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RESEARCH

O papel da atenção primária de saúde na constituição das redes de cuidado em saúde mental

The role of primary attention in health on the constitution of the network care in mental health

El papel de la atención primaria en la constitución de la red de atención en salud mental

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ABSTRACT

Objective: To characterize the mental health practices and care strategies developed by primary care teams in an urban area from Pesqueira/PE, Brazil. **Methods:** A descriptive exploratory study with a qualitative approach, developed through semi-structured interviews with health professionals and users of primary care network. Research protocol approved by CONEP with CAAE No 33110114.5.0000.5203. **Results:** Users with mental disorders and/or mental suffering are mainly attended in familiar and basic health units, and then referred to the Psychosocial Care Center (CAPS). Strategies and care practices in mental health vary according to the experience of each professional, and are centered on the medical consultation, prescription and medication control. **Conclusion:** Due to the recent implementation of CAPS, the psychosocial attention network of the municipality has structural and network problems between the different points of care, such as the difficulty of establishing a reference and counter-referralflow.

Descriptors: Mental Health, Standard of Care, Primary Health Care, Delivery of Health Care.

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RESUMO

Objetivo: Caracterizar as práticas e estratégias de Cuidado à Saúde Mental desenvolvidas pelas equipes de atenção primária na área urbana de Pesqueira/PE. **Métodos:** Estudo descritivo, exploratório, de abordagem qualitativa, desenvolvido mediante entrevistas semiestruturadas com profissionais de saúde e usuários da rede de atenção primária à saúde. Protocolo de pesquisa aprovado pela CONEP com CAAE 33110114.5.0000.5203. **Resultados:** Os usuários com transtorno mental e/ou sofrimento psíquico são atendidos, principalmente, nas unidades de saúde da família e unidades básicas de saúde, sendo, então, referenciados para o CAPS. As estratégias e práticas de Cuidado em saúde mental variam de acordo com a experiência de cada profissional e são centradas na consulta médica, prescrição e controle da medicação. **Conclusão:** Devido à recente implantação do CAPS, a rede de atenção psicossocial do município apresenta problemas de estruturação e coligação entre os diferentes pontos de assistência, a exemplo da dificuldade de estabelecimento de fluxo de referência e contrarreferência. **Descritores:** Saúde Mental, Padrão de Cuidado, Atenção Primária à Saúde, Assistência à Saúde.

RESUMEN

Objetivo: Caracterizar las prácticas y estrategias para el cuidado de la salud mental desarrollados por equipos de atención primaria, em la área urbana de Pesqueira/PE, em Brasil. **Métodos:** Estudio descriptivo, exploratorio, cualitativo, desarrollado a través de entrevistas semiestructuradas con profesionales y usuarios de la red de atención primaria. Protocolo de investigación aprobado por el CONEP con CAAE 33110114.5.0000.5203. **Resultados:** Los usuarios con trastornos mentales y/o sufrimiento mental son atendidos, principalmente, en unidades de salud de la familia y unidades básicas, y luego se refirieron a lo Centro de Atención Psicosocial (CAPS). Estrategias y prácticas de atención en salud mental varían con la experiencia de cada profesional y se centraron en la consulta médica, prescripción y control demedicamentos. **Conclusión:** Debido a la reciente implementación del CAPS, la red de atención psicosocial tiene problemas de estructuración y comunicación entre los puntos de atención, tales como la dificultad de establecimiento de flujo de referencia y contra-referencia. **Descriptores:** Salud Mental, Nivel de Atención, Atención Primaria de Salud, Prestación de Atención de Salud.

INTRODUCTION

The Network of Psychosocial Attention (RAPS) can be understood as articulations between several units that, through certain connections, exchange elements among themselves, strengthening each other; each node of the network represents a unit and each wire a channel through which these units are articulated through several flows.[1]

The Psychosocial Care Center (CAPS) is considered a strategic device for the organization of RAPS, since it is responsible for articulating all levels of care and for supervising mental health care in basic care, being able, thus, to promote integrality in mental health actions to users in psychological distress, in addition to enabling better flow and care.[2]

Among the services included in RAPS, the Family Health Strategy (FHS), as a community service that is closer to family and communities, focused on popular participation and the promotion of self-care, has become essential for the integration between the mental disorder patient, multiprofessional team, family and community in psychosocial rehabilitation, attending to the subject in all its aspects, guaranteeing the full and possible exercise of their citizenship.[3]

CAPS have great importance in taking care of people with mental disorders, because these health services are designed to meet the needs of people with mental disorders, especially severe and persistent disorders in their territory, ensuring a warm environment through the presence of responsible and trained professionals during the whole period of unit operation. Therefore, there must be a link between FHS and CAPS, as this specialized service provides a differentiated and quality care to mental health users.[4]

