Received: 30 August 2023 | Accepted: 17 June 2024

DOI: 10.1002/gps.6116

RESEARCH ARTICLE

International Journal of Geriatric Psychiatry WILEY

Healthcare practitioners' views of self-harm management practices in older adults in Ireland: A qualitative study

M. Isabela Troya[1,2] | Caoimhe Lonergan[3] | Eugene Cassidy[3] | Eve Griffin[1,2] | Sally Ann Lovejoy[4] | Faraz Mughal[5] | Vincent Russell[4] | Ella Arensman[1,2,6]

[1]School of Public Health, College of Medicine and Health, University College Cork, Cork, Ireland

[2]National Suicide Research Foundation, University College Cork, Cork, Ireland

[3]Department of Psychiatry and Neurobehavioral Science, University College Cork, Acute Mental Health Unit, Cork University Hospital, Wilton, Ireland

[4]National Clinical Programme for Self-Harm and Suicide-Related Ideation, Office of the National Clinical Advisor and Group Lead, Dr. Steevens Hospital, Dublin, Ireland

[5]School of Medicine, Keele University, Keele, UK

[6]Australian Institute for Suicide Research and Prevention, School of Applied Psychology, Griffith University, Brisbane, Queensland, Australia

Correspondence

M. Isabela Troya, School of Public Health, University College Cork and National Suicide Research Foundation, 4.07, Western Gateway Building, Cork, Ireland.
Email: isabela.troya@ucc.ie

Funding information

Irish Research Council, Grant/Award Number: GOIPD/2021/3; National Institute for Health and Care Research

Abstract

Objectives: To explore healthcare practitioners' views on management practices of self-harm in older adults.

Methods: Semi-structured interviews were conducted with healthcare practitioners, including consultant psychiatrists, general practitioners, clinical psychologists, psychotherapists, clinical nurse specialists and social workers. Purposeful sampling was used to recruit participants in the Republic of Ireland ensuring diverse perspectives of healthcare practitioners were included. Healthcare practitioners were recruited advertising via professional and clinical research networks, social media, and snowballing methods. Interviews were audio-recorded, transcribed verbatim, and analysed using reflexive thematic analysis.

Results: We conducted interviews with 20 healthcare practitioners from April to July 2023. Three main themes were generated: first, a perceived greater risk of suicide, and increased awareness of complexity in older adults' self-harm presentations. Second, integrated care as an avenue for improving the management of self-harm in older adults. Third, the importance of safety planning in risk assessments of older adults.

Conclusions: Healthcare practitioners viewed self-harm in older adults as complex, challenging, and associated with high suicide risk, approaching patients with care and caution. The need for integrated support and improved collaboration between relevant healthcare practitioners was identified. Suggestions were made for primary care having a lead role in identifying and managing older adults after self-harm. Increased mental health promotion and awareness of mental health and self-harm in this age group would help address current stigma and shame.

KEYWORDS

management, older people, qualitative, self-harm, suicide

Key points

- Self-harm in older adults is viewed by healthcare practitioners as complex, multifactorial, and with increased risk of suicide, necessitating a comprehensive and integrated approach to supporting this age group.
- Presentations of self-harm in older adults may be disguised through physical complaints, or not be readily apparent, therefore, training on diverse presentations in older age should be offered on a structural basis in the curriculum of healthcare practitioners supporting this age group.
- Primary care was identified as a setting that older adults often access and where identification, support, and prevention can be offered to this group, with more complex cases being referred to specialist services.
- Provision of care needs to be improved nationally through providing a greater range and consistency of supports, while also redressing disparities in access to mental health care for older adults after self-harm due to age cut offs.

1 | INTRODUCTION

Suicidal behaviour is a major public health concern, with over 700,000 deaths by suicide estimated worldwide annually.[1] Several interventions and prevention programmes have been created to prevent suicidal behaviour,[2] with an overall declining trend in suicides globally in the last decade.[3] However, despite suicide rates having declined, older adults continue to have the highest suicide rates worldwide, and there is a progressive increase in suicide rates with age, with older men being at highest risk.[4] Increasing rates in suicide among older adults are due to the use of highly lethal self-harm methods, declining health status, and higher levels of suicidal intent.[4,5]

Self-harm, defined in this study as the intentional drug overdose/self-poisoning or self-injury irrespective of the apparent purpose of the act, is strongly associated with death by suicide.[1,6] Despite suicide rates being highest in older adults globally, self-harm in older adults is generally less prevalent.[7,8] Psychiatric history, living alone, and comorbid physical conditions increase the risk of self-harm in older adults.[9,10] Furthermore, depression severity and cognitive impairment are associated with higher lethality of self-harm in older adults.[11]

A recent systematic review examining aftercare following self-harm in older adults identified a limited and poor-quality evidence base.[12] Research has shown that the conduct of clinical assessments is key for self-harm and suicide prevention and provision of assessments is associated with reduced self-harm repetition.[13,14] Older adults are in frequent contact with general practitioners (GPs) and healthcare practitioners, who often conduct these assessments therefore creating an opportunity for early self-harm assessment and intervention.[5,10]

Self-harm is a complex phenomenon which requires going beyond describing factors and understanding the multi-component healthcare systems. Qualitative research can enhance the understanding of self-harm through a more in-depth exploration from first-hand informants such as healthcare practitioners supporting older adults. In the Republic of Ireland (RoI), no research has focused on examining healthcare practitioners' views on supporting older adults who self-harm. The aim of this study was to gain an in-depth understanding about management practices of healthcare practitioners from diverse clinical settings when supporting older adults with self-harm behaviour.

