

## Impact of the educational intervention about suicide on the perception of nurses and community health agents\*

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Objective: to analyze the perception of nurses and community health agents in relation to suicide before and after an educational intervention. Method: a quasi-experimental research, of the before and after study type and with a qualitative approach, based on the theoretical framework of Knowledge Transfer. Two nurses and ten community health agents from a basic health unit in Campo Grande, state of Mato Grosso do Sul, participated in the study. The focus group technique was used for data collection before and after the educational intervention. Data analysis was performed using the technique of Triangulation of Methods. Results: two categories of data analysis emerged: "the perception of suicide in its different aspects", which brings perceptions, understandings, and concepts related to suicide; and "the context of health care in suicidal behavior", which is characterized by how suicide is experienced by the health professionals in care contexts. Conclusion: the educational intervention fostered changes in the participants' perception regarding the identification and approach of suicidal behavior, indicating the importance of actions of this nature for approaches concerning suicide prevention.

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Descritores: Suicídio; Estudo de Intervenção; Atenção Primária de Saúde; Tentativa de Suicídio.

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## **Impacto da intervenção educacional sobre suicídio na percepção de enfermeiras e agentes comunitários de saúde**

Objetivo: analisar a percepção de enfermeiras e agentes comunitários de saúde em relação ao suicídio antes e após uma intervenção educativa. Método: estudo quase experimental, do tipo antes e depois, de abordagem qualitativa, baseado no referencial teórico da Transferência de Conhecimento. Participaram do estudo duas enfermeiras e dez agentes comunitários de saúde de uma unidade básica de saúde de Campo Grande, do estado de Mato Grosso do Sul. Foi utilizada a técnica de grupo focal, para a coleta de dados, antes e após a intervenção educativa. A análise dos dados foi realizada por meio da técnica de Triangulação de Métodos. Resultados: emergiram duas categorias da análise dos dados, "a percepção do suicídio nos seus diferentes aspectos", que traz percepções, compreensões e conceitos relacionados ao suicídio e "o contexto da assistência à saúde no comportamento suicida", que mostra como o suicídio é vivenciado pelos profissionais de saúde nos espaços de cuidado. Conclusão: a intervenção educativa favoreceu mudanças na percepção dos participantes referentes à identificação e abordagem do comportamento suicida, indicando a importância de ações dessa natureza para abordagens inerentes à prevenção do suicídio.

Descriptors: Suicide; Intervention Study; Primary Health Care; Suicide Attempted.

## **Impacto de la intervención educativa sobre el suicidio en la percepción de enfermeras y agentes comunitarios de salud**

Objetivo: analizar la percepción de enfermeras y agentes comunitarios de salud en relación con el suicidio, antes y después de una intervención educativa. Método: estudio cuasi experimental, del tipo antes y después, con enfoque cualitativo, basado en el marco teórico de la Transferencia de Conocimiento. Los participantes del estudio fueron dos enfermeras y diez agentes comunitarios de salud de una unidad básica de salud de Campo Grande en el estado de Mato Grosso do Sul. Se utilizó la técnica del grupo focal se utilizó para recopilar datos antes y después de la intervención educativa. El análisis de los datos se realizó mediante la técnica del Método de Triangulación. Resultados: surgieron dos categorías de análisis de datos, "la percepción del suicidio en sus diferentes aspectos", que trae percepciones, entendimientos y conceptos relacionados con el suicidio y "el contexto de la atención en salud en el comportamiento suicida", que muestra cómo los profesionales de la salud experimentan el suicidio en los espacios de atención. Conclusión: la intervención educativa favoreció cambios en la percepción de los participantes con respecto a la identificación y el enfoque del comportamiento suicida, lo que indica la importancia de acciones de esta naturaleza para abordajes inherentes a la prevención del suicidio.

Descriptorios: Suicidio; Estudio de Intervención; Atención Primaria de Salud; Intento de Suicidio.

## Introduction

Suicide is a serious global public health problem and is among the twenty main causes of death in the world. In the period from 2010 to 2016, the global age-standardized suicide rate decreased by 9.8%, with reductions ranging from 19.6% in the Western Pacific region to 4.2% in Southeast Asia. However, in the same period<sup>(1)</sup> there has been an increase of 6% in these rates in the Americas.

