Essay

Survivors bereaved by suicide and the possibilities of postvention within Brazilian public health

Sobreviventes enlutados por suicídio e as possibilidades para posvenção no contexto da saúde pública brasileira

Eder Samuel Oliveira Dantas[a]
https://orcid.org/0000-0002-6595-6105
Email: edersamuel_rn@hotmail.com

Juliana Bredemeier[b]
https://orcid.org/0000-0002-9153-8660
E-mail: juliana.bredemeier@gmail.com

Karla Patricia Cardoso Amorim[a]
https://orcid.org/0000-0003-4047-6073
E-mail: amorimkarla@yahoo.com.br

[a]Universidade Federal do Rio Grande do Norte. Programa de Pós- Graduação em Saúde Coletiva. Natal, RN, Brasil.

[b]Instituto de Terapia Cognitivo Comportamental. Núcleo de Prática Baseada em Evidências. Porto Alegre, RS, Brasil.

Abstract

Death by suicide leaves many people negatively affected in its wake. Many so-called bereaved survivors will at some point need care and support, known as suicide postvention. This theoretical essay, based on the corresponding literature, institutional documents, and legal frameworks, seeks to discuss possibilities for suicide postvention within Brazilian public health. Suicide postvention is better structured internationally than in Brazil, which currently focuses on support groups for bereaved survivors centered in non-governmental organizations. We must look to territorial and community-based health services, like the Psychosocial Care Centers, and envisage affordable and resolute postvention actions, such as free prevention lines, early home visits, therapeutic listening and grief counseling.

Keywords: Suicide; Bereavement; Public Health; Integrality in Health; Brazilian National Health System.

Corresponding author
Eder Samuel Oliveira Dantas
Hospital Universitário Onofre Lopes. Av. Nilo Peçanha, 620, 4º andar. Natal, RN, Brazil. CEP: 59012-300.

Resumo

Após um suicídio, diversas pessoas são afetadas negativamente. Muitos dos denominados sobreviventes enlutados, em algum momento, precisarão de cuidados e apoio, a conhecida posvenção do suicídio. O objetivo deste estudo é discutir as suas possibilidades no contexto da saúde pública brasileira. Metodologicamente, o texto configura-se como um ensaio teórico apoiado na literatura da área, assim como em documentos institucionais e marcos legais. No cenário internacional, a posvenção do suicídio está mais bem estruturada do que no Brasil que, atualmente, tem o enfoque em grupos de apoio aos sobreviventes enlutados centrados em organizações não governamentais. É preciso lançar o olhar para os serviços de saúde de base territorial e comunitária, a exemplo dos Centros de Atenção Psicossocial, e vislumbrar ações de posvenção acessíveis e resolutivas, como as linhas telefônicas gratuitas de acolhimento, as visitas domiciliares precoces, as escutas terapêuticas e o aconselhamento para o luto.

Palavras-chave: Suicídio; Luto; Saúde Pública; Integralidade em Saúde; Sistema Único de Saúde.

Introduction

Suicide is a global public health issue and, notably, a complex, multidimensional, and multidetermined social phenomenon that involves psychological, social, biological, environmental, political, and cultural aspects. The World Health Organization (WHO) (2019) estimates that at least 703,000 people die due to suicide every year in the world, representing an average global rate of nine deaths per 100,000 inhabitants, and 77% suicides occur in low- and middle-income countries.

Brazil is among the 10 countries with the highest absolute numbers of suicides worldwide. In 2020, there were more than 13,000 suicides in the country, resulting in a national rate of 6.6 deaths per 100,000 inhabitants. In the period 2010-2019, the suicide rates increased in both sexes, and the highest ones were recorded in the states of Rio Grande do Sul, Santa Catarina, and Piauí, in this order (Brasil, 2021).

For each death by suicide, it is estimated that the lives of another five to 10 people are directly negatively impacted (WHO, 2008). People who experience such a loss of someone close are called bereaved survivors, and may be family members, friends, teachers, school or university colleagues, co-workers, that is, the network of subjects with some kind of bond or relationship with the individual who committed suicide (Shneidman, 1973).

