Establishing a Multicentre Self-Harm System in the Russian Federation – Progress and Implications for Intervention and Prevention

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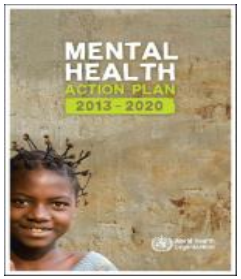
Overview

- Reflection on progress achieved in pilot regions
- Aspects for consideration and improvement
- Next steps towards a Multicentre Self-Harm Surveillance System
- Benefits and implications for self-harm intervention and suicide prevention self-harm

Context

- Global Mental Health Action Plan, 2013-2020: Commitment by Health Ministers in all 194 WHO member states to formally recognise the importance of mental health.



- Key targets:
  - 20% increase in service coverage for severe mental disorders
  - 10% reduction of the suicide rate in countries by 2020

- WHO Global Report on Preventing Suicide *(WHO, 2014)*

- UN Sustainable Development Goals: SDGs 2030, e.g. Target 3.4:
  By 2030, reduce by one third premature mortality from non-communicable diseases through prevention and treatment and promote mental health and well-being.

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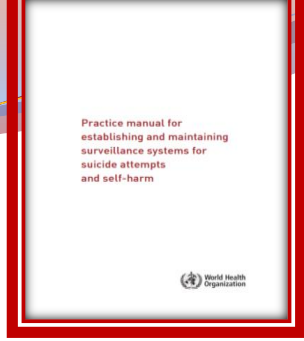

Background

- WHO Global Report on Preventing Suicide identified a need for guidance on surveillance of suicide attempts presenting to general hospitals (WHO, 2014)
  - -Number of countries with an established surveillance system for suicide attempts is limited
  - -Considerable between-system differences
  - -Variation across countries with regard to openness to report suicide attempt data due to cultural differences and criminalisation of suicide and attempted suicide

- In recent years, growing number of countries where first steps have been made in setting up a monitoring system of suicide attempts presenting to one or more hospitals

- Improved surveillance and monitoring of suicide attempts presenting to general hospitals is a core element of the public health model

- Information on trends and patterns of attempted suicide presentation can contribute to effective suicide prevention strategies

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Figure 1. **The public health model**

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Core components of national suicide prevention strategies

1) Surveillance	**7) Crisis Intervention**
2) Means Restriction	**8) Postvention**
3) Media	**9) Awareness**
4) Access to Services	**10) Stigma Reduction**
5) Training and Education	**11) Oversight and Coordination**
6) Treatment	

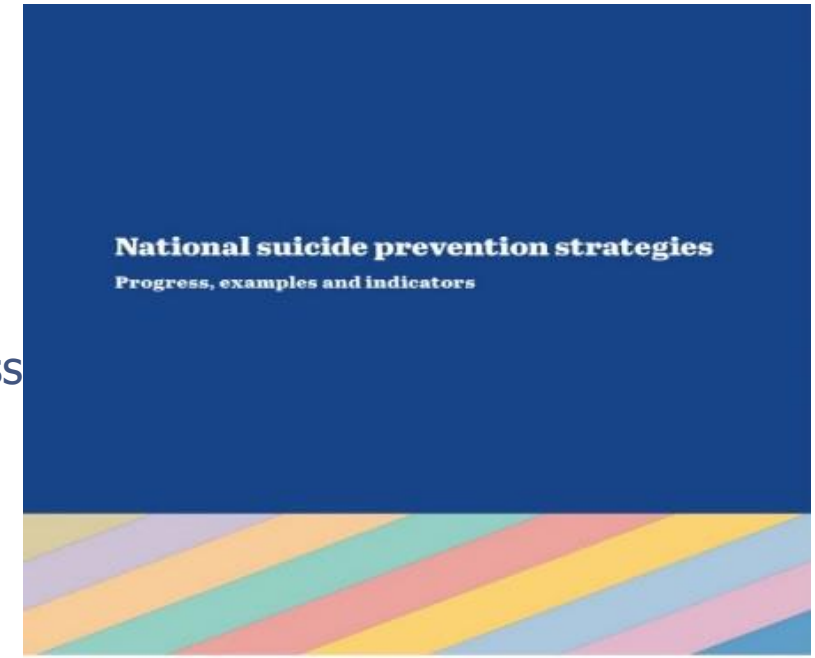
Country examples of 1st or 2nd national suicide prevention strategy

