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MENTAL DISORDER: KNOWLEDGE ASSESSMENT OF COMMUNITY HEALTH AGENTS

TRANSTORNO MENTAL: AVALIAÇÃO DO CONHECIMENTO DOS AGENTES COMUNITÁRIO DE SAÚDE

TRANSTORNO MENTAL: EVALUACIÓN DEL CONOCIMIENTO DE LOS AGENTES COMUNITARIOS DE SALUD

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ABSTRACT

Objective: to identify the level of knowledge of Community Health Agents on mental disorder. ***Method***: exploratory descriptive, and cross-sectional study with a quantitative approach, performed in Basic Health Units of Imperatriz/MA, with 140 Community Health Agents, between the months of May and June 2014. The data collected after the questionnaire were stored and tabulated on Excel spreadsheets software (Microsoft) and analyzed using Epi info ™ Version 6.04. ***Results***: 130 were females (93%), aged between 40 and 49 (45%); there was lack of knowledge involving mental health (46%) they did not know the concept of neuroses (37%) psychoses (38%) and mental retardation (31%) feeling of depression. ***Conclusion***: it is necessary to transfer information about mental illness for Community Health Agents. ***Descriptors***: Community Health Agent; Mental Health; Family Health; Mental Disorder; Public Health.

RESUMO

***Objetivo*:** identificar o nível de conhecimento dos Agentes Comunitários de Saúde sobre transtorno mental. ***Método*:** estudo exploratório e descritivo, transversal, com abordagem quantitativa, realizado em Unidades Básicas de Saúde de Imperatriz/MA, com 140 Agentes Comunitários de Saúde, entre os meses de maio e junho de 2014. Os dados coletados após a aplicação do questionário foram armazenados e tabulados em planilhas do *software Excel* (*Microsoft*®) e analisados segundo o programa Epi Info™ Versão 6.04. ***Resultados*:** a maioria pertencia ao sexo feminino 130 (93%), faixa etária entre os 40 e 49 (45%); houve deficit de conhecimentos que envolvem a saúde mental, (46%) não sabiam o que eram neuroses, (37%) psicoses, (38%) retardo mental e (31%) sensação de depressão. ***Conclusão*:** há a necessidade de repasse de informações sobre as doenças mentais para os Agentes Comunitários de Saúde. ***Descritores*:** Agente Comunitário de Saúde; Saúde Mental; Saúde da Família; Transtorno Mental; Saúde Pública.

RESUMEN

***Objetivo*:** identificar el nivel de conocimiento de los Agentes Comunitarios de Salud sobre trastorno mental. ***Método*:** estudio exploratorio y descriptivo, transversal, con enfoque cuantitativo, realizado en Unidades Básicas de Salud de Imperatriz/MA, con 140 Agentes Comunitarios de Salud, entre los meses de mayo y junio de 2014. Los datos recogidos después Del cuestionario fueron almacenados y tabulados en planillas del *software Excel* (*Microsoft*®) y analizados según el programa Epi Info™ Versión 6.04. ***Resultados*:** la mayoría pertenecía al sexo femenino, 130 (93%), grupo 40 a los 49 años (45%); hubo déficit de conocimientos que envuelven la salud mental, (46%) no sabían o que eran neurosis, (37%) psicosis, (38%) retardo mental e (31%) sensación de depresión. ***Conclusión*:** es necesario el repase de informaciones sobre las enfermedades mentales para los Agentes Comunitarios de Salud. ***Descriptores*:** Agente Comunitario de Salud; Salud Mental; Salud de la Familia; Trastorno Mental; Salud Pública.

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INTRODUCTION

The Unified Health System (SUS) was established by the Constitution of 1988 by social movements of stimulus known as Health Reform for all Brazilian citizens have access to public health service.[1]

In recent decades, this Brazilian Health System regulated by supplementary laws is gradually settling on the pillars of popular universality, comprehensiveness, decentralization, and participation.[2]

In Brazil, primary health care in 1990 came to be reformulated by the model of the Family Health through two main projects of the Ministry of Health: the Community Health Agents Program in 1991 and the Health Strategy 1994.[3] With the implementation of these programs, it was sought to humanize health care and the organization of primary care to meet the principles of the SUS.