Suicide grief has specificities because it is related to a violent and stigmatized death. In this perspective, there are impacts caused on the bereaved survivors' lives, and those people go through social, economic, physical, and emotional issues. One can list sudden changes in family dynamics, financial difficulties, rupture of marital and affective ties, increased risk of anxiety disorder, loss of sleep, depression, increased suicidal risk, abuse of alcohol and other psychoactive substances, in addition to others situations that may vary according to culture, geographic location, and political and historical moment (Wilson; Clark; 2005; Cerel; Jordan; Duberstein, 2008; Fukumitsu; Kovacs, 2016).

Actions, strategies and interventions aimed at bereaved survivors are part of what is conceptualized as postvention, term coined in 1968, by psychologist and precursor of suicidology Edwin Shneidman,

at the first conference of the American Association of Suicidology. In addition to the care directed at survivors, it is also a postvention task to destigmatize suicide and serve as a secondary prevention effort to minimize the subsequent risk of this type of death in the community (Shneidman 1996; Erlich et al., 2015).

In some countries, such as Australia, Canada, the United Kingdom, New Zealand, and the United States (USA), community suicide prevention programs or initiatives are better structured than in Brazil. It is also verified that research that deals with scientific evidence of interventions related to postvention is concentrated in these countries (Andriessen, 2014).

Brazil, despite showing an upward temporal trend of suicide in most age groups and regions (Rodrigues; Rodrigues; Konstantyner, 2015) and, therefore, a high number of people who need suicide postvention care, does not address the subject clearly and strongly in the main public policy related to the theme, Federal Law No. 13819 of 2019, which "institutes the National Policy for the Prevention of Self-Mutilation and Suicide, [...] implemented by the Union, in cooperation with the states, the Federal District and municipalities" (Brasil, 2019).

In addition, there is a shortage of scientific publications in the country that deepen theoretical knowledge and reflect on care strategies in suicide postvention (Ruckert; Frizzo; Rigoli, 2019). Therefore, this text starts from the premise that the bereaved survivors' health and life course cannot be neglected; besides, collective health productions and the theoretical-practical scope of public health should also be concerned with historically stigmatized biopsychosocial themes. In this sense, this essay aims to discuss possibilities of suicide postvention in Brazil.

Methodologically, the text is configured as a theoretical essay and is founded on the area literature, as well as institutional documents and legal frameworks. The emphasis is on topics focused on the bereaved survivors' perspective, analysis of postvention at the international and Brazilian levels, and discussion of intervention proposals.

For this purpose, this study (1) reports the main conceptual characteristics related to the term "bereaved survivors" and the experiences of suicidal bereavement; (2) describes the (inter)national scenario in relation to suicide postvention, and (3) lists possible interventions in the field of public health aimed at survivors of bereavement by suicide in Brazil.

Survival after suicide: grief

Conceptually, the term "survivor," coined by Edwin Shneidman, refers to all those individuals who experience the death by suicide of someone close to them and are negatively affected by it. In Brazil, the literal translation "survivor," or "bereaved survivor," has been used mainly to distinguish these from people who survived after their own suicide attempt.

Moreover, it is noted that there is a distinction between being a "bereaved survivor" and having been "exposed to suicide." According to Andriessen (2014), the first concept refers to the bereaved that had a personal and close relationship with the deceased, such as friends and family. The latter applies to people who did not personally know the person who died, but who was negatively exposed to the fatal act in some way, such as suicide with great media coverage, and/or with witnesses at the scene of the suicidal act (firefighters, police, and bystanders).

Therefore, in this text, the terms "survivor" and "bereaved survivor" will be used according to the definition given by the aforementioned authors, as the need for conceptual delimitation is stressed, including for the proposition of public health actions and care aimed at these individuals.

Over the years, some authors have conducted surveys on how many people would be directly affected by a death by suicide. In the late 1960s and early 1970s, Shneidman (1996) estimated that an average of six survivors would be affected by each death. Nevertheless, Wrobleski (2002) considers that the number of bereaved survivors after a suicide would be 10. In any case, both Shneidman and Wrobleski were in line with a later WHO publication (WHO, 2008), in which between five and 10 people are directly affected by each suicide committed. In a complementary and critical manner, Berman (2011) warns that estimates regarding the number of individuals vary, depending on the relationship, the frequency of contact between the deceased and the bereaved, and the age of the person who died, among others factors.

More than the certainty of the estimated number of bereaved survivors, recognizing and caring for these people is necessary. When thinking about Brazil's territorial and population extension, the inexistence of affirmative health policies and strategies directed at this part of the population, and the biopsychosocial damages resulting from deaths by suicide, it is possible to understand the urgency of treating it with the due importance, and consider it a public health issue.

