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REVIEW ARTICLE

Strategies adopted by emergency services in the face of attempted suicide

Estrategias adoptadas por los servicios de emergencia ante el intento de suicídio

Estratégias adotadas pelos serviços de emergência frente à tentativa de suicídio

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Abstract

The aim was to identify the strategies adopted by the emergency services to prevent further suicide attempts. Integrative literature review, in the periods from 2015 to 2019. The SciELO database and the indexed data in the VHL were used as search source, being: LILACS, BDENF and Medline. For the analysis of the data included in the study, we opted to use Bardin's content analysis. 13 articles were included. After the analysis, four main categories emerged in the face of action strategies in the face of suicide, namely: telephone follow-up; crisis card; outpatient, face-to-face referral, Psychosocial Care Centers, Basic Health Unit or psychiatric hospitalization and intervention; Use of severity scales to assess risk of attempted suicide. It is possible to note the absence of strategies and even the difficulty of research and studies in Brazilian territory, leading to inquiries about the strategies used in other countries as measures of intervention and prevention of suicide in Brazil. The strategies described in the present studies, affirm success in the face of new suicide attempts, being pertinent to the use and study of them to be applied in Brazil, contributing to the health area and in favor of the reduction of the suicide attempt.

Descriptors: Suicide Attempt; Nursing Care; Emergencies; Nursing; Mental Health.

Resumén

El objetivo fue identificar las estrategias adoptadas por los servicios de emergencia para prevenir nuevos intentos de suicidio. Revisión integrativa de la literatura, en los períodos de 2015 a 2019. Se utilizó como fuente de búsqueda la base de datos SciELO y los datos indexados en la BVS, siendo: LILACS, BDENF y Medline. Para el análisis de los datos incluidos en el estudio, se decidió utilizar el análisis de contenido de Bardin. Se incluyeron 13 artículos. Tras el análisis, surgieron cuatro categorías principales frente a las estrategias de acción ante el suicidio, a saber: seguimiento telefónico; tarjeta de crisis; consulta externa, presencial, Centros de Atención Psicosocial, Unidad Básica de Salud u hospitalización e intervención psiquiátrica; Uso de escalas de gravedad para evaluar el riesgo de intento de suicidio. Es posible notar la ausencia de estrategias e incluso la dificultad de las investigaciones y estudios en territorio brasileño, lo que lleva a cuestionar las estrategias utilizadas en otros países como medidas de intervención y prevención del suicidio en Brasil. Las estrategias descritas en los presentes estudios, afirman el éxito frente a nuevos intentos de suicidio, siendo pertinentes para el uso y estudio de los mismos para ser aplicados en Brasil, contribuyendo al área de salud y a favor de la reducción del intento de suicidio.

Descriptores: Intento de Suicidio; Cuidado de Enfermería; Emergencias; Enfermería; Salud Mental.

Resumo

Objetivou-se identificar as estratégias adotadas pelos serviços de emergência para evitar novas tentativas de suicídio. Revisão integrativa da literatura, nos períodos de 2015 a 2019. Foram utilizadas como fonte de busca a base SciELO e os dados indexados na BVS, sendo: LILACS, BDENF e o Medline. Para a análise dos dados inclusos do estudo optou-se por utilizar a analise de conteúdo de Bardin. Foram incluídos 13 artigos. Após a análise emergiram quatro categorias principais perante as estratégias de ação frente ao suicídio, sendo: acompanhamento telefônico; cartão crise; encaminhamento ambulatorial, presencial, Centros de Atenção Psicossocial, Unidade Básica de Saúde ou internação e intervenção psiquiátrica; Utilização de escalas de gravidade para avaliar risco de tentativa de suicídio. É possível notar a ausência de estratégias e até a dificuldade de pesquisas e estudos em território Brasileiro, levando a indagar-se sobre as estratégias usadas em outros países como medidas de intervenção e prevenção ao suicídio no Brasil. As estratégias descritas nos estudos presentes, afirmam sucesso perante as novas tentativas de suicídio, sendo pertinentes ao uso e estudo das mesmas serem aplicadas no Brasil, contribuindo com a área da saúde e em prol da redução da tentativa de suicídio.

Descritores: Tentativa de Suicídio; Cuidados de Enfermagem; Emergências; Enfermagem; Saúde Mental.

Introduction

Suicidal behavior is intrinsic to humans and represents an important public health problem worldwide. The spectrum of this behavior includes suicide, attempted suicide, and suicidal ideation. Suicide is marked by self-inflicted death, the suicide attempt is characterized by self-aggressive behavior, but without lethal evolution and the suicidal ideation in which the person thinks of destroying his own life[1].

Suicide attempt represents a complex and multidimensional phenomenon, which can result from the combination of social, economic, demographic factors and be related to intimate partner violence and post-traumatic stress disorder. In addition, there is a direct link between suicidal behavior and mental disorders, as out of 15,629 people who committed suicide, 90% of cases had some mental disorder. Depression is the disease that stands out the most, with a rate of 35.8% of suicide cases[1,2].

About 800,000 people commit suicide each year worldwide, being the second leading cause of death among people aged 15 to 29 years old. This represents a statistic that, in the world, every 40 seconds a person commits suicide. All countries report suicide cases, regardless of whether they are rich or poor. However, in 2016, it was identified that almost 80% of these deaths occurred in nations with low and medium per capita income, with most cases in rural and agricultural areas. Pesticide poisoning is the method used in 20% of all deaths. Other common means are hangings and the use of a firearm[3].

