

Review

Communication-based suicide prevention after the first attempt: A systematic review

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ABSTRACT

Previous suicide attempts are the strongest risk factor for a new suicide attempt, suicide death, the development of recurrent suicide behavior and even the development of suicidal ideation in the general population. Primary prevention aims to reduce new suicide attempts in the general population, while secondary prevention tries to reduce the chance of suicide attempts in patients with high risk. Tertiary interventions are targeted at individuals who have already made one or more suicide attempts and aim to prevent second or repetitive attempts and to suppress suicidal behavior. Communication with patients and family is a very effective way of preventing a second suicide attempt. The aim of this paper is to present an overview of tertiary suicide prevention interventions focusing on communication with the patient and their family and study their effectiveness. This systematic review was based on the PRISMA checklist and was conducted using the databases Pubmed, Scopus and Google Scholar for articles published between 2000 and 2020 focusing on communication with family and patient. All studies concerning at least one previous suicide attempt were included. The interventions described in the studies concerned: (1) face-to-face and telephone contacts, (2) communication with greeting cards and letters, (3) telephone contact with the patient and record keeping to facilitate the implementation of the action plan, (4) telephone contacts only, and (5) technology-based communication. Our investigation brought up 9 studies on interventions focusing on communication with the patient and their family. Family and patient communication interventions, with a particular emphasis on telephone and written communication, have shown a good level of effectiveness in the prevention of a new suicide attempt, especially if the intervention has been completed according to the schedule and the patient has not abandoned the treatment early. The generalization of the results is limited due to the inclusion of other types of studies jointly with randomized controlled trials and the variability among the samples of the studies. In conclusion, family and patient communication interventions have shown a positive effect on preventing a second suicide attempt. More studies are needed to investigate the effectiveness of different prevention approaches at hand and clarify in which patient populations each intervention could be more effective.

KEYWORDS: Second suicide attempt, prevention, interventions, family, communication.

Introduction

Suicidal behavior includes suicidal ideation (frequent thoughts of ending one's life), suicide attempt (the actual event where the person attempts to end their life) and complete suicide (the suicide attempt that results in death).¹ It is estimated that more than 700,000 people die each year by suicide, with 79% of the cas-

es being recorded in low- and middle-income countries.² Suicide is also the second most common cause of death among people aged 15–29³ and the 20th most common cause of death in the general population.⁴ In 2016, suicide was found to be the second or third most common cause of death among 15–19-year-olds, with regarding both girls and boys.⁵

Previous suicide attempts are the strongest risk factor for a new suicide attempt, suicide death, the development of recurrent suicide behavior and the development of suicidal ideation in the general population.³⁻⁶ Suicide prevention can be primary, secondary or tertiary. Primary prevention aims to reduce the number of the new cases of suicide, while secondary prevention aims to reduce the likelihood of a suicide attempt in patients at high risk.⁶ Tertiary prevention is targeted at individuals who have already made one or more suicide attempts.^{7,8}

The way mental health professionals communicate with patients, family and caregivers has been shown to have a profound impact on the way prevention is implemented. Hegerl et al found that a one-year telephone intervention program was effective in reducing the proportion of patients who attempted a new suicide attempt by 8%.⁹ In this study, about 50% of the people who attempted suicide and 90% of those who died by suicide did not complete the process of telephone monitoring from start to finish. Those who completed the telephone attendance were less likely to die from suicide. Communication with the family can concomitantly encourage hope and optimism – by boosting compliance with the intervention implemented, or instead can be perceived as promoting the stigma of the patient and his family.^{10,11} For example, the use of many clinical terms can be confusing – as they can be misinterpreted, thus impeding the development of a positive relationship.¹² The use of ‘labels’ on the person who attempted suicide (e.g., mentally ill) can also enhance stigmatization. By providing better family education programs, the effectiveness of tertiary prevention interventions can be ensured when based on respect and communication between the family and the health professionals.¹³

The importance of communicating with the patient is also confirmed in a study by Vandewalle et al.¹⁴ They evaluated communication with nurses in the case of suicidal ideation and showed that the patients found four important factors in the contact with nurses: (1) encountering a space to express suicidal thoughts and explore needs, (2) being recognized as a unique individual, (3) experiencing the nurses’ availability, information-sharing practice and transparency of their expectations, and finally (4) trusting nurses with communicating issues and thoughts on suicidality.

