INTERPSIQUIS 2020

XXI Congreso Virtual Internacional de Psiquiatría, Psicología y Enfermería en Salud Mental

Modelos de prevención del suicidio con resultados experimentales positivos

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Declaración de intereses

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Resumen

El suicidio es un problema de salud pública de primer orden en España (7,9 por 100.000 habitantes y año), y en jóvenes de 15-29 años es la segunda causa de muerte (INE, 2018).

Los dos modelos más destacados y con evidencias experimentales en la prevención de la muerte por suicidio son el programa *European Alliance Against Depression (EAAD)* y el norteamericano *Zero Suicides*. El programa EAAD tiene cuatro niveles de intervención, (población general, atención primaria, grupos de riesgo y otros agentes sociales). Los dos ingredientes principales son: a) mejorar la calidad del tratamiento de la depresión en atención primaria, con la participación de los especialistas en salud mental; b) asegurar el acceso rápido y continuado a la asistencia sanitaria de los pacientes de alto riesgo. El Código Riesgo Suicidio Catalunya generalizó esta práctica en toda la población de Catalunya de 7,5 millones de habitantes a partir de 2015, incluidos los jóvenes.

El modelo americano *Zero Suicides* es también una intervención multinivel más compleja y que precisa de una mayor financiación, pero es el único programa que ha demostrado que era posible reducir la mortalidad por suicidio hasta cero durante unos meses (Detroit, entre 2000 y 2010).

La muerte por suicidio debe considerarse como el desenlace fatal de un problema de salud mental que puede prevenirse si se aplican de forma continuada y sostenible las medidas sinérgicas apropiadas (basadas en evidencia científica) desde el ámbito de la salud y de la salud pública, incluidas las intervenciones en jóvenes.

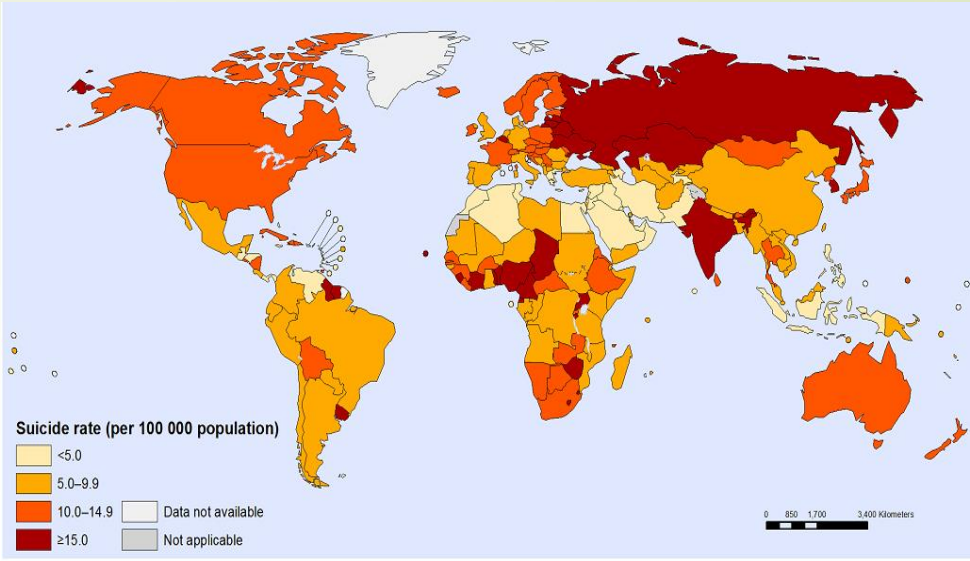
CONTEXTO SUICIDIO

MUNDIAL

800.000 suicidios anuales

2ª causa de muerte 15-29 años

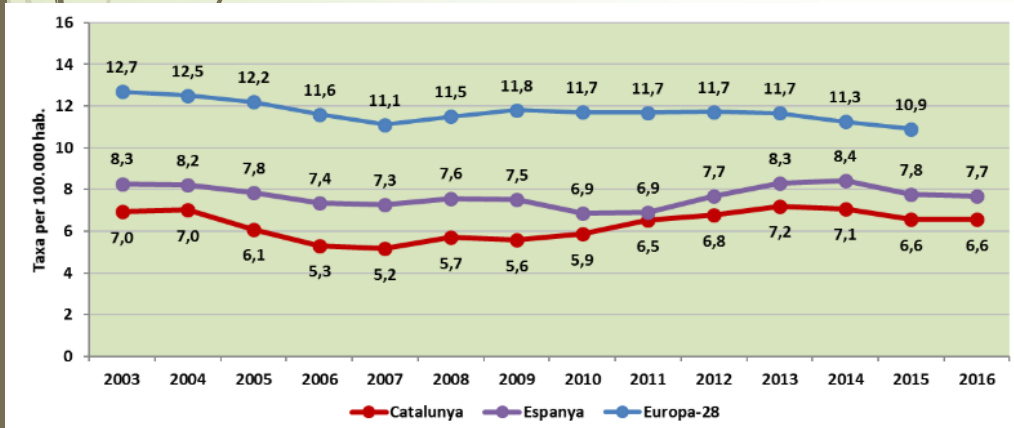
x10 veces víctimas por guerra



ESPAÑA (2017): 3.679 muertes por suicidio **INE(2018)**

7.9/100.000 hab.

1ª causa de muerte absoluta entre <u>hombres y mujeres</u> de 22 a 44 años



Font: Registre de Mortalitat de Catalunya, Ministerio de sanidad, Eurostat

A pesar del impacto en salud del suicidio, las tasas de suicido en Europa, España y Cataluña se han mantenido estables –con ligeras variaciones- en los últimos decenios

Figura 1. **El modelo de salud pública**

1. Vigilancia

¿Cuál es el problema?

Definir el problema del comportamiento suicida mediante una recopilación sistemática de datos

2. Identificar los factores de riesgo y de protección

¿Cuáles son las causas y qué puede amortiguar su repercusión?

Investigar para determinar las causas del comportamiento suicida y a quiénes afecta

3. Desarrollar y evaluar las intervenciones

¿Qué resulta eficaz y para quién?

