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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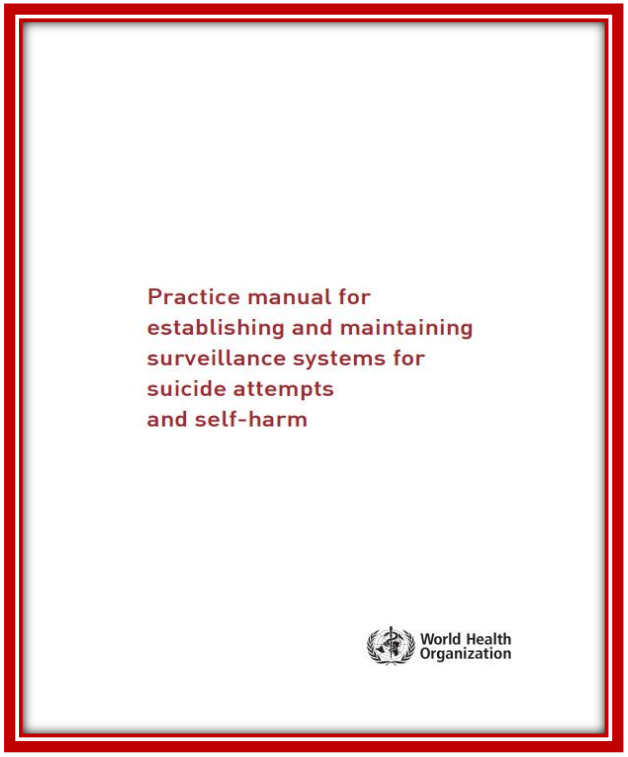
Collaboration with WHO: Practice manual



- 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

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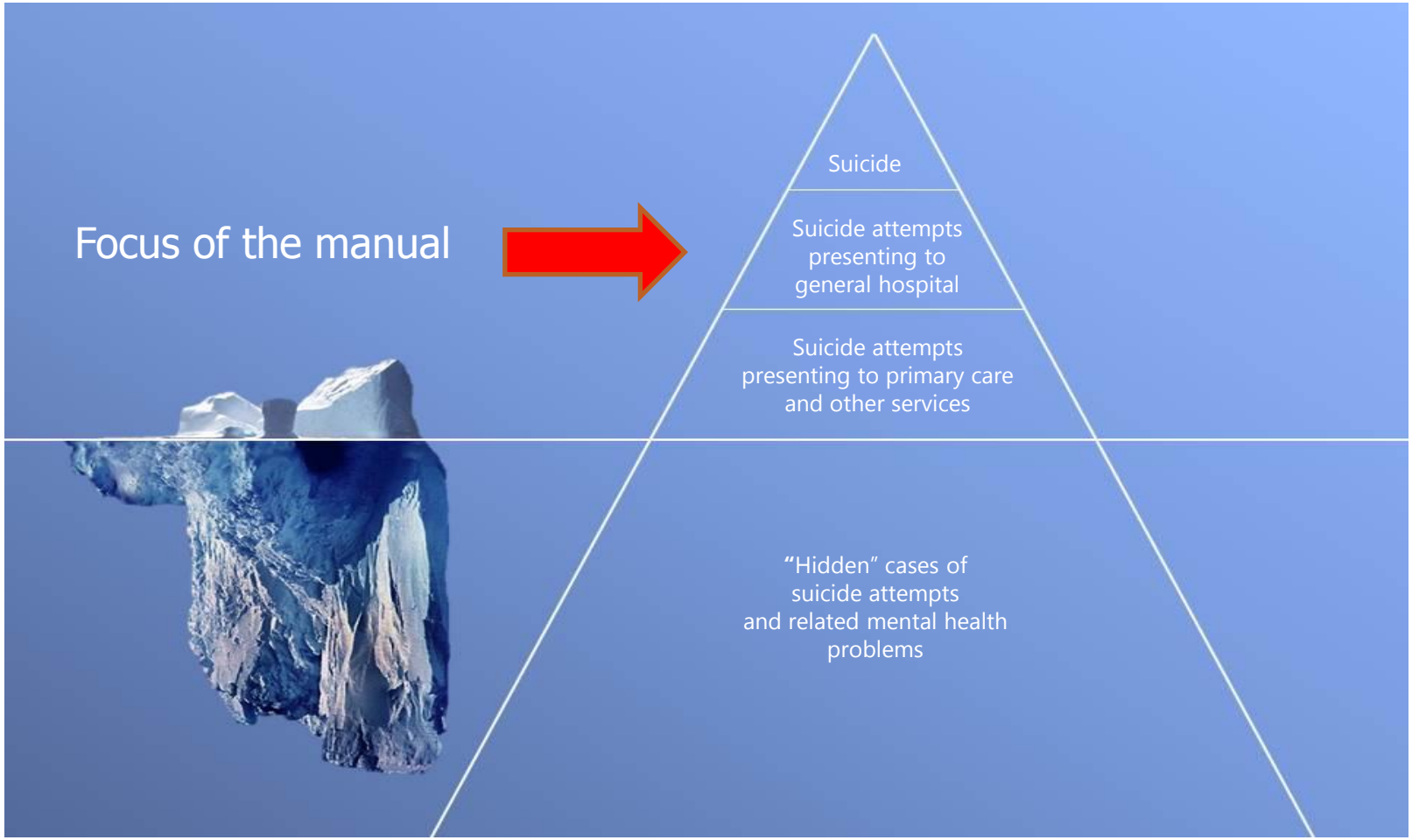
The extent of suicidal behaviour, fatal and non-fatal



