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CONTINUITY OF CARE FOR PATIENTS WITH SUICIDE IDEATION OR ATTEMPTED ASSISTED IN THE PSYCHIATRIC EMERGENCY

CONTINUIDADE DO CUIDADO DE PACIENTES COM IDEAÇÃO OU TENTATIVA DE SUICÍDIO ATENDIDOS NA EMERGÊNCIA PSIQUIÁTRICA

CONTINUIDAD DEL CUIDADO DE PACIENTES CON IDEACIÓN O INTENTO DE SUICIDIO ATENDIDOS EN LA EMERGENCIA PSIQUIÁTRICA

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Objective: to understand the continuity of care in the Psychosocial Care Network for people with suicide ideation or attempt after having passed through the emergency department. Method: qualitative study, conducted through the technique of thematic analysis, through interviews with people who went through the emergency department of a hospital in the interior of São Paulo for suicide ideation or attempt, from January to December 2020. Results: Most of the participants are women who live without a partner, with an average use of three psychoactive drugs. In the analysis of the interviews, the following themes were identified: difficulty in accessing services, lack of adherence to treatment, recurrence of ideations/attempts and improvement factors. Final considerations: in view of the results, it is necessary to invest more in the psychosocial care network, to increase access and improve the quality of care and support for these people.

Descriptors: Mental Health. Suicide. Suicide Attempted. Suicidal Ideation. Emergency Services, Psychiatric.

Objetivo: compreender a continuidade do cuidado na Rede de Atenção Psicossocial das pessoas com ideação ou tentativa de suicídio após ter passado pelo serviço de urgência e emergência. Método: estudo qualitativo, realizado

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por meio da técnica de análise temática, mediante entrevistas com pessoas que passaram pelo serviço de urgência e emergência de um hospital do interior paulista por ideação ou tentativa de suicídio, no período de janeiro a dezembro de 2020. Resultados: a maioria dos participantes são mulheres que vivem sem o companheiro, com uso, em média, de três psicofármacos. Na análise das entrevistas, foram identificadas as temáticas: dificuldade de acesso aos serviços, falta de adesão ao tratamento, recorrência das ideações/tentativas e fatores de melhora. Considerações finais: frente aos resultados encontrados, depreende-se a necessidade de maiores investimentos na rede de atenção psicossocial, para aumentar o acesso da população e melhorar a qualidade do atendimento e apoio a essas pessoas.

Descritores: Saúde Mental. Suicídio. Tentativa de Suicídio. Ideação Suicida. Serviços de Emergência Psiquiátrica.

Objetivo: comprender la continuidad del cuidado en la Red de Atención Psicosocial de las personas con ideación o intento de suicidio después de haber pasado por el servicio de urgencia y emergencia. Método: estudio cualitativo, realizado mediante la técnica de análisis temático, a través de entrevistas con personas que pasaron por el servicio de urgencia y emergencia de un hospital del interior paulista por ideación o intento de suicidio, en el período de enero a diciembre de 2020. Resultados: la mayoría de los participantes son mujeres que viven sin pareja, con uso, en promedio, de tres psicofármacos. En el análisis de las entrevistas se identificaron las temáticas: dificultad de acceso a los servicios, falta de adhesión al tratamiento, recurrencia de ideaciones/intentos y factores de mejora. Consideraciones finales: frente a los resultados encontrados, se deduce la necesidad de mayores inversiones en la red de atención psicosocial, para aumentar el acceso de la población y mejorar la calidad del cuidado y apoyo a estas personas.

Descriptores: Salud Mental. Suicidio. Intento de Suicidio. Ideación Suicida. Servicios de Urgencia Psiquiátrica.

Introduction

Suicide is a serious public health problem worldwide. It is a social phenomenon of extreme complexity, marked by the association of biological, psychological, social, cultural, economic and historical factors, occurring mainly in people with mental disorder, most commonly with depression. Its self-injurious character involves thoughts or actions that may culminate in complete suicide, attempt, preparation for the act, ideation, self-aggression without the intention of dying, unintentional self-mutilation or self-mutilation with unknown suicidal intent[1].

According to the World Health Organization (WHO), its occurrence affects all social classes, with one million deaths estimated per year, representing the fourth largest cause of death among young people aged 15 to 29[2].

More than one third of the people who committed suicide sought some form of health service a week before the act was carried out; more than half had spent health care a month before committing suicide and almost all of them, about a year before, had some contact with health services[3-4].

