# Suicide Prevention Program: case study in a municipality in the south of Brazil

## Programa de Prevenção ao Suicídio: estudo de caso em um município do sul do Brasil

Marta Conte [1]
Stela Nazareth Meneghel [2]
Aline Gewehr Trindade [3]
Roger Flores Ceccon [4]
Lilian Zielke Hesler [5]
Claudia Weyne Cruz [1]
Regina Soares [6]
Sanderlei Pereira [7]
Irani Jesus [8]

[1] Escola de Saúde Pública do RS. Av. Ipiranga 6311. 90610-001 Porto Alegre RS. martacte@terra.com.br
[2] Escola de Enfermagem, Universidade Federal do Rio Grande do Sul.
[3] Centro de Atenção Psicossocial, Secretaria Municipal de Saúde de Candelária (RS).
[4] Curso Técnico de Enfermagem e Radiologia, Universidade de Cruz Alta (RS).
[5] Grupo de Estudos em Saúde Coletiva, Escola de Enfermagem, Universidade Federal do Rio Grande do Sul.
[6] Estratégia de Saúde da Família, Secretaria Municipal de Saúde de Candelária (RS).
[7] Programa de Prevenção ao Suicídio, Empresa de Assistência Técnica e Extensão Rural.
[8] Universidade Federal do Rio Grande do Sul.

**Abstract** *This article focuses on the theme of suicide prevention based on analysis of a work in progress. A case study of the Program for Promotion of Life and Suicide Prevention of Candelária in the State of Rio Grande do Sul was conducted. It is a Brazilian municipality that has high suicide mortality rates in the general population and among the elderly. The scope of this paper is to present a experience that has proved successful and is based on a local initiative. The data presented here result from participant observation, interviews with the team carrying out the work, discussion groups and document analysis. The following categories were used: line of care, management and evaluation process. The results of intervention show that suicide rates declined from 5 deaths per year (21/100,000 inhabitants) between 1996 and 2000 to 3.6 deaths per year (12/100,000 inhabitants) between 2007 and 2009. The study establishes a dialogue with the experiences of others locations and provides contributions to prevention programs that can be set up in Brazil.*

**Key words** *Suicide, Suicide prevention programs, Networks*

**Resumo** *Este artigo está focado no tema da prevenção do suicídio a partir da análise de um trabalho em desenvolvimento. Foi realizado um estudo de caso do Programa de Promoção à Vida e Prevenção ao Suicídio de Candelária (RS), um município brasileiro que apresenta altos coeficientes de mortalidade por suicídio na população geral e de idosos. O objetivo deste texto é analisar uma experiência que vem obtendo êxito e tem a base numa iniciativa local. Os dados aqui apresentados resultam de observação participante, de entrevistas com a equipe que conduz o trabalho, dos grupos de discussão e da análise documental. Foram utilizadas as seguintes categorias: linha de cuidado, gestão e processo avaliativo. Os resultados da intervenção mostram que as taxas de suicídio decresceram de 5 óbitos/ano (21/100 mil habitantes) no período 1996-2000 para 3,6 óbitos/ano (12/100 mil) em 2007-2009. O estudo estabelece um diálogo com experiências de outros locais e traz contribuições para programas de prevenção que possam ser organizados no país.*

**Palavras chave** *Suicídio, Programas de prevenção do suicídio, Redes*

## Introduction

Suicide is social fact[1] of subjective repercussions. It is also a major public health problem[2]. According to the World Health Organization[3], suicide rates have increased by 60% in the last 45 years and suicide is world's 13th cause of death among the overall population.

In Brazil mortality coefficients are three to four times higher among males; currently the rate is 4 to 5 deaths for every 100,000 inhabitants[4,5]. The highest coefficients of suicide are found in Brazil's Southern states[6] and they have recently increased in the Middle-West[7] region.

Suicide is defined as self-inflicted violence and a decisive act which is initiated and performed to its completion by an individual who has full understanding or expectation of a fatal result[3]. It is a complex situation with multiple associated factors that change according to culture, historical moment and social group, and it is considered taboo in many societies[6].

Programs and interventions that aim to prevent suicide are being proposed in the last few years and such action includes improving the quality of life of groups affected the most and the elimination of stigma that surrounds the issue. The challenge of prevention consists of identifying people in vulnerable situations, understanding the circumstances that influence their suicidal behavior and structuring effective interventions[8].

