THE COMMUNITY HEALTH AGENTS IN IDENTIFYING SYMPTOMS OF DEPRESSION

OS AGENTES COMUNITÁRIOS DE SAÚDE NA IDENTIFICAÇÃO DE SINTOMAS DEPRESSIVOS

ABSTRACT

Objective: Identifying the actions of community health workers before the use of the Family Health Strategy with depressive symptoms. Method: A field study of a qualitative approach conducted with community health workers, which used the instrument as semi-structured interview guide, from April to June 2010. The empirical data were analyzed by the Content Analysis Technique. Results: The main actions of agents were based on the identification of depressive symptoms and acting on the change of behavior by hard work, sad and discouraging, sad and disheartening. Conclusion: The results showed the fragility of the routine of health workers before preventive care to depression as a result of lack of mental health policy targeted to small municipalities. Descritores: Mental Health; Depression; Primary Health Care.

RESUMO


RESUMEN

Objetivo: Identificar las acciones de los agentes comunitarios de salud en el usuario de la Estrategia Salud de la Familia con síntomas depresivos. Método: estudio de campo con un enfoque cualitativo realizado con los trabajadores comunitarios de salud, que utilizaron como instrumento de guía de entrevista semiestructurada, de abril a junio de 2010. Los datos empíricos fueron analizados por la Técnica de Análisis de Contenido. Resultados: las principales acciones de los agentes se basaban en la identificación de los síntomas depresivos y la actuación del cambio de comportamiento por su ardua labor, triste y desalentadora. Conclusión: los resultados mostraron la fragilidad de la actuación de los agentes de salud diante la atención preventiva a la depresión como resultado de la falta de una política de salud mental enfocada a los municipios pequeños. Descriptores: Salud Mental; Depresión; Atención Primaria de Salud.
INTRODUCTION

Depression is a mood disorder that presents itself nowadays as a serious public health problem, confirmed as the most common of the mental illnesses. This disorder is often associated with functional disability and impaired physical health, causing a negative impact on the person's daily life, at work, in family and social relationships. In more severe situations, it also results in death. Depression can present levels as mild, moderate and severe, with or without psychotic symptoms.1,2

The prevalence of depression in the population is of 18.4%, with the highest prevalence found among middle-income countries and in outpatient primary care, around 29.5%. Note that the diagnosis of depression is often troubled by the fact that such patients do not mention depression as the reason of the consultation, thus directing, clinical research to comorbidities, as well as by the difficulty of health team in recognizing it and the lack of attention to mental health in primary health care. Thus, 50% to 60% of the time the problem is not detected by professionals.1

Considering these shortcomings, reference is made to the risk of suicide with undiagnosed occurrence of depression and untreated, leading to tragic consequences, since it is responsible for significant death risk by about 15% of patients with mood disorder commit suicide and at least 66% of all suicides are preceded by depression. In order to avoid irreversible damage, this situation and concern on a national scale are demanding the need to address depression in the wake of public health programs, requiring ever earlier and creative responses on the part of primary health care services, based on early diagnosis combined with intervention of a skilled and articulate staff.1,4

National and international studies emphasize the importance of communion efforts between mental health and Primary Health Care, with the aim of reducing the vulnerability of individuals to certain minor behavioral disorders and track other cases in their particular.3,5

The Ministry of Health proposes that mental health practices in primary care/family health should be substitute to the traditional model, acting in a renewed manner, avoiding entrenched and criticized practices such as medicalization and psychiatrization of the subject. Thicken up the joint care network and social support network that constantly intersectoral

matricial, may constitute in authority production of intersectorialities and transverses of knowledge, promoting integrity and building a working process geared towards the needs natural and social and not only to the demands.8

The needs of the population enrolled in the FHS are identified, first, by the Community Health Agent (CHA) through home visits monthly. Such a professional has skills which makes it able to strengthen the integration between the community and the local health services, setting up thus as a key professional in monitoring people with mental disorders.

We agree that the CHA is potentially a key player in the psychiatric reform process of consolidation in the municipality.9

There is no doubt about the importance of the contributions that the FHS offer as well as the effective performance of the CHA as a team member; however, it is considered that the basic service is still incipient in regard to mental health care, specifically in assisting people with depression. Thus, it is considered important to analyze the factors that underlie depression in primary care. Thus, this study aims to:

- Identifying the actions of community health workers before the user of the Family Health Strategy with depressive symptoms.

