Original Article

Nursing care for people with mental disorders, and their families, in Primary Care*

Assistência de enfermagem às pessoas com transtornos mentais e às famílias na Atenção Básica

Asistencia de enfermería a las personas con trastornos mentales y a las familias en la atención básica

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ABSTRACT

Objectives: To know how nurses working in primary care, more specifically in the Family Health Strategy (FHS), perceive their preparation for assisting the person with mental disorders and his family, and to identify the activities developed by them. **Methods:** A qualitative study was conducted with 17 nurses of the ESF belonging to 21 Basic Health Units in the municipality of Maringá-PR (Brazil). Data were analyzed using content analysis methodology. **Results:** For analysis, two categories were established: "Preparation of nurses for the development of care" and "Activities performed by nurses with families. **Conclusion:** The nurses, for the most part, did not feel prepared / qualified to attend to the specific needs of patients in the area of mental health, and their activities were restricted to those already recommended by the service, not being prepared for health promotion activities that included the family of patients with mental disorders in the care.

Keywords: Mental disorders; nursing; Family Health Program.

RESUMO

Objetivos: Conhecer como os enfermeiros que atuam na Atenção Básica, mais especificamente na Estratégia Saúde da Família (ESF) percebem sua capacitação para assistir a pessoa com transtorno mental e sua família e identificar as atividades desenvolvidas por eles. **Métodos:** Estudo de abordagem qualitativa, realizado com 17 enfermeiros da ESF pertencentes à 21 Unidades Básicas de Saúde do município de Maringá-PR. Os dados foram analisados conforme a metodologia de análise de conteúdo. **Resultados:** Para análise, foram constituídas duas categorias: "Capacitação dos enfermeiros para o desenvolvimento do cuidado" e "Atividades desenvolvidas pelos enfermeiros com as famílias. **Conclusão:** Os enfermeiros, na sua maioria, não se sentem preparados/capacitados para atender às necessidades específicas dos pacientes na área de saúde mental e suas atividades desenvolvidas restringem-se às já preconizadas pelo serviço, não sendo elaboradas atividades de promoção à saúde que incluam a família na assistência ao paciente com transtorno mental.

Descritores: Transtornos mentais; enfermagem; Programa Saúde da Família

RESUMEN

Objetivos: Conocer cómo los enfermeros que actúan en la Atención Básica, específicamente en la Estrategia Salud de la Familia (ESF) perciben su capacitación para asistir a la persona con trastorno mental y su familia e identificar las actividades desarrolladas por ellos. **Métodos:** Estudio de abordaje cualitativo, realizado con 17 enfermeros de la ESF pertenecientes a 21 Unidades Básicas de Salud del municipio de Maringá-PR. Los datos fueron analizados conforme la metodología de análisis de contenido. **Resultados:** Para el análisis, se constituyeron dos categorías: "Capacitación de los enfermeros para el desarrollo del cuidado" y "Actividades desarrolladas por los enfermeros con las familias. **Conclusión:** Los enfermeros, en su mayoría, no se sienten preparados/capacitados para atender a las necesidades específicas de los pacientes en el área de la salud mental y sus actividades desarrolladas se restringen a las ya preconizadas por el servicio, no siendo elaboradas actividades de promoción a la salud que incluyan a la familia en la asistencia al paciente con trastorno mental.

Descriptores: Trastornos mentales; enfermería; Programa de Salud Familiar

** Part of the institutional project, "Mental Health in primary care: perspectives and intervention", linked to the Post-graduate Program (Master's) in Nursing, State University of Maringá – UEM, Maringá (PR), Brazil.*

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Received article **23/09/2010** and accepted **22/10/2011**

INTRODUCTION

The number of people who suffer from mental disorders is increasing in the population. Currently, worldwide, about four hundred million [1] individuals suffer from mental disorders and/or neurological or psychological problems, and, beyond suffering and lack of care, these people experience stigma, shame, exclusion, and, with high frequency, death.

This reality is intimately related to the health service and particularly with primary care. In Brazil, in particular, it is specifically related to the Family Health Strategy (FHS), as this is the principal gateway for those people seeking care for their health needs. It should be noted that this modality of care, attention within the mental health environment, includes not only assistance to individuals in psychological distress or with already established mental disorders [2], but also the development of preventive actions and early detection, that involve the individual and his family.