Diseñar, ejecutar y evaluar las intervenciones para determinar lo que funciona

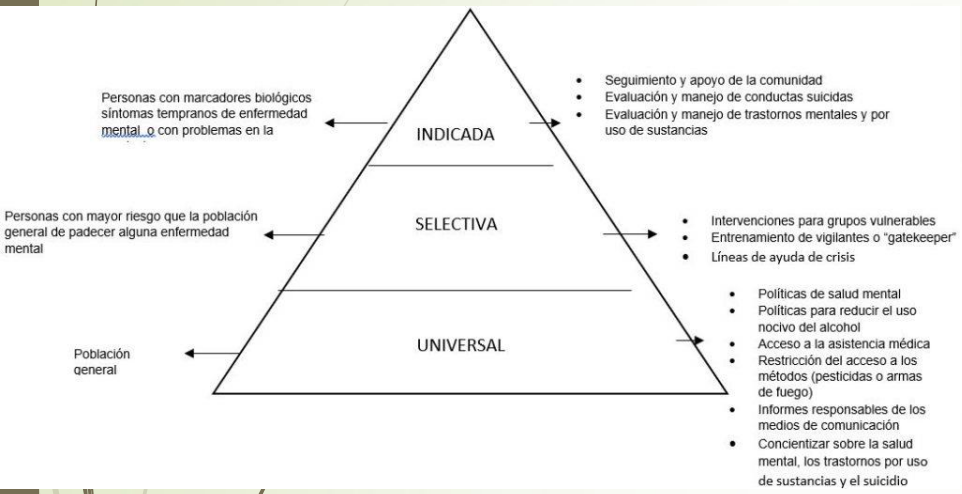
4. Ejecución

Ampliación a mayor escala de políticas y programas eficaces

Aumentar las intervenciones eficaces y prometedoras y evaluar su repercusión y efectividad

Plan de Acción OMS en Salud Mental 2013 - 2020: reducir la tasa de suicidio un 10% **Programa SUPRE (*Suicide Prevention*)**

Prevención del suicidio



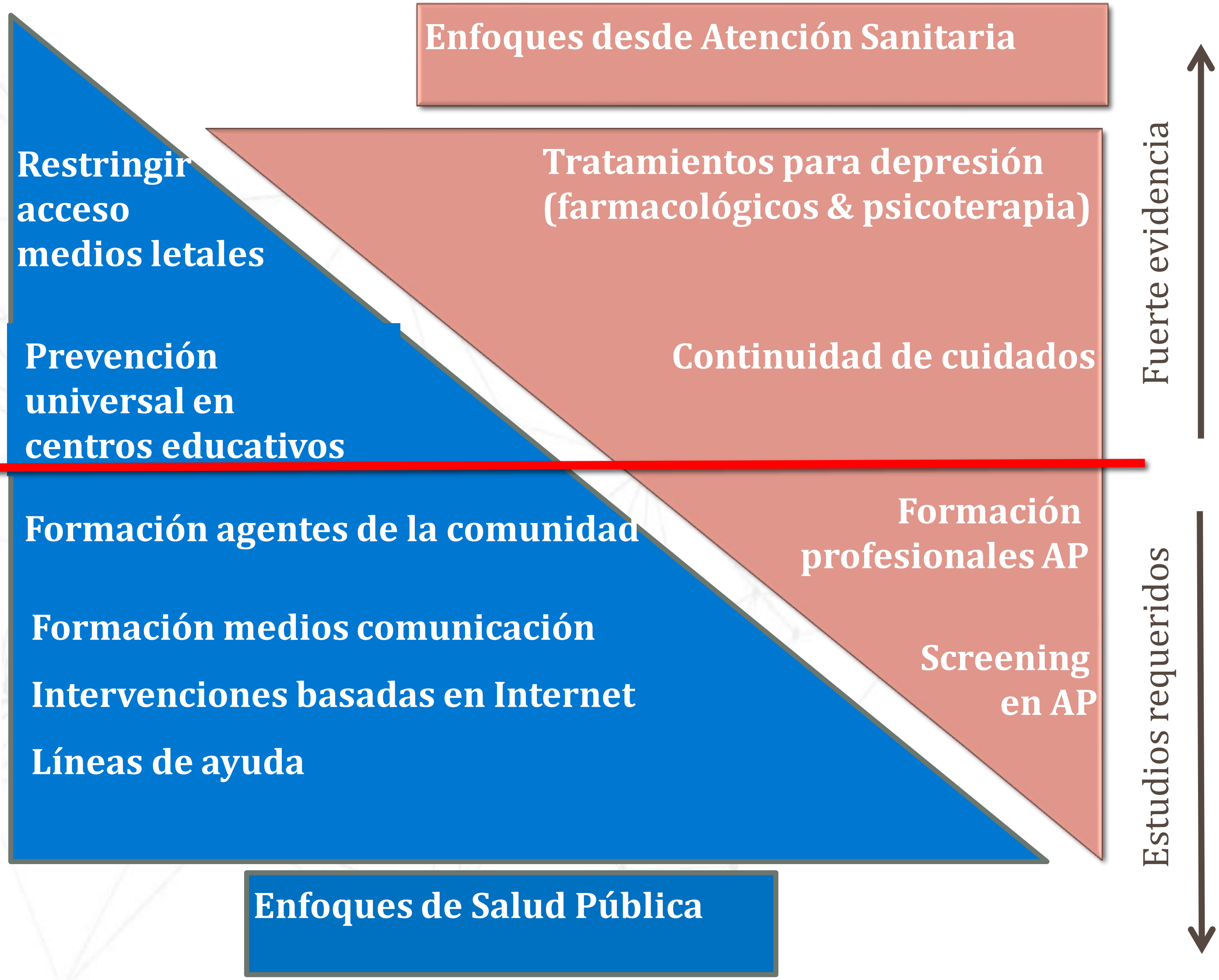
- **UNIVERSAL.** Población general, independ. del riesgo. Efectos a largo plazo.
- **SELECTIVA.** Grupos de alta vulnerabilidad para prevenir la aparición de conductas suicidas (p.ej. Depresión), relativamente sencillas de implementar. Los efectos no son fáciles de observar y medir.
- **INDICADA.** Grupos de alto riesgo (p.ej. TA previas): estrategias de gestión de casos al alta (CRS), tto. psiquiátrico y TCC grupal. El beneficio depende de la adaptación individual.

Stone D, Crosby A; Am J Lifestyle Med, 2014; 8(6):404-20)

Revisión de la evidencia científica en prevención del suicidio

Zalsman et al. Suicide prevention strategies revisited: 10-year systematic review.
Lancet Psychiatry, 2016 Jul;3(7):646-59..

