REVISTA ONLINE DE PESQUISA

CUIDADO É FUNDAMENTAL

UNIVERSIDADE FEDERAL DO ESTADO DO RIO DE JANEIRO • ESCOLA DE ENFERMAGEM ALFREDO PINTO

RESEARCH

DOI: 10.9789/2175-5361.rpcfo.v12.8388

CARE FOR CARRIERS OF MENTAL DISORDER IN PRIMARY CARE: AN INTERDISCIPLINARY AND MULTIPROFESSIONAL PRACTICE

O cuidado aos portadores de sofrimento mental na atenção primária: uma prática interdisciplinar e multiprofissional

El cuidado a los portadores de sufrimiento mental en la atención primaria: una práctica interdisciplinar y multiprofesionaleS

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How to cite this article:
Almeida DR, Soares JNC, Dias MC, Rocha FC, Andrade GRN, Andrade DLB. Care for carriers of mental disorder in primary care: an interdisciplinary and multiprofessional practice. Rev Fun Care Online. 2020 jan/dez; 12:420-425. DOI: http://dx.doi.org/10.9789/2175-5361.rpcfo.v12.8388.

ABSTRACT

Objective: to investigate how persons with mental disorders (MTP) are cared for under the Family Health Strategies in order to find out whether the professionals are secure in their performance. **Methodology:** this is a qualitative study, based on discourse analysis, carried out in the Family Health Strategies of a city in the northern region of Minas Gerais. Data was collected by means of a semi-structured interview. **Results:** We observe that the professionals feel insecure to act in this area pointing out deficiencies in the scientific theory and the lack of coordination of the network as the main difficulties. However on the positive side they share high expectations for the new tool designed to support a more holistic care: "the matrix *(matriciamento)*". **Conclusion:** there is a need to resolve the deficits in the scientific theoretical training of nursing professionals and to promote their continued professional development.

Keywords: Nursing Assistance, Mental health, Primary attention, Interdisciplinary, Multiprofessional.

RESUMO

Objetivo: conhecer como é realizado o cuidado ao Portador de Transtorno Mental (PTM) nas Estratégias de Saúde da Família, verificando se os profissionais estão seguros da sua atuação. **Metodologia:** trata-se de um estudo qualitativo, embasado na análise do

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discurso, realizado nas Estratégias da Saúde da Família de uma cidade da região norte de Minas Gerais; a coleta de dados realizou-se através de um roteiro de entrevista semi estruturada. **Resultados:** percebe-se que os profissionais se sentem inseguros para atuarem nessa área de concentração sendo levantados como dificultadores a deficiência na teoria científica e a desarticulação da rede, porém contraditório a esses surge uma nova expectativa: "o matriciamento" uma ferramenta implantada como apoio para a assistência que vem se tornando a principal arma para um cuidado mais holístico. **Conclusão:** há necessidade de reverter os défices na construção teórica cientifica dos profissionais da enfermagem assim como promover sua educação permanente.

Descritores: Assistência de Enfermagem, Saúde Mental, Atenção primária, Interdisciplinar, Multiprofissional.

RESUMÉN

Objetivo: conocer cómo se realiza el cuidado al Portador de Trastorno Mental (PTM) en las Estrategias de Salud de la Familia, verificando si los profesionales están seguros de su actuación. **Metodología:** se trata de un estudio cualitativo, basado en el análisis del discurso, realizado en las Estrategias de Salud de la Familia de una ciudad de la región norte de Minas Gerais; la recolección de datos se realizó a través de un itinerario de entrevista semi estructurada. **Resultados:** se percibe que los profesionales se sienten inseguros para actuar en esa área de concentración siendo levantados como dificultadores la deficiencia en la teoría científica y la desarticulación de la red, pero contradictoria a ellos surge una nueva expectativa: "el matriciamiento" una herramienta implantada como apoyo para la asistencia que se está convirtiendo en la principal arma para un cuidado más holístico. **Conclusión:** hay necesidad de revertir los déficit en la construcción teórica científica de los profesionales de la enfermería así como promover su educación permanente.

Descriptores: Asistencia de Enfermería, Salud Mental, Atención primaria, Interdisciplinario, Multiprofesional.