2 | MATERIALS AND METHODS

2.1 | Study design

Semi-structured one-to-one interviews were conducted with healthcare practitioners in RoI. This study adopted a qualitative methods approach using thematic analysis.[15] The theoretical approach underpinning this study design was pragmatism, which states that knowledge is constructed based on interactions between people and their environments.[16] The perspectives, experiences, and beliefs of healthcare practitioners with previous experience supporting older individuals who self-harm was examined.

2.2 | Population and participants

Healthcare practitioners residing and working in the RoI were invited to take part in the study. Practitioners must have previously worked with older individuals (aged 60 and older) who self-harm. Practitioners represented both primary (e.g. General Practitioners) and secondary care (Consultant Psychiatrists with and without experience in geriatric psychiatry, Non-Consultant Doctors specialising in psychiatry, Clinical Nurse Specialists in mental health services, Clinical Psychologists, Psychotherapists, and Social Workers in mental health services). Exclusion criteria: not able to provide informed consent, not fluent in English, no previous clinical experience supporting older adults who self-harm.

2.3 | Setting, participant recruitment and consent process

This study recruited healthcare practitioners representing both primary and secondary care settings involved in supporting older people with suicidal behaviour. Healthcare practitioners were recruited by advertising the study through professional body and clinical research networks, social media, and snowballing methods.[17] Purposeful sampling was used to ensure representation of the variety of healthcare practitioners included in terms of clinical area.[18] Participants were provided with information sheets and consent forms by email or post and sufficient time was allowed for any questions in terms of participation. All participants provided written informed consent. They had the opportunity to ask questions prior to signing the consent form. Informed consent was obtained at the start of each interview and checked again at the end.

2.4 | Data collection

From April-July 2023, the first author (with an academic background in clinical psychology and public health) and second author (active clinical psychiatrist), conducted individual semi-structured interviews with healthcare practitioners. A reflexive diary was kept by each of the interviewers and regular meetings were held during data collection to inform the data collection process. Following reflexive practice, throughout the duration of the study, acknowledgement of potential power imbalance was noted between interviewers and participants. Interviews conducted by the second author, an active clinician in psychiatry, had a shared insight into the understanding of day-to-day practices with participants. The first author had no clinical commitments and had over 5 years' experience conducting qualitative research in the area. These differences were acknowledged and reflected on throughout the duration of the study. The interviewers facilitated neutral reactions and interactions with participants to avoid any preconceptions being introduced to participants.

Interviews were conducted in person or via online platforms (Microsoft Teams/Zoom) and were audio-recorded. A topic guide informed data collection and was revised iteratively alongside data collection (Supporting Information S1).

'Information power' which states that data collection in qualitative research should cease when major categories have provided depth and variation was used to determine when data collection was complete.[19]

2.5 | Data analysis

All interviews were transcribed verbatim by the two authors conducting the interviews (MIT and CL). Transcripts were uploaded to QSR NVivo software version 12 to facilitate analysis and analysed using a reflexive thematic analysis.[15,20] Reflexive thematic analysis meant data was analysed inductively using a data-driven approach keeping researcher subjectivity central to the analytical process. We generated themes through data familiarisation, coding, theme development, and revision.[15,20] First, short, and descriptive codes were developed, followed by wider categories and then sub-theme development, which involved further interpretation of the dataset and exploring the relationship amongst codes to generate themes.[15,20] Initial candidate themes were generated, which were then refined and revised to result in the final themes. A thematic map with themes and sub-themes was developed and updated while the data analysis process continued, to explore which codes were developed into themes. Data analysis was an ongoing process as interviews were coded shortly after they were conducted to inform subsequent interviews.

The first author led the analysis process by coding all interviews and 40% of the transcripts were independently open coded by the second author to enhance trustworthiness of the data. A comparison of codes followed, with minor differences in generated codes which were resolved through discussion. Key to the analysis was reflexive practice to actively examine assumptions and positionings of the authors.[20] Regular meetings were held to discuss transcripts, preliminary codes, and themes.

2.6 | Ethical considerations

Ethical approval was granted by the Clinical Research Ethics Committee of the Cork Teaching Hospitals (ref ECM 4(o) 28/06/2022). Written consent was obtained for all conducted interviews and informed consent was checked at the beginning and end of the interview.