EESPP:
Programa de Prevención del Suicidio Basado en Evidencia



Science

Suicide—turning the tide

Merete Nordentoft and Annette Erlangsen

EDITORIAL

Suicide–turning the tide

Suicide is a devastating public health problem, afflicting individuals, families, and societies. Fortunately, continuous striving by the World Health Organization to strengthen suicide prevention efforts is paying off. The annual number of suicide deaths decreased from 1 million to 800,000 worldwide during recent decades. A gloomy exception to this trend is the increasing rate of suicide in the United States (14.0 per 100,000 in 2017). But Denmark's experience offers some hope that prevention of suicide is possible. Why has its decline in suicide been steeper than in most other countries?

Historically, the Danish suicide rate was among the highest in the world. In 1980, it was 38 per 100,000 inhabitants over 15 years of age (Hungary's rate was 52 per 100,000). But the Danish rate then began to decline, reaching 11.4 per 100,000 in 2007, roughly where it still stands today. This is among the lowest in high-income countries.

Denmark's strategy for tackling suicide was multipronged and spanned decades. One of the most effective elements was restricting access to dangerous means of suicide. The government initiated restrictions on the availability of medication with high case fatalities, such as sedatives (barbiturates) and opioids (dextropropoxyphene), and introduced less-toxic antidepressants (such as selective serotonin reuptake inhibitors). Removal of carbon monoxide from household gas and the introduction of catalytic converters in car exhaust systems (to reduce the emission of toxic concentrations of carbon monoxide) are likely to have been beneficial. In addition, restrictions on firearm availability and regulations requiring that weapons and am-

served in the suicide rate among people with mental illnesses over recent decades might be related to better outpatient treatments, which have seen a 66% increase in capacity since 2000.

Denmark also implemented initiatives to reach those who are at immediate high risk. For instance, Suicide Prevention Clinics have offered counseling, therapy, and practical support to persons with suicidal ideation or behavior nationwide since 2007. This therapy has been linked to long-term reductions in fatal (29%) and nonfatal (18%) suicidal acts. A Psychiatric Emergency Outreach team provides support to people in a severe crisis by having a psychiatrist and an ambulance on call 7 days a week. The Strengthening Outpatient Care After Discharge (SAFE) project recently began offering home visits and family support to patients discharged from a psychiatric hospital. In addition, the Danish nonprofit organization Lifeline is a suicide hotline that offers anonymous counseling by trained volunteers.

Can Denmark do even better? Further reductions in suicide could be achieved through targeted interventions for selected risk groups. Denmark has an abundance of unique, complete, and individual-level register data, which cover the entire nation and can be linked together through a personal identifier, thus providing excellent opportunities to pinpoint high-risk groups. These include populations with mental or somatic symptom disorders (including alcohol and substance abuse), as well as people experiencing social adversities and marginalized groups, such as homeless individuals, children in foster care, people living in sheltered housing and nursing homes, and incarcerated individuals. Careful moni-

"The Danish example shows that suicide prevention initiatives save lives."

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Prevención UNIVERSAL

- **Iniciativas de Educación Pública**: mejoran el conocimiento y las actitudes pero no han demostrado impacto en conductas actuales (Dumesnil H, Verger P, 2009); no mejoran la búsqueda de ayuda en pacientes con depresión (Fountoulakis et al 2011)
- **Campañas en medios de comunicación:** esencial las recomendaciones para evitar "contagios" –efecto Wherter-; campañas exitosas limitadas (p.ej. Reducción del 20% suicidios en el metro en Austria)
- **Compañas educativas en los colegios:** incrementan el conocimiento de los factores de riesgo, facilita recursos de ayuda a profesores y alumnos; algunos demuestran reducción en conductas suicidas (Robinson et al 2013; Wyman et al, 2010; Wilcox et al, 2008; Wasserman et al, 2015) e incluso reducción de suicidios en cinco años (Zenere et al 1997).
- **Restricción acceso a medios letales:** la intervención con apoyo más robusto (Mann JJ et al, 2005), cambiado normativas (p.ej. restricción armas de fuego, paracetamol, gases tóxicos, pesticidas, protección instituciones, puentes). Hay evidencias de reducción de suicidio (Sarchiapione et al, 2011; Miller et al, 2012). Son particularmente efectivos en suicidios impulsivos de alta letalidad, aunque se requieren seguimientos prolongados

School-based suicide prevention programmes: the SEYLE cluster-randomised, controlled trial

Danuta Wasserman, Christina W Hoven, Camilla Wasserman, Melanie Wall, Ruth Eisenberg, Gergö Hadlaczky, Ian Kelleher, Marco Sarchiapone, Alan Apter, Judit Balazs, Julio Bobes, Romuald Brunner, Paul Corcoran, Doina Cosman, Francis Guillemin, Christian Haring, Miriam Iosue, Michael Kaess, Jean-Pierre Kahn, Helen Keeley, George J Musa, Bogdan Nemes, Vita Postuvan, Pilar Saiz, Stella Reiter-Theil, Airi Varnik, Peeter Varnik, Vladimir Carli

Lancet 2015; 385: 1536–44

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See Comment page 1489

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Summary

Background Suicidal behaviours in adolescents are a major public health problem and evidence-based prevention programmes are greatly needed. We aimed to investigate the efficacy of school-based preventive interventions of suicidal behaviours.

Methods The Saving and Empowering Young Lives in Europe (SEYLE) study is a multicentre, cluster-randomised controlled trial. The SEYLE sample consisted of 11 110 adolescent pupils, median age 15 years (IQR 14–15), recruited from 168 schools in ten European Union countries. We randomly assigned the schools to one of three interventions or a control group. The interventions were: (1) Question, Persuade, and Refer (QPR), a gatekeeper training module targeting teachers and other school personnel, (2) the Youth Aware of Mental Health Programme (YAM) targeting pupils, and (3) screening by professionals (ProfScreen) with referral of at-risk pupils. Each school was randomly assigned by random number generator to participate in one intervention (or control) group only and was unaware of the interventions undertaken in the other three trial groups. The primary outcome measure was the number of suicide attempt(s) made by 3 month and 12 month follow-up. Analysis included all pupils with data available at each timepoint, excluding those who had ever attempted suicide or who had shown severe suicidal ideation during the 2 weeks before baseline. This study is registered with the German Clinical Trials Registry, number DRKS00000214.

Findings Between Nov 1, 2009, and Dec 14, 2010, 168 schools (11 110 pupils) were randomly assigned to interventions (40 schools [2692 pupils] to QPR, 45 [2721] YAM, 43 [2764] ProfScreen, and 40 [2933] control). No significant differences between intervention groups and the control group were recorded at the 3 month follow-up. At the 12 month follow-up, YAM was associated with a significant reduction of incident suicide attempts (odds ratios [OR] 0·45, 95% CI 0·24–0·85; p=0·014) and severe suicidal ideation (0·50, 0·27–0·92; p=0·025), compared with the control group. 14 pupils (0·70%) reported incident suicide attempts at the 12 month follow-up in the YAM versus 34 (1·51%) in the control group, and 15 pupils (0·75%) reported incident severe suicidal ideation in the YAM group versus 31 (1·37%) in the control group. No participants completed suicide during the study period.

