SELF-DIRECTED VIOLENCE SURVEILLANCE

UNIFORM DEFINITIONS AND RECOMMENDED DATA ELEMENTS

National Center for Injury Prevention and Control
Division of Violence Prevention

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Self-directed Violence Surveillance: Uniform Definitions and Recommended Data Elements

Version 1.0

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BACKGROUND

Background

Introduction

Self-directed violence (SDV) is an important cause of mortality and morbidity in the United States and worldwide. Though numerous organizations collect information on fatal and non-fatal SDV, there is considerable confusion about how to define the phenomenon. To address the current lack of uniform definitions, the Centers for Disease Control and Prevention (CDC) proposes the following surveillance* definitions for SDV. Use of consistent terminology with standardized definitions will improve communication among researchers, clinicians, and others working in this important area.

**In this document, the term "surveillance" is used in the public health sense and is defined as the ongoing, systematic collection, analysis, interpretation, and dissemination of data regarding a health-related event for use in public health action to reduce morbidity and mortality and to improve health.*[1]

Public Health Burden

The World Health Organization defines violence as: "The intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community, that either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment or deprivation."[2] The definition should be understood to include consequences such as psychological and social problems as well as physical problems, all of which are of concern to communities and place considerable burdens on the health, social and justice systems. This definition recognizes that the outcomes of violence are broader than physical injury, disability or death. Injuries and deaths resulting from self-directed violent behaviors represent a substantial drain on the economic, social, and health resources of the nation.

Self-directed violence (SDV) encompasses a range of violent behaviors, including acts of fatal and nonfatal suicidal behavior, and non-suicidal intentional self-harm (i.e., behaviors where the intention is not to kill oneself, as in self-mutilation). Though not a behavior, we have chosen to include suicidal ideation (i.e., thinking about, considering, or planning for suicide) in this document due to its association with self-directed violent behavior.[3] The National Center for Injury Prevention and Control (NCIPC) has adopted the public health approach to systematically address the problem of self-directed violence. The public health approach involves the following: defining and describing the nature of the problem; studying the factors that increase or lower risk; developing and evaluating ways to prevent the problem; and implementing interventions and disseminating information.[2]

Injury from self-directed violence is a major public health problem throughout the United States and the rest of the world.[2,4-6] In 2007 in the United States, suicide, one form of SDV, was the 11th leading cause of death overall, resulting in 34,598 deaths[7]; it was the third leading cause of death among persons aged 15–24 years, fourth among persons aged 25–44 years, and eighth among those aged 45–64 years.[8] Although suicide continues to be problematic throughout the life span, rates for males are highest among those aged 85+ years, while among females the rates are highest among those aged 45–49 years. Suicides reflect only a minor portion of the total impact of suicidal behavior which itself is a component of SDV. Substantially more persons are hospitalized as a result of nonfatal suicidal behavior than are fatally injured, and an even greater number are either treated in ambulatory settings or not treated at all.[9,10] There were an estimated average of 533,000 visits to U.S. hospital emergency departments for self-directed violence, the majority of which are suicide attempts, which occurred during 2005 and 2006.[11,12] Other research indicates that >50% of persons who engage in suicidal behavior never seek health services.[13] Consequently, prevalence figures based on health records substantially underestimate the societal burden of suicidal behavior and of SDV.

Comparative descriptions of suicidal ideation or behavior demonstrate certain key differences among population groups. For example, rates of suicide are higher among males than among females, while the reverse is found in studies of suicidal thoughts and nonfatal suicidal behavior.[14] Age-group specific suicide rates have traditionally been highest

among older adults aged >65 years compared to adolescents and young adults, but rates on nonfatal suicidal behavior are highest among the younger age groups and relatively low among older adults.[4] Certain US populations such as American Indians/Alaska Natives and African-Americans have their highest suicide rates among adolescents and young adults whereas other groups such as Asian-Americans and Hispanics have their highest rates among older adults.[15]

Total lifetime costs associated with nonfatal injuries and deaths caused by self-directed violence in 2000 were approximately $33 billion, including $1 billion for medical treatment and $32 billion for lost productivity.[16] Compounding these costs is the incalculable impact of loss of life and the emotional trauma experienced by surviving family, friends, and communities that are affected by each person's fatal or nonfatal suicidal behavior.[17]

Need for Better Data

Despite the large volume of data on certain types of SDV, the utility and reproducibility of the resulting information is sometimes questionable. Mortality data are problematic for several reasons: geographical differences in the definition of suicide and how equivocal cases are classified; jurisdictional differences in the requirements for the office of coroner or medical examiner affecting the standard of proof required to classify a death as a suicide; and differences in terms of the extent to which potential suicides are investigated to accurately determine cause of death.[18] The quality of the data on nonfatal suicidal behavior is even more problematic than that of suicides. The concerns about discrepancies in nomenclature[19-23] and accurate reporting[11,24] apply here even more than with suicides. Also, except for rare exceptions there is neither systematic nor mandatory reporting of nonfatal suicidal behavior in the United States at the state or local level, nor is there routine systematic collection of non-suicidal intentional self harm data.

These "system" problems with data collection have been discussed for more than a generation. Over 35 years ago, the National Institute of Mental Health (NIMH) convened a conference on suicide prevention at which a committee was charged with recommending a system for defining and communicating about suicidal behaviors.[25] More recently, two scientific reviews that addressed the state of suicide-related research also remarked on the need for consistent definitions. The Institute of Medicine issued a report entitled *Reducing Suicide: A National Imperative*.[4] This report states "Research on suicide is plagued by many methodological problems… definitions lack uniformity,…reporting of suicide is inaccurate.""There is a need for researchers and clinicians in suicidology to use a common language or set of terms in describing suicidal phenomena."The World Health Organization issued the *World Report on Violence and Health*.[2] In the chapter addressing self-directed violence the authors note "Data on suicide and attempted suicide should be valid and up to date. There should be a set of uniform criteria and definitions and – once established – these should be consistently applied and continually reviewed."

There are also "non-system" barriers to obtaining reliable SDV surveillance information. For example, the repetitive nature of some types of SDV, make it important to separate counts of the number of *individuals* affected from the number of *incidents* of SDV. This difficulty is compounded by the varying procedures used by different data collection sources. Health care organizations may file and treat each event separately, or they may record repeated incidents in the same patient file. In addition, there are social barriers to obtaining accurate SDV surveillance data. These barriers include the stigma associated with the topic; the guilt and shame that inhibit a patient's admission that act was intentional; and the lack of training and other concerns that inhibit health care personnel's capacity to elicit and record accurate accounts of SDV in official records. Furthermore, it appears only a minority of individuals engaging in SDV behavior ever seek help from the health care system.[13]

For example, to address just the suicide-related component of SDV as a public health problem would require the sustained and systematic collection, analysis and dissemination of accurate information on the incidence, prevalence and characteristics of fatal and nonfatal suicidal behavior. Surveillance is a cornerstone of public health, allowing realistic priority setting, facilitating the design of prevention programs, and the ability to evaluate such programs.[26] Official suicide rates have been used to chart trends in suicide; monitor the impact of change in legislation, treatment policies, and social change; and to compare suicides across regions, both within and across countries. In addition, suicide rates afford a method by which to assess population-based risk and protective factors for geographical areas (counties, states and countries). However, there exist serious inadequacies in the availability and quality of mortality data. The sources of data that are currently available remain "'thin' ... with no connection to other relevant data...".[27]

The need for improved and expanded surveillance systems is highlighted as one of the central goals of the National Strategy for Suicide Prevention.[14]

Inconsistent reporting of SDV has significant consequences for public health and application in problem description, assessment of risk and protective factors, understanding the longitudinal course and outcome of SDV processes, and the development and evaluation of effective preventive and treatment intervention strategies. Differential underreporting for certain groups means that our understanding of that population's risk and protective factors for SDV may contain significant inaccuracies. This could result in inattention to an at-risk population: if the true rates of SDV are higher than the official statistics indicate, not only is SDV likely to be viewed as a less important problem among this population, but the SDV risk factors identified by researchers might more accurately reflect the SDV process for some other group. When these faulty conclusions become the basis for developing SDV prevention programs, such programs might miss opportunities to address the factors more consequential for the targeted population. To correct this process, we need accurate data on each group.

CDC has initiated several activities with the goal of improving classification of certain forms of SDV. CDC developed national practice guidelines for determining suicide for coroners and medical examiners.[28] In addition, CDC has included an objective to examine surveillance methods for SDV in the National Center for Injury Prevention and Control's research agenda.[29] As a co-sponsor of the National Strategy for Suicide Prevention (NSSP), CDC supported the inclusion of items specifically addressing expansion and improvement of data systems including surveillance.[14] CDC's previous efforts developing uniform definitions and recommended data elements in the separate areas of intimate partner violence, sexual violence and child maltreatment have informed the process of developing the definitions for SDV.[30-32] CDC has also supported the development of SDV surveillance. For example, CDC has developed a module to assess self-directed violence in the National Electronic Injury Surveillance System-All Injury Program (NEISS-AIP) which includes data on hospital emergency department visits for nonfatal self-directed violence.[33] The module supplements information from the general NEISS-AIP by collecting additional information on the characteristics of persons presenting to hospital emergency departments (EDs) for self-directed violence; identifying specific substances used in the event; and acting as an early warning system on emerging problems in regard to self-inflicted injury.[34]

Recognizing the need to improve the quality of SDV data, the CDC's National Center for Injury Prevention and Control (NCIPC) initiated a process to address some of the conceptual difficulties inherent in the task. CDC decided to concentrate its new efforts on developing uniform definitions and data elements for SDV surveillance. The process involved a consultative procedure to address some of the scientific issues related to definitions and potential data elements that might be appropriate to collect as part of surveillance activities.

The SDV Consultative Process

- The history of CDC work on SDV surveillance definitions and recommended data elements, spans several years:
- In 2003, CDC commissioned an extensive review of the scientific literature that addressed self-directed violence (SDV) surveillance definitions. The information gathered from this review was synthesized in a report.
- CDC recruited a panel of scientists and practitioners representing multiple disciplines (e.g., medicine, psychology, epidemiology, sociology), various affiliations (e.g., government, academic institutions), and diverse areas of interest (e.g., suicidal behavior, public health surveillance, injury prevention). This panel was convened for a discussion of SDV surveillance definitions.
- The report from the literature review, select publications on suicide-related nomenclature, and other documents on public health and injury-specific surveillance were compiled as background material and distributed to the panel.
- The panel was convened in April 2004 to develop draft SDV definitions, data elements, and items for a glossary.
- The panel discussion was recorded and transcribed and the resulting meeting notes were compiled and distributed to panel members for review and commentary.
- The draft definitions were reviewed and discussed at an October 2005 meeting with suicide prevention leaders representing the U.S Army, Navy, Air Force, Marines and Coast Guard.

- The meeting notes and draft definitions were distributed to external reviewers nominated by the panel. Written feedback from the external reviewers on the definitions and glossary was compiled and added to the meeting notes. The meeting notes along with the external panel comments and suggestions were distributed to the original panel.
- The original 2004 panel was reconvened in April 2007 (with two substitutions) to examine comments from the external reviewers, discuss advances in the field since the last meeting and revise the definitions document.
- At the April 2007 meeting, the panel was charged with three main tasks: 1) finalizing the definitions to be used in the document; 2) revising the list of glossary terms, and 3) identifying a set of data elements that were considered essential for SDV surveillance. During the panel discussion, however, it became evident that there were no clearly identifiable criteria or procedures for determining which data elements could plausibly be collected in the diverse nature of national, state and local surveillance systems, or which ones were the highest priority. The data elements presented in this report are those identified by the panel as useful, acknowledging that some institutions participating in a surveillance system may be able to collect only a subset of the recommended elements. The panel also developed conceptual definitions of terms to be used in conjunction with the data elements. It became evident that these definitions might need to be operationalized (i.e., made measurable) in different ways, depending on the source of the data.
- The discussion at the April 2007 meeting was recorded, transcribed and distributed to panel members. CDC staff summarized the recommendations from the April 2007 meeting, and incorporated changes recommended by the panel members. CDC staff also researched definitions for the glossary terms, developed descriptions and criteria for the data elements and produced a document containing all of this information.
- A draft of the document using the 2007 meeting notes, glossary, data elements, and vignettes was sent to the panel, and other external reviewers nominated by the panel. Drafts of the definitions-only were also distributed to individuals representing the Department of Defense, Department of Veterans Affairs and Coast Guard for comments and suggestions.
- A summary of the draft definitions and recommended data elements was presented at several national suicide prevention conferences during 2008 and 2009 and comments were solicited from audience members.
- Selected comments from the various groups were incorporated into the document.
- Revisions were made to definitions and key terms to make them consistent with Department of Veterans Affairs' SDV classification system clinical tool.

Purpose and Scope

Self-directed Violence Surveillance: Uniform Definitions and Recommended Data Elements, is intended for use by individuals and organizations interested in gathering surveillance data on self-directed violence. The document is not meant as a mandate, but rather is intended to promote and improve consistency of SDV surveillance. If the recommended data elements can be uniformly recorded and the data made available to numerous users, then better estimates of SDV incidence and prevalence can be obtained and problems such as data incompatibility and high costs of collecting, linking, and using data can be substantially reduced.

