SSCLP
Swiss Society of
Consultation - Liaison Psychiatry

SSCLPP Satelliten-Symposium

Suicidality

SGPP Kongress 8.9.2022

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SSCLPP

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hepp-health

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SSCLPP Kongress 2023
4./5. Mai 2023
Neuchâtel

Collaboration interprofessionnelle:
l'avenir de la psychiatrie de liaison ?
Interprofessionelle Zusammenarbeit:
Die Zukunft der Konsiliar- und Liaisonpsychiatrie?

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Facts & Figures

Facts & Figures

The swiss suicide rate

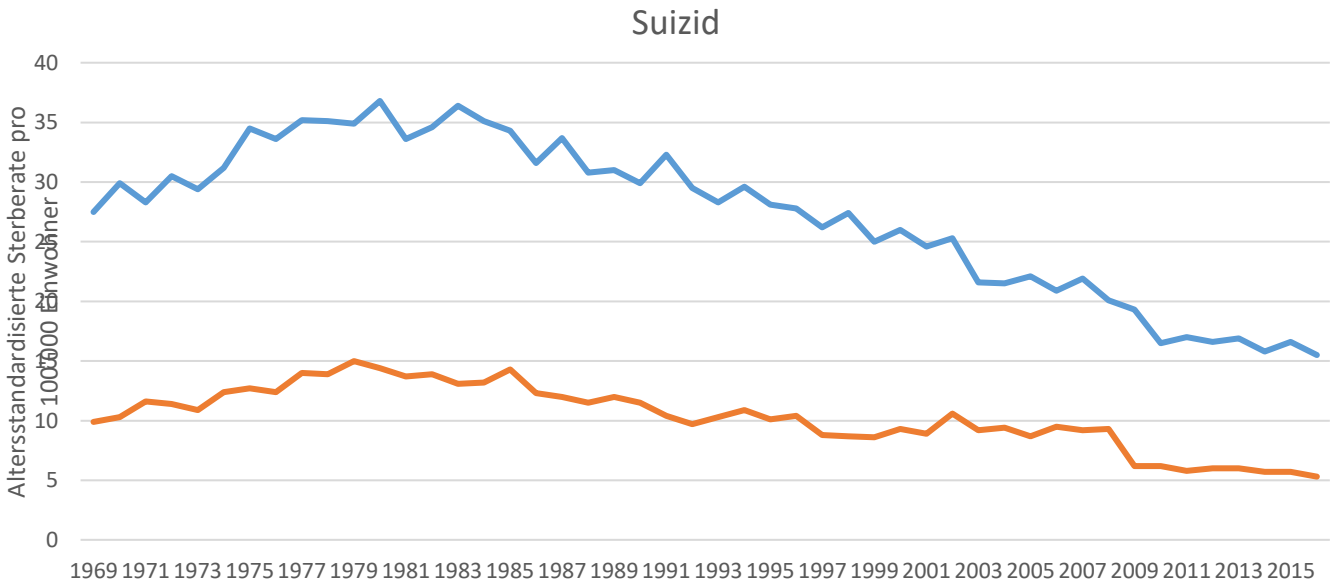
Total	ca.	12/100‘000
males	ca.	19/100‘000
females	ca.	6/100‘000

about 1000 suicides / year

A separate ICD-10 code for assisted suicide (X61.8) was introduced in 1998, which allows for differentiation between suicide/assisted suicide

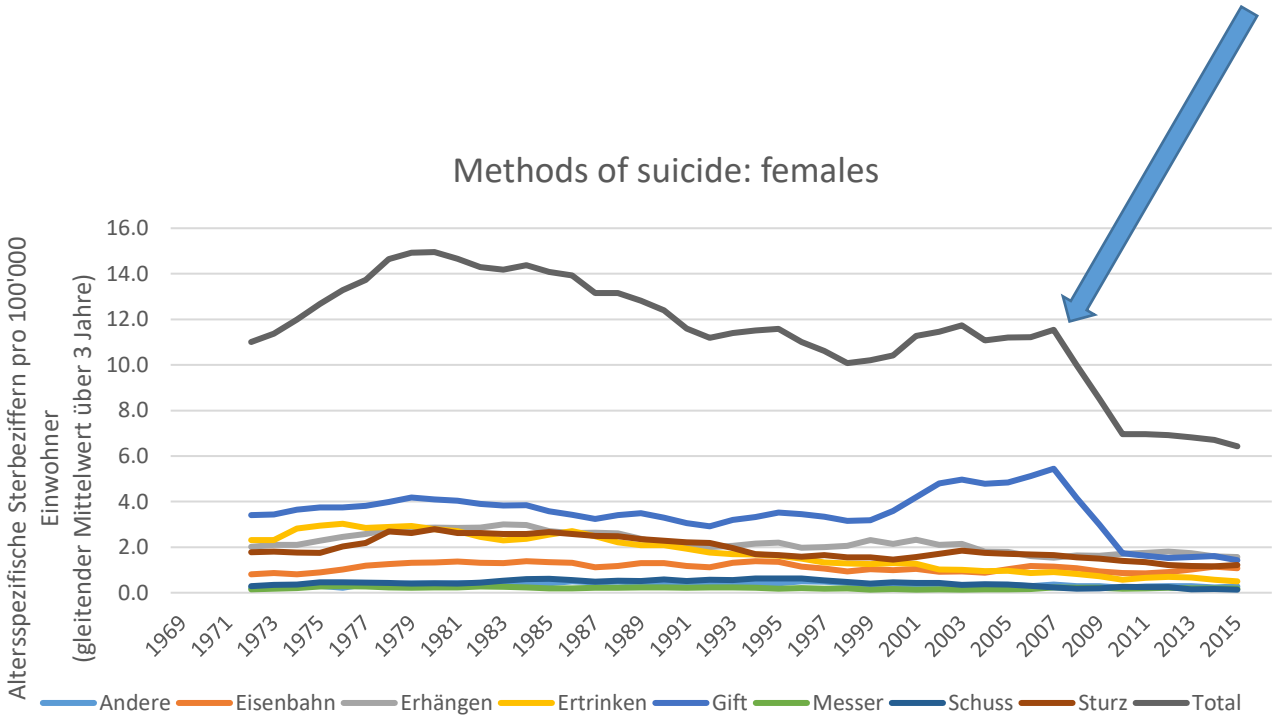
Since 2009 the assisted suicides are no longer counted as suicides in the Swiss mortality statistics.

