Why does mental health care not follow the structuring of primary care?

Antonio Moacir de Jesus LimaI, Eli Iola Gurgel AndradeII, Antonio Thomaz Gonzaga da Matta MachadoIII, Alainer de Fátima dos SantosII

I Universidade Federal dos Vales do Jequitinhonha e Mucuri. Faculdade de Ciências Biológicas e da Saúde. Departamento de Enfermagem. Diamantina, MG, Brasil
II Universidade Federal de Minas Gerais. Faculdade de Medicina. Programa de Pós-Graduação em Saúde Pública. Belo Horizonte, MG, Brasil
III Universidade Federal de Minas Gerais. Faculdade de Medicina. Departamento de Medicina Preventiva e Social. Belo Horizonte, MG, Brasil

ABSTRACT

OBJECTIVE: To verify if primary care teams with better structured primary health care (PHC) attributes could offer better mental health (MH) care.

METHODS: Cross-sectional study based on data from the external evaluation of the second cycle of the Programa de Melhoria do Acesso e da Qualidade da Atenção Básica (PMAQ-AB - Access and Quality Improvement of Primary Care Program), involving 31,587 primary care teams, between 2013 and 2014. Two typologies were built: quality of mental health care (dependent variable) and PHC structuring according to essential attributes (independent variable). We identified some contents for the construction of the mental health typology (module II of the PMAQ) and performed sums of questions for the categorization of indices. The Delphi technique rendered consensus in four rounds endorsed by experts, following the attributes of PHC structure. Multinomial logistic regression analyses verified the association between the typologies and identified which attribute most contributed to the quality of mental health care.

RESULTS: We found out that 29.2% of the teams are at low levels of quality in assistance to MH, while 7.5% of the teams have a low level of structuring the PHC according to essential attributes. Regional differences are maintained, both for the structuring of the PHC and for the quality of mental health care. There was a greater chance of providing care in MH with better quality when the PHC is better structured at a high level (OR = 14.74) and at a medium level (OR = 2.193). A high level of completeness is associated with a high level of Quality of Care in MH (OR = 3.21).

CONCLUSIONS: results indicate a predominance of low levels of quality in mental health care, out of step with the process of PHC structuring and its essential attributes.

DESCRIPTORS: Mental Health Assistance. Primary Health Care. Quality of Health Care. Health Services Administration.
INTRODUCTION

Mental disorders represent a high share of disease records globally. Only in the Americas, a study revealed a prevalence of 17%, being 22.5% in North America and 14.8% in Latin America. In Brazil, mental disorders also present a considerable 29.5% rate. Anxiety (19.9%) and mood disorders (11%) are most prevalent, followed by impulse control disorders (4.2%) and others, resulting from the use of psychoactive substances (3.6%). These numbers show that Brazil jumped from sixth to the third position in the Global Burden of Disease (GBD) between 1990 and 2015.

Screening for early detection and treatment performed in primary health care (PHC) may improve the life of patients, help make better use of investments in health care, and significantly reduce complications and medical comorbidities. Thus, mental health (MH) should be understood as a priority intervention field for the Family Health Strategy (FHS) teams, given the close work in the community, wherein users live and circulate, for example in health units and social space.

However, the inclusion of mental health in PHC practices is difficulty in some aspects, as shown by several studies. One of these obstacles is in professional training because workers developed their actions based on the biological model. Therefore, interventions focused on clinical consultation, medicalization, and diagnosis, aiming only at the remission of symptoms. Other studies reinforce this perception and point to the absence of co-responsibility for unnecessary referrals and an important weakness in the ability of FHS professionals to identify some cases. More recently, another study showed that more than 60% of PHC professionals said to feel unprepared to accept mental health demands.

Another obstacle is the work process of teams, considering the humanization of people with psychological distress has not yet been identified, although some practices are innovative. However, this process is still in the implementation phase and, therefore, needs to be expanded through the improvement of care.

This expansion of access also involves issues of infrastructure, both in basic units and in human resources, and the breakdown of the care network, which still maintains a hierarchical organization and communicational dynamics based on technical health protocols. In Salvador, Bahia, for example, a study indicated a dependence on the Rede de Atendimento Psicossocial (RAPS - Psychosocial Care Network) to the psychiatric hospital, pointing out the need for actions that promote the strengthening of the network, its articulation, and deinstitutionalization of the Centro de Atenção Psicossocial (CAPS - Psychosocial Care Center). In Fortaleza, Ceará, the medicalization of mental disorders was evidenced as mitigation of difficulties in front of CAPS accessibility by patients.

