

Professional approach and suicidal behavior in Primary Health Care

Abordagem profissional e o comportamento suicida na Atenção Primária à Saúde

Conducta profesional y comportamiento suicida en la Atención Primaria de Salud

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Abstract

Objective: To describe the professional approach to people with suicidal behavior in Primary Health Care and its associations with the sociodemographic, educational and occupational variables of health workers.

Methods: Cross-sectional study of 192 health professionals from 20 Basic Health Units in a municipality in greater São Paulo. A questionnaire for sociodemographic, educational and occupational characterization was applied, as well as the instrument for Evaluating Professional's Assistance to People with Suicidal Behavior. The results were presented using measures of central tendency and dispersion, and parametric and non-parametric tests were used in the analysis, considering the nature of the variables. A significance level of 5% was adopted.

Results: There was a predominance of females, average age of 43.27 years, higher education, and average working time of 10.71 years. The higher scores were reached in the Professional Sensibility and Knowledge/Abilities domains. Lower scores were obtained for Professional Experience and Organization of the Care Network, demonstrating frailty in the professional performance and in network coordination needed in the approach to suicidal behavior. Age, working time in the unit and the frequency of treatment of populations at risk for suicidal behavior were associated with scores in Professional Sensibility, Experience and Knowledge/Abilities.

Conclusion: Sensibility, knowledge and abilities of Primary Care health professionals contribute to the approach to suicidal behavior, associated with occupational and educational characteristics. Professional experience and Organization of the care network reveal the weaknesses in the coordination necessary to approach suicidal behavior, indicating paths for training and work in health.

Resumo

Objetivo: Descrever a abordagem profissional à pessoa com comportamento suicida na Atenção Primária à Saúde e suas associações com as variáveis sociodemográficas, de escolaridade e ocupacionais dos trabalhadores de saúde.

Métodos: Estudo transversal. Participaram 192 profissionais de saúde de 20 Unidades Básicas de Saúde de um município da grande São Paulo. Foram aplicados um questionário para caracterização sociodemográfica, de escolaridade e ocupacional, e a Avaliação da Assistência Profissional às Pessoas com Comportamento Suicida. Os resultados foram apresentados por meio de medidas de tendência central e dispersão, e a análise utilizou testes paramétricos e não-paramétricos, considerando a natureza das variáveis. Utilizou-se nível de significância de 5%.

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Conflicts of interest: none to declare.

Resultados: Houve predominância do sexo feminino, média etária de 43,27 anos, nível superior e tempo médio de trabalho de 10,71 anos. Os domínios Percepção Profissional e Conhecimento/Habilidade obtiveram as maiores pontuações. Experiência Profissional e Organização da Rede de Atenção obtiveram menores pontuações, demonstrando fragilidade na atuação profissional e na articulação em rede requeridas na abordagem ao comportamento suicida. Idade, tempo de atuação na unidade e a frequência com que são atendidas as populações de risco para o comportamento suicida estiveram associadas às pontuações na Percepção Profissional, Experiência e Conhecimento/Habilidade.

Conclusão: Percepção, conhecimentos e habilidades dos profissionais de saúde da Atenção Primária contribuem para a abordagem ao comportamento suicida, associando-se às características ocupacionais e de escolaridade. Experiência profissional e Organização da rede de atenção denunciam as fragilidades na articulação necessária para a abordagem ao comportamento suicida, indicando caminhos para formação e trabalho em saúde.

Resumen

Objetivo: Describir la conducta profesional hacia personas con comportamiento suicida en la Atención Primaria de Salud y su relación con las variables sociodemográficas, de escolaridad y ocupacionales de los trabajadores de la salud.

Métodos: Estudio transversal. Participaron 192 profesionales de la salud de 20 Unidades Básicas de Salud de un municipio de la Región Metropolitana de São Paulo. Se aplicó un cuestionario para la caracterización sociodemográfica, de escolaridad y ocupacional y la Evaluación de la Atención Profesional a Personas con Comportamiento Suicida. Los resultados fueron presentados mediante medidas de tendencia central y dispersión, y se utilizaron pruebas paramétricas y no paramétricas para el análisis, considerando la naturaleza de las variables. Se utilizó un nivel de significación del 5 %.

