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Home visit in mental health in Primary Health Care: perceptions of the nursing team

Visita domiciliar em saúde mental na Atenção Primária à Saúde: percepções da equipe de enfermagem

Visita domiciliaria en salud mental en Atención Primaria de Salud: percepciones del grupo de enfermeira

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ABSTRACT

Objective: To know the perceptions of nursing professionals regarding the performance of home visits in mental health in Primary Health Care.

Method: Qualitative research, conducted in a Primary Health Care Unit in a municipality in Southern Brazil, in 2024. Ten nursing professionals participated, including five nurses and five nursing technicians, through semi-structured interviews that were analyzed according to Thematic Analysis, from the perspective of the Psychosocial Care framework.

Results: Nursing professionals reported knowledge of the family environment, strengthening bonds, listening and welcoming, and health education as important factors in mental health

home visits. Furthermore, high workloads, a lack of mental health knowledge, and the absence of family members were cited as challenges. Therefore, strategies include planning home visits, monitoring by a multidisciplinary team, and the presence of community health workers.
Final Considerations: This study allowed to understand the perceptions of the nursing team regarding home visits in mental health, highlighting the importance of this care tool for people in psychological distress, from the perspective of Psychosocial Care. Overcoming the challenges requires collective work based on the comprehensiveness of care.
Descriptors: House Calls; Primary Health Care; Mental Health; Nursing Team.

RESUMO

Objetivo: Conhecer as percepções dos profissionais de enfermagem acerca da realização de visitas domiciliares em saúde mental na Atenção Primária à Saúde.
Método: Pesquisa qualitativa, realizada em uma Unidade Básica de Saúde de um município do Sul do Brasil, em 2024. Participaram 10 profissionais de enfermagem, sendo cinco enfermeiras e cinco técnicos de enfermagem, por meio de entrevistas semiestruturadas que foram analisadas conforme a Análise Temática, sob ótica do referencial da Atenção Psicossocial.
Resultados: Os profissionais de enfermagem relataram o conhecimento do ambiente familiar, o fortalecimento de vínculo, escuta e acolhimento e a educação em saúde como fatores importantes das visitas domiciliares em saúde mental. Além disso, a alta demanda de trabalho, o déficit de conhecimento na área de saúde mental e a ausência da família foram citados como desafios. As estratégias incluem o planejamento da visita domiciliar, acompanhamento da equipe multiprofissional e a presença dos agentes comunitários de saúde.
Considerações finais: Esse estudo permitiu conhecer as percepções da equipe de enfermagem acerca das visitas domiciliares em saúde mental, ressaltando a importância dessa ferramenta de cuidado às pessoas em sofrimento psíquico, na perspectiva da Atenção Psicossocial. A superação dos desafios requer um trabalho coletivo e pautado na integralidade do cuidado.
Descritores: Visita Domiciliar; Atenção Primária à Saúde; Saúde Mental; Equipe de Enfermagem.

RESUMEN

Objetivo: Saber las percepciones de los profesionales de enfermería sobre la realización de visitas domiciliarias en salud mental en Atención Primaria de Salud.
Método: Investigación cualitativa realizada en una Unidad de Atención Primaria de Salud de un municipio del sur de Brasil, en 2024. Participaron diez profesionales de enfermería, cinco enfermeras y cinco técnicos de enfermería, mediante entrevistas semiestructuradas que se analizaron según el Análisis Temático, desde la perspectiva del marco de Atención Psicosocial.
Resultados: Los profesionales de enfermería indicaron que el conocimiento del entorno familiar, el fortalecimiento de vínculos, la escucha y acogida, y la educación para salud son factores importantes en las visitas domiciliarias de salud mental. Además, la alta carga de trabajo, falta de conocimientos sobre salud mental y ausencia de familiares se mencionaron como desafíos. Por lo tanto, las estrategias incluyen planificación de las visitas domiciliarias, seguimiento por parte de un equipo multidisciplinario y la presencia de agentes de salud comunitarios.