The Brazilian Ministry of Health unveiled the National Strategy for Suicide Prevention in 2006, aiming to decrease the number of deaths and attempts, associated damage and impact on families. That same year the Suicide Prevention Manual for Mental Health Team Professionals was launched. It aimed to detect early conditions associated with the phenomenon and to put preventive measures into place[9].

Suicide prevention may be classified in universal, selective and specific terms. The so-called universal prevention aims to reduce the incidence of new cases through educational action; selective prevention focuses on groups exposed to risk situations; and specific prevention targets individuals who manifest suicidal wishes or ideations[10].

Countless prevention actions were carried out in several countries worldwide in the last decade, many of them through tracking vulnerability situations and educational actions[11]. There is evidence of successful results from prevention programs in European countries, in the United States and in Japan, which have significantly decreased deaths by suicide[12-14].

The World Health Organization launched recommendations in 2000 for suicide prevention which include encouraging research, measures to reduce access to lethal methods, improving healthcare services, rehabilitation for individuals with suicidal behavior and early recognition of mental suffering. In addition to those, it also highlighted the importance of disarmament and control over firearms possession, of placing obstacles in places that may induce fall, detoxifying domestic gas emission and limiting the access to toxic substances[8].

Community prevention programs who take in users seen by multidisciplinary teams have been obtaining satisfactory results. In Brazil the proposal of full attention and care being provided to users in lines of care represent one of the scenarios for organizing suicide attention policies, considering comprehensiveness and intersectoral action[15].

Even if there are violence prevention actions in Brazil, we have not found any specific references to suicide prevention programs, although local actions may be under way which have not yet been sufficiently evaluated and published. In that sense, we believe it is important to describe the experience obtained in a suicide prevention program in the city of Candelária, Rio Grande do Sul state/Brazil, in order to encourage dialogue with other initiatives and to contribute to analyzing strategic tools to address it.

## Methodology

The Candelária/RS Program to Promote Life and Prevent Suicide (PPS) was set up with the goal to address a historical situation of high coefficients of mortality by suicide, both in the overall and elderly populations.

The program known as "Yes to Life" (Vida Sim) began in 2009 based on a proposal drafted by the Municipal Secretariat of Health and by the Technical Support and Rural Extension Company (Empresa de Assistência Técnica e Extensão Rural - EMATER), with collaborations from several institutional actors.

This is a case study, a method which allows us to delve further into a unique phenomenon, in this case a suicide prevention program, and explore its complexity[16]. Theoretical propositions which have led to the case study are related to the field of collective health; its guidelines are comprehensiveness and intersectorality. Such guidelines have directed our research questions and

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shaped the data collection plan, the organization of analytical dimensions and interpretations that have appeared throughout the study.

Throughout our methodology we have used different investigation strategies. Conversations with program managers, participant observation and the discussion group were primary sources, in addition to the analysis of documents and media.

Participant observation occurred during visits to the city while the following research was conducted: "Is it possible to prevent the end from coming early? Suicide in the Elderly in Brazil and Possibilities for Action in the Healthcare Sector". This study is part of that research. The visit is an informal moment during which we communicated with the team and observed the "program in action", allowing us to identify it as a successful experience which should be analyzed and promoted.

The discussion group was chosen not only for data collection, but also to increase our understanding of the PPS as a whole. It also provided a space to understand actors' motivations, perceptions and involvement with the proposal[18,19]. The instrument which directed the discussion was a semi-structured interview guide that included the following topics: program organization, line of care, itineraries, network actions, case reports. However, such conversations extended beyond the list of questions, because during the discussions cross-sectional topics came up and the team evaluated their process and results.

One topic analyzed by the program's team is the relationship between suicide and agrotoxic products, since many suicidal individuals in the region are tobacco farmers; however this study was not designed to look into this association.

Research attempted to bridge the gap between researchers and subjects, providing a democratic space where each participant made their contribution[20]. The group was guided by the understanding that qualitative data do not precede the research meeting; rather it is produced during the investigation process through engaged and ethical listening. Such spaces for speech allow workers/professionals to transform daily wisdom into knowledge when they reflect on their practice[21]. Investigation enabled participants to ask themselves questions about where the ongoing process was headed and the meaning and relevance of a few key situations[22]. This helped systematize analytical dimensions that have come up after initial readings of discussion group dialogues.

