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Improvements to suicide preventive therapeutic practices in the brazilian Unique Health System – UHS

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ABSTRACT
Suicide is a public health problem. Besides the reduction in suicide taxa worldwide, in Brazil, this index is still growing. The adult population presented the bigger taxa of suicide mortality. Because of this, review the literature to identify preventive practices that can contribute to the improvement of current methods in the Brazilian Unique Health System. Were reviewed articles from PubMed and LILACS databases, applying the key words suicide, prevention and intervention, and the criteria of time among 2015 to 2020, available as an open-access resource. Following these criteria were analyzed three articles with studies carried out in Europe and focused on preventive practices against suicide. Obtaining that all new therapeutic involve self-report analyses due to confidence relationships between psychotherapists and patients. Applied psychometric tests are simple, analytically consistent, and easily adaptable to all health systems, measuring the suffering levels or possible suicide ideation. In Brazil, the Psychosocial Centers receive and follow patients with multiple psychological and/or psychiatric disorders. However, still hasn't been a standard to evaluate psychological suffering or even good practices to prevent suicide. As the main result, the present literature review indicated the alternatives to improves psychological reception to patients with suicide ideation. Suicide prevention through psychometric evaluations represents more than an alternative to reduces this class of intentional death. Implies in reductions of public investments to treatment, and patients live quality improvement through their life.

Keywords: Prevention, Suicide, Psychological evaluation.

1 INTRODUCTION

The World Health Organization (WHO) defines suicide as an intentional act by the individual to extinguish his or her own life (ASSOCIAÇÃO BRASILEIRA DE PSIQUIATRIA, 2020). Suicide has a multifactorial etiology, as there are numerous reasons that can culminate in this decision, and

among them are biological, social, psychological, and psychiatric factors (CORONEL; WERLANG, 2010). Along with this, many psychiatric conditions are associated with suicidal behavior. It is conceivable that about two-thirds of patients with suicidal behaviors present, for example, Major Depressive Disorder, among other psychopathologies (RYBERG *et al.*, 2019).

More than 800,000 people are known to commit suicide every year, which corresponds to about 1 to 4% of all deaths in the world. Suicide is already considered the second leading cause of death in the population aged between 15 and 29 years, behind only car accidents (WHO, 2019). Worldwide, the data showed that the prevalence of suicide in 2016 was 10.5 per 100,000 people. In addition, it is estimated that the rates of attempts are about ten to twenty times higher than those with a fatal outcome (CORONEL; WERLANG, 2010); that is, for every effective occurrence of suicide, another 10 to 20 unsuccessful attempts must occur (ZALSMAN *et al.,* 2016). In the United States alone, hospitalization costs for patients who have attempted suicide are around 4.7 billion dollars, with more than 1 million patients hospitalized per year (GYSIN-MAILLART *et al.*, 2016). Therefore, to avoid the worst outcome, interventional actions with patients from vulnerable groups need to be applied from a first attempt, or even earlier, through the identification of signs and symptoms that indicate suicidal ideation or risk. Considering the most vulnerable group, in the age group of 15 to 29 years, there is an urgent need to develop assessment and intervention strategies that are applicable to this population, significantly reducing the occurrence of suicide attempts and suicide in the young population.

Despite this scenario, in September 2019 the WHO reported that the suicide rate in the world, from 2010 to 2016, showed a reduction of 9.8%. On the other hand, in Brazil there was an increase of 7% in the same period (WHO, 2019). Although Brazil is the eighth country in the world in absolute number of suicides (ASSOCIAÇÃO BRASILEIRA DE PSIQUIATRIA, 2014), researchers believe that there is an underreporting of cases, combined with a low quality in the completion of death certificates (LOVISI *et al.,* 2009), which can generate lower rates, which do not reflect the real situation in the country.

Suicide is a potentially preventable cause of death, and therefore, the application of public policies that enable the reduction of rates is indispensable, especially in Brazil, due to the percentage increases recorded in the last decade. In view of this, some strategies have been developed in attempts to reduce the prevalence of deaths by suicide in the country, such as the "Yellow September" (ASSOCIAÇÃO BRASILEIRA DE PSIQUIATRIA, 2020), an awareness and prevention campaign. Created in 2015, it proposes to associate yellow with the month **that includes World Suicide Prevention Day, on** September 10. This is a period in which awareness on the subject is made by the dissemination of therapeutic and care alternatives, to help those who may be in psychological distress.

In this sense, it is contemplated that the risk of suicide has some characteristics that can be previously evaluated by health professionals, and that would help in the prevention of new cases.

Among them, the most important is the duty to be alert to new suicide attempts after a previous attempt, as the risk increases considerably (MICHEL *et al.*, 2017). In addition, the presence of negative symptoms, such as anhedonia, hopelessness, lack of future prospects, low self-esteem, and self-mutilation, should activate closer care from competent professionals.