However, the engagement of workers has resulted in successful experiences in various parts of Brazil, with the advance in the articulation between mental health and primary care, with more than 56% of the teams carrying out actions in this area, such as promotion of MH actions related to matrix support (AM), networking, diversity of practices, and social participation. Matrix support could increase the resolution and effectiveness of the actions of the FHS, with joint action between specialists and professionals from the teams in the field. Remarkable experiences enhanced the collective construction of knowledge and improved communication between workers, users, and managers. Moreover, they expand knowledge about mental health and greater co-responsibility, contributing to the identification and acceptance of cases and the construction of unique therapeutic projects.

Other forms of confrontation underway and are showing results. In Salvador, FHS teams carried out home admission to integrate MH actions to the PHC. In Ribeirão Preto, FHS teams opted for home visits, contributing to postponing psychiatric hospitalization by following up on discharge, guidance to family members, and other efforts to avoid the medicalization of psychological distress.
The MH actions developed in PHC contribute to the transformations in the psychiatric care paradigm, determining the deconstruction of the historical distance between excluding psychiatric practices and primary care. Thus, they reorient the model of care provided to people with mental suffering with community devices and are configured as a reality for the implementation of the National Policy on Mental Health.

This set of significant challenges and experiences indicates that the inclusion of MH actions in PHC constitutes a wide field of possibilities and complex issues. This study seeks to contribute to the assessment of this assertion. It intends to analyze whether primary care teams that have better-structured PHC attributes could offer better assistance in the area of Mental Health.

METHODS

Cross-sectional study based on data from the second cycle of the PMAQ-AB, coming about in 2013 and 2014 and involving 31,587 Primary Care Teams (EqAB) from Brazil as a whole. Data are shown in module II and relate to the external assessment and to the teamwork process, wherein questions are answered by the coordinator and contain 750 questions. The PMAQ-AB data collection was coordinated by a group of researchers from universities and research institutions responsible for the external evaluation. Researchers trained and accompanied the field interviewers and data collection supervisors.

31,587 EqAB took part in the study. However, 1,809 teams were excluded for various reasons: 713 did not participate in the entire evaluation cycle; 353 did not comply with the commitments assumed in the contract, and 743 obtained a zero grade. The final universe analyzed included 29,778 teams.

From these data, two typologies were elaborated: PHC structuring, based on its essential attributes (independent variable); and the quality of care provided in the area of Mental Health (dependent variable). In the first typology, researchers used the Delphi technique to agree on the questions that could compose each attribute. All items of the questionnaire were condensed into two hundred and five (205) questions and, thus, they were sent to five researchers with a doctoral degree in Public Health, authors of publications in national reference journals on the subject and linked to higher education institutions in different states. The goal was for these scientists to indicate which attribute each question referred to. This process excluded 70 questions: the judges defined 35 of them as “not applicable” and the other 35 mentioned the MH, being eliminated to avoid collinearity. After four rounds, experts achieved a consensus, allowing the assessment of each attribute of PHC.

The Box summarizes the relationship between each Essential Attribute of the PHC and the contents of the questions used in the PMAQ-AB, according to the consensus defined by experts.

For the typology of Quality of care provided in mental health, 35 questions were identified in form II PMAQ-AB, which include reception, consultation, follow-up, test requests, prescription of psychotropic drugs, referral to specialized services, and the multidisciplinary approach of NASF workers toward teams. More detailed questions were also asked about the professionals’ work process, involving treatment, promotion, prevention, harm reduction, and health rehabilitation for people with psychological distress and users of alcohol and other drugs. After the elaboration of typologies, researchers added questions and the categorized indexes (Box).

The two typologies (attributes and mental health) had their indexes categorized into three scenarios to express the low (0–32.99%), medium (33–65.99%), and high (66–100%) levels. The essential attributes expressed in its category are Integrality, Coordination, Longitudinality, and First Contact, in addition to a general variable, PHC, resulting from the sum of the
other four that make up this typology. For measuring purposes, researchers recoded the 18 polytomous variables of the second typology as dichotomous in their answers (1 = yes and 0 = no/don’t know/not applicable/no answer).