Resultados: Se observó predominancia del sexo femenino, de 43,27 años de edad promedio, nivel superior y con 10,71 años de tiempo de trabajo promedio. Los dominios que obtuvieron puntaje más alto fueron Percepción profesional y Conocimiento/habilidad. Los dominios Experiencia profesional y Organización de la red de atención recibieron el menor puntaje, lo que demuestra la debilidad de la actuación profesional y del trabajo en red requeridos para la adopción de una conducta profesional ante el comportamiento suicida. Las variables edad, tiempo de trabajo en la unidad y frecuencia con que se atiende a las poblaciones de riesgo de comportamiento suicida se asociaron con los puntajes de Percepción profesional, Experiencia y Conocimiento/Habilidad.

Conclusión: La percepción, los conocimientos y las habilidades de los profesionales de la salud de la Atención Primaria, junto con las características ocupacionales y de escolaridad, contribuyen para la adopción de una conducta profesional ante el comportamiento suicida. La experiencia profesional y la organización de la red de atención demuestran la debilidad de la unión necesaria para adoptar una conducta profesional ante el comportamiento suicida, e indican los caminos a seguir para la formación y el trabajo en el área de la salud.

Introduction

Suicidal behavior represents a global public health demand and the provision of care constitutes a challenge for Primary Health Care (PHC) professionals. Suicidal behavior is understood as a multidimensional problem resulting from the interaction between various aspects; environmental, social, cultural, economic, physiological, genetic and biological.⁽¹⁾

Studies express the complexity and multifactorial nature of suicidal behavior, and psychosocial and demographic factors have been related to the different patterns identified among people with this behavior.⁽²⁻⁵⁾ Relationships with marital status, aging, education, income, employment and social integration were observed in the Portuguese and Iranian populations.^(2,5) Access to firearms is a factor in the United States,⁽³⁾ while suicide attempts on railways are observed in the United Kingdom.⁽⁴⁾

The influence of clinical and genetic factors has been analyzed through the history of somatic diagnoses identified in male individuals attempting suicide by hanging.⁽⁶⁾ The lifetime diagnosis of Obsessive Compulsive Disorder was associated

with the population with multiple suicide attempts through polygenic risk analysis.⁽⁷⁾

The global suicide rate decreased by around 36% between 2000 and 2019 in clear reference to the fact that some countries have prioritized suicide prevention in their agendas. Some of them have developed suicide prevention strategies in order to meet the goal proposed by the World Health Organization (WHO) –reducing the global suicide rate by one third by 2030.⁽⁸⁾

In the opposite direction, Brazil presented a 43% increase in the annual number of deaths by suicide between 2010 and 2019, reaching a rate of 6.6/100 thousand inhabitants.⁽⁹⁾ Self-inflicted violence expressed similar behavior and increased by 39.8% between 2018 and 2019. The predominant population profile was female (71.3%), aged 20 to 39 years, self-reported white (47.3%) and black (42.4%) race/color, with between four and 11 years of schooling. The commonly used means were poisoning, sharp objects and hanging, and the residential scenario was the most frequent (83.9%).⁽⁹⁾

Although standardized suicide rates showed an increasing trend in all regions of the country, specificities are observed. The South and Central-West

regions show a higher prevalence compared to other Brazilian regions. The North and Northeast regions showed the highest growth trend in suicide rates in the period analyzed.⁽¹⁰⁾

Despite the recognized underreporting of suicidal behavior, data presented make it possible to analyze its different characteristics and trends, contributing to the development of public policies and recommendations for tackling the problem. In this sense, Law No. 13.819/2019 established the National Policy for the Prevention of Self-Mutilation and Suicide and one of its objectives was to encourage care for people with suicidal behavior.⁽¹¹⁾

