

National Suicide Research Foundation

Research Programme and Priorities

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22nd January 2009

National Suicide Research Foundation

Research Strategy 2009 – 2010

General objective:

To produce a nationally and internationally recognised body of reliable knowledge from a multidisciplinary perspective on the risk and protective factors associated with suicidal behaviour.

Outcome:

A solid evidence base for policy development and intervention in the prevention of suicide and the management of patients presenting with deliberate self harm.

I Epidemiology of deliberate self harm and suicide: *10 studies*

II Efficacy of intervention and prevention programmes for deliberate self harm and suicide, and attitudes towards suicidal behaviour and its prevention: *9 studies*



National Suicide Research Foundation

Objectives NSRF

➤ *Main objective:*

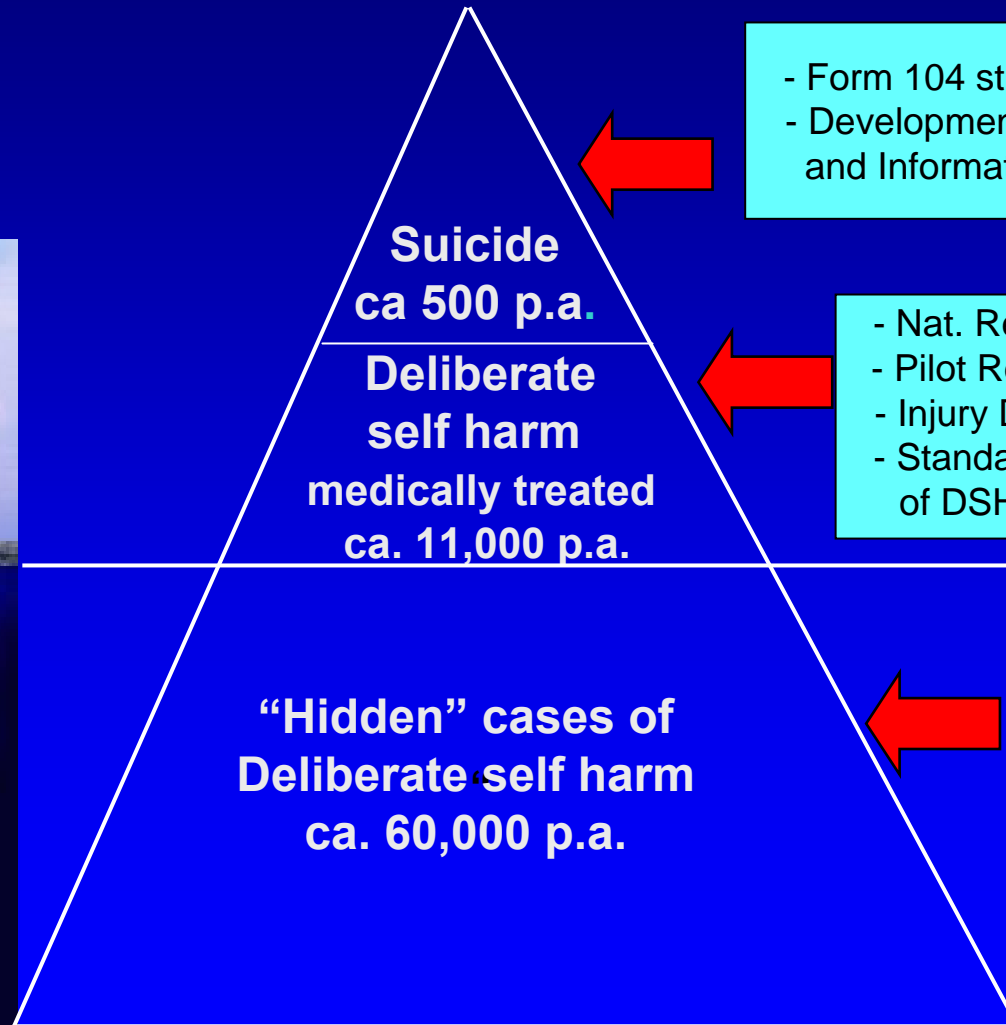
Research into the risk and protective factors of suicidal behaviour to support intervention and prevention of suicidal behaviour and the management of people engaging in deliberate self harm

➤ *Research related tasks:*

- Advisory role
- Training / education
- Supervision of students and trainees

Research priorities NSRF 2009-2010

In line with *Reach Out, Irish National Strategy for Action on Suicide Prevention (2005-2014)*