First strategy:

- Bhutan
- Guyana
- Iran
- Republic of Korea
- Switzerland
- Namibia (2nd national strategy in progress)
- Uruguay

Second strategy:

- England
- Ireland
- Sweden
- Japan
- USA



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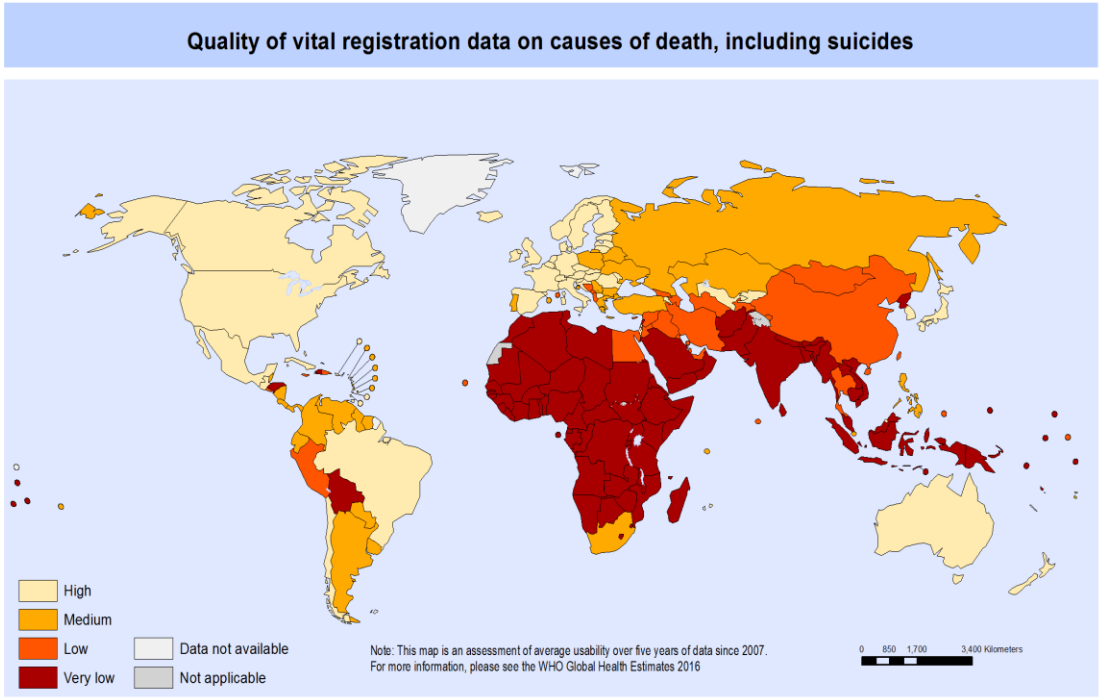
Data Quality

- The quality and availability of data on suicide and suicide attempts is poor globally
- ONLY 20 countries are known to have gathered national survey data and 3 have national hospital-based suicide attempt data
- ONLY 60 countries have good-quality vital registration data on suicide mortality
- Improvement of surveillance and dissemination of data is necessary to inform action



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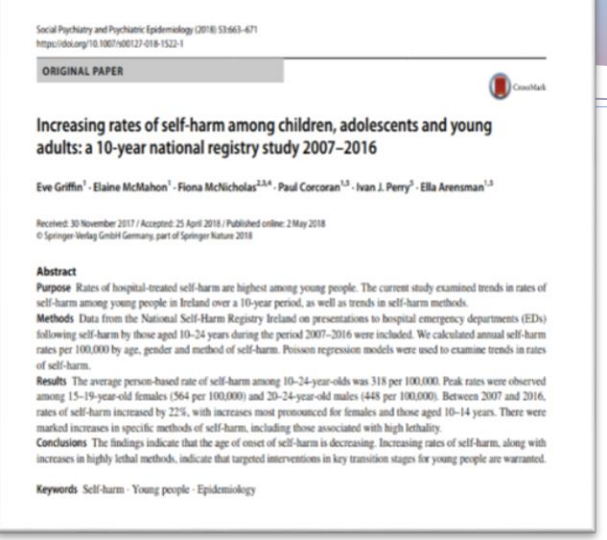
Annex 3. Examples of methods used in surveillance of hospital-presented suicide attempts and self-harm

