Develop a suicide (attempts) registry through multi-disciplinary collaborative approach

Technical Report

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Chapter 1: Background and Objectives

1.1 Background

Suicide is one of the major public health concerns today as it accounted for 1.4% of all deaths worldwide, making it the 15th leading cause of death according to the data of 2012[1]. It is estimated that, by 2020, 1.5 million people will die each year by suicide, and between 15 and 30 million will make a suicide attempt. 75% of global suicides occur in low- and middle-income countries,[2] WHO has modeled an age-standardized suicide rate for Nepal in 2012, ranking it 7th in the world at 24.9 per 100 000.[1] A 2014 scoping review of suicide in South Asia estimated the suicide rate in Nepal at 8.6 (standard deviation = 8.87) per 100 000 populations[3]. Nepal lacks routine national-level data on suicide. The available data are based on police reports or on specific populations, where there is a possibility of gross underestimation. Based on the current reporting mechanisms, collection and maintenance of data on suicidal deaths falls under many departments: health, administration and police. In the absence of one entity responsible for coordinating the reporting of suicides, all these sectors report suicidal deaths through their own information pathways. Many barriers and challenges in these reporting pathways have resulted in inaccurate reports. There is no information sharing among these systems. So, it has been recommended to have a collaborative, multi-sectorial approach, especially partnerships between law enforcement and the health system, to achieve reliable and accurate surveillance, and, ultimately, effective suicide prevention. A person with attempted suicide is most likely to land up in the emergency of a hospital or other nearby health care service. It is also likely that a person with attempted suicide be reported to the police department considering it as a medico-legal case. Similarly, a completed suicide is reported to the police department for recording. Hence, it is mandatory for a collaborative approach in order to build a registry of suicide.

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[1] *Preventing suicide: a global imperative. Geneva: World Health Organization; 2014*

[2] *World Health Organization. Suicide data*

[3] *Jordans MJ, Kaufman A, Brenman NF, Adhikari RP, Luitel NP, Tol WA et al. Suicide in South Asia: a scoping review. BMC Psychiatry. 2014; 14:358*

Considering this lacuna in the data collection and maintaining a central registry, we Department of Psychiatry, Patan Academy of Health Sciences, planned a pilot project in Lalitpur district titled "To develop a suicide (attempts) registry through Multi-disciplinary collaborative approach" on technical and financial support of WHO Country Office, Nepal. The other stake-holders involved for this collaboration are District Public Health Office (DPHO), Lalitpur, Metropolitan Police Range, Lalitpur and Suicide Prevention Network, Lalitpur.

1.2 Objectives:

The general objective of the project is to strengthen the reporting of suicide for better management.

The specific objectives are

1. To develop a record system for the attempted suicide presenting to hospital emergency
2. To develop and document record system of the completed suicide through police
3. To operationalize suicide helpline to help people with suicidal behavior
4. To provide awareness about suicide prevention and the reporting of the (attempted) suicide

CHAPTER 2: ACTIVITIES CONDUCTED

2.1. Review of Existing Record system:

The objective of the review was to know the current practices of data collection of suicide. We aimed at looking at the various aspects like presence or absence of standardized data forms, different parameters that were recorded and reported. We also looked at the mechanism how the data was taken from the cases of suicide attempts and completed attempts and reported to the higher authority. We planed to collect data in a structured format. For this the expert team of psychiatrists and psychologists of Department of Psychiatry, Patan Academy of health Sciences conducted a literature review and developed a set of questions (closed ended with two responses "yes or no". The questionnaire consisted of socio-demographic and clinical variables that were thought mandatory to be collected for a proper suicide registry.

The feedback from the record section of Patan hospital, DPHO, Suicide Prevention Network, and Metropolitan Police Range of Lalitpur was taken as applicable. The feedback was also sought from Mental Health consultant of WHO, country office. After all the consideration two different formats were developed for Emergency department of Health facilities and Police Stations. (Annexure 1 and 2).