The aim of the present work is to provide a systematic overview of the suicide prevention strategies after the first attempt, with emphasis on family and patient communication.

Material and Method

The review was conducted in accordance to the preferred reporting items for systematic reviews and meta-analysis (PRISMA) statement.¹⁵ This review includes articles referring to patients (female or male) with a history of at least one previous suicide attempt, published from 2000 to 2020 in English. There are neither age restrictions in this review nor other demographic constraints. Studies regarding interventions on patients with no history of previous suicide attempt were excluded from the review. Also, studies including interventions about the physical treatment of the patients as a result of suicide attempt were also ruled out.

The PubMed, Scopus and Google Scholar databases were searched to retrieve evidence, from 23 November 2018 to 23 December 2018 and an additional search was performed from 18 September of 2020 to 23 September 2020 with the following keywords: (suicid* OR deliberate self-harm* OR self- injur* OR suicidal behavior*) AND (re-attempt* OR multiple OR second OR repeat* OR recurren*) AND (patient OR family) AND (communication). In addition, forward citation and reverse citation tracking were conducted with regard to the articles. Throughout the process of the identification of articles on family and patient communication, the original search yielded 159 articles from the PubMed and Scopus databases, and 119 from Google Scholar. The duplicates were removed and eventually the remaining 95 papers published in scientific journals and conferences were selected. Subsequently, the title and abstract were checked for each one of the studies and the studies that did not meet the inclusion criteria were excluded. After examining the resulting work, 9 studies made it through the selection process. The flowchart of the search results and the final selection is shown in figure 1.

Results

The search led to a total of 9 studies of suicide prevention interventions after the first attempt based on communication with family and patient. The classification of the studies based on their methodological framework showed that they encompass: (1) 4 randomized controlled trials, (2) 2 systematic reviews, (3) 1 semi-experimental study, (4) 1 literature review, (5) 1 cross-sectional survey.

The interventions described in the studies included: (1) face-to-face and telephone contacts, (2) communication with cards and letters, (3) telephone contact with the patient and log keeping to facilitate the implementation of the action plan, (4) telephone contacts only, and (5) technology-based communication.

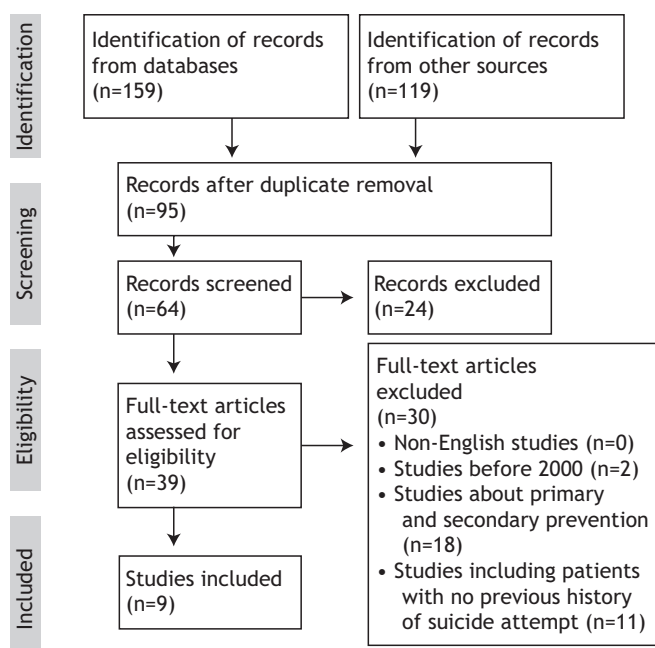


Figure 1. Flowchart of the selection of studies concerning communication-based interventions .

