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# CLINICAL NURSING CARE IN MENTAL HEALTH IN PRIMARY HEALTH CARE

## O CUIDADO CLÍNICO DE ENFERMAGEM EM SAÚDE MENTAL NA ATENÇÃO PRIMÁRIA À SAÚDE

## EL CUIDADO CLÍNICO DE ENFERMARÍA EN SALUD MENTAL EN LA ATENCIÓN PRIMÁRIA A LA SALUD

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**ABSTRACT**

***Objective:*** to understand the clinical nursing care in mental health in primary health care. ***Method:*** descriptive study with a qualitative approach. The subjects were nurses working in primary care units. Data was produced by semi-structured interviews and submitted to content analysis technique in the thematic analysis mode. The study project was approved by the Research Ethics Committee, protocol no. 184/2010. ***Results:*** clinical nursing care practice in mental health, in the context of Primary Health Care, reproduces a clinic focused on biological and medical aspects; is limited to user registration, the supply of medication and referral to specialized services. ***Conclusion:*** welcoming and qualified listening are not part of care directed to individuals in psychological distress. Nurses have shown a lack of qualification in mental health as a major impediment to the operationalization of care from the amplified clinic devices. ***Descriptors:*** Nursing; Mental Health; Primary Health Care.

**RESUMO**

***Objetivo*:** compreender o cuidado clínico de enfermagem em saúde mental na Atenção Primária à Saúde. ***Método*:** estudo descritivo, com abordagem qualitativa. Os sujeitos foram enfermeiros que atuam em unidades básicas de saúde. Os dados foram produzidos por meio de entrevista semiestruturada e submetidos à Técnica de Análise de conteúdo na modalidade Análise temática. O estudo teve aprovado o projeto pelo Comitê de Ética em Pesquisa, protocolo n$^0$. 184/2010. ***Resultados***: a prática clínica no cuidado de enfermagem em saúde mental, no âmbito da Atenção Primária à Saúde, reproduz a clínica biologicista e medicalizadora; limita-se ao cadastramento do usuário, ao fornecimento de medicação e ao encaminhamento para os serviços especializados. ***Conclusão*:** o acolhimento e a escuta qualificada não fazem parte da atenção destinada aos sujeitos em sofrimento psíquico. Os enfermeiros mostraram falta de qualificação em saúde mental como um grande entrave para a operacionalização do cuidado a partir dos dispositivos da clínica ampliada. ***Descritores***: Enfermagem; Saúde Mental; Atenção Primária à Saúde.

**RESUMEN**

***Objetivo*:** comprender el cuidado clínico de enfermaría en salud mental en la Atención Primaria a la Salud. ***Método*:** estudio descriptivo, con abordaje cualitativa. Los sujetos fueran enfermeros que actúan en unidades básicas de salud. Los datos fueron producidos por medio de entrevista semiestruturada y sometidos a la Técnica de Análisis de contenido en la modalidad Análisis temática. En el estudio fue aprobado el proyecto por el Comité de Ética en Investigación, protocolo n$^0$. 184/2010. ***Resultados***: la práctica clínica en el cuidado de enfermaría en salud mental, en el ámbito de la Atención Primaria a la Salud, reproduce la clínica biologicista y medicalizadora; se limita al catastro del usuario, al fornecimiento de medicación y al encaminamiento para los servicios especializados. ***Conclusión*:** el acogimiento y la escucha cualificada no hacen parte da atención destinada a los sujetos en sufrimiento psíquico. Los enfermeros mostraran falta de calificación en salud mental como un gran obstáculo para la operacionalización del cuidado a partir de los dispositivos de la clínica ampliada. ***Descriptores***: Enfermaría; Salud Mental; Atención Primaria a la Salud.

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## INTRODUCTION

Mental health care, within the primary health care (PHC), still does not meet the principles of the Brazilian Psychiatric Reform. The structure of mental health in PHC in Brazil is relatively new and complex, and the systematization of experiences and new intervention models is incipient, which shows difficulties in the exchange of knowledge and training of professionals.[1]

When visualizing this assistance in practice, we realize that it is restricted to delivery of prescription of psychotropic drugs to the patient, and sometimes, to some referrals to mental health services (CAPS, in Portuguese). In addition, it is noteworthy that, the very delivery of psychotropic prescriptions is made in a purely mechanical manner, without guidance or explanations about precautions, care and side effects that such psychotropic drugs may cause to the patient. Thus, there is a big gap regarding nursing assistance under the care to be provided to the patient in psychological distress. Still in a preliminary way, mental health care outlines experiences of desire, alterity and the issue of sharing of knowledge, a fact that requires a comprehensive and multifaceted, individual and social care.[2]

From this context and given the specificity of the subject in psychological distress, this study aimed to:

- Understand the clinical nursing care in mental health in primary health care.

