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Evaluation of an Intensive Suicide-Attempt-Prevention Programme based on Problem-Solving Therapy in a Catchment Area of 430,000 people in Madrid, Spain

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ABSTRACT

Background. Suicide prevention is a primary goal of mental health care, and a past history of suicide attempts is considered a high-risk factor for subsequent attempts. This study aims to evaluate the effectiveness of an intensive suicide-reattempt-prevention program (ISRPP) in a health catchment area of 430.000 inhabitants.

Methods. A 12-month follow-up study was conducted with all individuals who, between 1 January 2013 and 31 December 2015, had attempted suicide and sought mental health care in the area. Out of a total of 871 patients treated, 292 received treatment as part of ISRPP using short-term problem-solving therapy and a case management approach. Results were compared to those of 357 patients who received treatment as usual (TAU).

Results. Attempted suicide was repeated by 9,0% in the ISRPP group, compared to 23,3% in the TAU (Fisher's exact test $p<0,001$). The number needed to treat (NNT) was=7; 95% CI 95% (5-11). A multivariate Cox regression analysis showed that the TAU group had a hazard ratio (HR)=2,68; 95% CI (1,65-4,35) compared to the ISRPP group. The advantage of ISRPP was maintained when controlling for the non-homogeneous characteristics of the groups.

Conclusions. Applied after a suicide attempt, an intensive prevention programme based on brief cognitive be-

havioural therapy (CBT) and case management reduces and delays repeat suicide attempts at one-year follow-up. The clinical effort is remarkable (NNT=7).

Keywords (MEDLINE, MeSH). *Suicide attempt, recurrent, prevention, program*

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Evaluación de un Programa Intensivo de Prevención de Reintento de Suicidio (PIPRS) en un Área de Salud de 430.000 personas

RESUMEN

Introducción. La prevención del suicidio es objetivo prioritario en salud mental. Tener un antecedente de intento de suicidio se considera factor de alto riesgo para la repetición. Este estudio persigue evaluar la efectividad de un programa de prevención de reintentos de suicidio en un área sanitaria de 430.000 habitantes.

Metodología. Se realizó un estudio de seguimiento de 12 meses con todas (871) las personas que entre el 1 de enero de 2013 y el 31 de diciembre de 2015 habían realizado intentos de suicidio y solicitaron atención en salud mental del área. De estas, 292 recibieron tratamiento en un Programa Intensivo de Prevención de Reintentos de Suicidio (PIPRS) mediante terapia breve de solución de problemas y enfoque de gestión de caso y se compararon con 357 pacientes que recibieron tratamiento convencional (*Treatment as usual*, TAU).

Resultados. Repitieron intento de suicidio el 9,0% en el PIPRS frente al 23,3% del TAU (*Prueba exacta de Fisher*

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$p < 0,001$) y un NNT=7, IC 95% (5-11). El análisis multivariante de Regresión de Cox mostró que el grupo que recibió TAU tenía una HR= 2,68, IC 95% (1,65-4,35) respecto al grupo PIPRS. La ventaja del PIPRS se mantuvo al controlar por las características no homogéneas de los grupos.

Conclusiones. La aplicación de un programa de prevención mediante psicoterapia breve y enfoque de gestión de caso, tras un intento de suicidio, reduce y retrasa en el tiempo la repetición de intentos durante el año siguiente. Destaca un esfuerzo clínico (NNT=7) muy rentable.

Palabras clave (MEDLINE, MeSH). *Intento de suicidio, repetición, prevención, programa*

INTRODUCTION

In recent decades, an increase in suicide attempts has been observed in countries with a high socioeconomic level¹⁻⁴. In view of this situation, the European Commission has prioritised suicide prevention in health policies⁵. The factors that explain suicidal behaviour are complex and diverse⁶, meaning that prevention strategies must be multiple and targeted at different levels^{7, 8}. Mental-health services tend to focus preventive interventions on high-risk individuals⁹, especially those who have made a previous attempt, as they are considered to be at the highest risk for a repeat attempt¹⁰ and for suicide¹¹⁻¹⁴.

