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Mental health actions in Family Health Strategy: Family expectations

Ações de saúde mental na Estratégia Saúde da Família: Expectativas de familiares

Acciones de salud mental en la Estrategia Salud de la Familia: Expectativas de familiares

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Abstract

Objective: To understand the expectations of relatives of users with mental disorder participants of the Family Health Strategy (FHS), in relation to mental health actions. **Methods:** Qualitative research, using the context of Phenomenological Sociology. Semi-structured interviews were conducted with 12 family members of two units of FHS in Porto Alegre, Rio Grande do Sul, in 2010. Comprehensive analysis was used for the interpretation of specific categories: having support from the FHS staff; and have the FHS team's attention. **Results:** Family members have as expectations to have a genuine social relationship with FHS team to share their experiences, serving as support to overcome troubles, anxieties and feelings of impotence in the face of adversity to live with a person with mental disorder. **Conclusion:** The intersubjective relationship is an important aspect for mental health care in FHS, requiring more investments from the team.

Keywords: Mental Health; Primary Healthcare; Family Health Strategy; Family.

Resumo

Objetivo: Compreender as expectativas de familiares de usuários com transtorno mental da Estratégia Saúde da Família (ESF), em relação às ações de saúde mental. **Métodos:** Trata-se de uma pesquisa qualitativa, com utilização do referencial da Sociologia fenomenológica. Foram realizadas entrevistas semiestruturadas com 12 familiares de duas unidades de ESF de Porto Alegre, Rio Grande do Sul, em 2010. Utilizou-se a análise compreensiva para a interpretação das categorias concretas: *ter apoio da equipe da ESF*; e *ter atenção da equipe da ESF*. **Resultados:** Em essência, os familiares têm por expectativas ter um relacionamento social genuíno com a equipe da ESF para compartilharem suas vivências, servindo de suporte para superarem angústias, ansiedades e sentimentos de impotência frente às adversidades de conviver com uma pessoa com transtorno mental. **Conclusão:** A relação intersubjetiva é um aspecto relevante para o cuidado em saúde mental na ESF, necessitando de maiores investimentos da equipe.

Palavras-chave: Saúde Mental; Atenção Primária à Saúde; Estratégia Saúde da Família; Família.

Resumen

Objetivo: Comprender las expectativas de familiares de usuarios con trastorno mental participantes del Programa Estrategia Salud de la Familia (ESF) con relación a las acciones de salud mental. **Métodos:** Investigación cualitativa, con utilización del referencial de la Sociología Fenomenológica. Fueron realizadas entrevistas semiestructuradas con 12 familiares en dos unidades de ESF de Porto Alegre, Rio Grande do Sul, en 2010. Se utilizó el análisis comprensivo para la interpretación de categorías concretas: apoyo del equipo de ESF; atención del equipo de ESF. **Resultados:** Los familiares tienen la expectativa de tener una relación social genuina con el equipo de ESF para compartir sus vivencias y recibir soporte para superación de angustias, ansiedades y sentimientos de impotencia frente a las adversidades de convivir con una persona con trastorno mental. **Conclusión:** La relación intersubjetiva es un aspecto relevante para el cuidado en salud mental en ESF, necesitando de más inversión por parte del equipo.

Palabras clave: Salud Mental; Atención Primaria a la Salud; Estrategia Salud de la Familia; Familia.

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INTRODUCTION

The Brazilian National Policy on Mental Health has advocated, in recent decades, the need to approach the relatives of users with mental suffering or mental disorder, attended by health professionals, especially with the publication of Decree 3,088/2011, that establishing the configuration of services of psychosocial attention network[1]. The relevance of this approach is evident in territorialized services such as Psychosocial Attention Centers and the Primary Healthcare services, due to its proximity with the routines of people.

With the proposal to replace the asylum model (hospitalcentrics, focused on the disease and knowledge/medical power) by the psychosocial care model (network services, centered on the care of the subject and on an interdisciplinary and intersectoral perspective of teamwork), the mental health politic has among its aspirations to overcome the exclusion of family members of the users with mental disorders, welcoming them and supporting their health needs[1].