The FHS and the CAPS are able to offer a welcome to people needs in psychological distress, because they are closer to the families' social context, so the FHS expands the CAPS potential as an agent of new caring modes, of the user's co-responsibility and the links formation between the clientele and the health team.[5]

In the cities where CAPS are present, people sought their service to take care of severe mental disordered individuals, because the capacity for care is small compared to other Primary Care Services. The population served by FHS is largely characterized by depressive and anxious conditions, such as irritability and multiple psychosomatic symptoms.[6]

The present study is aimed at investigating how the care network for mentally ill people living in the urban area of a rural area of Pernambuco was created, regarding mental health care changes established by Law No 10.216/2001 and the creation of the Psychosocial Care Network by Administrative Rule No 3.088/2011.[7] Considering also that the offered network structure delimits the logic of interaction between its components, thus affecting the practices developed for the municipality mental health care, this study aims to characterize the practices and strategies of mental health care developed by the primary care teams in the urban area of Pesqueira/PE.

METHODS

This is a descriptive, exploratory study, with a qualitative approach that was developed in the primary health care network of the city of Pesqueira/PE.

This study's population was composed by health professionals and users of FHS in the urban area of Pesqueira/PE. The sample comprised six CAPS II's professionals, and four nurses, one nursing technician, one community health agent and three ESF users from the Urban Zone. The sampling procedure was intentional non-probabilistic in view of the accessibility of the subjects composing the sample.

We included in this study's sample, health professionals and service users of the primary network of health care. The users' number was planned according to the demand profile of the care of each health service, with the availability of the

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user, their choice of free participation and considering the saturation of the data object of analysis of this research.

Subjects who were not included in these groups previously described in the data collection period of the study were excluded from the sample.

The research began with the favorable substantiated opinion of the National Commission of Ethics in Research under number 1,038,951 and CAAE 33110114.5.0000.5203.

The data collection involved interviews, obeying the semi-structured script. All interview scripts were pre-tested in order to assess language clarity and reproducibility through its application to health professionals and SUS users who did not compose the study sample.

The interviews were conducted only with the consent of health professionals and users, through the reading and signing of the Term of Free and Informed Consent, as recommended in resolution 466/2012 CNS; The interviews were recorded, transcribed and double checked. The data collected were complemented by participant observation and records in the field diaries of the researchers. The professionals and users interviewed are identified in the text by the codes (E1, E2 ...).

With regard to Mental Health Care practices and strategies, we proceed to the identification of empirical categories that are composing their network of meanings, proceeding to the analysis of the content of the interviews according to the approach of Moraes and Galiazzi.[8]

The first stage involved the process of disassembling the texts or the process of unitarization. It required the examination of the texts in their details, fragmenting them in the sense of identifying their constituent units and the respective statements referring to the studied phenomena. The second stage involved the process of categorization, which involves building relationships between the base units, combining them and classifying them, bringing together the unit elements into sets, resulting in category systems. The two processes described above allowed for the emergence of a new understanding about the whole, as well as its critique and validation, resulting in the construction of a metatext that explains the new understanding reached.[8]

The analysis of the documents was operationalized through ATLAS.ti software, composed of a set of qualitative analysis tools appropriate for large textual data sets under license No 72BB1-ECAA3-57A7F-ROEN1-0039Y.

In the process of coding the textual corpus related to the interviews, it was possible to elaborate codes that express different forms of discursiveness about the practices and strategies of Mental Health Care and about the constitution and interrelations between the RAPS points in the municipality of Pesqueira/PE.

Among the codes that made up the network of senses (Network View), establishing relevant discursive relations with Mental Health Care we can mention: "caring x to medicate", "practices of care", "persistence of asylum practices", "Care strategies", "ignorance of health

professionals", "prejudice of society", "relationship between RAPS points", "risk as a danger", "care centered on disease", "Drug dependence", "New care spaces", and "CAPS as a new model of care".

The significant frequency with which the discourses on "Care" in Mental Health emerged in the discursive textual analysis allowed us to consider it an analytical category.

We proceeded to the construction of the metatext, seeking, through the selection of relevant textual quotations, to highlight the identified discursive relations, enriching and broadening the scope of the analyzes through the adoption of analytical axes, namely: "Relation between RAPS' points", "Difficulties in Care", "Mental Health Care Strategies", and "Family Involvement".

RESULTS AND DISCUSSION
Relation between RAPS' points

In the city of Pesqueira/PE, the initiative to implement the CAPS arose due to the increasing demand for care of patients with mental disorders in the municipal hospital.

"As there was no CAPS patients were every day in the hospital. The hospital together with the health secretary were responsible for the design of the CAPS project. The patients were there every day wanting to pass the doctor, always ran at the time of the outbreak were in the hospital." (E1)

Faced with this demand, in October 2012, the Center for Psychosocial Care was inaugurated in the city of Pesqueira; however only in April 2013 it actually begun to function effectively.