Prevention programmes indicated for suicidal behaviour are diverse^{15, 16}, and a range of therapeutic interventions have been shown to decrease the recurrence of suicide attempts in clinical studies¹⁷⁻¹⁹. However, systematic reviews and meta-analyses cast doubt on this assumption^{20, 21} and question the effectiveness for such interventions²². However, these systematic reviews and meta-analyses draw on data from randomised clinical trials and not real-life care programmes. They therefore have the limitations of being carried out on special populations in specific settings²³ and are also inconclusive as to the effectiveness of the treatments.

In the field of suicidal behaviour, the study by Hampton in an area of 200,000 people with various non-specific measures for the prevention of suicidal behaviour²⁴ marked a milestone in the field. There are few studies on the implementation of specific treatments for the prevention of suicidal behaviour involving an entire health catchment area. In our setting, one study on intensive telephone follow-up was conducted in 514 patients from an area of 400,000 inhabitants²⁵. Three other studies analysed catchment areas of fewer than 250,000 inhabitants, and their sample sizes were smaller, with 191 patients²⁶, 163 patients²⁷, and 347 patients²⁸. In one of the studies, suicidal ideation was included

in the study, which encompasses a broader phenotype²⁸. A search of literature from our setting found no studies of a therapeutic intervention programme for the prevention of suicidal behaviour in an area of more than 400,000 inhabitants with systematic follow-up of all individuals who have attempted suicide and sought care.

This study aims to evaluate an intensive suicide-attempt-prevention programme (ISRPP) using brief problem-solving therapy in conjunction with a case-management approach. The programme is aimed at individuals who, after a suicide attempt, sought care from the Area de Gestión Clínica de Psiquiatría y Salud Mental (AGCPSM) of the Hospital Universitario 12 de Octubre (HU12O), in Madrid, Spain.

MATERIAL AND METHODS

Research design

We included all persons residing in the catchment area assigned to the HU12O (total population of 431,325 inhabitants²⁹) who, between 1 January 2013 and 31 December 2015, had requested clinical care for a suicide attempt.

The criteria for assignment to the ISRPP established by the AGCPSM care protocol were as follows: individuals with a recent suicide attempt for which they requested care, residents of the catchment area, and absence of follow-up from mental-health services over the previous year. Those who were already receiving care at the time they presented for further medical attention were referred to the corresponding facilities to continue treatment with the same health professionals so as not to alter the therapeutic relationship; for the purposes of this study, the latter patients were included in the Treatment as Usual (TAU) group.

A 1-year follow-up was carried out to assess patient evolution after the suicide attempt³⁰. Outcome variables were defined as repeat attempts, time elapsed since last attempt, and retention in care programmes (ISRPP and TAU). Data were drawn from electronic medical records, including telephone monitoring at 6 and 12 months by members of the programme team, visits to the psychiatric emergency department, and visits to other health services.

Resources and tools used

The ISRPP was designed to provide flexible service tailored to the circumstances of each individual as articulated in a case-management system³¹. The programme begins with initial care in the emergency department (ED), where the crisis situation is addressed³². The assessment made in the

ED, which was independent of the research team, was the source of clinical-pathological, sociodemographic, psychosocial characteristics of the patient, the severity of somatic damage, and those concurrent with the suicide attempt that leads to inclusion in the study.

After discharge from the emergency department, early contact is made to provide face-to-face care within a maximum of one week³³. At the initial programme visit, a psychiatric assessment is performed to address the mental health disorder³⁴, if any. This assessment was not included in the data-collection protocol for this research. Initial psychiatric assessment is followed by a brief cognitive behavioural therapy (CBT) intervention using the problem-solving technique³⁵. Throughout the process of inclusion in the programme and follow-up, a psychiatric specialist nurse ensures the case-management approach. This is carried out through pre-scheduled face-to-face consultations and telephone follow-up³³.