The recommended data elements are designed to collect information of value for public health surveillance of SDV and to serve as a technical reference for automation of surveillance data. The 35 data elements are organized into 2 major sections: Identifying Information for the SDV Surveillance System and the Individual's Demographics; and Characteristics associated with the Individual's SDV behavior. A structured format, modified from the Data Elements for Emergency Department Systems (DEEDS), Release 1.0[35], is used to document each data element as follows: a Description/Definition of the data element; a description of its Uses; a Discussion of conceptual or operational issues; specification of the Data Type (and maximum allowed Field Length); an indication of when data element repetition may be necessary to include all answers that may apply; Field Values/Coding Instructions that designate recommended coding specification and valid data entries; and, where applicable, reference to one or more data standards or guidelines used to define the data element and its field values, and other references considered in developing the data element.[35] Data types and field lengths conform to specifications in Health Level 7 (HL7), a widely used protocol for electronic data exchange, and ASTM's (formerly known as the American Society for Testing and Materials) E1238-94: Standard Specification for Transferring Clinical Observations Between Independent Computer Systems.[36,37]

Notes on the Use of *Self-directed Violence Surveillance: Uniform Definitions and Recommended Data Elements,* Version 1.0

The "definitions" proposed here are likely to be valuable for a wide range of policymakers, researchers, public health practitioners, service providers, and media professionals seeking to clarify discussions about SDV. However, most terms in the "Uniform Definitions" are defined in only a general sense, and researchers and other users may need to further refine them. Other terms, such as "victim-precipitated" and "self-inflicted" are included in the key terms section. However, this document could not be exhaustive regarding terminology so users are referred to other documents such as the IOM report on suicidal behavior or the NSSP. Issues needing further clarification could be addressed in subsequent versions of the "definitions". It should be noted that the definitions proposed here are consistent with others which have undergone empirical testing and demonstrated good reliability.[38]

As you use the "Recommended Data Elements," consider the following points:

- Ethical and safety issues are foremost in any effort to examine self-directed violence. No data should be collected or stored in a manner that could jeopardize an individual's safety or privacy. Those interested in developing a surveillance system for SDV must be particularly conscious of the need to preserve confidentiality. The issue of confidentiality must be balanced with the need for data linkage across multiple data sources, perhaps through mechanisms such as encryption of unique identifiers.
- Concurrent with progress toward more uniform and accessible data, existing methods of protecting the confidentiality of data must be strengthened. Guaranteeing confidentiality will serve multiple purposes. First, it may protect individuals who engage in SDV from potential discrimination. Second, it may encourage those individuals to report SDV.
- Each data element is numbered for convenience of presentation and for easy identification. In addition, literature sources for the background section (i.e., public health burden, need for better data, SDV consultative process, purpose and scope, and next steps) are listed separately from the references for the data elements to ease use. The data elements are not meant to be "administered" as a survey or a questionnaire, but instead are presented as information to be gathered from appropriate data sources in the jurisdictions conducting SDV surveillance. Thus, the elements can be gathered in any order and can be obtained from one or more data sources for individuals engaging in self-directed violence. Each data element includes a code set that specifies recommended coding values and instructions for what to do when the data element is not applicable for a particular victim. Obviously, the accuracy and completeness of data collected on SDV events depends upon what is documented by the agency providing the information.
- Currently the "Recommended Data Elements" contains 35 items, however the list may be modified in the future. Persons implementing a surveillance system using this list may find that one or more variables need to be added, removed, or enhanced.[36] Further, the list should not discourage individuals who operate systems from collecting information that is not included in the recommended elements. Rather, the suggested elements will comprise a core set of data that should, if possible, be systematically be collected by all surveillance systems. Desirable data elements that are not feasible to collect as part of a surveillance system will need to be collected in other ways.
- The goals of SDV surveillance are to obtain an estimate of the number of people who are affected by self-directed violence and to describe the characteristics of people affected, the number and types of SDV episodes, the associated injuries, and other consequences. Counting injuries as part of a surveillance system is a common proxy for estimating the number of people affected. However, the large number of cases in which multiple forms of violence co-occur and the repetitive nature of SDV mean that such a proxy may be less accurate than is desired. To obtain more accurate estimates of the number of people affected by SDV, ultimately we will need to develop some mechanism for linking data, both within and across different data sources.[39, 40] For further discussion and information on setting up an injury surveillance system, please see the WHO's document Injury Surveillance Guidelines.[41]
- No single data source is likely to collect all of the components of SDV. As a consequence, it is likely that anyone setting up a surveillance system will need to integrate data from multiple sources (e.g., death certificates, hospital records, emergency medical system records, surveys, health care records and law enforcement records) to develop a comprehensive picture of SDV in their community.[42, 43]

- It is recognized that categorizing SDV behavior into suicidal and non-suicidal categories can be difficult. This is due to several considerations, first that the behavior is multi-dimensional rather that unitary and second that if information is collected from patients' self-reports, that the way the individual perceives his/her intent can change within a few hours. Nevertheless, due to the essential nature of this information to clinical and public health decision-making, it is critical to try to obtain it.[44]
- Vignettes are included after the data elements to provide the reader with an opportunity to make an assessment about SDV categorization in the situations described. Their purpose is to provide an opportunity for the reader to gauge his/her understanding of the material.

Next Steps

As with the CDC guidelines for recommended data elements for other forms of violence (*Intimate Partner Violence Surveillance: Uniform Definitions and Recommended Data Elements, Version 1.0,* 2002; *Sexual Violence Surveillance: Uniform Definitions and Recommended Data Elements, Version 1.0,* 2002; and *Child Maltreatment Surveillance: Uniform Definitions for Public Health and Recommended Data Elements, Version 1.0.,* 2008), this initial release of *Self-directed Violence Surveillance: Uniform Definitions and Recommended Data Elements, Version 1.0* is intended to serve as a starting point.[30-32] Many data element definitions and coding specifications are new, and field testing is necessary to evaluate them. Systematic field studies or pilot tests are needed to gauge the usefulness of Version 1.0 for SDV surveillance, to identify optimal methods of data collection, and to specify resource requirements for implementation. This testing will help to identify unforeseen problems with the data elements and adaptations needed for various settings, and to ensure that categories are mutually exclusive. Along with testing, evaluation of any surveillance system using these definitions is essential.[43]

These definitions can be applied in a variety of communities or settings where surveillance systems are either in-place or planned such as states, counties, or health clinics, emergency departments, hospitals, and institutions responsible for completing death certificates. Though the proposed definitions are not directly translatable to household or community survey application, the concepts of the definitions could be converted into data items for reliability and validity testing. Prospective users of Version 1.0 are invited to contact CDC to discuss their plans for evaluating or using some or all of the recommended data elements. Lessons learned through field testing and evaluation will be a valuable source of input for subsequent revisions, but all comments and suggestions for improving this document are welcome.

We hope that many organizations will try these definitions and data elements and provide feedback to CDC. Exploration of surveillance methods and assessments of the feasibility and utility of collecting this information will improve future versions of this document. We plan to use information obtained from trials of the initial version to refine the definitions and the number of recommended data elements in future versions.

Please send questions or suggestions for improving *Self-directed Violence Surveillance: Uniform Definitions and Recommended Data Elements, Version 1.0* to:

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UNIFORM DEFINITIONS

Uniform Definitions

Definitions

Self-directed violence (analogous to self-injurious behavior)

Behavior that is self-directed and deliberately results in injury or the potential for injury to oneself.

This does not include behaviors such as parachuting, gambling, substance abuse, tobacco use or other risk taking activities, such as excessive speeding in motor vehicles. These are complex behaviors some of which are risk factors for SDV but are defined as behavior that while likely to be life-threatening is not recognized by the individual as behavior intended to destroy or injure the self. (Farberow, N. L. (Ed.) (1980). The Many Faces of Suicide. New York: McGraw-Hill Book Company). These behaviors may have a high probability of injury or death as an outcome but the injury or death is usually considered unintentional. Hanzlick R, Hunsaker JC, Davis GJ. *Guide for Manner of Death Classification.* National Association of Medical Examiners. Available at: http://www.charlydmiller.com/LIB03/2002NAMEmannerofdeath.pdf. Accessed 1 Sept 2009.

Self-directed violence is categorized into the following:

Non-suicidal (as defined below)

Suicidal (as defined below).

Non-suicidal self-directed violence

Behavior that is self-directed and deliberately results in injury or the potential for injury to oneself.

There is no evidence, whether implicit or explicit, of suicidal intent. Please see appendix for definition of implicit and explicit.

Suicidal self-directed violence

Behavior that is self-directed and deliberately results in injury or the potential for injury to oneself.

There is evidence, whether implicit or explicit, of suicidal intent.

Undetermined self-directed violence

Behavior that is self-directed and deliberately results in injury or the potential for injury to oneself.

Suicidal intent is unclear based on the available evidence.

Suicide attempt

A non-fatal self-directed potentially injurious behavior with any intent to die as a result of the behavior.

A suicide attempt may or may not result in injury.

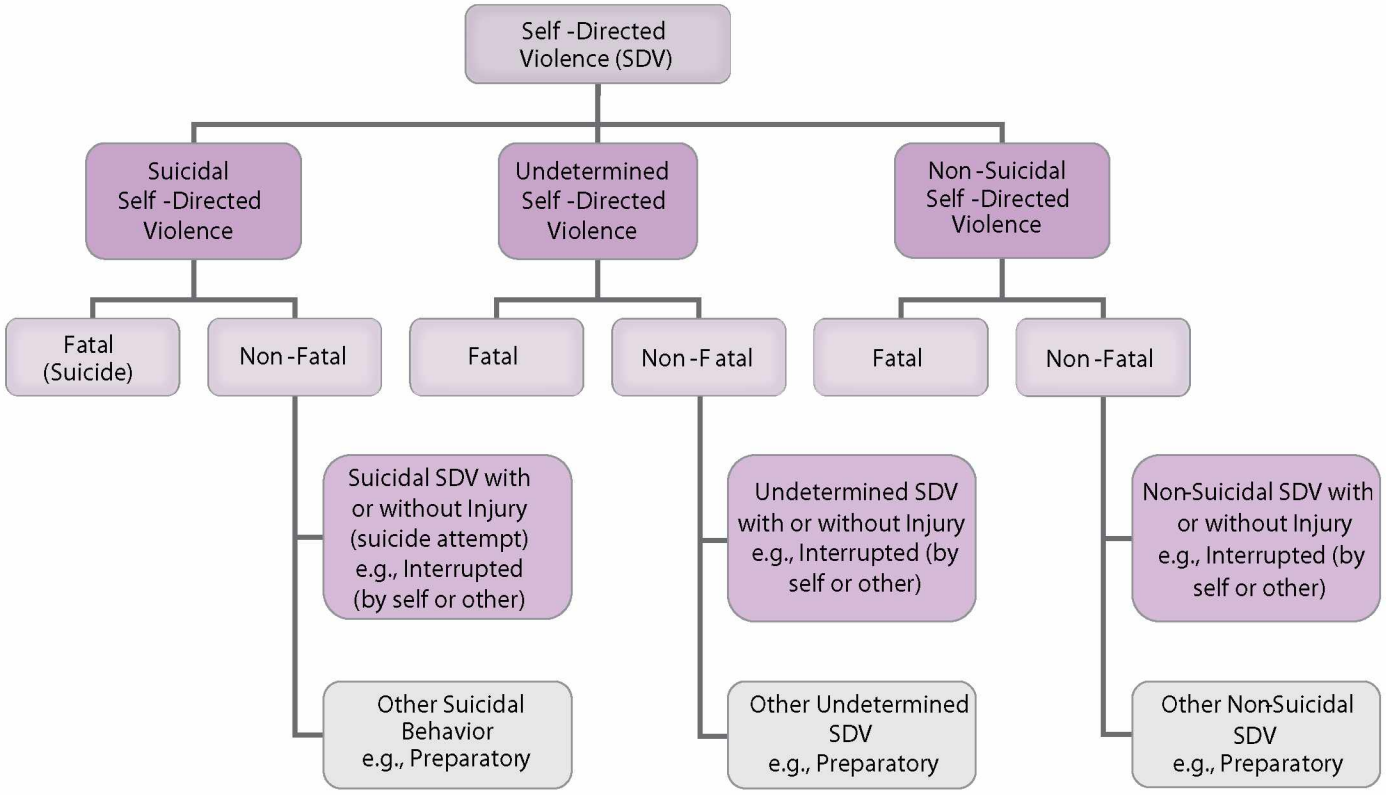
Interrupted self-directed violence – by self or by other

By other - A person takes steps to injure self but is stopped by another person prior to fatal injury. The interruption can occur at any point during the act such as after the initial thought or after onset of behavior.

By self (in other documents may be termed "aborted" suicidal behavior) - A person takes steps to injure self but is stopped by self prior to fatal injury.

Source: Posner K, Oquendo MA, Gould M, Stanley B, Davies M. Columbia Classification Algorithm of Suicide Assessment (C-CASA): Classification of Suicidal Events in the FDA's Pediatric Suicidal Risk Analysis of Antidepressants. Am J Psychiatry. 2007; 164:1035-1043. http://cssrs.columbia.edu/

Flowchart for Surveillance Definitions for Self-Directed Violence



Other suicidal behavior including preparatory acts

Acts or preparation towards making a suicide attempt, but before potential for harm has begun. This can include anything beyond a verbalization or thought, such as assembling a method (e.g., buying a gun, collecting pills) or preparing for one's death by suicide (e.g., writing a suicide note, giving things away). Posner et al, 2007.

Suicide

Death caused by self-directed injurious behavior with any intent to die as a result of the behavior.

Unacceptable Terms

The panel felt the following terms are unacceptable for describing self-directed violence:

- Completed suicide - This terminology implies achieving a desired outcome whereas those involved in the mission of "reducing disease, premature death, and discomfort and disability" (J. Last, Dictionary of Epidemiology 1988) would view this event as undesirable. Alternate term: suicide
- Failed attempt - This terminology gives a negative impression of the person's action, implying an unsuccessful effort aimed at achieving death. Alternate terms: suicide attempt or suicidal self-directed violence.
- Nonfatal suicide – This terminology portrays a contradiction. "Suicide" indicates a death while "nonfatal" indicates that no death occurred. Alternate term: suicide attempt
- Parasuicide – Formally used to refer to a person's self-directed violence whether or not the individual had an intent to die. However, the World Health Organization is now favoring the term suicide attempt. Alternate terms: non-suicidal self-directed violence or suicidal self-directed violence.
- Successful suicide – This term also implies achieving a desired outcome whereas those involved in the mission of "reducing disease, premature death, and discomfort and disability" would view this event as undesirable. Alternate term: suicide.
- Suicidality - This terminology is often used to refer simultaneously to suicidal thoughts and suicidal behavior. These phenomena are vastly different in occurrence, associated factors, consequences and interventions so should be addressed separately. Alternate terms: suicidal thoughts and suicidal behavior.
- Suicide gesture, Manipulative act, and Suicide threat – Each of these terms gives a value judgment with a pejorative or negative impression of the person's intent. They are usually used to describe an episode of nonfatal, self-directed violence. A more objective description of the event is preferable such as non-suicidal self-directed violence or suicidal self-directed violence.

RECOMMENDED DATA ELEMENTS

Recommended Data Elements

Introduction

Each of the sections to follow describes specific recommended data elements that can be included in a surveillance system designed to collect information on suicide. The order of the data elements as they appear in this document is not intended to suggest a hierarchy, users may choose the order of data elements that best fits their surveillance system.

For each data element some, or all, of the following categories of information are listed:

- Name of the data element;
- Description or Definition of the data element;
- Uses of the data element;
- Discussion of relevant conceptual or operational issues;
- Data Standards or Guidelines used to define the data elements and its field values;
- Multiple Response Option or Repetition, an indication of where it is appropriate to include more than one response, e.g. appropriate to code all answers or response options that apply;
- Other References consulted in developing the data elements.

Depending on the relevance of the information for a specific data element some of the previous categories (e.g., uses, discussion, etc) may be marked as not applicable.