Consideraciones finales: Este estudio permitió comprender las percepciones del equipo de enfermería sobre las visitas domiciliarias en salud mental, destacando la importancia de esta herramienta asistencial para personas con malestar psicológico, desde la perspectiva de la Atención Psicosocial. Superar los desafíos requiere un trabajo colectivo basado en la integralidad de la atención.
Descriptores: Visita Domiciliaria; Atención Primaria de Salud; Salud Mental; Grupo de Enfermería

INTRODUCTION

Primary Health Care (PHC) is, preferably, the point of entry for any individual into the Unified Health System (SUS), which carries out actions for the promotion and protection of health, with emphasis on the prevention of illnesses and the creation of a bond between the user and the institution, facilitating therapeutic follow-up[1]. Thus, care in PHC aims to increase equity of access to services, replacing the focus on the curative method with the preventive method, characterized by its multiprofessional work, with specific strategies designed to meet the demands of the population[2].

Among these actions, Home Visit (HV) is a work methodology in which the health professional enters the community to provide follow-up to the user in their home. In addition, it is a strategy that enables care for people with some disturbances in health conditions (physical or emotional dependence), allowing the breaking down of existing barriers between scientific and popular knowledge, combining them for the promotion of health at home[3].

Home visits programs have typically been an approach that forms part of a "*continuum*" of care and a network of services, implemented to support families with complex health needs. Furthermore, conducting interventions in a home environment has several benefits, including better relationship building and the involvement of the whole family[4]. Thus, the choice of home care aims to shift the focus away from the disease and towards the family within its housing context and interpersonal relationships, ensuring improved well-being, both in its physical and psychological aspects[5].

Through primary health care expansion policies, the Ministry of Health has recently encouraged actions that refer to the subjective dimension of users and mental health problems. This coordination between mental health services and primary health care is based on the principles of the notion of territory, the organization of a mental health network, and the promotion and construction of autonomy for users and their families[6].

Since the current model of mental health care, based on Psychosocial Care, has as its assumptions care in freedom and in the territory[6], the HV is understood as a care tool that enhances the integrality of individuals in mental distress at home[5]. In this context, the nursing team is involved in all the tools of the network and has a leading role in the mental health care of primary health care users, being responsible for establishing a therapeutic relationship, offering individual and group care, managing crises and promoting self-care strategies, establishing a relationship of trust and respect[7].

The motivation for this study arose from the authors' experiences in the field of mental health in primary health care. These experiences allowed them to observe difficulties related to territorial safety, the absence of family members in accompanying home visits, the high demand for cases of people experiencing mental distress in the covered area, and the lack of skills to manage these situations, especially on the part of the nursing staff.

The literature on home visits encompasses studies that present users' perceptions on the implementation of this care tool used in primary health care in their homes, as well as their experiences and suggestions for improvement[3]. In a nationwide study, the effectiveness of home visits was analyzed using scales that mapped the organization and frequency of care, which can contribute to understanding the characteristics of home visits carried out in the country[8]. On this topic, another study on the role of home care in Brazil reveals that home visits can be quite immersive, depending on the methods established for interaction actions, and the trust and bond between the user and the multidisciplinary team[9].

Regarding mental health, research was found that addresses the practice of home visits within the specialized psychosocial care network, understanding home visits as an instrument of care, promoting treatment and quality of life, considering the complexity of family and social relationships in challenging contexts[5,10-11]. Other studies only present the nurses' perspective on conducting home visits in primary health care[2,7,12]. However, a gap in knowledge is noted regarding the intersection of the subjects of home visits, primary health care, mental health and the nursing team, including nursing technicians, which justifies the present study.

To discuss home visits intended for people in psychological distress, the framework of Psychosocial Care makes important contributions, since it is characterized by the broadening of the concept of health, presupposing comprehensive and humanized care. In this model, the objective of the intervention, in this case home visits, shifts from the disease to the subjectivity of the person in psychological distress, choosing the territory as a space for the production of care[6].

Thus, the following question arises: What is the perception of nursing professionals regarding home visits in mental health within Primary Health Care? This study aims to value the perspective of nursing professionals, highlighting the relevance of home visits in psychosocial rehabilitation and in strengthening mental health care in Primary Health Care.

Therefore, the objective was to understand the perceptions of nursing professionals regarding home visits in mental health within Primary Health Care.