Figure 1: Data collection for review by psychiatrist and medical officers

For the purpose of data collection both psychiatrists and medical officers were mobilized. For this a focal person of the different institutions mentioned below was contacted and permission was taken from the authority. Then interview was conducted with the emergency staffs and police personnel regarding how they would collect the data. After that the registers or the documentation was audited by the team. The record of three months, Falgun 2073 to Baisakh 2074 of Nepali calendar (12th February 2017 to 14th May 2017) were reviewed.

The data was collected from

a. Two tertiary health facility
b. Two Primary Health Centers
c. Two Private Hospital
d. Two Police stations

As shown in Table 1 and 2 total review of records yielded total of 53 cases in three months from the eight facilities visited.

Table 1: Number of recorded cases of suicide attempt in Heath facilities (3 months)

SN	Source of Data	Number of cases
1	Patan Hospital	17
2	Mental Hospital Lagankhel	1
3	Sumeru City Hospital	1
4	Alka Hospital	3
5	Badhegaun PHC	1
6	Chapagaun PHC	0
	Total	**23**

In the health facilities it was seen that none had a standard data collection format for suicide. Most of the emergency workers gave anecdotal experience in dealing with cases of suicide attempts. When we looked the data keeping, we found that only consistent data was of socio-demographic profile. The clinically relevant data like past history of suicide attempt, history of mental illness, family history of mental illness, use of substance etc. were not included. Moreover, whether the referral to psychiatrist was made was not recorded, but on talking to the emergency health workers they specifically told that they would refer the cases. A part from that when the review of three months was done the number of cases were very less as compared to the projected data of self harm from different studies. This further suggests there is poor record keeping. The suicide reporting is not a part of Health Management Information System (HMIS) of Nepal. Hence, this data would not reach to the District Public Heath Office along with the data of other diseases.

Table 2: Number of recorded cases of suicide attempts and deaths in Police department (3 months)

SN	Source of Data	Number of cases
1	Metropolitan Police Range Lalitpur	7
2	Police station of Patan Hospital	21
	Total	**28**

While reviewing the data keeping of the deaths due to suicide the Police department, it was seen that they also didn't use the standard format. They collected the information in a paragraph and descriptive format. The good point about the data keeping was the presence of homogenous information. The list of information consisted of socio-demographic profile, place, time, mode of death. Interestingly, the data also consisted of important information like active stressors, history of recent loss and history of substance use as well. The clinical parameters like prior communication about suicide, history of mental illness, past history of attempts, family history of suicide and treatment of psychiatric illness were not present in the records. We got a feedback that a structured proforma would help in organization of the relevant information about the death due to suicide.

From the review of both kind of facilities (police and health) we concluded that there is a genuine lack of a proper recording and reporting system of the suicide data. It is mandatory to develop a relevant data registry.

2.2. Development of new format for the recording:

Further review of literature was done and an outline of the record keeping was developed. The findings from the review of records from health facilities and police department were also incorporated in making the record form wherever relevant. Apart from this, a meeting was conducted among the stakeholders for feedback collection. The feed-back meeting was attended by psychiatrists, clinical psychologists, medical officers, staffs from record section, staffs from DPHO, Mental Health Consultant from WHO, Senior Superintendent of Police with other police personnel. Discussion and feedback collection was done. All the relevant suggestions were

incorporated in making of the record form. Finally, two record forms were finalized, for the record keeping in the emergency of the health facilities and in the police stations in Nepali language (Annexure 3 and Annexure 4). The data form was printed and booklets were made to record the suicide attempts in case of health facilities and cases of completed suicide in case of police department.

2.3. Training of health personnel and police personnel on new data recording system:

One-day training was given to the health professionals working in different health facilities and police personnel of Lalitpur district on basic information about suicide and method of collection of data using the registry. Following steps were followed in training:

a. *Preparation of training material:*

   Literature review and discussion in the expert team consisting of psychiatrists and psychologist was done. The content for power point slides were prepared and finalized accordingly. The slides were then translated in Nepali language.

b. *Selection of training participants:*

   Discussions were held with the chief of DPHO and Metropolitan Police Range, Lalitpur and focal persons were assigned for finalization of the training participants. It was aimed to cover maximum number of health facilities and police stations so that whole of the Lalitpur district would be covered. The concerned offices did the work of communication with the participants after the venue and timings were finalized for the training. Table 3 provides the number of participants trained on four different days.

