The Role of Self-Harm Surveillance in Suicide Prevention within International Context

3-5th May 2022

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Overview

- Benefits of real-time surveillance systems
- Nomenclature, definitions and classification
- Standard Operating Procedures
- Recent initiatives in establishing self-harm surveillance systems in low and middle income countries
- The importance of self-harm surveillance during public health emergencies

Acknowledgements

- National Suicide Research Foundation & School of Public Health, University College Cork
- Australian Institute for Suicide Research and Prevention, Griffith University, Brisbane
- Health Research Board Ireland
- National Office for Suicide Prevention Ireland
- International COVID-19 Suicide Prevention Research Collaboration (ICSPRC)

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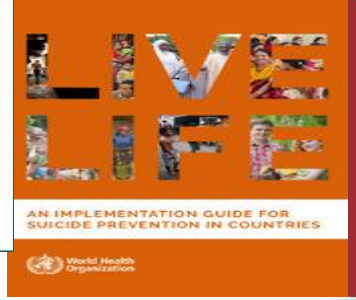
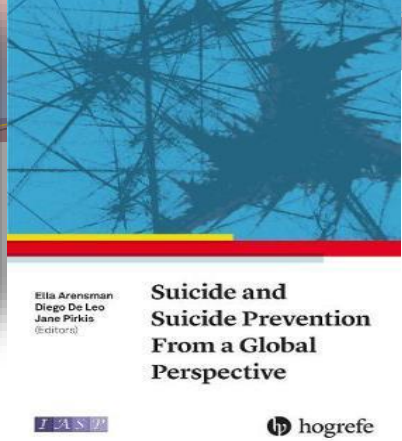
Background





- WHO Global Report on Preventing Suicide identified a need for guidance on surveillance of suicide attempts presenting to general hospitals (WHO, 2021; 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

- Information on trends and patterns of attempted suicide presentation can contribute to effective suicide prevention strategies

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Increasing interest from Low and Middle Income Countries to establish a self-harm surveillance system

Guidance on establishing and maintaining a self-harm surveillance system

- Iran
- Ecuador
- Guyana
- Trinidad-Tobago
- Suriname
- Kazakhstan
- Namibia

Large countries: Recommend Multi-centre self-harm surveillance system;
Small countries: Recommend National Self-Harm Surveillance System

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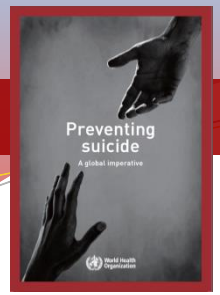

