REUFSM
REVISTA DE ENFERMAGEM DA UFSM

UFSM
Rev. Enferm. UFSM - REUFSM
Santa Maria, RS, v. 9, e69, p. 1-19, 2019
DOI: 10.5902/2179769227862
ISSN 2179-7692

Original Article Submission: 26/06/2017 Acceptance: 29//052019 Publication: 26/11/2019

Suicide and the psychosocial care network in the southern Brazilian capital

O suicídio e a rede de atenção psicossocial em uma capital no sul do Brasil

El suicidio y la red de atención psicosocial en una capital del sur de Brasil

Alan Cristian Rodrigues Jorge[I], Adriana Aparecida Paz[II], Annie Jeanninne Bisso Lacchini[III] Graciele Fernanda da Costa Linch[IV]

Resumo: Objetivos: analisar a progressão do coeficiente de mortalidade por suicídio e a oferta de serviços da rede de atenção psicossocial (RAPS) no atendimento de pessoas com risco ou tentativa de lesões autoprovocadas intencionalmente. **Método:** estudo de série histórica, entre 2001 a 2017, no município de Porto Alegre, Rio Grande do Sul, Brasil. Utilizaram-se dados secundários oriundos dos sistemas de informação e de relatório da gestão. **Resultados:** o coeficiente anual de suicídio foi de 6,51/100.000 habitantes. Predominou o sexo masculino (77,26%), faixa etária de 20 a 59 anos (76,18%) e raça branca (86,70%). A RAPS em parte atende as necessidades e demandas, com destaque para 183 leitos hospitalares e 12 Centros de Atenção Psicossocial. **Conclusões:** as ações de prevenção do suicídio precisam ser sinérgicas em todos os níveis de atenção à saúde, com profissionais de saúde qualificados por meio da educação permanente para atender essa complexidade do sofrimento psíquico.
Descritores: Suicídio; Saúde mental; Psiquiatria; Assistência ambulatorial; Serviços de saúde mental

Abstract: Objectives: To analyze the progression of the suicide mortality coefficient and the provision of psychosocial care network services (PCNS/RAPS in Portuguese) during the care service for people at risk or attempting intentional self-harm. **Method:** A historical series study, from 2001 to 2017, based on the city of Porto Alegre, Rio Grande do Sul, Brazil. Data from information and management reporting systems were used. **Results:** The annual suicide rate was 6.51/100,000 inhabitants. Prevalence was of males (77.26%), age group of 20 to 59 years old (76.18%) and white ethnicity (86.70%). RAPS partially meets the needs and demands, which refers, mainly, to 183 hospital beds and 12 Psychosocial Care Centers. Conclusions: Suicide prevention actions need to be synergistic at all levels of health care, with qualified health professionals through lifelong education to address this complexity of psychic suffering.
Descriptors: Suicide; Mental health; Psychiatry; Ambulatory care; Mental health services

I Enfermeiro. Mestre em Enfermagem. Serviço de Enfermagem Psiquiátrica - Hospital de Clínicas de Porto Alegre. Porto Alegre-RS, Brasil. E-mail: ajorge@hcpa.edu.br ORCID: 0000-0002-6591-3287

II Enfermeira. Doutora em Enfermagem. Programa de Pós-Graduação em Enfermagem da Universidade Federal de Ciências da Saúde de Porto Alegre. Porto Alegre-RS, Brasil. E-mail: adrianap@ufcspa.edu.br ORCID: 0000-0002-1932-2144

III Enfermeira. Doutora em Enfermagem. Programa de Pós-Graduação em Enfermagem da Universidade Federal de Ciências da Saúde de Porto Alegre. Porto Alegre-RS, Brasil. E-mail: annieb@ufcspa.edu.br ORCID: 0000-0002-3938-1256

IV Enfermeira. Doutora em Enfermagem. Programa de Pós-Graduação em Enfermagem da Universidade Federal de Ciências da Saúde de Porto Alegre. Porto Alegre-RS, Brasil. E-mail: gracielelinch@ufcspa.edu.br ORCID: 0000-0002-8802-9574

Resumen: Objetivos: analizar la progresión del coeficiente de mortalidad por suicidio y la oferta de servicios en la red de atención psicosocial (RAPS) para la atención de personas en riesgo o con intentos de lesiones autoinfligidas intencionalmente. **Método:** estudio de serie histórica (2001-2017) en la ciudad de Porto Alegre (capital de Rio Grande do Sul, Brasil). Se utilizaron datos secundarios de los sistemas de información y de informe de gestión. **Resultados**: el coeficiente anual de suicidio fue de 6,51/100.000 habitantes. Predominó el sexo masculino (77,26%), en la franja etaria de 20 a 59 años (76,18%) y de raza blanca (86,70%). La RAPS atiende parcialmente las necesidades y demandas, con 183 camas hospitalarias y 12 Centros de Atención Psicosocial. **Conclusiones**: las acciones de prevención del suicidio deben ser sinérgicas en todos los niveles de atención a la salud y estar a cargo de profesionales calificados mediante educación permanente para atender la complejidad del sufrimiento psíquico.
Descriptores: Suicidio; Salud mental; Psiquiatría; Atención ambulatoria; Servicios de salud mental

