2nd CORE SEMINAR in
MENTAL HEALTH
Etiology, intervention and prevention of suicide

CORE SALUT MENTAL

Retos de futuro en la investigación de la prevención del suicido

Diego J Palao Vidal

Professor de Psiquiatria. Departament de Psiquiatria i Medicina Legal

Director executiu de Salut Mental.

Parc Taulí Sabadell – Hospital Universitari. UAB

Barcelona, 4 de noviembre de 2015

Parc Taulí Sabadell
Hospital Universitari
Salut Mental

OSAMCAT

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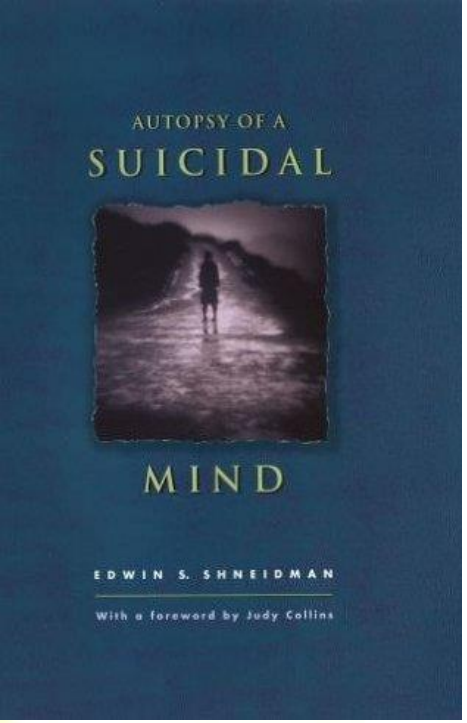
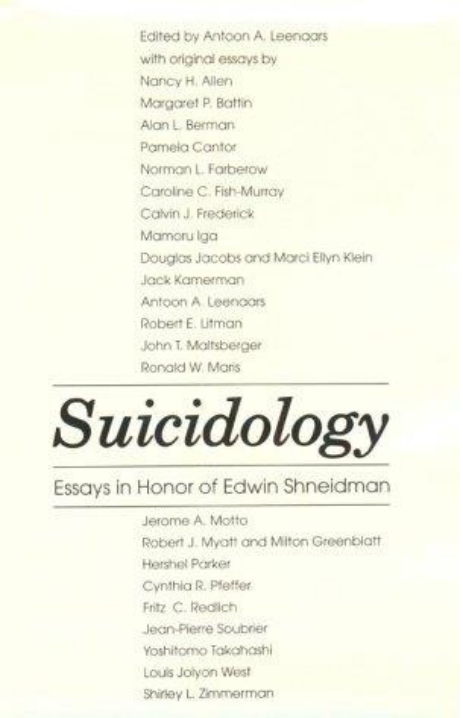
Universitat Autònoma de Barcelona

European Alliance Against DEPRESSION





PARA EMPEZAR…

"*Suicide is a* ***permanent solution*** *to a* ***temporary problem***"

Edwin Schneidman, MD.
Founder of Suicidology

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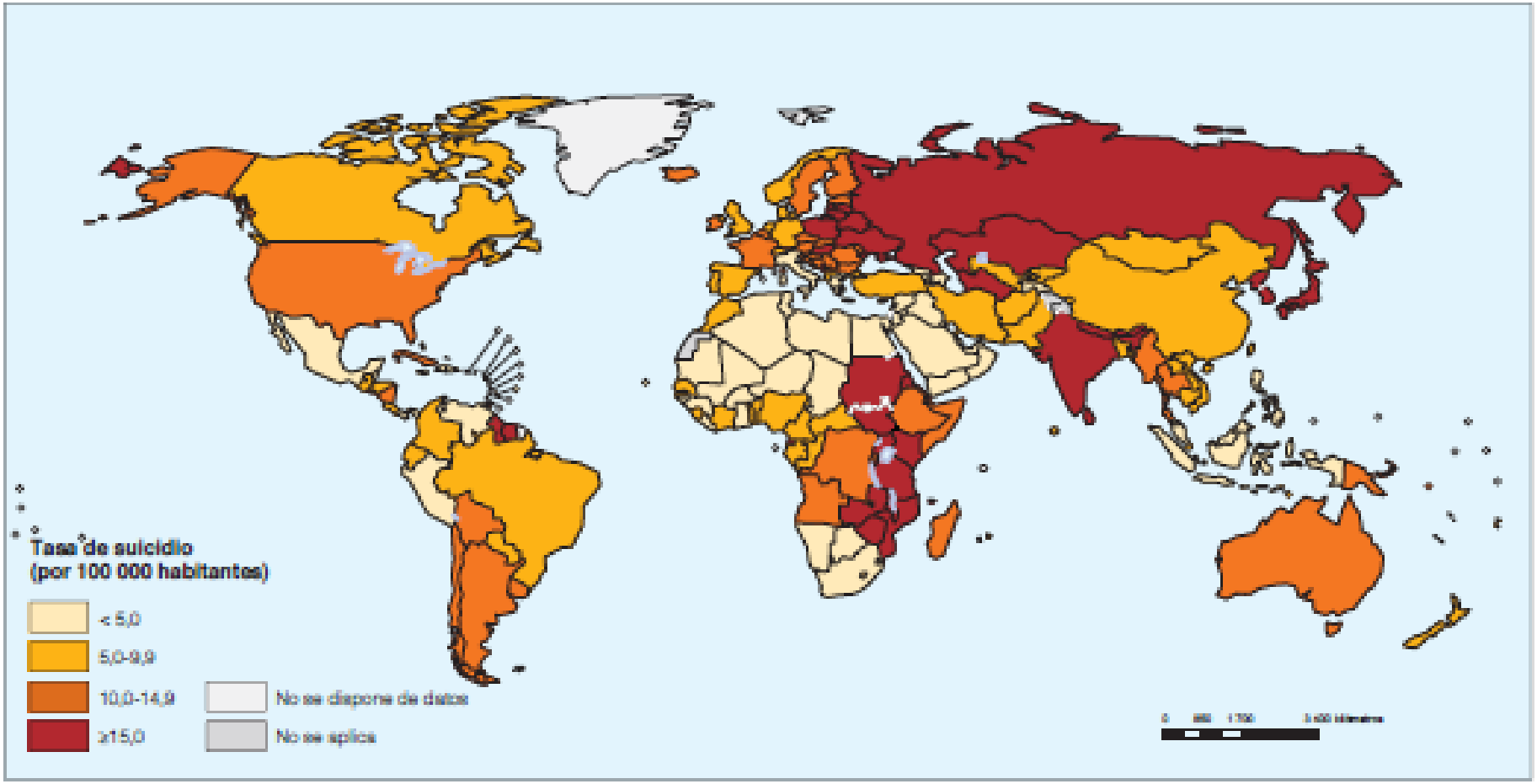
Conclusiones

Butterfly Landscape (The Great Masturbator in a Surrealist Landscape with D.N.A.). Dali ,1957

Mapa mundial del suicidio

Mapa 1. Tasas de suicidio normalizadas según la edad (por 100 000 habitantes), ambos sexos, 2012



Viewpoint

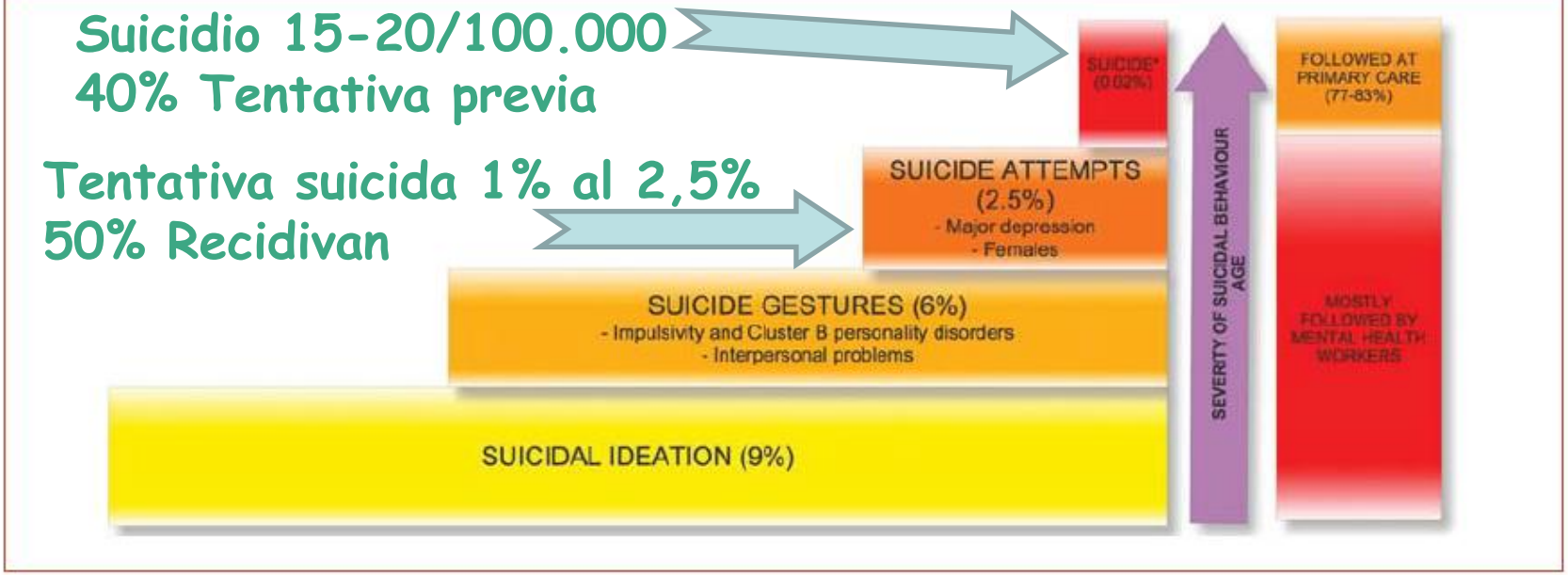
ANZJP

Management of suicidal behaviour: Is the world upside down?

