THE INTERVENTIONS OF PROFESSIONALS OF A PSYCHOSOCIAL CARE CENTER TOWARDS CLIENTS WHO ATTEMPTED OR ARE AT A RISK OF SUICIDE[1]

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ABSTRACT: The objective of this study was to understand the views and work of the professionals working in a Psychosocial Care Center regarding the embracement of people who attempted or are at the risk of suicide. This qualitative study was performed at a city in southern Rio Grande do Sul-Brazil. Twenty-six semi-structured interviews were performed with the professionals of a team from a Psychosocial Care Center, in the second half of 2006. The data were analyzed and organized according to the following themes: the embracing reality – the client who attempted or is at risk of suicide in the relevant area-territory; the paths of intersectoral collaborationi; and the care provided to clients of the Psychosocial Care Center who attempted or are at risk of attempting suicide. It was observed that there is a committed multiprofessional team that aims to perform humanized follow-up care, joining efforts with different systems and sectors of civil society, with the purpose of implementing a care plan and eliminating the client's risk of suicide.

DESCRIPTORS: User embracement. Mental health. Psychiatric Nursing.

AÇÃO DOS PROFISSIONAIS DE UM CENTRO DE ATENÇÃO PSICOSSOCIAL DIANTE DE USUÁRIOS COM TENTATIVA E RISCO DE SUICÍDIO

RESUMO: Objetivou-se conhecer a visão e a atuação dos profissionais de um Centro de Atenção Psicossocial, acerca do acolhimento de pessoas com tentativa ou risco de suicídio. O estudo qualitativo foi realizado num município da Região Sul do Rio Grande do Sul-Brasil. Foram realizadas 26 entrevistas semiestruturadas com os profissionais da equipe de um Centro de Atenção Psicossocial, no segundo semestre de 2006. Os dados foram analisados e organizados em temáticas: A rede que acolhe - o usuário com risco ou tentativa de suicídio no espaço-território vivido; Os caminhos de diálogo com a intersetorialidade; e Cuidado ao usuário do Centro de Atenção Psicossocial com tentativa ou risco de suicídio. Foi observada a existência de equipe multiprofissional comprometida, que procura realizar um acompanhamento humanizado, unindo esforços com diferentes sistemas e setores da sociedade civil, com a finalidade de implementar um plano de cuidado e eliminar o risco de suicídio do usuário.

DESCRITORES: Acolhimento. Saúde mental. Enfermagem psiquiátrica.

ACCIÓN DE PROFISIONALES EN UN CENTRO DE ATENCIÓN PSICOSOCIAL ADELANTE LOS USUARIOS CON RIESGO Y INTENTO DE SUICÍDIO

RESUMEN: Lo artículo tien lo objectivo de conhecer la visión y acciones de los profesionales de un Centro de Atención Psicosocial sobre el apoyo para el cuidado de las personas en riesgo y intento de suicidio. El estudio cualitativo fue realizado en una ciudad en el sur de Rio Grande do Sul, Brasil. Se realizaron 26 entrevistas semi-estructuradas con profesionales de un Centro de Atención Psicosocia en la segunda mitad de 2006. Los datos fueron analizados y organizados por temas: la red que aloja - el usuario en riesgo de suicidio

y intento en el territorio vivido; los caminos del diálogo con la intersectorial y la atención al usuario del Centro de Atención Psicosocia con o en riesgo y intento de suicidio. Se observó la existencia de un equipo multidisciplinario comprometido, que busca lograr una vigilancia humana, uniendo fuerzas con los distintos sistemas y sectores de la sociedad civil, con el fin de poner en práctica un plan de cuidados y eliminar el riesgo de suicidio de el usuario.

DESCRIPTORES: Acogimiento. Salud mental. Enfermería psiquiátrica.

