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# Family Health Strategy: community resources in mental health care

## Estratégia de Saúde da Família: recursos comunitários na atenção à saúde mental

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**Descritores**
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## Abstract

**Objective:** Assess the perception of the professionals working at the family health strategy on the resources present within the territory toward meeting mental health care demands.
**Methods:** Cross-sectional, qualitative study carried out with 27 primary health care professionals. Data were collected by means of interviews, focus groups and observation. Following data collection, data were transcribed and analyzed in the light of the structuralist theory.
**Results:** Nurses referred to the existence of formal instruments toward promoting mental health care and highlighted the health services. Care coordinators mentioned health services, universities and partnerships with Child Protective Services and the District Attorney's Office. Community agents showed to be more integrated with the territory and to have a broader knowledge of formal and informal social support sources. The observation of the territory pointed out social resources that were not addressed in the interviews.
**Conclusion:** The perception of the nurses regarding the community resources focused on formal health institutions or other entities related to the health care or health education areas. The coordinators identified other health services and social protection instruments. Community agents have a clearer perception of existing mental health resources.

## Resumo

**Objetivo:** Investigar a percepção de profissionais de estratégia de saúde da família sobre recursos existentes no território para atendimento de demandas em saúde mental.
**Métodos:** Estudo transversal, qualitativo realizado com 27 profissionais da saúde de serviços de atenção primária. Os dados foram coletados utilizando entrevistas, grupos focais e observação. Após a coleta, os dados foram transcritos e submetidos à análise à luz do conceito estruturalista.
**Resultados:** Os enfermeiros referiram dispositivos formais para apoio em saúde mental, enfatizando serviços de saúde. Os coordenadores mencionaram serviços de saúde, universidade e parcerias como conselho tutelar e promotoria pública. Os agentes comunitários demonstraram maior integração com o território e conhecimento abrangente de fontes de apoio social formal e informal. Na observação do território foram identificados recursos sociais não mencionados nas entrevistas.
**Conclusão:** A percepção dos enfermeiros em relação aos recursos comunitários centrou-se em instituições formais relacionadas à saúde ou ao ensino de cursos na área da saúde. Os coordenadores identificaram outros serviços de saúde e dispositivos de proteção social. Os agentes comunitários têm a maior percepção dos recursos existentes em saúde mental.

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## Introduction

The Family Health Strategy was created in the 1990's and stands out as the major proposal toward consolidating the Primary Health Care in Brazil. The individual-family binary, their relationship with the community and the surrounding environment are the main focuses of the strategy. The performance of the teams presupposes the articulation among the care service, the promotion of health to the population and preventive actions.[1,2]

The operation of the Family Health Strategy should imply the establishment of territorial bonds, accountability and longitudinal follow-up. Therefore, these teams are potentially prepared to approach the mental health status of families in the primary care level, especially because the public health and the mental health policies share common principles, such as the need for a territorially-based care network, cross-policy performance, notion of the territory, intersectoriality, and comprehensiveness toward the promotion of citizenship to patients.[2-4]

In order to develop actions that address these principles, healthcare services need to overcome the biomedical model limit and involve different social segments, as several community instruments stand out as a source of social support that can strongly contribute toward improving the mental health services and consequently the quality of life of the population.[2-6]

Additionally, the consolidation of intersectorial proposals resulting in a care network demands the recognition of resources available at the territorial level that could be inserted into the formulation of a variety of care plans. For this purpose, health professionals should consider the existing resources as potential partners in the composition of intersectorial action plans directed to health care promotion, prevention and rehabilitation.

Informal support stands out as the type of platform based on informality and on the similarity of experiences shared by ordinary people who are not trained to render a formal support, such as neighbors, partners, other patients, etc. Formal support, on its turn, is the type of platform provided by specialized institutions or trained people formally qualified to render professional services, such as psychologists, social assistants and nurses.[7,8]

Hence, the aim of this study was to assess the perception of nurses, health community agents and Family Health Strategy team coordinators on the resources or formal and informal social support sources within the territory that can be activated toward assisting the mental health care demands of the community.

## Methods

The study was carried out within the territory of five family health teams in a municipality located in the countryside of the State of Sao Paulo. This exploratory research made use of qualitative techniques for data collection, analysis and interpretation.