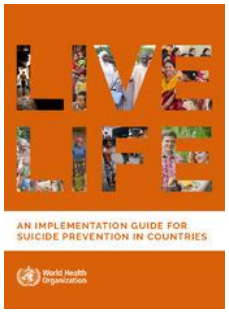

World Health Organization

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

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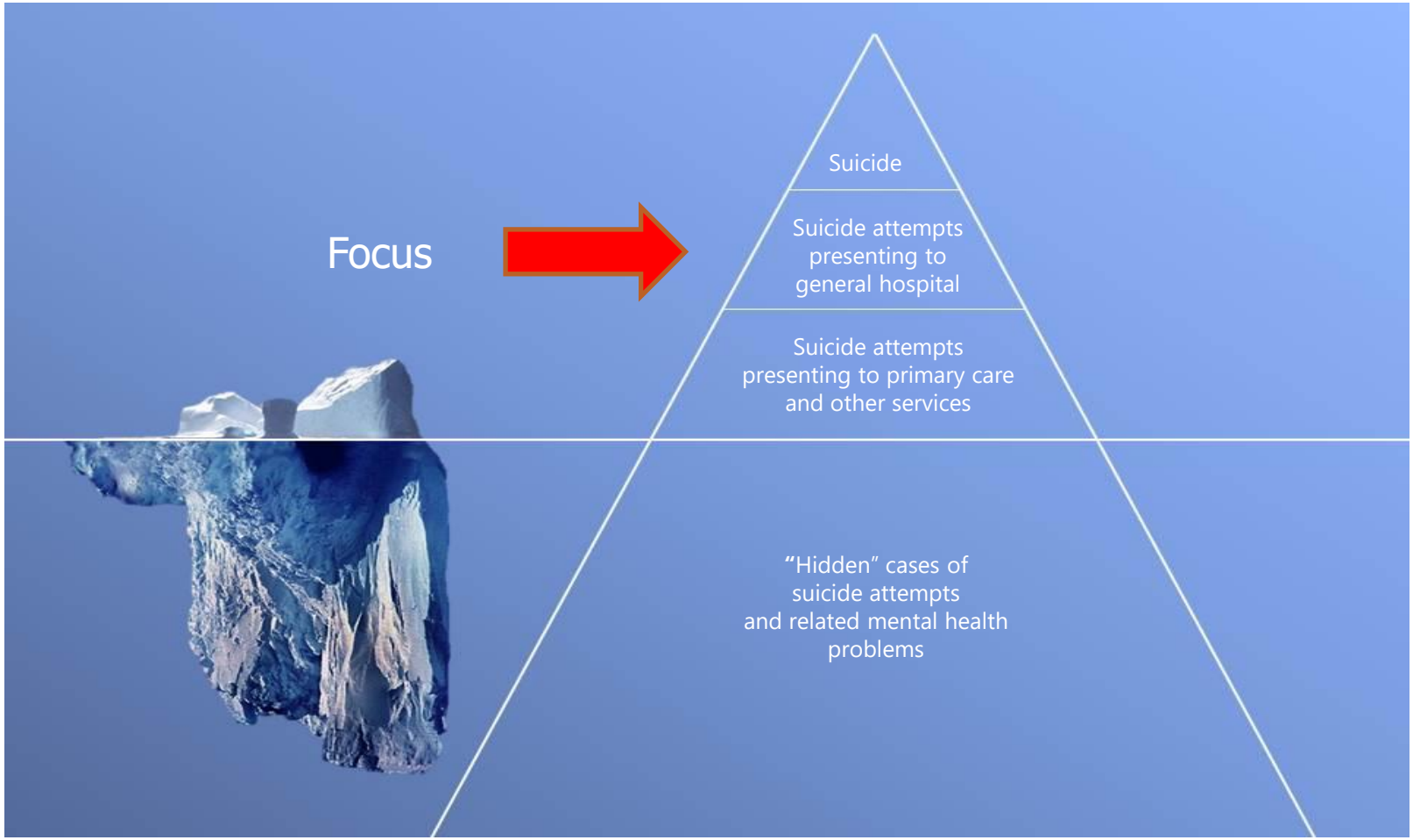
Focus on self-harm/suicide attempt presentations to general hospital



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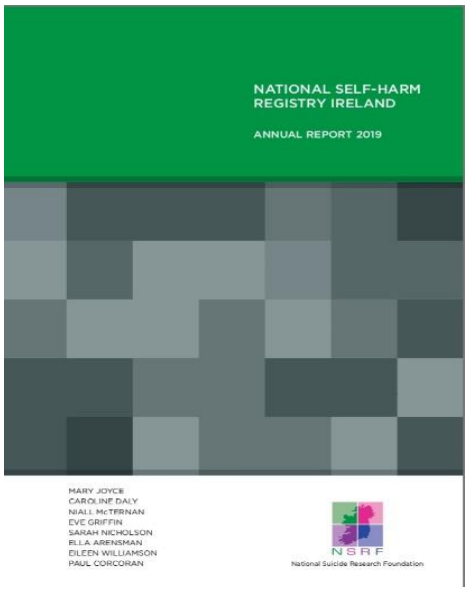
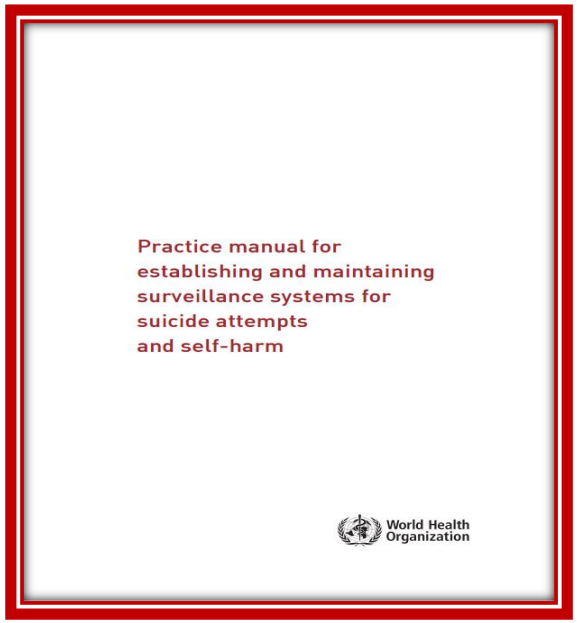
Establishing and maintaining Suicide Attempt/Self-harm Surveillance Systems





http://www.who.int/mental_health/suicide-revention/attempts_surveillance_systems/en/

