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THEMATIC EDITION:
GOOD PRACTICES AND FUNDAMENTALS OF NURSING WORK IN THE CONSTRUCTION OF A DEMOCRATIC SOCIETY

RESEARCH

Mental health in the Family Health Strategy as perceived by health professionals

Saúde mental na Estratégia Saúde da Família: a percepção dos profissionais

Salud mental en la Estrategia Salud de la Familia: la visión de los profesionales

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RESUMO

Objetivo: analisar o manejo das necessidades de saúde mental na atenção primária à saúde de acordo com a percepção dos profissionais da Estratégia Saúde da Família. **Método:** estudo qualitativo, descritivo exploratório, desenvolvido no território de abrangência de cinco equipes de saúde da família. Os participantes foram cinco enfermeiras, cinco coordenadores e 17 agentes comunitários de saúde. Os dados foram coletados utilizando observação, entrevistas grupais, entrevistas individuais semiestruturadas e grupos focais. Fez-se a análise de conteúdo com o auxílio de um *Software* de análise textual, e a interpretação baseou-se nas estruturas analíticas correspondentes. **Resultados:** inúmeras e desafiadoras demandas de saúde mental têm sido acolhidas nesse *setting*, para as quais as equipes identificaram recursos de atendimento; no entanto, apontaram dificuldades, sobretudo relacionadas à operacionalização e integração destes recursos. **Conclusão:** destaca-se a necessidade de uma rede de cuidados sensível a tais demandas, mais articulada e gerida de modo eficaz.

Descritores: Enfermagem; Saúde Mental; Atenção Primária à Saúde; Estratégia Saúde da Família; Enfermagem Psiquiátrica.

ABSTRACT

Objective: to analyze the management of mental health needs in primary care as perceived by Family Health Strategy professionals. **Method:** this was a qualitative descriptive exploratory study developed within the coverage area of five family health teams. The data were collected using observation, group interviews, individual semi-structured interviews, and focus groups. Content analysis was conducted using text analysis software and interpretation was based on the corresponding analytical structures. **Results:** numerous and challenging mental health demands occur in this setting, for which the teams identified care resources; however, they also indicated difficulties, especially related to the operationalization and integration of such resources. **Conclusion:** there is a need for a care network sensitive to mental health demands that are better coordinated and more effectively managed.

Descriptors: Nursing; Mental Health; Primary Care; Family Health Strategy; Psychiatric Nursing.

RESUMEN

Objetivo: analizar el manejo de necesidades de salud mental en la atención primaria de salud, según la visión de los profesionales de la Estrategia Salud de la Familia. **Método**: estudio cualitativo, descriptivo, exploratorio, desarrollado en el campo de acción de cinco equipos de salud familiar. Participaron cinco enfermeras, cinco coordinadores y diecisiete agentes comunitarios de salud. Datos recolectados mediante observación, entrevistas grupales, entrevistas individuales semiestructuradas y grupos focuses. Se aplicó análisis de contenido, con ayuda de software de análisis textual. La interpretación se basó en las correspondientes estructuras analíticas. **Resultados**: numerosas y desafiantes demandas de salud mental fueron recogidas en este *setting*, para las cuales los equipos identificaron recursos de atención;

aunque detectaron dificultades, particularmente relacionadas a la puesta en marcha e integración de tales recursos. **Conclusión**: se enfatiza la necesidad de una red de atención sensible a tales demandas, aunque articulada y gerenciada de manera eficaz.
Descriptores: Enfermería; Salud Mental; Atención Primaria de Salud; Estrategia de Salud Familiar; Enfermería Psiquiátrica.

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INTRODUCTION

Mental health demands can be described as the healthcare needs presented by individuals with psychiatric disorders and also as situations of potential suffering during life cycle transitions as responses to various stress factors. People with serious mental illness may present numerous challenges in their ability to engage with others and perform their responsibilities, which includes leading an independent life while integrated into the community and being committed to continuity of treatment[1].