The subjects of the study were five nurses, five service coordinators and 17 health community agents (non-technical professionals living in the community who perform family registration processes and regular home visits to the addressed population).

Data were collected by means of observation, group interviews, semi-structured individual interviews and focus groups. Five group interviews with the health community agents were initially performed. These interviews aimed to guide the future observations that were later performed in the territory in which the teams operate.

The next step was the territorial observation per se. The previously established observation process took 46 hours and aimed to identify formal and informal resources (non-governmental organizations, churches, leisure spaces, meeting spots, health services, social care).

Nurses and team coordinators were interviewed following the observation of the territory. The script of the interviews focused on the existing resources in the territory that could be activated toward the

implementation of articulated actions concerning the community's mental health demands.

Observation data were subsequently validated in two focus groups of nearly one hour each, counting on nine individuals in one group and eight in the other group. After achieving data validation, the results of the observation process and interviews were reassessed by a meeting with the research team.

The assessment and analysis process complied with the minimal protocol required to structuralist-based research.[8] The territory, encompassed by the previously defined Family Health Units, was then settled as the study's observational field and the perceptions of nurses, team coordinators and health community agents on the existing resources aimed to assist mental health care demands as elements to be investigated were addressed. The "social capital" concept was employed as the structuring principle in the interpretation process.[9] Next, based on the reading and reassessment of data by the researchers involved in the study, formal and informal resources referred to by the subjects were identified. These data were organized in the format of network maps, aiming to provide a more effective vision and to facilitate the comparison among the different perceptions of the professionals on the territory's framework.

Throughout the interpretative process of the interviews' transcription and focus groups, the testimonies of the participants in the study were compared both with the data of the municipality and the information extracted from the observation process in the territory. Hence, participatory observation data enabled the identification of potentially interchangeable resources in the interventions related to mental health promotion, prevention and rehabilitation.

Network maps were outlined in order to group health services, education-based instruments, safety and social protection into the "formal resources" category. The "informal resources" category considered the different support community groups and instruments related to leisure and religion.

The study complied with national and international ethics guidelines regarding research involving human beings.

## Results

From the 17 health community agents, 14 were women and three were men. The minimum age of the agents was 28 years old and the maximum age was 58. As for their educational level, one agent had completed elementary school, 13 had completed high school, one had finished a technical course and three were professionals with undergraduated degrees.

All of the five nurses approached were women, all graduated for at least eight years, with average age of 39 years and who had been working in the related services for four years or over. Three out of the five nurses had graduate degrees.

Four of the coordinators were men and one was a woman, with minimum age of 38 and maximum of 64 years, who had been working as coordinators for four years or more. All of them were physicians with a Ph.D. and university professors at the same time.

The resources pointed out by the respective subjects – nurses, coordinators and health community agents are presented in figures 1, 2 and 3.

As presented in the figure 1, nurses have not pointed out any informal resource; they also indicated the health services and the universities as partners toward mental health care.

The coordinators pointed out more instruments than the nurses did. Additionally, they also identified other health services and social protection instruments, such as Child Protective Services, District Attorney's Office and Therapeutic Centers. They referred to the church as a potentially interchangeable informal instrument as well.

Health community agents identified a higher amount of instruments in all formal and informal frameworks.

A few formal (CAPS III, CAPS for Children, Mental Health Regional Outpatient Unit, Downtown Mental Health Outpatient Unit, and Therapeutic Communities directed to drug addict patients) and informal (Alcoholics Anonymous, Spiritist Centers, businesses, public soccer fields, gyms and private sports courts) resources were not pointed out by the participants, in spite of being present in the territory.

