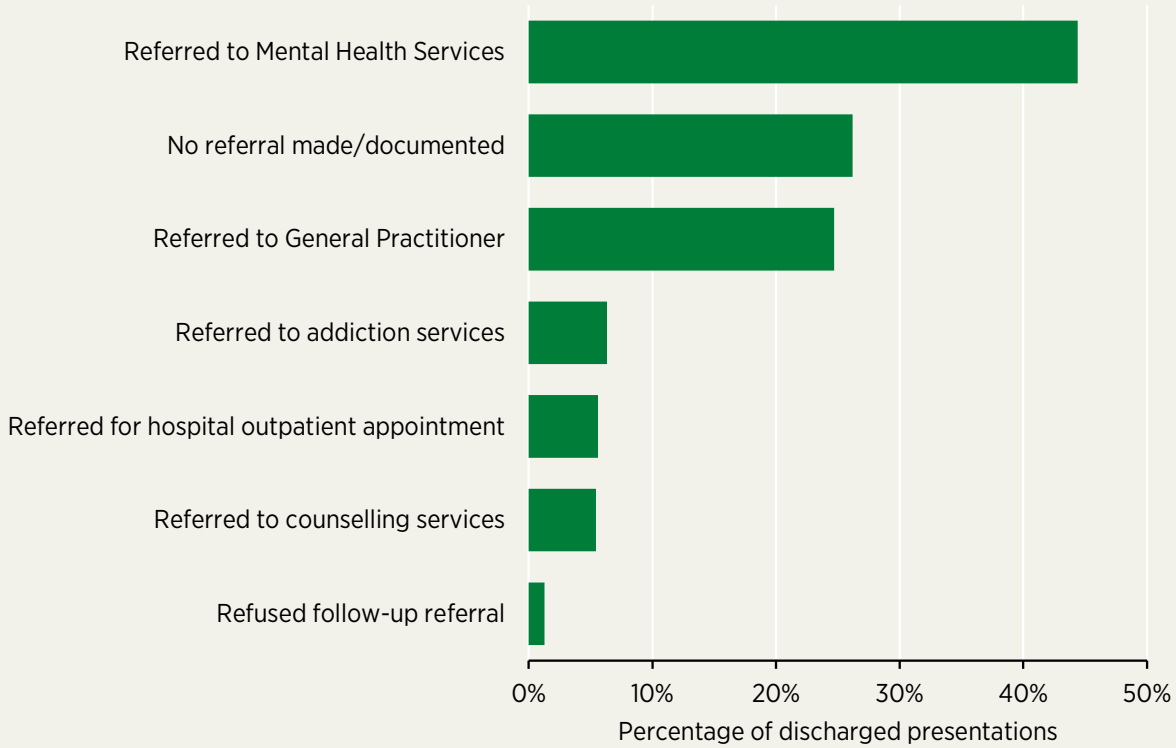

Figure 11: Self-harm presentation referral in 2024 following discharge from the Emergency Department.

- For 44% of presentations, patients were referred to Mental Health Services.
- A referral to the patient's General Practitioner (GP) was given in 25% of presentations.
- For 6% of presentations, the patient was referred for a general hospital outpatient appointment.
- Other services including counselling support services (e.g. Pieta) and addiction services were recommended for 12% of presentations discharged from the ED.
- For 26% of presentations, patients were discharged home from the ED with no referral recommendation either made or documented.

Referrals offered to self-harm patients following discharge from the ED varied by HSE health region. For example, 19% of presentations in HSE Dublin and Midlands received a referral to the patient's GP, as compared with 47% in HSE Mid West. A referral for a general hospital outpatient appointment was made for 20% of presentations in HSE Dublin and Midlands compared to fewer than 5% in all other regions. Turning to referrals to local support services, 76% of presentations in HSE West and North West received a referral to Mental Health Services compared with 10% in HSE South West. In HSE South West, fewer than 1% of presentations were referred to counselling support services such as Pieta, in comparison to 24% in HSE Mid West.

Mental Health Assessment

Information was recorded about whether the patient had a mental health assessment in the ED in 81% of presentations (8,562). For 59% of these presentations (5,050), an assessment was completed in the ED. For a further 6% (523), an assessment was later completed in the presenting hospital, and for a further 6% (512), an assessment was arranged in the presenting hospital. A minority of patients refused a mental health assessment at the time of presentation.

Assessment was most common for presentations with methods involving attempted hanging and attempted drowning (73-74% of presentations where assessment information is available). Those who presented with self-poisoning were least likely to receive an assessment (62%).

For 81% of presentations that resulted in discharge from the ED and where assessment data is available, patients received a mental health assessment prior to discharge. In contrast, only 8% of patients who left before recommendation received an assessment.

Provision of a mental health assessment varied according to whether the self-harm presentation was a repeat presentation or not. In 2024, 66% of first presentations of self-harm were assessed, compared with 56% of those with 5 or more presentations.

The plot in figure 12 illustrates the variation by hospital in the proportion of presentations that resulted in a mental health assessment.

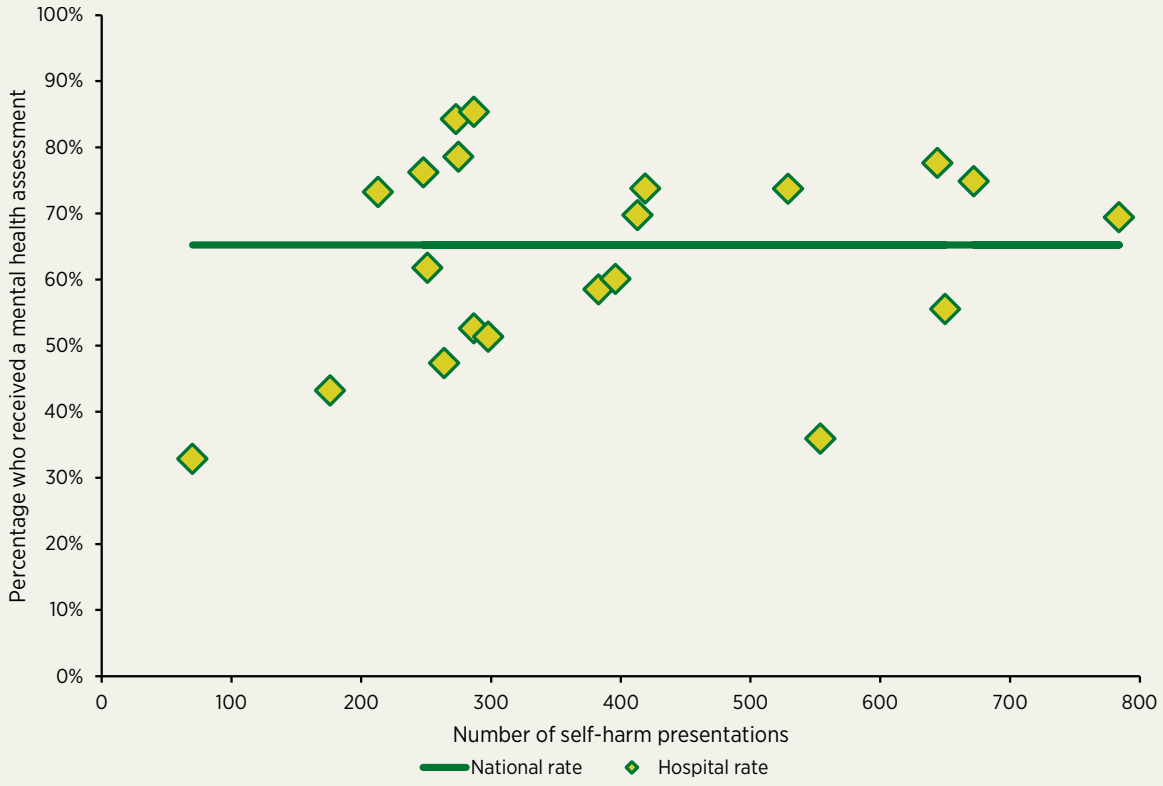

Figure 12: Plot of the percentage of presentations that receive a mental health assessment, by hospital, 2024.