Although the principles of the FHS recommend a closer relationship between users and professionals, in practice it does not meet the needs of families of people with mental illness or psychological distress [3,4]. The nurse, given the characteristics of his/her formation, can better understand the individual in his entirety, which favors a differentiated performance in the environment of health/mental disorders, even when this education is not specifically in this area. Therefore, it makes use of skills and scientific knowledge to understand, accept and support people with mental disorders and their families. Based on this situation, it is considered one of the attributions of nurses who work in promoting mental health of individuals and families served by the FHS.

To attend persons with mental disorders and their families is a primary action in the FHS that cannot be avoided, as people with mental illness spend a major part of the time in the community. This follows from deinstitutionalization that began in 1980 in Brazil, with the psychiatric reform movement, which proposed to substitute the mental hospitals for social, cultural, political or scientific and legal initiatives, and to modify the concepts and the relationship to society of people with mental disorders [5].

According to the Ministry of Health, in 2010, access to mental health care increased, reaching 63% coverage, with strong participation of primary care and intersectoral activities such as social inclusion through work, social assistance and promotion of rights. About 16,000 beds with low quality care were closed as agreed and scheduled. Psychiatric hospitals were smaller, and 44% of psychiatric beds were located in small hospitals. People with long histories of hospitalization were deinstitutionalized. Since 2006, federal spending on actions outside hospitals in this area increased in relation to hospital expenses. In 2009, for example, 67.7% of federal funds for mental health were spent on community action [6].

All of this mobilization occurred after 1980, and intensified after the passage of Law nº 10.216/01, which had for objectives the reduction of the number of inpatients and length of stay, and proposed the participation of families and the community in mental health care [7]. This important change in the country's health system characterized a privileged scenario for the implementation of significant practice changes and knowledge in the mental health area, so that the family is now seen as a liaison in the treatment of people. Moreover, gradually, new strategies emerged that fostered collective participation, recognizing the importance of the family in mental health care and inserting it into the therapeutic plan, in order to improve the quality of life both for those who are receiving care and those who provide the care [8,9]. The FHS represents the possibility of reversing a culturally imposed situation, the isolation of people with mental disorders, and also to promote the mental health of the population with basic actions that promote, restore, rehabilitate and reinsert them, through home visits and group activities, among others [10].

Thus we see that there is coherence in the purposes of the FHS and of mental health, as both have an integrated view of the subject and of the process of health and disease. "The object of psychiatry has become no more danger and the disease, but the existence of suffering of patients and their relationship with society" [11], which includes the family and the context within which they live.

This, in our view, creates new perspectives for the work of nurses in the mental health field, characterized by the transition from a essentially hospital-based practice for treatment of "mentally ill" to one that incorporates new principles and knowledge, based on interdisciplinarity and the recognition of other as a human being, inserted into a family and community context.

Although some studies show that nurses encounter difficulties in working with aspects related to mental health in primary care [3.4], the need for care of the individual with mental illness and his family is a reality. We cannot stop being concerned about how the nurse has acted in this process because, in the majority of the cases, she is the team coordinator of the FHS, and one of the greatest challenges in addressing mental health is the establishment of her competence [12].

The nurse plays an important role in assisting people with mental disorder, such as raising public awareness about the importance of their insertion in the community,

including collaborating and taking responsibility for the construction of new spaces for psychosocial rehabilitation, which will make these individuals feel valued; after all, the citizenship of these people and their families is assured through the policy of deinstitutionalization.

Nurses, therefore, need to be prepared to treat these patients with limitations and their families. The activities that the professional performs in the FHS, and the attitudes that aim to support and treat individuals in order to value not only the disease, but mainly the person holistically, favor the reintegration of patients into social interaction with qualified measures.

Given the above, the objective of this study was to know how the nurses who work in the FHS perceive their education for assisting the person with mental disorders and his family, and to identify the activities developed by them.

METHODS

This descriptive exploratory study used a qualitative methodology of content analysis, and was conducted in Maringá – PR. This city has 25 basic health units (BHU) and 69 teams in the FHS.

