

Article

Psychiatric Hospitalization for Attempted Suicide and Reattempt at the One-Year Follow-Up

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ABSTRACT

Background: People hospitalized for suicide attempt (SA) have a high risk of repeating and committing suicide during the first months after discharge. The aim of this study is to compare the usual treatment (TAU) with a TAU supplemented with a telephone follow-up programme (TAU + T). **Method:** multicentre, open-trial, ex post facto pre-post prospective study that compared two samples of 90 (TAU) and 101 (TAU + T) people admitted in 2018-2019 for attempted suicide in two psychiatry units after one-year follow-up. Repeated SAs were analysed. **Results:** A total of 31.4% ($n=60$) of the sample attempted suicide at least once during follow-up, with no differences between the units. A total of 32.5% ($n=62$) were readmitted during the following year, 15.6% of those readmissions were due to new suicide attempts. In TAU, the highest proportion of reattempts was among those diagnosed with personality disorders (77.8%) vs. other diagnoses (28.4%). In TAU + T, the highest proportion was found among those with previous SAs (50%) vs. those admitted for the first SA (4.4%). **Conclusions:** people admitted to psychiatric units for a first SA seem to benefit from TAU + T as it was associated with a lower recurrence of SA after discharge.

Hospitalización Psiquiátrica por Intento de Suicidio y Reintento al Año de Seguimiento

RESUMEN

Antecedentes: las personas hospitalizadas por un intento de suicidio (IS) tienen un riesgo alto de repetir/consumar el suicidio en los meses siguientes al alta. El objetivo de este estudio es comparar un tratamiento habitual (TAU) con un TAU complementado con un programa de seguimiento telefónico (TAU + T). **Método:** estudio multicéntrico, abierto, ex post-facto pre-post prospectivo de dos grupos que comparó dos muestras de 90 (TAU) y 101 (TAU+T) personas ingresadas en 2018-2019 por IS tras un año de seguimiento. Se analizó las repeticiones de los IS. **Resultados:** el 31,4% ($n=60$) realizó al menos un intento de suicidio en el seguimiento, sin diferencias entre los dos centros. El 32,5% ($n=62$) reingresó en el año siguiente, de ellos el 15,6% debido a nuevos intentos. En TAU, la mayor proporción de reintentos se dio entre quienes estaban diagnosticados de trastornos de personalidad (77,8%) vs. resto de diagnósticos (28,4%). En TAU + T la mayor proporción se dio entre quienes presentaban IS anteriores (50%) vs. ingresados por primer IS (4,4%). **Conclusiones:** las personas ingresadas en unidad de hospitalización por un primer IS, parecieron beneficiarse del TAU + T ya que se asoció a una menor recurrencia de los IS posterior al alta.

Palabras clave:

Ingreso en psiquiatría
Intento de suicidio
Trastorno mental
Tratamiento en salud mental
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The prevention of suicidal behaviour is currently a challenge for social and health policies in many countries. In 2020, suicide in Spain reached its highest incidence. Moreover, since 2008 death by suicide has been the leading cause of unnatural death (Instituto Nacional de Estadística, 2021). In the healthcare context, the indicated prevention model has been the most used and focuses mainly on people with mental disorders and/or with previous suicide attempts (SAs) (Al-Halabí & Fonseca-Pedrero, 2021; Gabilondo, 2020). From a health perspective, the planning and continuity of care of people at risk is prioritized (Zalsman et al., 2016), as well as early follow-up after hospital discharge (Qin & Nordentoft, 2005) and brief and active contact with the person to facilitate therapeutic continuity (Inagaki et al., 2019).

SAs, considered health emergencies, represent approximately 10–20% of the total care in psychiatric emergency services (Jiménez-Treviño et al., 2015), with a progressive increase in recent years (Ting et al., 2012), and are the main predictors of repetition (Geulayov et al., 2019; Larkin et al., 2014) and death by suicide (Bostwick et al., 2016). In the Spanish population, approximately 26% of emergency care for suicidal behaviour includes psychiatric hospitalization (Jiménez-Treviño et al., 2015).