Swiss suicide rates 1969-2016



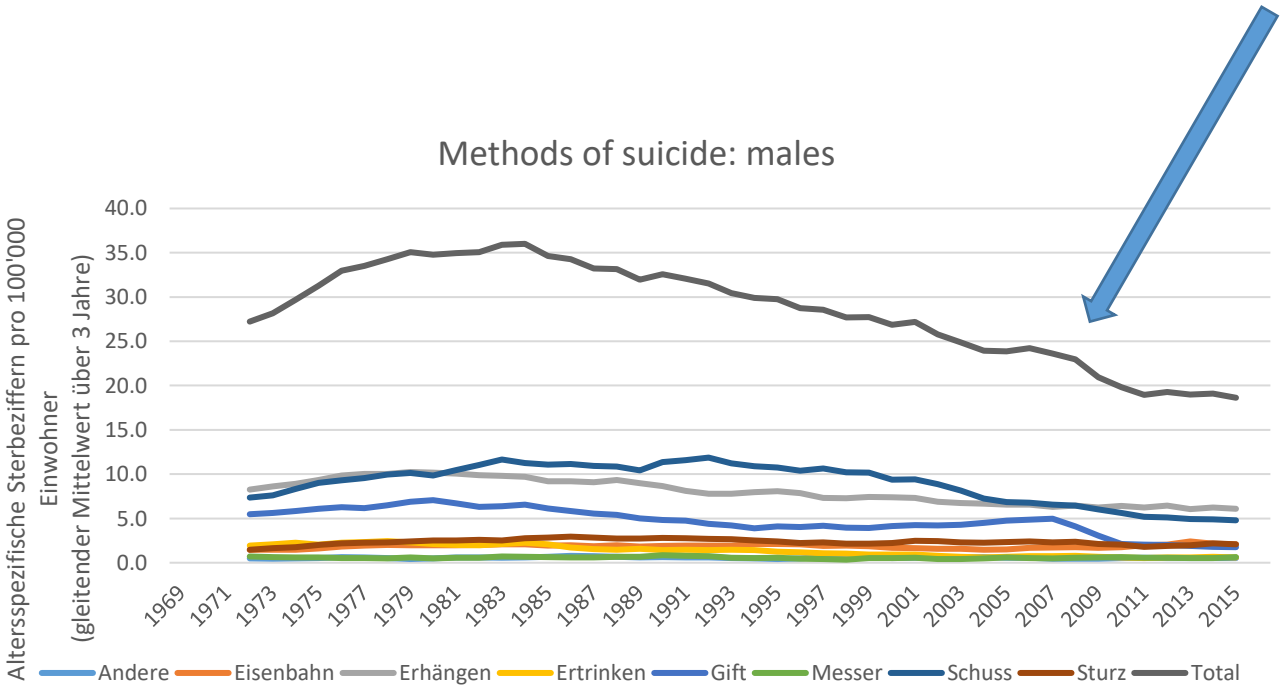
Stulz, Hepp, Kupferschmid, Raible-Destan, Zwahlen. Accepted for publication

Methods of suicide: females



Stulz, Hepp, Kupferschmid, Raible-Destan, Zwahlen. Accepted for publication

Methods of suicide: males



Stulz, Hepp, Kupferschmid, Raible-Destan, Zwahlen. Accepted for publication

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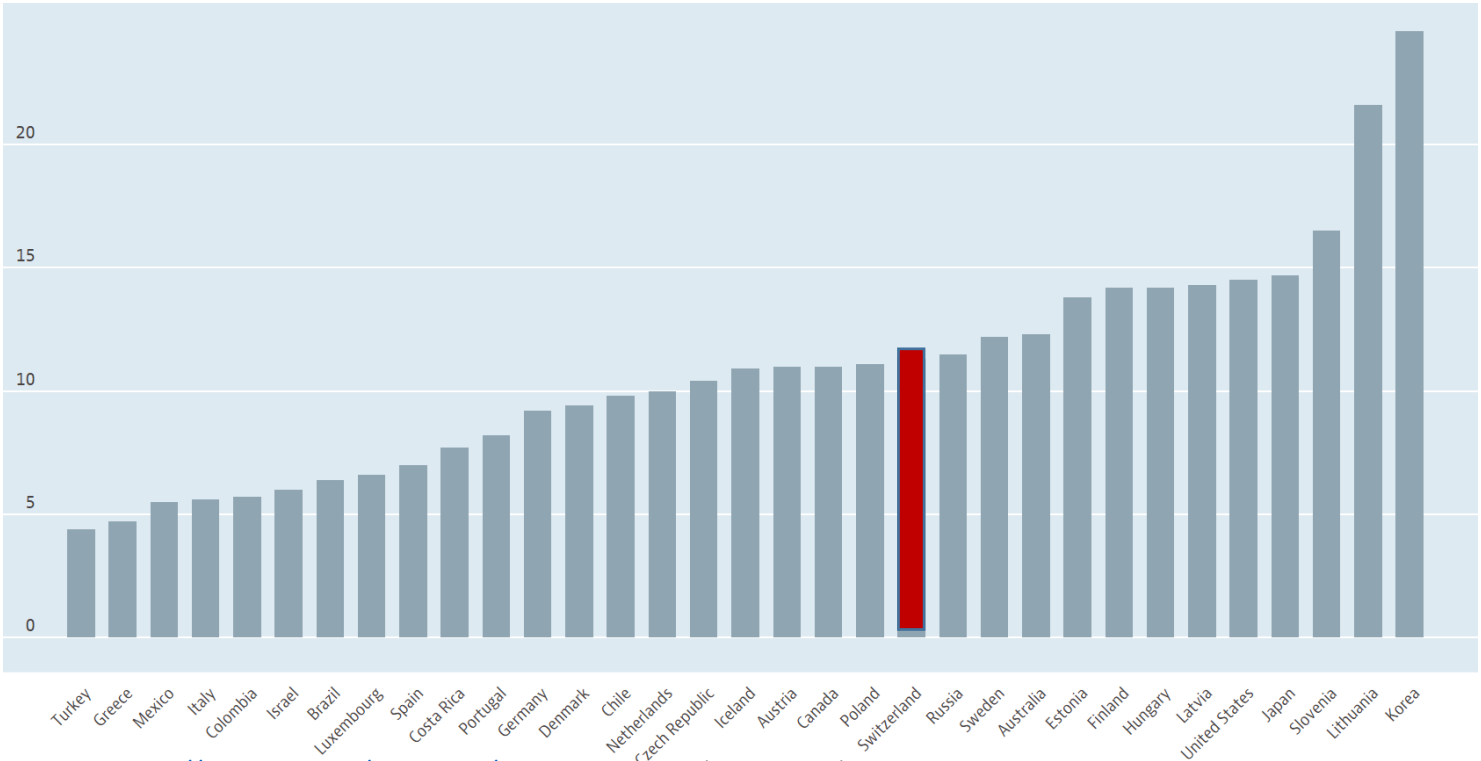
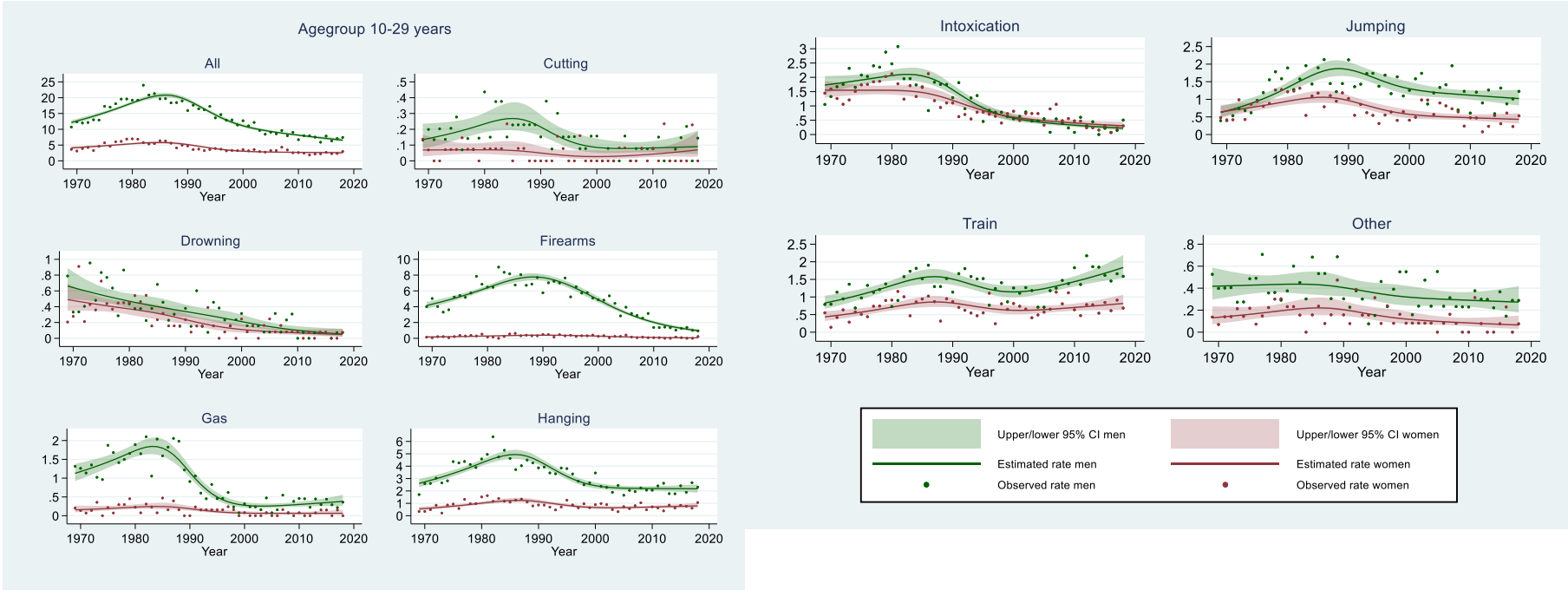
Swiss suicide rate – internationale comparison