"In 2012 it was the beginning of the inauguration of the CAPS in COHAB I. At that time almost did not work; We received some patients, but [...] in fact had a time that was left without anyone attending the CAPS. About six months later, it began to function normally [...] it was at this time that the number of patients began to increase [...]." (E1)

According to Ordinance No 336/2002, the CAPS should integrate outpatient care of daily characteristics according to the logic of the territory.[9] Therefore, it is necessary to articulate the CAPS with the other health services in the municipality to ensure the structuring of an efficient care network, from primary care to tertiary care.

According to Decree No 7,508/2011 universal, equal and orderly access to health actions and services starts at the entrance doors of the SUS and is completed in the regionalized and hierarchical network, according to the complexity of the service. Thus, they are considered entry points for psychosocial care within SUS: primary care

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services and psychosocial care services.[10] The gateway to RAPS in the city of Pesqueira is sometimes represented by the CAPS, as patients go directly to this service in search of care, but the Basic Health Units (UBS), the FHS and the Hospital General Municipalities also represent important actors in the reference of users to the CAPS.

"So sometimes the CAPS becomes the first door because there are patients who come directly here and sometimes they go to the UBS, ESF, hospital and they send the patient directly here, but CAPS is the mental health of Pesqueira. It only has the CAPS, so the CAPS is the mental health of the municipality. In my view the CAPS is this." (E2)

In the primary care services of the municipality, activities aimed at mental health users are still very scarce, which end up causing these users and their families, often, to seek direct care in the CAPS, since they believe that in this service they will be better served. In FHS, professionals refer patients to the CAPS, because in several cases, these primary care professionals do not feel prepared to perform care, or because they have a high demand for mental health users.

The effective participation of primary health care (FHS and UBS) in the mental health network allows a lower overload of this network as well as a serious escalation of cases in the health services that comprise it. An effective network with strengthened primary care alleviates specialized services (CAPS) to meet only necessary cases.[11]

In the primary care of the municipality of Pesqueira, users are served mainly in the ESF and UBS and referenced to the specialized service, represented in this municipality by the CAPS, but the fragility in the integration of this network is present in the discourse of professionals working in these reference services, Since they demonstrate willingness to enable primary care professionals to identify the profile of the users that should be referred and for which service they should be referenced.

"In relation to ESF and UBS, they [the CAPS users] are treated at the UBS and ESF as well, and I even have a desire to meet with the nurses, with all, to pass what is a CAPS, to tell the nurses that The CAPS answers that. Because they also do not know how it works, do not remember, we saw it too fast in college. But they are collaborative with us, the basic attention." (E2)

The level of secondary care of the RAPS in the municipality of Pesqueira is composed of CAPS, Polyclinic and Hospital Dr. Lídio Paraíba that attends the cases of emergency and psychiatric emergencies.

"There are patients who have already stabilized the outbreak with three days of injectable medication, because they have the family that would take them to the

hospital, apply the medication and go back, except that there is no place to stay here. [...] But I feel because I think if I had the psychiatric beds they would help a lot." (E2)

According to Ordinance nº 3.088/2011, the hospital reference service for care of people with mental illness or suffering offers hospital support through short-term hospitalizations, working in full regimen for twenty-four hours a day, seven days a week, without interruption of continuity between shifts.[7] The proposal of the anti-asylum fight movement is the dismantling of psychiatric hospitals with asylum characteristics that served as deposits of people with subhuman treatment, qualifying care for those suffering from mental disorders.[12]

"There is an interment in Ulysses Pernambucano, only the patient is not alone, the family stays with him [...] So today the patient stays and some family member is responsible for the patient." (E2)

In emergency cases, when out-of-hospital services are insufficient to control psychotic episodes, the Ulisses Pernambucano Hospital (Recife/PE) and the Providência Hospital (Garanhuns/PE), at the tertiary level of health, are responsible for the psychiatric hospitalizations of CAPS II Pesqueira's users.

In Brazil, psychiatric hospitals have ceased to form the basis of the care system, giving way to a network of substitutive services, however, psychiatric hospitalization remains a much used resource.[13]

"CAPS works. The CAPS theme is very good, very good, we know it works, but we need the hospital. Needs hospitalization, because the patient is always subject to outbreak." (E2)

According to Ordinance nº 3,088/2011, the psychiatric hospital can be activated to care for people with mental disorders in the health regions while the process of implantation and the RAPS' expansion is still not enough, and these health regions should prioritize the points of attention of the RAPS' expansion and qualification in order to continue the beds in psychiatric hospitals' replacement.[7,12]

The RAPS of the municipality is still being structured, mainly due to the lack of CAPS III, as well as the inexistence of a therapeutic residency, to welcome the users living on the streets, and the lack of psychiatric beds in the general hospital that can be used as support in more severe cases of outbreaks.

