Original Article

Mental health care network: the views of coordinators of the Family Health Strategy (FHS)

Rede de cuidado em saúde mental: visão dos coordenadores da estratégia saúde da família

Red de atención em salud mental: percepción de gestores de la estrategia salud de la familia

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ABSTRACT

Objective: This study aimed to analyze the opinions of the coordinators of the Family Health Strategy (FHS) on the mental health care network in the city of Pelotas/RS.

Method: Descriptive and exploratory study with a qualitative approach, carried out with six FHS coordinators, in 2012. Semi-structured interview was used in data collection, and the results were evaluated using the thematic analysis.

Results: The network designed by the coordinators consists of few formal services and is focused on the Psychosocial Care Centers (CAPS). The informal network has a greater number of care units. Exchange of information related to joint responsibilities in the care is scarce, with lack of dialogue.

Conclusion: The coordinators have scarce knowledge on the formal care network and on care focused on the ESF and CAPS. They also recognize the importance public policies that value and expand the informal care spaces in the territory.

Keywords: Mental health services. Mental health. Brazilian Health services reform. Primary health care. Nursing.

RESUMO

Objetivo: Objetivou-se analisar a visão de coordenadores da Estratégia Saúde da Família (ESF) sobre a conformação da rede de saúde mental no município de Pelotas/RS.

Método: Estudo descritivo e exploratório, com abordagem qualitativa, realizado com seis coordenadores de ESF no ano de 2012. Para a coleta dos dados, foi utilizada a entrevista semiestruturada, e os resultados foram avaliados por análise temática.

Resultados: A rede construída pelos coordenadores é composta por poucos serviços formais e focada no Centro de Atenção Psicossocial (CAPS), e a rede informal é descrita com maiores pontos de cuidado. As trocas de corresponsabilidade no cuidado em rede ocorrem de forma frágil, sem o diálogo necessário.

Conclusão: Os coordenadores demonstram pouco conhecimento da rede formal de cuidado e uma atenção focada nos serviços da ESF e no CAPS. Reconhecem a importância de haver políticas públicas que valorizem e ampliem os espaços informais de cuidado no território.

Palavras-chave: Serviços de saúde mental. Saúde mental. Reforma dos serviços de saúde. Atenção primária à saúde. Enfermagem.

RESUMEN

Objetivo: Se tuvo como objetivo analizar la visión de coordinadores de la Estrategia Salud de la Familia (ESF) sobre la configuración de la red de salud mental en el Municipio de Pelotas/RS.

Método: Estudio descriptivo y exploratorio, cualitativo, realizado con seis coordinadores de ESF en 2012. Se utilizó la entrevista semestructurada y los datos fueron analizados con uso del análisis temático.

Resultados: La red señalada por los coordinadores posee pocos servicios formales, enfocada en el Centro de Atención Psicosocial (CAPS). La red informal es más diversificada, pero los cambios de corresponsabilidad en el cuidado es de modo frágil.

Conclusión: Los coordinadores tienen poco conocimiento de la red formal de cuidado, con énfasis en la ESF y en el CAPS. Reconocen la importancia de que haya políticas públicas que valoren y amplíen los espacios informales de cuidado en el territorio, algo necesario en el cuidado en salud mental.

Palabras clave: Servicios de salud mental. Salud mental. Reforma de la atención de salud. Atención primaria de salud. Enfermería.

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INTRODUCTION

In Brazil, the movement to change the type of care delivered to people with mental illness began with the Brazilian Psychiatric Reform in the late 1970's, within a broader process of the Brazilian mental health reform and with the social movements against the military rule. This reform is a radical change in the mental hospitalization model, based on the construction of a new scientific, political and ethical paradigm of care[1].

In the past the only space for mental care was the mental hospital, but now there is also the Psychosocial Care Network (RAPS) that consists of services and facilities such as the Centers for Psychosocial Care (CAPS) types I, II and III, CAPS Alcohol and other drugs, CAPS Children's, Therapeutic Residential Care Services Therapy (SRT), Family Health Support Center, Outpatient Mental Health services, beds in general hospitals, Urgent and Emergency care Services and care provided by the Basic Healthcare Units, in addition to Social Centers and other spaces for social interaction[2].