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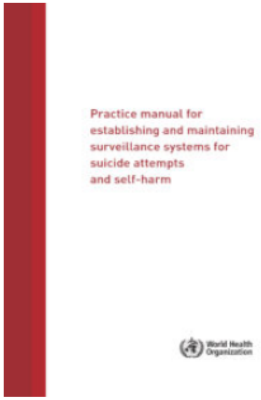
Establishing and Maintaining Surveillance Systems for Suicide Attempts and Self-Harm

The WHO Collaborating Centre for Surveillance and Research in Suicide Prevention at the National Suicide Research Foundation has developed a new E-Learning Programme based on the World Health Organisation Practice Manual for Establishing and Maintaining Surveillance Systems for Suicide Attempts and Self-Harm. This E-Learning programme was developed in collaboration with the WHO Department of Mental Health and Substance Abuse.



Course Content

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Module list

- Module 1: Background and Terminology
- Module 2: Development and Implementation
- Module 3: Training for Staff
- Module 4: Reporting of Surveillance Outcomes and Dissemination, Maintenance and Sustainability
- Module 5: Overview of Existing Surveillance Systems or Projects for Suicide Attempts and Self-Harm
- Supplementary Material

https://suicideresearchpreventionelearning.com/?sfwd-courses=establishing-and-maintaining-surveillance-systems-for-suicide-attempts-and-self-harm

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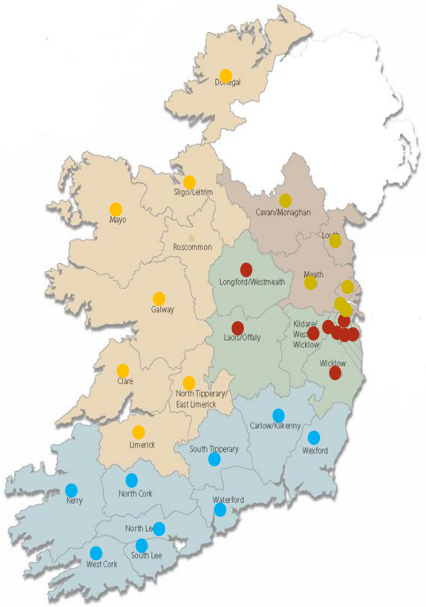
National Self-Harm Registry Ireland

- Operated by the National Suicide Research Foundation
- Full coverage since 2006 (24 hospitals)

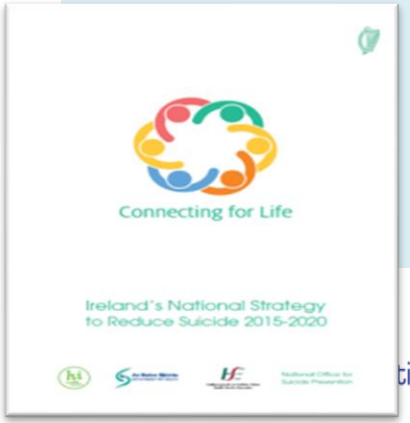


Northern Ireland Registry of Self-Harm

- Established in **2007** as a pilot project in the Western area
- Expanded to all trust areas (12 hospitals) since April 2012

Benefits of surveillance systems for hospital/health centre treated 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



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Social Psychiatry and Psychiatric Epidemiology (2018) 53:663–671
https://doi.org/10.1007/s00127-018-1522-1

ORIGINAL PAPER

Increasing rates of self-harm among children, adolescents and young adults: a 10-year national registry study 2007–2016

Eve Griffin[1] · Elaine McMahon[1] · Fiona McNicholas[2,3,4] · Paul Corcoran[1,5] · Ivan J. Perry[5] · Ella Arensman[1,5]