It is recognized that the family members of users assisted on Family Health Strategy (FHS) have an idea that mental health care, in this context, is the doctor's responsibility, for being this professional the holder of the necessary knowledge to answer their expectations[2], generally underpinned in the prescription of psychotropic drugs.

On the other hand, rarely family members seek or receive enough information to handle with their relatives with mental disorder, generating uncertainty as to the best way to take care of this patient[3]. In addition, many are disadvantaged because in some contexts, FHS professionals do not recognize/know the mental health needs of the people and consider it the sole responsibility of the families of users with mental disorders to search for health service[4].

When performed, the mental health actions of the FHS team have often been conducted in a climate of prejudice about the madness, leading to the implementation of specific and fragmented actions and, eminently, biomedical (focused on the disease and in the elimination of symptoms)[5].

In contrast, guidance and support to the family members have proved essential, therefore, they favor the understanding of the situation and contribute to treatment adherence[3]. In addition, other FHS contexts have revealed the recognition of the family as the requirements of a mental health assistance built from its link with the FHS, noting that this way of acting brings tangible results to people's lives[6].

It is understood, therefore, that the FHS can contribute decisively in the construction of psychosocial attention to the user with suffering or mental disorder, since the comprehensive care in partnership with the family reflects the proposal of deinstitutionalization and territorialization in mental healthcare[7].

This study aimed to understand the expectations of family members of users with mental disorder in relation to mental health actions developed at FHS.

The FHS scenario is an important space for the promotion of mental healthcare, for being a territorialized health unit and having the family as its focus of care, being necessary, therefore, to hear their expectations about mental health assistance in the FHS. This understanding can contribute to the construction of mental health actions in the ESF, welcoming the needs expressed by the family members in favor of the consolidation of the model of psychosocial care.

METHODS

This study is a qualitative approach and it is snipped from the doctoral thesis "Actions directed to mental health in the Family Health Strategy: intentions of the team and expectations of users and their families". It has as theoretical-methodological referential the Phenomenological Sociology of Alfred Schutz, turning to the understanding of the lived experience of the subject and their motivations from the meanings assigned by themselves to their actions[8]. It is recognized as such that sedimentation of all the experiences lived by the subject until a given moment of its existence, is defined as its biographical situation, and serves as a reference code for their motivations and actions in the social world[8].

The identification of the meanings of these individual motivations enables the description of the typical characteristics of the action[8] of the group as a whole, that is, allows to describe the motivations of the relatives of users with mental disorder to seek assistance in the FHS, revealing their expectations related to mental health actions in this scenario of care.

When looking at the motivations in a future perspective, it is revealed the *reasons for*[8] the subjects, as the intention of each one to perform a given action with goals to achieve. The description of this set of perspectives and network of action motivations enables to build the typical of action[8] of these subjects, as a social group, it means, to understand how they act, considering their expectations in relation to the mental health actions in the FHS.

The study was conducted in two units of the Family Health Strategy (FHS) located in Porto Alegre, Rio Grande do Sul. The choice of the field of study was intentional, because in these units occur practical activities of mental health disciplines of undergraduate degree in nursing from a public university.

The FHS units studied provide care to the population of its area covered by medical and nursing consultations and health education groups (hypertension, diabetes, pregnancy, among others) and activities related, mainly to women's and child's health programs. There are offered services such as vaccination, bandage, nebulization, medicine administration, blood pressure

measurement and dispensation of medicines. Generally, of the socio-economic point of view, the community is marked by characteristics common to the peripheries of large cities of the country, where violence, drug trafficking, unemployment, precarious living conditions and poverty are emblematic.

The main actions of mental health carried out by the FHS professionals are individual consultation, group therapy, homecare visits, attentive listening, orientation, hosting, professional experience report and targeting cases to the FHS[5] team. In addition, a mental health team of the district, where these units are located, supports some of these actions, helping professionals in therapeutic decision making through discussion and evaluation of cases.

