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CASE REPORT ARTICLE

CHANGES IN THE MENTAL HEALTH FIELD: EXTENSION ACTION IN A PSYCHOSOCIAL CARE CENTER

TRANSFORMAÇÕES NO CAMPO DA SAÚDE MENTAL: AÇÃO EXTENSIONISTA EM UM CENTRO DE ATENÇÃO PSICOSSOCIAL

TRANSFORMACIONES EN EL CAMPO DE LA SALUD MENTAL: ACCIÓN EXTENSIONISTA EN UN CENTRO DE ATENCIÓN PSICOSSOCIAL

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ABSTRACT

Objective: to report extension practices in a psychosocial care center. **Method:** action taken at the Psychosocial Care Center Arte de Viver, a city in the interior of Rio Grande do Norte, using participatory approaches to health, along with theoretical support from the mental health field. **Results:** the institution shows obstacles to work with patients who enter the service. Cataloging records allowed the selection of patients with schizophrenia and identified the need for working with families and health professionals. Home visits were to strengthen the link between professional/family/user. The unique therapeutic project emerged as welfare support multidisciplinary team. The community therapy represents a new therapeutic approach for the institution. **Conclusion:** these actions showed as supporting devices and support for mental health services. It is necessary to understand the importance of multidisciplinary work as facilitator of the work process and health care multiplier. **Descriptors:** Mental Health; Nursing; Mental Health Services.

RESUMO

Objetivo: relatar práticas extensionistas num centro de atenção psicossocial. **Método:** ação realizada no Centro de Atenção Psicossocial Arte de Viver, em um município do interior do Rio Grande do Norte, utilizando metodologias participativas para a área da saúde, junto com aporte teórico do campo da saúde mental. **Resultados:** a instituição apresenta entraves para trabalhar com os usuários que adentram no serviço. A catalogação de prontuários permitiu a seleção de usuários com esquizofrenia e identificou a necessidade de trabalhar as famílias e profissionais de saúde. A visita domiciliar buscou fortalecer o vínculo entre profissionais/família/usuário. O projeto terapêutico singular emergiu como apoio assistencial à equipe multiprofissional. A terapia comunitária representou uma nova abordagem terapêutica para a instituição. **Conclusão:** essas ações apresentaram-se como dispositivos de suporte e apoio aos serviços de saúde mental. É preciso compreender a importância do trabalho multiprofissional como facilitador do processo de trabalho e multiplicador do cuidado em saúde. **Descritores:** Saúde Mental; Enfermagem; Serviços de Saúde Mental.

RESUMEN

Objetivo: relatar prácticas extensionistas en un centro de atención psicossocial. **Método:** acción realizada en el Centro de Atención Psicossocial Arte de Viver, en una ciudad del interior de Rio Grande do Norte, utilizando metodologías participativas para el área de la salud, junto con el aporte teórico del campo de la salud mental. **Resultados:** la institución presenta trabas para trabajar con los usuarios que entran en el servicio. La catalogación de registros permitió la selección de usuarios con esquizofrenia e identificó la necesidad de trabajar las familias y profesionales de salud. La visita domiciliar buscó fortalecer el vínculo entre profesionales/familia/usuario. El proyecto terapéutico singular surgió como apoyo asistencial al equipo multiprofesional. La terapia comunitaria representó un nuevo enfoque terapéutica para la institución. **Conclusión:** esas acciones presentándose como dispositivos de soporte y apoyo a los servicios de salud mental. Es preciso comprender la importancia del trabajo multi-profesional como facilitador del proceso de trabajo y multiplicador del cuidado en salud. **Descriptores:** Salud Mental; Enfermería; Servicios de Salud Mental.

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INTRODUCTION

The Psychiatric Reform has as one of its aspects to bring the madness to the family environment, enabling the patient to be reinstated to social life and not being more isolated in asylums. It is noted that a transformation occurs in order to realize the carrier of mental disorders. In the course of deinstitutionalization process, the mental patients, excluded from family life is inserted into familiar routines, becoming participatory. From this change, there are the difficulties faced by the relatives before this new duty: dealing with madness in daily life and be an indispensable part for the social rehabilitation of mental patients.¹

In this context, the creation of substitutive services to the psychiatric hospital started to be favored, as care networks to mental health, Mental Health Centers (CAPS), psychiatric beds in general hospitals, therapeutic workshops, therapeutic residences, respecting the particularities and needs of each place. Local initiatives have received financial incentives through ministerial decrees, aiming to shift resources to alternative modes of psychiatric hospitalization and making compatible the procedures of the mental health services to the health care model.²⁻³

A network of this type of equipment is gradually replacing the hospital-centered and asylum model, of exclusive, oppressive and reductionist characteristics. In its place a support system has been built guided by the fundamental principles of the Unified Health System (SUS) (universality, fairness and completeness), plus the deinstitutionalization proposal - which goes well beyond the boundaries of health practices and reaches the social imaginary and culturally validated ways of understanding madness.⁴

It is important that professionals are aware of the needs of family members from carrying out activities such as family group, home visits, tours, and other activities that promote their inclusion in the service, within a perspective of the family needs to be cared, to make them feel stronger and may have and provide emotional support.⁵

However, the training process is discontinuous, tutelary with appreciation of the content and poor utilization of the real situations experienced by the student, especially in practical fields that represent dynamic spaces for the development of skills.

