Journal of Nursing
Revista de Enfermagem
UFPE On Line
ISSN: 1981-8963

INTEGRATIVE REVIEW ARTICLE

TREATMENT OF THE PERSON IN MENTAL SUFFERING IN PRIMARY CARE

ACOLHIMENTO À PESSOA EM SOFRIMENTO MENTAL NA ATENÇÃO BÁSICA

ACOGIDA A LA PERSONA EN SUFRIMIENTO MENTAL EN LA ATENCIÓN BÁSICA

Andrey Ferreira da Silva[1], Raíssa Millena Silva Florencio[2], Aline Macedo de Queiroz[3], Elizângela de Morais Santos[4], Laís Chagas de Carvalho[5], Josicélia Dumêt Fernandes[6], Álvaro Pereira[7], Vera Lucia de Azevedo Lima[8]

ABSTRACT

Objective: to know the difficulties faced and the strategies used by the professionals to improve the reception of the person suffering from mental illness in Primary Care. ***Method:*** integrative review in the databases LILACS, BDENF, Index Psychology, MEDLINE and Scielo virtual library of articles published from January 2001 to December 2017, using the descriptors: host, mental health and primary health care. The data was systematized using the Content Analysis technique. ***Results:*** 25 articles were analyzed in which difficulties related to the professional, sociocultural and structural fields were identified. Regarding the strategies, it is sought training by the professionals, which favors accountability, the improvement in the conformation of the network and the organization of the service flows. ***Conclusion:*** the lack of professional training, material inputs, and the lack of recognition of Primary Care as part of the network are elements that make it difficult to host. So the organization of the flow and the search for professional training are strategies that collaborate in the reception. ***Descriptors:*** Reception; Mental health; Primary Health Care; Family Health; Patient Care Team; Psychiatric Nursing.

RESUMO

Objetivo: conhecer as dificuldades enfrentadas e as estratégias utilizadas pelos profissionais para a melhoria do acolhimento à pessoa em sofrimento mental na Atenção Básica. ***Método:*** revisão integrativa nas bases de dados LILACS, BDENF, Index Psicologia, MEDLINE e biblioteca virtual Scielo de artigos publicados no período de janeiro de 2001 a dezembro de 2017, com emprego dos descritores: acolhimento, saúde mental e atenção primária à saúde. Realizou-se a sistematização dos dados pela técnica de Análise de conteúdo. ***Resultados:*** foram analisados 25 artigos em que identificaram-se dificuldades relacionadas aos campos profissional, sociocultural e estrutural. No tocante às estratégias, busca-se capacitação por parte dos profissionais, o que favorece a responsabilização, a melhoria na conformação da rede e a organização dos fluxos de atendimento. ***Conclusão:*** a falta de capacitação profissional, de insumos materiais, bem como o não reconhecimento da atenção básica como participe da rede são elementos que dificultam o acolhimento, para tanto, a organização do fluxo e a busca por capacitação profissional são estratégias que colaboram no acolhimento. ***Descritores:*** Acolhimento; Saúde Mental; Atenção Primária a Saúde; Saúde da Família; Equipe de assistência ao Paciente; Enfermagem Psiquiátrica.

RESUMEN

Objetivo: conocer las dificultades enfrentadas y las estrategias utilizadas por los profesionales para la mejora de la acogida a la persona en sufrimiento mental en la Atención Básica. ***Método:*** revisión integrativa en las bases de datos, LILACS, BDENF, Index Psicología, MEDLINE y biblioteca virtual Scielo de artículos publicados en el período de enero de 2001 a diciembre de 2017, con empleo de los descriptores: acogida, salud mental y atención primaria a la salud. Se realizó la sistematización de los datos por la técnica de Análisis de contenido. ***Resultados:*** fueron analizados 25 artículos en los que se identificaron dificultades relacionadas con los campos profesional, sociocultural y estructural. En cuanto a las estrategias, se busca capacitación por parte de los profesionales, lo que favorece la responsabilización, la mejora en la conformación de la red y la organización de los flujos de atención. ***Conclusión:*** la falta de capacitación profesional, de insumos materiales, así como el no reconocimiento de la atención básica como participan de la red, son elementos que dificultan la acogida, para tanto, la organización del flujo y la búsqueda por capacitación profesional son estrategias que colaboran en la acogida. ***Descritores*:** Acogimiento; Salud Mental; Atención Primaria de Salud; Salud de la Familia; Grupo de Atencion al Paciente; Enfermería Psiquiátrica.

