Cogitare Enfermagem

ORIGINAL ARTICLE

PERCEPTIONS OF NURSES IN BASIC HEALTH UNITS REGARDING THEIR ACTIONS IN CASES OF DEPRESSION

HIGHLIGHTS

1. Nurses at BHU face challenges in mental health care.
2. Difficulties include training, lack of time and human resources.
3. The importance of an interprofessional approach to comprehensive mental health care.
4. Need to expand strategies for effective care for depression.

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ABSTRACT

Objective: To understand how nurses deal with depression in basic health units. **Method:** Qualitative research was carried out in 2020 through an open interview with 15 nurses working in basic health units in a municipality in the Brazilian Midwest region. The interviews were subjected to content analysis. **Results:** It was possible to see that nurses have multifactorial difficulties in dealing with cases of depression. However, they point out strategies that indicate ways to qualify their clinical practice, such as the importance of professional training and strengthening teamwork, so they are prepared and qualified to offer effective and humanized nursing care to people with depression. **Conclusion:** Even in the face of the challenges that have arisen, the continuity of nursing actions aimed at patients with depression and other mental disorders is fundamental, especially in contexts with a weakened mental health care network.

DESCRIPTORS: Depression; Mental Health; Nurses; Nursing Care; Primary Health Care.

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INTRODUCTION

Depression is a mental disorder in which the individual shows permanent sadness and loss of interest in daily life, with the consequent impossibility of carrying out daily activities for two weeks or more, and may present mood swings, guilt, or lack of self-esteem, sleep or appetite disorders, feelings of tiredness, lack of concentration and, in the most severe cases, suicide[1]. Its occurrence is related to genetic, environmental, biological, and psychological factors[2].

A depressive episode can be classified as mild, moderate, or severe. Depending on the classification, there may be a loss of interest and difficulties in carrying out daily or social activities, the appearance of physical complaints, an association of four or more symptoms, or even psychotic symptoms such as hallucinations and delusions, and there may be a risk of suicide. Furthermore, the severity, frequency, and duration of depressive episodes vary according to the clinical case of each individual[2].

Epidemiologically, cases of depression have become the biggest cause of disability in the world, the most frequent mental disorder, with an estimated 300 million cases worldwide, and it is more common among women[2]. Other socio-demographic markers indicate a higher incidence among people with incomplete primary education and white people. In addition, regarding access to health care for these users, due to the availability of faster psychological care, private institutions are more sought after than Basic Health Units (BHU)[3].

In the BHU, the nurse is usually one of the professionals with whom the individual has their first contact, an important relationship for welcoming and detecting mental health problems. However, some professionals find it difficult to identify patients with depression due to the low expression of symptoms or a lack of professional knowledge/qualification in this field of care[4-5].

In addition, although there are some options for treating depression, many patients do not receive adequate care. Among the barriers preventing efficient treatment is the lack of trained professionals, one of the elements potentially affecting the monitoring and treatment of the disorder[1].

The scientific literature confirms that nurses lack the training and preparation to offer comprehensive and effective care to patients with depression, failing to identify depressive symptoms and incorporate technical skills for proper management[6]. Thus, it is assumed that the work of nurses in the BHU is marked by unpreparedness and professional overload, causing erroneous referrals to other services in the care network, intensifying the transfer of responsibilities, and the absence of a strengthened and multidisciplinary work process that meets the mental health needs of individuals belonging to the area of coverage, justifying the relevance of regional studies to identify local weaknesses and establish strategies to minimize this problem.

In light of these reflections, we sought to answer the following question: How do nurses deal with cases of depression in the BHU? This study aimed to understand how nurses deal with cases of depression in Basic Health Units.

METHODOLOGY

This is a descriptive, exploratory, and qualitative study. The criteria established in the COREQ protocol (*Consolidated criteria for reporting qualitative research*) were considered to structure the research report[7].

The research was carried out with 15 nurses working in a BHU in a municipality in the interior of the Brazilian Midwest. The municipality has 22 BHU, a Psychosocial Care Center (CAPS), and a public hospital where psychiatric urgencies and emergencies are treated. Despite infrastructure for the mental health care network, there is often unsystematic professional behavior and a lack of protocols that better define the referral, counter-referral, and follow-up of individuals with mental disorders.