3 | RESULTS

Participants' characteristics: From April-July 2023, 20 healthcare practitioners were interviewed (see Table 1). Interviews lasted 25–65 min. To maintain confidentiality of participants, quotes from clinical psychologists, psychotherapists, and social workers are labelled as 'Other clinical staff'. Healthcare practitioners offered diverse perspectives across general practice, community mental health services, liaison psychiatry, emergency department settings, and inpatient mental health units.

Main findings: Three main themes were generated and are described below.

3.1 | Perceived greater risk of suicide, and increased awareness of complexity in older adult presentations

Healthcare practitioners described interactions with older adults as complex and requiring more attention than younger populations due to the perceived increased risk of suicide.

TABLE 1 Participants characteristics.

Characteristics	Healthcare practitioners (n = 20)
Age range	
20–29 years	0 (0%)
30–39 years	6 (30%)
40–49 years	5 (25%)
50–59 years	9 (45%)
60 years and over	0 (0%)
Gender	
Male	3 (15%)
Female	17 (85%)
Region	
Leinster	7 (35%)
Ulster	0 (0%)
Munster	11 (55%)
Connacht	2 (10%)
Profession	
Nurse (n = 8)	
-Clinical nurse specialist in self-harm	4 (20%)
-Advanced nurse practitioner psychiatry	2 (10%)
-Community mental health nurse	2 (10%)
Doctor (n = 9)	
-General practitioner	3 (15%)
-Old age psychiatry consultant	4 (20%)
-Non consultant hospital doctor specialising in psychiatry	2 (10%)
Clinical psychologist or psychotherapist	2 (10%)
Social worker	1 (5%)
Years working in post	
Less than 1 year	0 (0%)
1–5 years	5 (25%)
6–10 years	6 (30%)
More than 10 years	9 (45%)

> I am more conscious of risk with older adults. If they think about suicide or attempted suicide, I have a lower threshold for admission. There's normally a kind of expected lethality fatality out of it.
>
> HCP 012, Advanced Nurse Practitioner

> When the elderly do it, they get it right, while with the younger ones, you'll get a lot of self-harm, cutting, alcohol/drug abuse, a lot of talk about it.
>
> HCP 010, General Practitioner

When asked to describe clinical presentations of older people, healthcare practitioners stated that those who presented with self-harm had a high risk of suicide due to the lethality behind the act.

> When they present with actual self-harming it is always going to be quite high lethality from my experience.
>
> HCP 105, NCHD

> Generally if older people self-harm for me that's really serious and really high risk. I think there is a one in two chance of a completed suicide after that.
>
> HCP 015, Old Age Consultant Psychiatrist

3.1.1 | Ageism and challenges experienced when supporting older adults

While there was an increased perceived risk of suicide, there were several identified challenges in the management of self-harm in older adults. Ageism and the mistaken attribution of mental health symptoms to older age was reported by participants.

> It's that kind of idea from other health professionals that ah it is just part of old age. We probably don't get referred a lot of elderly people saying, our life has been horrible, I'd be better off dead. I think these older people are seen and they think they've got chronic health issues, they maybe lost someone close to them and this is life and they don't see it as it is, you know, no, actually this person is really struggling.
>
> HCP 011, Old Age Consultant Psychiatrist

Stigma and shame also made it more difficult for older adults to access support. While healthcare practitioners recognised stigma and shame were present in all ages, they found it was further accentuated in older adults and this often stopped them from seeking support.

> Older people are often a lot less forthcoming. You have to really tease it out, do much more probing with older adults. There seems to be more awareness in the younger population to seek help for these things compared to the older population.
>
> HCP 108, NCHD

These feelings of shame could lead to ageism with healthcare practitioners describing older adults not asking for support due to this.

> They will often say to me oh, well, there are younger people who need care more than me and who deserve it. So, it is that internalization of ageism. Oh well why would you bother with me? I am old. I am like, no, age does not matter.
>
> HCP 015, Old Age Consultant Psychiatrist

Healthcare practitioners found supporting older adults who self-harm as challenging due to the increased risk of suicide, and complexity behind supporting the diverse stressors and risk factors, in particular when self-harm was related to a wider range of life stressors.

> Things like chronic pain, that is not something that could be fixed. So you can't change the things that are contributing to them feeling low, if it's bereavement, if it's isolation, if it's pain, whereas with younger people you can maybe try and plan about putting things in place to mitigate the risks.
>
> HCP 101, Other Clinical Staff

> One of the biggest challenges I find is if the trigger isn't a mental illness, if it's more of a life stressor. That can be harder because it means that there is not something specific for us as psychiatrists to treat.
>
> HCP 108, NCHD

> It's time consuming. And that's the biggest issue when we are under pressure. What has been helpful is the primary care team meetings. So, a lot of these very distressed patients come up there and you get a lot of the disciplines together.
>
> HCP 010, General Practitioner

3.2 | Integrated care as an avenue for improving the management of self-harm in older adults

Integrated care, involving the collaboration between healthcare professionals from different settings, was deemed as essential when supporting older adults. In particular when supporting the complex and broad factors affecting older people's self-harm.