In the descriptive analysis, the EqAB were distributed according to the structure of mental health care, the essential and general attributes of the PHC, and the classification by regions. We performed multinomial logistic regression analyzes to investigate the associations, sustaining the healthcare quality provided in MH as the dependent variable and the PHC attributes as the independent variable. The scenario of Low Structuring of MH was assumed as a reference category. Therefore, categories of typologies were dichotomized into low and medium/high.

The magnitude of the associations was represented by the odds ratio Odds Ratio (OR), with a respective confidence interval of 95% (95%CI) and significance level of 5% (p ≤ 0.05). We used the SPSS Statistics 20 program to perform statistical analyses.

The study complies with the standards and regulatory guidelines for research involving human beings of Resolution 466/2012. The Comitê de Ética em Pesquisa da Universidade Federal de Minas Gerais (Research Ethics Committee of the Federal University of Minas Gerais) approved this research, Registration 28,804, 5/30/2012.
RESULTS

Considering the distribution of Mental Health care (Table 1) by levels and regions, we observed that 52.1% of the teams are at the medium level, 29.2% at the low level and a small portion at the high level 18.7%.

The Southeast region had the highest number of high-level teams (23.7%) and the lowest number of low-level teams (23.7%), whereas the North region had the opposite indices: 52.9% of low-level and 7% high level.

Considering PHC structuring by levels and regions (Table 2), most teams are located at the average level of PHC structuring (86.52%), 7.5% are at the low level, and only 5.93% are at the high level of structuring.

For the regional distribution, the Southeast region once again had the highest number of high-level teams (7.5%), while the Northeast region had the lowest EqAB index at the low level (5.9%). The North Region stands out negatively for presenting the worst rates at all levels, with the largest number of low-level teams (16.9%) and the smallest number of high-level teams (1.5%).

In the distribution of the PHC structuring according to the essential attributes, by levels (Table 3), the Longitudinality attribute stands out, which presents 36% of the high-level EqAB. On the other hand, the Coordination attribute has the worst rates (28% low level and 0.7% high level).

In the association analysis (Table 4) between the quality of care provided in mental health and the structuring of primary care, based on the essential attributes by levels, we observed a positive association in medium and high-level PHC structuring scenarios. In the medium structuring scenario, the chance of achieving a higher quality of care in the mental health area increases (OR = 2.193). This result becomes significantly higher (OR = 14.742) when the

Table 1. Distribution of quality of mental healthcare by levels and regions, Brazil – PMAQ-AB 2014.

| Regions   | Low  |  |  | Average |  |  | High  |  |
|-----------|------|---|---|---------|---|---|-------|---|
|           | n    | % |  | n       | % |  | n     | % |
| South     | 1,118| 24.8 | | 2,370 | 52.6 | | 1,021 | 22.6 |
| Southeast | 2,288| 22.7 | | 5,416 | 53.6 | | 2,396 | 23.7 |
| Midwest   | 933  | 41.6 | | 1,082 | 48.3 | | 226  | 10.1 |
| Region    | 1,142| 52.9 | | 867   | 40.1 | | 151  | 7 |
| Northeast | 3,210| 29.8 | | 5,774 | 53.5 | | 1,784 | 16.6 |
| Total     | 8,691| 29.2 | | 15,509| 52.1 | | 5,578| 18.7 |

PMAQ-AB: Programa de Melhoria do Acesso e da Qualidade da Atenção Básica (Access and Quality Improvement Program in Primary Care).

Table 2. Distribution of the primary healthcare structuring by regions and levels, Brazil – PMAQ-AB 2014.

| Regions   | Low  |  |  | Average |  |  | High  |  |
|-----------|------|---|---|---------|---|---|-------|---|
|           | n    | % |  | n       | % |  | n     | % |
| South     | 364  | 8.1 | | 3,860 | 85.6 | | 285  | 6.3 |
| Southeast | 670  | 6.6 | | 8,668 | 85.8 | | 762  | 7.5 |
| Midwest   | 209  | 9.3 | | 1,961 | 87.5 | | 71   | 3.2 |
| Region    | 365  | 16.9 | | 1,762 | 81.6 | | 33   | 1.5 |
| Northeast | 638  | 5.9 | | 9,514 | 88.4 | | 616  | 5.7 |
| Total     | 2,246| 7.55| | 25,765| 86.52| | 1,767| 5.93|

PMAQ-AB: Programa de Melhoria do Acesso e da Qualidade da Atenção Básica (Access and Quality Improvement Program in Primary Care).
Why does mental health care not follow the structuring of primary care? Lima AMJ et al.