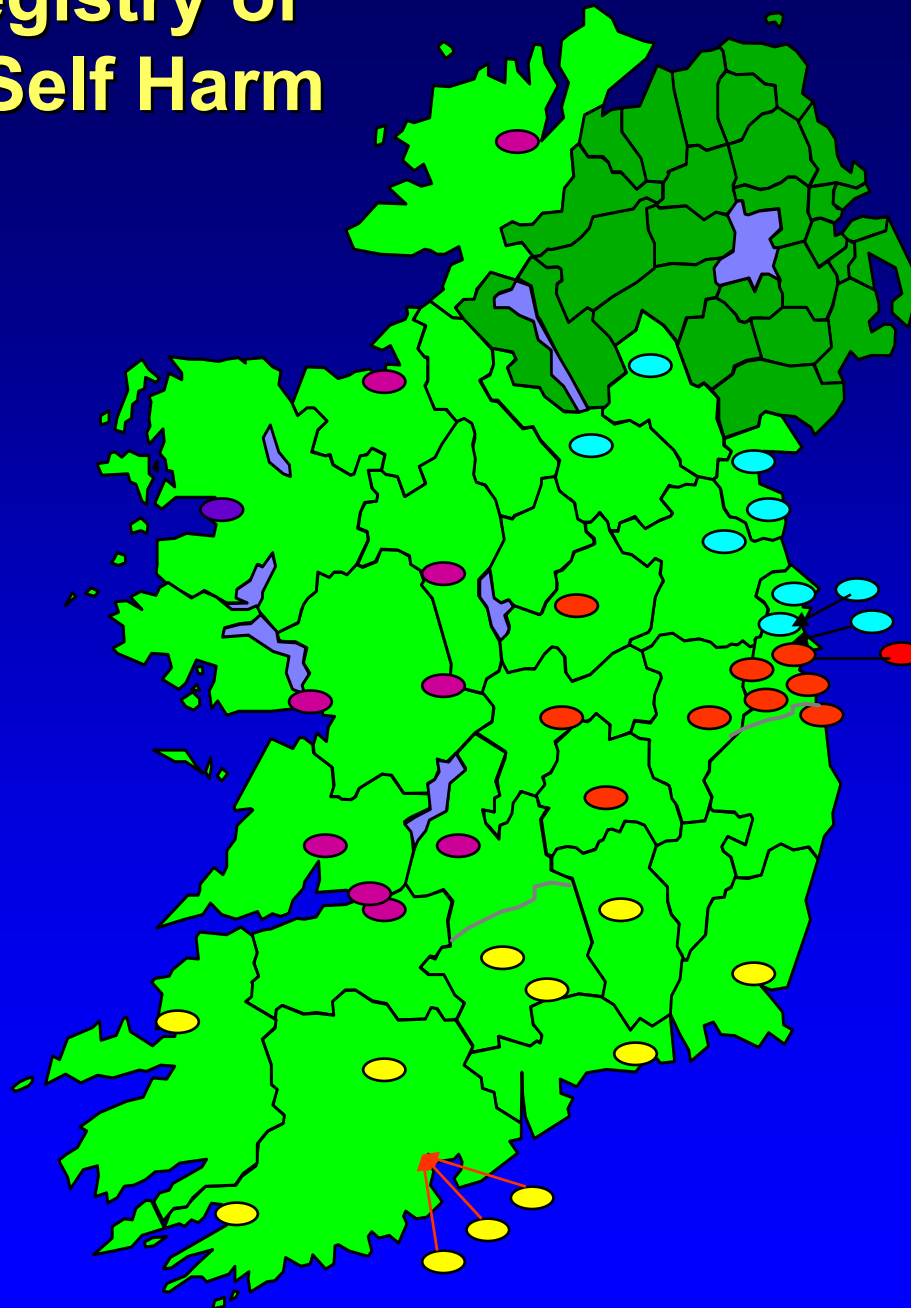
- Form 104 study
- Development Suicide Support and Information System

- Nat. Registry of DSH
- Pilot Registry NI
- Injury Database
- Standardised assessment of DSH

- OSPI-Europe
- SAYLE
- Mind Yourself

National Registry of Deliberate Self Harm (NRDSH)

Coverage:
All 40 Hospital
Emergency
departments in
Ireland



HSE Dublin/
Mid-Leinster

HSE Dublin/
North East

HSE South

HSE West

National Registry of Deliberate Self Harm (NRDSH) - Methodology

- Systematic monitoring of attendances to hospital emergency departments
- Identification of deliberate self harm presentations in accordance with an internationally-recognised definition (Platt et al, 1992)
- Data registration officers operate independently of the hospitals
 - Follow a standard operating procedures manual
 - Show a high level of agreement in case-ascertainment
- Data items: Standard sociodemographic characteristics, characteristics of self harm act and aftercare

Deliberate self harm in Ireland 2002-2007

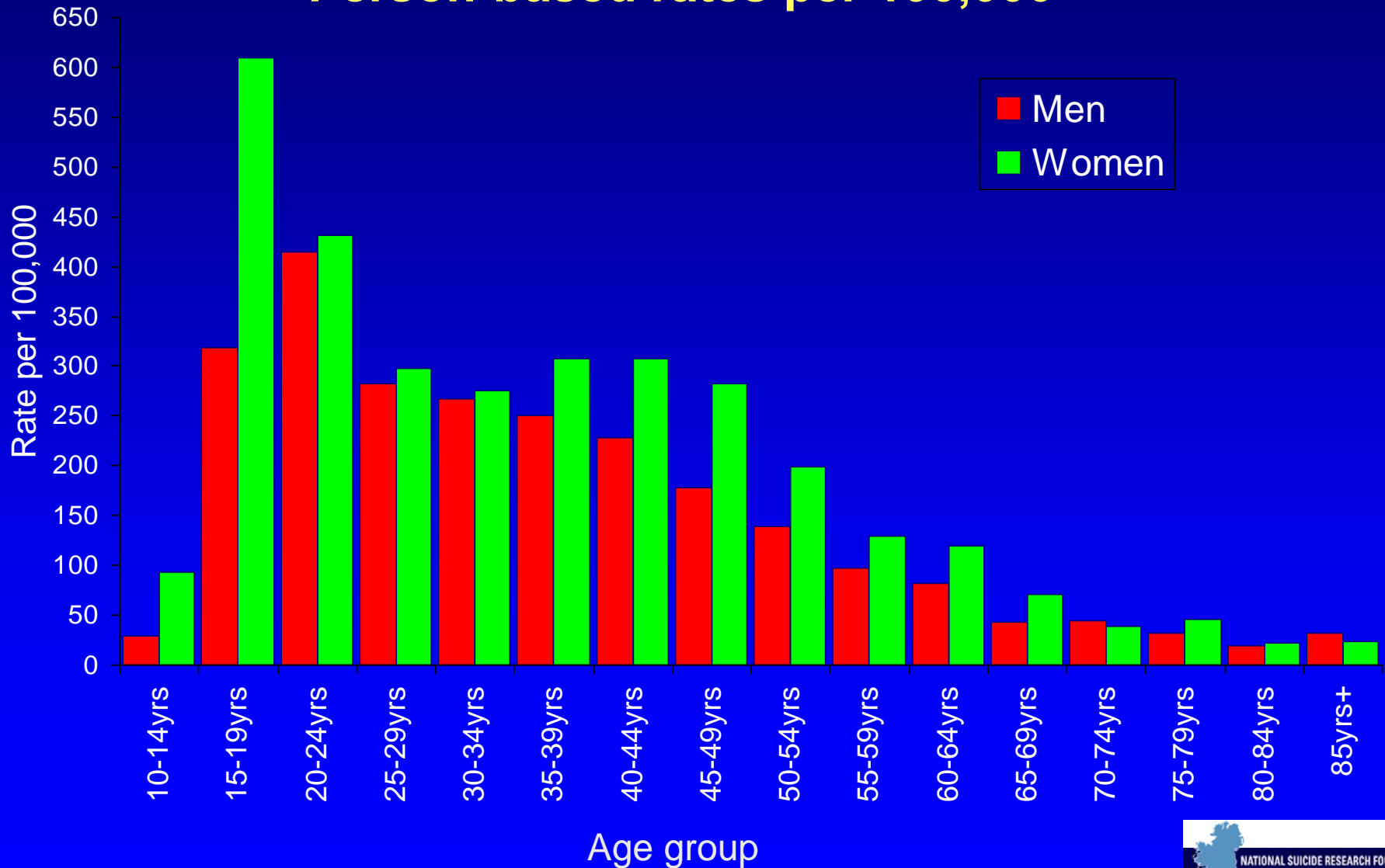
Person-based rates per 100,000 by gender