Note: Due to small numbers, data for Children's Health Ireland and Model 2 hospitals have been excluded. Data for an additional two hospitals has been excluded due to unavailable mental health assessment data.

Repetition of Self-Harm

There were 7,940 individuals who presented to hospital with 10,532 self-harm presentations in 2024. This implies that one in four (*n* = 2,592; 25%) of the presentations in 2024 were due to repeat acts. Of the 7,940 self-harm patients who presented to hospital, 1,265 (15.9%) presented more than once in the calendar year. This is slightly higher than the 15.3% reported in 2023, and marginally higher than what has been reported in recent years (2014–2023: 14.3%–15.7%). 147 individuals presented five or more times. These patients accounted for just 2% of all self-harm patients in the year but their presentations amounted to 12% of all self-harm presentations recorded in 2024 (*n* = 1,234).

The rate of repetition varied according to the method of self-harm involved in the self-harm act (Table 7).

	Intentional drug overdose	Alcohol	Self-poisoning	Attempted hanging	Attempted drowning	Self-cutting	Other	All
Number of individuals who presented	5,008	2,572	176	655	273	2,226	607	7,940
Number who repeated	799	422	31	90	45	411	90	1,265
Percentage who repeated	16.0%	16.4%	17.6%	13.7%	16.5%	18.5%	14.8%	15.9%

Table 7: Number and percentage of individuals who had a repeat self-harm presentation in 2024 by method of self-harm.

Of the most common methods of self-harm, self-cutting was associated with the highest level of repetition. 18% of individuals who used cutting as a method of self-harm in their index presentation made at least one subsequent self-harm presentation in the calendar year.

The rate of repetition nationally was the same for men and women (16%), but varied significantly by age. The proportion of individuals who repeated was highest amongst people aged 35–44 years (19%). Approximately 13% of all self-harm patients under twenty years of age re-presented with self-harm.

There was some variation in repetition rates when examined by HSE health region (Table 8). The lowest rate was among self-harm patients presenting in HSE Mid West (13%); the highest was in HSE South West (19%).

		HSE Dublin and North East	HSE Dublin and Midlands	HSE Dublin and South East	HSE Mid West	HSE South West	HSE West and North West	Republic of Ireland
Number of individuals who presented	Men	326	944	799	286	694	577	3,556
	Women	436	1,224	902	337	811	761	4,384
	Total	762	2,168	1,701	623	1,505	1,338	7940
Number who repeated	Men	53	158	122	37	131	98	568
	Women	60	185	173	47	150	118	697
	Total	113	343	295	84	281	216	1,265
Percentage who repeated	Men	16.3%	16.7%	15.3%	12.9%	18.9%	17.0%	16%
	Women	13.8%	15.1%	19.2%	13.9%	18.5%	15.5%	15.9%
	Total	14.8%	15.8%	17.3%	13.5%	18.7%	16.1%	15.9%

Table 8: Number and percentage of men and women who made a repeat self-harm presentation in 2024 by HSE Hospital Group.

The funnel plot in figure 13 illustrates the risk of repetition for each hospital. The average risk of repetition by hospital is 17%. For the majority of hospitals, the risk of repetition was similar to the average, indicating little variation across hospitals. Mercy University Hospital, Cork and Wexford General Hospital had the highest risk of repetition.

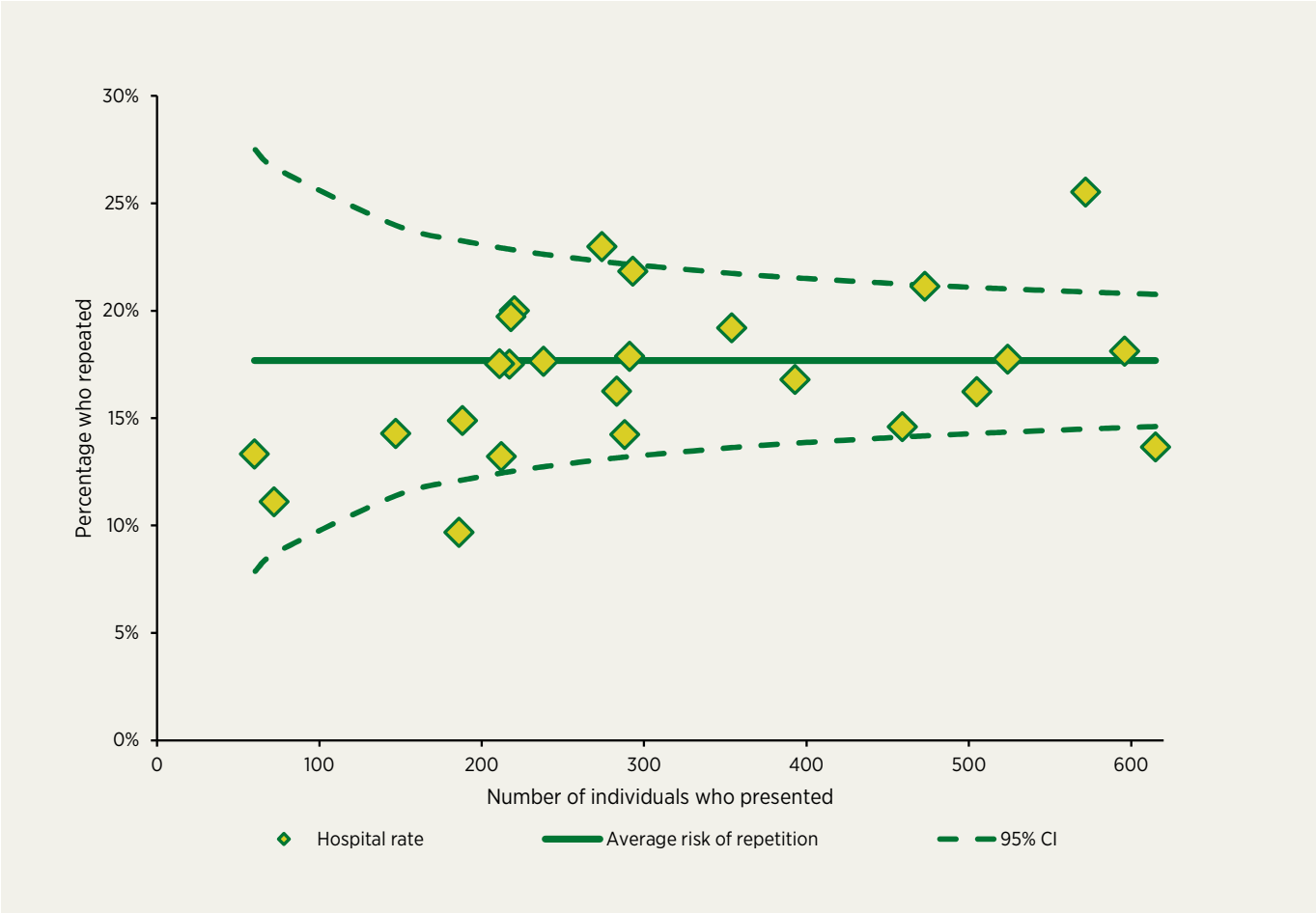

Figure 13: Funnel plot of the rate of repetition by hospital, 2024.

