

## Interventions for suicide prevention in Primary Health Care

## Intervenções para a prevenção do suicídio na atenção primária à saúde

## Intervenciones para la prevención del suicidio en la atención primaria a la salud

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Received: 24/09/2022 Accepted: 12/02/2023 Published: 16/03/2023

**Objective:** identify interventions for suicide prevention developed by professionals who work in health care. **Methods:** descriptive study of qualitative approach, conducted in the second semester of 2020. Semi-structured instrument based on the World Health Organization Guidelines on Suicide Prevention was used. Data were stored in databases built in Microsoft Word™ and were subjected to the analysis of central speeches and ideas through the collective subject's discourse software. **Results:** 66 professionals participated, of which 42.42% were nurses, 28.79% dentists and 27.27% doctors. Two themes emerged: *Identification of signs that express risk of suicide* and *Measures for suicide prevention*. Among the strategies to prevent suicide, the ones that stood out were: support groups, lectures, and health promotion actions. **Conclusion:** suicide is a theme that must be addressed at all levels of attention, notably in Primary Health Care and not just specialized mental health services.

**Descriptors:** Suicide; Prevention; Primary Health Care.

**Objetivo:** identificar as intervenções para a prevenção do suicídio desenvolvidas pelos profissionais que atuam na atenção primária de saúde. **Método:** estudo descritivo de abordagem qualitativa, realizado no segundo semestre de 2020. Utilizou-se instrumento semiestruturado fundamentado nas diretrizes da Organização Mundial de Saúde sobre a prevenção do suicídio. Os dados foram armazenados em bancos de dados construídos no Microsoft Word® e foram submetidos à análise das falas e ideias centrais por meio do software do Discurso do Sujeito Coletivo. **Resultados:** participaram 66 profissionais, dos quais 42,42% eram enfermeiros, 28,79% dentistas e 27,27% médicos. Dois temas emergiram: *Identificação de sinais que expressam risco de suicídio* e *medidas para a prevenção do suicídio*. Entre as estratégias para se prevenir o suicídio, destacaram-se: grupos de apoio, palestras, e ações de promoção da saúde. **Conclusão:** o suicídio é um tema a ser abordado em todos os níveis de atenção, notadamente na atenção primária à saúde e não apenas em serviços especializados em saúde mental.

**Descritores:** Suicídio; Prevenção; Atenção Primária à Saúde.

**Objetivo:** identificar las intervenciones para la prevención del suicidio desarrolladas por los profesionales que se encuentran en la atención primaria de salud. **Método:** estudio descriptivo de abordaje cualitativo, realizado en el segundo semestre de 2020. Se utilizó un instrumento semiestructurado basado en las directrices de la Organización Mundial de la Salud sobre prevención del suicidio. Los datos se almacenaron en bases de datos construidas en Microsoft Word® y se sometieron al análisis de los discursos y las ideas centrales mediante el software del Discurso del Sujeto Colectivo. **Resultados:** Participaron 66 profesionales, de los cuales: 42,42% eran enfermeros, 28,79% dentistas y 27,27% médicos. Surgieron dos temas: *Identificación de los signos que expresan el riesgo de suicidio* y *medidas para la prevención del suicidio*. Entre las estrategias para prevenir el suicidio destacan: los grupos de ayuda, palestras y acciones de promoción de la salud. **Conclusión:** el suicidio es un tema que debe abordarse en todos los niveles asistenciales, especialmente en la atención primaria y no sólo en los servicios especializados de salud mental.

**Descriptor:** Suicidio; Prevención; Atención Primaria de Salud.

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## INTRODUCTION

**S**uicide is a complex phenomenon, defined as a conscious and intentional act determined and executed by the individual themselves, using a means that they believe to be fatal to provoke their own death<sup>1-2</sup>.

Annually, more than 800,000 people die from suicide, representing 1.4% of all deaths worldwide, and there was a recent growth of 60% in deaths by suicide, reaching a world rate of around 16 deaths per 100 thousand inhabitants<sup>3-4</sup>.

From 2011 to 2015, 55,649 deaths were recorded by suicide in Brazil, with an overall rate of 5.5/100,000 inhabitants, ranging from 5.3 in 2011 to 5.7 in 2015. Brazil is among the ten countries with most suicides worldwide (in absolute numbers), and it has the fourth highest mortality rate among people between 15 and 29 years of age<sup>3,5</sup>. In the state of Minas Gerais, the suicide rate grew from 4.29 (deaths/100,000 inhabitants), from 1996 to 2007, to 5.33 (deaths/100,000 inhabitants) from 2006 to 2009<sup>6</sup>.

