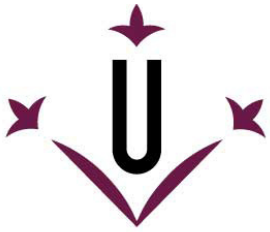
Intervenciones de enfermería para la prevención de las conductas suicidas

Teresa Sufrate Sorzano



Universitat de Lleida

TESIS DOCTORAL

Intervenciones de enfermería para la prevención de las conductas suicidas

Teresa Sufrate Sorzano

Memòria presentada per optar al grau de Doctor per la Universitat de Lleida
Programa de Doctorat en Cures Integrals i Serveis de Salut

Directores:
Fidel Molina Luque
Iván Santolalla Arnedo

Tutor:
Fidel Molina Luque

2024

Memoria de investigación en modalidad de compendio de artículos presentada por:

Teresa Sufrate Sorzano

Para optar al grado de:
Doctora Cuidados Integrales y Servicios de Salud
Por la Universidad de Lleida

Trabajo dirigido por:

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Catedrático de Sociología de la Universidad de Lleida.
Director del Instituto de investigación en Ciencias Sociales y Humanidades.

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Personal Docente e Investigador de la Facultad de Ciencias de la Salud
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Intervenciones de enfermería para la prevención de las conductas suicidas

Teresa Sufrate Sorzano

Directores:
Fidel Molina Luque
Iván Santolalla Arnedo

Tutor:
Fidel Molina Luque

2023

Universitat de Lleida

Para Mamá, Papá, María y Elena.

Para Juan, Andrés y Martín.

- Porque hablar del suicidio es también empezar a prevenirlo -

AGRADECIMIENTOS

En el proceso de culminar esta tesis doctoral, he tenido el privilegio de contar con el apoyo, la inspiración y el aliento de muchas personas. Sin su ayuda, este logro no habría sido posible. Por ello, quiero expresar mi más sincero agradecimiento a aquellos que han contribuido, de diversas maneras, a lo largo de este viaje:

A mi director de la Universidad de La Rioja, Iván Santolalla Arnedo, por su orientación, paciencia y dedicación. Su constante apoyo ha sido fundamental en cada etapa.

A Raúl Juárez Vela y Elena Garrote Cámara, por sus valiosas contribuciones, comentarios constructivos, recomendaciones y su compromiso con el proyecto.

A mis compañeros de investigación y coautores, por las discusiones enriquecedoras, las colaboraciones y el compañerismo que hemos compartimos en el desarrollo de la tesis. Entre todo, me habéis enseñado lo mejor de vuestro ámbito.

A la Universidad de La Rioja, Servicio Riojano de Salud (SERIS), Centro de Investigación Biomédica de La Rioja (CIBIR), al Gobierno de La Rioja y a la Universidad de Lleida, por brindarme los recursos y la infraestructura necesarias para llevar a cabo esta tesis.

A mis amigos, que me brindaron ánimo y comprensión en los momentos más desafiantes. Su presencia y su sentido del humor hicieron que este camino fuera más llevadero.

A mi familia, por su amor incondicional, su apoyo emocional y su comprensión durante todos estos años de estudio. Gracias por creer en mí y por ser mi fuente de fuerza y motivación.

Finalmente, quiero agradecer a todos aquellos que de alguna manera contribuyeron a este proyecto, aunque no estén mencionados aquí de manera individual.

Este logro es el resultado de un esfuerzo conjunto, y estoy agradecida por la oportunidad de aprender y crecer que he tenido a lo largo de este proceso. Espero que este trabajo contribuya de manera significativa al campo de la investigación y que pueda ser de utilidad para la comunidad académica y la sociedad.

A todos vosotros, GRACIAS.

Teresa Sufrate Sorzano

ÍNDICE

PRESENTACIÓN

PRESENTACIÓN

Actualmente, el suicidio es un problema de salud pública cuya prevención y tratamiento precisa ser priorizada en las políticas y programas de salud desarrollados a nivel mundial. La Organización Mundial de la Salud estima que por cada una de las muertes por suicidio que se producen, se llevan a cabo veinte intentos. La cifra de muertes por suicidio, próxima al millón de fallecidos cada año en el mundo, denota necesidades en el abordaje de la salud mental y de los múltiples factores que rodean a este fenómeno.

La investigación y visibilización de la prevención del suicidio son fundamentales debido a su impacto significativo en la salud pública y el bienestar emocional de las personas. En primer lugar, la comprensión profunda de los factores de riesgo y las causas subyacentes es esencial para desarrollar estrategias efectivas de prevención. La investigación proporciona datos cruciales que permiten a los profesionales de la salud mental y a las autoridades abordar las raíces del problema y diseñar intervenciones adaptadas a diferentes contextos y poblaciones.

La visibilización de la prevención del suicidio pretende destigmatizar los problemas de salud mental y promover la conciencia pública. A través del diálogo sobre este tema, se fomenta la empatía y la comprensión, contribuyendo a crear comunidades más solidarias y receptivas. La información accesible sobre recursos de apoyo y señales de alerta puede marcar la diferencia y la orientación en la búsqueda de ayuda.

La visibilización de la prevención del suicidio desde los profesionales de enfermería es de suma importancia debido al papel crucial que desempeñan en la atención integral de la salud, por su acceso directo al paciente, su capacidad de seguimiento, de detección precoz y de brindar apoyo emocional en situaciones difíciles.

La prevención del suicidio es un esfuerzo colectivo que involucra a profesionales de la salud, educadores, líderes comunitarios y la sociedad en general. La investigación y la visibilización son herramientas poderosas que, al trabajar en conjunto, pueden ayudar a dar luz en la desesperanza y mejorar la calidad de la salud mental a nivel global.

A continuación, se exponen las seis publicaciones que componen la tesis doctoral por compendio de artículos de Teresa Sufrate Sorzano, centradas todas ellas en las intervenciones de enfermería para la prevención del suicidio.

Las publicaciones han sido realizadas entre los años 2020 y 2023 en revistas nacionales e internacionales.

El primer artículo presentado se titula "**Conducta suicida. Cuidados de enfermería para la prevención e intervención en crisis".**

PRESENCIA
REVISTA INTERNACIONAL DE SALUD MENTAL, INVESTIGACIÓN Y HUMANIDADES
CIBERINDEX CANTARIDA

Presencia, 2020; v16: e12659
http://ciberindex.com/p/p/e12659
ISSN 1885-0219

Indexación: CUIDEN, HEMEROTECA CANTARIDA, CUIDEN CITACION

ORIGINAL

Recibido: 03.05.2020
Aceptado: 23.09.2020

Conducta suicida. Cuidados de enfermería para la prevención e intervención en crisis

Teresa *Sufrate Sorzano*, Iván *Santolalla Arnedo*, Félix *Rivera Sanz*, Carmen Amaia *Ramírez Torres*
Centro de Investigación Biomédica de La Rioja (La Rioja, España)

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Teresa Sufrate Sorzano y el Dr. Iván Santolalla Arnedo fueron los responsables de la hipótesis y diseño del trabajo. El papel de la primera autora, Teresa Sufrate Sorzano, fue realizar una revisión de la literatura y el cuestionario de evaluación, así como redactar el borrador del manuscrito, todo ello supervisado y tutelado por el Dr. Santolalla Arnedo. Los coautores contribuyeron con la cumplimentación del cuestionario y en la realización e interpretación del análisis estadístico. Todos los autores realizaron una revisión crítica del manuscrito y aportaron sugerencias constructivas para mejorar la versión definitiva. El artículo fue publicado en la revista *"Presencia. Revista Internacional de Salud Mental, Investigación y Humanidades"* en septiembre de 2020.

Indexación: CUIDEN, en la Hemeroteca CANTARIDA y en el fondo de revistas a texto completo SUMMA CUIDEN, en los directorios MIAR y DIALNET.

Citación: Sufrate-Sorzano T., Santolalla-Arnedo I., Rivera-Sanz F., Ramírez-Torres C. Conducta suicida. Cuidados de enfermería para la prevención e intervención en crisis. Presencia. 2020 Dec; 15:e12659

El segundo artículo presentado se titula "**Nursing interventions of choice for the prevention and treatment of suicidal behaviour: The umbrella review protocol**".

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DOI: 10.1002/nop2.1068

STUDY PROTOCOL

NursingOpen Open Access WILEY

Nursing interventions of choice for the prevention and treatment of suicidal behaviour: The umbrella review protocol

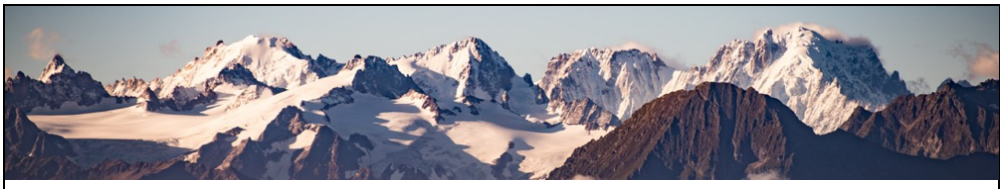
Teresa Sufrate-Sorzano[1,2] | Raúl Juárez-Vela[1,2,3] | Carmen Amaia Ramírez-Torres[1] | Félix Rivera-Sanz[1,4] | María Elena Garrote-Camara[1,5] | Pastells-Peiró Roland[6,7,8] | Montserrat Gea-Sánchez[6,7,9] | Pablo Del Pozo-Herce[1,10] | Vicente Gea-Caballero[3,11] | Beatriz Angulo-Nalda[5] | Iván Santolalla-Arnedo[1,2]

El papel de la primera autora, Teresa Sufrate Sorzano, fue la conceptualización de la investigación y metodología, así como elaborar el primer borrador, todo ello supervisado y tutelado por el Dr. Santolalla Arnedo. Los coautores contribuyeron con aportaciones relevantes para el planteamiento del protocolo de investigación y su transcripción en el Registro Prospectivo Internacional de Revisiones Sistemáticas (PROSPERO, International Prospective Register of Systematic Reviews). Todos los autores realizaron una revisión crítica del manuscrito y aportaron sugerencias constructivas para mejorar la versión definitiva. El artículo fue publicado en la revista *"Nursing Open"* en septiembre de 2021.

JCR 2021: 1,942. Q3 (69/125). Este artículo fue uno de los más descargados durante sus primeros 12 meses de publicación en Wiley.

SJR 2021: 0,496. Q2.

Citación: Sufrate-Sorzano T., Juárez-Vela R., Ramírez-Torres C.A., Rivera-Sanz F., Garrote-Cámara M.E., Roland P.P., Gea-Sánchez M., Del Pozo-Herce P., Gea-Caballero V., Angulo-Nalda B., Santolalla-Arnedo I. Nursing interventions of choice for the prevention and treatment of suicidal behaviour: The umbrella review protocol. Nursing open. 2022 Jan;9(1):845-50.



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Nursing interventions of choice for the prevention and treatment of suicidal behaviour: The umbrella review protocol

**Among work published in an issue between 1 January 2021 – 31 December 2021.*

El tercer artículo presentado se titula "**Health Plans for Suicide Prevention in Spain: A Descriptive Analysis of the Published Documents".**

El papel de la primera autora, Teresa Sufrate Sorzano, fue la conceptualización de la investigación, metodología y el análisis de los documentos, así como elaborar el primer borrador, todo ello supervisado y tutelado por el Dr. Santolalla Arnedo. Los coautores contribuyeron con aportaciones relevantes para el planteamiento de la investigación y la administración del proyecto. Todos los autores realizaron una revisión crítica del manuscrito y aportaron sugerencias constructivas para mejorar la versión definitiva. El artículo fue publicado en la revista *"Nursing Reports"* en febrero de 2022.

Indexación: CNKI, CNPIE, Digital Science, DOAJ, EBSCO, Scopus, Gale, PubMed, OpenAIRE, ProQuest y SafetyLit.

Este artículo está incluido en la Plataforma Nacional para el Estudio y la Prevención del Suicidio (https://www.plataformanacionalsuicidio.es/noticias/planes-de-prevencin-de-suicidio-en-espaa). Dicha plataforma se incluye dentro del Consorcio SURVIVE, formado por profesionales de la salud mental e investigadores de distintos hospitales, universidades y centros de investigación de España que colaboran con el objetivo de estudiar la conducta suicida para desarrollar programas de prevención y tratamiento eficaces. Este proyecto fue financiado por el Instituto de Salud Carlos III, con cofinanciación del Fondo Europeo de Desarrollo Regional (FEDER).

En la actualidad no existe un plan de prevención del suicidio que lleven a cabo todas las comunidades autónomas de forma generalizada

Un estudio comparativo de los diferentes planes de prevención del suicidio en España señala que no todas las comunidades autónomas tienen previstas actividades preventivas dirigidas a la población en general; si bien todas incluyen las relacionadas con el sector sanitario. Esta investigación ha sido llevada a cabo por el Grupo de Investigación en Cuidados (GRUPAC) de la Universidad de La Rioja, en colaboración con el Servicio Riojano de Salud, el Centro de Investigación Biomédica de La Rioja (GISOSS-CIBIR) y la Universidad Internacional de Valencia.

El objetivo del estudio era describir y comparar las intervenciones descritas en los planes de prevención del suicidio en las diferentes comunidades autónomas de España (incluyendo Ceuta y Melilla); escogiendo un único plan por comunidad, seleccionando el más reciente y excluyendo aquellos que no estuvieran avalados por las entidades gubernamentales y/o sanitarias. Los resultados de este estudio reflejan que los planes de prevención del suicidio en España, así como sus objetivos y las medidas propuestas en su defecto, son similares en la mayoría de las comunidades autónomas, aunque con diferentes particularidades en las intervenciones propuestas por cada uno de ellos. El estudio aprecia que la mayoría de las intervenciones se dirigen hacia los profesionales sanitarios, especialmente en el campo de la salud mental, así como hacia la población más vulnerable. Sin embargo, también se observan otro tipo de medidas enfocadas a ámbitos clave como puede ser la sensibilización en escuelas o la formación de agentes sociales.

Con respecto al género y durante los últimos años, el estudio refleja una variación en la proporción de hombres/mujeres que fallecen a causa del suicidio. Si anteriormente los suicidios se producían más frecuentemente entre varones y las tentativas en mujeres, actualmente se observa un aumento de la proporción de mujeres que llegan a consumar los actos suicidas. El estudio también señala que no todas las comunidades autónomas cuentan con un programa específico de prevención del suicidio, sino que la elaboración de este documento responde más a un objetivo incluido en planes más generales como el de salud mental, en ocasiones todavía no desarrollados. El estudio pone de manifiesto los aspectos de interés a incluir en las revisiones de los planes actuales o en los futuros planes que se desarrollen, entre estos aspectos la mejora de la atención a la salud mental, en especial en situaciones de aislamiento y confinamiento como la vivida en la pandemia Actualmente, este grupo de investigación de la Universidad de La Rioja (GRUPAC), está trabajando en la elaboración de una guía con recomendaciones para la exposición y difusión de las conductas suicidas en los medios de comunicación.

Los investigadores plantean que “es necesario desmitificar que el suicidio es un acto no prevenible, ya que las personas que sufren ideación suicida sienten emociones contradictorias y conviven con sentimientos ambivalentes de muerte hasta instantes previos a cometer el acto suicida; por lo que la elaboración de planes de prevención del suicidio, así como estrategias preventivas, es favorecedor y necesario para su prevención”.

Referencia al trabajo original: Sufrate-Sorzano, T., Jiménez-Ramón, E., Garrote-Cámara, M. E., Gea-Caballero, V., Durante, A., Júarez-Vela, R., & Santolalla-Arnedo, I. (2022). Health Plans for Suicide Prevention in Spain: A Descriptive Analysis of the Published Documents. *Nursing reports (Pavia, Italy)*, *12*(1), 77–89. https://doi.org/10.3390/nursrep12010009

En relación con dicho artículo, Teresa Sufrate Sorzano fue entrevistada y formó parte del reportaje *"Once vidas. Radiografía del suicidio en España"*, publicado en el periódico El Mundo en noviembre de 2022, tanto en versión online como impresa (enlace a la noticia completa:https://www.elmundo.es/cienciaysalud/salud/2022/11/11/6363cb0221efa021118b4591.html) .

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Familiares El complicado duelo tras una muerte por suicidio, lucha contra el dolor, el estigma y la soledad

El pasado 10 de septiembre se conmemoraba el Día Mundial para la Prevención del Suicidio. Desde entonces en España se han quitado la vida **682** seres humanos atrapados en un sufrimiento extremo . Muertes prevenibles en la mayoría de casos que no se pudieron evitar. Son datos que se extrapolan de la fría estadística que constata el incremento de los suicidios. En 2020 se consumaron **3.941, 11 cada día**. En esas 24 horas, otras 200 personas lo intentan y muchas otras, incontables, lo piensan. EL MUNDO comienza hoy la serie **'Once vidas'** para abordar durante un año con expertos y afectados este grave problema de salud pública que atañe a toda la sociedad. Ésta es la radiografía del suicidio en España.

EL MUNDO

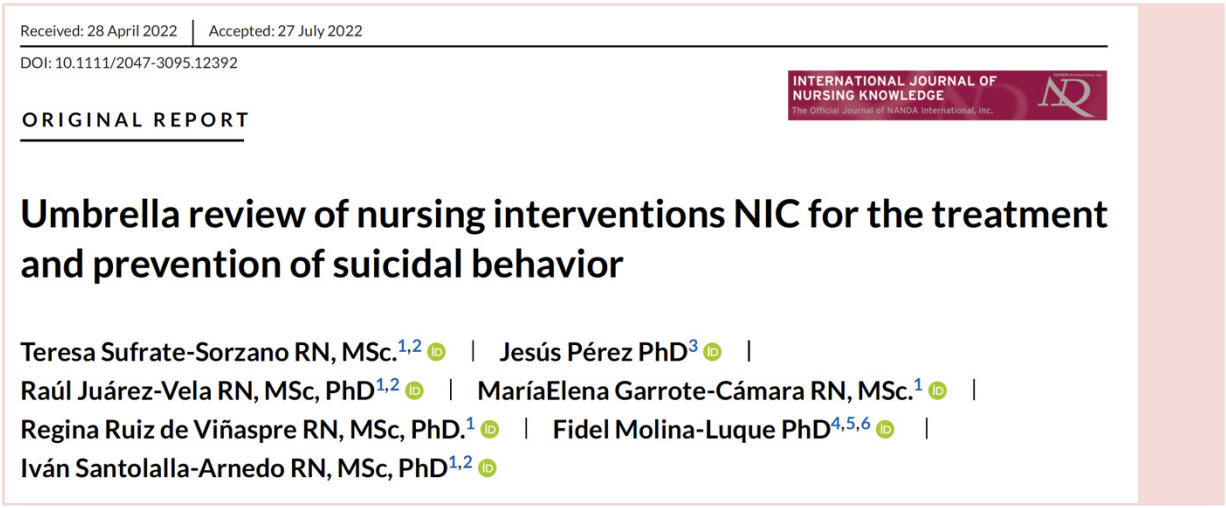
letales.

Hay una apuesta común de las CCAA por promover la **formación** de profesionales sanitarios, del entorno educativo, fuerzas y cuerpos de seguridad y medios de comunicación pero existen claras diferencias en las medidas propuestas en los servicios de salud en relación a mejorar las tasas de detección temprana de riesgo, desarrollo de guías y protocolos, códigos suicidas o programas de seguimiento. La investigadora Teresa Sufrate Sorzano destaca en este sentido la creación en Canarias de **'unidades de internamiento ultra breve'** destinada a pacientes con riesgo suicida considerable o en Cataluña o La Rioja de un **"código de riesgo suicida".** Los planes de prevención riojano, asturiano y navarro ponen especialmente en valor el papel de los profesionales de enfermería. La Rioja y Galicia también incluyen, como avance destacado, las técnicas de **"debriefing"** dirigidas al personal implicado en hechos traumáticos como la muerte de un paciente por suicidio.

Andalucía, Aragón, Baleares, Galicia, La Rioja y País Vasco apuestan por vigilar los "puntos negros", los lugares donde se suelen producir muertes por suicidio e instalar barreras arquitectónicas para impedir el acceso a estos sitios.

Citación: Sufrate-Sorzano T., Jiménez-Ramón E., Garrote-Cámara M.E., Gea-Caballero V., Durante A., Júarez-Vela R., Santolalla-Arnedo I.. Health plans for suicide prevention in Spain: A descriptive analysis of the published documents. Nursing Reports. 2022 Feb 8;12(1):77-89.

El cuarto artículo presentado se titula "**Umbrella review of nursing interventions NIC for the treatment and prevention of suicidal behavior".**



Received: 28 April 2022 | Accepted: 27 July 2022

DOI: 10.1111/2047-3095.12392

INTERNATIONAL JOURNAL OF NURSING KNOWLEDGE
The Official Journal of NANDA International, Inc.

ORIGINAL REPORT

Umbrella review of nursing interventions NIC for the treatment and prevention of suicidal behavior

Teresa Sufrate-Sorzano RN, MSc.[1,2] | Jesús Pérez PhD[3] |
Raúl Juárez-Vela RN, MSc, PhD[1,2] | MaríaElena Garrote-Cámara RN, MSc.[1] |
Regina Ruiz de Viñaspre RN, MSc, PhD.[1] | Fidel Molina-Luque PhD[4,5,6] |
Iván Santolalla-Arnedo RN, MSc, PhD[1,2]

El papel de la primera autora, Teresa Sufrate Sorzano, fue la conceptualización de la investigación y el desarrollo de la metodología, así como realizar el análisis formal y elaborar el primer borrador, todo ello supervisado y tutelado por el Dr. Fidel Molina Luque y el Dr. Santolalla Arnedo. Los coautores contribuyeron con aportaciones relevantes para el planteamiento de la investigación, el análisis de la revisiones sistemáticas y su transcripción en el Registro Prospectivo Internacional de Revisiones Sistemáticas (PROSPERO, International Prospective Register of Systematic Reviews). Todos los autores realizaron una revisión crítica del manuscrito y aportaron sugerencias constructivas para mejorar la versión definitiva. El artículo fue publicado en la revista "*International Journal of Nursing Knowledge"* en julio de 2022.

JCR 2022: 1,4. Q4 (95/125).

SJR 2022: 0,29. Q2.

Citación: Sufrate-Sorzano T, Pérez J, Juárez-Vela R, Garrote-Cámara M, de Viñaspre RR, Molina-Luque F, Santolalla-Arnedo I. Umbrella review of nursing interventions NIC for the treatment and prevention of suicidal behavior. International journal of nursing knowledge. 2022 Jul;34(3):204-15.

El quinto artículo presentado se titula "**Interventions of choice for the prevention and treatment of suicidal behaviours: An umbrella review".**

Received: 15 March 2022 | Revised: 25 February 2023 | Accepted: 5 May 2023
DOI: 10.1002/nop2.1820

SYSTEMATIC REVIEW

NursingOpen Open Access WILEY

Interventions of choice for the prevention and treatment of suicidal behaviours: An umbrella review

Teresa Sufrate-Sorzano[1,2] | Iván Santolalla-Arnedo[1,2] | María Elena Garrote-Cámara[1] | Beatriz Angulo-Nalda[3] | Ruth Cotelo-Sáenz[4] | Roland Pastells-Peiró[5,6,7] | Filip Bellon[8,9] | Joan Blanco-Blanco[7,8,9] | Raúl Juárez-Vela[1,2] | Fidel Molina-Luque[10,11,12]

El papel de la primera autora, Teresa Sufrate Sorzano, fue la conceptualización de la investigación y el desarrollo de la metodología, así como realizar el análisis formal y elaborar el primer borrador, todo ello supervisado y tutelado por el Dr. Fidel Molina Luque y el Dr. Santolalla Arnedo. Los coautores contribuyeron con la aportaciones relevantes para el planteamiento de la investigación, el análisis de la revisiones sistemáticas y su transcripción en el Registro Prospectivo Internacional de Revisiones Sistemáticas (PROSPERO, International Prospective Register of Systematic Reviews). Todos los autores realizaron una revisión crítica del manuscrito y aportaron sugerencias constructivas para mejorar la versión definitiva. El artículo fue publicado en la revista "*Nursing open"* en mayo de 2023.

JCR 2022: 2,3. Q2 (46/125).

SJR 2022: 0,64. Q1.

Citación: Sufrate-Sorzano T, Santolalla-Arnedo I, Garrote-Cámara ME, Angulo-Nalda B, Cotelo-Sáenz R, Pastells-Peiró R, Bellon F, Blanco-Blanco J, Juárez-Vela R, Molina-Luque F. Interventions of choice for the prevention and treatment of suicidal behaviours: An umbrella review. Nursing open. 2023 May 22.

El sexto artículo presentado se titula **"Media Exposure of Suicidal Behaviour: An Umbrella Review".**

El papel de la primera autora, Teresa Sufrate Sorzano, fue la conceptualización de la investigación y el desarrollo de la metodología, así como realizar el análisis formal y elaborar el primer borrador, todo ello supervisado y tutelado por el Dr. Fidel Molina Luque y el Dr. Santolalla Arnedo. Los coautores contribuyeron con aportaciones relevantes para el planteamiento de la investigación, el análisis de la revisiones sistemáticas y su transcripción en el Registro Prospectivo Internacional de Revisiones Sistemáticas (PROSPERO, International Prospective Register of Systematic Reviews). Todos los autores realizaron una revisión crítica del manuscrito y aportaron sugerencias constructivas para mejorar la versión definitiva. El artículo fue publicado en la revista "*Nursing Reports*" en octubre de 2023.

JCR 2023: 2,4. Q2 (49/190).

Citación: Sufrate-Sorzano T, Di Nitto M, Garrote-Cámara ME, Molina-Luque F, Recio-Rodríguez JI, Asión-Polo P, Durante Á, Gea-Caballero V, Juárez-Vela R, Pérez J, Santolalla-Arnedo I. Media Exposure of Suicidal Behaviour: An Umbrella Review. Nursing Reports. 2023 Oct 25;13(4):1486-99.

SOBRE TERESA SUFRATE SORZANO

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- Coordinadora de la *"Guía de Buenas Prácticas en Comunicación y Difusión para la Prevención de la Conducta Suicida*"**.** ISBN: 978 - 84 - 19221- 41- 4. 2023. Depósito Legal: LR-1406-2023.
- Graduada en Enfermería por la Universidad de Salamanca, 2023.
- Coordinadora de: *"Prevención del suicidio desde las aulas. Intervenciones para la prevención del suicidio"*. ISBN: 978-84-17235-84-0. Depósito legal: LR-209-2021.
- Máster oficial en Género y Salud por la Universidad Rey Juan Carlos de Madrid, 2016.
- Diplomatura en Enfermería por la Universidad de La Rioja, 2007.

https://orcid.org/0000-0003-3756-9914

Scopus Preview Scopus Author ID: 57264051400

GLOSARIO DE ABREVIATURAS

INE	Instituto Nacional de Estadística.
NANDA	North American Nursing Diagnosis Association.
NIC	Nurse Interventions Clasification. Clasificación de Intervenciones de Enfermería.
NOC	Nurse Outcome Clasification. Clasificación de Resultados de Enfermería.
OMS	Organización Mundial de la Salud.
PAE	Proceso de Atención de Enfermería.
PROSPERO	International Prospective Register of Systematic Reviews).

RESUMEN

En la actualidad, se registran aproximadamente 800.000 muertes en el mundo por suicidio cada año. Los factores que intervienen en el suicidio son múltiples y de diversa índole, abarcando todas las esferas y ámbitos de la persona desde el plano psicológico, biológico, social o cultural, y que se pueden asociar a eventos traumáticos o de estrés. Los cuidados y abordaje para la prevención de la conducta suicida requieren un equipo multidisciplinar de profesionales. La presente tesis doctoral tiene como objetivo contribuir al conocimiento científico a través del análisis de las intervenciones de enfermería más eficaces para la prevención de la conducta suicida.

Se comenzó analizando las estrategias de intervención de los profesionales de enfermería en pacientes con riesgo suicida específicamente en la Comunidad Autónoma de La Rioja. Se desarrolló un protocolo de investigación, se identificaron las intervenciones más eficaces para la prevención de la conducta suicida disponibles para los profesionales sanitarios y se determinaron las intervenciones de enfermería presentes en la taxonomía de la Clasificación de Intervenciones de Enfermería NIC. Posteriormente, se describieron y compararon las intervenciones descritas en los planes de prevención del suicidio en las diferentes provincias de España. Finalmente, se analizaron las intervenciones recomendadas para la difusión segura y responsable de conductas suicidas en los medios de comunicación con fines preventivos.

Los resultados expuestos en la presente tesis doctoral suponen un gran avance en la determinación de intervenciones eficaces para la prevención de la conducta suicida gestionada a través de los profesionales de enfermería; se presentan como una herramienta potente de acción preventiva y mejora de la calidad de la salud mental a nivel global.

RESUM

Actualment, es registren aproximadament 800.000 morts al món per suïcidi cada any. Els factors que intervenen en el suïcidi són múltiples i d'índole diversa, abastant totes les esferes i àmbits de la persona des del pla psicològic, biològic, social o cultural, i que es poden associar a esdeveniments traumàtics o d'estrès. Les cures i l'abordatge per a la prevenció de la conducta suïcida requereixen un equip multidisciplinari de professionals. Aquesta tesi doctoral té com a objectiu contribuir al coneixement científic mitjançant l'anàlisi de les intervencions d'infermeria més eficaces per a la prevenció de la conducta suïcida.

Es va començar analitzant les estratègies d'intervenció dels professionals d'infermeria en pacients amb risc suïcida específicament a la comunitat autònoma de la Rioja. Es va desenvolupar un protocol de recerca, es van identificar les intervencions més eficaces per a la prevenció de la conducta suïcida disponibles per als professionals sanitaris i es van determinar les intervencions d'infermeria presents a la taxonomia de la Classificació d'Intervencions d'Infermeria NIC. Posteriorment, es van descriure i comparar les intervencions descrites als plans de prevenció del suïcidi a les diferents províncies d'Espanya. Finalment, es van analitzar les intervencions recomanades per a la difusió segura i responsable de conductes suïcides als mitjans de comunicació amb fins preventius.

Els resultats exposats en aquesta tesi doctoral suposen un gran avenç en la determinació d'intervencions eficaces per a la prevenció de la conducta suïcida gestionada a través dels professionals d'infermeria; es presenten com una eina potent dacció preventiva i millora de la qualitat de la salut mental a nivell global.

ABSTRACT

Currently, there are approximately 800,000 deaths worldwide due to suicide each year. The factors involved in suicide are multiple and diverse, covering all spheres and areas of the person from the psychological, biological, social or cultural level, and which can be associated with traumatic or stress events. Care and approach for the prevention of suicidal behavior require a multidisciplinary team of professionals. The objective of this doctoral thesis is to contribute to scientific knowledge through the analysis of the most effective nursing interventions for the prevention of suicidal behavior.

We began by analyzing the intervention strategies of nursing professionals in patients at risk of suicide specifically in the Autonomous Community of La Rioja. A research protocol was developed, the most effective interventions for the prevention of suicidal behavior available to health professionals were identified, and the nursing interventions present in the taxonomy of the NIC Classification of Nursing Interventions were determined. Subsequently, the interventions described in the suicide prevention plans in the different provinces of Spain were described and compared. Finally, the recommended interventions for the safe and responsible dissemination of suicidal behaviors in the media for preventive purposes were analyzed.

The results presented in this doctoral thesis represent a great advance in determining effective interventions for the prevention of suicidal behavior managed through nursing professionals; They are presented as a powerful tool for preventive action and improvement of the quality of mental health at a global level.

INTRODUCCIÓN

1. MARCO CONCEPTUAL

En la actualidad, se registran unas 800.000 muertes en el mundo por suicidio cada año. Esta cifra incluye a toda la población, sin embargo, se debe hacer hincapié en los grupos poblacionales más vulnerables (1). Los factores que intervienen en el suicidio son múltiples y de diversa índole, abarcando todas las esferas y ámbitos de la persona desde el plano psicológico, biológico, social o cultural, y que se pueden asociar a eventos traumáticos o de estrés. De este modo, el suicidio no presenta un efecto restringido al plano individual, sino que afecta también al entorno de la persona que pone fin a su vida (2,3).

1.1. EPIDEMIOLOGÍA

Según los últimos datos aportados por la Organisation for Economic Co-operation and Development (OECD), a nivel internacional, Corea del Sur y Lituania son los países con las mayores tasas de suicidio (superiores a 20), mientras que los países que registran las tasas inferiores son Costa Rica, Brasil y México, con cifras inferiores a 7 suicidios por cada 100.000 habitantes (4).

Respecto a España, en 2022 y según los datos publicados por el Instituto Nacional de Estadística (INE), han fallecido por suicidio 4.097 personas en España, una media de 11,2 personas al día, comparando estas cifras con las previas de 2021, se han registrado un 2,3% más (5).

Durante el año 2019, en España se registró un aumento del 4% en el número de suicidios en comparación con el año anterior, alcanzando la cifra de 3.671 suicidios, dato al partir del cual se pudo inferir una media de 10 suicidios al día. Estas cifras continuaron en aumento, alcanzándose los 4097 fallecidos por suicidio en 2022, con un incremento del 2,3% respecto al 2021, que mantuvo el suicidio como principal causa de muerte externa por delante de las caídas accidentales y los ahogamientos (6).

Respecto a la distribución por comunidades autónomas, Andalucía, Cataluña y Valencia registran las mayores cifras con tasas por encima de 12 suicidios por cada 100.000 habitantes. La Rioja cuenta con una tasa de 7,2 suicidios frente a las comunidades que se encuentran en el extremo inferior y con tasas por debajo de 3 suicidios por cada 100.000 habitantes, como Ceuta y Melilla (5).

La distribución por sexo de estos fallecimientos en España queda representada por una marcada tendencia masculina, alcanza el 74%, y que es tres veces superior (26%) a la de las mujeres (6). Por grupos de edad, los jóvenes, son uno de los grupos poblacionales más afectados, para los cuales el suicidio se configura como una causa de muerte destacada entre los 15 y los 29 años. Este hecho se ve reflejado en los datos del INE, que muestran un aumento de los fallecidos menores de 20 años por suicidio durante 2022, registrándose la cifra máxima en 84 personas frente a las 75 del año 2021 (5).

Tras la consideración de las altas cifras de mortalidad, los organismos internacionales abogan por la reducción en un tercio de las tasas mundiales de mortalidad prematura, incluyendo las tasas de suicidio como indicador. Este plan forma parte de parte de los objetivos de desarrollo sostenible planteados por Naciones Unidas y la Organización Mundial de la Salud (OMS) a los diversos países para alcanzar en el año 2030 (7).