METHOD

This is a field study, descriptive of a qualitative approach, conducted in four Family Basic Health Units in the municipality of Abaíra/Ceará, two in rural areas and two in the urban area.

The population consisted of up to 22 CHAs, according to the following inclusion criteria: operating time of at least one year and to provide FHS users adscribed in the micro area, presenting depressive symptoms, conditions for dialogue and affordable home for home visits.

The data collection occurred from April to June 2010, from the previous contact with the 22 CHAs, inserted into four teams of FHS. It was requested from them availability to respond to a semi-structured interview guide about the actions performed to users of the FHS presenting depressive symptoms. In this sense, the sample was of 100% of the CHAs.

We opted for the Content Analysis Technique, based on interviews and organized into categories of analysis appropriate to the speeches. Content analysis comprises a set of discourse analysis techniques in order to obtain, through systematic and objective procedures, indicators through the
identification of reporting units and meaning it can be inferred knowledge of the conditions of production/reception of these messages. To this end, this analysis is to make logical deductions and explained, referring to the origin of the messages taken into account.¹⁰

There were considered the requirements contained in Resolution 466/2012 that regulates research with human beings, and this work approved by the Ethics Committee of the College Santa Maria, through the Protocol 3761209.

**RESULTS AND DISCUSSION**

The results were described into categories and quantified for better understanding and analysis of the content. There were categorized the meanings and responses, which expressed the actions of CHAs in identifying the FHS users with depressive symptoms. In addition, there were used themes for better understanding and visualization of the results.

- **Main theme I - identifying symptoms of depression**

At first, there was asked the CHAs if they were faced with someone presenting symptom of insomnia, hopelessness, lack of appetite, enthusiasm to give up everything and become isolated from the world. Mostly, twenty CHAs (91%) said find in their area, people presenting such depressive symptoms, one (4,5%) CHA has identified people with insomnia symptoms, hopelessness, lack of appetite, willingness to give up everything but reported not find anyone who expose or express the desire to be isolated from the world, and finally, other (4,5%) CHA claimed to have met people presenting only symptoms of insomnia, hopelessness and lack of appetite.

Then, there was asked to the same about the actions taken to identify these people. The first category of the main theme I was Guiding and/or Forward to the FHS, regardless of the intensity of complaints of depressive symptoms.

It was observed that the guidance practices of leisure and herbal use constitute a practice even with the failure of accumulation in the resolution and in control.

>I headed to the FHS and instructed to drink tea and avoid coffee and tobacco (Azurite).
>We guide to search for people to talk and try to do some activity (Alexandrite).
>I said that probably she had some depressive symptoms. Unfortunately we do not have much to do for these people for that monitoring does not exist (Topaz).

The community health agents in identifying...

We refer to the FHS doctor, even though a general practitioner, which is what we have … many times when the problem is not solved, we keep without knowing what to do (Tourmaline).

I forward only to the FHS, because we do not have more to do (Aventurine).

Forward to the FHS, despite knowing that we do not have professionals prepared for this (Turquoise).

I forward to the FHS, but were sad because we cannot do anything else, it is the end! (Sapphire).

I forwarded to the FHS and instructed her to talk to the neighbor. Her husband, I instructed not to leave her alone, but he does not always find a company before leaving for work, so he hides knife, sickle, because sometimes she attempts suicide, this weakness it happens… have many like this… (Sodalite).

The speeches of the subjects suggested that were held the same procedures, from the identification of the first symptoms to the worsening of depressive states, not being identified the addition increased by the CHA. Despite showing concern and interest to help and make the practice more effectively, the guidelines were limited. You see the lack of training of CHA, because although these users present strong symptoms suggestive of depression, in some situations the CHA had difficulties to identify them.

It corroborates that the inclusion of mental health in the FHS is something being built, requiring more investment managers in human and structural resources and vocational training, infrastructure, create conditions conducive to joint the network of integrated services and meets the social demands.¹¹

The CHA identified histories of suicide attempts at home. It is known that the desire for death and suicide ideas are symptoms that suggest worsening of depression. The lack of adequate treatment and health care in depressive states has shown and reflected a disastrous result, especially for the family of the depressed; that is: suicide. Suicide is possible as the condition of depression untreated.⁶ Therefore, patients with this symptom should receive, in addition to monitoring the FHS, specialized treatment.