## METHOD

This is an exploratory study with a qualitative approach, developed in three Basic Health Units (BHU), located in the municipality of Mossoró/RN, from July to September 2010. We chose BHU because they are fields of internship and supervised practices for nursing courses in the city. Thus, they are places where clinical practices play a pedagogical character, sometimes innovative, given the health care demands.

In these units, six nurses act as team members of the Family Health Strategy (ESF in Portuguese), and also act in the direct supervision of nursing students during mandatory supervised training; thus having different approaches to the amplified clinic proposition.

It was chosen semi-structured interview technique for compiling the data, from the following guiding questions: What is your perception on mental health care with the subject in psychological distress within the PHC? What strategies are adopted to expand the clinical practice directed for the subject in psychological distress within the PHC?

Interviews were recorded, and later transcribed and structured in a text that was submitted to content analysis.[3] This analysis was organized into three phases: pre-analysis, material exploration and treatment of results and interpretation.[3]

The first phase, pre-analysis, was the organization of the material to be analyzed and formulating ideas for the development of indicators for final interpretation. At this stage, reading of the data obtained was performed enabling closer relationship with the content. The second phase, called material exploration, was performed by carefully reading all the material to be analyzed, organizing speeches. The third phase, in turn, was the treatment and interpretation of results. At this stage, the interpretations and conclusions of the materials to be analyzed were carried out, as well as the correlation with the theoretical framework, increasing thus the knowledge of the subject studied.[3]

In accordance with the CNS/MS Resolution 196/96, the study project was submitted to the Ethics Committee of the Potiguar University, approved under the Protocol 184/2010.

## RESULTS AND DISCUSSION

From the interviews, we identified two categories that express how the nursing care to individuals in psychological suffering in PHC has been done. These categories present theoretical proximity when nurses conceive psychological distress as a disease in the light of the biomedical model. This model approaches the disease exclusively from the organic body and its morphological and functional manifestations.[4]

The everyday of health services has shown that, according to the model of care adopted, not always the health care is effectively committed to the promotion of mental health. It remains the adoption of practices based in a biological and medical model, operated through a clinical practice focused on disease rather than the individual who suffers.[5]

Clinic in mental health care, in PHC, is far from the purpose of the Brazilian psychiatric reform; it is restricted, sometimes, to a performance manipulated by inefficient protocols and routines in the production of healthcare bonds.[6]

### ● Clinic in nursing care to individuals in psychological suffering

This category brings reflection on the clinical nursing care in mental health, which is mainly characterized by a highly medical and curative care, separating the patient from his subjectivity.

> *What we do here is transcribing prescriptions and delivering medications, when we have here in the unit. (I2)*

This speech leads to two important points: conception of clinic and removal of subjectivity of the subject in psychological distress. The first is anchored in the conception of psychological distress as a disease. This meaning does not arise by chance; it was born in the thirteenth century, with the advent of scientific medicine, a clinic that sees all that escapes the standard as pathological.[7]

The second point is guided in anatomo-pathologic clinical whose doctor's look assumes a power capable of detecting unique events, as well as of describing them under their reason. From this point of view, the sign in anatomo-pathologic clinic seeks to exclude the subject, for only the doctor is able to relate, to legitimize and to make certify the disease as such.[8]

Thus, in anatomo-pathologic clinic, mental suffering is perceived as disease whose involvement must be ensured by means of procedures and medications. According to respondents' speeches, we could see the gap of professionals regarding the subject in psychological distress and the attempt to objectify this subject in an organic body, the seat of the disease. There is no seeking to accommodate the subject; instead, the priority is to give them a direction from the clinical picture of the disease. The fastest escape is then referral. So the clinic in nursing care is embodied in the delivery of medications and referral to specialist treatment.

> *I do not know how to identify who is seriously ill, who is not. I refer everybody to the doctor or to the Mental Health Unit, which has mental health experts. (I3)*

Clinical listening that should be the guiding practice of care practices of nurses to individuals in psychological distress is lacking, when it exists, is strongly guided by psychiatric nosology. It was even noticed an attempt to organize a typology of customers around the most frequent diagnoses.[9] As we can see in the report: "*I do not know how to identify who is seriously ill, who is not*".

Thus, we can visualize the challenges to carry out nursing care to individuals in psychological suffering in PHC. We highlight how this care and how the clinic is designed. In the research context, this concept is confused with the implementation of specific actions performed by nurses, transcription and delivery of drugs and referring patients. All actions are medical-centered and directed to the disease and not to individuals in psychological suffering, thus, devaluing their life history, values and the way they signify their own suffering.[10]

> *The patient arrives too agitated or anxious and just want the drug prescription. First they see the doctor. If they need drug prescription, they are referred to SAME to make their registry. In the registry it is put their name, address, date of birth and the community health worker responsible. Then they are referred for the nursing technician to receive the drug. (I3)*

Nurses' reports reflect a very disturbing reality: the distance that the professional seeks to establish with the subject in psychological distress:

> *[…] there is not, in practice, a care facing the subject with psychological distress, there is not even contact with this subject. (I6)*
>
> *There are some patients, when they arrive here, that my desire is to go away, to say I am not here. Sometimes I do not even get close, because I do not like to get involved with the madness of others. (I1)*

It is noticed that nurses play the following path: get bust in activities unrelated to care, exercising bureaucratic, specific tasks, ignoring their work process in mental health, strengthening eminently prescriptive, and modeler care actions, and consequently, they take the subject in psychological distress in abstract.