Data production consisted of a moment where they were generated and another when they were validated with the PPS through group discussion rounds, during which participants discussed the dynamic and flexible aspects of the proposal. Quantitative data included evaluating mortality indicators before and after the PPS implementation and program user follow-up.

## Breaking Taboos and Talking about Death: How the Program Started

The PPS started when a group of professionals and workers in the city of Candelária and three other municipalities met to discuss the issue of suicide and its impact on local reality. They were part of an inter-municipal project that studied suicide and the group provided a space for analyzing epidemiological indicators and to draft a manual to prevent it.

The group encountered a precarious network of care to people under risk of suicide and opposition from service managers to admit cases from emergency rooms:

***Nurse: In 2008, when we were working in a group that operated before the program was organized, we performed a psychological autopsy on a family and we found a young woman with ideation and suicidal plans. We agreed with her that she would receive medical care, but this did not happen.***

***Technician: She had already attempted*** [suicide] ***three times.***

***Psychologist: Then we argued with the service that they needed to provide care without prior appointments because this is an urgent situation.***

Considering the high prevalence of suicide in the region and lack of specific flows to provide care in risk situations, those professionals took up the challenge of organizing a suicide prevention program. Let us examine what they say about how they analyzed the situation:

***Nurse: The first step was to gather data, a historical series on suicide in the last few years. We surveyed this demand and to our disappointment healthcare services provided no information on patients' histories.***

***Psychologist: Only clinical symptoms.***

***Nurse: Clinical consults, headaches, no detailed medical record.***

***Psychologist: But over 60% of patients had been to a primary health clinic for an appointment in the last 30 days prior to the act, complaining of anguish, chest pain and tachycardia.***

***Nurse: This was very upsetting for us as healthcare professionals. Were we listening to those patients? We were frustrated as healthcare profession-***

***als and the major source of data was the Police Report, which described the suicide scene.*** [And we realized] ***they*** [police officers] ***listened to what healthcare professionals didn't.***

This finding was surprising for this small group. They found out that public security operators recorded the condition's history much more thoroughly than healthcare professionals. While the latter recorded medical histories, they did not relate them to signs and symptoms of suicidal behavior: this made it clear how difficult it was for such services to understand the problem. This detachment from this sector was confirmed by that fact that 60% of patients who had committed suicide had been to a Primary Healthcare Unit and the risk situation was not identified. This finding alerted the group being established that they should come up with an interdisciplinary approach to prevent suicide and work toward organizing the city's care network.

The first PPS strategic action aimed at demystifying the issue of death by suicide and consequently fostering possibilities to discuss the issue. The team found out that, although there was a high prevalence of suicide in the region, it was still a taboo topic about which people talked secretly. On the other hand, suicide was becoming natural to many families and treated as ordinary, while in others survivors were singled out and discriminated against. Such findings motivated the team to put the topic up for discussion:

***Psychologist: So let's start talking about suicide with everyone, in the Family Health Strategy, at the hospital!***

***Nurse: Before, the issue was concealed; no doctor would talk about suicide, so we started demystifying it. Training doctors and other professionals to identify people at risk. I think this was a huge victory we achieved in a short time.***

And so Candelária's PPS began - in a 30,000-inhabitant municipality, half of them living in rural areas -, centralized at the Center for Psychosocial Care (CAPS) and prioritizing care for all suicide attempts. Candelária's CAPS currently operates with a team of two psychiatrists, two psychologists, a social worker, two supervisors, a nurse, a nursing technician, a receptionist and a janitor. It is open from 8 a.m. to 5 p.m. Users referred to CAPS after a suicide attempt are seen and depending on their medical evaluation they receive care on that same day:

***CAPS Supervisor: Admission is fast and flexible; when in doubt a professional will call a colleague or consult with someone from the hospital. The network works well here.***

Setting up the PPS entailed training network professionals to detect and refer patients, in addition to agreements with the team to prioritize care to those cases and to allow the inclusion of people in vulnerable situations who had priority over regular demand:

***Psychologist: We wanted to train everybody and teach them what you have to do so that services would refer cases. All suicide attempts are sent to CAPS and receive urgent care.***

Therefore, by establishing unrestricted access to mental health admissions the PPS managing group has shown it is aligned with the understanding of collective mental health that this is a process that allows building social subjects who are engaged in social transformation, aiming to replace traditional practices with others that will enable life projects[23].

