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Original Article

Nursing actions in primary care to prevent suicide

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Primary care is the health care level at which the risk of suicide can be identified, with the possibility of early intervention. The objectives in this study were to describe the primary health care nurses' potential to prevent suicide and discuss the work process focused on prevention. An exploratory and descriptive study with a qualitative approach was undertaken, involving nurses from the Family Health Strategy. The content analysis technique was used to treat the data. The results revealed that the actions to prevent suicide in primary health care need to be included in the nurses' work process.

Descriptors: Prevention; Nurses; Suicide.

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Ações do enfermeiro na atenção básica para prevenção do suicídio

A atenção básica representa o nível de atenção à saúde no qual há potencial para identificação e intervenção precoce no risco de suicídio. Os objetivos, neste estudo, foram descrever as ações realizadas pelo enfermeiro da atenção básica para prevenção do suicídio e discutir o processo de trabalho voltado para prevenção. É estudo do tipo exploratório-descritivo, de abordagem qualitativa, realizado com enfermeiros da Estratégia Saúde da Família. Utilizou-se a técnica de análise de conteúdo para o tratamento dos dados. Por meio dos resultados, revelou-se que as ações para prevenção do suicídio na atenção básica necessitam ser inseridas no processo de trabalho de enfermeiros.

Descritores: Prevenção; Enfermeiras e Enfermeiros; Suicídio.

Aciones de la enfermera en la atención primaria para prevecion del suicídio

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Descriptores: Prevención; Enfermeros; Suicidio.

Introduction

Suicide has occurred since old age, but its relevance has been hardly explored in research, as it involves taboos, prejudices and unknowns concerning its history.

Self-extermination is considered a multidimensional phenomenon with non-specific repercussions, currently representing an important public health problem, as it exerts not only individual, but also collective influence. Another relevant factor to be taken into account refers to the global growth, considering the 50% growth in suicide rates in the past 50 years[1].

What suicidal behavior is concerned, it is estimated that the attempts surpasses the number of accomplished suicides by at least 10 times. Suicide attempts should be taken seriously, as a sign of alert, revealing the influence of non-specific and complex psychosocial phenomena. Thus, by the existence of an attempt, the occurrence of suicide can be predicted[1-2].

Although suicide is a source of concern, and in view of different inquiries on the problem, evidencing abundant scientific production on the theme, research does not seem to evidence abundant scientific production on the theme. Nevertheless, existing research does not seem to contribute considerably to reduce the incidence of cases, in view of the uncontrolled growth in the number of attempted or accomplished suicide cases around the world[3].

Although suicide involves a wide range of issues, such as genetic, sociocultural and psychodynamic

aspects, the groups most vulnerable to suicide attempts include people with some mental disorder, such as depression, schizophrenia or bipolar disorder[1]. In that sense, although most attempted or accomplished suicides are practiced by people previously diagnosed with some mental disorder, it is fundamental to highlighted that cases without any related with mental disorder should not be neglected.

Between 2002 and 2012, the total number of suicides in Brazil increased from 7,726 to 10,321, appointing a 33.6% growth in the number of cases, which is alarming, considering the fact that this increase surpassed the country's population growth in the same period, totaling 11.1%. Among the violent death rates, it displayed the largest growth in one decade, strongly exceeding homicides (2.1%) and mortality in traffic accidents (24.5%)[4].

In that sense, from the perspective of suicide prevention, the health teams working in primary health care, representing the first level of health care resources, have great potential to develop strategies and actions that favor the identification and early intervention in cases of suicide risk. The justifications for this potential of the primary care teams include the organization model defined by the Health Department (HD), in which primary care is the users' preferred entry door into the health system, promoting welcoming, bonding and accountability for attending to the needs of people who seek this care level[5].

Nevertheless, what the actions to prevent suicide are concerned, these practices have not been routinely evidenced in the development of these professionals' work process. Some actions focused on suicide prevention are only addressed in teams in which there are professionals who identify with the area, revealing gaps in the organization model of these actions in primary health care.

Preventing suicidal behavior is not easy. To permit bringing down this risk, the early detection of people with suicidal ideas and appropriate intervention are fundamental factors[6].

The health services need to be increasingly well structured and capable of promoting the ability to solve problems, such as suicide attempts. Therefore, it is fundamental for primary care nurses to be capable of identifying the patient's innate signs and symptoms early, paying them due attention, considering that, through proper welcoming, the quality of targeted care and the efficacy of the treatment can be guaranteed.

Method

Exploratory and descriptive qualitative research, developed at Primary Health Care Units (UBS) and Family Health Units (USF) where the Family Health Strategy (ESF) was implemented, in the city of Teresina, PI, Brazil. For the research, the following UBS and USF were selected: UBS Oséas Sampaio (Matadouro), USF Mafrense, USF Nova Brasília and ESF Poty Velho. These services were chosen due to the easy recognition of the territory where the therapeutic devices in the care network are mapped.

The criteria defined to include the participants were: being a nurse, at least one year of experience in primary care and accepting to participate in the research by signing the Free and Informed Consent Form (FICF). No restriction was imposed concerning the participants' gender.