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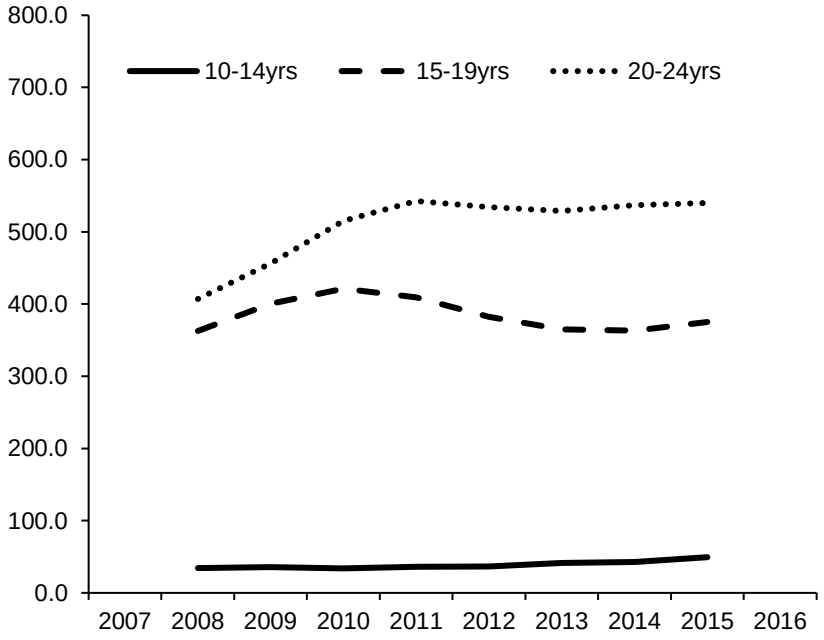
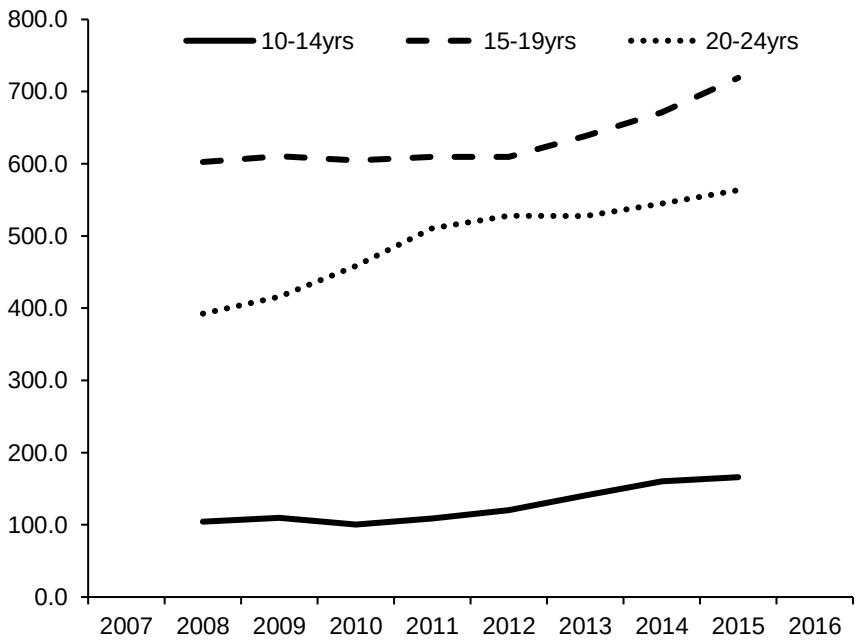
Abstract
Purpose Rates of hospital-treated self-harm are highest among young people. The current study examined trends in rates of self-harm among young people in Ireland over a 10-year period, as well as trends in self-harm methods.
Methods Data from the National Self-Harm Registry Ireland on presentations to hospital emergency departments (EDs) following self-harm by those aged 10–24 years during the period 2007–2016 were included. We calculated annual self-harm rates per 100,000 by age, gender and method of self-harm. Poisson regression models were used to examine trends in rates of self-harm.
Results The average person-based rate of self-harm among 10–24-year-olds was 318 per 100,000. Peak rates were observed among 15–19-year-old females (564 per 100,000) and 20–24-year-old males (448 per 100,000). Between 2007 and 2016, rates of self-harm increased by 22%, with increases most pronounced for females and those aged 10–14 years. There were marked increases in specific methods of self-harm, including those associated with high lethality.
Conclusions The findings indicate that the age of onset of self-harm is decreasing. Increasing rates of self-harm, along with increases in highly lethal methods, indicate that targeted interventions in key transition stages for young people are warranted.