The formation of a network of services aims to meet the mental health demands of users and their families, based on a broad view of the complexity of health care, focused on quality of life and access to essential goods and services for the promotion of a healthy life. Thus, the inter-sector nature of this network, with the participation of educational, housing, health, leisure and work sectors becomes crucial in the organization and management of health work, in order to ensure compliance with the principles of integral care, universality and decentralization of health actions.

An important achievement was the creation and implementation of the Family Health Strategy (FHS) in the health units. The care provided in the Basic Health Units is guided by the principles and guidelines of the National Policy on Primary Care. According to this policy, the FHS is essential to the organization of health care networks, proposing a territorial character with the establishment of ties with the users and families, universal and permanent access to services and integration of prevention, treatment and rehabilitation actions. The FHS is an important strategy that manages and coordinates the provision of effective, comprehensive and humanized care in health care networks[3].

The FHS plays a key role in the mental health care of the population[4]. It is a proposal aimed to transform the traditional biomedical model into a model centered on the individual as a whole, their family and socio-cultural relations. The FHS embraces a broader concept of health and of the determining factors of the health-disease process. According to this view, the combination of technical and popular knowledge and the mobilization of institutional and community resources is necessary to cope with health problems[5].

At the FHS, the care environment is composed of living spaces, such as streets, institutions, CAPS, and the territory, a common space for all subjects. In these spaces, there is the need to recreate forms of approach, contact and bonds between the different professionals, users, services and territories. Thus, care actions require the participation of different social actors, services and sectors to ensure a care centered on the users, their health needs, social relations and territory.[6]

The ESF is based on the understanding that knowledge of the families, lifestyles, health-access related problems is necessary to provide care to the population in its territory, and coordinating and sharing this knowledge with other health networks is essential. Therefore, care management under the FHS requires that the existing local resources are optimized, to encourage the establishment of different networks capable of responding to the demands of users and their families.

We are aware of the challenges faced by FHS coordinators in their care actions such as the management of human resources and professionals not cut out for the job, the organization of the services and the care to the people's needs. Work in the FHS teams is facilitated by the coordinators. They are supposed to ensure that planned, scheduled and unscheduled activities are performed in order of priority[7].

Thus, the coordinators of Family Health Units play a crucial role of facilitating the activities of the intersector network, identifying the formal and informal resources and promoting contacts with the territory. They are responsible, together with the team, for the consolidation of the FHS as responsible for organizing health care.

Regarding mental health care in primary care there are many challenges and uncertainties on how to manage the actions. There is little information about the network of care, the possibilities of coordination, the resources available in the territory and the dynamics of the movement of users suffering from mental distress in the health services and the community[8] This has motivated us to conduct this study.

Therefore, given the importance of the work performed by FHS coordinators in the management of mental health care in the territory and the challenges faced by these teams regarding the construction of these networks, the present study posed the following guiding question: "How do coordinators of Family Health Units perceive the care network in their territory and exchanges with other services necessary to promote the care of people with mental

distress?". Based on this question, this study aims to analyze the views of FHS coordinators on the structure of the health network in the city of Pelotas, Rio Grande do Sul.

It is expected that the results of this study provide a dimension of the complexity of work in the network of care to individuals with mental distress, contributing to the strengthening and expansion of network actions and to the improvement of the work of the nursing staff, which is very active in the FHS units.

METHODOLOGY

The present study exposed data from the research entitled "The mental health network structure, according to the coordinators of the Family Health Strategy"[9]. The participants were six FHS coordinators: four nurses, a doctor and a social worker. Regarding professional training, the most experienced coordinator had graduated 22 years ago, and the one with least experience had graduated 11years ago. The longest serving coordinators have been working at FHS for 10 years and the shortest serving coordinator has been there for one year.

The coordinators who performed their activities in a FHS unit in the city of Pelotas, Rio Grande do Sul, were invited to participate in the study. According to the selection criteria, participants should be FHS coordinators in the city of Pelotas and allow the publication of data collected in the survey. Those workers who were on sick leave or vacation during the period of data collection were excluded from the study.