Brazil has one of the highest rates of absolute suicide numbers in the world. In the period from 2010 to 2019, 112,230 deaths by suicide were recorded, and there was a growing increase in the risk of death in all regions of the country. These deaths occur predominantly in the residence itself and 41% of them had previous attempt[5].

The intention to take one's own life arises when the individual presents a pain large enough to imagine not being able to bear it, having death as the only alternative capable of solving the problem. The situation is aggravated by the fact that it is a stigmatized condition by society and even by health professionals who sometimes see suicidal behavior as optional to the individual. In health services, this thinking results in a service characterized by hostility, rejection and difficulty of humanized approach[1].

Some public policies have been established with a view to a humanized and integral service to these people. In this sense, the Psychosocial Care Network (RAPS - *Rede de Atenção Psicossocial*) was created with the purpose of organizing mental health services in the country, through the articulation of services from different levels of care of the Unified Health System (UHS), having as axis the co-responsibility of care between

services, based on the principle of integrality of care[6].

In addition, in 2019, the Law n. 13,819/2019 was sanctioned, which instituted the National Policy for the Prevention of Self-Mutilation and Suicide, with the objective of promoting access to psychosocial attention of people with a history of suicidal ideation, self-mutilation and suicide attempts, mainly aiming at the prevention of these events through the treatment of associated conditions[7].

In the context of care for people with suicide ideas or attempts, emergency services are essential because they often correspond to the first contact of these people with health professionals and services. At the moment when they are in crisis, it is in these spaces that acute measures are adopted, aimed at continuity of assistance, in order to contribute to the reduction of risk factors and prevention of new episodes.

Thus, in addition to a welcoming approach and therapeutic conduct consistent with the needs, the emergency services are responsible for providing a direction for these people, so that they can follow in their assistance. However, even in the face of advances made by psychosocial care policies, it has been observed that there are still many difficulties found in the necessary interrelations, since this new logic is not yet incorporated among the actors involved in the process[8]. The fact that there are few options available in the health system for referring people who need to follow-up care is a problem[9], which leads to the question about how the continuity of care performed in emergency services for suicide ideation or attempt has been occurring.

The present study aims to understand the continuity of care in the Psychosocial Care Network for people with suicide ideation or attempt after having passed through the emergency department.

Method

This is a qualitative research, with the purpose of obtaining information about the continuity of assistance after the care of people with suicide ideation or attempt in the specialty of Psychiatry in an emergency room of a Tertiary Hospital in Midwest of São Paulo.

The study was conducted in an emergency department of a state teaching hospital, located in a city in the interior of the state of São Paulo, where about 3900 patients are treated every month.

The municipality in question is inserted in the Psychosocial Care Network and has health equipment in several components. Primary Health Care has implemented 46 Family Health Units (FHU) and 9 Basic Health Units (BHU), as well as a Street Office Team – CR (Modality of a team in the Better at Home Program).

In relation to the Specialized Psychosocial Care, it has a CAPS II *Com-Viver* and with the children's CAPS, a CAPS AD (Alcohol and Drugs) and three non-hospital emergency units, being a mobile pre-hospital, Mobile Emergency Service (SAMU-192), and two fixed pre-hospital. Its Hospital Care has a general hospital with psychiatric ward and a specialized hospital. It also has the *Back to Home Program*, which assists psychosocial rehabilitation for patients who have been long-term in psychiatric hospitals in their reintegration into social life, in order to ensure their well-being and exercise of their civil, political rights and citizenship[10].

For the composition of the sample, ten care records were initially drawn from patients treated for suicide ideation or attempt in January, May and September of 2020, totaling 30 records. Nevertheless, there were some refusals, in addition to the difficulties of communication with participants, and new contacts were necessary until data saturation was obtained. Data collection took place between the months of June and September 2021. Patients who had in their clinical history suicide ideation or attempt at the time of treatment, with or without previous attempts and who resided in the city headquarters of the emergency room were included. Cases that did not involve suicide ideation or attempt were excluded, as well as people who did not have the cognitive conditions to provide the necessary information. The final sample was composed of 31 participants.

For data collection, semi-structured interviews were conducted, with a script that contained identification data such as: name, age, sex, marital status, schooling, medications used and the following questions: How was the service performed in the emergency department?; Talk about your life after having been treated in the emergency department; How was the continuity of treatment (services that have passed and if it has not continued, what was the reason); What were your expectations regarding life and the future?