The scenario is highly structured. The better the PHC structure, the better chances of assistance levels increasing to fourteen times greater. Positive associations in the highly structured PHC scenario were found for all attributes (completeness OR = 3.21; coordination OR = 2.31; longitudinality OR = 2.25; first contact OR = 1.55). Finally, for the medium structuring scenario, only the coordination, and first contact attributes showed a positive association.

**DISCUSSION**

This study demonstrates that Brazil has a long way to reach a high level of mental health care regarding PHC. Most of the teams are at an average level of mental care quality and almost a third of them have a poor level of quality, differing significantly from the general framework of PHC structuring in Brazil.

The number of teams in the worst quality scenario of MH (29.2%) tripled in comparison with PHC structuring. These results show problems highlighted by other studies that point to the ongoing process of structuring the PHC, with the challenge of incorporating mental health practices still lacking.

Indeed, higher PHC structuring co-occurs with better mental health actions, a reality that some studies focusing on urban centers have also found in structured MH services in network.

The data showed that the South and Southeast regions have better results in mental health care, while the North and Center-West regions have the worst results. This suggests that those regions are structured in different ways to include the care of MH in the PHC.

The analysis of PHC structuring degree indicates that few teams have a high degree of structuring and a significant majority are at the medium level, corroborating the results of other studies in face of percentage differences.
Regarding regions, it is observed that the relationship of regional differences is maintained both for the quality of care in MH and for the structuring of the PHC, indicating that the northern region had the worst results. Socioeconomic factors, problems in retaining professionals, and poor training processes are factors that contribute to this unfavorable scenario\textsuperscript{15,16}.

In general, national studies\textsuperscript{7,9,17,18} demonstrate a significant improvement in the structuring of PHC over time. This process enables the insertion of mental health actions at the primary level, promoting improved care.

Factors such as facing the challenges of psychiatric reform, the creation and expansion of services, the institution of RAPS, expansion, and definition of PHC as a priority for care, and having a wide range of substitute services are significant advances for mental health and primary care\textsuperscript{19,20}. However, it is still necessary to improve the insertion of MH actions in PHC.

There are controversies in the various studies on the structuring of attributes in PHC. Research using PCAtool highlights that first contact is one of the most fragile attributes of PHC\textsuperscript{21,22}. However, another study, using data from the PMAQ, and FHS (units and users), pointed out longitudinality and coordination as the worst evaluated attributes\textsuperscript{21}. This study, however, shows that the attributes act differently in high and low PHC structuring scenarios. The highest number of FHS in the best scenario has the structured longitudinality attribute. For the worst scenario, the coordination attribute is the one that needs to be structured.

The results of the analyzes of the association between the quality of care and the structuring of the PHC demonstrate a positive association that increases by 14 times the chance of the PHC to provide better services in mental health when the EqAB are better structured. In this sense, teams must prepare themselves to absorb care in MH, with professional training, changes in the teams’ work processes, and adaptation of the physical structure to face this great challenge\textsuperscript{7}.

We also stress that the inclusion of mental health actions is also resisted by professionals, who need to incorporate the principles of the substitute model, whence the EqAB prioritize mental disorders in the same way they do with other diseases\textsuperscript{4,23,24}. This research finds out how much the MH area still needs to advance in its organization process, considering the Brazilian primary care and focusing on mental health in the PHC structuring process.

