NATIONAL SELF-HARM REGISTRY IRELAND

ANNUAL REPORT 2025

NSRF
National Suicide
Research Foundation

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National Suicide Research Foundation
4th Floor
Western Gateway Building
University College Cork
Ireland

Tel: +353 21 4205551
Email: **infonsrf@ucc.ie**

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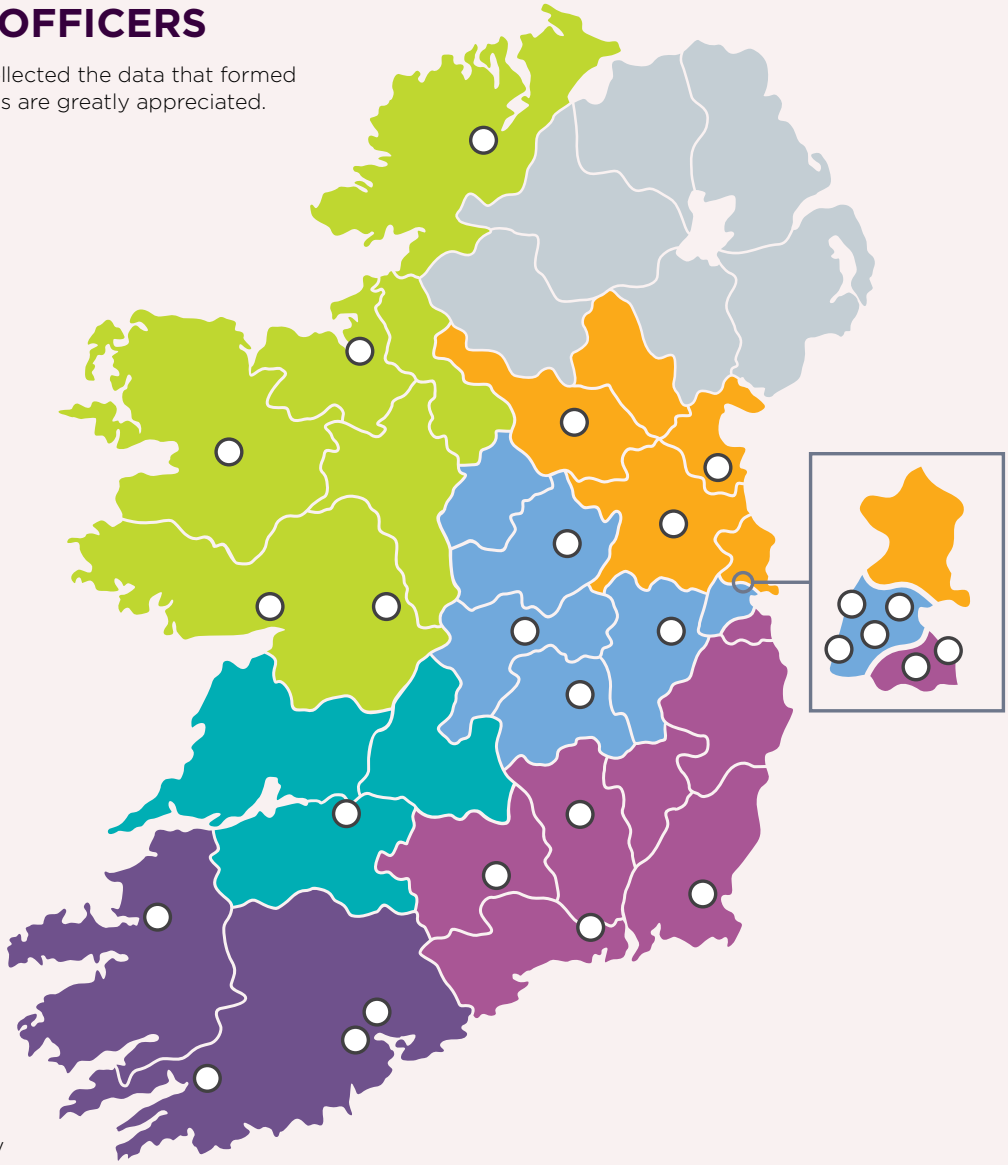
DATA REGISTRATION OFFICERS

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



HSE West and North West

Martina Callaghan
Letterkenny University Hospital

Ailish Melia
Sligo University Hospital

Helen Mellody
Mayo University Hospital
Portiuncula University Hospital
University Hospital Galway
Letterkenny University Hospital

Rebecca Curran
Letterkenny University Hospital
Mayo University Hospital

HSE Mid West

Catherine Murphy
University Hospital Limerick

HSE South West

Karen Twomey
University Hospital Kerry

Una Walsh & Ursula Burke
Bantry General Hospital
Cork University Hospital
Mercy University Hospital, Cork

HSE Dublin and South East

Deirdre Brennan & Clodagh Douglas
University Hospital Waterford
Wexford General Hospital
Tipperary University Hospital
St. Luke's General Hospital, Carlow Kilkenny

Ciaran Cluskey-Kelly
St. Michael's Hospital, Dún Laoghaire

Claire Fahey
St. Vincent's University Hospital, Dublin

HSE Dublin and North East

Rita Cullivan
Cavan Monaghan Hospital
Our Lady of Lourdes Hospital, Drogheda
Our Lady's Hospital, Navan

Ciaran Cluskey-Kelly
Our Lady of Lourdes Hospital, Drogheda

Rebecca Curran
Cavan Monaghan Hospital
Our Lady of Lourdes Hospital, Drogheda
Our Lady's Hospital, Navan

HSE Dublin and Midlands

Diarmuid O'Connor
Midland Regional Hospitals
(Mullingar, Portlaoise, Tullamore)
Naas General Hospital
Tallaght University Hospital

Ciaran Cluskey-Kelly
St. James's Hospital, Dublin

Alan Boon
Children's Health Ireland at Crumlin and Temple Street
St. James's Hospital
Tallaght University Hospital

Rebecca Curran
Tallaght University Hospital

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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 health 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 2025. Being published within nine months of the year's end represents a return to the publication schedule we had before the COVID-19 pandemic. 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. We continue to work with colleagues in several hospitals in order to return the Registry to being able to report on self-harm presentations to all hospital emergency departments in the country.

I would like to thank the members of our Advisory Panel who continue to provide guidance on the operation of the Registry, 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.

I welcome Ireland's Strategy to Reduce Suicide and Self-harm/Connecting for Life: 2026-2035. It was a pleasure working with colleagues in the Department of Health in the analysis of trends in suicide based on data provided by the Central Statistics Office and trends in hospital-presenting self-harm based on data provided by the Registry. The findings showed evidence that these two primary outcomes of the previous national strategy, Connecting for Life 2015-2024, have reduced during its implementation. We look forward to providing Registry data to the wide range of agencies involved in the implementation of the new strategy, in particular the Health Service Executive's National Office for Suicide Prevention and the National Clinical Programme for Self-Harm and Suicide Related Ideation.

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

Executive Summary

This is the twenty-third 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 2025. 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 2025. We estimated the number of presentations and people presenting to these hospitals using data from recent years to provide national estimates in 2025. All rate calculations presented in this report are based on those estimates.

Main findings

In 2025, the National Self-Harm Registry Ireland estimated that there was a total of 12,340 self-harm presentations made by 9,329 individuals. The estimated age-standardised rate of individuals presenting to hospital following self-harm in 2025 was 176 per 100,000. This is 3% lower than the rate in 2024, and 21% lower than the peak rate recorded by the Registry in 2010 (223 per 100,000). In 2025, the national female rate of self-harm was 194 per 100,000, 3% lower than 2024. The rate in 2025 marks a continuation of the decrease observed for women since 2021 and is the lowest rate recorded by the Registry for women. The male rate of self-harm in 2025 was 159 per 100,000, 2% lower than 2024. It is also the lowest rate recorded by the Registry for men.

The peak rate for women was in the 15–19-year-old age group, at 592 per 100,000. The female rate of hospital-presenting self-harm continues to be highest among 15-19 year-olds. Their rate increased by 50%, from approximately 600 per 100,000 in 2013 to almost 900 per 100,000 in 2021, however, the rate has fallen to around 600 per 100,000 since then. The peak rate for men in 2025 was among 20–24-year-olds and 25-29-year-olds at 323 and 322 per 100,000 respectively.

There were 592 presentations made by residents of homeless hostels or shelters and people of no fixed abode in 2025, accounting for approximately 6% of all presentations recorded by the Registry. This is comparable to the 6% reported in 2024 and 7% reported in 2023.

Consistent with previous years, intentional drug overdose was the most common method of self-harm, involved in almost three in five (59%) self-harm presentations in 2025. Minor tranquillisers were the most common drug type used, similar to previous years. Self-cutting was the other most common method, recorded in almost a third (32%) of presentations. Attempted hanging was involved in 8% of all self-harm presentations (13% 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 2% of presentations. Alcohol was involved in 31% of all presentations and was more often involved in presentations by men (37% vs 26% for women). In general, the type of method used in self-harm was similar to recent years.

For 68% of presentations in 2025, the patient was assessed by a member of the mental health team in the presenting hospital (*n* = 5,848). For a further 6%, an assessment was arranged in the presenting hospital (*n* = 521). Most commonly, in 49% of presentations, individuals were discharged following treatment in the ED. Almost three in four (72%) were provided with a recommended referral or follow-up appointment. In 13% 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 24% and as much as 38% of adult presentations across the six health regions, while the proportion of adult patients who left before a recommendation could be made ranged from 10% to 24%. Similarly, the proportion of adults discharged following treatment in the ED ranged from 31% in HSE Dublin and North East to 62% in HSE South West. This observed difference is likely to be due to variation in the availability of resources and services, but it also likely indicates that assessment and management procedures for self-harm patients vary across the country.

In 2025, we continued to gather information on the current care for individuals presenting to hospital with self-harm. For just over a third of presentations (34%; *n* = 3,528), it was recorded 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 (*n* = 185). For 4% of presentations, individuals were attending counselling or addiction services. Individuals were engaged with homelessness services in 2% of cases.

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There was a similar proportion of presentations accounted for by repetition in 2025 as in 2024 (24% and 25%, respectively). Of the 7,841 self-harm patients who presented to hospital in 2025, 1,203 (15%) 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 and HSE West and North West (17%). In 2025, at least five self-harm presentations were made by 136 individuals. These patients account for 2% of all self-harm patients but their presentations represented 11% 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.

Mary Joyce
Manager,
National Self-Harm Registry Ireland,
National Suicide Research Foundation, Cork

Shelly Chakraborty
Data Manager & Analyst,
National Self-Harm Registry Ireland,
National Suicide Research Foundation, Cork

James Camien McGuiggan
Data Analyst,
National Self-Harm Registry Ireland,
National Suicide Research Foundation, Cork

Paweł Hursztyn
Research Officer,
National Self-Harm Registry Ireland,
National Suicide Research Foundation, Cork

Ella Arensman
Chief Scientist,
National Suicide Research Foundation, Cork
Professor of Public Mental Health,
School of Public Health, University College Cork

Eve Griffin
Chief Executive Officer,
National Suicide Research Foundation, Cork

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

2025 Statistics at a Glance

Presentations
12,340

Persons
9,329

2025 rate is 3% lower than that recorded in 2024

RATES:

176
per 100,000
1 in every 568
had a self-harm act

Men: 20-29 year-olds
1 in every 310

Women: 15-19 year-olds
1 in every 169

PEAK RATES WERE AMONG YOUNG PEOPLE

TIME:

Peak time
8–9pm

Almost half of presentations made between 6pm–2am (45%)

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

August saw most presentations
December saw the fewest

METHOD:

6 in every 10
involved **overdose**

Men

Women

3 in every 10
involved **alcohol**

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

TREATMENT:

68% received a psychiatric assessment in the presenting hospital

72% received a follow-up recommendation after discharge

13% left ED before a recommendation was made

1 in 7
persons had a repeat attendance in 2025

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Recommendations

Recommendations of the findings in this report are set out below. 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

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 2026, and in the 2026-2035 National Suicide and Self-Harm Reduction Strategy, *Connecting for Life*, Domain 3.

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*, Domain 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, and *Connecting for Life*, Domain 3).

Clinical Management of Self-Harm

Recommendation 4
The delivery and implementation of the National Clinical Programme for Self-Harm and Suicide-related Ideation should continue to be supported in all hospitals nationally, with the aim for all people who present with self-harm to receive a mental health assessment, including those with dual diagnosis and co-morbid mental and physical health conditions.

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

Recommendation 6
Tailored assessment and treatment procedures for self-harm patients with patterns of frequent self-harm and those with high-risk self-harm should be implemented (*Connecting for Life*, Domain 3).

Restricting Access to Means

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 (*Connecting for Life*, Domain 2).

Recommendation 8
Findings from the work of the Preventing Paracetamol-Related Drug Overdose Working Group, and from projects such as RESTRICT and Dispose of Unused Medicines Properly (DUMP) Campaigns, should be disseminated to relevant stakeholders to increase awareness and advance understanding in relation to IDO. (*Connecting for Life*, Domain 2).

Self-Harm among Persons Experiencing Homelessness

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 in accordance with *Connecting for life*, Domain 1.

Recommendation 10
Evidence-based supports and targeted suicide prevention interventions should be identified for this priority group (*Connecting for Life*, Domain 1 and 3).

Surveillance of Self-Harm and Suicide and Prioritising Data Collection

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 Strategic Plan 2025-2030 from the National Suicide Research Foundation and *Connecting for Life*, Domain 5.

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.

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Impact of the Registry at National and Global Level

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

- In 2026, the NSRF continued as a designated collaboration centre for surveillance and research in suicide prevention with the World Health Organisation (WHO).
- In April 2026, Dr Eve Griffin and Prof Ella Arensman attended the first World Health Organisation global forum of collaborating centres in Lyon, France (7–9 April 2026). The conference provided insight on how we might better leverage the expertise in centres to address cross-cutting public health issues. The event also provided an opportunity to meet colleagues from the other Irish collaborating centres.
- Data from the Registry was integral to the evaluation of Connecting for Life 2015–2024. In December 2025, the Centre for Effective Services published a report on the implementation and intermediate outcomes of the strategy. Registry data, in addition was pivotal in providing the evidence base for the new Strategy to Reduce Suicide and Self-Harm, Connecting for Life: 2026–2035. Domain 5 of the new Strategy will focus specifically on self-harm surveillance in Ireland.

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

- Technical support was provided for the development of a National Suicide Prevention Plan for Costa Rica, including the development of a self-harm surveillance system.
- National Self-Harm Registry data was core to multiple presentations at the 21st European Symposium on Suicide and Suicidal Behaviour in Vilnius, 26–29 August 2026, including self-harm trends among young and older people.
- The National Self-Harm Registry was represented at the 70th Society for Social Medicine & Population Health Conference European Congress of Epidemiology, 9–11 September 2026.
- An educational video has been produced to promote self-harm surveillance and its importance to informing and evaluating national suicide prevention strategies:

  What is the National Self-Harm Registry? – National Suicide Research Foundation

Above: Members of the NSRF team at the 21st European Symposium on Suicide and Suicidal Behaviour, 2026.

Recent Publications from the Registry (2025–2026)

The Registry disseminates findings from the data we collect in various ways. One such way is via peer-reviewed articles that are published in academic journals. Information on a selection of articles published in 2025 and 2026 is provided below.

Since the introduction of HSE health regions in 2024, the Registry also reports on hospital self-harm presentations according to these areas. HSE Health Region Reports from 2024 onwards can be found on our website:

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

Recent Peer-Reviewed Publications

Harms associated with prescription drug misuse in Ireland: A national observational study of trends in treatment demand, non-fatal intentional drug overdoses and drug related deaths 2010–2020

Aims

To describe the health-related harms associated with the misuse of benzodiazepines/z-drugs, prescription opioids, gabapentinoids, and psychostimulants in Ireland by examining trends in their involvement in treatment demand, non-fatal intentional drug overdoses (IDOs), and drug related deaths (DRDs).