Care, understood here as an intersubjective connection with the other, takes place within a space of time, based on professional knowledge and relational technologies. In comprehensive care, the person's singularities are considered and there is an implication in the sense of forming an alliance with the professional, in which the person's needs and responsibilities are established and agreed. Interdisciplinarity, teamwork and the coordination between workers, health service managers and users strengthen the expanded clinic and work in intra-sectoral and intersectoral networks, resulting in the provision of comprehensive care in the daily routine of health units, which benefits the development of people as subjects of rights.⁽¹²⁾

The Psychosocial Care Network (RAPS) encompasses the set of actions and services that integrate care for people in psychological distress and meets the assumptions of Psychosocial Care. Primary Health Care, represented by the Basic Health Units (UBS), is one of its tools. In line with the Psychiatric Reform, care for people in psychological distress should prioritize community-based territorial actions, putting PHC professionals in contact with mental health demands, including suicidal behavior.⁽¹³⁾

According to data from the Notifiable Diseases Information System specifically on the municipality of this investigation, 679 cases of self-inflicted violence were reported between 2011 and 2018. Of this total, 447 (65.83%) cases involved female subjects and 232 (34.17%) males. In line with the

national context, an increase in the occurrence of self-inflicted injuries was observed in both sexes.

Considering suicidal behavior as a global public health problem, the complexity and dynamics of the factors that influence its outcomes, the importance of PHC professionals offering efficient prevention, detection and care measures, and loco-regional characteristics, it is important to investigate the professional approach to people with suicidal behavior in the context of PHC, together with the sociodemographic, educational and occupational characteristics of health professionals that influence the quality of this approach.

In this context, the aim of the present study was to describe the professional approach to people with suicidal behavior in PHC and its associations with the sociodemographic, educational and occupational variables of health workers.

Methods

This is a quantitative cross-sectional and correlational study,⁽¹⁵⁾ described based on the Strengthening the Reporting of Observational Studies in Epidemiology (STROBE).⁽¹⁶⁾

The study was developed in a municipality in the metropolitan region of São Paulo with an estimated population of 430 thousand inhabitants and 100% territorial coverage by the Family Health Strategy. All 20 UBS in the municipality were included.

An intentional and non-probabilistic sample was considered based on all professionals distributed among the aforementioned units. The professional categories included were community health agents, nursing assistants/technicians, oral health assistants/technicians, medicine, physical education, nursing, speech therapy, nutrition, dentistry, psychology, social work, in addition to UBS managers and administrative technicians. The inclusion criteria were being a health worker and working in PHC services. Any type of leave or leave of absence at the time of data collection was considered as an exclusion criterion.

Regarding sample size, the fact of the data collection period being between April and May 2021,

concomitant with the COVID-19 pandemic, led to the absence of professionals by health reasons and risk factors for COVID-19, which made it difficult to reach the proposed sample size. During this period, the number of active professionals was 741 individuals. Based on the formula $n = (N \cdot Z^2 \cdot p \cdot (1-p)) / (Z^2 \cdot p \cdot (1-p) + e^2 \cdot N - 1)$ (where: n : calculated sample, N : population, Z : normal variable, p : real probability of the event, e : sampling error), considering a sampling error of 5% and a confidence level of 95%, a representative sample of 253 participants was calculated.

Given the health context at the time, data collection was performed digitally and the instruments were transcribed into electronic forms (Google Forms). A questionnaire including three stages was prepared: (i) Registration of consent to participate in the study, (ii) Sociodemographic instrument and (iii) Instrument for Evaluating Professional's Assistance to People with Suicidal Behavior (IAAP-PCS). The electronic form was evaluated by the researchers and a pre-test was performed with ten health professionals from the municipality where the investigation was carried out. The average time to respond the form was 14 minutes and no considerations regarding content and format were made.⁽¹⁷⁾

The link to access the form was distributed to all active professionals via institutional email and messaging application (WhatsApp) on three dates at fortnightly intervals. Those who did not respond to the three attempts were considered as refusals.⁽¹⁷⁾

