20è ANIVERSARI

Consorci de Salut i Social de Catalunya

Sessions Tècniques del CSC 2020

Intervenciones para la prevención del suicidio

Diego J Palao

Profesor Titular de Psiquiatria. Universidad Autónoma de Barcelona.
Director de Salud Mental . Parc Taulí-Hospital Universitario. CIBERSAM (GC29)

Parc Taulí Sabadell
Hospital Universitari
Salut Mental

UAB
Universitat Autònoma de Barcelona

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Departament de Psiquiatria i Medicina Legal UAB

Declaración de intereses

Colaboración con compañías farmacéuticas:

Janssen-Cilag, Lundbeck, Servier, Kern, Ferrer, Adamed, Exeltis, Angelini

Fondos de investigación:

PERIS 2017-2019 – AQUAS – Barcelona

FIS 2017-2020 – ISCiii. Madrid

Índice

- Introducción: suicidio y evidencias en prevención
- Estrategia de pragmática de prevención del suicidio desde el ámbito de la salud
  - Modelo de gestión de casos SM-AP
  - Código Riesgo Suicidio Cataluña en Parc Taulí (2008-2019)
- Resultados
- Conclusiones

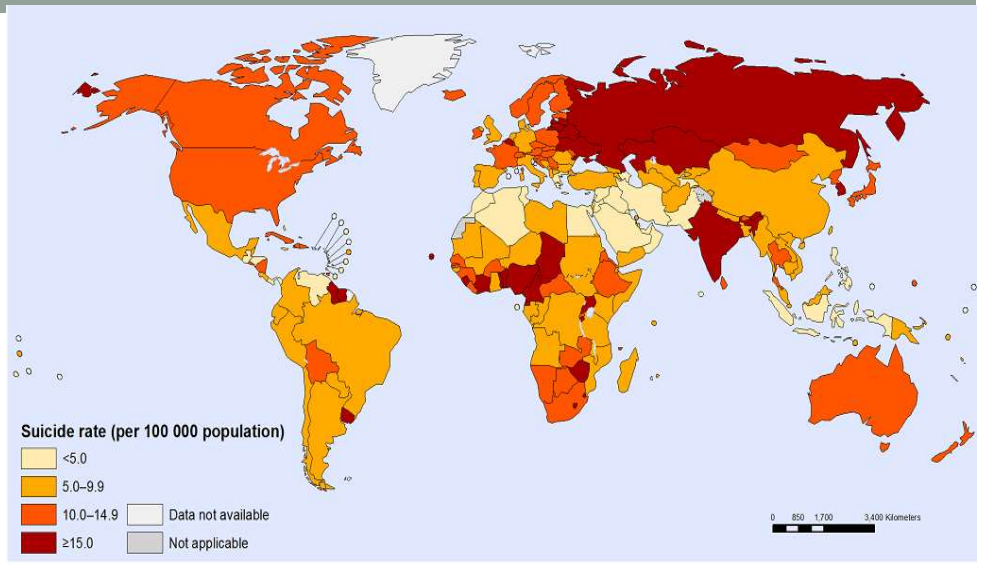
CONTEXTO

MUNDIAL

800.000 suicidios anuales

2ª causa de muerte 15-29 años

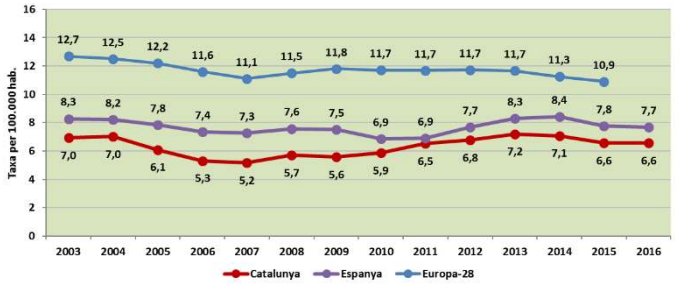
x10 veces víctimas por guerra



España (2017): 3.679 muertes por suicidio INE(2018)

7.9/100.000 hab.