Introduction

Because of its significant socioeconomic and cultural impact, suicide has become a serious public health problem of global magnitude, as approximately one million people in the world carry out the suicidal ideation and plan (which represents one death every 45 seconds). Also, in cases where self-injury is not fatal, attempts may be repeated 10 to 20 times.[1-2]

Given this context, the "*National suicide prevention strategies: progress, examples and indicators*" document, published in 2018 by the World Health Organization (WHO), emphasized the need to encourage people to know and monitor potential victims of intentional self-harm in order to promote public awareness. These strategies include promulgating the prevention week and the month of strengthening suicide prevention; implementing primary and secondary education discussions on prevention measures; disseminating accurate information on fatal self-harm and phenomena linked to this mortality outcome; and promoting public awareness campaigns on depression. In 2017, the World Health Day used the "Shall we talk?" slogan alluding to the problem of depression and its frequent consequences in suicide cases.[3]

Discussing Mental and Behavioral Disorders (MBDs) is a global imperative. There are evidences that nine out of 10 suicide cases originate from some treatable MBD. Recognizing this, deaths and attempts at fatal self-harm could be prevented if there was an adequate

coverage of psychosocial support services, skilled health professionals, social and community participation in identifying potential victims.[1,4]

In Brazil, mortality from this cause has increased by 29.5% in the last two decades, being predominant in men, elderly, indigenous, inhabitants of small/medium-sized cities, with the coexistence of MBD pathologies.[2] A study found that the national coefficient was 6.6 per 100,000 inhabitants in Brazil, while another survey conducted from 2000 to 2012 found a higher incidence in southern Brazil (9.8/100,000 inhabitants).[4-5] Studies attempt to explain this historical regional prevalence by pointing out two main hypotheses: the use of pesticides in crops (being a region with a centuries-old farming tradition) and the cultural influence of European immigrants, mainly Slavs and Germans (people with etiologically more rigid cultural patterns).[2,4-5]

In fact, mortality from intentional self-harm is worrisome and frightening due to the occurrence of premature deaths from the socioeconomic, health and family network perspective. Faced with the aggravation of diseases by MBD, the Ministry established the Psychosocial Care Network (*Rede de Atenção Psicossocial*, RAPS), by Ordinance No. 3,088/2011, with the purpose of creating, expanding and articulating the points of health care for people suffering or with mental disorder and needs arising from the use of crack, alcohol and other drugs within the Unified Health System (*Sistema Único de Saúde*, SUS).[6] It is up to the various services that constitute the RAPS to foresee users with potential risk of suicide who attend the services of less technological complexity (and density), so that care actions avoid psychic and emotional acutization, making it possible to prevent the execution of the suicide plan.

Considering the above and the magnitude of this problem installed in society, this study has the following as guiding questions: What are the characteristics of people who committed intentional self-harm? What are the services offered by the RAPS in the city of Porto Alegre and the quantitative magnitude of these to serve this population at risk and with suicide attempts?

Focusing on these questions, the objective of this research is to analyze the progression of the suicide mortality coefficient and the provision of services of the psychosocial care network in the care of people at risk or intentional self-harm.

Method

This is a historical series design from 2001 to 2017, conducted based on secondary data and indicators from the Department of Informatics of the SUS (DATASUS) in the "Demographic and socioeconomic" areas generated by the Brazilian Institute of Geography and Statistics (*Instituto Brasileiro de Geografia e Estatística*, IBGE), "Epidemiological and morbidities" of the SUS Hospital System Health (*Sistema de Internação Hospitalar*, SIH-SUS), "Vital Statistics" of the Mortality Information System (*Sistema de Informação sobre Mortalidade*, SIM) and of the RAPS provided by the Municipal Health Secretariat of Porto Alegre.[7-10] The study scenario covers the city of Porto Alegre, capital of Rio Grande do Sul (RS), Brazil.

This study population was the data of suicide deaths cases, organized in a tool called "VITAIS: health analysis" (VITAIS), which uses information from the SIM.[9] This tool is a database managed by the General Coordinator Agency of Health Surveillance (*Coordenadoria Geral de Vigilância em Saúde*, CGVS) of the Porto Alegre Municipal Health Secretariat (*Secretaria Municipal de Saúde de Porto Alegre*, SMS-POA) with public access for managers, professionals and users. Regarding hospitalizations, the data came from the SIH-SUS and from the estimate population of the IBGE.[7-8] The data collection period was determined by the availability of data in the VITAIS tool from 2001. The source of quantitative data of the RAPS was the 2017 Management Report, published by the SMS-POA.[10]

Data collection took place in January 2019, and the following variables were selected in the database by residence: geographic area Porto Alegre, period from 2001 to 2017, resident

population, gender, age group, race, cause "X60-84 Self-harm intentionally lesions", number of total hospitalizations and by MBD.[7-9] For the data of the services that constitute the RAPS, a diagnostic matrix of the psychosocial care network was used.[6]

For data organization and interpretation, a Microsoft Excel® spreadsheet was used, using descriptive statistical analysis (absolute, relative frequency, coefficient, mean, standard deviation, median and 25-75 percentiles). The mortality coefficient was calculated by number of deaths occurred in the period (numerator), divided by the population estimate in the same period (denominator), multiplied by a constant defined in 100,000 (equivalent to 100,000 inhabitants).