[1,2,3]Doctorate student, Federal University of Bahia / UFBA. Salvador (BA), Brazil. E-mail: silva.andrey1991@hotmail.com ORCID iD: https://orcid.org/0000-0002-1038-7443; E-mail: raissaflorencio@yahoo.com.br ORCID iD: https://orcid.org/0000-0002-5085-830X; E-mail: alinemacedo@ufpa.br ORCID iD: https://orcid.org/0000-0002-7374-011X; [4]Specialist, State School of Public Health of Bahia / EESP. Salvador (BA), Brazil. E-mail: elizms@hotmail.com ORCID iD: https://orcid.org/0000-0002-2890-4568; Master, Federal University of Bahia / UFBA. Salvador (BA), Brazil. E-mail: laischagas@ufba.br ORCID iD: https://orcid.org/0000-0002-1628-5480; [5,6]PhDs, Federal University of Bahia / UFBA. Salvador (BA), Brazil. E-mail: jodumet@hotmail.com ORCID iD: https://orcid.org/0000-0003-2946-5314; E-mail: alvao_pereira_ba@yahoo.com.br ORCID iD: http://orcid.org/0000-0003-1899-7374; [7]PhD, Federal University of Pará / UFPA. Belém (PA), Brazil. E-mail: veraluci@ufpa.br ORCID iD: https://orcid.org/0000-0003-0094-4530

INTRODUCTION

The person in mental suffering, for many years, has been seen as a person without discernment that scandalizes and threatens society. The social stigmas imposed on people in mental suffering are linked to contexts and relational situations of interpretation of the socially established norm of normality, which leads to a process of exclusion or marginality of the person. This corroborates, therefore, the social conception of the need for isolation for the treatment.[1]

In the 20th century, the use of psychotropic drugs and therapeutic experiences involving the inadequate management of the treatment of the person suffering from mental illness was prioritized in the 20th century.[2] However, institutionalization and the asylum model of care are strengthened by the use of these means of treatment, disrespecting the autonomy and citizenship of people in distress.[3]

This model was questioned in Brazil by relatives and professionals dissatisfied with the conditions of treatment and work in psychiatry due to the promotion of a precarious and inhuman therapy, in 1970, the Movement of Workers in Mental Health (MWMH).[1-3]

In 2001, after a 12-year process in the National Congress, Law No. 10,216, was enacted which "[...] provides for the protection and rights of persons with mental disorders and redirects the mental health care model." Since then, Brazilian psychiatric reform has been regulated with the objective of establishing and consolidating comprehensive care for people in mental suffering, with a view to promoting health and social reintegration.[2-4] However, only after ten years of this law, the Psychosocial Attention Network was established through ordinance 3,088 of December 23, 2011.[5]

It is invested, in the psychosocial care model, in new modalities of health technology, especially in so-called light technologies, observing positive results in changes in interactive patterns, interpersonal relations more dialogic and sensitive, opening a possibility of interacting with differences in society.[6]

The Psychosocial Care Network (PCN) was established for people suffering from or suffering from mental disorders and needs related to the use of crack, alcohol and other drugs was established with the purpose of creating, expanding and articulating health care points within the Unified Health System (UHS).[5] This network was organized in an attempt to overcome the hospital-centered and institutionalizing model, privileging the territories and promoting integrated care,[2] being composed of seven strategies: Specialized Psychosocial Care; Urgency and Emergency Care; Transitory Residential Care of Character; Hospital Attention, Strategies of Deinstitutionalization and Psychosocial Rehabilitation and Primary Care (PC).[7]

The PC in health is formed by the Basic Health Unit (BHU) and by the primary care team for specific populations and by the community centers. These services are made up of a multi-professional team, that has the responsibility to develop a set of actions, in the individual and collective scope, of mental health promotion, prevention and care of mental disorders, harm reduction actions, and care for people with consequent needs of the use of crack, alcohol and other drugs, shared with the objective of developing integral care that impacts on the health and autonomy situation of the people and on the determinants and health determinants of the communities, if necessary, with the other components of the network.[5]