Interpretation YAM was effective in reducing the number of suicide attempts and severe suicidal ideation in school-based adolescents. These findings underline the benefit of this universal suicide preventive intervention in schools.

Prevención SELECTIVA 1/3

- **Screening:** intervenciones mediante un proceso de dos pasos, p.ej. auto-escreening de depresión seguido de entrevista clínica:
  - **en colegios** han demostrado reducción de TA (Shaffer et al, 2004; Aseltine et al 2004)
  - **consultas de AP**, siempre que pueda asegurarse el diagnóstico, tratamiento eficaz y seguimiento (Preventive Services Task Force, AHRQ, 2012)
- **Entrenamiento de agentes:** que detectan personas con riesgo y facilitan el acceso a un tratamiento efectivo.
  - Programas en médicos (Rutz W et al, 1992), precursor EAAD
  - US Air Force con reducción del 33% (Knox et al, 2003)
  - jóvenes aborígenes (Cliford et al, 2013).

  Revisión de estudios en colegios con resultados positivos (Robinson et al, 2013).

  Aunque parece razonable, no se ha demostrado que el incremento de la búsqueda de ayuda se asocie a una reducción de conductas suicidas.

Prevención SELECTIVA 2/3

- **Educación de atención primaria:** es una intervención necesaria dada las bajas tasas de identificación y de tratamiento adecuado (Goldman et al 1999; Serrano et al 2010; Fernández et al 2013).
  - Intervenciones **en ancianos** han demostrado menores tasas de depresión e ideación suicida en estudios controlados:
    - *PROSPECT* (Alexopoulos et al, 2009)
    - *Improving Mood: Promoting Access to Collaborative Treatment* (Unützer J et al, 2006).
- **Mejora de la Calidad en los Servicios de Salud Mental:** ejemplar el programa de mejora de la Q "*Perfect Depression Care*" de la Henry Ford Health System con una reducción de suicidios del 82% (Hampton T, 2010; Coffey et al, 2013) que se expande con la iniciativa "Zero Suicide" www.zerosuicide.actionallianceforsuicideprevention.org

SUICIDIO Y SISTEMA DE SALUD I: atención médica previa, una oportunidad

- La mayoría de los pacientes que consuman el suicidio habían buscado previamente atención médica (*Luoma et al, 2002, Lee et al 2008, Parra et al 2013*):
  - En el año anterior **3:4** Médico de AP y **1:3** Psiquiatra
    - 100% de las mujeres y un 78% de los varones
  - En el mes anterior, **1:2** Médico AP y **1:5** Psiquiatra
    - 60% en >60 años y 23% en <35 años
  - En el mismo día, **18%** Médico de AP (*Isometsa, 1995*)
- Las víctimas de suicidio visitan a su Médico de AP/Psiquiatra más de **3x** en comparación con controles apareados (*Rutz, 1995; Rutz, 1997; Isometsa, 1994; Andersen, 2000*)
- El número de visitas médicas aumenta significativamente antes del acto suicida (*Appleby, 1996; Michel, 1997*)

IMPROVE

ZEROSuicide | INSTITUTE | EDC Learning transforms lives.

Apply data-driven quality improvement.

Use data to inform system changes that will lead to improved patient outcomes and better care for those at risk.

Overview: A Commitment to Quality Improvement

Organizations that adopt a Zero Suicide approach apply continuous, data-driven quality improvement strategies to ensure improved patient outcomes and better care for those at risk of suicide. Organizations should create a plan to assess system-wide fidelity to a comprehensive suicide care model and to evaluate the outcomes that systems, policy, and patient care changes are designed to produce.

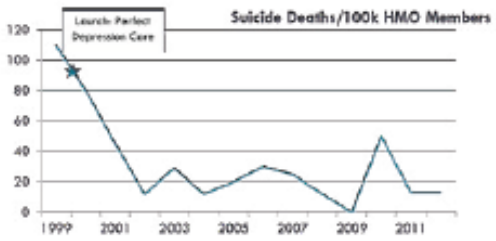
An organizational commitment to continuous quality improvement is necessary in order to achieve the aim of zero deficits and zero harm. This commitment fosters a culture in which every staff member—no matter their credentials or role—is comfortable with, and even praised for, disclosing errors without deference to authority.[1] When defining high-reliability organizations, Chassin and Loeb wrote that these organizations "assess the strength and resilience of their safety systems and the organization's defenses that prevent errors from propagating and leading to harm."[2] These types of Learning Health Care Systems are only successful in safety-oriented, just cultures where individual providers are supported when a patient attempts or dies by suicide.[3]

Recommendation: Orient Toward Measurement

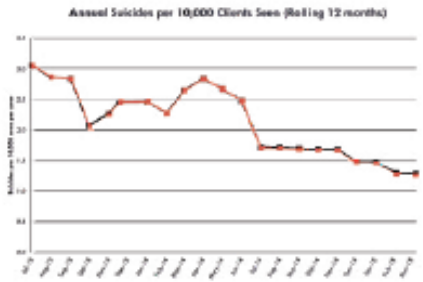
Three actions are central to a culture of safety that fully supports high reliability: trust, report, and improve.[3,4] It is essential to have clear processes for holding employees accountable for adherence to protocols, procedures, and recognizing errors of any size.[4]

The Henry Ford Health System achieved results through their Perfect Depression Care initiative—one of the inspirations for the Zero Suicide approach—by mapping current care processes, implementing measures of care quality, continually assessing progress, and adjusting the plan as needed. Through data collection and monitoring, Henry Ford Health System and Centerstone, another early adopter of Zero Suicide, found that operational improvements led to clinical improvements:

A Systems-Wide Approach to Health Care: Henry Ford Health System[5]



Zero Suicide at Centerstone: Results[6]



Mejora de la Calidad /1

La implementación de planes de prevención de suicidio requiere cambios organizativos profundos y el uso de una metodología de calidad mantenida. Un buen ejemplo es: www.Zerosuicides.org

Mejora de la Calidad /2

La implementación de recomendaciones preventivas en Servicios de Salud Mental, reduce la mortalidad por suicidio en población clínica, como demuestra el trabajo de While D et el, 2012.

