EUR/ICP/PSF 018
ENGLISH ONLY

WHO

REGIONAL OFFICE FOR EUROPE

WHO/EURO MULTICENTRE STUDY ON PARASUICIDE

Facts and Figures

by
Unni Bille-Brahe

SCHERFIGSVEJ 8
DK-2100 COPENHAGEN Ø
DENMARK

TEL.: (45) 39 17 17 17
TELEFAX: (45) 31 18 11 20
TELEX: 15348

1993

EUR/HFA TARGET 12

This activity was organized by the WHO Regional Office for Europe to promote work aimed at achieving the following targets in the health for all strategy.[a]

TARGET 12

REDUCING MENTAL DISORDERS AND SUICIDES

By the year 2000, there should be a sustained and continuing reduction in the prevalence of mental disorders, an improvement in the quality of life of all people with such disorders, and a reversal of the rising trends in suicide and attempted suicide.

ABSTRACT

Sixteen centres from thirteen European countries are involved in the Multicentre Study on Parasuicide organized by the WHO Regional Office for Europe. This report describes the participating areas and compares them in relation to social conditions, respective health care systems, suicidal behaviour data and treatment services for suicidal people.

Keywords

MENTAL HEALTH
SUICIDE – prevent/control
SOCIAL CONDITIONS
STATISTICS
QUESTIONNAIRES
INTERVIEWS
AUSTRIA
DENMARK
FINLAND
FRANCE
GERMANY
HUNGARY
ITALY
NETHERLANDS
NORWAY
SPAIN
SWEDEN
SWITZERLAND
UNITED KINGDOM

[a] *Updating of the European HFA targets.* Copenhagen, WHO Regional Office Europe, 1991 (document EUR/RC41/Inf.Doc./1 Rev.1).

CONTENTS

Preface

In 1984 the Member States of the European Region of the World Health Organization adopted a pan-European health strategy, the target for health for all.

Within the scope of public health concerns identified in the strategy, special attention has been paid to the rising trends in suicide in the Region. Target 12 of the targets for health for all states that by the year 2000 the current rising trends in suicide and attempted suicide in the Region should be reversed.

As a contribution to this aim, the WHO Regional Office for Europe is collaborating with Member States, and other intergovernmental and nongovernmental organizations, in monitoring trends in suicide and attempted suicide, developing strategies and programmes for preventing suicide and supporting international epidemiological studies in the field of suicidal behaviour.

In many countries, parasuicidal behaviour has been identified as a major public health problem with considerable impact on the use of resources at both primary and secondary levels.

In the absence of national data, information on parasuicide has been collected mainly from local surveys which vary widely in terms of the definition of parasuicide, representativeness of samples, the period covered, etc.

For these reasons, it was decided that the WHO Regional Office for Europe should stimulate and support an international collaborative study designed to provide a more appropriate epidemiological picture of parasuicide in the European Region.

The WHO/EURO multicentre study on parasuicide began in 1986 and covers two broad areas of research: monitoring of trends in the epidemiology of parasuicide (the monitoring study) and follow-up investigations in parasuicide populations with a view to identifying social and personal characteristics predictive of future suicidal behaviour (the repetition prediction study). The 16 centres, representing 13 countries collaborating in the study, are listed in the introduction together with the main research collaborators.

The first part of this report, prepared by Dr Unni Bille Brahe (technical coordinator of the study), gives the background to the study and describes in detail the areas involved in it. The second part includes the set of main research instruments developed for the study by Dr A.J.F.M. Kerkhof, Dr M. van Egmond, W. Bernasco, Dr U. Bille-Brahe, Dr S. Platt and Dr A. Schmidtke, and a copy of the article "Parasuicide in Europe: The WHO/EURO multicentre study on parasuicide. I. Introduction and preliminary analysis for 1989" published in *Acta psychiatrica Scandinavica*, **85**(2): 97 – 104, which analyses the data collected by the study areas for the year 1989.

The WHO Regional Office for Europe hopes that the preparation of this report will contribute to the dissemination of information in the study and stimulate interest in further research and international collaboration in this field.

J.G. Sampaio Faria
Regional Adviser

FACTS AND FIGURES

on the areas involved in the WHO/EURO multicentre study on parasuicide[a]

by

Unni Bille-Brahe

---

[a] Sponsored by the Rockwool Foundation, Denmark.

Introduction

During the 1970s, the World Health Assembly adopted a common main target for governments and the World Health Organization: health for all by the year 2000. The Member States of the European Region of WHO turned this very broad goal into 38 specific targets, which the Member States accepted in September 1984.

Target 12 concerns suicidal behaviour: "By the year 2000, the current rising trends in suicides and attempted suicides in the Region should be reversed".

Increasing rates of suicide and attempted suicide have caused great concern in most European countries for many years. In May 1985, an informal meeting was held at the WHO Regional Office for Europe in Copenhagen to discuss how to approach this target. A group of experts in suicidology was asked to act as a provisional planning group of advisers and to prepare a meeting for a Regional Office Working Group on Preventive Practices in Suicide and Attempted Suicide.

This meeting took place in September 1986 in York, United Kingdom, with 31 participants representing 15 European countries. As the incidence of attempted suicide increased dramatically in the 1970s, and as people who attempt suicide are at especially high risk of future suicidal behaviour, the Working Group advocated concentrating efforts on attempted suicide. A planning group (which eventually consisted of one representative from each participating research centre) was constituted; its task was to develop a strategy and then detailed plans for carrying out a coordinated multicentre European research project. It was decided that the project would cover two broad areas of research:

- monitoring of recent trends in the epidemiology of parasuicide, including the identification of risk factors (the monitoring study); and
- follow-up studies of parasuicide populations as a special high-risk group for further suicidal behaviour, with a view to identifying the social and personal characteristics predictive of future suicidal behaviour (the repetition-prediction study).

The detailed planning, including working out instruments to be used, was assigned to a Steering Group. The Steering Group was also responsible for facilitating progress during the preliminary phases, ensuring uniformity of method and closely controlling and supervising the research in progress.

The Steering Group consists of: Ad Kerkhof (Department of Clinical Health and Personality Psychology, University of Leiden, Netherlands), Armin Schmidtke (Department of Clinical Psychology, Psychiatric Clinic, University of Würzburg, Germany), Unni Bille-Brahe (Institute of Clinical Research, Unit for Suicidological Research, Odense University,

Denmark) and Stephen Platt, former technical coordinator, (Medical Sociology Unit, Glasgow University, United Kingdom).
At the Regional Office for Europe, the study falls under the responsibility of Dr. J.G. Sampaio Faria, Regional Adviser for Mental Health.

Sixteen centres from 13 different countries are now participating in the study (Fig. 1). The centres and the main research collaborators are:

Berne, Switzerland (Dr Konrad Michel)
Bordeaux, France (Dr Xavier Pommereau)
Emilia-Romagna, Italy (Dr Paolo Crepet and Dr L. Lo Russo)
Guipúzcoa, Spain (Dr Imanol Querejeta)
Helsinki, Finland (Professor Jouko Lönnqvist)
Innsbruck, Austria (Dr Christian Haring)
Leiden, Netherlands (Dr Ad Kerkhof)
Odense, Denmark (Dr Unni Bille-Brahe)
Oxford, United Kingdom (Dr Keith Hawton)
Padua, Italy (Dr Diego de Leo and Professor L. Pavan)
Pontoise, France (Dr A. Philippe)
Stockholm, Sweden (Dr Danuta Wasserman)
Szeged, Hungary (Dr Beata Temesvary)
Sør-Trøndelag, Norway (Professor Tore Bjerke)
Umeå, Sweden (Ms Ellinor Salander-Renberg and Professor Lars Jacobsson)
Würzburg, Germany (Dr Armin Schmidtke)

Fig. 1. Participating centres in the WHO/EURO multicentre study on parasuicide (total population of the catchment areas studied is about 6 million)

The catchment areas studied by these 16 centres differ to varying degrees as a result of differences in political and economic factors, culture, lifestyles and so forth. Each centre was therefore asked to describe its catchment area: demography, history and other general and specific characteristics.

The first part of this report is based on these descriptions. The first section describes the catchment areas, including the most essential demographic data; the second section provides information on social conditions and indicators of social instability; the third section more comprehensively covers health and health care; and the fourth section discusses the data on suicidal behaviour and on treatment of suicidal people in the various areas. All data in the tables are from the centres unless otherwise indicated.

A General Description of the Centre Catchment Areas

The 16 centres that are participating in the WHO/EURO multicentre study represent a variety of cultural patterns throughout Europe. The areas have characteristic ethnic, historical and political features and varying forms of social and economic development.

Tables 1 – 3 show some essential demographic data for the centres.

Table 1. Area and size of the population in the 16 centre catchment areas

	Year of census	Area in km^2	Area as a percentage of total area of country	Population of centre catchment area	Population as a percentage of total population of country
Sør-Trøndelag	1989	18 821	6.0	250 344	6.0
Umeå	1988	55 430	13.5	247 521	2.9
Stockholm	1989	360	0.1	248 162	2.9
Helsinki	1988–1990	365	0.1	491 148	10.0
Odense	1988	3 485	8.1	457 070	8.9
Oxford	1990	2 392	1.8	560 000	1.2
Leiden	1990	260	0.6	363 305	2.4
Würzburg	1987	1 056	0.4	261 639	0.4
Berne	1980	325	0.8	299 136	4.5
Innsbruck	1981	2 095	3.0	242 586	3.2
Szeged	1980	4 263	5.0	456 507	4.0
Bordeaux	1982	1 288	0.2	639 348	1.1
Pontoise	1982	788	0.1	349 815	0.6
Guipúzcoa	1986	1 996	0.4	689 200	1.8
Emilia-Romagna	1988–1989	1 189	0.4	353 011	0.7
Padua	1986	407	0.1	378 900	0.7

The centres are dispersed geographically all over Europe but were divided into three groups: the Nordic countries, western and central Europe and southern Europe.

Table 2. Demographic characteristics

	Average population density (per km^2 in the whole country)	Average population density (per km^2 in the catchment area)	Urban/rural distribution in the catchment area (%)	Sex ratio male/female	Percentage aged over 40 years
Sør-Trøndelag	14	14	63/37	0.98	42
Umeå	21	4	77/23	1.00	46
Stockholm	21	689	99/01	0.96	44
Helsinki	16	2611	100/00	0.82	45
Odense	119	131	55/45	0.98	46
Oxford	180	228	75/25	0.99	40
Leiden	439	1515	34/66	0.96	39
Würzburg	246	248	47/53	0.90	44
Berne	162	923	49/51	0.90	43
Innsbruck	90	116	48/52	0.91	39
Szeged	114	107	71/29	0.93	44
Bordeaux	101	497	95/05	0.90	38
Pontoise	100	444	89/11	0.97	34
Guipúzcoa	75	345	85/15	0.98	39
Emilia-Romagna		297	82/18	0.93	40
Padua		932		0.93	42

The Nordic countries

Five centres are in the Nordic countries: Sør-Trøndelag (Norway), Umeå and Stockholm (Sweden), Helsinki (Finland) and Odense (Denmark).

The Nordic countries (which also includes Iceland) have many features and characteristics in common. Except for most of the population of Finland and a small minority of Lapps of Mongolian origin, the populations of the Nordic countries are of Scandinavian origin. Except for Finnish, the languages have the same root and have many similarities. The Nordic countries became Christian in about the year 1000 and then converted from Catholicism to Protestantism during the Reformation in the sixteenth century. Today most people in these countries belong to the State Church, although the level and the strength of religiousness differ between (and within) the countries.

The population of the Nordic countries began to grow rapidly in the late 1800s as these countries began to industrialize. However, even though industrialization also started early, Norway remained mostly a farming society up to the 1930s. Industrialization also penetrated rather late in Finland. The age structure of the population has changed considerably during this century, but with a similar pattern in each country. The recent trend has been fewer young and more elderly people.

Table 3. Economic activity

	Workforce as a percentage of the total population			Distribution of economic activity (% of total)		
	Male	Female	Total	Agriculture, forestry and fishery	Construction and manufacturing	Trade, transport and services
Sør-Trøndelag	78	53[a]		10	26	64
Umeå	81	76[a]		7	25	66
Stockholm	77	73[a]		0.3	22	78
Helsinki	70	63[a]		9		
Odense			54	10	33	53
Oxford						
Leiden	62	41		3	24	73
Würzburg			47	5	26	69
Berne	50	40		3	30	67
Innsbruck	55	33				
Szeged						
Bordeaux			44	1	29	70
Pontoise	43	35		9	41	50
Guipúzcoa			30	4	49	47
Emilia-Romagna	43	41		10/17[b]	41/32[b]	50/52[b]
Padua	55	24		1	38	62

[a] Population aged 16 years and over.
[b] Men/women as a percentage of the total population in Reggio Emilia/Ferrara.

Norway was politically bound to the Danish crown for several centuries, and was then in union with Sweden for almost 100 years. The system of government, however, remained mainly Danish, and even after Norway became a monarchy in 1905, much of the administrative system was retained from the Danish period. Finland was part of the Kingdom of Sweden for several centuries, although it had considerable independence. In 1809 Finland was ceded to Russia, but up to 1917, when Finland became an independent republic, the country retained Swedish law and methods of government and Swedish as the official language.

Denmark, Norway and Sweden are monarchies and Finland is a republic, but the political climate is very similar, as all the countries are representative democracies that are dominated by centrist tendencies. During the 1960s and early 1970s all the Nordic countries experienced an explosive development in affluence and welfare that gave way to a somewhat weaker economy beginning in the late 1970s. All in all, the Nordic countries could be described as a peaceful and affluent corner of Europe.

Since 1945, the collaboration between the Nordic countries has been intensified under the auspices of the Nordic Council of Ministers. The internal borders between these countries can be crossed without a passport, the workforce is free to move from country to country and there is a network of cooperative organizations and various working committees constituted for special tasks.

In 1989 the five Nordic centres involved in the multicentre study established a Nordic Collaboration Group on Parasuicide Research (NOSAS), to be able to use the huge quantity of data collected via the multicentre study and to facilitate comparative studies and studies of aspects of suicidal behaviour of special relevance in the Nordic countries.

Sør-Trøndelag

The catchment area of the Sør-Trøndelag centre comprises Sør-Trøndelag county (one of the 19 counties in Norway), located in central Norway and comprising about 6% of the area and population of Norway (Table 1). More than half the population lives in Trondheim (about 135 000 inhabitants, population density 419 per km^2), which is the only large city in the area. The rest of the area consists mostly of rural districts and extremely sparsely populated areas (mountains and forests). About 10% of the population works in agriculture and fishery, 26% in construction and manufacturing and 64% in trade and services.

Trondheim (founded in AD 997) is the third largest city in Norway. It is also one of the oldest, its history dating back to the Vikings. During the Middle Ages, pilgrims from all over Europe visited the Cathedral of Nidaros and the city has been an educational centre for centuries. Today Trondheim has one of the four universities in Norway (about 15 000 students), and also colleges of engineering, economics, trade and education.

The population of Sør-Trøndelag County is ethnically very homogeneous, with less than 2% non-Norwegian citizens; of these, 50% are from European countries. More than 90% belong to the Norwegian Church, which is Lutheran Protestant. Judging by the amount of people attending Sunday services in church, religious activity is rather low. However, religion and the church community play a relatively more important role in Norway than in the other Nordic countries. The population is rather stable; 4% of the population moves into, out of or within the county each year. The age distribution, population density and socioeconomic characteristics of Sør-Trøndelag County are fairly representative of Norway as a whole.

Umeå and Stockholm

The centres in Sweden represent quite different aspects of the country: a mostly rural and sparsely populated area in the northern province and a section of the capital, Stockholm, in the lowlands of central Sweden. Nevertheless, both areas also have common national characteristics.

Sweden has had little foreign influence from the west because of the mid-Scandinavian highlands; it has therefore been more open to continental currents and has had strong relations with Germany and France. For example, the French Field Marshal Jean Bernadotte and his wife Desirée were popularly elected King and Queen of Sweden in 1810.

Sweden converted to Protestantism in the sixteenth century, as did the other Nordic countries. The choice of religion is free. The vast majority of the population belongs to the state church, which is Evangelical Lutheran. Only about 2.5% of the population (about 150 000 people) belong to the Catholic Church, the second most important congregation. Women have been ordained as priests since 1958.

Primary education, which became compulsory in 1842, is free of charge. Children attend school from 7 to 16 years. Secondary schools and education at other institutions such as universities are also free of charge.

Umeå is the northernmost of the 16 centres participating in the multicentre study. It is located in northern Sweden; the catchment area comprises Västerbotten County, which is a huge area covering about 14% of Sweden but with less than 3% of Sweden's population. The area is thus sparsely populated, although there is substantial variation within the county. The mountainous part of western Lapland along the border with Norway is the most sparsely populated area, with a population density of about 1 per km^2. There are vast forests in the centre of the county and farming land along the coast to the Baltic Sea, where the two biggest towns in the county, Umeå and Skellefteå, are located.

Northern Sweden is an attractive and exciting area for tourists, with world-class skiing resorts, lakes and rivers and a fascinating folk culture. The county offers very diverse kinds of human environments: traditional farming and forestry areas, a modern university city (Umeå), highly technically developed industrial production in forestry and mining, a thriving engineering industry and many small companies producing everything from caravans to computer components. About 7% of the economically active population are employed in agriculture or in forestry, 27% in construction and manufacturing and 66% in trade, transport, services, etc.

The oldest livelihood in Västerbotten is reindeer herding, an activity of the Lapps going back thousands of years. The Lapps originally settled the region but now only constitute a small minority of the population. Sweden has been transformed from a mainly agricultural society into a modern industrialized country, which has brought great changes to Västerbotten. Many people have moved from the inner parts of the county to southern Sweden and in recent years also to the Umeå area, which has become the expanding economic and cultural centre of the county. Umeå has about 85 000 inhabitants and is still growing, while in the inner parts of the county the population has declined greatly in recent decades.

There is a strong religious tradition in Västerbotten County. Most people are members of the state church, but there are also many nonconformist churches, some very active. Until recently, Sweden had limited ethnic and cultural influence from outside, but marked changes are taking place as immigration increases. Västerbotten has started to accommodate a significant number of refugees, similar to the rest of Sweden; most of them are Moslems.

The University of Umeå (about 8000 students) is the northernmost university in Sweden. It offers a wide range of graduate and postgraduate courses. Although it is relatively new, it has already established a considerable reputation for itself because of the extent and quality

of its research. Umeå also hosts the Royal College of Forestry, the Research Institute of the Swedish National Defence and the National Board of Occupational Safety and Health.

Stockholm. The catchment area of the centre in Stockholm includes one of ten sections under the Stockholm Health Care District: the districts of Huddinge and Botkyrka with 248 000 inhabitants, or almost one sixth of the total population of the city of Stockholm, which has about 1.6 million inhabitants.

Stockholm, the capital of Sweden since AD 1620, is located on several islands and the adjacent mainland between the Baltic Sea and Lake Mälaren. Stockholm – called the Venice of the North – is one of the most picturesque cities in northern Europe, and the archipelago east of the city offers unique facilities for recreation. Stockholm is the cultural and educational centre of the country. Stockholm University and other university institutions have about 40 000 students. The city has many theatres, concert halls, art exhibitions and other cultural attractions.

As recently as the first decade of this century, the catchment area was a quiet, sparsely populated area outside the main city with long distances between the villages and estates. Today it is quite different, having developed from sleepy countryside into a densely populated suburban community in the shadow of the metropolis. This has been a dynamic transformation, with all the concomitant problems. Nevertheless, the area has retained its easy access to nature and outdoor activities, as some parts still consist of woodlands, hills, lakes and meadows. The most important employers are the City of Stockholm and the Stockholm County Council, with public services and administration providing about 65% of all job opportunities. Manufacturing, construction, trade and transport account for most of the remaining employment. Several large international companies such as Saab-Scania, Alfa Laval and L.M. Ericsson are located in the area.

Helsinki

The catchment area of the Helsinki centre is the metropolitan area of Helsinki, the capital of Finland and its biggest city, situated in southern Finland on the Baltic Sea.

Helsinki is a relatively young city. It was founded in 1550 but was not made the capital until 1812. It was only in the twentieth century that Helsinki developed from a middle-sized town into a big city. Development was extraordinarily fast during the 1960s and 1970s, when the economic conditions of Finland changed markedly. The transformation from an agricultural country to an industrialized one was the fastest of the member states of the Organisation for Economic Co-operation and Development.

In this period Helsinki also developed into the cultural and educational centre of Finland. The University of Helsinki is the biggest university in the Nordic countries. Helsinki has seven other institutions at university level, and abundant theatres, concerts, art exhibitions and other cultural amenities. The way people live in Helsinki differs in many ways from life in the countryside or in smaller towns. The catchment area is thus not representative of Finland as a whole.

Migration into the area has been considerable since 1900, when Helsinki started to industrialize. After the Second World War this migration was accelerated by Karelian refugees, and then a second wave of migration took place in the 1960s and especially in the 1970s. Many young men left the northern provinces to get work and/or education in the Helsinki area. As a result the population of Helsinki doubled in three decades. Internal mobility has been high – nearly 100 000 people move house annually, that is, one in seven moves each year. Despite efforts to disseminate economic activity more uniformly all over Finland, three quarters of the net increase in jobs in the early 1980s was in the Helsinki metropolitan area. Today, the people moving into the city are mostly highly educated people or skilled workers, who could easily find suitable jobs in their home towns but prefer to live in the city. About 30% of the economically active people in the area are employed in public administration.

Most of the Finns are of another ethnic origin than the other Nordic populations. The population of Finland is perhaps also a bit less homogeneous. For centuries they have had strong cultural contacts eastwards with Russia and westwards with Sweden. Helsinki is still a bilingual city: according to the constitution, cultural and social services must be provided in both Finnish and Swedish. About 6% of the population have Swedish as their mother tongue, but most of them also speak Finnish.

Odense

The catchment area of the Odense centre comprises Funen County, which is one of 16 administrative regions in Denmark with an area and population almost 10% of that of the whole country. The county comprises the main island of Funen and several smaller islands, many of them inhabited. More than one third of its population live in Odense, which is the chief city in the county and the third largest city in Denmark. Several other towns are scattered throughout the county, mainly along the coastline. They are, however, relatively small: the largest has about 40 000 inhabitants.

Funen was settled rather early, and its known history goes back to before the Stone Age. This early period and the period of the Vikings are well documented by numerous excavations and archaeological findings. The early part of the history seems to have been rather peaceful. Funen was sheltered by Jutland from the impact of the Great Migration, and by Zealand from the warfare in the east. As a result of this and its central geographical position, Funen and especially its chief city Odense became the centre of Denmark in many ways. The city of Odense, which celebrated its millenium in 1988, became an important ecclesiastical centre in the early Middle Ages, and later played a decisive role during the Reformation, which took place in Denmark in 1536. Trade and commerce also prospered from this period, and except for the wars with Sweden in the mid-1600s, warfare has been rare in the region. Because of its strategic position, conditions were strained during the First and Second World Wars but no actual battles took place.

Throughout the centuries, Funen has played an important part in Denmark's political and cultural history. Today Odense is one of Denmark's leading centres for art and theatre. The educational service has been extended and comprises today the University of Odense (established in 1966) for about 6000 students, several colleges of advanced technology,

commerce, art and theatre, several schools for apprentices and 16 folk high schools. There are also several institutions for adult education such as the Open Folk University and evening schools and classes.
The population of Funen County has always been rather homogeneous and it still is, except for a few refugees and immigrants. The population grew rapidly during the first half of this century; it has now stabilized and has grown less than 0.1% per annum during the last decade.

Agriculture, fishery and seafaring have traditionally been the main industries on Funen. Trade and commerce have also played an important role. Industrialization started early, as the first factories were set up in about 1750. Since then, and especially after 1945, many big enterprises have been established in the area, and Odense is now one of the most heavily industrialized cities in Denmark. Farming and especially market gardening are, however, still very important in the rest of Funen County, as about 70% of the land is farm- and woodland. Some 10% of the workforce is employed in agriculture, about one third in construction and manufacturing, one third in trade and services and one fifth in public administration.

For many years it has been presumed that Funen is a miniature model of Denmark. Statistical analysis of various sociodemographic factors have now proved that the population of Funen constitutes a representative sample of Denmark as a whole.

Western and central Europe

The centres in western and central Europe include Oxford (United Kingdom), Leiden (Netherlands), Berne (Switzerland), Innsbruck (Austria), Szeged (Hungary) and Würzburg (Germany). In contrast to the Nordic centres, the catchment areas of these centres are extremely diverse ethnically, historically and socioeconomically.

Oxford

The Oxford centre catchment area lies in the centre of England on the boundary between southern England and the Midlands and has a population of 560 000. The city of Oxford, with 115 000 inhabitants, lies in the southern part of the area, approximately 60 miles north-west of central London and a similar distance south of Birmingham. Its history dates back to the eighth century, when the first municipal charter was granted by Henry the First. It has been a cathedral city since AD 1541.

Although Oxford is internationally renowned for its university, the city economy largely depends on one single industry, automobile production. Tourism, electronics and other small industries are, however, becoming increasingly important. The original central residential area of the city was demolished almost 30 years ago, and many of the inhabitants moved to local authority estates on the periphery.

Oxford University was founded in the twelfth century and is the oldest university in the United Kingdom. It has a student population of 12 000. The University is based on the

college system (unique to Oxford and Cambridge Universities); each college is a self-contained institution, although students attend lectures centrally. The majority of the colleges are based in very attractive, historic buildings.

The inner-city areas include areas with a socially and ethnically mixed and rapidly changing population; areas of greater social stability inhabited predominantly by working-class and white-collar workers; and areas inhabited predominantly by senior university staff.

The rest of the catchment area consists of mixed urban and rural localities. Oxford is surrounded by satellite towns, of which Abingdon, Witney, Bichester and Thame are the largest. There is also extensive farmland and many small villages populated by people working locally and commuters to Oxford. In the western part of the catchment area lies part of the Cotswolds, a picturesque region of low hills and attractive old villages.

Leiden

The catchment area of the Leiden centre is located on the coast of the North Sea in the centre of the western part of the Netherlands called the Randstad. The Randstad is a highly urbanized area with a very high population density, a high level of economic activity and a comprehensive infrastructure. The characteristics of this region are not very representative of the Netherlands as a whole. However, part of the catchment area is relatively rural (although it is rapidly developing more urban characteristics) and, generally speaking, the findings for the catchment area are therefore supposed to be representative of the national figures.

The catchment area has two districts: the Leiden area (110 000 inhabitants) and the Bulb district (253 000 inhabitants). Together they constitute a very attractive area, combining sites of historical interest and the cultural milieu in the city of Leiden with the wide sandy beaches along the North Sea and pleasant rural bulb-growing districts. The city of Leiden is located on the river Oude Rijn. It is a very old city and the regional centre for trade, industry, education and health services. Although the cultural importance of Leiden cannot be compared with that of such cities as Amsterdam or The Hague, various major theatre and music performances, exhibitions and festivals take place there and the city also houses a large number of museums, most of them originally founded as divisions of the university. The State University of Leiden (20 000 students) is the oldest university in the Netherlands, founded in 1575 shortly after the liberation of the city from the Spaniards. Another educational institution of importance is the Reinwardt Museum Academy. The workforce in the area comprises 182 000 people: 3% are employed in agriculture or fishery, 24% in construction and manufacturing and 73% in trade, transport and services.

Official statistics in the Netherlands do not include information on ethnicity. People who were born, or whose parents were born, in former Dutch colonies (Indonesia and Surinam) or in the Netherlands Antilles (still colonies) form definite (and large) ethnic minority groups, but they are not registered as such, as they are all born as Dutch citizens. Other large minority groups include Turks and Moroccans; a growing number of them are being given Dutch citizenship. The population in the area is rather stable: in any one year one person out of ten changes address.

Würzburg

The catchment area of the Würzburg centre comprises the city of Würzburg and the surrounding Würzburg County with 260 000 inhabitants. The city of Würzburg is the governmental seat and centre of the administrative district of Lower Franconia, which is located in the northern part of Bavaria in southern Germany. The river Main, which flows through the city, is often informally regarded as the border between northern and southern Germany. Because of its central location, Würzburg is an important intersection of motorways and railways from all directions. The city is a trade and economic centre for a region of several thousand square kilometres but, in general, the surrounding county has maintained a rather rural character.

Compared with other German cities, Würzburg is a city of white-collar rather than blue-collar workers. The University of Würzburg is the biggest employer, and there is relatively little manufacturing industry. Mainly because of its many historical sites and buildings, tourism is also an important economic factor. Some 40% of the people living in the city of Würzburg (51 500 people) are in the labour force; the corresponding figure for the county is 44% (66 800). In the catchment area, more than 5% work in agriculture or forestry, 26% in construction and manufacturing and 69% in trade, transport and services.

Würzburg is also the cultural centre for a wide region. The city has a very active cultural scene, with its own municipal theatre, 12 small theatres and cabarets, several museums and galleries, and numerous pop, rock and classical concerts throughout the year. The many historical sites include the Residence and the Fortress of Marienburg, which attract visitors from all over the world. After the city was almost completely destroyed in 1945, it was rebuilt in traditional style.

Würzburg is a city of schools and universities. The University of Würzburg, the Technical University and the College of Music have more than 20 000 students, and over 30 000 pupils are being educated in some 100 schools (including vocational schools).

The catchment area is predominantly Catholic. Würzburg has been a bishop's see since AD 742: today about two thirds of the population belong to the Roman Catholic Church and less than one third are Protestant. The population is rather stable: each year close to 3% move into the city, 3% move within the city and another 3% leave it. About 3% leave the county and 3% move in. Almost half of the changes of residence take place within the administrative region of Lower Franconia. The number of foreigners is small (4% in the city, 2% in the county), mostly Italians, Yugoslavs and Turks.

The area is representative of Germany as a whole in terms of demographic data, but seems to be more wealthy, Catholic and conservative and has more social stability than the rest of the country.

Berne

The Berne centre covers the city of Berne and its surrounding municipalities (the Canton of Berne) with about 300 000 inhabitants.

Berne was founded in AD 1191. It is the capital of Switzerland and the seat of the federal administration and is said to be the city of office clerks and administrators. The surrounding areas, however, are still mostly rural. Over half the inhabitants of the area are in the labour force; many of them live in the countryside and work in the city. Some 3% are employed in agriculture and forestry, 30% in construction and manufacturing and 67% in trade, transport and services.

Relative to its size, Berne offers a rather wide range of cultural activities. It has galleries, theatres and concerts and many opportunities for sports and outdoor activities, and the city also offers special activity programmes for young people. The University of Berne has 8245 registered students.

The demographic characteristics and some socioeconomic characteristics of the Berne catchment area are supposedly representative of Switzerland as a whole. However, Switzerland has three major ethnic, linguistic and cultural divisions: German, Italian and French (plus a fourth national language, Romansh). Berne is located in the German-speaking part: 86% of the population speak German as their mother tongue, and most of the rest speak French or Italian. Two thirds of the population are Protestant and one quarter Catholic. As in the rest of Switzerland, there are many non-Swiss citizens – almost 13% of the population of the city of Berne and 7% in the surroundings. Migration out of the area is about 8% of the population per year and inward migration about 9%. One quarter of the moves are by non-Swiss citizens.

Innsbruck

The catchment area of the Innsbruck centre covers the two central districts of the province of Tyrol: the city of Innsbruck and the surrounding Innsbruck County. The area extends from the German frontier in the north to the Italian border in the south and covers more than 2000 km^2, of which only 323 km^2 are permanently inhabited.

The city of Innsbruck is the capital of the province and the intellectual, cultural, political and administrative centre of the Tyrol. It is of increasing attraction to immigrants and commuters as well. During the last 15 years, the population of Innsbruck County has grown by 12%. As an affluent country, Austria is of special interest to workers from southern Europe, but the catchment area is also popular among non-Austrians for recreation or retirement. In Innsbruck County, 6.8% of the population are non-Austrian citizens. Of these, 33% are from Yugoslavia, 25% from Turkey and 14% from Germany. The economic activity in the catchment area is characterized by small and medium-size enterprises and a lack of large-size industrial undertakings. Most enterprises are involved in the wholesale or retail trades or related to tourism. About 45% of the population participates in the labour force.

The Tyrol is predominantly Catholic (87%). The vast majority of the population speak German; only a small minority have Slovene, Croat, Hungarian or Czech as their mother tongue.

Szeged

The Szeged catchment area comprises Csongrád County, one of the 19 counties in Hungary and one of the most densely populated areas of the country. Besides Szeged, which is the main city in the county, five other towns in the county have 20 000 – 50 000 inhabitants. Csongrád County is home to about 4% of the total population of Hungary.

The known history of Szeged and its surroundings dates back to the days of the Roman Empire. The Great Migrations surged repeatedly over the area: for instance, Szeged was a centre of the empire of Attila the Hun, and in the ninth century Hungarian tribes invaded the area. In 1246 Szeged was established as a town, and throughout the Middle Ages it remained the only town of importance on the Hungarian Plain. For 150 years beginning in the mid-1500s Szeged was occupied by the Turks, and in this period the population was almost wiped out. However, in 1686 the town came under Austrian rule, and in the following period Empress Maria Theresa brought in settlers from abroad, especially from Schwaben in Germany. Szeged was the capital of Hungary for a short period after the Hungarian War of Independence in 1848 – 1849. After the treaty with Austria in 1867, it started to develop into an industrial and trading town and, following the flood catastrophe in 1879, when all but 265 of the 5723 buildings in the town were destroyed, it was rebuilt as a modern city. However, much of the surroundings still remains farmland. More than half of the total national production of paprika and onions and one fifth of the vegetable production come from Csongrád County, and other agricultural products from the area supply most of the national demand. Heavy industry has started to develop in recent years; for example, almost three quarters of the oil and more than half of the natural gas produced in Hungary come from the oilfields in the vicinity of Szeged.

Szeged has been a centre for education since the founding in 1721 of a Piarist grammar school. Today it is a university town – the Kolozsvár University (founded in 1921) and other institutions of higher education are located in the city. The most important cultural event is the annual open air theatre festival, which started in the 1930s; music and art also play an important role in the cultural life of the area.

Csongrád County has many different ethnic groups, mainly because the original population was nearly wiped out during the Turkish occupation. Many Germans (descendants of the settlers brought in from Schwaben during the eighteenth century) live in the county and also large numbers of Slovaks, Romanians and Serbs. Gypsies comprise about 5% of the Hungarian population, and many of them live in the area around Szeged. Mobility within Hungary is reported to be rather high.

The Reformation spread in the sixteenth century, but most of the population remained Catholic. For instance, the order of St Francis was rather strong in the area, and Szeged has been a bishop's see since 1923. After the Second World War atheism was officially decreed, but the freedom to partake in religious activities was re-established following liberalization in the 1960s. Most of the population are still Catholic, but interest in both the Catholic Church and other churches is increasing, especially among young people.

The sociodemographic characteristics of the Szeged catchment area are representative of Hungary as a whole, but social stability is below average.

Southern Europe

The centres in southern Europe are Pontoise and Bordeaux (France), Guipúzcoa (Spain) and Emilia-Romagna and Padua (Italy).

Pontoise and Bordeaux

The *Pontoise* catchment area comprises four rural districts and the city of Cergy-Pontoise, located about 20 km west of Paris. The area has 210 000 inhabitants, of whom 159 000 live in Cergy-Pontoise, which is a new city of and a dormitory town with mostly new buildings. More than half the population has moved into the area within the last ten years, most of them young people who want to raise their families in modern housing. The population is thus younger than in the rest of France. The proportion of the population married or cohabiting is high, and compared with the wider region around Pontoise and with France in general, few people live alone.

The economy is mainly based on industries and services. Less than half of the economically active population work in the area: the majority commute to Paris. Some 9% work in agriculture, 41% in manufacturing and construction and 50% in trade, transport and services.

The *Bordeaux* catchment area covers the whole urban area of Bordeaux including the city centre and its suburban areas. Bordeaux is the fifth largest city (metropolitan area) in France, and the capital of the Aquitaine region. The area is located in the district of Gironde on the Atlantic coast in southern France. Bordeaux is a very old city: its history dates back more than 2000 years to the Roman Empire, when it was a very important trading city under the name of Burdigala. Later both Normans and Moors repeatedly harried the area, and from the mid-1100s to the mid-1400s, Bordeaux was under British rule.

In the eighteenth century, ambitious projects were undertaken to redesign the city in a spacious and grand manner. Most of the Roman ruins and medieval buildings that restrained development were demolished and removed. Bordeaux was completely renewed, except for the downtown area (Old Bordeaux) with its narrow, picturesque streets along the river. The Bordeaux area is famous for its vineyards, and the production and trading of wine has been the most important industry. Other branches of industry – aerospace, chemicals, electronics and so on – have been developed recently and are now growing. In the catchment area, 44% of the population are in the labour market: 1% in agriculture, 29% in manufacturing and construction and 70% in trade, transport and services.

Guipúzcoa

Guipúzcoa is the smallest province in Spain, covering less than 1% of the total area. The province is located in the Basque country on the north-western coastline. The area is prehistorically well described back to the Palaeolithic period. Its entry into the historical

period is also well described by such Greeks as Plutarch and Strabo. However, Guipúzcoa was only Romanized to some degree, and then only in its north-eastern part. For centuries the area avoided being conquered by Spain, with the help of the Visigoths and later the Muslims. In the eleventh century Guipúzcoa established itself as a distinct entity, first under the rule of the King of Castile and later under the Kingdom of Navarre. However, in 1200 it merged definitively with the Kingdom of Castile. In 1463 it became a relatively independent province under the rule of the King of Spain.

Ever since the early Middle Ages, the area has been plagued by feuds, revolts and wars. Finally, during the Civil War, and after the loss of Guipúzcoa in 1937, the last remnants of the self-government of the province (the Economic Agreements) were abolished. After the Franco period, political reforms and the approval of the Guernica Statute have, however, led to the revival of Juntas Generales and the Diputación Foral.

San Sebastián, the capital of the province, was founded in 1180 but had to be completely rebuilt after being burned down in 1813 in the Napoleonic Wars. Today it is the centre of trade and commerce of the province. However, contrary to the population of other parts of the Basque country, the population of Guipúzcoa is not concentrated in and around the capital but is spread rather evenly throughout the mostly suburban areas in the whole province.

Agriculture in Guipúzcoa traditionally meant stockbreeding and forestry. However, the importance of these and of fishery has diminished and industry has become the most important economic activity. Only 30% of the population is in the labour force: 4% in agriculture and fishery, 49% in manufacturing and construction and 47% in trade, transport and services.

Guipúzcoa has many educational institutions. Four universities (two public and two private) are located within the catchment area. Several art schools are reviving the ancient crafts of Basque art (pottery, carving and wrought iron).

Despite all the upheavals, the population has a very homogeneous (Basque) origin with the original Basque language, Euskera, as their mother tongue. The Basque language is totally different from all other languages in the surrounding countries, and it is supposed to have arrived in western Europe some 4000 years ago. The Basque culture also shows itself in the many old traditions and customs still in practice. An example is the many Basque games and sports whose rules are transmitted orally.

In recent decades the population of Guipúzcoa has increased, especially because of the substantial migration into Guipúzcoa (and the other Basque provinces) in the 1960s, when the region was industrialized. At present, however, this is being replaced by migration from Guipúzcoa, mainly to Madrid and Barcelona.

Emilia-Romagna and Padua

The research centre in *Emilia Romagna* covers two of the health districts in the region, Reggio Emilia and Ferrara.

