DOI: 10.1590/1413-812320152010.13572014

Mental health care: how can Family Health teams integrate it into Primary Healthcare?

Guilherme Gryschek [1]
Adriana Avanzi Marques Pinto [2]

Abstract *Mental health is one of the responsibilities of Brazil's Family Health system. This review of literature sought to understand what position Mental Health occupies in the practice of the Family Health Strategy. A search was made of the scientific literature in the database of the Virtual Health Library (Biblioteca Virtual de Saúde), for the keywords: 'Mental Health'; 'Family Health'; 'Primary Healthcare'. The criteria for inclusion were: Brazilian studies from 2009 through 2012 that contributed to understanding of the following question: "How to insert Mental health care into the routine of the Family Health Strategy?" A total of 11 articles were found, which identified difficulties and strategies of the professionals in Primary Healthcare in relation to mental health. Referral, and medicalization, were common practices. Matrix Support is the strategy of training and skill acquisition for teams that enables new approaches in mental health in the context of Primary healthcare. It is necessary for Management of the Health System to take an active role in the construction of healthcare networks in mental health.*

Key words *Primary healthcare, Mental health, Family Health*

[1] Programa de Clínica Médica-Ensino em Saúde, Faculdade de Ciências Médicas, Unicamp. R. Tessália Vieira de Camargo 126, Cidade Universitária Zeferino Vaz. 13083-887 Campinas SP Brasil. ggryschek@gmail.com
[2] Programa de Pós-Graduação em Enfermagem, Faculdade de Medicina de Botucatu, Universidade Estadual Paulista.

Introduction

In recent decades we have seen a significant increase in the areas covered by the Family Health Strategy (*Estratégia de Saúde da Família* – ESF) in primary healthcare (Atenção Primária à Saúde – APS) in Brazil, and of substitution of new services in mental health (MH), resulting, respectively, from the processes of the Health Reform and of the Psychiatric Reform[1,2]. At the same time, the articulation between mental health and APS is awakening growing scientific interest, since mental disorders are a significant portion of the demand of APS[3].

International estimates, and those of Brazil's Health Ministry, indicate that 3% of the population need continuous care in MH due to serious and persistent mental disorders[4]. A further 9% need occasional care for minor problems, grouped as 'Common Mental Disorders', which today may represent between one third and 50% of the demand of APS[3,4]. Adding this demand to the problems arising from alcohol and drugs, for which 6% and 8% of the population reportedly have a need for regular care, one can have an idea of the breadth of the problem to be dealt with in care for mental health[4].

It is known that the demand for mental health in basic healthcare has particularities and complexities that cannot be solved by the classical knowledge of Psychiatry[1], and this has resulted in new proposals for de-institutionalization of the care given to those with mental disorders: multi-professional team care, an integrated approach, accountability for the team linked to a community, an approach spanning sectors, and integration between the primary and specialized levels of the network[5]. Since the 1970s the World Health Organization has been indicating the breadth of the problem in mental health, proposing decentralization of services, integration of psychiatric services into basic healthcare, and increase in community participation[6].

Coherently with the recommendation of the WHO, in several countries a Psychiatric Reform has centered on de-institutionalization of those with mental disturbances, and the consolidation of territorial bases of care in mental health through networks that are part of APS[5], taking as a starting point the fact that a large part of mental health problems can be solved at this level of care, without the need for referral to the specialized levels[7].

Under the present mental health policy in Brazil, which currently guides the Psychiatric Reform, the CAPs (*Psycho-social Care Centers – Centros de Atenção Psicossocial*) are "strategic devices for organization of the healthcare network in mental health"[4], organized by territory and able to use the potential of the community services in each area, with a view to reintegration of its users into society, and able to be put in place in municipalities with populations of up to 20,000.

Although the CAPs are considered to be strategic, mental health care has increasingly been understood as a care network that includes basic healthcare, therapeutic homes, outpatient facilities, convenience centers, and leisure clubs, among other resources[4]. However, one finds a complaint that these professionals lack the mechanisms to intervene in MH, which often generates a precipitate referral of these patients to the CAPs[8]. For this reason, in spite of the stimulus to 'territorialization', and an articulation in amplified mental health service networks, there appears to be a great distance between the guidelines of the Mental Health Policy and what one observes in concrete reality[5].

