SCIENTIFIC LETTERS

Heterogeneity of regional protocols for the management of suicide attempts in emergency departments in Spain: The need for a unified framework

Heterogeneidad de los protocolos autonómicos de actuación ante intentos de suicidio en los servicios de urgencias en Spain: necesidad de un marco unificado

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Suicide is a major public health problem and a preventable cause of mortality. According to the World Health Organization (WHO), nearly 700,000 people die by suicide worldwide each year,[1] with an estimated ratio of 10–20 nonfatal suicide attempts for every completed suicide.[2] In Europe, the average rate is approximately 13.9 deaths per 100,000 inhabitants.[3] In Spain, the *Instituto Nacional de Estadística* (INE) recorded a total of 4,227 deaths by suicide in 2022, the highest figure since records began and one of the leading causes of external death.[4] A marked male predominance was observed (3,126 men vs 1,101 women), attributed to the greater lethality of the methods used by men.[5] Suicidal behavior is a complex, multifactorial phenomenon determined by biological, psychological, social, and financial factors.[6]

Hospital and prehospital emergency services represent the first health care contact for most suicide attempts and constitute a critical point for early detection, stabilization, and referral to mental health services.[7] Through the LIVE LIFE initiative, the WHO recommends strengthening emergency care, restricting access to lethal means, training health care professionals, and establishing clear and standardized protocols.[8] However, health care decentralization in Spain has led to considerable heterogeneity among autonomous communities regarding the existence, structure, and scope of their protocols for suicidal behavior management.[9] The objective of this study was to analyze the existence, similarities, and differences among regional protocols for the management of suicide attempts in hospital and prehospital emergency services and to identify deficiencies and possible lines of improvement toward a unified framework.

We conducted a nationwide scoping systematic review following the PRISMA 2020 guidelines,[10] with the aim of identifying and comparing regional protocols for the management of suicide attempts in hospital and prehospital emergency settings in Spain. The search was performed in databases (PubMed, CINAHL, SciELO, Dialnet), official portals of regional health care systems and the Ministry of Health, as well as through direct email consultation with the health departments of the 17 autonomous communities and the 2 autonomous cities. Official documents published between 2010 and 2025 (protocols, guidelines, codes, or strategic plans) were included, whereas unofficial, duplicate, or outdated materials were excluded.

The initial search identified 112 documents; 22 duplicates were removed, leaving a total of 90 records. Of these, only 45 articles had full text available. After reviewing titles and abstracts, 15 documents were excluded because they were not specifically directed toward health care personnel, as they addressed prevention in educational settings, guidelines for individuals with suicidal ideation, relatives or survivors, as well as recommendations for the media. Finally, 30 documents were included in the analysis. Information was synthesized using a comparative matrix evaluating document type, scope of application, screening tools, and care pathways. The complete process is represented in the PRISMA diagram in Figure 1.

The results demonstrated a marked territorial gradient.

Catalonia has had the Suicide Risk Code (CRS) since 2015, which establishes early detection, priority referral, and intensive follow-up dur-

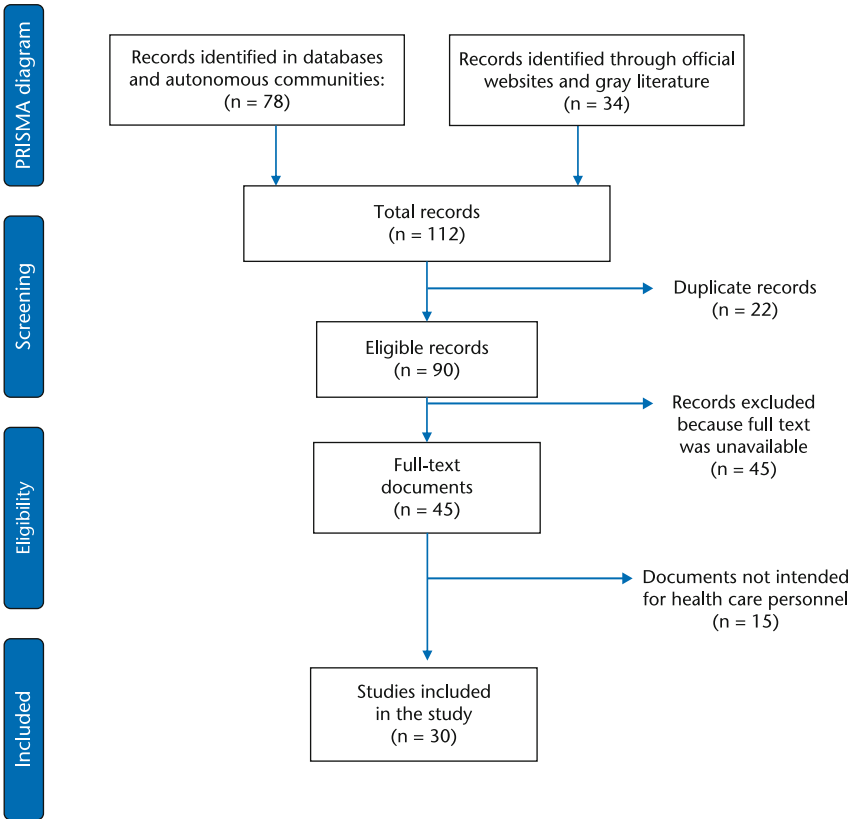

Figure 1. PRISMA diagram of the study.
Source: authors' own elaboration.