Providing universal and continuous access to quality and resolute health services is one of the foundations and guidelines of PC. The establishment of mechanisms that ensure accessibility and reception presupposes that the health unit should receive and listen to all those who seek it. BHU must organize itself to assume its central function of welcoming, listening and offering a positive response. Proximity and capacity for reception, bonding, accountability and resolution are fundamental for the effectiveness of PC as a contact and preferential entrance door of the attention network.[8]

It is emphasized that hospitality is an extremely powerful technology present in health services that enables the formation of trust and care practice bonds between professionals and users. It also allows the knowledge of the health situation of the population in its territory so as to bring professionals closer to the daily reality of the subjects about their responsibility and the other services belonging to the networks of care necessary for each case. It is from the reception that the health teams can create collective and individual resources of follow-up, such as therapeutic groups, operative groups, approaches with the family, groups of coexistence, generation of income, therapeutic accompaniment, among others.[9]

Regarding the reception of the professionals in the PC, it is questioned: what

are the difficulties faced to guarantee PMS care in PC? What strategies are used by health professionals?

OBJECTIVE

♦ To know the difficulties faced and the strategies used by the professionals for the improvement of the reception to the person in mental suffering in the Primary Care.

METHOD

It is an integrative literature review (ILR) that is guided by the six recommended steps: (1) identification of the problem and definition of the guiding question; (2) search and selection of studies according to sampling criteria; (3) data extraction; (4) critical analysis of the selected studies; (5) interpretation of the results and (6) preparation of the synthesis and final report.[10]

Considering the stages of the integrative review, the research is guided by the following question: what are the difficulties faced and the strategies used to improve the reception of the mentally ill person in Primary Care?

The period selected was from 2001 to 2017, with 2001 being chosen due to the sanction of Law 10.216 - which provides for the protection of PMS rights. Through the use of Health Sciences Descriptors (DeCS): "reception", "mental health" and "primary health care", the Boolean operator "and" was used among the expressions, given that this operator is an intercession of the descriptors, delimiting the search.

The search for scientific articles was carried out in the following sources: LILACS (Latin American Literature Database, in Health Science), BDENF (Nursing Library), Index Psychology (Periodicals Indexed in Psychology Databases) MEDLINE (Medical Literature Analysis and Retrieval System Online) and SCIELO (Scientific Electronic Library Online). In order to refine the sample, the following inclusion criteria were used: original articles, in Portuguese, English and Spanish, published between 2001 and 2017. Theses, dissertations, monographs, and studies that did not address the subject, duplicate articles.

A total of 65 scientific texts were found, 44 of them in the LILACS database, 14 in the BDENF database, six in the Psychology Index and two in Medline, and no scientific material was found on the topic in SCIELO. After applying the exclusion criteria and floating reading of titles and abstracts, a total of 40 studies were excluded, being theses, two monographs, 16 duplicates, three for not being original and 14 for not answering the research question, according to (Figure 1).

