Demands of mental health: nurses' perceptions of family health teams*

Demandas de saúde mental: percepção de enfermeiros de equipes de saúde da família

Demandas de salud mental: percepción de enfermeros de equipos de salud de la familia

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ABSTRACT

Objective: To describe how the needs of mental health (MH) of family health teams are identified and embraced, according to the conception of the nurses. **Methods:** This was an exploratory, descriptive study, of qualitative character. We used semi-structured interviews with five nurses, and interpretation was guided by proclaimations of the Brazilian Ministry of Health about the inclusion of the actions of MH in primary care. **Results:** We identified that the lack of indicators in the Information System of Primary Care (ISPC) affected the planning of the actions for MH and other chronic diseases, such as diabetes and hypertension, that are priorities for the teams. The actions of MH have been gradually incorporated in the work process of family health teams, and consulting psychiatry plays an important role. **Conclusion:** We recognize the need for continuous education revision of ISPC and, especially, creation of systematized therapeutic projects and the provision for new ways of caring.
Keywords: Health services needs and demand; Mental health; Perception; Nursing, team; Primary health care; Family health

RESUMO

Objetivo: Descrever como são identificadas e acolhidas as necessidades de saúde mental (SM) por equipes de saúde da família, conforme a concepção de enfermeiros. **Métodos:** Estudo exploratório, descritivo de caráter qualitativo. Utilizaram-se entrevistas semiestruturadas junto a cinco enfermeiros e a interpretação foi norteada pelas preconizações do Ministério da Saúde Brasileiro sobre a inclusão das ações de SM na atenção básica. **Resultados:** Identificou-se que a falta de indicadores no Sistema de Informações da Atenção Básica (SIAB) afeta o planejamento das ações de SM e que outras doenças crônicas, como diabetes e hipertensão, são prioritárias para as equipes. As ações de SM vêm sendo incorporadas gradativamente no processo de trabalho das equipes de saúde da família, e a consultoria de psiquiatria exerce importante papel nisso. **Conclusão:** Reconhece-se a necessidade de educação permanente, revisão do SIAB e, sobretudo, criação de projetos terapêuticos sistematizados e à disposição para novos modos de cuidar.
Descritores Necessidades e demandas de serviços de saúde; Saúde mental; Percepção; Equipe de enfermagem; Atenção primária à saúde; Saúde da família

RESUMEN

Objetivo: Describir cómo identifican y acogen las necesidades de salud mental (SM) los equipos de salud de la familia, conforme la concepción de enfermeros. **Métodos:** Estudio exploratorio, descriptivo de carácter cualitativo. Se utilizaron entrevistas semiestructuradas aplicadas a cinco enfermeros y la interpretación fue norteada por lo que preconiza el Ministerio de Salud Brasileño sobre la inclusión de las acciones de SM en la atención básica. **Resultados:** Se identificó que la falta de indicadores en el Sistema de Informaciones de la Atención Básica (SIAB) afecta a la planificación de las acciones de SM y que otras enfermedades crónicas, como la diabetes e hipertensión, son prioritarias para los equipos. Las acciones de SM vienen siendo incorporadas gradualmente en el proceso de trabajo de los equipos de salud de la familia, y la consultoría de psiquiatría ejerce un papel importante en eso. **Conclusión:** Se reconoce la necesidad de educación permanente, revisión del SIAB y, sobre todo, creación de proyectos terapéuticos sistematizados y la disposición para nuevos modos de cuidar.
Descriptores: Necesidades y demandas de servicios de salud; Salud mental; Percepción; Grupo de enfermería; Atención Primaria de salud; Salud de la familia

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INTRODUCTION

Approximately 14% of global spending on health have been attributed to mental disorders due to chronic nature of depression, schizophrenia, alcohol and drug dependency and other mental illnesses. This estimate highlights the importance of mental health in the context of public health and implies the need for approaches that articulate mental health problems with other health conditions[1].

