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Original Article

Mental health care and primary health care as a training field for nurses

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Objective: to present the view of two students from the last year of an undergraduate nursing program at a federal higher-education institution concerning a primary health care service and the network care provided to individuals with mental suffering. Method: this is a descriptive experience report presented through a narrative, which was produced from records on field diaries. Results: there is a lack of articulation between theory and practice in the network care provided to individuals with mental suffering; the need to observe the practice scenario in articulation with the reality where the service operates is considered. Conclusion: the students' point of view contributes to the reflection on the teaching practice in mental health as a component that permeates global health.

Descriptors: Mental Health; Primary Health Care; Nursing; Education.

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Cuidado em saúde mental e atenção primária em saúde como campo formador para a enfermagem

Objetivo: apresentar o olhar de duas acadêmicas do último ano do Curso de Enfermagem de uma Instituição Federal de Ensino Superior sobre um serviço da atenção primária em saúde em relação ao cuidado a pessoa em sofrimento mental em rede. Método: estudo descritivo do tipo relato de experiência apresentado por meio de narrativa, que foi construída a partir do registro em diários de campo. Resultados: observa-se a não articulação entre teoria e prática no atendimento em rede da pessoa em sofrimento mental; considera-se a necessidade de observar o cenário de prática articulado à realidade onde o serviço está inserido, apontando-se a necessidade de avaliação da formação do futuro enfermeiro nesse sentido. Conclusão: o ponto de vista do aluno contribui para pensar a prática docente no ensino da saúde mental enquanto componente que perpassa a saúde global.

Descritores: Saúde Mental; Atenção Primária em Saúde; Enfermagem; Educação.

Articulación de teoría y práctica en enfermería y salud mental en atención primaria

Objetivo: presentar la opinión de dos estudiantes del último año del Curso de Enfermería de una Institución Federal de Educación Superior sobre un servicio de atención primaria de salud en relación con la atención de la persona co problemas mentales en una red. Método: un estudio descriptivo del informe de experiencia tipo presentado a través de la narrativa, que se construyó a partir del registro en diarios de campo. Resultados: existe una falta de articulación entre la teoría y la práctica en la observación de la atención en red de la persona con angustia mental; Se considera la necesidad de observar el escenario de práctica articulada la realidad donde se inserta el servicio, la necesidad de evaluar la formación de futuras enfermeras en este sentido. Conclusión: el punto de vista del alumno contribuye a pensar que la práctica docente en la enseñanza de la salud mental es un componente que impregna la salud global.

Descriptores: Salud Mental; Atención Primaria de Salud; Enfermería; Educación.

Introduction

The ideas of movement, projects, changes, construction and reconstruction, occupation of spaces/territories and inclusion practices permeate the psychiatric reform in Brazil and in the world. Social participation was and still is necessary in such political movement, in which the care for mental suffering has been redirected, in line with the principles of the Unified Health System (SUS), the Brazilian health reform and the country's redemocratization[1-2].

In order to sustain this change in the way of viewing and experiencing madness, it was necessary to think of society and the community as a social space for persons with mental suffering, since such individuals must not be cared for outside that space, under the risk of institutionalizing people and professionals with their clinical practices in mental suffering.

In place of substitute services for psychiatric hospitals and their work logic, the Psychosocial Care Network was created, which must operate under the logic of providing care to individuals in a network, considering the principles of psychosocial rehabilitation and the acknowledgement of individuals' rights and autonomy[1].

The Brazilian psychiatric reform has promoted changes and generated advances in public policies in the social context and in the Unified Health System. Despite the criticism to the model and the setbacks observed in recent years, to the detriment of the technical issues that support a psychosocial care model, we can consider that thinking of health and mental suffering without taking into account that individuals hold rights, as provided for by the Brazilian constitution, or their inclusion in the territory that they inhabit is a setback in itself[2].

It is the territory that the subject's identity inhabits and vice versa. Care for an individual with mental suffering, when provided in the territory, operates from the subject's health needs, in what he has in common with the community and in what is singular in his life. It is in such place that health is produced, at home, in the street, at school, in the community center, in a social project, in religious agencies and also in primary health care[3].

With this regard, the use of health services is the subject's relationship with the care provision network to which he has been assigned, with service workers and with service provision, considering the social determinants in health and mental health[4-5].

Health services work according to the demand presented to them, based on the logic of referral and counter-referral, of care in the territory and of the principles that have sustained and made SUS operate in its 30 years, among other factors, thus making it possible for mental suffering, regardless of its severity, to become part of the routine of the health units composing the health care network[6-7].