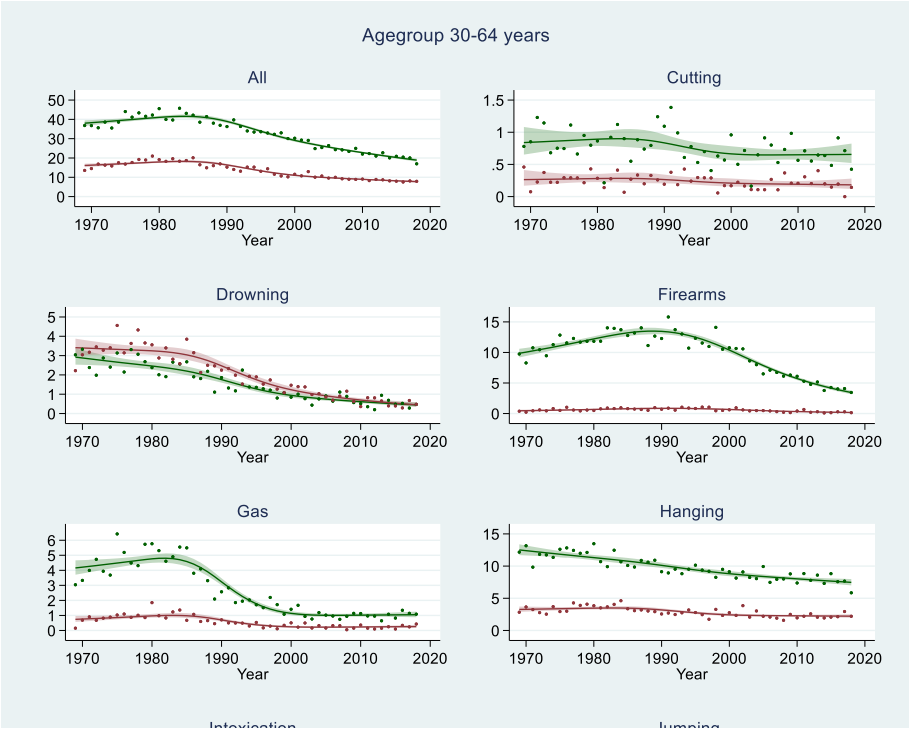
Source: https://data.oecd.org/healthstat/suicide-rates.htm (18.01.2022)