La Unión Europea ampara el derecho de cualquier persona a recibir atención sanitaria y unos cuidados de calidad en favor de prevenir la enfermedad y promover la salud. Sin embargo, a nivel mundial la prevención del suicidio no se concibe de la misma manera. Actualmente existen 23 países en los que el suicidio e incluso, los intentos de suicidio constituyen un delito y son procesados de acuerdo con su legislación (8). Los sentimientos de miedo, la criminalización y el estigma social que generan estas normas dificultan la atención temprana. En estos casos, el reconocimiento de los factores sociales, biológicos, ambientales o culturales que son determinantes en las conductas suicidas, resultan invisibles a ojos de la sociedad (9).

1.2. CONCEPTOS RELACIONADOS CON EL SUICIDIO

El término suicidio, que se define como el acto que realiza una persona para intencionalmente ocasionar su propia muerte, procede del latín *sui*, “sí mismo” y *caedere,* “matar” (10).

Prestigiosos autores y organismos internacionales especializados en el tema han intentado circunscribir el concepto de suicidio con el fin de facilitar su estudio y compresión, entre ellos la OMS, en 1986, definió el suicidio como *“Un acto con resultado letal, deliberadamente iniciado y realizado por el sujeto, sabiendo o esperando su resultado letal y a través del cual pretende obtener los cambios deseados*” (11). Sería a continuación, en 1897 cuando Èmile Durkheim (sociólogo y filosofo) publicó el libro “*Le suicide*”, dónde se define el suicidio como “*Todo caso de muerte que resulte, directa o indirectamente, de un acto, positivo o negativo, realizado por la víctima misma, a sabiendas del resultado*” (12).

El suicidio conlleva otras entidades relevantes, como pueden ser el intento de suicidio, la conducta suicida, el parasuicidio, la comunicación o la ideación suicida, términos transitan íntimamente de la mano de la persona con comportamientos suicidas. Aunque realmente no existe un consenso universal que unifique la nomenclatura sobre conducta suicida, todos los conceptos relacionados con ello están definidos en base a dos criterios, “auto-inflingido” y “propósito de muerte”.

Una de las mayores controversias gira alrededor de la intencionalidad o no de algunos de los actos autolíticos. Si bien en muchos casos se opta por excluir de la conducta suicida las lesiones autoinfligidas sin intencionalidad suicida, la OMS opta, por lo contrario, incluir en la definición “intento de suicidio”, la lesión autoinfligida no mortal sin intención suicida, ateniéndose a que la intención suicida puede ser difícil de evaluar por estar rodeada de ambivalencia.

Conceptos relacionados (9,13):

- **Intento de suicidio**: acto llevado a cabo con el objetivo de provocar la muerte pero que no alcanza ese resultado. Pese a no alcanzar la letalidad, los intentos de suicidio conllevan un deseo por parte de acabar con la vida, y consecuencia de que el intento de suicidio es considerado como el principal factor de riesgo a la hora de alcanzar el suicidio. El intento de suicidio, si es detenido deliberadamente por la propia persona, recibe el nombre de intento de suicidio abortado. Por el contrario, si el intento ha sido inconcluso por otra persona, recibe el nombre de intento de suicidio interrumpido.
- **Conducta suicida**: acto o comportamiento que contenga en algún grado una intencionalidad de terminar con la vida.
- **Gesto suicida**: acto suicida de escasa intencionalidad, por lo que no conlleva lesiones relevantes en la persona. También es denominado **parasuicidio.**
- **Comunicación suicida**: transmisión de pensamientos, deseos o intencionalidad de acabar con la propia vida, para los que existe evidencia implícita o explícita de que este acto de comunicación no supone por sí mismo una conducta suicida. La comunicación suicida, verbal o no verbal, es un punto intermedio entre la ideación y la conducta suicidas.
- **Amenaza suicida**: acto verbal o no verbal que puede predecir una conducta suicida en un futuro próximo.
- **Ideación suicida**: pensamientos relacionados con la voluntad de quitarse la vida sin comportamientos asociados a ese pensamiento. En la ideación, la muerte queda conceptualizada como vía escape ante los problemas presentes.

- **Plan suicida**: ideas y conductas organizadas para cometer suicidio. Incluye el método, lugar, momento… para alcanzar el propósito, por lo que indica un alto riesgo de realización.
- **Deseo suicida**: voluntad variable de cometer un acto suicida. Se caracteriza por la inconformidad e insatisfacción con la vida.

2. FACTORES DE RIESGO, PRECIPITANTES Y PROTECTORES

Para abordar el riesgo de suicidio y su prevención, es fundamental conocer los diversos factores que rodean a la conducta suicida y que pueden suponer un peligro para la vida de la persona o, por el contrario, proteger su integridad. Resulta de vital importancia orientar las intervenciones de prevención y abordaje hacia la potenciación de los de factores protectores y la eliminación o disminución de factores de riesgo y precipitantes.

2.1. FACTORES DE RIESGO

Un factor de riesgo es cualquier rasgo o característica de una persona que aumenta la probabilidad de sufrir determinado acontecimiento o enfermedad (1,9,14). Los factores de riesgo se pueden clasificar en función de su relación individuo, la familia y la comunidad (tabla 1).

Tabla 1. Factores de riesgo de la conducta suicida. Elaboración propia.

Factores de riesgo de la conducta suicida		
Personales	**Familiares**	**Comunitarios**
Trastorno mental de base Rasgos personales: - impulsividad - rigidez cognitiva - perfeccionismo … Intento de suicidio previo Adolescencia Edad avanzada Hombres: mayor letalidad Mujeres: más intentos autolíticos	Antecedentes familiares Ausencia de redes de apoyo	Prejuicios sobre la búsqueda de ayuda Exposición inadecuada de medios de comunicación de noticias relacionadas con la conducta suicida Estigma Cargos alta responsabilidad Falta de interacción social Jubilación Pérdida de empleo

2.2. FACTORES PRECIPITANTES

Los factores precipitantes hacen referencia a acontecimientos o situaciones que pueden provocar un aumento del estrés en un momento determinado y que pueden desencadenar en comportamientos suicidas (1,9,14). Tabla 2.

Tabla 2. Factores precipitantes de la conducta suicida. Elaboración propia.

Factores precipitantes de la conducta suicida
- Trastornos mentales inadecuadamente controlados - Problemas económicos, laborales o familiares - Fallecimientos de personas allegadas - Diagnóstico reciente de enfermedad - Maltrato físico o abuso sexual - Violencia de género - Acoso

2.3. FACTORES DE PROTECCIÓN

Los factores protectores para los comportamientos suicidas son características y herramientas que fortalecen ayudando a disminuir el riesgo de suicidio de una persona. Estos factores no eliminan la posibilidad de suicidio, pero su potenciación ayuda a prevenirlo (1,9,14). La capacidad con la que se hace frente a las adversidades de la vida o la habilidad para resolver problemas reduce la probabilidad de desesperanza. Se pueden clasificar por su relación con la persona y comunidad (tabla 3).

Tabla 3. Factores de protección de la conducta suicida. Elaboración propia.

Factores de protección de la conducta suicida	
Personales	**Comunitarios**
- Capacidad afrontamiento y resolución - Flexibilidad cognitiva - Confianza y autoestima - Autocontrol - Hábitos de vida saludables	- Dificultad en acceso a medio letales - Estabilidad relaciones personales - Redes de apoyo familiar y social - Accesibilidad a servicios de salud - Prácticas religiosas seguras - Adecuación de los medios de comunicación a la exposición de noticias relacionadas con el suicidio

3. INTERVENCIÓN DE ENFERMERÍA PARA EL ABORDAJE DE LA CONDUCTA SUICIDA

En España, la intervención sanitaria para la población con riesgo suicida se lleva a cabo desde los equipos de atención primaria, unidades de urgencia y específicamente en las unidades de las redes de salud mental (15). Desde estos servicios, el personal de enfermería desarrolla intervenciones concretas con los pacientes, como pueden ser la terapia cognitiva-conductual, terapia de resolución de problemas, intervenciones en supervivientes o intervención breve y de contacto. Este tipo de intervenciones realizadas por profesionales de enfermería son bien aceptadas por el paciente debido a la disponibilidad, accesibilidad y relación terapéutica enfermería-paciente (16).

Los pacientes con riesgo suicida presentan una alteración importante en sus patrones funcionales y/o necesidades básicas de salud. Centrando la mirada en el modelo de atención de necesidades de salud de Virginia Henderson, se encuentran diferentes necesidades alteradas como la de alimentación, higiene, sueño-descanso o comunicación, pero la necesidad fundamental que justifica en primer término la actividad de enfermería en el cuidado de estos pacientes. Es la novena necesidad descrita por Virginia Henderson *"evitar los peligros del entorno",* incluye la valoración de los conocimientos del paciente sobre los peligros del entorno y su correspondiente prevención e intervención (17).

En el modelo de Necesidades Básicas propuesto por Virginia Henderson, la agrupación de datos se realiza en base a las catorce necesidades descritas por la autora (18): respirar normalmente, comer y beber de forma adecuada, eliminar los desechos corporales, moverse y mantener una postura adecuada, dormir y descansar, elegir la ropa adecuada, mantener la temperatura corporal, mantener la higiene corporal, evitar los peligros del entorno, comunicarse con los otros, actuar con arreglo a la propia fe, trabajar para sentirse realizado, participar en diversas formas de entretenimiento y la última necesidad, aprender, descubrir o satisfacer la curiosidad 18).

En 1950, fruto de la necesidad de un instrumento que facilitara y estandarizara la calidad de la atención y la toma de decisiones en la práctica enfermera, surge el llamado "Proceso de Atención de Enfermería" (PAE). Los PAE son la expresión escrita de la aplicación del proceso enfermero y se configuran como el instrumento necesario para documentar y comunicar la situación del paciente, familia o comunidad, además de establecerse como el método científico

de los cuidadores profesionales (20). Está compuesto por una serie de etapas claramente definidas, ordenadas y jerarquizadas: Valoración, Diagnóstico, Planificación, Ejecución y Evaluación.

En esta línea, en 1982 se creó la North American Nursing Diagnosis Association (NANDA), dando lugar a la primera taxonomía de diagnósticos de enfermería (21). Posteriormente, en Iowa se desarrollarán dos organizaciones más de reconocido interés, la Clasificación de Intervenciones de Enfermería - NIC (Nursing Interventions Classication) y en 1991, la Clasificación de Resultados de Enfermería - NOC (Nursing Outcomes Classification) (22,23). Para esta tesis doctoral, se toma como referencia el diagnóstico de enfermería NANDA “Riesgo de suicidio”, que se define como: riesgo, por parte del paciente, de lesión autoinfligida que pone en peligro su vida.

OBJETIVOS

OBJETIVOS

La presente tesis doctoral tiene como objetivo general contribuir al conocimiento científico a través del análisis de las intervenciones de enfermería más eficaces para la prevención y el tratamiento de la conducta suicida.

Entre sus objetivos específicos, se pueden destacar:

- Analizar las estrategias de intervención de los profesionales de enfermería en la prevención y tratamiento de la conducta suicida.
- Desarrollar un protocolo de investigación para determinar intervenciones, desde una perspectiva enfermera, que puedan considerarse de elección para la prevención y el tratamiento de la conducta suicida.
- Determinar las intervenciones más eficaces para la prevención y el tratamiento de la conducta suicida.
- Identificar las intervenciones de la taxonomía Nursing Interventions Classifications eficaces para la prevención y tratamiento de la conducta suicida.
- Describir y comparar intervenciones descritas los planes de prevención del suicidio a nivel nacional.
- Analizar las recomendaciones para una difusión segura y responsable de la información relacionada con la conducta suicida.
- Establecer recomendaciones para la optimización y mejora de la intervención de enfermería en la prevención y cuidado de la conducta suicida.
- Desarrollar un marco teórico sólido que sirva de base para diseñar intervenciones innovadoras y personalizadas de prevención en conductas suicidas.

Específicamente, en cada artículo publicado, se han marcado unos objetivos clave que guíen la consecución global de la meta de esta tesis doctoral:

Artículo 1: Conducta suicida. Cuidados de enfermería para la prevención e intervención en crisis.

Objetivo: Analizar las estrategias de intervención de los profesionales de enfermería en pacientes con riesgo suicida en la Comunidad Autónoma de La Rioja, con el fin de establecer recomendaciones para la optimización y mejora de la intervención de estos profesionales en la prevención y cuidado de la conducta suicida en la comunidad autónoma.

Artículo 2: Nursing interventions of choice for the prevention and treatment of suicidal behaviour: The umbrella review protocol.

Objetivos: Determinar qué intervenciones, desde una perspectiva enfermera, pueden considerarse de elección para la prevención y el tratamiento de la conducta suicida. Identificar las intervenciones enfermeras de la taxonomía de la Clasificación de Intervenciones de Enfermería (NIC) con evidencia para este propósito.

Artículo 3: Health Plans for Suicide Prevention in Spain: A Descriptive Analysis of the Published Documents.

Objetivo: Describir y comparar las intervenciones descritas en los planes de prevención del suicidio en las diferentes provincias de España.

Artículo 4: Umbrella review of nursing interventions NIC for the treatment and prevention of suicidal behavior.

Objetivos: Determinar las intervenciones de enfermería más eficaces para la prevención y el tratamiento de la conducta suicida. Identificar las intervenciones de la taxonomía Nursing Interventions Classifications con evidencia para este fin.

Artículo 5: Interventions of choice for the prevention and treatment of suicidal behaviours: An umbrella review.

Objetivo: Determinar qué intervenciones pueden considerarse eficaces en la prevención y el tratamiento de la conducta suicida.

Artículo 6: Media Exposure of Suicidal Behaviour: An Umbrella Review.

Objetivo: Analizar las intervenciones recomendadas para la difusión segura y responsable de conductas suicidas en los medios de comunicación con fines preventivos.

METODOLOGÍA

METODOLOGÍA

Para el primer artículo, se realizó un estudio transversal en las unidades de la red de salud mental de La Rioja. Se diseñó un cuestionario con el objeto de recoger de forma semiestructurada variables que permitieran evaluar indicadores claves de la investigación. El cuestionario se estructuró en base a las intervenciones de enfermería identificadas en la *"Guía de buenas prácticas en enfermería. Valoración y cuidado de los adultos en riesgo de ideación y conducta suicida"* de la Registered Nurses' Association of Ontario – RNAO (24).

Los primeros ítems del cuestionario hacían referencia a edad, sexo, unidad de trabajo y experiencia profesional. El resto de los ítems a las intervenciones de los profesionales de enfermería en relación con la práctica clínica, la formación y a la organización.

El tratamiento de los datos y los cálculos estadísticos se realizaron con la versión 17.0 del programa informático SPSS STATISTICS para Windows. Para la interpretación de los resultados, se eligió un nivel de significación estadística de $p<0.05$ para un intervalo de confianza del 95%.

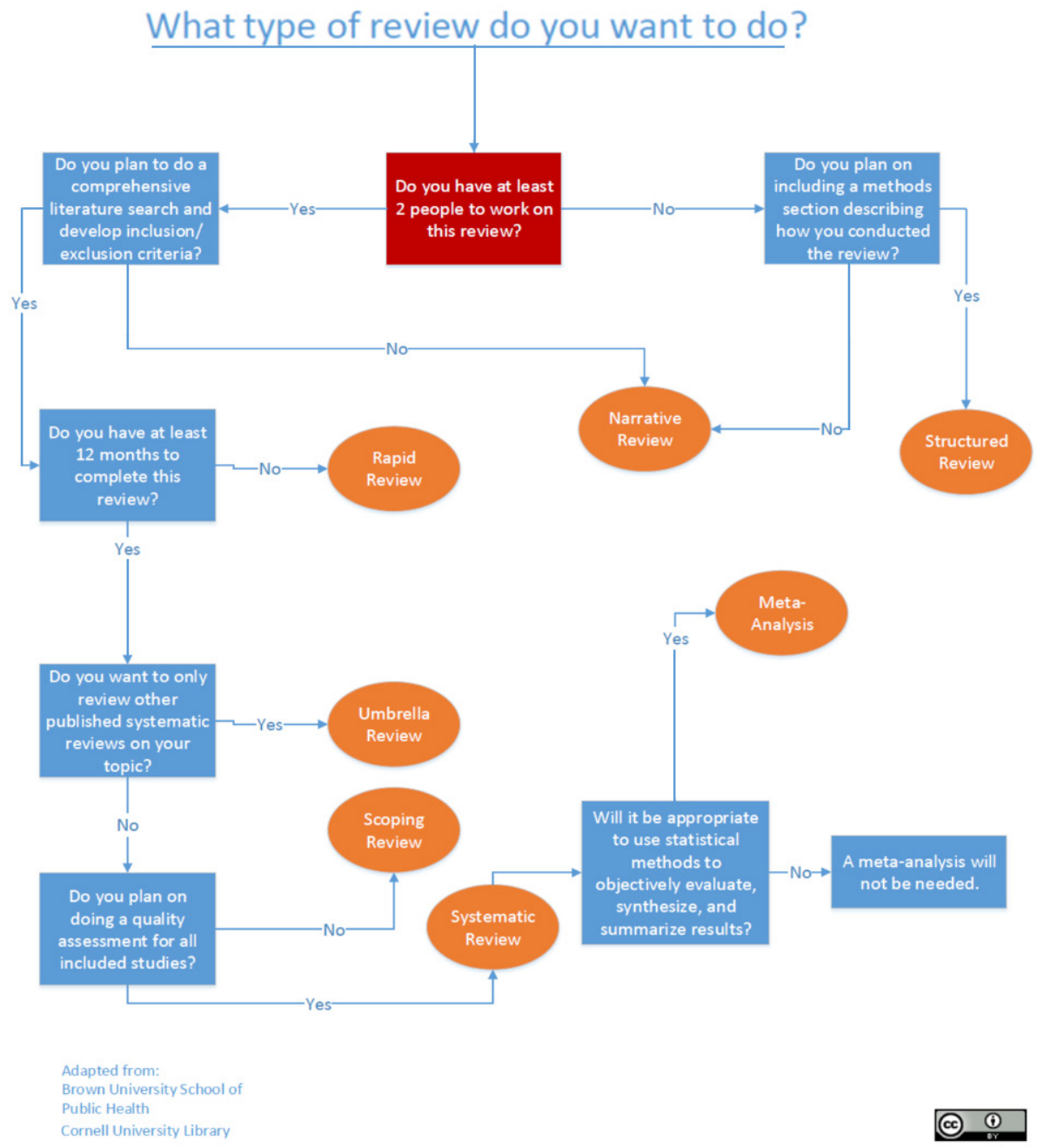
En el resto de los artículos incluidos en esta tesis doctoral se emplea la revisión sistemática como metodología de investigación. Específicamente, se empleó "umbrella review" debido a que aporta un enfoque útil para sintetizar y evaluar la evidencia acumulada en múltiples revisiones sistemáticas y metaanálisis sobre un tema de interés específico, en este caso, sobre la prevención y abordaje de las conductas suicidas. Esta "revisión de revisiones sistemáticas" se diseña para agrupar y analizar revisiones sistemáticas previas, lo que permite ofrece una visión más completa y generalizada del tema de estudio.

La necesidad de emplear esta metodología se fundamenta en obtener una comprensión global y actualizada de la evidencia disponible sobre la intervención de enfermería para la prevención y abordaje de las conductas suicidas (25). Conlleva un proceso de trabajo riguroso y ordenado, en el que cada etapa ha sido realiza cegada y paralelamente realizada por varios investigadores hasta confluir en determinadas fases de acuerdo o desacuerdo.

Los pasos clave y sintetizados para la realización de revisiones umbrella review tras la definición de la pregunta de investigación comprenderían, en primer lugar, la búsqueda exhaustiva en bases de datos de las revisiones sistemáticas que abordan el tema de interés y la selección según criterios de inclusión y exclusión. A continuación, se analiza la calidad de las revisiones sistemáticas a través de herramientas estandarizadas y posteriormente se extraen la información clave de cada revisión sistemática seleccionada. Para la definición de la síntesis de la evidencia, se exponen y comparan los resultados y conclusiones de las revisiones sistemáticas, proceso seguido de la interpretación de resultados y determinación de las conclusiones en base a la fuerza y consistencia de la evidencia. Para finalizar, se identifican las áreas de mejora que precisan mayor investigación o diferentes metodologías y diseños.

En resumen, la metodología umbrella review ha proporcionado un enfoque de síntesis de evidencia que ha promovido una perspectiva más integral para abordar la prevención y abordaje de las conductas suicidas.

Imagen 1. ¿Qué tipo de revisión realizar?



Extraído de Indiana University School of Medicine (26).

PUBLICACIONES

ARTÍCULO 1

CONDUCTA SUICIDA. CUIDADOS DE ENFERMERÍA EN LA PREVENCIÓN E INTERVENCIÓN EN CRISIS

Año de publicación	2020
Revista	Presencia. Revista Internacional de Salud Mental, Investigación y Humanidades.
Indexación	CUIDEN, en la Hemeroteca CANTARIDA y en el fondo de revistas a texto completo SUMMA CUIDEN, en los directorios MIAR y DIALNET
Autores	Teresa Sufrate Sorzano Iván Santolalla Arnedo Félix Rivera Sanz Carmen Amaia Ramírez Torres

PRESENCIA
REVISTA INTERNACIONAL DE SALUD MENTAL, INVESTIGACIÓN Y HUMANIDADES
CIBERINDEX CANTARIDA

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Conducta suicida. Cuidados de enfermería para la prevención e intervención en crisis

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Resumen
Objetivo. El acto suicida viene determinado por una compleja interacción de factores que suponen un riesgo, así como factores protectores y escenarios predisponentes que pueden precipitar a una conducta suicida. El suicidio conforma un problema de salud pública en las sociedades occidentalizadas a nivel mundial y por lo que, los cuidados de salud profesionales deben ser orientados hacia la prevención e intervención en crisis. Por lo expuesto, el objetivo de este trabajo es analizar las estrategias de intervención de los profesionales de enfermería en pacientes con riesgo suicida en la Comunidad Autónoma de La Rioja. Metodología. El trabajo de investigación se fundamenta en un estudio transversal que tiene por finalidad el análisis de las estrategias de intervención de los profesionales de enfermería, en pacientes con riesgo suicida en la Comunidad Autónoma de La Rioja. Se diseñó un cuestionario con el objeto de recoger de forma semiestructurada variables que permitieran evaluar indicadores claves de la investigación. El cuestionario se estructura en base a las intervenciones de enfermería identificadas en guías de práctica clínica enfermera. Resultados. Se muestra interés significativo por parte de enfermería por esta problemática de salud pública, los participantes señalan capacidad para establecer relaciones terapéuticas, valorar las necesidades del paciente, ofrecer asistencia sanitaria, movilizar recursos y en la observación y seguimiento de estos pacientes. Por el contrario refieren carencias en la detección, tanto de los factores de riesgo como de los factores de protección vinculados a estas conductas, en el apoyo emocional, control de impulsos y en la ayuda al afrontamiento. Conclusiones. Se evidencia un interés significativo desde enfermería por esta problemática de salud pública, apreciándose carencias interventivas para ofrecer unos cuidados de calidad al paciente con riesgo suicida. Estas carencias son susceptibles de mejora mediante formación.
Palabras clave: Suicidio. Enfermería. Intervenciones. Prevención.

Suicidal behavior. Nursing care for prevention and intervention in crisis

Abstract
Aim. The suicidal act is determined by a complex interaction of protective and risk factors, which conditionate suicidal behavior. Suicide is a public health problem at global level in western societies. Under those circumstances, health professional must to be focus on prevention and intervention actions. Therefore, the main aim of this study was the evaluation of interventional nursing procedures with patients on suicide risk in La Rioja region. Methodology. The research work is based on a cross-sectional study whose purpose is to analyze of interventional nursing procedures with patients on suicide risk in La Rioja region. A semi structured questionnaire was designed to collect answer to evaluate indicators. The questionnaire is structured based on the nursing interventions identified in the nursing clinical practice guidelines. Results. A significant interest is shown by the nursing part in this public health issue, the parcipants point out the ability to establish therapeutical relationships, to value the patient needs, to offer health assistance, to mobilize the resources and the observations and constant update on these patients. On the contrary, they refer deficiencies in the detection of the risk factors as well as the protection factors linked to these impulses and tge help given to copy with it. Conclusions. There is a significant interest from nursing in this troublesome public health, appreciating interventional deficiencies to offer quality care to the patient with suicidal risk. These deficiencies are susceptible to improvement through formation and training.
Key-words: Suicide. Nursing. Interventions. Prevention.

Introducción

El suicidio se configura como un problema de salud pública cuya prevención debe ser priorizada en las políticas y programas de salud desarrollados a nivel mundial.[1] La Organización Mundial de la Salud (OMS) estima que cerca de 800.000 personas se suicidan cada año y que, por cada una de estas muertes, se llevan a cabo 20 intentos.[2] Los intentos de suicidio son reiterados al cabo de un año entre un 15%-30% y cerca de un 2% consuman el suicidio entre los 5 y 10 años posteriores,[3]

configurándose así el intento previo como el factor de riesgo individual más relevante.[4]

El acto suicida viene determinado por una compleja interacción de factores que suponen un riesgo para desarrollar conductas letales, factores protectores que aportan seguridad para el mantenimiento de la vida y circunstancias predisponentes que pueden precipitar a una conducta suicida.[5] Es por ello que la intervención profesional debe ser orientada a la potenciación de factores protectores[6] *(cohesión con el grupo, resiliencia, restricción al acceso de métodos letales),* a la erradicación de factores de riesgo[7] *(intento de suicidio previo, existencia de trastornos mentales, consumo de alcohol)* y al correcto manejo de las situaciones precipitantes[6] *(empeoramiento de enfermedades, pérdida de seres queridos, soledad)*.

En relación con la epidemiología, a nivel internacional, los países con mayores tasas de suicidio son Lituania, Corea del Sur y Eslovenia, mientras que Grecia, Turquía y Sudáfrica cierran la lista con tasas inferiores a 4.5 muertes por cada 100.000 habitantes.[8] En España, durante 2017 se produjeron 3.679 suicidios (110 fallecimientos más que en el año anterior) consolidándose, así como una tendencia en aumento desde el año 2014.[9] Las mayores tasas de suicidio por habitantes y comunidad autónoma se producen en Asturias, Galicia y Canarias, en contraposición Cantabria, Ceuta y Melilla registran las menores tasas. La Rioja presenta una tasa de suicidio del 7.60 por 100.000 habitantes, muy próxima a la del índice nacional. En dicha comunidad, se produjeron 25 muertes por suicidio en 2017 y respecto a los medios empleados, al igual que ocurre a nivel nacional e internacional, el ahorcamiento y la precipitación son los métodos mayormente seleccionados.[8]

La intervención sanitaria para la población con riesgo suicida se lleva a cabo desde atención primaria, unidades de urgencia y específicamente en las unidades de las redes de salud mental, desde donde enfermería desarrolla intervenciones concretas sobre estos pacientes, como son terapia cognitiva-conductual, terapia de resolución de problemas, intervenciones en supervivientes, terapia interpersonal, contacto, seguimiento o técnicas de intervención en crisis, entre otras. Se ha demostrado que este tipo de intervenciones realizadas por enfermería son más eficaces y aceptadas por el paciente debido a la disponibilidad y accesibilidad de la atención en comparación con intervenciones dirigidas por psiquiatras debido al estigma asociado a estos facultativos.[10]

La actividad enfermera en relación con la intervención y prevención de conductas suicidas quedaría circunscrita en la novena necesidad descrita por Virginia Henderson en el modelo de "Necesidades Básicas": Evitar los peligros del entorno, que incluye la valoración de los conocimientos del paciente sobre los peligros del entorno y su correspondiente prevención.[11] Tomando como referencia la existencia del diagnóstico de enfermería "Riesgo de suicidio", entre otros posibles, las intervenciones NIC (Nursing Interventions Classification) a desarrollar podrían ser: 4420- Acuerdo con el paciente, 5330– Control del humor, 6160– Intervención en caso de crisis y 6340– Prevención del suicidio.[12]

Por todo lo expuesto, el objetivo de este estudio es analizar las estrategias de intervención de los profesionales de enfermería en pacientes con riesgo suicida en la Comunidad Autónoma de La Rioja, con el fin de establecer recomendaciones para la optimización y mejora de la intervención de estos profesionales en la prevención y cuidado de la conducta suicida en la comunidad autónoma.

Metodología

El trabajo de investigación se fundamenta en un estudio transversal realizado en las unidades de la Red de Salud Mental del Servicio Riojano de Salud, unidades donde se precisa con mayor frecuencia la intervención enfermera ante el riesgo y la conducta suicida. La Red de Salud Mental del Servicio Riojano de Salud se compone de Unidades de Salud Mental (USM) ubicadas en distintos Centros de Salud de Atención Primaria de La Rioja; Unidad de Salud Mental Infanto-Juvenil; Hospital de Día (HD), Unidad de hospitalización parcial; Unidad de Día Infanto-Juvenil; Unidad de Rehabilitación Psicosocial de Área (URA) y la unidad especializada en la rehabilitación psicosocial de pacientes afectos de Trastorno Mental Grave (TMG); completan la Red las Unidades de Hospitalización, Unidad de Corta Estancia (UCE), Unidad de Media Estancia (UME) y la Unidad de Larga Estancia (ULE). Como objetivos de la intervención de enfermería en estas unidades señalar la estabilización; la mejoría psicopatológica y conductual del paciente; la rehabilitación de la autonomía y las discapacidades, con mejora de habilidades y de autocuidado; evitar la institucionalización de personas que pertenezcan a grupos de riesgo; la externalización de pacientes con capacidad de integración en la comunidad; la coordinación con el entorno socio–comunitario y con el resto de dispositivos de la Red de Salud Mental; y el desarrollo de líneas de formación e investigación.[13]

Se diseñó un cuestionario, "Cuestionario Evaluación Intervención Enfermería Prevención Riesgo y Conducta Suicida 2018", con el objeto de recoger de forma semiestructurada variables que permitieran evaluar indicadores claves de la investigación. El cuestionario se estructura en base a las intervenciones de enfermería identificadas en guías de práctica clínica enfermera.[14] Los primeros ítems del cuestionario hacen referencia a edad, sexo, unidad de trabajo y experiencia profesional. El resto de las cuestiones hacen referencia a las intervenciones enfermeras en relación con la práctica clínica, la formación y a la organización. El cuestionario preserva en todo momento el anonimato de encuestado.

Los sujetos del estudio fueron enfermeras pertenecientes a las unidades indicadas que se encontraban en activo en el momento del periodo a estudio. La participación fue voluntaria y la cumplimentación del cuestionario anónima. Los sujetos a estudio, previamente a su participación en el mismo, fueron informados de los objetivos del estudio y la metodología, firmando el consentimiento informado especifico. Con el objeto de garantizar el juicio experto de los participantes, la selección se realizó en función de su experiencia y conocimiento mediante un filtrado para adecuar su idoneidad, tomando como base los criterios de selección propuestos por Skjong y Wentworht:[15] experiencia profesional, reputación en la comunidad, conocimiento relativo al estudio y participación previa en estudios de este ámbito. Para participar en el estudio se aseguró que el experto al menos obtuviera puntuación en al menos 3 de las 4 fuentes de argumentación. De entre los profesionales que cumplían los criterios de adhesión al estudio la tasa de respuesta global fue del 88,69%.

Los datos fueron codificados y grabados en formato informático. El tratamiento de los datos y los cálculos estadísticos se realizaron con la versión 17.0 del programa informático

SPSS STATISTICS para Windows. Para la interpretación de los resultados, se eligió un nivel de significación estadística de $p<0.05$ para un intervalo de confianza del 95%.

Resultados

El 93,4% de la muestra refiere considerar seriamente las afirmaciones de los pacientes cuando refieren deseos de muerte (tabla 1). No se encuentran diferencias significativas por edad, por antigüedad, o por unidad.

Tabla 1. *Como enfermera, te tomas seriamente cualquier afirmación realizada por un paciente que indique, sea directa o indirectamente, sus deseos de morir suicidándose, y/o toda información disponible que indique riesgo de suicidio*

	Frecuencia	Porcentaje	Porcentaje acumulado
SIEMPRE	23	50	50
CON FRECUENCIA	20	43,4	93,4
A VECES	3	6,6	100
Total	46	100	

El 87% de la muestra refiere establecer "siempre" o "con frecuencia" una relación terapéutica con los pacientes en riesgo de comportamiento e ideación suicida (tabla 2). No se encuentran diferencias significativas por edad, antigüedad o unidad.

Tabla 2. *Como enfermera, trabajas para establecer una relación terapéutica con los pacientes en riesgo de comportamiento e ideación suicida*

	Frecuencia	Porcentaje	Porcentaje acumulado
SIEMPRE	18	39,2	39,2
CON FRECUENCIA	22	47,8	87
A VECES	6	13	100
Total	46	100	

En relación con el apoyo emocional (NIC 5270), solo el 16,4% de los entrevistados puntúan alto en esta intervención. No se encuentran diferencias significativas por edad, antigüedad o unidad; a pesar de ello las puntuaciones más altas en esta intervención se desarrolla en las Unidades de Salud Mental.

En relación con la detección de factores de riesgo, solo el 19,5 % de los entrevistados refieren reconocer estos factores; y un 76% de la muestra refiere no reconocerlos "nunca" o "casi nunca" (tabla 3). No se encuentran diferencias significativas por edad o antigüedad. En dependencia con la unidad donde se desarrolla la intervención, se encontró una relación estadísticamente significativa (p=0,007), siendo las Unidades de Salud Mental, la Unidad de Rehabilitación y el Hospital de Día donde más se reconocen estos factores.

Tabla 3. *Como enfermera, reconoces los factores de riesgo de comportamiento suicida*

	Frecuencia	Porcentaje	Porcentaje acumulado
CON FRECUENCIA	9	19,5	19,5
A VECES	2	4,5	24
CASI NUNCA	3	6,5	30,5
NUNCA	32	69,5	100
Total	46	100	

Respecto a la valoración de la ideación suicida, la elaboración del plan de cuidados y su registro, solo el 19,6% de los entrevistados puntúan alto en esta variable. No se encuentran diferencias significativas por edad o antigüedad. En relación con la unidad donde se desarrolla la intervención, se encontró una relación estadísticamente significativa (p=0,018), siendo las Unidades de Salud Mental, la Unidad de Rehabilitación y el Hospital de Día donde más se trabaja la valoración, el plan de cuidados y el registro específico.

En relación con la detección de factores de protección, solo el 17,3 % de los entrevistados refieren reconocer estos factores; un 78,2% de la muestra refiere no reconocerlos "nunca" o "casi nunca" (tabla 4). No se encuentran diferencias significativas por edad o antigüedad. En relación con la unidad donde se desarrolla la intervención, se encontró una relación estadísticamente significativa (p=0,03), siendo las Unidades de Salud Mental, la Unidad de Rehabilitación y el Hospital de Día donde más se reconocen estos factores protectores.

Tabla 4. *Como enfermera, reconoces los factores protectores asociados con la prevención del suicidio*

	Frecuencia	Porcentaje	Porcentaje acumulado
CON FRECUENCIA	8	17,3	17,3
A VECES	2	4,5	21,8
CASI NUNCA	4	8,7	30,5
NUNCA	32	69,5	100
Total	46	100	

Respecto a obtener información colateral de fuentes disponibles, un 89,2% de los entrevistados se identifican activos en esta intervención, un 23,9% la desarrollan "siempre" o "con frecuencia" (tabla 5). No se encuentran diferencias significativas por edad, antigüedad o unidad.

