Conception of Family Health Strategy Professionals on Mental Health in Primary Care

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This article aims to analyze the design professionals of the Family Health Strategy on mental health based on the National Mental Health Policy. We conducted a field research with qualitative approach and the participation of 20 professionals. Data were collected through a semi-structured interview and investigated from the content analysis and grouped into categories. It was possible to identify the relative demand for more frequent mental health is the renewal of prescriptions medicals and interventions are fragmented by specialties and referrals. It considered the importance of matric support involved with the accountability of health professionals in intersectoriality and integration of actions multidisciplinarys to mental health with users, family and community.

Descriptors: Health Professionals; Family Health Strategy; Mental Health.

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Concepção de Profissionais da Estratégia Saúde da Família sobre a Saúde Mental na Atenção Básica

Este artigo teve como objetivo analisar a concepção de profissionais da Estratégia Saúde da Família sobre saúde mental com base na Política Nacional de Saúde Mental. Realizou-se uma pesquisa de campo, com abordagem qualitativa e a participação de 20 profissionais. Os dados foram coletados por meio de uma entrevista semiestruturada e investigados a partir da análise de conteúdo e agrupados em categorias. Foi possível identificar que a demanda relativa à saúde mental mais frequente é a de renovação de receitas médicas e as intervenções são fragmentadas por especialidades e encaminhamentos. Considerou-se a importância do apoio matricial envolvido com a responsabilização dos profissionais de saúde na intersetorialidade e integração das ações multidisciplinares de saúde mental com os usuários, família e comunidade.

Descritores: Profissionais de Saúde; Estratégia Saúde da Família; Saúde Mental.

Estrategia de Salud de los Profesionales de Diseño de la Familia de la Salud Mental en Atención Primaria

Este artículo tiene como objetivo analizar los profesionales del diseño de la Estrategia Salud de la Familia en la salud mental basado en la Política Nacional de Salud Mental. Se realizó una investigación de campo con enfoque cualitativo y la participación de 20 profesionales. Los datos fueron recolectados a través de una entrevista semiestructurada e investigados a partir del análisis de contenido y se agrupan en categorías. Fue posible identificar la demanda relativa de salud mental más frecuente es la renovación de las recetas médicas y las intervenciones fragmentado por especialidades y referencias. Se considera la importancia del apoyo matricial con la responsabilidad de los profesionales de la salud en enfoque intersectorial y la integración de acciones de salud mental multidisciplinar con los usuarios, familia y comunidad.

Descriptores: Profesionales de la Salud, Estrategia de Salud Familiar, Salud Mental.

Introduction

From the 1970s to the 1980s, the World Health Organization (WHO) recognized the magnitude of mental health problems and admited that it is impossible to expect that care be exclusively provided by specialists. WHO advocates the decentralization of the existing services, integration of psychiatric services into general care units, trainement for non-specialized caregivers, and the increase of community participation[1].

One of the challenges that are currently imposed to the Unified Health System (SUS) is the effective implementation of the Psychiatric Reform, consolidated with the Law nº 10.216/2001. In fact, the Psychiatric Reform ensures comprehensive health care for users of mental health services through the structuring of community-based services that - in line with the principles of Health Reform - must be configured in care networks capable of practicing equity in the provision of care and promoting social reintegration[2].

The integration of the Family Health Strategy (FHS) into mental health policies, in turn, also implies profound changes in institutionalized health practices. The logic of "expertises", still deeply rooted in the medical and

hospital-centered culture and found among technicians and even among the user population, makes it difficult to implement new forms of care. Such logic presupposes hierarchical relations of knowledge and powers between the different team members and of the team with the users[3]. This means that changes in the organization of services must take place grounded on changes in the established sets of knowledge that define who is qualified and who has the authority to deal with mental disorders.

Data that allow knowing the level of implementation of mental health actions in the basic healthcare network are still very incipient. Aiming to contribute to lessen this gap, some studies have presented researches converging with the principles of the Psychiatric Reform, based on epistemological foundations focused on the rupture of the naturalistic and classic medical paradigm, assigning a new social place to madness and, for this, establishing a Psychosocial Care Model[4].

This new model must be in contradiction with the old model, the one centered on the asylum, in four main parameters: in the definition of "its object" and the theoretical and technical "means" of intervention; in the forms of organization of institutional devices; in the modalities of relationship with users and with the population; and in the ethical implications of the effects of their practices in legal, theoretical, technical and ideological terms[5].