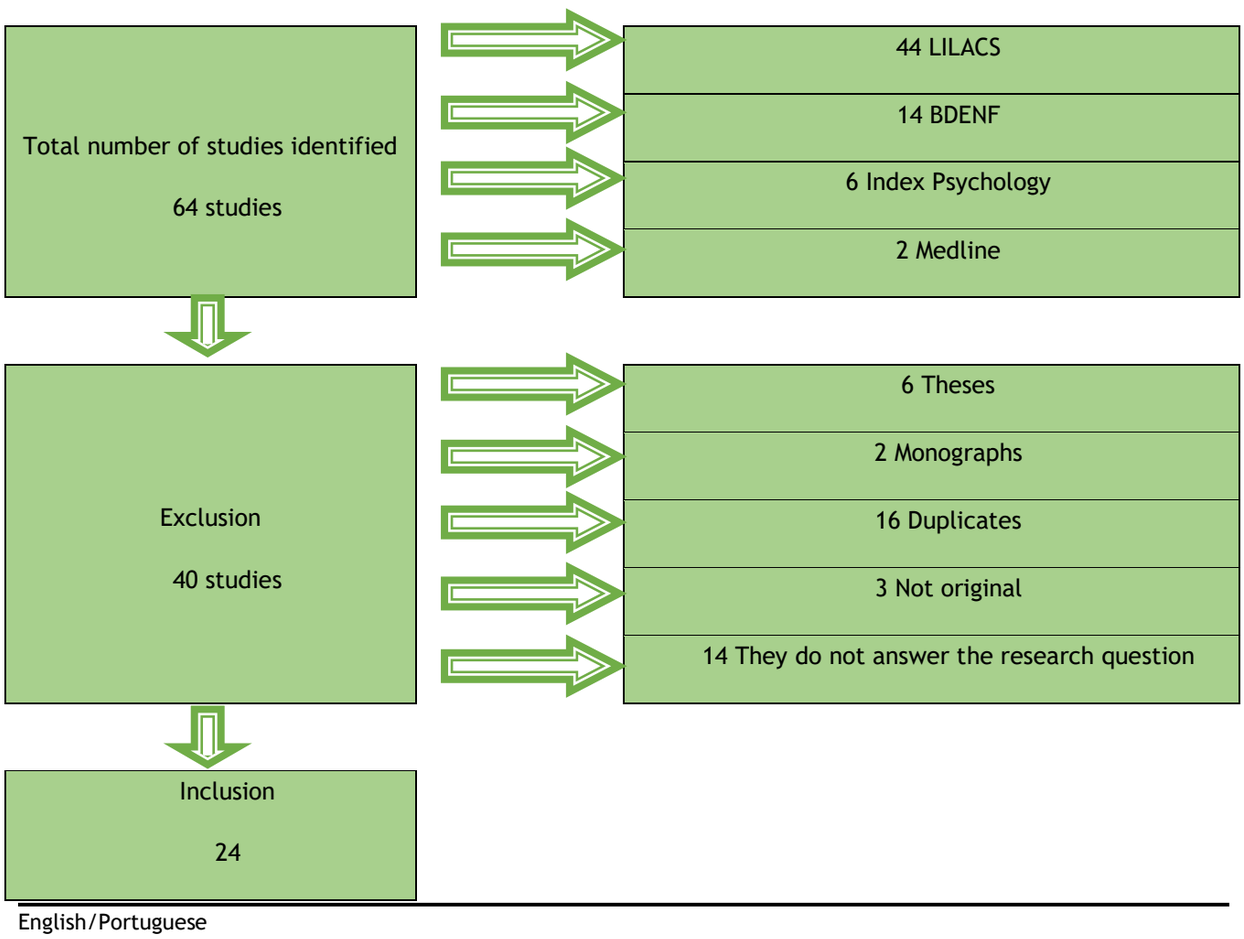

Figure 1. Strategy for article selection. Salvador (BA), Brazil, 2017.

After selection, the articles were organized according to the periodical, year of publication, name of the authors, and were classified by the level of evidence (LE), which deals with the hierarchy of publications according to external evidence and considers seven levels: I - systematic reviews or meta-analysis of relevant clinical trials; II - evidence of, at least, one well-delineated randomized controlled trial; III - well-delineated clinical trials, without randomization; IV - well-delineated cohort and case-control studies; V - systematic review of descriptive and qualitative studies; VI - evidence derived from a single descriptive or qualitative study; VII - opinion of authorities or committees of experts, including interpretations of non-research based information.

For the systematization of the data, the Thematic Content Analysis Technique was used, [11] following the following steps: pre-analysis, exhaustiveness rule, material exploration and data processing, inferences and interpretations. The floating reading of the articles was the initial stage, followed by the exhaustive reading, aiming at capturing the difficulties faced and strategies used to improve the reception of PSM in AB. Finally, the registration units were coded according to the analogy of the meanings and the abstraction of the categories.

According to the Copyright Law, Law nº 12.853, of August 14, 2013, which came into force changing Law No. 9.610 / 1998, ethical aspects were met by the study, once the copyright of the collected research was respected. [12] Also, due to its scientific profile, the submission of the study to a Research Ethics Committee was dispensed by the integrative review.[13]

RESULTS

A total of 25 scientific articles were selected that dealt with the reception of people suffering from mental illness in PC. The following is the list of articles selected according to their code, periodical, year of publication, authorship, title and level of evidence.

