

PREVENTING SUICIDE

A RESOURCE FOR NON-FATAL SUICIDAL BEHAVIOUR CASE REGISTRATION



Department of Mental Health and Substance Abuse
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FOREWORD

Suicide is a complex phenomenon that has attracted the attention of philosophers, theologians, physicians, sociologists and artists over the centuries. It is estimated that almost one million deaths are due to suicide every year, the majority of which occur in low- and middle-income countries. Many of those who attempt suicide require medical attention and they are at high risk for completing suicide. As suicide is the second leading cause of death globally for 10-24 year olds, there is a massive loss of young people to societies around the world, which does not take into account the ripple effect suicide has on the lives of many families, friends, colleagues, and communities.

As a serious public health problem it demands our attention, but its prevention and control, unfortunately, are no easy task. State-of-the-art research indicates that the prevention of suicide, while feasible, involves a whole series of activities, ranging from the provision of the best possible conditions for bringing up our children and youth, through the effective treatment of mental disorders, to the environmental control of risk factors. Appropriate dissemination of information and awareness-raising are essential elements in the success of suicide prevention programmes.

In 1999 WHO launched the SUPRE programme (Suicide Prevention), its worldwide initiative for the prevention of suicide. This booklet is one of a series of resources prepared as part of SUPRE and addressed to specific social and professional groups that are particularly relevant to the prevention of suicide (primary health care workers, media professionals, etc.). It represents a link in a long and diversified chain involving a wide range of people and groups, including health professionals, educators, social agencies, governments, legislators, social communicators, law enforcers, families and communities. After the publication of a booklet on suicide case registration, this booklet more specifically is aimed at staff in hospital emergency departments or other emergency-care settings and at the diverse health-care providers attending to

persons who harmed themselves as well as the relevant administrators responsible for registries.

The resources are now being widely disseminated, in the hope that they will be translated and adapted to local conditions - a prerequisite for their effectiveness. Comments and requests for permission to translate and adapt them will be welcome.

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Introduction

The depth of our knowledge on suicide prevention relies on the quality of the data on suicide mortality and non-fatal suicidal behaviour available to researchers. Many countries have national systems to record, collect and process information related to suicide (mortality registries); yet, very few have an equivalent system specifically dedicated to non-fatal suicidal behaviour (sometimes referred to as morbidity registers).

The lack of non-fatal suicidal behaviour registries leaves a large gap in our understanding of not only the number of non-fatal cases, but also the dimension of suicide, because available research indicates that non-fatal suicidal behaviour is the strongest predictor of suicide. Therefore, it would be crucially important for each country to try to create a national registry of non-fatal suicidal behaviour/attempted suicide¹.

The objective of this booklet is to advocate for taking non-fatal suicidal behaviour more seriously and to put it on the agenda, as it has been overshadowed by death from suicide or forgotten about altogether. However, non-fatal suicidal behaviour needs to find its place in registration systems as well as in any planning and shaping of health care and suicide prevention efforts due to its relevance as a risk factor for suicide and the suffering it causes to individuals, families, and communities. It is not an easy, but a complex task to register cases of non-fatal suicidal behaviour which should not be an excuse for not making every effort to capture it as much as possible.

¹ As many people are familiar with the term “attempted suicide”, in this document it is used interchangeably with non-fatal suicidal behaviour, acknowledging the complexities involved as outlined in the following sections.

What information to record in non-fatal suicidal behaviour registries

The most convenient way to record non-fatal suicidal behaviour is by registration in health facilities, even if this represents only a partial picture of the real dimension of the problem, with a large number of self-harmers never entering in contact with health facilities. However, health facility records would constitute a valuable source of information. This is the reason why this booklet is primarily addressed at staff in hospital emergency departments or other emergency-care settings and at the diverse health-care providers attending to persons who harmed themselves as well as the relevant administrators responsible for registries.

Essentially, every health facility should have a unique identification number for each person who enters as a way to distinguish those who repeat non-fatal suicidal behaviour from those who present only once; this would also capture people moving from one area to another, and assist in linking morbidity data with mortality data. Establishing a unique identification for each individual is also a key to understanding patterns in prevalence of non-fatal suicidal behaviour (single episode and repeats). In Appendix A, an example of a possible series of variables to be recorded is shown.