Psychiatric diagnoses are only risk factors, that is, they do not fully explain an individual's choice for suicide (ASSOCIAÇÃO BRASILEIRA DE PSIQUIATRIA, 2014). This fact has led scholars to question whether specific treatment for psychiatric conditions is really effective in reducing risk factors and suggests that, in fact, specific treatments for suicidal ideation may be more effective in reducing the risk of suicide and suicidal behaviors (RYBERG *et al.,* 2019). In this context, interventional methods and therapeutic practices have been developed worldwide, in order to optimize preventive results concomitantly with the reduction of time and costs related to treatment. In Brazil, there are still no reports that are recognized by us about the revisiting and specific development of protocols for the prevention of suicidal ideation. However, the problem of suicide among men and women is already recognized, and requires different approaches, including considering the risk factors inherent to each sex (VIEIRA *et al.*, 2021). The training materials available are adaptations of the WHO manuals and recommendations, which does not guarantee clinical effectiveness and sociocultural adequacy for a more successful intervention and prevention.

In view of this scenario, there seems to be a need to develop a literature review that seeks, within the world's scientific production, the intervention methods that are most effective in the clinical practice of suicide prevention. These therapies should also focus on the adult population and on an outpatient basis, because as already highlighted, currently the young population is the one with the highest suicide rates, and intervention methods for this age group should be prioritized. Finally, interventions should be intended to have a low level of complexity, but with long-lasting effects and a good cost-benefit ratio, which democratizes their application and allows replicability in numerous health systems. These precautions in the search for alternative intervention protocols should prioritize the improvement of the current methods employed in primary care of the Unified Health System in Brazil. With this, it is expected to contribute to the reduction of suicide attempts in the country, by identifying points of improvement to the protocols currently employed.

Thus, the present study sought to carry out a systematic review of the literature to answer the following question: what are the intervention methods, currently applied, that focus on the prevention of suicidal behavior in the general population, and that are effective for a low-cost intervention in primary health care? Based on the data obtained, the objective is a critical description of the methods employed, their effectiveness, replicability and potential for adaptation to countries with increasing suicide rates in the young population, as is the case of Brazil.

2 MATERIALS AND METHODS

The present study consists of a systematic review, adapted from the PRISMA system (ITENS *et al.,* 2015). The search was carried out by two independent reviewers simultaneously, between August and October 2019. Two databases, PubMed and LILACS, were used in order to verify a global and Latin American overview of the theme.

For the search engine, the keywords suicide, *prevention and intervention*, *included in the search interface of the selected platforms, were simultaneously used*. Last 5 years *and* Clinical Trial *filters were applied*. The choice of filters was based on the fact that the present study focused on the most recent methods disseminated for suicide prevention intervention, and that have proven their efficacy through randomized clinical trials, with statistics that reflected the reduction of suicidal ideation and/or attempt.

Articles in English, Portuguese and Spanish were accepted, and were fully available in the respective databases. Initially, as a result of the process of searching and applying the filters, the 206 studies found were compiled. Subsequently, the abstracts of the papers were read, when a selection questionnaire was applied to analyze the articles that corresponded to the desired criteria. The form was developed according to the recommendations of the Brazilian Ministry of Health (BRASIL, 2012). The criteria set out herein are described in detail in sequence.

The selection took place in stages, in which the sequential fulfillment of the criteria determined the inclusion or exclusion of the work from the database. After the first reading, all works that presented "themes that were totally outside the scope of investigation", that is, did not deal with suicide, were discarded. Subsequently, studies that did not constitute randomized clinical trials and those that reported a theme other than an intervention for suicide prevention were withdrawn. For example, some publications showed interventions that prevented suicide, but were actually a consequence of the treatment of another psychiatric comorbidity, such as therapy for depression and that, finally, also reduced the symptoms of suicidal ideation, but did not focus on its prevention. All studies that presented only preliminary data, or that could not have their statistical efficacy proven, were also withdrawn.

Sequentially, studies that did not deal with interventions directly applied to patients, but rather actions with agents or health professionals in contact with suicidal patients, were excluded. In the next step, in accordance with the objective of the present study to find effective prevention interventions applicable to adults and generalists, articles that covered only specific populations, such as certain age groups, health conditions, or professions, were discarded. In the end, articles that were not fully available in open access format were excluded, to ensure access to the data by all audiences.