Although adherence to the 2nd cycle of the PMAQ-AB was quite high, the analysis of only the teams that voluntarily joined may overestimate some results, which presents a limitation for this study. The link of the PMAQ-AB with financial resources to support the program can also compromise the results found. The PMAQ-AB data collection instrument also presents limitations in the formulation of some questions in the mental health area, such as in the characterization of investigated subgroups (users of drugs and psychotropic medications) and of some offered actions. Still, other aspects related to group care, prevention, and mental health promotion actions are not adequately structured in the PMAQ-AB. Therefore, mental health care is underdeveloped, even though understood as part of the scope of ABS actions. Despite these limits, the data from the PMAQ-AB allow a view of how the area is structured in PHC in Brazil.

**CONCLUSIONS**

The quality of care in MH in PHC in Brazil still has a long way to go, more than a third of EqAB have poor quality of structuring actions. Mental health care does not follow the structuring of PHC in a linear way, requiring additional efforts for its implementation. We observed that comprehensiveness and coordination are attributes that most contribute to a better offer of good quality care.

The mental health movement has structured the care network centered on substitute equipment. Nowadays, developing MH actions in PHC becomes even more important,
because mental health policies are facing setbacks that might be catastrophic. Thus, the consideration of such aspects can significantly contribute to the realization of mental health care with quality and excellence.

REFERENCES

1. Kohn R, Ali AA, Puac-Polanco V, Figueroa C, López-Soto V, Morgan K, et al. Mental health in the Americas: an overview of the treatment gap. Rev Panam Salud Publica. 2018;42:e165. https://doi.org/10.26633/RPSP.2018.165

2. Bonadiman CSC, Passos VMA, Mooney M, Naghavi M, Melo APS. A carga dos transtornos mentais e decorrentes do uso de substâncias psicoativas no Brasil: Estudo de Carga Global de Doença, 1990 e 2015. Rev Bras Epidemiol. 2017;20 Supl 1:191-204. https://doi.org/10.1590/1980-54972017000500016

3. Mulvaney-Day N, Marshall T, Downey Piscopo K, Korsen N, Lynch S, Karnell LH, et al. Screening for behavioral health conditions in primary care settings: a systematic review of the literature. J Gen Intern Med. 2018;33:335-46. https://doi.org/10.1007/s11606-017-4181-0

4. Souza LGS, Menandro MCS, Couto LLM, Schimith PB, Lima RP. Saúde mental na Estratégia Saúde da Família: revisão da literatura brasileira. Saude Soc. 2012;21(4):1022-34. https://doi.org/10.1590/S0104-12902012000400019

5. Moliner J, Lopes SMB. Saúde mental na atenção básica: possibilidades para uma prática voltada para a ampliação e integralidade da saúde mental. Saude Soc. 2013;22(4):1072-83. https://doi.org/10.1590/S0104-12902013000400010

6. Rocha BS, Werlang MC. Psicofármacos na Estratégia Saúde da Família: perfil de utilização, acesso e estratégias para a promoção do uso racional. Cienc Saude Coletiva. 2013;18(11):3291-300. https://doi.org/10.1590/S1413-812320130001100019

7. Gerbaldo TB, Arruda AT, Horta BL, Carnelo L. Avaliação da organização do cuidado em Saúde Mental na Atenção Básica à Saúde do Brasil. Trab Educ Saude. 2018;16(3):1079-94. https://doi.org/10.1590/1981-7746-sol00150

8. Silva Filho JA, Bezerra AM. Acolhimento em Saúde Mental na Atenção Primária à Saúde: revisão Integrativa. Id on Line Rev Multidiscipl Psicol. 2018 [cited 2020 Jan 31];12(40). Available from: https://idonline.emnuvens.com.br/id/article/view/1138/0

9. Frateschi MS, Cardoso CL. Práticas em saúde mental na atenção primária à saúde. Psico (Porto Alegre). 2016;47(2):159-68. https://doi.org/10.15448/1980-8623.2016.2.22024

10. Medrado ACC, Cruz MG, Baião JJ, Souza MA, Araújo PS. Os laços e nós de uma rede de atenção psicossocial. Cad Bras Saude Mental. 2018;10(27):53-70.