The clinical criteria for hospitalization as the best resource for the treatment of these people include psychopathological decompensations that lead to acute emotional crises with a high risk of suicide and severe and persistent ideation of death, the presence of a structured plan, a highly lethal SA and a personal psychiatric history, among others (Rangel-Malo et al., 2020). However, the indication of this type of admission may vary from one hospital to another, taking into account other psychosocial factors apart from strict clinical factors (Miret et al., 2011; Suominen & Lonnqvist, 2006).

There is evidence that people hospitalized for suicidal behaviour have a high probability of repeating and committing suicide during the 12 months immediately following discharge (Gunnell et al., 2008; Hayashi et al., 2012; Suarez-Pinilla et al., 2020) and exhibit suicidal behaviour that can persist for years (Chung et al., 2017).

Currently, comprehensive intervention models such as AIM-SP (Assess, Intervene and Monitor for Suicide Prevention) are being introduced. AIM-SP includes assessment, intervention and monitoring of high-risk individuals, pursuing chain of care and supervision in periods of high risk (Al-Halabí & García-Haro, 2021). Therapeutic strategies that facilitate close and structured contact at transition points between services that can prevent repetition of these behaviors are gaining prominence (Barzilay et al., 2019; Deisenhammer et al., 2019). Telephone follow-up programs stand out but need replication (Turecki et al., 2019).

In relation to the analysis of therapeutic strategies, the contribution of this work is to compare the evolution of two samples of people admitted to two psychiatric units due to SAs in two autonomous communities. The main objective is to determine the existence of repeated suicidal behaviour in the 12 months following discharge from psychiatric hospitalization. In the follow-up, one of the samples, in addition to receiving the usual treatment in the health network (TAU), participated in a brief and structured telephone follow-up programme (TAU + T). Therefore, the specific objectives of this study are 1) to compare

the sociodemographic and clinical variables of both samples; 2) to analyse whether the TAU + T reduces repeated SAs; and 3) to identify possible specific profiles of people associated with suicide reattempts.

Method

This research was authorized by the Clinical Research Ethics Committee of the Department of Health of the Government of Navarra (project No. 69/2019) and the Department of Health of the Government of Aragon (project No. 74/2020).

Participants

This multicenter, open, ex post-facto pre-post prospective two-group study involved a total of 191 participants, with a mean age of 45.88 years (S.D. = 15.5) of whom 101 were women (52.9%). This sample was obtained from people admitted during 2018 and 2019, in two psychiatric units of two neighboring Spanish autonomous communities. The first sample (n = 101; 52.9%) was collected in the Navarra Hospital Complex (Complejo Hospitalario de Navarra, CHN) that covers the Pamplona area and serves a population of 362,386 inhabitants. The second sample (n = 90) was collected in the Lozano Blesa University Clinical Hospital (Hospital Clínico Universitario Lozano Blesa, HCULB) that belongs to sector III of Zaragoza and serves 267,525 inhabitants. Both have a 24-hour psychiatric emergency service. In both samples, all people who were admitted for a SA were followed up. The characteristics of the participants are presented in table 1. A follow-up study with the CHN sample was previously published (López-Goñi & Goñi-Sarriés, 2021).

SA was defined as all self-inflicted behaviour, potentially harmful, with a nonfatal result, for which there was evidence, explicit or implicit, of an intention to die (O'Carroll et al., 1996). The inclusion criteria were age older than 18 years and admitted for a SA for at least two days. The exclusion criteria were being unable to respond, having difficulty with the language or suffering from intellectual disability.

Suicide reattempt was defined as when the person was treated again, at least once, during the year of follow-up, after the SA for which he or she was included in the study. For cases in which there was more than one repetition, only the first repetition was analysed.

Instruments

Sociodemographic, clinical and follow-up variables were collected.

The sociodemographic variables were age, sex, place of birth, education level, employment status, cohabitation and having children.