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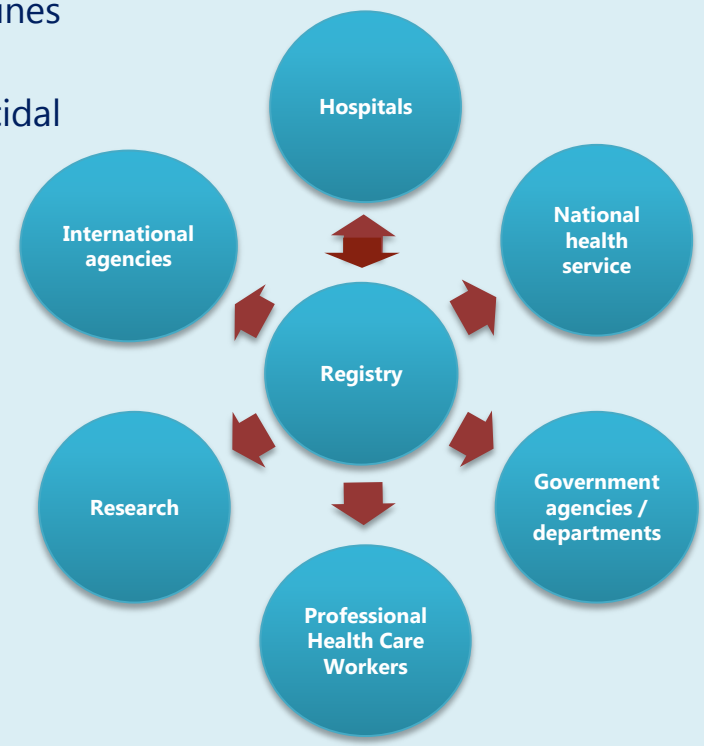
Benefits of surveillance systems for hospital treated suicide attempts