Data elements

Identifying Information

1 Case ID

2 Data Source

Individual Sociodemographics

3 Sex

4 Age, Birth Date of person

5 Race

6 Ethnicity

7 Marital status

8 Person's Residence (City, State, and County)

Socioeconomic status

9 Education

10 Occupation

11 Economic activity

Event information

12 Manner of injury
13 Place of occurrence
14 Date and Time of injury
15 Nature of injury
16 Mechanism (firearm, cutting/piercing, etc)
17 Activity
18 Alcohol use
19 Drug use
20 Injury severity
21 Disposition
22 Medical care
23 Self-directed violence category
24 Suicidal thoughts at time of injury
25 Risk-Rescue rating

Individual and family history

Previous medical history

26 Somatic
27 Mental
28 Previous suicidal behavior
29 Previous suicidal thoughts
30 Family medical/psychiatric history
31 Sexual orientation
32 Military service

Associated factors

33 Proximal factors (Include precipitating events such as recent history of personal crisis)
34 Protective factors
35 Incident summary

1. Case ID

Definition: This data element is substituted for confidential identifying information in datasets. It is unique to each case and is intended for properly merging data on individuals from multiple sources and avoiding double-counting. It may be assigned by the facility/agency responsible for surveillance or it may be a generic unique identifier that belongs to the presenting case e.g. national ID with a date suffixed to distinguish between visits and incidents. Alternatively, secure in-house datasets may use a medical record number as the identifier.

Uses: The facility's internal identifier allows appropriate data exchange between approved parties while health care is being delivered and ensures that accessed, entered, or altered records correspond with the proper person. It also facilitates data linkage for administrative and research purposes.

Discussion: Until a universal person identifier is established, a locally assigned identifier is needed. To protect personal privacy and confidentiality, access to this data element must be limited to authorized personnel.

Repetition: No

Data Standards or Guidelines: *Health Level 7, Version 2.3* (HL7, 1996).

Other References: None.

2. Data Source

Definition: Agency or source from which SDV surveillance information is abstracted.

Uses: Identifies the agency or organization that supplied data for this person. It will enable linkage of multiple agency contacts for the same individual.

Code	Description
01	Hospital in-patient
02	Hospital emergency department
02	Other hospital department
03	Other ambulatory health care, including mental health
04	Police/Sheriff/Law enforcement
05	Prosecutor/District attorney
06	Social service agency
07	Telephone hotline for crisis services
08	Other social service agencies
09	Coroner or medical examiner

10	Vital statistics office within state health department
11	Other agency or data source

Discussion: This variable is essential in order to be able to distinguish the source of the information and the differences in definition from various sources such as police reports, coroner's investigative reports, hospital documents, etc. No single agency is likely to collect all of the data elements recommended. As a consequence, it is likely that anyone setting up a surveillance system will need to combine data from a number of sources (e.g., health care records and police records) using a relational database. This will allow information on data elements to be gathered from each data source used.

A unique identifier is the preferred tool for linking documents across all data sources. This identifier may or may not be identical to the data element Case ID.

Repetition: No

Data Standards or Guidelines: None

Other References: None.

3. Sex

Definition: Sex of person.

Uses: The person's sex is standard demographic and identifying information used in clinical care and for multiple additional purposes. Rates of suicide are higher among males than among females, while the reverse is found in studies of suicidal thoughts and nonfatal suicidal behavior.

Code	Description
M	Male
F	Female
O	Other (e.g. Hermaphrodite, Transsexual)
U	Unknown

Discussion: None.

Repetition: No

Data Standards or Guidelines: *E1384-96* (American Society for Testing and Materials, 1996) and *Health Level 7, Version 2.3* (HL7, 1996).

Other References: None

4. Date of birth

Definition: The calendar date on which the person was born.

Uses: Date of birth can be used to calculate the person's age. Year, month, and day of birth are entered in the format YYYYMMDD. For example, a birth date of August 12, 1946, would be encoded as 19460812. Date and time of birth are entered in the format YYYYMMDDHHMM which uses the 24 hour clock in the time component. For example, a birth at 10:30 pm on June 1, 1997, would be encoded as 199706012230. If age itself is recorded it is strongly recommended that the actual age be collected and if needed later collapsed into groups on analysis. If actual age is unknown, estimate to the nearest 10 years, whenever possible. Age-group specific suicide rates show important differences in suicidal behavior. Suicide rates are highest among older adults aged >65 years compared to adolescents and young adults, but rates on nonfatal suicidal behavior are highest among the younger age groups and relatively low among older adults.

Discussion: None.

Repetition: No

Data Standards or Guidelines: *E1384-96* (American Society for Testing and Materials, 1996) and *Health Level 7, Version 2.3* (HL7, 1996).

Other References: None.

5. Race

Definition: Race is a concept used to differentiate population groups largely on the basis of physical characteristics transmitted by descent. Racial categories are neither precise nor mutually exclusive, and the concept of race lacks clear scientific definition. The common use of race in the United States draws upon differences not only in physical attributes, but also in ancestry and geographic origins. Since 1977, the federal government has sought to standardize data on race and ethnicity among its agencies through the Office of Management and Budget's (OMB) Statistical Policy Directive Number 15: Race and Ethnic Standards for Federal Statistics and Administrative Reporting (OMB, 1978). Directive Number 15 standards were developed to meet federal legislative and program requirements, and they are used widely in the public and private sectors. The directive provides five basic racial categories but states that the collection of race data need not be limited to these categories. However, any additional reporting that uses more detail must be organized in such a way that the additional categories can be aggregated into the five basic groups. Although the directive does not specify a method of determining an individual's race, OMB prefers self-identification to identification by an observer whenever possible. The directive states that persons of multiple racial origins should be coded using multiple categories, and not a multiracial category.

Uses: Data on a person's race are used as a marker, proxy for a related factor such as socio-economic status, in public health surveillance, and epidemiologic, clinical, and health services research. Patterns of suicidal behavior differ among certain US populations. For example using the traditional race categories, American Indians/Alaska Natives and

African-Americans have their highest suicide rates among adolescents and young adults whereas other groups such as Asian-Americans have their highest rates among older adults.

Code	Description
1	American Indian or Alaskan Native. A person having origins in any of the original peoples of North America, and who maintains cultural identification through tribal affiliation or community recognition.
2	Asian. A person having origins in any of the original peoples of the Far East, Southeast Asia, the Indian subcontinent, or the Pacific Islands. This area includes, for example, China, India, Japan, Korea, the Philippine Islands, Thailand, or Vietnam.
3	Native Hawaiian/Other Pacific Islander. A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.
4	Black. A person having origins in any of the black racial groups of Africa.
5	White. A person having origins in any of the original peoples of Europe, North Africa, or the Middle East.
9	Unknown.

Discussion: Although the biological significance of race has been scientifically questioned, data on race retain use, albeit limited, in public health surveillance and epidemiologic, clinical, and health services research.

Repetition: Yes

Data Standards or Guidelines: *Statistical Policy Directive Number 15: Race and Ethnic Standards for Federal Statistics and Administrative Reporting (OMB, 1978), Standards for the Classification of Federal Data on Race and Ethnicity (OMB, 1995), and E1633-96* (American Society for Testing and Materials, 1996).

Other References: *Core Health Data Elements* (National Committee on Vital and Health Statistics, 1996).

6. Ethnicity

Definition: Ethnicity is a concept used to differentiate population groups on the basis of shared cultural characteristics or geographic origins. A variety of cultural attributes contribute to ethnic differentiation, including language, patterns of social interaction, religion, and styles of dress. However, ethnic differentiation is imprecise and fluid. It is contingent on a sense of group identity that can change over time and that involves subjective and attitudinal influences. Since 1977, the federal government has sought to standardize data on race and ethnicity among its agencies through the Office of Management and Budget's (OMB) *Statistical Policy Directive Number 15: Race and Ethnic Standards for Federal Statistics and Administrative Reporting* (OMB, 1978). *Directive Number 15* standards were developed to meet federal legislative and program requirements, and they are used widely in the public and private sectors. The directive provides two basic ethnic categories — *Hispanic* and *Not of Hispanic Origin* — but states that collection of ethnicity data need not be limited to these categories. However, any additional reporting that uses more detail must be organized in such a way

that the additional categories can be aggregated into the two basic groups. OMB prefers that data on race and ethnicity be collected separately. The use of the Hispanic category in a combined race/ethnicity data element makes it impossible to distribute persons of Hispanic ethnicity by race and, therefore, reduces the utility of the four basic racial categories by excluding from them persons who would otherwise be included. Although the directive does not specify a method of determining an individual's ethnicity, OMB prefers self-identification to identification by an observer whenever possible. The directive states that persons of mixed ethnicity should use the single category that most closely reflects the individual's recognition in his or her community.

Uses: Data on a person's ethnicity are used in person care, public health surveillance, and epidemiologic, clinical, and health services research. For example, differential risks for SDV, have been attributed at least partly to cultural acceptance of suicidal behavior which differs across ethnic groups.

Code	Description
1	Hispanic. A person of Mexican, Puerto Rican, Cuban, Central or South American, or other Spanish culture or origin, regardless of race.
2	Not of Hispanic Origin. Anyone with a known ethnicity not fitting the definition of Hispanic.
9	Unknown.

Discussion: Personal self-identification of ethnicity is preferable to observer-identification. Enter 9 if neither method yields an identification of ethnicity.

Repetition: No.

Data Standards or Guidelines: *Statistical Policy Directive Number 15: Race and Ethnic Standards for Federal Statistics and Administrative Reporting* (OMB, 1978), *Standards for the Classification of Federal Data on Race and Ethnicity* (OMB, 1995), *E1633-96* (American Society for Testing and Materials, 1996), and *Core Health Data Elements* (National Committee on Vital Health Statistics, 1996).

Other References: None.

7. Marital status

Definition: Legal marital status of the person at the time when the incident occurred

Uses: Risk of SDV has been shown to vary by legal marital status.

Code	Description
1	Separated. A person legally separated.
2	Divorced. A person divorced and not remarried.
3	Married. A person currently married (includes living together and not living together). Classify common-law marriage as married.

4	Single/Never married. A person who has never been married or whose only marriages have been annulled.
5	Widowed. A person widowed and not remarried.
9	Unknown/not stated.
Discussion:	Some unmarried partners may be cohabiting. In some states this may qualify as common-law marriage.
Repetition:	No.
Data Standards or Guidelines:	CDC HISSB Common Data Elements Implementation Guide.
Other References:	None

8. Residence or address

Definition: Injured person's normal place of residence

Uses: The address is useful for patient follow-up and billing. It also is used to determine the agency responsible for potential public health interventions and to link patient-specific data with census data so that incidence rates can be calculated. Some components of this element such as street address may not be necessary to collect, however in some jurisdictions suicide attempts are classified as a reportable condition to the health department which may warrant collecting information which enables the health authorities to locate the individual. To protect an individual's privacy and confidentiality access to this data element must be limited to authorized personnel.

The following order is the model:

Component 1 is the street address.

Component 2 is the second line of the address (e.g., apartment number).

Component 3 is the city.

Component 4 is the state or province.

Component 5 is the zip or postal code.

Component 6 is the country.

Component 7 is the type of address (e.g., mailing).

Component 8 is another geographic designation (e.g., catchment area ID).

Component 9 is the county/parish code.

Component 10 is the census tract

Discussion: This information probably is available from registration and billing record systems, in which addresses are routinely entered and stored. The naming convention used will be determined by the application area. It may be a region, state, village, community, or some appropriately defined physical area.

Repetition: Yes, if the patient has more than one address.

Data Standards or Guidelines: *Health Level 7, Version 2.3* (HL7, 1996).

Other References: None.

9. Education

Definition: The highest level of education within a formal system that a person has completed measured in years.

Uses: Socioeconomic factors (such as education level, income, and occupation) are strong predictors of morbidity and mortality in the United States and many other countries, including those engaging in SDV. These data can be used to describe the relationship between socioeconomic factors and self-directed violence.

"What is the highest grade of school the subject has completed, or the highest degree this person has received?"

Code	Description
0	Less than 1st grade
1-4	1st-4th grade
5-8	5th-8th grade
9	9th grade
10	10th grade
11	11th grade
12	12th grade or high school graduate
13-15	Some college or associate's degree
16	Bachelor's degree
>16	More advanced than bachelor's degree

Discussion: This standard should be consistent with standards from the Bureau of the Census. Education should be coded in a standard format to improve compatibility between systems and datasets. Individuals with foreign educations will map into this standard according to the UNESCO ISCED (International Standard Classification of Education) referenced in this document.

Years of schooling - Highest grade of schooling completed by the person. For children under the age of 18, the individual's status and the mother's highest grade of schooling completed should be obtained.

Repetition: No.

Data Standards or Guidelines: *Core Health Data Elements* (National Committee on Vital Health Statistics, 1996).

Other References: Bureau of the Census *Current Population Survey;* Bureau of the Census *Census 2000;* National Center for Education Statistics (NCES) http://nces.ed.gov/pubs/eiip/eiip.html; United Nations Educational, Scientific, and Cultural Organization (UNESCO); *International Standard Classification of Education (ISCED)* http://unescostat.unesco.org/Documents/isced.asp; National Center for Health Statistics (NCHS); *E1384-96* (American Society for Testing and Materials, 1996) and *Health Level 7, Version 2.3* (HL7, 1996).

10. Occupation

Definition: Description of person's current work.

Uses: Routine screening information concerning the person's current job activity is used in clinical evaluation and management, and it is needed to assess the person's eligibility for workers' compensation benefits. Data on occupation and industry also are useful for public health surveillance and epidemiologic research. Some studies have shown that suicide rates differ by occupation but these studies often lack comparison groups. Occupation and industry together serve as a surrogate for a person's socioeconomic status.

Each occupation in the Standard Occupational Classification (SOC) system is placed within one of these 23 major groups:

11-0000	Management Occupations
13-0000	Business and Financial Operations Occupations
15-0000	Computer and Mathematical Occupations
17-0000	Architecture and Engineering Occupations
19-0000	Life, Physical, and Social Science Occupations
21-0000	Community and Social Services Occupations
23-0000	Legal Occupations
25-0000	Education, Training, and Library Occupations
27-0000	Arts, Design, Entertainment, Sports, and Media Occupations
29-0000	Healthcare Practitioners and Technical Occupations
31-0000	Healthcare Support Occupations
33-0000	Protective Service Occupations
35-0000	Food Preparation and Serving Related Occupations
37-0000	Building and Grounds Cleaning and Maintenance Occupations
39-0000	Personal Care and Service Occupations
41-0000	Sales and Related Occupations

43-0000	Office and Administrative Support Occupations
45-0000	Farming, Fishing, and Forestry Occupations
47-0000	Construction and Extraction Occupations
49-0000	Installation, Maintenance, and Repair Occupations
51-0000	Production Occupations
53-0000	Transportation and Material Moving Occupations
55-0000	Military Specific Occupations
98	Other Specified Occupation
99	Unspecified Occupation

Discussion: A succinct description of the person's work can be used to encode occupation (or job title) and industry. Incorporating information about both occupation and industry is important, because similar occupations confer different health risks depending on the industry. For example, a painter in a shipyard is subject to different exposures than a painter in a residential setting. Occupation, combined with industry, is used frequently as an indicator of socioeconomic status. However, its use for this purpose requires linkage between specific occupation groups and socioeconomic status. The codes shown above illustrate only the major categories. More detailed codes exist within each major code. By comparison, the person's educational level is a simple-to-use indicator of socioeconomic status, but occupation and industry are more routinely collected in Emergency Departments because of their clinical relevance. The 2000 Standard Occupational Classification (SOC) system is used by Federal statistical agencies to classify workers into occupational categories for the purpose of collecting, calculating, or disseminating data. All workers are classified into one of over 820 occupations according to their occupational definition. To facilitate classification, occupations are combined to form 23 major groups, 96 minor groups, and 449 broad occupations. Each broad occupation includes detailed occupation(s) requiring similar job duties, skills, education, or experience. For detailed information, coding instructions, and inclusions and exclusions, refer to http://stats.bls.gov/soc/soc_majo.htm.