The IAAP-PCS was applied. This questionnaire has 50 items distributed among five domains: Professional Characterization (14 items), Professional Sensibility (9 items), Professional Experience (7 items), Professional Knowledge/Abilities (12 items) and Organization of the Care Network (8 items). Except for the first domain (professional characterization), all the others are composed of statements with responses organized in a five-point Likert scale in which a score of "1" corresponds to the minimum agreement and a score of "5" the maximum. There are no items that require inversion of the Likert scale and the score is calculated by adding the scores of items of each domain or the total instrument. The minimum and

maximum total scores are 36 and 180, respectively. The instrument was validated using the Delphi technique, semantic analysis and internal consistency, and satisfactory results were achieved.⁽¹⁸⁾

In relation to the domains, Professional Characterization covers items that address training, qualification, time of experience and frequency of professionals' exposure to people with relevant risk factors to suicidal behavior. Professional Sensibility refers to how the professional understands suicidal behavior and the importance of the approach in the context of PHC. In Professional Experience, the items seek to recall the professionals' experiences and their influence in making them more or less experienced in relation to approaching people with suicidal behavior in PHC. The Professional Knowledge/Abilities domain is dedicated to identifying theoretical-practical knowledge that enables a politically and scientifically based approach. The Network Organization is related to the identification of the physical structure, care resources and work processes established in the logic of Health Care Networks.⁽¹⁸⁾

The responses from the electronic form were compiled into an Excel - Microsoft Package® database and the Statistical Package of Social Science (SPSS) was used. Categorical variables were described using relative and absolute frequencies; continuous variables, mean, standard deviation (SD), minimum, median and maximum. The Pearson or Spearman correlation coefficient was used to analyze the four domains of the data collection instrument and the continuous variables. In the analysis of Professional Sensibility and Professional Experience domains between the categorical variables, the Mann-Whitney test (two categories) and the Kruskal-Wallis test (three or more categories) were applied. The Professional Knowledge/Abilities and Organization of the Care Network domains, as well as the categorical variables were analyzed using the T test (two categories) and ANOVA (three or more categories). A significance level of 5% (p -value < 0.05) was considered in all analyses.

This study was approved by the Research Ethics Committee of the Universidade Federal de São Paulo in March 2021 under protocol number