Tabla 5. *Como enfermera, obtienes información colateral de las fuentes disponibles: familia, amigos, soportes comunitarios, historial médico y profesionales de la salud mental*

	Frecuencia	Porcentaje	Porcentaje acumulado
SIEMPRE	5	10,8	10,8
CON FRECUENCIA	6	13,1	23,9
A VECES	30	65,3	89,2
CASI NUNCA	5	10,8	100
Total	46	100	

Respecto a movilizar recursos sanitarios y sociales, un 58,8% de los entrevistados identifican esta intervención como de desarrollo propio. No se encuentran diferencias significativas por edad, antigüedad o unidad.

En relación con la observación y seguimiento, un 95,7% de los entrevistados se identifican como agentes activos. No se encuentran diferencias significativas por edad, antigüedad o unidad (tabla 6).

Tabla 6. *Como enfermera, eres agente activo de la observación y seguimiento del paciente*

	Frecuencia	Porcentaje	Porcentaje acumulado
SIEMPRE	20	43,5	43,5
CON FRECUENCIA	20	43,5	87
A VECES	4	8,7	95,7
CASI NUNCA	2	4,3	100
Total	46	100	

Respecto a participar como agente activo en la comprensión del paciente y valoración de necesidades, un 100% de los entrevistados se identifican activos en esta intervención, un 60,8% la desarrollan "siempre" o "con frecuencia". No se encuentran diferencias estadísticamente significativas por

edad, antigüedad o unidad; pero se puede observar mayores porcentajes interventivos conforme aumenta la antigüedad (tabla 7).

Tabla 7. *Como enfermera, eres agente activo en la comprensión del paciente y valoración de sus necesidades*

	Frecuencia	Porcentaje	Porcentaje acumulado
SIEMPRE	2	4,3	4,3
CON FRECUENCIA	26	56,5	60,8
A VECES	18	39,2	100
Total	46	100	

En relación con la ayuda al afrontamiento (NIC 5230) y al apoyo en la toma de decisiones (NIC 5250), solo el 7,8% de los entrevistados puntúan alto en estas intervenciones. En relación con la edad, se encontró una relación estadísticamente significativa (p=0,0015), siendo las profesionales de mayor edad y antigüedad los que más puntúan en estas intervenciones. No se evidencian diferencias significativas por unidad.

En relación con la edad, se encontró una relación estadísticamente significativa (p=0,004), siendo las profesionales de mayor edad los que refieren estar más al día de los tratamientos actuales en relación con la intervención de riesgo suicida. No se evidencian diferencias en esta variable por antigüedad o unidad.

En el caso de la intervención psicológica breve debriefing, más del 90% del personal de enfermería, sin diferencia entre unidades o antigüedad, muestra que no participa junto con otros profesionales del equipo de salud en el proceso (tabla 8). En relación con la edad, se encontró una relación estadísticamente significativa (p=0,02), siendo las profesionales de mayor edad los que refieren tener mas participación en este tipo de intervenciones.

Tabla 8. *Como enfermera, participas en el proceso de intervención psicológica breve "debriefing" con otros profesionales del equipo de salud*

	Frecuencia	Porcentaje	Porcentaje acumulado
A VECES	4	8,7	8,7
CASI NUNCA	5	10,9	19,6
NUNCA	37	80,4	100
Total	46	100	

A razón de la participación enfermera en grupos de trabajo, foros de profesionales, sesiones clínicas o reuniones de equipo, un 45,1% de los contribuyentes refieren participar "a veces", mientras que otro 45,1% refiere no participar "nunca" o "casi nunca". En función de la edad, con significación estadística (p=0,002), el grupo de enfermería que recoge los 20-30 años es el que refiere casi nunca participar. El grupo de 61-70 años manifiesta que intervienen con frecuencia. No se evidencian significaciones en función con la antigüedad o unidad.

Un 73% de la muestra refleja que "casi nunca" llevan a cabo intervenciones especificas de apoyo emocional (NIC 5270) en este grupo de pacientes. Hay que destacar, con diferenciación estadística (p=0,000) que el grupo de mayor edad en su totalidad sí que refiere realizar este tipo de intervenciones con el paciente.

Respecto al desarrollo de intervenciones con el fin de disminuir la ansiedad (NIC 5820), más de un 80% de los participantes manifiestan que no realizan mediaciones, siendo este hecho más prevalente en el grupo de enfermería más joven, con una significación estadística (p=0,000). Se observa en la muestra que esta intervención está más presente en unidades de URA y HD.

En un 73,9% de la muestra, refleja que se llevan a cabo intervenciones para el manejo de la patología mental de base "siempre" o "casi siempre" (tabla 9). No se evidencia significaciones por edad o unidad. Se observan diferencias significativas por antigüedad (p=0,03), siendo los profesionales de mayor antigüedad los que más refieren participar de estas intervenciones.

Tabla 9. *Como enfermera, desarrollas intervención de manejo de la enfermedad psiquiátrica de base (alteración del humor, alucinaciones, delirios, pánico, trastorno personalidad,) con objeto de prevenir la conducta suicida (6340)*

	Frecuencia	Porcentaje	Porcentaje acumulado
SIEMPRE	23	50	50
CON FRECUENCIA	11	23,9	73,9
A VECES	7	15,2	89,1
CASI NUNCA	5	10,9	100
Total	46	100	

En el caso de intervenciones en casos de crisis (NIC 6160) para el manejo de la conducta de autolesión (4354), el 80,5% de los encuestados afirma realizarlas "siempre" o "casi siempre" (tabla 10), sin diferencia entre unidades, edad, ni antigüedad.

Tabla 10. *Como enfermera, desarrollas intervenciones en caso de crisis (6160), manejo de la conducta de autolesión (4354)*

	Frecuencia	Porcentaje	Porcentaje acumulado
SIEMPRE	17	37	37
CON FRECUENCIA	20	43,5	80,5
A VECES	7	15,2	95,7
CASI NUNCA	2	4,3	100
Total	46	100	

En el entrenamiento para el control de impulsos (NIC 4370), el 78% de los encuestados refieren no desarrollar estas intervenciones "nunca" o "casi nunca". Existen diferencias significativas por unidad (p=0,04), siendo el HD y la URA donde mas se evidencia esta intervención; así mismo se evidencia significación estadística (p=0,01) por edad del profesional, siendo los profesionales de mayor edad los que más participan en esta intervención.

En relación con la intervención de manejo ambiental (NIC 6486), un 81% de los entrevistados se identifican como agentes activos en esta intervención. En relación con la antigüedad, se encontró una relación estadísticamente significativa (p=0,01), siendo las profesionales de mayor antigüedad los que más puntúan en estas intervenciones. No se evidencian diferencias significativas por edad o unidad.

En relación con la formación recibida por los profesionales en relación con la intervención y manejo del paciente con riesgo de suicidio y/o conductas suicidas, el 100% de los profesionales entrevistados refieren no haber recibido formación continuada o de postgrado relativa a estos contenidos; y solo el 4% de los profesionales refieren haber contado con contenidos formativos relacionados en su formación de pregrado universitaria.

Un 43% de los participantes tienen la formación en especialistas en salud mental. Con significación estadística (p=0,001), en función de la antigüedad laboral, los profesionales con una

experiencia superior a 16 años conforman el 83% de este groso de enfermería especialista.

En relación con la dotación de recursos humanos el 51% de los entrevistados valora de "inadecuado" la dotación existente. Se evidencian diferencias significativas por unidad (p=0,000), siendo la UME y la ULE donde mayor percepción de problemas de personal se refieren.

Los resultados respecto al apoyo que ofrece la organización en las investigaciones relacionadas con el suicidio y la salud mental, un 61,8% lo califica de "inadecuado" o "muy inadecuado", sin evidenciar significación estadística en función de la edad, la antigüedad o la unidad de procedencia.

En relación con la existencia de un plan específico de intervención ante la conducta suicida el 100% de los profesionales refieren su inexistencia; así como de una comisión comunitaria para la prevención de la conducta suicida y de las plazas de especialistas en enfermería de salud mental.

Discusión

Tras el estudio realizado y en lo que respecta a la percepción de los profesionales de enfermería respecto a la intervención enfermera en pacientes con riesgo suicida en nuestra comunidad autónoma, la respuesta de los participantes en el estudio muestra interés significativo por parte de enfermería por esta problemática de salud pública, y una absoluta consideración de necesidad de cuidados cuando los pacientes expresan riesgo en relación con estas conductas. Los profesionales muestran capacidad para establecer relaciones terapéuticas con los pacientes en riesgo de comportamiento e ideación suicida; así como se muestran agentes activos a la hora de valorar las necesidades del paciente, obtener información colateral de fuentes disponibles para mejorar la comprensión y la asistencia sanitaria del paciente, agentes activos en la movilización de recursos sanitarios precisos, y en la observación y seguimiento de estos pacientes. Este interés descrito por los profesionales y la necesidad de intervención mediante relaciones terapéuticas se evidencia en distintos estudios como el de Schwartz-Lifshitz,[16] Witt[17] y Batterham.[18] El riesgo suicida se relaciona prevalentemente con patología mental de base, la depresión y los trastornos afectivos son patologías que aparecen en la literatura relacionadas con un riesgo superior a la población general.[18-21] Como refiere Arensman[19] en un estudio realizado en el año 2015 y en línea a lo descrito en los resultados, la intervención de los profesionales en el manejo de estas patologías, alteraciones del humor, alucinaciones, delirios, trastorno personalidad, incide en la prevención de la conducta suicida; los profesionales de enfermería del estudio refieren intervenir con frecuencia en las descompensaciones y crisis conductuales derivadas de la patología de base, y se consideran agentes activos principales en el manejo ambiental. La antigüedad en el puesto se evidencia como una variable que favorece tanto la intervención en el manejo de estas patologías de base como en el manejo ambiental.

Existe evidencia descrita por diferentes autores[16-22] que relaciona la conducta suicida tanto con factores de riesgo como con factores de protección de esta. En nuestro estudio los profesionales refieren carencias en la detección, tanto de los factores de riesgo como de los factores de protección vinculados a estas conductas. Las Unidades de Salud Mental, la Unidad de Rehabilitación Psicosocial y el Hospital de Día, son las unidades donde más se interviene sobre estos factores, en contraposición a las unidades de hospitalización completa donde más dificultad existe para la detección de estos e intervención a este nivel por parte de los profesionales de enfermería.

Los resultados del estudio, en la línea de las necesidades señaladas por Schwartz-Lifshitz,[16] Naohiro[22] y Niederkrotenthaler,[23] reflejan una escasa intervención por parte de los profesionales a nivel emocional, así como en el entrenamiento para el control de impulsos, las Unidades de Salud Mental son las que más refieren intervenir a nivel emocional con estos pacientes, y el Hospital de Día y la Unidad de Rehabilitación las que más trabajan a nivel de control de impulsos. Son estas tres unidades las que refieren realizar en mayor porcentaje intervenciones de valoración de la ideación suicida, así como elaborar planes de cuidados específicos y registro; a pesar de ello este tipo de intervenciones de valoración, planificación y registro específico son muy reducidas. Los profesionales refieren como muy limitadas las intervenciones relativas al apoyo en la toma de decisiones, ayuda al afrontamiento, en la intervención psicológica breve debriefing e intervenciones para reducir la ansiedad que acompaña a estos pacientes; en el caso de este grupo de intervenciones, la edad del profesional y la antigüedad en el puesto de trabajo son variables relacionadas con un mayor nivel interventivo.

Los profesionales de enfermería refieren una importante falta de contenidos formativos, tanto en el pregrado universitario, como en formación continuada y de postgrado, en lo que respecta a formación que facilite la intervención y manejo del riesgo de conductas suicidas. Esta percepción es compartida por los profesionales, con indiferencia de la edad y del itinerario formativo. En diferentes estudios de investigación se denota la importancia de la formación y actualización de los profesionales, la protocolización de programas de intervención y la capacitación en intervenciones basadas en la evidencia que resultan efectivas en la prevención e intervención sobre estas conductas de riesgo.[18-24] En los resultados obtenidos se señala una falta de actualización, escasa participación en grupos de trabajo, foros profesionales y sesiones clínicas, especialmente los profesionales de menor edad; así como carencias formativas para el desarrollo de intervenciones basadas en la evidencia presente, los profesionales con mayor antigüedad suplen en parte, esta falta formativa, con la experiencia.

A nivel institucional, se refieren mayores problemas en la dotación de recursos humanos que en recursos materiales, especialmente en las unidades de hospitalización completa, Unidad de Media Estancia y Larga Estancia. Con relación a la existencia de un plan específico de intervención ante el suicidio, los profesionales refieren su inexistencia; así como de una comisión comunitaria para la prevención de la conducta y de plazas de especialistas en enfermería de salud mental. Se refiere, así mismo, escaso apoyo a la investigación relacionada con esta problemática.

Las limitaciones de este estudio se encuentran relacionadas con la participación voluntaria, puesto que, es posible que desconocer la opinión de los no participantes influya en los resultados.

Conclusiones

Tras el análisis de las estrategias de intervención de los profesionales de enfermería en pacientes con riesgo suicida en la

Comunidad Autónoma de La Rioja, podemos constatar que existe un interés significativo y preocupación por parte de los profesionales de la salud y en particular por los profesionales de enfermería, por la prevención e intervención sobre la conducta suicida; ante esta problemática de salud pública, se evidencia una absoluta consideración de necesidad de cuidados. Ante las diferentes opciones terapéuticas descritas en la evidencia científica y las recogidas en diferentes guías de intervención clínica, en relación a la prevención e intervención ante la conducta suicida, se aprecian carencias interventivas en las percepciones de los profesionales de enfermería, para ofrecer unos cuidados de calidad al paciente con riesgo suicida, tanto a nivel comunitario desde las Unidades de Salud Mental, como desde las unidades de hospitalización y rehabilitación. Estas carencias son susceptibles de mejora mediante la formación en los itinerarios formativos del grado universitario de enfermería, especialización y formación de postgrado y continuada. Asimismo mediante la implantación de guías basadas en la evidencia y el establecimiento de medidas autonómicas y nacionales a través de planes de intervención destinados a la prevención de este grave problema de salud pública. Fomentar un conocimiento enfermero basado en la evidencia científica es la base para una adecuada intervención preventiva, manejo y cuidado del paciente en riesgo suicida, generando competencias e intervenciones profesionales de calidad en pro de la salud del paciente.

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Letters, green cards, telephone calls and postcards: systematic and meta-analytic review of brief contact interventions for reducing self-harm, suicide attempts and suicide. British Journal of Psychiatry Mar 2015;206(3):184-190.

ARTÍCULO 2

NURSING INTERVENTIONS OF CHOICE FOR THE PREVENTION AND TREATMENT OF SUICIDAL BEHAVIOUR: THE UMBRELLA REVIEW PROTOCOL

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STUDY PROTOCOL

Nursing interventions of choice for the prevention and treatment of suicidal behaviour: The umbrella review protocol

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Abstract

Aim: To determine which interventions, from a nursing perspective, can be considered as the interventions of choice for the prevention and treatment of suicidal behaviour. In this way, the umbrella review attempts to identify nursing interventions from the Nursing Interventions Classification (NIC) taxonomy with evidence for this purpose.

Design: Descriptive study protocol.

Methods: This umbrella review will consist of an extensive, systematic search of published systematic reviews and meta-analyses of studies examining interventions of choice for the prevention and treatment of suicidal behaviour. A systematic search of papers indexed in PubMed, CINAHL, Cochrane Database of Systematic Reviews, Scopus, ISI Web of Knowledge and the Joanna Briggs Institute databases will be carried out; the results will be evaluated for inclusion by two independent reviewers. In addition, the bibliographic references of the included reviews will be searched. The assessment of the methodological quality of the included systematic reviews and meta-analyses, and data extraction, will be performed by two independent

PROSPERO registration number. CRD42020221516.

reviewers. Conflicts between reviewers will be resolved by an independent third reviewer. Research Ethics Committee approval is not required for this umbrella review.
Results: We will determine which of the interventions identified as being of choice in the review are included in the Nursing Interventions Classification (NIC); they may be an effective therapeutic tool for nurses in the prevention and treatment of suicidal behaviour.

KEYWORDS
Attempted suicide, Risk factors, Risk reduction behavior, Suicidal Ideation, Suicide

1 | INTRODUCTION

Suicidal behaviour is determined by a complex interplay of factors that pose a risk for the development of lethal behaviour; protective factors that provide life-sustaining safety; and predisposing circumstances that may precipitate suicidal behaviour (Anseán, 2014). Therefore, professional intervention should be oriented towards the enhancement of protective factors (group cohesion, resilience and restriction of access to lethal methods) (Anseán, 2014); the eradication or control of risk factors (previous suicide attempts, existence of mental disorders and alcohol consumption) (World Health Organization, 2014); and the correct management of precipitating situations (worsening of illnesses, loss of loved ones and loneliness) (Anseán, 2014).

Nowadays, suicide is a public health issue for which prevention and treatment must be prioritized by politicians and in health programmes developed worldwide (World Health Organization, 2014). The Pan American Health Organization, PAHO (2017) estimates that almost 800,000 people commit suicide every year worldwide, and for every one of these suicides, it is estimated that there are 20 suicide attempts, so we can estimate that there are more than 16 million suicide attempts every year worldwide. Suicide attempts are repeated by 15%–30% of patients in 1 year, and almost 2% end up committing suicide in 5–10 years of their initial suicide attempt (Cano et Al., 2009); the initial suicide attempt is therefore the most relevant risk factor (World Health Organization, 2020).

Internationally, the countries with the highest suicide rates are Lithuania, South Korea and Slovenia; while Greece, Turkey and South Africa appear at the bottom of the list with rates below 4 deaths per 100,000 inhabitants (Spanish Foundation for Suicide Prevention, 2020). In Spain, more than 3,500 people commit suicide every year, and this has been on an upward trend since 2014 (National Institute of Statistics, 2020). The highest suicide rates per inhabitant and autonomous community are in Asturias, Galicia and Murcia; while Cantabria, Ceuta and Melilla have the lowest rates. Both nationally and internationally, hanging and jumping from a height are the most commonly selected methods (Spanish Foundation for suicide prevention, 2020).

A recent systematic review with meta-analysis aimed at evaluating the effect of suicide prevention interventions concludes that they are effective in preventing both completed suicide and suicide attempts. Among the interventions analysed were gatekeeper, health education, counselling, telephone follow-up and cognitive behavioural therapy (Hofstra et al., 2020).

Several published reviews aimed at studying interventions for the prevention and treatment of suicidal thoughts and behaviour point to the effectiveness of multilevel intervention in adults, with statistically significant results in reducing suicidal thoughts and repetition of behaviour (Briggs et al., 2019; Büscher et al., 2020; Gøtzsche et al., 2017; Larsen et al., 2016; Melia et al., 2020). Riblet et al. (2017), in a review of 78 studies, conclude that the WHO's brief contact intervention is a promising suicide prevention strategy; interventions, such as telephone follow-ups, training, group therapy, pharmacological administration of Lithium, education and counselling and cognitive behavioural therapy reduced deaths by suicide. Cognitive behavioural therapy is shown to be more effective compared with other treatments in reducing the risk of new suicide attempts (Gøtzsche et al., 2017; Lai et al., 2014). Several studies of this multilevel intervention point to cognitive behavioural therapy, individual and group support, brief contact, counselling, access to health services, support groups led by health professionals, education and information, mental health awareness, community awareness, coping support, stress management and symptom detection training as effective interventions (Hofstra et al., 2020; Lai et al., 2014). With this in mind, noting the effectiveness of brief professional–patient contact, Milner et al. (2015) report after a review of 12 articles that brief contact interventions were successful in reducing the frequency with which people reattempted self-harm; interventions such as telephone follow-ups or contact by post were analysed. Several reviews, analysing the use of new technologies as a monitoring and contact tool, conclude that some applications provide elements of evidence-based best practice with significant preventive outcomes (Larsen et al., 2016); and that mobile technology, used in this area, has a positive impact on reducing depression, distress and self-harm by improving coping strategies (Melia et al., 2020).

In Spain, health intervention for those at risk of suicide is carried out by primary care teams, emergency units and specifically mental health network units (La Rioja Government, 2018). From these services, nurses develop specific interventions for these patients, such as cognitive behavioural therapy, problem-solving therapy, survivor interventions, interpersonal therapy, contact, medication

administration, follow-up or crisis intervention techniques among others (Registered Nurses' Association of Ontario, 2009). Such interventions by nursing professionals are generally well accepted by the patient due to the availability, accessibility and therapeutic nurse–patient relationship (Silva et al., 2018). Nursing activity in relation to intervention and prevention of suicidal behaviour is circumscribed in the ninth need described by Virginia Henderson in the Basic Needs nursing model, "avoidance of environmental hazards", which includes assessment of the patient's knowledge of environmental hazards and their corresponding prevention and intervention (Gallego et al., 2015; Henderson, 1965). Reference is made to the existence of the NANDA (North American Nursing Diagnosis Association) nursing diagnosis "Suicide Risk", among other possible diagnoses, which is defined as the risk of life-threatening self-inflicted injury by the patient (NANDA International, 2019); it is of interest to determine which interventions, from a nursing perspective, can be considered to be of choice for the prevention and treatment of suicidal behaviour, and to identify nursing interventions from the Nursing Interventions Classification (NIC) taxonomy with evidence to this end (Butcher et al., 2019).

Systematic reviews and meta-analyses describing interventions for the prevention and treatment of suicidal behaviour, which can be developed by nursing professionals as they are included in the NIC, apply different methodologies and do not offer a joint vision that allows us to identify the most effective interventions of choice. The umbrella review allows for a synthesis of a higher level of evidence and contributes to an overall and comprehensive vision to respond to the desired objectives. This methodology also provides an assessment of the quality of existing evidence (Aromataris et al., 2015; Biodi-Zoccai et al., 2016).

2 | OBJECTIVE

The aim of this umbrella review is to determine which interventions, from a nursing perspective, can be considered as the interventions of choice for the prevention and treatment of suicidal behaviour. In this way, the umbrella review attempts to identify nursing interventions from the Nursing Interventions Classification (NIC) taxonomy with evidence to this end (Butcher et al., 2019).

3 | METHODS AND ANALYSIS

To improve the quality of this protocol, the guidelines of the PRISMA-P checklist (see supplementary file 1) have been followed; the use of "Preferred Reporting Items for Systematic Review and Meta-Analysis Protocols" has the potential to improve both the quality of the protocol and the execution of systematic reviews (Prady et al.,2008; Smidt et al., 2006; Turner et al., 2012). In line with these guidelines, this umbrella review protocol has been registered with the International Prospective Register of Systematic Reviews (PROSPERO) with registration number CRD42020221516. The procedure followed in this umbrella review is described in Figure 1.

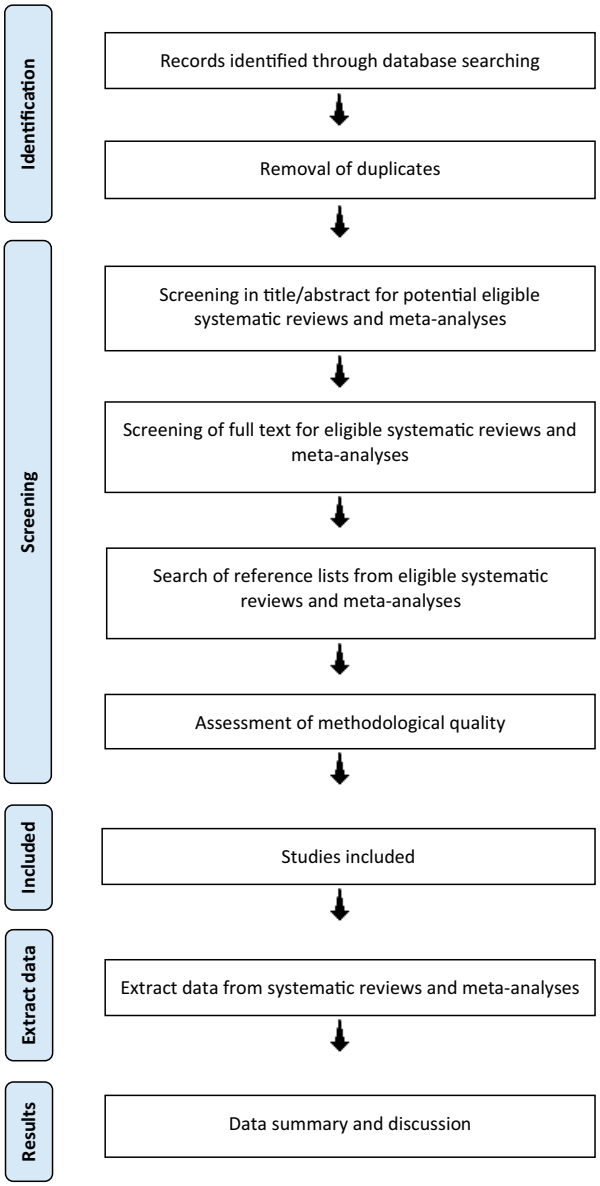

FIGURE 1 Flowchart of the umbrella review

3.1 | Patient and public involvement

Neither this protocol nor the subsequent development of the umbrella review requires the participation of patients or the general public.

3.2 | Search strategy

3.2.1 | Database search

A systematic search of papers indexed in the databases PubMed, CINAHL, Cochrane Database of Systematic Reviews, Scopus, ISI Web

of Knowledge and the Joanna Briggs Institute will be carried out. The results will be assessed for inclusion by two independent reviewers. In addition, the bibliographic references of the included reviews will be searched. The assessment of the methodological quality of the included systematic reviews and meta-analyses, and data extraction, is performed by two independent reviewers. Conflicts between reviewers will be resolved by an independent third reviewer.

3.2.2 | Search terms

A systematic search will be carried out based on the following keywords: Suicide, Attempted, Suicide, Suicidal Ideation, Primary Prevention, Secondary Prevention, Tertiary Prevention, Risks, Risk Assessment, Risk Factors, Risk Reduction Behaviour, and systematic review. They shall be combined by means of Boolean operators (AND and OR) and adapted to each database in a specific way. Supplementary file 2 shows the complete search string.

3.3 | Eligibility criteria

3.3.1 | Study design

This umbrella review will include systematic reviews and meta-analyses in adult humans (18 years and older) of both sexes.

3.4 | Inclusion and exclusion criteria

The following inclusion and exclusion criteria have been established:

- Full systematic reviews with or without meta-analysis describing the systematic search chain and study selection criteria.
- Systematic reviews and selected meta-analyses included in the umbrella review should examine studies in adult humans (18 years and older) of both sexes.
- The studies included must be published in Spanish or English, and be no more than 10 years old (depending on the date of publication).
- Selected systematic reviews and meta-analyses should examine health interventions for the prevention or treatment of suicidal behaviour, whether attempted or completed suicide.
- Reviews and meta-analyses of studies in the general population will be included, excluding studies based on specific populations (e.g. military personnel, war veterans, armed forces or prison populations).

3.5 | Study selection

The selection of systematic reviews and meta-analyses is carried out using Covidence software (Veritas Health Innovation, 2020). The initial search is carried out by one of the researchers, while duplicate elimination and the review of titles and abstracts to verify inclusion and exclusion criteria will be carried out by two independent reviewers. All studies selected by at least one of the reviewers will be retrieved in full text for further review. In the case of disagreement, the resolution of conflicts will be carried out by a third independent reviewer. Once conflicts have been resolved, the reference list of included studies will be reviewed manually to identify other publications that may meet the inclusion criteria.

3.6 | Data extraction

Systematic reviews, and included meta-analyses, will be independently analysed by two reviewers. One of the researchers in the study will develop a data extraction form, which will be used by the two independent reviewers to extract the information. Discrepancies in the extraction of information will be resolved by a third independent reviewer. The information extracted and collected in the data extraction form will include first author, year of publication, type of study, number of studies included, aim of the study, interventions for the prevention and treatment of suicidal behaviour, results and main conclusions. For meta-analyses, statistically significant levels will be extracted.

3.7 | Assessment of methodological quality

The assessment of the methodological quality of the included systematic reviews and meta-analyses will be carried out by two independent reviewers using the Joanna Briggs Institute tool “Critical Appraisal Checklist for Systematic Reviews and Research Syntheses” (Joanna Briggs Institute, 2020). Disputes will be resolved by a third independent reviewer. Assessing methodological quality will be included in the discussion of the results of the respective systematic and meta-analytical reviews.

4 | DISCUSSION

The umbrella review will provide a high-level methodological synthesis to identify the most effective interventions of choice for the treatment and prevention of suicidal behaviour. It will provide a joint and comprehensive view of therapeutic alternatives with a higher level of evidence, which can serve as a basis for the development of clinical intervention guidelines, specific suicide prevention plans, protocols and intervention procedures. It will provide healthcare professionals with evidence for decision-making in their daily practice. On the other hand, from a nursing perspective, the aim is to provide a consistent, evidence-based response to the NANDA nursing diagnosis "Suicide risk” (NANDA International, 2019). We will determine which of the interventions identified as being of choice in the review are included in the Nursing Interventions Classification (NIC)

(Butcher et al., 2019); they may be an effective therapeutic tool for nurses in the prevention and treatment of suicidal behaviour.

5 | RELEVANCE TO CLINICAL PRACTICE

This study will provide nursing professionals with the evidence necessary for quality clinical practice in the care, prevention and treatment of patients at risk of suicide. The therapeutic alternatives offered will provide evidence for clinical intervention guidelines, plans, programmes and specific intervention protocols.

6 | ETHICS AND DISSEMINATION

Formal Research Ethics Committee approval is not required for this umbrella review under Spanish law, as no primary data are collected and no patient intervention is involved. This review will be submitted for publication in an international, peer-reviewed, open access journal. The results will also be disseminated at international congresses and conferences.

7 | STRENGTHS AND LIMITATIONS OF THIS STUDY

To our knowledge, this is the first protocol for an umbrella review of interventions for the prevention and intervention of patients at risk of suicide. A broad search strategy is used to ensure a comprehensive synthesis of systematic reviews and meta-analyses in this area. Search results will be assessed for inclusion by two independent reviewers, and data extraction. The methodological quality of the included systematic reviews and meta-analyses was assessed. The evaluation of data extraction and methodological quality will be carried out by two independent reviewers.

As this is an umbrella review, the quality of the results will depend on the quality and content of the systematic reviews and meta-analyses that are available.

CONFLICTS OF INTEREST

The authors declare no conflicts of interest.

AUTHOR CONTRIBUTIONS

Conceptualization: Teresa Sufrate-Sorzano. Methodology: Teresa Sufrate-Sorzano and Ivan Santolalla-Arnedo. Investigation: Teresa Sufrate-Sorzano, María Elena Garrote-Cámara. A. and Roland Pastells- Peiró. Resources: Félix Rivera-Sanz and Carmen Amaia Ramirez Tórres. Data curation: Montserrat Gea Sanchez and Vicente Gea Caballero. Writing, original draft preparation. Teresa Sufrate-Sorzano, Beatriz Angulo-Nalda and Pablo del Pozo-Herce. Writing, review and editing: All authors Supervision: Ivan Santolalla Arnedo. Project administration: Ivan Santolalla Arnedo. All authors have read and agreed to the published version of the manuscript.

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SUPPORTING INFORMATION

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ARTÍCULO 3

HEALTH PLANS FOR SUICIDE PREVENTION IN SPAIN: A DESCRIPTIVE ANALYSIS OF THE PUBLISHED DOCUMENTS

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Autores	Teresa Sufrate Sorzano Elena Jiménez Ramón Maria Elena Garrote Cámara Vicente Gea Caballero Ángela Durante Raúl Juárez Vela Iván Santolalla Arnedo

nursing reports

MDPI

Review

Health Plans for Suicide Prevention in Spain: A Descriptive Analysis of the Published Documents

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Abstract: The number of deaths by suicide worldwide each year is more than 800,000 people, which is equivalent to one death every 40 seconds. Suicide prevention has been listed by the World Health Organisation as a global imperative and has become a priority for global public health. This descriptive study describes and compares the intervention components included in the suicide prevention plans in the different provinces of Spain. We analysed the published documents through an extensive literature search and summarised the findings using descriptive content analysis. The search was carried out through the official websites of the government and health departments of each province in addition to consulting other official digital platforms such as the National Suicide Observatory, the World Health Organisation and the National Institute of Statistics. The results show the most relevant differences between the prevention plans, revealing that although all the activities included were related to the health sector, not all of them include prevention aimed at the general population level. We conclude that there is a lack of interventions related to the application of universal prevention, while selective and indicated prevention are the most developed tools in Spain.

Keywords: suicide; prevention; risk factors; health care plan/programme

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1. Introduction

Suicide is a serious health problem affecting people of all ages and in all countries. Suicide prevention, listed by the World Health Organisation (WHO) as a global imperative, has grown in importance in recent years to become a priority task in global public health [1]. Suicide death rates are high, with an estimated 800,000 deaths by suicide each year. Preventing these deaths is of paramount importance, as is preventing self-injurious behaviour and suicide attempts, as they are the main risk factor for suicide [2].

For all these reasons, prevention measures have been increased and strengthened in recent years in line with WHO guidelines. This organisation proposed to carry out global preventive work with the aim of reducing the suicide rate by 10% by 2020, highlighting the importance of working on the prevention and management of suicidal behaviour with the use of universal, selective and indicated tools [1].

Universal prevention refers to awareness-raising measures aimed at the general population focused on aspects such as improving access to health care or restricting access to potentially lethal objects. Selective prevention is related to support measures for vulnerable groups such as people who have suffered abuse or face discrimination, and indicated

prevention measures focus on treatment and follow-up after discharge for people at high risk of suicide, such as those who have made a previous attempt [3].

The development of preventive interventions related to risk factors (such as loneliness, hopelessness or diagnoses of serious illness) is necessary to reduce the recorded rates. Different initiatives have been developed at the international level, such as the National Alliance for Suicide Prevention (NASP) created in the United States and subsequently expanded to different countries, including Spain. This initiative establishes the pillars of the Zero Suicide model, which outlines an approach to suicidal behaviour (Lead, Train, Identify, Engage, Treat, Improve and Transition), as well as the different related risk factors [4,5].

Health care Plans as a Preventive Measure against Suicide

WHO urges countries to develop a national suicide prevention strategy as the main preventive methodology, with government commitment, a multisectoral and holistic approach to the problem and the establishment of measures adapted to each country's situation [1]. A health plan for suicide prevention is a document that reflects general information about suicide and its associated behaviours, as well as recommended actions to be taken in situations of risk [6].