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Difficulties in Assistance

Assistance to mental health users has several strategies and care practices for their effective realization, but there are multiple obstacles to effective and effective care. The main difficulty reported by the interviewees was the lack of specialized professionals to perform care in mental health, such as psychiatrists and psychologists.

"[...] There is a psychiatrist for the municipality [pause] even if you want it to be [...] having [just] a psychiatrist is [...] but it's just that she has no other person [pause] so I I think they are not well, they are not well distributed, we have a lack of psychologist, because then [pause] we do what we can, but each one has its limits, there is a professional prepared for that, right, so we have [...] a psychologist at the NASF, which is the Family Health Support Center, only so that this psychologist works more like a bridge, he does the educational part [...]." (E9)

The municipality has only one professional psychiatrist who attends all levels of care, and this is a major problem encountered, because the consultations end up being carried out quickly, so this professional can manage to meet all the city's demands, which causes the consultations are directed only at the medicines' prescription.

Another difficulty reported is the lack of mental health skills for primary care professionals, as they report that it would be a way to provide better care for this specific public.

"[...] The lack of [pause] first thing to us, training, we do it, all this, but so mental health training we do not have, right, I've been here for how many years, more than 12 years, I always wanted to work on mental health. [...]." (E9)

In some notes in the field journal it was possible to perceive that some professionals do not find the training relevant and end up doing them many times because they are obliged or do not put into practice what should have been apprehended in these capacitations, this ends up interfering in the assistance provided to the users Mental health.

Education must be seen as a dynamic and continuous process of knowledge construction, based on dialogue, in which all actors assume an active role in the learning process, through a critical approach reflective of reality, which reaffirms the idea of the Psychosocial Paradigm, and brings forth an inventive and complex look, which a single theory not always can afford.[14]

In relation to the integration between the RAPS points the main difficulty reported is the lack of counter-referencing of the users. Users are referred to the specialty service, but there is no counter-reference to the primary care service that ends up not having more information about the evolution of the treatment of that referral user.

"Soon we have a good interaction with the network, just do not have it, it is worth mentioning, this part of counterreference on the part of specialties, we do not have this counter-reference, CAPS we are also articulating a [...] Protocol of counterreference [...] in the network we send to the CAPS, we make the referral, we tell all the summary of the patient's history, then we will refer to the CAPS, there in the CAPS it is evaluated and the problem Is this we are not having sometimes the counterreference, which I already, we have already combined and have already brought us here to a list of people who are evaded, because sometimes they do not tell the health agent that they are not going right, and we do not know if they are going to CAPS or not [...]." (E8)

During the interviews, it was possible to perceive a divergence in the speeches of the professionals interviewed, since on the one hand, the CAPS professionals reported that the FHT teams only refer users and do not seek information about the evolution of the treatment, that is, they do not follow these basic care as a member of the community. On the other hand, ESF professionals have stated that CAPS professionals do not counter-reference these users, so they do not know about the user, not even if they are still attending CAPS.

Referral is shown as the main form of contact between ESF and CAPS, but there is no sharing of the therapeutic project, but a passage of cases that are assessed and thought by each team in isolation. Even if there is a contact between the teams it is given to scheduling the user's screening, so that it goes through an evaluation that will define their place of care in one or another service.[15]

It is expected that the corresponsabilization of the cases among the teams will increase the problem resolution capacity of the local team, without referrals. Thus, over time and gradually, workers in the reference team become better able to solve problems they once considered difficult. With the maximum resolution of problems in the territory, avoiding unnecessary referrals, giving continuity to the care and, fundamentally, increasing the degree of singularization of the team/user relationship.[16]

The lack of specialized medical professionals to care for the mental health user is considered a great difficulty to be able to provide a resolving service, as well as the fact that primary care professionals often feel unprepared, resulting in overcrowding of specialized services with cases that could be resolved in primary health care.

Mental Health Care Strategies

The strategies and practices of mental health care developed in primary care in the municipality of Pesqueira are not uniform, they change according to the experience and experience of each caregiver.

"In Health Units, each unit is organized in the way that it deems most convenient of its reality, [...]." (E7)

With the emergence of community mental health services it was necessary to reorganize the work processes and, consequently, the institutional therapeutic project.[17] The professionals who conduct the consultation in the FHS should seek to build spaces for exchange and production of health, placing the disease in parentheses and providing a contact that breaks with the simplified structure of diagnosis and prescribing. What is wanted in any health action is to give attention, to receive, to consider and to listen carefully to a person who is not reduced to his illness.[18]

One of the main care practices developed in the FHT investigated were the group activities whose main objective was to identify the profile of the mentally ill person, ie, whether the patient has a confirmed diagnosis or is dependent on psychotropic medications, but has no diagnosis of no mental illness. The activities developed in these groups were briefly reported.