Methods

A repeated cross-sectional study using data from the National Drug Treatment Reporting System (NDTRS), the National Self-Harm Registry Ireland (NSHRI) and the National Drug Related Deaths Index (NDRDI) between 2010 and 2020. Trends over time (2010–2020) in treatment demand, IDOs and DRDs involving benzodiazepines/z-drugs, prescription opioids excluding opioid agonist therapy drugs, gabapentinoids, or psychostimulants (alone or concurrently), adjusting for age and gender (Negative Binomial Regression).

Findings

A total of 102,661 treatment entry cases; 51,126 people presenting with at least one IDO; and 3626 DRDs included. Benzodiazepines/z-drugs were involved in 341 per 1000 treatment entry cases; 408 per 1000 IDOs; and 546 per 1000 DRDs, followed by prescription opioids (36 per 1000 treatment entry cases; 133 per 1000 IDOs; and 207 per 1000 DRDs) and gabapentinoids (5 per 1000 treatment entry cases; 54 per 1000 IDOs; and 118 per 1000 DRDs). Benzodiazepines/z-drugs, and prescription opioid involvement was stable over time with little or no changes observed in treatment demand, IDOs and DRDs. However, NPS-Benzodiazepines (etizolam) involvement in DRDs increased by 47% annually (Adjusted Rate Ratio (ARR) 1.47, 95% Confidence Interval (CI) 1.30–1.65, $p < 0.0001$). Gabapentinoids (primarily pregabalin) associated with a large annual increase in treatment demand (+44% annually, ARR 1.44, 95% CI 1.36–1.52, $p < 0.0001$), DRDs (+35% annually, ARR 1.35, 95% CI 1.25–1.46, $p < 0.0001$), and IDOs (+9% annually, ARR 1.09, 95% CI 1.07–1.10, $p < 0.0001$). Polysubstance use harms increased with respect to treatment demand, IDOs and DRDs over study period.

Conclusions

While benzodiazepines account for the greatest overall harm with respect to treatment demand, IDOs and DRDs, gabapentinoids (primarily pregabalin) had the largest annual increase in harm over the study period.

Source: Durand, L., Arensman, E., Corcoran, P., Daly, C., Bennett, K., Lyons, S., Keenan, E., & Cousins, G. (2025). Harms associated with prescription drug misuse in Ireland: A national observational study of trends in treatment demand, non-fatal intentional drug overdoses and drug related deaths 2010–2020. *Drug and alcohol dependence* 272, 112669. **https://doi.org/10.1016/j.drugalcdep.2025.112669**

Cost of acute hospital treatment and initial aftercare for hospital-presenting self-harm in Ireland: National registry study

Background

Understanding the economic cost of self-harm is essential for evaluating intervention cost-effectiveness and guiding funding allocation and service planning.

Aims

To estimate the cost associated with self-harm presentations to hospital emergency departments and investigate key predictors of cost.

Method

Data on presentations to hospital for self-harm in all Irish emergency departments were analysed for 2018 and 2019. Costs of hospital treatment following self-harm were identified (in 2019 euros) using top-down and bottom-up approaches. The perspective taken was that of the health service. Factors associated with costs were investigated using generalised linear models.

Results

There were 25,053 self-harm presentations from 2018 to 2019. The average annual cost of self-harm was approximately €26.5 million; almost half of the total cost was due to repeat self-harm presentations (47.3%). The mean cost per presentation was €2117 (s.d. €1845), which incorporates acute hospital costs (mean €2067, s.d. €2127) and those of initial aftercare (mean €50, s.d. €69). Psychiatric and medical admissions were associated with highest costs, three times that of presentations resulting in emergency department discharge (incidence rate ratio (IRR) 3.01, 95% CI 2.72–3.36 and IRR 2.88, 95% CI 2.72–3.36, respectively). Other factors associated with higher costs included older age, emergency department medical assessment unit admission, receiving a psychosocial assessment and self-harm involving a firearm. Demographic and clinical predictors of cost varied according to care pathway.

Conclusions

Significant costs associated with repeat attendances and hospital admission provide evidence for investment in emergency department services providing comprehensive care for those presenting with self-harm, as well as in community-based mental health services.

Source: Cully, G., McElroy, B., Corcoran, P., Puertolas-Gracia, B., Kelleher, E., Cassidy, E., & Griffin, E. (2026). Cost of acute hospital treatment and initial aftercare for hospital-presenting self-harm in Ireland: national registry study. *BJPsych Open* 12(2), e78.
https://doi.org/10.1192/bjo.2026.10978

Methods

Background

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

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 NSRF at the request of the Department of Health and Children and is funded by the Health Service Executive's National Office for Suicide Prevention (NOSP). This report has been commissioned by the NOSP.

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, 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: for example, 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 routinely checked for consistency and accuracy. In addition, the Registry also undertakes a cross-checking process in which pairs of Data Registration Officers (DROs) 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 DROs.

Data recording

Since 2020, the Registry records data via a cloud-based clinical data management platform, Castor Electronic Data Capture (Castor 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, the Code Generator, 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.

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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

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 patients, date of birth is used to calculate age.

Area of residence: Patient addresses are geocoded to the appropriate Electoral Division and Small Area where applicable. In cases of patients without a household address in the Republic of Ireland (e.g. those who are homeless, in prison, in other residential care facilities), high-level information about the patient's housing situation is recorded.

Date and hour of attendance at hospital

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, strangulation and suffocation (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 (namely, whether the method was hanging, strangulation or suffocation).

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

Medical card status

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

Next care: Where known, any follow-up care recommended by the hospital staff following self-harm treatment is recorded.

Current care: Information about the psychiatric, mental health or social care the patient is receiving, or services they are under the care of in Ireland, at the time of presentation, is recorded.

Confidentiality and data protection

Confidentiality is strictly maintained. The NSRF 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 the 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 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 2025, self-harm data were collected from 27 hospitals in the Republic of Ireland (pop: 5,458,600). The hospitals for which data are presented in this report are listed by HSE health region in the table on page 15.

Data were collected in three of the six acute hospitals in HSE Dublin and North East, eight of the nine acute hospitals in HSE Dublin and Midlands (including two Children's Health Ireland hospitals), and 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).

A number of hospitals were re-designated as Model 2 hospitals as part of the HSE's Securing the Future of Smaller Hospitals Framework in 2013, with some of these hospitals closing their EDs and others operating their EDs on reduced hours. The Model 2 hospitals included in this Report are Bantry General Hospital (which has an Injury Unit) and St. Michael's Hospital, Dún Laoghaire (whose ED is open from 8 a.m. to 8 p.m. every day).

In total, self-harm data were collected for the full calendar year of 2025 for 25 of the 29 EDs, and two Model 2 hospitals, that operated in Ireland during this year.

Population data

For 2025, the Central Statistics Office population estimates were utilised. These estimates provide age–sex-specific population data for the country.

Calculation of rates

In 2025, 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 2025 were not available from three general hospitals and one Children's Health Ireland hospital. We used the following approach to estimate the national figures for hospital-presenting self-harm that would have been recorded for 2025 if these hospitals had contributed data. We reviewed several years of data from the three CHI hospital emergency departments, which determined that one of those CHI hospitals had a similar number and profile of presentations to the hospital missing in 2025. We calculated a weighting based on the number of self-harm presentations to those hospitals in 2023 (the last year for which both hospitals contributed data) and applied that weighting to the data from the hospital that contributed data in 2025. 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 2025.

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 (EASRs) are the incidence rates that would be observed if the population under study had the same age composition as a theoretical European population. Adjusting for the age composition of the population under study ensures that differences observed by sex 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 2025.

A note on confidence intervals

Confidence intervals (CIs) 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% CI 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 we can have 95% confidence that the rate is $25 \pm 2\sqrt{25}$ or 15 to 35, self-harm presentations. We can then determine the rate for a given population at risk, p. The 95% CI around a rate ranges from $(n - 2\sqrt{n})/p$ to $(n + 2\sqrt{n})/p$. The Registry expresses rates per 100,000 population, so these quantities are multiplied by 100,000.

A 95% CI may be calculated to establish whether two rates differ statistically significantly. First, the difference between the rates is calculated. The 95% CI for this rate difference (rd) ranges from $rd - 2\sqrt{(n_1 / p_1^2 + n_2 / p_2^2)}$ to $rd + 2\sqrt{(n_1 / p_1^2 + n_2 / p_2^2)}$, where n_1 and n_2 refer to the incidence of an event (e.g., self-harm presentations) and p_1 and p_2 refer to two populations (e.g., men and women). If the rates are 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 rate difference 95% CI, then the difference between the rates is statistically significant.

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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 Portlaoise
	Midland Regional Hospital Tullamore
	Naas General Hospital
	Midland Regional Hospital Mullingar
	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
	St. Vincent's University Hospital, Dublin
	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 2025, the Registry recorded 10,275 self-harm presentations to hospital that were made by 7,841 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 12,340 self-harm presentations by 9,329 individuals. Thus, the number of self-harm presentations was lower than that recorded in 2024 while the number of persons was similar. 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%
2025	12,340	–2%	9,329	–1%

Table 1: Number of self-harm presentations and persons who presented to hospital in the Republic of Ireland in 2002–2025 (2002–2005 and 2020–2025 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 2025 was 176 per 100,000 (95% confidence interval (CI): 172–179). This was a decrease of 3% from the 2024 rate of 181 per 100,000 (95% CI: 177–184). The incidence of self-harm in Ireland is examined in more detail in Section II of this report.

Of the recorded presentations in 2025, 56% were made by women. Self-harm presentations were higher among the younger age groups. Almost half of all presentations (48%) were by people under 30 years of age and 84% of presentations were by people aged less than 50 years. The number of self-harm presentations to hospitals in Ireland are provided by age and sex in Appendix A, Tables A1–A6.

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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-old age group, where there were almost three times as many female presentations (1,804 for women vs 612 for men). The number of presentations by men was marginally higher than the number by women among those aged 25–39 and those aged over 75.

There were 1,032 presentations from non-household residents, accounting for 10% of all presentations. Of these, 592 presentations were made by residents of homeless hostels and people of no fixed abode, representing 6% of all presentations, the same proportion as in 2024. Adolescents in residential care units accounted for 207 presentations (2% of the total).

Self-Harm by HSE Health Region

Based on figures acquired from the HSE Business Information Unit, self-harm accounted for 0.74% 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 0.62% in HSE Dublin and South East, 0.63% in HSE Dublin and North East, 0.66% in HSE West and North West, and 0.74% in HSE Dublin and Midlands to 0.82% in HSE Mid West and 1.08% in HSE South West.

The proportion of self-harm presentations accounted for by each HSE health region ranged from 8% in HSE Mid West and 9% in HSE Dublin and North East, to 17% in HSE West and North West, 19% in both HSE South West and HSE Dublin and South East, and 28% in HSE Dublin and Midlands.

In 2025, the proportion of male to female self-harm presentations was 44% to 56% nationally. When examined by HSE health region, the proportion of male to female self-harm presentations varied across the regions, though presentations by women outnumbered those by men in all regions (Figure 1).

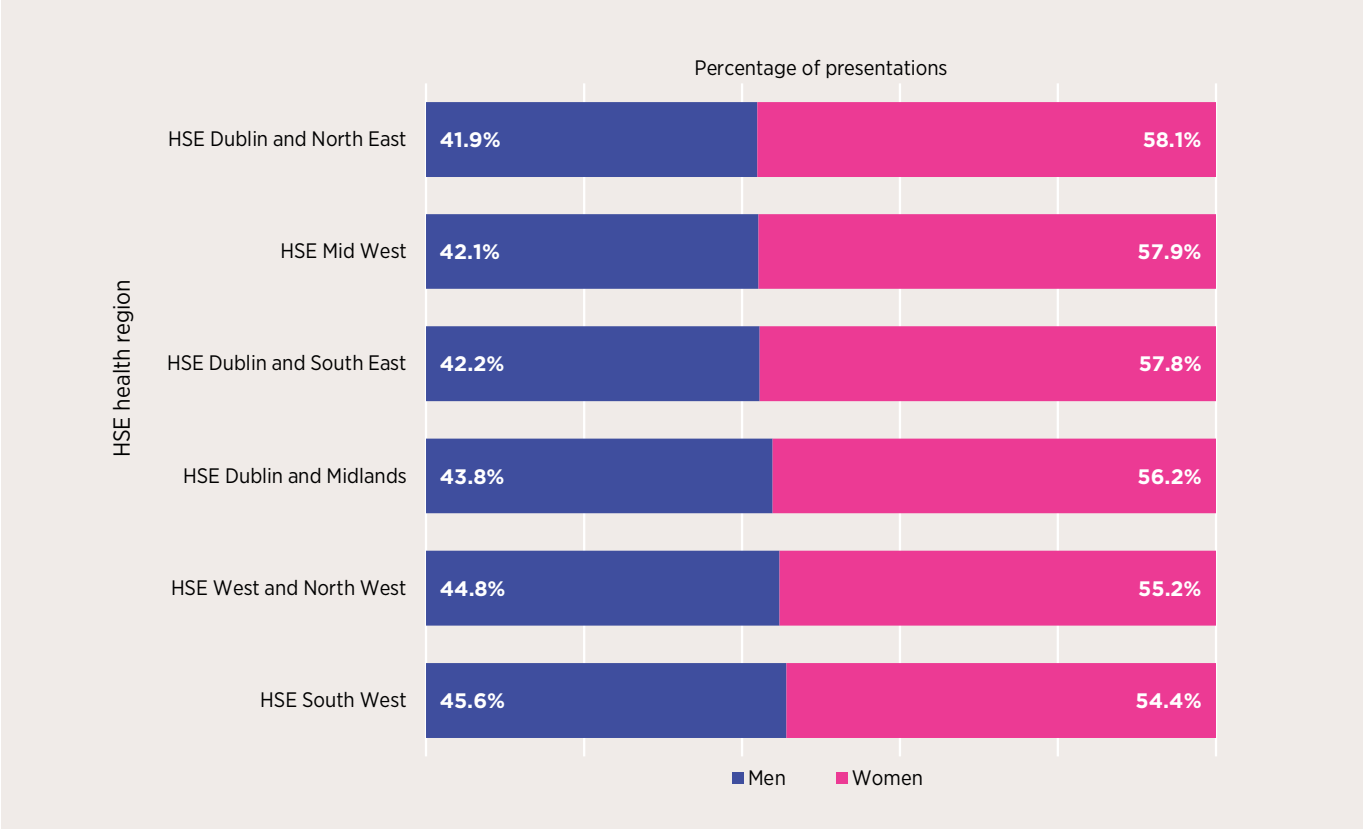

Figure 1: Proportion of male and female self-harm presentations by HSE health region, 2025.

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 2025 was lower than that recorded in 2024, there was variation in the number of presentations recorded at individual hospital level. There were thirteen hospitals in which an increase was observed from 2024 to 2025, while a decrease was observed for ten hospitals during the same time period (Figure 2). There was a <1% change in four hospitals. The largest increase (44%) was recorded for Children's Health Ireland at Crumlin. However, the increase in presentations in 2025 follows on from a decrease reported from 2023 to 2024 (28%).