National prevention strategies must be resourced and periodically re-evaluated to take account of evolving societal changes [1]. In addition to these strategies, health plans for suicide prevention developed by each province are essential to reinforce general preventive measures and adapt them to the type of population and resources of each community [6]. The elaboration of these preventive strategies and plans is a highly relevant act of research and data collection as measures are put in place. This allows the identification of at-risk and vulnerable groups; of the needs of the population; of gaps in current knowledge; and of the main risk, precipitating and protective factors for each group. This allows interventions to be tailored according to the needs of the provinces [1,6].

The year 2020 was the year with the highest number of suicides in the history of Spain since data have been recorded, totalling 3941 people, which is an average of 11 suicides per day or one every 2.2 h [7,8]. This is why it is necessary to review the literature in order to analyse and discern points for improvement.

Suicide prevention involves not only the health sector, but also several key sectors such as social services, education and politics, as well as society as a whole. Therefore, the WHO encourages governments to invest in multisectoral strategies to reduce the rates of suicide deaths and suicide attempts [1].

Since 2000, several countries have developed preventive strategies against suicide. Spain is one of them, having created the Clinical Practice Guideline for the Prevention and Treatment of Suicidal Behaviour in 2012, which was revised in 2020 by a group of experts who considered maintaining the validity of the proposed interventions [9]. This guide addresses important issues such as the care and attention of the different sectors involved, as well as preventive measures. It also includes screening and identification of risk groups, promotion of the development of protective factors, restriction of access to lethal means, training programmes for health and non-health personnel, information for media professionals, care for family members and relatives and the development of diagnostic and therapeutic strategies [9,10]. In Spain, all provinces agree with the statement published by the WHO declaring suicide and its associated behaviours as preventable acts if appropriate measures are taken in the vulnerable population [11–33].

On the occasion of the last World Suicide Prevention Day, on 10 September 2020, the Spanish Mental Health Confederation proposed the development of suicide prevention plans at the national level given the worsening suicide rates due to the global pandemic caused by SARS-CoV-2. The autonomous cities of Ceuta and Melilla also decided to join the message conveyed by this entity and to implement proposals for their future plans [32,33].

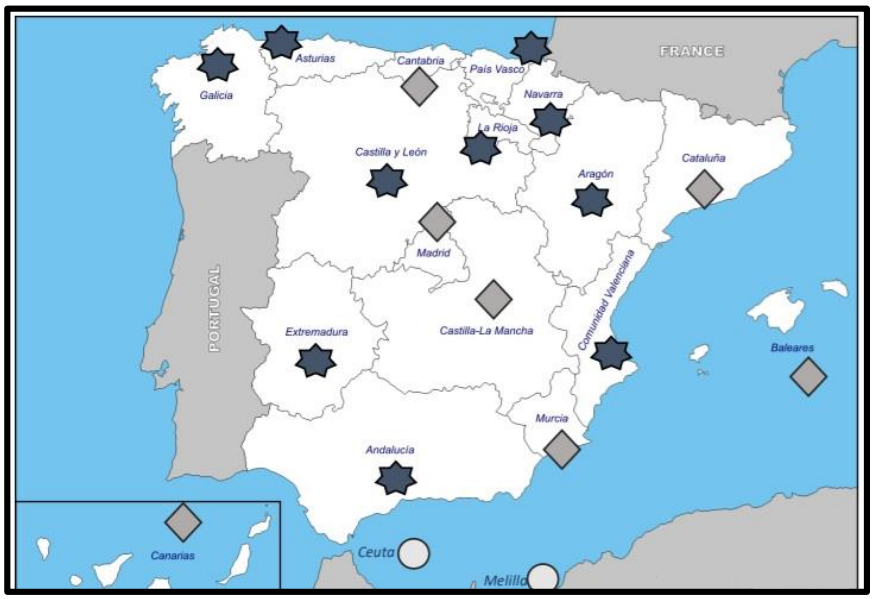
In these future plans, priority is given to raising public awareness and reduce the stigma associated with suicide, to train health professionals and to act from school age to promote mental health by improving emotional education. It also includes key aspects

such as awareness campaigns, public and free telephone assistance, recommendations for the media and social entities related to the problem [32,33].

For all of the above reasons, the aim of this literature review is to describe and compare the interventions described in suicide prevention plans in the different provinces of Spain.

2. Materials and Methods

Descriptive analysis allows for the collection of existing data in order to organise them and describe the results. We carried out a review of the different suicide prevention plans in the 17 provinces and 2 autonomous cities of Spain (Figure 1). In order to access the suicide prevention plans, we conducted a search on the websites of the government and health departments of each of them, as well as in the databases of the computer programmes of the corresponding health systems. Several useful documents were available in various communities, so the inclusion criterion for choosing a single plan per community was to select the most recent one, and to exclude those that were not endorsed by the governmental and/or health entities of each community.



Provinces with a specific suicide prevention plan.

Provinces with a general plan or other official document related to suicide prevention.

Provinces that do not have official suicide prevention plans or documents

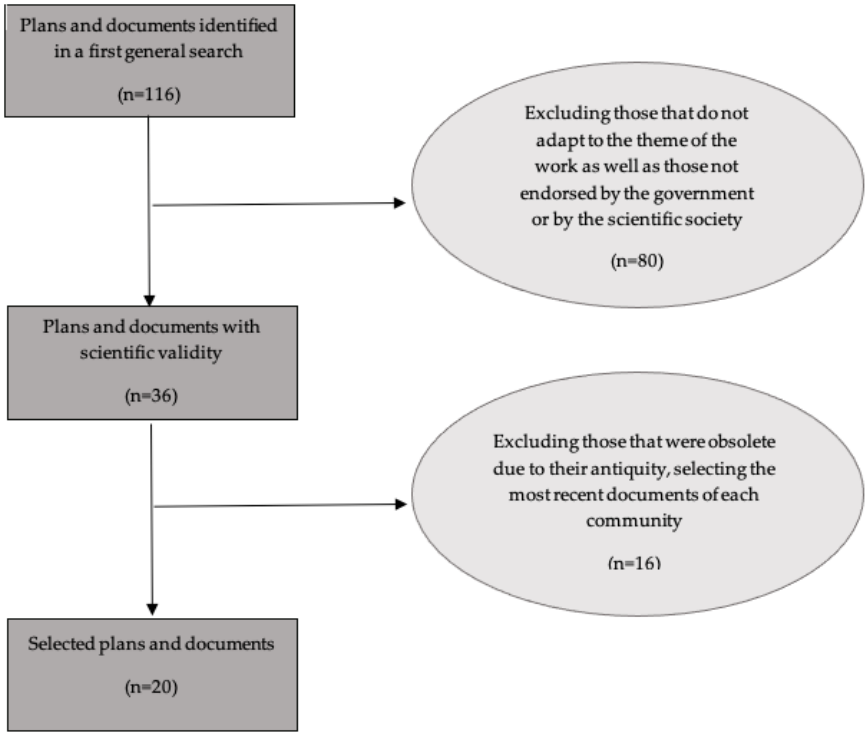
Figure 1. Spanish provinces.

Inclusion criteria were that the documents were no more than 10 years old, that they were published in Spanish, English or the official language of each province, and that the full text was available. Executive summaries that were not found in their entirety were excluded.

A manual search was carried out and official digital platforms with scientific validity were consulted, such as the National Suicide Observatory [7], the WHO [2] and the National Statistics Institute (INE).

In several provinces, the suicide prevention plan was included in the Strategic Plan for Mental Health, a document that addresses the general objectives and interventions to be developed within mental health and not specifically suicide. These plans also include, in a more general way, the actions to be addressed in the future suicide prevention plan, so the information for the development of this review in relation to some of the provinces was extracted from these documents. In the case of Ceuta and Melilla, general health plans were found that did not specifically address suicide prevention. However, information was obtained on proposed interventions for the future suicide prevention plans of these communities, which are currently under development.

The selection of the papers was made mainly by year of publication, i.e., the most recent papers were given priority over the older ones. Two members of the research team independently critically read the papers for inclusion or exclusion. Disagreements were arbitrated by a third researcher in consensus. The extraction of the interventions was carried out in the same way (Scheme 1).



Scheme 1. Diagram of the analysis process.

Using a descriptive methodology that synthesises the information to give precision and order to the data, the objectives proposed by each province, the target population and the type of intervention developed (general, training, health) were analysed.

3. Results

3.1. Comparison of the Proposed Objectives

Around 82% of the communities include the improvement of early detection, assessment, prevention and intervention in situations of suicide risk, with the Valencian Community being the only one that details a time interval in its objectives in such a way that it projects a proposal for improvement with respect to the past 5 years [12–15,17–20,25–31].

On the other hand, Galicia, La Rioja and Madrid propose different measures in their targets to evaluate the reduction of suicide mortality. The first two focus on a more

statistical approach by proposing a decrease in incidence and prevalence, while Madrid includes in its general objectives more explicit actions aimed at primary and secondary prevention [11,26,27].

Almost 30% of the communities include the dissemination of information related to suicide prevention, but not all of them have the same final objectives. Aragon is the only community that includes information aimed at the general population; in contrast, Andalusia, Extremadura, Madrid and Murcia refer to training in the health care setting. In addition, Extremadura also highlights both the training of media professionals and the improvement of risk detection in schools [12–15,25,28].

The unification of criteria with the aim of improving care is present among the objectives of the communities of Asturias, Extremadura and Murcia. The latter, together with Madrid, propose an improvement in care for survivors when a suicide attempt or completed suicide has occurred [5,25,27,28].

Interdisciplinary coordination appears in the interventions of most of the communities; however, only three of them mention it in their general objectives: Castilla y León, Castilla La Mancha and Madrid. The improvement of coordination is not only focused on the different levels of health care, but also encompasses related areas such as socio-health and education. Madrid adds networking to this interdisciplinary coordination [19,20,27].

Cantabria, Castilla La Mancha, Extremadura and Madrid incorporate into their objectives the improvement of epidemiological knowledge and research related to suicide and the behaviours involved, so that valid information can be obtained for the development of measures that are adjusted to real data [18,20,25,27].

Finally, the main objective of the Canary Islands and the Balearic Islands is the creation of a suicide prevention plan of their own, as the current information is collected in the mental health plans of these communities [16,17].

3.2. Comparison of Proposed Interventions

For better management and analysis of the interventions, they have been categorised into three groups: general, training and health.

With regard to the general interventions set out in the measures of each plan, it can be seen that most of them revolve around four categories: raising awareness among the general population together with the implementation of help contacts, restricting access to potentially lethal means and pharmacological control, inter-institutional coordination and the promotion of research related to suicidal behaviour.

With regard to training interventions, four categories are considered in terms of the type of population to be targeted: general population and at-risk groups; establishing awareness-raising measures compatible with those described in the group of general interventions; recommendations and training workshops for an appropriate treatment of the subject of suicide in the media; and training aimed at health and non-health professionals in sectors such as education, social assistance or the security forces.

Finally, health care interventions are grouped differently according to the layout of each community, as not all communities have a specific organisation for dealing with suicide and suicidal behaviour. However, there are common activities that can be classified into three general categories: unification of criteria, improvement of early detection and definition of competencies according to the service (Figure 2).

3.2.1. General Interventions

In the group of general interventions, the plans of the province of Asturias and Castilla y León are excluded as they are documents aimed at health professionals and, therefore, their interventions are focused on this area [15,19].

Awareness-raising among the general population is applied in all provinces and cities except the Balearic Islands, which focuses on other preventive aspects. To promote public awareness, most communities propose activities on key days related to suicide such as 10 September (World Suicide Prevention Day) and actions to improve the detection of

suicidal risk in order to enable the population to recognise risk factors and enable the early detection of suicidal ideation. On the other hand, the population is also provided with truthful information and scientific evidence on social networks and official websites, in addition to the fact that most communities are equipped with an extensive infrastructure for telephone assistance and help contacts. The province of Aragon focuses especially on telematic care and the use of new technologies to raise awareness among the general population due to the arrival of the pandemic caused by COVID-19 [13–15,17–30].

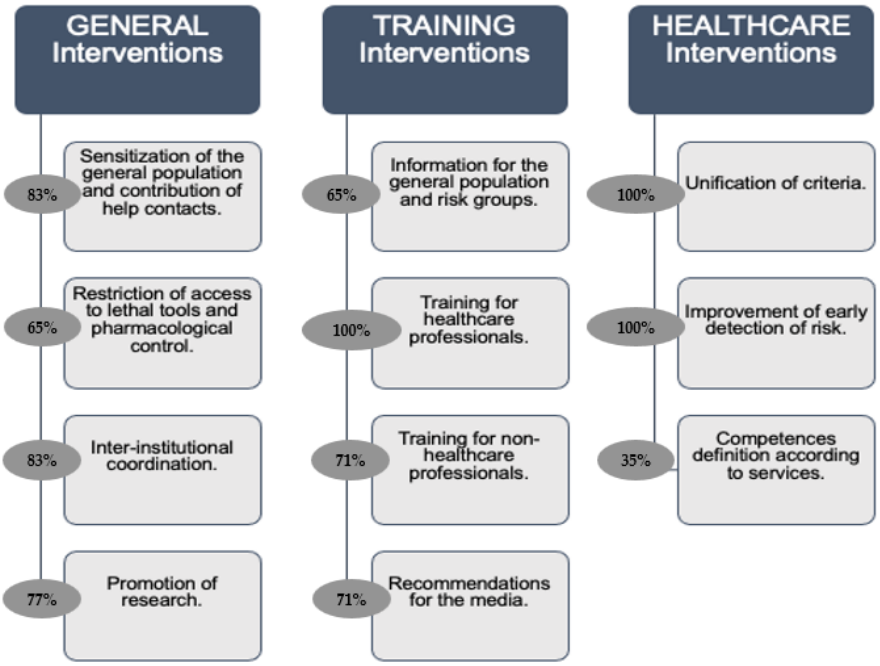


Figure 2. Categorisation of suicide prevention interventions and percentage of provinces that carry them out.

The regions of Extremadura and Murcia, on the other hand, only include in this section the detection of risk factors in vulnerable groups [25,28].

Approximately 65% of the communities (Andalusia, Aragon, Balearic Islands, Canary Islands, Cantabria, Galicia, La Rioja, Madrid, Navarre, Basque Country and Valencia) mention among their general interventions the importance of placing restrictions on potentially lethal means. These measures are comprehensive in nature as they integrate several aspects. All the plans that mention measures related to restricting access to lethal means agree that the epidemiology of suicide in the area must be known in order to prevent the development of new cases that follow the same methodology of suicide [11–14,16–18,26,27,31–39].

Several communities add the surveillance of dangerous places considered as "suicide black spots" due to the accumulation of several deaths due to suicide. Architectural barriers are proposed to be installed to prevent and/or hinder access to these sites, as most of them are high-rise areas [3,5,12–14,16,26].

Pharmacological control and vigilance are closely related to health interventions, consisting of ensuring that the medication guidelines for people at risk of suicide are correct and appropriate. In relation to the control of doses and their administration, preventive measures are mentioned in the plans of 8 of the 17 provinces: Andalusia, Aragon, Balearic Islands, Galicia, La Rioja, Madrid, Navarre and the Basque Country. The province of Madrid lists control of access to drugs as its main measure in terms of restricting access to lethal drugs [11–14,16,26,27,29,30].

Inter-institutional coordination is essential for the development of preventive measures, both in the health system and at the social level. This is why almost 83% of the provinces include this aspect among the proposed interventions. Most of them propose the improvement of their coordination strategies both at a territorial level and between the different disciplines related to the detection and approach to suicide and related behaviours. The main institutions referred to by most communities are health centres, educational centres, socio-health centres and security forces, such as police or fire brigades. Collaboration with prisons and coordination with the state and public administrations in arranging new measures such as patient associations or mutual help groups are also mentioned [12–14,17,18,20–31].

Some provinces have created, or propose to create, the formation of working groups whose functions are exclusively aimed at guaranteeing and monitoring coordination between the different bodies and services involved in order to improve suicide prevention [11,26,29,30].

Asturias, in proposing a prevention plan focused on health care, establishes coordination measures, but refers only to the different points of health care and the relationship of continuity that they should have [15]. The measures proposed for the development of a suicide prevention plan in the Balearic Islands' Strategic Plan for Mental Health concern broader measures, but coincide with Asturias in terms of the health care approach to coordination [16].

More than half of the Spanish provinces agree on the need to improve research related to suicide and self-injurious behaviour. In this way, facilities are proposed to prevent suicide in vulnerable people or those with associated pathologies such as depression. Alongside this improved research, epidemiological surveillance and its major impact on the effectiveness of preventive interventions within the community are discussed. To this end, the communities of Aragon, Baleares, Canarias, Cantabria, Castilla La Mancha, Cataluña, Extremadura, Galicia, La Rioja, Madrid, Navarre, País Vasco and Valencia allude to an improvement in recording cases of death by suicide by means of periodic reports or data-recording strategies such as the use of psychological highways, this being the technique that is most frequently reiterated throughout the plans presented [11,13,14,16–18,20–27,29–34].

To strengthen epidemiological surveillance, the Spanish Foundation for Suicide Prevention has created an organisation, the Spanish Suicide Observatory, whose mission encompasses the analysis and dissemination of epidemiological data related to suicide in order to enable its prevention. Many of the provinces have decided to create a Suicide Observatory at the provincial level to extract data specific to their area [7].

3.2.2. Training Interventions

The communities of Asturias and Castilla y León, as in the group of general interventions, are excluded from the group of training interventions, focusing only on how to deal with a crisis situation on the part of health personnel [15,19].

The most frequently mentioned risk group with which training activities are intended to be carried out is the school environment. All communities except Asturias, Cantabria, Castilla y León, Extremadura, Madrid and Murcia propose workshops and courses aimed at both schoolteachers and pupils. The main objective of these training workshops is to train teachers to detect and deal with possible cases of suicidal behaviour and crisis situations, in order to increase their knowledge related to the identification of risk factors and the strengthening of protective factors, as well as to guide students not only in the detection of possible cases, but also in the correct mutual support among them, forming mutual help groups in the classroom and improving their coping skills [11–14,16,17,20–24,26,29–31]. The autonomous cities of Ceuta and Melilla consider strengthening emotional education from the school years onwards as a measure to be included in their future prevention plans [32,33].

In addition, training actions aimed at other groups such as adolescents, survivors in cases of death of a loved one due to suicide, the elderly and their informal carers, inmates

in penitentiary centres and people in situations of discrimination or violence of any kind are mentioned. People suffering from Severe Mental Disorder (SMD) are added as one of the main vulnerable groups receiving the necessary information primarily from mental health centres [11–14,16,17,20–24,26,29–31].

The province of La Rioja includes the main activities to be carried out in schools, penitentiary centres, juvenile centres, centres for the elderly and in the field of forensic medicine [26]. In addition, the Suicide Prevention Strategy of Aragon includes the university population as a vulnerable group due to the psychological distress of students experiencing states of anxiety, social dysfunction and even symptoms compatible with depression [13,14].

Training aimed at health care professionals focuses on keeping current information up to date, as well as training staff to identify early risk and warning signs using indicators, improving clinical interview techniques to obtain more accurate information, making appropriate referrals between services by promoting coordination and agreeing on unified protocols and procedures. To this end, continuous face-to-face, blended and online training activities are presented [12–31].

Both the 17 provinces and the two autonomous cities agree to carry out these activities aimed at health personnel [12–33]. Asturias and Castilla y León, as mentioned in previous paragraphs, dedicate their plan exclusively to actions by the health sector in risk situations and do not explicitly mention training for this group. At the same time, they propose interventions for which this training is necessary, such as the use of the clinical interview or the recognition of risk factors [15,19].

It also shows the trend towards the development of training work among non-health professionals, which is defined in 12 of the 17 Spanish provinces. A general mention is made of the group of non-health professionals in relation to at-risk patients or vulnerable groups, although the importance of providing adequate training for social service workers, social health and security forces, including police and firefighters, is highlighted [11,12,16–18,21,24,26,27,29–31]. In addition, the strategy for suicide prevention in the Basque Country incorporates the promotion of psychological first aid in these interventions, as well as training aimed at staff providing telephone assistance to people at risk [30].

Finally, around 71% of the provinces include training interventions together with the dissemination of information and recommendations for the media, so that an adequate approach to suicide in the press is possible, one that does not have a negative impact on suicide rates [12–14,16,18,20–27,29,30]. One of the main concerns reported by the WHO is the ease with which the general population can access inappropriate information related to suicidal practices through the media and the internet. WHO includes the following objective among the components that should be included in national strategies: "Promote implementation of media guidelines to support responsible reporting of suicide in print, broadcasting and social media" [1,34].

The WHO document "Preventing suicide" emphasises collaboration and educational engagement with the media to achieve this goal. It also describes preventive measures related to responsible communication in the media, including interventions such as the use of responsible language; dissemination of information about available treatments; information about organisations, mobile apps and social networks as support mechanisms; and avoiding sensationalism, simplification or detailed description of the event [1].

3.2.3. Health Interventions

To improve the rates of early detection of risk (Figure 3), all communities except the Balearic and Canary Islands agree that it is necessary to improve assessment techniques, mainly those used in the first care received by patients, in order to identify the problem as early as possible and the risk factors that may lead to suicidal behaviour and act accordingly [10–14,17–30]. To this end, the plans of several communities focus on the risk assessment carried out in primary care and emergency and telephone services together

with the emergency psychiatric assessment carried out by mental health professionals once an indication of risk has been detected at earlier points in the care chain, cited in the plans of Andalusia, Castilla y León, Catalonia and La Rioja [12,19,21–24,26].

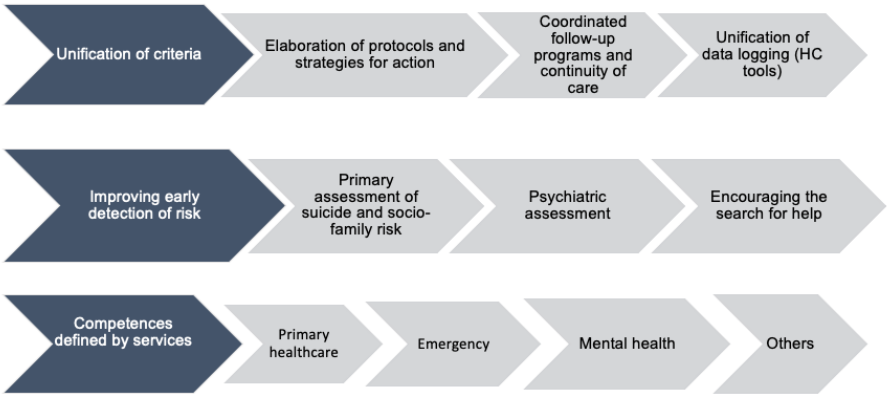


Figure 3. Classification of health interventions.

Another point to be taken into account in improving risk assessment is the appropriate use of tools such as indicators included in clinical history, assessment scales and improved clinical interview techniques. The regions that are most focused on these elements are Castilla y León and Navarre (adding physical examination), followed by Asturias and Galicia, whose plans focus exclusively on standardised assessment scales [11,15,19,29].

The detection of risk factors is an element to be considered in the assessment of each patient. On numerous occasions, it is related to the socio-family situation of the victim, an aspect mentioned only by the Protocol for Detection and Case Management in Persons at Risk of Suicide in Asturias [18], while the detection and approach to risk factors in vulnerable groups are dealt with by four of the seventeen provinces [11,12,26,29].

To complement the detection of risk and improve the quality of care, almost 24% of the communities suggest that professionals who detect risk should encourage help-seeking and the active participation of the patient [10–13,19,28]. In addition, Castilla La Mancha and Navarre promote protective factors and healthy lifestyle habits, respectively [20,29].

In order to achieve the unification of criteria, all communities agree on the need to draw up guidelines and protocols that dictate how to act in certain situations related to suicidal behaviour [12–31].

Andalusia, the Balearic Islands, the Canary Islands, Castilla La Mancha, Extremadura and Navarre propose the implementation of action plans in the different hospital services with the aim of homogenising the criteria for action [12,16,17,20,25,29]. La Rioja includes the activities of other institutions in addition to health services, such as educational, penitentiary, juvenile, elderly and forensic medicine centres [26]. La Rioja, Aragon, Castilla y León, Madrid and Murcia focus their future programmes on patient safety, as well as on creating individualised plans at discharge, during hospitalisation and involving the family [13,17,19,26–28]. Extremadura includes the consideration of suicidal risk in other action plans such as Cancer or Drug Dependency [25].

The implementation of suicide codes is present in 4 of the 17 provinces [11,21–25,30]. In the Canary Islands, a suicide risk code protocol is not specifically established, but the Mental Health Plan mentions the creation of a crisis line with a suicide risk hotline [17].

In relation to the development of patient follow-up protocols and ensuring continuity of care during the process, 82% of the Spanish provinces mention related interventions in their plans. Most establish time periods in which to provide initial care on arrival of the patient, when the risk is identified, or the time between the patient's discharge and the next consultation. In general, the plans establish a time period of between 24 h and 7 days

for the initiation of patient follow-up either by telephone or face-to-face consultations. Most of them also agree on the duration of the follow-up process, extending it for at least 12 months, with the exception of Navarre, which establishes a follow-up of at least 6 months [11–16,19–29,31]. The protocol for the detection and case management of people at risk of suicide in Asturias establishes in greater detail the time periods and how to contact the patient during follow-up [15]. In the La Rioja Suicide Prevention Plan, only weekly visits are mentioned in terms of time periods for follow-up, and the documents drafted by the Balearic Islands, Castilla La Mancha and Murcia do not establish time periods for the proposed follow-up [16,20,26,28].

In this follow-up, the family is involved in addition to monitoring the patient and the access to dangerous means such as pharmacological control during their dispensation while the patient is hospitalised and when he/she is discharged. In any case, but especially in those involving family and relatives, it is necessary to maintain confidentiality and obtain informed consent from the patient, as their problem will be discussed with other people. Not all regions highlight this aspect, but Castilla y León, Catalonia and Navarre mention it in their plans [19,21–24,29].

With regard to the unification of criteria, it is also necessary to add the homogenised registration of cases with tools and forms available in the clinical history, in order to facilitate the development of better research into the epidemiology of suicide in each community. This is only proposed in five provinces: Asturias, Castilla y León, Madrid, Murcia and Euskadi [15,19,27,28,30].

Thirty-five percent of the communities specifically describe the competences of the priority health services, both preventive and in suicidal crises [12,19,20,27–29]. The plans of the provinces of Asturias and Navarre describe the care to be provided by nursing staff in cases of suicidal behaviour or suicide, the most frequent actions being telephone follow-up, surveillance and supervision, pharmacological administration and control, cognitive behavioural therapy, emotional support and active listening, identification of personal risks, involvement of the family in care, promotion of healthy habits and environmental management [15,29].

Likewise, the Canary Islands propose the possibility of creating an Ultra Short Stay Unit in the different provinces for patients with considerable and uncertain risk [17], and Navarre adds the interventions to be carried out by social services and the creation of a specific partial hospitalisation device for psychogeriatrics [29].

Finally, La Rioja and Galicia include care for professionals involved in dealing with cases of suicide [12,26]. This is known as "debriefing", a technique in which reflection and emotion management are worked on through the communication of staff involved in traumatic events such as, in this case, the death of a patient due to suicide, as the actions taken and decisions made during the care process are re-evaluated, making it possible to detect errors in order to improve them in the future [35].

4. Discussion

It is necessary to demystify that suicide is a non-preventable act, as people suffering from suicidal ideation feel conflicting emotions and live with conflicting feelings of death until moments before completing suicide [1]. Therefore, the development of suicide prevention plans and preventive strategies is favourable and necessary to achieve this. The aim of this review is to describe and compare the interventions described in the suicide prevention plans of the Spanish provinces by comparing the proposed objectives and categorising their interventions. The prevention plans established in all Spanish provinces establish universal, selective and indicated preventive measures. While it is true that not all of them focus on providing information related to suicide and its associated behaviours to the general population, it is noted that interventions aimed at risk detection and assistance to vulnerable groups are much more prevalent, so much so that they appear in 100% of Spanish suicide prevention plans. As it is perceived that most preventive interventions are reduced to the management of crisis situations and attention to at-risk groups, it is estimated that encour-

aging other types of activities focused on primary prevention could improve the results obtained in suicide rate records [12,19,20,27–29]. In other words, reducing risk factors and providing quality information for the general population and unrestricted access to health care would reduce the stigma developed by society towards this type of behaviour.

Suicide prevention plans in Spain, as well as their objectives and proposed measures, are similar in the different provinces. It can be seen that most of the interventions are directed towards health professionals, especially in the field of mental health, as well as towards the most vulnerable populations. There are also other types of measures focused on key areas such as awareness-raising in schools or the training of social agents (gatekeepers) [5,11–31].

The similarity of the objectives proposed by each of the provinces for tackling suicidal behaviour is a reflection of the magnitude of the problem. Specifically, the importance of prevention in public health can be appreciated, since the objectives are clearly aimed at the early screening of the population at risk and the subsequent achievement of statistically lower incidence and prevalence figures. In this line, the concern of the provinces for the correct registration of these deaths in order to improve the quality of the data for research stands out.

With regard to the evolution of suicide rates over the past few years, oscillating data are perceived as Galicia, Andalusia, Balearic Islands, Castilla La Mancha, Navarre, Basque Country, La Rioja, Ceuta and Melilla [11,12,16,20,26,29,30,32,33] show a downward trend of suicides until reaching the lowest figures in 2018; on the contrary, Asturias, Castilla y León and Madrid [15,19,27] start in 2012 from the lowest figures recorded in the study period, and Murcia ends the study period with the highest number of suicides in the community [28]. It is also observed that the year in which the highest number of deaths due to suicide occurred was 2014, and it is possible that this figure is related to the year in which the plans were published in most of the Spanish provinces, after that date. Of the prevention plans selected for this study, only two were published prior to 2014, in Andalusia and Navarre, which are included in the group of regions that have achieved a downward trend in death rates [12,29]. Specifically, in recent years, there has also been a variation in the proportion of men and women who die by suicide; until now, the majority of deaths have been in the male group [8].

In relation to gender and the variation in the male/female ratio, in the past, suicides were more frequently completed by males and attempted by females [35]. There is currently an increase in the proportion of women who actually completed suicide [36,37], a fact that encourages researchers to further develop established preventive measures, as well as to study possible limitations and gender biases in suicide research.

The results of this review will be shared with the research team on suicidal behaviours belonging to the Centre for Biomedical Research (CIBIR) and the association of mental health nursing professionals collaborating with the government working group for the review and update of new documents.

It is also noted that not all communities have a suicide prevention programme, but that the development of this document is an objective included in more general plans such as the mental health plans of the respective communities, which have not yet been developed [32,33].

5. Conclusions

The data obtained reflect the need to update and adapt prevention plans as the evolution of society implies changes in the variants that can affect the causes of suicide. One of the major aspects to be assessed and included in revisions of current or future plans is the decline in the care and attention given to mental disorders during the global pandemic caused by COVID-19. Following the publication and analysis of the papers, an increase in suicide rates can be expected in the near future, not only because of the reduced care, but also because the confinement and new lifestyle brought about by the pandemic aggravate suicide risk factors, such as a lack of social relationships and social support,

loneliness or depression, and even suffering from the disease can be a precipitating factor for suicide [39].

Suicide is a fact of life that continues to be underdiagnosed due to its illegality in some countries or its incorrect classification as an accidental death [1]. Given the known unreliability of the statistical information generated on suicide deaths, it is necessary to promote the improvement of registration methods, as well as the reduction of the stigma attached to suicide, in order to ascertain the real rates and adopt preventive measures in a way that is valid and consistent with the epidemiology of each community [38]. Epidemiological knowledge is the basis for establishing quality measures that are in tune with the real problems of each community, so in future reviews of established plans, it is an aspect to be evaluated and/or added where it is not present.

Education is essential to improve suicide rates in each area, as it is necessary for the general population as well as health and non-health professionals to maintain an adequate and up-to-date level of information regarding preventive measures, as well as knowledge of risk and protective factors.

6. Limitations

The research team mainly reflects two limitations. One is the absence of previous research studies on the subject. The other limitation that has been identified relates to the quantity and quality of information on epidemiology and suicide rates. Suicide is perceived to be under reported, as these deaths are sometimes under-recorded and even under-recorded. Encouraging improved recording methods as well as reducing the stigma attached to suicide is considered necessary in order to know the real data.

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ARTÍCULO 4

UMBRELLA REVIEW OF NURSING INTERVENTIONS NIC FOR THE TREATMENT AND PREVENTION OF SUICIDAL BEHAVIOR

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ORIGINAL REPORT

Umbrella review of nursing interventions NIC for the treatment and prevention of suicidal behavior

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Abstract

Purpose: The aim of this umbrella review was to determine the most effective nursing interventions for the prevention and management of suicidal behavior. In order to do so, the review identifies interventions from the Nursing Interventions Classifications taxonomy with evidence to this end.

Methods: A systematic search was conducted for systematic reviews included in the PubMed, CINAHL, Cochrane, Scopus, Web of Knowledge, and Joanna Briggs Institute databases between January 1, 2011 and May 1, 2020.

Findings: The review is made up of 21 systematic reviews. In order to carefully analyze the interventions described, these were coded into categories, grouping the interventions into those based on psychological therapy, interventions related to pharmacotherapy, interventions related to the professional relationship between health professional and patient, and interventions aimed at the general public.

Conclusions: Nursing interventions for suicide risk management are prevalent in the scientific literature and are shown to be effective for patients with suicidal ideation or suicide attempts. Prevention and treatment of suicidal behavior require the provision of coping tools, behavioral interventions that directly address suicidal thoughts and behaviors, and support through therapeutic partnerships, among others.

Implications for nursing practice: This paper synthesizes the most current evidence on the most effective Nursing Interventions Classifications interventions for the treatment and prevention of suicidal behavior. It provides nursing practitioners with a comprehensive review of the therapeutic interventions with the best evidence and is useful for the development of clinical guidelines and protocols, as well as for the development of health policies and plans.

KEYWORDS
attempted suicide, nursing interventions, risk reduction behavior, suicidal ideation, suicide

INTRODUCTION

Suicidal behavior (ideation, attempt, and death by suicide) is the result of a complex interaction of factors grouped under diathesis-stress models, which are also called vulnerability-stress models. These include risk factors that can trigger suicidal behavior, such as unemployment; relationship problems; drug and alcohol abuse, and social, psychological, genetic, and educational precipitating factors, along with protective factors such as self-confidence; resilience; social integration, and lethal means restriction (Wasserman, 2001; World Health Organization, 2002). Consequently, the intervention of the nursing professional should aim to promote protective factors, reduce risk factors, and mitigate precipitating factors (Anseán, 2014; World Health Organization, 2014).

The World Health Organization – WHO (2014) has warned health authorities that suicidal behavior is a major public health problem, which is why working on its prevention and management should be a priority for public health policies worldwide. Annual figures released by the Pan American Health Organization (2020) are as high as 700,000 deaths by suicide each year worldwide, as well as more than 16 million suicide attempts (since for every suicide there are around 20 attempts). Suicide attempts are considered to be the most significant individual risk factor in the general population (World Health Organization, 2018) because these acts are repeated by up to 30% of people during the first year, with 2% subsequently committing suicide successfully in the next 5 or 10 years (Cano et al., 2009).

