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INTRODUCTION

The current scenario of mental health in Brazil is the result of extensive movements and social discussions about people with mental illness1 who require better quality medical care. Although the law of Brazilian Psychiatric Reform, on the rights of people with psychological disorders and the reorientation of the care model, was approved more than fifteen years ago, mental health care provision persists challenging; spaces are needed in society to guarantee the reincorporation of patients into society and the respect for their lives.2,3

The Brazilian Psychiatric Reform movement favored the creation of an extra-hospital mental health care network where the rights and social reintegretion of people with psychic disorders are valued. However, these goals are a daily struggle and the pursuit of an effective and expanded care network has taken decades.4

It is with this perspective that the Ministério da Saúde (BR) instituted the Rede de Atenção Psicossocial (RAPS). This network aims to overcome the fragmentation of services and management of the Sistema Único de Saúde (SUS), improving its political-institutional functioning in order to respect the diversity of regional contexts, socioeconomic differences, and the population’s health needs.1 Thus, the proposal of the RAPS in the context of care for people with mental disorders adopts a broad, diversified, integrated, articulating and effective perspective in the different points of attention, aiming at the recovery of citizenship and the process of social inclusion.5

Networks composed of health teams and health institutions can be articulated by connecting basic health units to emergency services or hospitals. In short, the paths to be traveled are triggered according to each case and defined by the needs of the users and by the resources available for their care.6 Services that work for the benefit of people with mental disorders need to be articulated in a horizontal work process, guaranteeing mental health care in all points of attention of SUS.7 However, mental health care still lacks strategies capable of proposing solutions to the obstacles that arise in daily routine. Professionals committed and with the ability to deal with eventualities and challenges arising in this field are sorely needed.2

However, the availability of health services and actions alone does not guarantee that care will, in fact, be comprehensive and troubleshooting. Elements such as management models can help in the effectiveness of the care network, to direct the steps of managers and health professionals and consequently improve the care provided to users.8 In the search for comprehensive care through the RAPS, it is important to highlight health care management as an important tool to aid in this construction.

Health care management can be defined as the use of technologies that take into account human individuality in the promotion of more security and autonomy for the well-being of users. To that end, health care management is anchored in six multiple dimensions, namely: individual, family, professional, organizational, systemic and societal dimension. Each dimension has a particularity, but there are connections between the various dimensions that produce a complex network of contact points, shortcuts, collateral paths and possibilities more or less visible and/or controlled by workers and managers.9

In the field of mental health, care management has faced barriers that jeopardize its solidification, resulting in instability in the articulation between services and in the implementation of qualitative care practices.5 Associated with this, concern and questioning with the quality of care people with mental suffering have been intensified. Such questioning stimulates the reconfiguration of the methodological and conceptual bases of care management and promotes the expansion of therapeutic actions and activities, shared with other health care services.10

In this context, taking into account the importance of care management for the implementation of the psychosocial care network, this study aimed to understand the management of mental health care from the perspective of the health care network.

METHODS

This is a qualitative study based on the theoretical reference of Grounded Theory (GT).11

The municipality where the study was conducted is located in the south of the state of Santa Catarina. It has a population of approximately 29,000 inhabitants,12 eight teams of the Núcleo de Apoio à Saúde da Família, Centro de Atenção Psicossocial, Clínica Materno-Infantil, Saúde da Homem, Policlinica de Atendimento Municipal and a General Hospital as municipal reference.

Following the methodology of GT, the participants of the research were indicated based on the realization of the study, by means of the composition of a theoretical sample consisting of the inclusion of different subjects to refine and to increase the categories that appear throughout the study. Three sampling groups composed the theoretical sampling, making up the total of 27 participants, defined with basis on the circularity of the data and on the constant comparative method.