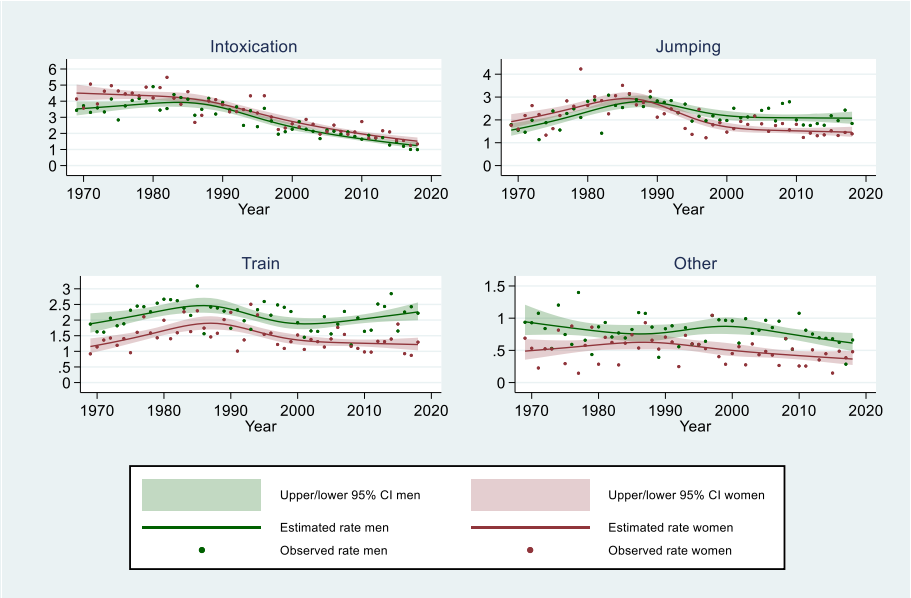
Methods of suicide agegroup 10-29 years



Stulz, Hepp, Kupferschmid, Raible-Destan, Zwahlen. Accepted for publication

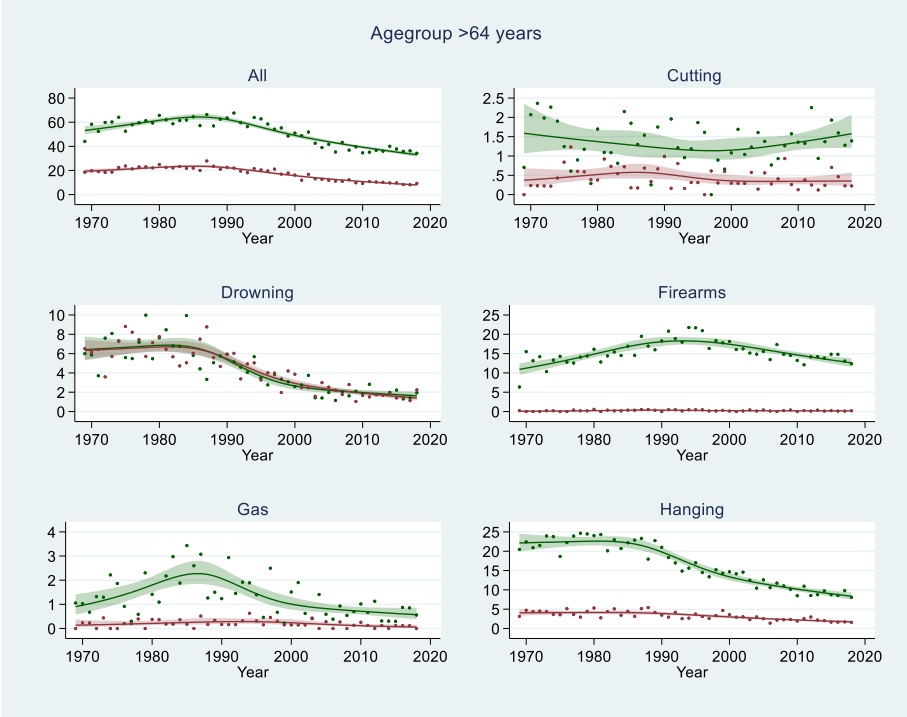
Methods of suicide agegroup 30-64 years

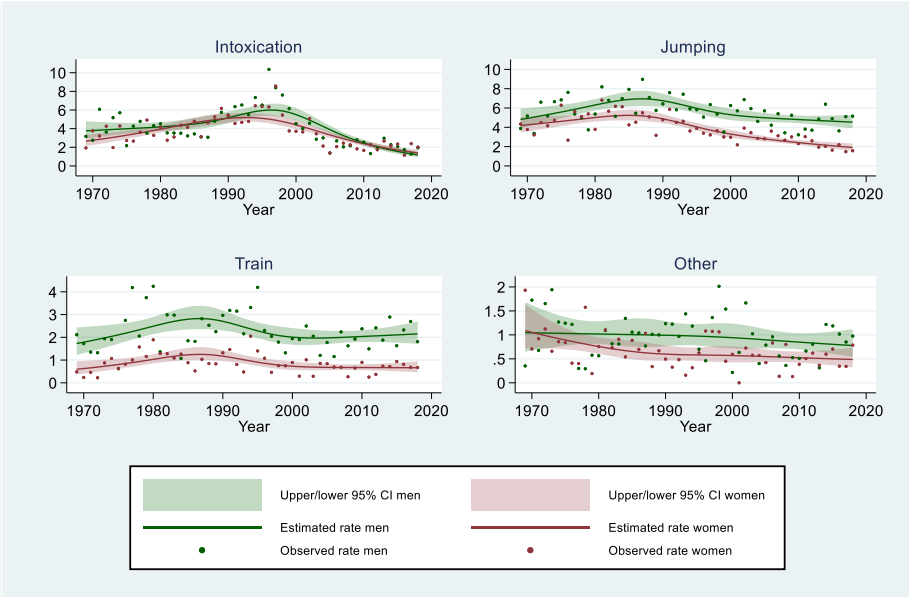




Stulz, Hepp, Kupferschmid, Raible-Destan, Zwahlen. Accepted for publication

Methods of suicide agegroup >64 years





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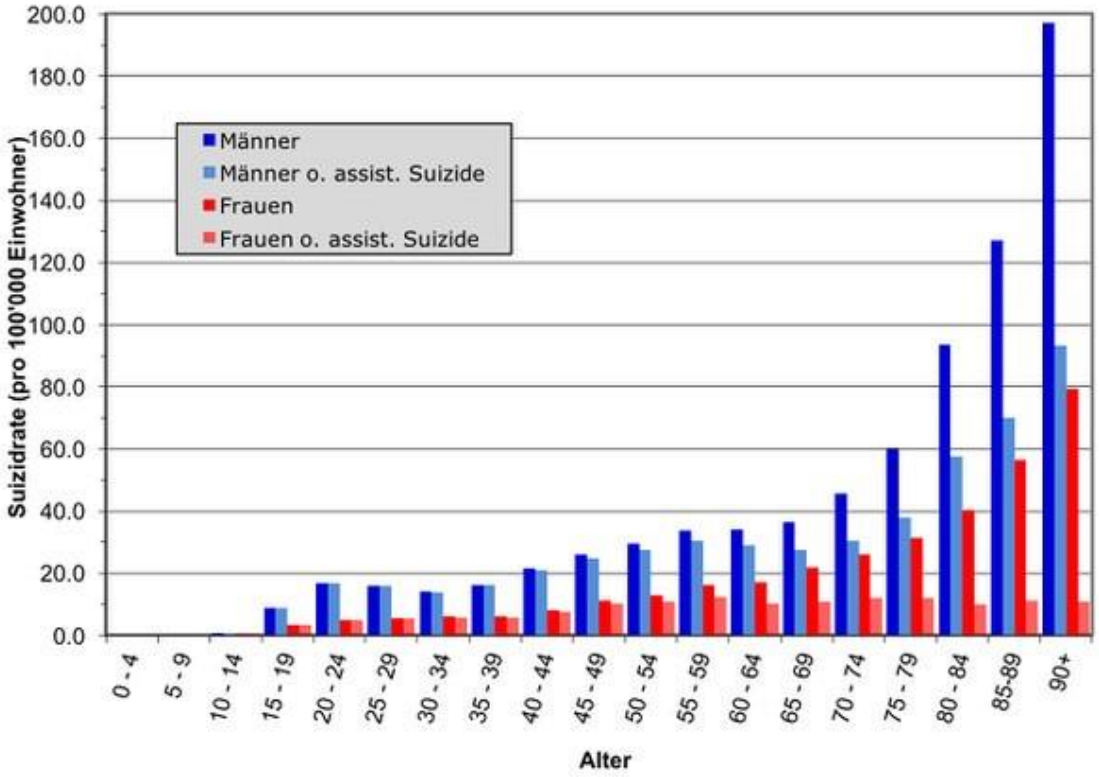
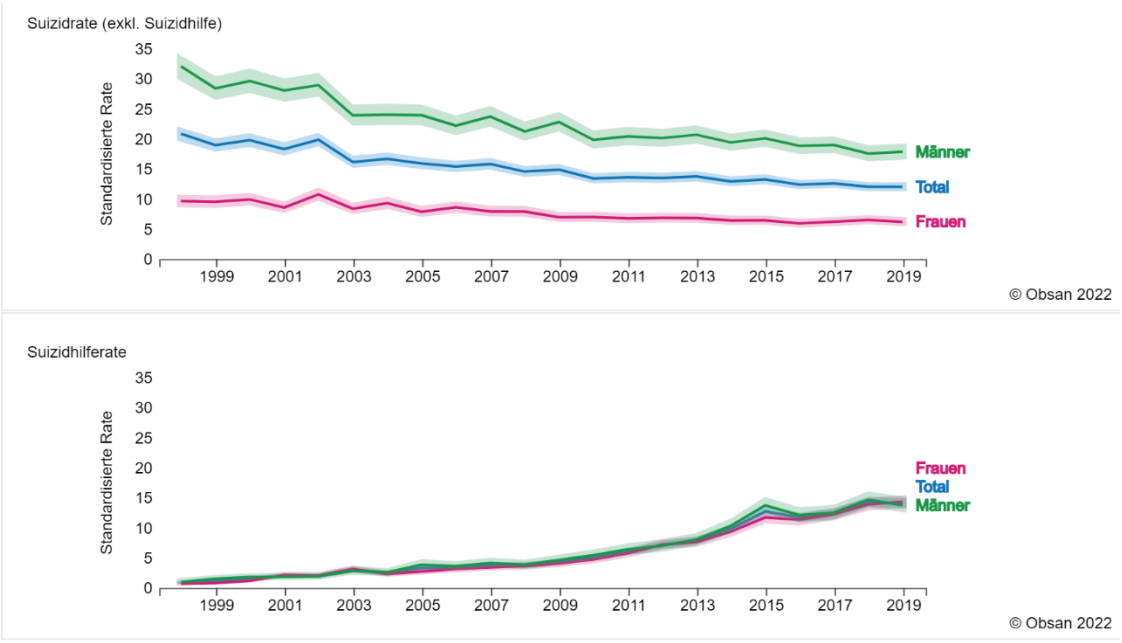
Suizidrate nach Alter und Geschlecht