Implementation of mental health service recommendations in England and Wales and suicide rates, 1997–2006: a cross-sectional and before-and-after observational study

David While, Harriet Bickley, Alison Roscoe, Kirsten Windfuhr, Shaiyan Rahman, Jenny Shaw, Louis Appleby, Navneet Kapur

Summary

Background Research investigating which aspects of mental health service provision are most effective in prevention of suicide is scarce. We aimed to examine the uptake of key mental health service recommendations over time and to investigate the association between their implementation and suicide rates.

Methods We did a descriptive, cross-sectional, and before-and-after analysis of national suicide data in England and Wales. We collected data for individuals who died by suicide between 1997 and 2006 who were in contact with mental health services in the 12 months before death. Data were obtained as part of the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness. When denominator data were missing, we used information from the Mental Health Minimum Data Set. We compared suicide rates for services implementing most of the recommendations with those implementing fewer recommendations and examined rates before and after implementation. We stratified results for level of socioeconomic deprivation and size of service provider.

Findings The average number of recommendations implemented increased from 0·3 per service in 1998 to 7·2 in 2006. Implementation of recommendations was associated with lower suicide rates in both cross-sectional and before-and-after analyses. The provision of 24 h crisis care was associated with the biggest fall in suicide rates: from 11·44 per 10 000 patient contacts per year (95% CI 11·12–11·77) before to 9·32 (8·99–9·67) after (p<0·0001). Local policies on patients with dual diagnosis (10·55; 10·23–10·89 before *vs* 9·61; 9·18–10·05 after, p=0·0007) and multidisciplinary review after suicide (11·59; 11·31–11·88 before *vs* 10·48; 10·13–10·84 after, p<0·0001) were also associated with falling rates. Services that did not implement recommendations had little reduction in suicide. The biggest falls in suicide seemed to be in services with the most deprived catchment areas (incidence rate ratio 0·90; 95% CI 0·88–0·92) and the most patients (0·86; 0·84–0·88).

Interpretation Our findings suggest that aspects of provision of mental health services can affect suicide rates in clinical populations. Investigation of the relation between new initiatives and suicide could help to inform future suicide prevention efforts and improve safety for patients receiving mental health care.

Lancet 2012; 379: 1005–12
Published Online February 2, 2012
DOI:10.1016/S0140-6736(11)61712-1

See Comment page 981

National Confidential Inquiry

Figure 1: Number of recommendations implemented by National Health Service mental health services with time

	Number of services implementing		Suicide rate (95% CI)		p value
	0–6 implementations	7–9 implementations	0–6 implementations	7–9 implementations	
2002	86	3	Not calculated	Not calculated	..
2003	67	22	11·45 (10·73–12·20)	10·52 (9·43–11·71)	0·183
2004	44	45	12·63 (11·70–13·61)	10·80 (9·99–11·65)	0·004
2005	29	60	13·45 (12·27–14·72)	10·50 (9·80–11·23)	<0·0001
2006	24	65	11·03 (9·86–12·31)	9·13 (8·51–9·79)	0·005

Table 1: Annual suicide rates per 10 000 patients in contact with National Health Service mental health services implementing up to six recommendations compared with those implementing seven to nine recommendations

Prevención INDICADA 1/3

- **Intervenciones clínicas:** el 90% de suicidios consumados están asociados a **enfermedad mental** (Isometsa, 2001), aunque la mayoría de los casos fallecen de otras causas, la mejora del tratamiento de los T. Afectivos puede ser un componente útil de la prevención (Zalsman et al 2016).
- **Psicofármacos:** el tratamiento inadecuado con **antidepresivos** y **psicoterapia** se asocia a mayor riesgo de suicidio (Gibbons and Mann, 2011), también en adolescentes (March et al, 2007). El **litio** en pacientes con T. Afectivos (Cipriani et al, 2013)y la **clozapina** en esquizofrenia (Meltzer et al, 2003), también han demostrado eficacia antisuicida. Efecto rápido de Ketamina (Bartoli et al 2017)
- **Psicoterapia:** ha demostrado reducción del 32% en TA en estudios controlados (O'Connor et al, 2013; Hawton et al 2016), que incluyen a familias en el caso de adolescentes (Brent et al 2013)

Meta-análisis de estudios de Autopsias Psicológica: riesgo de suicidio consumado

Environ Health Prev Med (2008) 13:243–256
DOI 10.1007/s12199-008-0037-x

REVIEW

Suicidal risk factors and completed suicide: meta-analyses based on psychological autopsy studies

Kouichi Yoshimasu · Chikako Kiyohara · Kazuhisa Miyashita · The Stress Research Group of the Japanese Society for Hygiene

Principales Factores de riesgo de suicidio consumado:

- **Tentativas de suicidio y autolesiones previas**
  [OR=16.33; 95% CI=7.5-35.5]
- **Depresión y T. Afectivos**
  [OR=13.42; 95% CI=8.05-22.37]
- **Trastornos por Uso de Alcohol y otras sustancias**
  [OR=5.24; 95% CI=3.3-8.3]
- **"Vivir solo"**
  [OR=2.1; 95% CI=1,5-2,9]

Psychosocial interventions following self-harm in adults: a systematic review and meta-analysis

Keith Hawton, Katrina G Witt, Tatiana L Taylor Salisbury, Ella Arensman, David Gunnell, Philip Hazell, Ellen Townsend, Kees van Heeringen

Lancet Psychiatry 2016; 3:740–50

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See Comment page 697

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Summary

Background Self-harm (intentional acts of non-fatal self-poisoning or self-injury) is common, particularly in young adults aged 15–35 years, often repeated, and strongly associated with suicide. Effective aftercare of individuals who self-harm is therefore important. We have undertaken a Cochrane systematic review and meta-analysis of the effectiveness of psychosocial interventions for self-harm in adults.

Methods We searched five electronic databases (CCDANCTR-Studies and References, CENTRAL, MEDLINE, Embase, and PsycINFO) between Jan 1, 1998, and April 29, 2015, for randomised controlled trials of psychosocial interventions for adults after a recent (within 6 months) episode of self-harm. Most interventions were assessed in single trials. We report results for interventions for which at least three randomised controlled trials comparing interventions with treatment as usual have been published and hence might contribute to clinical guidance. The primary outcome was repetition of self-harm at the conclusion of treatment and at 6, 12, and 24 months' follow-up analysed, when available, with the intention-to-treat method; if this was not possible, we analysed with all available case data.