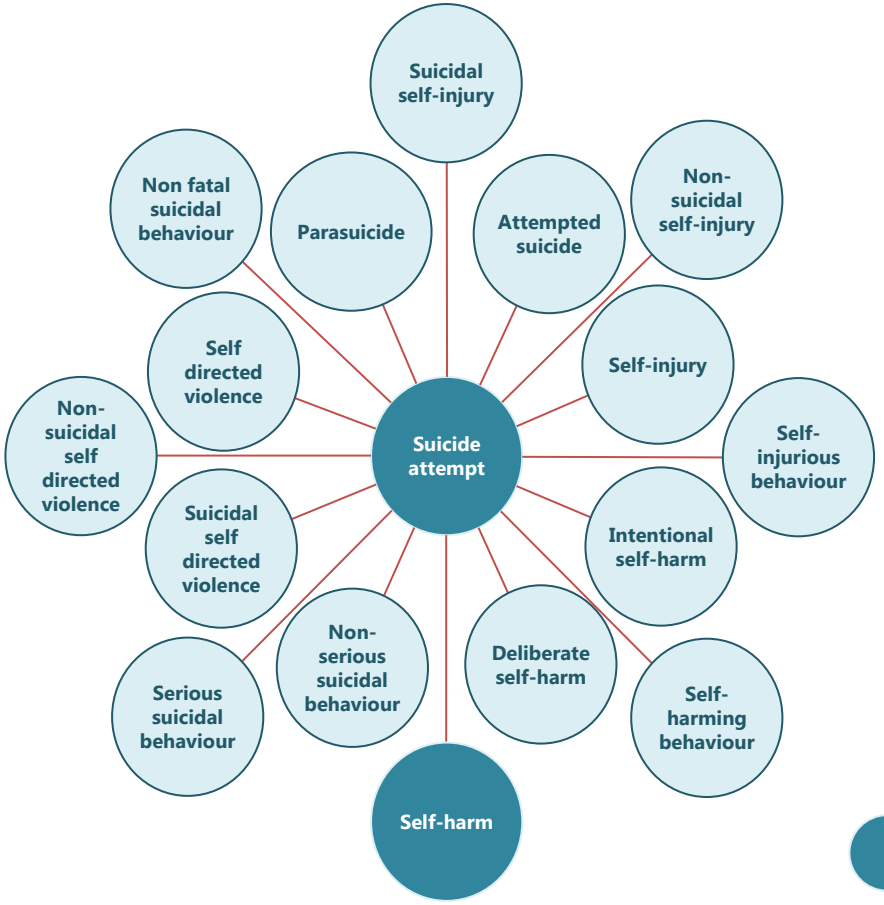
- Informing:
  - Service provision, resource deployment and guidelines for self-harm management
  - Assessment and interventions for non-fatal suicidal behaviour
- "Real Time Data"
- Evaluation of interventions
- Regional variations
- Clinical management of self-harm
- All attendances to hospital Emergency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



Recommended terms

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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

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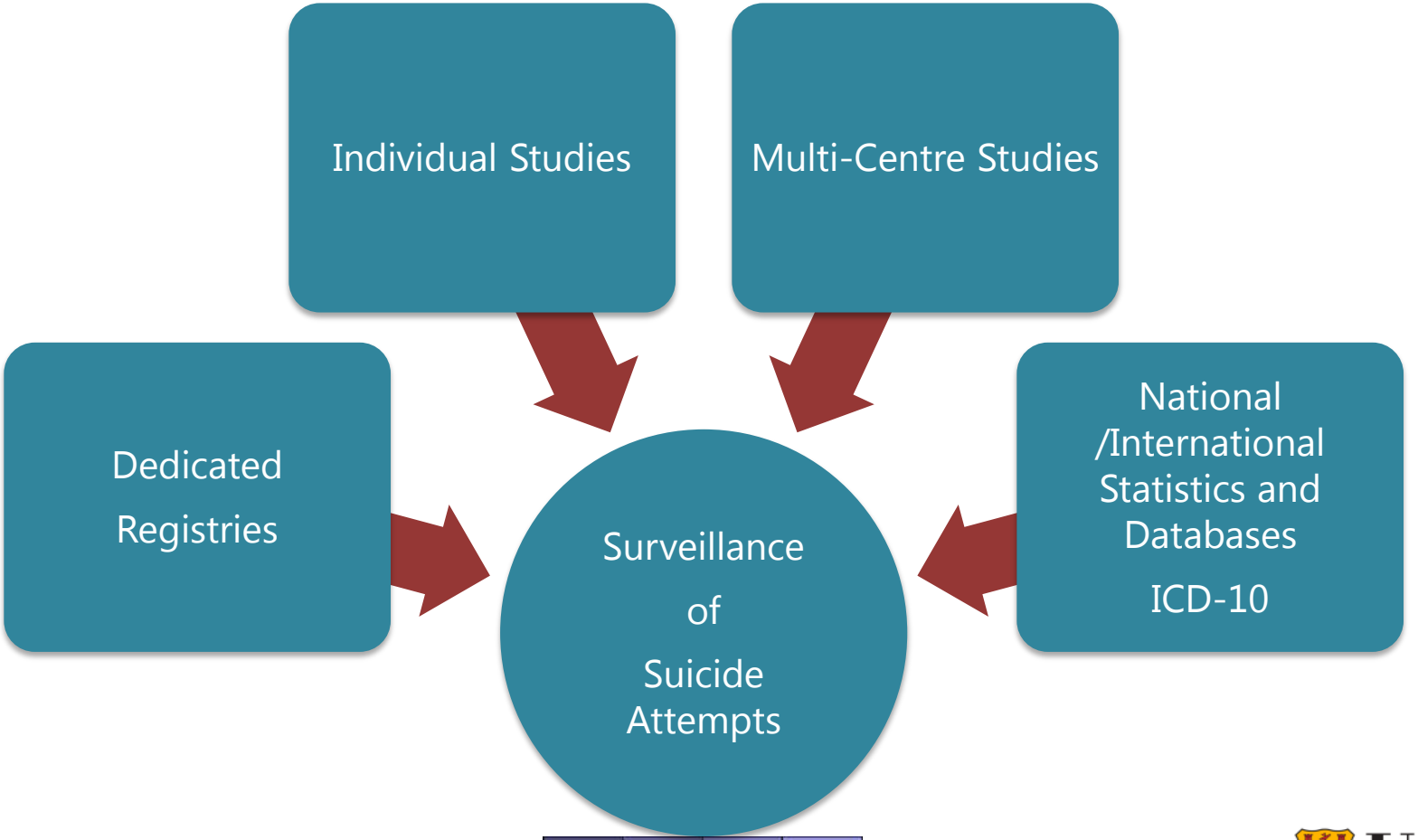
Different methods used in surveillance of hospital treated suicide attempts