The first group consisted of 17 professionals (P1- P17) who worked in the Estratégia de Saúde da Família (ESF) and Núcleo de Apoio à Saúde da Família (NASF) in the city studied. They were four nurses, four physicians, four nursing technicians, one psychologist, one nutritionist, one physical educator, one pedagogue and one physical therapist. It was decided to start with ESF and NASF professionals because the ESF is commonly classified as the gateway to the health care network of the SUS.
As the interviews took place and the respective sample group analyses progressed, relevant facts were persistent in some interviews, among them the accumulation of statements about the role of the Centro de Atenção Psicossocial (CAPS) for the care of mental health users. This factor triggered the formation of the second sample group, composed of five professionals (P18 - P22) who worked in the CAPS, who consisted of one nurse, one psychiatrist, one nursing technician, one psychologist, and one social worker.

During the analysis of these interviews, it was relevant to identify that the hospital is the service that serves mental health users in case of psychiatric emergencies. Based on this observation, a third sample group was created, composed of five professionals (P23-P27) who worked in the emergency unit of a general hospital; they were two nurses, two nursing technicians and one physician.

The size of the theoretical sample was determined based on theoretical saturation of data, as recommended by the method. The inclusion criterion for composition of the sample groups was the existence of professional experience in the provision of care for people with psychic disorders.

Data were collected in August and September 2015 through an intensive interview. The interviews were conducted individually at sites of the participants’ preference and followed a script with open questions related to care management in the psychosocial care network. The interviews were transcribed verbatim in a Microsoft Office Word® document. The average duration of the interviews was 30 minutes, and they generated approximately 128 transcribed pages.

Two coding steps were used in data analysis: initial and focused. The initial coding consists of dividing and naming each segment of the data with codes that express the meanings present in the respondents’ speeches. In the focused coding, the most significant or frequent initial codes are classified, integrated, synthesized and organized into subcategories and categories until the central phenomenon or central category of the research is identified. The phenomenon is the central idea on which a set of actions or interactions is adopted by people. The NVIVO®10 software for qualitative analysis was used to organize and categorize the data.

Ethical aspects were respected according to Resolution 466 of December 12, 2012, of the Conselho Nacional de Saúde (BR). The study was approved by the Comitê de Ética em Pesquisa (CEP), under Opinion nº 1.125.508. The participants consented with the interviews by signing the Termo de Consentimento Livre e Esclarecido Informado (TCLE) after receiving explanations of the objectives and methods of the study. The statements obtained were identified with the letter “P” of professionals, associated with numbers that corresponded to the order of interviews.

RESULTS

The three categories and respective subcategories that emerged from the data analysis are presented in Table 1. Based on the interconnection of categories, the following phenomenon was obtained: “articulating the multiple dimensions of the management of care for people with mental disorders in the psychosocial care network”. Each category is described below.

Table 1 - Categories, subcategories and phenomenon of the study

<table>
<thead>
<tr>
<th>Categories/subcategories</th>
<th>PHENOMENON</th>
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<tbody>
<tr>
<td>Describing the individual and family dimension of the management of care for people with mental disorders</td>
<td>Articulating the multiple dimensions of the management of care for people with mental disorders in the psychosocial care network</td>
</tr>
<tr>
<td>1. Choosing the type of health service to seek treatment</td>
<td>The first category, “Describing the individual and family dimension of the management of care for people with mental disorders”, revealed aspects experienced by the professionals during mental health care.</td>
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<tr>
<td>2. Suffering prejudice for having a family member with mental disorder</td>
<td>Although primary care is referred to as the gateway to the SUS, many people end up going to other services to receive initial care, even if the problem does not represent an emergency or urgency. In mental health this process is not averse; people with the CAPS mental disorders have not always sought care in the Estratégia de Saúde da Família, making or hospital emergency units the initial alternatives.</td>
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<tr>
<td>3. Realizing the need to offer support to family members of people with mental disorders</td>
<td>[...] these mental patients do not always seek the FHS because they often go straight to secondary care, in this case, the CAPS [...] (P10).</td>
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<tr>
<td>4. Understanding the cause of mental disorders as a social issue</td>
<td>Having a family member with a mental disorder is challenging because, besides having to deal with all the problems</td>
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<tr>
<td>Developing the professional and organizational dimension of care management in different points of the health care network</td>
<td>of care for people with mental disorders</td>
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<td>5. Seeing the FHS as gateway and as responsible for health prevention and promotion</td>
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<td>6. Assisting people with mild mental disorders in the FHS, severe mental disorders in the PCC, and emergencies in the hospital</td>
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<td>7. Facing challenges in the work with people with mental disorders</td>
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<td>8. Minimizing psychiatric hospitalizations through the PCC</td>
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<tr>
<td>Developing the systemic and societal dimension of the management of care for people with mental disorders</td>
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<td>9. Building a network of mental health care in the municipality</td>
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<tr>
<td>10. Perceiving the articulation of services in the care for people with mental disorders</td>
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<tr>
<td>11. Referring people with mental disorders to different points in the network</td>
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</table>
caused by the mental illness, they still have to face the prejudice of society. In this sense, the professionals realize the need to offer care not only for the person with mental disorder, but also for the whole family.