The results are presented in figures and tables according to the period defined by the availability of data in VITAIS, which occurred from 2001. Because they are public domain data, approval by the Research Ethics Committee was not required. However, this research respects the ethical precepts based on Resolution No. 466/2012 of the National Health Council.[11]

Results

From 2001 to 2017, there were 1,587 deaths from the "X60-84 Intentional self-harm lesions" cause group in Porto Alegre, with 1,235 (77.82%) males. Regarding the gender ratio, it was observed that the fatal self-injuries occurred 3.72 times for males compared to females.

Figure 1 presents the annual suicide mortality coefficient and the frequency between the genders.

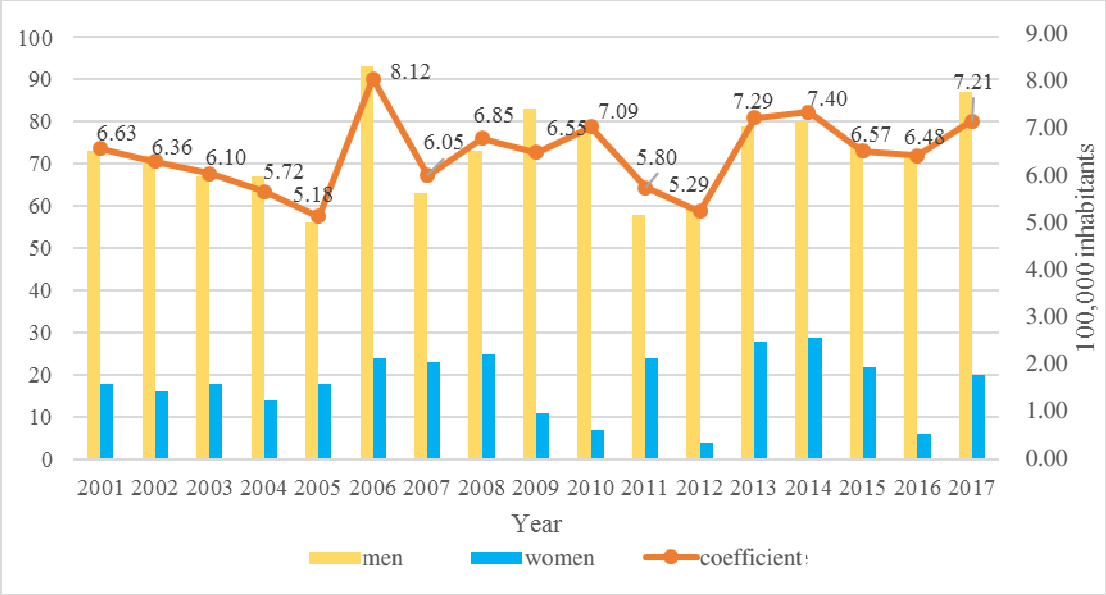

Figure 1 – Annual mortality coefficient for intentional self-harm lesions and gender distribution, from 2001 to 2017, in Porto Alegre, Rio Grande do Sul, Brazil. Source: SIM/VITAIS/CGVS/SMS-POA (2019)

There was a fluctuation in the suicide mortality coefficient from 5.18 to 8.12/100,000 inhabitants, in the period from 2001 to 2017. The mean of the historical series was 6.51±0.78 deaths per 100,000 inhabitants in Porto Alegre. Regarding the occurrence of deaths by gender, the annual mean for males was 72.65±10.17 and for females, 20.71±5.01 cases.

Figure 2 shows the distribution of mortality occurrence and age group of the 1,587 deaths, in the period from 2001 to 2017. In the adult age group, there were 1,209 (76.18%) deaths, 287 elderly (18.08%), 90 infants and adolescents (5.67%) and 1 case (0.06%) of unknown age for lack of registration in 2006.

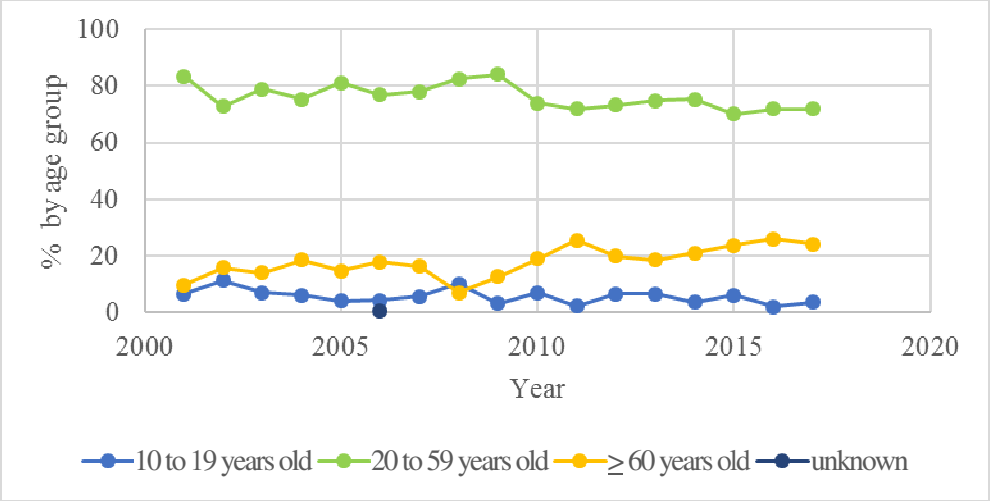

Figure 2 – Proportional mortality due to intentional self-harm lesions by age group, in the period from 2001 to 2017, in Porto Alegre, Rio Grande do Sul, Brazil. Source: SIM/VITAIS/CGVS/SMS-POA (2019)

In the historical series, the data show a rising tendency of proportional mortality by self-harm lesions in the age group of 60 years old and over, while a slight decline was observed in the age groups of 10-19 years old and 20-59 years old. The annual mean was 5.71±2.52 deaths in the 10-19-year old age group in the state capital. Greater expression was found in the age group of 20 to 59 years old, 76.25±4.41, followed by the age group ≥ 60 years old: 17.99±5.32 years old.

