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
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.
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
Figure 1. The public health model

1. Surveillance

What is the problem?

Define the problem of suicidal behaviour through systematic data collection

2. Identify risk & protective factors

What are the causes & what can buffer their impact?

Conduct research to find out why suicidal behaviour occurs and who it affects

3. Develop & evaluate interventions

What works & for whom?

Design, implement and evaluate interventions to see what works

4. Implementation

Scaling up effective policies & programmes

Scale up effective and promising interventions and evaluate their impact and effectiveness
Core components of national suicide prevention strategies

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<td>Surveillance</td>
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<td>Means Restriction</td>
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<td>3</td>
<td>Media</td>
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<td>Access to Services</td>
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<td>Training and Education</td>
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<td>Stigma Reduction</td>
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<td>11</td>
<td>Oversight and Coordination</td>
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Country examples of 1\textsuperscript{st} or 2\textsuperscript{nd} national suicide prevention strategy

**First strategy:**
- Bhutan
- Guyana
- Iran
- Republic of Korea
- Switzerland
- Namibia (2\textsuperscript{nd} national strategy in progress)
- Uruguay

**Second strategy:**
- England
- Ireland
- Sweden
- Japan
- USA
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.
### 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

<table>
<thead>
<tr>
<th>Location</th>
<th>Web link</th>
<th>Coverage</th>
<th>Centres</th>
<th>Population</th>
<th>Duration</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>UK multicentre</td>
<td><a href="http://cebmh.warne.ox.ac.uk/csr/mcr/">http://cebmh.warne.ox.ac.uk/csr/mcr/</a></td>
<td>Subnational (Derby, Manchester, Oxford)</td>
<td>6</td>
<td>51 206 (sample analysed)</td>
<td>From 2000 (ongoing)</td>
<td>Treated in health system</td>
</tr>
<tr>
<td>UK Oxford</td>
<td><a href="http://cebmh.warne.ox.ac.uk/csr/monitoring.html">http://cebmh.warne.ox.ac.uk/csr/monitoring.html</a></td>
<td>Subnational (Oxford)</td>
<td>1</td>
<td>450 000</td>
<td>From 1976 (ongoing)</td>
<td>Presentations to inpatient and outpatient departments</td>
</tr>
<tr>
<td>Belgium</td>
<td><a href="http://bjp.rcpsych.org/content/183/3/260">http://bjp.rcpsych.org/content/183/3/260</a></td>
<td>Subnational (Flanders)</td>
<td>62</td>
<td>225 393</td>
<td>From 1986 (ongoing)</td>
<td>General and psychiatric presentations (also prisons and sentinel centres)</td>
</tr>
</tbody>
</table>
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
Self-harm among young people in Ireland, 2007-2016

Male

Female

National Suicide Research Foundation
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.
Comparing existing suicide attempt surveillance systems to WHO guidelines for suicide attempt/self-harm surveillance

<table>
<thead>
<tr>
<th>Existing suicide attempt surveillance systems in the 3 pilot regions</th>
<th>WHO guidelines for establishing and maintaining surveillance systems for suicide attempts and self-harm</th>
</tr>
</thead>
<tbody>
<tr>
<td>Data collection is conducted by healthcare staff</td>
<td>Designated data collectors, independent from healthcare services</td>
</tr>
<tr>
<td>Data compiled by healthcare staff</td>
<td>Data compiled by data manager</td>
</tr>
<tr>
<td>Only inclusion of cases involving suicidal intent</td>
<td>All cases involving deliberately initiated self-harm and varying levels of suicidal intent and varying underlying motives</td>
</tr>
<tr>
<td>No additional funding</td>
<td>Specially allocated funding</td>
</tr>
<tr>
<td>Existing suicide attempt surveillance systems in the 3 pilot regions</td>
<td>WHO guidelines for establishing and maintaining surveillance systems for suicide attempts and self-harm</td>
</tr>
<tr>
<td>Different services/agencies involved in data collection</td>
<td>Focus of surveillance is on all suicide attempt/self-harm presentations to general hospital</td>
</tr>
<tr>
<td>Possible differences in case ascertainment and data collection</td>
<td>Standardised approach to case ascertainment and data collection</td>
</tr>
<tr>
<td>Less emphasis on data protection</td>
<td>Strong emphasis on data protection</td>
</tr>
<tr>
<td>Data mainly used for interventions/actions at the level of clinical practice</td>
<td>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</td>
</tr>
</tbody>
</table>
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 self-harm and suicide intervention and prevention.
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
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

- Relief from state of mind
- Wanted to die
- Show feelings of desperation
- Punish myself
- To see if someone loved me
- Wanted to frighten someone
- Wanted to get attention
- Get my own back on someone

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

Kevin Hines

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
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

Focus

Suicide

Suicide attempts presenting to general hospital

Suicide attempts presenting to primary care and other services

“Hidden” cases of suicide attempts and related mental health problems
Towards a Multi-Centre Self-Harm Surveillance System
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, what they want is a different life”

(Wieg, 2003; Zwagerman, 2015)