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COMMENTARY

A much-needed focus on self-harm in older adults

Commentary on "Hospital-presenting self-harm amongst older adults living in Ireland: 13-year trend analysis from the National Self-Harm Registry Ireland" by Troya *et al.*

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Self-harm monitoring systems or registers, provide a unique longitudinal insight into population prevalence over time and form a solid foundation for the exploration of subpopulation differences (WHO, 2016). Such systems enable an improved understanding of the clinical needs, clinical management and future risk at the population level, as well as the impact of societal events which can effectively inform decision making, policy and practice.

The value of a data monitoring system is exemplified in *Hospital-presenting self-harm amongst older adults living in Ireland: 13-year trend analysis from the National Self-Harm Registry Ireland* (Troya *et al.*, 2023). As indicated by the title, the authors utilise over a decade of data from a national register of self-harm attendances to hospital emergency departments in Ireland, to extend understanding of trends and subgroup differences in adults aged 60 years and over, amplifying the call to take an act of self-harm by an older adult extremely seriously.

Troya *et al.* (2023), found self-harm related emergency department attendances to be much less prevalent in older adults, than in younger age groups within Ireland, but evidence a heightened risk of suicide – notably, the absence of the *"gender paradox of suicidal behaviour."* Seen in younger age groups, this phenomenon of higher self-harm rates amongst females, but higher suicide rates in males (despite self-harm being a risk factor for suicide (Cannetto and Sakinofsky, 1998)), is a trend which is not maintained in older age. Rather, self-harm and suicide rates closely mirror each other, particularly for males aged 80 years and older. Indeed, the Multicentre Monitoring Study of Self-harm in England identified that older adults who self-harm are alarmingly 67 times more likely to die by suicide than those within the general population (Murphy *et al.*, 2012). Together, such findings strongly advocate that all self-harm acts by older adults must be considered suicide attempts.

Previous findings also inform us that self-harm in older age more closely resembles suicide, involving greater suicidal intent and lethality of method (Draper, 1996). While intent is not explored in Troya *et al*'s (2023) study, high intent is inferred from self-cutting presentations involving sutures or referral to plastic surgery. Conversely, low intent does not necessarily equal low risk, so we advise caution when inferring suicidal intent in practice and provide a reminder of the strong association between self-harm and future suicide risk (Hawton and Harriss, 2006; Murphy *et al.*, 2012; Troya *et al.*, 2019a).

Alongside the elevated risk of suicide, there may be a reduced opportunity to intervene, as there is evidence older adults are less likely to re-present to hospital following self-harm, relative to younger age groups (Kapur *et al.*, 2006; Owens *et al.*, 2002), and display fewer help-seeking behaviors (Teo *et al.*, 2022; Troya *et al.*, 2019b). It is therefore a research priority to establish why older adults are less likely to re-present to hospital and to understand how help-seeking behaviors can be encouraged in this population.

Crucially, Troya *et al*'s (2023) study reminds us to not view older adults as one homogenous group. Mental and physical health concerns are commonly reported problems that precede self-harm in older adults (Morgan *et al.*, 2018; Patel *et al.*, 2023; Troya *et al.*, 2019a), but gender comparisons have long shown differences in a multitude of other risk factors or precipitating problems, which may be equally important considerations for assessment and treatment (Hawton and Harriss, 2006).

Naturally, one reason such marked differences are evident within this population is due to the vast

age range used to categorize our senior years. Individuals with 40 years difference in age can fall within this group, meaning life events encountered can also vary greatly. Some individuals are still regularly working and displaying characteristics closely aligned with a younger working age group, whereas others may be newly or several decades into retirement, and some experiencing significant deterioration in physical and/or mental health and cognitive function. Troya *et al.* (2023), attempt to overcome some of these issues through their age subgroup analysis, adding to the existing knowledge of within group differences in the older adult population (Morgan *et al.*, 2018; Murphy *et al.*, 2012; Patel *et al.*, 2023), which may provide important considerations for care provision.

Such gender and age differences are clearly demonstrated in the authors' findings around the impact of the 2008 economic recession being greatest amongst males and the younger age group (60–69 years), with significantly more self-harm presentations between 2007 and 2012, compared with subsequent years (2013–2019). Troya *et al.* (2023) highlight the post pandemic challenges now facing our society combined with the effect of international unrest and conflict as important considerations for responding to increases in self-harm presentations in older adults, with previous research indicating that self-harm rates increase with such events (Hawton *et al.*, 2016).

