ISCTM SIB Consensus Statements for the Nomenclature & Classification Working Group

Members of the Nomenclature & Classification Working Group:

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Objective of WG: Review status of currently used systems and develop consensus on the principles and characteristics of a standardized nomenclature and classification scheme for SIB.

The WG established two subcommittees, as described below, each focusing on different components of the overall objective.

Subcommittee #1 addressed the conceptual basis of SIB Nomenclature and Classification Systems, covering such questions as:

(1) What constitutes SIB (categorical vs dimensional terms; flat vs hierarchic systems)

(2) What terms to use and how to define them

(3) What categories and qualifiers to use

(4) What a classification system might look like that incorporates those concepts/terms

Members

- Mort Silverman, Lisa Brenner, Greg Brown, Diego De Leo, John Rush, Kelly Posner, David Sheehan

Summary of the Output of Subcommittee #1

A list of the statements, terms, and definitions considered by Subcommittee #1 and the full Workgroup is presented below following a brief summary of the work of Subcommittee #2. These tables include both statements where consensus was reached as well as statements of areas where there is continuing disagreement.

Subcommittee #2 reviewed the currently used SIB classification systems to characterize their strengths and weaknesses and determine what gaps exist. Each system was systematically assessed using criteria based on the UN Best Practices Guideline for Developing Classifications (2011), which was agreed by the full Workgroup as the appropriate standard to use. The systems assessed included:

- FDA C-CASA (FDA Draft Guidance to Industry, Sept 2010)
- FDA C-SSRS/C-CASA (FDA Draft Guidance to Industry, August 2012)

  - World Health Organization (DeLeo, et al, 2006)
  - MIRECC VA/DoD Self-Directed Violence Classification System (SDVCS) (Brenner et al, 2011)
  - Centers for Disease Control Self-Directed Violence Surveillance System (Crosby et al, 2011)

- Members
  - Phil Chappell, Suresh Durgam, Rob Goldman, Susan Kozauer, Shane McInerney, Leonardo Tondo

Summary of the Output of Subcommittee #2

The systematic review performed by Subcommittee #2 revealed that each of the current systems has strengths, weaknesses, and limitations. There remains limited data on reliability and validity of most systems, although there is more extensive data on the C-SSRS which has the most widespread use. There is a continuing lack of psychometric data on the use of any scale or classification system in young children, elderly, and patients with dementia. Specific concerns impacting all systems include the difficulty of reliably assessing and measuring "intention to die" (a critical element for deciding if an action is suicidal or not); the lack in some systems of an "undetermined" or "indeterminate" category (of SI, SB, or preparatory actions) for cases where intent cannot be reliably established; lack of comprehensiveness in the classification of types and combinations of suicidal ideation; and continuing challenges with imprecise definitions of terms and concepts. The subcommittee compiled a table listing and comparing all of the concepts and specific terms across the 5 systems. The total number of concepts and terms ranged from 9 in the 2010 C-CASA system [5] to 31 in the 2011 MIREEC VA/DoD SDVCS [2] system, suggesting that the cost of greater comprehensiveness and granularity is increasing complexity. Subcommittee 2 concluded that the present state of SIB Nomenclature and Classification is fragmentary and comprised of multiple competing systems, with limited tools for "cross walk" between them. The development of a uniform standardized nomenclature and universally accepted classification system remains an elusive goal. The creation of a uniform system may require the establishment of an ongoing NIMH-Matrics-like initiative involving all concerned stakeholders.

The reviews of individual nomenclature and classification systems performed by Subcommittee 2 can be accessed at the following link: https://isctm.org/nomenclature-and-classification/

Collated Statements

Statements concerning principles, concepts, terms, and best practices for SIB nomenclature and classification are presented below.

These statements include both statements of consensus and also statements of important issues, terms, and definitions where it was not possible to establish a consensus view at this time and where additional work must be done to advance the field. The statements, whether of consensus or lack of consensus, reflect the discussions and debates of the Workgroup and its two Subcommittees over several months leading up to the ISCTM consensus meeting (in November 2015), the results of an extensive pre-meeting survey, and the results of the debates and voting which took place at the actual meeting in Washington, D.C.

The statements are presented in three sections:

(1) We first present the three statements which were debated and voted on at the November 2015 Consensus Meeting.