Figure 2: Training of police personnel by Psychiatrist

Table 3: Total number of participants for one day training on new registry

S..N	Days	Participants	Number
1	Day 1	Police personnel	50
2	Day 2	Police personnel	50
3	Day 3	Police personnel	50
4	Day 4	Health workers (Health facility worker, Emergency doctors)	52
Total Police personnel **Total Health workers**			**150** **52**

c. *Training Content:*

The training content for the health workers was mainly focused in the intervention model as they would deal with the patient with suicide attempt. The training for police personnel was focused on verbal autopsy model as they would deal with the completed suicide. The training content for both the groups were in Nepali language. The training was conducted for one day. The basic format of the content was divided into three areas; the introduction of suicide, the basic psychosocial support either to the suicide survivors or to the bereaved family wherever applicable and the hands on training on the filling of suicide registry.

Figure 3: Training of Health Workers

The detailed content of the training along with the time attributed to each sessions is provided in table below

Table 4: Content of Training for Health Professionals and police personnel

Time	Topic of presentation	Facilitator
	Introduction about Project Suicide: An Overview	Psychiatrists
1 hour	*For health workers:* Handling of patient with suicide attempt & basic psycho-social support to family members *For Police:* Handling of suicide survivors and family members of completed suicide cases	Clinical Psychologist
1 hour	Workshop on Filling Pro-forma for Data Collection	Psychiatrists
30 minutes	Conclusion and feedback collection	Psychiatrists and Clinical psychologist

d. *Techniques and interventions during the training:*

Several techniques and interventions were used in the training. As with other trainings, power point presentations and mini-lectures were given on introduction of suicide. Group work and discussions were encouraged so that all of the participants would engage and gain same level of knowledge. We also focused on

role plays which were pivotal in teaching the skills needed for interviewing. We also shared case stories drawn from the clinical experiences of the psychiatrists present. The hands on training on how to fill up the proforma was given that helped the participants to be confident on the variables listed in register.

e. *Distribution of data register:*

The registers were then distributed to each health facility or each police station.

2.4. Testing of New System:

After the training and distribution of the data register the final phase is testing of the new system. The responsibility of collection of Data from these registers was given to DPHO, Lalitpur and Metropolitan Police Range, Lalitpur. Department of Psychiatry, PAHS will help in analysis of the data. The challenges in testing of system are mentioned in different section. The data collection will continue and the system will be updated continuously as per need even after the time of project phase out.

2.5. *Operationalize Suicide helpline*:

Utilizing the principles of crisis intervention, giving hope of recovery and providing practical assistance to patients with active suicidal thoughts, many countries and institutes have adopted the concept of a 24 hours' phone line dedicated to handling such emergency conditions. In a view to that Department of Psychiatry, Patan Academy of Health Sciences had been running suicide help line service, however due to lack of logistic support it was not operating. Under this project we operationalized this help line.

a. *Development of check-list and record form for suicide helpline:*

   Review of literature and discussions were carried out in the team of department of psychiatry and a list of items to be incorporated during the conversation were collected. The arrangement of items was done in order and unwanted items were removed. Testing was done in the form of role-play and feedback was collected. After that a final check-list was developed (Annexure 5). Along with the check-list a recording proforma was made in parallel fashion (Annexure 6).

b. *Operationalize suicide help line:*

Two numbers that had been already operating were further strengthened with the logistic support form this project.

S.N	Phone number	Place of operation	Operators
1	9813476123	Department of Psychiatry, Patan Academy of Health Sciences	Medical Officer who are on duty (On call)
2	9851215688	Metropolitan Police Range, Lalitpur	Police staffs on duty

The two phase training on operation of suicide help-line to the police department was provided earlier under the joint initiative of Department of Psychiatry, Patan Academy of Health Sciences, Metropolitan Police Range, Lalitpur and Suicide Prevention Network, Lalitpur before the initiation of this project. However, the logistic support from this project in the form of mobile phones with recording functions further strengthened the initiative. In the proposal we mentioned about the procurement of a toll-free line for the help line. But considering the sustainability of the help line it was not procured as we didn't have enough fund to operationalize a toll-free number. Instead of that two mobile phones were bought with a recording facility. One was donated to the Metropolitan Police Range Lalitpur and another one operated at Department of Psychiatry, PAHS, so that the help line could be operationalized without any further investment of funds.