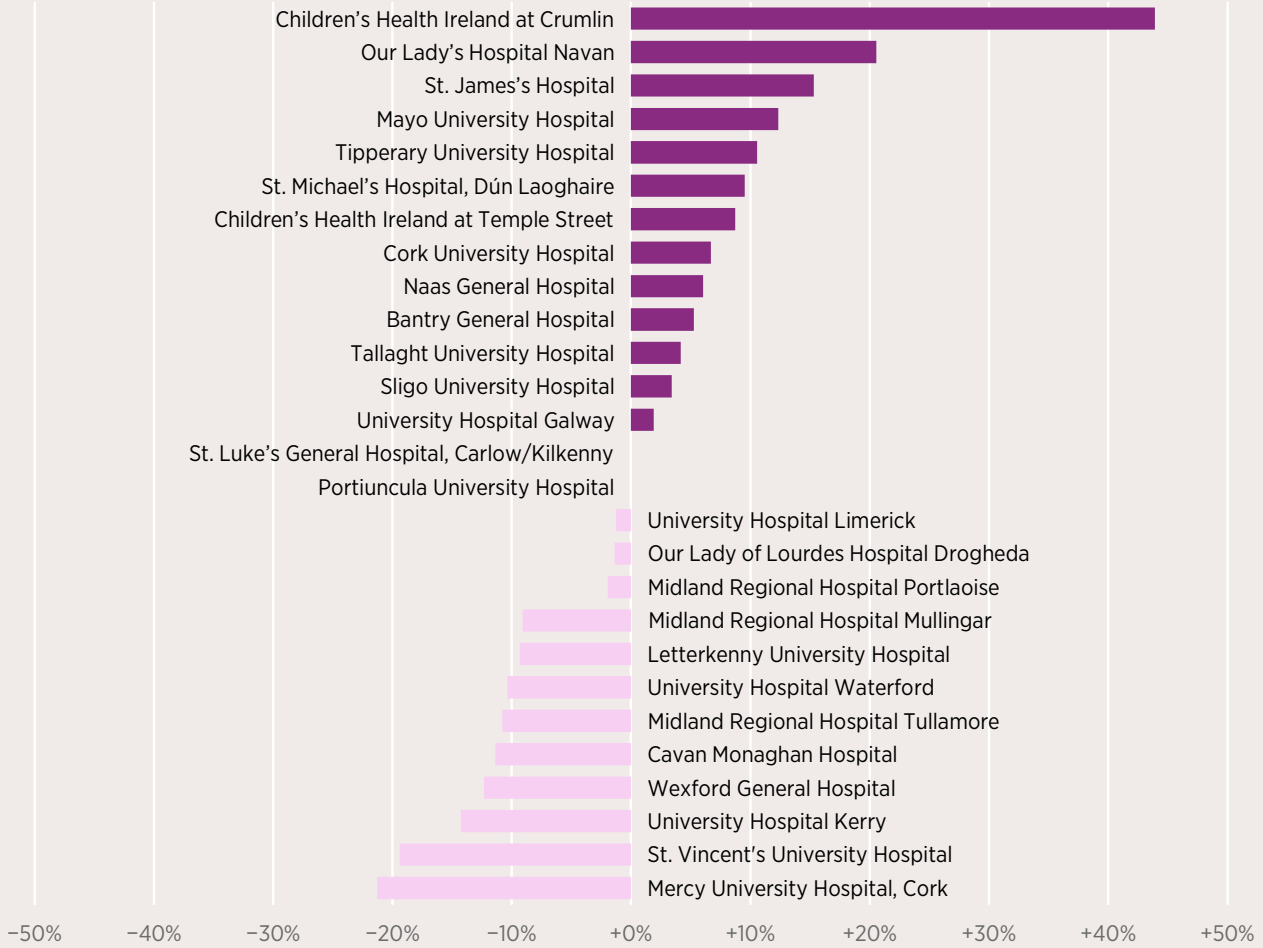

Figure 2: Percentage change in number of presentations to hospitals from 2024 to 2025.

Presentations by Time of Occurrence

Variation by month

The monthly number of self-harm presentations to hospitals in 2025 is outlined for men and women in Table 2.

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total
Men	330	335	404	362	388	391	380	427	389	419	335	332	4,492
Women	494	465	514	460	529	447	501	497	495	455	505	421	5,783
Total	824	800	918	822	917	838	881	924	884	874	840	753	10,275

Table 2: Number of self-harm presentations in 2025 by month for men and women.

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The monthly average number of self-harm presentations to hospitals in 2025 was 856. 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 2025.

The number of self-harm presentations exceeded expected levels in March, May, August and September. 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 2025 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	683	705	602	616	650	599	637	642
	15.2%	15.7%	13.4%	13.7%	14.5%	13.3%	14.2%	14.3%
Women	913	844	860	815	792	754	805	826
	15.8%	14.6%	14.9%	14.1%	13.7%	13.0%	13.9%	14.3%
Total	1,596	1,549	1,462	1,431	1,442	1,353	1,442	1,468
	15.5%	15.1%	14.2%	13.9%	14.0%	13.2%	14.0%	14.3%

Table 3: Self-harm presentations in 2025 by day of the week for men and women.

The number of self-harm presentations was highest on Mondays and Tuesdays. 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.

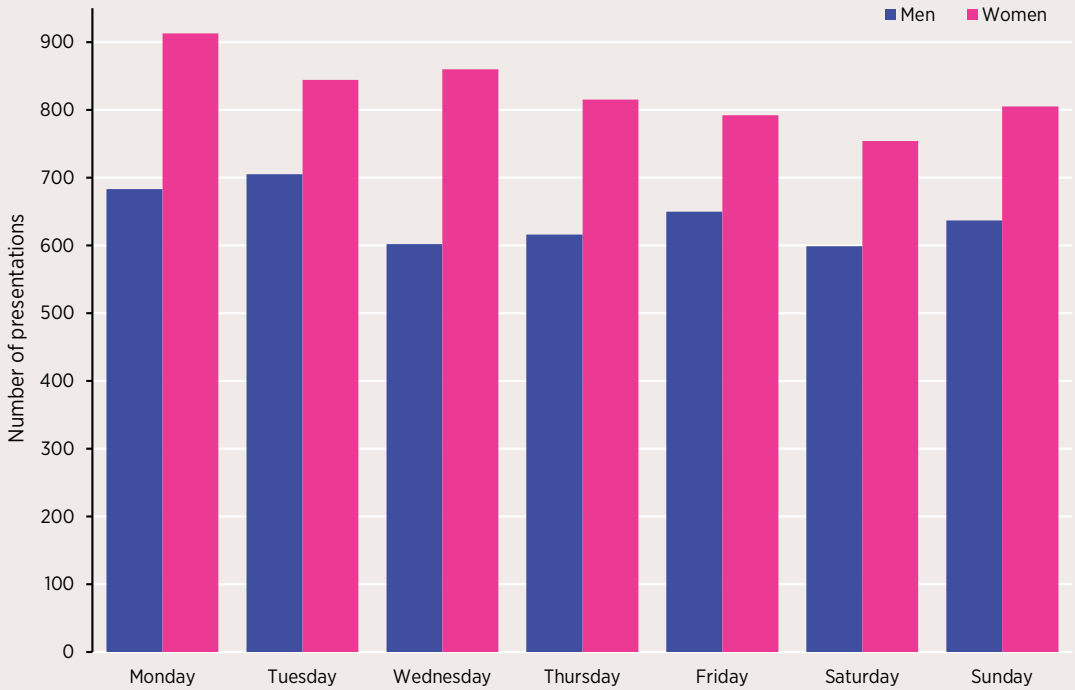

Figure 4: Number of self-harm presentations in 2025 by day of the week for men and women.

In 2025, there was an average of 28 self-harm presentations to hospital each day. Notably, there were ten days in 2025 on which 40 or more self-harm presentations were made, including January 1st and March 25th, which had the highest number of presentations (*n* = 47). Conversely, there were 25 days in 2025 on which fewer than twenty self-harm presentations occurred, eight of which were in December (1st, 6th, 10th, 16th, 21st, 23rd, 25th and 31st).

Variation by hour

The number of self-harm presentations to hospitals in 2025 is presented by time of attendance for men and women in Figure 5.

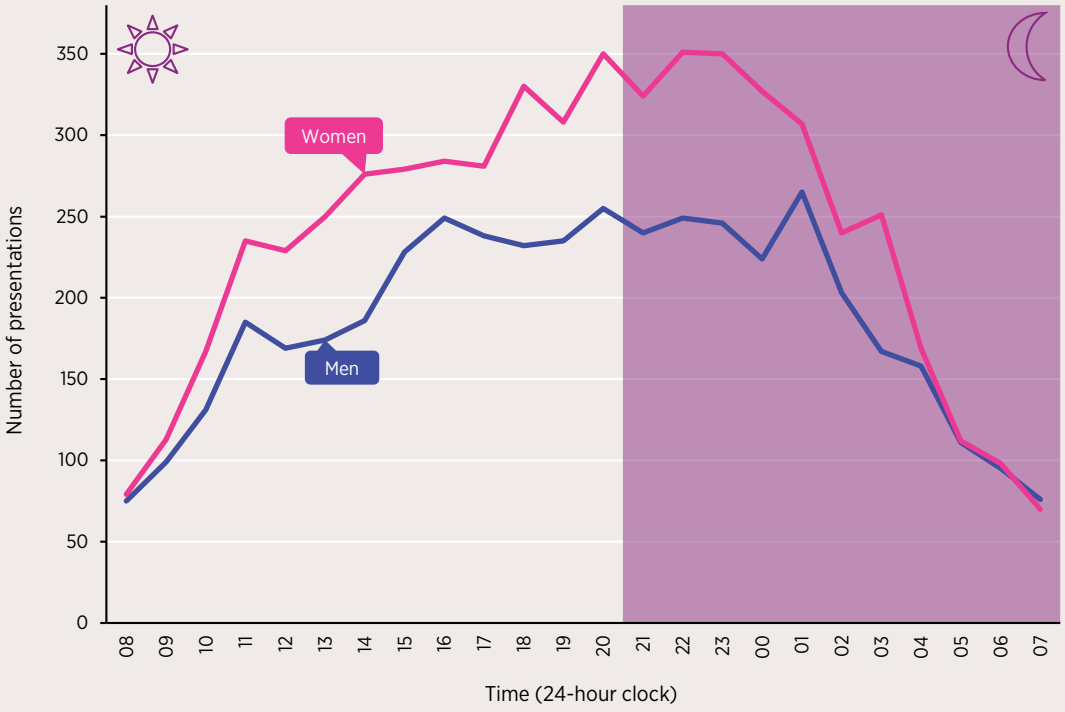

Figure 5: Number of self-harm presentations in 2025 by time of attendance for men and women.

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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 1–2 a.m. while it was 10–11 p.m. for women. Almost half of the total number of presentations (45%) 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 2025, 5,702 (55%) 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 22% of presentations, individuals were brought to hospital (or accompanied) by someone (e.g., a family member or friend) and for 16% 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 44% of presentations between noon and 4 p.m., to 72% of presentations between 4 a.m. and 8 a.m.

Method of Self-Harm

The methods of self-harm[1] involved in presentations to hospital in 2025 are presented in Table 4.

	Intentional drug overdose	Alcohol	Self-poisoning	Attempted hanging	Attempted drowning	Self-cutting	Other
Men (*n* = 4,492)	2,535	1,645	119	581	213	1,341	535
	56.4%	36.6%	2.6%	12.9%	4.7%	29.9%	11.9%
Women (*n* = 5,783)	3,566	1,515	134	264	158	1,896	426
	61.7%	26.2%	2.3%	4.6%	2.7%	32.8%	7.4%
All (*n* = 10,275)	6,101	3,160	253	845	371	3,237	961
	59.4%	30.8%	2.5%	8.2%	3.6%	31.5%	9.4%

Table 4: Methods of self-harm involved in presentations to hospital in 2025 by sex.

In 2025, 59% of all self-harm presentations to hospitals in 2025 involved an intentional drug overdose (IDO). IDO was more commonly used as a method of self-harm by women than by men, involved in 62% of female and 56% of male presentations. Alcohol was involved in 31% of presentations and was more likely to be involved in male than female presentations (37% vs. 26% respectively).

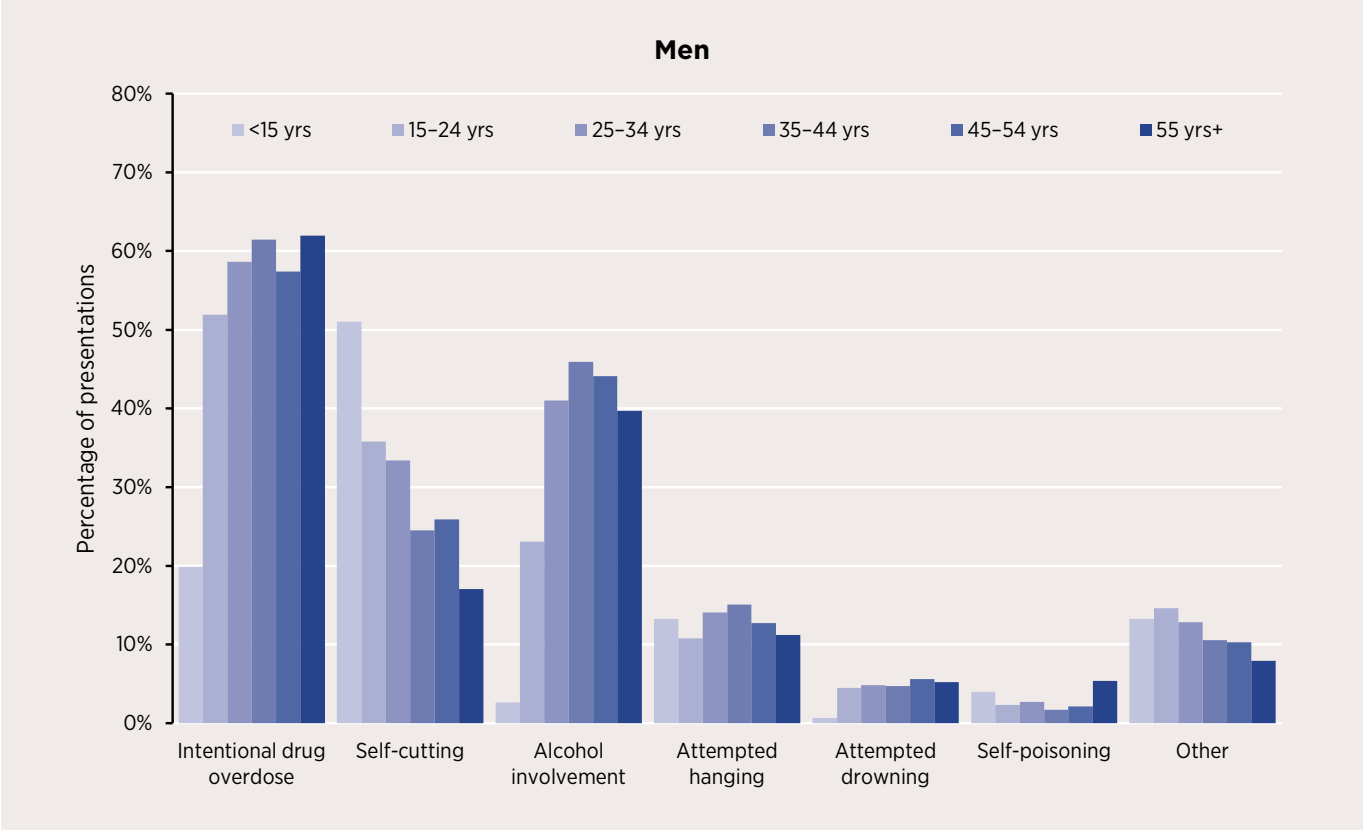
Self-cutting was the only other common method of self-harm, involved in 32% of all presentations. Self-cutting presentations were more common among women (33%) than men (30%).

In 64% of all cases involving self-cutting, the treatment received was recorded. Of these, the majority either had their wound cleaned and/or dressed (37%), and a further 23% did not require any treatment. In 27% of presentations, the patient received steristrips, stitches or sutures, 2% had their wound glued and 3% were referred for plastic surgery. Overall, the treatment for self-cutting was similar for men and women except for plastics/surgery which was required more often for men than women (5% vs 2%).

Attempted hanging was involved in 8% of self-harm presentations (13% for men and 5% for women). Attempted drowning was involved in 4% of presentations (*n* = 371) and self-poisoning was involved in 2% of presentations.