The brief cognitive behavioural therapy programme is structured in eight weekly sessions³⁶. In the first session, a psychological assessment is carried out and the suitability of the therapy for the person is analysed, making any necessary adaptations³⁷; also during this session, the intervention is explained and planned. A plan for critical situations¹⁹ is also established. In the second session, different ways of coping with suicidal behaviour are discussed, including strategies for management of suicidal thoughts¹⁹. In the third session, the problem-solving intervention is initiated based on the original technique³⁸, and the underlying problem is investigated and defined. In this session, the achievable goals of the therapy are also established and different solutions to the problem are generated³⁹. In the fourth session, the preferred solution is selected, and the terms and scope of implementation are established, and implementation is encouraged. In the fifth and sixth sessions, use of the problem-solving strategies by the patient is reviewed, the difficulties encountered are analysed, and solutions are sought. The seventh session focuses on aspects of relapse prevention¹⁹. In the eighth and final session, an evaluation is made of the strategies implemented, their effectiveness, and any necessary modifications are determined.

Care for patients in the TAU group was provided in accordance with the usual treatment in the care facilities in the area. Continuity of care was preserved, and the professionals who had previously treated the patient were maintained. Patients were seen within a maximum of 7 days after the suicide attempt, as established in the ARSUIC plan of the Madrid regional government⁴⁰. Intervention in these cases was not time-limited or limited to a specific number of sessions.

Statistical analysis

As this work assesses the implementation of a programme in real-world patients, random assignment to the ISRPP and TAU groups was not possible. For this reason, we performed a homogeneity analysis of the ISRPP and TAU groups to identify ways in which the 2 study groups differed. To address the lack of homogeneity between the ISRPP and TAU groups, multivariate techniques (logistic regression and Cox regression) were used to control for the effect of confounding variables. Analyses were stratified by sex and age to measure their influence on suicidal behaviour in terms of repetition and lethality.

Categorical variables were compared using the Chi-square test or Fisher's exact test. All odds ratios reported are based on two-tailed tests. The level of statistical significance was set at p values <0.05 .

Survival rates in the 2 groups were calculated using the Kaplan-Meier model. For the comparison of survival curves, the log rank test was used.

For the analysis of predictor variables of repeated suicide attempts, the Cox regression model was used. Multivariate analysis was performed and stratified by potential confounding variables. Associations between variables were measured by means of the hazard ratio (HR) with a confidence interval of 95% and a significance level of $p=0.10$.

SPSS software (version 24) was used for statistical calculations.

Ethical considerations

The Clinical Research and Ethics Committee of the HU120 authorised the evaluation of the prevention programme implemented in the AGCPSM for the catchment area of the HU120 under approval number 11/024. Information identifying the individuals was disaggregated in separate databases, so that they were anonymised prior to statistical processing. For the confidentiality of the data, compliance with the provisions of the Spanish Data Protection Act 15/1999 was guaranteed.

