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MENTAL HEALTH PRACTICES IN PRIMARY CARE FROM THE PERSPECTIVE OF PROFESSIONAL MANAGERS

PRÁTICAS DE SAÚDE MENTAL NA ATENÇÃO BÁSICA SOB A ÓTICA DOS PROFISSIONAIS GESTORES

PRÁCTICAS DE SALUD MENTAL EM LA ATENCIÓN BÁSICA BAJO LA ÓPTICA DE LOS PROFESIONALES GESTORES

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Objective: describing mental health practices in primary care from the perspective of professional managers. Method: this was a descriptive, qualitative study carried out between February and May 2019, using a semi-structured questionnaire sent to professionals who directly assist mental health users in 24 municipalities and an interview with a technician from a health region in Paraná. The data was analyzed using Bardin's content analysis technique. Results: the following categories were identified: risk stratification as a practice in mental health care services; the work of family health support center professionals; networking; therapeutic follow-up. Final considerations: the professionals' perceptions are heterogeneous, but there is a consensus on the fragility of the role of primary care in constituting an efficient and resolutive gateway and that risk stratification is often not carried out.

Descriptors: Health Planning. Health Personnel. Mental Health. Mental Health Services. Mental Health Assistance..

Objetivo: descrever as práticas de saúde mental na atenção básica sob a ótica dos profissionais gestores. Método: pesquisa descritiva, qualitativa, realizada no período de fevereiro a maio de 2019, mediante aplicação de questionário semiestruturado enviado aos profissionais que atendem diretamente os usuários de saúde mental em 24 municípios e entrevista com um técnico de uma região de saúde do Paraná. Os dados foram analisados de acordo com a técnica de análise de conteúdo de Bardin. Resultados: foram identificadas as seguintes categorias: estratificação de risco como prática nos serviços de atenção em saúde mental; o trabalho dos profissionais do núcleo de apoio à saúde da família; o trabalho em rede; o acompanhamento terapêutico. Considerações finais: as percepções dos profissionais

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são heterogêneas, contudo há consenso sobre a fragilidade no papel da atenção primária em constituir uma porta de entrada eficiente e resolutiva e a estratificação de risco, muitas vezes, não é realizada.

Descritores: Planejamento em Saúde. Pessoal de Saúde. Saúde Mental. Serviços de Saúde Mental. Assistência à Saúde Mental.

Objetivo: describir las prácticas de salud mental en la atención primaria bajo la perspectiva de los profesionales gestores. Método: es una investigación descriptiva, cualitativa, realizada entre febrero y mayo de 2019, mediante cuestionario semiestructurado enviado a profesionales que prestan atención directa a usuarios de salud mental en 24 municipios y entrevista a un técnico de una región sanitaria de Paraná. Los datos se analizaron mediante la técnica de análisis de contenido de Bardin. Resultados: se identificaron las siguientes categorías: la estratificación del riesgo como práctica en los servicios de atención a la salud mental; el trabajo de los profesionales de los centros de apoyo a la salud familiar; el trabajo en red; el seguimiento terapéutico. Consideraciones finales: las percepciones de los profesionales son heterogéneas; no obstante, se nota un consenso sobre el frágil papel de la atención primaria en constituir una puerta de entrada eficaz y resolutiva, y sobre la estratificación del riesgo, que muchas veces, no se lleva a cabo.

Descriptores: Planificación en Salud. Personal de Salud. Salud Mental. Servicios de Salud Mental. Atención a la Salud Mental.

Introduction

The implementation of public policies aimed at tackling financial, structural, operational and management challenges made it possible to consolidate the Unified Health System (SUS), focusing on Primary Health Care (PHC), in order to achieve a resolution of actions that promote, protect and recover health[1].

The national mental health policy was drawn up following the reorganization of the model of care for users, in accordance with the principles of the Brazilian psychiatric reform, seeking to break with the asylum model, aiming to insert users into the social environment, a process that requires occupation of the city, territories and community, with the implementation of new forms of care[2].

There is a gap between the demand and supply of health services for the care of Common Mental Disorders (CMD), given that "[...] their impact and prevalence have received little attention from public policies, and consequently from the health system, more specifically in PHC"[3:60]. Thus, the integration of mental health and primary care poses operational challenges which, if adjusted, can reduce costs and optimize mental health care in the healthcare network.

