

external hydrocephalus are, therefore, highly warranted. In addition, accurate quantification of extra-axial CSF volume in infants is necessary for characterising normal extra-axial CSF distributions and defining volumetric boundaries for clinical concern. Additional MRI measures indicative of increased intracranial pressure and CSF composition might augment the potential clinical utility of the extra-axial CSF measure in identifying individuals with poor developmental outcomes. Such studies would enable researchers to assess the validity and clinical utility of the new and exciting autism biomarker proposed by Shen and colleagues.

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Self-harm in older adults: room to improve clinical care

Self-harm and suicide among older adults is a worldwide population health issue.¹ Risk factors for self-harm among older adults have been widely explored, including the influence of mental health conditions, physical illness, and psychosocial factors.^{1,2} Self-harm research in older adults has largely focused on describing the incidence and identifying risk factors for self-harm with the use of emergency department presentation, hospital admission, registry, and mortality data. Research examining self-harm among older adults using primary care records is scarce.³

In *The Lancet Psychiatry*, Catharine Morgan and colleagues⁴ assessed 4124 people aged 65 years or older who had a self-harm episode reported between 2001 and 2014 from the Clinical Practice Research Datalink of 674 registered general practices in the UK. Electronic primary care records enabled follow-up of clinical management, including referrals to mental health specialist services and medications prescribed with linkage to death registrations for mortality data. The authors found at the 12-month follow-up that

only 11.7% of older adults who had self-harmed had been referred to a mental health specialist and that, compared with the least socioeconomically deprived areas, adults in the most deprived areas were 33% less likely to be referred for specialist care (hazard ratio [HR] 0.67 [95% CI 0.45–0.99]). 11.8% of adults were prescribed tricyclic antidepressants (TCAs), despite known associations with risk of toxicity in overdose.⁵

Compared with a matched comparison cohort, older adults who had self-harmed had twice the prevalence of a previous mental illness (ratio 2.10 [95% CI 2.03–2.17]) and a 20% higher prevalence of a physical illness (1.20 [1.17–1.23]). The self-harm cohort were up to 20 times more likely to have an unnatural death in the 12 months after the self-harm attempt (HR 19.65 [95% CI 11.69–33.05]) and this risk remained high in later years (3.41 [2.17–5.35]) compared with the comparison cohort.

Through this research, Morgan and colleagues⁴ have provided evidence that the clinical management of older adults who self-harm needs to improve,



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particularly around providing referrals to mental health specialists and the avoidance of TCAs when prescribing psychotropic medication. Of particular note was the finding that older adults with a reported self-harm episode had twice the prevalence of dementia before the episode compared with the comparison cohort (ratio 2.47 [95% CI 2.19–2.80]). A diagnosis of dementia for some older adults can create fear of dependency, leading to depression and consideration of suicide because individuals feel they do not want to be a burden, despite potentially having many quality years of life remaining.⁶ Recognition of the need for management of self-harm risk among older adults with dementia who retain insight, particularly in the months after initial diagnosis, is crucial.⁶

Some of the challenges of self-harm research, in general, lie in the difficulty of identification of self-harm through determination of intent. In some cases, older adults might be unwilling to disclose their intent or their motives might remain unclear. Morgan and colleagues⁴ acknowledge potential limitations of underenumeration of self-harm episodes in their study, but inequity of access to health care for some older adults could have had an effect on the calculation of the incidence of self-harm, with adults from more disadvantaged areas not always using primary care or hospital services.⁷ Yet, primary care has potential for early recognition of self-harm risk and could provide an opportunity to prevent premature mortality for the older adult population.

Further research still needs to be done on self-harm among older adults, including the replication of Morgan and colleagues⁴ research in other countries, to increase our understanding of how primary care could present an early window of opportunity to prevent repeated self-harm attempts and unnatural deaths. Exploration of self-harm and suicide risk among older adults in long-term care facilities has been scant. Little is known regarding the factors that might influence or be protective of the risk of self-harm among residents in long-term care compared with older adults living in the general community.⁸

With the advance of record linkage capabilities, future self-harm research could adopt a life course

epidemiological approach⁹ and follow the health service use of a population-based cohort as they age. A life-course approach could provide information to target prevention initiatives for high-risk groups and allow identification of risk accumulation and critical risk periods. Accompanied by qualitative studies that focus on life experiences,¹⁰ social connectedness, resilience, and experience of health care use, snapshots of the continuum of health care use and potential unmet health care and social needs could be created.

This study has raised questions regarding adherence to recommended clinical guidelines for the clinical management of older adults who self-harm and has signalled the need for improved quality of health care for this population. Further research of self-harm with the use of primary care records should be encouraged.

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