The bearer of mental disorders have higher risk for diseases and conditions, on the other hand, many health conditions leverage the vulnerability to mental disorders. Thus, awareness about the importance of mental health should be incorporated into the whole context of health; system planning and offering of primary and secondary care, as well as social policy[1].

According to the conceptions and guidelines of current health policies, the relationship between mental health and primary care presuppose a care network model, adopting principles such as the notion of territory, intersectoriality, interdisciplinarity and psychosocial rehabilitation in favor of promoting of users citizenship[2].

The program of community health workers (PACS) and the Family Health Program (FHP), are implemented programs major part of Brazil, in order to extend basic health care to population segments without access to these services. The creation of this programs started primarily at regional level and later municipal, which has acquired varying features in accordance with local needs[3].

Based on these assumptions, the article describes how are identified and received the needs of mental health for family health teams, according to the nurses conception.

METHODS

Exploratory descriptive study based in a qualitative perspective by using the semi-structured interview technique[4,5] for data collection. The research project was approved by the Research Ethics Committee of the Nursing School of Ribeirão Preto, University of São Paulo (Protocol No. 426/2010) and all participants signed a Free and Informed Consent.

Five nurses were interviewed from five family health teams in a city within the São Paulo State. We used a semi-structured interview, which is a strategy for collecting qualitative data that the researcher asks to the interviewee a series of questions, predetermined, but open[6]. The script of interviews had six questions about families with mental health demands and about team's organization to receive them. We included all nurses of five teams. The interviews were conducted individually in a private room of the health service. The interviews were recorded, transcribed and proceeded to data analyze, following five methodological steps[7]: compiling, disassembling, reassembling, interpreting and concluding.

After transcribing each interview (compiling) data reading and rereading were successive made. In the data deconstruction, the information was fragmented according to the issues to which they related. In the reconstruction, we considered the statements that referred to the same subjects and the data were coded and reordered, based on the patterns that emerged from the following fragments: mental health as a priority of the team; structure of the Information System Primary Care (SIAB) as limiter, team training, consulting and mental health; dichotomy completeness versus specialties.

Data interpretation was guided by three strategic recommendation of the Brazilian Ministry of Health regarding the inclusion of mental health services in primary care, namely: Matrix support of mental health to primary care teams; Professional training for implementation of the mental health services; Inclusion and mental health in the SIAB[2].

Mental health matrix support to primary care teams is described as an organizational arrangement to increase the capacity to resolve health problems and expand the clinic's local team, understanding "clinic expansion" as the rescue and recovery of other dimensions beyond biological and symptoms, i.e. incorporating psychosocial aspects[2].

Training as priority strategy for inclusion of mental health in primary care calls for courses and training consistent with the principles of the Psychiatric Reform and which intertwine with the support matrix in order to form lines of continuing education and in service[2].

The inclusion of mental health on the SIAB is considered strategic for assessment and health planning. Therefore, point out the need for reformulation, including indicators related to mental health, such as the problems of harmful use of alcohol and other drugs, as well as other mental disorders[2].

The two axes of mental health actions with development potential in primary care are: detection of complaints regarding to the psychic suffering and promotion of qualified listening to these complaints; dealing with the problems encountered, offering treatment in the own primary care or referral of patients to specialized services[8].

RESULTS

Regarding nurses, study subjects, all were trained for over eight years, mean age 39 years and with time

working in their services of four years or more. Three of the five nurses have postgraduate.

Based on the axes mentioned, the results were organized for presentation in two broad categories: "Identification of mental health demands" and "Reception of mental health needs", according to Figure 1.

In each of these categories were incorporated patterns resulting from data reconstruction, resulting in the flow of information shown in Boxes 1 and 2.

Box 1 shows the category and subcategories related to Axis I, which concern about ways of detecting complaints relating to psychic suffering

and promotion of qualified listening to these complaints. As can be seen, the results were: domiciliary visits by user spontaneous demand and demands identification of mental health to other concomitant consultation.