The greater involvement of IDO as a method of self-harm for women in comparison to men is illustrated in Figure 6. IDO also accounted for a higher proportion of self-harm presentations in the older age groups (65% of IDO presentations by 45–54-year-olds and 71% among those aged over 55, compared to an average across all age groups of 59%). This was especially true for women: IDO was involved in 72% of presentations by 45–54-year-olds and 78% among those aged over 55, compared to an average across all age groups of 62%. By contrast, self-cutting was less common among these age groups: 15% of presentations by those aged over 55 involved self-cutting compared to an overall average of 32%. Self-cutting was the most common method of self-harm in both boys and girls aged 14 years old or younger, involved in half (51% and 49% respectively) of presentations. IDO was the most common method among girls and women aged 15–24 (involved in 54% of presentations).

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



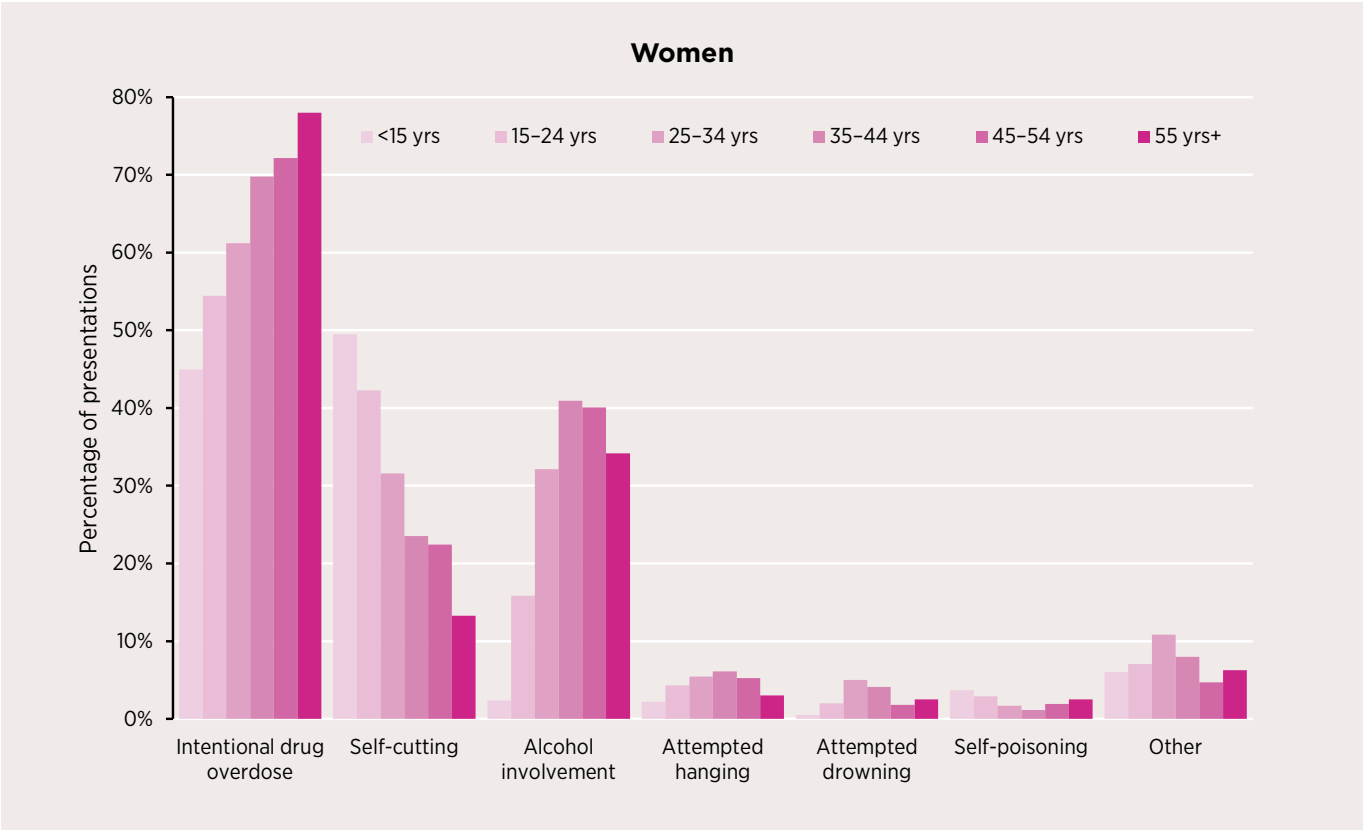


Figure 6: Method of self-harm used by men and women across age groups in 2025.

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Drugs Used in Intentional Drug Overdoses

The total number of tablets taken was known for 65% of presentations involving intentional drug overdose (IDO). On average, 29 tablets were taken in IDO presentations. Of IDO acts in which the number of tablets taken is known, 75% involved fewer than 35 tablets, approximately 46% involved 20 tablets or fewer and 25% involved 10 tablets or fewer. On average, the number of tablets taken in IDO presentations was higher among men than women (mean: 32 vs. 27). Figure 7 illustrates the number of tablets taken in IDO presentations by sex. Nearly half of female IDO presentations (49%) and 43% of male presentations involved 10–29 tablets.

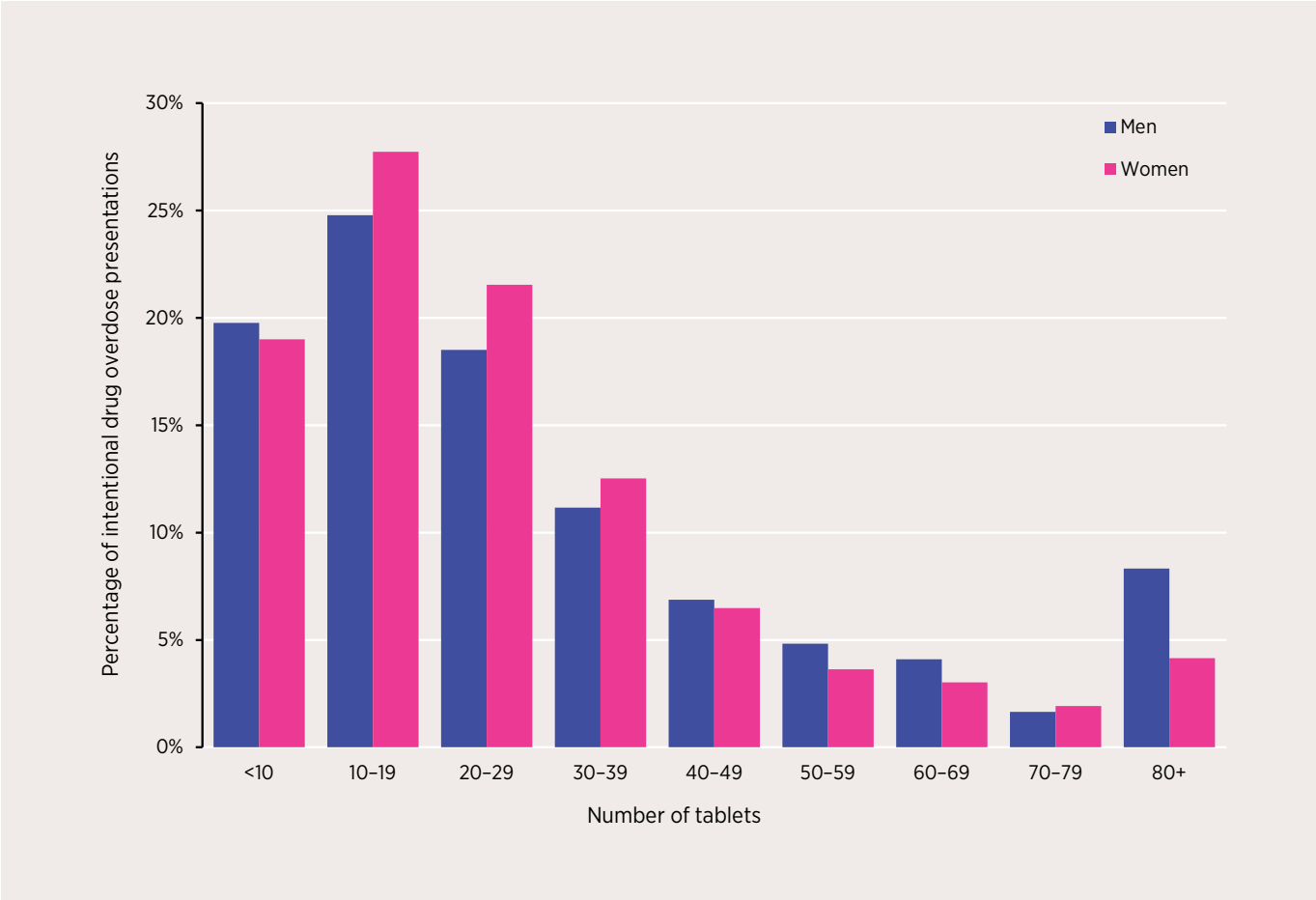

Figure 7: Number of tablets taken by men and women in intentional drug overdoses in 2025.

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

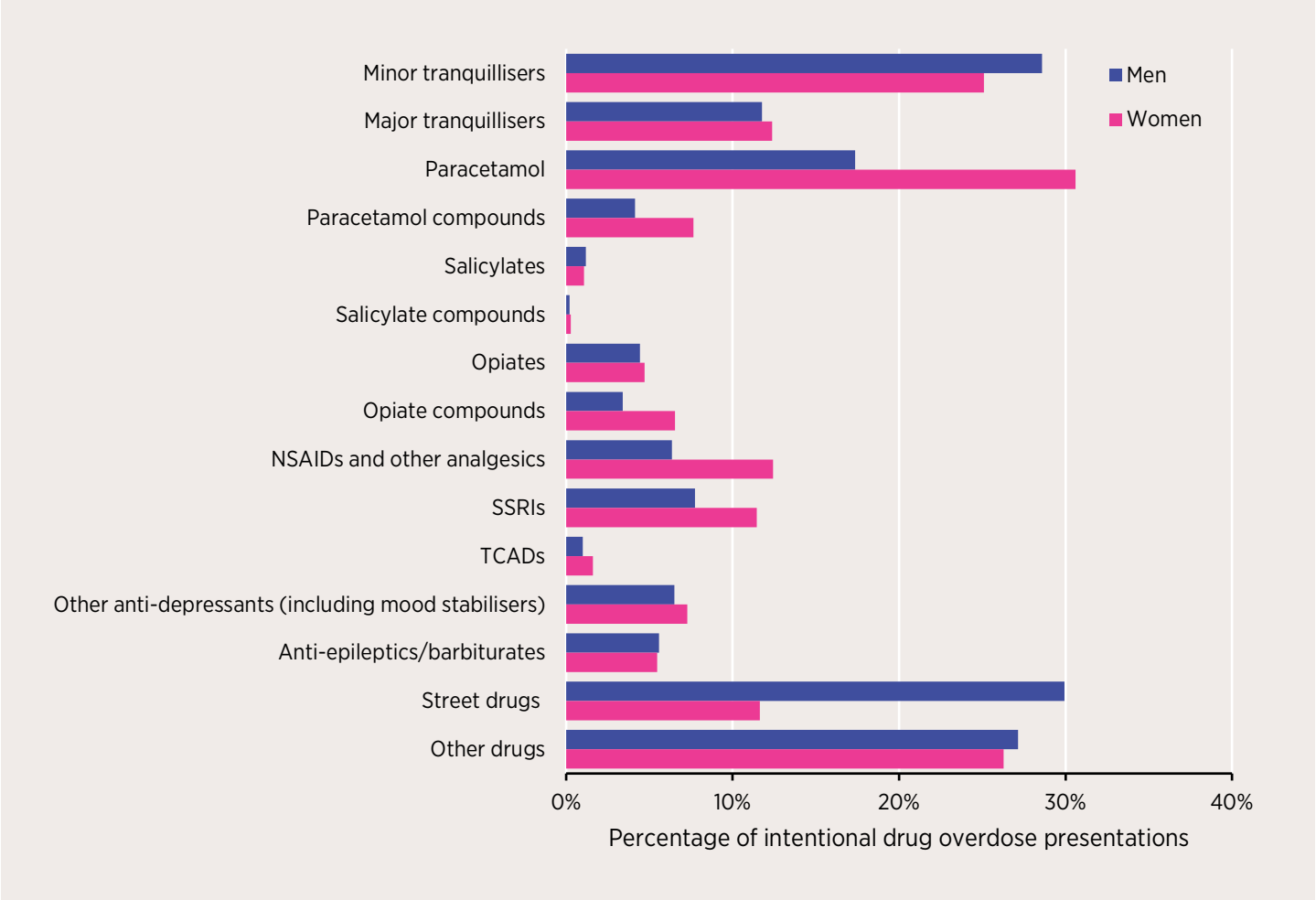

Figure 8: Types of drugs used by men and women in IDO presentations in 2025.

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

Of all IDO presentations, 27% involved a minor tranquilliser; these were more often used by men than women (29% vs. 25% respectively). A major tranquilliser was involved in 12% of IDO presentations. In total, analgesics were used in 47% of female and 29% of male overdoses. 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%). One in six (17%) 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 30% of male and 12% of female IDOs. Other prescribed drugs were taken in 27% of all IDOs.

In recent years, there has been some fluctuation in the proportion of presentations involving each of the drug types mentioned here. In 2025, paracetamol was the drug most commonly involved in IDO presentations; in 2024, it was minor tranquillisers.

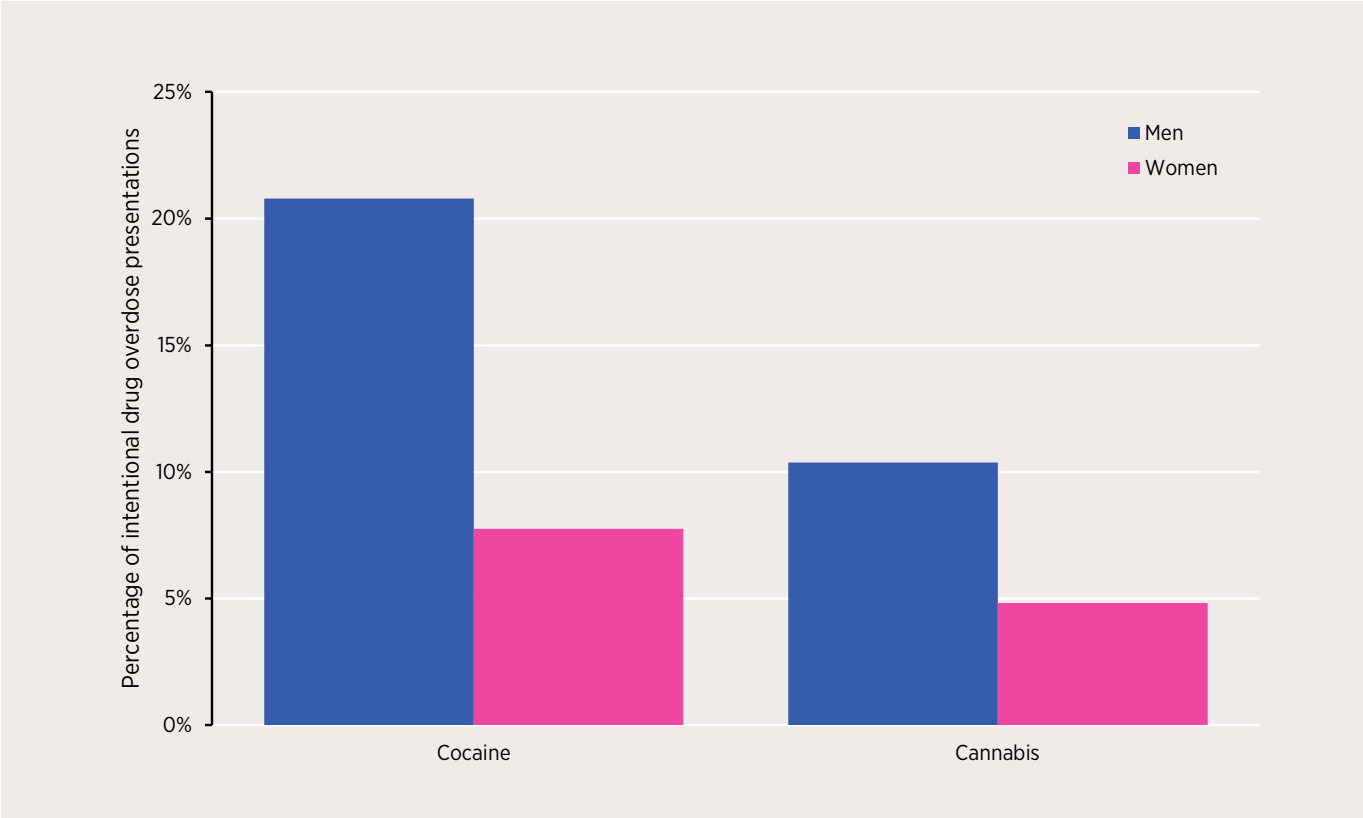

Figure 9: Cocaine and cannabis involvement in self-harm presentations in 2025.

