



# Monitoring Suicidal Behaviour in Europe



MONSUE

## Final Report

on the Implementation of the Action  
(2007-06-01 - 2010-06-01)

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"Monitoring Suicidal Behaviour in Europe"  
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## CONTENT

<b>1. Aim of the MONSUE project</b>	<b>7</b>
1.1 History of the study of suicidal behaviour in Europe	7
1.2 Deliverables of the project	8
<b>2. The MONSUE project group</b>	<b>10</b>
2.1 Participating MONSUE centres and countries	10
2.2 MONSUE meetings and initiatives	12
2.3 Process and challenges within the project	15
2.3.1 Hall, Austria	16
2.3.2 Salzburg, Austria	17
2.3.3 Helsinki, Finland	18
2.3.4 Nancy, France	19
2.3.5 Hamburg, Germany	20
2.3.6 Riga, Latvia	21
2.3.7 Ankara, Turkey	22
2.4 Description of national suicide prevention initiatives by the MONSUE centres	23
2.4.1 Brussels, Belgium	23
2.4.2 Odense, Denmark	24
2.4.3 Tallinn, Estonia	25
2.4.4 Leipzig and Wuerzburg, Germany	27
2.4.5 Pecs, Hungary	28
2.4.6 Campobasso, Italy	29
2.4.7 Maribor, Slovenia	30
2.4.8 Oviedo, Spain	31
2.4.9 Stockholm, Sweden	32



<b>3. Methods</b>	<b>35</b>
<b>3.1. Definitions</b>	<b>35</b>
3.1.1 Suicide	35
3.1.2 Suicide attempt	35
3.1.3 Rate	35
3.1.4 Hot spot	36
<b>3.2 Development of the MONSUE monitoring form</b>	<b>36</b>
<b>3.3 Definition of the MONSUE catchment areas</b>	<b>38</b>
<b>3.4 Calculation of the estimation factor</b>	<b>44</b>
<b>3.5 Process of data checking and data analysis procedure</b>	<b>46</b>
<b>3.6 Suicide data</b>	<b>51</b>
3.6.1 Description of the data collection process	51
3.6.2 Description of databases for analyses	52
<b>3.7 Suicide attempt data</b>	<b>53</b>
3.7.1 Description of the data collection process	53
3.7.2 Description of databases for analyses	53
3.7.2.1 <i>Assessment periods</i>	53
3.7.2.2 <i>Number of registered episodes of suicide attempts and individuals with a suicide attempt</i>	56
<b>4. Results</b>	<b>59</b>
<b>4.1 Descriptive results regarding completed suicides</b>	<b>59</b>
4.1.1 Suicide rates	59
4.1.1.1 <i>Suicide rates in the countries</i>	59
4.1.1.2 <i>Suicide rates in the catchment areas</i>	66
4.1.2 Suicide methods	72
4.1.3 Association between suicide rates and sociodemographic variables	76
<b>4.2 Descriptive results regarding suicide attempts</b>	<b>77</b>
4.2.1 Suicide attempt rates in the catchment areas	77



<b>4.2.2 Cross-national analyses</b>	<b>88</b>
<b>4.2.2.1 Cross-national analyses of suicide attempt methods</b>	<b>89</b>
<b>4.2.2.2 Cross-national analyses of characteristics of the suicide attempt</b>	<b>92</b>
<b>4.2.2.3 Cross-national analyses of psychiatric diagnoses of suicide attempters</b>	<b>94</b>
<b>4.2.2.4 Cross-national analyses of sociodemographic variables</b>	<b>95</b>
<b>4.2.2.5 Cross-national analyses of repetition variables</b>	<b>101</b>
<b>4.2.3 Country-specific analyses</b>	<b>104</b>
<b>4.2.3.1 Country-specific analyses of methods</b>	<b>105</b>
<b>4.2.3.2 Country-specific analyses of psychiatric diagnoses</b>	<b>108</b>
<b>4.2.3.3 Country-specific analyses of sociodemographic variables</b>	<b>110</b>
<b>4.2.3.4 Country-specific analyses of repetition variables</b>	<b>113</b>
<b>4.2.4 Longitudinal analyses</b>	<b>115</b>
<b>4.2.4.1 Longitudinal analysis over 12 years</b>	<b>115</b>
<b>4.2.4.2 Longitudinal analysis over 18 years</b>	<b>116</b>
<b>4.2.5 Risk groups for repetition</b>	<b>118</b>
<b>4.2.5.1 Identification of special risk groups for repetition on the basis of specific methods used in the first suicide attempt</b>	<b>118</b>
<b>4.2.5.2 Specific psychiatric disorders as risk factors for the repetition of a suicide attempt</b>	<b>120</b>
<b>4.2.5.3 Sociodemographic variables as risk factors for the repetition of a suicide attempt</b>	<b>122</b>
<b>4.2.5.4 Frequencies of contacts to the health system after the latest attempt as risk factor for repetition</b>	<b>124</b>



<b>5. Discussion and conclusions</b>	<b>126</b>
5.1 General discussion of the results	126
5.2 Conclusions for political actions for suicide prevention in Europe	132
5.2.1 Primary prevention strategies	132
5.2.2 Secondary prevention strategies	134
5.2.3 Tertiary prevention strategies	136
5.3 Open issues and future perspectives	137
<b>6. References</b>	<b>138</b>
Appendix A: MONSUE monitoring forms	



# ***1. Aim of the MONSUE project***

Aim of the final report is to summarize all information about the evaluation process, to give an overview of all data obtained within the MONSUE study, and to discuss the results of the analyses of suicide attempt data with respect to the development of prevention strategies. The project period funded by EC started in June 2007 and ended in June 2010.

## **1.1 History of the study of suicidal behaviour in Europe**

Suicidal behaviour displays a major public and mental health problem in the majority of European countries. Continuous monitoring of suicide and attempted suicide is the basis for a successful implementation of suicide prevention programmes and for their evaluation.

The MONSUE project is based on the experiences of the WHO/EURO Multicentre Study on Suicidal Behaviour. Since completed suicide is systematically assessed in nearly all European countries, it is all the more astonishing that no systematic cross-national assessment of suicide attempts is being conducted. A first approach towards a systematic assessment of suicide attempts was started in 1989 in the context of the WHO Network for Suicide Prevention. Due to funding by EC, it was possible to improve and validate previously collected data by initiating the MONSUE project. After the amendment of the Grant Agreement in 2007 and the study process, actively participating countries, covering all parts of Europe, were Belgium (Brussels), Odense (Denmark, Estonia (Tallinn), Germany (Leipzig, Wuerzburg), Hungary (Pecs), Italy (Campobasso), Slovenia (Maribor), Spain (Oviedo), Sweden (Stockholm) and Berne (Switzerland). Berne in Switzerland participated as associated centre without EC funding and assessed data on episodes of suicide attempts with the WHO monitoring form, which were included in later analyses.



## 1.2 Deliverables of the project

Within the MONSUE project a systematic assessment of the frequency, characteristics and repetition of suicidal behaviour, mainly of suicide attempts, in several European countries was realized.

The main interest of the project group was the comprehensive assessment of various variables in persons with at least one suicide attempt with the objective of identifying predictive variables and defining special groups at risk. Not only individual and social causal factors should be systematically assessed, but also their changes over time. For this purpose, the MONSUE data were compared with data on suicidal behaviour previously collected by the WHO Network for Suicide Prevention.

The main deliverables attained in the MONSUE project can be summarized as follows:

1. Putting in place mechanisms for a systematic and homogeneous data collecting procedure on the base of a common monitoring form for the assessment of suicide attempts;
2. Comparison of suicide data, i.e. on completed suicides in relation to attempted suicides as well as their changes over time;
3. Evaluation and assessment of the main suicide and suicide attempt methods in Europe;
4. Assessment of restriction of methods, access to “hot spots” and preventive measures for specific groups at risk;
5. Detection of indicators for suicidal behaviour;
6. Development of a proposal for an action plan for suicide prevention in Europe.

Besides the assessment of suicide attempts, also data on completed suicide had to be collected. Thus, each of the participating country's tasks was the conduction of a national survey on suicide rates and methods as well as suicide prevention strategies. For this purpose, it is necessary to merge information from various data bases, i.e. official data bases (such as EUROSTAT), national and regional health agencies of the catchment areas as well as results from previous projects and initiatives.





Since an exhaustive interpretation of suicidal behaviour and its prevention needs a synergistic approach, integrating and comparing data from various data bases is necessary.

On the basis of the synergistically collected and integrated data it is possible to formulate proposals for the implementation of preventive strategies to reduce the frequency of suicidal behaviour.



## **2. The MONSUE project group**

### **2.1 Participating MONSUE centres and countries**

The 10 active MONSUE centres and the associated centre without EC funding consist of the following institutions and project leaders:

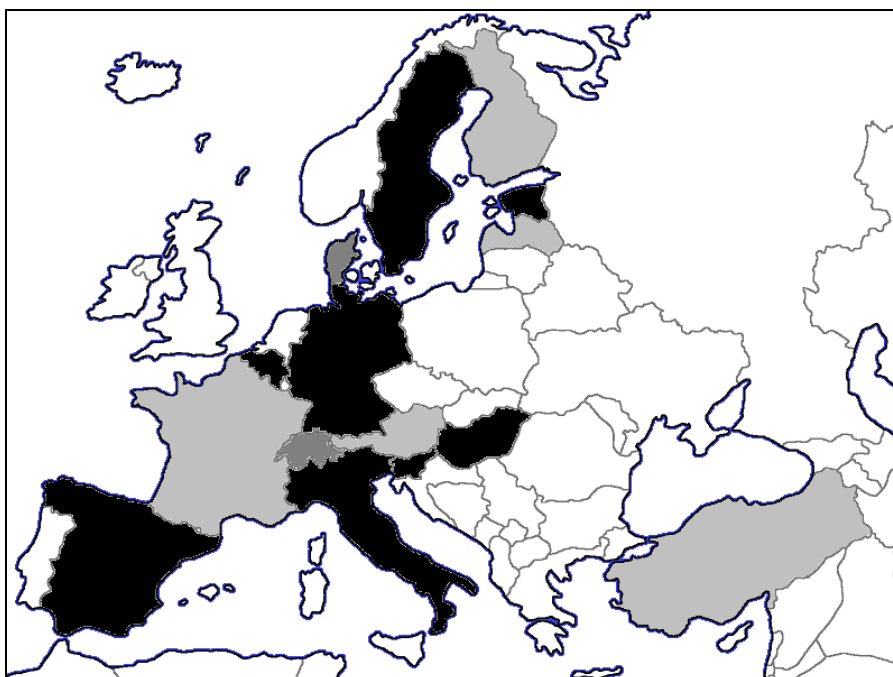
- Centre Hospitalier Universitaire Brugman Brussels, Belgium, project leader: Prof. P. Verbanck
- Centre for Suicide Research Odense, Denmark, project leader. Prof. L. Zöllner (partially active centre)
- Estonian-Swedish Suicidology Institute Tallinn, Estonia, project leader: Prof. A. Vaernik
- University of Leipzig, Germany, project leader: Prof. U. Hegerl
- Coordination centre University Hospital of Wuerzburg, Germany, project leader: Prof. A. Schmidtke
- University Medical School of Pecs, Hungary, project leader: Prof. S. Fekete
- Università degli Studi del Molise Campobasso, Italy, project leader: Prof. M. Sarchiapone
- University of Primorska, Slovenia, project leader: S. Temnik
- University of Oviedo, Spain, project leader: Prof. J. Bobes
- Karolinska Institute Stockholm, Sweden, project leader: Prof. D. Wasserman
- University Clinic and Policlinic for Psychiatry Berne, Switzerland, project leader: Prof. T. Reisch (as associated partner without EC funding)

In the context of the WHO network for Suicide Prevention a steering group was formed that also took over steering tasks within the MONSUE project. This steering group consisted of Prof. Schmidtke (leader of the centre in Wuerzburg), Prof. Wasserman (leader of the centre in Stockholm), Prof. Vaernik (leader of the centre in Tallinn), Prof. Loennqvist (leader of the centre in Helsinki) and Prof. Zoellner (leader of the centre in Odense).



Actively participating countries, covering all parts of Europe, were Belgium (Brussels), Estonia (Tallinn), Germany (Leipzig, Wuerzburg), Hungary (Pecs), Italy (Campobasso), Slovenia (Maribor), Spain (Oviedo) and Sweden (Stockholm). In addition, Odense in Denmark as partially active centre developed a Danish MONSUE monitoring form and was able to provide epidemiological data (suicide and suicide attempt rates), but did not deliver suicide attempt data assessed with the MONSUE monitoring form. Berne participated as associated centre, but did not receive EC funding. Therefore this centre was not obliged to provide further deliverables (e.g. epidemiological data).

Figure 1 illustrates the geographical distribution of the centres that actively participated in MONSUE during the time period from 2007 to 2010 as well as the centre in Berne (Switzerland). The participating centres of the MONSUE project consist of 2 centres in Northern Europe (including Denmark as partially active centre), 3 in Eastern Europe, 1 in Western Europe, 2 in Central Europe (3 including the associated centre of Berne) and 2 in Southern Europe. The collected data on suicide attempts thus provide a representative picture of all regions in the EC.



**Figure 1:** Geographical Distribution of countries with active centres (black) and non-active centres (grey) in 2008 and 2009. Also included is Denmark (dark grey) as partially active centre and Switzerland (dark grey) as a country with a centre providing data, but not belonging to the MONSUE beneficiaries.



## 2.2 MONSUE meetings and initiatives

In the context of the MONSUE project several meetings and congresses were held. Table 1 displays an overview of project conferences and meetings during the project resp. project termination period which dealt with the topic of prediction and prevention of suicidal behaviour, especially for specific groups at risk as well as hot spots. Members of the MONSUE project, mostly steering group members, prepared these conferences and provided expert knowledge as well as preliminary results that were obtained in the context of the MONSUE project.

**Table 1:** Overview of conferences in the framework of the MONSUE project

Topic	Location and year
Preparation of the study	Wuerzburg, February 2005
Revision of the monitoring form	Berlin, April 2005
Prevention models and definition of working groups	Berlin, May 2007
Discussion of suicide prevention activities	Stockholm, August 2007
Discussion of suicide prevention activities	Stockholm, January 2008
Discussion of suicide prevention activities	Nice, April 2008
International symposium on Suicidology	Wuerzburg, June 2009
Hot spots for suicidal behaviour	Berlin, September 2009
Survivors of suicide attempts	Guenzburg, March 2010
Discussion of an action plan for suicide prevention in Europe	Wuerzburg, October 2010

In February 2005 the first official MONSUE meeting with all beneficiaries took place in Wuerzburg in order to prepare the study, despite the fact that the financial contribution from EC was not yet available at this time. It was then decided that the WHO monitoring form had to be complemented.

In April 2005 the members of the steering group met in Berlin to develop a revised MONSUE version of the monitoring form which included several new variables.



Two years later, in May 2007, steering group members and other beneficiaries met again in Berlin to discuss various suicide prevention models. Different working groups were formed to deal with special groups at risk which analyzed data from the literature and prepared specific analyses with the MONSUE monitoring form.

In August 2007 and January 2008 some members of the steering group met in Stockholm for a discussion about the ongoing activities in the field of suicide prevention. In April 2008 a meeting of steering group members took place in Nice in the context of a scientific conference.

Since the project leader, members of the steering group and several leaders of MONSUE centres took part in these conferences and presented relevant suicide and suicide attempt data mostly obtained with the MONSUE monitoring form, these meetings were an important contribution to the elaboration of guidelines on suicide prevention that were developed in the MONSUE project.

On the occasion of the retirement of Professor Dr. Armin Schmidtke, the project leader of the MONSUE project, a symposium was organised to present and discuss the current situation of suicide monitoring and suicide prevention in Europe. International experts in the field were invited for a presentation of their work. .

Table 2 gives an overview of the speakers and the topics of the presentations.

**Table 2:** Speakers and topics of the International Symposium on Suicidology in Wuerzburg, 2009

Name of speaker	Topic
Jürgen Schefflein	Introduction: Prevention of Suicide- priority theme of the European Pact for Mental Health and Well-being
Wolfgang Rutz	Prevention of Depression and Suicide – an urgent matter of health promotion and public mental health
Danuta Wasserman	Genetics of the HPA axis as a systemic modulator of the stress in suicidal behaviours
Manfred Wolfersdorf & Eva Schaller	Depression and suicide - overview and clinical aspects
David Lester	Suicide in mass and serial murderers
Antoon Leenaars	What is the “best” psychotherapy with suicidal people?
David Clark	How closely are urgent suicidal impulses related to underlying severity of depression?
Werner Felber, Ute Lewitzka, Harald Tedone & Peter Winiacki	Are National Suicide Prevention Programs effective?



The symposium focused on suicidal behaviour and its prevention in Europe. About 100 researchers and interested persons from different EU countries participated in the lectures and discussions and contributed their experiences. This meeting therefore was a significant step in the development of an action plan on political guidelines in the field of suicide prevention.

In September 2009 and March 2010 preliminary results of the MONSUE project were presented by the project leader in the context of meetings in Berlin and in Guenzburg focusing on suicide prevention.

The most relevant meeting with regard to the development of the MONSUE action plan took place in October 2010 in Wuerzburg. On two days (October 29 and 30) all centre leaders, respectively their co-workers, from the active centres and also Prof. Alan Apter (Tel Aviv, Israel) participated and extensively discussed the draft for an action plan on political guidelines in the field of suicide prevention provided by the coordination centre on the basis of MONSUE and other data.



## 2.3 Process and challenges within the project

Originally, 17 centres of all parts of Europe were selected as MONSUE beneficiaries. Until November 2009 only 4 of these had provided data based on the MONSUE monitoring form to the coordination centre. Since November 2009 extensive coordination work has been done to compensate for previous difficulties with several centres. Due to intense approaching 10 out of 17 centres fulfilled project tasks as agreed in the Grant Agreement with EC.

Centres that did not provide an appropriate data file during the required time period were defined as non-active. The following section presents an overview of the coordination centre's efforts to cope with the 7 non-active centres.



### 2.3.1 Hall, Austria

Due to the fact that the centre in Hall did not provide any suicide attempt data for the requested time period, the centre was marked as “non active”. The coordination centre has demanded reimbursement of the paid tranches. Table 3 displays the communication of the coordination centre with the centre in Hall.

**Table 3:** Past communication with the centre in Hall

Date	Form	Content	Appendix
20.11.2007	Letter	Amendments of GA	Copy of new EU contract (Amendment GA), Letter EU, Time Table, List of deliverables, Budget Plan, Form for bank account, Copy of Monitoring form, Coding list for Monitoring form
04.01.2008	Letter	Information about new project period	
11.03.2008	Letter	Prefinancing payment	Financial identification sheet
25.03.2008	e-mail	Prefinancing payment	Financial identification sheet
16.04.2008	Letter	Information about start of project	Copies of transfer receipts
02.05.2008	e-mail	Request for missing SWIFT-number	
17.07.2008	Letter	Request for missing SWIFT-number	
18.07.2008	Letter	Request for 1 <sup>st</sup> Interim report	Template
18.07.2008	e-mail	Request for 1 <sup>st</sup> Interim report	Structure, tables, financial statement
10.11.2008	Letter	Reminder 1 <sup>st</sup> Interim report	
17.02.2009	Letter	Asked for cooperation	
14.07.2009	e-mail	Request for 2 <sup>nd</sup> Interim Report	Structure, tables, financial statement
19.10.2009	Letter	Reminder 2 <sup>nd</sup> Interim Report	Templates
26.10.2009	e-mail	Reminder 2 <sup>nd</sup> Interim Report	Structure, tables, financial statement
23.04.2010	Letter	Termination and request for SPSS data	
04.05.2010	Letter	Termination and request for SPSS data	
11.05.2010	e-mail	Request for data	
25.06.2010	Letter e-mail	Asked for reimbursement	
22.07.2010	Letter	Asked for reimbursement	
29.11.2010	Letter	Reminder for reimbursement by the legal office of the coordination centre	





### 2.3.2 Salzburg, Austria

The centre in Salzburg also was not able to hand in the requested data files. Since this centre did not receive any EC funding, no reimbursement had to take place. Table 4 summarizes the communication of the coordination centre with the centre in Salzburg.

**Table 4:** Past communication with the centre in Salzburg

Date	Form	Content	Appendix
20.11.2007	Letter	Amendments of GA	Copy of new EU contract (Amendment GA), Letter EU, Time Table, List of deliverables, Budget Plan, Form for bank account, Copy of Monitoring form, Coding list for Monitoring form
04.01.2008	Letter	Information about new project period	
11.03.2008	Letter	Prefinancing payment	Financial identification sheet
25.03.2008	e-mail	Prefinancing payment	Financial identification sheet
16.04.2008	Letter	Information about start of project	Financial identification sheet
17.07.2008	Letter	Transfer of money	Financial identification sheet
18.07.2008	Letter	Request for 1 <sup>st</sup> Interim report	Template
18.07.2008	e-mail	Request for 1 <sup>st</sup> Interim report	Structure, tables, financial statement
21.07.2008	Letter	Request for 1 <sup>st</sup> Interim report	Template
10.11.2008	Letter	Reminder 1 <sup>st</sup> Interim report	
14.07.2009	e-mail	Request for 2 <sup>nd</sup> Interim Report	Structure, tables, financial statement
19.10.2009	Letter	Reminder 2 <sup>nd</sup> Interim Report	Templates
26.10.2009	e-mail	Reminder 2 <sup>nd</sup> Interim Report	Structure, tables, financial statement
17.02.2010	Letter	Demand note	
17.02.2010	Letter	Termination and request for cooperation	
23.04.2010	Letter	Termination and request for SPSS data	
04.05.2010	Letter	Termination and request for SPSS data	



### 2.3.3 Helsinki, Finland

The centre in Helsinki had to be defined as non-active, too, because it handed in a data file that merely contained 10 out of the requested 45 variables of the monitoring form for the requested time period. Due to this insufficiency of data quality, the centre had to repay the EC funding, which they immediately did. Table 5 displays the communication of the coordination centre with the centre in Helsinki.

**Table 5:** Past communication with the centre in Helsinki

Date	Form	Content	Appendix
20.11.2007	Letter	Amendments of GA	Copy of new EU contract (Amendment GA), Letter EU, Time Table, List of deliverables, Budget Plan, Form for bank account, Copy of Monitoring form, Coding list for Monitoring form
04.01.2008	Letter	Information about new project period	
11.03.2008	Letter	Prefinancing payment	Financial identification sheet
25.03.2008	e-mail	Prefinancing payment	Financial identification sheet
16.04.2008	Letter	Information about start of project	Copies of transfer receipts
18.07.2008	Letter	Request for 1 <sup>st</sup> Interim report	Template
18.07.2008	e-mail	Request for 1 <sup>st</sup> Interim report	Structure, tables, financial statement
10.11.2008	Letter	Reminder 1 <sup>st</sup> Interim Report	
14.07.2009	e-mail	Request for 2 <sup>nd</sup> Interim Report	Structure, tables, financial statement
19.10.2009	Letter	Reminder 2 <sup>nd</sup> Interim Report	Templates
26.10.2009	e-mail	Reminder 2 <sup>nd</sup> Interim Report	Structure, tables, financial statement
23.04.2010	Letter	Termination and request for SPSS data	
04.05.2010	Letter	Termination and request for SPSS data	
11.06.2010	e-mail	Information about insufficiency of data	
25.06.2010	e-mail	Request for reimbursement	
22.07.2010	Letter	Confirmation of the receipt of reimbursement	



### 2.3.4 Nancy, France

The centre in Nancy informed the coordination centre about the fact that the MONSUE data collection regulations could not be implemented. The French centre could not provide the requested data file based on the MONSUE form and, thus, had to be marked as non-active. Since this centre did not receive any tranches, there had to be no reimbursement. Table 6 summarizes the communication of the coordination centre with the centre in Nancy.

**Table 6:** Past communication with the centre in Nancy

Date	Form	Content	Appendix
20.11.2007	Letter	Amendments of GA	Copy of new EU contract (Amendment GA), Letter EU, Time Table, List of deliverables, Budget Plan, Form for bank account, Copy of Monitoring form, Coding list for Monitoring form
04.01.2008	Letter	Information about new project period	
11.03.2008	Letter	Prefinancing payment	Financial identification sheet
25.03.2008	e-mail	Prefinancing payment	Financial identification sheet
18.07.2008	Letter	Request for 1 <sup>st</sup> Interim report	Template
18.07.2008	e-mail	Request for 1 <sup>st</sup> Interim report	Structure, tables, financial statement
28.08.2008	Letter	Request for French monitoring form	
22.09.2008	Letter	Request for French monitoring form	Monitoring form
10.11.2008	Letter	Reminder 1 <sup>st</sup> Interim Report	
13.02.2009	Letter	Request for French monitoring form	
14.07.2009	e-mail	Request for 2 <sup>nd</sup> Interim Report	Structure, tables, financial statement
19.10.2009	Letter	Reminder 2 <sup>nd</sup> Interim Report	Templates
26.10.2009	e-mail	Reminder 2 <sup>nd</sup> Interim Report	Structure, tables, financial statement
23.04.2010	Letter	Termination and request for SPSS data	
04.05.2010	Letter	Reminder on termination and request for SPSS data	



### 2.3.5 Hamburg, Germany

Because the centre in Hamburg had difficulties with respect to data protection regulations, it was not able to provide the requested monitoring files including data on suicide attempts and, therefore, had to be marked as non-active. The centre in Hamburg transferred both EC tranches back to the coordination centre. Table 7 displays the intensive contact with this centre.

**Table 7:** Past communication with the centre in Hamburg

Date	Form	Content	Appendix
20.11.2007	Letter	Amendments of GA	Copy of new EU contract (Amendment GA), Letter EU, Time Table, List of deliverables, Budget Plan, Form for bank account, Copy of Monitoring form, Coding list for Monitoring form
04.01.2008	Letter	Information about new project period	
11.03.2008	Letter	Prefinancing payment	Financial identification sheet
25.03.2008	e-mail	Prefinancing payment	Financial identification sheet
16.04.2008	Letter	Information about start of project	Financial identification sheet
15.05.2008	Letter	Reminder MONSUE activity	
23.05.2008	Letter	Reminder project work	
06.06.2008	e-mail	Meeting to clarify project work	
10.06.2008	Letter	Reminder project work	
23.06.2008	e-mail	Information about financing	
01.07.2008	e-mail	Definition of age groups	
17.07.2008	Letter	Transfer of money	Financial identification sheet
18.07.2008	Letter	Request for 1 <sup>st</sup> Interim report	Template
18.07.2008	e-mail	Request for 1 <sup>st</sup> Interim report	Structure, tables, financial statement
29.07.2008	e-mail	Reminder project work	
10.11.2008	Letter	Reminder 1 <sup>st</sup> Interim report	
14.07.2009	e-mail	Request for 2 <sup>nd</sup> Interim Report	Structure, tables, financial statement
19.10.2009	Letter	Reminder 2 <sup>nd</sup> Interim Report	Templates
26.10.2009	e-mail	Reminder 2 <sup>nd</sup> Interim Report	Structure, tables, financial statement
date missing	e-mail	Reminder project work	
17.02.2010	Letter	Demand Note	
23.04.2010	Letter	Termination and request for SPSS data	
04.05.2010	Letter	Termination and request for SPSS data	
12.05.2010	e-mail	Sending of bank details	
17.05.2010	e-mail	Thanking for initiation of reimbursement	
22.07.2010	Letter	Confirmation of the receipt of reimbursement	



### 2.3.6 Riga, Latvia

In Riga the jurisdiction changed between several health care institutions. As a consequence, none of these institutions accomplished to fulfil the MONSUE tasks. Since no money was transferred to the centre in Riga, no reimbursement was necessary. Table 8 summarizes the communication with the centre in Riga.

**Table 8:** Past communication with the centre in Riga

Date	Form	Content	Appendix
20.11.2007	Letter	Amendments of GA	Copy of new EU contract (Amendment GA), Letter EU, Time Table, List of deliverables, Budget Plan, Form for bank account, Copy of Monitoring form, Coding list for Monitoring form
04.01.2008	Letter	Information about new project period	
18.01.2008	Letter	Change of responsible institution	
11.03.2008	Letter	Prefinancing payment	Financial identification sheet
25.03.2008	e-mail	Prefinancing payment	Financial identification sheet
16.04.2008	Letter	Information about start of project	Financial identification sheet
17.07.2008	Letter	Information about EC funding	Financial identification sheet
18.07.2008	Letter	Request for 1 <sup>st</sup> Interim report	Template
18.07.2008	e-mail	Request for 1 <sup>st</sup> Interim report	Structure, tables, financial statement
21.07.2008	Letter	Request for 1 <sup>st</sup> Interim report	Template
25.07.2008	Letter, e-mail	Effort to search for a new responsible project leader	
09.09.2008	Letter	Unable to find a new responsible project leader; stop of communication	



### 2.3.7 Ankara, Turkey

In the centre in Ankara, no requested data on suicide attempts were assessed. As the Turkish centre did not receive any EC funding, there had to be no reimbursement. Table 9 displays the correspondence of the coordination centre with the centre in Ankara.

**Table 9:** Past communication with the centre in Ankara

Date	Form	Content	Appendix
20.11.2007	Letter	Amendments of GA	Copy of new EU contract (Amendment GA), Letter EU,
			Time Table, List of deliverables, Budget Plan, Form for bank account,
			Copy of Monitoring form, Coding list for Monitoring form
04.01.2008	Letter	Information about new project period	
11.03.2008	Letter	Prefinancing payment	Financial identification sheet
25.03.2008	e-mail	Prefinancing payment	Financial identification sheet
16.04.2008	Letter	Information about start of project	
01.05.2008	Letter	Change of project leader	
17.07.2008	Letter	Change of project leader	
17.07.2008	Letter	Information about EC funding	Financial identification sheet
18.07.2008	Letter	Request for 1 <sup>st</sup> Interim report	Template
18.07.2008	e-mail	Request for 1 <sup>st</sup> Interim report	Structure, tables, financial statement
28.08.2008	Letter	Participation MONSUE	
29.08.2008	Letter	Participation MONSUE	
10.11.2008	Letter	Reminder 1 <sup>st</sup> Interim Report	
10.11.2008	Letter	Ask for financial identification sheet	
14.07.2009	e-mail	Request for 2 <sup>nd</sup> Interim Report	Structure, tables, financial statement
19.10.2009	Letter	Reminder 2 <sup>nd</sup> Interim Report	Templates
26.10.2009	e-mail	Reminder 2 <sup>nd</sup> Interim Report	Structure, tables, financial statement
17.02.2010	Letter	Response to letter of withdrawal	
23.04.2010	Letter	Termination and request for SPSS data	
04.05.2010	Letter	Termination and request for SPSS data	



## **2.4 Description of national suicide prevention initiatives by the MONSUE centres**

In general, some nations make use of comprehensive suicide prevention strategies which are multifaceted programmes that integrate various components, as is the case in Sweden and Finland. Other nations have national suicide prevention programmes which target isolated factors, for example Estonia and Germany. Moreover, there are countries without any national suicide prevention activities, such as Slovenia and Hungary. These initiatives tend to have a lot of issues in common.

The following section gives an overview of general strategies of suicide prevention and of specific issues of suicide prevention on the three different levels (table 10 - 18). Primary prevention strategies address the general population, whereas secondary prevention strategies address risk groups for suicidal behaviour. Tertiary prevention in the field of suicidal behaviour aims at reducing the risk of relapse.

### **2.4.1 Brussels, Belgium**

In the Flemish region, a Suicide Prevention Action Plan has been installed for the time period of 2006 to 2010 which was initiated by the Flemish Ministry of Well-being, Health and the Family. On the one hand, this action plan centralizes the suicide prevention initiatives, such as the mental health centres, GPs, hospitals and telephone lines. On the other hand, it has established new actions, e.g. the introduction of media guidelines for reporting about suicidal behaviour. The action plan has also led to the institution of inter-ministerial meetings with representatives of the Regional and Federal Ministries of Health and Well-being that take place regularly. Nevertheless, these initiatives have not resulted in a national suicide prevention programme for Belgium up to now. Specific issues of prevention of suicidal behaviour are depicted in table 10.

**Table 10:** Overview of prevention strategies in Belgium

Country	Level	Strategy	Effectiveness
Belgium	Primary Prevention	<ul style="list-style-type: none"> <li>• Regional initiatives: crisis hotlines</li> <li>• Public awareness campaigns to increase sensibility towards suicidal behaviour</li> <li>• Internet forum for suicide prevention</li> <li>• Campaigns for students</li> </ul>	<ul style="list-style-type: none"> <li>• Up to now no systematic evaluation of isolated measures</li> </ul>
	Secondary Prevention	<ul style="list-style-type: none"> <li>• Interventions in crisis institutions</li> <li>• Training for professionals</li> </ul>	
	Tertiary Prevention	<ul style="list-style-type: none"> <li>• Aftercare of suicide attempters</li> <li>• Education of parents after a suicide attempt of their child</li> </ul>	

#### 2.4.2 Odense, Denmark

The suicide rate in Denmark was among the highest in Europe in 1980, and even though suicide rates have declined steadily in Denmark since then, Denmark still has higher suicide rates than other countries in Scandinavia and most countries in Western Europe. In almost all age groups for both men and women, Denmark was the country in Europe that experienced the largest decline in suicide rate from 1980 to 2000. The Danish suicide prevention strategy is outlined in the Proposal for a National Programme for Prevention of Suicide and Suicide Attempt in Denmark (Danish National Board of Health, 1998). Table 11 shows prevention strategies in Denmark.



**Table 11:** Overview of prevention strategies in Denmark

Country	Level	Strategy	Effectiveness
Denmark	Primary Prevention	<ul style="list-style-type: none"> <li>Youth education (Saving Young Lives in Europe SAYLE): enhancement of personal well-being and training for the development of resources</li> </ul>	<ul style="list-style-type: none"> <li>Up to now no systematic evaluation of isolated measures</li> </ul>
	Secondary Prevention	<ul style="list-style-type: none"> <li>Prevention of suicidal behaviour among elderly people, particularly elderly men (handbook for the personnel of the health care field: better tools in order to identify signs of poor personal welfare and suicidal behaviour among elderly people)</li> <li>Prevention strategies targeting young people, particularly girls with eating disorders: psycho-educative programmes</li> <li>Prevention strategies targeting mentally disordered, particularly those just discharged from a psychiatric department</li> </ul>	
	Tertiary Prevention	<ul style="list-style-type: none"> <li>Collection of information on suicide attempters</li> </ul>	

### 2.4.3 Tallinn, Estonia

In 1993, Estonia initiated its suicide prevention activities which intended to integrate suicide awareness in society. Estonian politicians and authorities were informed about the magnitude of suicidal behaviour and alerted to this important public health issue. In 2001 a draft for a suicide prevention programme was submitted by the Estonian-Swedish Mental Health and Suicidology Institute (ERSI) and empowered by the Estonian Ministry of Social Affairs. Since its beginning, the suicide prevention programme has implemented numerous activities among certain risk groups. The work of ERSI on suicide and suicide-related topics has a high profile in the media. Within the framework of this prevention programme, an interdisciplinary team of specialists in the fields of psychiatry, public health, statistics, psychology, sociology and social work has been promoting mental health. Estonia has the lowest suicide rate among the Baltic States and Russia, although it started on the same level as its neighbouring countries (Värnik & Wasserman, 2009). Table 12 summarizes the prevention strategies in Estonia.

**Table 12:** Overview of prevention strategies in Estonia

Country	Level	Strategy	Effectiveness
Estonia	Primary Prevention	<ul style="list-style-type: none"> <li>• Public-relations activities to integrate suicide behaviour awareness into Estonian society. Topics on suicide behavior already have high profile in the media (TV, radio, press)</li> <li>• Raising awareness of Estonian policy- and decision-makers by providing sufficient information about the magnitude of suicidal behavior as an important public health and economic burden</li> <li>• Restriction of access to lethal means (regulations on medications, restriction of availability of alcohol etc.)</li> <li>• Providing guidelines to media about “safe” reporting of suicidal behaviours with indicating the possible aid and avoiding “copycat” suicidal behaviour.</li> <li>• Epidemiological and clinical research – (surveys of the distribution and dynamics of suicide and suicidal behaviours among specific groups, risk and protective factors, availability, quality and capacity of public health services, with respect to assessment and treatment of suicidal patients)</li> </ul>	<ul style="list-style-type: none"> <li>• The suicide rate in Estonia has decreased steadily since 1995. It is now the lowest (20 per 100,000 inhabitants) among the Baltic States and Russia, the neighbouring post-soviet countries. ERSI’s work has gradually shifted towards earlier stages of the suicidal process, and towards the promotion of positive mental health.</li> </ul>
	Secondary Prevention	<ul style="list-style-type: none"> <li>• Education / basic course in suicidology and specific-related topics for health sector ( physicians, nurses), hotlines workers, psychologists, social workers, schoolteachers, police officers and other gatekeepers</li> <li>• Consultations related to special suicidological cases for medical staff and other specialists if needed</li> <li>• Strengthening protective factors and promoting positive mental health through e-learning courses for specific settings and risk groups (schools, workplaces, elderly care facilities)</li> <li>• Community programmes for migrants, unemployed and other risk groups</li> </ul>	
	Tertiary Prevention	<ul style="list-style-type: none"> <li>• Follow-up of suicide attempters and proper aftercare by professionals</li> <li>• Compulsory psychiatric observation after suicide attempter is admitted to emergency care department or in any other hospital</li> <li>• Collaboration with family members</li> <li>• Monitoring of suicide attempters</li> </ul>	



#### **2.4.4 Leipzig and Wuerzburg, Germany**

In 2002, the German Association for Suicide Prevention (DGS) initiated the National Suicide Prevention programme for Germany (NaSPro). In the past 8 years, this programme has received increasing attention and cooperation in Germany. The prevention approach of NaSPro is broad and integrative and acknowledges that suicidal behaviour is a multifaceted phenomenon. Thus, the programme involves experts from various fields of science, as well as practitioners, relatives' organizations and representatives of political, religious and other organizations that might contribute to the task of suicide prevention. NaSPro includes actions on a horizontal level, i.e. for certain target groups such as adolescents, elderly etc., as well as on a vertical level, i.e. comprising specific interventions such as media initiatives and restricting access to means. Different working groups focus their activities on specific risk groups, settings or structures. Up to now, NaSPro consists of seventeen working groups dealing with various topics, such as addiction, the elderly, networking, specific risk groups, primary prevention, the workplace, and the armed forces. The German suicide prevention programme also receives substantial political support, including the federal committee on health in the German Bundestag, but so far it has not become a governmental initiative. Another comprehensive strategy in the field of suicide prevention in Germany comprises the four-level approach (interventions for the public, GPs, risk groups and multipliers) in the frame of the project EAAD (European Alliance Against Depression). Table 13 presents an overview of suicide prevention strategies in Germany.

**Table 13:** Overview of prevention strategies in Germany

Country	Level	Strategy	Effectiveness
Germany	Primary Prevention	<ul style="list-style-type: none"> <li>• In 60 cities in Germany the EAAD four-level approach is implemented</li> <li>• Public awareness campaigns (Press conferences in connection with the World Suicide Prevention Day, presentations for the public, flyers and posters)</li> <li>• Restriction of access to lethal means (e.g. car exhausts fumes, medications, prohibition of selling alcohol in petrol stations after 10 p.m., registering and safeguarding of hot spots)</li> <li>• Media recommendations for reporting about suicide (flyer, press conferences)</li> </ul>	<ul style="list-style-type: none"> <li>• Reduction of suicide and suicide attempt rates in regions, which have implemented the EAAD multilevel concept, but also in Germany in total over the last 30 years</li> <li>• Up to now no systematic evaluation of isolated measures</li> </ul>
	Secondary Prevention	<ul style="list-style-type: none"> <li>• In 60 cities in Germany the EAAD four-level approach is implemented</li> <li>• Flyers, posters and presentations for risk groups (relatives/survivors, substance-related disorders, elderly, young people, prisoners)</li> <li>• Training for multipliers and gatekeepers (e.g. teachers, priests, prison guards)</li> <li>• Crisis hotlines</li> </ul>	
	Tertiary Prevention	<ul style="list-style-type: none"> <li>• Training for professionals (e.g. nurses, general practitioners) regarding treatment of suicide attempters</li> <li>• Green card models (aftercare of suicide attempters)</li> </ul>	

#### 2.4.5 Pecs, Hungary

In 2000, scientists of the American Foundation for Suicide Prevention (AFSP) played a leadership role in initiating a suicide prevention initiative that aimed at training GPs, in consultation with psychiatrists, to identify and treat depressed patients. The project focused on the region of Kiskunhalas where the suicide rate was two thirds higher than that of Hungary in general. After five years, annual suicide rates decreased significantly in the target region in comparison to a control region with a comparably high suicide rate and to the whole country. Moreover, the target region showed a greater increase in the use of antidepressant treatment than the control region.



Despite the fact that Hungary has had the highest suicide rate in the world for the largest part of the past century, no national suicide prevention plan has been implemented in Hungary up to now. Table 14 displays suicide prevention strategies in Hungary.

**Table 14:** Overview of prevention strategies in Hungary

Country	Level	Strategy	Effectiveness
Hungary	Primary Prevention	<ul style="list-style-type: none"> <li>Nationwide S.O.S LIFE Hotline Service providing help between 7 p.m. and 7 a.m. daily for people in difficulties</li> </ul>	<ul style="list-style-type: none"> <li>Up to now no systematic evaluation of isolated measures</li> </ul>
	Secondary Prevention	<ul style="list-style-type: none"> <li>Training of help-line personnel in crisis resolution</li> <li>Training of GPs in consultations with psychiatrists in identifying and treating depressive patients initiated by the American Foundation for Suicide Prevention (AFSP)</li> </ul>	
	Tertiary Prevention	<ul style="list-style-type: none"> <li>Not specified</li> </ul>	

#### 2.4.6 Campobasso, Italy

Suicide prevention activities in Italy are implemented by non-governmental organizations, like private agencies or associations, psychiatric associations and universities. These initiatives are mostly local and deal with specific issues of suicide prevention, but do not reach the comprehensiveness of a national prevention strategy. The topics include public awareness campaigns of depression and suicide risk, media campaigns, suicide prevention in schools, a crisis centre for adolescents, a counselling service for parents, teachers and survivors of suicide, a telephone helpline for the elderly and the reduction of access to lethal means and methods of self-harm. These activities have not yet resulted in a national prevention strategy for Italy (Sarchiapone, 2009). Table 15 specifies preventive strategies in Italy.

**Table 15:** Overview of prevention strategies in Italy

Country	Level	Strategy	Effectiveness
Italy	Primary Prevention	<ul style="list-style-type: none"> <li>Public awareness campaigns (Conference in connection with the suicide prevention day)</li> <li>Mental health awareness campaign within the project "Saving and Empowering Young Lives in Europe" (SEYLE)</li> </ul>	<ul style="list-style-type: none"> <li>No systematic evaluation available</li> <li>Evaluation currently ongoing. Results will be available in 2011.</li> </ul>
	Secondary Prevention	<ul style="list-style-type: none"> <li>Gatekeeper training for teachers in high schools about how to recognize and refer adolescents at risk for suicide, in the context of the SEYLE project</li> <li>Professional screening for high schools at risk, within the SEYLE project</li> <li>Suicide prevention program for prisoners conducted in different Italian regions</li> </ul>	<ul style="list-style-type: none"> <li>Evaluation currently ongoing. Results will be available in 2011.</li> <li>Evaluation currently ongoing. Results will be available in 2011.</li> <li>No systematic evaluation available</li> </ul>
	Tertiary Prevention	<ul style="list-style-type: none"> <li>Training for mental health professionals about suicide prevention in persons with a suicide attempt</li> <li>CME course for physicians about suicide prevention in persons with a suicide attempt</li> </ul>	<ul style="list-style-type: none"> <li>Evaluation is scheduled for 2011 and results expected by the end of 2011. Treatment given before and after the training will be evaluated.</li> <li>No systematic evaluation available</li> </ul>

#### 2.4.7 Maribor, Slovenia

To date, there is no systematic and comprehensive national suicide prevention plan in Slovenia. However, there are specific activities on a local level, such as education courses for GPs in order to improve the recognition of depressive disorders in practice. These activities aim to improve mental health awareness and reduce mental ill-health and, thus, suicide risk. The organization in charge of most of these initiatives is the Slovene Association for Suicide Prevention which is non-



governmental and multidisciplinary. Its activities include the support of crisis telephone lines, cooperation with different crisis centres and counselling services, education of future professionals and the public, as well as raising awareness on suicide. The Slovenian Government has recently accepted a mental health legislation which seems to be the first step into a distinct public mental health policy that also includes a national suicide prevention plan. In table 16, the prevention strategies in Slovenia are listed.

**Table 16:** Overview of prevention strategies in Slovenia

Country	Level	Strategy	Effectiveness
Slovenia	Primary Prevention	<ul style="list-style-type: none"> <li>Professional and general public awareness campaigns; symposia in connection with the World Suicide Prevention Day, with expert discussions, workshops and presentations, good media coverage of these events</li> <li>Informative websites on mental health</li> </ul>	<ul style="list-style-type: none"> <li>Improved awareness regarding suicide-stigma among experts and the general public</li> </ul>
	Secondary Prevention	<ul style="list-style-type: none"> <li>Flyers for risk groups (i.e. mental health patients), available at various (mental health and other) treatment centres</li> <li>Crisis hotlines</li> <li>Training for professionals (e.g. nurses, general practitioners) in recognizing the symptoms of mental disorder, specifically depression, among their patients</li> </ul>	<ul style="list-style-type: none"> <li>Up to now no systematic evaluation of isolated measures</li> <li>Improved recognition of depression by the GPs (research evidence)</li> </ul>
	Tertiary Prevention	<ul style="list-style-type: none"> <li>Not specified</li> </ul>	

#### 2.4.8 Oviedo, Spain

So far, there is no national suicide prevention programme in Spain. Nevertheless, there are local non-governmental organizations that are concerned with suicide prevention issues. Their activities target specific risk groups, such as prisoners and survivors of suicide attempts. Moreover, some regions in Spain are a member of the European Alliance against Depression (EAAD) which aims at improving the diagnosis



and treatment of depression. Spain indeed has one of the lowest suicide rates in Europe (8.7 per 100,000), but also experienced one of the highest increases in its suicide rates from 1975 to 1994. After 1995, however, suicide rates have been rather stable. Table 17 gives a summary on suicide prevention strategies in Spain.

**Table 17:** Overview of prevention strategies in Spain

Country	Level	Strategy	Effectiveness
Spain	Primary Prevention	<ul style="list-style-type: none"> <li>• Public awareness campaigns:               <ol style="list-style-type: none"> <li>1. Public conferences in connection with the World Suicide Prevention Day.</li> <li>2. Press presentations</li> <li>3. Interviews in radio programs.</li> </ol> </li> <li>• Media recommendations for reporting about suicide.</li> <li>• Restriction of access to lethal means (e.g. medications, weapons, railings on bridges, car exhausts fume).</li> </ul>	<ul style="list-style-type: none"> <li>• Up to now no systematic evaluation.</li> </ul>
	Secondary Prevention	<ul style="list-style-type: none"> <li>• Intervention program for adolescents (Oviedo):               <ol style="list-style-type: none"> <li>1. Awareness intervention for pupils at schools (including poster and booklets).</li> <li>2. Training for gatekeepers (teachers).</li> <li>3. Screening for pupils at schools. Professional interview for pupils at risk (including referral to the mental health system if needed).</li> </ol> </li> <li>• Crisis hotlines</li> </ul>	
	Tertiary Prevention	<ul style="list-style-type: none"> <li>• Case management intervention program for suicide attempters (Oviedo), start in 2011:               <ol style="list-style-type: none"> <li>1. Follow-up interviews</li> <li>2. Psychoeducation groups</li> </ol> </li> </ul>	

#### 2.4.9 Stockholm, Sweden

In 1994, the National Centre for Suicide Research and Prevention of Mental Ill-Health (NASP) was founded at the National Institute of Psychosocial Medicine (IPM), Karolinska Institute (KI) in Stockholm. The first step into the development of a national strategy was the establishment of the Swedish National Council for Suicide





Prevention. In 1995, “Support in Suicidal Crisis” was published as the first Swedish national suicide prevention programme (National Council for Suicide Prevention, 1995). NASP has an advisory function in the WHO Multisite Intervention Study on Suicidal Behaviours (SUPRE-MISS), is a WHO Europe Lead Collaborating Centre for the Prevention of Suicide and Mental Ill-Health, and also acts as an advisor to European Union programmes on Improving Mental Health (European Commission, 2005). In 2006 and 2007, the Second National Suicide Prevention programme was developed by the National Board for Health and Welfare and the National Institute of Public Health, with support from NASP and other regional suicide prevention networks in Sweden (Proposition of the Swedish Government, 2007). This prevention programme consists of public health as well as health care strategies and was ratified by the Swedish parliament in June 2008 (Parliamentary Protocol 2008). Table 18 informs about the preventive strategies in Sweden.

**Table 18:** Overview of prevention strategies in Sweden

Country	Level	Strategy	Effectiveness
Sweden	Primary Prevention	<ul style="list-style-type: none"> <li>• National Programme for suicide prevention (first 1995-2007; second started in 2008) with the following objectives:               <ul style="list-style-type: none"> <li>-To reduce availability of means to commit suicide;</li> <li>-To promote better life opportunities in order to support the groups that are most at need;</li> <li>-To support voluntary organizations</li> </ul> </li> <li>• Public awareness campaigns in connection with the Suicide Prevention Day with press-releases and wide media coverage</li> <li>• School based interventions on adolescents which comprised projection of a film and discussion</li> </ul>	<ul style="list-style-type: none"> <li>• A continuous evaluation of the National Program for suicide prevention is performed with process oriented and epidemiological measures. Suicide rates decline markedly and continuously in Sweden, both for males and females in all age groups, with the exception of the 15-24 age group in which suicide rates are stable.</li> <li>• No systematic evaluation is performed.</li> <li>• A decrease in suicidal ideation has been measured one year after the intervention.</li> </ul>



		<ul style="list-style-type: none"> <li>• Adaptation and implementation in Sweden of the program Mental Health First Aid to the general population</li> <li>• Training of school staff in suicide prevention</li> </ul>	<ul style="list-style-type: none"> <li>• The program will be pilot-tested on 2000 persons from the general population in the first half of 2011. Results are expected to be available in early 2012.</li> <li>• A decrease in suicidal ideation in students has been observed after the intervention.</li> </ul>
	Secondary Prevention	<ul style="list-style-type: none"> <li>• Objectives within the National program for suicide prevention:             <ul style="list-style-type: none"> <li>▪ To minimize alcohol consumption in target and high-risk groups;</li> <li>▪ To educate gatekeepers about effective management of persons with suicide risk;</li> </ul> </li> <li>• To disseminate knowledge about evidence-based methods for reducing suicide</li> </ul>	
	Tertiary Prevention	<ul style="list-style-type: none"> <li>• Objectives within the National program for suicide prevention regarding of treatment with individuals with a suicide attempt:             <ul style="list-style-type: none"> <li>• To support medical, psychological and psychosocial services in preventing suicide;</li> <li>• To systematically analyse within the framework of the National Board for Health and Welfare all suicides which occur in the health care system during care and 28 days after discharge from the hospital;</li> <li>• To raise the competence of health-care personnel;</li> <li>• To build up rehabilitation services for suicide attempters</li> </ul> </li> <li>• Zero vision on suicide program implemented by the Stockholm County Council which aims at training all health care staff in hospitals.</li> <li>• Training of mental health professionals through a train-the-trainer programme</li> </ul>	<ul style="list-style-type: none"> <li>• Evaluation is ongoing and results will be available in early 2011</li> <li>• Improvement of trained staff in terms of knowledge about suicide, attitudes towards suicidal patients, self-confidence in their work.</li> </ul>



## **3. Methods**

### **3.1. Definitions**

#### **3.1.1 Suicide**

In suicidology research, mainly three definitions of suicide are used. An often quoted definition is that of O'Carroll et al. (1996), stating that “the term *suicide* refers to “death from injury, poisoning, or suffocation where there is evidence (either explicit or implicit) that the injury was self-inflicted and that the decedent intended to kill himself/herself.” The WHO definition implies that “for the act of killing oneself to class as suicide, it must be deliberately initiated and performed by the person concerned in the full knowledge or expectation of its fatal outcome” (1998).

#### **3.1.2 Suicide attempt**

As regards the definition of a suicide attempt, WHO (Platt et al., 1992) uses only one working definition, stating that a suicide attempt is “... an act with non-fatal outcome, in which an individual deliberately initiates a non-habitual behaviour that, without intervention from others, will cause self-harm, or deliberately ingests a substance in excess of the prescribed or generally recognized therapeutic dosage, and which is aimed at realizing changes which the subject desired via the actual or expected physical consequences.”

#### **3.1.3 Rate**

To achieve meaningful results about the epidemiological frequency of suicide and suicide attempts, rates were computed. A rate is the number of events or persons related to the population. The usually used number of inhabitants – if not explicitly given differently – for computing a rate is 100.000. Due to this step, events between differently large regions and countries become comparably.



### 3.1.4 Hot spot

The expression “hot spot” is often used when relating to locations, such as buildings or bridges, where suicides accumulate. A feasible definition is that a suicide “hot spot” is a location with more than 0.5 suicides per year over a time period of 10 years. Shorter time units (e.g. 5 years) should be defined for recently built locations in order to address the problem of suicide in due time.

## 3.2 Development of the MONSUE monitoring form

When the WHO network for suicide prevention started data collection in 1989 in the frame of the WHO Multicentre Study on Suicidal Behaviour (Schmidtke et al. 2004), beforehand a questionnaire was developed to monitor relevant variables concerning suicide attempts. The monitoring form comprised data concerning age, sex, place, date and time of suicide attempt and the method of the suicide attempt according to the new ICD-10 X- code. Furthermore information about various sociodemographic variables, such as current marital status, household composition, religious denomination, level of education (based on appropriate national standards), level of vocational training, economic situation at the time of the suicide attempt, change of address during the past year, information about previous suicide attempts and the treatment offered after suicide attempt was recorded (Platt et al., 1992; Schmidtke et al., 1993, Schmidtke et al. 2004).