## Admitting and Bonding: the Line of Care

By analyzing the Candelária program it is possible to define it as a public health experience that comes from intersectoral communication and that includes educational, prevention and health promotion actions. Selective prevention works with groups subject to greater social vulnerability, even in the absence of suicidal behavior, and specific prevention targets people who have already attempted suicide or who have suicidal ideation[10]. Individual prevention actions include providing care to individuals in a crisis; identifying and following risk situations, including ideation and attempts; and the inclusion and accountability of family members. In the collective sphere, the PPS aims to change prejudiced views on suicide by promoting wide and open discussion in order to generate action and public policies.

The program was structured according to the view of line of care. This consists of providing safe and guaranteed flows of care to users[24] in order to meet their health needs and to promote comprehensive care, establishing bonds and accountability. The line draws the route the user takes within a network, including segments that are not necessarily included in the healthcare system, such as community, social assistance and rural population development entities.

In order to build the program's line of care, those responsible for healthcare services had to agree on flows and reorganize their work process in order to eliminate access barriers to users. This work involved the Family Health Strategy (ESF) teams, workers from Primary Healthcare Units (UBS), from the Center for Psychosocial Care

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(CAPS) and from the local hospital. In addition to network healthcare professionals, EMATER technicians also joined the line of care. They conduct work to improve the quality of life of rural families. Medical emergency rescuers from the Mobile Urgent Healthcare Service (SAMU), firefighters and police officers also joined, since they are the first to provide care to suicide victims.

The program's second strategic action emphasized training healthcare professionals to pay attention to risk identification and conceptual differences in approaches to ideation, planning or suicide attempt. It has been demonstrated[9,25] that people who attempt suicide should be part of priority groups to receive care from prevention programs. There is favorable impact on indicators when people in such groups are successfully identified and cared for. After sensitizing teams to identifying and referring individuals in a situation of risk, suicidal ideation started being addressed by Primary Healthcare services. The work of community agents was crucial for this. People with ideation are referred for care at UBS or ESF by those agents, while attempts are referred to CAPS. The team organized healthcare flows, prioritizing this group:

***Psychologist: We interrupted team activities to talk about suicide and we did this with everybody, at the hospital, with community health agents, we explained the difference between ideation and attempt, and who should be referred to CAPS or to UBS.***

The program extended care to survivors and to do so it actively looked for families who had fatal losses prior to the implementation of the program. EMATER, as a partner institution, promotes the program in rural areas and is responsible for leading health promotion groups. The program currently has several entry pathways and care strategies, as one of the managing group members explains:

***Psychologist: Now every attempt that comes through the Family Health Strategy, the hospital, the urgent care service, the military brigade, you know, through any of the services, they're all referred to CAPS. When they get to CAPS we admit them and decide on an individual treatment plan for each case. There is a different chart for suicide attempts, they're patients we call periodically, we talk to their families and ask if everything's alright.***

The line of care is flexible and does not only work under established reference and counter-reference protocols, but also by organizing itineraries in order to facilitate a user's access to services. This approach aims to build and strengthen social networks of neighbors and family members, especially in cases of users who live in rural areas and in regions of difficult access. Family members receive instructions on how to deal with risk situations. They receive recommendations not to leave the person alone during the initial stage of treatment, to follow their use of medication and to restrict access to guns and toxic materials.

***Psychologist: The psychiatrist and I go on home visits and this takes an entire morning when people live far away. So we set up a social network so that neighbors are ready to act and the family is alert. If they notice some of the situations we mention, they call us. They often don't have a phone, so they let the agent know and they will call CAPS. The community agent provides follow-up and checks on medication.***

Comprehensiveness in the line of care is achieved through an Individual Treatment Plan (PTI). This is regarded as a set of care actions designed to solve an individual's given health problem, based on the assessment of clinical, social, economic, environmental and emotional risk. The treatment plan enables the healthcare service to operate focusing on individuals' needs and no longer on service offer[26].