The impossibility of the CHA to help these people is sadness reason and anguish for these, as accompany all the suffering of the people and even being a health professional, knowing the importance of an effective treatment, even with availability in help does not find support, reference, causing feeling of vulnerability.
The actions of mental health in primary care should take effect and be based on the principles of the Unified Health System (SUS) and the Psychiatric Reform, working in networks, with a territorial basis and transversal activities with other specific policies. The proposed work for the inclusion of the mental health services in primary care directs and draws a joint work plan in order to promote mental health and prevent disease taking into account the National Health Plans. Among them, there are the matrix teams, as from this, the CHA would have the whole team working together, ie, they would receive the necessary support to provide quality care to these patients.

Other 12 (54.5%) CHAs not fit into the second category the main theme I, forward to the expert, consisted of four (18.2%) CHAs. The psychiatrist was considered qualified to diagnose and prescribe the proper treatment. However, the municipality of Abaiara-Ceará did not have this professional, and the people were educated by the CHA to seek specialists in neighboring municipalities.

There is no psychiatrist in the city, so we guide people to look for an expert. People have to ask the mayor or secretary money for private consultation, but it's hard to find them and, moreover, it is difficult to find a space available, even if particular. All this is very difficult (Aquamarine).

The Municipal Secretariat of Health (SMS) had the partnership of CAPS in the municipality of Brejo Santo-CE; however the demand was greater than the supply of that service. Thus, both the CAPS service as investment in private consultations were limited.

Another problem identified in this study referred to the absence of monitoring of these people by the psychiatrist, since there was no monitoring of psychopharmacological scheme of this patient, which is why the patient remained two to four months taking the same medication prescribed, returning to the specialist only in times of crisis. It is noteworthy that this return is not always the expert consulted earlier, compromising the effectiveness of treatment. In some of these crises, referral is needed for the Psychiatric Hospital Santa Tereza, located in Crato-CE, by the FHS doctor. The speeches showed chronicity situation of users.

Usually the doctor of my health center has to hospitalize in Santa Tereza (Obsidian). There is a patient who made an appointment in Recife and the doctor ran a battery of medication, but did not give result. Then I told her to go back to the doctor, but there's no way... (Malachite).

It is notorious the lack of preventive care and monitoring practices those that would avoid psychiatric hospitalizations, occurrences, crises and guarantee disease control or even a possible cure, thus becoming a serious problem for the small city.

It agrees that joint action between mental health and primary care is a necessity which, given the number of people who suffer from behavioral disorder, there are, today, a demand for teams from FHS. However, there are challenges need to be addressed and some issues must be prioritized as improve service, through training, the support matrix and the incorporation of cases of serious mental disorders assistance in the area. A third category of thematic axis I, Emotional Support, cited by three (13.6%) CHAs.

I put myself at the disposal and show that the strength of will to live comes from God (Calcite).
I said to have faith in God (Kunzite).
I advised the person to not despair, have hope and faith in God (Opal).

The spiritual help was an alternative to the CHAs found to help people in their areas of coverage that had depressive symptoms. From the cultural point of view, the spiritual assistance is contested when it becomes impossible to human intervention, either by lack of resources, availability of medicine limits or even access, ie when it is exhausted the hope of care, treatment, control or cure of the disease. Not to find solutions and come across a multitude of difficulties and obstacles, these CHAs turned to divine help.

Already in the scientific point of view, there is good evidence that religiosity is able to prevent and contribute to the treatment and recovery of people with mental disorders, as religious beliefs affect how people deal with stress, suffering and vital problems. The religious experience can facilitate the adaptation of patients to the limitations imposed by the disease, reducing the effects on the occurrence and recurrence of depression.12

Regarding the fourth category of the main theme I, Emotional Support, cited by three (13.6%) CHAs, referred to the offer of words of encouragement and help, in order to convey positive messages in an attempt to counteract the negativity characterized by depression.

