

## Needs in Mental Health and Research

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Psychic suffering is a public health problem in the world because it is strongly related to the loss of functionality, and to the presence of drastic reflexes in personal life and in the social context. Psychic suffering presents as determinants not only the abilities of individuals to deal with thoughts, emotions, behaviors, interactions, but also aspects related to life in society. It should be noted that these determinants are directly influenced by public policies, which are responsible for the conditions for social protection.

Macroeconomic actors are expression factors that determine psychic suffering, since they lead to the reduction of investments in the health sector in spite of the increase of demands. According to the World Health Organization (WHO)<sup>(1)</sup>, psychic suffering contributes to much of diseases burden to the world, and depression has great expressiveness for years lived in a dysfunctional way. Suicide is today the second leading cause of death in young people, and it is necessary to consider emerging issues such as: the number of unemployed youths with image and esteem changes, highly influenced by perverse media; consequent marginalization and impoverishment of society as a stimulus to domestic violence and abuse; issues of work overload, often informal and to cause worries and stress, in addition to other aspects to be observed from each reality and context.

Of the population in severe psychic suffering, 76% to 85% do not receive treatment if they are citizens of emerging countries against 35% to 50% for citizens of developed countries. Moreover, investments in mental health care are below the needs: two dollars per capita per year are invested in emerging countries and this amount goes up to \$50 in developed countries, with the aggravation that most of the resources go to hospitals in lieu of community-based services. Hospital services have limited capacity and are unable to meet either quantitative or qualitative needs of mental health care<sup>(1)</sup>.

Another important issue to consider is the health workforce that has only 1% of it working in mental health. Nevertheless, we observed the lack of training of professionals for the care of psychic suffering, which includes management of biological treatments and the use of light health technologies such as welcoming, sensitive listening, support and strengthening through health education, information and guidance relevant to and necessary for self-management<sup>(2)</sup>.

WHO highlights that since 2011, the number of nurses working in mental health has grown by 35%. However, the number of nurses remains insufficient in all specialties, especially in emerging countries<sup>(3)</sup>.

Studies show that investments for training health professionals for the use of light technologies in health and the accomplishment of drug treatment in the case of depression have a compensatory return, since they have an impact on the improvement of the capacity of individuals suffering from psychic suffering and also on health levels.<sup>(2)</sup>

To address these issues, the World Health Organization, in its 2013-2020 Mental Health Action Plan, set out the following objectives: to encourage countries to develop policies and plans to address mental health needs in line with human rights instruments; to encourage mental health care to be comprehensive, integrated, resolving and performed in community-based mental health services, thus giving priority to the psychosocial approach; to encourage the implementation of strategies for promotion and prevention in mental health; and, lastly, strengthen information systems, seeking evidence in the care provided by encouraging research in the area of mental health<sup>(1)</sup>.

The WHO presents results of data collected after the agreement of the Plan of Action on Mental Health 2013-2020 in the Atlas of Mental Health 2014. It is highlighted that, despite the plan cited to have as one of the objectives to be achieved the incentive to research in mental health, there is no allusion to this subject in

the Mental Health Atlas of 2014. The objective is cited in the table as one of the research items. However, the results presented refer to a systemic process of data generation according to the WHO's programmatic request<sup>(3)</sup>.

Regarding the production of mental health research, except for studies related to pharmacological attention within the area of medical research, it is focused on diagnostic studies and lacks the intervention or experimental studies regarding the psychosocial approach advocated. Thus, we lack studies that promote the development of evidence for psychosocial care, an approach that should be the guiding principle of public assistance policies, professional training and research in the area of mental health. We question the engagement of this production in the maintenance and extension of the respect to the individual in psychological suffering and its demands, besides the reinforcement to the attainment of rights. We need boldness to socialize experiences and their evaluation processes, to generate possibilities of considerations of the scientific community and of the professionals who use research to modify their practices.

The insufficiency of professionals working with mental health impairs the assistance and production of research in the area. However, we may ask ourselves: what impacts have research conducted presented for the modification of our reality in mental health care?

Yes, we need to ask that. We need to question how critically we have been about the main objective of this study that would be its contribution to the improvement in quality of life. It is essential that research in mental health be encouraged to establish information systems and source of evidence for care to be provided. And that these studies are politically engaged with improving living and health conditions of individuals in psychological distress, along with the psychosocial rehabilitation approach.

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