So, in order that actions in mental health can be developed within APS, it is a fundamental need that these teams should be trained through permanent activities of discussion of cases with mental health teams, making possible strategies of care that (a) take into account the multiple determining factors in the process of health/illness, and (b) support a view that supersedes the simple approach via medicalization in care for people with mental disorders[1]. Team discussion of mental health cases makes it possible for data to be acknowledged that were not previously perceived and accepted because there was no understanding of their importance for all those involved in care. This team discussion, in a certain way, promotes integration of the services and consequently better capacity to achieve real solutions, because it is possible to make integrated care for an individual who has some mental disorder a concrete reality[8].

The application of the principle of full integral care for both mental health and basic healthcare can be made viable by the *Matrix Support* (MS) Model[9], which is understood as a 'model for integration of specialists into the primary healthcare network'. The MS Model is an institutional arrangement that promotes two-way conversation between mental health teams and the Healthcare Unit teams, disseminating knowledge horizontally, and making it operate throughout the field of work of the teams[10]. It is an important technical-pedagogical device for defining flows, adding an extra component of knowledge and qualification to the ESF, and promoting joint and shared care. According to this model, workers in various specialties interact with the APS reference teams and develop actions such as: technical-pedagogical consultancy, joint care sessions, specific collective care actions, and, exceptionally, individual care[11].

In view of the MH needs that are present in Brazilian APS, it is of fundamental importance to

Ciência & Saúde Coletiva, 20(10):3255-3262, 2015

understand how the teams of the ESF can offer mental healthcare with the due efficacy and capacity to provide solutions. This study reviews the scientific literature to provide an understanding of how mental health currently fits in with the care offered by the ESF.

Methodology

The study comprised a review of the scientific literature, starting with a search in the Virtual Health Library. This Library brings together the principal databases in Health Sciences, such as *Lilacs* (Health Sciences Literature of Latin America and the Caribbean), *SciELO* (Scientific Electronic Library Online) and *Medline* (Medical Literature Analysis and Retrieval System Online), carried out over the period July 15–20, 2013, with the following combined keywords: *Mental health, Family Health, Primary healthcare.*

Criteria for inclusion applied: studies available in electronic form, published in Brazil in the last five years – so as to include the most recent scientific literature on the subject. Articles were selected which, after reading, were able to give contributions to the question posed by the survey: "How to insert Mental Healthcare into the routine of the Family Health Strategy?" Initially, 1,725 articles were found. On application of the criterion of inclusion by country of publication, this was reduced to a group of 72 articles, and the criterion of publication within the last five years reduced this total to 36 articles. After careful reading of the articles in full, by two authors, and discussions on the possible contributions of each article to the question posed by the study, 11 articles were selected which provided findings and discussions that dealt with the routine of mental health in basic healthcare, published over the period 2009 to 2011[3,10,12-20].

Results

Below (Chart 1) is a summary of the 11 articles selected and their principal results.

After reading of the articles and analysis of their principal findings, and discussions, three principal aspects were identified, which constitute the joint thematic subjects of the 11 articles, which we have grouped into the three following sections: The presence of mental health care in APS and the ESF; the limitations of mental health care in APS; and discussions on how to increase the power and effect of mental health actions in APS.

Mental health in APS and the ESF

The communities in which the ESF is inserted are poor areas, which have few community and social resources, and in which the presence of drugs, violence and unemployment is common. These conditions of exclusion are associated with problems of mental health[12].

Thus, in the daily routine of care in the ESF there is an important mental health demand, but the teams do not always know how to deal with this demand[12,13] or do not treat some of its day-to-day practices as 'mental health care'[10]. The reason for this is the persistence of the biomedical and positivist model in the training and activity of those professionals, making them feel that they 'lack the capacity' to learn, to train and acquire knowledge and skills, and to operate in mental health in their daily practice[10].

At the same time, the ESF teams have potential to offer mental health care, especially due to the link that they establish with families[14]. For interventions that promote mental health, the Community Health Agents have a strategic role in identification of potential offers, and in providing listening and welcoming support in a manner that is closer to the population[15].

One does see a need for the professionals of the ESF to assume a central role in integrated care for mental health, making the local units of the ESF not only units of diagnosis and referral, but also units that can offer mental health care[14].

