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CONTRIBUTIONS FOR IMPROVING THE PSYCHOSOCIAL ATTENTION NETWORK REGARDING SUICIDE PREVENTION

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ABSTRACT

Suicide is a complex public health problem and requires longitudinal and integral follow-up in the Family Health Strategy, and other services which replace hospitalization. However, some of these services demonstrate weaknesses in care. In this way, the objective is to propose strategies to improve the services composing the Psychosocial Care Network, strengthening suicide prevention, and qualified multiprofessional care. Current health scenario does not follow the coverage of suicide issues, requiring differentiated interventions that consider the social context, epidemiological factors, and provision of resources for the promotion of mental health. In primary health care, development of new therapeutic strategies, operated by the Multiprofessional Group for the Prevention of Suicide Attempts, is indicated. In Psychosocial Care Centers is recommended the creation of care groups, as well as construction of Single Therapeutic Projects. The importance of team meetings with case discussion and notification of self-harm contexts is highlighted. Specially in institutionalized patients constituting the Sentinel Network in the Hospitalization Unit in General Hospital. Thus, it is considered fundamental to awaken to dialogic practices and permanent education in services by re-evaluating interventions directed at vulnerable groups in the community in order to reduce self-directed violence.

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INTRODUCTION

Since the middle of the 20th century, suicide has ceased to be considered as a purely philosophical or religious issue, becoming a complex phenomenon considered as a psychosocial public health problem of multiple causes, usually related to a behavior resulting from a mental disorder (Bezerra Filho et. al., 2012).

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Data point out to one death every 40 seconds in the world, Brazil being the eighth country in absolute numbers of suicide (World Health Organization, 2014). According to data from the Mortality Information System (SIM), in 2013 there were 11,736 self-inflicted deaths, more than 29 deaths per day, corresponding to a rate of 5.7 per 100 thousand inhabitants (Brasil, 2015). Alarming mortality rate still does not reveal the complexity of the phenomenon, since it does not represent the attempts of suicide and the under-reported injuries that are estimated to surpass the deaths around ten times more (Oliveira, 2010).

Among risk factors, there are previous suicide attempts, having mental disorders (especially Depression and general mood disorders), abuse/dependence of alcohol and other drugs, suicide history in the family, social, family and love conflicts, feeling of loss, lack of leisure and emotional balance (Cavalcante, Minayo and Mangas, 2013). Situations generating stress and suicidal ideation such as: accidents, unemployment, involvement in legal proceedings, death of loved ones, divorce, abrupt change of routine, religious conflicts, emergence of serious illnesses, and exposure to situations of violence and economic vulnerability are even more frequent in the society, contributing to the problem's swelling. Scarcity of resources in health, cultural barriers, and the generation of taboos and stigmata for the person who attempted suicide and their socializing group is worth considering since they hamper the adequate attendance of professionals who rarely see this topic be addressed in the actions of permanent education. Failing in this way in following up of each case in its family and community context with the perspective to prevent further attempts and promote mental health, the services of the Psychosocial Network have only witnessed the progression of this aggravation mainly among adolescents and young adults implementing few effective interventions(Pires *et al.,* 2014; Oliveira *et al*.,2015). A study, with a sample of 153 suicide attempt cases and 153 controls, identified individuals with some underlying psychiatric disorder were ten times more likely to attempt suicide (Félix, 2016). Through this strong association, it is urgent to improve the Psychosocial Care Network with a focus on therapeutic options. Thus, the question is: How has mental health services addressed this issue from the perspective of prevention and follow-up? Which strategies have been used to track the risk? Which therapeutic acts are performed with the notified cases and their relatives? How are these acts related in the perspective of the Care Networks? What mental health promotion initiatives are carried out in the services that replace the hospitalization?. Therefore, creating warning devices in health facilities to promote reporting, selecting risk groups for self-harming, and implementing follow-up actions in order to reduce incidence and mortality rates are necessary. To propose general strategies for improving services that composes the Psychosocial Care Network, strengthening municipal suicide prevention policies, is the objective of this article.