Keywords Self-harm · Young people · Epidemiology

Male



Female



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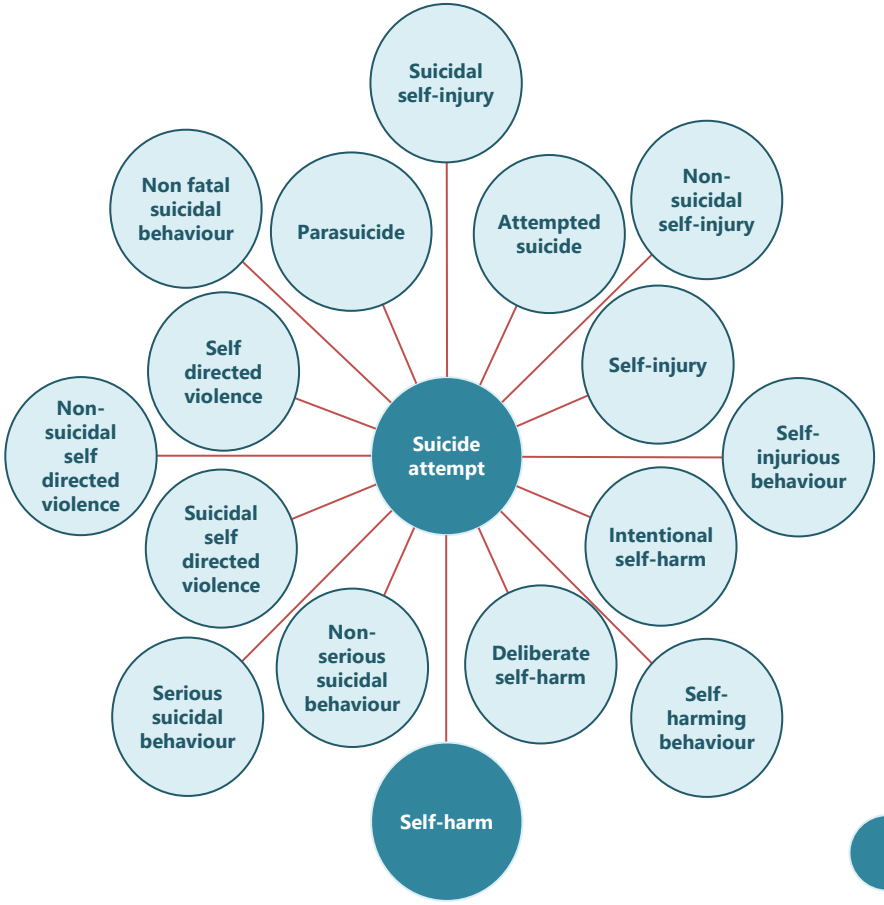
Nomenclature, definitions and classification - Challenges

- 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



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Proposed terminology and definition