The Family Health Strategy (FHS) is defined through various actions such as health promotion and protection, disease prevention, diagnosis, treatment, rehabilitation and maintenance of health, performed by the professional health team consisting of a general medical practitioner or family doctor, a nurse, an auxiliary or nursing technician and four to six community health agents (CHA).[4] In turn, the FHS is directed to all people established in the territory.[5]

The Community Health Agents Program began in 1980 in the state of Ceará.[6] Its appearance was related to the problems of drought and work policies, commonly adopted in this situation of emergency.[3]

Six thousand needy women were hired, who had as their main function the perform of health services and identify people at risk of hunger (or already hunger). However, there was no professional qualification before acting on the service because the program´s inclusion criterion is that women be recognized and respected in the community.[6]

After a few years, the Ministry of Health decided to make this experience in national program, but only in 1991 was inserted into the National Program for Community Health Agents (PNAS), and in 1992, it started to be called as Program of Community Health Agents (PACS) regulated only on July 10, 2002, through Law 10.507.[3]

Decree 3189 of 1999, determined by the federal government describes the CHA duties as to develop disease prevention and health promotion activities through individual and collective educational activities in households and community.[7]

The community health agent (CHA) is a piece of paramount importance, which provides the connection between the Family Health Unit (FHU) and the community because they guide the population´s health actions.[8] CHA know religions, values, language, dangers and opportunities of the reality in which they live, as they live in the place where they perform their work.[4]

Another significant move for Public Health took place at the end of the 1980s, which brought changes to the Mental Health called the Brazilian Psychiatric Reform also added to the Anti-Asylum Movement.[9]

The principles of the reform stand in deinstitutionalization, the rescue of citizenship, the uniqueness of individuals and the creation of services that tend to psychosocial rehabilitation of people with disorders,[10] as formerly they were assisted in the asylum model.[11]

Mental health is established timidly in training programs for health professionals outside the specific scope, and the Family Health Program is no different, still suffering modifications since this fact often hinders the delivery of assistance including household as health care place mainly to the CHA. They are often grounded in empirical knowledge for patients with mental disorders.[12]

It is noteworthy that if the CHA is an essential professional monitoring of people with mental disorders, given that he is responsible for giving information and enhancing the relationship between users and BHU.[13-14] Therefore, the CHA is part of the community where he works, he has connections and knows it.[14] He is considered one of the professionals responsible for giving information of their area for the FHS. It is important to emphasize the need for CHA to be trained in the mental health area, since through their knowledge, it is possible to act more effectively in the care of patients with mental disorders. Thus, the aim of this study is:

- To identify the level of knowledge on the mental disorder of the Community Health Agents.

METHOD

A quantitative approach to study, with cross-sectional, is characterized as the development time. The quantitative approach works with variables expressed in the form of numerical data and uses rigid resources and statistical techniques to classify them and evaluate them, and the development of cross-sectional type is the research done in short period in a given moment.15

The study was conducted at BHU, whose data were collected with the selection of 140 community health agents belonging to the Health Teams of Imperatriz-MA, chosen randomly and working daily with the community. The research was authorized by the coordinator of the Primary Care Department, and then the data collection was done with CHA teams. For each professional, the Consent Form (TCLE) was presented according to the provisions of Resolution 466/2012 that after having read and signed in duplicate, one way was given to the participant and the other way was given to the researcher.[16]

The questionnaires were applied between the months of May and June 2014, addressing the gender, age, education, working time, and the following aspects: what are neuroses, psychosis, mental retardation, sadness and feelings of depression; patients from their area; number of patients followed by the CHA; actions of their team; suffered aggression; fear; need for training and conducting training for nurses.

Participation in the survey was by free volunteer and without payment. It was up to the CHA the decision to participate or not in the research, being presented the risks and benefits for the subjects and guaranteed the principles of justice and autonomy, as well as beneficence and non-maleficence. Inclusion criteria established were: accepting to participate, being registered in the CNES, and being active in BHU of Imperatriz/MA. The exclusion criteria were: not being registered in the CNES, being on leave or vacation and those who have not agreed to participate.

Data were collected through the questionnaire, and then stored and tabulated on Excel spreadsheets software (Microsoft) and analyzed using Epi Info™ Version 6.04. Quantitative variables were expressed as frequencies (N) and percentage (%), presented in tables.

