Mental health in primary health care: practices of the family health team

SAÚDE MENTAL NA ATENÇÃO BÁSICA: PRÁTICA DA EQUIPE DE SAÚDE DA FAMÍLIA

SALUD MENTAL EN ATENCIÓN BÁSICA: PRÁCTICA DEL EQUIPO DE SALUD DE LA FAMILIA

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ABSTRACT
The inclusion of mental health care actions in the context of the Brazilian Public Health System (SUS; Sistema Único de Saúde) contributes to the consolidation of the Brazilian Psychiatric reform and demands redirecting the practices of family health teams with users with mental health needs. The objective of this study is to identify and analyze the scientific production and actions developed by family health team professionals in mental health care. Systematic analysis originated the following themes: home visits to mentally ill patients and their relatives; attachment and welcoming; referrals; therapeutic workshops. In conclusion, the mental health actions developed in primary care are not performed consistently and depend on the professional or on the political decision of the administrator, which shows that professionals should use new practices to develop comprehensive care, and, therefore, there is a need to invest in improving the qualification of the professionals.

DESCRIPTORS
Family health
Mental health
Primary health care
Patient care team
Psychiatric nursing

RESUMO
A inclusão das ações de saúde mental no contexto do Sistema Único de Saúde (SUS) contribuiu para a consolidação da Reforma Psiquiátrica Brasileira bem como demanda a reorientação da prática das equipes de saúde da família junto aos usuários com necessidades do campo da saúde mental. Este estudo tem por objetivo identificar e analisar na produção científica as ações realizadas pelos profissionais da equipe de saúde da família na atenção à saúde mental. Mediante análise sistemática emergiram os seguintes temas: visita domiciliar ao doente mental e seus familiares; vínculo e acolhimento; encaminhamento; oficinas terapêuticas. Concluiu-se que as ações de saúde mental desenvolvidas na atenção básica não apresentam uniformidade em sua execução e ficam na dependência do profissional ou da decisão política do gestor indicando que os profissionais devem apropriar-se de novas práticas para desenvolverem uma assitência integral e, portanto, há necessidade de investimentos para qualificação dos profissionais.

DESCRITORES
Saúde da família
Saúde mental
Atenção primária à saúde
Equipe de assistência ao paciente
Enfermagem psiquiátrica

RESUMEN
La inclusión de acciones de salud mental en el contexto del Sistema Único de Salud-SUS contribuyó a la consolidación de la Reforma Psiquiátrica Brasileña, así como a la demanda y reorientación de la práctica de los equipos de salud de la familia junto a los pacientes del área de salud mental. Este estudio objetivó identificar y analizar en la producción científica las acciones realizadas por profesionales del equipo de salud de la familia en atención de salud mental. Mediante análisis sistemático emergieron los siguientes temas: visita domiciliaria al enfermo mental y familiares; vinculo y consideración; derivación; talleres terapéuticos. Se concluye que las acciones de salud mental desarrolladas en atención primaria no presentan uniformidad de ejecución y dependen del profesional o de la decisión política del gestor, e indican que los profesionales deben informarse sobre nuevas prácticas para brindar atención integral, por lo cual existe necesidad de inversión para calificación de profesionales.

DESCRIPTORES
Salud de la familia
Salud mental
Atención primaria de salud
Grupo de atención al paciente
Enfermería psiquiátrica

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INTRODUCTION

In recent decades, in the framework of the ongoing Psychiatric Reform in Brazil, various transformations in the mental health care model have been witnessed, prioritizing actions aimed at the social inclusion, citizenship and autonomy of people with mental disorders. These changes, however, have faced obstacles to overcome the biomedical and hospital-centered model in mental health care. In this context, the protagonist role of professional, users and family members' social movement is identified, which has enhanced legislative changes and the proposal of new mental health care models throughout the process.

The Psychosocial Care Center (CAPS) is a strategic service to enhance dehospitalization, understood here as the offering of territorial services, compatible with the Psychiatric Reform principles and with the guidelines of the National Mental Health Policy. The CAPS and service delivery within a psychosocial approach still are not sufficient to cover mental health demands in different Brazilian regions.

In recent years, through expansion policies and the formulation, establishment and assessment of Primary Care, the Ministry of Health has stimulated actions remitting to the *subjective dimension of users and the severest mental health problems* of the population at this care level. The Family Health Strategy (FHS), considered a guideline for the reorganization of Primary Care in the context of the Unified Health System – SUS has become fundamental for care delivery to mental disorder patients and their relatives, through community actions that enhance these people's social inclusion where they live and work.