This population represents one of the most complex challenges for public healthcare managers when it comes to resources, as mental health demands have been associated with high rates of mental health service use, poorer treatment outcomes, high rates of re-hospitalization and numerous medication errors, factors that increase healthcare costs. In general, these patients are extremely vulnerable, die 25 years earlier than the population in general, and highly use of emergency services[2].

Regarding these demands, there are major barriers that patients face to access the necessary care, i.e., lack of resources, lack of team sensitivity to such demands, in addition to ineffective treatment and referrals that culminate in chronification and the perpetuation of inadequate use of health services[3].

Different researchers have shown the importance of implementing actions to encourage mental health care delivery in primary healthcare settings[4-6]. In addition to providing care near to peoples' communities and homes, such actions contribute both to the early screening of mental health needs and help reduce the stigma related to patients with mental disorders or in situations of psychic suffering.

In light of the above, the objective of the present study was to analyze the management of mental health needs in the context of primary care as perceived by family health strategy (FHS) professionals in a health district within a municipality in the state of São Paulo, Brazil.

The results may contribute by indicating the limitations of and making recommendations for effective mental health care in this setting.

METHOD

Ethical aspects

The study was approved by the Research Ethics Committee of the Ribeirão Preto School of Medicine Health Center, University of São Paulo (FMRP-CSE-USP) and abided by the principles set forth in Resolution no. 196/96 (currently 466/2012) by the Brazilian National Health Council that provides for research involving human beings. Subjects who agreed to participate in this study signed a free and informed consent form.

Participant anonymity was protected through different codes depending on the form of data collection (individual interview or focus group). In the case of individual interviews, the codes were NURSE (nurses) and COORD (coordinators), followed by the corresponding number for each participant. The discussions held by the focus groups were coded as GROUP 1 and GROUP 2, indicating the order in which they were conducted.

Theoretical and methodological framework and study type

This was a qualitative descriptive exploratory study. The investigation and analysis process followed a minimal structural research protocol[7], the field of observation was the area covered by the FHS teams, and the elements of investigation consisted of the perceptions of nurses, coordinators, and community health agents about how mental health care demands are addressed.

Study setting

The study was developed in a sub-region of the health district within a municipality in the state of São Paulo. During data collection, this territory had 16,143 inhabitants and counted with five family health teams.

Source of data

The participants were nurses, coordinators, and community health agents part of the FSH teams, totaling five nurses (aged 30 to 51 years and over four years on the job), five coordinators (aged between 38 and 64 and at least four years on the job) and 17 community health agents (aged between 28 and 58, and at least one year on the job).

Data collection and organization

The data were collected via observation, group interviews, individual semi-structured interviews and focus groups. First, five group interviews were conducted, one with each FHS team. Thus, each meeting had one nurse and five or six community health agents. The guiding question for these interviews was: "What are the characteristics of this family health team's area of coverage in terms of infrastructure and resources?" The results were analyzed and served as material to construct a guiding script for territorial observations in the area covered by the FHS teams. This script prompted observation of formal and informal resources (nongovernment organization, churches, leisure spaces, meeting points, health services, social services).

After creating the script, 46 hours of field observation took place during business hours (8AM to 5PM). The researchers split into pairs or trios into micro-areas within the larger area covered by the five teams, alternating between morning and afternoon shifts. Transcriptions of the observations provided the researchers with an overview of the studied region, underpinning cross-referencing of information from different data sources and also composed the final corpus for qualitative analysis.

Following field observation, individual interviews were conducted with nurses and team coordinators, and focus groups

with community health agents. The interview scripts and conduction of the focus groups addressed healthcare provision for the most common mental health demands in primary care.

Ten individual interviews were carried out (with nurses and coordinators) and two focus groups, with nine community health agents in one group and eight in the other. Both the interviews and each focus group lasted approximately an hour. After data collection, the information was transcribed and the results of the observations, interviews and focus groups were re-read in a meeting with the group of researchers involved.

Data analysis

The interviews, field observation notes and focus group recordings were transcribed and grouped into one corpus of information. The corpus text was submitted to analysis using Iramuteq v.0.6 alpha 3[8] software, which uses textual statistics and analysis of similitude (similarities and connections among words), classifying text fragments according to structural similarities among them. The classes are then visualized via a dendrogram that provides an overview of the connections between them and the distribution (in percentage) of the text fragments allocated to their respective classes. Based on this analysis, researchers interpreted the results by considering the classes obtained and defined the corresponding analytical structures.