The catchment area covers about 1200 km^2 on the plain of Po in the north-eastern part of Italy, with a population of 350 000. The area is densely populated with 12 towns and cities. It is dominated by industry and commerce, but some parts are still farmland. In Reggio Emilia 45% of the population are in the labour market; in Ferrara the figure is 41%. In Reggio Emilia 10% work in agriculture, 41% in manufacturing and construction and 50% in trade, transport and services. In Ferrara the figures are 17%, 32% and 52%.

The University of Ferrara has schools of law, medicine, social science, pharmacy and education. In all, 5037 students are registered. The University Department of Agriculture (affiliated with the University of Bologna) is also located within the area, as are several theatres and museums.

Most of the population is Catholic. The migratory balance is very stable in both areas.

The two areas under study are representative of Emilia-Romagna but not of Italy as a whole: the birth rate is lower, the average age higher and migration lower than in southern Italy. Emilia-Romagna is more developed and affluent than the rest of Italy and has the highest standard of living in Italy.

The *Padua* catchment area covers the city of Padua and its 18 surrounding municipalities, which together constitute one of the health districts of the Veneto region. Padua, which is located 30 km west of Venice, was originally founded as a Roman colony (89 BC). The city prospered throughout the Middle Ages, and became a famous centre of painting (the Paduan School).

The University of Padua was founded in 1222 and is the largest university in the Veneto, with 47 000 students. The city has many cultural activities such as museums, exhibitions and theatre performances, and the area is very popular among tourists from all over the world. During recent decades suburban towns have developed. The urban structure is usually good, and there are few examples of poor urban development.

Padua's economy is linked to business, services and the university. Numerous medium-sized industrial plants are located on the outskirts of the city. In the suburban areas the main activities are arts and crafts, and small or medium-sized industrial enterprises. Only three of the 18 municipalities have some farming. Of the economically active population, less than 1% are employed in agriculture, 38% work in manufacturing and construction and 62% in trade, transport and services.

As in the rest of Italy, almost all inhabitants are Catholic. Most of the (few) migrants to the region come from other parts of Italy. The population of Padua decreased by about 7% during the 1980s.

The sociodemographic characteristics of the catchment area are similar to those of the rest of Italy, but the economy, labour market and social stability of the area are not representative. Similar to Emilia-Romagna, Padua is representative of northern Italy, which is more economically developed and far more affluent than southern Italy.

2

Indicators of Social Conditions, Including Social Instability

The catchment areas studied by the research centres participating in the study vary from densely populated metropolitan areas to those where most people live scattered over vast areas. Consequently, social conditions vary and also often differ from national averages. Social problems tend to accumulate in big cities, and we would therefore expect, for example, crime or drug abuse to be more frequent in the Helsinki catchment area than that in Finland as a whole and in most of the other catchment areas in the multicentre study, which usually include both urban and rural communities. To compare information on social conditions and social instability, the sociodemographic characteristics of the various areas must be kept in mind (Tables 1 – 3).

Describing and comparing the social conditions in the various catchment areas produces several difficulties. National statistics, which are usually the basis of the data presented by the centres, are not always directly comparable: data may be collected and statistics calculated in different ways, or the validity of the national statistics may vary.

Housing conditions

Only two of the 16 catchment areas, namely Helsinki and Stockholm, are totally urbanized (Table 1), but the population density is also very high in Leiden and Padua. All the centres in southern Europe cover some highly urbanized areas but in general they are not that densely populated.

The differences in housing conditions may indicate the density and thus the nature of the areas. The housing conditions in the catchment areas are described below.

Sør-Trøndelag

Half the population lives in owner-occupied one- or two-family houses, and one fifth in blocks of flats. About 45% of the total number of dwellings were built after 1960. Most have one occupant or less per room.

Umeå

More than two thirds of the population live in owner-occupied one-family houses and 28% in multiunit blocks. About three quarters of all dwellings consist of more than two rooms plus kitchen and bathroom. The average number of persons per room is 0.52.

Stockholm

More than one third of all dwellings are in detached houses; 70% have more than two rooms plus kitchen and bathroom.

Helsinki

More than half the total dwellings are owner-occupied. Because of a shortage, housing prices have more than doubled in five years. Some 15% of the population live in overcrowded dwellings (more than 1 person per room). About 20 000 flats still lack sewerage, sanitary facilities or central heating, and 5000 – 6000 people are homeless.

Odense

About three quarters of the population live in owner-occupied dwellings, mostly one- to two-family houses. Most dwellings are roomy (98% of the population have more than one room each) and 85% comply with modern standards.

Leiden

About half of the dwellings are privately owned and about one third were built after 1945. No overcrowding is reported, but there are some housing shortages, especially for students.

Würzburg

Most of the buildings were rebuilt after 1945. Most dwellings have 3 – 4 rooms. The inner city is fairly densely populated, but there is no real overcrowding. It is, however, rather difficult to find housing within the city, especially for students.

Berne

Within the city of Berne, 90% of the population live in rented dwellings and 10% own their houses. In the rural areas, most of the population live in their own dwellings. In some parts of the city blocks of flats predominate; these areas are densely populated and mainly inhabited by underprivileged people.

Szeged

Most dwellings in the city of Szeged and in the suburban area are in blocks of flats. In the rural districts, most people still live in houses of the traditional village style. The housing standard is above the national average, but many of the dwellings lack modern amenities.

Pontoise

As Pontoise is a newly developed city, most dwellings are new modern houses with all the amenities.

Emilia-Romagna

In Reggio Emilia, 44% of all dwellings are rented. The dwelling are generally small, with 1.6 occupants per room. Some of the buildings are rather old (14% built before 1919), but more than half (56%) were built after 1960.

Thus, there seems to be no unambiguous link between urbanization and the population density in an area and its housing conditions. Nor are affluence and welfare the only determinants of the overall housing conditions: historical development, culture and traditions seem to be as important in influencing the housing standard and especially the size of the dwellings in an area.

Family life

The problems of comparing different areas are especially pronounced for family life.

Statistics on civil status usually include the number of inhabitants that are unmarried, married, separated, divorced or widowed. These categories are not unequivocal, however: a person may be registered as unmarried because he or she has never been married or is not married at the time (but divorced or widowed). The main problem with the statistics on civil status is that more and more people are cohabiting. Some countries register people living in common-law marriage as legally married; other countries register them as unmarried or single. The problem is complicated by the fact that the prevalence of common-law marriages and how they are registered depend on the cultural and religious attitudes in each country. The invalidity of the statistics on civil status then affects information on the incidence of divorce. Little is known about how often common-law marriages break up, but it seems reasonable to suppose that the dissolution rate is even higher than that of legally registered marriages.

The figures presented in Table 4 should thus be taken with several grains of salt. However, most centres stress that both the incidence of divorce and the number of single-parent families have increased dramatically, indicating that family stability and family support are declining all over Europe.

Standard of living

The standard of living is not only a question of material assets. Nevertheless, data on the economy and business cycles have traditionally been used as indicators of living conditions. Table 5 shows some of these indicators.

The unemployment rate varies markedly from less than 1% in Berne to 24% in Guipúzcoa. The proportion receiving public assistance varies considerably, but this variance may be due to differences in the level of welfare and to the number of people in need.

Social security and welfare

The social welfare systems in the catchment areas differ in various ways. One main difference is how benefits and subsidies are financed. Except for unemployment benefit, which is based on insurance in all areas, social support in the Nordic countries is paid via taxes, whereas in other countries most benefits are based on the principle of insurance.

Table 4. Family life

	Number of people per household	Single people as a percentage of the total population	Single-parent families as a percentage of all families	Divorced people as a percentage of the total population	Annual divorce rate per 1000 marriages
Sør-Trøndelag	2.2	23	8	4	
Umeå	2.6	13	3		
Stockholm	2.5	17	5	9	16
Helsinki		46	20	9	
Odense	2.1	46	14		
Oxford	2.6	55	9	4	NA
Leiden	2.4	46	10	3	9
Würzburg	2.3	44	NA	3	NA
Berne	2.2	43	NA	4	NA
Innsbruck		47		4	
Szeged		19		7	10
Bordeaux	2.6	43	9	4	7
Pontoise		5	5		
Guipúzcoa		48		1	
Emilia-Romagna		47/45[a]	2/1[a]	2/1[a]	
Padua	3.0	44		1	

[a] In Reggio Emilia and in Ferrara respectively.
NA The centre reports that these statistics are not available.

The welfare systems in the *Nordic countries* are similar. In addition to benefits in the event of sickness, the Nordic welfare systems comprise unemployment benefit, old-age pension, early-retirement pension and ordinary public assistance.

Unemployment benefit is based on the principle of insurance, is usually administered by the unions and is conditional on previous employment. The benefit is payable for only 1 – 2 years. Other pensions and assistance are paid for through taxes. The normal retirement age is 65 – 67 years, at which everyone is entitled to old-age pension, regardless of income. Civil servants are usually entitled to a special pension as part of their contract. In addition, private and union-owned insurance companies offer various private pension schemes. Most people are entitled to an early-retirement pension if their working capacity is permanently reduced by at least 50%. Public assistance is the last resort in the welfare system. It is usually administered and financed by local authorities (municipalities), but the expenses are reimbursed by the government in accordance with specific and detailed rules.

In addition, there are several special schemes and various systems of subsidies: for example, grants to families with children and especially to single parents, and grants to students. Especially in Norway, care, counselling and support is often offered by agencies run by

Table 5. Some indicators of the standard of living

	Unemployment rate	Percentage receiving social assistance	Per capita income in US $
Sør-Trøndelag	5.7	2.6	7 889
Umeå	3.1	3.0	14 336 [b]
Stockholm	0.7	8.5	19 904
Helsinki	2.5	7.3	20 667
Odense	10.0	5.2	12 818
Oxford	7.6	NA	NA
Leiden	6.0	1.4	13 512
Würzburg	8.1 – 6.1 [a]	2.2	NA
Berne	0.73	3.0	30 080
Innsbruck	2.7 – 4.5 [a]	3.6	13 284
Szeged			
Bordeaux	10.0		25 804
Pontoise			
Guipúzcoa	23.8		9 666
Emilia-Romagna		1.1	1 658
Padua	3.9	0.1	9 043

[a] Variance within the area, usually inside/outside the city.
[b] Population over 20 years of age.
NA The centre reports that these statistics are not available.

volunteers (such as church congregations or the Norwegian Red Cross). The government then reimburses some of the expenses.

The welfare system in the *Netherlands* differs from the Nordic systems in that social benefits are based on insurance. However, there are several supplementary acts for people whose income is below a certain minimum. For instance, under the Supplementary Benefit Act the income of those receiving unemployment, sickness or disability benefit, plus that of any partner, is supplemented up to a certain (legal) minimum. In addition, the welfare system in the Netherlands, as in Norway, comprises a variety of nongovernmental or quasigovernmental agencies providing counselling and support, some run by volunteers.

The welfare system in *Germany* is statutory and highly organized. In addition to sickness benefit, the employees' insurance covers unemployment benefit and retirement pension. People whose income is below a certain limit may get public assistance. In addition, there are some subsidy schemes; for instance, students may receive loans, depending on their parents' income.

In *Switzerland*, unemployed people receive unemployment benefit for a limited period of time in accordance with the duration of previous employment. People whose income is insufficient to cover the cost of daily living can get financial assistance from the commune.

In *Austria*, almost every economically active person is a member of the public social insurance scheme, which provides health insurance, unemployment benefit and old-age pension.

As most of the population in *Hungary* (until recently) has been (permanently) employed by the state, a welfare contribution to cover sickness benefit and old-age pensions has automatically been deducted from salaries. Steps have been taken to change the system into an insurance system, and people may take out pension-improving policies.

The welfare system in *France* is based on an obligatory financial contribution paid monthly by both employees and employers (general regime), or through obligatory individual contracts for self-employed people. In addition to health insurance, social security includes a family allowance and old-age pension. Private insurance completes the social security system.

In *Italy* social insurance for employees is administered by a state agency that also pays an old-age pension proportional to the number of years people have worked. Social and disability pensions are provided directly by the state, but people may purchase insurance from private companies.

Social problems: crime and substance abuse

Using absolute figures to determine the differences in the magnitude and type of social problem between the various catchment areas is hazardous. The data shown in Tables 6 and 7 only intend to give an initial picture.

Table 6. Litres of pure alcohol consumed per capita for the entire population

Country	1960	1988	Change (%)
France	17.5	13.3	– 32.6
Spain	6.6	12.1	+ 83.3
Italy	12.1	9.0	- 25.6
Hungary	6.8	10.5	+ 54.2
Switzerland	9.1	11.0	+ 20.0
Germany, Federal Republic of	6.8	10.4	+ 52.9
Denmark	4.2	9.7	+131.0
Austria	8.5	9.9	+ 16.5
Netherlands	2.6	8.3	+219.2
United Kingdom	4.2	7.4	+ 76.2
Finland	2.1	7.3	+247.6
Sweden	3.9	5.5	+ 41.0
Norway	2.6	4.2	+ 76.2

Source: Danish alcohol statistics 1991.

Alcohol consumption has been increasing in most countries. Only in France and Italy, where consumption has traditionally been highest, is it declining.

In *Sør-Trøndelag* the annual incidence of crime is 32 per 1000 population versus 40 per 1000 in Norway as a whole. The annual incidence of violent crime is less than 1 per 1000. In Norway, as in Sweden, the distribution of alcoholic beverages is restricted by a state monopoly, and wine and alcohol can only be bought at special government shops or at specially licensed restaurants. Alcohol consumption in Sør-Trøndelag is relatively low; according to official statistics, the per capita consumption (above 15 years of age) is 5.4 litres per year. However, illicit distilling is not at all rare in Norway. The rate of reported drug abuse is approximately 10 per 100 000, which is close to the national average.

The prevalence of social problems differs markedly in the two Swedish centres. In *Umeå* the crime rate has been stable and low for decades compared with other counties in Sweden and with the national average. Alcohol consumption has traditionally been low and lower than in Sweden as a whole. However, during the 1970s drinking increased considerably, and the mortality rate from alcohol-related diseases, although still low, nearly doubled during the decade. Drug abuse is relatively infrequent.

Table 7. Social problems

	Crimes reported per 1000 inhabitants per year[a]		Abusers of alcohol per 1000 population	Users of prescription tranquilizers per 1000 population	Drug abusers per 1000 population
Sør-Trøndelag	32	(1)	NA	1	NA
Umeå	67		3	32	NA
Stockholm	NA		NA	NA	NA
Helsinki	140		NA	30	NA
Odense	100	(3)	48	100	2
Oxford	142		45	21	2
Leiden	79		7–28	100	1
Würzburg	43		NA	NA	3
Berne	50	(4)	NA	NA	NA
Innsbruck	68	(6)	12	50	2
Szeged	13	(1)	100	NA	NA
Bordeaux		(9)	2	NA	1
Pontoise					
Guipúzcoa	NA		50	NA	10
Emilia-Romagna	57		NA	NA	1
Padua	3	(0.1)	NA	142	5

[a] Figures in brackets indicate violent crimes reported per 1000 population.
NA The centre reports that these statistics are not available.

In *Stockholm*, however, alcohol and drug abuse and crime are above the national average. Exact figures are not available for the catchment area, but for the whole city of Stockholm the number of crimes per year is 213 per 1000 inhabitants (national average 142). The number of heavy consumers of alcohol in Stockholm is estimated to be 100 per 1000 for men and 30 per 1000 for women, 20 – 25% above the national average. The number of drug addicts is 3 – 5 per 1000 (national average 2 per 1000).

Social problems usually accumulate in cities, and this is definitely true in *Helsinki*. For instance, the incidence of assault in Helsinki is 2.5 times the incidence in smaller towns in Finland (less than 10 000 inhabitants). Nevertheless, the number of offences committed by juveniles (under 21 years), which comprise about one fifth of all offences, is below the national average. Most of the juvenile delinquents come from the suburbs, where socioeconomic status is not uniform. The number of assaults in Helsinki is increasing; many are carried out under the influence of alcohol. However, the most common offences in Helsinki are fraud and robbery. Each year, some 2% of the population are sentenced to imprisonment or fined. Most crimes take place in the city centre, but many are committed by people who live outside Helsinki.

Alcohol is practically the only intoxicant abused in Finland. In accordance with traditional drinking habits, large amounts of alcohol are consumed with the sole purpose of getting drunk. It is only very recently that urban culture has slowly begun to change these habits towards a more continental way of drinking: more wine, and drinking located in the context of social events. Despite this change, alcohol consumption has increased, especially among young women. This fourfold increase in overall alcohol consumption over 30 years was especially marked in the late 1960s and early 1970s. Some 70% more alcohol is sold per capita in Helsinki than elsewhere in Finland. Some of this difference may be caused by the higher standard of living in Helsinki.

Compared with other European countries, the use of narcotics is very modest in Finland. The reasons are cultural and geographical. Narcotics have never been serious competitors to alcohol, and geographical isolation and strict control have prevented the spread of abuse. The use of narcotics is a criminal offence in Finland, and each year about 1000 people are brought to court for this offence. Half of the narcotic offences in Finland take place in Helsinki. The most common drug is hashish, which together with marijuana accounts for 70% of the total abuse. Psychoactive drugs account for 20%, and the remaining 10% comprise LSD, heroin and amphetamines. The average age of those brought to trial is about 25 years, and four fifths are men.

In Denmark the incidence of crime has increased markedly since the late 1960s. About 500 000 offences (100 per 1000 population) are reported each year, and the incidence in the *Odense* catchment area is close to the national average. The increase in malicious damage, assault and other acts of violence has been especially steep. Most offences are committed by very young people: offences against property are usually committed by 16 to 17-year-old adolescents.

Alcohol consumption has increased markedly since the beginning of the 1960s, but during the 1980s it seems to have stabilized at a high level (13.9 litres of pure alcohol per person aged 15 years and older). This means that, on average, everyone in Denmark above the age of 14 years drinks 2.5 servings of alcohol (15 ml of pure alcohol) each day. Affluent and well educated people consume the most, but it is the underprivileged people that are registered in the care system and thus labelled as abusers.

The use of narcotics is not illegal in Denmark, but possession of large quantities and selling narcotics are criminal offences. The first narcotics, from hashish to heroin and LSD, appeared in the wake of the youth revolt in 1968. The results of several studies indicate that almost half of all young people aged 19 – 29 years have had some experience with narcotics, usually with hashish. There are no exact statistics on the number of abusers; estimates vary from 4000 to 12 000. Another type of narcotic, speed agents such as amphetamines and cocaine, have entered the market recently, and new types of designer drug, such as phentanyl, are on the way. A special type of abuse popular among very young people is sniffing lighter fluid, cellulose thinner, petrol, etc.

Another problem in Denmark is the increasing use of medicine, especially psychoactive drugs. The consumption of psychoactive drugs is 113.1 defined daily doses per 1000 population, which is 50% more than in the second-ranking Nordic country. Each day more than one in ten people in Denmark gets one full dose of sedative or sleeping pills. It is difficult to distinguish between ordinary use and addiction, but an increasing number of people are probably addicts. The situation in the Odense catchment area is similar to the national average.

Information on crime rates in the *Leiden* area has to be gathered from statistics on the rates in the provinces and for cities with more than 50 000 inhabitants. In the South Holland province, 249 586 crimes were reported to the police in 1984: 228 961 for violations of the Criminal Law Act, 18 336 for violations of the Traffic Law Act and 1322 for violations of the Narcotics Law Act. The number of crimes per 100 000 inhabitants was 7919 against the national average of 7409. Only the province of North Holland (which includes Amsterdam) had a higher crime rate. Of the 228 961 violations of the Criminal Law Act, 28 469 were violent crimes, 2558 sexual and 197 441 crimes against property. In South Holland, 13 933 (21%) of the 66 818 suspects in crimes reported to the police were aged under 18 years; this percentage is only slightly higher than the national average of 18%.

In the Netherlands, alcoholism and drug abuse are considered alarming phenomena. A nationwide campaign against alcohol abuse was started recently. Between 100 000 and 400 000 people are dependent on alcohol (0.7% to 2.8% of the population, according to the definition used). Alcoholism seems to be spread fairly uniformly all over the country, and the estimate is therefore probably also valid for the catchment area. Drug abuse (especially of such hard drugs as heroin and cocaine) is concentrated in the metropolitan areas of Amsterdam and Rotterdam.

In *Würzburg* the police recorded 11 319 criminal offences in 1987, i.e. 43 per 1000 inhabitants. In the city, one quarter of the offences were committed by people below 18

years; in the surrounding areas only about one tenth of the suspects were that young. Juvenile delinquency was clearly concentrated in two specific areas within the city.

No data on alcoholism and drug abuse are available for the catchment area, so statistical information from a wider area covering two other counties is therefore used. In 1987 more than 300 people with alcohol dependence or abuse contacted the Caritas Welfare Centre, which specializes in alcohol problems in the region. Most of the clients were between 30 and 50 years of age. The Municipal Drug Welfare Centre saw 650 clients, of whom 40% were heroin addicts. Every year there are about 100 new heroin-addicted clients. The police estimate that there are about 1500 drug addicts within the region (the three counties). One of the reasons for the relatively high number of addicts in the area is that it is close to Frankfurt, a centre of the international drug trade. No separate data for the city and the countryside are available, but it is known that the drug problem is not restricted to urban areas.

There were 14 932 criminal cases reported for 1987 in the city of *Berne* (50 per 1000 population). There was only one case of homicide and one case of manslaughter. The majority of cases were crimes against property, followed by violations of the controlled drug law (629); 149 of the latter were committed by people under the age of 20 years.

Most cases of alcoholism are referred to the Sociomedical Service of the City of Berne, which treated 423 people in 1987. Most of these people were aged 30 – 40 years and worked in industry or the service sector. The number of drug addicts is not known. A special problem in Berne is that many young people often find it difficult to adjust to society and strongly oppose the pressure to conform. Conflicts have resulted in young people occupying certain areas or buildings and proclaiming them as autonomous areas, which has led to various harsh and sharply criticized police actions.

In *Innsbruck*, the police recorded 8268 criminal offences in the first half of 1988 (68 per 1000 inhabitants per year). Four fifths were offences against property.

In the *Szeged* area 6086 criminal acts (13 per 1000 population) were recorded in 1987 but only 3096 people were sentenced. Theft and destruction of public property were the most common offences.

Alcoholism has become a serious problem throughout Hungary. The number of registered alcoholics is less than 50 000, but the real number is estimated to be closer to 500 000. The number of people at risk of becoming chronic alcoholics is estimated to be one million. In 1987, 79 people (17 per 100 000 population) in Csongrád County died of alcohol-related liver cirrhosis. In 1987, 842 cases of detoxification, 497 cases of alcoholic psychosis and 496 cases of predelirium or delirium tremens were reported (in all, 4 per 1000 inhabitants of all ages). Alcohol consumption in the catchment area is above the national average.

The incidence of crime in *Bordeaux* has increased dramatically. In 1984, 167 845 offences were reported, 150% more than the 66 761 cases reported in 1973. The proportion considered serious or very serious crimes was 16.5%, and 83.5% were less serious. The proportion of serious or very serious crimes has also increased (from less than 13% in 1974

to 16.5% in 1984). Excluding less serious offences, the incidence of crime was 43 per 1000 population per year, comprising 50% of the offences in the region of Aquitaine.

In 1987, 1020 cases of alcoholism and 695 cases of drug abuse were reported to the health facilities in the Gironde district.

Data on crime and substance abuse are not yet available for the *Guipúzcoa* area, but the results of an epidemiological survey give some information on alcohol and drug abuse. The prevalence of alcoholism (defined as daily consumption of at least 150 ml or 10 standard servings of pure alcohol) was 5%. In addition, cause-of-death statistics show that 59 per 100 000 population die from alcohol-related liver cirrhosis per annum. More than 6% of the population habitually (two or more times per week) use cannabis, 1% opiates and 1.5% amphetamines.

Information on indicators of social instability in the centres in Italy is scarce. In the *Emilia-Romagna* area, the incidence of crime in Reggio Emilia is 57 per 1000 inhabitants. Less than 1% of the offences are committed by people under 18 years.

Alcohol consumption is very high in Italy, but no data are available on alcohol consumption or abuse in the catchment areas. Based on figures from Ferrara, the number of drug abusers in contact with the commune facility for drug addicts is equivalent to 1 – 2 per 1000 inhabitants a year.

In *Padua* the police reported 1170 arrests in 1988; 750 concerned drugs and 915 were other types of crime, most often against property. The incidence of crime in Padua (3 per 1000 population per year) is less than half the national average. Data on alcohol abuse are not available, but the Veneto region has the second highest per capita alcohol consumption in Italy.

Drug abuse seems to be an increasing problem: each year about 150 – 180 new drug addicts are treated at the centre for drug addiction. The number of deaths from overdose has almost doubled in one year, from 14 in 1987 to 27 in 1988 (7 per 100 000 population per year).

3

Health and Health Care

Table 8 shows some indicators used to describe health conditions in an area.

Table 8. Health indicators

	Life expectancy at 0 years of ag	Total mortality rate per 100 000 per year[a]	Total fertility	Infant mortality per 1000 live births[a]	Percentage of population receiving disability pension
Sør-Trøndelag	72.9 / 79.7	1031 / 585	1.77	9.6	4.4
Umeå	76.6 / 82.7	1200 / 1030	1.4	"low"	7.5
Stockholm	71.3 / 78.3	646 / 520	1.9	6.0	5.4
Helsinki	68 / 75	1100		6.0	6.0
Odense	71.9 / 78.7	1214 / 971	1.5	8.9 / 6.5	5.0
Oxford	72.8 / 78.3	414 / 415	1.7	7.6	NA
Leiden	73.1 / 79.6	900 / 1770	NA	7.6	5.4
Würzburg	72.4 / 78.7	1222	NA	6.7	NA
Berne	73.6 / 80.3	1086 / 615	NA	6.8	NA
Innsbruck					
Szeged	65.7 / 73.7			17.3	
Bordeaux	71.2 / 79.2	970		7.7	
Pontoise	75.2			8.4	
Guipúzcoa					
Emilia-Romagna	76 / 78			3.5	
Padua	71.1 / 77.8	901		8.4	

[a] Two numbers indicate males/females.

NA The centre reports that these data are not available.

The figures on life expectancy show the familiar pattern that women live 6 – 8 years longer than men. Life expectancy varies among the centres, however, by about 10 years for both men and women. It is lowest in Szeged (65.7 years for men, 73.7 for women) and highest in Umeå (76.6 years for men, 82.7 for women). The low life expectancy in Szeged is related to the high infant mortality. The mortality rates vary, but comparison is difficult as the rates are not standardized. All centres report cardiovascular diseases as the most frequent cause of death, followed by malignant neoplasms. Little information is available on the prevalence of mental disorders, but most centres say that the number of psychiatric patients is increasing.

Being healthy or feeling well are very personal feelings that are affected by the prevailing social conditions, habits and norms. Perceptions and endurance of pain and suffering may

differ, not only from person to person but more systematically over time and from place to place. For instance, recent studies in Denmark indicate that the threshold of pain tolerance is declining and that most people are becoming more insistent on being treated for even minor ailments and handicaps. The information in Table 8 and on the numbers of people who have various diseases do not therefore necessarily adequately portray the general health conditions as they are experienced and perceived by the people involved.

In most European countries, health care services are provided free of charge or at reduced cost, and a national or regional administrative body is responsible for the services. Compensation for loss of income due to sickness, accident or disability is usually regulated by law and provided by public insurance. In this respect, all the centres participating in the study represent their national standard. This may not, however, be the case for the quantity of services. Table 9 shows that there are considerable variations in the quantitative level of services available.

Table 9. Health care facilities in the catchment areas

	Number of general hospitals	Number of beds in somatic departments per 1000 inhabitants	Number of psychiatric hospitals	Number of beds in psychiatric departments per 1000 inhabitants	Number of patients per general practitioner
Sør-Trøndelag	3	13	1	3.4	1503
Umeå	3	12	2	1.0	2500
Stockholm	1	5.5	3	1.1	2850
Helsinki	13	11.6	4	3.0	2273
Odense	10	5.4	3	1.1	1432
Oxford	4	3	3	0.8	1860
Leiden	3	4.5	3	3.1	2550
Würzburg	11	11	2	1.7	1722
Berne	9	7.7	3	1.6	934
Innsbruck	6	10.7	2	3.4	532
Szeged	6				420
Bordeaux	4	6	1	1.5	500
Pontoise					
Guipúzcoa	9	4.4	3	1.4	5343
Emilia-Romagna					1217
Padua	1	3.3	4	0.1	1255

Sør-Trøndelag

The health care system in Norway is mostly publicly financed. The counties run nearly all hospitals and are also responsible for specialist services. The municipal councils are responsible for general practitioner (GP) services (including night-duty services), nursing and physiotherapy. These responsibilities may be discharged by employing health personnel or by contracting with self-employed health workers. Formally, the municipalities are responsible for the costs, but the expenses are paid by subsidies granted by the national government (block grants and reimbursement).

Public insurance (the National Insurance Scheme) pays most of the personal costs connected with sickness and accidents, and individuals or private insurance pay a minor part. Only expenses exceeding NKr 800 per year are refunded.

In the event of sickness, all employees receive a benefit equal to their regular income up to a maximum of six times the basic amount of the national insurance. The National Insurance administers this scheme through its local offices. The employers pay for the first two weeks of absence. Self-employed people are not compensated for the first two weeks; thereafter they receive a benefit equal to 65% of their regular income. In general, people can receive sick benefit for one year. After that, further benefits may be granted in connection with a need for special medical treatment and/or vocational rehabilitation or the patient may be referred to disability pension or early-retirement pension. A person is entitled to early-retirement pension if his or her capacity to work is permanently reduced by at least 50% because of sickness, injury or disability. People who are born disabled or lose at least half their capacity to work before the age of 21 years also receive a supplementary pension.

The largest hospital in Sør-Trøndelag is the Regional Hospital, a university hospital situated in Trondheim. Two smaller hospitals are located in Orkanger and Röros. Sør-Trøndelag has 13 beds in somatic departments per 1000 inhabitants. Of these, 5 beds are in general hospitals and 8 in nursing homes. Psychiatric departments or institutions have 3.4 beds per 1000 inhabitants. For each health service employee, there are 317 inhabitants in the county. The population to health personnel ratio and the number of beds in hospitals per capita are close to the national average; the number of physicians per capita is, however, somewhat lower in Sør-Trøndelag than in Norway as a whole.

Umeå and Stockholm

Most of the health care in Sweden is governed by national legislation and provided under the responsibility of the county councils. Each municipality constitutes a primary health care district with clinic(s) staffed by district GPs and nurses serving the needs of the local population. Each health care district also has a nursing home.

As in Norway, personal costs connected with treatment are mostly paid for by public means. Compensation for income lost because of sickness is covered by public insurance, and permanently disabled people are entitled to a pension.

In the *Umeå* centre catchment area, Västerbotten County, the hospital services are centred at the university hospital in the provincial capital and at two smaller hospitals in the two other main towns in the area, Skellefteå and Lycksele. Until recently, psychiatric care has been concentrated in Umeå at the Umedalen Mental Hospital or at the University Psychiatric Clinic, but care has been decentralized with the establishment of outpatient units (community psychiatry) in various parts of the area. Only a few doctors in the area work as private practitioners (specialists), and all hospitals are public.

Västerbotten County is one of the largest counties in Sweden, comprising both densely and sparsely populated areas with highly different features. The health care system therefore

provides a very broad variety of services, from advanced treatment at the university hospital to primary care by district nurses, similar to the rest of Sweden. The amount of care received is, however, higher than in the rest of Sweden for somatic treatment but not for psychiatric inpatient treatment.

The *Stockholm* centre catchment area comprises the districts of Huddinge and Botkyrka. The main hospital is Huddinge University Hospital, the largest hospital in Sweden. The catchment area also has a small somatic hospital, Södertälje Hospital, and Karlberga Hospital, which has psychiatric wards. Some residents of the district receive psychiatric care in hospitals outside the area (Långbro Hospital and Rålambshov Hospital). This area also has numerous district health care centres. The range of health services available is normal by Swedish standards.

Helsinki

Health care in Finland is mainly a public service under the responsibility of the municipalities. However, most towns also have private practitioners and clinics. The health care system is hierarchical. People go first to the local health centre, which, according to the Primary Health Care Act of 1972, is responsible for all primary care in a district, including primary treatment, screening, maternal and child health care, dental care, health education, ambulances, occupational health care, medical rehabilitation and the first-aid set-up in the area.

Mental health care is provided according to the same principle: people's primary contact if they have mental health problems is the local health centre, and from there people are referred to the mental health centre of the district.

Primary care developed strongly after the Primary Health Care Act was passed in 1972. The changes started in the northern and eastern parts of Finland, and gradually the reform was introduced in the southern part. However, resources ran out before the reforms could be implemented in the Helsinki area, and consequently private health care has played an important role in the health care system in Helsinki, as private treatment has often been the only way to see a doctor within a reasonable period of time. Sickness insurance, which is similar to the public insurance in the other Nordic countries, refunds 60% of private practitioners' fees; in some cases, fees for laboratory tests and physiotherapy are reimbursed.

Helsinki is divided into seven health care service districts with 25 local health care centres; each centre is responsible for about 20 000 inhabitants. Helsinki University Hospital is in the catchment area, as are several other general hospitals and three mental hospitals. A total of 7032 hospital beds are available: 14.5 beds per 1000 inhabitants, or 5.2 beds per 1000 in primary care, 6.3 in special care and 3.0 in mental health care. Many health services are available, but a considerable proportion is private, and primary health care in Helsinki does not function as well as in other parts of Finland. As people in Helsinki depend on private health care, access to health care services is unequal. Nevertheless, resources for public primary health care were increased by more than one third during the 1980s, and the level of care in Helsinki is now approaching that recommended in all of Finland.

Odense

The health service system in Denmark comprises almost entirely public or semi-public facilities, either paid directly or reimbursed by the public health insurance. The health service system has two levels: the primary sector and the hospital sector. The primary sector includes services by GPs, private specialists and pharmacies, and various community services such as home nursing, health visitors, nursing homes and old people's homes. Access to GPs is easy in Denmark because they are dispersed geographically and because there are relatively few patients per practitioner (on average 1500). The private specialists mostly practise in the towns, but the distance to the nearest specialist is relatively short. Most specialists, however, have waiting lists. Psychologists mostly work at hospitals. A few operate in private practice, but as the public health care system does not pay for psychologists' services (as they do for GPs and specialists), these services are expensive.

The hospital sector comprises hospitals and other treatment institutions and is mostly run by the counties. All treatment is free of charge.

In accordance with the rules of the public health insurance, all residents of Denmark are entitled to free general practice consultations, provided that they are registered with one GP (chosen for a period of at least one year). Tests, treatment, specialist services, home nursing and other services prescribed by the GP are partly refunded by the public insurance. In addition, many people have private insurance that covers the part not paid by the public insurance and some specific extra services. People who do not want to be obligated to contact one particular GP only or who want to contact any specialist directly can do so by a special agreement at a charge of 25% of the fees (which can be paid by private insurance). Wage-earners have two days' sick leave (paid by the employer) without loss of income. Thereafter, loss of income is compensated by public insurance at 90% of previous income up to a certain maximum equal to that of the unemployment benefit. However, as part of their contract, many salaried workers are entitled to full pay during sickness for at least three months a year. Self-employed people are also entitled to public insurance in accordance with the same rules, but many are also covered by private insurance. Permanently disabled people are eligible for public pensions.

The main hospital in the catchment area is Odense University Hospital, one of the biggest hospitals in Denmark with 7000 employees. The catchment area of the Hospital covers almost half the population of Funen county; in addition, people from neighbouring counties are referred to it for specialized treatment. The area also has nine smaller hospitals, two of which have departments of psychiatry. About 3000 beds (6.5 per 1000 inhabitants) are available. The total capacity at the departments of psychiatry is 506 beds, 1 per 1000 inhabitants. This is low for Denmark, as the average for the whole country is about 2. However, most older people with mental health problems are usually referred to other special institutions or to sheltered homes. Psychiatric treatment is also offered at well developed outpatient clinics and, for mentally retarded people, at the institution Strandhøj, which has 228 beds. In addition, special clinics for alcoholics are affiliated to the various departments of psychiatry. Centres for community psychiatry have been established recently. These centres are formally part of the hospital sector but operate at the primary level.

The Odense catchment area (Funen county) has several small private recreation centres or homes and other institutions for which the public health insurance fully or partly reimburses the fees. The most important ones are a sanatorium for people with neurotic disorders (located in a neighbouring county) in which Funen County has 10 beds and an alcohol treatment centre with a capacity of 54 patients. The Odense catchment area has 317 GPs; the number of patients per GP varies from below 1000 to just above 1500 (average 1432). Most people's GPs are within 10 km of their homes.

Leiden

Health care in the Netherlands originated mainly from private initiatives, usually on a charitable basis. The sick were first cared for by monastic orders, and Catholic and Protestant hospitals, services and nursing homes still exist today. Health care facilities are also provided by groups organized on nondenominational, Jewish or humanistic lines. Sectarianism has resulted in separate Catholic, Protestant and state hospitals, often close together. In recent years, however, such divisions have become considerably less marked and, in general, health services are no longer organized on a sectarian basis.

The history of health care reflects the changing relationship between the government and the private sector. Today public health is part of the portfolio of the Minister of Welfare, Health and Cultural Affairs. The total cost of health care in the Netherlands amounts to f. 34 thousand million (ECU 15 thousand million), equivalent to 8.6% of the gross national product. The administrative and executive powers for health care are vested by legislation in both the municipal and provincial authorities. Thus there are municipal medical services and hospitals and provincial hospitals and mental institutions. The state administers and runs seven of the eight teaching hospitals. The municipal and provincial authorities are responsible for ensuring that the health services they provide comply with national standards.

The Health Care Charges Act is intended to achieve a balanced system of charges. The term charges covers all payments made in return for any form of health care, such as surgery, hospital nursing or the services of a district nurse.

The health system has both compulsory national health insurance and voluntary insurance. About 62% of the population is covered by compulsory insurance under the 1966 Health Insurance Act. Health insurance is compulsory for people whose income is under a certain ceiling (the employee and employer each pay one half of the premium) and for people below the age of 65 receiving such benefits as disability pension, unemployment benefit or social assistance. The non-employed spouses and children are insured free of charge. People not insured under the Health Insurance Scheme can take out various private insurance policies.

The Exceptional Medical Expenses (Compensation) Act provides for a national scheme under which everyone is insured regardless of income. The Act covers expenses incurred because of long-term illness or serious disability that may be difficult to insure and for which the patient cannot pay. Care in hospitals (including psychiatric hospitals) for more than 365 days is covered by this Act, as are stays at nursing homes, institutions for mentally

handicapped people, children's homes, hostels for handicapped people, etc. Part of the premium is graduated according to income. The employer pays the full premium for employees.

Every inhabitant of the Netherlands is entitled to free assistance from one of 59 regional institutes for outpatient mental health care (RIAGG). Psychotherapy is excepted, as a small charge is made. Each RIAGG has a catchment area of 150 000 to 300 000 inhabitants. RIAGGs are organizations with their own management, independent of the state, church or local authorities and funded under the Exceptional Medical Expenses Act. Besides the RIAGGs, many non- and quasigovernmental organizations provide specialized health care and social work assistance, such as treating alcohol- and drug-related problems, birth control and sexuality (the Rutgershuis), telephone hotlines and support for juvenile runaways, former psychiatric patients, non-citizens, etc. Some of these organizations are run (partly) by volunteers.