According to the WHO, the main factors that lead the individual to commit suicide, involve mental disorders, family relationships, gender, sexual orientation, alcohol, drug or pharmaceutical abuse and unfavorable social situations, such as poverty and unemployment. These causes are related to the population in general, regardless of social and economic class, however, in high-income countries, the causes are more related to mental health problems, such as depression and disorders caused by alcohol use[4].

Brazil has been adopting strategies and policies for the prevention of suicide for years. It started with Ordinance No. 2,542 / 2005, which establishes a working group with the objective of elaborating and implementing the National Strategy for the Prevention of Suicide. This generated a second ordinance, number 1,876 / 2006, which instituted the guidelines for the prevention of suicide, to be implemented throughout the national territory[5,6].

In 2018, Ordinance No. 1,315 was published, which enabled States to receive financial incentives for the development of health promotion, surveillance and comprehensive health care projects aimed at preventing suicide within the scope of the Psychosocial Care Network. To further intensify the confrontation of this problem, in 2015 Brazil created the “September Yellow” campaign to raise awareness about suicide prevention, with the proposal of associating the yellow color with the month that marks the world day for the prevention of suicide, 10 September[7,8].

The Psychosocial Care Network (RAPS) is part of the National Mental Health Policy and is responsible for establishing points of care for the care of people with mental problems, including the use of crack, alcohol, and other drugs. It is made up of various services and equipment, such as: The Psychosocial Care Centers (CAPS); Residential Therapeutic Services (SRT); the Community and Culture Centers, the Reception Units (UAs), and the comprehensive care beds (in General Hospitals, in CAPS III)[9].

However, even in the face of these public policies and professional bodies producing materials for the prevention of suicide, the rates are alarming. Brazil, even though it is a populous country, has a relatively low suicide rate. Even so, it is among the ten countries that record the highest absolute numbers of suicides. In absolute numbers of occurrences, Brazil recorded 183,484 suicide deaths in the period between 1996-2016, with a 69.6% increase in suicide cases in Brazil in this period[10].

From 2010 to 2013, the Ministry of Health recorded, in absolute numbers, a total of 38,074 suicide deaths, with the record-breaking state of this figure, São Paulo, followed by Minas Gerais and Rio Grande do Sul. Santa Catarina occupies the fifth position in these statistics, with a total of 2,076 suicide deaths in the same period. In Santa Catarina, from 2010 to 2018, the Epidemiological Surveillance Directorate - DIVE, recorded a total of 38,495 deaths by suicide, with the municipality of Joinville having the highest number of occurrences, followed by Florianópolis and Blumenau[11].

In relation to the suicide attempt (self-harm), the Brazilian database of the Ministry of Health, through the Information System for Notifiable Diseases (SINAN), and the Department of Informatics of the Unified Health System (DATASUS), recorded, in the period from 2009 to 2016, 186,891 notifications, of which 3,941 in 2009, 6,739 in 2010, 14,940 in 2011, 21,164 in 2012, 25,468 in 2013, 29,707 in 2014, 39,464 in 2015, and 45,468 in 2016[12].

Suicide attempts are estimated to outnumber the number of suicides by at least ten times. Regarding suicide attempts around the world, it is projected that 15 to 25% of people who have attempted suicide once, will make another effort in the following year, and that 10% of them will be able to take their own life in a period of 10 years. years old. Thus, those who made a recent suicide attempt are at high risk of dying from suicide in the future, especially during the period immediately after leaving the hospital emergency. It is estimated that the risk of suicide, after an attempt, rises at least 100 times in relation to the general population. In this context, the transition from hospital care to the community is an important strategy to mitigate suicide rates[13,16].

Suicide attempt is the main risk factor for the future realization of this attempt. Because of this, attempts should be taken seriously, as a warning sign indicating the performance of complex psychosocial

phenomena. Therefore, giving special attention to a person who tried to commit suicide is one of the main strategies to prevent a future suicide[13].

Thus, the patient with suicidal behavior needs to be cared for beyond his physical needs. It is essential that now of the crisis he can feel heard and welcomed. There are cases in which the subject tries to commit suicide with the intention of causing changes in a suffering situation that he is living[17]. Also, in another study[18] showed that of the 16 people interviewed who attempted suicide, 5 needed hospitalization, 7 considered their act as a "cry for help", stressing the importance of this "request for help" being really considered.

It is understood that nurses and other health professionals have a fundamental role in assisting individuals at risk of suicide, in preventing other episodes and in planning actions and interventions, so that the so-called recurrences do not occur. For this, it is necessary to identify suicidal behavior, considering that more often it is the nursing professionals who have the first contact with the patient in the emergency services[19].

The interest in the theme, attempted suicide, emerged from the authors' professional practice, as both are nursing technicians and perform their activities in an overly complex hospital and routinely assist patients who attempted suicide. Through these consultations, we verified that it is a topic that deserves to be approached more frequently, whether in the academic, political and / or community spheres, mainly because it is still very linked to social stigmas and deficits in strategies to avoid recurrences of suicide attempts.

Suicide attempt is considered a public health problem of great magnitude, mainly due to the high risk of recurrence, as well as the outcomes that can culminate in the person's death. It is believed that nurses through their care practice can be an agent that contributes to avoiding further suicide attempts, through qualified listening, as well as empathy for the person attempting suicide.

Therefore, the question is: What are the strategies adopted by the emergency services to prevent a new suicide attempt? The objective was to identify the strategies adopted by the emergency services to avoid further suicide attempts.

Methodology

It is an integrative literature review that consists of a broad analysis of the literature on a given research topic. The objective of this research method is to obtain knowledge on a given subject based on previous studies, in a systematic and organized manner, contributing to the deepening of the investigated topic. To this end, it is necessary to follow a methodological standard, clarity in the presentation of the results, so that the reader can identify the characteristics of the studies included in the review[20].