Using these four parameters, the Psychosocial Model proposes that political, biopsychic and sociocultural factors be taken as determinants of diseases[5]. This way, therapies would come out of the exclusive, or preponderant, drug scope and the subject would gain prominence as the primary participant in the treatment, including the family and eventually a larger group as key agents of care.

However, it is noteworthy that in the primary care setting, the majority of patients with mental disorders do not have their diagnosis defined, and are therefore not properly treated. Among the main reasons for the non-recognition of mental disorders is the fact that these patients are more likely to report only somatic symptoms in the consultation, and FHS professionals have difficulty to recognize these symptoms as indicatives of mental disorders[5].

Based on this information, the existing mental health practices at the basic level of health care do not always match what was expected and. In view of this, the guiding question of this study was defined as: what is the conception of Family Health Strategy professionals on mental health in primary care?

To get closer to the problem presented and considering the guidelines of the National Mental Health Policy, mental health care is not something from another world or beyond the daily work in basic care. On the contrary, the interventions are conceived in the daily reality of the territory, with the singularities of patients and their communities[6].

In view of the above, this study aimed to analyze the conception of professionals of the Family Health Strategy on mental health based on the National Mental Health Policy.

Materials and Methods

The present study is a field research, with descriptive, exploratory and qualitative approach which provides a more comprehensive understanding of the history, representations, beliefs and relations of the participants involved in the study[7]. This approach is coherent and at the same time consistent to deal with the subjectivity of study participants, within the methodological contribution of data construction, analysis and discussion, as well as respect for ethical principles[8].

The research was conducted at a Family Health Center (FHC) in the state of Ceará. The research participants were 20 FHS professionals (05 nurses; 02 physicians; 02 dentists; 08 community health agents; and 03 nursing technicians).

Inclusion criteria were FHS professionals registered in the National Registry of Health Establishments (NRHE) and with more than two (2) years of professional experience in FHC. Preceptors, trainees and professionals from other health care services were excluded from the study.

The data were collected through the technique of interview with aid of a detailed and organized semi-structured script and with the following open questions: What are the mental health demands that are accompanied by FHS professionals? and can you please describe the mental health actions performed in the FHC?

The interviews took place spontaneously and were performed in the months of July and August 2015 in the rooms of the study scenario, according to the participants' availability, and each interview had an average duration of 30 minutes. They were recorded in audio and transcribed verbatim, after detailed explanation of the purpose of the study, and after the participants' explicit acceptance in sharing in the research and signing the Informed Consent Term (ICT). Anonymity was maintained by identifying the participants with natural numbers.

Thematic categorical analysis technique was used for the analysis of the information obtained in the

interviews. This technique is operationally organized in three phases: pre-analysis, material exploration and treatment of the results obtained and interpretation[9]. Interviews were transcribed verbatim and the data were later systematized in order to maintain the basic contents of the thoughts and the meanings of the messages provided by the participants. It is worth mentioning that the themes that emerged from the transcribed reports were grouped into context units. Three thematic categories were created and discussed along with literature.

The research project followed the ethical and legal precepts of Resolution 466/12 of the National Health Council (NHC) and was approved by the Research Ethics Committee (REC) of the University Center UNINOVAFAPI in Teresina - Piauí, through the consubstantiated Opinion nº 1,415,624 and Certificate of Presentation for Ethical Assessment - CAAE nº 44611415.7.0000.5210.

Results and Discussion

For the purposes of this study, 20 professionals from the Family Health Strategy (05 nurses; 02 physicians; 02 dentists; 08 community health agents; and 03 nursing technicians), aged between 30 and 50 years and with professional experience of more than 02 years at the research site.

For the analysis of the results, three categories were compiled: types of mental health demand experienced in the Family Health Center; mental health actions developed in the Family Health Center; and the importance of support matrix for Family Health Strategy professionals. These categories and their respective discussions are presented below:

Types of mental health demand experienced at the Family Health Center

In general, the most frequent mental health demand in the Family Health Center is that of patients seeking to ask for medical prescriptions in order to continue the drug treatment. Other demands were also mentioned, such as the use of alcohol and other drugs and situations found to be of mental disorder in the area covered by the team. However, the demand for renewal of medical prescriptions seems to be more common and more alarming.

It is worth mentioning below the verbalizations of the participants:

Demands come up, patients with depressive complaints, just as today there was one, a patient who suffers anguish caused by the loss of a relative, patients who make chronic use of controlled medication (Participant 1).

We have many patients who have been using medication prescribed by a psychiatrist for a long time (Participant 3).