After 15 years of use and the agreement of EC in funding the monitoring process in order to derive guidelines for political actions, an adaption of the monitoring form to current needs was conducted. For this purpose a meeting of a special group (leadership by Prof. Dr. Vaernik) was held in Berlin (2005). About 50% of the assessed items from the original version were kept (about 20 items) and about 20 new items were added. New questions focused on more detailed information on the method of the attempted suicide. In this context it is recorded whether the medication used for the suicide attempt was prescribed or not. In the MONSUE monitoring form the place of the suicide attempt is also recorded. In addition the reasons for the suicide attempt (interpersonal conflict, bereavement or severe illness of family



member/partner/friend, physical illness, mental health disturbance, financial difficulties, mistreatment and legal problems) are assessed. In the new MONSUE monitoring form up to three psychiatric diagnoses (ICD-10: F-Code) could be registered. Items concerning migration background were added to the sociodemographic variables, since migration was assumed to be a potential risk factor for suicidal behaviour. For this purpose the ethnical background of the families of suicide attempters was assessed. Another topic also concerns the family of origin with regard to being brought up in a traditional family, by a single parent, by other relatives, in adoption or care families or in institutions. Special interest is also paid to the work situation of suicide attempters and new variables were created with regard to occupation (according to the International Standard Classification of Occupation ISCO88) and level of economic position. To improve the specification of tertiary prevention strategies, the treatment after previous suicide attempts including health system and other services was assessed.

All the above mentioned items were included, in order to give a comprehensive overview about the suicide attempt, its previous and following conditions. The MONSUE monitoring form includes 45 items and is used by the centres since 2008. Since there are more than 50 percent of overlap between the previous and the new MONSUE monitoring form, various data from all time periods can be compared among each other.

As for the original WHO monitoring form, also for the MONSUE monitoring form a manual was designed, which includes all relevant coding rules. The manual was designed by the coordination centre and sent to the main beneficiaries of the project.

First step for the participating centres in this context was to translate the English version into the particular national language. Up to now the MONSUE monitoring form is available in 9 languages: Danish, English, Estonian, German, Hungarian, Italian, Slovenian, Spanish and Swedish (table 19).



**Table 19:** Available languages of the MONSUE monitoring form to assess suicide attempts

Language	Used by centre
Danish	Odense (Denmark)
English	Brussels (Belgium)
Estonian	Tallinn (Estonia)
German	Leipzig (Germany), Wuerzburg (Germany)
Hungarian	Pecs (Hungary)
Italian	Campobasso (Italy)
Slovenian	Maribor (Slovenia)
Spanish	Oviedo (Spain)
Swedish	Stockholm (Sweden)

All available monitoring forms are attached to this report (Appendix A).

### 3.3 Definition of the MONSUE catchment areas

Simultaneously to the translation of the monitoring form, all participating MONSUE centres had to define the spatial area in which data collection should take place. In the MONSUE study, this area is called the “catchment area”. All catchment areas had to fulfil certain criteria which are described below.

In the MONSUE study, a catchment area was defined as the main city of the recording centre and the administrative district. Between 250.000 and 500.000 inhabitants should be calculated for each centre, except for Brussels as the largest catchment area.

To be able to calculate suicide attempt rates for a specific catchment area, some conditions must be fulfilled:



A catchment area must be clearly defined, e.g. by city or district and in addition the catchment area population figures must be obtainable, separated into groups by sex and five-year age groups. It must be possible to collect all data of suicide attempters, who had contact with health facilities in the catchment area after a suicide attempt.

Furthermore the catchment area should be described in detail regarding location, general background information (size, economic profile, cultural profile) and sociodemographic characteristics (marital status, employment and main economic activities, population distribution and housing, main ethnic and religious groups). Beside this, indicators of social instability and disorganisation like criminal activity and violence, alcoholism and drug abuse, population mobility, poverty and deprivation, divorce/marriage breakdown and overcrowding should be described. Other features of the catchment area like the health and welfare system should also be known.

In general the catchment area should be representative for the country as a whole to enable conclusions from the regional suicide attempt rates of the catchment area to the suicide attempt rates of the country.

The main characteristics of the selected catchment areas are listed in the table below (table 20).

**Table 20:** Description of the MONSUE catchment areas

	<b>Location and background information</b>
Brussels, Belgium	The Belgian centre assesses suicide attempt data in Brussels city. The city has 148 900 inhabitants. The demographic situation is very heterogeneous. Data are collected in the Psychiatric emergency ward of the University Hospital Brugmann.
Odense, Denmark	The district of Funen consists of Assens, faaborg-Midtfyn, Kerteminde, Langeland, Middelfart, Nordfyns, Nyborg, Odense, Svendborg, Aeroe. On July 1, 2008 there are 483 123 inhabitants, of which approximately 390 000 are 15 years and older. About one third of the population is living in Odense which is the main city of this district. Studies on sociodemographic and socio-economic variables have shown that the inhabitants of the Funen County constitute a representative sample of the Danish population.
Tallinn, Estonia	The catchment area of the Estonian centre comprises Tallinn, the largest and capital city of Estonia. It is located in Northern Estonia – Harju County, at the Baltic Sea and presents well-developed urban district. Area of Tallinn is 158.27 km <sup>2</sup> (Estonia 43 432.3 km <sup>2</sup> ) with 2 518.4 of inhabitants per square meter (2009).Tallinn has the highest number of population in Estonia, 30% of the population of Estonia lives in Tallinn. In 2009 the city of Tallinn had 398 594 residents, of whom 45.2% are males and 54.8% are females, 3 189 divorces and 5 362 marriages were registered in Estonia, 1 433 divorces and 2 443 marriages of them in Tallinn.
Leipzig, Germany	The catchment area Leipzig was defined as the area of the district free city of Leipzig. The city of Leipzig is located in the Western part of the federal state of Saxony, Germany, Capital: Dresden, The federal state of Saxony (4 192 801 inhabitants) is divided in ten rural districts and three district free cities. Leipzig itself consists of nine urban districts and is located in the Western part of the federal state of Saxony, in the former German Democratic Republic (GDR). The catchment area has an area of 297.36 km <sup>2</sup> . Leipzig has 518 862 inhabitants, 251 748 males (48.5%) and 267 114 females (51.5%). There are high rates of emigration (particularly in 1989 and 1990) followed the reunification of Germany until 1998. 1999 was the first year after reunification of Germany when more persons moved to Leipzig. Since 1999 the population of Leipzig has increased, most of the population are protestants, the divorce rate per 10 000 marriages is 94.





<p>Wuerzburg, Germany</p>	<p>Wuerzburg is a city in the region of Franconia which lies in the northern tip of Bavaria, Germany. Located at the Main River, it is the capital of the Regierungsbezirk Lower Franconia. The city of Wuerzburg is not included in the district of Wuerzburg, but is its administrative seat (Landkreis). Wuerzburg is divided into 13 municipals which are additionally structured 25 boroughs. In the following overview, the boroughs and their numbers are allocated to the 13 municipals. The area of Wuerzburg is 87.63 km<sup>2</sup>. Its population (city and county) is 293 774. The population consisted of 141 401 males (48%) and 152 373 females (52%). 133 501 persons lived in the city and 160 273 persons in the county of Wuerzburg. The mean age of the population is 42.3 years (Males 41 years, females 43.5 years; Germans 42.6 years, foreigners 39.5 years), The population is mainly catholic (73%) and protestant (21%), 0.21% of the population are divorced, 16% live in households with children, 23% married couples, 16% single households.</p>
<p>Campobasso, Italy</p>	<p>The region Molise is located in central Italy and is the newest and second smallest of the Italian regions. The region was established in 1963 and covers 4 438km<sup>2</sup> Molise has 320 838 inhabitants; 156 183 (48.7%) males and 164 655 (51.3%) females.</p>
<p>Maribor, Slovenia</p>	<p>The Podravska region which was chosen for data collection after the death of the former centre leader is one of the 12 statistical regions of Slovenia and covers 2 170 km<sup>2</sup>. Podravska has 319.144 inhabitants. Maribor as the main city of this region, together with its more narrow environment has approx. 200 000 inhabitants, 49% males and 51% females, with an average age of 38.3 years. The age structure of the population is very close to the national average, the only exception being the percentage of people under the age of 25 which is slightly below the national average.</p>
<p>Oviedo, Spain</p>	<p>Oviedo is the capital city of the Principality of Asturias in northern Spain, and is the administrative and commercial centre of the region. Oviedo is the capital city of the Principality of Asturias in northern Spain, and is the administrative and commercial centre of the region. It has population of population of 226 398, 46.75% males and 53.25% women. The density of population is about 1 200 hab/km<sup>2</sup>.</p>
<p>Stockholm, Sweden</p>	<p>The land area of the two municipalities is about 325 km<sup>2</sup> and the numbers of inhabitants per km<sup>2</sup> were 417 for Botkyrka and 729 for Huddinge in 2009. The mobility is rather high, and the net effect is a growing population. The number of inhabitants in the catchment area is around 300 000 people, males 49.4%, females 59.6%, married 31.9%, divorced 10.3%, mean age 38.9 years, mean number of children aged 0-21 was less than two per family. About half (39-51%) were living in own houses, 30-40% in rental and 20% in owned apartments.</p>
<p>Berne, Switzerland</p>	<p>The Swiss area under study comprises the region of Berne. Berne and its agglomeration have a total population of 324 000 inhabitants. The catchment area differs little in the demographic and socioeconomic characteristics from the rest of the country. The greater part of the inhabitants in the catchment area lives in the urban area.</p>



Beside the information about the location of the catchment area and its population, the economic profile (table 21) as well as the percentage of foreigners (table 22) was surveyed.

**Table 21:** Education and employment status of the MONSUE catchment areas

	Education	Employment
Tallinn, Estonia	It is characteristic of Tallinn that the level of education of the population is higher than the average in Estonia. Considering share of the educational level of labour force the highest percentage was for upper secondary education, post-secondary, non-tertiary education (49.0%), 43.6% of labour force had tertiary education (professional secondary education based on secondary education or higher education or Master's and Doctor's degree). Below upper secondary education was 7.5% of labour force (2009).	The employment rate for the population group aged 16 until pension age was 70.3% and unemployment rate was 14.3% (2009). Share of pensioners in total population in 2009 was 25.9%.
Leipzig, Germany	In general Leipzig has a high educational level. The percentage without school leaving certificate is 10-12%, with migration background higher (19%).	In Leipzig 205 709 persons are employed (40%). The unemployment rate is 14.1% (males 15.2%, females 12.9%).
Wuerzburg, Germany	The percentage of persons not yet in school is 7%, of students 17% and of persons with finished school 76%.	In December 2009 6 277 were unemployed; the unemployment rate in the city was 5.3% and in the county 3.1%; in Bavaria as a whole 4.2% and in Germany in total 7.5%.
Campobasso, Italy		Unemployment rate in Campobasso is 7.5% for males and 8.8% for females.
Maribor, Slovenia	In Maribor the average years of education are 10.60 years with 43 856 pupils in primary, lower and upper secondary schools. 13 432 of them attended primary school, 14 056 lower secondary schools and 16 368 upper secondary schools, Maribor has 15 985 (5%) college/university students.	Of the total population 70.9% are of working age, the employment rate is 42.3% and is higher for men (49.3%) than for women (35.8%). The rates of registered unemployment amount for 10.4%. 118 164 persons are employed and 19 949 persons are registered as unemployed.



Stockholm, Sweden	The number of individuals 20-25 years of age who did not work and who were not studying was 20-23% and the corresponding figures for individuals 20-64 years were 18-24%. The number of gainfully employed individuals was 71-77%, and 6-7 % had been registered as unemployed.
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**Table 22:** Percentage of foreigners in the MONSUE catchment areas

	Percentage of foreigners*
Tallinn, Estonia	Tallinn population is multinational. In 2009, 55.2% of residents in Tallinn were Estonians, 36.4% Russians, 3.5% Ukrainians, and in smaller percentages other ethnicities (Byelorussians, Finns, Tatars, Latvians, Poles, Jews, Lithuanians, Germans and others).
Leipzig, Germany	Leipzig has 486 564 German inhabitants (93.7%) and 32 298 foreigners (6.3%) from 160 countries. 47 982 persons with a background of migration lived in Leipzig. Most foreigners came from Russian Federation (2 332), Ukraine (2 379) and Vietnam (2 197).
Wuerzburg, Germany	The region of Wuerzburg consists of 270 289 Germans (92%) and 23 485 foreigners (8%), the largest foreign group is Turkish (0.7%), followed by Yugoslavian (0.4%).
Campobasso, Italy	The immigration rate in Campobasso is 4.6%. Most immigrants come from Romania, Marocco, Albania and Poland.
Maribor, Slovenia	The percentage of people of foreign nationality in the population of Maribor is 3.4%, mostly immigrants from other parts of former Yugoslavia, Croats and Serbs and their descendants, who live almost exclusively in the larger towns.
Oviedo, Spain	In Oviedo are counted a total of 16 702 people with foreign nationality. Of these, 49.02% are male. The most important source countries are: Romania (13.4%), Ecuador (12.4%), Colombia (8.44%), Paraguay (6.97%), Brazil (6.87%), Senegal (5.50%), and Portugal (4.23%).
Stockholm, Sweden	In Stockholm, 27.6% have a foreign background; the immigrant percentage is 9.3%. The catchment area is characterized by a larger number of individuals with a non-Swedish background. People who were not born in Sweden were most frequently born in countries outside of the other Nordic countries and the EU/EFTA region, 26% and 17% for Botkyrka and Huddinge, respectively.



### 3.4 Calculation of the estimation factor

In the case of suicides, an estimation factor is not needed, since all causes of death in a region or country are legally required to be registered. The computation of an estimation factor, however, is necessary for calculating suicide attempt rates, as not all suicide attempts in a given catchment area are necessarily monitored.

For the calculation of the estimation factor, the treatment of suicide attempters in the catchment area has to be assessed. Health facilities, social psychiatric services in which suicide attempts are treated, typical routes of treatment and the incidence of suicide attempts which do not receive treatment has to be known. Each centre had to analyse problems in covering all health facilities in the particular catchment area and their possible influences on the project

After ascertaining typical routes of treatment of suicide attempters each centre had to decide, whether data should be collected on a sampling basis or if the centre is able to assess the “real” number of suicide attempts (total basis) in the catchment area. If the sampling basis is chosen, the centre must be able to provide a so-called “estimation factor” that enables to calculate the representativeness of the sample. “Sampling procedure” means, that only a sample of the health care institutions to which suicide attempters turn to, is selected for assessment. Afterwards the real number of suicide attempts has to be estimated by multiplying the number by the estimation factor. If, for example, only  $\frac{1}{3}$  (33.3%) of the health facilities in the catchment area is covered, the factor is 3 (100% / 33.3%). If,  $\frac{3}{4}$  (75%) of the health facilities are covered the factor must be 1.33 (100% / 75%).

Most of the centres assessed suicide attempts in the largest psychiatric hospital of their catchment area. Some centres were able to include most of their psychiatric and somatic clinics. The more institutions are included, the more precise the estimation of the suicide attempt rates will be. Table 23 shows an overview about the estimation factors in the different catchment areas, which were used for estimating the “real” suicide attempt rates and which were calculated by the respective centres.

**Table 23:** Estimation factors of the catchment areas

	<b>Estimation factor</b>
Odense, Denmark	Three institutions are involved in the monitoring process: Odense University Hospital, Svendborg Hospital and Middelfart Hospital. The calculation factor is estimated at 1.
Tallinn, Estonia	Altogether after negotiating with heads of appropriate institutions, not more than maximum 20% of suicide attempters in Tallinn could be treated out of Regional Hospital, ie at least 80% we met in Regional Hospital. The estimation factor is 1.25
Leipzig, Germany	Since 50% of the institutions which suicide attempters address to are covered, the estimation factor is 2.0
Wuerzburg, Germany	During the years 1989 until 1993 nearly all hospitals, health agencies and all relevant practitioners were included in the assessment of suicide attempts. In total 5 clinics in Wuerzburg area (3 of them are Psychiatric clinics), 17 out of 192 GPs and 23 out of 60 Psychiatrists and Psychotherapists and all (10 of 10) help agencies helped to collect suicide attempt data in the beginning of the WHO data collection in 1989. On the basis of this highly representative number of suicide attempts, a formula for the calculation of the estimation factor was developed. Currently the University Psychiatric Hospital, two psychiatrists and two help agencies are participating in the data collection. Therefore the current estimation factor is 2.8.
Pecs, Hungary	Data assessment controlled by emergency services, recalculated estimation factor 1.05.
Campobasso, Italy	The following is the population (last available data: 2001) served by each of the districts (3 out of 4 have been monitored): District I: 14.284 inhabitants (not monitored) District II: 77.066 inhabitants (monitored) District III: 131.231 inhabitants (monitored) District IV: 104.596 inhabitants (monitored) Total population: 327.537 Population not covered by monitoring activities: 14.284 (4,36%) Population covered by monitoring activities: 313.253 (95.64%) Calculated estimation factor: 1.05.
Maribor, Slovenia	In Podravska region, about 10% of suicide attempts in Slovenia get registered annually. University Clinical Centre Maribor typically covers approx. 64,3% of these cases (based on annual national and regional suicide attempt rates), the rest being covered mainly by the psychiatric hospital Ormoz. Calculated estimation factor: 1.55.



Oviedo, Spain	The research group does not use a sample. All the suicide attempts detected in the catchment area have been included in the data files. Therefore the estimation factor is 1.0.
Stockholm, Sweden	It is estimated that at least 90-95 percent of patients who seek medical care within the catchment area after an attempted suicide, seek care at the Huddinge University Hospital and very few go to district medical centres. The reliability and validity of this estimation has been tested on several occasions in the past. Consequently, a calculation factor of 1.0 was used for the three 12-month periods when estimating the rates of suicide attempts.

### 3.5 Process of data checking and data analysis procedure

A common SPSS data file of suicide attempts was generated including all variables assessed with the MONSUE monitoring form by the participating centres.

Systematic reviewing of the submitted data files by the coordination centre was conducted in order to standardise the obtained information and to optimise the validity of the data. In general great importance was attached to the checking of missing data and the screening for the use of the accurate coding for each of the variables. This is implemented by checking the frequency of all coding and testing for plausibility.

Furthermore, only persons with a suicide attempt which were residents of the catchment area and over 15 years of age were included.

As it is the case in other studies, regulations for data protection in the active centres had to be considered. Some centres were not allowed to send data on the birth date of included subjects. For these centres repeaters have to be identified by the centres themselves by either using the same identification number for persons with more than one suicide attempt or by coding specified repeater variables.

Table 24 shows an overview of the quality of data and the possibility of identifying repeaters.

**Table 24:** Missing data and possibility of identifying repeaters

	Missing Data	Possibility of identifying repeaters
Brussels, Belgium	many	n.t.d.
Tallinn, Estonia	few	Yes
Leipzig, Germany	few	Yes
Wuerzburg, Germany	few	Yes
Pecs, Hungary	few	Yes
Campobasso, Italy	few	Yes
Maribor, Slovenia	few	Yes
Oviedo, Spain	few	Yes
Stockholm, Sweden	few	Yes
Berne, Switzerland	23 Variables	Yes

For each variable assessed with the MONSUE monitoring form the coding for the purpose of statistical evaluation is mentioned (table 25). Due to reasons of practicability of the statistical evaluation this coding does not exactly correspond with the coding in the monitoring form in every variable. Variables, for which no coding is mentioned, are metric or full text variables.

**Table 25:** Description of variables of the MONSUE monitoring form

Variable	Description
AGE	Age distribution with 8 age groups (15-24 years, 25-34 years, 35-44 years, 45-54 years, 55-64 years, 65-74 years, 75-84 years, 85+ years) is expected to be converse to age distribution of suicide attempts. Highest rates are expected for persons in the younger age groups, especially for female adolescents and young female adults from 15 to 30 years (for example see Schmidtke et al., 2004).
METHOD(S) OF THE SUICIDE ATTEMPT	Up to four suicide methods per monitoring form can be coded. Our clinical experience shows, that many suicide attempters use two methods at the same time (e.g. drugs and cutting). In the SPSS Syntax these methods are coded as follows: Method Suicide Attempt_1; Method Suicide Attempt_2; Method Suicide Attempt_3; Method Suicide Attempt_4. Suicide attempt methods can be classified as follows: soft poisoning (X60-X65),



	hard poisoning (X66-X69), hard methods (X70-X84). Among suicide attempt methods “soft methods” are predicted to be the most frequent methods.
MEDICATION PRESCRIBED	Coding: no; yes, for me; yes, for somebody else). It is predicted, that medication used for intoxication is usually prescribed for somebody else rather than for the person using it for suicide attempt.
PLACE OF SUICIDE ATTEMPT	Coding: home, medical institution, other public place). By this variable we are looking for hot spots: are there specific public places that are used frequently for attempting suicide
CURRENT CIVIL STATE	Coding: single, married, divorced/separated. Social instability is supposed to be a predictor of an increased risk for suicidal behaviour (e.g. Kerkhof, Schmidtke, Bille-Brahe, De Leo & Lönnqvist, 1994) For example there is a higher risk for persons who are divorced or living alone (Diekstra, 1989). Results of the WHO-study showed that 51% of the male 47% of the female suicide attempters never have been married. Divorced and separated persons taken together were counting for 14% of the male and 17% of the female suicide attempters. 29% each of male and female suicide attempters were married.
BROUGHT UP	Coding: in traditional family, by single parent, by other relatives, in adoption or care family, in institution. Broken home (=brought up by single parent, other relatives, adoption or care families, in institutions) is hypothesised to be a risk factor for suicidal behaviour.
USUAL HOUSEHOLD COMPOSITION DURING THE LAST YEAR/ USUAL HOUSHOLD COMPOSITION AT THE TIME OF THE SUICIDE ATTEMPT	Coding: living alone, living without partner with children, living with others, living in an institution. A higher risk for attempting suicide is predicted for persons badly integrated into society (about one fourth of the suicide attempters living alone, 5% are living in an institution). Furthermore it is assumed, that there is a higher percentage of persons switching their household composition during the last year before the suicide attempt (household while suicide attempt), mainly from a more integrated form of living to a less integrated form (14% of the males and 9% of the females).
LEVEL OF EDUCATION	Coding: low, middle, high. Suicide attempts are predicted to be more frequent in lower social classes (Arensman, Kerkhof, Hengeveld, & Mulder, 1995; Hawton, Fagg, Simkin & Mills, 1994). Persons with a lower level of education are overrepresented among suicide attempters.
LEVEL OF ECONOMIC POSITION, EMPLOYMENT STATUS	Coding: economically active employed, economically active unemployed, economically inactive. It is assumed





	that individuals with a lower economic status undergo a higher risk for suicidal behaviour.
DURATION OF UNEMPLOYMENT	Coding in weeks. Unemployment, especially the duration of unemployment, has shown to be a risk factor for suicidal behaviour (Kerkhof, et. Al., 1994; 18% of the males und 9% of the females were unemployed, also see revised Second Interim Report: 6.2.2 Secondary and tertiary prevention).
OCCUPATION	Coding: legislators, senior officials and managers; professionals; technicians and associate professionals; clerks; service workers and shop and market sales workers, skilled agricultural and fishery workers; craft and related trade workers; plant and machine operators; elementary occupations
CURRENT OR LAST OCCUPATION	This variable tries to identify special risk groups by occupational categories and specific occupations (e.g. lawyers, medical doctors, teachers).
PSYCHIATRIC DIAGNOSIS	The risk to attempt suicide is supposed to be much higher for persons suffering from psychiatric disorders (Clark & Fawcett, 1992): especially adjustment disorders, affective disorders, schizophrenia, addiction and personality disorders. Moreover persons suffering from psychiatric disorders are especially at risk to attempt suicide more than once. (Asnis et al., 1993; Petronis, Samuels, Moscicki & Anthony, 1990). The highest percentage of repeaters is expected to be found within the group of schizophrenic patients (WHO-study). But also patients with affective disorders, addiction disorders and personality disorders have been shown to have an increased risk of repetition. In contrast patients suffering from acute stress disorder and adjustment disorders more often seem to attempt suicide only once (usually this attempt is the reason for diagnosis).
CLASSIFICATION OF SUICIDE ATTEMPT	According to Feuerlein (1971): the intention of the suicide attempt – coded by the person in charge of the patient’s treatment – is assumed to covary with age. The older the person the more serious the suicide attempt (Schmidtke, Fricke & Weinacker, 1994). Furthermore there was shown a covariation with gender: males doing more serious suicide attempts than females.
CONTACT WITH HEALTH SYSTEM AFTER PREVIOUS SUICIDE ATTEMPT (number); CONTACT WITH OTHER SERVICES AFTER PREVIOUS SUICIDE ATTEMPT (number); PREVIOUS ATTEMPTS WITHIN ONE	Coding: no, yes (specified). These variables assess, if the person ever did a suicide attempt and had contact to the health system afterward in general and during the last year. It is assumed that contact to a help system lowers the probability of a repetition of suicide attempts. Furthermore quick access to treatment and a sufficient continuity of treatment are supposed to have an



YEAR (number); CONTACT WITH HEALTH SYSTEM AFTER PREVIOUS SUICIDE ATTEMPTS WITHIN ONE YEAR (number); CONTACT WITH OTHER SERVICES AFTER PREVIOUS SUICIDE ATTEMPT WITHIN ONE YEAR (number); CONTACT HEALTH SYSTEM AFTER THE MOST RECENT SUICIDE ATTEMPT; RECOMMENDED NEXT CARE	important influence on reducing suicide attempts and their repetition (e.g. see Fekete, Osváth & Michel, 2004; Revised Second Interim Report 6.2.2 Secondary and tertiary prevention). Revised Second Interim Report: 6.2.2 Secondary and tertiary prevention).
COUNTRY OF BIRTH; DURATION OF LIVING IN COUNTRY; COUNTRY OF DESTINATION; CITIZENSHIP; ETHNICITY; MOTHER'S COUNTRY OF BIRTH; FATHER'S COUNTRY OF BIRTH	Migration background is supposed to be a further risk factor (e.g. Löhr & Schmidtke, 2006).
MAIN REASON SUICIDE ATTEMPT; SECOND REASON SUICIDE ATTEMPT; THIRD REASON SUICIDE ATTEMPT	Coding: interpersonal conflicts with family member, partner & friend; bereavement or severe illness of family member, partner, friend; physical illness; mental health disturbance; financial difficulties; mistreatment; legal problems; other). Interpersonal conflicts are predicted to be the most frequent reason for attempting suicide (e.g. Löhr & Schmidtke, 2004).
NUMBER OF PREVIOUS ATTEMPTS	This variable of special interest in order to identify repeaters for further analysis.

Variables assessed with the MONSUE monitoring form were compared separately for males and females, as well as for different age groups, centres and time periods.

Data were analysed descriptively for frequencies and distribution of percentages. In a further step, exploratory analyses were performed in order to test for statistical significance ( $\chi^2$ -test, level of significance  $p=0.05$ ). In-depth analyses regarding specific questions, such as logistic regression analyses, will be conducted within the context of scientific publications by the project participants.



## 3.6 Suicide data

### 3.6.1 Description of the data collection process

Although suicide rates are available in databases in the Internet, the demanded age-distribution of 5-years age groups had to be obtained by the centres, since the WHO and EUROSTAT databases only provide larger age groups or rates in total. Furthermore, not only suicide rates for the country were needed for comparison, but also suicide rates from the different catchment areas. Each centre had to contact the responsible statistical office, to get the demanded data, i.e. number of suicides and number of population, broken down by sex and five-year age groups. The data were sent to the coordination centre and integrated into a general matrix, out of which the rates were computed.

In addition, since one deliverable of the MONSUE study is the analysis of suicide methods, all centres had to gather suicide methods on the basis of the ICD-classification (X60-X84), broken down by sex and five-year age groups. This information is not available in a transnational common database in the internet. Especially the suicide methods for the catchment areas had to be collected from regional offices (for example police, health agencies). As was the case in the data mentioned above, all centres sent the data on suicide methods to the coordination centre, where the analyses were done.

As already mentioned in the beginning of the report, the associated centre in Berne (Switzerland) was, due to no EC funding, not obliged to deliver data on suicide and suicide attempt rates, as well as suicide methods.



### 3.6.2 Description of databases for analyses

The following table gives an overview of the time period of evaluating suicide rates (table 26) and methods (table 27) for the countries and the catchment areas, within the MONSUE project.

**Table 26:** Available time periods of assessment of suicide rates for the MONSUE study

	<b>Suicide rates Country</b>	<b>Suicide rates Catchment area</b>
Odense, Denmark	2006	2006
Tallinn, Estonia	2007	2004-2007
Leipzig, Germany	2004-2008	2004-2007
Wuerzburg, Germany	2004-2008	2004-2008
Pecs, Hungary	2007-2008	2007-2008
Campobasso, Italy	./.	2008
Maribor, Slovenia	2007-2008	2008
Oviedo, Spain	2007-2008	2007-2008
Stockholm, Sweden	2006-2008	2006-2008

**Table 27:** Available time periods of assessment of suicide methods for the MONSUE study

	<b>Suicide methods Country</b>	<b>Suicide methods Catchment area</b>
Odense, Denmark	2006	2006
Tallinn, Estonia	2004-2007	2004-2007
Leipzig, Germany	2005-2008	2004-2007
Wuerzburg, Germany	2005-2008	2009
Pecs, Hungary	2007-2008	2007-2008
Campobasso, Italy	./.	./.
Maribor, Slovenia	2008	2008
Oviedo, Spain	2007-2008	2008
Stockholm, Sweden	2006-2008	2006-2008

In order to calculate the percentage of suicides in relation to all causes of death, data from the WHO database (European Health for All Database: HFA-DB) were used. In addition, for relating suicide rates to social variables (migration, unemployment) data from the EUROSTAT database were used.



## 3.7 Suicide attempt data

### 3.7.1 Description of the data collection process

The WHO Network for the prevention of suicidal behaviour started data collection with the original monitoring form in 1989. Five out of the 10 active MONSUE centres not only are beneficiaries of the MONSUE study, but also are a member of the WHO-Network for suicide prevention. Since the project duration after amendment covered 3 years, first steps before data collection were the definition of the catchment area, the selection of institutions, in which the data should be assessed, the translation of the monitoring form in the national language and the training of personnel, how to fill out the monitoring form. Due to this reasons, some centres have a lower number of assessed months. The partially active centre in Denmark did not provide suicide attempt data assessed with the MONSUE monitoring form, but only rates. By contrast, the centre in Switzerland provided suicide attempt data assessed with the monitoring form, but no rates. Since it was the aim of the MONSUE study not only to describe and analyse characteristics of suicide attempters and the suicide attempt itself, but also to give an overview about epidemiological variables of suicidal behaviour, all centres had to count out the number of suicide attempts, broken down by sex and five-year age groups. Furthermore they had to send the number of inhabitants in each country and catchment area, again broken down by sex and five-year age groups, to the coordination centre. Based on these data, the coordination centre was able to compute suicide attempt rates.

### 3.7.2 Description of databases for analyses

#### 3.7.2.1 *Assessment periods*

The following table (table 28) shows the previous and current time periods of assessment of suicide attempts with the monitoring form, for the MONSUE study as well as for the WHO-network. Two centres, Brussels (Belgium) and Berne (Switzerland) collected data about suicide attempts with the previous WHO monitoring form during the MONSUE time period. Due to this, fewer variables were assessed and these centres could not be included in all analyses.

**Table 28:** Overview of time periods of assessment of suicide attempts with the monitoring form

	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	
Brussels, Belgium																							
Tallinn, Estonia													*	*	*	*	*	*	*				
Leipzig, Germany																							
Wuerzburg, Germany																							
Pecs, Hungary																							
Campobasso, Italy																							
Maribor, Slovenia																							
Oviedo, Spain																							
Stockholm, Sweden																							
Berne, Switzerland																							

\* Tallinn, Estonia: 2001 – 2008 regular hospital monitoring of suicide attempts without the official MONSUE monitoring form

Time periods of assessment with the WHO monitoring form

Time periods of assessment with the MONSUE monitoring form



The exact assessment period during which data were obtained within the MONSUE project, is listed below (table 29).

**Table 29:** Assessment periods of suicide attempt data in the active centres (and Berne)

	<b>Previous time periods within the WHO-network</b>	<b>Monitoring Files (SPSS)</b>	<b>Number of months within the MONSUE period</b>
Brussels, Belgium	./.	01.01.2008-01.06.2009	18
Tallinn, Estonia	1995-2000*	22.11.2008-20.04.2010	17
Leipzig, Germany	./.	01.10.2007-01.06.2010	32
Wuerzburg, Germany	1989-2006	01.07.2007-01.06.2010	35
Pecs, Hungary	1997-2001	01.07.2007-01.06.2010	35
Campobasso, Italy	./.	01.01.2008-01.06.2010	29
Maribor, Slovenia	./.	01.01.2008-01.06.2010	29
Oviedo, Spain	2003	01.04.2008-01.06.2010	26
Stockholm, Sweden	1989-2005	01.07.2007-30.03.2010	18**
<i>Berne, Switzerland</i>	<i>1989-1990; 1993-1998 2004-2007</i>	<i>01.07.2007-31.12.2009</i>	<i>30</i>

\* Tallinn, Estonia: 2001 – 2008 regular hospital monitoring of suicide attempts without the official monitoring form

\*\* Stockholm, Sweden: although the period covers 33 months, the centre had only 18 months of assessment (6 months/year).



### **3.7.2.2 Number of registered episodes of suicide attempts and individuals with a suicide attempt**

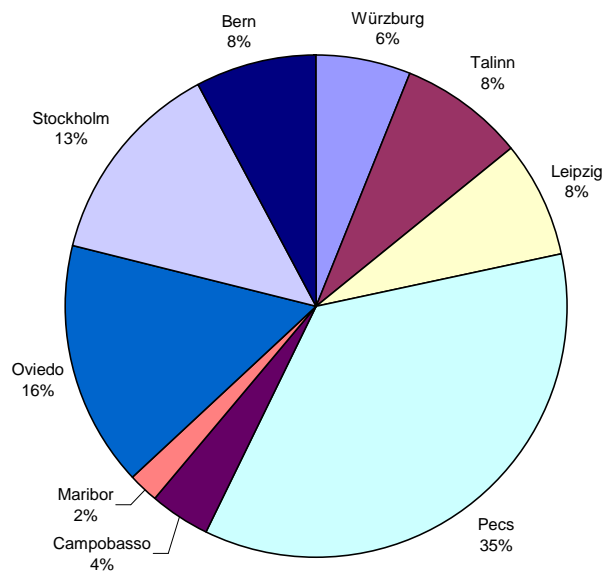
During the MONSUE project period a total of 4683 episodes of suicides attempts was registered in the active centres (table 30). Separate from the number of episodes the number of persons attempting suicide is listed. Due to this the identification of repeaters is possible. If, for example, one person attempts suicide three times, the number of persons is one and the number of episodes is three.

**Table 30:** Number of episodes and number of individuals with a suicide attempt collected within the 3-year period by the active MONSUE centres

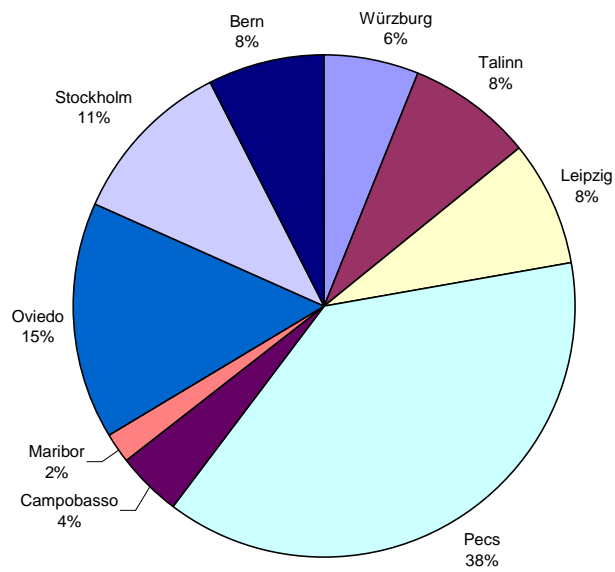
	<b>Episodes</b>	<b>Persons</b>
Brussels, Belgium	558	n.t.d.
Tallinn, Estonia	324	303
Leipzig, Germany	309	298
Wuerzburg, Germany	225	218
Pecs, Hungary	1397	1075
Campobasso, Italy	162	155
Maribor, Slovenia	82	81
Oviedo, Spain	663	579
Stockholm, Sweden	548	402
Berne, Switzerland	415	384
SUM	4683	

The proportion of episodes of suicide attempts and individuals with suicide attempt of each participating centre is shown in the following figures (cf. figure 2 for episodes, figure 3 for persons). The distribution has to be kept in mind when looking at “cross-national results”, that means results, which were deduced from the total sample.





**Figure 2:** Percentages of episodes registered in each centre



**Figure 3:** Percentages of persons registered in each centre



Suicide attempt rates are calculated on the basis of the information in the monitoring form regarding age and gender. Table 31 presents an overview of available suicide attempt rates computed within the MONSUE project. Suicide attempt rates were either stated for the last available year or an average for all available years of the suicide attempt rates for each centre was calculated, depending on the available data.

**Table 31:** Available suicide attempt rates in the catchment areas from the active centres computed within the MONSUE project

	<b>Suicide attempt rates*</b>
Odense, Denmark	2004+2007
Tallinn, Estonia	2004-2009
Leipzig, Germany	2007-2008
Wuerzburg, Germany	2004-2009
Pecs, Hungary	2007-2008
Campobasso, Italy	2008
Maribor, Slovenia	2008
Oviedo, Spain	2005+2008
Stockholm, Sweden	2007-2009

\* first listed year is 2004, since rates usually are available one year later and the MONSUE project started in 2005 before the amendment

Like it was the case for the correlation of suicide rates and social variables, also for the descriptive analyses of suicide attempt variables and social variables, data concerning migration and unemployment from the EUROSTAT database were used.



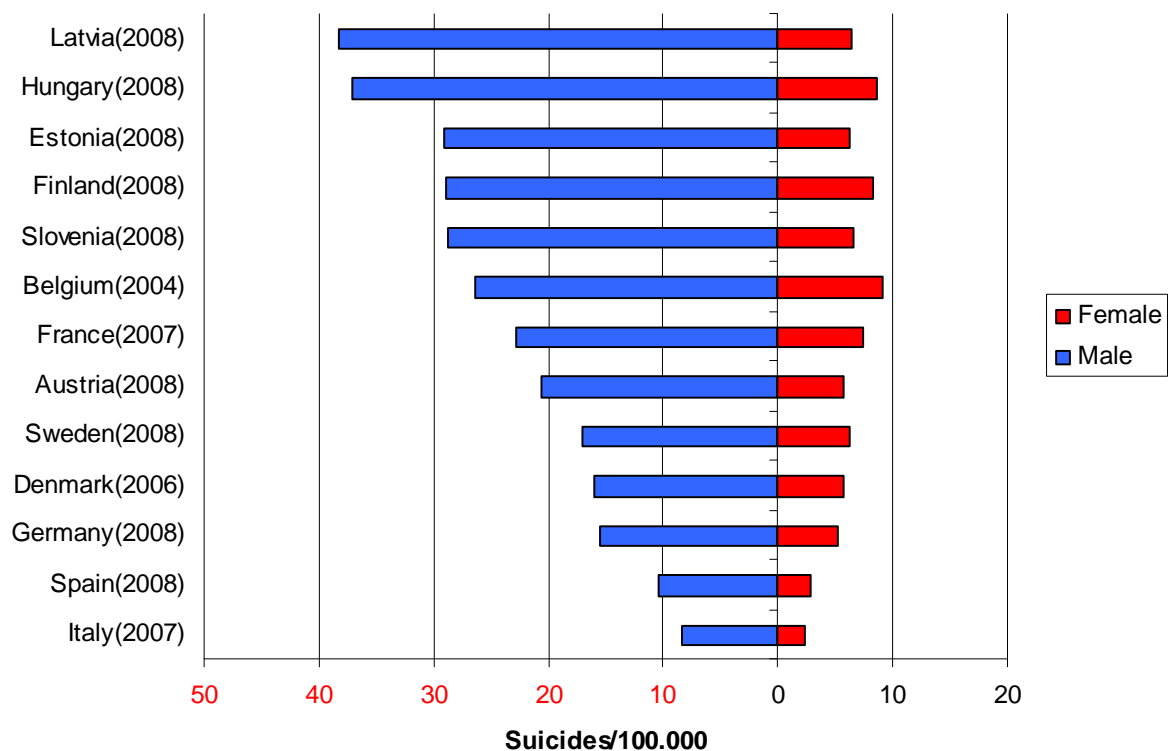
## 4. Results

### 4.1 Descriptive results regarding completed suicides

#### 4.1.1 Suicide rates

##### 4.1.1.1 Suicide rates in the countries

Total suicide rates for European countries have been collected from the EUROSTAT-database. All countries which participated in the study after the amendment (active and non-active centres) are included in figure 4. Eastern European countries (for example Hungary, Estonia) have the highest suicide rates. Suicide rates decline in the Central and Western European nations (for example Belgium, Germany) and reach the lowest level in the South (for example Spain, Italy). In general suicide rates in all countries are three times higher in men than in women.

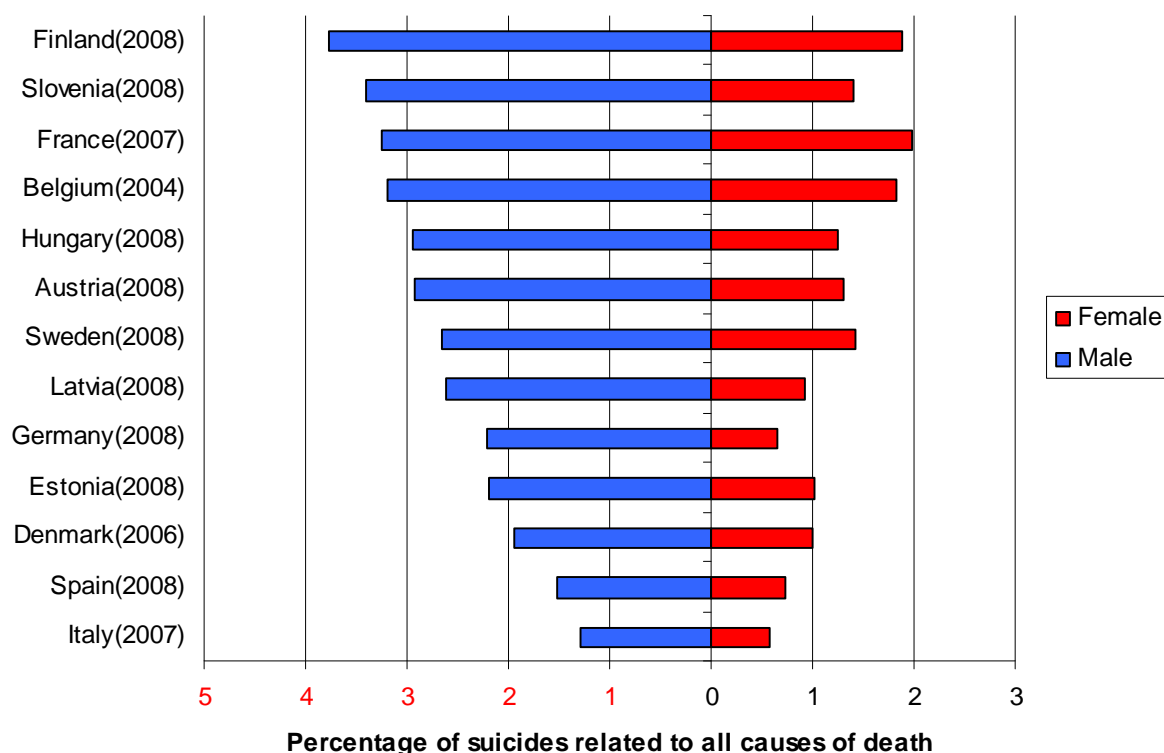


**Figure 4:** Suicide rates in Europe (EUROSTAT database, all age groups, last available year)

When calculating the percentage of suicides in relation to all causes of death, the importance of suicide prevention becomes clearly evident. In most European



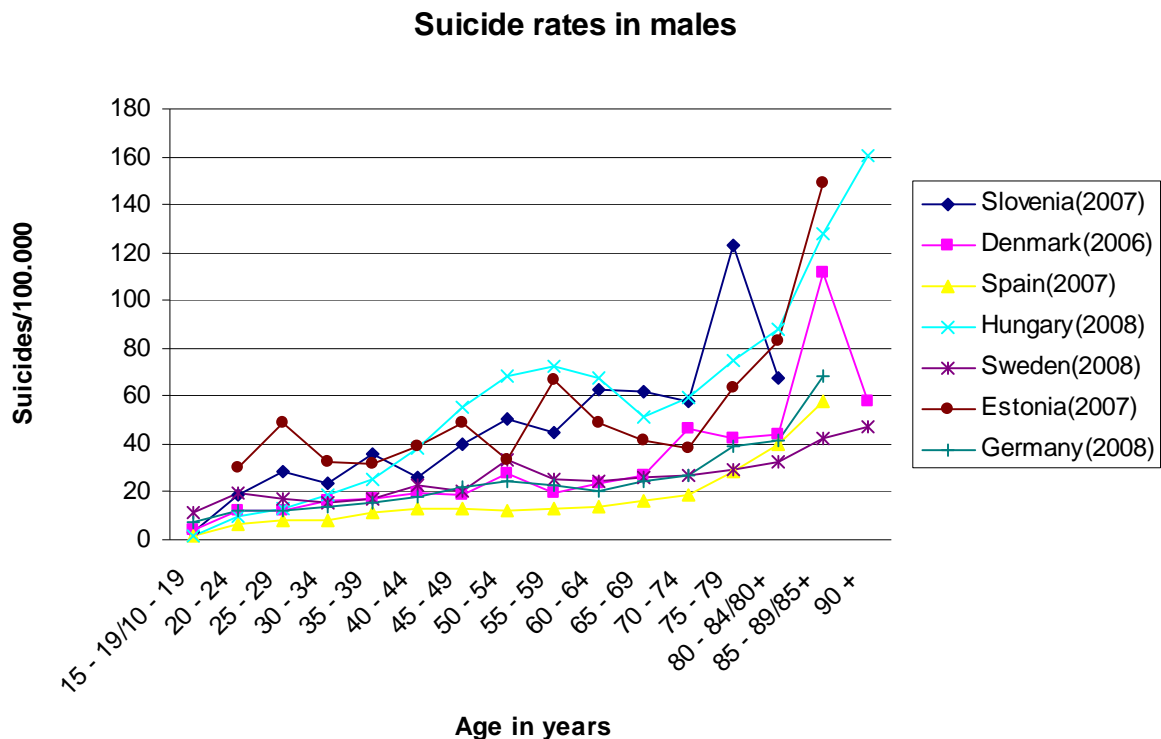
countries suicides constitute between 1 and 2% of all causes of death (figure 5). There are not only the Eastern European countries that show particularly high proportions, but also the Northern and Central European nations. As was the case for suicide rates, the Southern European countries also have the lowest proportions of suicide in relation to all causes of death.



**Figure 5:** Percentage of suicides in relation to all causes of death (EUROSTAT database, all age groups, last available year)

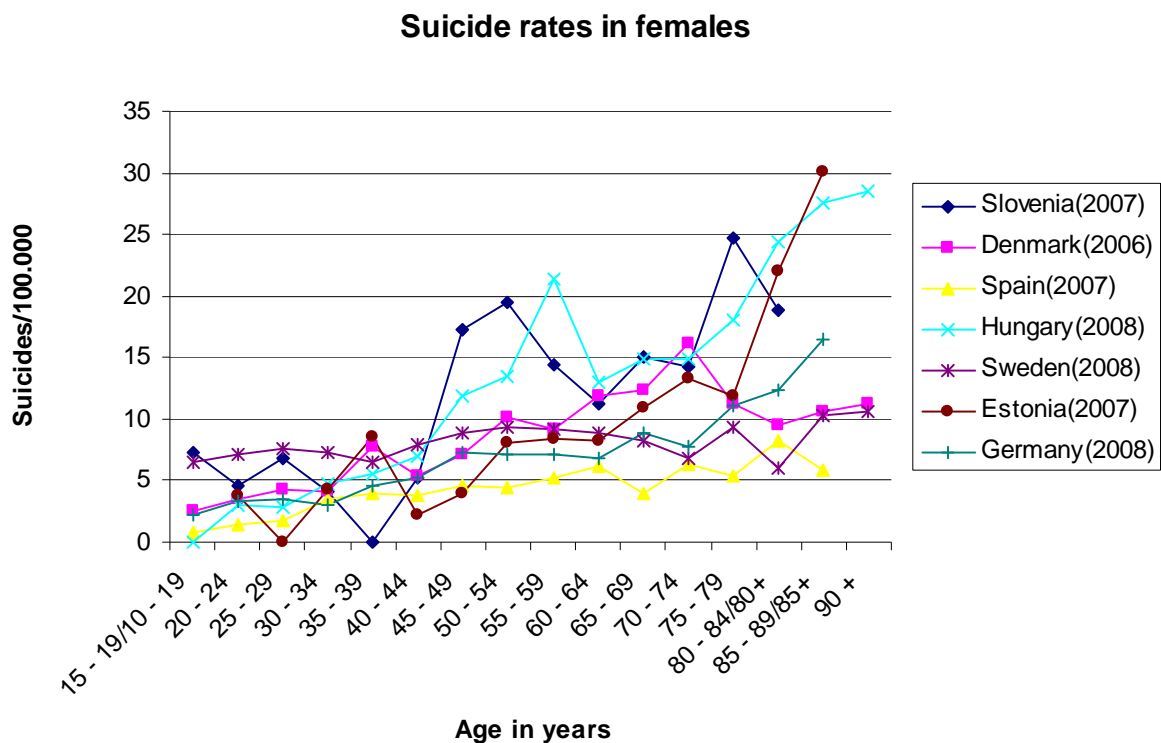
For further analyses and comparisons suicide rates in 5-year age groups were obtained and provided from national sources by the MONSUE centres.

Concerning suicide rates in males, there is an increase with age in all actively participating countries (figure 6). Whereas the rates of young people are close to each other, they vary quite a lot in the older age groups. The highest suicide rates in elder people can be found in the Eastern European countries. In all centres, the peak of suicide rates in men is in the older age groups of at least 75 years.



**Figure 6:** Suicide rates in males in the MONSUE centres broken down by age (15+ years, last available year)

In contrast to the distribution of suicide rates in males, that of females in the actively participating countries varies a lot more (figure 7). There is also a tendency for an increase with age, but there are also peaks in the age group of 50-65 years in Hungary and Slovenia as well as a peak in the middle-aged groups in Sweden.



**Figure 7:** Suicide rates in females in the MONSUE centres broken down by age (15+ years, last available year)

Suicide rates in most European countries, broken down by sex and age groups, follow the so-called Hungarian pattern: they increase with age. Since suicide rates in men are about threefold higher than those in females, the rise becomes the much explicit. The following figures show a detailed overview of the suicide rate patterns in the different countries. Four different distribution patterns can be observed.

The most typical distribution of suicide rates, the so-called Hungarian pattern, is most evident in Germany (figure 8) and Spain (figure 9). In these countries, rates increase steadily with age.

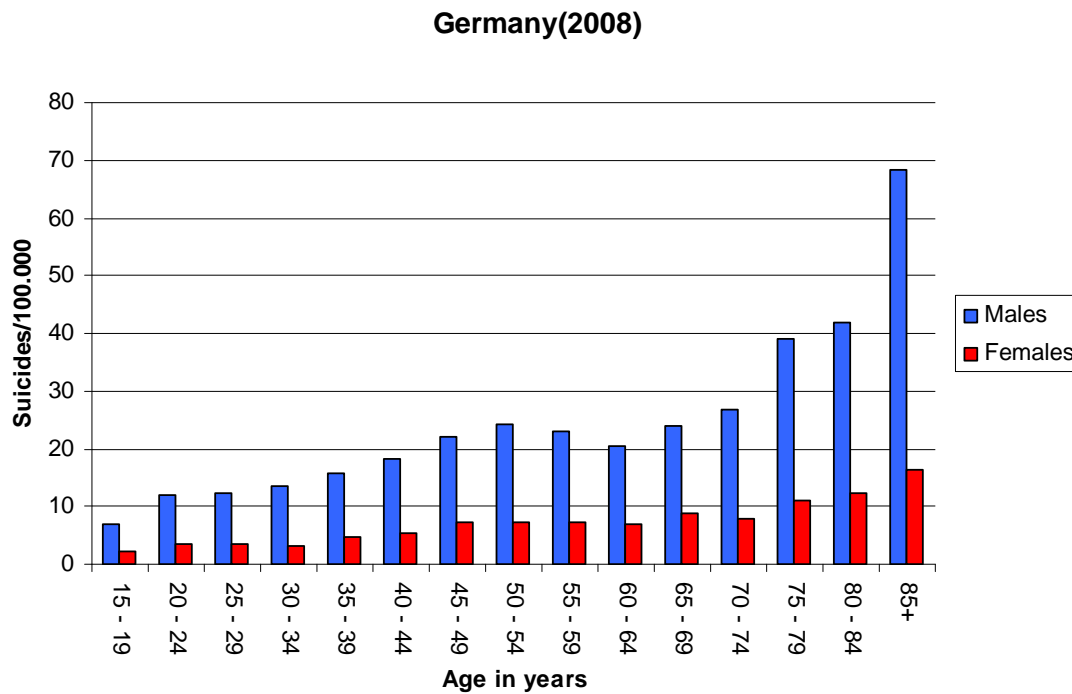


Figure 8: Suicide rates in Germany 2008, broken down by sex and age

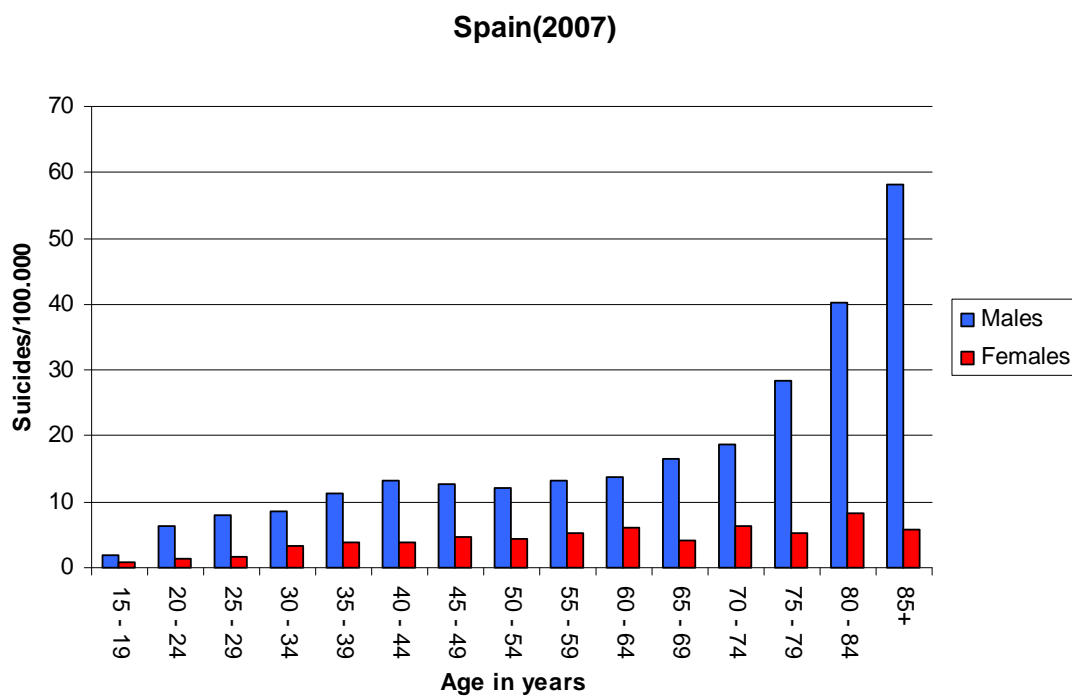


Figure 9: Suicide rates in Spain 2007, broken down by sex and age



Similarly obvious is the Hungarian pattern in Denmark (figure 10) and Slovenia (figure 11), but with the special exception that suicide rates decrease notably in the eldest age group, especially in males.