From 1996 to 2015, in Brazil there was an increase in the number of deaths in the North, Northeast, and Southeast regions, a decrease in the South region, and a stable trend in the Center-West region. In the South region, a suicide prevention program was created in 2009, strengthening basic care and including the identification of risks in professional training courses. Reinforcing, thus, the need for the development of educational actions that include widespread communication of the risks, of prevention programs, and of suicide-related complications, with priority in primary health care<sup>(2)</sup>.

In view of this, the Brazilian reality still indicates certain weakness in the implementation of a national surveillance program and of effective strategies for suicide prevention in order to confront this public health problem. Investments in training the professionals who assist individuals with suicidal behavior (SB) and their relatives are essential, especially for adequate health care and assistance<sup>(3)</sup>.

It is also of common knowledge that many health professionals still have negative attitudes towards SB individuals. This demonstrates the relevance of developing training programs that include, in addition to knowledge, changes in the attitudes of the health professionals encouraging empathy and understanding of SB by all health professionals<sup>(4)</sup>.

Thus, educational interventions about suicide can improve the attitudes of the health care team members, contributing to the proper performance of their due role in health care<sup>(5)</sup>. The change in perception about the care and performance of the nurse and of the Community Health Agents (CHAs) when caring for the person with SB is a tool for suicide prevention<sup>(6)</sup>.

Given this, the following question arises: Can the educational intervention on suicide prevention and postvention for nurses and CHAs favor changes in the perception and attitude towards the theme and its care actions? Thus, the objective of this study was to analyze the perception of nurses and CHAs regarding suicide before and after an educational intervention.

## Method

A quasi-experimental study, of the before and after type and with a qualitative approach, based on the theoretical framework of Knowledge Transfer<sup>(7)</sup>. The qualitative approach was chosen because of the objective of analyzing the perception and attitudes towards suicide, before and after an educational intervention.

For the development of the educational intervention of this study, the knowledge transfer theoretical model was used, so-called the "Knowledge-to-Action" (KTA) process, which aims to direct the application of knowledge. The KTA process defines that all the end-users of knowledge are important actors in the knowledge transfer process, which occurs in two simultaneous phases: the knowledge creation phase and the action phase.<sup>(7)</sup> This referential model was chosen because it allows for the participants' perception of the SB to be analyzed, as well as building together possibilities for improvements that could be applied in the care provided in this context.

The study site was a basic health unit (*Unidade Básica de Saúde*, UBS) in Campo Grande, Mato Grosso do Sul, consisting of three CHA strategy teams, with one nurse and ten CHAs each. The unit was chosen because of its territorial proximity to the Center for Psychosocial Attention (*Centro de Atenção Psicossocial*, CAPS), a reference for the care of individuals with suicide ideation and attempts, a factor that would be a facilitator for the matrix support among the care units.

As study participants, all the nurses and CHAs of the three teams were invited, totaling 30 CHAs and 3 nurses. The invitation to the nurses was made with the help of the unit's manager and that to the CWAs, by the lead researcher herself. The inclusion criteria were the following: nurse professionals and CHAs with a working time in the research site equal to or longer than one month (a period that allows the CHAs to have an understanding of their attributions and of the community). Professionals on vacation or on leave from work in the study period were excluded.

The educational intervention was carried out only by the lead researcher. It lasted a total of 24 hours divided into eight weekly meetings. The program content was developed through active methodologies and addressed the concept of suicide, epidemiology, protective and risk factors for suicide, professional approach, SB assessment and management, and suicide prevention and postvention actions.

A sociodemographic questionnaire and an interview using the focus group technique were used for data collection. The sociodemographic questionnaire was designed by the authors themselves and contained data regarding profession, gender, age group, schooling,

working time in the unit, and possible participation in courses, seminars, congresses, and/or lectures on the theme of suicide.

The focus group was chosen as the data collection method because its technique subsidizes the application of the KTA theoretical framework. It is a relevant technique that allows the participants to be active subjects in the construction of the data, fostering the approximation between practice scenarios and research studies<sup>(8)</sup>.

The focus groups were conducted by two trained researchers, both nurses, one being the lead researcher, who conducted the group; and the other recorded the observation. A meeting was held before and another after the educational intervention meetings, and they were conducted by means of the following guiding questions: What do you think about the person who attempts suicide? What do you believe makes it easier to identify a person with SB? As a health professional, what is your attitude before a person with SB? How would you talk to the relatives of a person who attempted suicide?

The period between the first focus group, the educational intervention, and the last focus group was from September to October 2018. They were recorded on digital audio media, transcribed in full, and organized for analysis. The analysis was made by means of the Triangulation of Methods Analysis, in an inductive way, which aims to articulate the information obtained through the research<sup>(9)</sup>.