INTRODUCTION

Since mid-1980s, psychiatric care reform in Brazil has been inducing significant changes that are breaking paradigms and prejudices and promoting social reintegration of Persons with Mental Disorders (PMD) into society. Since then, this movement has taken a leading role in the struggle for a society without asylums and a more humane and holistic treatment of PMDs. Confirmation of May 18 as the national day of anti-asylum struggle is a milestone in this process.[1]

In 1988 with the creation of the Unified Health System (SUS), Mental Health (SM) became a part of the comprehensive care system and care model became more focused on the needs of the individual. Thus began the development of a new model and policy for patient care in this area of coverage called the model of psychosocial care. One of the first movements in favor of Brazilian psychiatric reform took place in 1987 at the II National Congress of Mental Health Workers, which brought a new vision regarding "madness" and professional practices in mental health.[2]

Throughout the 1990s, shortly after the implementation of the SUS and the approval of some state laws based on social mobilization in health, federal regulations established the territorial-based service network. In the 2000s, the Psychosocial Care Network was expanded to include, under Decree No. 7508/2001, primary health care network consisting of specialized psychosocial care composed by the modalities of Psychosocial Care Center (CAPS); support teams for the transitional residential care component services; urgent and emergency care; deinstitutionalization and psychosocial rehabilitation strategies; all indispensable networks in the constitution of healthcare regional services.[3]

In 2001, years after the national congress, the law 10,216 was sanctioned that guarantees the rights of people with mental disorders and orients the model of assistance to PMD based on the initial principles of the movements in the 1980s, making them a state policy.[4]

According to SUS policy, under the Family Health Strategies (FHS), it is the duty and responsibility of nurses to care for patients, even if they do not have a specialty focused on mental disorders because they are generalist professionals who must ensure comprehensive assistance to their patients in accordance with the principles of primary care. Therefore, it is within their competence to promote prevention and rehabilitation looking at the individual as a whole, considering not only their physical health but the biopsychosocial care of the patient and his family as well.[5]

A qualified health team conveys a more focused and directed help in response to the problems presented, highlighting the nurse's role in this interaction, placing it as a "key piece" of the Family Health Strategies, also emphasizing that the nurse must establish a bond trusted by the CAPS team to better assist the patient.[6]

With the implementation of a new care model, the nurse became a therapeutic agent emphasising psychosocial care differentiated in each care modality. This model transition is still recent so the difficulty in adopting this mode of care is noticeable, especially regarding its objective of working with psychosocial paradigms.[7]

Given the above information, this study aims to analyse how the care of PMD is performed by the nurse under the FHS, verifying if the professionals are secure in their performance.

METHODOLOGY

This research is a descriptive, prospective study with a qualitative approach based on discourse analysis, where it was possible through the interviewees' statements to verify how professionals analyze the assistance provided to PMD in their management.

Qualitative research seeks data from direct observation of the participant, collection and analysis of text (spoken or written) focusing on the interpretation and perspectives that the participant has in the situation under study. The data is preferably collected in the context in which the facts occur, and the analysis is developed during the survey process.[8]

The research project was elaborated and sent to the Research Ethics Committee approved by the opinion number 1.484.500, and all ethical precepts for conducting research with human beings were obeyed. The research was conducted in five Family Health Strategies (FHS) and in a Psychosocial Care Center (CAPS) in a city of northern Minas Gerais, chosen at random. Participants who participated in this

study are nurses, men and women. As an inclusion criterion, we chose nurses who provide assistance in these FHS and CAPS, with at least 6 months of work in these establishments. Only nurses who had no contact with a patient with mental disorder were excluded as well as those who were for some reason away from work activities in the last 6 months.

As support for data collection, an interview script with semi-structured questions was used. They were performed in the interviewees' own work environment, and these interviews were recorded and later transcribed in full. At first, an initial approach was made with the respondents to present the proposal and inform about the research, requesting their participation. Afterwards the interview was scheduled with those who agreed to participate. A priori, the interview was conducted by three researchers after signing the Informed Consent Form (ICF) by the respondents. The average interview time was 20 minutes. Thus, the discourses, their convictions through the speeches and the feeling that each individual expressed in their eventual answers were analyzed. For the discussion a central axis was established from which three categories emerged. Respondents are represented here by the codenames "E" followed by a numeral that only served to identify the sequence of the interview.

RESULTS AND DISCUSSIONS

The research participants were composed of 6 (100%) nurses of both sexes, among them 4 (66.66%) were male and 2 (33.33%) female, with an average age between 25 and 45 years old. Although they do not have specialization in the area of mental health, all provide care to patients with MD.

From the data collected, it was possible to infer an interdisciplinary and multiprofessional line of thought, a sine qua non practice for the care of PMDs, where they currently diverge and converge from nursing actions in mental health. From then on, the categories around which this paper establishes its discussion stood out, namely: i) the deficiency in the theoretical construction and its reflection on care, which is still much discussed in articles, but apparently without changes in practice; ii) the structural disorganization of the network, which demonstrates a weakness of the health system itself, and iii) matrix *"matriciation"*: a starting point for continuing education, this has been the main support tool not only in the conduct of clinical cases but also in the recovery / construction of knowledge.