"[...] We have a group [pause] so it's already two years or three that we have this group, I made this group like that [...] the goal was is [...] see if people would decrease, wean the medication [...], so it goes like this, you already have the chronic disease in quotation marks right, and others do not even have the chronic disease, but it becomes chronic because you never to take the medication because you have a depression, For a reason 'x' starts there [...] medication, then the doctor does not remember to do the weaning [pause] his whole life, then we, I made this group thinking about it, mainly, then, then I started with my group [...]." (E9)

Not all FHSs have groups with mental health users and those who have not described psychotherapeutic activities, only activities focused on medication control and identification of users who are dependent on some weaning medication. No family involvement was reported in any time.

The nurse participates in groups and workshops, and is responsible for their coordination. In some cases these groups are carried out sporadically and are not systematized. These group activities should be done in an organized way, with pre-defined objectives, with the theme according to the reality of the community and often, since they are closely linked to one of the main objectives of the psychiatric reform that is the biopsychosocial rehabilitation.[2]

The matriciation strategy becomes important in this scenario, since the participation of mental health professionals in the primary care professionals in these groups, in a joint coordination, facilitates the learning of the FHS professionals regarding the management of the subjective aspects of the group process, to whom these professionals often feel insecure.[4]

Nursing appointments and home visits are also important in the development of mental health care. Home visits are a practice in which professionals have the possibility to work in the adjoining territory with the user, establishing a link between the health team and the community, as well as allowing professionals to identify the risk and vulnerability of these people.[2] However, the interview of professionals interviewed did not describe the home visit of professionals of higher level, only the visit of the Community Health Agent (ACS).

"[...] There is the ACS that he is already [...] a professional that he goes to people's homes, he already detects and he already gives us the list of people who have a disorder of [...] humor, some Mental health problem, so they already tell us this, then we go and focus, we do a planning a method of care for people with these disorders, to identify, evaluate, what is it going to be like? Part, part of, treatment of it [...]." (E8)

In the practice of Psychiatric Nursing, it stands out as exclusive actions of the nursing the nursing consultation as an important resource to the person and his family.[17]

"I also do this monitoring at the level, as I said, at the level of [...] at the level of health education, motivation [...]." (E8)

"So what is it that we are thinking about [...] allocating one day only to the care of these patients, so that we can give one is [...] a differentiated care not in the sense of differentiating from the other patients , But in the sense of [...] is [...] identifying [...] is the needs, what is needed, how can we be doing to improve this assistance." (E7)

From the reports it is possible to perceive that the professionals only perform the reception to the users who are identified with mental disorder, there is no reception for the demands of psychic suffering, that is, the care is very focused on the diagnosis of mental disorder and not the SUS users.

For an integral Mental Health Care, an extended vision is necessary, which implies considering the subject as a complete being, composed of body, mind, culture and influencing and influenced by the environment, that is, seeing it as a be integral and not fragmented. The users will only delegate the care of themselves to the health professionals in certain circumstances in which they perceive that they are

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not being able to overcome alone, when they feel valued in its singularity.[19-20]

FHS professionals work with listening and dialogue when users bring their problems from their homes, such as crises and stresses that they face in everyday life and that are affecting the quality of life.[2]

The professionals interviewed report that the relationship with the CAPS is more focused on the reference of the users with more severe disorders, but recently, there were meetings so that the CAPS professionals can help in the treatment of the users treated in the FHT, through therapeutic groups directed for these users.

According to Administrative Rule nº 3,088/2011, activities in the CAPS are carried out primarily in collective spaces (groups, user assemblies, daily team meetings), in articulated way with other points of attention of the health network and other networks.[7]

In the context of the primary health care of the municipality studied, medication control is the main practice of care developed in mental health, compromising the principles advocated by the National Mental Health Policy for the social reinsertion of the user and the strengthening of their autonomy.

Persistence of Manicomial Practices and Medication of Psychic Suffering

Despite the changes that occurred after the installation of the CAPS II in Pesqueira that provided an extension of RAPS and subsidized a change in the way to approach the user with mental disorder, the practices developed are still very focused on the medication and hospitalization of patients in crisis.

