

MONSUE



A European Multicentre Study on Suicidal Behaviour
and Suicide Prevention

EU-Grant 2003/791077-MONSUE

Background

In many European countries, suicidal behaviour constitutes a major public and mental health problem and a considerable drain on resources in both primary and secondary health care settings. Therefore, EU and the European region of WHO identified prevention of suicidal behaviour as a main target.

Evaluation-Monitoring

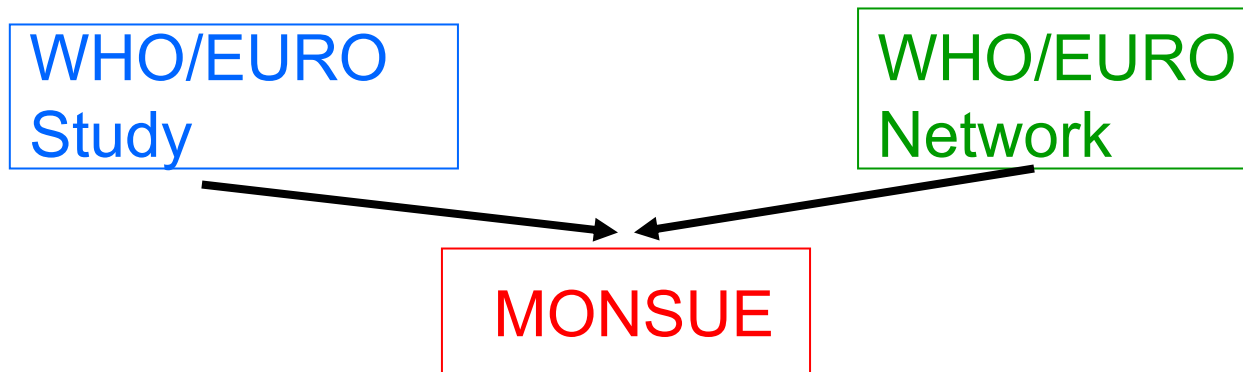
To develop primary and secondary prevention strategies indicators for this behaviour are required.

Therefore, an important strategy in suicide prevention is not only to initiate and implement suicide preventive programs, but also the continuous monitoring of suicide **and attempted suicide** as well as repetition rates in order to delineate suicide trends and suicide risk groups as well as protective factors and effects of preventive measures.

MONSUE is an extensive research project, carried out within 15 EU countries and 8 countries within the EUROPEAN region of WHO

Evaluation-Monitoring

The project is based on the experiences of the [WHO/EURO Multicentre Study on Suicidal Behaviour](#) and is coworking with the [WHO/EURO Network on Suicide Research and Prevention](#)



Main beneficiaries and EU-status MONSUE

Centres in EU-Member States:

- Hall (Austria)
- Salzburg (Austria)
- Odense (Denmark)
- Tallinn (Estonia)
- Helsinki (Finland)
- Nancy (France)
- München (Germany)
- Hamburg (Germany)
- Würzburg (Germany)
- Athens (Greece)

- Pecs (Hungary)
- Szeged (Hungary)
- Rome (Italy)
- Riga (Latvia)
- Ljubljana (Slovenia)
- Oviedo (Spain)
- Stockholm (Sweden)

Centres in Applicant/Other

Countries:

- Oradea (Romania)
- Ankara (Turkey)

Participating centres WHO-Network

COUNTRY

CENTRE

GUS (Russia)

