

LINES OF CARE FOR SUICIDAL BEHAVIOR: ANALYSIS OF CASES FOLLOWED UP AT PSYCHOSOCIAL CARE CENTERS

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Highlights: (1) Although care offerings are more diversified, they are standardized for all cases. (2) Care is poorly grounded in the needs of the person with suicidal behavior. (3) There is a lack of records on class, race and sexuality markers and their relationship with care. (4) Treatment success is individualized in users and their families. (5) The way non-adherence is understood may either strengthen the subject or increase their vulnerability.

PRE-PROOF

(as accepted)

This is a preliminary, unedited version of a manuscript that was accepted for publication in Revista Contexto & Saúde. As a service to our readers, we are making this initial version of the manuscript available, as accepted. The article will still be reviewed, formatted and approved by the authors before being published in its final form.

<http://dx.doi.org/10.21527/2176-7114.2026.51.17189>

How to cite:

Iglesias A, Roffes AA, da Silva SV, Dimenstein MD. Lines of care for suicidal behavior: analysis of cases followed up at psychosocial care centers. Rev. Contexto & Saúde. 2026;26(51):e17189

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ABSTRACT

Objective: To understand the management of care for people with suicidal behavior at Psychosocial Care Centers. **Method:** A qualitative, exploratory-descriptive study carried out in five psychosocial care services in two municipalities in Southeastern Brazil. Twelve medical records of people accompanied due to suicidal behavior (with satisfactory and unsatisfactory outcomes) were analyzed through documentary analysis and content analysis technique. **Results:** Municipality 1 offers a greater diversity of care actions. However, these offerings appear to be poorly grounded in the needs of the population served, showing no differentiation between cases. Municipality 2, in turn, presents a more restricted range of offerings, which does differ between cases with regard to intersectoral articulations and case discussions in situations with a satisfactory outcome. The classification of cases by their outcome is based mainly on whether or not users and families adhere to the teams' prescriptions, in a process of individualizing the issue and holding these people responsible for the success or failure of treatment. **Conclusion:** These results highlight the need for institutional spaces within these services to debate the production of psychological suffering today, the impact of social inequities on suicidal behaviors, the existence of precarious lives and the racialization of suicide in the country.

Keywords: Health Care; Suicide, Attempted; Mental Health Services.

INTRODUCTION

Suicidal behavior, understood as a process ranging from suicidal ideation and suicide attempts to suicide itself, frequently emerges as the most extreme expression of psychological suffering and subjective helplessness¹. Suicide is increasing worldwide and is one of the leading causes of death, constituting a serious public health problem that affects more than 700,000 people annually across the world, which accounted for 1.3% of all global deaths in 2019². In Brazil, the situation is equally worrying, with a progressive increase in rates — which jumped from 9,454 at the beginning of the decade to 13,523 occurrences in 2019 — particularly among young and Indigenous populations and people in contexts of socioeconomic vulnerability^{3,4}.

Within the Brazilian context of Psychiatric Reform, Psychosocial Care Centers (CAPS) plays an important and strategic role in the reception, care and follow-up of these situations.

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They are co-responsible for providing specialized support to people at suicide risk, preventing tragic outcomes through longitudinal and territorial risk management. Interventions range from immediate reception to long-term care planning, with the joint construction — by the user, their family members and the multiprofessional team — of a Singular Therapeutic Project (PTS), which must consider the particularities of each case and the important elements of the subject's history⁵.

However, despite the significant advance that CAPS represents in the mental health field, the teams that care for people with suicidal behavior deal with unfavorable attitudes toward suicide and face numerous challenges, such as the stigmatization and prejudice that still surround suicide, even within health services^{6,7}. The literature has pointed to problems in the training and qualification of the specialized care teams of the Unified Health System (SUS) to deal with the complexity of suicidal behavior, whose management requires a comprehensive, sensitive approach grounded in engaged listening and in building a relationship of trust with the user and the family, with possibilities of support in the territory^{8,9}.