Note: Due to small numbers, data for Model 2 hospitals have been excluded.

The repetition rate by hospital for men, women and all patients who presented to hospital with self-harm are detailed in Appendix C, Tables C1–C5. Caution should be taken in interpreting the repetition rates associated with smaller hospitals as the calculations may be based on a small number of patients.

SECTION II:
Incidence Rates

For the period from 1 January to 31 December 2024, the Registry recorded 10,532 self-harm presentations to hospital that were made by 7,940 individuals. These figures do not include presentations to four hospitals as outlined earlier (see Methods). Adjusting for the absence of data from these four hospitals, we estimate that there was a total of 12,621 presentations made by 9,436 individuals. Based on these estimates, the person-based crude and age-standardised rate of self-harm in 2024 was 175 (95% CI: 172–179) and 181 (95% CI: 177–184) per 100,000 respectively. The age-standardised rate, which accounts for the age distribution of the population, indicates that there was a 5% decrease in the rate of persons presenting to hospital as a result of self-harm from 2023 to 2024.

Table 9 presents the age-standardised rates for men and women and all persons, and the change in rates each year, since the Registry reached near national coverage in 2002.

	Men		Women		All	
Year	Rate	% difference	Rate	% difference	Rate	% difference
2002	167	–	237	–	202	–
2003	177	+7%	241	+2%	209	+4%
2004	170	–4%	233	–4%	201	–4%
2005	167	–2%	229	–1%	198	–2%
2006	160	–4%	210	–9%	184	–7%
2007	162	+2%	215	+3%	188	+2%
2008	180	+11%	223	+4%	200	+6%
2009	197	+10%	222	–<1%	209	+5%
2010	211	+7%	236	+6%	223	+7%
2011	205	–3%	226	–4%	215	–4%
2012	195	–5%	228	+1%	211	–2%
2013	182	–7%	217	–5%	199	–6%
2014	185	+2%	216	–	200	+1%
2015	186	+1%	222	+3%	204	+2%
2016	184	–1%	228	+3%	205	+<1%
2017	181	–2%	219	–4%	199	–3%
2018	193	+7%	229	+5%	210	+6%
2019	187	–3%	226	–1%	206	–2%
2020	177	–5%	225	–<1%	200	–3%
2021	160	–10%	232	+3%	196	–2%
2022	168	+5%	227	–2%	197	+<1%
2023	167	–<1%	217	–4%	191	–3%
2024	163	–2%	201	–7%	181	–5%

Table 9: Person-based age-standardised rate of self-harm in the Republic of Ireland, 2002–2024 (extrapolated data used for 2002–2005 and 2020–2024 to adjust for non-participating hospitals).

Variation by Sex

The person-based age-standardised rate of self-harm for men and women in 2024 was 163 (95% CI: 158–168) and 201 (95% CI: 195–206) per 100,000 respectively. This represents a 2% decrease in the male rate of self-harm from 2023 and a 7% decrease in the female rate.

Figure 14 provides a visual overview of the age-standardised rates of self-harm for men and women from 2002 to 2024.

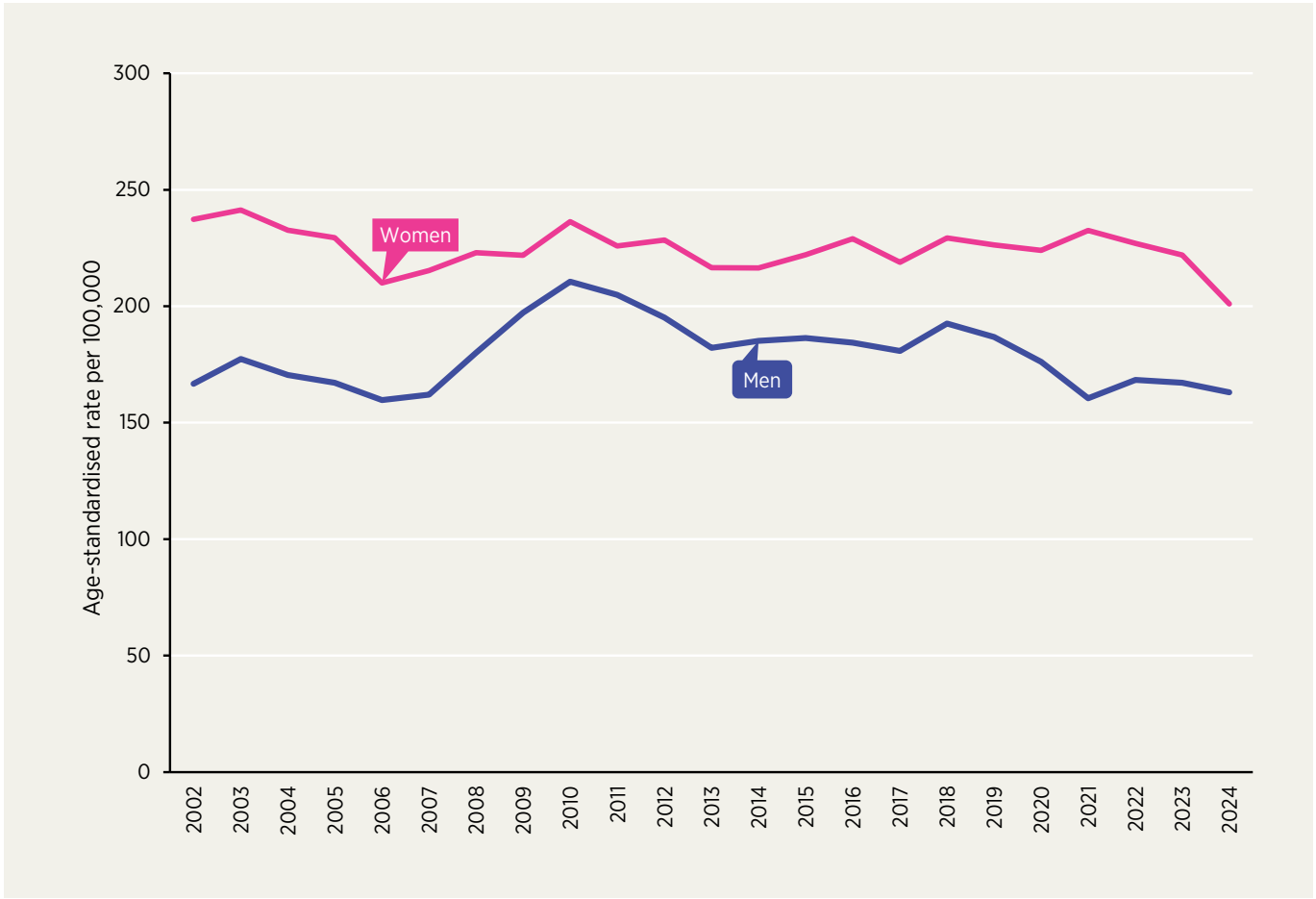

Figure 14: Person-based age-standardised rate of self-harm in the Republic of Ireland for men and women, 2002–2024.

