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# KNOWLEDGE AND PRACTICES OF COMMUNITY HEALTH AGENTS IN MENTAL HEALTH DEMANDS

*Conhecimentos e práticas de agentes comunitários de saúde frentes às demandas de saúde mental*

*Saberes y prácticas de agentes comunitarios de salud frente a las demandas de salud mental*

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## ABSTRACT

**Objective:** to identify knowledge and practices by Community Health Agents in the face of mental health demands in Primary Care. **Method:** qualitative exploratory study, carried out in a municipality on the West Frontier of Rio Grande do Sul. Data collection took place between October and November 2022, through semi-structured interviews,  content analysis. The study included 12 Community Health Agents working in three Family Health Strategies. **Results:** the biomedical paradigm is present in the daily practices of the interviewed professionals. The care provided to people in psychological distress and their families is limited due to the Agents' lack of knowledge. **Final Considerations:** the importance of Continuing and Continuous Education activities with Community Agents is highlighted, in order to improve the quality of care, increase the scope of mental health actions in the territory and reduce exclusionary and stigmatizing practices.

**DESCRIPTORS:** Community health agent; Primary care; Health strategy family; Mental health.

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## RESUMO

**Objetivo:** identificar conhecimentos e práticas de Agentes Comunitários de Saúde frente às demandas de saúde mental na Atenção Básica. **Método:** estudo qualitativo de caráter exploratório, realizado em um município da Fronteira Oeste do Rio Grande do Sul. A coleta de dados ocorreu entre outubro e novembro de 2022, através de entrevistas semiestruturadas, tratadas por Análise de Conteúdo. Participaram do estudo 12 Agentes Comunitários de Saúde atuantes em três Estratégias Saúde da Família. **Resultados:** o paradigma biomédico está presente no cotidiano das práticas dos profissionais entrevistados. O cuidado prestado às pessoas em sofrimento psíquico e suas famílias é limitado devido a falta de conhecimento dos Agentes. **Considerações Finais:** destaca-se a importância de atividades de Educação Permanente e continuada junto aos Agentes Comunitários, a fim de melhorar a qualidade do cuidado, aumentar a abrangência das ações de saúde mental no território e reduzir práticas excludentes e estigmatizantes.


**DESCRITORES:** Agente comunitário de saúde; Atenção básica; Estratégia saúde da família; Saúde mental.


## RESUMEN

**Objetivos:** identificar saberes y prácticas de Agentes Comunitarios de Salud frente a las demandas de salud mental en la Atención Primaria. **Método:** estudio exploratorio cualitativo, realizado en un municipio de la Frontera Oeste de Rio Grande do Sul. La recolección de datos ocurrió entre octubre y noviembre de 2022, a través de entrevistas semiestructuradas, tratadas por Análisis de contenido. El estudio contó con 12 Agentes Comunitarios de Salud actuando en tres Estrategias de Salud de la Familia. **Resultados:** el paradigma biomédico está presente en las prácticas cotidianas de los profesionales entrevistados. La atención que se brinda a las personas con malestar psíquico y sus familias es limitada debido al desconocimiento de los Agentes. **Consideraciones finales:** se destaca la importancia de las actividades de Educación Continua y Continua con Agentes Comunitarios, con el fin de mejorar la calidad de la atención, ampliar el alcance de las acciones de salud mental en el territorio y reducir las prácticas excluyentes y estigmatizantes.


**DESCRIPTORES:** Agente comunitario de salud; Atención primaria; Estrategia de salud familia; Salud mental.

## INTRODUCTION

The mental health care model has undergone several transformations involving the technical-scientific and socio-cultural fields, especially in recent years. Faced with these changes, policies aimed at people suffering from mental illness have sought to broaden and strengthen the scope of actions within the territory.

To this end, various strategies have been implemented, such as the creation of the Psychosocial Care Network (RAPS), which aims to qualify care, articulate care facilities focused on mental health needs and users' support networks in their own territory and expand mental health care.[1]

Within this network, the interface with Primary Care (PC) has gained prominence, as it is often the first place where there is interaction with the user, since its units are closer to the community, facilitating knowledge of the peculiarities of the place and allowing the team a panoramic view of the users of the network in their daily routines.[2]

Thus, it can be seen that primary care has priority access, providing users with health care, including those with mental health demands. It is therefore understood that mental health care in primary care is strategic due to the ease with which teams can access users and vice versa. As a result, it is common for health professionals to come across people suffering from mental illness all the time.[3]