Grief is a natural response to the death of someone the person had a relationship with, and most people will experience it at some point in their lives. However, it is a stressful, difficult, and painful situation to go through. During this process, different emotions and reactions are experienced, such as despair, hopelessness, fear, deep sadness, anger, and revolt, among others. In some cases, it can evolve even more unfavorably, affecting the mental and physical health and the bereaved's entire socio-family dynamics (Nunes et al., 2016).

People bereaved by suicide may experience more shock or trauma in this situation than in other categories of death, due to the unexpected, violent, and unjustified nature of the suicidal act. Besides, some of the survivors may be the people who find the body after death, having to deal with the scene and the memories that flood back.

It is important to emphasize that, after a suicide, one immediately starts to face unexplained questions and speculations about the life of the person who committed suicide. At the same time, survivors have life stories that need to go on, that is, they need to go on with grief and beyond. Additionally, in the course of this so-called survival, several feelings arise, with a certain frequency: accusation, guilt, anger and revolt, shame and fear. In short, there are multiple issues that permeate the bereaved's lives and can negatively affect their mental and physical health (Fukumitsu, 2019).

It is also observed that suicide grief inevitably brings to the bereaved survivors an incessant search for the meaning of this extreme act and the value of life itself, as well as an arduous process in an attempt to understand how they were unable to perceive or value the risk of suicide of a loved one and make a timely intervention (Duarte; Tassinari, 2019).

In fact, suicide is multicausal, including a number of issues and causes that make simplistic explanations impossible. Although there are risk factors evidenced in the literature (severe mental disorders, abusive use of psychoactive substances, previous suicide attempts, social isolation, histories of lives marked by violence, childhood abandonment, etc.), there will always be questions that cross the bereaved's lives and, perhaps, this is one of the points that differentiate this type of grief from what is associated with other causes of death (Fukumitsu, 2019).

Despite the advance of theories and studies on suicidal behavior around the world, knowing clearly why human beings take their own lives is always a difficult task. Often, not even the person committing suicide knows the complicated reasons for self-destruction (Shneidman, 1996). And, in this process of doubt that can increase the stigma around suicide, bereaved survivors may be reluctant to confide that the death was in fact self-inflicted, causing even more isolation from the community and also from family members who could give them support.

It is also emphasized that the way subjects deal with death by suicide also depends on individual and collective issues, as they depend on the subjectivity inherent to each one (personality, perception of the world, and psychological resilience), and on the interrelationships and adjustments that the person can make according to the interaction with society, culture, and the environment (religion, community, family support, and access to health services) (Fukumitsu, 2019).

Since the 1980s, Shneidman (1985) has argued that the biggest public health issue in relation to suicide was not the prevention or clinical management of attempts, but taking care of the negative effects caused by a death by suicide on bereaved survivors. Their lives change forever and, for various reasons people face this problem without the support they deserve and need.

Suicide postvention in Brazil and the world: what exists?

By means of information and reception, postvention aims to support and assist people who lost someone to suicide, acting in the face of biopsychosocial complications that arise during

the grieving process. It also seeks to minimize negative impacts on community places such as schools, churches, universities, and workplaces (Shneidman, 1996; Andriessen, 2014).

Since 2014, by the "Preventing Suicide: a global imperative" report, WHO (2014) recognized that postvention should enter the agenda of structural actions related to suicide. In this document, it is considered that communities should provide support for bereaved survivors and develop psychosocial interventions. In addition, countries should include issues related to care for survivors in national suicide prevention programs.

Some international strategies have shown successful results, demonstrating effectiveness both in individual and collective actions and in public health macro policies. Over the years, support services have been provided to survivors, mainly in European countries and North America. However, there are difficulties in carrying out scientific research using these interventions, which generates low levels of evidence in relation to what is carried out around the world (Andriessen et al., 2019).

The main difficulties in scientific research on postvention are related to the selection and continuity of the individuals' participation. It is pointed out the almost inexistence of studies that deal with interventions aimed at children, adolescents, and older people. In addition, most pieces of research focus on psychotherapy for grief, making evidence of effective activities in the community, school environment, or participants' own homes rare (Linde et al., 2017; Andriessen et al., 2019) .