Data analysis resulted in seven classes, each corresponding, approximately, to 12% or 16% of the text fragments. The researchers used World Health Organization (WHO) recommendations for the integrating mental health actions into primary health care[9-10] (namely: reasons for, challenges, and recommendations) to structure their interpretations. Thus, following the reading and re-reading of the text fragments corresponding to each class, three analytical structures emerged: "Mental health demands," "Health team actions" and "Resources and challenges in mental health care," as illustrated in Figure 1.

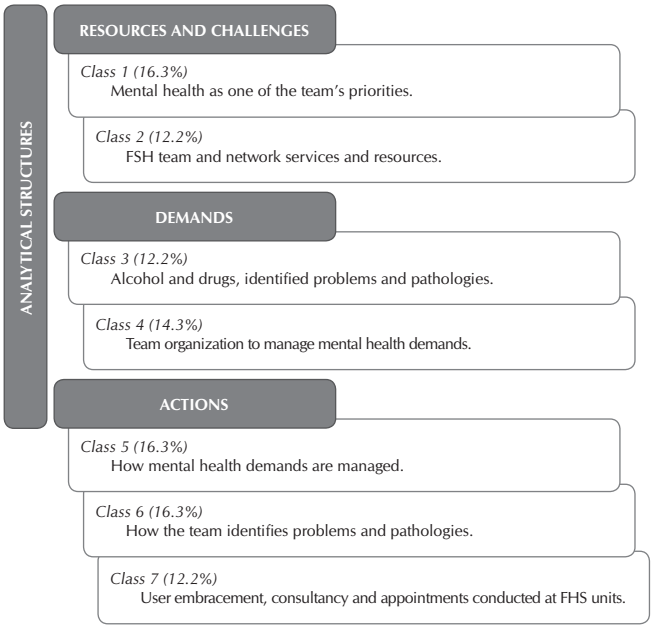

Figure 1 – Data classification and respective analytical structures

RESULTS

The results of the present study are summarized in Figure 2.

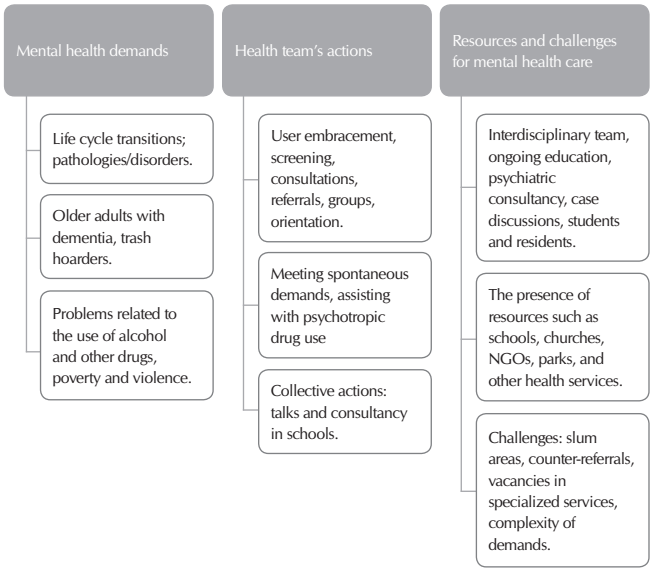

Figure 2 – Summary of results by respective categories

Mental health demands

According to the participants, the demands presented by the users of the referred primary care service range from situations of psychic suffering, drug use and mild disorders, to more serious and persistent illnesses.

> *Mental health demands* [specific to] *the life cycle: family development problems, marriage, birth, death, teenagers leaving home, adults marrying and leaving home, separation, ageing.* (COORD 3)

> *Depression, anxiety, severe mental illness, specific and unspecific complaints.* (GROUP 1)

> *Older adults with dementia and who are isolated at home.* (GROUP 1)

> *Panic disorder, mental disability, trash hoarders.* (GROUP 2)

> *Drug and alcohol abuse, personality disorders.* (COORD 2)

In terms of the covered areas, those with lower income presented the highest number of mental health demands precisely because of socioeconomic issues inherent to this process.