<i>Year</i>	<i>Women</i> Rate	% difference	<i>Men</i> Rate	% difference
2002	237	-	167	-
2003	241	+2%	177	+7%
2004	233	-4%	170	-4%
2005	229	-1%	167	-2%
2006	210	-8%	160	-4%
2007	216	+3%	163	+2%

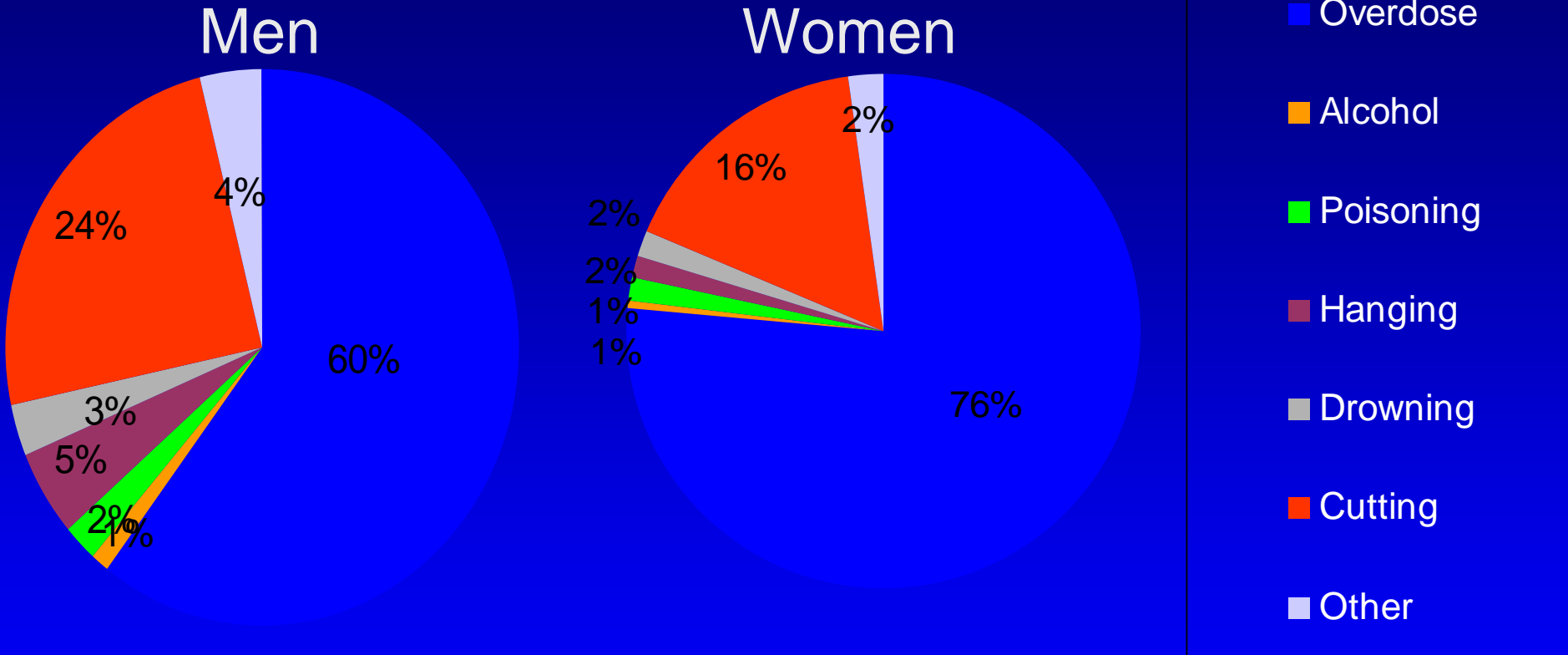
Average annual number of DSH presentations: N=10,899;
 Average number of persons involved: N=8,542 ;
 Ratio episodes: persons: annually 2002-2007: 1.25 to 1.28

