

The development of a Suicide and Self-Harm Observatory

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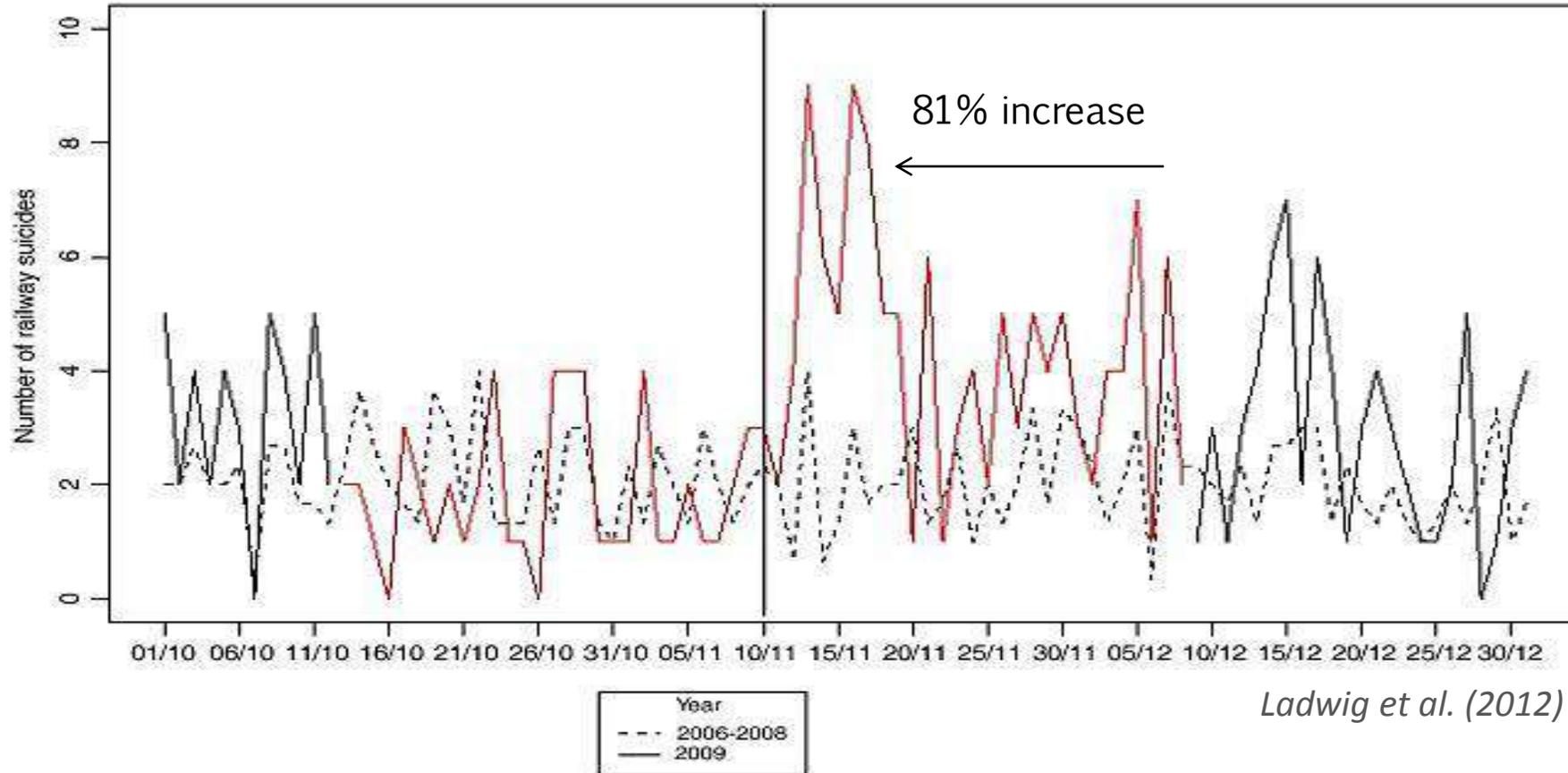
Terminology and definitions