To carry out a relevant integrative review that can assist in the implementation of effective interventions in patient care, it is necessary that the steps are followed and are clearly described. Thus, for the construction of the integrative review, it is necessary to follow six distinct stages: identification of the theme and selection of the hypothesis or research question; establishment of criteria for inclusion and exclusion of studies / sampling; definition of the information to be extracted from the selected studies; evaluation of the studies included in the integrative review; interpretation of results; presentation of the knowledge review / synthesis[20].

Establishment of hypotheses or research question

In this context, with the objective of identifying the scientific evidence about effective interventions for people assisted in an emergency resulting from suicide attempt and subsidizing health professionals, especially nurses in the implementation of the care offered to these patients, it is questioned: What are the strategies adopted by the emergency services in the face of the patient attempting suicide?

Sampling or literature Search

In this stage, the search source is also established. In this study, the databases of the Scientific Electronic Library Online (SCIELO) and the indexed data in the Virtual Health Library (VHL) were used, being the database Latin American and Caribbean Health Sciences Literature (LILACS), Nursing Database (BEDENF) and the Online Medical Literature Search and Analysis System (Medline).

Chart 1. Database search strategies. Florianópolis, SC, Brazil, 2020

Data base	Search Strategy
Virtual Health Library (BVS)	"tentativa de suicídio" enfermagem OR "cuidados de enfermagem" emergência* AND (fulltext:("1") AND db:("MEDLINE" OR "LILACS" OR "BDENF") AND la:("en" OR "es" OR "pt")) AND (year_cluster:[2015 TO 2020])
Scientific Electronic Library Online (SciELO)	"tentativa de suicídio" enfermagem OR "cuidados de enfermagem" emergência* AND la:("pt"OR"em"OR"es") AND year_cluster:("2015" OR "2016" OR "2017" OR "2018" OR "2019" OR "2020") AND type:("research-article")

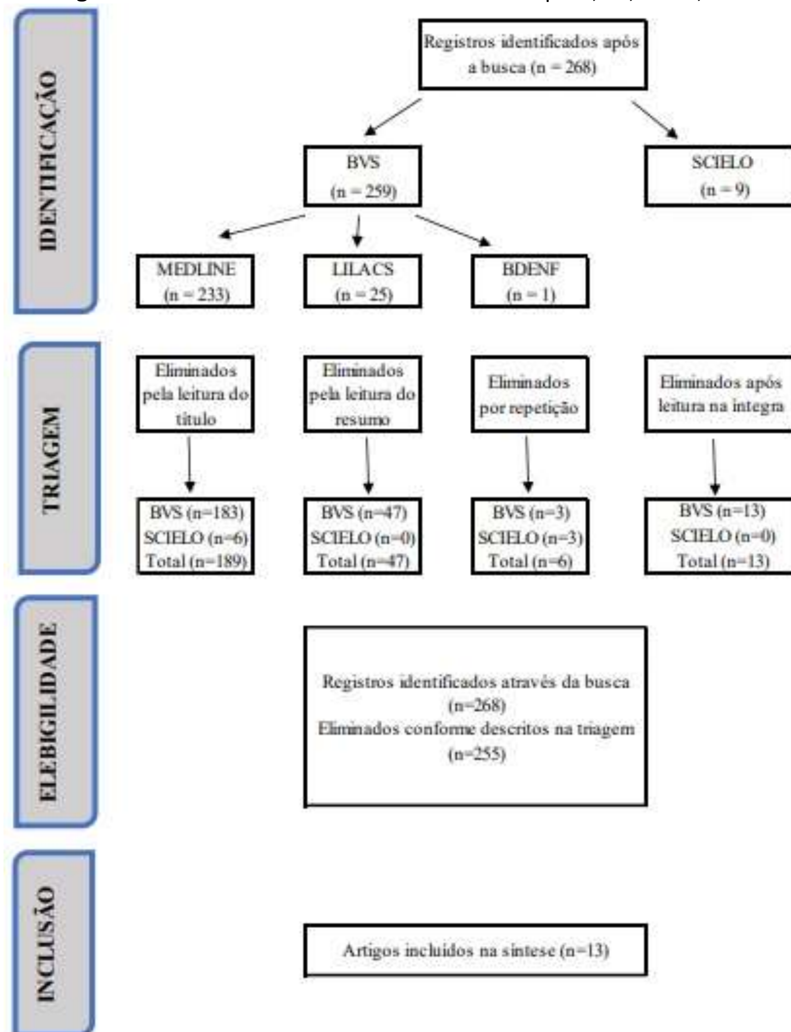
The search was carried out in April 2020 and determined by the following descriptors in the given order: "suicide attempt" Nursing OR "nursing care" AND "emergency". Where each search strategy is described in Chart 1.

The inclusion criteria adopted for this research were: original articles with free access, published in Portuguese, English and Spanish, available electronically in full, published in the last five years (2015-2020) and that answered the research question. The exclusion criteria were: editorials; cards; reviews; literature review; reports of theoretical experiences and reflections; dissertations; theses and monographs; summaries in annals of events, expanded abstracts; repeated articles; articles that after reading the title and abstract do not include the research question; articles that after reading in full do not meet the objective, studies published in languages other than Portuguese, English and Spanish and articles that addressed the attempted suicide in children.

For the selection of articles, the authors read the titles and abstracts of the publications to identify which articles corresponded to the research question and were relevant to the present review, considering the established inclusion and exclusion criteria.