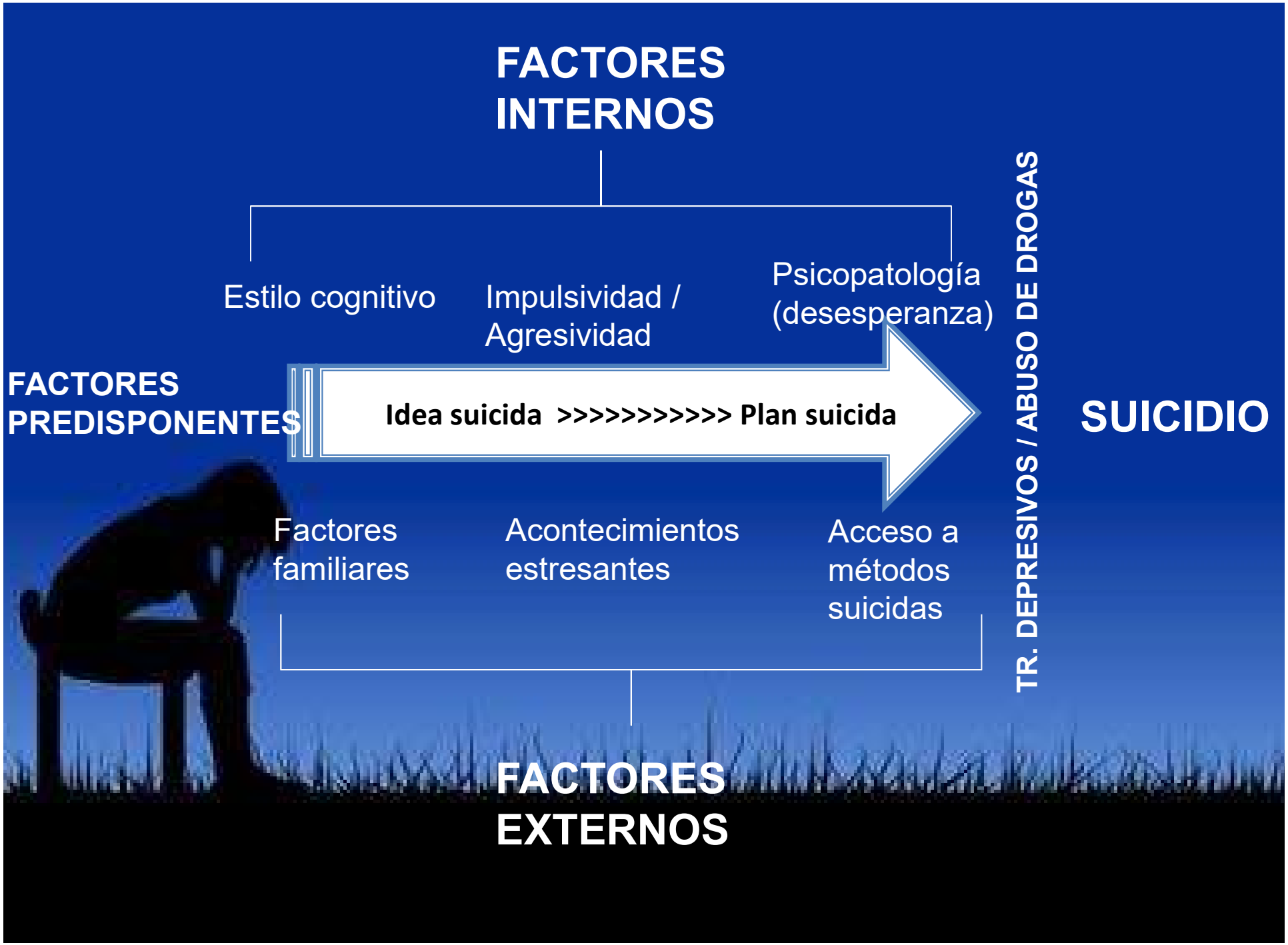
1ª causa de muerte absoluta entre hombres y mujeres de 22 a 44 años



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

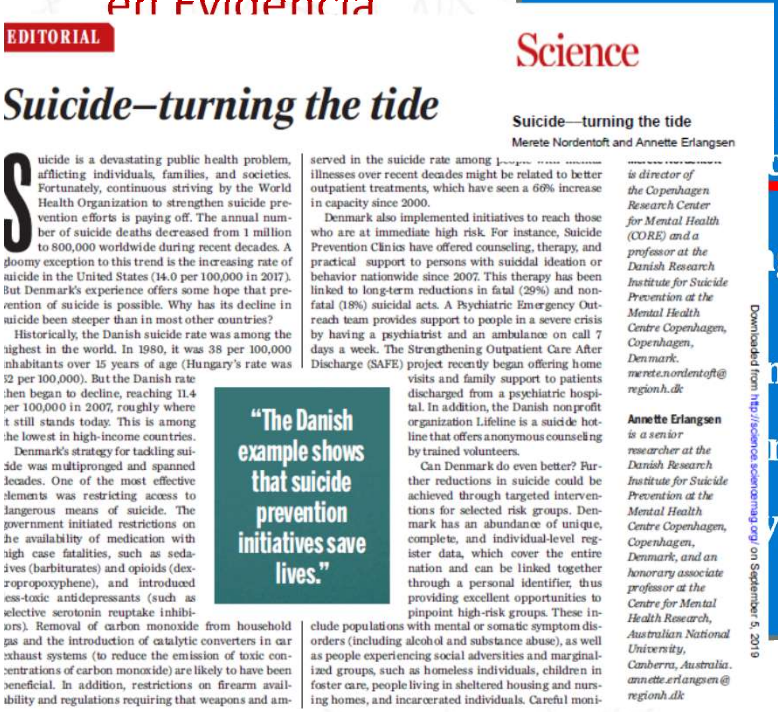
Plan de Acción OMS en Salud Mental 2013 - 2020: reducir la tasa de suicidio un 10%