INTRODUCTION

Suicide is a complex phenomenon having different causal factors, thus it is an important quality of life indicator. In the area of health care, the study of suicidal attempts and ideation aims to determine the negative effects of this event on society, considering that suicide is an expression of a wish for death as voiced by the victim, resulting in repercussions in the context of his or her relationships.[1]

In Brazil, epidemiological data show there has been an increase in the rates of death by suicide. While the Brazilian mean is around 4.3 deaths by suicide for every 100,000 people, in some states the rates are higher. Some of these states are Rio Grande do Sul, with a mean incidence of 10.2 suicides for every 100,000 people from 1980 to 1999, Santa Catarina, with a mean of 7.9/100,000 people and Parana, with 7.1/100,000 people, followed by São Paulo and Goiás.[2-3]

In the studied city, the mean number of deaths by suicide between the years 1997 and 2007 was 15/100,000, i.e., above both national and state means. These figures demonstrate that prevention and surveillance interventions in mental health are important, aimed particularly at this specific population.[4]

With the purpose of minimizing suicide rates and the repercussions associated with attempted suicides, the Mental Health Coordination designed the National Strategy for Suicide Prevention. The goal of this strategy was to develop the National Guidelines for Suicide Prevention together with some Ministry of Health departments. The resulting regulation was approved in 2006, by Ordinance number 1,876.[5]

The challenge lies in avoiding deaths by means of interventions that aim at health promotion and disease prevention. Furthermore, it is important to establish an organized service network that can meet the needs identified by the professionals and those who work closely with them, identifying the determining and predictive factors in order to minimize the burdens and prevalence of these events.

The Psychosocial Care Centers (Centros de Atenção Psicossocial - CAPSs) are strategic to the domain of public policies in mental health. These centers seek to incorporate new technologies in mental health, as opposed to "being open", which does not necessarily correlate with the humanization and systematization of care. What actually differentiates them is the respect shown towards clients and their right to citizenship, with the incorporation of new methods and ways of thinking about mental disorders as a phenomenon of existence, without the reproduction of static and crystalized roles which are typical of excluding models, such as the hospital model.[6-7]

In this sense, suicide ranks as one of the many complex demands of community mental health services. Furthermore, it requires the rethinking of the knowledge and practices of health teams. In the dynamic context of the psychiatric reform movement and the restoration of mental health care, it becomes necessary to be aware of the demands made on health professionals regarding situations of suicide and, furthermore, understand, disseminate, and discuss the innovative practices that have obtained good results in these cases.

Therefore, the present study aims at understanding the views and interventions of the professionals of a certain CAPS regarding the embracing of people who attempted or are at risk of suicide.

METHODS

This is a qualitative study, performed based on an excerpt from a research project entitled "Avaliação dos Centros de Atenção Psicossocial na região sul do Rio Grande do Sul (CAPSUL)" – *The Evaluation of Psychosocial Care Centers in southern Rio Grande do Sup (CAPSUL)*, which used a fourth generation, constructivist, responsive evaluation, using a hermeneutic-dialectic approach. To accomplish this, interviews were performed with the team of professionals, clients and relatives, in addition to field observations. The referred project addressed five cities in southern Brazil. The present article was composed using the data generated from interviews with 26 professionals of the CAPS II of one of the cities who, among others, answered the following guiding question: does the CAPS receive support to embrace people who have attempted suicide or are at risk of committing

suicide? The data were collected in the second half of 2006, by a team of five researchers.

The mental health network of the studied city is comprised of a CAPS II for the treatment of severe psychiatric disorders in adults, a children's CAPS I, a CAPS-ad which deals specifically with the treatment of alcohol and substance abuse (undergoing the process of being acknowledged) and therapeutic residency and psychiatric beds in general hospitals, with a general coordination of the services in addition to local coordination. It should be noted that the service was chosen because it offers individual and group care, and also because it is concerned with the social inclusion of the adult client with mental illness.[8]

Among the 26 interviewed professionals, there were 23 (88.5%) women and only three (11.5%) men. The participants' professions and occupations were: five psychologists, five workshop facilitators (an occupation that involves performing workshops with the CAPSs clients), two nurses, two nurses' aides, two receptionists, two housekeeping assistants, one nursing technician, one coordinator (physician), one educator, one social worker, one cook, one driver, one occupational therapist and one psychiatrist.