To complete the study, inclusion criterion were defined as: a complete team from each FHS of each BHU, as recommended by the Ministry of Health, which, in this format, would provide for better quality care for the family and the people with mental disorders (PMD).

At the time of data collection the BHU had only 21 complete teams. However, some nurses refused to participate in the study and some nurses were not working at the BHU on the day and location established by the researchers. Therefore, there were 17 nurses included as study participants.

Data were collected between March 2008 and July 2009, by means of semi-structured individual interviews. The instrument utilized a script consisting of two parts: the first dealt with sociodemographic features (age, gender, education, length of education, the time working in the FHS) and the second had questions relating to the objectives of the study, which included: 1) What do you understand by mental health? 2) Of the activities that you develop in your daily work, which do you classify as mental health promotion? and 3) Why? 4) Of the health promotion activities, which do you believe contribute to improving the mental health of clients/families? 5) Do you feel you have the capacity to attend to the families of patients with mental disorders? and 6) Why? 7) What type of service is offered to the family who has a mentally ill member, independent of whether or not he procures service for himself? 8) When a patient or family seeks care for experiencing a specific problem or mental disorder (depression in old age, changes in behavior in the adolescent or infant, postpartum depression) what is your conduct? 9) How do you evaluate your performance with patients with mental disorders and their families?

The research project was approved by the Standing Committee on Ethics in Human Research of the UME (Opinion n.º 110/2007) and the participants who agreed to participate were informed about its objectives in two ways, and signed the Terms of Free and Informed Consent.

RESULTS

The 17 nurses who participated in the study were between the ages of 23 and 46 years (mean = 34 years), the majority were females (16), educated between 6 and 10 years (11), and worked in the FHS between one and five years. Four nurses had graduated less than five years ago (E2, E4, E14 and E15); only two had graduated more than 10 years ago (E3 and E17). As for work experience in the FHS, four had worked there less than a year (E2, E8, E13, and E14), 12 between two and five years, and one (E7) for six years. In relation to education, only eight nurses had specialization in the area of public health (E8 and E11).

Data were categorized into two thematic categories: "Education of nurses for the development of care" and "Activities performed by nurses with families."

Category I: Education of nurses for the development of care

In this category we perceived a difficulty for the nurses in dealing with the PMD. They said they did not feel capable, due to a lack of preparation in regard to educational courses and training, or even the absence or deficiency of this content in their education. Some reported not having the skills to treat these patients, feeling uncomfortable in attending to them.

"First, the majority that come to us are very aggressive and the people cannot attend, cannot get to what they really need, because they are very confused. The family itself, we help because they need it to vent, to talk, and people all try to guide where they can. Now with the patient, I feel an enormous difficulty, I do not know how to reach him, I even try, but he refuses and this restricts the dialogue, it is a very big difficulty" (E13).

"I never liked these patients, I do it, because as a professional it is necessary and to the extent possible I try to do what is within my reach" (E6).

We can highlight that the nurses did not go through any specific training to care for the PMD and the majority reported only a few experiences in the undergraduate course. Although all referred to receiving content to care for the mentally ill, they reported that this was insufficient to work with this disease.

"The only time I saw mental health was in college and it was very little. I know, too, that the health department does not have many courses, many updates, in mental health, so, I never had this and I have difficulty in attending to these families. I think I have a blockage by not knowing. It is not due to being afraid, it is due to lack of knowledge itself and how to handle these patients. I have great difficulty" (E8).

"Very little. We just do not have the education; it was a long time ago, we met with the unit psychologist, to discuss the cases, because we have difficulty dealing with that kind of person. And so, we sat down and asked for her help, how could we deal with this type of patient. We just stopped doing it, and yet we find it difficult to attend to this clientele, because I do not think we are very well prepared to deal with these patients" (E2).

Another concern highlighted by the nurses was with respect to medication control. In this context, we can infer that the healing activities are even more relevant than promotion and health prevention.

"Our biggest concern, I think that any professional has, is if he is doing drug therapy, adhering to treatment, and taking it right, if it is taken on time. We realize that he has a lot of confusion, especially if he has more than one disorder. And even if the treatment is having a result, if he needs any other kind of medication added." (E10).