Programa SUPRE (*Suicide Prevention*)


FACTORES INTERNOS
Estilo cognitivo
Impulsividad / Agresividad
Psicopatología (desesperanza)
FACTORES PREDISPONENTES
Idea suicida >>>>>>>>>>> Plan suicida
SUICIDIO
TR. DEPRESIVOS / ABUSO DE DROGAS
Factores familiares
Acontecimientos estresantes
Acceso a métodos suicidas
FACTORES EXTERNOS

Evidencias científicas

EESPP:
Programa de Prevención del Suicidio Basado en Evidencia



EDITORIAL

Suicide–turning the tide

Science

Suicide—turning the tide

Merete Nordentoft and Annette Erlangsen

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-

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

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.

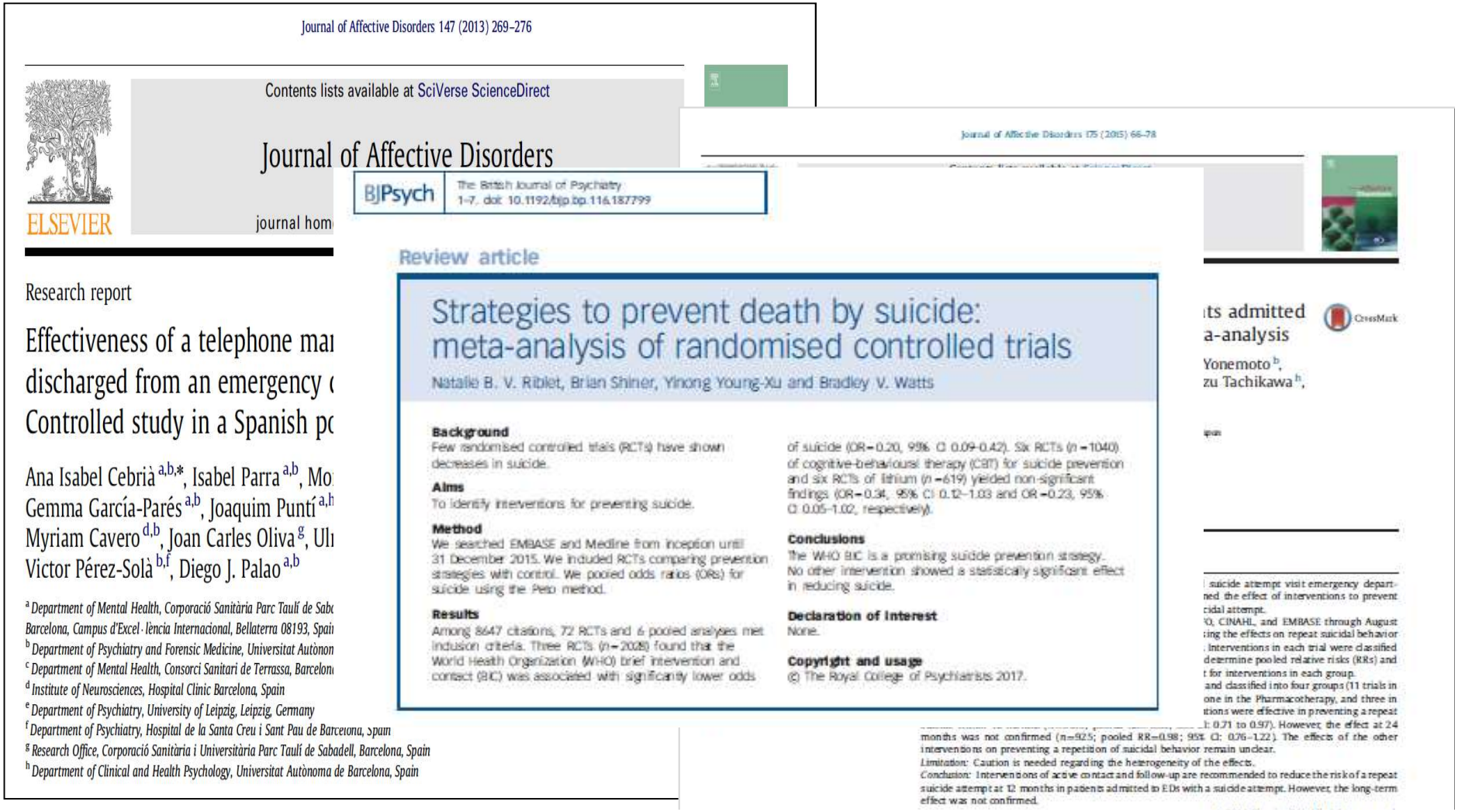
Can Denmark do even better? Further reductions in suicide could be achieved through targeted interventions for selected risk groups. Denmark has an abundance of unique, complete, and individual-level register data, which cover the entire nation and can be linked together through a personal identifier, 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-