Nurses working at the BHU for at least three months were included, as they may already be more adapted to the work process. The criterion of data saturation determined the number of participants. There were no refusals or withdrawals from the study.

Data was collected by an undergraduate nursing student from a public Higher Education Institution (HEI) in December/2019 and January/2020 under the supervision of two teachers from the course. Both the academics and the teachers were members of a research group for scientific investigation in nursing and health, which set up the main research project and the focus of this study. It should be noted that the academic had no relationship with the people interviewed in the study, nor did she have any professional ties with the BHU.

The approach was made through prior contact with the municipal primary care coordinator. After explaining the objectives and importance of the study to the participants, they read and signed the Informed Consent Form (ICF) in two copies. Data was collected through an open-ended interview based on the guiding question: "How do you deal with cases of depression at the BHU?" with further questioning if necessary. The interviews took place individually, guaranteeing the interviewee's privacy in the BHU where the nurse works, respecting a maximum time of one hour stipulated by the researcher. The interviews were recorded with a digital device, with the participants' authorization, and then transcribed in full.

The thematic content analysis technique proposed by Bardin[8] was used in stages: pre-analysis of the material, coding, treatment, and interpretation of the results. Pre-analysis involved organizing the material, reading the data superficially and comprehensively, and returning to the research objectives. When coding the material, an in-depth reading was carried out, capturing the nuclei of meaning and then categorizing them. The findings were interpreted in conjunction with the theoretical framework in the final stage. The first author carried out all the steps thoroughly, with the support and supervision of the team of researchers.

After carefully analyzing the corpus and the nuclei of meaning initially produced, the results were grouped and refined, giving rise to two categories.

This is an excerpt from a matrix project approved by the research ethics committee of the State University of Mato Grosso, opinion No. 2.964.893. The participants signed an informed consent form, and codes were used, the letter "P" (professionals) followed by the respective number in the order of the interviews, to maintain the subjects' anonymity.

RESULTS

Fifteen nurses took part, aged between 23 and 41, mostly female, brown and single. The length of time they had worked at the BHU ranged from five months to 10 years. Of the professionals, 10 had specializations, but none in mental health, and two had qualifications in Collective Health with an emphasis on Family Health or Primary Health Care management. The empirical data was organized into two categories, as detailed in Table 1: Knowledge about depression and the role of primary care nurses in caring for people with symptoms of depression and Difficulties and challenges faced by primary care nurses in caring for people with symptoms of depression.

Chart 1 - Cores of meaning produced from thematic content analysis. Tangará da Serra, MT, Brazil, 2023

Core of meaning	Category
Knowledge about depression	Knowledge about depression and the role of primary care nurses in dealing with people with symptoms of depression
Clinical manifestations of depression identified by the professional	
Training offered during graduation and professional practice	
Qualified listening/Welcoming as a nurse's behavior	
Referral to other professionals/services as the nurse's conduct	
Drug treatment as an aid for patients with depression	
Continuous monitoring of patients by professionals - nurses, Community Health Agents (CHAs), and home visits as conducted	
Therapeutic strategies used by nurses as an alternative to help treat patients with depressive symptoms or those already diagnosed	
Strategies to be implemented to support patients with mental disorders, including depression	
Seeking help from the primary healthcare team	
Lack of time as a difficulty in treating patients with depressive symptoms	Difficulties and challenges faced by primary care nurses in caring for people with symptoms of depression
Affinity with the mental health field is challenging in caring for patients with depressive symptoms.	
Difficulties in dealing with patients with depressive symptoms	
Lack of professional training is a difficulty in caring for people with depressive symptoms	
Difficulties in caring for patients with depressive symptoms related to insufficient numbers of professionals, inadequate structure, and problems with other services	

Source: The authors (2023).