Principal limits of mental health in APS

MH is a cause for concern of the teams of the ESF, because they feel unprepared for, and afraid of dealing with, difficult situations in mental health, such as suicide attempts and psychotic episodes[13]. This is because 'mental health care' is focused on medication and referrals to specialized evaluation[16]. Even when there is a proposal for MS, many professionals are not clear about the proposal because they have not participated in its construction. As a result they see any expansion of supply of mental health care within basic healthcare as an 'addition' to their work, and a 'lack of assumption of responsibility' on the part of Specialized Care[10,16].

Coherent with this overview, mental health care thus becomes focused on intramural actions (within the Health Units), with a psychological approach (individual psychotherapy) or a psychiatric approach (specialized, and focused on medicalization)[17]. Instruments of mental health care such as acceptance and welcoming, and listening, are little explored by the ESF teams, and the assistentialist and medicalized logic is maintained[17].

Chart 1. Study, Author, Year of publication, Type of study and Principal results.

Title	Authors	Year	Study	Principal results
Common mental disorders in Petrópolis, Rio de Janeiro State: a challenge for integration between mental health care and the Family Health Strategy[3].	Fortes S, Lopes CS, Villano LAB, Campos MR, Gonçalves DA, Mari JJ	2011	Quantitative	There is a group especially at risk for mental disorders in primary healthcare: poor women with little social support. In other countries, special interventions have been developed for them to be assisted by primary healthcare.
Challenges facing mental health care in the Family Health Strategy[10].	Cavalcante CM, Pinto DM, Carvalho AZT, Jorge MSB, Freitas CHA	2011	Qualitative	Mental Health actions are carried out by some health workers in the Family Health Strategy: matrix support, relationship technologies, home visits, and community therapy. It was found that there is a deficiency in the training and skills acquisition of basic healthcare professionals, due to the persistence of the pathological/curative model of health care.
Work processes in healthcare: practices for care of mental health in the Family Health Strategy[12].	Camuri D, Dimenstein M	2010	Qualitative	Work processes in health care are organized in a bureaucratic and hierarchical manner, and healthcare practices perpetuate the knowledge/practices of each professional involved. The logic of specialty-based care persists; and teams do not welcome nor accept responsibility for the demand – referring cases to other services.
Conceptions of mental health care as perceived by a Family Health team, in a historical and cultural perspective[13].	Dalla Vecchia MD, Martins STF	2009	Qualitative	The team finds the following important: determination of life conditions in the health/illness process of the population served; the need to use diversified strategies in care beyond the consultation; the importance of the team taking care of its own mental health; the difficulties in the approach to the family.
The praxis of Mental Health in the ambit of the Family Health strategy: contributions to construction of fully integrated care[14].	Arce VAR, Sousa MF de, Lima MG	2011	Qualitative-quantitative	Population with difficulty of access to mental health care, due to the lack of a structured support network. It was found that there was a low capacity to resolve problems in practice in the Family Health Program, since the response that was provided primarily consisted of out-patient medical consultations and referrals for hospitalizations, thus showing both the hegemony enjoyed by the biomedical model and also the healthcare network's lack of a coordinated structure for ensuring fully integrated care.