Semi-structured interviews were conducted with 12 family members between May and June of 2010, using the following guiding questions: How has the FHS team contributed to the treatment of your family (and for you)? What do you expect from the FHS team? The inclusion criteria of the participants were: have 18 years of age or older; be the most involved family member in care of a user with mental disorder assisted by FHS; and resident in the territory of the ascription of FHS. It is important to mention that in this study, it is understood that family is a network of people who derive from a large social system that interact for various reasons, joined by different bonds, affinity, consanguinity or descent, and occupying the same environment[9].

Participants of this study were accessed from the indication of FHS team and the validation of this information to the user with a mental disorder as its family member, which fulfilled the inclusion criteria. The place where the interviews were performed was the most convenient for the participants in the study, and among the 12 relatives interviewed, seven were visited at home and five attended the FHS units.

The closure of conducting new interviews happened at the time that was observed repeating in the content of the answers of the interviewees about their motivations - 'reason-for'- "What do you expect from the FHS team?". The interviews were recorded and transcribed, fully, for further analysis and interpretation. And to preserve the anonymity of respondents each was coded with the letter "F" and the sequence number of the interview (F1, F2 to F12).

For organization and categorization of results and, more specifically, regarding to the phenomenological question, we employed the following steps[10-12]: sequential, detailed and exhaustive reading of the interviews, seeking to identify, among others, the significance of units of action, grouping them according to their similarities, allowing locate specific categories of lived action. This process of emerging meanings of action and identification of concrete lived categories of action involved the identification of the *reasons for* of the subjects to look for the FHS, converging on the description of the typical characteristics of the significance of the action (the typical of the action of the family).

This study was approved by the Research Ethics Committee of the Municipal Health Department of Porto Alegre (number 001.015735.10.9) and all the participants signed the Term of Consent before the interview.

RESULTS AND DISCUSSION

Of the 12 family members interviewed, seven are women, and eight have age of 50 years or more (mature adult). The main types of relationship and/or affiliation between the relative and the referred user were wife/husband, daughter and mother, reflecting the importance of the kinship relations in the involvement of user care of FHS. In situations related to their mental health, most of the families look for support on FHS team, both of Community Health Agents ("CHA") or health professionals of the FHS.

Following the analysis steps, emerged from the speeches two specific categories of lived action: *having support from the FHS staff*; and *have the FHS team's attention*.

Comprehensive Analysis

In the category *have support from the FHS staff*, family members have, by expectations, the meeting of their demands and, above all, to the user, through guidance, medical consultation, medication, homecare visits and referrals.

Family members seek the FHS team (CHA and health professionals) in order to receive aid for themselves, for the user and, when necessary, for their other family members. Thus, their interests are directed so that their own demands are met, and, above all, the demands of their relative with a mental disorder.

> *They [wife and mother] always when they need they are helped. [...] [I hope] whenever they need, they assist them well. (F4).*
>
> *We come here and is right we can [have consulting], both for me and for him. (F8).*

This sought aid is achieved when the team guide the family members about the healthcare with its relative with disorder (food, medication and dealing with crises), when the families receive home visits, have medical consultation, gets referrals to specialized services and when they are accompanied by the team regularly.

It is observed that the expectations of family members and the mental health actions offered in the FHS, are configured as reasons to establish health needs, because, on the one hand the families present demands and, on the other hand, the service of the FHS, through technical knowledge and professional action, establish demands and consumption (supply)[13]. This relationship is evidenced, for example, in the responses to the demand of families when the team requests exams, conducts prescription and provides medicine (supply).

[...] When she had an outbreak, we had enough difficulty [...] it is not clear how to take care of these people [...] and they always helped us [...]. They always guide. (F1).

The drug. When we need, we go there. (F2).

With medication, how to do with food [...] examinations they refer. (F9).

The staff is very good, they go home to visit. (F10).

The clinical treatment provided by the FHS team is recognized by family members as a way of promoting mental health professionals in the territory[2], since the use of the existing care technologies is according to the needs of each one[13]. However, the use of medication, while a care technology, for example, has taken on too much importance to the detriment of other aspects of mental health assistance that could be articulated for treatment, such as leisure activities, sports and culture now available in the territory[14].

The FHS team should not be restrict to their actions to mere reproduction of the biomedical model of care, since in the context of primary healthcare, the health work perspective has, among its aspirations, to overcome such reductionism in favor of psychosocial care model.