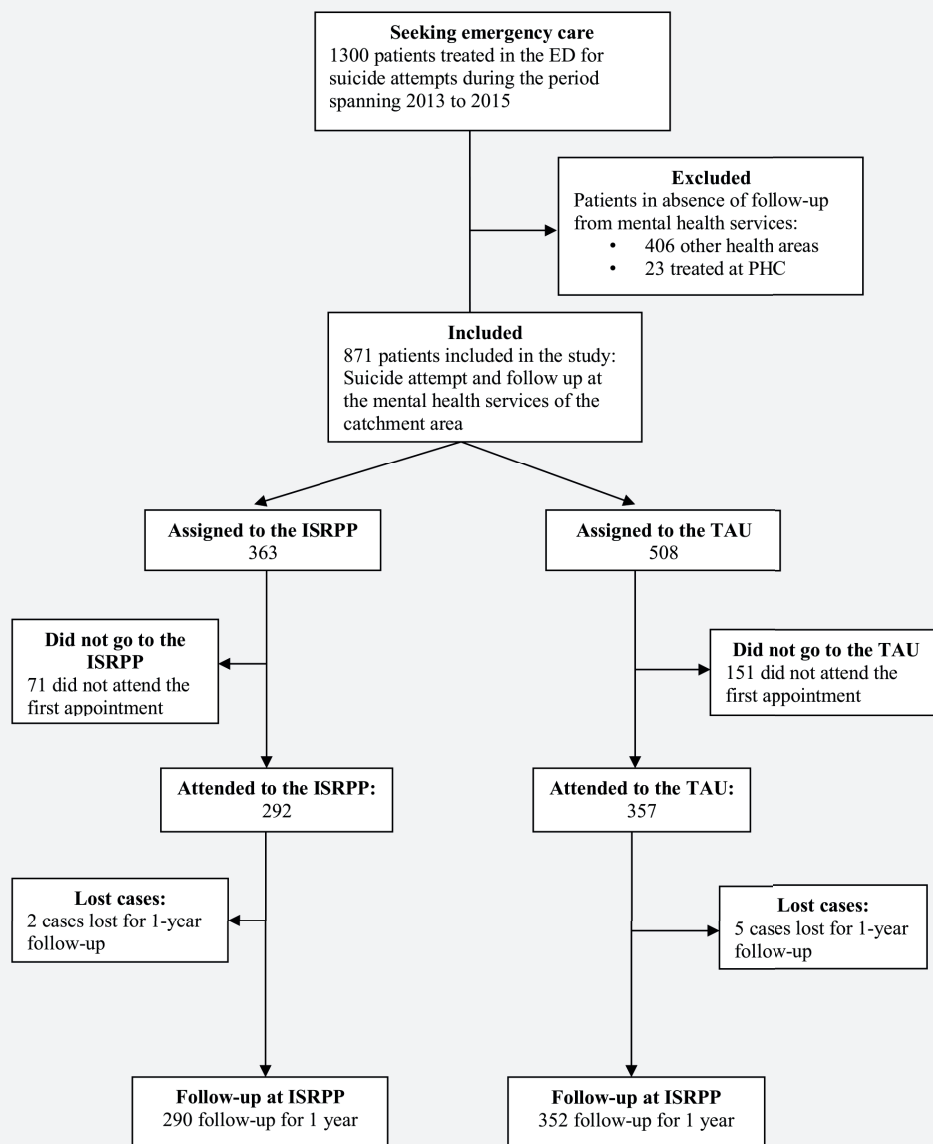
Results

During the period spanning 1 January 2013 to 31 December 2015, 1151 suicide attempts were recorded corresponding to 871 persons residing in the catchment area assigned to the HU120 in Madrid, Spain. This represents a rate of 88.95 suicide attempts per 100,000 inhabitants per year for this area.

Of the 871 patients seen, 363 were referred to the ISRPP and 508 patients underwent TAU. A total of 292 patients started treatment in the ISRPP group and 357 in the TAU. Figure 1 shows the patient flow. At 1-year follow-up of the 649 patients who were seen in the two programmes, 7 cases were lost to follow-up (2 ISRPP and 5 TAU).

Characteristics of the ISRPP and TAU groups

The two groups were homogeneous in terms of socio-demographic characteristics such as gender, whether they had a partner, and whether they had children. The two were also homogeneous in their psychosocial characteristics such as family or social support, cohabitation, level of education,



Abbreviation: ED = Emergency Department; ISRPP = Intense Suicide Reattempt Prevention Program; TAU = Treatment as Usual; PHC= Primary Health Care
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Figure 1

Flow chart of study subjects by intervention

and employment. Both groups had similar rates of family history of suicide. Regarding concurrent factors, the two groups were homogeneous in terms of suicidal ideation and criticism after the attempt. As for the characteristics of the suicide attempt, the two groups were homogeneous in terms of method of suicide, planning, likelihood of discovery, relief request following suicide attempt, and self-initiative to seek emergency care. They were also homogeneous with regard

to the severity of somatic damage caused by the suicide attempt (see Table 1).