> I think it is really a multidisciplinary approach. It is not just one type of picture, there could be very different needs. A person who has a severe psychotic depression with no physical health problems, is very different from someone who's terminally ill. It really depends on the patient and their needs. The best outcomes are if all the disciplines are working together.
>
> HCP 103, Old Age Consultant Psychiatrist

As a part of integrated care, the need for increased awareness on mental health of older adults was identified, in particular amongst healthcare practitioners not specialised in mental health.

> I think for GPs more of an understanding that feeling low is not actually normal aging and someone speaking like that they need to see someone, and it might not be that they need to be referred to secondary psychiatry.
>
> HCP 015, Old Age Consultant Psychiatry

3.2.1 | Difficulties recognising and supporting self-harm presentations in older adults

Difficulty recognising self-harm presentations in older adults due to limited help-seeking was mentioned by healthcare practitioners.

There were concerns that primary care colleagues, who had less experience supporting this group, would not be able to identify and support self-harm in this age group, highlighting again the importance of integrated and collaborative care.

> It can be difficult to recognise. I like to think we're obviously experts and we have worked in this field for a long time. But again, these are people that are going to the GP, maybe a different complaint, and they're afraid to say something about feeling suicidal. Maybe they are not being asked, it's just how they present. They present differently to someone that is under the age of 60.
>
> HCP 102, Community Mental Health Nurse

To improve the management of self-harm and provide integrated care, broadly available services are needed, as identified by participants.

> We are only a 9-5 service and sending someone to hospital that's in acute mental health crisis after hours, this can be very it's uncomfortable.
>
> HCP 102, Community Mental Health Nurse

Accessing support during a difficult time such as a self-harm event, was further complicated by a lack of clear referral pathways and accessibility of services. Participants described lack of clear communication between the different services, highlighting the lack of integrated and collaborative care.

> The referral pathways aren't too straightforward, and there seems to be a lot of services, and there's a big drive nationally to get a lot of services up and running. But the communication between the services always isn't clear and I think if we're finding it confusing, clients and families are definitely finding it confusing.
>
> HCP 106, Clinical Nurse Specialist

> Better access to primary care psychology, and that's a disaster. I think the local waiting times the moment are 7 months and that's just a disaster.
>
> HCP 011, Old Age Consultant Psychiatrist

Integrated care, as described by participants, involves older adults receiving support from primary care as well as accessing more specialist treatment when needed. However, some of the supports identified as helping older adults, such as psychological therapies, were not available to older adults due to age cut offs.

> I think the main challenges would be the lack of dedicated psychological therapies, a lot of those interventions are age cut off, there is less psychotherapies available for older people.
>
> HCP 018, Old Age Consultant Psychiatrist

Furthermore, disparity of care at a national level was identified by healthcare practitioners. Some regions had well established mental health teams while other regions had not yet implemented some of these services.

3.2.2 | Primary care: A potential setting for leading the management of self-harm in older adults

Participants commented on the suitability of where is best to attend older patients presenting with self-harm. Attending EDs to receive support for self-harm was deemed as unsuitable by participants due to time and resource constraints.

> I think the whole ED is quite a high stress environment. When you're waiting to be triaged and walking through the pods it is just not a nice environment for either patients or members of staff trying to work. It's just asking the impossible of everybody. If you're fragile, you're not well and you're an older person, it's really just hard hard place.
>
> HCP 101, Other Clinical Staff

Participants identified primary care as a suitable environment where older adults could receive support for their self-harm, however due to lack of resources, participants described patients being sent to EDs.

> There's a huge issue with accessing GP care. That delay can mean that someone's physical health and mental health can deteriorate. If there was a means to intervene sooner in primary care, it may not progress to needing secondary care or may not progress to become a deteriorating mental illness or suicidal.
>
> HCP 103, Old Age Consultant Psychiatrist

Some participants stated older adults may feel more comfortable attending primary care due to the decreased stigma in accessing these services and suitability of environments.

> People would feel more comfortable in a primary care centre or a local GP surgery then having to come into the ED. Patients have waited so long before being triaged out in the waiting room. By the time we are called to see them, they may be waiting quite a while. The waiting room in the ED is very busy and noisy and not maybe the most appropriate place.
>
> HCP 016, Clinical Nurse Specialist

General Practitioners themselves acknowledged primary care to be a key place to support older adults who self-harm given the frequent contact with older adults. They identified primary care as the ideal environment to identify and support older adults given their close relationship with patients and the community.

> I think the GP really has a central role in supporting older patients with suicidal behaviour because I know these people for many years, and I would know them before, during and after.
>
> HCP 007, General Practitioner

> I think that it should be primary care driving it because we know the families, the environment, we're the ones going into the house. Seeing the situations, the neighbours are contacting us to say we haven't seen so and so for 2–3 days, he's not coming out. So I think for that age group who don't really want to be in hospital settings, I think it should be primary care directed at this very close work with the social workers, home help and public health nurses are valuable in that sort of situation and ourselves.
>
> HCP 010, General Practitioner

3.2.3 | A multidisciplinary approach led by primary care to supporting the complexity of self-harm in older adults

Supporting older adults within the community was deemed essential for this cohort, as opposed to hospital settings. While clinicians identified primary care as having a key role in supporting older adults who self-harm, clinicians mentioned the importance of integrated support and multidisciplinary teams. Furthermore, primary care clinicians stated that while they would support most patients who self-harm, improved access to specialised services is needed for complex cases.