From this perspective, it is understood that mental health care in PHC has not been consolidated, despite the fact that the services that make it up are the gateway to the Psychosocial Care Network (RAPS), which was set up with the aim of strengthening them for mental health care[3]. In this sense, given its importance, if PHC, as the network's organizer and coordinator, does not play its angular role, its ability to resolve problems and organize health services contributes to the fragmentation of mental health care, low efficiency and effectiveness of the RAPS.

This study therefore asks: How do mental health practices take place in PHC from the point of view of managers? The aim was to describe the perception of professional managers about mental health practices in primary care.

Method

This is an exploratory, descriptive study with a qualitative approach, part of the master's thesis entitled Mental Health Care Network in a Health Region of Paraná. The inclusion criteria for the study were: working in the mental health area for at least six months and carrying out management activities that promote care for individuals in psychological distress. Professionals who were on vacation or on leave were excluded.

The researchers were not involved in the field of research and made prior contact by telephone, discussing the study and inviting people to take part. Twenty-four authorizations were obtained from managers, with only one municipality not agreeing to take part in the study due to the lack of an exclusive professional to deal with the demand from users of this profile.

Subsequently, the information was collected by the master's student, a nurse, between February and March 2019, by means of a questionnaire sent by mail to the managers of the mental health services already contacted. The questionnaires were also returned via courier to the 10th Regional Health Department, along with the signed Informed Consent Form. Respondents were given the opportunity to read their questions again before sending them to the researcher.

To complement the research, a face-to-face, recorded interview was carried out with a representative of the Mental Health Coordination of the 10th Regional Health Department of Cascavel, a mental health technician, who was also able to check his answers and modify them if he wished.

Thus, 24 professionals who coordinate mental health services in the municipalities linked to the 10th Regional Health Department and a representative of the regional management, a mental health technician from the central level, took part in the research.

The questionnaire used was designed with questions about risk stratification, services, work and therapeutic follow-up, items that should be considered in mental health care, both in primary and specialized care, for continuity of care, as well as open-ended questions to understand the professional's perception of the user's therapeutic follow-up in primary care.

The questionnaire was evaluated by five judges, who were not related to the participants in the research and who specialized in mental health, in order to correct the aesthetics and functionality of the data collection instrument. After critical analysis and suggestions, the necessary changes were made to the instrument.

Two pilot tests were carried out to validate the semi-structured questionnaire and check its reliability, validity and operability. To do this, two professionals were selected who were not taking part in the research, and the instrument was applied after prior contact for an in-person demonstration.

The information was analyzed after transcription using Bardin's content analysis technique[4], following the steps: pre-analysis; data organization and processing; inference and interpretation. The following categories emerged: Risk stratification as a practice in mental health care services; The work of professionals from the Family Health Support Center (FHSC); Networking; Therapeutic follow-up. These categories were predetermined by the questions that made up the data collection instrument.

The anonymity of the professionals was guaranteed and they were identified with the letter P, for professional, and the Arabic number, P1, P2 ... P24 according to the order in which they were returned; the central level professional was identified as G1.

Ethical precepts were observed in accordance with Resolution 466/2012 of the National Health Council[5]. The research was approved by the Research Ethics Committee under Opinion No. 3.053.977, Certificate of Submission for Ethical Appraisal (CAAE): 02330518.1.0000.0107.

Results

The participants were 13 psychologists, 6 nurses, 3 social workers, 1 physiotherapist, 1 pharmacist and 1 nursing technician. In the category on risk stratification as a practice in mental health care services, it was identified that the professionals who carry it out use the form implemented by the state of Paraná in 2014.

> [...] *standard mental health risk stratification form filled in by the psychologist*. (P16).

Stratification is carried out so that professionals can learn more about the patient and discuss them, planning management actions according to their needs.

> [...] *used from the first interview with the patient and concluded after some time of intervention and discussion with the team*. (P3).

Professionals who do not perform risk stratification reveal that there is a weakness in the role of PHC as an efficient and resolutive gateway for mentally ill patients. They commented that:

> […] *there is no specific protocol for this in the municipality* (P1).

> [...] *excessive spontaneous demand, lack of organization in the network and in the care of mental health patients* (P7).

They perceive a growing demand and concern about the lack of management for these cases, reporting that:

> [...] *The tool exists, but has not yet been used*. (P19).

The health region's mental health coordinator understands that professionals are unprepared to meet this demand. It recognizes that the role of the state is to provide training and guidance on the possibilities of mental health services and to strengthen PHC.