In addition, the dismantling of the Psychosocial Care Network (RAPS) — understood as the continuous process of defunding open community services¹⁰ — has aggravated the shortage of continuing education spaces on prevention and care regarding suicidal behavior and has contributed to strengthening the hegemony of the psychiatric paradigm in the RAPS care points. Thus, mental health teams face daily difficulties ranging from reception, through the shortage of specialized professionals, to obstacles in following up cases within the network and in the continuity and comprehensiveness of care¹⁰.

Currently, national and international scientific literature has concentrated its efforts on the epidemiological characterization of suicidal behavior^{2,3} and on the identification of risk factors associated with vulnerable groups^{4,7}. In the psychosocial care setting, qualitative investigations and systematic reviews show that, although normative guidelines exist for the design of PTSs, care practice is strained by impasses in crisis management and by the ethical-political suffering of teams in the face of the precarization of the network^{1,6,9}.

However, a gap is observed in scientific knowledge regarding the detailed and comparative analysis of the care trajectories documented in the daily routine of the services, contrasting cases in which the crisis was stabilized with those marked by persistent instability of the clinical condition. There is also a scarcity of studies focusing on the recording of suicidal

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behavior management in order to map what effectively sustains or weakens the line of care in the services of the network.

It is precisely in this gap that the present research is situated, seeking to understand how CAPS teams have structured the management of care for people who have attempted suicide or are at risk of suicide. Through the documentary analysis of medical records with a qualitative focus, we sought to understand how teams structure lines of care — that is, case follow-up, care offerings and actions developed in relation to cases with crisis stabilization and those with recurrent clinical instability. In addition, we sought to identify the difficulties faced in managing these cases in a way that allows possible gaps and weaknesses in the care process to be identified.

METHOD

This is a documentary, exploratory-descriptive study using secondary data drawn exclusively from medical records. The research was carried out in two municipalities in the Southeast of the country: one (municipality 1) located in a metropolitan region, with a population of 467,722 inhabitants, and the other (municipality 2) located in the interior of the state, with 134,629 inhabitants. Municipality 1 comprises five health regions, which encompass: 10 Basic Health Units (UBS), 10 Family Health Units (USF), 1 Specific Care and Basic Oral Health Unit, 1 Municipal Secondary Care Center (CEMAS), 1 Testing and Counseling Center for AIDS and Viral Hepatitis (CTA), 1 Dental Specialties Center (CEO), 1 Psychosocial Care Center for Alcohol and Other Drugs (CAPSad), 1 Child and Adolescent Psychosocial Care Center (CAPSi), 1 Psychosocial Care Center II (CAPS II), 1 Street Outreach Office team, 2 Emergency Care Units, 1 Municipal Hospital and 1 Reference Center for the Care of Older Adults. Municipality 2, in turn, comprises: 01 Regulation Center, 01 Health Management Center, 02 Psychosocial Care Centers (CAPS I and CAPS AD), 25 Basic Health Units, 01 Supply Center, 03 Specialized Clinics/Specialized Outpatient Clinics, 02 Municipal Pharmacies, 01 Polyclinic, 01 Health Academy Hub, 02 Diagnostic and Therapy Service and Support Units, 03 Health Surveillance Units (Sanitary, Environmental and Epidemiological), 03 Mobile Land Units and 02 Pre-Hospital Level Units in the emergency area.

The choice of the two municipalities was made through intentional sampling combined with criteria of feasibility and care relevance for health regionalization. The analytical intent

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was based on the opportunity to contrast the organization of the Psychosocial Care Network (RAPS) of an urban center in the metropolitan region with that of a hub municipality in the interior.

The first municipality, located in the Metropolitan Region, was selected because it constitutes an important population hub in the state, with high demographic density and significant demand for specialized services. The second municipality, located in the interior, was included because of its strategic role in regional health governance, acting as the reference municipality of the Northern Health Region and playing a driving role in the negotiation and articulation of the network in the region. As a complementary criterion for inclusion and operational feasibility, the formal consent of the municipal health departments involved and the effective guarantee of access to the documentary records for meeting the research objectives were considered.