> Even though we deal with 90%-95% of all presentations, we do need help at times with the difficult case, that's where we need secondary care. A consultant psychiatrist, but also ideally having access to a similar to the home-based crisis team we have for younger adults, but the older adults don't have. That will give us the rapid access in a situation. So, this is the missing link to secondary care, we don't need them for everything. But when we do need them, we need that multidisciplinary approach, which does include everything from OT to see a social work as well in in deprivation issues.
>
> HCP 009, General Practitioner

Integrated care and multidisciplinary teams were identified as the best approach for the management of self-harm in older adults. As risk factors for self-harm ranged from various personal to medical to social aspects, involvement of multiple teams was identified: psychiatry, general practice, psychological therapies, occupational therapy, social welfare, home assistance, financial support, amongst others.

3.3 | Risk assessment in older adults: The importance of safety planning due to increased risk

Healthcare practitioners previously identified perceived high risk of suicide amongst older adults was also reflected when conducting risk assessments. Careful considerations were taken to ensure older adults were provided with the care and support prior to discharge. Safety plans were developed to identify risk factors and older adults' support system, if any, and remove any triggers or access to lethal means if possible.

> I ask people, have you considered harming yourself? I would assess them in terms of, what their thoughts are, have they got a formal plan, what their supports are, the broad supports particularly social supports. I would be particularly concerned with people who are very socially isolated and lots of older people are and then all the usual things like financial problems, family problems, health problems.
>
> HCP 007, General Practitioner

When conducting risk assessments, alongside conducting biopsychosocial assessments to gather relevant information, safety plans were developed. Safety plans were used to follow up patients, offering broad and personalised support.

> We give everybody an emergency care plan with some safety planning. And so that they know what to do if something happens contact numbers and then we would follow them up carefully. If we provide medication usually, we'll have a nurse follow up. Specifically, to monitor the response to the medication as we wait for them to recover and then look at more psychosocial things as well. So, we have social worker on the team, occupational therapist. We can call them in as needed.
>
> HCP 015, Old Age Consultant Psychiatrist

Participants identified that when conducting a safety plan, older adults had limited social support which further increased their risk.

> They (younger people) normally have quite good support. One of the big difficulties with older adults is about safety planning because maybe their supports

> aren't, there. That would be why I'd kind of be more considerate of risk because you are sending them into a situation where they're on their own again.
>
> HCP 012, Advanced Nurse Practitioner

When evaluating risk, participants agreed that when possible, older adults should be offered support within the community via the different available services as this would be a more holistic approach towards recovery.

> I'm a huge advocate for the community. I don't think the hospital is helpful. I think what's best is to be at home surrounded by the people that know you best. Because we're removing you from them completely and surrounding you by people who are gonna feed you, tell you to get up out of bed, hand you your tablets. It takes away all the responsibility, which obviously makes you feel better, but you have to go back. But if you were at home, and being supported, I think your recovery would be a lot faster.
>
> HCP 014, Clinical Nurse Specialist

However, healthcare practitioners also identified that community supports were not always available. Furthermore, for a select high-risk group of older adults, the community approach may not be possible, and hospitalisation may be necessary.

> I think an acute setting is definitely warranted for certain situations if there's immediate risk, I would have a lower threshold for older adults. But if we can safety plan appropriately, I do think that the Community teams can link in with them quite quickly and we can support with home visits. So, I do think outside of a hospital setting is preferable, if it's practical and safe.
>
> HCP 012, Advanced Nurse Practitioner

Lastly, participants identified the importance of easy contact and accessibility to services for older adults who had received a risk assessment. Offering patients, a list of available mental health and social support services in the area was key when finalising a risk assessment and conducting safety plans with older adults.

4 | DISCUSSION

To our knowledge, this is the first study conducted in RoI to examine management practices for older adults who self-harm from the perspectives of a broad group of healthcare practitioners. The study found that these clinicians identify self-harm in older adults as complex and challenging, and perceived a greater risk of suicide, approaching patients with care and caution. Due to the limited availability of mental health services, supports were often limited due to cut off age criteria or disparity of care at a national level. The need for integrated support provided by multidisciplinary teams was identified, with suggestions of primary care clinicians having a lead role in identifying and assessing older adults who self-harm. Increased mental health promotion and awareness of mental health and suicidal behaviour in this age group would be beneficial, given elevated levels of stigma and shame. Table 2 was developed based on the findings of this study, providing recommendations for improving support offered to older adults presenting with self-harm.