METHOD

This is a descriptive qualitative research[13] that followed the recommendations of the *Consolidated Criteria for Reporting Qualitative research* (COREQ), which includes 32 criteria in three domains: research team and reflexivity, study concept, analysis and results, which allowed the study to be qualified[14].

The research was conducted at a Primary Health Care Unit (PHCU) in a municipality in southern Brazil. This PHCU serves approximately 18,500 families, with about 45,000 registered users, and has a multidisciplinary team composed of nurses, nursing technicians, doctors, community health workers, nutritionists, pharmacists, social workers, as well as professors, residents, and undergraduate students from the aforementioned areas. It is worth highlighting that nursing is one of the categories with a leading role in discussions regarding mental health home visits.

The nursing team consisted of five nurses and 11 nursing technicians. Participant selection was intentional and based on convenience, following prior contact during a presentation of the study at a team meeting in the primary health care unit (UBS), where the objectives, purposes, and reasons for conducting the study were explained. Nursing professionals with a permanent contract of six months or more were included in the study. Nursing professionals who were on sick leave, maternity leave, or vacation during the interview period were excluded.

Application of the selection criteria showed that three nursing technicians had less than six months of work experience, two were on vacation, and one was on sick leave. Therefore, 10 participants were included: five nurses and five nursing technicians who agreed to participate in the study, and there were no dropouts.

For data collection, invitations were personally extended to members of the nursing team, and upon confirmation of acceptance, interviews were scheduled according to each participant's availability. The method used for data collection was a semi-structured interview, conducted in person at the primary health care unit (UBS), in a private and quiet

room, ensuring the privacy of the respondents. Furthermore, the interviews were conducted by the study's authors, who had prior experience in qualitative research data collection; one was a master's student and the other an undergraduate research fellow. The researchers had no prior interpersonal relationship with the participants to avoid bias.

The semi-structured questionnaire contained closed-ended questions about the participants' profiles, such as gender, age, self-declared race/color, professional background, postgraduate studies, work experience, and weekly workload. The open-ended questions included: "What do you understand by home visit in mental health?", "What are the difficulties in conducting home visits in the mental health field?", and "Do you have any plan for conducting home visits? If so, please describe it." Participants could elaborate on the proposed topic and add more information if they felt it necessary. A pilot test was conducted with a nurse and a nursing technician to verify if the questions were adequate for the respondents' understanding; these individuals were not included in the study.

Data was collected between November and December 2024, with interviews lasting 10 to 25 minutes. The interviews were audio-recorded with the participants' prior consent and subsequently transcribed in full by the researchers. At the end, participants were asked if they wished to hear the content of the interviews. Therefore, only the authors had access to the respondents' answers, which were coded to preserve privacy and maintain anonymity. Nurses were coded with the letter "N" followed by a number corresponding to the sequence in which the interview occurred, such as "N1", "N2", and so on. Nursing technicians were coded with the letter "T" followed by a number corresponding to the sequence of interviews, such as "T1", "T2", and so on.

The transcripts were analyzed using the Thematic Analysis method proposed by Minayo, with the following steps: pre-analysis, exploration of the material, and treatment of the results obtained and interpretation[13].

The first stage consisted of revisiting the initial research objectives. During this phase, floating reading was conducted to allow for direct and intensive contact with the field material, in order to understand the content and construct a *corpus*, which corresponds to the content examined in its entirety, resuming the process of the exploratory stage and using as a parameter the exhaustive reading of the material and the initial questions.

Also at this stage, the recording units, the context units (the delimitation of the context of understanding of the recording unit), the coding modality and the most general theoretical concepts that guided the analysis were determined[13], such as: “include the family support network”, “observe the organization of the living space”, “high internal work demand”,

“network resources”, “fear of aggressiveness”, “availability of people to receive the home visit”, “focus on diagnosis and medicalization”, “study the medical record”, “discuss the case in a team meeting”, “include the family in the home visit”, “assess the risks” and “explain the reason for the visit”.

The second stage involved grouping the content into categories, in order to understand the text. Categorization is a process of reducing the text, resulting in the classification and aggregation of data, sorting them into categories responsible for specifying the themes[13], where the following categories emerged: “The importance of home visits in mental health care”, “The challenges for carrying out home visits in mental health” and “The strategies used to carry out home visits in mental health”.