The first articulation was the transcription and evaluation of data for the elaboration of categories for analysis, which are the empirical data (the reports addressed in the focus group). In the second stage of the articulation, a review of the existing scientific evidence on the object was conducted for contextualization. In the third stage, the conjuncture analysis, the object of the study related to the social atmosphere was analyzed, articulating the collected data with the regulations of the theme.

Finally, a reinterpretation was conducted involving empirical data, scientific evidence on the theme, and the analysis of the conjuncture emerging from the local knowledge to the wider field of research. The statements from the focal group will be presented with the letters A – CHA (from ACS in Portuguese) and E – Nurses (from *Enfermeiros* in Portuguese), and divided into moment 1 (pre-intervention) and moment 2 (post-intervention).

The study was conducted according to the guidelines for conducting research studies with human beings<sup>(10)</sup>. It was approved by the Research Ethics Committee for Research with Human Beings of the Federal University of Mato Grosso do Sul (*Universidade Federal de Mato Grosso do Sul*, UFMS), CAAE: 83059318.0.0000.0021,

and all the participants signed the Free and Informed Consent Term.

## Results

Of the 33 health care professionals, a total of two nurses and ten CHAs agreed to participate in the study. Of these, two CHAs withdrew their participation in the study during its development due to personal reasons.

Thus, of the 10 participants, two were nurses and eight were CHAs; 83% were female, 50% were between 31 and 45 years old, 33% were between 46 and 55 years old, and 17% were between 25 and 30 years old. Regarding their schooling, 42% had completed high school, 25% had a higher education degree, and 17% were specialists. With respect to the time working in the unit of study, half of the participants had worked there for more than 4 years, and the other half, for less than 2 years. Only 33% of the participants had already had contact with the theme of suicide in lectures and/or seminars.

From the data analysis, two categories arose: "the perception of suicide in its different aspects" and "the context of health care in SB".

### *The perception of suicide in its different aspects*

This category describes the perceptions, understanding, and concepts regarding suicide that are present in the focus groups before the educational intervention, and the changes that can be perceived after the intervention.

Before carrying out the educational intervention (moment 1), suicide was described by the participants as an event that represents suffering, many times because the individuals do not know how to deal with their problems, and they are tired of not being able to cope with conflicting situations, or as a desperate act.

*...that she doesn't see a way out, that she commits. She doesn't see a plausible way out of that situation. She doesn't want to kill herself, she wants to get rid of the problem. So she doesn't see a solution to get rid of the problem, and ends up committing...(A10) - moment 1*

For the participants, the individuals who are at risk of committing suicide show or appear to show sadness and suffering. In this way, they mention the difficulty in understanding and identifying SB in individuals who do not fit this stereotype, who have social and spiritual support, and no health problems.

*I know only one colleague who killed himself. An extremely happy colleague. That is why I tell you that this experience of seeing the person crying, not that most visible depression. Extremely joyful, that very day we were together, all happy for life. Never, ever, anything, you know? And he killed himself,*

*he hung himself... he had no addiction, he had nothing.*  
(A9) - moment 1

This perception implies the idea that some individuals who attempt suicide do so to attract the attention of their family and the people around them. Thus, the behavior of individuals who threaten to commit suicide is frequently perceived as attitudes of someone who will not really do so. Alert phrases not considered by the families or by other people were also mentioned in the focus groups, indicating that they did not believe the individuals would have the courage.

*...that we must win, it's really such a difficulty. It's this prejudice that we have; when a case comes in, we say... ah, they're just trying to get attention... We never think about the real reason that provoked that...(E1) - moment 1*

There is an ambivalence expressed by the participants about the understanding of suicide. They link the act of committing suicide to an act of courage, for managing to do it, or to an act of cowardice, for not facing their problems.

*...but that person who commits suicide becomes so brave to put an end his own life. Because he has to be brave; and he becomes so coward for not facing it. And, he thinks it's the contrary, that he's a coward, not facing the life situation he's going through, but even he becomes a brave man...*  
(A2) - moment 1

However, the analysis of the statements from the focus group after the educational intervention indicated the participants perceiving suicide in another way. The impulsiveness in the SB is indicated as one of the factors for the act, and is no longer described as an act of courage or cowardice. There was an understanding that different mental disorders, and not just depression, are important factors in SB.