This research highlights the CAPS as the sites for collecting data from the medical records of users with suicidal behavior: CAPS II, CAPS AD and CAPSij (municipality 1) and CAPS I and CAPS AD (municipality 2). In the health context, the user's medical record is a document built collaboratively from the information recorded by the professionals of the multiprofessional team about the physical, mental and social aspects of the case, as well as about the professional care practices provided to the user treated at the service, which justifies its use for producing the data of this research^{11,12}.

After authorization by the University's Research Ethics Committee (CEP) (opinion no. 5,462,461) and by the municipal governments involved, data collection began. The researchers visited each of the CAPS at times previously arranged with the teams in order to present the research proposal. Upon the team's acceptance, each of them was asked to indicate at least two striking cases of people with suicidal behavior treated at the service, for qualitative analysis of their medical records. As a selection criterion, it was suggested that the teams indicate emblematic care situations that had strongly mobilized the service's therapeutic planning because of their complexity.

Specifically at the CAPSij of municipality 1, the indication of four cases was requested — two corresponding to childhood and two to adolescence. The researchers instructed the teams to indicate, among the cases that stood out for them: one case with a satisfactory outcome — stabilization of the crisis — and one case with an unsatisfactory outcome — frequent

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instability of the clinical condition — taking into account the modes of reception, the care offerings, the actions developed, the difficulties in management and the follow-up of the case. It should be noted that the outcomes were defined based on the clinical and institutional judgment of the teams themselves.

Twelve medical records were analyzed (eight from municipality 1 and four from municipality 2). The data were collected in person at the CAPS, and the entries in the medical records were transcribed using electronic devices — tablet and computers. Individual text files were generated for each of the cases for subsequent analysis using the content analysis technique.

It is worth noting that, to ensure the anonymization of users, all real names — of both users and professionals — were replaced by pseudonyms, and institutional data or numerical identification records were entirely suppressed. The confidentiality of the information was ensured by storing the collected data in digital files accessible exclusively to the responsible researchers, with a formal commitment not to use the information for purposes unrelated to the objectives of this study.

RESULTS AND DISCUSSION

Chart 1 presents the identification of the cases highlighted by the teams. Charts 2 and 3 present the sociodemographic characteristics of the users indicated by municipalities 1 and 2. Chart 4 shows the categorization of the information contained in the medical records regarding the care offerings and the justifications for the team's classification of the case as having a satisfactory or unsatisfactory outcome. Next, a summarized description of the similarities and differences between the cases regarding the psychosocial stressors and/or clinical conditions presented in the medical records is provided, followed by the theoretical discussions.

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Chart 1 – Identification of the cases according to outcome, service and municipality

Service	Satisfactory outcome		Unsatisfactory outcome	
	Municipality 1	Municipality 2	Municipality 1	Municipality 2
CAPS ad	Ivo	Bernardo	Rodolfo	Olavo
CAPS I	-	Eloá	-	Diana
CAPS II	Wagner	-	Ingrid	-
CAPSij – Childhood	Igor	-	Lázaro	-
CAPSij – Adolescence	Kamila	-	Jéssica	-

Source: Prepared by the authors

Chart 2 – Sociodemographic characteristics of the users indicated in Municipality 1

Case classification	Name	Age	Life cycle	Service	Race/Color	Marital status	Diagnostic hypothesis/ICD
Satisfactory outcome	Igor	9 years	Childhood	CAPSij	Black	Single	F90 + F70
	Kamila	19 years	Adolescence	CAPSij	White	Single	F31 + F41
	Wagner	48 years	Adulthood	CAPS II	Brown	Divorced	F33.3
	Ivo	60 years	Older adult	CAPSad	Brown	Divorced	F10.3 + F32.2
Unsatisfactory outcome	Lázaro	6 years	Childhood	CAPSij	Brown	Single	F20 + F90
	Jéssica	18 years	Adolescence	CAPSij	Brown	Single	F60.3 + F33
	Ingrid	24 years	Adulthood	CAPS II	White	Single	F60 + F33 + F10
	Rodolfo	25 years	Adulthood	CAPSad	White	Single	F31 + F19 + F10.2 + F60.3