The somatic and mental health services and facilities in the Leiden catchment area include three general hospitals, three psychiatric hospitals and about 135 GPs. The average number of inhabitants per GP is 2550 (the national average is 2450). The University Hospital is the largest general hospital in the catchment area. It is a state hospital with a psychiatric department. The Diaconessenhuis is located close to the university hospital. It was originally a Protestant hospital and is the smallest general hospital in the region. St Elisabeth Hospital in Leiderdorp is the second largest general hospital, and was originally Roman Catholic. For educational and research purposes the University Hospital and the Jelgersma Clinic maintain close relationships with each other and with other university departments. The St Bavo Centre is located inside the catchment area, but many patients live outside the area (in Rotterdam and surroundings). As the health care system in the Netherlands is a national system, there are few interregional differences, and the situation in the catchment area is typical of the situation in the Netherlands at large, both regarding health insurance regulations and the number of GPs, hospital beds, etc. per inhabitant.

Würzburg

Health care in Germany is based on insurance, with a mixture of public, cooperative and privately run health insurance schemes. Almost everyone is required to belong to one of these schemes. Most employed people are members of regionally organized public insurance schemes; the insurance covers family members with no income. Health insurance usually covers the costs of most services, but to reduce increases in insurance rates, patients are increasingly being required to pay a share of the cost of services. For people who receive social welfare support, the welfare office also pays the cost of medical treatment. The health insurance schemes have contracts with the suppliers of medical services, which are also either public or private. Physicians work in private practices. Hospitals are run by various public agencies, nonprofit organizations or private enterprises. People usually have their own GPs, who refer patients to a specialist or to a hospital if necessary.

In 1986, 985 physicians worked in the city of Würzburg. Most of them were employed in one of the 10 hospitals with 2818 beds; 230 practitioners, of whom 19 were psychiatrists, were working in private practices. The county also has an additional hospital with 170 beds

and 93 practitioners, of whom 3 are psychiatrists. The psychiatric hospital of the University of Würzburg has an average of 1300 inpatients per year. About the same number of patients are seen on an outpatient basis or in a liaison service. Two other psychiatric hospitals just outside the county treat many of the patients from the catchment area. The University also has a psychiatric hospital for children and adolescents: about 200 children per year are treated as inpatients and 200 as outpatients.

Berne

Medical services in Switzerland are basically private, although most hospitals are heavily supported by the state. People belong to private sickness insurance schemes that cover outpatient and inpatient care. Very few people have no insurance cover, and they either pay directly or, if necessary, the expenses are covered by social welfare schemes.

There is a free choice of doctors and hospitals, and many patients consult more than one doctor. Patients are free to make appointments with medical specialists (such as psychiatrists). The GPs of Berne offer a 24-hour emergency service covered by a duty scheme in which all the practitioners participate. Practitioners in the suburban areas have their own on-call schemes.

The main hospital in the Berne catchment area is the University Hospital of Berne with 1072 beds. The hospital includes all relevant somatic departments and a psychiatric department that also provides outpatient care, liaison services and community care. There are two other public hospitals in the city and six private hospitals in the catchment area.

The psychiatric services comprise one psychiatric hospital with 486 beds, which admits 1800 people per year; a social psychiatric clinic, which provides community-based outpatient services and has a crisis-intervention ward (1000 outpatients and inpatients per year); one outpatient and liaison service that treats 3500 patients per year, and one psychiatric service for children and adolescents with 320 outpatients and 17 inpatients per year. The catchment area has a small psychiatric service for drug addicts. The psychology department of the University of Berne has a counselling service, and 90 psychologists practise in the area.

Innsbruck

In Austria almost every working person is a member of the public social insurance system , which includes health, accident, old-age and unemployment insurance. Health and accident insurance also cover family members. The insurance system usually covers the costs for all medical service and remedies. Several health insurance companies provide cash benefits. In the Innsbruck catchment area the most important is the Tyrol Provincial Sickness Fund, but there are also special insurance companies for farmers, teachers, employees of the federal railways, etc. GPs provide medical care and can refer people to a specialist or a hospital.

The largest hospital in the catchment area is the university hospital in Innsbruck, which is also the provincial hospital responsible for basic medical services in the Tyrol. Its catchment area extends to the neighbouring provinces and the southern Tyrol. The hospital has 1700 beds, the district hospital in Hall 235 beds, the provincial hospital in Natters 206 beds, and

the provincial hospital in Hochzirl 120 beds. The provincial psychiatric hospital in Hall offers 830 beds for acute and chronic psychiatric patients. There are 2 sanatoria with 330 beds. In all, 3421 hospital beds are available in the Innsbruck catchment area. In the Innsbruck catchment area, 532 doctors work in private practice; 176 are GPs, 24 general or accident surgeons, 47 internal specialists, 49 paediatricians and 20 neurologists or psychiatrists.

A number of psychiatric care services for different population groups are available. There are several public and private services for emergency care, such as outpatient departments and telephone services. The catchment area has facilities for the professional rehabilitation and social reintegration of mentally ill people, and homes and mobile services for old and disabled people (taxi service, home nursing, catering service and emergency alarm system). Public, private and church counselling services have been established for homeless people and for people who have been released from prison. During the past few years, several social occupational services have been established. There are counselling services and therapy centres for people with alcohol and drug problems (groups of Alcoholics Anonymous) and for people with AIDS. Further, there are counselling services for families, pregnant women and adolescents as well as women's shelters. The number of self-help groups (for example, for homosexuals or people with bulimia, enterostomy, mucoviscidosis or cancer) is continually increasing.

Szeged

Under the provisions of an act that was due to come into force on 1 July 1992, health care services in Hungary are to be provided through an insurance scheme. Every Hungarian citizen will have the right to be insured. Employees will be insured through the levy of a special tax (based on an amount equal to 44% of the employee's salary to be paid by the employer and an amount equal to 10% of the salary to be paid by the employee); pensioners will be covered automatically and based on insurance already paid, and children and non-working spouses will also be covered. Private companies also pay an insurance contribution. Unemployed people will receive an insurance card from the same office that issues unemployment benefits. This will apply for one and a half years, after which time the person will apply to the local government. A basic level of service will be provided through this insurance scheme. Extra services (such as a single room, telephone, etc.) will either be paid for directly by the patient or through additional insurance coverage. Medicaments will be provided in different groupings: life-saving medicaments will be covered through the insurance scheme, whereas important but non-vital medicaments will be provided against a small financial contribution from the patient. "Luxury" medicaments, such as sleeping pills, which are not required as a result of illness will be covered by the patient. Most Hungarian workers are still employed by the state, but with the rapid move towards privatization this is changing. People on sick leave receive 75% of salary, irrespective of whether they are treated in hospital or at home.

There are around 4800 GPs in the country. They are called family physicians and now receive special postgraduate training. One of the main topics in the new training curriculum is psychology and doctor/patient relationships.

There are two municipal hospitals in Szeged (one of them with a psychiatric ward) and several special clinics including a psychiatric clinic and two institutes of mental health (one for children). Apart from the lack of a county hospital, the catchment area around Szeged does not differ significantly from the national average in respect of health care services.

Bordeaux and Pontoise

In France, expenses relating to sickness, maternity and infirmity are covered by the social security system, which is based on obligatory membership. Full coverage can be obtained by private insurance.

The Bordeaux catchment area hosts the Bordeaux University Medical Centre, which includes 4 hospitals with 3832 beds. There is also a military hospital with 303 beds, a psychiatric hospital with 765 beds and several private clinics (medical or psychiatric) with 524 beds. These services are representative of urban France.

Guipúzcoa

The health care services in Guipúzcoa are under the authority of the Basque regional government. Most services are public, although some are provided privately.

Primary care is given by GPs working together in small clinics; Guipúzcoa has 41 of these clinics. The area also has 6 clinics staffed with various specialists and 11 private clinics.

The Hospital de Guipúzcoa, which is one of three district hospitals in the area, has a psychiatric department. Guipúzcoa also has the main hospital of the Basque Country, one public and one private mental hospital and nine community mental health centres.

Emilia-Romagna and Padua

In Italy, the National Health Service provides any required medical service free of charge to all residents of Italy. The country is divided into health districts; for example, the catchment area in Emilia-Romagna consists of two health districts in which outpatient and inpatient services are provided. Each citizen selects his or her own GP, who is supposed to take care of up to 1500 patients. Emergency house-call services are available at all times. Specialized outpatient services are also available. Each district has hospital facilities; bigger hospitals with more specialized departments, such as a university hospital, serve several health districts. There are also several private clinics, most of which cooperate with the National Health Service, and the service costs are reimbursed.

Emilia-Romagna has two general hospitals with 2727 beds. There are 14 psychiatric community centres and 22 homes and rehabilitation centres. The area hosts 290 GPs. The health care services offered in Emilia-Romagna are far more developed than those available in southern Italy, and this is also true for *Padua*.

4

Suicidal Behaviour and the Treatment of Suicidal People

The reliability and the comparability of national statistics on suicide have been discussed intensively for many years. Differences in religious and cultural attitudes towards suicide, various registration procedures and practices, and individual variations in determination of the manner of death (often linked to the profession of the investigator) have affected and may still affect the final statistics. According to studies initiated by WHO in 1974 on the reliability of the registration of suicide in a number of European countries, these differences were so great that "... to construct epidemiological or sociodemographic theories about suicide will remain a hazardous occupation until the statistics can be proved".[a]

Others have voiced a more optimistic view on the question of reliability. For instance, based on results from several studies of the topic, Peter Sainsbury concludes that "... the mortality statistics are sufficiently accurate to warrant epidemiologists' using the data to see with which national, demographic, social or other characteristics and their trends they correlate; and thereby not only to test hypotheses about factors predisposing to suicide, but also to identify those groups in a population who are most at risk, and what implications they have for preventive action". And he continues, "Suicide is underreported for a number of reasons, and the rates are subject to many errors of a kind encountered in reporting mortality figures in general. Nevertheless, the findings from studies designed to settle the point indicate that these errors are randomized, at least to an extent that allows epidemiologists profitably to compare rates between countries, within them, and over time".[b]

Suicide

Table 10 lists the incidence of suicide in countries of the centres involved in the study. The rates were stable during the first half of the 1980s, but despite the considerable differences between the countries in variation in rate by age and sex between the countries (Table 11), the trends are cause for great concern.

---

[a] Brooke, E.M. *Suicide and attempted suicide*. Geneva, World Health Organization, 1974 (Public Health Papers, No. 58).

[b] Sainsbury, P. The epidemiology of suicide. *In*: Ray, A., ed. *Suicide*. Baltimore, Williams & Wilkins, 1986.

Table 10. Registered suicide rates per 100 000 inhabitants of all ages per year, 1981 – 1985

	1981	1982	1983	1984	1985
Norway	13	14	15	14	14
Sweden	16	19	19	19	18
Finland	24	24	24	25	25
Denmark	30	29	29	29	28
United Kingdom	9	9	9	9	9
Netherlands	10	11	12	12	11
Germany, Federal Republic of	22	21	21	21	21
Switzerland	24	25	25	25	25
Austria	27	28	27	27	28
Hungary	46	44	46	46	44
France	20	21	22	22	23
Spain	5	5			
Italy	7	7	8		

Source: Data gathered by the WHO Regional Office for Europe.

Not all centres have provided exact data on suicide within the area (Table 12).

Parasuicide

Statistics on completed suicides have been available in most countries for more than a hundred years, but no country can provide national statistics on suicide attempts (parasuicide). Our knowledge of the incidence of parasuicide is mainly based on surveys and studies carried out in some local areas, and the comparability of results from these studies is indeed questionable. The monitoring study carried out as part of the WHO/EURO multicentre study on parasuicide is intended to produce more reliable data, as the registration in all areas is carried out according to the same procedure, using the same definition and the same instruments. Fig. 2 shows preliminary data from the first period of investigation.

Treatment of suicide attempters

Not all centres have reported specific procedures to be followed prior to the registration survey in cases of suicidal behaviour or any special treatment offered to suicide attempters. For instance, this is the case in *Sør-Trøndelag*, probably because suicidal behaviour has not been considered a serious problem in Norway until recently. In some other countries, systematic procedures and treatment have been introduced only recently.

Table 11. Percentage changes in age-specific suicide rates per 100 000 population per year (from average for 1972 – 1973 to average for 1983 – 1984)[a]

	Age (years)													
	15 – 24		25 – 34		35 – 44		45 – 54		55 – 64		65 – 74		≥75	
Men														
Norway	+	136	+	84	+	33	+	32	+	65	+	43	(+	43)
Sweden	-	10	+	9	-	18	-	7	-	29	-	5	+	4
Finland	+	13	+	19	-	2	-	5	-	23	-	11	-	16
Denmark	+	26	+	50	+	16	+	8	+	9	+	4	+	24
England and Wales	+	18	+	44	+	34	+	29	+	10	-	9	+	9
Netherlands	+	18	+	127	+	47	+	30	+	17	+	17	+	24
Germany, Federal Republic of	-	6	+	7	-	2	-	2	-	17	-	2	+	15
Switzerland	+	48	+	52	+	17	+	23	+	1	+	8	-	10
Austria	+	52	+	27	+	27	+	17	-	21	+	12	+	22
Hungary	+	5	+	25	+	41	+	34	+	13	+	21	+	16
France	+	113	+	174	+	109	+	74	+	53	+	82	+	185
Spain	+	83	+	29	-	4	-	7	-	15	-	25	+	8
Italy	+	33	+	41	+	15	+	28	-	1	+	4	+	5
Women														
Norway	(+	13)	(+	22)	(+	78)	+	62	+	94	+	75	(+	91)
Sweden	-	27	+	19	-	5	-	1	-	22	+	7	+	6
Finland	-	31	+	13	-	12	+	8	-	20	-	10	(+	25)
Denmark	(-	24)	+	111	+	15	+	3	-	0	+	10	+	67
England and Wales	-	63	-	25	-	12	-	9	-	5	-	3	-	6
Netherlands	+	13	+	56	+	18	+	19	+	12	+	37	+	28
Germany, Federal Republic of	-	13	-	10	-	2	-	24	-	21	-	2	+	1
Switzerland	+	27	+	18	+	37	+	7	+	11	+	43	-	5
Austria	+	34	+	3	+	15	-	3	-	13	+	8	+	6
Hungary	+	18	+	21	+	51	+	7	+	11	+	7	+	21
France	+	7	+	67	+	56	+	28	+	16	+	24	(+	42)
Spain	+	50	-	14		0	-	17	-	16	-	18	-	6
Italy	+	5	+	14	+	23	+	20	+	8	+	24	+	25

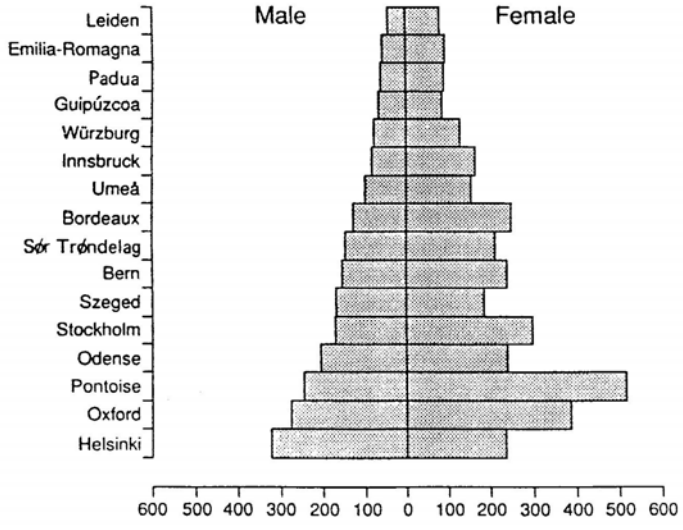
[a] The rates in brackets are based on a mean of less than 20 suicides per annum in one or both time periods except for the following countries (latest years in brackets): Italy (1980 – 1981), Spain (1979 – 1980).

Source: Platt, S. Suicide trends in 24 European countries, 1972 – 1984. *In*: Moeller, H.-J. et al, ed. *Current issues of suicidology*. Berlin, Springer, 1988, pp. 3 – 13.

Table 12. Incidence of suicide in the centre catchment areas

	Rates per 100 000 population				Suicide as a percentage of all deaths	Sex ratio male/female
	Year	Male	Female	Total		
Sør-Trøndelag	1988-1989	25	7			3.6
Umeå	1988			19		
Stockholm	1987	45	26	35		1.7
Helsinki	1982-1988	44	16	30		2.7
Odense	1989	34	20	27	2.3	1.7
Oxford	1990	8	2	5	1.2	3.5
Leiden	1985				1.8	
Würzburg	1989	19	11	15	2.2	1.7
Berne	1989	37	15	25		2.2
Innsbruck	1987				2.6	
Szeged	1987			60		
Bordeaux	1985			36		
Pontoise						
Guipúzcoa						
Emilia-Romagna						
Padua						

Fig. 2. Rates of parasuicide (persons) per 100 000 population aged 15 years and over, according to sex, 1989



In *Umeå*, each of the three health districts has its own hospital where most people attempting suicide are received and treated in the acute phase. A few are treated by GPs only, and these are usually not serious cases – but one potential reason for this is that the hospitals are too far away. Most patients leave hospital immediately after acute medical treatment or after only a few hours' stay. Appointments for aftercare in a psychiatric outpatient unit are made for some people before they leave, but compliance is generally very low.

In the *Stockholm* area, most people attempting suicide are admitted to the accident and emergency units at Huddinge University Hospital. As hospital care in this area (in contrast to Umeå) is easily accessible, few people attempting suicide contact or are brought to the district medical centres. The patients are examined and assessed at the hospital emergency unit, and then they may be admitted to a somatic department for observation, sent to an intensive care or medical ward, or referred to a psychiatric ward. Half of the people attempting suicide leave hospital after brief observation. Aftercare, which is usually outpatient care at psychiatric treatment centres, district medical centres or social welfare offices or in nursing homes for psychiatric patients or alcoholics, may be arranged, but about 20% leave hospital after a short period of observation without making an appointment.

In *Helsinki*, people who have attempted suicide are usually taken to the outpatient department of a general hospital. The person's somatic condition is assessed and first aid given, and then he or she may be sent home or insist on going home, or may be transferred to another somatic hospital (for surgery, for instance) or to a psychiatric hospital. Less than half the cases are given psychiatric consultation to assess the need for further treatment. Psychiatric treatment may be carried out in a hospital ward, as outpatient treatment or as noninstitutional care. Since 1973, all self-poisonings and most suicide attempts by other methods have been directed to Meilahti Hospital, a general hospital belonging to the Helsinki University Central Hospital. All cases are received in the outpatient department and are then transferred, if necessary, to other wards. Some suicide attempters are treated at two local general hospitals, but ambulance personnel are ordered to bring people who have attempted suicide to Meilahti Hospital.

In Denmark, the two main gateways to the health service system for everyone, including people who attempt suicide, are the GPs and the emergency wards; from then on, various departments and/or institutions may be involved. At Odense University Hospital (whose catchment area covers about half of the Odense study), an open psychiatric emergency ward and an observation unit were established in 1981, and people from the catchment area who attempt suicide are usually brought there. Further, by long-standing tradition the great majority of suicidal people admitted to the hospital (for example, into intensive care units) are registered with the Department of Psychiatry. Suicide attempters from the rest of the area under study are often brought directly or immediately transferred to Odense University Hospital or to one of the two other main hospitals in the area that have departments of psychiatry. In principle, all suicide attempters brought to any hospital in Funen county are supposed to be seen by a psychiatrist, but in practice many people leave hospital very quickly before contact with a psychiatrist can be established or they refuse to see a psychiatrist. For the rest, treatment (beside medical treatment) is usually carried out during a

short stay (median in 1989 = 2 days) at the Department of Psychiatry. Before discharge, arrangements for aftercare may be made; usually this would be in outpatient units or at alcohol ambulatories or various agencies or institutions under the social welfare system. However, no data on compliance are available.

In *Oxford*, most of the catchment area is served by one general hospital, the John Radcliffe Hospital, to which all hospital-referred suicide attempters are sent. Just over 80% of the patients are admitted to hospital beds, the rest being discharged from the accident and emergency department. Of the total group, 85% are assessed by a member of the general hospital psychiatric service. This service is composed of five very experienced nurses, a social worker and two junior psychiatrists, who are supervised daily by a senior psychiatrist. The team member who makes the initial assessment usually makes aftercare arrangements, which can include outpatient care provided by that person (25%), inpatient psychiatric admission (5 – 10%), outpatient care at one of the local psychiatric hospitals (15%), referral to such agencies as social services and voluntary agencies (20%) and referral back to the GP (30 – 35%). There are close links between the alcohol abuse service and the general hospital. An early study showed that the proportion of people attempting suicide who are seen by GPs and not referred to the general hospital is low. However, many episodes do not come to medical attention at all.

In the *Leiden* area, most suicide attempters who are brought to a general hospital are referred to the University Hospital, which is the only general hospital in the area with a department of psychiatry. About 90% of all people attempting suicide admitted to the University Hospital are seen by a psychiatrist. After medical recovery, 25% are transferred to the Department of Psychiatry for further treatment. However, studies have shown that many of the parasuicides that take place in the area are not treated at hospitals. Some are treated by GPs only, some at various agencies or institutions such as the RIAGGs and many (according to the studies mentioned, the majority) do not come to the attention of health facilities at all.

In *Würzburg*, most of the people attempting suicide are admitted directly to the emergency or intensive care unit of one of the general hospitals. They are usually seen by a psychiatrist, who may recommend psychiatric or psychotherapeutic inpatient or outpatient treatment. Many people are admitted directly, or after initial ambulatory somatic treatment, to the psychiatric hospital. It seems that a small percentage of all people having any contact with health facilities are treated only on an outpatient basis by a GP, psychiatrist or a counselling service.

This is also the case in the *Berne* area, but the psychiatric care system in the area offers several relevant services, such as a social psychiatric clinic that provides community-based outpatient services and has a crisis-intervention ward; an outpatient and liaison service; and a special psychiatric service (inpatients and outpatients) for children and adolescents.

In *Innsbruck* there is no special form of treatment for suicide attempters, but a number of services are available for different groups of the population. For example, there are several public and private services for emergency care, such as outpatient units, telephone services

and counselling services, and therapy centres for people with alcohol and drug problems, etc.

In *Szeged*, people who attempt suicide are first taken care of by the ambulance service, which gives immediate treatment. Serious cases are thereafter transferred to the intensive care unit or to a relevant somatic department for medical treatment and then to the department of psychiatry. Less serious cases are transferred to outpatient departments, usually at the University Clinic. About 30 – 50% of all people attempting suicide are treated by psychiatrists – one third either at the psychiatric clinic at the University Hospital or at the Mental Hygiene Institute and one third at an outpatient department. Alcohol abuse is a serious problem in about 30% of the cases; these patients are treated at a special department at the hospital. Special treatment is also offered to the very young attempters, either at the Child and Juvenile Neurotherapy Institute or at a special unit for children and adolescents at the University Clinic. Since 1978, a group of specialists at the University Clinic has carried out special procedures in assessing and treating people who attempt suicide. At the beginning, these activities were carried out as part of the usual everyday clinical work, but a reorganization of the location of the departments and the structure of the clinic has improved the conditions and made it easier to extend treatment. Besides crisis therapy, analytical therapy, hypno-behavioural therapy and also some group therapy are offered at the suicidological outpatient department.

In *Bordeaux*, 9 out of 10 people attempting suicide poison themselves. Most of them are brought to the emergency and intensive care unit at the Pellegrin-Tripode Hospital, where they are also assessed by a psychiatrist. About one quarter are referred to psychiatric departments (public or private); the rest go home after a short stay at the hospital (24 – 48 hours). About 25% receive outpatient psychiatric care. It is estimated that 200 – 300 of the people attempting suicide each year do not receive any health services.

In *Guipúzcoa* most attempters are brought to one of the emergency services at the hospitals in San Sebastián. There are no special crisis centres or other institutions, but GPs and the community mental health centres may be involved in aftercare.

In the *Emilia-Romagna* area, people attempting suicide are treated mainly in general hospital settings (including psychiatric units), although some are treated by psychiatric community facilities and/or by GPs (when there is no need for emergency care). Very young attempters may also be treated by the special children's service. There are no specific facilities such as crisis intervention units or special general or psychiatric hospital wards. Most attempters are brought directly to the emergency department of a general hospital or to some other wards (psychiatric, general medicine or other). Some are first seen by a GP and then, if necessary, brought to the hospital. They might receive aftercare at the psychiatric unit at a general hospital or from a psychiatric community service.

In *Padua*, most attempters are brought to the emergency service at the Padua City Hospital, where a psychiatrist is present. From there, those who do not leave the unit immediately after treatment may be transferred to a somatic department or, in some cases, to a psychiatric unit. During admission to somatic wards, most attempters are seen and assessed by a psychiatrist, and then the person may be transferred to the psychiatric service. About 15% of all attempters are first seen by a GP, and about 10% receive no further treatment from other facilities.

6

Concluding Remarks

This work has portrayed the catchment areas being studied by the 16 research centres participating in the WHO/EURO multicentre study on parasuicide.

The individual participating centres provided the information on the local, regional and national characteristics which is relevant for this continuing study of suicidal behaviour. The final picture has been painted with rather bold strokes. This is because nuances had to be omitted because information was too scarce or too few centres provided it, or details had to be skipped because the data were presented in a way that made it impossible to compare them.

Another problem is that the facts and figures presented are inadequate to describe people's everyday lives, their feelings of fulfilment and satisfaction or of deprivation and misery, or the general sense in a community of mutual and close interdependence or of alienation and loneliness.

Nevertheless, I hope that the historical, demographic and socioeconomic patterns and general health conditions in the areas under study have emerged, and that this may be of some value to those working in the field of suicidology in Europe.

ANNEXES

Annex 1

WHO/EURO Multicentre Study on Parasuicide

European Parasuicide Study Interview Schedule (EPSIS)

EPSIS VERSION 5.1
Initial interview

Dr A.J.F.M. Kerkhof W. Bernasco

Dr. U. Bille-Brahe Dr. S. Platt Dr. A. Schmidtke

December 1989

Correspondence address:

Dr. A.J.F.M. Kerkhof
Department of Clinical, Health and Personality Psychology
University of Leiden
Wassenaarseweg 52
2300 AK Leiden
The Netherlands

CONTENTS

* SR = Self-report scale or questionnaire

PREAMBLE

Introduction

The European Parasuicide study Interview Schedule (EPSIS) was designed to be used in the repetition-prediction project of the WHO/EURO multicentre study on parasuicide. In this project, hospital-admitted parasuicide patients are interviewed twice. The first interview takes place within a week of hospital admission due to parasuicide; the second interview takes place one year later. The first (initial) interview is a structured psychosocial interview schedule with a short medical questionnaire included. The psychosocial interview is internationally standardized and should be carried out according to the instructions given below. Pages 8 – 63 contain the complete text of the psychosocial interview. For the medical questionnaire (pages 5 and 6), centres may choose how to obtain the information requested. Medical information may be obtained from the people responsible for the patient's treatment, hospital administration files or a clinical interview with the patient.

This document contains the unedited version 5.1 of the EPSIS. The first draft of an interview schedule for the study was prepared by Dr R.F.W. Diekstra in September 1986. The contents of the schedule were extensively discussed at meetings of the Steering Group in London (1987), Bologna (1987) and Edinburgh (1988). At the Edinburgh meeting, Dr A.J.F.M. Kerkhof took responsibility for preparing a completely revised version for further discussion at the next Steering Group meeting (December 1988 in Leiden). The interview schedule that resulted from Steering Group discussions was sent to all participating centres for field testing in February 1989. Based on the comments received, the Steering Group prepared the current version (version 5.1) during a meeting in May 1989 in Leiden.

Instructions for the medical questionnaire

The medical questionnaire may be completed before or after the psychosocial interview is carried out. The most time-consuming aspect of the medical questionnaire is obtaining a psychiatric diagnosis (question 11). The diagnosis should be made by a doctor responsible for the patient's treatment or by a member of the research team within one week of the parasuicide. It should preferably be made according to the ninth edition of the International Classification of Diseases (ICD-9). The research protocol does not prescribe a standard procedure for making the diagnosis (such as based on a structured interview, a clinical nonstructured interview or observation). If it is not possible to provide an ICD-9 diagnosis, a psychiatric diagnosis according to another acceptable classification system should be made. In case of a DSM-III or DSM-III-R diagnosis, only an Axis I diagnosis is required. To obtain complete information, questions 7 and 8 of the medical questionnaire should be completed or updated after the patient is discharged from hospital.

Instructions for the psychosocial interview

Contact should preferably be established in the hospital by the interviewer: when necessary, after consent has been obtained from those responsible for the patient's treatment. The people in charge of this treatment should not themselves ask the patient to participate in the interview. Patients should be completely informed about the purpose and content of the interview. It is not necessary to tell patients that they will be asked to agree to a follow-up contact after the interview unless they ask about this. Instructions for introduction are given on page 8. If the patient agrees to participate, a consent form (page 9) should be signed.

The average time taken by the interview is estimated to be about 1.5– 2 hours for experienced interviewers. Interviewers should have mastered basic interview techniques and be familiar with the EPSIS so as to proceed smoothly through the interview. They should follow the order shown, including the self-report scales; these should be completed by the patients during the interview, with the interviewer physically present to provide help or support. If for some reason patients cannot fill in the self-report scales, they can be taken through them orally. All self-report scales have the heading SELF-REPORT at the top of each page. Centres are advised to include them in the EPSIS booklet; to ensure that separate sheets do not get lost,

interviewers can hand over the whole booklet to the patient for completion of the scales. Each scale ends with the instruction to hand the booklet back to the interviewer. The EPSIS has seven self-report scales (the Motives List twice for patients with at least one previous parasuicide). The Beck Depression Inventory (BDI, 1978 version), the Hopelessness Scale (HS), the State Trait Anger Scale (STAS) and the Rosenberg Self Esteem Scale (SES) are validated instruments. Validated translations of some of these, notably the BDI and the HS, exist in several languages; centres should use these translated and validated versions when they are available.

In this version of the EPSIS, the text printed in bold between double quotes is meant to be literally said or asked. When bold text appears in brackets with an oblique stroke in between, the interviewer should choose the phrase that applies to the patient's situation (for example, say "poisoned yourself" in cases of self-poisoning, and "harmed yourself" in cases of self-injury). Underlined text is meant to be supplementary information for the interviewer only. Text between square brackets is not part of the EPSIS, but contains instructions or comments on translation or adjustment to the national or regional situation. A line of dots indicates that the interviewer is expected to fill in a number or text on that line. All other items should be scored by circling the applicable alternative from a list of possible answers (numbered or separated with an oblique stroke).

The Life Events and History Scale contains some redundant questions that have been asked before or will be asked later during the interview. This was necessary in order to simplify coding at later stages.

MEDICAL QUESTIONNAIRE

1. Research Centre

   .....

2. Hospital

   .....

3. Patient's identification number (numbered list of patient's names should be kept elsewhere)

   .....

4. Date of parasuicide

   .....

5. Time of parasuicide

   .....

6. Date and time of admission to hospital

   .....

7. Date of (probable) discharge from hospital
   (In case of access to hospital administration files, discharge date can be taken from the files)

   .....

8. Wards where patients were supervised or treated State if hospital different from hospital mentioned in answer to question 2. If the patient was already staying in a hospital ward at the time of parasuicide, include that ward.

   1. ..... from ..... to ..... (date & time)

   2. ..... from ..... to ..... (date & time)

   3. ..... from ..... to ..... (date & time)

   4. ..... from ..... to ..... (date & time)

   5. ..... from ..... to ..... (date & time)

9. Psychiatric diagnosis made by (doctor's name)

   .....

10. Date and time of psychiatric diagnosis

    .....

11. Psychiatric diagnosis according to ..... Preferably ICD-9 (codes on page 7). If DSM-III, only axis I diagnosis required)

1. .....

2. .....

3. .....

4. .....

12a. Method(s) of parasuicide (verbal description)

.....

.....

.....

.....

.....

12b. Method(s) of parasuicide (ICD-code(s), see below. More alternatives may be applicable)

.....

ICD codes for intentional self-harm (X60-X84)

X60 Intentional self-poisoning by non-narcotic analgetics, antipyretics and antirheumatics
X61 Intentional self-poisoning by barbiturates, other sedatives. hypnotics and other psychotropic agents
X62 Intentional self-poisoning by opiates, related narcotics and psychodysleptics
X63 Intentional self-poisoning by other drugs acting on the central and autonomic nervous systems
X64 Intentional self-poisoning by other drugs and medicaments
X65 Intentional self-poisoning by alcohol, not elsewhere classified
X66 Intentional self-poisoning by petroleum products, other solvents and their vapours, not elsewhere classified
X67 Intentional self-poisoning by other gasses and vapours
X68 Intentional self-poisoning by pesticides, herbicides and other toxic agricultural chemicals
X69 Intentional self-poisoning by other chemicals and noxious substances
X70 Intentional self-harm by hanging, strangulation and suffocation
X71 Intentional self-harm by submersion (drowning)
X72 Intentional self-harm by handgun discharge
X73 Intentional self-harm by rifle, shotgun and larger firearm discharge
X74 Intentional self-harm by other and unspecified firearm discharge
X75 Intentional self-harm by explosive material and devices
X76 Intentional self-harm by fire and flames
X77 Intentional self-harm by steam, hot vapours and hot objects
X78 Intentional self-harm by sharp object
X79 Intentional self-harm by blunt object
X80 Intentional self-harm by jumping from a high place
X81 Intentional self-harm by jumping or lying before moving object
X82 Intentional self-harm by crashing of motor vehicle
X83 Intentional self-harm by other specified means
X84 Intentional self-harm by unspecified means

MEDICAL QUESTIONNAIRE

1. Research Centre

   .....

2. Hospital

   .....

3. Patient's identification number (numbered list of patient's names should be kept elsewhere)

   .....

4. Date of parasuicide

   .....

5. Time of parasuicide

   .....

6. Date and time of admission to hospital

   .....

7. Date of (probable) discharge from hospital
   (In case of access to hospital administration files, discharge date can be taken from the files)

   .....

8. Wards where patients were supervised or treated State if hospital different from hospital mentioned in answer to question 2. If the patient was already staying in a hospital ward at the time of parasuicide, include that ward.

   1. ..... from ..... to ..... (date & time)

   2. ..... from ..... to ..... (date & time)

   3. ..... from ..... to ..... (date & time)

   4. ..... from ..... to ..... (date & time)

   5. ..... from ..... to ..... (date & time)

9. Psychiatric diagnosis made by (doctor's name)

   .....

10. Date and time of psychiatric diagnosis

    .....

ICD codes for psychiatric diagnosis

INSTRUCTIONS FOR CONTACTING PATIENTS

Below are instructions for introducing yourself to the patient, and for giving him/her information regarding the contents and aims of the interview. Of course, the most important aspect of the first contact with the patient is to establish rapport, to gain his/her trust in you, and to make him/her feel at ease. Be polite, but not too formal. Note that most patients will be in a state of personal crisis. Also note that patients may be suspicious of your intentions. Make sure that the patient is not drowsy and therefore too slow in comprehension to be interviewed. In introducing your request, give complete information on what you are requesting, but do it clear and simple.

- Introduce yourself, including the institution you are working for. Make clear that you have nothing to do at all with his/her somatic or psychiatric treatment.
- Tell patient that you know he/she has poisoned or harmed him/herself, and how you have come to know. Emphasize that he/she is not the only one, but that there are many people who have done so, and that this is the reason why a study is being performed now to gain more insight in why people poison or injure themselves.
- Tell patient that you want to ask him/her to help YOU, to do YOU a favour, but that you cannot do very much for him/her, except listen to his/her story. Make clear that as a result of the study, in the future some people who have problems may be helped so they won't need to harm themselves.
- Tell patient that you would like to talk with him/her about the self-poisoning or self-injury and about the reasons that have led to this behaviour. Inform patient about the estimated time duration and contents of the interview: 1½ to 2 hours, circumstances of self-harm, reasons, life history, family and friends, some self-report scales on well-being, etc.
- Emphasize that if he/she agrees to be interviewed, this does not imply that he/she is obliged to answer each and every question. That if he/she finds some topics too private or embarrassing to discuss, he/she will not be pressed to do so, and that he/she can decide to finish the interview at any time.
- Emphasize that the contents of the interview are strictly confidential, that no information from the interview will be known to doctors, nurses, relatives, friends, or any other persons. Also emphasize that his/her name will be not be anywhere recorded, except for a consent form which has to be signed before the interview. Explain that this consent form is necessary for legal reasons, so that others can see that the cooperation is voluntary and that he/she has been not forced to cooperate, that no financial or other rewards have been promised, and that he/she has been informed about the aims and contents of the interview and about its confidentiality.
- Ask patient if he/she has understood what you have said, and whether he/she has any questions before deciding whether to cooperate or not. Try to answer these questions.
- Ask patient if he/she agrees to be interviewed by you, or if he/she needs some time to think it over. Emphasize that if he/she is willing, you would like to do the interview as soon as possible.
- If the patient agrees, make an appointment for when to do the interview or start with the interview immediately (consent form first!). Thank him/her for the participation.
- If the patient refuses to be interviewed, ask for the reasons (do not press if he/she is not willing to give reasons for his/her refusal). If given, record the reasons for refusal. Thank him/her for the attention.

- If the interview is not administered immediately, repeat the introduction the next time you meet the patient (some patients even may have forgotten all about who you are and what you came for).

CONSENT FORM

I herewith declare to be willing to be interviewed by ..... (name of interviewer) in a study on deliberate self-poisoning and self-injury. I have been informed about the aims of the study and about the content of the interview. I have also been informed that the interview is confidential. What I say during the interview will have no consequences for the treatment I receive or for decisions others make about my future in all but the most exceptional circumstances. I know that I will not receive any financial or other reward for my participation in the interview. I have been told that I have the right to refuse to answer questions when I don't want to, and that I can decide to finish the interview at any moment.

Date: .....

Name: .....

Signature: .....

PATIENT IDENTIFICATION NUMBER .....

AFTER FILLING IN THIS FORM, INCLUDING PATIENT IDENTIFICATION NUMBER, REMOVE THIS PAGE FROM BOOKLET

GENERAL INTERVIEW INFORMATION

1. Research Centre

   .....

2. Name of interviewer

   .....

3. Patient identification number

   .....

4. Place of interview

   .....

5. Date and time of interview

   First session: ..... (date) ..... (time started) ..... (time ended)

   If interview completed in two sessions

   Second session: ..... (date) ..... (time started) ..... (time ended)

6. Special observations or remarks: reason for refusal or interview not taking place or interview partially completed

   .....

   .....

   .....

   .....

   .....

   .....

   .....

SOCIO-DEMOGRAPHIC INFORMATION

"Now that you know what this interview is for and have signed the consent form, let us start with some general questions about your age, living arrangements, work or study, etc.. If on any question you either cannot or don't want to give an answer, please say so. I would rather have a 'don't know' or 'don't want to say' answer than one that does not really reflect your situation or your opinion. Now before we start, do YOU have any questions?"

1. Gender (circle) Male / Female / Transsexual

2. **"What is your date of birth?"** .....(day) .....(month) .....(year)

3. **"In which country were you born?"** .....

4. **"What is your nationality?"** .....

5. **"Are you presently married or are you widowed, separated or divorced, or are you single?"**

   (circle) Single / Married / Widowed / Divorced / Separated

6. **"Are you currently living with someone as though you were married (for at least three months)?"**
   (circle) No / With male partner / With female partner

7. **"How many times have you legally been married?"**
   Number of previous marriages (including current marriage) .....

8. **"(So you have never been / How many times have you been) divorced?"**

   Number of divorces .....
   If divorced:
   "When (were you / was the last time) you divorced?"

   Month and year of (last) divorce .....(month) .....(year)

9. If widowed:
   "When did your (last) husband/wife die?"
   Month and year of (last) husband/wife's death .....(month) .....(year)

10. **"How many times have you been living with someone, for at least three months, as though you were married (including current cohabitation)?"**

    ..... times

11. If married or living together as married:
    "How long have you been (married/living as though you were married) with your current partner?"