The research project was approved by the Research Ethics Committee of the Federal University of Maranhão (UFMA), CAAE 32888914.3.0000.5087.

RESULTS AND DISCUSSION

It is observed in Table 1 that the sample included 140 community health agents (CHA), with the following characteristics: 93% were women, aged between 40 to 49 years old (45%) were the most prevalent, followed by the age between 30 and 39 (30%). Regarding the level of education, 70% had a high school degree followed by 21% with university level. The BHU operating time (59.3%) was from 11 to 15 years.

The findings corroborate a study with twelve CHA working in five BHU of FHP/Zerbini, located in the district of Vila Prudente/Sapopemba, the southeast region of São Paulo. The study found that 100% of the group were female, with aged between 25 and 48 years old, 80% completed the high school.[11]

Table 1. Distribution of Community Health Agents, according to gender, age, education and working time. Imperatriz, Brazil,2014.

Variable	n	%
Gender		
Male	10	7
Female	130	93
Age		
20-29	1	0,71
30-39	42	30
40-49	63	45
50-59	31	22
60-69	2	1.43
70-79	1	0.71
Education		
Complete Elementary	6	4
Incomplete High school	7	5
Comlete high school	98	70
Universtiy	29	21
Working time (years)		
6 to 10	35	25
11 to 15	83	59
16 to 20	7	5
21 to 30	14	10
>30	1	1
Total	140	100%

Table 2 shows that some questions were held addressing the mental health care, to check the knowledge of community health agents on this subject, such as: what the neuroses and psychoses are, and more than half of the sample were wrong or did not know the answer. They had correct answers on the Disability or Mental Retardation (58%). Concerning the sad and depressed feeling (69%), they answered correctly.

Some studies exposed a great lack of information and training for dealing with complex situations present in the daily work of the Community Health Agents. These data showed that, by acting in this diversity, the CHA still have lack of specific training, which must be dynamic and guided by the reality experienced by each community, allowing coping present conflicts in the exercise of such professional assistance.[2]

Table 2. Distribution of the results of the participants according to neuroses, psychosis, mental retardation, sadness and feeling of depression. Imperatriz, Brazil, 2014.

Variable	Correct		Incorrect		They do not know	
	n	%	n	%	n	%
What are neuroses?	44	31	64	46	32	23
What are psychoses?	50	36	52	37	38	27
What is Disability or Mental Retardation?	81	58	54	38	5	4
What is sadness and feeling of depression?	96	69	44	31	-	-
Total	140	100	140	100	140	100

As can be seen in Table 3, 96% of CHAs know people with mental disorders in their area. About the number of patients visited with mental disorders by CHA, 66% follow from 1 to 5. According to the CHA, when a person is found with a mental disorder in the area, 84% are accompanied by the BHU team and the Psychosocial Care Center - CAPS.

Aiming to map the concepts and practices developed by CHA entered in the FHP against the experience of madness, research was conducted using a semi-structured questionnaire with 14 CHA. Among the 14 agents interviewed, only 01 reported not knowing someone suffering from mental disorder. By identifying these people, most participants referred to the FHP users of the areas that they cover.[17]

Regarding the monitoring of cases of mental disorders, more than 80% of participants in another study reported having mutual monitoring by the CAPS and FHS, that is, the existence of matrix support in cases where the FHS needs grants for their work.[18]

Table 3. Distribution of the results of the research participants, according to patients in their area, number of patients followed by CHA and their team actions. Imperatriz, Brasil.2014.

Variables	n	%
Do you know people with mental disorders in your area?		
Yes	134	96
No	6	4
Patients with mental illnesses accompanied by CHA.		
None	21	15
1 to 5	92	66
6 to 10	11	8
< to 10	16	11
When do you o when you find a person with mental disorder?		
Your team gives the responsibility of the case for CAPS.	23	16
Your team follows the case with the CAPS.	117	84
Total	140	100

It is observed in Table 4 that when asked if they had experienced any aggression when visiting these patients, 22% answered yes, and 58% are afraid to deal with the mentally ill. Another finding of this study was that 94% ensure that there is a need for training on this subject. Thus, in this study, it was observed the feeling of fear of some CHA compared to patients with mental disorder, by rating them as aggressive, because disturbances in behavior.