Moscow

Serbia and Montenegro

Novi-Sad

Switzerland

Bern

Basel

Ukraine

Odessa

United Kingdom

Manchester

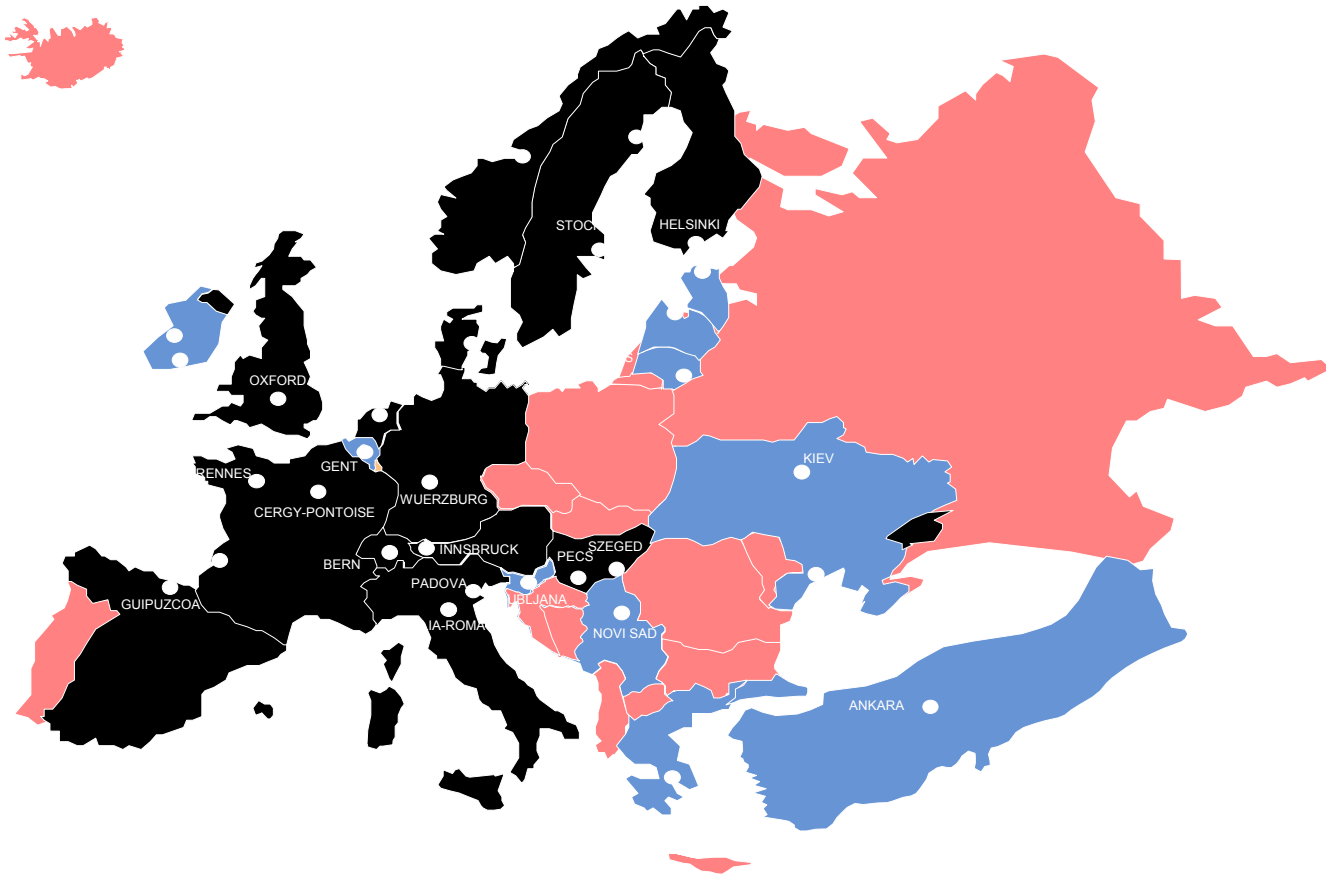
Oxford

Israel

Holon

Galilee

PARTICIPATING CENTRES MONSUE



- Old centres WHO Multicentre Study
- New centres
- Not participating

Evaluation-Monitoring

Goals

1. Collecting suicide and suicide attempt data
2. Determination of trends
3. Assessment of a sociodemographic picture of suicides and suicide attempters (e. g. ethnicity, social status, immigrant status, employment status, profession)
4. Assessment of treatment and the use of treatment after a suicide attempt
5. Assessment of the efficacy of treatment procedures
6. Assessment of the efficacy of measures within primary suicide prevention activities (e. g. media guidelines, building of fences on bridges, railway and subway tracks, etc.)

Evaluation-Monitoring

Methods and Material

Common instruments (Monitoring form)

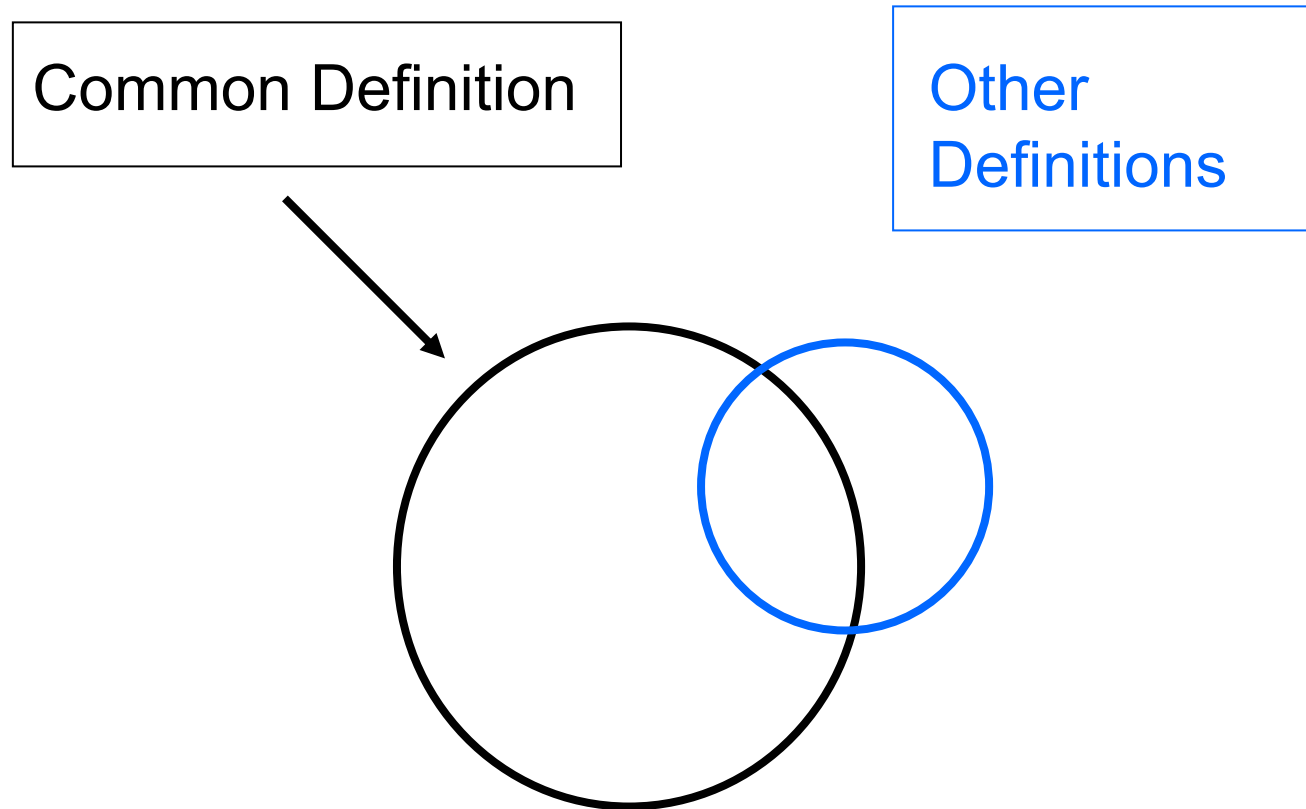
Common Definition of a catchment area

(150.000 – 250.000 inhabitants, availability of demographic data)

Common definition of suicide attempt

Comparison of measures in the various catchment areas

Example: Possibility of testing of other definitions



Common Definition

The group agreed at a meeting in Würzburg in February 2005 to adopt the WHO working definition, used in the WHO Multicentre study and to test the usefulness of other definitions (e. g. the terms parasuicide/DSH/SIB).

Suicide attempt is defined as:

“... an act with non-fatal outcome, in which an individual deliberately initiates a **non-habitual behaviour** that, without intervention from others, will cause self-harm, or deliberately ingests a substance in excess of the prescribed or generally recognized therapeutic dosage, and which is aimed at realizing changes which the subject desired via the actual or expected physical consequences.”

MONSUE Cooperations

Cooperation with the following other EU projects or EUROPEAN or WHO activities:

WHO/EURO Network on Suicide Research and Prevention

EAAD (Würzburg, Tallin, and other centres)

EMIP (WHO Network)

Various National Suicide Prevention Programs (e. g. in Germany, Switzerland, Sweden)

Future plans

1. Development, testing and revision of the common monitoring form
2. Assessment of preventive measures in the various catchment areas
3. Starting with the monitoring
4. Encouragement of preventive activities
5. Testing the effects of preventive measures
6. Development of guidelines

