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**MODEL OF COMMUNITY MENTAL HEALTH CARE FROM THE
FIRST LEVEL OF HEALTH CARE: CASE UDA CANELONES AL
ESTE, BARROS BLANCOS, URUGUAY**

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Summary. The present study is part of the thesis for the Master's degree in Clinical and Health Psychology. The objective was to design a model of community mental health care based on the experience of the Canelones al Este Teaching Care Unit of the First Level of Care, Barros Blancos, Uruguay between 2018-2020. It is a qualitative study, based on a case study. The techniques for data collection were interviews and documentary research. The results show the theoretical/technical training competencies, intervention criteria, difficulties, epistemic positioning and meanings of the experiences of the professionals who make up the case and give meaning to the model. A model was obtained that can be replicated in other Teaching Assistance Units of the First Level of Care, as well as in devices of the National Mental Health Plan of Uruguay within the framework of the Mental Health Law.

Key words: mental health, first level of care, model, intervention

**MODELO DE ATENCIÓN EN SALUD MENTAL COMUNITARIA
DESDE EL PRIMER NIVEL DE ATENCIÓN SANITARIO: CASO
UDA CANELONES AL ESTE, BARROS BLANCOS, URUGUAY**

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Resumen. El presente estudio se enmarca en la tesis para el título de Máster en Psicología Clínica y de la Salud. El objetivo fue diseñar un modelo de atención comunitario en salud mental tomando como base la experiencia de la Unidad Docente Asistencial Canelones al Este del Primer Nivel de Atención, Barros Blancos, Uruguay entre 2018-2020. Es un estudio cualitativo, en base al estudio de un caso. Las técnicas para la recolección de datos fueron la entrevista y búsqueda documental. Los resultados muestran las competencias

formativas teórico/técnicas, criterios de intervención, dificultades, posicionamiento epistémico y, sentidos de las experiencias de los/as profesionales que conforman el caso y dan sentido al modelo. Se obtuvo un modelo que se puede replicar en otras Unidades Docentes Asistenciales del Primer Nivel de Atención, así como en dispositivos del Plan Nacional de Salud Mental de Uruguay en el marco de la Ley de Salud Mental.

Palabras clave: salud mental, primer nivel de atención, modelo, intervención

Introduction

The incidence of mental health problems, the need to articulate interdisciplinary and interprofessional work and the importance of the first level of health care are recognized worldwide. Likewise, its incidence on physical health, such as cardiovascular, oncological, metabolic diseases, HIV/AIDS infection, etc., is well known. According to the WHO, the global burden of mental health problems and the consequent comorbidity that is generated requires strategic plans that include programs and legislation guided by Human Rights, with community health and social services that provide a comprehensive response adapted to local characteristics. Notwithstanding the evidence and recommendations, in many places a logic that responds to the hegemonic medical model of large asylum institutions (asylums) and mental health clinics prevails, to the detriment of clinical-community devices from the First Level of Care (PNA) and the strategy of Primary Health Care (PHC) as recommended.

In Uruguay, a mental health law has been in force since 2017, which in its articles proposes a complex and comprehensive approach that prioritizes the first level of care and the community space.

At the international level, with regard to mental health care models in the NIP, we identified that in the mental health clinic there is a marked predominance of a biomedical and pharmacological approach with few positive responses. There are few systematized experiences of the community approach in the NAP from the health sector, as opposed to alternative initiatives developed from the social sector. Regarding mental health training related to the ANP, at the international level there are difficulties, for example, regarding the notion of Health Psychology, Psychology in the ANP and the possibility of interprofessional work with Family and Community Medicine.

The study has been necessary in order to provide a model of community mental health care, through the experience carried out through the work of the UDA Canelones al Este team in Barros Blancos, Uruguay. This work mainly includes the praxis of Family and Community Medicine professionals in articulation with Clinical and Health Psychology. The results allow us to know theoretical/technical training competencies, intervention criteria, difficulties, epistemic positioning that transversalizes the practices, as well as meanings and senses of the experiences for the intervening professionals that make the case and the construction of the proposed model.