The PTI is designed for each user when they enter CAPS and it covers therapy groups, individual and family care, and painting, music, cooking and crafts workshops. Furthermore, community activities are also offered, even though in the beginning of treatment people rarely accept taking part, since they are imprisoned by the idea of death as the only way to escape their situation. However, one observes that after a few months of treatment program users become interested in therapy workshops. In the team's view this represents a landmark and important progress to build a life project. Each takes their own subjective time reaching this landmark and the program respects this process:

***Psychologist: Every Thursday we gather the CAPS team to make decisions on individual treatment plans of people who have arrived in the last week. We get together and discuss, there's this suicide case, who's going to be in charge of whom, whether the patient is going to use any medication, in summary, what's going to be done.***

The concept that provides the grounds for care and therapeutic plan design involves understanding the uniqueness of each case, the work with the family, a patient's access to services and medication (if that is the case), the possibility of inclusion in Primary Healthcare Units, listening to social networks, teamwork with co-responsi-

bility, constant follow-up of risk situations and the importance of confidentiality and ethics:

***Psychologist: We work with an individual treatment plan, so each case is different from the other and we cater to people's uniqueness. For instance, I can't assign a patient to weekly therapy sessions when I know they live in a region of difficult access and that there's no daily bus service. In those cases you need to consider other types*** [of activity]***.***

In summary, in order to organize lines of care it is necessary to develop communication and negotiation skills, involving all actors in a care agreement that guarantees available resources and the offer of primary and secondary care; individual-focused flows, facilitating their ***walk along the network***; and the tools which will guarantee safe referrals to different levels of complexity and the UBS team's responsibility to develop the treatment project that will be followed in the line of care[24]. Building an intersectoral line of care has changed admission practices and clinical history started including questions about sleep problems, thoughts about death and use of agrotoxic products.

The program used already existing resources and also prioritized using professionals that were already in the network to rearrange service actions by agreeing on new work processes, reorganizing networks and involving the community. It should also be highlighted that the PPS management team have formed bonds of trust, solidarity, team spirit, mutual collaboration and network activity, all crucial for lines of care to work and to make room for creativity and possible reinventions considering the needs, possibilities and wishes of people who receive their service.

### Comprehensiveness and Work Management in the PPS

The proposal to provide comprehensive healthcare begins with a reorganization of work processes in the basic network and it adds to other care actions, following a complex web of actions, procedures, flows, routines, knowledge, in a communicative and complementary process that also involves dispute. All of this forms what is understood as healthcare[27].

Access is an important indicator to define the degree of ease or difficulty with which people gain access to health services; it reflects the features of the healthcare system and it is influenced by individual factors, by the profile of health needs and by people's values and preferences[28].

A dimension appreciated by the PPS refers to accessibility of health actions, made possible by strengthening Primary Care, since social reintegration occurs through CAPS and focuses on the individual and the community. Accessibility implies providing access to all resources the user needs, from home visits to hospital admissions[26]. In Candelária difficult access for rural populations is expected to be solved by hiring community health agents to achieve 100% ESF coverage.

Permanent education is one of the management and work process follow-up tools. Permanent education is thought as an educational process that places health work under analysis and enables building collective spaces to reflect on and make sense of actions taken in everyday life[29]. Professional training, with an integrated perspective between teaching and work, is incorporated into the daily routine of services.

***Nurse: We get involved in permanent education and all health units are closed for one period during the week for teams to meet and discuss cases, organize a work model and for evaluation.***

Permanent education occurs as the program is implemented and includes shared planning of flows, the proposal of "open doors" to care at CAPS, designing individual therapy plans, continuous supervision, strengthening the network, community and intersectoral actions.

The program expands the debate so as not do reduce suicide to an individual matter and to think about it as a social problem that requires collective and community solutions.

### The Evaluation Process

A program's evaluation is understood as judgment that may range from dichotomic qualitative or quantitative value judgment to an analysis that involves the phenomenon as a whole[30]. The expanded concept of evaluation aims to overcome the false opposition between qualitative versus quantitative approaches, prioritizing the construction of an object and mobilizing all possible techniques to analyze it[31]. As far as possible evaluation should involve all actors who take part in the program and aim to adjust routes and improve action[32,33].

Evaluation includes a wide range of activities, from subjective judgments on a social practice, such as "did we do well?", "did we get any results?", "are we satisfied?" to the so-called evaluative research[34,35] that combines methods, theories and techniques in a more objective way[32,33].