The city of Pelotas has an estimated population of 328,865 inhabitants and is divided into seven geographical macroregions. The region selected for this study is the macroregion with the lowest per capita income and which has experienced a significant population increase in in recent years[10]. This region has twelve health units, and six have implemented the FHS.

The formal mental health network of Pelotas has six CAPS II, distributed in its macroregions, and two specific CAPS: one for alcohol and drugs users (CAPS AD) and another for children and adolescents (CAPSi). The city counts on mental health clinics connected to universities and to the local public network, as well as on a service that provides workshops on labor and income called "Reabilitação, Trabalho e Arte – RETRATE"[9].

The network has psychiatric beds in one general hospital, two Social Centers in the rural area and the Harm Reduction program. Recently, the School Care Center targeted to children with learning problems has integrated the mental health network. Mental health activities are performed in the Primary Health Units and in the Social Care Centers. The informal network consists of groups of youngsters and elderly individuals connected to churches and leisure activities developed by schools, non-governmental organizations (NGOs) and by the Gaucho Traditions Center (CTGs)[9].

The study was based on a descriptive and exploratory research with a qualitative approach. The qualitative approach is characterized by answering questions related to a level of reality that cannot be fully quantified, such as meanings, aspirations, beliefs, values, attitudes and culture. This set of human phenomena is part of the social reality where humans are distinguished from other species because of their ability to think, act and interpret their actions based on their experiences[11].

Data was collected from April to May 2012, through semi-structured interviews. The interviews were previously scheduled with the participants, according to their availability, and conducted in the health unit. Each interview lasted approximately thirty minutes and all of them were recorded and fully transcribed by the research authors. The questions used in the interview were 1 – Talk about the structure of the mental health network; 2 – Describe how you perceive the composition of the mental health network; 3 – Talk about a remarkable situation of mental health care where the health network was necessary (identifying the exchanges and co-responsibility in care); 4 – What are the challenges of the health network structure regarding mental health, and the potential to strengthen this network? An ecomap with the picture of the user and his/her family in the center was given to the coordinator when question 2 was posed.

Data were analyzed with thematic content analysis[11]. There was floating and exhaustive reading of all the material collected during the research. Subsequently, the data were analyzed by extracting relevant parts and fragments of text, which were divided into topics, identified as information units, and then all similar information units was gathered to form the units of meaning. The analytical categories of the study emerged after this process. Finally, an interpretative synthesis was carried out based on the processing of the results obtained, which were subjected to complex or simple operations that allowed to highlight the research data.

The research project was approved by the Research Ethics Committee of the Nursing School of Universidade Federal de Pelotas, under statement No. 24/2012, in accordance with Resolution 196/96. The participants were identified with the letter G and the number corresponding to the order of the interview, to ensure their anonymity.

RESULTS AND DISCUSSION

The two analytical categories that emerged from analysis of the content of the interviews with FHS coordinators of Pelotas RS were formal and informal network in mental health care and the exchanges of co-responsibility in care in the network.

The formal and informal network in mental health care

The movement that resulted in the Brazilian Health and Psychiatric Reform has made it possible to establish a health care network guided by the principles of universality, equity and integrality, with practices targeted to thee resolution of social needs such as lack of resources for health, difficult family relationships, lack of employment and housing, among other determinants of the health-disease process of the population[12]. The Brazilian Psychiatric Reform Movement supported the fight for rights and social reintegration of people with mental disorders, by creating an extra-hospital care network.

In Brazil, the movement to change the type of care delivered to people with mental distress began with the Brazilian Psychiatric Reform in the late 1970's, within a broader process of the Brazilian mental health reform.

However, the creation and implementation of a broader care network requires a daily mobilization of the involved parties. The city where the study was conducted, for example, faces challenges related to the lack of some important health services, such as the SRT, the CAPS III and Family Health Care centers. Another major challenge to the advancement of the psychiatric reform process in the city is the presence of a psychiatric hospital.

During the research period, there was a lack of professionals in all FHS units assessed, particularly of Community Health Agents (ACS) and doctors. This can be explained, among other things by dissatisfaction over pay and absence from the work due to sick leave.