Figure 3 shows the distribution of the occurrence of mortality from intentional self-harm lesions in relation to race, in the period from 2001 to 2017. Among all deaths by fatal self-injury and race, 1,376 (86.7%) were white, 116 (7.31%) black, 81 (5.1%) brown, 2 (0.13%) yellow, and 12 (0.76%) as unknown race. The number of unregistered cases considered as "unknown" for the characterization of the race denotes the professionals' lack of attention when completing the death certificate, in which all items should be fully registered, in order to contribute to the quality of the information of the SIM.

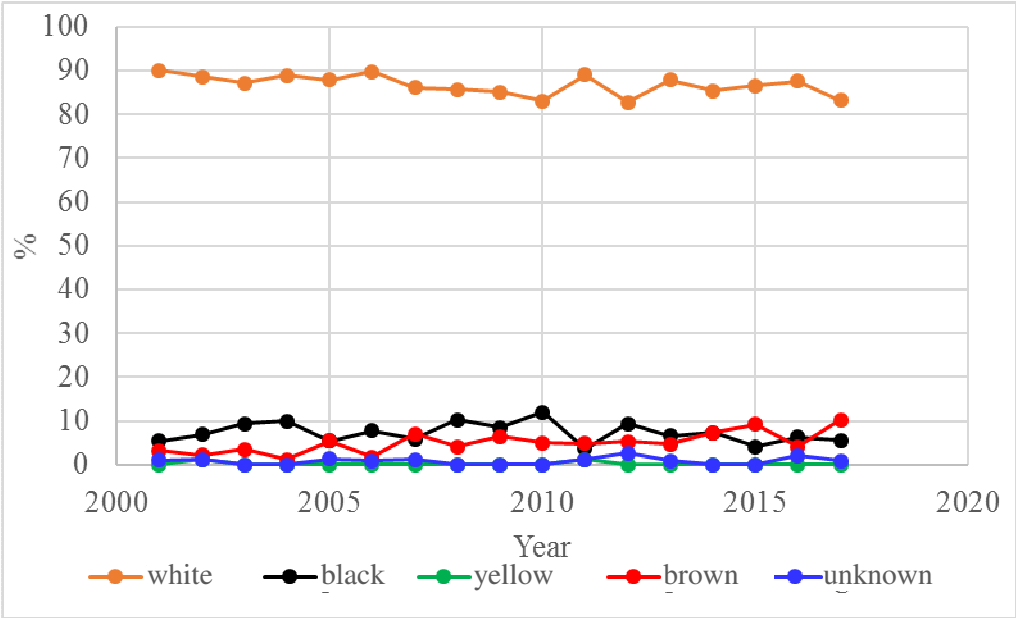

Figure 3 – Proportional mortality due to intentional self-harm lesions by race, in the period from 2001 to 2017, in Porto Alegre, Rio Grande do Sul, Brazil. Source: SIM/VITAIS/CGVS/SMS-POA (2019)

The historical series of mortality due to race-related suicide presents a slight increase of the brown race, and a brief decline of black and white in Porto Alegre. The annual mean was 80.94±10.77 deaths for the white race, 6.82±2.32 for the black race and, for the brown race. the annual median was 4 (2-6).

The municipal RAPS covers three levels of service complexity, which are presented in Table 1.

Table 1 – Health services network according to the 2017 Management Report 2017, of the city of Porto Alegre, Rio Grande do Sul, Brazil, 2019.

Care Level		**n**
Low Complexity		
Basic Health Care	Basic Health Unit	140
	Family Health Strategy (teams)	237
	Street Office	2
	Family Health Support Center	8
Medium Complexity		
Ambulatory Psychosocial Care	Mental Health for Adults (team)	8
	Child and Adolescent Health (team)	8
	Specialized Outpatient General Hospital	3
Strategic Psychosocial Care	Psychosocial Care Center (*Centro de Atenção Psicossocial*, CAPS) AD III	3
	CAPS AD II	2

	CAPS II	4
	CAPS Childhood	3
Psychosocial Rehabilitation Strategy	Workshop and Income Generation	1
High Complexity		
Urgency and Emergency Care	Mental Health Care Emergency Room	2
	Mobile Emergency Care Service (*Serviço de Atendimento Móvel de Urgência*, SAMU)	1
Hospital Care	General and Specialized Hospital Beds	183
Transient Residential Care	Therapeutic Community	2
Deinstitutionalization Strategy	Therapeutic Residential Service	2
	Homecoming Program (beneficiaries)	102

Source: 2017 Management Report/SMS-POA.