*It is the impulse, not courage. If that moment of impulse has passed, they won't kill themselves anymore. I think that after everything we've seen here in the course, it's not courage or weakness...(A5) - moment 2.*

Regarding the right to commit suicide, even after the educational intervention, the participants remained expressing the conflict over whether only God has the right over life. However, after the educational intervention, a question arises about the situation of the person with SB being ill and with an altered ability to make decisions. Additionally, the belief that spirituality can serve as support for these individuals.

*...for example, every person has the right to put an end to their own life. We discussed that question before, that the person is not mentally healthy; obviously, they do not have that right. Nevertheless, this also exists, it is their right as the owners of themselves...(A9) - moment 2*

Regarding the stigma and the preconception against mental illness, the participants mentioned the perception that people do not reflect on the reasons for suicide.

They associated this difficulty with the stigma and taboo of talking about it, and to the belief that talking about it can influence the SB. After the educational intervention, the preconception and the difficulty of talking about suicide with other health professional were associated with lack of knowledge and training.

*...at all health levels, starting from the community health agent. As (A3) said, with the nurse. I'll take you, sometimes it's preconception, sometimes it's lack of training...(A5) - moment 2*

### **The context of health care in the SB**

This category is characterized by the way in which suicide is experienced by the health professionals in the care spaces. In the reports, it was also possible to notice the change in this perception after the educational intervention.

For the participants, before the educational intervention and since the signs and symptoms of SB are specific, only a specialist could be able to identify and recognize it. After the intervention, they signaled the importance of paying attention to the warning phrases that a person with SB can use, and of understanding that an apparently happy person can have suicidal ideation, even if it is more difficult to identify.

*...indeed, the individuals who attempt it, most of the time, they give signs. Generally they are thinking about doing something, it can be based on the behavior, the attitudes, the person's discourse, so I think we have to be prepared to know how to identify it...(E1) - moment 2*

Before the educational intervention, they stated that they did not feel prepared to hold a consultation with someone with SB. And that, because of that, they postpone investigating notifications on suicide attempts. In this context of care, they reported believing that insistence on the matter can break the bond with the family and with the individual. Strategies for approaching the family by sharing personal problems or through religion have been described.

*I'm looking at the violence records there and I have to go. How am I going to approach them? I don't know yet, that's why I keep them. I know that I have to hold on to those charts, because I know that there is a chart of a girl who has tried four times and between the suicide attempts, there is the domestic violence she has been suffering. What I would do is refer her to a psychologist, she would go to the CAPS and start the treatment, I go up to there. (e2) - moment 1; But this thing of talking, approaching. One thing is you talking about your problems, your experience, your personal problems and show that there is not only my problem, her problem, everyone has a problem. It is a good way of approaching when the person is open to it. (A6) - moment 1*

After the educational intervention, the reports indicated that the participants felt more prepared to make approaches and to dialog with individuals

with SB, families and other users, without the fear of inciting thoughts and SB, and without using automatic questions, focusing only on the physical conditions. They understood that they play an important role in managing situations of distress and suffering. However, they mentioned the fear of getting emotionally involved.

*Because I thought that I could not ask the question. Why a person wants to kill oneself, the researcher made it clear that no, that it is important, sometimes, to ask what the person thinks. I feel more prepared after the course...(A3) – moment 2.*

In relation to the family, before the educational intervention, they said that it should be at the discretion of the health professional whether to approach or not the family or the individual as regards the issue, especially when there was a history of attempted suicide. However, they indicated that the family living in this context is in intense suffering and, with this, the importance of helping the family to understand SB and suicide.

*If the person did not commit suicide yet, then you have to make the family try to understand that they are trying to kill themselves. And when the person didn't commit suicide it's this way. But, when the person has already committed suicide, then you have to say that it's nobody's fault, that the person was running away from a problem, you have to make people understand why their loved one killed themselves. (A3) – moment 1*

Prior to the educational intervention, the participants mentioned actions to be mediated with residents regarding the SB, in which there could be referrals by the basic health unit such as psychologists and psychiatrists, and the formation of family groups as a support network. However, with actions always focused only on the figure of the medical professional and/or psychologist.

*...I would refer to a psychologist or a psychiatrist. The nurse can refer to the psychologist... (E2) – moment 1*

However, after the educational intervention, they reported the importance of assisting this individual and their family, throughout the process, helping the family and the individual to understand what they are experiencing. And also the importance of working with the survivors of suicide. As assistance suggestions, they exemplified the possibility of creating a group of family members from the residents who had experienced similar situations in the area of the unit.