Repetition: Yes; multiple entries in this field are appropriate if the person has more than one job.

Data Standards or Guidelines: U.S. Department of Labor, Bureau of Labor Statistics, Revising the Standard Occupational Classification System, June 1999, Report 929 http://stats.bls.gov/soc/socrpt929.pdf

Other References: None.

11. Industry or Economic activity

Definition: The type of industry or business in which the injured person was working at the time of injury.

Uses: Knowing the type of industry or business the injured person was working in can help employers and practitioners develop interventions that address work-related factors associated with SDV. For example, certain occupations may have access to highly lethal means for suicide which could be modified. For all injuries related to paid work, select the code that best describes the industry or business in which the injured person was involved.

Economic Activity: Overview of Codes

11	Agriculture, Forestry, Fishing and Hunting
21	Mining, Quarrying, and Oil and Gas Extraction
22	Utilities
23	Construction
31-33	Manufacturing
42	Wholesale Trade
44-45	Retail Trade
48-49	Transportation and Warehousing
51	Information
52	Finance and Insurance
53	Real Estate and Rental and Leasing
54	Professional, Scientific, and Technical Services
55	Management of Companies and Enterprises
56	Administrative and Support and Waste Management and Remediation Services
61	Educational Services
62	Health Care and Social Assistance
71	Arts, Entertainment, and Recreation
72	Accommodation and Food Services
81	Other Services (except Public Administration)
92	Public Administration

Discussion: A summary description of the person's work, identifying both occupation (or job title) and industry can be used to encode both occupation and industry. Incorporating information about both occupation and industry is important, because similar occupations confer different health risks depending on the industry. For example, a painter in a shipyard

is subject to different exposures than a painter in a residential setting. The Office of Management and Budget (OMB) and the U.S. Bureau of the Census have developed systems for encoding industry (OMB, 1987; U.S. Bureau of the Census, 1992). The National Institute for Occupational Safety and Health is developing and evaluating personal computer software to encode text entries for occupation and industry.

Some existing economic activity codes are based on the International Standard Industrial Classification of All Economic Activities (ISIC), Revision 3 (United Nations, 1990). The North American Industry Classification System (NAICS) is the standard used by Federal statistical agencies in classifying business establishments for the purpose of collecting, analyzing, and publishing statistical data related to the U.S. business economy. NAICS was developed under the auspices of the Office of Management and Budget (OMB), and adopted in 1997 to replace the Standard Industrial Classification (SIC) system. It was developed jointly by the U.S. Economic Classification Policy Committee (ECPC), Statistics Canada and Mexico's Instituto Nacional de Estadistica, Geografia e Informatica

Repetition: Yes; multiple entries in this field are appropriate if the person works in more than one industry.

Data Standards or Guidelines: U.S. Office of Management and Budget's (OMB) North American Industry Classification System (NAICS, pronounced Nakes) - 1997 North American Industry Classification System-1987 Standard Industrial Classification Replacement; Notice. Vol. 62, No. 68, April 9, 1997

Other References: None.

12. Manner of injury

Definition: The role of human intent in the occurrence of the injury incident

Uses: Data describing the injury intent are used in immediate patient care and to arrange appropriate consultations and follow-up. For example, recognizing that an injured patient's wounds were deliberately self-inflicted allows emergency physicians and nurses to take actions that prevent further self-destructive behavior, and establishing that a patient's injury resulted from an assault can be instrumental in protecting the patient from future harm. Cumulative injury intent data are useful for public health surveillance, health care planning and administration, and clinical, health services, and epidemiologic research.

Data Values:

Code	Description
1	*Unintentional (*sometimes called "accidental" injuries*)* injury or poisoning that is not inflicted by deliberate means with the intent to harm and includes those injuries and poisonings described as an "accident," regardless of whether the injury was inflicted by oneself or by another person. Includes person hitting wall with fist when angry with no intent to harm oneself.
2	*Self-directed violence* (Includes fatal and non-fatal suicidal behavior and nonsuicidal behavior. Please see glossary for definition of intentional self-harm)

2a	*Suicidal self-directed violence* *Includes Interrupted by self and Interrupted by other*
2b	*Non-suicidal self-directed violence*
3	*Assault* (Interpersonal violence, assaults, victim-precipitated assault, etc) Injury from an act of fatal or nonfatal violence where physical force by one or more persons is used with the intent of causing harm, injury, or death to another person; or an intentional poisoning by another person. Includes perpetrators, and intended and unintended (e.g., innocent bystanders) victims of violent acts.
4	*Undetermined* Available information is insufficient to make a distinction between unintentional injury event, self-directed violence, assault or other violence.
8	*Other* This may include:
8a	*Legal interventions Injury or poisoning caused by police or other legal authorities during law enforcement activities and includes injuries and poisonings inflicted during legal action or execution, or while attempting to enforce the law, such as an arrest or restraint of arrested person.*
8b	*Operations of war and civil insurrection*
8c	*Euthanasia*
9	*Unspecified* Injury resulting from unknown incident

Discussion:

Injuries are the acute physical conditions which are listed in Chapter XIX of the Tenth Revision of the International Statistical Classification of Diseases and Health-related Conditions (ICD-10) and which result from the external causes listed in Chapter XX (WHO, 1994). External cause of injury codes are also found in the *International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM)* external cause-of-injury codes.

Further description of certain manners of injury may be included in the incident summary such as the circumstances of a victim-precipitated assault. This description should allow for better rationale for the use of a specific manner.

Repetition:

Yes, if two or more unrelated events cause separate injuries.

Data Standards or Guidelines:

World Health Organization. *International Classification for External Causes of Injuries (ICECI): Guidelines for counting and classifying external causes of injuries for prevention and control.* Consumer Safety Institute: Netherlands; 1998.

Holder Y, Peden M, Krug E et al (Eds). *Injury surveillance guidelines.* Geneva, World Health Organization, 2001.

Other References:

None.

13. Place of occurrence

Definition: Type of place where the injury event occurred.

Uses: Data on the type of place where an injury occurred help to describe the injury-producing event and are valuable for planning and evaluating injury prevention programs. Place of occurrence data help group injuries by areas of responsibility and may help injury prevention practitioners better target interventions and use resources more effectively. This information can also provide insight into injury etiology. For example, a grouping of SDV events occurring at a bridge may initiate an examination of environmental modifications that reduce risk of injury.

Code	Description
10	Home
20	Residential institution
30	School, other institution, and public administrative area
40	Sports and athletic area
50	Street and highway
60	Trade and service area
70	Industrial and construction area
80	Farm
88	Other specified place
99	Unspecified place

Discussion: Each broad location code shown above includes several more specific location descriptions. Place of occurrence usually has two coding levels, the second level being more detailed. Not all places, however, have a second coding level. NOTE: The codes represent where the injured person was when the injury event began, not when the injury event ended. For detailed information and coding instructions, refer to http://www.rivm.nl/who-fic/ICECI/ICECI_1-2_2004July.pdf

Repetition: Yes, if two or more unrelated events cause separate injuries at separate locations.

Data Standards or Guidelines: *International Statistical Classification of Diseases and Related Health Problems, 10th Revision* (World Health Organization, 1992).

Other References: ICECI Coordination and Maintenance Group (2004). International Classification of External Causes of Injuries (ICECI) version 1.2. Consumer Safety Institute, Amsterdam and AIHW National Injury Surveillance Unit, Adelaide.

14. Date/time of Injury Onset

Definition: Onset date and time of acute injury resulting from this incident. Date that injury event occurred. Code according to date format conventions of environment Example: YYYY/MM/DD Time of the day that injury event occurred. If resources permit, capture actual time of injury event and use the 2400 hour clock.

Uses: Data that specify when an individual's symptoms or complaints began are used by practitioners to triage, evaluate, and make diagnoses during a clinical encounter. This may be critical for an event of SDV poisoning for which an antidote may need to be administered within a certain time to be effective. In aggregate form, these data also support clinical, epidemiologic, and health services research by allowing for variation in risk by time of day, day of the week, season, etc..

Data values:

1	0000(Midnight) – 0059
2	0100 – 0159
3	0200 – 0259
4	0300 – 0359
5	0400 – 0459
6	0500 – 0559
7	0600 -- 0659
8	0700 – 0759
9	0800 – 0859
10	0900 – 0959
11	1000 – 1059
12	1100 – 1159
13	1200 -- 1259
14	1300 – 1359
15	1400 – 1459
16	1500 – 1559
17	1600 – 1659
18	1700 – 1759
19	1800 -- 1859
20	1900 – 1959
21	2000 – 2059

22	2100 – 2159
23	2200 – 2259
24	2300 – 2359

Discussion: Since some individuals delay seeking care, it is important to record as accurately as possible the actual time that the acute illness or injury occurred.

Repetition: No.

Data Standards or Guidelines: None.

Other References: *E1744-95* (American Society for Testing and Materials, 1995).

Holder Y, Peden M, Krug E et al (Eds). *Injury surveillance guidelines*. Geneva, World Health Organization, 2001.

15. Nature of injury

Definition: The injury, real or suspected, which brought the injured person to the service. If more than one, select the most serious. Nature-of-injury codes are grouped according to the type of injury, e.g., fractures, intracranial injury, and open wound.

Uses: These categories allow for standardized retrieval of injury cases for epidemiological, clinical, and management oriented analyses. They can be used to characterize the patterns of injury using clinically meaningful diagnostic categories and may assist in determining the severity of the injury.

Data Values:

1	Fracture
2	Dislocation
3	Internal organ injury
4	Open wounds
5	Amputations
6	Blood vessels
7	Contusions/superficial
8	Crush
9	Burn
10	Effect of foreign bodies entering orifice
11	Other effects of external causes
12	Poisoning

13	Toxic effects
14	Multiple injuries
15	Other specified injury
16	Unspecified injury

Discussion: This element can be used for retrieval of injury events for epidemiologic analyses. It could be used to: characterize the patterns of injury resulting from diverse circumstances; serve as a standard for incident comparison across time and place; and, simplify the process of classifying injuries.

Repetition: No.

Data Standards or Guidelines:

L.A. Fingerhut and M. Warner, The ICD-10 Injury Mortality Diagnosis Matrix, Injury Prevention, 2006;12;24-29. Available at http://www.cdc.gov/nchs/data/ice/10_diamatrix.pdf

International Statistical Classification of Diseases and Related Health Problems, 10th Revision (World Health Organization, 1992).

Centers for Disease Control and Prevention. Recommended framework for presenting injury mortality data. MMWR 1997;46(No.RR-14):1-30.

CDC. Clinical modification, (ICD-9-CM). In: International classification of diseases. 6th ed. 9th rev. Hyattsville, MD: US Department of Health and Human Services, CDC; 2007. Available at http://www.cdc.gov/nchs/datawh/ftpserv/ftpicd9/ftpicd9.htm.

Other References:

Miniño AM, Anderson RN, Fingerhut LA, Boudreault MA, Warner M. Deaths: Injuries, 2002. National vital statistics reports; vol 54 no 10. Hyattsville, Maryland: National Center for Health Statistics. 2006.

Proceedings of the International Collaborative Effort (ICE) on Injury Statistics, Volume I. (PHS) 95-1252. March 1995 (Edited by LA Fingerhut).

16. Mechanism of injury

Definition: How the injury was inflicted i.e. how the person was hurt. If more than one mechanism, record the most serious injury. If able to record more than one injury, place the injuries in order from most serious to least.

Uses: The classification by mechanism characterizes the external agents or particular activities that caused the injury (e.g., motor vehicle, firearm, submersion, fall, and poisoning). The mechanisms of injury are important because evaluation research indicates that "passive protection" through modification of products and environments can be effective in reducing injury—regardless of intent. For example, interventions for pesticide poisoning-related suicidal behavior in certain regions have been shown to reduce the behavior.

Data Values:

1	Cut/Pierce
2	Drowning
3	Falls
4	Fire/burn, hot object/substance
5	Firearm
6	Machinery
7	All transportation (e.g., MV traffic, Pedal cyclist, Pedestrian, etc)
8	Natural/ environmental (e.g, Bites/stings)
9	Overexertion
10	Poisoning
11	Struck by, against
12	Suffocation, strangulation, asphyxiation
13	Other
14	Unspecified
15	Adverse effects
99	Unknown

Discussion: Injuries are often the result of a sequence of events. Three types of objects/substances may be involved in the injury event:

- Underlying object/substance—the object/substance involved at the start of the injury event

- Direct object/substance—the object/substance producing the actual physical harm

- Intermediate objects/substances—other objects/substances involved in the injury event

Repetition: No.

Data Standards or Guidelines: *International Statistical Classification of Diseases and Related Health Problems, 10th Revision* (World Health Organization, 1992).

Centers for Disease Control and Prevention. Recommended framework for presenting injury mortality data. MMWR 1997;46(No.RR-14):1-30.

Other References: Proceedings of the International Collaborative Effort (ICE) on Injury Statistics, Volume I. (PHS) 95-1252. March 1995 (Edited by LA Fingerhut).

17. Activity

Definition: What the injured person was doing at time of incident.

Uses: The type of activity at the time of injury helps to describe the circumstances of the injury-producing event and identify possible opportunities for prevention programs, policies, or strategies. Identification of work-related injuries serves multiple purposes. Better understanding of SDV that occurs while a person is on the job is needed.

Data Values:

Code	Description
10	*Sports.* Comprises exercises with functional purpose (e.g., golf, jogging, riding, school sports and athletics, skiing, swimming, hiking, waterskiing). Includes activities described as a ball game, but excludes those described as play with ball.
20	*Leisure.* Comprises activities with the purpose of entertainment or recreation (e.g., performing hobby activities or going to the theater, a dance, or a party). Includes activities described as play with ball, but excludes activities described as a ball game.
30	*Paid work.* Comprises manual or professional work for salary, bonus, or other income. Includes: — apprentice and vocational activities — rest breaks on employer premises (in hallway, rest room, cafeteria, storage area) — work on, arrival at, or departure from employer parking lot — work for pay or compensation at home — work in family business, including family farm (activity should be clearly related to profit-oriented business) — traveling on business, including to and from customer/business contacts and work activities in which a vehicle is considered the work environment Excludes: — recreational activities on employer-controlled facilities — visits for non-work purposes, when not on official business — domestic activities by a homemaker — nonprofit work for oneself (e.g., mowing lawn, repairing roof, or performing hobby or recreational activities) — school activities by a student — vehicle use (personal or commercial) for non-work purposes — commute to or from work site — illicit work (e.g., drug trafficking)

40	*Unpaid work.* Comprises duties for which one would not normally gain an income. Includes volunteer work and domestic duties (e.g., caring for children and relatives, cleaning, cooking, gardening, and maintaining a household). Excludes learning activities (e.g., attending school or university).
50	*Educational activity.* Comprises learning activities (e.g., attending school or university). Excludes apprenticeship.
60	*Vital activity.* Comprises resting, sleeping, eating, or engaging in other vital activities.
88	*Other specified activity*
99	*Unknown activity*

Discussion: None.