After searching the database, a total of 268 articles were found. Thus, with the establishment of the systematic steps of the research and employing the inclusion and exclusion criteria of the research, 27 articles were selected for reading in full and after careful reading 13 articles were selected to compose the present research. Figure 1 below was elaborated to show in detail the search and final sampling process selected.

Figure 1. Flowchart of article selection. Florianópolis, SC, Brazil, 2020



Categorization of studies

A data collection instrument was developed in Microsoft Excel with the following information: Article No., Title, Authors, Database, Year of Publication, Objective, Method, Main points. Chart 2 serves as a basis for the development of the results.

Chart 2. Selected articles that make up the integrative review addressing the strategies adopted by the emergency services in the face of attempted suicide. Florianópolis, SC, Brazil, 2020

Title and Year	Authors	Objective	Method	Main Points
Aceitação da orientação para atendimento no pronto-socorro após tentativa de suicídio. / 2017	Dekker, W P H; Vergouwen, A C M; Buster, M C A; Honig, A.	The study aims to improve continuity of care after hospital discharge after attempting suicide, focusing on the effectiveness of actions.	This cross-sectional study included all patients who subordinate in the emergency room at OLVG-West Amsterdam an attempted suicide or intentional self-mutilation and were referred for psychiatric evaluation. Data were collected over a period of twenty months, using a semi-structured questionnaire.	GtC acceptance is high among patients who transfer to ED after suicide attempt. The patients who were most reluctant to accept the GtC were young suicide bombers of non-Western ethnicity who were not currently undergoing treatment.
Predictive utility of an emergency department decision support tool in patients with active suicidal ideation. / 2018	Boudreaux, Edwin D; Larkin, Celine; Kini, Nisha; Capoccia,	The objective was to help stratify those who could be considered "less risky" and prioritized for discharge, those who present "greater risk" and who need further evaluation by a mental health doctor.	Detailed descriptions of the development of the ED-SAFE study, scenario, participants, procedures, data collection, protection of human individuals and notification of previously published adverse events.	In 2015, for Substance Abuse and Mental Health Services Administration (SAMHSA) and Suicide Prevention Resource Center (SPRC) use a RAND consensus methodology to create a guide or treatment for suicide risk in DEs (SPRC, 2015a) Decision support to be used with patients who had screening or clinical results, suggesting the presence of passive (thoughts of being in an adverse situation) or active (suicidal thoughts) suicidal ideation.
Immediate and brief intervention after suicide attempts on patients without major psychiatric morbidity-A pilot study in northern Israel. / 2018	Givon, Limor; Levi, Avi; Bloch, Boaz; Fruchter, Eyal.	Suicide prevention, through a pilot program with the specific target, patients at high risk of suicide, without serious mental illness or previous association with the mental health system.	The field project opened patients who made a suicide attempt or were at high risk for suicide.	212 subjects were referred to the project. Three quarters of the referrals were female. Most of them were of Jewish nationality. 137 continued to participate after the initial call. During the intervention, there was a decline in suicide rates in the participating districts.
Combining green cards, telephone calls and postcards into an intervention algorithm to reduce suicide reattempt (AlgoS): P-hoc analysis of an inconclusive randomized controlled trial./ 2019	Messiah, Antoine; Notredame, Charles-Edouard; Demarty, Anne-Laure; Duhem, Stéphane; Vaiva, Guillaume.	Identifying brief contact intervention measures (BCIs) can be classified as suicide prevention.	Randomized controlled study carried out in 23 French hospitals. Suicide attempts were randomly assigned to the intervention group (AlgoS) or to the control group (treatment as usual ATU).	With the study, it was identified that new sets of analyzes are needed so that crisis cards may be able to prevent new ones from SA among those who try for the first time, while calls are likely not likely to be delayed among those who try several.
Effectiveness of assertive case management on repeat self- harm in patients admitted for suicide attempt: Findings from ACTION-J study / 2018	Furuno, Taku; Nakagawa, Makiko; Hino, Kosuke; Yamada, Tomoki; Kawashima, Yoshitaka; Matsuoka, Yutaka; et al.	To study the effectiveness of the AÇÃO-J program in the repetition of self-mutilation in patients admitted for attempted suicide.	ACTION-J was a randomized, multicentre controlled study conducted in emergency and psychiatric departments at 17 general hospitals in Japan.	The number of self-mutilation episodes per person-year was lower in the intervention group (TIR) 0.88, 95% CI 0.80-0.96, p = 0.0031). A subgroup analysis shows a greater reduction in self-mutilation episodes in general among patients with no previous suicide attempt at baseline (adjusted IRR 0.73, 95% CI 0.53-0.98, p = 0.037).