To conduct the interviews, the basic health unit of the territory of the interviewees was located and the support of the Community Health Agent (CHA) was requested for making contacts. The CHA informed the participants about the research and, in cases of adherence to participation, contacts were made through telephone calls. The data were processed through the thematic analysis technique, which seeks to identify, analyze and report patterns (themes) within the data and interpret various aspects of the research theme. In this form of analysis, the coding process occurs through the own data. A theme represents something important, extracted from the data in relation to the research question, regardless of whether it appears with great prevalence in the set of information[11].

In its operationalization, six phases were developed. Initially, familiarity with the data is considered, which includes immersion through repeated readings of the data in order to approximate the depth and breadth of the content. The second phase involves the production of initial codes of data, and these represent a semantic or latent content that refers to the most basic segment or element of the data. In this phase, the set of data that were obtained is worked systematically, seeking to identify interesting and significant aspects of the text[11]. Phase three refers to the topic search, developed on the basis of the code list, and involves screening different codes into potential topics. In phase four, it is time to revisit the themes, which involves their refinement, taking into account the criteria of internal homogeneity and external heterogeneity. In the following, the themes are defined and named, the essence of the subject of each theme is identified. In the last phase, the final analysis and writing of the report begins. In this report, the excerpts from the participants' speeches need to be incorporated into the analytical narrative, in order to illustrate the content that is intended to be shown[11].

Confidentiality was guaranteed on the information provided, for exclusive use for scientific purposes, adopting the letter E followed by sequential numbering according to the order of the interviews. The research was approved by the Research Ethics Committee of the proposing institution under the Certificate of Presentation of Ethical Appreciation (CAAE) 42705021.0.0000.5413. To participate, all respondents signed the Informed Consent Form (ICF).

Results

Of the 31 participants in the study, 22 (71%) are women and 9 (29%) are men, with ages ranging from 20 to 66 years old, 19 (61.3%) living without a partner (single or separated) and 12 living with a partner (married). Regarding education, 5 (16.1%) have complete or incomplete higher education, 15 (48.4%) have complete or incomplete secondary education, 10 (32.2%) complete or incomplete basic education and 1 (3.2%) is illiterate.

Concerning the use of psychoactive drugs among the interviewees, only one was not using psychoactive drugs at the time of the interviews, and the others used on average three, highlighting antidepressants (29.9%), antipsychotics (23.6%) and mood stabilizers (19.3%).

In the analysis of the interview data, four themes were identified: Difficulty in accessing specialized mental health services; Lack of adherence to treatment; Recurrence of ideations/attempts; Improvement factors.

Difficulty in accessing specialized mental health services

The interviewees reported difficulty in accessing both psychological care and specialized medical treatment, which is considered as fundamental

for their recovery. When followed up by primary care, they considered that the treatment offered is insufficient to be effective.

Moreover, the difficulty of accessing public care led them to seek private services; however, financial resources were not always sufficient, causing, in many cases, the non-continuity of treatment, culminating in its abandonment. The existence of a physical barrier is also considered as an aspect that makes treatment difficult, especially the distance to the place where the treatment is being performed and the financial difficulty in bearing the transportation costs.

Nevertheless, those who were hospitalized after the suicide ideation or attempt had greater ease to access services, since they already left with the outpatient appointment scheduled. The following are fragments of interviews that explain this scenario:

> *I just wish the psychologist would call me soon, because I'm on the waiting list, because I really miss talking to someone, as I live alone I don't talk to anyone* [...]. (E3).

> [...] *because I haven't found a psychiatrist yet, so I go to the health center with a general doctor* [...]. (E7).

> [...] *it's far away and sometimes I get lost, but I would like to have the service at...* [psychiatry outpatient] *because it's closer*. (E4).

> *I had difficulty getting a place in the UHS, so I had to opt for private care and I still don't have psychological care, but as soon as things get better I want to start doing so.*. (E28).

> [...] *it was quick, I think that, at most, a month later I already had an appointment scheduled at the outpatient clinic, I came with a referral because I had been hospitalized* [...]. (E2).