This knowledge has practical application and is an input for other Teaching Units of the First Level of Care dependent on the Department of Family and Community Medicine. Moreover, the study is available in Uruguay for the implementation of the National Mental Health Plan 2020 within the framework of the Mental Health Law.

Method

Design

The study comprises a qualitative methodological design that seeks to understand, explain and analyze experiences in mental health care provided by the Canelones al Este Teaching and Assistance Unit.

We worked from a case study strategy as proposed by Stake (1999, p. 11) where "a case when it has a very special interest in itself. We look for the detail of the interaction with their contexts. The case study is the study of the particularity and complexity of a singular case, in order to understand its activity in important circumstances". The case of the Unidad Docente Asistencial (UDA) Canelones al Este is relevant and deserves research attention due to its experience in community mental health.

The UDA's headquarters are located in the city of Barros Blancos, 23 km from Montevideo. Barros Blancos has a population of approximately 30,000 inhabitants and, as a public health institution, the UDA serves almost half of this population. Barros Blancos is one of the most impoverished and vulnerable populations in the country. The UDA manages the service mainly with physicians specialized in Family and Community Medicine, among professionals from other disciplines such as Gynecology, Pediatrics, Psychology, Nutrition and Nursing. In addition to assistance, it develops activities of Health Promotion, inter-institutional articulation and participation, research, among others.

Samples

The qualitative approach does not involve a probabilistic sample selection as in the typical case of quantitative research. The study sample was convenience or purposive and responds to the characteristics of the ADU, managed and composed mainly of family and community physicians.

Two key groups were generated as sampling units;

Group of documents as secondary sources: 12 undergraduate and graduate programs and university training plans (current and previous) related to community mental health, focused on the health sector; programs of the School of Medicine; specialty in Family and Community Medicine, adult and pediatric psychiatry, postgraduate programs in Psychotherapy in Health Services, Integrative option, Cognitive Behavioral, Psychodrama and, from the Faculty of Psychology, Gender, Sexuality and Reproductive Health program, Conceptions, Determinants and Policies in Health program, Psychology and Human Rights program, Psychological Development and Evolutionary Psychology program and Specialization in Psychology in Health Services. We worked with legislation (1 law), the national mental health plan and 86 academic presentations related to mental health in the First Level of Care of the UDA.

Group of 4 professionals involved in the mental health approach as primary sources, which included physicians specializing in Family and Community Medicine. As an inclusive criterion in addition to seniority in the UDA and hierarchy, having worked in the UDA between the years 2018 - 2020 was considered.

Variables

The study followed an inductive-hypothetical-deductive process, where variables of interest are obtained as the study progressed. However, some previous or deductive

categories were used as a guiding strategy. The a priori deductive categories (qualitative variables), definitions and starting subcategories were as follows;

- 1- Clinical Approach
- 2- Community Focus
- 3- Academic Actions

Techniques

The study involved documentary review and semi-structured interviews. Documentation review is a process of organizing and representing knowledge that is codified, recorded. The purpose of this technique is to recover this construction. The semi-structured interview makes it possible to gain access to the interviewees' approaches by means of the spoken word. Interviews were conducted with established guidelines and, with the openness to introduce other questions.

Measuring instruments

Digital and physical content files were used for the documentary review. Each file was identified with a type of documentary record.

For the semi-structured interviews, the measurement instrument inquired about professional training related to mental health in the NAP with a community approach, characteristics of NAP mental health work with a community approach, interprofessional team, meaning of interventions with a community approach, interdisciplinary work and characteristics of the device(s). The interviews lasted between 50 and 70 minutes, conducted through the Zoom platform with audio recording, with informed consent.

Procedures

The procedure consisted of three stages, which are detailed below:

Table 1

General procedural steps

Stages	Shares	Weather	Materials
1- Data collection	Conduct semi-structured interviews Conduct documentary review	First month	Computer with Office 2021 package, Zoom platform.
2- Data analysis	Conduct content analysis of interviews and documents. Deepening of the system of categories and subcategories. Coding of these.	Second month	Computer, program MAXQDA 2021
3- Results and	Triangulation of the	Third month	Computer with Office

conclusions	data analysis with the reference bibliography in the theoretical framework. Model design of community mental health care	package 2021
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Ethical aspects

This study is based on respect for human rights, where participation in the study was voluntary, unpaid and confidential in relation to the data obtained through the different data collection techniques used, as well as confidentiality regarding the identity of the participants.