The PPS evaluation was based on the understanding that evaluation processes of social practices are an integral part of proposal consolida-

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tion. And in this paper we make an effort to analyze the valuation process conducted by the actors involved in the PPS themselves.

Evaluating a program to confront suicide is no easy task, since measuring results produced by social interventions, especially when pertaining to multi-cause situations as in this case, consists of a complex procedure. The program team performs continuous assessments using elements produced in case discussions, work meetings and in informal conversations between members:

***Nurse: The three of us meet every month to discuss what's working, how groups are going, what has to change.***

***Psychologist: When the patient returns to the ESF they may have severe symptoms so the ESF coordinator calls us and asks us what we think.***

In the PPS team's view, organizing the intersectoral network was one of their highest impact actions:

***Psychologist: The great thing we did was getting the network organized, in fact that's all we did. And it's not a high cost program. It's the brochures, the posters we're making and that was it, because labor comes from the secretariat*** [Municipal Secretariat for Health] ***and doctors are those from the Family Health CAPS, while EMATER works with groups as they already did before the program.***

The team takes an important indicator into account, the increase in referrals of people with a history of attempting suicide, located at the different levels of healthcare. The monthly average of service provided to people in that situation has increased as a result of active search and CAPS currently offers consults to a total of 800 people every month, including follow-up to 100 of them who joined the program after the activities already mentioned were implemented.

Other indicators assessed by the team are: user satisfaction, resolubility of care, monitoring of medication checked out at the Municipal Drugstore to investigate whether people are using drugs and adherence to CAPS services. With that information home visits or contact with families are scheduled in order to review the individual treatment plan. Active search does not occur as an imposition, but a new option users and families have to be included in the line of care. Indicator assessment revealed that suicide cases that were not avoided in the last two years concerned people who did not have access to the healthcare network:

***Psychologist: All patients who joined*** [the program] ***for having attempted suicide in the last year and a half, all of them are fine, several are back to their units, they've gone back to work. We see during appointments that they're fine; nobody talks about depressive symptoms anymore. So this means that if you organize the network and offer proper treatment, this will prevent death.***

The coordinator made the following comment while remembering a model case, ***a case that worked out ok.***

***Psychologist: I remember the mother of one of our patients who found her son hanging from a gallows. He had attempted suicide before, but the family thought he was a substance abuser and that he wasn't going to commit suicide. The mother said the son was going to work in the woodwork shop in the back of her house and she went to lie down after noon, but she couldn't sleep so she got up and went looking for the young man. He has hanging in a rope from the balcony and she called the brigade who called us. We took the young man to the hospital. He was admitted and started treatment at CAPS, it's been a year now, today he's doing really well, he's no longer a substance abuser and mother and son attend CAPS group meetings every week. And we have many other cases like this one.***

With respect to the program's impact, measured by quantitative indicators, it was possible to obtain evidence that ever since the PPS was implemented there have been no cases of suicide among people receiving care after a previous attempt. This is an indicator of the program's efficiency and effectiveness, since the risk of suicide is greater in this group. In the four cases of suicide that occurred between 2009 and 2010, people were not seen by CAPS and lived in rural areas of difficult access and in a region that was not covered by the Family Health Strategy.

According to the team's statement, another datum worthy of attention is a decrease in the frequency of suicides. In terms of coefficients of mortality by suicide in Candelária[36], we observe that cases and coefficients in three different periods show an average of 5.4 deaths/year, which represents 18.6 deaths/100,000 inhabitants in 1996-2000. In the following period (2001-2006) there was a significant increase to 6.5 deaths (21.4 deaths/100,000 inhabitants). In 2007-2009 this fell approximately by half with an average of 3.6 cases/year, which represents a coefficient of 12/100,000 inhabitants.

## Final Considerations

Candelária's PPS represents an innovative program to prevent suicide, both in terms of the originality and relevance of its proposition and in terms of the impact on its mortality rates. Even so, PPS professionals find it important to expand the participation of other segments of the community to provide political support to the program. This may prevent the current technical-assistive model, based on strengthening primary care and on building an intersectoral network, from going back to a perspective based on the biomedical model.

With respect to program management weaknesses, one notices that CAPS professionals may become overburdened, considering the increasing demand from people at risk. This fact could be minimized by expanding referral of less severe cases to the primary network, as long as professionals are trained and sensitized to assist and detect problems. Strengthening the network will enable early detection and providing care in crisis situations, before they become suicide attempts.