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In different Brazilian regions, successful experiences are demonstrating the transformative potential of primary care workers' practices, through the inclusion of mental health in primary care by means of specialist orientation, like the Family Health Program support teams – NASF for example[1]. Much remains to be done though to advance in the perspective of a mental health network construction through the articulation of services that should operate within the logic of territorialization, co-accountability and comprehensiveness of mental health practices.

In view of this situation, this study aims to identify and analyze family health team professionals' mental health care actions in scientific production. Thus, the researchers hope this study can lead to the rethinking of mental health care in primary care and contribute to family health team workers' practice involving mental disorder patients and their relatives.

METHOD

Bibliographic research is developed based on previously elaborated material, mainly comprising scientific papers, documents and books. The main advantage of bibliographic research is the fact that it allows researchers to cover a much broader range of phenomena than what could be directly investigated[2], permitting the synthesis and critical analysis of what was produced on the study theme.

First, a literature review was developed to define the study's conceptual system and theoretical foundations. This previously published material was consulted to identify the stage the knowledge on the research theme has reached.

In the order of stages developed, descriptors were identified in the Health Sciences Descriptors (DeCS), created by BIREME, where journal articles, technical reports, congress annals and other types of scientific literature are indexed. The following descriptors were used: *saúde mental, transtornos mentais, enfermagem psiquiátrica, psiquiatria comunitária*, which were also associated with the descriptors: *visita domiciliar, visitadores domiciliares, atenção básica, programa saúde da família, saúde da família, enfermagem em saúde comunitária, visitas a pacientes, família*, besides the words *mental* and *mentais*.

To select the articles, the databases *Latin American and Caribbean Health Science Literature (LILACS) and the Nursing Database (BDENF)* were used, which are part of the Virtual Health Library (VHL); in the attempt to broaden the research field and minimize interferences in this study stage.

The survey in the selected databases was based on the following search criterion: Brazilian scientific papers, published in a five-year period, between 2005 and 2009. This search led to the identification of 131 abstracts whose contents addressed the theme: *mental health care for people in psychic suffering and their relatives attended by family health team professionals*. After reading these, 17 papers were selected which complied with the defined criteria. Twelve of these were research reports involving one or more FHP team members, two experience reports, two theoretical reflections and one literature review.

In the bibliographic research, the reading of the selected articles revealed the information and data available in the material; permitted establishing relations between this information and the proposed problem; and analyzing consistency between the information and data the authors presented. It should adopt the following order: explanatory reading, selective reading, analytic reading and interpretative reading[2].

After reading the texts, four central themes emerged, called Categories[3]. The themes that emerged and converged determined reflections on the actions the FHP teams developed, which were: home visit to mental patients and their relatives; bonding and welcoming; forwarding; therapeutic workshops.

The themes that emerged were discussed and analyzed based on the selected papers and connections with other references from literature.

RESULTS AND DISCUSSION

In this research phase, with the categories at hand, the information and data the authors presented were analyzed.

The category home visit to mental patients and their relatives stands out although, in many papers, many FHS team professionals highlight that they do not deliver care to or do not know about the existence of mental patients in their coverage area. Thus, among the actions workers perform, *home visits* stood out among the most frequent ones and because this action aroused discussions and inquiries in the team about what would be the best way of working, approaching and taking care of these people and their families.

During the home visits, the authors indicate that the professionals monitor patients' adequate medication use, acquisition of psychotropic prescriptions, clarify relatives' doubts about the mental illness and provide orientations to manage the mental patient's behaviors, with a view to improving contact among relatives, including the family in treatment and, mainly, tightening bonds.

Home Visits mainly permit to get to know the reality of mental disorder patients and their families, enhancing the understanding of psycho-affective-social and biological aspects and promoting bonds among users, relatives and workers.

The construction of bonding necessary to manage the situations demands at home, as a result of the family member's conflict with the patient, and often with the neighborhood, cause effects on the entire family's health and health services and workers do not know how to deal with this or offer the necessary support[4] to intervene in crisis situations.

The chronicity of conflicts generates modifications at the heart of the family, deriving from the family burden. Before the appearance of the disease, the person contributed to financial and domestic activities and responsibilities. After the first crisis, these activities, which used to be shared, are no longer, and relatives still need to carry the responsibility of helping the sick person with his/her treatment[5].

Home visits are defined as a home care instrument. They comprise the set of systemized actions to permit care delivery to people with some level of alteration in the health status (physical or emotional dependence) or to accomplish activities linked with health programs[6].

The family health team is responsible for recognizing that the family core also needs support from the health service and that the family plays a fundamental role with a view to the good development of user care.