The rate of self-harm for men had been mostly decreasing since 2010 when the peak rate of 211 per 100,000 was recorded. In 2021, the male self-harm rate of 160 per 100,000 was as low as had been recorded by the Registry since 2006. Apart from a slight increase to 168 per 100,000 in 2022, the male self-harm rate has been relatively static in recent years, with the 2024 rate of 163 per 100,000 only 2% higher than the 2021 low.

The self-harm rate of 201 per 100,000 for women in 2024 is the lowest female rate recorded by the Registry. The rate in 2024 also marks a continuation of the decrease observed for women since 2021. The 7% decrease in the female rate from 2023 to 2024 is the largest annual decrease for women since 2006 when an 8% reduction was recorded.

The female rate of self-harm in 2024 was 23% higher than the male rate. This in in line with the sex difference of 10–24% reported in the ten years up to and including 2019. In contrast, the female self-harm rate was 30–45% higher than the male rate between 2021 and 2023.

Variation by Age

When examined by age, there was a striking pattern in the incidence of self-harm, with the highest rates among younger age groups (see Figure 15). At 652 per 100,000, the peak rate for women was among 15–19-year-olds. This rate implies that one in every 153 girls in this age group presented to hospital in 2024 following an episode of self-harm. The rate reported in 2024 was a 10% decrease from 2023. The peak rate for men in 2024 was among 25–29-year-olds at 373 per 100,000. This rate implies that in 2024, one in every 268 men in this age group presented to hospital following self-harm. In the previous three years (2021–2023), the peak rates for men were among 20–24-year-olds.

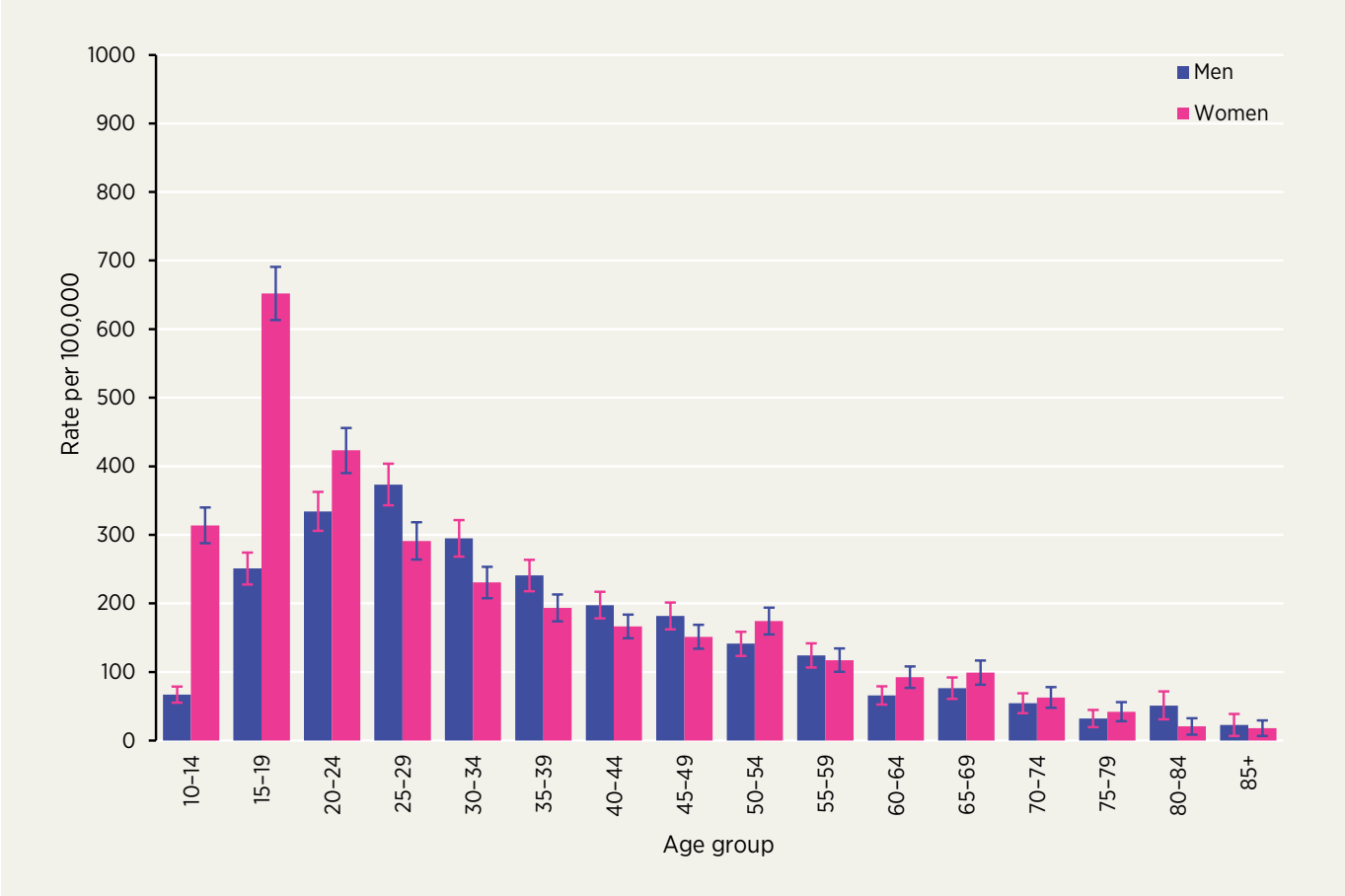

Figure 15: Person-based rate of self-harm for men and women in 2024 by 5-year age group.

In 2024, the incidence of self-harm gradually decreased with increasing age for men. This was the case for women as well, with the exception that the self-harm rate for 50–54-year-olds was slightly higher than for 45–49-year-olds. Population figures and the number and rate of persons who presented to hospital following self-harm are given for men and women by age group in Appendix D.

Sex differences in the incidence of self-harm varied with age. In 2024, the female rate was more than four times the male rate for 10–14-year-olds (314 vs 67 per 100,000), almost three times higher in 15–19-year-olds (652 vs 251 per 100,000) and it was 27% higher in 20–24-year-olds (423 vs 334 per 100,000). In other age groups, rates were similar except for 60–64-year-olds where the female rate was 40% higher (92 vs 66 per 100,000) and 65–69-year-olds where it was 30% higher (99 vs 76 per 100,000).

In 2024, the male rate of self-harm among 10–24-year-olds was 210 per 100,000, 6% lower than the rate of 224 per 100,000 in 2023. In contrast, the female rate for this age group decreased by 9%, from 507 to 460 per 100,000.

In 2024, the peak rates among younger people (<25 years) were in 15-year-old girls and 22-year-old men with rates of 814 and 372 per 100,000 respectively (see figure 16).