Source: Prepared by the authors

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Chart 3 – Sociodemographic characteristics of the users indicated in Municipality 2

Case classification	Name	Age	Life cycle	Service	Race/Color	Marital status	Diagnostic hypothesis/ICD
Satisfactory outcome	Eloá	22 years	Adulthood	CAPS I	Not specified	Single	E31 + F60.9 + F31.6
	Bernardo	29 years	Adulthood	CAPS AD	Not specified	Single	F06.3 + F19
Unsatisfactory outcome	Diana	52 years	Adulthood	CAPS I	Not specified	Single	F71
	Olavo	24 years	Adulthood	CAPS AD	Not specified	Single	F12+ F41

Source: Prepared by the authors

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Chart 4 – Categorization of the care offerings and case classification, according to municipality

Category	Satisfactory outcome		Unsatisfactory outcome	
	Municipality 1	Municipality 2	Municipality 1	Municipality 2
Care offerings	Individual care	Individual care	Individual care	Individual care
	Multiprofessional care	Multiprofessional care	Multiprofessional care	Multiprofessional care
	Collective/group activities		Collective/group activities	Collective/group activities
	Family care		Family care	Family care
	Case discussion within the service	Case discussion within the service	Case discussion within the service	
	Matrix support with PHC and the hospital		Matrix support with PHC and the hospital	
	Intersectoral articulation – school/APAE/Guardianship Council/SINE	Intersectoral articulation	Intersectoral articulation – school/APAE/Guardianship Council/SINE	
	Active search – through home visits and/or telephone contact		Active search – through home visits and/or telephone contact	
	Referrals to the Emergency Room/SAMU		Referrals to the Emergency Room/SAMU	
	Guidance during crisis – hospital emergency room and CVV		Guidance during crisis – hospital emergency room and CVV	
	Medication dispensing	Medication dispensing	Medication dispensing	Medication dispensing
	Remote care			
Justifications for case classification	Adherence to the CAPS therapeutic offerings		Non-adherence to the CAPS care offerings/Resistance to treatment	

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	Participation in activities in the territory suggested by the CAPS		Non-participation in activities in the territory suggested by the CAPS	
	Bonding with the team		Failure to comply with the CAPS rules	
	Family support	Family support	Lack of family support and other support networks	Lack of family support and other support networks
	Entry into the labor market	Entry into the labor market		
	Admission to university	Admission to university		
	Presence of plans for the future			
	Continuity of care in PHC		Difficulty in the continuity of care by another health service	
			Difficulties in managing symptoms and instability of the condition	Difficulties in managing symptoms and instability of the condition
	Stabilization and remission of symptoms	Stabilization and remission of symptoms	Strong suicidal ideation and death by suicide	Strong suicidal ideation and death by suicide

Source: Prepared by the authors

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In line with the literature on suicide risk factors, the medical records present a variety of psychosocial stressors experienced by people with suicidal behavior treated at CAPS^{14,15,16,17}. Markers of different natures stand out, whether individual, social, psychological or family-related, or related to social distancing, difficulties in accessing the service, etc. With regard to the similarities in psychosocial stressors and/or clinical conditions among the cases selected by the teams, the following were found: sadness, anguish, despair, discouragement, irritability, aggressiveness, anxiety, self-harm, helplessness, a history of violence, fear, feelings of loneliness — few social interactions and/or social isolation —, suicidal ideation and/or attempt, a history of psychiatric hospitalizations, family conflicts and low self-esteem.

As for the differences, they relate to the diagnostic hypothesis and to the singularities of the user's life histories, such as how episodes of violence were experienced, or specificities related to age, gender, socioeconomic status, marital status and race/color, such as experiences of racism, loss of functionality, marital infidelity and financial difficulties.