The current findings highlight the crucial role data monitoring systems and registers play in providing an awareness of the broader influences on trends in self-harm rates – older adults may not typically be considered as most at risk from the impacts of economic recession. Furthermore, connecting up findings from multiple national systems, enables powerful international insights and a broader understanding of self-harm (WHO, 2014). This is particularly important for older adults as they are highly underrepresented in self-harm research relative to other age groups.

Troya *et al.* (2023) found self-poisoning was the most common method of self-harm, as is the case with younger groups, and is consistent with previous findings (Morgan *et al.*, 2018; Murphy *et al.*, 2012; Patel *et al.*, 2023; Troya *et al.*, 2019a), but there were also differences by subgroup. Females were more likely to self-poison and this method was more common in 60–69-year-olds. In a UK primary care cohort study, prescription rates for psychotropic medications were found to be high within 12 months of a self-harm episode (Morgan *et al.*, 2018).

To reduce access to means, caution with prescribed medication for mental health conditions (taking into account the toxicity of the medication), is advised where there is a known risk of self-harm (Morgan *et al.*, 2018; NICE, 2022). Regular medication reviews by a medical professional and awareness raising with family and carers around the removal of medications, no longer required from the home are essential. We must consider that an overdose taken by an elderly person who may be physically frailer, might lead to greater harm than in a younger, healthier individual due to reduced tolerance.

Due to the close association of self-harm and suicide (Geulayov *et al.*, 2016), and the important considerations around heterogeneity within the older adult population, the significance of a thorough psychosocial assessment for the prevention of future harm (Kapur *et al.*, 2008; NICE, 2022), is central to exploring the self-harm episode and the experiences of the individual. NICE guidance (2022) on the assessment and management of self-harm in the UK identifies specific recommendations for assessing older adults following self-harm. Assessments should be completed by an appropriately experienced healthcare professional, which in combination with the specific factors recommended by NICE, should enable an individualized assessment. The more that is known about an individual's previous history, risk factors and problems precipitating the self-harm episode, the better aided the healthcare professional to generate a comprehensive formulation. This informs the care or safety plan which in turn helps to mitigate or reduce the risk of future harm. Along with existing local and national guidance, our understanding of risk or precipitating factors can be informed by available population-based findings, such as Troya *et al*'s study (2023).

However, older age is only one life stage we pass through in our life cycle. Life stages prior to older age are therefore equally important in the formation of risk and protective factors personal to us. Cohort studies only offer a snapshot of a whole life cycle and there is the potential for longitudinal national health studies such as the new "Our Future Health (2023)" program in the UK to deepen our understanding of risk and protective factors within our life cycles if self-harm is included. This has been achieved on a more localized scale within the Avon Longitudinal Study of Parents and Children (University of Bristol, 2023), also in the UK.

Additionally, it is important to acknowledge that the identified age and sex differences within the older adult self-harm population need to be explored further to understand the underlying causes of such variances, to clearly translate their application for policymakers, clinical practice, and training. Previous qualitative research has explored the diverse narratives of self-harm experiences in later life (Troya *et al.*, 2019b), however this remains a greatly under researched area and more qualitative research is needed, particularly in those individuals that do

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not appear to have any history of self-harm until they reach older age.

Hospital-presenting self-harm amongst older adults living in Ireland: 13-year trend analysis from the National Self-Harm Registry Ireland brings much-needed focus to self-harm in older adults. As a stand-alone study, or alongside other national monitoring systems of self-harm, these findings demonstrate the importance of monitoring programs in detecting trends, risks and in identifying the broader influences on self-harm at the population level. Discussion of the *"gender paradox of suicidal behaviour"* emphasizes the need for more research to understand what changes occur in older age (and throughout the wider lifecycle), leading to the closer alignment of self-harm and suicide, particularly in older males. Great heterogeneity exists within this group, knowledge of which must challenge our perceptions of what it is to be an older adult and more accurately inform clinical care and prevention approaches.

Conflicts of interest

JN and KW are leads for the Multicentre Monitoring study of Self-Harm in England. KW is a Non-Executive Director for Storm Skills Training, a not-for-profit Community Interest Company. AP declares no competing interests. The views expressed are those of the authors and not necessarily those of Derbyshire Healthcare NHS Foundation Trust, the NHS, or the Department of Health and Social Care.

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