Merete Nordentoft is director of the Copenhagen Research Center for Mental Health (CORE) and a professor at the Danish Research Institute for Suicide Prevention at the Mental Health Centre Copenhagen, Copenhagen, Denmark. merete.nordentoft@regionh.dk

Annette Erlangsen is a senior researcher at the Danish Research Institute for Suicide Prevention at the Mental Health Centre Copenhagen, Copenhagen, Denmark, and an honorary associate professor at the Centre for Mental Health Research, Australian National University, Canberra, Australia. annette.erlangsen@regionh.dk

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

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



Journal of Affective Disorders 147 (2013) 269–276

Contents lists available at SciVerse ScienceDirect

Journal of Affective Disorders

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ELSEVIER

Research report

Effectiveness of a telephone mar
discharged from an emergency
Controlled study in a Spanish po

Ana Isabel Cebrià [a,b,*], Isabel Parra [a,b], Mo
Gemma García-Parés [a,b], Joaquim Puntí [a,h]
Myriam Cavero [d,b], Joan Carles Oliva [g], Uli
Victor Pérez-Solà [b,f], Diego J. Palao [a,b]

[a] Department of Mental Health, Corporació Sanitària Parc Taulí de Sab
Barcelona, Campus d'Excel·lència Internacional, Bellaterra 08193, Spai
[b] Department of Psychiatry and Forensic Medicine, Universitat Autònon
[c] Department of Mental Health, Consorci Sanitari de Terrassa, Barcelon
[d] Institute of Neurosciences, Hospital Clinic Barcelona, Spain
[e] Department of Psychiatry, University of Leipzig, Leipzig, Germany
[f] Department of Psychiatry, Hospital de la Santa Creu i Sant Pau de Barcelona, Spain
[g] Research Office, Corporació Sanitària i Universitària Parc Taulí de Sabadell, Barcelona, Spain
[h] Department of Clinical and Health Psychology, Universitat Autònoma de Barcelona, Spain

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 = 2098) 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.

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Journal of Affective Disorders 175 (2015) 66–78

ts admitted
a-analysis

Yonemoto [b],
zu Tachikawa [h],

CrossMark

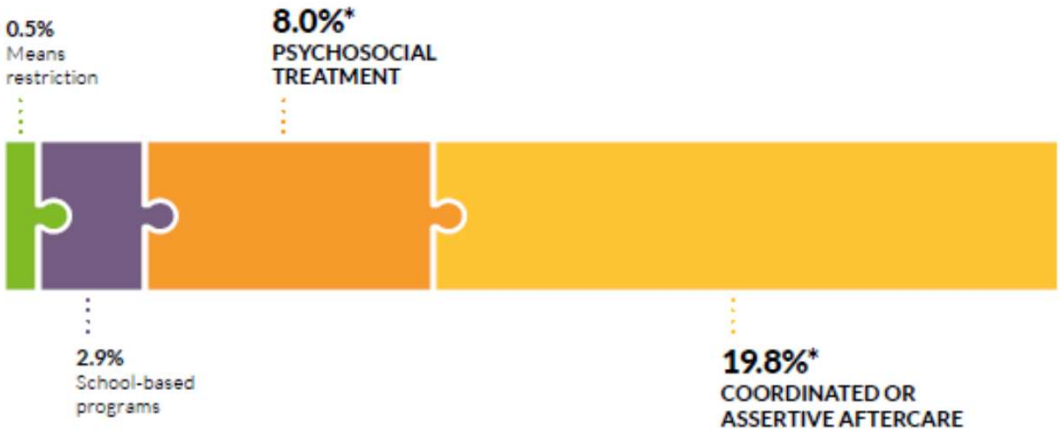
suicide attempt visit emergency depart-
ned the effect of interventions to prevent
cidal attempt.
O, CINAHL, and EMBASE through August
ing the effects on repeat suicidal behavior
Interventions in each trial were classified
determine pooled relative risks (RRs) and
t for interventions in each group.
and classified into four groups (11 trials in
one in the Pharmacotherapy, and three in
tions were effective in preventing a repeat
I: 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.

Black Dog Institute: sistema de prevención basado en pruebas

Figure 3.

Estimated reduction in *suicide attempts* for certain strategies

*Priority strategies for reducing suicide attempts.