*...clarifying to the family that the suicide victim did not kill themselves, neither for lack of love towards the family nor because they did not love their family, but according to the study we did, it is not about that, when the family can understand that, it is consolation, liberation. (A5) – moment 2; It's a support group... we have more than one family that could form such a group, we could start with the support of a psychologist and then, maybe continue without a psychologist. (E2) – moment 2*

Before the educational intervention, they explained that training courses on the theme can help them feel more secure in addressing the issue and know what related attitudes they can adopt and what follow-up services the Public Health System offers.

*...courses like that for us, since we're there, face to face with the tip, as they say, they don't value it. Courses like these to know how to deal, to identify a person who is wanting to commit suicide, what that family is needing at that moment, in which the son or someone committed suicide. We can talk of the subject matter itself with a little more property. (A9) – moment 1*

Regarding this issue, after the educational intervention they also mentioned the preconception with the theme of suicide among the health professionals themselves and that this could be a barrier that would make it difficult to approach the theme. They linked preconception to lack of training.

*It's not because you're a health professional that you're free from preconceptions. So among the health professionals, even nursing itself, we see a lot of preconception. In the UPA X, we listen to a lot of things that hurt our hearts, from colleagues, from technicians, so I find it more difficult to talk to the professionals, try to convince them...(E2) – moment 2*

For them, questions about suicide should be elucidated since childhood and adolescence, in the process of school education, and that there is no approach to the theme of suicide in the process of university training and that they feel unprepared to receive demands on the subject.

*I am not someone who is prepared to deal with that. Even due to my academic training, because in college, I don't remember a single moment in which we have dealt with it, in any of the subjects of my course. It's faulty, to a certain extent... (E1) – moment 1*

In relation to the health system, they mentioned the slowness to meet the needs of the residents, including those at risk of suicide. They perceive unwillingness in the professionals to follow up on the cases and that, when referred or indicated the need for referrals, they do not receive feedback on the cases.

*It's there that it falls on the public health care, there is the problem of the delay, there isn't a specialist, there is always a problem too; the person goes there and speaks, there is the CAPS, there is the unit to help you, the person goes there and doesn't find it; that also gets in the way. (A6) – moment 1*

## Discussion

It can be identified that, before the educational intervention, they had doubts and questions about suicide. The explanations of the SB causes were based on the influence of the media and of social factors, in stigmas and preconceptions of mental illness, and associations with diseases and religion.

Stigma and preconceptions can interfere with the perception of suicide and the way the health care professional promotes care for individuals with SB. That is, uncertainties and indecisions in the conducts of the health professionals may be related to this lack of knowledge on the theme, to stigmas, preconceptions, and myths such as the belief of talking about suicide can favor thoughts of death, or that those who talk about suicide will not kill themselves<sup>(11)</sup>.

Little understanding of subjective aspects involving a suicide attempt generates a negative reaction from the health care team to the individual and may cause harms to the care offered<sup>(12)</sup>. In this way, the discussions about suicide during the undergraduate Nursing course should be expanded, and the inclusion of this theme may generate changes in the feelings and attitudes of the students<sup>(13)</sup>. A study showed that Nursing students have low specific educational exposure to the theme of suicide, thus identifying the importance of developing attitudinal and not only cognitive and procedural knowledge to intensify the insertion of more positive attitudes<sup>(14)</sup>.

It is highlighted that the nursing professionals can carry out educational activities in order to promote knowledge on the theme and to encourage tolerance, respect, and acceptance of the differences. And, in conjunction, welcoming and understanding attitudes must be adopted in the nursing care to help reduce the impact of the stigma related to mental disorders<sup>(15)</sup>.

Religion can also influence behaviors and beliefs and, with this, there can be an increase in the stigma surrounding suicide and in the search for professional help<sup>(16)</sup>. Some religions are modifying the way to approach mental disorders and suicide, but training on the theme should be offered to religious individuals<sup>(17)</sup>.

In this study, after the educational intervention spirituality is mentioned as a protective factor against suicide, as a source of support for the individual with SB. The literature also indicates that faith can also be a protective factor against suicide and that spirituality can help many individuals to keep on living during a crisis<sup>(16)</sup>.

Regarding the association of the expression of sadness and suffering with SB, or with a behavior to draw attention, it is known that individuals who committed suicide showed signs of their intentions. Thus, the presence of suicidal plans characterizes a moderate to severe degree of risk, and mentions of suicide should always be considered, mainly by the health professionals<sup>(11,16)</sup>.