2.6: Awareness program on suicide prevention and reporting*:*

This is an on-going initiative of Department of Psychiatry, PAHS. In continuation to different programs held here a brochure developed by the department of psychiatry in different collaborator on suicide prevention was distributed to various stake holders like the trainees from police and health facilities, patients attending psychiatry OPD of Patan Hospital, Private Hospitals etc. Apart from that the flex with a theme of suicide prevention and advertisement of the help-line was kept in the emergency department, Psychiatry OPD and gate of Patan Hospital.

The awareness campaign was continued in the form different media interviews, newspaper articles etc. of the consultants of the department.

CHAPTER 3: OUTPUTS

The project is a preliminary initiative to develop a record keeping system of the suicide (both attempted and completed). Under this we achieved the following outcome:

a. A record keeping format for suicide attempts has been developed for the health facilities and distributed in Lalitpur district.
b. A system for recording completed suicide has been developed and distributed to major police facilities.
c. A single day training curriculum for basic introduction of suicide and basic psycho-social support to survivors and family members, assessment of suspicious deaths and identification of deaths due to suicide for police personnel has been developed and implemented in the trainings given.
d. Operation of suicide-help line is continuing in both Patan hospital and metropolitan police range Lalitpur.
e. Mental health awareness and stigma reduction activities conducted.

CHAPTER 4: BEYOND THE PROJECT PERIOD

- The suicide helpline at the department of psychiatry, Patan Academy of health Sciences will continue to be operated 24 hours from internal resource of the institution.
- Similarly, the department of Police has assured the smooth running of helpline at the Metropolitan Police Range as well.
- The attempts to continue data collection by utilizing the existing resources will be continued.
- The awareness programs will be continued as earlier periods under the leadership of the department within the hospital and outside.

CHAPTER 5: CHALLENGES, AND RECOMMENDATIONS

5.1. Challenges:

There were few challenges in implementation of the project. The local election going on in Nepal during the project implementation period delayed the training date, so, had to be completed on last month. The busy schedule of emergency doctors and police personnel would make difficult to fill up the proforma. In the feedback collection with the emergency department of PAHS it was found that the one duty doctor had to fill up other proforma too and dearth of manpower would make it difficult. Similarly, the data collection would be difficult as the suicide registry is not a part of HMIS of government reporting system.

5.2. Recommendations:

After the successful implementation of the activities stated above, it is very feasible to start a suicide registry at a national level in collaboration of stakeholders working in the health and police department. We would like to recommend the following points:

a. The suicide (both attempted and completed) should be recorded in all the health facilities and reported to the central level along with HMIS. The Primary Health Care Revitalization Division can play a crucial role.
b. The assessment of suspicious deaths and identification of deaths due to suicide falls under the domain of Police Department, hence the method of verbal autopsy for suicide should be made mandatory along with proper recording and reporting to the center.
c. One of the easy and effective way to deal with suicide is 24 hour help line. Hence, we recommend all the tertiary care centers with psychiatry department should start their own help line.

Annexure 1

Multi-disciplinary collaborative approach to develop a suicide (attempts) registry
Department of Psychiatry
Patan Academy of Health Sciences

Name of health facility:
Case no:
Date of collection of data:
Date of examination:
Hospital no:

SN	ITEMS	YES	NO
1	Name		
2	Age/ Sex		
3	Marital Status		
4	Education		
5	Occupation		
6	Religion		
7	Ethnicity		
8	Address		
9	Time(date)of Attempt		
10	Place of Attempt		
11	Mode of Attempt		
12	Nature of Attempt(planned/impulsive/accidental)		
13	Influence of drug		
14	Intention (death, anger, revenge etc.)		
15	Prior communication about suicide		
16	Note about Suicide note		
17	History of psychiatric illness recorded		
18	Treatment of psychiatric illness recorded		
19	History of prior attempt recorded		
20	History of medical illness recorded		
21	History of treatment of medical illness recorded		
22	Family history of psychiatric illness recorded		
23	First contact to health care recorded		
24	Provisional diagnosis made		
25	Treatment given		
26	Psychiatric consultation sought		
27	Family education done		

Any other information collected? If yes, elaborate:

Feedback from the emergency physician:

Annexure 2

Multi-disciplinary collaborative approach to develop a suicide (attempts) registry
Department of Psychiatry
Patan Academy of Health Sciences

Name of police station:
Case no:
Date of collection of data:
Date of examination:
Registration no. (Police):

SN	ITEMS	YES	NO
1	Name		
2	Age/ Sex		
3	Marital Status		
4	Education		
5	Occupation		
6	Religion		
7	Ethnicity		
8	Address		
9	Relationship of the respondent		
10	Time(date)of Attempt		
11	Mode of attempt		
12	Time(date)of death		
13	Cause of death		
14	Site of death		
15	Death discovered by		
16	Prior communication about suicide		
17	Influence of drug		
18	Note about Suicide note		
19	History of prior attempt recorded		
20	History of psychiatric illness recorded		
21	Treatment of psychiatric illness recorded		
22	Family history of suicide recorded		
23	Active stress listed		
24	Recent loss listed		
25	History of substance use recorded		

Any other information collected? If yes, elaborate:

Feedback from the station in-charge:

Annexure 3

सि.नं. .....

आत्महत्या प्रयास गरेकाको विवरण

१) प्रयासकर्ताको परिचय:

क) नाम:

ख) उमेर / लिङ्ग: ग) वैवाहिक अवस्था:

घ) शैक्षिक योग्यता: ङ) पेशा:

च) धर्म: छ) जाति:

ज) ठेगाना:

अ) स्थायी:

आ) अस्थायी:

२) आत्महत्याको प्रयासको विवरण:

क) प्रयास गरेको ठाउँ:

ख) प्रयास गरेको मिति:

ग) प्रयास गरेको समय:

घ) प्रयास गरेको माध्यम:

अ) झुण्डिएर आ) विष सेवन गरेर

इ) धारिलो हतियारले काटेर ई) डुबेर

उ) हाम फालेर ऊ) जलेर

ए) अन्य

ङ) प्रयासको किसिम:

अ) योजना बनाएर आ) आवेशमा आएर

इ) दुर्घटनावश

च) मादक वा लागु पदार्थको नशा लागेको अवस्था: थियो / थिएन

छ) प्रयास गर्नुको कारण (प्रयासकर्ताका अनुसार):

अ) मृत्यु आ) रिसको झोकमा

इ) बदला लिन ई) धम्की दिन

उ) चाहेको कुरा पाउन ऊ) उत्सुकता

ए) ध्यान आकर्षित गर्न ऐ) अन्य

३) प्रयास अघि:

क) प्रयास बारे अवगत गराएको: थियो / थिएन

ख) मानसिक रोग: थियो / थिएन

अ) थियो भने उपचार भएका: थियो / थिएन

ग) शारीरिक रोग: थियो / थिएन

अ) थियो भने उपचार भएका: थियो / थिएन

घ) परिवारमा मानसिक रोग: थियो / थिएन

ङ) यो भन्दा पहिले आत्महत्याको प्रयास गरेको: थियो / थिएन

अ) थियो भने कति पटक:

च) परिवारमा आत्महत्याको घटना भएको: थियो / थिएन

छ) प्रारम्भिक निदान (प्रोभिजनल डाएग्नोसिस्):

ज) उपचार दिएको:

अ) औषधि आ) मनोवैज्ञानिक

इ) परिवारलाई काउन्सेलिङ

झ) मानसिक रोग विशेषज्ञसँग सल्लाह लिईएको: थियो / थिएन

Annexure 4

सि.नं. .....