Box 2 gathers interviews discourse related to Axis II, namely: dealing with problems detected, providing treatment in primary care units or patients referral to specialized services. The results found, as can be seen below, were: psychiatric consultancy, team meeting, training and capacity building, listening, consultation, medication and referral to specialized services.
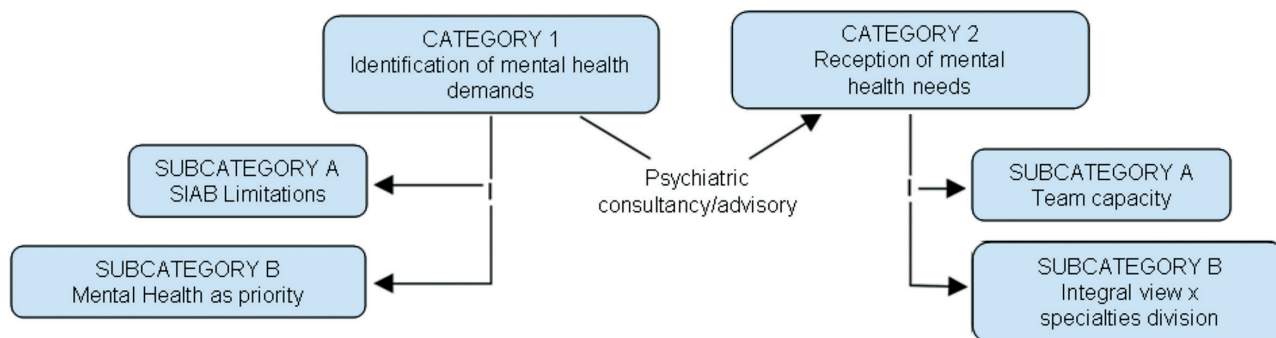

Figure 1 – Categories of study.

Box 1 – First category – Identification of mental health demands

	Subcategories: SIAB Limitations	**Mental health as priority**
Interview 1	"For effect of the official information system of the Ministry, you do not have this mental health indicator."	"When the Family Health Program was idealized, some priorities were raised for the service. These priorities did not include the mental disorder, because observation of day-to-day, many families that we caters present an interface with mental health."
Interview 2	"This [mental health demands] doesn't exist in the SIAB, it is one of the things that we questioned from the beginning, because actually many people have come. It is a disease that has grown absurdly, especially the depression, but we do not have where to put it in the SIAB."	"All of us identify it [mental health demands]. The community agent identifies it at home, nurses identify in the reception, the physician identifies at the clinic, and then we do everything."
Interview 3	"In the SIAB does not have this data (...)We have many cases of mental illness, but I can not tell you how many cases we have in numbers currently. (...) Even so, the agents take note... But, in time to add, we do not have in the system."	"For example, they [community agents] make their visits and identify any changes or the patient complains at their houses, they pass it to us in meetings."
Interview 4	"The SIAB is very controversial about it. He has mental illness, but does not appropriately accept depression." "The bedridden is also not included in the SIAB, we put them there, for considering them an important problem (...),we did that [an internal framework of the agents in the room] so to facilitate home visits."	"There are many people coming by spontaneous demand, for example, for suicide risk. I think that this is important for the unit, because the person can communicate that she has that ideation (is sign that it is linked), I think this is a positive point for the team. Then [the family health unit] is not just for cough, fever and malaise, they are there for psychological discomfort, also the door is open and people come."
Interview 5	"In the SIAB, [mental health demands], it does not appear this information, we know that there is a huge number, but I do not know how to speak, because there is no an information system of registration so we can't quantify this."	"...I can not tell you "in the family 3, at microarea 4, there's a person who has a mental disorder" I know there's a pregnant woman in the family X, I know that there's a diabetic in the family Y, I know that there is hypertensive patient in family Z, if you have a person with tuberculosis, I'll know which family is, but for mental disorder, I cannot know."