I said not to give up the goals and raise the head, move on and fight not to let the sadness win (Fluorite).
I told people not to think about negative things, not isolate, do not think of suicide, try to feed and try to sleep (Moonstone).
It was found that the CHAs demonstrated dedication to work to seek various forms and ways to help people with depressive symptoms, but generated poor solutions, being insufficient to achieve satisfactory results. Considering practices of mental health in primary health care is investment in the choice of the principles of health promotion and psychiatric reform, emphasizing the possibility of comprehensive care and the inclusion of people in mental distress in an extended care network. To this end, the gaps should be worked out and overcome challenges in order to establish the FHS/mental health link in practice, in order to offer assistance in this area in the three levels of assistance.11

- Main theme II - the act on behavior change

It was asked to 22 CHAs about identifying someone with visible change of behavior, such as talking to himself, agitated, gesticulating, running or walking fast. The answers showed that, from the 22 CHAs, twenty-one (95,5%) said they encountered in their daily practice people presenting such symptoms, and only one (4,5%) reported never having come across any person who presented change in behavior, or worthy of attention.

It wondered if the CHA has the actions taken to identify those people with visible change in behavior. From the 21 CHAs who claimed to have found people with behavioral change, seventeen (80,9%) reported that they did nothing, integrating the first category of the thematic axis II Nothing Done, expressing justifications, such as: difficulty in communication, presentation of aggressive behavior, fear, lack of a reference center for direct them in the city, little education and training to proceed.

They also reported that they changed their sidewalk or street to not have to meet these people. When I encounter people in these situations do nothing, because they are very aggressive, are cursing people, there can be no dialogue (Gypsum).

I've tried to talk, but I could not because I was disturbed, then I did nothing (Jasper).

Do not do anything [laughs], I fear the reaction of the person (Alexandrite).

I did nothing because I'm afraid to get up close [laughs] (Kunzite).

Here where agents live has many people with mental illness and help to offer a coffee, a plate of food and water, but the majority are cause of fear and are discriminated even by the family that does not give the appropriate follow-up, they are not prepared to the care of the mentally ill (Topaz).

Actually I do not even know what to do, so do not do anything, on the contrary, I changed was the way [laughs] (Fluorite).

I do not do anything for that in our municipality there is no care, does not have a professional to meet this kind of person (Sodalite).

Nothing, I could not do anything, because we do not know guiding and is complicated by the forwarding of a person that kind, because we do not have this kind of treatment (Onyx).

It was observed the presence of fear, which is why these patients are isolated and even living in the community, they have not entered into this because people avoid them, ignore them, becoming invisible socially, although there is in the community a situation of presumed avoided and tolerance. This fact worsens as they discuss the speeches of the CHA to make visible the lack of capacity by the same, demonstrating inability and incompetence facing mental illness.

The CHA presented distancing speech of people with mental disorder, because of the fear caused by the front estrangement to certain behaviors and the possibility that people with mental disorders suffer sudden lack of control, implying aggression and violent behavior. Despite the fear does not present concrete experiences that justifies it, this is related to the possibility of experiencing such experiences. No life experiences directly, but shared through exchange of information; transmission of everyday stories experienced by others and even from empirical observation experiences by other subjects of their social environment contribute to the strengthening of fear related to people with mental disorders.9

The deficiency in mental health training of CHA causes the same to dissolve before mental patients, since they know the problem through contact in their professional practice, but the strategies for dealing of this conjuncture are self-reported, allowing the existence and uncertainties and doubts. Thus, given the complexity of the situations of serious psychological distress and limited knowledge of the professionals who do not have expertise in the area, the job becomes even more difficult and distressing.11

The second category of thematic axis II, Forward, appointed for three (14,3%) CHA; matched the routing as action taken to identify people showing behavior change.

I forward to the FHS doctor and he gives a controlled drug or forwards it to the Psychiatric Hospital and when come back from hospital, there is no monitoring by the team, we only health worker is to continue
visiting. There are mental patients here who do not even know what a psychologist and a psychiatrist are (Aventurine).

It was evident forwarding people to the FHS. Crisis was evident in the Psychiatric Hospital Santa Tereza, located in Crato-CE. It is noteworthy that, when returning from hospital for socializing in the city, the person does not receive any follow-up. The main intervention carried out by the FHS top level professionals is the referral to specialized professionals.