In one of the papers selected, the authors observed important initiatives to make psychiatric internment more difficult through the monitoring of discharged patients, family orientations and efforts to avoid the medicalization of mental suffering[7].

In a study on psychosocial rehabilitation models, a specialist[4] observed that researchers using behavioral family therapy affirm that this type of therapy does not prevent relapses, but achieves an extension, so that the duration of the intervention cannot be previewed.

Therefore, mental health actions in family health should be based on the principles of the SUS and the Psychiatric Reform. Concerning the main principle of the Psychiatric Reform, with is deinstitutionalization and which presupposes the maintenance of mental patients within their territory, i.e. avoiding internment in daily work and, if necessary, preferably short-term and in emergency psychiatry services, thus permitting the preservation of family bonds and social networks.

The new knowledge the FHP has gained proposes mental health actions in primary health care, which determine modifications in the psychiatric care paradigm, determining the deconstruction of the historical distancing between excluding psychiatric practices and primary health care[8], which can happen through the internment of mental patients at their home.

A study[9] on home care reports that, in FHP documents, home internment is indicated as a practice the program encourages, but that it does not replace traditional hospitalization. It should be used, however, with a view to humanization and guaranteed quality and comfort for patients.

The category *bonding and welcoming* adds two very important concepts the authors attributed to the development of actions in primary health care delivery to mental patients and their relatives.

In primary health care, welcoming and bonding are guiding care axes, mainly if developed with mental patients, granting patients humanized health care[10].

Every day, primary care teams are confronted with mental health problems as, according to data, about 56% of the teams indicate the accomplishment of mental health actions. That makes them an important strategic resource to cope with this. And, to take care of this population, the Ministry of Health finds the articulation between mental health and primary health care both important and necessary[11].

Thus, the data the Ministry of Health found make it practically impossible for FHP team professionals not to meet people with some kind of mental disorders in the homes within their coverage region.

When proposing the FHP, the Ministry of Health aimed to reorganize the Primary Health Care Units, to enable them to solve problems, establish bonds of commitment and accountability between health professionals and the population[12].

The Family Health Teams should establish bonds of commitment and co-accountability between their health professionals and the population, linked through individuals and families' knowledge and resources available in the communities; ranging from the active search for users and their families to long-term monitoring of health-disease processes, which are affecting or can affect them; welcoming; and humanized and continuous care over time[13].

Through these bonds of commitment with the population, an apprehension of responsibilities is gradually incorporated into professionals' practice, in view of the FHP, cases cannot be passed on, even when a hospitalization, surgery or more complex treatment is indicated, the patient is still covered by the team while living in the same neighborhood. Bonding and continuity demand coping with human suffering, a process the technicians are not prepared[14].

The FHP values the principles of territorialization, bonding with the population, teamwork and democratic, participatory and solidary community participation according to members' true needs, identifying risk factors and intervening when necessary[15].

When the Psychiatric Reform came about, the prioritization of care and monitoring of mental patients in the community implied these patients' increased demand at health units. Efforts towards care delivery to mental patients in the community have increased, as well as concerns with their families, as these may experience social, cultural, physical and psychological problems.

In this context, the FHP's involvement in Mental Health is observed, as its teams are engaged in the community's daily reality, with close bonds, and also enhance health promotion and education actions from the perspective of improving the population's living conditions[16].

Thus, the Family Health Strategy develops mechanisms that are capable of hearing, listening and orienting, thus representing the practical application of fundamental SUS principles in the development of its practices, such as comprehensiveness and problem solving of the problems met.

A distinguished form of welcoming is essential for the inclusion of mental patients. Thus, it is important to understand equity as a principle that determines equality in health care, with actions and services that are prioritized in function of certain individuals and population groups' risk situations, living and health conditions[17].

Concerning the category forwarding of mental patients, the selected articles revealed that FHP professionals forward patients to a wide range of services with different goals, which are: consultations with the clinician for care delivery to physical complaints, acquisition of prescriptions to obtain psychotropic drugs and forwarding for specialized consultations; to the community center: to the CAP; to the outpatient clinic, among others.

While some professionals facilitate and accomplish this type of care, others neglect offering this care to mental patients or push the problem forward by sending the patient to another professionals or another city. Without solving the problem.

In the report of the III National Mental Health Conference contains guarantees for the right to care involving health actions between hub or referral cities, with a view to avoiding or eliminating the conduct of endless forwarding, leading to a lack of care[10]. The Mental Health care network is organized as care delivery that includes: community center, therapeutic residences, primary health care, outpatient clinic and leisure clubs, among others[18].