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Suicide Prevention in an Emergency Department Population: The ED-SAFE Study. / 2017	Miller, Ivan W; Camargo, Carlos A; Arias, Sarah A; Sullivan, Ashley F; Allen, Michael H; Goldstein, Amy B; Manton, Anne P; et al.	Determine whether an intervention specified by ED reduces subsequent suicidal behavior.	The multicenter study of 8 EDs in the United States involved adults with a recent attempt or suicidal ideation and was composed of 3 sequential phases.	The primary end point was suicide attempts (non-fatal and fatal) during the 52-week follow-up period. The proportion and the total number of attempts were analyzed.
Effect of telephone follow-up on repeated suicide attempt in patients discharged from an emergency psychiatry department: a controlled study. / 2017	Exbrayat, Sophie; Coudrot, Clotilde; Gourdon, Xavier; Gay, Aurélia; Sevos, Jessica; Pellet, Jacques; et al.	To evaluate the effectiveness of telephone follow-up of patients referred to an emergency psychiatric unit for attempted suicide in other attempts in the following year.	A single center-controlled study with the intention of treating, we evaluated the effectiveness of a telephone follow-up protocol of 436 patients at 8, 30 and 60 days after treatment for attempted suicide. As comparison controls, we evaluated patients with similar social and demographic characteristics referred to our emergency psychiatric unit in the year prior to the study, who were not followed up by telephone after their initial hospitalization. The data were presented by logistic regression.	The exceedingly early telephone follow-up of our patients effectively reduced recurrence and appeared to be the only protective factor against repeated suicide attempts.
Do acolhimento ao encaminhamento para: Assistência ao suicídio em contextos hospitalares. / 2017	Ana Paula Araújo de Freitas; Lucienne Martins Borges.	Investigate the reception, care and referrals made to users assisted by attempted suicide, in two urgencies and two hospital emergencies in a municipality in southern Brazil.	Of a qualitative character, 16 health professionals from higher education, from different professional categories, were interviewed.	Predominance of care for women, such as intoxications as the most frequent method and the use of attempted suicide as a way of drawing attention. Still, there was evidence of availability of care, which, however, presented problems in post-discharge referrals to the health network. Thus, the need to train professionals to deal with this demand is highlighted, as well as the better articulation of the Health System and other policies to accommodate users after discharge.
Suicide attempts and emergency room psychiatric consultation. / 2015	Zeppegno, Patrizia; Gramaglia, Carla; Castello, Luigi Mario; Bert, Fabrizio; Gualano, Maria Rosaria; Ressico, Francesca; et al.	Investigate the frequency with which patients visiting a hospital emergency room (ER) essential to a psychiatric consultation for attempted suicide and outline the characteristics of this population.	Studies and research in emergency consultations for psychiatric causes between the years 2008 and 2011 at the Hospital “Maggiore” in Novara.	280 of 1888 patients who needed psychiatric consultation were referred to the emergency room for attempted suicide. Those who attempted suicide were more often female. Suicide attempts were more frequent among patients with a history of psychiatric disorders; however, as suicides were more common among those who had not been previously hospitalized in a psychiatric ward or were not under the care of a psychiatrist.
Teen options for change: an intervention for young emergency patients who screen positive for suicide risk. / 2015	King, Cheryl A; Gipson, Polly Y; Horwitz, Adam G; Opperman, Kiel J.	Previous research has documented the feasibility of screening in emergency services for adolescent suicide risk.	Case study involving 49 young people, from 14 to 19 years old, who sought services for non-psychiatric emergencies.	Adolescents assigned to OCD dissipation had greater reductions in depression than adolescents assigned to the comparison group. OCD can be a brief and promising intervention for adolescents who seek emergency services and are at risk of suicide.

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Predicting Future Suicide Attempts Among Adolescent and Emerging Adult Psychiatric Emergency Patients. / 2015	Horwitz, Adam G; Czyz, Ewa K; King, Cheryl A.	Longitudinally examine specific characteristics of suicidal ideation in combination with histories of suicide and non-suicidal self-injury (NSSI) to better assess the risk of a future attempt among high-risk adolescents and emerging adults.	Case study, with participants: 473 patients (253 women, 220 men), partners between 15 and 24 years old (M = 19.38, SD = 2.9; 48% were 18 years old or less, 76% were 21 years old or plus), who sought emergency psychiatric services from a university hospital (PE), located in the Midwest United States.	Suicide is the third leading cause of death among adolescents and emerging adults aged between 15 and 24 years. There were no significant sex differences for a psychiatric history or a history of physical abuse; however, as female participants they were more likely to report stories of sexual abuse, NSSI and suicide.
Columbia- suicide severity rating scale: predictive validity with adolescent psychiatric emergency patients. / 2015	Gipson, Polly Y; Agarwala, Prachi; Opperman, Kiel J; Horwitz, Adam; King, Cheryl A.	The study examined the predictive validity of a highly promising tool, the Columbia-Suicide Severity Rating Scale (C-SSRS).	A case study involved 178 adolescents (44.4% male; aged between 13 and 17 years) in search of EF Services. A C-SSRS interview and the selected medical data were collected for the index consultation and subsequent visits during a year of follow-up.	Concern about the risk of suicide was the most common main complaint (50.6%) in this sample, and almost a third of adolescents (30.4%) reported a history of suicide attempt throughout their lifetime. Sixty-two adolescents (34.8%) had at least one return visit during follow-up. Suicide is the second leading cause of death among adolescents between 13 and 17 years of age, 1 and recent nationally representative data indicate that 7.8% of high school students attempted suicide one or more times in the previous year and 15, 8% seriously considered attempting.2 In addition, approximately 2% of high school students report having medical treatment for one or more suicide treatments in the previous year.
Combining brief contact interventions (BCI) in a decision-making algorithm to reduce suicide attempt: the VigilanS study protocol. / 2018	Duhem, Stéphane; Berrouiguet, Sofian; Debien, Christophe; Ducrocq, François; Demarty, Anne Laure; Messiah, Antoine; et al.	Vigilans' main objective is to reduce suicide rates and suicide attempts both at the individual level (patients included in Vigilans) and at the population level (inhabitants of the Nord-Pas-de-Calais region).	Integrative intervention with patients. Every tempter from a participating center receives a crisis card with an emergency number to contact in case of anguish. Patients are systematically re-contacted six months later. An additional 10-day call is also made if an index suicide attempt fails for the first time. The clinical evaluation during the call, the liaison team, can carry out provoked crisis operations.	Suicides that occurred in the weeks after the release of a ward accounted for 5% of the total self-inflicted deaths. The initial post-trial period is one of the time windows with the highest risk of attempting or completing suicide.