- Confusion between suicide ‘contagion’ and suicide ‘clustering’
- Contagion: Suicidal behaviour may facilitate the occurrence of subsequent suicidal behaviour, either directly (via contact or friendship with the index suicide) or indirectly (via the media) (*Haw et al, 2012*)
- A single suicide increases the risk of additional suicides within a community and may serve as a catalyst for the development of a cluster (*Johansson et al, 2006; Gould et al, 1990*)
- Suicide clusters can be considered as the end result of a contagious process in which vulnerable individuals connect to influence one another (*Johansson et al, 2006; Berman & Jobes, 1994; Gould et al, 1990*)

Suicide contagion

- Research has consistently shown that following the detailed portrayal of suicide in the media or in a film/TV series, the risk of suicide involving the same method increased from 81% to 175% in the weeks and months after the release (*Ladwig et al, 2012; Sisask & Varnik, 2012; Hawton et al, 1999; Schmidtke & Häfner, 1988*).
- Suicide contagion is associated with over-identification with a celebrity or a fictional person results in creating a 'meaningful' connection increasing suicidal impulses, in particular among young vulnerable people (*Pumariega & Sharma, 2018; Stack, 2003*).

Significant increase in railway suicides after the suicide of the goal keeper: Robert Enke in Germany, 10 november 2009



In addition to the short term increase in railway suicides, *Hegerl et al (2013)* identified a long-term effect: 19% increase in railway suicides in the two years after the suicide by Robert Enke

Risk of suicide contagion via internet and social media

Families blame '13 Reasons Why' for the suicides of 2 teens in California (US), April 2017)

Netflix drama series blamed for inspiring teens' attempted suicide (Austria)

'13 Reasons Why' copycat suicide in Peru

Increase in teen suicidal behaviour linked to '13 Reasons Why', Toronto, June 2017

Netflix officials defend 13 Reasons Why against claims it glamorises suicide



Dylan Minnette and Katherine Langford in 13 Reasons Why



- Suicide-related searches were **15-44%** higher than expected, 12-19 days after the show's premiere
- Searches “*how to commit suicide*” (26%); “*commitsuicide*” (18%); “*howtokillyourself*” (9%) were all significantly higher
- Queries related to help seeking were also higher

(Ayers et al., 2017)



Specific aspects associated with online media and risk of suicide contagion

- Online series and social media can be accessed at all times, which increases viewing patterns, such as 'marathon' or 'binge watching'.
- This can further intensify the over-identification with people who take their lives (real-life and fictional), and therefore increase the negative impact on vulnerable people.

Negative impact of misinformation

In terms of media reporting, there is a need for sensitive and factual reporting in order to minimise harm and increase awareness:

- › Important to verify statistics with credible source (e.g. Queensland Suicide Register)
- › The graphic nature of reporting and the reporting of specific details of methods involved can trigger copycat cases: the effects of exposure on suicidal behaviour and violence are well documented
- › Media professionals should consider the vulnerable reader who might be in crisis when they read the story: coverage should not be glorified or romanticised, should emphasise consequences of the event for others, and list sources of help
- › The impact of these events can be devastating on families and communities and extreme caution when reporting cases of murder-suicide, in particular is required

Example of misinformation

Mental health and suicide crisis 'a national emergency'



992

Thursday, November 24, 2016



The Government is under pressure to make mental health and suicide prevention a national emergency after the Dáil heard concerns about 16 people taking their own lives in two weeks in Cork.



Challenges in relation to harmful information on internet and social media

- › Harmful/potentially harmful media can be accessed across jurisdictions
- › Increasing speed of circulation of information via social media
- › Absence of code of conduct for film directors, in line with code of conduct for media professionals
- › Unclear whether regulatory agencies for traditional media are responsible for monitoring social media
- › Existing evidence on suicide contagion not translated into practice for all media stakeholders, including film and show directors

Background to the Suicide and Self-Harm Observatory

- The process of causes of death, including suicides in Ireland involves several months and in some cases up to two years due to the requirement of a Coroner's inquest and the involvement of the Police, pathologists, and Vital Statistics Registrars. A reliance on mortality statistics published by the CSO two years after the calendar year in which they took place results in delays of reviews and modifications to suicide prevention plans.