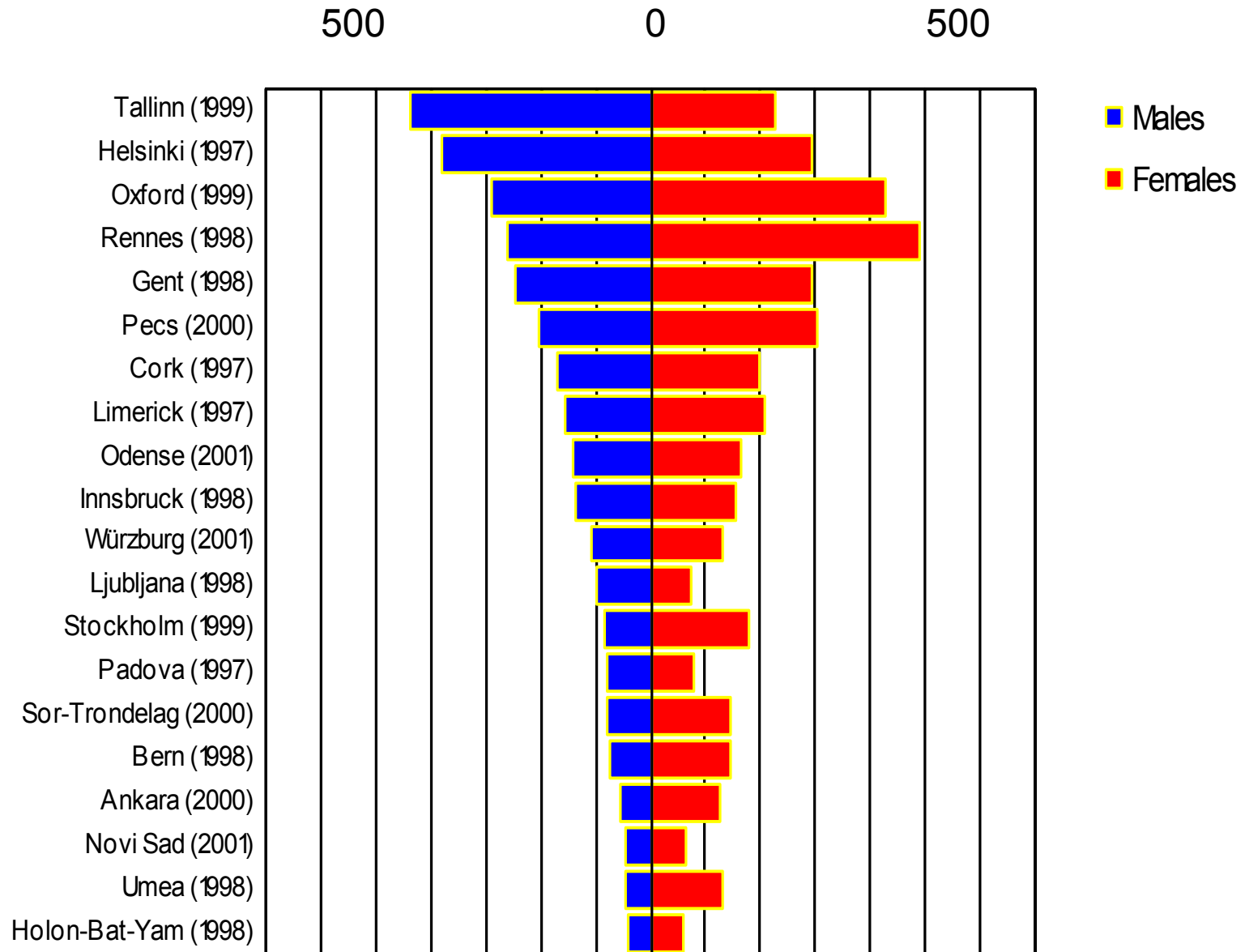
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Some results of the previous study

Publication of previous results

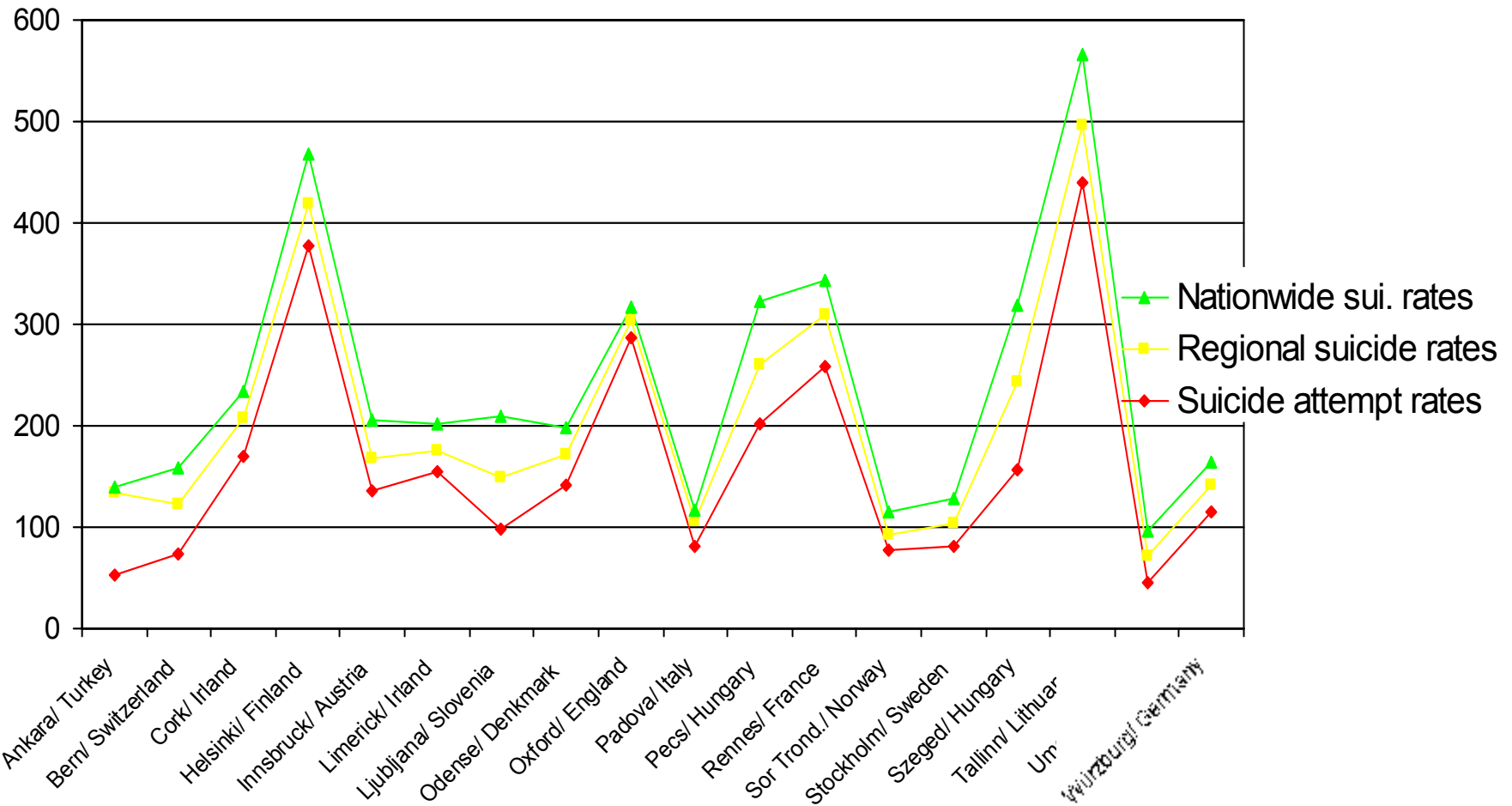


Rates of Suicide Attempts in Europe: Males and Females (Latest available year)