Category II: Activities performed by nurses with families

In relation to the activities performed by nurses in relation to the PMD and his family, respondents answered the following question: "When there is a family that has a person with mental disorder in your coverage area, regardless of whether or not she seeks the health service, does the FHS offer some kind of differentiated service to the family?"

It was possible to verify the reports that among the activities conducted by professionals, the vast majority of treatment is based on medical consults, nursing consults and home visits.

"First, every month there is a visit from a health worker and there he captures the problem and brings it to us, we do not always go on visits, but the ACS makes monthly visits. So, when it is requested, we will go ... Just like this patient that we had, we tried to converse, but, many times, they do not even open the door, then it is very difficult to work with them, but if they open up we try to talk, raise awareness and we have some that accept!" (E10).

"[...] Well, first the ACS makes a home visit and when confronted with someone with mental problems, they communicate to us, and so to the extent possible, I accompany the visits and if necessary a consultation with the doctor" (E5).

"The opportunity to participate in the group of psychotropic and psychological care is offered. It has been suggested to form a self-help group with involvement of a psychologist, but the latter prefers clinical psychology" (E7).

In some units it was noted that the introduction of these groups for PMD by the FHS was not successful nor did they have continuity, because the patients did not participate and thereby discouraged their implementation.

"Initially, a unit would set up a group for mental health, but it just did not succeed, because people who have these problems, who suffer from depression, who have some kind of disorder, they do not come to the unit; it's very difficult, then it would be a group without success. They do not seek, they do not have the courage to come, they have a preconception against them" (E17).

"[...] with regard to mental health, as we do not work, I can not speak" (E2).

"We have groups for the elderly, handicrafts and the academy for seniors (AFS). One of the objectives we have is that we do not speak about only one subject. If it is an elderly group, we will talk about hypertension and diabetes, but also ask how is the environment in which he lives, what he does, the activities he performs, and they enjoy the time to talk too (to vent). At AFS, for example, we bring the physical education teacher to develop activities and increase the self-esteem of patients. So, our activities are not specific, but they addressing the patient with mental disorders" (E1).

DISCUSSION

According to these responses, it was possible to verify that a large part of the nurses do not feel qualified to work in mental health within the FHS, a condition encountered in other realities, as a result of insufficient education directed to the topic, which maximizes the existence of barriers impede the development of care interventions aimed at this population [4].

Considering that the FHS functions with the BHU, as a gateway into the public health system, it is important to highlight the role of nurses in caring for people with mental disorders and their families. In this respect, their role should be highlighted, since he is the professional who must offer the family and the mental patient the information and support necessary, contributing to their social reintegration. The lack of education of these professionals prejudices the care of these people, who must be attended to in accordance with health policy, in other words, in a dignified, humane and respectful manner [14].

Knowing that the FHS is an assistance model that promotes the actions of health promotion and disease prevention, especially with the mental disorders, the nurse has a key role in this context, since she promotes preventive care and a welcoming atmosphere in order to provide holistic and humanized care, and thereby contribute to a better quality of care delivery [15]. Nevertheless, what we see in practice is that, many times, these professionals maintain traditional practices, based on routine care, with activities such as triage and control

of medicines superimposed upon the other. This situation is not consistent with the guidelines established by the Policy for Integral Attention to Mental Health, which proposes the transformation of psychiatric care to a mode of attention that gives priority to the activities that promote the social inclusion process for the bearer of mental disorders [16].

As antecedent factors to the inefficient care for patients in mental distress and his family, we were referred to the deficiency in the academic formation (deficient knowledge), the lack of updating and training in the area, exhausting working hours, insufficient pay and excessive responsibilities.

Besides these factors, the lack of professional identification with the area of mental health and a lack of ethics deserve to be highlighted, as observed in some reports as well as in bodily expressions (eyes, facial grimaces, restlessness) of the professionals during data collection.

To improve the quality of care provided by the FHS in primary care for the PMD, it is necessary to have qualified professionals and know their limitations, important points that must be taken into consideration for continuing health education, and to provide care that satisfies the needs of the client and his family and seek the resolution of their problems.

This study found evidence that the FHS offers care based on the logic of fulfillment of duties and does not always prioritize the mental health of these people, thus failing to provide them with better quality of life. Nurses, many times, restricted them to routine activities, without developing more specific activities, aimed at mental health promotion and prevention.