The first category discusses nurses' knowledge of depression and their actions when dealing with patients with sadness, mood swings, reduced daily activities, guilt or lack of self-esteem, sleep or appetite disorders, and feelings of tiredness, among other characteristic symptoms. The professionals described the concept and some of the clinical manifestations of the disorder:

Depression has various levels, ranging from mild to moderate to more serious, which needs treatment like any other illness. (P1)

This is when there is a prolonged condition in which there is no longer any pleasure in carrying out even everyday functions, things that the person used to enjoy doing, their interests, and they abandon these tastes, these pleasures. (P2)

The definition of depression is when a person feels… it can be the word depressed, sad, for a long time, right, not momentarily. (P12)

It was possible to observe that the nurses demonstrated correct knowledge from a clinical point of view but superficial. According to the testimonies above, most professionals could identify the disease through the clinical manifestations reported by patients or noticed during nursing consultations.

The superficiality of their knowledge of pathology may be related to the lack of more specific training in the area, given that some professionals reported that their knowledge was only acquired through the mental health course offered at university, describing how their academic/professional training was configured:

I never took a specific course separate from the curriculum in my degree. I had what was in the subject of mental health, which was already on the course curriculum. (P1)

As an undergraduate, we have a psychology subject, but at least for me, it was a bit vague. (P2)

In academic training, we've heard about depression, but it's quite superficial, isn't it? (P8)

As for the actions carried out by nurses in the BHU, the main ones that stand out are welcoming and active listening, with the provision of physical spaces for care:

What we have here to deal with patients is that the first port of call is welcoming listening. (P3)

When a patient comes to me with symptoms of depression, I have a therapeutic conversation first. (P5)

We have a room that we set up to welcome this type of person, anyone who wants to talk; we welcome them, we try to listen, which is listening, right? (P14)

The professionals also emphasized the multidisciplinary approach in this context, associating nursing with a kind of first aid capable of directing the next steps in health care:

We refer them to the doctor, who assesses the case, and if it's not the case for them, for example, deep depression, they refer them to the CAPS […]. (P2)

I forwarded the information to the unit's doctor. You can go in for drug therapy or be referred to psychology, and depending on the severity of the depression, you can also be referred to CAPS. (P5)

However, these reports show that the professionals do not consider a specific role for nursing, locating it in dialogue with other areas, such as medicine and psychology, but with nursing care responsible for directing the therapeutic process and precisely integrating multidisciplinary care.

They also emphasized the importance of the work of the CHAs and joint home visits, aimed at continuous monitoring of patients, the correct use of prescribed medication, and expanding the range of guidance offered:

We also have the support of the community agent as a resource because we don't get to see this patient every day or every week, so we get news, and in some cases, we make home visits to observe the environment better and provide guidance. (P2)

So, the CHA has a very strong connection; they bring us news, and it's a strategy to find out how the patient is doing. (P12)

These findings show that nurses are the first professionals to receive patients with depressive symptoms in the BHU but do not report specific care. Sometimes, they mention specificities attributed to CHAs, doctors, and psychologists in mental health care, which may suggest that nurses, in a way, establish themselves apart from this care, only building connections with other professionals. This may indicate that although they have basic knowledge of mental health, they are far removed from comprehensive care, which should not seek specialty but integrate intelligibility in interprofessional work.

The second category describes the main difficulties and challenges nurses face in

caring for people with symptoms of depression. They highlighted the lack of time experience in the mental health field, infrastructure, and insufficient professionals to meet the clinical and managerial demands, among others. Initially, they pointed out that lack of time is one of the biggest challenges:

Today is the time to serve them! Because the demand is very high, mental health has been growing a lot, right? (P3)

So, in primary care, it's difficult, especially for nurses, who have to take care of everything and more. (P9)

[…] We don't always have time. And to listen to a depressed patient, you need quality time, which we don't have here. (P10)

To have time for exclusive listening. We must spend thirty to forty minutes or an hour with a patient to listen and guide […]. (P15)

However, the narrative of a lack of time cannot be understood simply as an indication of a work constraint. This explanation for the difficulty in promoting listening in mental health must be interpreted from other markers that point, for example, to the insecurity of working in this field without specific training or experience in handling these cases. Another aspect highlighted was the lack of experience in the mental health field, which made it difficult for nurses to approach and monitor patients with symptoms of depression:

[…] I really struggle to know how to deal with these situations. But I know that I still need to improve my care, to give more guidance and ways to help the patient. (P4)

[…] We rarely get cases like this. Then, as I found myself in this situation for the first time, I was a bit afraid of what to ask, how to act, sometimes saying something that would hurt. (P8)

The nurses also pointed out difficulties and challenges in terms of insufficient human resources and infrastructure to meet the demand for cases:

We don't have enough psychologists to handle the number of cases we refer. I've been referring adolescent patients who are at risk to the psychological service, and the mothers come back to tell me that the queue has been waiting for December, for example, this year, for more than eight or nine months. And we know that in a case of depression, this can be serious or fatal. (P7)

There's no psychiatrist, so we offer support and refer them to CAPS, where they're assessed. (P9)

The main difficulty is the demand, which is high for the structure we have to serve the municipality. (P13)

There's no network psychiatrist in the municipality. And many patients spend a long time on the waiting list, sometimes up to a year waiting for psychological care. So, we end up playing the role of psychologist within the unit. (P14)

It should be emphasized that this lack of resources is detrimental to the functioning of the care network. If there are no resources, there is a lack of people and physical infrastructure to care for patients. In this context, nurses take on the roles of other professionals.

Given this, the nurses suggested strategies that could be sought to minimize the difficulties and challenges encountered in the context of their work. The first and most mentioned would be the provision of periodic training for health professionals, considering the weakness or lack thereof:

Since I started working, there has been little training in mental health, even though demand

is very high. (P4)

I think we should have six-monthly or annual mental health training every time we enter any public or private institution. (P9)

[…] If we'd had more training, we'd have been able to cope better. […] If we'd had more training, we'd feel safer talking to the patient. (P12)

As you can see, training is very important from their perspective, considering that when professionals receive training, they feel better prepared to provide care. In addition, it is important that training goes beyond offering specific knowledge in mental health, fostering interprofessional care that precisely opposes the rigid location of each category's work and prioritizes dialogue between knowledge and actions in comprehensive care.

The nurses also reinforced the strategy of strengthening teamwork, always aiming to welcome the individual during their visit to the BHU:

When a patient arrives at a primary care unit or anywhere else, it's not just the senior professional who will attend to them; everyone has to do the welcoming. the welcoming has to start at the door! (P6)

Initially, these patients arrive at the reception desk and have already reported something; there is already a different look at them. Then they go to the triage room with the technicians who have already heard some complaints reports and have a different look at things. After that, they come to me, and I do some qualified listening, then I call the doctor, she comes to the office, and we do an assessment and a study of the patient. (P13)

This emphasizes the importance of teamwork in caring for patients with clinical manifestations of depression at the BHU. Finally, they mentioned other strategies that were being planned and implemented, such as the implementation of mental health projects in more vulnerable areas, the creation of care protocols and therapeutic groups, the provision of complementary activities, and the availability of a specific space in the BHU to receive the subjects:

We're thinking of carrying out a project in a neighborhood here that is very deprived; we see that the mental health issue is glaring. (P4)

[…] training, preferably every six months, focusing on a checklist, something for screening, because the questions we ask are subjective, and the patient answers them so we can identify them better. (P9)

We have a project for 2020 to implement therapeutic workshops here and conversation circles, which will be held weekly on Fridays at the unit itself. (P7)

[…] We've set up a room to welcome anyone who wants to talk; every unit should have a comfortable little room. (P14)

The professionals suggest implementing strategies to improve patients' quality of life. The highlight of this investigation is precisely the elucidation of these strategies because, in some of the units, these projects/actions were in operation. Auriculotherapy, conversation circles, and a room prepared to welcome these patients were created to provide better care. It's worth noting that the initiative for these actions came from professionals who identify with mental health or are interested in developing these strategies for other groups.

DISCUSSION

In the first category, the testimonies show a superficial knowledge of the pathology, which may be associated with the weaknesses the nurses pointed out in their academic mental health training. This is reflected in the difficulties professionals encounter in providing quality care to patients with mental disorders, even though the Primary Health Care (PHC) network has the scope to offer comprehensive care to these individuals[10].