Thematic analysis was the strategy used for data analysis. The data were ordered, categorized into themes, and then a final analysis was performed. It is important to stress that the data were treated following a continuous and simultaneous process, with steps that were connected and complementary to each other, with an aim of understanding the manifested reality.[9]

Based on the analysis, two fundamental themes were identified: the first referred to the network that embraces the client who attempted or is at risk of committing suicide in the referenced area-territory and the paths of intersectoral collaboration; the second referred to the care provided to CAPS clients who were in a situation of attempting or at a risk for suicide.

The study was approved (Document 074/2005) by the Ethics and Research Committee at the College of Medicine/Universidade Federal de Pelotas. To preserve participant anonymity, in compliance with Resolution 196/96 of the Ministry of Health, all subjects signed the Informed Consent Form, and were identified with the letter "I" (Interviewee), followed by the number corresponding to their order in the interview (for example, I4).

RESULTS AND DISCUSSION

The organization of society has ruptures that are manifested through the practice of suicide. This practice has been growing in our country due to the crises and disturbances of the collective subject, who generally exhibits a melancholic attitude towards life. By using the term 'collective subject', it is understood that society, as a social group, exists not as a mass of individuals, but as a collective representation with symbols, values, and rules that override the individual aspect. In this sense, suicide is not related to biological, hereditary, or ethnic factors, but to the fact that the suicidal person no longer sees any meaning in living as part of the group.[1] Hence, a need emerges to perform interdisciplinary and intersectoral collaborative interventions to connect with the support available in the community, for the purpose of optimizing comprehensive care for individuals in order to prevent suicide.

With a view to presenting the work dynamics of the CAPS professionals regarding the clients who have attempted or are at the risk of suicide, the following themes will be discussed.

The network that embraces the client who attempted or is at risk of suicide in the referenced area-territory and the paths of intersectoral collaboration

The area-territory that involves the client who attempted or is at risk of suicide covers the human and institutional collectivity within a community context. In the studied city, it can be said that the area in the territory is addressed and encouraged in terms of mental health care.

In this complex system, in which the leading role of services and professionals is fundamental, we highlight client embracement as a strategy that values humanized care and interdisciplinary cooperation as a system of care through networks, which are actions perceived in the following statements:

[...] *yes, we embracement them.* [...] *people are always accepted* (E-16).

[...] *we embracement* [...], *they will receive care from me, from the psychologist, we will analyze the risk* (E-25).

Client embracement provides openings for discussions and interaction between clients and relatives. These opportunities are created by the professionals during individual medical, psycho-

logical, social service and nursing consultations and in group therapy through therapeutic workshops, and activities that involve sports, cooking and personal hygiene, as well as festive gatherings. In this sense, client embracement becomes a supportive life tool, capable of assigning new meanings to working processes, services and people[10]. Therefore, the suicide attempt mobilizes and sensitizes the mental health worker, who is encouraged to connect with other health workers to form an interdisciplinary network that promotes care, attention, and solidarity in this time of psychological suffering.

Consequently, the existence of a multidisciplinary team to approach the client at risk of suicide has helped to reduce the number of deaths due to this cause. This occurs by supporting the reentry of the individual into society with his or her family through a systemized follow up by the professionals connected to the mental health teams. From this perspective, it appears that hospital admissions can be avoided provided there is a service that respects and responds to the specific needs of these individuals.[11]

The following statements illustrate the accurate and contextualized perception of the teams regarding the suicide attempts, which underline the importance of interdisciplinary work, bringing health interventions closer to the experienced reality.