At minimum, a registration system for non-fatal suicidal behaviour should aim to capture basic information such as:

- Sex;
- Age;
- Method of non-fatal suicide (using ICD-10 codes, refer to Appendix B);
- Date of non-fatal suicidal behaviour;
- Time of non-fatal suicidal behaviour;

- Place of residence;
- Statement on intention to die and, possibly, other intentions;
- Lethality of method;
- History of non-fatal suicidal behaviour (previous suicide attempts).

Aside from this basic information, it would be also useful to gather information that may help reconstruct the circumstances preceding the non-fatal suicidal behaviour. Areas for further investigation may include (but are not limited to):

- Nationality;
- Country of origin;
- Mental disorder(s);
- Alcohol or drug use;
- Chronic pain and/or physical illness;
- History of physical or mental health treatment(s);
- Acute emotional distress (e.g. adverse life experience such as recent break up in relationship, family discord, job loss, financial difficulties, etc.);
- Sexual orientation (e.g. homosexual, heterosexual, bisexual, transsexual);
- Ethnicity (ethnic origin as adapted to the local context);
- Marital status;
- Employment status at the time of non-fatal suicidal behaviour;
- Socio-economic status;
- Suicide in the family;
- Non-fatal suicidal behaviour in the family;
- Knowledge of suicidal behaviour in peers/friends;
- Knowledge of suicidal behaviour from the internet or other media.

It should be noted that factors related to non-fatal suicidal behaviour are likely to differ according to the cultural, economic and social context, as demonstrated by transcultural comparisons (Fleischmann et al., 2005).

How to avoid double counting

It is important that the person in charge of recording data pays attention to the distinction between “persons” or “actors” and “episodes” or “events”. In fact, the same individual can make several non-fatal suicidal behaviours during the same calendar year (“repeater”). If not accurately noted, this might generate confusion in data analysis and interpretation and lead to an over-estimate of the number of individuals involved in non-fatal suicidal behaviour. The repetition of suicidal acts is frequently observed in clinical practice; consequently, a clear identification of a single person involved is of primary importance, together with an accurate counting of the number of episodes for the same person.

Electronic databases require that demographics of persons are carefully reported and implemented. Errors in the transcription of names or dates of birth may artificially duplicate the number of non-fatal suicidal behaviour actors and, eventually, lead to difficulties in tracing repeaters.

Examples of non-fatal suicidal behaviour registries

There have been several efforts to document non-fatal suicidal behaviour. The WHO/EURO Multicentre Study on Parasuicide in the 90s is a prominent example of an international study with data collection on non-fatal suicidal behaviour from designated centres within countries. In general, those centres did not represent countries, but were able to perform the study and provide identifiable catchment areas

from which the rates of non-fatal suicidal behaviour were calculated. In this study, parasuicide was defined as:

“An act with a non-fatal outcome in which an individual deliberately initiates a non-habitual behaviour that, without intervention from others, will cause self-harm, or deliberately ingests a substance in excess of the prescribed or generally recognised therapeutic dosage, and which is aimed at realising changes which the subject desired, via the actual or expected physical consequences” (Platt et al., 1992).

At the conclusion of the study, there was an effort to make the definition simpler while retaining the essential characteristics of the old one, which led to the definition of non-fatal suicidal behaviour as:

“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).

The WHO/EURO Multicentre Study on Parasuicide found its continuation in the Monitoring Suicide in Europe (MONSUE) project in the 90s and 2000s. Regardless of the termination of the study, some of the centres involved continued to collect data, e.g. the centre in Padua, Italy, the Centre for Suicide Research and Prevention of Mental Ill-Health at Karolinska Institutet, Sweden, and the Suicide Research Centre in Oxford, United Kingdom of Great Britain and Northern Ireland.

Other examples of international studies are the WHO Multisite Intervention Study on Suicidal Behaviours (SUPRE-MISS) in the early 2000s, and the WHO/WPRO Suicide Trends in At-Risk Territories (START) study. The latter was initiated in 2007 in the Western Pacific Region of the World

Health Organization. By now it is in operation on a wider geographical scale, and specifically aims at establishing an effective and reliable registration and monitoring system for both fatal and non-fatal suicidal behaviour.

To date, there is knowledge of only one national registry for deliberate self-harm, located in Ireland. This registry has been running since 2006, with full coverage of all general and paediatric hospital emergency departments of the country (Perry et al., 2012).