Lack of adherence to treatment

The analysis of the interviews showed that in addition to the difficulties for the continuity of treatment, due to the limited offer of services and professionals, patients have difficulties to adhere to the treatments proposed and referrals, putting at risk the opportunity for treatment by not attending consultations or not following the guidelines.

> [...] *I started my follow-up at the outpatient clinic, I didn't stop, but I almost lost my place a while ago because I had absences, I end up forgetting*. (E9).

> [...] *I don't attend the psychiatrist. The right thing was once a month. The deal was... the truth is that I changed therapists*. (E2).

Recurrence of ideations/attempts

Based on the participants' speech, it can be deduced that they continue to present suicidal ideas, in addition to other feelings that demonstrate the perpetuation of suicide risk. Routinely, attempts are successive and even with the use of drugs, they present the desire to repeat the act and maintain the idea of death. Moreover, there is a lack of perspective for the future and the absence of feeling of happiness. They also mention the presence of anxiety, mental confusion and *disturbed head*.

> *I've tried to kill myself with a rope. It was more than one attempt and now, even taking medication, it's too hard because there are times when you remember it again and you want to do it again. I tried to cut my wrists with a knife but I couldn't.*. (E10).

> [...] *I usually say that I don't remember what happiness feels like* [...] *I don't have dreams or goals, I say that I'm only going to live until the day I die*. (E31).

> *But I'm like this, biting concrete, extremely anxious, you know, I think all the time, every moment*. (E20).

> [...] *I still have thoughts today, I also have thoughts of killing people, I don't feel completely safe being alone with someone because then I feel that urge, if I don't leave, I do it, so I have the courage and I do it.*. (E13).

Improvement factors

The participants' reports show that they consider the use of psychotropic drugs to be of great relevance, because they claim to need them to feel good. Thus, they seek to make correct use of them and when they try to be without them, they do not succeed, due to the worsening of the picture. Sometimes adjustments in dosage are necessary. The improvement also comes from the consultations and support of family members, leading them to enjoy life and themselves more, as seen in the following speeches.

> *I felt an improvement, I'm taking the medication, I had some crises, then I had to adjust some doses, but today I'm fine, adapting to each situation*. (E29).

> *For a while I still suffered from sadness and anguish, but as time went by and with the medicines the doctor*

prescribed me and the follow-up consultations, I began to feel better. (E28).

Now I like life more, now I like myself [...] *I am another person, I like myself and I have learned to live and my husband supports me a lot, helps me a lot, so for me, it is very good.* (E30).

So I have to take the medicine or I'll feel bad, my head will be heavy, I want to die sometimes [...] (E24).

Discussion

Regarding the sex of the respondents, the paradoxical difference between men and women is confirmed, since, in relation to risk factors, there is a preponderance of non-fatal suicidal behavior among women, while among men suicide is more frequent. As for the methods of suicide attempt, women use substances and men tend to hang[12].

Concerning the marital status, most of the interviewees live without a partner, which can lead to feelings of loneliness, helplessness, lack of social and emotional support[13].

In relation to the use of psychoactive drugs, the interviewees used an average of three of them, with emphasis on antidepressants, antipsychotics and mood stabilizers. Despite this use in patients with suicide ideation or attempt, it is necessary to consider that the phenomenon of suicide is far from having a unidimensional and reductionist sense and although the development of new drugs has had an impact on the treatment of mental diseases, the decrease in suicidal behaviors has not yet been observed. The medications, therefore, have more specifically the purpose of treating basic mental diseases or comorbidities, since these are largely associated with the ideation, attempt and consummation of the act[14].

However, the increase of pharmacological options for the treatment of patients, either in the Urgency and Emergency Unit or ambulatory, are considered necessary. For example, the majority of suicidal people suffer from depression, and less than 50% of depressed patients will have total remission of symptoms, while about 30% have treatment-resistant depression[15].

In the present study, which sought to analyze how the continuity of assistance occurs after passing through the urgency and emergency service of people with suicide ideation or attempt, it is argued that whatever the situation involving the suicidal attempt or ideation, it is necessary to consider that this is a complex condition, which involves great investment in health care, so that a greater tragedy can be avoided. However, the findings of this research showed that one of the most relevant aspects is the difficulty in accessing specialized services. It seems even more complicated when it comes to access to psychological support, as mentioned in the interviews, even if these professionals are inserted into the primary care network through the Expanded Family Health Center (NASF - *Núcleo Ampliado de Saúde da Família*).

