WHO Guidelines for establishing and maintaining surveillance for suicide attempts and self-harm at global level

Les Enjeux de la Surveillance pour la Prévention des Tentatives de Suicide

28th November 2017, Luxembourg

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Collaboration with WHO: Practice manual

- WHO Global Report on Preventing Suicide identified a need for guidance on surveillance of suicide attempts presenting to general hospitals (WHO, 2014)
  - Limited number of countries with an established surveillance system for suicide attempts
  - Considerable between-system differences
  - Variation across countries with regard to openness to report suicide attempt data
  - Information on trends and patterns of attempted suicide presentation essential to informing effective suicide prevention strategies

Aim of Manual:
To improve standardization within and between countries with regard to establishing and maintaining a surveillance system of hospital presented suicide attempts

The extent of suicidal behaviour, fatal and non-fatal

Focus of the manual

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

IASP

National Suicide Research Foundation

UCC
Aim of the manual

To improve standardization within and between countries with regard to establishing and maintaining a surveillance system of hospital presented suicide attempts
Benefits of surveillance systems for hospital treated suicide attempts

• 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
Nomenclature, definitions and classification - Challenges

- Need for consistency in terminology and definitions in order to achieve comparable data on suicide attempts within and across countries

- Reaching agreement on the terminology and definition is complicated by the varying levels of suicidal intent and heterogeneity of motives reported by people engaging in self-harming behaviour (Scoliers et al, 2009; McAuliffe et al, 2007; Hjelmeland et al, 2002)

- Globally, more similarities between definitions compared to the wide ranging terminology

- Translating English language terms in other languages may have a different meaning

- Quantification of suicidal intent cannot be fully represented by one term and would be more suitable for classification (operational criteria).
Terms used to describe intentional self-harming behaviour

- Suicidal self-injury
- Attempted suicide
- Non-suicidal self-injury
- Parasuicide
- Self-injury
- Intentional self-harm
- Self-injurious behaviour
- Non-fatality
- Self-directed violence
- Serious suicidal behaviour
- Non-serious suicidal behaviour
- Deliberate self-harm
- Self-harming behaviour

Recommended terms
Proposed 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)
Countries with a suicide attempt registry of any kind - based on IASP-WHO survey
Different methods used in surveillance of hospital treated suicide attempts

- Individual Studies
- Multi-Centre Studies
- Dedicated Registries
- National/International Statistics and Databases
  - ICD-10
Content of manual

Developing and implementing a surveillance system

Training of staff

Reporting of outcomes and dissemination

Maintenance and sustainability over time

Terminology and nomenclature

Overview of existing systems/projects

**Aim**

- To assess extent of problem of hospital-treated self-harm, globally

**Who is it for?**

- Health professionals
- Data officers
- Researchers
- Statisticians
- Ministries of Health
- NGOs
Development and implementation of a surveillance system for suicide attempts

**Important aspects and elements:**

- Informing and engaging governments and relevant stakeholders
- Governance and requirements of coordinating agencies
- Costs and potential funding sources
- Setting up a surveillance system
  - Standard Operating Procedures
  - Case ascertainment
  - Data items
- Registration forms and data entry
  - Coding and data entry
- Ethical requirements, confidentiality and data protection
Data items

• Core data items:
  - Data collector
  - Date of registration
  - Hospital number
  - Unique event number
  - Unique person identification number
  - Sex
  - Date of birth
  - Age
  - Postal code/area code
  - Date of presentation
  - Time of presentation
  - Mode of arrival at the hospital
  - Seen by on arrival at the hospital
  - Date of self-harm
  - Day of the week of the self-harm
  - Time of the self-harm
  - Location of the self-harm
  - Method(s) according to ICD-10 codes
  - Medical severity of the self-harm
  - Statement of intention to die
  - History of self-harm
  - Psychological/psychiatric assessment in the hospital
  - Diagnosis
  - Admission to hospital
  - Discharge

• Optional data items, e.g:
  - Nationality
  - Country of origin
  - Ethnicity
  - Religion
  - Marital status
  - Employment status etc.
Training of staff involved in data collection

Why is this important?
• Available information in hospital records on cases of suicide attempts is limited and sometimes incomplete

• Achieving standardisation and uniformity within and across countries will contribute to improved accuracy and comparability of data on hospital referred suicide attempts globally

Innovative element of manual:
• Active learning section involving a series of case vignettes and guidance based on inclusion and exclusion criteria following from the definition. In addition to cases, non-cases and ambiguous cases are also included.
Inclusion criteria

- All methods of self-harm are included i.e., drug overdoses, alcohol overdoses, lacerations, illicit drug overdose, ingestion of pesticides, attempted drowning's, attempted hangings, gunshot wounds, etc. where it is clear that the attempt was intentionally inflicted;

- All individuals alive on admission to hospital following an act of attempted suicide are included;

- All methods of self-harm as per ICD-10 coding.