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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

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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*

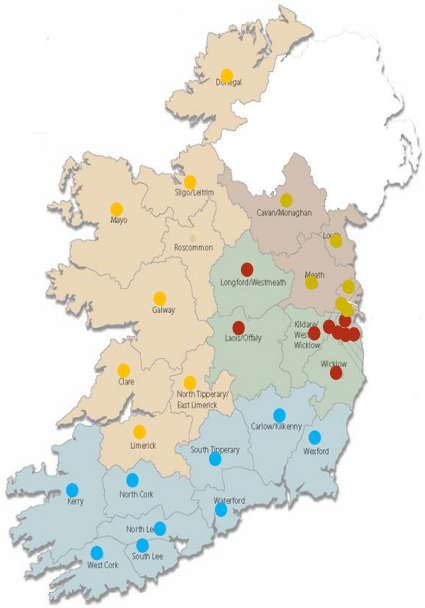
Vignette – example 2

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

Trends in self-harm, 2004-2016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IJEA

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Original article

Original article

Impact of the economic recession and subsequent austerity on suicide and self-harm in Ireland: An interrupted time series analysis

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Abstract

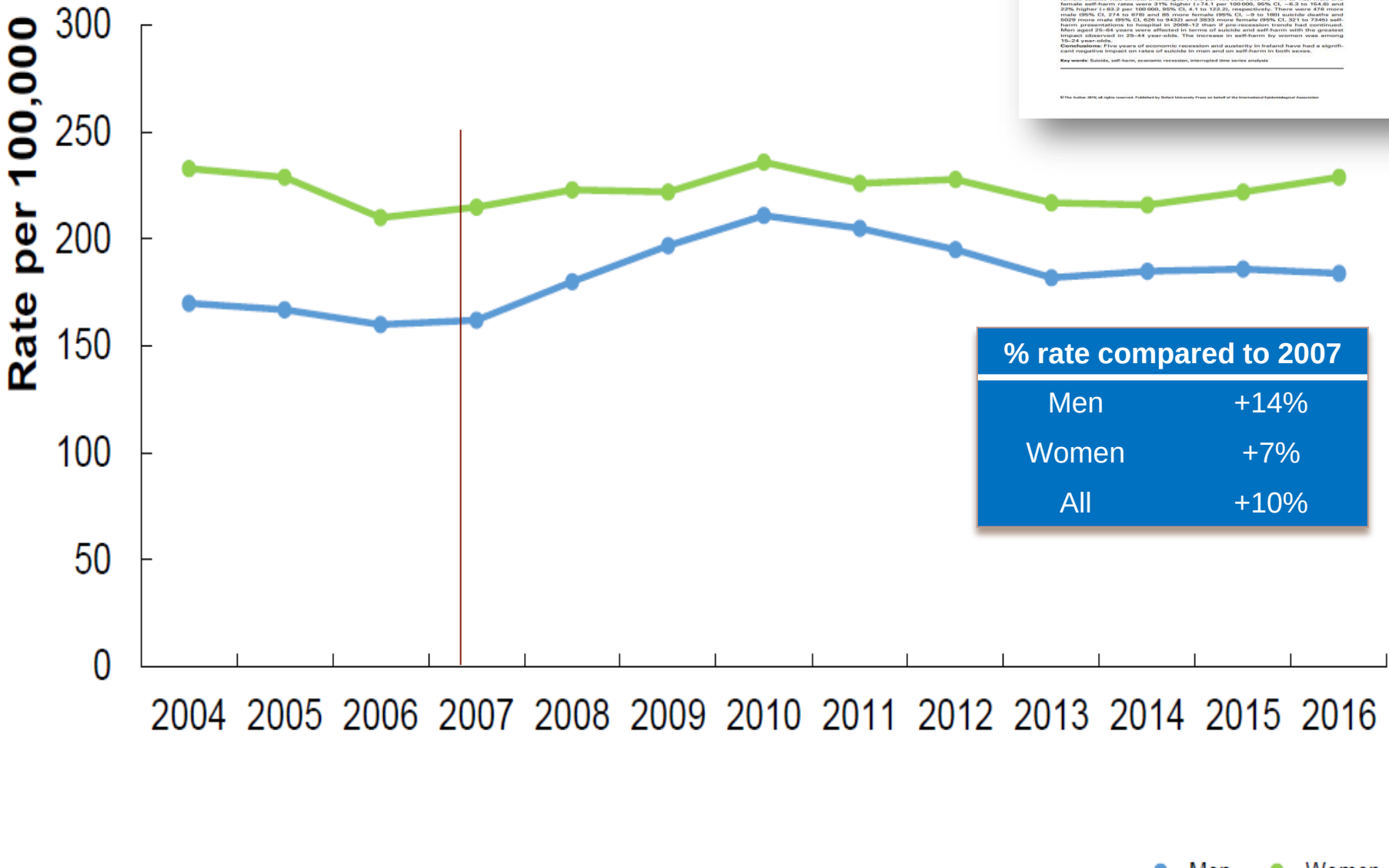
Background: The recent economic recession has been associated with short-term increases in suicide in many countries. Data are lacking on the longer-term effect on suicide and on the impact on non-fatal suicidal behaviour.