Findings We identified 29 non-overlapping randomised controlled trials with three independent trials of the same intervention. Cognitive-behavioural-based psychotherapy (CBT; comprising cognitive-behavioural and problem-solving therapy) was associated with fewer participants repeating self-harm at 6 months' (odds ratio 0·54, 95% CI 0·34–0·85; 12 trials; n=1317) and at 12 months' follow-up (0·80, 0·65–0·98; ten trials; n=2232). There were also significant improvements in the secondary outcomes of depression, hopelessness, suicidal ideation, and problem solving. Patients receiving dialectical behaviour therapy (in three trials) were not less likely to repeat self-harm compared with those provided with treatment as usual at 6 months (odds ratio [OR] 0·59, 95% CI 0·16–2·15; n=267, three trials) or at 12 months (0·36, 0·05–2·47; n=172, two trials). However, the secondary endpoint of frequency of self-harm was associated with a significant reduction with use of dialectical behaviour therapy (mean difference –18·82, 95% CI –36·68 to –0·95). Four trials each of case management (OR 0·78, 95% CI 0·47–1·30; n=1608) and sending regular postcards (OR 0·87, 95% CI 0·62–1·23; n=3277) did not reduce repetition of self-harm.

Interpretation CBT seems to be effective in patients after self-harm. Dialectical behaviour therapy did not reduce the proportion of patients repeating self-harm but did reduce the frequency of self-harm. However, aside from CBT, there were few trials of other promising interventions, precluding firm conclusions as to their effectiveness.

Funding National Institute for Health Research.

Prevención INDICADA 2/3

- **Intervención Breve y Continuidad:** en los supervivientes de TA. Los programas de envío de cartas, seguimiento telefónico (Cebrià A et al 2013) han demostrado reducir riesgo de reintentos (Inagaky M et al 2015) y también de muerte por suicidio (Riblet N et al, 2017)…incluso en países en vías de desarrollo (Fleischmann A et al, 2008). Un ejemplo de implementación exitosa es el Código Riesgo Suicidio Cataluña

https://catsalut.gencat.cat/web/.content/minisite/catsalut/proveidors_professionals/normatives_instruccions/2015/instruccio_10_2015/instruccio-codi-risc-suicidi-8-9-2015.pdf

SUICIDIO Y SISTEMA DE SALUD II: atención en urgencias, exigencia de continuidad asistencial

De todos los intentos de suicidio atendidos en Urgencias, **1:3** realizará un nuevo intento el año siguiente (*Pérez-Barrero, 2002; Owens D et al 2002; Chistiansen et al 2007; Cebrià A et al 2013, Olfson M et al 2017*) y **7-10%** finalmente puede completar el suicidio (*Jenkins, 2002; Hawton K, 2015*), hasta un **15%** si utilizaron armas de fuego (Olfson M et al 2017)

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Research report

Suicide following self-harm: Findings from the Multicentre Stud of self-harm in England, 2000–2012

Keith Hawton[a,*], Helen Bergen[a], Jayne Cooper[b], Pauline Turnbull[b], Keith Waters[c], Jennifer Ness[c], Nav Kapur[b]

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ABSTRACT

Background: Self-harm is a key risk factor for suicide and it is imp information on the extent of risk.
Methods: Mortality follow-up to 2012 of 40,346 self-harm patients ident Multicentre Study of Self-harm in England between 2000 and 2010.
Results: Nineteen per cent of deaths during the study period (N=2704) w in 1.6% of patients (2.6% of males and 0.9% of females), during which tim than the general population risk. Overall, 0.5% of individuals died by sui 0.82% of males and 0.27% of females. While the absolute risk of suicide relative to that in the general population was higher in females. Risk of su self-poisoning had been the most frequent method of self-harm, hanging of subsequent suicide, particularly in males. The number of suicides

Suicide Following Deliberate Self-Harm

Mark Olfson, M.D., M.P.H., Melanie Wall, Ph.D., Shuai Wang, Ph.D., Stephen Crystal, Ph.D., Tobias Gerhard, Ph.D., Carlos Blanco, M.D., Ph.D.

Objective: The authors sought to identify risk factors for repeat self-harm and completed suicide over the following year among adults with deliberate self-harm.

Method: A national cohort of Medicaid-financed adults clinically diagnosed with deliberate self-harm (N=61,297) was followed for up to 1 year. Repeat self-harm per 1,000 person-years and suicide rates per 100,000 person-years (based on cause of death information from the National Death Index) were determined. Hazard ratios of repeat self-harm and suicide were estimated by Cox proportional hazard models.

Results: During the 12 months after nonfatal self-harm, the rate of repeat self-harm was 263.2 per 1,000 person-years and the rate of completed suicide was 439.1 per 100,000 person-years, or 37.2 times higher than in a matched general population cohort. The hazard of suicide was higher after initial self-harm events involving violent as compared with nonviolent methods (hazard ratio=7.5, 95% CI=5.5–10.1), especially firearms (hazard ratio=15.86, 95% CI=10.7–23.4; computed with poisoning as reference), and to a lesser extent after events of patients who had recently received outpatient mental health care (hazard ratio=1.6, 95% CI=1.2–2.0). Compared with self-harm patients using nonviolent methods, those who used violent methods were at significantly increased risk of suicide during the first 30 days after the initial event (hazard ratio=17.5, 95% CI=11.2–27.3), but not during the following 335 days.

Conclusions: Adults treated for deliberate self-harm frequently repeat self-harm in the following year. Patients who use a violent method for their initial self-harm, especially firearms, have an exceptionally high risk of suicide, particularly right after the initial event, which highlights the importance of careful assessment and close follow-up of this group.

Am J Psychiatry 2017; 174:765–774; doi: 10.1176/appi.ajp.2017.16111288

Seguimiento y continuidad asistencial TA post-alta

Se ha demostrado que el seguimiento psiquiátrico de los pacientes de riesgo reduce el riesgo de reintento *(Cebrià A et al, 2013; Inagaki M et al 2015)* y también puede reducir la muerte por suicidio *(Riblet N et al, 2017)*

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Research report

Effectiveness of a telephone management programme for patients discharged from an emergency department after a suicide attempt: Controlled study in a Spanish population

Ana Isabel Cebrià [a,b,*], Isabel Parra [a,b], Montserrat Pàmias [a,b], Anna Escayola [a], Gemma García-Parés [a,b], Joaquim Puntí [a,h], Andrés Laredo [a], Vicenç Vallès [c], Myriam Cavero [d,b], Joan Carles Oliva [g], Ulrich Hegerl [e], Victor Pérez-Solà [b,f], Diego J. Palao [a,b]

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Special review artide

Interventions to prevent repeat suicidal behavior in patients admitted to an emergency department for a suicide attempt: A meta-analysis

Masatoshi Inagaki [a,*], Yoshitaka Kawashima [b], Chiaki Kawanishi [c], Naohiro Yonemoto [b], Tatsuya Sugimoto [d], Taku Furuno [e], Katsumi Ikeshita [f], Nobuaki Eto [g], Hirokazu Tachikawa [h], Yohko Shiraishi [i], Mitsuhiko Yamada [b]

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BJPsych The British Journal of Psychiatry
1–7. doi: 10.1192/bjp.bp.116.187799

Review article

Strategies to prevent death by suicide: meta-analysis of randomised controlled trials

Natalie B. V. Riblet, Brian Shiner, Yinong Young-Xu and Bradley V. Watts

Background
Few randomised controlled trials (RCTs) have shown decreases in suicide.