Self-harm in older adults can clinically present differently when compared to younger populations as highlighted by participants. Research shows healthcare practitioners often overlook mental health conditions and self-harm in older adults and struggle to identify these due to different presentations which are often combined or masked by physical symptoms.[21] Therefore, training on diverse presentations in older age should be offered on a structural basis in the curriculum of healthcare practitioners supporting this age group to improve the identification of self-harm. Our study found that healthcare practitioners perceived a greater risk of suicide in older adults. While our study adhered to a definition of self-harm where both suicidal and non-suicidal acts are considered, it was noted that when participants described management of self-harm as complex, it was due to the perceived increased risk of suicide.

Consistent with international research,[22–24] participants identified primary care practitioners to have a key role in early detection and intervention to prevent deterioration of mental health. However, participants noted that primary care clinicians needed more support, including optimised referral trajectories, and enhanced communication with secondary care colleagues for more specialised patients. Previous research[25] conducted in primary care settings supporting mental health of older patients has shown that multidisciplinary, integrated, and collaborative care led by GPs, results in improved patient outcomes. While findings from our study suggest that the primary care setting may be most suitable for the management of self-harm presentations in older adults, the training needs of primary care clinicians remain unmet. National[26,27] and international[22] studies have further explored the perspectives and needs of GPs supporting patients who self-harm. These studies have found that improved guidance and training needs must be addressed in GPs to allow them to confidently support patients presenting who self-harm.[22,26] In particular, GPs training in the area of communication skills, confidence in decision making, and the assessment and management of patients after self-harm has been identified.[22,26] Furthermore, while some GPs may have a special interest or training in mental health and/or self-harm, the mentioned studies noted that this is not the case for all. Multidisciplinary teams within or available to primary care settings are needed, to best support patients with complex presentations of self-harm.

In the RoI, the National Clinical Programme for Self-Harm and Suicide Related-Ideation (NCPSHI) was established in 2016 and offers standard and evidence-based interventions to people presenting with self-harm or suicide-related ideation in EDs. The NCPSHI has dedicated clinical nurse specialists and doctors nationally who

TABLE 2 Recommendations for improving support offered to older adults presenting with self-harm.

Policy level	Increased resources and funding for adequate staffing and training
	Delivery of community mental health services and psychological therapies to include older adults
Healthcare level	Improved awareness and detection of self-harm in older adults
	Improved communication between primary and secondary care
Societal level	Increased mental health promotion (including self-harm) in older adults
Individual level	Psychoeducation to increase mental health literacy/awareness and reduce stigma

support patients presenting to EDs with self-harm or suicide-related ideation. The latest update of the NCPSHI model of care seeks to improve the response to patients with suicidal ideation within community and primary care settings, via a primary care-based Suicide Crisis Assessment Nurse (SCAN) service. This operational guidance for this service specifies that it has no age cut-off.[28] SCAN nurses are clinical nurse specialists in self-harm that attend patients presenting with self-harm in primary care. SCAN nurses have not been implemented at a national level, with only 20% of the population having access to them.[28] The NCPSHI Model of Care states SCAN nurses are to be rolled out nationally, and primary care should be regarded as the first point of medical care for self-harm patients, consistent with findings from our research.[28] Crisis Resolution Services have recently been implemented by the healthcare system to support Community Mental Health Services across the country. Crisis Resolution Teams are community-based multidisciplinary teams providing rapid assessment and intensive support to people in a mental health crisis. However, as noted by participants, there is disparity of care with not all regions/services having this service implemented. Furthermore, not all Crisis Resolution Teams offer support to older adults, with age cut-off of services from 18 to 65, limiting the care offered to older adults.

National[28] and international[6,29] clinical guidance for self-harm list older adults as a priority group and emphasise the importance of conducting a psychosocial assessment. Specialist trained staff who can undertake these assessments are needed, and they must be afforded time to conduct assessments compassionately and thoroughly. Furthermore, given the focus and support to older people, other primary healthcare professionals such as public health nurses would be an important target group for training considering early detection of self-harm in this age group. Several of the recommendations made from this study involve increased resources in health and social care, given the complexity behind self-harm behaviour. Nationally, and internationally, accessing limited resources and specialist staff may hinder adopting the recommendations from the present study, due to the limited availability of these.[29]

Previous research has examined the perspectives of older adults, carers, and support workers.[23,24,29–32] Research suggests that healthcare practitioners experience difficulties in recognising self-harm and mental health problems such as depression, often due to ageism.[21] Similar to findings from this research, previous qualitative research conducted in Australia found that ageism, limited services, funding, and training, often preclude offering of better support for older adults who self-harm.[33]

4.1 | Strengths and limitations

We recruited a wide range of healthcare practitioners at a national level addressing a knowledge gap in mental health clinical practice. While we had a good response rate, covered relevant healthcare settings, and finalised recruitment when information power was reached, representativeness at a national level was not equal, with certain regions and clinical specialists being more represented than others. Future research can include further perspectives of GPs as primary care was identified as a potential avenue for leading support of self-harm in older adults. Furthermore, our study captured only the perspectives of healthcare practitioners and while this is a group which can offer rich insight, we did not include the perspective of people with lived experience such as older adults with self-harm behaviour.