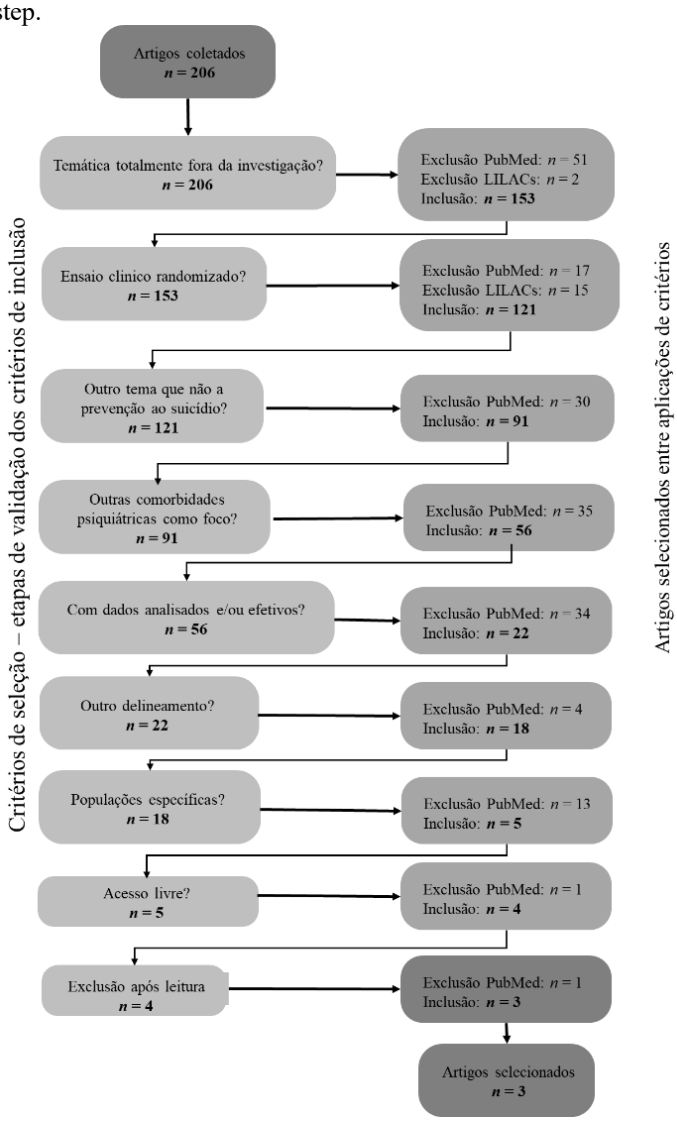
3 RESULTS

3.1 DATABASE VALIDATION

After compilation, of the 206 articles found, 189 were from the PubMed database and 17 from the LILACS database. According to the exclusion criteria adopted, 203 studies were excluded from the overall composition of the database, as shown in Figure 1. The three studies analyzed met all the criteria selected at the beginning of the research and were established as parameters for inclusion of the studies in the database.

It is noteworthy that all articles in the LILACS database were excluded, as none of the studies met the established criteria. The exclusion of the articles from this database was since 2 had a theme that was totally outside the investigation, i.e., their content did not concern suicide, and 15 because they were not randomized clinical trials.

Figure 1 - Schematic representation of the stages of literature selection, and application of search filters to the articles evaluated. In each step, the values of articles excluded after applying the filter are presented, and the number of articles evaluated in the subsequent step.



Source: Prepared by the authors (2021).

All selected studies originated from European countries, were published in English and in international journals, presenting a comparative analysis between a new therapy and usual therapy. As the analysis focused on therapeutics for young adults was desired, the mean age obtained in the selected studies was 37.3 years, fulfilling the initially proposed objective. For content analysis purposes, details on the therapies and methods adopted in the studies will be presented in the following items, and a brief summary of the data is presented in Table 1.

Table 1 - Summary of data for the therapies analyzed in the present study.

Descriptor	Study 1	Study 2	Study 3
Authorship	Ryberg et al. (2019)	Ducasse et al. (2018)	Gysin-Maillart et al. (2016).
Qualis / Impact Factor	A1a - 3,892b	A2a-14,864c	A2A – 10,500D
N° of participants	78	40	120
Average age	35,9	38,2	37,8
Method of intervention applied*	Collaborative Assessment and Management of Suicidality (CAMS).	Acceptance and Commitment Therapy (ACT) e Relaxation.	Attempted Suicide Short Intervention Program (ASSIP).
Duration of sessions	50-60 min	2h	60-90 min
Duration of therapy	Average of 17.8 weeks	7 weeks	3 weeks
Follow-up after therapy	Up to 12 months	3 months	Up to 24 months

Note: a https://sucupira.capes.gov.br/sucupira/ (CAPES, 2020). B https://www.journals.elsevier.com/journal-of-affective-disorders. C https://www.karger.com/Journal/Home/223864. D https://journals.plos.org/plosmedicine/, Recuperados em 03 Agosto, 2020.
(*) The name of the therapies and their respective acronyms are presented in English, according to the original language of publication.
Source: Prepared by the authors (2021).