This quantitative magnitude of health services in the state capital is distributed in eight District Managements (DMs), which organize the health services for an estimated population of 1,481,019 (2017 population estimate). The RAPS forums have been held in six DMs since 2013. The municipality also has two expanded RAPS forums on the specific themes of Alcohol and other Drugs, and Childhood and Adolescence.

Figure 4 shows the hospitalizations by MBD and the proportion in relation to the total number of hospitalizations occurred in Porto Alegre, in the period from 2001 to 2017.

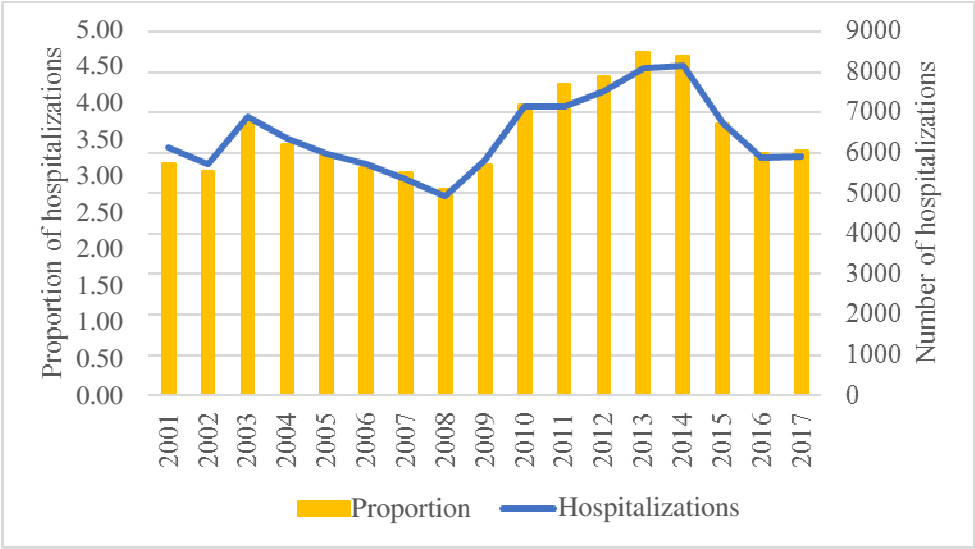

Figure 4 – Hospital admissions for occurrence of mental and behavioral disorders, in the period from 2001 to 2017, in Porto Alegre, Rio Grande do Sul, Brazil. Source: SIH-SUS/DATASUS (2019)

Hospital morbidities due to MBD have an annual mean of 3.62±0.58 hospitalizations, that is, from three to four patients every 100 hospitalizations of different morbidities. These hospitalizations had a rising tendency until 2014, and thereafter there was a sharp decline by one point from the annual mean.

Data on hospitalizations due to MBD were collected, as recognized the existence of some treatable associated disorder was recognized and because of the inexpressive representativeness as a cause of intentional self-harm in the period from 2001 to 2017. Most suicide attempts are diagnosed by other pathologies, which may be from the MBD cause group, or from other groups according to medical evaluation. Throughout the period, 22 cases of hospitalizations were caused by self-injury. Of these cases, in 2001, 7 were found, and in 2002, 15 were hospitalizations. This inexpressive number of hospitalizations does not allow us to understand the representativeness of the problem experienced by the professionals in the health services.

Discussion

The results of this study revealed the progression of the suicide mortality coefficient and the provision of RAPS services in the care of people at risk or with attempts of intentional self-harm. Thus, analyzing the epidemiological trends in mortality from this cause becomes relevant for the elaboration of health planning to prevent successful and frustrated attempts by people with suicidal ideation. For official data, the "unknown" result in the demographic characteristics denotes the lack of attention of the professional who records the death certificate, thus impairing the quality of the data and, consequently, the planning of prevention strategies[2,12]

The results show a fluctuation in the mortality coefficient due to intentional self-harm lesions from 2000 to 2017, which promotes the proposition of research studies of socioeconomic history and of the health services, to understand the reasons for the occurrence of the reduction

in a given period, such as in 2004, where the lowest coefficient of 5,18/100.000 was obtained. In a study assessing the suicide rates of 1990 and 2015, a 19% decline in fatalities was observed, starting from a mean of 8,1(7,5-8,6) to 6,6 (6,1-7,9)/100.000 Brazilians, respectively.[5] Still in the same study, among all the evaluated federative units, the state of RS led the fatal self-injury mortality ranking from 13,4 to10.5/100,000 gauchos, respectively, in 1990 and 2015.[5] In 2015, the coefficient evaluated in Porto Alegre was similar to the national mean, but lower than the state average by 37.4%.