The Canelones Healthcare Teaching Unit was duly informed about the objectives of this study, the methodologies and techniques used, as well as the handling of the data, results and conclusions.

The study included informed consent in order to obtain the authorization of those persons participating in the study. The same was explained and the participant was asked to sign it as a way of expressing his/her will, thus respecting the principle of autonomy and beneficence specified in Article 4 of Chapter II and Chapter III in all its articles and paragraphs of Decree No. 379/008 on research with human beings of the Oriental Republic of Uruguay.

All participants were informed about the confidentiality of the information they provided, maintaining the private nature of their identities, and they could decide whether or not to participate in the study.

By performing a risk-benefit analysis of the techniques to be used, the study did not generate risks for the participants.

The information collected had a purely scientific purpose, responding to the objectives of the study and in no case will it question the participants of the study, thus complying with the ethical safeguards that guarantee anonymity.

The above ethical considerations allow us to affirm that this study is within the framework of the regulations in force in the Oriental Republic of Uruguay regarding human studies (Decree CM/515 of the Executive Power).

Results

University education, mental health and NAPs

The documents analyzed at the higher education (university) level were 12 training programs.

The documents were analyzed using the MAXQDA software tool. The process was inductive, starting from a single variable operationalized in categories and subcategories. The variable was denominated "Undergraduate and graduate university training in mental health and first level of care".

From the programs analyzed, the specialty in "Family and Community Medicine" is the one most closely related to community mental health care. It is followed by the program

"Conceptions, determinants and policies in health" and by the program "Adult psychiatry". Few subcategories were found in the other programs, with the cut-off point for subcategories being 40% of the categories induced in the largest program. The total number of subcategories present in the programs of interest was as follows:

Table 1

File 1 Significant programs and subcategories

Program name	Institutional affiliation	Number of identified subcategories
Family and Community		
Medicine	Faculty of Medicine	86
Conceptions, determinants and health policy	Faculty of Psychology	43
Adult psychiatry	Faculty of Medicine	42

The cut-off point for inductive subcategories corresponds to 1/3 of their presence in the sum of all documents. The inductive subcategories with the highest presence among all the documents were:

Community and Networks, Health Promotion, Human Rights, Integrality, Life Cycles, Health Psychology.

The inductive subcategories found in the documents were grouped together to generate an interconnected network. Those that have shown the greatest interconnection are:

Community and Networks, Health Promotion, Human Rights, Comprehensiveness, Life Cycles, Health Psychology, First Level of Care, Teamwork, Determinants/determinants of health, Non-hegemonic/alternative approach

Academic instances of mental health at the UDA

A total of 86 academic productions developed by the UDA were analyzed. These productions include posters, academic presentations, course programs and reports and activity proposals.

The information was organized in a single computer file as follows:

Table 2

UDA academic documents file

Name of the program file	Number of documents	Description
Academic presentations	63	Academic production that covers a variety of topics worked on by UDA
Reports and proposals for activities	8	Detail of the execution and results of various activities developed.
Course Programs	3	Detail of elective, elective and proprietary courses developed by the UDA
Posters	2	Systematized academic production

The academic productions were analyzed using the MAXQDA 2020 software tool. It is obtained that the spaces that have represented an original formative instance of the UDA have been:

Seminars, followed by conferences and meetings, congresses, courses and finally activities developed with and in the community.

The following table shows the relationship between the academic instances and their absolute frequency.

Table 3

Academic instances based on documents

Category	Subcategory	Number of identifications
Academic instances	Seminars	8
	Conferences, meetings	6
	Courses	3
	Congresses	3

Training on the NAP of Health and Mental Health is shown to be central and interconnected with other topics of interest.