Section 2 – Recommendations for implementing the systems approach within PHNs

Strategy two: Psychosocial and pharmacotherapy treatments

Mental illness, diagnosed or undiagnosed, is associated with the majority of suicide attempts. Providing accessible and appropriate mental health care is therefore essential to any suicide prevention plan. The two main therapeutic options include psychosocial and pharmacotherapy treatments, both of which are outlined below.

Psychosocial

Psychotherapy, such as cognitive behaviour therapy and dialectical behaviour therapy, has been found to be effective in reducing suicidal thoughts and behaviours.[21,22] Psychotherapy is particularly effective for high-risk individuals such as those with borderline personality disorder or patients admitted to an emergency department after a suicide attempt.[22,23]

Several psychotherapies have been shown to reduce **suicidal behaviour** including:

- Cognitive behaviour therapy for suicide prevention and mentalisation-based treatment – for adults
- Multi-systemic therapy and group therapies – for adolescents
- Dialectical behaviour therapy – for individuals with borderline personality disorder
- Problem solving therapy to reduce repeat hospitalisation – for individuals with a history of prior self-harm

Pharmacotherapy

Although early studies found that antidepressants do not reduce suicide attempts or deaths more than placebo,[24-26] more recent studies reported that fluoxetine and venlafaxine decreased suicidal thought and behaviours for adult and geriatric patients.[27] For youth (18–24 years), no reductions in suicidal thoughts and behaviours were found, although there were reductions in depression symptoms.[27] There is a small increase in suicidal thoughts, but not suicides, among young people taking fluoxetine (and perhaps other selective serotonin reuptake inhibitors) for depression, usually during the initial treatment phase, and possibly due to increased agitation as a medicatio side effect. Higher rates of antidepressant prescribing correlate with reduced rates of suicide in a number of countries,[28-30] including Australia.[31] Those countries which had the greatest increase in selective serotonin reuptake inhibitors prescribing have also seen the mos marked decline in suicide rates.[32] However, the increa in prescription rates may not have necessarily caused the decrease in suicide as other factors (e.g. improved care) may have also contributed to suicide decline. Nevertheless, pharmacotherapy forms part of an overall suicide prevention plan.

The risk of suicide is highest in the month before starti an antidepressant, rapidly declines in the first week of treatment, and continues to decrease at a slower, mor

Ridani, R., et al (2016). An evidence-based systems approach to suicide prevention: guidance on planning, commissioning, and monitoring. Sydney: Black Dog Institute.

Estrategia de prevención del suicidio desde la salud: continuidad asistencial

1. Estrategias organizativas:
   - Modelo colaborativo de gestión de la depresión en atención primaria
   - Continuidad de cuidados en SM: del EAAD al Código Riesgo Suicidio Cataluña

2. Mejora calidad en el tratamiento de la depresión y prevención del suicidio:
   - Tratamiento psicofarmacológico y psicoterapéutico

INDI: Un modelo de Gestión de DM como "enfermedad crónica" en Primaria

BMC Health Services Research

STUDY PROTOCOL Open Access

Development and assessment of an active strategy for the implementation of a collaborative care approach for depression in primary care (the INDI-i project)

Enric Aragonès[1,2,11*], Diego Palao[3,4], Germán López-Cortacans[1,2], Antonia Caballero[1,2], Narcís Cardoner[3,4], Pilar Casaus[5], Myriam Cavero[6], José Antonio Monreal[5], Víctor Pérez-Sola[7,8], Miquel Cirera[9], Maite Loren[9], Eva Bellerino[10], Catarina Tomé-Pires[2,11,12] and Laura Palacios[1]

Abstract

Background: Primary care is the principal clinical setting for the management of depression. However, significant shortcomings have been detected in its diagnosis and clinical management, as well as in patient outcomes. We developed the INDI collaborative care model to improve the management of depression in primary care. This intervention has been favorably evaluated in terms of clinical efficacy and cost-effectiveness in a clinical trial. Our aim is to bring this intervention from the scientific context into clinical practice.

Methods: *Objective:* To test for the feasibility and impact of a strategy for implementing the INDI model for depression in primary care.