Australian & New Zealand Journal of Psychiatry
1–3
DOI: 10.1177/0004867414525847

Paula Artieda-Urrutia[1], Isabel Parra Uribe[2,3], Gema Garcia-Pares[2,3], Diego Palao[2,3], Jose de Leon[4] and Hilario Blasco-Fontecilla[1,5]

Figure 1. Graphical representation of the different types of suicidal behaviours, and the health setting where the individuals displaying each specific behaviour are followed-up. The graphical representation of rates of suicide completion is not proportional as the prevalence is very low (i.e. 20 suicides per 100,000 or 0.02%). Furthermore, do note that figures represented here are summarizing data from literature, and not data from a single population. Patients who completed suicide are characterized by the presence of somatic disorders, social isolation, alcohol use, narcissistic personality disorder, and male gender.



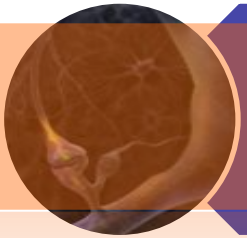
Suicidio: conducta multifactorial

Investigación orientada a la prevención

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

Índice

Introducción



Neurobiología y factores psicologicos y sociales

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Butterfly Landscape (The Great Masturbator in a Surrealist Landscape with D.N.A.). Dali ,1957

Meta-análisis de estudios de autopsias psicológicas

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

Factores de riesgo de suicido 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]
- **T. abuso 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]**

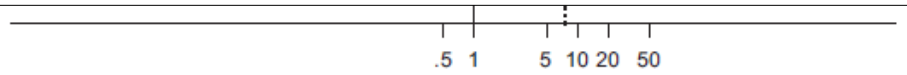
Del Riesgo Relativo (RR) al Riesgo Poblacional Atribuible (PAR)

Table 3
Population attributable risk for mental disorders (ICD/DSM) and socio-economic status (SES) measures.

	Pooled RR (95%CI)	%[a]	Median PAR% (95%CI)[a]	%[b]	Minimum PAR% (95%CI)[b]	%[c]	Maximum PAR% (95%CI) [c]
Males							
Psychiatric disorders							
Affective disorder	11.00 (7.71–15.68)	3.6	26.3 (19.3–34.4)	0.7	6.7 (4.6–9.6)	8.3	45.4 (35.9–55.0)
Schizophrenia	11.85 (10.94–12.84)	0.7	6.6 (6.1–7.1)	0.7	6.6 (6.1–7.1)	0.7	6.6 (6.1–7.2)
Substance abuse	6.88 (4.51–10.05)	4.0	19.0 (12.3–27.5)	0.9	5.0 (3.0–7.8)	5.3	23.9 (15.8–32.5)
Anxiety disorder	2.95 (1.51–5.76)	2.5	4.6 (1.2–10.4)	1.1	2.1 (0.6–5.0)	8.7	14.5 (4.3–29.3)
Personality disorder	4.14 (2.95–5.80)	5.7	15.2 (10.0–21.5)	3.5	9.9 (6.4–14.3)	12.2	27.6 (19.2–36.9)
Socioeconomic factors							
Income	2.18 (1.47–3.22)	9.7	10.2 (4.3–17.7)	3.3	3.8 (1.5–6.9)	16.0	15.9 (7.0–26.2)
Education	2.42 (1.03–5.70)	48.8	40.9 (1.4–69.6)	16.0	18.5 (0.5–42.9)	61.3	46.5 (1.8–74.2)
Occupation	2.67 (1.53–4.68)	29.6	33.1 (13.6–52.1)	15.5	20.5 (7.6–36.3)	43.7	42.2 (18.8–61.7)
Unemployment	1.68 (1.11–2.54)	6.1	4.0 (0.7–8.5)	2.0	1.3 (0.2–3.0)	22.7	13.4 (2.4–25.9)
Females							
Psychiatric disorders							
Affective disorder	14.41 (13.46–15.43)	3.5	31.6 (30.1–33.2)	1.7	18.6 (17.5–19.7)	15.0	66.8 (65.1–68.4)
Schizophrenia	12.64 (11.47–13.94)	0.8	8.3 (7.6–9.2)	0.8	8.3 (7.6–9.2)	0.8	8.3 (7.6–9.2)
Substance abuse	14.59 (12.79–16.65)	2.5	25.4 (22.8–28.1)	0.4	4.8 (4.2–5.5)	3.5	31.9 (28.9–35.1)
Anxiety disorder	2.33 (0.72–7.55)	10.0	11.7 (–2.9–39.6)	4.4	5.5 (–1.2–22.2)	20.7	21.6 (–6.1–57.5)
Personality disorder	1.84 (0.65–5.22)	7.0	5.5 (–2.5–22.6)	1.0	0.8 (–0.3–4.0)	7.5	5.9 (–2.7–24.0)
Socioeconomic factors							
Income	1.45 (0.95–2.21)	9.3	4.0 (–0.5–10.1)	9.3	4.0 (–0.5–10.1)	9.3	4.0 (–0.5–10.1)
Education	1.48 (0.94–2.34)	53.0	20.3 (–3.3–41.5)	47.8	18.7 (–3.0–39.1)	58.2	21.8 (–3.6–43.8)
Occupation	1.27 (0.54–2.94)	27.0	6.8 (–14.2–34.4)	16.3	4.2 (–8.1–24.0)	37.7	9.2 (–21.0–42.2)
Unemployment	1.68 (1.09–2.59)	3.2	2.2 (0.3–4.9)	2.0	1.3 (0.2–3.1)	4.5	2.9 (0.4–6.6)

Note: PAR: population attributable risk; RR: odds ratio; LCI: lower confidence interval; UCI: upper confidence interval Pooled estimates of RR derived from random effects (DerSimonian-Laird) model.

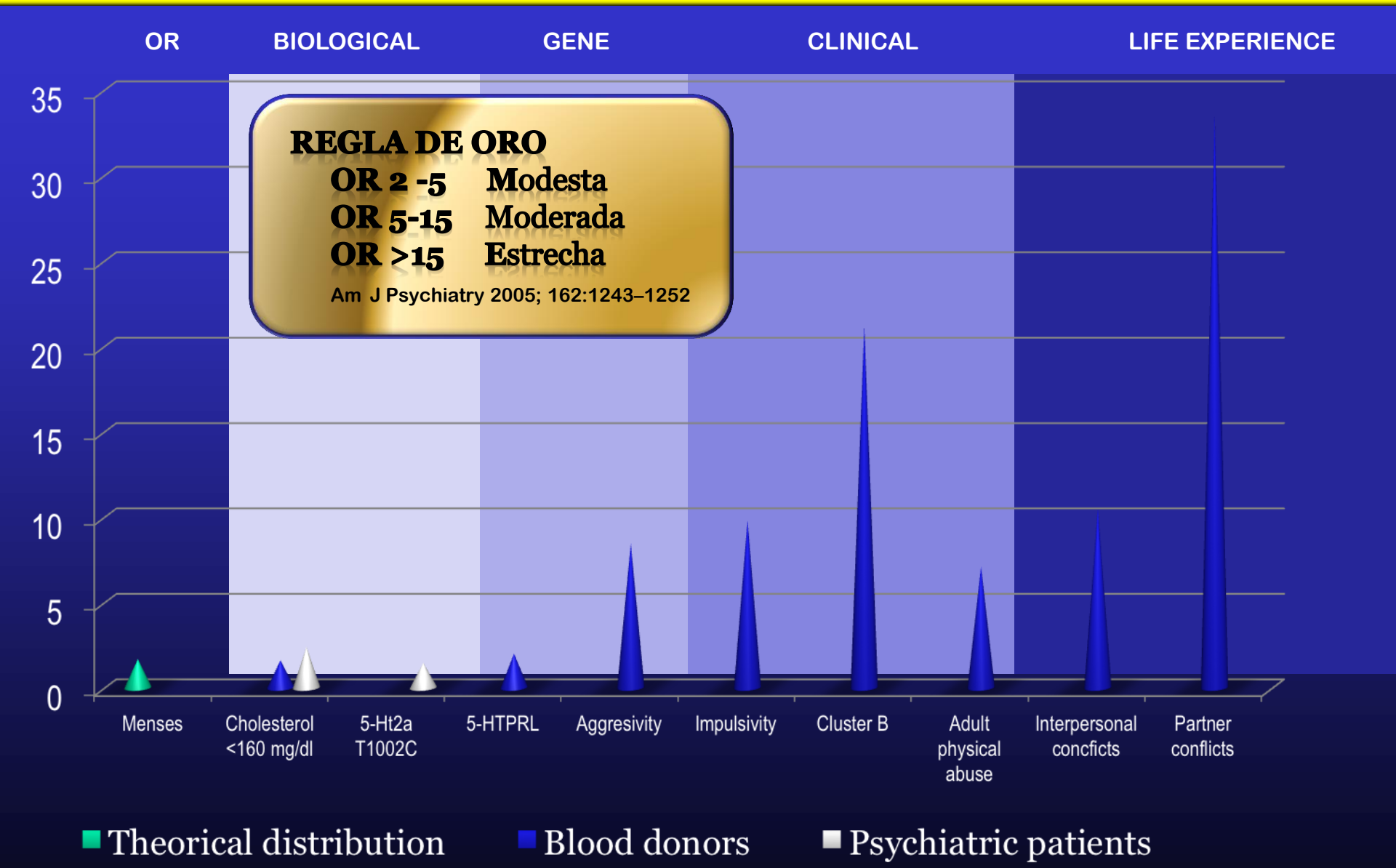
[a] Prevalence for PAR% calculations based on median prevalence of exposure in control groups.
[b] Prevalence for PAR% calculations based on minimum prevalence of exposure in control groups.
[c] Prevalence for PAR% calculations based on maximum prevalence of exposure in control groups.