Hence, six ESF nurses participated in the research who complied with the inclusion criteria. Three of the nurses who complied with the inclusion criteria refused to participate in the research and three were on holiday. Despite the nurses' difficulty to adhere to the research, the number of participants permitted responding to the research problem and achieving the objectives, as the saturation of the statements was clearly evidenced in the interviews.

The data were collected in April 2015 through semistructured interviews, based on the following script: participant's code, interview date, name of the interviewer and duration of the interview. To better characterize the participants, criteria were defined, such as age, gender, time since graduation, length of experience in ESF and specialization in Mental Health (MH). At the end of the script, the guiding question was asked: what action s due nurses perform in primary health care to prevent suicide?

The interviews were held individually, in a private room at the primary health care unit, aiming to guarantee the interviewee's safety and privacy. The answers were recorded after informing about the research and obtaining the participant's consent. Nevertheless, the interviews only started after obtaining a favorable opinion from the Research Ethics Committee (CAAE: 41748015.1.0000.5210). In addition, all ethical and legal aspects of Resolution 466/12 on research involving human beings were complied with.

The data were analyzed through the content analysis technique in the light of Minayo's theoretical framework. This technical resource serves to analyze

data from written or transcribed messages. Hence, in the content analysis technique, we aimed to discover the cores of meaning in communication whose presence or frequency meant something for the analytic objective[7]. These data are discussed in a thematic category.

Results and Discussion

Based on the application of a semistructured interview script to collect the data, containing closed questions on the research participants, these professionals' profile could be outlined, as described in Figure 1.

Participants	Sex	Age	Length of experience	Specialization in MH
P1	Female	45	15 years	No
P2	Female	39	10 years	No
P3	Female	26	4 years	No
P4	Female	50	30 years	No
P5	Female	36	12 years	Yes
P6	Female	45	16 years	No

Figure 1 – Characteristics of nurses who participated in the study. Teresina, PI, Brazil, 2015

It should be mentioned that, during the data collection period, in view of the measures related to the nurse's work process, as established in the national suicide prevention policy, in the data analysis, we aimed to describe the preventive actions these professionals performed, identifying through these testimonies, if they execute measures to prevent suicide or not. Thus, the analysis of the testimonies converged towards a single thematic category – the primary care nurse and actions to prevent suicide: challenges of the work process.

It is interesting that, in the analysis and discussion of this category, we aimed to compare the reality studied in the literature and the ESF nurses' work model to prevent suicide.

The primary care nurse and actions to prevent suicide: challenges of the work process

Despite the relevance of this study for public health, the composition of what can be analyzed during the research is a limiting factor and should be taken into account.

As the ESF teams develop their work process in the territory where the users live and plan their actions based on the identification of the population's risks and needs, the actions to prevent suicide should be part of the teams' work agenda, constituting activities inherent in their daily reality. The nurses' attributions, as members of the family health team, include the responsibility for user welcoming by listening to their needs, making it possible to identify the risks and vulnerabilities in their work process, permitting the planning of care[5].

Nevertheless, although the ESF team, and particularly the nurse as a team member, has broader tasks to take care of the health needs of the population, with regard to suicide prevention actions, no organized actions are found yet in this professional's work process that permit the identification of risks and vulnerabilities related to suicide, as the participants expose next.

I do not develop any suicide prevention activity at my service yet today. I don't know, like, due to the fact that suicide is an issue we do not address much yet (P3)

[...] *in our team at least, we don't have any action* [...] (P1).

In contexts in which suicide prevention should be part of the range of activities inherent in the daily work of the ESF health teams, it is extremely important for nurses, as fundamental participants in user care, to plan effective and continuing actions with regard to suicide prevention.

According to the above statements, it was evidenced that there is no specific planning focused on the theme, nor truly preventive actions by primary health care professionals. The lack of these actions was clear in the research participants' reports as, according to them, there are no concrete actions at the UBS where they work.

At the health services, the teams' activities to verify risk factors for suicide and the use of preventive strategies for this condition can promote greater efficacy in terms of suicide prevention. In an earlier study, it was evidenced that more than 75% of the suicide victims visited a primary health care service in the year of their death and, in this group, 45% visited the UBS in the same month as they committed suicide[3].

The first contact with the patient is extremely important. The nurse's calm and open approach of acceptance and non-judgment is fundamental to facilitate communication. Creating this bond is

important by itself to reduce suicidal patients' level of despair[8].

In primary care, at the Family Health Strategy level, we hardly address the theme with the users. What we have right now is hardly anything… We don't have, like, guidance to solve these problems, prevention by itself does not happen (P5).

I don't have that much space yet to talk about suicide. For me, it's still difficult to talk about the theme with the patient, because we're not prepared to cope with this borderline situation, so that might be difficult for me (P3).

I don't feel prepared to cope with this. I see suicide as despair, it's anguishing, I even avoid talking about the theme. I feel great anguish, without knowing what to do. The solution I see is to forward to another professional (P6).