Repetition: Yes, if a single injury cannot be described adequately with one activity code (e.g., police officer ingests overdose of non-prescription medication) or if injuries occur during separate activities (e.g., forearm laceration from non-suicidal SDV and head injury from crash on the way to hospital).

Data Standards or Guidelines: *Classifying Deaths as on the Job* (Harshbarger and Stout, 1995), *Draft: International Classification for External Cause of Injuries* (World Health Organization Working Group on Injury Surveillance Methodology Development, 1995), and *NOMESCO Classification of External Causes of Injury* (Nordic Medico-Statistical Committee, 1996).

Other References: None.

18. Alcohol use

Definition: Suspicion or evidence of alcohol use preceding the injury event by the injured person and/or other persons involved in the injury event.

Uses: Alcohol use is a known risk factor for injuries including SDV. Therefore, it is important to collect information about the involvement of alcohol use in injury events. In some cases, quantitative biological information about alcohol use (e.g., blood or breath alcohol level) is available. In other cases, one may merely suspect alcohol use (e.g., if the patient smells of alcohol). This data element indicates whether there is either suspicion or evidence of alcohol use. No distinction is made between suspicion and evidence because criteria for each category are too difficult to define.

Alcohol Use:

1	Suspected (by report or observation) or confirmed by biological evidence
2	No information available

Discussion: Code this item for each injury case, regardless of the severity of injury, age of the injured person, or intent of the injury event. If more information is available (e.g., type of suspicion or evidence, characterization of others involved in the injury event), this detail can be added to the narrative summary. If possible include objective measure such as blood alcohol concentration.

Repetition: No.

Data Standards or Guidelines: Holder Y, Peden M, Krug E et al (Eds). *Injury surveillance guidelines.* Geneva, World Health Organization, 2001.

Other References: ICECI Coordination and Maintenance Group (2004). International Classification of External Causes of Injuries (ICECI) version 1.2. Consumer Safety Institute, Amsterdam and AIHW National Injury Surveillance Unit, Adelaide.

World Health Organization. *International Classification for External Causes of Injuries (ICECI): Guidelines for counting and classifying external causes of injuries for prevention and control.* Consumer Safety Institute: Netherlands; 1998.

19. Other drug or psychoactive substance use

Definition: Suspicion or evidence of psychoactive drug use (e.g., opiates, cocaine, amphetamines, cannabinoids, sedatives, hypnotics) or other psychoactive substance use (eg., hair spray, gasoline, glue) preceding the injury event by the injured person and/or other persons involved in the injury event.

Uses: Use of psychoactive drugs or other substances is a known risk factor for injuries including SDV. Therefore, it is important to collect information about the involvement of drug use and other substance use in injury events. In some cases, biological quantitative information about drug or substance use (e.g., blood/urine drug level) is available. In other cases, one may merely suspect drug or substance use (e.g., because of the patient's current behavior or history). This data element indicates whether there is either suspicion or evidence of alcohol use. No distinction is made between suspicion and evidence because criteria for each category are too difficult to define.

Psychoactive Drug or Substance Use:

1 Suspected (by report or observation) or confirmed by biological evidence

2 No information available

Discussion: Code this item for each injury case, regardless of the severity of injury, age of the injured person, or intent of the injury event. If more information is available (e.g., type of suspicion or evidence, characterization of others involved in the injury event), this detail can be added to the narrative summary. If possible include objective measure such as blood or body fluid concentration.

Repetition: No.

Data Standards or Guidelines:

ICECI Coordination and Maintenance Group (2004). International Classification of External Causes of Injuries (ICECI) version 1.2. Consumer Safety Institute, Amsterdam and AIHW National Injury Surveillance Unit, Adelaide.

Other References:

World Health Organization. *International Classification for External Causes of Injuries (ICECI): Guidelines for counting and classifying external causes of injuries for prevention and control.* Consumer Safety Institute: Netherlands; 1998.

20. Injury severity

Definition:

State the clinical evaluation of the injury. Injury severity generally describes the impact of an injury in terms of the extent of tissue damage and/or the physiologic response of the body to that damage.

Uses:

These data are designed to quantify the type and severity of the injuries in a standard fashion, which allow providers to communicate in common terms. These data are used widely in injury research and in health care quality improvement processes. An assessment of severity based on the cumulative injuries suffered by the individual is preferred.

Data values:

1	No apparent injury
2	Minor, i.e. superficial injuries e.g. bruises, minor cuts
3	Moderate, requiring some skilled treatment e.g. fractures, sutures
4	Severe, requiring intensive medical/surgical management e.g. internal hemorrhage, punctured organs, severed blood vessels

Discussion:

There are a number and variety of injury severity scales reflecting recognition that severity classification is critical for surveillance, epidemiological investigations and evaluations of programs and policies aimed at mitigating the impact of injury at both the individual and societal levels.

Repetition:

No.

Data Standards or Guidelines:

None

Other References:

Baker SP, O'Neill B, et al. (1974). "The injury severity score: a method for describing patients with multiple injuries and evaluating emergency care." J Trauma 14(3): 187-96.

Gennarelli T, Wodzin E. (2005). The Abbreviated Injury Scale- 2005. Des Plaines, Il, Association for the Advancement of Automotive Medicine.

Beck, AT, Beck R, Kovacs M. (1975). Classification of suicidal behaviors: I.

Quantifying intent and medical lethality. American Journal of Psychiatry, 132(3), 285-287.

21. Disposition

Definition: Action or status after attendance at facility or person's anticipated location or status following medical encounter usually outpatient visit.

Uses: Data on the disposition can be compared on demographics, various diagnostic categories or with data from steps in the person's medical encounter to determine factors associated with the health outcome or serve as a proxy to describe the severity of the health problem. Disposition data are used in identifying and tracking trends. The following codes are recommended for encoding the disposition:

Code	Description
10	Discharged to home or self-care (routine discharge)
20	Transferred/discharged to another short-term general hospital for inpatient care
30	Transferred/discharged to skilled nursing facility
40	Transferred/discharged to intermediate care facility
50	Transferred/discharged to another type of institution for inpatient care or referred for outpatient services to another institution
60	Transferred/discharged to home under care of a home IV drug therapy provider
70	Transferred/discharged to home under care of certified home care provider/program
80	Left without receiving medical advice against leaving (includes left without being seen, eloped)
90	Left after receiving medical advice against leaving (i.e., left AMA)
100	Placed in designated observation unit (not considered an in-person hospital admission)
110	Admitted to hospital floor bed
120	Admitted to intermediate care/telemetry unit
130	Admitted to intensive care unit
140	Admitted to operating room
150	Died
888	Other
999	Unknown

Users may expand this table to meet local needs for more detailed data. For example, disposition category 130 could be expanded as follows:

Code	Description
131	Admitted to medical intensive care unit
132	Admitted to cardiac care unit
133	Admitted to surgical intensive care unit
134	Admitted to burn unit
135	Admitted to neonatal intensive care unit
136	Admitted to pediatric intensive care unit

Discussion : None.

Repetition: No.

Data Standards or Guidelines: None.

Other References: Uniform Bill-92 (National Uniform Billing Committee, 1996) and E1744-95 (American Society for Testing and Materials, 1995).

22. Medical care received by individual

Definition The medical health care received by the individual following the most recent SDV episode.

Uses Documents the medical health care received by the individual. May be useful in documenting the effect of SDV events on the medical care system and the range of services that individuals receive for their incidents.

Code	Description
0	The individual was known not to have received any medical health care following the most recent SDV episode.
1	The individual received outpatient medical treatment (e.g., emergency room or physician office visit), not followed by inpatient medical health care, after the most recent SDV episode.
2	The individual received outpatient medical treatment (e.g., emergency room or physician office visit), followed by inpatient medical health care, after the most recent SDV episode.
3	The individual received outpatient medical treatment (e.g., emergency room or physician office visit), unknown if followed by inpatient medical health care, after the most recent SDV episode .
4	The individual received no outpatient medical health care (e.g., emergency room or physician office visit), but did receive inpatient medical health care, after the most recent SDV episode.
5	Unknown if the individual received outpatient medical health care (e.g., emergency room or physician office visit), but did receive inpatient medical health care, after the most recent SDV episode.

9	Unknown if the individual received any medical health care following the most recent SDV episode.

Discussion: In addition to documenting the individual's medical care, this data element can be used as a proxy for injury severity, but it must be used in conjunction with other data elements.

Repetition: No.

If the individual died as a result of the SDV event then this data element should be used to indicate any medical care related to the most recent SDV prior to death.

Data Standards or Guidelines: None.

Other References: None.

23. Self-directed violence category

Definition: Assessment of the self-directed behavior

Uses: Self-directed violence (SDV) is behavior that deliberately results in injury or the potential for injury to oneself irrespective of suicidal intent. SDV encompasses a range of violent behaviors, including acts of fatal and nonfatal suicidal behavior, and non-suicidal intentional self-injury (i.e., behaviors where the intention is not to kill oneself, as in self-mutilation). The assessment of which type of SDV a particular event represents is a crucial issue, which has implications on decisions for the individual, his/her family, and society regarding prevention and treatment. The data from this element can help practitioners identify unique circumstances that put individuals at risk for the various types of SDV and guide development of appropriate prevention strategies. The data are also useful for public health surveillance, health care planning and administration, and clinical, health services, and epidemiologic research. Research that definitively characterizes specific categories of SDV is needed to establish the utility of potential interventions.

Data Values:

Code	Description
1	*Non-suicidal self-directed violence* (Other terms include self-harm, self mutilation, self cutting, self battery)
1a	*Non-fatal non-suicidal SDV (sucide attempt)* Including interrupted by self and interrupted by other
1b	*Fatal non-suicidal SDV*
2	*Suicidal self-directed violence.* (Includes fatal and non-fatal suicidal SDV)
2a	*Non-fatal suicidal SDV* Including interrupted by self and interrupted by another and suicide attempt
2b	*Fatal suicidal SDV (sucide)*

3	Undetermined self-directed violence (SDV with suicidal intent undetermined) *(Includes fatal and non-fatal undetermined SDV)*
3a	*Non-fatal undetermined SDV* Including interrupted by self and interrupted by another
3b	*Fatal undetermined SDV*

Discussion:

The assessment in this element is based on the best available evidence to the recorder of the victim's behavior.

Certain types of SDV events are more difficult to categorize. For example, poisoning events may be suicidal or undetermined. In some settings, such as hospital emergency departments, the priority may be treating the injury and not collecting information on the events leading up to the incident. Though ideally the information should be elicited from the person who sustained the injury, data collectors may need to solicit information from other sources such as family members or acquaintances of the injured person or other organizations like law enforcement or social service agencies.

Sensitivity, and confidentiality must be exercised in collecting information from persons who have already undergone trauma from a violent event. Persons who gather injury information must be empathetic and well-trained.

Further description of certain manners of injury may be included in the incident summary such as the circumstances of a victim-precipitated assault. This description should allow for better rationale for the use of a specific manner.

Repetition:

Yes, if two or more unrelated events cause separate injuries.

Data Standards or Guidelines:

None.

Other References:

De Leo D, Burgis S, Bertolote JM, Kerkhof AJFM, Bille-Brahe U. Definitions of suicidal behavior: Lessons learned from the WHO/EURO Multicentre Study. Crisis: The Journal of Crisis Intervention and Suicide Prevention. 2006; 27:4-15.

Posner K, Oquendo MA, Gould M, Stanley B, Davies M. Columbia Classification Algorithm of Suicide Assessment (C-CASA): Classification of Suicidal Events in the FDA's Pediatric Suicidal Risk Analysis of Antidepressants. Am J Psychiatry. 2007; 164:1035-1043.

24. Suicidal thoughts at time of injury

Definition: Record individual's acknowledgment of his/her perception of outcome as a result of their behavior.

Uses: Detecting and measuring the existence, or intensity of an individuals' specific attitudes, behaviors, and plans to commit suicide may influence the intervention strategy. This information is necessary to distinguish a suicide attempt from non-suicidal self-directed violence.

How did the patient describe his/her intent to the staff, other people, or in a (suicide) note?

Code	Description
	*(Please indicate the **most severe intent,** e.g. intent to die before intent to injure oneself. Using the coding scheme below 1>2>3>4>5 or 6 [5=6])*
1	"Intent to die" described
2	"Intent to injure oneself but not die" described
3	"Intent to escape" described
4	Other intent described (e.g. intent to attract attention) Please specify: _____
5	Intent unclear
9	Unknown or no information

Discussion: Suicidal thoughts can be a risk factor for subsequent fatal and nonfatal suicidal behavior and are sometimes associated with other disorders. In general suicidal thoughts do not focus upon the actual suicide process. Suicidal planning involves a much higher complex cognitive process. Those who actually engage in suicide planning that may require more extensive evaluation and/or intervention.

Repetition: No.

Data Standards or Guidelines: None

Other References: None

25. Risk-Rescue rating

Definition: A term used in assessing a suicide act that indicates the degree to which the situation allowed for the possibility of intervention by others to prevent death.

Uses: This scale is a descriptive and quantitative method of assessing the lethality of SDV. There are five risk and five rescue factors which are defined, weighted and scored. Documentation of the circumstances surrounding an incident may assist in developing and evaluating preventive interventions.

Risk factors (numbers = scoring points)

A. Risk mechanism:

1. Ingestion, cutting, stabbing
2. Drowning, asphyxiation, strangulation
3. Jumping, shooting

B. Risk impaired consciousness:

1. None in evidence
2. Confusion, semicoma
3. Coma, deep coma

C. Risk lesions/toxicity:

1. Mild
2. Moderate
3. Severe

D. Risk reversibility:

1. Good, complete recovery expected
2. Fair, recovery expected with time
3. Poor, residual expected, if recovery

E. Risk treatment required:

1. First aid, outpatient

   Includes hospital emergency dept
2. Hospital admission, routine in-patient care
3. Intensive care, special treatment

Total risk points _____

Risk score

High risk:	13-15 risk points
High moderate:	11-12 risk points
Moderate:	9-10 risk points
Low moderate:	7-8 risk points
Low risk:	5-6 risk points

Rescue factors (numbers = scoring points)

A. Rescue location:

3. Familiar

2. Non-familiar, non remote

1. Remote

B. Rescue person initiating rescue:

3. Key person (knows or is known by the subject)

2. Professional

1. Passerby

C. Rescue probability of discovery by any rescuer

3. High, almost certain

2. Uncertain discovery

1. Accidental discovery

D. Rescue accessability to rescue:

3. Asks for help

2. Drops clues

1. Does not ask for help

E. Rescue delay until discovery:

3. Immediate <1 hour

2. > 1hour but < 4 hours

1. > 4 hours

Total rescue points _____

Rescue score*

Least rescuable:	5-7 rescue points
Low moderate:	8-9 rescue points
Moderate:	10-11 rescue points
High moderate:	12-13 rescue points
Most rescuable:	14-15 rescue points

Self rescue automatically yields a rescue score of 5

The risk-rescue rating is determined by the formula risk score/risk score + rescue score. Scores range from 17 to 83. Low= 17-39, Moderate=40-59, High=60-83.