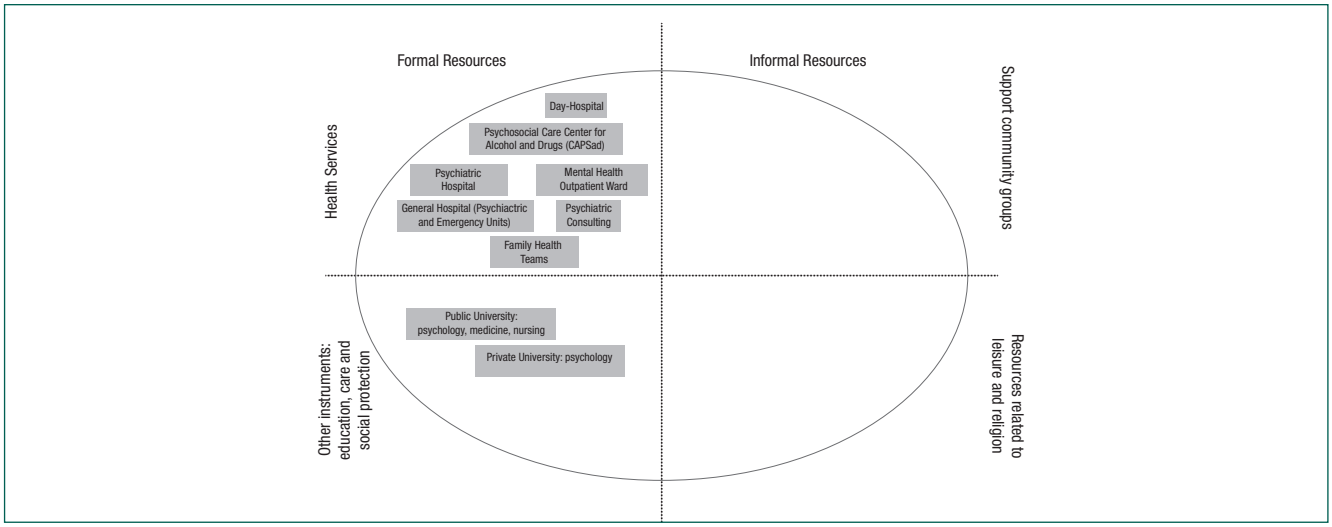


**Figure 1.** Map of mental health-related resources, according to the perception of the nurses

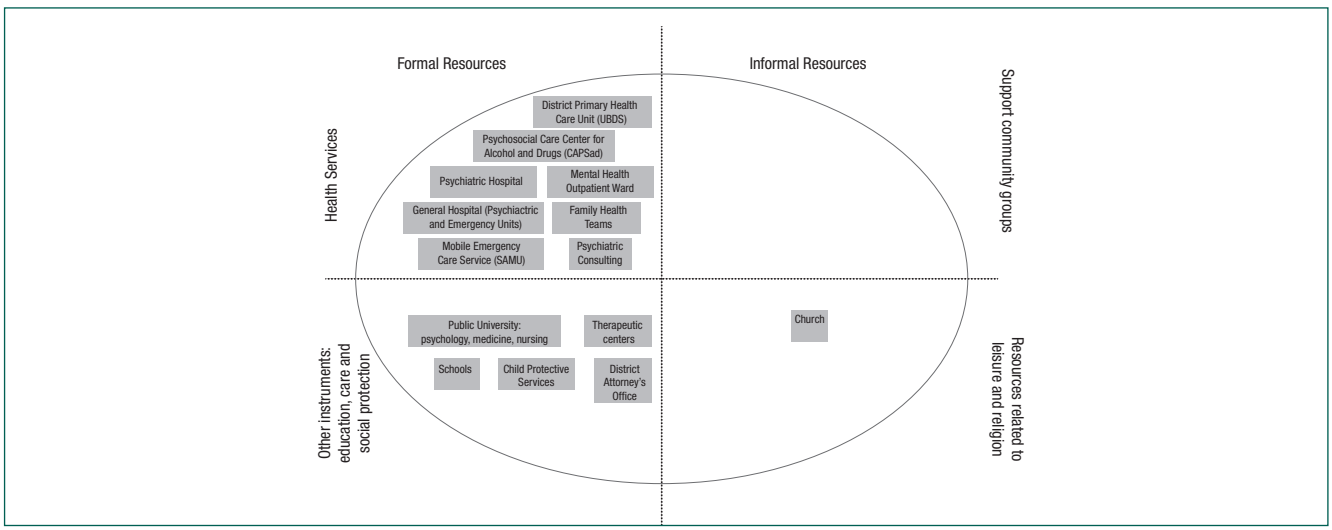


**Figure 2.** Map of mental health-related resources, according to the perception of the coordinators

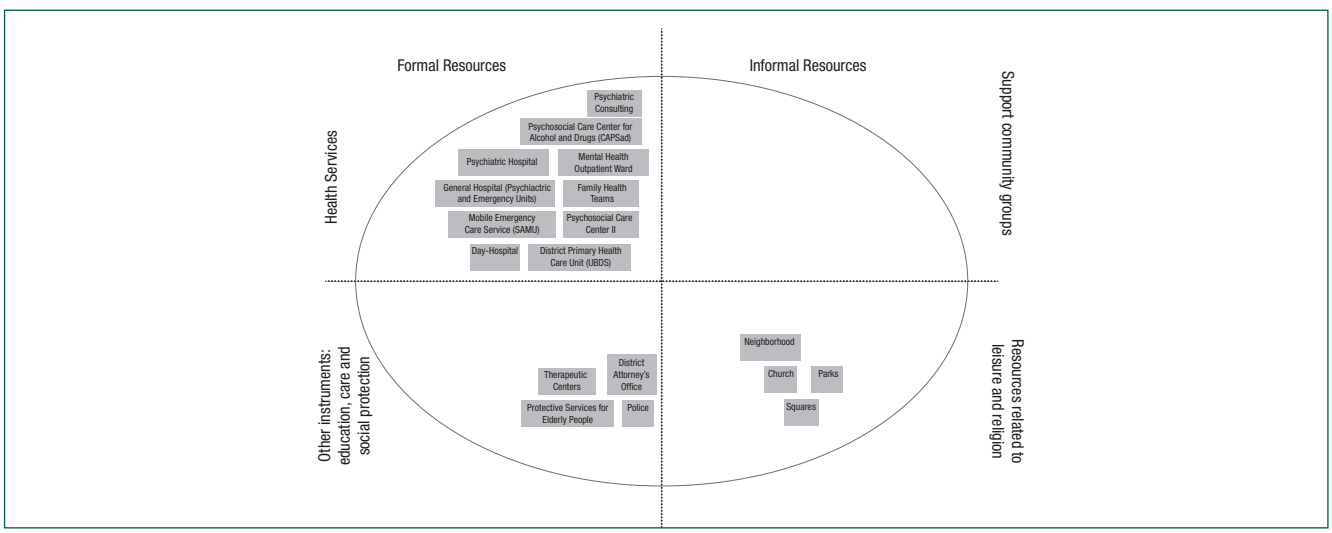


**Figure 3.** Map of mental health-related resources, according to the perception of the health community agents

## Discussion

The present study was limited by the fact that the data resulting from the qualitative data collection process do not allow any generalization concerning the findings. Nevertheless, it should be highlighted that the employment of three techniques (individual interviews, focus groups and observation) strengthens the results, allowing for exchange processes among the data achieved.

The results of this research generate subsidies that promote relevant reflections on the strategies toward consolidating the current recommendations of the Brazilian Ministry of Health concerning the creation of Psychosocial Care Networks that should count on the presence of interdisciplinary care resources directed to the mental health of communities. In this debate, the nursing practice plays a crucial role, bearing in mind the integrating character of interdisciplinary-based care practices and their ability to promote articulation processes among the different social and health instruments existing in the territory.

The social capital concept was proposed by Pierre Bourdieu as a set of social pathways observed in relationships and contact networks.[9] This "umbrella concept" encompasses aspects related to social cohesion, integration/participation and support, in addition to other mental and general health social determining agents. The debates surrounding the social capital concept have been playing quite a relevant role in fields related to health, community and participation, allowing for reflection processes that stem from micro (individual, personal or family resources) and macro (neighborhood, community, formal and informal groups) levels.[10]

The city approached by this study counts on a wide array of formal and informal support sources that can be considered as potential resources toward developing intersectorial actions within the territory. Nonetheless, the social capital conception implies not only the existence of resources, but also the establishment of correlations among the resources, aiming at promoting exchange pathways. In this perspective, the embracement issue, as the core of the health service process, stands out as an important aspect toward consolidating the social capital.[2,11]

Embracement may be defined as a "conversation network", or in other words, the moment when the welcoming, interconnecting and offering roles are correlated with identified health needs. This is the time when accesses may be broadened, care practices may be humanized and work processes may be reorganized.[12]