MATERIALS AND METHODS

Proposals are based on the results obtained in a dissertation research titled: 'Fatores de risco para a tentativa de suicídio em um hospital de referência da mesorregião noroeste do Ceará: estudo caso-controle' ('Risk factors for suicide attempt in a referral hospital of northwestern mesoregion of Ceará: a case-control study') (Félix, 2016). In the study, 153 cases of suicide attempt and 153 controls were addressed in the emergency service of a referral hospital, identifying risk factors such as: previous suicide attempt, dependence of crack, alcohol and other drugs, and presenting some mental disorder. Results showed 37.2% of the cases had a basal diagnosed mental disorder, however inadequately managed by the Mental Health Network; 38.6% of the cases had previously attempted suicide and were not being followed by the CAPS (Psychosocial Care Center) or Family Health Strategy (ESF). Many users were monitored by CAPS-AD (Psychosocial Care Center for Alcohol and other Drugs) but not monitored for self-harm risk. This presentsassistance gaps which need to be solved.

Conceptual framework for elaboration of these contributions includes the integrative review linked to research that also considered local experiences reports of some municipalities that were successful in innovating and the development of municipal policies to prevent self-directed violence (Félix *et al.,* 2016). Suggestions are also based on ethical principles and on the National Plan for Suicide Prevention 2013-2017.

Psychosocial network services' panorama: Previously to the Psychiatric Reform, the therapy applied to the mental disorder did not consider the autonomy of the subject and of the family, using isolated methodologies of the life history with few possibilities of rehabilitation and social reintegration (Pinto *et al*., 2011). Gradual change of these old paradigms has found difficulties in improving health education and in teaching-service integration as indicated in the National Plan for Suicide Prevention - 2013/2017 and the Plan of Action on Mental Health 2013-2020 (World Health Organization, 2013). Initially, we present the devices that compose the Psychosocial Attention Network in Brazil in a general way. Figure 1 shows the reference units, but other social devices and projects in the field of public health should be based on the elaboration of municipal prevention guidelines. Emphasis should go to the sharing of data through electronic medical records, settlement of mental health demands, and effective communication within the Network.

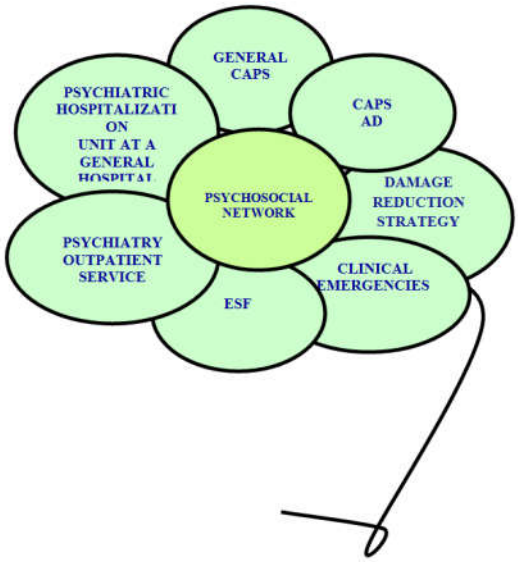
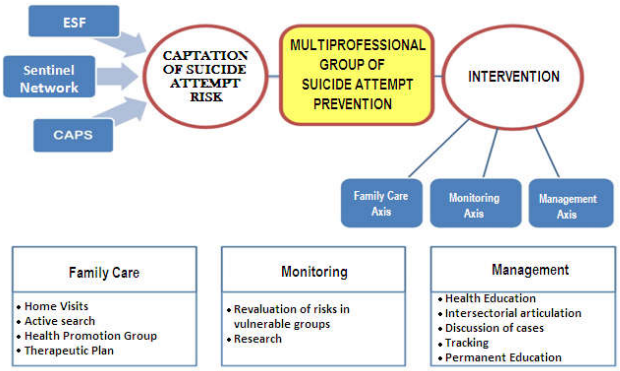


Figura 1. Services which composes the Brazilian Psychosocial Care Network

Considering this current scenario, we must go beyond listing interventions. We propose to rethink inter-sectoral therapeutic plans that capture the multidimensionality of the suicide attempt, and favor the development of new competencies with longitudinality and integrality in care. Therefore, the suggestions will be pointed out distinctly to the services with more contact with cases of suicide crisis, they are: CAPS, ESF, Psychiatric Hospitalization Unit, Clinical Emergencies, and outpatient services for psychological care.