The clinical variables were previous SA, first-degree relative family history of suicide, history of mental disorder with mental health treatment, mental health follow-up, diagnosis according to the International Classification of Diseases (ICD-10), method used in the SA, lethality of the SA (*low - high*), attitude towards the attempt, concomitant consumption of toxins prior to the SA, care in the last year in the psychiatric emergency department, and

previous psychiatric hospitalization in the last year. As in previous studies, low SA was considered when it was not required hospital admission, and high SA was considered when it was required admission for more than 24 hours due to organic or psychiatric complications (Goñi-Sarriés et al., 2019).

The follow-up variables were mental health treatment, repeated SA, psychiatric hospitalization, and completed suicide.

Procedure

The evaluations were performed by psychiatric specialists and resident psychiatrists in the context of the psychiatric emergency services at the two general hospitals in both autonomous communities. The interviews were conducted after the physical and mental health of the person was stabilized. The decision regarding psychiatric hospitalization was made based on clinical protocols. At discharge from hospitalization, the follow-up period began. Subsequently, one year after inclusion in the study, the clinical situation was assessed by accessing each person's history.

Treatment

The two samples in this study received the usual treatment at discharge from psychiatric hospitalization, which consisted of a clinical follow-up in mental health services. The CHN sample also participated in a telephone follow-up programme in parallel (TAU + T). This consisted of six calls (the day after discharge, at 15 days, and at 2, 4, 8 and 12 months after the SA) that were made by a specialist nurse. The objectives of the first call were to introduce the participant to the nurse, explain the programme, reevaluate the risk of suicide, reinforce the therapeutic plan indicated at discharge, explore possible life stressors and verify that a follow-up appointment with the referring professional was scheduled within less than 10 days. During subsequent follow-up calls, attempts were made to reinforce therapeutic adherence or facilitate return if treatment had been voluntarily stopped as well as to reevaluate the risk of suicide or identify significant changes during the elapsed period. For cases in which the nurse detected a crisis situation, the nurse coordinated an emergency department visit and/or to arranged for a faster appointment with the referring professional (psychiatrist or clinical psychologist).

Data Analysis

Descriptive analyses were performed for all variables. In the comparisons between groups (comparison between samples or between those who had made an attempt and those who did not during follow-up), the χ^2 test or Student's *t* test was used based on the nature of the variables analysed, considering $p < .05$ as significant. For determining the different subsamples of people, chi-squared automatic interaction detection (CHAID) analysis was used. This technique evaluates the discriminant capacity of a nominal variable (in this case, the presence or absence of a SA during follow-up) by means of the χ^2 significance. For this, a CHAID analysis was performed including the hospital centre as variable to determine the differences between the two hospitals. All statistical analyses were performed using the statistical package SPSS (v. 25.0).

Results

Description and Comparison in Sociodemographic and Clinical Variables of Both Samples

Table 1 provides the sociodemographic characteristics and the variables related to mental health and the SA that resulted in admission. Regarding to the presence of clinical variables most of the people has a history of mental disorders (85.9%; $n = 164$), a psychiatric diagnosis (78.5%; $n = 151$), was in treatment for mental health (76.4%, $n = 146$), used drug poisoning in the SA (70.7%; $n = 135$), expressed regret for the suicide attempt (70.2%; $n = 134$), SA's level of lethality was high (52.9%; $n = 101$), and was admitted in Psychiatric Emergency Services in the last year (51.8%; $n = 99$).

In the comparison between the two hospitals, at TAU, compared with TAU + T, the statistically significant differences found were the following: a lower proportion of women (44.4% vs. 60.4%) and of previous attempts (40% vs. 55.4%) and a higher proportion of psychotic disorder diagnoses (21.1% vs. 7.9%); in turn, among those treated at TAU + T, there was a higher proportion of personality disorder diagnoses (20.8% vs. 10.0%) and SAs through intoxication (77.2% vs. 63.3%).

At the time of admission, 76.4% ($n = 146$) of the sample were receiving treatment through the mental health network. 74.4% of people admitted for SI in TAU and 78.2% in TAU + T had current mental health follow-up, with no significant differences between the two hospitals ($\chi^2 = 0.4$; $df = 1$; $p = .540$).