Table 3

Topics with the greatest presence in UDA training

Category	Subcategory	Number of identifications
Topics	PNA and Mental Health	17
	Mental health promotion	11
	Demanicomialization	10
	Approach model	6
	Health Psychology	5

Atonserving the clinical, community, and academic

From the semi-structured interviews with professionals, the practical experiences of working in the field of mental health in the NAP of health are obtained. Four hours of interviews were analyzed using the MAXQDA program.

In the Clinical Approach variable, 4 inductive categories were generated that were subsequently operationalized into subcategories. From the analysis it emerges as significant that the experience of clinical approach in mental health that is carried out from the UDA, more specifically in its headquarters of the polyclinic of La Loma in the municipality of Barros Blancos, is remarkable to have counted and to have clinical competencies related to:

comprehensive approach to individuals, families and communities, knowing how to position oneself professionally based on interdisciplinarity, longitudinality, teamwork, critical and ethical attitude, empathy, respect, communication skills.

The categories developed above generate a sense and meaning that is identified by the interviewees as an enabling practice:

continuity of the user in the health system, improvement in the quality of care, rights-based approach, comprehensive mental health and teamwork.

Interviewees reported a critical notion of accessibility that goes beyond geographic perspectives. The improvement of quality involves an integrating process where the differential is the territory with its determining characteristics on health/illness/attention and care. The human rights approach is a guiding and humanizing pillar.

Among the approach devices identified in the study, the most important are the individual clinical ones, such as consultation with a physician specializing in family and community medicine and inter-consultations at the center with a psychologist. On the other hand, in addition to having a strong individual, interprofessional, quick access clinical device, the UDA has implemented a group mental health intervention device. In the Community Focus variable within the activities identified, we appreciate its orientation centered on the person and the place where he/she lives. The community represents the privileged space given its multiple determinants of protection, care and health and rights promotion.

Discussion and conclusions

The proposed model is transversalized by specific training in the specialty of Family and Community Medicine. In this sense, Novoa (2019, p. 95-113) conducts research on the

mental health training of these specialists where he identifies, as in our study, that the specialty program has broad inputs that contribute to mental health training. Another study by Moreno (2012, p. 319) refers that between 67.5% and 68.8% of family physicians received training for the diagnosis and treatment of mental health problems, 81.8% have not participated in mental health research and 96.1% refer to needing more information on mental health.

As for training in psychology, as in other places, training in community mental health and especially within the NAP is scattered, and in our study we found that the best contribution would be made by the Conceptions, Determinants and Health Policy Program of the School of Psychology. As suggested by Pastor (2008, p. 281) also in our case we did not find a "concrete and evaluable planning that defines objectives regarding the training of professionals, resourcing and psychological assistance in primary care", the same difficulty is found in other studies such as the one conducted in Costa Rica by Ramiro where "there is still no professional profile in the area of Health Psychology in the various institutions that make up the health sector, which generates difficulties in the incorporation of mental health in the health system" (2019, p. 153). In Chile, Scharager and Molina (2007, p. 154) report that 30.5% of psychologists reported needing adjustments in the curricula to facilitate insertion into the NAP. Among the needs, it was identified "to include topics related to clinical (31.5%) and community psychology (16.8%), public policies (15.8%) and the management and specificities of PHC (8.4%)". A percentage mentioned needs for health psychology content (6.6%) and teamwork training (5.8%)" (2007, p. 154).

The data in terms of training content and competencies correlate with competency studies in the NAP. Moncada (2015, p. 296) studied the competencies necessary for psychologists in the NAP, obtaining as significant for the development of the role from the NAP the cognitive competencies on family/community health, health psychology, institutional networks, interdisciplinary language, attitudinal characteristics such as tolerance, assertiveness, proactivity, teamwork, procedural competencies such as communication skills, empathy, kindness, group management and community contexts.

Although the competencies of the proposed model are related to those found by Monarca, the study identifies difficulties in the integrated approach, teamwork, interdisciplinary work and other necessary competencies. A study by Alonso, Lorenzo, Flores and García (2018) identifies that the comprehensive and team approach, in space with psychologists in the NAP remains a difficulty. However, as the study identifies, for Pastor, "many of the clinical problems seen in general practice services cannot be adequately addressed from an exclusively biomedical framework of care" (2008, 282).