It is also noted that the psychosocial stressors presented are associated with the profile of each service, in addition to varying according to age: unemployment is frequently reported by adults, bullying by children and adolescents, the abusive use of alcohol and other drugs by the users who attend the CAPS ad, and experiences of hallucinations with derogatory and commanding voices among the cases treated at CAPS I and II. Some other situations aggravating suicidal behavior mentioned among the striking cases also stand out: insomnia, the loss of important people, missing one's children, feelings of guilt regarding the past, social vulnerability, marital separation, and family members' difficulty in accepting the person's sexual orientation.

With regard to the care offerings and the classification of outcomes, it is observed that municipality 1, being larger and having better coverage of services and teams than municipality 2, provides a greater diversity of actions carried out inside and outside the service. However, despite the importance and diversity of this municipality's offerings — such as group practices, matrix support, intersectoral articulations and home visits, among others — they appear to be poorly grounded in the specific needs of the population served, such as racism, violence and the lack of basic subsistence resources, so that the offerings are standardized for all cases that reach the services. In other words, the offer does not differ between cases considered to have a satisfactory outcome and those with an unsatisfactory

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outcome. Municipality 2, in turn, presents a much more restricted range of care offerings, which does differ between cases with satisfactory and unsatisfactory outcomes. This is the case of the intersectoral articulations and the case discussions among the service team for situations with a satisfactory outcome.

This result calls for reflection on the organization of the work process in the CAPS, on the ways of planning and delivering care, on the problems of adapting the care offerings to the profile of needs and demands, and on the absence of a culture of continuous research and evaluation in the services regarding the procedures adopted and the results achieved. In the case of the participating municipalities, the relationship between standardized/diversified care offerings and satisfactory/unsatisfactory outcomes could be the subject of further investigation by the teams and of Continuing Health Education actions, especially when it comes to people with suicidal behavior, who require longitudinal, continuous and long-term care.

One of the consequences of the fragility of the health evaluation process is the lack of adjustment of reception, care planning, the definition of clinical conduct and the lines of care to the different profiles of users and the contexts in which they are inserted. Regarding suicidal behavior, academic efforts have concentrated on identifying mortality rates, epidemiological profiles and possible associated factors, monitoring risk conditions and determining the degree of vulnerability to suicide, generally based on universal assumptions. Moreover, its management is not always situated within a reality of work overload, scarce organizational resources and the insufficient training capacity of the teams observed in the RAPS^{18,19,20,21}.

In Brazil, the Ministry of Health's guideline since 2006 has been directed in a limited way toward the early identification of risk factors and toward medical interventions associated with the use of medication — a care offering unanimously present in the cases of both municipalities studied. For this reason, authors such as Dahl and Dias¹⁶ emphasize the importance of a paradigm shift in order to understand the circumstances that created the vulnerabilities and to carry out a “comprehensive, intersectoral project that addresses not specifically the act of suicide and its immediate circumstances, but the entire set of circumstances that culminated in a situation in which the person sees no horizon, no possibilities” (p. 58). In this direction, social vulnerabilities must be considered as an indicator of inequity and social inequality that precedes and determines risk²², which calls

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for focused and situated action on problems and needs.

From the medical records analyzed, the commitment of the workers of the services studied to offering safe, effective and humanized actions for people with suicidal behavior is undeniable: multiprofessional care, group activities, matrix support, intersectoral articulations and home visits, among others. However, it was not possible to identify in the medical records how this care was proposed and/or offered, with limited records of the users' statements. There is no indication of how the team builds a singularized proposal for each user, whether the offerings meet their needs, or whether they derive from matrix support with the Primary Care teams that cover the area where the user lives, from what was observed during a home visit, or from the contact the professional had with the spaces where these people live and where their rights are sometimes violated.