Suicide requires a critical and detailed look, as countless people try to take their own lives both worldwide and in Brazil, and it is necessary to recognize suicide prevention strategies, especially in the scope of primary care, which represents the “gateway” of health services.

Currently, there are several factors that contribute to suicide: biological, medical, environmental, psychiatric and psychological, philosophical-existential and social motivations, therefore being a multidimensional phenomenon<sup>7-8</sup>.

In general, people with suicidal behavior in adulthood experience situations of personal, professional or family failure, social disapproval, loneliness, lack of social support network, and bad prognosis of chronic diseases<sup>9</sup>.

Personal failure, social disapproval and loneliness can come from external, biological or psychiatric problems such as depression, unemployment, death of a loved one, physical disability and constant exposure to stress, thus exacerbating a mental health state already affected by all external turbulence the individual may suffer<sup>10-11</sup>.

Depression, schizophrenia and mood disorders are among the mental disorders that cause the highest predisposition to suicide, so that 90% of people who commit suicide have any of these disorders<sup>9</sup>.

Such disorders are frequent. Depression is an interlocutory appeal that affects about 4.4% of the world's population. There are 75,000 new diagnoses of schizophrenia in Brazil every year, which represents 50 cases per 100,000 inhabitants. And the incidence of mood disorders ranges from 0.5% to 1%<sup>12-13</sup>.

Mental disorders are recurring in Brazil and the world, and they tend to predispose to suicide, especially when paired with contemporary psychosocial problems (unemployment, economic and political crises, among others).

In 2020, the world experienced the COVID-19 pandemic, that represents the largest sanitary, economic, social and political crisis of the 21<sup>st</sup> century. The pandemic has aggravated several problems in society, such as unemployment, sedentary lifestyle, depression, eating disorders, stress and emotional disorders. Such factors, in turn, are remnants of social isolation and also the loss of loved ones due to the virus<sup>14</sup>.

The need for social distancing, along with the background of mental disorders, can culminate in a suicide attempt. Thus, it is necessary to broaden the discussions about the implications of social distancing to mental health and the prevention of suicide, in view of the non-consummation of the act<sup>15</sup>.

In Brazil, Primary Health Care should establish actions for the sake of mental health through multidisciplinary monitoring with the distribution of medicine, and it is expected that there is a greater proximity to users and their families, which favors knowing the life story of people and their bonds with the community, and family members, suffering, anguish and mental illnesses, for better approach and understanding of suicide, especially because, in Primary Health Care (PHC), mental health care is strategic for the ease of access of access teams to users<sup>1,16</sup>.

PHC has the potential to develop two main types of mental health actions: detection of complaints related to psychic suffering, through qualified listening; and understanding the various ways of dealing with the problems detected, offering treatment in the health units themselves or referring to specialized services<sup>17</sup>.

From PHC singularities, the General Coordination of Mental Health developed guidelines for mental health care at PHC, such as: matricial support in mental health with Family Health Program teams; prioritizing mental health in the formation of teams; monitoring and evaluation actions of mental health actions; creating matricial support teams to develop supervision actions, shared care and training in service<sup>17</sup>.

Thus, it is considered important to recognize the interventions for the prevention of suicide developed by professionals working in the PHC, because it is believed that professionals who work at this level of attention can more easily identify people predisposed to this act and thus try to avoid it<sup>18</sup>. From this perspective, this study aimed to identify interventions for suicide prevention developed by professionals who work in health care.

## METHODS

This is a descriptive study with qualitative approach developed with the Family Health teams (FHS) that work in the urban area of Sanitary District II and III of a city of the Triângulo Mineiro region. The choice of these districts is due to the fact that they do not have any specialized mental health services (psychosocial or outpatient care centers), which makes the community's mental health demands closely followed in PHC.

Higher level professionals (doctors, nurses and dentists) were considered to be part of the Family Health Teams and the following inclusion criteria were established: to have at least six months of expertise in the area of scope and to have one year or more of graduation. The exclusion criteria were: to be on leave from work activities due to illness, maternity leave or vacation and work with the Extended Family Health Center (*Núcleo Ampliado de Saúde da Família* - NASF).

Data collection was held from June to November 2020, which was preceded by the signing of the Free and Informed Consent Form by each of the participants and occurred during the professional's working hours, when a semi-structured interview was conducted, following a script previously prepared by researchers and validated by professionals specialized in mental health. This script contained two open questions that addressed suicide prevention strategies.