A study that investigated the importance of teaching the subject of depression in undergraduate courses, with the aim of training university students to act professionally with the attributions and competencies required, showed that the interviewees rated their theoretical and practical knowledge as insufficient for effective professional action. One of the reasons for this was the lack of practical fields and the reduction in the number of hours spent on internships in the mental health area[11], data that corroborates this study. However, despite this weakness, the interviewees perceive the importance of welcoming and qualified listening through communication between nurse and patient in a natural and humanized way, in which the user feels safe to talk about their feelings.

A humanistic approach has to be prioritized by the nursing team when dealing with patients with depression to value the small reports made by the patient, given that in depression, the feelings mentioned by the individual can be crucial for diagnosing the pathology[4]. In PHC, it is essential to implement mental health interventions to achieve an effective therapeutic relationship, which is continuously developed between professionals and users in the joint construction of mental health care tools and strategies; these interventions should not be limited to "curing illnesses," but should consider the possibilities and ways of life of each person, respecting their wishes, desires, values, and choices[5].

Qualified listening is one of the strategies that contributes to the care provided to people with mental disorders. When offered to individuals suffering from mental illness, it can ease the burden, strengthen dialog, and contribute to understanding the situation the person is experiencing through the trust established between patient and professional[12].

In addition, the nurses considered referrals a resolutive conduct they carried out. Referral to other services is also pointed out by other authors, especially when acute cases of anxiety, depression, and other disorders are found[13].

They also emphasized the importance of joint actions with the CHAs. Through this link, the patient's health condition is brought to the attention of other BHU professionals, thus maintaining a link with the service and multidisciplinary monitoring, viewing the entire context of the patient. Given this, it is essential to emphasize the importance of mental health care in PHC, given that this care is strategic given the easy access users have to the teams and vice versa[5].

In summary, the particularities presented in the first category and the reflections based on the empirical material reinforce what is commonly found in other research contexts at local and national levels. There are strengths and weaknesses in the nurse's role in dealing with cases of depression, and these can reveal ways of expanding strategies that are better adapted to the real mental health needs of individuals, groups, and populations.

In the second category, the participants highlighted the difficulties in attending to cases due to lack of time, pointing out that patients with depressive symptoms require a greater amount of time for qualified listening and that due to the number of attendances, they are unable to offer quality care to these users. Data from other authors also corroborate these findings and point out that nurses' numerous duties at the BHU make it difficult to attend to more specific groups, such as mental health[14].

It should be noted that PHC is the main gateway to care for users of the Unified Health System (SUS), so professionals must understand the need to incorporate mental

health assistance into their care practices daily, not necessarily requiring work beyond what is already demanded; for example, recognizing mental health needs in the different reports and complaints of users who arrive at the BHU, aiming for comprehensive health care[5].

Another difficulty reported was the nurses' insecurity in dealing with patients with depression due to their lack of professional experience. The results of one study showed that PHC professionals have no specialization in mental health, whether acquired through courses or experience in the field. The authors also stressed the importance of offering professional training[15].

The interviewees also cited as a challenge the lack of specialized human resources (psychiatrists, psychologists, etc.) and infrastructure to provide adequate care for patients with depression. The difficulties and challenges encountered here are detrimental to nurses' ability to deal with these cases and to the care of the population, whether individual or collective[14].

In addition to the lack of specialized professionals, such as psychologists and psychiatrists, it can be seen that nurses still have a fragmented view of PHC care. This is because their speeches reinforce the defense of specialty (mental health professionals are needed to treat mental health cases). In this way, they position themselves as professionals who are not mental health professionals, who do not have this specialty, nor even the availability to work beyond this fragmentation, understanding that the BHU teams should also cover mental health care.

The nurse's role here is reduced to referrals to CAPS, psychiatrists, and psychologists. These professionals are of fundamental importance in mental health. Still, building a culture in which mental health care permeates the entire healthcare structure, from the home to the most specialized is important. This would avoid positions like that of (P14), who says that nurses need to do the work of psychologists. This statement can be challenged here: there is the suggestion that there is work in mental health that the psychologist should carry out; but also, that there is no perspective of interprofessional work, predominantly fragmentation and the valorization of specialist knowledge, which hinders comprehensive care.