Journal	Year of publication	Author	Title	Level of evidence
Cogitare Enferm.	2006	Buchele F, Laurindo DLP, Borges VF, Coelho EB[14]	The interface of mental health in Primary Care.	VI
Revista Gaúcha Enfermagem.	2008	Caçapava JR, Colveiro LA[15]	Mental health care strategies in basic health units.	VI
Revista Cogitare Enfermagem.	2008	Botti NCL, Andrade WV[16]	Mental health in primary care - articulation between the principles of UHS and psychiatric reform	VI
Online Brazilian Journal of Nursing.	2008	Abreu KP, Kohlrausch E, Lima MADS[17]	Service to the user with suicidal behavior: the vision of community health agents.	VI
Ciência & Saúde Coletiva.	2009	Silveira DP, Vieira A LS[18]	Mental health and basic health care: analysis of an experience at the local level	VI
Ciência & Saúde Coletiva.	2009	Delfini PSS, Sato MT, Antonelli PP, Guimarães POS[19]	Partnership between CAPS and FHP: the challenge of building a new knowledge.	VII
Ciência & Saúde Coletiva.	2009	Vecchia MD, Martins STFM [20]	Concepts of mental health care by a family health team in a historical-cultural perspective.	VI
Ciência & Saúde Coletiva.	2009	Tanaka OYT, Ribeiro ELR[21]	Mental health actions in primary care: a path to the expansion of integral care.	IV
Estud. pesqui. psicol.	2010	Barros SCM, Dimenstein M[22]	Institutional support as a device to reorganize work processes in	VII

			primary care	
Rev. Bras. Promoç. Saúde.	2011	Oliveira FBO, Guedes HKA, Oliveira TBSO, Júnior JFLJ[23]	(Re) constructing scenarios of action in mental health in family health strategy.	VI
Revista RENE.	2011	Oliveira FB, Silva JCC, Silva VHF, Cartaxo CKA[24]	Mental health nursing work in the family health strategy	VI
Revista de Enfermagem da UERJ.	2011	Oliveira EB, Mendonça JLS[25]	Difficulties faced by the family in the reception of patients with mental disorders after hospital discharge	VI
Revista de Pesquisa: Cuidado é fundamental Online.	2012	Magalhaes VC, Pinho LB, Lacchini AJB, Schneider JF, Olschowsky A[26]	Mental health actions developed by health professionals in the context of Primary Care.	VI
Temas em Psicologia.	2013	Lima AIOL, Severo AK, Andreade NL, Soares GP, SILVA LM[27]	The challenge of building integral care in mental health in primary health care.	VI
Revista de Pesquisa: Cuidado é fundamental Online.	2013	Andrade JMO, Rodrigues CAQ, Carvalho APV, Mendes DG, Leite MT [28]	Multi-professional care for mentally ill patients from the perspective of family health.	IV
Revista Eletrônica de Enfermagem.	2014	Cortes LF, Terra MG, Pirres FB, Heinrich J, Machado KL, Weiller TH, Padoin SMM[29]	Treatment of users of alcohol and other drugs and the limits of the composition of networks	VI
Aletheia.	2014	Carsoso MP, Agnol RDA, Taccolini C, Tansini K, Vieira A, Hirdes AS[30]	The perception of users about the approach of alcohol and other drugs in primary health care.	VI
Psicologia em Estudo.	2014	Paula ML, Bessa, MS, Vasconcelos JMGF, Alburquerque RA [31]	Drug user assistance in primary health care	VI
Physis.	2014	Fratschi MS, Cardoso CL [32]	Mental health in primary health care: evaluation from the perspective of users.	VI
Revista de Pesquisa: Cuidado é fundamental Online.	2015	Muniz MP, Abrahão AL, Souza ÂC, Tavares CMM, Cedro LF, STORANI M [33]	Broadening the network: when the drug user accesses the psychosocial care for Primary Care.	VI
Texto & Contexto Enfermagem.	2015	Jorge MSB, Diniz AM, Lima LL, Penha JC[34]	Matrix support, individual therapeutic project and production in mental health care	VI
Psicologia: ciência e profissão.	2015	Minoia NP, Monozzo F[35]	Mental Health Home: Operating Changes in Primary Health Care	VII
Revista REME.	2016	Rigotti DG, Garcia, APRF, Silva NG, Mitsunaga TM, Toledo VP[36]	Reception of drug users in a basic health unit	VI
Revista Psicologia Ciência e profissão.	2017	Silva G, Iglesias A, Dalbello-Araujo M, Badaró-Moreira MI[37]	Comprehensive Care Practices for People with Mental Illness in Primary Care	VI

Figure 2. Integrative review articles according to their code, periodical, year of publication, authorship, titles and level of evidence, Salvador (BA), Brazil, 2017.