Incidence of DSH in Ireland by age and gender, 2006-2007

Person-based rates per 100,000



Main Method of DSH, 2002-2007

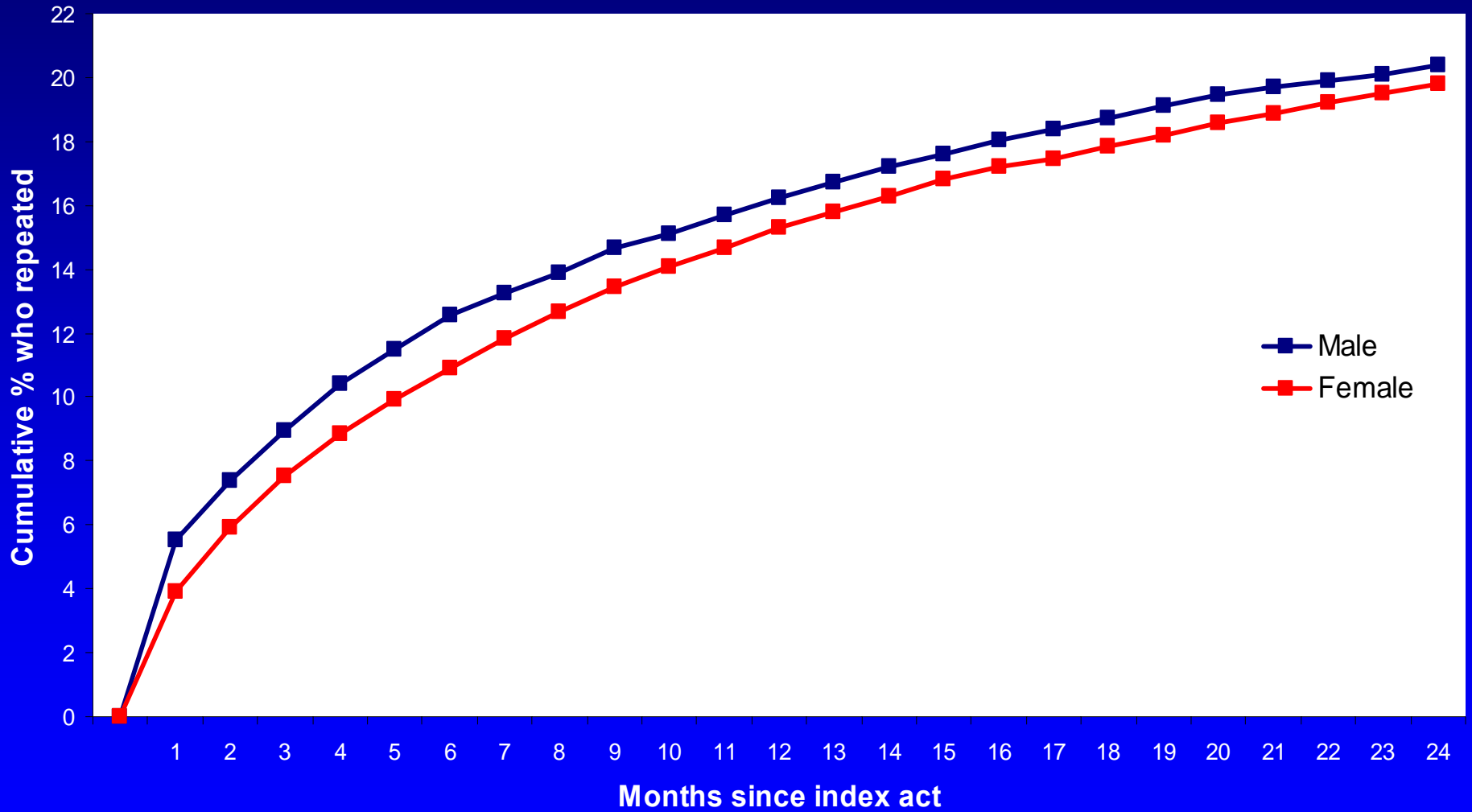


p<.01

Alcohol was involved in 46% and 38% of male and female DSH acts, respectively

Women: N=34,213; Men: N=26,254

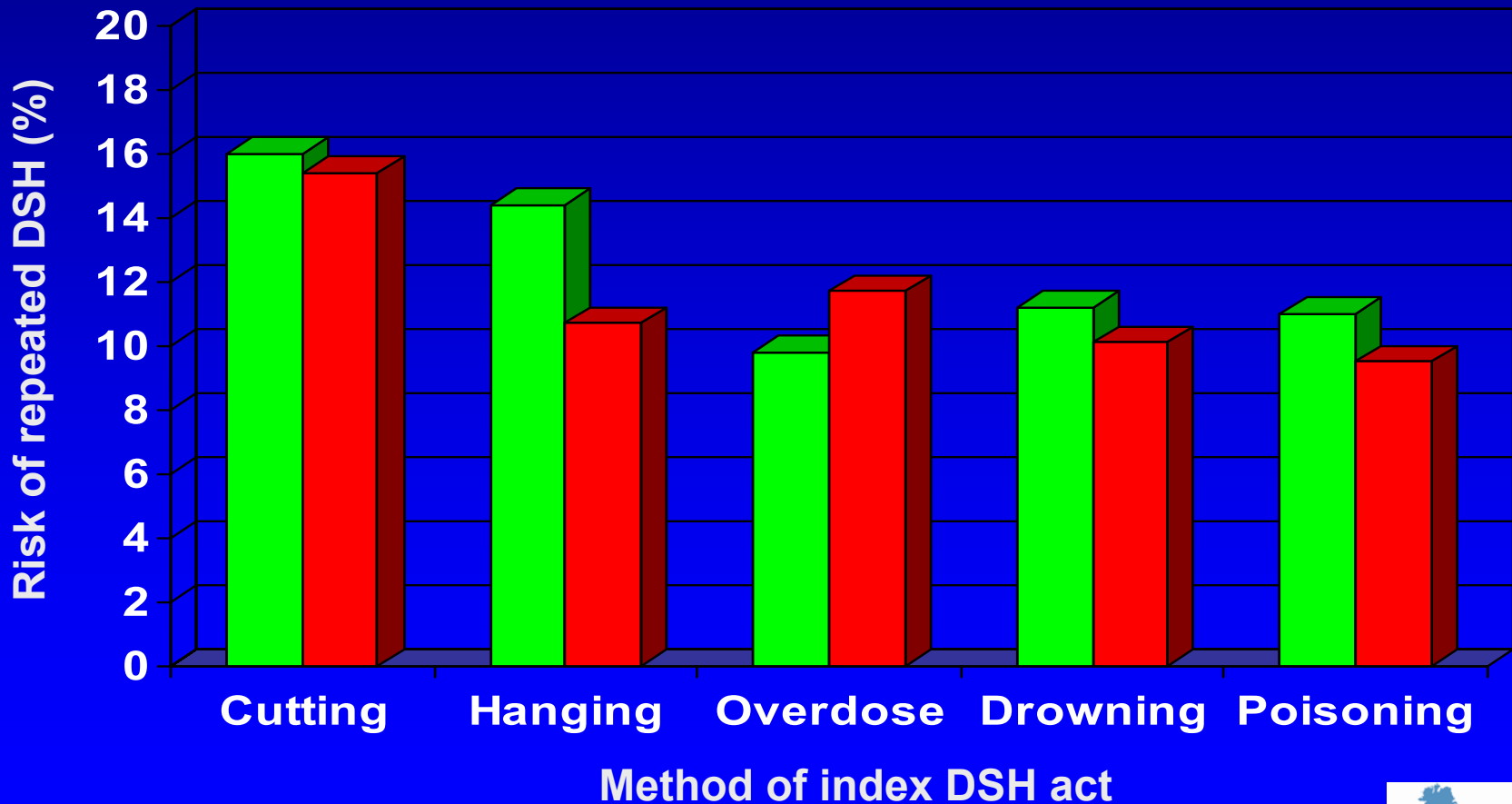
Repetition of DSH by gender 24 months prospectively following index DSH act