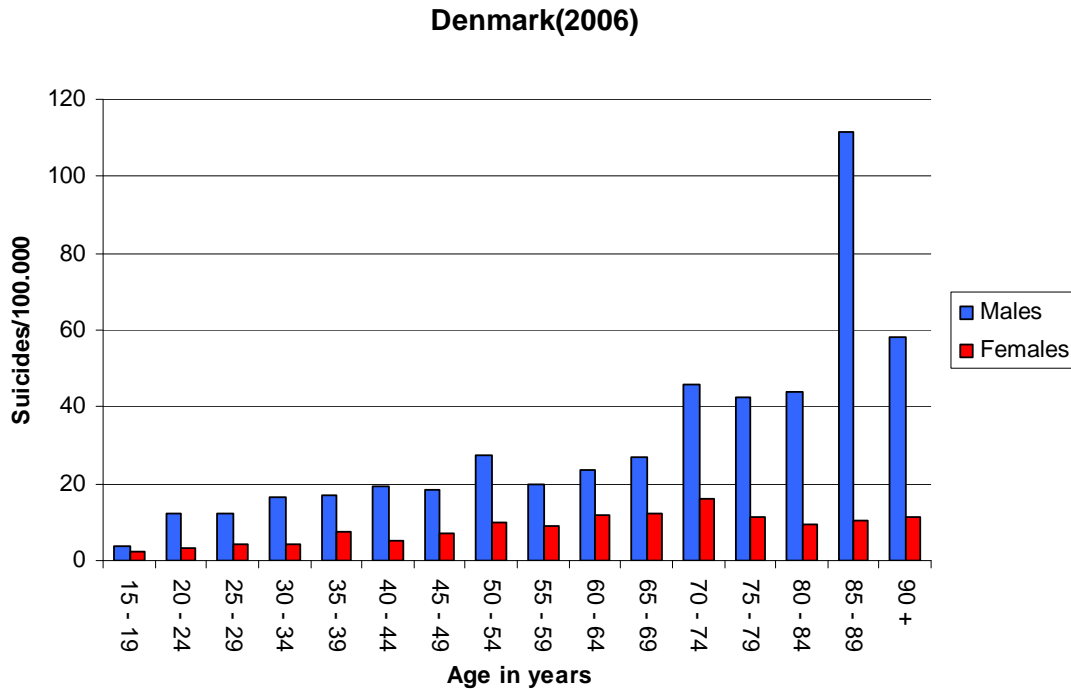


Figure 10: Suicide rates in Denmark 2006, broken down by sex and age

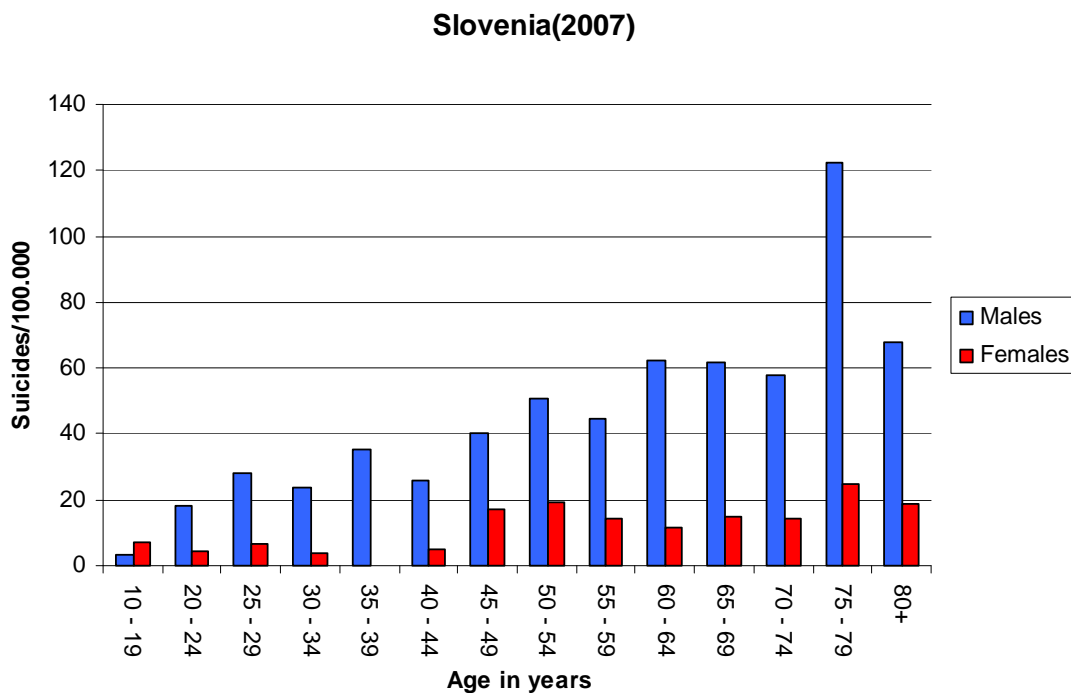
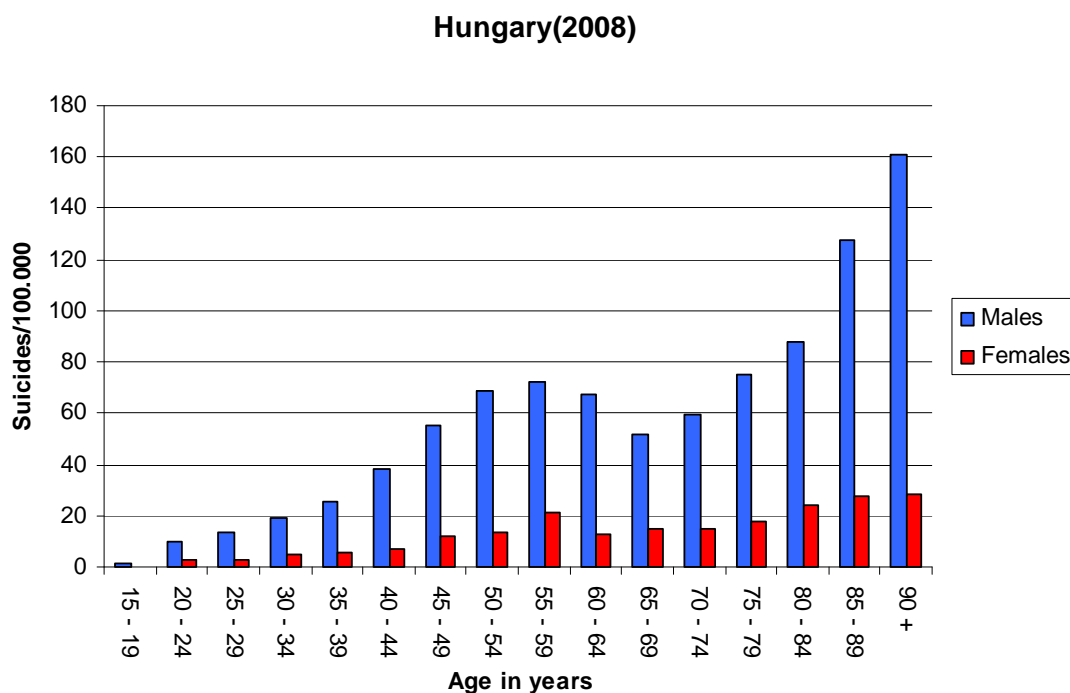


Figure 11: Suicide rates in Slovenia 2007, broken down by sex and age

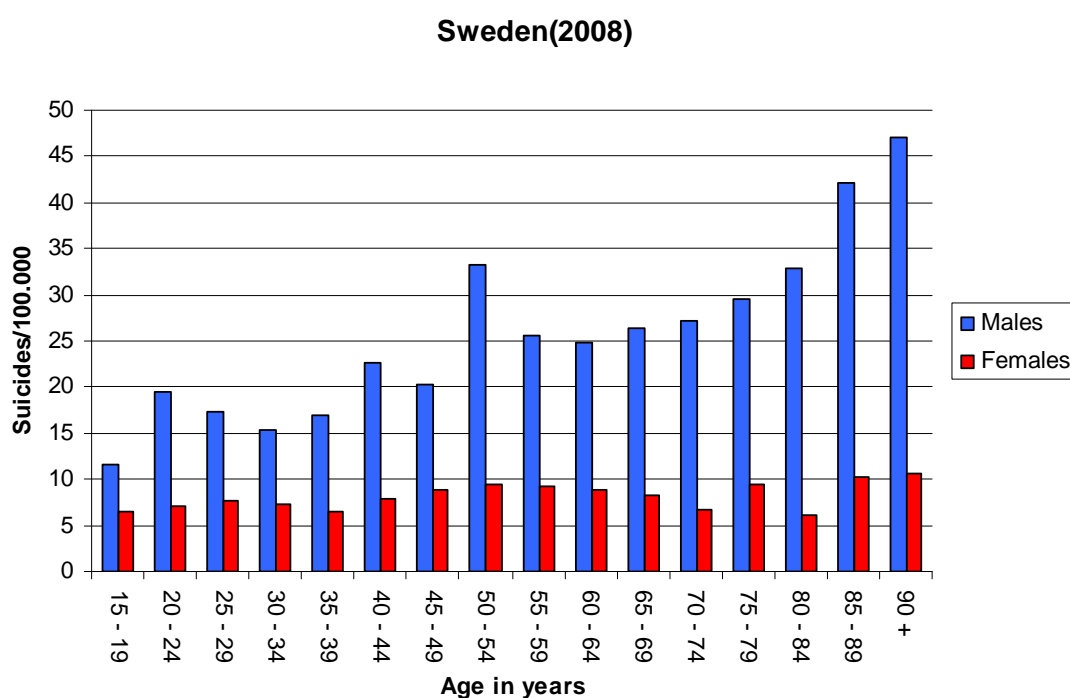




A third pattern can be observed for Hungary (figure 12) and Sweden (figure 13), with a first increase in the middle-age groups and a further increase within the elder age groups.



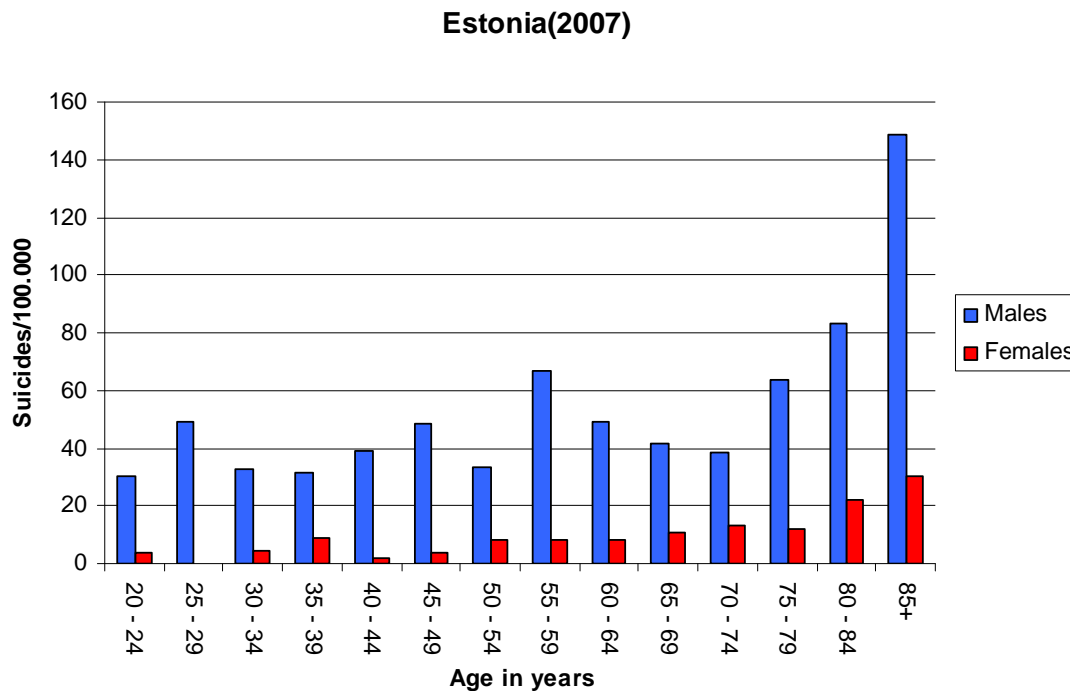
**Figure 12:** Suicide rates in Hungary 2008, broken down by sex and age



**Figure 13:** Suicide rates in Sweden 2008, broken down by sex and age



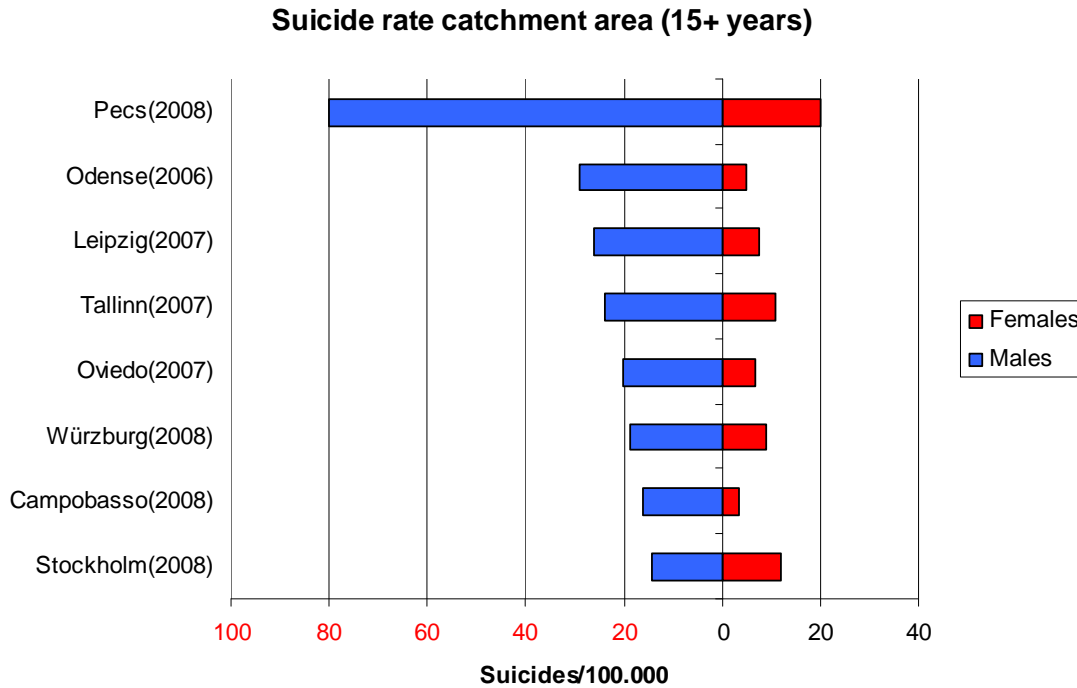
In Estonia (figure 14) suicide rates vary little until the age group of 75 years and show a high increase in the eldest age group.



**Figure 14:** Suicide rates in Estonia 2007, broken down by sex and age

#### **4.1.1.2 Suicide rates in the catchment areas**

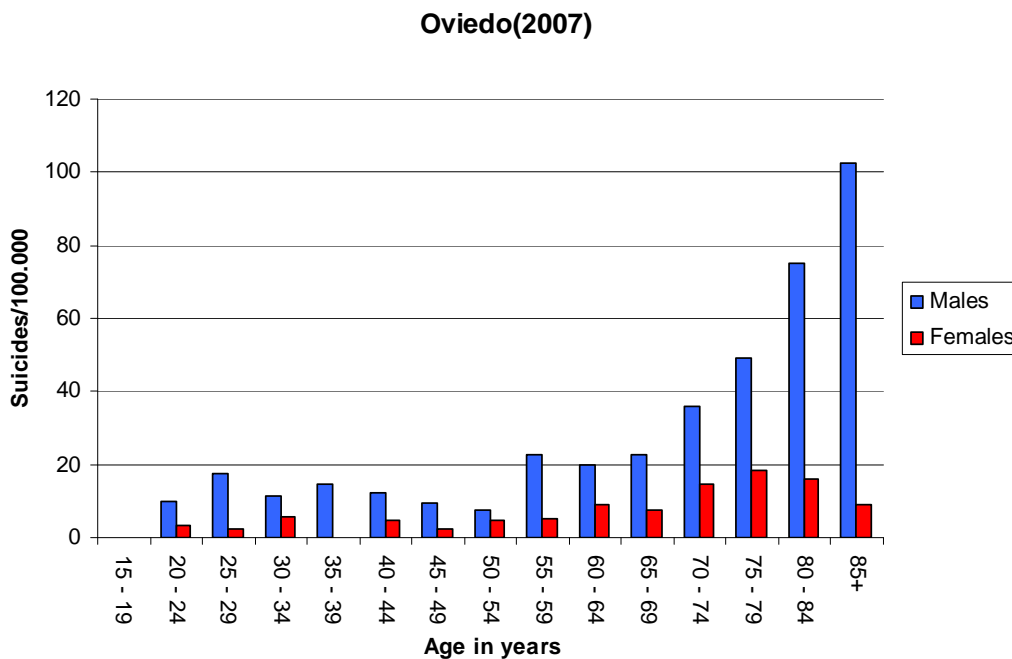
Comparing suicide rates in the respective catchment area as obtained and provided by the MONSUE centres with suicide rates in the country, a slightly other order can be found (figure 15). Whereas the suicide rate in Pecs (Hungary) still remains the highest one and the one in Campobasso (Italy) the second lowest, the middle positions have changed. Especially the difference between the two German centres (Wuerzburg and Leipzig) is considerable. However, the difference within Germany is well explainable, since historically Eastern German states (e.g. Leipzig in Saxony) have always had higher rates than Western German states (e.g. Wuerzburg in Bavaria). Such differences may also occur within different regions in other countries.



**Figure 15:** Suicide rates in the MONSUE catchment areas (15+ years, last available year)

Regarding the age specific suicide rates in the different catchment areas a more heterogeneous picture can be found, probably due to the smaller sample sizes.

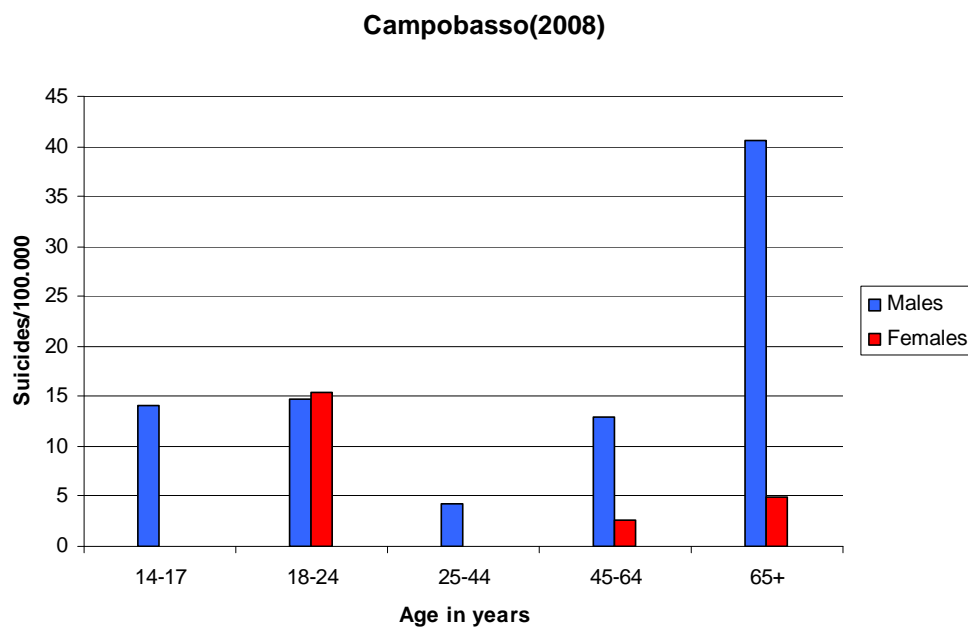
Oviedo (Spain) is the only centre, in which the typical Hungarian pattern becomes clearly apparent (figure 16).



**Figure 16:** Suicide rates in Oviedo (Spain) 2007, broken down by sex and age



In Campobasso (Italy), the assessed age groups have a larger range compared to the other centres, probably due to data collection characteristics. However, elder men constitute the group with the highest risk (figure 17).



**Figure 17:** Suicide rates in Campobasso (Italy) 2008, broken down by sex and age

In Odense (Denmark) particularly high suicide rates in elder men also become apparent (figure 18), whereas in Pecs (Hungary) middle-aged and old men have comparably high suicide rates (figure 19).



### Odense(2006)

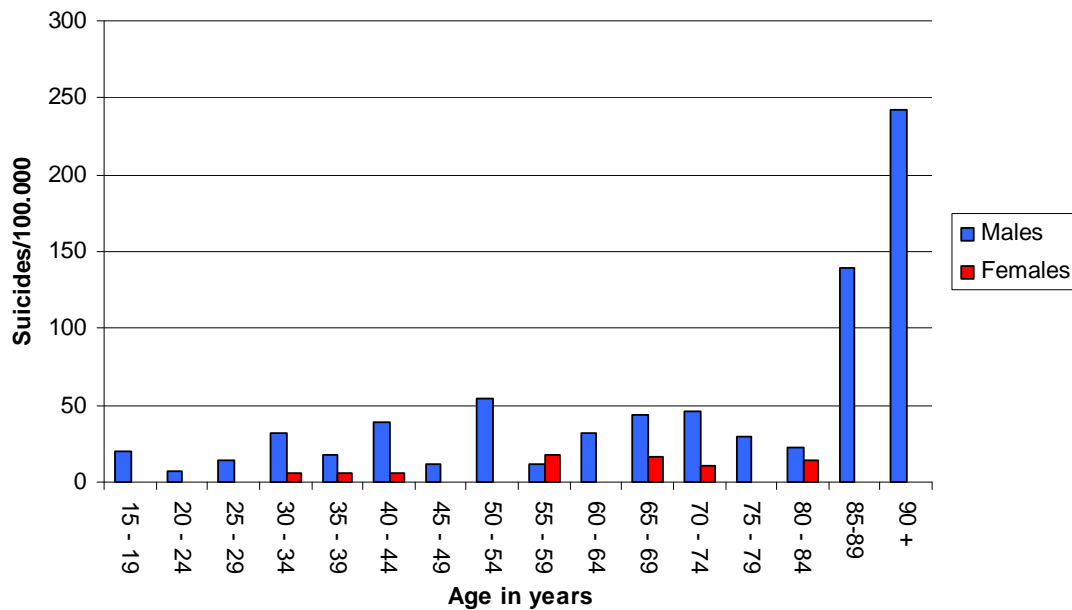


Figure 18: Suicide rates in Odense (Denmark) 2006, broken down by sex and age

### Pecs(2008)

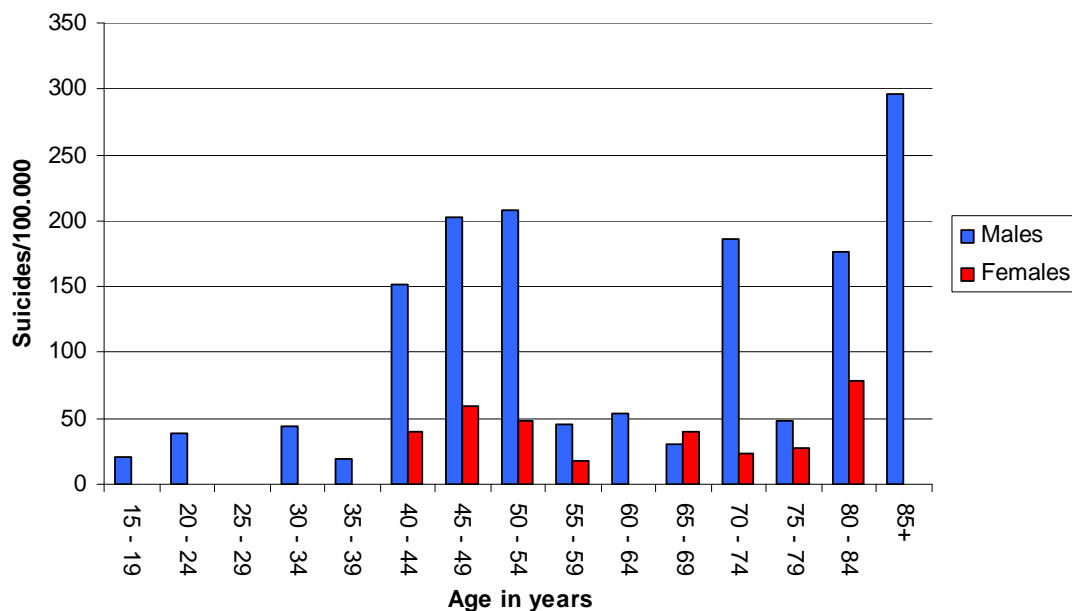
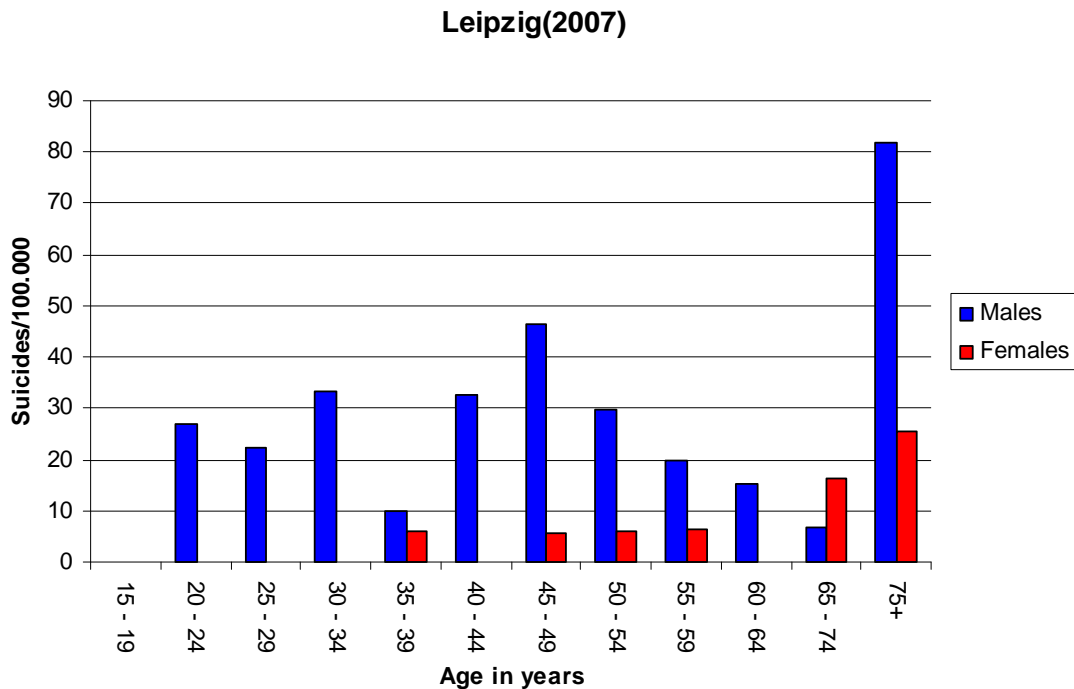


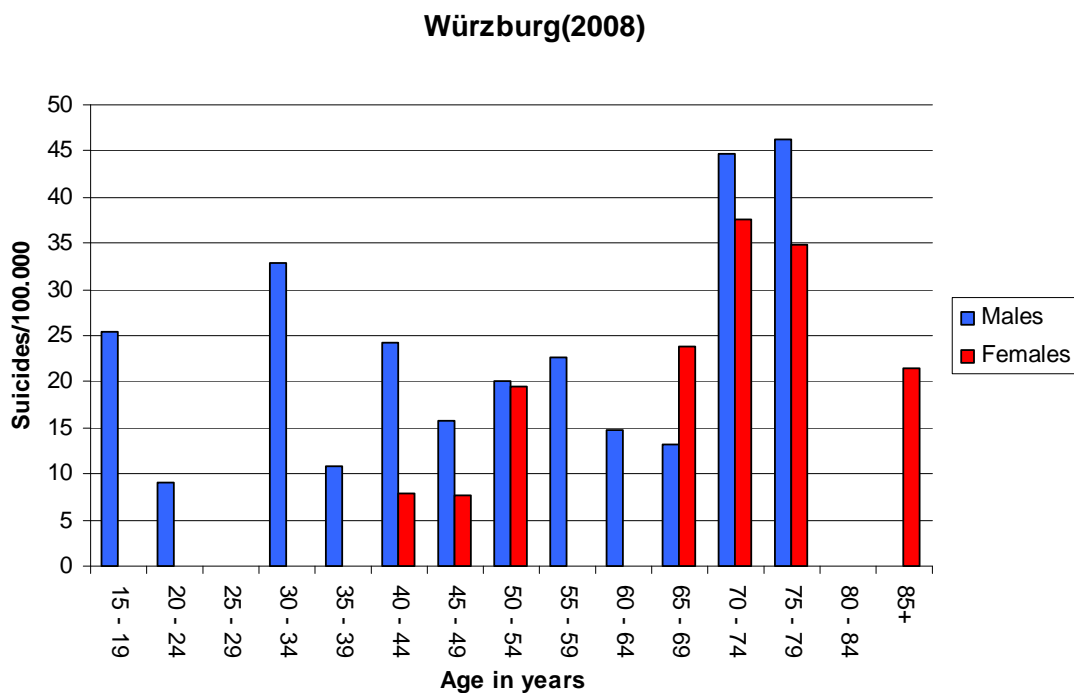
Figure 19: Suicide rates in Pecs (Hungary) 2008, broken down by sex and age



In the two German centres (Leipzig and Wuerzburg), significant differences in age distribution can be found (figures 20 and 21). In Leipzig middle-aged males constitute a group at risk beside the eldest age group. In Wuerzburg, on the contrary, younger males as well as men and women in their 70s have the highest suicide rates.



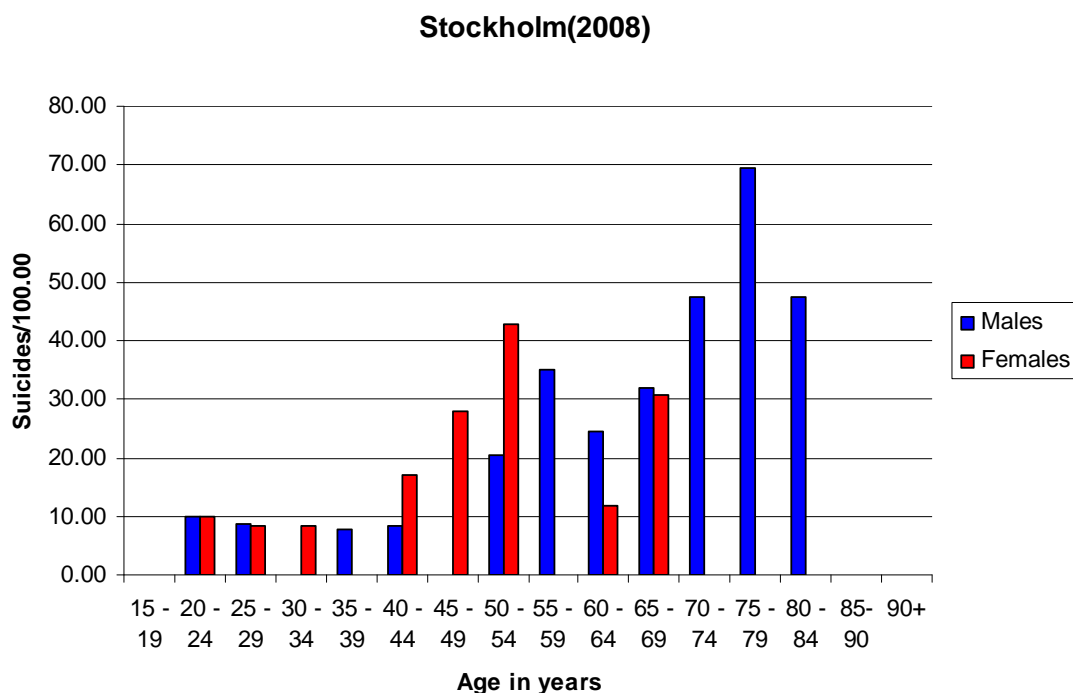
**Figure 20:** Suicide rates in Leipzig (Germany) 2007, broken down by sex and age



**Figure 21:** Suicide rates in Wuerzburg (Germany) 2008, broken down by sex and age

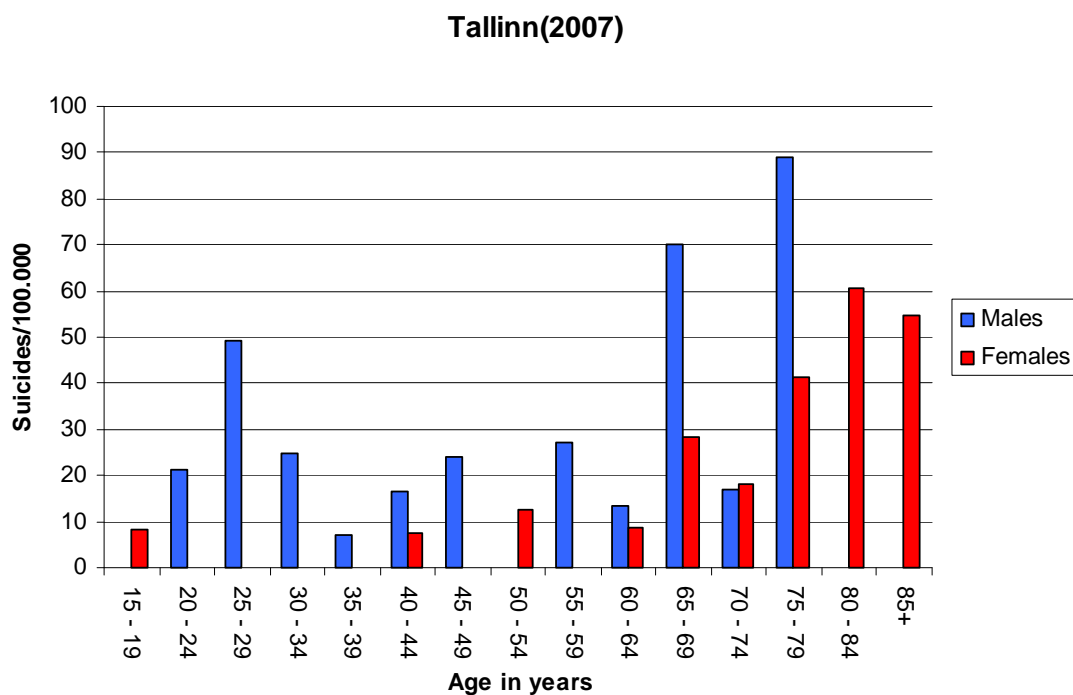


In Stockholm (Sweden) high suicide rates can be found for middle-age females and elder males (figure 22).



**Figure 22:** Suicide rates in Stockholm (Sweden) 2008, broken down by sex and age

In Tallinn (Estonia), suicide rates in elder females are remarkably high (figure 23).



**Figure 23:** Suicide rates in Tallinn (Estonia) 2007, broken down by sex and age



The increase of suicide rates in elder individuals can be identified in the MONSUE catchment areas, too. The generally higher variability in the distribution of age specific suicide rates between the countries and the catchment areas can be explained by significantly smaller sample sizes in the catchment areas.

#### 4.1.2 Suicide methods

Considering the suicide methods as obtained and provided by the MONSUE centres, in the majority of the participating countries hanging is the most frequently used method, followed by poisoning (table 32). A special exception is that of Southern European women (Italy and Spain), for which jumping is the most common suicide method. Another exception is the choice of suicide methods in Slovenia. Slovenian people rarely make use of hanging as suicide method – even in males, but instead poison themselves in the great majority of cases.

**Table 32:** Suicide methods in the countries of the active MONSUE centres (15+ years, last available year)

		<b>Suicide methods country</b>						
		Poisoning %	Hanging %	Drowning %	Guns %	Jumping %	Moving objects %	Crashing by car %
Denmark (2006)	m	21.32	42.86	6.18	13.22	5.33	3.62	0.43
	f	40.68	28.25	14.12	0.00	9.60	4.52	0.00
Estonia (2007)	m	2.44	80.49	0.49	8.29	1.46	0.98	0.00
	f	8.70	73.91	0.00	2.17	10.87	0.00	0.00
Germany (2008)	m	13.44	51.62	2.17	10.90	7.87	6.42	0.68
	f	28.55	34.33	6.98	1.29	13.59	6.65	0.54
Hungary (2008)	m	9.33	69.27	1.52	3.93	4.56	4.82	0.05
	f	33.22	40.99	2.83	0.35	13.43	4.59	0.00
Italy (2004)	m	7.07	42.95	0.00	20.43	19.95	2.58	0.00
	f	11.65	26.47	10.65	2.16	36.69	3.60	0.00
Slovenia (2008)	m	66.10	8.47	0.42	3.81	5.93	0.42	0.00
	f	85.95	0.41	0.41	0.00	3.31	0.83	0.00
Spain (2008)	m	8.22	55.04	3.10	6.95	16.95	3.02	0.26
	f	17.48	31.49	7.20	1.03	32.65	2.57	0.13
Sweden (2008)	m	20.12	44.91	3.98	13.92	5.38	5.50	0.70
	f	46.50	29.30	7.01	0.32	4.78	8.28	0.96





Comparing suicide methods of the catchment area with those of the country nearly the same pattern can be found (table 33). Hanging is by far the most often used suicide method. The country specific distribution also becomes obvious, for example that jumping is the most frequent method in females in Oviedo (Spain). The specific exception for Slovenia becomes evident in Maribor as well.

**Table 33:** Suicide methods in the catchment areas of the active MONSUE centres (15+ years, last available year)

		Suicide methods catchment area						
		Poisoning %	Hanging %	Drowning %	Guns %	Jumping %	Moving objects %	Crashing by car %
Odense (2006)	m	25.00	28.57	7.14	23.21	0.00	7.14	0.00
	f	30.00	50.00	0.00	0.00	10.00	0.00	0.00
Tallinn (2007)	m	0.00	75.00	0.00	11.11	2.78	2.78	0.00
	f	19.05	52.38	0.00	4.76	19.05	0.00	0.00
Pecs (2008)	m	16.33	59.18	0.00	8.16	2.04	6.12	0.00
	f	46.67	20.00	6.67	0.00	20.00	0.00	0.00
Campobasso (2004)	m	6.67	53.33	0.00	13.33	0.00	0.00	0.00
	f	25.00	50.00	0.00	0.00	25.00	0.00	0.00
Maribor (2008)	m	47.06	29.41	0.00	5.88	0.00	0.00	0.00
	f	83.33	0.00	0.00	0.00	0.00	0.00	0.00
Oviedo (2008)	m	5.06	51.90	6.33	10.13	12.66	7.59	0.00
	f	18.18	18.18	12.12	0.00	48.48	0.00	0.00
Wuerzburg (2009)	m	5.00	35.00	15.00	0.00	10.00	20.00	0.00
	f	42.86	0.00	28.57	0.00	28.57	0.00	0.00
Leipzig (2007)	m	13.79	51.72	1.72	6.90	15.52	5.17	3.45
	f	33.33	38.89	0.00	0.00	22.22	0.00	0.00
Stockholm (2008)	m	16.67	66.67	0.00	0.00	5.56	0.00	0.00
	f	80.00	13.33	0.00	0.00	0.00	6.67	0.00



These results indicate that the selected catchment areas are quite representative for each of the countries with regard to suicide methods. Regional specifics do not seem to play a large role. To evaluate possible differences in the choice of suicide methods between the total sample and elder people, the frequency of various suicide methods was calculated separately for people over 65 years.

In general, it can be seen that elder people (over 65 years) chose nearly the same methods for suicide as the total sample (table 34). The same country specific differences become obvious.

**Table 34:** Suicide methods of elder people (65+ years) in the countries of the active MONSUE centres (last available year)

Suicide methods MONSUE country: elderly*								
		Poisoning %	Hanging %	Drowning %	Guns %	Jumping %	Moving objects %	Crashing by car %
Denmark (2006)	m	17.53	49.35	8.44	14.29	5.19	0.65	0.65
	f	37.93	31.03	18.97	0.00	12.07	0.00	0.00
Estonia (2007)	m	0.00	78.05	0.00	9.76	0.00	0.00	0.00
	f	13.04	69.57	0.00	4.35	8.70	0.00	0.00
Germany (2008)	m	9.10	53.08	3.08	16.75	7.86	2.95	0.26
	f	22.33	40.35	10.48	0.98	13.42	4.11	0.10
Hungary (2008)	m	10.91	69.44	1.79	3.37	5.75	2.58	0.00
	f	33.79	46.58	4.57	0.00	9.59	0.91	0.00
Slovenia (2008)	m	38.46	11.54	0.00	15.38	3.85	0.00	0.00
	f	74.19	0.00	0.00	0.00	3.23	0.00	0.00
Spain (2008)	m	5.33	58.06	5.21	4.61	19.03	2.06	0.12
	f	12.87	36.40	12.13	0.00	31.25	1.84	0.00
Sweden (2008)	m	17.43	40.37	7.80	19.72	7.34	1.38	0.00
	f	44.74	26.32	18.42	0.00	3.95	2.63	0.00

\* In Italy data on suicide methods are not available separated into age groups



Regarding suicide methods in elder people in the MONSUE catchment areas the typical distribution becomes also evident (table 35).

**Table 35:** Suicide methods of elder people (65 + years) in the catchment areas of the active MONSUE centres (last available year)

		<b>Suicide methods MONSUE catchment area: elderly*</b>						
		Poisoning %	Hanging %	Drowning %	Guns %	Jumping %	Moving objects %	Crashing by car %
Odense (2006)	m	23.53	35.29	11.76	23.53	0.00	0.00	0.00
	f	25.00	50.00	0.00	0.00	25.00	0.00	0.00
Tallinn (2007)	m	0.00	72.73	0.00	9.09	0.00	0.00	0.00
	f	18.75	56.25	0.00	6.25	12.50	0.00	0.00
Wuerzburg (2009)	m	0.00	33.33	33.33	0.00	0.00	33.33	0.00
	f	0.00	0.00	100.00	0.00	0.00	0.00	0.00
Leipzig (2007)	m	0.00	71.43	0.00	14.29	14.29	0.00	0.00
	f	42.86	42.86	0.00	0.00	14.29	0.00	0.00
Pecs (2008)	m	9.09	72.73	0.00	9.09	9.09	0.00	0.00
	f	50.00	0.00	16.67	0.00	16.67	0.00	0.00
Maribor (2008)	m	*/*	*/*	*/*	*/*	*/*	*/*	*/*
	f	50.00	0.00	0.00	0.00	0.00	0.00	0.00
Stockholm (2008)	m	14.29	57.14	0.00	0.00	14.29	0.00	0.00
	f	50.00	50.00	0.00	0.00	0.00	0.00	0.00

\* In Italy data on suicide methods are not available separated into age groups



### 4.1.3 Association between suicide rates and sociodemographic variables

To address the question, if suicide rates covary with sociodemographic variables, data from the EUROSTAT database were extracted and analyzed.

By computing the correlations between suicide rates and rates of foreign citizens for young people (15-24 years), a coefficient is  $-0.36$  ( $r_{\text{Pearson}}$ ) for males and  $-0.03$  ( $r_{\text{Pearson}}$ ) for females. Accordingly there seems to be no correlation between suicide rates in young females and the rates of young female foreign citizens. In young males higher rates of foreign citizens in a country seem to covary with a lower suicide rate.

As for persons with migration background the same analyses were done for unemployed people for the age group from 15 to 24 years. The correlation between suicide and unemployment rates is  $-0.08$  ( $r_{\text{Pearson}}$ ) in males and  $-0.12$  ( $r_{\text{Pearson}}$ ) in females. Consequently the variance in unemployment rates does not explain much variance in the suicide rates.

Rates of migration and unemployment, however, are only available for the general population and not for the sample of suicides rendering these data less informative than MONSUE data for the sample of suicide attempts.

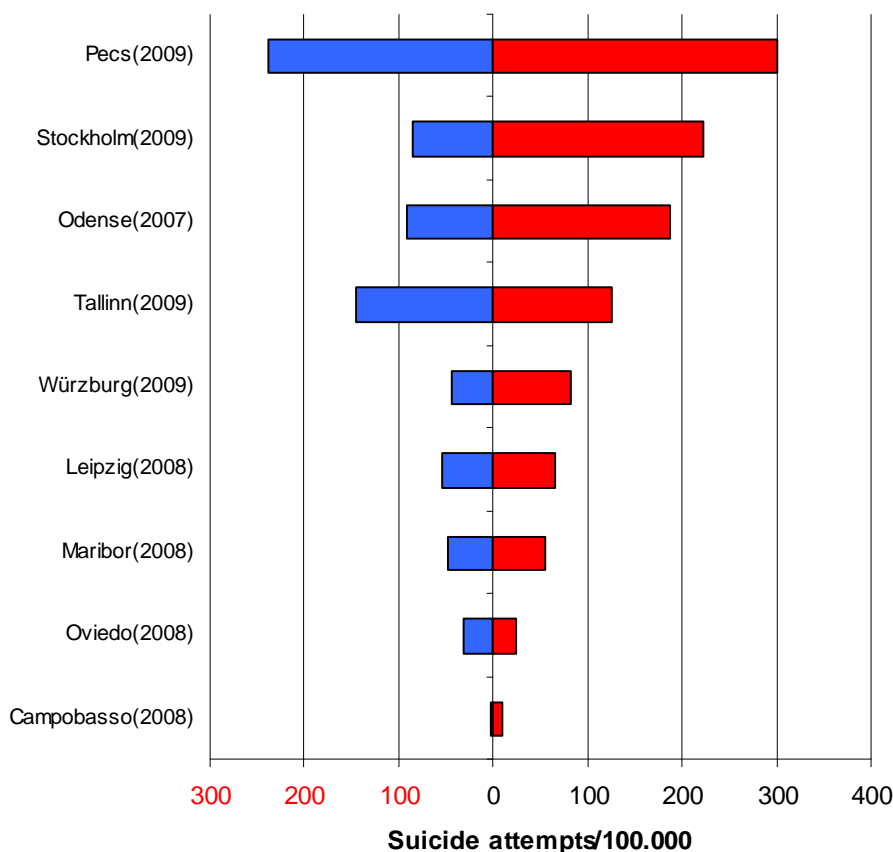


## 4.2 Descriptive results regarding suicide attempts

### 4.2.1 Suicide attempt rates in the catchment areas

In order to present a representative overview of the distribution of suicide attempt rates, the rates were averaged for each age group in each centre for the last available years, starting from 2005 (at maximum 4 years up to 2009).

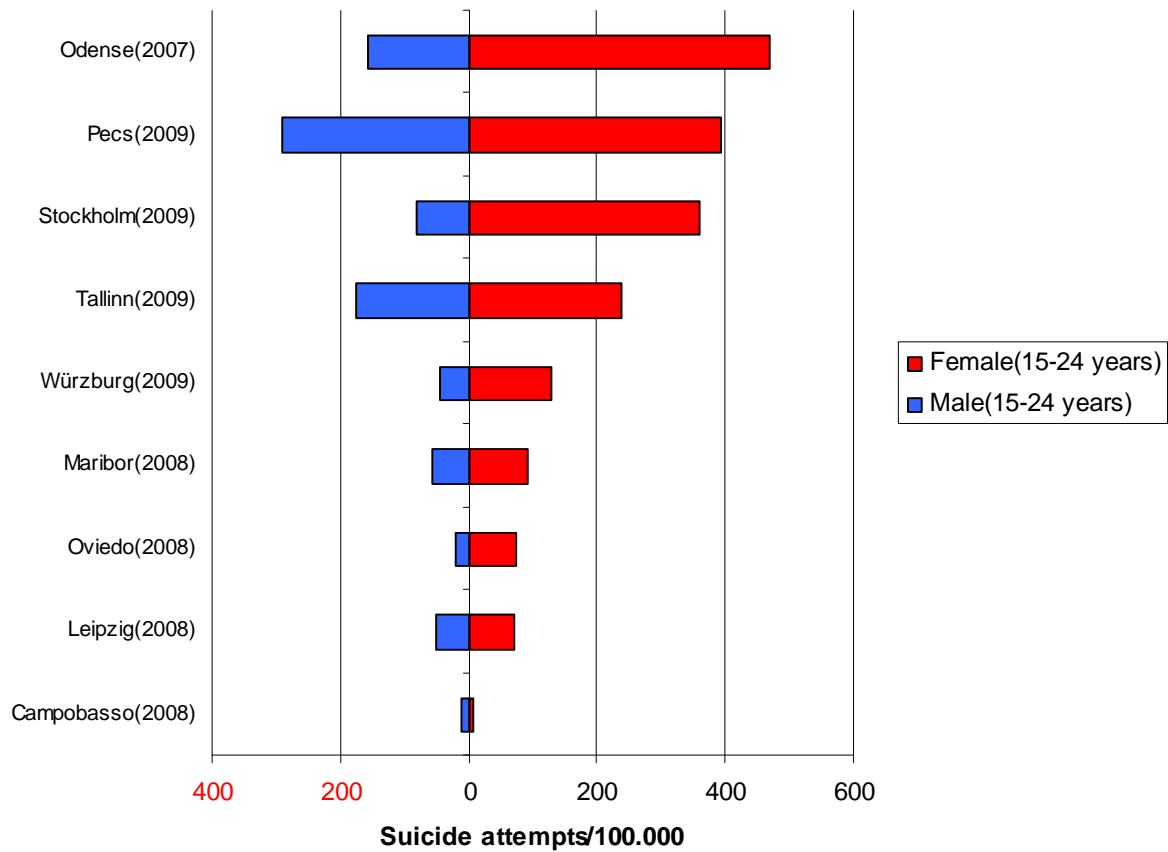
Considering suicide attempt rates in the different catchment regions, the ranking of the different EC countries remains similar compared with suicide rates. The Eastern European countries, like Hungary and Estonia, have the highest rates, whereas the South European countries (Italy and Spain) have the lowest (figure 24).



**Figure 24:** Suicide attempt rates in the MONSUE catchment areas (last available year)



A relatively similar sequence can be found in suicide attempt rates of young males and females (figure 25).



**Figure 25:** Suicide attempt rates of young people (15 – 24 years) in the MONSUE catchment areas (last available year)



Considering suicide attempt rates in males, a general tendency for a decrease with age becomes obvious, except for the Hungarian centre (Pecs) (figure 26). In Pecs, suicide attempt rates differ significantly from those in the other centres. This indicates a relation between suicide and suicide attempt rates, as Hungary also has by far the highest suicide rates. Moreover, elder men seem to represent a group with a higher risk for suicide attempts.

### Suicide attempt rates in males

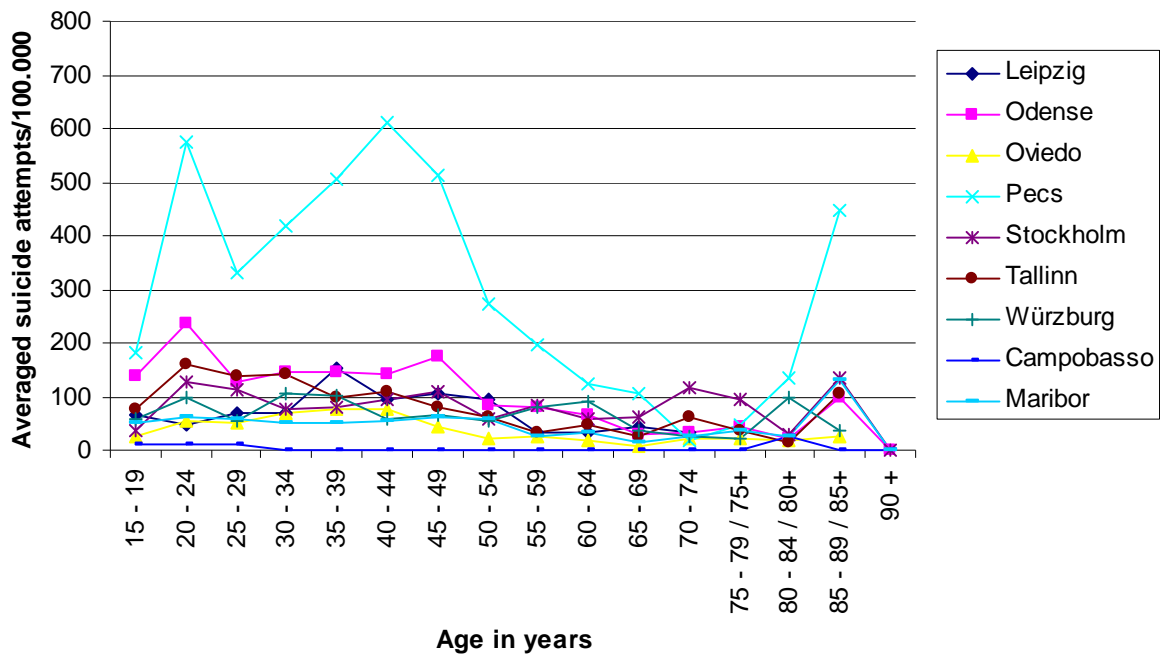


Figure 26: Averaged suicide attempt rates of males in the MONSUE catchment areas



With regard to suicide attempt rates in females, the differences between the centres are larger and seem to be more dependent on country-specific features than those of males (figure 27). In addition, the tendency for a decrease of suicide attempt rates with age becomes more obvious. In general, women’s suicide attempt rates are much higher than men’s in most countries with the exception of Pecs (Hungary), which shows comparable suicide attempt rates in males and females.