Discussion: A description of the lethality characteristics of self-directed violence can help clinicians and researchers communicate efficiently about the similarities and differences of the behaviors under study. There are various ways of defining lethality. However a complete appraisal of lethality should only partially be based on any kind of rating or scale, a more comprehensive assessment of the physical, psychological, and social characteristics of the individual and his or her environment is required.

Repetition: No.

Data Standards or Guidelines: None.

Other References: Weissman, A. D., & Worden, J. W. (1972). Risk-rescue rating and suicide assessment. Archives of General Psychiatry. 1972; 26: 553–560.

26. Medical/Somatic history

Definition: Has individual ever experienced or been diagnosed by a health care professional with a somatic or physical illness or injury.

Uses: There is limited information on the association of non-mental health diseases or injuries with SDV. Collection of this variable would be helpful in documenting whether certain conditions are associated with an increase or reduction in risk for SDV especially chronic diseases or conditions and traumatic injuries. These data are also needed for continuity of care, and they are useful for quality-of-care monitoring, public health surveillance, and clinical, health services, and epidemiologic research.

Code	Description
0	No
1	Yes, if yes, record actual illness(es)
8	Not applicable
9	Unknown/not stated

Can describe specific illness within the following organ system categories:

- Cardiovascular
- Nervous
- Respiratory
- Digestive
- Endocrine
- Reproductive
- Urinary
- Musculoskeletal
- Dermatological
- Infectious disease
- Immunological

Discussion: A clinician's reported diagnosis is the basis for diagnostic coding and classification. In most instances, a clinical description will provide more detail than a diagnostic code and its associated rubric. Practitioners and other authorized data users may need to read unaltered text or search it electronically for words or phrases of interest.

Repetition: Yes

Data Standards or Guidelines: Uniform Hospital Discharge Data Set (UHDDS).

Other References: Office of the Secretary, Department of Health and Human Services: Health Information Policy Council: 1984 Revision of the Uniform Hospital Discharge Data Set. Federal Register, Volume 50, No. 147. July 31, 1985.

27. Psychiatric history

Definition: Has individual ever been diagnosed by a health care professional with a mental health condition and/or has a current diagnosis.

Uses: Biological, psychological, social, and cultural factors all have a major impact on the risk of suicidal behavior. Studies have estimated that a large percentage of suicide decedents have symptoms or a diagnosis consistent with mental illness and/or alcohol and substance misuse disorder.

Code	Description
0	No
1	Yes, if yes, record actual diagnosis(es) and whether individual is under current treatment
8	Not applicable
9	Unknown/not stated
	Can use the following categories though this list is not comprehensive - Depression - Bipolar disorder - Schizophrenia - Anxiety disorder - Post-traumatic stress disorder - Alcohol or substance abuse disorder - Other (specify)

Discussion: Estimates of lifetime risk of suicide for mental illness show that a majority of people with mental illness don't die of suicide. This confirms that suicidal behavior results from an interaction of factors not just mental illness so other categories of factors should also be collected. Current diagnosis should also be included in this category.

Repetition: Yes

Data Standards or Guidelines: Uniform Hospital Discharge Data Set (UHDDS).

Other References: Office of the Secretary, Department of Health and Human Services: Health Information Policy Council: 1984 Revision of the Uniform Hospital Discharge Data Set. Federal Register, Volume 50, No. 147. July 31, 1985.

28. Previous nonfatal self-directed violence

Definition: Record actual number of previous events of suicidal or non-suicidal self-directed violence. This applies to events where an action occurred, not thoughts only.

Uses: Number of events may be used to estimate the human and economic cost of this behavior.

Code	Description
0	Individual has engaged in 0 events of SDV
1	Individual has engaged in 1-2 events of SDV ever.
2	Individual has engaged in 3-5 events of SDV ever.
3	Individual has engaged in 6-10 events of SDV ever.
4	Individual has engaged in 10 or more events of SDV ever.
9	Unknown how many events of SDV have occurred.
	If there has been more than one SDV event, the code should reflect the total of all events.

Discussion: A history of one or more incidents of self-directed violence is a risk factor for subsequent fatal and nonfatal suicidal behavior.

Repetition: No.

Data Standards or Guidelines: None

Other References: None

29. Past suicidal thoughts or ideation

Definition: Record individual's acknowledgment of previous suicidal ideation.

Uses: Detecting and measuring the existence, or intensity of an individuals' specific attitudes, behaviors, and plans to commit suicide may influence the intervention strategy.

Code	Description
Yes	If yes, could record its chronological proximity to the most recent self-directed violent behavior, include whether the person made a specific plan for carrying out the self-harm act.
	Chronological proximity:
	1 within past 24 hours
	2 > 24 hrs less than 7 days
	3 7 days – 13 days
	4 14 days – 27 days
	5 28 days – 180 days (approximately 1 month to 6 months)
	6 >180 days – 364 days (just over 6 months to slightly less that 1 year)
	7 365+ (greater that 1 year)
	Plan:
	1 The individual reports outlining a plan to methodically take his or her life.
	2 No reported plan
No	No known history
Unknown	Unknown

Discussion: Suicidal thoughts can be a risk factor for subsequent fatal and nonfatal suicidal behavior and are sometimes associated with other disorders. In general suicidal thoughts do not focus upon the actual suicide process. Suicidal planning involves a much higher complex cognitive process. Those who actually engage in suicide planning that may require more extensive evaluation and/or intervention.

Repetition: No.

Data Standards or Guidelines: None

Other References: None

30. Family history

Definition: Have family members ever been diagnosed by a health care professional with a somatic or psychiatric condition or suicidal behavior. Emphasis of documentation should be on immediate family. Immediate family includes spouse, parents and grand parents, children and grand children, brothers and sisters, mother-in-law and father-in-law, brothers-in-law and sisters-in-law, daughters-in-law and sons-in-law. Adopted and step members are also included in immediate family.

Uses: Research has established associations between parental psychopathology and their offspring's suicidal behavior. There is also limited evidence to suggest that a family history of suicidal behavior is associated with increased risks of suicidal behavior among a variety of relatives. This element can be used to identify factors connected to self-directed violence risk.

Code	Description
0	No
1	Yes (If yes, record actual illness(es) and the relationship.)
8	Not applicable
9	Unknown/not stated

The following categories can be used for family members:

Adopted Son	Great Grandfather	Stepfather
Adopted Daughter	Great Grandmother	Stepmother
Aunt	Half-brother	Stepsister
Brother	Half-sister	Stepson
Brother-In-Law	Husband	Uncle
Cousin	Mother - Adoptive	Unrelated, Friend
Daughter	Mother - Biological	Ward
Daughter-In-Law	Mother-In-Law	Wife
Father - Adoptive	Nephew	Other (specify)
Father - Biological	Niece	
Father-In-Law	Sister	
Foster Child	Sister-In-Law	
Granddaughter	Son	
Grandfather	Son-In-Law	
Grandmother	Stepbrother	
Grandson	Stepdaughter	

Discussion: Health conditions that exist in an individual's family could indicate a predisposition for the same or similar conditions in the person.

Repetition: Yes

Data Standards or Guidelines: Relationship categories - ASTM E1633 (American Society for Testing and Materials), X12 (American National Standards Institute Accredited Standards Committee X12), NCVHS

(National Committee on Vital and Health Statistics), Bureau of the Census - *Current Population Survey*

Other References: None

31. Sexual Orientation

Definition: The sexual preference of the individual.

Uses: Adding these questions will help identify and monitor progress toward reducing disparities. Sexual orientation can be an important factor in health outcomes. Studies have shown that people who identify themselves within certain categories of sexual orientation tend to have different socialization, expectations, and lifestyles. Certain groups as a result of identifying their orientation are differentially exposed to stigma, discrimination, and other factors that affect and interact with health. Studies of nonfatal suicidal behavior have found an increased occurrence of this behavior among those who identify as homosexual, bisexual or transgender.

Data Values Do you consider yourself to be?

Code	Description
1	Heterosexual
2	Homosexual
3	Bisexual
4	Transgender
5	Or something else? Specify _____
9	Unknown/not stated.

Discussion: Sexual orientation has been discussed as two definitional components: the psychological component and the behavioral component. Definitions of the psychological component may include the terms "sexual attraction", "sexual interest", or "sexual preference."

Definitions of the behavioral component are often described with terms such as "sexual intercourse" or "sexual contact". Each one of these presents challenges for those collecting data. For example, how should each of these terms be defined and how should they be operationalized for measurement?

The data element listed above addresses the issue of sexual identity but not behavior. Personal self-identification of sexual orientation is preferable to observer-identification. Enter 9 if neither method yields an identification of sexual orientation.

Repetition: No.

Data Standards or Guidelines: CDC, National Center for Health Statistics, National Health and Nutrition Examination Survey (NHANES)

Other References: Sell RL, Becker JB. Sexual Orientation Data: Inclusion in Health Information Systems Used to Monitor HP2010. American Journal of Public Health. 2001;91(6):876-82.

National Survey of Family Growth (NSFG) as described in: Citation: Mosher WD, Chandra A, Jones J. Sexual behavior and selected health measures: Men and women 15-44 years of age, United States, 2002 . Advance data from vital and health statistics; no 362. Hyattsville, MD: National Center for Health Statistics. 2005.

Behavioral Risk Factor Surveillance System (BRFSS), CDC as described in San Francisco Department of Public Health AIDS Office. San Francisco HIV Behavioral Risk Factor Telephone Survey. 1998. Accessed on 7 November 2008 from http://www.dph.sf.ca.us/PHP/RptsHIVAIDS/new_brfs.pdf.

Youth Risk Behavior Surveillance System as described in Garofalo R, Wolf RC, Kessel S, Palfrey J, DuRant R. The Association Between Health Risk Behaviors and Sexual Orientation Among a School-based Sample of Adolescents. *Pediatrics.* 1998:101(5), 895-902

32. Military service

Definition: A person who has served or is currently serving in the armed forces. If resources permit, capture specific information about military service such as actual length of time served, which branch (e.g., Army, Navy, Air Force, Marines), and experiences (e.g., combat, international travel).

Uses: Military service can have an influence on an individual's health through recruitment, training, tours of duty, exposure to combat and adjustment to military culture. Military service can also affect the health of the military person's family through economic and social means. Veteran status, including the period of military service, can be used to measure the needs of veterans and to evaluate the impact of military service on health care needs. These data are needed to conduct policy analysis, program planning, and budgeting for federal veterans' programs and for reports to Congress on state projections of veterans' facilities and services.

Data values:

A. Has this person ever served on active duty in the U.S. Armed Forces, military Reserves, or National Guard? Active duty does not include training for the Reserves or National Guard, but DOES include activation, for example, for the Persian Gulf War.

1 Yes, now on active duty

2 Yes, on active duty in past, but not now

3 No, training for Reserves or National Guard only

4 No, never served in the military

B. When did this person serve on active duty in the U.S. Armed Forces? Mark for *EACH period in which this person served.*

1 April 1995 or later

2 August 1990 to March 1995 (including Persian Gulf War)

3 September 1980 to July 1990

4 May 1975 to August 1980

5 Vietnam era (August 1964—April 1975)

6 February 1955 to July 1964

7 Korean conflict (June 1950—January 1955)

8 World War II (September 1940—July 1947)

9 Some other time (please specify)

C. In total, how many years of active-duty military service has this person had?

1 Less than 2 years

2 2 years or more (if possible specify the exact number of years)

Discussion: This standard should be consistent with standards from the Bureau of the Census. At state and county levels, veteran status is used for budgeting and program planning for medical services for veterans. Veteran status is used as one factor to determine the segments of the population who may not be receiving needed medical services.

Repetition: No.

Data Standards or Guidelines: U.S. Census Bureau, Census 2000 questionnaire. http://nces.ed.gov/pubs/eiip/eiip.html;http://www.census.gov/prod/2003pubs/c2kbr-22.pdf, and www.census.gov/prod/cen2000/doc/sf3.pdf

Other References: Bureau of the Census. Current Population Survey, September 2003: Veterans Supplement, Technical Documentation CPS-03 (Census Bureau, 2004);

Department of Veterans Affairs (VA) National Survey of Veterans (NSV) http://www1.va.gov/vetdata/docs/survey_final.htm. US Census American Community Survey Veteran status and period of military service asked 1840, 1890, 1910, since 1930). http://www.census.gov/acs/www/SBasics/SQuest/QbyQfact/veteran.pdf

33. Proximal risk factors

Definition: Data element that describes the most recent crises that led to the self-harm incident. Summarizes external circumstances believed to have played a role in precipitating the suicidal behavior. Select all that apply and indicate the one which is most closely connected to the event.

Uses: Documentation of the circumstances surrounding an incident may assist in developing and evaluating preventive interventions. Identification of suicidal behaviors that follow an acute life crisis (such as a suicide committed immediately after an arrest) may indicate some level of impulsivity in the suicide act.

Data values:

Code	Description
1	Physical health problem (e.g. terminal disease, debilitating condition)
2	Intimate partner problem (e.g. divorce, breakup, discord)
3	Other relationship problem (e.g. family argument)
4	Job problem (e.g. layoff, problems at work, job pressure)
5	School problem (e.g. failure, academic pressure, bullying)
6	Financial problem (e.g. bankruptcy, debts, foreclosure)
7	Recent suicide of friend or family member
8	Other death of friend or family member
9	Criminal legal problem (e.g. recent or impending arrest, police pursuit, recently committed crime, currently in jail, impending criminal court date)
10	Other or unspecified legal problems (e.g. custody dispute, civil lawsuit)
11	Perpetrator of interpersonal violence (specify type such as intimate partner, child maltreatment, sexual violence, etc.)
12	Victim of interpersonal violence (specify type such as intimate partner, child maltreatment, sexual violence, etc.)
13	Crisis within two weeks of injury
14	Other: Specify_____
15	Unknown

Discussion: Medical examiners' and coroners' reports and police incident reports often include detail on the circumstances that contributed to self directed violence. While this information is not consistently documented, the data element is being treated as an important one to underline the need for coroners, medical examiners, and police to document this information.

Repetition: Yes.

Data Standards or Guidelines: ICECI Coordination and Maintenance Group (2004). International Classification of External Causes of Injuries (ICECI) version 1.2. Consumer Safety Institute, Amsterdam and AIHW National Injury Surveillance Unit, Adelaide.