The detailed description of the methods of application of each therapy, in the following sub-items, aims to enable the perception of the differences and congruences between them. In addition, it presents to readers in the health area a theoretical basis on the application of the treatment methods exposed, and a comparison to the traditional methods applied as a therapeutic basis in different countries.

3.2 SYNTHESIS OF CAMS, ACT AND ASSIP THERAPIES – THEORETICAL REVISITING OF THE METHODS EMPLOYED

3.2.1 Description of the CAMS method

The study developed by Ryberg et al.3, in Norway, evaluated the efficacy in reducing suicidal behavior using the CAMS method, loosely translated here as "Collaborative Assessment and Management of Suicidality" (ACGS).

CAMS translates into a patient-centered method, with humanistic values and an empathetic posture (MICHEL; JOBES, 2011), so that suicidal thinking and behavior are the main focus of therapy. The goal is to identify and deactivate suicide drivers (hereinafter, called "triggers"), that is, factors that

lead the patient to consider suicide as the only solution. These factors can be direct, such as specific situations, thoughts, or behaviors that increase mental distress, or indirect, such as past traumas, that make the person vulnerable. To this end, during the therapeutic process, patient and therapist work as a team, trying to understand the reasons for moments of crisis.

The central therapeutic tools and features that permeate the process in CAMS therapy include the systematic and collaborative use of multi-purpose assessment, planning, and treatment strategies, called the Suicide Status Form (SSF) (JOBES *et al.,1997),* and the establishment and agreement of a comprehensive treatment plan, where suicidal triggers are addressed and assessed at each session. Each CAMS therapy session begins with the completion of the SSF form, classifying suicidal markers (psychological pain, stress, agitation, hopelessness and self-hatred) on a Likert scale (from 1 to 5), in addition to the therapist making a subjective assessment of suicide risk. In the first session, the patient was also asked to provide a qualitative description for each suicidal marker (i.e., what specifically makes him feel hopeless or agitated) and to rate these items on the SSF, on a scale from lowest to highest importance.

The CAMS structured stabilization plan is compiled during the first session and modified with each consecutive session. This plan addressed limiting access to lethal means, warning signs for suicidal thoughts and behaviors, coping strategies, ways to reduce isolation, a list of people to contact before and during the crisis, and potential obstacles that could appear.

The strict focus on identifying, questioning, and modifying suicidal thoughts, suicidal behaviors, and suicide triggers was maintained, until the patient was no longer suicidal, as operationalized by three consecutive sessions in which he rated himself with a score less than or equal to 2 on overall risk, while also effectively managing suicidal thoughts and feelings. After the end of the method, the patient could follow the therapeutic treatment with a focus on other psychic comorbidities3.

3.2.2 Description of the ACT method

The study by Ducasse *et al.* (2018) aimed to analyze the efficacy of the ACT method, here translated as "Acceptance and Commitment Therapy" (TAC). This consists of a behavioral therapy, which aims to change the subject's relationship with their psychological and contextual experiences. It targets experiential avoidance, i.e., the tendency to avoid unwanted thoughts or emotions, and cognitive dysfunction, in the sense of changing the way the individual interacts and relates to thoughts, through the creation of contexts in which harmful functions are diminished (FREITAS *et al.*, 2014). It seeks to train psychological flexibility, the ability to get in touch with one's values and engage in behavior congruent with them, seeking to help patients learn how to: i. accept inevitable events and simply perceive them as transitory mental events different from the self; and ii. identify and participate

in value-driven actions (DUCASSE *et al.*, 2018).

Patients under ACT therapy, at the end of each session, received a written summary to help them practice the skills worked on at home, as well as behavioral impairment exercises. The psychotherapeutic protocol was based on the books describing the ACT, and other selected references, such as the study by Ducasse *et al.* (2014). The sessions followed a standard process of reviewing homework, new therapeutic skills, and the distribution of written abstracts. Three evaluation sessions were planned with the patients: the first of "inclusion or pre-treatment", 2 weeks before the start of therapy; the second "post-therapy assessment" session within the first week after completion of therapy, and the third and final after 21 weeks of completion of therapy (follow-up). During the evaluations, sociodemographic and clinical data, including suicidal characteristics and medication use, were recorded (DUCASSE *et al.*, 2018).

3.2.3 Description of the ASSIP method

In the study by Gysin-Maillart et al.6, the Swiss researchers developed a treatment model called ASSIP ("Short Intervention Program for Suicide Attempt"), which aims to be a rapid and easy-to-implement intervention program. One of the main goals of ASSIP is to implement safety strategies for suicidal behavior, not to reduce suicide rates. As part of the treatment, patients were told that suicide attacks could be triggered again at any time in the future.

