

Executive Summary

At least 30,000 Americans die by suicide each year. For every person who completes the act, it is thought that 8 - 25 more people attempt. Even using conservative estimates, the number of suicides and attempted suicides clearly indicates a public health crisis.

But why is there such disparity in the number of attempted suicides? What can be done to provide more precise and reliable information to guide suicide prevention policies and programs?

In April 2006, the Suicide Prevention Action Network USA (SPAN USA) hosted a roundtable discussion to tackle these challenging questions. Experts involved with state and national public health surveillance systems and academia discussed current public health surveillance activities and recommended ways to strengthen non-fatal suicide attempt surveillance systems.

Currently, non-fatal suicide attempt data are gathered from (1) hospital discharge data for inpatients, (2) emergency department data, and (3) population-based randomized phone surveys and self-administered questionnaires. These data sources were not developed specifically for capturing information about suicide attempts, so each provides a partial look at the incidence and circumstances surrounding attempts. Together, the data sources offer an incomplete, and likely understated, account of the problem. However, policy makers and planners need more specific data to better assess and respond to the needs of at-risk individuals, particularly as those who survive a suicide attempt are at increased risk for subsequent attempts.

In their review of current public health surveillance activities, roundtable experts noted the limitations of current systems. One over-arching problem is the lack of infrastructure. The experts expressed great concern about the lack of resources and infrastructure within state and local health departments to conduct surveillance, conduct epidemiologic analysis and disseminate data. Five states do not have systems to collect hospital discharge data, while twenty-five states lack hospital emergency department data systems.

Another significant shortcoming is data variability. There is no standard set of uniform definitions or coding schemes for key variables relevant to suicide and suicide attempt surveillance. For example, states that collect hospital discharge and emergency department data use a variety of fields to record external-cause-of-injury codes (used to identify cases of suicide and non-fatal intentional self harm in hospital records). This lack of standardization makes it difficult to aggregate and compare data across states.

To frame their recommendations, the expert group first agreed upon general principles to guide decision-making about public health surveillance. The principles were:

- Public health surveillance is necessary as a foundation for addressing suicide.
- Healthcare providers need to identify and report suicide attempts.
- Public health professionals need to track and analyze the data.

- A national data clearing house needs to aggregate the data and identify available data sources for suicide and suicide attempts.
- National and state-based data on the incidence and characteristics of suicide and suicide attempt events should inform policy and program decisions.

The group then went on to recommend specific strategies for putting these principles into action. The experts came up with a series of seven steps aimed at strengthening non-fatal suicide attempt surveillance over the short- and long-term. Their recommendations were to:

- (1) Mandate external-cause-of-injury coding for all inpatient hospitalizations and outpatient visits reimbursed by Medicaid and Medicare
- (2) Improve charting and other systems used in external-cause-of-injury coding
- (3) Educate others about suicide and suicide attempts as a public health concern, including the importance of reliable national and state-based non-fatal surveillance systems to monitor suicides and suicide attempts
- (4) Address ethical issues associated with suicide surveillance (e.g., privacy concerns)
- (5) Build upon existing public health surveillance systems
- (6) Hold joint meetings with the epidemiology and suicidology fields to discuss surveillance
- (7) Provide decision makers with the best data on suicide attempt that are currently available

The experts elaborated on these recommendations, providing background information and suggesting implementation strategies. The group agreed that an initial first step would be to coordinate information produced by current public health surveillance systems and put forth an expert consensus opinion on which estimate is most accurate.

In the end, the expert roundtable discussion affirmed the value of a national, uniform public health surveillance system for collecting data on suicide attempts. Participants called for a more standardized and cohesive approach to public health surveillance that would produce high quality data to better inform prevention policies and interventions.