[...] *we provide care, face the situation, and if you're alone, someone from the team offers support. I was following a client separately* [...] *at risk of suicide. It is a very complicated life story* [...]. *I was her therapeutic reference. I am a social worker, and I have assisted people at risk of suicide before. The psychologists always have group and individual sessions; nursing has done that, too. I think that our challenge is to move from the expertise of a profession to actual mental health care. In addition, being collective is what keeps us full of energy* (E-5).

[...] *generally, we consider these suicide attempts the priority, if the person comes in.* [...] *as one girl did last week and said she wanted to kill herself, we don't even let her leave here. The nurse talks to her, then refers her to the physician* [...], *and then a psychologist* [...] (E-7).

Sometimes you notice it is a special case as soon as the person arrives at the front door [...] *sometimes there is no need for him or her to speak, because usually a relative or neighbor comes with them* [...] *There was one case* [...] *she had tried to kill herself and she didn't even have to say that and the whole team got involved. She went to see the physician, talked to the psychologist and received family guidance. They went to see the family. I think clients receive good care* (E-12).

In this sense, in regards to how embracement is offered at the CAPSs, the addressed subjects remarked on the importance of teamwork (physician, nurse, psychologist, social worker, workshop facilitators, and receptionists) as a means to deal with the risk of suicide present in the community.

It therefore becomes relevant to understand the cultural specificity and the values within each social context, which are filled with meanings that could be related to practices that perpetuate self-violence.[12] The emotional issue can be considered as a causal factor if it is analyzed under the perspective of social isolation and sadness accompanied by depression, which makes necessary the constant partnership between the different professionals that are responsible for dealing with this prominent social problem.

Thus, valuing the heterogeneity of people at risk of suicide requires understanding their limitations and the reasons that led them to choose this route. Community health care makes it possible for these individuals who suffer to remain in their own environment, within their social niche.

The following statements reveal the necessity of Family Health Team agents, as a support to the mental health team, in addition to the critical analysis of the professionals in view of the development of knowledge.

[...] *this network, like, with the health agents, is a very, very solid network* [...]. *When there is something we need to know they call us* [...] *they inform us* (E-1).

It is a challenge to be constantly learning what to do, without losing the direction of the profession, [...] *but you know you are much more than your profession, you are part of a mental health team* (E-5).

Therefore, by mobilizing the community resources, and with the help of community health agents as a complex dimension of health care services, namely in situations involving the risk of death, workers are constantly expected to identify problems and solve them within their own daily practice. They begin to understand that individual care does not offer the opportunity to provide the necessary complex interventions needed to minimize or eliminate the risks associated with a suicide attempt.

In planning implementations for at-risk individuals, inclusion of the individual with a mental disorder into their social networks encourages their socialization and provides them with sup-

port. It also shows that they are valued in society. These actions are performed for the purpose of understanding the meanings that created the need to harm themselves.[13] Nursing works directly with these interventions, providing, along with the other professionals, mental health care by participating in the process of referring and receiving clients within the different networks also willing to achieve the same goal.[14]

In this way, the intersectoral collaborative network will strive to involve the clients' family, neighbors, friends and close relatives, in addition to referral to community and health services, among other domains of civil society. The excerpts below highlight this tendency:

[...] *the greatest concern is the family. When someone actually says they want to kill themselves, we go straight to the family* (E-1).

[...] *when we believe the risk is very high, we request the client to be admitted* [...] (E-25).

The professionals' statements point to the possibilities of support within the territory, considering the CAPS service works as "radar" that identifies and receives clients and helps them overcome their suffering through the network.

In community mental health services, the family is part of the client's network, and some studies point out that it is one of the main resources for the rehabilitation of individuals with mental suffering. Therefore, a partnership must be established between the subject, their family and the professional, considering that this rehabilitation process also involves the local community.[7-15]

To achieve this, the professionals reported an extremely important component, the construction or recovery of attachment, both with the client as well as with their relatives, in this specific time of psychological suffering, as can be observed in the following statements:

[...] *they become attached to you* [...] *we talk a lot* (E-21).