Evolution of the Sample During Follow-Up (TAU vs. TAU + T)

During the follow-up period (table 2), three people (1.6%) died by suicide (two at TAU and one at TAU + T). A total of 31.4% ($n = 60$) of people carried out at least one SA, with no statistically significant differences between the two centres (TAU: $n = 30$; 33.3%; TAU + T: $n = 30$, 29.7%). In addition, 62 people (32.5%) were readmitted, specifically, 30 in the TAU group (33.3% of those assisted) and 32 in the TAU + T group (31.7% of those assisted). Of these new admissions, 14 (15.6%) in the TAU group and 16 (15.8%) in the TAU + T group were due to a new SA.

Table 3 provides a comparison between individuals at each centre who reattempted suicide and who did not reattempt suicide. People who reattempted suicide at TAU presented the highest proportion of follow-up for mental health prior to the attempt (90.0%; $n = 27$).

People who reattempted in the follow-up period, presented a higher proportion of readmissions to Psychiatric Hospitalization Units (73.3%; $n = 22$ in TAU and 66.7%; $n = 20$ in TAU + T) than people who no reattempted (13.3%; $n = 8$ in TAU and 16.9%; $n = 12$ in TAU + T).

People that did not reattempt in TAU, were treated through the mental health network in the follow-up period in minor proportion than people who reattempted in TAU (65%; $n = 39$; vs. 93.3%; $n = 28$).

People who reattempted suicide at TAU presented higher proportion of admission to Psychiatric Hospitalization Units in the last year prior to the attempt than people than did not reattempt in TAU + T (43.3%; $n = 13$; vs. 14.1%; $n = 10$).

Table 1.
Description and Comparison of People Admitted to a Psychiatric Unit for a Suicide Attempt in the Two Communities.

	Total (n = 191)		Usual treatment (TAU) (n = 90)		Telephone follow-up programme (TAU + T) (n = 101)		χ^2 (df)	p	Phi
	N	%	n	%	n	%			
Sex									
Male	90	47.1	50 ^a	55.6	40 ^b	39.6	4.9 (1)	.027	.160
Female	101	52.9	40 ^a	44.4	61 ^b	60.4			
Place of birth									
Spain	163	85.3	80	88.9	83	82.2	1.7 (1)	.191	.095
Other	28	14.7	10	11.1	18	17.8			
Education									
Primary	66	34.6	29	32.2	37	36.6			
Secondary	96	50.3	46	51.1	50	49.5	0.5 (2)	.764	.053
University	29	15.2	15	16.7	14	13.9			
Employment									
Active (works, studies...)	88	46.1	42	46.7	46	45.5	0.1 (1)	.877	.011
Other	103	53.9	48	53.3	55	54.5			
Living situation									
Alone	35	18.3	17	18.9	18	17.8	0.1 (1)	.849	.014
Other	156	81.7	73	81.1	83	82.2			
Children (yes)	104	54.5	49	54.4	55	54.5	0.0 (1)	.999	.001
Previous attempt	92	48.2	36 ^a	40.0	56 ^b	55.4	4.6 (1)	.033	.154
Family history of suicide	28	14.7	11	12.2	17	16.8	0.8 (1)	.369	.065
History of mental disorders	164	85.9	76	84.4	88	87.1	0.3 (1)	.595	.038
Current diagnosis									
No diagnosis	41	21.5	20 ^a	22.2	21 ^a	20.8	9.6 (4)	.047	.225
Affective disorder	63	33.0	29 ^a	32.2	34 ^a	33.7			
Psychotic disorder	27	14.1	19 ^a	21.1	8 ^b	7.9			
Personality disorder	30	15.7	9 ^a	10.0	21 ^b	20.8			
Other disorder	30	15.7	13 ^a	14.4	17 ^a	16.8			
Follow-up for mental health	146	76.4	67	74.4	79	78.2	0.4 (1)	.540	.044
Attempt method used									
Intoxication	135	70.7	57	63.3	78	77.2	4.4 (1)	.035	.152
Other	56	29.3	33	36.7	23	22.8			
Lethality									
Low	90	47.1	49	54.4	41	40.6	3.7 (1)	.056	.139
High	101	52.9	41	45.6	60	59.4			
Attitude regarding attempt									
Repentance	134	70.2	60	66.7	74	73.3	0.9 (1)	.320	-.072
Regret nonfatal	57	29.8	30	33.3	27	26.7			
Consumption of toxins prior to the attempt	91	47.6	39	43.3	52	51.5	1.3 (1)	.260	.081
Psychiatric ES care in the last year prior to the attempt	99	51.8	53	58.9	46	45.5	3.4 (1)	.065	.133
Previous admission to PHU in the last year prior to the attempt	49	25.7	28	31.1	21	20.8	2.7 (1)	.103	.118
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>	<i>t</i> (df)	<i>p</i>	<i>d</i>
Age	45.88	15.50	46.91	15.84	44.96	15.21	0.9 (189)	.387	.126

