

Unofficial report. No working papers available.

FOLLOW-UP MEETING ON PREVENTIVE PRACTICES
IN SUICIDE AND ATTEMPTED SUICIDE
LONDON, 23-26 MARCH 1987

3 MEDICAL PPT
SUMMARY
ICP/PSF 018

8953



WHO-EURO Multicentre Study on Parasuicide
Minutes of meeting held in London, 23-26 March 1987

Present: U. Bille-Brahe, P. Crepet (not 26th), H-J. Moller (not 26th),
A. Schmidtke, R.F.W. Diekstra (not 25th, 26th), S.D. Platt,
J. Henderson (not 25th), A. Kerkhof (not 26th), E. Renberg,
J. Faria (26th only).

Apologies: J. Llonqvist

1. The Group discussed definitions of suicide and parasuicide and agreed to the revised version proposed at the York 1986 meeting. The latest definitions are given in the Summary Report of the York meeting (WHO-EURO document ICP/PSF 017(S)).
2. There was a broad discussion about the aims and rationale of the two main components of the proposed research programme.
 - (a) In relation to the monitoring exercise we identified the following purposes:
 - (i) estimation of the true incidence of medically treated parasuicide and trends over time.
 - (ii) identification of sociodemographic (risk) factors significantly associated with parasuicide.
 - (iii) assessment of the feasibility of using local case registers to monitor parasuicide in a defined catchment area.
 - (iv) ascertainment of variations in patterns of treatment following parasuicide in different cultural contexts (with a view to establishing more effective services for the prevention of this behaviour).
 - (b) In relation to the follow-up studies, we identified the following purposes:
 - (i) identification of personal and social characteristics predictive of future suicidal behaviour (suicide and parasuicide).
 - (ii) estimation of the social, psychological and economic burden of repeated parasuicide to the individual, his/her community and the wider society.
 - (iii) assessment of the utilisation of health and social services by the parasuicide population and the effectiveness of the different treatments offered.
 - (c) A further more general outcome of the research might be the creation of a Diagnostic Interview Schedule for use with this type of patient. One use for such a schedule could be the establishment of a link between specific types of parasuicide and specific types of after-care.
3. Design issues
 - (a) Monitoring of parasuicide (all ages) in all catchment area health facilities will be carried out for one year in each centre. Thereafter monitoring will be selective, based on general hospitals and a sample of general practitioners. Other facilities, e.g. psychiatric hospitals, will also be checked if a significant proportion of parasuicide contacts are treated in them. Thus, to some extent, the choice of facilities to be monitored after the first year will depend on the findings of the total survey carried out during the first year. Monitoring will continue for at least 5 years in each centre, although ideally it should last until 1999 in order to assess whether or not Target 12 of HFA 2000 has been achieved.

A number of technical issues were discussed:

- (i) the possibility of being able to link episodes over a number of years in the same individual. Is this desirable? Is it feasible? (Attention was drawn to difficulties caused by data protection laws in various countries.)
 - (ii) ensuring that a standardised definition of parasuicide is applied in all centres.
 - (iii) preferably data should be obtained from the patient by a doctor or interviewer and entered immediately on the research item sheet.
- (b) It was confirmed that the follow-up studies would not include data on a control (non-parasuicide) group. Only parasuicide in children (under 15 years) was to be excluded.

Technical issues discussed included:

- (i) Type of sample: random or stratified (by age and gender). No decision yet taken. Will depend in part on characteristics of treated parasuicide population.
- (ii) Facilities to be surveyed: definitely general hospitals (including accident and emergency); other facilities to be included if significant proportion of parasuicides are treated there (e.g. psychiatric hospitals in Germany, GPs in Sweden).
- (iii) First interview to be carried out within one week of episode, preferably in health facility.
- (iv) Sample size: probably ~~200~~ interviewed in each centre.
- (v) Start of first interview of follow-up study to be delayed until results of monitoring exercise are available.
- (vi) Number of interviewers: preferably one highly trained person, though possibility of two persons was discussed (one to collect psychiatric data, the other to collect social data).
- (vii) Discussion of role and status of interviewer. How important is it that the interviewers should be seen to be independent of treatment? Issue not resolved.
- (viii) Discussion of ethical problems. E.g. What does the interviewer do if parasuicide reveals information about criminal activities, or states intention to harm self or others once out of hospital, and this information has not been given to treatment team? How confidential is the interview?
POSITION PAPER NEEDED.
- (ix) Special attention to be paid to problems of non-contact and non-response. Each centre to consider this and make recommendations.