Professional training, teamwork, and the implementation of specific projects and actions were cited as strategies for expanding care at the BHU for patients with depression.

Since nurses provide the first care and follow-up for patients suffering from mental illness, training is essential and helps ensure that the care provided is qualified. However, it is necessary to provide all the necessary conditions for this to happen, such as time, financial, and structural resources, and, in addition to professionals, managers are interested in implementing these strategies[15-16].

In this context, the interviewee (P9) suggests training using some kind of "*checklist*" to screen cases, considering the lack of training of professionals in not knowing what questions to ask the patient to help identify and diagnose the depressive episode, as well as the proper management of the case.

It is important to point out that knowledge about symptoms, risks, and protection factors is important for early diagnosis and development of prevention and intervention strategies for mental health problems. In this sense, the use of evidence-based actions and tools such as the genogram and ecomap contribute to understanding the case; it is also reinforced that this assessment should be thought of in an integrated and organized way, from the initial approach to the preparation and implementation of the Single Therapeutic Project (STP)[5].

However, this cannot be limited to a bureaucratic procedure; it must be a process of co-responsibility, participation, and active monitoring by the multidisciplinary team from the moment the case arrives until the next service where the user will be assisted[5].

When courses or training are offered, professionals generally participate, positively contributing to improving care[17]. However, as discussed here, these trainings need to reinforce not necessarily specific mental health knowledge but the PHC guidelines regarding interprofessional, comprehensive, and humanized care.

Concerning teamwork as a strategy for strengthening care and patient reception in PHC, it should be done through a set of collectively constructed attributions, with common objectives and shared responsibilities, including the participation of users and the community in producing care and health promotion[18].

Furthermore, developing strategies to attract patients' interest is fundamental to promoting their health. Therapeutic groups and the adoption of techniques such as auriculotherapy, for example, can help in the treatment of people with symptoms or diagnoses of depression[15], since these practices, when developed in the BHU, contribute to not worsening the clinical picture, allowing professionals to act in a more humanized way. Therapeutic groups in PHC are a care technology that offers a space for guidance, reflection, and exchange of experiences and are essential for promoting mental health, comprehensive care, and strengthening the autonomy of users and the community[5].

The nurses consider the strategies described beneficial for patients, as they contribute to caring for individuals with mental disorders, including depression. In this sense, we believe that these professionals can help people diagnosed with depression who are treated at the BHU through changes that involve the structural dimension of care but also a reorientation that situates mental health as a perennial, interprofessional care that should include all levels of assistance; in addition, they also collaborate so that users with symptoms suggestive of depression are identified, assessed and monitored by the devices and teams in the territory. The embodiment of this culture in primary care can favor comprehensive care from the outset and better health outcomes, which can and should be monitored and investigated more closely in future studies in this context.

The limitations of this study are that it deals with the perceptions of professionals in a territory with limited mental health care. This weakness must be tackled by providing more specific knowledge and from the perspective of interprofessional dialog capable of showing that mental health care must take place in an integral way and in conjunction with the territorialities and intersectionalities that cross care in this field.

FINAL CONSIDERATIONS

This investigation found that nurses working at BHU in the interior of Brazil have difficulties in the mental health work process, which interferes with their work in dealing with cases of depression. It is considered that the issue addressed here still presents challenges, especially given the fragility of professional qualification, from the training aspects in undergraduate courses to care work.

In summary, the main difficulties faced by nurses in caring for patients with depression were a lack of time, a lack of training and experience with mental health, as well as a lack of human resources and specific knowledge about the disorder. These difficulties infer mental health care focused only on specialized equipment or the specialist professionals responsible for this assistance. If mental health care is not referred to as something that can be carried out by nursing, the difficulties will not be located in this category but in gaps observed in other professionals.

The study allows us to reflect that PHC work must be committed to an interprofessional network capable of providing and embodying comprehensive and humanized care. This goes beyond the fragmentation of work between the different categories. This reinforces the importance of coordination between managers and health services to train professionals,

offer a systematic mental health care network, and expand and strengthen the work of professionals in dealing with mental disorders.

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