Whenever an embracement status is able to listen the patients with more attention, problems and needs that will not be sorted out only in the health service level are brought to light, thus turning intersectorial articulations and the search for external health-based partnerships into indispensable actions.[13]

Hence, the development of work processes that establish new types of relationship between professionals and the community is quite a necessary step; in other words, health actions need to be humanized, resolutive, intersectorial and articulated, in such a way that available resources are effectively transformed into social capital, a relevant determinant toward the development, health and well-being of the community and a protection factor against negative influences of either the environment or the immediate context.[12-16]

The perception of nurses (Figure 1) on community resources focused either on health-based or education-based formal institutions. This perception may be possibly reproduced in the clinical practice, an aspect that would explain the logic of forwarding patients to specialized services and the limited integration with other social instruments and informal support sources.

The expansion of the primary care, especially seen in the implementation of the family health strategy, enhanced the geographical accessibility of the health services; however, the appropriation of the territory and its resources has not yet been uniformly achieved and the activities are often bound to the physical spaces where the services are offered.[17]

Figure 2 shows that the coordinators conceived the following mental health actions as interchangeable resources: educational institutions, specialized mental health services, child protective services

and the District Attorney's Office. It is worth highlighting that the coordinators were also university professors, according to the subjects' profiles; therefore, they enjoy the privilege of having open access to knowledge, including the knowledge related to public policies.

Nonetheless, compared with the other interviewed professionals, the perception of the health community agents (Figure 3) was the most comprehensive. As they had closer contact and stronger articulation with the population,[18] the agents are in a position of having broader access to informal sources of knowledge, which are quite relevant toward a more precise comprehension of the territory. It should be highlighted that the vast majority of resources pointed out by the interviewees was grounded on examples gathered from daily work experiences of these professionals, thus differing from the others.

It is also important to emphasize that the division of activities in the organization of the teams' service processes implies the application of distinct tools, purposes, tasks and, consequently, different conceptions of the work subject (health, disease, quality of life) and the resources located in the territory. Following such logic, the health community agent has the community space as his/her labor locus and aims to establish bonds between the health services and the community, which would possibly justify the more broadened perception of this professional on the resources available.

The differences observed in the testimonies may be originated in the positions these subjects take in the network of relationships; in other words, although coordinators, nurses and health community agents are part of the same work team, they have distinct competences, knowledge and practices. Additionally, in spite of being organized to deal with the same object (the health needs of people), they may have different conceptions and purposes in their daily work processes, as well as a differentiated access to certain information.

The educational background of the interviewees approached by this study was not directly proportional to granting them a broader vision of the real resources existing in the territory. The fragmented teaching-learning standard, reduced to addressing disciplines, may contribute to such limitation seen in the health practice field. Therefore, educational innovations should be recommended so that a closer contact between students from healthcare areas and the community is prioritized.[18,19]

Despite these different perceptions, it is worth highlighting that the subjects stand out as individual workers in a team; therefore, the creation of opportunities for exchanging processes and strengthening the relationships would bring plenty of increment to the perceptions of these professionals, thus generating resource complementarity and new goals for the patients' therapeutic plans, as well as expanding the structures that shape social capital trends toward the mental health demands in the studied territory.

Additionally, based on the results of this study, the establishment of interventions aimed at empowering the social capital available stands out as an indispensable action; in other words, the care model should be reoriented and both the health framework and the policies of formal institutions and community organizations should be altered toward enhancing the social support and broadening access to these support sources, taking into account aspects such as the organization of work processes, working schedules, dissemination of information and active search.[6,20,21]

## Conclusion

The analysis of the results originated from the different data sources allowed for the identification of formal and informal social support sources or resources in the territory, based on the perception of Family Health Strategy professionals. Such status allowed to pinpoint fragilities and potentialities related to the composition of support networks within the territory, aimed to identify mental health demands.

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## Collaborations

Souza J; Almeida LY; Veloso TMC; Barbosa SP and Vedana KGG declare that they have contributed to the study conception and project, analysis and interpretation of data, drafting the article, critical review of its relevant intellectual content, and final approval of the version to be published.

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