Here in the FHC, mothers who make use of medication because of the suffering caused by the disappearance of a child involved with drugs, these mothers are received here; women with breast cancer weakened by the treatment; woman who feel afraid at the nights; in case of mistreatment by husbands (Participant 5).

Also, men who use drugs and who "hear voices" come here, they want to take psychotropic medication; they come for prescriptions of stronger drugs because the medication they are using is not working well (Participant 10).

We always have mental health patients. They promptly go to the drug section and they want the medicine, they come with the prescription of the psychiatrist and then they leave. Unfortunately this is the reality: they just want to get the medicine (Participant 19).

Suicide attempt by ingestion of diazepam, haloperidol or tryptanol; men who keep pots of urine and garbage in the room and want to take medication to control compulsions (Participant 11).

There is demand for reports of SUS psychiatrists to obtain the retirement; rape victims who have panic attacks and want controlled medication; families that seek the FHC because they think the mother is "crazy" and needs medication (Participant 17).

The prevailing mode in the embracement of the demands of users with mental disorders and also with family conflicts, suicidal behaviors and situations of drug addiction and several forms of violence, which was expressed in the interviews, indicates the overestimation of specialized and medicated care for the resolution of health problems of the population. This is reflected in two ways: the referral of these demands to the services/professionals specialized in mental health and the provision of medical prescriptions.

Medicines are seen as the main therapeutic practice in the public health network and is often considered the only resource available to those who need this type of care or are at risk, leading users to become dependent[10]. This phenomenon is related to the dominant role of the pharmaceutical industry in the health care of families and the strength of the biomedical model, still hegemonic in the monitoring of the physical, emotional and social complaints of the population.

The process of medicalization is very present today and occupies an important place in the game of interests of economic power. The consumption of drugs has a significant impact on society. It is the main means of combating diseases and other problems related to current therapeutic practices, and it has also

a significant economic significance. Allied to this is the fact that medical consultations almost always result in prescriptions, due to a short-sighted view of health where drugs have become the main tool[11].

Therefore, this is no longer a comprehensive view of the difficulties and/or vulnerabilities of users and their determinants, since the Family Health Strategy has as main proposal the reorganization of health care for the development of assistance by an interdisciplinary team oriented by expanded conceptions of the health/disease process and by the development of family-centered psychosocial care practices within their territory[3].

In order to be aligned with the above information, mental health care is reoriented from hospital-centered to community-based. The incorporation of mental health actions in primary care will contribute to this transformation, offering greater assistance coverage and potential for psychosocial rehabilitation[12]. But for this, it is important to understand that the execution of these mental health actions requires a straightforward attitude on sanitary responsibility in the territory and resolution of the issues presented.

Mental health actions developed in the Family Health Center

Faced with the cases received at the Family Health Center, health professionals, in general, renew their psychiatric prescriptions without further questioning about this intervention strategy. It is possible to perceive that the conception of mental health actions is quite compartmentalized, with interventions fragmented into many specialties.

The respondents presented the following answers:

We receive them, but it is usually the case of patients who are already followed up by a psychiatrist and who come just to us to ask a transcription of the prescription (Participant 2).

We can not give a therapeutic support, mental health diagnosis, which is a very specialized thing (Participant 4).

I have several difficulties in developing mental health actions because of the lack of specific knowledge in mental health; our training is generalist or with specialties in other areas. And thus, my participation in the daily demands of mental health becomes fragile (Participant 13).

FHC doctors usually forward the patient to a specialist because they can not prescribe these medications, right? So you have to actually forward them to a specialist. Thus, they have done this (Participant 14).

I basically have to send the patient to the psychiatrist; I do not feel totally confident to follow this type of patient. However, I am aware of the Sanitary and Psychiatric Reform movement and the legal support of the Constitution and the SUS, that it is no longer possible to think of health in a

compartmentalized way, because "mental" and "physical" aspects are not dissociated (Participant 8).

So, I think that there should be comprehensiveness, but in practice, every professional acts only in his specialty and that's it. Basic care is responsible for the population of a territory. Thus, it shouldn't be responsible only for one aspect of human life, but it should embrace everything and be fully effective (Participant 12).

In view of these reports, we can see the increasing fragmentation of medicine and other health professions, leading to the creation of distinct areas of knowledge with differentiated intervention objects and making it difficult to produce comprehensive mental health actions that favor concreteness of the subjects' lives.

The predominantly fragmented view of work in mental health, based on expertise, also fosters the logic of referrals[13]. As a consequence, mental health interventions always presuppose a hierarchical logic, with a distinction of power/knowledge between those who refer and those who receive, and also transference of responsibility.