The ASSIP treatment program was planned for application in 3 weekly sessions, with a fourth session being added, if necessary, according to the patient. The first session is a narrative interview, in which the patient is asked to tell personal stories of how he or she came to the suicide attempt. The objective of this narrative interview is to understand the individual mechanisms that lead to suicidal behavior, by elucidating the vulnerability factors and triggering events of suicide crises. All interviews are videotaped, with the patient's written consent. In this first session, the SSF-III questionnaire is also used to identify the patient's risk of suicide6.

In the second session, patient and therapist watch together the sequences of the recording of the first session. The goal of this step is to reactivate the patient's mental state during the crisis in a safe environment, and to provide a detailed reconstruction of the transition from an experience of pain and psychological stress to suicidal action. Automatic thoughts, emotions, psychological changes, and contingent behavior are identified. In addition, the patient receives a psychoeducational leaflet, arguing that suicide is not a rational act, as a task to be brought up with personal comments in the third session. In the third and final session, the patient's written comments are discussed. The case is reviewed collaboratively between therapist and patient. A list of long-term goals, individual warning signs, and safety strategies are developed in cooperation with the patient, and copied into a tiny leaflet (the size of a credit card). The conceptualization of the case, along with personal safety strategies and a list of

private phone numbers of professionals who can be contacted in cases of crises, are printed and delivered to the patient. The patient is instructed to carry the two leaflets with him at all times, and to use them in the event of a seizure. As a follow-up, the patient received letters every 3 months in the first year, and every 6 months in the second year, reminding him of the long-term risk of suicide and the importance of safety strategies. The letters were personalized by the therapists of the ASSIP program.

3.2.4 Intervention in the Unified Health System in Brazil: analysis of protocols and methods of approach

The Unified Health System (SUS) in Brazil is a reference when it comes to free and universal clinical care. Established by the Federal Constitution of 1988 (BRASIL, 1988), it offers from simple outpatient and hospital services to highly complex procedures. In this way, the entire population is supported by free access to quality health (FIOCRUZ, 2020; BRAZILIAN MINISTRY OF HEALTH, 2015).

On the other hand, when the availability of psychological and psychiatric care services is assessed, gaps can be pointed out within their structure. Care is centralized in Psychosocial Care Centers (CAPS) and Reception Units (UA) (BRASIL, 2015). The latter are specific for the home and inpatient treatment of patients who need constant monitoring (i.e., disorders resulting from drug abuse or situations of social and psychological vulnerability).

The CAPS, created and implemented in the late 1980s, have as their fundamental role the reception, follow-up and treatment of patients with psychiatric and psychological disorders. These patients are part of society and should be treated in a way that is monitored by health agents, instead of being hospitalized in an asylum form. In the CAPS, care is provided by a multidisciplinary team, which includes psychologists, psychiatrists, clinical physicians and nursing professionals. In addition to the patient, family monitoring and support are also offered, so that everyone can have access to individual or collective therapy practices (BRASIL, 2015).

Unfortunately, in clinical practices there is no single establishment of protocols and approaches focused exclusively on suicide prevention, which are developed within the Brazilian sociocultural context. Currently, the manuals used by the SUS are derived from translations and adaptations of the manuals of the World Health Organization (ORGANIZATION MUNDIAL DA SAÚDE, 2000). In these manuals, when suicide prevention is addressed, it is observed that the recommendations are therapeutic practices based on the establishment of a contract of trust, where the patient can communicate empathetically with the health professional (D'OLIVEIRA, 2006; WORLD HEALTH ORGANIZATION, 2000). This, in turn, should listen without judgment, interventions or judgment bias, welcoming the patient and identifying some key points:

- If there are any other psychic comorbidities that contribute to suicidal ideation;
- The patient's current mental state, and possible influence of narcotics and/or medications;
- The current state of planning in relation to the idealization of death;
- And the support and support network in the patient's surroundings, consisting of family members, friends and other health professionals.

Although these practices are in line with the therapies previously analyzed, the suicide prevention manual for health professionals lacks methodological structuring. Initially, no type of methods and protocols for the approach to the patient are indicated, indicated or patched. Thus, it can be seen that primary care in suicide care and prevention still consists of mostly intuitive interventions, based on the perception of the health professional and his previous experience, without counting on metrics or instruments for monitoring or measuring psychological suffering, which can result in an attempt and even a suicidal outcome.

Another important point is related to the contribution of these interventions to future clinical studies and the development of specific protocols for the SUS. With the lack of standardization in intervention methods, it is not possible to establish evaluation points for the efficacy of the proposed therapy, nor a temporal evaluation to propose improvements to the developed protocols. Thus, we sought to draw parallels between the therapies raised in the literature review, discussing and suggesting a structure for the preventive clinical intervention for suicide in Brazil, as an improvement to the current manuals available for professional training and psychological care in CAPS.

