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Trabalho na Atenção Básica: integralidade do cuidado em saúde mental
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Work in primary health care: a comprehensive mental health care

TRABALHO NA ATENÇÃO BÁSICA: INTEGRALIDADE DO CUIDADO EM SAÚDE MENTAL

TRABAJO EN LA ATENCIÓN PRIMARIA DE SALUD: INTEGRALIDAD DEL CUIDADO EM SALUD MENTAL

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ABSTRACT

This study intends to map the health care given to the usuary with needs in the mental health field in a primary health care unity, analyzing the team work in the light of the integrate primary health care practices. The participants are health workers from different professions, who belong to the service's mental health working processes. The data collection technique used was the analytic flowchart. The results show us that the connective flows among the professionals and between them and the health unity's, in the primary health care unit, has been producing and proliferated diverse exchanges' spaces, making possible health actions aligned to the integrality in people's care through a enlarged understanding of health mental disease process, by means of human relationships' valuation and subjectivities involved in the health work space.

KEY WORDS

Mental health.
Patient care team.
Primary health care.
Comprehensive health care.
Cartography.

RESUMO

Este estudo tem por objetivo cartografar o cuidado ao usuário com necessidades no campo da saúde mental em uma Unidade Básica de Saúde, analisando o trabalho em equipe à luz da integralidade das ações de saúde. Seus participantes são trabalhadores de saúde, de diferentes profissões, que fazem parte dos processos de trabalho em saúde mental do serviço. A técnica de coleta de dados utilizada foi o fluxograma analisador. Os resultados nos mostram que, na Unidade Básica, os fluxos conectivos entre os diversos trabalhadores - e entre estes e os usuários - vêm produzindo e proliferando vários e distintos espaços coletivos de trocas, possibilitando ações de saúde alinhadas à perspectiva da integralidade, através de uma compreensão ampliada do processo saúde-doença mental, construída pela valorização das relações humanas e das subjetividades envolvidas no espaço do trabalho em saúde.

DESCRITORES

Saúde mental.
Equipe de assistência ao paciente.
Atenção primária à saúde.
Assistência integral à saúde.
Cartografia.

RESUMEN

Este estúdio de abordaje cualitativa tiene como objetivo cartografiar el cuidado al usuário con necessidades en lo campo de la salud mental en uma Unidad Básica de Salud, a través de la análisis del trabajo en equipo a la luz de la integralidad de las acciones de salud. Sus partipantes son trabajadores de salud mental, de diferentes profesiones, que son parte de los procesos de trabajo en salud mental de lo servicio. La colección de datos fue construida mediante lo fluxograma analizador. Los resultados muestran que, en la Unidad Básica, los flujos conectivos entre los diversos trabajadores - y entre estes y los usuarios - están a producir y proliferar vários y distintos espacios colectivos de intercâmbios, permitiendo acciones integrales de salud a través de una comprensión ampliada del proceso de salud-enfermedad mental, construida por médio de la valorización de las relaciones humanas y de las subjetividades involucradas en lo espacio del trabajo en salud.

DESCRIPTORES

Salud mental.
Grupo de atención al paciente.
Atención primaria de salud.
Atención integral de salud.
Cartografia.

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INTRODUCTION

Research on mental health in Primary Health Care show that, although Basic Health unit (BHU) workers acknowledge social factors as determinants of the population's health-disease process, the object of their work is the mental illness and, starting from this object, diagnoses and medication prescriptions are the most valued means or work instrument for interventions involving people with mental health needs[1].

About this discussion, the comprehensiveness of health care needs to be addressed in different dimensions to be achieved as fully as possible. This gives rise to the notions of *focused comprehensiveness* and *expanded comprehensiveness*[2].

Expanded comprehensiveness refers to each health service's articulation with a more complex network, composed of other health services and institutions that do not necessarily belong to the *health* sector; that is, comprehensiveness at the *macro* level. Focused comprehensiveness, on the other hand, is defined as the *fruit of efforts and the confluence of different types of knowledge in a multiprofessional team, in the concrete and unique space of health services*[2].