For data analysis, transcription was performed in full and databases were built in the Microsoft Word™ program, which was succeeded by reading and extraction of essential elements to constitute the Collective Subject Discourse (CSD). Among the elements, the following stood out: evidence of central ideas, key expressions and converging and divergent aspects in speeches<sup>19</sup>.

In the analysis of the data, DSCsoft™ was used, which is a software based on the CSD theory. It analyzes the speeches and from them highlights the Central Ideas (CI) that express the meaning of the reports and the Key Expressions (KE) that represent the aspects present in the speeches, as well as the possibility of measuring the frequency in which some words appear, which corresponds to the KE that must be grouped in a speech to represent the collective conception<sup>19</sup>.

This work was approved by the Universidade de Uberaba Research Ethics Committee - UNIUBE (CAAE: 20428719.00000.5145), with an Approval No. 3,660,848.

## RESULTS

66 professionals participated, of which 28 (42.42%) were nurses, 19 (28.79%) were dentists, 18 (27.27%) were doctors and 1 (1.52%) did not report their professional category. Of the total professionals, 54 (81.82%) were female. Most (53.03%) had graduated over 10 years before. There was a predominance of professionals who worked between 2 and 4 years in PHC (40.91%) followed by those who worked for over 10 years (34.85%). Most (70.0%) had a postgraduate degree in Family Health.

Of the speeches, two CSDs emerged, which had the themes: *Identification of signs that express risk of suicide* and *Measures for suicide prevention*. Each theme is related to a central idea. CSD 1 represents the discourse of 64 participants and CSD 2 corresponds to the discourse of 52 participants.

The first discourse refers to the identification of signals that indicate risk of suicide and the second discourse is related to the actions used by professionals to prevent suicide.

### Theme 1: Identification of signs that express risk of suicide

CI 1: Hopelessness, apathy, withdrawn behavior, report of desire to die and abandonment of treatment represent the main signs for suicidal risk.

CSD1: We always must explore the causes of abandonment of treatment (it may be psychiatric treatment or any other health problem) which is a very frequent sign in these patients at risk of suicide. This is often accompanied by hopelessness, apathy and withdrawn behavior. After talking a little more with the patient, they often say they want to die and then we detected that they require specialized treatment. We believe that by investigating these signs in Primary Health Care we are preventing suicide in people at risk.

### Theme 2: Measures for suicide prevention

CI 2: Support groups, lectures, referral to the psychologist and health promotion represent measures to prevent suicide.

CSD 2: There are no specific measures for people who have signs, as they are referred to specialized services (Psychosocial Care Center, outpatient clinics and even emergency care unit), but in the work routine, support groups are developed that help people to live happier lives and when they have emotional problems, they are referred to the psychologist. The health promotion that we develop all the time also helps to prevent it, because the person is not divided into body and mind.

## DISCUSSION

Early identifying mental illness and suicidal behaviors is paramount to suicide prevention, which needs to be implemented in PHC, by protagonism in the Health Care Network (HCN) under the Unified Health System (SUS)<sup>16</sup>. Identification conduct was pointed out as a strategy to prevent suicide.

Tracking signs that represent a suicidal risk was mentioned as the main intervention for early identification and, among these signs, hopelessness, apathy, introverted behavior, report of the desire to die and abandonment of treatment stand out, which corroborates another work<sup>20</sup> that expresses the demonstration of these risk signs in the family and community context, which constitutes the performance scenario of PHC services.

Light technology permeated by bonding and welcoming is predominantly used in PHC services and this allows professionals to pay attention to the verbalizations of suicidal behavior represented by the following speeches and feelings: *I feel like a burden to those around me, I feel hopelessness, sadness, low self-esteem, impulsiveness and I plan my death*<sup>21-22</sup>.

However, there is still frequent negligence of PHC professionals in the face of these signs<sup>23</sup>, which did not seem to be part of the practice of those surveyed, which does not exempt the need for municipal managers to sensitize and equip these professionals, increasingly valuing these signs of people assisted in the areas where they work, as it is possible to preventively intervene in more than half of the cases in which there is suicidal ideation/intent<sup>23</sup>.

Suicide prevention should also be worked on with the general population in the daily life of the PHC, as mentioned (support groups, lectures and health promotion) and this corroborates the recent investigation, which points to the need to offer support community<sup>24</sup> to favor people's ability to face conflicts and to empower them to build their health.