The care for individuals with mental suffering in primary health care has strengths and weaknesses that are widely discussed by social actors in and out of this scenario. However, certain actions, which are developed at the intersection between primary care and the mental health network, go beyond mental suffering, since these individuals require specific care that does not fit in the specialized network, and they will benefit from it when the treatment is moved from specialty-service sites to daily-life sites with the routine of health needs[7].

The workers' work process uses different technologies to manage the demand from users of the health system; however, there is a point of convergence: the relationship with the subject, thus producing what is defined as live work in action. They are important operators when producing health in environments where disease, illness and health are also embraced through health promotion, disease prevention and care provision[8].

The relationship with the subject is something important for mental health and for service users as it is a powerful operator in the treatment, from the initial approach to the subject to care maintenance. Thinking of mental health in a fragmented fashion is not a good predictor of actions that benefit the subject, his family, the social network or the community.

Mental suffering should not be considered exclusively on the list of illnesses and diseases that can be cured. It is mostly chronic, severe in some cases, and it aligns with the subject's ability to live regardless of his diagnosis or the limitations imposed by his psychic condition.

In this perspective, it is necessary to find embracement and visibility in the different care provision sites, regardless of the network to which the treatment of a subject with mental suffering has been assigned. Being visible and seen by the eyes of health workers makes this subject someone who admittedly needs health care. It moves the subject from the place where, in theory, he should be, that is, the specialized service, to the place where he needs to be at that moment in his life, whether articulation exists in the network or not[9].

This study aims at presenting the view of two students from the last year of the undergraduate nursing program at a federal higher-education institution (IFES), during their internship in a primary health care service, in relation to network care for people with mental suffering, and at using their description to discuss the topic based on the literature.

Method

The study aims to report the experience of two nursing students during a four-month internship at a health unit in a municipality in the metropolitan region of Belo Horizonte. The experience took place from Monday to Friday during the opening hours of the health unit, from March to June 2017, in which users were received by the students and other activities composing nurses' training were carried out.

It is a descriptive experience report presented through a narrative produced by the students from records on field diaries. The research project was approved by the Research Ethics Committee of the Federal University of Minas Gerais under number 0482.0.203.000-09[9].

The results are presented as follows: characterization of the municipality and its health care network, in order to locate the object studied on a screen; the narrative as a resource for the presentation of what was recorded on field diaries and the discussion.

Results

The municipality's health network

The health unit was located in a municipality that, according to data from the Brazilian Institute of Geography and Statistics (IBGE), had an estimated population of 135,968 inhabitants in 2017 and a territorial unit area of 302.419 square kilometers, that is, a demographic density of 449.6 inhabitants per square kilometer. In 2010, 97.48% of people lived in the municipality's urban area. The Municipal Human Development Index (MHDI) in 2010 was 0.731 (considered high) and the per-capita Gross Domestic Product (GDP) in 2014 was R$ 15.969,67 (US$ 3,696.77); however, in 2010, 33.2% of the population had a nominal per-capita monthly income of up to half a minimum wage (US$ 120.95).

At the time of data collection, the municipality had 22 basic health units and one state hospital that performed elective surgeries through referrals from the regulation center. In addition, it had an emergency care unit (UPA), a philanthropic hospital (Santa Casa de Misericórdia), which provided private services as well as services to health insurance customers. It also provided hospitalization beds for the Unified Health System and a specialized service center. Regarding the mental health service, it consisted of two Psychosocial Care Centers (CAPS), one for adults, according to modality II, and another for children, to serve the population.

CAPS II worked from Monday to Friday, from 7 a.m. to 5 p.m. It consisted of a team comprising three psychiatrists, two social workers, four psychologists, one occupational therapist, one nurse and three nursing technicians. The service was provided through spontaneous demand and referrals from primary health units, hospitals, the social development secretariat and other services. Users were initially received by a professional on the team who had higher education. After this first consultation, the case was discussed with the rest of the team and then a therapeutic plan was designed.

The service provided care in two modalities: outpatient consultations and day stay. The day stay applied to patients who were in crisis and had a recommendation to remain in the service during the entire opening hours. These users were offered food and transportation back home.

The children's CAPS worked from Monday to Friday, from 7 a.m. to 4 p.m. The team consisted of four psychologists, two speech therapists, one occupational therapist, one psychiatrist, a manager and an administrative team. It provided care for children and adolescents from zero to twenty-five years old, who were referred by schools, primary health care units, the guardianship council and spontaneous demand. It provided consultations with professionals in addition to having a specialized group for autistic patients. It did not provide day stay.

The health unit was located in an industrial and residential neighborhood, next to an elementary and high school and a day care center, and it was part of the Family Health Strategy. Its assigned population, according to data provided by the health unit, was divided into seven micro areas, totaling 6,026 thousand people distributed in urban and rural regions, with the rural area being located approximately five kilometers away from the unit.