### Suicide attempt rates in females

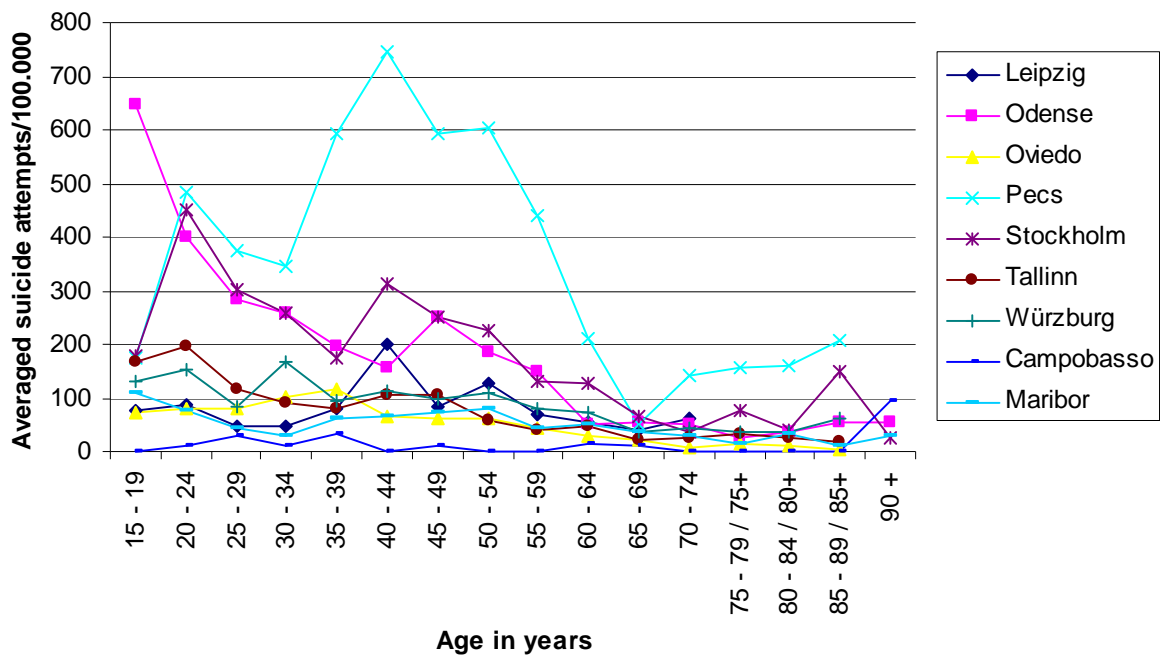
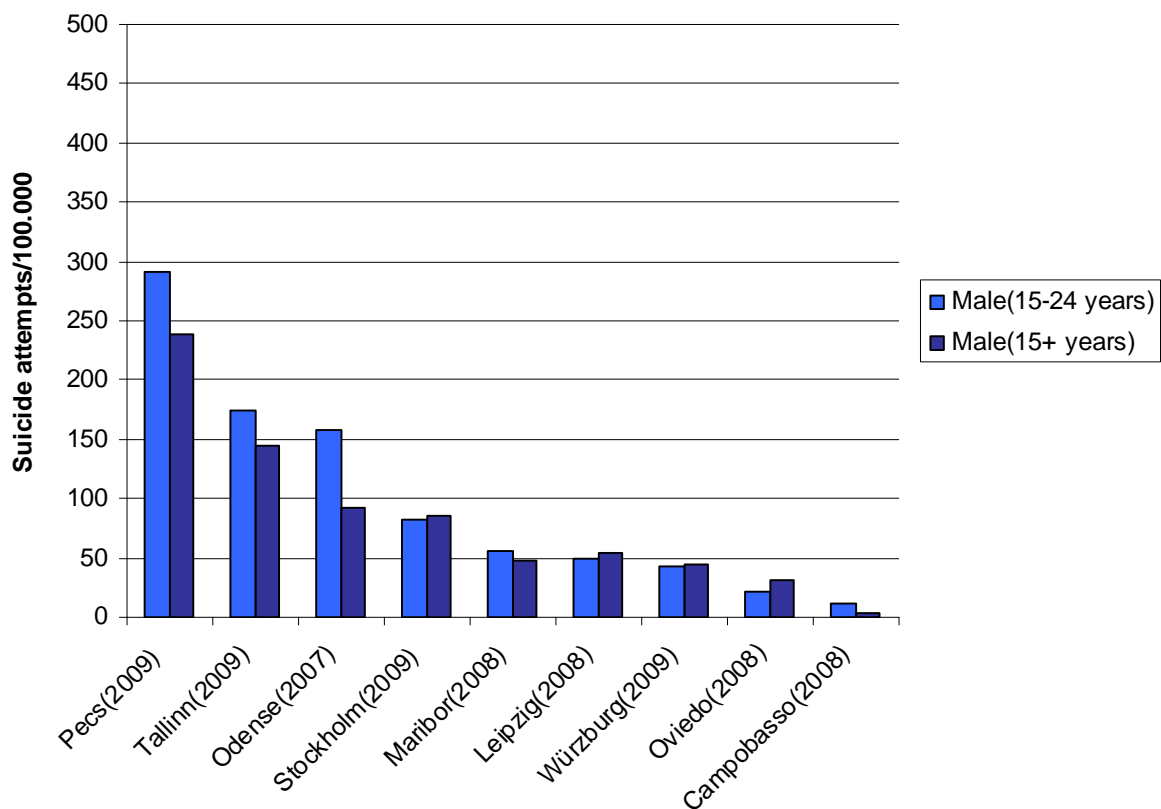


Figure 27: Averaged suicide attempt rates of males in the MONSUE catchment areas





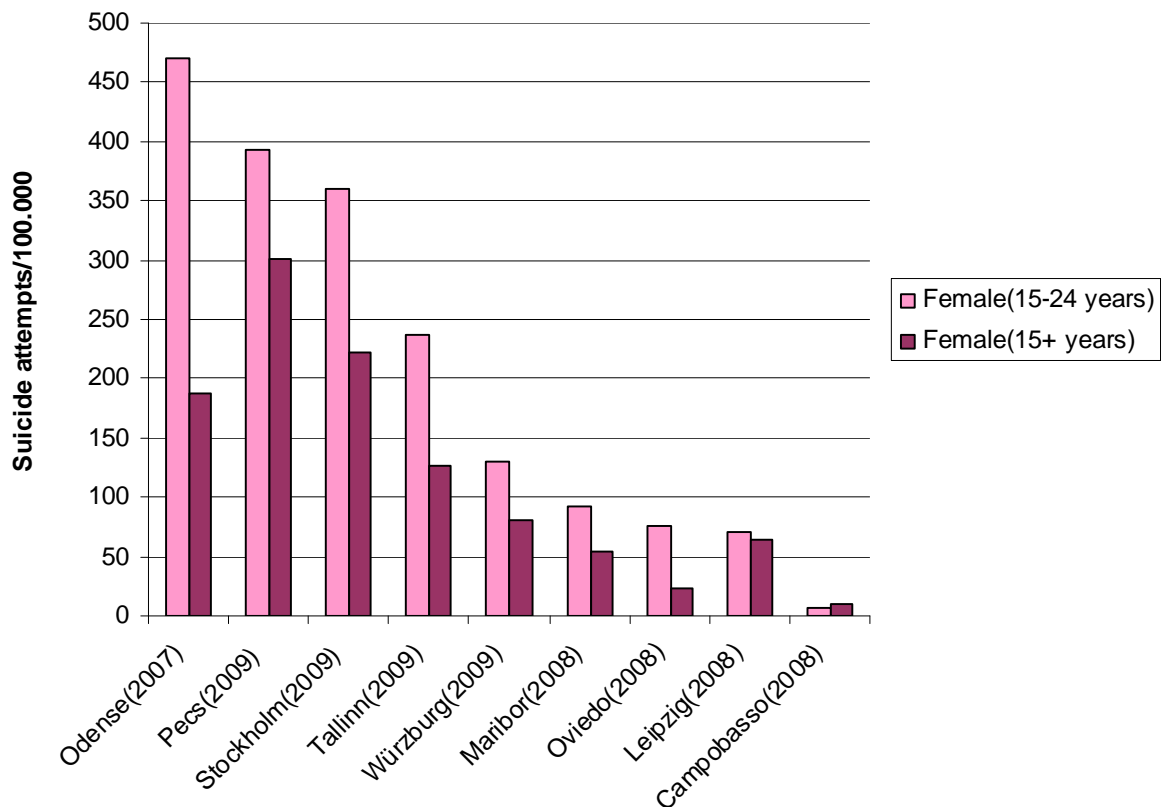
Comparing suicide attempt rates in the different centres in males in total and young males (15-24 years) only in Odense (Denmark) a significant difference becomes apparent (figure 28). In Denmark young men have a considerably higher suicide attempt rate than men in general (all age groups over 15 years). For all other centres no major difference between the age groups can be found.



**Figure 28:** Comparison of averaged suicide attempt rates of young males (15- -24 years) and males in total



A different pattern arises when looking at the suicide attempt rates in females of different age groups (figure 29). In most of the centres, mainly in Stockholm (Sweden), Odense (Denmark) and Tallinn (Estonia), young women have a nearly twofold higher suicide attempt rate than women of all age groups.

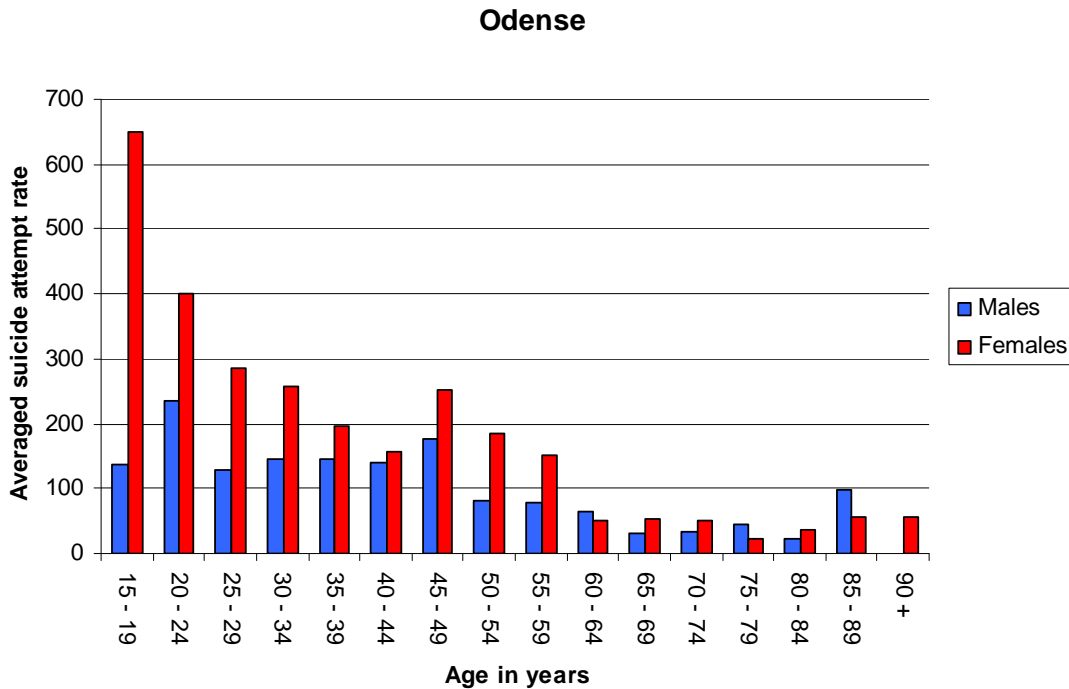


**Figure 29:** Comparison of averaged suicide attempt rates of young females (15- -24 years) and females in total

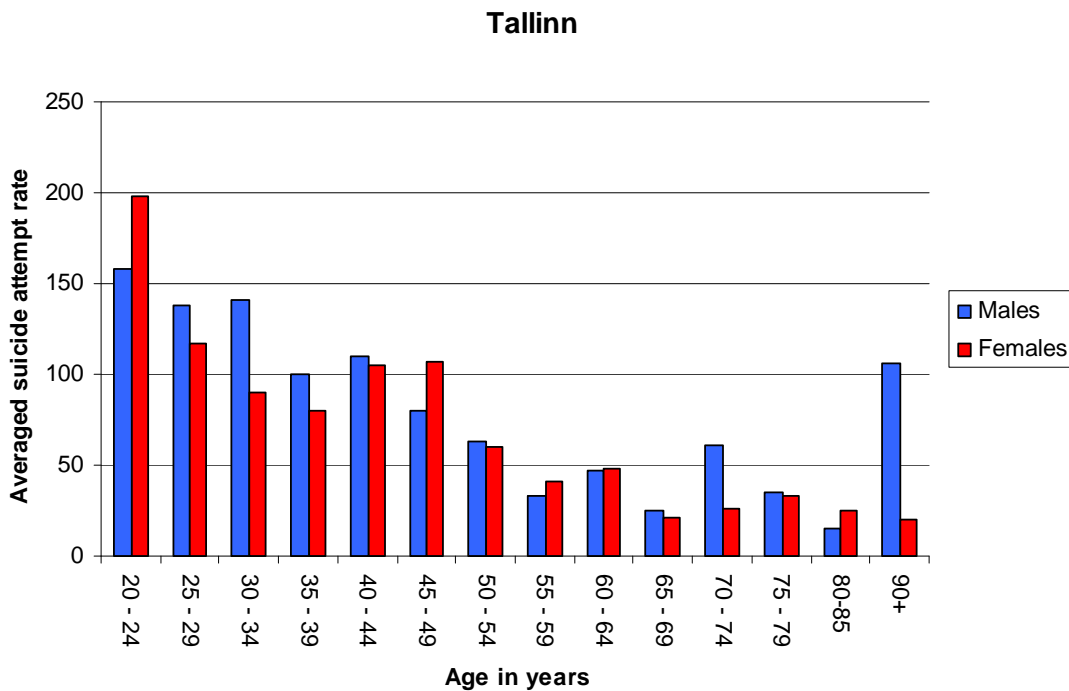
Regarding the distribution of the age-related suicide attempt rates in the catchment areas, basically three different patterns can be observed.



The typical pattern of suicide attempt rates, which decline with age, can be best observed in Odense (figure 30) and Tallinn (figure 31).



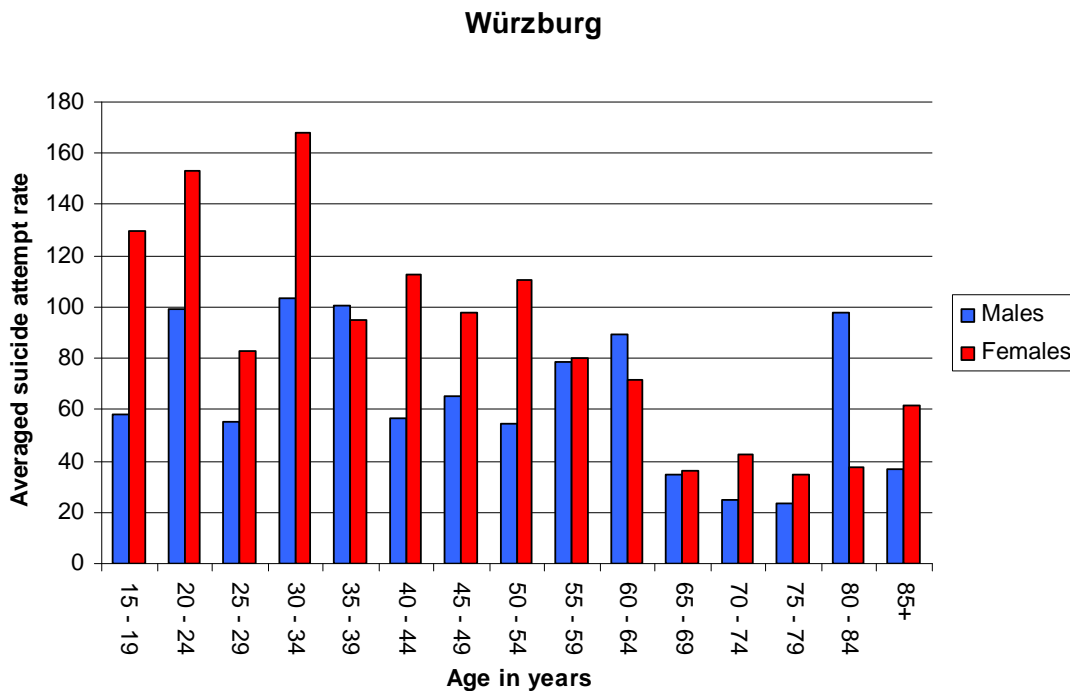
**Figure 30:** Averaged suicide attempt rates in Odense (Denmark), broken down by sex and age



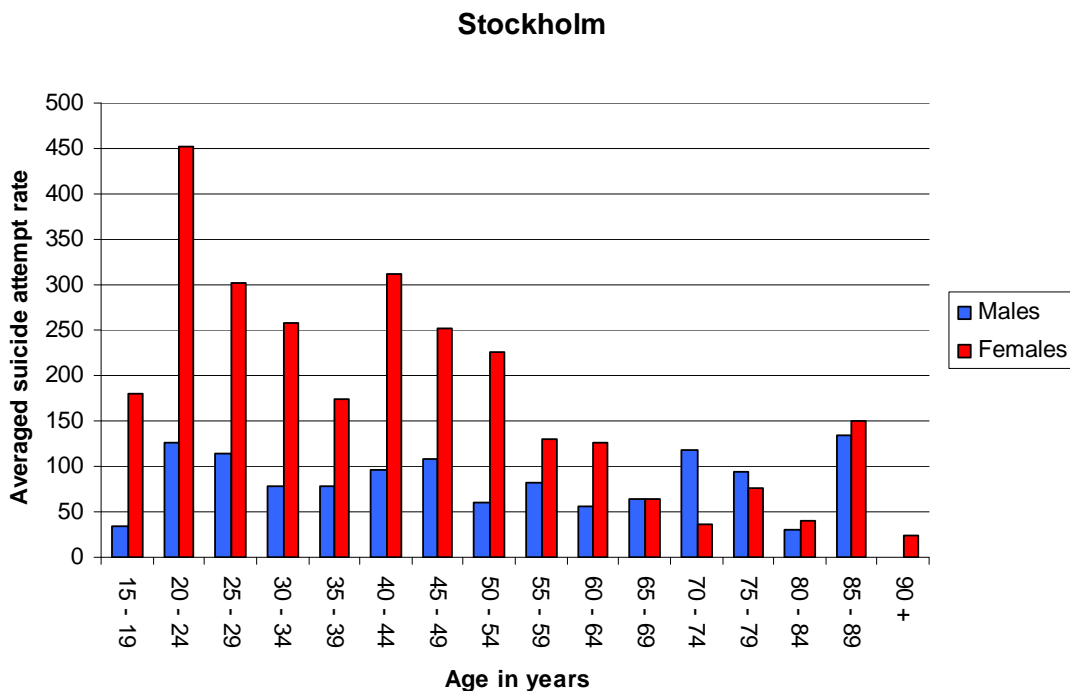
**Figure 31:** Averaged suicide attempt rates in Tallinn (Estonia), broken down by sex and age



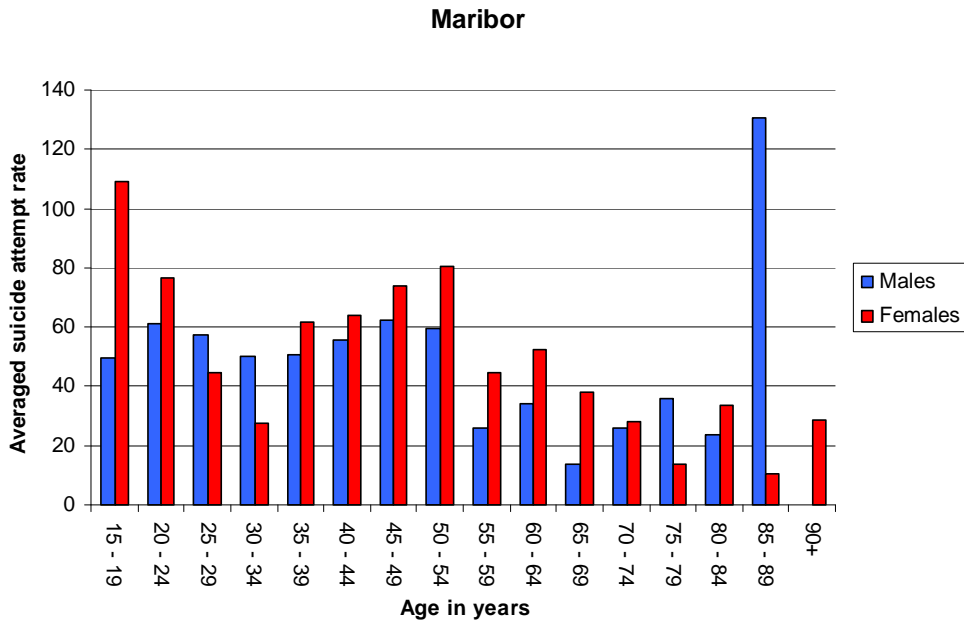
In Wuerzburg (figure 32), Stockholm (figure 33) and Maribor (figure 34) the same trend with decreasing suicide rates in elder age groups becomes evident, but with little variations in the younger age groups and a high suicide attempt rate in the second eldest age group.



**Figure 32:** Averaged suicide attempt rates in Wuerzburg (Germany), broken down by sex and age

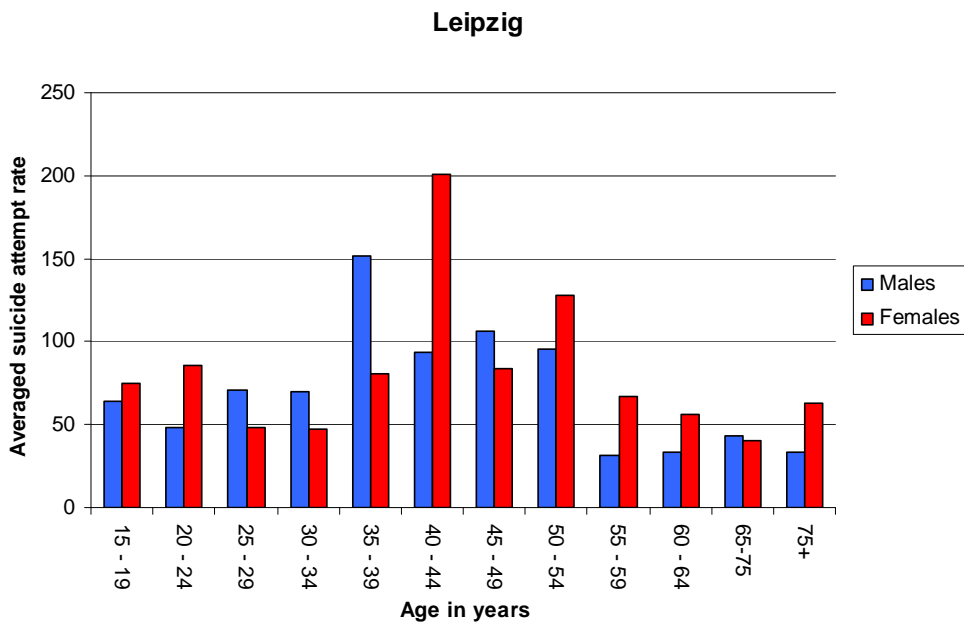


**Figure 33:** Averaged suicide attempt rates in Stockholm (Sweden), broken down by sex and age

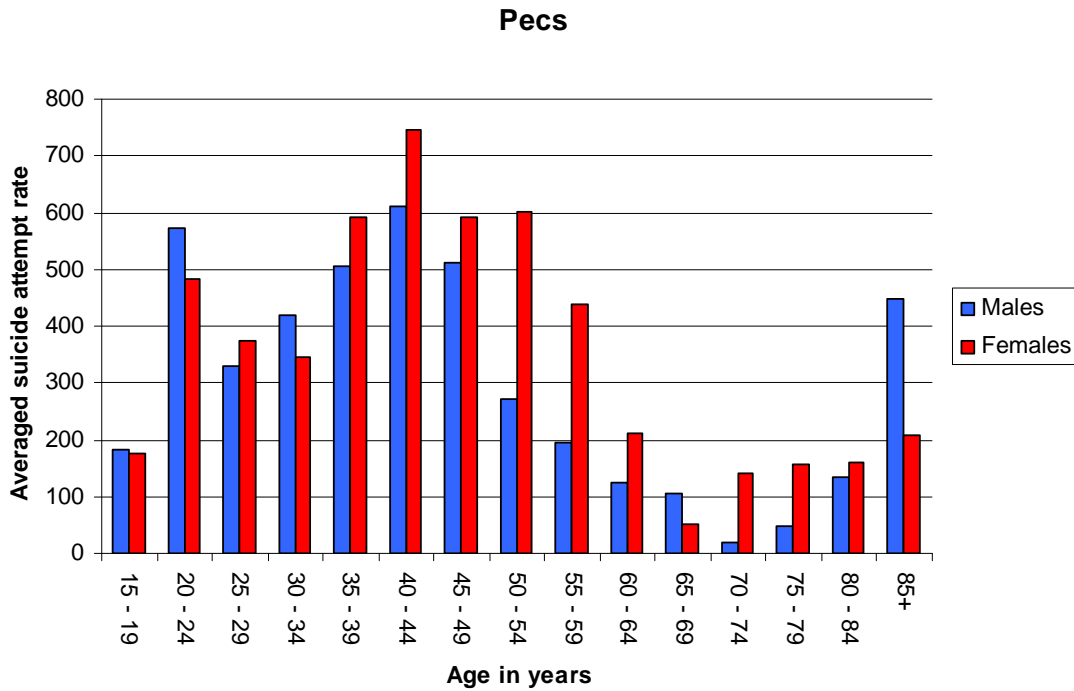


**Figure 34:** Averaged suicide attempt rates in Maribor (Slovenia), broken down by sex and age

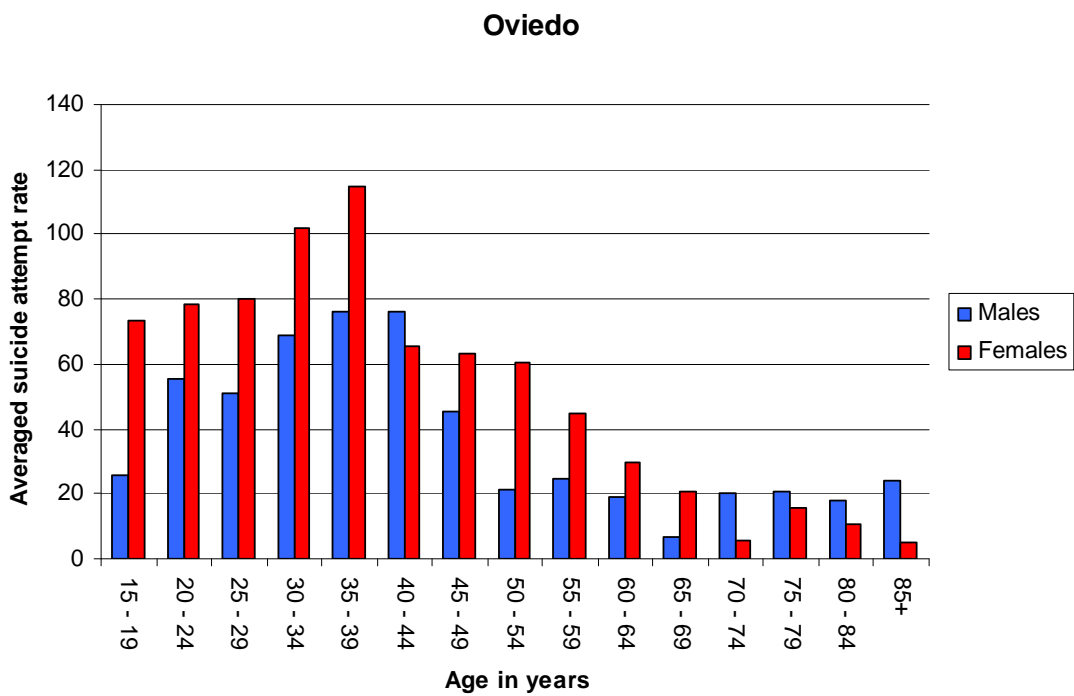
A third pattern can be noticed in Leipzig (figure 35), Pecs (figure 36) and Oviedo (figure 37). This pattern is defined by the highest suicide attempt rates located in the middle age groups. In addition, especially in Pecs an increase in rates can be observed in elder males.



**Figure 35:** Averaged suicide attempt rates in Leipzig (Germany), broken down by sex and age



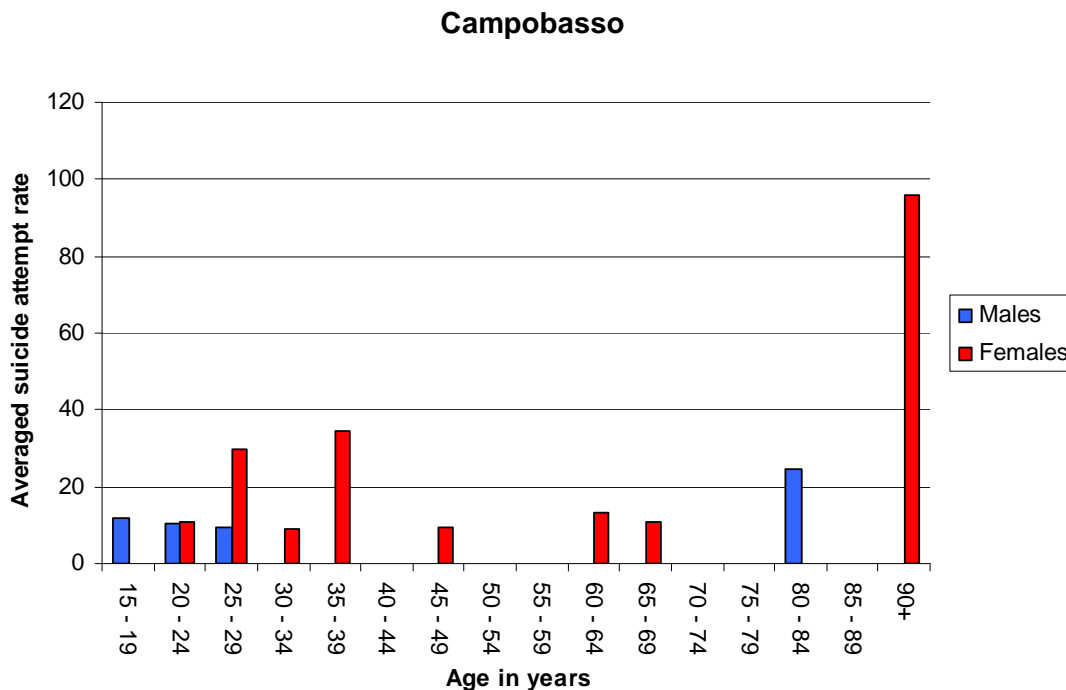
**Figure 36:** Averaged suicide attempt rates in Pecs (Hungary), broken down by sex and age



**Figure 37:** Averaged suicide attempt rates in Oviedo (Spain), broken down by sex and age



In Campobasso (figure 38) no special pattern in suicide attempt rates can be observed. Notably is the high rate in the eldest age group in women.

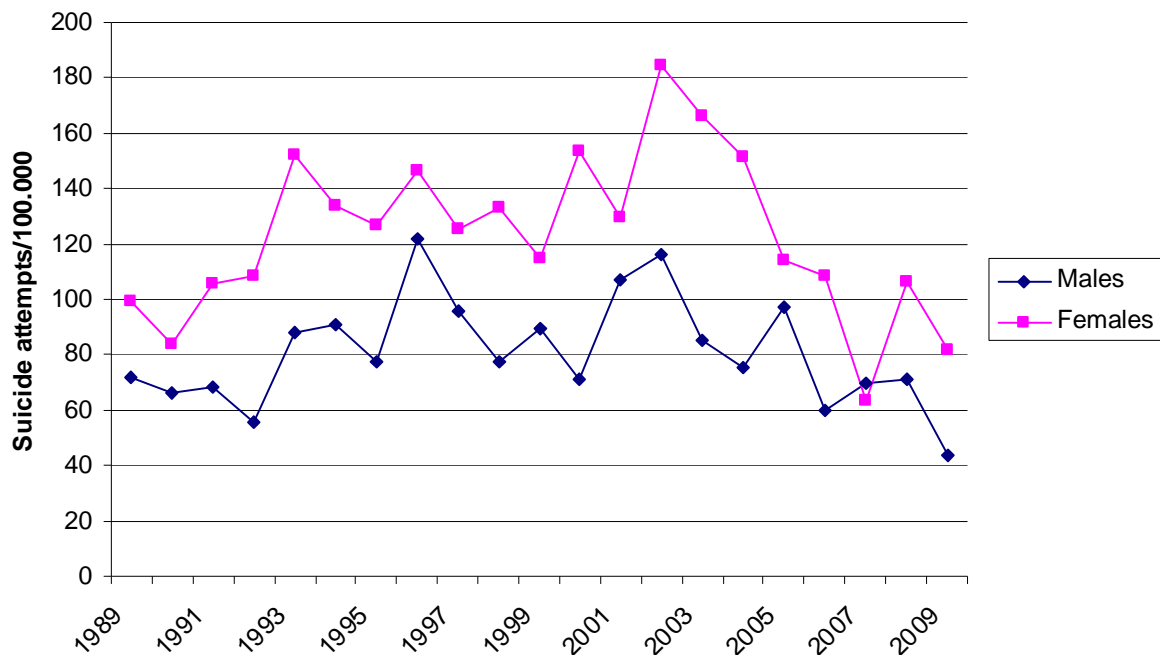


**Figure 38:** Averaged suicide attempt rates in Campobasso (Italy), broken down by sex and age

In general most of the existing hypotheses concerning age- and sex-specific distributions of suicide attempt rates could be confirmed by the MONSUE results. A new important observation is the extension of the “young” age group as high risk group for suicide attempts up to the age of 45. Furthermore the results show, that the eldest age groups also have a high rate of suicide attempts in several countries.

Since the MONSUE project is related to the WHO/EURO study, data periods of suicide attempts are available for three centres (Tallinn, Wuerzburg, Stockholm) for at least 15 (Tallinn) and up to 21 years (Wuerzburg, Stockholm). Time trends of suicide attempt rates are presented for Wuerzburg as an example (figure 39), since Wuerzburg can provide continuous monitoring data on suicide attempt rates.

### Suicide attempt rates in Würzburg 1989-2009



**Figure 39:** Time trend of suicide attempt rates in Wuerzburg (15+ years, 1989-2009)

It can be seen, that there is a considerable annual variation in suicide attempt rates. As general trend a decrease in suicide attempt rates can be observed in the last years after a peak in 2002.

#### 4.2.2 Cross-national analyses

For the analysis of sociodemographic variables data for 4683 suicide attempt episodes were available. Data in the MONSUE SPSS-Database for suicide attempts are provided from ten centres in 9 European countries: Tallinn (Estonia), Brussels (Belgium), Leipzig and Wuerzburg (Germany), Pecs (Hungary), Campobasso (Italy), Maribor (Slovenia), Oviedo (Spain), Stockholm (Sweden) and Berne (Switzerland).

Suicide attempts are more common in females and younger age groups. Due to this fact the following analyses were conducted separately for three age groups (youngsters: 15 to 29 years, middle-aged: 30 to 59 years, elderly: 60+) and the two sexes (males, females).





#### 4.2.2.1 Cross-national analyses of suicide attempt methods

Most suicide attempters use soft poisoning, which means intoxication with different kinds of medications like anticonvulsants, antidepressants, benzodiazepines etc. (55 to 85%, figure 40). Far less use hard poisoning (pesticides, gases, solvents etc., up to 5%). Hard methods (cutting, jumping, hanging) are more frequently used by males than by females (males: 30 to 42%; females: 14 to 19%). Young male suicide attempters more frequently use hard methods than middle-aged male suicide attempters.

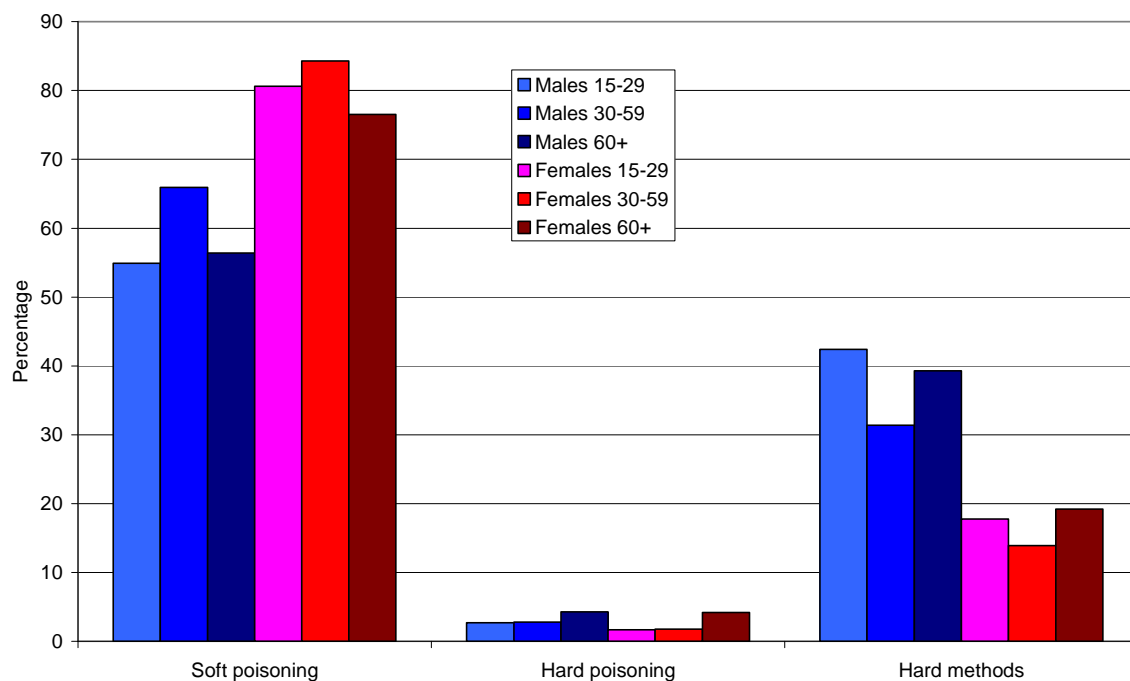
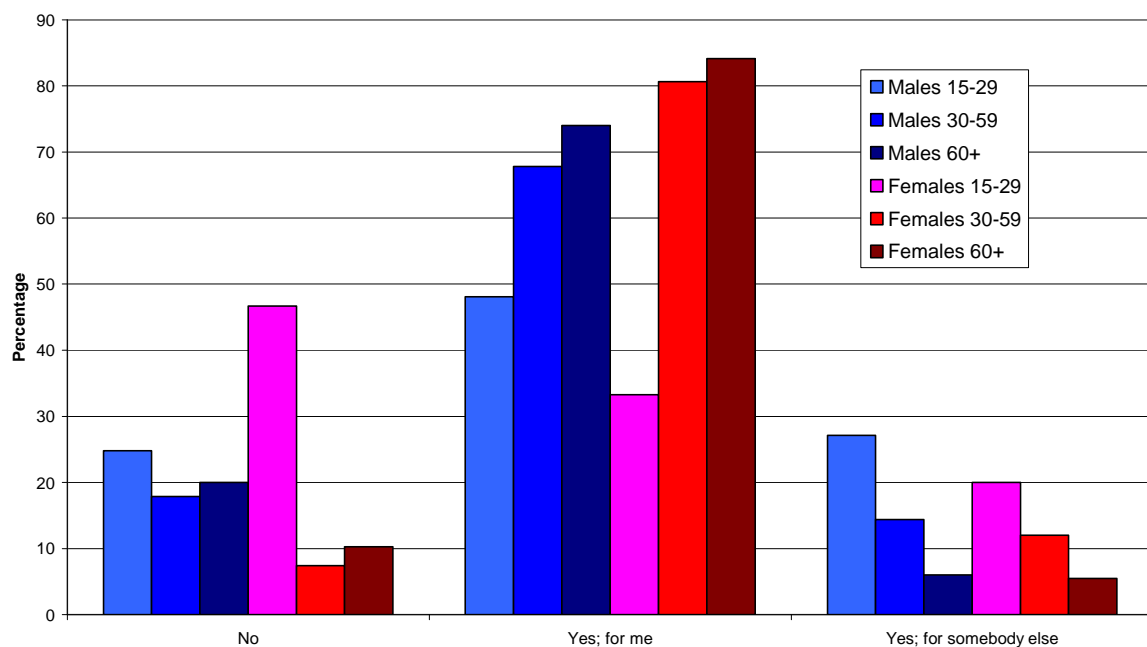


Figure 40: Methods of suicide attempt



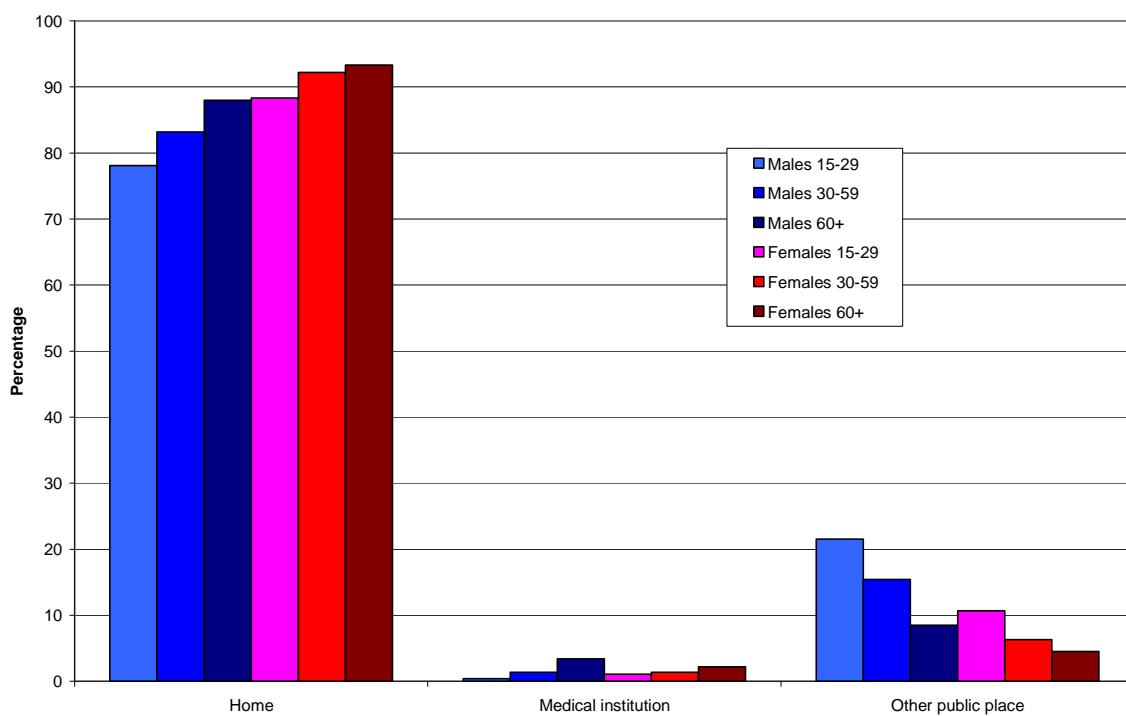
Within the group of young female suicide attempters using medication as method of suicide attempt almost half are using non-prescribed medications (figure 41). Most of the other suicide attempters use medication that was prescribed for them. A much smaller percentage of suicide attempters is using medications prescribed for somebody else, but especially young males use medication prescribed to somebody else rather frequently. Young females also often use medication that was not prescribed for them. This finding is of course relevant with regard to prescription guidelines.



**Figure 41:** Prescription of medication



Male and even more female suicide attempters mainly conduct the attempt at their homes (figure 42; males: 78 to 88%; females: 88 to 94%). Less than 5% of all suicide attempts took place within medical institutions and 5 to 20% - depending on the age group – were conducted at other public places. For the younger suicide attempters (males: 21%, females: 10%) this percentage is significantly higher than for the older age groups, hinting to the fact that hot spots are of more relevance in younger than in older suicide attempters.

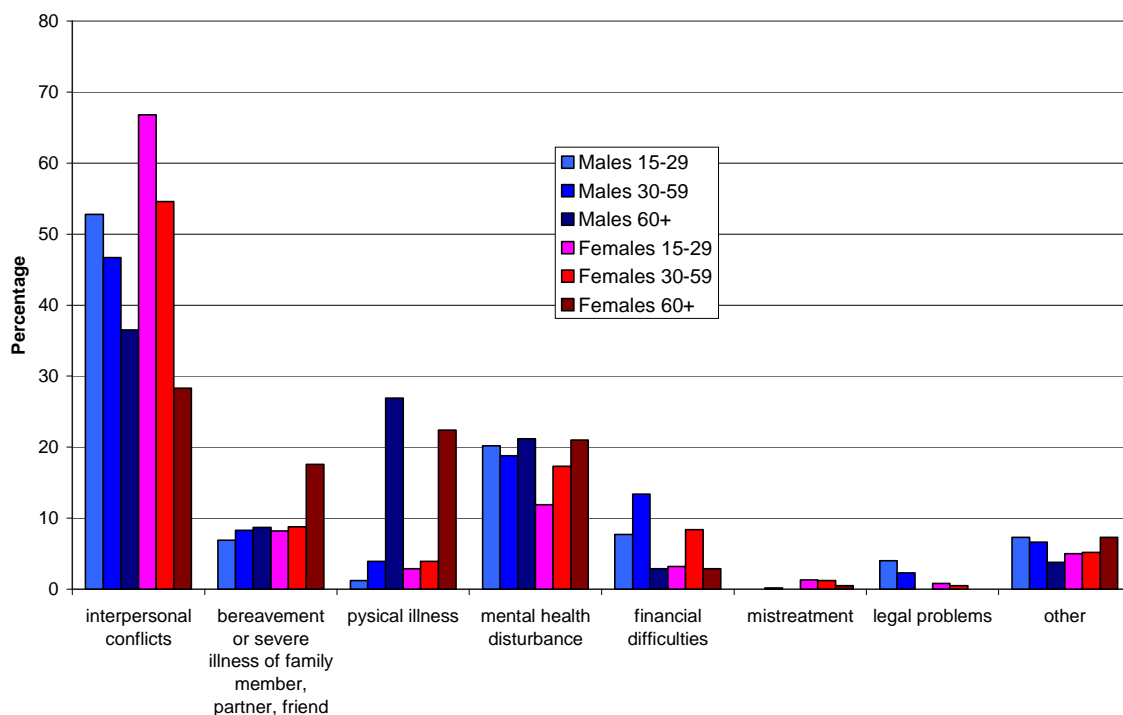


**Figure 42:** Place of suicide attempt



#### 4.2.2.2 Cross-national analyses of characteristics of the suicide attempt

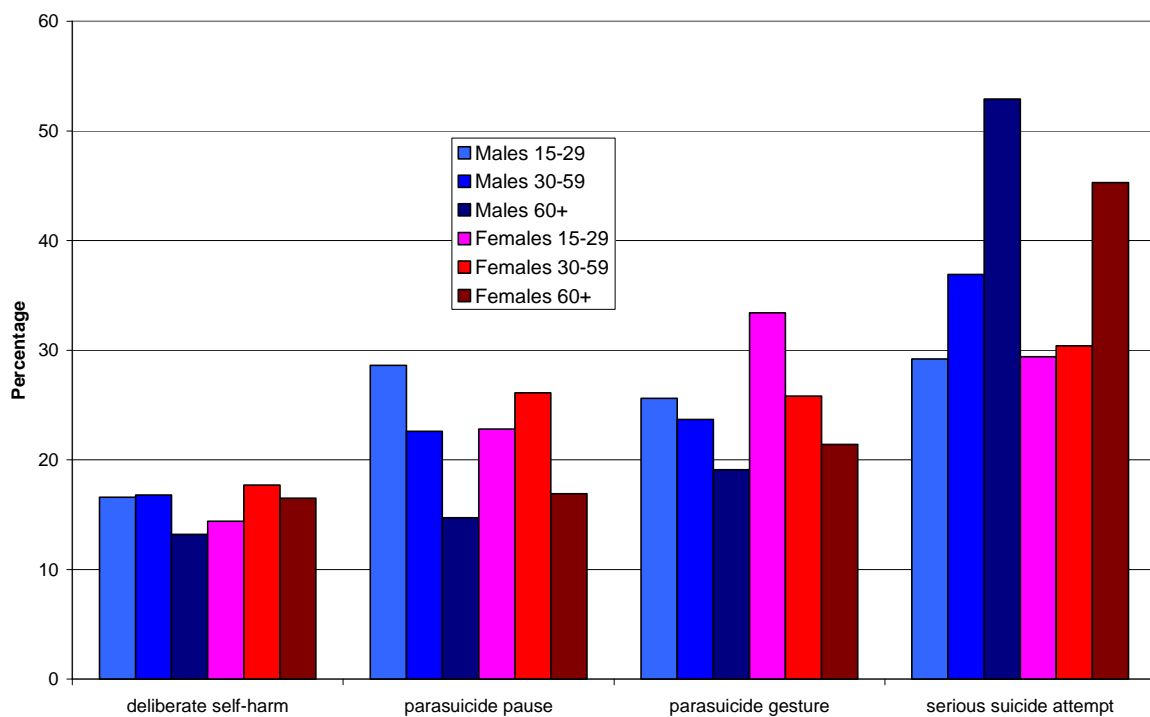
Through all age- and sex groups for most suicide attempters (figure 43) interpersonal conflicts were the main reason for attempting suicide (29% of older female suicide attempters to 77% of young female suicide attempters). For older suicide attempters another frequent reason for attempting suicide was physical illness (males: 29%, females: 22%) and mental health disturbances (males and females: 21%). Mental health disturbances also were the second most frequent reason for attempting suicide for the young and middle-aged suicide attempters (10 to 20%).



**Figure 43:** Reasons for attempting suicide (rated by medical professional)



In line with earlier findings within the older age groups about half of all suicide attempts are classified as serious suicide attempts (figure 44). About one fourth of the suicide attempts is classified as parasuicidal gestures; here a significantly higher percentage is found within the group of young females (33%). About one fifth is classified as parasuicidal pauses; here the highest percentage is found within young males (28%). Parasuicidal pauses are less frequent in older suicide attempters (males: 15%; females: 16%). Suicide attempt is classified as deliberate self-harm in 14 to 18% of all cases.

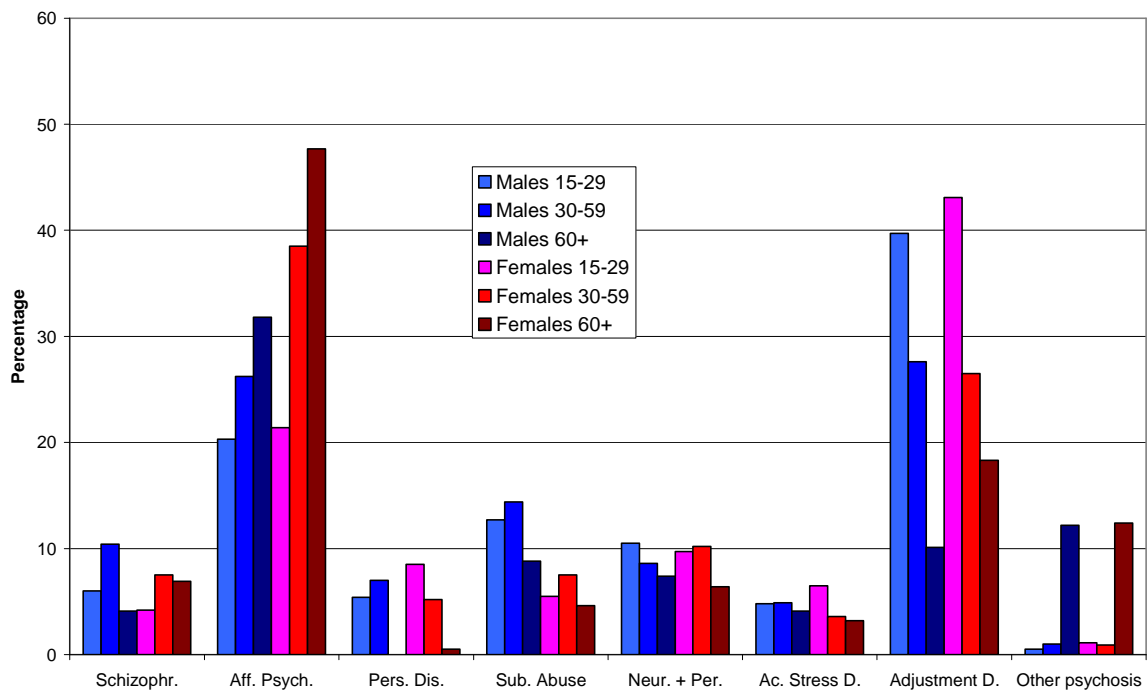


**Figure 44:** Classification of suicide attempt



#### 4.2.2.3 Cross-national analyses of psychiatric diagnoses of suicide attempters

Most suicide attempters have a diagnosis of either affective or adjustment disorders (figure 45), followed by substance abuse. Older suicide attempters are significantly more frequently diagnosed as suffering from affective disorders (males: 32%; females 48%) than younger suicide attempters, whereas the latter are significantly more frequently diagnosed as having adjustment disorders (males: 40%, females: 43%).