These data are consistent with a survey conducted in Sobral/CE, where fourteen agents who work in the Family Health Strategy/FHS were interviewed. The speeches of the CHA confirmed the idea of removal of people with mental disorder, since professionals report difficulties in approach, because of the fear caused by the strangeness against certain behaviors.[14] In this respect, professionals point to the possibility that people with mental disorders suffer sudden uncontrolled, resulting in violent behavior.

In the same table, there are 85% of the sample confirming the need for training on this subject. Another study of nine CHA in a BHU of the southern part of the city of Londrina - PR, which answered a questionnaire with open and self-administered questions, when asked about the need for training on mental illness, seven of the nine individuals of the sample said that there is the need for training, justified by the existence of cases of mental disorders in their area of expertise and need to prepare to deal with such situations.[18]

Table 4. Distribution of the results of the research participants, according to aggression, fear and the need for training. Imperatriz, Brasil.2014.

Variables	n	%
Have you experienced any aggression when visiting a patient with mental illness?		
Yes	31	22
No	109	78
Are you afraid to deal with the mentally ill?		
Yes	81	58
No	59	42
Do you think there is a need for training on this subject?		
Yes	119	85
No	21	15
Total	140	100

Regarding the training already carried out by the nurses of the family health strategy about mental illness, 38% ensured that none was performed (Table 5). It is noteworthy that the CHA training is primarily the nurse supervisor responsibility, as stated in Decree 1886/GM of December 18, 1997, approving the Rules and Guidelines of the Community Agents of Health Program and the Family Health Program.[19] Thus, when detected the need for better preparation to deal with certain situations, the nurse supervisor must stand ready to offer the appropriate training.

Table 5. Distribution of the results of the research participants, in conducting training. Imperatriz, Brasil, 2014.

Variables	None		Once		Twice		More than twice	
	n	%	n	%	n	%	n	%
Has the nurse of the family health strategy conducted some training on mental illness?	53	38	27	19	17	12	43	31
How many actions do you perform along with your team with these patients?	75	54	19	13	8	6	38	27
Total	140	100	140	100	140	100	140	100

Regarding the actions taken by the CHA, along with his team, 54% stated that no activity was performed with them. One possible explanation for this result could be the fact that in a survey of 45 CHA belonging to 21 BHUs in Maringá - PR when questioned on the target public health actions in which they have the opportunity also to work mental health, they concluded that these actions are limited to the so-called risk groups, including adolescents, pregnant women, elderly, hypertensive and diabetics.[2]

It is noticed that the BHU developing activities aimed at health promotion is restricted to certain groups, which people with mental illness are not always included. However, these activities aim to provide a better quality of life for people to maintain their independence, through health care which is critical to assist in treating these patients.

CONCLUSION

It is clear that the incidence of disorders has increased rapidly in the last decades. Therefore, it is necessary that the Community health agents have enough knowledge to work with these patients in their area. However, the results indicate a lack of knowledge involving mental health; they do not know what are neuroses (46%), psychoses (37%), mental retardation (38%) and feeling of depression (31%).

The nurse as a health team coordinator has the responsibility to impart knowledge to community health agents, which is an important tool for monitoring and identification of people with mental illness in their area. However, this study reveals that 38% of CHA received no training on mental illness.

Of the 96% professionals who know patients with a mental disorder in their area, 11% did not accompany them. This demonstrates the deficiency of the Family Health Strategy as not only the CAPS being responsible for the patient as well as the team in which he is registered. There must be not only the reference is referring patients to a specialized unit with reference also to the patient being directed to a unit of lesser complexity, to continue the treatment.

For the questionnaire, the difficulty was to find some community health agents in basic units. Since they work in the area with the community, they just go to the health center in the delivery week for production to the nurse and when they were found had no time to answer it.

Among professions constantly experiencing violence between professionals and users, the CHA are highlighted in which the study reveals that 22% had experienced some aggression and 58% are afraid to visit the patient with mental disorders, hindering to approach these professionals with him. Thus, it can be seen the difficulty that CHA have for the interaction with these patients due to their behavior, seen that many of them still have little knowledge in focused practice assists in mental health, prejudices and fears, so it is essential to be made permanent education with all the team's Basic Health Unit, propose training course for professionals, training sessions, so that besides basis for their performance, they are also braking barriers aimed at developing a more qualified assistance.

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