The preventive actions to reduce this coefficient are proposed by the WHO as a way of guiding managers and health professionals to address this serious public health problem, highlighting the following: offering psychosocial support in various situations that impel the user to act against their own life; restricting access to places and chemicals considered to be hazardous to health; guiding the family to use information and communication technology (games, virtual groups, messages/warnings, among others); instructing caregivers, families and health professionals to identify and manage the ideation and attempt of suicide; expanding/publicizing the RAPS services of the municipality; and public awareness.[3]

To actually institute these preventive and care actions for people at risk or with suicidal attempts, the need for the permanent education of the nursing and interprofessional teams was evidenced, as fragility was observed in the knowledge of the professionals about suicidal behavior to define and perform interventions in the hospital setting (emergencies and clinical-surgical units), and thus make this moment of care effective in the face of psychological distress.[2,13-14]

The results showed a mean annual male variation of 62 to 82 death cases as predominant in this study, and the mean annual female variation was 15 to 25 cases. Several studies indicate that, as males prevail over females in consummate acts, this group is considered to be highly vulnerable, being 3.7 times more frequent.[4-5,12] This fact brings to discussion the fact that other

studies indicate that men almost do not seek care in the health unit for different reasons.[15-16] Suicide-related stigma can be a barrier to access the health services, making it impossible for health professionals to identify signs of psychological distress and thus reverse a suicidal ideation or plan.[3]

When data are stratified by age groups and mortality from intentional self-harm lesions, it is observed that Porto Alegre had the highest proportion among people aged 20 to 59 years old, with the age group similar to that reproduced in other countries.[1-3] A study conducted in 2015 observed the highest frequency in the young adult age group from 20 to 34 years old.[5] This age group of 20 to 59 years old is of working age, confirming that the fatal self-injury, besides being recognized with a serious social problem, can also be due to a mosaic of unsatisfactory complex family, economic, health, affective and work situations.[1,4-5,12-14,17]

There was a tendency for suicide to occur in the age group ≥ 60 years old, which is worrying since it is one of the most vulnerable groups in the world.[1-2,5,14] The study that evaluated the 2012 data for this age group observed a coefficient of 16/100,000 elderly inhabitants.[4] Another investigation pointed out that there were 34,166 suicide attempts recorded by self-poisoning in an elderly population from 2005 to 2013. Underreporting of self-harm attempts by older people undermines the recognition of the seriousness of this problem for the inclusion of protective actions on the political agenda.[14]

In the population of infants and adolescents, family, schools and health services need to be more attentive in identifying signs that may evidence psychological distress, as attempts at self-harm are occurring earlier and earlier.[1,10,13] Moreover, adolescents are in full physiological, intellectual and productive capacity, so shortening their lives results in invaluable costs, both individual and collective, in the social, family and socioeconomic sphere.[1,4-5] In 2017, the city of Porto Alegre, published a technical note guaranteeing unrestricted access to emergencies for

cases of attempted suicide among children and adolescents via Mental Health Shifts. This action allowed 67 receptions in a CAPS Childhood that same year, being predominant of adolescents.[10]

Being a city of European colonization, where the white race predominates, Porto Alegre differs from studies carried out in other geographical areas, such as North and Northeast (where brown and black predominate). In a national investigation, in 2000, the prevalence of fatal self-injury mortality of the indigenous race (8.6/100,000), followed by yellow (6.4/100,000) and white (5.4/100,000) was verified. It also evidenced the increase in 2012 of the indigenous race (14.4/100,000), brown (5.9/100,000) and the reduction of yellow (2.2/100,000).[4] A study conducted in Itapecerica-Minas Gerais observed that suicide mortality prevailed among white people (72.7%), followed by brown (18.2%) and black (9.1%).[12] In another study conducted in the Brazilian capitals through the Surveillance System of Violence and Accidents (VIVA), it was observed that, in a 30-day period, in 2014, of the care cases for victims of emergency self-harm injuries, 62.4% were black and brown, and 34.3% white.[17]

In the period evaluated in this study, it was observed that the municipality of Porto Alegre faced a significant increase in hospitalizations due to MBD from 2009 to 2014, with a subsequent decline, which may be due to the fact that users were able to succeed in the fatal self-injury (as mortality coefficient rises in 2017). This fact may also be the result of actions for monitoring and coordinating the services, aiming at reducing the number of hospitalizations and enabling the inclusion and linking of users in other RAPS services (it was observed that the mortality coefficient remained at the annual mean in 2015 and 2016).[14]

To meet all these hospitalizations due to MBD, Porto Alegre currently has 183 beds in specialized and general hospitals, i.e., 2.81 times more beds than recommended by the WHO (one bed per 23,000 inhabitants).[6] It is worth noting that in these beds the hospitalizations in

Psychiatric Hospitals are computed, with two still operating in the city, contrary to the Law of Psychiatric Reform.[10]

In a suicide attempt situation, the person is referred to first care in emergency units, where there is usually no specialized mental health care and no notification flows established, although the importance of monitoring is recognized.[14] In this scenario, the reception is almost always performed by nursing staff, and these professionals often do not have enough knowledge to handle and propose effective interventions in the face of psychic pain.[10,13]

The emergency unit, after clinical stabilization, makes the referral of the person for psychosocial care in the CAPS. However, it is also necessary to communicate the situation to the health unit so that the primary care professionals are aware, and thus all RAPS points can act simultaneously in favor of preserving life. In a study of elderly people who were treated in emergencies due to attempted intentional self-injury, the findings reveal that the care model is still centered on the biomedical, and that the substitution with an Extended Clinic model could contribute to suicide prevention (but not yet consolidated in service organization and work processes).[2,14]

The Ministry of Health advises that, in order to cover psychosocial care, it is necessary to enable at least one CAPS II, one CAPS Childhood, and one CAPS Alcohol and Drugs (AD) per 100,000 inhabitants and, for every 150,000 inhabitants, one CAPS III or AD III.[6] According to the current services in this type of CAPS, previously presented in Table 1, in Porto Alegre this offer of psychosocial care services could be expanded, which would contribute to the reduction of hospitalizations due to MBD and mortality from fatal self-injuries. Thus, using the 2012 population estimate, it was observed that for full coverage of the CAPS in Porto Alegre, there must be a CAPS Childhood (369,603 infants/adolescents), and a CAPS II to serve adults and the elderly.