[...] we need to support these relatives, because, in fact, I think they are the ones who suffer the most and this goes unnoticed. Sometimes we try to treat this patient with medicine or we give support in case of psychotic outbreak, but the relatives are the ones who suffer the most, and they end up not receiving professional help (P3).

We know there’s prejudice, I know because I’ve been through it; my brother has schizophrenia, and it’s very difficult to deal with this. The way people look at him, people call him crazy, and so on. It hurts a lot. Relatives do not like this treatment, because it’s not an issue of madness there, it’s not something he wants, do you understand? (P26).

When assisting varied range of people with mental disorders, the health professionals realized that, sometimes, social issues are triggers of this problem, making the treatment further complex.

The patients themselves are mostly sad, and we see that it is actually a social problem. So, it is the family environment that has a problem, it’s a problem at work, it’s a lack of money, and then everything turns to depression, anxiety and they think medicine will solve. So, basically the vast majority is this way. Some have disorders that need to be followed up, but the vast majority of patients you realize that it is a social problem rather than a psychiatric problem: I’m not saying that it is not psychiatric, right, but the social problem itself leads to discouragement and everything else. Then, the patient takes a pill and he will feel better; unfortunately this is not true (P8).

Most of them, nowadays, with this rush of modern world; it is generalized anxious disorder, anxiety disorder, then it comes depression; people often confuse sadness with depression. There are several aspects, from schizophrenia to a simple sadness or mourning for losing a loved one, something similar (P11).

The second category, “Developing the professional and organizational dimension of care management in different points of the health care network”, revealed the professional and organizational dynamics for the implementation of care management. Health professionals perceived the ESF as the genitor and responsible for actions to promote health and prevent illnesses. This would be the gateway for mental health users in the SUS, as well as responsible for avoiding the onset and/or aggravation of existing mental disorders.

The role of primary care is very important; it is the embrace, it is the gateway. They will look for the basic health unit near their house, and sometimes they create this bond with the nurses, with the nursing technique, where they seek this support, with the physician; this initial support is very interesting (P11).

To better organize the care, a hierarchy of care measures was established within the health care network, with the ESF being responsible for the care of mild mental disorders, the for the most severe cases, and the general hospital for psychiatric emergencies.

So here at the ESF, when patients ask us for help, we embrace them, try to welcome them, try to talk in the first moment, see what they need. Sometimes a good conversation is enough to help. Of course, they are usually milder cases [...] (P5).

[...] the profile of CAPS patients of high complexity, schizophrenic patients, patients with personality disorder, patients with bipolar mood and severe depression; the other condition we leave for the Family Health Strategy or Psychiatry Outpatient Clinic (P21).

The role of the hospital is the initial care during the emergencies, psychotic outbreaks, the first care measure is to provide the necessary support for the survival of that patient (P23).

Professionals who work in the ESF and general hospital indicated that care for people with mental disorders is permeated by adversity. Overwork, lack of training in mental health, and inadequate physical structure were cited as the main difficulties faced to provide quality care.

I do not know how to deal with psychiatric patients, I do not know what to say, sometimes they come here and you see that they are patients who have a psychiatric problem, depression. Regardless of anything I say: calm down, it’ll be all right! But anybody can say that. As a health professional, I am not prepared to talk to the patient [...] (P7).