    Length of marriage/cohabitation .....(months) .....(years)

12. **"How many children do or did you have, including children who are yours by adoption and including children of a new partner when you are remarried?"** Do not count children who were born dead.

    Number of children .....

13. **"With whom do you live presently (at the time you were admitted to the hospital)?"**
    Household composition at time of parasuicide. More alternatives may be applicable. Circle
    1. Living alone
    2. Living alone with child(ren)
    3. Living with partner without child(ren)
    4. Living with partner and child(ren)
    5. Living with parents
    6. Living with other relatives/friends
    7. Living in institution
    8. Other, specify

    .....

14. **"During the past year, with whom did you live most of the time? (what was the usual situation)?"** Household composition during past year (usual situation). More alternatives may be applicable. Circle
    1. Living alone
    2. Living alone with child(ren)
    3. Living with partner without child(ren)
    4. Living with partner and child(ren)
    5. Living with parents
    6. Living with other relatives/friends
    7. Living in institution
    8. Other, specify

    .....

15. Usual area of residence at time of parasuicide.
    [Use same categories as in Monitoring Form]

16. **"What type of education have you completed?"**
    [Code according to national census data, use same categories as in monitoring form]

17. **"What was your employment status at the moment you were admitted to the hospital and what is/was your usual employment status?"**
    Patient's employment status

Ad admittance (circle):		Usual
1:	full-time employed (including self-employed)	1.
2:	part-time employed (including self-employed)	2.
3:	employed, temporarily off sick	3.
4:	unemployed, looking for work (continue with sub 1)	4.
5:	unemployed, waiting to take up job already accepted (continue 1c sub 1)	5.
6:	unemployed, assisting partner (continue with sub 1)	6.
7:	armed services	7.
8:	full-time student	8.
9:	disabled, permanently sick (continue with sub 2)	9.
10:	retired (continue with sub 3)	10.
11:	homemaker/housewife	11.
12:	other, namely	12.

    .....

Sub 1: **"How long have you been unemployed?"** If more than 1 year, continue with question 19

..... years and ..... months

Sub 2: **"How long have you been disabled?"** If more than 1 year, continue with question 19

..... years and ..... months

Sub 3: **"How long have you been retired?"** If more than 1 year, continue with question 19

..... years and ..... months

18. **"During the past year (that is: between now and one year ago), have you been unemployed for some time? With unemployed I mean that you were looking for a job but could not find one. If, yes, how long in total have you been unemployed during the past year?"**
Fill in zero if patient has not been unemployed

..... months and ..... weeks

19. **"What is or was your occupation? If you are unemployed or not economically active: What was your last occupation?"**
State if patient never had paid job

.....

.....

.....

20. **"What is or was the occupation of your father (or stepfather, or foster farther)?"**

a) .....

"What is or was the occupation of your partner?" (if applicable).

b) .....

21. **"What is you religious denomination, if any?"** (circle)
1. None
2. Protestant
3. Catholic
4. Jewish
5. Muslim
6. Hindu
7. Greek orthodox
8. Buddhist
9. Other, specify .....

CIRCUMSTANCES OF PRESENT PARASUICIDE

"Now, after the general questions, let us talk about the things yhat happened just before for your admission to the hospital. Please think back to what happened and describe as exactly as possible what led to your admission to the hospital. What did you do to yourself?"

Write out essentials. Probe with the SIS-questions in the left column below, in order to score the Suicide Intent Scale (SIS) in the right column. Only if you are completely sure about it, skip questions on which the answers are clearly implicit in patient's account of what happened.
[Interviewers should make themselves familiar with the coding of the SIS in such a way that they can code all items as a result of a normal conversation. Please encourage the resondent to give a narrative of what has happened, and use the questions below as a checklist to make sure that you have covered all the relevant topics. In order to give codes you shoould be absolute sure. So if you are not completely sure, use your own additional probings, or use the questions written down, in such a way that it facilitates coding.]

Concerning questions 1 to 8 on pages 14 and 15 you should give your rating, your judgement, according to your impression of the narrative of the respondent. Questions 9 to 15 concern the communications of the respondent. Please code what the respondent sais, even though you might have another impression.

S I S

TO BE ASKED BY INTERVIEWER	TO BE SCORED BY INTERVIEWER CIRCLE 0, 1 or 2
1. **"Was anybody near you when you tried to harm yourself? e.g. in the same room, telephone conversation."**	Isolation 0. Somebody present 1. Somebody nearby or in contact (e.g. telephone) 2. No one nearby or in contact

2. **"At what moment did you do it? Were you expecting someone. Could someone soon arrive? Did you know that you had some time before anyone could arrive? Or didn't you think about the possibility?"**

Timing
0. Timed so that intervention is probable
1. Timed so that intervention is not likely
2. Timed so that intervention is highly unlikely

3. **"Did you do anything to prevent that someone could find you? e.g. disconnect the telephone, put a note on the door, etc."**

Precautions against discovery and/or intervention
0. No precautions at all
1. Passive precautions, such as avoiding others but doing nothing to prevent their intervention (e.g. being alone in room with unlocked door)
2. Active precautions (e.g. being alone in room with door locked)

4. **"After you harmed yourself, did you call someone to tell what you just did?"**

Action to gain help after the attempt
0. Notified potential helper regarding attempt
1. Contacted but did not specifically notify potential helper regarding attempt
2. Did not contact or notify helper

5. **"Did you do anything such as paying bills, say goodbye, write a testament, once you decided to harm yourself."**

Final act in anticipation of death
0. None
1. Patients thought about making or made some arrangements in anticipation of death
2. Definite plans made (making up or changing a will, giving gifts, taking out insurance)

6. **"Had you planned it for some time? Did you make any preparations such as saving pills, etc.?"**

Degree of planning
0. No preparation (no plan)
1. Minimal or moderate preparation
2. Extensive preparation (detailed plan)

7. **"Did you write one or more farewell letters?"**
If yes: to whom?
If no : did you think about writing one?

Suicide note (farewell letter)
0. Neither written a note, nor thought about writing one
1. Thought about writing one, but had not done so
2. Presence of note, or note written but torn up

8. **"During the past year, did you tell neighbors, friends and/or family members, implicitly or explicitly, that you had the intention to harm ourself?"**

Communication of intent before act
0. None
1. Equivocal communication (ambiguous or implied)
2. Unquivocal communication (explicit)

9. **"Can you tell me what you hoped to accomplish by harming yourself?"**

Purpose of act
0. Mainly to manipulate others
1. Temporary rest
2. Death

10. **"What did you think were the chances that you would die as a result of your act?"**

Expectations regarding fatality of act
0. Patient thought that death was unlikely or didn't think about it
1. Patient thought that death was possible but not probable
2. Patient thought that death was probable or certain

11. If overdose **"Did you think that the amount of pills you took were more, or less, than the dose that would kill you? (Did you have more pills?)"**
Else **"Did you think about other methods that would be more, or less, dangerous than what you did?"**

Conceptions of method's lethality
0. Patient did less to him/herself than he/she thought would be lethal, or patient didn't think about it
1. Patient was not sure or, thought what he/she did might be lethal
2. Act exceeded or equaled what patient thought was lethal

12. **"Did you consider your act to be an attempt to take your life?"**

Seriousness of attempt
0. Patient did not consider act to be a serious attempt to end his/her life
1. Patient was uncertain whether act was a serious attempt to end his/her life
2. Patient considered act to be a serious attempt to end his/her life

13. **"What were your feelings toward life and death? Did you want to live more strongly than you wanted to die? or didn't you care whether to live or to die?"**

Ambivalence towards living
0. Patient did not want to die
1. Patient did not care whether he.she lived or died
2. Patient wanted to die

14. **"What did you think were the chances to survive if you would receive medical treatment afterwards?"**

Conception of reversibility

0. Patient thought that death would be unlikely if he/she received medical attention
1. Patient was uncertain whether death could be averted by medical attention
2. Patient was certain of death even if he/she received medical attention

15. **"How long before your act had you decided to do it? Had you thought about it for some time or did you do it impulsively?"**

Degree of premediation

0. None, impulsive
1. Act contemplated for three hours or less prior to attempt
2. Act contemplated for more than three hours before attempt

PRECIPITATING FACTORS OF PRESENT PARASUICIDE

1. **"What caused you to (take the pills/injure yourself)? Were there any special events or circumstances that led to your act?"**

Narrative. Write out answer

2. **"There may be many reasons why people who have problems take pills or injure themselves. Please indicate whether the problems that I will mention had a major influence on what you did, had a minor influence on what you did or had no influence at all."**

Problem checklist (read out categories, skip categories that are clearly not applicable)

1.	Problems with your partner	No / Minor / Major
2.	Problems with your parents	No / Minor / Major
3.	Problems with your children	No / Minor / Major
4.	Feelings of loneliness	No / Minor / Major
5.	Problems in making or maintaining friendships and social relations	No / Minor / Major
6.	Rejection by a lover	No / Minor / Major
7.	Physical illness or disability	No / Minor / Major
8.	Mental illness and psychiatrical symptoms	No / Minor / Major

9. Unemployment — No / Minor / Major

10. Addiction (to alcohol, drugs, medicines, gambling, etc.) — No / Minor / Major

3. **"Where there any other events or circumstances that had an influence on what you did?"**

If patient mentions one or more events or circumstances specify:

1. ..... / Minor / Major

2. ..... / Minor / Major

3. ..... / Minor / Major

MOTIVES FOR PRESENT PARASUICIDE

1. **"Just like there can be many problems that lead people to take pills or injure themselves, there can be many different intentions for it. I will hand over to you a list of reasons, and I would like you to indicate for each reason, whether it was a reason for YOU to do what you did.**
Please start with reading the instruction carefully, and ask me if you need help."

TURN THIS PAGE AND HAND OVER BOOKLET TO THE PATIENT

SELF-REPORT

Below are fourteen reasons people can have for taking pills or harming themselves. Please think back to how you felt before you took pills or injured yourself, and indicate to what extent these reasons applied to you. Circle NO INFLUENCE if the reason mentioned played no role in what you did. Circle MINOR INFLUENCE if the reason played a minor role, circle MAJOR INFLUENCE if the reason played a major role in what you did. There are no right or wrong answers. Please do not skip items. Do not spend too much time on any one statement. If you need help, please ask the interviewer.

NOW PLEASE READ EACH STATEMENT CAREFULLY,
AND CIRCLE THE ANSWER THAT APPLIES BEST TO YOU

1.	My thoughts were so unbearable, I could not endure them any longer.	No influence / Minor influence / Major Influence
2.	I wanted to show someone how much I loved him/her.	No influence / Minor influence / Major Influence
3.	It seemed that I lost control over myself, and I do not know why I did it.	No influence / Minor influence / Major Influence
4.	The situation was so unbearable that I could not think of any other alternative.	No influence / Minor influence / Major Influence
5.	I wanted to get away for a while from an unacceptable situation.	No influence / Minor influence / Major Influence
6.	I wanted others to know how desperate I felt.	No influence / Minor influence / Major Influence
7.	I wanted to die.	No influence / Minor influence / Major Influence
8.	I wanted to get help from someone.	No influence / Minor influence / Major Influence
9.	I wanted to know if someone really cared about me.	No influence / Minor influence / Major Influence
10.	I wanted others to pay for the way they treated me.	No influence / Minor influence / Major Influence
11.	I wanted to make someone feel guilty.	No influence / Minor influence / Major Influence
12.	I wanted to persuade someone to change his/her mind.	No influence / Minor influence / Major Influence
13.	I wanted to make things easier for others.	No influence / Minor influence / Major Influence
14.	I wanted to sleep for a while.	No influence / Minor influence / Major Influence

WHEN FINISHED, PLEASE HAND OVER THIS BOOKLET BACK TO THE INTERVIEWER

Check whether motives list has been filled in correctly and completely. If items are missing, ask whether that reason played a role.

2. **"Were there any other reasons that had an influence on what you did? can you tell what they were?"**

1. .....
.....
Minor influence / Major Influence

2. .....
.....
Minor influence / Major influence

3. .....
.....
Minor influence / Major influence

PHYSICAL HEALTH

1. "Do you have a physical illness or disability that is a consequence of your (poisoning/harming) yourself and that is likely to affect you for a long period of time?".
   Circle Yes / No

   If Yes:
   A. "What is the matter with you?"

   .....

   .....

2. "Do you have any longstanding physical illness or disability that has troubled you for at least one year?
   Circle Yes / No

   If Yes:
   A. "What is the matter with you?"

   .....

   .....

   .....

   B. "How long have you had it?"

   ..... (from birth on)

   C. "Does this illness or disability limit your activities in any way?"

   Circle Yes / No

   D. If Yes: "What activities does it limit?"

   .....

3. "Now I would like you to think about the two weeks before you were admitted to the hospital. During these two weeks, did you have to cut down on any of the things you usually do because of physical illness or injury?"

   Circle Yes / No

   If Yes:
   A. "What was the matter with you?"

   .....

   B. "How many days was it in all that you had to cut down on the things you usually do (including weekends)?"

   ..... days

4. "Over the last three months, would you say your physical health on the whole has been excellent, good, fair, or poor?"

   Circle Excellent / Good / Fair / Poor

MENTAL HEALTH

1. "Do you or did you ever experience for prolonged periods of time (for over at least one year) troubles within yourself that hindered your functioning? (Make this question more clear if needed by giving examples like:) For example fears of places, or anxiety to leave your house, or excessive fear of people in general, or depressive feelings, or other emotions or thoughts that influenced you repetedley, like obsessions or may be to be compelled to clean yourself or your house, etc."

   Circle Yes / No

   If Yes:
   A. "What is/was the matter with you?"

   .....

   .....

   B. "How long have you had this?"

   ..... (from birth on)

   C. "Does this limit your activities in any way?"

   Circle Yes / No

   D. If Yes: "What activities does it limit?"

   .....

2. "Now I would like you to think about the two weeks before you were admitted to the hospital. During these two weeks, did you have to cut down on any of the things you usually do because of feelings or thoughts or any other troubles like the one's I mentioned you just before (like fears of places, depressive feelings, obsessions or compulsions, or any other psychological condition)?" (Please note that it concerns afflictions which must severely hinder normal functioning)

   Circle Yes / No

   If Yes:
   A. "What was the matter with you?"

   .....

   B. "How many days was it in all that you had to cut down on the things you usually do (including weekends)?"

   ..... days

3. "Over the last three months, would you say your mental health on the whole has been excellent, good, fair, or poor?"

   Circle Excellent / Good / Fair / Poor

BECK DEPRESSION INVENTORY (21 items. 1978) & HOPELESSNESS SCALE (20 items. 1974)

"In order to assess how you feel at this moment and how you feel about the future, I would like you to complete two questionnaires. Please read the instructions on top of the questionnaires carefully, and ask me if you have any questions."

TURN THIS PAGE AND HAND OVER BOOKLET TO THE PATIENT

SELF-REPORT

On this questionnaire are groups of statements. Please read each group of statements carefully. Then pick out the one statement in each group which best represents THE WAY YOU FEEL RIGHT NOW. If several statements in the group seem to apply equally well, circle each one. Be sure to read all the statements in each group before making your choice.

NOW READ EACH GROUP OF STATEMENTS CAREFULLY AND CIRCLE THE STATEMENT THAT BEST REPRESENTS THE WAY YOU FEEL RIGHT NOW

1. 0. I do not feel sad.
   1. I feel sad.
   2. I am sad all the time and it can't snap out of it.
   3. I am so sad or unhappy that I can't stand it.

2. 0. I am not particularly discouraged about the future.
   1. I feel discouraged about the future.
   2. I feel I have nothing to look forward to.
   3. I feel that the future is hopeless and that things cannot improve.

3. 0. I do not feel like a failure.
   1. I feel I have failed more than the average person.
   2. As I look back on my life, all I can see is a lot of failures.
   3. I feel I am a complete failure as a person.

4. 0. I get as much satisfaction out of things as I used to.
   1. I don't enjoy things the way I used to.
   2. I don't get real satisfaction out of anything anymore.
   3. I am dissatisfied or bored with everything.

5. 0. I don't feel particularly guilty.
   1. I feel guilty a good part of the time.
   2. I feel quite guilty most of the time.
   3. I feel guilty all of the time.

6. 0. I don't feel I am being punished.
   1. I feel I may be punished.
   2. I expect to be punished.
   3. I feel I am being punished.

7. 0. I don't feel disappointed in myself.
   1. I am disappointed in myself.
   2. I am disgusted with myself.
   3. I hate myself.

8. 0. I don't feel I am any worse than anybody else.
   1. I am critical of myself for my weaknesses or mistakes.
   2. I blame myself all the time for my faults.
   3. I blame myself for everything bad that happens.

9. 0. I don't have any thoughts of killing myself.
   1. I have thoughts of killing myself, but I would not carry them out.
   2. I would like to kill myself.
   3. I would kill myself if I had the chance.

SELF-REPORT

10. 0. I don't cry any more than usual.
    1. I cry more now than I used to.
    2. I cry all the time now.
    3. I used to be able to cry, but now I can't cry even though I want to.

11. 0. I am no more irritated now than I ever am.
    1. I get annoyed or irritated more easily than I used to.
    2. I feel irritated all the time now.
    3. I don't get irritated at all by the things that used to irritate me.

12. 0. I have not lost interest in other people.
    1. I am less interested in other people than I used to be.
    2. I have lost most of my interest in other people.
    3. I have lost all of my interest in other people.

13. 0. I make decisions about as well as I ever did.
    1. I put off making decisions more than I used to.
    2. I have greater difficulty in making decisions than before.
    3. I can't make decisions at all anymore.

14. 0. I don't feel I look any worse than I used to.
    1. I am worried that I am looking old or unattractive.
    2. I feel that there are permanent changes in my appearance that make me look unattractive.
    3. I believe I look ugly.

15. 0. I can work as well as before.
    1. It takes an extra effort to get started at doing something.
    2. I have to push myself very hard to do anything.
    3. I can't do any work at all.

16. 0. I can sleep as well as usual.
    1. I don't sleep as well as I used to.
    2. I wake up 1-2 hours earlier than usual and find it hard to get back to sleep.
    3. I wake up several hours earlier than I used to and cannot get back to sleep.

17. 0. I don't get more tired than usual.
    1. I get tired more easily than I used to.
    2. I get tired from doing almost anything.
    3. I am too tired to do anything.

18. 0. My appetite is no worse than usual.
    1. My appetite is not as good as it used to be.
    2. My appetite is much worse now.
    3. I have no appetite at all anymore.

19. 0. I haven't lost much weight, if any lately.
    1. I have lost more than 5 pounds.
    2. I have lost more than 10 pounds.
    3. I have lost more than 15 pounds.

I am purposely trying to lose weight by eating less.
0. No
1. Yes

SELF-REPORT

20. 0. I am no more worried about my health than usual.
    1. I am worried about physical problems such as aches and pains; or upset stomach; or constipation.
    2. I am very worried about physical problems and it's hard to think of much else.
    3. I am so worried about physical problems, that I cannot think about anything else.

21. 0. I have not noticed any recent change in my interest in sex.
    1. I am less interested in sex than I used to be.
    2. I am much less interested in sex now.
    3. I have lost interest in sex completely.

WHEN FINISHED, PLEASE TURN THIS PAGE AND CONTINUE WITH THE NEXT QUESTIONNAIRE

SELF-REPORT

Below are twenty statements regarding your future. Please read each one carefully and mark the option (TRUE or FALSE) which reflects best the way you feel AT THE PRESENT TIME. Please circle the word TRUE if you agree with the statement, circle the word FALSE if you disagree. There are no right or wrong answers. Please circle TRUE or FALSE for all statements. Do not spend too much time on any one statement.

NOW PLEASE READ EACH STATEMENT CAREFULLY AND CIRCLE EITHER TRUE OR FALSE

01.	True / False	I look forward to the future with hope and enthusiasm
02.	True / False	I might as well give up because I can't make things better for myself
03.	True / False	When things are going badly, I am helped by knowing they can't stay that way forever
04.	True / False	I can't imagine what my life would be like in 10 years
05.	True / False	I have enough time to accomplish the things I most want to do
06.	True / False	In the future, I expect to succeed in what concerns me most
07.	True / False	My future seems dark to me
08.	True / False	I expect to get more of the good things in life than the average person
09.	True / False	I just don't get the breaks, and there's no reason to believe I will in the future
10.	True / False	My past experiences have prepared me well for my future
11.	True / False	All I can see ahead of me is unpleasantness rather than pleasantness
12.	True / False	I don't expect to get what I really want
13.	True / False	When I look ahead to the future, I expect I will be happier than I am now
14.	True / False	Things just don't work out the way I want them to
15.	True / False	I have great faith in the future
16.	True / False	I never get what I want so it's foolish to want anything
17.	True / False	It's very unlikely that I will get any real satisfaction in the future
18.	True / False	The future seems vague and uncertain to me
19.	True / False	I can look forward to more good times than bad times
20.	True / False	There's no use in really trying to get something I want because I probably won't get it

WHEN FINISHED, PLEASE HAND OVER THIS BOOKLET BACK TO THE INTERVIEWER

LIFE EVENTS AND HISTORY

"Now I would like to continue with another questionnaire, one that contains questions on the kind of events and problems you have experienced in life.

The questionnaire consists of seven sections, and each section deals with people who have played a role in your life, such as your parents, brothers or sisters, other important persons, etc., and of course you yourself. When a section is not applicable to you (for instance the section on brothers and sisters if you have never had borthers or sisters) you can skip this section, as indicated in the questionnaire.

On the left side of each page you will find a question, for example asking whether your parents have been divorced. On the right side of each page there are three columns. In the first column, which is labeled (labeled 'childhood') you should indicate whether the particular event (for instance a divorce of your parents) happened during your childhood or not. In this questionnaire, 'childhood' means when you were under 15 years of age. For some events, the 'childhood' column is missing, because it clearly is not applicable. Indicate in the second column (labelled 'later in life') whether an event happened to you or not later in life; that is: from when your became 15 years until one year ago. In the third and last column (labelled 'last year'), please indicate whether an event happened during the last year (between now and one year ago).

Some events mentioned in this questionnaire may not seem applicable to you at first sight. In such cases you may skip the question. However, in case of doubt, please ask me.

Of course there can be more events of importance that happened to you and are not explicitly mentioned in the questionnaire. Please feel free to write down any event that happened in your life that had a big impact on you."

IF YOU FEEL THAT THE PATIENT UNDERSTANDS WELL, TURN TWO PAGES (TO PAGE 30) AND HAND OVER THE BOOKLET TO THE PATIENT

F YOU DOUBT WHETHER THE PATIENT HAS CLEARLY UNDERSTOOD, LET HIM/HER READ THE INSTRUCTION AND THE EXAMPLE, AND HELP HIM/HER FILL IN THE FIRST PAGE (30):

"Now I propose that we look at the first few questions together, so that you get the idea of how to fill in the questionnaire. Please study the example first, before we start with the questions."

NOW TURN THIS PAGE AND HAND OVER THE QUESTIONNAIRE TO THE PATIENT

(Please be very sensitive to the emotional needs of the respondent while filling in this self report scale. It may be very difficult for some patients because of the memories that may come forward. Try to facilitate filling in by showing interest, by encouraging the respondent to talk about his or her experiences if needed. Help the repondent if needed. Try to sit in an angle of 90 degrees. DO NOT LEAN BACK AS IF YOU HAVE NOTHING TO DO WITH IT. As you will experience, the way in which you behave while going over the respondent's past is very important for the quality of your relationship with the respondent.)

SELF-REPORT

This questionnaire is meant to establish what kind of problems and events you have experienced in your life, and in which stages in your life you experienced them.

The questionnaire consists of seven sections, labelled parents, brothers and sisters, other persons important to you, partner(s), children, yourself, and other events. On the left side of each page there is a question, asking whether a particular event happened during your life. On the right side of each page there are three columns. Please indicate in the first column (labelled CHILDHOOD) whether the particular event happened during your childhood or not. With childhood is meant when you were a child under 15 years of age. For some events, the CHILDHOOD column is missing, because it clearly is not applicable. Indicate in the second column (labelled LATER IN LIFE) whether an event happened to you or not later in life; that is: from when your became 15 years until one year ago. In the third and last column (labelled LAST YEAR), please indicate whether an event happened during the last year (between now and one year ago).

Some events mentioned in this questionnaire may not seem applicable to you at first sight. In such cases you may skip the question. However, in case of doubt, please ask the interviewer.

Of course there can be more events of importance that happened to you and are not explicitly mentioned in the questionnaire. Please feel free to write down any event that happened in your life that had a big impact on you. Study the example below before you start with the questionnaire.

EXAMPLE

	CHILDHOOD		LATER IN LIFE		LAST YEAR	
A. Was one or both of your parents ever fired from his/her job?	Yes	No	Yes	No	Yes	No

If either your father or your mother was never fired when you were younger than 15 years, you circle No under CHILDHOOD. If one or both were fired (once or several times) when you were 15 years or older, but before one year ago, circle Yes under LATER IN LIFE. If one or both were fired during the last year - between now and one year ago - circle Yes under LAST YEAR.

Please answer all the questions but do not think too long about any particular question. If at any moment you have questions or when you feel you need help, please say so to the interviewer.

Now you can turn this page and start with the questionnaire.

Parents						SELF-REPORT	
		CHILDHOOD		LATER IN LIFE		LAST YEAR	
01.	Were you separated from either or both of your parents for a year or more when you were a child (younger than 15)?	Yes	No				
02.	Were you mainly brought up by others than your parents (by relatives, foster parents, or in a children's home)?	Yes	No				
03.	Did your father die?	Yes	No	Yes	No	Yes	No
04.	Did your mother die?	Yes	No	Yes	No	Yes	No
05.	Did your parents divorce (separate)?	Yes	No	Yes	No	Yes	No
06.	Did one or both of your parents ever suffer from a chronic physical disease?	Yes	No	Yes	No	Yes	No
07.	Was one or both of your parents ever admitted to a psychiatric hospital?	Yes	No	Yes	No	Yes	No
08.	Was one or both of your parents away from home for long periods when you were a child?	Yes	No				
09.	Did you have to take care of your brothers and sisters many times when your mother or father could not care for them?	Yes	No	Yes	No	Yes	No
10.	Did you often think your parents did not love you and did not want to take care of you?	Yes	No	Yes	No	Yes	No
11.	Did your parents have serious financial problems?	Yes	No	Yes	No	Yes	No
12.	Were you often neglected or left alone by those responsible for your upbringing?	Yes	No				
13.	Did your father or mother die because of suicide?	Yes	No	Yes	No	Yes	No

SELF-REPORT

		CHILDHOOD		LATER IN LIFE		LAST YEAR	
14.	Was one or both of your parents addicted to alcohol, drugs or medicines for a period of one year or more?	Yes	No	Yes	No	Yes	No
15.	Was one or both of your parents ever sentenced to jail?	Yes	No	Yes	No	Yes	No
16.	Are you ever seriously beaten up or otherwise physically mistreated by those responsible for your upbringing.	Yes	No	Yes	No	Yes	No
17.	Have you ever been mentally mistreated by those responsible for you upbringing; by means of teasing, humiliating, etc. over prolonged periods of time?	Yes	No	Yes	No	Yes	No
18.	Did your father or mother ever force you to have sexual intercourse against your will?	Yes	No	Yes	No	Yes	No
19.	Did your father or mother ever force you to do or to endure sexual activities (other than intercourse) against your will?	Yes	No	Yes	No	Yes	No
20.	Did your father and mother ever have serious relationship problems with each other?	Yes	No	Yes	No	Yes	No
21.	Have your father or mother ever attempted suicide (without fatal outcome)?	Yes	No	Yes	No	Yes	No
22.	Did you ever have a very bad relationship with one of your parents in such a way that you hated him or her?	Yes	No	Yes	No	Yes	No
23.	Is there any other problem or event in relation to your parents that influenced your life and that is not mentioned on the previous pages? (Please specify below)						
	1.	Yes	No	Yes	No	Yes	No
	2.	Yes	No	Yes	No	Yes	No

SELF-REPORT

Brothers and sisters

Fill in if you have (or ever had) one or more brothers or sisters (including, stepbrothers and stepsisters). If you never had a brother or a sister, continue with the section 'Partner(s)' (page 33, question 35).

		CHILDHOOD		LATER IN LIFE		LAST YEAR	
24.	Did (one of) your brother(s) or sister(s) die?	Yes	No	Yes	No	Yes	No
25.	Did (one of) your brother(s) or sister(s) die because of suicide?	Yes	No	Yes	No	Yes	No
26.	Did (one of) your brother(s) or sister(s) suffer from a chronic physical disease?	Yes	No	Yes	No	Yes	No
27.	Were you ever severely beaten up or otherwise physically mistreated by (one of) your brother(s) or sister(s)?	Yes	No	Yes	No	Yes	No
28.	Did (one of) your brother(s) or sister(s) force you to have sexual intercourse with you against your will?	Yes	No	Yes	No	Yes	No
29.	Did (one of) your brother(s) or sister(s) force you to do or endure sexual activities (other than intercourse) against your will?	Yes	No	Yes	No	Yes	No
30.	Was (one of) your brother(s) or sister(s) ever admitted to a psychiatric hospital?	Yes	No	Yes	No	Yes	No
31.	Did (one of) your brother(s) or sister(s) ever attempt suicide (without fatal outcome)?	Yes	No	Yes	No	Yes	No
32.	Was (one of) your brother(s) or sister(s) ever addicted to alcohol, drugs or medicines for a period of a year or longer?	Yes	No	Yes	No	Yes	No
33.	Have you ever had such a bad relationship with (one of) your brother(s) or sister(s) that you hated him or her?	Yes	No	Yes	No	Yes	No

SELF-REPORT

	CHILDHOOD		LATER IN LIFE		LAST YEAR	
34. Are there any other problems or events in relation to your brother(s) or sister(s) that influenced your life and that were not mentioned yet on the previous pages? (Please specify below)						
1.	Yes	No	Yes	No	Yes	No
2.	Yes	No	Yes	No	Yes	No

Partner(s).
Please fill in this section if you are (or have been) married, or are (or have been) living together as married with someone for at least three months. If this is not the case, continue with the section on children.

	LATER IN LIFE		LAST YEAR	
35. Did you ever have rows or arguments with your partner(s), or hostility that made your relationship(s) bad for a long time? (over a year).	Yes	No	Yes	No
36. Was your partner(s) addicted to alcohol, drugs or medicines for one year or longer?	Yes	No	Yes	No
37. Did you and your partner(s) ever had serious relationship problems?	Yes	No	Yes	No
38. Did you ever have any sexual problems with your partner(s)?	Yes	No	Yes	No
39. Did your partner(s) ever beat you up or physically mistreat you?	Yes	No	Yes	No
40. Did your partner(s) ever mentally mistreat you by teasing, nagging, yelling at you, etc.?	Yes	No	Yes	No
41. Did you and your partner ever have financial problems?	Yes	No	Yes	No

		SELF-REPORT			
		LATER IN LIFE		LAST YEAR	
42.	Did you and your partner ever have housing problems?	Yes	No	Yes	No
43.	Did your partner ever prevent you from achieving or becoming what you wanted?	Yes	No	Yes	No
44.	Did your partner ever attempt suicide (without fatal outcome)?	Yes	No	Yes	No
45.	Was/were your partner(s) ever admitted to a psychiatric hospital (during your relationship)?	Yes	No	Yes	No
46.	Did you and your partner ever suffer difficulties in conceiving children?	Yes	No	Yes	No
47.	Did your partner(s) ever force you to have sexual intercourse against your will?	Yes	No	Yes	No
48.	Did your partner(s) ever force you to do or endure sexual activities against your will?	Yes	No	Yes	No
49.	Did your partner ever force you to prostitute yourself?.	Yes	No	Yes	No
50.	Did (one of) your partner(s) die? (During your relationship). Please specify cause of death:	Yes	No	Yes	No
51.	Did (one of) your partner(s) die because of suicide?	Yes	No	Yes	No
52.	Did you have a divorce from (one of) your partner(s)?	Yes	No	Yes	No
53.	Did (one of) your partner(s) suffer from a physical disease?	Yes	No	Yes	No
54.	Was (one of) your partner(s) ever sentenced to jail, or to any other correctional institution? (During your relationship)	Yes	No	Yes	No

		SELF-REPORT			
		LATER IN LIFE		LAST YEAR	
55.	Is there any other problem or event in relation to your partner(s) that influenced your life and was not mentioned yet on the previous pages? (Please specify below)				
	1.	Yes	No	Yes	No
	2.	Yes	No	Yes	No

Children

If you have never had any children, continue with the section on 'Other persons important to you'.

56.	Did you ever have any problems in bringing up your children?	Yes	No	Yes	No
57.	Did you ever have any of your children adopted, or brought up by other relatives or ex-partner, or taken into care?	Yes	No	Yes	No
58.	Did (one of) your child(ren) turn out to be addicted to alcohol, drugs or medicines?	Yes	No	Yes	No
59.	Has (one of) your child(ren) been admitted to a psychiatric hospital?	Yes	No	Yes	No
60.	Has (one of) your child(ren) been arrested, or in contact with the police regularly?	Yes	No	Yes	No
61.	Did (one of) your child(ren) ever attempt suicide (without fatal outcome)?	Yes	No	Yes	No
62.	Did (one of) your child(ren) suffer from a chronic or threatening physical disease?	Yes	No	Yes	No
63.	Did (one of) your child(ren) die? Please specify cause of death:	Yes	No	Yes	No

SELF-REPORT

		LATER IN LIFE		LAST YEAR	
64.	Is there any other problem or event in relation to your child(ren) that influenced your life, and is not yet mentioned on the previous pages? (Please specify below) 1. .... 2.	Yes	No	Yes	No
		Yes	No	Yes	No

Other persons important to you

		CHILDHOOD		LATER IN LIFE		LAST YEAR	
65.	Did you ever had a long lasting bad relationship with somebody important to you?	Yes	No	Yes	No	Yes	No
66.	Did you ever lose anybody to death to whom you were close? Who was that? (Please specify below)	Yes	No	Yes	No	Yes	No
67.	Did you ever have serious problems with superiors at your work or somewhere else (e.g. in the army)?			Yes	No	Yes	No
68.	Did you ever have problems in finding a life companion (because you did not know how to make contact, how to date)?			Yes	No	Yes	No
69.	Did you ever have problems with a boy/girlfriend (quarrels, rows, etc.)?	Yes	No	Yes	No	Yes	No
70.	Were you ever physically mistreated by someone who was important to you?	Yes	No	Yes	No	Yes	No
71.	Was there ever somebody important to you who took advantage of you?	Yes	No	Yes	No	Yes	No

SELF-REPORT

	CHILDHOOD		LATER IN LIFE		LAST YEAR	
72. Were you ever mentally mistreated, teased or pestered by somebody important to you?	Yes	No	Yes	No	Yes	No
73. Is there any other problem or event in relation to somebody important to you that influenced your life and that is not mentioned on the previous pages? (Please specify below)						
1.	Yes	No	Yes	No	Yes	No
2.	Yes	No	Yes	No	Yes	No

Yourself	CHILDHOOD		LATER IN LIFE		LAST YEAR	
74. Have you ever had troubles that, as far as you know, were caused by complications at the time of your birth?	Yes	No	Yes	No	Yes	No
75. Did you ever suffer from any physical illness that (might have) meant serious deformity or incapacity or that was life-threatening?	Yes	No	Yes	No	Yes	No
76. Did you ever have to stay home for prolonged periods of time (for three months or more) or have to stay in a hospital because of physical illness?	Yes	No	Yes	No	Yes	No
77. Did you ever have to stay in a psychiatric hospital for a prolonged period of time (for three months or more)?	Yes	No	Yes	No	Yes	No
78. Did you ever experience a failure to achieve an important goal? (e.g. an important examination, or to be accepted for a career)?	Yes	No	Yes	No	Yes	No

		CHILDHOOD		LATER IN LIFE		LAST YEAR	
79.	Did you ever had any difficulties on a job, like being fired against your will, quarrels with co-workers or superiors?			Yes	No	Yes	No
80.	Have you ever been without a job against your will for long periods of time (for six months or more)?			Yes	No	Yes	No
81.	Have you ever had serious worries about money, like having no money at all, having too much debts, having to ask for social welfare?			Yes	No	Yes	No
82.	Have you ever moved to another city or country and because of that lost touch with relatives and friends?	Yes	No	Yes	No	Yes	No
83.	Did you ever experience serious housing problems (like not being able to find a suitable house, problems with landlord, too much rent, etc.?			Yes	No	Yes	No
84.	Did you ever witness a serious crime or offense involving violence (even if the victim was a stranger)?	Yes	No	Yes	No	Yes	No

SELF-REPORT

		CHILDHOOD		LATER IN LIFE		LAST YEAR	
85.	Did you ever have problems with school or study?	Yes	No	Yes	No	Yes	No
86.	Did you ever have problems with religion?	Yes	No	Yes	No	Yes	No
87.	Have you ever experienced problems in making contact with other people (because of shyness, inability to start conversations, etc.)?	Yes	No	Yes	No	Yes	No
88.	Have you ever had any problems in making friends or keeping friends?	Yes	No	Yes	No	Yes	No
89.	Have you ever experienced loneliness over a long period (having no one to talk to, no friends or visitors, lonely even when people visit you)?	Yes	No	Yes	No	Yes	No

SELF-REPORT

		CHILDHOOD		LATER IN LIFE		LAST YEAR	
90.	Did you ever experience problems in sexuality (like inability to enjoy, problems in making love or cuddling, or other problems)?	Yes	No	Yes	No	Yes	No
91.	Have you or your partner ever had any miscarriages, or had any pregnancy terminated or suffered any stillbirths?			Yes	No	Yes	No
92.	Did you ever have caring responsibilities, like nursing and attending to an elderly or a sick relative over a prolonged period of time (for three months or more)?	Yes	No	Yes	No	Yes	No
93.	Did you ever suffer from anxiety for things or places in such a way that it hindered your life?	Yes	No	Yes	No	Yes	No
94.	Were you ever addicted to alcohol, drugs or medicines for one year or longer? Please specify when that was:	Yes	No	Yes	No	Yes	No
95.	Have you ever been convicted for a criminal offense, or have you ever been sentenced to jail or any other correctional institution?	Yes	No	Yes	No	Yes	No
96.	Did you ever have problems with eating, like not eating enough and losing weight, or eating too much?	Yes	No	Yes	No	Yes	No
97.	Were you ever obsessed with food and eating, in such a way that it handicapped you?	Yes	No	Yes	No	Yes	No

	CHILDHOOD		LATER IN LIFE		SELF-REPORT LAST YEAR	
98. Was there any other problem or event in your life that influenced you, and that was not yet mentioned on the previous pages? (Please specify below).						
1.	Yes	No	Yes	No	Yes	No
2.	Yes	No	Yes	No	Yes	No
Other events						
99. Did you ever experience a crime in which you were personally a victim (including theft of your property, physical assault, or any other crime)?	Yes	No	Yes	No	Yes	No
100. Have you ever been raped by strangers, a neighbour, a relative or any other person you knew (other than parents, brothers or sisters)?	Yes	No	Yes	No	Yes	No
101. Did you ever experience a sudden and unexpected emergency, like fire, flood, war or natural disasters, car or train accident?	Yes	No	Yes	No	Yes	No
102. Did you ever (have to) make money by selling your body (prostitution)?	Yes	No	Yes	No	Yes	No
103. Was there any other event or problem that influenced your life suddenly, and that is not mentioned on the previous pages? (TAKE SOME TIME TO THINK). Please specify below.						
1.	Yes	No	Yes	No	Yes	No
2.	Yes	No	Yes	No	Yes	No

SELF-REPORT

104. From all events and circumstances mentioned (or recorded by you yourself), which were the three most important> Which three events have most strongly influenced your life?