Assuming that health facility-based registries for non-fatal suicidal behaviour have the limitation of not capturing all self-harmers in the population, because only a certain proportion of them enters into contact with health facilities, another option to learn more about the burden of non-fatal suicidal behaviour would be through surveys which, however, carry their own limitations, such as non-reporting of this behaviour in the survey, for instance. It would be important to provide standardized or uniform definitions of the behaviours to the respondents in order to improve clarity and consistency across populations being surveyed. Such a survey could be carried out in a specified catchment area to provide a local picture. Ideally, a survey would opt for a nationally representative sample of the population to tell about the problem at the national level. A novelty in this direction is the inclusion of a suicidal behaviour module in the WHO STEPwise approach to surveillance (STEPS) survey. By using the same standardized questions and protocols, STEPS can be used not only for monitoring within-country trends, but also for making comparisons across countries. The approach encourages the collection of small amounts of useful information on a regular and continuing basis. It is hoped that STEPS will be picked up by many more countries and that the examples presented will eventually lead to the implementation of more national registries for non-fatal suicidal behaviour.

Use of data collected from non-fatal suicidal behaviour registries

A non-fatal suicidal behaviour case registration system can provide information about the burden of suicidal acts (both single episodes and repeats) within a country (or province/region), and instruct suicide prevention initiatives, not only at the population level, but also targeted at those most in need. The information collected in registries is relevant to a wide range of stakeholders, including:

- Government officials;
- Policy makers;
- Researchers and scholars;
- Health professionals;
- Community groups;
- Non-governmental organizations; and
- International organizations.

Whereas researchers and scholars need to analyse and interpret the data collected in the registries, health professionals are primarily the group to not only register the data, but also to apply findings into clinical practice, and potentially change clinical practice accordingly. Community groups, non-governmental and international organizations need the information to feed into the evidence base and into advocacy efforts for government officials and policy makers to react in their planning and implementation.

Providing accurate registration of non-fatal suicidal behaviour is essential in understanding the dimension of this phenomenon and its characteristics, as well as in developing and implementing interventions and strategies for those who harm themselves in order to eventually prevent suicide. Equally important is the monitoring of the data to assess trends and the use of the data for evaluation purposes.

Assessment of suicide intention

It can be quite difficult to assess whether an individual is suicidal or not. This is because people may deliberately deny or conceal their intentions, as they are afraid of possible consequences, such as admission to a psychiatric ward or stigmatization. For many self-harmers the initial point of contact with the health system is represented by an emergency department. Frequently, rooms in this type of facility do not permit sufficient privacy; the time allocated to patients might be dictated by the busyness of the moment (e.g. concomitance of other emergencies, insufficient personnel, etc.) and patients might not be in the cognitive/emotional state to allow for a reliable record even of their demographic data. However, questions about suicide intention (and all other types of intention, such as anger, cry for help, desire to escape from an unbearable situation, etc.) should be made in a sensitive manner and registered. The WHO/EURO Multicentre Study on Suicidal Behaviour collected data on more than 50,000 self-harmers, offering a unique transcultural perspective of non-fatal acts. It identified 14 different intentions behind acts, and was able to reliably demonstrate the simultaneous presence of multiple motivations in suicidal individuals (Hjelmeland et al., 2002).

In assessing the nature and severity of intent, it would be important for clinicians to take seriously any behaviour that requires careful consideration and has to be registered, such as ingestion of non-therapeutic dosages (e.g. four to five tablets) of a common over-the-counter medication, e.g. aspirin or paracetamol, or episodes (and also the number of repetitions) of superficial self-mutilation. Persons performing those acts represent a population at higher risk of suicide compared to the general population.

Traditionally, psychiatrists used to be the only health professionals considered to be able to reliably assess suicidal behaviour. However, non-specialized health workers, such as general practitioners, nurses, or social workers, can also be equipped to effectively assess suicidal behaviour with proper training (WHO, 2010). The need to extend education in the assessment and management of suicidal behaviour to non-specialists stems from the consolidated knowledge that non-fatal suicidal behaviour represents a major risk factor for subsequent fatal and non-fatal suicidal behaviour, with the greatest risk of suicide during the first 12 months after an episode of deliberate self-harm (Harriss et al., 2005).