The two groups differed in sociodemographic characteristics such as age: the ISRPP group had a higher percentage of young people (41.4%), while there were more middle-aged individuals in the TAU group (62.2%) ($\chi^2=8.17$, $df=2$, $p=0.017$) (Table 1). The ISRPP group had a larg-

Table 1 Baseline^a characteristics covariates of the total subjects and by intervention

Characteristics	Total <i>n</i> =649	ISRPP <i>n</i> =292	TAU <i>n</i> =357	Test χ^2 or Fisher ^b
<i>Sociodemographic</i>				
Female	451 (69.5)	206 (70.5)	245 (68.6)	$p=0.608$
Age (years)				
<35	235 (36.2)	121 (41.4)	114 (31.9)	$\chi^2=8,168$
35-65	371 (57.2)	149 (51.0)	222 (62.2)	$df=2$
>65	43 (6.6)	22 (7.5)	21 (5.9)	$p<0.017$
Not partner	367 (57.1)	158 (54.1)	209 (59.5)	$p=0.174$
Not children	257 (39.7)	107 (36.6)	150 (42.3)	$p=0.170$
<i>Psychosocial</i>				
Cohabitation (alone)	76 (11.8)	37 (12.8)	39 (11.0)	$p=0.540$
Immigrant	159 (25.2)	94 (33.0)	65 (18.8)	$p<0.001$
Low family or social support	104 (16.2)	54 (18.6)	50 (14.2)	$p=0.162$
Education (primary school)	262 (50.2)	133 (50.6)	129 (49,8)	$p=0.930$
Unemployed	216 (34.4)	99 (34.4)	117 (34.5)	$p=1.000$
<i>Clinical</i>				
Main diagnosis ^c at ED				
No diagnosis	28 (4.3)	18 (6.2)	10 (2.8)	
Mood (affective) disorders	274 (42.2)	143 (49.0)	131 (36.7)	
Anxiety disorders	62 (9.6)	24 (8.2)	38 (10.6)	$\chi^2=20,99$
Schizophrenia and delusional disorder	25 (3.9)	5 (1.7)	20 (5.6)	$df=6$
Alcohol or drug abuse	83 (12.8)	34 (11.6)	49 (13.7)	$p<0.002$
Behavioral disturbances	125 (19.3)	47 (16.1)	78 (21.8)	
Psychopathology not specified	52 (8.0)	21 (7.2)	31 (8.7)	
Family history of psychiatric disorders	248 (51.5)	117 (45.0)	131 (59.0)	$p=0.003$
Personal history of suicide attempts	262 (43.2)	84 (29.1)	178 (56.0)	$p<0.001$
Personal history of self-harm	117 (23.0)	36 (13.7)	81 (33.1)	$p<0.001$
Family history of suicide behavior	81 (18.9)	48 (19.4)	33 (18.2)	$p=0.435$
<i>Concurrent factors</i>				
Suicidal ideation	245 (39.1)	122 (43.3)	123 (35.7)	$p=0.058$
No criticism of attempted suicide	41 (6.4)	14 (4.8)	27 (7.7)	$p=0.146$
<i>Characteristics of the suicide attempt</i>				
Suicide planning	81 (12.7)	42 (14.6)	39 (11.2)	$p=0.232$
Likelihood of discovery (low)	241 (39.1)	106 (37.3)	135 (40.7)	$p=0.409$
Relief request by others	381 (61,0)	168 (58.5)	213 (63.0)	$p=0.285$
Serious injuries (hospitalization)	54 (8.3)	31 (10.6)	23 (6.4)	$p=0.063$

a. Estado de partida= Situación previa a la intervención

b. El valor de la p se obtiene de la prueba de χ^2 o del Test Exacto de Fisher para variables cualitativas categoriales

c. Diagnostico= DSM IV-TR

Abreviatura PIPRS=Programa Intensivo de Prevención de Reintento de Suicidio; TAU=Tratamiento Convencional

er migrant population (33%) than the TAU group (18.8%) (Fisher's exact test $p < 0.001$). The distribution between ISRPP and TAU was slightly different for certain diagnoses, such as mood disorders (49.0% vs 36.7%), psychotic disorders (1.7% vs 5.6%), and personality disorders (16.1% vs 21.8%) ($\chi^2 = 20.99$, $df = 6$, $p = 0.002$). There was a difference in family history of psychiatric disorders (ISRPP 45.0% vs TAU 59.0%) (Fisher's exact test $p = 0.003$). Differences were also found for previous suicide attempts (ISRPP 29.1% vs TAU 56.0%) (Fisher's exact test $p < 0.001$) and history of self-harm (ISRPP 13.7% vs TAU 33.1%) (Fisher's exact test $p < 0.001$).