1) (MOST IMPORTANT) .....

.....

2) (SECOND MOST IMPORTANT) .....

.....

3) (THIRD MOST IMPORTANT) .....

.....

WHEN FINISHED, PLEASE HAND OVER THIS BOOKLET BACK TO THE INTERVIEWER

PREVIOUS PARASUICIDES

1. **"During your life, have you ever before deliberately poisoned or injured yourself? For instance by taking an overdose of medicines or drugs, by cutting your wrists, by trying to hang or drown yourself, by provoking accidents involving yourself, etc. How many times have you done such things?**

   Number of parasuicides .....

   IF NO PREVIOUS PARASUICIDES CONTINUE WITH MODELS SECTION ON PAGE 47.

2. **Can you tell me all about these happenings? Please start with the last time you previously poisoned or harmed yourself. That is: not the one last week, but the last time you did this before".**

   Probe with questions for each parasuicide:
   A. What did you do?
   B. How long ago did it happen?
   C. What happened next? Were you treated in a general hospital?
   D. Did you receive any other professional help afterwards, e.g. by a psychiatrist?

Start with last previous parasuicide (= 1) and then go back in time (2, 3, 4, 5). Only the last 5 parasuicides need to be coded.

	PREVIOUS PARASUICIDE NUMBER				
A. Method	1	2	3	4	5
1. Poisoning					
2. Hanging	.....	.....	.....	.....	.....
3. Drowning					
4. Cutting					
5. Jumping from height					
6. Jumping in front of moving vehicle					
7. Burning					
8. Other					
B. Time lapse between event and present parasuicide (hierarchically)	1	2	3	4	5
1. less than 1 day	.....	.....	.....	.....	.....
2. less than 1 week					
3. less than 1 month					
4. less than 3 months					
5. less than 12 months					
6. 12 months or more					
C. Somatic treatment	1	2	3	4	5
1. None					
2. General Practitioner	.....	.....	.....	.....	.....
3. General hospital					
4. Other					
D. Psychiatric treatment	1	2	3	4	5
1. None					
2. In-patient	.....	.....	.....	.....	.....
3. Out-patient					

PRECIPITATING FACTORS OF LAST PREVIOUS PARASUICIDE

1. **"Now I would like to ask you about the last time you (poisoned/harmed) yourself, thus not about what you did last week but the previous time** (refer to time period, see previous page). **At that time, were there any special events or circumstances that led to your act?"**

   Narrative. Write out answer

2. **"There may be many reasons why people who have problems take pills or injure themselves. Please indicate whether the problems that I will mention had major influence on what you did then, had a minor influence on what you did or had no influence at all."**

   Problem checklist (read out categories, skip categories that are clearly not applicable)

1.	Problems with your partner	No / Minor / Major
2.	Problems with your parents	No / Minor / Major
3.	Problems with your children	No / Minor / Major
4.	Feelings of loneliness	No / Minor / Major
5.	Problems in making or maintaining friendships and social relations	No / Minor / Major
6.	Rejection by a lover	No / Minor / Major
7.	Physical illness or disability	No / Minor / Major
8.	Mental illness and psychiatrical symptoms	No / Minor / Major
9.	Unemployment	No / Minor / Major
10.	Addiction (to alcohol, drugs, medicines, gambling, etc.)	No / Minor / Major

3. **"Where there any other events or circumstances that had an influence on what you did?"**

   If patient mentions one or more events or circumstances specify:

   1. ..... / Minor / Major
   2. ..... / Minor / Major
   3. ..... / Minor / Major

CONSEQUENCES OF LAST PREVIOUS PARASUICIDE

1. **"What happened then? Have you been treated in a general hospital, by a general practitioner or private doctor, or didn't you receive medical treatment?"**
   Somatic treatment (circle)

   No treatment / G.P. or private doctor / General hospital

2. **"Afterwards, did you receive any professional help for your problems? Where you admitted to a psychiatric hospital or psychiatric ward, did you receive out-patient psychiatric help, or didn't you receive help for your problems?"**
   Psychiatric treatment (circle)

   No treatment / In-patient psychiatric care / Out-patient care (any type)

3. **"I would like to know how then, after the previous time you (poisoned/harmed) yourself, your relatives and friends reacted to what you had done. I will mention some possible reactions, and I would like you to indicate whether such a reaction was showed by no one of your family and friends, by some of them, or by all of them."**
   Read out reactions A to F and circle

   A. they felt pity for you — No one / One person / Some people

   B. they showed understanding — No one / One person / Some people

   C. they showed anger or irritation — No one / One person / Some people

   D. they felt embarrassed, tried to avoid you — No one / One person / Some people

   E. they felt uncertain — No one / One person / Some people

   F. they laughed at you — No one / One person / Some people

4. **"I would also like to know how you felt, after the previous time you (poisoned/harmed) yourself. I will again mention some possible feelings, and I would like you to say whether that applied to you. Please think back to how you felt one week after the previous time you (poisoned/harmed) yourself."**
   Read out A to F and circle

   A. Did you feel good? — Yes / No

   B. Did you feel released? — Yes / No

   C. Did you feel proud because you managed to carry it through? — Yes / No

   D. Did you feel pity about yourself? — Yes / No

   E. Did you feel angry about yourself? — Yes / No

   F. Did you feel afraid of yourself? — Yes / No

   G. Did you feel uncertain of yourself? — Yes / No

   H. Did you feel ashamed of yourself? — Yes / No

   I. Did you feel uncertain towards others? — Yes / No

   J. Did you feel embarrassed? — Yes / No

MOTIVES FOR LAST PREVIOUS PARASUICIDE

1. "Just like there can be many problems that lead people to take pills or injure themselves, there can be many different intentions for it. I will hand over to you a list of reasons, and I would like you to indicate for each reason, whether it was a reason for YOU for the previous time you (poisoned/harmed) yourself. It is the same list as you filled in before with respect to your (poisinging/harming) yourself last week, but now I would like you to indicate what reasons played a role in what you did the previous time.
Please start with reading the instruction, and ask me if you need help."

TURN THIS PAGE AND HAND OVER BOOKLET TO THE PATIENT

SELF-REPORT

Below are fourteen reasons people can have for taking pills or harming themselves. Please think back to how you felt before you took pills or injured yourself (not last week, but the previous time), and indicate to what extent these reasons applied to you. Circle NO INFLUENCE if the reason mentioned played no role in what you did. Circle MINOR INFLUENCE if the reason played a minor role, circle Major INFLUENCE if the reason played a major role in what you did. There are no right or wrong answers. Please do not skip items. Do not spend too much time on any one statement. If you need help, please ask the interviewer.

NOW PLEASE READ EACH STATEMENT CAREFULLY,
AND CIRCLE THE ANSWER THAT APPLIES BEST TO YOU
THE PREVIOUS TIME YOU POISONED OR INJURED YOURSELF

1.	My thoughts were so unbearable, I could not endure them any longer.	No influence / Minor influence / Major Influence
2.	I wanted to show someone how much I loved him/her.	No influence / Minor influence / Major Influence
3.	It seemed that I lost control over myself, and I do not know why I did it.	No influence / Minor influence / Major Influence
4.	The situation was so unbearable that I could not think of any other alternative.	No influence / Minor influence / Major Influence
5.	I wanted to get away for a while from an unacceptable situation.	No influence / Minor influence / Major Influence
6.	I wanted other to know how desperate I felt.	No influence / Minor influence / Major Influence
7.	I wanted to die.	No influence / Minor influence / Major Influence
8.	I wanted to get help from someone.	No influence / Minor influence / Major Influence
9.	I wanted to know if someone really cared about me.	No influence / Minor influence / Major Influence
10.	I wanted other to pay for the way they treated me.	No influence / Minor influence / Major Influence
11.	I wanted to make someone feel guilty.	No influence / Minor influence / Major Influence
12.	I wanted to persuade someone to change his/her mind.	No influence / Minor influence / Major Influence
13.	I wanted to make things easier for others.	No influence / Minor influence / Major Influence
14.	I wanted to sleep for a while.	No influence / Minor influence / Major Influence

WHEN FINISHED, PLEASE HAND OVER THIS BOOKLET BACK TO THE INTERVIEWER

Check whether Motives list has been filled in correctly and completely. If items are missing, ask whether that reason played a role.

2. **"Were there any other reasons that had an influence on what you did? can you tell what they were?"**

1. .....
.....
Minor influence / Major Influence

2. .....
.....
Minor influence / Major influence

3. .....
.....
Minor influence / Major influence

SUICIDAL BEHAVIOUR BY MODELS

"To your knowledge, has one of your relatives or close friends ever deliberately poisoned or injured him or herself? Can you tell me all about such happenings?".

Probe with questions for each model:

A. **"What relation was/is he/she to you?"**
B. **"Did (relation) die as a result of this act?"**
C. **"How long ago did it happen?"**
D. **"What did he/she do?"**
E. If not a relative: **"Did you know this person because you met in some kind of treatment facility?"**
F. **"Were you personally involved in what he/she did? By that, I mean whether you were physically present, in telephone contact, or whether you advised immediately before or after the act."**

	MODEL NUMBER				
	1	2	3	4	5
A. Relationship of model to subject (model was/is subject's ....)	.....	.....	.....	.....	.....
1. Wife					
2. Husband					
3. Cohabitee					
4. Daughter					
5. Son					
6. Mother					
7. Father					
8. Sister					
9. Brother					
10. Grandmother					
11. Grandfather					
12. Other relative					
13. Close friend					
B. Type of behaviour					
1. Parasuicide 2. Suicide	.....	.....	.....	.....	.....
C. Time lapse between model event and present parasuicide (hierarchically)	.....	.....	.....	.....	.....
1. less than 1 day					
2. less than 1 week					
3. less than 1 month					
4. less than 3 months					
5. less than 12 months					
6. 12 months or more					
D. Method model event					
1. Poisoning	.....	.....	.....	.....	.....
2. Hanging					
3. Drowning					
4. Cutting					
5. Jumping from height					
6. Jumping in front of moving vehicle					
7. Burning					
8. Other					
E. Was contact in treatment facility?					
1. Yes	.....	.....	.....	.....	.....
2. No					
F. Personal involvement of subject in model's act	.....	.....	.....	.....	.....
1. Yes (physically present; in telephone contact; advised immediately before/after act)					
2. No (other)					

USE OF ALCOHOL, DRUGS AND MEDICATION

"I would like to continue with some questions on alcohol, drugs and medication. Let's start with the questions on alcohol."

1. **"During the week before you (poisoned/harmed) yourself, what did you drink during this week?"** [Interviewer should get a clear picture of total amount of alcohol within last week] Fill in at least 'Type of beverage' and 'Amount'. You can look up volume alcohol percentage of the beverage and calculate 'Volume in cl.' later on.

Type of beverage	Volume % alcohol	Amount	Volume in cl.
.....	.....	.....	.....
.....	.....	.....	.....
.....	.....	.....	.....
.....	.....	.....	.....
.....	.....	.....	.....

2. **"Was this a typical week? During the past year, did you normally drink more, much more, less, much less, or about the same compared to the week before you (poisoned/harmed) yourself?"**
circle

Normally much less / Normally less / About the same / Normally more / Normally much more

3. **"Do you consider alcohol to be a problem for you at the present time?"**
circle

No problem / Minor problem / Major problem

4. **"In the past year, have you considered or tried to cut down on drinking (alcohol)? If yes, did you find it difficult to cut down?"**
circle

Not tried, not considered / Only considered / Tried, no difficulty / Tried with difficulty (of any degree)

5. **"In the past year, have people annoyed you by confronting you with your drinking behaviour?"**

circle Yes / No

6. **"In the past year, have you ever felt guilty about your drinking behaviour?"**

circle Yes / No

7. **"In the past year, have you ever started the day with a drink to relax, to calm down or to suppress a hang-over?"**

circle Yes / No

8. **"Now I would like to continue with a question on medication and drugs. I would like to know whether during the week before you (poisoned/harmed) yourself, you used any drugs or medicines".**

		"Did you use ...?"	**"Was this more, equal or less than you generally used during the last year?"**	**"In the last year, did you have problems with this medicine or drug?"**
1.	Sleeping pills, tranquillizers or other medicines that help you to relax.	Yes / No	More / Equal / Less	Yes / No
2.	Antidepressants, pills against depression	Yes / No	More / Equal / Less	Yes / No
3.	Antipsychotics	Yes / No	More / Equal / Less	Yes / No
4.	Medicines for physical complaints (e.g. for high blood pressure)	Yes / No	More / Equal / Less	Yes / No
5.	Hashish or marihuana	Yes / No	More / Equal / Less	Yes / No
6.	Cocaine or heroin	Yes / No	More / Equal / Less	Yes / No
7.	Other (specify)	Yes / No	More / Equal / Less	Yes / No
	.....	Yes / No	More / Equal / Less	Yes / No
	.....	Yes / No	More / Equal / Less	Yes / No
	.....	Yes / No	More / Equal / Less	Yes / No

9. **"Do you consider drugs and/or medicines to be a problem for you at the present time?"** circle

No problem / Minor problem / Major problem

STATE-TRAIT ANGER SCALE

"I would like you to complete a short questionnaire with deals with feelings of anger. There are two groups, each consisting of ten statements. The first ten statements deal with how you feel in general, the second ten statements deal with how you feel right now. Please read the instruction before you begin."

TURN THIS PAGE AND HAND OVER BOOKLET TO THE PATIENT

SELF-REPORT

Below are 10 statements dealing with feelings of anger. Please indicate for each statement whether, in GENERAL (how you generally feel) it applies to you ALMOST NEVER, SOMETIMES, OFTEN or ALMOST ALWAYS. Please do not skip statements. Do not think too long about any one statement.

NOW READ EACH STATEMENT AND CIRCLE THE ANSWER THAT REPRESENTS BEST HOW YOU GENERALLY FEEL

01.	I have a fiery temper	Almost never / Sometimes / Often / Almost always
02.	I am quick-tempered	Almost never / Sometimes / Often / Almost always
03.	I am a hot-headed person	Almost never / Sometimes / Often / Almost always
04.	I makes me furious when I am criticized in front of others	Almost never / Sometimes / Often / Almost always
05.	I get angry when I'm slowed down by others mistakes	Almost never / Sometimes / Often / Almost always
06	I feel infuriated when I do a good job and get poor evaluation	Almost never / Sometimes / Often / Almost always
07.	I fly off the handle	Almost never / Sometimes / Often / Almost always
08.	I feel annoyed when I am not given recognition for doing good work	Almost never / Sometimes / Often / Almost always
09.	When I get mad, I say nasty things	Almost never / Sometimes / Often / Almost always
10.	When I get frustrated, I feel like hitting someone	Almost never / Sometimes / Often / Almost always

NOW TURN THIS PAGE TO CONTINUE

SELF-REPORT

Below are 10 other statements dealing with angry feelings. Please indicate for each statement whether NOW (how you feel it this moment) it applies to you VERY MUCH, MODERATELY SO, SOMEWHAT or NOT AT ALL. Please do not skip statements.

NOW READ EACH STATEMENT AND CIRCLE THE ANSWER THAT REPRESENTS BEST HOW YOU FEEL RIGHT NOW

01.	I am furious	Not at all / Somewhat / Moderately so / Very much so
02.	I feel like banging on the table	Not at all / Somewhat / Moderately so / Very much so
03.	I feel angry	Not at all / Somewhat / Moderately so / Very much so
04.	I feel like yelling at somebody	Not at all / Somewhat / Moderately so / Very much so
05.	I feel like breaking things	Not at all / Somewhat / Moderately so / Very much so
06.	I am mad	Not at all / Somewhat / Moderately so / Very much so
07.	I feel irritated	Not at all / Somewhat / Moderately so / Very much so
08.	I feel like hitting someone	Not at all / Somewhat / Moderately so / Very much so
09.	I am burned up	Not at all / Somewhat / Moderately so / Very much so
10.	I feel like swearing	Not at all / Somewhat / Moderately so / Very much so

WHEN FINISHED, PLEASE HAND OVER THIS BOOKLET BACK TO THE INTERVIEWER

CONTACT WITH HEALTH SERVICES

General practitioner

1. **"How many times did you see a general practitioner or family doctor, or specialists during the last year?"** Excludes dentist, psychiatrist

   circle not / one time / 2-3 times / 4 or more times

2. **"Could you give the approximate dates of the last you contacted a doctor before you (poisoned/harmed) yourself? Why did you contact him/her, what were your complaints? Did the doctor prescribe any medicines?"**

   Date of last contact (before parasuicide): .....(day) .....(month) .....(year)

   Reason (circle): physical / psychological / both physical and psychological

   Medicines prescribed (circle): Yes / No

   If medicines prescribed, ask:
   "Did you use any of the medicines prescribed in that contact for self-poisoning (did you deliberately overdose)?"

   circle Yes / No

3. **"At the time of your last contact with the doctor, did you have thoughts about poisoning or injuring yourself?"**

   Circle No / To some extent / Yes, definitely

   If 'To some extent' or 'yes, definitely' ask:

   "Did you talk to the doctor these thoughts? Maybe you vaguely referred to such plans, or didn't you talk about it at all?"

   circle Yes / Vaguely referred to / No

In-patient psychiatric treatment (includes treatment on psychiatric ward of general hospital)

4. **"How many times, if ever, have you been treated in a psychiatric hospital, in a psychiatric ward of a general hospital, or in any other in-patient institution for people with mental problems?"** Be sure that the patient refers to in-patient treatment: **"you were in the hospital both night and day"**. In-patient treatment after the index-parasuicide not included.

   circle never / 1 time / 2-3 times / 4 times or more

   If 'never' continue with question 6 on page 53

5. If one or more times in-patient treatment:
   "Could you, as accurately as possible and for each admission separately, describe: when you were admitted, how long you stayed there, and for which reasons you were admitted.
   Start with last admission. If patient in in-patient psychiatric treatment at time of parasuicide, start facts on this treatment. Do not code admissions after present parasuicide.

	Admission	Length of stay	Reason for admission
1	.....(month) .....(year)	..... (months)	.....
2	.....(month) .....(year)	..... (months)	.....
3	.....(month) .....(year)	..... (months)	.....
4	.....(month) .....(year)	..... (months)	.....
5	.....(month) .....(year)	..... (months)	.....
6	.....(month) .....(year)	..... (months)	.....

6. Out-patient psychiatric treatment and day care

"Have you ever been in contact with one of the following professional services for treatment or advice?"
[TO BE FILLED IN ACCORDING TO NATIONAL SITUATION, CODES SHOULD INCLUDE TREATMENT BY PRIVATE PSYCHIATRIST. AN EXAMPLE (BASED ON HEATH SERVICES THE NETHERLANDS) IS GIVEN BELOW FOR REFERENCE]

[EXAMPLE]

Yes / No		Psychiatric service, polyclinic service
Yes / No		Psychiatric service, day-care
Yes / No		Community Mental Health Centre
Yes / No		Private psychologist or psychiatrist
Yes / No		Consultation service for alcohol and drug related problems
Yes / No		Consultation service for relational and sexual problems

7. Other treatment of emotional problems

"Have you ever received treatment or assistance for emotional problems from anyone else? For instance self-helps groups like Alcoholics Anonymous, S.O.S. telephone services, etc."
Specify:

.....

.....

.....

.....

8. This question only if respondent has treatment
Did anything happen in the treatment you received that in your view may have had something to do with you (poisoning/injuring) yourself last week? If yes, could you say what it was that happened?"
Specify:

.....

.....

.....

.....

SOCIAL SUPPORT

"Now I would like you to fill in a short questionnaire which deals with the question to what extent you feel you get support from and give support to your relatives and your friends. In the questionnaire, two types of support are distinguished. On the one hand practical support, which means help with practical things such as looking after the house when one is away, helping with minor repairs or other practical things one finds difficult, and providing financial support (for instance by lending or giving money). On the other hand moral or emotional support, which means being available for a talk when one feels bad, talking about feelings or giving advice in emotional matters. Start with reading the instruction and if you have any questions regarding the questionnaire, please ask me."

NOW TURN THIS PAGE AND HAND OVER BOOKLET TO THE PATIENT

SELF-REPORT

This questionnaire is about the extent that you feel you need and get support from your family and friends in daily life, and about the extent that your family and friends need and get support from you. In the questionnaire two general kinds of support are distinguished:

- practical support refers to support concerning daily activities such as looking after your house when you are away, looking after your children, pets or flowers, looking after you or doing the shopping when you are ill, etc.. Practical support also includes financial support.
- moral support refers to emotional support when minor or mayor problems arise. Moral support includes that people are available to share worries with, to talk about personal problems, etc.

Please read each question (on the left side of the page) carefully. Then circle in both the columns on the right side of the page (labelled FROM FAMILY and labelled FROM FRIENDS) the answer that applies best to how you feel about it (either 1, 2 or 3). Please answer all questions. Do no spend too much time on any one question. If you have any questions or need help, please ask the interviewer.

WHETHER YOU NEED SUPPORT	FROM FAMILY	FROM FRIENDS
01. Do you feel that you need practical support?	1. no, not at all 2. to some extent 3. yes, very much 4. not applicable	1. no, not at all 2. to some extent 3. yes, very much 4. not applicable
02. Do you feel that you need moral support?	1. no, not at all 2. to some extent 3. yes, very much 4. not applicable	1. no, not at all 2. to some extent 3. yes, very much 4. not applicable
WHETHER YOU GET SUPPORT	FROM FAMILY	FROM FRIENDS
03. Do you feel that you get the practical support you need?	1. no, not at all 2. to some extent 3. yes, very much 4. not applicable	1. no, not at all 2. to some extent 3. yes, very much 4. not applicable
04. Do you feel that you get the moral support you need?	1. no, not at all 2. to some extent 3. yes, very much 4. not applicable	1. no, not at all 2. to some extent 3. yes, very much 4. not applicable
WHETHER YOU ARE NEEDED FOR SUPPORT BY	FAMILY	BY FRIENDS
05. Do you feel that you are needed for practical support?	1. no, not at all 2. to some extent 3. yes, very much 4. not applicable	1. no, not at all 2. to some extent 3. yes, very much 4. not applicable
06. Do you feel that you are needed for moral support?	1. no, not at all 2. to some extent 3. yes, very much 4. not applicable	1. no, not at all 2. to some extent 3. yes, very much 4. not applicable

WHETHER YOU GIVE SUPPORT	TO FAMILY	TO FRIENDS
07. Do you feel that you give the practical support that is needed from you?	1. no, not at all 2. to some extent 3. yes, very much 4. not applicable	1. no, not at all 2. to some extent 3. yes, very much 4. not applicable
08. Do you feel that you give the moral support that is needed from you?	1. no, not at all 2. to some extent 3. yes, very much 4. not applicable	1. no, not at all 2. to some extent 3. yes, very much 4. not applicable

WHEN FINISHED, PLEASE HAND OVER THIS BOOKLET BACK TO THE INTERVIEWER

SOCIAL INTEGRATION

1. **"I would like to know how often, in the past year, you had contact with the following persons. The question is how often you had contacts, either by telephone, through visits, letters, etc., with these persons."** In case of more than 5 brothers, or more than 5 friends, only fill in for the five with whom the respondent has most contact.

   For each type of relationship (e.g. siblings), code for every person (e.g. every brother and every sister) the frequency of contacts, according to the following hierarchical categorization:

   0. never during the last year
   1. more than once a year
   2. more than once a month
   3. more than once a week
   4. more than 3 times a week

If not applicable (e.g. patient has no children) do not code anything.

RELATIONSHIP		FREQUENCY OF CONTACT FOR EACH PERSON THAT IS A CHILD/PARENT/SIBLING ETC. OF THE PATIENT				
		1	2	3	4	5
A.	children (including adopted, etc.)	.....	.....	.....	.....	.....
B.	parents (including foster, stepparent)	.....	.....	.....	.....	.....
C.	brothers/sisters	.....	.....	.....	.....	.....
D.	grandparents	.....	.....	.....	.....	.....
E.	grandchildren	.....	.....	.....	.....	.....
F.	children in law	.....	.....	.....	.....	.....
G.	parents in law	.....	.....	.....	.....	.....
H.	other relatives (only if at least one contact during last year)	.....	.....	.....	.....	.....
I.	friends	.....	.....	.....	.....	.....

2. **"Are you an active member or do you currently do any unpaid voluntary work for organizations like charities concerned with the welfare of people, education or arts groups, trade unions, political parties or groups, human rights groups, conservation, environmentalist or animal welfare groups, youth work, sport clubs, etc.?"**

   circle no / one such organization / 2 or more such organizations

ROSENBERG SELF ESTEEM SCALE

"Now I would like you to fill in one more short questionnaire on how you feel about yourself at this moment. After this we will be ready. Please read the instruction carefully before you start."

TURN THIS PAGE, AND HAND OVER BOOKLET TO THE PATIENT

SELF-REPORT

Below are ten statements about how you feel about yourself. Please read each statement carefully and mark the option which best reflects the way you feel about yourself AT THE PRESENT TIME. Circle the words STRONGLY AGREE if you completely agree with the statement. Circle AGREE if you agree but not completely. Circle DISAGREE if you on the disagree, but not completely. Circle STRONGLY DISAGREE if you think the statement does absolutely not reflect the way you feel about yourself.

There are no right or wrong answers. Please do not skip statements. Do not spend too much time on any one statement.

NOW PLEASE READ EACH STATEMENT CAREFULLY AND CIRCLE THE ANSWERS THAT REFLECT BEST HOW YOU FEEL ABOUT YOURSELF RIGHT NOW.

1.	On the whole I am satisfied with myself.	Strongly agree	/	Agree	/	Disagree	/	Strongly disagree
2.	At times I think I am no good at all.	Strongly agree	/	Agree	/	Disagree	/	Strongly disagree
3.	I feel that I have a number of good qualities.	Strongly agree	/	Agree	/	Disagree	/	Strongly disagree
4.	I feel that I do not have much to be proud of.	Strongly agree	/	Agree	/	Disagree	/	Strongly disagree
5.	I am able to do things as well as most people.	Strongly agree	/	Agree	/	Disagree	/	Strongly disagree
6.	I certainly feel useless at times.	Strongly agree	/	Agree	/	Disagree	/	Strongly disagree
7.	I feel that I am a person of worth, at least as good as others.	Strongly agree	/	Agree	/	Disagree	/	Strongly disagree
8.	I wish I could have more respect for myself.	Strongly agree	/	Agree	/	Disagree	/	Strongly disagree
9.	I take a positive attitude towards myself.	Strongly agree	/	Agree	/	Disagree	/	Strongly disagree
10.	All in all I am inclined to feel that I am a failure.	Strongly agree	/	Agree	/	Disagree	/	Strongly disagree

WHEN FINISHED, PLEASE HAND OVER THIS BOOKLET BACK TO THE INTERVIEWER

FOLLOW-UP CONTACT

"Now we have finished the interview, I have one more question. In order to assess how you are and what has happened, I would like to have an interview with you next year. If you consent to be contacted once again, one year after now, I can assure that no one (for instance your family) will be told about the subject of the interview we had now or of the reasons for the next interview. You will be contacted personally be me or, if that is not possible, by one of my co-workers. If course you may, when you are contacted, decide not to be interviewed. The reason why I ask you to consent to be contacted is that for contacting you I need your permission, as well as your home address. Is it all right with you to be contacted one year after now for a second interview? Do you have any questions?"

IF PATIENT AGREES, FINISH WITH THE CONSENT FORM ON THE NEXT PAGE

THANK PATIENT FOR HIS/HER COOPERATION

WHEN ANOTHER APPOINTMENT IS NEEDED TO FINISH THE INTERVIEW, MAKE SURE THAT THIS APPOINTMENT IS HELD WITHIN ONE WEEK

CONSENT FORM

I herewith give ..... (name of interviewer), or someone who replaces him/her, permission to contact me about one year after now, in order to ask me to take part in a follow-up interview. He/she may also contact the people whose names and addresses have been recorded below, in order to inform about my place of residence. By signing this consent form I do NOT promise to take part in such an interview, I only give permission to be contacted. I have been informed that the reason of this interview will not be made known to any of my relatives or friends.

Date: .....

Name: .....

Signature: .....

My home address is..... (address)

..... (telephone)

or (alternative) ..... (address)

..... (telephone)

Persons who may be asked next year about my residence at that time are:

Person nr. 1: ..... (name) ..... (relation)

..... (address)

..... (telephone)

Person nr. 2: ..... (name) ..... (relation)

..... (address)

..... (telephone)

PATIENT IDENTIFICATION NUMER .....

AFTER FILLING IN THIS FORM REMOVE THIS PAGE FROM BOOKLET

Annex 2

WHO/EURO Multicentre Study on Parasuicide

European Parasuicide Study Interview Schedule (EPSIS)

EPSIS II VERSION 3.2
Follow-up interview

Dr. A.J.F.M. Kerkhof **Dr. M. van Egmond**

Dr. U. Bille-Brahe **Dr. S. Platt** **Dr. A. Schmidtke**

Prepared at the Department of Clinical, Health and Personality Psychology, University of Leiden

December 1990

Correspondence address:

Dr. A.J.F.M. Kerkhof
Department of Clinical, Health and Personality Psychology
University of Leiden
Wassenaarseweg 52
NL-2333 AK Leiden
The Netherlands

CONTENTS

SR = Self report scale or questionnaire

PREAMBLE

Introduction

This interview schedule is designed to be used as a follow-up interview instrument in the WHO/EURO multicentre study on parasuicide. This instrument, or parts of it, should not be used, quoted, reproduced or distributed without the written permission of the Steering Group of the study.

The first interview in this repetition-prediction project will have taken place shortly after a person was admitted to hospital due to parasuicide. The follow-up interview is scheduled to take place exactly one year after the initial interview. The participating centres are asked to try to stick to this one-year follow-up period. There may be reasons to delay the interview, but please ensure that each and every case is interviewed (or at least traced).

Although the time required to make interview arrangements may be lengthy, start making arrangements in good time (11 months after the initial interview). The most important factor for this repetition-prediction project is a high response rate. Please try to get as high a response rate as possible. The cases that are most difficult to trace are probably the most important ones to find. So please try to trace and locate every patient that was interviewed the first time. Sometimes it will take much effort, as many as three home visits or more to trace some people. Be prepared for that.

INSTRUCTIONS FOR CONTACTING PATIENTS OR RELATIVES OF PATIENTS

A. General instructions

- It has definite advantages when the interviewer who administered the initial interview is the same person who tries to contact the respondent again. If this is not the case, the interviewer should prepare him-/herself well by studying the initial interview.
- In the process of contacting the respondent for this follow-up interview, the most important criterion variable must be determined: whether the person is still alive or not, and if not, whether he or she has died because of suicide.
- So every effort should be made to determine whether this particular person is still alive or not and whether he or she died of suicide. This can be a very difficult and cumbersome task. The interviewers and representatives from each centre should use all of their creativity to find ways to determine possible deaths and death causes.
- It is stressed that all centres adhere to their national rules and regulations about interviewing surviving family members, data protection laws and all other ethical demandments of each country. As these regulations differ between countries, we cannot give detailed advice how to handle. Each centre should specify the procedures of interviewing and determining whether in fact someone died of suicide.
- In some countries it might be possible that researchers from participating centres can obtain access to mortality data from the region on an individual base. It might require an offical request to the persons or agencies that certify death causes. When that is granted, researchers might notice death of any respondent during the follow-up period. Be aware: not all deaths through suicide are officially registered as suicides. It might be that in the process of this study some suicides may be discovered that are not officially registered as such. Of course this would be a very important outcome.
- When a respondent has died during follow-up period, be sure to gather at least as much information as to fill in the questionnaire 'When patient has died' (page 6 of this Follow-up interview).
- When you need to visit respondent or his/her relatives personally in order to make the follow-up contact, it is advised to bring the signed Consent Form with you. Whenever necessary you can show this form to respondent or relatives.

B. Respondent is at home / on telephone / in contact

- When respondent picks up the telephone / opens the door, the interviewer has to try to make arrangements for the follow-up interview. It might be that the respondent does not want to be interviewed for a second time, for several reasons (shame that he/she did it again, fear of having to go through intense emotions again, etc.). The interviewer should be very diplomatic and empathatic in this situation. Use all of your social skills and imagination to persuade the respondent to contribute. The interviewer should be aware, though, that for some respondents it might in fact be a very painful experience.
- When the respondent gives reasons why he/she does not want to be interviewed, please do not counterargue these reasons. The best thing to do is to repeat the specific objections and to confirm that you can understand that he/she has this particular argument. Our experience is that when the interviewer confirms all possible fears and arguments not to participate, the resistance slowly decreases.
- The interviewer should be prepared for the following. When life has become much better for the respondent, he or she might be all to happy to participate in the interview. When living conditions have not improved in this year, or even deteriorated, respondents might feel ashamed, reluctant, and might be more inclined to refuse.

C. When respondent is not at home and someone else answers the phone/opens the door

- When the interviewer makes contact through the telephone number given by the respondent in the initial interview, the phone could be picked up by a family member. It is important to tell this family member (after you have given your name and the name of the research centre) that this telephone number was given to you by the respondent him- or herself some time ago, so that you can tell this family member that the respondent authorized you to try to get in touch with him/her.

- You might notice that the family member is somewhat embarrassed, or reluctant to speak to you, may be because he or she has to tell you that the person you are asking for, died in the last year.
- The following few minutes are of crucial importance for the study. You should use all your creativity and social skills to be very empathatically with this family member, to try to live in the position the family member has at that moment, and at the same time, be very determined to obtain all the information you should collect, while at the same time being aware of all rules and regulations that govern this kind of research in your country.
- It might be that the family member sais to you: 'It is not possible for you to speak to my (son, spouse, etc.)', and sais no more than that. In that case it might be helpful to express that you notice that there is some difficulty for the other person in giving more information. You might ask whether your feeling is correct that there is some difficulty in saying why you cannot speak to the person you are looking for. If this is correct you should then ask whether the respondent has died. It might help the family member to say 'yes' or 'no', which is easier to say than 'he/she has died'. It might give the impression that you more or less expected the respondent to be dead (which in fact is true, you knew that there was a chance). When the contact person thinks that you more or less expected that the person you were looking for could be dead, that could break the ice and could facilitate the release of more information. But it might turn out otherwise also.
- There may be many reasons why the person who picked up the telephone doesn't want to put you through the person you are looking for. Still this contact person is the most important source of information, and it might be the only one who could help you. So it is very important to build a good report with this person. One of the most important things to say is that you yourself or a colleague, spoke intensively and for a long period of time with the person you are looking for, and that this conversation was in connection to a kind research which had something to do with his/her stay in hospital one year ago. That one of the aims of this research was to follow-up all participating respondents after exactly one year. PLEASE: do NOT tell the contact person that the initial interview took place because of a parasuicide undertaken by the respondent, this is private information. Ask the contact person whether the respondent ever told him/her that this interview had been administered. Repeat that the respondent him-/herself has given you this telephone number in order to reach him/her after one year. Ask what kind of relationship there is (was) between the person you are looking for and the one who picked up the telephone (or who opened the door).
- Remember that all persons who you'll meet in the process of searching the respondent, have the right to remain silent. But of course you have the right to put questions, even when they are painful. But you cannot force people to give you the answers that you want. All you can do is be very gentle, polite, neat, etc. as you can be, in order to persuade this person to give you the information you want.
- Be clear in your intentions. You need this information because it is very important to you (it might not be very important to the other person or to the respondent). Be explicit in that you can say to the other: 'It may be difficult for you or for the respondent, but for me it is very important'.
- Whenever you hear that the respondent has deceased (first express condolances), your next task is to determine whether he/she committed suicide or died because of another cause. Don't be vague about this. This is what you want to know, so you could well be explicit about it. Try to obtain as much information as possible through relatives/contacting persons. When was the date of death?
- Whenever you have a good contact with this relative, try to obtain relevant information: did he or she attempt suicide with non-fatal outcome between the initial interview and time of death? Where did he/she find treatment? What was his/her opinion about treatment. What precipitating factors could have played a role, etc. After the telephone call you could fill in as much as possible into the EPSIS-II.
- Try to have a second source that can verify the cause of death, e.g. through files of death certifying agencies, through health caregivers that might have treated the person, through the family doctor or by inspection of newspapers anouncements (obituaries).
- Whenever you want to contact the respondent's family doctor, have him called by a psychiatrist or medical doctor of your centre. Family doctors might be more willing to share information with other doctors than with non-medical interviewers.

D. Respondent is not at home but in inpatient treatment

- It might turn out that the respondent is treated in a psychiatric hospital or is kept in another residential setting, where other persons may have some responsibility over the respondent.
  In such cases the interviewer has to be aware that some caregivers might object against the respondent

being interviewed, e.g. when there is a risk of a serious fall back in progress due to emotional turmoil as a possible consequence of the follow-up interview.

- While some of these fears of caregivers might appear overemphasized, it can be a correct estimation of such a risk. So the interviewer has to negotiate with caregivers about the time and conditions of the interview. This might take some time. Hoewever: do not skip such cases. Remember that the respondent him- or herself authorized you to contact him/her again. No caregiver can prevent you from contacting the respondent. However, to administer the EPSIS-II might be - in some cases - too intrusive given the condition the patient is in. There is no other solution than to wait until this condition has improved. (do not skip this case before termination of the study).
- It is advisable for each Research Centre to write a letter to all Psychiatric Hospitals in your surroundings. In this letter you can explain the aim of the Multicentre Study and the fact that one or more of the hospital's patients might be a participant in this study (and will be contacted for the follow-up interview during their admittance there).
- It is also advisable to ask in advance the caregivers' permission for having an interview with the patient for whose treatment the caregiver is responsible.

INSTRUCTIONS FOR THE INTERVIEWER

- Before you see the respondent for the follow-up interview, please prepare yourself well. Go through the information as gathered in the initial interview, and skip questions from the follow-up interview schedule which are not applicable for the respondent. This prevents you from putting silly questions like: 'Did your father die last year', when the respondent stated in the first interview that his father died 10 years ago!
- If it wasn't you who did the initial interview, you should make clear to the respondent at the beginning of the interview, that you have gone through the initial interview schedule to prepare yourself for this follow-up interview.
- Emphasize that the contents of the interview are strictly confidential, that no information from the interview will be known to doctors, nurses, relatives, friends, or any other persons. Also emphasize that his/her name will be not be anywhere recorded, except for a consent form which has to be signed before the interview. Explain that this Consent Form is necessary for legal reasons, so that others can see that the cooperation is voluntary and that he/she has not been forced to cooperate, that no financial or other rewards have been promised, and that he/she has been informed about the aims and contents of the interview and about its confidentiality.
- Ask patient if he/she has understood what you have said, and whether he/she has any questions before deciding whether to cooperate or not. Try to answer these questions.
- Ask patient if he/she agrees to be interviewed by you, or if he/she needs some time to think it over. Emphasize that if he/she is willing, you would like to do the interview as soon as possible.
- If the patient agrees, make an appointment for when to do the interview or start with the interview immediately (Consent Form first!). Thank him/her for the participation.
- If the patient refuses to be interviewed, ask for the reasons (do not press if he/she is not willing to give reasons for his/her refusal). If given, record the reasons for refusal. Thank him/her for the attention.
- If the interview is not administered immediately, repeat the introduction the next time you meet the patient (some patients even may have forgotten all about who you are and what you came for).
- It is recommended to write a summary narrative of the most important information as gathered in the follow-up interview, after finishing this interview. Such a short narrative is very useful for quick inspection purposes.