Aims
To identify interventions for preventing suicide.

Method
We searched EMBASE and Medline from inception until 31 December 2015. We included RCTs comparing prevention strategies with control. We pooled odds ratios (ORs) for suicide using the Peto method.

Results
Among 8647 citations, 72 RCTs and 6 pooled analyses met inclusion criteria. Three RCTs ($n=2028$) found that the World Health Organization (WHO) brief intervention and contact (BIC) was associated with significantly lower odds of suicide (OR=0.20, 95% CI 0.09–0.42). Six RCTs ($n=1040$) of cognitive-behavioural therapy (CBT) for suicide prevention and six RCTs of lithium ($n=619$) yielded non-significant findings (OR=0.34, 95% CI 0.12–1.03 and OR=0.23, 95% CI 0.05–1.02, respectively).

Conclusions
The WHO BIC is a promising suicide prevention strategy. No other intervention showed a statistically significant effect in reducing suicide.

Declaration of interest
None.

ABSTRACT

Background: A huge number of patients with self-harm and suicide attempt visit emergency departments (EDs). We systematically reviewed studies and examined the effect of interventions to prevent repeat suicidal behavior in patients admitted to EDs for a suicidal attempt.
Method: We searched the databases of MEDLINE, PsycholNFO, CINAHL, and EMBASE through August 2013. Eligible studies were randomized controlled trials assessing the effects on repeat suicidal behavior of interventions initiated in suicidal patients admitted to EDs. Interventions in each trial were classified into groups by consensus. Meta-analyses were performed to determine pooled relative risks (RRs) and 95% confidence intervals (CIs) of repetition of suicide attempt for interventions in each group.
Results: Out of 5390 retrieved articles, 24 trials were included and classified into four groups (11 trials in the Active contact and follow-up, nine in the Psychotherapy, one in the Pharmacotherapy, and three in the Miscellaneous). Active contact and follow-up type interventions were effective in preventing a repeat suicide within 12 months ($n=5319$; pooled RR=0.83; 95% CI: 0.71 to 0.97). However, the effect at 24 months was not confirmed ($n=925$; pooled RR=0.98; 95% CI: 0.76–1.22). The effects of the other interventions on preventing a repetition of suicidal behavior remain unclear.
Limitation: Caution is needed regarding the heterogeneity of the effects.
Conclusion: Interventions of active contact and follow-up are recommended to reduce the risk of a repeat suicide attempt at 12 months in patients admitted to EDs with a suicide attempt. However, the long-term effect was not confirmed.

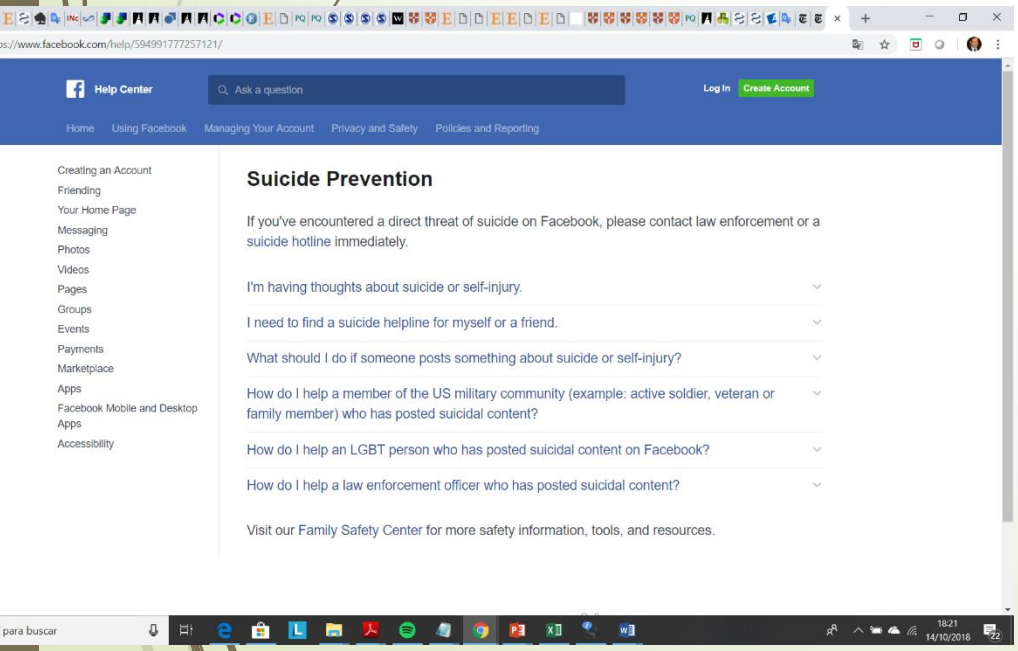
Prevención INDICADA 3/3

- pervivientes de TA
cialmente después del
al 2002) y de suicidio
mas de envío de
t al 2013) han
(Inagaky et al 2015) y
t al, 2017)…incluso en
n A et al, 2008)

- **Psicoterapia Grupal:** basada en TCC, como la DBT han demostrado reducción de conductas suicidas en adultos y adolescentes (Linehan MM et al, 2006; Lynch et al, 2007)
- **"Hotlines" y Centros de Crisis:** un meta-análisis del programa americano "hotline" demostró un efecto preventivo global en USA (Lester 1997) y en Canadá la correlación entre CC y TA (Leenaars and Lester, 2004)
- **Postvención:** son las intervenciones post-suicidio para prevenir otros asociados en la familia, la ciudad, el colegio o el centro de trabajo. No han demostrado eficacia preventiva pero si reducción del estrés psicológico (Cox et al, 2012). https://www.despresdelsuicidi.org/