Finally, in the third stage, the information obtained is highlighted and, based on it, inferences and interpretations were made[13], relating them around new theoretical dimensions proposed by the psychiatrist Paulo Amarante, one of the pioneers of the Brazilian Psychiatric Reform movement and the Psychosocial Care framework[6].

The study began after review by the Research Ethics Committee (CEP) of the institution that manages the UBS, and was approved under protocol No 7.020.708 (CAAE 81178324.7.0000.5327). The participants were assured of the preservation of their identity, and the items contained in Resolution No. 466/12[15] and Resolution No. 510/16[16] of the National Health Council (CNS), which provide for the ethical standards that regulate research involving human beings, were observed.

The personal data obtained were handled in accordance with the General Data Protection Regulation (LGPD)[17], which provides for the processing of personal data by individuals or by a legal entity under public or private law, with the aim of protecting the fundamental rights of freedom and privacy and the free development of personality.

Each participant was provided with the Informed Consent Form (ICF), which was read, explained, and signed in duplicate by the researcher who conducted the interview and by the respondent, each receiving a copy of identical content. The ICF contained information on the research project, such as objectives, risks, and benefits, and guaranteed the voluntary nature of participation, the maintenance of anonymity, and the possibility of withdrawing consent at any stage of the study without any penalty or prejudice. The risks related to participation concerned a possible discomfort or embarrassment when addressing the content of the questions.

RESULTS

Regarding the characteristics of the participants, nine were female and one was male, aged 34-68 years. As for race/color, eight professionals self-identified as white and two self-identified as black. Regarding professional training, all the interviewed nurses had postgraduate degrees; two of them specialized in mental health. The interviewed nursing technicians did not have any specialization courses. The professionals' length of service at the primary health care unit ranged from 7 months to 14 years, and the working hours for all nursing professionals were 36 hours per week.

The importance of home visits in mental health care.

Regarding the first category, the respondents mentioned six aspects that highlight the importance of conducting home visits in mental health care, such as knowledge of the home environment, strengthening bonds, listening and providing support, and health education.

Knowledge of the home environment was exposed by nursing professionals as a way to gain a broad view of the user's routine. The respondents also said that in the home visits they were often able to identify behaviors that would otherwise be missed in a traditional appointment.

> *We understand that we are supposed to evaluate the organization of the individual and the family. During the visit, we observe the organization of living spaces, family relationships, how people are integrated into the community, and reflect on these strategies based on what we identify. Based on how someone organizes their space, we understand how other aspects of life function; the residence says a lot about the people who live there and about that environment.*(/N4)

> *It's a way for us to assess the patient in their family and community life, in terms of mental health. [...] If the patient comes to the appointment, you assess the individual and, by doing the assessment in the environment where the patient lives, you can assess the family, the interpersonal relationships, the relationship with friends, with the neighbors, right? Observing the place where they live, the living conditions of that person and especially the family life, that's how you can get that perspective.* (N5)

> *When we need to better understand the context of the user, their family, and the community they live in, we often find that our interpretations here aren't sufficient, so we need to go to their home to understand the context.* (T1)

The resources available on-site, the organization of the environment, and family and community relationships were reported by nursing professionals as enabling them to perceive potential aggravating factors and plan care according to the individual needs of the users.

By visiting the homes of the users, the health professionals build relationships, strengthening the bonds with these individuals, which is another powerful aspect in

conducting home visits in mental health care. Based on their experiences, they noticed that people feel welcomed when they perceive that the team is interested in their care by conducting home visits.

> *I also think the bond is strengthened when you go to people's homes; they see that you're interested in taking care of them in some way.* (N1)

> *I understand that it's about providing support, trying to offer support in the best way possible, whether mentally or physically.* (T5)

> *I think it's about going and listening, right? Perhaps, the security that the patient feels at home, in their own house, will make it easier for them to open up and talk than if they have to come to a health unit. I believe that's it, right? But they will feel more comfortable talking if they are in an environment they know.* (T4)

According to the testimonies, people experiencing psychological distress feel more comfortable discussing their needs within their home environment compared to receiving care in a doctor's office.