Regarding worldwide national programs aimed at the bereaved, only 14 out of the 52 member countries of the International Association for Suicide Prevention (IASP) have such strategies. In countries such as Norway, New Zealand, Ireland, and Belgium, suicide postvention has been carried out systematically, with services aimed at caring for survivors and strengthening health professional training in caring for the bereaved. In most of these countries, these actions count on government's support and articulation (Andriessen, 2014; Myfanwy; Vita; Sharon, 2019).

In Australia, the StandBy Response Service is an active prevention program that offers global care and actions for people bereaved by suicide that, in addition to developing the community's ability to manage and respond appropriately and effectively to death, improves the quality of infrastructure of health services and partnership networks, in addition to encouraging more studies related to postvention in the country (Andriessen, 2014).

The USA has several suicide prevention strategies; some of them are included in its national plan, others are actions of social organizations. Moreover, there are different community associations of survivors that work to support other bereaved. In some US states, community leaders are trained to provide counseling on issues relevant to the moment of suicide grief (Scavacini, 2018).

In the UK, there are helplines for survivors and online support via email and chat service, as well as psychoeducational programs for children and adolescents in school settings. In addition, as in the USA, Australia and Belgium, a national survival day is held in the country for the bereaved, giving visibility to this situation (Andriessen, 2014).

In the national suicide prevention action plan, New Zealand develops actions aimed at survivors, such as immediate health care for family members after suicide, psychoeducation on loss and grief for the community, and advice on legal issues involving the police and legal entities. It also offers specialized care provided by mental health professionals (psychologists, nurses, and social workers). Community-based work is carried out for at least one year after the suicide to monitor and assist survivors, either from an individual or institutional perspective (Ministério da Saúde, 2011).

Suicide postvention actions and strategies in Brazil are not developed based on a national plan, nor with the federal government's articulation. In the last four years, some municipalities and states have included postvention in suicide prevention plans, such as the state of Piauí (2017), and the municipalities of Maringá (2017) and Fortaleza (2019). In the public sphere, when analyzing the three aforementioned plans, there is a focus on postvention actions to train professionals through events on the subject and availability of instructional materials, such as booklets and manuals.

When analyzing the Brazilian scenario more comprehensively, it can be seen that postvention is

concentrated in Non-Governmental Organizations (NGOs), mainly in the activities of support groups for bereaved survivors. These groups are guided by mutual support, rescuing bonds and reducing the stigma involved in suicide.

The Support Groups for Suicide Survivors of the *Centro de Valorização da Vida* (CVV), which operate in the municipalities of São Paulo (SP), Porto Alegre (RS), Novo Hamburgo (RS), Curitiba (PR), and Cuiabá (MT), enable support via different means, such as telephone, chat service, e-mail, and face-to-face service (in 80 service stations). In São Paulo, there are also postvention actions through the Vita Alere Institute for Suicide Prevention and Postvention, which develops support groups for bereaved survivors in person and online (Ruckert; Frizzo; Rigoli, 2019; Scavacini; Cornejo; Cescon, 2019).

That said, it is undeniable that the interventions provided by NGOs represent a practice of reception, communication, mutual support, and collective support for the bereaved. However, it is necessary to recognize that when certain actions are not institutionalized through public policies, their reach becomes limited. In other words, the issue cannot depend only on individual or isolated "will and solidarity," but it should be, above all, treated as a State policy.

It is pointed out that, through the *Setembro Amarelo* [Yellow September] campaign – a month aimed at raising awareness of suicide – created in 2015, Brazil has debated the issue of suicide in a broader way. The Ministry of Health (MS) began to publish epidemiological bulletins on suicide attempts and deaths from 2017, with the last version in 2021. There are also MS manuals aimed at the health, education, and media professionals' performance in the face of suicidal behavior.

Nonetheless, the country's suicide prevention policy, established by Law No. 13.819, of April 26, 2019, does not seem to have had an effective impact on the development of programs and concrete actions for bereaved survivors. In any case, article 3, item V, of the aforementioned Law establishes: "proper approach to family members and people close to suicide victims and the guarantee they will receive psychosocial support" (Brasil, 2019).

Although Brazil's young suicide prevention policy represents an unprecedented advance, the text is generic in terms of support, care, and attention to those bereaved by suicide. In addition, the policy is fragile because it does not suggest directly any program and/or service within the Brazilian National Health System (SUS) that can be implemented or improved with regard to suicide postvention and prevention (Dantas, 2019).