In this way, health policies have strengthened this reorientation of healthcare through the matrix support, having among its basic prerogatives the support of a specialized team to the staff of FHS and the primary attention, both in the care aspects, sharing direct assistance, when necessary, regarding to the technical-pedagogical aspects, giving educational support to the team[1,15].

In the context of mental health, this type of organizational arrangement has provided: better communication between professionals-users-managers; an increase in co-responsibility and strengthening of the bond; the overcoming of medicalized practices of users (curative, individual and hospitalcentrics); and an appreciation of the role of the CHA and the Family Health Support Centers ("FHSC")[15]. Although, there is the support of a specialized team for the FHS staff in the context studied, this interface still looks incipient, since the family members are unaware of and do not even know the possibilities of this type of work in the territory of FHS.

The search of the relatives for the FHS team's attention reflects, at the same time, the interest in taking care of their own health and to provide better assistance to their family member, user of FHS with mental disorder. These expectations are related to the biographical situation[8] of these families, often characterized by the overload experienced in living with a person with disorder, especially when requesting team orientation to deal in crisis situations, monitoring the medication and watching this familiar.

They are always willing to help [...]. Always guide. (F1).

[...] They are always there, at my home, [...] They are always charging us "have you been there to get the medicine?" (F9).

I think it would be important to monitor the cases, continue visitations. (F3).

The interaction with the user is often a major problem for the family members due to additional financial burdens, in family routines, in the manifestation of physical and emotional illness of its members, in the restriction and deprivation of leisure activities and social relations changes, given to the stigma of the user with mental disorder[16].

Therefore, it is necessary to insert the family in the assistance process of users, with the health team devoting care to the families, supporting them to better conduct their lives. This family support provides continuity of care for users, particularly in health services in the community, because they are closer to their homes.

The FHS provides a continuous and longitudinal contact with the users and their families, contributing to the comprehensive care due to identification of an assigned area, the registration of all families and recognition of the needs of each user and family, even when the user is conducted to other services[17].

However, the provision of care by the team should consider both the needs of the user, as the family's needs, integrating the care and strengthening the bond between its members[14]. That is because the users' mental health promotion is related to the role of the family, because it is responsible for the values, beliefs, knowledge and practices of the family group, serving as a reference for guiding the behavior of its members. These aspects are relevant to the reflections of mental health actions in the FHS, since it corroborates the construction of the psychosocial model.

The FHS staff is important to the consolidation of psychosocial care in the territory, since they adopt a friendly attitude, listening and building links with users and their families. These characteristics are the starting point for the team to act in the context of geographical and existential territory of the subjects.

For the family members of this study, an important way to promote the continuity of care in the territory occurs through domiciliary visit, especially those carried out by CHA, because they meet the people in their households more frequently to monitor the health situation of the subjects, inviting them to participate in activities on groups of FHS and perform scheduling of appointments.

They [CHA] always call the mother to do something there, to occupate her time. (F5).

There is an agent who comes down here, visit the houses to see how everything is. (F12).

The domiciliary visit has provided the meeting of these subjects with the reality of suffering of the user, where respect and coexistence with differences have been the principal focus[6], and also serving as instrument of approach and favoring the bond[18].

Although the home visit is an important strategy of continuity of care in the territory, it can at the same time, favor or compromise the integrity of the care of users in FHS, depending on how it is conducted by the team. The visit favors comprehensive care when establishes and strengthens the bond between user-staff and user-family, however, it compromises the comprehensive care when it is held only for one user and not for the family, and the user is seen in isolation, and detached from its context and family relationships[17].

The visit provides the closest contact with family members and users, promoting the relationship of trust and credibility in the team work. This involvement with families allows to know in fact the biographic situation[8] of its members, especially, of the user and the relative more involved with its care. This is evident when the families talk about the team:

> *[...] They also treated me very well, they know me since I was a kid. (F5).*
>
> *[...] Sometimes she [user] cannot come here [FHS], I bring my exams, then she [doctor] transmits for me, if it have a problem or not (F9).*

The fact of knowing the people in the community and their stories is important for a better understanding of the situations experienced by them, revealing, in part, the world social interpretation codes used to act socially, it means, revealing the probable reasons that drive their actions[8]. This understanding favors the recognition of the specific health needs of family members, serving as a resource for planning actions to be worked by the FHS team.