Building a bond and fostering close relationships between professionals and users are essential characteristics in promoting mental health. They lead to greater autonomy and engagement in the progress and continuity of care, as well as encouraging greater adherence to health education and empowering individuals to take a leading role in their treatment.

> *Continuity of work. We provide care within the patient's home, within their routine, educating the patient and educating the family, and the neighbors, if necessary. Sometimes there isn't a family, but there are neighbors, to try to guide the care, both in terms of medication and routine.* (T3)

Finally, the use of home visits as a care tool in the health education process was mentioned by the nursing team professionals, since the home environment provides relevant information about routine and organization, offering ways to educate the family and educate the user about the necessary care for their own health condition.

The challenges of conducting home visits in mental health.

In this category, challenges arose for conducting home visits in mental health, such as high work demands, lack of knowledge in mental health, and the absence of family.

Respondents cited the high workload as a factor that makes it difficult for them to make home visits in mental health, since, in their daily practice, they realized that due to the large number of appointments carried out daily at the primary health care unit, they were often unable to provide care at home.

> *I think maybe the problem is the workload itself, you know? Because we end up going for what's most pressing, right?* (N2)

> *I think what makes it most difficult for a technician to leave is the internal demand. To be able to cover the rooms we have here, covering the unit will always be a priority rather than leaving. There's a lot of demand here.* (T4)

> *We still do very little work with mental health, which in primary care is very focused on diagnosis and medication. The high demand doesn't allow us to provide much care, because we end up focusing on more urgent things. I think we over –medicate..* (N1)

According to reports, the biomedical model based on diagnosis, symptoms, and medicalization was still present in the primary health care unit (UBS) of the municipality investigated and was reinforced by the high workload. A considerable amount of time then had to be dedicated to internal tasks of the unit. Hence, mental health care was neglected, as professionals need more time to provide such care, given its subjective nature.

The biomedical model and the knowledge deficit in mental health reinforce the stigmas surrounding people experiencing mental distress, which creates a challenge for conducting home visits in mental health.

> *The patient's condition itself is sometimes a challenge for us; sometimes when we arrive there, the patient is aggressive or very agitated, which makes it a challenge for us to even communicate with them.* (T1)

> *I think I'm scared because sometimes people with impaired mental health are more aggressive and also because I'm short, and sometimes the patients are stronger, so I am afraid of the violence.* (T5)

> *Sometimes you get a little overwhelmed, wondering how to act in that situation. So, I think we should be continuously learning, I think there could be more training on how can we approach people with impaired mental health, sometimes I'm kind of at a loss for what to do.* (T1)

> *Here I am a primary care nursing technician, I am not a nursing technician who has worked in or has experience in psychiatry or mental health.* (T3)

According to the testimonies, health professionals often do not know how to provide care to users with mental health conditions, feeling insecure about providing care. This insecurity may stem from deeply rooted stigma and prejudices, in which the person suffering from mental distress is still seen as unpredictable and aggressive.

The absence of family during home visits was identified as another challenging factor, as, according to the respondents, it offers a one-sided perspective, limiting the care provided.

> *We have many patients who should be accompanied, right? Elderly patients, dependent patients, even those in mental health, who should be accompanied by family members and aren't. And often, these are patients who wouldn't be able to receive us alone. So, for me, it's a challenge to make the visit, to find the patient alone, when they are able to receive us, right? And also to have this one-sided view, it's only a matter of what the patient is bringing. Often, they are confused, disoriented; with this type of patient, there should be a family member who gives you*

a better perspective. (N5)

Family involvement is strategic in planning and building comprehensive mental health care, aligning with the principles of the psychosocial care model, since the family's role is important for the treatment and management of the user at home.

Strategies used for conducting home visits in mental health.

In this category, respondents reported the strategies used to carry out home visits to people experiencing psychological distress, such as planning, monitoring by a multidisciplinary team, and the presence of community health workers.

Planning home visits, through the study of medical records and case discussions in team meetings, was cited by professionals as a strategy used to conduct home visits in mental health, aiming to define the best approach according to the needs of the users.