After the intervention, it was noticed that this link to behavior and physical appearance stereotypes was replaced by the understanding of psychic suffering and by the perception of the need to provide support to the individuals with SB and their relatives. There

was an acknowledgment of the impulsive behavior as a predisposing factor for the act, replacing the ambivalence between courage and weakness. And, with this, the reflection on the right to commit suicide.

A study with the objective to evaluate an educational intervention, by means of a university extension course on SB with nursing students, identified that, after the course, there was a change in the factors related to the negative feelings and to the perception of the professional ability. However, there were no changes for those related to the right to commit suicide. It demonstrated that the training offered can positively change the attitudes of the Nursing students towards SB<sup>(18)</sup>.

The participants also mentioned the lack of knowledge and preparedness to deal with the theme has an influence on the postponement of research studies on notifications of suicide attempts. Training courses approaching the issues related to mental health care are important, and continuous qualification is relevant for the consultation with the patient who attempts suicide so that they may not be submitted to stigmatization and lack of empathy, interfering with the quality of care<sup>(12)</sup>.

Another important factor deals with media influence. Evidence indicates that the Internet, as well as social media, websites, and chats can facilitate access to content on suicide and to information on methods, identification, encouragement, cyberbullying, and even transform suicide into a show, with encouragement of suicide pacts, mainly among adolescents<sup>(16,19)</sup>.

However, the media can be used as a protection tool for the individuals to promote mental health and prevent suicide, with resources like support groups, apps, and serious games and websites, considering that, in certain situations, anonymity can help in the search for help<sup>(19,20)</sup>.

The results of this study also indicated that Primary Health Care (PHC) is not yet perceived as a gateway for the care of individuals with SB. And that the professionals did not feel capable of contributing to the prevention and postvention of suicide. Nevertheless, after the educational intervention the participants demonstrated knowledge on the need to evaluate the risk of suicide, in order to decide the possible actions to be taken.

Neither was it possible in another study to identify the actions organized in the work process of this professional that would enable identifying risk factors associated with suicide in PCH. The lack of training would be one of the possible reasons the absence of prevention actions in this context<sup>(21)</sup>.

Due to the close contact with the families by the PHC teams, this is considered to be the first strategy for the suicide prevention activities, as well as welcoming, identification of risks, and organization of the proposed

care<sup>(16)</sup>. These difficulties of the nursing professionals and of the CHAs in the care and classification of the risk degree of SB affect the care provided, as well as the quality of the referrals to the mental health specialists<sup>(22)</sup>.

In this sense, the Ministry of Health launched an Agenda for Strategic Actions aimed at suicide surveillance and prevention in Brazil, which contemplates, among other items, the inclusion of the theme of suicide in the qualification of the professionals in the gateways to the SUS, thus implementing the Welcoming guideline of the National Humanization Policy<sup>(23)</sup>.

The need to seek solutions through referrals to the specialized services, accessibility, and the slowness in the continuity of service provision were concerns stated by the participants. However, after the intervention, the perception was evidenced that all the health professionals should be prepared to provide care to these individuals.

In a study, the users do not perceive articulation between basic care services and the specific mental health service and refer to the need for greater contact with other equipment in their territories. When entering the CAPS, they feel they have definitively left the health network and perceive few partnerships between the CAPS centers and basic care, with the demands of mental health centralized in the specialized services<sup>(24)</sup>.

In order to verify the attitudes of PHC professionals towards SB, a study concluded that effective team training for early identification and proper treatment for the prevention of suicide and of suicide attempts is a viable option that contributes to reducing suicide mortality rates<sup>(4)</sup>.

After the educational intervention, the importance of working with the survivors of suicide was mentioned, as well as the need to interact with the family and to build a support network. The experience among those bereaved by suicide is an important strategy for the prevention and postvention of suicide, in which the experience in groups becomes an environment for the elaboration of the grief for a tragic loss and teachings about belonging and welcoming without judgment<sup>(25)</sup>. The training of health professional during undergraduate and graduate courses, and in-service is essential to deal with someone who wishes to legitimate their psychological pain<sup>(26)</sup>.

After the intervention, the fear of becoming responsible for the life of the individual with SB was expressed. The professional needs to understand the difference between being responsible for the treatment of someone with suicidal ideation and being responsible for that person's life. Talking about suicide prevention with the individual, the professionals, and others

involved in care is a way to share concerns and feel responsible for someone's life<sup>(16,27)</sup>.