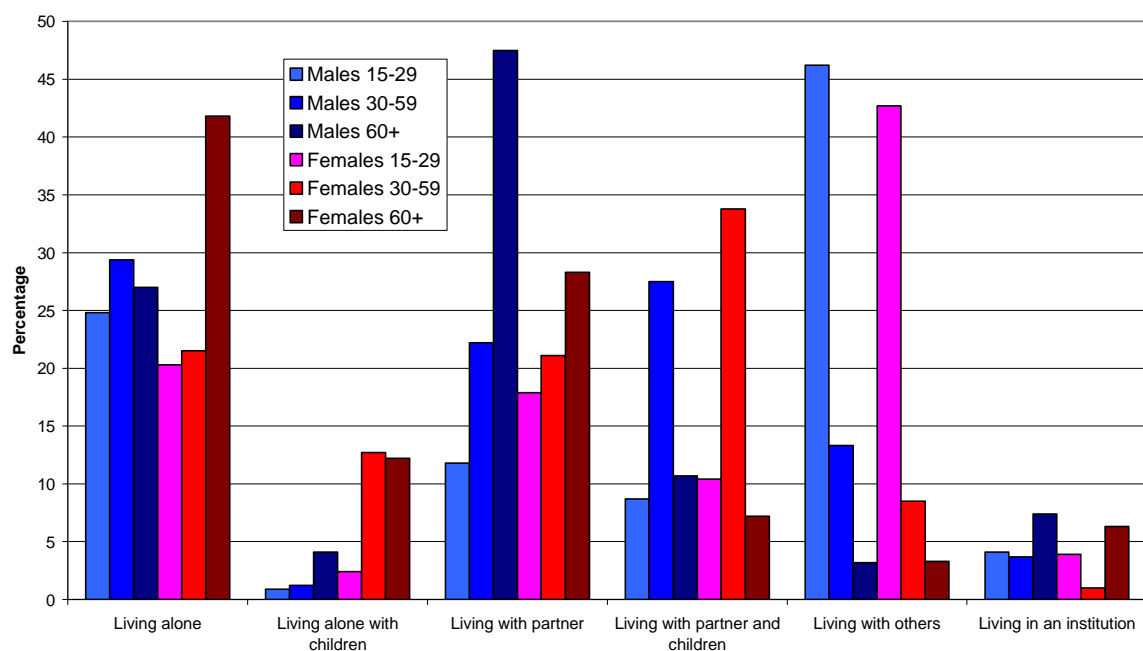
**Figure 45:** Psychiatric diagnoses



#### 4.2.2.4 Cross-national analyses of sociodemographic variables

Naturally the groups differ with regard to civil state. In the younger age groups 75 to 80 percent are single. In the older age groups 18 (males) to 43 (females) percent are widowed. Older males are mainly married (58%), for older females the percentage is much lower (38%). Within middle-aged males about one third is married or single and 24% are divorced or separated. Middle-aged females are either married (38%) or divorced/separated (29%), 19% are single.

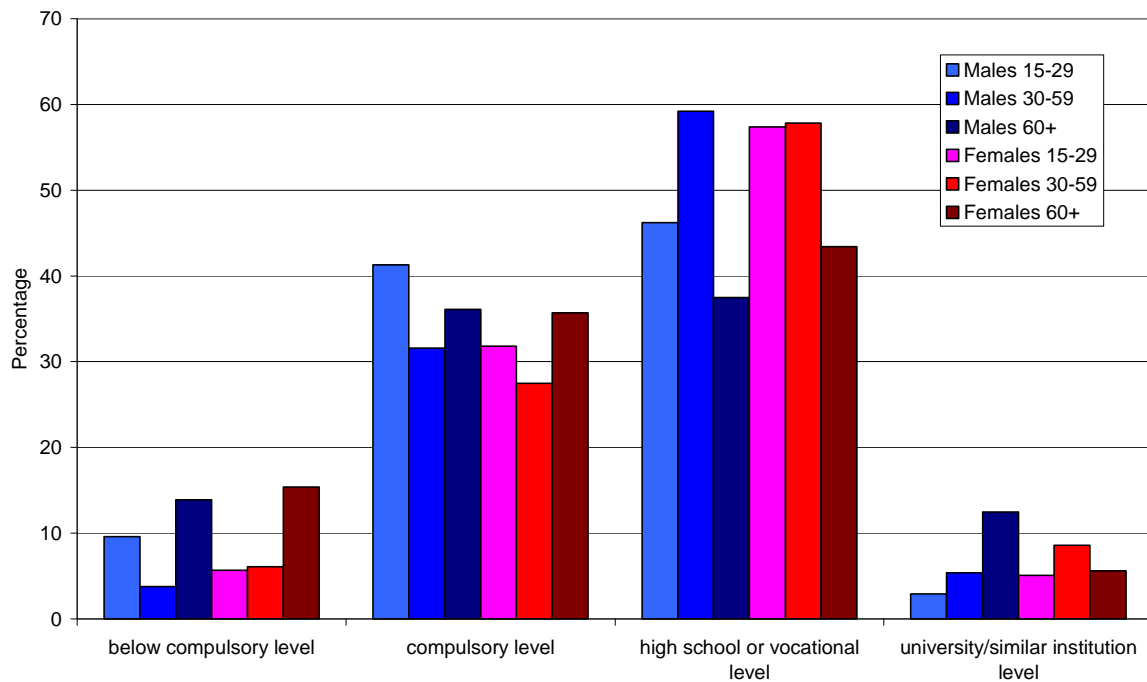
The evaluation of the household composition shows that most of the young suicide attempters are living with others (figure 46), which means parents, relatives or friends (males: 46%; females: 42%). Middle-aged males are either living alone (29%) or with partner (22% without children, 27% with children), middle-aged females are mostly living with partner (21% without children, 34% with children) or living alone (22%). Elderly males are mainly living with partner (47%) or alone (27%), whereas in elderly females highest percentage is living alone (41%), followed by living with partner (28%). One to 7% of all suicide attempters are living in institutions (psychiatric institutions, prisons, elderly homes or other institutions).



**Figure 46:** Usual household composition during the year before the suicide attempt



In line with the normal population through all groups most suicide attempters (38 to 59%) have high school or vocational level of education, followed by compulsory level (28 to 41%; see figure 47). There are only low percentages of suicide attempters with either a level of education below compulsory level (4 to 15%) or university level (3 to 13%).

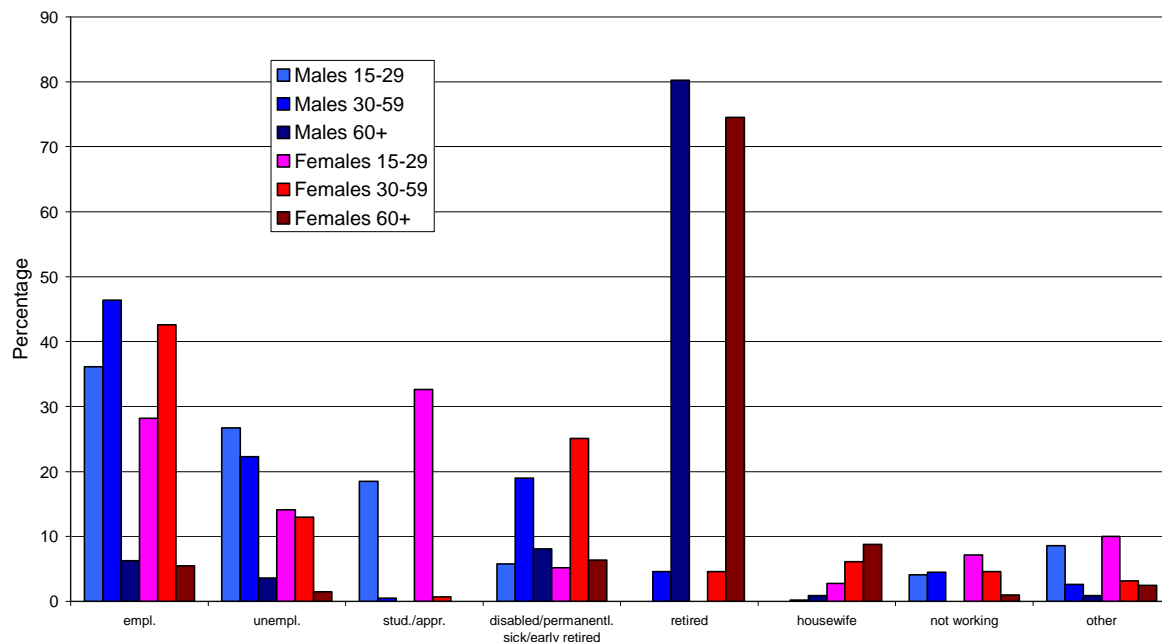


**Figure 47:** Level of education





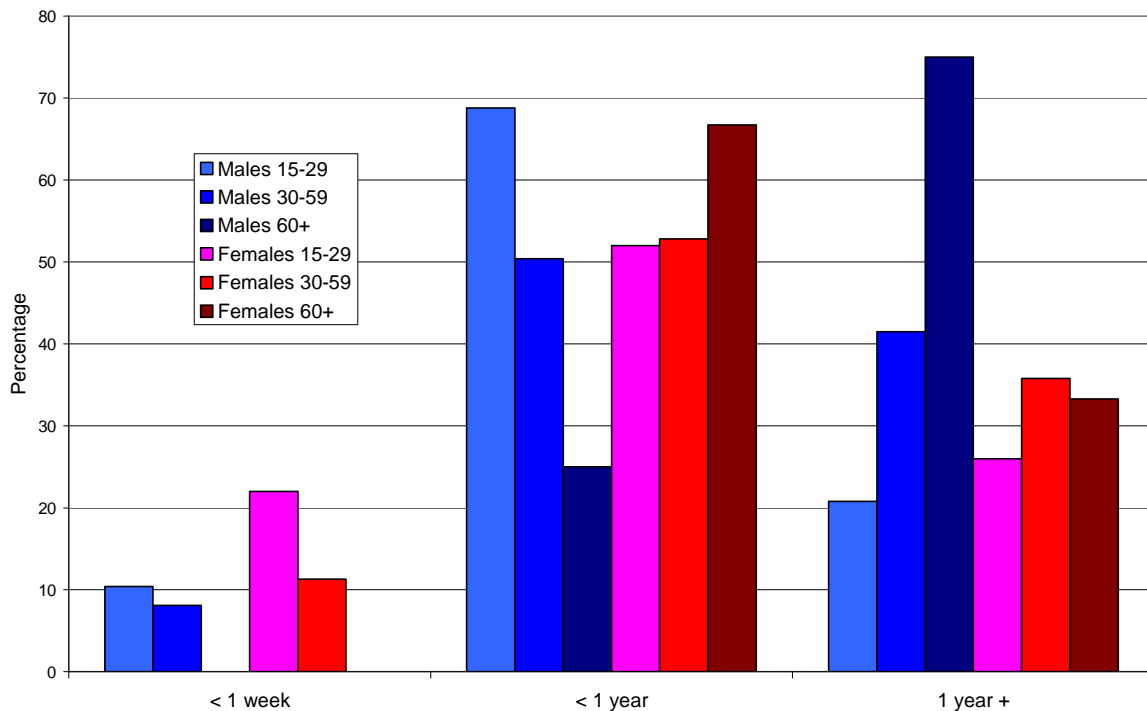
Compared to the general population quite high percentages of suicide attempters are unemployed: more than 20% of the young and middle-aged male suicide attempters and more than 10% of the young and middle aged female suicide attempters (figure 48). Furthermore in relation to the general population there is a quite high percentage of middle aged male (19%) and female (25%) suicide attempters, who is disabled, permanently sick or early retired because of sickness. Naturally older male and female suicide attempters are mainly retired (males: 80%, females: 75%).



**Figure 48:** Employment status



Within the group of unemployed suicide attempters up to 21% (young female suicide attempters) have only been unemployed very shortly (less than 1 week, figure 49). Depending on age and sex 50% and more – except for the older male suicide attempters - attempt suicide during the first year of unemployment. Taking together “very short” and “short” duration of unemployment it becomes obvious that the first year of unemployment seems to be a special risk time for attempting suicide, especially for females. For males unemployment still is a risk factor even if it lasts longer than a year. 20 to 40 % of all unemployed suicide attempters have been unemployed for more than one year – except for older male suicide attempters: here it is 75%.



**Figure 49:** Duration of unemployment



Among the young suicide attempters 33% of the young male and 30% of the young female suicide attempters were not raised within traditional families (figure 50). For the middle-aged and older suicide attempters this percentage varies between 25 and 16%). More than 20% of the young male and female suicide attempters and about 10% of the middle-aged and even less percent of the older suicide attempters were raised by single parents.

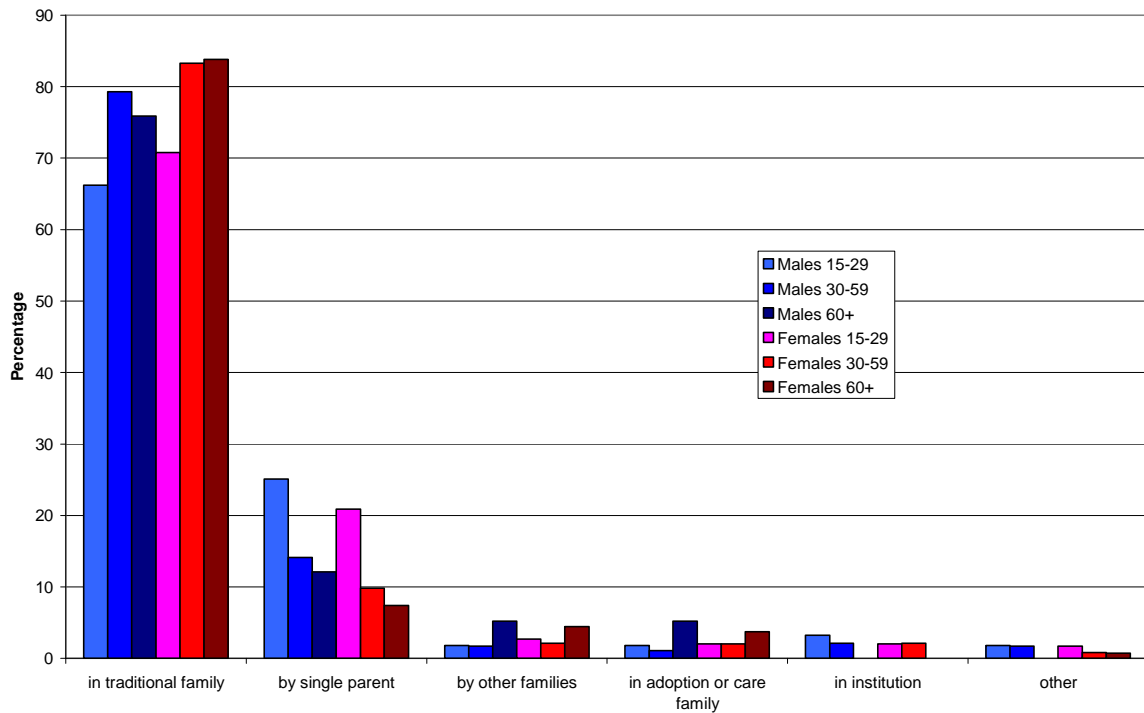
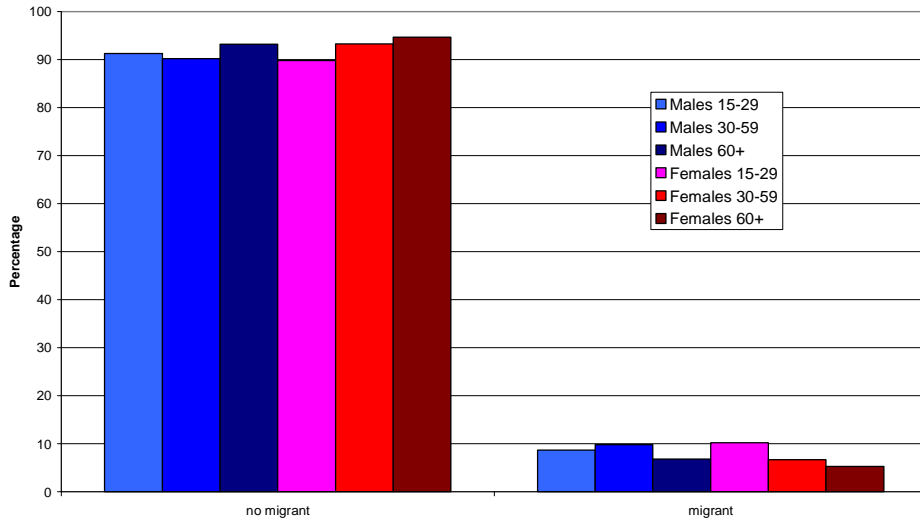


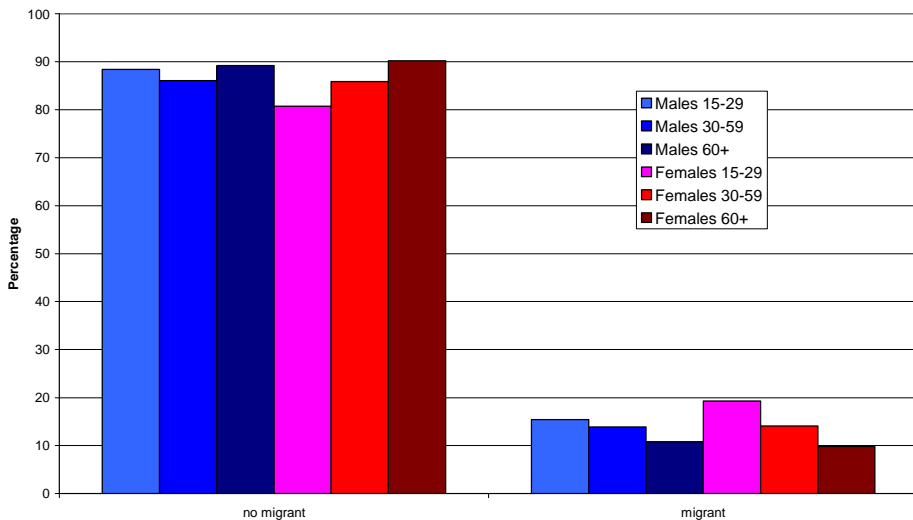
Figure 50: Brought up



About 90% of all suicide attempters are no migrants when looking at their own nationality (figure 51), but a considerable percentage does have migration background when looking at country of birth of parents (figure 52). The highest percentage here is found for young female suicide attempters (19%).



**Figure 51: Migration (1. Generation)**

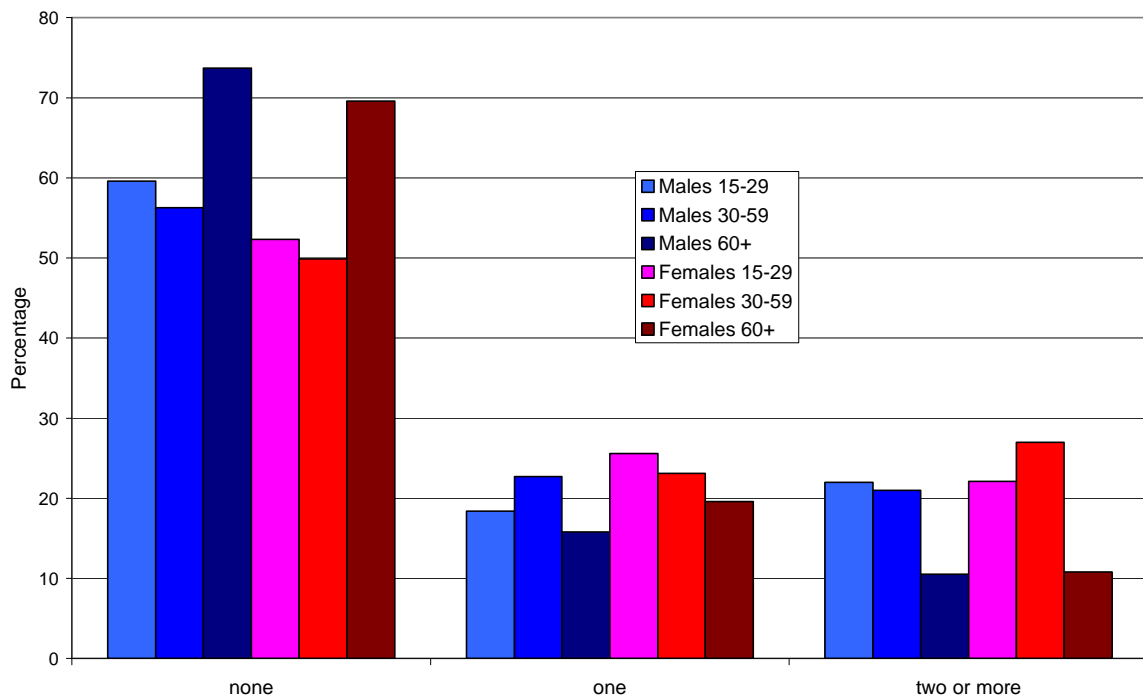


**Figure 52: Migration (2. Generation)**



#### 4.2.2.5 Cross-national analyses of repetition variables

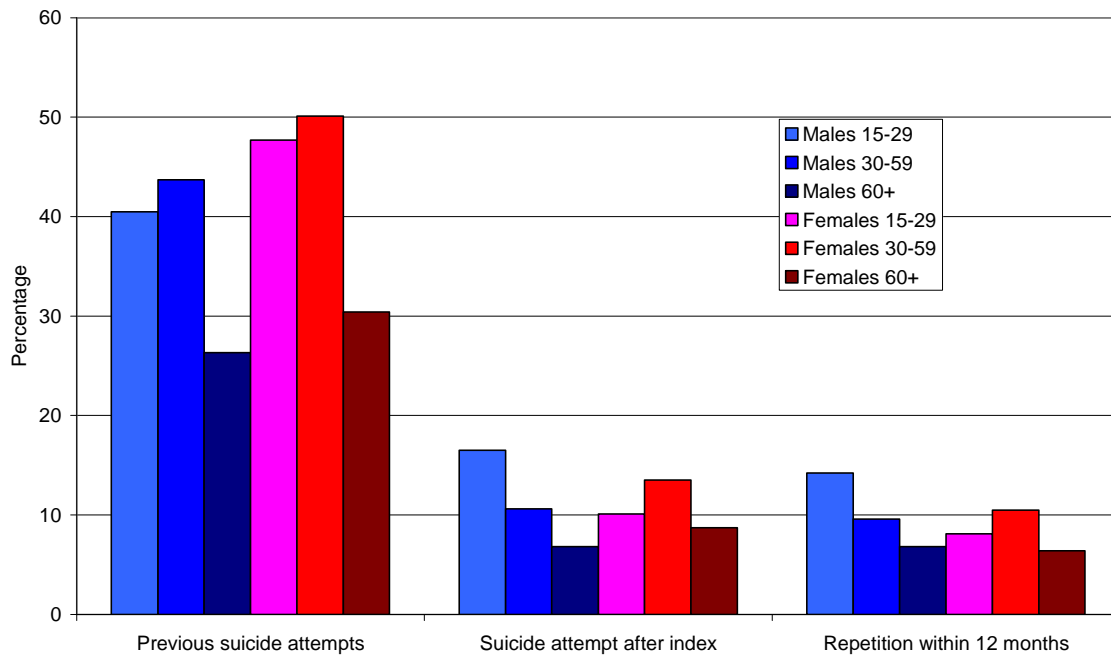
About 40% of all suicide attempters reported on previous suicide attempts prior to inclusion in the study (figure 53): 15 to 25% report on one prior attempt, 10 to 27% had two or more prior attempts. Older suicide attempters more frequently did not have any prior attempts (males: 73%, females: 70%) than younger suicide attempters (males: 60%, females 52%).



**Figure 53:** Number of previous attempts

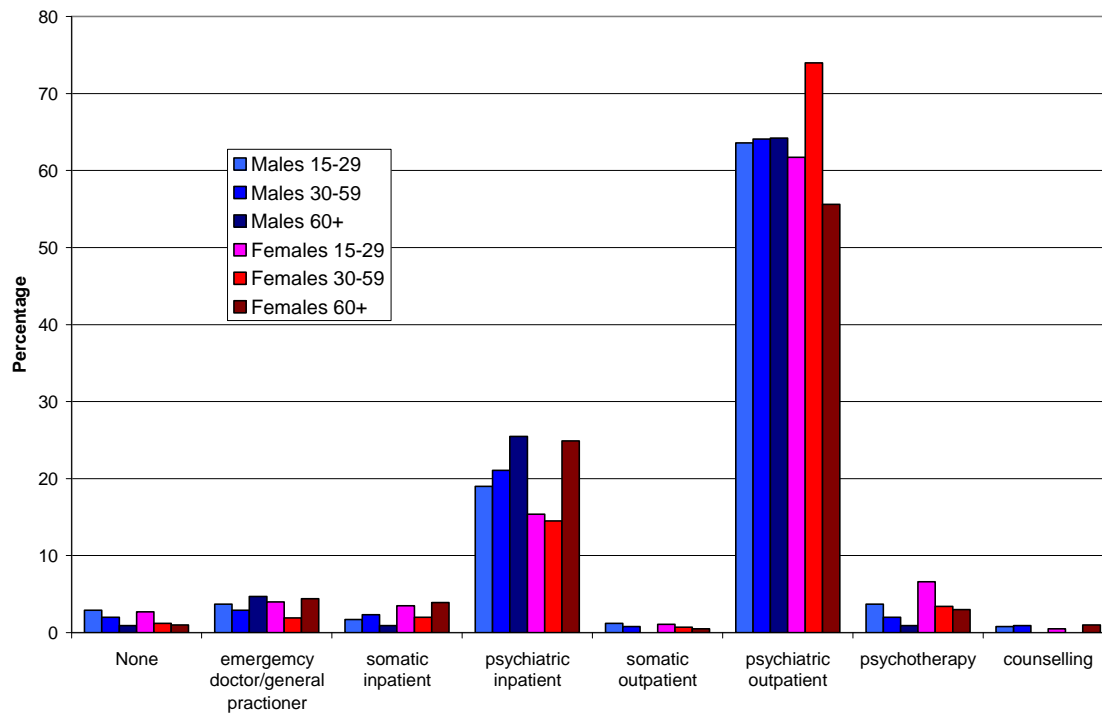


Six to 16 percent repeated a suicide attempt after inclusion in the study (figure 54; observation period varying between centres, 35 months at the longest), most of them within the first 12 months (6 to 14%).



**Figure 54:** Repetition frequency (in relation to Index-attempt)

After the suicide attempt the by far most recommended aftercare was psychiatric outpatient care (figure 55; 55 to 75%), followed by psychiatric inpatient care (15 to 25%). Psychotherapy was only recommended for 1 to 6% of all age- and sexgroups.



**Figure 55:** Recommended next care

## Summary of crossnational results

- More than half of all suicide attempters use soft poisoning as *method of suicide attempt*. About one third of the male suicide attempters uses hard methods like cutting, jumping and hanging. In female suicide attempters hard methods are used by less than one fifth. Mostly medication used for the suicide attempt was prescribed to the suicide attempter himself. Especially young female suicide attempters frequently use medication that was not prescribed (“over the counter medication”). Younger males and females also relatively often use medication prescribed for someone else.
- *Interpersonal conflicts* are the most frequent reason for attempting suicide, followed by mental health disturbances and in the older age groups physical illness. Suicide attempt is more frequently judged as a serious attempt in the older age groups, in the younger and middle-aged groups serious attempts are as frequent as parasuicidal gestures and pauses.
- Suicide attempts are mainly conducted at home, also public places are relevant especially in the younger age groups.
- Most frequent *psychiatric diagnoses* are affective and adjustment disorders, followed by substance abuse. Older suicide attempters more frequently are



diagnosed as suffering from affective disorders, whereas in the younger age groups adjustment disorders are more frequent.

- With regard to *sociodemographic variables* it can be shown that suicide attempters mostly have highschool or vocational level of education. Quite high percentages are unemployed – especially since less than 12 months, or disabled, permantly sick or early retired due to sickness. Elderly female suicide attempters mostly live alone, one third was not raised in a traditional family, about one fifth of the young female suicide attempters has migration background
- About 40% of all suicide attempters reported on prior attempts, *repetition* was mainly conducted within 12 months after prior attempt. Recommended aftercare was mainly psychiatric in- and outpatient care.

#### 4.2.3 Country-specific analyses

Distribution of age- and sex groups is shown in figure 56. Suicide attempts are more common in females and younger age groups through all centres.

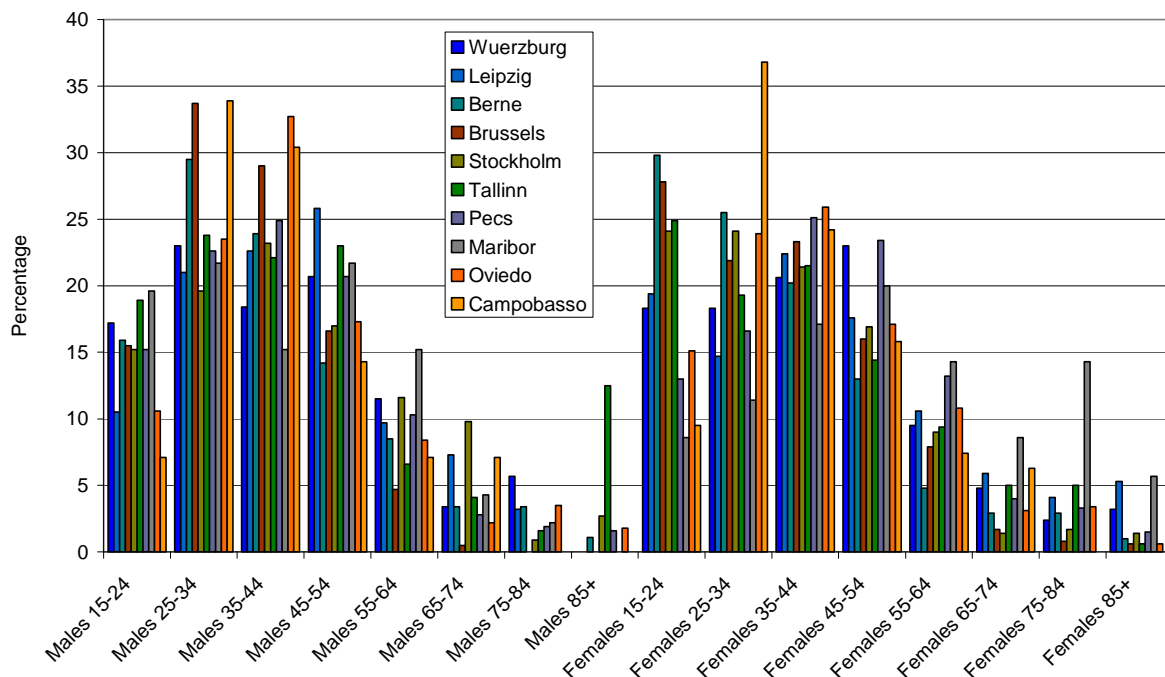


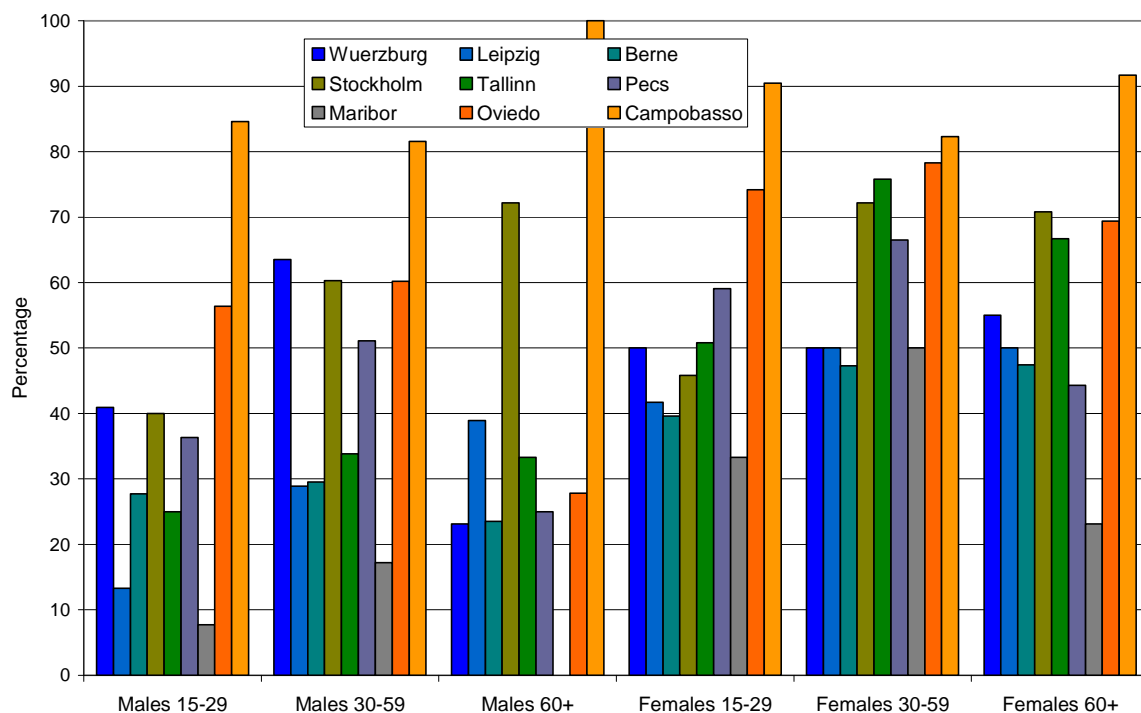
Figure 56: Age groups





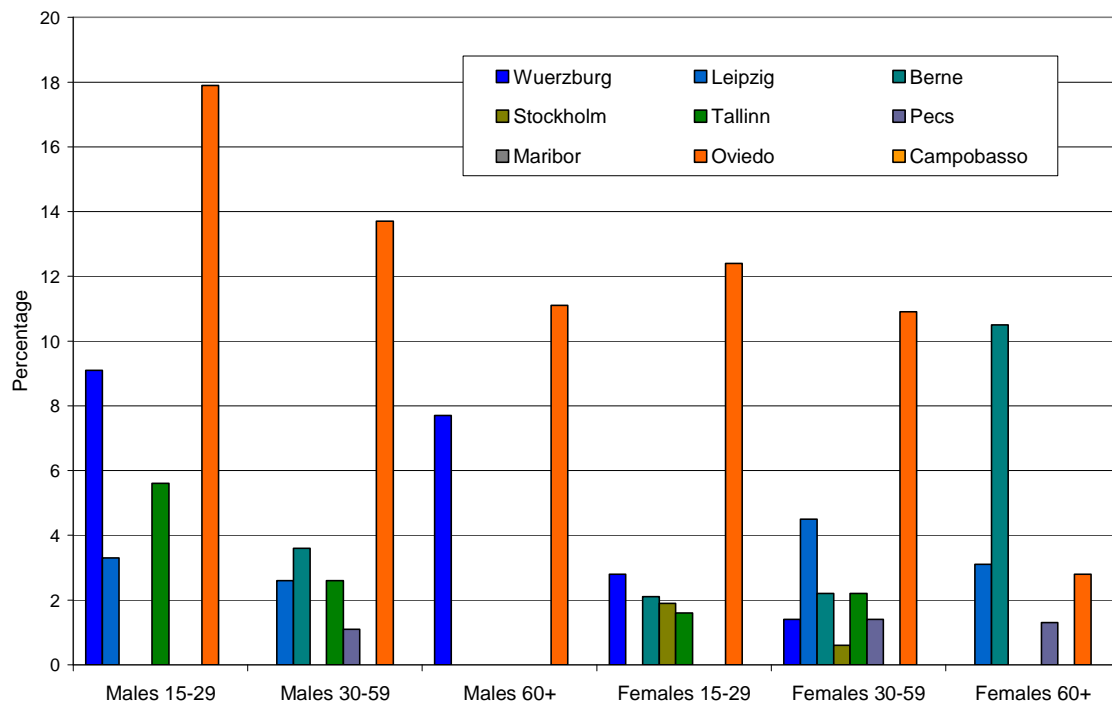
#### 4.2.3.1 Country-specific analyses of methods

Use of sedative drugs as method of suicide attempt varies a lot between centres (figure 57). Highest percentages (up to 100% in elder male suicide attempters) are found in Campobasso; lowest (0% in elder males to 50% in middle-aged females) are found in Maribor.



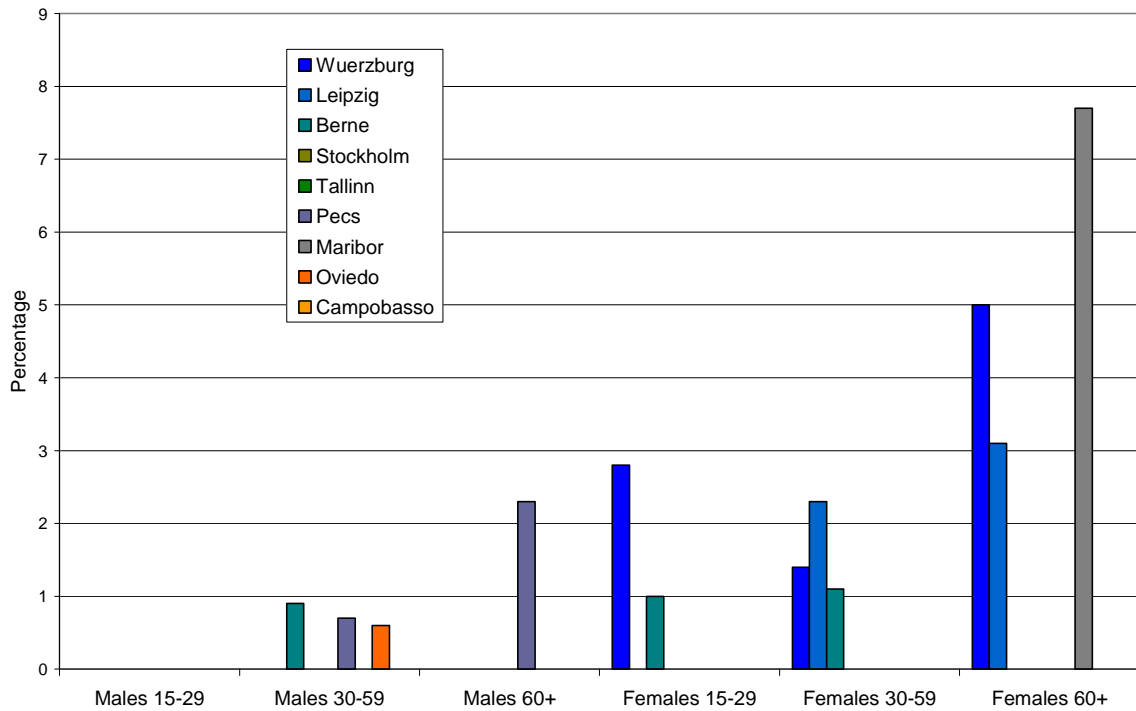
**Figure 57:** Intoxication with sedative drugs as suicide attempt method

Alcohol intoxication as method of suicide attempt is used in 0 to 18% of all sex- and age groups (figure 58). Most frequently it is used in Oviedo, but also more than 10% of the older female suicide attempters in Berne use alcohol as method of suicide attempt.



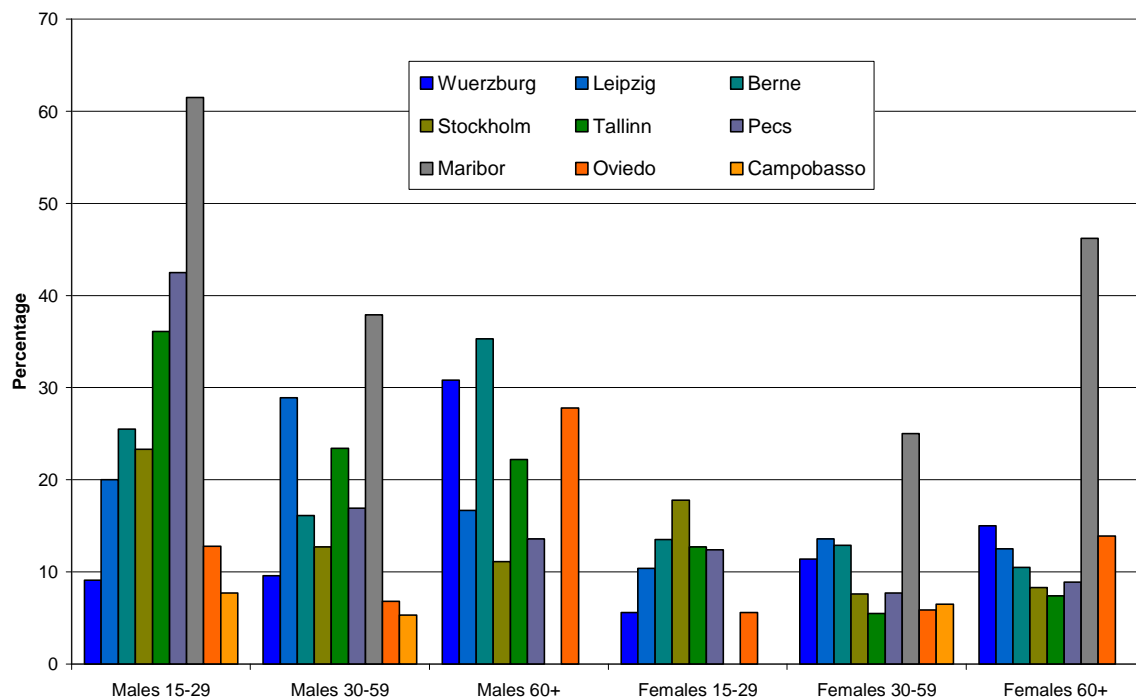
**Figure 58:** Alcohol as method of suicide attempt

Pesticides are only in some centres relevant as a method for suicide attempt. Especially in elder females in Maribor (8%), Wuerzburg (5%) and Leipzig (3%) this method is used (figure 59).



**Figure 59:** Pesticides as method of suicide attempt

Cutting as method of suicide attempt is more frequent in males than in females (figure 60). Highest percentages are found in Maribor (up to 62% in young male suicide attempters and 45% of the older female suicide attempters); lowest are found in Campobasso (less than 10%).

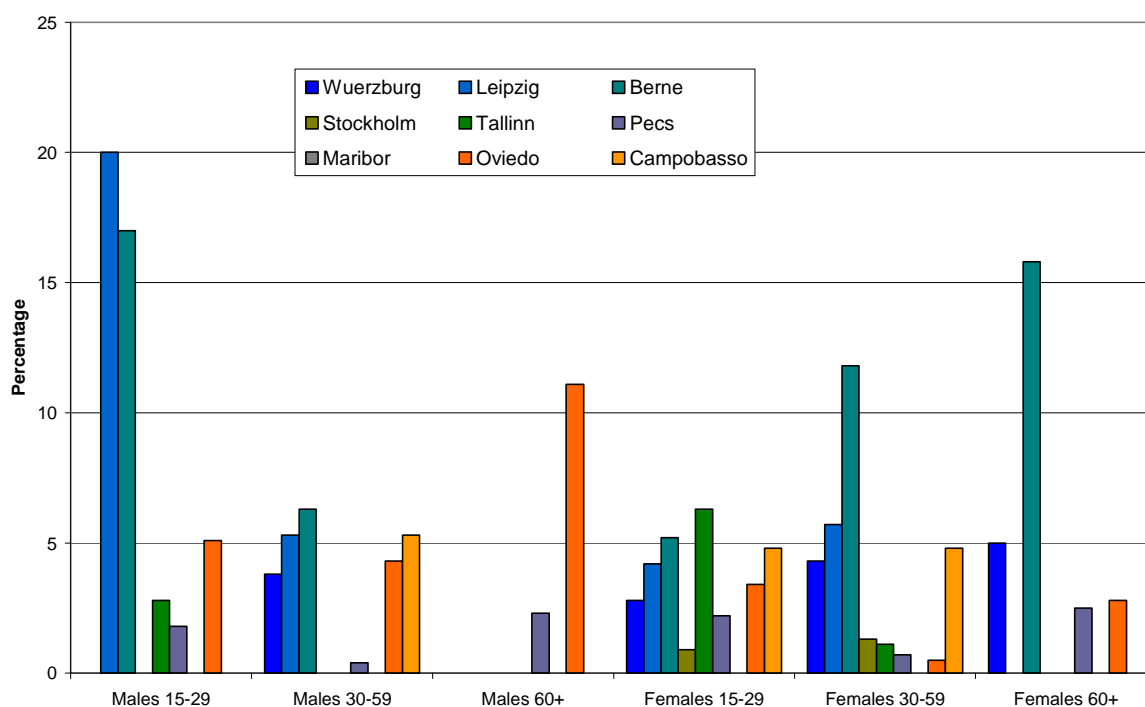


**Figure 60:** Cutting as method of suicide attempt



Shooting as a suicide attempt method is rather rare (highest percentage 1,3% within the group of middle-aged males), since it has usually a lethal outcome and therefore is much more frequent in completed suicides.

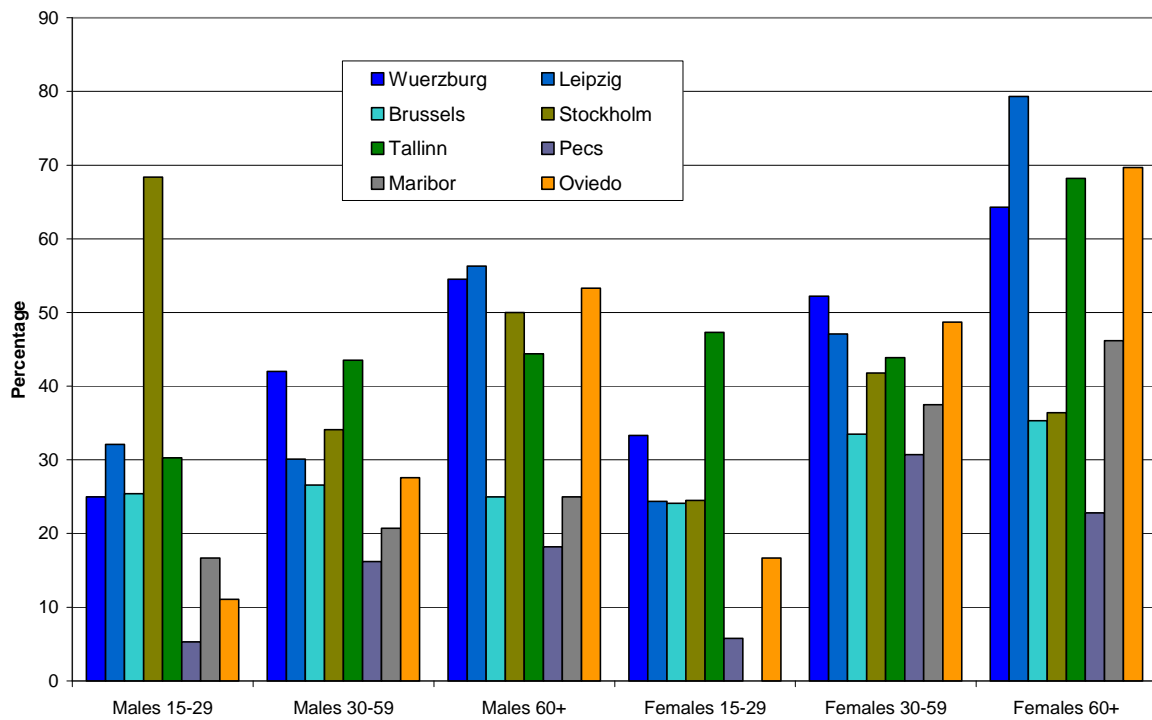
For jumping as method of suicide attempt percentages vary between 0 and 20% between the centres (figure 61). Highest percentage is found in Leipzig for young males (20%). In Berne jumping is also quite frequent (17% in young male suicide attempters and 16% in older female suicide attempters). In Leipzig the so-called Battle of the Nations Monument could be identified as hot spot for jumping.



**Figure 61:** Jumping as method of suicide attempt

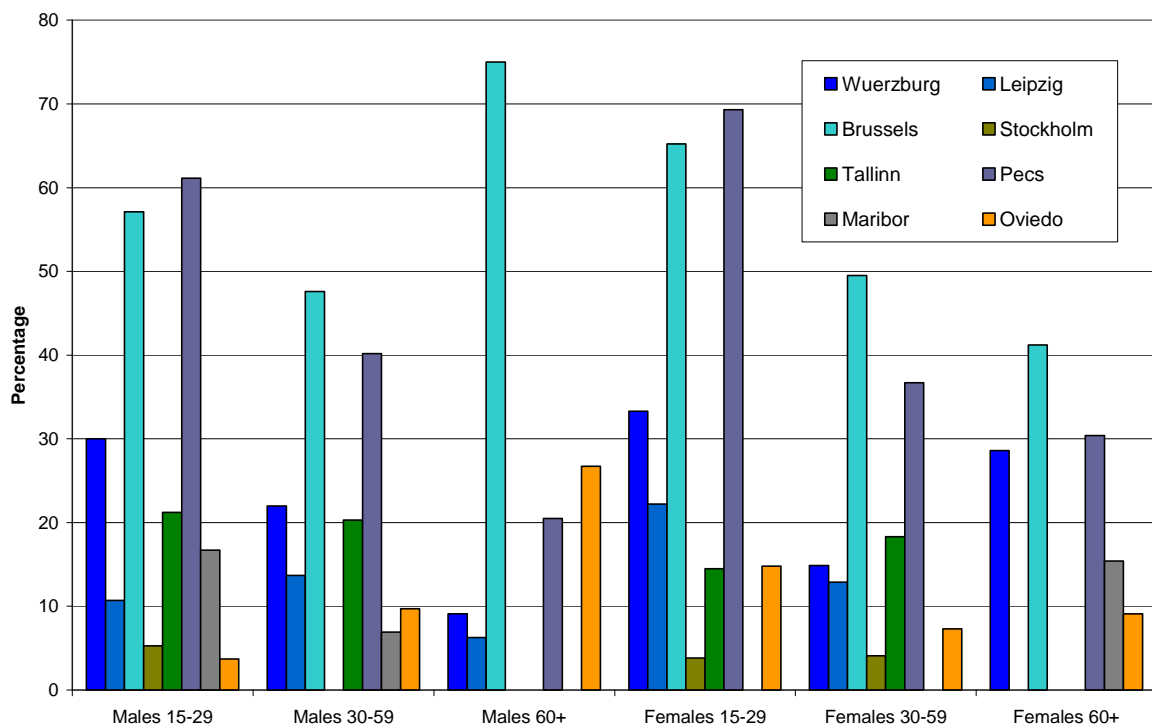
#### 4.2.3.2 Country-specific analyses of psychiatric diagnoses

Affective disorders are most commonly diagnosed in middle-aged and older female suicide attempters (figure 62), highest percentage is found in Leipzig (almost 80%), lowest is found in Pecs (22%). Over all centres the lowest percentages of affective disorders are found in Pecs and Brussels, the highest in Wuerzburg, Leipzig, Tallinn and Stockholm.



**Figure 62:** Affective disorders as psychiatric diagnosis in suicide attempters

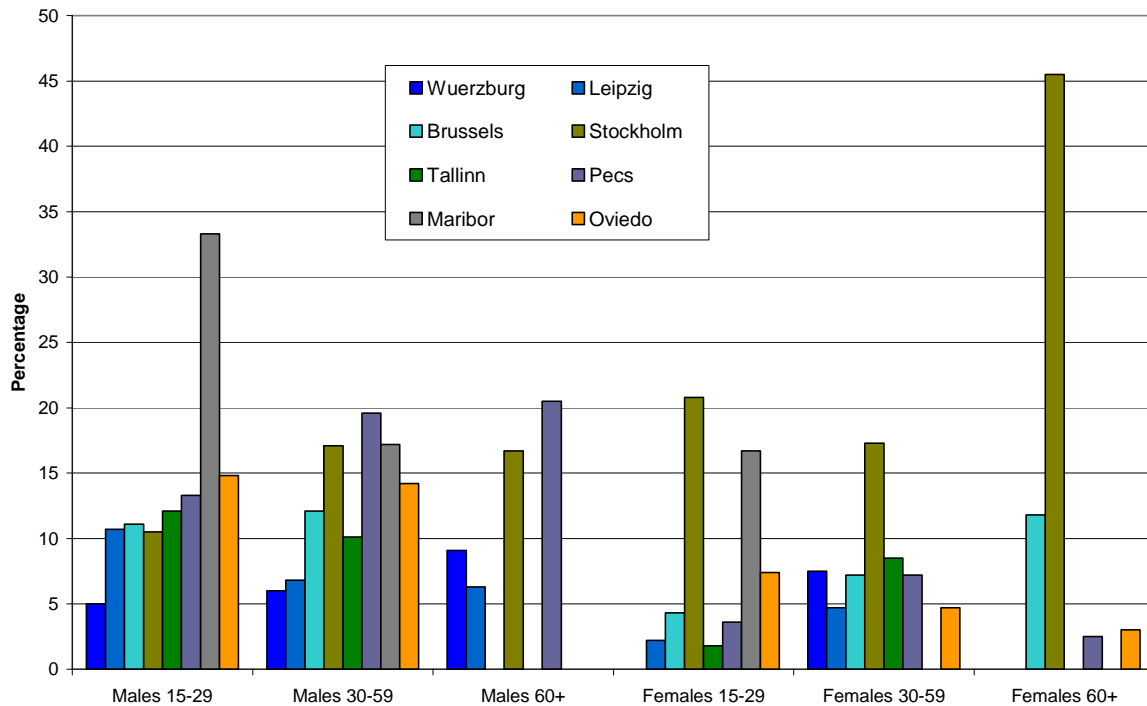
In contrast, diagnosis of adjustment disorders (figure 63) is most common in Brussels (up to 75%) and Pecs (up to 70%). In Stockholm, Maribor and Oviedo adjustment disorders are diagnosed less frequently.