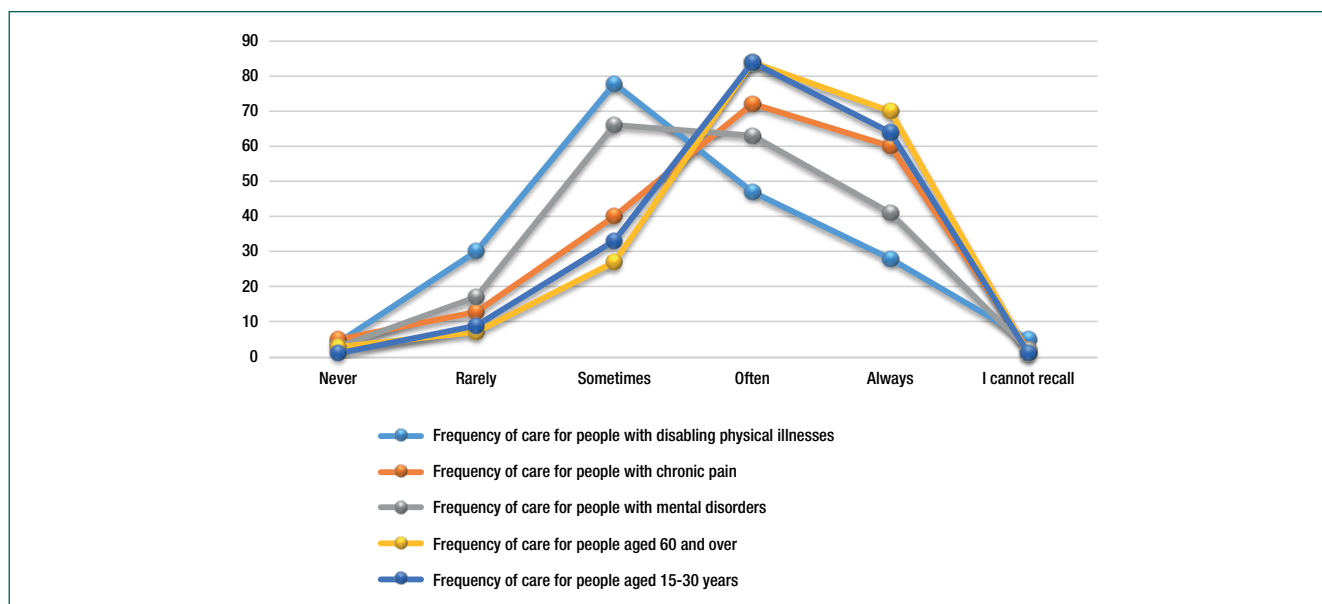


Figure 1. Absolute frequency in relation to care for people with higher risk outcomes for suicidal behavior

4.573.816 (Certificate of Presentation of Ethical Appreciation: 36139120.7.0000.5505) and complies with resolution number 466/ 12, referring to research involving human beings.⁽¹⁹⁾

Results

Participation of 192 PHC health professionals. The average age of participants was 43.27 years old, with a standard deviation of 10.01, minimum age of 21 years old and maximum age of 72 years old (n=186). There was a predominance of females (n=168; 87.5%), 54.7% (n=105) declared to have higher education and some type of postgraduate degree. The average length of experience in PHC was 10.71 years, with a standard deviation of 7.21. Regarding the frequency of care for populations with risk factors for suicidal behavior (Figure 1), 84 (44%) often treated patients aged 60 or over and people aged 15 to 30; 78 (41.7%) sometimes treated people with disabling physical illnesses; 72 (37.9%) often treated patients with chronic pain and 66 (34.7%) sometimes treated people with mental disorders.

With regard to the IAAP-PCS, the average score in the Professional Sensibility domain was 37.45 (SD±5.51) and in Professional Knowledge/Abilities 40.52 (SD±6.81), corresponding re-

spectively to 83.2% and 60.63% of total scores. These results demonstrate that both domains are favorable to assisting people with suicidal behavior. Unlike this, Professional Experience and Care Network Organization scores were lower, as detailed in table 1.

Table 1. Scores obtained between the instrument domains

Domains of the IAAP-PCS instrument	M(SD)	Med	Min	Max
Professional Sensibility	37.45(5.51)	38	11	45
Professional Experience	21.23(9.28)	23	7	35
Professional Knowledge/Abilities	40.52(6.81)	41	24	55
Organization of the Care Network	24.97(6.04)	25	9	40

Younger professionals with less time working at the health unit correlated with the score in the Professional Sensibility domain. This correlation demonstrates that this professional profile has understandings that favor the approach to people with suicidal behavior. As illustrated in table 2, there were no other correlations between the IAAP-PCS domains and the continuous variables.

The analysis presented in table 3 demonstrates the association of categorical variables with the Professional Sensibility, Professional Experience and Professional Knowledge/Abilities domains. The variables that showed a correlation with the three domains were: having a postgraduate degree, having taken more than four subjects that addressed

Table 2. Correlation between IAAP-PCS domains and continuous variables

Continuous variables	Statistical analysis	Domains of the IAAP-PCS instrument			
		DI	DII	DIII	DIV
Age	R	-0.27*	-0.06*	-0.10	-0.11
	p-value	0.0002	0.4414	0.1591	0.1336
	N	186	186	186	186
Working time in the current health unit	R	-0.15*	0.02*	-0.10*	0.02*
	p-value	0.0341	0.7608	0.1558	0.8012
	N	191	191	191	191
Working time in primary care services	R	-0.03*	0.09*	-0.02*	0.04*
	p-value	0.6600	0.2101	0.7670	0.5539
	N	192	192	192	192
Training time in the profession	R	-0.09*	-0.07*	-0.04*	0.03*
	p-value	0.2021	0.3300	0.5787	0.6654
	N	187	187	187	187

*Spearman Correlation Coefficient; R - Pearson Correlation Coefficient; DI (Domain - Professional Sensibility); DII (Domain - Professional Experience); DIII (Domain - Professional Knowledge/Abilities); DIV (Domain - Organization of the Care Network)

suicidal behavior in academic training, participation in training and scientific events on the topic, and the frequency of care for people with disabling illnesses and mental disorders. The Care Network Organization domain did not correlate with any categorical variable.