Retention in care programmes

The odds ratio for the ISRPP was 1.74; CI 95% (1.26-2.40) versus TAU (Fisher's exact test $p = 0.001$).

Effect of intervention

Within one year of follow-up, 108 patients repeated the attempt (16.6% of the total): 26 (9.0%) of those in the ISRPP group, and 82 (23.3%) receiving TAU. With an odds ratio of TAU to ISRPP of 3.08; CI 95% (1.92-4.95) (Fisher's exact test $p < 0.001$). The NNT was 7; CI 95% (5-11).

Kaplan-Meier analysis showed a median survival time of 344 days in the ISRPP group with a standard error of 4; CI 95% (335-352), and 312 days in the TAU group with a standard error of 6; CI 95% (301-323).

In the test for equality of survival distributions for the different levels of log rank (Mantel-Cox) intervention the $\chi^2 = 22.82$, $df = 1$, $p < 0.001$. Survival curves are shown in Figure 2.

To control for different characteristics between the TAU and ISRPP groups, a Cox regression was performed. Variables found to be significant on univariate analysis were entered into the model, i.e., emigration, diagnosis (personality disorder only), previous suicide attempts, history of self-harm, suicidal ideation, and criticism of the attempt made. The type of intervention was also entered into the model.

The results after controlling for these variables showed a significant association for repeat suicide attempts with the type of treatment received, with an HR of 2.68; CI 95% (1.65-4.35) (χ^2 Wald= 16.032, $df = 1$, $p < 0.001$) for the TAU group with respect to the ISRPP group. Of the remaining variables, the only one that showed an effect was a previous suicide attempt, with an HR of 3.08; CI 95% (1.88-5.05) (χ^2 Wald= 19.95, $df = 1$, $p < 0.001$).

Multivariate analysis stratified by age-sex maintained differences between the two intervention types with an HR