Comparison of suicide attempt rates, national and regional suicide rates

Latest available corresponding year: Males



Suicide and suicide attempts/ 100.000 in different centres/ countries



Major problems of multicentre studies over long time periods are:

1. The fading out of the monitoring system
2. The drop out of centres

1. The fading out of the monitoring system

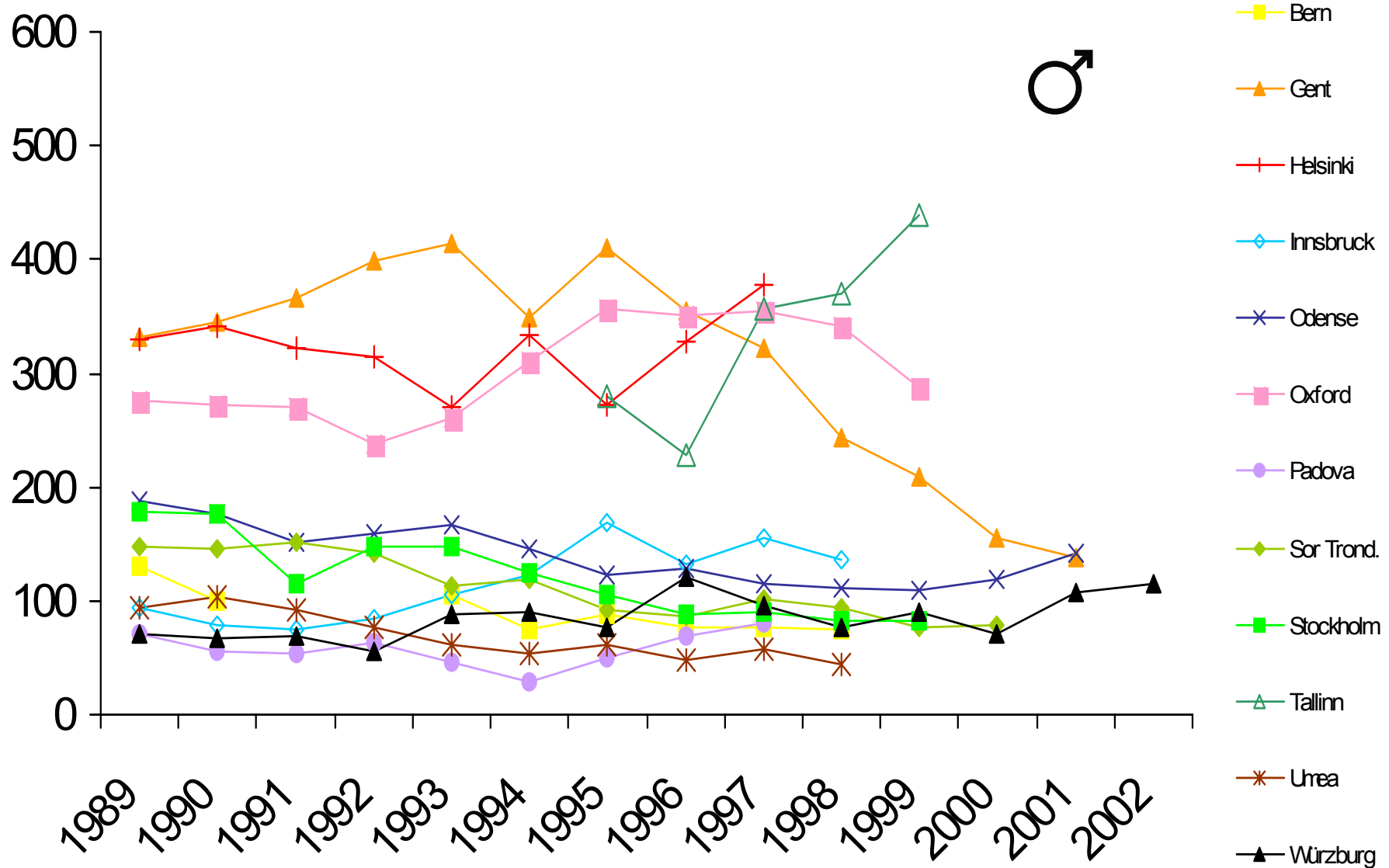
No general trends of decreasing rates in the various centres observable

A continuous decrease could not be found; rather, in most of the centres, an increase over the years observed could be found