The findings of the four randomized controlled trials included in the systematic review are summarized in table 1.

Randomized control trials

Fleischmann et al investigated whether a telephone-based intervention in combination with face-to-face contact with patients who attempted suicide, was effective at reducing the subsequent suicide mortality in a total of 1,867 individuals who were admitted to emergency units due to suicide attempt.¹⁶ The intervention group (922 patients with mean age 23 years) received the intervention mentioned above, while the control group (945 patients with mean age 23 years) received usual care. The main outcome measured was death by suicide during an 18-month period. The results showed significantly fewer suicide deaths in the intervention group than in the control group (0.2% vs 2.2%) ($p < 0.001$), suggesting that this brief low-cost intervention may be a significant part of suicide prevention programs and may be applicable to patients in low- and middle-income countries because of its low cost.

In the second randomized controlled trial, Gysin-Maillart et al investigated the effectiveness of an intervention program on the basis of maintaining patient communication with cards and letters.¹⁷ Patients who had been admitted to emergency departments in

health units were randomized into two groups (n=60 in each group), one of which received intervention whereas the other group received usual care. In the intervention group, patients (mean age 37.8) received three treatment sessions followed by regular contact with personalized letters for 24 months. The participants completed a set of psychosocial and clinical questionnaires every 6 months for a 24-month follow-up period. The primary variable that was measured was new suicide attempts during the 24-month follow-up period. During that period, five patients made suicide attempts anew in the intervention group, while in the control group (mean age 39.2) the corresponding number was 41 (8.3% vs 26.7%) ($p < 0.001$). Intervention was associated with an 80% reduced risk of a new suicide attempt ($p < 0.001$), indicating that it may be effective as a means of preventing a second suicide attempt in people with a previous history.

In the third randomized controlled trial, King et al studied the effectiveness of a Teen Prevention Program (Teen Options for Change).¹⁸ The study involved 49 adolescents (aged 14 to 19 years) who were assigned to two groups. One group received the prevention program (27 adolescents) and the control group received routine care (22 adolescents). Adolescents in the control group received a crisis management leaflet with emergency phone numbers which also contained written information on depression, suicide risk, fire protection and local mental health services. The adolescents in the intervention group received the same material, as well as personalized feedback on their exam responses, while they also participated in a customized motivation interview (approximately 35–45 minutes) with mental health professionals with a total duration of 40 hours. Depression (RADS-2: SF scale) and suicidal ideation (SIQ-JR scale) were assessed at the baseline and two months later. Adolescents in the intervention group showed greater decreases in depression rates than adolescents in the control group. Results showed a statistically significant decrease in depression rates ($p < 0.01$) in the intervention group, but no significant effects were found for suicidal ideation. Although the intervention group scored better on the suicidal ideation scale, the differences with the control group were not statistically significant.

Finally, in the fourth randomized controlled trial, Miller et al examined the effectiveness of a telephone contact intervention in suppressing suicidal behavior.¹⁹ The study involved 1,376 adults at the age of 26–47 who had a recent suicide attempt. Participants displaying suicidal ideation or having made a recent attempt were recruited from 8 Emergency Departments (ED) across 7 states in the United States, ranging from

Table 1. Summary of randomized controlled trials of suicide prevention interventions after first attempt and communication with family and patient.