आत्महत्याबाट मृत्यु भएकाको विवरण

१) मृतकको विवरणः

क) नामः

ख) उमेर / लिङ्गः

ग) वैवाहिक अवस्थाः

घ) शैक्षिक योग्यताः

ङ) पेशाः

च) धर्मः

छ) जातिः

ज) ठेगानाः

अ) स्थायीः

आ) अस्थायीः

२) मृत्युको विवरणः

क) आत्महत्याको सोच आएको बारे अवगत गराएकोः थियो / थिएन

ख) यो भन्दा पहिले आत्महत्याको प्रयास गरेकोः थियो / थिएन

अ) थियो भने कति पटकः

ग) प्रयासको किसिमः

अ) योजना बनाएर

आ) आवेशमा आएर

इ) दुर्घटनावश

घ) मानसिक समस्या भएकोः थियो / थिएन

अ) थियो भने उपचार भएकोः थियो / थिएन

ङ) परिवारजनमा आत्महत्याको घटना भएकोः थियो / थिएन

च) आत्महत्याको प्रयास भएको दिनः

छ) मृत्यु भएको दिनः

ज) मृत्यु भएको समयः

झ) मृत्यु भएको स्थानः

ट) घटना पत्ता लगाउने व्यक्ति (नाता):

ठ) मृत्युको कारणः

अ) झुण्डिएर

आ) विष सेवन गरेर

इ) धारिलो हतियारले काटेर

ई) डुबेर

उ) हाम फालेर

ऊ) जलेर

ए) अन्य

ड) कुनै देखिने खालको तनावको अवस्थाः थियो / थिएन

ढ) हालसालैको कुनै नोक्सानजन्य घटनाः थियो / थिएन

Annexure 5

Suicide Help line checklist

Department of Psychiatry
Patan Academy of Health Sciences

१. आभिवादन/ Greeting

२. सेवाप्रदयाकको परिचय/ Introduction of service provider

३. सेवाग्राहिको परिचय/ Introduction of caller

४. सेवाग्राहीले भनेका कुराका गोपनियताबारे जानकारी/ About Confidentiality

५. सेवाग्राहीले कस्तो अवस्थामा फोन गरेको छ सोबारे जानकारी/ Current situation of caller

६. समस्याका बारेमा प्रश्नहरु/ Questions about problems

७. समानुभुतीका कुराहरु ब्यक्त/ Empathy

८. आत्महत्या सम्बन्धी सोच मात्र वा योजना/ Suicidal ideas or Plan

९. आत्महत्या गर्नुपर्ने हालका कारणबारे प्रश्न/ Ask reasons to commit suicide

१०. बिगतमा आत्महत्याका प्रयास तथा योजना/ Past history of suicide attempt

११. कुनै मनसिक रोग वा उपचार सम्बन्धमा प्रश्नहरु/ History of Psychiatric illness and treatment

१२. सेवाग्राही बाच्नुपर्ने कारणहरु पहिचन गर्नका लागि सहयोग/ Help to identify reasons to live

१३. समस्याको समाधान गर्न सकिन्छ भनेर छलफल र आशावादी बनाउने प्रयास/ Problem solving and try making patients hopeful

१४. थप मद्दतका बारे जानकारी दिने (मानसिक स्वास्थ सेवा वा पुलिस को सहयोग)/ Inform about the availability of Help

१५. फेरी यस्तै सोच दोहोरिए मा पुनः सम्पर्क गर्न सक्नुहुनेछ / If similar thoughts persist patient can call again

Annexure 6

Multi-disciplinary collaborative approach to develop a suicide (attempts) registry
Department of Psychiatry
Patan Academy of Health Sciences

Socio-demographic profile:

Name Age/Sex

Marital status Education

Occupation Religion

Ethnicity

Address: Temporary: Permanent

Called after: 1. Attempt 2. Planning 3. Only ideas 4. Inquire about help line 5. Others

Help seeking attempt over phone: 1st 2nd 3rd

Past history of suicide attempt: Yes / No If Yes number of times:

History of Psychiatric illness: Yes / No

If Yes treatment: Yes / No

Willing to seek help in person in OPD: Yes / No

-----the end of report------