To a lesser extent, the teams offer some activities that claim to be targeted to patients with mental disorders, for example, psychotropic drug groups, handicraft groups, physical education and fitness for the elderly (AFS). In some units, it was noted that the organization of groups of people with mental disorders by the FHS did not succeed or have continuity, because patients did not attend these groups and, therefore, their functionality was discouraged .

It is important to note that the BHU in which these groups are conducted only address people with mental disorders, and not their families, which also need care and support in order to contribute to holistic care. From the moment that a family member is deinstitutionalized and needs to be reinserted in the community and socially accepted, the family suffers from not having access to services and activities known as extramural. It is then that the need for public health services is highlighted, especially for the FHS to provide care also to caregivers, in order to provide adequate guidance, and provide subsidies to enable them to care for those who are fragile.

After the process of deinstitutionalization, mental health services began to offer attention to families, forming partnerships in a new form of care, especially using group strategies to make possible exchanges of experience, as well as guidance about how to deal with and live with the patient with mental disorders [17]. In the same logic, the family health teams also began conducting group activities such as handicrafts, as a way to involve the community, but they have not always taken advantage of this moment to promote and restore mental health. The women's handicrafts group in the FHS, for example, constitutes a way of maintaining and restoring mental health, that serves to help people who already have an established pathological process and also serves as a means of prevention and promotion of mental health for the individual and family [10].

Conforming to the new guidelines recommended by the Psychiatric Reform, the FHS should have the family as an ally in the treatment of PMD; but, for their integration, it is necessary that the service offers support that is ongoing, technical and humanized. The health service workers, especially nurses, need to be conscious of the importance of family involvement for people with mental disorders in the projects of reinsertion into the community.

In order to make this possible, we need the commitment of the nurse, the family, of the patient and his family, with a view to breaking with the traditional knowledge and practices of psychiatry for a more encompassing reality, so that care is understood in a model of holistic care, that also considers psychosocial and spiritual aspects of the individual, family and community.

Therefore, nurses need to know the policy of the psychiatric reform and have the skills for working with the deinstitutionalized person with mental disorders, in other words, who is prepared to welcome and support families in their needs, since living daily in contact with a person with chronic illness at home is not easy.

CONCLUSION

Through this study, we produced evidence that the majority of nurses who participated felt neither prepared nor capable of attending to specific needs in the area of mental health. As a consequence, the assistance to individuals with mental disorders is impaired, and does not reach the presuppositions of holism that includes promotion, prevention, recuperation and rehabilitation of health.

Considering that the nurse is the professional who coordinates the team's actions in the FHS, it is important that she is qualified for the development of activities and care in mental health aimed at reinforcing the care, since many times, as seen this study, neither the family nor the PMD have all of their needs addressed.

Given the recent paradigm shift in attention to individuals with mental disorders, we must consider this task to be a great challenge to nurses. It is in this intention that this study contributes to the search for new strategies in the care provided by the FHS to these patients and their families, since, in actuality, social reintegration of the individual, having the family included in the care and activities aimed at health promotion, are instruments which must be considered as substitutive action to the traditional model, in which the only care supported was the treatment of disease.

Some limitations in the development of the study should be considered in view of the fact that they are related to the fact that this present study was part of a larger project. First of all, there is the fact that only nurses in the FHS teams that were complete were included in the study. This is because of the various objectives of the larger project; the remaining team members should also be interviewed, and the number of teams included was limited. The second is related to the fact that the same instrument was used in the project for conducting the interview with all team professionals. It was not possible to explore the limitations and activities of the nurses' work, nor the gaps in their education, as pointed out by some. But, the instrument does not allow us to deepen this question, leaving a gap to be investigated in further studies.

The study also failed to analyze the teaching conditions for mental health to professionals during their education; however, in light of the restrictions cited, as limitations in the care of the patient suffering psychological distress and his family, we can infer that this instruction was insufficient and, therefore, we suggest that future studies specifically address mental health care in nursing education.

The importance of the nurse receiving refresher courses/training in mental health at the institution where he works should also be highlighted, to enhance his work in order to achieve the desired success in service provided. Thus, the FHS could provide care and appropriate shelter to people with mental disorders and their families.

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