From the analysis made in the selected articles, it was possible to highlight the main difficulties faced and the strategies used by the professionals to improve the reception of the mentally ill person in Primary Care. In this way, two thematic categories emerged: "Difficulties for the reception of mentally ill people in Primary Care" and "Strategies used by professionals to improve the reception of mentally ill people in Primary Care", as shown in the following figure.

Difficulties for the reception of mentally ill people in primary care	Strategies used by professionals to improve the reception of people suffering from mental illness in Primary Care
• Absence of trained professionals to recognize mental health demands. • Fear and prejudice of the professional during the reception. • Lack of material resources. • Physician-centered attention model.	• Professional training in mental health • Professional Responsibility. • Improved conformation and articulation of PCN. • Organization of the flow of care

Figure 3. Presentation of the thematic categories according to the reality found in the Brazilian scientific literature. Salvador (BA), Brazil, 2017.

DISCUSSION

♦ Difficulties for the reception of mentally ill people in primary care

It is known that one of the difficulties evidenced in the reception of PMS in AB refers to the absence of professionals trained to the demands in MS.[17,22-3,27,36] This reality has a direct impact on the quality not only of the reception, but, also of the assistance provided to these users when, due to their lack of professional training, their needs are not cured, generating inadequate demand for mental health care.[23]

In addition to the inadequacy of care and care practices, it is inferred that due to lack of training, professionals are led to experience feelings such as fear and prejudice, which is the difficulty pointed out by the scientific literature as an obstacle to the reception of the person suffering from mental illness in primary care.[15,17,24] The social conception about PMS as a transgressor of moral and social norms has a direct repercussion on the way it is received in health services, which strengthens existing prejudices in society.[38]

In addition to conceptions based on fear and prejudice, the lack of material resources was identified as a barrier in the reception process because it made it difficult to use therapeutic methods that would facilitate the creation of a link between the user and the professional.[19,21,25, 34,36] This is not an exclusively Brazilian reality. In a study carried out in Chile, it is revealed that the lack of material resources in health services compromises the work processes and, consequently, the reception of users with mental problems.[39] However, it is worth noting that reception is a light health care technology which is established in the relationship between the professional and the person with mental disorder, without relying exclusively on material resources.

The physician-centered attention model is seen as an obstacle to the reception in Primary Care when it shows care practices vertically positioned with regard to knowledge and powers, impacting on the actions of other health workers of PC.[16,20-1,31]

In addition to the difficulties raised, it is revealed in the literature that one of the factors that negatively influence the reception of the mentally ill person in primary care is the non-recognition of this as a participant in the psychosocial care network.[14,18-9,29] In a study carried out with users of a FHU, it is demonstrated that they do not feel welcomed in their demands of MS for several factors, such as: lack of professional knowledge, disease-based view, prejudice.[19] In addition, from this obstacle, the non-execution of reception and integral care beyond mental illness.

♦ Strategies used by professionals to improve the reception of people suffering from mental illness in Primary Care

Basic Attention is characterized as a preferential entrance door in the UHS with the objective of developing integral care that takes care of health situations, turning to the autonomy of the people from their social determinants of health. The actions of mental health in Primary Care should be carried out by all professionals working in this area, taking as a point the territorial recognition and the link between the teams and the users.[12]

It is believed that the care given to the articulation between mental health and Primary Care, starting from the framework of the extended and shared clinic, has as one of the priority objectives the pursuit of freedom and autonomy of the subjects in front of the production of their own individual health, but also collective. Thus, expanded mental health has both a therapeutic and a preventive perspective, built on the encounter of empathic subjectivities in the exercise of

one's own freedom and the freedom of the other. Therefore, it is required that ethical and political values are part of the care practices in the field of mental health-Primary Care, as well as a sharing in the elaboration of policies and therapeutic practices.[40]

Through selected studies, it can be seen that the professionals who work in primary care seek, on their own, elements to better train themselves, which favors the reception and demands in mental health.[17,23,26-7] Health mental health should be included not only in undergraduate courses, but also in the capacities focused on Primary Care as a cross-cutting theme.[41] This would be a possibility for the training of health professionals focused on integral (biopsychosocial) care that understands that PMS does not needs only the specialized mental health service, but of the entire PCN.