males, by type of mental disorder (ICD/DSM diagnosis). Note: *: cohort study; RR/OR refer to adjusted/unadjusted odds ratio

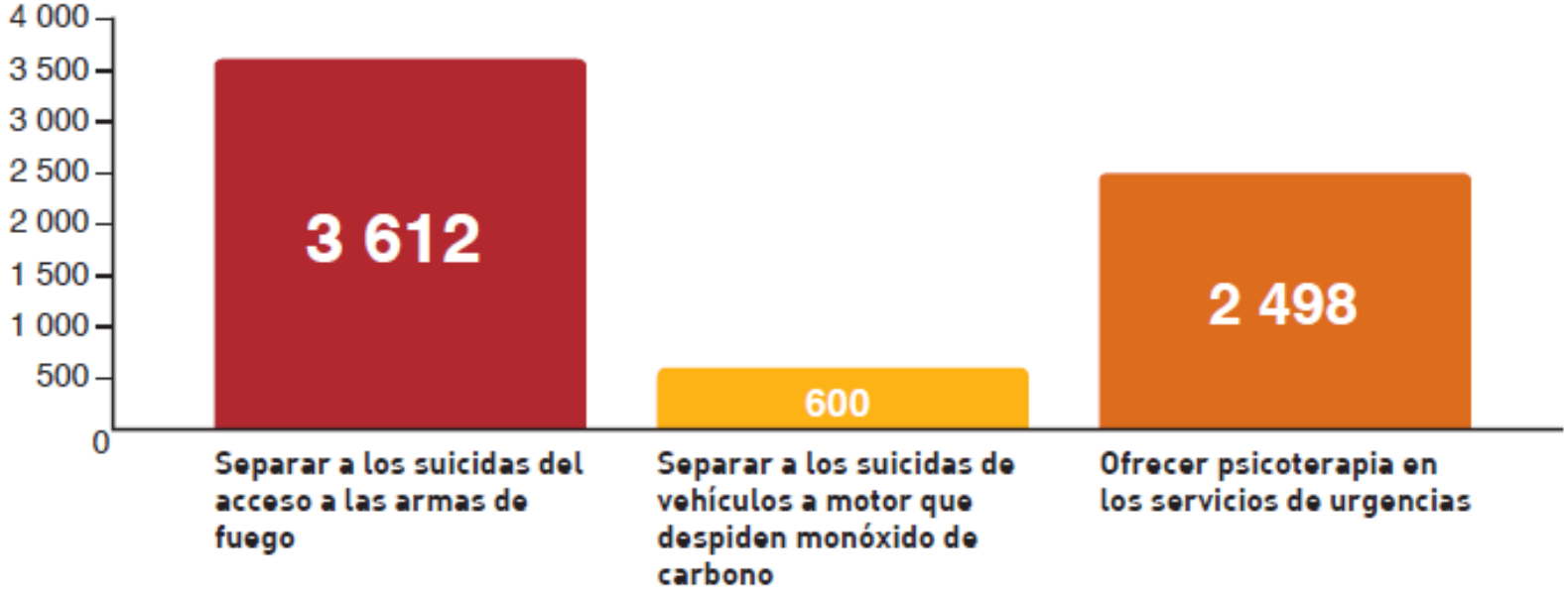
wer socio-economic strata (more distal risk factors) have the
l effects as strategies which target more proximal psychiatric
of suicide.

Riesgo de tentativa de suicidio: peso relativo de factores biologicos y clínicos



Neuropsychophram 2001; Psychos Med 2003; JCP 2006; Stress and Health, 2007; AM J Med Gen 2008; JCP 2008.

Figura 8. Muertes por suicidio evitadas mediante las intervenciones propuestas, que permiten prever una reducción del 20% en el número de muertes por suicidio en comparación con las registradas en el 2010 en los Estados Unidos (55)



La figura 8 muestra una combinación de tres abordajes cuya plena implementación permitiría salvar muchos miles de vidas solo en un año en los Estados Unidos. Sin embargo, es importante señalar que la cifra es resultado de la modelación de la ejecución óptima de unos pocos abordajes (55).

C.) Key Questions

The following questions were explored to identify the state of the science, pathways for progress, and specific objectives:

Key Question 1: Why do people become suicidal?

Key Question 2: How can we better or optimally detect/predict risk?

Key Question 3: What interventions are effective? What prevents individuals from engaging in suicidal behavior?

Key Question 4: What services are most effective for treating the suicidal person and preventing suicidal behavior?

Key Question 5: What other types of preventive interventions (outside health care systems) reduce suicide risk?

Key Question 6: What new and existing research infrastructure is needed to reduce suicidal behavior?

National Action Alliance for Suicide Prevention: Research Prioritization Task Force. (2014). *A prioritized research agenda for suicide prevention: An action plan to save lives.* Rockville, MD: National Institute of Mental Health and the Research Prioritization Task Force.

II.) Research Objectives

The table below outlines the Short-term and Long-term Objectives for each Key Question. These Objectives are discussed in more detail in Section IV of this document.

Table 1. Key Questions and Research Objectives

Question	Short-term Objectives	Long-term Objectives
Question 1—Why do people become suicidal?	1.A.—Discover models that explain contagion as well as resilient healthy social connections among at-risk groups. 1.B.—Identify biomarkers (e.g., genetic, epigenetic, immune function, neuropsychiatric profiles) and their interactions that are associated with current and future risk status. 1.C.—Identify cognitive dysfunction/neural circuitry profiles (e.g., anhedonia, impaired executive functioning) associated with suicide risk that may be amenable to current interventions.	1.A.—Determine how to improve and sustain beneficial social connection processes that reduce suicide risk. 1.B.—Identify multiple risk models based on integrated data sources (genetic, epigenetic, life event exposure, health conditions, traits, brain circuitry, neuropsychological profiles, etc.) for future intervention development. 1.C.—Determine if processes that reduce risk conditions (e.g., insomnia, addiction, agitation, pain, etc.) also mitigate suicide risk.
Question 2—How can we better or more optimally detect/predict risk?	2.A.—Develop risk algorithms from health care data that can be used for suicide risk detection. 2.B.—Improve care efficiencies and decision making tools by identifying screening approaches with concurrent and predictive validity with multiple care settings. 2.C.—Develop screening approaches using multiple methods that identify risk over time (e.g., activity monitors, mood assessments).	2.A.—Overcome base rate challenges and response bias by identifying innovative bio-statistical and other research methods. 2.B.—Determine low, moderate, and high lifetime-risk screening approaches for individuals so that appropriate preventive efforts can be sought. 2.C.—Find a valid, feasible suicide risk screening approach that can be used across care settings, such as the Healthcare Effectiveness Data and Information Set (HEDIS).
Question 3—What interventions are effective? What prevents individuals from engaging in suicidal behavior?	3.A.—Identify feasible and effective, fast acting interventions (e.g., new medicines with properties similar to certain fast acting anesthetics; treatment engagement interventions). 3.B.—Determine if adjunct interventions (e.g., safety planning; adherence interventions) focused on suicidal crises for patients receiving usual care for health conditions (psychiatric, substance use, physical illness conditions) are effective. 3.C.—Find interventions for the highest risk groups in care settings or community settings (e.g., substance abuse specialty; jails, prisons, and courts; American Indian reservations) that reduce the risk of suicide.	3.A.—Determine whether treatment of risk conditions (e.g., insomnia, psychosis, agitation, parental psychopathology), including optimal adherence and complete response, mitigates suicide risk. 3.B.—Identify biomarkers (neurocognitive profiles; genes; traits) that point to promising treatments (new, repurposed); and/or predict treatment response. 3.C.—Refine treatments for different high risk populations (demographic groups; disease groups) by identifying prognostic variables/ moderators of response and associated mechanisms from secondary analyses.
Question 4—What services are most effective for treating the suicidal person and preventing suicidal behavior?	4.A.—Identify efficient ways to increase the number of providers who implement adequate suicide assessment and management skills that improve care. 4.B.—In randomized practical trials, along with possible moderators (e.g., financial stress; patient gender) and intermediate outcomes (e.g., disengagement from care; functional limitations), find quality improvement components associated with reduced suicide risk. 4.C.—In at-risk populations, substantially increase effective help seeking and treatment engagement (e.g., involve family members, peers, information disseminated by media).	4.A.—Prevent suicide crises and injuries through effective novel care system practice approaches matched to at-risk patient needs (e.g., alternatives to inpatient care). 4.B.—Reduce suicide attempt and death outcomes through multiple, synergistic components of quality improvement within and across responsible systems (e.g., health care; justice systems, military installations, older adult care settings). 4.C.—Sustain effective quality improvements (e.g., stakeholder feedback mechanisms such as service ratings and 'report cards,' quality improvement collaborative involvement, etc.) that include input from those affected by those systems (e.g., patients, providers, family members, policy leaders, and funders).