Examples of dedicated registries for hospital-presented suicide attempts and self-harm

Location	Web link	Coverage	Centres	Population	Duration	Source
Ireland	http://nsrf.ie/wp-content/uploads/reports/NSRF%20National%20Self-Harm%20Registry%20Ireland%20Annual%20Report%202014.pdf	National (26 counties)	40	All	From 2003 (ongoing)	Hospital-based monitoring (including all hospitals)
Costa Rica	https://www.ministeriodesalud.go.cr/index.php/centro-de-prensa/noticias/662-noticias-2014/698-costa-rica-vigila-los-intentos-de-suicidio-por-primera-vez-desde-el-2013	National	-	All	From 2013 (ongoing)	Presentations to public and private hospitals
Northern Ireland	http://www.publichealth.hscni.net/publications/northern-ireland-registry-self-harm-annual-report-201314	Subnational	3	All	From 2007 (ongoing)	Presentations to emergency departments
UK multicentre	http://cebmh.warne.ox.ac.uk/csr/mcm/	Subnational (Derby, Manchester, Oxford	6	51 206 (sample analysed)	From 2000 (ongoing)	Treated in health system
UK Oxford	http://cebmh.warne.ox.ac.uk/csr/monitoring.html	Subnational (Oxford)	1	450 000	From 1976 (ongoing)	Presentations to inpatient and outpatient departments
Belgium	http://bjp.rcpsych.org/content/183/3/260	Subnational (Flanders)	62	225 393	From 1986 (ongoing)	General and psychiatric presentations (also prisons and sentinel centres)

Benefits of surveillance systems for hospital treated suicide attempts/self-harm

- Informing:
  - Service provision, resource deployment and guidelines for self-harm management
  - Assessment and interventions for non-fatal suicidal behaviour
- "Real-Time Data"
- Evaluation of interventions
- Regional variations
- Clinical management of self-harm
- All attendances to hospital Emergency Departments



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ORIGINAL PAPER

Increasing rates of self-harm among children, adolescents and young adults: a 10-year national registry study 2007–2016

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Abstract

Purpose Rates of hospital-treated self-harm are highest among young people. The current study examined trends in rates of self-harm among young people in Ireland over a 10-year period, as well as trends in self-harm methods.

Methods Data from the National Self-Harm Registry Ireland on presentations to hospital emergency departments (EDs) following self-harm by those aged 10–24 years during the period 2007–2016 were included. We calculated annual self-harm rates per 100,000 by age, gender and method of self-harm. Poisson regression models were used to examine trends in rates of self-harm.

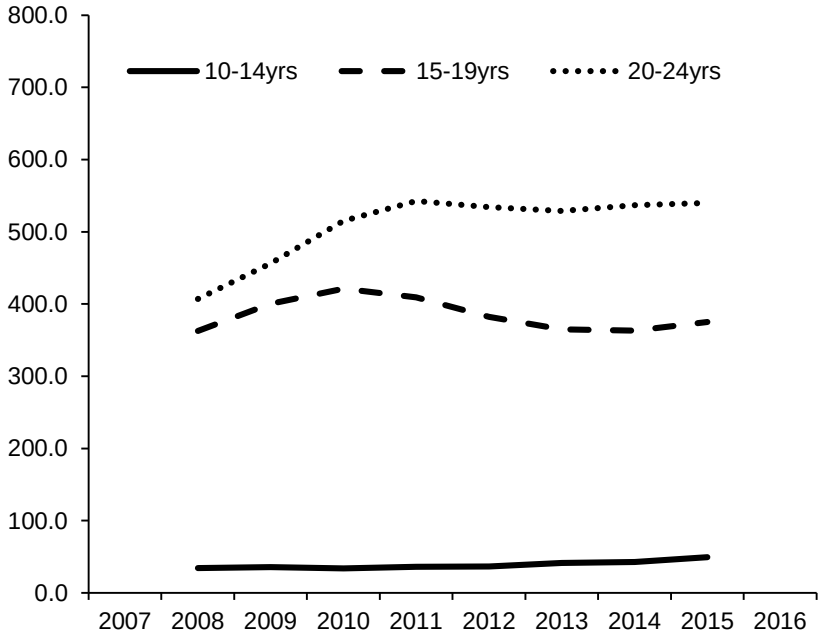
Results The average person-based rate of self-harm among 10–24-year-olds was 318 per 100,000. Peak rates were observed among 15–19-year-old females (564 per 100,000) and 20–24-year-old males (448 per 100,000). Between 2007 and 2016, rates of self-harm increased by 22%, with increases most pronounced for females and those aged 10–14 years. There were marked increases in specific methods of self-harm, including those associated with high lethality.