"[...] But the culture of the population is not direct to the hospital, so here we sometimes do not have, when it's really a case that the doctor thinks it is, that he has to take injectable medication, then it's The doctor directs you to the hospital, when you see that you really have to have more attention, it is more complex, but generally most outbreaks can be resolved with medication, but they seek hospital." (E8)

"There is a patient who is [pause] like that, he still has it, he still does it because he's running out, but still, once a while he has to do it, aggressive patient, there he goes to the hospital and makes the bridge". (E9)

Medicationization is described as one of the main practices of mental health user assistance. In most interviews the practitioners describe the use of the drug as the key to control the outbreaks or even to avoid them. In addition to the professionals, the users and their families are still very involved in the drug model, being considered fundamental to the user the prescription of the drug, leaving aside other practices that are also important for the treatment of these users, such as therapeutic workshops.

Medicalization is a process whereby non-medical problems are defined and treated as medical problems, translating into illness. It means that a problem will be defined, using medical jargon, understood from the adoption of medical concepts and treated through medical interventions. There are a number of social and economic forces that determine medical practice, what is called the "engines of medicalization", therefore, the understanding of medicalization as a process is fundamental so that one does not err in interpreting the term "medicalization" as a movement of the medical corporation, moving away from a broader understanding that considers its procedural dimension. Medicationalization refers to the use of medicinal products to treat problems that have been medicalized.[21]

Among the principles for the organization of substitutive mental health services, it is necessary to point out the essential shift from the perspective of the intervention of psychiatric hospitals to the community; The displacement of the center of interest only from the disease to the subject in psychological distress and to their social disability and the displacement of an individual action to a collective action in the confrontations of the users with their contexts.[2]

In the speeches of the professionals and users interviewed it is possible to perceive the great importance given to the medical treatment, the main report when speaking about practices of Care is the reference to the consultations with the psychiatrist and the use of the medicine. Discontinuation of drug treatment is considered to be one of the triggering factors for outbreaks.

"Well my reality here is [...] the family members accompany in the consultation, but what we do here is only the consultation that is the medical consultation, does not have groups formed with the development of other activities, then the participation of the [...], is more focused on [...] medication, the truth, that's the truth, the family comes here in search of medication to continue treatment." (E7)

"[...] the reasons why they are in crisis are the most diversified right, patient that is [...] is not doing the [...] appropriate treatment, which refuses to [...] take medication and so on [...]." (E7)

During the interview with a SUS user, it was possible to notice that it does not give importance to the psychotherapeutic activities for its treatment, nor to the consultations with psychologists, the main point reported was the consultation with the psychiatrist for the prescription of the medication. Other professionals expose that many users and family members find psychotherapeutic activities "silly" or "wasted".

One of the findings about the performance of nursing professionals in mental health is that it is still possible to perceive, frequently, attributions of the nurses focused on the individual scope and very close to the activities performed in a psychiatric hospital environment, also valuing pharmacological treatment. Psychiatric consultation is very important for the care of a user, but it is not enough to promote psychosocial resocialization and should not be highlighted as the only therapeutic possibility in mental health services.[2,17,22]

Studies indicate that pharmacological treatment still continues to be the most valued action by professionals, who administer and deliver the medications, as well as give guidance on the correct use.[2]

Drug treatment is still conceived as a central aspect of psychosocial care, constituting itself as a disciplinary strategy of physical and psychic containment of the person in mental suffering. It is possible to observe that the medicine plays a fundamental social role in the way the user bonds with himself and his suffering. Faced with the impossibility of giving meaning to their malaise, to their symptoms, the medicine seems to solve all the difficulties in being situated in the social bond, in relating with others.[20,23]

Consultation with the psychiatrist is still highly valued by professionals, users and family members, as well as the use of medication and hospitalization in cases of outbreaks, which represents the persistence of the old hospital-centered medical model, leaving aside the most important: the user and not the disease.

Family Participation

One of the practices in the model of psychosocial care widely used by professionals interviewed is the participation of the family in the therapeutic follow-up. Family participation, despite being very important, is highlighted as difficult to help with treatment, since relatives often prefer to admit the patient as a way to "get rid" of the "problem".

"Difficult, hard, difficult. What the agent does is [...] when the agent has a family with difficulty then the staff asks for Josefa's help who is our NASF psychologist, because it is incredible how the family does not want to support that person. For the family [pause] they think it is better [...] admitting [...]." (E8)

"[...] has a family that changes even from address so it can not be found [...]." (E5)

It is possible to notice that stigma persists in the studied population; This is also the case with family members of mental health users who often take these users to the CAPS as a way to transfer responsibility and do not help with treatment, instead they end up harming their family

members' social reintegration because they do not accept them and To see them as a "danger".