Another strategy that entails forwarding and was observed in these papers is the integration between the FHP team and Mental Health Team professionals. The Ministry of Health intends to restructure psychiatric care, recommending the existence of specialized family health support teams. Specialized orientation is an organizational arrangement that aims to provide technical support in specific areas to the teams responsible for primary health care delivery to the population[19].

In the attempt to mitigate these mental patients' demands in Primary Care, the Ministry of Health, through decree 154/2008, recommends the hiring of one mental health professional for each NASF[1].

The articulation between mental health services and Primary Care should be based on the following principles: the notion of territory, the organization of a mental health network, intersectoriality, multi and interdisciplinarity, deinstitutionalization, promotion of users' citizenship and construction of possible autonomy for users and family members[13].

The Family Health Strategy Team workers' engagement in Mental Health has resulted in successful experiences, demonstrating that articulation between SUS and Psychiatric Reform principles is possible[10].

With regard to the category related to the theme **therapeutic** workshop, these workshops are mentioned in the selected papers as the group activities the FHS team developed, in which the mental patients participate. These are developed either at the primary care unit or in

the community itself. Various activities are developed, including: craftsmanship workshops, handwork workshops, walking groups, community therapy, painting workshop, mental health reception, individual care when necessary, family incorporation and participation.

One of these papers discusses that, besides collective actions, the primary care unit maintains individual consultations for users, in this case for patients in mental suffering who demand individual intervention. As the Ministry of Health proposed, through individualized therapeutic interventions, respecting the local reality and social reinsertion[20]. One activity refers to the possibility of the team's subjective expression, in which anguish and suffering is expressed.

Other studies develop workshops with handwork, which emerged as a mental health action at the primary care unit and contributes to put in practice the humanization principle in the SUS. Care humanization refers to mutual accountability between the health service and the community and tightening of the bond between the professional team and the population[17].

Community health agents develop workshops at the primary care unit, with psychosocial rehabilitation and citizenship promotion actions, through activities like painting and walking groups, which give rise to interaction and participation. They incorporate the family in these individuals' recovery. These activities permit communication among individuals and enhance their social and professional network. Other workshops develop activities that permit financial gains.

These activities developed in these studies promote the teaching of skills, minimizing the symptoms of patients' disability, and also improve family members and patients' quality of life, and these are the goals proposed for psychosocial rehabilitation[4].

This new treatment mode determines a construction process of a care model, aiming for the mental patients' rehabilitation and life in society, who need help to construct their citizenship, enhancing their contractuality power, which appears in three contexts: the habitat (home), the social network and work[4].

The therapeutic process of Psychosocial Rehabilitation occurs through the construction of individuals' needs to exert citizenship, which happens when chronicity is destroyed, patients' contractual capacity towards the community is enhanced and when it is verified what variables influence the patients' improvement or worsening[4].

To gain citizenship and be socially included, individuals need a power of contractuality, which appears in three contexts. The first would be the habitat (home), which is the space where one lives, with high levels of contractual power in the organizational relation and in the affective relation with other people. The second would be the social network scenario, which would be impoverished, with few bonds. And the third context would be work, where the individual is of social value, in a solidary (cooperative) economic context, thus overcoming the reference framework of *protected work*[4].

Thus, individuals work in these three contexts with bargaining power, sometimes more and sometimes less able or sometimes disabled due to the lack of contractual power, when they need rehabilitation[21].

CONCLUSION

When the SUS was put in practice together with the Psychiatric Reform, different changes occurred in the Brazilian health system, mainly in the mental health care model.

Using SUS principles regarding universality and integrality and the Psychiatric Reform proposal, these papers revealed no uniformity in the primary health care practice of mental health actions. The performance of these mental health care actions depends on the professional or the manager's political decision.

Therefore, innovative treatment devices should be used, giving rise to new practices and ways professionals should learn to develop more comprehensive care delivery, working towards mental patients' psychosocial rehabilitation and construction of citizenship, and also seeking knowledge to support family members.

It is observed that the best strategy for successful mental health care in the FHP was to invest in professional qualification through education and permanent training in this area.

Despite the increasing number of studies on this theme, research presenting concrete solutions to this problem is still scarce.