Efforts to scale up the prevention of fatal self-harm are understood to require coordination and collaboration of various intersectoral society services beyond the RAPS. However, this participation must be added to this network so that, in a comprehensive, integrated and synergistic way, it can address this complex situation, reducing the obstacle of the suicide-related stigma.[12-14] The WHO states that creating social change in coping with this psychological distress requires three factors: knowledge (scientific and informed by practice and data), public support (political will) and a social strategy (goals) of public and intersectoral awareness for reduction of fatal self-injury cases.[1,3]

Conclusion

The mortality coefficient for intentional self-harm lesions presented the annual mean of 6.51/100,000 inhabitants in Porto Alegre, being similar to the studies conducted in Brazil, but lower than the one calculated in the state of RS. The prevalent characteristics of people who committed intentional self-harm were male, 20 to 59 years old and white. Such characteristics may be different when compared to other demographic groups and temporality due to biological, psychic, socioeconomic, and family factors, among others. This study revealed an essential component of health care: the need to expand and update means for an effective real-time monitoring of fatal self-harm and suicide attempts. This can optimize prevention efforts at the various points in the RAPS.

Given the above, it is understood that having real data of this problem is to provide a better understanding of this phenomenon, in order to develop and implement health planning with effective strategies for the RAPS to serve these users who have a neglected condition in the health system. In order to strengthen these RAPS monitoring actions in Porto Alegre, the constant updating of all health professionals is evident, especially the nurses who provide care, at all levels of complexity, through permanent education with mental health approach. This

space of socialization of knowledge needs to reinforce the discussion regarding the registration, reference and attention of users with signs of suicidal ideation, as well as their follow-up after a failed attempt to end their lives.

Although the city of Porto Alegre meets almost the entire population of what is recommended by the WHO and by the Ministry of Health, through a total of 183 hospital beds and 12 CAPS services, it still lacks incentives to improve assistance to users in psychiatric care emergencies and specialized outpatient care, increasing two more units in the psychosocial care modality. In this way, it is possible to reduce the mortality coefficient due to intentional self-harm. Thus, the decline of this coefficient may recognize the efforts of managers and professionals to prevent suicide and the quality of care at all points of the RAPS by welcoming the user in psychological distress.

This study limitations are due to the use of official secondary data sources made available for public access, which are completed, collected and digitized by different professionals, at different times, and may be underreported, or by diagnoses and records for other causes of death occurred. In addition, data on hospitalizations by private agreement are not aggregated with the SIH/SUS, a system that includes the authorization for hospitalization, for which the SUS financial transfer is performed. However, when assessing these official numbers, it is evident that it is possible to reflect and find answers to contribute to the health planning needed to produce care for users with potential capacity for fatal self-injury, as well as the proposition of new studies at different RAPS points to broaden the understanding of this health problem.

References

1. World Health Organization (WHO). Preventing suicide: a global imperative [Internet]. Genebra: World Health Organization; 2014 [acesso em 2019 fev 23]. Disponível em: https://apps.who.int/iris/bitstream/handle/10665/131056/9789241564779_eng.pdf

2. Botega NJ. Comportamento suicida: epidemiologia. Psicol USP [Internet]. 2014 [acesso em 2019 fev 18];25(3):231-6. Disponível em: http://dx.doi.org/10.1590/0103-6564D20140004

3. World Health Organization (WHO). National suicide prevention strategies: progress, examples and indicators Genebra: World Health Organization; 2018 [acesso em 2019 fev 22]. Disponível em: https://apps.who.int/iris/bitstream/handle/10665/279765/9789241515016-eng.pdf

4. Machado DB, Santos DN. Suicídio no Brasil, de 2000 a 2012. J Bras Psiquiatr [Internet]. 2015 [acesso em 2019 fev 20];64(1):45-54. Disponível em: http://dx.doi.org/10.1590/0047-2085000000056

5. Malta DC, Minayo MCS, Soares Filho AM, Silva MMA, Montenegro MMS, Ladeira RM, et al. Mortalidade e anos de vida perdidos por violências interpessoais e autoprovocadas no Brasil e Estados: análise das estimativas do estudo carga global de doença, 1990 e 2015. Rev Bras Epidemiol [Internet]. 2017 [acesso em 2019 fev 15];20(1):142-56. Disponível em: http://dx.doi.org/10.1590/1980-5497201700050012

6. Brazil Ministério da Saúde. Portaria n. 3.088, de 23 de dezembro de 2011. Institui a Rede de Atenção Psicossocial para pessoas com sofrimento ou transtorno mental e com necessidades decorrentes do uso de crack, álcool e outras drogas, no âmbito do Sistema Único de Saúde (SUS) [Internet]. 2011 [acesso em 2019 fev 19]. Disponível em: http://bvsms.saude.gov.br/bvs/saudelegis/gm/2011/prt3088_23_12_2011_rep.html

7. Ministério da Saúde (BR), Departamento de Informática do Sistema Único de Saúde. Informações de saúde. Demográficas e socioeconômicas. População residente [Internet]. 2019 [acesso em 2019 fev 20]. Disponível em: http://tabnet.datasus.gov.br/cgi/tabcgi.exe?ibge/cnv/poptrs.def