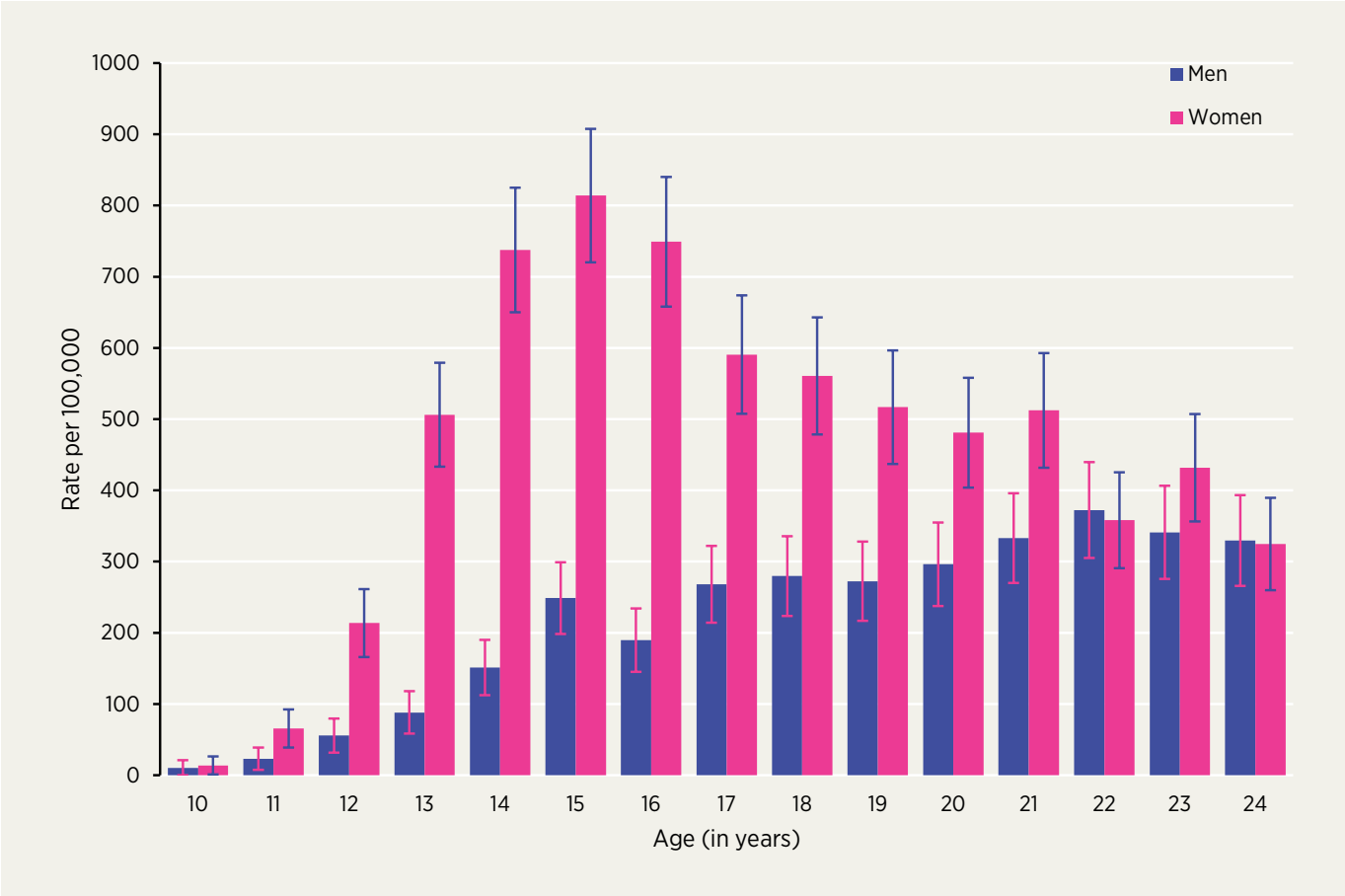

Figure 16: Person-based rate of self-harm for men and women aged 10–24 years old in 2024 by single year of age.

Hospital-presenting self-harm by 10–12-year-old boys and 10- and 11-year-old girls was relatively rare in 2024. However, with each single year increase in age the rate increased significantly, and this was especially so for girls. The rate was 214 per 100,000 for 12-year-old girls, but it was more than twice as high, at 506 per 100,000, for 13-year-olds and a further 61% higher, at 814 per 100,000, for 15-year-olds.

As a consequence of the earlier and greater increase in female self-harm by age, the maximum ratio of girls to boys was among 13-year-olds, for whom the female rate was almost six times that of boys (506 vs 88 per 100,000). The female rate of hospital-presenting self-harm was significantly higher than the male rate at each age from 12–21 years. The peak male rate – 372 per 100,000 among 22-year-olds – was higher than the female rate for the same age (358 per 100,000).

Trend over Time by Sex and Age

Figure 17 illustrates the trend in hospital-presenting self-harm by sex and age since 2007 when the Registry achieved national coverage of all hospitals. Until 2019, 20–24-year-olds consistently had the highest rate for men, but the rate was higher among 25–29-year-old men in 2020 and the two age groups have had similar rates since: the rate was marginally higher among 20–24-year-old men from 2021 to 2023, but was higher among 25–29-year-old men again in 2024. The rate among this age group has been volatile but similar for men and women. There was a striking increase during the years of the 2008 global financial crisis and ensuing period of austerity, after which the rate decreased for several years before increasing again around 2018. The rate has returned to its pre-recession level in recent years. The rate for 20–24-year-old women has decreased in recent years but is still significantly higher than pre-recession levels.

In contrast, male and female hospital-presenting self-harm among 15–19-year-olds has been very different in both incidence and trend. In 2007, the female rate of 600 per 100,000 was approximately twice the male rate. The global financial crisis and the periods of austerity and recovery that followed were associated with a marked increase and decrease in the male rate but no change in the female rate. From 2013 to 2021, the female self-harm rate increased almost every year and was 50% higher with the largest increase from 2020 to 2021, but it declined in 2022, 2023 and further in 2024. The rate in 2024 – 652 per 100,000 – is 73% of its 2021 peak. The male self-harm rate among 15–19-year-olds increased gradually from 2013 to 2019 but has sharply declined since then. As a result, the male rate among 15–19-year-olds has declined from 335 per 100,000 in 2013 to 251 per 100,000 in 2024, though is 9% higher than the all-time low of 231 per 100,000 recorded in 2023.

Among young adolescents aged 10–14 years old, hospital-presenting self-harm has increased for both boys and girls. The male self-harm rate was low but it has increased steadily, reaching approximately 67 per 100,000 in 2024. The increasing trend for girls aged 10–14 years has been much more pronounced: from approximately 100 per 100,000 in 2011, the rate increased more than threefold to 345 per 100,000 in 2021, and it has remained at this level since: in 2024, it was 314 per 100,000.

Among adults aged at least 30 years old, the incidence of hospital-presenting self-harm in 2024 was highest among 30–39-year-olds. The rate decreases with increasing age and is lowest among persons aged 60 years or older. For all of these age groups, the incidence is similar for men and women. There were increases in hospital-presenting self-harm by men across the age range 30–59 years during 2007–2011, and among men and women aged 30–39 years from 2014 to 2019. However, for all four age groups presented, the male and female self-harm rate in 2024 was similar to, or lower than, what it was in 2007.