The unit was small and had a family health team, which consisted of: a nurse, who was also responsible for the unit's management, two nursing technicians, a doctor, a support doctor who was scheduled to work at the unit once a week, and seven community health agents. The community agents were assigned to administrative activities within the unit due to the lack of professionals to perform such tasks. In addition, the unit had a cleaning employee, a security guard, four dentists and three dental assistants.

Where I see you from

During the internship in primary care, we observed the demand from people with mental suffering, who turned to the health unit for care. In some cases, we realized that people with mental suffering were not easily perceived in their psychic condition. At other times, they were labeled or stigmatized as "problematic" or "CAPS patients".

Our perception was that the link between primary care and secondary care proved to be non-existent, that is, what was supposed to be an interconnected care network that provides autonomy and security to individuals with mental suffering did not work as it should. In some cases, we observed that the link with CAPS was interrupted or considerably spaced, and its users started to integrate and attend only the health unit - most of the time to renew a prescription or in order to minimize the idleness that they were experiencing.

In the day-to-day observations of the service, we identified relevant weak points in relation to the municipality's CAPS: the difficulty in meeting the demand, the reduced service hours and the failure in meeting the population's health needs. Thus, we considered that its operation was limited when compared to the demand observed at the health unit.

In addition, there is the number of appointments that could be scheduled in relation to demand, such as the waiting time of four to six months for an appointment at CAPS, the fact that consultations were exclusively with a psychiatrist and the constant lack of certain medications that ought to be provided by the service.

As regards the health unit, the fragility in training the primary care health team to receive and monitor individuals with mental suffering in their daily demands was noticeable. Referrals from the specialized service to the health unit were perceived as a one-way street, where the logic was to 'relieve' CAPS in relation to the number of appointments, without considering the training of professionals or their difficulties in managing people with mental suffering.

We observed the vulnerability of users, in addition to the complexity on the part of professionals in handling these individuals, and the difficulties in treating and caring for a person with mental suffering. The presence of other clinical comorbidities was observed, in addition to mental disorder, especially diabetes and hypertension, and one of the main challenges to the team was to articulate the needs and demands from service users with the capacity to manage these cases.

It was noted that, for the professionals at the health unit, it was a challenge to perform educational actions to prevent diseases and promote health for this clientele, as well as to care for the associated comorbidities.

At the end of the observations, when discussing with the study supervisor, it was noted that reality was viewed without an articulation of practice and theory; such view was devoid of the necessary articulations to understand reality. From this perception, there is a need to search the literature for elements that will help understand what was experienced from another perspective, one that would enrich training and move away from common sense.

Discussion

The internship in the last year of the undergraduate nursing program is an important moment for the training of future nurses, during which it is expected that questions concerning nurses' work in health services will be answered. It is also where new questions regarding theory and practice and the reality of performing and knowing how to perform in health care are asked and, most importantly, it is where students approach the reality experienced by health workers - nurses - in different health care networks[10].

The literature points out that psychiatric nursing education is based on traditional ways of producing knowledge with and for students, but that many programs perform actions, by using active methodologies, so that future nurses can learn that mental suffering has its particularities, as it is a chronic illness that cannot be understood as an individual's only health care need to the detriment of other illnesses, whether acute or chronic[11-12].

With this regard, one of the challenges in nurses' training is to add content to curricula that takes into account the biological issues of disorders, but that will not neglect psychosocial aspects and the social determinants of health and mental health. Such balance can provide future nurses with an expanded view of the reality of a health service, as described in this article, considering, for example, the municipality's population, its demographic density, urban space occupation, MHDI, GDP and the nominal per-capita income, as well as the possible health network for such municipality, taking into account its revenue and the management of its income, among other factors.

Once this is understood, it is possible to view the service in a different way, as a space that reflects health management in the municipality, the relationships among services, how the network is organized, the relationship of professionals with individuals undergoing mental suffering, the working conditions of service workers who care for patients with similar demands and have points of convergence and divergence, the estrangement caused by providing or not providing care for the health needs of such individuals, which can be done in primary or secondary care, depending on the demand that they present.

The social stigma carried by people with mental suffering is described in the literature, and it is part of their lives, as well as promoting non-stigmatization is part of the routine of the mental health network and should be present in the agenda of other health services. Stigma generates the invisibility of the subject and his demands, which are then classified as a single one. In addition to the diagnosis, the subject is charged with belonging to a certain location: the specialized

service, which is CAPS in this case. Thus, the subject is left with the inconvenience that he causes to the service because it does not know what to do about him or about his demand[13].