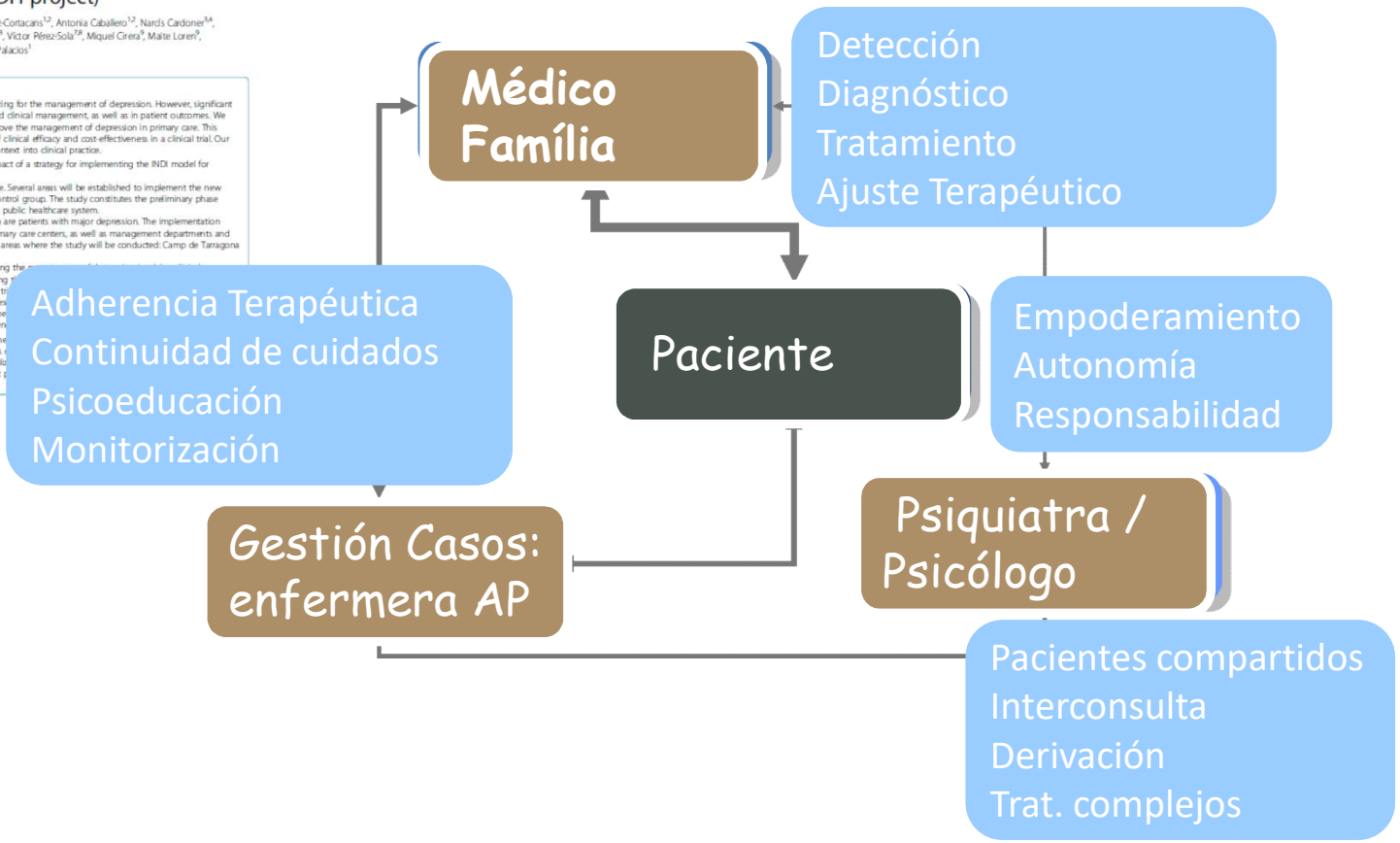
Design: A quasi-experiment conducted in primary care. Several areas will be established to implement the new program and other, comparable areas will serve as control group. The study constitutes the preliminary phase preceding generalization of the model in the Catalan public healthcare system.

Participants: The target population of the intervention are patients with major depression. The implementation strategy will also involve healthcare professionals, primary care centers, as well as management departments and the healthcare organization itself in the geographical areas where the study will be conducted: Camp de Tarragona and Valles Occidental (Catalonia).

Intervention: The INDI model is a program for improving the
instructional, and organizational interventions including t
and efficiency of which has been proven in a clinical tr
model based on the PARIHS (Promoting Action on Res
Measures: Qualitative and quantitative measures will be
implementation of the model: acceptability, utility, per

Discussion: This project tests the transferability of a he
clinical practice. If implementation is successful in this
experience obtained to propose and plan the gener
healthcare system. We expect the program to benefit

(Continued on next page)



Aragonès E et al. Effectiveness of a multi-component programme for managing depression in primary care: a cluster randomized trial. The INDI project. J Affect Disord. 2012 Dec 15;142(1-3):297-305.