it continues

Chart 1. continuation

Title	Authors	Year	Study	Principal results
Mental health in primary healthcare: evaluation study in a major Brazilian city[15].	Campos RO, Gama CA, Ferrer AL, Santos DVD, Stefanello S, Trapé TL, Porto K.	2011	Qualitative	Matrix Support showed potential for defining flows, training of teams and creating joint and shared care. Strategic role of the Community Healthcare Agent for identifying potential offers and providing a listening role from a position closer to the population. Health promotion practices not yet consolidated. When professional staff are employed outside the health units, actions that are more removed from the "treat them and move them on" approach are possible.
Matrix Support in units of the Family Health Program: trying out innovations in mental health[16].	Dimenstein M, Severo AK, Brito M, Pimenta AL, Medeiros V, Bezerra E.	2009	Qualitative	Proposal for Matrix Support is not clear to the team, and a great deal of demand for mental health care is not met.
Mental health and basic healthcare: analysis of an experience at local level[17].	Silveira DP, Vieira ALS.	2009	Qualitative	Actions in mental health at local level show the biomedical model of organization of healthcare still dominant – with psychiatry being the standard approach, the work process bureaucratized, and action centralized action within the health units.
Mental health in primary care: the need to build competencies[18].	Neves HG, Lucchese R, Munari DB.	2010	Essay	To achieve real improvement in health care there is a need to establish synchronization of knowledge and actions with the psycho-social care and guidelines of the SUS.
Partnership between CAPs and the Family Health Program: the challenge of construction of a new knowledge[19].	Delfini PSS, Sato MT, Antoneli PP, Guimarães POS.	2009	Qualitative	The strategies used are team meetings, in which there is training, discussion of cases, acceptance and preparation of therapeutic projects, and joint home visits. Difficulties found: high demand for health services and absence of institutional guidelines for the actual making of the partnership. A vision and approach that take in the family and the social context has results that are positive in comparison to the approaches in which the vision is centered only on the illness. Joint work enriches practice and makes possible a wider network of care in the territory.
Building the mental health care chain with the Matrix tool[20].	Sousa FSP, Jorge MSB, Vasconcelos MGF, Barros MMM, Quinderé PHD, Gondim LGF.	2011	Qualitative	Matrix Support is a potent structure for making it possible to build an articulated network system in the SUS, not limited to the frontiers of any one given service.

As well as this, other points in relation to the process of work need to be taken into account. It is necessary to overcome the rigidity and the formatting of management of the ESF, which materializes in the execution of prescriptive programs and frequently does not include the whole of the complexity of mental health care[18]. It is necessary to deal with the scarcity of human resources that are qualified for work in mental health; and to de-bureaucratize the process of work that has been an obstacle to interaction between the MH and APS teams[17].

How to power up the relation between MH and APS

There are many possibilities for mental health care within basic care. The professionals of basic care need to be trained, and acquire skills, to a level above the simple technical knowledge involving diagnosis and the use of medications, and also to achieve skills in communication, capacity to work in an amplified model of care, and handling of psycho-social problems[3,18]. These actions by themselves alone already strengthen the welcome for the patient, and the link, bringing benefits in mental health.

Various psycho-social interventions can be made[10], such as the use of therapeutic relationship, in which the professional uses him/herself and clinical techniques to stimulate self-analysis and behavioral changes; and community therapy, which is a form of activity in a public space in which there is a re-signification of relationships, eliminating hierarchies, and all the participants have the power to participate, and are heard, exposing themselves as people and reaffirming their identities – the result being construction and strengthening of relationships, in which the legitimacy of other people's view of the world is recognized and respected. There are also therapeutic groups, in which the relationship with the collective is therapeutic, and, through the sharing of ideas and feelings, an individual treatment of each member emerges in the presence of the others[10].

For the development of these fundamental skills in the professionals of the ESF teams, it is important that professionals of mental health should be present in APS[19]. However, it is not enough to insert mental health professionals into basic healthcare and plan actions of supervision of the teams of the ESF. These professionals need to be trained to detect mental health problems in the territory and to propose appropriate forms of intervention; and also to create cooperation and coordination between the basic healthcare and the specialized care[12,18]. This happens with MS, which is discussed in 7 of the 11 articles as the principal strategy for developing skills and abilities, and making new mental health approaches in APS possible[10,12,15,16,18-20].

MS makes it possible "to expand the local power to provide solutions, to alter the compartmentalized logic of referral and counter-referral, to think in terms of amplified inter-sector actions, to promote therapeutic projects in partnership, and to make other relevant institutions in the process of attention to mental health jointly responsible"[15]. This mobilizes various actors (doctors, nurses, community agents, social assistants, among others) to deal with the progress of the cases discussed, creating a wide variety of strategies, while enriching the care networks and making it more possible for them to articulate with each other[3,20].

By this means, MS makes possible a shared process of construction of care, enabling approximation between specialized services and basic healthcare, and re-emphasizing that it is not necessarily through mental health care alone that mental health problems are resolved, but through something that is a fundamental characteristic of the ESF: a fully integrated approach and action[16].