Note. ES = Emergency service; PHU = Psychiatric hospitalization unit.

Values in the same row and sub-table with different superscripts are significantly different from one another at $p < .05$ in the two-sided test of equality for column proportions. Bonferroni correction was applied

Table 2.
Evolution of the Sample During Follow-Up (TAU vs. TAU + T).

	Total (N = 191)		Usual treatment (TAU) (n = 90)		Telephone follow-up programme (TAU + T) (n = 101)		χ^2 (df)	p	Phi
	N	%	n	%	n	%			
Deaths by suicide	3	1.6	2	2.2	1	1.0	--	--	
At least one suicide attempt in the follow-up	60	31.4	30	33.3	30	29.7	0.3 (1)	.590	.039
New entries in the follow-up	62	32.5	30	33.3	32	31.7	0.1 (1)	.808	.006
For attempted suicide	30	15.7	14	15.6	16	15.8	0.0 (1)	.957	.002
For another reason	32	16.8	16	17.8	16	15.8	0.1 (1)	.721	.012

Table 3.
Description and Comparison Between Individuals at Each Hospital Who Reattempted Suicide and Those Who Did Not Reattempt Suicide.

	Usual treatment (TAU; N = 90)				Telephone follow-up programme (TAU + T; N = 101)				χ^2	(df)	p
	No reattempt (n = 60)		Reattempt (n = 30)		No reattempt (n = 71)		Reattempt (n = 30)				
	n	%	n	%	n	%	n	%			
Previous attempt	20 ^a	33.3	16 ^a	53.3	28 ^a	39.4	28 ^b	93.3	32.3	(3)	< .001
Family history of suicide	6	10.0	5	16.7	11	15.5	6	20.0	1.9	(3)	.602
History of mental disorder	50	83.3	26	86.7	62	87.3	26	86.7	0.5	(3)	.925
Current diagnosis											
No diagnosis	17 ^a	28.3	3 ^a	10.0	18 ^a	25.4	3 ^a	10.0			
Affective disorder	21 ^a	35.0	8 ^a	26.7	25 ^a	35.2	9 ^a	30.0	33.9	(12)	.001
Psychotic disorder	13 ^a	21.7	6 ^a	20.0	8 ^a	11.3	0	--			
Personality disorder	2 ^a	3.3	7 ^{b,c}	23.3	9 ^{a,b}	12.7	12 ^c	40.0			
Other disorder	7 ^a	11.7	6 ^a	20.0	11 ^a	15.5	6 ^a	20.0			
Follow-up for mental health	40 ^a	66.7	27 ^b	90.0	52 ^a	73.2	27 ^a	90.0	9.7	(3)	.021
Attempt method used											
Intoxication	41	68.3	16	53.3	53	74.6	25	83.3	7.3	(3)	.061
Other	19	31.7	14	46.7	18	25.4	5	16.7			
Lethality											
Low	32	53.3	17	56.7	26	36.6	15	50.0	5.3	(3)	.153
High	28	46.7	13	43.3	45	63.4	15	50.0			
Attitude regarding attempt											
Repentance	39	65.0	21	70.0	55	77.5	19	63.3	3.2	(3)	.356
Regret nonfatal	21	35.0	9	30.0	16	22.5	11	36.7			
Consumption of toxins prior to the attempt	27	45.0	12	40.0	33	46.5	19	63.3	3.9	(3)	.276
Psychiatric ES care in the last year prior to the attempt	30 ^{a,c,d}	50.0	23 ^{a,b}	76.7	25 ^c	35.2	21 ^{b,d}	70.0	19.3	(3)	< .001
Previous admission to PHU in the last year prior to the attempt	15 ^{a,b}	25.0	13 ^a	43.3	10 ^b	14.1	11 ^{a,b}	36.7	11.8	(3)	.008
Readmission to PHU in follow-up period	8 ^a	13.3	22 ^b	73.3	12 ^a	16.9	20 ^b	66.7	56.7	(3)	< .001
Member of the mental health network in follow-up period	39 ^a	65.0	28 ^b	93.3	57 ^{a,b}	80.3	22 ^{a,b}	73.3	9.9	(3)	.020
Age	<i>M</i>	<i>S.D.</i>	<i>M</i>	<i>S.D.</i>	<i>M</i>	<i>S.D.</i>	<i>M</i>	<i>S.D.</i>	<i>F</i>	<i>(df)</i>	<i>p</i>
	47.45 ^a	16.37	45.83 ^a	14.93	47.35 ^a	15.87	39.30 ^b	11.97	2.3	(3)	.082