The results of this study are similar to those of the survey of individuals over the age of 14 who sought care in primary care in basic health units linked to the Catholic University of Pelotas-RS, to identify gaps in assistance provided to the subject affected by depression. In that city, the alarming occurrence of depression was found and the results indicated that there is great demand for psychiatric patients being treated in primary health care, and these patients undiagnosed and are treated improperly because of lack of training of the FHS team, which routinely perform only referral to other professionals.¹

The third category of thematic axis II, supervised seek the Church, there was reported by one (4,8%) CHA:

Look, had a case when I came across a saw a desolated person and as he approached I was afraid for not expecting him and asked: Why are you very distressed and crying? And he said that his life no longer had meaning and that moment was going to kill himself. Then I said, seeks Jesus Christ, he does not want you to destroy, seek faith, go to Church, seek the Blessed and tell him everything, everything that's going on. And, thank God, if that person would commit suicide at that moment, God spoke, because then he came and said: Look, I thank you for helping me at that moment; it was God who put you in that moment. This has happened not only with one person but with several (Calcite).

The use of spiritual support to help the person in illness situation presents itself as a cultural resource to alleviate the problems generated by the lack of mental health services, since the assistance available in the city are non-existent, what motivates many people to commit suicide by the lack of adequate treatment.

Religion is presented as an important protective factor against suicidal thoughts and behavior, since beyond this provide a social support network; other mechanisms are proposed to explain its protective effect against suicide. They are: belief in life after death, self-esteem and goals in life, crisis coping models, meant for the difficulties of life, a social hierarchy that differs from the socioeconomic hierarchy of society, and emphatic disapproval of suicide.¹

- Main theme III - work hard, sad and disheartening

Asked up to CHA about the performance in a micro area where there were people with symptoms of depression, but with limited resources and support network of mental health services in the municipality of Abaiara-CE. From the 22 CHAs respondents, the majority, 16 (72%), did not fit in the first category of the thematic axis V, Very Hard.

It is difficult for you encounter problems, see the suffering that family and when you're hands are tied helplessly for that family (Aquamarine).

It's awful, because we see people with difficulty, suffering and has no way to help! (Jasper).

It is a pain working in a poor community, unattended and no resource turned to mental health (Alexandrite).

It is difficult because we have no resource, it is far from the major centers, often do not have a car! We only have one FHS, only! And more. So, it is God's way. It's difficult! It is very difficult! Hard for us and for families. Everyone suffers! Suffers the whole team (Aventurine).

It is very difficult, we need urgent help, it is time that were crying because these creatures are human beings who need to be in society, but who are isolating themselves more and more! (Calcite).

It is difficult because we also need a support nurse specialized in mental health and nurses from the FHS trained accompanying us in these cases (Sapphire). It is shocking moment for us [silence] I'm only is hurt by this situation. We need to seek solution to the municipality, the State and the Union, it is important that we hunt a means to bring professionals to our people (Sodalite).

It's complicated, people first seek CHAs, we cannot solve the problem and will appear other cases, the problem is getting old and more difficult to cure or control and we CHAs were unreliable. We're alone in the field in the area of Mental Health (Turquoise).

For me, I feel useless because I have a desire to do an efficient job and that assistance is deficient and contradictory, because we are working with health while mental health steps aside. For me it's like missing a piece of care (Obsidian).

In these lines, it is observed that the expressed feeling of futility, since working unable to exercise it successfully becomes difficult, dead and unproductive, due to lack
psychiatrist, entering involuntarily chronicity circle caused by the lack of support and encouragement on compliance and monitoring, due to the costs of medication and subsequent consultations if elucidates that one must consider the social contexts and cultural forces that shape the everyday, that give meaning to interpersonal relationships and life events. Thus, the understanding of the disease also encompasses its sociocultural context.

The Health Secretariat of Abaiara-CE had a program that offered high cost of medication for the population, but among the required documentation, prescription medication every three months by the medical expert was required. Therefore, it is suggested the availability of a psychiatrist, as a support to the FHS, so the population would also have access to free medication and, consequently, access to appropriate treatment.

The second category of thematic axis V, Very sad, was reported by five (22.7%) CHAs.

It is very sad because that's too bad you see the problem of the people, listening to the outpourings and have no where to refer, for that while you do your part, you listen, if you are not a professional, a person to meet those people and follow a treatment will not do anything those words and encouragement that the health worker gives (Amethyst).

It agrees that the FHS professionals base their interventions on the directions given by the Ministry of Health, in specific care programs. This statement is consistent with the results of a survey conducted in major Brazilian cities, which identified priority setting considering such programs, with the lack of reference to mental health.