Kaplan-Meier survival analysis 2002-2007

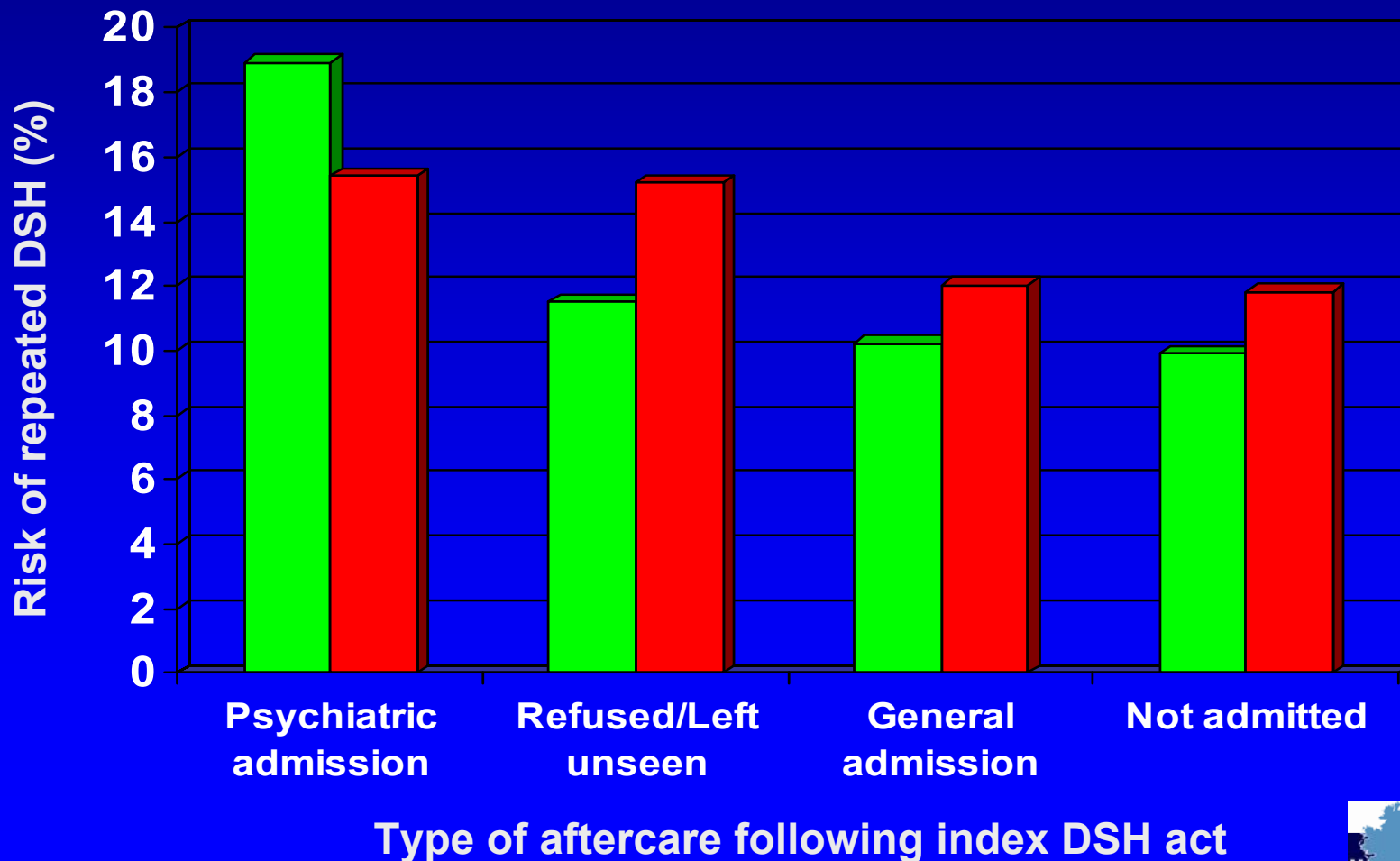
Repetition of DSH 6 months prospectively by method of index DSH act and gender

■ Women ■ Men



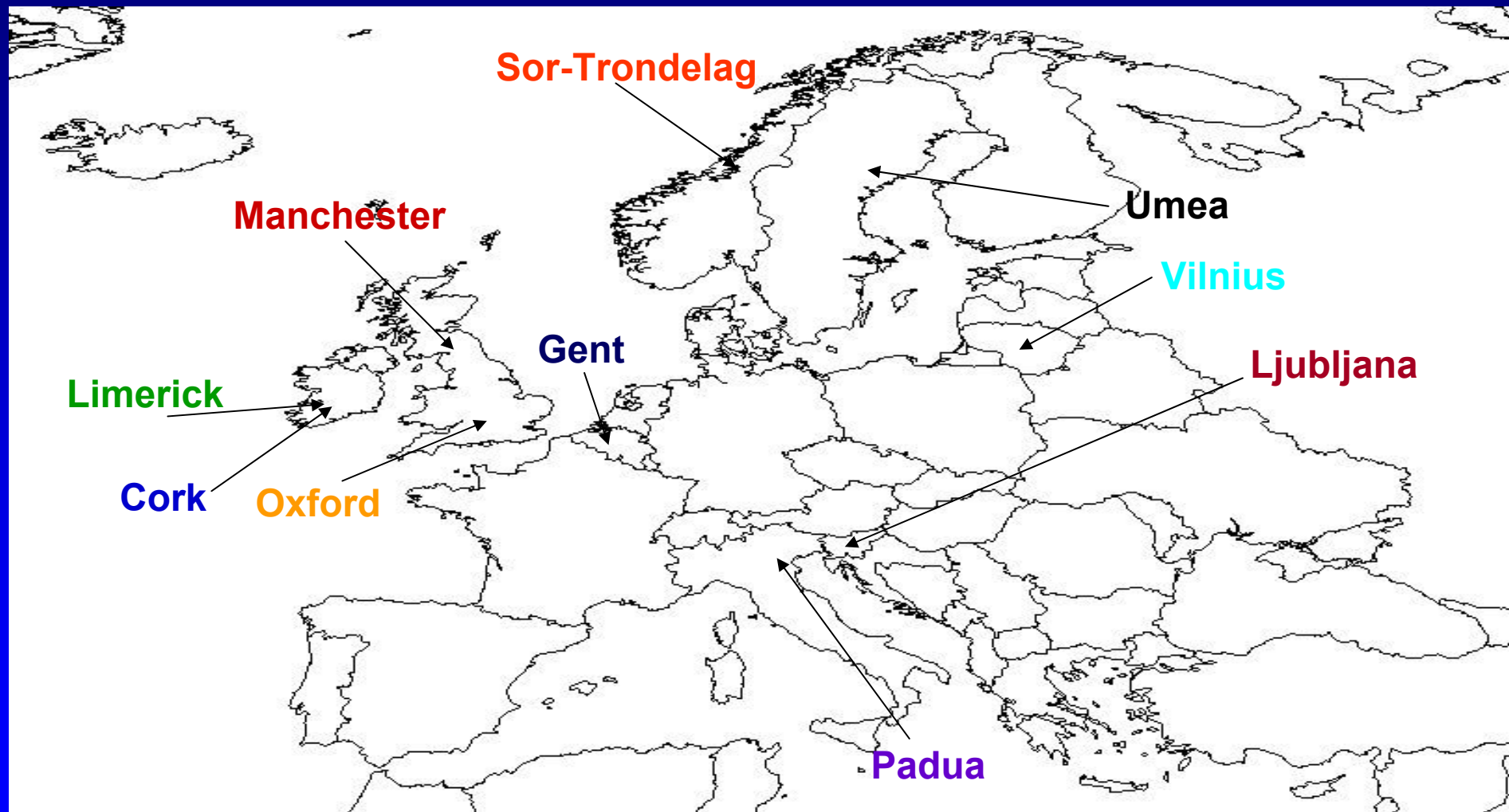
Repetition of DSH 6 months prospectively by type of aftercare following index DSH act and gender