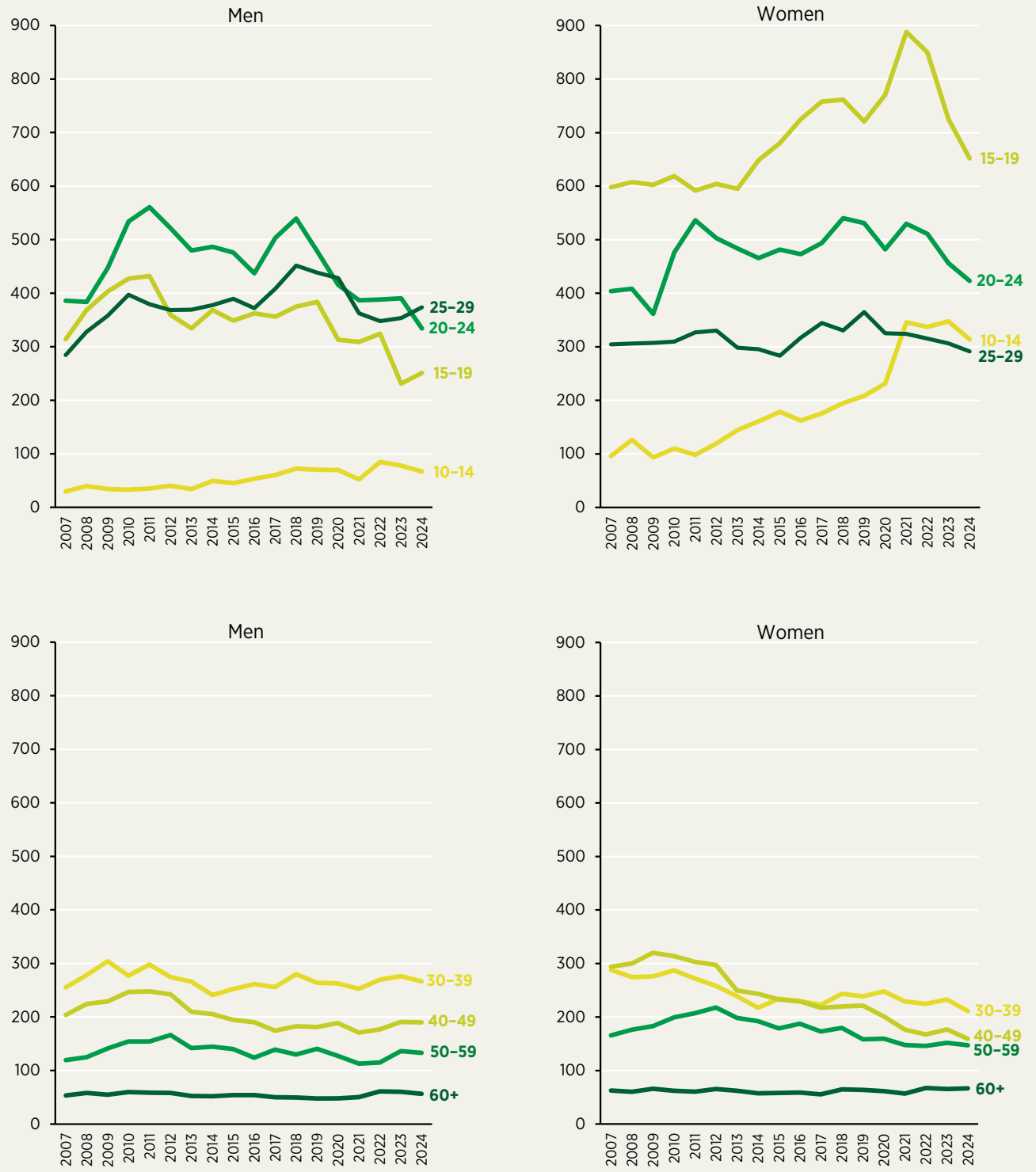

Figure 17: Trend in the rate of hospital-presenting self-harm by sex and age group, 2007–2024.

Appendices

Appendix A: Self-harm presentations to hospitals in the Republic of Ireland

Table A1: Self-harm presentations to hospitals in the Republic of Ireland[1] by HSE health region, 2024

HSE health region	HSE Dublin and North East		HSE Dublin and Midlands		HSE Dublin and South East		HSE Mid West		HSE South West		HSE West and North West		Republic of Ireland[2]		Republic of Ireland (Estimate)[3]	
Age Group	Men	Women	Men	Women	Men	Women	Men	Women	Men	Women	Men	Women	Men	Women	Men	Women
10–14yrs	13	72	45	198	22	98	6	32	21	107	17	102	124	609	140	713
15–19yrs	51	134	116	344	104	237	58	78	87	219	91	228	507	1,240	598	1,469
20–24yrs	57	55	163	197	171	160	44	71	118	159	105	156	658	798	766	930
25–29yrs	50	37	182	130	137	127	51	39	149	122	98	78	667	533	815	641
30–34yrs	48	50	126	111	139	83	40	42	115	78	84	78	552	442	675	542
35–39yrs	29	34	148	131	101	110	40	31	106	106	85	63	509	475	597	598
40–44yrs	39	37	115	112	75	98	44	45	93	79	73	88	439	459	569	547
45–49yrs	34	30	115	111	63	103	29	28	81	59	65	48	387	379	455	449
50–54yrs	33	38	59	85	73	66	22	28	45	113	27	53	259	383	335	466
55–59yrs	14	20	66	44	42	45	14	9	39	43	26	51	201	212	238	251
60–64yrs	6	15	18	32	21	25	5	13	21	36	28	32	99	153	115	173
65–69yrs	12	6	16	44	23	26	6	<5	13	31	15	18	85	127	102	150
70–74yrs	<5	7	10	12	10	14	<5	5	22	11	5	18	54	67	61	85
75–79yrs	<5	<5	<5	6	*	7	<5	<5	5	*	6	<5	23	34	29	38
80–84yrs	<5	0	<5	<5	9	<5	<5	0	6	*	<5	<5	22	9	29	12
85yrs+	0	<5	0	<5	*	<5	<5	0	0	0	<5	<5	8	5	8	10
Total	**395**	**540**	**1,183**	**1,562**	**1,003**	**1,203**	**366**	**426**	**923**	**1,180**	**731**	**1,020**	**4,601**	**5,931**	**5,539**	**7,082**

[1]Presentations of persons aged <10 years are not included in this table to avoid risk of disclosure.

[2]Number of self-harm presentations for all except four hospitals in the Republic of Ireland during 2024.

[3]Estimated number of self-harm presentations for all hospitals in the Republic of Ireland in 2024.

*At least one cell in this column has a value of <5. This is done to avoid showing disclosive data.