As for the NASF, formed by professionals from different areas of training, its task is to meet specific demands in a coordinated manner with the teams of the Family Health Strategy, which includes mental health care. However, important weaknesses were identified among professionals who integrate these sectors in relation to the lack of academic training, experience in this logic of action and absence of the institution in processes of Permanent Education, which hinders the implementation of changes in the way of acting and thinking about health care in the logic of integrality[16].

Referring to the care offered by the Unified Health System, it is found that the Health Care Networks, although considered as an essential condition for the proper functioning of the system, still have important gaps in relation to access and coverage, especially when it comes to the Psychosocial Care Network. In this perspective, a study conducted in three northeastern states revealed that investments are needed in the identification and monitoring of cases of mental disorder of different levels of severity, in order to develop plans for care based on longitudinality and networking, which includes making resources available in the territory through actions of the Primary Care and Specialized Care team[17].

On the other hand, although there have been investments in primary care in recent decades in the perspective of the bond and

longitudinality, observed in this study, when, after the suicide ideation or attempt, the patient passes through hospitalization, longitudinal care occurs more frequently, since there is greater initial adherence to treatment. This refers to reflections on the importance of having a large investment in continuity, in addition to acute care, which contributes to reducing the risk of recurrence of attempts[3-4].

Among the interviewees of this study, it is observed that basic care, although part of the health care network and place of the establishment of bond and responsibility for care, was not present as a point of support for them, because patients do not feel safe/confident in maintaining their treatment by this route, being dependent on specialized outpatient care or even private services when possible, but that, according to most of the reports, are not maintained by financial limitations when seeking this alternative.

A study that analyzed the conceptions of professionals from the Family Health Strategy (FHS) on mental health care found that the action is based on fragmented logic, which extends to the relationship with the NASF team, indicating deep challenges to be overcome through structural organization, training of professionals, strengthening of collective dialogue, planning and evaluation of actions[18]. The results of a systematic review on evaluation of mental health services in Brazil found that the expansion of the Brazilian mental health network does not appear to be sufficient to meet the needs[19].

In this perspective, it is important to rescue the WHO's Mental Health Action Plan 2013-2020[2], according to which there should be a broad approach to mental health care through comprehensive government strategies of promotion, prevention, treatment and recovery, considering that people with mental disorders have high rates of disability and mortality, warning that suicide is the second most common cause of death among young people worldwide.

For the continuity of treatment of the person with suicide ideation or attempt, it is also important to adhere to the treatment, which is considered as a multifactorial condition, since it involves internal and external factors. Examples are the lack of empathy in the patient's medical relationship; intolerable side effects of drugs; low access to alternative treatment therapies, such as psychotherapy; lack of understanding about their psychiatric disease; use of alcohol and/or drugs as a form of self-medication. For patients who need continuous care, it was found that adherence increases when there is effective communication between the different teams that make up the mental health care network[3].

Almost half (49%) of patients with major psychiatric disorders do not adhere to psychoactive medication, with greater expressiveness the people with schizophrenia, major depressive disorder and bipolar affective disorder, group known to be more prone to suicide attempts and ideation. In addition to this risk, there are numerous other impairments in the lives of these people, such as reduced treatment effectiveness, higher number of hospitalizations, worsening quality of life, reappearance of symptoms and waste of health resources[20].

The intense suffering that leads to the devaluation of life is found in the interviewees' speech, which they translate as absence of happiness, anxiety and disturbed head. The feeling of helplessness in life and hopelessness are strong predictors of suicidal behavior. In this sense, it is understood that suicidal ideation is an important sign of mental distress, and it is necessary to identify whether the psychic disorder is present or not, aiming at the proper conduct of the therapeutic approach[21].

As for the factors that contribute to improving the mental health conditions of the respondents, it is found the correct use of medicines, follow-up with professionals and support from family members. In a systematic review on the association of suicide prevention interventions with subsequent suicide attempts, it was found that active follow-up after discharge from the emergency room reduced as well as the contact by means of telephone calls and receipt of handwritten notes by mail in weeks following the fact[3].

Instituting suicide prevention measures means intervening in a problem of great magnitude and transcendence, considering its high prevalence and the personal and social damage. The first step to be guided is the identification of risk factors. In this context, people who have been treated in emergency services for suicide ideation or attempt need appropriate professional accompaniment and services, so that they are considered in their individuality from the perspective of the comprehensiveness of care[22].