■ Women ■ Men



$p < .01$

Participating regions in the Network on International Collaboration on Evidence in Suicide Prevention (NICE-SP)



Methodology

- Data collection in 8 regions in 6 European countries
- Patients, aged ≥ 15 years presenting to hospital following DSH from hospital catchment area
- Standardised method of data collection, developed as a standard for European regions collaborating in the WHO Multicentre Study on Suicidal behaviour (*Platt et al, 1992; Schmidtke et al, 1996; Schmidtke et al, 2004*): Demographic variables and characteristics of the DSH episode.
- All regions except Manchester participated in the WHO Multicentre study between 1989 and 2000.
- Data on suicides for the countries involved was obtained from the national statistics offices in each country (ICD9 / ICD10).

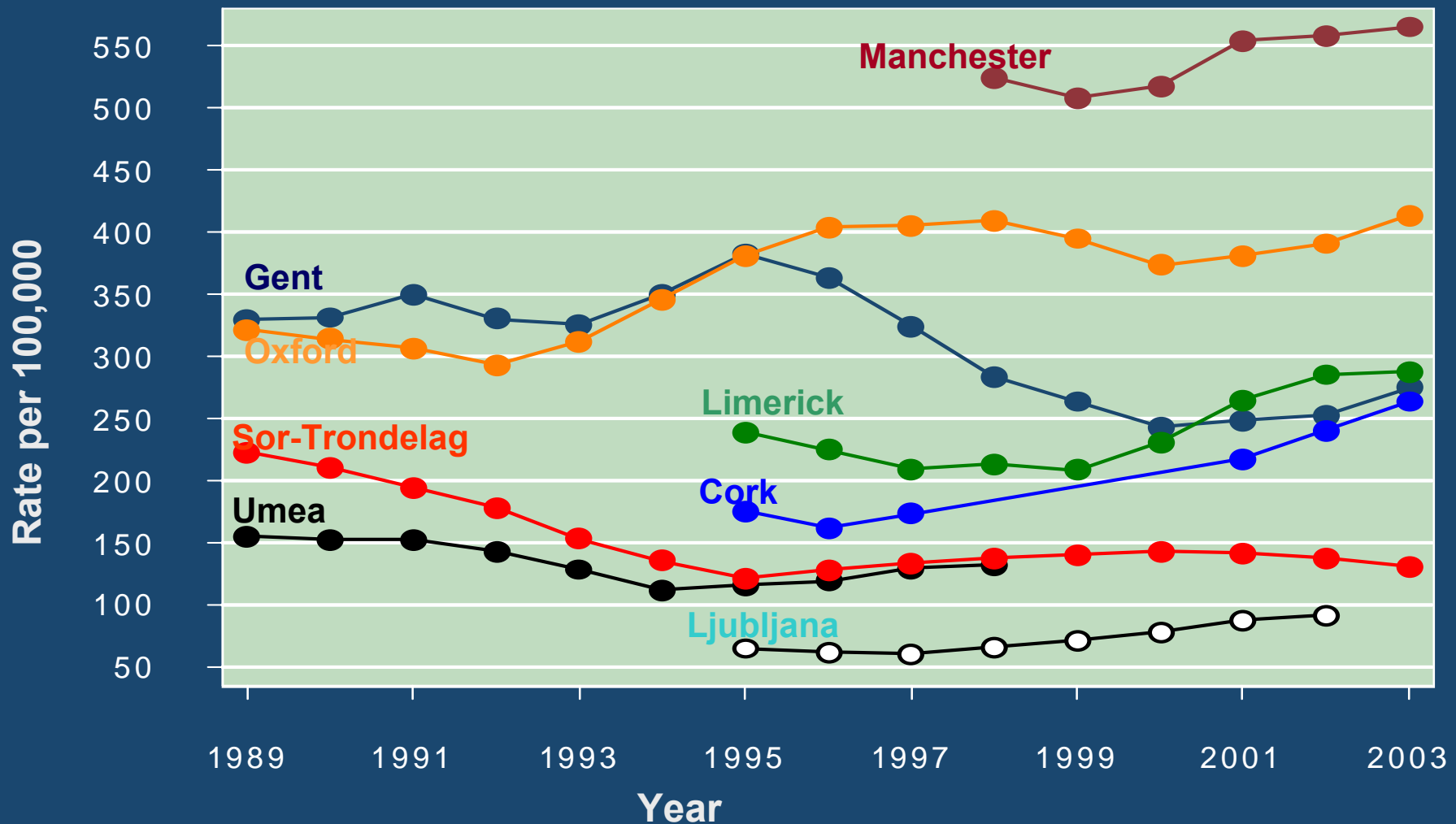
Methodology ctd.