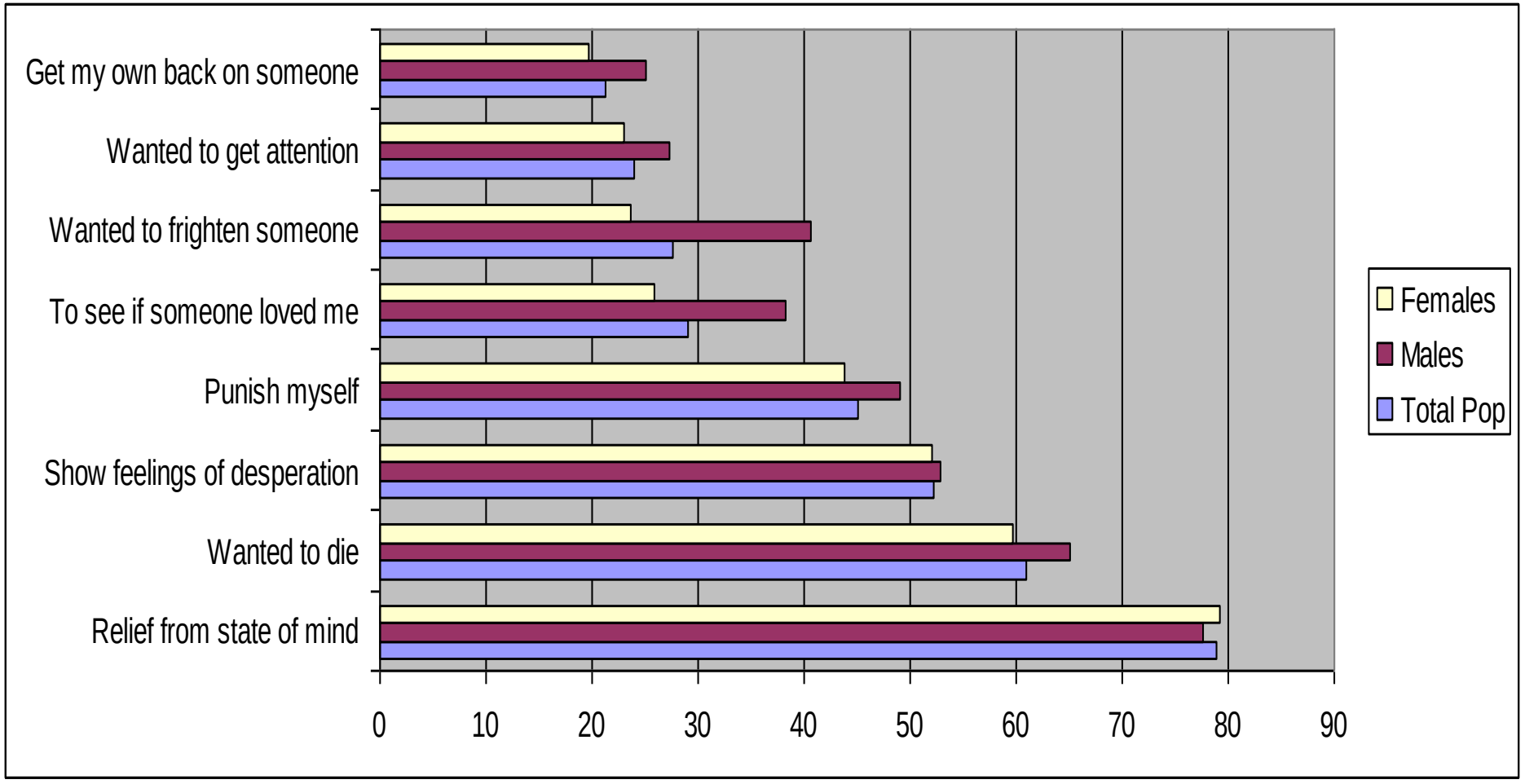
- The terms ‘self-harm’ or ‘self-harming behaviour’ offer the most common ground internationally

- 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)

Motives related to self-harm by gender



Scoliers et al, 2009; Rasmussen et al, 2016

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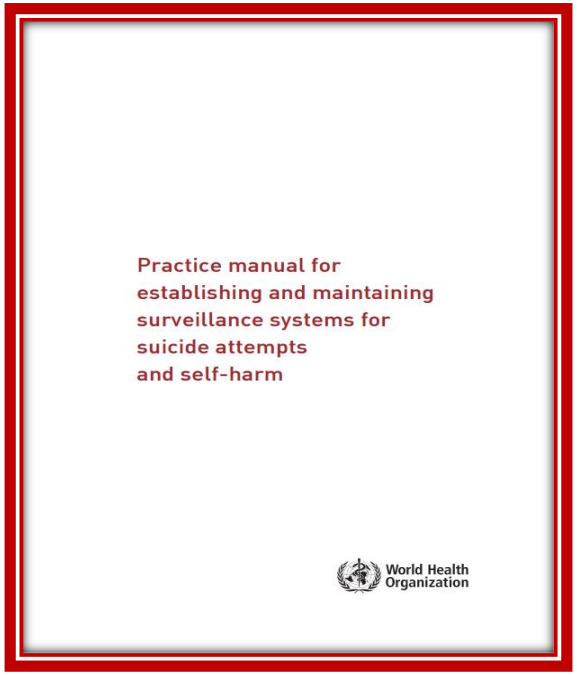
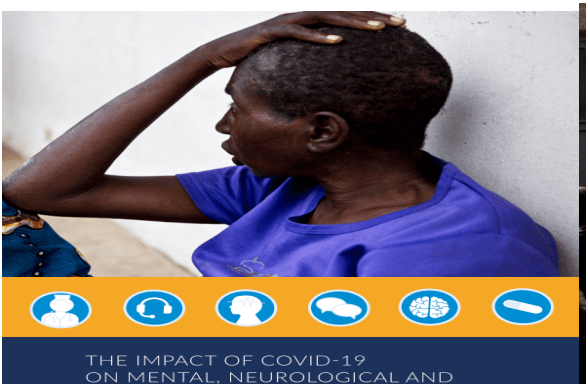
Importance of Standard Operating Procedures

- Ensure transparency in data collection
- Allow for comparison across regions and countries
- Outline roles for staff working on the system
- Standardise how:
  - Cases are identified
  - Inclusion/exclusion criteria are applied
  - Data is collected
  - Data is recorded/ uploaded
- Uniformity of surveillance systems