Box 2 – Secund category – Reception of mental health needs

	Subcategories: Training Team	Full view x division into specialties
Interview 1	"All professionals involved in the PSF team need training, [mental health] each in his degree of responsibility and technical competence has to know (...) is he a janitor? Does he work here? Each of them has to know how to act, agent, aide, nurse, the doctor, it is a necessity."	"When you propose to care about the family health with a extended clinic you will look at the person as a whole (...) she will be known like this: "Look, she has a diagnosis of diabetes, she has a diagnosis of major depression, she has a diagnosis of personality disorder", she will be identified that extended clinic." "[Some cases] one arrives at the conclusion that it is necessary to manage by the specialty, but most have done only until here (...) some serious cases were followed here for a while and then realized that it was necessary to forward."
Interview 2	"There are the mental health consultancy from the start of our work (...) 1h30, 2h, once a week, the psychiatrist comes and gives guidelines. When he does not come, the residents from the 3rd year show up and they also help in the attendance as well as on giving guidelines on how to deal with these people."	"We discuss with the mental health staff to know if we could handle without the help of consultants, if they understand they need specialized care they do the scheduling."
Interview 3	"One of the resident doctors had trained community agents and nursing assistants. He gave a short training (...), so that they remained more sensitive, had a greater sense of the cases that were going on here and so they would know how to deal with patients who seek this service."	"In the scheduled consult, the patient comes to lose weight or to control hypertension; he or she is identified if having any disorder or emotional change, then we immediately begin the service as well as treatment." "We've had patients at home in psychotic break, we did visit, medicated the patient at home and regulate but the family did not want to wait [specialty center] and they were waiting a vague for a week. We just could not intern the patient, we kept monitoring in primary care."
Interview 4	"All residents, when they turn one year of course, which I also did, so they can identify these issues on the user and know how to handle them. So we all have some training."	"In all my visits, I try to address the issue [mental health]. It has happened many times to have a consultation to reap a cytology, and it turned into a mental health consultation of sorting. So, no problem, I just explain to her: 'I can not do two things in one attendance, just because I do not have time for that' (...) then many Papanicolaou queries (...) they exchange : 'look, so if I can not do the cytological examination today and I can talk about it [the emotional aspects] I prefer." "When the need is for a more intensive care, you have to refer [to specialties and hospitals] ... We make a great effort to meet as much as possible and so to have good and successful stories."
Interview 5	"Once a week, the psychiatrist comes here on the unit and discusses the cases with the team, on the idea of continuing education and gives support to staff in the diagnosis and monitoring of persons with psychiatric disorders."	"She's coming for baby's nursery, but I'm looking for the baby's mother that has depression symptoms. Mental health is in the midst of everything, there's no way to say "now, I'm only seeing the mental health and I will not see anything else." (...) If the person has a mental health disorder along with other issues then it will be seen that the query is a query in full."

DISCUSSION

The approach of the demands for mental health primary care team consists of a powerful marker that indicates the practical incorporation of expanded concept of disease process, moving from a role based in the "complaint-conduct" for intersectoral action and articulation with community resources [8].

The data show that the interviewees are aware of the importance of integrating mental health services in primary care and for this reason, they understand that the team must be sensitive to this demand. The identification of the demands in the services studied (Box 1), despite considering mental health as an important aspect, the testimony of the interview 5 denoted a perception that prioritizes other medical conditions (such as diabetes, hypertension), i.e., mental health issues are considered secondary to other priorities listed by the team, although there are many psychosocial aspects involved in those diseases.

The fact may be related to the history of the implementation of the Family Health Strategy, as the PACS, established in 1991, and subsequently, the FHP in 1994,

were the first initiatives of the Ministry of Health to change the care organization health with emphasis on Primary Attention. Such initiatives were associated with the action of the federal government to address the high rates of infant morbidity and mortality and some epidemics of northeastern Brazil, then extended to priority areas of greatest social vulnerability [9,10].