Infrastructure Needs

Question 6: What new and existing research infrastructure is needed to reduce suicidal behavior?	• Develop standard definitions, common data elements, and processes for harmonization efforts to enhance clarity of research findings • Expand biobanking (e.g., brain tissue banks; genetic repositories) • Develop patient registries • Expand data sharing and warehousing; supplement existing studies • Establish a clearing house for policy research opportunities • Develop communications partnerships for public messaging/media research and best practices • Conduct periodic reviews and updates of surveillance data/databases • Facilitate health care organization-researcher partnerships to field studies • Support research workforce development

		surveillance and prevention efforts with other effective community programs, such as prevention of substance abuse and child abuse and neglect.

Figure 11. 12 Aspirational Goals (as a result of the Stakeholder Survey)

Aspirational Goal 1—Know what leads to, or protects against, suicidal behavior, and learn how to change those things to prevent suicide.

Aspirational Goal 2—Determine the degree of suicide risk (e.g., imminent, near-term, long-term) among individuals in diverse populations and in diverse settings through feasible and effective screening and assessment approaches.

Aspirational Goal 3—Find ways to assess*who is at risk for attempting suicide in the immediate future.

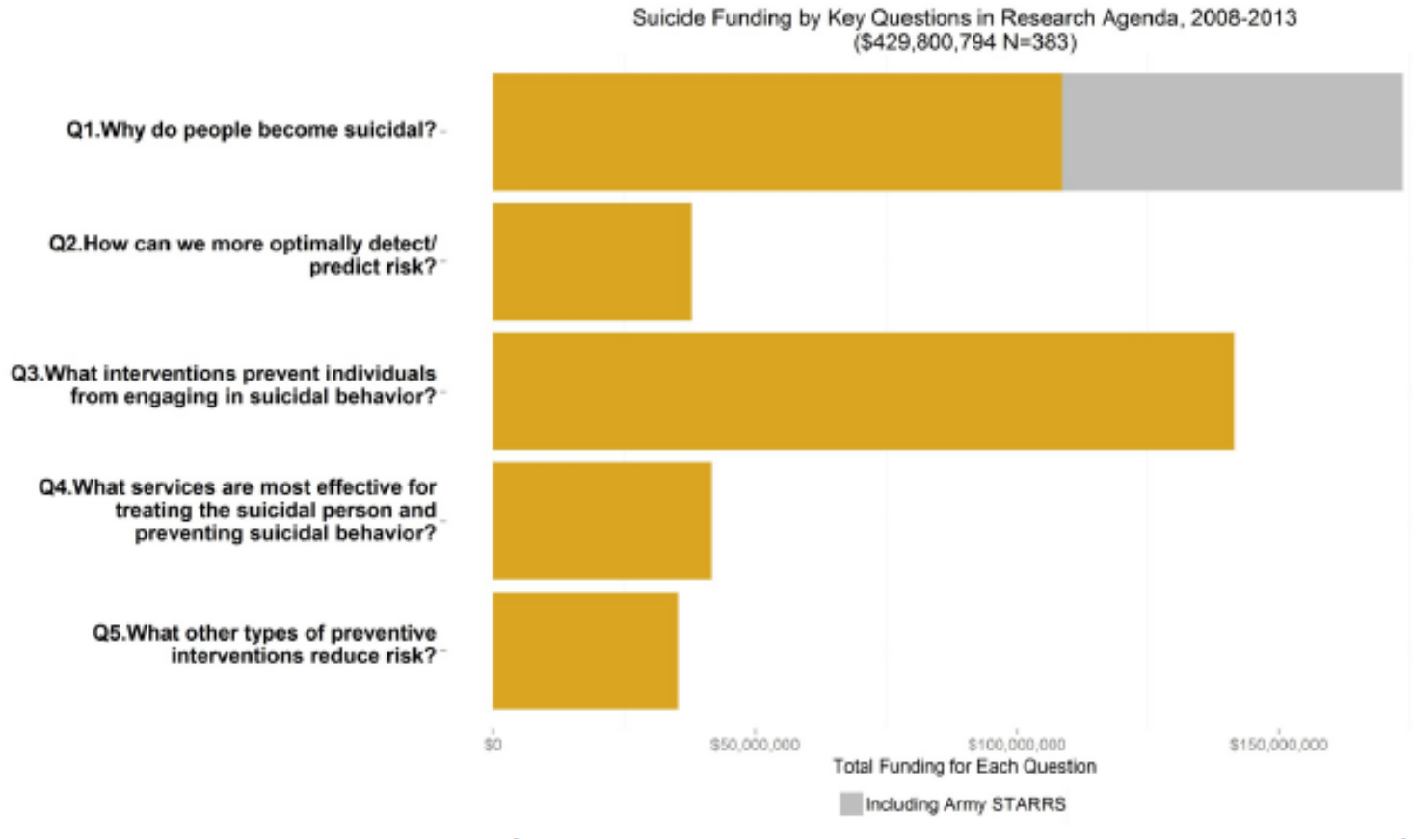
1. The highest-rated Aspirational Goals were grouped and labeled Tier One. They are:
   - **Aspirational Goal 6**—Ensure that people who have attempted suicide can get effective interventions to prevent further attempts.
   - **Aspirational Goal 9**—Ensure that people getting care for suicidal thoughts and behaviors are followed throughout their treatment so they don't fall through the cracks.
   - **Aspirational Goal 7**—Ensure that health care providers and others in the community are well trained in how to find and treat those at risk.
   - **Aspirational Goal 8**—Ensure that people at risk for suicidal behavior can access affordable care that works, no matter where they are.

most effective prevention programs to build resilience and reduce risk in broad-based populations.

Aspirational Goal 12—Reduce access to lethal means that people use to attempt suicide.

**While stakeholders indicated that predicting who is at imminent risk was an aspirational research goal, expert consultants recommended that assessments focused on finding treatable conditions or symptoms was more actionable than prediction per se. Therefore, this goal has been reworded.*

Figure 4: Suicide Funding by Key Questions in Research Agenda



an agenda for research that has the potential to reduce morbidity (attempts) and mortality (deaths) each, by at least 20% in 5 years, and 40% or greater in 10 years, if implemented successfully.

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
of suicide is scarce. We aimed to examine
investigate the association between their i

Methods We did a descriptive, cross-sect
and Wales. We collected data for indivic

Panel 1: Key service recommendations

- Ligature points; removal of potential ligature points on inpatient wards, including all non-collapsible curtain rails.
- Assertive outreach; community services include an assertive outreach team that provides intensive support for people with severe mental illness who are difficult to engage in more traditional services.
- 24 h crisis team; community services include a single point of access for people in crisis available 24 h a day. These teams are intended to promptly respond to mental health crisis in the community and so prevent inpatient admission. They provide short-term input until other services are available.
- 7 day follow-up; written policy on follow-up of patients within 7 days of psychiatric inpatient discharge.
- Non-compliance; written policy on response to patients who are non-compliant with treatment.
- Dual diagnosis; written policy on the management of patients with dual diagnosis (patients diagnosed with a psychiatric illness and drug or alcohol dependence or misuse).
- Criminal justice sharing; written policy on sharing information about risk with criminal justice agencies.
- Review; written policy on multidisciplinary review and information sharing with families after a suicide.
- Training; front-line clinical staff receive training in the management of suicide risk at least every 3 years.

Three of the original recommendations were not included in this study. These were: patients with a history of self-harm in the past 3 months to receive supplies of medication covering no more than 2 weeks; atypical antipsychotic medication to be available for all patients with severe mental illness who are non-compliant with typical drugs because of side-effects; all patients with severe mental illness and a history of self-harm or violence to receive the most intensive level of care.