When respondent appears to be acutely suicidal

It may happen that at or around the time of the follow-up interview the respondent seems to be acutely suicidal. Information given to you in the interview might convince you of the immediate danger of a pending suicide. In that case the research and the interview should be considered of less importance than the management of the suicide risk. So it might be necessary to stop the interview and to act according to what you would normally do when you were confronted as a care giver with suicidal risk.

First inquire after treatment the respondent may have at that time. Is there a psychiatrist who you

could phone, is there a care giver, like the family physician, who could be called upon to assess and treat the suicide risk? Whenever the patient has out-patient treatment it is advisable to telephone that person and to discuss the potential resources.

Express to the respondent that you have decided to inform this other caregiver. Express firmly that you are obliged to undertake some action in order to take care of the respondent in the condition that you have observed. It is very important that you can convince the respondent that the action you decided to take is on behalf of the respondent. Explain that you are an expert in assessing suicide risk and that your opinion is that the respondent - at least temporarily - is not very good in judging the danger of continuing without help.

Be as creative as you can in dealing with this situation. Do not put yourself at risk however. When the respondent becomes agressive, please take care of yourself first. (we don't expect this to happen, though, but prepare yourself to all possible conditions).

When there appears to be an acute suicide risk, and the respondent has no help, or no relatives to watch over him, you should be able to fall back onto your Research Centre's facilities in dealing with suicide risk. It might be useful to make an agreement that whenever you think it is necessary you can telephone the resident psychiatrist of the research hospital, and he or she should immediately come to the place where you are and take over the responsibility.

Fortunately, in most cases there will be no need to act as actively as in the above mentioned cases. But please prepare yourself and the psychiatrists that may be involved in order to train yourself for possible emergency situations.

It may happen that because of the interview you consider the respondent as someone who urgently needs help, while the person has no regular contact with a mental health care professional. In that case you are expected to try to convince the respondent that he needs help, that in your opinion the person will not get better without help, that you are worried and that you would be much more at ease if you would know that the person was seeing a professional, or his family physician.

It may happen that you come to know that the respondent has a regular contact with a psychiatrist, but that the respondent is very dissatisfied and does not attend appointments anymore. In that case it might be wise to convince the respondent that it is better to try to discuss this dissatisfaction with the psychiatrist, rather than to try to arrange another contact with someone else.

In general, try to restore contacts of respondents with caregivers, rather than to bring in new caregivers.

In most cases it will be sufficient to express your worries if you have them and to convince the respondent that he should do something.
You must always be alert not to make the impression that you are taking away responsibility or autonomy from the respondent. Only in exceptional cases , such as acute suicide risk, you should take over responsibility.

INSTRUCTIONS PSYCHOSOCIAL INTERVIEW

Patients should be informed completely about the purpose and content of the interview.

The average administration time of the interview is estimated to be about 1½ to 2 hours for experienced interviewers. Interviewers should not only master basic interview techniques, but should also have made themselves familiar with the EPSIS-I and EPSIS-II, in order to proceed smoothly through the interview. The EPSIS should be administered in the given order, including the self-report scales. The self-report scales should be completed by the patients during the interview, with the interviewer being physically present to provide help or support. If for some reason self-report scales cannot be filled in by the patient, they may be administered orally. All self-report scales have a heading 'SELF-REPORT' on top of each page. Centres are advised to include self-report scales in the EPSIS-booklet. To assure that separate sheets do not get lost, interviewers can hand over the whole booklet to the patient for filling in the scales. Each self-report scale ends with the instruction to hand over the booklet back to the interviewer. In the EPSIS-II, there are two self-report scales (the Utrecht Coping Questionnaire (UCL) and the Social Support Scale

(SSS).

In this version of the EPSIS, text printed in bold between double quotes ("like **this**") is meant to be literally said or asked. Where bold text appears in brackets with a slash in between (e.g. "**first alternative/next alternative**"), the interviewer should choose the phrase that applies to the patient's situation (e.g. say "poisoned yourself" in case of self-poisoning, and say "harmed yourself" in case of self-injury). Underlined text is meant to be supplementary information for the interviewer only. Text between square brackets [like this] is not part of the EPSIS, but contains instructions or comments on translation or adjustment to the national or regional situation.

In the current version of the EPSIS, a line of periods (.....) indicates that the interviewer is expected to fill in a number or a text on that line. All other items should be scored by circling the applicable alternative from a list of possible answers (numbered, or separated with a slash).

The Life Events during follow-up (KLEHS) contains some redundant questions that have been asked before or will be asked later during the interview. This was necessary in order to simplify coding in later stages.

In this follow-up interview a great deal of information is gathered with respect to what is called: THE FOLLOW-UP PERIOD. This is defined as the period between DATE OF INITIAL INTERVIEW (thus NOT date of index parasuicide!) and DATE OF FOLLOW-UP INTERVIEW. Interviewer, please be alert on this and explain to respondent about which period you question him or her (mention the exact date of initial interview, etc.)

WHEN PATIENT HAS DIED

1. When did patient die? .....(day) .....(month) .....(year)

2. What was the cause of death?

(circle):
1. suicide
2. other, namely: .....
3. undetermined
4. uncertain, specify : .....
.....
.....

3. By whom have you been (first) informed about patient's death / cause of death?

(circle):
1. Parent(s) of patient
2. Partner/husband of patient
3. Child/children of patient
4. Relative of patient
5. Friend / acquaintance / neighbour of patient
6. Family doctor
7. Psychiatrist
8. Other

4. How specifically have you (interviewer) been informed about cause of death?

(circle):
1. Suicide unambiguously stated as cause of death
2. Suicide mentioned as probable cause of death
3. Suicide mentioned as possible cause of death
4. Suicide mentioned as unprobable cause of death
5. Suicide is excluded as cause of death

5. Did you verify cause of death?

(circle):
1. Yes
2. No

6. If yes, through which agent/person?

(circle):
1. Death certifying officer/coroner
2. Family doctor
3. Psychiatrist
4. Psychiatric Hospital
5. Hospital Records
6. Other relatives

CONSENT FORM
Follow-up interview

I herewith declare to be willing to be interviewed by ..... (name of interviewer) in a study on deliberate self-poisoning and self-injury. I have been informed about the aims of the study and about the content of the interview. I have also been informed that the interview is confidential. What I say during the interview will have no consequences for any treatment I receive or for decisions others make about my future in all but the most exceptional circumstances. I know that I will not receive any financial or other reward for my participation in the interview. I have been told that I have the right to refuse to answer questions when I don't want to, and that I can decide to finish the interview at any moment.

Date: .....

Name: .....

Signature: .....

PATIENT IDENTIFICATION NUMBER .....

AFTER FILLING IN THIS FORM, INCLUDING PATIENT IDENTIFICATION NUMBER, REMOVE THIS PAGE FROM BOOKLET

GENERAL INTERVIEW INFORMATION

1. Research Centre: .....

2. Name of interviewer: .....

3. Patient identification number: .....

4. Place of follow-up interview: .....

5. Date and time of follow-up interview:

   First session: ..... (date) ..... (time started) ..... (time ended)

   If follow-up interview completed in two sessions:

   Second session: ..... (date) ..... (time started) ..... (time ended)

6. Date of index parasuicide: ..... (date)

7. Date of initial interview: ..... (date) (if more than one sessions take date of first session).

8. Time elapsed between date of index parasuicide and date of initial interview:

   ..... (Express in number of days)

9. Time elapsed between date of initial interview and date of follow-up interview:

   ..... (Express in number of months)

10. Special observations or remarks: reason for refusal of follow-up interview, or interview not taking place or interview partially completed:

    (circle):
    1. Interview completed
    2. Interview partially completed
    3. Interview not administered, because:
       a. patient refused
       b. patient's caregiver refused
       c. patient's parent refused
       d. patient was not traceable
       e. patient died
       f. patient could not be interviewed e.g. because of his or her bad mental or physical condition

Comment:

.....

.....

.....

.....

SOCIO-DEMOGRAPHIC INFORMATION

(with respect to changes in situation during the period between date of initial interview till follow-up interview)

"Now that you know what this interview is for and have signed the consent form, let us start with some general questions about things that might have changed over the last year. With last year I mean the period between the first time you were interviewed and the interview now. Here and further on in the interview I will also use the term 'the follow-up period' to refer to this period. So, have things changed with respect to your living arrangements, work or study, etc. during this follow-up period? If on any question you either cannot or don't want to give an answer, please say so. I would rather have a 'don't know' or 'don't want to say' answer than one that does not really reflect your situation or your opinion. Now before we start, do YOU have any questions?"

Interviewer: Please read the EPSIS initial interview schedule before the follow-up interview en try to memorize what was mentioned there with respect to respondent's socio-demographic characteristics. Some of the questions need not to be repeated now (e.g. gender and age) whereas others should be checked for the situation now. Make frases like: "Last year you told me (or the other interviewer) that your nationality was ..... (mention nationality). Has there been any change in your nationality during the past year?

1. **"Has there been any change in your nationality during the period between the interview last year and now?"**

   (circle) Yes / No

   If yes: specify current nationality .....

2. **"Has there been any change in your marital state during the period between the interview last year and now?"**

   (circle) Yes / No

   If yes, specify current marital state:
   1. Single
   2. Married
   3. Widowed
   4. Divorced
   5. Separated

3A. **"Last year you told me (the other interviewer) that during the year before that interview, you lived most of the time with .....** (interviewer mention answer indicated at question 14 from EPSIS initial interview). **"Did that situation change during the follow-up period?** If yes: **With whom did you live most of the time during the past year?"** (Household composition during past year: usual situation).

3B. **"Last year you told me (the other interviewer) that you were then living with .....** (interviewer mention answer indicated at question 13 from EPSIS initial interview). **Is this situation now changed?** If yes: **"With whom do you live presently?"** (Household composition: current situation).

3A. Change in usual household composition:	3B. Change in current household composition:
(circle) Yes / No	(circle): Yes / No
If yes, specify: A. Respondent's usual household composition during the follow-up period was: 1. Living alone 2. Living alone with child(ren) 3. Living with partner without child(ren) 4. Living with partner and child(ren) 5. Living with parents 6. Living with other relatives/friends 7. Living in institution 8. Other, specify	If yes, specify: B. Respondent's current household composition is: 1. Living alone 2. Living alone with child(ren) 3. Living with partner without child(ren) 4. Living with partner and child(ren) 5. Living with parents 6. Living with relatives/friends 7. Living in institution 8. Other, specify .....
.....	.....

4. **"Has there been any change with respect to your education in the period between the interview last year and now. In the interview last year you said that you had completed .....** (Interviewer mention respondent's answer on type of education completed as indicated at question 16 in EPSIS initial interview).

(circle) Yes / No

If yes: **"Did you start, change, stop or complete school, study or course?"**

(circle: more alternatives possible):	Description of kind of school, study, course:
1. Respondent started with:	.....
2. Respondent changed from:	..... to .....
3. Respondent stopped with:	.....
4. Respondent completed:	.....

[Code type of education according to national census data, use same categories as in monitoring form]

5A. **"Last year you told me (the other interviewer) that during the year before that interview, your usual employment status than was .....** (interviewer mention answer indicated at question 17 from EPSIS initial interview). **"Has there been any change in this usual employment status during the follow-up period? If yes: What was your usual employment status during the follow-up period?"**

5B. **"Last year you told me (the other interviewer) that your employment status at that moment was .....** (interviewer mention answer indicated at question 17 from EPSIS initial interview). **Is this situation now changed? If yes: "What is your current employment status?**

5A. Change in usual employment status:	5B. Change in current employment status:
(circle) Yes / No	(circle): Yes / No
If yes, specify:	If yes, specify:
A. Respondent's usual employment situation:	B. Current employment situation:
1. full-time employed (including self-employed)	1.
2. part-time employed (including self-employed)	2.
3. employed, temporarily off sick	3.
4. unemployed, looking for work (continue with sub 1)	4.
5. unemployed, waiting to take up job already accepted (continue with sub 1)	5.
6. unemployed, assisting partner (continue with sub 1)	6.
7. armed services	7.
8. full-time student	8.
9. disabled, permanently sick (continue with sub 2)	9.
10. retired (continue with sub 3)	10.
11. homemaker/housewife	11.
12. other, namely	12.

Sub 1: **"How long have you been unemployed during the period between the interview last year and now?"**

..... months

Sub 2: **"How long have you been disabled during this follow-up period?"**

..... months

Sub 3: **"How long have you been retired during this follow-up period?"**

..... months

6. **"Has there been any change in your occupation during this follow-up period?"**

(circle) Yes / No

If yes, specify current occupation:

.....

7. ***Has there been any change in your religious denomination during the period between the interview last year and now?**

   (circle) Yes / No

   If yes, specify current religious denomination:
   1. None
   2. Protestant
   3. Catholic
   4. Jewish
   5. Muslim
   6. Hindu
   7. Greek orthodox
   8. Buddhist
   9. Other, specify .....

DEALING WITH PROBLEMS AND UNPLEASANT EVENTS

"Now I would like you to fill in a short questionnaire on the way in which you in general deal with problems and unpleasant events. People have different ways of reacting, when they are confronted with problems or unpleasant events. One's reaction is often dependent on the nature and the severity of the problem, or on the moment in which the event occurs. In this questionnaire you will find a number of descriptions, which indicate different ways in which one can think or react when facing a problem. I am asking you to indicate on each sentence how often you would find yourself reacting in this way. Start with reading the instructions and if you have any questions regarding the questionnaire, please ask me"

PLEASE HANDOVER BOOKLET TO THE RESPONDENT

SELF-REPORT

People in general have different ways of reacting, when they are confronted with problems or unpleasant events. One's reactions is often dependent on the nature and the severity of the problem, or on the moment in which the event occurs. On this page and the following one you will find a number of descriptions, which indicate different ways in which one can think or react when facing a problem.
Please indicate on each sentence how often you would find yourself reacting in this way. Do this by circling on each sentence one of the four answers given (seldom or never, sometimes, often, or very often). There are no "right" or "wrong" answers. Please do not omit any sentence.

	CIRCLE:			
1. Showing one's annoyance	Seldom or never	Sometimes	Often	Very often
2. Taking a gloomy view of the situation	Seldom or never	Sometimes	Often	Very often
3. Showing one's anger with those responsible for the problem	Seldom or never	Sometimes	Often	Very often
4. Giving in - in order to avoid difficult situations	Seldom or never	Sometimes	Often	Very often
5. Resigning oneself to the situation	Seldom or never	Sometimes	Often	Very often
6. Sharing one's worries with someone	Seldom or never	Sometimes	Often	Very often
7. Making a direct intervention, when problems occur	Seldom or never	Sometimes	Often	Very often
8. Considering problems as a challenge	Seldom or never	Sometimes	Often	Very often
9. Trying to dispell one's worries temporarily by taking a break	Seldom or never	Sometimes	Often	Very often
10. Looking for distraction	Seldom or never	Sometimes	Often	Very often
11. Finding out all about the problem	Seldom or never	Sometimes	Often	Very often
12. Trying to avoid difficult situations as much as possible	Seldom or never	Sometimes	Often	Very often
13. Considering different solutions to the problem	Seldom or never	Sometimes	Often	Very often
14. Using a direct approach in order to solve the problem	Seldom or never	Sometimes	Often	Very often
15. Worrying about the past	Seldom or never	Sometimes	Often	Very often

16. Asking someone to help	Seldom or never	Sometimes	Often	Very often
17. Making several alternative plans for handling a problem	Seldom or never	Sometimes	Often	Very often
18. Being totally preoccupied with the problems	Seldom or never	Sometimes	Often	Very often
19. Directing one's thoughts toward other matters	Seldom or never	Sometimes	Often	Very often
20. Trying to make oneself feel better one way or the other	Seldom or never	Sometimes	Often	Very often
21. Telling oneself that other people also have their problems from time to time	Seldom or never	Sometimes	Often	Very often
22. Realising every cloud has a silver lining	Seldom or never	Sometimes	Often	Very often
23. Showing one's feelings	Seldom or never	Sometimes	Often	Very often
24. Seeking sympathy and comfort from somebody	Seldom or never	Sometimes	Often	Very often
25. Showing there are things, which are bothering you	Seldom or never	Sometimes	Often	Very often
26. Feeling unable to do anything	Seldom or never	Sometimes	Often	Very often

WHEN FINISHED, PLEASE HANDOVER THIS BOOKLET BACK TO THE INTERVIEWER

SUICIDAL IDEATION DURING FOLLOW-UP PERIOD

"Last year you were asked to participate because you were admitted to the ..... Hospital after having taken too many pills or trying to injure yourself. I would like to know whether you have had further thoughts (or considered seriously) about poisoning/harming yourself in the period between discharge from general hospital last year and this moment."

1. **"Did you have thoughts or plans of doing one of the following things during the last year?" If so, how many times?**

(circle):	(circle):
1. **Poison yourself**	Never / Once / More than once / Often / Very often
2. **Hang yourself**	Never / Once / More than once / Often / Very often
3. **Drown yourself**	Never / Once / More than once / Often / Very often
4. **Cut yourself**	Never / Once / More than once / Often / Very often
5. **Jump from height**	Never / Once / More than once / Often / Very often
6. **Jump in front of moving vehicle**	Never / Once / More than once / Often / Very often
7. **Burn yourself**	Never / Once / More than once / Often / Very often
8. **Other things, namely .....**	Never / Once / More than once / Often / Very often

SUICIDAL IDEATION DURING THE PAST WEEK

"Now I would like to know whether you had further thoughts about (or considered seriously to) poisoning/harming yourself during the past week."

(Interviewer: probe with the SSI-items below, in order to score the Scale for Suicide Ideation (SSI) in the right column. Interviewers should make themselves familiar with the coding of the SSI in such a way that they can code all items as a result of a normal conversation.
Please be sensitive to the severity of suicidal ideation the respondent may appear to have. Think of the instructions for the interviewer section "When respondent appears to be acutely suicidal" mentioned on page 5 and 6 of this EPSIS-II).

TO BE ASKED BY INTERVIEWER	TO BE SCORED BY INTERVIEWER CIRCLE 0, 1 OR 2
I. Characteristics of attitude toward living/dying	
1. **"What were your feelings toward living the past week. Did you wish to live, and how strong was this wish?"**	Wish to live 0. Moderate to strong 1. Weak 2. None
2. **" What were your feelings toward dying the past week. Did you wish to dy and how strong was this wish?"**	Wish to die 0. None 1. Weak 2. Moderate to strong
3. **"What were your feelings toward reasons for living and dying. Did your reasons for living outweigh those for dying, were they about the same, or did your reasons for dying outweigh those for living?"**	Reasons for living/dying 0. For living outweigh for dying 1. About equal 2. For dying outweigh for living
4. **"Did you have a desire to harming or poisoning yourself the past week?"**	Desire to make active suicide attempt 0. None 1. Weak 2. Moderate to strong
5. **"During the past week, did you have thoughts about (or may be actually did) crossing the street carelessly, not caring whether you would be overrun by a vehicle? Or did you avoid steps necessary to save or maintain life?"**	Passive suicidal attempt 0. Would take precautions to save life 1. Would leave life/death to chance (e.g. carelessly crossing a busy street) 2. Would avoid steps necessary to save or maintain life (e.g. diabetic ceasing to take insulin)

N.B.: IF ITEMS 4 AND 5 ARE SCORED WITH "0", SKIP SECTIONS II, III, and IV (=items 6 to 19).
Please continue with the questions about "Parasuicides during follow-up period" on page 21.

II. Characteristics of suicide ideation/wish

6. **"When you thought about poisoning or harming yourself during the past week, did these thoughts last only a few seconds (like in a flash back) or longer like sitting down and thinking about poisoning or harming yourself for two hours or more, or did you think about it all day?"**

Time dimension: Duration
0. Brief, fleeting periods
1. Longer periods
2. Continuous (chronic), or almost continuous

7. **"How frequent did you have these thoughts during the past week. Maybe once in this week or once every day, or more frequent?"**

Time dimension: Frequency
0. Rare, occasional
1. Intermittent
2. Persistent or continuous

8. **"What is your attitude toward your idea of harming or poisoning yourself. Do you reject it, or do you accept it?"**

Attitude toward ideation/wish
0. Rejecting
1. Ambivalent; indifferent
2. Accepting

9. **"Do you think you have a sense of control over your wish to harming or poisoning yourself?"**

Control over suicidal action/ acting-out wish
0. Has sense of control
1. Unsure of control
2. Has no sense of control

10. **"Do you have any deterrents like family, religion, the possibility of serious injury if you are unsuccessful, that prevent you from an active attempt?"**

(Indicate deterrents, if any:
.....
.....)

Deterrents to active attempt (e.g., family, religion; possibility of serious injury if unsuccessful; irreversibility)
0. Would not attempt suicide because of a deterrent
1. Some concern about deterrents
2. Minimal or no concern about deterrents

11. **"Can you tell me what you hope to accomplish by harming yourself?"**

Reason for contemplated attempt
0. To manipulate the environment; get attention, revenge
1. Combination of "0" and "2"
2. Escape, surcease, solve problems

III. Characteristics of contemplated attempt

12. **"Have you thought about how you will going to harm or poison yourself. What method were you going to use?"**

Method: Specificity/planning
0. Not considered
1. Considered, but details not worked out
2. Details worked out/well formulated

13. **"Is this method available and do you think you will have the opportunity to carry out your act?"**

Method: Availability/opportunity
0. Method not available; no opportunity
1. Method would take time/effort; opportunity not readily available
2a. Method and opportunity available
2b. Future opportunity or availability of method anticipated

14. **"Do you feel you are capable of carrying out your act?"**

Sense of "capability" to carry out attempt
0. No courage, too weak, afraid, incompetent
1. Unsure of courage, competence
2. Sure of competence, courage

15. **"Do you think you are actually going to carry out the act?"**

Expectancy/anticipation of actual attempt
0. No
1. Uncertain, not sure
2. Yes

V. Actualization of contemplated attempt

16. **"Have you made any preparations, such as saving pills, etc.?"**

Actual preparation
0. None
1. Partial (e.g., starting to collect pills)
2. Complete (e.g., had pills, razor, loaded gun)

17. **"Did you write one or more farewell letters?"**

Suicide note
0. None
1. Started but not completed; only thought about it
2. Completed

18. **"Did you do anything such as paying bills, say goodbye, write a testament?"**

Final acts in anticipation of death (e.g. insurance, will, gifts)
0. None
1. Thought about or made some arrangements
2. Made definite plans or completed arrangements

19. **"During the past week, did you tell neighbours, friends and/or family members, implicitly or explicitly, that you had the intention to harm yourself?"**

Deception/concealment of contemplated attempt (Refers to communication of ideation to interviewing person)
0. Revealed ideas openly
1. Held back on revealing
2. Attempted to deceive, conceal, lie

PARASUICIDES DURING FOLLOW-UP PERIOD

1. **"After the interview we had last year at ..... (day, month, year; mention date of initial interview), did you ever again try to deliberately poison or injure yourself? For instance by taking an overdose of medicines or drugs, by cutting your wrists, by trying to hang or drown yourself, by provoking accidents involving yourself, etc. How many times did you do such things in the period between interview last year and this moment?"**

   Number of parasuicides: .....

   If patient cannot recall the exact number of parasuicides, please indicate the estimated number of parasuicides during follow-up:
   (circle):
   a. < 4 parasuicides
   b. 5 - 10 parasuicides
   c. 11 or more parasuicides

IF NO PARASUICIDES DURING FOLLOW-UP PERIOD CONTINUE WITH SECTION "SUICIDAL BEHAVIOUR BY OTHER PERSONS" ON PAGE 33.

2. **"Can you tell me more about these happenings? Please start with the first time you poisoned or harmed yourself after the interview last year."**

   Probe with questions for each parasuicide:
   A. What did you do?
   B. How long was the period between interview last year and that time you poisoned/harmed yourself?
   C. What happened next? Were you treated in a general hospital?
   D. Did you receive any other professional help afterwards, e.g. by a psychiatrist?

Start with first subsequent parasuicide after initial interview (= 1) and then go forward in time (2, 3, 4, 5, 6, 7, 8, 9 and 10). If more than 10 parasuicides: score the first 9 parasuicides at numbers 1 to 9 and the last (= most recent) parasuicide at section number 10.

FOLLOW-UP PARASUICIDE NUMBER

	1	2	3	4	5	6	7	8	9	10 (or if >10: last parasuicide)
A. Method										
1. Poisoning										
2. Hanging	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....
3. Drowning										
4. Cutting										
5. Jumping from height										
6. Jumping in front of moving vehicle										
7. Burning										
8. Other										

	1	2	3	4	5	6	7	8	9	10 (or if if >10: last parasuicide)
B. Time lapse between initial interview and event (hierarchically)										
1. less than 1 day	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....
2. less than 1 week										
3. less than 1 month										
4. less than 3 months										
5. less than 12 months										
6. 12 months or more										

FOLLOW-UP PARASUICIDE NUMBER

C. Somatic treatment	1	2	3	4	5	6	7	8	9	10 (or if >10: last parasuicide)
1. None										
2. General practitioner	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....
3. General hospital										
4. Other										
5. General practitioner and general hospital										

D. Psychiatric treatment	1	2	3	4	5	6	7	8	9	10 (or if >10: last parasuicide)
1. None										
2. In-patient	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....
3. Out-patient										
4. In-patient and out-patient										

3. **"In the period between your admission in the ..... Hospital last year because of taking too many pills/self-injury and the date of interview last year, did you ever again try to deliberately poison or injure yourself?"** (Interviewer: indicate to respondent how long the time lapse was between index parasuicide and date of initial interview).

Number of parasuicides in period between index parasuicide and initial interview: .....

CIRCUMSTANCES OF FIRST SUBSEQUENT AND LAST (= MOST RECENT) PARASUICIDE

(Interviewer: First ask circumstances of FIRST SUBSEQUENT parasuicide and fill out all the SIS-items, than (in case of more than one repeated parasuicide during follow-up period) ask the same questions for the LAST parasuicide. If patient has done one parasuicide during follow-up: score in column 'LAST parasuicide').

"Now, after the general questions, let us talk about the things that happened just before the FIRST SUBSEQUENT / LAST time you poisoned/harmed yourself. Please think back to what happened and describe as exactly as possible what led to your self-poisoning/self-harming."

Write out essentials. Probe with the SIS-questions in the left column below, in order to score the Suicide Intent Scale (SIS) in the right column. Only if you are completely sure about it, skip questions on which the answers are clearly implicit in patient's account of what happened.
(Interviewers should make themselves familiar with the coding of the SIS in such a way that they can code all items as a result of a normal conversation. Please encourage the respondent to give a narrative of what has happened, and use the questions below as a checklist to make sure that you have covered all the relevant topics. In order to give codes you should be absolute sure. So if you are not completely sure, use your own additional probings, or use the questions written down, in such a way that it facilitates coding).

Concerning questions 1 to 8 you should give your rating, your judgement, according to your impression of the narrative of the respondent. Questions 9 to 15 concern the communications of the respondent. Please code what the respondent sais, even though you might have another impression.

TO BE ASKED BY INTERVIEWER	S I S TO BE SCORED BY INTERVIEWER CIRCLE 0,1 or 2	FIRST subseq. paras.	LAST
1. **"Was anybody near you when you tried to harm yourself? e.g. in the same room, telephone conversation."**	Isolation		
	0. Somebody present	0	0
	1. Somebody nearby or in contact (e.g. telephone)	1	1
	2. No one nearby or in contact	2	2
2. **"At what moment did you do it? Were you expecting someone. Could someone soon arrive? Did you know that you had some time before anyone could arrive? Or didn't you think about the possibility?"**	Timing		
	0. Timed so that intervention is probable	0	0
	1. Timed so that intervention is not likely	1	1
	2. Timed so that intervention is highly unlikely	2	2
3. **"Did you do anything to prevent that someone could find you? e.g. disconnect the telephone, put a note on the door, etc."**	Precautions against discovery and/or intervention		
	0. No precautions at all	0	0
	1. Passive precautions, such as avoiding others but doing nothing to prevent their intervention (e.g. being alone in room with unlocked door)	1	1
	2. Active precautions (e.g. being alone in room with door locked)	2	2

			FIRST subseq.	LAST paras.
4.	**"After you harmed yourself, did you call someone to tell what you just did?"**	Action to gain help after the attempt		
		0. Notified potential helper regarding attempt	0	0
		1. Contacted but did not specifically notify potential helper regarding attempt	1	1
		2. Did not contact or notify helper	2	2
5.	**"Did you do anything such as paying bills, say goodbye, write a testament, once you decided to harm yourself."**	Final act in anticipation of death		
		0. None	0	0
		1. Patients thought about making or made some arrangements in anticipation of death	1	1
		2. Definite plans made (making up or changing a will, giving gifts, taking out insurance)	2	2
6.	**"Had you planned it for some time? Did you make any preparations such as saving pills, etc.?"**	Degree of planning		
		0. No preparation (no plan)	0	0
		1. Minimal or moderate preparation	1	1
		2. Extensive preparation (detailed plan)	2	2
7.	**"Did you write one or more farewell letters?"** If yes: to whom? If no: did you think about writing one?	Suicide note (farewell letter)		
		0. Neither written a note, nor thought about writing one	0	0
		1. Thought about writing one, but had not done so	1	1
		2. Presence of note, or note written but torn up	2	2
8.	**"During the past year, did you tell neighbours, friends and/or family members, implicitly or explicitly, that you had the intention to harm yourself?"**	Communications of intent before act		
		0. None	0	0
		1. Equivocal communication (ambiguous or implied)	1	1
		2. Unequivocal communication (explicit)	2	2
9.	**"Can you tell me what you hoped to accomplish by harming yourself?"**	Purpose of act		
		0. Mainly to manipulate others	0	0
		1. Temporary rest	1	1
		2. Death	2	2
10.	**"What did you think were the chances that you would die as a result of your act?"**	Expectations regarding fatality of act		
		0. Patient thought that death was unlikely or didn't think about it	0	0
		1. Patient thought that death was possible but not probable	1	1
		2. Patient thought that death was probable or certain	2	2

		FIRST subseq.	LAST paras.
11. If overdose **"Did you think that the amount of pills you took were more, or less, than the dose that would kill you? (Did you have more pills? Else "Did you think about other methods that would be more, or less dangerous than what you did?"**	Conceptions of method's lethality		
	0. Patient did less to him/herself than he/she thought would be lethal, or patient didn't think about it	0	0
	1. Patient was not sure or, thought what he/she did might be lethal	1	1
	2. Act exceeded or equaled what patient thought was lethal	2	2
12. **"Did you consider your act to be an attempt to take your life?"**	Seriousness of attempt		
	0. Patient did not consider act to be a serious attempt to end his/her life	0	0
	1. Patient was uncertain whether act was a serious attempt to end his/her life	1	1
	2. Patient considered act to be a serious attempt to end his/her life	2	2
13. **"What were your feelings toward life and death? Did you want to live more strongly than you wanted to die? or didn't you care whether to live or die?"**	Ambivalence towards living		
	0. Patient did not want to die	0	0
	1. Patient did not care whether he/she lived or died	1	1
	2. Patient wanted to die	2	2
14. **"What did you think were the chances to survive if you would receive medical treatment afterwards?"**	Conception of reversibility		
	0. Patient thought that death would be unlikely if he/she received medical attention	0	0
	1. Patient was uncertain whether death could be averted by medical attention	1	1
	2. Patient was certain of death even if he/she received medical attention	2	2
15. **"How long before your act had you decided to do it? Had you thought about it for some time or did you do it impulsively?"**	Degree of premediation		
	0. None, impulsive	0	0
	1. Act contemplated for three hours or less prior to attempt	1	1
	2. Act contemplated for more than three hours before attempt	2	2

PRECIPITATING FACTORS OF FIRST SUBSEQUENT AND LAST (= MOST RECENT) PARASUICIDE

(If patient has done one parasuicide during follow-up: score questions on section 'LAST parasuicide').

1A. **'Now I would like to ask you about the FIRST SUBSEQUENT time you (poisoned/harmed) yourself. At that time, were there any special events or circumstances that led to your act?'**

Narrative. Write out answer

(After having written down the narrative go on with question number 2 and 3 on the next page section 'FIRST SUBSEQUENT parasuicide', and then (if necessary) go on with question 1B, 2 and 3 about the last parasuicide)

1B. **'Now I would like to ask you about the LAST time you (poisoned/harmed) yourself. At that time, were there any special events or circumstances that led to your act?'**

Narrative. Write out answer

2. **"There may be many reasons why people who have problems take pills or injure themselves. Please indicate whether the problems that I will mention had major influence on what you did then, had a minor influence on what you did or had no influence at all."**

Problem checklist (read out categories, skip categories that are clearly not applicable)

		FIRST SUBSEQUENT PARASUICIDE	LAST PARASUICIDE
1.	Problems with your partner	No / Minor / Major	No / Minor / Major
2.	Problems with your parents	No / Minor / Major	No / Minor / Major
3.	Problems with your children	No / Minor / Major	No / Minor / Major
4.	Feelings of loneliness	No / Minor / Major	No / Minor / Major
5.	Problems in making or maintaining friendships and social relations	No / Minor / Major	No / Minor / Major
6.	Rejection by a lover	No / Minor / Major	No / Minor / Major
7.	Physical illness or disability	No / Minor / Major	No / Minor / Major
8.	Mental illness and psychiatrical symptoms	No / Minor / Major	No / Minor / Major
9.	Unemployment	No / Minor / Major	No / Minor / Major
10.	Addiction (to alcohol, drugs, medicines, gambling, etc.)	No / Minor / Major	No / Minor / Major
11.	Problems with treatment	No / Minor / Major	No / Minor / Major

3. **"Where there any other events or circumstances that had an influence on what you did?"**

If patient mentions one or more events or circumstances specify:

FIRST SUBSEQUENT PARASUICIDE	LAST PARASUICIDE
1. ..... / Minor / Major	1. ..... / Minor / Major
.....	.....
2. ..... / Minor / Major	2. ..... / Minor / Major
.....	.....
3. ..... / Minor / Major	3. ..... / Minor / Major
.....	.....

MOTIVES FOR FIRST SUBSEQUENT AND LAST (= MOST RECENT) PARASUICIDE

(Interviewer: when patient reported to have done more than one parasuicide during follow-up period, please start with asking the following questions with respect to the first subsequent parasuicide and then with respect to the last parasuicide. If patient reported to have done one parasuicide during follow-up period, please fill out the answers in the column LAST parasuicide).

1. **"Just like there can be many problems that lead people to take pills or injure themselves, there can be many different intentions for it. Here I have a list with a number of reasons people can have for taking pills or harming themselves. Please think back to how YOU felt the FIRST SUBSEQUENT / LAST time you took pills or injured yourself after the initital interview. I will read the reasons in the list to you, and I would like you to indicate for each reason, whether it was a reason for YOU the FIRST SUBSEQUENT / LAST TIME you poisoned/harmed yourself. Please indicate if the reason played no role in what you did** (interviewer: circle NO INFLUENCE) **the reason played a minor role** (circle MINOR INFLUENCE) **or if the reason played a major role in what you did** (circle MAJOR INFLUENCE). **There are no right or wrong answers."**

TO BE ASKED BY INTERVIEWER	TO BE SCORED BY INTERVIEWER: CIRCLE 1, 2 OR 3	FIRST subseq. paras.	LAST paras.
1. My thoughts were so unbearable, I could not endure them any longer.	1. No influence	1	1
	2. Minor influence	2	2
	3. Major influence	3	3
2. I wanted to show someone how much I loved him/her.	1. No influence	1	1
	2. Minor influence	2	2
	3. Major influence	3	3
3. It seemed that I lost control over myself, and I do not know why I did it.	1. No influence	1	1
	2. Minor influence	2	2
	3. Major influence	3	3
4. The situation was so unbearable that I could not think of any other alternative.	1. No influence	1	1
	2. Minor influence	2	2
	3. Major influence	3	3
5. I wanted to get away for a while from an unacceptable situation.	1. No influence	1	1
	2. Minor influence	2	2
	3. Major influence	3	3
6. I wanted others to know how desperate I felt.	1. No influence	1	1
	2. Minor influence	2	2
	3. Major influence	3	3
7. I wanted to die.	1. No influence	1	1
	2. Minor influence	2	2
	3. Major influence	3	3

			FIRST subseq. paras.	LAST paras.
8.	I wanted to get help from someone.	1. No influence	1	1
		2. Minor influence	2	2
		3. Major influence	3	3
9.	I wanted to know if someone really cared about me.	1. No influence	1	1
		2. Minor influence	2	2
		3. Major influence	3	3
10.	I wanted other to pay for the way they treated me.	1. No influence	1	1
		2. Minor influence	2	2
		3. Major influence	3	3
11.	I wanted to make someone feel guilty.	1. No influence	1	1
		2. Minor influence	2	2
		3. Major influence	3	3
12.	I wanted to persuade someone to change his/her mind.	1. No influence	1	1
		2. Minor influence	2	2
		3. Major influence	3	3
13.	I wanted to make things easier for others.	1. No influence	1	1
		2. Minor influence	2	2
		3. Major influence	3	3
14.	I wanted to sleep for a while.	1. No influence	1	1
		2. Minor influence	2	2
		3. Major influence	3	3

2. **"Were there any other reasons that had an influence on what you did? can you tell what they were?"**

FIRST SUBSEQUENT PARASUICIDE		LAST PARASUICIDE	
	Circle:		Circle:
1.	Minor infl./ Major infl.	1.	Minor infl./ Major influence
.....		.....	
2.	Minor infl./ Major infl.	2.	Minor infl./ Major influence
.....		.....	
3.	Minor infl./ Major infl.	3.	Minor infl./ Major influence
.....		.....	

CONSEQUENCES OF INDEX- AND LAST (= MOST RECENT) PARASUICIDE

(Interviewer: The following questions in this section should always be asked for the INDEX PARASUICIDE. Besides that, if applicable, these questions should also be asked for the LAST PARASUICIDE undertaken during follow-up period).

1. **"I would like to know how then, after the TIME YOU POISONED/HARMED YOURSELF LAST YEAR AND WERE INVITED TO PARTICIPATE IN THIS STUDY** (=index parasuicide), **your relatives and friends reacted to what you had done. I will mention some possible reactions, and I would like you to indicate whether such a reaction was showed by no one of your family and friends, by one of them, or by some of them."** (Interviewer: score answers in column INDEX parasuicide)

2. (If applicable:) **"Now, I would like to know how, after the LAST TIME you poisoned/harmed yourself, your relatives and friends reacted to what you had done. I will mention some possible reactions, and once again I would like you to indicate whether such a reaction was showed by no one of your family and friends, by one of them, or by some of them."** (Interviewer: score answers in column LAST parasuicide)

Read out reactions A to G and circle in the column concerned

			INDEX paras.	LAST paras.
A.	They felt pity for you	1. No one	1	1
		2. One person	2	2
		3. Some people	3	3
B.	They showed understanding	1. No one	1	1
		2. One person	2	2
		3. Some people	3	3
C.	They showed anger or irritation	1. No one	1	1
		2. One person	2	2
		3. Some people	3	3
D.	They felt embarrassed, tried to avoid you	1. No one	1	1
		2. One person	2	2
		3. Some people	3	3
E.	They felt uncertain	1. No one	1	1
		2. One person	2	2
		3. Some people	3	3
F.	They laughed at you	1. No one	1	1
		2. One person	2	2
		3. Some people	3	3
G.	Other	1. No one	1	1
		2. One person	2	2
		3. Some people	3	3

3. **"I would also like to know how you felt, after that time you poisoned/harmed yourself and were invited to this study. I will again mention some possible feelings, and I would like you to say whether that applied to you. Please think back to how you felt one week after that time you (poisoned/harmed) yourself."** (Interviewer: score answers in column INDEX parasuicide).