However, in the work presented here, referral to a psychologist was the only measure adopted for people who have suicidal behavior. This demonstrates that it is necessary to expand measures such as: reducing access to the means used for suicide (pesticides, firearms, medicines and others); follow-up with students, track risks, provide access to specialized mental health services for people with mental disorders and/or who abuse psychoactive substances, as well as those who have attempted suicide and/or have chronic pain and acute emotional suffering<sup>24</sup>.

In this sense, WHO also recommends the following interventions: providing accurate information on where to seek help; educate the public about the facts and prevention of suicide

without spreading myths; reporting stories of coping with life stressors or suicidal thoughts; be careful with the suicide communication and know how to guide the victim's relatives<sup>25</sup>.

In general, it should be added to the attentive look of PHC professionals to identify suicidal risk, awareness of the dissemination of suicide prevention strategies, through educational interventions that enable people to face challenging situations<sup>26</sup>, especially among people who show suicidal behavior and this expresses the importance of knowing the WHO protocols and the suicide prevention strategies adopted in Brazil<sup>27</sup>.

The reality evidenced in this investigation corroborates PAHO's notes, which express that there are still technical, operational and scientific "gaps" in relation to this theme, which reinforces the importance of carrying out interventions for the prevention of suicide<sup>28</sup>.

## CONCLUSION

Among the interventions for suicide prevention that are most developed by professionals who work in Primary Health Care, the following stand out: the recognition of signs that express risks represented by abandoning treatment, hopelessness, withdrawn behavior, reports of a desire of suicide and apathy.

Faced with these signs, these professionals refer people to specialized mental health services, which expresses the measure adopted to prevent suicide for this specific public.

However, it was found that there are measures aimed at the general community, which involve the daily work of the PHC (support groups, education and health promotion) and were mentioned as strategies to prevent suicide, as they favor empowerment of the community to face adverse situations and the continuous follow-up of these people favors the early identification of suicidal risk.

Among the limitations of this investigation, we highlight the fact that it was developed only with higher education professionals who work in Family Health Strategy teams and it would be interesting to expand the investigation among other team members who establish continuous and prolonged contact with the community, such as Community Health Agents and mid-level nursing and dental professionals.

However, it is believed that the results presented here may favor the understanding that suicide prevention strategies can occur at all levels of health care and not just in specialized mental health services, and the possibility of reviewing practices in PHC.

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**Associated Publisher:** Rafael Gomes Ditterich.

**Conflict of Interests:** the authors declared there is no conflict of interests.

**Financing:** none.

#### CONTRIBUTIONS

**Marciana Fernandes Moll, Aldo Matos, Gabriela Alexia Cardoso Costa, Julia Caxito Sangiovani and Lorryayne Rocha Camargo** contributed to the conception, collection and analysis of data, writing and revision. **Carla Aparecida Arena Ventura** collaborated in the writing and revision.

#### How to cite this article (Vancouver)

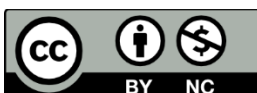
Moll MF, Matos A, Costa GACC, Sangiovani JC, Camargo LR, Ventura CAA. Interventions for suicide prevention in Primary Health Care. Rev Fam, Ciclos Vida Saúde Contexto Soc. [Internet]. 2023 [cited in *insert day, month and year of access*]; 11(1):e6421. Available from: *insert access link*. DOI: *insert DOI link*

#### How to cite this article (ABNT)

MOLL, M. F.; MATOS, A.; COSTA, G. A. C. C., SANGIOVANI, J. C., CAMARGO, L. R., VENTURA, C. A. A. Interventions for suicide prevention in Primary Health Care. **Rev. Fam., Ciclos Vida Saúde Contexto Soc.**, Uberaba, MG, v. 11, n. 1, p. e6421, 2023. DOI: *insert DOI link*. Available from: *insert access link*. Access in: *insert day, month and year of access*.

#### How to cite this article (APA)

Moll, M.F., Matos, A., Costa, G.A.C.C., Sangiovani, J.C., Camargo. L.R., & Ventura, C.A.A. Interventions for suicide prevention in Primary Health Care. (2023). Intervenções para a prevenção do suicídio na atenção primária à saúde. *Rev. Fam., Ciclos Vida Saúde Contexto Soc.*, 11(1). Retrieved in *insert day, month and year of access* from *insert access link*. DOI: *insert DOI link*.



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