Table 1. Comparison of Existing Protocols in Spain

Corresponding Author	Emergency department protocol	Recommended assessment scales	Continuity of care after discharge	Prehospital resources
Andalusia	Suicide Prevention Plan, limited in emergency settings	Dependent on each hospital	Limited	Uneven among provinces
Aragón	No	No	No	Guide for detection, prevention, and intervention in cases of suicidal ideation in leisure and recreational settings
Cantabria	CARS Program intended for Area I	Not specified	No	No
Castile and León	No	No	No	Suicide behavior prevention strategy in Castilla y León
Castile -La Mancha	No	Not specified	No	No
Catalonia	Yes (Suicide Risk Code)	C-SSRS, SAD PERSONS	Yes (3-month intensive follow-up)	Specialized mobile teams
Ceuta	Yes (Primary care)	Not specified	No	No
Community of Madrid	Suicide Prevention Plan, without a homogeneous pathway, and Code 100	Dependent on each hospital	Limited	Uneven among hospitals
Valencian Community	Mental Health Plan, nonspecific Suicide Code	Nonstandardized	Partial	Limited
Extremadura	Yes (Suicide Code)	Not specified	No	No
Galicia	Mental Health Plan 2025–2027	Not specified	Yes	No
Balearic Islands	Mental Health Plan 2016–2022	Nonstandardized	Yes	No
Canary Islands	Mental Health Plan 2019–2023	Nonstandardized	Yes	No
La Rioja	Yes (Intensive Interventions Plan)	Not specified	No	No
Melilla	No	No	No	No
Chartered Community of Navarre	Yes (Suicide Code)	IS PATH WARM	Yes (prehospital coordination)	Mobile teams and primary care coordination
Basque Country	Yes (Recent Suicide Attempt Code)	C-SSRS	Yes (immediate referral and protocolized follow-up)	Specialized mobile teams
Principality of Asturias	Mental Health Plan 2023–2030	EuroQoL	Yes (prehospital coordination)	Specialized centers
Region of Murcia	Psychological Emergencies Manual (2007); Coordination protocol for transfers and admissions of patients with mental illness (2014)	No	Yes (prehospital coordination)	No

ing the 3 months after the attempt.[11] The Basque Country has the Recent Suicide Attempt Code (CISR), with immediate referral to mental health services and protocolized follow-up, although it is not publicly available.[12] Navarre and Extremadura have also developed specific codes or plans that include emergency department management, whereas in communities such as Madrid, Galicia, or the Valencian Community, general prevention plans lack homogeneous pathways.[13] In other autonomous communities, management is based on internal regulations or local criteria without updated official protocols,[9] as shown in Table 1.

Despite these differences, all documents coincide in considering suicide a health care emergency and emphasize the need for coordination with mental health services. Most recognize the essential role of emergency nursing in early detection, risk assessment, and therapeutic support.[7,9] However, the differences are concentrated in 5 main areas. The first concerns care pathways: autonomous communities with specific codes establish clear algorithms and defined referral times, whereas in others management depends on individual clinical judgment. The second concerns risk screening: some regions use validated scales (C-SSRS, SAD PERSONS), whereas others omit standardized tools, thereby hindering comparability of data.[14] The third emphasizes prehospital resources, since where mobile crisis intervention teams exist, the response is faster and more coordinated. The fourth concerns continuity of care, as only some regions include proactive follow-up after discharge from emergency services, despite the fact that the initial period after a suicide attempt carries the highest risk of recurrence.[13] Finally, differences also exist regarding the definition of response times: in the most developed protocols, referral to mental health services occurs within less than 72 hours, whereas in others no specific time frames are established.

Comparison with international strategies shows that decentralized systems such as the Spanish health care system face similar difficulties in standardizing care.[9] In countries with integrated national frameworks, such as the United Kingdom or Australia, the existence of unified protocols is associated with greater interinstitutional coordination and reduction in

repeat suicide attempts.[8] Evidence also supports the combined use of standardized scales and clinical judgment to improve risk detection,[14] as well as specific training for emergency personnel, especially nursing staff, because of their key role in triage.[7]

These findings highlight the need to develop a national reference protocol establishing common criteria for screening, management, response times, and continuity of care. Such a framework, aligned with international recommendations, would promote territorial equity and enable comparative evaluation of outcomes. It should include systematic implementation of validated screening tools and intensive postdischarge follow-up mechanisms, strengthening of the nursing role, and development of homogeneous prehospital care teams.

In conclusion, the management of suicide attempts in emergency services in Spain presents marked regional heterogeneity that affects equity and quality of care. Implementation of a unified national protocol, evidence-based and agreed upon with health care professionals, is a necessary measure to guarantee a rapid, effective, and homogeneous response to one of the main current health care and social challenges.

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