Globally, suicide was the fourth leading cause of death in the 15–29 age group in 2019, with more than 77% of all cases occurring in low- and middle-income countries (Pan American Health Organization, 2020). The geographical distribution of the highest suicide rates includes Slovenia, South Korea, and Lithuania, with figures in the range of 27 deaths/100,000 inhabitants. In contrast, countries such as Greece, Turkey, and South Africa have a rate of less than 4 deaths/100,000 population, with hanging and jumping being the most commonly selected methods (National Institute of Statistics, 2020).

The recently published WHO (2021) strategy for suicide prevention in all countries, "Live Life," recommends the implementation of effective evidence-based interventions, including restricting access to the most commonly used means (pesticides, firearms, or certain medications), prevention in the general population, educating the media on the appropriate dissemination of information, developing socioemotional skills in adolescents, and early detection, follow-up, assessment and treatment of the at-risk population (World Health Organization, 2021).

Due to the multiple factors involved in the development of suicidal behavior, prevention requires the coordination and cooperation of different sectors of society, such as education, health, law enforcement, politics, and the media. Studies aimed at the prevention and treatment of suicidal behavior highlight the effectiveness of multilevel intervention in adults with significant results in reducing ideation and repetition of the behavior (Melia et al., 2020; Büscher et al., 2020; Briggs et al., 2019; Gøtzsche & Gøtzsche, 2017; Larsen et al., 2016). Cognitive behavioral therapy, individual and group support, brief contact, counseling, improved access to health services, support groups led by health professionals, education and information, mental health promotion, community awareness, coping support, stress management, and symptom detection training have all been proposed as effective interventions (Hofstra et al., 2020; Lai et al., 2014).

In relation to the most recent publications on the effect of interventions for the prevention and management of suicidal behavior, Hofstra et al. (2020), in their systematic review which includes a meta-analysis, highlight the effectiveness of interventions such as health education and training, telephone counseling and follow-up, promotion of gatekeeper figures, and cognitive behavioral therapy. In terms of brief and contact intervention as a skilled strategy for suicide prevention, the WHO indicates that suicide rates decrease with follow-up interventions, training, education and counseling, the administration of lithium in specific pathologies, group therapy, and cognitive behavioral therapy, with the latter emerging as one of the most effective therapies in routine treatment (Gøtzsche & Gøtzsche, 2017; Lai et al., 2014; Riblet et al., 2017). Several studies report a decrease in self-harming events, following brief contact interventions including telephone or postal mail follow-up (Milner et al., 2015). New technologies employed for the promotion of contact interventions offer promising and significant results in prevention, as well as a positive impact on the promotion of coping strategies in reducing depression, distress, and self-harm (Larsen et al., 2016; Melia et al., 2020).

Professional health intervention for the care of people at risk and/or with suicidal behavior is carried out by community care teams, hospitalization and emergency services and particularly by the different units that make up the mental health care networks of the health services. From these units, the nursing professional, as part of the multidisciplinary team, develops general and specific interventions on population, patient and/or user, health education, contact, follow-up and case management, cognitive behavioral therapy, problem-solving therapy, survivor interventions, interpersonal therapy, medication administration, and crisis intervention techniques, among others (Registered Nurse's Association of Ontario, 2009). These types of interventions carried out by nursing professionals are generally well received by the patient due to the availability, accessibility, and therapeutic relationship established between the patient and the professional (Silva et al., 2018). Nursing professionals contribute their knowledge and skills at the levels of care, management, education, and research (Galvis, 2015).

Nursing activity in relation to the intervention and prevention of suicidal behavior is fundamentally encapsulated by the ninth need described by Virginia Henderson in the Basic Needs nursing model, "Avoidance of environmental hazards," which includes the assessment of the patient's knowledge of environmental hazards and their corresponding prevention and intervention (Gallego et al., 2015; Henderson, 1961). The NANDA-International (NANDA-I) nursing diagnosis on the risk of suicide (00150) is defined as the situation where there is a danger of self-inflicted life-threatening injury (Ackley et al., 2021).

This study will use the nursing diagnosis Risk for suicide (00150) as a reference to determine, according to current scientific evidence, which interventions are effective in nursing practice for the prevention and treatment of suicidal behavior, identifying these in the Nursing Interventions Classification (NIC) taxonomy (Butcher et al., 2018).

Systematic reviews and meta-analyses describing interventions for the prevention and treatment of suicidal ideation and/or attempted suicidal behavior employ heterogeneous methodologies, which impede a joint perspective that would allow for the identification of the most effective interventions that nurses can implement. An umbrella review is a systematic review that synthesizes the highest level of evidence and contributes to a global and complete vision to respond to the objectives pursued, providing an assessment of the quality of the existing evidence (Aromataris et al., 2015; Biondi-Zoccai, 2016). One of the main utilities of this methodology is that a more holistic perspective on the available scientific evidence can be obtained from several systematic reviews answering the same question and with a more systematic and rigorous focus than an integrative review (Fusar-Poli & Radua, 2018). The creation of an umbrella review involves compiling the studies with the best evidence, in this case for the search for effective nursing interventions for the treatment and prevention of suicidal behavior, in order to generate a high-quality overview of the issue in question (Chambergo-Michilot et al., 2021).

OBJECTIVE

The aim of this umbrella review was to identify and gather scientific evidence on nursing interventions from the NIC taxonomy that have been shown to be effective in the prevention and treatment of suicidal behavior (Butcher et al., 2018).

The overarching review question for the study was as follows: What nursing interventions have been shown to be effective in the prevention and treatment of suicidal behavior in adults?

METHODS AND ANALYSIS

This systematic review was conducted according to the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guidelines. The umbrella review was registered in the International Prospective Register of Systematic Reviews (PROSPERO) with registration code CRD42020221516.

Eligibility criteria

Systematic reviews with or without meta-analyses on the effectiveness of nursing interventions on suicidal behavior in men and women over 18 years of age, in Spanish and English, and less than 10 years old. To compile evidence on interventions that could be extrapolated to the general population, research was excluded if the sample consisted of specific population groups with particular idiosyncrasies, such as military authorities, armed forces personnel, war veterans, or the prison population.

Sources of information

A systematic search was conducted of papers published between January 1, 2011 and May 1, 2020 listed in the PubMed, Cumulative Index to Nursing and Allied Health Literature (CINAHL), Cochrane Database of Systematic Reviews (CDSR), Scopus, Institute for Scientific Information Web of Knowledge (ISI WoK), and the Joanna Briggs Institute (JBI) databases. In 2011, the European Community called on member states to include strategies focusing on the treatment and prevention of suicidal behavior in their health policies (Scheftlein, 2011). In the same year, the WHO published a protocol guide for the intervention and assessment of patients with suicidal behavior and mental disorders, among others (World Health Organization, 2011). Subsequently, at the World Health Assembly in 2013, an agreement was made to develop the "WHO Comprehensive Mental Health Action Plan 2013–2020," one of the priority goals of which was to reduce the suicide rate by 10% by 2020 (World Health Organization, 2013).

The keywords used were suicide attempted, suicide, suicidal ideation, primary prevention, secondary prevention, tertiary prevention, risks, risk assessment, risk factors, risk reduction behavior, and systematic review. These were combined with the Boolean operators and adapted specifically to each database.

Search strategy

The search strategy is shown in the file "Supplementary 1."

Selection process for studies

The inclusion of papers was assessed by two independent reviewers and they assessed the methodological quality of the included systematic reviews and meta-analyses and data extraction. Selection conflicts between reviewers were resolved by an independent third reviewer.

The process began with the initial search and exclusion of duplicate studies; the review of the title and abstract was conducted by two independent reviewers. Papers that were only selected by one reviewer were retrieved for full-text reanalysis by both reviewers. Conflict resolution was carried out by a third-party reviewer.

The search comprised a total of 3711 papers, obtained 575 from PubMed, 341 from CINAHL, 22 from CDSR, 1156 from Scopus, 1563 from WOS, and 54 from JBI. Duplicates were eliminated and 2302 results were included for analysis by title and abstract. After applying the defined inclusion and exclusion criteria, a total of 314 papers were critically analyzed. Following this analysis, 23 studies moved on to the next phase.

Data extraction procedure

The Covidence program was used as a tool for reviewing and selecting papers for review (Covidence, 2020). A form for data extraction was developed using an adapted version of the "JBI data-extraction tool." The data extracted through the extraction form and based on the research question were analyzed in order to identify and summarize the nursing interventions represented in the selected studies.

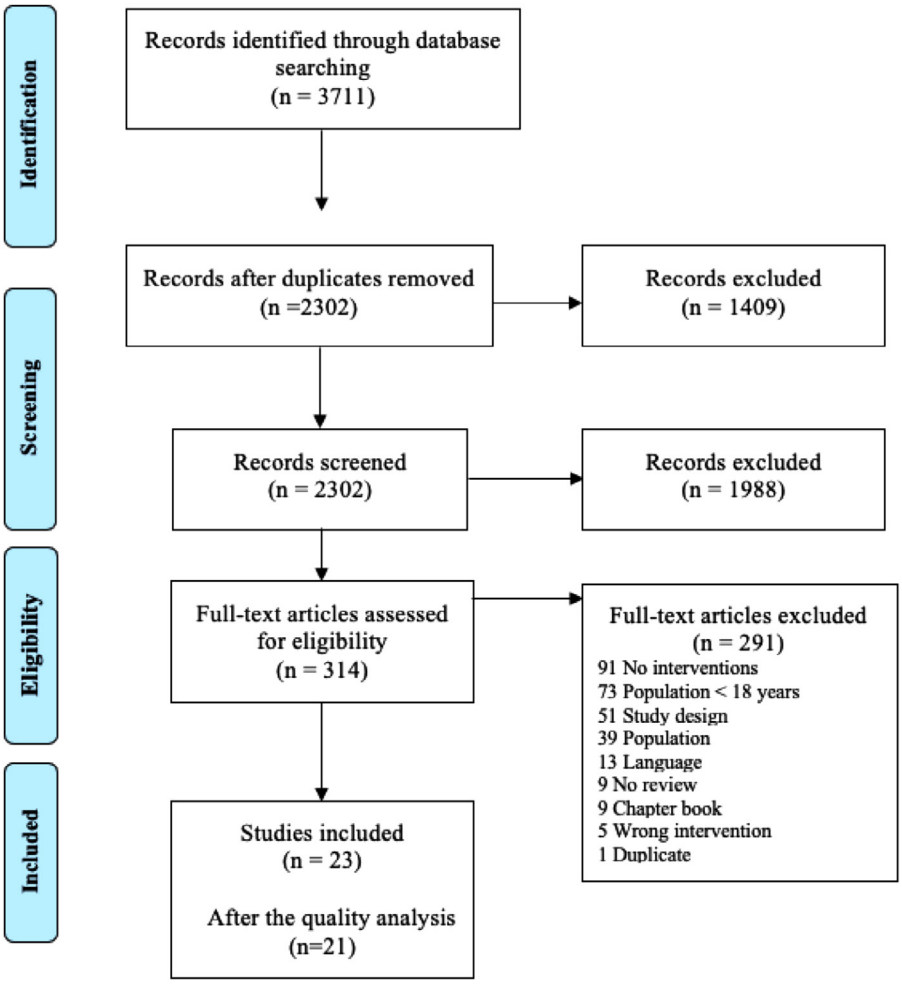

FIGURE 1 Adapted PRISMA flowchart

Risk of bias assessment (quality of reviews)

As at all stages of the process, the assessment of the quality of the papers was carried out independently by two reviewers (TSS and ISA) and in case of disagreement, a third reviewer arbitrated the decision (FML). The tool used was the "JBI Critical Appraisal Checklist for Systematic Reviews and Research Syntheses" (Joanna Briggs Institute, 2020). This instrument is based on 11 criteria that give each paper a quality rating ranging from "low" if the score is below 40%, "medium" if it scores 70%, and "high quality" if it scores above 70%. After two papers obtained a quality assessment of less than 40% (low quality), the research group decided to exclude them from the research, so a total of 21 reviews were finally selected (Figure 1). Regarding the results of the quality analysis, 14 documents were rated with a high-quality level, and seven with a medium-quality level. Lack of clarity in the exposition of the review question and the absence of methods to minimize errors in data extraction were the most frequent reports in the evaluation. The "Supplementary 2" document contains the complete quality analysis of the reviews included.

RESULTS

The results are presented as a narrative synthesis highlighting the main findings. The evaluated interventions were coded into categories: interventions based on psychological therapy, interventions related to pharmacotherapy, interventions related to the therapeutic relationship between health professionals and patients, and interventions aimed at the general population.

The umbrella review consists of 21 systematic reviews that were published between 2011 and 2020. The characteristics of the reviews included for analysis are shown arranged chronologically in Table 1.

Seven of the reviews included meta-analyses (Büscher et al., 2020; Hofstra et al., 2020; Briggs et al., 2019; Gøtzsche & Gøtzsche, 2017; Meerwijk et al., 2016; Milner et al., 2015; Winter et al., 2013), one paper focused on the working environment (Milner et al., 2014), and one was based on a population aged 60+ (Okolie et al., 2017). Several reviews examined the prevention of suicidal behavior through the use and employment of online tools, mobile apps, and social networks

TABLE 1 Details of the included systematic reviews

Authors	General objective	Studies	Categories of intervention that they include
Lapierre et al. (2011)	To examine the outcomes of interventions and identify successful strategies	19	Therapy based; pharmacological intervention; health professional-patient relationship
Winter et al. (2013)	To assess the current state of prevention and its effectiveness	112	Therapy based; health professional–patient relationship
Christensen et al. (2014)	Examining online suicide detection, the effectiveness of interventions, and proactive interventions after identifying people at risk from their posts	9	Therapy based; health professional–patient relationship; community
Lai et al. (2014)	Review and evaluate suicide prevention strategies available on the web	15	Therapy based; health professional–patient relationship; community
Milner et al. (2014)	Evaluate suicide prevention activities in the workplace	13	Health professional–patient relationship; community
Macedo et al. (2014)	To evaluate the effectiveness of interventions to promote resilience in adults. To assess their efficacy on suicidal behavior	13	Therapy based; health professional–patient relationship, community
Milner et al. (2015)	To synthesize the evidence regarding the effectiveness of brief contact interventions in reducing self-harm, suicide attempts, and completed suicide	12	Therapy based; health professional–patient relationship
Robinson et al. (2016)	To identify current evidence related to social media as a tool for suicide prevention	30	Therapy based; health professional–patient relationship
Meerwijk et al. (2016)	To assess whether psychosocial and behavioral interventions that address suicidal thoughts and behaviors are more effective in reducing suicides and suicide attempts than interventions that only address associated symptoms	53	Therapy based; pharmacological intervention; health professional–patient relationship
Larsen et al. (2016)	To examine the compatibility of the features of available apps with current scientific evidence on effective suicide prevention strategies	49	Therapy based; health professional-patient relationship; community
Okolie et al. (2017)	To identify and evaluate the evidence on the affectivity of interventions for older adults on preventing suicidal behavior and reducing suicidal ideation	21	Therapy based; pharmacological intervention; health professional–patient relationship, community
Gøtzsche & Gøtzsche (2017)	To assess the effectiveness of cognitive behavioral therapy in suicide prevention	20	Therapy based
Riblet et al. (2017)	To identify interventions for suicide prevention	78	Therapy-based; pharmacological intervention; health professional–patient relationship
Tighe et al. (2018)	To assess the effectiveness of acceptance and commitment therapy in reducing suicidal ideation and self-harm	5	Therapy based
Mendez-Bustos et al. (2019)	To review available scientific evidence on the effectiveness of psychotherapeutic tools designed to treat patients at risk of suicide	40	Therapy based; health professional–patient relationship; community-.
Briggs et al. (2019)	To systematically review randomised controlled trials of psychoanalytic and psychodynamic psychotherapies for suicide attempts and self-harm	12	Therapy based; health professional–patient relationship
Dt'Anci et al. (2019)	To assess risks/benefits of suicide prevention interventions	23	Therapy based; pharmacological intervention.
Hoffberg et al. (2019)	To review the clinical effectiveness of psychotherapeutic tools designed to treat patients at risk of suicide	40	Therapy based; health professional–patient relationship
Melia et al. (2020)	To examine the effectiveness of available mobile technology tools for the prevention of any suicidal tendencies	7	Health professional–patient relationship
Büscher et al. (2020)	To study whether internet-based self-help interventions are associated with a reduction in suicidal ideation	6	Therapy based
Hofstra et al. (2020)	Evaluating the effect of suicide prevention interventions	16	Therapy based; health professional–patient relationship; community

(Büscher et al., 2020; Melia et al., 2020; Larsen et al., 2016; Robinson et al., 2016; Christensen et al., 2014; Lai et al., 2014).

Six reviews examine which interventions are effective for the prevention of suicidal behavior (Hoffberg et al., 2019; Hofstra et al., 2020; D'Anci et al., 2019; Méndez-Bustos et al., 2019; Riblet et al., 2017; Lapierre et al., 2011) and more specifically, some work focused on evaluating the functionality of specific interventions in the prevention of suicidal behaviors such as the development of resilience in the adult population (Macedo et al., 2014), brief contact (Milner et al., 2015), or acceptance and commitment therapy (Tighe et al., 2018).

Interventions based on psychological therapies

Under the category of interventions based on psychological therapies, dialectical behavioral therapy, cognitive behavioral therapy, problem solving and adjustment therapy), psychodynamic therapy, psychoanalytic therapy, acceptance and commitment therapy, and family, interpersonal, or group therapy are observed as effective interventions (Hofstra et al., 2020; Briggs et al., 2019; D'Anci et al., 2019; Hoffberg et al., 2019; Méndez-Bustos et al., 2019; Tighe et al., 2018; Gøtzsche & Gøtzsche, 2017; Okolie et al., 2017; Riblet et al., 2017; Larsen et al., 2016; Meerjwijk et al., 2016; Milner et al., 2015; Winter et al., 2013; Lapierre et al., 2011).

Interventions focusing on pharmacological treatment

In the review, the health interventions focusing on pharmacological treatment that stand out for their effectiveness are education and training on the prescribed treatment; long-term control and monitoring of pharmacological guidelines; information and education on the most frequent side effects; adequate monitoring of the patient with prescriptions for ketamine and lithium; promotion of adherence to prescribed guidelines and pharmacological treatment for affective disorders (Okolie et al., 2017; Riblet et al., 2017; Meerjwijk et al., 2016; Lapierre et al., 2011).

Interventions related to the relationship between the health professional and the patient

Health interventions, related to the broader health professional–patient relationship, would include active patient follow-up and the establishment of follow-up meetings/consultations, brief intervention (via telephone, email, or mail), early detection and treatment of depression and its symptoms, training, and counseling in self-care, acceptance, social and coping skills training, mood monitoring and promotion of resilience (Hofstra et al., 2020; Melia et al., 2020; Briggs et al., 2019; Hoffberg et al., 2019; Méndez-Bustos et al., 2019; Okolie et al., 2017; Riblet et al., 2017). Stress management, strengthening protective factors, crisis contact and support, mood and emotion management, therapeutic alliance, support group membership, and the development of a personalized care plan are also reported as effective interventions (Larsen et al., 2016; Meerwijk et al., 2016; Robinson et al., 2016; Milner et al., 2015; Christensen et al., 2014; Lai et al., 2014; Macedo et al., 2014; Milner et al., 2014; Winter et al., 2013; Lapierre et al., 2011). For the implementation of these interventions, scheduled nursing consultations, telephone, and new technology-based follow-ups and consultations, and supportive home visits through assertive community therapies have been shown to be effective (Büscher et al., 2020; Robinson et al., 2016; Christensen et al., 2014; Lai et al., 2014; Macedo et al., 2014). Because of the strong relationship between suicide and hopelessness (Ribeiro et al., 2018), interventions for more acute contexts may include providing hope, managing self-harming behavior, limit setting, and crisis intervention or even first aid (Butcher et al., 2018).

Interventions targeting the general public

Interventions related to the general population (society/community) for the treatment and prevention of suicidal behavior include raising awareness and understanding of the problem, facilitating access to health services, reducing access to the most commonly used means, promoting the role of community gatekeepers, promoting mental health and reducing isolation. In addition, they encompass the production and distribution of standardized, nonsensationalized, truthful information through social networks, media, and websites, as well as the early identification of harmful content (Hofstra et al., 2020; Méndez-Bustos et al., 2019; Okolie et al., 2017; Christensen et al., 2014; Larsen et al., 2016; Lai et al., 2014; Macedo et al., 2014; Milner et al., 2014). In this context, the interventions of the NIC taxonomy that are related to the community aspects are as follows: environmental management – safety; health education in general and particularly in the prevention of substance abuse; establishment of consultations or visits that promote mental health; listening visits; exchange of health care information; improvement of access to health information; and training in first aid. In addition, and specifically in the community closest to the patient, increasing family and social support systems, and enhancing socialization are effective interventions (Butcher et al., 2018).

Table 2 shows specifically coded interventions from the NIC taxonomy that are most effective for the correct management of patients with suicidal behavior.

DISCUSSION

This review has identified and compiled the scientific evidence that addresses the prevention, management, and treatment of suicidal behavior using nursing interventions from the NIC taxonomy so that the objective set by the research team has been achieved.

Due to the magnitude of the serious public health problem of suicide, the reduction of suicidal behavior must become a priority in social, political, media and health agendas, where greater

TABLE 2 Interventions codified in the NIC taxonomy which are most effective for the proper management of patients exhibiting suicidal behavior

1460. Progressive muscle relaxation: Facilitating the tensing and releasing of successive muscle groups while attending to the resulting differences in sensation

2300. Medication administration: Preparing, giving, and evaluating the effectiveness of prescription and nonprescription drugs

2395. Medication reconciliation: Comparison of the patient's home medications with the admission, transfer, and/or discharge orders to ensure accuracy and patient safety

2380. Medication management: Facilitation of safe and effective use of prescription and over-the-counter drugs

4340. Assertiveness training: Assistance with the effective expression of feelings, needs, and ideas while respecting the rights of others

4350. Behavior management: Helping a patient to manage negative behavior

4352. Behavior modification: Provision of a therapeutic milieu that safely accommodates the patient's attention deficit and/or overactivity while promoting optimal function

4354. Behavior management: Self-harm: Assisting the patient to decrease or eliminate self-mutilating or self-abusive behaviors

4360. Behavior modification: Promoting behavior change.

4380. Setting limits: Establishing the parameters of desirable and acceptable patient behavior.

4410. Establishment of common objectives: Collaboration with the patient to identify and prioritize care goals and then develop a plan to achieve these goals.

4420. Patient contracting: Negotiating an agreement with an individual that reinforces a specific behavior change

4480. Self-responsibility facilitation: Encouraging a patient to assume more responsibility for own behavior

4500. Substance use prevention: Prevention of an alcoholic or drug use lifestyle

4700. Cognitive restructuring: Challenging a patient to alter distorted thought patterns and view self and the world more realistically

4860. Reminiscence therapy: Using the recall of past events, feelings, and thoughts to facilitate pleasure, quality of life, or adaptation to present circumstances

4920. Active listening: Attending closely to and attaching significance to a patient's verbal and nonverbal messages

5000. Complex relationship building: Establishing a therapeutic relationship with a patient to promote insight and behavioral change

5020. Conflict mediation: Facilitation of constructive dialogue between opposing parties with the aim of resolving conflicts in a mutually acceptable manner.

5100. Socialization enhancement: Facilitation of another person's ability to interact with others

5230. Coping enhancement: Facilitation of cognitive and behavioral efforts to manage perceived stressors, changes, or threats that interfere with meeting life demands and roles

5240. Counseling Use of an interactive helping process focusing on the needs, problems, or feelings of the patient and significant others to enhance or support coping, problem solving, and interpersonal relationships

5250. Decision-making support: Providing information and support for a patient who is making a decision regarding health care

5270. Emotional support: Provision of reassurance, acceptance, and encouragement during times of stress

5300. Guilt work facilitation: Helping another to cope with painful feelings of actual or perceived responsibility

5310. Hope inspiration: Enhancing the belief in one's capacity to initiate and sustain actions

5326. Life skills enhancement: Developing an individual's ability to independently and effectively deal with the demands and challenges of everyday life

5328. Listening visits: Empathic listening to genuinely understand an individual's situation and work collaboratively over a number of home visits to identify and generate solutions to reduce depressive symptoms

5330. Mood management: Providing for safety, stabilization, recovery, and maintenance of a patient who is experiencing a dysfunctionally depressed or elevated mood

5380. Security enhancement: Intensifying a patient's sense of physical and psychological safety

5390. Self-awareness enhancement: Assisting a patient to explore and understand his/her thoughts, feelings, motivations, and behaviors

5395. Self-efficacy enhancement: Strengthening an individual's confidence in his/her ability to perform a healthy behavior

5400. Self-esteem enhancement: Assisting a patient to increase his or her personal judgment of self-worth

5430. Support group: Use of a group setting to provide emotional support and health-related information to its members.

5440. Support system enhancement: Facilitation of support to patient by family, friends, and community

5450. Therapy group: Application of psychotherapeutic techniques to a group, including the utilization of interactions between members of the group

(Continues)

TABLE 2 (Continued)

5460. Touch: Providing comfort and communication through purposeful tactile contact

5480. Values clarification: Assisting another to clarify her/his own values in order to facilitate effective decision-making

5510. Health education: Developing and providing instruction and learning experiences to facilitate voluntary adaptation of behavior conducive to health in individuals, families, groups, or communities

5515. Health literacy enhancement: Assisting individuals with limited ability to obtain, process, and understand information related to health and illness

5616. Teaching: prescribed medication: Preparing a patient to safely take prescribed medications and monitor for their effects

5880. Calming technique: Reducing anxiety in patient experiencing acute distress

5960. Meditation facilitation: Facilitating a person to alter his/her level of awareness by focusing specifically on an image or thought

6040. Relaxation therapy: Use of techniques to encourage and elicit relaxation for the purpose of decreasing undesirable signs and symptoms such as pain, muscle tension, or anxiety

6160. Crisis intervention: Use of short-term counseling to help the patient cope with a crisis and resume a state of functioning comparable to or better than the precrisis state

6240. First aid: Providing immediate care for minor burns, injuries, poisoning, bites, and stings

6340. Suicide prevention: Reducing the risk for self-inflicted harm with intent to end life

6486. Environmental management – safety: Monitoring and manipulation of the physical environment to promote safety

6520. Health screening: Detecting health risks or problems by means of history, examination, and other procedures

6610. Risk identification: Analysis of potential risk factors, determination of health risks, and prioritization of risk reduction strategies for an individual or group

7100. Family integrity promotion: Promotion of family cohesion and unity

7110. Family involvement promotion: Facilitating participation of family members in the emotional and physical care of the patient

7130. Family process maintenance: Minimization of family process disruption effects

7140. Family support: Promotion of family values, interests, and goals

7150. Family therapy: Assisting family members to move their family towards a more productive way of living

7200. Normalization promotion: Assisting parents and other family members of children with chronic illnesses or disabilities in providing normal life experiences for their children and families

7800. Quality monitoring: Systematic collection and analysis of an organization's quality indicators for the purpose of improving patient care

7910. Consultation: Using expert knowledge to work with those who seek help in problem solving to enable individuals, families, groups, or agencies to achieve identified goals

7960. Health care information exchange: Providing patient care information to other health professionals

8020. Multidisciplinary care conference: Planning and evaluating patient care with health professionals from other disciplines

8100. Referral: Arrangement for services by another care provider or agency

8180. Telephone consultation: Eliciting patient's concerns, listening, and providing support, information, or teaching in response to patient's stated concerns, over the telephone

8190. Telephone follow-up: Providing results of testing or evaluating patient's response and determining potential for problems as a result of previous treatment, examination, or testing, over the telephone

8340. Resiliency promotion: Assisting individuals, families, and communities in development, use, and strengthening of protective factor to be used in coping with environmental and societal stressors

awareness and training of professionals are needed, through knowledge of evidence-based interventions. This article identifies the most effective interventions from the NIC taxonomy described for the prevention and treatment of patients presenting with suicidal ideation and behavior. In order to get a broad and comprehensive view of existing interventions supported by the best evidence, an extensive search was conducted, including systematic reviews and meta-analyses. An assessment of the methodological quality of the included systematic reviews and meta-analyses by two independent reviewers determined a high-quality rating for most of the studies. Taking into account the concepts that integrate the holistic nursing metaparadigm (person, health, environment, care), as well as the different integral models of nursing care such as the critical-holistic model of Miotto Wright (Wright, 2000), intervention against suicidal ideation and the prevention of suicidal behavior offers the nursing discipline a wide field of intervention. The results of this study confirm the efficacy of holistic (bio-psycho-social) interventions, based on psychological therapy, pharmacotherapy, interventions related to the relationship between the health professional and the patient, and interventions aimed at the general population.

NIC interventions based on psychological therapies for the management and reduction of suicide risk are prevalent in the scientific literature and are shown to be effective for patients with suicidal ideation or previous suicide attempts (D'Anci et al., 2019; Gøtzsche & Gøtzsche, 2017; Lai et al., 2014; Meerwijk et al., 2016; Méndez-Bustos et al., 2019; Milner et al., 2014). In this line, P. C. Gøtzsche and P. K. Gøtzsche associated interventions based on modifications of the patient's thought processes, improvement of self-confidence, and cognitive restructuring with a 50% reduction in the repetition of suicidal behavior. Interventions to build resilience, and improve self-awareness, self-esteem and coping have been shown to be effective in reducing suicidal risk (Pérez et al., 2021; Revuelta et al., 2016). After these interventions, patients' expression improved self-acceptance and were able to recognize some positive personal characteristics; several studies report a significant improvement in the Rosenberg Self-Esteem Scale after these NIC interventions (Rodríguez et al., 2014). The use of self-help interventions, aimed at working on self-esteem and coping strategies, based on new information technologies (chats, social networks, apps, email, and so on) are associated with significant reductions in suicidal ideation when developed on the basis of scientific evidence and best practices (Büscher et al., 2020; Christensen et al., 2014; Lai et al., 2014; Larsen et al., 2016; Melia et al., 2020; Robinson et al., 2016). In this area, some studies have shown the development of these techniques in online formats using new technologies and tools to be effective, including mobile applications, group chats, and social networks (Büscher et al., 2020; Robinson et al., 2016; Christensen et al., 2014; Lai et al., 2014; Macedo et al., 2014).

Patients with suicidal ideation and/or behavior often require pharmacological treatment, especially when suicidal ideation and/or behavior is related to the presence of a mental disorder (Barbero et al., 2010; Sansaloni et al., 2020; Rodríguez et al., 2014). NIC nursing interventions related to medication management, including patient education (teaching of prescribed medication) on the use of psychotropic drugs, appropriate follow-up by nursing professionals, adherence, and side effect management showed significant evidence for the prevention and treatment of suicidal behavior (D'Anci et al., 2019; Lapierre et al., 2011; Meerwijk et al., 2016; Okolie et al., 2017; Riblet et al., 2017). Mood regulators, such as lithium, are among the most commonly used drugs in these preventive programs (D'Anci et al., 2019).

Interventions related to the nurse/patient relationship should be singled out as high-quality preventive interventions by assessing the active follow-up of patients and enabling the nursing practice to develop NIC interventions such as health counseling and education, decision support, values clarification, emotional support, mood management, active listening, and contact. Several studies link brief contact interventions to a reduction in suicide attempts (Milner et al., 2015; Riblet et al., 2017). The effectiveness of these interventions has been demonstrated both for direct contact in consultation or at home, and for contact by telephone, email, or post (Büscher et al., 2020; Christensen et al., 2014; Melia et al., 2020; Riblet et al., 2017; Robinson et al., 2016; Consejería de Sanidad y Dependencia, 2008). The scientific literature has linked contact interventions where emotional support is provided to the reduction of self-harm related to suicidal ideation (Briggs et al., 2019; Hoffberg et al., 2019; Méndez-Bustos et al., 2019; Winter et al., 2013). The therapeutic nurse/patient relationship is a protective element against suicidal behavior (Briggs et al., 2019; Lapierre et al., 2011; Riblet et al., 2017); from this supportive relationship, it is possible to help maintain positive family processes and promote family integration. Some authors have emphasized the preventive role of the nuclear family. The family context can become a positive source in terms of self-control, verbal conflict resolution, counseling, emotional support, monitoring, and protection from self-destructive and risky behaviors (Becoña Iglesias, 2001; Sánchez et Carrillo, 2002; Barbero et al., 2010; Villa et Hermida, 2001).

In terms of community intervention, in the NIC taxonomy, we can highlight the identification and management of risks in the environment (environmental management). In this regard, restricting access to the most widely used lethal methods is one of the most prevalent preventive measures; however, efforts should be directed towards exploring new methods which could replace them, with the aim of working proactively (Méndez-Bustos et al., 2019; Okolie et al., 2017; Christensen et al., 2014; Larsen et al., 2016; Lai et al., 2014). Health education and improved access to health information are key preventive elements. It is a priority to "break the silence," the traditional obscurantism, and to break with false myths, thinking and beliefs in relation to suicidal behavior, proposing actions to raise awareness and promote mental health from nursing consultations and advising the media in the dissemination of campaigns and news (Brito et al., 2020; Revuelta et al., 2016; Galán et al., 2010). New communication technologies, including social networks, chat rooms, online platforms, and mobile applications, are now key tools for community awareness raising. The reach, anonymity, instantaneity, and accessibility of these new information and communication technologies allow them to act as key elements alongside traditional media (Larsen et al., 2016; Macedo et al., 2014; Robinson et al., 2016).

Based on the latest edition of the NIC catalog of interventions (Butcher et al., 2018), this review identifies the various interventions that have been shown to be effective for individual and group work with the patient, family, and community. Prevention and treatment of suicidal behavior require comprehensive management in which patients, family, and community are provided with coping tools; behavioral interventions that directly address suicidal thoughts and behaviors; emotional management through psychological therapies; conventional therapies together with new information and communication technologies; support through therapeutic alliances and brief contact interventions; support for adherence to treatment, environmental management, and health education for patients and community.

LIMITATIONS

The research team worked within a time range of 10 years and used the latest published version of the NIC taxonomy, but the review focuses only on the most effective and specific NIC interventions for the prevention and treatment of suicidal behaviors, so there may be a bias of

interventions available to the nurse that is not described in this paper, as there is also learning from negative results.

CONCLUSION

This paper offers a highly methodological synthesis that identifies the most effective NIC interventions for the treatment and prevention of suicidal behavior. It provides a thorough and comprehensive review of the best evidence-based therapeutic interventions and can serve as a basis for clinical intervention guidelines and protocols and specific suicide prevention plans. These results enable nursing professionals to use the evidence to make decisions in their daily practice.