> *Strategically, we usually think about the week ahead, what will be done. If it's a home visit for wound care, we have to know what is the patient's support network like, and who will we talk to? There's always someone we'll contact, ask how they're doing. We have a team meeting weekly, and we usually say in the team meeting: "Look, I went to collect samples, and I think Mr. So-and-so isn't doing well, maybe we'll have another doctor this week, another one next week, so we can get a better overview."* (T3)

> *It's about reviewing the medical record, then, before leaving, so we have an idea of what to expect, as well as how the previous care went, in short, so we have an idea of where the situation stands, right?* (T4)

> *I always check the medical record to understand the person's potential needs, and in some cases, I call beforehand to find out what the person needs, to identify the needs of the person and the family. When there is a mental health problem, we discuss the case with the team and define the referrals.* (N3)

Making advance calls to the patient and their family, reviewing medical records, and discussing these in team meetings were strategies mentioned for planning home visits. So, home visits begin long before the professional leaves the unit, since these devices require prior organization.

Case discussions during team meetings facilitate the analysis of the need for home visits to be accompanied by another member of the multidisciplinary team. This strategy was cited by respondents as a way to increase the professional's safety during home visits.

> *Sometimes, in certain situations, it is complicated for us to go alone, right? Because we don't know the degree of illness of the person and the conditions of the place itself. Sometimes we have risky situations that require attempts to minimize them, or we need to surround ourselves with safety measures to make the individual visit and do a little more assessment of the place.* (N4)

> *Not going alone in the home visit and check whether someone else faces a more problematic situation, whether we want to involve another family member, not going at a time when the individual faces a risk of self-harm and harm to others, and when an emergency mental health assessment is needed.* (N4)

> *When we go to make a mental health visit, we never go alone. This is a strategy we use because we don't know the patient's conditions at home, so we try never to go alone.* (T1)

During the home visit, the respondents were concerned about the safety of the territory and their own safety, as they organized themselves in pairs for the displacement and home care of the users. These measures can inhibit risky situations in the home and in the community, mitigating the fear of unpredictability in care.

Among the team members, the presence of Community Health Agents (ACS) stands out as an effective strategy for carrying out home visits, since they are embedded in the community and strengthen the bond between users and other professionals, including the nursing team.

> *Demands about mental health issues are always brought up in team meetings because sometimes there are health agents who already know the family, especially in mental health cases [...]* (N1)

> *I usually use the health agent's follow-up because they know well the area where the patient live, they know the neighbors, they know friends, and they have that interaction.* (N5)

Community Health Agents (ACS) are professionals who know the territory, the available resources, the families, and the community in general—factors that can contribute positively to the planning of mental health nursing care during home visits to people experiencing psychological distress.

DISCUSSION

The approach to family structure and dynamics made possible by home visits shows its importance, constituting an object of intervention by the team, which allows for a better understanding of how these interfere in the lives of people in mental distress[5]. By getting to know the users' home and organization, the professionals can insert themselves into their context, having the necessary sensitivity to understand how care is carried out. This perspective is consistent with the Brazilian Psychiatric Reform movement, which proposes care based on the integrality of care and the inclusion of the family and the territory as fundamental dimensions of the therapeutic process[6].

This insertion makes it possible to obtain information about their health and care needs, their level of autonomy, the dynamics of the family environment and support network, and hence to know the conditions and particularities of each individual in psychological distress[3]. This corroborates the framework of Psychosocial Care, which proposes a break with the traditional biomedical, disease-centered model, and emphasizes territorialized, interdisciplinary care focused on building bonds and the autonomy of the subject[6]. In addition, home visits in mental health allow for closer user-professional relationships, being a key device for sharing information, feelings and concerns, which uses open communication and support for the needs of the individuals and their family caregivers[18].

Welcoming through qualified listening enables the nursing team to promote comprehensive care in the assistance provided to users in the field of mental health [19] and are practices that materialize care in freedom, replacing control and guardianship with horizontal and supportive relationships between professionals and users[6]. In addition, it is an essential tool for building and maintaining the bond, respecting the singularities and diversities between caregivers and people in mental distress[19]. Thus, care makes sense when there is longitudinality with a lasting bond and practice centered on the person, and not on the disease, since mental health is not dissociated from physical health[18].

This knowledge is important for the nursing team, since health education is an important component for building care, aiming to encompass the participation of all actors involved in the stages of the educational process through the protagonism, co-responsibility and autonomy of the users[20]. Furthermore, family members should be seen as partners in the provision of mental health care, being encouraged to participate in the process of building this care at home[21].