In addition to this issue, the opportunity to transform comprehensive care into a social, political and health-provision act is lost at that moment. The field of studies of Global Mental Health contributes to such understanding because, when discussing ways to reduce inequities in the access and care for this population, it points out three strategies that can directly and indirectly contribute to this issue, namely: integration of mental health services with primary health care services; the sharing and delegation of tasks and the incorporation of technological innovations to the existing models of mental health care provision services[14].

It is noteworthy that, in 2020, according to data from the World Health Organization, depression will be the second largest cause of disability in the world. Mental health services will not be able to handle so many cases[15].

The integration of services in the Brazilian case works with referral and counter-referral, with a matrix support and the articulation of networks. Its operationalization features nodes that rely on the inventiveness of the actors involved and implicated in solving the day-to-day difficulties of joint actions. The sharing and delegation of tasks can be apprehended in the context of network functioning as the virtuous strategy of matrix support in mental health, a powerful mechanism to disentangle complex cases that require different approaches, the involvement of different actors and institutions in managing in and out of the territory[16].

The sharing and delegation of tasks as well as the transfer of care technologies operated within the mental health service seem to be an important path that deserves investment in the production of care for people with mental suffering in primary care. It is not enough to view CAPS as fragile, but it is necessary to reflect on its potential for creativity and inventiveness in producing individuals' autonomy, so as to enable their personal and collective projects, as it is important to reflect on how this is managed within the mental health service to occur in the daily life of the territory.

The sharing of such know-how with the primary health care teams by the CAPS team can generate more fluid actions in the care for others; others who, in addition to mental suffering, live with different comorbidities that, in some cases, put their lives at risk and must be addressed.

Permanent education is the point that supports the provision of quality services by health workers regardless of the care network to which they have been assigned. To produce qualified, ethical and aesthetic health care, it is necessary for workers to be sure of their actions, to have support from their team and from the service as part of a network. The health needs of individuals seeking primary care are the most diverse; therefore, professionals need to be trained to deal with such plurality, at the same time that they cannot lose perception of what each one is in his or her singularity[17].

It is a complex balance that requires effort on the part of managers of the health system as a whole, at all levels. The management of mental health service users has particularities in some moments; however, in others, their needs do not differ from those of users of other clinics with regard to their health. We can infer that this difficulty is associated with the idea of danger, stigma, prejudice and fear, which would lead us to a historical, political and social discussion about mental suffering. Another way is to think that these issues can be minimized if perceived as challenges for the care of the territory and its beings[18].

The literature, as a base for understanding what was observed, generated the possibility of discussing with students the need for articulation between theory and practice, based on the principle that the health professional's view must not be shifted from this horizon.

It is understood that there are nodes at the points of convergence and divergence of the different health care provision networks as regards individuals with mental suffering, but in addition to these necessary discussions, the view/text, in this case, was an excuse to discuss some existing nodes in the field of agreements and disagreements between the mental health service network and primary health care with the training of undergraduate students as a background.

Concluding Remarks

The study shows limitations that are inherent to experience reports. The first is that there is no possibility of generalizations, which is followed by the view of two students on a certain topic associated with a specific context where elements must be considered not only in the observation scenario, but also in the very subject who observes. Hence the need for further studies, with different theoretical approaches that explore the topic of the view of future professional nurses in relation to the health services where they are trained.

This discussion started from the perspective of nurses undergoing training as regards a complex issue. Based on the literature on that topic, it sought to contribute to the discussion about the care needs of people with mental suffering and how this is perceived by nursing students, based on concepts and theoretical assumptions that aim to contribute to thinking of health in an articulated fashion, taking into account its social,

political and financial determinants, among others, with regard to nurses' training.

Knowing the student's point of view with this regard contributes to thinking about the teaching practice, reviewing contents and forms of approaching them, thinking about the weaknesses of what has been learned, but not necessarily apprehended. It is necessary to articulate discussions that take into account the reality of services and considering the place where they operate becomes an important point in planning education in mental and general health care when thinking about working in networks within a system that is unified.

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Authors' contributions

Research conception and design: Amanda Márcia dos Santos Reinaldo. Data collection: Bárbara Jéssica de Melo Cezar Dias and Fernanda Martinez de Oliveira. Data analysis and interpretation: Amanda Márcia dos Santos Reinaldo, Bárbara Jéssica de Melo Cezar Dias and Fernanda Martinez de Oliveira. Funding acquisition: no funding. Manuscript writing: Bárbara Jéssica de Melo Cezar Dias, Fernanda Martinez de Oliveira Resende, Giulia Ribeiro Schettino Regne, Amanda Márcia dos Santos Reinaldo, Maria Odete Pereira and Marcus Luciano de Oliveira Tavares. Critical revision of the manuscript: Amanda Márcia dos Santos Reinaldo.

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