Note. ES = Emergency service; PHU = Psychiatric hospitalization unit.

Values in the same row and sub-table with different superscripts are significantly different from one another at $p < .05$ in the two-sided test of equality for column proportions. Cells with no superscript are not included in the test. Bonferroni correction was applied

People who did not reattempt in TAU + T were admitted in minor proportion in Psychiatric Emergency Service in the last year prior to the attempt (35.2%; $n = 25$) than people who reattempted in the follow-up in TAU (76.7%; $n = 23$) and TAU + T (70%; $n = 21$). Also, those who did not reattempt in TAU (50.0%; $n = 30$) were admitted in minor proportion than those who reattempted in TAU + T.

People who reattempted suicide at TAU + T presented the highest proportion of previous attempts (93.3%; $n = 28$), diagnosis of personality disorder (40%; $n = 12$) compared to people who no reattempted in (TAU 3.3%; $n = 2$) and in TAU + T (12.7%; $n = 9$) and were youngest ($M = 39.3$; $S.D. = 11.97$).

Specific Profiles of People Associated With Suicide Reattempts

Figure 1 shows the main differences between the two hospitals from a multivariate perspective. At TAU, the first variable that discriminated between those who had carried out a SA during follow-up was diagnosis. A total of 77.8% ($n = 7$) of those with a personality disorder made at least one SA, compared with 28.4% ($n = 23$) of those with other diagnoses. In addition, among those who presented with other diagnoses, compared with those who used intoxication, a greater proportion of those who used a SA method other than intoxication made a repeated SA (41.9%; $n = 13$ vs. 20.0%; $n = 10$).