Among PPS potentials we highlight the commitment of the current healthcare manager to providing political-institutional support to the project and the fact that the Municipal Secretariat for Health has adopted a democratic management. We emphasize the importance of the current participatory analysis process, which appreciates the leading role of actors involved in this work.

Finally, we would like to mention the management team's participation in other inter-municipal and interstate discussion networks, in social control, in research that focuses on other possible causes, as agrotoxic products and the tobacco green sickness, their being open to what is new and their availability to cooperate with other groups aiming to conduct health and life promotion activities.

## Collaborations

M Conte, SN Meneghel, AG Trindade, RF Ceccon, LZ Hesler, CW Cruz, R Soares, S Pereira and I Jesus participated equally in all stages of preparation of the article.

## References


1. Durkheim E**.** ***O Suicídio.*** 3º ed. Lisboa, Portugal: Editorial Presença; 1982.
2. Haqqi S. Suicide and Domestic Violence: Could There Be a Correlation? ***Medscape J Med*** 2008; 10(12): 287.
3. Organização Mundial de Saúde (OMS). ***Relatório Mundial sobre Violência e Saúde***: Sumário. Genève: OMS; 2002.
4. Botega JN, Marin-Leon L, Oliveira HB, Barros MBA, Silva VF, Dalgalarrondo P. Prevalências de ideação, plano e tentativa de suicídio: um inquérito de base populacional em Campinas, São Paulo, Brasil. ***Cad Saude Publica*** 2009; 25(12):2632-2638.
5. Brzozowski FS; Soares GB ; Jucemar Benedet J; Boing AF; Peres MA. Suicide time trends in Brazil from 1980 to 2005 2010. ***Cad Saude Publica*** 2010; 26(7):1293-1302.
6. Meneghel SN, Victora CG, Faria NM, Pinheiro L. Características epidemiológicas do suicídio no Rio Grande do Sul. ***Rev Saude Publica*** 2004; 38(6):804-810.
7. Waiselfisz JJ. ***Mapa da violência 2011***: os jovens no Brasil**.** São Paulo, Brasília: Instituto Sangari, Ministério da Justiça; 2011.
8. Organização Mundial de Saúde (OMS). ***Prevenção do suicídio***: um manual para profissionais da saúde em atenção primária**.** Genebra: OMS; 2000.
9. Brasil. Portaria n.1.876, de 14 de agosto de 2006. Define diretrizes nacionais de prevenção ao suicídio. ***Diário Oficial da União*** 2006; 15 ago.
10. Mrazek PJ, Haggerty RJ. ***Reducing risks for mental disorders: Frontiers for preventive intervention research.*** Washington DC: National Academy Press; 1994.
11. Bean G, Baber K. Connect: An Effective Community-Based Youth Suicide Prevention Program. ***Suicide Life Threat Behav*** 2011; 41(1):87-97.
12. Keith H, Bale E. Self-Cutting: Patient Characteristics Compared with Self-Poisoner. ***Suicide and Life Threatening Behavior*** 2004; 34(3):199-208.
13. Hegerl U, Wittmann M, Arensman E, Van Audenhove C, Bouleau JH, Van Der Feltz-Cornelis C, Gusmao R, Kopp M, Löhr C, Maxwell M, Meise U, Mirjanic M, Oskarsson H, Sola VP, Pull C, Pycha R, Ricka R, Tuulari J, Värnik A, Pfeiffer-Gerschel T. The European Alliance against depression – a four-level intervention programme against depression and suicidality. ***Suicidologi*** 2008; 13(1):12-14.
14. Motohashi Y, Kaneko Y, Sasaki, H. Community-based suicide prevention program in Japan using a health promotion approach. ***Environ Health Prev Med*** 2004; 9(1):3-8.
15. Gomes R, Minayo MCS, Assis, SG, Njaine K, Shenker M. ***Êxitos na prevenção da violência.*** Brasília, São Paulo: Hucitec; 2010.
16. Trivinos ANS. ***Introdução à pesquisa em Ciências Sociais***. São Paulo: Atlas; 1994.