Methods: Using interrupted time series analyses, we have assessed the impact of economic recession and austerity in Ireland on national rates of suicide mortality and self-harm presentations to hospital in 2008–12.

Results: By the end of 2012, the male suicide rate was 57% higher (+8.7 per 100 000, 95% confidence interval (CI), 4.8 to 12.5) than if the pre-recession trend continued, whereas female suicide was almost unchanged (+0.3 per 100 000, 95% CI, −1.1 to 1.8). Male and female self-harm rates were 31% higher (+74.1 per 100 000, 95% CI, −6.3 to 154.4) and 23% higher (+63.2 per 100 000, 95% CI, 4.1 to 122.2), respectively. There were 476 more male (95% CI, 274 to 678) and 85 more female (95% CI, −9 to 180) suicide deaths and 5029 more male (95% CI, 626 to 9432) and 3833 more female (95% CI, 321 to 7345) self-harm presentations to hospital in 2008–12 than if pre-recession trends had continued. Men aged 25–64 years were affected in terms of suicide and self-harm with the greatest impact observed in 25–44 year-olds. The increase in self-harm by women was among 15–24 year-olds.

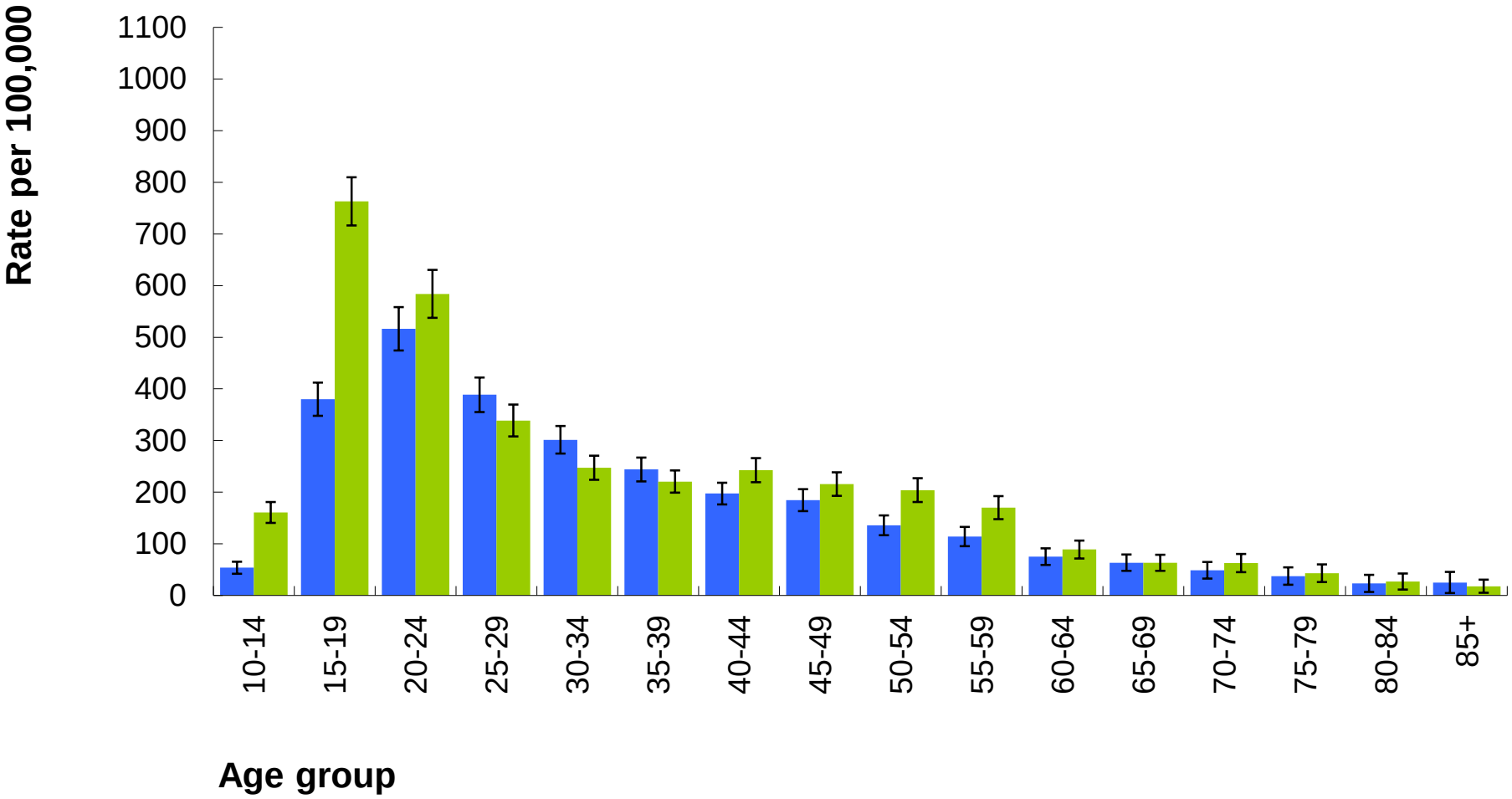
Conclusions: Five years of economic recession and austerity in Ireland have had a significant negative impact on rates of suicide in men and on self-harm in both sexes.

Key words: Suicide, self-harm, economic recession, interrupted time series analysis



% rate compared to 2007	
Men	+14%
Women	+7%
All	+10%

Self-harm by age and gender, 2016



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Alcohol involvement in self-harm

- 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

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The involvement of alcohol in hospital-treated self-harm and associated factors: findings from two national registries