The practice of MS with the ESF team takes place through meetings and home visits. In the meetings, the teams of ESF and MH jointly discuss cases, there is an exchange of experiences, and sources of concern, and difficulties, experienced by the professionals of the ESF are raised, accepted and discussed. There is a stimulus toward joint accountability, and joint decision on when to refer to the specialized level. At these moments, it is perceived that the joint construction of strategies is essential to the care, as well as enabling horizontal training, with discussions of cases that lead to reflections in theory and practice.

Home visits are made in situations of greater vulnerability, of crisis, when there is a risk of psychiatric hospitalization, family conflicts, intense psychic suffering or cases that do not reach the mental health services, such as threats, violence and imprisonment. The joint visits, with participation of professionals from both teams, can be part of the therapeutic project, with discussion and learning, as well as giving value to the strategic role of the Community Health Agents, for their link with and care for, the families[19].

However, for basic healthcare to function effectively and resolve actual problems in mental health it is necessary that, as well as the MS, there should be Mental Health Service Networks, made up of various tools that replace the logic of psychiatric internment (CAPs, specialized outpatient facilities, and therapeutic home facilities, for example) as well as inter-articulation with the tools of the various areas, such as justice and culture (among others), and including inter-sector actions[20].

Ciência & Saúde Coletiva, 20(10):3255-3262, 2015

Finally, it is not enough for the health teams to wish to be trained: It is important that there be real concern on the part of Health Management to make this possible and encourage it. In the general context, Public Policies for mental health should be applied and strengthened. These include: commitment on the part of managers to expansion of mental health in basic care; creation of guidelines for mental health actions; promotion of conditions for implantation of mental health care through contracting of specialists for MS, with training and qualification of the support to enable it to be an integral part of the network; articulation of inter-sector policies to operate on the social determinants of the health/illness process; promotion of network care – sharing knowledge about psychotropic drugs and thus avoiding unnecessarily medicalization; and encouraging the training of specialists in mental health who know how to call for joint responsibility, and favor participation of the mental disorder patient in the choice of treatment and therapy.[15].

Final considerations

In the present day, problems related to mental health are present, and they represent a significant portion of the demand in basic healthcare. In spite of this, the teams of the ESF do not always feel able to deal with the demand for mental health care, or focus on actions that perpetuate the logic centered on specialized medical care and drug-based therapy. At the same time, basic healthcare, through the ESF team, has all the conditions necessary to develop and offer integrated mental health care to the individuals and families under its responsibility.

Considering this potential for mental health care within basic healthcare, the literature presents MS as the appropriate tool for training and increasing the abilities of the ESF. It allows insertion of mental health professionals in basic healthcare in a proposal for joint work, led by quality education and an integrated approach in mental health care, involving professionals of the ESF, of mental health, users, the community and managers. As a result, persistence is important in implanting and improving this model of MS, to deal with mental health care problems within basic care, having in mind its potential for real resolution of problems, contributing to a more rational use of the whole of the health system.

This effort is part of the actions that are necessary to organize the mental health care network. That network should be structured based on the basic healthcare network and should include various techniques, especially better use of communication, of the link, of welcoming and support, and of integrative and collective practices. Although this is a difficult task, there are evidences of the potential of this arrangement, with experiences that show positive results for the health teams and communities involved. Management has a fundamental role of giving incentive and support in the establishment and strengthening of a new model of mental health care within APS. Periodic assessments and surveys of the results achieved with MS in APS are essential, for expansion and full integration of mental health care actions in Brazil.

Colaboration

G Gryschek worked in conception, research, discussion and final review; A Avanzi worded in research, discussion and final review.