IMPLICATIONS FOR NURSING PRACTICE, RESEARCH, AND EDUCATION

This umbrella review synthesizes the most up-to-date evidence on the most effective NIC interventions for the treatment and prevention of suicidal behavior. It provides nursing practice with a review of the therapeutic interventions with the best evidence, being useful for the development of guidelines and protocols in clinical and care settings, as well as providing the up-to-date and evidence-based documentation that is necessary for the development of health policies and plans focused on the prevention and management of suicidal behaviors.

The standardized nursing interventions that have been detailed in this work allow the care provided to the patient, family, and community to be recorded and evaluated in a universal way, and thus to assess the impact on the needs and health of the units to be treated. Nursing professionals working in the field of research use standardized nursing language that facilitates the study and analysis of the quality and efficacy of the care provided. Therefore, the results obtained in this review can be used as quality indicators and can easily be compared with interventions and care provided worldwide. In the same way, these results synthesize the most current and effective scientific evidence, making it a necessary tool in the educational field for training future nursing professionals.

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CONFLICT OF INTEREST

The authors declare no conflict of interest.

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All authors have read and agreed to the published version of the manuscript.

ETHICS STATEMENT

Formal ethical approval is not required for this umbrella review under Spanish law, as no primary data are collected, and no patient intervention is involved.

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ARTÍCULO 5

INTERVENTIONS OF CHOICE FOR THE PREVENTION AND TREATMENT OF SUICIDAL BEHAVIOURS: AN UMBRELLA REVIEW

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SYSTEMATIC REVIEW

Interventions of choice for the prevention and treatment of suicidal behaviours: An umbrella review

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Abstract

Aim: This umbrella review aims to determine which interventions can be considered as effective in the prevention and treatment of suicidal behaviour.

Design: Umbrella review.

Methods: A systematic search was conducted of works indexed in the PubMed, CINAHL, Cochrane Database of Systematic Reviews, Scopus, ISI Web of Knowledge and Joanna Institute Briggs databases. The search covered works published from 2011 to 2020.

Results: The scientific literature shows that, in addition to being the most prevalent interventions in use, dialectical and cognitive behavioural therapies are the most effective in the treatment and management of suicide attempts and suicidal ideation. It is shown that the prevention and treatment of suicidal behaviour requires multidisciplinary and comprehensive management. Among the interventions that stand out the most are the promotion of providing coping tools, work based on thought and behaviour, and behavioural, psychoanalytic and psychodynamic therapies for the management of emotions.

KEYWORDS
attempted suicide, risk factors, risk reduction behaviour, suicidal ideation, suicide

1 | INTRODUCTION

Within the multidisciplinary framework that encompasses the act of suicide—and with specific regard to the factors that may positively or negatively influence the development of suicidal behaviour—protective factors, predisposing factors and risk factors can be described. Protective factors are those that provide the strength to overcome problems and thus to continue with life. Predisposing factors are considered as drivers of suicidal behaviour and risk factors increasing the likelihood of progressing to suicide (Campo-Arias & Suárez-Colorado, 2019). Consequently, professionals should focus their actions on promoting life-sustaining components, such as limiting access to lethal tools or improving access to health systems (Anseán, 2014), in addition to training in the recognition of risk factors, including previous suicide attempts or the presence of a mental illness (World Health Organization, 2014) and reducing the impact of those which could act as predisposing factors (Oliván et al., 2021). Suicide is now a public health problem; therefore, professional and community intervention must be a global priority of health and political programmes (World Health Organization, 2014). An estimate by the same organisation puts the number of people who die by suicide at 700,000 per year, while each of these lethal events is accompanied by twenty attempts (World Health Organization, 2021a, 2021b). From these figures, it can be inferred that there are more than 16-million suicide attempts in the world each year and a previous suicide attempt has been determined to be the most relevant individual risk factor (World Health Organization, 2018).

Milner et al. (2015) reviewed 12 articles and concluded that brief professional–patient contact interventions successfully reduced the frequency of repeated self-harm; the effectiveness of telephone and letter contact was studied. Research focusing on new technologies available as follow-up tools determined their statistically significant effectiveness in the preventive field (Larsen et al., 2016). In addition, such mobile technology reduces depression, anxiety and self-harm, improving coping strategies (Melia et al., 2020).

In 2017, a manuscript in which the authors analysed 78 reviews concluded that brief contact intervention, as indicated by the World Health Organization (WHO), was competent and effective in the prevention of suicidal behaviour; telephone contact interventions, group therapies, education, management and treatment with lithium and counselling, and cognitive behavioural therapy also reduced deaths from suicide (Riblet et al., 2017). Cognitive behavioural therapy has been identified to be more effective than traditional treatments in reducing the risk of new suicide attempts (Gøtzsche & Gøtzsche, 2017; Lai et al., 2014). Considering multilevel intervention, several studies have indicated the effectiveness of cognitive behavioural therapy, individual and group support, brief contact, counselling, support groups led by well-trained health professionals, early detection of risk symptoms, improved access to the health care system, community education and awareness, mental health promotion, stress management and coping support (Hofstra et al., 2020; Lai et al., 2014).

In 2020, a systematic review identified that dialectical behavioural therapy, cognitive behavioural therapy, health education, contact and follow-up and gatekeepers were effective tools for the treatment and prevention of suicidal behaviour and the prevention of both completed suicide and suicide attempts (Hofstra et al., 2020).

The most recent work focusing on intervention in suicidal behaviour highlighted the validity of interventions at different levels, statistically significantly reducing ideation and behaviour repetition (Briggs et al., 2019; Büscher et al., 2020; Gøtzsche & Gøtzsche, 2017; Larsen et al., 2016; Melia et al., 2020).

Despite the current scientific basis, it is not known whether there is proven efficacy in any specific intervention compared to others or whether there is a gender perspective in the study of suicidal behaviour due to the different epidemiological distribution. Specifically concerning to gender, one review reflected greater effectiveness of recognition and treatment of depression in women (Lapierre et al., 2011).

Another question is whether there are differences in the effectiveness of interventions that focus on addressing suicidal behaviour compared to interventions that address the symptomatology that may accompany it, such as hopelessness.

In Spain, the first national document focusing on the treatment and prevention of suicidal behaviour was published in 2011 (Grupo de Trabajo de la Guía de Práctica Clínica de Prevención y Tratamiento de la Conducta Suicida, 2011), which represented a breakthrough in nursing intervention by reducing the variability of healthcare. Specifically, in La Rioja, the II Health Plan in force in 2011 strongly recommends the development of strategies for suicide prevention (Ministry of Health, 2009). In the same year, the European Commission formally urged EU Member States to prioritise suicide prevention strategies in their health policies (Scheftlein, 2011). At the same time, PAHO and WHO published a guideline protocolising the intervention and assessment of patients with suicidal behaviour and mental, neurological or substance use disorders (World Health Organization, 2011). At the international level, the 66th World Health Assembly adopted the WHO Comprehensive Mental Health Action Plan 2013–2020, whose main objectives included reducing the suicide rate by 10% by 2020 (World Health Organization, 2013). In addition, this work could be useful for evaluating the national plan for addressing suicidal behaviour in Spain, which was due to end in 2020. This fact,

which coincided in time with the designation of 2020 as the international year of the nursing and midwifery profession, established the deadlines for the search for reviews, with the aim of subsequently presenting the results to the community and emphasising the work of the nursing professional in the areas of management, clinical, teaching and research.

Because the most powerful works analysing tools for intervention and prevention of suicidal behaviour are conducted with heterogeneous methodologies, it is not possible to obtain a unified approach to discerning which interventions are considered as effective and more efficacious. Therefore, conducting an umbrella review provides an assessment of the quality of the existing evidence and contributes to the creation of an overview (Aromataris et al., 2015; Biondi-Zoccai, 2016). An umbrella review is a review of reviews. That is, it is a methodology used to identify studies that synthesise higher levels of evidence on a specific topic to generate synthesis synopses (Chambergo-Michilot et al., 2021).

This general review aims to determine which interventions can be considered effective in the prevention and treatment of suicidal behaviour.

2 | METHODOLOGY

A detailed research protocol (Sufrate-Sorzano et al., 2021), was prepared and registered in the Prospective International Register of Systematic Reviews (PROSPERO) with registration number CRD42020221516.

2.1 | Database search

A search was carried out for papers published from 1 January 2011 to 1 May 2020. The databases used were Scopus, Cumulative Index to Nursing and Allied Health Literature (CINAHL), Joanna Institute Briggs, Institute for Scientific Information Web of Knowledge (ISI WoK), PubMed and Cochrane Database of Systematic Reviews. The inclusion of the results was carried out by two reviewers independently. Next came an analysis of the references found in the papers that were included. Methodological quality analysis and data extraction from systematic reviews and meta-analyses were performed independently by two people. A third reviewer independently arbitrated any discrepancies resulting from the work of the two reviewers.

2.2 | Search terms

The keywords used for the systematic search were: Systematic review, Tertiary prevention, Secondary prevention, Primary prevention, Risk reduction behaviours, Suicidal ideation, Suicide attempt, Suicide, Risk, Risk assessment, Risk factors. Boolean AND and OR operators combined the terms and were adapted according to the database used. The search strategy is shown in Supplement S1.

2.3 | Eligibility criteria

Systematic reviews and meta-analyses of men and women aged 18 years or older were included for analysis.

2.4 | Inclusion and exclusion criteria

The inclusion and exclusion criteria were systematic reviews indicating the databases used for the search and the selection of papers, whether or not they included meta-analyses. Specifically, the subject of the study had to be health interventions for the management or prevention of suicidal behaviour, suicide attempts or suicide itself. Systematic reviews were selected from the general community, that is population groups such as armed forces professionals, prisoners, war veterans and the military were not part of the analysis. All were published within the last 10 years in English or Spanish.

2.5 | Study selection

The selection process for the systematic reviews and meta-analyses was developed using Covidence software. Covidence is a screening and extraction tool that allows, among other functions, uploading search results, screening abstracts and full-text study reports, completing data collection, performing risk of bias assessment and resolving disagreements (Covidence, 2020). The initial search was conducted by one researcher. For the elimination of duplicates and the review of titles and abstracts, two independent peer reviews were used to confirm inclusion and exclusion criteria. Papers that were selected by at least one of the reviewers were analysed in full for re-evaluation. If discrepancies occurred, a third reviewer was asked to referee. In order to cover multidisciplinarity, the reviewers were a nurse, a psychologist and a graduate in medical anthropology.

The researchers retrieved a total of 3711 articles (PubMed 575, CINAHL 341, Scopus 1156, WOS 1563, CENTRAL 22 and JBI 54). After eliminating duplicate papers, 2302 results were analysed, first by title and abstract. The papers were selected by two reviewers following independent evaluation, and the disagreements that arose were discussed with a third reviewer. Next, the inclusion and exclusion criteria described above were applied, and 314 papers emerged as relevant, which were then critically analysed. Finally, 23 systematic reviews were chosen for this review. The procedure followed in this 'umbrella review' is shown in Figure 1. At each stage, three reviewers implemented measures to minimise the risk of bias and error.

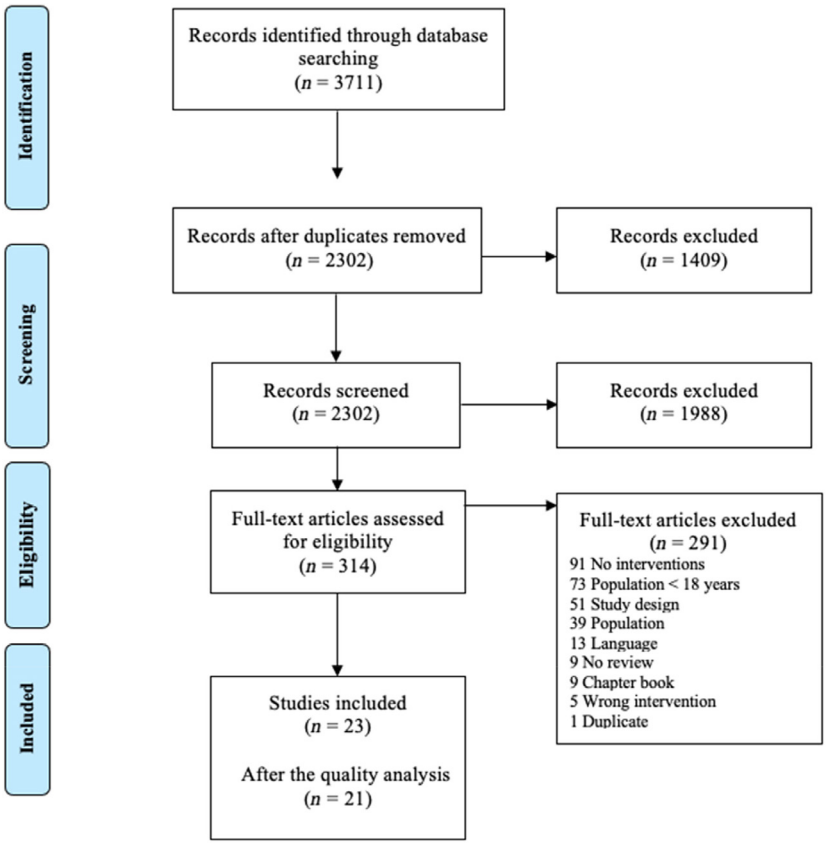

FIGURE 1 Adapted PRISMA flowchart.

2.6 | Quality assessment

An independent quality assessment of the key papers was conducted by two reviewers using the 'JBI Critical Appraisal Checklist for Systematic Reviews and Research Syntheses' (Joanna Briggs Institute, 2021). This tool uses 11 criteria that assign a general quality rating to each work, ranging from low quality, if the score is below 40%, to medium quality, if it is between 40%–70%, and high quality, when it exceeds 70%. In cases of disagreement, a consensus was reached through discussion with a third reviewer. In this phase of the investigation, the team agreed to exclude two papers whose quality level was lower than 40% (36% and 27%, respectively). The vast majority of the reviews included (14) were rated as being of 'high' quality, with scores ranging from 72% to 91%, and the rest of the papers (7) were rated as 'medium' with scores between 45% and 63%. The most common caveats were related to no details in the review question and a lack of methods for minimising errors during data extraction. The document Supplementary S2 shows the quality assessment of the reviews included.

2.7 | Data extraction

An adapted version of the 'JBI data extraction tool' was developed to create a data extraction form. This tool was piloted by eight members of the research team. The data extracted using this form were analysed based on the research question by two independent reviewers, who identified and summarised the interventions described in each study. The items included in the extraction tool include data on the reviewer, the date of the article, author, objectives of the study, number of studies analysed, method used, author's conclusions, comments and the date the review was carried out.

2.8 | Ethics

Research Ethics Committee approval was not required.

3 | RESULTS

A total of 21 reviews published from 2011 to 2020 were included.

Table 1 (description of selected studies) is organised by the year of publication of the reviews and summarises the selected studies in detail, including their stated objectives, main results and the number of studies covered by each review.

Most of the studies attempted to determine which interventions were effective for the prevention of suicidal behaviour (D'Anci et al., 2019; Hoffberg et al., 2019; Hofstra et al., 2020; Lapierre et al., 2011; Méndez-Bustos et al., 2019; Riblet et al., 2017). Some

TABLE 1 Description of the selected studies: objectives, numbers of studies and most important results.

Reference	Objectives	Studies	Results
Lapierre et al. (2011)	Examine results of interventions and identify successful strategies.	19	The detection and treatment of depression together with a reduction in isolation showed lower levels of ideation and suicide rates. In addition, it was more effective in women.
Winter et al. (2013)	Understand the current status of prevention and its effectiveness.	112	There is evidence for suicide prevention through cognitive behavioural therapy (CBT), dialectical behavioural therapy (DBT) and problem-solving therapy (PS).
Christensen et al. (2014)	Examine online suicide detection, the effectiveness of interventions and proactive interventions after identifying people at risk using their posts.	9	Online suicide screening: This appears to be accepted among the population but requires further research. The effectiveness of interventions increases if they are focused on suicidal thoughts and behaviour and not on symptoms associated with depression. Social networks show statistically significant potential for identifying people at risk.
Lai et al. (2014)	Review and evaluate suicide prevention strategies available on the web.	15	Internet-based cognitive behavioural therapy reduced ideation in the general population, and there are probable benefits of other web-based strategies for suicide prevention.
Milner et al. (2014)	Evaluate suicide prevention activities in the workplace.	13	No conclusions can be drawn about the effectiveness of suicide prevention in the workplace (observational or quasi-experimental studies with a lower capacity for making causal inferences).
Macedo et al. (2014)	Assess the effectiveness of resilience promotion interventions in adults. Assess their effectiveness for suicidal behaviour.	13	Most of the included studies report some degree of improvement in resilience among subjects exposed to a health promotion program.
Milner et al. (2015)	Synthesise evidence regarding the effectiveness of brief contact interventions for reducing self-harm, suicide attempts and completed suicide.	12	Brief contact interventions were successful in reducing the frequency of reversion to self-harm.
Robinson et al. (2016)	Identify current evidence related to social networks as a tool for suicide prevention.	30	Research of social networks as suicide prevention tools presented positive findings due to their reach, anonymity, instantaneity, acceptability and absence of prejudice, showing key advantages over other methods.
Meerwijk et al. (2016)	Assess whether psychosocial and behavioural interventions that address suicidal thoughts and behaviours are more effective for reducing suicides and suicide attempts than interventions that address only associated symptoms	53	Psychosocial and behavioural interventions that directly address suicidal thoughts and behaviours are effective in both the short and long term, while treatments that address symptoms associated with suicidal behaviour are only effective in the long term.
Larsen et al. (2016)	To examine the concordance of the characteristics of available applications with the current scientific evidence on effective suicide prevention strategies.	49	Some applications provide evidence-based best-practice elements with statistically significant preventive results, but none provide comprehensive, evidence-based support. Harmful online content has been identified, so caution must be employed when recommending its use.
Okolie et al. (2017)	Identify and evaluate the evidence on the effectiveness of interventions for older adults for the prevention of suicidal behaviour and reduction of suicidal ideation.	21	Multifaceted interventions in older adults can be effective for preventing suicidal behaviour and reducing ideation.
Gøtzsche & Gøtzsche (2017)	Assess the efficacy of cognitive behavioural therapy for suicide prevention.	20	Cognitive behavioural therapy compared to usual treatment reduces the risk of a new suicide attempt by 50%.

(Continues)

TABLE 1 (Continued)

Reference	Objectives	Studies	Results
Riblet et al. (2017)	Identify interventions for suicide prevention.	78	The WHO brief contact intervention (BIC) is a promising suicide prevention strategy. No other intervention showed a statistically significant effect in reducing suicide; lithium and CBT trials reduced deaths from suicide but without definitive statistical conclusions.
Tighe et al. (2018)	Assess the efficacy of acceptance and commitment therapy for reducing suicidal ideation and self-harm.	5	In 2 studies (pre- and post-intervention), acceptance and commitment therapy (ACT) was effective for reducing suicidal ideation. There is insufficient evidence to recommend ACT as a preventive intervention.
Méndez-Bustos et al. (2019)	Review available scientific evidence on the effectiveness of psychotherapeutic tools designed to treat patients at risk of suicide.	40	The results confirm the effectiveness of psychotherapeutic interventions for the management and reduction of suicide risk. DBT and CBT seem to be the most widely used psychotherapeutic interventions for patients who present suicidal ideation or past suicide attempts.
Briggs et al. (2019)	Systematically review randomised controlled trials of psychoanalytic and psychodynamic psychotherapies for suicide attempts and self-harm.	12	Psychoanalytic and psychodynamic psychotherapies are effective for reducing suicidal behaviour and self-harm and improving psychosocial well-being.
D'Anci et al. (2019)	Assess risks/benefits of interventions related to suicide prevention.	23	In-person or online CBT shows moderate evidence for reducing suicide attempts, suicidal ideation and hopelessness compared to standard treatment. There is moderate evidence for the use of intravenous ketamine in the short term to reduce suicidal ideation and the use of lithium to reduce suicide.
Hoffberg et al. (2019)	Review the clinical effectiveness of psychotherapeutic tools designed to treat patients at risk of suicide.	40	DBT and CBT are the most widely used psychotherapeutic interventions, and they show promising results. Group therapies and Internet-based therapies are promising treatments and require further study.
Melia et al. (2020)	Examine the effectiveness of mobile technological tools available for the prevention of suicidal tendencies.	7	Mobile technology reduces depression, distress and self-harm and increases coping strategies.
Büscher et al. (2020)	Study whether internet-based self-help interventions are associated with a reduction in suicidal ideation.	6	Internet-based self-help interventions are associated with statistically significant reductions in suicidal ideation.
Hofstra et al. (2020)	Evaluate the effects of suicide prevention interventions.	16	The findings show that preventive interventions are effective for preventing both completed suicides and suicide attempts. The effect size is larger for completed suicides than for suicide attempts.

studies evaluated specific interventions such as brief contact (Milner et al., 2015), the promotion of resilience in adults (Macedo et al., 2014), and acceptance and commitment therapy (Tighe et al., 2018) and assessed their role in suicide prevention. In the quality analysis, the review by Milner et al. (2015) scored 45%, with shortcomings mainly in the assessment of the likelihood of publication bias and methods to minimise errors in data extraction. Tighe et al. (2018) exceeded 60% and Macedo et al. (2014) reached a 90% score.

The interventions described in the selected reviews were placed into five main categories to facilitate proper analysis: therapy-based interventions, pharmacotherapy-related interventions, Internet-based interventions, patient and healthcare professional-related interventions and community-related interventions.

3.1 | Therapy-based interventions

Therapy-based interventions include those based on dialectical behavioural therapy, cognitive behavioural therapy, problem-solving and adaptation therapy, psychodynamic therapy, psychoanalytic therapy, family, interpersonal, group therapy and acceptance and commitment (Briggs et al., 2019; D'Anci et al., 2019; Gøtzsche & Gøtzsche, 2017; Hofstra et al., 2020; Lai et al., 2014; Lapierre et al., 2011; Meerwijk et al., 2016; Melia et al., 2020; Milner et al., 2015; Okolie et al., 2017; Riblet et al., 2017; Tighe et al., 2018; Winter et al., 2013).

Briggs et al. (2019) concluded that psychoanalytic and psychodynamic psychotherapies are effective for reducing suicidal behaviour and self-harm and for improving psychosocial well-being. Along the

same lines, two reviews published in 2019 determined that dialectical behavioural therapy and cognitive behavioural therapy—the most widely used psychotherapeutic interventions—showed the most promising and effective results among all treatments for patients with suicidal ideation or suicide attempts (D'Anci et al., 2019; Méndez-Bustos et al., 2019), and further determined that cognitive behavioural therapy reduces the risk of a new suicide attempt by 50% compared to the usual treatment (Gøtzsche & Gøtzsche, 2017). There is insufficient evidence to recommend acceptance and commitment therapy as a prevention intervention, although in pre–post studies, such therapy was effective for reducing suicidal ideation (Tighe et al., 2018). Group-based therapies require further study (Hoffberg et al., 2019).

3.2 | Pharmacotherapy-related interventions

Interventions related to pharmacotherapy included educating patients about pharmacological treatments and controlling side effects while providing information on topics such as improving adherence to achieve greater stabilisation (D'Anci et al., 2019; Lapierre et al., 2011; Meerwijk et al., 2016; Okolie et al., 2017). A 2017 review concluded that trials with lithium reduced deaths from suicide, although without definitive statistical conclusions (Riblet et al., 2017). Subsequently, 2 years later, moderate evidence was identified regarding the use of short-term intravenous ketamine to reduce suicidal ideation, and the use of lithium to reduce suicide (D'Anci et al., 2019). Along with those lines, a systematic review with meta-analysis from Meerwijk et al. (2016) confirmed that promoting patient adherence to treatment by means of postcards, telephone calls, home visits or letters of support was effective in addressing the symptoms associated with suicidal behaviour. Furthermore, this review, with meta-analysis, showed that interventions that directly target suicidal behaviour are effective immediately and in the long term, while interventions that target related symptoms are only effective in the long term.

3.3 | Internet-based interventions

Interventions developed by using online technologies and platforms, the applications available for mobile devices, and social networks have been classified as Internet-based interventions. Evidence has been identified for the effective use of psychological therapies such as cognitive behavioural therapy, self-help therapy, support groups and group chats in online formats (Büscher et al., 2020; Christensen et al., 2014; Lai et al., 2014; Larsen et al., 2016; Melia et al., 2020; Robinson et al., 2016). Along these lines, Internet-based cognitive behavioural therapy reduced suicidal ideation in the general population (Lai et al., 2014). Furthermore, a systematic review from 2016 showed evidence that social media is a suicide prevention tool with key advantages over other methods, due to its scope, anonymity, instantaneity, acceptability and absence of prejudice (Robinson et al., 2016). A meta-analysis by Büscher et al. (2020) concluded that Internet-based self-help interventions were associated with statistically significant reductions in suicidal ideation. Notably, the quality analysis of this review scored over 90% (high quality). Specifically, online intervention is also effective for improving resilience (a protective factor for suicidal behaviour) in adult patients using health promotion programmes (Macedo et al., 2014). Christensen et al. (2014) determined that online suicide screening is accepted among the population, but additional research is required to determine its correct application. Some applications available for mobile devices showed evidence-based elements of best practice with statistically significant results at a preventive level, but none provided comprehensive, evidence-based support. Harmful content has been identified online (Picardo et al., 2020); therefore, caution must be exercised when recommending such interventions (Larsen et al., 2016). A 2020 systematic review examined the effectiveness of the mobile technological tools available for the prevention of all suicidal tendencies and determined such technology had the positive impacts of reducing depression, anxiety and self-harm, in addition to increasing coping strategies (Melia et al., 2020). No evidence was found on how a health professional may go about assessing the risk of suicide.

3.4 | Patient and healthcare professional-related interventions

Winter et al. (2013) determined that teaching patients social and coping skills was an effective strategy, while work by Meerwijk et al. (2016) established that psychosocial and behavioural interventions that directly address suicidal thoughts and behaviours are effective in both the short and long term, while treatments that address the symptoms associated with suicidal behaviour are only effective in the long term. Lapierre et al. (2011) expanded upon this idea, determining that the detection and treatment of depression together with the reduction of isolation were associated with lower levels of ideation and suicide rates, more so in women than in men. The therapeutic alliance established between professional therapist and patient has been determined by several reviews to be the basis of health care and protective elements (Briggs et al., 2019; Lapierre et al., 2011; Riblet et al., 2017).

3.5 | Community-related interventions

The prevention of suicidal behaviour requires multidisciplinary action; therefore, collaboration of the population with related organisations is necessary. Therefore, strategies categorised as community-related interventions promote access to health services, community awareness, standardisation of the information included when publishing suicides in the press, reduction of access to the media, gatekeeper figures in the community, evaluation of the quality of the information contained on web pages and mental health (D'Anci et al., 2019; Hofstra et al., 2020; Lai et al., 2014; Lapierre et al., 2011; Macedo et al., 2014; Milner et al., 2014; Okolie et al., 2017). Table 2 displays the interventions analysed in each review.

TABLE 2 Interventions found in the reviews analysed.

Interventions\Authors	Briggs et al. (2019)	Büscher et al. (2020)	Christensen et al., 2014)	D'Anci et al. (2019)	Gøtzsche & Gøtzsche (2017)	Hoffberg et al. (2019)	Hofstra et al. (2020)	Lai et al. (2014)	Lapierre (2011)
Dialectical behavioural therapy		x	x	x		x	x		x
Cognitive behavioural therapy		x	x	x	x	x	x		x
Problem-solving/adaptation therapy			x			x			
Psychodynamic therapy	x					x			
Psychoanalytic therapy	x								
Family therapy						x			
Interpersonal therapy						x			x
Therapy/support groups								x	
Therapy based on acceptance and commitment									
Gatekeeper							x		
Personalised therapeutic relationship/alliance	x								x
Active follow-up, contact and brief intervention *(by phone, e-mail, postal mail)*			x			x	x	x	x
Pharmacotherapy, adherence to treatment and control of side effects				x					x
Detection and treatment of depression									x
Skills training *(social, coping)*									
Phycological education, self-care and counselling	x					x	x	x	
Online intervention *(cognitive behavioural therapy, self-help therapy, chat, support groups)*		x						x	

Interventions\Authors	Briggs et al. (2019)	Büscher et al. (2020)	Christensen et al. (2014)	D'Anci et al. (2019)	Gøtzsche & Gøtzsche (2017)	Hoffberg et al. (2019)	Hofstra et al. (2020)	Lai et al. (2014)	Lapierre (2011)
Follow-up visits/meetings						x			x
Promotion of mental health, stress management and strengthening of protective factors *(resilience, hope)*									x
Contact and support in crisis									
Control of mood and emotions	x								
Instructions on publication to the press							x		
Community awareness									
Reduced access to media									
Access to health services								x	
Evaluation of the quality of informational websites								x	

4 | DISCUSSION

In this article, we identified the most effective tools described for the treatment and intervention of patients exhibiting suicidal behaviour and conduct. To achieve a broad and comprehensive overview of existing interventions supported by the best evidence, a broad search was conducted encompassing systematic reviews and meta-analyses. An assessment of the methodological quality of the included systematic reviews and meta-analyses performed by two independent reviewers determined a high-quality rating for most of the studies.

Larsen et al. (2016)	Macedo et al. (2014)	Meerwijk et al. (2016)	Melia et al. (2020)	Méndez-Bustos et al. (2019)	Milner et al. (2015)	Milner et al. (2014)	Okolie et al. (2017)	Riblet et al. (2017)	Robinson et al. (2016)	Tighe et al. (2018)	Winter et al. (2013)
x		x	x	x							x
		x		x	x			x			x
		x		x			x				x
				x							x
				x							x
				x							x
				x			x				
	x	x					x	x			x
			x							x	
						x	x				
									x		
		x		x	x		x	x	x		
		x					x	x			
						x	x				
		x	x	x		x					x
x			x	x		x	x	x			
	x								x		

Larsen et al. (2016)	Macedo et al. (2014)	Meerwijk et al. (2016)	Melia et al. (2020)	Méndez-Bustos et al. (2019)	Milner et al. (2015)	Milner et al. (2014)	Okolie et al. (2017)	Riblet et al. (2017)	Robinson et al. (2016)	Tighe et al. (2018)	Winter et al. (2013)
		x		x							x
	x					x					
x			x		x				x		
x			x	x							
						x					
						x					

The results confirmed the effectiveness of psychotherapeutic interventions for the management and reduction of suicide risk. The scientific literature shows that—in addition to being the most prevalent interventions in use—dialectical behavioural therapy and cognitive behavioural therapy are the most promising and effective interventions for patients with suicidal ideation or previous suicide attempts (D'Anci et al., 2019; Gøtzsche & Gøtzsche, 2017; Lai et al., 2014; Meerwijk et al., 2016; Méndez-Bustos et al., 2019; Milner et al., 2014).

Along these lines, Gøtzsche and Gøtzsche (2017) related interventions based on cognitive behavioural therapy to a 50% reduction

in the repetition of suicidal behaviour. Psychoanalytic and psychodynamic therapies, although used less frequently, are effective for improving the emotional well-being of patients, which helps reduce self-harm (Briggs et al., 2019; Hoffberg et al., 2019; Méndez-Bustos et al., 2019; Winter et al., 2013).

As for restricting access to the most widely used lethal methods, there is clear evidence this is beneficial in prevention. However, research efforts should now be directed towards exploring what new methods could replace them, with the aim of working proactively.

The umbrella review identified interventions specifically aimed at selective and indicated prevention, but few interventions directly related to the universal prevention of suicidal behaviour.

New communication technologies, including social networks, chats, online platforms and mobile applications are therapeutic tools with statistically significant preventive results. The scope, anonymity, instantaneity and acceptability of these new information and communication technologies allow them to act as key therapeutic elements. Internet-based self-help interventions, online cognitive behavioural therapy, support groups through group chats and new mobile applications that provide users with evidence-based, best-practice elements are associated with statistically significant reductions in suicidal ideation (Büscher et al., 2020; Christensen et al., 2014; Lai et al., 2014; Larsen et al., 2016; Melia et al., 2020; Robinson et al., 2016). However, harmful content and even inducers of suicidal behaviour have been identified on the Internet. Trained health professionals should review these applications before recommending their use to patients, in addition to controlling and monitoring them.

These online suicide prevention strategies have become complementary to conventional strategies (Larsen et al., 2016; Macedo et al., 2014; Robinson et al., 2016) and open up new possibilities for health policies and programmes to examine their resources and adapt to the new needs of society. In this vein, questions are being raised about the management of confidentiality, the professional–patient relationship and intervention in acute crises involving immediate risk. More studies are needed to evaluate the effectiveness of online interventions and foster their use over conventional interventions.

In many cases, the aetiology of suicidal behaviour is related to the presence of a serious underlying mental disorder, and in these cases, adherence to treatment in order to stabilise a patient is essential for the prevention of suicidal behaviour. Therapeutic interventions related to the administration of medication, including patient training on the use of psychotropic drugs, proper follow-up, adherence and the control of side effects showed statistically significant evidence of being interventions of choice for the prevention and treatment of suicidal behaviour (D'Anci et al., 2019; Lapierre et al., 2011; Meerwijk et al., 2016; Okolie et al., 2017; Riblet et al., 2017). Mood regulators such as lithium are included among the drugs most commonly used in these preventive programmes (D'Anci et al., 2019).

In relation to conventional antidepressant treatment, some patients do not respond correctly or suffer the adverse effects of this treatment, which is a problem especially when suicidal risk behaviours may develop. In relation to conventional antidepressant treatment, some patients do not respond well or suffer the adverse effects of it, being a problem especially when suicidal risk behaviours may develop. Triple Chronotherapy (sleep deprivation, sleep phase advancement and bright light therapy) is safe and effective in producing a rapid and stable improvement of depressive symptoms and a reduction of suicidal risk (D'Agostino et al., 2020).

Brief contact interventions should be highlighted as high-quality preventive interventions when assessing active patient follow-up. Several studies link brief contact interventions with reduced suicide attempts (Milner et al., 2015; Riblet et al., 2017). The efficacy of these interventions has been demonstrated for direct contact and contact via telephone, e-mail or postal mail (Büscher et al., 2020; Christensen et al., 2014; Melia et al., 2020; Riblet et al., 2017; Robinson et al., 2016).

The therapeutic alliance between a healthcare professional and a patient has been established to be a protective element against suicidal behaviour, in addition to protocolised active contact and follow-up (Briggs et al., 2019; Lapierre et al., 2011; Riblet et al., 2017).

The epidemiology of suicide shows, on the one hand, that men have a higher suicide rate than women due to the greater lethality of the suicide methods used, and on the other hand, that women make a greater number of attempts (Barroso Martínez, 2019). The reviews we analysed do not allow us to determine a greater or lesser effectiveness for interventions based on sex (anatomy) or gender (social construction), so it is necessary to conduct new research that addresses suicide from a gender perspective to build new evidence based on the roles and characteristics of the population.