8. Ministério da Saúde (BR), Departamento de Informática do Sistema Único de Saúde. Informações de saúde. Epidemiológicas e morbidades. Morbidade hospitalar do SUS (SIH/SUS) [Internet]. 2019 [acesso em 2019 fev 20]. Disponível em: http://tabnet.datasus.gov.br/cgi/tabcgi.exe?sih/cnv/mirs.def

9. Prefeitura Municipal de Porto Alegre (RS), Secretaria Municipal de Saúde. Coordenadoria Geral de Vigilância em Saúde. Eventos vitais: análises em saúde. Sistema de Informação de Mortalidade [Internet]. 2019 [acesso em 2019 fev 20]. Disponível em: https://public.tableau.com/profile/eugenio.lisboa5167#!/vizhome/porto_alegre_mortalidade/MORT

10. Prefeitura Municipal de Porto Alegre (RS), Secretaria Municipal de Saúde. Relatório anual de gestão 2017 [Internet]. 2017 [acesso em 2019 fev 21]. Disponível em: http://lproweb.procempa.com.br/pmpa/prefpoa/sms/usu_doc/rag.pdf

11. Brazil Ministério da Saúde, Conselho Nacional da Saúde (BR). Resolução n. 466, de 12 de dezembro de 2012. Dispõe sobre as diretrizes e normas regulamentadoras de pesquisa envolvendo seres humanos [Internet]. 2013 [acesso em 2019 jan 15]. Disponível em: https://bvsms.saude.gov.br/bvs/saudelegis/cns/2013/res0466_12_12_2012.html

12. Vieira VAS, D'Alessandro FCS, Silva FMR, Coelho KR, Quadros KAN. Caracterização dos indivíduos

que realizaram prática/tentativa de autoextermínio em Itapecerica, Minas Gerais, Brasil. Rev Enferm Cent Oeste Min [Internet]. 2017 [acesso em 2019 fev 27];7:e1681. Disponível em: http://seer.ufsj.edu.br/index.php/recom/article/view/1681

13. Reisdorfer N, Araujo GM, Hildebrandt LM, Gewehr TR, Nardino J, Leite MT. Suicídio na voz de profissionais de enfermagem e estratégias de intervenção diante do comportamento suicida. Rev Enferm UFSM [Internet]. 2015 [acesso em 2019 fev 26];4(4):718-26. Disponível em: http://dx.doi.org/10.5902/2179769216790

14. Conte M, Cruz CW, Silva CG, Castilhos NRM, Nicolella ADR. Encontros ou desencontros: histórias de idosos que tentaram suicídio e a Rede de Atenção Integral em Porto Alegre/RS, Brasil. Ciênc Saúde Colet [Internet]. 2015 [acesso em 2019 fev 25];20(6):1741-9. Disponível em: http://dx.doi.org/10.1590/1413-81232015206.02452015

15. Miranda TN, Teixeira JC, Oliveira ACR, Fernandes RTP. Fatores que influenciam negativamente na assistência integral ao usuário da atenção básica na saúde do homem. J Health Connect [Internet]. 2018 [acesso em 2019 fev 25];2(1):30-43. Disponível em: http://periodicos.estacio.br/index.php/journalhc/article/view/4062/47964818

16. Chaves JB, Fernandes SCS, Bezerra DS. A ausência masculina na atenção primária à saúde: uma análise da teoria da ação planejada. Estud Interdiscip Psicol [Internet]. 2018 [acesso em 2019 fev 24];9(3):38-57. Disponível em: http://pepsic.bvsalud.org/scielo.php?script=sci_abstract&pid=S2236-64072018000300004&lng=pt&nrm=iso

17. Bahia CA, Avanci JQ, Pinto LW, Minayo MCS. Lesão autoprovocada em todos os ciclos da vida: perfil das vítimas em serviços de urgência e emergência de capitais do Brasil. Ciênc Saúde Colet [Internet]. 2017 [acesso em 2019 fev 24];22(9):2841-50. Disponível em: http://dx.doi.org/10.1590/1413-81232017229.12242017

Corresponding author:

Alan Cristian Rodrigues Jorge
E-mail: ajorge@hcpa.edu.br
Address: Rua Sarmento Leite, 245, sala 401A, Porto Alegre, Rio Grande do Sul, Brazil
ZIP CODE: 90050-170

Authorship Contributions

1 – Alan Cristian Rodrigues Jorge
Contributions: conception and planning of the manuscript, analysis and interpretation of data, writing and critical review.

2 – **Adriana Aparecida Paz**
Contributions: conception and planning of the manuscript, analysis and interpretation of data, writing and critical review.

3 – **Annie Jeanninne Bisso Lacchini**
Contributions: analysis and interpretation of data and critical review.

4 – **Graciele Fernanda da Costa Linch**
Contribution: conception and planning of the manuscript, analysis and interpretation of data, writing and critical review.

How to cite this article

Jorge ACR, Paz AA, Lacchini AJB, Linch GFC. Suicide and the psychosocial care network in the southern Brazilian capital. UFSM. 2019 [Accessed on: Year Month Day];vol.9, e69: 1-19. DOI: https://doi.org/10.5902/2179769227862