We have so many activities to do that there is not much time left, and these patients need time to talk, time for a good embracement (P3).

In the emergency unit we do not have a specific physical space to attend patients with mental disorders. They end up being attended together with the other patients [...] (P25).
Professionals working at the CAPS usually have some specialization in this area and this make them feel prepared to deal with this group. The CAPS develops a series of activities with these users and offers professional support in order to alleviate the symptoms and help these patients to re-enter society, especially after hospitalization in psychiatric hospitals.

[...] from the moment the patient goes through embracement, we insert him into a CAPS group so that he will participate in the groups. We have the group of crafts, group of garden therapy, music therapy, groups of people with drug dependency, the family support group, we have several groups, groups of psychotherapy (P21).

That’s why the openness of the CAPS. The CAPS is a Centro de Atenção Psicossocial that the government actually launched to try to reduce hospitalizations and try to insert more psychiatric patients into society (P19).

The third category, “Developing the systemic and societal dimension of the management of care for people with mental disorders”, approaches the organization of the systemic and societal dynamics that make up the management of care for people with mental disorders.

The creation of some health services such as CAPS and the Núcleo de Apoio à Saúde da Família (NASF) represented an advance for the implementation of SUS principles, especially equity and comprehensiveness. After the creation of these services, the professionals perceived a greater involvement between the different points of attention with the matrixing, representing a moment when the municipality began to discuss and to work in network.

[...] we are always matrixing; we do the matrixing, that is, this exchange of information. We follow how the patients are going, how is the therapeutic plan of these patients going on. Sometimes the ESF always has more information to give about these patients. It is the strategy that is there day by day, the community agents, nurses, nursing technicians, you know, the family history (P18).

We have a very good relationship with network services, programs that are popping up all out there like CAPS and NASF, they are coming just to contribute (P6).

Despite the improved interaction between the services that make up the network, communication difficulties still persist, mainly in the referral of users to different services.

But situations that we find, we refer the patient to the CAPS, and when he gets there, no, this patient does not meet the CAPS profile. Then, he returns to the ESF, and the patient keeps wandering [...] (P9).

By articulating the categories and subcategories, combining reflective thinking about the event studied, the phenomenon “Articulating the multiple dimensions of the management of care for people with mental disorders in the psychosocial care network” was obtained. Figure 1 represents the interaction of the categories with the phenomenon.
DISCUSSION

Mental health care in Brazil has undergone changes in its context in the last decades, in the provision of care, mainly mediated by the transformations that have occurred with the Psychiatric Reform. Since then, a new model of care has been inserted in the scenario of mental health, breaking with the practice traditionally institutionalized and exclusively focused on the treatment of mental illness.13

Primary health care (PHC) is characterized in the Brazilian scenario as the main gateway to health care in the SUS, including mental health care. PHC should be considered the center of communication between health care levels, ordering the referral and counter-referral at the primary, secondary and tertiary levels.14 In contrast, data found in this study revealed that users rarely use the PHC for initial treatment of their health condition, compromising their treatment from the outset and making it difficult to provide comprehensive and troubleshooting care within the health care network.

Regarding the individual and family dimension of the management of care for persons with mental disorders, the presence of a family member has important consequences, not only related to the disease, but also to the social context, derived from prejudices that individuals and their families need to face. This dimension of analysis corroborates the results of a study that evaluated the resilience of health teams in the care of people with mental disorders.15 Despite the advances arising from the Psychiatric Reform and the updating of public policies related to mental health, negative social representations on people with mental disorders are still present in the different segments of society.16

A study carried out in the state of Rio Grande do Sul aimed at understanding the expectations of family members of patients with mental disorders regarding the actions performed by the ESF presented the need for family insertion in the mental health care of patients. The study revealed that by providing support for the guidance of their lives, the effectiveness of mental health care will be increased, minimizing undesirable consequences in families who have a member with mental disorder.16