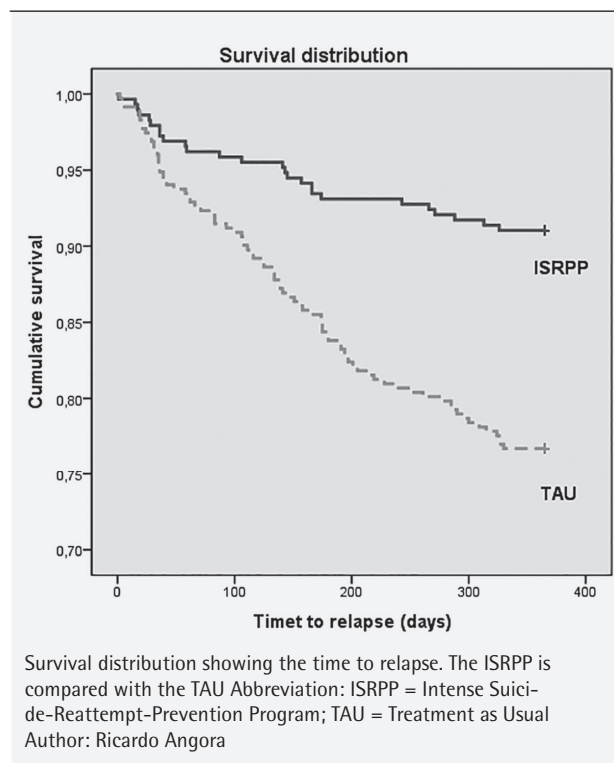


Figure 2

Survival distribution Kaplan Meier

of 2.78; CI 95% (1.69-4.55) (χ^2 Wald=16.41, $df = 1$, $p < 0.001$) for the TAU group relative to the ISRPP group. Stratification by previous suicide attempts also maintained differences between the two intervention types with an HR of 2.68; CI 95% (1.65-4.34) (χ^2 Wald=15.96, $df = 1$, $p < 0.001$) for the TAU group relative to the ISRPP group. Stratification by migrant status also maintained differences between the two intervention types with an HR of 2.63; CI 95% (1.61-4.29) (χ^2 Wald=15.05, $df = 1$, $p < 0.001$) for the TAU group compared to the ISRPP group. Stratification by diagnosis also maintained differences between the two intervention types with an HR of 2.70; CI 95% (1.66-4.38) (χ^2 Wald=16.30, $df = 1$, $p < 0.001$) for the TAU group compared to the ISRPP group. Stratification by family history of psychiatric pathology also maintained the differences between the two intervention types with an HR of 2.40; CI 95% (1.44-4.01) (χ^2 Wald=11.22, $df = 1$, $p < 0.001$) for the TAU group compared to the ISRPP group. Stratification by history of self-harm also maintained differences between the two intervention types with an HR of 2.49; CI 95% (1.52-4.08) (χ^2 Wald=13.12, $df = 1$, $p < 0.001$) for the TAU group compared to the ISRPP group.

DISCUSSION

Our results show that early and intensive intervention after a suicide attempt consisting of a brief psychotherapy

programme focused on problem-solving in addition to application of a case-management approach reduces and delays repeat attempts in the following year. The risk of repeat suicide attempts for patients in the TAU group was three times higher than for patients who attended the Intensive Suicide-Prevention Programme (ISRPP). In addition, 7 people needed to be treated in ISRPP to avoid a repeat suicide attempt, which speaks to the high cost-effectiveness of this dual approach in terms of clinical effort⁴¹.

The results also show that the time of subsequent repeat attempts is delayed. Survival analysis reveals higher survival in the ISRPP group than in the TAU group at 1-year follow-up (Figure 2). Thus, the programme has a double protective effect in terms of fewer repeat attempters and better survival over time. Moreover, these results are independent of the sociodemographic, psychosocial, and clinicopathological characteristics of the subjects, and of concurrent or intrinsic factors of the attempt, as well as the severity of the self-harm.

Multivariate models that control for potential confounders have shown that only a history of suicide attempts and the suicide-prevention programme itself were related to the incidence of repeat attempts. Although when stratified by the variable "previous suicide attempt," the difference in the protective effect of ISRPP on TAU was maintained, with an HR of 2.68. This analysis reveals a nearly 3-fold higher risk associated with repeat attempt in the TAU group. Thus, the protective effect of the programme on repeat suicide attempts is confirmed.

Sources of non-comparability between groups have been controlled for, and although some residual confounding is possible, we adjusted for all confounders and stratified patients according to age-sex, and thus our results can be considered robust.

Comparison with other studies

This study shows the effectiveness of a specific, intensive treatment programme for patients who have made a suicide attempt in the real world.

The results found in this study regarding the effectiveness in preventing repeat suicide attempts through a CBT programme are in line with other research^{26, 36}, although other publications found no differences between the intervention group and the TAU⁴². The results are similar to the study of the L'Eixample Dreta neighbourhood in Barcelona²⁸ (11% for the intervention group vs. 32% for the TAU), and somewhat higher than the study of the Orense area, also in Spain²⁶ (10% vs. 20.6%).

The results regarding delayed attempt repetition, and therefore higher survival, achieved with ISRPP are similar to other published studies²⁶.

Analysing the use of brief therapy, the results of this study are in line with existing publications⁴³, as is the case when comparing the CBT technique applied^{19, 44, 45}. As in the studies referred to, therapy decreased the number of repeat attempts in the one-year period, although with the programme evaluated the decrease was more significant.