> […] *advising municipalities on the implementation of the policy, both to organize with them the implementation of services and to organize the flows, mainly focused on primary care* […]. (G1).

In the category of the work of NASF professionals, it can be seen that the service was presented as an important device, showing that the work of the team in some municipalities is multidisciplinary and interdisciplinary. However, the NASFs are still structuring their practices and the organization of care, as there are reports of activities such as:

> [...] *therapeutic groups, home visits, guidance for patients"* (P2). *Furthermore, "the PSF and NASF teams hardly ever meet. However, whenever necessary, we occasionally exchange information about the patient* (P3)

> [...] *the NASF is in the process of being set up, there is a lack of professionals to complement the team effectively*. (P13)

In the municipalities that do not have an NASF, the fragility of the professionals in absorbing the demand for mental health is clear, as they limit their care to the biomedical model, which focuses on the curative model, centred on the disease and the medicalization of the user's suffering:

> [...] *referred for consultation with a psychiatrist who works here at the PCC, and a psychologist, and when they need to be hospitalized, this is done via the bed center*. (P8).

The words of the region's mental health coordinator confirm the above, reiterating that:

> […] *this difficulty that municipalities have in managing Primary Care, it's something that recurs a lot*. (G1).

In the category on networking, it was observed that professionals prefer to work in a network and communicate informally or formally between services and through devices available in the municipality where they work. Others stated that they don't network but communicate informally or formally. However, some do not network or communicate between services.

The professionals who work in a network and expressed communication in a formal or informal way responded that they conceive of it only as a referral to specialized services, not recognizing PHC as a point of reception for the user in mental distress, because*:*

> [...] *in most cases, referrals are made and, after initial contact with the user, a meeting is held to study the case*. (P15).

In this scenario, comprehensive and continuous care becomes ineffective since fragments around organization and communication are present.

> *Fragmented networking, lack of commitment from some representatives of the care network*. (P6).

There was a lack of communication channels or an emphasis on discussing cases through electronic resources, informalizing user care and promoting psychological suffering:

> [...] *there is little communication due to the short time and turnover of network professionals*. (P9).

The professionals who said they didn't work in networks showed a lack of information on the subject, reporting that:

> [...] *there is no Psychosocial Care Network team nearby*. (P14).

In the category of therapeutic follow-up, all the professionals reported that the practice is carried out, either through manual written or electronic medical records, in practices such as:

> [...] *informal personal screening by the professional, risk stratification, follow-up in the integrated system, informal and formal referrals [through the NASF] to the Primary Care Center of coverage and electronic application* [WhatsApp]. (P6).

Discussion

Risk stratification for care management means recognizing that people have different degrees of risk and vulnerability, indicating different needs. Monitoring the most serious cases, group care and actions to prevent and promote mental health are important factors in discriminating the level of mental health care on offer and for organizing the actions of PHC as a whole to offer care to the population in its territory of operation[6].

Risk stratification can be used as part of the provision of mental health care in primary care, contributing to the management of care, i.e. the planning of user assistance, at an individual or collective level, in order to promote health in the psychosocial sphere[7].

Among the important limitations in the organization of PHC around the provision of care to users are: the lack of central management levels, the absence of protocols, deficiencies in actions for cases of chemical dependency, which imply the impairment of flows, identification, stratification and a safe approach to mental health cases[8].

In this way, the supply of services is based on the demand that comes to the service, and not on the real health needs of the population, which contributes to intervention only in cases of exacerbation of symptoms, understanding psychological suffering in the practice of cure, medicalization and centered on specialized services[9].

As a strategy for strengthening PHC and expanding its capacity to provide solutions, including mental health, the NASF was formulated based on an interdisciplinary apparatus, operationalized with a focus on matrix support for the Family Health Strategy (FHS) team and on the bond between professionals, with the aim of providing comprehensive therapeutic support to the stratified population, with the production of a singular therapeutic project[10].

This matrix support is configured as an enhancer of comprehensive mental health care and consolidation of intersectoriality, in which the multidisciplinary team elaborates the care, performs the joint consultation based on the assumptions of the expanded clinic, thus enabling the expansion of the psychosocial approach and the confrontation of attention only on spontaneous demand and treatment of exacerbations[10].