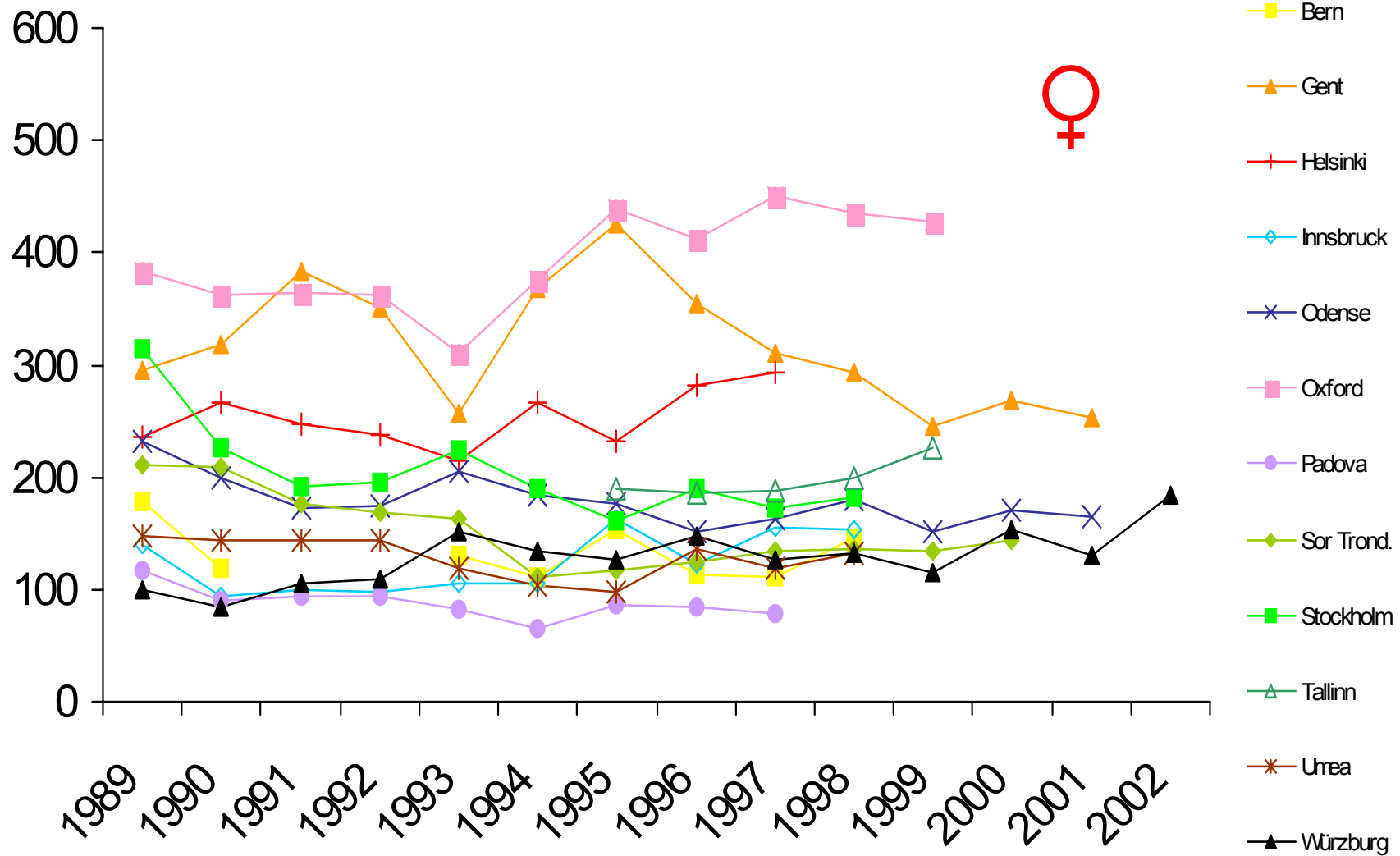
2. The drop out of centres

Not avoidable

Trends in suicide attempt rates: Males

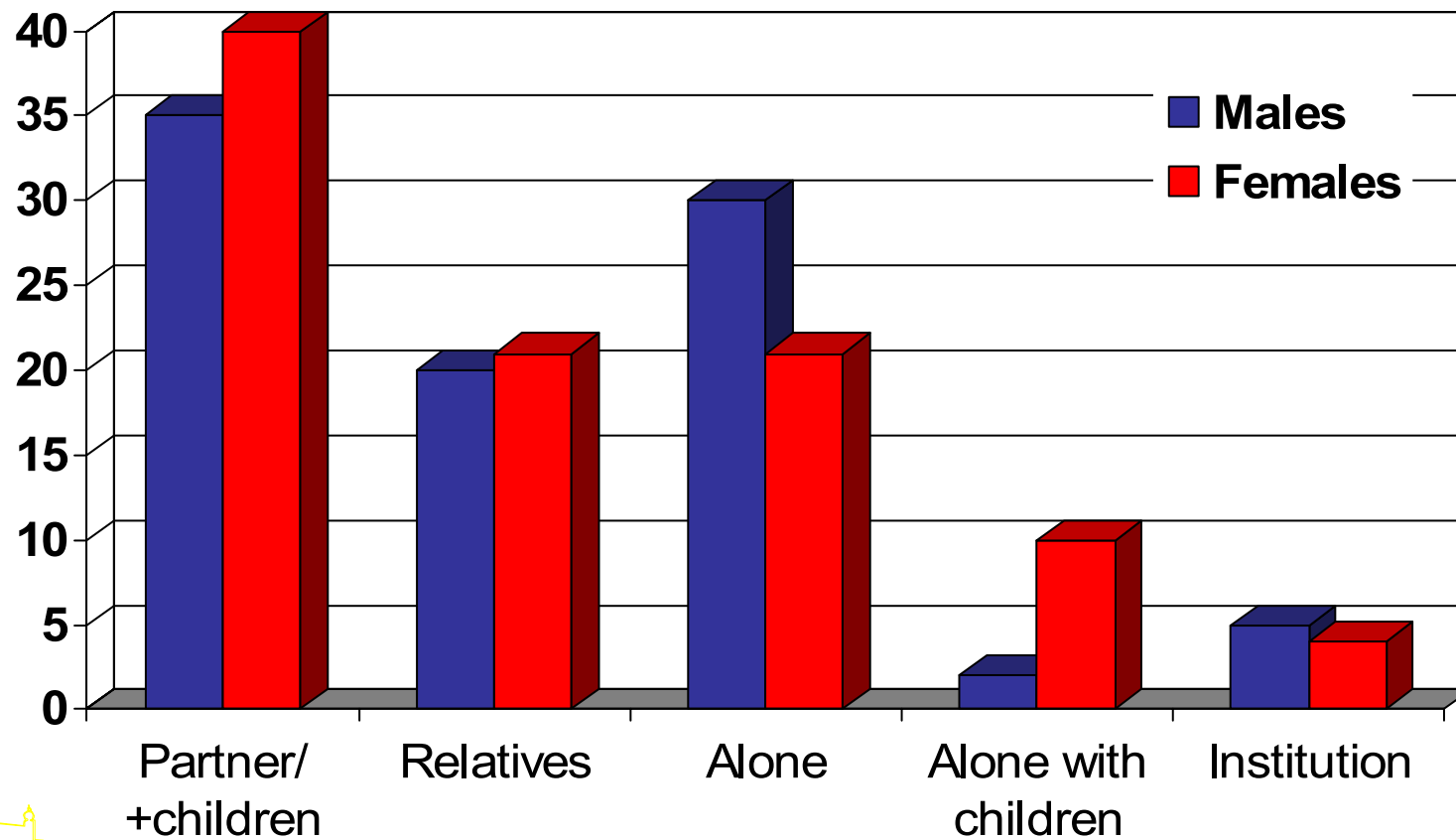


Trends in suicide attempt rates: Females

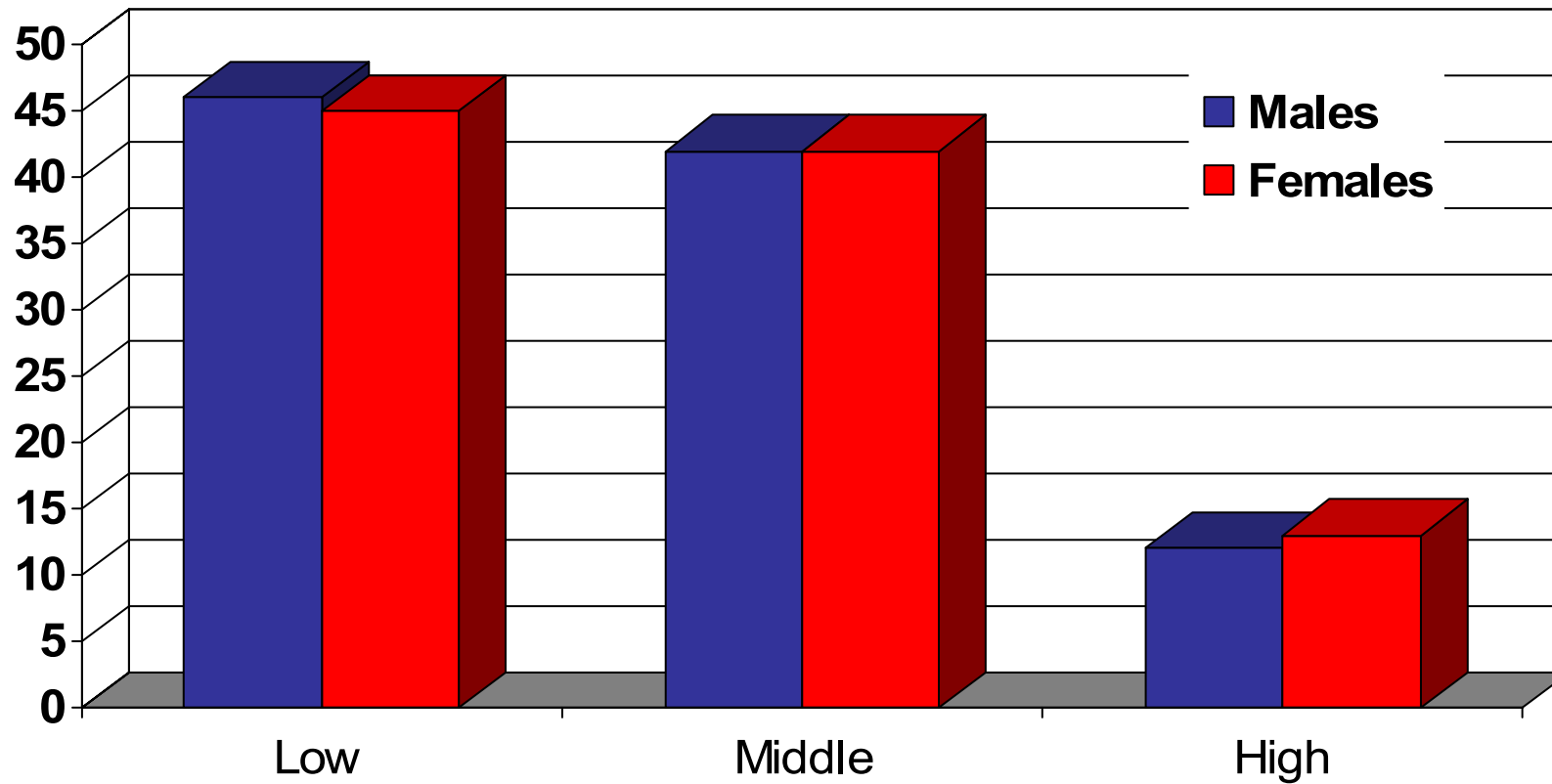


The rank order of the centres over time did not change very much

WHO/EURO Multicentre Study on Suicidal Behaviour: Usual household composition

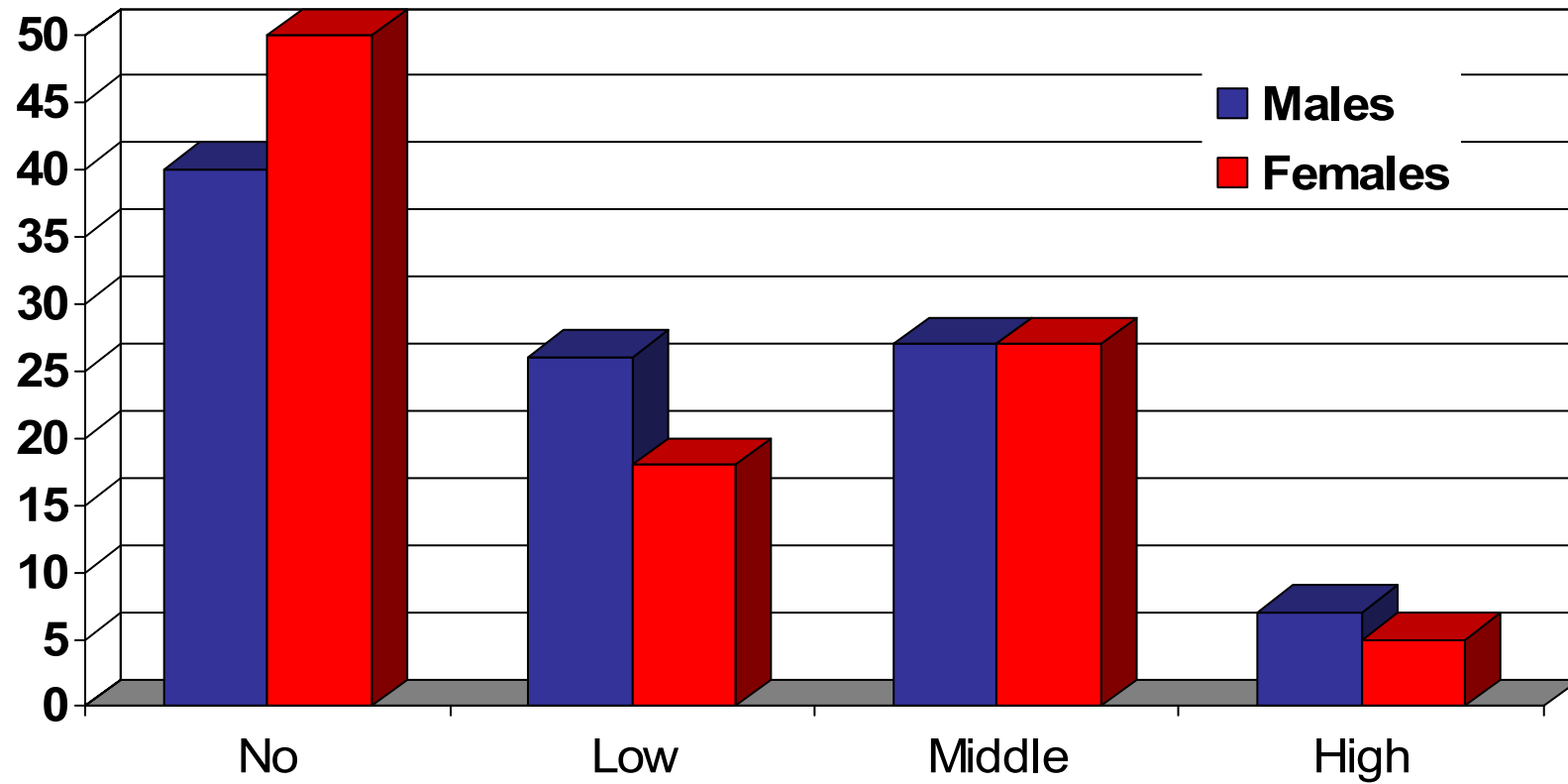


WHO/EURO Multicentre Study on Suicidal Behaviour: Level of education

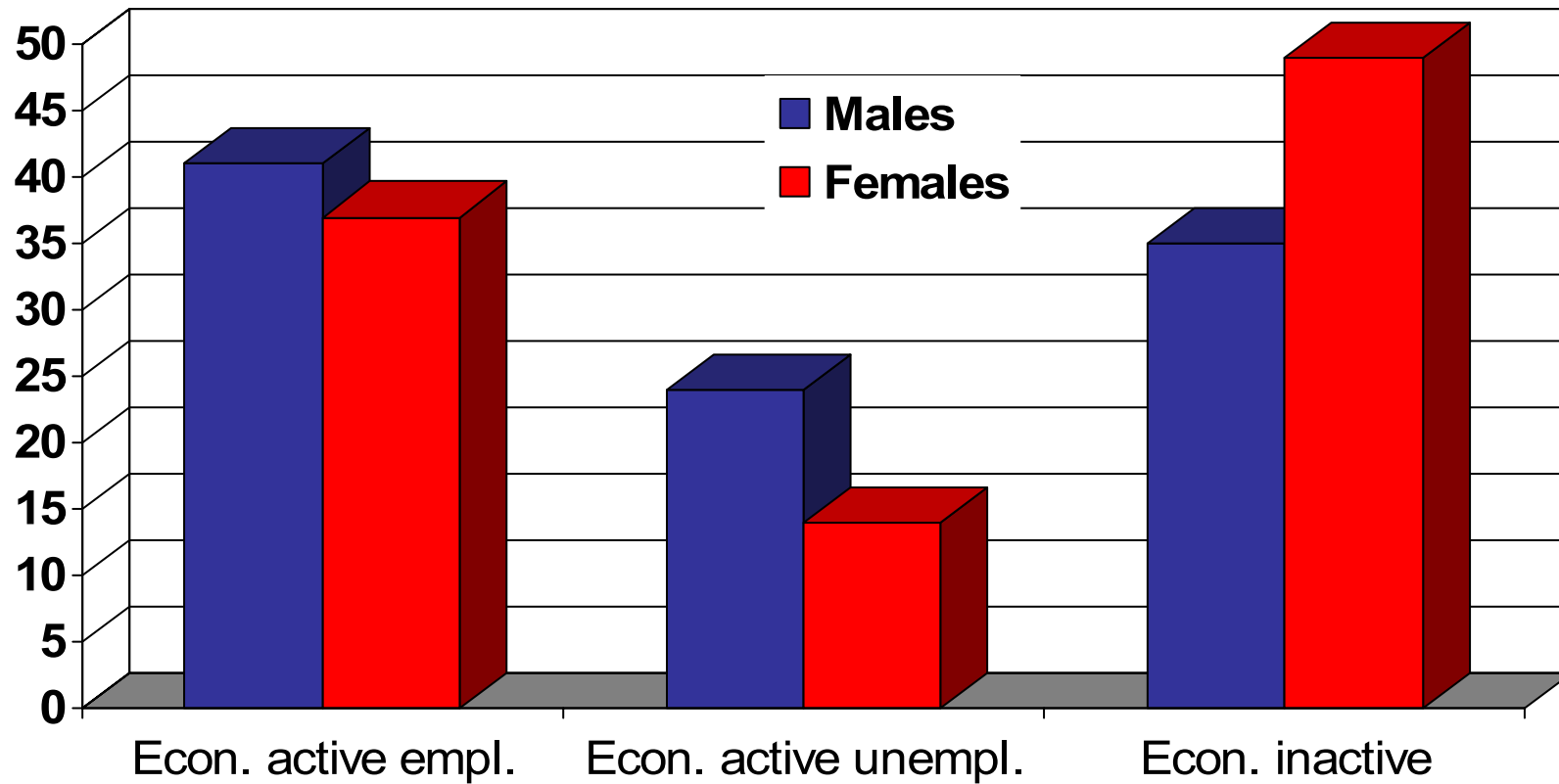


WHO/EURO Multicentre Study on Suicidal Behaviour

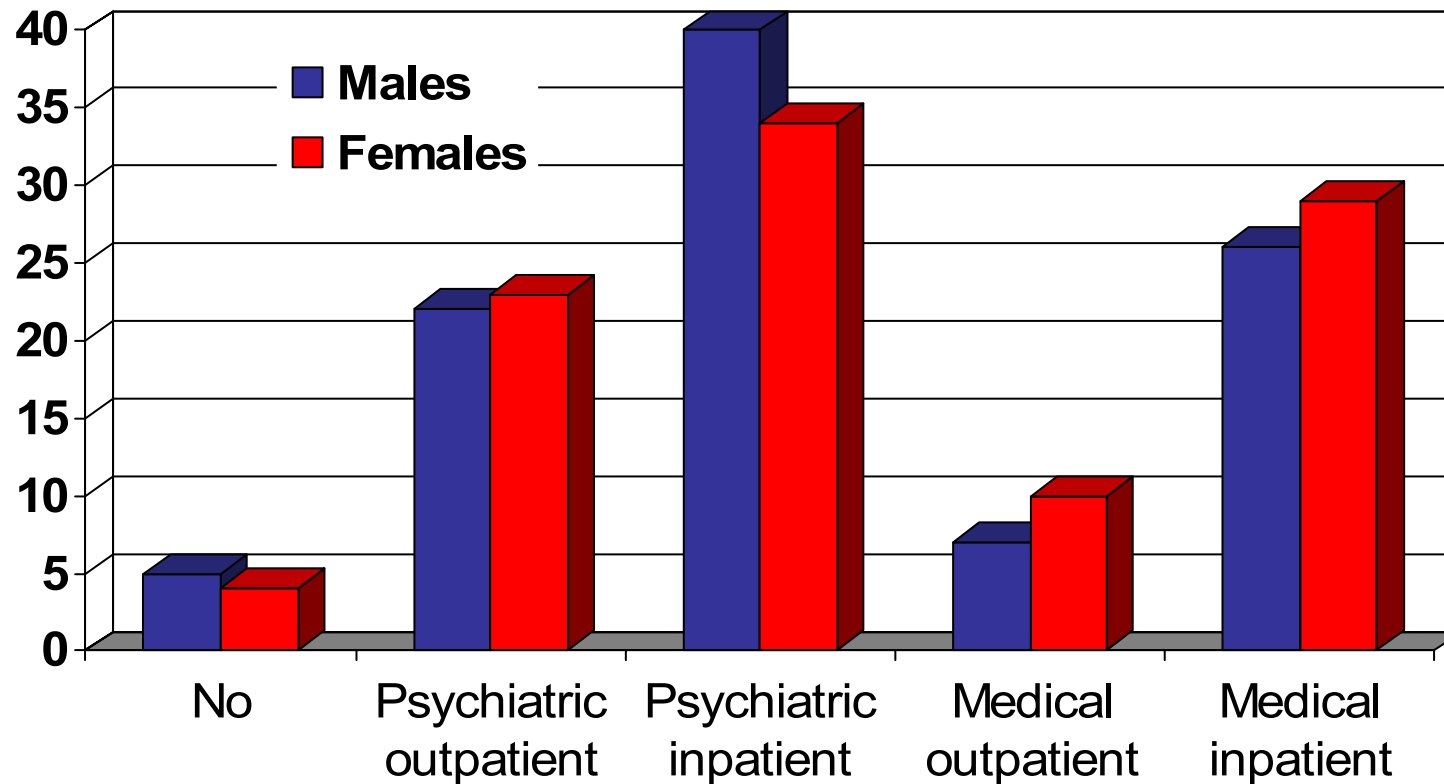
Level of vocational training



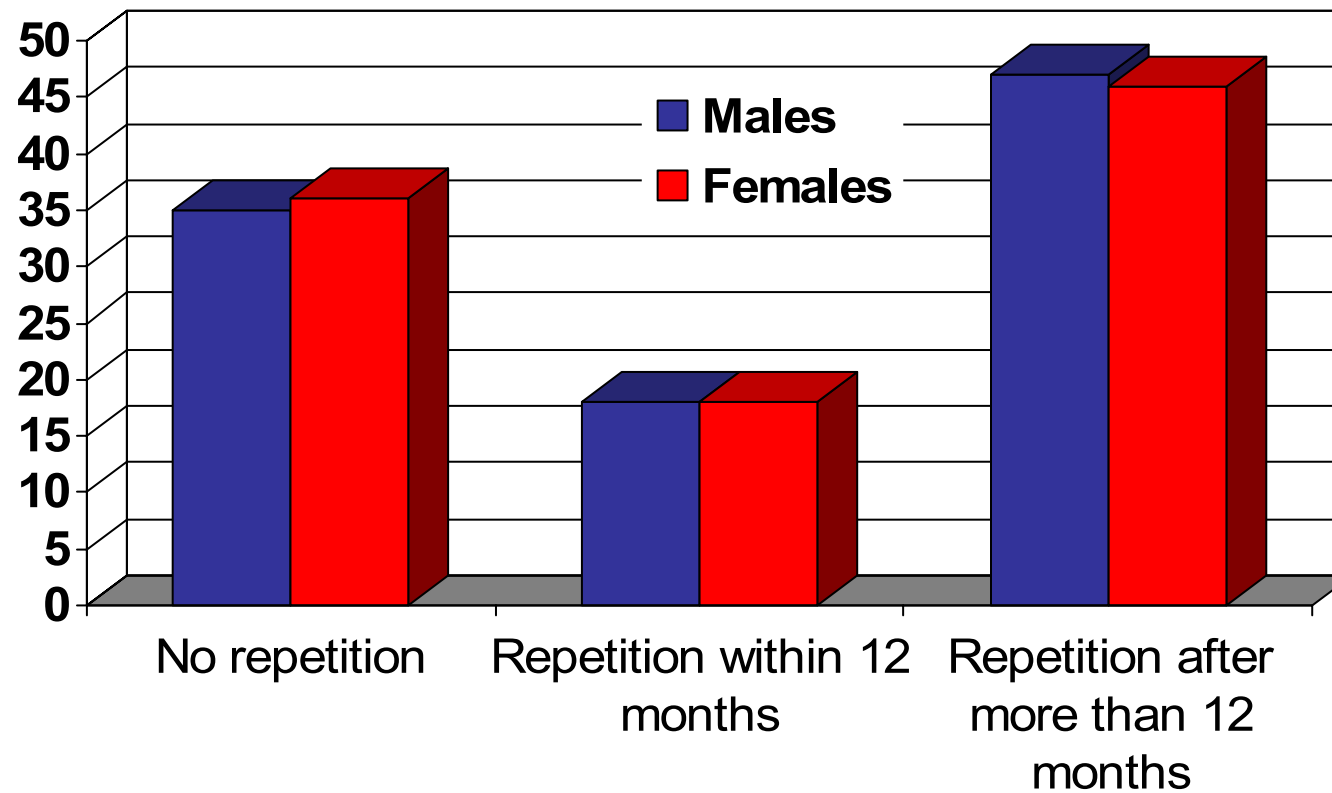
WHO/EURO Multicentre Study on Suicidal Behaviour Employment status



WHO/EURO Multicentre Study on Suicidal Behaviour Recommended aftercare



WHO/EURO Multicentre Study on Suicidal Behaviour Repetition