**Figure 63:** Adjustment disorders as psychiatric diagnosis in suicide attempters



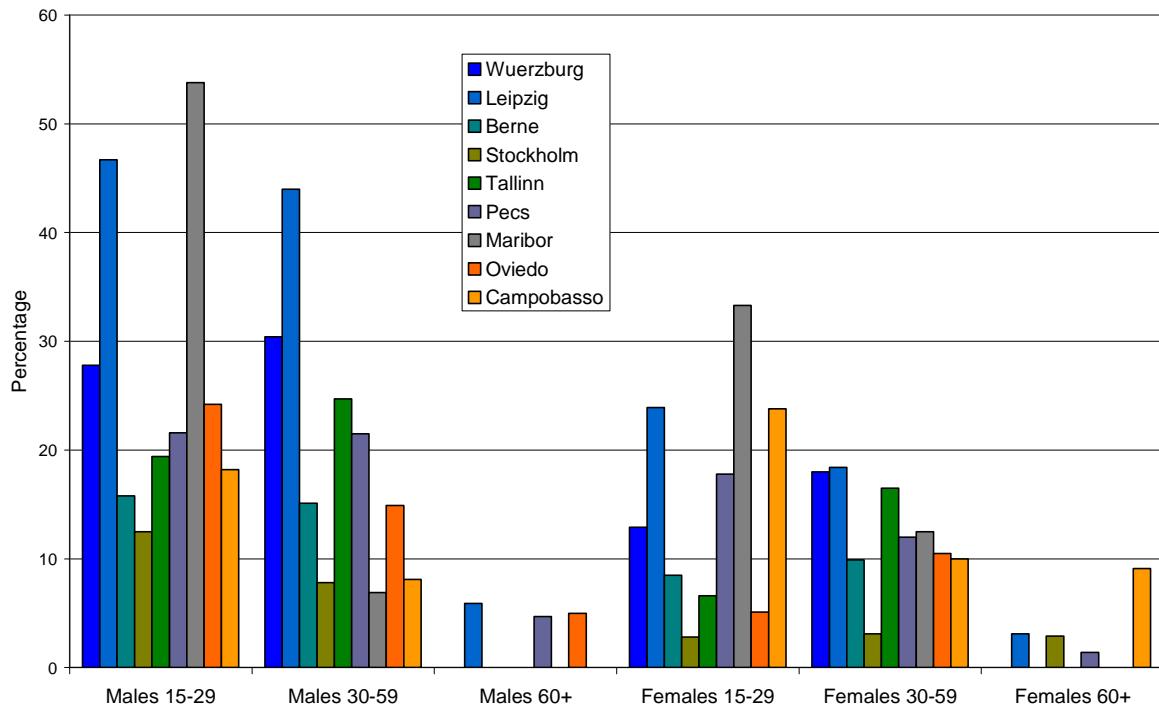
Substance-related disorders (figure 64) are by far most frequently diagnosed in older female suicide attempters in Stockholm (45%) and younger males in Maribor (33%). Rather low percentages are found in the two German centres, the Belgian centre, the Estonian and the Spanish centre.



**Figure 64:** Substance-related disorders as psychiatric diagnosis in suicide attempters

#### 4.2.3.3 Country-specific analyses of sociodemographic variables

The percentual amount of unemployed persons within suicide attempters has been shown to be quite high (see figure 48). The percentages differ a lot between the centres (figure 65). They are highest in Maribor (young males: 54%) and Leipzig (young males: 47%, middle-aged males: 44%). Lowest percentages are found for Stockholm. For older suicide attempters the percentages naturally are low. For all centres unemployment is higher in males and the younger age-groups and it is higher than unemployment rates stated by the centres in table 21. Naturally unemployment is low in the older age groups.



**Figure 65:** Percentage of unemployed persons

Percentual amounts of migrants (1. generation) within suicide attempters differ considerably between the centres (figure 66), which can be explained by the different percentages of migrants in the individual centres (see table 14). The percentage of migrants within suicide attempters is particularly high in Tallinn. This is explained by the high percentage of Russians, Ukrainians, and other ethnicities in this centre. The percentage of migrants within suicide attempters in general is comparable in size with the percentage of migrants in the general population.

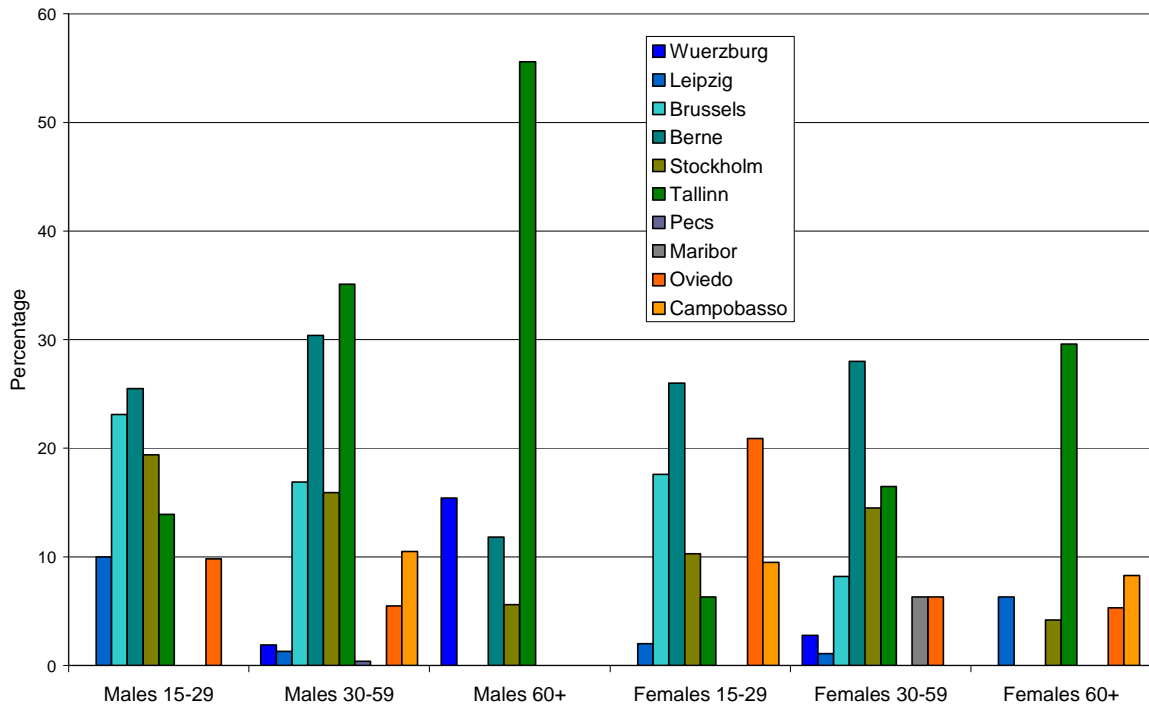


Figure 66: Percentages of migrants (1. generation)

Percentual amounts of migrants (2. generation) are shown in figure 67.

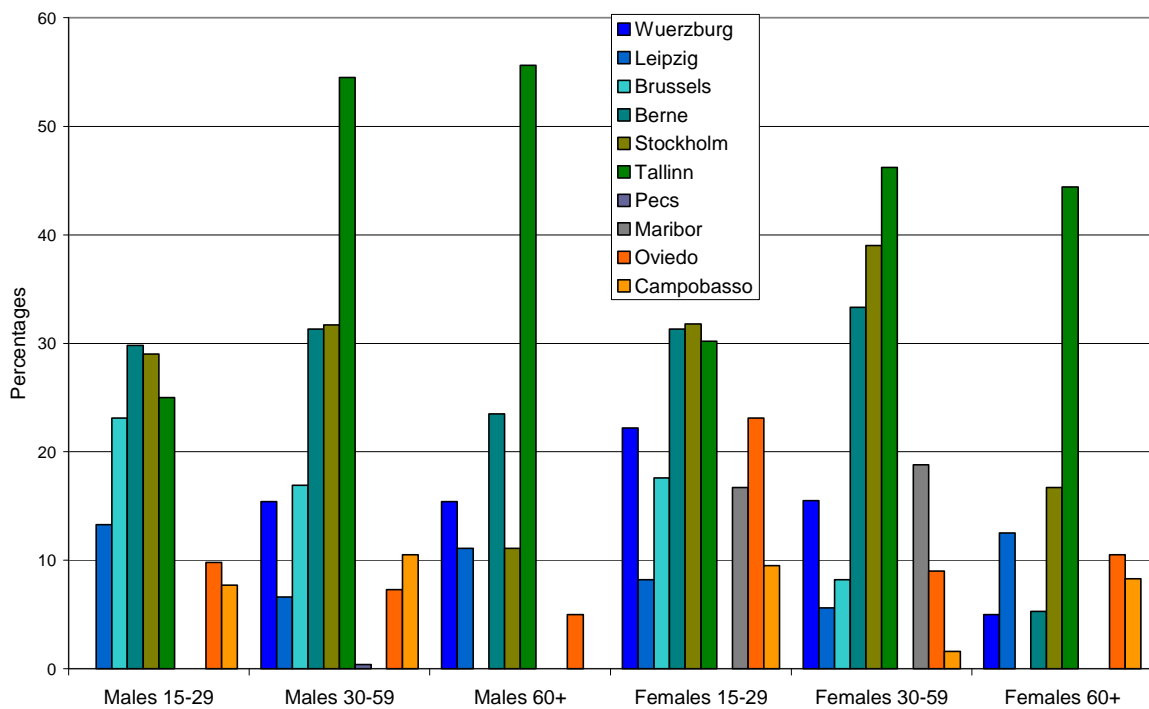


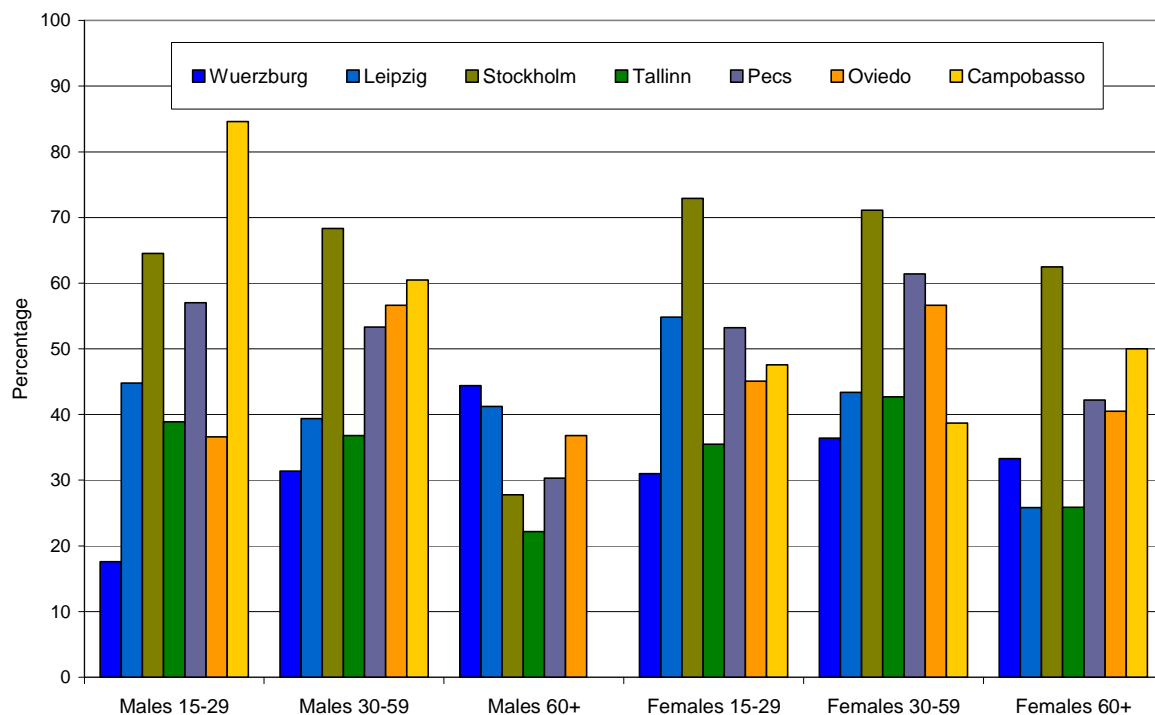
Figure 67: Percentages of migrants (2. generation)





#### 4.2.3.4 Country-specific analyses of repetition variables

The repetition rate takes into account all attempts conducted prior or after the index attempt (inclusion into the study). Striking differences are found between the centres (figure 68): it is especially high in Stockholm (65-72%) – through all age and sex groups, except for elderly males – and in Campobasso for young males (85%). Lowest repetition rate is found for young males in Wuerzburg (18%).



**Figure 68:** Repetition rate



## Summary of country-specific results

- With regard to *method of suicide attempt* there are marked differences between the centres: use of sedative drugs is frequently observed in Campobasso and least frequently in Maribor. Alcohol as method is often registered in Oviedo, but also in Berne and Wuerzburg. Pesticides are not used frequently as a method, only in elderly females in Maribor and in the two German centres. Cutting is used more frequently by males than by females, highest percentages are found in Maribor, lowest in Campobasso. Jumping is mostly found in Leipzig and Berne, probably due to jumping hot spots in these regions.
- Affective disorders are the most frequent *psychiatric diagnosis* in Wuerzburg, Leipzig, Tallinn and Stockholm and least frequently diagnosed in Pecs and Brussels. At the same time adjustment disorders are most common in Brussels and Pecs, whereas they are not diagnosed frequently in Stockholm, Maribor and Oviedo. Substance-related disorders are most frequently diagnosed in Stockholm and Maribor and least frequently diagnosed in Wuerzburg, Leipzig, Brussels, Tallinn and Oviedo.
- Unemployment is higher within young and middle-aged male suicide attempters than in the general population. It is especially high in Maribor and Leipzig.
- Percentage of migrants is not higher within suicide attempters than in the general population of the centres.
- *Repetition rate* is quite high in Stockholm and Campobasso and relatively low in Wuerzburg.



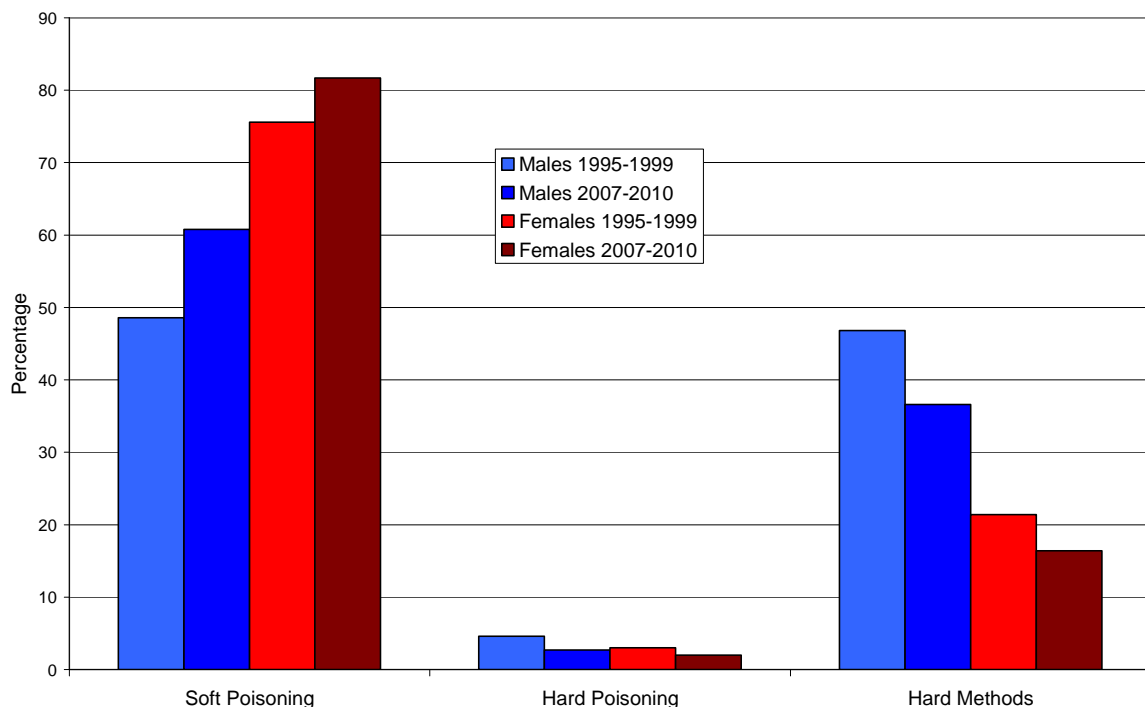
#### 4.2.4 Longitudinal analyses

Results of MONSUE can be compared to the results of the WHO/EURO Multicentre Study on Suicidal Behaviour with regard to some centres and variables.

##### 4.2.4.1 Longitudinal analysis over 12 years

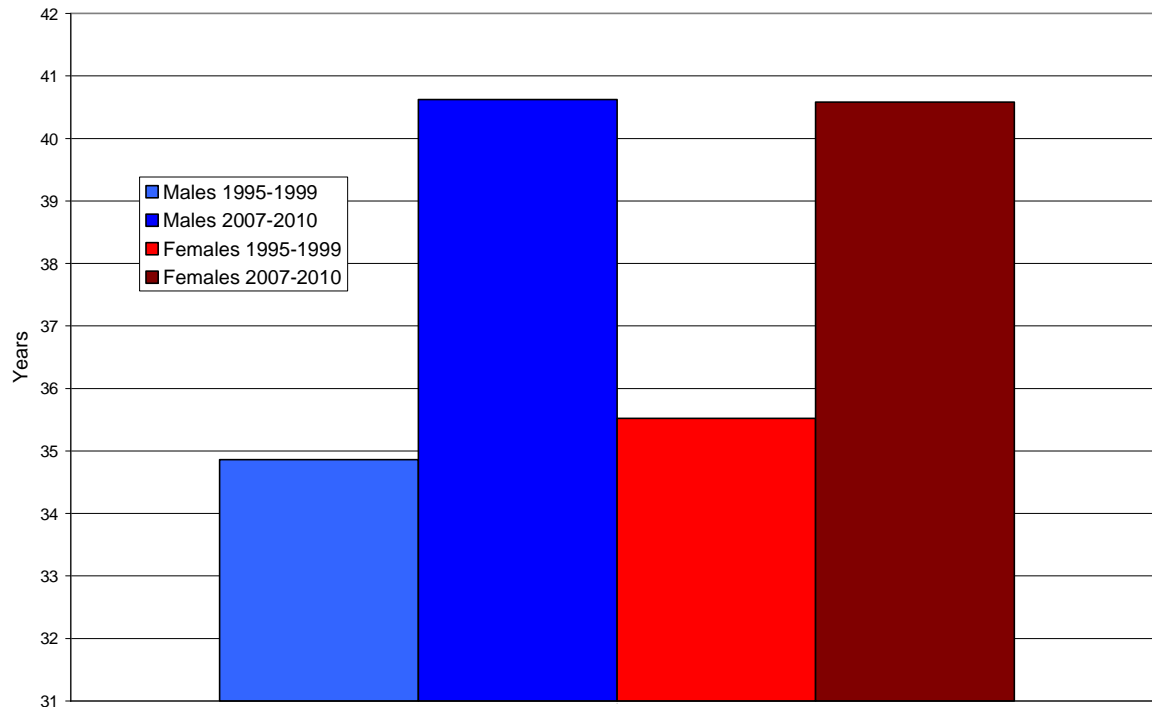
For the years 1995 to 1999 it is possible to compare a sample of 5416 persons collected in Berne (N=484), Pecs (N=567), Stockholm (N=974), Tallinn (N=2748) and Wuerzburg (N=643) to the MONSUE data of these centres.

With regard to methods of suicide attempt (figure 69) a marked increase is found for soft poisoning (males: 12% increase; females: 6% increase). In contrast, hard methods are decreasing.



**Figure 69:** Method of suicide attempt compared for two time periods (1995-1999 to 2007-2010)

Mean age of suicide attempters (figure 70) is increasing over time: for males it was 34,86 years in 1995 to 1999 and 40,62 years in 2007 to 2010; for females it was 35,52 years in 1995 to 1999 and 40,58 years in 2007 to 2010 (increase in males and females: 5 years)

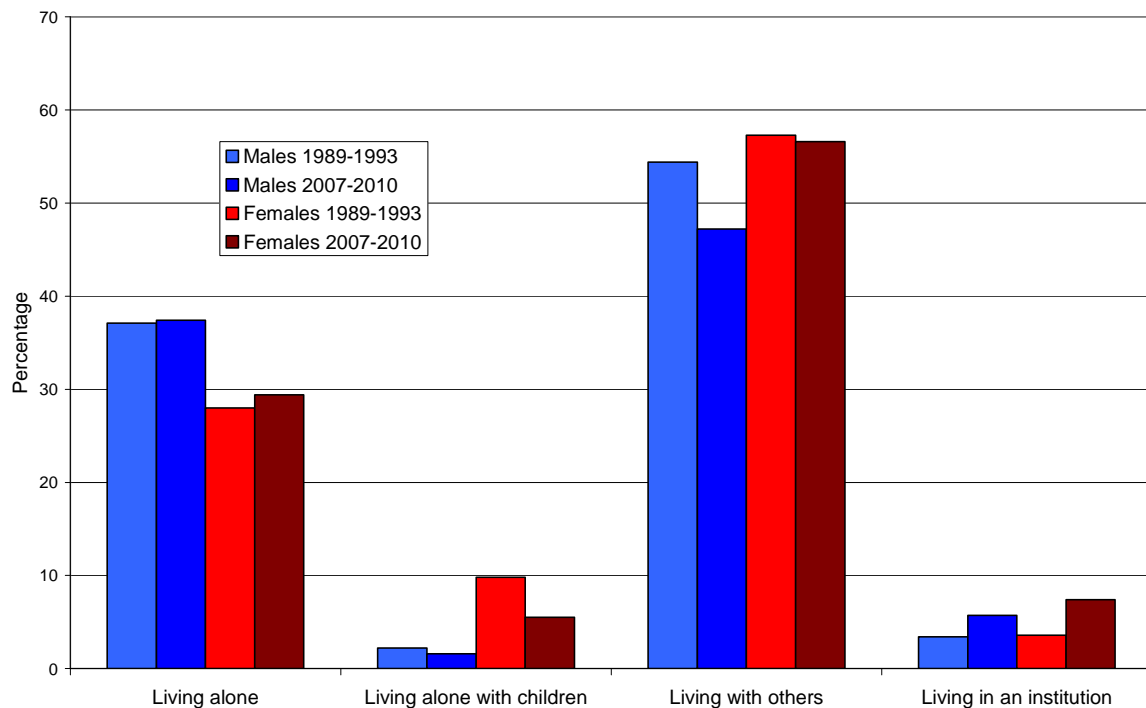


**Figure 70:** mean age of male and female suicide attempters compared for two time periods (1995-1999 to 2007-2010)

#### ***4.2.4.2 Longitudinal analysis over 18 years***

For the years 1989 to 1993 it is possible to compare a sample of 2923 persons collected in Berne (N=794), Stockholm (N=1480) and Wuerzburg (N=649) to the sample analysed within MONSUE.

Compared to 1989 to 1993 during the MONSUE period clearly more female suicide attempters are living in institutions (figure 71).



**Figure 71:** Usual household composition compared for two time periods (1989-1993 to 2007-2010)

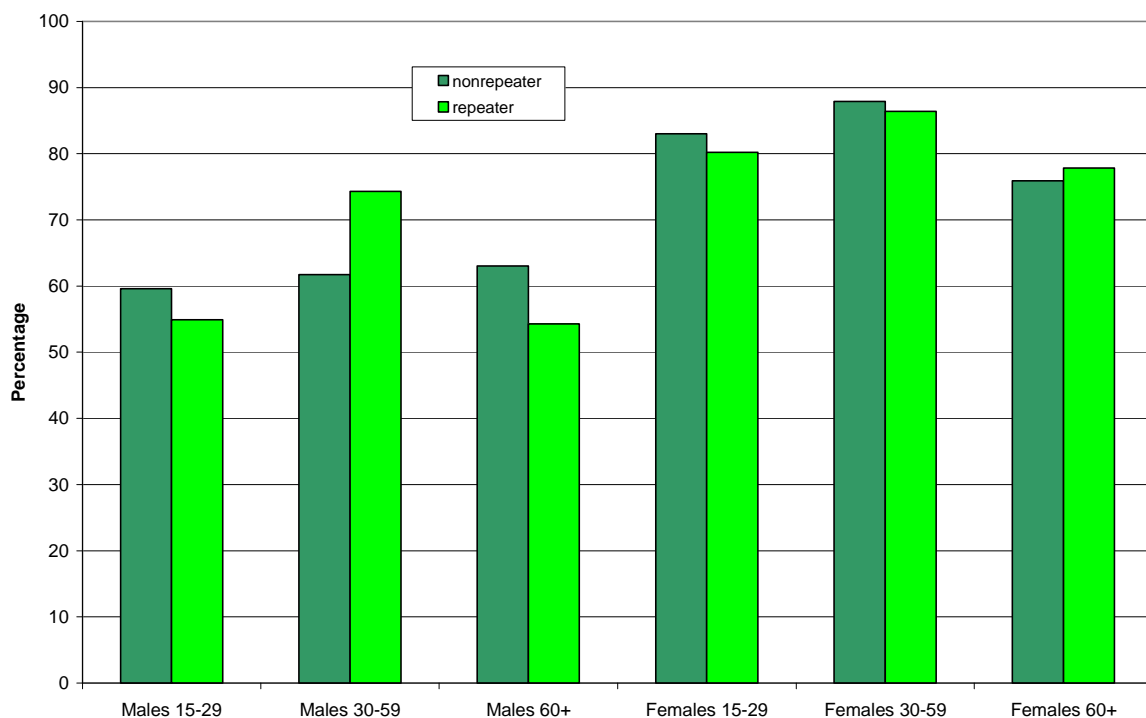
### Summary of longitudinal results

- With regard to *method of suicide attempt* a considerable increase of soft poisoning and decrease of hard methods is found over the last 10 years.
- Mean age is increasing over time: male and female suicide attempters today are about five years older than they used to be 10 years ago.
- Nowadays more female suicide attempters live in institutions than 20 years ago.

## 4.2.5 Risk groups for repetition

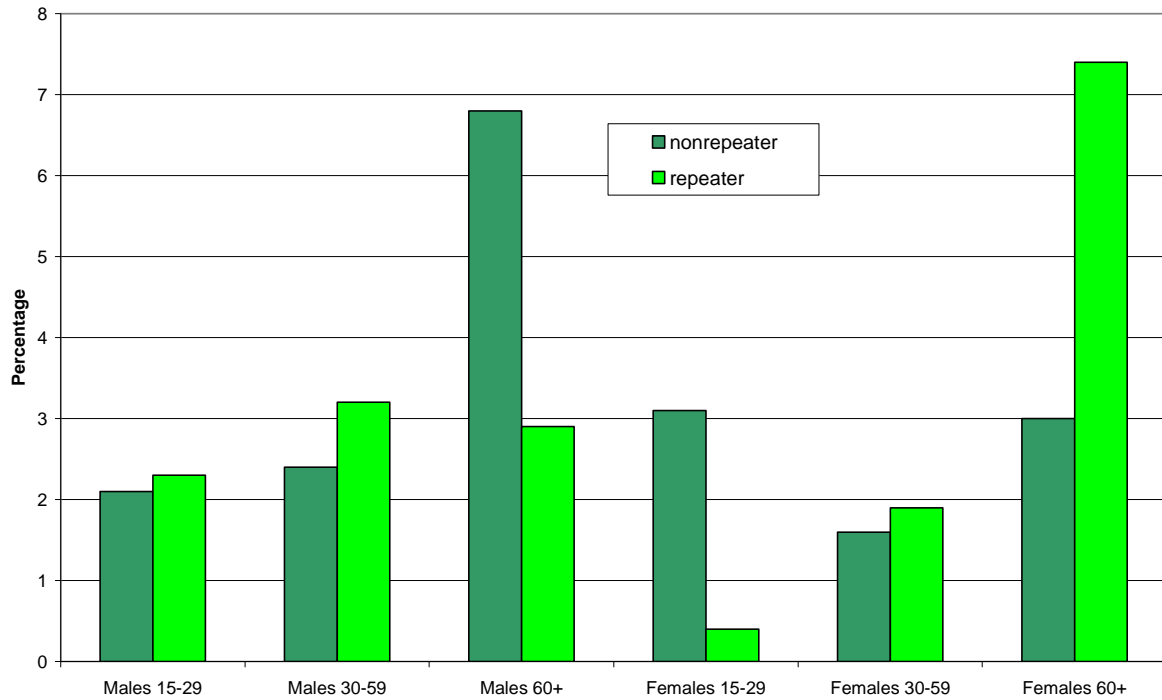
### 4.2.5.1 Identification of special risk groups for repetition on the basis of specific methods used in the first suicide attempt

Nonrepeaters and repeaters do not differ significantly with regard to the frequency of the use of soft poisoning for the first suicide attempt (figure 72), except for middle aged males: here repeaters (74%) more frequently use soft methods than nonrepeaters (61%).



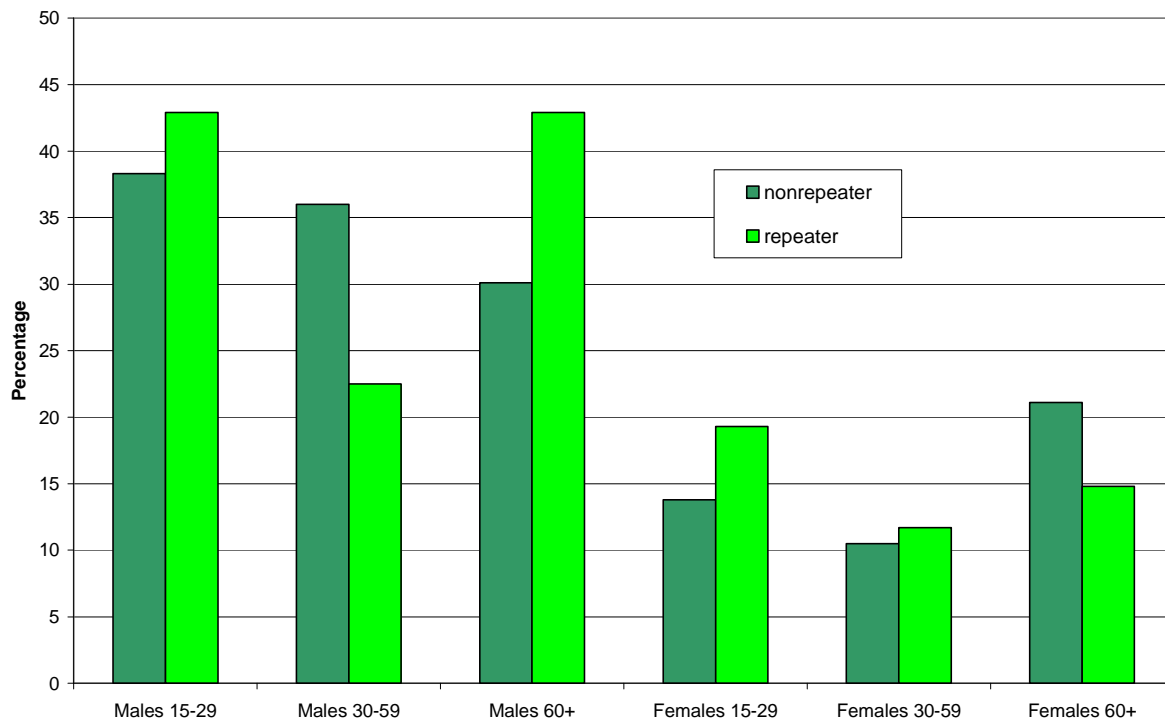
**Figure 72:** Soft poisoning as method of first suicide attempt

Older male nonrepeaters more frequently use hard poisoning (figure 73) as a method of first suicide attempt (7%) than repeaters (3%); whereas in older females it is the other way round (nonrepeaters: 3%; repeaters: 7%).



**Figure 73:** Hard poisoning as method of first suicide attempt

Hard methods as method of first suicide attempt (figure 74) are more frequently used in male repeaters (young and older male repeaters: 43%) than in nonrepeaters (young male nonrepeaters: 38%; older male nonrepeaters: 30%).

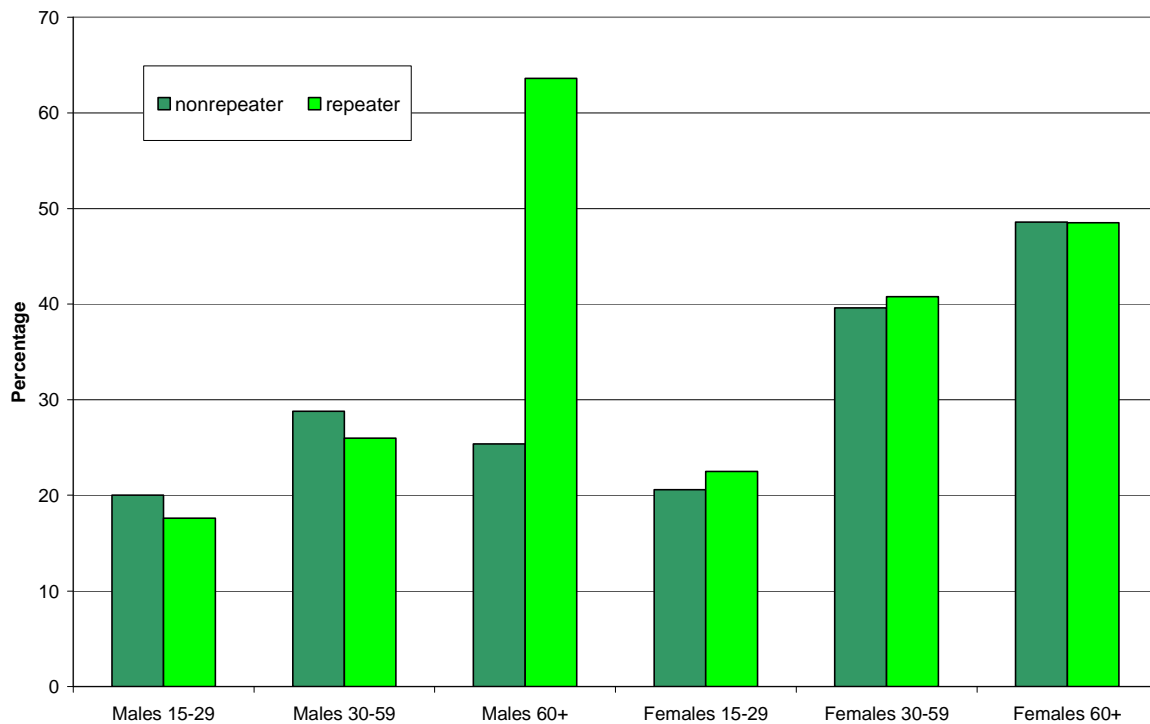


**Figure 74:** Hard methods as method of first suicide attempt



#### 4.2.5.2 Specific psychiatric disorders as risk factors for the repetition of a suicide attempt

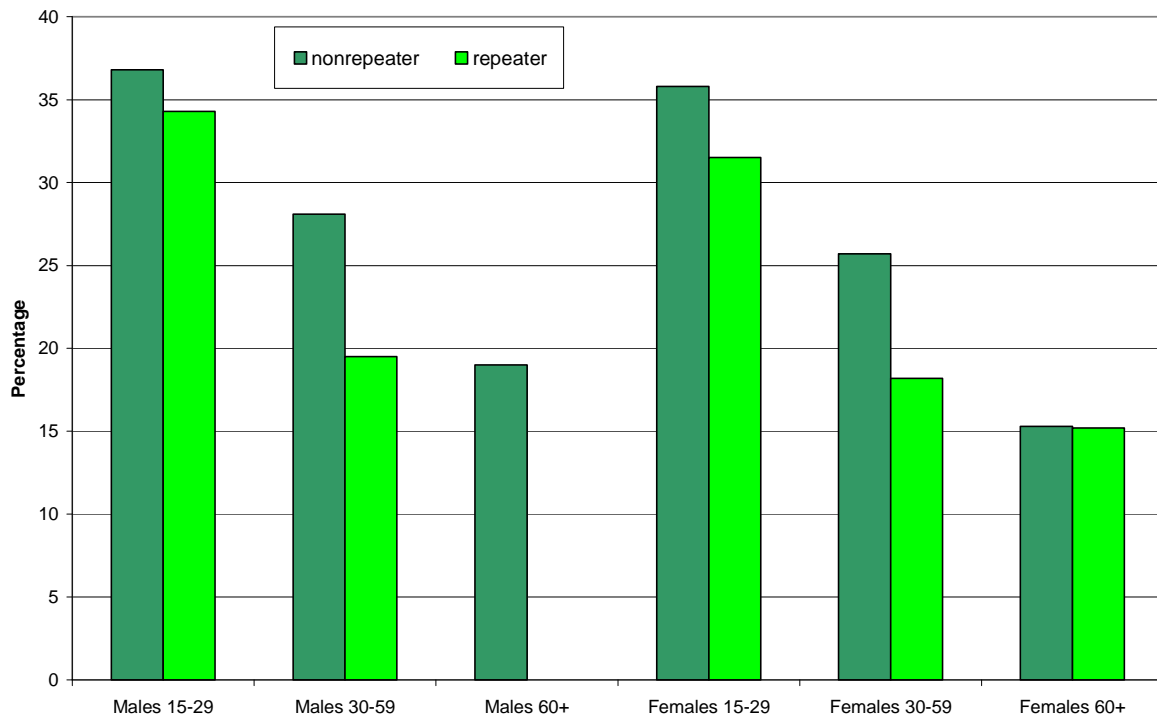
Affective disorders (figure 75) are most frequently diagnosed in older male repeaters (64%), which differs significantly from the older male nonrepeaters (25%).



**Figure 75:** Affective disorders as psychiatric diagnosis in nonrepeaters and repeaters

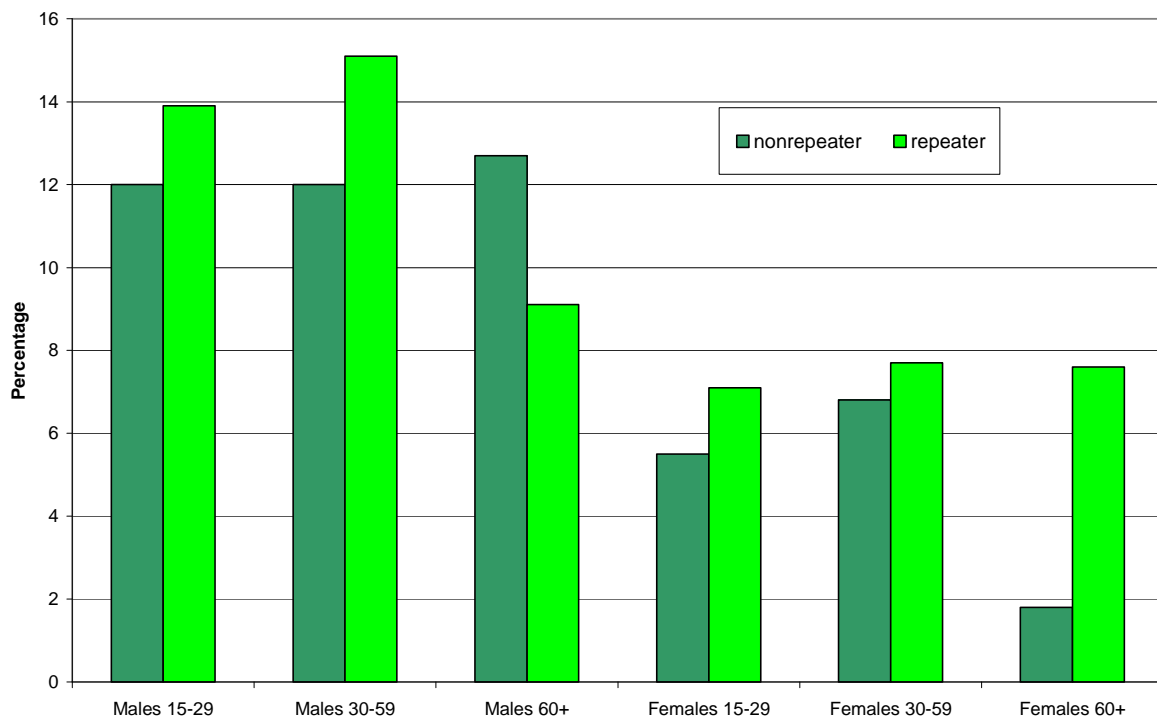
In contrast adjustment disorders (figure 76) are not diagnosed at all in older male repeaters, which differs significantly from older male nonrepeaters (19%).





**Figure 76:** Adjustment disorders as psychiatric diagnosis in nonrepeaters and repeaters

With regard to substance-related disorders (figure 77) there are no significant differences between repeaters and nonrepeaters.

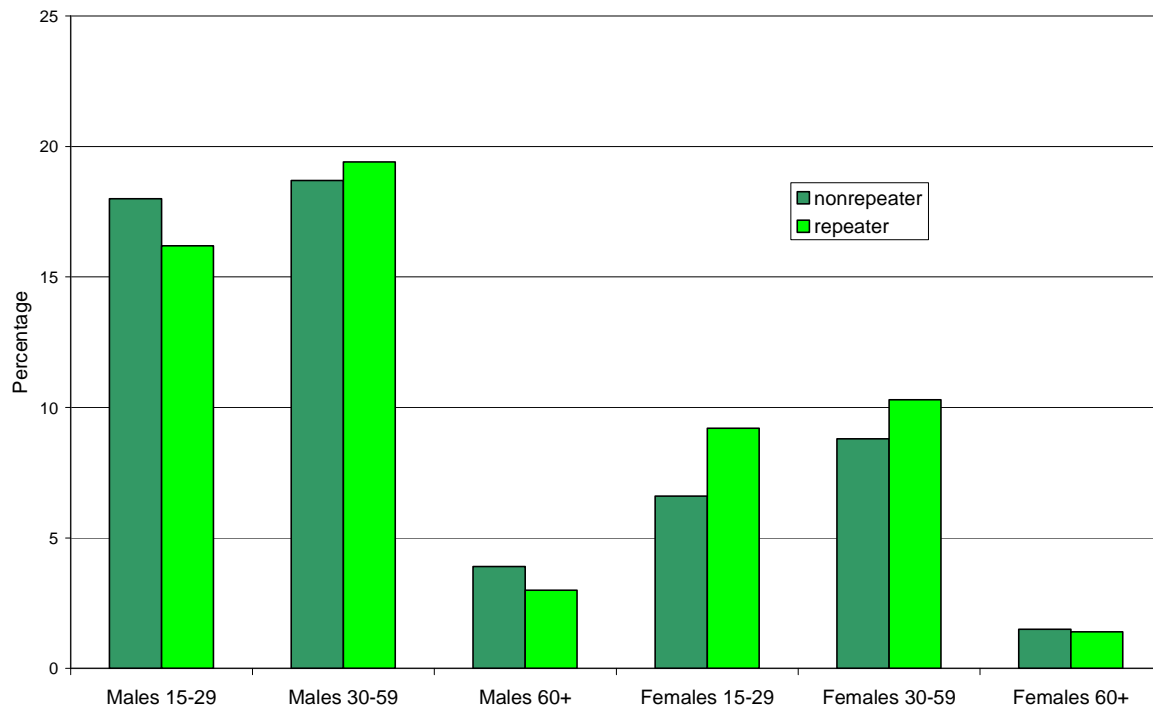


**Figure 77:** Substance-related disorders as psychiatric diagnosis in nonrepeaters and repeaters



#### 4.2.5.3 Sociodemographic variables as risk factors for the repetition of a suicide attempt

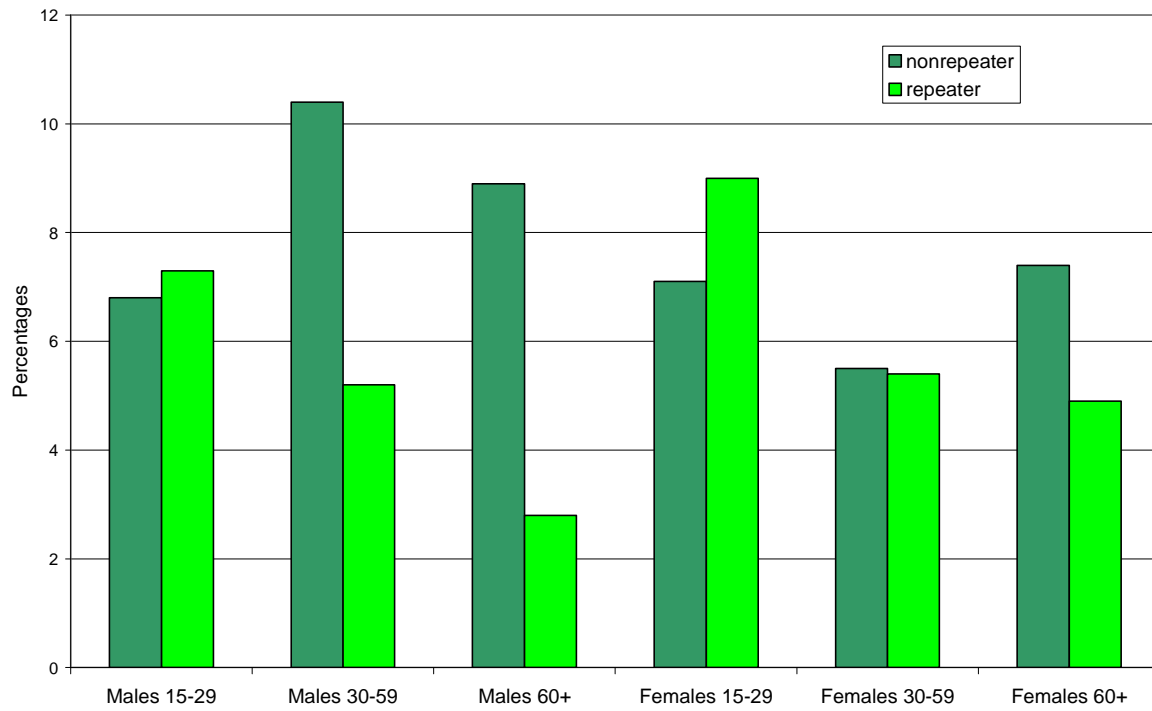
Nonrepeaters and repeaters do not differ with regard to unemployment (figure 78).



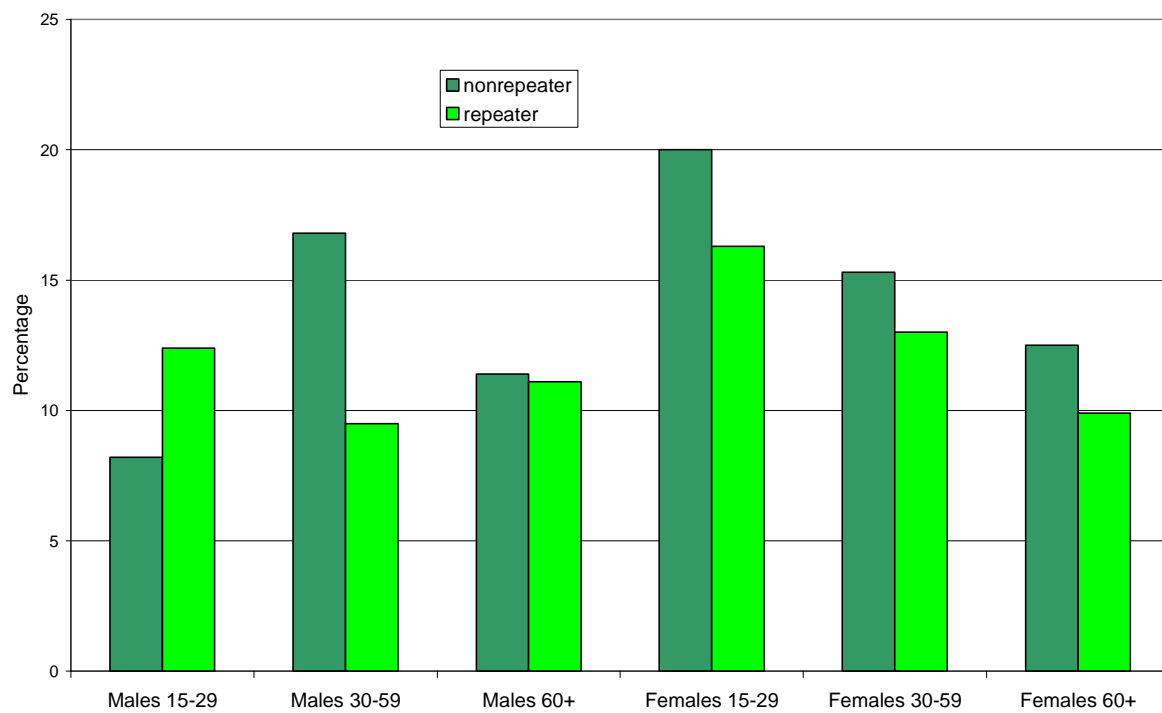
**Figure 78:** Frequency of unemployment of nonrepeaters and repeaters

Nonrepeaters and repeaters differ with regard to the percentual amount of migrants (1st generation; figure 79): for middle-aged males the percentage of migrants is significantly higher within nonrepeaters than within repeaters. The most relevant result for the identification of risk groups can be found in young female migrants: this group has a higher amount in repeaters than in nonrepeaters.

The same result regarding middle aged migrants is found, when looking at the second generation (figure 80).



**Figure 79:** Frequency of migrants (1st generation) in nonrepeaters and repeaters

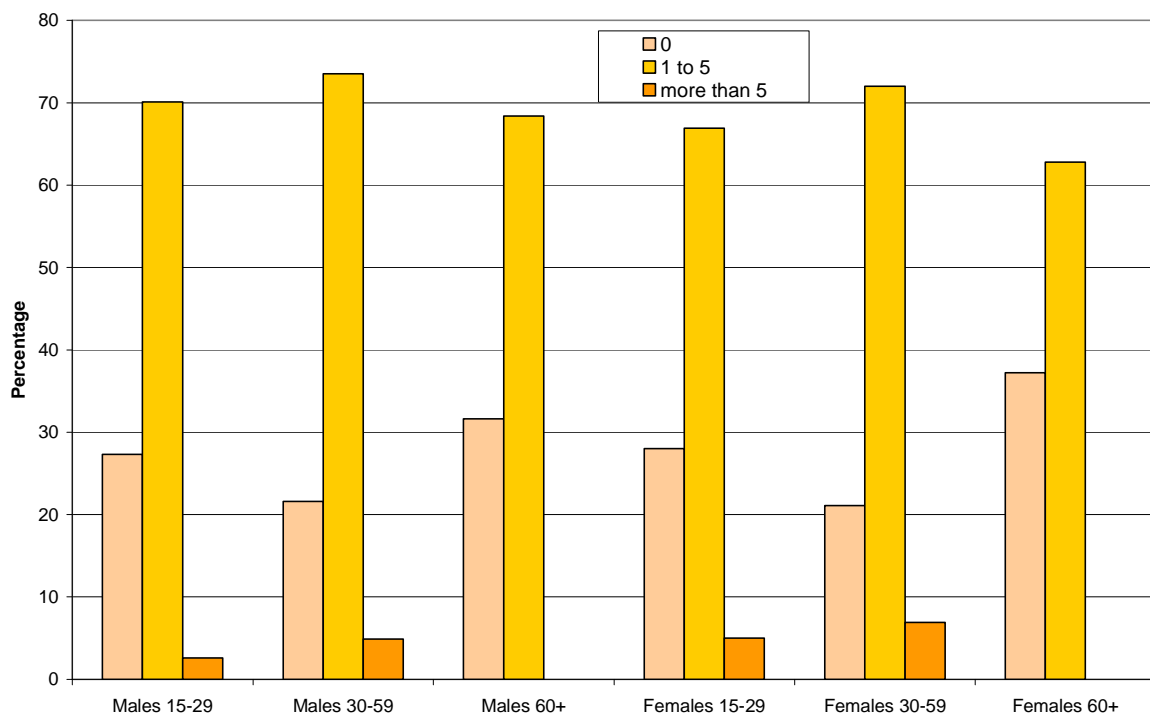


**Figure 80:** Frequency of migrants (2<sup>nd</sup> generation) in nonrepeaters and repeaters



#### 4.2.5.4 Frequencies of contacts to the health system after the latest attempt as risk factor for repetition

Quite high percentages of repeaters did not have any contact to the health system after the latest suicide attempt (figure 81) or only had up to five contacts, which means that no constant psychotherapy has been conducted. Only up to 6% of all repeaters had more than 5 contacts to the health system after their latest attempt. For the older male and female suicide attempters it is even 0%, which hints to the fact that more psychotherapy on a regularly basis for suicide attempters, especially for the older ones is needed.



**Figure 81:** Number of contacts to the health system after the latest attempt



## Summary of results with regard to special risk groups for repetition

- More middle-aged male repeaters use soft poisoning as *method of suicide attempt* in comparison to middle-aged nonrepeaters. Older male nonrepeaters more frequently use hard poisoning than older male repeaters. Younger and older male repeaters more frequently use hard methods than their counterpart nonrepeaters.
- Affective disorders are the most frequent *psychiatric diagnosis* in older male repeaters, their diagnosis less frequently are adjustment disorders.
- A high percentage of suicide attempters is unemployed, but *unemployment* is not a special risk factor for repetition.
- Young male *migrants* are more frequently repeating suicide attempt than nonmigrants. Within the group of young female suicide attempters migrants are overrepresented, but with regard to repetition there is no difference between migrants and nonmigrants within this group.
- Within repeaters we find high percentages of suicide attempters through all age groups, who only had up to five *contacts to health system* after their latest attempt.



## ***5. Discussion and conclusions***

### **5.1 General discussion of the results**

Within the framework of the MONSUE project, suicide and suicide attempt rates broken down by sex and five-year age groups were assessed. The distribution of suicide and suicide attempt frequencies according to sex and age found in previous epidemiological studies is confirmed by the MONSUE findings which show that suicide rates increase with age and are about three times higher in males than in females. A reverse distribution appears for suicide attempt rates which decrease with age and are higher in women than in men. One notable exception of the MONSUE results is Hungary where a similarly high rate of suicide attempts can be observed for both males and females. In general, suicide attempt rates in the MONSUE sample as well as in previous studies are about ten times higher than suicide rates.