Table A2: Self-harm presentations to hospitals in HSE Dublin and North East, 2024

	Cavan Monaghan Hospital		Our Lady of Lourdes Hospital, Drogheda		Our Lady's Hospital, Navan	
Age Group	Male	Female	Male	Female	Male	Female
<16yrs	10	32	12	65	0	0
16–17yrs	5	30	10	18	<5	13
18–24yrs	28	36	49	58	6	9
25–34yrs	28	28	59	52	11	7
35–44yrs	21	22	46	45	<5	<5
45–54yrs	12	14	51	46	<5	8
55–64yrs	8	7	10	25	<5	<5
65yrs+	5	4	12	14	<5	0
Total	**117**	**173**	**249**	**323**	**29**	**44**

Table A3: Self-harm presentations to hospitals in HSE Dublin and Midlands, 2024

	Midland Regional Hospital, Mullingar		Midland Regional Hospital, Portlaoise		Midland Regional Hospital, Tullamore		Naas General Hospital		St. James's Hospital		Tallaght University Hospital	
Age Group	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
<16yrs	11	29	18	43	<5	7	0	<5	0	*	0	0
16–17yrs	5	15	7	16	<5	7	7	22	*	20	18	61
18–24yrs	12	25	24	29	18	19	35	60	54	67	62	78
25–34yrs	29	20	31	13	21	17	42	48	94	96	91	47
35–44yrs	22	31	32	29	12	18	42	47	89	53	66	65
45–54yrs	22	19	12	24	13	24	28	43	50	55	49	31
55–64yrs	*	*	*	14	6	0	12	19	27	20	30	19
65yrs+	*	*	*	9	<5	8	6	<5	*	*	11	23
Total	**108**	**156**	**128**	**177**	**76**	**100**	**172**	**242**	**325**	**322**	**327**	**324**

*At least one cell in this column has a value of <5. This is done to avoid showing disclosive data.

Table A4: Self-harm presentations to hospitals in HSE Dublin and South East, 2024

	St Luke's General Hospital, Carlow/Kilkenny		St Michael's Hospital, Dún Laoghaire		Other		Tipperary University Hospital		University Hospital Waterford		Wexford General Hospital	
Age Group	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
<16yrs	10	28	<5	<5	*	*	*	7	13	68	12	37
16–17yrs	6	14	<5	<5	*	38	8	14	9	24	*	22
18–24yrs	39	44	<5	<5	70	98	24	19	53	41	31	36
25–34yrs	57	27	<5	<5	85	70	29	22	61	47	43	40
35–44yrs	33	26	<5	<5	60	59	23	30	28	44	31	48
45–54yrs	18	25	<5	<5	37	82	11	18	47	21	22	21
55–64yrs	8	*	0	<5	26	30	8	7	10	15	*	10
65yrs+	6	*	<5	0	18	*	*	7	8	13	12	10
Total	**177**	**174**	**9**	**12**	**310**	**396**	**113**	**124**	**229**	**273**	**165**	**224**

*At least one cell in this column has a value of <5. This is done to avoid showing disclosive data.

Table A5: Self-harm presentations to hospitals in HSE Mid West and HSE South West, 2024

	Bantry General Hospital		Cork University Hospital		Mercy University Hospital, Cork		University Hospital Kerry		University Hospital Limerick	
Age Group	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
<16yrs	0	0	24	114	*	7	5	32	9	47
16–17yrs	0	<5	23	45	*	15	7	20	18	42
18–24yrs	<5	<5	64	124	65	92	31	33	81	92
25–34yrs	<5	<5	66	69	153	86	43	44	91	81
35–44yrs	<5	6	67	50	97	95	33	34	84	76
45–54yrs	<5	<5	42	49	57	92	23	27	51	56
55–64yrs	<5	<5	22	23	27	30	8	23	19	22
65yrs+	<5	5	17	22	16	19	12	10	13	10
Total	**13**	**25**	**325**	**496**	**423**	**436**	**162**	**223**	**366**	**426**

*At least one cell in this column has a value of <5. This is done to avoid showing disclosive data.

Table A6: Self-harm presentations to hospitals in HSE West and North West, 2024

	Letterkenny University Hospital		Mayo University Hospital		Portiuncula University Hospital		Sligo University Hospital		University Hospital Galway	
Age Group	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
<16yrs	*	33	6	20	*	17	5	37	13	45
16–17yrs	10	23	*	19	*	18	12	12	*	29
18–24yrs	31	40	23	25	11	26	27	37	52	106
25–34yrs	39	44	23	16	47	28	34	24	39	44
35–44yrs	26	52	35	15	33	18	19	18	45	48
45–54yrs	21	23	12	17	18	15	19	10	22	36
55–64yrs	22	14	*	11	6	19	10	17	11	22
65yrs+	*	8	10	10	7	9	5	7	*	8
Total	**160**	**237**	**118**	**133**	**131**	**150**	**131**	**162**	**191**	**338**

*At least one cell in this column has a value of <5. This is done to avoid showing disclosive data.

Appendix B: Recommendations for next care following self-harm presentation

Table B1: Recommended next care by hospital in HSE Dublin and North East, 2024

	Cavan Monaghan Hospital (*n* = 290)	Our Lady of Lourdes Hospital, Drogheda (*n* = 572)	Our Lady's Hospital, Navan (*n* = 73)
Admitted (general, psychiatric, ICU)	39.7%	22.6%	30.1%
Patient would not allow admission	0.0%	0.3%	0.0%
Left before recommendation	12.8%	25.0%	23.3%
Not admitted	45.5%	28.1%	23.3%

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 Tables B1–B5 may be underestimates.

Table B2: Recommended next care by hospital in HSE Dublin and Midlands, 2024

	Midland Regional Hospital, Mullingar (*n* = 264)	Midland Regional Hospital, Portlaoise (*n* = 305)	Midland Regional Hospital, Tullamore (*n* = 176)	Naas General Hospital (*n* = 414)	St. James's Hospital (*n* = 647)	Tallaght University Hospital (*n* = 651)	Children's Health Ireland at Crumlin (*n* =82)	Children's Health Ireland at Temple Street (*n* = 206)
Admitted (general, psychiatric, ICU)	31.4%	58.7%	35.2%	26.1%	23.2%	31.2%	80.5%	57.3%
Patient would not allow admission	0.8%	0.0%	1.7%	1.0%	0.0%	0.8%	0.0%	0.5%
Left before recommendation	9.8%	13.1%	10.8%	12.3%	18.7%	16.9%	0.0%	2.9%
Not admitted	44.7%	27.9%	30.1%	58.9%	53.8%	49.8%	18.3%	38.8%

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 Tables B1–B5 may be underestimates.

Table B3: Recommended next care by hospital in HSE Dublin and South East, 2024

	St. Luke's General Hospital, Carlow/Kilkenny (*n* = 351)	St. Michael's Hospital, Dún Laoghaire (*n* = 21)	Other (*n* = 706)	Tipperary University Hospital (*n* = 237)	University Hospital Waterford (*n* = 502)	Wexford General Hospital (*n* = 389)
Admitted (general, psychiatric, ICU)	57.3%	33.3%	21.0%	34.2%	30.5%	32.1%
Patient would not allow admission	1.1%	0.0%	1.0%	2.1%	1.2%	0.3%
Left before recommendation	9.4%	4.8%	12.5%	14.8%	16.7%	11.1%
Not admitted	26.8%	38.1%	55.8%	35.9%	50.2%	42.4%

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 Tables B1–B5 may be underestimates.

Table B4: Recommended next care by hospital in HSE Mid West and HSE South West, 2024

	Bantry General Hospital (*n* = 38)	Cork University Hospital (*n* = 821)	Mercy University Hospital, Cork (*n* = 859)	University Hospital Kerry (*n* = 385)	University Hospital Limerick (*n* = 792)
Admitted (general, psychiatric, ICU)	57.9%	37.4%	8.6%	24.9%	15.8%
Patient would not allow admission	0.0%	0.0%	0.2%	1.8%	1.4%
Left before recommendation	15.8%	4.6%	13.0%	22.9%	14.9%
Not admitted	13.2%	53.6%	74.6%	49.9%	59.6%

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 Tables B1–B5 may be underestimates.