The interviews made it possible to observe that this propitiates and reinforces the difficulty of these professionals to deal with mental health demands received in the FHC, besides the crystallization of traditional interventions in mental health, and in global health, of prescription of medicines and referrals. However, many actions can be developed in partnership with Psychosocial Care Centers (CAPS's), including consultations/care, group work, home visits, meetings and training with all professionals involved in mental health care[14].

Thus, in order to meet the principle of integrality, it is necessary to include attention to those suffering from psychological distress in primary health care actions. Integrality of care is understood as an articulated and continuous set of preventive and curative, individual and collective actions and services required in each case, at all levels of complexity[3].

The importance of support matrix for Family Health Strategy professionals

In relation to the professionals of the Family Health Strategy, it was possible to see that the proposal of matrix support is still unclear and there are many uncertainties and mistaken expectations on the part of these professionals. The scarce definitions have identified the relevance of matrix support as a strategy of decentralization in mental health care, and thus the following accounts can be considered:

So, in practice, with matrix support, it is intended that people deal better with this demand because specialized

services are not enough, so they want the FHS to include a mental health work (Participant 18).

Matrix support has to occur continuously and systematically, since there is no articulation between the services of the primary and specialized network, except when it comes to some referrals, starting from them and sent to specialized services. When this referral happens, there is no follow-up of the case, nor return from the part of the specialized service (Participant 6).

Matrix support represents the need to have support for embracing in mental health (Participant 9).

The contribution of matrix support to the teams could be carried out through the provision of improvements, training and lectures in the specific area of mental health (Participant 7).

I think they should develop the matrix support, because that would be a channel that they, the CAPS professionals, would have to listen to us too. They are seeing that in practice it is not so easy to leave mental health in the hands of unprepared FHS teams, because in practice, we will not have the ability to assist the patient, and he himself will not want that assistance (Participant 20).

In order to make matrix support feasible, the presence of a psychologist in each Basic Health Unit is necessary, as well as a vehicle to transport users with mental disorders (Participant 16).

This matrix support should be an emotional support for FHS professionals (Participant 15).

Concerning the answers given by the participants, it is possible to see that the prospect of effective care for the mental health demand in the basic unit is envisaged; however, the possibility of an articulated work between the FHS and the specialized service is not so clear.

A proposal like this, involving many actors in its elaboration and execution, should be discussed by all the involved parties; the actions should be built in partnership in the course of the process. It is not, therefore, only a matter of decision-making at the management level, in a centralized and isolated manner, but rather in a shared and agreed manner.

Traditionally, the hierarchical health care model has produced fragmentation and bureaucratization in the relationships between health services, instituting ways of conceiving and intervening in health institutions and leading to lack of accountability rather than co-responsibility among professionals and services[15]. Thus, the provision of care for the mental health demand is seen as extra work and a lack of responsibility of the specialized services.

Thus, the proposal of the matrix support is to articulate the basic care and the specialized services, promoting meetings of different sets of knowledge so as to provide a more integral and less fragmented action. This way, the CAPS, in the role of specialized service,

would not be disregarding its demand, but acting in another perspective, one of decentralized care, bringing care closer to the user[16]. The professionals of this service would be guiding and building, along with primary care professionals, a new model of care, in which the greatest beneficiary is the user. There is, therefore, no deviation but a sharing of responsibilities.

It is a new reference system between professionals of the FHS and users for the effectiveness of the proposal of matrix support, in which the patient uses a matrix service and never ceases to be a client of the reference team. In this sense, there is no referral but rather the design of therapeutic projects that are not only executed by the reference team but by a broader set of workers[17]. In any case, the primary responsibility for conducting the cases would continue in the hands of the primary care team.

The proposal of matrix support is rooted upon the movement of integrative and therapeutic actions between the primary care reference team and the team of other services adequate to the demand of each case. In this sense, mental health care will be monitored and strengthened by the specific knowledge of the various health professionals.

In addition, the focus of this arrangement is on the exchange of knowledge between teams and professionals with the aim of offering actions/services that have the potential to positively modify the health problems (in their broad sense) of an individual or collective subject, with the most rational use of all available resources[16].

The daily practice of cultivating a respectful relationship between general knowledge and specialized knowledge is necessary, likewise in the relationship between the knowledge of the user and that of the health professional. These must be considered as different legitimate sets of knowledge. It is in this sense that matrix support implies a two-way multidirectional exchange logic for participants in the process (learning and teaching), rather than a hierarchical and descending chain that places the everyday knowledge and practices of primary care services as subservient to a naturalized way of considering the expert's competence.