(2) We next present a prioritized list of statements that were included in the pre-meeting survey, both statements where the survey results supported a consensus view as well as statements where the survey results were divided and there appeared to be a lack of consensus.

The pre-meeting survey was sent to 129 individuals who were members of ISCTM actively working on SIB issues and/or had registered to attend the Consensus Meeting. The response rate to the survey was 69% (89/129). A consensus result was arbitrarily defined as a statement for which ≥70% of the survey responses were in agreement. Statements for which the survey results were divided were taken as areas where there was likely to be lack of consensus in the field. In most instances, the opinions of the Workgroup members were aligned with the results of the pre-meeting survey. The complete results of the pre-meeting survey can be accessed at the following link: [Place link to survey results here,]

(3) Finally, we present a list of SIB terms and definition, which are currently in use in different settings (such as the VA, DOD, CDC, or FDA), or that have been recently developed and proposed. All of these terms and definitions were extensively discussed and debated by Subcommittee #1 in an effort to reach agreement on core terms and definitions to be included in an ideal SIB nomenclature. However, recommendations emanating from the SC, were not discussed or voted on by the broader Workgroup to determine an overall consensus. The list is included as an illustration of the continuing challenges that remain for the establishment of a standardized nomenclature.

Table 1 **Statements Voted on at F2F Meeting on November 18, 2015**		**Yes**	**No**	**Not Sure**
In a clinical trial setting, a qualified mental health professional is required to assess the intent to die by suicide, when the intent is unclear (Assumptions: Using a standard classification and using a standard scale).	Number of responses	36	23	9
	% responses	52.9	33.8	13.2
The term suicidality should be retained because it is clinically relevant, linguistically economical and meets the need for an over-arching term encompassing all suicide-related phenomena.	Number of responses	34	32	8
	% responses	45.9	43.2	10.8
The terms "passive suicidal ideation" and "active suicidal ideation" should be retained in the context of clinical trial.	Number of responses	36	22	10
	% responses	52.9	32.3	14.7

Table 2 **Pre-Meeting Survey Consensus Statements** **(As Defined by ≥ 70% Agreement)**
1. An optimal nomenclature for suicide terminology should be clinically relevant, reliable and valid, and easily understood and applied.
2. An optimal classification system for suicide terminology should be clinically/population health relevant, comprehensive, reliable and valid, and easily understood and applied.
3. Definitions of suicide and suicide related phenomena should be free of value judgments and “culturally normative” (i.e., broad enough to apply to a range of belief systems and cultures).
4. Definitions of suicide and suicide related phenomena should be theory-neutral (i.e., not based on a particular theoretical perspective such as sociological (Durkheim), psychological (Freud), or existential (Camus).
5. The intention to die (whether explicit or implicit/inferred) is the most critical distinction between suicidal and non-suicidal thoughts and behaviors.
6. A suicide nomenclature and classification system should also include categories for non-suicidal thoughts and behaviors of self-injury.
7. Because many patients deny suicidal intent when engaging in self-injurious thoughts and behaviors, or the available evidence for determining whether a thought or action was truly suicide-related is inconclusive, there should be a classification heading titled, “Undetermined,” as in “Undetermined Suicide Ideation,” and ”Undetermined Suicidal Behavior.”
8. Behavior that results in death and is purposely reckless, or purposely failing to act to prevent death, or negligent (e.g., deliberately failing to take insulin prescribed to treat one’s diabetes) should not be labeled as a suicide, even if it is not possible to infer the person intended to die.
9. When an attempt to die by suicide is not interrupted by self or other, is it best to refer to this behavior as a suicide attempt.

10. The definition of Suicide Ideation should specifically include the phrase “wish to die” and refer to the act of “killing oneself” or “ending one’s life.”
11. It is clinically important to add the qualifiers “With Intent,” “With Undetermined Intent,” and “Without Intent,” to the term “Suicide Ideation” to better differentiate and classify the type of suicide ideation.
12. A method or means of dying by suicide and a suicide plan are distinct components of suicidal thinking, which are clinically relevant, unambiguous and easily understood and applied.
13. Preparatory Behaviors (toward self-injury), such as writing a suicide note, making a will, buying a gun, etc., can be interrupted by self or by others.
14. Determination of the intentions behind suicidal-related actions (especially when they are implicit) requires assessment by a trained mental health professional.*

*On the pre-meeting survey, 78% (69/88) of respondents agreed with the statement “Determination of the intentions behind suicidal-related actions (especially when they are implicit) requires assessment by a trained mental health professional.” However, the Workgroup members themselves could not reach consensus around this statement, so it was presented, debated and voted on at the face to face meeting in November 2015 (results shown above in Table 1). The response to the repeat vote was more divided (with 53% agreed to the statement, 34% disagreed, and 13% Not Sure).