Eve Griffin[1], Ella Arensman[1,2], Ivan J Perry[2], Brendan Bonner[3], Denise O'Hagan[3], Caroline Daly[1], Paul Corcoran[2,4]

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ABSTRACT

Background Alcohol is often involved in hospital-treated self-harm. Therefore it is important to establish the role of alcohol in self-harm as well as to identify associated factors, in order to best inform service provision.

Methods Data on self-harm presentations to hospital emergency departments in Ireland and Northern Ireland from April 2012 to December 2013 were analysed. We calculated the prevalence of alcohol consumption in self-harm. Using Poisson regression models, we identified the factors associated with having consumed alcohol at the time of a self-harm act.

Results Alcohol was present in 43% of all self-harm acts, and more common in Northern Ireland (50 versus 37%). The factors associated with alcohol being involved were being male, aged between 25 and 64 years, and having engaged in a drug overdose or attempted drowning. Presentations made out-of-hours were more likely to have alcohol present and this was more pronounced for females. Patients with alcohol on board were also more likely to leave without having been seen by a clinician.

Conclusions This study has highlighted the prevalence of alcohol in self-harm presentations, and has identified factors associated with presentations involving alcohol. Appropriate out-of-hours services in emergency departments for self-harm presentations could reduce the proportion of presentations leaving without being seen by a clinician and facilitate improved outcomes for patients.