4 DISCUSSION

4.1 CONSIDERATIONS ON THE WORLDWIDE PRODUCTION OF LITERATURE FOCUSED ON SUICIDE PREVENTION

The first objective of this study was to analyze the worldwide scientific production on effective suicide prevention methods, and to systematize the results found for the critical analysis of a possible universalization of the methods applied to countries with high and/or increasing suicide rates, as is the current case of Brazil. A gap in the production of scientific articles on the development of new therapies was found, since only 3 studies met all the criteria explained in the search filters. Still, of all the articles examined, 153 studies addressed suicide as a theme, and at least 91 demonstrated some form of intervention to prevent it. The significant amount of research on the subject converges with the epidemiological data on suicide, which demonstrate the prevalence of the phenomenon as a significant portion of deaths worldwide4. Although developed countries have shown a reduction in mortality by suicide, an important portion of the population is still lost to this preventable cause of death, which calls for measures to reduce the outcome. Especially in underdeveloped countries, such as Brazil, where suicide rates are increasing, intervention and application of more effective preventive methods

is urgent.

In view of the analysis carried out, it was noticed that developed countries perform much more innovative preventive strategies. In comparison, the scientific production of Latin America was small, and all the articles in the LILACS database, which mainly includes Latin American studies, were discarded in the process of applying the filters. This fact allows us to understand the reasons why mortality due to self-harm has been reducing over the years in first-world countries, but not in Brazil and still slowly in Latin America. This fact may indicate a stagnation of research in the area of health focused on the modernization of the treatment of suicidal behavior, identified by the low number of publications with evidence testing. In order to reduce the current suicide rates, it is necessary to improve preventive methods, since there are still few studies that demonstrate a real efficacy in reducing suicidal behavior, and that these methods are applicable to the general public at low cost.

The three studies analyzed were developed in the European continent, and demonstrated the efficacy in preventive therapies to the detriment of traditional practices of intervention and suicide prevention, currently applied in their respective health systems. In addition, the results of these showed greater efficacy when compared to these traditional therapies. However, it is worth noting that the three studies analyzed here lack more in-depth data regarding the usual therapeutic practices applied to which they were compared. There are descriptive gaps to these traditional methods in all studies, and additional information on all therapeutic practices available and recommended by health agencies for suicide prevention. Furthermore, as other possible therapies available and/or applied are not mentioned, it is not possible to infer whether the proposed alternative practice would have the same efficacy in relation to other existing methods. Likewise, it is not possible to extend this comparison to other therapeutic practices applied in other countries. Therefore, caution is needed when comparing the effectiveness of the methods analyzed, with specific case studies for comparisons to other intervention practices.

It is worth noting, however, that the new therapies proposed showed positive results in the long term, with a reduction in suicidal ideation in the groups evaluated, compared to traditional methods. Despite this, the answer to the question "what would be the best treatment method to prevent suicide?" cannot yet be fully defined based on the present results. Even so, as demonstrated in the three studies analyzed, the progressive transition to these new therapies, or at least the association between them and conventional therapies, is necessary to obtain better preventive and long-term results. With this, the population considered at risk will be able to find effective therapeutic alternatives in case of crisis situations, increasing the preventive power before the suicide attempt occurs.

The fact that there is still no fully effective therapeutic model for suicide prevention sends the message that this problem may not have a solution. However, one cannot fail to analyze the multifactorial nature of the phenomenon, which makes it complex, and lacks interactive and

associative efforts by competent bodies and health professionals. From the moment that new therapies are likely to be used, and present significant results in reducing suicide rates, efforts should not be spared to apply them widely. The health professional, using the right tools, has the possibility of rescuing hope in people's lives, by restoring their perspective for the future.

Thus, the insertion of the practice of linking to the traditional methods already adopted can be a strategic solution for the adaptation and implementation of these therapeutic approaches for the most different health systems, especially primary care. Associatively, with greater public and private investments, and the performance of interested and properly trained health professionals, to put into practice the therapeutic methodologies analyzed through this study and their due particular adaptations, more lives can be saved, contributing to a reduction in suicide mortality rates in the world scenario.

4.2 CONSIDERATIONS FOR STRUCTURING THE METHODS OF INTERVENTION AND SUICIDE PREVENTION OFFERED BY THE SUS

According to the literature survey, it can be seen that the therapies used in these studies presented models that were easy to apply in different health systems. This is because, in the three therapies described, the quantification of the risk of suicide is performed using forms composed of simple and objective questions to be answered. In addition, through an analysis based on the answers provided by the patient, and on their mental health status at the time of the interview, the work is developed, together with a qualified therapist, in order to avoid the mental triggers that corroborate the suicide attempt from being activated. With this, it is possible for the individual to perceive risk situations, identify the moments and thoughts that can provoke a suicide attempt, and appropriate tools to seek help and activate trusted contacts. These are crucial measures to avoid suicidal outcome.