After reviewing the scientific literature, no intervention has been found in the set analysed that specifically stands out for its efficacy over the others, so the prevention and treatment of suicidal behaviour requires comprehensive management in which patients are provided with coping tools (Winter et al., 2013), behavioural interventions that directly address suicidal thoughts and behaviours (Meerwijk et al., 2016), emotional management through psychoanalytic and psychodynamic therapies, conventional therapies coupled with new information and communication technologies, support through therapeutic alliances and brief contact interventions, and treatment adherence support (Milner et al., 2015).

Within the theory of Basic Human Needs of the nurse Virginia Henderson, the importance of avoiding dangers in the environment is described, understanding as such 'the ability to maintain and promote one's own physical and mental integrity of oneself and others, in knowledge of the potential dangers of the environment' (Henderson, 1961). This research provides nursing professionals with the necessary basis for quality clinical practice in the care, prevention and treatment of patients at risk of suicide. The different therapeutic interventions described allow nurses to develop their professionalism with scientific evidence.

4.1 | Limitations

The main limitation of this umbrella review is that the decisions about the evidence for interventions are based on the judgement

of the research team, which means that reproducing the findings may be more difficult than in a meta-analysis. To minimise this, ten researchers were part of the process and conflicts were arbitrated by consensus. A meta-analysis was not possible due to the heterogeneity of the methodologies. Another limitation could be the language of the publications, as only English and Spanish reviews were considered. Finally, the review covers the years from 2011 to 2020.

5 | CONCLUSION

This work offers a highly methodological synthesis that allows for the identification of the most effective interventions of choice for the treatment and prevention of suicidal behaviour. It provides a joint and comprehensive review of the therapeutic interventions with the best evidence and may serve as the basis for clinical intervention guidelines and protocols and specific suicide prevention plans. These results allow health professionals to utilise evidence when making decisions in their daily practice.

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CONFLICT OF INTEREST STATEMENT

None declared.

DATA AVAILABILITY STATEMENT

Data available on request from the authors. The data that support the findings of this study are available from the corresponding author upon reasonable request. Sufrate-Sorzano, T.; 2023; Data repository Interventions of choice for the prevention and treatment of suicidal behaviours: an umbrella review; Dropbox.

ETHICS AND DISSEMINATION

Formal Research Ethics Committee approval is not required for this umbrella review under Spanish law, as no primary data are collected, and no patient intervention is involved.

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SUPPORTING INFORMATION

Additional supporting information can be found online in the Supporting Information section at the end of this article.

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ARTÍCULO 6

MEDIA EXPOSURE OF SUICIDAL BEHAVIOUR: AN UMBRELLA REVIEW

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MDPI

Systematic Review

Media Exposure of Suicidal Behaviour: An Umbrella Review

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Abstract: Aim: To analyse recommended interventions for the safe and responsible dissemination of suicidal behaviour in the media for preventive purposes. Background: Suicide is a serious public health problem that leads to more than 700,000 deaths per year, which translates into one death every forty seconds. The media play a significant role in shaping public perceptions and reflecting societal issues. Because of its active role in the construction of reality, the way in which the media report and expose suicidal behaviour has the capacity to influence the population in either a preventive or harmful way. Design: An umbrella review was carried out and a report was written according to the Preferred Reporting Items for Overviews of Reviews. Methods: We systematically searched for reviews published from inception to February 2023 in MEDLINE (PubMed), CINAHL and PsycInfo (via EBSCOhost), Web of Science, Embase, Cochrane Library of Systematic Reviews, Scopus, and Google Scholar. A narrative synthesis of the results was conducted. Results: Six systematic reviews with a moderate to high quality level were selected. Among the recommended interventions were the inclusion of positive messages of hope, resilience, or of overcoming the event, narratives with information on available resources or the promotion of support-seeking attitudes as an effective prevention mechanism, as well as the avoidance of repetitive reporting of the same suicide. The appropriate and responsible dissemination of information on suicidal behaviour in the media with complete and up-to-date information on available centres, organisations, institutions, and resources has proven to be effective, especially in vulnerable populations. Conclusion: Educating and training the media in an appropriate approach to disseminating suicidal behaviour helps to reduce the number of suicidal behaviours. Knowing what information is advisable to include in the news item as well as what information to avoid is a strong point. Guidelines to promote responsible media reporting are a key component of suicide prevention strategies. This study was prospectively registered in the International Prospective Register of Systematic Reviews (PROSPERO) on 23 April 2022 with the registration number CRD42022320393.

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1. Introduction

In 1976, the World Health Organization (WHO) defined the term suicide as "*an act with a lethal outcome, deliberately initiated and carried out by the subject, knowing or expecting its lethal outcome and through which they intend to obtain the desired changes*" [1]. It is known that the first suicidal behaviour dates to prehistoric times. The social conception of this universal phenomenon has changed according to the cultural, religious, and intellectual principles of history. Thus, the same lethal act has been accepted in some cultures as a transition to a new immortal stage, and in others, it has been punished and penalised as a crime [2]. Human beings have redefined what suicide represents in each historical context, and although the approaches have been disparate, no one has been indifferent to this phenomenon [3].

Suicide is now recognised as a serious public health problem due to the fact that there are more than 700,000 deaths per year, which translates into one death every forty seconds, and for every suicide, an estimated twenty attempts are made [4]. In addition, the psychological impact of suicidal behaviour (suicide ideation, attempt, and death by suicide) on close, personal circles, affecting, on average, six suicide loss survivors, is also highly significant [5]. Furthermore, it is currently estimated that an average of 100 community members may be affected after each suicide [6,7]. For these reasons, both the United Nations Sustainable Development Goals and the WHO's Comprehensive Mental Health Action Plan 2013–2030 have set a target of reducing these figures by one-third [8,9].

Suicidal behaviour is a complex phenomenon caused by a multitude of biological, psychological, social, cultural, and environmental factors which are associated with situations of crisis, stress, or traumatic moments that have not been dealt with, triggering suicide as an escape route [10]. Prevention is possible, and this requires the collaboration and coordination of different multidisciplinary teams that are committed to providing integrated and holistic care, as an individual approach is not effective in such a complex process [11].

Among the various health professionals needed to tackle the problem, the generalist nurse, and, specifically, the mental health specialist, play key roles in prevention. Their functions include treating underlying mental disorders and the identification and assessment of populations in situations of vulnerability, controlling environmental risk factors and stressful life events, identifying alcohol withdrawal, limiting access to the resources most frequently used for suicide, breaking the socio-cultural stigma that prevents access to mental health services, and promoting community health education as a highly vital method for the responsible, safe, and useful dissemination of information through the media [12].

The media play a significant role in shaping public perceptions and reflecting societal issues by allowing the transmission of information between sender and receiver; specifically, when the receiver is a social group, they are called Mass Media. Among the most prominent media are radio, internet, and television, whose news influences people's thoughts, values, and actions on political, economic, and social issues. Therefore, the media play an active role in society due to their direct influence on the way reality is perceived [13].

This approach is based on the theory of agenda-setting, which explains how the media are the most notable factor in the social construction of everyday reality so that the issues dealt with in the media will become the issues of greatest concern to society by directing attention and changing the way people think about them [14]. Therefore, the way in which the media report and expose suicidal behaviour can have a preventive or protective influence on suicidal behaviour or, conversely, a detrimental influence by causing an increase in numbers through contagion or imitation.

The origin of the Werther effect alludes to Goethe's novel "The Sorrows of Young Werther", where the protagonist takes his own life by shooting himself. After its publication, a wave of young people died by suicide using the same method, wearing the same clothes as the character, and making references to the work in their suicide notes [15–17]. Some authors propose that this effect may have originated earlier with William Shakespeare's Romeo and Juliet, as it caused a multitude of deaths among those unlucky in love. However, it was the sociologist Phillips in 1974 who framed this effect, stating that the more suicide was portrayed in the media, the higher the suicide figures were later on [15,16].

The basis of the protective effect, also called Papageno, aims to repeal the existing taboo on suicide by relying on responsible and truthful communication [16]. Such communication should meet established criteria such as the use of clear and understandable terminology, informing about the preventable nature of suicide, providing helpline numbers, informing about the link between suicide and depression, emphasising that it is a treatable condition, respecting the privacy of affected families, raising awareness among the general public so that they can be aware of risk indicators in the immediate environment, and providing information about support services and prevention programmes [17–19].

The Werther effect has repeated itself on several occasions throughout history; a recent media example is the broadcast of the series "13 Reasons Why" in March 2017 which explicitly and graphically showed the suicide of the teenage protagonist. Specifically, between March and April 2017, there were 1.5 million searches related to suicide on Google, with the most frequently searched phrases being "*how to slit your wrists*", "*how to commit suicide*", and "*how to kill yourself*" [20]. In 2019, research by Niederkrotenthaler et al. found an increase in suicides in the three months following the premiere of the series, higher than the general trend, among 10–19-year-olds and especially in females [21].

Frequently, media reports exaggerate the most tragic, lethal, and unusual methods, such as using a firearm or jumping onto railway tracks. These methods do not often correspond to the reality in most countries, where hanging is more common [22]. In this umbrella review, the concept of intervention is used to refer to the mode of media exposure and dissemination of suicidal behaviour. For that, we aimed to analyse the recommended interventions for the safe and responsible reporting of suicidal behaviour in the media for preventive purposes.

2. Materials and Method

This is an umbrella review conducted according to the Joanna Briggs Institute (JBI) methodological manual [23]. This systematic approach is guided by providing a comprehensive and objective synthesis through the use of rigorous and transparent methods. A preliminary search was conducted on PubMed to identify existing systematic reviews that met the inclusion criteria. From this preliminary search, several systematic reviews potentially falling within the inclusion criteria were found, which justified the use of an umbrella review for the purpose of the study. The report was written according to the Preferred Reporting Items for Overviews of Reviews (PRIOR) statement [24]. The protocol of this umbrella review was registered in the International Prospective Register of Systematic Reviews (PROSPERO) with registration code CRD42022320393.

Ethical considerations related to the review process: None of the data presented in this paper have been plagiarised, invented, manipulated, or distorted.

2.1. Search Strategy

A systematic search was conducted for systematic reviews published from inception to the 13 February 2023. Eight databases were consulted: MEDLINE (PubMed), CINAHL and PsycInfo (via EBSCOhost), Web of Science, Embase, Cochrane Library of Systematic Reviews, Scopus, and Google Scholar.

The search terms that guided the search were: suicide, "suicide, completed", "suicidal ideation", "suicide, attempted", "audiovisual aids", radio, television, telecommunications, and "systematic review". The search was first performed in PubMed, applying Mesh terms,

free text terms, and using wildcards if deemed appropriate. Then, the final search was tailored for use in all the other databases considered. The complete search strategy can be found in Supplementary File S1.

2.2. Inclusion and Exclusion Criteria

We included all systematic reviews written in English, Spanish, or Italian regarding the dissemination of news in the communication media with the aim of reducing suicidal intentions. Primary studies, books, book sections, and grey literature (theses, conference proceedings, etc.) were excluded, as well as systematic reviews that did not focus on our topic.

2.3. Outcome Measures

The primary outcome of this umbrella review was suicide rate reduction following news dissemination. The secondary outcomes considered were the number of suicides and suicidal behaviour reduction.

2.4. Review Selection

All studies were retrieved from each database and were uploaded to a Microsoft Excel® (Version 16.66.1) spreadsheet and duplicates were removed. The Excel® tool was used to manage data collection, facilitating the organisation of information by title, journal, database, keywords, abstract, or year. Titles and abstracts were screened by two separate authors (Author 1 and Author 2) in accordance with the criteria for eligibility. After the preliminary phase, they separately evaluated the full texts of studies that might be pertinent for inclusion.

Any discrepancies were resolved by discussion between the authors, and when consensus was not reached, a third researcher (Author 3) was consulted.

2.5. Quality Assessment

The methodological quality of the selected papers was analysed independently by two reviewers (Author 1 and Author 2) (Table 1). When a consensus was not reached, a third researcher (Author 3) participated in the quality assessment. For this purpose, the Critical Appraisal Skills Programme Spanish (CASPe) tool was used in its version for systematic reviews [25]. The checklist consists of ten items designed to assess quality and considers three broad areas when evaluating a systematic review: are the results valid; what are the results; will the results help locally? The research team considered that if there was at least one response scored as "no" or "unclear" on one of the ten items, a moderate quality of the review would be inferred. If there were at least three "no" or "unclear" responses, it would be defined as a low-quality review. In the presentation of the results and the generalisation of the results, the reported quality was considered. The results obtained are shown in Table 1.

Table 1. Methodological quality analysis tool for systematic reviews using CASPe. Each criterion is scored as yes, no, or unclear.

	Authors					
Items	**Niederkrotenthaler et al., 2022 [26]**	**Niederkrotenthaler et al., 2021 [27]**	**Niederkrotenthaler et al., 2020 [28]**	**Torok et al., 2017 [29]**	**Sisask et Värnik, 2012 [30]**	**Mann et al., 2005 [31]**
Did the review address a clearly focused question?	Yes	Yes	Yes	Yes	Yes	Yes
Did the authors look for the right type of papers?	Yes	Yes	Yes	Yes	Yes	Yes
Do you think all the important, relevant studies were included?	Yes	Yes	Yes	Yes	No	No

Table 1. *Cont.*

Items	Authors					
	Niederkrotenthaler et al., 2022 [26]	**Niederkrotenthaler et al., 2021 [27]**	**Niederkrotenthaler et al., 2020 [28]**	**Torok et al., 2017 [29]**	**Sisask et Värnik, 2012 [30]**	**Mann et al., 2005 [31]**
Did the review authors do enough to assess the quality of the included studies?	Yes	Yes	Yes	Unclear	Unclear	Unclear
If the results of the review have been combined, was it reasonable to do so?	Yes	Yes	Yes	Yes	Yes	Yes
What are the overall results of the review?	Yes	Yes	Yes	Yes	Yes	Yes
How precise are the results?	Yes	Yes	Yes	Data was synthesised using a qualitative approach	Data was synthesised using a qualitative approach	Data was synthesised using a qualitative approach
Can the results be applied to the local population?	Yes	Yes	Yes	Yes	Yes	Yes
Were all important outcomes considered?	Yes	Yes	Yes	Yes	Yes	Yes
Are the benefits worth the harm and costs?	Yes	Yes	Yes	Yes	Yes	Yes

2.6. Data Extraction

Following the screening phase, two authors (Author 1 and Author 2) separately collected and extracted all data using a standard data collection form regarding systematic review characteristics: reference and year, general objective, review typology, databases, the period covered, and outcome data. Conflicts were resolved by consultation with a third reviewer (Author 3).

2.7. Data Synthesis

According to the JBI methodological manual [23], which emphasises that the results of an umbrella review are reported to provide existing research syntheses relevant to a particular topic, the data of the included systematic reviews were summarised in narrative form. The results were presented both in the form of a table and within the text.

3. Results

The search collected a total of 4520 articles (PubMed 204, CINAHL and PsycInfo 2981, Web of Science 212, Embase 936, Cochrane 115, Scopus 50, and Google Scholar 22). After the removal of duplicates, 4035 results were reviewed by title and abstract to assess relevance and eligibility criteria, eliminating 4010 records and including 25 papers. Finally, after eliminating 19 papers (n = 5 were not considered truly systematic reviews due to their methodology and n = 14 did not answer the research question posed for this umbrella review), 6 systematic reviews were analysed for the development of this research. Of the included reviews, three also included meta-analyses. The time range covered by the final reviews is from 2005 to 2022. The procedure followed in this umbrella review is described in Figure 1.

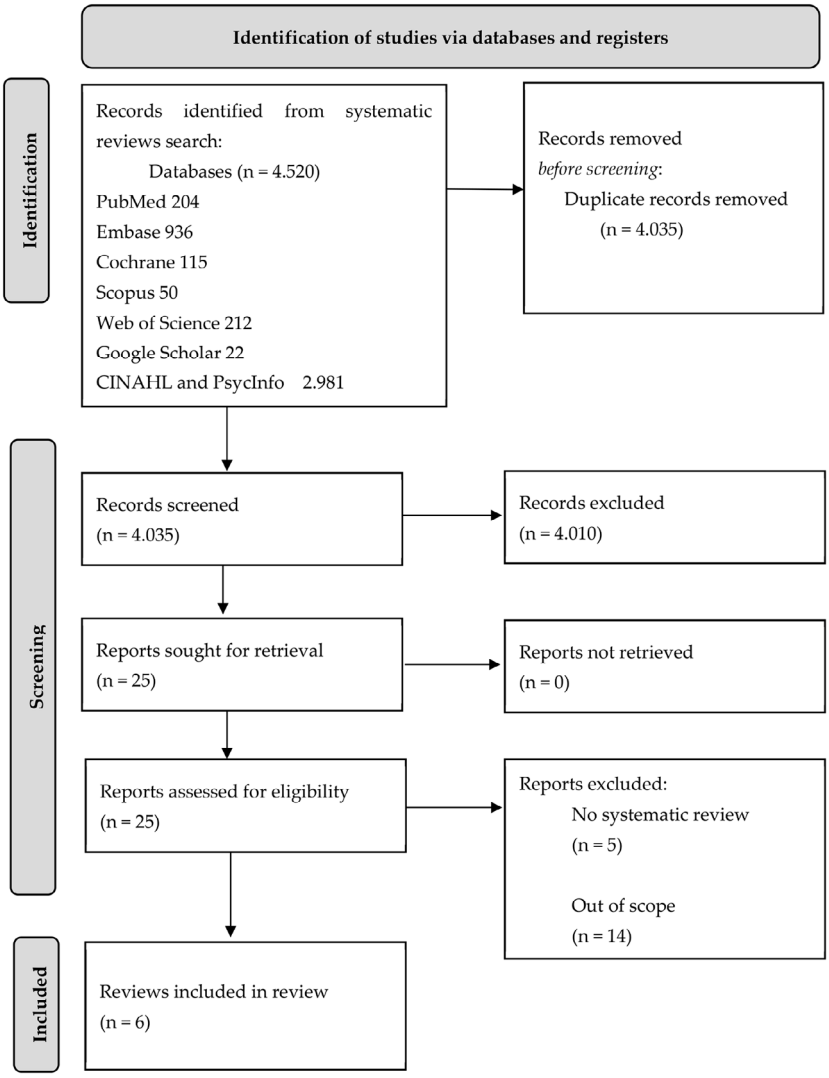

Figure 1. PRIOR flow diagram.

3.1. Methodological Quality Assessment

In relation to the assessment of methodological quality, three reviews were inferred to be of high quality [26–28] and three of moderate quality [29–31]. All reviews were included in the umbrella review as their results could be generalised and applied to the population. The main findings are presented as a narrative synthesis.

3.2. Characteristics of the Included Studies

The literature search dates of the included reviews ranged from the inception of the database to 2021. The reviews included a total of 195 unique primary studies. Descriptive observational designs were the most frequent primary study type (n = 136), followed by randomised controlled trials (n = 29), analytical observational studies (n = 25), and quasi-experimental studies (n = 5). A median of five primary studies (inter-quartile range 3–7) were included.

In the reviews included, the strategies or tools recommended being implemented by the media for the responsible and safe dissemination of suicidal behaviours to the

population were considered as an intervention, either by adding certain aspects (n = 9) or by eliminating certain characteristics related to the suicidal behaviour described (n = 4).

A summary of the general characteristics of the included reviews is reported in Table 2.

Table 2. Data extraction form with the characteristics of the six systematic reviews included. Chronological order.

Reference and Year	General Objective	Review Typology	Database Included	Period Covered	Main Findings
Niederkrotenthaler et al., 2022 [26]	Summarise findings from randomised controlled trials on the effects of stories of hope and recovery on individuals with some degree of vulnerability to suicide.	Systematic review and meta-analysis.	PubMed, Scopus, Embase, PsycInfo, Web of Science, and Google Scholar	From inception until 6 September 2021	Exposure to narratives about hope and overcoming suicidal crises appears to have a beneficial effect on people with some vulnerability to suicidal ideation.
Niederkrotenthaler et al., 2021 [27]	Examine the association between portrayals of suicide and suicide attempts in entertainment media and suicidal behaviour in the population.	Systematic review and meta-analysis.	PubMed, Scopus, Embase, PsycInfo, Web of Science, and Google Scholar	From inception until 20 April 2021	The diffusion of suicidal behaviour in the media can increase suicides and suicide attempts among the population. Therefore, they should respect existing guidelines on their safe representation.
Niederkrotenthaler et al., 2020 [28]	Examine the association between reporting on suicides, especially deaths of celebrities by suicide, and subsequent suicides in the general population.	Systematic review and meta-analysis.	PubMed, Scopus, Embase, PsycInfo, Web of Science, and Google Scholar	From inception until 1 September 2019	Guidelines for responsible reporting of suicidal behaviour in the media are the best prevention intervention for the population. They should be more widely applied and promoted.
Torok et al., 2017 [29]	Address key knowledge gaps regarding how mass media campaigns can be optimised to prevent suicide by looking at their global efficacy and mechanisms related to successful outcomes.	Systematic review	PubMed, Scopus, Embase, PsycInfo, Web of Science, Cochrane Library, and Cochrane Central Register of Controlled Trials	From inception until 1 April 2016	Multilevel mass media outreach has positive effects on both suicide rates and suicide attempts. Repeated exposure and community involvement are key aspects of prevention campaigns.
Sisask et Värnik, 2012 [30]	Monitor and provide an overview of the research performed on the roles of the media in suicide prevention in order to find out the possible effects that the media reporting on suicidal behaviours might have on actual suicidality.	Systematic review	PubMed, PsycInfo, and Cochrane Library	From inception until 1 July 2011	Media reports are not representative of official data on suicides. They tend to sensationalise with the exposure of dramatic and very lethal methods which are infrequent in reality.
Mann et al., 2005 [31]	Examine the evidence for the effectiveness of specific suicide-preventive interventions and make recommendations for future prevention programmes and research.	Systematic review	PubMed, PsycInfo, and Cochrane Library	From 1966 to June 2005	Media exposure to suicide as a solution to problems may exacerbate the risk of developing these behaviours.

3.3. Overlap between Included Systematic Reviews and Studies

The primary studies included across the systematic reviews and relevant to the aim of this study were mapped and the overlap among all reviews was analysed. Only one primary study overlapped with another review. A total of thirty primary studies were cited

thirty-one times across the six systematic reviews included in this overview, resulting in an overall corrected covered area (CCA) of 0.07, indicating almost no overlap across the included reviews. In Table 3, it can be seen that only one of these primary studies overlaps, i.e., it was analysed in two of the systematic reviews. This result is considered positive for the research as it infers that the included reviews did not analyse the same primary studies [32] (Table 3).

Table 3. Overlap between the systematic reviews and the studies included.

Studies	Authors					
	Niederkrotenthaler et al., 2022 [26]	Niederkrotenthaler et al., 2021 [27]	Niederkrotenthaler et al., 2020 [28]	Torok et al., 2017 [29]	Sisask et Värnik, 2012 [30]	Mann et al., 2005 [31]
Ftanou et al., 2021	x					
Niederkrotenthaler et al., 2020	x					
Till et al., 2020	x					
Niederkrotenthaler et al., 2019			x			
Till et al., 2019	x					
Handley et al., 2018		x				
King et al., 2018	x					
Sinyor et al., 2018			x			
Till et al., 2018			x			
Schmidt, 2017		x				
Till et al., 2017	x					
Arendt et al., 2016	x					
Kontopantelis et al., 2015		x				
Hawton et al., 2014		x				
Matsubayashi et al., 2014				x		
Niederkrotenthaler et al., 2014			x			
Robinson et al., 2014				x		
Robinson et al., 2013				x		
Till et al., 2013				x		
Chen et al., 2010					x	
Jenner et al., 2010				x		
Klimes-Dougan et al., 2010				x		
Niederkrotenthaler et al., 2010			x		x	
Niederkrotenthaler et al., 2009			x			
Klimes-Dougan et al., 2009				x		
Oliver et al., 2008				x		
Daigle et al., 2006				x		
Hegerl et al., 2006				x		
Sudak and Sudak, 2005					x	
Etzersdorfer et al., 1998						x

3.4. Summary of Evidence

For a better analysis and to facilitate understanding, the results are presented in terms of the aspects or characteristics that the media should include in the information dissemination related to suicidal behaviour and those that should be avoided, all with the ultimate aim of developing responsible dissemination based on prevention.

3.5. Recommended Strategies to Be Included in Responsible Dissemination

With regard to the strategies that are recommended to be included in the dissemination and found to be most widely represented in the reviews, the first is the inclusion in the narrative of positive messages of hope, resilience, and overcoming adversity [26–28,30,31], finding a protective effect of up to one month's duration in vulnerable populations [26]. Subsequently, the promotion and encouragement of the search attitude as an effective

care tool for the general population are present in three studies [27,29,30]. In this line, the effectiveness of such an intervention when specifically focused on the male gender is worth highlighting [26,29]. With regard to the detrimental effect or Werther effect of developing suicidal behaviour following media reports, the work of Sisask et Värnik shows a strong association with age and gender, making young and old people more vulnerable to the imitation effect [30].

The inclusion in the narrative of complete and up-to-date information on available facilities, organisations, institutions, and resources has been shown to be effective [26,29,31]. This exposure includes providing the population with complete information, including contact telephone numbers or updated website addresses.

The media awareness of mental health and mental disorders [29,31] along with the dissemination of treatment availability, especially for depression, have also proven to be effective in the responsible and preventive dissemination of suicidal behaviour in the media [29]. Along these lines, there is a reference to awareness-raising as a method for literacy and public awareness in order to decrease the stigma of mental health in general and suicide in particular [29].

In the reviews analysed, some strategies focus on the contribution that health professionals and survivors of suicide can make to society, and community involvement has been shown to be critical to success [29]. Survivors are understood as those people negatively and significantly affected by the suicide of someone around them or those people who have faced a suicide attempt, highlighting, as a strategy in suicidal ideation, the dissemination of real personal stories and the sharing of stories that reflect overcoming or recovering from suicidal crises [26]. Regarding the specific role of healthcare professionals, the work of journalists or scriptwriters with experts in the field of mental health is effective for safe exposure [27]. Narratives that include the idea that suicide prevention is possible are also effective [29].

3.6. Strategies to Avoid Responsible Dissemination

In this section, as mentioned above, the strategies found in the included reviews that should be avoided for the dissemination and safe exposure of suicidal behaviour will be analysed. The omission of an explicit description of the method used and the location where the suicidal behaviour took place stands out in most of the works [27,28,30,31]. This strategy is based on the correspondence found between the subsequent increase in suicide rates following the media coverage of suicidal behaviour related to the explicit dissemination of the method used [29]. Along these lines, narratives that avoid a romantic, dramatic, or glorified depiction of suicidal behaviour have also been shown to be effective [28,30,31].

Not repeatedly reporting the same behaviour and not depicting suicide as an inevitable event with no option to intervene in prevention have also been shown to be effective interventions [28]. One response to these facts may lie in the bystander normalisation of suicidal behaviour as a quick escape route or solution to problems. In Table 4, the interventions found in the review are represented chronologically.

Table 4. Interventions found in the studies reviewed.

Interventions	Authors					
	Niederkrotenthaler et al., 2022 [26]	Niederkrotenthaler et al., 2021 [27]	Niederkrotenthaler et al., 2020 [28]	Torok et al., 2017 [29]	Sisask et Värnik, 2012 [30]	Mann et al., 2005 [31]
Positive messages of hope, resilience, and overcoming adversity.	x	x	x		x	x
Narratives with information on available centres, organisations, and resources.	x			x		x
Promote the attitude of seeking help as an effective mechanism.	x		x	x		

Table 4. *Cont.*

Interventions	Authors Niederkrotenthaler et al., 2022 [26]	Niederkrotenthaler et al., 2021 [27]	Niederkrotenthaler et al., 2020 [28]	Torok et al., 2017 [29]	Sisask et Värnik, 2012 [30]	Mann et al., 2005 [31]
Personal narratives of overcoming suicidal crises.	x					
Specific information aimed at promoting support-seeking oriented towards the male gender.	x		x			
No explicit description of the method used or place/location.		x	x		x	x
No romantic, dramatic, or glorified description of suicide.			x		x	x
No repeated reporting of the same suicide.			x			
Narratives on the availability of treatment for mental disorders.				x		
No portrayal of suicide as inevitable.			x			
Narratives that suicide prevention is possible.				x		
Raise awareness of mental health in the media.				x		x
Work with mental health experts to ensure safe dissemination and exposure.		x				

4. Discussion

This is the first general review that explores the media as a key interpersonal and social factor. The media may function as a protective and/or risk factor for suicidal behaviour because it plays an active role in society by directly influencing the way reality is perceived. The way in which the media report and expose information related to suicidal behaviour is decisive. Well-managed information or exposure has a preventive influence in reducing suicide rates, while poor media reporting can lead to an increase in numbers through contagion or imitation. A broad search strategy has been used to ensure a comprehensive synthesis of the systematic reviews in this area, providing an integrated and comprehensive overview of a high level of evidence. The assessment of the methodological quality of the included systematic reviews, conducted by three independent reviewers, determined a high-quality rating for the majority of studies.

The results confirm that the inclusion in the narrative of positive messages of hope, resilience, and overcoming adversity is present as preventive and protective information in the most current systematic reviews published between 2020 and 2022 [26–28]. Establishing the adequate and responsible dissemination of suicidal behaviour in the media with complete and updated information on the centres, organisations, institutions, and resources available for dealing with suicidal behaviour has proven to be effective, especially in vulnerable populations and/or those with difficulties in accessing the health system [12,26,29,31]. The use of the media as a health literacy tool, reducing the stigma of mental illness in general and suicidal behaviour in particular, as well as the dissemination of available treatments, have been shown to be a preventive strategy in several studies [29,31]. Silencing suicide does not contribute to reducing the number of suicidal behaviours, but rather causes continuous stigmatisation of the event and its consequent consideration as a taboo subject by society [33]. The figure of the gatekeeper, understood as the person who acts as an information specialist, in the media is key to the prevention of suicidal behaviour, working in not only a *reactive* capacity, i.e., responding effectively to the demands for information that they receive, but also *proactively*, i.e., anticipating information needs before they are perceived [14]. Promoting the figure of the gatekeeper is a line of action to develop competencies for the prevention of suicidal behaviour in social agents who are in direct contact with the population [11]. The work of gatekeepers in the media

for the protection of mental health and reduction in suicidal ideation and attempts can be carried out by health professionals, mental health nurses, psychologists, psychiatrists, etc., as well as by survivors or patients who tell personal stories of overcoming suicide; community participation has been shown to be fundamental for preventive success, with the key being to show suicide prevention as possible in the media [27,29]. The results of this umbrella review are in line with existing recommendations in the field and along the lines of providing well-managed information for suicide prevention. The WHO recommends providing accurate information on where to seek help; educating the community about the facts of suicide and suicide prevention, without spreading myths; and disseminating stories about how to cope with life stressors or suicidal thoughts, and how to obtain help [17]. The Action Alliance in its 2022 report suggests preventively working with mental health experts to ensure safe outreach and exposure; using non-judgmental language; and providing narratives with information on available facilities, organisations, and resources (including up-to-date contact numbers or websites) [34].

Following a review of the scientific literature, it can be determined that certain media interventions may become risk factors for suicidal behaviour. With regard to the placement of news about suicide, the Canadian Psychiatric Association and the Canadian Association for Suicide Prevention state that news about suicidal behaviour should not be displayed on the front or back page of newspapers, should avoid sensationalism, should not provide details about the site/location, should not explicitly describe the medium used, should not use photographs, video footage, or social media links, and should not repeat the news story unduly [35,36]. This is in line with the WHO, which has worked on several manuals to approach this issue, and their recommendations [17,37,38]. In 2017, an observational study by Acosta-Artiles et al. showed that the press publishes news in an unjustified manner, one-third of which is avoidable; it does not provide new information and it contains a high percentage of characteristics that are harmful to viewers, which may increase the risk of contagion. It should be taken into consideration that not only the quality of dissemination has an influence, but also the quantity [39]. In research by Armstrong et al., semi-structured interviews were conducted with media professionals in India who had previously published news about suicides, and several participants stated that violent and novel methods of suicide were of great interest to the press [40]; media education and intervention at this level is essential to prevent the dissemination of this type of sensationalist information which is a high-impact risk factor. The Action Alliance's 2022 report along these lines recommends not explicitly describing the method used and not reducing the multi-causality of suicidal behaviour to a single precipitating factor or a simple explanation [34].

In Spain, there is no suicide prevention plan at the national level on which to contrast results. In some autonomous communities, the Suicide Prevention Plan is included within a Strategic Mental Health Plan, a document that addresses the general objectives and interventions to be developed within mental health, but not expressly for suicide [41]. Specifically, in the community of La Rioja, there is a Suicide Prevention Plan. This document includes a specific section related to the prevention of suicidal behaviour and the media [42].

The results of this review are in line with this regional plan where the training of communication professionals and the development of style guides are indicated as effective interventions for the dissemination of suicidal behaviour.

5. Limitations

A possible limitation of the study is that if alternative search commands were used, additional studies might have been found. However, the authors believe that if the search procedure is modified, the conclusions may be largely the same, so this may not be such a serious limitation.

The focus of this umbrella review on suicidal behaviour and the media was on news descriptions and their dissemination. However, research on the specific representation of

suicide in films, series, performing arts, or other forms of social dissemination could be of great interest.

Similarly, the number of studies included and the moderate quality in three of them can also be considered a limitation.

6. Implication for Practice

Although psychiatric disorders significantly increase the risk of suicide, interpersonal and social factors also play an important role. The media is a feature of the social environment in which suicidal behaviour can be learned; though the effect is probably smaller than that of other psychosocial risk factors for suicide, it is a significant agent in the social construction of reality, especially for vulnerable people [43].

7. Conclusions

Evidence confirms that suicide is preventable and that the comprehensive coordination of different multidisciplinary teams is necessary to be effective in suicide prevention. Educating and training the media in the appropriate approach for disseminating suicidal behaviour helps to reduce the number of suicidal behaviours. Knowing what information is advisable to include in the news item as well as what information to avoid is a strong starting point. Guidelines to encourage the responsible reporting of suicide in the media are a key component of suicide prevention strategies. Multidisciplinary health teams in collaboration with the media could be helpful in ensuring prevention-based outreach.

Supplementary Materials: The following supporting information can be downloaded at: https://www.mdpi.com/article/10.3390/nursrep13040125/s1, The complete search strategy can be found in Supplementary File S1. Supplementary File S2 contains the studies that met the inclusion criteria.

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DISCUSIÓN

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Tras el estudio realizado en lo que respecta a la percepción de los profesionales de enfermería en a la intervención de enfermería en pacientes con riesgo suicida en la comunidad autónoma de La Rioja (15), los resultados mostraron que los participantes en el estudio tenían un interés significativo por esta problemática de salud pública, y una absoluta consideración de necesidad de cuidados cuando los pacientes expresan riesgo en relación con estas conductas.