The essence of the NASF is to support the actions of the FHS, sharing cases and helping to organize the work, applying strategies in conjunction with the health services and sectors present in the municipality. However, corroborating the concept of health-disease in PHC as restrictive to the hegemonic model centered on the professional doctor and drug assistance, there have been distortions in understanding since the implementation of the NASF, seen as a way of financing specialties, detaching itself from the role of matrix support. As is the case in the 4th and 5th Health Regions of Paraná, these are challenges also faced in this region of the state[7].

However, some municipalities see the NASF as an important device, showing that there is a multidisciplinary and interdisciplinary team, focusing on group care and information exchange for user follow-up[11]. It is noteworthy that the primary care center and the FHSs that do not have the NASF, when attending to the user in psychological distress, refer them to specialized services, which poses a challenge for this service[12].

As an organizational proposal for mental health services, RAPS was created by Ministerial Ordinance No. 3,088 in 2011 to provide coordination between the health care points that attend to mentally ill users[13]. Since then, PHC has been the focus of efforts to implement and strengthen the networking proposal, established as a strategy to defragment the health service[14].

However, there is evidence of weakness in the organization of the networking process, identified in the use of informal communication, which occurs through technologies such as instant messaging via WhatsApp®, messaging, telephone,

email and cell phone. In this sense, in this form of communication, "[...] the passing of information is characterized as mere verbalism, which hinders action and dialogical reflection"[15:1541].

Therapeutic Accompaniment (TA) brought the proposal of inserting the user into the social environment with the help of the health professional, which should provide and contemplate individual needs, concomitant with the study of possibilities of coping with the daily problems to be faced by the user[16].

TA has come to be considered a clinical-political device and its synonym is the politics of friendship, with the aim of building new social relationships. It is a practice that addresses the different social spaces, with an emphasis on the Psychiatric Reform proposal, in a communal and subjective way, with unprecedented experiences, which must be noticed by the companion and the companion with a life project and supervision pre-elaborated by a multidisciplinary team[17].

In this context, welcoming and qualified listening are important characteristics, as they favor the bond between the user and the team, to provide internal and external activities that prioritize psychosocial rehabilitation with an emphasis on autonomy[18]. TA is not limited to the environment of the health center, hospital or outpatient clinic, but seeks to expand the territory of wandering beyond the internal space of institutions[19].

The municipalities surveyed showed a number of undefined mental health care practices, similar to other countries such as Portugal, in that superficial and poorly implemented articulation models coexist. Therefore, even with the National Mental Health Policy, there is still a weak implementation of the Integrated Continued Mental Health Care Network. Reports by the National Commission for the Restructuring of Mental Health Services in Portugal and in Europe show negligence in this area, leading to discrimination[20].

It is understood that mental health care in PHC, based on the regionalization of services, is weakened. This is because municipalities vary in size, service infrastructure and human resources qualifications. In addition, there is underfunding of the public sector, dependence on the private sector, difficulty in collaboration between municipalities and the multiplicity of coordination bodies, predominance of the biomedical model of care and fragility in the regulation of health work[21].

The study has limitations in terms of the methodology used, especially with regard to the data collection technique, since interviews would have made it possible to uncover other aspects in greater depth, such as the process and working conditions in mental health care. However, the research contributes to improving mental health practices in PHC by reflecting on the factors that weaken this care, as well as helping to strengthen mental health policies and improve client care.

Final considerations

The research showed that health professionals' perceptions of the organization of mental health care practices are heterogeneous. There was a consensus among the research participants about the fragility of PHC's role as an efficient and resolutive gateway. In this sense, health professionals recognize that a change is needed in the organizational way of working with mental health.

The organization of PHC work focused on spontaneous demand and not on the health needs of the population in their respective areas of coverage, which leads to intervention only in cases of worsening symptoms, reducing the possibilities of treatment and centralizing care in the proposal of medicalization as a response to psychological suffering.

It was found that risk stratification is often not carried out. This compromises the organization of comprehensive and effective user care based on proposals for individual and unique care based on collective planning. In addition, professionals do not feel qualified to work in mental health, a reality attributed to a lack of training.

Collaborations:

1 – project conception and planning: Marcia Makiyama and Gicelle Galvan Machineski;

2 – data analysis and interpretation: Marcia Makiyama and Gicelle Galvan Machineski;

3 – writing and/or critical review: Maria Lucia Frizon Rizzotto, Cintia Nasi and Bruna Tais Zack;

4 – approval of the final version: Gicelle Galvan Machineski.

Conflicts of interest

There are no conflicts of interest.

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