In the proposed model, training in community, community mental health and psychiatry acquires a relevant character that goes beyond the mere concept of being in the community or the good intentions of community work. According to Bang (2014) "although strategies can be multiple, community work has a specificity and clinical-epistemological foundations in the field of mental health practices. Its inclusion requires an epistemological openness towards the recognition of subjective sufferings in their complexity as dynamic processes of health-disease-care". In this sense, it is central to think about mental health conditions from a community perspective for which, according to the author, "a change of perspective seems necessary, an openness that includes the collective, the diverse and the historical in the reading of the conditions of an era, that allows us to accept new demands, to work from contradictions and to build with others in heterogeneity and from disorder" (p. 111). The implementation of interdisciplinary individual clinical, therapeutic group and complex cases/seminars in a university academic unit, which also articulates with assistance,

led to the development of its own training proposals, as well as to the participation in national and international spaces of exchange and dissemination of knowledge, addressing the widest range of situations that are usually problematized in the first level of care. A study conducted in Ecuador highlights the transcendence and importance of university actions towards the community. As Camas (2018, p. 3) refers, the "universities offer the possibility of carrying out projects linked to the community and pre-professional practices that are not oriented towards the biomedical hospital and welfare model".

The care model designed is organized into four axes and/or components: Welfare, social/community, academic/teaching, and research. It is proposed in accordance with the National Mental Health Plan, the Uruguayan Mental Health Law and the international literature on the subject. The conceptual and procedural characteristics and principles of the model of care are based on Health Promotion, Social Determination of Health, Critical Epidemiology, Critical Psychology, Health Psychology and Family and Community Medicine.



Figure 1: Axes or components of the care model

The care model works on the basis of the dimensional conception of the human being. Following Read, Mosher and Bentall (2006, p. 63) "in addition to using reliable variables, another principle that is important to apply is to think in dimensions and not in discrete categories (...) dimensional measures of mental health are more reliable than diagnoses". There is thus an inside and an outside, a network of complex relationships that are constructed and deconstructed, where the following dimensions of the human being emerge: family, social, labor and subjective. These dimensions are spaces of intervention in themselves, which need to be thought of in their complexity and intertwining. There are situations that, when touching a line of the network within a dimensional space, will cause consequences in other nodes of the network and in other dimensions. It is necessary to see

that these networks upon networks, nodes upon nodes and interconnections, unfold like a cartographic map to navigate mental health situations.

The model implies a conceptual and operative change that affects care procedures and community interventions.