4. **"Now, I would also like to know how you felt, after the LAST TIME you poisoned/harmed yourself. Once again, I will mention some possible feelings, and I would like you to say whether that applied to you. Please think back to how you felt one week after the LAST TIME you poisoned/harmed yourself."** (Interviewer: score answers in column LAST parasuicide).

Read out A to K and circle

			INDEX paras.	LAST paras.
A.	Did you feel good?	1. Yes 2. No	1 2	1 2
B.	Did you feel released?	1. Yes 2. No	1 2	1 2
C.	Did you feel proud because you managed to carry it through?	1. Yes 2. No	1 2	1 2
D.	Did you feel pity about yourself? to carry it through?	1. Yes 2. No	1 2	1 2
E.	Did you feel angry about yourself?	1. Yes 2. No	1 2	1 2
F.	Did you feel afraid of yourself?	1. Yes 2. No	1 2	1 2
G.	Did you feel uncertain of yourself?	1. Yes 2. No	1 2	1 2
H.	Did you feel ashamed of yourself?	1. Yes 2. No	1 2	1 2
I.	Did you feel uncertain towards others?	1. Yes 2. No	1 2	1 2
J.	Did you feel embarrassed?	1. Yes 2. No	1 2	1 2
K.	Other	1. Yes 2. No	1 2	1 2

SUICIDAL BEHAVIOUR BY OTHER PERSONS

"To your knowledge, has one of your relatives or close friends or (if applicable) other patients deliberately poisoned or injured him or herself last year? Can you tell me more about such happenings?".

Probe with questions for each other person:

A. **"What relation was/is he/she to you?"**
B. **"Did (relation) die as a result of this act?"**
C. **"How long ago did it happen?"**
D. **"What did he/she do?"**
E. If other patient: **"Was this a patient admitted to the same ward as you were in, or was he/she a patient from another ward?"**
F. **"Were you personally involved in what he/she did? By that, I mean whether you were physically present, in telephone contact, or whether you advised immediately before or after the act."**

	OTHER PERSON NUMBER				
	1	2	3	4	5
A. Relationship of other person to respondent (other person was/is respondent's ....)	.....	.....	.....	.....	.....
1. Wife					
2. Husband					
3. Cohabitee					
4. Daughter					
5. Son					
6. Mother					
7. Father					
8. Sister					
9. Brother					
10. Grandmother					
11. Grandfather					
12. Other relative					
13. Close friend					
14. Other patient in general hospital					
15. Other patient in psychiatric ward					
B. Type of behaviour					
1. Parasuicide 2. Suicide	.....	.....	.....	.....	.....
C. Was the other person's suicidal behaviour before or after the last parasuicide respondent ever did? In case of before: what was the time lapse between model event and respondent's last parasuicide?	.....	.....	.....	.....	.....
1. After respondent's last parasuicide					
2. Before: less than 1 day					
3. Before: less than 1 week					
4. Before: less than 1 month					
5. Before: less than 3 months					
6. Before: less than 12 months					
7. Before: 12 months or more					
D. Method used by other person	.....	.....	.....	.....	.....
1. Poisoning					
2. Hanging					
3. Drowning					
4. Cutting					
5. Jumping from height					
6. Jumping in front of moving vehicle					
7. Burning					
8. Other					

	OTHER PERSON NUMBER 1	2	3	4	5
E. (In case other person was **other patient**): Was other person in-patient at the same ward as where respondent was admitted to?	.....	.....	.....	.....	.....
1. Other person was in-patient at the same psychiatric ward as where respondent was in-patient at the same time.					
2. Other person was in-patient at another psychiatric ward as where respondent was in-patient at the same time.					
F. Personal involvement of respondent in other person's act	.....	.....	.....	.....	.....
1. No					
2. Yes, physically present					
3. Yes, in telephone contact					
4. Yes, advised immediately before/after act					
5. Yes, other					

GENERAL HEALTH

"In order to assess how your health has been in general over the past few weeks, I would like you to complete the following questionnaire. Please read the instructions on top of the questionnaire carefully, and ask me if you have any questions."

TURN THIS PAGE AND HAND OVER BOOKLET TO THE RESPONDENT

SELF-REPORT

"We should like to know if you have had any medical complaints, and how your health has been in general over the past few weeks. Please answer ALL the questions on the following pages simply by circling the answer which you think most nearly applies to you. Remember that we want to know about the present and recent complaints, not those that you had in the past. It is important that you try to answer ALL the questions."

HAVE YOU RECENTLY:	CIRCLE:			
1. been able to concentrate on whatever you're doing?	Better than usual	Same as usual	Less than usual	Much less than usual
2. lost much sleep over worry?	Not at all	No more than usual	Rather more than usual	Much more than usual
3. been having restless, disturbed nights?	Not at all	No more than usual	Rather more than usual	Much more than usual
4. been managing to keep yourself busy and occupied?	More so than usual	Same as usual	Rather less than usual	Much less than usual
5. been getting out of the house as much as usual?	More so than usual	Same as usual	Less than usual	Much less than usual
6. been managing as well as most people would in your shoes?	Better than most	About the same	Rather less well	Much less well
7. felt on the whole you were doing things well?	Better than usual	About the same	Less well than usual	Much less well
8. been satisfied with the way you've carried out your task?	More satisfied	About same as usual	Less satisfied than usual	Much less satisfied
9. been able to feel warmth and affection to those near to you?	Better than usual	About same as usual	Less well than usual	Much less well
10. been finding it easy to get on with other people?	Better than usual	About same as usual	Less well than usual	Much less well
11. spent much time chatting with people?	More time than usual	About same as usual	Less time than usual	Much less than usual
12. felt that you are playing a useful part in things?	More so than usual	Same as usual	Less useful than usual	Much less useful
13. felt capable of making decisions about things?	More so than usual	Same as usual	Less so than usual	Much less capable
14. felt constantly under strain?	Not at all	No more than usual	Rather more than usual	Much more than usual
15. felt you couldn't overcome your difficulties?	Not at all	No more than usual	Rather more than usual	Much more than usual

16. been finding life a struggle all the time?	Not at all	No more than usual	Rather more than usual	Much more than usual
17. been able to enjoy your normal day-to-day activities?	More so than usual	Same as usual	Less so than usual	Much less than usual
18. been taking things hard?	Not at all	No more than usual	Rather more than usual	Much more than usual
19. been getting scared or panicky for no good reason?	Not at all	No more than usual	Rather more than usual	Much more than usual
20. been able to face up to your problems?	More so than usual	Same as usual	Less able than usual	Much less able
21. found everything getting on top of you?	Not at all	No more than usual	Rather more than usual	Much more than usual
22. been feeling unhappy and depressed?	Not at all	No more than usual	Rather more than usual	Much more than usual
23. been loosing confidence in yourself?	Not at all	No more than usual	Rather more than usual	Much more than usual
24. been thinking of yourself as a worthless person?	Not at all	No more than usual	Rather more than usual	Much more than usual
25. felt that life is entirely hopeless?	Not at all	No more than usual	Rather more than usual	Much more than usual
26. been feeling hopeful about your own future?	More so than usual	About same as usual	Less so than usual	Much less hopeful
27. been feeling reasonably happy, all things considered?	More so than usual	About same as usual	Less so than usual	Much less than usual
28. been feeling nervous and strung-up all the time?	Not at all	No more than usual	Rather more than usual	Much more than usual
29. felt that life isn't worth living?	Not at all	No more than usual	Rather more than usual	Much more than usual
30. found at times you couldn't do anything because your nerves were too bad?	Not at all	No more than usual	Rather more than usual	Much more than usual

WHEN FINISHED, PLEASE HAND OVER THE BOOKLET BACK TO THE INTERVIEWER

PHYSICAL HEALTH

1. **"In the period between the interview last year and this interview, did you have a physical illness or disability that was a consequence of your poisoning/harming yourself and that has affected you or is likely to affect you for a long period of time?"** (Interviewer: include index parasuicide and all other repeated parasuicides during follow-up period)

   Circle: Yes / No (If Yes: continue with 1A en 1B)

1A. If yes: Physical disability was a consequence of:

	Circle:
Index parasuicide	Yes / No
First subsequent parasuicide	Yes / No
Any other (but last) parasuicide during follow-up	Yes / No
Last parasuicide	Yes / No

1B. If Yes:
"What was the matter with you?"

.....

.....

2. **"Over the last three months, would you say your physical health on the whole has been excellent, good, fair, or poor?"**

   Circle Excellent / Good / Fair / Poor

MENTAL HEALTH

1. **"Did you this year experience for prolonged periods of time (for 3 months or more) troubles within yourself that hindered your functioning? (Make this question more clear if needed by giving examples like:) For example fears of places, or anxiety to leave your house, or fear of people in general, or depressive feelings, or other emotions or thoughts that influenced you repeatedley, like obsessions or may be to be compelled to clean yourself or your house, etc."**

   Circle Yes / No

1A. If Yes:
"What was the matter with you?"

.....

.....

2. **"Over the last three months, would you say your mental health on the whole has been excellent, good, fair, or poor?"**

   Circle Excellent / Good / Fair / Poor

CONTACT WITH HEALTH SERVICES IN THE PERIOD BETWEEN INDEX PARASUICIDE AND FOLLOW-UP INTERVIEW

(INSTRUCTION: Please read this carefully before filling out this questionnaire!

The purpose of this questionnaire is to summarize all contacts with health care services respondent has had in the period between date of index parasuicide and follow-up interview.

SECTION A: starts with some questions about the admission/treatment in general hospital because of the index parasuicide last year.

The next sections (B, C and D) all concern respondent's contacts with MENTAL health care services in the period between discharge from general hospital last year and follow-up interview.

SECTION B: focuses on contacts with a general practitioner or family doctor in this period.

SECTION C: focuses on help received through in-patient psychiatric treatment (in psychiat. hospital/ward), out-patient treatment by a psychiatrist, psychologist, social worker or any other mental health care professional.
The beginning + end of these in- and out-patient treatments are to be indicated on the flowchart at page 42. This flowchart has to be filled out precisely, since the period in which respondent was in a certain kind of treatment facility will be coded on base of this flowchart (sie also instructions at section C).

SECTION D: concerns the evaluation of in-patient and out-patient treatment.
Per category "In-patient psychiatric treatment" (= 'I' at the flowchart) and per category "Out-patient treatment (= 'IIa, IIb and IIc' at the flowchart) the FIRST treatment respondent received after the index parasuicide is evaluated with the questions in section D. All the other possible contacts with mental health care services later on in the follow-up period are not evaluated. Only their beginning and end are indicated at the flowchart. Reasons for not evaluating all contacts are that: a) it would take too much time in the interview, and b) this study is primarily interested in the evaluation of mental health care treatment immediately following the index parasuicide.)

SECTION A: INFORMATION ON ADMISSION OR TREATMENT IN GENERAL HOSPITAL WHERE RESPONDENT WAS TREATED BECAUSE OF INDEX PARASUICIDE

"First I would like you to think back to ..... (interviewer: mention date of index parasuicide) **when you were treated in the ..... Hospital because of poisoning/harming yourself. I mean the time you were also invited to participate in this study."**

1. **"Do you have any recollections of your stay in that Hospital?"**

   (circle): Yes / Vaguely / No

2. **"How long did you stay in that hospital? How many days?"**

   Number of days: .....
   If less than one day, specify:
   a. less than 6 hours
   b. less than 12 hours
   c. less than 24 hours

   (When this information is already known from the first interview, please copy this information on the dotted line and check whether it was correct)

3. **"What did you think of the treatment you received in that hospital:**

   a. With respect to the somatic/medical aspects of the treatment?"

   (circle): Very bad / Bad / Not good, not bad / Good / Very good

   b. "With respect to the psychosocial aspects of the treatment. E.g. did you feel that you and your problems were taken seriously?"

   (circle): Very bad / Bad / Not good, not bad / Good / Very good

4. **"When you were discharged from hospital then, did the hospital refer you to any health care service?"**

   (circle): No / Yes / Don't know anymore

   If yes: **"Where were you referred to** (answer in first column below). **Were you already treated there just before that time you poisoned/harmed yourself?"** (answer in second column below).

Respondent was referred to: (circle, more alternatives possible):	Respondent was already treated there just before the index parasuicide:
1. General practioner/family doctor	Yes / No
2. Psychiatric hospital (in-patient)	Yes / No
3. Out-patient treatment by psychiater	Yes / No
4. Out-patient treatment by psychologist	Yes / No
5. Out-patient treatment by social worker	Yes / No
6. Out-patient treatment by other mental health care profssional, namely	Yes / No
7. Other, namely	Yes / No

SECTION B: CONTACT WITH GENERAL PRACTITIONER / FAMILY DOCTOR

5. **"In the period between discharge from hospital last year and this moment: how many times did you see a general practitioner or family doctor?"**

   (circle): Not / One time / 2-3 times / 4 or more times (if Not: continue with question 8)

6. **"Could you give the approximate date of the first contact you had with G.P. in this period?"**

   Time lapse between date of discharge from hospital and first contact with G.P. is:

   (circle):
   1. less than 1 week
   2. less than 2 weeks
   3. less than 1 month
   4. less than 2 months
   5. less than 3 months
   6. less than 12 months
   7. 12 months or more

7. **"On the whole, what do you think of your contact(s) with the G.P. this year?"**

   (circle): Very bad / Bad / Not good, not bad / Good / Very good / Not applicable

SECTION C: CONTACT WITH IN-PATIENT PSYCHIATRIC SERVICES AND OUT-PATIENT MENTAL HEALTH CARE SERVICES: TIME PERIODS

8. **"Now I would like to ask you to summarize ALL contacts with mental health care services you (might) have had in the period between discharge from hospital last year and this moment. What I would like to know is when these contacts / this treatment began and when this ended. Here I have a flowchart on which I will draw lines to indicate the periods in which you had contacts with these services. So, after discharge from hospital, where did you go to first?"** Continue with questions like: **"After you finished your contacts/treatment at ..... did you have any other contacts with mental health care professionals in this period."** If yes: **"When did this begin and when did this end?"** Continue untill you have had all contacts with mental health care services in this period.

   (Interviewer: Indicate at the flowchart at the next page the beginning + end of ALL treatment services respondent has had contact with to in the period between discharge from general hospital and date of follow-up interview. As you can see on the flowchart at page 42, there are several lines indicating the number of months passed since date of index parasuicide. You are asked to indicate on the line concerned when contact/treatment/admission started and when it ended. If respondent was already in the mental health care service concerned just before the index parasuicide, the beginning of the period should start on the 0 (zero= date of index parasuicide). If a contact/treatment/admission is not ended at time of follow-up interview, but is still going on, the month in which follow-up interview takes place will be considered as the end.
   IN THE APPENDIX (at page 62 et seq.) AN EXAMPLE IS GIVEN OF HOW TO USE THE FLOWCHART. Always fill out the date of index parasuicide, date of discharge from general hospital, date of initial interview and date of follow-up interview in order to structure respondent's memory.)

   When finished continue with SECTION D at page 43.

CONTACT WITH MENTAL HEALTH CARE SERVICES IN PERIOD BETWEEN INDEX PARASUICIDE AND FOLLOW-UP INTERVIEW

DATE OF: index parasuicide: ... - ... - 19...; discharge from gen. hospital: ... - ... - 19...; initial interv.: ... - ... - 19...; follow-up interv.: ... - ... - 19...

MONTHS AFTER INDEX PARASUICIDE:

	0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18
Contact with mental health services:																			
I. In-patient psychiatric treatment:																			
1.																			
2.																			
3.																			
4.																			
IIa. Out-pat. treatm.: by psychiatrist:																			
1.																			
2.																			
3.																			
4.																			
IIb. Out-pat. treatm.: by psychologist:																			
1.																			
2.																			
3.																			
4.																			
IIc. Out-pat. treatm.: by social worker or any other mental health care professional (please specify):																			
1.																			
2.																			
3.																			
4.																			
5.																			
6.																			

SECTION D: EVALUATION OF FIRST IN-PATIENT PSYCHIATRIC TREATMENT AND/OR FIRST OUT-PATIENT TREATMENT AFTER INDEX PARASUICIDE

If patient has had any in- or out-patient contact with a mental health care service:

9. **"You just told me what kind of professional help you have received during the past year. Now I would like to ask you what you think about the help/treatment you received (immediately) following your discharge from hospital last year.** If apllicable: **" With respect to your first admission in a psychiatric hospital and** (if apllicable) **with respect to your first out-patient contact with a mental health care professional I would like to ask you some questions."**

If applicable:
Fill out questions 9A to 9L (page 44-45) for the FIRST admission in a psychiatric hospital which has taken place after index parasuicide (section I of the flowchart).
Fill out questions 9A to 9H for the FIRST contact/treatment with an out-patient mental health service the patient has had after the index parasuicide (section IIa, IIb or IIc of the flowchart).
The evaluations are made irrespective of whether the treatment/admission is ended at time of follow-up interview or not. All other treatments/ contacts are NOT evaluated.

Questions 9A to 9L our filled out with respect to:
I. First in-patient psychiatric treatment: Yes / No / Not applicable

Period in which this admission took place (to be filled out by interviewer: see flowchart):
Month beginning: ..... (write down number of months after index parasuicide similar to the number indicated at the flowchart. E.g. if respondent was admitted to a psychiatric hopsital within a month after discharge from general hospital: month beginning = 1. If patient was already admitted to this psychiatric hospital at moment of index parasuicide: month beginning = 0 (zero)).

Month end: ..... (write down number of months after index parasuicide similar to the number indicated at the flowchart. E.g. if admission ended at a date 6 months after index parasuicide: month ending = 6.)

Duration of admission in weeks: ..... (number of weeks)

II. First out-patient mental health care treatment: Yes / No / Not applicable
If yes, circle:
a. from psychiatrist
b. from psychologist
c. from social worker
d. from other mental health care professional, namely .....

Period in which treatment took place (to be filled out by interviewer: see flowchart):
Month beginning: ..... (write down number of months after index parasuicide similar to the number indicated at the flowchart. See also example above.
Month end: ..... (write down number of months after index parasuicide similar to the number indicated at the flowchart. See also example above)

(Interviewer, ask additional information with respect to number of contacts with mental health care professional + average length of contacts):
"With respect to the first out-patient treatment you have had with the psychiatrist/psychologist/social worker/..... (other professional), **How many contacts did you have with this professional and what was the average length per contact?"**

(Estimated) number of contacts: .....

Average length of contacts: ..... (in minutes)

	I In-patient psychiatric treatment	II Out-patient treatment
9A. **"Did you and the mental health care professional** (in case of admission to Psychiatric Hosp.: **the doctor who treated you) discuss the fact that you had taken too many pills/ injured yourself** (interviewer: refer to the date of index parasuicide) **and the motives or reasons you had to do that?"** 1. Extensively 2. Considerably 3. More or less 4. A little bit 5. Not at all	.....	.....
9B. **"Was the mental health care professional** (in case of admission in Psychiatric Hosp.: **the doctor who treated you) able to show understanding for you and your problems?"** 1. Very well 2. Well 3. Not well / not badly 4. Badly 5. Very badly	.....	.....
9C. **"How did the treatment link up with your problems?"** 1. Very well 2. Well 3. Not well / not badly 4. Badly 5. Very badly	.....	.....
9D. **"Did you feel you and your problems were taken seriously?"** 1. Very well 2. Well 3. Not well / not badly 4. Badly 5. Very badly	.....	.....
9E. **"Did you feel at ease during this contact / admission?"** 1. Very well 2. Well 3. Not well / not badly 4. Badly 5. Very badly	.....	.....
9F. **"Did the mental health care professional(s) had an open attitude on critics?"** 1. Very much 2. Rather much 3. Not much / little 4. Hardly 5. Not at all	.....	.....

	I In-patient psychiatric treatment	II Out-patient treatment
9G. **"Did you feel the mental health care professional(s) paid enough attention to you and your problems?"** 1. Very much 2. Rather much 3. Not much / little 4. Hardly 5. Not at all	.....	.....
9H. **"If family or friends of you would have the same problems as you had then, would you recommend them to ask for help at the same mental health care professional / hospital?"** 1. Yes, surely 2. Yes, probably 3. Don't know 4. Probably not 5. Surely not	.....	.....
Questions 9I to 9L only in case of in-patient psychiatric <u>treatment:</u>		
9I. **"Was the nursing staff able to show understanding for you and your problems?** 1. Very well 2. Well 3. Not well / not badly 4. Badly 5. Very badly	.....	
9J. **"What did you think of the contact you had with fellow patients?"** 1. Very pleasant 2. Pleasant 3. Not pleasant / not unpleasant 4. Unpleasant 5. Very unpleasant	.....	
9K. **"What did you think of your privacy?"** 1. Very good 2. Good 3. Not good / not bad 4. Bad 5. Very bad	.....	
9L. **"What did you think of the atmosphere at the hospital / ward?"** 1. Very pleasant 2. Pleasant 3. Not pleasant / not unpleasant 4. Unpleasant 5. Very unpleasant	.....	

LIFE EVENTS DURING FOLLOW-UP PERIOD

"Now I would like to continue with another questionnaire. This section contains questions on the kind of events and problems you, or other people who play a role in your life, have experienced in the period between the interview last year and this interview. The questionnaire refers to six groups of people, and each group deals with people who may play a role in your life, such as your PARENTS, BROTHERS OR SISTERS, PARTNER, CHILDREN, OTHER IMPORTANT PERSONS, and of course you YOURSELF."

(Interviewer, please prepare yourself on this questionnaire on basis of the information gathered in the initial interview. This is to prevent you from putting silly questions, e.g. about the section 'Parents' whilst respondent's parents have died before index parasuicide, or e.g. the section "Child(ren), whilst the respondent doesn't have any children. When a section/group is not applicable to the respondent, e.g. you can fill in 'not applicable' (=na) as indicated in the questionnaire).

"In the following I am going to ask you whether certain events have happened in the period between the interview last year and this moment, and to whom these events did happen. Of course there can be more events of importance that happened to you and are not explicitly mentioned in this questionnaire. Please feel free to tell me any event that happened last year that had a big impact on you."

IF YOU FEEL THAT THE PATIENT UNDERSTANDS WELL, PROCEED WITH THE QUESTIONNAIRE

(Please be very sensitive to the emotional needs of the respondent while filling in this scale. It may be very difficult for some patients because of the memories that may come forward. Try to facilitate filling in by showing interest, by encouraging the respondent to talk about his or her experiences if needed. Help the repondent if needed. Try to sit in an angle of 90 degrees. DO NOT LEAN BACK AS IF YOU HAVE NOTHING TO DO WITH IT. As you will experience, the way in which you behave while going over the respondent's past is very important for the quality of your relationship with the respondent.)

(CIRCLE at each question and each column either a Y (=Yes), N (=No), or na (=not applicable):

	Parents	Brothers/ Sisters	Partner	Child(ren)	Other important persons	Your-self
01. Did anyone die?	Y/N/na	Y/N/na	Y/N/na	Y/N/na	Y/N/na	
02. Did anyone die because of suicide?	Y/N/na	Y/N/na	Y/N/na	Y/N/na	Y/N/na	
03. Did anyone divorce or separate?	Y/N/na	Y/N/na	Y/N/na	Y/N/na	Y/N/na	Y/N/na
04. Did anyone suffer from a chronic physical disease?	Y/N/na	Y/N/na	Y/N/na	Y/N/na	Y/N/na	Y/N/na
05. Was anyone admitted to a psychiatric hospital?	Y/N/na	Y/N/na	Y/N/na	Y/N/na	Y/N/na	Y/N/na
06. Only with respect to parents: Did you often think this year your parents did not love you and did not want to take care of you?	Y/N/na					
07. Did anyone have serious financial problems?	Y/N/na	Y/N/na	Y/N/na	Y/N/na	Y/N/na	Y/N/na
08. Was anyone addicted to alcohol, drugs or medicines?	Y/N/na	Y/N/na	Y/N/na	Y/N/na	Y/N/na	Y/N/na
09. Was anyone convicted for a criminal offense or sentenced to jail, or to any other correctional institution?	Y/N/na	Y/N/na	Y/N/na	Y/N/na	Y/N/na	Y/N/na
10. Did anyone seriously beat you up or otherwise physically mistreated you? If yes, who did that?	Y/N/na	Y/N/na	Y/N/na	Y/N/na	Y/N/na	
11. Did anyone mistreat you mentally by means of teasing, humiliating, etc. over a prolonged period of time? If yes, who did that?	Y/N/na	Y/N/na	Y/N/na	Y/N/na	Y/N/na	
12. Did anyone force you to have sexual intercourse against your will? If yes, who did that?	Y/N/na	Y/N/na	Y/N/na	Y/N/na	Y/N/na	
13. Did anyone force you to do or endure sexual activities (other than intercourse) against your will? If yes, who did that?	Y/N/na	Y/N/na	Y/N/na	Y/N/na	Y/N/na	

(CIRCLE at each question and each column either a Y (=Yes), N (=No), or na (=not applicable):

	Parents	Brothers/ Sisters	Partner	Child(ren)	Other important persons	Your-self
14. Only if you have a partner: Did your partner force you to prostitute yourself?			Y/N/na			
15. Did anyone attempt suicide without fatal outcome?	Y/N/na	Y/N/na	Y/N/na	Y/N/na	Y/N/na	Y/N/na
16. Did you have a very bad relationship with one of the persons mentioned in this list, in such a way that you hated him or her? If yes, with whom?	Y/N/na	Y/N/na	Y/N/na	Y/N/na	Y/N/na	
17. Did anyone have housing problems?	Y/N/na	Y/N/na	Y/N/na	Y/N/na	Y/N/na	Y/N/na
18. Did anyone prevent you from achieving or becoming what you want? If yes, who did that?	Y/N/na	Y/N/na	Y/N/na	Y/N/na	Y/N/na	
19. Has anyone been arrested or in contact with the police?	Y/N/na	Y/N/na	Y/N/na	Y/N/na	Y/N/na	Y/N/na
20. Did anyone have to stay home for a prolonged period of time (for three months or more) or have to stay in a hospital because of a physical disease?	Y/N/na	Y/N/na	Y/N/na	Y/N/na	Y/N/na	Y/N/na
21. Only when you have a child/children: Did you have any problems in bringing up your children?				Y/N/na		
22. Did you have any of your children adopted, or brought up by other relatives or ex-partner, or taken into care?				Y/N/na		
23. Only with respect to other persons important to you: Did you have problems in finding a life companion (because you did not know how to make contact, how to date)?					Y/N/na	
24. Did you have problems with a boy-/ girlfiend (quarrels, rows, etc.)?					Y/N/na	

(CIRCLE at each question and each column either a Y (=Yes), N (=No), or na (=not applicable):

	Parents	Brothers/ Sisters	Partner	Child(ren)	Other important persons	Your-self
25. Was there somebody important who took advantage of you?					Y/N/na	
The following questions are only with respect to yourself:						
26. Did you have troubles last year, that, as far as you know, were caused by complications at the time of your birth?						Y/N/na
27. Did you have to take care of your brothers and sisters many times when your mother or father could not care for them?						Y/N/na
28. Did you experience a failure to achieve an important goal? (e.g. an important examination, or to be accepted for a career).						Y/N/na
29. Did you have any difficulties on a job, like being fired against your will, quarrels with co-workers or superiors?						Y/N/na
30. Have you been without a job against your will for six months or more?						Y/N/na
31. Have you moved to another city or country and because of that lost touch with relatives and friends?						Y/N/na
32. Did you witness a serious crime or offense involving violence (even if the victim is a stranger)?						Y/N/na
33. Did you have problems with school or study?						Y/N/na
34. Did you have problems with religion?						Y/N/na
35. Have you experienced problems in making contact with other people (because of shyness, inability to start conversations, etc.)?						Y/N/na

(CIRCLE at each question and each column either a Y (=Yes), N (=No), or na (=not applicable):

	Parents	Brothers/ Sisters	Partner	Child(ren)	Other important persons	Your-self
36. Have you had any problems in making friends or keeping friends?						Y/N/na
37. Have you experienced loneliness over a long period (having no one to talk to, no friends or visitors, lonely even when people visit you)?						Y/N/na
38. Did you experience problems in sexuality (like inability to enjoy, problems in making love or cuddling, or other problems?						Y/N/na
39. Did you and your partner suffer from difficulties in conceiving children?						Y/N/na
40. Have you or your partner had miscarriages, or pregnancy terminated or suffered stillbirths?						Y/N/na
41. Did you have caring responsibilities, like nursing and attending to an elderly or a sick relative for three months or more?						Y/N/na
42. Did you suffer from anxiety for things or places in such a way that it hindered your life?						Y/N/na
43. Did you have problems with eating, like not eating enough and losing, or eating too much?						Y/N/na
44. Were you obsessed with food and eating in such a way that it handi-capped you?						Y/N/na
45. Did you experience a crime in which you were personally a victim (including theft of your property, physical assault, or another crime)?						Y/N/na
46. Have you been raped by strangers, a neighbour, a relative or any other person you knew (other than parents, partner, brothers or sisters)?						Y/N/na

(CIRCLE at each question and each column either a Y (=Yes), N (=No), or na (=not applicable):

	Parents	Brothers/ Sisters	Partner	Child(ren)	Other important persons	Your-self
47. Did you experience a sudden and unexpected emergency, like fire, flood, war or natural disasters, car or train accident?						Y/N/na
48. Did you (have to) make money by selling your body (prostitution)?						Y/N/na
49. Was there any other event or problem this year, that influenced you, and that was not yet mentioned on the previous pages? Please specify below:						
1.						Y/N/na
2.						Y/N/na

50. From all the events and circumstances mentioned (or recorded by you yourself), which were the three most important? Which three events have most strongly influenced your life this year?

1) (MOST IMPORTANT) .....

.....

2) (SECOND MOST IMPORTANT) .....

.....

3) (THIRD MOST IMPORTANT) .....

.....

USE OF ALCOHOL, DRUGS AND MEDICATION

"I would like to continue with some questions on alcohol, drugs and medication. Let's start with the questions on alcohol."

1. **"During this week, what did you drink during this week?"** (Interviewer should get a clear picture of total amount of alcohol within last week)
   Fill in at least 'Type of beverage' and 'Amount'. You can look up volume alcohol percentage of the beverage and calculate 'Volume in cl.' later on.

Type of beverage	Volume % alcohol	Amount	Volume in cl.
.....	.....	.....	.....
.....	.....	.....	.....
.....	.....	.....	.....
.....	.....	.....	.....
.....	.....	.....	.....

2. **"Was this a typical week? During the past year, did you normally drink more, much more, less, much less, or about the same compared to last week?"**
   circle

   Normally much less / Normally less / About the same / Normally more / Normally much more

3. **"Do you consider alcohol to be a problem for you at the present time?"**
   circle

   No problem / Minor problem / Major problem

4. **"Since the interview last year, have you considered or tried to cut down on drinking (alcohol)? If yes, did you find it difficult to cut down?"**
   circle

   Not tried, not considered / Only considered / Tried, no difficulty / Tried with difficulty (of any degree)

5. **"Since the interview last year, have people annoyed you by confronting you with your drinking behaviour?"**

   circle Yes / No

6. **"Since the interview last year, have you ever felt guilty about your drinking behaviour?"**

   circle Yes / No

7. **"Since the interview last year, did you start with a treatment program because of the fact you thought you were drinking too much alcohol?"**

   circle Yes / No

8. **"Since the interview last year, have you ever started the day with a drink to relax, to calm down or to suppress a hang-over?"**

   circle Yes / No

9. **"Now I would like to continue with a question on medication and drugs. I would like to know whether during the last week, before this interview, you used any drugs or medicines".**

		"Did you use ...?"	**"Was this more, equal or less than you generally used during the last year?"**	**"In the last year, did you have problems with this medicine or drug?"**
1.	Sleeping pills, tranquillizers or other medicines that help you to relax.	Yes / No	More / Equal / Less	Yes / No
2.	Antidepressants, pills against depression	Yes / No	More / Equal / Less	Yes / No
3.	Antipsychotics	Yes / No	More / Equal / Less	Yes / No
4.	Medicines for physical complaints (e.g. for high blood pressure)	Yes / No	More / Equal / Less	Yes / No
5.	Hashish or marihuana	Yes / No	More / Equal / Less	Yes / No
6.	Cocaine or heroin	Yes / No	More / Equal / Less	Yes / No
7.	Other (specify)	Yes / No	More / Equal / Less	Yes / No
	.....	Yes / No	More / Equal / Less	Yes / No
	.....	Yes / No	More / Equal / Less	Yes / No
	.....	Yes / No	More / Equal / Less	Yes / No

10. **"Do you consider medicines to be a problem for you at the present time?"**

    circle No problem / Minor problem / Major problem

11. **"Do you consider drugs to be a problem for you at the present time?"**

    circle No problem / Minor problem / Major problem

12. **"Since the interview last year, did you start with a treatment program because of the fact you thought you were using too much medicines?"**

    circle Yes / No

13. **"Since the interview last year, did you start with a treatment program because of the fact you thought you were using too much drugs?"**

    circle Yes / No

SOCIAL SUPPORT

"Now I would like you to fill in a short questionnaire which deals with the question to what extent you feel you get support from and give support to your relatives and your friends. In the questionnaire, two types of support are distinguished. On the one hand practical support, which means help with practical things such as looking after the house when one is away, helping with minor repairs or other practical things one finds difficult, and providing financial support (for instance by lending or giving money). On the other hand moral or emotional support, which means being available for a talk when one feels bad, talking about feelings or giving advice in emotional matters. Start with reading the instruction and if you have any questions regarding the questionnaire, please ask me."

NOW TURN THIS PAGE AND HAND OVER BOOKLET TO THE PATIENT

SELF-REPORT

This questionnaire is about the extent that you feel you need and get support from your family and friends in daily life, and about the extent that your family and friends need and get support from you. In the questionnaire two general kinds of support are distinguished:

- practical support refers to support concerning daily activities such as looking after your house when you are away, looking after your children, pets or flowers, looking after you or doing the shopping when you are ill, etc.. Practical support also includes financial support.
- moral support refers to emotional support when minor or mayor problems arise. Moral support includes that people are available to share worries with, to talk about personal problems, etc.

Please read each question (on the left side of the page) carefully. Then circle in both the columns on the right side of the page (labelled FROM FAMILY and labelled FROM FRIENDS) the answer that applies best to how you feel about it (either 1, 2 or 3). Please answer all questions. Do no spend too much time on any one question. If you have any questions or need help, please ask the interviewer.

WHETHER YOU NEED SUPPORT	FROM FAMILY	FROM FRIENDS
01. Do you feel that you need practical support	1. no, not at all 2. to some extent 3. yes, very much 4. not applicable	1. no, not at all 2. to some extent 3. yes, very much 4. not applicable
02. Do you feel that you need moral support	1. no, not at all 2. to some extent 3. yes, very much 4. not applicable	1. no, not at all 2. to some extent 3. yes, very much 4. not applicable
WHETHER YOU GET SUPPORT	**FROM FAMILY**	**FROM FRIENDS**
03. Do you feel that you get the practical support you need?	1. no, not at all 2. to some extent 3. yes, very much 4. not applicable	1. no, not at all 2. to some extent 3. yes, very much 4. not applicable
04. Do you feel that you get the moral support you need?	1. no, not at all 2. to some extent 3. yes, very much 4. not applicable	1. no, not at all 2. to some extent 3. yes, very much 4. not applicable
WHETHER YOU ARE NEEDED FOR SUPPORT	**BY FAMILY**	**BY FRIENDS**
05. Do you feel that you are needed for practical support?	1. no, not at all 2. to some extent 3. yes, very much 4. not applicable	1. no, not at all 2. to some extent 3. yes, very much 4. not applicable
06. Do you feel that you are needed for moral support?	1. no, not at all 2. to some extent 3. yes, very much 4. not applicable	1. no not at all 2. to some extent 3. yes, very much 4. not applicable

WHETHER YOU GIVE SUPPORT	TO FAMILY	TO FRIENDS
07. Do you feel that you give the practical support that is needed from you?	1. no, not at all 2. to some extent 3. yes, very much 4. not applicable	1. no, not at all 2. to some extent 3. yes, very much 4. not applicable
08. Do you feel that you give the moral support that is needed from you?	1. no, not at all 2. to some extent 3. yes, very much 4. not applicable	1. no, not at all 2. to some extent 3. yes, very much 4. not applicable

WHEN FINISHED, PLEASE HAND OVER THIS BOOKLET BACK TO THE INTERVIEWER

SOCIAL INTEGRATION

1. **"I would like to know how often, in the past year, you had contact with the following persons. The question is how often you had contacts, either by telephone, through visits, letters, etc., with these persons."** In case of more than 5 brothers, or more than 5 friends, only fill in for the five with whom the respondent has most contact.

   For each type of relationship (e.g. siblings), code for every person (e.g. every brother and every sister) the frequency of contacts, according to the following hierarchical categorization:

   0. never during the last year
   1. more than once a year
   2. more than once a month
   3. more than once a week
   4. more than 3 times a week

If not applicable (e.g. patient has no children) do not code anything.

RELATIONSHIP	FREQUENCY OF CONTACT FOR EACH PERSON THAT IS A CHILD/PARENT/SIBLING ETC. OF THE PATIENT				
	1	2	3	4	5
A. Children (including adopted, etc.)	.....	.....	.....	.....	.....
B. Parents (including foster, stepparent)	.....	.....	.....	.....	.....
C. Brothers/sisters	.....	.....	.....	.....	.....
D. Grandparents	.....	.....	.....	.....	.....
E. Grandchildren	.....	.....	.....	.....	.....
F. Children in law	.....	.....	.....	.....	.....
G. Parents in law	.....	.....	.....	.....	.....
H. Other relatives (only if at least one contact during last year)	.....	.....	.....	.....	.....
I. Friends	.....	.....	.....	.....	.....

2. **"Are you an active member or do you currently do any unpaid voluntary work for organizations like charities concerned with the welfare of people, education or arts groups, trade unions, political parties or groups, human rights groups, conservation, environmentalist or animal welfare groups, youth work, sport clubs, etc.?"**

   circle No / One such organization / 2 or more such organizations

ROSENBERG SELF ESTEEM SCALE

"Now I would like you to fill in one more short questionnaire on how you feel about yourself at this moment. After this we will be ready. Please read the instruction carefully before you start."

TURN THIS PAGE, AND HAND OVER BOOKLET TO THE PATIENT

SELF-REPORT

Below are ten statements about how you feel about yourself. Please read each statement carefully and mark the option which best reflects the way you feel about yourself AT THE PRESENT TIME. Circle the words STRONGLY AGREE if you completely agree with the statement. Circle AGREE if you agree but not completely. Circle DISAGREE if you on the disagree, but not completely. Circle STRONGLY DISAGREE if you think the statement does absolutely not reflect the way you feel about yourself.

There are no right or wrong answers. Please do not skip statements. Do not spend too much time on any one statement.

NOW PLEASE READ EACH STATEMENT CAREFULLY AND CIRCLE THE ANSWERS THAT REFLECT BEST HOW YOU FEEL ABOUT YOURSELF RIGHT NOW.

		CIRCLE:
1.	**On the whole I am satisfied with myself.**	Strongly agree / Agree / Disagree / Strongly disagree
2.	**At times I think I am no good at all.**	Strongly agree / Agree / Disagree / Strongly disagree
3.	**I feel that I have a number of good qualities.**	Strongly agree / Agree / Disagree / Strongly disagree
4.	**I feel that I do not have much to be proud of.**	Strongly agree / Agree / Disagree / Strongly disagree
5.	**I am able to do things as well as most people.**	Strongly agree / Agree / Disagree / Strongly disagree
6.	**I certainly feel useless at times.**	Strongly agree / Agree / Disagree / Strongly disagree
7.	**I feel that I am a person of worth, at least as good as others.**	Strongly agree / Agree / Disagree / Strongly disagree
8.	**I wish I could have more respect for myself.**	Strongly agree / Agree / Disagree / Strongly disagree
9.	**I take a positive attitude towards myself.**	Strongly agree / Agree / Disagree / Strongly disagree
10.	**All in all I am inclined to feel that I am a failure.**	Strongly agree / Agree / Disagree / Strongly disagree

WHEN FINISHED, PLEASE HAND OVER THIS BOOKLET BACK TO THE INTERVIEWER

OPTIONAL FOLLOW-UP CONTACT IN FEW YEARS TIME

Each centre is free to try to have follow-up data on several more years. If so, use this page for obtaining consent to get in touch with respondent in x-years time.