It is fundamental for the nurse to be available and attentive to possible signs and symptoms of patients with suicidal ideas. This professional is capable of performing qualified listening, with a focus on the patient only and on aspects that put him/her in a situation of total despair and hopelessness. This professional should be capable of leaving aside possible judgments and biases that emerge in view of borderline situations like suicide.

It is clear in the study that, besides the lack of preparation to cope with such a delicate and complex situation, there are also unknowns regarding the theme for the professional himself who, not knowing how to cope with the situation, ends up feeling anguish, which can reflect the difficulty to see possible solutions to the problem.

The fact that the primary care professional is available and accessible favors the establishment of the vital bond between the community and the health system. These factors can culminate in an important step to prevent suicide(9). The early detection and appropriate treatment of these conditions are extremely relevant what prevention is concerned.

In that context, through the human relationships, the nurse observes the patient, experiencing a wide range of emotions that occur between them, such as pain, discomfort, sadness, relief or hope(10).

[...] *we notice it when we talk to the patient, we notice that he has some kind of depression, or he presents signs, right, like crying, anxiety, insomnia* [...] (P2).

Today, I usually tell the health agents that there's a specialized service at Lineu Araújo. Based on this knowledge, which I got through training at Caps Norte, we started to instruct the health agents. I've had the opportunity to deliver leaflets to the families, because we know there's a very high suicide rate in Teresina (P4).

The primary care nurse often has a strong relationship with the patient due to the bonding, which is strengthened with every new nursing consultation. This tool allows the nurse to identify negative changes in the behavior of who receives care, an aspect evidenced in one of the participants' reports above. This can promote the perception of the nursing diagnosis that characterizes the risk of suicide.

The actions, then, are characterized as potentially effective intervention measures, which can culminate in the preservation of a life, even if executed not that specifically, as reported in P4's statement, who aims to forward the patient to a service with professionals specialized in suicide issues.

In Brazil, the comprehensive care proposal in primary health care and people's health care along care lines represent a favorable scenario for the organization and execution of the suicide care policies and their guidelines with a view to care integrality. Concerning community prevention programs intended to welcome the users of this system, such as the Hiperdia program, which contributes to prevent and treat arterial hypertension and diabetes, satisfactory results are evidenced[11].

Specifically concerning suicide, however, we agree that, despite the existence of actions to prevent this type of self-inflicted violence in Brazil, no specific references are found to suicide prevention, although local actions may be under development but without sufficient disclosure.

In the following statements of the participants, the lack of preparation to cope directly with suicide issues could be identified. This compromised ability can reflect the absence of specific knowledge regarding the science of MH as, among the six research participants, only one reported holding a specialist degree in this area. The statements also reveal possible motives for which actions to prevent suicide have not been put in practice. No training whatsoever was found with a focus on this problem.

We have never received any training to cope with this type of problem. There is other basic daily training: tuberculosis, Hansen's disease, pregnant women, prenatal care, that is greatly explored. But only focusing on suicide, there has never been anything focused on us, no (P1)

We receive plenty of training to cope with tuberculosis, Hansen's disease, more on these public health conditions really. It's not that suicide is not a public health concern, it's a concern, but I think that we are not prepared yet to cope with suicide. I think that's really lacking, training (P3).

What suicide prevention is concerned, we don't have any program that the foundation has launched to work with suicide prevention, there has been no training. What happens is together with the other programs in which we deliver care, which are groups for diabetics, hypertensive patients, prenatal care and the Family Grant (P2).

The educative actions indicated concerning the range of universal suicide prevention should be part of the nurse's work process in primary health care, considering that nurses already execute activities related to health education, involving conditions that are widely discussed and explained, such as those referred to by the three participants above.

In that perspective, a partnership among managers, health professionals and nurses is important for each to understand his role exactly. The health managers need a true notion of the problem's dimension and, consequently, of the importance of offering information media, training and qualification of these health professionals, so that they are prepared to properly cope with the problem and capable of not only identifying possible signs and innate symptoms of patients with suicidal ideas, but also apt to properly intervene in the crises.

It should be emphasized that primary care nurses understand the relevance of seeking relevant information on this theme. Therefore, it is fundamental for the professional to seek knowledge on this topic. The nurses should include systematic planning in their work process, followed by effective educational actions to promote suicide prevention, combining specific knowledge necessary with the practice of effective measures for the sake of prevention.

Conclusion

Concerning the actions to prevent suicide, focused on in this study, it was verified that, although nurses perceive the need to plan interventions in this problem, considering the severity of this fact, no organized and homogeneous actions are found yet on the work agendas of the nursing professionals who participated in this study. The interviewed professionals appoint this shortage due to different causes, ranging from a lack of professional identification with the area and inability to cope with this issue to the lack of resources, through training and qualification about suicide, which can allow the nurse to develop skill and technical competency to cope with and intervene in this problem. Based on these study results, also, the need is signaled to expand and strengthen the care network for suicide-related issues, so that the professionals are prepared to develop prevention actions, as well as to intervene in crisis situations in view of suicide. Therefore, the proper involvement and commitment of managers, health professionals and the community are fundamental.

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