Capacity-building initiatives are provoked, such as the "Pathways of Care: Training in Mental Health (crack, alcohol and other drugs)" project carried out at PC throughout the national territory, have provoked the awareness of the FHS teams regarding the professionals' about MS, demystification of the disease and possibilities of care, favoring the understanding of belonging to the PCN.[42]

This training space was offered to middle-level workers, but their development could enable higher level workers to identify new technologies for their work, better understanding the needs and their responses as health practices.

Based on training, it is possible that there is greater accountability of primary care professionals to mentally ill users in the territories assigned to health units.[32,35,37] Matrix-based strategies has shown to be an important technology capable of promoting the reception of quality. Although the limited number of specialist practitioners became a significant impediment,[40,43,45] the Family Health Support Centers (FHSC) emerged as a possibility for community intervention strongly focused on MS care from the present specialties belonging to each professional core.[24]

In a study carried out in Rio Grande do Sul, it was revealed that, after sensitization by the multi-professional team of a Basic Health Unit for the cases of psychic suffering, the reception that was initially performed by two professionals, in a shift and stipulated day, to be the responsibility of all professionals, who discussed the cases at meetings. Thus, the construction of the Unique Therapeutic Project was carried out once a week with the presence of psychology supervision.[1]

In this way, the interdisciplinary teams of Mental Health and Primary Care in the collective production of care begin to recognize themselves as participants in PCN and act on new paradigms, such as psychosocial rehabilitation and health promotion, acting on the social determinants of health.[40] From new experiences in mental health, it is possible to improve the conformation of the PCN, a strategy pointed out by the scientific literature for the improvement of the reception of the person in mental suffering.[18-9,37]

The circulation of health work processes, the sharing and exchange of knowledge among the actors present in the care scenario are prioritized by the continuous transformation of government policies from a pyramidal health care model to a network format. Although the National Primary Care Policy refers to the coordination of care in the care networks based on case sharing and monitoring of the health needs of the population, this process has been very incipient in many regions of Brazil.[45]

Much better organization of mental health flows is achieved by improving PCN conformation, and this strategy is pointed out in the literature[14,18-9,36-7] for facilitating the user's orientation to services based on their demands, which provides, to the professional who is providing assistance, security in the reception and care process.[36-7]

The reception must be produced by all members of the health team and occupy the most diverse spaces, being a dynamic process that requires openness and ability to produce increasingly horizontal dialogs from the needs presented by users systematically.

CONCLUSION

It is revealed by the scientific literature, that the difficulties encountered for improving the host are related to the lack of PC trained professionals, prejudice and fear in attending these users, lack of material resources, a physician-centered attention model and non-recognition of PC as a participant in the PCN.

In addition, a range of strategies used by the professionals to improve the reception of PMS in the PC, ranging from the improvement in the conformation and articulation of the PCN, the organization of the flow of care, the professional qualification.

An interweaving of strategies can be seen, in which, as one is carried out, it is possible to carry out the other. As a result, new challenges emerge and consist of back-and-

forth strategies as a network. The reception is a unique moment in the construction of PMS care, the creation of the professional-user bond, as well as the establishment of trust and, consequently, the effectiveness of the network. For this, it is necessary to know the health professional, especially about the concept of MS, and also the demystification of the prejudices that afflict the sick person.

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Submission: 2018/02/01
Accepted: 2018/07/24
Publishing: 2018/09/01

Corresponding Address

Andrey Ferreira da Silva
Caminho das Árvores
Rua Alceu Amoroso Lima, 698, Ap. 503
CEP: 41820770 – Salvador (BA), Brazil