Conclusions The findings indicate that the age of onset of self-harm is decreasing. Increasing rates of self-harm, along with increases in highly lethal methods, indicate that targeted interventions in key transition stages for young people are warranted.

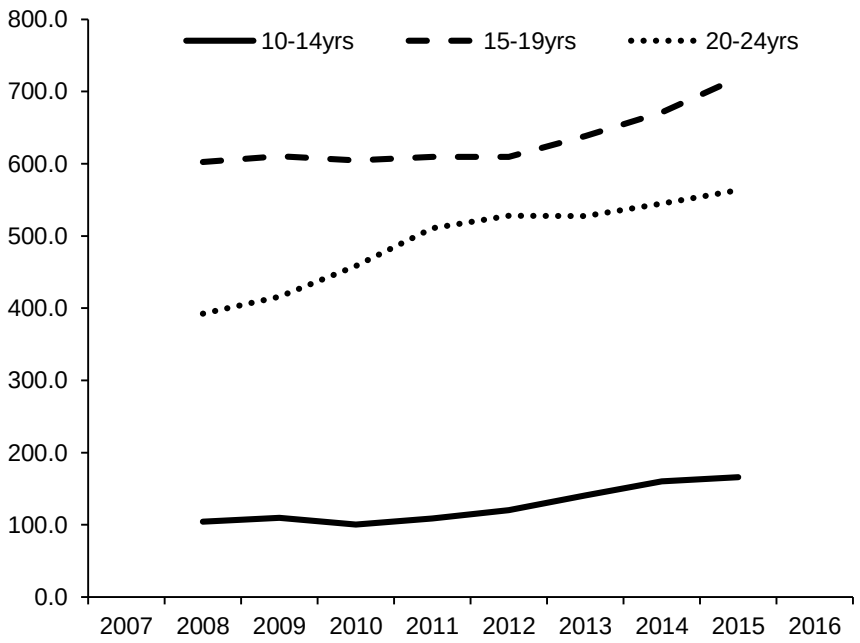
Keywords Self-harm · Young people · Epidemiology

Self-harm among young people in Ireland, 2007-2016

Male



Female



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Progress suicide attempt/self-harm surveillance in the 3 pilot regions

- **Stavropol Krai:** Surveillance Center for suicide and suicide attempts established in 2014.

- **Sverdlovsk Oblast:** Suicide attempts being recorded since 2013 and access to suicide mortality data from the Forensics Office.

- **Zabaikalsky Krai:** Suicide and suicide attempts being recorded since 2012, suicides and suicide attempts are being recorded in Zabaikalsky Krai.

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Comparing existing suicide attempt surveillance systems to WHO guidelines for suicide attempt/self-harm surveillance

Existing suicide attempt surveillance systems in the 3 pilot regions	WHO guidelines for establishing and maintaining surveillance systems for suicide attempts and self-harm
Data collection is conducted by healthcare staff	Designated data collectors, independent from healthcare services
Data compiled by healthcare staff	Data compiled by data manager
Only inclusion of cases involving suicidal intent	All cases involving deliberately initiated self-harm and varying levels of suicidal intent and varying underlying motives
No additional funding	Specially allocated funding

Existing suicide attempt surveillance systems in the 3 pilot regions	WHO guidelines for establishing and maintaining surveillance systems for suicide attempts and self-harm
Different services/agencies involved in data collection	Focus of surveillance is on all suicide attempt/self-harm presentations to general hospital
Possible differences in case ascertainment and data collection	Standardised approach to case ascertainment and data collection
Less emphasis on data protection	Strong emphasis on data protection
Data mainly used for interventions/actions at the level of clinical practice	Data used for multiple purposes: 1. Surveillance and epidemiological purposes 2. Implications/action at the level of clinical practice 3. Implications/actions for the purpose of self-harm and suicide prevention

Comparing existing suicide attempt surveillance systems to WHO guidelines for suicide attempt/self-harm surveillance

Overall, there was consensus that there would be added value of having a standardised suicide attempt/self-harm surveillance system in order to inform both clinical practice in relation to self-harm patients and by providing the evidence base supporting key priorities for improving improve self-harm and suicide intervention and prevention.