Regarding suicide methods the MONSUE results show, that hanging is the most frequently used suicide method in Europe, especially for males. For females, besides hanging, poisoning is a preferred suicide method. Women in Southern European countries are an exception, since their most chosen method is jumping. Suicide methods in the countries and the catchment areas are relatively similar to each other. Furthermore age does not seem to play an important role as regards the choice of suicide method.

Besides computing rates of suicidal behaviour, as well as the comparison of the frequency of different suicide methods, the assessment of suicide attempts with the official MONSUE monitoring form was the major aim of the study. A total of 4683 episodes of suicides attempts was registered in the active centres. On the basis of these monitoring forms, characteristics of suicide attempts, their contextual factors as well as related sociodemographic variables of suicide attempters were identified. These data in combination with data from previous studies allow an evaluation of the effects of prevention strategies in different countries. As already mentioned in the chapter on data analysis procedure (3.6), data were analysed descriptively for frequencies and distribution of percentages. A further step was the performing of exploratory analyses in order to test for statistical significance. In-depth analyses



regarding specific questions will be conducted within the context of scientific publications from the project participants.

Prevention strategies on the primary level address the general population. They include the restriction of access to lethal means, awareness campaigns and media recommendations for reporting on suicidal behaviour. Methods of suicidal behaviour were systematically assessed with the MONSUE monitoring form and the obtained data constitute the basis for the development of prevention strategies for restricting the access to these means. Awareness campaigns and media guidelines, however, were not approached within the MONSUE research.

Concerning the choice of method, most suicide attempters in the MONSUE study take soft poisons (different kinds of medication). Hard poisons (e.g. pesticides) or other methods are less often observed, whereas in Slovenia and Germany more elder women intoxicate themselves with hard poisons than in the other centres. The majority of persons that intoxicate themselves with pharmaceuticals take medication prescribed for them and do not use drugs prescribed for somebody else. The MONSUE results reveal that especially younger people use also medication prescribed for another person. With regard to country-specific results, particularly Italian males and females of all age groups strongly prefer the method of soft poisoning (more than 80%). By contrast, in Slovenia this method is used less often for all sex and age groups. On average, more women intoxicate themselves with sedative drugs than men. The restriction of access to drugs and medication therefore is an important primary prevention strategy (Leenaars, Lester, Baquedano et al., 2009).

The MONSUE results show that, compared with the other participating centres, alcohol is most often used as single suicide attempt method in Spain. In addition, it is a relevant co-factor for attempting suicide, and the restriction of alcohol consumption may be effective in reducing suicide and suicide attempt rates. Both aggregate-level and individual-level studies showed that the reduction of overall national or regional alcohol consumption led to a decrease in national and regional suicide rates (Wasserman and Hadlaczky, 2009).



Another important primary prevention strategy addressing the general population is the identification of “hot spots” for jumping in suicidal intention and the subsequent restriction of access to these locations. As regards jumping as suicide attempt method, young males from Leipzig (Germany) and the associated centre in Berne (Switzerland) show a higher percentage than those of the other centres. This leads to the conclusion that there probably are certain hot spots for jumping in Leipzig and Berne. In Leipzig the so-called Battle of the Nations Monument could be identified as hot spot. Restrictions of access to this monument have recently been implemented (barriers and net constructions). A systematic evaluation of the influence of this prevention strategy on the number of suicides and suicide attempts still needs to be conducted in those regions of Germany, Switzerland and other countries where hot spots have been identified. There is increasing evidence that suicide by jumping can be prevented by protecting bridges and high buildings through the installation of appropriate safety barriers, and that this measure decreases suicides by jumping in the surrounding area (Beautrais et al., 2009; Wohner et al., 2005; Lindqvist et al., 2004).

Since the largest proportion of the individuals in the MONSUE sample attempt suicide in their homes, the restriction of access to hot spots is particularly relevant to completed suicides. Hot spots are mainly related to the use of hard methods (jumping) and, thus, to high case fatalities.

In line with the MONSUE results, hard poisons (e.g. pesticides) are not frequently used as method of suicide attempt. The highest percentages are found in elder female suicide attempters in Slovenia and Germany. As a consequence, access to pesticides needs to be paid special attention as primary prevention strategy in Slovenia and Germany. With regard to controlling the access to hard poisons, the detoxification of domestic gas was shown to be effective in reducing annual suicide rates by 19% (Mann, Apter, Bertolote et al., 2005).

Controlling gun availability is a further important aspect in suicide prevention (Leenaars, 2009). Studies reveal that the rate of suicide by firearms increases with the availability of guns, especially among young people. The importance of this suicide prevention strategy is underlined by the fact that firearms are a method with high case fatalities. This is in line with the MONSUE results, since these show that





young and elder men using hard methods for their suicide attempt have an extremely high risk for repetition. Restricting the access to guns led to a decline in annual suicide rates of at least 1.5% (Mann, Apter, Bertolote, et al., 2005).

As regards suicide prevention on the secondary level risk groups in the MONSUE study were identified on the basis of either a higher frequency of suicidal behaviour in comparison with the general population or by analysis of the risk for repetition.

The following risk groups could be detected by MONSUE and previous studies: people with interpersonal conflict situations (especially young people), people with psychiatric disorders (especially affective disorders, adjustment disorders, substance-related disorders), persons with migration background (especially young females), unemployed (especially young males), elderly with physical illness and elder females living alone (De Leo et al., 2009; Mäkinen and Wasserman, 2009; Mehlum, 2009; Sharma and Bhugra, 2009; Ochoa et al., 2005).

In particular, young males and females often mention interpersonal conflicts as the major reason for attempting suicide. Therefore, the implementation of hotlines for interpersonal conflicts as well as training to cope with social crises (social skills training) are secondary prevention strategies deduced from these results. Telephone hotlines have been proved to have a high potential to serve vulnerable individuals in crisis (Gould and Kalafat, 2009). Studies also highlight the need for improved training of crisis counsellors.

Suicide is the most severe outcome of mental ill-health and no other known risk factor has such high prevention potential regarding suicide as psychiatric disorders (Mehlum, 2009). On the basis of the MONSUE results, it becomes evident that the frequency of affective disorders among suicide attempters is quite high and increases with age. Especially in elder females of most centres the percentage of affective disorders is very high. Additionally, adjustment disorders seem to be an important risk factor, mainly in young males and females. In addition, substance-related disorders appear to be associated with suicidal acts. Substance-related comorbidity particularly plays a role in males. A further risk group for repetition is the existence of an affective disorder in elder men.



Optimizing treatment strategies for these psychiatric disorders therefore appears as an indicated secondary prevention strategy, too. According to the scientific literature, the education of primary care physicians was shown to be effective in reducing annual suicide rates by at least 22% (Mann et al., 2005).

Moreover, the MONSUE results displayed that in elder persons physical illness is a major reason for suicidal behaviour. Support for coping with physical illness thus seems to be an important secondary prevention strategy for this age group. Suicidal behaviour among the elderly still attracts very little attention from the media as well as public health planners (De Leo et al., 2009), despite the fact that suicide rates significantly increase with age. This may be due to the existence of an ageism culture which considers depression as a normal feature of the old age and, consequently, suicide of elderly as unpreventable (Draper, 2006). Suicide prevention in this field has to affect the conditions of life in nursing homes as well as the quality of pain treatment.

Regarding the usual household composition one year before the suicide attempt, elder females living alone constitute a special risk group for attempting suicide and should thus receive special attention as regards suicide prevention.

Another important risk group detected in the majority of the MONSUE centres is that of the unemployed: Twenty to 30% of the young males in the sample of suicide attempters are jobless. This percentage differs from the unemployment rate of young males in the general population. Suicide prevention issues in this regard concern unemployment policies, the reduction of work-related access to means of suicide and the use of the workplace as a base for suicide prevention (Mäkinen and Wasserman, 2009). Awareness campaigns and trainings for employees in job centres as well as psychosocial coaching for persons who lose their jobs are further possible secondary prevention strategies. Since unemployment is frequently associated with a low economic status and, in some cases, with homelessness (Brux, 2007), socially disadvantaged people also constitute a group at risk for suicidal behaviour.

A much smaller risk group, but highly relevant for political actions, are immigrants or persons with migration background (Sharma and Bhugra, 2009). Given the impact of socio-cultural aspects in the development and clinical manifestations of mental health



problems, it is necessary to know the demands of the immigrant population and to adjust current facilities to its needs (Ochoa et al., 2005). Looking at the MONSUE sample, it becomes obvious that being a young female with migration background heightens the probability to attempt suicide. According to these results, people with migration background, especially young females, constitute a group at risk for suicidal behaviour. Specific secondary prevention strategies for this particular group should therefore be taken into consideration. Preventative strategies for migrants must be adapted to the type of migration, the reason for migration and to culture-specific as well as social aspects.

Tertiary prevention in the field of suicidal behaviour aims at reducing the risk of relapse. In particular, this means providing information and education to general practitioners and psychiatrists/psychotherapists regarding the necessity of intensive aftercare for suicide attempters.

Between 30 to 50% of the suicide attempters in the MONSUE study had a history of at least one previous suicide attempt. According to the MONSUE results, a critical time period for tertiary prevention is 12 months after the suicide attempt, since then the probability of repetition is at its highest level. According to these results, the improvement of the aftercare for suicide attempters as well as an implementation of tertiary prevention strategies at the earliest is indicated. Since the percentage of repeaters is about 50% among young and middle-aged persons, special programmes for these groups are necessary, in particular the follow-up of suicide attempters and proper psychiatric care after a suicide attempt. Concerning tertiary prevention, increasing antidepressant prescriptions led to a decline in annual suicide rates of 3.2% (Mann, et al., 2005). Furthermore, Lithium treatment, due to its anti-suicidal effect, is an empirically validated strategy to reduce the risk for repeating a suicide attempt in patients with affective disorders (Guzzetta et al., 2007). With the exception of lithium, though, empirical studies testing the decline of suicidal behaviour caused by the implementation of a particular secondary or tertiary prevention strategy for specific risk variables still need to be conducted.

The MONSUE results suggest that most repeaters of a suicide attempt do not receive adequate treatment, i.e. continuous and highly frequent treatment, after their suicide attempt. In the study sample less than 5% of the suicide attempters obtain



longer-lasting aftercare which is a necessary precondition for reducing the risk of repetition. Consequently, the provision of better aftercare for suicide attempters, especially during the first 12 months, is proposed.

## **5.2 Conclusions for political actions for suicide prevention in Europe**

The MONSUE consortium agreed on an integrative suicide prevention approach, that includes measures on the primary, secondary and tertiary level of prevention. The recommendations for these preventions are based on the MONSUE results as well as results from previously conducted studies.

A public health approach and a health care approach of suicide prevention can be distinguished. The public health approach intends to control the access to means of suicide, to implement a media policy, to increase knowledge through public education and to change disapproving attitudes in society to mental illness and suicide. Its purpose is to establish effective support networks as well as good environmental conditions. The health care approach aims at improving health care services, diagnostic procedures, treatment, follow-up and rehabilitation especially for individuals of risk groups, as well as increasing awareness among health care staff and changing their condemnatory attitudes and taboos concerning suicide.

### **5.2.1 Primary prevention strategies**

As regards primary prevention measures the MONSUE results lead to the proposal of the following prevention strategies, which are focussed on the restriction of access to methods of suicide and suicide attempts.



### **Intoxication with pharmaceutical drugs in suicidal intention can be prevented by:**

- Restricting maximum package sizes of prescribed drugs and intervals of repetitive prescription, obligations to the prescription of OTC drugs (e.g. Paracetamol) in case of the purchase of a higher amount of medication and obligations regarding the type of packages of medication (blistering of medication)
- Training of pharmacists
- Strict monitoring of prescriptions by doctors and pharmacists
- Educating parents how to safely store their pharmaceuticals

### **Intoxication with alcohol in suicidal intention can be prevented by:**

- Governmental regulation of sales (i.e. of the number of outlets and alcohol sales at retail level) and implementation of licenses for private operators
- Regulating alcohol prices and taxes
- Implementing bans on drinking in streets and public places; bans on selling alcohol to young people in the evening hours
- Restricting alcohol marketing
- Educating about alcohol-related harm via mass-media campaigns, the internet, family initiatives and school programmes

### **Intoxication with hard poisons in suicidal intention can be prevented by:**

- Restricting the access to pesticides for people other than farmers (especially in Slovenia and Germany)
- Implementing safety measures for toxic gases (detoxification) and car exhausts (automatic stop switches after a certain period of running of the engine without driving)

### **Shooting in suicidal intention can be prevented by:**

- Restricting the access to guns among groups at risk of suicide
- Gun control legislation and, especially, the enforcement of this legislation



### **Jumping in suicidal intention can be prevented by:**

- **Implementing norms for kind and heights of barriers and fences on bridges, roofs of tall buildings and railings with the aim of building maximally “safe” bridges and houses with regard to potential suicidal acts**

## **5.2.2 Secondary prevention strategies**

Concerning secondary prevention strategies MONSUE results lead to the proposal of the following measures, that aim at interventions regarding risk groups for suicidal behaviour.

### **Prevention strategies targeting the reasons for suicidal behaviour:**

- **Implementation of stress management trainings in schools**
- **Implementation of crisis hotlines, especially for young people**
- **Education of first-line help providers in suicidal de-escalation techniques**
- **Training of general practitioners concerning recognition and management of suicide risk in individuals with a psychiatric diagnosis, but also in people with severe physical illness, especially chronic pain or chronic disease**

### **Prevention strategies targeting patients with psychiatric disorders:**

- **Improvement of the early recognition and sufficient treatment of patients with psychiatric disorders, especially depression**
- **Training of the staff of general and psychiatric hospitals in recognition of depression and suicidality**
- **Implementation of norms for building new psychiatric hospitals as well as general hospitals and nursing homes, regarding the distance from identified suicide hot spots, safety measures for windows, bath rooms, hooks, access to electricity, ropes, etc. Additionally, implementation of regulations for security measures in existing psychiatric and general hospitals as well as homes for the elderly**



### **Prevention strategies targeting persons with risk-elevating living situations:**

- **Improvement of depression care and the responsiveness of services to the needs of elder females living alone**
- **Implementation of measures for socially disadvantaged people to prevent loneliness, to improve autonomy and the facilitated access to social activities**

### **Prevention strategies targeting unemployed persons**

- **Implementation of mental health promoting measures at work place, especially for people threatened by unemployment. This means the provision of information material regarding depression, addiction and other psychiatric problems as well as the availability of professional help and recommendations to employment centres, employers' associations and trade unions to facilitate the distribution of such material. In addition, low-threshold psychiatric emergency services should be installed**
- **Information on how to cope with unemployment distributed by the job centres (e.g. leaflets); training of personnel managers how to cope with co-workers to be dismissed; education of co-workers in job centres which deal with unemployed people**
- **Provision of information material regarding depression, addiction and other psychiatric problems and the availability of professional help via specific aid organizations working with homeless people.**
- **Reintegration of mentally ill persons into work life and social life**
- **Exemption of the poor from co-payment for treatment**

### **Prevention strategies targeting persons with migration background**

- **Provision of native language information material to immigrants regarding depression, addiction and other psychiatric problems**
- **Availability of professional help and improvement of the availability of psychiatric/psychotherapeutic care in patients' native language, mainly for young females with migration background**



### **5.2.3 Tertiary prevention strategies**

With respect to tertiary prevention strategies the results of the MONSUE study allow the proposal of the following measures aiming at a minimization of the risk of repetition among suicide attempters.

#### **Prevention strategies to reduce the risk for repetition of a suicide attempt**

- **Proper and continuous follow up of suicide attempters**
- **Monitoring of prevalence, service use, self-perceived health and social status of suicide attempters**
- **Implementation of support groups in the local communities**
- **Special aftercare programmes for young and middle-aged persons, patients with psychiatric disorders and persons with migration background**

#### **Prevention strategies targeting the aftercare of suicide attempters**

- **Evaluation and psychiatric care after the first suicide attempt, not just the treatment of medical consequences in emergency care settings**
- **Improvement of the density of care and continuity of treatment after a suicide attempt, especially in the first 12 months**
- **Involvement of families in taking care of the suicidal patient, better collaboration with family members**
- **Green card models (a document that facilitates immediate access to the respective treatment institution)**
- **The optimization of treatment must include adequate pharmacological treatment**





### 5.3 Open issues and future perspectives

Suicide and suicide attempts are complex phenomena that arise in very individualistic ways. Therefore, the complexity of causes requires a multifaceted approach to prevention.

MONSUE has laid a fundament for a systematic assessment of suicide attempts and prevention strategies in Europe.

Whereas suicides are and will be continuously monitored by means of common databases (WHO, EUROSTAT), suicide attempts and the efficacy of prevention strategies will not be systematically assessed in the future after the termination of MONSUE. This seriously handicaps the coordination and interconnection of prevention strategies.

The continuation of the MONSUE effort therefore appears to be absolutely necessary for the improvement of suicide prevention. Thus, it is recommended to establish a European umbrella institution or office that is steadily concerned with this important issue. There are different ways of implementing such an entity: 1. a call for tenders in the framework of a network; 2. an EC-wide centre that is connected with country specific institutions; or 3. the integration of this task into an already existing division of EC.

The continuation of data collection on suicide attempts and prevention strategies will be the essential prerequisite of the continuous improvement of prevention of suicide attempts and suicides. With Europe becoming a united house this is not a national, but a European challenge.



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## **Appendix A:** MONSUE monitoring forms

English version

Estonian version

German version

Hungarian version

Italian version

Slovenian version

Spanish version

Swedish version



1	<b>Hospital:</b> ..... <input type="checkbox"/>	2	<b>Department:</b> ..... <input type="checkbox"/>
3	<b>Name, first name:</b> .....  <b>ID-Nr.</b> <input type="text"/>	4	<b>Sex:</b> 01 – male 02 – female 03 – changed from male to female 04 – changed from female to male 09 – not known
5	<b>Date of birth:</b> (day/month/year) ...../...../.....	6	<b>Age (years)</b> .....
7	<b>Date of suicide attempt:</b> ...../...../.....	8	<b>Time of suicide attempt:</b> ..... (hours)
9	<b>Country of birth:</b> ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	10	<b>Duration of living in the country of current residence:</b> .....(years)
11	<b>Country of destination:</b> (arrived from which country) ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	12	<b>Citizenship:</b> (name of the country) ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
13	<b>Ethnicity:</b> ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		
14	<b>Mother's country of birth:</b> (name of the country) ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	15	<b>Father's country of birth:</b> (name of the country) ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
16	<b>Brought up:</b> 01 – in traditional family    03 – by other relatives    05 – in institution    09 – not known 02 – by single parent    04 – in adoption or care family    06 – something else, specify.....		
17	<b>Residence within the catchment area at the time of the suicide attempt:</b> (national classification) <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Postal code: <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		
18	<b>Change of address during the last 12 months:</b> 01 – one year ago was the same 02 – change of address in same catchment area 03 – change of address, resided outside catchment area 04 – change of address, resided abroad 09 – not known	19	<b>Religious affiliation:</b> 01 – none (atheist) 02 – no religious affiliation (indifferent) 03 – protestant    08 – greek orthodox 04 – catholic    09 – Buddhist 05 – jewish    10 – other, specify ..... 06 – muslim    99 – not known 07 – hindhu
20	<b>Current civil state:</b> 01 – never married    03 – divorced    05 – first marriage    07 – legal cohabiting 02 – widowed    04 – separated    06 – second or subsequent marriage    09 – not known		
21	<b>Usual household composition during the last year:</b> 01 – living alone 02 – living alone with children 03 – living with partner without children 04 – living with partner and children 05 – living with parents 06 - living with other relatives/friends 07 – living in psychiatric institution 08 – living in jail 09 – living in institutions 10 – living in homes for elderly 11 – other, specify ..... 99 – not known	22	<b>Household composition at the time of the suicide attempt:</b> 01 – living alone 02 – living alone with children 03 – living with partner without children 04 – living with partner and children 05 – living with parents 06 – living with other relatives/friends 07 – living in psychiatric institution 08 – living in jail 09 – living in institutions 10 – living in homes for elderly 11 – other, specify ..... 99 – not known
23	<b>Level of education:</b> (highest completed education) 01 – below compulsory level    03 – high school or vocational level    09 – not known 02 – compulsory level    04 – university/similar institution level		
24	<b>Current (or last) occupation:</b> .....		
25	<b>Occupation:</b> 1000 – legislators, senior officials and managers 2000 – professionals 3000 – technicians and associate professionals 4000 – clerks 5000 – service workers and shop and market sales workers 6000 – skilled agricultural and fishery workers 7000 – craft and related trades workers 8000 – plant and machine operators 9000 – elementary occupations 0008 – not applicable 0009 – not known	26	<b>Level of economic position, employment status:</b> 01 – full time permanently employed (incl. self-empl.) 02 - part-time permanently employed (incl. self-empl.) 03 – employed, but on sick level 04 – full-time temporary work 05 – part-time temporary work 06 – unemployed 07 – full-time student or apprentice 08 – military service 09 – imprisoned 10 – disabled, permanently sick or early retired due to sickness 11 – retired



			12 – housewife/homemaker 13 – not working 14 – other, specify .....
27	<b>Duration of being factually unemployed:</b> ..... (weeks)                      888 – not applicable                      999 – not known		
28	<b>Specification of the mean of suicide attempt: (the method(s) and circumstances of suicide attempt)</b> ..... .....		
29	<b>Method(s) of the suicide attempt: (according to the ICD-10, Chapter XX)</b>		<b>ICD-10 code</b>
	Method 1 .....		<input type="text"/>
	Method 2 .....		<input type="text"/>
	Method 3 .....		<input type="text"/>
	Method 4 .....		<input type="text"/>
30	<b>Injury, poisoning and other consequences: (according to the ICD-10, Chapter XX)</b>		<b>ICD-10 code</b>
	.....		<input type="text"/>
31	<b>Medication prescribed:</b> 01 – no 02 – yes, for me 03 – yes, for somebody else 04 – not applicable 09 – not known	32	<b>Place of suicide attempt:</b> 01 – home 02 – medical institution 03 – other public place, specify ..... 09 – not known
33	<b>Number of previous suicide attempts:</b>  00 – never <input type="text"/> 99 – not known                      (number)	34	<b>Contact with health system after previous suicide attempt:</b>  00 – never <input type="text"/> 88 – not applicable                      (number) 99 – not known
35	<b>Contact with other services after previous suicide attempt:</b>  00 – never <input type="text"/> 88 – not applicable                      (number) 99 – not known	36	<b>Previous suicide attempts within 1 year:</b>  00 – never <input type="text"/> 99 – not known                      (number)
37	<b>Contact with health system after previous suicide attempt within 1 year:</b>  00 – never <input type="text"/> 88 – not applicable                      (number) 99 – not known	38	<b>Contact with other services after previous suicide attempt within 1 year:</b>  00 – never <input type="text"/> 88 – not applicable                      (number) 99 – not known
39	<b>Contact with health system after the most recent suicide attempt:</b> 01 – no 02 – yes, with emergency doctor 03 – yes, general practitioner 04 – yes, non-psychiatric (somatic) inpatient 05 – yes, psychiatric inpatient 06 – yes, non-psychiatric (somatic) outpatient 07 – yes, psychiatric outpatient 08 – yes, psychotherapeutic inpatient 09 – yes, psychotherapeutic outpatient 10 – yes, professional counselling services 11 – yes, voluntary services (e.g. telephone hotline, other voluntary service) 12 – yes, addiction treatment 13 – other, specify .....	40	<b>Recommended next care:</b> 01 – no 02 – yes, with emergency doctor 03 – yes, general practitioner 04 – yes, non-psychiatric (somatic) inpatient 05 – yes, psychiatric inpatient 06 – yes, non-psychiatric (somatic) outpatient 07 – yes, psychiatric outpatient 08 – yes, psychotherapeutic inpatient 09 – yes, psychotherapeutic outpatient 10 – yes, professional counselling services 11 – yes, voluntary services (e.g. telephone hotline, other voluntary service) 12 – yes, addiction treatment 13 – other, specify .....
41	<b>Psychiatric diagnosis: (according to ICD-10, Chapter V)</b> First psychiatric diagnosis .....		<b>ICD-10 code</b>
	Second psychiatric diagnosis .....		<input type="text"/>
	Third psychiatric diagnosis .....		<input type="text"/>
42	<b>Classification of suicide attempt:</b> 01 – deliberate self-harm (non-habitual) 02 – parasuicide pause/temporary test 03 – parasuicide gesture 04 – serious suicide attempt 09 – not known	43	<b>Certainty of rating of classification:</b> 01 – certain 02 – uncertain 09 – not known
		44	<b>Accidental overdose:</b> 01 – yes 02 – no 09 – not known



<b>45</b>	<b>Reasons of suicide attempt:</b> <i>(direct risk factors)</i>	
	01 – interpersonal conflict (with family member, partner, friend)	05 – financial difficulties
	02 – bereavement or severe illness of family member, partner, friend	06 – mistreatment
	03 – physical illness	07 – legal problems
	04 – mental health disturbance	09 – not known
	08 – other, specify .....	
<b>Contacts of the interviewer:</b>		
<b>Name:</b> ..... <b>Phone:</b> .....		

## SUITSIIDIKATSETE REGISTREERIMISE ANKEET

1	Haigla: .....	2	Osakond: .....
3	Nimi ja eesnimi: .....		4 Sugu: 03 – muudetud mehest naiseks 01 – mees 04 – muudetud naisest meheks 02 – naine 09 – sugu teadmata
5	Sünniaeg: ___/___/___ (päev, kuu, aasta) ID nr	6	Vanus (aastates) ---
7	Suitsiidikatse kuupäev: ___/___/___ (päev, kuu, aasta)	8	Suitsiidikatse kellaeg: --
9	Sünnimaa nimetus: .....	10	Praeguses elukohas elanud: ___ (aastat)
11	Kust saabus: .....	12	Kodakondsus: (maa nimetus) .....
13	Rahvus: .....		
14	Emma sünnimaa: (maa nimetus) .....	15	Isa sünnimaa: (maa nimetus) .....
16	Kasvas üles: 01 – tavalises perekonnas, 02 – ühe vanema juures, 03 – mõne sugulase juures, 04 – adopteerituna perekonda, 05 – lasteasutuses, 06 – mujal ..... 09 – teadmata		
17	Elukoht suitsiidikatse ajal: (rahvusvahelise klassifikatsiooni järgi) (postiindeks) .....		
18	Aadressi muutmise viimase 12 kuu jooksul: 01 – aasta tagasi sama mis praegu 02 – aadressi muutmise oma elukoha piires 03 – aadressi muutmise seoses oma elukohast väljapoole elama asumisega 04 – aadressi muutmise seoses välismaale asumisega 09 – teadmata	19	Religioosne kuuluvus: 06 – moslem 01 – eitav (ateist) 07 – hinduist 02 – puudub (erapooletu) 08 – õigeusklik 03 – protestant 09 – budist 04 – katoliiklane 10 – muu 05 – judaist ..... 99 – teadmata
20	Praegune perekonnaseis: 01 – vallaline, 02 – lesk, 03 – lahutatud, 04 – elavad eraldi, 05 – esimene abielu, 06 – teine või korduv abielu, 07 – seaduslik kooselu, 09 – teadmata		
21	Leibkond viimase aasta jooksul: 01 – elab üksinda 02 – elab lastega 03 – elab kaaslasega ilma lasteta 04 – elab kaaslase ja lastega 05 – elab vanematega 06 – elab sugulaste (sõprade) juures 07 – elab psühhiaatriaiaiglas 08 – asub vanglas 09 – elab hooldekodus 10 – elab vanadekodus 11 – elab mujal ..... 99 – teadmata	22	Leibkond suitsiidikatse ajal 01 – elab üksinda 02 – elab lastega 03 – elab kaaslasega ilma lasteta 04 – elab kaaslase ja lastega 05 – elab vanematega 06 – elab sugulaste (sõprade) juures 07 – elab psühhiaatriaiaiglas 08 – asub vanglas 09 – elab hooldekodus 10 – elab vanadekodus 11 – elab mujal ..... 99 – teadmata
23	Haridus: 01 – lõpetamata põhi, 02 – põhi, 03 – kesk- või keskeri, 04 – kõrgem, 09 – teadmata		
24	Praegune (viimane) amet: .....		
25	Elukutse: 1000 – poliitik, vanem ametnik, asutuse juht 2000 – spetsialist 3000 – tehniline töötaja 4000 – ametnik 5000 – teenindaja	26	Tööga hõivatus: 01 – täisajaga (sh füüsilisest isikust ettevõtjana) 02 – osalise ajaga (sh füüsilisest isikust ettevõtjana) 03 – haiguslehel 04 – täisajaga ajutine töö 05 – osalise ajaga ajutine töö

	6000 – oskustöoline põllumajanduses, kalanduses 7000 – käsitöoline 8000 – oskustöoline tehases 9000 – lihtöoline 0008 – muu 0009 – teadmata		06 – töötü 07 – statsionaarne üliõpilane/õpilane 08 – kaitseväes 09 – kinnipeetav 10 – puudega, haiguse tõttu tööks mitte kõlbulik 11 – pensionär 12 – kodune 13 – ei tööta 14 – muu ..... 99 – teadmata
<b>27</b>	<b>Töötuse kestvus:</b> _ _ _ (nädalates) 888 – pole kohaldatav 999 – teadmata		
<b>28</b>	<b>Suitsiidikatsede asjaolude iseloomustus (meetod ja olustik):</b> ..... .....		
<b>29</b>	<b>Suitsiidikatsede teostamise meetodid (vastavalt RHK-10, XX peatükk, X60-X84): RHK-10 kood</b> 1. meetod ..... 2. meetod ..... 3. meetod ..... 4. meetod .....		
<b>30</b>	<b>Vigastus, mürgistus või muu (vastavalt RHK-10, XIX peatükk, S00-T98):</b> .....		
<b>31</b>	Ravim oli välja kirjutatud: 01 – ei olnud retseptiravim kohaldatav 02 – jah, minu enese jaoks 03 – jah, kellegi teise jaoks	04 – pole 09 – teadmata	<b>32</b> Suitsiidikatsede teostamise koht: 01 – kodu 02 – meditsiiniamet 03 – mõni avalik koht, täpsustada .....
<b>33</b>	<b>Varasemate suitsiidikatsede arv:</b> 00 – ei ole 99 – teadmata (arv) <input type="text"/>	<b>34</b> <b>Kontakt meditsiiniametustega pärast eelnenud suitsiidikatsed:</b> 00 – ei ole 88 – pole kohaldatav 99 – teadmata (arv) <input type="text"/>	<b>35</b> <b>Kontakt teiste asutustega pärast suitsiidikatsed:</b> 00 – ei ole 88 – pole kohaldatav 99 – teadmata (arv) <input type="text"/>
<b>36</b>	<b>Varasemad suitsiidikatsed viimase aasta jooksul</b> 00 – ei ole 99 – teadmata (arv) <input type="text"/>	<b>37</b> <b>Kontakt meditsiiniametustega aasta jooksul pärast eelmist suitsiidikatsed:</b> 00 – ei ole 88 – pole kohaldatav 99 – teadmata (arv) <input type="text"/>	<b>38</b> <b>Kontakt teiste teenistustega aasta jooksul pärast eelmist suitsiidikatsed:</b> 00 – ei ole 88 – pole kohaldatav 99 – teadmata (arv) <input type="text"/>
<b>39</b>	<b>Kontakt tervishoiusüsteemiga pärast eelmist suitsiidikatsed:</b> 01 – ei 02 – jah, kiirabi arstiga 03 – jah, perearstiga 04 – jah, mitte psühhiaatiline (somaatiline) statsionaarne ravi 05 – jah, psühhiaatiline statsionaarne ravi 06 – jah, mitte psühhiaatiline (somaatiline) ambulatoorne ravi 07 – jah, psühhiaatiline ambulatoorne ravi 08 – jah, psühhoterapeutiline statsionaarne ravi 09 – jah, psühhoterapeutiline ambulatoorne ravi 10 – jah, professionaalsed konsultatsioonid 11 – jah, vabatahtlikud abistajad (Eluliin, Usaldustelefon) 12 – jah, sõltuvusravi 13 – muu, täpsustada 88 – pole kohaldatav 99 – teadmata		<b>40</b> <b>Soovitud järelravi:</b> 01 – ei 02 – jah, kiirabi arstiga 03 – jah, perearstiga 04 – jah, mitte psühhiaatiline (somaatiline) statsionaarne ravi 05 – jah, psühhiaatiline statsionaarne ravi 06 – jah, mitte psühhiaatiline (somaatiline) ambulatoorne ravi 07 – jah, psühhiaatiline ambulatoorne ravi 08 – jah, psühhoterapeutiline statsionaarne ravi 09 – jah, psühhoterapeutiline ambulatoorne ravi 10 – jah, professionaalsed konsultatsioonid 11 – jah, vabatahtlikud abistajad (Eluliin, Usaldustelefon) 12 – jah, sõltuvusravi 13 – muu, täpsustada 88 – pole kohaldatav 99 – teadmata



<b>41</b>	<b>Psühhiaatriline diagnoos</b> (vastavalt RHK-10, V peatükk, F00-F98)	<b>RHK-10 kood</b>			
	Esmane psühhiaatriline diagnoos .....	<input type="text"/>			
	Teisene psühhiaatriline diagnoos .....	<input type="text"/>			
	Kolmandane psühhiaatriline diagnoos .....	<input type="text"/>			
<b>42</b>	<b>Suitsiidikatse klassifitseerimine:</b> 01 – tahtlik enesekahjustus 02 – parasuitsidaalne paus/ajutine puhkus 03 – parasuitsidaalne žest 04 – surmasooviga suitsiidikatse 09 – teadmata	<b>43</b>	<b>Klassifitseerimise tõesuse hindamine:</b> 01 – kindel 02 – ebakindel 09 – teadmata	<b>44</b>	<b>Juhuslik üledoos:</b> 01 – ei 02 – jah 09 – teadmata
<b>45</b>	<b>Suitsiidikatse põhjus (otsesed riskitegurid):</b> 01 – inimestevaheline konflikt (pereliikmega, partneriga, sõbraga) 02 – pereliikme, partneri, sõbra surm või tõsine haigestumine 03 – kehaline haigus 04 – vaimsed häired 05 – majanduslikud 06 – väärkohtlemine 07 – õigusrikkumised 08 – muu, täpsusta 09 – teadmata				
<b>Intervjueerija kontaktandmed: (nimi)</b> .telefon: .....					



	<b>Name der Einrichtung/Klinik:</b> <input type="text"/>	<b>2</b>	<b>Abteilung/Station:</b> <input type="text"/>
<b>3</b>	<b>Name, Vorname</b> ..... <b>ID-Nr.</b> <input type="text"/>	<b>4</b>	<b>Geschlecht:</b> 01 - männlich 02 - weiblich 03 - Geschlechtsumwandlung (m → f) 04 - Geschlechtsumwandlung (f → m) 09 - nicht bekannt
<b>5</b>	<b>Geburtsdatum:</b> (Tag/Monat/Jahr) ...../...../.....	<b>6</b>	<b>Alter (Jahre)</b> .....
<b>7</b>	<b>Datum des Suizidversuchs:</b> ...../...../.....	<b>8</b>	<b>Uhrzeit des Suizidversuchs:</b> .....
<b>9</b>	<b>Geburtsort:</b> <input type="text"/>	<b>10</b>	<b>Bisherige Aufenthaltsdauer im Land des ständigen Wohnsitzes:</b> .....(Jahre)
<b>11</b>	<b>Geburtsland:</b> <input type="text"/>	<b>12</b>	<b>Staatsangehörigkeit:</b> <input type="text"/>
<b>13</b>	<b>Bundesland:</b> <input type="text"/>		
<b>14</b>	<b>Geburtsland der Mutter:</b> <input type="text"/>	<b>15</b>	<b>Geburtsland des Vater's:</b> <input type="text"/>
<b>16</b>	<b>Aufgewachsen:</b> 01 - in traditioneller Familienzusammensetzung 02 - bei einem Elternteil 03 - bei anderen Verwandten		04 - in Adoptions- oder Pflegefamilie 05 - im Heim 06 - sonstiges, bitte angeben..... 09 - nicht bekannt
<b>17</b>	<b>ständiger Wohnsitz zur Zeit des Suizidversuches:</b>		Postleitzahl: <input type="text"/>
<b>18</b>	<b>Umzüge innerhalb der letzten 12 Monate:</b> 01 - keine 02 - Umzug innerhalb des Einzugsgebietes 03 - Umzug außerhalb des Einzugsgebietes 04 - frühere Adresse im Ausland 09 - nicht bekannt	<b>19</b>	<b>Religionszugehörigkeit:</b> 01 - keine (Atheist) 02 - keine feste religiöse Ausrichtung (indifferent) 03 - evangelisch 04 - katholisch 05 - jüdisch 06 - muslimisch 07 - hinduistisch 08 - griechisch orthodox 09 - buddhistisch 10 - sonstiges, bitte angeben: 99 - nicht bekannt
<b>20</b>	<b>Familienstand:</b> 01 - ledig 02 - verwitwet 03 - geschieden 04 - getrennt lebend 05 - 1. Ehe 06 - 2. oder weitere Ehe 07 - nicht-eheliche Lebensgemeinschaft 09 - nicht bekannt		
<b>21</b>	<b>Übliche Haushaltszusammensetzung innerhalb des letzten Jahres</b> 01 - allein lebend 02 - allein lebend mit Kindern 03 - mit Partner zusammenlebend ohne Kinder 04 - mit Partner und Kindern zusammenlebend 05 - bei den Eltern lebend 06 - mit Verwandten/Freunden zusammenlebend 07 - in einer psychiatrischen Einrichtung lebend 08 - inhaftiert 09 - in einer Einrichtung lebend 10 - im Altenheim lebend 11 - sonstiges, bitte angeben ..... 99 - nicht bekannt	<b>22</b>	<b>Haushaltszusammensetzung zur Zeit des Suizidversuches:</b> 01 - allein lebend 02 - allein lebend mit Kindern 03 - mit Partner zusammenlebend ohne Kinder 04 - mit Partner und Kindern zusammenlebend 05 - bei den Eltern lebend 06 - mit Verwandten/Freunden zusammenlebend 07 - in einer psychiatrischen Einrichtung lebend 08 - inhaftiert 09 - in einer Einrichtung lebend 10 - im Altenheim 11 - sonstiges, bitte angeben ..... 99 - nicht bekannt
<b>23</b>	<b>Schulbildung: (höchster Abschluss)</b> 01 - Sonderschule 02 - Hauptschule 03 - Realschule 04 - Gymnasium oder Vergleichbares 05 - Universität, Fachhochschule, o.ä. 09 - nicht bekannt		<input type="text"/>
<b>24</b>	<b>Aktuelle (oder letzte) berufliche Tätigkeit:</b> .....		
<b>25</b>	<b>Art der Beschäftigung:</b> 1000 - akademische/r Selbständige/r, Unternehmer/in 2000 - selbständige/r Handwerker/in, Landwirt, Kleingewerbe 3000 - leitende/r Angestellte/r (z.B. Akademiker/in) 4000 - qualifizierte/r Angestellte/r (z.B. Sachbearbeiter/in, Beamte/r gehobener Dienst) 5000 - Angestellte/r (z.B. Schreibkraft, Verkäufer/in, Beamte/r mittlerer Dienst) 6000 - Facharbeiter/in oder abgeschlossene Lehre 7000 - an-, ungelernete/r Arbeiter/in 8000 - bisher nicht berufstätig, Auszubildende/r 9000 - geringfügige Beschäftigung	<b>26</b>	<b>Arbeitssituation:</b> 01 - Vollzeitbeschäftigung (inkl. Selbstständigkeit.) 02 - Teilzeitbeschäftigung (inkl. Selbstständigkeit.) 03 - beschäftigt, aber momentan krank geschrieben 04 - Zeitarbeiter in Vollzeit 05 - Zeitarbeiter in Teilzeit 06 - arbeitslos 07 - Student/in oder Auszubildende/r 08 - Wehr-/Zivildienst 09 - inhaftiert 10 - behindert, permanent krank oder vorzeitig berentet 11 - berentet 12 - Hausfrau/mann



	0008 – nicht anwendbar 0009 – nicht bekannt		13 – nicht beschäftigt 14 – sonstiges, bitte angeben.....				
<b>27</b>	<b>Dauer der Arbeitslosigkeit:</b> ..... (Wochen)                                 888 – nicht zutreffend                                 999 – nicht bekannt						
<b>28</b>	<b>Spezifizierung der Suizidabsichten:</b> (Methode/n und Umstände des Suizidversuches) ..... ..... .....						
<b>29</b>	<b>Methode des Suizidversuches:</b> (gemäß ICD-10, Kapitel XX) Methode 1 ..... Methode 2 ..... Methode 3 ..... Methode 4 .....		<b>ICD-10 Code</b> <table border="1" style="width: 100%;"><tr><td> </td></tr><tr><td> </td></tr><tr><td> </td></tr><tr><td> </td></tr></table>				
<b>30</b>	<b>Art der Verletzung, Vergiftung oder andere Konsequenzen:</b> (gemäß ICD-10, Kapitel XX) .....		<b>ICD-10 Code</b> <table border="1" style="width: 100%;"><tr><td> </td></tr></table>				
<b>31</b>	<b>Verordnete Medikation:</b> 01 – keine 02 – ja, für mich 03 – ja, für jemand anderen 04 – nicht anwendbar 09 – nicht bekannt	<b>32</b>	<b>Ort des Suizidversuches:</b> 01 – zuhause 02 – in einer medizinischen Einrichtung 03 – sonstiger öffentlicher Ort, bitte angeben ..... 09 – nicht bekannt				
<b>33</b>	<b>Anzahl vorausgegangener Suizidversuche:</b> 00 – keine <input type="checkbox"/> 99 – nicht bekannt                                 (Anzahl)	<b>34</b>	<b>Kontakt mit einer Einrichtung des Gesundheitssystems nach vorausgegangenen Suizidversuchen:</b> 00 – kein Kontakt <input type="checkbox"/> 88 – nicht anwendbar                             (Anzahl) 99 – nicht bekannt				
<b>35</b>	<b>Kontakt mit anderen Einrichtungen nach vorausgegangenem Suizidversuch:</b> 00 –kein Kontakt <input type="checkbox"/> 88 – nicht anwendbar                             (Anzahl) 99 – nicht bekannt	<b>36</b>	<b>Vorausgegangene Suizidversuche innerhalb des letzten Jahres:</b> 00 – keine <input type="checkbox"/> 99 – nicht bekannt                                 (Anzahl)				
<b>37</b>	<b>Kontakt mit einer Einrichtung des Gesundheitssystems nach vorausgegangenen Suizidversuchen innerhalb des letzten Jahres:</b> 00 – kein Kontakt <input type="checkbox"/> 88 – nicht anwendbar                             (Anzahl) 99 – nicht bekannt	<b>38</b>	<b>Kontakt mit anderen Einrichtungen nach vorausgegangenen Suizidversuchen innerhalb des letzten Jahres:</b> 00 – keiner <input type="checkbox"/> 88 – nicht anwendbar                             (Anzahl) 99 – nicht bekannt				
<b>39</b>	<b>Kontakt mit einer Einrichtung des Gesundheitssystems nach dem jüngsten Suizidversuch:</b> 01 – kein Kontakt 02 – mit dem Notarzt 03 – Hausarzt 04 – nicht-psychiatrisch (somatisch) - stationär 05 – psychiatrisch - stationär 06 – nicht-psychiatrisch (somatisch) - ambulant 07 – psychiatrisch - ambulant 08 – psychotherapeutisch - stationär 09 – psychotherapeutisch - ambulant 10 – professionelle Beratungsstelle 11 – ehrenamtliche Dienste (Telefonseelsorge, etc.) 12 – Suchtbehandlung 13 – sonstiges, bitte angeben .....	<b>40</b>	<b>Empfohlene Weiterbehandlung:</b> 01 – keine 02 – durch den Notarzt 03 – Hausarzt 04 – nicht-psychiatrisch (somatisch) - stationär 05 – psychiatrisch - stationär 06 – nicht-psychiatrisch (somatisch) - ambulant 07 – psychiatrisch - ambulant 08 – psychotherapeutisch - stationär 09 – psychotherapeutisch - ambulant 10 – professionelle Beratungsstelle 11 – ehrenamtliche Dienste (Telefonseelsorge, etc.) 12 – Suchtbehandlung 13 – sonstiges, bitte angeben .....				
<b>41</b>	<b>Psychiatrische Diagnosen:</b> (gemäß ICD-10, Kapitel V) Erstdiagnose..... Zweitdiagnose..... Drittidiagnose.....		<b>ICD-10 Code</b> <table border="1" style="width: 100%;"><tr><td> </td></tr><tr><td> </td></tr><tr><td> </td></tr></table>				
<b>42</b>	<b>Klassifizierung des Suizidversuches:</b> 01 – Selbstschädigung/verletzung 02 – parasuizidale Pause 03 – parasuizidale Geste 04 – ernsthafter Suizidversuch 09 – nicht bekannt	<b>43</b>	<b>Sicherheitsgrad der Beurteilung:</b> 01 – sicher 02 – Verdacht 09 – nicht bekannt				
		<b>44</b>	<b>Unbeabsichtigte Überdosierung:</b> 01 – ja 02 – nein 09 – nicht bekannt				



<b>45</b>	<p><b>Ursachen des Suizidversuches:</b> <i>(Direkte Risikofaktoren)</i></p> <p>01 – interpersoneller Konflikt (mit Familienmitglied/ern, Partner, Freund)                  02 – Verlust oder schwere Erkrankung eines Familienmitglieds, des Partners oder Freundes                  03 – körperliche Krankheit                  04 – psychische Gesundheitsbeeinträchtigung                  05 – finanzielle Schwierigkeiten</p> <p style="text-align: right;">06 – Misshandlung                  07 – juristische Schwierigkeiten                  08 – sonstiges, bitte angeben.....                  09 – nicht bekannt</p>
<p><b>Kontaktdaten der/des InterviewerIn/s:</b></p> <p><b>Name:</b> ..... <b>Tel:</b> .....</p>	



1	Pécs, Magyarország <input type="checkbox"/>	2	PTE ÁOK Pszichiátriai és Pszichoterápiás Klinika <input type="checkbox"/>
3	Név : .....  ID-Nr. <input type="text"/>	4	Nem: 01 – férfi 02 – nő 03 – nemet változtatott férfi 04 – nemet változtatott nő 09 – nem ismert
5	Születési datum: (nap/hónap/év) ...../...../.....	6	Kor (év) .....
7	Szucid kísérlet ideje: ...../...../..... (nap/hónap/év)	8	Szucid kísérlet ideje: ..... (óra)
9	Születési hely: ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	10	Ha nem Mo.-on született, hány éve él itt? ..... (év)
11	Ha nem magyar, akkor honnan érkezett: ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	12	Állampolgárság: (ország neve) <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
13	Etnikum: 1. Kaukázusi 2. Egyéb (éspedig).....		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
14	Anyja születési helye: (ország neve) <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	15	Apja születési helye: (az ország neve) <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
16	Hogyan nevelkedett? 01 – hagyományos családban 03 – más rokon nevelte 05 – nevelőintézetben 09 – nem ismert 02 – egyik szülő nevelte 04 – örökbefogadó vagy nevelőszülők 06 – mások, éspedig:.....		
17	Lakhely: 1. Pécs 2. Pécs környéke 3. Ellátási területen kívüli Irányítószám: <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		
18	Lakóhelyváltozás az elmúlt egy évben: 01 – nem volt 02 – lakóhelyváltozás a régió belül 03 – lakóhelyváltozás a régió kívül 04 – lakóhelyváltozás, az előző lakóhelye külföldön volt 09 – nem ismert	19	Vallási hovatartozás: 01 – nincs - ateista 02 – nem gyakorolja vallását - közömbös 03 – protestáns 08 – görögkatolikus 04 – katolikus 09 – buddhista 05 – zsidó 10 – egyéb, éspedig..... 06 – muszlim 99 – nem ismert 07 – hindu
20	Családi állapot: 01 – nőtlen/hajadon 03 – elvált 05 – első házasságban él 07 – hivatalosan együtt él (élettárs) 02 – özvegy 04 – különélő 06 – második (vagy többedik) házasságban él 09 – nem ismert		
21	Kivel élt az elmúlt egy évben: 01 – egyedül 02 – egyedül él, gyermekével 03 – partnerrel él, gyermek nélkül 04 – partnerrel és gyermek(ek)kel él 05 – szüleivel él 06 – más rokonnal/baráttal él 07 – pszichiátriai otthonban él 08 – börtönben van 09 – egyéb intézményben él 10 – idősok otthonában él 11 – egyéb, éspedig..... 99 – nem ismert	22	Kivel élt a szucid kísérlet idején: 01 – egyedül 02 – egyedül él, gyermekével 03 – partnerrel él, gyermek nélkül 04 – partnerrel és gyermek(ek)kel él 05 – szüleivel él 06 – más rokonnal/baráttal él 07 – pszichiátriai otthonban él 08 – börtönben van 09 – egyéb intézményben él 10 – idősok otthonában él 11 – egyéb, éspedig..... 99 – nem ismert
23	A legmagasabb iskolai végzettség: 01 – kevesebb, mint 8 általános 03 – középfokú iskola 09 – nem ismert 02 – 8 általános 04 – főiskolai/egyetemi végzettség		
24	A jelenlegi (vagy a legutóbbi) foglalkozása: .....		
25	Foglalkozás: 1000 Törvényhozók, igazgatási, érdekképviselői vezetők, gazdasági vezetők 2000 Felsőfokú képzettség önálló alkalmazását igénylő foglalkozások 3000 Egyéb, felsőfokú vagy középfokú képzettséget igénylő foglalkozások 4000 Irodai alkalmazott, hivatalnok 5000 Szolgáltatásban, kereskedelemben dolgozó 6000 Mezőgazdasági dolgozó 7000 Ipari-építőipari dolgozó 8000 Gépkészítők, összeszerelők, járművezetők 9000 Szakképzettséget nem igénylő (egyszerű) foglal-	26	A gazdaságban betöltött helyzet: 01 – teljes munkaidőben dolgozik (egyéni vállalkozást is beleértve) 02 – részmunkaidőben dolgozik (egyéni váll.-t is beleértve) 03 – munkaviszonya van, de táppénzen van 04 – alkalmi munka teljes munkaidőben 05 – alkalmi munka részmunkaidőben 06 – munkanélküli 07 – nappali tagozatos tanuló 08 – katonai szolgálatot teljesít 09 – börtönbüntetését tölti 10 – tartósan betegállományban van, vagy rokantnyugdíjas 11 – nyugdíjas

	kozások (pl.betanított munkás) 0008 Nem alkalmazható 0009 Nem ismert		12 – háztartásbeli 13 – nem dolgozik 14 – egyéb, éspedig .....
27	<b>A tényleges munkanélküliség ideje:</b> ..... (hét) 888 – nem alkalmazható 999 – nem ismert		
28	<b>A szuicid kísérlet leírása: (módszer(ek), gyógyszerek neve, adagja, a kísérlet körülményei)</b> ..... ..... .....		
29	<b>A szuicid kísérlet módszere: (BNO 10 szerint)</b> Módszer 1 ..... Módszer 2 ..... Módszer 3 ..... Módszer 4 .....		<b>BNO kód</b> ..... ..... ..... .....
30	<b>Sérülés, mérgezés, vagy egyéb szomatikus következmény: (BNO 10 szerint)</b> .....		<b>BNO kód</b> .....
31	<b>A gyógyszert orvos írta fel?</b> 01 – nem 02 – igen, a páciensnek 03 – igen, de másnak 04 – nem alkalmazható 09 – nem ismert	32	<b>Hol történt a szuicid kísérlet?</b> 01 – otthon 02 – egészségügyi intézményben 03 – más nyilvános helyen, éspedig ..... 09 – nem ismert
33	<b>Korábbi szuicid kísérletek száma:</b> 00 – nem volt <input type="checkbox"/> 99 – nem ismert <input type="checkbox"/> (kísérletek száma)	34	<b>Kapcsolat az egészségügyi ellátó rendszerrel a korábbi kísérlet után:</b> 00 – nem volt <input type="checkbox"/> 88 – nem alkalmazható <input type="checkbox"/> 99 – nem ismert <input type="checkbox"/> (találkozások száma)
35	<b>Kapcsolat más ellátó rendszerrel a korábbi kísérlet után:</b> 00 – nem volt <input type="checkbox"/> 88 – nem alkalmazható <input type="checkbox"/> 99 – nem ismert <input type="checkbox"/> (találkozások száma)	36	<b>Szuicid kísérlet az elmúlt egy évben:</b> 00 – nem volt <input type="checkbox"/> 99 – nem ismert <input type="checkbox"/> (kísérletek száma)
37	<b>Kapcsolat az egészségügyi ellátó rendszerrel az elmúlt egy évben történt kísérlet után</b> 00 – nem volt <input type="checkbox"/> 88 – nem alkalmazható <input type="checkbox"/> 99 – nem ismert <input type="checkbox"/> (találkozások száma)	38	<b>Kapcsolat más ellátó rendszerrel az elmúlt egy évben történt kísérlet után</b> 00 – nem volt <input type="checkbox"/> 88 – nem alkalmazható <input type="checkbox"/> 99 – nem ismert <input type="checkbox"/> (találkozások száma)
39	<b>Kapcsolat az egészségügyi ellátó rendszerrel a legutóbbi szuicid kísérlet után:</b> 01 – nem volt 02 – volt, sürgősségi ellátás 03 – volt, háziorvos 04 – volt, szomatikus osztályos kezelés 05 – volt, pszichiátriai osztályos kezelés 06 – volt, szomatikus ambuláns kezelés 07 – volt, pszichiátriai ambuláns kezelés 08 – volt, pszichoterápiás osztályos kezelés 09 – volt, pszichoterápiás ambuláns kezelés 10 – volt, professzionális tanácsadó szolgálat 11 – volt, önkéntes szolgálat (pl. telefonszolgálat, vagy egyéb önkéntes szervezet) 12 – volt, addiktológiai kezelés 13 – egyéb, éspedig..... 88 – nem alkalmazható 99 – nem ismert	40	<b>A páciens további kezelés javasolt (továbbirányítás):</b> 01 – nem volt 02 – igen, sürgősségi ellátás 03 – igen, háziorvos 04 – igen, szomatikus osztályos kezelés 05 – igen, pszichiátriai osztályos kezelés 06 – igen, szomatikus ambuláns kezelés 07 – igen, pszichiátriai ambuláns kezelés 08 – igen, pszichoterápiás osztályos kezelés 09 – igen, pszichoterápiás ambuláns kezelés 10 – igen, professzionális tanácsadó szolgálat 11 – igen, önkéntes szolgálat (pl. telefonszolgálat, vagy egyéb önkéntes szervezet) 12 – igen, addiktológiai kezelés 13 – egyéb, éspedig..... 88 – nem alkalmazható 99 – nem ismert
41	<b>Pszichiátriai diagnózis: (BNO 10 szerint)</b> Fő diagnózis ..... 2. diagnózis..... 3. diagnózis.....		<b>BNO kód</b> ..... ..... .....
42	<b>A szuicid kísérlet osztályozása:</b> 01 – szándékos önsértés (nem szokásos) 02 – paraszuicid próbálkozás 03 – paraszuicid gesztus 04 – súlyos szuicid kísérlet 09 – nem ismert	43	<b>Az osztályozás megbízhatósága:</b> 01 – biztos 02 – bizonytalan 09 – nem ismert
		44	<b>Véletlen túladagolás</b> 01 – igen 02 – nem 09 – nem ismert



<b>45</b>	<b>A szuicid kísérlet oka: (közvetlen rizikó faktorok)</b> 01 – interperszonális konfliktus (családtaggal, partnerrel, baráttal) 02 – veszteség, gyász vagy családtag, partner, barát súlyos betegsége 03 – testi betegség 04 – lelki betegség 08 – egyéb, éspedig .....	05 – anyagi, egzisztenciális problémák 06 – bántalmazás 07 – törvénnyel való összeütközés 09 – nem ismert
	<b>A kérdőívet kitöltötte:</b> .....	