Study year	Country	Sample (I,C)	Age (years)	Gender (Male, Female)	Duration	Intervention (Intervention group: patients or family)	Primary outcome measures	Results	Long term monitoring
Fleischmann et al. (2008)	Brazil, India, Sri Lanka, Islamic Republic of Iran, China	1867 (922, 945)	Mean age: 23	M:43.4% F:56.6%	18 months	Phone contacts combined with face to face contacts (Patients)	Suicide attempts (self-reported)	Intervention group had fewer suicides than control group (0.2% vs. 2.2%) (p <0.001)	–
Gysin-Maillart et al. (2015)	Switzerland	120 (60, 60)	Mean age: 37.8 (SD:14.4)	M:50% F:50%	24 months	Communication with cards and letters (Patients)	Suicide attempts (self-reported)	The intervention group reported less suicide attempts than the control group (8.3% vs. 26.7%) (p <0.001)	–
King et al. (2015)	United States	49 (27,22)	14–19	M:51% F:49%	2 months	Motivational Interview with Mental Health Professionals (Patients)	Suicide ideation (SIQ-JR) Depression (RADS-2:SF)	No statistically significant differences were found between the two groups in suicidal ideation Lower levels of depression were found in the intervention group compared to the control group (p <0.01)	–
Miller et al. (2017)	United States	1376 (497, 377, 502)	26–47	M:44.1% F:55.9%	12 months	Only phone contacts (Patients)	Suicide attempts (self-reported)	The intervention group reported less suicide attempts than the control group (18.3% versus 22.9% respectively) (p <0.001)	–

I: Intervention Group; C: Control Group

small community hospitals to large academic centers. To increase generalization, no participating ED had any psychiatric services located within or adjacent to the ED. Patients were divided into three groups. The first group (497 patients) received usual care, the second group (377 patients) received a suicide risk assessment screening and the third group (502 patients) also received the screening intervention in addition to the intervention program with telephone contacts. The primary measure was new suicide attempts. A total of 288 participants (20.9%) had at least 1 suicide attempt, and a total of 548 suicide attempts were recorded among participants. There were no significant differences in the rates of new suicide attempts between the first two groups (23% in the usual treatment group versus 22% in the preventive control group). However, there were statistically significant differences in suicide rates between the first group and the intervention group (23% and 18% respectively), with a relative risk reduction of 20%. Participants in the intervention group scored 30% less overall suicide attempts than participants in the first group ($p < 0.001$).

Evidence on telephone and web-based interventions

The rest of the relevant research explores interventions based on online communication and other technologies. The emergence of information and communication technologies in recent years has offered a new dimension to human communication and, in this context, has also been tested in the field of suicide prevention.

Franco-Martin et al conducted a systematic review of research papers published in the years 2007–2017 in order to categorize the types of applications in existence for suicide prevention in this field.²⁰ A total of 30 studies were identified. Among the applications included, one can find web technologies (51.61%), mobile applications (22.58%), social networks (12.90%), learning applications (3.23%) and others technologies (9.68%).

In their systematic review, Kreuze et al explored how technology-based interventions can reduce the risk of suicide and protect the users.²¹ The search yielded 16 studies that used state-of-the-art interventions to address the determinants of suicidal behavior. Interventions were provided through mobile applications (text messages), computer and the internet, as well as CD-ROM and video material. Studies on the effectiveness of these interventions have shown significant variability, but there have been several web-based technology applications that have shown statistically

significant efficacy in reducing suicidal ideation and depressive symptoms. The effect of the studies under examination, as assessed by the Cohen coefficient, was moderate to high.

In addition, in a literature review, Khan and Costanza discussed how health-care mobile applications can be used by staff in emergency departments of health units as complementary tools to the existing suicide prevention strategies.²² The researchers claimed that these applications can be considered as a part of prevention strategies in order to maintain patient communication, as they offer personalized planning and support for home security planning interventions, in addition to being designed to identify and manage the risk factors of suicide.

Other studies

In a semi-experimental study, Larsen et al described the process they followed to create an electronic application that can be used in suicide prevention intervention programs for the communication between healthcare providers and their patients (aged from 18 to 65), who have attempted suicide.²³ The application that was created included brief messages sent to the patient, which also contained additional web-based therapeutic content, being targeted at key suicide risk factors. The researchers claimed that the designed application has the potential to reduce the number of recurrent suicide episodes and provide affordable and cost-effective support to people who cannot seek face-to-face treatment.