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Regió Sanitària Barcelona

Generalitat de Catalunya
Departament de Salut

Programa Europeo contra la Depresión: EAAD en Cataluña

(Dreta Eixample y Sabadell)

Intervención multinivel

Parc Taulí Sabadell
Hospital Universitari
Salut Mental

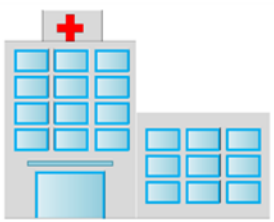
http://www.eaad.net

Código Riesgo Suicidio Cataluña (CRS-cat)

DETECCIÓN | **CÓDIGO RIESGO SUICIDIO - CRS**

Detección y cribado → **Evaluación clínica especializada y seguimiento proactivo** → **Atención integral**

sem 061 emergències mèdiques

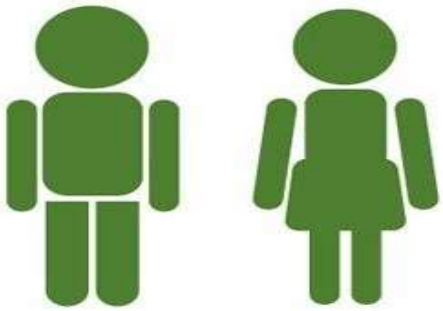


061 CatSalut Respon

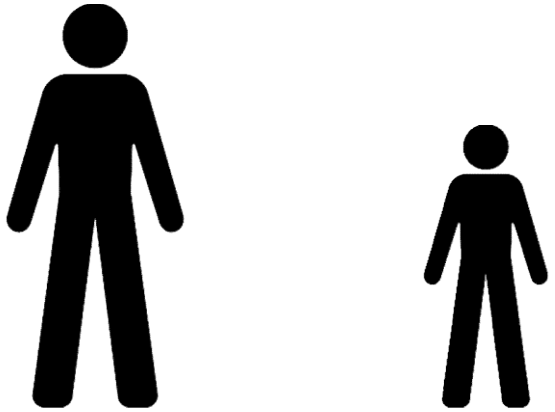
1ª atención Sospecha CRS	Atención fase aguda	Visita post-alta	Llamada 30 días	Seguimiento longitudinal
▪ Ciudadanía ▪ APS ▪ 061 CatSalut Respon ▪ CUAP ▪ CSM/CAS/HD ▪ Fuerzas de seguridad	▪ Urgencias hospitalarias ▪ Ingreso hospitalario	<u>Adultos (10 d)</u> ▪ CSMA ▪ CAS ▪ HDA <u>Menores (72 h)</u> ▪ CSMIJ ▪ HDIJ	▪ 061 CatSalut Respon ▪ EMSE	▪ APS ▪ CSM ▪ CAS

Código Riesgo Suicidio Cataluña: Junio 2014 - Septiembre 2019

13.327 personas han realizado 15.397 episodios de autolisis
1.213 (9%) personas con más de un intento durante este periodo



4.791 (35,9%) **8.536** (64%)



Adultos: 11.823 (88,7%) **Menores*: 1.505** (11,3%)
4.480 V / 7.342 M (62%) 311 V / 1.194 M (79%)

Datos hasta 14 septiembre 2019:

- ✓ 11.024 (82%) (10.531 -89%- adultos y 1389 -92%- menores) realizan la primera visita en el plazo previsto
- ✓ 11.921 (89%) acepta el seguimiento telefónico a los 30 días
- ✓ 381 (2,8%) exitus
  (sólo 17 asociación explícita a suicidio)