## Conclusion

This study allowed us to analyze the perception of nurses and community health agents regarding suicide before and after an educational intervention, and the changes that occurred. The educational intervention promoted expansion of the understanding of SB, facilitating the identification of risk behaviors and warning signs, and developing the ability to investigate the degree of suicide intentionality, as well as offering support to the relatives of the person with suicidal ideation.

In addition, it was possible to identify the fragility in the training of the professionals on the theme of suicide and its management in the population, and in the public health system in terms of accessibility and continuity of care.

It was perceived that training on suicide can be a facilitator for the access of the individual with SB to PHC, enabling improvements in the work process and in the care provided, as well as in the articulation of the care network.

It is believed that this study can contribute with the evidence on the importance of teaching, qualification proposals, training, and permanent education of the health professionals; as well as to the sensitization of managers, health professionals, and educators about the importance of knowledge acquisition for building a support network to collaborate in the prevention and postvention of suicide, mainly in PHC.

As a limitation, the study was developed with only one health unit in a specific territory. The need is highlighted for new studies of the educational intervention type for better understanding the process of knowledge transfer of this theme and for establishing more efficient and effective educational processes to improve the care provided.

## References

1. World Health Organization. Suicide in the world. Global health estimates. Geneva: WHO, 2019. Available from: <https://www.who.int/publications-detail/suicide-in-the-world>.
2. D'Eça AE Júnior, Rodrigues LS, Meneses EP Filho, Costa LLN, Rêgo AS, Costa LC, Batista, RFLB. Mortality by suicide in the Brazilian population, 1996-2015: what's the predominant trend? *Cad Saúde Coletiva*. 2019; 27(1):20-2. doi: 10.1590/1414-462X201900010211.