Category I - Deficiency in theoretical construction and its reflection on care: *"Very little, very little, very little ..."*

The fear present in some professionals in dealing with cases of mental disorders is still clear, either due to lack of knowledge, to fear of the reaction of patients or the lack of specialization in the area. This is visibly weakening the adhesion and expansion of current policy.[4]

It is important to create more and more satisfactory strategies even within the formative schools, which will help future professionals to adhere to the psychiatric reform, thus building a care focused more on human being and not on illness.[9]

It is easy to perceive in the statements that follow the nurses' insecurity in assisting the PMDs. The descriptions are answers to the question that has been raised about the self-confidence in caring for PMDs. Linked to this insecurity is the lack of scientific knowledge in this area of specialization due to the deficit of knowledge offered during studies and subsequently the lack of continuous training.

> *Very little, very little, very little. I believe I would have to have better training, because then they are patients that at least in my point of view they require a better dedication, you understand. ... So often for me specifically I have some difficulty.* (E1)

> *Not totally. Because I think our undergraduate degree was not so grounded in mental health, mental health is a subject you go through. It's not that deep got it?* (E4)

> *No. Our academic background leaves much to be desired in this regard and I also think the same, I'm talking, I can have a very good education, but if I can't study and practice with the range of assignments that nurses have today, there is no condition ...* (E3)

> *... yes I am prepared, but I am not fully prepared, I am preparing more every day.* (E5)

Similar reasoning is mentioned here as a depressing factor for qualified care. The broad "range of attributions" that demands from these professionals fragmented approach to care making it impossible for them to perform holistic and integral care, as provided for under the SUS principles.

Care focused on mental health in primary care centers is provided properly, when professionals providing this care are prepared to hear and recognize that the demands of patients go beyond the pathology of mental disorder, therefore they should focus on psychosocial care beyond referral and/or counter-referral to established mental health services.[10]

In the interviewees' statements, it is not possible to understand clearly what types of actions are developed by them in the assistance. There is much talk about home visit care, but there is no talk about systematization of care, care plan with implementation and evaluations, and little about Singular Therapeutic Project.

> *So we had the cases, the patient arrives, who makes the approach, who listens, who does all the anamnesis is the nurse, who I do not think is fully prepared to do this...* (E4)

...we detect the patient who has a greater need for follow-up, who has a mental disorder we consult with the general practitioner here, accompany them at home visits if necessary... (E3)

The importance of continuing training can be seen in studies that highlight a clear need in the team to have continuing education in the area of mental health, so that care would be more scientifically effective and more holistic thus strengthening the team's performance.[11]

Category II - Structural disorganization of the network: a three pronged approach and its operation

The main goal of the psychosocial care network is to ensure the interaction of the services offered, so that each component of this network provides the user with the necessary support so that they have a better quality of life. In order to achieve this goal, it is necessary that each FHS has CAPS as its reference service and aims to make the network work in a more coordinated way allowing each professional to know what care was provided to patients and what are the needs that remain. But what we still see today is that services are scattered and isolated, making it difficult for this network to function properly.[12]

SUS is governed by key principles such as resolution, which aims to solve clients' problems when seeking assistance, the organization that tends to meet the individual's needs through the referral and counter-referral of health services and the responsibility of placing the professional as co-responsible for the patient's problem. Therefore, the SUS is based on a three-pronged approach, where different components are interconnected, and if one of them is deficiend, all others are affected as well.[13]

In the statements, it is clear that the interconnection between FHS health services and specialized services in mental health or even other types of services that SUS offers to these patients is fragile. Thus the organization is defective, making it impossible for such patient to receive full and collaborative treatment of his reintegration into society.

But there is no counter reference set, right, and followed by the protocol for example, for every patient who goes there... (E1)

... that the network is more articulated, understand? That we have a referral and counter-referral service that works [...] and that we should have a better articulation not only of the nurse, but of the whole team. (E3)

...there is still a lot to improve, but we had a very big advance... (E5)

CAPS are considered strategic instruments for changing mental health care model that make it possible to develop autonomy, citizenship and a better quality of life. Thus, the nurse should perform home visits, screening, service coordination, structuring therapeutic groups, and other activities such as celebrations, fairs and other events aimed at integrating the service into the lives of family members and users and the community.[7]

If there is no comprehensive service, how can you ensure that this patient is being assisted in order to meet his needs, that his right to be reintegrated in society in a healthy and free of prejudice way is guaranteed?