> *In low-income communities, poverty results in serious problems.* (NURSE 2)

> [...] *lack of resources, crimes, drug trafficking.* (GROUP 1)

Team's mental health actions

The service's mental health actions involved both the identification and embracement of demands and also providing follow-up, consultations and referrals to specialized services.

> *Identifying substance dependence and mental disorders, individual consultations, referrals to inpatient and specialized services, orientation, groups.* (COORD 2)

> *Screening, follow-up, managing spontaneous demands, supporting the use of psychotropic drugs, embracement.* (COORD 1)

The participants pointed to the importance of psychiatric consultancy, performed by a psychiatrist and a specialized nurse, to develop skills among the general healthcare team and also as a form of providing direct care in more complex cases.

> *Consultancy provides the team with multiprofessional education, ongoing education and support.* (COORD 2)

> *With consultancies we can also give priority to mental health care, prescribing medications, referring patients to other services within the network, referrals, clinical follow-up of comorbidities, case discussions.* (COORD 1)

Within the community, the researchers observed education and healthcare actions conducted in collective public spaces (such as schools and squares), which impacted the mental health of individuals in this community.

> *The team promotes better quality of life through nonspecific actions. They give talks at schools, provide consultancy to teachers and direct care to children.* (COORD 2)

Resources and challenges for mental health care

The participants considered the health services (general and specialized) and other community instruments as resources for managing mental health:

> *Schools, churches, NGOs* [...] *ecological parks, informal resources that impact mental health.* (GROUP 1)

> *Primary healthcare services and other services within the network.* (COORD 1)

> *Intersectoriality, partnerships with the judicial branch, child protective services and church leaders.* (COORD 2)

Another important resource indicated by the participants was the interdisciplinary nature of the FHS teams. In addition to the permanent team, there are undergraduate interns and residents who also receive training, via consultancies, to track mental health demands.

> *Resident students, doctors, and nurses trained to identify mental health demands, community health agents with significant experience in mental health.* (COORD 2)

Regarding challenges, the subjects referred to some specific issues that limit the teams' work in terms of the mental health of the covered population.

> *Counter-referrals are complicated; we don't get any feedback* [...] *there are no vacancies in specialized services* (GROUP 1)

> *How to handle the complexity of post-hospitalization?* (NURSE 2)

> *Uncertainty and risks, complexity of the needs in slum areas, prostitution, drugs, thefts* (NURSE 1)

According to the field observations, the area covered by the studied teams, in general, had wastewater treatment, electricity and running water. It is predominately constituted by large houses, with masonry construction and finishing, however, there were micro-areas with smaller houses, with no exterior finishing, and three groups of houses built with recycled waste material, with no wastewater treatment and surrounded by narrow lanes and alleys, of which most are not paved and have no sidewalks.

In the micro-areas with larger houses, there was less flow of people on the streets and public spaces (squares, sports courts, associations, and businesses) and in the area with smaller houses and house groupings/conglomerates, the researchers observed poorly conserved squares, improvised soccer fields and small-scale businesses. Social protection services (social services, support centers, violence prevention centers) and leisure options were scarce in these regions. However, field observations indicated the presence of neighborhood associations and two nongovernment organizations specifically aimed at adult professional training and recreational support for children and adolescents.

The area's social characteristics represented one of the difficulties indicated by the professionals, coupled with issues related to available mental health services.

> *When territorializing services, there is an arbitrary delimitation of territory* [...] *there's a large slum area, which lacks community centers, resources, recreation activities* [...] *there are no leisure options.* (GROUP 1)

> *The mental health network is still in its early stages in terms of resource organization.* (COORD 1)

> *The flow of patients with mental health demands isn't well organized within the network, there is much demand for such care and that complicates the system.* (GROUP 1)

> *Administration of public health needs to improve, lack of mental health resources, difficulty in care provision.* (GROUP 1)

The complexity of treating patients affected by mental disorders was also highlighted by the participants as a challenge.