The difficulty of cooperation with family members causes pain to professionals as it prevents or hinders the progress of the treatment, thus provoking a sense of uselessness of the implemented actions.[24]

It is necessary to think of people with psychiatric disorders in the chronic phase and to investigate whether families and the community are prepared to accept them, and that professionals must give the necessary support. Thus, family members should be encouraged to participate in the treatment and rehabilitation process, since the contact with the family allows the individual to develop care and self-care skills in the context of coexistence, as well as to access social services in their community in a participatory manner, that the person with mental disorder perceives himself welcomed and belonging to society.[25-6]

"The important thing of care that we perceive here, if we could bring to the improvement of all the patients is their family, to work together with us. We have some patients that the family contributes a lot, but there are others who do not help people. If they were careful to always be with the patient along with us, the recovery for them would be of good evolution." (E1)

The family's participation in the reinsertion of the mental health user in society is reported as essential and facilitator of this process, but it is also a difficulty because, according to the interviewees, some families do not participate in the treatment or end up making it difficult to rehabilitate the users. This is a problem that occurs in all points of the RAPS in the context studied, especially in the ESF and CAPS, because the services that have a greater contact with the territory of the user and that seek to create the link between professionals, users and family.

It should be noted that the positive family environment is fundamental for the reintegration of the user into his family and into the social environment and that the treatment does not only involve the health professional, but also the user and his/her relatives. These may be important allies in the treatment, however, for this to occur both should receive help from the health teams to resolve or lessen their difficulties.[2]

The transition from a tutelary regime to another form of care that proposes the production of practices of freedom is a process full of crossings, so that even users inserted in the substitutive services are subject to behaviors and remaining positions of the asylum culture.[27]

Family participation is of fundamental importance for social reintegration and strengthening of the autonomy of the user, but a family that is unstructured, uninformed or does not provide adequate support to the user, can make therapeutic treatment difficult, leading these users to services that often end up not being resolutive.

CONCLUSION

This study helps to understand how the psychosocial care network is structured in the city of Pesqueira. Due to the recent implementation of the CAPS, the RAPS of the municipality of Pesqueira/PE, Brazil, is still suffering from some problems of structuring and coalition between the different points of care, but a great evolution has already occurred in Mental Health care, which was previously focused only for outbreak control at the Psychiatric Hospital.

Mental health care should not rely solely on the psychosocial care center. With the RAPS organized and consolidated, it is understood that users in mental suffering will have a more resolving service for their demands, from primary health care, and that many of the paradigms of stigmatization so present in health services and society are deconstructed.

It is observed that the strategies and practices related to mental health care are still very focused on consultations with the psychiatrist and on medication, which ends up harming the goals of the psychiatric reform. Professionals should prioritize other therapeutic practices that involve the user with society and that would increase their autonomy. The lack of specialized professionals and the lack of training for primary care professionals are pointed out as difficulties in order to provide better quality care for those with mental disorders.

Actions directed at mental health care are ignored by FHS professionals who only care about the delivery of medicines. These professionals should carry out more activities aimed at receiving the issues arising from psychic suffering so that users can develop their autonomy, as advocated by the Mental Health Policy.

For resolute mental health care, dialogue and joint planning between FHS and CAPS teams will provide the development of parenting as a strategy for a unique therapeutic project to be implemented, and for these points of care to assist practitioners FHS who often do not feel empowered to provide quality care to mental health users.

REFERENCES

1. Antonacci MH, Kantorski LP, Willrich JQ, Argiles CTL, Coimbra CC, Bielemann VLM. Estrutura e fluxo da rede de saúde mental como possibilidade de mudança nos serviços de atenção psicossocial. Rev Esc EnfermUSP.2013;47(4):891-8.

2. Duarte EOS, Nasi C, Camatta MW, Schneider JF. Caracterização das práticas de assistência na rede de atenção em saúde mental revisão integrada. Rev GaúchaEnferm. 2012;33(4):191-99.

3. Pini JS, Waidman MAP. Fatores interferentes nas ações da equipe da Estratégia Saúde da Família ao portador de transtorno mental. Rev Esc Enferm USP. 2012;46(2):372-9.

4. Borba LO, Guimarães NA, Mazza VA, Maftum MA. Assistência em saúde mental sustentada no modelo psicossocial narrativas de familiares e pessoas com transtorno mental. Rev Esc Enferm USP.2012;46(6):1406-13.

5. Azevedo DM,Santos AT. Ações de Saúde Mental na Atenção Básica Conhecimento de Enfermeiros Sobre a Reforma Psiquiátrica. Rev. Pesqui. Cuid. Fundam. [Online]. 2012out-dez; 4(4):3006-14.

6. Martins AKL, Braga VAB, Souza AMA. Práticas em saúde mental na Estratégia Saúde da Família um estudo bibliográfico. Rev. RENE. 2009;10(4):165-72.

7. Portaria nº 3.088 de 23 de dezembro de 2011.Institui a Rede de Atenção Psicossocial para pessoas com sofrimento ou transtorno mental e com necessidades decorrentes do uso de crack, álcool e outras drogas, no âmbito do Sistema Único de Saúde (SUS). Diário Oficial da União. 25 maio 2013.