For the articulation of health actions in services, professionals need to acknowledge and evidence existing connections and links between interventions, either related to their own work process or to the actions of other team members[3].

In view of these premises, the goal in this research is to reach a deeper understanding of a health service's micro-policy, through subjects' daily actions in their mutual relations and in the scenario they act in[4].

OBJECTIVE

The aim of this research is to map care for users with mental health needs at a BHU, analyzing teamwork in the light of the comprehensiveness of health actions.

METHOD

A qualitative design was chosen, which can incorporate the issue of meaning and intentionality as inherent in actions, relations and social structures. The latter are considered in their development and transformation, as human constructions that can be apprehended through daily reality and experience[5].

The study context is a BHU in São Paulo city, which is also considered a Complementary Practice Center, since it offers Traditional Chinese Medicine and Homeopathic care.

Data collection was based on the collective construction of an analytic flow chart, involving health workers who are active in mental health work processes at the service: psychologist (two); nursing auxiliary (one); physician (three); social worker (one). Two meetings were held, each of which took approximately 90 minutes.

The analytic flow chart can be defined as a diagram used to *draw* all steps in the work process, based on the user's trajectory through the service, that is: entry into or exit from the service production process (represented by the ellipse); moments of decision making to continue the work (represented by the parallelogram) and the moment of intervention, action on the process (represented by the rectangle)[6].

Therefore, workers should choose a *typical user*, which they should take a closer look at to describe his/her trajectory through the services, asking them to take into account some proposed guidelines in this choice: attending the service for at least six months, which permits a picture that is more in line with the reality of their daily work; having received care from at least three service professionals, so as to assess the integration among professionals' actions and the service's relations with the user[7].

All names mentioned here are fictitious.

The comprehensiveness of health care needs to be addressed in different dimensions to be achieved as fully as possible.

Approval for the research was obtained from the Research Ethics Committee at the São Paulo Municipal Health Secretariat (opinion No 283/07).

RESULTS

Flow chart description

Workers chose the user Bernardo who, according to them, stood out because he had mobilized the entire multiprofessional team.

Bernardo's entry into the service departed from his mother Manuela, who contacted the service's social worker with a demand for advice on where to get medication. In their talk, Manuela complained of feeling depressed and was forward to the psychologist. Before this consultation however, the social workers contacts her colleague to discuss the case. During the consultation with the psychologist, this professional invites Manuela to participate in the Psychotherapy Group (GP) at the BHU, where the user first mentions Bernardo, saying, according to the psychologist, that *she had a son with a problem*, because he presented the same behaviors as her late husband, who was schizophrenic and was hospitalized for many years; a situation that, according to Manuela, was very difficult to live with.

In the GP, the mother is advised to bring her son to the service on one of the dates set for mental health welcoming. Participating in Bernardo's welcoming, who was 16 years old, the same psychologist forwards him to the Adolescent Group (GA).

Thus, Bernardo starts to participate in the GA, while his mother Manuela continues in the GP and, on the psychologist's invitation, also takes part in the Parent Orientation Group (GOP).

At a given time, the mental health team professionals decide, through these discussions, in view of his articulations and interactions, that Bernardo should also be seen by the homeopath, who was a member of the same team and worked with groups of children and school health. That physician feels the need to forward Bernardo to the psychiatrist of the referral service for the same territory, called Referral Center (CR) here.

The health professionals responsible for the GA also perceive that, as the user displays quite a regressed behavior, he did not manage to bond with the group. This issue was discussed in the mental health team meeting. It was decided to forward Bernardo to the Group of Children aged 10 and 11 years, the Play Orientation Group (GOL). According to the psychologist and the homeopath, who coordinated the group, *that was the group where he went better.*

This trajectory shows that (individual and collective) conversation networks took form, which connected the mental health team workers, welcoming both Bernardo and Manuela at the service, also permeated by two-weekly mental health team meetings and a flow of informal conversation among workers, feeding users' power to produce relations in different spaces at the BHU.