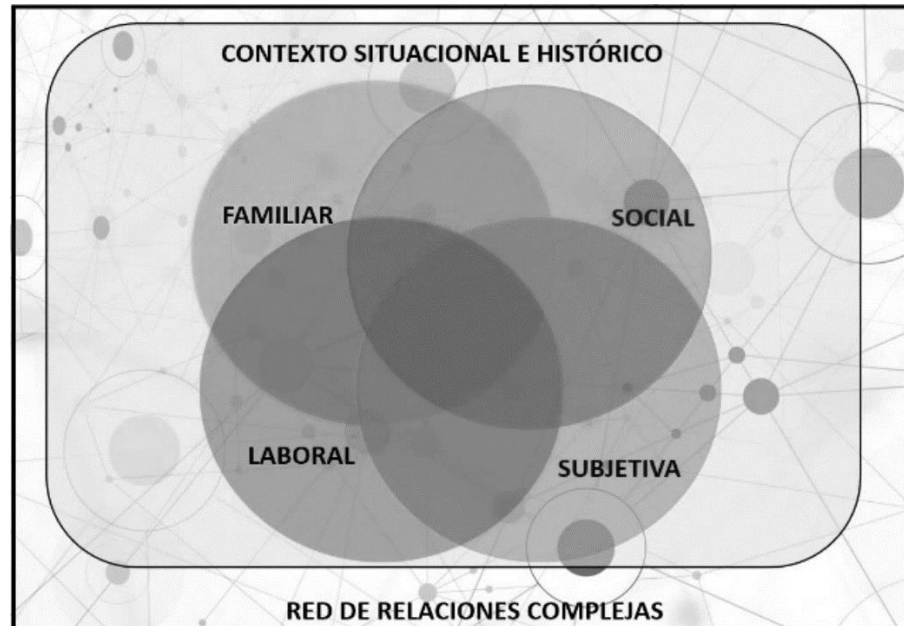


Figure 13: Intervention dimensions

The model implies a comprehensive approach to the four dimensions produced and produced by the multi-relational network context.



Figure 14: Integral cross-linking; model components and intervention dimensions

Since 2011, our country has had a Comprehensive Health Care Plan (PIAS, Decree 305/011) of the Ministry of Public Health of Uruguay, which provides the benefits required of the National Integrated Health System's providers. The model generated through the study provides the concrete formulation of the PIAS benefits and, at the same time, devices that meet the aspirations of the new National Mental Health Plan. It is a system of devices that contributes to and transcends the benefits currently available in mental health in Uruguay within the Health System. In terms of individual services, it offers a comprehensive, interdisciplinary service (family and community medicine/health psychology), which covers the lives of individuals and families longitudinally, accessible and close, with a broad epistemological perspective that offers more interventions (services) than psychotherapy at the psychological level, or psychopharmacology. The therapeutic group device is another of the benefits/services identified in the study. It is a broad space, without psychopathological profiles, which also works from the constitutive integrality of the human being. The device offers a therapeutic group service that covers different ages and life situations, with the central point of intervention being the production of each participant. At the social/community level, the UDA offers annual intervention devices that articulate the participation of neighbors, civil society organizations (CSOs), undergraduate medical students and UDA professionals. Interventions are co-designed, implemented and evaluated with community stakeholders. On the other hand, the UDA offers the population a service that is coordinated with other institutions present in the territory. Taking into account the special care of data, confidentiality and privacy of users, the UDA integrates inter-institutional spaces together with the National Institute for Children and Adolescents of Uruguay (INAU), the Integral System for the Protection of Children and Adolescents against Violence (SIPIAV) and the Inter-institutional Node of the Ministry of Social Development of Uruguay.

Finally, the study shows that the UDA offers a very powerful device for problematizing the "more" complex cases it works on. It is an interdisciplinary space of problematization and search for alternatives to offer to the users. It also serves as a

teaching/learning space for students in their final year of medical school as interns and for residents in the specialty of family and community medicine.

The community mental health care model studied involves human resources trained mainly in Family and Community Medicine, Health Psychology, Social Work, Nursing and administrative staff. The interdisciplinary view of the model proposes a comprehensive approach that provides evidence in the sense of other studies such as that of Alonso, Lorenzo, Flores, García and García, in terms of accessibility to "psychological intervention as another community resource (2018, p. 313).

The study provides the country and the region with inputs to influence the approach to the most characteristic discomforts found in the NAP. Studies indicate that the NAP is the ideal place to promote mental health and prevent future deeper problems. We know that:

within the 90% of cases not transferred to the specialized field, there are a good number of "non-cases", i.e. people who do not suffer from any "real" depressive or anxiety disorder, but only from life problems, unduly medicalized or even, if you will, psychologized (Pérez Álvarez and Fernández Hermida, 2008, p. 252)

It is essential to take experiences such as the one modeled in this study, because they represent a substantive and professionalized advance that incorporates sustainable alternatives for a substantial transformation of mental health care. The analyzed experience presents a team approach respecting disciplinary specificities. It articulates the principles of first level of care, mental health promotion with the practices, substantially, of family and community medicine and health psychology.

The impact on the community and in the field of psychological and mental health through this type of models would generate benefits in the quality and good living of people. In this way, there is a concrete and real possibility of working on psychological/mental health situations in the place where people live, taking into account their relational frameworks and their history as determinants. The community mental health care model studied provides a modern alternative adjusted to the 21st century, humanized and integrating the knowledge of psychology, family medicine and the community.

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