"Now we have finished the interview, I have one more question. In order to assess how you are and what has happened, I would like to have another interview with you over .. years. If you consent to be contacted once again, .. years after now, I can assure that no one (for instance your family) will be told about the subject of the interview we had now or of the reasons for the next interview. You will be contacted personally be me or, if that is not possible, by one of my co-workers. If course you may, when you are contacted, decide not to be interviewed. The reason why I ask you to consent to be contacted is that for contacting you I need your permission, as well as your home address. Is it all right with you to be contacted one year after now for a second interview? Do you have any questions?"

IF PATIENT AGREES, FINISH WITH THE CONSENT FORM ON THE NEXT PAGE

THANK PATIENT FOR HIS/HER COOPERATION

WHEN ANOTHER APPOINTMENT IS NEEDED TO FINISH THE INTERVIEW, MAKE SURE THAT THIS APPOINTMENT IS HELD WITHIN ONE WEEK

CONSENT FORM

I herewith give ..... (name of interviewer), or someone who replaces him/her, permission to contact me about ..... years after now, in order to ask me to take part in another follow-up interview. He/she may also contact the people whose names and addresses have been recorded below, in order to inform about my place of residence. By signing this consent form I do NOT promise to take part in such an interview, I only give permission to be contacted. I have been informed that the reason of this interview will not be made known to any of my relatives or friends.

Date: .....

Name: .....

Signature: .....

My home address is..... (address)

..... (telephone)

or (alternative) ..... (address)

..... (telephone)

Persons who may be asked next time about my residence at that time are:

Person nr. 1: ..... (name) ..... (relation)

..... (address)

..... (telephone)

Person nr. 2: ..... (name) ..... (relation)

..... (address)

..... (telephone)

PATIENT IDENTIFICATION NUMBER .....

AFTER FILLING IN THIS FORM REMOVE THIS PAGE FROM BOOKLET

APPENDIX

In this appendix an example is given how to fill out the flowchart with respect to contacts with mental health care services in the period between discharge from general hospital and follow-up interview.

EXAMPLE

Respondent A.
Date of index parasuicide : 4th April 1990
Date of initial interview : 4th April 1990
Date of follow-up interview: 5th May 1991

A. was admitted to a psychiatric hospital at the time he did the index parasuicide. He was treated in general hospital because of this parasuicide for one day. After discharge from general hospital he was referred back to the psychiatric hospital. He stayed there for another 3 months, then he was discharged at 9th July 1990. The psychiatric hospital had referred him to an out-patient mental health service for aftercare. He was treated there by a psychologist. The first contact with this psychologist was July 24 and lasted 2 months (till September 20). Since respondent's mental condition was worsening, he had to be admitted again to the psychiatric hospital. Date of second admission was September 24. Admission lasted till February 10 1991. The psychiatric hospital referred respondent to a social worker for after care. The first contact with this social worker was on February 25 1991. Up to the moment of follow-up interview respondent still has contact with this social worker.

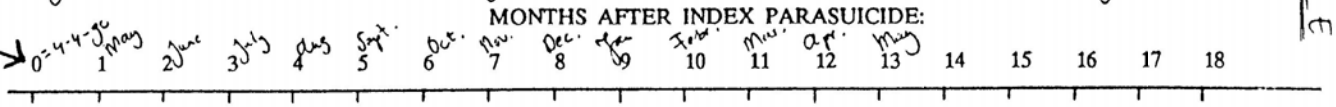
On basis of this information the flowchart + question 9 of section D should be filled out as follows (see the next two pages.

EXAMPLE

CONTACT WITH MENTAL HEALTH CARE SERVICES IN PERIOD BETWEEN INDEX PARASUICIDE AND FOLLOW-UP INTERVIEW

DATE OF: index parasuicide: 4 - 4 - 1990 discharge from gen. hospital: 5. - 4. - 1990 initial interv.: 4. - 4. - 1990 follow-up interv.: 5. - 5. - 1991

MONTHS AFTER INDEX PARASUICIDE:



Contact with mental health services:

I. In-patient psychiatric treatment:
1. psychiatric hospital 1
2. psychiatric hospital 2
3.
4.

IIa. Out-pat. treatm.: by psychiatrist:
1.
2.
3.
4.

IIb. Out-pat. treatm.: by psychologist:
1. psychologist
2.
3.
4.

IIc. Out-pat. treatm.: by social worker or any other mental health care professional (please specify):
1. Social worker
2.
3.
4.
5.
6.

EXAMPLE:

SECTION D: EVALUATION OF FIRST IN-PATIENT PSYCHIATRIC TREATMENT AND/OR FIRST OUT-PATIENT TREATMENT AFTER INDEX PARASUICIDE

If patient has had any in- or out-patient contact with a mental health care service:

9. **"You just told me what kind of professional help you have received during the past year. Now I would like to ask you what you think about the help/treatment you received (immediately) following your discharge from hospital last year. If apllicable: " With respect to your first admission in a psychiatric hospital and (if apllicable) with respect to your first out-patient contact with a mental health care professional I would like to ask you some questions."**

If applicable:
Fill out questions 9A to 9L (page 44-45) for the FIRST admission in a psychiatric hospital which has taken place after index parasuicide (section I of the flowchart).
Fill out questions 9A to 9H for the FIRST contact/treatment with an out-patient mental health service the patient has had after the index parasuicide (section IIa, IIb or IIc of the flowchart).
The evaluations are made irrespective of whether the treatment/admission is ended at time of follow-up interview or not. All other treatments/ contacts are NOT evaluated.

Questions 9A to 9L our filled out with respect to:
I. First in-patient psychiatric treatment: (Yes) / No / Not applicable

Period in which this admission took place (to be filled out by interviewer: see flowchart):
Month beginning: ...0... (write down number of months after index parasuicide similar to the number indicated at the flowchart. E.g. if respondent was admitted to a psychiatric hopsital within a month after discharge from general hospital: month beginning = 1. If patient was already admitted to this psychiatric hospital at moment of index parasuicide: month beginning = 0 (zero)).

Month end: ...3... (write down number of months after index parasuicide similar to the number indicated at the flowchart. E.g. if admission ended at a date 6 months after index parasuicide: month ending = 6.)

Duration of admission in weeks: .....14.... (number of weeks)

II. First out-patient mental health care treatment: (Yes) / No / Not applicable
If yes, circle:
a. from psychiatrist
(b.) from psychologist
c. from social worker
d. from other mental health care professional, namely .....

Period in which treatment took place (to be filled out by interviewer: see flowchart):
Month beginning: ...4... (write down number of months after index parasuicide similar to the number indicated at the flowchart. See also example above.
Month end: ...6..... (write down number of months after index parasuicide similar to the number indicated at the flowchart. See also example above)

(Interviewer, ask additional information with respect to number of contacts with mental health care professional + average length of contacts):
"With respect to the first out-patient treatment you have had with the psychiatrist/(psychologist)/social worker/..... (other professional), How many contacts did you have with this professional and and what was the average length per contact?"

(Estimated) number of contacts: ..10..

Average length of contacts: 60 (in minutes)

Annex 3

Parasuicide in Europe: the WHO/EURO multicentre study on parasuicide. I. Introduction and preliminary analysis for 1989

Platt S, Bille-Brahe U, Kerkhof A, Schmidtke A, Bjerke T, Crepet P, De Leo D, Haring C, Lonnqvist J, Michel K, Philippe A, Pommereau X, Querejeta I, Salander-Renberg E, Temesvary B, Wasserman D, Sampaio Faria J. Parasuicide in Europe: the WHO/EURO multicentre study on parasuicide. I. Introduction and preliminary analysis for 1989.
Acta Psychiatr Scand 1992: 85: 97–104.

The WHO/EURO multicentre study on parasuicide is a new, coordinated, multinational, European study that covers two broad areas of research: monitoring trends in the epidemiology of parasuicide (epidemiological monitoring study); and follow-up investigations of parasuicide populations, with a view to identifying the social and personal characteristics predictive of future suicidal behaviour (repetition prediction project). This article provides background information on the development and organization of the multicentre study, and presents selected findings from the epidemiological monitoring project, based on a preliminary examination of data collected in 15 centres on parasuicides aged 15 years and over treated in health facilities in defined catchment areas during the year 1989. The overall parasuicide incidence varied considerably across the centres, from a high (event) rate of 414 per 100,000 males in Helsinki to a low of 61 among males in Leiden. The highest female event rate was 595 in Pontoise, and the lowest 95 in Guipuzcoa. The mean event rate across all centres was 167 among males and 222 among females. Parasuicide incidence tended to be elevated among 15- to 34-year-olds, with lowest rates among those aged 55 years and over. With one exception (Helsinki), the female parasuicide rate was higher than the male rate, the F:M ratio ranging from 0.71:1 to 2.15:1, with a median of 1.5:1 (events). Short-term repetition rates (as measured by the event:person ratio) differed between centres, from 1.03 to 1.30 (median = 1.12) among males, and from 1.07 to 1.26 (median = 1.13) among females. Although we warn against generalizing from our findings to make statements about differences in parasuicide between countries, we argue that the differences between centres are valid and should be addressed in further research.

S. Platt, U. Bille-Brahe, A. Kerkhof, A. Schmidtke, T. Bjerke, P. Crepet, D. De Leo, C. Haring, J. Lonnqvist, K. Michel, A. Philippe, X. Pommereau, I. Querejeta, E. Salander-Renberg, B. Temesvary, D. Wasserman, J. Sampaio Faria

WHO/EURO multicentre study on parasuicide, c/o MRC Medical Sociology Unit, Glasgow, United Kingdom

Key words: parasuicide; sex difference; epidemiology; World Health Organization

Stephen Platt BA, MSc, PhD, MRC Medical Sociology Unit, 6 Lilybank Gardens, Glasgow G12 8QQ, Scotland, UK

Accepted for publication July 20, 1991

"By the year 2000, the current rising trends in suicides and attempted suicides in the Region should be reversed." (target 12 of the European targets for health for all by the year 2000) (1).

As part of the plan of action to implement target 12 of the WHO European strategy for health for all by the year 2000, the WHO Regional Office for Europe (WHO/EURO) convened a Working Group on Preventive Practices in Suicide and Attempted Suicide in York, England, in September 1986 (2). The Working Group, attended by 31 participants from 15 countries, considered the problems involved in undertaking comparative research on parasuicide (attempted suicide) and concluded that there was a need for a coordinated multinational European study covering two broad areas of research: first, monitoring of trends in the epidemiology of parasuicide, including the recognition of risk factors (epidemiological monitoring project); and, second, follow-up investigations of parasuicide populations, with a view to identifying the social and personal characteristics predictive of future suicidal behaviour (repetition prediction project).

Within two years of the York meeting WHO

Source: *Acta psychiatrica Scandinavica*, **85**(2): 97 – 104, Copenhagen, Munksgård, 1992.

EURO had approved applications from 16 centres to participate in the research project. The list of participating centres and main collaborators is given in the Appendix.

Each participating centre is responsible for obtaining the financial support necessary to carry out the research in their area. The steering group assists in working out budgets and formulating applications, while WHO/EURO provides infrastructural support (such as organizing annual meetings of representatives from participating centres and more regular meetings of the steering group; assisting with centralized data preparation and analysis, and the development of research instruments; promoting the study in member states; and helping participating centres to raise funds from national and local sources).

This article presents selected findings from the epidemiological monitoring project, based on a preliminary examination of data collected in 1989. More detailed and extensive analysis will be published when the full dataset for 1989 becomes available, and future reports will also examine trends over time. The repetition prediction project did not start until 1990; publication of the findings from the first wave of interviews cannot be expected before 1992.

Background to the epidemiological monitoring project

In many countries, parasuicidal behaviour has been identified as a major public health problem and a considerable drain on resources in both primary and secondary health care. Unfortunately, because of cross-cultural differences both in the medical treatment of parasuicide and in research methods, it has proved almost impossible to make valid comparisons between European countries about any aspect of such behaviour (3). In the absence of national data, researchers have been forced to rely on local surveys, which vary markedly in terms of their nominal and operational definitions of parasuicide, the representativeness of the final sample, the time period covered, the amount of information gathered, etc. In addition, local studies have not always been adequate epidemiologically (for example, failing to identify risk factors for parasuicide) or from the perspective of health service referral (for example, failing to identify the pattern of treatment following parasuicide). For these reasons, it was decided that WHO/EURO should support a collaborative multicentre monitoring project designed to provide an epidemiological picture of parasuicide in Europe.

The monitoring project has four main purposes:

- assessing the feasibility of using local case registers to monitor parasuicide in a defined catchment area;
- estimating the true incidence of medically treated parasuicide and trends over time, using standardized definitions and case-finding criteria;
- identifying sociodemographic risk factors significantly associated with parasuicide; and
- ascertaining variations in patterns of treatment following parasuicide in different cultural contexts (with the aim of establishing more effective services for preventing this type of behaviour).

Parasuicide data, disaggregated by age and gender, relating to all or part of the year 1989, are now available for 15 centres (all except Munich). These are presented below, in partial fulfilment of the second and third main purposes.

The medical management of parasuicide in the European Region

The medical management of parasuicide is by no means uniform across the European Region: it is difficult to identify a typical pathway through the health system followed by the majority of parasuicide patients. (Even within one local area there may be several different management patterns. This is especially likely where there is a highly developed and pervasive network of private health care facilities.) The starting-point in urban centres is usually referral (by self, family, ambulance service, police or primary care physician) to the accident and emergency department of the (main or university) general hospital, whereafter treatment routes diverge considerably. Medically serious cases tend to go to intensive care, cases of self-injury often require special surgical treatment, and patients exhibiting mental symptoms or a continuing high suicide risk are transferred to psychiatric care. Some centres have routine psychiatric assessment in accident and emergency or in general medical wards, and elsewhere only a minority of parasuicide patients are seen by psychiatrically trained staff. Follow-up psychiatric care can be offered in hospital wards (both open and closed), on an outpatient basis or at home (via community mental health centres or community psychiatric services). It is generally observed that parasuicide patients are poor compliers and only a minority present themselves for outpatient appointments. Management of parasuicide exclusively by general practitioners is considered unusual (although it is calculated that 13% of all parasuicides in Bordeaux are treated in this way). Estimates of the proportion of all parasuicide treated in health facilities ranges from 90% in Bordeaux to 33% in Leiden and 28% in Umeå.

Material and methods

Sources of data

In each study catchment area, considerable efforts have been made to check admissions to a wide range

Table 1. Sources of data on parasuicide in 15 European centres, 1989

	Type of health facility covered					Percentage of parasuicide events from hospitals
	Psychiatric unit or hospital	General hospital	General practice	Private doctor	Other	
Odense	X	X	X	X	Prisons	52
Emilia-Romagna	X	X	X			?
Padua	X	X	X	X	[Not specified]	79
Helsinki		X				100
Umeå	X	X	(X)			100
Leiden	X	X	(X)		Community mental health centre	55
Stockholm	X	X				100
Pontoise		X				100
Bordeaux	X	X				100
Sor-Trondelag	X	X	X	X	Prisons	95
Innsbruck	X	X	(X)		Psychotherapeutic unit	?
Szeged	X	X	X		Ambulance service	?
Guipuzcoa	X	X	X	X	Out of hospital emergency services	45
Berne	X	X	(X)	(X)		94
Würzburg	X	(X)	(X)	(X)	Private counselling service	?

X = full coverage (X) = partial coverage.

of health facilities where parasuicide patients are likely to be treated. (No attempt has been made to assess accurately the extent of non-medically treated parasuicide.) In all centres data have been gathered from general hospitals and, with only 2 exceptions (Helsinki and Pontoise), from psychiatric units or hospitals (Table 1). General practice was covered in 11 centres, private medicine in 6 centres and a variety of other facilities in 8 centres. In 7 of the 11 centres for which a disaggregation by health facility is available, over 90% of subjects were treated in hospital (Table 1). The exceptions were Padua (79%), Leiden (55%), Odense (52%) and Guipuzcoa (45%). Overall, in these 11 centres, approximately 88% of subjects included in the study were treated in hospital.

Centres were asked to estimate the number of parasuicides aged ≥ 15 years admitted to health facilities in the catchment area who were not included in the 1989 dataset. Of the 15 centres providing this information, 8 reported full coverage of known medically treated parasuicide, and 5 claimed that missed events amounted to 5–12% of the estimated total (Umeå – 5%; Berne – 10%; Bordeaux – 11%; Padua – 11%; Emilia-Romagna – 12%). Würzburg and Innsbruck could not estimate the percentage of missing cases. In all centres the achieved sample was considered to be representative of the total population of medically treated parasuicides.

Definition of parasuicide

Parasuicide was defined as "an act with nonfatal 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". The definition includes acts that are interrupted before actual self-harm occurs, such as the behaviour of a person who lies across railway tracks with the intention of being run over by a train, but is rescued before the train arrives. Self-harmful acts by persons who do not understand the meaning or consequences of their own action (by reason of mental subnormality or insanity) are excluded. It should be noted that the apparent purpose or motivation underlying the act was not taken into account when making the diagnosis.

Subjects

The data presented are based on parasuicide admissions to health facilities among persons aged 15 years or more and resident within the local study catchment area. Two types of rates have been calculated. The numerator for event rates consists of all episodes of parasuicide admitted to the monitored service during the period under review, including repeat admissions by the same individual. The numerator for the person rate excludes repeat contacts by the same individual during this same time period. Findings are presented separately for men and women and are also disaggregated by age (except for Innsbruck, for which only the overall rate is given).

With only one exception, the period covered is 12 months. Eleven centres (Emilia-Romagna, Padua, Helsinki, Umeå, Leiden, Stockholm, Pontoise, Sor-Trondelag, Szeged, Guipuzcoa, Innsbruck and Würzburg) report data for the 1989 calendar year

and a further 2 centres for a slightly different 12-month period (Bordeaux: 15 October 1988 to 14 October 1989; Berne: 1 March 1989 to 28 February 1990). Odense was able to supply data for a 9-month period (1 April to 31 December 1989); estimated annual rates are given in tables and figures for this centre.

Population estimates

Centres provided the latest available population estimates for the catchment area, disaggregated by age and gender. The earliest such estimate is for the year 1985; the majority refer to 1988 or 1989.

Results

Overall parasuicide rates among persons aged 15 years and over varied widely between the different centres (Fig. 1–4). There was almost a sevenfold difference between the highest male event rate (Helsinki, 414 per 100,000) and the lowest (Leiden, 61). The overall mean rate was 167 and the median, 131 (Fig. 1). The female event rate was highest in Pontoise (595) and lowest in Guipuzcoa (95), more than a sixfold difference. The overall mean rate was 222, with a median of 202 (Fig. 2). Considering parasuicide among male persons (Fig. 3), we find the highest rate in Helsinki (323) and the lowest in Leiden (57), a ratio in excess of 5:1 (Fig. 3). The mean rate was 139 and the median, 120. Finally, the female person rate was highest in Pontoise (516) and lowest in Guipuzcoa (85), a more than sixfold difference (Fig. 4). The mean rate was 189 and the median, 165.

Age-sex specific parasuicide rates are shown in Tables 2 and 3. In about half the centres, the highest event rate (Table 2) was found most commonly in the 25- to 34-year-old age group (7 centres – men; 7 centres – women), but also among 15- to 24-year-olds (2 centres – men; 5 centres – women) and 35- to 44-year-olds (5 centres – men; 2 centres – women). In the majority of centres (11 – men; 13 – women)

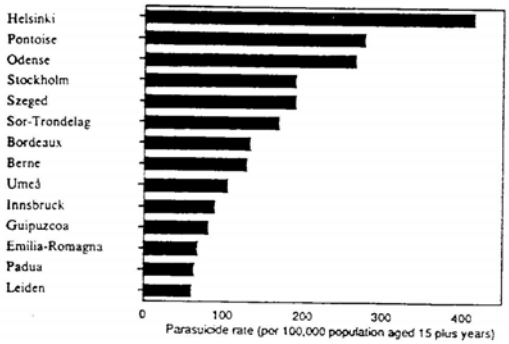


Fig. 1. Male parasuicide event rates in 14 European centres, 1989.

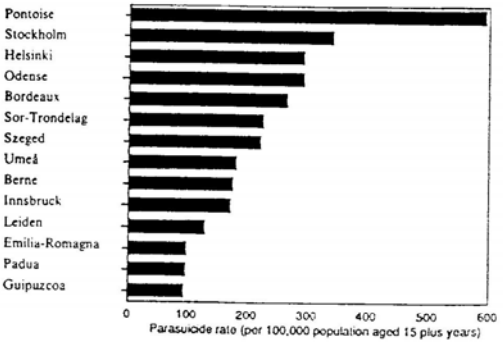


Fig. 2. Female parasuicide event rates in 14 European centres, 1989.

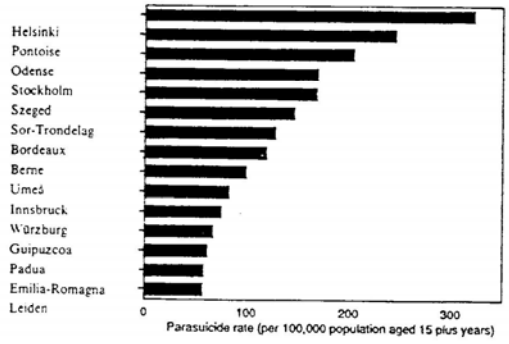


Fig. 3. Male parasuicide person rates in 15 European centres, 1989.

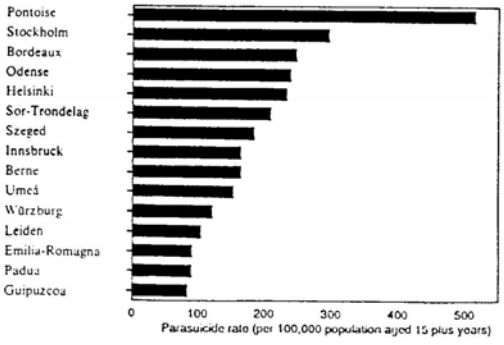


Fig. 4. Female parasuicide person rates in 15 European centres, 1989.

Table 2. Parasuicide in 15 European centres – annual number of events and event rates (per 100,000), by gender and age-group, 1989

	Szeged		Umeå		Bordeaux		Helsinki		Emilia-Romagna		Berne		Guipuzcoa	
	n	Rate	*n*	Rate	*n*	Rate	*n*	Rate	*n*	Rate	*n*	Rate	*n*	Rate
Men														
15–24	43	262	21	119	81	153	127	426	20	86	30	134	19	147
25–34	42	213	26	152	102	187	286	653	30	125	59	242	9	84
35–44	33	197	31	164	79	207	223	550	18	79	33	141	8	76
45–54	20	139	13	92	32	93	66	240	10	45	15	90	4	48
≥55	40	151	12	38	26	43	59	140	18	38	16	50	5	40
all ≥15	178	190	105[a]	106	320	133	761	414	96	68	153	129	45	82
Women														
15–24	56	406	51	309	241	435	134	399	34	153	66	283	14	112
25–34	50	281	42	261	192	347	211	450	38	163	71	286	25	237
35–44	52	306	40	229	164	412	186	414	28	119	46	195	8	77
45–54	34	177	25	178	82	220	89	283	14	59	25	139	5	60
≥55	38	106	25	69	59	66	70	90	42	64	32	70	3	19
all ≥15	230	222	183	182	738	266	690	294	156	99	240	177	55	95

	Leiden		Odense		Sor-Trondelag		Innsbruck		Pontoise		Padua		Stockholm		Würzburg	
	n	Rate	*n*	Rate	*n*	Rate	*n*	Rate	*n*	Rate	*n*	Rate	*n*	Rate	*n*	Rate
Men																
15–24	23	72	87	242	34	164	26	118	39	326	24	75	27	156	N/A	–
25–34	26	84	147	438	52	262	24	118	53	374	28	105	45	227	N/A	–
35–44	18	66	159	451	53	287	15	83	42	299	12	45	51	257	N/A	–
45–54	10	53	59	220	16	129	6	42	9	150	11	47	35	222	N/A	–
≥55	8	26	42	78	13	46	11	51	1	17	16	46	27	109	N/A	–
All ≥15	85	61	494	266	168	169	87[b]	90	144	277	91	64	185	190	N/A	–
Women																
15–24	42	131	119	355	53	269	63	292	87	763	39	129	69	393	N/A	–
25–34	43	141	116	362	64	347	32	152	105	688	45	167	112	564	N/A	–
35–44	53	201	145	426	51	292	31	172	88	635	22	78	76	390	N/A	–
45–54	32	168	101	380	33	273	28	196	25	435	23	91	48	315	N/A	–
≥55	23	56	87	130	32	90	21	63	13	181	26	54	51	160	N/A	–
All ≥15	193	130	568	294	233	226	188[c]	173	318	595	156[d]	98	356	342	N/A	–

N/A: not available. [a] Age not known for 2 cases. [b] Age not known for 5 cases. [c] Age not known for 13 cases. [d] Age not known for 1 case. All data refer to the calendar year 1989, with the following exceptions: Bordeaux – 15 October 1988 to 14 October 1989. Berne – 1 March 1989 to 28 February 1990. Odense – 1 April 1989 to 31 December 1989 (9 months).

the rate among people aged 55 years or more was the lowest.

In view of widespread concern about high parasuicide incidence among teenagers and young adults, we further subdivided 15- to 29-year-olds into 3 five-year age groups. Among men, event rates increased from a mean of 106 per 100,000 (median = 85) among 15- to 19-year-olds to 232 (median = 193) among 20- to 24-year-olds and 270 (median = 188) among 25- to 29-year-olds. Among women, by contrast, event rates were fairly similar in the 3 age groups: 323 (median = 272), 297 (median = 312) and 304 (median = 319), respectively. The highest event rate in any age group (male or female) was 911 per 100,000, among 15- to 19-year-old women in Pontoise; the second highest rate was 791, among 15- to 19-year-old women in Szeged.

Turning now to parasuicide person rates (Table 3), we find the highest incidence in the 25- to 34-year age group (9 centres – men; 7 centres – women), followed by the 15- to 24-year age group (3 centres – men; 5 centres – women). The lowest rate was found among those aged 55 years or more in most centres (11 centres – men; 13 centres – women).

With only one exception (Helsinki), overall parasuicide rates were higher among women than among men. The ratio of female: male rates for each centre is shown in Table 4. The range for events was 0.71:1 to 2.15:1, with a median value of 1.50:1. The range for persons was 0.72:1 to 2.10:1, with a median value of 1.54:1.

The ratio of the event rate: person rate gives an approximate indication of parasuicide repetition within the calendar year. This ratio varied considerably between centres, from a low of 1.03 to a high of 1.30 among males, and between 1.07 and 1.26 among females (Table 5). The median values across all centres was 1.12 (males) and 1.13 (females).

Table 3. Parasuicide in 15 European centres – annual number of people and person rates (per 100,000), by gender and age group, 1989

	Szeged		Umeå		Bordeaux		Helsinki		Emilia-Romagna		Berne		Guipuzcoa	
	n	Rate	*n*	Rate	*n*	Rate	*n*	Rate	*n*	Rate	*n*	Rate	*n*	Rate
Men														
15–24	40	244	18	102	79	149	106	355	16	69	30	134	15	116
25–34	39	198	26	152	98	180	208	475	24	100	54	222	7	65
35–44	29	173	28	148	76	199	163	402	16	71	30	128	7	66
45–54	17	118	13	92	32	93	58	211	9	40	14	84	3	36
≥55+	33	125	12	38	25	41	59	140	17	35	15	47	5	40
all ≥15	158	169	99[a]	100	310	129	594	323	82	58	143	120	37	67
Women														
15–24	39	283	38	230	228	411	111	330	31	140	62	265	14	112
25–34	49	275	34	211	174	314	164	349	35	150	66	265	19	180
35–44	45	265	39	223	148	371	140	311	25	107	42	178	8	77
45–54	31	161	19	135	78	209	74	235	14	59	23	128	5	60
≥55	28	78	25	69	59	66	60	78	40	61	30	66	3	19
All ≥15	192	185	155	154	687	248	549	234	145	92	223	165	49	85

	Leiden		Odense		Sor-Trondelag		Innsbruck		Pontoise		Padua		Stockholm		Würzburg	
	n	Rate	*n*	Rate	*n*	Rate	*n*	Rate	*n*	Rate	*n*	Rate	*n*	Rate	*n*	Rate
Men																
15–24	23	72	70	195	33	159	N/A	–	36	301	22	69	27	156	30	145
25–34	23	75	119	354	46	232	N/A	–	51	359	27	101	41	207	27	110
35–44	17	62	109	309	42	227	N/A	–	33	235	12	45	43	217	9	54
45–54	10	53	46	171	15	121	N/A	–	7	117	10	43	30	190	11	64
≥55	6	19	36	67	11	39	N/A	–	1	17	16	46	25	101	7	26
All ≥15	79	57	380	205	147	147	80	83	128	246	88[b]	61	166	170	84	75
Women																
15–24	36	112	95	283	48	243	N/A	–	74	649	38	126	62	353	52	237
25–34	34	111	87	271	63	342	N/A	–	91	596	39	145	89	449	46	192
35–44	43	163	117	344	47	269	N/A	–	75	542	22	78	67	343	34	209
45–54	27	142	92	346	29	240	N/A	–	24	417	22	87	44	289	11	63
≥55	16	39	72	108	30	85	N/A	–	12	167	23	48	47	147	12	29
All ≥15	156	105	463	240	217	210	179	165	276	516	145[c]	91	309	297	155	122

NA: not available. [a] Age not known for 2 cases. [b] Age not known for 1 case. [c] Age not known for 1 case. See note to Table 2.

Discussion

Cross-sectional and longitudinal analyses of parasuicide in the European Region are hampered by the virtual absence of appropriate national data. Previous attempts to examine the epidemiology of parasuicide in Europe (4, 5) have been forced to rely on information gathered in different centres using non-standardized definitions and case-finding criteria. One major objective of the WHO/EURO multicentre study on parasuicide is to provide data of sufficient reliability and validity that an accurate picture of parasuicidal behaviour in the Region (across and over time) can be assembled. Our strategy has been based on the assumption that governments are (and will continue to be) unable to produce such data on a national basis, even where restricted to hospital admissions. Instead, we have sought to develop a multinational research project that incorporates catchment-area surveys of parasuicide treated in all types of health facility, and devotes painstaking attention to methodological details, such as standardization of definition, quality control of data collection and continuity of monitoring over time.

As a result of efforts by the steering group and the high level of research expertise and experience available at the local level, we can be reasonably confident that comparisons between centres are valid: like is being compared with like. The same nominal definition was (and continues to be) applied in each centre, and care has been taken to ensure that local operationalizations of the definition are consistent. In the majority of centres, it has been estimated that all adult parasuicides admitted to health facilities in the catchment area have been monitored, and in the other centres only about 10% of cases appear to have been missed. However, it is important to remember that inter-centre differences in respect of parasuicide treated in health facilities may not necessarily be replicated at the community level. If es-

Table 4. Ratio of female: male parasuicide rates (per 100,000 population aged ≥ 15 years) in 15 European centres, 1989

	Events	Persons
Szeged	1.17	1.09
Umeå	1.72	1.54
Bordeaux	2.00	1.92
Helsinki	0.71	0.72
Emilia-Romagna	1.46	1.59
Berne	1.37	1.38
Guipuzcoa	1.16	1.27
Leiden	2.13	1.84
Odense	1.11	1.17
Sor-Trondelag	1.34	1.43
Innsbruck	1.92	1.99
Pontoise	2.15	2.10
Padua	1.53	1.49
Stockholm	1.80	1.74
Würzburg	N/A	1.63

N/A: not available. See note to Table 2.

Table 5. Ratio of event: person rates (per 100,000 population aged ≥ 15 years) in 15 European centres, 1989

	Men	Women
Szeged	1.12	1.20
Umeå	1.06	1.18
Bordeaux	1.03	1.07
Helsinki	1.28	1.26
Emilia-Romagna	1.17	1.08
Berne	1.08	1.07
Guipizcoa	1.22	1.12
Leiden	1.07	1.24
Odénse	1.30	1.23
Sor-Trondelag	1.15	1.08
Innsbruck	1.08	1.05
Pontoise	1.13	1.15
Padua	1.05	1.08
Stockholm	1.12	1.15
Würzburg	N/A	N/A

N/A: not available. See note to Table 2.

timates of the ratio of medically treated: non-medically treated parasuicide provided by Bordeaux and Umeå (see above) are correct, then any comparison of parasuicide incidence in the two centres would depend critically on prevailing case-finding criteria. Restricting parasuicide to health-facility-treated cases only, the overall event rate (male and female combined) in 1989 was 42% higher in Bordeaux (204) than in Umeå (144). If, however, all cases were to be included (assuming that the estimates of non-treated cases in each centre were correct), the relationship between the centres would be completely reversed: the rate in Umeå (510) would be about 125% higher than the rate in Bordeaux (227). Given the near-impossibility of establishing a true parasuicide population rate, we believe that the only sensible research decision is to concentrate on ensuring the complete coverage of medically treated parasuicide in the various centres.

Is it possible to go beyond the claim that inter-centre comparisons are meaningful and valid? In particular, can we generalize from our findings to make statements about differences and similarities in parasuicide profile between countries? The answer to this question depends on the extent to which each centre is typical of the whole country (or state) in which it is located. We have therefore asked centres to assess the representativeness of their catchment area (compared with the whole country) in respect of (a) sociodemographic profile, (b) indicators of social instability and disorganization, and (c) health and welfare systems. Unfortunately, the quality of data provided thus far do not permit any general conclusions to be drawn, although it is likely that centres will cover the whole spectrum of typically or generalizability, from very low (such as Helsinki) to very high (such as Sor-Trondelag and Leiden). Furthermore, variation from the national norm may be in the direction of worse (such as Szeged on measures of social instability) or better (such as Umeå on the same measures). For the present, we should avoid turning differences between centres (such as the male event rate being 9 times greater in Helsinki than in Leiden) into differences between their respective mother countries (such the male event rate in Finland being 9 times that of the Netherlands).

When the full 1989 dataset for each centre is available, it will be possible to examine the relationship between parasuicide and several other sociodemographic risk variables, including social class, economic position (especially unemployment), marital status, educational level and religious affiliation. The availability of datasets covering the years 1990 onwards will permit the examination of trends over time. In this preliminary report we have been able to provide a breakdown of parasuicide by age and gender and for the year 1989, only. The main findings and their implications can be briefly summarized:

1. The wide variation across Europe in the incidence of parasuicide among adults does not appear to result from deficiencies in study design or method. It will be necessary to devise and test competing explanations (hypotheses) for these inter-centre differences, and possibly, plan appropriate intervention studies in high-rate areas.
2. Although parasuicide is a behaviour more commonly found among teenagers and young adults than among middle-aged and elderly people, there is little evidence of a simple inverse association between age and parasuicide. The highest event rate was found most often in the 25- to 34-year age group, and among males in 5 centres the highest rates were in the 35- to 44-year age group.

A comparison of our findings with those relating to the 1970s (4) suggests the possibility that the peak age for parasuicide may now be somewhat older than previously, but this is a rather speculative interpretation of inadequate data.

3. There are firmer grounds for arguing that the sex ratio in 1989 is markedly lower than that found in the 1970s. Reviewing a number of studies, Diekstra (4) showed that the ratio of female: male parasuicide (person) rates across several European cities varied between 1.37 and 4.00. In contrast, the range in our study (person rates) was 0.72 to 2.10. The higher parasuicide incidence among men in Helsinki is an outstanding finding, but an elucidation of the general trend towards parity between women and men in respect of overall parasuicide rates requires a further research effort.
4. The short-term repetition of parasuicide behaviour is extremely high in a number of centres, especially Guipuzcoa, Helsinki, Odense and Szeged. Our findings support the decision taken by collaborating centres to combine the epidemiological monitoring project with a study that aims (in part) to identify predictors of future suicidal behaviour among parasuicides.

References

1. WHO Regional Office for Europe. Targets for health for all. Copenhagen: WHO Regional Office for Europe, 1985 (European Health for All Series, No. 1).
2. WHO Regional Office for Europe. Working Group on Preventive Practices in Suicide and Attempted Suicide: summary report. Copenhagen: WHO Regional Office for Europe, 1986 (document ICP/PSF 017(s) 6526V).
3. PLATT S, HAWTON K, KREITMAN N, FAGG J, FOSTER J. Recent clinical and epidemiological trends in parasuicide in Edinburgh and Oxford: a tale of two cities. Psychol Med 1988: 18: 405–418.
4. DIEKSTRA RFW. Epidemiology of attempted suicide in the EEC. In: WILMOTTE J, MENDLEWICZ J, ed. New trends in suicide prevention. Basel: Karger, 1982: 1–16 (Bibliotheca Psychiatrica, 162).
5. DIEKSTRA RFW. Suicide and suicide attempts in the European Economic Community: an analysis of trends, with special emphasis upon trends among the young. Suicide Life Threat Behav 1985: 15: 27–42.

Appendix

Centres participating in WHO/EURO multicentre study on parasuicide (main research collaborators are given in parentheses)

1. Odense, Denmark (Dr U. Bille-Brahe)
2. Emilia-Romagna, Italy (Dr P. Crepet)
3. Padua, Italy (Dr D. de Leo, Professor L. Pavan)
4. Helsinki, Finland (Professor J. Lonnqvist)
5. Würzburg, Germany (Dr A. Schmidtke)
6. Munich, Germany (Professor H.-J. Moller)
7. Umeå, Sweden (Ms E. Salander-Renberg, Professor L. Jacobsson)
8. Leiden, the Netherlands (Professor R.F.W. Diekstra, Dr A. Kerkhof)
9. Stockholm, Sweden (Assistant Professor D. Wasserman)
10. Pontoise, France (Dr A. Philippe)
11. Bordeaux, France (Dr X. Pommereau)
12. Sor-Trondelag, Norway (Professor T. Bjerke)
13. Innsbruck, Austria (Dr C. Haring)
14. Szeged, Hungary (Dr B. Temesvary)
15. Guipuzcoa, Spain (Dr I. Querejeta)
16. Berne, Switzerland (Dr K. Michel)

At the WHO Regional Office for Europe (Copenhagen, Denmark), the study falls under the responsibility of Dr J.G. Sampaio Faria, Regional Advisor for Mental Health. General coordination and management is in the hands of Dr J.H. Henderson (Medical Director, St Andrew's Hospital, Northampton, UK, formerly European Regional Officer for Mental Health), and Dr S. Platt (nonclinical scientist at the MRC Medical Sociology Unit, Glasgow, UK) is responsible for technical coordination and guidance. To facilitate progress during the pilot phase and to ensure strict adherence to the protocol during the main phase, a small steering group was appointed: Dr S. Platt, Dr U. Bille-Brahe (Unit for Suicidological Research, Department of Psychiatry, Odense University Hospital, Denmark), Dr A. Schmidtke (Department of Clinical Psychology, Psychiatric Clinic, Würzburg, Germany) and Dr A. Kerkhof (Department of Clinical Health and Personality Psychology, University of Leiden, the Netherlands).