Keywords alcohol, emergency care, mental health

Introduction

The relationship between alcohol and suicidal behaviour is well established.[1,2] A recent study found that premature, alcohol-related deaths were nine times more likely among those who engage in self-harm compared to the general population.[3] Furthermore, acute alcohol consumption is linked to impulsive suicidal behaviours.[4,5] One in ten self-harm patients have an alcohol dependency and alcohol misuse is associated with between 23 and 36% of acts.[6,7] Alcohol is often consumed prior to or during an act of self-harm, with reported involvement ranging from 26 to 60%.[7–9]

Alcohol consumed during a self-harm act poses specific challenges for the management and assessment of self-harm patients in acute hospital settings. Having alcohol on board may lead to delayed assessment following a self-harm act as well as posing difficulties for medical staff in treating such patients.[6] Co-morbidity and dual diagnoses add further complexity. Therefore, it is important to establish a profile of self-harm patients who present to emergency departments (EDs) following self-harm where alcohol is involved.

In this study, data from the National Self-Harm Registry Ireland and the Northern Ireland Registry of Self-Harm are utilized. We have previously established the incidence of

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Denise O'Hagan, Consultant in Public Health Medicine
Caroline Daly, PhD Researcher
Paul Corcoran, Senior Lecturer

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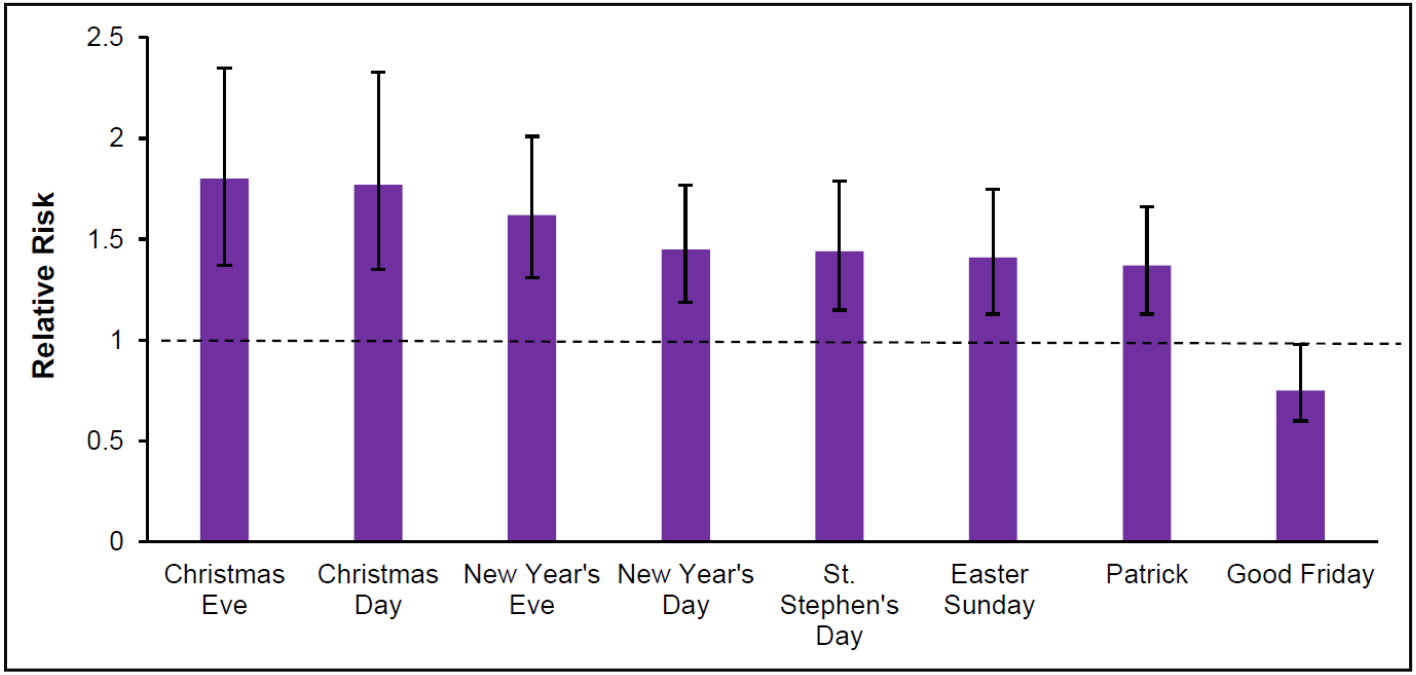
Self-harm on public holidays