Possibilities of suicide postvention actions and interventions in Brazil

Postvention actions and interventions are developed after suicide in order to minimize negative health outcomes and facilitate recovery among the bereaved. In public health, the application of postvention should go beyond psychotherapy and not only focus on individual progression in relation to difficulties in adapting to loss (especially in complicated grief). In other words, it is not restricted to the clinical and psychopathological fields (Andriessen et al., 2019; Andriessen, 2014).

Health services that propose carrying out postvention activities can have either an individual or collective perspective, focusing on the survivors' psychosocial needs, and can be operationalized via different activities: counseling, psychotherapy for bereavement, support and group support, increased awareness of the topic among the general population, creation of socio-educational campaigns, and development of practices to promote mental health in care actions (Scavacini, 2018).

Postvention actions and interventions made available in the services may have a more traditional (passive) model characteristic, when they await the bereaved survivors come to them. On the other hand, they can adopt the model that intends to be an extension of the (active) service, in order to provide support and resources as quickly as possible; therefore, professionals would search for the survivors in the community (Survivors of Suicide Loss Task Force, 2015).

However, when thinking about postvention activities in Brazil, regarding the potential and challenges of this Health System and in the SUS perspective, some important considerations have to be made. Initially, it is emphasized that postvention structuring actions need to be developed based on the integrality principle. It is what guides, within the health services, the professionals' action, good quality

health care that considers the multiple dimensions and complexities of public and people's health issues, with a multidimensional vision of individual and collective health (Tesser; Luz, 2008).

Therefore, the great power of Primary Health Care (AB) and the Psychosocial Care Network (RAPS) in Brazil is emphasized in the plural practices in health and in the ordering of care. The first, currently governed by Ordinance No. 2.436, of September 21, 2017, is characterized by a "set of health actions, at the individual and collective levels, which covers the promotion and protection of health, the prevention of diseases, diagnosis, treatment, rehabilitation and health maintenance" (Brasil, 2017).

This role played by AB, which has Family Health as its priority tool, can substantially contribute to suicide postvention strategies, particularly due to its territory- and community-based character. The existence of multidisciplinary teams, with the presence of Community Health Agents (ACS), and the inclusion of the community in the organization of services, are considered strong tools for articulating health actions in AB (Sousa et al., 2019).

Although AB concentrates most of the population's health demands, RAPS, instituted in Brazil through Ordinance No. 3.088, of December 23, 2011, and which has the Psychosocial Care Center as the strategic beacon of action, is the one that serves and receives the most complex situations related to mental health (Brasil, 2011). Thus, RAPS should have the technical and structural potential to address issues related to suicide postvention.

RAPS was created as an organizational proposal for mental health services in the country. Its objective was to integrate care in an orderly manner, from the articulation of territory-based services, at the various levels and points of the SUS care. The implementation of RAPS in Brazil has shown substantial advances, in a logic that invests resources in the expansion of community services, in the development of innovative care practices, and in the users' active participation (Sampaio; Bispo, 2021).

However, despite the RAPS advances and the Brazilian population's achievements coming from AB, it is necessary to think about the suicide postvention also with the enormous challenges imposed on the SUS and some setbacks – especially related to the structural dismantling that it has been facing in the last decade –, which became more severe after 2016. In this regard, we can highlight the priority financial incentive that the "new Mental Health policy" of 2019 directs to Therapeutic Communities and the increase of these values for hospitalizations in psychiatric beds, satisfying the asylum paradigm that circumscribes psychiatry (Cruz; Gonçalves; Delgado, 2020).

With regard to setbacks, we also emphasize the approval of Constitutional Amendment No. 95 of 2016, which froze investments in health for a period of 20 years, affecting the quality and sufficiency of health services provision throughout the country (Brazil, 2016). More recently, in 2019, there was a weakening of Primary Care and some of its devices, such as the Family Health Support Centers (NASF), excluded from programs that would have funding guaranteed by the federal government through Ordinance No. 2.979, of November 12, 2019 (Castro et al., 2019).