The literature has highlighted that care offerings formatted a priori end up fixating on the regularity of situations, imposing views and practices that do not relate to the real subject in their particular variability. Consequently, they become ineffective, since they do not reach what is singular in each person^{23,24}. For Campos²³ (p. 5), “situations that are similar from a classificatory point of view may have different effects depending on the history and the subjective and material resources of each subject.” It is therefore a matter of escaping an assembly-line perspective in the treatment of these situations — sometimes based on graded risk levels — which equates the offering made by a service to a 40-year-old Black woman at risk of suicide, living in a region with high poverty rates, a single mother of six children and unemployed, with that made to another user, a 50-year-old brown-skinned woman also at risk of suicide, living in another region with many vulnerabilities, married and a victim of domestic violence, and of moving instead toward a line of care grounded in the singular needs of these people in distress, who at that moment are limited in their capacity for contractuality and in their conditions for building networks²⁵.

Research conducted by Botega¹⁵ with two groups of people who had attempted suicide indicates that the group that received home visits and regular telephone calls from professionals, in addition to the usual treatment — referrals to the mental health network — presented ten times fewer suicidal acts compared with the group that was offered only referrals to the mental health network, showing the importance of a close subject/user–subject/professional relationship that ensures support for that user in moments of suffering and in the exercise of their rights to a dignified life.

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In this direction, the recommendation to participate in a given group, for example, must make sense for a specific user, presenting itself to them as a possibility for the joint invention of new ways of living, and not simply make sense to the professional caring for people with suicidal behavior and little sociability, through the mere gathering of people in the same space. Likewise, multiprofessional teamwork — via matrix support or through meetings between sectors, for example — should not consist of the sum of the actions of each professional, service or sector, with hierarchical and rigid roles²⁴, but should be effectively collaborative and affective, sustained by joint action aimed at expanding the possibilities of life. This could not be detected in the analysis of the medical records.

Ferigato et al.²⁶ warn how fundamental it is that care for these people is not provided solely by mental health services, making it essential to build a support network beyond the CAPS. The authors mention that this network can be constituted through articulation with other health services and, outside them, in an intersectoral manner, encompassing sports, cultural and leisure activities, social assistance and whatever else makes sense in that subject's life. The Ministry of Health itself²⁷ reiterates the importance of participation in community activities, in neighborhood associations or other institutions existing in the community, aiming at social exchanges and the integration of users with the community and society in general, as a means of mental health care and, consequently, of care for people with suicidal behavior.

Ferreira et al.²⁸ name this mobilization *tutela autonomizadora* (autonomizing guardianship), which consists of seeking to produce movements together with users in the territory, “in which the living action of one [professional] triggers the production of life in the other [user],” running counter to a form of guardianship — sometimes present in rigid offerings — that generates dependence and, consequently, limits the inventive possibilities of life that are indispensable for people with suicidal behavior.

Thus, from the perspective of expanded psychosocial care with co-responsibility, the classification of the cases in this study as having satisfactory or unsatisfactory outcomes — based predominantly on whether or not families participate and on whether or not users adhere to the teams' prescriptions, in a process of individualizing the issue and holding the user and their family responsible/blameworthy for the success or failure of treatment — must be questioned. The centrality of care on the subject presupposes shared responsibility with them, rather than placing the responsibility for suicidal behavior and the success or failure

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of the intervention solely on the user and their family.

According to Bertolozzi et al.²², adherence cannot be reduced to an act of personal will; it depends on various factors involving people's lives and daily routines — such as the various psychosocial stressors and clinical conditions indicated in the results — the organization of work processes, accessibility to health care, and living and working conditions. Although it was not possible to apprehend this from the medical records analyzed, according to Onocko-Campos et al.²⁹ it is common for CAPS users to refer to their limited participation in the decision-making processes concerning their therapeutic plans, to the limited information obtained about their treatment, and to the difficulties in talking with the physician and understanding the language of health professionals, which may represent an obstacle to adherence.