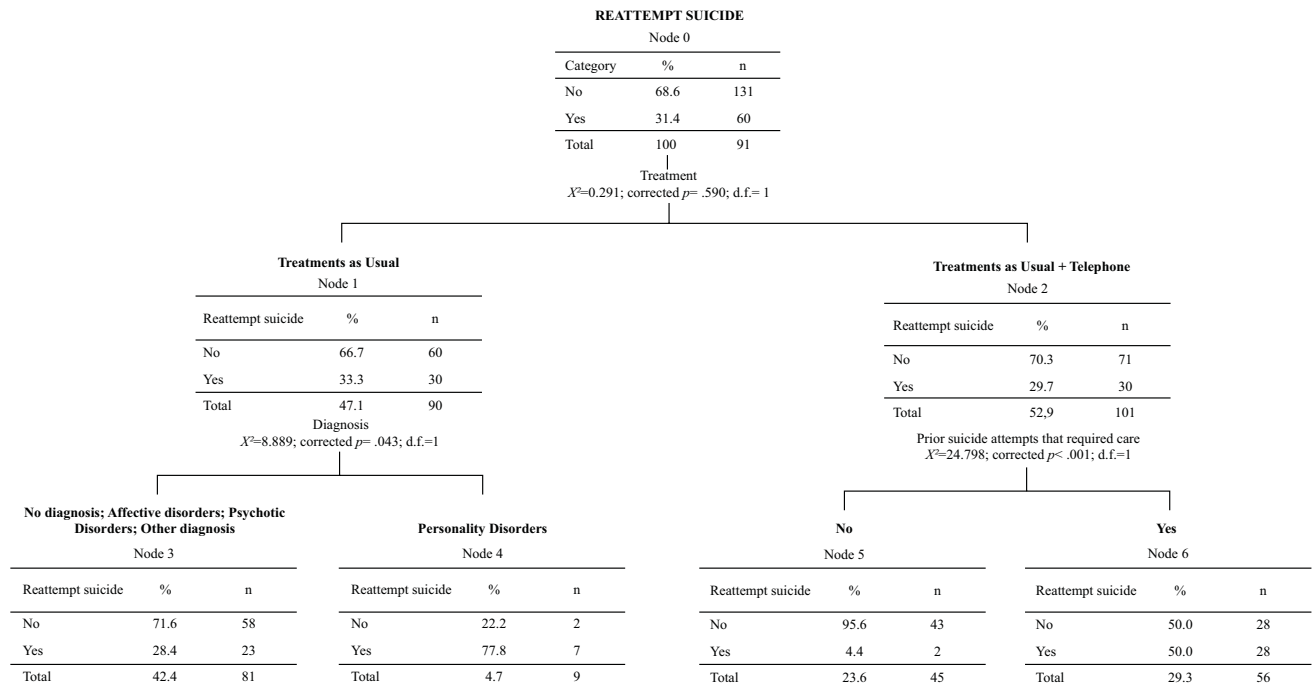


Figure 1. Multivariate Comparison Between Individuals at Each Hospital Who Reattempted Suicide and Those Who Did not Reattempt Suicide.

At TAU + T, the main variable in the differentiation between those who did or did not carry out a SA during follow-up was inclusion in the study with a previous attempt. Fifty percent ($n = 28$) of those who had a previous SA made a repeated attempt, compared to 4.4% ($n = 2$) of those whose first SA led to their inclusion in the study.

Discussion

In this study, conducted in two hospitals in two different communities with people admitted to psychiatric units for SAs, it was found that almost one-third of the people made at least one reattempt in the year following admission. In addition, almost another third was readmitted to the same psychiatric unit. The main contribution of this study is that at the hospital in which a brief contact telephone follow-up programme is offered at discharge, those who were admitted for their first attempted suicide had a lower reattempt rate during follow-up. The protective effect of this type of programme has already been verified when people are monitored from the first month of hospital discharge, with four-fold reduction in the recurrence of suicidal behaviour (Plancke et al., 2020). This result may be related to a more serious patient profile because the same effect has not yet been reported for other types of people who are treated through emergency services for SAs, probably given their heterogeneity (Milner et al., 2015). At this hospital, those who were admitted but already had previous attempts, although they participate in the telephone-follow-up programme, repeat suicidal behaviour. These data indicate that a previous attempt predisposes people to repetition, as other studies have already shown, and therefore, it is a risk factor that must always be taken into account (Goñi-Sarriés et al., 2018; Hayashi et al., 2012; López-Goñi et al., 2020; Suarez-Pinilla et al., 2020).