Figure 5. Health Care System Characteristics That Were Associated with Lower Suicide Rates upon Implementation

Most Effective across All Sites
- **A.** Providing 24-hour crisis teams

Moderately Effective across All Sites
- **B.** Managing patients with co-occurring disorders (mental and substance use disorder)
- **C.** Conducting multidisciplinary reviews
- **D.** Sharing information with families after a suicide and making future care improvements as a result

Most Effective for Inpatient Settings
- **E.** Removing ligature points

Most Effective for Noncompliance
- **F.** Conducting follow-up with patients within 7 days of discharge

Most Effective for People with History of Missed Appointments
- **G.** Conducting assertive community outreach

Overall, Largest Effects Were in Low Income Areas
- **H.** Providing regular training to frontline clinical staff on the management of suicide risk
- **I.** Responding to patients who are not complying with treatment
- **J.** Sharing information with criminal justice agencies

In 1998, few of the 91 mental health services in the study were carrying out any of these recommendations. By 2004, about half were implementing at least seven recommendations, and by 2006, about 71% were doing so. Over time, as more recommendations were implemented, suicide rates among patients declined. Each year, from 2004 to 2006, mental health services that implemented seven or more recommendations had a lower suicide rate than those implementing six or fewer. (While et al., 2012)

Early Evidence on the Effects of Regulators' Suicidality Warnings on SSRI Prescriptions and Suicide in Children and Adolescents

Robert D. Gibbons, Ph.D.

C. Hendricks Brown, Ph.D.

Kwan Hur, Ph.D.

Sue M. Marcus, Ph.D.

Dulal K. Bhaumik, Ph.D.

Joëlle A. Erkens, Pharm.D., Ph.

Ron M.C. Herings, Pharm.D., Ph.D.

J. John Mann, M.D.

FIGURE 1. SSRI Prescription Rates in the United States, 2002–2005, Stratified by Age Group and Expressed as a Percentage of the 2003 Rate

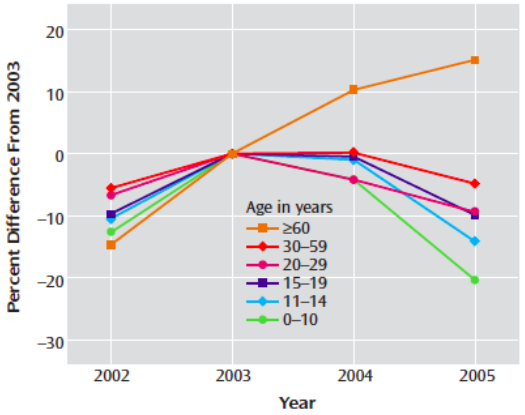


FIGURE 2. Suicide Rate in Children and Adolescents (Ages 5–19 Years) in the United States, 1988–2004

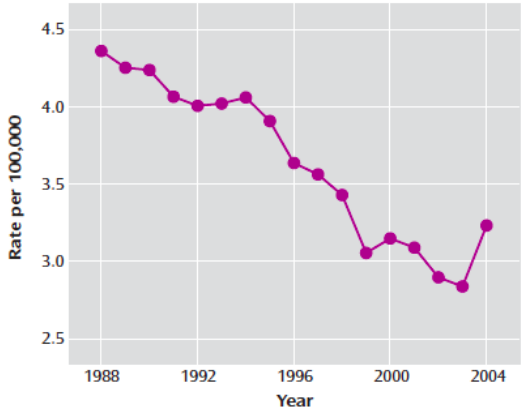


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FIGURE 4. SSRI Prescription Rates in the Netherlands, 1998–2005, Stratified by Age and Expressed as a Percentage of the 2003 Rate

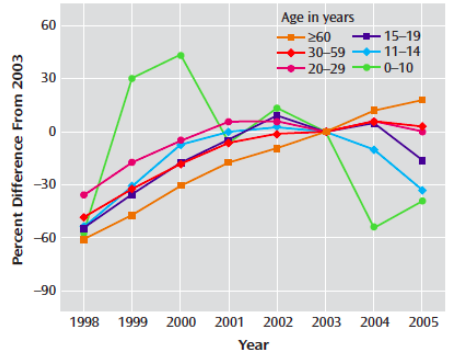

FIGURE 5. Suicide Rate in Children and Adolescents (Up to Age 19) in the Netherlands, 1998–2005

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(Am J Psychiatry 2007; 164:1356–1363)

Journal of Psychiatric Research 47 (2013) 1925–1931

Contents lists available at ScienceDirect

Journal of Psychiatric Research

journal homepage: www.elsevier.com/locate/psychires

Electrodermal hyporeactivity as a trait marker for suicidal propensity in uni- and bipolar depression

L.H. Thorell [a, *], M. Wolfersdorf [b], R. Straub [c], J. Steyer [c], S. Hodgkinson [c], W.P. Kaschka [c], M. Jandl [c]

[a] Department of clinical and experimental medicine, Linköping University and Emotra AB, Gothenburg, Östgötagatan 60B, 582 32 Linköping, Sweden
[b] Department of Psychiatry and Psychotherapy, State Hospital, Bayreuth, Germany
[c] Department of Psychiatry and Psychotherapy I, University Hospital Ulm, ZfP (Zentrum für Psychiatrie)-Südwürttemberg, Ravensburg, Germany

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Stability

ABSTRACT

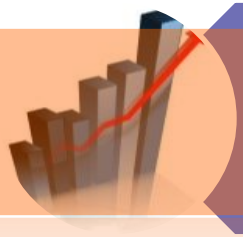
Table 4
Sensitivity and raw specificity of electrodermal hyporeactivity for suicide and violent attempt in the whole sample and in the diagnostic groups.

Categories	Suicides or violent attempts	Hyporeactives		Reactives	Suicides or violent attempts	
	n	n	%	n	n	%
Diagnostic groups:			**Sensitivity**			**Specificity**
Bipolar	22	21	95.5	25	1	96.0
Unipolar	87	59	67.8	176	28	84.1
Other	11	9	81.8	49	2	95.9
Grand totals	120	89	74.2	250	31	87.6

Índice

Introducción

Neurobiología y factores psicologicos y sociales



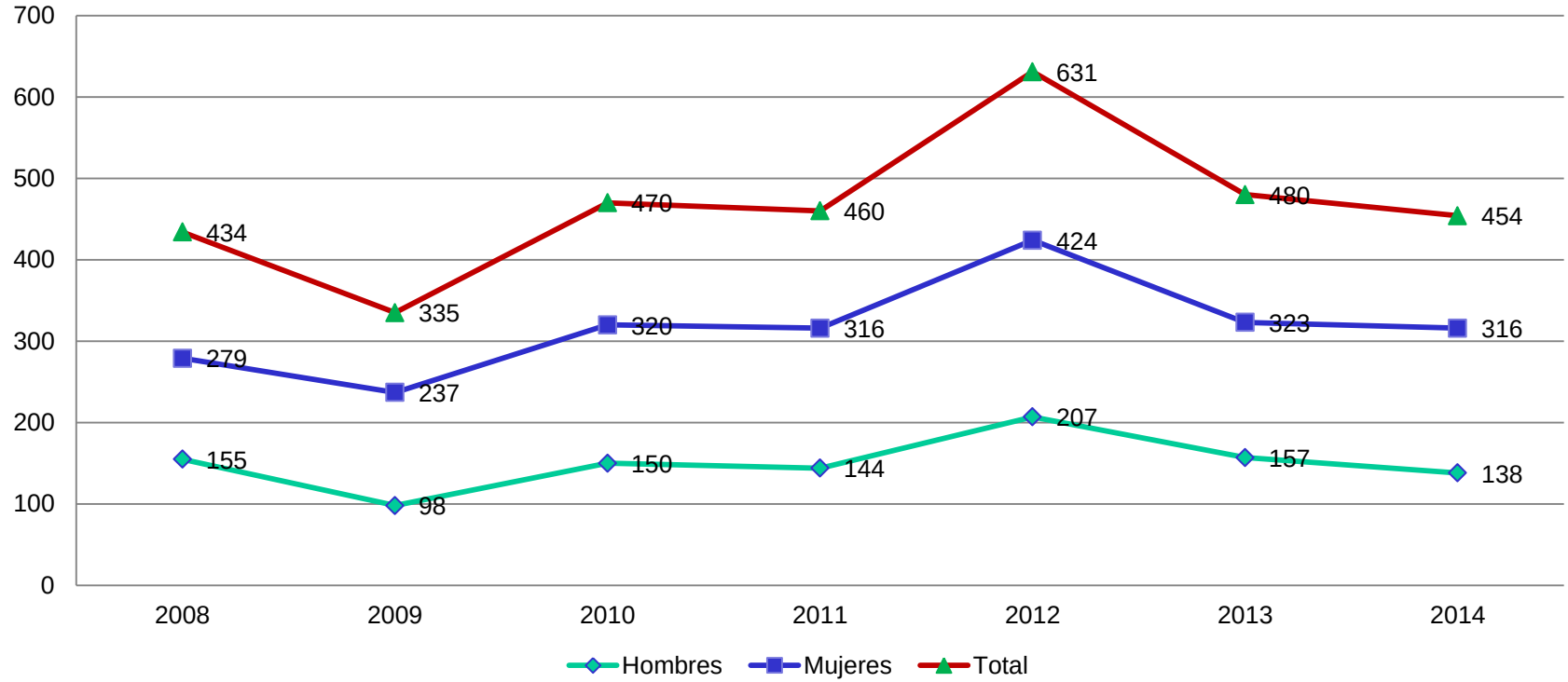
Resultados en nuestro entorno

Conclusiones

Butterfly Landscape (The Great Masturbator in a Surrealist Landscape with D.N.A.). Dali ,1957