- Some individuals may use a combination of methods, such as overdose of medication together with self-cutting. If the individual has engaged in multiple methods of intentional self-harm at the time of presentation, all methods should be recorded.
Exclusion criteria

- Alcohol overdoses/intoxication only BUT without the intention to self-harm and when no other methods of self-harm are combined;

- Accidental overdoses of street drugs where there is a clear link with regular drug use or addiction;

- Specific examples of self-harm without a deliberate intention to cause self-harm:
  - Individual put his/her foot through the door in anger.
  - Individual took usual medication twice by accident to relieve chronic back pain.
  - Drugs taken to induce abortion.
  - Self-referral due to thoughts/ideation e.g. had thoughts of drowning by jumping off bridge but took no action and went to emergency department for help.
Vignette – example 1

**Admission notes:** 35-year-old man brought in by social worker. Alcohol intoxicated and suspected overdose as found with 5 empty 100 ml bottles of Calpol (liquid paracetamol). HIV+.

**Behaviour:** Sweating and nauseous, expressing suicidal intent due to HIV status*
Vignette – example 2

**Admission notes:** 28-year-old man with head injury. Profoundly autistic, accompanied by carer who explains he has a pattern of head-banging.

**Behaviour:** Not communicative. No eye contact. Rocking back and forth and reluctant to allow head examination.
National Self-Harm Registry Ireland

- Operated by the National Suicide Research Foundation via the Department of Health and Children
- Full coverage since 2006 (36 hospitals)
- Pop (2013 est): 4,593,300

Northern Ireland Registry of Self-Harm

- Established in 2007 as a pilot project in the Western area
- Expanded to all trust areas (12 hospitals) since April 2012
- Pop (2013 est): 1,829,700

Rate per 100,000

% rate compared to 2007

- Men: +14%
- Women: +7%
- All: +10%
Self-harm by age and gender, 2016

Rate per 100,000

Age group

Men
Women
Alcohol was present in 31% of self-harm presentations to hospital EDs in 2016

Increased risk of:

- Attending out-of-hours and at weekends
- Leaving without being seen
- Arriving by ambulance
- Associated with repeat attendances
- Not receiving an assessment
Self-harm on public holidays

- Mean number of presentations increased on public holidays
- More likely to involve alcohol
- More likely to attend out-of-hours
- More first attenders
Impact of the Registry on policy and clinical practice

Clinical management of self-harm
- Improve psychosocial and psychiatric assessment
- Improve access to evidence-based interventions

Restricting access to means
- Frequently used medication (e.g. minor tranquilisers, street drugs)
- Role of alcohol misuse in self-harm presentations

High-risk groups
- Increase in presentations by homeless
- Presentations associated with high lethal self-harm methods, and those with frequent self-harm repetition

Benefits, research and innovation
- Improving benefits of data via linkage studies
- Enhancing core data of Registry
Enhancing the impact of Registry outcomes on policy and clinical practice
Challenges

Data systems not uniform across hospitals
- Standardised case ascertainment approach in each hospital, including multiple sources (e.g. triage and psychiatric notes)

Hospital policy on visitation times/ space
- Data Registration Officers (DROs) must be flexible in working in the ED
- DRO will visit in the evening/at weekends

Assuring data quality
- Annual cross-validation of consecutive cases
- Team meetings and up-skilling of DROs (at least 2 per year)

Motivating hospitals
- Quarterly reporting on hospital data
- Presentations for staff
- Allowing access to data for research

Any country-specific needs / challenges?
Acknowledgements

World Health Organization:
Dr Shekhar Saxena
Dr Alexandra Fleischmann
Ms Sutapa Howlader

National Suicide Research Foundation and School of Public Health, University College Cork
Ms Eileen Williamson, Dr Eve Griffin
Dr Paul Corcoran
Ms Grace O’Regan
Ms Justina Hurley
Mr Niall McTernan
Dr Christina Dillon