Discussion

Regarding the approach to people with suicidal behavior in PHC, the results make it possible to state that the Professional Sensibility and Professional Knowledge/Abilities domains presented higher scores, while Professional Experience and Organization of the Care Network had lower scores. These results indicate that although the understanding and theoretical-practical knowledge of professionals contribute to the approach to suicidal behavior, professional experience, working conditions and the organization of RAPS represent negative factors and weaken the approach to this problem in PHC.

Younger professionals with less time of work at the UBS understand suicidal behavior in a more empathetic way and recognize the importance of health services in facing this demand. This finding leads to the hypothesis that the more recent the academic training, the better the preparation of professionals for managing suicidal behavior. Furthermore, this association corroborates others, such as: having a

postgraduate degree, having four or more subjects on suicide during the course, participating in events and training on suicide, variables that were related to a higher overall IAAP-PCS score, highlighting the importance to invest in initial and continuing professional qualification.

In this sense, knowledge and abilities related to suicidal behavior are dimensions that directly interfere with professional attitudes during their approach and care. Different professional training strategies are described and favorably defended in the scientific literature.⁽²⁰⁾ Training on suicidal behavior using the Question, Persuade and Refer method (gatekeepers) offered to professionals in education, health, the socioeconomic sector and other sectors of the suicidal society have significantly increased the participants' knowledge, approach and self-confidence to conduct initial contact with the person expressing suicidal behavior.⁽²¹⁾

Workshops are strategies also explored to qualify the knowledge, abilities and attitudes of RAPS health professionals. By applying active and reflective pedagogical strategies, an increase in the awareness and knowledge of health professionals was observed, favoring co-responsibility between PHC services and strategic care represented by the Psychosocial Care Centers (CAPS).⁽²²⁾

The findings showed that health professionals willing to modify their approach in the face of new learning and those with qualified training were more willing to approach people with suicidal behavior. However, considering undergraduate courses in the health area, improvements in the curricula are needed in relation to the development of professional skills around mental health and the approach to people with suicidal behavior.⁽²³⁻²⁵⁾

The weaknesses observed in initial training reflect on the conceptions and attitudes of health professionals in relation to the problem, allowing the gap in technical and scientifically based knowledge to be filled by common sense, beliefs and stigmas. Consequently, persistent negative attitudes and conceptions are observed, making the approach to people with suicidal behavior iatrogenic, whether in hospital care,⁽²⁶⁾ PHC services⁽²⁷⁾ or in training spaces.⁽²⁸⁻²⁹⁾

Table 3. Correlation between the Professional Sensibility, Professional Experience and Professional Knowledge/Abilities domains and the categorical variables