REFERENCES

1. Brasil. Ministério da Saúde. Portaria GM n. 154, de 24 de janeiro de 2008. Cria os Núcleos de Apoio à Saúde da Família – NASF [Internet]. Brasília; 2008 [citado 2010 fev. 15]. Disponível em: http://dab.saude.gov.br/docs/legislacao/portaria154_24_01_08.pdf

2. Gil AC. Métodos e técnicas de pesquisa social. 5ª ed. SãoPaulo: Atlas; 1999.

3. Minayo MCS. O desafio do conhecimento: pesquisa qualitativa em saúde. 8ª ed. São Paulo: Hucitec; 2004.

4. Saraceno B. Libertando identidades: da reabilitação psicossocial à cidadania possível. Rio de Janeiro: Te Cora; 1999.

5. Koga M, Furegato ARF. Convivência com a pessoa esquizofrênica: sobecarga familiar. In: Labete RC, organizador. Caminhando para assistência integral. Ribeirão Preto: Scala; 1999. p. 363-75.

6. Lopes JMC, Fernandes CL, Lenz MLM, Heyer MB, Valvassori S. Manual de assistência domiciliar na atenção primária à saúde: experiência do Serviço de Saúde Comunitária do Grupo Hospitalar Conceição [Internet]. Porto Alegre; 2003 [citado 2010 fev. 15]. Disponível em: http://www.cuidardeidosos.com.br/wp-content/uploads/Manual_Cuidadores_Profissionais.pdf

7. Vecchia MD, Martins STF. Concepções dos cuidados em saúde mental por uma equipe de saúde da família, em perspectiva histórico-cultural. Ciênc Saúde Coletiva. 2009;14(1):183-93.

8. Ribeiro CC, Ribeiro LA, Oliveira AGB. A construção da assistência à saúde mental em duas Unidades de Saúde da Família de Cuiabá - MT. Cogitare Enferm. 2008;13(4):548-57.

9. Rehem TCMSB. Assistência domiciliar em saúde: subsídios para a atenção básica [dissertação]. Salvador: Instituto de Saúde Coletiva; 2003.

10. Brasil. Ministério da Saúde; Conselho Nacional de Saúde. Relatório final da III Conferência Nacional de Saúde Mental [Internet]. Brasília; 2002 [citado 2010 fev. 15]. Disponível em: http://conselho.saude.gov.br/biblioteca/Relatorios/saude_mental.pdf

11. Brasil. Ministério da Saúde; Coordenação de Saúde Mental; Coordenação de Gestão da Atenção Básica Ministério da Saúde. Circular conjunta n. 01, de 13 de novembro de 2003. Saúde Mental e Atenção Básica: o vínculo e o diálogo necessários [Internet]. Brasília; 2003 [citado 2010 fev. 15]. Disponível em: http://portal.saude.gov.br/portal/arquivos/pdf/diretrizes.pdf

12. Sousa MF, Fernandes AS, Araujo CL, Fernandes MC. Gestão da atenção básica: redefinindo contexto e possibilidades. Divulg Saúde Debate. 2000;(21):7-14.

13. Brasil. Ministério da Saúde. Secretaria de Atenção à Saúde. Departamento de Atenção Básica. Manual de estrutura física das unidades básicas de saúde: saúde da família. Brasília; 2006.

14. Lancetti A. Radicalizar a desinstitucionalização. In: Brasil. Ministério da Saúde; Conselho Nacional de Saúde. III Conferência Nacional de Saúde Mental: caderno de texto [Internet]. Brasília; 2001 [citado 2010 fev. 15]. Disponível em: http://bvsms.saude.gov.br/bvs/publicacoes/3_conf_mental.pdf

15. Costa Neto MM. Educação permanente. 3ª ed. Brasília: Ministério da Saúde; 2000. {Cadernos de Atenção Básica).

16. Cabral B. Estação comunidade. In: Janete A, Lancetti A, organizadores. Saúde mental e saúde da família. 2ª ed. São Paulo: Hucitec; 2001. p. 137-54.

17. Brasil Ministério da Saúde. Secretaria de Assistência à Saúde. Manual para a organização da Atenção Básica. Brasília; 1999.

18. Brasil. Ministério da Saúde; Secretaria de Atenção à Saúde. Saúde mental no SUS: acesso ao tratamento e mudança do modelo de atenção. Relatório de Gestão 2003-2006. Brasília; 2007.

19. Lancetti A. Saúde mental nas entranhas da metrópole. In: Lancetti A, coordenador. Saúde mental e saúde da família. São Paulo: Hucitec; 2000. (Saúde e loucura, 7)

20. Saraceno B. Reabilitação Psicossocial: uma estratégia para a passagem do milênio. In: Pitta A, organizadora. Reabilitação Psicossocial no Brasil. São Paulo: Hucitec. 2001: 13 – 18.

21. Caçapava JR, Colvero LA, Martines WRV, Machado AL, Aranha e Silva AL, Vargas D, et al.Trabalho na atenção básica: integralidade do cuidado em saúde mental. Rev Esc Enferm USP. 2009;43(n.esp):1256-60.

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