Prevención de suicidio multinivel e integrada

- Programa US Air Force Suicide Prevention: 11 componentes
- Programa "*European Alliance Against Depression*": 4 componentes
- The Vauing Young Lives en Australia: 88 componentes
- TIC's para la prevención del suicidio (oportunidad):
  - Agentes de detección virtuales, chat de apoyo online en crisis y tele-psiquiatría (Hailey D et al 2008; Nuij Ch et al 2018; Aragonés et al 2018)
  - Facebook



Registros electrónicos y suicidio: Guía Depresión en e-CAP Cataluña

Aten Primaria. 2016;xxx(xx):xxx–xxx

Atención Primaria

www.elsevier.es/ap

ARTÍCULO ESPECIAL

Un sistema informatizado de apoyo a las decisiones clínicas para el manejo de la depresión en atención primaria

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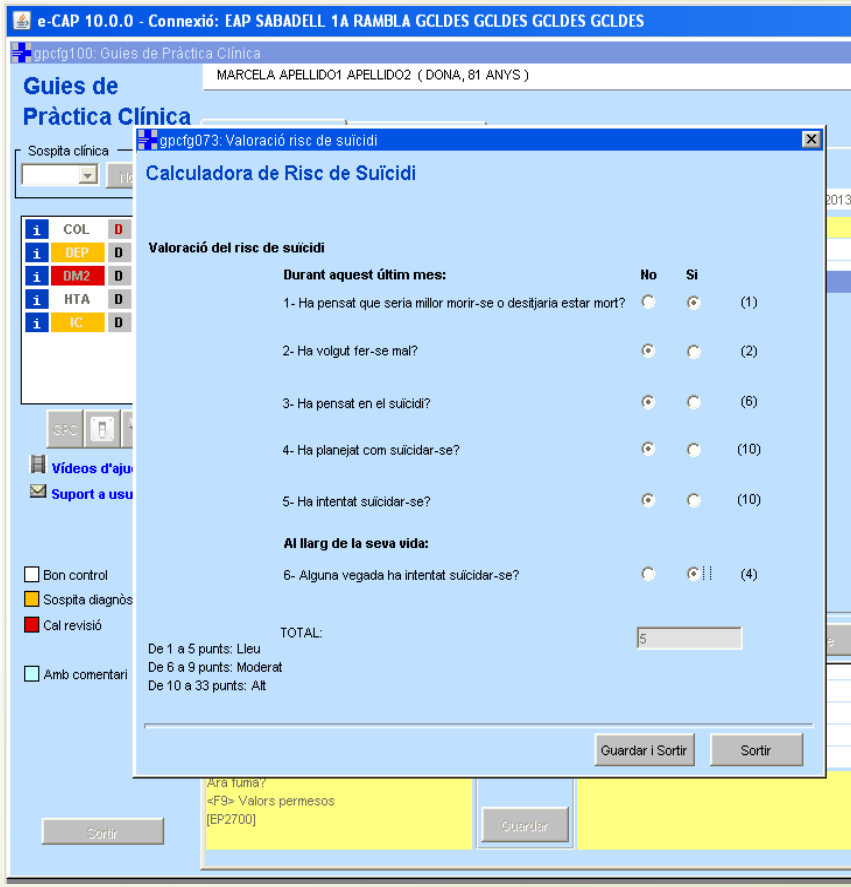
PALABRAS CLAVE
Trastorno depresivo mayor;
Guía de práctica clínica;
Atención primaria de salud;
Historia clínica electrónica;
Toma de decisiones asistida por ordenador

Resumen A pesar de su relevancia clínica y de su importancia como problema de salud pública existen importantes deficiencias en el abordaje de la depresión. Las guías clínicas basadas en la evidencia son útiles para mejorar los procesos y los resultados clínicos, y para facilitar su implementación se ha ensayado su transformación en sistemas informatizados de apoyo a las decisiones clínicas. En este artículo se describen los fundamentos y principales características de una nueva guía clínica informatizada para el manejo de la depresión mayor desarrollada en el sistema sanitario público de Cataluña. Esta herramienta ayuda al clínico a establecer diagnósticos de depresión fiables y precisos, a elegir el tratamiento idóneo a priori según las características de la enfermedad y del propio paciente, y enfatiza en la importancia de un seguimiento sistemático para evaluar la evolución clínica y adecuar las intervenciones terapéuticas a las necesidades del paciente en cada momento.



Conclusión: dos modelos globales de intervenciones multinivel preventivos

European Alliance Against DEPRESSION

National Action Alliance for Suicide Prevention

what is ZERO SUICIDE?

Zero Suicide is a commitment to suicide prevention in health and behavioral health care systems, and also a specific set of tools and strategies. It is both a concept and a practice.

Its core propositions are that suicide deaths for people under care are preventable, and that the bold goal of zero suicides among persons receiving care is an aspirational challenge that health systems should accept. The Zero Suicide approach aims to improve care and outcomes for individuals at risk of suicide in health care systems. It represents a commitment to patient safety—the most fundamental responsibility of health care—and also to the safety and support of clinical staff, who do the demanding work of treating and supporting suicidal patients.

4 niveles de actuación

- MEDIDAS DE INFORMACIÓN A LOS CIUDADANS
- INTERVENCIÓN EN GRUPOS DE RISGO
- COOPERACIÓN CON MÉDICOS DE FAMILIA
- COOPERACIÓN CON OTROS ESTAMENTOS

European Alliance Against DEPRESSION

www.eaad.net

Zero Suicide: State Efforts and Partners

Organization	State
Magellan of Arizona	Arizona
Alhambra Hospital (UHS)	California
Charlotte Behavioral Health Care	Florida
Bloomington Meadows (UHS)	Indiana
Community Health Network	Indiana
Centerstone	Indiana, Tennessee
Kansas Gov's Behavioral Health Services Planning Council	Kansas
Kentucky Dept for Behavioral Health	Kentucky
Brentwood (UHS)	Louisiana
Henry Ford Health System, Behavioral Health Services	Michigan
Institute for Family Health	New York
Montefiore Comprehensive Family Care Services	New York
New York Office of Mental Health	New York
Brynn Marr Hospital (UHS)	North Carolina
State Govt, DHHS, Div of Public Health	North Carolina
Coleman Health	Ohio
Oklahoma Department of Mental Health and Substance Abuse Services	Oklahoma
Oregon Public Health Division	Oregon
Texas Department of State Health Services	Texas
Utah Division of Substance Abuse and Mental Health	Utah
Group Health Research Institute	Washington
WI Dept of PH Services	Wisconsin

www.Zerosuicides.org

¡Muchas Gracias!

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