Faced with the demand for mental health, it is believed that the Family Health team should be able to offer generalist care and resolve situations that require immediate interventions, such as those associated with the harmful use of alcohol and other drugs, psychiatric inpatients, the inappropriate use of benzodiazepines, people diagnosed with serious disorders and situations arising from violence and social exclusion.[3]

In this scenario, Community Health Agents (CHAs) have a unique position within the team, since their proximity to the community encourages them to create bonds, generating the possibility of interventions for health care.[4] This differentiated social insertion of CHAs in the daily life of the community is their main power for psychiatric reform: in a personalized relationship with users, more flexibility is possible in procedural routines, adapting interventions to unique needs.[5]

The roles of CHAs have progressively expanded, with mental health being one of the new fields to emerge. However, the perspective of care is still marked by the stigmatization of users and the unregulated use of diagnoses, logics that are present at the various levels of care, including Primary Care.[6]

With this in mind, the aim of this study is to identify the knowledge and care practices of Community Health Agents when faced with mental health demands in Primary Care.

## METHOD

This is an exploratory qualitative study conducted in three Family Health Strategies in a municipality on the western border of Rio Grande do Sul. The Family Health Strategies (FHS) were chosen because they concentrate the highest demand for mental health cases in Primary Care, according to data provided by the municipality.

Data collection took place between October and November 2022, by means of a semi-structured interview containing open-ended questions, where participants could freely discuss their ideas, and closed-ended questions, which are structured in a specific way allowing the participant to choose from the stipulated alternatives.[7]

As for the inclusion criteria, participants had to be CHAs working in the FHS chosen for the study and have worked in these services for at least six months. It is believed that this minimum period of work is necessary for the professional to become aware of and experience a large part of the health demands in the territory.

The interviews were pre-scheduled, on a day and at a time when each participant was available, and lasted approximately 30 minutes. A Word document was then created for transcribing and analyzing the material collected. In order to maintain anonymity, the participants were identified by the code name "Interviewee" followed by the order in which the interviews were carried out, for example: Interviewee 1.

This study used Thematic Data Analysis, which is the interpretation and description of the information collected within a theme, based on existing theories and themes.[8] This method is divided into three stages: pre-analysis, exploration and treatment and interpretation.[9] The results obtained were structured and discussed using the categorization method, where the data collected was distributed into categories constructed by the researchers, with the aim of developing the conclusions obtained from the study in a more organized way.[10]

The study complied with the recommendations of Resolution 466/12 of the National Health Council and was approved by the Research Ethics Committee of the Federal University of Pampa under Report No. 4.368.334.

## RESULTS

Twelve CHAs took part in the study, 75% female and 25% male. The professionals were aged between 22 and 50, with 25% aged between 22 and 30, 33.33% aged between 30 and 40 and 33.33% aged between 40 and 50. It was found that 33.33% had completed high school and 66.67% had incomplete higher education. With regard to the length of time the CHAs have been working, 91.64% have been working in the health service for less than 2 years and 8.33% for 5 years or more.

In order to achieve the objectives set out in this study, three categories were constructed from the analysis of the data: Demand for mental health: a dichotomous conception; Knowledge and practices of mental health care in the daily work of CHAs; Challenges and potential in mental health care in Primary Care, to be described below.

**Mental health demand: a dichotomous conception**

During the interviews, the CHAs were asked about their understanding of the concept of mental health demand. It was observed that the concept oscillated between two paradigms, from the perspective of the participants. The first conception is closely related to the traditional, biologicist and biomedical logic of mental health, taking into account only psychiatric diagnoses and/or a syndromic set of mental disorders, as evident in the following statements:

> *People who have some kind of mental illness.* (Interviewee 10)

> *Problems with anxiety and anxiety attacks, deep depression, I think that's what it is.* (Interviewee 11)

Another perspective found is related to a broader concept of mental health, which goes beyond psychiatric symptoms, considering human suffering and the bio-psycho-social aspects of individuals, as identified in the speeches:

> *Any kind of mental suffering, even those that the person themselves doesn't recognize.* (Interviewee 1)

> *A mental health case would be a patient who has mental symptoms that affect their physical state and state of well-being, causing problems in their social life.* (Interviewee 3)

> *Demand is when someone in pain comes in asking for help. I understand mental health to mean not only those people who are suffering, who need help.* (Interviewee 6)

**Knowledge and practices of mental health care in the daily work of CHAs**

With regard to the care practices carried out by CHAs, it was identified that their work is limited in relation to mental health demands. Most of those interviewed said that their interventions ended up being restricted to referrals and scheduling appointments with higher-level professionals at the FHS itself, as well as with professionals and services specializing in mental health care in the municipality, according to the following statements:

> *When we identify a case, we usually offer to schedule an appointment with the general practitioner.* (Interviewee 1)

> *I identify the case, I go to the unit, I go to the head nurse and then she goes there with me and then they'll be referred, then she has the contact of the CAPS staff, she opens these doors, so to speak.* (Interviewee 2)

> *We pass on the family situation to the nurse, and then she sees what she's going to do.* (Interviewee 9)

> *In the consultation with the clinician, he will refer the patient to a psychologist/psychiatrist or accompany them, and the ACS will actively search for absentees and see if they are taking their medication correctly.* (Interviewee 3)

The statements of some professionals reveal that care practices related to mental health demands are still linked to psychiatric diagnoses and the use of psychotropic drugs, as can be seen in the following statements.

*There are some people who come every two months to get a prescription, they come to us a lot, but it's quiet, you know, very quiet, in my micro-area there are quite a few people, I think 80% to 90%, who come to us for prescriptions for controlled drugs.* (Interviewee 3)

*We help them, we try to refer them to the doctor, make sure they're taking their medication correctly.* (Interviewee 4)

*The biggest difficulty I find in my area is the users' acceptance of mental illness and taking their medication correctly.* (Interviewee 3)

*They say no, they don't have a mental health problem, and then we tell them you're in some kind of treatment, taking some medication for depression, and then they say, yes, I've been taking it for many years, sometimes they don't want to say it's a mental health problem.* (Interviewee 4)

With regard to the role of the CHA in mental health care in the territory, the professionals reflect on the possibility of building bonds, listening, exercising empathy and welcoming people into the community, as well as acting in the context of mental health promotion, disease prevention and identifying cases of psychological distress.

*Our role is always to promote and prevent health, so I think we're very important, because we're the ones who identify these cases.* (Interviewee 5)

*Our role is to help, right, to welcome, that's what we do.* (Interviewee 5)

*That's what you have to look at, you have to have that different look, that empathy to understand.* (Interviewee 2)

*The person needs help, sometimes it's just an outburst. We just need to listen, right, and not belittle their suffering.* (Interviewee 5)

**Challenges and potential for mental health care in Primary Care**

Although most mental health interventions are limited to referrals to higher education professionals and specialized services, some CHAs recognize that they have the experience and capacity to identify the mental health demands of the territory, as seen in the following statements:

*Yes, I think I can identify, home visits with other professionals bring a lot of knowledge.* (Interviewee 1)

*I do because I've worked at CAPS, I worked at CAPS for 4 years, so I can identify, there are some things I have difficulty with, there are still a lot of things I don't know...* (Interviewee 2)

*I think so, with time and experience we learn more and more, we're learning every day.* (Interviewee 1)

On the other hand, the majority of professionals revealed that they are poorly prepared to provide care in the face of the various mental health demands found in the area. They report that subjects related to the field of mental health are little explored during training activities, as evidenced in their statements:

*No, we have lectures there from time to time, but not continuing training, like a course, something. Not continuing training!* (Interviewee 5)

*No, not really. I need to prepare myself more.* (Interviewee 6)

*No, not permanent or ongoing! Eh, we sometimes have training on meeting days, which are every fortnight, with different topics, right, sometimes they talk about high blood pressure, diabetes, but we don't have mental health.* (Interviewee 8)

*The biggest difficulty is the lack of instruction, sometimes how to deal with a patient who has some kind of illness, and we don't know how to deal with it.* (Interviewee 10)

Other difficulties mentioned by the CHAs in providing comprehensive mental health care refer to coordination with the municipality's Psychosocial Care Network and the work overload of professionals, according to their statements:

*Access to the rest of the network, a lack of dialogue between the primary network and the others.* (Interviewee 1)

*It's a service of little ants, one helping the other, we need support, so one helps the other to be able to help the patient throughout our network.* (Interviewee 4)

*Lack of more staff, now we're even on the register.* (Interviewee 9)

*And I think it's overloaded, the agendas, because of the lack of people with experience, to look after these people, right, to help, to listen.* (Interviewee 5)

## DISCUSSION

In recent decades, an important political movement has been built to transform the model of care for users suffering from mental illness, prioritizing actions aimed at social inclusion, citizenship and people's autonomy.[11]

In this sense, humanized and contextualized care is advocated in Primary Care, considering aspects of integrality and promotion of mental health, through the Expanded Clinic.[11] In this model, the highlight for care are soft technologies, which are fundamental in the production of care, based on welcoming, bonding and access, and in building users' autonomy.[12]