Minder J, Ajdacic-Gross V, Hepp U. Swiss Medical Forum 2018; 18 (10):230-235

Assisted suicides

Assisted and non-assisted suicides



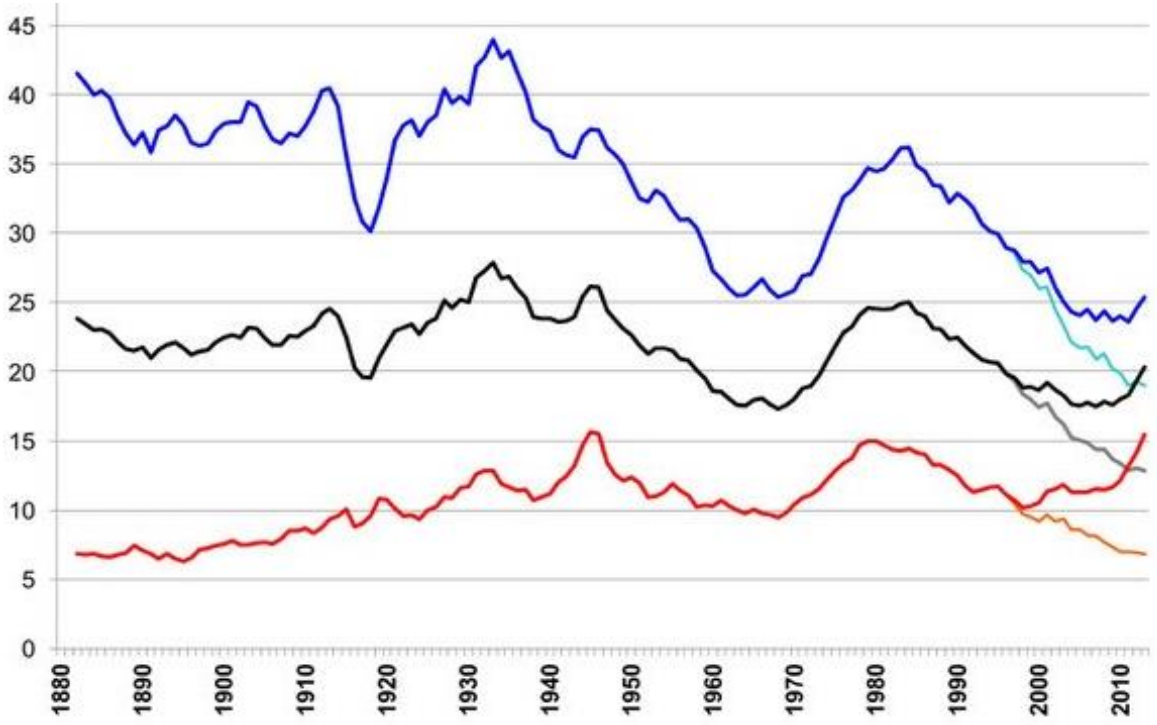
Quelle: BFS – Statistik der Todesursachen (TU) und Statistik der Bevölkerung und der Haushalte (STATPOP)
Die Daten sind mit dem 95% Vertrauensintervall dargestellt. Der Bereich innerhalb der Fehlerbalken enthält mit einer Wahrscheinlichkeit von 95% den tatsächlichen Wert in der Bevölkerung.
Die standardisierten Raten basieren auf der europäischen Standardpopulation 2010.

Erstellt am: 18.1.2022, 13:34:34 https://ind.obsan.admin.ch/de/indicator/obsan/suizid-und-suizidhilfe

males 14.3/100’000
total 12.0/100’000
females 6.2/100’000

males 13.7/100’000
total 14.0/100’000
females 14.3/100’000

Assisted and non-assisted suicides



source BfS Swiss mortality statistics – Ajdacic-Gross

- **SR inclusive AS**
- **SR exclusive AS**

- **male SR Inclusive AS**
- **male SR exclusive AS**

- **female SR inclusive AS**
- **female SR exclusive AS**

SR: rate of suicides
AS: rate of assisted suicides

Risk factors - The view back or the view forward?

Risk factors for suicide / suicidal behaviour

- prior deliberate self-harm / attempted suicide
- psychiatric disorder
- substance use
- actual or former psychiatric in-patient treatment
- somatic disieases
- male sex
- age
- unemployment
- death of partner / spouse

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Risk Factors for Suicidal Thoughts and Behaviors: A Meta-Analysis of 50 Years of Research

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Evan M. Kleiman
Harvard University

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Suicidal thoughts and behaviors (STBs) are major public health problems that have not declined appreciably in several decades. One of the first steps to improving the prevention and treatment of STBs is to establish risk factors (i.e., longitudinal predictors). To provide a summary of current knowledge about risk factors, we conducted a meta-analysis of studies that have attempted to longitudinally predict a specific STB-related outcome. This included 365 studies (3,428 total risk factor effect sizes) from the past 50 years. The present random-effects meta-analysis produced several unexpected findings: across odds ratio, hazard ratio, and diagnostic accuracy analyses, prediction was only slightly better than chance for all outcomes; no broad category or subcategory accurately predicted far above chance levels; predictive ability has not improved across 50 years of research; studies rarely examined the combined effect of multiple risk factors; risk factors have been homogenous over time, with 5 broad categories accounting for nearly 80% of all risk factor tests; and the average study was nearly 10 years long, but longer studies did not produce better prediction. The homogeneity of existing research means that the present meta-analysis could only speak to STB risk factor associations within very narrow methodological limits—limits that have not allowed for tests that approximate most STB theories. The present meta-analysis accordingly highlights several fundamental changes needed in