5 | CONCLUSION

Self-harm in older adults is perceived as complex and challenging by healthcare practitioners. Integrated and multidisciplinary care is fundamental to comprehensively support this group, given the complexity of self-harm in older adults. Provision of care needs to be improved at a national level, with different supports still needing to be implemented across the country. Primary care was identified as a setting that older adults often access and where identification, support, and prevention can be offered to this group, with more complex cases being promptly referred to specialist services. Future research should explore the perspectives of older adults on how they would like to receive care for their self-harm.

ACKNOWLEDGEMENTS

We would like to thank participants for contributing to this study and to the various clinical and professional networks that helped us share the study recruitment details. This work was supported by the Irish Research Council under a Government of Ireland Postdoctoral Fellowship (grant number GOIPD/2021/3). FM is funded by a NIHR Doctoral Fellowship (300957) and supported by the NIHR Greater

Manchester Patient Safety Translational Research Centre (NIHR204295). The views expressed are those of the authors and not necessarily those of the NIHR or the Department of Health and Social Care.

Open access funding provided by IReL.

CONFLICT OF INTEREST STATEMENT

FM was a member of the 2022 United Kingdom National Institute for Health and Care Excellence self-harm guideline development committee. The remaining authors declare no competing interests.

DATA AVAILABILITY STATEMENT

The data from this study are not publicly available due to the nature of the research containing sensitive information that could compromise the privacy of research participants.

ETHICS STATEMENT

Ethical approval has been granted by the Clinical Research Ethics Committee of the Cork Teaching Hospitals (ref ECM 4 (o) 28/06/2022).

ORCID

M. Isabela Troya https://orcid.org/0000-0003-0474-3832

REFERENCES

1. World Health Organization. Suicide Worldwide in 2019: Global Health Estimates; 2021. Accessed June 6, 2023. www.who.int/publications/i/item/9789240026643
2. Witt KG, Hetrick SE, Rajaram G, et al. Psychosocial interventions for self-harm in adults. *Cochrane Database Syst Rev*. 2021;4. https://doi.org/10.1002/14651858.cd013668.pub2
3. Naghavi M. Global, regional, and national burden of suicide mortality 1990 to 2016: systematic analysis for the Global Burden of Disease Study 2016. *BMJ*. 2019;364:l94. https://doi.org/10.1136/bmj.l94
4. De Leo D. Late-life suicide in an aging world. *Nat Aging*. 2022;2(1):7-12. https://doi.org/10.1038/s43587-021-00160-1
5. Morgan C, Webb RT, Carr MJ, et al. Self-harm in a primary care cohort of older people: incidence, clinical management, and risk of suicide and other causes of death. *Lancet Psychiatr*. 2018;5(11):905-912. https://doi.org/10.1016/s2215-0366(18)30348-1
6. National Institute for Health and Care Excellence. Self-harm: assessment, management and preventing recurrence. 2022. Accessed June 6, 2023. www.nice.org.uk/guidance/ng225
7. Joyce M, Chakraborty S, O'Sullivan G, et al. National self-harm registry Ireland annual report 2020. 2022. Accessed March 30, 2023. https://www.nsrf.ie/wp-content/uploads/2022/11/NSRF-National-Self-Harm-Registry-Ireland-annual-report-2020-Final-for-website.pdf
8. McManus S, Gunnell D, Cooper C, et al. Prevalence of non-suicidal self-harm and service contact in England, 2000–14: repeated cross-sectional surveys of the general population. *Lancet Psychiatr*. 2019;6(7):573-581. https://doi.org/10.1016/s2215-0366(19)30188-9
9. Beghi M, Butera E, Cerri CG, et al. Suicidal behaviour in older age: a systematic review of risk factors associated to suicide attempts and completed suicides. *Neurosci Biobehav Rev*. 2021;127:193-211. https://doi.org/10.1016/j.neubiorev.2021.04.011
10. Troya MI, Babatunde O, Polidano K, et al. Self-harm in older adults: systematic review. *Br J Psychiatr*. 2019;214(4):186-200. https://doi.org/10.1192/bjp.2019.11
11. Barker J, Oakes-Rogers S, Leddy A. What distinguishes high and low-lethality suicide attempts in older adults? A systematic review and meta-analysis. *J Psychiatr Res*. 2022;154:91-101. https://doi.org/10.1016/j.jpsychires.2022.07.048
12. Wand AP, Browne R, Jessop T, Peisah C. A systematic review of evidence-based aftercare for older adults following self-harm. *Aust N Z J Psychiatr*. 2022;56(11):1398-1420. https://doi.org/10.1177/00048674211067165
13. Carroll R, Metcalfe C, Steeg S, et al. Psychosocial assessment of self-harm patients and risk of repeat presentation: an instrumental variable analysis using time of hospital presentation. *PLoS One*. 2016;11(2):e0149713. https://doi.org/10.1371/journal.pone.0149713
14. Steeg S, Emsley R, Carr M, Cooper J, Kapur N. Routine hospital management of self-harm and risk of further self-harm: propensity score analysis using record-based cohort data. *Psychol Med*. 2018;48(2):315-326. https://doi.org/10.1017/s0033291717001702
15. Braun V, Clarke V. *Thematic Analysis*. American Psychological Association; 2012.
16. Allemang B, Sitter K, Dimitropoulos G. Pragmatism as a paradigm for patient-oriented research. *Health Expect*. 2022;25(1):38-47. https://doi.org/10.1111/hex.13384
17. Parker C, Scott S, Geddes A. *Snowball Sampling*. SAGE research methods foundations; 2019.
18. Palinkas LA, Horwitz SM, Green CA, Wisdom JP, Duan N, Hoagwood K. Purposeful sampling for qualitative data collection and analysis in mixed method implementation research. *Adm Pol Ment Health*. 2015;42(5):533-544. https://doi.org/10.1007/s10488-013-0528-y
19. Malterud K, Siersma VD, Guassora AD. Sample size in qualitative interview studies: guided by information power. *Qual Health Res*. 2016;26(13):1753-1760. https://doi.org/10.1177/1049732315617444
20. Braun V, Clarke V. Reflecting on reflexive thematic analysis. *Qual Res Sport Exerc Health*. 2019;11(4):589-597. https://doi.org/10.1080/2159676x.2019.1628806
21. Burroughs H, Lovell K, Morley M, Baldwin R, Burns A, Chew-Graham C. 'Justifiable depression': how primary care professionals and patients view late-life depression? A qualitative study. *Fam Pract*. 2006;23(3):369-377. https://doi.org/10.1093/fampra/cmi115
22. Mughal F, Troya MI, Dikomitis L, Chew-Graham CA, Babatunde OO. Role of the GP in the management of patients with self-harm behaviour: a systematic review. *Br J Gen Pract*. 2020;70(694):e364-e373. https://doi.org/10.3399/bjgp20x708257
23. Troya MI, Chew-Graham CA, Babatunde O, Bartlam B, Mughal F, Dikomitis L. Role of primary care in supporting older adults who self-harm: a qualitative study in England. *Br J Gen Pract*. 2019;69(688):e740-e751. https://doi.org/10.3399/bjgp19x706049
24. Wand AP, Peisah C, Draper B, Brodaty H. How do general practitioners conceptualise self-harm in their older patients? *Aust J Gen Pract*. 2018;47(3):146-151. https://doi.org/10.31128/afp-08-17-4311
25. Unützer J, Katon W, Callahan CM, et al. Collaborative care management of late-life depression in the primary care setting: a randomized controlled trial. *JAMA*. 2002;288(22):2836-2845. https://doi.org/10.1001/jama.288.22.2836
26. O'Donohoe MS. General practitioners' experiences of self-harm in primary care. *J Nurse Pract*. 2022;18(9):983-987. https://doi.org/10.1016/j.nurpra.2022.06.001
27. Moriarty A, Nearchou F, Byrne M, Cullen W, Hennessy E. General practitioners' training and their attitudes towards young people who self-harm: a cross-sectional survey. *Early Interv Psychiatr*. 2021;15(2):271-277. https://doi.org/10.1111/eip.12936