<b>COGNOME E NOME (iniziali, prime due lettere)</b>		<b>SESSO</b>	M	2	F	<b>DATA DI NASCITA</b>	<b>ETA'</b>
<b>ASL</b>	<b>REPARTO</b>	<b>DATA TENTATIVO DI SUICIDIO</b>		<b>ORA TENTATIVO DI SUICIDIO</b>			
<b>STATO DI NASCITA</b>	<b>PROVENIENZA DA ALTRA NAZIONE</b> <input type="checkbox"/> SI <input type="checkbox"/> NO	<b>DA QUANTO TEMPO VIVE IN ITALIA?</b>		<b>CITTADINANZA</b>	<b>GRUPPO ETNICO</b>		
<b>STATO DI NASCITA (padre)</b>				<b>STATO DI NASCITA (madre)</b>			
<b>AMBIENTE DI CRESCITA</b> <input type="checkbox"/> Famiglia tradizionale <input type="checkbox"/> Genitore single <input type="checkbox"/> Altri parenti <input type="checkbox"/> Famiglia adottiva <input type="checkbox"/> Istituzione <input type="checkbox"/> Altro							
<b>RESIDENZA AL MOMENTO DEL TENTATIVO</b>		<b>CAMBIO DI RESIDENZA ULTIMI 12 MESI</b> <input type="checkbox"/> SI <input type="checkbox"/> NO		<b>GRUPPO RELIGIOSO</b>			
<b>STATO CIVILE</b> <input type="checkbox"/> Mai sposato <input type="checkbox"/> Vedovo <input type="checkbox"/> Divorziato <input type="checkbox"/> Separato <input type="checkbox"/> Primo matrimonio <input type="checkbox"/> Matrimonio successivo  <input type="checkbox"/> Convivente legale							
<b>ORGANIZZAZIONE FAMILIARE (ultimo anno)</b> <input type="checkbox"/> Vive da solo <input type="checkbox"/> Vive da solo con figli <input type="checkbox"/> Vive con il partner senza figli <input type="checkbox"/> Vive con il partner con figli  <input type="checkbox"/> Vive con I genitori <input type="checkbox"/> Vive con altri parenti/amici <input type="checkbox"/> Vive in istituto psichiatrico <input type="checkbox"/> Vive in carcere  <input type="checkbox"/> Vive in casa di riposo <input type="checkbox"/> Altro							
<b>ORGANIZZAZIONE FAMILIARE AL MOMENTO DEL TENTATIVO</b> <input type="checkbox"/> Vive da solo <input type="checkbox"/> Vive da solo con figli <input type="checkbox"/> Vive con il partner senza figli <input type="checkbox"/> Vive con il partner con figli  <input type="checkbox"/> Vive con I genitori <input type="checkbox"/> Vive con altri parenti/amici <input type="checkbox"/> Vive in istituto psichiatrico <input type="checkbox"/> Vive in carcere  <input type="checkbox"/> Vive in casa di riposo <input type="checkbox"/> Altro							
<b>SCOLARITA'</b> <input type="checkbox"/> Sotto il livello dell'obbligo <input type="checkbox"/> Scuola dell'obbligo <input type="checkbox"/> Scuola superiore <input type="checkbox"/> Università					<b>OCCUPAZIONE ATTUALE (o ultima)</b>		
<b>STATO OCCUPAZIONALE</b> <input type="checkbox"/> Tempo pieno permanente <input type="checkbox"/> Part-time permanente <input type="checkbox"/> Occupato ma in malattia <input type="checkbox"/> Tempo pieno temporaneo  <input type="checkbox"/> Part-time temporaneo <input type="checkbox"/> Disoccupato <input type="checkbox"/> Studente o apprendista <input type="checkbox"/> Servizio militare <input type="checkbox"/> Prigioniero <input type="checkbox"/> Disabile  <input type="checkbox"/> Pensionato <input type="checkbox"/> Casalinga <input type="checkbox"/> Non lavora <input type="checkbox"/> Altro							
<b>TEMPO DI DISOCCUPAZIONE ( in settimane)</b>				<b>METODO SUICIDARIO (descrizione)</b>			
<b>METODO SUICIDARIO 1 (ICD-10)</b>	<b>METODO SUICIDARIO 2 (ICD-10)</b>	<b>METODO SUICIDARIO 3 (ICD-10)</b>	<b>METODO SUICIDARIO 4 (ICD-10)</b>				

<b>LESIONI RICONTRATE SUCCESSIVE AL T.S.</b>		<b>PRESCRIZIONE MEDICINE</b> <input type="checkbox"/> No <input type="checkbox"/> Si, per il paziente <input type="checkbox"/> Si, per altri <input type="checkbox"/> Non applicabile	
<b>LUOGO TS</b> <input type="checkbox"/> Propria residenza <input type="checkbox"/> Istituzione medica <input type="checkbox"/> Altro luogo pubblico			<b>NUMERO DI TENTATIVI PRECEDENTI</b>
<b>CONTATTO SISTEMA SANITARIO TS PRECEDENTI</b> <input type="checkbox"/> SI <input type="checkbox"/> NO	<b>CONTATTO ALTRI SERVIZI TS PRECEDENTI</b> <input type="checkbox"/> SI <input type="checkbox"/> NO	<b>PRECEDENTI TENTATIVI NELL'ULTIMO ANNO</b> <input type="checkbox"/> SI <input type="checkbox"/> NO	
<b>CONTATTO SISTEMA SANITARIO TS ULTIMO ANNO</b> <input type="checkbox"/> SI <input type="checkbox"/> NO	<b>CONTATTO ALTRI SERVIZIO TS ULTIMO ANNO</b> <input type="checkbox"/> SI <input type="checkbox"/> NO	<b>CONTATTO SISTEMA SANITARIO TS RECENTE</b> <input type="checkbox"/> SI <input type="checkbox"/> NO	
<b>TRATTAMENTO RACCOMANDATO</b> <input type="checkbox"/> Nessuno <input type="checkbox"/> Emergenza <input type="checkbox"/> Medico di base <input type="checkbox"/> Reparto medico o chirurgico <input type="checkbox"/> Reparto psichiatrico  <input type="checkbox"/> Ambulatorio medico <input type="checkbox"/> Ambulatorio Psichiatrico <input type="checkbox"/> Ricoverato per psicoterapia <input type="checkbox"/> Ambulatorio di psicoterapia  <input type="checkbox"/> Counseling professionale <input type="checkbox"/> Servizi di volontari <input type="checkbox"/> Servizio Tossicodipendenze <input type="checkbox"/> Altro <input type="checkbox"/> Non applicabile			
<b>DIAGNOSI PSICHIATRICA 1 (ICD-10)</b>	<b>DIAGNOSI PSICHIATRICA 2 (ICD-10)</b>	<b>DIAGNOSI PSICHIATRICA 3 (ICD-10)</b>	
<b>CLASSIFICAZIONE TENTATIVO DI SUICIDIO</b> <input type="checkbox"/> Gesto auto lesivo <input type="checkbox"/> Parasuicidio <input type="checkbox"/> Ts serio		<b>SICUREZZA CLASSIFICAZIONE</b> <input type="checkbox"/> Certa <input type="checkbox"/> Incerta	<b>OVERDOSE ACCIDENTALE</b> <input type="checkbox"/> SI <input type="checkbox"/> NO
<b>MOTIVAZIONE TS PRINCIPALE</b> <input type="checkbox"/> Conflitto interpersonale <input type="checkbox"/> Lutto <input type="checkbox"/> Malattia somatica <input type="checkbox"/> Malattia psichiatrica <input type="checkbox"/> Difficoltà finanziarie  <input type="checkbox"/> Maltrattamenti <input type="checkbox"/> Problemi legali <input type="checkbox"/> Altro			
<b>MOTIVAZIONE TS SECONDARIA</b> <input type="checkbox"/> Conflitto interpersonale <input type="checkbox"/> Lutto <input type="checkbox"/> Malattia somatica <input type="checkbox"/> Malattia psichiatrica <input type="checkbox"/> Difficoltà finanziarie  <input type="checkbox"/> Maltrattamenti <input type="checkbox"/> Problemi legali <input type="checkbox"/> Altro			
<b>MOTIVAZIONE TS 3</b> <input type="checkbox"/> Conflitto interpersonale <input type="checkbox"/> Lutto <input type="checkbox"/> Malattia somatica <input type="checkbox"/> Malattia psichiatrica <input type="checkbox"/> Difficoltà finanziarie  <input type="checkbox"/> Maltrattamenti <input type="checkbox"/> Problemi legali <input type="checkbox"/> Altro			
<b>TELEFONO INTERVISTATORE</b>			



1	<b>Bolnišnica:</b> ..... <input type="checkbox"/>	2	<b>Oddelek:</b> ..... <input type="checkbox"/>
3	<b>Koda pacienta:</b> .....	4	<b>Spol:</b> 01 – moški 02 – ženski 03 – sprememba iz moškega v žensko 03 – sprememba iz ženske v moškega 09 – neznano
5	<b>Datum rojstva:</b> (dan/mesec/leto) ...../...../.....	6	<b>Starost (let)</b> .....
7	<b>Datum poskusa samomora:</b> ...../...../.....	8	<b>Čas poskusa samomora:</b> ..... (ure)
9	<b>Država rojstva:</b> ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	10	<b>Bivanje v državi trenutnega prebivališča?</b> .....(let)
11	<b>Matična država:</b> (izvorna država) ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	12	<b>Državljanstvo:</b> (ime države) ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
13	<b>Narodnost:</b> ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		
14	<b>Materina država rojstva:</b> (ime države) ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	15	<b>Očetova država rojstva:</b> (ime države) ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
16	<b>Odraščanje:</b> 01 – v tradicionalni družini 03 – pri drugih sorodnikih 05 – v zavodu 09 - neznano 02 – starš samohranilec 04 – posvojiteljska ali rejniška družina 06 – drugo, opišite .....		
17	<b>Bivališče v omejenem področju v času poskusa samomora: (nacionalna klasifikacija)</b> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Poštna številka: <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		
18	<b>Sprememba naslova v zadnjih 12 mesecih:</b> 01 – naslov je bil pred enim letom isti 02 - sprememba naslova, a isto omejeno področje 03 – sprememba naslova, bivališče zunaj omejenega področja 04 – sprememba naslova, bivališče v tujini 09 – neznano	19	<b>Veroizpoved:</b> 01 – nobena (ateist) 02 – brez veroizpovedi (ni pomembno) 03 – protestantska 08 – grško ortodoksna 04 – katoliška 09 - budistična 05 – judovska 10 – drugo, opišite .....
20	<b>Trenutni zakonski stan:</b> 01 – nikoli poročen 03 – ločen 05 – prvi zakon 07 – zunajzakonska skupnost 02 – ovdovel 04 – razvezan 06 – drugi ali kateri naslednji zakon 09 - neznano		
21	<b>Sestava gospodinjstva v preteklem letu:</b> 01 – sam 02 – sam z otroki 03 – s partnerjem brez otrok 03 – s partnerjem in otroki 05 – s starši 06 – s sorodniki/prijatelji 07 – v psihiatrični ustanovi 08 – v zaporu 09 – v ustanovah 10 – v domu za upokojence 11 – drugo, opišite .....	22	<b>Sestava gospodinjstva v času poskusa samomora:</b> 01 – sam 02 – sam z otroki 03 – s partnerjem brez otrok 03 – s partnerjem in otroki 05 – s starši 06 – s sorodniki/prijatelji 07 – v psihiatrični ustanovi 08 – v zaporu 09 – v ustanovah 10 – v domu za upokojence 11 – drugo, opišite .....
23	<b>Stopnja izobrazbe: (najvišja končana izobrazba)</b> 01 – nedokončana osnovnošolska 03 – srednješolska ali poklicna 02 – osnovnošolska 04 – univerzitetna/ podobna raven izobrazbe <input type="checkbox"/>		
24	<b>Trenutno (ali zadnje) delovno mesto:</b> .....		
25	<b>Poklic:</b> 1000 – zakonodajalci, visoki uradniki in menedžerji 2000 - strokovnjaki 3000 – tehniki in drugi strokovni sodelavci 4000 - uradniki 5000 – poklici za storitve, prodajalci . 6000 – kmetovalci, gozdarji, ribiči 7000 – obrtniški poklici 8000 – upravljalci strojev in naprav 9000 - poklici za preprosta dela 0008 - nerazvrščeni 0009 – neznano	26	<b>Ekonomski status, zaposlitveni status:</b> 01 – poln delovni čas, stalna zaposlitev (vključno samozapos.) 02 – polovični delovni čas, stalna zaposlitev (vključno samozapos.) 03 – zaposlen, a na bolniškem dopustu 04 – poln delovni čas, začasno delo 05 – polovičen delovni čas, začasno delo 06 - brezposeln 07 – redni študent ali vajenec 08 – vojaška služba 09 – zaprt v zaporu 10 – invalid, kronično bolan ali predčasno upokojen zaradi

			bolezni 11 - upokojen 12 - gospodinja/gospodinjec 13 - brez dela 14 - drugo, opišite .....
27	<b>Trajanje dejanske brezposelnosti:</b> ..... (tedni) 888 - ne ustreza 999 - neznano		
28	<b>Opis poskusa samomora:</b> (način/i in okoliščine poskusa samomora) ..... .....		
29	<b>Način(i) poskusa samomora:</b> (po klasifikaciji ICD-10, Poglavlje XX) Način 1..... Način 2..... Način 3..... Način 4.....	<b>ICD-10 koda</b> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	
30	<b>Poškodbe, zastрупitve in druge posledice:</b> (po klasifikaciji ICD-10, Poglavlje XX) .....		<b>ICD-10 koda</b> <input type="text"/>
31	<b>Predpisana zdravila:</b> 01 - ne 02 - da, zame 03 - da, za nekoga drugega 04 - ne ustreza 09 - neznano	32	<b>Kraj poskusa samomora:</b> 01 - doma 02 - zdravstvena ustanova 03 - drugi javni prostor, opišite ..... 09 - neznano
33	<b>Število prejšnjih poskusov samomora:</b> 00 - nič <input type="text"/> 09 - neznano <input type="text"/> (število)	34	<b>Stik z zdravstvenim sistemom po prejšnjem poskusu samomora:</b> 00 - nikoli <input type="text"/> 88 - ne ustreza 99 - neznano
35	<b>Stik z drugimi službami po prejšnjem poskusu samomora:</b> 00 - nikoli <input type="text"/> 88 - ne ustreza 99 - neznano	36	<b>Prejšnji poskusi samomora v enem letu:</b> 00 - nikoli <input type="text"/> 09 - neznano <input type="text"/> (število)
37	<b>Stik z zdravstvenim sistemom po prejšnjem poskusu samomora v enem letu:</b> 00 - nikoli <input type="text"/> 88 - ne ustreza 99 - neznano <input type="text"/> (število)	38	<b>Stik z drugimi službami po prejšnjem poskusu samomora v enem letu:</b> 00 - nikoli <input type="text"/> 88 - ne ustreza 99 - neznano <input type="text"/> (število)
39	<b>Stik z zdravstvenim sistemom po zadnjem poskusu samomora:</b> 01 - ne 02 - da, dežurni zdravnik 03 - da, splošni zdravnik 04 - da, ne-psihiatrično (somatsko) bolnišnično 05 - da, psihiatrično bolnišnično 06 - da, ne-psihiatrično (somatsko) ambulantno 07 - da, psihiatrično ambulantno 08 - da, psihoterapevtsko bolnišnično 09 - da, psihoterapevtsko ambulantno 10 - da, strokovna svetovalna služba 11 - da, prostovoljne službe (npr. telefonska pomoč, druge prostovoljne službe) 12 - da, zdravljenje odvisnosti 13 - drugo, opišite .....	40	<b>Priporočena nadaljnja oskrba:</b> 01 - ne 02 - da, dežurni zdravnik 03 - da, splošni zdravnik 04 - da, ne-psihiatrično (somatsko) bolnišnično 05 - da, psihiatrično bolnišnično 06 - da, ne-psihiatrično (somatsko) ambulantno 07 - da, psihiatrično ambulantno 08 - da, psihoterapevtsko bolnišnično 09 - da, psihoterapevtsko ambulantno 10 - da, strokovna svetovalna služba 11 - da, prostovoljne službe (npr. telefonska pomoč, druge prostovoljne službe) 12 - da, zdravljenje odvisnosti 13 - drugo, opišite .....
41	<b>Psihiatrična diagnoza:</b> (po klasifikaciji ICD-10, Poglavlje V) Prva psihiatrična diagnoza ..... Druga psihiatrična diagnoza ..... Tretja psihiatrična diagnoza .....		<b>ICD-10 koda</b> <input type="text"/> <input type="text"/> <input type="text"/>
42	<b>Klasifikacija poskusa samomora:</b> 01 - namerna samopoškodba (neobičajno) 02 - parasuicidalna pavza/trenutni poskus 03 - parasuicidalna gesta 04 - resen poskus samomora 09 - neznano	43	<b>Gotovost klasifikacije:</b> 01 - gotovo 02 - negotovo 09 - neznano
		44	<b>Prevelik odmerek po nesreči:</b> 01 - da 02 - ne 09 - neznano



<b>45</b>	<b>Vzroki poskusa samomora:</b> <i>(neposredni dejavniki tveganja)</i>	
	01 – medosebni konflikt (z družino, partnerjem, prijatelji)	05 – finančne težave
	02 – izguba ali težka bolezen druž.člana, partnerja, prijatelja	06 - zloraba
	03 – fizična bolezen	07 – pravne težave
	04 – duševna motnja	09 - neznano
	08 – drugo, opišite .....	
<b>Podatki o anketarju:</b>		
<b>Ime:</b> ..... <b>Telefon:</b> .....		



1	Hospital: <input type="checkbox"/>	2	Departamento: <input type="checkbox"/>
3	Nombre y Apellidos: .....  Nº Historia <input type="text"/> <b>SI ES POSIBLE PONER ETIQUETA IDENTIFICATIVA</b>	4	Sexo: 01 – hombre 02 – mujer 03 – cambio de hombre a mujer 04 – cambio de mujer a hombre 09 – desconocido
5	Fecha nacimien: (día/mes/año) ...../...../.....	6	Edad (años) .....
7	Fecha tentativa suicida: ...../...../.....	8	Hora tentativa suicida: ..... (hora)
9	País de nacimiento: <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	10	Años vívidos en país de residencia actual: ..... (años)
11	País de procedencia: (si viene de otro país) <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	12	Nacionalidad: (nombre del país) <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
13	Raza: <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		
14	País de nacimiento de la madre: (nombre del país) <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	15	País de nacimiento del padre: (nombre del país) <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
16	Criado en / por: 01 – familia tradicional      03 – otros familiares      05 – institución      09 – desconocido 02 – familia monoparental      04 – adoptado      06 – otros, especificar.....		
17	Lugar de residencia en el momento de la tentativa: (poner nombre de calle / ciudad) <input type="text"/> Codigo postal: <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		
18	Cambio de dirección durante el ultimo año: 01 – no ha habido cambio 02 – cambio de dirección, pero misma ciudad 03 – cambio de dirección, distinta ciudad 04 – cambio de dirección, ciudad extranjera 09 – desconocido	19	Religión: 01 – ninguna (ateo) 02 – ninguna (indiferente) 03 – protestante      08 – griego ortodoxo 04 – católico      09 – budista 05 – judío      10 – otras, especificar..... 06 – musulman      99 – desconocido 07 – hindú
20	Estado civil actual: 01 – nunca casado      03 – divorciado      05 – primer matrimonio      07 – cohabitación legal 02 – viudo      04 – separado      06 – segundo o más matrimonio      09 – desconocido		
21	Convivencia habitual durante el ultimo año: 01 – sólo 02 – solo con hijos 03 – con pareja sin hijos 04 – con pareja e hijos 05 – con padres 06 – con otros familiares / amigos 07 – institución psiquiátrica 08 – prisión 09 – otra institución 10 – residencia de ancianos 11 – otras, especificar ..... 99 – desconocido	22	Convivencia en el momento de la tentativa suicida: 01 – sólo 02 – solo con hijos 03 – con pareja sin hijos 04 – con pareja e hijos 05 – con padres 06 – con otros familiares / amigos 07 – institución psiquiátrica 08 – prisión 09 – otra institución 10 – residencia de ancianos 11 – otras, especificar ..... 99 – desconocido
23	Nivel educativo: (máximo nivel completado) 01 – menos que educación primaria      03 – bachiller superior / FP      09 – desconocido 02 – educación primaria      04 – diplomatura / licenciatura		
24	Ocupación actual (ó última ocupación): .....		
25	Ocupación: 1000 – legislador / directivo / gerente 2000 – profesionales científicos / intelectuales 3000 – técnicos y profesionales de nivel medio 4000 – empleados de oficina 5000 – trabajadores en servicios, comerciantes y dependientes 6000 – trabajador cualificado de agricultura / pesca 7000 – oficiales, operarios y artesanos de artes mecánicas y otros oficios 8000 – operadores de instalaciones y maquinaria y montadores 9000 – trabajadores no cualificados	26	Nivel económico: 01 – empleo permanente a tiempo completo (incl. autónomo) 02 – empleo permanente a tiempo parcial (incl. autónomo) 03 – baja laboral 04 – empleo temporal a tiempo completo 05 – empleo temporal a tiempo parcial 06 – desempleo 07 – estudiante a tiempo completo 08 – servicio militar 09 – preso 10 – discapacitado / jubilado por enfermedad 11 – retirado 12 – ama de casa



	0008 – no aplicable 0009 – desconocido		13 – no trabaja 14 – otros, especificar.....				
27	<b>Duración del tiempo de desempleo:</b> ..... (semanas)                      888 – no aplicable                      999 – desconocido						
28	<b>Especificar intención de TS: (método(s), y circunstancias de TS)</b> ..... ..... .....						
29	<b>Método(s) de la tentativa suicida: (Códigos CIE-10, Capítulo XX)</b> Método 1 ..... Método 2 ..... Método 3 ..... Método 4 .....		<b>Código CIE-10</b> <table border="1"><tr><td> </td></tr><tr><td> </td></tr><tr><td> </td></tr><tr><td> </td></tr></table>				
30	<b>Grupo por método: (CIE-10, Capítulo XX)</b> .....		<b>Código CIE-10</b> <table border="1"><tr><td> </td></tr></table>				
31	<b>Si en la TS usó fármacos, habían sido prescritos:</b> 01 – no 02 – sí, para el paciente 03 – sí, para otras personas 04 – no aplicable 09 – desconocido	32	<b>Lugar de la tentativa suicida:</b> 01 – hogar 02 – institución médica 03 – otro lugar público, especificar ..... 09 – desconocido				
33	<b>Número de tentativas suicidas previas:</b>  00 – ninguna <input type="checkbox"/> 99 – desconocido <input type="checkbox"/> <p style="text-align: center;">(número)</p>	34	<b>Contacto con el sistema de salud tras una tentativa previa:</b>  00 – nunca <input type="checkbox"/> 88 – no aplicable <input type="checkbox"/> 99 – desconocido <input type="checkbox"/> <p style="text-align: center;">(número)</p>				
35	<b>Contacto con otros servicios tras una tentativa previa:</b>  00 – nunca <input type="checkbox"/> 88 – no aplicable <input type="checkbox"/> 99 – desconocido <input type="checkbox"/> <p style="text-align: center;">(número)</p>	36	<b>Tentativa suicida previa en el ultimo año:</b>  00 – nunca <input type="checkbox"/> 99 – desconocido <input type="checkbox"/> <p style="text-align: center;">(número)</p>				
37	<b>Contacto con el sistema de salud tras una tentativa previa realizada en el último año:</b>  00 – nunca <input type="checkbox"/> 88 – no aplicable <input type="checkbox"/> 99 – desconocido <input type="checkbox"/> <p style="text-align: center;">(número)</p>	38	<b>Contacto con otros servicios tras una tentativa previa realizada en el último año:</b>  00 – nunca <input type="checkbox"/> 88 – no aplicable <input type="checkbox"/> 99 – desconocido <input type="checkbox"/> <p style="text-align: center;">(número)</p>				
39	<b>Contacto con el sistema de salud tras la tentativa previa más reciente:</b> 01 – no 02 – sí, medico de urgencias 03 – sí, MAP 04 – sí, ingreso no-psiquiátrico (somático) 05 – sí, ingreso psiquiátrico 06 – sí, paciente ambulatorio no-psiquiátrico (somático) 07 – sí, paciente psiquiátrico ambulatorio 08 – sí, psicoterapia en hospital 09 – sí, psicoterapia ambulatoria 10 – sí, “counselling” profesional 11 – sí, servicios no profesionales (x ej. teléfono de la esperanza...) 12 – sí, tratamiento por toxicomanía 13 – otros, especificar .....	40	<b>Tratamiento recomendado tras tentativa actual:</b> 01 – no 02 – sí, medico de urgencias 03 – sí, MAP 04 – sí, ingreso no-psiquiátrico (somático) 05 – sí, ingreso psiquiátrico 06 – sí, paciente ambulatorio no-psiquiátrico (somático) 07 – sí, paciente psiquiátrico ambulatorio 08 – sí, psicoterapia en hospital 09 – sí, psicoterapia ambulatoria 10 – sí, “counselling” profesional 11 – sí, servicios no profesionales (x ej. teléfono de la esperanza...) 12 – sí, tratamiento por toxicomanía 13 – otros, especificar .....				
41	<b>Diagnóstico psiquiátrico: (CIE-10, capítulo V)</b> Diagnóstico psiquiátrico <b>principal</b> ..... Diagnóstico psiquiátrico <b>secundario</b> ..... Diagnóstico psiquiátrico <b>terciario</b> .....		<table border="1"><tr><td> </td></tr><tr><td> </td></tr><tr><td> </td></tr></table>				
42	<b>Clasificación de la tentativa suicida:</b> 01 – autoagresión sin intención suicida (no habitual) 02 – pausa parasuicida 03 – gesto parasuicida 04 – tentativa suicida grave 09 – desconocido	43	<b>Certeza de clasificación:</b> 01 – seguro 02 – inseguro 09 – desconocido				
		44	<b>Sobredosis accidental:</b> 01 – si 02 – no 09 – desconocido				



<b>45</b>	<b>Causa de la tentativa suicida: (factores de riesgo directos)</b> 01 – conflicto interpersonal (con familiar / pareja / amigos) 02 – muerte o enfermedad grave de familiar / pareja / amigo 03 – enfermedad física 04 – enfermedad mental (problema psiquiátrico) 08 – otros, especificar.....	05 – dificultades económicas 06 – maltrato 07 – problemas legales 09 – desconocido
<b>Datos del entrevistador:</b> <b>Nombre:</b> ..... <b>Teléfono:</b> .....		

**WHO:s multicenterstudie och nationell studie  
beträffande självmordsförsök  
CENTER 10**

Intervjuarens namn: ..... Tel: .....

Klinik/mottagning: .....

Information om studien delgiven patienten:  ja  nej

Uppgifterna bygger på: 1 Personlig intervju  
2 Telefonintervju  
3 Journaluppgifter

**OBS!**

**Gå igenom alla alternativ, då flera svar kan vara aktuella**

<p>1) Sjukvårdsområdet där intervjun äger rum 1 Huddinge sjukhus</p>	<p>12) Metod vid självmordsförsöket</p> <p>Specificera läkemedel: .....</p> <p>.....</p> <p>.....</p> <p>Antal tabl.: .....&lt;5.....6-10.....11-20.....21-50.....101&lt;</p>
<p>2) Datum för intervjun (År, Mån, Dag)</p>	<p>60 Förgiftning med analgetika av icke-narkotisk typ, anti-pyretika och anireumatiska medel.</p>
<p>3) Plats för intervjun (spec. vårdavd./mottagning)</p>	<p>61 Förgiftning med barbiturater, andra sedativa, hypnotika, ataraktika, antidepressiva medel, neuroleptika och antipsykotiska medel.</p>
<p>4) Patientens kodnummer 2 första ..... 4 sista siffrorna ..... i personnumret</p>	<p>62 Förgiftning med opiater, narkotika och psykodysleptiska medel.</p>
<p>5) Kön 1=Man 2=Kvinna</p>	<p>63 Förgiftning med andra medel som påverkar det centrala och autonoma nervsystemet som t ex anti-epileptika, medel mot Parkinsonism, lokala bedövningsmedel, spasmolytika, adrenergika, anti-adrenergika, kolinergerika och antikolinergerika.</p>
<p>6) Ålder .....år</p>	<p>64 Förgiftning med andra läkemedel t ex hormoner, antibiotika, mineraler.</p>
<p>7) Datum för självmordsförsöket (År, Mån, Dag)</p>	<p>64a Förgiftning med okänd typ av läkemedel.</p>
<p>8) Tidpunkt på dygnet för självmordsförsöket (24-tim kl.) I:lockan.....</p>	<p>65 Förgiftning med alkohol.</p>
<p>9) Datum när kontakt togs med sjukvården efter det aktuella självmordsförsöket (År, Mån, Dag)</p>	<p>66 Förgiftning med bensinprodukter, organiska lösningsmedel och deras ångor.</p>
<p>10) Rekommenderad kontakt/efftervård</p> <p>01 Ingen 02 Patienten avvek ej läkarbedömd 03 Psykiatrisk öppenvård 04 Psykiatrisk slutenvård 05 Primärvård (distriktsläkare etc) 06 Somatisk slutenvård 07 Alkoholmottagning/narkomanvård öppenvård 08 Alkoholavdelning/narkomanvård slutenvård 09 Familjerådgivning 10 Barn/ungdomspsykiatrisk avdelning/mottagning (PUB) 11 Övrigt (spec.) .....</p>	<p>67 Förgiftning med andra gaser och ångor.</p>
<p>11) Alkoholkonsumtion i samband med det aktuella självmordsförsöket</p> <p>1 Nej 3 Vet ej 2 Ja 4 Vill ej lämna uppgift</p>	<p>68 Förgiftning med insekts-, ogräsbekämpningsmedel och tox. bekämpningsmedel som används i jordbruk.</p>
	<p>69 Förgiftning med andra kemiska och skadliga substanser.</p>
	<p>70 Självmordsförsök genom hängning, strypning eller kvävning.</p>
	<p>71 Självmordsförsök genom dränkning.</p>
	<p>72 Självmordsförsök med revolver.</p>
	<p>73 Självmordsförsök med gevär och större sjutvapen.</p>
	<p>74 Självmordsförsök med andra och ospec. sjutvapen.</p>
	<p>75 Självmordsförsök genom explosiva ämnen eller anordningar.</p>
	<p>76 Självmordsförsök genom eld.</p>
	<p>77 Självmordsförsök genom ånga och varma föremål.</p>
	<p>78 Självmordsförsök genom vassa föremål.</p>
	<p>79 Självmordsförsök genom trubbiga föremål.</p>
	<p>80 Självmordsförsök genom hopp från höjd.</p>
	<p>81 Självmordsförsök genom hopp framför ett fordon i rörelse eller genom att lägga sig framför ett fordon i rörelse.</p>
	<p>82 Självmordsförsök genom fordonskrock.</p>
	<p>83 Självmordsförsök genom andra spec. metoder. ..... .....</p>
	<p>84 Självmordsförsök genom ospec. metoder. ..... .....</p>

<p><b>12a) Vid intoxikationen använda läkemedel erhållits genom:</b></p> <ol style="list-style-type: none"> <li>1 Eget recept</li> <li>2 Släkt, vänner, bekantas recept</li> <li>3 Utan recept</li> <li>4 Annat, vad .....</li> <li>5 Vill ej lämna uppgift</li> <li>6 Vet ej</li> </ol>	<p><b>19) Partnerförhållande under senaste 3 mån</b></p> <ol style="list-style-type: none"> <li>1 Har ingen partner</li> <li>2 Har partner av motsatt kön</li> <li>3 Har partner av samma kön</li> </ol>																																		
<p><b>13) Har tidigare självmordsförsök inträffat (oavsett om de behandlats)</b></p> <ol style="list-style-type: none"> <li>1 Aldrig</li> <li>2 Ja – under den senaste 12 mån. perioden</li> <li>3 Ja – för mer än 12 mån. sen</li> <li>4 Ja båda alt. 2 och 3</li> <li>5 Ja – men tidpunkten osäker/okänd</li> </ol>	<p><b>20) Har patienten separerat under de senaste 12 månaderna. (Ange från vem?)</b></p> <ol style="list-style-type: none"> <li>1 Nej</li> <li>2 Ja                    2a Från .....</li> <li>3 Ingen uppgift</li> </ol>																																		
<p><b>14) Födelse- och nationalitet</b></p> <table border="0"> <thead> <tr> <th>Land</th> <th>Nationalitet</th> </tr> </thead> <tbody> <tr><td>01 Sverige</td><td>01</td></tr> <tr><td>02 Finland</td><td>02</td></tr> <tr><td>03 Norge</td><td>03</td></tr> <tr><td>04 Danmark</td><td>04</td></tr> <tr><td>05 Turkiet</td><td>05</td></tr> <tr><td>06 Jugoslavien</td><td>06</td></tr> <tr><td>07 Grekland</td><td>07</td></tr> <tr><td>08 Polen</td><td>08</td></tr> <tr><td>09 Västtyskland</td><td>09</td></tr> <tr><td>10 Storbritannien</td><td>10</td></tr> <tr><td>11 Övriga Europa</td><td>11</td></tr> <tr><td>12 Chile</td><td>12</td></tr> <tr><td>13 Syrien</td><td>13</td></tr> <tr><td>14 Övrigt .....</td><td>14</td></tr> <tr><td>15 Ingen uppgift</td><td></td></tr> <tr><td>06/a fd Jugoslaven spec .....</td><td></td></tr> </tbody> </table>	Land	Nationalitet	01 Sverige	01	02 Finland	02	03 Norge	03	04 Danmark	04	05 Turkiet	05	06 Jugoslavien	06	07 Grekland	07	08 Polen	08	09 Västtyskland	09	10 Storbritannien	10	11 Övriga Europa	11	12 Chile	12	13 Syrien	13	14 Övrigt .....	14	15 Ingen uppgift		06/a fd Jugoslaven spec .....		<p><b>21) Boendeförhållande vid det aktuella självmordsförsöket.</b></p> <ol style="list-style-type: none"> <li>01 Ensamboende</li> <li>02 Ensamboende med barn</li> <li>03 Sammanboende m make/maka u barn</li> <li>04 Sammanboende m make/maka m barn</li> <li>05 Sammanboende m partner utan barn</li> <li>06 Sammanboende m partner, med barn</li> <li>07 Boende med föräldrar</li> <li>08 Boende med andra släkt/vänner</li> <li>09 Boende på institution</li> <li>10 Annat boende (spec) .....</li> <li>11 Uppgift saknas</li> </ol>
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<p><b>15) Huvudsaklig bostadsord vid tiden för det aktuella självmordsförsöket</b></p> <p>Kommun/församling.....Gata .....</p> <p>Postnummer.....Gata .....</p>	<p><b>22) Om patienten flyttat för tiden för det aktuella självmordsförsöket, ange tidigare boendeförhållande</b></p> <ol style="list-style-type: none"> <li>01 Ensamboende</li> <li>02 Ensamboende med barn</li> <li>03 Sammanboende m make/maka u barn</li> <li>04 Sammanboende m make/maka m barn</li> <li>05 Sammanboende m partn. utan barn</li> <li>06 Sammanboende m partn. med barn</li> <li>07 Boende med föräldrar</li> <li>08 Boende med andra släkt/vänner</li> <li>09 Boende på institution</li> <li>10 Annat boende (spec) .....</li> <li>11 Uppgift saknas</li> </ol>																																		
<p><b>16) Tillfällig bostadsort vid tiden för det aktuella självmordsförsöket (svar endast om pat. ej bor som i fråga 15)</b></p> <p>Kommun/församling.....Gata .....</p> <p>Postnummer.....Gata .....</p>	<p><b>22a) Hemmaboende barn</b></p> <p>antal ..... ålder.....</p>																																		
<p><b>17) Adressändring under senaste året</b></p> <ol style="list-style-type: none"> <li>1 Nej</li> <li>2 Tidigare under året bosatt annan adress, dock samma kommun/län</li> <li>3 Tidigare under året bosatt annan kommun/län</li> <li>4 Tidigare bosatt utomlands</li> </ol>	<p><b>23) Religionstillhörighet</b></p> <ol style="list-style-type: none"> <li>1 Ingen</li> <li>2 Protestant/frikyrklig</li> <li>3 Katolsk</li> <li>4 Judisk</li> <li>5 Muslimska</li> <li>7 Grekisk ortodox</li> <li>9 Annat .....</li> <li>11 Uppgift saknas</li> </ol>																																		
<p><b>18) Formellt civilstånd</b></p> <table border="0"> <tbody> <tr> <td>1 Ogift</td> <td>5 Frånskild</td> </tr> <tr> <td>1a ogift/sambo</td> <td>5a Frånskild/sambo</td> </tr> <tr> <td>2 Gift (1a ggn)</td> <td>6 ogift/separerad</td> </tr> <tr> <td>3 omgift</td> <td>6a frånskild/separ</td> </tr> <tr> <td>4 Änka/änkling</td> <td>9 Ingen uppgift</td> </tr> </tbody> </table>	1 Ogift	5 Frånskild	1a ogift/sambo	5a Frånskild/sambo	2 Gift (1a ggn)	6 ogift/separerad	3 omgift	6a frånskild/separ	4 Änka/änkling	9 Ingen uppgift	<p><b>24) Utbildning (markera högst utbildningsnivån oavsett om avslutad eller ej)</b></p> <ol style="list-style-type: none"> <li>1 Grund-, folk-, enhetsskola</li> <li>2 Gymnasie- (2 år), folkhög-, real-, yrkesskola</li> <li>3 Gymnasieskola (3–4 årig)</li> <li>4 Högskola</li> <li>5 Övrigt (spec).....</li> <li>6 Uppgift saknas</li> </ol>																								
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<p>25) Är den högsta ovan markerade utbildningsnivån</p> <ol style="list-style-type: none"> <li>1 Avbruten</li> <li>2 Pågående</li> <li>3 Avslutad</li> <li>4 Uppgift saknas</li> </ol>	<p>33) Anställningsstat aktuellt/senaste (gäller även pensionärer)</p> <ol style="list-style-type: none"> <li>1 Aldrig haft betalt arbete</li> <li>2 Anställd</li> <li>3 Egen företagare</li> <li>4 Arbetsledare/chefsposition</li> <li>5 Uppgift saknas</li> </ol>						
<p>26) Avslutad yrkesutbildning (typ o längd)</p> <p>.....</p> <p>.....</p> <p>.....</p>	<p>34) Bostadsförhållanden vid tiden för det aktuella självmordsförsöket</p> <ol style="list-style-type: none"> <li>1 Ägare – småhus/villa</li> <li>2 Ägare – bostadsrätt, andelslägenhet</li> <li>3 Hyreskontrakt, allmännyttig</li> <li>5 Inneboende</li> <li>6 Boende hos föräldrar/vårdnadshavare</li> <li>7 Boende på institution</li> <li>8 Bostadslös</li> <li>9 Uppgift saknas</li> </ol>						
<p>27) Yrke-aktuellt/senast (gäller även pensionärer)</p> <p>.....</p> <p>.....</p>	<p>35) Bostadsstorlek</p> <table border="0"> <tr> <td>1 1 rum ej kök</td> <td>2 1 rok</td> </tr> <tr> <td>3 2 rok</td> <td>4 3-4 rok</td> </tr> <tr> <td>5 5 rok ell större</td> <td>6 ingen uppgift</td> </tr> </table>	1 1 rum ej kök	2 1 rok	3 2 rok	4 3-4 rok	5 5 rok ell större	6 ingen uppgift
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<p>28) Aktuella arbetsförhållanden</p> <ol style="list-style-type: none"> <li>01 Förvärvsarbete 35 t/v eller mer</li> <li>02 Förvärvsarbete mindre än 35 t/v</li> <li>03 Ledig/tjänstledig</li> <li>04 Sjukskriven 1/1 sedan .....</li> <li>05 Sjukskriven 1/2 sedan .....</li> <li>06 Sjukbidrag sedan .....</li> <li>07 Sjuk/förtidspensionär sedan .....</li> <li>08 Ålderspensionär</li> <li>09 Heltidsstuderande</li> <li>10 Hemarbetande</li> <li>11 Flykting/assylsökande</li> <li>12 Arbetslös</li> <li>12a Arbetslös/sjukskriven sedan .....</li> <li>14 Uppgift saknas</li> </ol>	<p>36) Platsen för det aktuella självm.försöket</p> <ol style="list-style-type: none"> <li>1 Hemmet</li> <li>2 Sommarstugan</li> <li>3 Utomhus</li> <li>4 Sjukhus</li> <li>5 Annat .....</li> <li>6 Uppgift saknas</li> </ol>						
<p>29) Om arbetslös ange sedan hur länge</p> <p>(ange antal dagar, mån eller år)</p> <p>.....</p>	<p>37) Hur togs kontakten med sjukvården</p> <ol style="list-style-type: none"> <li>1 Ringde/sökte själv</li> <li>2 Med hjälp av anhörig/bekant</li> <li>3 Annat (spec) .....</li> <li>4 Uppgift saknas</li> </ol>						
<p>29a) Anledning till arbetslöshet</p> <ol style="list-style-type: none"> <li>1 Nedläggning av företag/avdelning/nedskärning</li> <li>2 Arbetet upphörde pga vikariat/provanställning</li> <li>3 Egen uppsägning</li> <li>4 Aldrig haft betalt arbete</li> <li>5 Annat vad? .....</li> </ol>	<p>38) Vård de senaste 14 dagarna före det aktuella självmordsförsöket</p> <ol style="list-style-type: none"> <li>01 Ingen</li> <li>02 Psykiatrisk öppenvård</li> <li>03 Psykiatrisk slutenvård</li> <li>04 Primärvård (distriktsläk. etc)</li> <li>05 Somatisk slutenvård</li> <li>06 Alkoholmottagning/narkomanvård öppenvård</li> <li>07 Alkoholavdelning/narkomanvård slutenvård</li> <li>08 Familjerådgivning</li> <li>09 Barn/ungdomspsykiatrisk avdelning/mottagning (PBU)</li> <li>10 Socialbyrå</li> <li>11 Annat (spec) .....</li> <li>12 Uppgift saknas</li> </ol>						
<p>29b) Negativa följder av arbetslöshet</p> <ol style="list-style-type: none"> <li>1 Separation</li> <li>2 Ändring av boendeförhållanden</li> <li>3 Annan ekonomisk förlust, vad? .....</li> <li>4 Annat (spec) .....</li> </ol>							
<p>30) Har patienten soc.bidrag vid tiden för s.försöket</p> <p>1 nej                      2 ja                      3 uppgit saknas</p>							
<p>31) Arbetar för närvarande inom:</p> <ol style="list-style-type: none"> <li>1 Offentliga sektorn</li> <li>2 Privata sektorn</li> <li>3 Förvärvsarbetar ej (gå vidare till fråga 33)</li> <li>4 Uppgift saknas</li> </ol>							
<p>32) Nuvarande arbetstider</p> <table border="0"> <tr> <td>1 dagarbete</td> <td>2 Nattarbete</td> </tr> <tr> <td>3 Skiftarbete</td> <td>5 Uppgift saknas</td> </tr> </table>	1 dagarbete	2 Nattarbete	3 Skiftarbete	5 Uppgift saknas			
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<p>39) Vård de senaste sex månaderna före det aktuella självmordsförsöket</p> <p>01 Ingen                  02 Psykiatrisk öppenvård                  03 Psykiatrisk slutenvård                  04 Primärvård (distriktsläk. etc)                  05 Somatisk slutenvård                  06 Alkoholmottagning/narkomanvård öppenvård                  07 Alkoholavdelning/narkomanvård slutenvård                  08 Familjerådgivning                  09 Barn/ungdomspsykiatrisk avdelning/mottagning (PBU)                  10 Socialbyrå                  11 Annat (spec) .....                  12 Uppgift saknas</p>	<p>40c) Suicidal kommunikation genom att berätta eller visa sin avsikt före det aktuella självmordsförsöket</p> <p>1 Nej                  2 Ja/berättade för föräldrar                  3 Ja/berättade för partner                  4 Ja/berättade för syskon                  5 Ja/berättade för annan släkt/vän                  6 Ja/berättade för läkare/vårdpers                  7 Ja/berättade för annan pers. Vem?                  7a Hur reagerade hon/han? .....                  .....                  8 Skrivit testamente                  9 Skrivit avskedsbrev                  10 Gav bort sina ägodelar                  11 Gjort annat (spec) .....</p>
<p>40) Anledning till det aktuella självm.försöket (enligt patienten upplevd orsak)</p> <p>1 Separation från partner                  1a Separation från annan pers. Vem?                  2 Hotande separation                  3 Närståendes sjukdom/dödsfall                  4 Relationsproblem med partner                  5 Relationsproblem med annan person                  5a Relationsproblem med föräldrar                  6 Egen sjukdom (somatisk)                  7 Egen sjukdom (psykiatrisk)                  8 Problem med arbetet                  8a Arbetslöshet                  9 Problem med utbildningen                  10 Problem med bostad                  11 Problem med ekonomi                  12 Annat (spec)                  12a Hur länge haft dessa problem.....                  13 Uppgift saknas</p>	<p>41) Antal tidigare självmordsförsök</p> <p>1 Aldrig                  2 1 självmordsförsök                  3 2-3 självmordsförsök                  4 4-5 självmordsförsök                  5 6 eller fler självmordsförsök                  6 Uppgift saknas</p>
<p>40a) Känslomässiga orsaker/inflytande till det aktuella självmordsförsöket</p> <p>1 Skamkänslor                  2 Skuldskänslor                  3 Känslor av ilska/vrede                  4 Kränkning/förlorad ära                  5 Maktlöshet/förtvivlan                  6 Sorg                  7 Känslor av misslyckande                  8 Vill straffa någon/andra                  9 Annat (spec) .....</p>	<p>42) När inträffade det första självmordsförsök</p> <p>1 Aldrig                  2 0-6 mån sedan                  3 7-12 mån sedan                  4 1-5 år sedan                  5 6-10 år sedan                  6 Mer än 10 år sedan                  7 Uppgift saknas                  8 Hur gammal var pat-n då .....</p>
<p>40b) Självmordstankar före det aktuella självmordsförsöket</p> <p>1 Nej                  2 Ja under senaste veckan                  3 Ja under senaste månaden                  4 Ja under senaste 6 mån                  5 Ja under senaste 12 mån                  6 Ja längre än 12 månader</p>	<p>43) Självmordsförsök i familjen</p> <p>1 Ingen                  2 Biologisk mor/far vem .....                  3 Biologiska syskon vem .....                  4 Annan biol.släkt vem .....                  5 Barn                  6 Adoptivmor/far vem .....                  7 Adoptivsyskon vem .....                  8 Annan adopt.släkt vem .....                  9 Uppgift saknas</p>
	<p>44) Självmord i familjen</p> <p>1 Ingen                  2 Biologisk mor/far vem .....                  3 Biologiska syskon vem .....                  4 Annan biol.släkt vem .....                  5 Barn                  6 Adoptivmor/far vem .....                  7 Adoptivsyskon vem .....                  8 Annan adopt.släkt vem .....                  9 Uppgift saknas</p> <p>45) Självmordsförsök i den närmaste omgivningen</p> <p>1 Ingen                  2 Partner                  3 Vänner/bekanta                  4 Uppgift saknas</p>

<p><b>46) Självmord i den närmaste omgivningen</b></p> <ol style="list-style-type: none"> <li>1 Ingen</li> <li>2 Partner</li> <li>3 Vänner/bekanta</li> <li>4 Uppgift saknas</li> </ol>	<p><b>50) Sedan hur länge har patienten använt narkotika? (år, mån)</b> .....</p>																								
<p><b>46a) Patienten växte huvudsakligen upp</b></p> <ol style="list-style-type: none"> <li>1 I sin biologiska familj</li> <li>2 I adoptiv familj</li> <li>3 Fosterhem</li> <li>4 Om adopt/fosterhemplac. vid vilken ålder .....</li> </ol>	<p><b>51) Läkemedelsmissbruk vid tiden för det aktuella självmordsförsöket (allt bruk utöver läkare ordination)</b></p> <ol style="list-style-type: none"> <li>1 Nej (om nej, gå vidare till fråga 54)</li> <li>2 Ja Medel.....</li> <li>3 Uppgift saknas (gå vidare till fråga 54)</li> </ol>																								
<p><b>46b) Barndomstrauma/livshändelser (före 15 årsåldern)</b></p> <ol style="list-style-type: none"> <li>1 Ingen</li> <li>2 Flyttade ofta mellan olika släkt/fosterhem</li> <li>3 Mor/far alkohol/missbruksproblem</li> <li>4 Fysiskt/psykiskt misshandlad av .....</li> <li>5 Incest/sex utnyttjad/våldtagen av .....</li> <li>6 Viktig persons död, vem .....</li> <li>7 Annan händelse (spec) .....</li> <li>8 Åldern när händelsen inträffade .....</li> </ol>	<p><b>52) Frekvens av aktuellt läkemedelsmissbruk</b></p> <ol style="list-style-type: none"> <li>1 Okänd</li> <li>2 Någon gång i månaden</li> <li>3 Någon gång i veckan</li> <li>4 Flera gånger i veckan</li> <li>5 Dagligen</li> </ol>																								
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3 Har du någonsin tyckt du borde minska din alk. konsumtion?	Nej	Ja																							
4 Har andra irriterat dig genom att kritisera ditt sätt att dricka?	Nej	Ja																							
5 Har du någonsin känt dig illa till mods eller haft skuld känslor för ditt sätt att dricka?	Nej	Ja																							
6 Har du någonsin druckit på morgonen, för att bota en baksmälla?	Nej	Ja																							
7 Alk. problem enligt journal	Nej	Ja																							
7a Alk. problem sedan (år, mån) .....																									
<p><b>48) Narkotikamissbruk vid tiden för det aktuella självmordsförsöket</b></p> <ol style="list-style-type: none"> <li>1 Nej (om nej gå vidare till fråga 51)</li> <li>2 Ja Medel.....</li> <li>3 Uppgift saknas (gå vidare till fråga 51)</li> </ol>	<p><b>54) Diagnos/er (somatiska och/eller psykiatriska, enligt journal efter läkarbedömning.)</b></p> <ol style="list-style-type: none"> <li>1 Okänd</li> <li>2 Ange ICD-9 nummer alt. ICD-10 eller diagnosnamn ..... .....</li> </ol>																								
<p><b>49) Administrationssätt av narkotika</b></p> <ol style="list-style-type: none"> <li>1 Okänt</li> <li>2 Rökning/sniffning</li> <li>3 Peroralt</li> <li>4 Intravenöst</li> </ol>	<p><b>55) Kompletterande uppgifter/kommentarer</b> ..... ..... ..... ..... .....</p>																								





**56) CAGE – FRÅGOR NÄR DET GÄLLER FÖRÄLDRAR/VÅRDNAÐSHAVARE**

(Dessa frågor skall ställas för att ta reda på föräldrars/vårdnadshvares förhållande till alkohol, under de år den intervjuade var 0–16 år eller äldre.)

- 1 Tyckte Du någonsin under Din uppväxt, att någon av eller båda Dina föräldrar borde ha minskat sin alkoholkonsumtion?  
Nej Ja A) far eller motsvarande  
B) mor eller motsvarande  
C) båda
- 2 Blev Du någonsin under din uppväxt irriterad på andra människor för att de kritiserade din/a förälders/rars sätt att dricka?  
Nej Ja
- 3 Kände Du dig någonsin (under Din uppväxt) illa till mods, fick skuld­känslor för Din/a förälders/rars sätt att dricka?  
Nej Ja
- 4 Kommer Du ihåg om någon av eller båda Dina föräldrar drack det första de gjorde på morgonen för att lugna nerverna, eller för att bota baksmälla (tagit en återställare)?  
Nej Ja A) far eller motsvarande  
B) mor eller motsvarande  
C) båda

**57) FÖRFÄRDERS URSPRUNG/NATIONALITET**

- 1 Är/var Dina föräldrar av svensk nationalitet? (Om ej svensk ange vilket)  
Nej Ja A) far från .....  
B) mor från .....  
C) båda från .....
- 2 Är/var Dina föräldrar av svensk nationalitet? (Om ej svensk ange vilket)  
Nej Ja A) farmor från .....  
B) farfar från .....  
C) båda från .....
- 3 Är/var Dina föräldrar av svensk nationalitet? (Om ej svensk ange vilket)  
Nej Ja A) morfar från .....  
B) mormor från .....  
C) båda från .....

57a) Kompletterande uppgifter .....

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