Regarding the structure of the network, most managers reported little contact between the services of the different sectors. Some services have scarce knowledge about formal specific mental health services, others are unable to identify the CAPSi and the mental health outpatient facilities, and RETRATE was not identified by any participant. However, most are aware of the informal services available in the neighborhood.

Therefore, the comprehensive care network is organized by health services, and the territorial resources are the people active in this network. Integration between health services and these individuals is crucial to the achievement of the main purpose of the network: delivery of care to a given population[13].

G03, who has graduated in Social Work, describes a larger network that provides with specific and non – specific mental health services necessary to promote appropriate care.

> *We are in touch with the CAPS: CAPS AD and CAPSi. The mental health clinic and the CRAS are targeted to mental health [...] the mental health group has long existed here. We contact the reception desk of the department of mental health, Hospital Espírita. The district attorney's office is also our partner, and Casa Lar receives people with mental disorders (G03).*

This statement describes different care services in the network that could be explored, because intersector actions are necessary to provide care to individuals with mental distress, in all its complexity, in addition to the care provided by the health sector.[4] However, the above statement does not reflect the views of the other respondents, since most of their care activities are targeted to the health sector.

Thus, the CAPS were identified as the main health service available for people with mental distress, as shown in the statements of the participants. However, it was not clear whether the coordinators were aware of the number and types of CAPS available in the city.

> *The nearest health service is the CAPS. So the most serious cases are referred to other health facilities {...} to Hospital Espírita (the local psychiatric hospital) and the CAPS (G01).*

> *To my knowledge the CAPS are the most important health services for mental distress. They are available in the different zones and neighborhoods (G02).*

> *Formal health care is provided by the CAPS, all the CAPS we contact, particularly the one located in our area (G03).*

According to the managers, the CAPS is a key health service, the main point of care in the network. Given the restructuring of the mental health policy, according to which care should be targeted to the territory, the CAPS is a strategic care point of the network. However, the managers exposed a more restricted view regarding the mental care facilities, by strongly emphasizing the CAPS and not mentioning the other important territorial resources.

Thus, we must emphasize that all the services have an important role in health care, and the CAPS are not the only

health service available to individuals with mental illness. Primary care, for example, is the gateway to the health system for people with mental distress, and is responsible for the delivery of care to people with minor disorders such as s anxiety, distress and depression, while the CAPS is responsible for serious mental disorders. Thus, primary care and the CAPS are responsible for the coordination of mental health care[14].

Only two managers identified their health facility as a mental health care space. The other participants identified the mental health group of their units as informal network resources, and one participant identified the work of the Community Health Agents (ACS) as crucial for people with mental distress, because the agents visit the houses of these individuals and listen to their demands. However, the referred participant believes that the activities of ACS consist in informal care work.

However, we emphasize that mental health groups are provided for by the mental health policy in primary care. Therefore, they are formal care resources available in the network. Regarding the work of the ACS, we are confident in the ability of these professionals, as well as in the ability of the other FHS professionals to provide appropriate mental health care.

Another aspect highlighted by the managers concerns the psychiatric hospital, which integrates the mental health care network. The psychiatric reform establishes the progressive replacement of psychiatric beds by other forms of mental care. However, the local psychiatric hospital is still active in Pelotas and integrates the network of FHS managers.

Health professionals may become complacent with the presence of the psychiatric hospital in the local health network, since many crises of mental health patients are treated at that hospital. In addition, it is necessary to train CAPS professionals to be able to treat the crises of these patients, create new psychosocial care areas such as a 24-hour operational CAPS III , increase the number of psychiatric beds in general hospitals and improve the training of the SAMU specialized in psychiatric emergency cases[15]. We would like to stress that there have been recent advances in the local management of the city of Pelotas after data collection for the current study: the city now counts on a CAPS AD III and one Therapeutic Residential Care Service (SRT).

Thus, regarding the informal mental health resources available in the neighborhoods of users, it should be noted that health professionals are part of the territory of the subject's life and contribute for the cultural, economic and social configuration, being responsible for re (configuring) the space of social relations. Thus, professionals should rethink care actions, going beyond the boundaries of the institution to meet the users in the streets, in the neighborhoods and in the community[16].