Access to self-harm surveillance data during public health emergencies

- Risk of increasing trends of self-harm during and after public health emergencies, in particular among vulnerable groups
- Access to self-harm surveillance data will facilitate timely and effective responses and can prevent an increasing trend
- Access to self-harm surveillance data will facilitate monitoring and evaluation of the effectiveness of responses and interventions during public health emergencies





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Research paper

Self-harm during the early period of the COVID-19 pandemic in England: Comparative trend analysis of hospital presentations

Keith Hawton [a,b,*], Deborah Casey [a], Elizabeth Bale [a], Fiona Brand [a], Jennifer Ness [c], Keith Waters [c], Samantha Kelly [c], Galit Geulayov [a]

[a] Centre for Suicide Research, Department of Psychiatry, University of Oxford, Warneford Hospital, OX3 7JX, UK
[b] Oxford Health NHS Foundation Trust, Warneford Hospital, Oxford OX3 7JX, UK
[c] Centre for Self-harm and Suicide Prevention Research, Derbyshire Healthcare NHS, Foundation Trust, Derby, UK

ABSTRACT

Background: The COVID-19 pandemic and public health measures necessary to address it may have major effects on mental health, including on self-harm. We have used well-established monitoring systems in two hospitals in England to investigate trends in self-harm presentations to hospitals during the early period of the pandemic.

Method: Data collected in Oxford and Derby on patients aged 10 years and over who received a psychosocial assessment after presenting to the emergency department following self-harm were used to compare trends during the three-month period following lockdown in the UK (23rd March 2020) to the period preceding lockdown and the equivalent period in 2019.

Results: During the 12 weeks following introduction of lockdown restrictions there was a large reduction in the number of self-harm presentations to hospitals by individuals aged 10 years and over compared to the pre-lockdown weeks in 2020 (mean weekly reduction of 13.5 (95% CI 5.6 - 21.4) and the equivalent period in 2019 (mean weekly reduction of 10.0 (95% CI 13.9 - 22.1). The reduction was greater in females than males, occurred in all age groups, with a larger reduction in presentations following self-poisoning than self-injury.

Conclusions: A substantial decline in hospital presentations for self-harm occurred during the three months following the introduction of lockdown restrictions. Reasons could include a reduction in self-harm at the community level and individuals avoiding presenting to hospital following self-harm. Longer-term monitoring of self-harm behaviour during the pandemic is essential, together with efforts to encourage help-seeking and the modification of care provision.

1. Introduction

The challenges to health and society posed by the COVID-19 pandemic are huge. Understandably, while the initial focus was on physical health and prevention of spread of the disease and of deaths, attention has also increasingly turned to the potential mental health consequences of the pandemic (Holmes et al., 2020), including the possible impacts on suicidal behavior (Gunnell et al., 2020; Reger et al., 2020; Niederkrotenthaler et al., 2020). Concerns have been expressed about the psychological consequences of the necessary public health measures, including lockdown and social distancing (Brooks et al., 2020; Pierce et al., 2020). Lockdown was introduced in the UK on March 23rd 2020, easing of lockdown in England being announced on May11th 2020. Attention has also turned to what the potential impacts of the longer-term consequences of the pandemic may be for mental health, including, for example, those resulting from unemployment, financial problems, reduced access to schooling, and bereavement (Gunnell et al., 2020; Holmes et al., 2020; Niederkrotenthaler et al., 2020).

Suicide and self-harm are tangible measures of mental health problems. Both are known to be affected by social and economic factors (Hawton et al., 2014; Turecki et al., 2019). In this study we have used well-established monitoring systems to investigate trends in self-harm presentations to hospitals in England, particularly focusing on the three-month period following lockdown in the UK (from March 23rd, 2020), and including comparison with the pattern preceding lockdown in 2020 and the equivalent period in 2019. We have examined trends by gender, age and method of self-harm.

2. Method

2.1. Patients

We used information on all patients aged 10 years and over presenting to emergency departments following self-harm who received a

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Available online 13 January 2021

- Data collected in Oxford and Derby on adults who received a psychosocial assessment after presenting to the EDs following self-harm; examined trends during the three-month period following lockdown in the UK (23rd March 2020) to the period preceding lockdown and the equivalent period in 2019.
- Substantial decline in hospital presentations for self-harm occurred during the three months following the introduction of lockdown restrictions. Reasons could include a reduction in self-harm at the community level and individuals avoiding presenting to hospital following self-harm.
- Longer-term monitoring of self-harm behaviour during the pandemic is essential, together with efforts to encourage help-seeking and the modification of care provision.