What happened then was that, due to a severe ophthalmological problem, his mother took Bernardo to a general hospital, where physicians forwarded him to the psychiatry sector. At this sector, the adolescent was diagnosed with schizophrenia, although BHU mental health team professionals found that controversial, considering not only the signs and symptoms, but particularly the family context involved:

> Bernardo was labeled with schizophrenia by a more clinical psychiatric view, which does not have much to do with reading the family, it is more of psychopathology (Geranium).

And, from the general hospital, Bernardo was forwarded to the CAPS but, at the same time, remained at the BHU for a short time, approximately one month. According to the social workers, Manuela still attended the service, because she participated in the GP, although she missed a lot of meetings; she had given up the GOP however. According to BHU professionals, with regard to Bernardo, Manuela's visits were important, even if time went by between different visits, because these offered opportunity to talk, ask questions about the adolescent, a way of knowing how he was getting along in life, how the relation between mother and son was going...

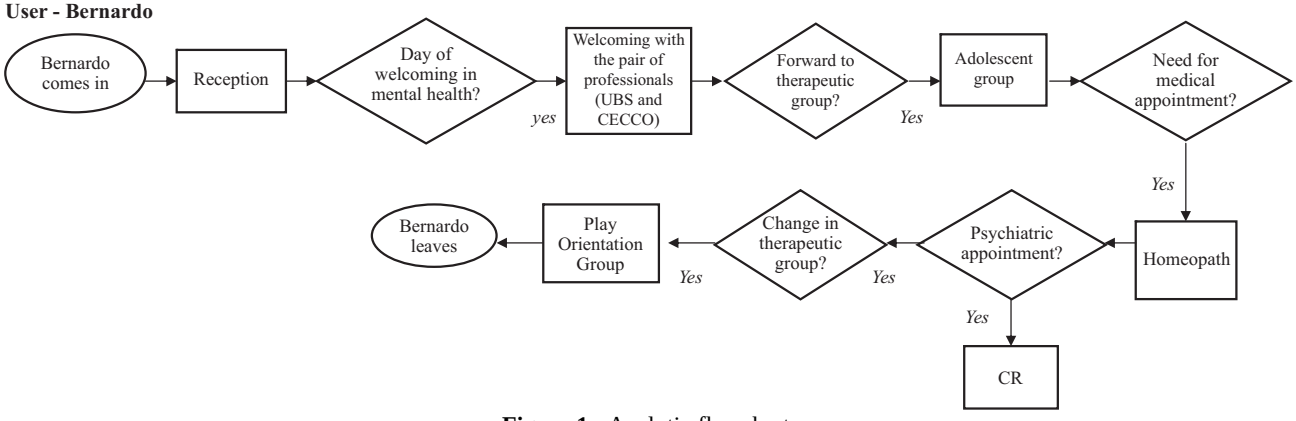

Figure 1 - Analytic flowchart

DISCUSSION

Based on the BHU's first welcoming of Manuela, when she met with the social worker, it could be observed that qualified listening and good conversation can facilitate the user's flow at the service as, when the social workers investigated Manuela's needs, much beyond simply advising her about the medication, which was her demand, this approaches a notion of care that goes beyond technical care, which implies caring for the person, getting involved with her[8].

According to the physician Tulip, who is an acupuncturist, her professional experienced at the BHU gradually provided her with an *expanded look on the clinic*, through which she started to understand physical pain as an expression of mental pain, exemplifying a case in which a patient considerably improves when the physician starts to *give herself* more to the relationship, through *interested listening,* which granted both an *insight* that the problem in question was related to way the user had been facing her life.