On the other hand, the other statements (Box 1) describe the service as sensitive to psychological demands, as well as other disease situations, emphasizing spontaneity of patients in communicating their psychic needs.

The fact that the Information System of Primary Care (SIAB) does not have a specific indicator for the demands of mental health issues, the most common, was appointed by nurses as a weakness that holds back the systematization of the specific demands of mental health issues within the territory (Box 1) .

Whereas SIAB has indicators of diabetes, hypertension, pregnant women and children, which facilitates the location and survey of families with these needs. But in the case of mental health, this is not a reality.

The inclusion of mental health in this system appears to be the teams urgent demand . This type of indicator is important for planning of health actions, at local level as well as for making decisions related to health policy at the federal level.

Despite this legitimate criticism, on the form of the SIAB, on the item diseases listed there is the option "alcoholism"[11] which is also a mental health condition, but that was not mentioned by any of the respondents.

We observe, based on the results, that SIAB acts as much as a base of the actions as it serves as a pretext for the "inflexibility" of the team in relation to local specificities. The lack of a System of Information indicator can not be a justification for not systematizing the care to a specific demand, which is identified in the territory. There is an exemple which shows that changes independents of the system can be inserted, i.e., the inclusion of bedridden in an internal control team, when it suited them. (Box 1, interview 4).

Another consequence of the lack of mental health indicators in the SIAB is the issue of epidemiological underreporting , noting that some specific mental health indicators were implemented as a result of the Pact for Life (coverage rate of CAPS/100.000 inhabitants and coverage rate of the Program back to Home), however, mental health in primary care was not provided, although there are already proposals to this end [8].

The need for training of the staff appeared as an important aspect for accommodating the demands of mental health nurses understand that training is strategic for the expansion of clinical teams and therefore a constant need (Box 2).

Given this, the nurse demonstrates key role with other professionals that are under their supervision,

namely those who are the community health agents and nursing assistants.

The lack of training to deal with mental health problems produces great psychological distress and undermines the outcomes of intervention [12]. On the teams studied, beyond the capacity building made by doctors and nurses for the consultancy was also mentioned as a way of effecting the proposed continuing education.

In addition to instrument training, consultancy was described as an important strategy to accommodate the demands of mental health. Such consulting is accomplished by a psychiatrist and a nurse, both linked to a higher education institution of a public character. They provide care set (staff-consultants-resident-patient) and discussion of the cases considered more complex, aiming to instrumentalization of staff on this issue.

The psychiatry consulting and liaison on the health teams of studied family is a pioneer situation in the municipality, however, this initiative is restricted to services that have agreements with the institution of higher education which consultants (physician and nurse) are linked.

The presence of a nurse in the consulting team allows an approach more tailored to the skills and reality of professional and corroborates the proposed interdisciplinary guidelines recommended by the Guide to Specialist Orientation Ministry of Health [13].

Therefore, it is understood, that there is need for this arrangement to be institutionalized as a process of care within the municipality, that is, formalized as a matrix support for local managers to be extended to other basic health units. That certainly promote the empowerment of teams to meet growing demand for mental health in primary care. Within nursing context, it would be translated into an expansion of knowledge and practice of technology and increase psychosocial work.

The consultation-liaison psychiatry, in its beginnings, has emerged as a strategy to integrate psychiatric intervention in general hospitals; under strong influence of Social Psychiatry and Psychosomatics, included clinical support services, education about mental health and psychosocial aspects of residents and students medicine aimed at coordination between the services (specialized or not), seen as essential to the continuum of care [14].

The consultancy is the presence of a specialist in psychiatry or general service unit, upon request of a professional from another specialty, to assess and indicate the specific treatment. Such connection relates to a closer link between this specialized professional and the staff who spend their share of meetings, discussions and care [15].