In the field of suicidal behavior, the way this non-adherence is understood and managed by the teams — whether limited to the idea of a lack of interest and responsibility on the part of the user and their family, or understood in a more contextualized way — may mean either the strengthening of that subject in life or the expansion of their vulnerability, as they feel blamed and more alone, which increases their difficulties in expressing their pain³⁰. Thus, understanding and welcoming the reasons for users' and families' non-adherence to care proposals, in order to use them for the evaluation and reorganization of work processes and, consequently, for the redirection of therapeutic proposals, is essential to achieving results that are in fact satisfactory and successful³¹.

Based on the information presented, it is recognized that building comprehensive lines of care for people with suicidal behavior involves recognizing the health inequities and psychosocial vulnerabilities that affect certain population groups, detecting factors harmful to mental health in the territories, building longitudinal care bonds within the Health Care Networks, developing technical capacities and skills in multiprofessional teams for management that is culturally sensitive to the cultural diversity of groups and populations, and confronting the structural fragilities of the RAPS services — but, especially, promoting an intersectional understanding of psychological suffering and suicidal behavior based on the social markers of social class, race, gender and sexuality^{32,33,34}.

Accordingly, a comprehensive and equitable line of care for people with suicidal behavior must be constituted through agreements among various social actors, especially those leading services and care resources, since it necessarily involves frequent

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reorganizations of work processes and of social relations as a whole³⁵. It is known that one of the major problems to be addressed in the RAPS, for example, is the underreporting of the race/ethnicity marker in service records. This is what occurred with the medical record data in municipality 2. In this sense, the pursuit of equitable and comprehensive care that is appropriate to the singular needs of subjects requires agreements among various instances, care actors and sectors of society; it requires a more systematic and regular presence of professionals in the territories; and it requires institutional guarantees of time, autonomy and participation of workers in decision-making processes, among other working conditions.

Thus, the results of this study point to the need to broaden the levels of awareness and critical reflection and to open institutional spaces in the CAPS to debate the production of psychological suffering today and the impact of social inequities on suicidal behaviors, as well as the existence of precarious lives and the racialization of suicide in the country³⁷. An anti-asylum, anti-racist, intersectional and culturally sensitive line of care constitutes a powerful device for rupturing the asylum-based, serialized and racist logic still present in our society and in health services, moving toward the construction of public policies and the repositioning of the mental health field and of the Brazilian Psychiatric Reform^{37,38,39,40}.

FINAL CONSIDERATIONS

The present study showed that the management of care for people with suicidal behavior at Psychosocial Care Centers (CAPS) still faces significant structural and conceptual challenges. Although teams make efforts to offer diversified actions, a tendency prevails toward the standardization of care practices and toward basing outcomes — satisfactory or not — on the adherence or resistance of users and their families to institutional prescriptions. This process reduces the complexity of the phenomenon to an individual plane, disregarding the centrality of social determinants in the production of psychological suffering.

For the Psychosocial Care Network (RAPS) to advance toward comprehensive care, it is urgent to overcome strictly symptomatic management or management centered on the pharmacological apparatus. It is imperative to strengthen anti-asylum, anti-racist, intersectional and territorially connected lines of care, capable of welcoming the singularities of race, class, gender and sexuality that run through life trajectories and the precarization of existence. This requires guaranteeing institutional spaces for Continuing Health Education

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and strengthening the working conditions of multiprofessional teams.

Finally, a limitation of this work is that the analysis was restricted to the entries in the medical records, which often omit the perspective of the subjects and the social markers of vulnerability. It is recommended that future investigations incorporate qualitative and direct listening to users, family members and network workers, deepening the understanding of the meanings of care, the barriers to access and the strategies for strengthening life in the daily routine of psychosocial care.

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Submitted: April 17, 2025

Accepted: July 31, 2026

Published: September 28, 2026

Author contributions	
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All authors approved the final version of the manuscript.	
Conflict of interest:	There is no conflict of interest.
Funding:	This study received no funding.
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Editor:	Adriane Cristina Bernat Kolankiewicz. PhD

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