11. Bezerra IC, Jorge MSB, Gondim APS, Lima LL, Vasconcelos MGF. “Fui lá no posto e o doutor me mandou foi pra cá”: processo de medicamentalização e (des)caminhos para o cuidado em saúde mental na Atenção Primária. Interface. 2014;18(48):61-74. https://doi.org/10.1590/1807-57622013.0650

12. Correia VR, Barros S, Colvero LA. Saúde mental na atenção básica: prática da equipe de saúde da família. Rev Esc Enferm USP. 2011;45(6):1501-6. https://doi.org/10.1590/S0080-62342011000600032

13. Machado DKS, Camata MW. Apoio matricial como ferramenta de articulação entre a saúde mental e a atenção primária à saúde. Cad Saude Coletiva. 2013;22(2):224-32.

14. Quinderé PHD, Jorge MSB, Nogueira MSL, Costa LFA, Vasconcelos MGF. Acessibilidade e resolubilidade da assistência em saúde mental: a experiência do apoio matricial. Cienc Saude Coletiva. 2013;18(7):2157-66. https://doi.org/10.1590/S1413-81232013000700031

15. Lima JG, Giovannella L, Fausto MCR, Bousquet A. Qualidade da atenção básica por tipos de regiões de saúde: nota técnica. Novos Caminhos. 2016 [cited 2020 Jan 17];(12):1-76. Available from: https://www.resbr.net.br/wp-content/uploads/2016/07/NovosCaminhos12.pdf

16. Fausto MCR, Giovannella L, Mendonça MMH, Seidl H, Gagno J. A posição da Estratégia Saúde da Família na rede de atenção à saúde na perspectiva das equipes e usuários participantes do PMAQ-AB, 2012. Saude Debate. 2014;38 N° Espec:13-33. https://doi.org/10.5935/0103-1104.20140003

17. Chaves LA, Jorge AO, Cherchiglia ML, Reis IA, Santos MAC, Santos AF, et al. Integração da atenção básica à rede assistencial: análise de componentes da avaliação externa do PMAQ-AB. Cad Saude Publica. 2018;34(2):e00201515. https://doi.org/10.1590/0102-311X00201515
18. Cavalli LO, Rizzotto MLF, Guimarães ATB. O médico no processo de avaliação externa do Programa Nacional de Melhoria do Acesso e da Qualidade da Atenção Básica, ciclos I e II. Saude Debate. 2016;40(111):87-100. https://doi.org/10.1590/0103-1104201611107

19. Santos AB, Silva GG, Pereira MER, Brito RS. Saúde mental, humanização e direitos humanos. Cad Bras Saude Mental. 2018;10(25):1-19. Segundo volume da Edição Especial III Fórum de Direitos Humanos e Saúde Mental.

20. Amarante P, Nunes MO. A reforma psiquiátrica no SUS e a luta por uma sociedade sem manicômios. Cienc Saude Coletiva. 2018;23(6):2067-74. https://doi.org/10.1590/1413-81232018236.07082018

21. Silva GS, Alves CRL. Avaliação do grau de implantação dos atributos da atenção primária à saúde como indicador da qualidade da assistência prestada às crianças. Cad Saude Publica. 2019;35(2):e00095418 https://doi.org/10.1590/0102-311X00095418

22. Prates ML, Machado JC, Silva LS, Avelar PS, Prates LL, Mendonça ET, et al. Desempenho da Atenção Primária à Saúde segundo o instrumento PCATool: uma revisão sistemática. Cienc Saude Coletiva. 2017;22(6):1881-93. https://doi.org/10.1590/1413-81232017226.14282016

23. Campos RTO, Ferrer AL, Gama CAP, Campos GWS, Trapé TL, Dantas DV. Avaliação da qualidade do acesso na atenção primária de uma grande cidade brasileira na perspectiva dos usuários. Saude Debate. 2014;38 Nº Espec:252-64. https://doi.org/10.5935/0103-1104.2014S019

24. Mendonça MHM, Matta GC, Gondim R, Giovanella L, organizadores. Atenção Primária à Saúde no Brasil: conceitos, práticas e pesquisa. Rio de Janeiro: Fiocruz; 2018. Introdução; p. 29-47.

Authors’ Contribution: Study design and planning: AMJL, AFS, EIGA. Data collection, analysis, and interpretation: AMJL, AFS, EIGA. Manuscript preparation or revision: AMJL, AFS, EIGA, ATMM. Final version approval: AMJL, AFS, EIGA, ATMM. Public responsibility for the content of the article: AMJL, AFS, EIGA, ATMM.

Conflict of Interest: The authors declare no conflicts of interest.