RESULTADOS
Parc Taulí Sabadell 2008- 2014

Nº de casos de Tentativas de Suicidio atencidas en el Servicio de Urgencias del Parc Tauli por sexo y año



***2014: 104 casos de tentativas de suicidio x 100.000 hab./ año**

Parc Taulí Sabadell
Hospital Universitari
Salut Mental

RESULTADOS

Parc Taulí Sabadell: estudio controlado 2007-2008

Journal of Affective Disorders 147 (2013) 269–276

Contents lists available at SciVerse ScienceDirect

Journal of Affective Disorders

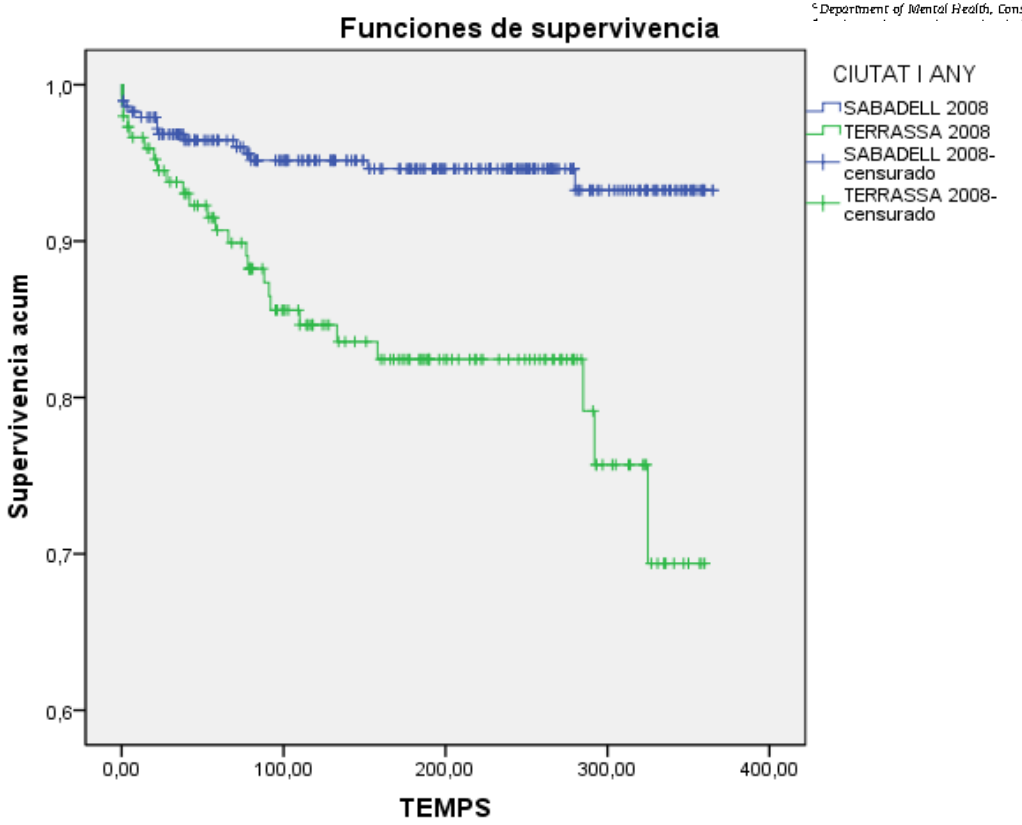
journal homepage: www.elsevier.com/locate/jad

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

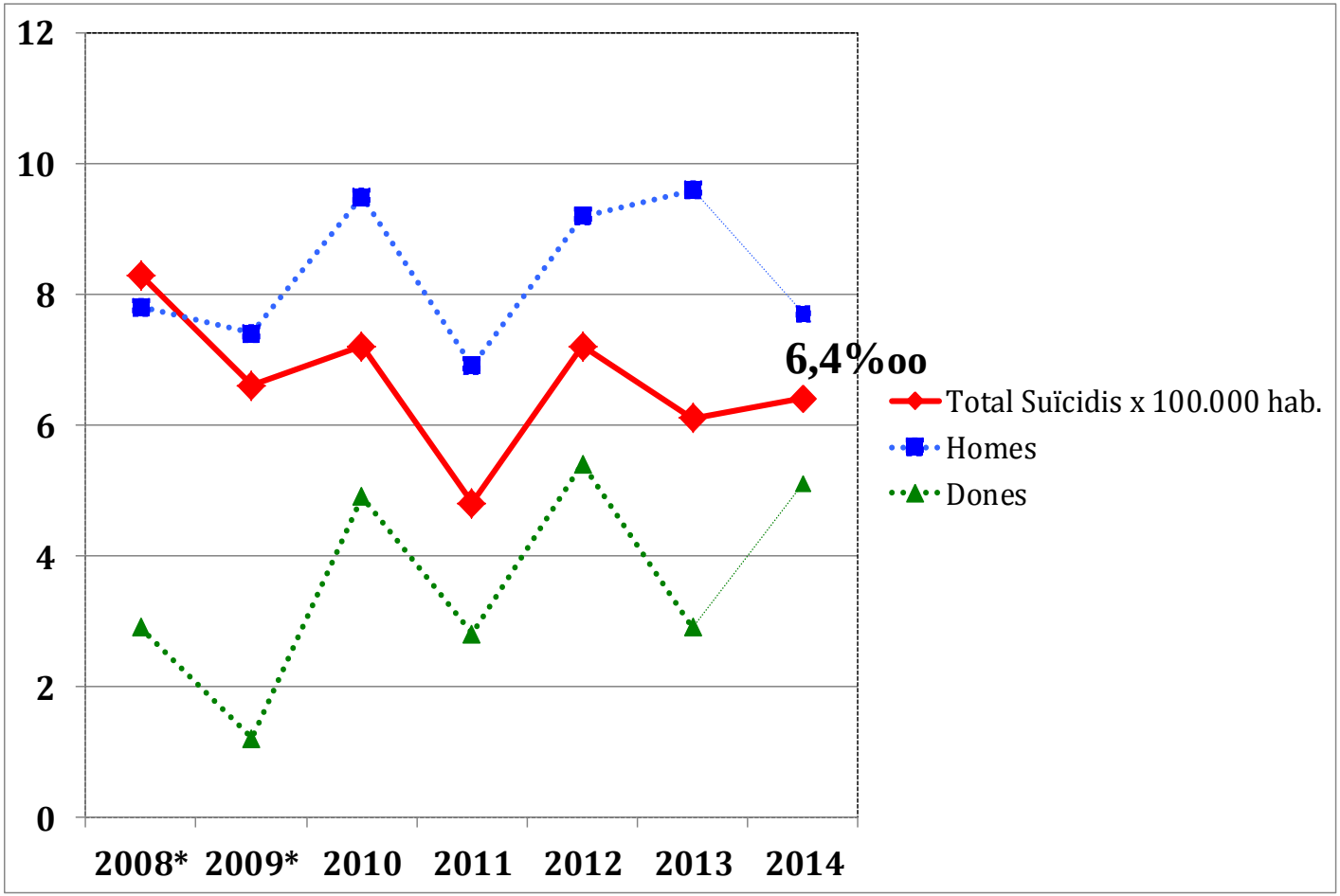
Ana Isabel Cebrià [a,b,*], Isabel Parra [a,b], Montserrat Pàmias [a,b], Anna Escayola [a], Gemma García-Parés [a,b], Joaquim Puntí [a,h], Andrés Laredo [a], Vicenç Vallès [c], Myriam Cavero [d,b], Joan Carles Oliva [g], Ulrich Hegerl [e], Victor Pérez-Solà [b,f], Diego J. Palao [a,b]

[a] Department of Mental Health, Corporació Sanitària Parc Taulí de Sabadell (Barcelona), Institut Universitari Parc Taulí Universitat Autònoma de Barcelona, Campus d'Excel·lència Internacional, Bellaterra 08193, Spain
[b] Department of Psychiatry and Forensic Medicine, Universitat Autònoma de Barcelona, Spain
[c] Department of Mental Health, Consorci Sanitari de Terrassa, Barcelona, Spain



- Desde 2007 se han registrado más de 3.000 casos de tentativas de suicidio y han iniciado programa de gestión telefónica más del **90%.**
- Hasta un **70%** de los casos han finalizado el seguimiento telefónico de 12 meses