The main objectives of the Suicide and Self-Harm Observatory (SSHO) are:

1. To develop an observatory for surveillance of emerging self-harm and suicide clusters
2. To prevent contagion and clustering of suicide or self-harm
3. To facilitate timely support for people bereaved by suicide



Methods

- Building on the Suicide Support and Information System, which accesses information relating to consecutive cases of suicide and open verdicts upon completion of a coronial inquest, the Suicide and Self-Harm Observatory (SSHO) has been developed with the aim to obtain minimal data on suspected suicide cases in advance of inquest.
- A systematic approach will be applied to the data collection process. Evidence based screening criteria will be applied to ensure that only cases which meet the criteria for suspected suicide are entered into the minimal encrypted database.
- Preservation of confidentiality is an important factor in developing the SSHO and all efforts will be made to ensure that the identity of the deceased remains confidential, thus avoiding upset to next of kin.

Data sources

Suspected suicide data sources:

1. The Coroners of Cork city and county

In order to maintain real-time surveillance data on all cases of suspected suicide in Cork, contact will be made with the office of the Coroners for the Cork region via phone on a biweekly basis. Based on minimal data items, information that is available before coronial inquest will be collected and input into the minimal database.

2. Health Service Executive (HSE)

A representative of the HSE will be contacted by phone on a biweekly basis in order to gather data relating to service users recorded in the register as having died as a result of suspected suicide. This information will aid in elucidating whether the deceased was in the care of the HSE at the time of death and will provide clarification on the particular service with which the deceased had been engaged with.

Self-harm data source:

National Self-Harm Registry Ireland (NSHRI)

The NSRF currently collects data on consecutive self-harm presentations to all hospitals in Ireland via the NSHRI, established in 2003. Information on self-harm cases in Cork city and county will be accessed via the NSHRI for surveillance of self-harm in the region.

Link between data sources for suspected suicide cases

The Coroners of Cork city and county

Only information that can be provided prior to coronial request will be made available by the coroner for entry to the minimal dataset.

Information provided by the coroners will not be used by the NSRF/UCC to approach family members directly

Data obtained from the coroners will provide the most complete information on case of suspected suicide



Health Service Executive

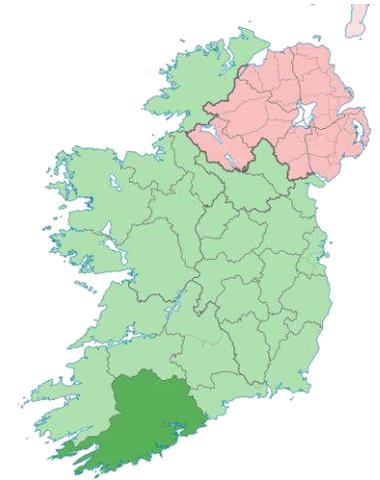
- A two way pathway will exist between the NSRF and the HSE:
 1. Information relating to the suspected suicide of a service user will be obtained from the HSE patient mortality register.
 2. Information from the minimal dataset will be shared with the Suicide Resource Officer (SRO) in order to facilitate early response to emerging suicide clusters.
- The SRO takes into consideration families in need due to the sudden death of a family member based on best practice.
- The SRO also provides support to schools and other community services in the region that has been affected by the sudden death of a student.

Minimal data items forming the SSHO

- Name
- Age
- Gender
- Marital status
- Address/ addresses (including educational)
- Location of death
- Manner, cause and method(s) used

Data analysis

- All data will be input into a live database including mapping and time series features.
- Geospatial analysis will be conducted utilising a Geographic Information System, such as QGIS, to determine the proximity of suspected suicide and self-harm in terms of space and time.
- Trend analysis will be carried out on data to identify trends in methods of suicide, where people take their own lives, at risk areas and populations.



Outcomes of the development of the SSHO

- Data obtained by the SSHO will increase the capacity for early intervention when potential suicide and self-harm clusters are identified and facilitate implementation or activation of local plans to respond to emerging clusters. In addition, the SSHO will assist with optimising resource allocation and inform health service responses in geographical areas with recurring clusters.
- The development and implementation of the SSHO meets key priorities of Ireland's National Strategy to reduce suicide, **Connecting for Life**, 2015-2020. In particular, **Goal 7** of the strategy focuses on the *Improvement of surveillance, evaluation and high quality research relating to suicidal behaviour with a key objective emphasising Improved access to timely and high quality suicide and self-harm data.*
- In recent months, HSE Suicide Resource Officers in County Kerry and County Donegal have expressed an interest in implementing the SSHO template in these counties also.



Thank you!

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