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Risk factors for suicide

Prior attempted suicide is the strongest risk factor

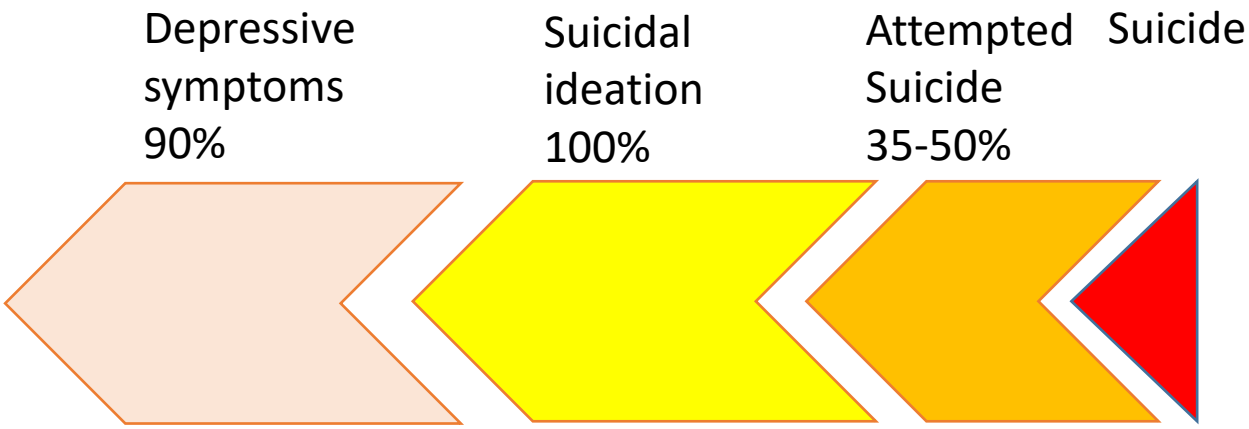
BUT

It still is a weak predictor

BECAUSE

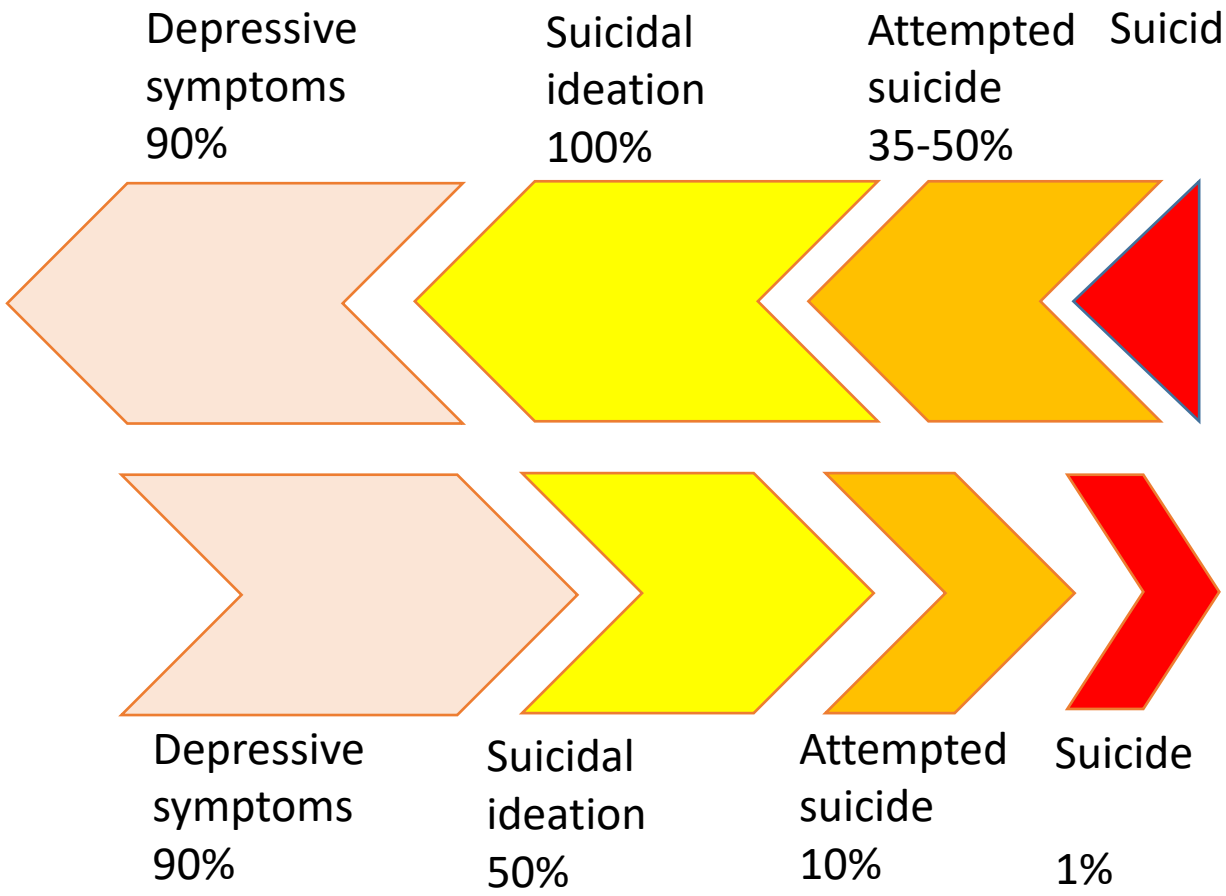
9 of 10 people with a history of attempted suicide will not commit suicide