3. Silva DA, Marcolan JF. Epidemiology of suicide in Brazil between 1996 and 2016 and the public policy. *Res Soc Develop*. 2020; 9 (2): e79922080. doi: <http://dx.doi.org/10.33448/rsd-v9i2.2080>.
4. Storino BD, Campos CF, Chicata LCO, Campos MA, Matos MSCM, Nunes RMCM, Vida CEL. Attitudes of health professionals toward suicidal behavior. *Cad Saúde Coletiva*. 2018; 26 (4):369-77. doi: [10.1590/1414-462X201800040191](https://doi.org/10.1590/1414-462X201800040191).
5. Ramberg IL, Lucca MA, Hadlaczky G. The Impact of Knowledge of Suicide Prevention and Work Experience among Clinical Staff on Attitudes towards Working with Suicidal Patients and Suicide Prevention. *Int J Environ Res Public Health*. 2016; 13:195. doi: <https://doi.org/10.3390/ijerph13020195>.
6. Magalhães CA, Neves DMM, Brito LMDM, Leite BBC, Pimenta MMF, Vidal CEL. Attitudes of medical Students toward Suicide. *Rev Bras Educ Médica*. 2014; 38(4):470-6. doi: <https://doi.org/10.1590/S0100-55022014000400008>.
7. Graham ID, Tetroe JM. The Knowledge to Action Framework. In: Rycroft Malone, J.; Bucknall, T. Models and frameworks for implementing evidence-based practice: Linking evidence to action. WestSussex-UK: Wiley-Blackwell; 2010. p. 207-221.
8. Backes DS, Colomé JS, Erdmann RH, Lunardi V.L. Grupo focal como técnica de coleta e análise de dados em pesquisas qualitativas. *O Mundo da Saúde*. 2011; 35 (4):438-42.
9. Marcondes NAV, Brisola EMAB. Analysis by Triangulation of Methods: A Reference to Qualitative Research. *Rev Univap*. 2014; 20 (35). doi: <http://dx.doi.org/10.18066/revunivap.v20i35.228>.
10. Resolução nº 466, de 12 de dezembro de 2012 (BR). Diário Oficial da União, Poder Executivo, Brasília, DF, 13 jun. 2013. Seção 1, 59. Disponível em: <https://www.jusbrasil.com.br/diarios/55483111/dou-secao-1-13-06-2013-pg-59>.
11. Bertolote JM. O suicídio e sua prevenção. 1th ed. Unesp, 2012.
12. Fontão MC, Rodrigues J, Lino MM, Kempfer SS. Nursing care to people admitted in emergency for attempted suicide. *Rev Bras Enferm*. [Internet]. 2018; 71 (suppl 5): 2329-35. doi: <http://dx.doi.org/10.1590/0034-7167-2017-0219>.
13. Silva LLT. Atitudes e percepções de estudantes e professores de enfermagem frente ao suicídio de adolescentes [tese]. Programa de Pós graduação em Ciências da Saúde da Faculdade de Medicina da Universidade de São Paulo; 2014. Disponível em: <https://repositorio.ufmg.br/handle/1843/BUBD-9VZJ4H>.
14. Moraes SM, Magrini DF, Zanetti ACG, Santos MA, Vedana KGG. Attitudes and associated factors related to suicide among nursing undergraduates. *Acta Paul Enferm*. 2016; 29 (6):643-9. doi: <http://dx.doi.org/10.1590/1982-0194201600090>.
15. Vedana KGG, Silva DRAS, Miasso AI, Zanetti ACG, Borges TL. The Meaning of Stigma for People with Mental Disorders in Brazil. *Issues Mental Health Nurs*. 38(12):1022-9. Doi: [doi.org/10.1080/01612840.2017.1346013](https://doi.org/10.1080/01612840.2017.1346013).
16. Botega NJ. Crise suicida: avaliação e manejo. Porto Alegre: Artmed; 2015.
17. Scavacini K. O suicídio é um problema de todos: a consciência e a competência e o diálogo na prevenção e posvenção do suicídio [tese]. Instituto de Psicologia da Universidade de São Paulo. São Paulo; 2018. doi: [10.11606/T.47.2018.tde-26102018-155834](https://doi.org/10.11606/T.47.2018.tde-26102018-155834).
18. Botti NCL, Araújo LMC, Costa EE, Machado JSA. Nursing students attitudes across the suicidal behavior. *Invest Educ Enferm*. 2015; 33(2): 17-24. doi: [10.17533/udea.iee.v33n2a16](https://doi.org/10.17533/udea.iee.v33n2a16).
19. Pereira CCM, Botti NCL. Suicide in the communication of virtual social networks: Integrative literature review. *Rev Portuguesa Enferm Saúde Mental*. 2017; (17), 17-24. doi: <http://dx.doi.org/10.19131/rpesm.0179>.
20. Vedana KGG. Social mediais and suicide. *SMAD, Rev. Eletrônica Saúde Mental Álcool Drog*. 2018; 14(4): 194-195. doi: [10.11606/issn.1806-6976.smad.2018.152315](https://doi.org/10.11606/issn.1806-6976.smad.2018.152315).
21. Silva NKN, Carvalho CMS, Magalhães JM, Carvalho JAM Júnior, Sousa BVSS, Moreira WC. Nursing actions in primary care to prevent suicide. *SMAD, Rev Eletrônica Saúde Mental Álcool Drog*. 2017; 13 (2): 71-7. doi: [10.11606/issn.1806-6976.v13i2p71-77](https://doi.org/10.11606/issn.1806-6976.v13i2p71-77).
22. Silva PF, Nóbrega MPSS, Oliveira, E. Knowledge of the nursing team and community agentes on suicide behavior. *J Nurs UFPE on line*. 2018; 12(1): 112-7. doi: <https://doi.org/10.5205/1981-8963-v12i01a23511p112-117-2018>.
23. Ministério da Saúde (BR). Agenda de ações estratégicas para a vigilância e prevenção do suicídio e promoção da saúde no Brasil [Internet]. Brasília: BVSMS; 2017. Available from: [http://bvsms.saude.gov.br/publicacoes/acoes\\_estrategicas\\_vigilancia](http://bvsms.saude.gov.br/publicacoes/acoes_estrategicas_vigilancia).
24. Moreira MIB, Campos RTO. Mental health care actions in the psychosocial care network viewed by users. *Saúde Soc*. 2017; 26 (2): 462-74. doi [10.1590/S0104-12902017171154](https://doi.org/10.1590/S0104-12902017171154).
25. Scavacini K, Cornejo ER, Cescon LF. Support Group to the Bereaved by Suicide: an experience of postvention and social support. *Revista M*. 2019; 4 (7). doi: <http://dx.doi.org/10.9789/2525-3050.2019.v4i7.201-214>.
26. Santos JC. Suicide: can we prevent the most mysterious act of the human being? *Rev Portuguesa Enferm Saúde Mental*. [Internet]. 2015; [Acesso 28 maio 2020]. 2(edição especial):7-8. Disponível em: [www.scielo.mec.pt/scielo](http://www.scielo.mec.pt/scielo).

php?pid=S1647-21602015000100001&script=sci\_arttext&tling=en.

27. Botega NJ. A tristeza transforma, a depressão paralisa. São Paulo: Benvirá; 2018.

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