- 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 an 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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IJEA

Original article

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Psychiatry Psychiatr Epidemiol
DOI 10.1007/s00127-014-0997-z

ORIGINAL PAPER

The iceberg of suicide and self-harm in Irish adolescents: a population-based study

Elaine M. McMahon · Helen Keeley · Mary Cannon · Ella Arensman · Ivan J. Perry · Mary Clarke · Derek Chambers · Paul Corcoran


Other topics

Characteristics of small areas with high rates of hospital-treated self-harm: deprived, fragmented and urban or just close to hospital? A national registry study

I B O'Farrell,[1] P Corcoran,[2] I J Perry[1]


BMC Psychiatry

RESEARCH ARTICLE Open Access

Risk of repeated self-harm and associated factors in children, adolescents and young adults

Marco Bernasconi, Elaine McMahon, Paul Corcoran, Eve Griffin and Ella Arensman


The involvement of alcohol in hospital-treated self-harm and associated factors: findings from two national registries

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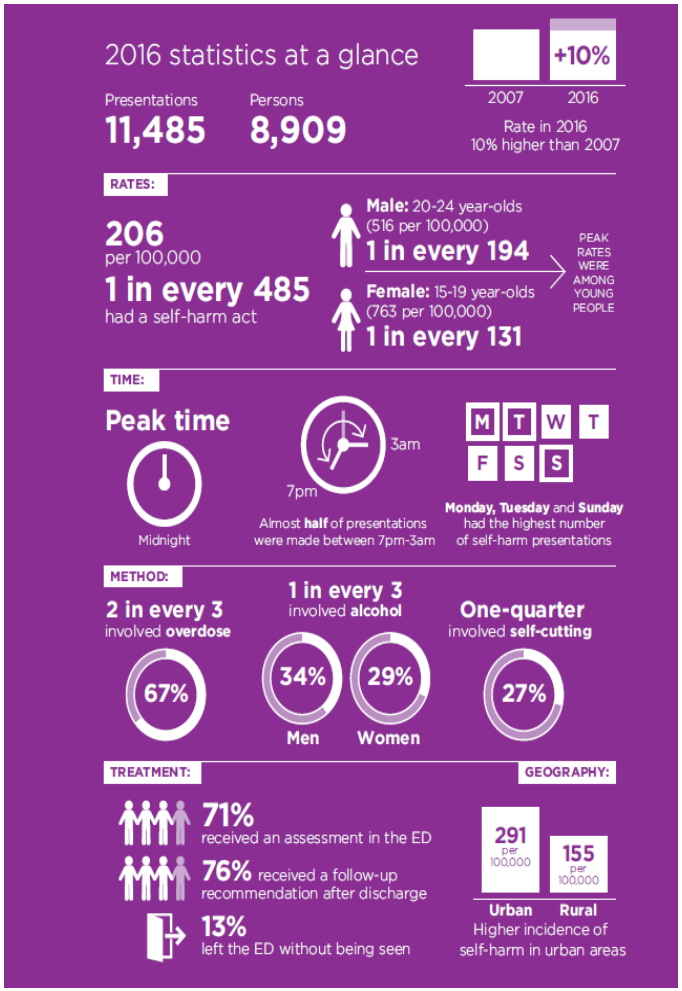

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Challenges

? 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)

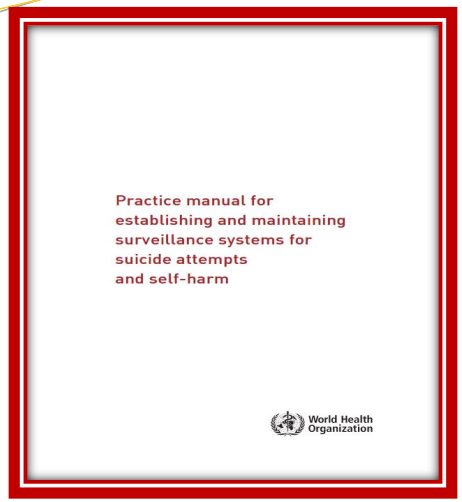
? Motivating hospitals

✓ Quarterly reporting on hospital data

✓ Presentations for staff

✓ Allowing access to data for research

Any country-specific needs / challenges?



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Ms Justina Hurley

Mr Niall McTernan

Dr Christina Dillon

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