Risk factors for suicide



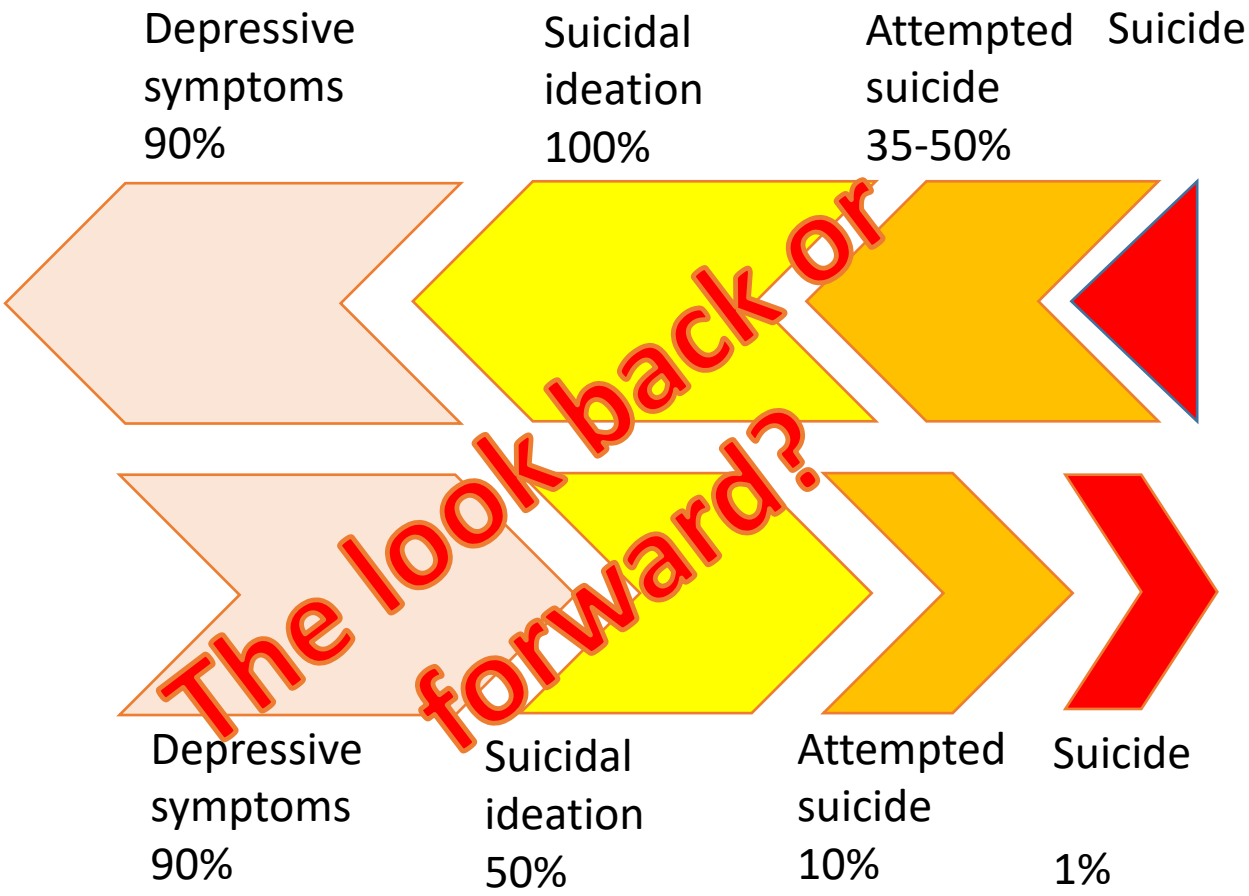
Ajdacic-Gross, Hepp et al. J Affect Disord. 2019

Risk factors for suicide



Ajdacic-Gross, Hepp et al. J Affect Disord. 2019

Risikofaktoren für Suizide



Ajdacic-Gross, Hepp et al. J Affect Disord. 2019

risk assessment?

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Who uses assessment tools for the assessment of the suicide risk?

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Suicide assessment

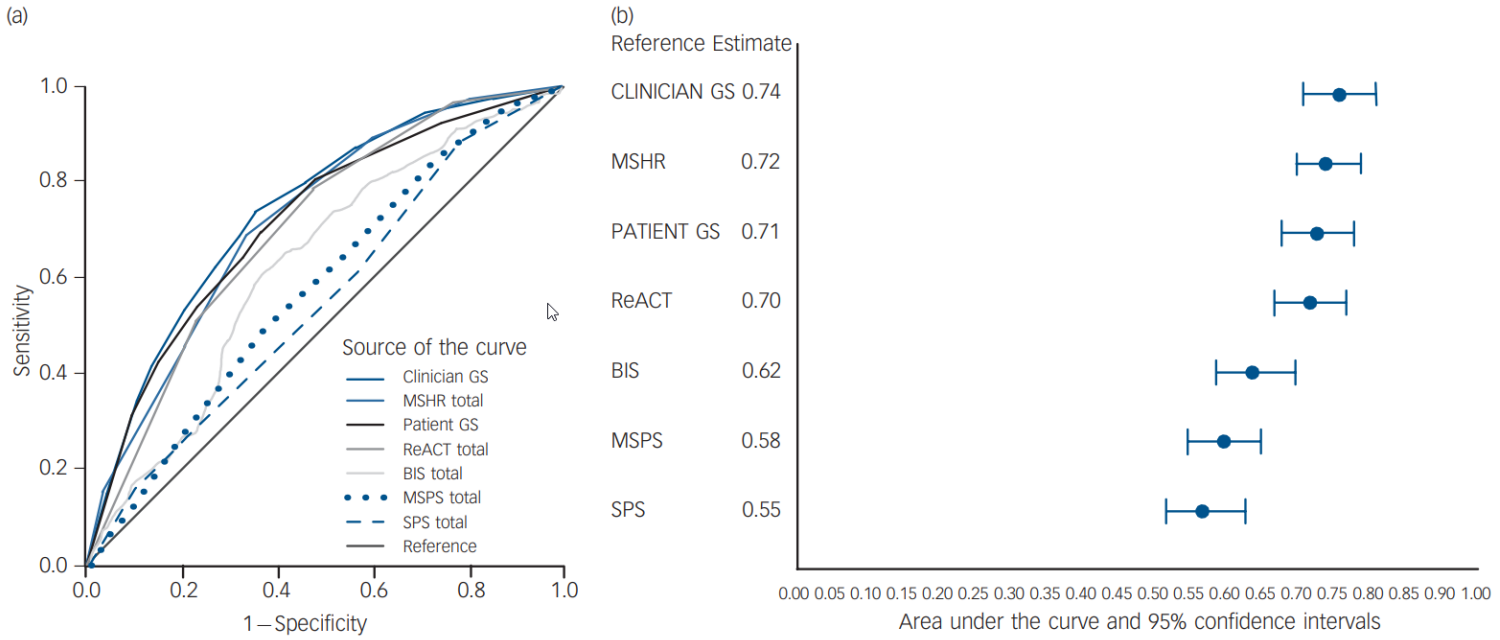


Fig. 1 The receiver operator characteristic curves (a) show the relationship between the proportion of true positives (sensitivity) and the proportion of false positives for the seven scales. The forest plot (b) shows the area under the curve estimates and 95% confidence intervals for the scales.

Clinician GS, clinician global scale; MSHR, Manchester Self-Harm Rule; Patient GS, patient global scale; ReACT, ReACT Self-Harm Rule; BIS, Barratt Impulsiveness Scale; MSPS, Modified SAD PERSONS Scale; SPS, SAD PERSONS Scale.

The British Journal of Psychiatry (2017) 210, 429–436. doi: 10.1192/bjp.bp.116.189993

Suicide assessment

NICE Guidelines

- **Do not use** risk assessment tools and scales to predict future suicide or repetition of self-harm.
- **Do not use** risk assessment tools and scales to determine who should and should not be offered treatment or who should be discharged.

NICE: Self-harm in over 8s: long-term management (2011) NICE guideline CG133

Suicide assessment

NICE Guidelines

- **Do not use** risk assessment tools and scales to predict future suicide or repetition of self-harm.
- **Do not use** risk assessment tools and scales to determine who should and should not be offered treatment or who should be discharged.

New Guidelines
Provisional Schedule
7.9.22

NICE: Self-harm in over 8s: long-term management (2011) NICE guideline CG133

Suicide assessment

Self-harm: assessment, management and preventing recurrence

NICE guideline [NG225] Published: 07 September 2022

https://www.nice.org.uk/guidance/ng225/chapter/Recommendations
Access 7.9.2022

Suicide assessment

1.6 Risk assessment tools and scales

1.6.1 Do not use risk assessment tools and scales to predict future suicide or repetition of self-harm.

1.6.2 Do not use risk assessment tools and scales to determine who should and should not be offered treatment or who should be discharged.

1.6.3 Do not use global risk stratification into low, medium or high risk to predict future suicide or repetition of self-harm.