From the moment the patient is aware of his pathological condition, he learns to be more attentive to the signs of danger to himself. Self-knowledge contributes to reducing suicide attempts, by avoiding situations that trigger these thoughts, in addition to helping to maintain control and know what measures the individual should take to avoid suicide. In addition, the three methods analyzed highlight the importance of individual commitment to the therapeutic practice, to the health professional who guides him/her, and the value of establishing the patient-professional-method bond in the effectiveness and longevity of the therapeutic results.

Specifically for Brazil, as highlighted, the use of simple forms and the interaction between therapist and client can be a facilitator in suicide prevention. In addition, the methods analyzed have a low cost of implementation, and it is necessary to modify and complement the academic training of health professionals for their correct application and adaptation to the cultural and social reality of the country.

As pointed out by Menezes and Murta (MENEZES; MURTA, 2018), the importation of clinical

intervention methods can have high associated costs, since they require the purchase of didactic and advisory materials for professional training. In addition, the authors highlight the need to adapt to the cultural and social realities of the country of application, which in the case of Brazil, incorporate multiple realities of difficulty in accessing psychological treatments by the general public. Even so, the methods investigated here are accessible for consultation by professionals, with articles available in open access, and the adaptation of both forms and clinical interaction practices can be easily incorporated into Brazilian health systems. Therefore, the incorporation of medium and long-term therapeutic practices for suicide prevention should be encouraged, such as the methods analyzed here, which have promising results due to their commitment to therapeutic continuity, and which can be significant in reducing suicide rates in Brazil.

Specifically, the SUS already has the organizational structure for the provision of therapeutic practices in the CAPS, where clients are welcomed and undergo different clinical treatments and professional follow-up. By inserting structured protocols and specific metrics to measure the patient's psychic state, such as the SSF and SSF-III forms (suggested by Ryberg et al.3 and Gysin-Mailart et al.6, respectively), the clinical perception of some signs of suicidal ideation can be better detected. According to the recommendations of the protocols adapted from the WHO by the Brazilian Ministry of Health (MENEZES; MURTA, 2018), it was highlighted that the main risk factors to be observed by Brazilian health professionals are a previous attempt and the registration of another preexisting psychological/psychiatric comorbidity (MENEZES; MRURT, 2018). However, as pointed out, these signs are more subtle and may not be indicative of suicidal ideation, since psychic suffering itself has nuances and complexities that compose and characterize individual conditions. Thus, the application of metrics to measure emotional distress through these forms, which can be repeated over time to monitor the condition, may be a better strategy to approach clients treated at SUS CAPS.

Also with regard to the CAPS, its multiprofessional structure and possible integration with family health professionals should be valued; these professionals are included in a multidisciplinary team (FIOCRUZ, 2020) of doctors, nurses, nursing assistants and community health agents (CHA), whose main role is to create bonds with people, in order to promote inclusive and holistic health, monitoring all aspects of the individual's health throughout their lives (BRASIL, 1997; DEPARTMENT OF PRIMARY CARE, 2000). However, as highlighted by the Ministry of Health manual (FIOCRUZ, 2020), other health professionals can be integrated into the team, in order to provide complete care in all spheres of each citizen's life. In this way, the dialogue between CAPS professionals and family health agents should be closer and more fluid, allowing the monitoring of psychological care clients in all aspects of health promotion and well-being. As pointed out, the social, biological, and psychological conditions that lead the individual to suicidal thoughts are multiple, and derived from complex factors. Therefore, the better the training of health teams in the use of

identification metrics, monitoring of pathological signs, and intervention in suicidal ideation, the greater the capacity of the SUS to prevent suicide. Thus, it is expected that mortality rates caused by intentional harm will be reduced over time, while therapeutic practices, with a humanistic and empathetic character, focused on the individual and on self-care and trust contracts with health professionals, can be a factor that promotes suicide prevention in Brazil.

REFERENCES

ASSOCIAÇÃO BRASILEIRA DE PSIQUIATRIA. Suicídio: informando para prevenir. Brasília: Conselho Federal de Medicina; 2014. Disponível em: http://www.flip3d.com.br/web/pub/cfm/index9/?numero=14. Acesso em: set. 2021.

ASSOCIAÇÃO BRASILEIRA DE PSIQUIATRIA. A campanha Setembro Amarelo salva vidas! Brasil: ABP. 2020. Disponível em: https://www.setembroamarelo.com/. Acesso em: set. 2021.

BRASIL. Constituição da República Federativa do Brasil de 05 de outubro de 1988. Brasília, DF: Diário Oficial da União 1988. Disponível em: http://www.planalto.gov.br/ccivil_03/constituicao/constituicao.htm. Acesso em: set 2021.

BRASIL. Diretrizes metodológicas: elaboração de revisão sistemática e metanálise de ensaios clínicos randomizados. Brasília, DF: Ministério da Saúde; 2012.