Final Remarks

It is considered that the results of the research pointed to the preeminence of the biomedical paradigm in health care, in which medical care such as the indiscriminate prescription of psychotropic drugs is favored in the resolution of health problems of the population. The predominantly fragmented view of health work, in turn, anchored in the specialized

knowledge, also propitiates the extension of the proposal of referrals.

These obstacles were identified based on the difficulties of primary care professionals to develop a conception about the particularities of mental health, since training, as well as the great demand of the clientele for which they are responsible in their work, leaving little time for the intersectoriality and psychosocial rehabilitation of users with mental disorders.

The study clarified that the involvement of primary care professionals alone is not enough to reorganize practices in the field of mental health care, because actions are not restricted exclusively to the health sector. It is worthwhile to intensify intersectoral policies, as inseparable, expanding possibilities and opportunities, helping local progress and re-dimensioning the notion of law and citizenship. This calls attention to the explicit need to build networks from and between services.

Therefore, it is imperative to work towards the effective implementation of the mental health care network in basic care, in the sense of interdisciplinary work and community participation, linked to the perception of health and illness in the subjective, physical and social components of the users and their family members.

Acknowledgments

References

1. Gonçalves AM, Sena RR. Psychiatric reform in Brazil: contextualization and consequences regarding the care for the mentally ill in their family environment. Rev. Latino-Am. Enfermagem. São Paulo. 2010;9(2):48-55.

2. Barroso SM, Silva MA. Reforma Psiquiátrica brasileira: o caminho da desinstitucionalização pelo olhar da historiografia. Rev. SPAGESP. São Paulo. 2011;12(1):66-78.

3. Mattos RA. A integralidade na prática (ou sobre a prática da integralidade). Cad. Saúde Pública. Rio de Janeiro. 2012;20(5):1411-16.

4. Figueiredo MD, Campos RO. Saúde mental na atenção básica à saúde de Campinas, SP: uma rede ou um emaranhado? Ciência e Saúde Coletiva. Rio de Janeiro. 2013;14(1):129-38.

5. Alverga A, Dimenstein M. Salud mental en la atención básica. Construyendo La integralidad en el Sistema Unico de Salud en Brasil. Revista Alternativas en Psicología. México. 2010;40(3):67-77.

6. Amaral MA. Atenção à saúde mental na rede básica: estudo sobre a eficácia do modelo assistencial. Rev. Saúde Pública. Rio de Janeiro. 2014;31(3):288-95.

7. Gil AC. Métodos e técnicas de Pesquisa Social. 6. ed. São Paulo: Atlas; 2011.

8. Bosi MLM. Pesquisa qualitativa em saúde coletiva. Ciência e Saúde Coletiva. Rio de Janeiro. 2012;17(3):575-86.

9. Bardin L. Análise de conteúdo. 70. ed. São Paulo; 2015.

10. Carvalho LF, Dimenstein M. O modelo de atenção à saúde e o uso de ansiolíticos entre mulheres. Estudos de Psicologia. Natal. 2011;9(1):121-29.

11. Souza AMA, Braga VAB. Brazilian psychiatric reform: a lot to reflect on. Acta Paul. Enferm. São Paulo. 2012;7(1):131-42.

12. Mostazo RR, Kirschbaum DIR. Users of a psychosocial care center: a study of their social outcomes about psychiatric treatment. Rev. Latino-Am. Enfermagem. São Paulo. 2013;11(6):786-91.

13. Souza LV, Santos MA. Group process and psychologist work in primary health care. Rev Bras Cresc e Desenv Humano. São Paulo. 2012;22(3):388-95.

14. Pitta AMF. Reorientação do modelo de atenção: equidade e justiça social na organização de serviços de saúde mental. Rev. SPAGESP. São Paulo. 2013;18(1):70-8.

15. Bower P, Sibbald B. On-site mental health workers in primary care: effects on professional practice. Acta Paul. Enferm. São Paulo. 2013;12(1):160-72.

16. Nicácio MFS. Utopia da realidade: contribuições da desinstitucionalização para a invenção de serviços de saúde mental. Arq. Ciênc. Saúde. São Paulo. 2014;15(2):140-52.

17. Yasui S. Rupturas e encontros: desafios da reforma psiquiátrica brasileira. Ciência e Saúde Coletiva. Rio de Janeiro. 2015;12(1):30-43.