Categorical variables	n(%)	Sensibility			Experience			Knowledge/Abilities		
		Mean	SD	p-value	Mean	SD	p-value	Mean	SD	p-value
Sex										
Female	168(87.5)	37.31	5.65	0.4462	21.18	9.3	0.8811	40.17	6.74	0.0563
Male	24(12.5)	38.42	4.39		21.63	9.37		43	6.93	
Total	192(100)	37.45	5.51		21.23	9.28		40.52	6.81	
Religion										
No religion	16(8.42)	39.70	4.1	0.0833	24.8	8.15	0.0963	45.07	7.85	0.0065
Has religion	176(91.67)	37.25	5.6		20.89	9.34		40.11	6.6	
Total	192(100)	37.45	5.53		21.2	9.29		40.5	6.82	
Specialization Postgraduate Program										
No	105(54.69)	36.49	5.8	0.0101	19.68	9.13	0.0066	38.79	6.46	0.0001
Yes	87(45.31)	38.61	4.93		23.11	9.17		42.61	6.66	
Total	192(100)	37.45	5.51		21.23	9.28		40.52	6.81	
Number of courses in training that addressed the topic of suicide										
None	60(40.27)	36.65	4.92	0.0205	15.2	8.58	<0.0001	38.03	6.31	0.0004
1 – 2	69(46.31)	38.45	5.88		24.74	8.11		42.03	6.53	
3 – 4	12(8.05)	39.08	3.75		23.58	7.76		42.92	6.89	
More than 4	8(5.37)	40.13	4.05		28.63	5.37		45.63	6.91	
Total	149(100)	37.87	5.34		21.01	9.45		40.68	6.83	
Participation in scientific events on the topic "suicide"										
No	118(61.46)	36.23	5.9	0.0001	18.44	8.83	<0.0001	38.98	6.15	0.0001
Yes	74(38.54)	39.39	4.71		25.69	8.23		42.97	7.13	
Total	192(100)	37.45	5.51		21.23	9.28		40.52	6.81	
Training in mental health in the last 12 months										
No	151(78.65)	37.04	5.65	0.0302	20.15	9.15	0.0015	39.77	6.55	0.0033
Yes	41(21.35)	38.95	4.73		25.22	8.75		43.27	7.12	
Total	192(100)	37.45	5.51		21.23	9.28		40.52	6.81	
Frequency of care for people with disabling physical illnesses										
Never/Rarely	34(18.18)	35.53	6.58	0.0080	16.65	8.68	<0.0001	38.56	6.34	0.0371
Sometimes	78(41.71)	37.19	5.28		19.96	9.03		40.13	6.51	
Often	47(25.14)	39.17	4.39		24.04	8.61		42.34	6.33	
Always	28(14.97)	39.14	4.49		27	7.85		42.49	7.6	
Total	187(100)	37.68	5.36		21.44	9.27		40.72	6.71	
Frequency of care for people with chronic pain										
Never/Rarely	18(9.47)	36.33	7.28	0.5700	17.78	10	<0.0001	39.83	5.97	0.0462
Sometimes	40(21.06)	37.1	4.84		16.75	8.56		38.18	7.14	
Often	72(37.89)	37.53	5.52		21.61	8.79		41.36	5.87	
Always	60(31.58)	38.08	4.31		25.02	8.56		41.68	7.27	
Total	190(100)	37.5	5.49		21.3	9.27		40.65	6.71	
Frequency of care for people with mental disorders										
Never/Rarely	20(10.53)	34.45	6.88	0.0013	12.55	6.57	<0.0001	36.05	5.28	<0.0001
Sometimes	66(34.74)	36.45	5.81		18.23	8.15		38.36	5.89	
Often	63(33.16)	38.3	4.39		22.71	9.14		41.62	5.74	
Always	41(21.57)	39.49	4.85		28.2	6.78		45.17	6.98	
Total	190(100)	37.51	5.49		21.27	9.31		40.67	6.68	
Frequency of care for people aged 60 and over										
Never/Rarely	10(5.24)	38.6	3.47	0.7883	13.8	9.02	0.0078	37.1	8.13	0.3087
Sometimes	27(14.14)	36.52	5.86		19.11	8.95		40.19	6.42	
Often	84(47.98)	37.69	5.26		20.83	9.36		40.57	6.84	
Always	70(36.65)	37.5	5.84		23.57	8.77		41.31	6.45	
Total	191(100)	37.5	5.47		21.23	9.31		40.61	6.72	
Frequency of care for people aged 15-30 years										
Never/Rarely	10(5.23)	36.1	3.81	0.4808	12.4	7.96	0.0318	36	6.94	0.1245
Sometimes	33(17.28)	37.73	5.35		21.97	8.28		40.21	7.13	
Often	84(43.98)	37.33	5.69		21.26	9.15		40.7	6.31	
Always	64(33.51)	37.83	5.52		22.17	9.67		41.41	6.85	
Total	191(100)	37.5	5.47		21.23	9.31		40.61	6.72	

Based on the research findings, professional performance demonstrated that frequent care for people with disabling illnesses and mental disorders was associated with the Professional Sensibility, Experience and Knowledge/Abilities domains of the IAAP-PCS. The low score observed in the second domain stands out, allowing the conclusion that care for population segments at greater risk for suicidal behavior in PHC has low potential to qualify the professional approach.