The importance of mental health care in the home setting allows for understanding the context of the home and the territory, strengthening the bond between nursing professionals, the person experiencing mental distress, and their family, through welcoming and qualified listening. It is up to primary health care professionals to view the family as a powerful care unit for health education in the area, which will certainly result in more qualified and conscious care on the part of caregivers. However, there are challenges to using this mental health care tool, since the high workload in primary health care services results in a scarcity of time for activities outside the primary health care unit, prioritizing other clinical and internal care within the service[22].

Furthermore, home visits motivated by clinical issues are sometimes prioritized by the team, as there are users with chronic diseases in the territory[9], which makes home visits

focused on mental health more difficult to occur. The biomedical model, still consolidated in primary health care, challenges the care of people in mental distress, since professionals focus on pathologies and diagnosis[7]. Thus, the Brazilian Psychiatric Reform movement sought to establish new relationships between society, mental suffering and institutions with the purpose of deconstructing the asylum model and developing a care practice in an open setting, in which these people become active subjects and not mere objects of intervention[6,23].

Despite the progress made over time, challenges still persist for the effective implementation of the deinstitutionalization process and the consolidation of mental health care in the territory. Among the main difficulties found in the literature, the following can be highlighted: the insufficiency and unequal distribution of services, underfunding, the fragility in intra- and intersector coordination, the stigma attributed to subjects in mental suffering and the difficulties of social (re)integration[23].

This finding corroborates the lack of knowledge among these professionals to work in mental health care, since clinical signs and symptoms appear to overshadow the mental aspects of users, resulting in inadequate management by professionals, who, in turn, often feel unprepared to care for people in psychological distress[24]. In the home setting, this knowledge gap becomes even more noticeable, as professionals may find themselves facing unfamiliar homes and histories, making them vulnerable to unexpected mental health management situations.

Knowledge in the field of mental health can provide care based on a holistic view of the person, which points to the need for intersector and interdisciplinary action. Comprehensiveness in the Psychosocial Care model is understood as a dimension that encompasses the individual in their totality, based on social, political, and economic aspects, as well as their relationship with family, community, and society, encompassing not only the care perspective but also other dimensions of life[6,23] .

Thus, continuing education plays a fundamental role in the process of promoting spaces for professional qualification for mental health care for users, being an alternative for changing reality and breaking paradigms through learning[18] the psychosocial care model. In this model, the participation of families in the treatment of people in mental distress is of utmost importance, as they are part of the main support network, assisting in the daily care of the users at home.

Conversely, the absence of family in home visits is a negative factor in the process of building care with regard to mental health, making it difficult to build healthy relationships and bonds and hence potentially exacerbating the condition of people in distress[25].

It can be affirmed that in the context of the Psychosocial Care model, families experience diverse situations regarding the care of people in psychological distress. Often, these families feel unprepared, as the reconfiguration of family dynamics requires confronting stigmas and prejudices[6,26], since these configurations are unique and interfere in different ways of dealing with the health/illness processes of their members[18].

Furthermore, the inclusion of the family in care projects is a guideline of the psychosocial care model proposal, as it is understood that the family has a role of great relevance in the therapeutic process both as a caregiver, sharing responsibilities with the team, and as an object of care[5].

In order to mitigate the challenges faced in carrying out home visits in mental health at the primary health care unit investigated, planning these visits by nursing staff can be a strategy to enhance the mapping of territorial resources to be incorporated into care processes, which should assess the context of the individual and their family, regarding life in the territory[5].

Prior reading of medical records emerges in the respondents' discourses as a tool that favors the planning of care for users at home, since it contains the records made by the multidisciplinary team, which plans care according to their needs[26]. Moreover, team meetings help in the organization and discussion of individualized care plans for each person in psychological distress who will receive home visits from the nursing team.

Recognizing that this care planning for people in psychological distress is a complex and dynamic process, the combined knowledge of the multidisciplinary team helps to promote comprehensive care, based on Psychosocial Care. A single professional could not globally meet the needs of each user[6]. Thus, multiprofessional care is based on the collective construction of knowledge, from practical experiences and the exchange of experiences, with the aim of ensuring the comprehensiveness in health actions[23].