In the meantime, mental health care in Primary Care becomes strategic, given the emphasis on the bond and relationship established by the teams, as well as the ease of access to users and vice versa.[12] In addition, territorial proximity makes it possible to carry out home visits, which are important strategies in mental health prevention and promotion actions.[11]

In line with this, it is possible to analyze that some of the professionals interviewed have a broader view of mental health demands in the area. It is understood that health is more complex than the manifestations of diseases and includes social, economic, cultural and environmental aspects.[13] Mental health interventions should promote new possibilities for modifying and qualifying living conditions and ways of life, oriented towards the production of life and health, and not restricted to curing diseases.[14]

In order to do this, it is necessary to look at the individual in their multiple dimensions, with their desires, longings, values and choices.[2] This broadened perception on the part of primary care professionals contributes to the early identification of mental suffering in the territory, to more humanized care and to interventions aimed at the singularity and life context of users.

However, in many situations there is a mismatch between the ideal care and the reality in the praxis of health services, while it is not uncommon to observe the use of care practices that reproduce a reductionist logic, influenced by the traditional biomedical model. The biomedical view of mental disorders is associated with the production of negative stereotypes that interfere with the care relationship and contribute to the creation of barriers to access.[12]

Some studies have also pointed out that mental health care in primary care maintains a biologicist tendency, in which referral is seen as an isolated care strategy, disregarding the service's responsibility for the user and for comprehensive care.[15,16]

Nevertheless, the results also showed that most of the conceptions of mental health demand pointed out by CHAs are influenced by the biomedical paradigm, i.e. classification of psychiatric diagnoses, medicalization and excessive referrals to specialized services and professionals.

It is a major challenge to introduce singular and collective care practices capable of promoting quality mental health care that goes beyond scientific knowledge, encompassing the establishment of solid relationships with users and the community, in order to meet real needs.[17] This, therefore, denotes the importance of a humanized approach on the part of the health team and all those who work in network care. In this context, it is understood that intersectoral coordination is necessary to meet the social needs that directly or indirectly affect the population's mental health, both inside and outside the health system.[18]

In view of this, the welcoming-bonding-accountability tripod is considered indispensable in the exercise of mental health care by CHAs. This accountability requires an active stance in relation to the user, which is necessary for changing the care model: overcoming a responsive model, based on resolving demands, to a proactive model, which seeks to intervene in health needs, even if they have not yet been formulated directly as a demand on the service.[5]

The lack of knowledge related to mental health demands was also highlighted by CHAs as a challenge to be overcome in their daily practices. This context has also been evidenced in other studies, which point out that the lack of specific knowledge in mental health can give rise to care practices permeated by stigma and prejudice in relation to psychological suffering. Thus, the qualification and expansion of the scope of mental health actions by CHAs also involves the continuing education of these professionals.[19,20]

It is important to emphasize the need for more investment in the training of Primary Care teams through permanent and continuing education activities,[11] especially for Community Health Agents, who are considered professionals at the cutting edge of the health system, i.e. the front line in community care.

In addition, it should be noted that situations such as devaluation of the work, a reduced number of professionals, pressure from users, staff and managers, as well as the failure of the health system to solve the population's problems, contribute to the overload of the CHAs, given that these needs go beyond their control, causing suffering due to the conflict between what is idealized and the expectation in relation to their competence.[21]

## FINAL CONSIDERATIONS

Important advances have been made in the field of mental health and primary care in recent decades, with the aim of guaranteeing effective, comprehensive care for people suffering from mental illness. However, there are still many barriers that need to be overcome, including breaking away from the biomedical and hospital-centered model.

Contributing to this perspective, the aim of this study was to identify the knowledge and practices of Community Health Workers when faced with mental health demands in Primary Care.

The results of this research show that the professionals' conception of mental health demands is mostly based on a logic of care based on the biomedical and medicalizing model. In addition, the participants pointed to the need for greater knowledge about mental health care, given that they are fundamental components of the multi-professional primary care teams, as well as the main actors in the interlocution of community demands.

On the other hand, some potential was observed, including the CHAs' search for individual knowledge through higher education, the development of care practices based on the use of soft technologies such as building bonds, listening, exercising empathy and welcoming people in psychological distress in the community.

In addition, the reflections brought up in this study also highlight the importance of promoting the training of CHAs who work in Primary Care services in the municipality investigated. It is believed that continuing education activities can help to minimize these professionals' feelings of insecurity, improve the quality of care, increase the scope of mental health actions in the territory, and reduce exclusionary and stigmatizing practices in everyday mental health practices in the territory by producing new responses to their health needs.

It is suggested that further studies be carried out to broaden the discussion about perceptions of mental health, including users and their families, other professional categories, as well as other services in the health network.

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