This result is worsened by the Brazilian scenario of epidemiological and demographic transition,⁽³⁰⁾ as well as the growing trend in suicide rates, with emphasis on the high number of suicides among young people aged 15 to 29 years.⁽⁹⁾ This situation puts PHC professionals in contact with the population at risk for suicide and requires the establishment of early mechanisms for the tracking, identification, stratification and management.^(11,31)

The low score in the Organization of the Care Network domain draws attention to the competence of PHC professionals in using health equipment and intersectorality as a strategy in approaching people with suicidal behavior. This result is related to the lack of coordination between RAPS services and the disregard for the Care Network as a mechanism that supports the work of professionals in PHC who deal with suicidal behavior.

This domain was not associated with the variables investigated in this study, such as level of education and training, which represents a second consequence related to the perceptions attributed to suicidal behavior by PHC health professionals. As the approach is understood as specialized demand, it results in fragmentation of care and referrals without implications between RAPS services. The notions underlying the unpredictability and dangerousness of the person in psychological distress make it difficult to establish an ethical, embracing and resolute attitude.⁽²⁶⁾

In RAPS, the centrality of PHC in the development of its attributes of ordering, coordination and longitudinality of care constitute a challenge for managers, coordinators and health workers. One of the purposes of RAPS is to implement the assumptions of psychosocial care for people with suicidal

ideation and their family members based on the construction of Singular Therapeutic Projects and continuous monitoring of cases.⁽³²⁾

Strategies such as Continuing Health Education and Matrix Support coordinate care and management, involving workers in the construction of solutions that could respond to the negative results explained by the Professional Experience and Organization of the Care Network domains.⁽³²⁾ Interventions carried out in PHC by using Continuing Health Education indicate the strengthening of the coordination between APS and CAPS, mobilizing workers towards the Psychiatric Reform.^(31,33) Although the municipality researched has the history of instituted strategies of Continuing Health Education, there were no ongoing processes during the period of this study.

Matrix Support benefits health teams in PHC as a space for sharing doubts, expectations and responsibilities in approaching people with suicidal behavior, their family members and significant people in their support network.⁽³⁴⁾ In the municipality analyzed, matrix support between CAPS and UBS through the participation of psychologists and social workers in team meetings was underway. These spaces validate and facilitate dialogue within RAPS and agreements between services, although the turnover of professionals requires frequent renegotiation and coordination.

This study highlighted the characteristics of the approach to people with suicidal behavior in PHC. The need to offer spaces for reflection on perception, knowledge/abilities and professional experience as continuing professional qualification on the issue stands out. On-the-job training strategies, especially continuing health education, motivates learning linked to professional action through a critical-reflective character. The importance of spaces that problematize care and work management in addressing suicidal behavior is discussed. Considering the organization of health care networks, such situations return to the qualification of sensibility, knowledge and professional ability. Finally, undergraduate programs as privileged spaces for meaningful learning also need to prepare future professionals to identify and deal

with the multifactorial phenomenon of suicidal behavior.

The limitations of the study arise from the health context of the COVID-19 pandemic during data collection, which made it difficult to reach the number of participants proposed by the sample calculation. Furthermore, as the study design does not allow establishing causal relationships that could explain the scores found in the domains of the instrument, longitudinal studies are recommended to advance the production of knowledge on this topic.

Conclusion

It was found that PHC professionals, with regard to approaching people with suicidal behavior, perform better in the Professional Sensibility and Professional Knowledge/Abilities domains. These results were associated with the age range of professionals, and the quality of initial and continuing training, and the frequency with which they treat people with disabling illnesses and mental disorders. The Professional Experience domain obtained a low score and was associated with the characteristics of initial and continuing education and the frequency of care for populations at risk for suicidal behavior. The Care Network Organization domain demonstrated a low score and no associations were identified.

Collaborations

Negrão AIO, Silva TD, Frangonari TF e Horta ALM collaborated with the study design, analysis and interpretation of data, writing the article, relevant critical review of the intellectual content and approval of the final version to be published.

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