Categoy III - Matriciamento: a starting point for the permanent education: "*...has helped us a lot...*"

The participation of the multiprofessional team provides a particular point of view of each professional according to their participation and intervention in care. Doctors and psychologists are responsible for pharmacological and psychosocial treatment, while nurses are responsible for preparing care plans and interventions offered by their team.[14]

The implementation of the Family Health Support Center (NASF) since 2008 has been bringing benefits to mental health, as it provides more support to nurses, with the objective of broadening the scope of influence of primary care composed of a multidisciplinary team. The meetings of this team as well as the discussions of the cases and their eventual outcomes is called matrixing.[15]

Matrix support (AM) instituted in 2004 by the Ministry of Health comes as a facilitating strategy capable of articulating mental health services and Basic Health Units (BHU). Defined as an organizational arrangement that aims to increase the effectiveness of health actions, matrixing reformulates the mode of service provision and relationships between specializations, allows providing technical support to interdisciplinary teams of primary care, supports a network connection, and enables co-responsibility between teams and the diversity of therapeutic support through a mental health professional who follows work processes of the FHS and can identify the demand for mental healthcare in primary care institutions.[16]

The matrixing can happen through shared case discussions, joint care, joint interventions in the territory, planning of the actions aiming to increase the team's resolution capacity, approximation and defragmentation between the UBS and the Reference Units, expansion and qualification of care offers within the territory and dissemination of technical knowledge.[17]

Matrixing nowadays seems to be a path of hope, where professionals place their expectations for a better future in PMD care. The importance of support to assist such professionals in the management of their functions is intensified in statements.

So here in our unit we have the mental health matrixing that is done once a month and then comes the psychiatrist, the psychologist, comes the CAPS nurse, understand, so it has helped a lot, because the cases that have appeared to us, the doctor, the nurse, they are going to these professionals

and they are opening our minds and giving us new strategies to be working with these patients and until now we are gaining from it... (E1)

...there have been strategies such as matrixing, that right here we have matrixing with the psychiatrist, there is also a psychologist who does the matrixing, so it's starting to improve... (E3)

Matrixing is a tool that helps enhance mental health care network, since it helps professionals to feel more secure in the care that they provide, making it indispensable.

...right now we have the matrix that he provides a very large service support, it extends the assistance even of the FHS with this support, with this matrix. So the cases are taken, discussed, we from the primary care come on, we take our doubts that are numerous in the conduct of cases and this care is done, this way of shared care and the discussion of clinical cases during matriculation... (E2)

FINAL CONSIDERATIONS

According to the findings, it appears that nursing care provided to the PMDs in the FHS still has deficiencies in terms of ensuring the SUS principles and the psychosocial care model. One of the factors underlying this reality, according to the reports of professionals, is the incipient nature of training in the area. Current difficulties in the field of mental health directly affect the actions and strategies employed to assist PMD, while leading to nurse insecurity regarding the management of cases. Therefore, it is necessary to invest in training of nurses in mental health so that this paradigm can be changed and so that the quality of mental health care, as determined by the policies and the psychosocial care model, can be consolidated.

The introduction of matrixing as an essential and indispensable support in helping health professionals in FHS is helping to rekindle the hope lost in this type of care. Matrix support in mental health aims to integrate specialist professionals with non-specialist professionals enabling an interdisciplinary practice so that support to generalist professionals is guaranteed allowing the expansion of the scope and quality of care. Among the main actions are systematic pedagogical support, ensuring in-service training that results in improved care provided by the FHS, as well as shared practice that enables greater resolution of cases and discussions that can optimize networking. This tool of clinical management of the practices can potentially solve the problems discussed here, such as the deficient education and training of the professionals and the lack of coordination of the network. For this reason, we believe that it is a "light" that will guide the PMDs to their reintegration in society.

In the past the humanity experienced a production line management in the factory, where each worker played his role and faithfully carried out their mission without coordinating with other professionals, but Taylor's theory failed as it did not perceive the company as a whole. Perhaps this can also support the matrixing, which emerged from the perception that a network of multiple professionals is not enough, interdisciplinarity and collaboration among them is necessary.

As a limitation of this study, we point out the need for further research on the theme, analysing the role of the entire care team including the professionals in other specialties, so that it encompasses a working reality of the entire multidisciplinary team that are assisting the mentally ill patient as well as their family members on a daily basis, so that they seek improvement in the services provided and full adherence to the treatment offered.

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Received in: 06/12/2018
Required revisions: 20/05/2019
Approved in: 22/07/2019
Published in: 23/03/2020

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Disclosure: The authors claim to have no conflict of interest.