The results from this study show a recurrence of suicidal behaviour of 31.4% at one year of follow-up, without differences between the two hospitals, consistent with previous results (Chung et al., 2017; Hawton et al., 2015; Hayashi et al., 2012). It has been suggested that the risk of suicide or reattempted suicide in the first weeks and in the first year after discharge from a psychiatric hospitalization can be explained as the hospitalization being a sort of “time out” from problems and the return home being an exacerbation of previous stressors or new stressors caused by hospitalization (Owen-Smith et al., 2014). In any case, these data highlight the importance of continuing to offer therapeutic alternatives that improve coping strategies for stressors. Another explanation given is that after hospital discharge, the chain of care can be broken if the transition from hospitalization to other services is not taken care of. For this reason, motivational work with the people during hospitalization is necessary to ensure therapeutic continuity after discharge as well as careful coordination with the service to which they will be referred. It has also been pointed out that the impact of psychological treatments carried out in hospitalization units needs to be studied in greater depth (Fedyszyn et al., 2016). In any case, the recurrence of suicidal behavior highlights the importance of continuing to investigate therapeutic alternatives that improve the chain of care for people with IS.

In general, the two populations that are compared in this study seem similar, but the detailed analysis shows differentiated profiles. Affective disorders were the most prevalent diagnoses among the individuals admitted to both hospitals, as has already been described (Qin & Nordentoft, 2005). However, at TAU + T, people diagnosed with psychosis did not make reattempts, in comparison with TAU, where some were admitted for SA during follow-up. In addition, personality disorders were much more present at TAU + T and associated with high recurrence rates

at both hospitals. The main risk factors for being admitted for suicidal behaviour were being male, having previous attempts, a clinical diagnosis of affective disorder, personality disorder or psychosis, a previous psychiatric admission, using a method other than overdosing and living alone (Jiménez-Treviño et al., 2015; Miret et al., 2011). These differences in clinical profiles may be due not so much to different criteria for hospitalization but to the difference in mental health resources in the two communities. Compared with that for the community served by TAU, the public network of outpatient and hospital services for the community served by TAU + T is well equipped for the care of severe mental disorders, and this could partly explain these results (Rueda, 2012).

Sixty to seventy percent of individuals with personality disorders self-harm and make SAs, with a suicide rate of 10% (Soloff & Chiappetta, 2017), indicating that this issue requires urgent attention. In this study, a high recurrence of suicidal behaviour during the one-year follow-up was evident, calling into question whether the admission of these people to the psychiatry unit was based more on a lack of appropriate resources than the best clinical evidence (Vera-Varela et al., 2019). However, if there is an indication for admission, it is beneficial when hospitalization is brief and is accompanied by crisis intervention until clinical stabilization is achieved. In addition, hospitalization must be integrated with therapeutic targets of a treatment plan and agreed upon by the person (Liljedahl et al., 2017).

This study has a number of limitations that may affect the generalization of the results. First, the two hospitals, in different cities, that participated potentially used different clinical protocols and even different hospitalization criteria. Despite this, both populations shared similar sociodemographic characteristics. Second, some eligible people may have been admitted to other wards, such as the intensive care unit, traumatology or internal medicine, and may not have been included. Third, the data collected during follow-up were obtained from the electronic health records of both autonomous communities, with different levels of development. Importantly, information was not available for cases where care had previously been received. Despite the limitations mentioned, the strengths of this work include the use of natural samples analysed in the same period of time and in different communities. The population under study was homogeneous with respect to people admitted to the hospital for attempted suicide who received different interventions; therefore, the study has great ecological validity.

In summary, this study found a high recurrence of suicidal behaviour upon discharge from a psychiatric unit for a SA as well as new readmissions during the year of follow-up. Therefore, the clinical implication is the need to improve the chain of care by offering different therapeutic offers adjusted to the risk and contextual profile of the person (Al-Halabi & Fonseca-Pedrero, 2021). In addition, first-time attempters seem to benefit from brief contact interventions such as, in this case, a telephone follow-up programme. However, those who have already made previous attempts seem to need other types of treatment, more continuous over time (Al-Halabi & García-Haro, 2021). There is a need for further evidence on the treatments offered.

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