Despite the need for suicide prevention, the World Health Organization, recognizing it as a relevant health problem, makes public the World Suicide Report, bringing prevention as a high priority issue in the global agenda focused on public health. In this perspective, the importance of the family, the search for the meaning of life and the appreciation of self-esteem are highlighted, as observed in the speeches of participants of this study[23].

Thus, studies have shown the relevance of different interventions. When evaluating the effectiveness and acceptability of a physical activity, by means of two days of walking 30 minutes/week, comparing with sedentary patients hospitalized in psychiatric unit for suicide attempt, found that physical activity was effective in alleviating the mental suffering of these patients[24]. A post-treatment program for people with suicidal ideation, which had the follow-up of the ideators themselves and their families, showed a strong tendency to reduce suicidal behavior. This reinforces the importance of post-care and follow-up for people at risk of suicide[25].

Social support, such as having a confidant and a quality friendship, also helps to reduce attempts. In addition, it was verified the importance of investment in social determinants of health and identification and facilitation of access to interventions that promote social connection for the most vulnerable[23].

A limitation of this study concerns those that are typical of the qualitative study, which mainly involves the fact that it does not allow the generalization of the data and was carried out in a single place. Furthermore, the large refusal to participate in interviews may compromise the evidence of conditions for continuity of care even more complex than those found in this study. However, its results contribute to bring to light important aspects for reflections about the limitations in continuity of care after the occurrence of suicide ideation or attempt.

Final Considerations

In the present study, which sought to interpret how continuity of care has occurred after the care of people with suicide ideation or attempt in an urgency and emergency service, it is important to highlight, based on the sociodemographic data, that the majority is female and lives without a partner, on pharmacological treatment, with use of, on average, three psychotropic drugs.

In the analysis of the interviews, it was evident the difficulty of access to specialized services in mental health, mainly psychotherapeutic follow-up. They have little connection with the Primary Health Care, indicating fragility in the Psychosocial Care Network and in the role of establishing a link and accountability with the health needs of the population enrolled. In addition to the difficulty of access, the interviewees showed, in their speeches, non-adherence to the necessary follow-up of services offered for various reasons.

It was also shown, as a concern, the presence of feelings of deep emotional suffering that leads to difficulties in visualizing value for life, making the risk of suicide evident. They point out as conditions for improvement, the support of family members, the use of medicines and follow-up with health professionals in the area of mental health.

According to the results found, it is necessary to recognize that there is a need to increase the population's access to health services in order for diagnoses to be made and appropriate treatment instituted, with consequent improvement in quality of life. In addition, there should be greater articulation of the Psychosocial Care Network, rescue of the link and accountability of PHC with the health needs of this population, considering

the impact that prevention actions can cause in relation to the consequences of suicide ideations and attempts.

Therefore, to empower and show the importance of mental health for professionals who are in primary care is a fundamental way, so that there is change in the numbers that have triggered an avoidable global tragedy, sometimes underreported. If no changes occur, the irreparable outcomes of today's dysfunctional health care structure will continue.

Given this context, the study provides important inputs for reflections on emergency care in mental health, allowing the reorganization of work processes and management of health services, as well as definition of prevention strategies, coping and post-suicide intervention, with a view to the comprehensiveness of care. Future investigations shall be able to expand knowledge on the subject in question, so that devices are developed that facilitate access and continuity of health care for people with suicide ideation or attempt.

Collaborations:

1 – Conception and planning of the project: Juliane de Souza Cavazzana, Fernanda Vieira Gimenez and Maria José Sanches Marin;

2 – Analysis and interpretation of data: Juliane de Souza Cavazzana, Fernanda Vieira Gimenez, Maria José Sanches Marin, Márcia Aparecida Padovan Otani, Fabiana Sanches Grecco and Paula Karine Jorge;

3 – Writing and/or critical review: Juliane de Souza Cavazzana, Fernanda Vieira Gimenez, Maria José Sanches Marin, Márcia Aparecida Padovan Otani, Fabiana Sanches Grecco and Paula Karine Jorge;

4 – Approval of the final version: Juliane de Souza Cavazzana, Fernanda Vieira Gimenez, Maria José Sanches Marin, Márcia Aparecida Padovan Otani, Fabiana Sanches Grecco and Paula Karine Jorge.

Competing interests

There are no competing interests.

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