Family Health Strategy: For Primary Care level, we recommend the complete focus to the professional qualification, the development of new mental health promotion strategies, and the resignification of the team in the community. To do so, the first step is to define risk strata as people with mental disorders, users of psychoactive substances, cases of previous attempts, people with manifested

death ideation, and family members who experience the crisis. Approach to these people should be individual and for the family; however, collective therapies or approaches should be avoided as a 'follow-up group for people who have attempted suicide' in order to avoid characterization and stigmatization with such public. Thus, approach could be performed with the support from Health Community Agents and analysis of the medical records to identify the priority public and from this, organize the matrix support in Mental Health with help of the multiprofessional teams of Mental Health Residency and Family Health Support Nucleus (NASF). Follow-up teams can reassess risk and propose Individual Therapeutic Projects (PTS) periodically to plan care actions according to the individual's reality, as well as to support and stimulate self-care, bonding, and approximation and interaction among professionals, users, and family in order to promote protective factors and to identify any intercurrences in advance, intervening when necessary, based on the principle of bioethics. Within the Network, this can operate through multiprofessional and academic extension work groups hosted in the ESF. We call this proposal as *Multiprofessional Group for Suicide Attempts Prevention,* with the objective to carry out home visits, active search, health education, risk detection, monitoring, referral to specialized services, validation of research instruments, family follow-up, motivational interviews, community articulation, post-discharge vigilance, care systematization, and health promotion.



Source: Elaborated by the authors

Figura 2. Diagram with suggestions of interdisciplinary actions for validation of the Multiprofessional Group for Suicide Attempts Prevention

Academic extension can positively integrate the university, the various categories of health, and the psychosocial network, identifying areas of higher incidence to initiate actions. Purpose of these contributions is not to standardize a model, but to present alternatives to maintain the minimum, fast, and resolvable follow-up of patients at risk under the co-responsibility of the ESF and the referral CAPS. From the evidence of the research from which this article is based, restriction to means, medication, and a punitive or guilty conduct are understood to not treat suicidal ideation and do not prevent self-injurious behavior. Therefore, development of periodic campaigns and a more focused approach at each point of attention go towards the reconstruction of the line of care in self-harm with a focus on light technologies and construction of mutual care with these individuals.

Psychosocial care centers

CAPS-General: CAPS are strategic for prevention of the suicide attempt favoring the innovative citizen practices that incorporate and the multiplicity of roles, co-responsibility, and autonomy in this new flow of attention. It is recommended the formation of a specific group to support individuals and families with a history of self-directed violence and manifestation of suicidal ideation. In addition, the use of the Beck Depression Inventory (Cunha, Werlang and Fin, 1997) is suggested in reception and individual care consultations, aiming the appropriation of the risk factors to proceed with the appropriate referrals. This practice is intended to support the patient in crisis, involving not only the clinical treatment, but also a broader understanding. Reception of patients, as a life-enhancing tool, can be improved, since "individual care does not give way to the complexity of needed interventions to minimize or eliminate the risks related to suicide attempts" (Heck *et al*., 2012, p. 29, our translation).

Caps-ad e damage reduction strategy: As evidenced in the study, illegal drug use contributes significantly to self-injurious behavior. In specific mental health services for dependent users, it is necessary to invest in Single Therapeutic Project (PTS) that incorporates a shared assessment of a person's condition and how vulnerable it is to exposure to substances of abuse. Thus, PTS brings a prospective discussion and establishes flows and itineraries to guarantee reception and integrality in this demand, including in home visits with damage reducers. Permanent Education of employees is necessary to be strengthened, generating the ability to detect risk in all approaches and to conduct each case appropriately (Moura *et al*., 2011). CAPS AD multiprofessional team should understand the thresholds of suicidal ideation, teach families about the risk signs, and provide support in contact with the other devices of the Network for a care free of prejudices and value judgments. Considering the preservation and appreciation of the singularities of each unit/team it is possible to reorganize the work processes facing such a challenging theme. The strengthening of these themes in the groups is suggested. Group psychotherapy enables exchange of experiences, solution for common problems; it promotes a sense of belonging, and promotes co-responsibility for their own health. "At Psychosocial Care Centers, this modality, under the name of groups and workshops, is the main therapeutic resource, aiming to promote the development of cognitive, communicational, relational, and contractual skills" (Ribeiro, Marin, and Silva, 2014, our translation). Each user should also be evaluated using the Beck Depression Inventory (Cunha, Werlang, and Fin, 1997).