Regarding comprehensive care in the context of mental health, the results pointed out that professionals recognize this practice as a complex and multifaceted process. Sometimes the social situations experienced are mediators of the mental disorders in people and are included in the set of factors listed by the World Health Organization as influencing the onset of mental disorders in the population. Their development is linked to the inability of a person to administrate his thoughts, emotions and social interactions. Moreover, the social, cultural, economic, environmental, working and housing conditions and community issues can interfere with the mental health of any individual and conduct to the development of mental disorders.17 Working in this setting requires skills to deal with the human being, in view of the need to understand him considering the multiple aspects that influence the development of mental disorders.18

Regarding the professional and organizational dimension of care management in different points of the health care network, the professionals considered the ESF as responsible for developing actions to avoid the onset and aggravation of mental disorders. In addition, they considered that the hierarchy of work from the point of view of the care network represents a predictor for the achievement of comprehensiveness in mental health. A study carried out in the South of Brazil showed that the ESF represents an important space for promoting mental health care since it has territoriality and the family as its focus of care. However, ESF teams are often restricted to reproducing the biomedically model when it comes to mental health, jeopardizing the quality of the actions that could be developed.16

In the scenario of this study, users with severe clinical conditions were monitored by the CAPS, while those with acute conditions were referred for care in the emergency unit of the general hospital. The profile of the users that made up the population served by the CAPS was evaluated in a study carried out in the Northeast of Brazil whose results showed that they are people with severe mental disorders or people with severe psychic impairment. This is in line with the findings of the present study. The CAPS should be considered as a substitute service that aims to guarantee daily clinical care, avoiding hospitalizations and promoting the reinsertion of its patients in the social environment.19

Users with mental disorders or with severe psychic impairment experience critical moments that sometimes coincide with the onset of an outbreak. At such moments, users are directed to hospitals to receive care. In fact, acute mental health situations must be addressed by general hospitals that are part of the health care network, through the implementation and qualification of psychiatric beds and the provision of psychiatric emergency services.20,21

However, there are difficulties in this work when it comes to assisting users with mental disorders outside the psychosocial care service. Other studies15,22 found that the professionals claimed not knowing what to say or to ask, and they had fears that the condition of the patient progressed worse or they understood that this field of knowledge was not available to them. Many of the professionals developed competencies to care for people in mental health based on their own professional experience.15,22

In the systemic and societal dimension of the management of care for people with mental disorders in this study, the professionals recognized that the joint work of the different services favored the practice of comprehensive and troubleshooting mental health care. Despite this progress, there were still difficulties of communication and access between the different points of

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the network. The articulated work in health care networks must have communication, and must have unilateral and interconnected care services. The paths to be travelled in the network must be activated according to each case and must be based on the needs of users and on the resources available for their care.6

Effective and comprehensive care depends, in large part, on the shared construction of a pedagogical-therapeutic interventions, which is called matrixing. Correct matrixing requires professionals to have both pedagogical and managerial skills that favor the construction of spaces for collective and democratic dialogues. Without these competencies, the reorganization of the work process and the transformation of care practices guided by this principle become fragile and the a network cannot be firmly established after created.23-24

Inadequate access to mental health services has resulted in the worsening of the mental health status of people with mental disorders and thus contributed to high rates of suicide in the United States.25 These considerations indicate the need to strengthen health care networks, regarding mental health, aiming at improving access conditions and guaranteeing comprehensive care practices, avoiding the worsening of the psychiatric disorder.

CONCLUSION

The present study made it possible to understand the management of care for mentally ill people, thus contributing to the recognition of fragilities and potentialities of the Psychosocial Care Network and its effects on society, family members, professionals and also on the people mental disorders.

Integration between health care networks needs to be improved and this is possible, especially with the practice of matrixing, as well as by training professionals in mental health, and integrating the services that make up such networks.

The ESF, the NASF, the CAPS and the hospitals are the main services that make up the psychosocial care network. Despite advances in care for the mentally ill, difficulties in the articulation between these services were observed.

It should be emphasized that the present study presented limitations because it was carried out in a single context, preventing the generalization of the phenomenon to other realities. However, studies on the management of mental health care are scarce. Further research in this area is therefore recommended, particularly comparing the construction and articulation of the health care network in small and large municipalities.

REFERENCES


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