Table 3 **Statements or Topics Where There Was Lack of Consensus** **Based on the Pre-Meeting Survey (<70% Agreement)**
1. Should the patient’s perspective or perception on whether or not there is potential for harm as a result of their thought or action be a necessary component for determining whether a thought or behavior is suicide-related?*
2. What is the best term for an overarching classification category that subsumes all suicide-related phenomena (ie, self-directed violence, self-directed violence with suicidal intent, suicidality, self-injurious thoughts and behaviors, suicidal self-directed violence, or suicidal thoughts and behaviors)?
3. The best descriptor for suicide-related phenomena is self-inflicted/self-injurious/or self-harming.
4. What is the best term or label for death caused by self-directed injurious behavior with any intent to die as a result of the behavior (ie, suicide, completed suicide, death by suicide, or died by suicide).
5. How is behavior that is self-directed and deliberately results in injury or the potential for injury to oneself where there is evidence, either implicit or explicit, of suicidal intent best referred to (ie, as suicidal self-directed violence, suicidal behavior, or suicide attempt)?
6. The term “Self-Directed Violence” (defined as behavior that is self-directed and deliberately results in injury or the potential for injury to oneself) is clinically relevant, unambiguous, and easily understood and applied.
7. Is it clinically important to add the qualifiers “With Injury” and “Without Injury” to the term “Suicide Attempt” to better differentiate and classify the behavior?
8. Suicidal intent is described variably as a wish, desire, need, or a preference to be injured or to die by self-inflicted injury. It has also been defined as the state of a person’s mind that directs them towards a specific action. Can there be suicide-related thoughts and behaviors without intent to die?
9. Should the term “fleeting suicidal ideation” be included in a nomenclature?

10. Planning to end one's life is a suicide-related phenomenon. It can be just a thought ("In order to buy a gun I must go get money from the bank"), or it can be behavior ("I went to the bank and got out money to buy a gun"). How is "Planning" best classified (ie, as a type of suicidal ideation, a type of preparatory behavior, a type of suicide attempt -without injury, or planning of any type should be its own separate category)?
11. Motivations (the reasons for wanting to die by suicide) are distinct from the intent (wish, desire) to die. Should suicidal motivations be part of a classification system?
12. It would be clinically useful and relevant to have a classification for Suicide Communications, in addition to Suicide Ideations and Suicide Behaviors.

*This statement had 69% agreement (ie, Yes response) on the survey, just failing to make the cut-off for inclusion as a consensus statement in Table 2.

Table 4 **Terms and Definitions Not Voted on by the Full Workgroup**
Self-Directed Violence defined as 'behavior that is self-directed and deliberately results in injury or the potential for injury to oneself.' [References 1, 2]
Non-Suicidal Self-Directed Violence defined as '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.' [References 1, 2])
Non-Suicidal Self-Injurious Behavior defined as any (set of) behavior(s), either incomplete or completed, that are either 1) not viewed by the patient to be potentially lethal and stop short of taking action on a self-injury attempt, but assist the patient in preparing to take action on a self-injury attempt *or* 2) perceived by the patient to not be potentially lethal, connected with no level of intent [##] (= 0) to die, that does not result in a fatality *or* 3) a fatality clearly and confidently (evidence beyond a reasonable doubt) caused by self-injurious or purposely reckless behavior that is connected with no level of intent[##] to die (= 0) as a result of this self-injurious or purposely reckless behavior." [##] "Intent is defined as the state of a person's mind that directs them towards a specific action." [Reference 3]
Undetermined Self-Directed Violence defined as 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.' [References 1, 2]
Suicidal Self-Directed Violence/Suicidal Behaviors defined as 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. [References 1, 2]
Suicidal Behavior is defined as any (set of) behavior(s), either incomplete or completed, that are either 1) not viewed by the patient to be potentially lethal and stop short of taking action on a suicide attempt, but assist the patient in preparing to take action on a suicide

attempt *or* 2) perceived by the patient to be potentially lethal, connected with any level of intent ## (> 0) to die, that does not result in a fatality *or* 3) a fatality clearly and confidently (evidence beyond a reasonable doubt) caused by self-injurious or purposely reckless behavior that is connected with any level of intent## to die as a result of said self-injurious or purposely reckless behavior.