The coordinators identified in the informal network points within the community that can be considered mental health producers, providing bridges to support the formal care network, such as churches, NGOs, CTGs, schools and a group of recyclers. Most participants stressed the key role of these spaces that provide social networks and collaborate in mental health prevention, and strongly recommend the expansion of these informal arrangements. The importance of these spaces in the community is shown in the following statements:

> *The CTG does a wonderful job here. (...) It surely promotes more activities than the school (G01).*

> *The association also includes a NGO that involves assistance to people in social vulnerability, including beneficiaries of the Bolsa Família program (G04).*

> *We have a group of mothers there, which was created by one resident. . The group promotes activities, such as a children's dance group, handicraft and gymnastics (G06).*

Therefore, the coordinated action of the informal and informal services of the network must be systematically developed. These territory spaces should integrate the therapies administered to the users as a strategy of care, socialization and strengthening of social networks.

The managers also stress the need to value and ensure the existence of community spaces, due to their significant contribution to the population's social well – being. Thus, the managers stress the need for public policies that encourage and promote these spaces in the neighborhoods.

> *The community also lacks public infrastructure support. It would be interesting that we had a space for mental health activities that also included community activities... (G03).*

> *What can we do in our neighborhoods, each one with its own peculiarities? Let's create a place that offers more opportunities... for example, what are youngsters doing in the afternoons in the neighborhood? (G04).*

The informal activities should be tailored to the interests of the local population, aiming to promote a broad social reintegration, citizenship and appreciation of life projects, work and the strengthening of social relations in their own territory. The statements of the managers are valuable

in the process of rethinking and re-creating new informal spaces for gatherings and care in each neighborhood.

The importance of the implementation of projects targeted to the production of community services, spaces for expression, for social interaction and the generation of positive experiences becomes evident. Users have the right to obtain locally the necessary treatment for their mental disorders, benefitting from a network of psychosocial care[17].

Policies targeted to the creation of spaces for social interaction and the development of territorial activities are necessary to promote health and prevent diseases. Some activities such as dance groups, crafts, hiking and the spaces for exchanges between people are also examples of resources to be developed in the community.

Changes in co-responsibility in the care network

Concerning the care exchanges in the network, the coordinators were asked to describe a remarkable situation of mental health care experienced, exposing the care provided to the user and the steps taken by the health network, as well as the exchanges of care between health workers of each service.

The family health teams are also responsible for care and have greater penetration in the territory. However, regarding mental health actions, the CAPS and the health care teams should promote joint actions with the FHS teams to improve training. In addition, the mental health programs set up under the ESF should be pervaded by the involvement and co-responsibility of the users and their families[17].

The testimonies of the interviews show that the CAPS provided care to users referred to these centers by the FHS teams:

> *The CAPS staff received the patient and treated her there, but she was not taking the medication. So they used to send her home to take the medicine, and the family ended up involved in the process (G01).*

> *Every time we referred the patient to the CAPS, she felt better because having someone to listen to her made her calm down (G02).*

> *I believe so. Users become co-responsible for the care process, though sometimes they transfer the responsibility to health professionals (G04).*

The services most commonly mentioned by the coordinators were CAPS II and CAPS AD, which were considered effective when triggered by the FHS teams. The CAPS play an important role on mental health care in Pelotas, a city that has a considerable number of people with mental distress and drug users. They are excellent alternative health services and are expected to meet the needs of all users.

The coordinated joint action of FHS and CAPS is essential for the delivery of high quality mental health care services. It promotes greater confidence among FHS professionals, who are sometimes insecure about their abilities in mental health care, and ensures permanent care in the network. The CAPS is a transitional care service, and, therefore, a coordinated action with the FHS is crucial to the transfer of care to the users' territory, which involves both health teams[13].

In the present study, the exchange of care between health professionals often occurs by phone contacts and referrals of patients by FHS to the CAPS. Integral care involves communication between the professionals regarding the most sensitive cases:

> *When our colleagues have questions they come here to talk to us. We then examine the situation and, if necessary, we contact their service (G01).*

> *We went to the hospital to visit her. We tried to schedule an appointment through the CAPS, As it was not possible, hospitalization was necessary. So we contacted the hospital, and as the patient was unable to return to home, we spoke to the district attorney to take the necessary measures (G03).*

> *Yes, because we made the first consultation by phone and then referred the patient. She was later referred to us and was monitored. It is all interconnected (G05).*

In the care network, health professionals mobilize other sectors when necessary. This coordination is aimed to meet specific care needs in mental health and clinical demands, being crucial to promote effective care.