Evaluation of studies included in the review

For the analysis of the data included in our study, we opted to use the Bardin method. Bardin's Content Analysis research method[21] it has the following stages for its conduct: pre-analysis; exploration of the material; data processing and interpretation.

The pre-analysis phase consists of organizing the material so that the research becomes useful. At this stage, the researcher must read and place the material by standardization and equivalence. In the next step, the exploration of the material, the researcher must define the categories, classifying the constituent elements of a set characterized by differentiation and performing the grouping by analogy by means of previously defined criteria to provide the inference. The final stage of the organization of the analysis stage is the treatment of the results obtained (raw) and their interpretation[21].

Interpretation of results

This stage corresponds to the phase of discussion of the main results in the research. In it, the researcher based on the results of the studies included in the research makes a comparison with the theoretical knowledge, the identification of conclusions and implications resulting from the integrative review. The identification of gaps allows the researcher to point out suggestions for future research directed to the topic in question[20].

Presentation of the review / synthesis of knowledge

This step consists in the elaboration of the document that must include the description of the steps taken by the researcher and the main results evidenced by the analysis of the included articles, will be presented in the topic of results and discussion[20].

Ethical aspects

As it is a literature review accompanied by an integrative review in official data, whose data are already published and are characterized as secondary sources, this study was not submitted to the Ethics Committee. According to the National Research Ethics Commission, research involving only public domain data, which does not identify research participants, or only integrative review, without involving human beings, does not require approval by the CEP / System CONEP.

Results and Discussion

After the selection and analysis of the 13 articles that made up the integrative review, it was possible to carry out the categorization according to the objectives proposed by the present study, being presented and discussed below.

Telephone monitoring

In 2015, observational studies proved the importance of follow-up after hospital discharge of patients who had attempted suicide. According to this study, the management after hospital discharge of these patients decreases the risk of new attempts. Thus, it was possible to show that some studies have shown that emergencies use telephone follow-up as a strategy to prevent further suicide attempts[22,29].

The time for telephone follow-up varied from one study to another. In some studies, the telephone call was made only to make appointments and / or therapy sessions, occurring between the first 24 hours after hospital discharge and between the tenth and twenty-first day after discharge from the emergency[22,27,29]. In study[28], the follow-up of the patient after a suicide attempt admitted in an emergency was carried out for up to six months after discharge, however the phone calls were made only when the nurse was unable to schedule the interviews in person. Another study[23] used as a strategy three telephone contacts with eight, 30 and 60 days after treatment for attempted suicide, demonstrating that early follow-up after attempted suicide can prevent further attempts.

Two other studies[24,25] adopted this telephone follow-up strategy for one year. One of them[25] contacted the patients at six, 12, 24, 36 and 52 weeks after the attempt, and underwent an evaluation to detect those who were at low and high risk for a new suicide attempt. However, the authors concluded that no tool is robust enough to accurately predict new attempts after admission to emergencies. In addition to a risk assessment tool, it is necessary to survey predisposing factors and a qualified clinical assessment as part of a comprehensive and patient-centered approach. What corroborates with the other study[24], where in addition to telephone contact, the patient received a security plan and information provided by the nursing team and in the absence of telephone service, letters were forwarded showing concern for the same. The study demonstrated that the combination of these brief interventions during and after discharge from the emergency, decreased suicidal behavior.

Research[29] also concluded in his study that phone calls were not effective for those who have attempted suicide more than once, which then calls for further interventions to be made in these cases.

However, not all patients immediately accept interventions after discharge, as shown by a study[22], among these were young people of non-Western ethnicity who were not undergoing psychiatric treatment or drug addiction at that time.

There are many studies examining interventions designed to prevent subsequent suicide attempts. In one study[30], a Brief Intervention Contact (BIC) that included patient follow-up and education, multifaceted intervention (brief intervention and a series of phone calls after discharge) produced a significant reduction in the proportion of participants who attempted suicide during the 12-month observation period and a reduction 30% of the total number of suicide attempts.

In the selected articles, several interventions were found for suicidal patients, and together with other interventions, contact via telephone is always evidenced, approached, and considered as a valid intervention method. Study[26] developed the program called VigilanS based on an algorithmic system to adapt the provisions of surveillance and brief contact interventions to individuals who were discharged after a suicide attempt. The study results in a new call after 10 days (extra call) that the nurse or the telephone intervention team can identify the state of that patient, and depending on the evaluation of that call, the team can still perform proportional and corresponding interventions to the patient.

Telephone interventions proved to be a valuable intervention tool to prevent further suicide attempts, however, deadlines and perceptions should be encouraged at the time of the call, so that one can be in front of the individual and prevent the act. Brief contact interventions can be considered reliable strategies for suicide prevention, showing their effectiveness in selected field articles, reducing new cases of suicide[26]. The potentiation of the action of being in contact with the patient, improves the detection of suicide and causes an impediment to the act.

Crisis Card

This intervention strategy consists of the distribution of cards with telephone numbers for support in the event of suicide emergencies. Three articles[26,29,31] were categorized as a strategy for distributing crisis cards. However, this strategy was not used in isolation, but in conjunction with others such as: telephone follow-up, sending postcards, motivational interview, and standard referral to psychiatric outpatient clinics.

In one study[29], it was estimated that the crisis card would be more efficient for the first tempters, while the multiples would try to prefer a phone call. Postcards would be used as substitutes if the participant was not accessible and in addition to the telephone call for the

most serious cases (not adhering to post-discharge treatment and / or in suicide crises). The study was given to the first attempted, who received a crisis card at discharge, showing a toll-free number that could be called, but when it comes to the multi tempters, the intervention becomes a telephone method, offering support and evaluating the mental health of the patient. patient. Thus, the study showed a significant reduction in the risk of suicide among patients who first attempted to deliver crisis cards.