Another strategy mentioned by professionals is that they relied on the presence of a multidisciplinary team alongside them, as the fear of the unexpected during home visits can be a limiting factor. In order to feel more secure, professionals can adopt measures that inhibit complications in risky situations in the user's home or in the community, such as, for example, carrying out visits accompanied by other members of the multidisciplinary team[10], enhancing exchanges that help in the construction of comprehensive care.

This practice is aligned with the psychosocial model based on the Psychiatric Reform and the principles of RAPS, which value shared responsibility and support for deinstitutionalization, promoting the autonomy and sociability of users through interdisciplinary and community care[6, 23].

Often, mental health care is still linked to stereotypes such as unpredictability, violence, and stigmas about the fear of hetero-aggression, aimed at people in psychological distress, which can favor the maintenance of hegemonic and disjointed biomedical models, far from the integrality proposed by Psychosocial Care[23]. In this logic, to qualify the care for these people it is necessary to break the paradigms through knowledge, so that health professionals can provide care in a welcoming way[24].

Within the multidisciplinary team, the presence of the ACS is strategic for mental health care in primary health care, as their proximity to the community, due to their insertion in the territory also as residents, enhances the conditions of care related to psychosocial rehabilitation[27]. These workers are able to create more lasting and longitudinal bonds, facilitating the monitoring of users and their families, and the ACS's partnership with nursing in carrying out home visits allows for a more assertive insertion of the team in the care of people in psychological distress[28].

This study was limited by the lack of observation of the performance of the nursing staff interviewed during the home visits in the field, since including this data collection strategy would have allowed for further qualification of the results obtained.

This study contributes to disseminating the importance of home visits in mental health and to highlighting how the nursing team, despite recognizing the relevance of this tool and creating strategies to provide comprehensive home care to people experiencing mental distress, still perceives challenges in their practice that can be minimized through the pursuit of knowledge in the field of mental health.

FINAL CONSIDERATIONS

The nursing team's perception of conducting home visits in mental health made it possible to understand the factors that make home visits an important tool for the effectiveness of care for users experiencing psychological distress in the community. It was also possible to understand, from the respondents' statements, the difficulties these professionals face when conducting home visits in mental health, as well as the strategies used by nursing staff to overcome them.

In the first category, it can be understood that the nursing team recognizes the importance of bonding and acceptance as relational tools for working in the home, as they promote knowledge of the user's environment. Furthermore, it is in the home that health education is put into practice, assisting users and families in building collective care, reinforcing the importance of conducting home visits in the context of mental health within primary health care.

Regarding the challenges identified by the professionals interviewed in the second category, the high workload and the prioritization of clinical care influenced by the biomedical model historically imposed on healthcare are factors that hinder the implementation of home visits in the context of mental health. The knowledge deficit in the area of mental health generates apprehension among professionals in providing care, reinforcing stigmas and prejudices related to the care of users experiencing psychological distress. Furthermore, the absence of family during home visits also challenges home care, since the presence of the users' support network positively influences the construction of care.

Finally, in the last category, statements emerged from the respondents regarding the planning of home visits through team meetings, reading the users' medical records, and knowledge of the resources available in the territory as strategies for carrying out home visits, in order to provide people in psychological distress with comprehensive care according to their needs. Furthermore, being accompanied by other professionals on the team, especially the Community Health Agents (ACS), helps in situations of insecurity for nursing staff, since the ACS are residents of the territory and know the resources available in the area covered by the Primary Health Care Unit (UBS).

What was evidenced in the first and third categories relates to the principles of Psychosocial Care and the potential of Primary Health Care in mental health care. Regarding the challenges expressed by the nursing team, it was evident that the biomedical model is still present, at times, in the daily work routine of these health services. It is worth emphasizing that overcoming these challenges requires collective work based on the comprehensive care of people experiencing mental distress.

Further studies are suggested that include other professionals from the multidisciplinary team, in order to capture their understanding of home visits in mental health, especially the inclusion of managers in these studies, in order to reduce the challenges experienced in the practices of these professionals, contributing to the use of this mental health care tool in the routine of primary health care units.

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