Furthermore, given the current health situation, in order for suicide prevention to take place systematically in Brazil and as a State policy,it is possible to think that the actions take place within the scope of existing health services and programs. In order to collaborate with this development in the future, the following are proposals for suicide prevention actions and interventions, to be considered in public health:

(1) Counseling for grief – provision of support for the bereaved to face issues intrinsic to the suicide grieving process, preferably carried out in the community where they live. This intervention can be performed by trained professionals from the Family Health team, such as nursing technicians, nurses, community health agents, and physicians, or by NASF professionals;

(2) Individual/collective care provided by a Mental Health professional – provision of care to bereaved survivors by a mental health professional (specialist nurse, psychologist, psychiatrist, among others). Priority should be given to receiving the individuals', families' and groups' demands, to therapeutic listening and bonding. This action should be part of RAPS activities. Creative strategies that use artistic expressions should be considered, whenever possible;

(3) Support groups for bereaved survivors – creation of support and mutual support groups for bereaved survivors, led by health professionals trained for this activity, prioritizing the sharing of survivors' experiences and obtaining mutual support. They can be conducted by NASF, developed at AB or other RAPS services, and may even be linked to the NGOs' work;

(4) Development of manuals and booklets on suicide postvention in health services – equip health professionals to fully meet the survivors' demands. Manuals need to be in line with the best practices carried out in the world and consider cultural, historical, political, and economic aspects in order to be up to date;

(5) Free national hotlines and chat services – provision of adequate information and guidance to survivors on where to seek help in the community, in addition to carrying out confidential emergency listening, focusing on reception. This postvention strategy can be implemented by the Federal Government to ensure a greater level of coverage;

(6) Guidance on social and legal issues related to rights arising from death by suicide – immediate guidance after death by suicide, related to legal and legal issues, such as the need to preserve the scene of death, the need to perform necropsy, the cause of death, the course of investigation necessary to rule out another type of violent death, and the preservation of family intimacy and the image of the person who died. These guiding actions can be part of the dynamics of social workers in any health service. Professionals from other areas of knowledge need to be attentive to provide the same clarifications when necessary and to think about the possibility of formulating informative and educational materials for the general population;

(7) Psychotherapy for grief – offer of psychotherapy for grief, within the scope of RAPS. This intervention can be carried out individually or collectively and needs to seek to develop the subjects' autonomy. Emphasis should be given to those cases which AB or the RAPS mental health service identified as more complex situations with an unfavorable evolution related to grief, regardless of how much time has passed after the close person having committed suicide;

(8) Educational work with the theme suicide grief – educational work performed in university and/or school health programs, such as the School Health Program (PSE). In addition, education activities can be directed to worker health programs, within the scope of municipalities and states. The main purpose of the educational strategies in these programs is to: a) help schools, universities and work environments develop reception strategies, after the occurrence of suicide of any of their members, and b) prevent subsequent suicides and favor the reduction of stigma;

(9) Home visit by a professional/health team – guarantee of at least one postvention home visit to the person and/or family bereaved by suicide, which must be carried out by the Family Health team to which the bereaved person is assigned. The visit should be previously scheduled with the bereaved person(s) and prioritize: a) early listening; b) assessment of the need for support in other postvention strategies, and c) referral of survivors to RAPS or to services of the intersectoral network, when necessary.

Although the interventions/actions have been didactically demonstrated separately, they should be used articulated with each other and in a combined manner, when possible and/or necessary, according to available (human and structural) resources.

It is reiterated that the aforementioned actions deal with postvention possibilities in public health that considered, especially, the SUS territory- and community-based health services. In this way, there are still discussions and alternatives for postvention activities in the proposed field of action, which is broad and comprehensive.

Final considerations

This text discusses the possibilities of suicide postvention in Brazil within public health, based on the difficult experience of bereaved survivors and on the international scenario. It is observed that, in some countries, the suicide postvention is treated with more robustness, organization, and political planning than in Brazil. In the country, suicide postvention actions are still concentrated in large centers and focused on support groups for bereaved survivors, and they are developed mainly from NGOs.

It is pointed out that, despite the numerous current challenges faced by the SUS, possibilities of postvention actions aimed at bereaved survivors were presented, using the potential of AB and RAPS, especially with regard to the scope and power of resolution in the plurality of actions of territory- and community-based services.

The expectation is that the reflection, undertaken now, can incite the necessary and urgent critical dialogue between different social actors and institutions in the country. Finally, although this text has focused on public health, the work intersectorality with complex themes such as suicide is paramount, involving, especially in this case, education, social assistance, and the law, which can contribute, even more significantly, to the lives of people bereaved by suicide in Brazil.

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