Assessment of suicide intent can be assisted by - but never relegated only to - the administration of scales and questionnaires. Several instruments are available and some have widespread use, such as the Beck Scale for Suicide Ideation (Beck et al., 1979), the Reasons for Living Inventory (Linehan et al., 1983), the Suicide Probability Scale (Cull and Gill, 1992), or the more recent Columbia Suicide Severity Rating Scale (Posner et al., 2011).

Terminologies

Rarely, the same terminology is attributed to self-injurious behaviours, which are thus recorded under a myriad of different terms, either generic (e.g. self-injury, parasuicide, attempted suicide, etc.) or descriptive of the act (e.g. self-cutting, ingestion of caustics, self-poisoning with medications, etc.). Sometimes acronyms are present in substitution of full terms (e.g. S.A., O.D., S.H. - suicide attempt, overdose, self-harm, respectively), which may be reflective of time pressures for hospital staff and emergency department staff in particular. Sometimes, it might reflect an effort to disguise the motive for

referral, especially in countries where suicidal behaviour is highly stigmatized or prosecuted as a criminal act.

The standardization of terminologies describing suicidal behaviour has been the subject of an enduring debate, with many attempts to uniformize nomenclatures (Silverman et al., 2007a). Different motives have constituted the basis for those efforts, first of all the importance of non-fatal suicidal behaviour of all kind being a strong predictor of subsequent, fatal acts (Hawton et al., 2012). A lot of research has been dedicated to identify and differentiate intention(s) behind a non-fatal act, primarily in a prognostic perspective, in order to be able to produce reliable predictions on persisting present or future suicide risk. In the United Kingdom of Great Britain and Northern Ireland, and generally in countries of the British Commonwealth, the terminology “deliberate self-harm” has a long tradition of clinical use, while in North America “suicide attempt” has so far tended to prevail. Both have shortcomings, noted by several authors; for example, Kreitman et al. (1969) in the United Kingdom maintained that “self-harm” failed to properly identify individuals with suicide intention and substantially ignored the link with subsequent suicide. To overcome the problem, he proposed the term “parasuicide”, to combine all non-fatal suicidal behaviour into one category, without bothering to assess the true motivation of the behaviour and without preserving the link to completed suicide, which was later reflected in the original title of the WHO/EURO Multicentre Study on Parasuicide.

The term “parasuicide” created great difficulties, because it was not easily translated into other languages, as “para” means “similar to”, but also “pretending”, and these are not defining characteristics of non-fatal suicidal acts. In addition, “parasuicide” did not become the omnibus term that it was hoped to be, but instead, added confusion to registration procedures (particularly at the international level) in that it was

sometimes used interchangeably with “attempted suicide” or that it was considered to be the “light” version of attempted suicide (indicating little or no intention to die). To address some of the shortcomings of the term “parasuicide”, the outcome-based terms “fatal” and “non-fatal” suicidal behaviour were introduced by the steering group of the WHO/EURO multicentre study, and it was officially renamed into the WHO/EURO Multicentre Study on Suicidal Behaviour. “Fatal” and “non-fatal” are not meant to define the level of intent. They encompass a range of suicidal behaviour, while also respecting that the intention to die is not always present within suicidal behaviour. Basically, the new terms were introduced with the motivation that they were theory-neutral, based on purely phenomenological and descriptive criteria, free of value judgements (such as in the case, e.g. of “successful” or “failed” attempt, or in expressions like “committing suicide”), and considered to be adaptable to culturally diverse contexts.

In North America, where “self-harm” has never been a widely used term, several attempts were made to provide satisfactory nomenclatures for clinical and research purposes, the most notable of them were from O’Carroll et al. (1996) and Silverman et al. (2007b). Recently, the apparent increase in repeated self-injury cases (by self-cutters in particular) without intention to die has resulted in the proposal of a new diagnostic entity “non-suicidal self-injury” (NSSI). Several arguments were used in support of the proposition of the new diagnosis, such as the need to avoid a complete overlapping between repeated self-injury and the diagnosis of borderline personality disorder, cost savings, but also insurance reimbursements, disability payments, and eligibility for school services in young patients. The proposal for the diagnosis of non-suicidal self-injury has also received criticism. In particular, the idea that self-cutters could be at very low risk of suicide is seriously challenged by the long-term results of the Multicentre Study of Self-Harmers in England, which demonstrated that

those self-harmers are actually at higher risk of suicide than those overdosing with medication, a behavioural category excluded from the criteria for the diagnosis of non-suicidal self-injury (Hawton et al., 2012). The findings of this study underline the need for psychosocial assessment in all cases.