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Variation in case ascertainment

Indications for primary inclusion of self-harm acts associated with high suicidal intent;

Considering:

- Terminology: ‘suicide attempt’

- Relatively low rates of suicide attempts per 100,000 population compared to other countries

Terminology and definition

- The terms ‘self-harm’ or ‘self-harming behaviour’ offer the most common ground internationally

- However, this term cannot always be translated with the same meaning in other languages. Therefore, the term ‘suicide attempt’ might be preferred in such instances

- Proposed definition, which is common in several surveillance systems and monitoring studies:

“*A non-habitual act with non-fatal outcome that the individual, expecting, or taking the risk, to die or to inflict bodily harm, initiated and carried out with the purpose of bringing about wanted changes” (De Leo et al, 2004)*

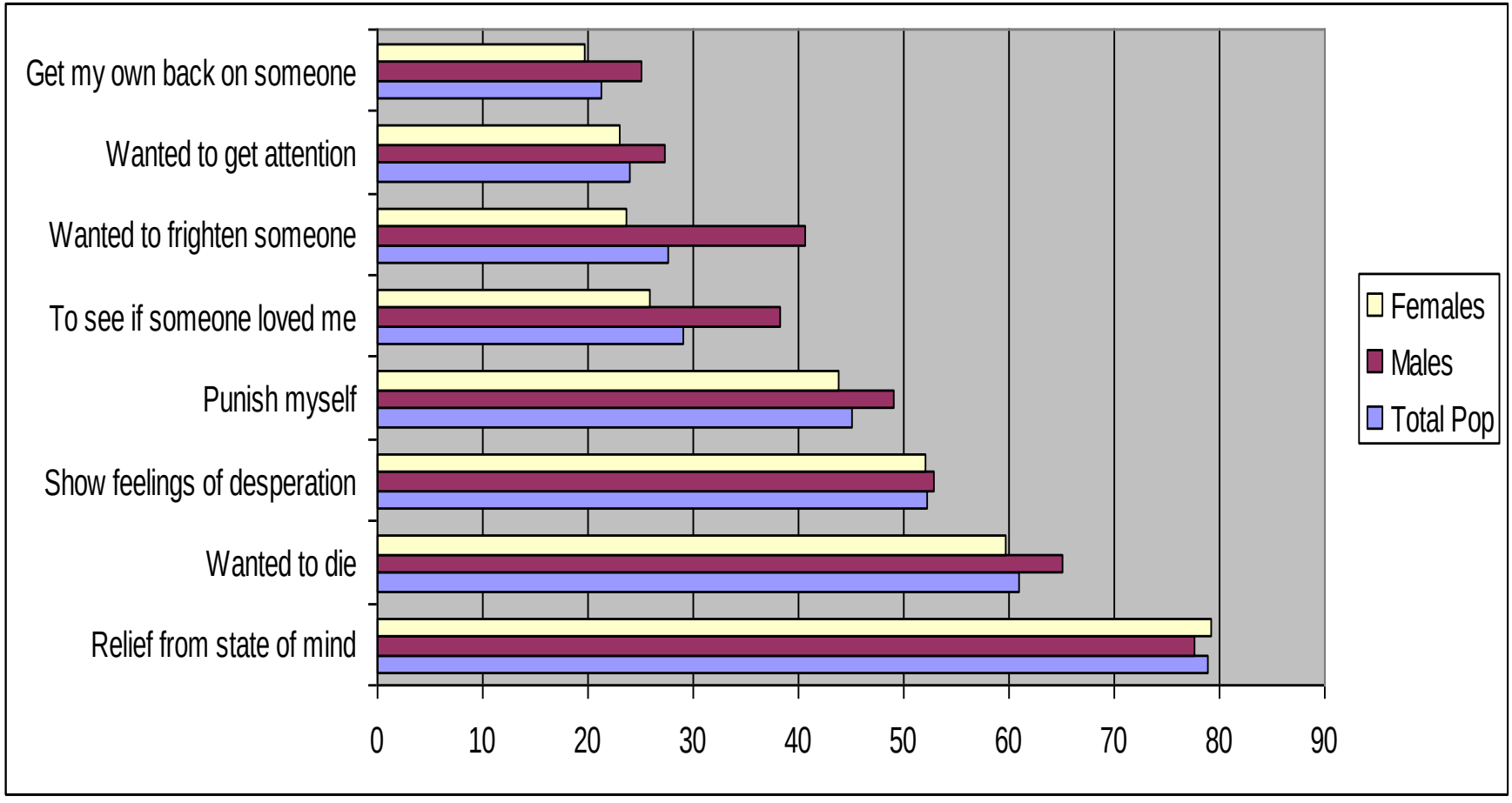
Operationalization of self-harm cases/suicide attempts