Other References: Centers for Disease Control and Prevention. National Violent Death Reporting System (NVDRS) Coding Manual [Online].(2003). National Center for Injury Prevention and Control, Centers for Disease Control and Prevention (producer). Available from: http:// www.cdc.gov/injury

34. Protective factors

Definition: Summarizes internal or external factors that interact with a risk factor to reduce or nullify its effect among at-risk individuals or populations. Select all that apply.

Uses: Research has found that many successful interventions both reduce risk factors and promote protective factors. Focusing on promoting protective factors is a more productive approach than reducing risk factors alone due to the following: protective factors are positive attributes that strengthen all families, not just those at risk; these factors are usually attributes that individuals and families themselves want to improve which often provides more motivation to participate.

Based on the best information available, describe the contextual factors. This axis can be coded multiple times in order to fully describe the contextual factors that may have prevented self-directed violence. Record the factors listed as present, absent, or unknown.

Categories and sub-types:

A. Personal resources such as:

1	Positive/resilient temperament
2	Social competency and problem-solving skills
3	Perception of social support from adults and peers
4	Positive expectations/optimism for the future

B. Community resources or relationships such as:

5	Bonding or connectedness to family
6	Bonding or connectedness to school (attachment to teachers, belief, commitment)
7	Presence and involvement of caring, supportive adults (for adolescents)
8	Integration into social networks
9	Cultural and religious beliefs that discourage suicide and support self preservation
10	Quality and access to social services and health care

C. Other: Specify_____

Discussion: This classification is an exploratory classification among the data elements. Less is known about the relationship between self-directed violence some of the factors listed in the classification. Therefore, data collected by using this classification may contribute to generate hypotheses to elucidate these relationships.

Protective factors are believed to operate in three ways: buffering risk factors so that they provide a cushion against negative effects; by interrupting the processes through which risk factors operate; or by preventing the initial occurrence of a risk factor. Fewer studies have been done on protective factors than on risk factors, so many have not been identified making this information somewhat harder to collect.

Personal self report by the subject for this element is preferred. However, the information may need to collected from a proxy of the subject if the subject is unable to respond.

Repetition: Yes. If person has one or more protective factor, record all that apply and specify which type.

Data Standards or Guidelines: None.

Other References:

Risk and Protective Factors for Suicide and Suicidal Behaviour: a Literature Review. Joanne McLean, Margaret Maxwell, Stephen Platt, Fiona Harris, Ruth Jepson.Scottish Government Social Research. Edinborough. 2008. Accessed on 10 December 2008 at http://www.scotland.gov.uk/Publications/2008/11/28141444/0

Beautrais AL, Collings SCD, Ehrhardt P, et al. 2005. Suicide Prevention: A review of evidence of risk and protective factors, and points of effective intervention. Wellington: New Zealand Ministry of Health.

35. Incident summary

Definition:

Brief description of injury incident that precipitated the current event. A free text field that describes the circumstances surrounding the incident. It should capture information not collected under the other elements. For example, it should answer questions like the following:

"What were you doing at the time of the incident?"

"What were you feeling emotionally at the time of the incident?"

"What were you expecting to happen as a result of your action?"

"How did it happen?"

"How did you hurt yourself?"

"Who discovered what happened?"

"How did you get help?"

Uses:

Data describing the cause of injury are used in evaluating and treating individual patients, and these data are useful for public health surveillance and clinical and epidemiologic research. This element should be a concise text description of the injury-producing event or circumstance, including the mechanism by which bodily harm was produced and what the patient was doing when injured. Specify the agent or class of agents in poisonings, toxic exposures, and adverse drug reactions.

Examples:

Individual ties a rope around his neck and attempts to hang self while incarcerated after arrest for intoxicated driving. Feeling despondent due to possible loss of job and did not want to live. Was discovered by corrections officer.

Person ingests more than recommended dosage of medication. Had argued with boyfriend that afternoon. After taking pills called boyfriend and told him about ingestion. He notified emergency medical services.

Motor vehicle driver crashes into bridge support. Found unconscious by passing motorist who called police.

Discussion:

This data element is intended for use in describing the injury that led to the clinical encounter, and its intended use encompasses initial treatments, treatments of injury sequelae (late effects), patient transfers from other health care facilities, and referrals from elsewhere within the hospital. This information is not intended for use in a scheduled return visit following initial treatment (e.g., suture removal). Researchers can use the injury incident description in two ways: 1) they can read unaltered text or search it electronically for words or phrases of interest; 2) they can apply injury coding and classification systems to existing text entries.

Repetition: No.

Data Standards or Guidelines: None.

Other References: None.

References (general surveillance or injury surveillance)

ASTM. *E1384-96: Standard Guide for Content and Structure of the Computer-Based Patient Record.* West Conshohocken, Pennsylvania: ASTM, 1996.

ASTM. *E1633-96: Standard Specification for Coded Values Used in the Computer-Based Patient Record.* West Conshohocken, Pennsylvania: ASTM, 1996.

ASTM. *E1744-95: Standard Guide for View of Emergency Medical Care in the Computerized Patient Record.* West Conshohocken, Pennsylvania: ASTM, 1995.

Holder Y, Peden M, Krug E et al (Eds). ***Injury surveillance guidelines***. Geneva, World HealthOrganization, 2001.

International Organization for Standardization (ISO). *ISO 2995-83 Information Processing — Representation of SI and Other Units in Systems with Limited Character Sets.* Geneva, Switzerland: ISO, 1983.

National Center for Injury Prevention and Control. Data elements for emergency department systems, release 1.0. Atlanta, GA: Centers for Disease Control and Prevention, 1997.

World Health Organization. *International Classification for External Causes of Injuries (ICECI): Guidelines for counting and classifying external causes of injuries for prevention and control.* Consumer Safety Institute: Netherlands; 1998.

Other resources on data elements

Duke University Medical Center Information Center Home Page

http://www.mcis.duke.edu/

Logical Observation Identifier Names and Codes(LOINC)

http://www.mcis.duke.edu/standards/HL7/termcode/loinclab/loinc.html

Health Care Financing Administration (HCFA)

http://www.mcis.duke.edu/standards/government-organizations/hcfa.htm

ANSI X12

http://www.mcis.duke.edu/standards/X12N/x12.htm

Health Level 7 (HL7)

http://www.hl7.org

National Standards Systems Network (NSSN) - Search for standards

http://www.nssn.org/

National Committee on Vital and Health Statistics (NCVHS)

http://aspe.os.dhhs.gov/NCVHS/

X12 Implementaton Guides

http://www.wpc-edi.com/pubs.cfm?pub=001

U.S. Census

http://www.census.gov/

American National Standards Institute(ANSI)

http://www.ansi.org/

Data Interchange Standards Association (DISA) - X12

http://www.disa.org/

International Organization for Standardization (ISO) ISO Standard 3166 - Countries

http://www.hike.te.chiba-u.ac.jp/ikeda/ISO/home.html

American Medical Informatics Association (AMIA)

http://www.amia.org/

Medical Records Institute (MRI)

http://www.medrecinst.com/

Systematized Nomenclature of Human and Veterinary Medicine (SNOMED)

http://snomed.org/

VIGNETTES

Vignettes

Vignettes

Vignettes are brief descriptions of events or situations to which the reader is asked to react. The descriptions, which can either be fictitious or based on fact, are structured to elicit information about the reader's perceptions, opinion, attitudes, or knowledge about some phenomenon. The following vignettes are descriptions of hypothetical persons in a particular situation which the reader is asked to evaluate to determine which SDV term fits best.

The purpose of these vignettes is multifaceted, for example they can provide an opportunity for the reader to engage in self-assessment on understanding of the material, compare responses to the writers, or generate questions about how a solution was determined. Further, the vignettes can help contextualize the definitions to which the situation is linked.

These vignettes are adapted from training materials developed by Drs. Morton Silverman and Lisa Brenner for the Department of Veterans Affairs' project for developing a Suicide and Self-Harm Classification System Clinical Tool and materials developed by Dr. Kelly Posner for the Columbia Classification Algorithm of Suicide Assessment (C-CASA) and used by permission of the authors.

Vignette		Terms (please circle the correct term)
1.	After being diagnosed with breast cancer, a client goes to meet with the oncology nurse regarding her chemotherapy regime. Seeing that she is tearful and seemingly depressed, the nurse inquires whether or not she has been feeling suicidal. The client indicates that she has had thoughts, but before she can fully respond to the question, she begins crying uncontrollably.	A. Suicidal ideation B. Suicide attempt C. Suicide D. Non-suicidal self-directed violence E. Suicide attempt interrupted by self F. Suicide attempt interrupted by other G. Other suicidal behaviors H. Unintentional injury I. Not enough information/undetermined
2.	The patient stated that she experienced heartbreak over the "loss of a guy" a week before the interview. She stated that she took four clonazepam, called a girlfriend, and talked/cried it out while on the phone. She was dismissive of the seriousness of the attempt, but indicated that she wanted to die at the time she took the overdose.	A. Suicidal ideation B. Suicide attempt C. Suicide D. Non-suicidal self-directed violence E. Suicide attempt interrupted by self F. Suicide attempt interrupted by other G. Other suicidal behaviors H. Unintentional injury I. Not enough information/undetermined

Vignette		Terms (please circle the correct term)
3.	The patient was feeling extremely guilty and felt he deserved to die. He held a gun to his head. Just before he pulled the trigger, his wife came in the room and pulled the gun from his hand.	A. Suicidal ideation B. Suicide attempt C. Suicide D. Non-suicidal self-directed violence E. Suicide attempt interrupted by self F. Suicide attempt interrupted by other G. Other suicidal behaviors H. Unintentional injury I. Not enough information/undetermined
4.	After months of expressing the desire to end her own life, a client maneuvered around barriers and jumped to her death from a very tall building.	A. Suicidal ideation B. Suicide attempt C. Suicide D. Non-suicidal self-directed violence E. Suicide attempt interrupted by self F. Suicide attempt interrupted by other G. Other suicidal behaviors H. Unintentional injury I. Not enough information/undetermined
5.	After a long argument with his wife, a client with previous suicidal behaviors left the house and went to a bar where he drank heavily. He then got in his car, drove erratically, and broke the speed limit. He called his wife on the way home, and they shouted at each other briefly before he hung up. Shortly thereafter, his car hit a pole. He was taken by ambulance to the hospital where he was unconscious and could not answer questions about what happened and why.	A. Suicidal ideation B. Suicide attempt C. Suicide D. Non-suicidal self-directed violence E. Suicide attempt interrupted by self F. Suicide attempt interrupted by other G. Other suicidal behaviors H. Unintentional injury I. Not enough information/undetermined

Vignette		Terms (please circle the correct term)
6.	The patient wanted to escape from her mother's home. She researched lethal doses of ibuprofen. She took six ibuprofen pills and said she felt certain from her research that this amount was not enough to kill her. She stated she did not want to die, only to escape from her mother's home. She was taken to the emergency room where her stomach was pumped and she was admitted to a psychiatric ward.	A. Suicidal ideation B. Suicide attempt C. Suicide D. Non-suicidal self-directed violence E. Suicide attempt interrupted by self F. Suicide attempt interrupted by other G. Other suicidal behaviors H. Unintentional injury I. Not enough information/undetermined
7.	A former Navy pilot has bipolar disorder and is delusional in the midst of a mixed episode. Friends report that he has been rambling about themes of religious self-sacrifice, and the need to atone for the sins of the world. The client is found dead after falling to his death from the roof of his apartment building.	A. Suicidal ideation B. Suicide attempt C. Suicide D. Non-suicidal self-directed violence E. Suicide attempt interrupted by self F. Suicide attempt interrupted by other G. Other suicidal behaviors H. Unintentional injury I. Not enough information/undetermined
8.	During pill count on the hospital ward, the staff discovered that six tablets were missing. Upon questioning, the patient admitted that she was saving them up so she could take them all together at a later time in order to kill herself.	A. Suicidal ideation B. Suicide attempt C. Suicide D. Non-suicidal self-directed violence E. Suicide attempt interrupted by self F. Suicide attempt interrupted by other G. Other suicidal behaviors H. Unintentional injury I. Not enough information/undetermined

Vignette		Terms (please circle the correct term)
9.	A patient is receiving inpatient rehabilitation after a lower limb amputation. His Rehabilitation Psychologist has noted that he has become decreasingly engaged in therapies and asked about his current level of suicidality. He responds that he has been thinking about hanging himself with his bed sheets.	A. Suicidal ideation B. Suicide attempt C. Suicide D. Non-suicidal self-directed violence E. Suicide attempt interrupted by self F. Suicide attempt interrupted by other G. Other suicidal behaviors H. Unintentional injury I. Not enough information/undetermined
10.	A man was feeling very depressed, and he wanted to die. He went to the roof to jump off. He changed his mind about wanting to die once he got to the roof, and he came down.	A. Suicidal ideation B. Suicide attempt C. Suicide D. Non-suicidal self-directed violence E. Suicide attempt interrupted by self F. Suicide attempt interrupted by other G. Other suicidal behaviors H. Unintentional injury I. Not enough information/undetermined
11.	The patient was feeling ignored. She went to the kitchen where her mom and sister were talking, took a knife out of the drawer, and made a cut on her arm. She denied that she wanted to die at all. She said she just wanted them to pay attention to her.	A. Suicidal ideation B. Suicide attempt C. Suicide D. Non-suicidal self-directed violence E. Suicide attempt interrupted by self F. Suicide attempt interrupted by other G. Other suicidal behaviors H. Unintentional injury I. Not enough information/undetermined

Vignette		Terms (please circle the correct term)
12.	As the level of conflict between a client and his girlfriend escalated, he said, "Maybe you'd be better off if I shot myself." When she asked him what he meant or what he might do, he paused and then said "I don't know, but I want us to stop fighting."	A. Suicidal ideation B. Suicide attempt C. Suicide D. Non-suicidal self-directed violence E. Suicide attempt interrupted by self F. Suicide attempt interrupted by other G. Other suicidal behaviors H. Unintentional injury I. Not enough information/undetermined
13.	A client is drinking to excess near a lake with a group of friends on Labor Day. He and a buddy decide to "swim it off" (something that has "worked" before) so that he can drive home sober. He gets disoriented and exhausted and drowns.	A. Suicidal ideation B. Suicide attempt C. Suicide D. Non-suicidal self-directed violence E. Suicide attempt interrupted by self F. Suicide attempt interrupted by other G. Other suicidal behaviors H. Unintentional injury I. Not enough information/undetermined
14.	A very intoxicated client is brought to the emergency room by the police who found him walking beside a busy road. When asked about whether or not he was feeling suicidal, the client mumbled, "I am so tired of everything." He then passed out.	A. Suicidal ideation B. Suicide attempt C. Suicide D. Non-suicidal self-directed violence E. Suicide attempt interrupted by self F. Suicide attempt interrupted by other G. Other suicidal behaviors H. Unintentional injury I. Not enough information/undetermined

Vignette		Terms (please circle the correct term)
15.	A man put a gun to his head because he wanted to kill himself. He pulled the trigger, and the gun failed to fire.	A. Suicidal ideation B. Suicide attempt C. Suicide D. Non-suicidal self-directed violence E. Suicide attempt interrupted by self F. Suicide attempt interrupted by other G. Other suicidal behaviors H. Unintentional injury I. Not enough information/undetermined
16.	A patient had a big fight with her ex-husband. She took 15-20 imipramine tablets and went to sleep. She woke many hours later unable to walk. She called EMS, was taken to the ER and given charcoal, and was admitted to the hospital. The patient was unable to verbalize her intent but stated she was well-aware of the dangers of TCA overdose and the potential for death.	A. Suicidal ideation B. Suicide attempt C. Suicide D. Non-suicidal self-directed violence E. Suicide attempt interrupted by self F. Suicide attempt interrupted by other G. Other suicidal behaviors H. Unintentional injury I. Not enough information/undetermined
17.	The patient was unconscious when he was admitted to the ER after taking 300 prescription pills. He woke up later in the ICU and denied any intention to die.	A. Suicidal ideation B. Suicide attempt C. Suicide D. Non-suicidal self-directed violence E. Suicide attempt interrupted by self F. Suicide attempt interrupted by other G. Other suicidal behaviors H. Unintentional injury I. Not enough information/undetermined

Answers and explanations for vignettes:

1. Answer: A. Suicidal ideation. Based on the information stated in the vignette, the patient has only endorsed suicidal thoughts and the description did not indicate any behavior. It is possible that she has engaged in suicidal behaviors as well, but at this point, that information is not available and only suicidal ideation was endorsed.