> *It's easier to treat pain, treating the mind is more difficult.* (GROUP 1)

> *Patients* [with mental disorders] *want to see a professional as soon as they arrive,* [...] *they have a hard time adhering to treatment.* (GROUP 2)

> *There is a lot of discrimination when it comes to mental health.* (GROUP 2)

DISCUSSION

The demands presented in this study can be discussed from two perspectives, collective and individual. The first regards the shortcomings in the area that impact community mental health needs, and the second, individual demands presented by users of primary care services.

Regarding the collective demands, the researchers observed the precarious living conditions in some areas of the territory, a fact that was vehemently pointed out by the participants, referring both to the importance of infrastructure[9-11] in effective mental health care and to the adverse impact of social and economic aspects in the manifestation of mental disorders[12].

Regarding individual demands, various situations indicated by the participants showed that mental health needs are inherent to some life cycle transitions and associated with clinical demands. However, they also occur directly with the manifestation of psychiatric symptoms and disorders. These results corroborate the WHO model recommendations about the importance of identifying comorbid mental and physical disorders health problems[9-10].

Substance misuse was also reported by the participants. Primary care is a prominent part of care related to this type of demand and therefore, general health professionals should develop skills to address such situations[13]. Furthermore, early detection and prevention for these disorders are expected from primary care services that intend to integrate mental health into their work process[7,9].

Discussions about including mental health care into primary care also address the fact that, theoretically, this level of care is directed at less complex needs (common mental disorders with no serious physical comorbidity)[9-10], but some shared care models, such as consultancy, allow professionals to deal with more "problematic" cases[13-14], as identified in the studied teams.

It is understood that meeting these demands at the primary level minimizes the stigma of treatment, favors adherence and enable care that fits the context of individuals' reality[9-10]. These aspects gain even more importance in this discussion when considering that geographic access, the stigma related to treatment in specialized services, and the preference for self-management have been indicated as some of the important factors that negatively impact treatment adherence in mental health treatments in specialized services[12,15].

Regarding the demands reported by the patients, two other aspects were emphasized: the increase in older adults with mental health needs and patients affected by hoarding disorders. Both situations have been documented in the literature[12,16-19], but are worth emphasizing in the present study, as they were conditions identified by the primary care teams.

The mental health actions found in the present study were also classified into either individual or collective actions, with special emphasis to those performed via psychiatric consultancy. Although collective health promotion actions were not mentioned frequently by the teams, they tend to be integrated into other health-related themes, considering that these teams develop educational actions, lectures, and consultancies in schools, among others. These collective and integrating activities promote the appropriation of public spaces, in addition to interaction among residents and, consequently, can be defined as unspecific collective mental health actions. These results corroborate the WHO model[9-10] in terms of facilitating intersectoral actions and coordination with community-based services.

Individual actions presented in this study were similar to those recommended in different studies about psychosocial care. These authors[3-4,15,20-22] emphasize that the rehabilitation and recovery process of patients must take into account a psychosocial assessment, which consists on identifying sources of stress, social problems, and the need for specialized interventions. Other essential actions to meet mental health demands are drug management, referral to specialized services when necessary, group activities, lifestyle counseling, and working with families[3-4,15,20-22]. It is of utmost importance that teams help users maintain their independence and implement strategies to combat stigma and social isolation[9-10,22].

Another recommendation for unspecific mental health actions is for teams to use therapeutic alliances to explain to patients the connections that exist among behaviors, beliefs and feelings that they do not perceive. This action can be more effective if adapted to the "clinical formulation" model[23] that, in Brazil, corresponds to the individual therapeutic project recommended by current mental health policies.

Another significant recommendation regards the need for a positive professional-patient alliance that inspire trust, honesty, and collaborative decision making with patients and other areas of knowledge[19].

Emphasis also goes to consultancy actions that increment and optimize the mental health care delivery of these teams. This resource has been well documented in the literature as a factor that leads to effective provision of psychosocial care[3,9-10], in addition to enabling the health team to give priority to mental health care in primary care, including following up on more complex demands[13-14].