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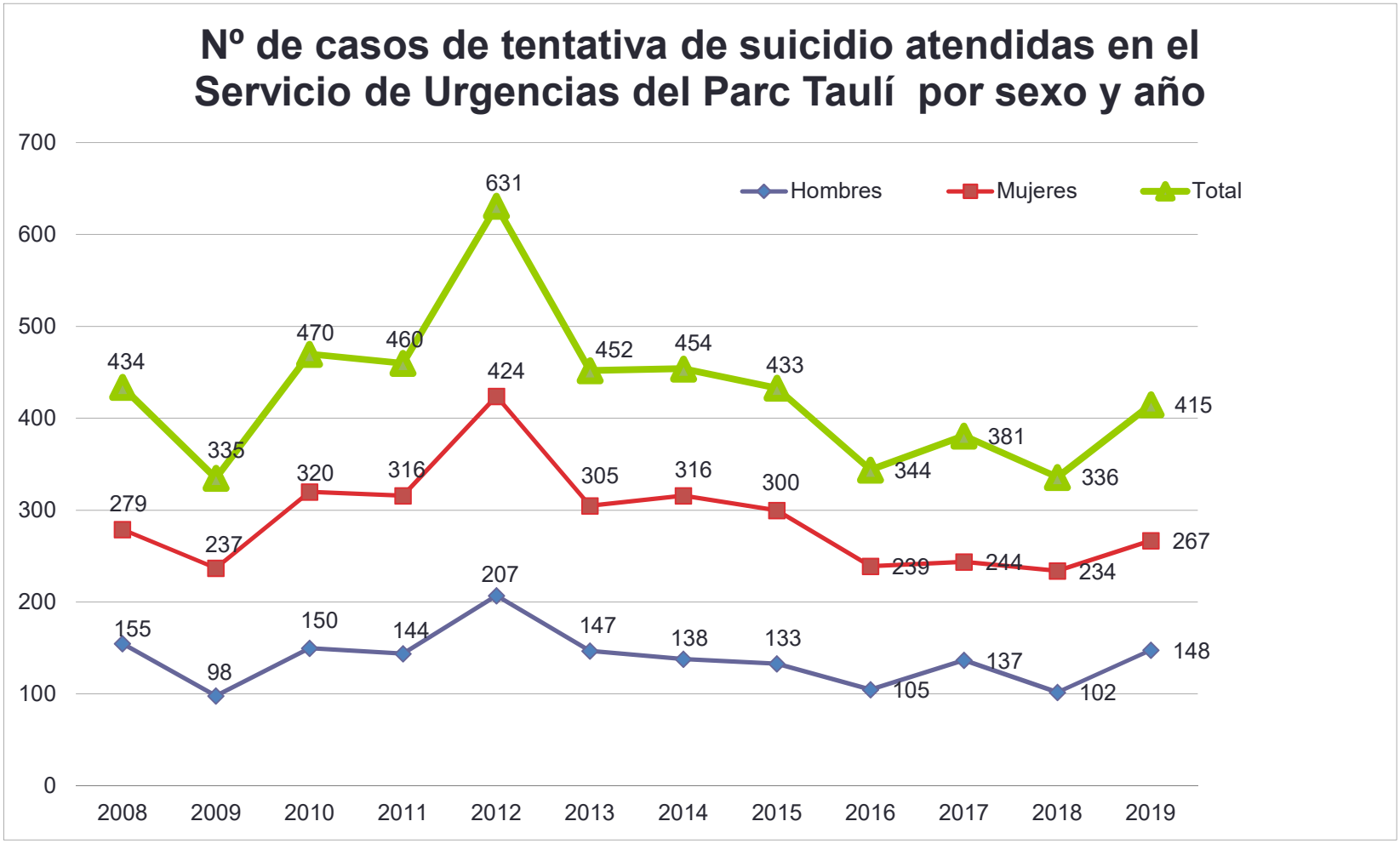
Registro de Tentativas de Suicido
Parc Taulí Sabadell 2008- 2019



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Salut Mental

Tasa incidencia anual 2019= **87** x 100.000 hab /año
(área urgencias 475.000 hab.)

Resultados Seguimiento Telefónico
Tentativas de Suicido. Parc Taulí 2018- 2019

	1ª LLAMADA	2ª LLAMADA	3ª LLAMADA	4ª LLAMADA	5ª LLAMADA	6ª LLAMADA
TOTAL	330	330	330	330	330	330
NO	53	52	49	55	64	82
SI	277	278	281	275	266	248
	83,94%	84,24%	85,15%	83,33%	80,61%	75,15%

Nº LLAMADAS	%	Nº casos	Total	ACUMULADO
6	65,76%	217	330	
5	15,76%	52	330	81,52%
4	2,42%	8	330	
3	1,52%	5	330	
2	1,52%	5	330	
1	1,82%	6	330	
0	11,21%	37	330	18,48%

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Tasa incidencia anual 2019= **87** x 100.000 hab /año
(área urgencias 475.000 hab.)

CONCLUSIÓN: ***es preciso aportar evidencias pragmáticas para impulsar el cambio en la estrategia de prevención del suicidio, implementarla y mantenerla en cada área de salud***

Cambiar de Perspectiva desde:	Hasta:
Aceptar el suicidio como inevitable	Ca… puede prevenir
Formación y herramientas individuales	…tural y general de …s, incluyendo cambio …cepción social
Juicio clínico y accion…	*Screening* estandarizado, valoración y estratificación de riesgo e intervenciones en todo el SNS
Hospital… …odios de cris…	Interacciones productivas a lo largo de una continuidad de cuidados
… salvar una vida...”	“¿Cuantas muertes son aceptables?

Necesitamos: PLAN NACIONAL DE PREVENCIÓN DEL SUICIDIO


Promover enfoques sinérgicos
Contra la vergüenza, el estigma y el silencio
Promover la "conectividad" como factor de protección
Compromiso Multi-sectorial
Postvención y cuidados posteriores
Fortalecer la continuidad de cuidados
Dirigido a las necesidades de grupos vulnerables
Estrategia avanzada de salud pública y salud mental
Formación clínica y evaluación
Alternativas de abordaje y tratamiento

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Hospital Universitari
Salut Mental

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¡Gracias por vuestra atención!

dpalao@tauli.cat

@DiegoJPalao www.tauli.cat