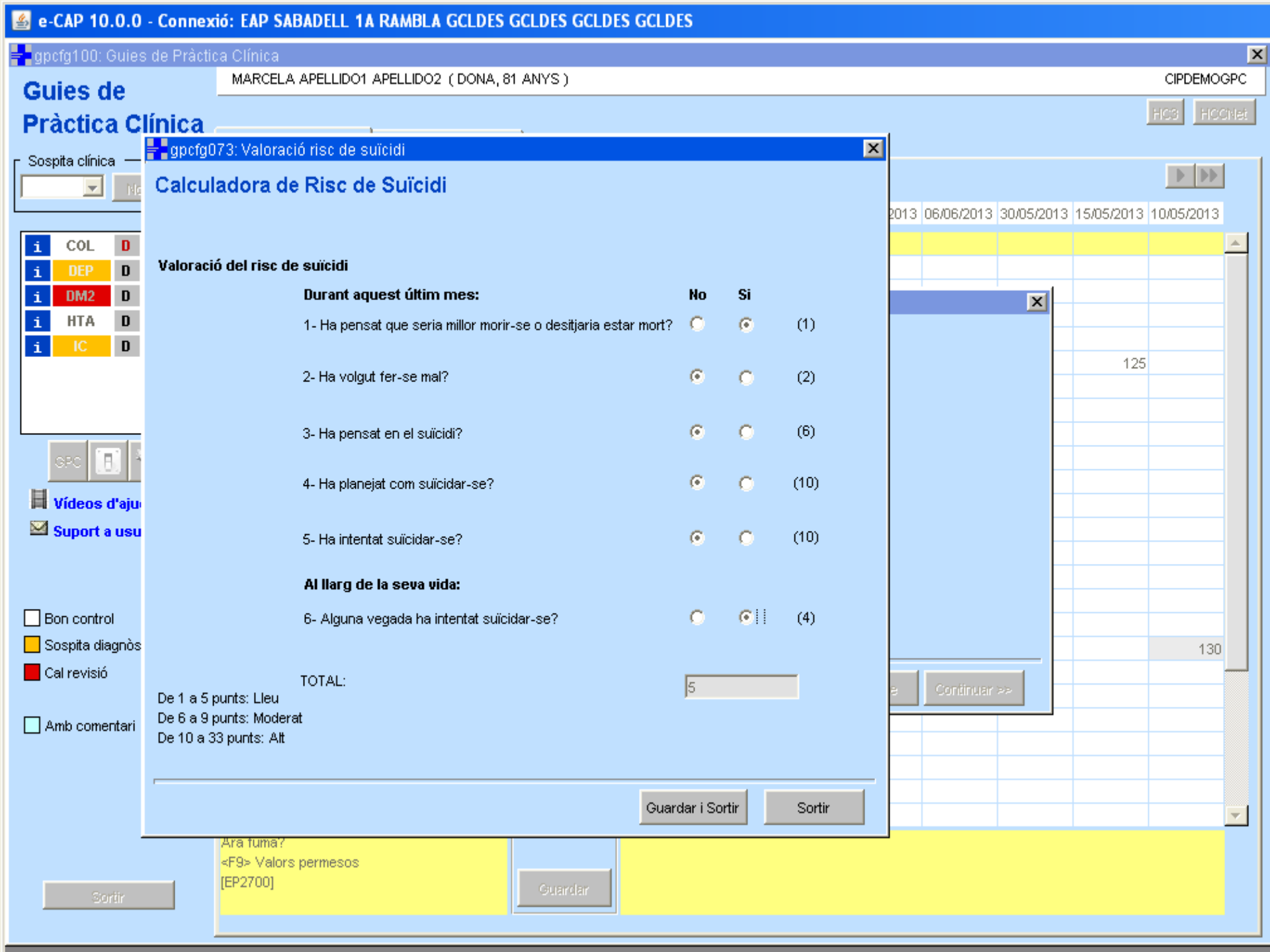
Evolución de suicidios consumados
Vallès Occ. Est (Sabadell) 2008-2014



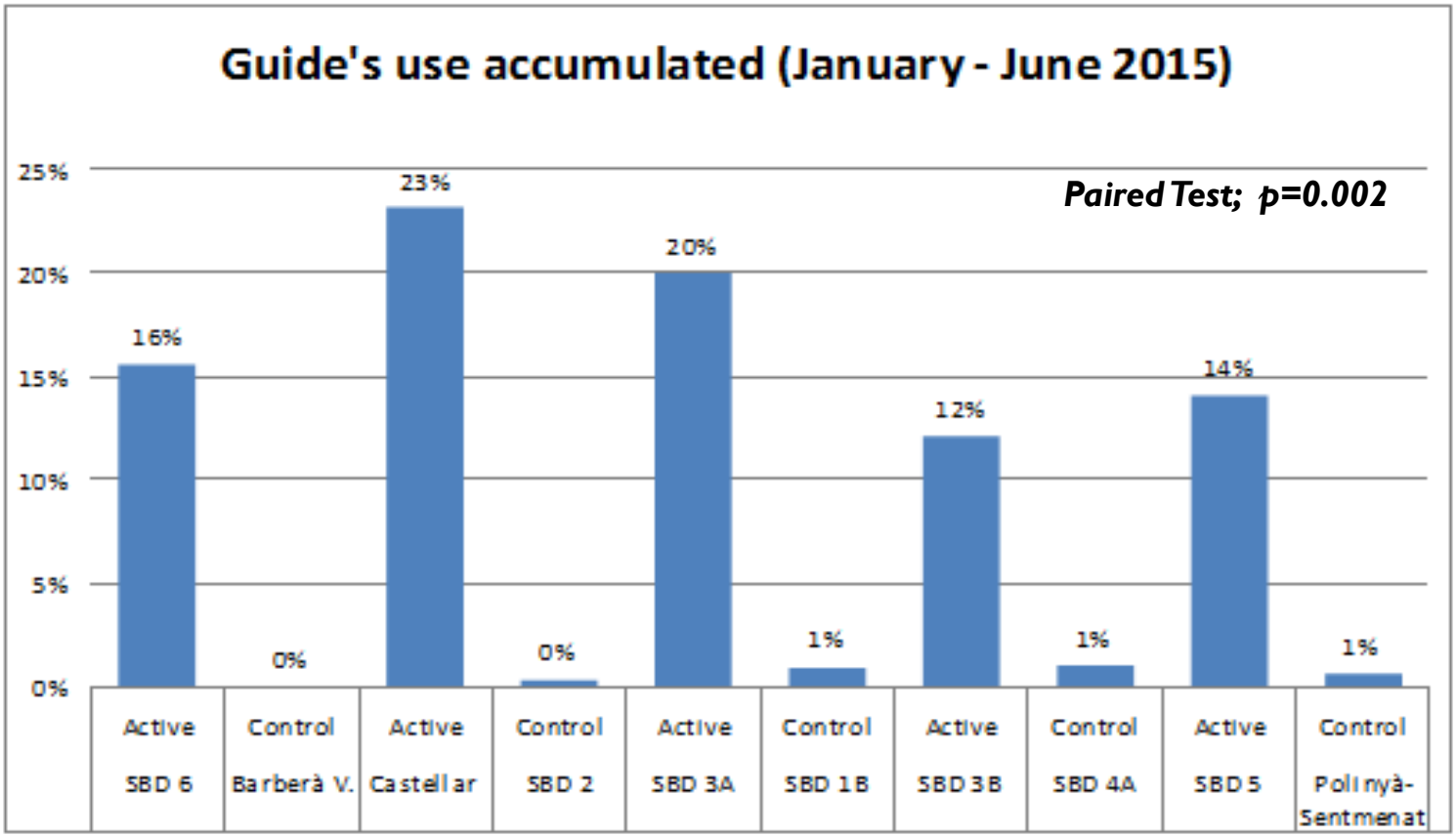
Tasa total en España 2013: 8,3 / 100.000 hab. (12,7‰ H; 4,1 ‰ M)

INE, 2015.

- ✓ ***Hasta 2009: 300.667 hab.**
- ✓ **2010: 474.778 hab./ 2012: 468.453 hab. (51,2% D / 48,7% H)**


e-CAP 10.0.0 - Connexió: EAP SABADELL 1A RAMBLA GCLDES GCLDES GCLDES GCLDES
gpcfg100: Guies de Pràctica Clínica
Guies de Pràctica Clínica
MARCELA APELLIDO1 APELLIDO2 (DONA, 81 ANYS)
CIPDEMOGPC
HC3
HCCNet
Sospita clínica
COL D
DEP D
DM2 D
HTA D
IC D
GPC
Vídeos d'aju
Suport a usu
Bon control
Sospita diagnòs
Cal revisió
Amb comentari
Sortir
gpcfg073: Valoració risc de suïcidi
Calculadora de Risc de Suïcidi
Valoració del risc de suïcidi
Durant aquest últim mes:
No
Si
1- Ha pensat que seria millor morir-se o desitjaria estar mort? (1)
2- Ha volgut fer-se mal? (2)
3- Ha pensat en el suïcidi? (6)
4- Ha planejat com suïcidar-se? (10)
5- Ha intentat suïcidar-se? (10)
Al llarg de la seva vida:
6- Alguna vegada ha intentat suïcidar-se? (4)
TOTAL:
5
De 1 a 5 punts: Lleu
De 6 a 9 punts: Moderat
De 10 a 33 punts: Alt
Guardar i Sortir
Sortir
06/06/2013
30/05/2013
15/05/2013
10/05/2013
125
130
Continuar >>
Ara fuma?
<F9> Valors permesos
[EP2700]
Guardar

Resultados 6 meses estudio aleatorizado de implementación GPC-DEP-cat: *Cambio en Uso de la Guía*



Uso de la GPC-DEPc –al menos una vez al mes- a los 6 meses en pacientes con diagnóstico de DM (%): comparación entre Centros de AP de Sabadell Activos y Controles apareados.