[...] *to ensure safety* [...] *we called the military brigade* [...]. *with the authorization of the family* [...]. *Sometimes even the neighbors start coming to help. Then the client is taken to the Emergency Room* [...] *and medicated. Actually, the client is sedated, and the physician makes the referral and decides if the client must be admitted for treatment, or if they will start treatment here* [...] (E-2).

Some cases require admission to hospital due to the nature of the emergency. However, when the individual who attempted to harm themselves has already received primary health care in his/her community, the length of stay in the hospital can be reduced,[11] which means that the health interventions performed by the team necessitate reestablishing the person with mental suffering into their community setting in a humanized and holistic way.

Therefore, the organization of a comprehensive mental health network, from the logic of territorial services, needs to use strategic, health and sociocultural methods that integrate several dimensions of the individual's life, thus functioning as connected centers of primary health care, including the family health strategy, outpatient clinic network, tertiary services, and social care and support activities.[16]

Thus, the web woven between the different systems and sectors of civil society for the purpose of embracing the client who attempted or is at risk of suicide appears to strengthen the multiple facets of mental health care; this requires innovative ways of performing daily practices, providing flexibility and encouraging creativity among the group of workers within the services.

The care of CAPS clients who attempted or are at risk of suicide

According to the social development theme in Brazil, it is observed that suicide attempts are usually associated with an end of suffering in the minds of individuals who, when trying to end their misery, convince themselves that death is preferable to life.[17-18] In this perspective, the theme is characterized as a mental health emergency, as it poses a risk of imminent death and requires the identification of factors that are possibly associated with this self-aggressive behavior, aiming at reducing them.

Through the analysis of the data obtained in the study, it is observed that the professionals working in mental health services consider suicide risk or attempt to be an emergency situation, which is expressed in the following statement:

[...] *that quick. We immediately leave the room and call the family: 'we are admitting him/her, it's an emergency, they are at risk for suicide'. We know there is a risk and it happens, because we act quickly. If we have to call the secretary* [...] *to request a bed, we call and say: 'look, if you don't get us the bed, we won't be held responsible, it is a serious case'. We have managed a find a way* (E-11).

Therefore, it is understood that the care provided must be timely, provided through dialogue,

and responsible towards people with suicidal ideation, in order to intervene and provide humanized and empathetic primary care.

Another significant aspect is the accessibility to appropriate treatment, which, if conducted in agreement with each individual who attempted suicide, reduces the numbers of deaths. From this aspect, a concern emerges regarding the high incidence of suicides in southern Brazil, because this region has the highest rates in the country.[17]

The education and qualification of the professionals who work in the Family Health Strategies and community services is an essential process that contributes to improving the identification and interventions provided to individuals at risk.[18]. Thus, it is understood that the intellectual background surrounding the embracement of individuals vulnerable to suicide promotes the teams' greater reflection and discussion regarding treatment, prevention and continued supervision.[13]

In terms of the care provided to clients who have attempted suicide, the interviewed professionals reported that nursing plays an important role in offering security to those working at the CAPS as well as to individuals who use the service. In this sense, the work performed by the psychologists was also referred to as an intervention included in the care plan, changing the joint efforts and performance of the professionals into organized health practices, as shown in the following excerpt:

[...] *the psychologists, when present, also support these emergency situations. I do too. Our safe harbor is nursing, because there is a nurse in the morning and another in the afternoon. So the girls manage it* (E-3).

[...] *I always talk to one or another psychologist or nurse colleague. I always search for someone to see the client* (E-19).

Therefore, it is evidenced that dialogue, listening and the organization of the working process are part of the health interventions in this Psychosocial Care Center. As observed, the working process is based on humanization, through perception and making rapid decisions coherent with the current facts, which respects and preserves the individuality of the clients.