There is evidence of a high prevalence of demand for mental health in primary care in Brazil among the population served, characterized largely by cases of depressive and anxious-lightweight frames. In addition to this clientele, it is the FHS unit to promote actions for the promotion of mental health and the risk of recognition for mental illness, working at all levels of care, from programming to the assistance of identified cases. Health services should be structured in order to provide responses to the demand of customers. Finally, one (4.6%) CHA fell within the third category of thematic axis V, describing the work as Discouragement.

The feeling that we have is discouragement. For I have had depressive problems, I have a great desire to help those people who also face this difficulty. If agent could rely on a support, more training by health, gives a greater monitoring, help these families to...
take care of these patients, guide relating to their integration into society and clarify a few things to agent is also doubt it would be very interesting and above all a place to refer these people. When we talk about depression, we know it’s a disease that can be prevented and that has many things we can do, but we are not trained to deal with these people and not to guide the family... (Topaz).

It was observed that the practice pointed to the incipient activities of FHS professionals in mental health. Identified and analyzed research studies have indicated that actions have been based on referrals to other services of the care network, generating fragmented care and devoid of ties between the clientele and the health team. Some of these barriers due to the little preparation of these professionals to deal with mental health issues, resulting from the origin, as well as great customer demand for which is responsible in the service, leaving little time for full and sensitive attention to the needs of population. These gaps must be worked since graduation in order to carry out the ideals of the Psychiatric Reform in the context of primary health care.11-9

About identifying the weaknesses of the service to mental health, primary care, together with the CHA in this study, we realized the need for the development and implementation of a Mental Health Program in Primary Care engaged the three levels of government, federal, state and municipal. In this sense, the tasks of Federal Level, the program concerns the development of indicators to enable the assessment of the actions annually, enabling the planning of the executed assistance as well as the addition of incentives for the Primary Care Floor (PAB), directed, specifically, investments in mental health. The State, in turn, would take over the coordination of the program in the state, which is linked to the coordination of existing primary care.

Concerning the Municipal Sphere, the action would be directed to the preparation, coordination, execution and evaluation of the program, from diagnosis of the main problems identified in the municipality to the election of the priorities to be worked towards remedying the problems identified in this study. To this end, through the PAB incentives, the city would hire a specialist mental health nurse working with the Health Secretariat to coordinate the program, promote training courses for the staff of the FHS and offer support to CHA in home visits to the most aggravating cases with achievement screens, formal referrals and enforcement of referral and counter mental health reference.

The FHS would have the support of professional psychiatrist and psychologist to promote health promotion, prevention and support for mental health. It is considered necessary and urgent system organization in primary mental health care, allowing the execution of formal referrals and conducting reference and counter reference in mental health, promoting the practice of preventive activities, early identification, treatment provision in timely monitoring and consequent reduction of severe depression and suicide rates, among other issues not discussed in this study.

As study limitation stands out the participant's opinion by the interview; however, the CHAs were affordable and not have difficulties in responding to interview script questions, as they are treated in their work practice.

CONCLUSION

The primary health care, among the cases of depression, should be present, since this, in addition to the prevention focus, takes responsibility for assistance to most Brazilians. As a professional active in this scenario, the CHA has developed some actions before people with depressive symptoms, ie realization of recreational and medicinal teas guidance, referrals to the FHS staff and specialist, offering emotional support and spiritual help.

Despite the availability to performing effective work with people with depressive symptoms, CHA did not receive follow-up of top-level professionals from the FHS staff and training in the area, causing who performed actions in a disorderly manner and without planning. In addition, the city was devoid of reference and counter reference in mental health, causing the actions of CHA do not come in a satisfactory result.

This fact allows the assertion that the CHA work among the population with depressive symptoms is being neglected and denounces the neglect of Abaíra municipality in this area and probably in others that have the same characteristics, since there is no mental health policy directed to small towns, and they do not have specific resources to invest in this area.

For such, the results of this study point to the importance of investments in mental health program in primary care, providing the system organization, allowing the execution of formal referrals and conducting reference and
counter reference in mental health, promoting the practice of preventive activities, early identification of cases and providing treatment in a timely manner.

REFERENCES


The community health agents in identifying...