- Start monitoring of DSH:
Oxford, Gent, Sor-Trondelag, Umea, Padua: 1989
Cork, Limerick, Ljubljana: 1995
Manchester: 1998

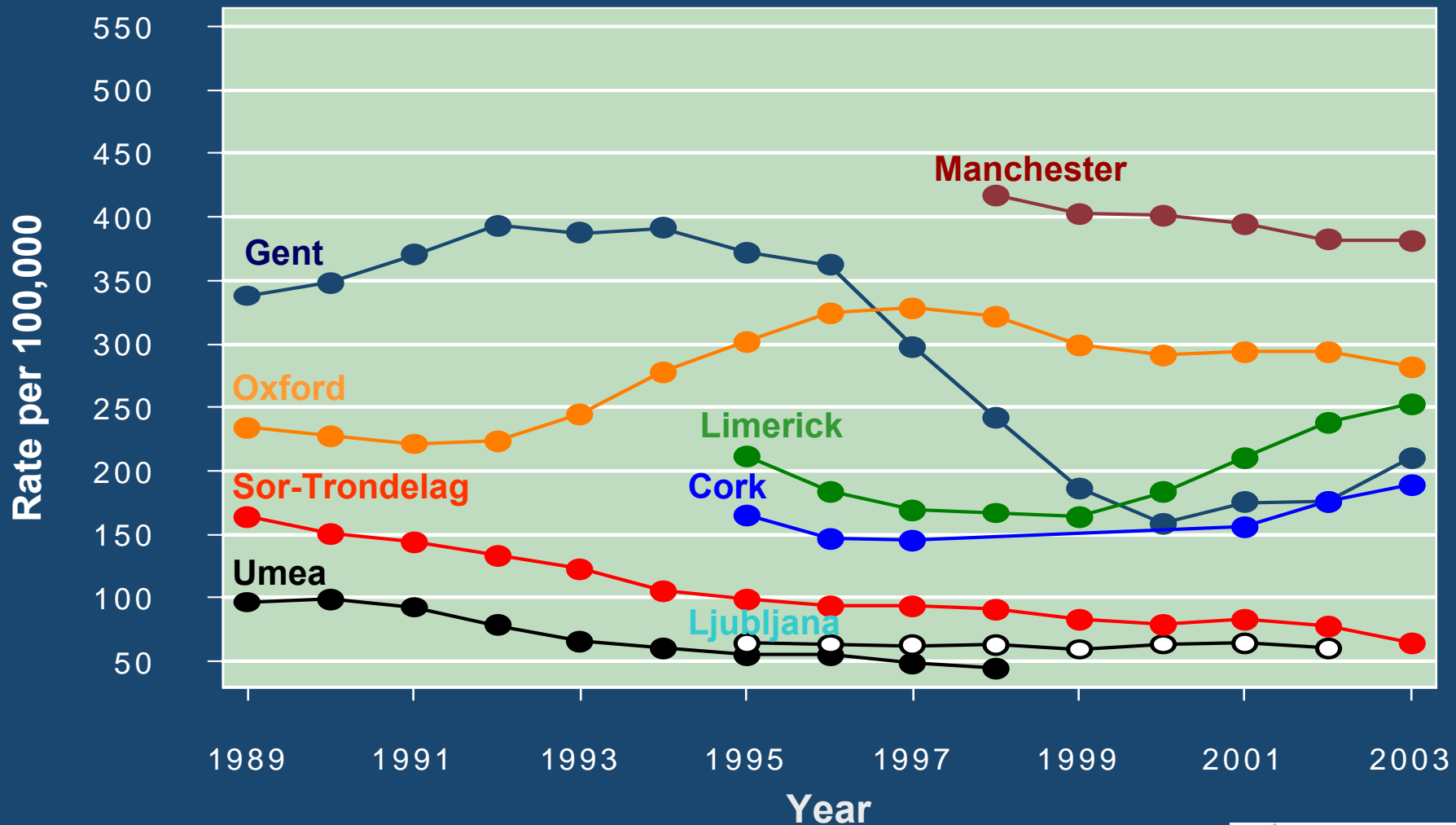
Total number of DSH episodes 1989-2003: N=44,495

- Data analysis:
 - Annual person-based rates of DSH age-standardised
 - Three-year rolling averages

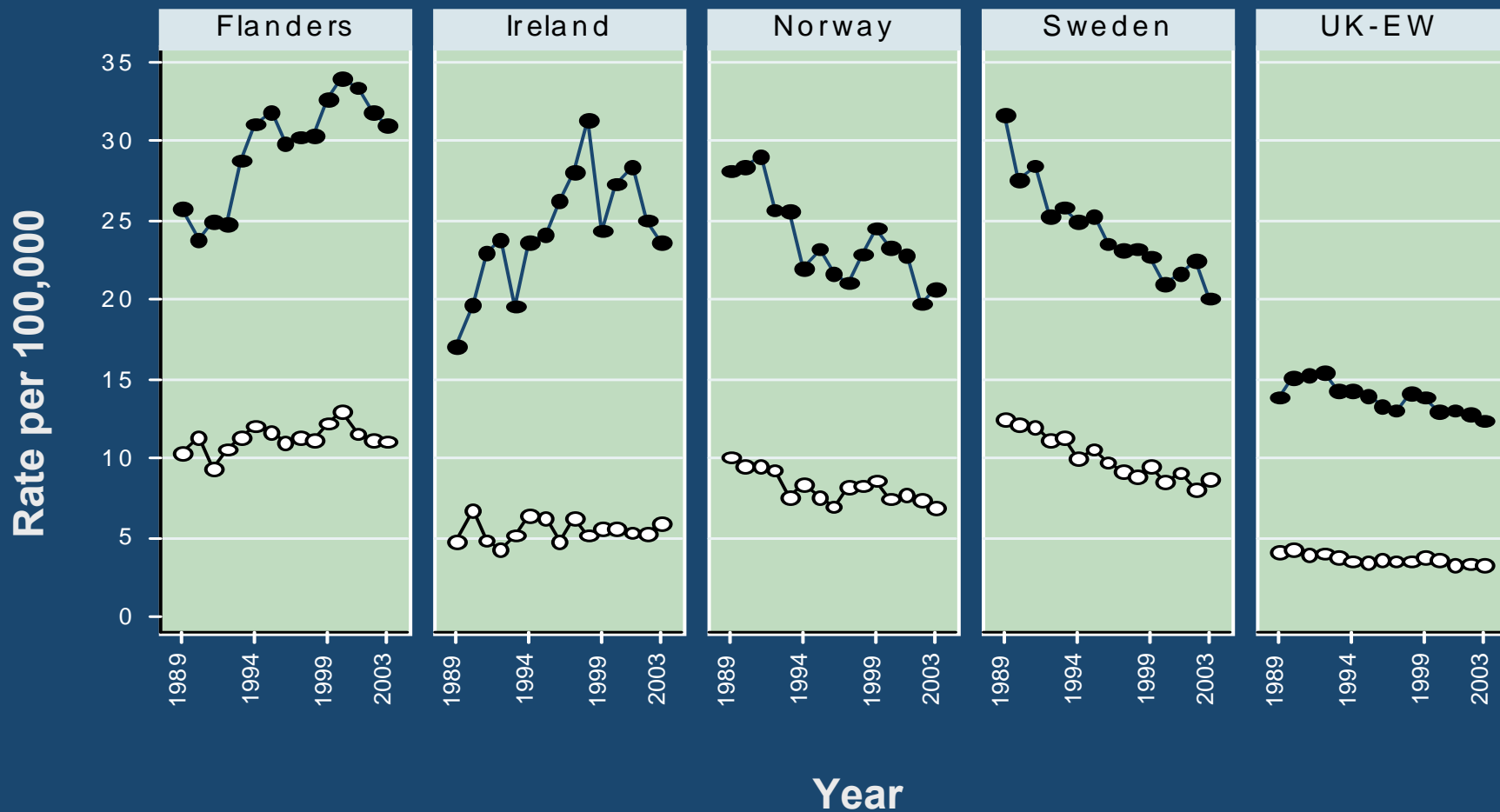
Deliberate Self Harm: person-based three-year rolling average rates per 100,000 for women