Since 2022, information has been recorded by the Registry about whether cocaine or cannabis were involved in self-harm presentations. Of all presentations in 2025 (*n* = 10,275), cocaine was involved in 8% of presentations and cannabis was involved in 4% (equivalent to 13% and 7%, respectively, of all IDO presentations). A greater proportion of presentations by men involved these drugs: 12% of all presentations by men and 5% of all presentations by women involved cocaine (21% and 8% of all IDO presentations (see Figure 9)), and 6% of all presentations by men and 3% of all presentations by women involved cannabis (10% and 5% of all IDO presentations).

For both drugs, the majority (59–61%) of presentations by men and women were among those aged 20–34 years.

Recommended Next Care

In 2025, most commonly, in 49% of presentations, patients were discharged following treatment in the ED. An inpatient admission was the next care recommended for 32% 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, 24% resulted in admission to a general ward in the treating hospital, 6% were admitted for psychiatric inpatient treatment and 1% 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 13% 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 2025 were similar for men and women. However, men more frequently left the ED before a recommendation was made than women (15% vs. 11%). Conversely, women were more frequently admitted to a general ward of the treating hospital in comparison to men (26% vs. 21%).

The recommendations for next care also varied according to the method of self-harm (Table 5). Approximately 31% of presentations involving intentional drug overdose and 32% of presentations involving self-poisoning were admitted for general inpatient care. For other methods of self-harm, general inpatient care was recommended for 9–22% 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 involving self-cutting, 61% 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 (12% for each). Admission to an ICU was highest for presentations involving attempted hanging and intentional drug overdose (2%).

	Intentional drug overdose (*n* = 6,101)	Alcohol (*n* = 3,160)	Self-poisoning (*n* = 253)	Attempted hanging (*n* = 845)	Attempted drowning (*n* = 371)	Self-cutting (*n* = 3,237)	Other (*n* = 961)	All (*n* = 10,275)
General admission	30.9%	21.8%	32.4%	11.7%	9.4%	13.3%	13.5%	23.5%
Psychiatric admission	5.5%	5.3%	4.7%	12.0%	12.1%	4.8%	8.5%	5.9%
Admission ICU	2.0%	1.4%	1.6%	1.9%	0.3%	0.6%	0.5%	1.5%
Patient refused admission	1.0%	1.0%	0.8%	1.5%	1.9%	0.6%	0.8%	0.9%
Transferred to another hospital/ psychiatric unit/ psychiatric hospital	5.2%	5.3%	5.5%	10.2%	8.9%	5.9%	7.6%	5.7%
Left before recommendation	12.7%	17.9%	10.3%	9.5%	11.6%	13.2%	13.0%	12.6%
Discharged from ED	42.1%	46.6%	44.7%	52.8%	54.7%	60.9%	55.4%	49.3%

Table 5: Recommended next care by methods of self-harm in 2025.

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 10% in HSE South West to 24% in HSE Dublin and North East. Across the health regions, inpatient care (irrespective of type and whether the patient refused) was recommended for 24% of presentations in HSE Mid West, 25% of presentations in HSE South West, 26% of presentations in HSE Dublin and North East, 35% of presentations in HSE Dublin and Midlands, 36% in HSE Dublin and South East, and 38% in HSE West and North West.

As a corollary to this, the proportion of cases discharged following emergency treatment ranged from 31% in HSE Dublin and North East to 62% 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* = 909)	HSE Dublin and Midlands (*n* = 2,901)	HSE Dublin and South East (*n* = 1,996)	HSE Mid West (*n* = 782)	HSE South West (*n* = 1,922)	HSE West and North West (*n* = 1,765)	Republic of Ireland (*n* = 10,275)
General admission	22.3%	28.6%	25.8%	14.5%	20.7%	20.5%	23.5%
Psychiatric admission	1.1%	4.8%	7.1%	5.1%	2.0%	13.6%	5.9%
Admission ICU	2.1%	0.7%	2.0%	1.8%	1.2%	2.1%	1.5%
Patient refused admission	0.2%	0.7%	1.0%	2.2%	0.7%	1.4%	0.9%
Transferred to another hospital/ psychiatric unit/ psychiatric hospital	19.1%	4.2%	6.6%	5.9%	2.9%	3.1%	5.7%
Left before recommendation	23.9%	11.4%	12.8%	12.3%	10.0%	11.6%	12.6%
Discharged from ED	30.9%	49.1%	44.1%	58.1%	62.3%	46.8%	49.3%

Table 6: Recommended next care in 2025 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.

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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 2025, 13% 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. In most 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.

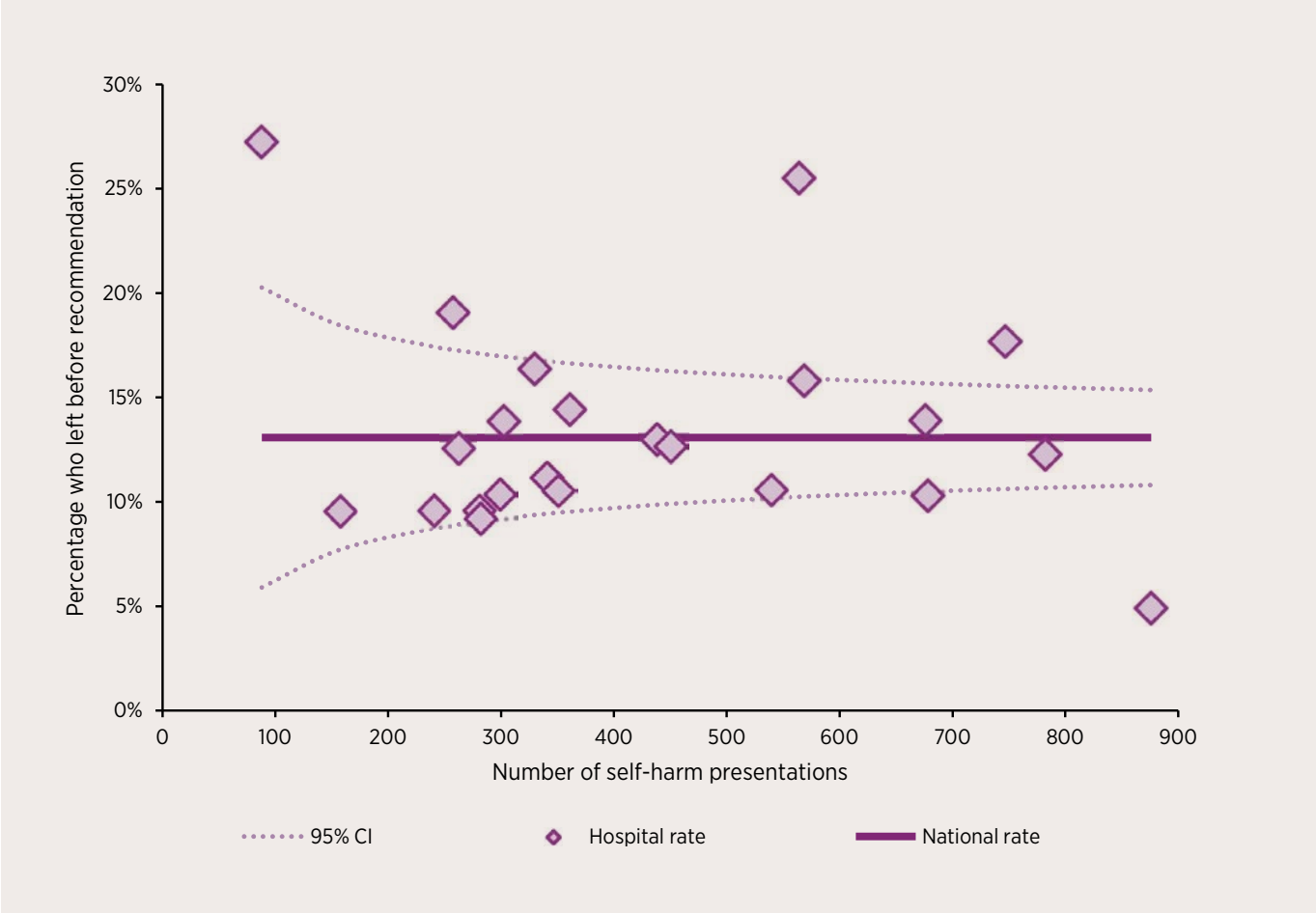

Figure 10: Funnel plot of the percentage of presentations in which the patient left before recommendation, by hospital, 2025.

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 2025. For 34% of presentations (*n* = 3,528), it was noted that the patient was currently attending Mental Health Services. In a further 2% of presentations (*n* = 185), it was noted that the patient had previously been referred and was awaiting an appointment with Mental Health Services. For 4% of presentations (*n* = 392), individuals were attending addiction services while for 2% of presentations, individuals were engaged with homeless services (*n* = 208). For a large number of cases however, (43%; *n* = 4,455), information on current care was not documented.

Women were more likely than men to be engaged with Mental Health Services (64% vs. 36%). Conversely, men were more likely than women to be attending addiction services (65% vs. 35%) and homeless services (61% vs. 39%).

Self-Harm Cases Discharged from Emergency Department

For presentations that resulted in the patient being discharged from the ED following treatment (*n* = 5,063), information on the type of follow-up care or referral offered is presented in Figure 11.

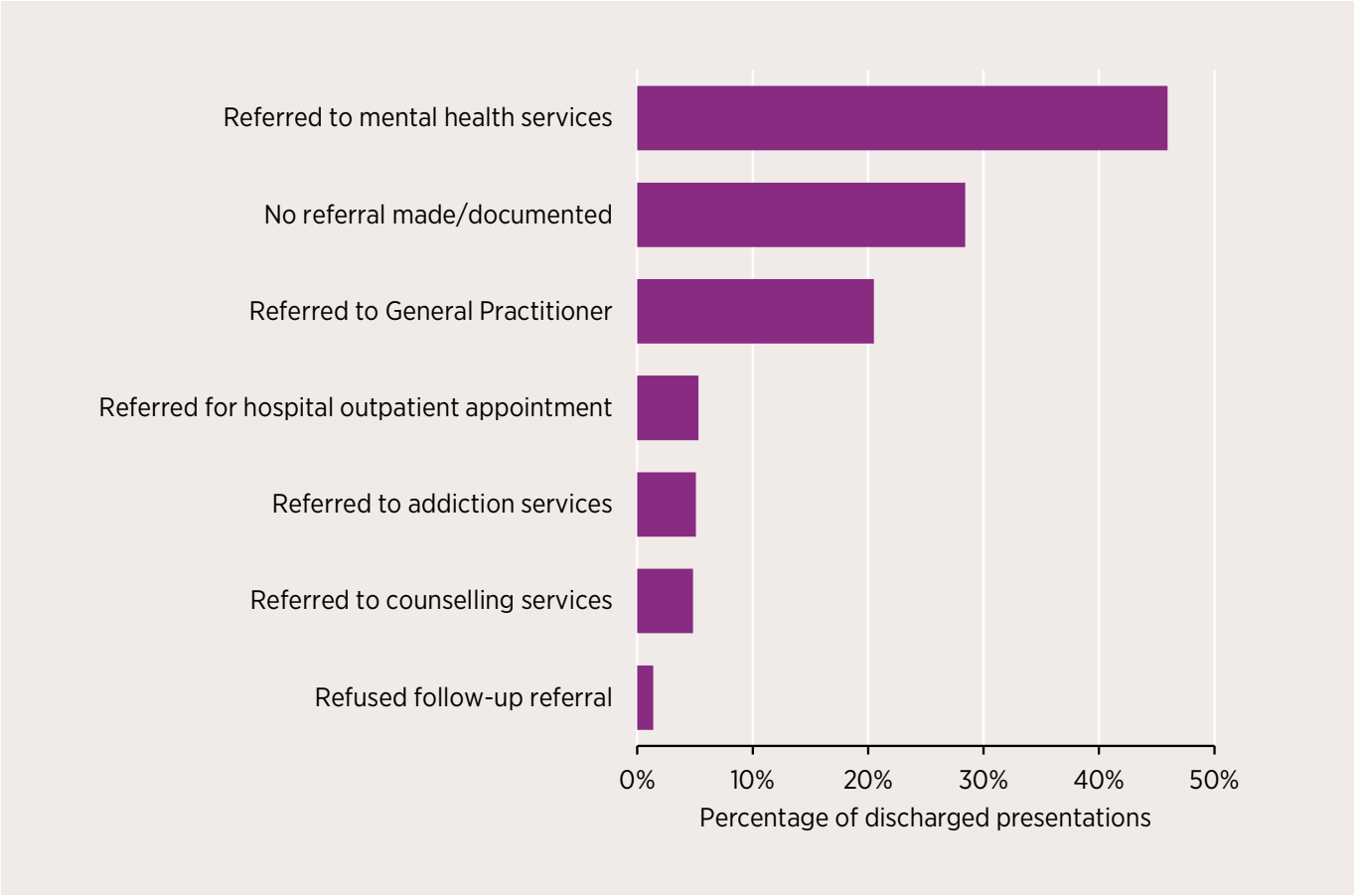

Figure 11: Self-harm presentation referral in 2025 following discharge from the Emergency Department.

- For 46% of presentations, patients were referred to Mental Health Services.
- A referral to the patient's General Practitioner (GP) was given in 21% of presentations.
- For 5% 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 10% of presentations discharged from the ED.
- For 28% 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, 15% of presentations in HSE West and North West received a referral to the patient's GP, compared with 44% in HSE Mid West. A referral for a general hospital outpatient appointment was made for 16% of presentations in HSE Dublin and Midlands compared to fewer than 3% in all other regions. Turning to referrals to local support services, 72% of presentations in HSE West and North West received a referral to Mental Health Services compared with 12% in HSE South West. In HSE South West, no referrals were made to counselling support services such as Pieta, in comparison to 21% in HSE Mid West.

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Mental Health Assessment

Information was recorded about whether the patient had a mental health assessment in the ED in 83% of presentations (*n* = 8,569). For 61% of these presentations (*n* = 5,227), an assessment was completed in the ED. For a further 7% (*n* = 621), an assessment was later completed in the presenting hospital, and for a further 6% (*n* = 521), 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 (76–80% of presentations where assessment information is available). Those who presented with self-poisoning were least likely to receive an assessment (65%).

For 82% 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 10% 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 2025, 69% of first presentations of self-harm were assessed, compared with 65% of those with 5 or more presentations.

The funnel plot in Figure 12 illustrates the variation by hospital in the proportion of presentations that resulted in a mental health assessment. A larger number of hospitals than expected are outside the bounds of the 95% confidence interval. This indicates significant departure from the national average rate of assessment for these hospitals and it suggests that provision of psychiatric assessment is variable across EDs. In particular, two hospitals had a low rate of approximately 30% being assessed.