In the category *have the attention of the FHS staff*, family members have the expectations to get a *face to face* relationship in which their experiences are shared, recognized and valued in the FHS.

Family members reveal the expectation of establishing a direct social relationship with the FHS team, which in Phenomenological Sociology referential represent an intersubjective relationship experienced in face to face, namely, mutual recognition of singularities and the particular interests of those involved in social interaction[8]. This kind of relationship is revealed as they report the "conversation" as a therapeutic resource key.

> *It has helped to give me strength, and conversation help [...]. [I hope] that they continue helping [...] participating and talking. (F2).*
>
> *They [CHA] talk to me a lot, give me support. [...] They [FHS team] help me to help my mother, they also talk to my mother so she can help me, one helps the other. (F5).*

Learning and exchange of experiences, from an intersubjective relationship, have been singled out as important expectations of relatives with mental health treatment, to meet their needs[19]. According to family members, this conversation has as characteristics, active listening, the welcoming and the responsibility that the team dedicates to both families and users. This type of relationship has strengthened and helped family members and users to face and overcome the difficulties experienced.

Another important feature of the relationship between the subjects regarding to the way the team interacts with the users and its relatives, especially when the guidance provided are explained "calmly" and when the professional adopts a friendly posture and proximity, principally with the user, allowing to be touched by him.

> *They give all the attention to me, [...] all I need [...] they explain it calmly. (F7).*
>
> *She [doctor] let herself be touched because, normally, people do not allow themselves to be touched by people who are sick [mental] and I noticed, and she permitted. (F11).*

The action of touching the other person can be considered a communicative tool that favor the professional-user interaction. Along with the listening, the touch can serve as a support for the user, especially in delicate situations in which the professional understand that the use of words is not enough to support the user. However, it is necessary that this feature be used carefully, as appropriate, in each situation (casual greetings, during the procedures, in situations involving compassion, comfort and grief) and with different people (moral, cultural and social values)[20].

The affective aspect, listening and reception of the user are considered by family members an important way of promoting mental health of these individuals, especially when they interact with the FHS team[2].

The Phenomenological Sociology shows that the findings described earlier, indicate the relevance of the intersubjective relationship, experienced in meeting *face to face*, as a potent promoter care strategy for mental health in the FHS. This is because it provides a familiarity relationship between the subjects, through a direct social relationship[8], closeness and mutual recognition of singularities, breaking with an impersonal logic of relationship between a healthcare professional with a mere individual with mental disorder.

On the other hand, the attention desired by families reveals the intention to establish a direct social relationship with a professional that meets both the users as their own families, because they refer to not feeling welcomed sufficiently within subjective or relational context.

> *I need a psychological support, I need a psychiatrist. (F3).*
>
> *The family also needs to talk. (F11).*

To live with a family member with mental disorder generates feelings of anxiety, anger, insecurity, fear and loneliness in the family that sometimes they feel guilty by the disease and anxious due to not knowing how to deal with the behaviors displayed by the sick family member[3].

By using verbs in the future tense - "I would like to" and "I should" -, the relatives express the expectation of a *face to face* interaction with a specialized professional to deal with issues related to mental health. Refer to the *psi* professionals (psychologist and psychiatrist) or even the nurse who takes care of the field of mental health issues, as the most suitable and qualified professionals to meet this need.

> *I think you should deploy at least two professionals who are in CAPS for attendance, a psychologist for family could talk, a psychiatrist, even if once a week, then it would help a lot, especially the family. (F3).*
>
> *I wish that we had a psychologist once a week to talk or a psychiatrist and even a nurse to come and participate, explain more the disease. (F11).*

Although the interviewed reported, above all, to professionals socially legitimized by tradition in *psi* area, essentially, they hope to have a space of relationship and meeting, where it will be possible to the family members to share their experiences, whether in a private area with a professional (individually) or on the collective level (group).