1.6.4 Do not use global risk stratification into low, medium or high risk to determine who should be offered treatment or who should be discharged.

1.6.5 Focus the assessment (see the section on principles for assessment and care by healthcare professionals and social care practitioners) on the person's needs and how to support their immediate and long-term psychological and physical safety.

1.6.6 Mental health professionals should undertake a risk formulation as part of every psychosocial assessment.

https://www.nice.org.uk/guidance/ng225/chapter/Recommendations

Access 7.9.2022

Suicide assessment

Risk formulation

A collaborative process between the person who has self-harmed and a mental health professional that aims to summarise the person's current risks and difficulties and understand why they are happening in order to inform a treatment plan. Formulation typically includes taking into consideration historical factors and experiences, more recent problems, and existing strengths and resources.

Safety plan

A written, prioritised list of coping strategies and/or sources of support that the person who has self-harmed can use to help alleviate a crisis. Components can include recognising warning signs, listing coping strategies, involving friends and family members, contacting mental health services, and limiting access to self-harm methods.

Self-harm

Intentional self-poisoning or injury irrespective of the apparent purpose of the act. The treatment and care of repetitive, stereotypical, self-injurious behaviour (such as head banging) is not covered by this guideline.

Therapeutic risk taking

A process that aims to empower people who self-harm to make decisions about their own safety and to take risks to enable recovery.

https://www.nice.org.uk/guidance/ng225/chapter/Recommendations

Access 7.9.2022

Suizid Assessment

About 15% repetition rate within within 12 months

< 60% psychiatric/ psychosocial assessment

If there was a psychiatric-psychosocial assessment the risk of repetion was lowerd by 40% within 12 months

Referral to inpatient-treatment was associatied with higher repetion risk

PLoS one2013 Aug 1;8(8):e70434. doi: 10.1371/journal.pone.0070434. Print 2013.

NICE Self-harm Guidelines

Principles for assessment and care by professionals from other sectors

1.8.1 When a person who has self-harmed presents to a non-health professional, for example, a teacher or a member of staff in the criminal justice system, the non-health professional should:

- treat the person with respect, dignity and compassion, with an awareness of cultural sensitivity
- work collaboratively with the person to ensure that their views are taken into account when making decisions
- address any immediate physical health needs resulting from the self-harm, in line with locally agreed policies; if necessary, call 111 or 999 or other external medical support
- seek advice from a healthcare professional or social care practitioners, which may include referral to a healthcare or mental health service
- ensure that the person is aware of sources of support such as local NHS urgent mental health helplines, local authority social care services, Samaritans, Combat Stress helpline, NHS111 and Childline, and that people know how to seek help promptly
- address any safeguarding issues, or refer the person to the correct team for safeguarding.

https://www.nice.org.uk/guidance/ng225/chapter/Recommendations

Access 7.9.2022

Aftercare?

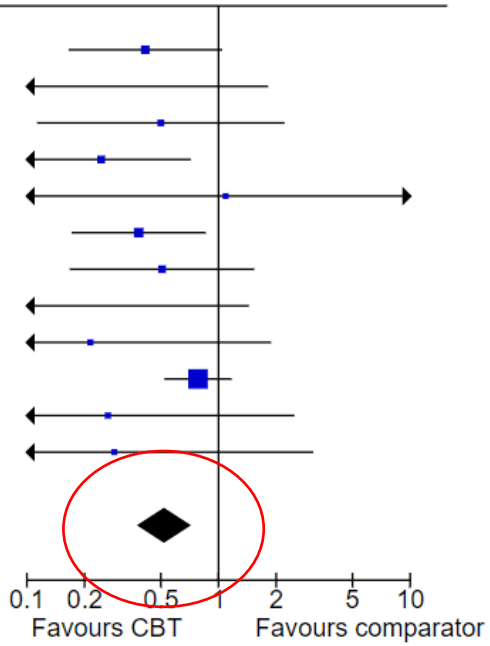
Aftercare

Study or Subgroup	CBT-based psychotherapy Events	Total	Comparator Events	Total	Weight	Odds Ratio M-H, Random, 95% CI
Brown 2005	9	50	18	52	10.6%	0.41 [0.17 , 1.04]
Davidson 2014	4	10	4	4	0.9%	0.08 [0.00 , 1.81]
Evans 1999b	10	18	10	14	4.1%	0.50 [0.11 , 2.21]
Guthrie 2001	5	58	17	61	7.8%	0.24 [0.08 , 0.71]
Husain 2014	1	102	1	111	1.2%	1.09 [0.07 , 17.64]
Lin 2020	11	72	24	75	13.7%	0.38 [0.17 , 0.86]
Owens 2020	7	30	12	32	7.4%	0.51 [0.17 , 1.54]
Salkovskis 1990	0	12	3	8	0.9%	0.06 [0.00 , 1.44]
Tapolaa 2010	2	9	4	7	2.0%	0.21 [0.02 , 1.88]
Tyrer 2003	64	213	77	217	47.9%	0.78 [0.52 , 1.17]
Wei 2013	1	35	4	40	1.8%	0.26 [0.03 , 2.49]
Weinberg 2006	12	15	14	15	1.6%	0.29 [0.03 , 3.12]
Total (95% CI)		**624**		**636**	**100.0%**	**0.52 [0.38 , 0.70]**
Total events:	126		188			

Heterogeneity: Tau² = 0.01; Chi² = 11.26, df = 11 (P = 0.42); I² = 2%

Test for overall effect: Z = 4.22 (P < 0.0001)

Test for subgroup differences: Not applicable



Cochrane Database of Systematic Reviews

https://doi.org/10.1002/14651858.CD013668.pub2

Inpatient referral?

Suizide während Klinikaufenthalten

About 5% of all sucides occur during inpatient treatment

Suicide rate 160-860/ 100’000 inpatient-years

about 1/3 within the inpatient ward

about 1/3 on agreed leave, outside the ward

Rund 1/3 outside the ward, without agreed leave

The longer the hospitalisation, the more often suicides occur outside the ward, on agreed leave

0.14-0.32% of all inpatients

0.08-0.19% of all referrals

Madsen & Nordentoft (2017). Int J Envoron Res Public Health

Suicides after discharge from inpatient treatment

In the three months after discharge the suicide risk is increased by a factor 100

In the midterm the risk is about 50x increased

DG Chung (2017). JAMA Psychiatry

- keep the longterm outcome in mind!
- keep the therapeutic alliance in the focus!

Suicides after discharge from inpatient treatment

S3-Leitlinie "Umgang mit Suizidalität"

Kick-off was 1.9.2022

Conclusions

Conclusion

- The prediction of suicide is / rests a difficult task
- Risk-Assessments have a low positiv predictive value
- NICE Guidelines recommend to not use assessment tools

  („*Do not use risk assessment tools and scales to predict future suicide or repetition of self-harm*“)

- A clinical assessments and a therapeutic allicance can reduce repeated attemps / suicide

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Collaboration interprofessionnelle:
l'avenir de la psychiatrie de liaison ?
Interprofessionelle Zusammenarbeit:
Die Zukunft der Konsiliar- und Liaisonpsychiatrie?