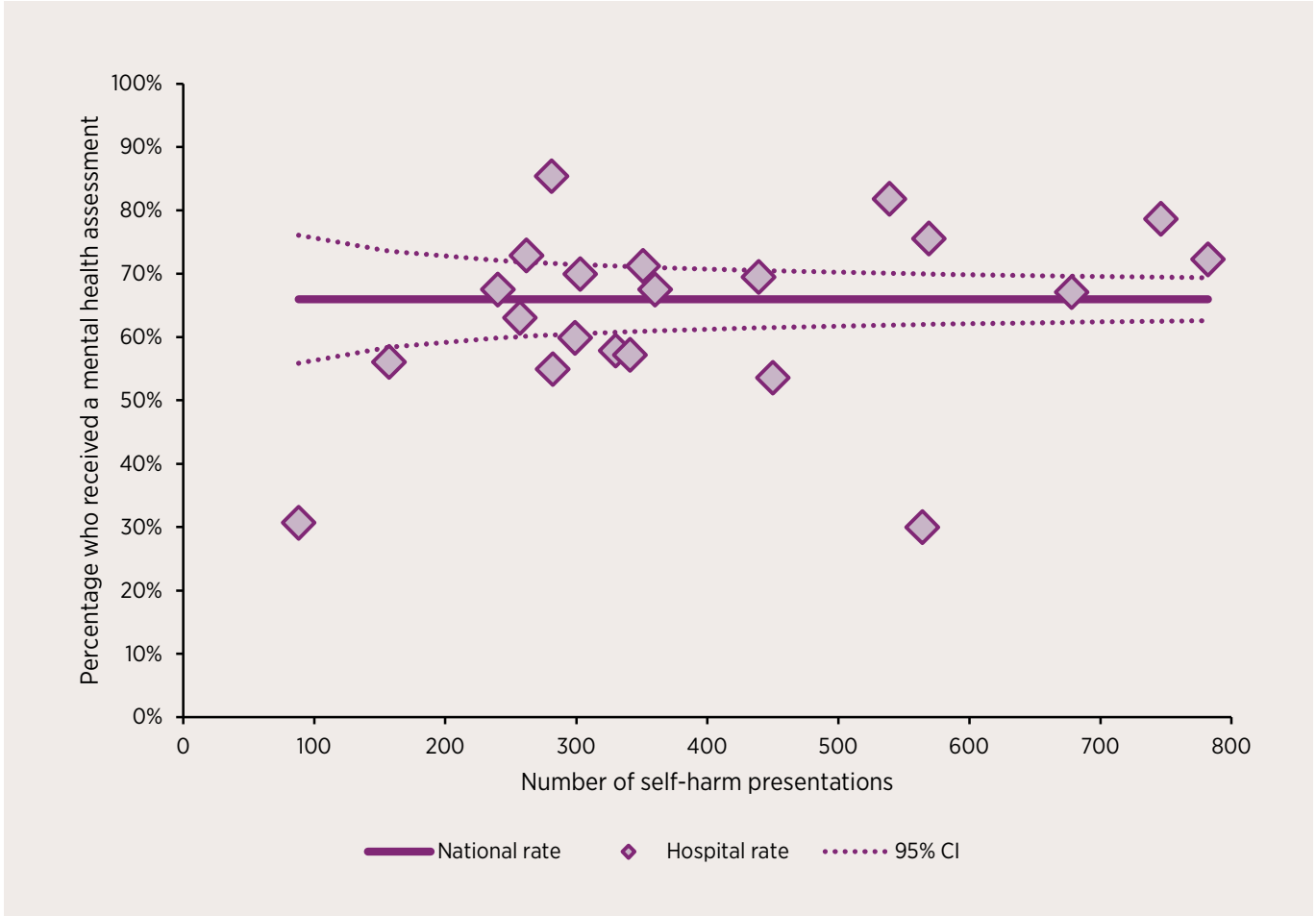

Figure 12: Funnel plot of the percentage of presentations that receive a mental health assessment, by hospital, 2025.

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 7,841 individuals who presented to hospital with 10,275 self-harm presentations in 2025. This implies that one in four (*n* = 2,434; 24%) of the presentations in 2025 were due to repeat acts. Of the 7,841 self-harm patients who presented to hospital, 1,203 (15.3%) presented more than once in the calendar year. This proportion is in line with recent years (the 2015–2024 calendar-year repetition rate is 14.3–15.9%). 136 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 11% of all self-harm presentations recorded in 2025 (*n* = 1,112).

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	4,872	2,465	175	670	273	2,267	682	7,841
Number who repeated	711	371	24	75	49	419	112	1,203
Percentage who repeated	14.6%	15.1%	13.7%	11.2%	17.9%	18.5%	16.4%	15.3%

Table 7: Number and percentage of individuals who had a repeat self-harm presentation in 2025 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 similar for men and women (15% vs 16%) but varied significantly by age. The proportion of individuals who repeated was highest amongst people aged 25–44 years (17%). Approximately 14% 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 (14%); the highest was in HSE South West (17%).

		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	313	1,017	693	283	681	602	3,541
	Women	423	1,249	874	353	758	708	4,300
	Total	736	2,266	1,567	636	1,439	1,310	7,841
Number who repeated	Men	47	151	109	40	93	103	530
	Women	59	198	139	48	145	113	673
	Total	106	349	248	88	238	216	1,203
Percentage who repeated	Men	15.0%	14.8%	15.7%	14.1%	13.7%	17.1%	15.0%
	Women	13.9%	15.9%	15.9%	13.6%	19.1%	16.0%	15.7%
	Total	14.4%	15.4%	15.8%	13.8%	16.5%	16.5%	15.3%

Table 8: Number and percentage of men and women who made a repeat self-harm presentation in 2025 by HSE health region.

The funnel plot in Figure 13 illustrates the risk of repetition for each hospital. The average risk of repetition by hospital was 16%. For the majority of hospitals, the risk of repetition was similar to the average, indicating little variation across hospitals. No hospital's rate of repetition was significantly outside the expected range.

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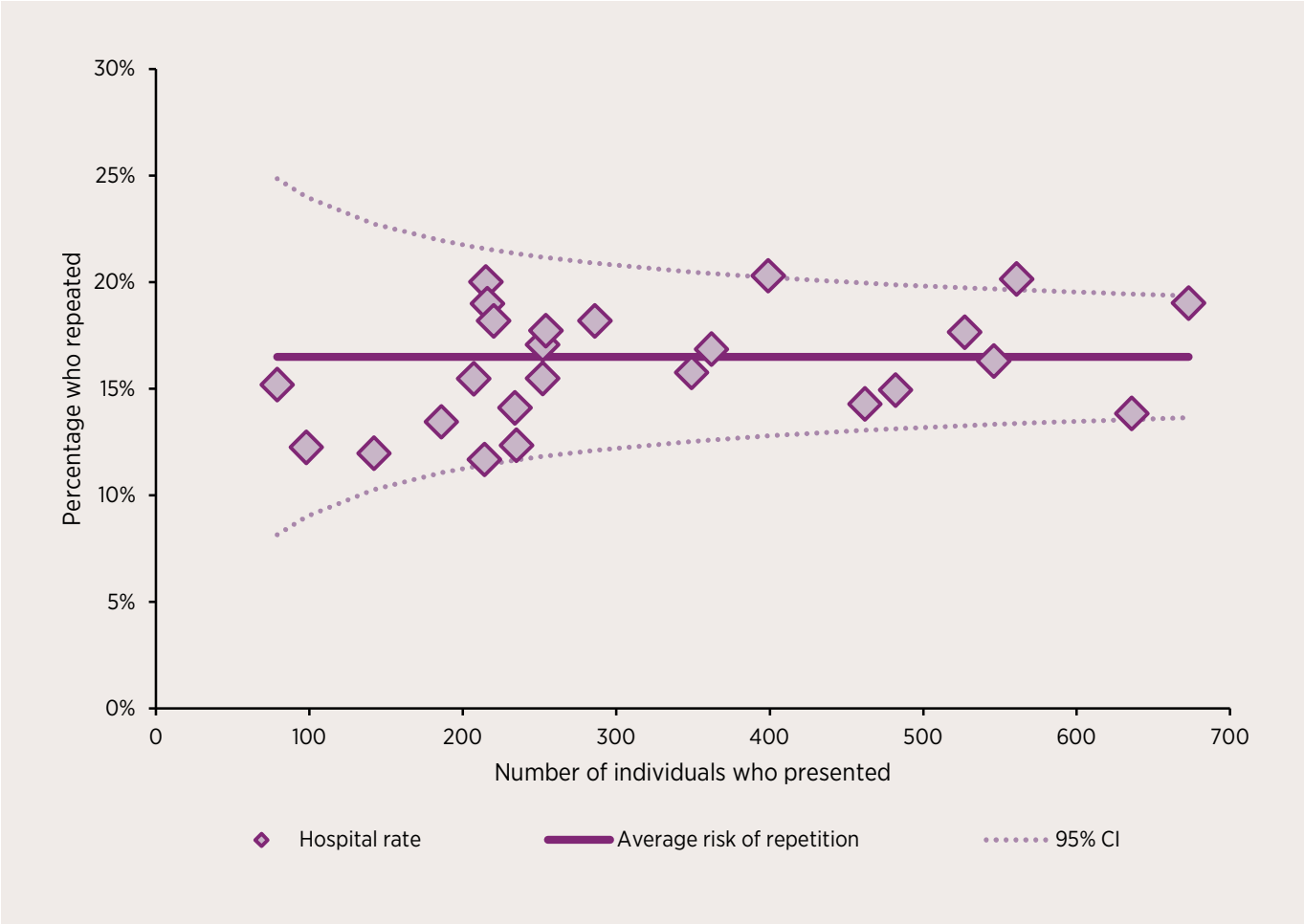

Figure 13: Funnel plot of the rate of repetition by hospital, 2025.

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 2025, the Registry recorded 10,275 self-harm presentations to hospital that were made by 7,841 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 12,340 presentations made by 9,329 individuals. Based on these estimates, the person-based crude and age-standardised rate of self-harm in 2025 was 171 (95% CI: 167–174) and 176 (95% CI: 172–179) per 100,000 respectively. The age-standardised rate, which accounts for the age distribution of the population, indicates that there was a 3% decrease in the rate of persons presenting to hospital as a result of self-harm from 2024 to 2025.

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%
2025	159	–2%	194	–3%	176	–3%

Table 9: Person-based age-standardised rate of self-harm in the Republic of Ireland, 2002–2025 (extrapolated data used for 2002–2005 and 2020–2025 to adjust for non-participating hospitals).

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Variation by Sex

The person-based age-standardised rate of self-harm for men and women in 2025 was 159 (95% CI: 154–163) and 194 (95% CI: 189–200) per 100,000 respectively. This represents a 2% decrease in the male rate of self-harm since 2024 and a 3% 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 2025.

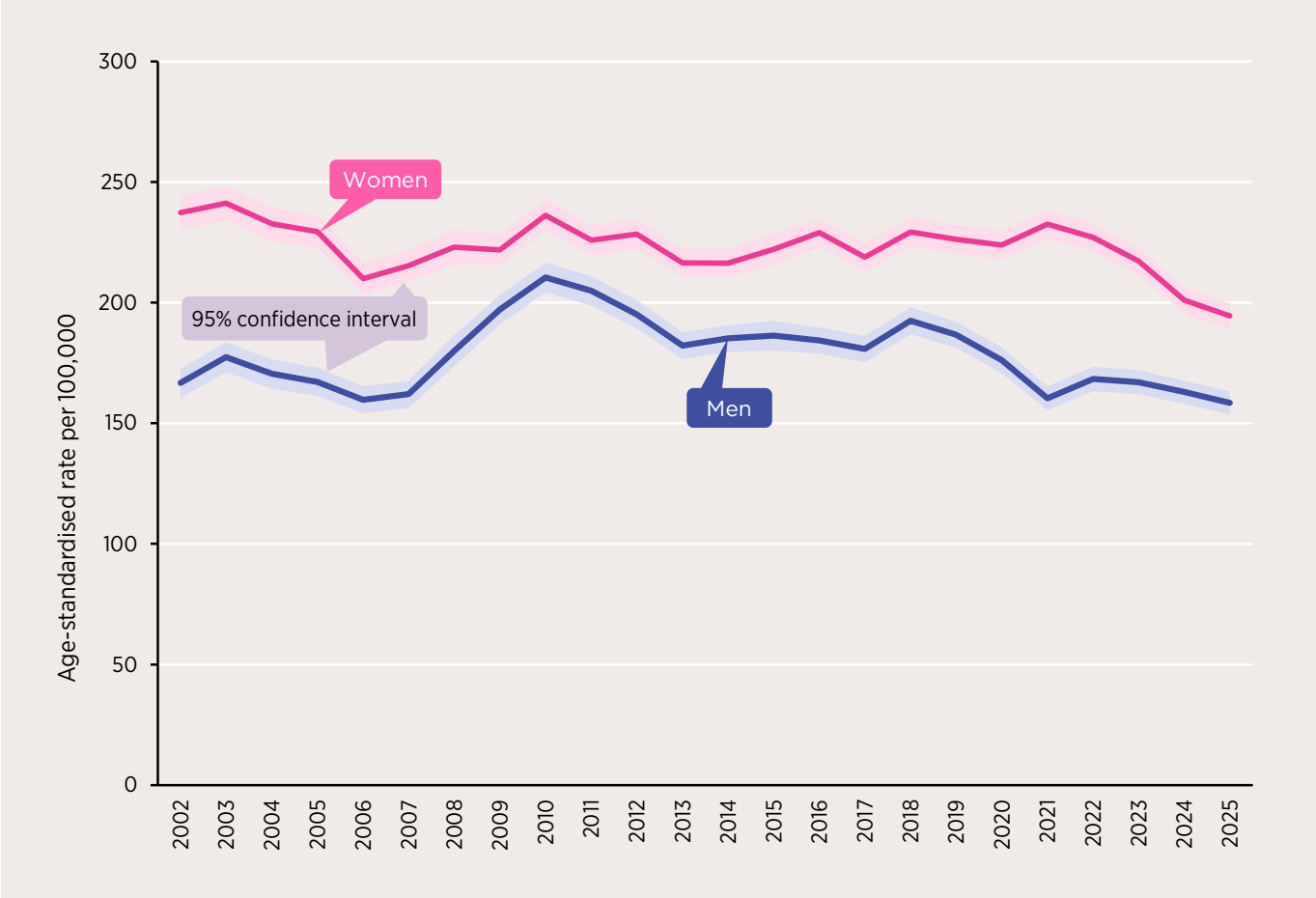

Figure 14: Person-based age-standardised rate of self-harm in the Republic of Ireland for men and women, 2002–2025.

The self-harm rate for men in 2025, 159 per 100,000, is the lowest rate recorded by the Registry since it reached near national coverage in 2002. The male self-harm rate has been mostly decreasing since 2010 when the peak rate of 211 per 100,000 was recorded.

The self-harm rate for women in 2025, 194 per 100,000, is the lowest rate recorded for women in the history of the Registry. The rate in 2025 marks a continuation of the decrease since 2021 when female rates had reached a peak after the recession in 2010. The decrease of 3% in the female rate follows a 7% decrease reported for women in 2024.

The female rate of self-harm in 2025 was 23% higher than the male rate. This is the same as reported in 2024, and is also in line with the sex difference of 10–27% reported in the ten years up to and including 2020. By contrast, the female self-harm rate was 30–45% higher than the male rate in 2021–2023.

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 592 per 100,000, the peak rate for women in 2025 was among 15–19-year-olds. This rate implies that one in every 169 girls in this age group presented to hospital in 2025 following an episode of self-harm. The rate reported in 2025 was a 9% decrease from 2024.