It could be perceived that the network of conversations established at the service was supported by interaction and articulation among professionals. Through different discussions, they reflected on their individual and collective ways of acting and, based on these debates, they de-

cided what therapeutic itineraries had to be attempted, thus touting singularities and welcoming one another. According to Violet, even in difficult situations (cases of sexual abuse and suicide attempts were mentioned), workers know they have someone to share things with; they have support that grants them security to continue...

With regard to Manuela and Bernardo, the way professionals attempted to interconnect both cases stands out, promoting comprehensive care through a broader understanding of both users' psychic suffering.

The flow chart revealed the BHU mental health team's sensitization and mobilization with respect to the case, articulating and interacting so as to seek possibilities to welcome Bernardo and establish bonding with the service, despite the difficulties professionals mentioned to involve Manuela in the perspective of promoting the adolescent's autonomy in life, dissuading her from her obstinacy to put a diagnostic label on her son; to the extent that this was only given by another health service.

And, according to Amaryllis, the *wealth* of this team's work in relation to this case was the professionals' availability and the space they received, democratic and directed by collective action, with powers to intervene, because it was care for Bernardo and two other adolescents that led to the creation of the adolescent group at the BHU. Hence, according to Geranium, the construction of this group occurred:

> [...] through a lot of discussion, 'going for it together' and removing that immediate urge to solve things, thinking about discussing the type of solution we could offer and what the person wants; that is when things started to work out and we obtained an increasingly close discourse [...].

At the time of data collection, BHU mental health team professionals reported that they knew about Bernardo's good evolution through Manuela and Peony (who worked at the service and at the CAPS; he participated in an adolescent group at the CAPS and was also dating a user. This news was considered very positive, as one of the main difficulties indicated with regard to the user was his affection. Moreover, the social worker comments that Bernardo had received a free public transport ticket, and that he had started to move around the neighborhood by bus alone.

Then, they were asked how this care had affected them as workers and how, in their opinion, it had affected users, their way of being, thinking, acting and feeling. Some *insights* emerged about their teamwork processes at the BHU, reflecting on how they shared cases by privileging *spaces for discussion and exchange* with *dynamism and tuning.*

It was proposed that workers should attempt to return to each person's care concept and reflect on whether they would propose changes in mental health work processes at the BHU and, if yes, what these changes would be. Then, it was perceived that, based on this discussion, the maps of conflicts this team faces at the BHU were truly revealed, as they reported that *unfortunately*, this articulation and interaction did not take place with other service professionals, who did not want to work in groups and even manifested this during technical meetings.

According to Amaryllis, this impermeability among different professional categories is very bad because, on the opposite:

> When there is an exchange, this thing we see here in this team is gone, looks are different, and this benefits the patient...

In this perspective, some issues can be raised about the importance of a health service turning into a comfortable, participatory and satisfactory space, as this would be a way of valuing workers and give them the chance to be liberating and creative[9].

FINAL CONSIDERATIONS

According to the findings, at the BHU, the organization of mental health work processes is engendered by the work of a team that interacts and articulates when welcoming users, that is, triggering multiple conversation networks during meetings between those users and other workers, users, services and the community; in short, encounters among life territories, guided by the axis of comprehensive care.

On the opposite, it was noticed that the workers also perceive, in their daily work, relations that do not allow professional groups to meet – in the sense of articulating knowledge and actions to produce health intervention projects – considering these relations as *capturing* the users' subjective world and their way of representing and constructing health needs because, based on this care mode, users can include their *complex world* of will, desire and knowledge.

Hence, the collective construction of the flow chart mobilized workers' discussion on affective relations between the subjects involved in service meetings, either workers or users, in the perspective of a critical-reflexive look on conversation spaces at the health services.

This study allowed the team to try out and reflect in order to: avoid that workers lock themselves up in their problem-solving concreteness and powers; reinvent a daily reality that also mainstream the organization of resistant professionals' work processes, so that these dare to create new anti-hegemonic possibilities in the understanding of the multiple nature of users' psychic suffering.

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