When it comes to the first suicide attempt, the use of the crisis card seems effective according to the study [29], corroborating with a study[32] carried out in 2005, where it was found that the risk reduction can vary from one fifth in the worst scenario to three quarters in the best scenario. In addition, the delivery of crisis cards is an easy, low-cost, and relatively safe intervention to implement.

Research[31] also found a positive result with the use of crisis cards in his study of young people between 14 and 19 years of age. However, the research was carried out with the application of a questionnaire in three stages: initial evaluation, two-month follow-up evaluation and final evaluation. For each stage completed, young people received a financial incentive. Thus, the positive result may have been masked due to the financial incentive, which would still be a valid strategy.

Unlike these two studies, a study[26] created a program called VigilanS based on an algorithmic system to tailor surveillance arrangements and brief contact interventions to individuals who were discharged from the hospital after a suicide attempt. VigilanS includes the use of a crisis card with a free telephone number, along with an information letter about the program.

Upon discharge, the patient receives the crisis card, and even if they do not call, there is a contact action on the 10th day and after 06 months. The crisis cards described by the study[26] they are sent whenever patients are inaccessible by other contact methods such as the telephone. The author also shows the effectiveness of using crisis cards, as it is an easy and quick dissemination method, however the study is still in the phase of comparing results and collecting data, that is, without concrete results.

It is estimated that with the methodology of this process more than ten thousand suicide bombers can be reached, obtaining a more concrete database and information, providing dynamic actions among the attackers, and using the monitoring system for the prevention[26].

In a 2019 study, Algo-S was used, characterized by an algorithm intended to correspond to an intervention group or to the treatment control group in patients who attempted suicide for the first time with the use of cards, being considered a composite ICB test. The study brought a significant reduction in suicide attempts, after the intervention of the crisis card that was distributed to those who attempted suicide for the first time, preventing further attempts[29].

The application of the crisis cards brings a positive intervention when the reduction and the intervention for control, it is soon understood that when the patient is at a higher level of crisis or in a more serious condition, the use of the crisis card has inconclusive results when compared to a strategic form of treatment intent[29].

Crisis cards are used according to the categorized studies, as a form of prevention, of subsequent contact after the suicide attempt, being used in a preventive way combined with support for mental health and telephone contact. Research[26] also emphasizes that the use of the crisis card is also considered when telephone contact is not obtained, sending the cards by post.

Outpatient, face-to-face referral, Psychosocial Care Center, Basic Health Units or psychiatric hospitalization and intervention

This strategy consists of the care that the suicidal or tentative person, pre-disposed to the act receives for support and treatment, occurring through referrals to other institutions or through orientations to the support network. In the referrals made to the institutions, those directed to the Units of the Municipal Health Network, psychiatric evaluation or admission to the Psychiatric Institute and the referrals to the non-governmental network stood out. The guidelines for the support network, on the other hand, were directed to families and the nearby support network[29,33,34].

The Municipal Health Network is the primary source of referrals for patients after hospital discharge, with two important options, the first being the Basic Health Units (UBS), where the patient will be able to continue his treatment close to his home and the second option being the CAPS (Psychosocial Care Center). However, if the patient maintains suicidal ideation or poses a risk to himself or others, the conduct adopted is to refer him for psychiatric evaluation or admission to the Institute of Psychiatry in the region[34].

Research[33] evidenced the role of the medical professional regarding the evaluation and request for follow-up with a specialist in the field of psychiatry for patients seen in the emergency service. According to the hospital's guidelines, all suicide attempts are referred to the psychiatrist, however, those who need clinical stabilization after attempting suicide, are subsequently evaluated by psychiatrists. Still, the study reveals that of the 1888 patients who required psychiatric consultation, 280 (14.8%) were referred to the emergency room due to suicide attempt and of these 34.6% required hospitalization in a psychiatric ward. These data demonstrate that the emergency service is decisive for the assertive referral of patients after attempted suicide.

Conduct after an attempted event is essential for the prevention of new occurrences and needs to be considered in all its aspects, as demonstrated by a study[35], having the decision about the patient to remain in the emergency service until the next day or on the weekends, since mental health services usually do not

work these days, can have repercussions on new negative outcomes for the patient. This is a delicate situation, as there is a high number of patients who have attempted suicide and are diagnosed with a mental disorder and need specialized monitoring.

Some suicide bombers suffer from severe mental illness and will need intensive hospitalization and psychiatric treatment, while others have attempted suicide as an impulsive reaction to a stressful life event, but are mentally stable, thus reinforcing the need for specialized assessment[36].

In one of the studies carried out in Israel, patients were introduced before a hospital discharge to a therapy project, having the first contact via telephone after 24hrs of the suicide attempt, scheduling a therapeutic meeting - if the patient agreed. The intervention consisted of a series of 12 to 15 sessions, focused on crisis intervention. The therapeutic intervention program at the end found a reduction of approximately 10% in suicide attempts[27].

Monitoring patients was a positive strategy, according to the ACTION-J study that examined the effects of assertive case management on repeated suicide attempts in the emergency department setting. This contact-type intervention was introduced by the case manager during admissions to the emergency department for suicide attempts and consisted of assertive and continuous case management (for at least 18 months) based on psychiatric diagnoses, social risks, and patient demands. The intervention significantly reduced the number of individuals with the first recurrent suicide attempt, for up to six months, the intervention actions included: encouraging participants to adhere to psychiatric treatment and other medical or social care and, if necessary, coordinated for use these resources to meet individual demands[28].