The peak rates for men in 2025 was among 20–24-year-olds and 25–29-year-olds at 323 and 322 per 100,000 respectively. These rates imply that in 2025, one in every 310 men aged 20–29 years presented to hospital following self-harm. The peak rates for men in 2021–2023 were among 20–24-year-olds, and in 2024, it was among 25–29-year-olds. The rate for 25–29-year-old men in 2025 was 14% lower than the rate of 373 per 100,000 for the same age group in 2024.

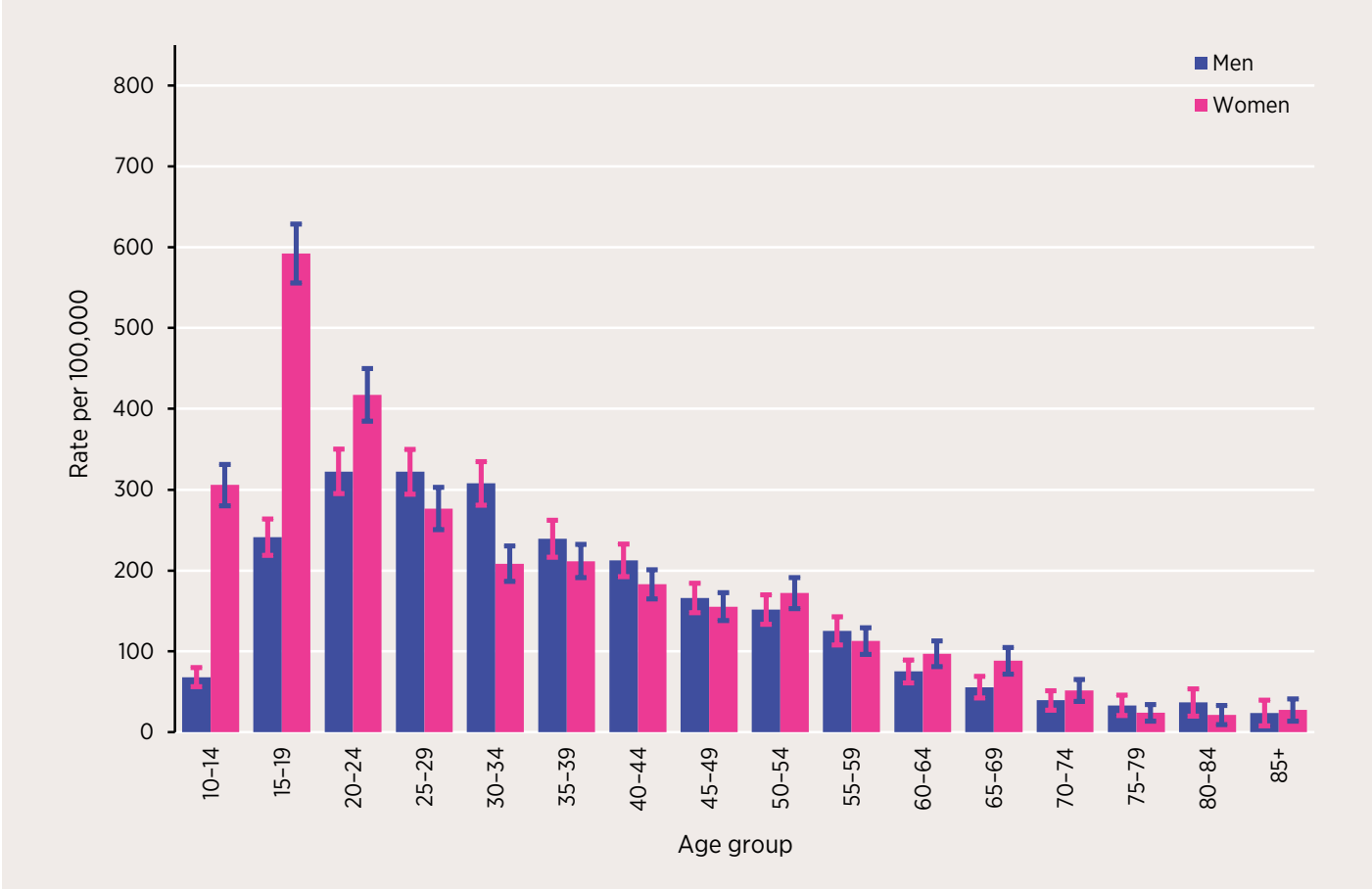

Figure 15: Person-based rate of self-harm for men and women in 2025 by 5-year age group.

In 2025, 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 2025, the female rate was four and a half times the male rate for 10–14-year-olds (306 vs 68 per 100,000), almost two and a half times higher for 15–19-year-olds (592 vs 241 per 100,000) and 29% higher for 20–24-year-olds (417 vs 323 per 100,000). In other age groups, rates were mostly similar except for 65–69-year-olds where the female rate was 57% higher (88 vs 56 per 100,000) and 70–74-year-olds where it was 33% higher (52 vs 39 per 100,000).

In 2025, the male rate of self-harm among 10–24-year-olds was 206 per 100,000, 2% lower than the rate of 210 per 100,000 in 2024. Similarly, the female rate for this age group decreased by 4%, from 460 to 441 per 100,000.

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In 2025, the peak rates among younger people (<25 years) were in 15–year-old girls and 22–year-old men, with rates of 725 and 375 per 100,000 respectively (see Figure 16).

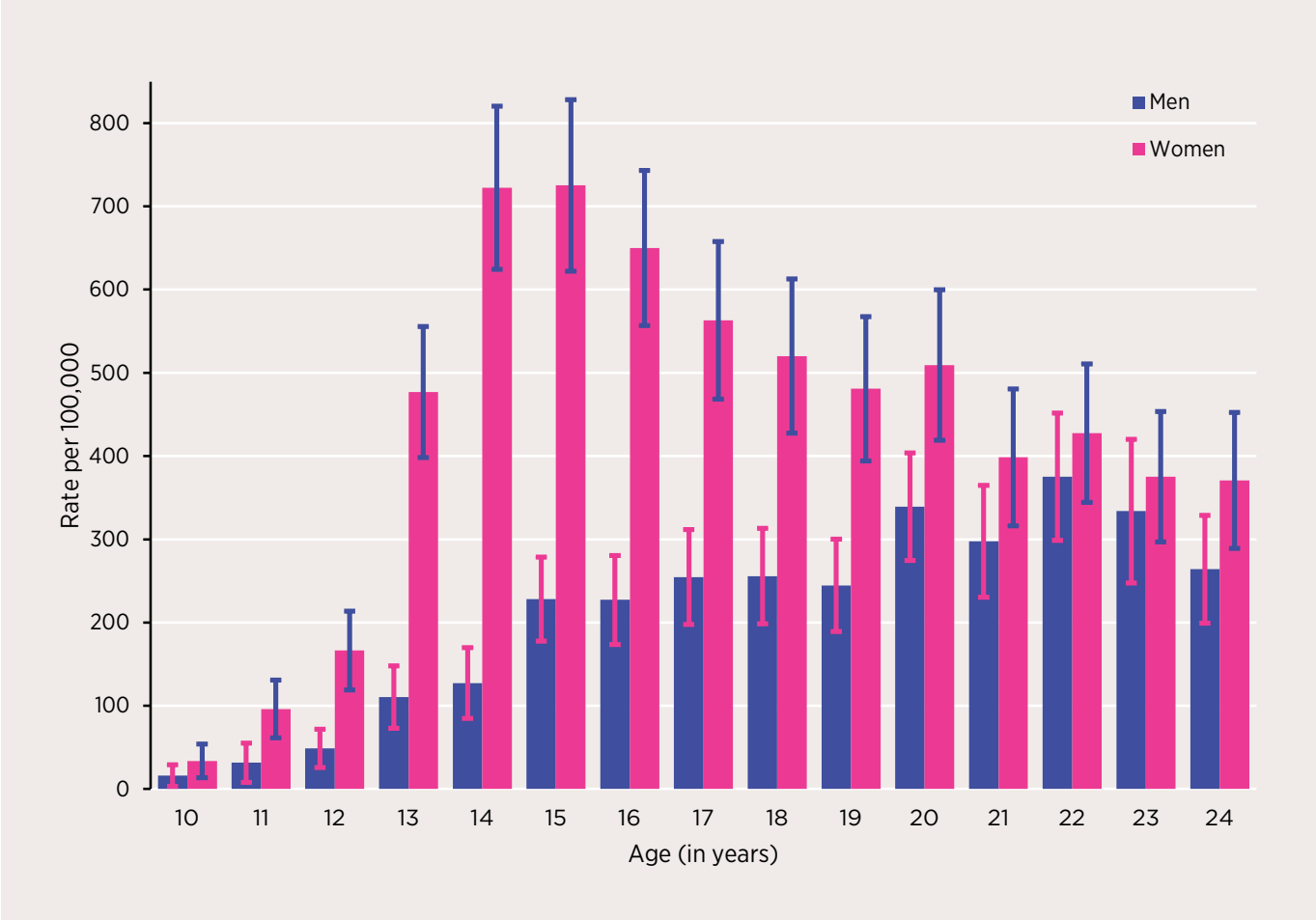

Figure 16: Person-based rate of self-harm for men and women aged 10–24 years old in 2025 by single year of age.

Hospital-presenting self-harm by 10–12-year-old boys and 10- and 11-year-old girls was relatively rare in 2025. However, with each single year increase in age, the rate increased significantly, and this was especially so for girls. The rate was 166 per 100,000 for 12-year-old-girls, but it was almost three times higher at 477 per 100,000 for 13-year-olds, and a further 51% higher at 722 per 100,000 for 14-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 14-year-olds, for whom the female rate was more than five times that of boys (722 vs 127 per 100,000). The female rate of hospital-presenting self-harm was significantly higher than the male rate for every year of age between 11 and 20 years old. The peak male rate – 375 per 100,000 among 22-year-olds – was still lower than the female rate for the same age (428 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. Consistently until 2019, 20–24-year-olds had the highest rate for men, but since 2020 this age group and 25–29-year-old men have had similar rates and in 2025 the rates were almost identical: 323 per 100,000 for 20–24-year-olds, and 322 per 100,000 for 25–29-year-olds. Across the wider age range of 15-29 years, there has been a significant decrease in the male rate of hospital-presenting self-harm since 2018/2019.

The female rate of hospital-presenting self-harm continues to be highest among 15-19 year-olds. Their rate increased by 50%, from approximately 600 per 100,000 in 2013 to almost 900 per 100,000 in 2021, however, the rate has returned to around 600 per 100,000 since then. Recent years have also seen reductions in the rate among the other young age groups in the female population.

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 its peak in 2021, the female self-harm rate increased almost every year, with the largest increase from 2020 to 2021, but it has declined every year since. The rate in 2025 – 592 per 100,000 – is 33% lower than the 2021 rate and in line with the rate from 2007 to 2013. The male self-harm rate among 15–19-year-olds increased gradually from 2013 to 2019 but then sharply declined, reaching an all-time low in 2023 and remaining at that level since; in 2025, the rate was 241 per 100,000.

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 has increased steadily, reaching 68 per 100,000 in 2025. The increasing trend for girls aged 10–14 years has been much more pronounced: from approximately 100 per 100,000 in 2011, the rate had increased more than threefold to 345 per 100,000 by 2021. It remained at that elevated level in 2022 and 2023, but has slightly decreased over the past two years: in 2025, it was 306 per 100,000.

For men and women aged at least 30 years, the incidence of hospital-presenting self-harm in 2025 was highest among 30–39-year-olds. The rate decreases with increasing age. For all of these age groups, the incidence is similar for men and women. Since 2007, a few trends are notable. There were increases in hospital-presenting self-harm by men across the 30–59-year-old age group and women aged 50–59 years during 2007–2011/2012. There has been a slow but significant decrease in the incidence of hospital-presenting self-harm among women aged 40–49 years. From 320 per 100,000 in 2007, it more than halved to 147 per 100,000 in 2024 and was 170 per 100,000 in 2025. The rate among 50–59-year-old women has also decreased steadily since 2012. Consistently, the lowest rate is among men and women aged at least 60 years.

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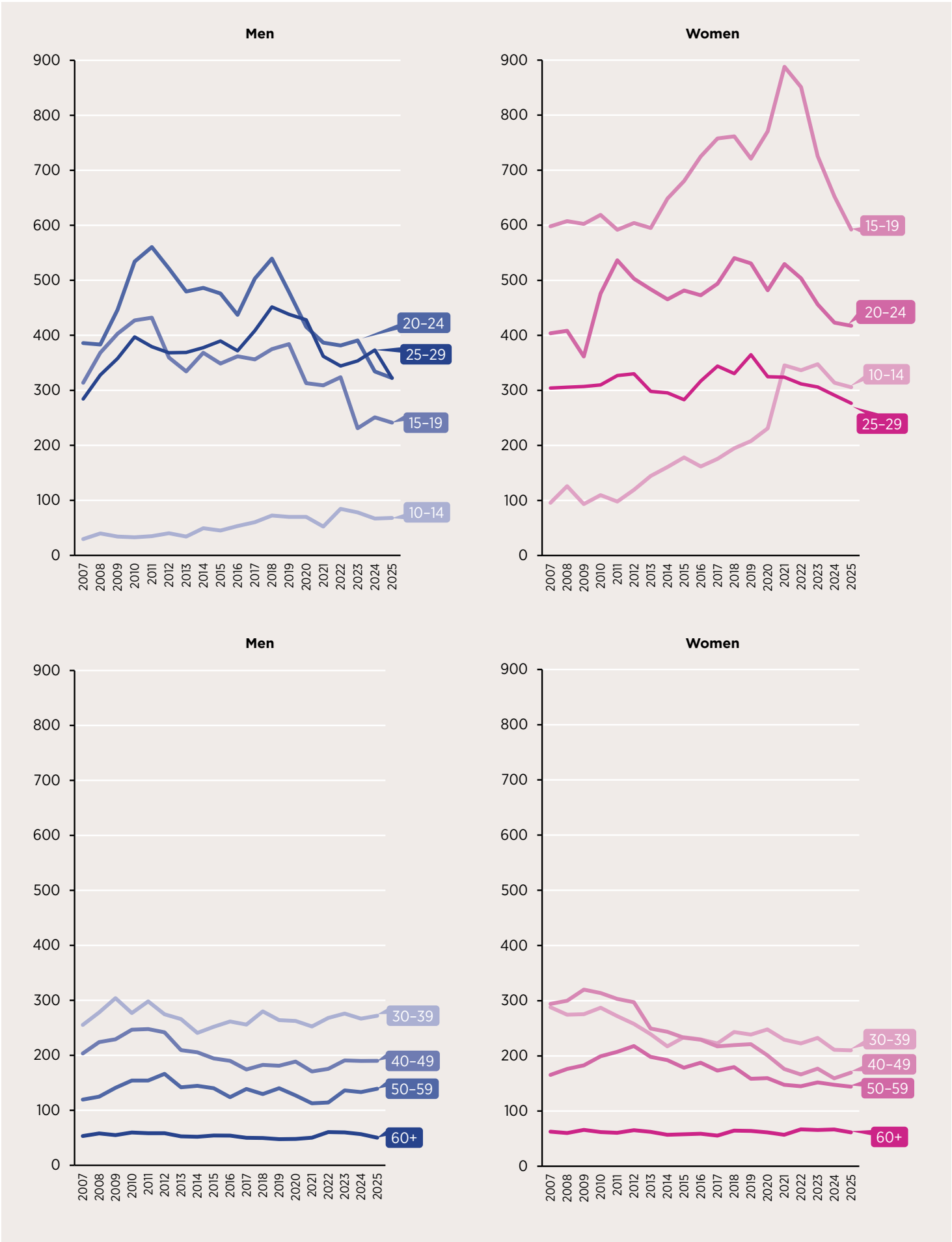

Figure 17: Trend in the rate of hospital-presenting self-harm by sex and age group, 2007–2025.