Nurses should be aware of the healthcare needs, both of the user and of his family member, since the latter usually are not covered by the health team. Thus, these professionals can appreciate the relationships family-user, nurse-user and nurse-family, acting for the well-being (physical, mental and social) of all, using, in particular, education activities in health of reflective character and unique, individually or collectively[19].

The assistance provided by the primary care professionals of mental health is still focused on meeting the needs of the user with mental disorder, especially the clinical needs, without family involvement[3]. To create opportunities to family members to verbalize anxieties, fears and doubts about the family member with mental disorder and their own suffering is important for the team to approach the everyday world of these people and expand the range of mental health action possibilities.

According to the family members, in the collective scope, group meetings can serve as an opportunity for them to learn more about mental disorder and know other people who experience similar situations in the FHS territory of context. Finally, it serves as a space where mutual support among its participants is the main focus.

> *The hospital offers a family meeting every Tuesday, so went there to talk, to listen to the other's problem. You know that yours is not the only problem in the world [...]. If the other has a son in crisis, everybody turns to that problem and you know that yours is okay, you have to take care and observe for your family member not reach that stage. (F11).*

Family members have the expectation that the FHS team know their experiences, promoting space to be shared, recognized and valued, by means of a *face to face* relationship of familiarity[8], it means, in a genuine intersubjective social interaction. So, the family members show that they need information and support to promote coexistence and the care of their relatives, being in tune with the reality experienced by them.

As a result, families expect their meetings with the team, be it individual or collective, and serve as support to overcome the anguish, anxiety, low self-esteem and the feeling of impotence to face the adversity[19]. From this perspective, work with family group must, above all, make sense to themselves, and the health professionals should be alert not to reduce this space of encounter and social exchange, to a mere lecture space on a particular theme.

The family member of a user with mental disorder values the exchange of knowledge with other family members who live similar situations in their daily lives. These care needs of family health (basic human needs and human adaptation, needs as ethical-moral expression and as subjective construction) should be considered in mental healthcare of the population, from a view, both interdisciplinary as for nursing[19].

The typical of action

The convergence of the meanings of the action expressed by the different *reasons for*[8] of the relatives allowed to capture the typical of action, namely, common expectations of the subjects to seek assistance from the FHS team, revealed by two concrete categories of lived: *having support of FHS team* and *have the FHS team attention*.

It can be said that, typically, when family members seek care from the FHS team, their intention is expressed by expectations of *having support of FHS team* to meet their demands and, above all, to the user, through guidance, medical consultation, medication, domiciliary visit and referrals; and *have the FHS team attention* through a *face to face* relationship in which their experiences are shared, recognized and valued.

FINAL CONSIDERATIONS

This study allowed understanding the expectations of family members with mental disorders who look for assistance in the FHS. By the using of Phenomenological Sociology was possible to trace the typical actions of these families, revealing the reasons for why they tend to seek care in the FHS.

Family members seek care in the FHS to solve their own demands, however, the tone of this search focuses on the demands of their relative with mental disorder, as it features more care needs, and contributes to the suffering of other members of family. This shows the need for the FHS services perform the mental health services that support both for users and for their families.

Regarding to the actions, the family expressed the need to establish a social relationship with the FHS team, especially when they seek a "conversation" with them. In essence, they have expectations for having a space for relationship and meeting, as it favors them the opportunity to share their experiences (individually or in groups), serving as support to overcome troubles, anxieties and feelings of impotence to adversity.

Family members revealed that the implementation of mental health actions involves not only *psi* professionals, but also all professionals of the FHS, including CHA and nurses. In addition to technical knowledge, they consider it important to have a space of interaction and genuine dialogue on mental health care.

This study shows the importance of the expectations of family members of individuals with mental disorders to the delineation of mental health actions offered by the FHS professionals, highlighting the intersubjective interaction, the group support, the role of the nurse in this context and the potential of matrix support on mental health in the FHS. These elements are important strategies to build the psychosocial care model in the context of the FHS.

The findings of this study should not be generalized, however can be compared to similar contexts. It is suggested to carry out further studies with the same reference, adding the perspective of users, professionals and managers about mental health actions in the FHS, as well as other approaches and collection techniques and analysis of information about these actions, to deepen this understanding.

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