Adding to the complexity is the absence versus presence of suicide intention and its non-dichotomy. Patients often change the acknowledgement on the suicidal nature of their act over time, and there may be remarkable variations in the attribution of suicidal intent between patients, clinicians and relatives. Suicide intention is characterized by different degrees of intensity/severity, and is a multi-dimensional variable that involves all possible aspects of human experiences (cultural, existential, spiritual, etc.). Reducing it to a dichotomy can imply a simplification, such as the lowering of clinical attention levels on individuals considered as being without suicide intention. However, ample evidence exists on the dynamic nature of suicidal processes, and the existence of a continuum of different features of suicidal behaviour, especially in depressed patients. This approach has contributed to recognizing the increased risk of suicide in those who self-harm, even if there are uncertainties about intent determination.

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Appendix A: Example registration form for non-fatal suicidal behaviour/attempted suicide

Date of case registration (Day / Month / Year):	Not applicable	Unknown
Country/province/state:		
City or sample area:		
Case name (if authorized):		
Case identification number (assigned):		
Residential address:		
Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transsexual		
Date of birth (Day / Month / Year):		
Age (in years):		
Date of non-fatal suicidal behaviour (Day / Month / Year):		
Day of the week of non-fatal suicidal behaviour:		
Time of non-fatal suicidal behaviour (Hour / Minute):		
Location of non-fatal suicidal behaviour:		
Time entered in hospital (Hour / Minute):		
Non-fatal suicide method(s) used (according to ICD-10 codes):		
Description of non-fatal suicide method(s) and its (their) lethality:		
Statement of intention to die (Yes / No):		
Description of intent:		
History of non-fatal suicidal behaviour (previous suicide attempts):		
Time left hospital (Hour / Minute):		
Any diagnosis associated with the patient:		

Appendix B: ICD-10 codes for intentional self-harm

- X60 Intentional self-poisoning by and exposure to nonopioid analgesics, antipyretics and antirheumatics
- X61 Intentional self-poisoning by and exposure to antiepileptic, sedative-hypnotic, antiparkinsonism and psychotropic drugs, not elsewhere classified
- X62 Intentional self-poisoning by and exposure to narcotics and psychodysleptics (hallucinogens), not elsewhere classified
- X63 Intentional self-poisoning by and exposure to other drugs acting on the autonomic nervous system
- X64 Intentional self-poisoning by and exposure to other and unspecified drugs, medicaments and biological substances
- X65 Intentional self-poisoning by and exposure to alcohol
- X66 Intentional self-poisoning by and exposure to organic solvents and halogenated hydrocarbons and their vapours
- X67 Intentional self-poisoning by and exposure to other gases and vapours
- X68 Intentional self-poisoning by and exposure to pesticides
- X69 Intentional self-poisoning by and exposure to other and unspecified chemicals and noxious substances
- X70 Intentional self-harm by hanging, strangulation and suffocation
- X71 Intentional self-harm by drowning and submersion
- X72 Intentional self-harm by handgun discharge
- X73 Intentional self-harm by rifle, shotgun and larger firearm discharge
- X74 Intentional self-harm by other and unspecified firearm discharge
- X75 Intentional self-harm by explosive material
- X76 Intentional self-harm by smoke, fire and flame
- X77 Intentional self-harm by steam, hot vapours and hot objects
- X78 Intentional self-harm by sharp object
- X79 Intentional self-harm by blunt object
- X80 Intentional self-harm by jumping from a high place
- X81 Intentional self-harm by jumping or lying before moving object
- X82 Intentional self-harm by crashing of motor vehicle
- X83 Intentional self-harm by other specified means
- X84 Intentional self-harm by unspecified means

Appendix C: Summary of key points

ESTABLISHING A CASE REGISTRATION SYSTEM FOR NON-FATAL SUICIDAL BEHAVIOUR:

KEY POINTS

- Clear assessment of non-fatal suicidal behaviour.
- Accurate registration practices using the ICD-10 codes for intentional self-harm.
- Collection of case information using a standardized recording form.
- Linking the non-fatal suicidal behaviour registry with the suicide mortality registry.
- Non-fatal suicidal behaviour is a major risk factor for suicide.
- Registering and documenting non-fatal suicidal behaviour cases is of crucial importance in designing suicide prevention programmes and strategies.