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, 2025

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	14	54	62	239	11	69	11	43	25	101	20	83	143	589	175	712
15–19yrs	45	115	100	336	86	245	37	102	98	174	103	243	469	1,215	549	1,427
20–24yrs	41	65	196	187	121	151	38	77	132	142	118	115	646	737	753	859
25–29yrs	56	42	156	134	117	111	32	62	110	99	112	76	583	524	713	631
30–34yrs	40	39	155	134	135	107	34	34	119	88	72	71	555	473	678	580
35–39yrs	39	40	149	167	84	87	43	25	88	86	89	60	492	465	577	585
40–44yrs	46	39	141	122	76	77	28	27	89	119	75	104	455	488	590	582
45–49yrs	35	41	121	94	56	105	32	23	73	54	69	53	386	370	454	438
50–54yrs	27	39	76	86	52	71	26	21	54	79	39	60	274	356	354	433
55–59yrs	13	21	58	47	57	46	22	6	25	25	30	50	205	195	243	231
60–64yrs	8	11	30	30	17	37	11	11	16	33	24	32	106	154	123	175
65–69yrs	10	15	12	33	18	26	5	10	14	23	9	13	68	120	82	142
70–74yrs	3	3	7	10	7	13	8	8	13	9	11	8	49	51	55	64
75–79yrs	1	1	3	4	5	5	1	0	10	6	7	5	27	21	33	24
80–84yrs	1	1	1	4	0	1	0	2	6	0	7	2	15	10	20	13
85yrs+	2	1	1	1	1	1	1	1	1	4	5	0	11	8	11	16
Total	**381**	**528**	**1,272**	**1,629**	**843**	**1,153**	**329**	**453**	**877**	**1,045**	**790**	**975**	**4,492**	**5,783**	**5,420**	**6,920**

[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 2025.
[3]Estimated number of self-harm presentations for all hospitals in the Republic of Ireland in 2025.

In the following tables, non-zero numbers smaller than five are masked to reduce the risk of disclosure. If only one number in a column is smaller than five, the next highest cell value is marked with an asterisk.

Table A2: Self-harm presentations to hospitals in HSE Dublin and North East, 2025

	Cavan Monaghan Hospital		Our Lady of Lourdes Hospital, Drogheda		Our Lady's Hospital, Navan	
Age Group	Male	Female	Male	Female	Male	Female
<16yrs	9	30	15	51	<5	<5
16–17yrs	7	15	7	25	<5	11
18–24yrs	17	25	28	69	13	8
25–34yrs	29	28	59	48	8	5
35–44yrs	15	23	63	50	7	6
45–54yrs	19	18	39	52	<5	10
55–64yrs	5	*	15	19	<5	5
65yrs+	6	*	10	14	<5	<5
Total	**107**	**150**	**236**	**328**	**38**	**50**

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Table A3: Self-harm presentations to hospitals in HSE Dublin and Midlands, 2025

	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	7	30	11	59	<5	6	0	0	0	0	0	0
16–17yrs	8	19	<5	17	<5	*	*	26	*	19	21	53
18–24yrs	16	18	28	19	12	17	38	38	78	81	54	84
25–34yrs	21	12	21	17	22	14	63	39	91	116	93	70
35–44yrs	23	32	25	51	17	16	41	56	98	70	86	64
45–54yrs	11	21	16	14	11	16	34	48	69	54	56	27
55–64yrs	*	10	6	*	6	*	19	*	33	12	22	19
65yrs+	*	5	<5	*	<5	6	*	*	*	15	9	20
Total	**93**	**147**	**111**	**188**	**74**	**83**	**204**	**235**	**379**	**367**	**341**	**337**

Note: In the two CHI hospitals in this region, the number of self-harm presentations was 23 male and 95 female in CHI at Crumlin and 47 male and 177 female in CHI at Temple Street respectively, all aged less than 16 years.

Table A4: Self-harm presentations to hospitals in HSE Dublin and South East, 2025

	St Luke's General Hospital, Carlow/Kilkenny		St Michael's Hospital, Dún Laoghaire		St Vincent's University Hospital		Tipperary University Hospital		University Hospital Waterford		Wexford General Hospital	
Age Group	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
<16yrs	7	26	0	0	0	0	<5	8	8	31	*	36
16–17yrs	*	*	0	<5	9	44	<5	11	11	18	<5	27
18–24yrs	31	36	0	5	40	98	31	23	42	42	19	42
25–34yrs	48	28	0	<5	76	65	40	31	57	58	31	33
35–44yrs	33	29	<5	<5	44	54	28	19	34	32	18	27
45–54yrs	27	23	0	<5	27	44	13	26	27	30	14	50
55–64yrs	16	21	<5	<5	21	22	9	*	16	19	11	13
65yrs+	*	*	0	<5	11	14	<5	*	6	19	8	5
Total	**169**	**182**	**<5**	**19**	**228**	**341**	**133**	**129**	**201**	**249**	**108**	**233**

Table A5: Self-harm presentations to hospitals in HSE Mid West and HSE South West, 2025

	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	35	117	0	0	10	23	15	72
16–17yrs	0	<5	31	50	7	7	8	14	14	31
18–24yrs	<5	<5	86	105	54	70	25	29	57	120
25–34yrs	5	<5	82	76	110	81	32	27	66	96
35–44yrs	<5	<5	53	84	88	83	34	35	71	52
45–54yrs	<5	<5	40	49	53	58	32	22	58	44
55–64yrs	<5	5	15	18	17	18	8	17	33	17
65yrs+	<5	<5	15	20	18	12	7	7	15	21
Total	**17**	**23**	**357**	**519**	**347**	**329**	**156**	**174**	**329**	**453**

Table A6: Self-harm presentations to hospitals in HSE West and North West, 2025

	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	8	51	<5	18	*	24	11	16	10	40
16–17yrs	14	21	5	12	8	15	8	11	12	35
18–24yrs	32	29	36	20	18	25	22	40	51	84
25–34yrs	27	39	33	20	51	25	21	25	52	38
35–44yrs	23	38	31	23	40	25	30	17	40	61
45–54yrs	25	23	16	20	6	13	29	20	32	37
55–64yrs	10	*	8	25	6	*	12	22	18	12
65yrs+	6	*	<5	9	*	*	13	6	10	7
Total	**145**	**215**	**135**	**147**	**139**	**142**	**146**	**157**	**225**	**314**

Appendix B: Recommendations for Next Care Following Self-Harm Presentation

Table B1: Recommended next care by hospital in HSE Dublin and North East, 2025

	Cavan Monaghan Hospital (*n* = 257)	Our Lady of Lourdes Hospital, Drogheda (*n* = 564)	Our Lady's Hospital, Navan (*n* = 88)
Admitted (general, psychiatric, ICU)	37.4%	19.1%	31.8%
Patient would not allow admission	0.8%	0.0%	0.0%
Left before recommendation	19.1%	25.5%	27.3%
Not admitted	37.0%	29.8%	20.5%

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.

Table B2: Recommended next care by hospital in HSE Dublin and Midlands, 2025

	Midland Regional Hospital, Mullingar (*n* = 240)	Midland Regional Hospital, Portlaoise (*n* = 299)	Midland Regional Hospital, Tullamore (*n* =157)	Naas General Hospital (*n* = 439)	St. James's Hospital (*n* =746)	Tallaght University Hospital (*n* = 678)	Children's Health Ireland at Crumlin (*n* =118)	Children's Health Ireland at Temple Street (*n* = 224)
Admitted (general, psychiatric, ICU)	35.0%	53.2%	34.4%	22.1%	23.5%	34.5%	60.2%	50.9%
Patient would not allow admission	0.4%	0.0%	1.3%	2.7%	0.0%	0.6%	0.0%	0.4%
Left before recommendation	9.6%	10.4%	9.6%	13.0%	17.7%	10.3%	0.0%	1.8%
Not admitted	45.0%	35.5%	29.9%	60.1%	53.2%	51.6%	39.8%	46.4%

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.

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Table B3: Recommended next care by hospital in HSE Dublin and South East, 2025

	St. Luke's General Hospital, Carlow/Kilkenny (*n* = 351)	St. Michael's Hospital, Dún Laoghaire (*n* = 23)	St Vincent's University Hospital (*n* = 569)	Tipperary University Hospital (*n* = 262)	University Hospital Waterford (*n* = 450)	Wexford General Hospital (*n* = 341)
Admitted (general, psychiatric, ICU)	57.0%	47.8%	16.0%	33.2%	42.7%	33.7%
Patient would not allow admission	0.9%	0.0%	0.7%	0.0%	2.2%	0.9%
Left before recommendation	10.5%	0.0%	15.8%	12.6%	12.7%	11.1%
Not admitted	27.4%	47.8%	56.9%	43.5%	40.4%	45.2%

Note: It may not always be recorded in the Emergency Department that a patient has been directly admitted to psychiatric inpatient care. Therefore, the figures for direct psychiatric admission detailed in Tables B1–B5 may be underestimates.

Table B4: Recommended next care by hospital in HSE Mid West and HSE South West, 2025

	Bantry General Hospital (*n* = 40)	Cork University Hospital (*n* = 876)	Mercy University Hospital, Cork (*n* = 676)	University Hospital Kerry (*n* = 330)	University Hospital Limerick (*n* = 782)
Admitted (general, psychiatric, ICU)	72.5%	33.2%	10.5%	20.6%	21.4%
Patient would not allow admission	0.0%	0.1%	0.1%	3.6%	2.2%
Left before recommendation	2.5%	4.9%	13.9%	16.4%	12.3%
Not admitted	20.0%	55.4%	75.4%	59.1%	58.1%

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, 2025

	Letterkenny University Hospital (*n* = 360)	Mayo University Hospital (*n* = 282)	Portiuncula University Hospital (*n* = 281)	Sligo University Hospital (*n* = 303)	University Hospital Galway (*n* = 539)
Admitted (general, psychiatric, ICU)	43.3%	44.3%	35.6%	29.7%	31.2%
Patient would not allow admission	2.5%	1.1%	1.1%	0.3%	1.5%
Left before recommendation	14.4%	9.2%	9.6%	13.9%	10.6%
Not admitted	38.1%	42.2%	37.4%	53.1%	56.4%

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.

Appendix C: Self-Harm Repetition for Individuals Who Presented to Hospital with Self-Harm in 2025

Table C1: Self-harm repetition for individuals who presented to hospitals in HSE Dublin and North East, 2025

		Cavan Monaghan Hospital	Our Lady of Lourdes Hospital, Drogheda	Our Lady's Hospital, Navan
Number of individuals who presented	Men	85	198	36
	Women	122	264	43
	All	207	462	79
Number who repeated	Men	14	27	6
	Women	18	39	6
	All	32	66	12
Percentage who repeated	Men	16.5%	13.6%	16.7%
	Women	14.8%	14.8%	14.0%
	All	15.5%	14.3%	15.2%

Table C2: Self-harm repetition for individuals who presented to hospitals in HSE Dublin and Midlands, 2025

		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	87	88	68	176	295	285	*	*
	Women	127	132	74	186	266	261	*	*
	All	214	220	142	362	561	546	186	98
Number who repeated	Men	8	16	9	28	55	46	*	*
	Women	17	24	8	33	58	43	*	*
	All	25	40	17	61	113	89	25	12
Percentage who repeated	Men	9.2%	18.2%	13.2%	15.9%	18.6%	16.1%	*	*
	Women	13.4%	18.2%	10.8%	17.7%	21.8%	16.5%	*	*
	All	11.7%	18.2%	12.0%	16.9%	20.1%	16.3%	13.4%	12.2%

Table C3: Self-harm repetition for individuals who presented to hospitals in HSE Dublin and South East, 2025

		St. Luke's General Hospital, Carlow/Kilkenny	St Vincent's University Hospital	Tipperary University Hospital	University Hospital Waterford	Wexford General Hospital
Number of individuals who presented	Men	137	193	112	164	97
	Women	149	289	104	185	155
	All	286	482	216	349	252
Number who repeated	Men	25	32	21	25	11
	Women	27	40	20	30	32
	All	52	72	41	55	43
Percentage who repeated	Men	18.2%	16.6%	18.8%	15.2%	11.3%
	Women	18.1%	13.8%	19.2%	16.2%	20.6%
	All	18.2%	14.9%	19.0%	15.8%	17.1%

Note: Due to small numbers, the number of patients who presented to St Michael's Hospital, Dún Laoghaire are not included in this table to avoid risk of disclosure.

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Table C4: Self-harm repetition for individuals who presented to hospitals in HSE Mid West and HSE South West, 2025

		Cork University Hospital	Mercy University Hospital, Cork	University Hospital Kerry	University Hospital Limerick
Number of individuals who presented	Men	281	292	118	283
	Women	392	235	134	353
	All	673	527	252	636
Number who repeated	Men	43	42	18	40
	Women	85	51	21	48
	All	128	93	39	88
Percentage who repeated	Men	15.3%	14.4%	15.3%	14.1%
	Women	21.7%	21.7%	15.7%	13.6%
	All	19.0%	17.6%	15.5%	13.8%

Note: Due to small numbers, the number of patients who presented to Bantry General 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, 2025

		Letterkenny University Hospital	Mayo University Hospital	Portiuncula University Hospital	Sligo University Hospital	University Hospital Galway
Number of individuals who presented	Men	114	111	104	107	181
	Women	140	124	111	127	218
	All	254	235	215	234	399
Number who repeated	Men	18	15	23	18	39
	Women	27	14	20	15	42
	All	45	29	43	33	81
Percentage who repeated	Men	15.8%	13.5%	22.1%	16.8%	21.5%
	Women	19.3%	11.3%	18.0%	11.8%	19.3%
	All	17.7%	12.3%	20.0%	14.1%	20.3%

Appendix D: Number and Rate of Persons with Hospital-Presenting Self-Harm in 2025

Table D1: Estimated number and rate of persons with hospital-presenting self-harm in the Republic of Ireland in 2025

Age group	Men				Women			
	Population	Self-Harm			Population	Self-Harm		
		Persons	Rate	95% CI[1]		Persons	Rate	95% CI[1]
0–4yrs	147,100	0	0	±0	142,900	0	0	±0
5–9yrs	168,200	9	5	±4	161,900	6	4	±3
10–14yrs	194,200	132	68	±12	185,800	568	306	±26
15–19yrs	191,500	462	241	±22	178,000	1,054	592	±36
20–24yrs	169,900	548	323	±28	157,200	656	417	±33
25–29yrs	167,900	541	322	±28	161,900	448	277	±26
30–34yrs	169,400	521	308	±27	174,700	364	208	±22
35–39yrs	184,700	442	239	±23	199,400	422	212	±21
40–44yrs	209,700	446	213	±20	225,800	413	183	±18
45–49yrs	199,800	332	166	±18	207,300	322	155	±17
50–54yrs	183,800	279	152	±18	186,700	321	172	±19
55–59yrs	162,800	204	125	±18	165,100	186	113	±17
60–64yrs	147,800	111	75	±14	153,800	149	97	±16
65–69yrs	125,800	70	56	±13	131,400	116	88	±16
70–74yrs	106,800	42	39	±12	112,500	58	52	±14
75–79yrs	84,300	28	33	±13	91,900	22	24	±10
80–84yrs	51,600	19	37	±17	60,900	13	21	±12
85yrs+	37,700	9	24	±16	58,300	16	27	±14
Total[2]	**2,703,200**	**4,195**	**159**	**±5**	**2,755,400**	**5,134**	**194**	**±5**

[1]95% confidence interval.

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

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Mary Joyce
Shelly Chakraborty
James Camien McGuiggan
Paweł Hursztyn
Ella Arensman
Eve Griffin
Paul Corcoran

4th Floor
Western Gateway Building
University College Cork
Ireland

Tel: +353 21 420 5551
Email: infonsrf@ucc.ie
www.nsrf.ie

NSRF
National Suicide
Research Foundation

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