Psychiatric hospitalization unit in general hospital: Routine of a Psychiatric Hospitalization Unit in General Hospital reveals several possibilities to identify the risk, when the patient is no longer hospitalized precisely for attempted suicide. Opportunity for 24-hour follow-up, and access to medication allow the evaluation of the patient's responsiveness, his integration with the family, and other factors that compose the concept of death itself. The environment of psychiatric hospitalization is conducive to arousing suicidal ideation and could culminate in new attempts. Such events could happen within the unit or lead to false answers in medical evaluations to obtain hospital discharge and then conclude the suicide project. Identification of such behaviors depends on the expertise of the professionals. According to Pacheco *et al*. (2003), in general, as days go by, the team's caution decreases without a respective decrease of the risk. At such times, the individual can take advantage of the monitoring failures to try

achievement within the hospital. Consequently, team meetings are vitally important, alongside with frank discussion of information/impressions on each case. Risk of suicide requires assertive and directive actions. Attitudes from all team members should be cohesive and directed towards vigilance, and containment of anxiety. In this context, a specific care protocol for people whose cause of hospitalization was the suicide attempt is fundamental to be implemented. Another very important measure to be taken is the creation of a database for surveillance and monitoring; it is not mandatory to be computerized, a logbook and an occurrences book would already encompass this information. From these data, team would be able to verify the frequency of the hospitalizations associated with the self-injurious behavior and the previous history of violent impulses against itself. Families who are utterly tired especially in cases of sequential suicide attempts are not uncommon to be found. Family members often feel beaten, powerless and tend to give up. Thus, therapeutic family bond even during hospitalization is also recommended, especially at the time of the visit. Risk of self-injurious behavior cannot be annulled, however, to minimize it, compromise within the network is necessary. Adaptation of light health technologies (reception, bonding, co-responsibility and autonomy), risk screening, monitoring, group work and medical referral are suggested. In this perspective, adherence to treatment ensures dynamicity to jointly overcome the problem.

Clinical emergencies and outpatient units network: Beyond encouraging isolated actions, priority should be given to the following up of cases where the risk is clearly higher, as in people who have committed self-harm recently. Therefore, first step would be the establishment of a Sentinel Network in referral hospital and outpatient services with the objective of notifying the risk. Consequently, after clinical discharge, the cases could be managed until the psychological discharge which must occur with the patient at home, with the family, activating protection factors, with therapeutic and pharmacological follow-up when necessary. Thus, development of promotion of mental health, and quality of life are generally reached months after the occurrence. In this context the Multiprofessional Group Suicide Attempts Prevention would be the enhancing tool of this care.

The practice in the system: Some successful experiences in municipal spaces have been shared and adapted to different realities. Conte *et al*. (2012) present a Suicide Prevention Program (PPS) developed in a municipality in the south of Brazil. "PPS of Candelária represents an innovative program for the prevention of suicide, both in terms of the originality and relevance of the proposal, and in terms of the impact on mortality from the disease" (p.2024; our translation). This encourages critical reading and sharing of these initiatives. "Steps to implement the PPS are to organize the workflow in order to reduce restriction to users, involvement of the teams linked to the program and to health, qualification of health professionals for care and risk identification, and for differences between ideation, plan and suicide attempt" (Machado, Leite, and Bando, 2014, p. 348, our translation).
In addition to these aspects, municipal programs should include schools, media disclosure on related issues, restrictions on marketing of toxic potentials and other means that can be used for self-extermination, and assurance of availability of anonymous direct connections and help centers, including over telephone (Koch, and Oliveira, 2015). Programs and public policies for suicide prevention have existed for about a hundred years in the world. "However, cultural differences and the specificities of populations must be weighed (...). Complexity of the suicidal phenomenon imposes a local consideration for the formulation of public policies" (Koch, and Oliveira, 2015, p.164, our translation).

Final considerations: Results demonstrate that risk determiners integrate themselves in a way which isolated actions over an only aspect will hardly decrease the possibilities for suicide attempt. Thus, the awakening for more creative, prospective and flexible practices is necessary, so it promotes a dialogical service for this health emergency. In a micro-situation context, the services composing the Psychosocial Network are supported by a strong prevention municipal policy, which can effectively generate a positive impact on communities decreasing the stigma and helping those who need it. Professionals must be in tune with the anti-asylum movement and its modalities of service since graduation is emphasized. For this generates a reflexive praxis about the multiprofessional approach to the survivors and their families, providing them with tools for the exercise of citizenship, for the self-care, and for social reinsertion. This article seeks to instigate and provoke local movements for creation or improvement of prevention municipal policies of and qualification of mental health professionals. Suicide, considered from an extended social perspective, should be more debated in the Network, since, except for destructive impulses, the high number of deaths reflects chronicity of risk factors in people with mental disorders without proper follow-up.

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