Although the statements of the respondents suggest the existence of a care network, we found that most care is delivered at the CAPS and the FHS. There were few exchanges between the different teams and few coordinated actions in the territory.

Care actions are the responsibility of the entire health system due to the complexity of human life and its disorders[17]. However, professionals and a referral service are necessary to coordinate the care network, mobilizing the network and involving all the professionals in the process of care delivery. In this case, the professional/service most

attached to the user is responsible for the mobilization of the network: its care reference is the FSH or the CAPS.

It should be stressed that some professionals are committed to a practice more consistent with the psychosocial model, making partnerships with the community, working in network and promoting a dialogue between workers, which is necessary for effective care[13].

It was found that care is more available at the CAPS or FHS services, with little exchange between the teams outside the health services. For some managers there is no exchange of co-responsibility among the professionals of the network, and referral and counter-referral documents are the only information about the users.

> *No, sometimes the only information that we exchanged was the referral document. It is a form of communication {...} the justification for patient referral (G02).*

> *But what really upsets me is that there despite the availability of a health center specialized in mental care, with qualified professionals, this person had not the opportunity to be seen by these professionals and voice her fears and distress (G04).*

> *The patients return to us when they have to go to the health unit to get the prescription for the medication... but then who will monitor these patients? (G06).*

The CAPS is sometimes unable to provide appropriate care to its users. The statement of G04 describes a situation in which therapeutic listening was not used in the care of a patient and G02 noticed the difficult communication between the CAPS and the health unit, exposing the weaknesses in the exchange of care actions. Furthermore, the FHS services were used merely to ensure the prescription of psychotropic drugs.

Thus, work in mental health in services like CAPS requires affection, creativity to be able to transform care, do more and to change the old asylums care practices. These workers must fight for a social cause[18] Thus, listening should always be available in the CAPS and other care services.

Another important issue concerns the medicalization of mental health, which should be debated by health professionals, because the needs of users are not restricted to psychiatric drugs. In a public service, for example, an extremely high number of users of psychotropic drugs was identified in a public health service, which fails to comply with a policy of care targeted to the autonomy and citizenship of the subjects[19].

Finally, permanent network work with the exchange of care, information, flexibility and joint action, is necessary. A care network that in addition to perform referrals, counter-referrals of patients, exchanges of prescriptions, establishes joint care, coordinating the territory and other sectors, and s capable of effectively meet the social and health needs of users and their families.

CONCLUSION

The study brought to light a major dilemma in public health policies that directly affect the quality of care provided to people with mental distress. This dilemma concerns the perception of services and resources other than the traditional mental health network services, which are of utmost importance in care delivery.

The structure of the network created by the coordinators consists of formal services, but it is difficult to recognize the services of a mental intersector health network, and care is focused on the FHS and CAPS services. At the informal network, the coordinator foresee a diversified network in the territory and point to the need to promote effective public policies for the creation and maintenance of new informal care spaces in the territory. This aspect deserves special attention, since public health policies targeted to care attach a significant importance to the role of the territory.

Regarding the exchanges of co-responsibility in care provided by the network, they were found to be fragmented sometimes, without the establishment of the necessary bonds and dialogue among the professionals, exposing the difficulties faced by services in a care network..

Most participants were coordinators at the FHS. Therefore, the study also contributed to qualify the management of care provided by these professionals, encouraging them to learn more about the territories in which they operate, the informal resources of care, the needs of the target population so that they can build new and diversified resources to ensure permanent mental health care in the territory. Therefore, we stress that the FSH can be considered strategic in the strengthening of primary care as locus of mental health care, responsible for the coordination of the intersector network.

Thus, the Psychiatric Reform Movement attempts to ensure integral care and that all the involved workers are aware of the networks of formal and informal mental health services, since persons with mental distress need comprehensive care networks. The limitations of this study included the small size of the sample and the fact that it was conducted in one particular setting.

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