28. Health Service Executive. National clinical programme for self-harm & suicide-related ideation. 2022. https://www.hse.ie/eng/about/who/cspd/ncps/self-harm-suicide-related-ideation/moc/mhncp-self-harm-model-of-care.pdf
29. World Health Organization. mhGAP Intervention Guide for mental, neurological and substance use disorders in non-specialized health settings Version 2.0. 2016. https://iris.who.int/bitstream/handle/10665/250239/9789241549790-eng.pdf?sequence=1
30. Troya MI, Dikomitis L, Babatunde OO, Bartlam B, Chew-Graham CA. Understanding self-harm in older adults: a qualitative study. *EClinicalMedicine*. 2019;12:52-61. https://doi.org/10.1016/j.eclinm.2019.06.002
31. Wand APF, Peisah C, Draper B, Brodaty H. Carer insights into self-harm in the very old: a qualitative study. *Int J Geriatr Psychiatr*. 2019;34(4):594-600. https://doi.org/10.1002/gps.5057
32. Wand APF, Peisah C, Draper B, Brodaty H. Understanding self-harm in older people: a systematic review of qualitative studies. *Aging Ment Health*. 2018;22(3):289-298. https://doi.org/10.1080/13607863.2017.1304522
33. Wand AP, Karageorge A, Browne R, Jessop T, Peisah C. A qualitative study of multiple voices to inform Aftercare services for older persons following self-harm. *Int J Geriatr Psychiatr*. 2023;38(1):e5876. https://doi.org/10.1002/gps.5876

SUPPORTING INFORMATION

Additional supporting information can be found online in the Supporting Information section at the end of this article.

How to cite this article: Troya MI, Lonergan C, Cassidy E, et al. Healthcare practitioners' views of self-harm management practices in older adults in Ireland: a qualitative study. *Int J Geriatr Psychiatry*. 2024;e6116. https://doi.org/10.1002/gps.6116