The short-term repetition of suicidal behaviour is high in several centres. This could lead to the hypothesis that suicide attempters can be relatively easily separated into two groups: one group with only one or two attempts and one with three or more attempts.

In comparison to findings from the 1980s, it also seems that the rates of repetition of suicide attempts within 12 months of an attempt are increasing.

Aftercare of Patients after a Suicide Attempt: Results of the WHO Multicentre Study

First contact

GENERAL
HOSPITALS
65 %

PSYCHIAT.
CLINICS
14 %

DOCTOR IN
PRACTICE
16 %

PLACES OF
ADVICE
6 %

Second contact

CONSULTATION
52 %

PSYCH.CILINIC
32 %

DOCTOR IN PRACTICE
10 %

GENERAL HOSPITAL
10 %

ADVICE
2 %

NO FURTHER
TREATMENT IN
HOSPITAL
2 %

iNSIDE
35 %

ADVICE
10 %

GENERAL HOSPITAL
7 %

DOCTOR IN PRACTICE
8 %

NO FURTHER
TREATMENT IN
HOSPITAL
41 %

PSYCH.CILINIC
34 %

GENERAL HOSPITAL
31 %

DOCTOR IN PRACTICE
12 %

ADVICE
9 %

NO FURTHER
TREATMENT IN
HOSPITAL
14 %

ADVICE
18 %

GENERAL HOSPITAL
14 %

DOCTOR IN PRACTICE
12 %

PSYCH.CILINIC
59 %

NO FURTHER
TREATMENT IN
HOSPITAL
52 %

Continuity of Treatment

In contrast to many results of treatment studies, the continuity of treatment is not sufficient. A high percentage of persons has after a suicide attempt contacts with at least 5 „treatment providers“

Failure of Diagnosing of Psychiatric Disorders in Psychotherapy

Often psychiatric disorders are not recognised. Therefore, necessary treatment is often not provided or not provided in time.

Results of the WHO Multicentre Study (2004)

1269 patients after a SA were interviewed after the SA and 601 one year later:

58 %: First contact immediately or within the first month

18 %: First contact only after 6 months

On average 20 contacts (other than with GPs)

Range 1 - 60

Results of the WHO Multicentre Study (2004)

Inpatient treatment:

60 % satisfied with the medical and social treatment

7 % dissatisfied with the medical aspects

24 % dissatisfied with the psychosocial aspects

Outpatient treatment:

Only 16 % were dissatisfied with the psychosocial aspects



Paradox results of the WHO Multicentre Study

601 patients after a SA:

The better or more satisfactory the treatment seemed to the attempter, the higher the risk of recidivism

This paper was produced for a meeting organized by Health & Consumer Protection DG and represents the views of its author on the subject. These views have not been adopted or in any way approved by the Commission and should not be relied upon as a statement of the Commission's or Health & Consumer Protection DG's views. The European Commission does not guarantee the accuracy of the data included in this paper, nor does it accept responsibility for any use made thereof.