- A hospital-focused surveillance system will inevitably represent cases of self-harm with varying levels of suicidal intent and varying underlying motives, and not only suicide attempts characterized by high levels of suicidal intent.

- The complexity in deciding on the most suitable term is related to **intent to self-harm**, which to some extent has to be present in order to classify an act as non-accidental.

- Consequently, a very fine line has to be followed, where suicidal intent is recognized as fundamental to naming an act as non-accidental yet the term cannot carry the sense of suicidal intent only because this also involves a wide range of other motives, such as relief from unbearable thoughts, self-punishment and seeking attention.

Motives related to self-harm

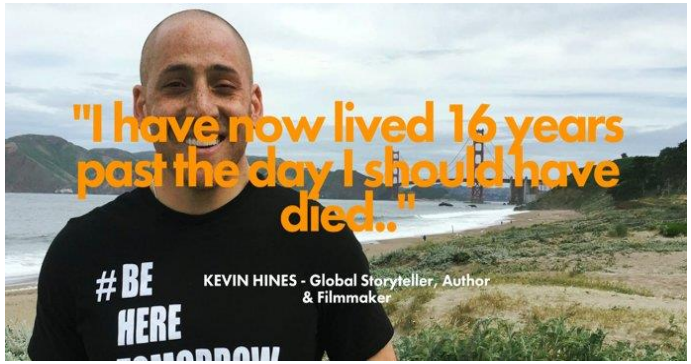


Scoliers et al, 2009; Rasmussen et al, 2016

The importance of understanding **Ambivalence**

- A critical feature in working with those who self-harm is to recognise their ambiguity and the fragility and temporality of their decisions about their destiny.

Bermans et al, 2009; 2017



- I said to myself, If somebody comes up to me and says, *'Are you okay? Is something wrong? Can I help you?' I was going to tell them my whole life story and they were going to make me safe."*

- A suicidal person needs to hear: *"That we care about you, your life does matter and that all we want is for you to stay,"* he says. *"If someone had looked at me on that bridge or that bus and said that to me, I would have begged for help."*
Kevin Hines