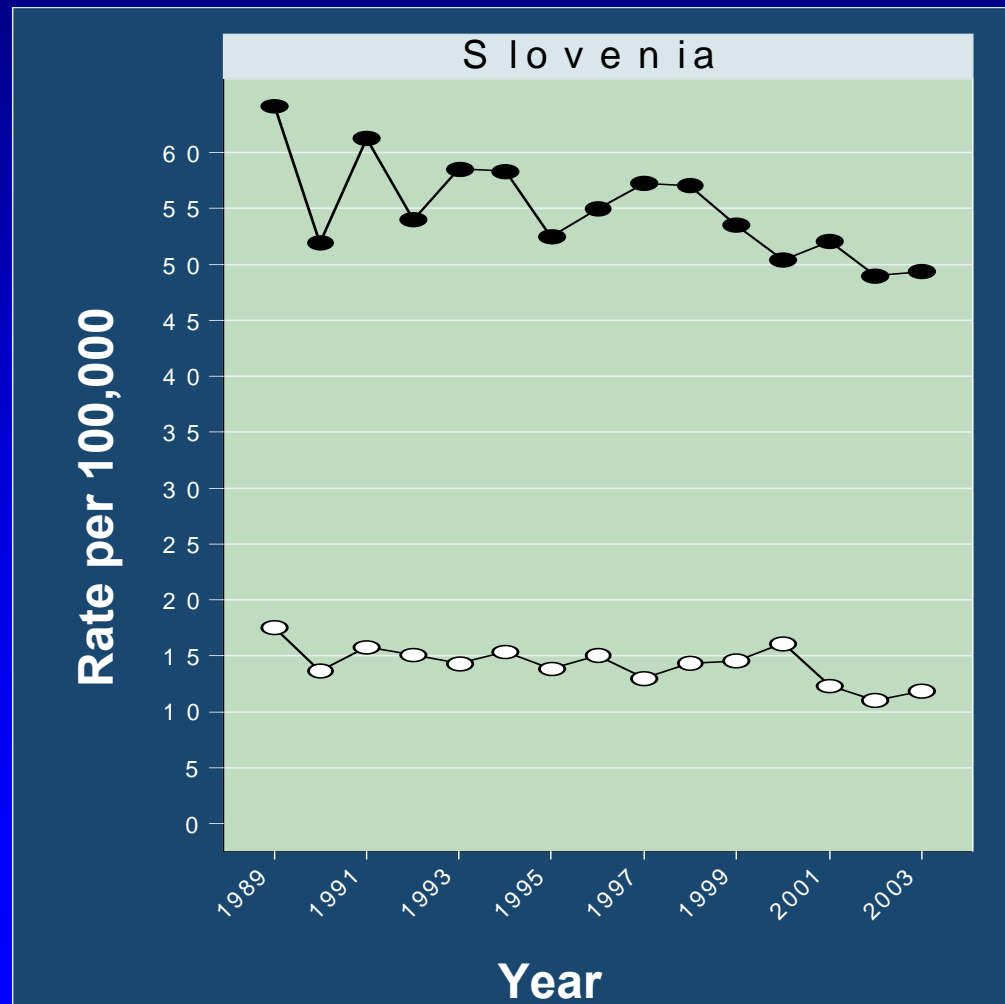
Deliberate Self Harm: person-based three-year rolling average rates per 100,000 for men in 8 European regions



Suicide: three-year rolling average rates per 100,000 for men (●) and women(○)



Suicide: three-year rolling average rates per 100,000 for men (●) and women(○)



For males a significant association was found between the rate of change in DSH rates at regional level and suicide rates nationally ($r=0.71$, $p<0.05$), but not for females ($r=0.57$, $p=0.14$)

Summary

- Trends in DSH rates varied considerably across the different European regions and by gender
- DSH rates were consistently higher for women, with highest rates in Manchester, Oxford and Gent
- In most regions similar trends in DSH were found for female and male DSH rates
- Across the European regions there was greater temporal variation in both genders in the incidence of DSH compared to the temporal variation in the incidence of suicide

Summary ctd.

- Regions with high DSH rates did not consistently show a pattern of high suicide rates at national level
- However, in males a significant association was found between the rate of change in DSH rates at regional level and national suicide rates
- The extremely high suicide rates among males in Slovenia may be particularly related to high levels of alcohol abuse and access to firearms (Bilban and Skibin, 2005)

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