"Intent is defined as the state of a person's mind that directs them towards a specific action."

[Reference 3]

Preparatory Suicidal Behaviors defined as 'acts or preparation towards engaging in suicidal behaviors, 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). These behaviors may or may not be interrupted by self or by other.' [References 1, 2]

Suicide Behaviors Interrupted by Self or Others defined as

By other – 'A person takes steps to injure self but is stopped by another person or circumstances 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 –A person takes steps to injure self but is stopped by self 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. [References 1]

Suicide Attempt Halted defined as any incomplete (set of) behavior(s) perceived by the patient to be potentially lethal connected with any level of intent## (> 0) to die that does not result in a fatality. The behavior may or may not result in any actual harm to the patient. The (set of) behavior(s) may be incomplete due to an interruption by events outside the patient's body or existence or may be incomplete due to the patient aborting the already started, perceived lethal behavior(s) before it (they) are fully executed. The intent to die can be inferred by a reasonable group of experts, but should not always be assumed, unless the evidence is compelling. This intent to die refers to the intent at the time of initiation of the suicide attempt." "Intent is defined as the state of a person's mind that directs them towards a specific action."

A "suicide attempt halted" can also be further classified as either an "aborted action: any action that is stopped by the subject on their own initiative, without interruption by an external intervention" or an "interrupted action: any action perceived by the patient to intervene to the extent of stopping the action from proceeding."

[Reference 3]

Suicide Behaviors Not Halted defined as any completed (set of) behavior(s) perceived by the patient to be potentially lethal that is connected with any level of intent## (> 0) to die that does not result in a fatality. The behavior may or may not result in any actual harm to the patient and the behavior does not have to be potentially injurious. Only the patient's perception that it is self-injurious is necessary. The intent to die can be inferred by a reasonable group of experts, but should not always be assumed unless the evidence is compelling. This intent to die refers to the intent at the time of initiation of the suicide attempt.

"Intent is defined as the state of a person's mind that directs them towards a specific action."

[Reference 3]

Suicide attempt defined as '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.' [References 1, 2]
Death by Suicide defined as 'death caused by self-directed injurious behavior with any intent to die as a result of the behavior.' (Subcommittee term & CDC/MIRECC definition)
Non-Suicidal Self-Directed Violence Ideation defined as self-reported thoughts regarding a person's desire to engage in self-inflicted potentially injurious behavior. There is no evidence of suicidal intent.'
Suicide Ideation defined as 'thoughts of engaging in suicide-related behavior.' [References 1, 2]

Table 5
Definitions of Suicidal Ideation Not Voted on by the Full Workgroup

Source	Definition
CDC [1]	Thoughts of engaging in suicide-related behavior
MIRECC VA/DoD [2]	Thoughts of engaging in suicide-relaed behavior
C-CASA [5]	Passive thoughts about wanting to be dead or active thoughts about killing oneself, not accompanied by preparatory behavior.
C-SSRS [6]	5 subtypes: (1) Wish to be Dead (2) Non-Specific Active Suicidal Thoughts (3) Active Suicidal Ideation with any Methods (Not Plan) without Intent to Act (4) Active Suicidal Ideation with Some Intent to Act, without a Specific Plan (5) Active Suicidal Ideation with Specific Plan and Intent
Sheehan & Giddens [3]	A desire or wish or need or preference to be dead or a thought about being dead in relation to another experience of suicidality or a thought to hurt, harm, or injure oneself with the intent or awareness that one could die as a result or any strategizing for or accounting of or thought(s) of future action(s) for a suicide attempt (including thoughts to make a plan). The ideation may concern, but is not limited to, the method, the means, the location, the date, and / or any unfinished tasks.

NIMH Workgroup [8]	Thoughts, images, or other cognitions that indicate a wish to die or to kill oneself (die by suicide).

References

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7. Best Practice Guideline for Developing International Statistical Classification, United Nations Department of Economic and Social Affairs, Statistics Division, Expert group meeting on International economic and social classifications, New York, 18-20 May 2011.

8. NIMH Workgroup