8. Moraes R, Galiazzi MC. Análise Textual Discursiva. 2 ed. rev. Ijuí: Editora UniJuí; 2011.

9. Portaria nº 336, de 19 de fevereiro de 2002. Estabelece diretrizes para o funcionamento dos Centros de Atenção Psicossocial. Brasília, DF: Ministério da Saúde; 2002.

10. Decreto nº 7.508, de 28 de Junho de 2011.Regulamenta a Lei no 8.080, de 19 de setembro de 1990, para dispor sobre a organização do Sistema Único de Saúde - SUS, o planejamento da saúde, a assistência à saúde e a articulação interfederativa, e dá outras providências. Diário Oficial da União.29jun 2011.

11. Barros REM, Tung TC, Mari JJ. Serviços de emergência psiquiátrica e suas relações com a rede de saúde mental brasileira. Rev braspsiquiatr.2010 out;32(2):571-7.

12. Stefanelli MC, Fukuda IMK, Arantes EC. Enfermagem psiquiátrica em suas dimensões assistenciais. São Paulo: EditoraManole; 2008. Cap. 2-4.

13. Cardoso L, Galera SAF. O cuidado em saúde mental na atualidade. RevEscEnferm USP. 2011;45(3):687-91.

14. Almeida AB, Nascimento ERP, Rodrigues J, Schweitzer G. Intervenção nas situações de crise psíquica dificuldades e sugestões de uma equipe de atenção pré-hospitalar. Rev bras enferm. 2014 set-out;67(5):708-14.

15. Delfini PSS. Centro de Atenção Psicossocial Infantojuvenil e Estratégia de Saúde da Família: articulação das ações voltadas à saúde mental de crianças e adolescentes. 2010. [Access: 03 de Jul de 2015]. Available at: <http://www.teses.usp.br/teses/disponiveis/6/6136/tde-16122010-161656/pt-br.php>.

16. Delfini PSS, Sato MT, Antoneli PP, Guimarães POS. Parceria entre CAPS e PSF o desafio da construção de um novo saber. Ciênc saúde coletiva. 2009;14(Supl. 1):1483-92.

17. Esperidião E, Silva NS, Caixeta CC, Rodrigues J. A enfermagem psiquiátrica, a ABEN e o departamento científico de enfermagem psiquiátrica e saúde mentalavanços e desafios. Revbrasenferm. 2013;66(esp):171-6.

18. Mielke FB, Olschowsky A. Ações de saúde mental na estratégia saúde da família e as tecnologias em saúde. Esc Anna Nery Rev Enferm. 2011 out-dez;15(4):762-8.

19. Morais FRC, Silva CMC, Ribeiro MCM, Pinto NRS, Santos I. Resgatando o cuidado de enfermagem como prática de manutenção da vida concepções de Collière. Revenferm UERJ, Rio de Janeiro, 2011 abr-jun;19(2):305-10.

20. Barbosa VFB. O cuidado em saúde mental e o dispositivo de segurança no Brasil: transversalidade discursivas referentes à problemática do risco. Florianópolis. Tese [Doutorado Interdisciplinar em Ciências Humanas]. Universidade Federal de Santa Catarina; 2014.

21. Peter C. The Medicalization of Society: on the transformation of human conditions into treatable disorders. Baltimore: The Johns Hopkins University Press. 2007.

22. Camata WC, Wetzel C, Scheider JF. Users' expectations with regard to mental health actions: a phenomenological study. [Internet] 2012;11(3). [Access: 14 de mar de 2016]. Available at: <http://www.objnursing.uff.br/index.php/nursing/article/view/3908/html_2>.

23. Junior ZAM, Caponi SNC. Condicionantes relacionados ao uso crônico de clonazepam no Brasil: uma história de vida. Cad de PesqInterdisc em Ci-s. Hum-s. 2014;15(106):117-39.

24. Campos RO, Baccari IP. A intersubjetividade no cuidado à Saúde Mental: narrativas de técnicos e auxiliares de enfermagem de um Centro de Atenção Psicossocial. Ciênc saúde coletiva. 2011;16(4):2051-58.

25. Castro LM, Maxta BSB. Práticas Territoriais de Cuidado em Saúde Mental: experiência de um Centro de Atenção Psicossocial no município do Rio de Janeiro. SMADRev eletrônica saúde mental alcooldrog. 2010;6(1):1-9.

26. Salles MM, Barros S. Inclusão social de pessoas com transtornos mentais: a construção de redes sociais na vida cotidiana. Ciênc saúde coletiva. 2013;18(7):2129-38.

27. Amorim AKMA, Dimenstein M. Desinstitucionalização em saúde mental e práticas de cuidado no contexto do serviço residencial terapêutico. Ciênc saúde coletiva. 2009;14(1):195-204.

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