Finally, Leung et al studied the satisfaction of primary care clinical leaders with embedded mental health providers for a range of conditions, including suicide risk, and examined the association between overall satisfaction and technology.²⁴ The results showed that the use of technology was positively associated with satisfaction due to a decrease in the suicide risk that was identified ($p = 0.002$).

Discussion

The studies under consideration in the present work probe into providing information and counseling to people with suicidal ideation and with a history of attempted suicide, helping them to identify problems and factors related to their behavior, motivating them to participate in security planning and instigating them to seek help. However, among the studies exploring this issue, despite their common focus, one can find significant variations in the type of intervention and in the evaluation of the resulting variables measured. That makes the comparison difficult. Also, more

comparative studies are needed to determine what the optimal frequency of communication with the patient may be.

Prevention strategies based on new technologies have begun to gain ground in recent years, yet research is very limited in this area. It is quite important that such a strategy can be affordable. Therefore, more research is needed to prove their effectiveness and also research that will analyze the cost-effectiveness of their use in clinical practice and in reducing suicidal ideation. The utility of technology in suicide prevention is also facing an important challenge; to educate both health professionals (psychiatrists, therapists and nurses) and patients and their families in the use of these applications in order to gain the expected benefit for the patient.

We have to take in mind that every person who has made a suicide attempt is usually admitted to emergency departments, where they receive psychiatric and/or suicide risk assessment along with routine care. Therefore, the results of our research can be applied in mental health services regarding the evaluation and referral of patients with suicidal behaviors. It appears to be of great importance for mental health professionals to be trained to recognize the suitable intervention for each patient.

Limitations

An important limitation in this review was the methodological framework of the included studies. Although the majority of studies were randomized controlled trials, studies that followed other methodological frameworks, such as semi-experimental studies, systematic reviews, meta-analyses, and a literature re-

view were also included. Including these studies in our review was considered necessary because there were cases where randomization into two or more groups was not feasible (e.g., interventions given in the emergency departments). These studies were also included because they allowed us to report suicide prevention strategies after the first attempt, which were not identified in other articles, thus providing a more complete picture of the subject. Another limitation of the present research is the group of patients that were investigated in each study. There were no restrictions on the demographics of the patients who received the intervention. Therefore, the studies include a wide range of patients, such as adolescents as well as older patients. Consequently, the results cannot be generalized to the general population facing a high risk of a new suicide attempt. Additionally, there was no limitation in terms of comorbidity in the studies included in this review. Therefore, it is necessary for future research to investigate separately the interventions delivered to different patient groups, in order to clear out which intervention is more effective in each patient group.

Conclusion

Since suicide-induced death is a major public health problem, this systematic review investigates the impact of suicide prevention interventions after the first attempt based on the communication between patient and therapist. More studies are needed to investigate the efficacy of different treatment approaches, their appropriate characteristics (intensity, duration, etc.) and the patient groups in which the former can be most effective. In light of this, the findings may be important in future clinical policy-making to prevent recurrent suicidal behavior.

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Ανασκόπηση

Παρεμβάσεις πρόληψης αυτοκτονίας μετά την πρώτη απόπειρα, σχετιζόμενες με επικοινωνία με την οικογένεια και τον ασθενή: Μια συστηματική ανασκόπηση