Table B5: Recommended next care by hospital in HSE West and North West, 2024

	Letterkenny University Hospital (*n* = 397)	Mayo University Hospital (*n* = 251)	Portiuncula University Hospital (*n* = 281)	Sligo University Hospital (*n* = 293)	University Hospital Galway (*n* = 529)
Admitted (general, psychiatric, ICU)	40.3%	41.0%	28.5%	33.1%	29.5%
Patient would not allow admission	4.8%	2.8%	1.4%	3.8%	2.6%
Left before recommendation	13.1%	10.0%	11.4%	10.9%	16.4%
Not admitted	41.1%	44.6%	41.6%	50.2%	50.5%

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 Tables B1–B5 may be underestimates.

Appendix C: Self-harm repetition for individuals who presented to hospital with self-harm in 2024

Table C1: Self-harm repetition for individuals who presented to hospitals in HSE Dublin and North East, 2024

		Cavan Monaghan Hospital	Our Lady of Lourdes Hospital, Drogheda	Our Lady's Hospital, Navan
Number of individuals who presented	Men	98	201	*
	Women	135	270	*
	All	233	471	66
Number who repeated	Men	18	32	*
	Women	25	35	*
	All	43	67	8
Percentage who repeated	Men	18.4%	15.9%	*
	Women	18.5%	13.0%	*
	All	18.5%	14.2%	12.1%

*At least one cell in this column has a value of <5. This is done to avoid showing disclosive data.

Table C2: Self-harm repetition for individuals who presented to hospitals in HSE Dublin and Midlands, 2024

		Midland Regional Hospital, Mullingar	Midland Regional Hospital, Portlaoise	Midland Regional Hospital, Tullamore	Naas General Hospital	St. James's Hospital	Tallaght University Hospital	Children's Health Ireland at Crumlin	Children's Health Ireland at Temple Street
Number of individuals who presented	Men	95	109	67	142	254	261	*	*
	Women	123	147	87	163	250	269	*	*
	All	218	256	154	305	504	530	74	187
Number who repeated	Men	16	21	9	26	55	41	*	*
	Women	21	21	12	38	45	41	*	*
	All	37	42	21	64	100	82	8	18
Percentage who repeated	Men	16.8%	19.3%	13.4%	18.3%	21.7%	15.7%	*	*
	Women	17.1%	14.3%	13.8%	23.3%	18.0%	15.2%	*	*
	All	17.0%	16.4%	13.6%	21.0%	19.8%	15.5%	10.8%	9.6%

*At least one cell in this column has a value of <5. This is done to avoid showing disclosive data.

Table C3: Self-harm repetition for individuals who presented to hospitals in HSE Dublin and South East, 2024

		St. Luke's General Hospital, Carlow/Kilkenny	St. Michael's Hospital, Dún Laoghaire	Other	Tipperary University Hospital	University Hospital Waterford	Wexford General Hospital
Number of individuals who presented	Men	141	*	258	95	176	131
	Women	149	*	288	97	207	157
	All	290	21	546	192	383	288
Number who repeated	Men	21	*	31	13	28	29
	Women	20	*	62	15	40	34
	All	41	5	93	28	68	63
Percentage who repeated	Men	14.9%	*	12.0%	13.7%	15.9%	22.1%
	Women	13.4%	*	21.5%	15.5%	19.3%	21.7%
	All	14.1%	23.8%	17.0%	14.6%	17.8%	21.9%

*At least one cell in this column has a value of <5. This is done to avoid showing disclosive data.

Table C4: Self-harm repetition for individuals who presented to hospitals in HSE Mid West and HSE South West, 2024

		Cork University Hospital	Mercy University Hospital, Cork	University Hospital Kerry	University Hospital Limerick
Number of individuals who presented	Men	275	321	123	286
	Women	372	282	173	337
	All	647	603	296	623
Number who repeated	Men	46	76	23	37
	Women	62	70	29	47
	All	108	146	52	84
Percentage who repeated	Men	16.7%	23.7%	18.7%	12.9%
	Women	16.7%	24.8%	16.8%	13.9%
	All	16.7%	24.2%	17.6%	13.5%

Note: Due to small numbers, the number of patients who presented to Bantry Hospital are not included in this table to avoid risk of disclosure.

Table C5: Self-harm repetition for individuals who presented to hospitals in HSE West and North West, 2024

		Letterkenny University Hospital	Mayo University Hospital	Portiuncula University Hospital	Sligo University Hospital	University Hospital Galway
Number of individuals who presented	Men	123	97	105	104	160
	Women	163	120	121	123	240
	All	286	217	226	227	400
Number who repeated	Men	21	15	19	22	25
	Women	25	13	19	22	41
	All	46	28	38	44	66
Percentage who repeated	Men	17.1%	15.5%	18.1%	21.2%	15.6%
	Women	15.3%	10.8%	15.7%	17.9%	17.1%
	All	16.1%	12.9%	16.8%	19.4%	16.5%

Appendix D: Number and rate of persons with hospital-presenting self-harm in 2024

Table D1: Estimated number and rate of persons with hospital-presenting self-harm in the Republic of Ireland in 2024

Age group	Men				Women			
		Self-Harm				Self-Harm		
	Population	Persons	Rate	95% CI[1]	Population	Persons	Rate	95% CI[1]
0–4yrs	148,900	0	0	(±0)	144,300	0	0	(±0)
5–9yrs	171,700	7	4	(±3)	163,700	8	5	(±3)
10–14yrs	195,400	131	67	(±12)	186,400	585	314	(±26)
15–19yrs	185,700	466	251	(±23)	173,300	1,130	652	(±39)
20–24yrs	165,500	553	334	(±28)	156,700	663	423	(±33)
25–29yrs	161,200	602	373	(±30)	159,000	463	291	(±27)
30–34yrs	166,100	490	295	(±27)	175,200	404	231	(±23)
35–39yrs	182,400	439	241	(±23)	200,500	388	194	(±20)
40–44yrs	209,100	413	198	(±19)	225,900	376	166	(±17)
45–49yrs	193,200	351	182	(±19)	200,400	303	151	(±17)
50–54yrs	180,900	255	141	(±18)	184,200	321	174	(±19)
55–59yrs	159,400	198	124	(±18)	163,000	191	117	(±17)
60–64yrs	144,600	95	66	(±13)	150,600	139	92	(±16)
65–69yrs	123,200	94	76	(±16)	128,200	127	99	(±18)
70–74yrs	104,600	57	54	(±14)	110,000	69	63	(±15)
75–79yrs	81,100	26	32	(±13)	88,000	37	42	(±14)
80–84yrs	48,800	25	51	(±20)	58,100	12	21	(±12)
85yrs+	35,400	8	23	(±16)	55,800	10	18	(±11)
Total[2]	**2,657,200**	**4,210**	**163**	**(±5)**	**2,723,100**	**5,226**	**201**	**(±5)**

[1] 95% confidence interval.

[2] The total rates are age-standardised rates per 100,000.

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