In relation to mental healthcare resources, the participants reported possibilities within the teams and the area covered by the unit. However, most of the difficulties listed by the participants are relative to the operationalization and integration of these resources.

One of the difficulties mentioned was about providing direct care to patients with mental disorders who, according to the participants, present complex demands. The teams' discomfort and reluctance to address such demands are a challenge that has been addressed by the WHO in relation to integrating mental health actions in primary care[9-10]. These difficulties refer to the need for training that emphasize communication skills and psychosocial management of psychiatric patients[3] and developing notions about ongoing care for this population[22].

Other difficulties mentioned were counter-referrals and integration with specialized services within the health network. The integrated use of services within the network is an important recommendation[9-10], however, the results of this study showed that, despite their existence, consolidating a network of sensitive and co-responsible care is still one of the main needs of the studied teams.

The stigma associated with the field of mental health, lack of integration and communication among services, lack of

counter-referral and the difficulty of adhering to treatment presented by some patients are obstacles that have also been indicated by other studies[3,14-15]. Furthermore, the social precariousness observed in the area covered by these teams is another factor described as negatively impacting adherence of patients to psychiatric treatment[14].

Contributions to the fields of nursing, health or public policy

Based on the results of the present study, the researchers outlined some recommendations to contribute to the improvement of health practices. The first refers to giving greater emphasis to psychosocial care skills, instead of giving priority only to case identification[3-4]. Psychosocial interventions should be developed, including psychotherapy resources, such as cognitive and behavioral approaches, which have been associated with lower rates of re-hospitalization[22].

Another recommendation is shifting from a perspective centered on psychopathology to an empathy-centered approach[22], giving priority to actions based on "clinical formulation" or "individual therapeutic project" techniques within the scope of primary care. These should focus on the situational, psychological, and social processes of patients, and highlight the factors that trigger suffering[22-23].

In more general terms, health policies should give priority to community-based mental health care and services (i.e. as geographically close as possible to where users reside) to follow up on the course of the illness/suffering in a more contextualized manner, and supporting families, as patient needs are transitory throughout life cycle stages[21].

Other suggestions indicated by the literature involve standardizing the flow of referrals among the various services in the network in order to optimize comprehensive care[15], in addition to better coordination between mental health actions and local community resources.

Study limitations

Limitations of this study include data collection in successive stages (instead of simultaneously) and the fragmented groups of subjects, i.e., conducting the focus groups with all of the teams' members would have provided more in-depth data about their perceptions.

FINAL CONSIDERATIONS

Primary care and especially family health teams are important tools to provide comprehensive health care and essential resources for mental health care delivery in communities. This interface allows not only the early detection and viability of treatment, but also contributes to minimizing the stigma related to patients affected by mental disorders.

The results of this study showed that primary care professionals have been dealing both with very well defined psychiatric needs (such as mental disorders and substance misuse) and more complex demands (poverty and violence) that require an intersectoral approach. Some of the resources identified are considered very specific to the studied context, such as a team composed of residents from different professional categories. However, others are foreseen by the guiding principles of FHS, namely: interdisciplinary team, psychiatric consultancy, spaces for case discussions and ongoing education.

Using these resources, the studied teams developed different and significant mental health actions, such as embracing people with mental health needs (patients in treatment and spontaneous demands), screening for disorders, consultations, groups, patient and family orientation, aiding in psychotropic drug management. They also conducted actions within the covered area, such as lectures, and consultancies in local schools. The challenges listed were related to the existence of slum areas, that present complex situations such as drug trafficking, crime, violence, lack of sanitary and social infrastructure, and the difficulty of meeting mental health needs that are polysemic and require a health care network that is well coordinated and precisely administered.

In conclusion, the results of the present study highlight the numerous and challenging mental health demands cared for in this setting and the resources used by the teams to meet such demands. The results also show the difficulties faced by the teams, especially those related to the operationalization and integration of these resources. This overview indicates the need for a care network sensitive to such demands, that is better coordinated and managed more effectively in order to expand the technical capacity of primary care teams, and the access of patients and communities to mental health care.

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