References

1. Dalla Vecchia MD, Martins STF. Desinstitucionalização dos cuidados a pessoas com transtornos mentais na atenção básica: aportes para a implementação de ações. *Interface (Botucatu)* 2009; 13(28):151-164.
2. Brasil. Ministério da Saúde. Portaria nº 648/GM, de 28 de março de 2006. Aprova a Política Nacional de Atenção Básica, estabelecendo a revisão de diretrizes e normas para a organização da Atenção Básica para o Programa Saúde da Família (PSF) e o Programa Agentes Comunitários de Saúde (PACS). *Diário Oficial da União* 2006; 29 mar.
3. Fortes S, Lopes CS, Villano LAB, Campos MR, Gonçalves DA, Mari JJ. Transtornos mentais comuns em Petrópolis-RJ: um desafio para a integração da saúde mental com a estratégia de saúde da família. *Rev Bras Psiquiatria* 2011; 33(2):150-156
4. Brasil. Ministério da Saúde (MS). Secretaria de Atenção a Saúde. *Saúde Mental e atenção básica: o vínculo e o dialogo necessários* [Internet]. Brasília: MS; 2003 [acessado em 2015 abr 20]. Disponível em: http://portal.saude.gov/portal/arquivos/pdf/diretrizes.pdf
5. Nunes M, Jucá VJ, Valentim CPB. Ações de saúde mental no programa saúde da família: confluências e dissonâncias das práticas com os princípios das reformas psiquiátrica e sanitária. *Cad Saude Publica* 2007; 23(10):2375-2384.
6. World Health Organization (WHO). *Mental health care in developing countries: a critical appraisal of research findings*. Geneva: WHO; 1984.
7. World Health Organization (WHO). *Organization of mental health services in developing countries*. Geneva: WHO; 1975. (Sixteen report of WHO Expert Committee on Mental Health).
8. Quinderé PHD, Jorge MSB, Nogueira MSL, Costa LFA, Vasconcelos MGF. Acessibilidade e resolubilidade da assistência em saúde mental: a experiência do apoio matricial. *Cien Saude Colet* 2013; 18(7):2157-2166.
9. Campos GWS, Domitti AC. Apoio matricial e equipe de referência: uma metodologia para gestão do trabalho interdisciplinar em saúde. *Cad Saude Publica* 2007; 23(2):399-407.
10. Cavalcante CM, Pinto DM, Carvalho AZT, Jorge MSB, Freitas CHA. Desafios do cuidado em saúde mental na estratégia saúde da família. *Rev Brasileira em Promoção da Saúde* 2011; 24(2):102-108.
11. Tófoli LF, Fortes S. O apoio matricial de saúde mental na atenção primária no município de Sobral, CE: o relato de uma experiência. *Sanare* 2007; 6(2):34-42.
12. Camuri D, Dimenstein M. Processos de trabalho em saúde: práticas de cuidado em saúde mental na estratégia saúde da família. *Saúde Soc* 2010; 19(4):803-813.
13. Dalla Vecchia MD, Martins STF. Concepções dos cuidados em saúde mental por uma equipe de saúde da família, em perspectiva histórico-cultural. *Cien Saude Colet* 2009; 14(1):183-193.
14. Arce VAR, Sousa MF de, Lima MG. A práxis da Saúde Mental no Âmbito da Estratégia Saúde da Família: contribuições para a construção de um cuidado integrado. *Physis Revista de Saúde Coletiva* 2011; 21(2):541-560.
15. Campos RO, Gama CA, Ferrer AL, Santos DVD, Stefanello S, Trapé TL, Porto K. Saúde mental na atenção primária à saúde: estudo avaliativo em uma grande cidade brasileira. *Cien Saude Colet* 2011; 16(12):4643-4652.
16. Dimenstein M, Severo AK, Brito M, Pimenta AL, Medeiros V, Bezerra E. O apoio matricial em unidades de saúde da família: experimentando inovações em saúde mental. *Saúde Soc.* 2009; 18(1):63-74.
17. Silveira DP, Vieira ALS. Saúde mental e atenção básica em saúde: análise de uma experiência no nível local. *Cien Saude Colet* 2009; 14(1):139-148.
18. Neves HG, Lucchese R, Munari DB. Saúde mental na atenção primária: necessária constituição de competências. *Rev Bras Enferm* 2010; 63(4):666-670.
19. Delfini PSS, Sato MT, Antoneli PP, Guimarães POS. Parceria entre CAPS e PSF: o desafio da construção de um novo saber. *Cien Saude Colet* 2009; 14(Supl. 1):1483-1492.
20. Sousa FSP, Jorge MSB, Vasconcelos MGF, Barros MMM, Quinderé PHD, Gondim LGF. Tecendo a rede assistencial em saúde mental com a ferramenta matricial. *Physis Revista de Saúde Coletiva* 2011; 21(4):1579-1599.

Article submitted 09/09/2014
Approved 15/05/2015
Final version submitted 17/05/2015