BRASIL. Ministério da Saúde. Centros de Atenção Psicossocial e Unidades de Acolhimento como lugares da atenção psicossocial nos territórios: orientações para elaboração de projetos de construção, reforma e ampliação de CAPS e de UA. Brasília, DF: Ministério da Saúde, 2015.

BRASIL. Ministério da Saúde. Saúde da Família: uma estratégia para a reorientação do modelo assistencial. Brasília: Ministério da Saúde; 1997.

CORONEL, M.K.; WERLANG, B.S.G. Problem-solving and suicide attempt: systematic review. Rev Bras Ter Cognitivas, v. 6, n. 2, p. 59-82, 2010.

D'OLIVEIRA, C.F.; BOTEGA, N.J. (org.). Prevenção do suicídio: Manual dirigido a profissionais das equipes de saúde mental. Brasil: Ministério da Saúde; 2006.

DEPARTAMENTO DE ATENÇÃO BÁSICA. Secretaria de Políticas de Saúde. Programa saúde da família. J. Public Health, v. 34, n. 3, p. 316-319, 2000.

DUCASSE D. *et al*. Acceptance and commitment therapy for the management of suicidal patients: A randomized controlled trial. Psychother Psychosom, v. 87, n. 4, p. 211-222, 2018.

Ducasse D. *et al.* Acceptance and commitment therapy for management of suicidal patients: a pilot study. Psychother Psychosom, v. 83, p. 374-376, 2014.

FIOCRUZ. Saúde da família. Brasil: Fundação Oswaldo Cruz. Disponível em: https://pensesus.fiocruz.br/saude-da-familia. Acesso em: set. 2021.

FIOCRUZ. Sus. Brasil: Fundação Oswaldo Cruz. 2020. Disponível em: https://pensesus.fiocruz.br/sus. Acesso em: set. 2020.

FREITAS S.B. *et al*. Cognitive-behavioural therapy and cognitive-behavioural coaching: differences and similarities between the two approaches. Rev Bras Ter Cognitivas, v. 10, n. 1, p. 54-63, 2014.

GYSIN-MAILLART, A. *et al.* A novel brief therapy for patients who attempt suicide: A 24-months follow-up randomized controlled study of the Attempted Suicide Short Intervention Program (ASSIP). PLoS Med, v. 13, n. 3, p. 1–21, 2016.

ITENS P. *et al.* Principais itens para relatar revisões sistemáticas e meta-análises: A recomendação PRISMA. Epidemiol Serv Saúde, v. 24, n. 2, p. 335–342, 2015.

JOBES, D.A. *et al.* Assessment and treatment of suicidal clients in a university counseling center. J Couns Psychol, v. 44, n. 4, p. 368-377, 1997.

LOVISI, G.M. *et al.* Análise epidemiológica do suicídio no Brasil entre 1980 e 2006. Braz J Psychiatry, v. 31, p. 86–94, 2009. (Supl. 2).

MENEZES, J.C.L.; MURTA, S.G. Adaptação Cultural de Intervenções Preventivas em Saúde Mental Baseadas em Evidências. Psico-USF Campinas, v. 23, n. 4, p. 681-91, 2018.

MICHEL, K.; JOBES, D.A. Building a therapeutic alliance with the suicidal patient. Washington, DC: American Psychological Association, 2011.

MICHEL K. *et al*. A novel therapy for people who attempt suicide and why we need new models of suicide. Int J Environ Res Public Health, v. 14, n. 3, p. 243, 2017.

MINISTÉRIO DA SAÚDE DO BRASIL. SUS: 27 anos transformando a história da saúde no Brasil. Brasília, DF: Ministério da Saúde, 2015. Disponível em: http://www.blog.saude.gov.br/35647-sus-27-anos-transformando-a-historia-da-saude-no-brasil. Acesso em: set. 2021.

ORGANIZAÇÃO MUNDIAL DA SAÚDE. Prevenção do suicídio: um manual para profissionais da saúde em atenção primária. Genebra, Suíça: OMS; 2000.

ORGANIZAÇÃO MUNDIAL DA SAÚDE. Suicide data. Base de dados, 2019. [*S.l.*]: OMS, 2019. Disponível em: https://www.who.int/mental_health/prevention/suicide/suicideprevent/en/. Acesso em: set. 2021.

RYBERG W. *et al*. Managing suicidality within specialized care: A randomized controlled trial. J Affect Disord, v. 249, p. 112-120, 2019.

VIEIRA, M.T. *et al.* Fatores de risco de suicídio em homens e mulheres: uma revisão de literatura. Brazilian Journal of Health Review, v. 4, n. 2, p. 6474-6484, 2021.

ZALSMAN G. *et al*. Suicide prevention strategies revisited: 10-year systematic review. Lancet Psychiatry, v. 3, n. 7, p. 646-659, 2016.