In this way, it is understood that the patient's relationship with the health professional, from the reception until leaving the service, is an important instrument for the continuity or not of the referrals made, as well as for the prevention of new suicide attempts[35].

Recognizing that physical, psychological, social conditions and available health resources in the territory are variables that need to be investigated, professionals also pointed out difficulties in carrying out referrals, pointing out that the options available in the network are scarce in view of the demand served[37].

A Research[38] it also reinforced the importance of the family in this process, pointing out that 45.2% of patients seen in a hospital emergency after attempting suicide were discharged from the hospital, 36.6% were hospitalized and 11.6% were referred for outpatient treatment. It is then assessed that adequate family instruction helps to prevent suicide.

Finally, dialectic cognitive and behavioral therapies are effective in monitoring patients, however the rapid induction of these methods is difficult in the emergency department for patients in acute suicide crisis[28].

Use of severity scales to assess risk of attempted suicide

The use of tools to assess the risk of attempting suicide is of great value for the continuity of care after hospital discharge after a suicide attempt, mainly to define the most appropriate intervention for each case. In this line of research, four articles were raised addressing the use of scales and / or questionnaires to assess the risk of attempted suicide[22,25,39,40].

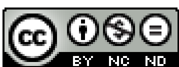
One of the main problems faced by the health team in emergencies when attending a patient who attempted suicide, is deciding who can be discharged without further mental health assessments and who should be admitted or receive any other intervention before discharge. Thus, a decision support tool was developed aiming to provide a simple way to assist this process, in a guaranteed way, suggesting factors that could prioritize a patient for discharge from the emergency room, assuming that there were no other clinical factors that suggested an assessment of mental health. However, this tool did not perform well as a decision making, as almost all patients evaluated had a criterion for the classification of “high risk”[25].

Population assessment methods help to identify people potentially at risk and facilitate the transfer to appropriate care, most people who meet the risk criteria do not attempt or die from suicide. There is an ongoing challenge to determine which individuals, within a risk group, will continue to attempt suicide. For this purpose, several tools are used, such as the self-report, the Suicidal Ideation Questionnaire - Junior, the Beck Hopelessness Scale, the Reynolds Adolescent Depression Scale and the Suicide Probability Scale and the Columbia Suicide Severity Rating Scale (C-SSRS)[39,40].

Psychiatric emergency service providers can appropriate the C-SSRS together with other questionnaires or other forms of investigation, assessing risks to the point of assisting clinical interventional decisions[40]. All the tools used to collect numbers and statistics are used to design treatments, identify those likely to return to attempted suicide and design preventive actions with specific niches.

Given the significant increase in suicide rates and attempts, there is an increasing demand for care in these situations in hospital contexts. However, a study[18] revealed that only one in three people attempting suicide, one is seen at a hospital medical service, influenced by the demand for this resource given the severity of the self-injury and risk of death, ease of access to the health service and user confidence in the system, stigma of other people in relation to their behavior and fear of being criminalized. In general, it is a small number in view of the estimates of attempts that are practiced[18,41].

Thus, when presenting, it is perceived that it is salutary to include the risk assessment of new suicide attempts in the routine of urgent and emergency services before the patient is discharged, so that the proposed referral is consistent with their need[17]. This requires that the health team has technical competence and use the appropriate instruments to assess all the patient's



vulnerabilities while he is in the hospital environment.

Final Considerations

The realization of the present study made it possible to identify the strategies adopted by the emergency services to avoid further suicide attempts, thus achieving the proposed objective. The importance of this study is justified by the increase in suicide attempts in the population and by the great impact on the lives of individuals and family members who face this reality.

The study also made it possible to identify the scarcity of work carried out in Brazil, reflecting the absence of Brazilian strategies for the prevention of new suicide attempts in the scope of emergency services. It is also questioned that this evidenced reality can be understood by the flow of counter-reference from emergency services to primary care services and especially to psychosocial care centers. Even so, actions by these services that become the gateway to psychiatric patients and that often assist them in times of extreme crisis, such as attempting suicide, are considered essential.

With the articles, it is possible to note some successful interventions in the face of new suicide attempts, such as the use of telephone intervention and crisis cards. As for the use of crisis cards, they are considered useful to prevent suicide attempts, however, in view of the studies collected, it is ineffective after attempted people with a history of more than one attempt, just as the telephone call becomes ineffective after a greater number of failed attempts.

The nursing professional who has contact with the individual after the suicide attempt, must be able to approach, care for and refer the patient. The promotion of care and interventions after a suicide attempt is to restore this individual's strength to live, strength to fight the disease, which in general is depression. The methods that professionals perform, must be able to predict and identify suicidal behavior.

Qualified listening is paramount and should not be immersed in a prejudiced and judgmental discourse, considering that the person may not always be willing to express their feelings, and a new challenge for nursing professionals.

In short, the strategies used to combat new suicide attempts are essential so that you can combat not only the act itself, but other illnesses related to suicide, such as depression. It is also necessary that more and more studies and research be applied so that there is more information on the subject, being able to outline methods of inclusion for a broader population.

For the elaboration of the study, barriers were found mainly regarding the offer in the Brazilian literature on strategies pertinent to the fight against suicide, which leads to consider that new measures, studies, information, and sources of action within the fight against suicide need to be discussed. and addressed in Brazil, also considering the implementation of the strategies of other countries in the country. With the development of the study, new experiences, and new ways of acting in the field of nurses were discovered, which can act at strategic, clinical, listening and intervention levels to fight not only suicide, but also in a broader way, of all strategies that aim at the well-being and self-care of the other.

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