4. Contents of interviews

- (a) Agreed to drop income from monitoring schedule. SP to draw up draft form to include all other variables listed in Minutes of September meeting, para 9.
- (b) Following items were considered for inclusion in the first follow-up study interview. Initials in parenthesis refer to persons responsible for producing draft schedule. (Discussion based on list in van Egmond and Diekstra (ICP/PSF 017/7) and document submitted by Bille-Brahe (February 1987).)
 - (1) Diagnosis: AXIS I and AXIS II. (Discussed possibility of using DSM3 or field version of ICD10 for AXIS I and PDE or PAS for AXIS II) (HJM and AS).
 - (2) Sociodemographic information, including household circumstances (SP).
 - (3) Social network/support/integration (UBB and SP).
 - (4) Previous psychiatric history and history of suicidal

- behaviour (HJM).
- (5) Suicide ideation and intention (AK).
 - (6) Coping strategies (AS).
 - (7) Precipitating factors (AK).
 - (8) Circumstances of the act, including communications and interactions (ER).
 - (9) Lethality and medical seriousness of act (ER).
 - (10) Motives and intention of act (AK).
 - (11) Hopelessness and depression (AS and HJM).
 - (12) Treatment, disposition and aftercare (AK).
 - (13) Life events (SP).
 - (14) Childhood experiences and life history, including child abuse, broken home, separation (UEB).
 - (15) Physical and psychosomatic illness (AW and ER).
 - (16) Suicidal behaviour in family and significant others (models) (SP).
 - (17) Alcohol mis(use), substance (mis)use, medication (AW).
 - (18) Cognitive style (AS).
 - (19) Deviant behaviour (UEB).
 - (20) Attitudes to suicidal behaviour, including estimated chance of repetition (AK).
- (c) Following items were considered for inclusion in second interview (one year after first interview):
- (1) Repetition of parasuicide (via official records and in-person interview).
 - (2) All deaths, especially suicide (via official records and, possibly, significant others).
 - (3) Psychological well-being.
 - (4) Physical and psychosomatic complaints.
 - (5) Changes in social and economic conditions/circumstances.
 - (6) Contact with helping agencies (since original episode).
 - (7) Characteristics of repeated episodes of self-harm.
 - (8) Life events and difficulties (since first interview).
 - (9) Social functioning and adjustment.
 - (10) Depression and hopelessness.
 - (11) Perceived fulfilment of expectations/motives associated with index parasuicide
 - (12) Suicidal behaviour among family and significant others (since first interview)
 - (13) Treatment and compliance.
 - (14) Consumer appreciation.
 - (15) Perceptions of staff attitudes and behaviour towards patient.
 - (16) Receipt of sexual abuse and violence (especially by spouse).
 - (17) Changes in social integration/network/support.
- (d) Following items were suggested as possible specialised (non-core) topics (at first and/or second interviews):
- (1) Effect of parasuicide on social milieu (especially children) (UEB).
 - (2) Biochemical aspects (AS and HJM).
 - (3) Employment and unemployment (SP).
 - (4) Personality (HJM).
 - (5) Community and societal attitudes to parasuicide (GR).
 - (6) Alternatives, parallels to parasuicide (e.g. bulimia, anorexia, alcohol misuse); broader view of self-destructive behaviour (ER and UEB).
 - (7) Cognitive styles (second interview) (AS).
 - (8) AIDS and parasuicide.
 - (9) Changing role of women and division of labour.
 - (10) Transsexuality and sexual paraphilias.
 - (11) Gender and sexual identity.

5. Steering Group

In order to speed up progress during this preliminary phase, and to ensure tight control over the research once it is in progress, a small Steering Group was appointed. This consists of four members: Diekstra, Platt, Bille-Brahe and Schmidtke. The Steering Group is provisionally scheduled to meet in Bologna in October (11-12), at the invitation of Emilia-Romagna regional health department.

6. Organisational issues

- (a) WHD (EURO) to supply each centre with two letters: the first a general welcome and request to collaborate in the research project; the second targetted more specifically to the institution or agency from which local funds are being sought.
- (b) JH confirmed that WHD Target 12 funds are available only for management and coordination of the project, and not directly for research. The 1987 budget is now (over)spent. However, it might be possible to get an advance from the 1988 budget for covering some of the costs of a meeting of the Steering Group later this year. Some funds for the research should be available until at least 1995.
- (c) The Summary Report of the 1986 York meeting should be sent to counterparts in a number of European countries (suggestions included Greece, Spain, Portugal, Belgium, Yugoslavia), with an invitation to join the research project. Direct contacts to be made in Bilbao, Spain and with INSERM in France by Henderson. Platt to keep in touch with team in Oxford and Bille-Brahe to approach team in Bergen, Norway. Deadline for inclusion in the study as collaborating centre is Autumn 1987. Agreed that any new centre would have to pay one member of Steering Group to carry out briefing on site.
- (d) Data preparation and analysis will be carried out at one or more of the collaborating centres under the direction of the Steering Group. No financial or supervisory role for WHD (EURO) in this.
- (e) Agreed to aim at producing a publication in the Public Health in Europe series.
- (f) No central role for WHD (EURO) concerning ethical issues. These to be considered by the Steering Group and individual centres.
- (g) Might be possible to get some help from WHD (EURO) with German-English translation. JF to investigate.
- (h) Agreed to consider the field version of ICD10 for possible use in project. RD to follow up. JF should be sent names of interested centres and which language version is requested.
- (i) Agreed to consider field testing of the suicide chapters of ICD10. RD to follow up.
- (j) Each centre is responsible for seeking funds to cover local costs of research. However, the Steering Group should help local centres to prepare budgets for the research and should also approach international organisations (e.g. EEC, NATO) for funding.

WHO/EURO - Multicentre Studies on Parasuicide

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