When comparing the case-management approach with other studies, the results lead us to infer that this approach contributes to the effectiveness of the programme as in published studies⁴⁶, although it differs from others in which this effectiveness was not evidenced⁴⁷. The case-management model also led to greater follow-up of cases, with fewer drop-outs from the programme, as also reflected in other studies⁴⁸.

LIMITATIONS

This study evaluates the effectiveness of an ongoing suicide-prevention programme. One criterion for receiving care in the ISRPP after the attempt was to not have undergone mental-health treatment during the previous year in order to maintain continuity of care and the therapeutic relationship with the corresponding professional. This selection bias may have conditioned the results obtained; however, the results of the study, contrasting all those variables that are not homogeneous in both groups, show that only the rate of previous attempts is a confounding factor. With stratification strategies and multivariate analysis, we were able to control for the effect of this variable.

The initial assessment of the patients, which included, among other things, patient characteristics and diagnosis, was blinded since the allocation to the two groups followed the ED assessment. The assessment of outcome variables was done in non-blinded manner using automated review of electronic medical records, so there is no bias in the assessment of the study.

Another limitation is the 1-year follow-up period^{28, 49}. It can be argued that the effect of the suicide-prevention programme in reducing repeat suicide attempts compared to conventional treatment may diminish over time and eventually converge. Future studies should investigate the ISRPP lasting effect, and even if it would be appropriate to make long-term treatment plans that include repeating this therapy.

The fact that the intervention combines psychotherapy intervention and case management does not allow us to assess the effect of each separately. Therefore, our study de-

sign cannot determine the extent to which repeat suicide attempts were prevented owing to psychotherapy or, conversely, due to the case-management system. A new study could be designed to isolate the two interventions.

STRENGTHS

This is a real-life study in a catchment area of 430,000 inhabitants. This area has a moderate-to-low socioeconomic level, so most of the population only uses the public health system, where the ISRPP has been implemented.

The study has a high number of cases that have been followed for at least one year, which strengthens the results achieved.

ISRPP is a programme that encompasses several interventions with patients: psychiatric care, brief psychotherapy, focused problem-solving therapy, and a case-management approach. All can enhance the benefits of each intervention separately.

With regard to case management, aspects such as the motivation and support provided to the patient not only facilitated the therapy, but also increased patient support from those in patients' surroundings by maintaining contact with the family and mobilising the social support network. This is considered a desirable and value component in care for individuals during the critical moments that follow a suicide attempt.

Conflict of interest

The authors declare that there are no conflicts of interest related to the publication of this article.

Acknowledgements

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Table 2		Suicide attempt Method		
Table 2. Baseline^a characteristics covariates of the total subjects and by intervention				
Characteristics of the suicide attempt	Total <i>n</i> =649	ISRPP <i>n</i> =292	TAU <i>n</i> =357	TestX ² <i>p</i> ^b
<i>Method of attempted suicide</i>				
Over-intake of medications with sedative effect	449 (69.4)	201 (68.8)	248 (69.9)	
Over-intake of medications without sedative effect	69 (10.7)	25 (8.6)	44 (12.4)	
Wrist cut	42 (6.5)	25 (8.6)	17 (4.8)	X ² =9,54 df=9
Fall from height	20 (3.1)	12 (4.1)	8 (2.3)	
Hanging	12 (1.9)	5 (1.7)	7 (2.0)	p<0.389
Hit by vehicle (car, train; subway)	5 (0.8)	3 (1.0)	2 (0.6)	
Stabing themselves	15 (2.3)	6 (2.1)	9 (2,5)	
Over-intake of psychoactive substance use	10 (1.5)	3 (1.0)	7 (2.0)	
Chemicals intake	14 (2.2)	6 (2.1)	8 (2.3)	
Others (fire arms; drowning; gas; fire; electrocution)	11 (1.7)	6 (2.1)	5 (1.4)	
a: Baseline characteristics = Previous situación to intervention				
b: p values are obtained from X ² test for categorical qualitative covariates				
Abbreviation: ISRPP= Intensive Suicide-Reattempt-Prevention Programa; TAU= Treatment as Usual; df=degrees of freedom				

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