The subject is listened, however the "listening" is understood as a mechanism for obtaining information for the further development of interventions. There is the idea that one must, initially, refine what the patient brings to the service as a complaint, but it is only the professional that can determine the solutions and answers to their problems.[11] Without knowing how to deal with what is not palpable, nursing care is characterized by: referral, transcribing prescriptions, recording disease information, and the subject remains in brackets "subjugated".

### ♦ Strategies and difficulties in clinical practice directed to the subject in psychological distress

When nurses were asked about the care strategies conducted with individuals in psychological distress, they reported that strategies oriented by the management, focused on advice of standard procedures, prevail.

> *The organization of mental health demand is made for monitoring, inspection and*

> *determination of the municipal management. (I5)*

In this sense, nursing care for the individuals in psychological distress assumes actions of interventionist nature through governments' policies and programs with vertical and imposing structures in the way of thinking and living: "I tell them to have hygienic care and give medication". (I1)

The therapeutic group appears in nurses' discourse as one of the educational strategies that enables the sharing of situations and feelings by individuals in psychological distress attending health services, but the respondents believe that there is a lack of trained professionals to enhance this integration activity in social life.

> *It would be nice the formation of groups, but with guidance from trained professionals, specialized in mental health. (I1)*

The formation of therapeutic groups becomes important since PHC receives a constant demand of subjects with psychosomatic complaints, alcohol and drug abuse, dependence on benzodiazepines, among others, however, it is necessary to question the imposing and standardized way of content addressed in groups, often with information exclusively about disease or medications.[12]

Perhaps the rationale for standardizing content refers to the difficulty of nurses in performing a care that is beyond the body, because the psychic dimension is not possible to objectify, it is not palpable. The following speech addresses this difficulty:

> *The manager says we should form groups, but how will I do that? They do not prepare us to serve these people, I am not able. (I2)*
>
> *[...] Sometimes we fell unable to deal with individuals with special needs that require technical and informational preparation. (I3)*

Another point observed by nurses as a barrier to operationalize the care of individuals in psychological distress in PHC is specific and disjointed performance of health services with other services of the own municipal network.

> *[…] there is not even an incisive articulation with other mental health services, at best, sporadic contacts regarding referrals (I3).*

Research conducted in Campinas/SP sought to identify the link between the Health Family Strategy and the Mental Health Strategy in that municipality, and reached perplexing conclusions about the change in the logic of work proposed by the Ministry of Health. It was shown that networking is not an easy activity to be undertaken by the teams, and this does not occur automatically with the determination of the guidelines issued, but also involves the commitment of the professionals involved in each service.[13]

Respondents also expressed concerns about the lack of a plan that fulfills the needs required for the implementation of a mental health policy in this scenario, mainly due to excess workload issued by other programs:

> *[…] inadequacy of the 'mental health' policy to the routine of BUH, and lack of time. (I2)*
>
> *[...] excess workload of nursing in various health programs, and also the service organization that requires a lot from these professionals. (I4)*

Given these situations of difficulties in the implementation of comprehensive and subjective clinical care to individuals in psychological distress in the context of policies aimed at primary care and mental health, there has been a recognition that the supremacy of the biomedical model still prevails in the organization of actions in this sector. So, being a local public health policy, the inclusion of mental health in Family Health Program requires the rupture of these old welfare standards and overcoming the modern medical rationality, still hegemonic in the care actions that are conducted currently.

We realize that the inclusion of mental health in PHC requires on the one hand, the involvement and co-responsibility of all professionals involved in healthcare; and on the other, the necessary rupture with the old welfare standards, reinventing other forms of care in the everyday.[14]

The planning of health actions in primary care combined to mental health policies and the implementation of the matrix support intervention devices may help in the allocation of each actor and service in psychosocial care network and lead to greater integration of the actions developed in communities, and also give voice to the subject in psychological distress in decision making of their therapeutic treatment.

## FINAL REMARKS

Clinical practice in nursing care in mental health, in the context of primary healthcare, plays a clinic focused on biological and medical aspects, without establishing contact with the subject who is suffering, and is limited to the user registration, the supply of prescribed medication, and the referral to specialized services.

Contrary to the principles of the Brazilian psychiatric reform, host and qualified listening are not part of attention directed to individuals in psychological distress. There is an emptying of these principles in everyday,

as well as there is recognition of this context and of the lack of qualification in mental health as a major impediment to the operationalization of care from the amplified clinic devices.

The PHC may constitute an area of mental health care capable to strengthen the process of deinstitutionalization and psychosocial rehabilitation of the subject in psychological distress.

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