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ΠΕΡΙΛΗΨΗ

Οι προηγούμενες απόπειρες αυτοκτονίας είναι ο ισχυρότερος παράγοντας κινδύνου για μια νέα απόπειρα αυτοκτονίας, θάνατο από αυτοκτονία, ανάπτυξη επαναλαμβανόμενης συμπεριφοράς αυτοκτονίας και ανάπτυξη αυτοκτονικού ιδεασμού στον γενικό πληθυσμό. Η πρωτογενής πρόληψη στοχεύει στη μείωση νέων προσπαθειών αυτοκτονίας στον γενικό πληθυσμό, ενώ η δευτερογενής πρόληψη προσπαθεί να μειώσει την πιθανότητα απόπειρας αυτοκτονίας σε ασθενείς με υψηλό κίνδυνο. Τριτοβάθμιες παρεμβάσεις είναι εκείνες που στοχεύουν άτομα που έχουν ήδη μία ή περισσότερες απόπειρες αυτοκτονίας και στοχεύουν στην αποτροπή δεύτερων ή επαναλαμβανόμενων προσπαθειών και στην καταστολή της αυτοκτονικής συμπεριφοράς. Η επικοινωνία με τους ασθενείς και την οικογένεια είναι ένας πολύ αποτελεσματικός τρόπος πρόληψης μιας δεύτερης απόπειρας αυτοκτονίας. Ο σκοπός αυτής της ανασκόπησης είναι να παρουσιάσει τις τριτοβάθμιες παρεμβάσεις πρόληψης αυτοκτονίας και να μελετήσει την αποτελεσματικότητά τους, εστιάζοντας στην επικοινωνία με τους ασθενείς και τις οικογένειες των ασθενών. Για τη συστηματική ανασκόπηση, η οποία βασίστηκε στη λίστα ελέγχου PRISMA, έγινε αναζήτηση μελετών στις βάσεις δεδομένων Pubmed, Scopus και Google Scholar, για άρθρα που δημοσιεύθηκαν την περίοδο 2000–2020. Η αναζήτηση έγινε σχετικά με την επικοινωνία με οικογένεια και ασθενή. Συμπεριλήφθηκαν όλες οι μελέτες που αφορούσαν παρεμβάσεις σε άτομα που είχαν ιστορικό τουλάχιστον μίας προηγούμενης απόπειρας αυτοκτονίας. Οι παρεμβάσεις που περιγράφονται στις σχετικές μελέτες αφορούν: (1) πρόσωπο με πρόσωπο επικοινωνία και τηλεφωνικές επαφές, (2) επικοινωνία με κάρτες και γράμματα, (3) τηλεφωνική επαφή με τον ασθενή και τήρηση αρχείων για τη διευκόλυνση της εφαρμογής του σχεδίου δράσης, (4) τηλεφωνικές επαφές μόνο, (5) επικοινωνία με βάση την τεχνολογία. Η αναζήτηση επέφερε συνολικά 9 έρευνες που αφορούσαν παρεμβάσεις με έμφαση στην επικοινωνία με την οικογένεια και τον ασθενή. Οι παρεμβάσεις διατήρησης της επικοινωνίας με την οικογένεια και τον ασθενή μέσω τηλεφωνικής επικοινωνίας και επικοινωνίας με κάρτες έδειξαν ένα καλό επίπεδο αποτελεσματικότητας στην πρόληψη μιας νέας απόπειρας αυτοκτονίας, ειδικά εάν η παρέμβαση έχει ολοκληρωθεί σύμφωνα με το πρόγραμμα και ο ασθενής δεν εγκατέλειψε τη θεραπεία νωρίς. Η γενίκευση των αποτελεσμάτων περιορίζεται από τη συμπερίληψη όχι αποκλειστικά τυχαιοποιημένων ελεγχόμενων δοκιμών και από τη μεταβλητότητα μεταξύ των δειγμάτων των ερευνών. Συμπερασματικά, οι παρεμβάσεις επικοινωνίας με την οικογένεια και τον ασθενή, έδειξαν θετικό αποτέλεσμα στην πρόληψη μιας δεύτερης απόπειρας αυτοκτονίας. Απαιτούνται περισσότερες μελέτες διερεύνησης της αποτελεσματικότητας των διαφορετικών θεραπευτικών προσεγγίσεων και των πληθυσμών των ασθενών στους οποίους κάθε παρέμβαση θα μπορούσε να είναι περισσότερο αποτελεσματική.

ΛΕΞΕΙΣ ΕΥΡΕΤΗΡΙΟΥ: Δεύτερη απόπειρα αυτοκτονίας, πρόληψη, παρεμβάσεις, οικογένεια, επικοινωνία.