Los profesionales manifestaron capacidad para establecer relaciones terapéuticas con los pacientes en riesgo de comportamiento e ideación suicida; y se mostraron como agentes activos a la hora de valorar las necesidades del paciente, obtener información colateral de fuentes disponibles para mejorar la comprensión y la asistencia sanitaria del paciente. De igual manera, se consideran agentes activos en la movilización de recursos sanitarios precisos, y en la observación y seguimiento de estos pacientes, resultados que van en línea con otras evidencias (27,28).

De igual manera, los resultados obtenidos muestran que el riesgo de conductas suicidas se relaciona prevalentemente con patología mental de base. Específicamente, la depresión y los trastornos afectivos son las patologías que aparecen en la literatura relacionadas con un riesgo superior a la población general (27). Existe evidencia descrita por diferentes autores que relaciona la conducta suicida tanto con factores de riesgo como con factores de protección de esta (29). En nuestro estudio los profesionales refieren carencias en la detección, tanto de los factores de riesgo como de los factores de protección vinculados a estas conductas, resultados en línea con el estudio realizado Niederkrotenthaler et al. en 2019.

Los profesionales refirieron como muy limitadas las intervenciones relativas al apoyo en la toma de decisiones, ayuda al afrontamiento, en la intervención psicológica breve debriefing y en las intervenciones para reducir la ansiedad. Por ello, el siguiente paso consistió en identificar las intervenciones de elección más eficaces para el tratamiento y la prevención de la conducta suicida para proporcionar una visión conjunta y global de las alternativas terapéuticas de los profesionales sanitarios (30). Además, desde la perspectiva enfermera, se pretendió aportar una respuesta consistente y basada en la evidencia al diagnóstico enfermero NANDA “Riesgo de suicidio” (21). Para ello, se determinaron cuáles de las intervenciones identificadas están incluidas en la Clasificación NIC y eran una herramienta terapéutica eficaz para las enfermeras en la prevención y tratamiento de la conducta suicida (22, 31).

Los resultados de la revisión sobre intervenciones para la prevención de la conducta suicida (30), confirmaron la eficacia de las intervenciones psicoterapéuticas. La literatura científica muestra que, además de ser las intervenciones más prevalentes en uso, la terapia dialéctico-conductual y la terapia cognitivo-conductual son las intervenciones más prometedoras y eficaces para los pacientes con ideación suicida o intentos de suicidio previos (32-34). Las terapias psicoanalíticas y psicodinámicas, aunque se utilizan con menor frecuencia, son eficaces para mejorar el bienestar emocional de los pacientes, lo que ayuda a reducir la autolesión (34-36).

Respecto a las intervenciones de contacto breve, destacan por su alta calidad, resultado en consonancia con estudios que relacionan este tipo de Intervenciones con la reducción del intento de suicidio (37,38).

La literatura científica expone que, la tendencia epidemiológica del suicidio muestra, por un lado, que los hombres tienen una tasa de suicidio más alta que las mujeres debido a la mayor letalidad de los métodos suicidas utilizados, y, por otro lado, que las mujeres realizan un mayor número de intentos (39). En nuestras investigaciones, no se puede determinar una mayor o menor efectividad de las intervenciones basadas en el sexo (anatomía) o el género (construcción social).

Tras revisar la literatura científica sobre intervenciones para el abordaje y manejo de las conductas suicidas por parte de los profesionales sanitarios, no se ha encontrado ninguna intervención que destaquee específicamente por su eficacia sobre los demás, por lo que la prevención y el tratamiento de las tendencias suicidas requiere un manejo integral en el que los pacientes reciban herramientas de afrontamiento (40), intervenciones conductuales que abordan directamente pensamientos y comportamientos suicidas (41), la gestión emocional a través del psicoanálisis y terapias psicodinámicas, terapias convencionales acopladas con las nuevas tecnologías de la información y la comunicación, apoyo a través de alianzas terapéuticas e intervenciones de contacto breve, y apoyo al cumplimiento del tratamiento (37). En el **anexo 1**, se muestran las intervenciones analizas, presentes en la literatura científica.

Dentro de la teoría de las Necesidades Humanas Básicas de la enfermera Virginia Henderson, la importancia de evitar peligros en el medio ambiente se describe, entendiendo como tal "*la capacidad de mantener y promover la propia integridad física y psíquica de uno mismo y otros, con conocimiento de los peligros potenciales del medio ambiente*" (18). La investigación específica sobre Intervenciones de enfermería NIC proporciona a los profesionales de enfermería las bases necesarias para una práctica clínica de calidad en la atención, prevención y tratamiento de pacientes con riesgo de suicidio. Lo intervenciones terapéuticas descritas permiten a la enfermería desarrollar su profesión con evidencia científica (31).

El estudio reciente de Pérez et al., de 2021, demuestra que la autoestima y el afrontamiento son eficaces para reducir riesgo suicida (42). Tras estas intervenciones, la expresión de los pacientes mejoró en la autoaceptación y fueron capaces de reconocer algunas características personales positivas.

Basado en la última edición del catálogo de intervenciones del NIC (22), la investigación identificó las diversas intervenciones que han demostrado ser eficaces para paciente, familia y comunidad. En el **anexo 2**, se expone la relación de intervenciones de enfermería NIC codificadas encontradas en la literatura científica.

Tras determinar las intervenciones, se planteó describir y comparar las intervenciones descritas en la literatura y conocer como estaban abordadas en los planes autonómicos de España para la prevención del suicidio (43).

Los planes de prevención en todas las provincias españolas establecen medidas preventivas universales, selectivas e indicadas. Si bien es cierto que no todos ellos se centran en proporcionar información relacionada con el suicidio y sus conductas asociadas a la población general, se observa que las intervenciones dirigidas a la detección del riesgo y la asistencia a grupos vulnerables están presentes en el 100% de los planes españoles de prevención del suicidio.

Los planes de prevención del suicidio en España, así como sus objetivos y medidas propuestas, son similares en las distintas provincias. Se observa que la mayoría de las intervenciones están dirigidas a los profesionales sanitarios, especialmente en el ámbito de la salud mental, así como a la población más vulnerable. También existen otro tipo de medidas centradas en áreas clave como la sensibilización en las escuelas o la formación de agentes sociales (gatekeepers).

Con esta investigación, se apreció la importancia de la prevención en Salud Pública, ya que los objetivos se dirigen claramente al cribado precoz de la población de riesgo y a la posterior consecución de cifras de incidencia y prevalencia estadísticamente más bajas.

En esta línea, destaca la preocupación de las provincias por el correcto registro de estas muertes con el fin de mejorar la calidad de los datos. Cabe destacar, que no todas las comunidades tienen un programa de prevención del suicidio, sino que la elaboración de este documento es un objetivo incluido en planes más generales como los planes de salud mental de las respectivas comunidades.

Como último punto y basado en la inmediatez y universalización de los medios de comunicación y su alto impacto en la percepción social, así como la importancia de los profesionales de la

salud y en particular de las enfermeras/os como agentes activos en educación para la salud y agentes comprometidos con una difusión y comunicación con valor preventivo, se analizaron las recomendaciones para una difusión responsables de la información relacionada con el suicidio en general y las conductas suicidas en particular (44). Los medios de comunicación pueden funcionar como un factor protector y/o de riesgo para la conducta suicida, ya que desempeñan un papel activo en la sociedad al influir directamente en la forma en que se percibe la realidad. Una información o exposición bien gestionada tiene una influencia preventiva en la reducción de las tasas de suicidio, mientras que una información deficiente por parte de los medios de comunicación puede provocar un aumento de las cifras por contagio o imitación.

Los resultados confirmaron que la inclusión en la narrativa de mensajes positivos de esperanza, resiliencia y superación de la adversidad está presente como información preventiva y protectora (45-47). Establecer una difusión adecuada y responsable de la conducta suicida en los medios de comunicación con información completa y actualizada sobre los centros, organizaciones, instituciones y recursos disponibles para el abordaje de la conducta suicida ha demostrado ser eficaz, especialmente en poblaciones vulnerables y/o con dificultades de acceso al sistema sanitario (45,48,49).

El uso de los medios de comunicación como herramienta de alfabetización sanitaria, la reducción del estigma de la enfermedad mental en general y de la conducta suicida en particular, así como la difusión de los tratamientos disponibles, han demostrado ser una estrategia preventiva en (49). Silenciar el suicidio no contribuye a reducir el número de conductas suicidas, sino que provoca una estigmatización continua del suceso y su consiguiente consideración como tema tabú por parte de la sociedad (50).

CONCLUSIONES

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Como conclusiones de la presente tesis doctoral y desde el análisis de las intervenciones de enfermería que a lo largo de esta investigación se han considerado con objeto de la prevención, tratamiento y cuidado de la conducta suicida, se puede enunciar:

- Los profesionales de enfermería muestran un gran interés por esta problemática de salud pública, y una absoluta consideración de necesidad de cuidados específicos para desde su disciplina ser agentes claves para la acción preventiva, tratamiento y cuidado de la conducta suicida.

- Los profesionales de enfermería refirieren como muy limitadas las intervenciones relativas al apoyo en la toma de decisiones, ayuda al afrontamiento, en la intervención psicológica breve debriefing y en las intervenciones para reducir la ansiedad. Así mismo refieren dificultad para identificar intervenciones que les permita reducir los factores de riesgo y potenciar los de protección.

- Los resultados de la revisión sobre intervenciones para la prevención de la conducta suicida, confirmaron la eficacia de las intervenciones psicoterapéuticas, además de ser las intervenciones más prevalentes en uso, la terapia dialéctico-conductual y la terapia cognitivo-conductual son las intervenciones más prometedoras y eficaces para los pacientes con ideación suicida o intentos de suicidio previos.

- Las terapias psicoanalíticas y psicodinámicas, aunque se utilizan con menor frecuencia, son eficaces para mejorar el bienestar emocional de los pacientes, lo que ayuda a reducir la autolesión.

- Las intervenciones de contacto breve, destacan por su alta calidad, se relaciona este tipo de Intervenciones con la reducción del intento de suicidio.

- No se ha encontrado ninguna intervención que destaque específicamente por su eficacia sobre los demás, por lo que la prevención y el tratamiento de las tendencias suicidas requiere un manejo integral en el que los pacientes reciban herramientas de afrontamiento, intervenciones conductuales que abordan directamente pensamientos y comportamientos suicidas, la gestión emocional a través del psicoanálisis y terapias psicodinámicas, terapias convencionales acopladas con las nuevas tecnologías de la

información y la comunicación, apoyo a través de alianzas terapéuticas e intervenciones de contacto breve, y apoyo al cumplimiento del tratamiento.

- La investigación específica sobre Intervenciones de enfermería NIC proporciona a los profesionales de enfermería las bases necesarias para una práctica clínica de calidad en la atención, prevención y tratamiento de pacientes con riesgo de suicidio. Lo intervenciones terapéuticas descritas permiten a la enfermería desarrollar su profesión con evidencia científica. La investigación identificó las diversas intervenciones que han demostrado ser eficaces para paciente, familia y comunidad.

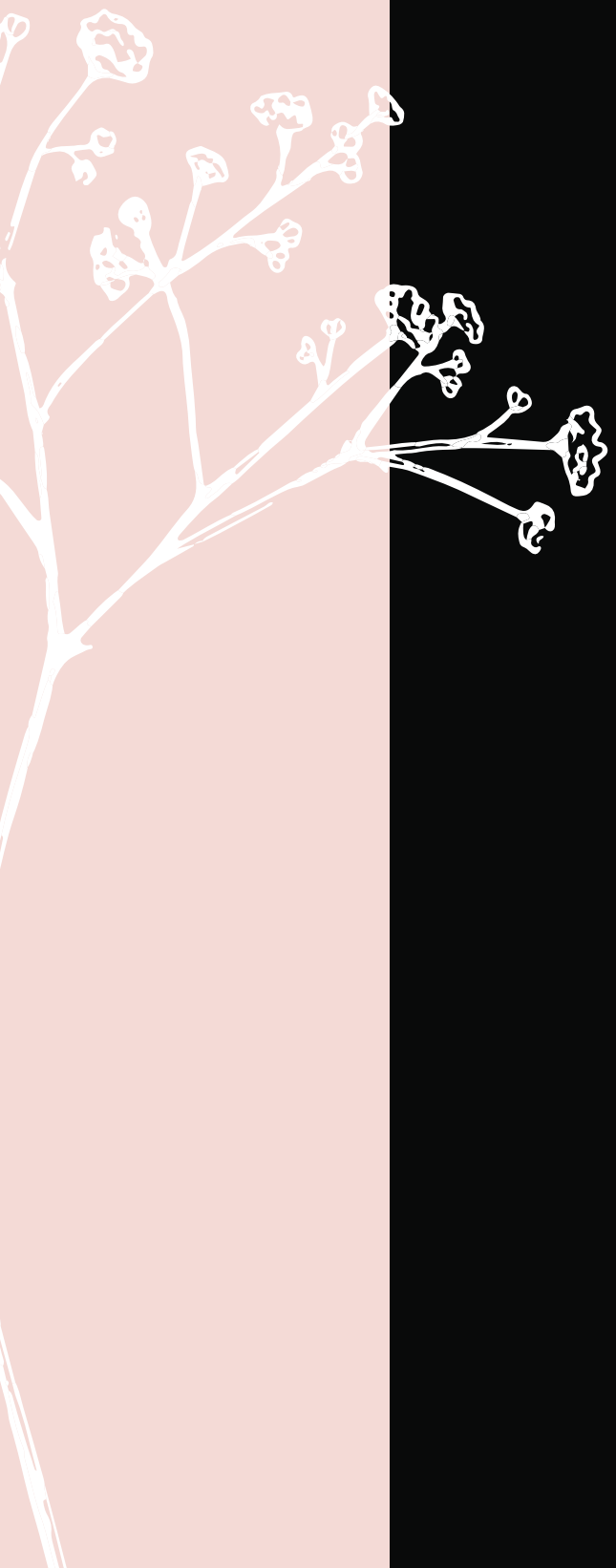
- Los planes de prevención en todas las provincias españolas establecen medidas preventivas universales, selectivas e indicadas. Si bien es cierto que no todos ellos se centran en proporcionar información relacionada con el suicidio y sus conductas asociadas a la población general, se observa que las intervenciones dirigidas a la detección del riesgo y la asistencia a grupos vulnerables están presentes en el 100% de los planes españoles de prevención del suicidio.

- Los planes de prevención del suicidio en España, así como sus objetivos y medidas propuestas, son similares en las distintas provincias. Se observa que la mayoría de las intervenciones están dirigidas a los profesionales sanitarios, especialmente en el ámbito de la salud mental, así como a la población más vulnerable. También existen otro tipo de medidas centradas en áreas clave como la sensibilización en las escuelas o la formación de agentes sociales (gatekeepers). No todas las comunidades tienen un programa de prevención del suicidio, sino que la elaboración de este documento es un objetivo incluido en planes más generales como los planes de salud mental de las respectivas comunidades.

- Los medios de comunicación pueden funcionar como un factor protector y/o de riesgo para la conducta suicida; una información o exposición bien gestionada tiene una influencia preventiva en la reducción de las tasas de suicidio. Los resultados confirmaron que la inclusión en la narrativa de mensajes positivos de esperanza, resiliencia y superación de la adversidad está presente como información preventiva y protectora.

- Establecer una difusión adecuada y responsable de la conducta suicida en los medios de comunicación con información completa y actualizada sobre los centros, organizaciones, instituciones y recursos disponibles para el abordaje de la conducta suicida ha demostrado ser eficaz, especialmente en poblaciones vulnerables y/o con dificultades de acceso al sistema sanitario.

- El uso de los medios de comunicación como herramienta de alfabetización sanitaria, la reducción del estigma de la enfermedad mental en general y de la conducta suicida en particular, así como la difusión de los tratamientos disponibles, han demostrado ser una estrategia preventiva.



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ANEXOS

ANEXO 1

INTERVENCIONES DE ELECCIÓN A DESARROLLAR POR PROFESIONALES SANITARIOS PARA LA PREVENCIÓN DE LA CONDUCTA SUICIDA

Intervención	Definición
Terapia dialéctica conductual	Enfoque que combina estrategias cognitivas y conductuales para tratar trastornos emocionales. Se centra en el equilibrio entre aceptación y cambio.
Terapia cognitivo conductual	Enfoque centrado en identificar y modificar patrones de pensamiento y comportamiento disfuncionales, a través de modificar pensamientos negativos y conductas.
Terapia resolución / adaptación problemas	Enfoque centrado en desarrollar habilidades para identificar, analizar y abordar eficazmente los problemas de la vida cotidiana, fomentando la toma de decisiones y la resolución constructiva de dificultades emocionales o situacionales. Se orienta hacia la adquisición de herramientas para enfrentar y superar obstáculos
Terapia psicodinámica	Enfoque que explora las influencias inconscientes en el comportamiento y busca comprender y abordar conflictos internos, patrones repetitivos y experiencias pasadas para promover la autoconciencia y el cambio emocional. Se centra en la relación terapéutica y la interpretación de procesos mentales profundos.
Terapia psicoanalítica	Basado en las teorías de Sigmund Freud. Orientado a explorar el inconsciente del paciente, examinar las experiencias pasadas y relaciones significativas para comprender y abordar conflictos psicológicos subyacentes y promover la resolución de problemas emocionales.
Terapia familiar	Abordaje los problemas mediante la exploración de las dinámicas y relaciones dentro de una familia. Se centra en mejorar la comunicación, resolver conflictos y promover cambios positivos en el sistema familiar para mejorar el bienestar de sus miembros.
Terapia interpersonal	Enfoque breve y estructurado que se centra en las relaciones interpersonales y los roles sociales. Busca identificar y abordar problemas de comunicación, conflicto interpersonal y déficits en las habilidades sociales para mejorar la calidad de las relaciones y la salud emocional.
Terapia / grupos de apoyo	Participación de personas que comparten experiencias similares para brindarse mutuo apoyo emocional y compartir estrategias de afrontamiento. Fomenta la conexión interpersonal, proporciona un espacio seguro para expresar sentimientos y promueve el aprendizaje en la superación de desafíos comunes.

Intervención	Definición
Terapia basada en la aceptación y compromiso	Enfoque psicoterapéutico que busca aumentar la flexibilidad psicológica, promoviendo la aceptación de experiencias internas y la toma de acciones alineadas con los valores personales. Se centra en cambiar la relación del individuo con sus pensamientos y emociones.
Gatekeeper	Profesional que decide o facilita el acceso a servicios terapéuticos o de tratamiento
Relación / Alianza terapéutica personalizada	Adaptación de la relación terapéutica a las necesidades individuales, reconociendo y respetando sus preferencias, estilos de comunicación y metas específicas para lograr una colaboración efectiva entre durante el proceso.
Seguimiento activo, contacto e intervención breve	Componentes de una estrategia proactiva que involucra un monitoreo constante, la iniciación de contacto regular y la aplicación de intervenciones breves para abordar as necesidades de la persona y prevenir crisis.
Farmacoterapia, adherencia al tratamiento y control efectos secundarios	Supervisión y gestión de las reacciones no deseadas de la medicación y potenciar la consistencia del paciente en las indicaciones terapéuticas para lograr una gestión efectiva de su salud mental
Detección y tratamiento de la depresión	Abordaje temprano y adecuado de la salud mental para mejorar el bienestar emocional, las relaciones, la calidad de vida y el desempeño laboral.
Entrenamiento de habilidades (sociales, afrontamiento)	Desarrollar la capacidad de interactuar eficazmente en situaciones sociales y adquirir estrategias para manejar el estrés, las emociones y los desafíos de manera adaptativa, mejorando así la resiliencia emocional.
Educación psicológica, autocuidado y asesoramiento	Proporcionar información sobre aspectos psicológicos para aumentar la comprensión y promover la salud mental. Implica prácticas individuales que fomentan el bienestar emocional, y la provisión de orientación para abordar problemas emocionales o de vida.
Intervención en línea	Enfoque terapéutico que utiliza medios digitales para proporcionar apoyo psicológico, terapia o asesoramiento a través de plataformas online. Se adapta a la conveniencia y accesibilidad, permitiendo la interacción terapéutica a distancia
Visitas / reuniones de seguimiento	Encuentros consensuados para evaluar el progreso, discutir cambios necesarios y ajustar estrategias con el objetivo de mantener un monitoreo regular y mejorar resultados.
Promoción de la salud mental, manejo del estrés.	Actividades que fomentan el bienestar psicológico, incluye técnicas y enfoques para gestionar y reducir el impacto negativo de las tensiones diarias en la salud mental.
Fortalecimiento de factores de protección (resilencia, esperanza)	Reforzar aspectos positivos de una persona, como habilidades sociales, apoyo emocional y recursos, para aumentar la resiliencia. Orientado a construir una base sólida de bienestar.
Contacto y apoyo en crisis	Brindar asistencia inmediata ante situaciones difíciles. Proporciona orientación, empatía y recursos para ayudar a las personas a afrontar y superar momentos de crisis emocional.

Intervención	Definición
Control del estado de ánimo y emociones	Gestión consciente de los sentimientos para mantener un equilibrio emocional. Incluye estrategias como la regulación emocional y el autoconocimiento para mejorar la salud mental y el bienestar.
Instrucciones de publicación a la prensa	Establecer pautas específicas que orientan la presentación segura y responsable de información relacionada con la prevención del suicidio, asegurando la sensibilidad y evitando la promoción o glorificación de conductas suicidas.
Concienciación de la comunidad	Educar y destigmatizar los problemas de salud mental a nivel comunitario, fomentando la comprensión, empatía y apoyo para promover un ambiente que valore y cuide la salud mental de manera inclusiva.
Reducir el acceso a los medios	Limitar el acceso a métodos letales, como armas o sustancias tóxicas. Se centra en medidas preventivas para crear entornos más seguros y reducir el riesgo de autolesiones.
Acceso a los servicios de salud	Facilitar la disponibilidad y asequibilidad de intervenciones psicológicas, reduciendo barreras para que las personas puedan buscar y recibir tratamiento de manera oportuna y efectiva.
Evaluación de la calidad de las webs de información	Implica analizar la fiabilidad, relevancia y seguridad de los recursos en línea destinados a ofrecer información y apoyo en temas relacionados con la prevención del suicidio, garantizando la precisión y utilidad de la información proporcionada.

ANEXO 2

INTERVENCIONES DE ENFERMERÍA NIC PARA LA PREVENCIÓN, MANEJO Y CUIDADO DE LA CONDUCTA SUICIDA

Código	NIC	Definición
0066	Acuerdo con el paciente	Negociar un acuerdo con el paciente para reforzar un cambio de conducta específico.
1460	Relajación muscular progresiva	Facilitar la tensión y relajación de grupos musculares sucesivos mientras se presta atención a las diferencias de sensibilidad resultantes.
2300	Administración de medicación	Preparar, administrar y evaluar la efectividad de los medicamentos prescritos y de libre dispensación.
2395	Control de la medicación	Comparación de las medicaciones que el paciente toma en casa con la prescripción al ingreso, traslado y/o alta para asegurar la exactitud y la seguridad del paciente.
2380	Manejo de la medicación	Facilitar la utilización segura y efectiva de los medicamentos prescritos y de libre dispensación.
4340	Entrenamiento de la asertividad	Ayuda para la expresión efectiva de sentimientos, necesidades e ideas, respetando los derechos de los demás.
4350	Manejo de la conducta	Ayudar al paciente a controlar una conducta negativa.
4352	Modificación de la conducta	Ayudar al paciente para que desarrolle o mejore las habilidades sociales interpersonales.
4354	Manejo conducta de autolesión	Ayudar al paciente para que disminuya o elimine la conducta de autolesión o abuso de sí mismo.
4360	Modificación de la conducta	Promoción de un cambio de conducta.
4380	Establecer límites	Establecer los parámetros de una conducta deseable y aceptable del paciente.
4410	Establecimiento objetivos comunes	Colaboración con el paciente para identificar y dar prioridad a los objetivos de cuidados y desarrollar luego un plan para alcanzar estos objetivos.
4480	Facilitar la autorresponsabilidad	Animar a un paciente a que asuma más responsabilidad de su propia conducta.
4500	Prevención consumo sustancias	Prevenir un estilo de vida que incurra en el alcoholismo y el consumo de drogas.
4700	Reestructuración cognitiva	Estimular al paciente para modificar patrones de pensamiento distorsionados y para que se vea a sí mismo y al mundo de forma más realista.

Código	NIC	Definición
4860	Terapia de reminiscencia	Utilización del recuerdo de sucesos, sentimientos y pensamientos pasados para facilitar el placer o la adaptación a las circunstancias actuales.
4920	Escucha activa	Prestar gran atención y otorgar importancia a los mensajes verbales y no verbales del paciente.
5000	Elaboración relaciones complejas	Establecimiento de una relación terapéutica para promover la introspección y el cambio conductual.
5020	Mediación de conflictos	Facilitación del diálogo constructivo entre partes opuestas con el objetivo de resolver conflictos de una manera aceptable para ambas partes.
5100	Potenciación de la socialización	Facilitar la capacidad de una persona para interactuar con los demás.
5230	Mejorar el afrontamiento	Facilitación de los esfuerzos cognitivos y conductuales para manejar factores estresantes que interfieran para satisfacer demandas y de la vida.
5240	Asesoramiento	Utilización de un proceso de ayuda centrado en las necesidades, problemas o sentimientos para apoyar el afrontamiento, la capacidad de resolver problemas y las relaciones interpersonales.
5250	Apoyo en la toma de decisiones	Proporcionar información y apoyo a un paciente que debe tomar.
5270	Apoyo emocional	Proporcionar seguridad, aceptación y ánimo en momentos de tensión.
5300	Facilitar la expresión de culpa	Ayudar a una persona a afrontar los sentimientos dolorosos de responsabilidad, real o percibida.
5310	Dar esperan	Aumentar la creencia de la propia capacidad para iniciar y mantener acciones.
5316	Potenciación de las aptitudes para la vida diaria	Desarrollar la capacidad del individuo para afrontar de forma independiente y eficaz las exigencias y dificultades de la vida diaria.
5328	Visitas domiciliarias de apoyo	Escuchar empáticamente para comprender la situación del paciente y trabajar para identificar y elaborar soluciones para educir los síntomas depresivos
5330	Control del estado de ánimo	Proporcionar seguridad, estabilidad, recuperación y mantenimiento a un paciente que experimenta un estado de ánimo disfuncionalmente deprimido o eufórico.
5380	Potenciación de la seguridad	Intensificar el sentido de seguridad física y psicológica de un paciente.
5390	Potenciación de la autoconciencia	Ayudar a un paciente a que explore y comprenda sus pensamientos, sentimientos, motivaciones y conductas.
5395	Mejora de la autoconfianza	Fortalecer la confianza de una persona en su capacidad de realizar una conducta saludable.
5400	Potenciación de la autoestima	Ayudar a un paciente a que mejore el juicio personal de su autovalía.

Código	NIC	Definición
5430	Grupo de apoyo	Uso de un ambiente grupal para proporcionar apoyo emocional e información relacionada con la salud.
5440	Aumentar los sistemas de apoyo	Facilitar el apoyo del paciente por parte de la familia, los amigos y la comunidad.
5450	Terapia de grupo	Aplicación de técnicas psicoterapéuticas a un grupo, incluida la utilización de interacciones entre los miembros
5460	Contacto	Proporcionar consuelo y comunicación a través de un contacto táctil intencionado.
5480	Clarificación de valores	Ayuda a una persona a clarificar sus propios valores con el objeto de facilitar la toma de decisiones eficaces.
5510	Educación para la salud	Desarrollar y proporcionar instrucción y experiencias de aprendizaje que faciliten la adaptación de la conducta para conseguir la salud en personas, familias, grupos o comunidades.
5515	Mejorar el acceso a la información sanitaria	Ayudar a las personas con capacidad limitada para obtener, procesar y comprender la información relacionada con la salud y la enfermedad.
5616	Enseñanza de medicamentos	Preparar al paciente para que tome de forma segura los medicamentos prescritos y observar sus efectos.
5880	Técnica de relajación	Disminución de la ansiedad del paciente que presenta angustia aguda.
5969	Facilitar la meditación	Facilitar que una persona modifique su nivel de consciencia centrándose en una imagen o pensamiento.
6040	Terapia de relajación	Uso de técnicas para favorecer e inducir la relajación con objeto de disminuir signos / síntomas indeseables.
6160	Intervención en caso de crisis	Utilización de asesoramiento a corto plazo para ayudar.
6240	Primeros auxilios	Proporcionar los cuidados iniciales en casos leves de quemaduras, lesiones, intoxicaciones, mordeduras…
6340	Prevención del suicidio	Disminución del riesgo de los daños autoinfligidos con la intención de acabar con la vida.
6486	Manejo ambiental	Vigilar y actuar sobre el ambiente físico para fomentar la seguridad.
6520	Análisis de la situación sanitaria	Detección de riesgos o problemas para la salud por medio de anamnesis, la exploración y otros procedimientos.
6610	identificación de riesgos	Análisis de los factores de riesgo potenciales, determinación de riesgos para la salud y asignación de la prioridad a las estrategias de disminución de riesgos.
7100	Estimulación de integridad familiar	Favorecer la cohesión y unidad familiar.
7110	Fomentar la implicación familiar	Facilitar la participación de los miembros de la familia en el cuidado emocional y físico del paciente.
7130	Mantenimiento procesos familiares	Minimizar los efectos de la alteración de los procesos familiares.
7140	Apoyo a la familia	Fomento de los valores, intereses y objetivos familiares.

Código	NIC	Definición
7150	Terapia familiar	Ayuda a los miembros de la familia a vivir de un modo más productivo.
7200	Fomentar la normalización familiar	Ayudar a los progenitores y otros familiares de niños con enfermedades crónicas o discapacidades a tener experiencias vitales normales para sus niños y familias.
7800	Control de calidad	Recopilación y análisis sistemáticos de los indicadores de calidad de un centro para mejorar la asistencia.
7910	Consulta	Uso de los conocimientos técnicos para trabajar con aquellos individuos que solicitan ayuda en la resolución de problemas para permitir que alcancen los objetivos identificados.
7960	Intercambio de información de cuidados de salud	Proporcionar información sobre la atención del paciente a otros profesionales sanitarios.
8020	Reunión multidisciplinar sobre cuidados	Planificación y evaluación de los cuidados del paciente con profesionales sanitarios de otras disciplinas.
8100	Derivación	Hacer los preparativos para que el paciente sea atendido por otros cuidadores o institución.
8180	Consulta por teléfono	Identificar las preocupaciones del paciente, escucharlo y proporcionar apoyo, información o enseñanzas por teléfono en respuesta a dichas preocupaciones.
8190	Seguimiento telefónico	Usar la vía telefónica para dar los resultados de una prueba o evaluar la respuesta del paciente y determinar posibles problemas como resultado del tratamiento.
8340	Fomentar la resilencia	Ayudar a individuos, familias y comunidades en el desarrollo, uso y fortalecimiento de factores protectores para ser utilizados para afrontar factores estresantes ambientales y sociales.

ANEXO 3

COLABORACIONES DE TERESA SUFRATE SORZANO EN OTROS ARTÍCULOS CIENTÍFICOS

Durante la tesis, he colaborado en la elaboración de los siguientes artículos publicados:

- Ramírez-Torres CA, Rivera-Sanz F, Cobos-Rincon A, **Sufrate-Sorzano T**, Juárez-Vela R, Gea-Caballero V, Tejada Garrido CI, Colado Tello ME, Durante A, Santolalla-Arnedo I. Perception of patient safety culture among nursing students: A cross-sectional study. Nursing Open. 2023 Oct 19. https://doi.org/10.1002/nop2.1995

- Garrote-Camara ME, Juárez-Vela R, Rodríguez-Muñoz PM, Pérez J, Sánchez-González JL, Rubinat-Arnaldo E, Navas-Echazarreta N, **Sufrate-Sorzano T**, Santolalla-Arnedo I. NANDA nursing diagnoses associated with the occurrence of psychomotor agitation in patients with severe mental disorder: a cross-sectional study. BMC nursing. 2023 Aug 28;22(1):292. https://doi.org/10.1186/s12912-023-01434-2

- Ramírez-Torres CA, Rivera-Sanz F, **Sufrate-Sorzano T**, Pedraz-Marcos A, Santolalla-Arnedo I. Closed Endotracheal Suction Systems for COVID-19: Rapid Review. Interactive Journal of Medical Research. 2023 Jan 10;12(1):e42549. DOI: 10.2196/42549

- Garrote-Cámara ME, Santolalla-Arnedo I, Ruiz de Viñaspre-Hernández R, Gea-Caballero V, **Sufrate-Sorzano T**, del Pozo-Herce P, Garrido-García R, Rubinat-Arnaldo E, Juárez Vela R. Psychometric Characteristics and Sociodemographic Adaptation of the Corrigan Agitated Behavior Scale in Patients With Severe Mental Disorders. Frontiers in Psychology. 2021 Dec 8;12:5558. https://doi.org/10.3389/fpsyg.2021.779277

- Garrote-Cámara ME, Juárez-Vela R, **Sufrate-Sorzano T**, Durante A, Ferrara P, Terzoni S, Pérez J, Santolalla-Arnedo I. Transcultural Adaptation of and Theoretical Validation Models for the Spanish Version of the Nurses' Global Assessment of Suicide Risk Scale: Protocol for a Multicenter Cross-sectional Study. JMIR research protocols. 2022 Sep 21;11(9):e39482. DOI:10.2196/39482

- Gea-Caballero V, Marín-Maicas P, **Sufrate-Sorzano T**, Di Nitto M, Rozensztrauch A, Juárez-Vela R. Nursing, Commitment, and Leadership: More Nurses for a Better Health Care Model—Be a Nurse to Be a Leader. International Journal of Environmental Research and Public Health. 2022 May 20;19(10):6223. https://doi.org/10.3390/ijerph19106223

- Garrote-Cámara ME, Gea-Caballero V, **Sufrate-Sorzano T**, Rubinat-Arnaldo E, Santos-Sánchez JÁ, Cobos-Rincón A, Santolalla-Arnedo I, Juárez-Vela R. Clinical and sociodemographic profile of psychomotor agitation in mental health hospitalisation: a multicentre study. International journal of environmental research and public health. 2022 Nov 30;19(23):15972. https://doi.org/10.3390/ijerph192315972

- Ruiz de Viñaspre-Hernández R, García-Erce JA, Rodríguez-Velasco FJ, Gea-Caballero V, **Sufrate-Sorzano T**, Garrote-Cámara ME, Urra-Martínez R, Juárez-Vela R, Czapla M, Santolalla-Arnedo I. Variability in Oral Iron Prescription and the Effect on Spanish Mothers' Health: A Prospective Longitudinal Study. Journal of Clinical Medicine. 2021 Nov 8;10(21):5212. https://doi.org/10.3390/jcm10215212

- Rivera Sanz F, Santolalla Arnedo I, Jodrá Espartero B, **Sufrate Sorzano T**. Estudio comparativo de casos sobre el papel del modelo europeo de excelencia en la sostenibilidad de las organizaciones sanitarias. Archives of Nursing Research. 2019 Dec 21;3(1):71-88. DOI:10.24253/anr.3.71