On the other hand, according to the institutions that embrace the referred clients, psychosocial rehabilitation must be seen as an essential part of the treatment, with a view to building awareness in the population regarding this public health issue.[13]

In order to fill in the gap created by the clients' lack of trust, despair, and hopelessness, the professionals must be emotionally available, pay close attention to the client's views and engage in qualified listening,[5] which was detected in the statements of the professionals from the studied city:

[...] *you have to seek that care through listening. Many times in psychotherapy we hear the person say that* [...] *it really must be teamwork, you must think that that person can truly move from speaking to action* [...]. *Never disregard a statement like this. Sometimes the family structure is so broken that the person cannot take it any longer* (E-4).

Therefore, to promote health among professionals, CAPS clients, relatives and communities, there is a need to design therapeutic strategies that value listening and the observation of the context of the client at risk of suicide.

Nursing, together with the rest of the team, must be mindful regarding the complexity of the many lifestyles, because suicide is a challenging theme that demands joint efforts in order to deliver a collaborative work, with global support.[14]

Care in the home of clients at risk of suicide is associated with the proposition of increasing the comprehensiveness of health care and expanding the care that is provided,[19] considering that this health care model requires systematized interventions that begin before the visit and continue after it[20]. Furthermore, in this model, the client, family, home environment, caregiver and multidisciplinary team are all essential aspects.[21]

Therefore, the CAPS professionals reported that in order to maintain or strengthen the attachment, both with clients and with their relatives, they perform home visits actively searching to understand the reality that the client lives in, in an effort to preserve life. This is observed in the following statements:

[...] *the nursing team makes the first visit, and they analyze the situation, then they come here and ask a psychologist to follow up, to go there and visit the person again* [...] (E-15).

[...] *when we receive the client the first thing we do is to ask the girls* [health professionals] *to go visit the home* (E-19)

They call here, and the nurses leave, the psychologists go together (E-22).

The home visit enables health professionals to observe the reality and the environmental context, whether it is the physical structure or the personal relationships between family members. It also permits the professionals to develop interventions that encourage the client in the health-disease

process, because it is essential to reduce or even eliminate the factors that influence risks to health. Therefore, it is understood that the challenge of working in the client's home lies in the need to support and strengthen the family relationships, respecting bonds of affection and social solidarity networks unique to each location.[19]

The intervention through contact and qualified listening has a high chance of success. This is due to the conflicting feelings of the person who contemplates suicide, because while they wish to die, they also want to live. The predominance of the wish to live over the wish to die is the factor that permits suicide prevention[5]. Professionals must be able to work as a team and utilize humanized interventions, thus providing comprehensive support to the clients and their families.

FINAL CONSIDERATIONS

Today, we live in a society that condemns suicide while it apparently forgets to reflect on its role and contribution to reducing the growing cases in Brazil. From this perspective, the family can be an important partner in helping health care professionals to understand the reasons that led the individual to consider suicide and overcoming crisis situations. Family bonding also contributed to demystifying certain ideas held by the suicidal individual, such as death as a means of ending all of life's problems. When these reasons are heard and understood, suicide may be prevented because the family usually seeks assistance from the social networks in their community.

Therefore, health care services, particularly the CAPSs, consist of professional teams to embracement clients and relatives experiencing this situation. There are constant demands for educational investment, commitment and the ability to work as a team. The statements of the professionals from the analyzed service point to some creative initiatives in mental health that can be replicated by other professionals, such as the effort to connect different systems and sectors of civil society for the purpose of embracing the client who attempted or is at risk of suicide, and also the capacity to promote multidisciplinary work that is committed to the risk situation of the client and his or her relatives, considering their life context. Perhaps there is where the challenge lies, in promoting the organization of the team as a collective unit, so that they are all directed towards promoting healthcare.

With this study, we emphasized the importance of performing more studies regarding suicide, from the qualitative perspective that leads to the understanding of the working processes of the CAPSs in terms of suicide prevention, in order to contribute to the dissemination and understanding of the several strategies of health care in the face of this social problem. Furthermore, this study points to the need for quantitative historical studies to evaluate if the number of CAPS and the growing implementation of mental health networks has had an effect on the reduction of deaths by suicide.

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