2. Answer: B. Suicide attempt. The patient engaged in a behavior where the potential for injury has occurred (ingested at least one pill) with the intent to die as a result of the act (the reason she took the pills was to end her life/e.g. the method to kill herself). As soon as one pill is ingested, even if they change their mind shortly thereafter and it couldn't have been lethal yet, it has become a suicide attempt at that point.

3. Answer: F. Suicide attempt interrupted by other. The patient began to take steps towards making a suicide attempt but was stopped by external circumstances before starting the potentially self-injurious act. Behavior was engaged in, but it could not have hurt him at that point (potential for harm). If the trigger had been pulled, it would be a suicide attempt. If not for this interruption, an actual attempt would have occurred.

4. Answer: C. Suicide. The patient died as a result of self-inflicted behavior engaged in order to end her life. It's clear that she jumped because she wanted to die (no other feasible intent).

5. Answer: I. Not enough information. Based on the vignette, it is unclear whether the man intentionally hit the pole with his car or that he wanted to kill himself. There is also nothing that indicated he had any suicidal thoughts. We know from the vignette that he was engaged in reckless behavior, but it is unclear whether hitting the pole was accidental or intentional. In this example, neither the intent nor the behavioral piece of the definition is clear.

6. Answer: D. Non-suicidal self-directed violence. The patient makes it clear that she did not want to die as a result of taking the ibuprofen and she did not believe the amount taken would kill her. She actually did research to make sure she took an amount that wouldn't harm her, because she ONLY wanted to escape from her mother's home. Her intention was not to die but entirely to make people believe she had made a suicide attempt in order to get out of the house

7. Answer: I. Not enough information/undetermined. Based on the available information, it is unclear whether he intended to jump off the roof, or if it was accidental. It is possible that there was some suicidal ideation and content (themes about self-sacrifice) but it is not clear this was related to his falling from the building. If he had expressed command hallucinations about jumping or killing himself, or there was no logical reason why he was on the roof, there would be more compelling information to infer suicidal intent.

8. Answer: G. Other suicidal behavior. As the patient states, she began making preparations towards an imminent suicide attempt. She indicated that she engaged in a behavior (collecting pills) associated with suicidal intent, so it has gone beyond suicidal thoughts.

9. Answer: A. Suicidal ideation. The patient endorsed thoughts of killing himself (active suicidal thoughts) with thoughts of a method (not formulated enough to call it a plan yet), but has not engaged in any behavior.

10. Answer: E. Suicide attempt interrupted by self. The man took steps towards making a suicide attempt (walked up to the roof) but stopped himself/changed his mind before the potential for harm had begun.

11. Answer: D. Non-suicidal self-directed violence. This is non-suicidal self-directed violence because she ONLY wanted to get attention and that's why she cut herself, not at all because she wanted to kill herself. The behavior was intentional but the suicidal intent component of the definition of attempt is not indicated.

12. Answer: I. Not enough information. This example does not clearly indicate suicidal ideation. If he had said he wanted to die or shoot himself it would reflect suicidal thoughts, but it is not clear. Alternatively, if he had said he said it only to get them to stop fighting but did not actually have thoughts of wanting to be dead or killing myself, then it would be clear there was NO suicidal ideation.

13. Answer: H. Unintentional injury death. Based on the available information, this person's death is more likely an unintentional injury than a suicide as there was no indication of suicidal intent . His intention was clearly for another reason ('to swim it off").

14. Answer: I. Not enough information. It is possible that this man is alluding to suicidal ideation by his statement and may have been considering a suicide attempt by walking in the busy road, but there is not enough information to support making such assumptions. Thus, it is not clear there is suicidal ideation or behavior.

15. Answer: B. Suicide attempt. This is a suicide attempt because the patient indicated he was trying to kill himself and as soon as he pulled the trigger he could have been injured (the potential for harm), which fulfills both the components of the definition of suicide attempt (behavior and intent).It is important to note that there does not have to be injury or harm for it to be called a suicide attempt, so even though the gun failed to fire and there was no injury, as soon as the trigger was pulled it became an attempt.

16. Answer B. Suicide attempt. Even though her stated/explicit intent is unclear, intent can be inferred (implicit) because she thought it could have killed her.

17. Answer B. Suicide attempt. Even though he denied having tried to kill himself on purpose (explicit), intent can be inferred form the clinical circumstances. It was such a highly lethal act, no other intent but suicide can be inferred (implicit).

APPENDIX

Appendix

Key terms

Additional terms that the reader is likely to encounter in other documents discussing self-directed violence are included and defined here. In addition, some of the data standards or guidelines mentioned in this document may use terms which are not part of the definitions derived by this process but may be important for the reader to be familiar with when using the document.

Term	Definition	Source
Act	The performance of any function or the bringing about of any effect Example - A suicidal act may result in death (suicide), injuries, or no injuries	Dorland's Illustrated Medical dictionary, W. B. Saunders Company, Philadelphia, 1974
Death of undetermined intent	A death whose manner is unclear when all available information is considered.	CDC. Medical Examiners' and Coroners' Handbook on Death Registration and Fetal Death Reporting. Washington, D.C.: U.S. Department of Health and Human Services; 2003 publication # 2003-1110
Direct	Pertaining to an association between a factor and a condition where the factor occurs prior to the condition, the change in the factor is correlated with a change in the condition and the correlation is not itself the consequence of the factor and the condition being correlated with some prior factor	Mausner & Bahn *Epidemiology: An introductory text*. W.B. Saunders, Philadelphia, 1985
Distal risk factor	The underlying vulnerability that potentiates a characteristic, variable, or hazard which increases the likelihood of development of an adverse outcome which is measurable and precedes the outcome	Mościcki EK. Epidemiology of completed and attempted suicide: Toward a framework for prevention. Clinical Neuroscience Research. 2001; 1:310-323.
Episode	A developed situation that is integral to but separate from a continuous narrative	ICECI version 1.2, WHO, 2004
Explicit	Fully revealed or expressed without vagueness, implication, or ambiguity; leaving no question as to meaning or intent	Rosenberg ML, Davidson LE, Smith JC, Berman AL, Buzbee H, Gantner G, Gay GA, Moore-Lewis B, Mills DH, Murray D, O'Carroll PW, Jobes D. Operational criteria for the determination of suicide. Journal of Forensic Science. 1988; 33(6):1445-56.

Fatal	Causing death	Dorland's Illustrated Medical dictionary, W. B. Saunders Company, Philadelphia, 1974
Immediate cause of death	The final disease, injury, or complication directly causing death	CDC. Medical Examiners' and Coroners' Handbook on Death Registration and Fetal Death Reporting.
Implicit	Being without doubt or reserve, implied though not directly expressed; inherent in the nature of something	Rosenberg et al, 1988.
Impulsivity	Cognitive Impulsivity -The intellectual or mental process which results in an act performed without delay, reflection, voluntary direction or obvious control in response to a stimulus Behavioral Impulsivity - An act performed without delay, reflection, voluntary direction or obvious control in response to a stimulus	Diagnostic and Statistical Manual of Mental Disorders, 4th Edition, Text Revision, American Psychiatric Association, American Psychiatric Association, Arlington, VA, 2000.
Indirect	Pertaining to an association between a factor and a condition because both are related to some common underlying condition	Mausner, 1985
Inferred	To derive as a conclusion from facts or premises	International Epidemiological Association. Dictionary of Epidemiology, fourth edition. Last JM, editor. New York: Oxford; 2001.
Injury	A (suspected) bodily lesion resulting from acute overexposure to energy (this can be mechanical, thermal, electrical, chemical or radiant) interacting with the body in amounts or rates that exceed the threshold of physiological tolerance. In some case an injury results from an insufficiency of vital elements, such as oxygen. Acute poisonings and toxic effects, including overdoses of substances and wrong substances given or taken in error are included, as are adverse effects and complications of therapeutic, surgical and medical care. Psychological harm is excluded in this context.	World Health Organization. International statistical classification of diseases and related health problems, tenth revision. 2nd edition. Geneva, Switzerland. 2004. chapter XIX (19)

Institution	An established organization or corporation, such as a hospital/urgent care center (emergency facility), mental health facility, clinic	ICECI Coordination and Maintenance Group (2004). International Classification of External Causes of Injuries (ICECI) version 1.2. Consumer Safety Institute, Amsterdam and AIHW National Injury Surveillance Unit, Adelaide.
Intentional self-harm	Purposely self-inflicted poisoning or injury	World Health Organization. International statistical classification of diseases and related health problems, tenth revision. 2nd edition. Geneva, Switzerland. 2004.
Non-fatal	Not causing death	Dorland's Illustrated Medical dictionary, W. B. Saunders Company, Philadelphia, 1974
Physical Injury	A (suspected) bodily lesion resulting from acute overexposure to energy (this can be mechanical, thermal, electrical, chemical or radiant) interacting with the body in amounts or rates that exceed the threshold of physiological tolerance. In some case an injury results from an insufficiency of vital elements, such as oxygen. Acute poisonings and toxic effects, including overdoses of substances and wrong substances given or taken in error are included, as are adverse effects and complications of therapeutic, surgical and medical care. Psychological harm is excluded in this context.	ICECI Coordination and Maintenance Group (2004). International Classification of External Causes of Injuries (ICECI) version 1.2. Consumer Safety Institute, Amsterdam and AIHW National Injury Surveillance Unit, Adelaide.
Precipitating event	Factors associated with the definitive onset of a disease, illness, accident, behavioral response, or course of action. Examples include exposure to specific disease; circumstance, condition, or agent	International Epidemiological Association. Dictionary of Epidemiology, fourth edition. Last JM, editor. New York: Oxford; 2001.
Proximal risk factor	A measurable characteristic, variable, or hazard that increases the likelihood of development of an adverse outcome and is more immediately antecedent to the outcome, acting as a precipitant	Mościcki, 2001

Rescueability	A term used in assessing a suicide act that indicates that the situation allowed for the possibility of intervention by others to prevent death	Weissman, A. D., & Worden, J. W. (1972). Risk-rescue rating and suicide assessment. Archives of General Psychiatry. 1972; 26: 553–560.
Self Harm Behavior/self-inflicted/ self Injurious	The act of injuring oneself intentionally by various methods such as self-laceration, self-battering, taking overdoses or exhibiting deliberate recklessness but with no intent to die	U.S. Public Health Service. *National Strategy for Suicide Prevention: Goals and Objectives for Action*. Washington, DC: U.S. Department of Health and Human Services, 2001.
Self harm ideation	Any thought of or communication regarding a person's desire to engage in self-inflicted potentially injurious behavior. There is no evidence of intent to die.	Silverman MM, Berman AL, Sanddal ND, O'Carroll PW, Joiner TE. Rebuilding the Tower of Babel: a revised nomenclature for the study of suicide and suicidal behaviors. Part 2: suicide-related ideations, communications, and behaviors. Suicide Life Threat Behav 2007;37:264–277.
Suicidal ideation	Thoughts of engaging in suicide-related behavior	National Strategy for Suicide Prevention: Goals and Objectives for Action.
Suicidal intent	There is evidence (explicit and/or implicit) that at the time of injury the individual intended to kill self or wished to die and that the individual understood the probable consequences of his or her actions	World Health Organization. International Classification of External Causes of Injuries (ICECI) version 1.2, WHO, 2004 . Available at: http://www.iceci.org. Accessed November 21, 2007.
Suicidal plan	A thought regarding a self-initiated action that facilitates self-harm behavior or a suicide attempt this will often include an organized manner of engaging in suicidal behavior such as a description of a time frame and method.	Silverman MM et al, 2007.

Types of suicide	Categories of suicides within a broad social context. Based on the work of Durkheim, they include egoistic, altruistic, anomic, and fatalistic. Egoistic suicide - This is the type of suicide that occurs where the degree of social integration is low and there is a sense of meaninglessness among individuals. Altruistic suicide - This is the type of suicide that occurs when integration is too great. The person feels deeply committed to group norms and goals and see their own lives as unimportant, they die for a "cause". Anomic suicide - This type of suicide occurs when there is social instability resulting from breakdown of standards and values, regulation is too low. To individuals, life seems aimless. Fatalistic suicide - When regulation is too strong, the individual sees no hope of change against the oppressive discipline of the society.	Durkheim, Emile. Suicide: A Study in Sociology (1897). New York. The Free Press reprint 1997.
Underlying cause of death	The disease, injury, or complication, if any, that gave rise to the immediate cause of death	CDC. Medical Examiners' and Coroners' Handbook on Death Registration and Fetal Death Reporting. Washington, D.C.: U.S. Department of Health and Human Services; 2003 publication # 2003-1110
Undetermined injury incident	Events where available information is insufficient to enable a medical or legal authority to make a distinction between unintentional, self-directed and assault.	World Health Organization. International Statistical Classification of Diseases and Related Health Problems, 10th Revision Version for 2007, Available at: http://apps.who.int/classifications/apps/icd/icd10online/ Accessed October 11, 2009.
Victim-precipitated assault or homicide	An act in which a person engages in actual or apparent danger to others in an attempt to get oneself killed or injured.	Sheehan DC, Warren JI, editors. Suicide and law enforcement: A compilation of papers from the 1999 Suicide and Law Enforcement Conference, Published 2001, U.S. Dept. of Justice, Federal Bureau of Investigation (Washington, D.C)

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Telephone: 1-800-CDC-INFO (232-4636)/TTY:1-888-232-6348
Email: cdcinfo@cdc.gov Web: www.cdc.gov/violenceprevention

National Center for Injury Prevention and Control
Division of Violence Prevention

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