The idea of matrix support emerges as a proposal to overcome the logic of consulting and connection proposing the empowerment of teams the exchange

of knowledge, expansion of listening and joint construction of new ways of dealing with the subjectivity of users, aiming to deal with the professionals all of these subjects [14]. This arrangement is guided in sharing cases, the co-responsibility, stimulating discussions and joint interventions and gradually expanding the interdisciplinary clinical team [2,13].

Thus, with regard to the reception of mental health needs on health teams of the studied families , it is a fact that is subsidized by the consultant psychiatrist who works along the lines of matricial. Generally, it is understood that through this support, the teams are instrumentalized for individual care, home visits, meeting demand spontaneous, consultation and monitoring with specialized professional reference. These results corroborate several studies that link the matrix support in primary care as an important resource in promoting coordinated actions of health care by providing rear and exchange of knowledge, enriching the practices and providing the connection to the network of care [16-18]. Moreover, the matricial has been pointed out as a possible arrangement with management potential to extend clinical interdisciplinary teams [19].

Either the PACS and the PSF have a proposal to take the family and community, as the organization guide of health care, taking responsibility over the territory by continued attention, intersectoral and resolute instead of the traditional approach centered on individual disease [12].

While assuming this notion of expanding the clinic and the concern of integrating the mental health care with other health needs, there is some ambiguity in the speech of those workers who conceive attendances within a proposed comprehensive care, but as they present dichotomic speeches regarding the integral vision versus division into specialties (Box 2, interviews 4:01).

As shown in the results, nurses describe that they recognize and prioritize these demands, however, they have no mapping of cases or a more systematic survey of families with mental health needs, indicating that there is no specific therapeutic project to the service / reception and accompanying this demand.

It is understood the therapeutic project as a proposal for interventions, therapeutic goals and evaluation of results for a given demand. It consists of a structured process that includes aspects related to care management and planning of a technology, knowledge and modes of action that support caregivers actions in order to meet specific health needs within a proposed humanization [20,21].

The active surveillance appears as a central aspect of the strategy for the consolidation of family health andaccording to the nurses, either the home visit and the spontaneous demand consists of hosts flow for the demands of mental health (Box 1, interviews 2, 3 and 4).

The reports suggest that the identification and host actions show up as parts of the same process. Thus, there is consideration of the case, assessment of approach possibilities on service and decision making with regard to maintain care on primary care or forwarding it to specialty (Box 2).

According to the nurses, primary care must be responsible for cases considered "mild". The management of the most complex is touted as "exception", because they understand that these patients should be referred to specialist services (Box 2).

The main challenges and weaknesses of the PSF are related to their own Health System vulnerability , i.e., as marks of a fragmented system with few links between services and actions disintegrated, and the unequal access to different levels of care, in other words, there is a lack of organizational support tools for resolution and / or referral of users' needs [8-9]. In the context of mental health, the the reflexes are the same that are also producing a gap between the devices of mental health.

The results suggest that the implementation of strategies on primary care to prevent hospitalization do not result from a specific therapeutic project underpinned by the psychosocial rehabilitation, but of an arrangement by the team because of a lack of beds or referral difficulties. That is, these gaps on the flows of reference-versus-reference , quite often have "forced" the primary care teams to create new hosting processes and care given to the mental health needs, both considered as the most serious as well as the lightest, which require consulting.

CONCLUSION

Despite all the caveats in relation to the way that mental health services are being inserted on primary care, based on this study it may be suggested that this inclusion have been gradually happening and certainly the psychiatry consulting and connection play an important role its insertion. However, nurses recognize the need for continuing education and continuing under the mental health clinic to extend the logic of integrated care on primary care and emphasize the urgency of revising the SIAB indicators . Above all, it is necessary the creation of therapeutic projects systematized and creativity and the willingness of staff to new ways of caring that overcome the dichotomy completeness versus division into specialties.

Limitations of the study include that the data were restricted to the nurses view. Further studies will be undertaken with coordinators, community health workers and users of their units to expand the possibilities of analysis.

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