Código Riesgo Suicidio Catalunya:

Detecc
criba
061-Ca
Resp

Alerta

•AP
•CSM /CAS
•CUAP
•061
•Fuerzas de seguridad
•Ciutdadanía

1a atenci
Sospecha

CatSa
Servei Català de la Salut

SEGUIMENT PROACTIU

061 CatSalut Respon

SEGUIMENT CRS

- Ha rebut la trucada del seu CSM?
- Té dia de visita confirmada?
- Es troba millor?
- Ha estat visitat al seu CSM?

IDENTIFICACIÓ FACTORS DE RISC

- Estar deprimit/da.
- Diagnòstic psiquiàtric de:
  - Transtorn depressiu.
  - Transtorn psicòtic.
  - Transtorn bipolar.
  - Transtorn límit de la personalitat.
  - Transtorn conducta alimentària.
- Agitació, agressivitat, impulsivilitat, nivell de consciència alterat.
- Consum excessiu i/o dependència de l'alcohol.
- Consum i/o addicció a d'altres substàncies.
- Malalties orgàniques greus.
- Altres factors de risc:
  - Gènere home.
  - >65 anys o adolescent.
  - Problemes socials.
  - Esdeveniments vitals estressants <3 mesos (laborals, parella, econòmics, família)
- Accés a armes, tòxics i altres mitjans letals o situacions de violència.
- Antecedents familiars (1r grau) de suïcidi consumat.

codi RISC SUÏCIDI

Atenció d'emergència a la sospita de risc de suïcidi

canalsalut.gencat.cat

Generalitat de Catalunya
Departament de Salut

emergències mèdiques

miento
entivo
dinal CRS
neses

o telefónico:
atSalut Respon
o 1 vez al mes post-
ctivación CRS)

sgo leve /
oderado:
guimiento
eventivo y
aluación del
riesgo

•AP
CSM i/o
CAS

tat de Catalunya
ment de Salut

Estado de situación del registro CRS (05 agosto 2015)

Regiones Sanitarias	Personas identificadas (domicilio)	personas sin episodio registrado	Hospitales	episodios informados según hospitales	episodios con alta registrada	altas derivadas a seguimiento en CSM (registro)
Lleida	158	0	H-1	88	86	71
			H-2	78	71	30
total Lleida				166	157	101
Girona	39	3	H-Girona	37	28	18
Camp Tarragona	113	10	H-3	104	101	66
Barcelona	1.077	49	H-4	175	148	130
			H-5	114	86	79
			H-6	9	2	2
			H-7 / Sant Pau	269	269	189
			H-8	124	65	63
			H-9	5	5	5
			H-10 / Sabadell	380	365	364
			H-11	7	7	7
			H-12	33	24	22
total Barcelona	1.077	49		1.116	971	861
Otras	13	3				
Totales	1.242	65		1.423	1.261 (88%)	1.046 (73%)

Publicación de la Instrucción 10/2015

8 de septiembre de 2015

CatSalut Servei Català de la Salut

Generalitat de Catalunya
Departament de Salut

CatSalut. Instrucció 10/2015
Atenció a les persones en risc de suïcidi.
Codi risc de suïcidi (CRS)

Assumpte

Atenció a les persones en risc de suïcidi. Codi risc de suïcidi (CRS)

Àmbit

Servei Català de la Salut (CatSalut)

Sistema sanitari integral d'utilització pública de Catalunya (SISCAT)

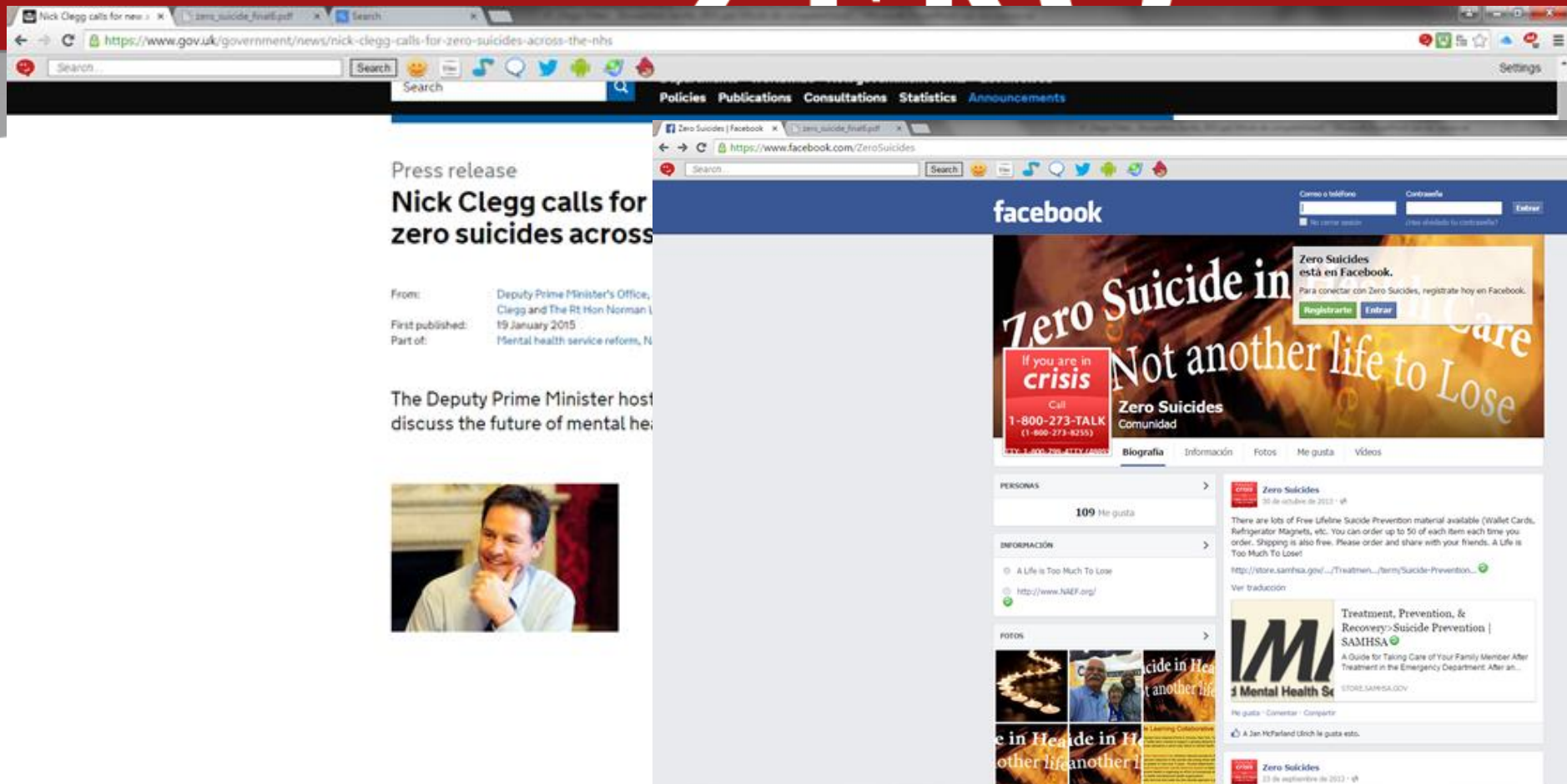
Sistema d'Emergències Mèdiques (SEM)

1. Exposició de motius

El suïcidi és un problema de salut pública de primera magnitud i l'Organització Mundial de la Salut (OMS) estima que el 2020 representarà un 2,4% de la càrrega total de problemes de salut.

S'estima que cada any un milió de persones se suïciden al món i preocupa especialment perquè és una de les primeres causes de mortalitat prematura en persones joves d'ambdós sexes (el grup de 25 a 44 anys constitueix el primer grup de risc). Així mateix, cal tenir en compte que les estadístiques no registren les

what is ZERO


https://www.gov.uk/government/news/nick-clegg-calls-for-zero-suicides-across-the-nhs
Search
Policies Publications Consultations Statistics Announcements
Press release
Nick Clegg calls for
zero suicides across
From:
First published:
Part of:
The Deputy Prime Minister host
discuss the future of mental hea
https://www.facebook.com/ZeroSuicides
facebook
Zero Suicides
está en Facebook.
Para conectar con Zero Suicides, regístrate hoy en Facebook.
Registrarte
Entrar
Zero Suicide in
Not another life to Lose
If you are in
crisis
Call
1-800-273-TALK
(1-800-273-8255)
Zero Suicides
Comunidad
Biografía
Información
Fotos
Me gusta
Videos
109 Me gusta
Zero Suicides
There are lots of Free Lifeline Suicide Prevention material available (Wallet Cards, Refrigerator Magnets, etc. You can order up to 50 of each item each time you order. Shipping is also free. Please order and share with your friends. A Life is Too Much To Lose!
Treatment, Prevention, & Recovery>Suicide Prevention | SAMHSA
A Guide for Taking Care of Your Family Member After Treatment in the Emergency Department: After an...

Conclusiones