Hawton et al, 2021

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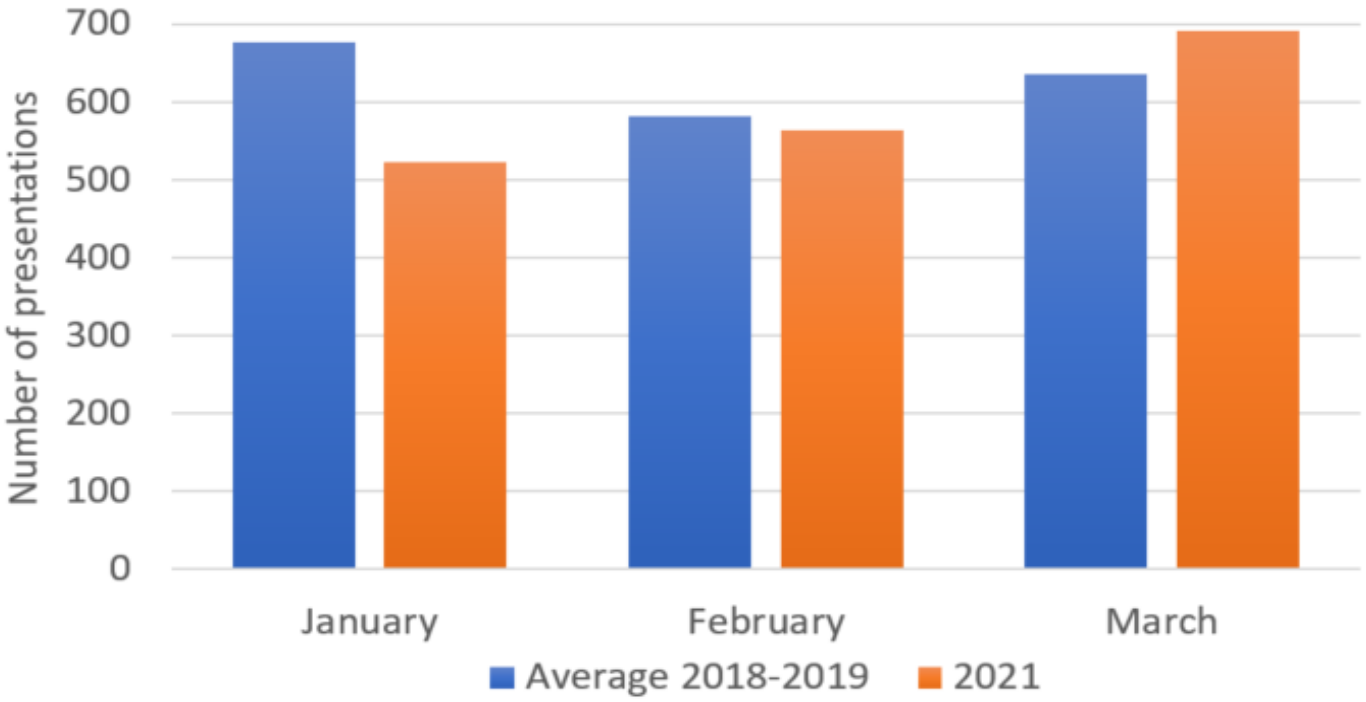
Monthly self-harm presentations to 18 hospitals during January-March 2018-2019 and 2021 - National Self-Harm Registry Ireland



The overall rate ratio (RR) for self-harm rate in the first 3 months of 2021 was equal or similar to the rate in 2018-2019.

The date indicates a possible stepped increase in self-harm for 2021.

(*Corcoran et al, 2021)*

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Self-harm surveillance data informing suicide prevention policy and practice

- Development, implementation and evaluation of national suicide prevention strategies.
- Development of task forces to address the use of specific substances (e.g. medications, pesticides) on the basis of observed patterns of intentional self-poisoning.
- To inform the decision to allocate specialized nurses to emergency departments, prioritizing specific hospitals or emergency care centers on the basis of the volume of suicide attempts and self-harm.
- Planning and implementation of treatment programs for individuals who present to hospital after a suicide attempt or act of self-harm.
- Validation and verification of media statements and articles in relation to self-harm.

Thank you!

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