17. Minayo MCS, Cavalcante, FG. ***É possível prevenir a antecipação do fim?*** Suicídio de Idosos no Brasil e possibilidades de Atuação do Setor Saúde. [Projeto de pesquisa]. Rio de Janeiro: CLAVES, Fiocruz; 2010.
18. Ibáñez J. ***Más allá de la sociología.*** El grupo de discusión: Técnica y crítica**.** Madrid: Siglo Veintiuno Editores; 1992.
19. Ibáñez J. ***El regreso del sujeto.*** La investigación social de segundo orden. Madrid: Siglo XXI Editores; 1994.
20. Viganó C. A construção do caso clínico**.** ***Opção Lacaniana online nova série*** [periódico na Internet]. 2010 [acessado 2012 jul 5];1(1):[cerca de 9 p.]. Disponível em: http://www.opcaolacaniana.com.br/pdf/numero_1/A_construcao_do_caso_clinico.pdf
21. Dejours C. Subjetividade, trabalho e ação. ***Revista Produção,*** 2004; 14(3): 27-34.
22. Minayo MCS. ***O desafio do conhecimento*** – Pesquisa qualitativa em saúde**.** São Paulo: Editora Hucitec; 2008.
23. Fagundes S. ***Águas da Pedagogia da Implicação***: Intercessões da educação para políticas públicas de saúde [dissertação]. Porto Alegre: Universidade Federal do Rio Grande do Sul; 2006.
24. Franco CM, Franco TB. ***Linhas do Cuidado Integral: Uma proposta de organização da rede de saúde.*** In: Secretaria de Estado de Saúde do RS. [página na Internet]. [acessado 2011 nov 16]. Disponível em: http://www.saude.rs.gov.br/dados/1306960390341linha-cuidado-integral-conceito-como-fazer.pdf
25. Brezo J, Paris J, Barker ED, Tremblay R, Vitaro F, Zoccolillo M, Hébert M, Turecki G. Natural history of suicidal behaviors in a population-based sample of young adults. ***Psychol Med***. 2007; 37(11):1563-1574.
26. Brasil. Ministério da Saúde (MS). Secretaria de Atenção à Saúde. Política Nacional de Humanização. Grupo de trabalho em humanizações – tecendo redes para superar o sofrimento psíquico. In: Brasil. Ministério da Saúde, Secretaria de Atenção à Saúde, Política Nacional de Humanização. ***Formação e intervenção***. Brasília: MS; 2010.
27. Cecilio LCO, Mehry EE. A integralidade do cuidado como eixo da gestão hospitalar. Campinas, 2003. [página na Internet]. [2011 nov 30]. Disponível em: http://www.uff.br/saudecoletiva/professores/merhy/capitulos-07.pdf
28. Travassos C, Martins M. Uma revisão sobre os conceitos de acesso e utilização de serviços de saúde. ***Cad Saude Publica*** 2004; 20(Supl.2):S190-S198.
29. Ceccim RB. Educação Permanente em Saúde. ***Interface Comun Saúde Educ*** 2005; 9(16):161-177.
30. Hartz ZMA, Vieira-da-Silva LM, organizadores. ***Avaliação em saúde***: dos modelos teóricos à prática na avaliação de programas e sistemas de saúde**.** Salvador: EDUFBA/ Rio de Janeiro: Editora Fiocruz; 2005.
31. Bourdieu P. O campo científico. In: Ortiz R, organizador. ***Pierre Bourdieu***. Rio de Janeiro: Editora Ática; 1983. (Coletânea Grandes Cientistas Sociais)
32. Minayo MCS, Assis SG, Souza ER, organizadores. ***Avaliação por triangulação de métodos***. Rio de Janeiro: Editora Fiocruz; 2005.
33. Minayo MCS. Los conceptos estructurantes de la investigación cualitativa. ***Salud Colectiva*** 2010; 6(3): 251-261.

34. Suchman EA. ***Evaluative Research – Principles and Practice in Public Service and Social Action Programs.*** New York: Russel Sage Foundation; 1967.
35. Weiss CH. ***Evaluation Research Methods for Assessing Program Effectiveness***. New York: Prentice-Hall Inc., Englewood Cliffs; 1972.
36. Brasil. Ministério da Saúde. DATASUS. [site na Internet]. [acessado 2011 nov 30]. Disponível em: http://www.datasus.gov.br/DATASUS

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