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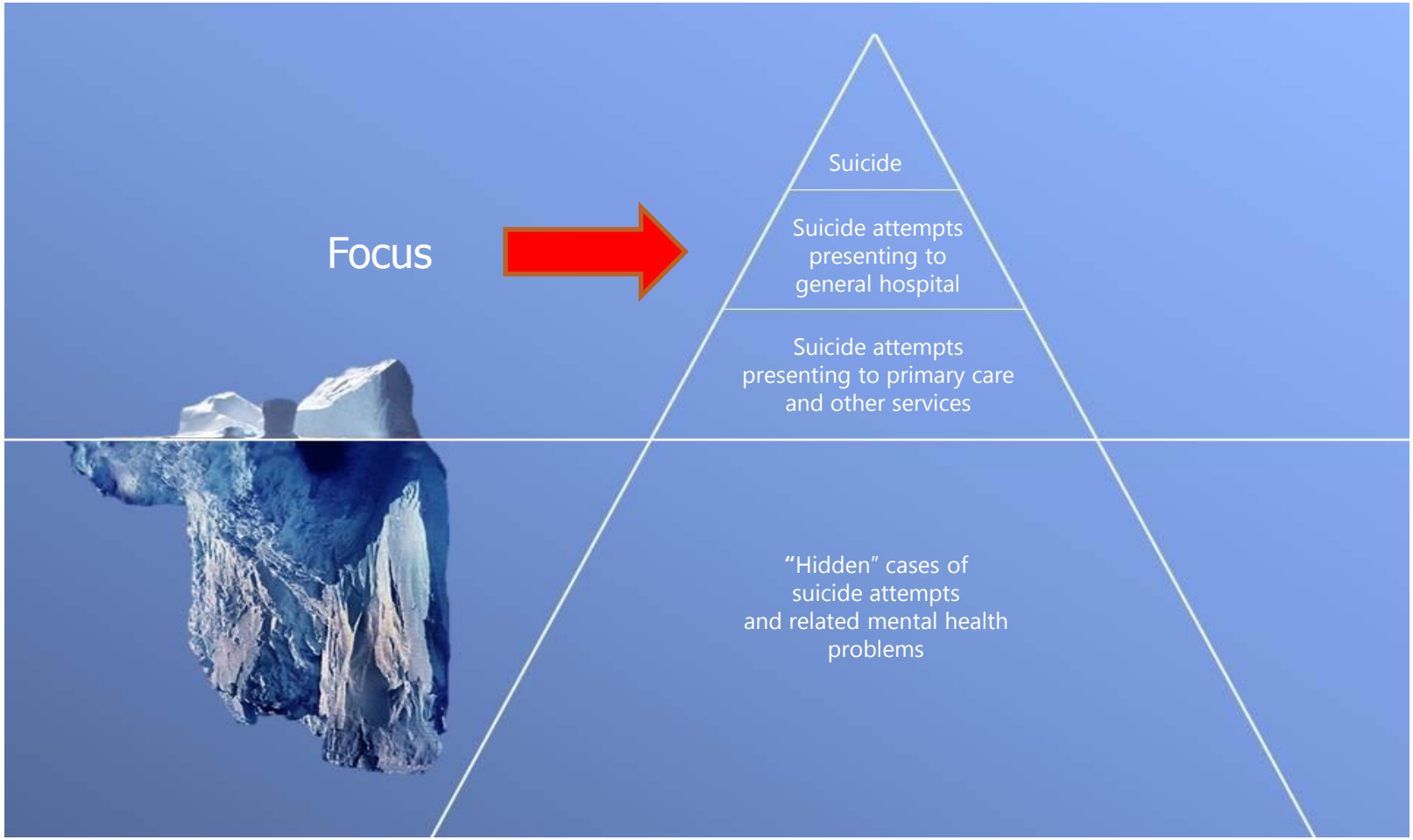
Suicide rates versus suicide attempt/ self-harm rates

- In some of the pilot regions, suicide attempt/self-harm rates have been reported to be lower than suicide rates over a number of years; this is in contrast with outcomes of surveillance systems and epidemiological research in other countries, e.g. Ireland, UK, Belgium etc.

- *Possible explanations:*

- Not all general hospitals within the 3 regions have been involved in data collection;
- Across the hospitals, some cases of suicide attempts/self-harm acts have not been included due to incomplete data capture by hospital staff and/or differences in the operational criteria applied for case ascertainment

Surveillance of hospital presentations of suicide attempts/self-harm



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Towards a Multi-Centre Self-Harm Surveillance System

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Next steps

- Agree a Standard Operating Procedures, initially among the 3 pilot regions in accordance with WHO (2016)
- Agree a common definition of self-harm and associated inclusion and exclusion criteria for case ascertainment in accordance with WHO (WHO, 2016).
- Agree on the set of core and optional data items to be included in the Multi-Centre Self-Harm Surveillance System;
- Following the initial training of staff members, it would be recommended to arrange meetings on a regular basis (every 2-3 months) in order to ensure the highest level of standardised data collection and to discuss ambiguous cases.
-

Next steps

- In order to calculate rates of self-harm per 100,000 population at regional level, it would be recommended to collect data on hospital presentations of self-harm from all general hospitals in the region.

- Following the initial training of staff members, it would be recommended to arrange meetings on a regular basis (every 2-3 months) in order to ensure the highest level of standardised data collection and to discuss ambiguous cases.

- It would be recommended to implement a common computerized system for data entry for the purpose of the Multi-Centre Self-Harm Surveillance System within the three regions. This will facilitate pooling of the data and conducting comparative data analysis.

"People who engage in suicidal behaviour don't want to die, wat they want is a different life"

(Wieg, 2003; Zwagerman, 2015)

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