The university extension is configured as a privileged place, since it mobilizes several

resources in the students, fostering reflection-in-action, developing care projects with strategies, implementation and evaluation, allowing autonomy attitudes and learner's creativity.⁶

From this perspective, a group of students and a professor at the State University of Rio Grande do Norte (UERN) developed the Extension Project "Deconstructing the fear: therapeutic strategies of coping and approaching family members with schizophrenia patients of a CAPS" aimed at is to present approaching strategies between the caregivers and the health service, as well as providing an understanding of family members about schizophrenia and the development of tactics to make the family an ally of the health service.

Thus, this study aims to report extension practices in a psychosocial care center. It is noteworthy that the theoretical framework of the extension project is based in the National Curriculum Guidelines for Undergraduate Nursing Courses and with the Mental Health and Humanization National Policies.^{2,7-8}

METHOD

The extension project consisted in studies in rounds with scientific texts containing issues about schizophrenia, home visits, practices and skills of professionals in mental health services, community therapy and others that allowed the extension become familiar as the field mental health and approach the singular reality of Mental Care Centers- CAPS.

Participants were inserted in CAPS Arte de Viver located in a city in the interior of Rio Grande do Norte. The choice of this place was because of being a mental health reference for the entire geographical macro-region.

This institution serves about 250 patients with mental disease, composed of 20 health professionals including doctors, nurses, nutritionists, psychologists, occupational therapists, pharmacists, physical educators and monitors. It is located in a distant region of the city center, and in the same building of the former mental hospital, representing a major challenge for patients' access to the service and for professionals seeking to be out of the asylum hegemonic model that prevailed for decades.

In the activities, there were 25 participants, five families, six members of CAPS staff and four students of the Undergraduate Course in Nursing of Caicó Campus (CAC), participants of the extension action along with one teacher of the same

course. The adopted pedagogical tools were education workshops on health and communication and the Community Therapy (CT).⁹⁻¹⁰ Thus, five actions were developed in the CAPS: to know the special circumstances of the institution; cataloging records; home visits to families; conducting individual therapeutic project (PTS) and; CT with patients. For achieving these actions, the extension project was carried out from November 2011 to November 2012.

First, the extension participants knew the physical structure and working conditions of the multidisciplinary team of CAPS. Then, the cataloging records allowed the choice of five patients with schizophrenia, by the health needs that these subjects had. Then, there were home visits to families to meet their living conditions and health. From the reality found, the PTS have been prepared. Finally, the project participants have developed the CT with twenty patients of CAPS, five family members and six health professionals.

The approaches adopted to achieve and operationalization of actions were discussed and planned in meetings between professionals of the institution and extension participants. After the completion of each activity, the assessment of actions occurred.

The assessment of cataloging records for choosing the members, who participated in home visits and PTS, was by the professionals of the institution who agreed or not with the choice of patients. With regard to home visits, the evaluation was through these professionals through the answers of family members in service after meeting them. The PTS has been evaluated both by the coordination of CAPS as by project participants. Finally, the CT was evaluated by patients, professionals and extension participants.

RESULTS AND DISCUSSION

The first action developed was the inclusion of extension participants in CAPS aiming to approach the singular reality of the institution, knowing their actions and health practices. It was noticed the absence of inputs for performing actions. Professionals reported difficulties to work with patients who enter the service in semi-intensive and intensive system, given the minimum conditions of hospitalization, lack of medical professionals and the presence of drug therapy as the primary approach to health care activities. These results highlight the lack of commitment of management and the lack of skills and abilities of professionals in the mental health field to develop interventions

that encourage the participation of the mentally ill person.

These results are unsatisfactory to the field of mental health, considering the investments made by the Ministry of Health in recent years and the reorientation of health care that offers courses to qualify professionals to meet the psychiatric patients in a humanized perspective and meeting the requirements new psychosocial care model.^{2,11}

To perform a mental health care in psychosocial model, training/capacitation of professionals should be focused on the patients' probation in mental distress, with anti-asylum ideas aimed at autonomy and independence of the subject and their insertion in the community, essential conditions that should be thoughtful and encouraged by managers, offered by educational institutions and also sought by the workers in the health field.¹²

It is necessary the articulation of health actions in the services, since it provides the professional to recognize and put in evidence the connections and the existing links between the interventions, referring both to his own work process as the actions performed by others team members, and contribute to the health/disease process of patients with mental suffering and their health needs, considering their subjectivity, desires and anxieties that involve their social imaginary.¹³

Nevertheless, the service performs therapeutic workshops that allow the improvement of the carrier with mental suffering proposing as a manual production space and do not constitute potentially as differences and singularities living environment that will enable the exchange of experiences and knowledge.

Working with groups appears as one of the main therapeutic tools in various health care contexts and, more specifically, in the area of mental health. This is from the conditions favored from the psychiatric reform, with a focus on rehabilitation and enhancement of the autonomy of the individual in mental distress. It also allows the formation of emotional bonds between participants and health professionals, collaborating in the treatment process.¹⁴

Therapeutic workshops are characterized as a place to practice multiple knowledge, and the professionals responsible for providing all actions to mental patients, necessary to assure the rehabilitation, but also becomes an object of attention of many knowledge.

The second action developed by the participants was the selection of patients with

schizophrenia. For that, it was necessary to cataloging records identifying those who needed more attention. Among the 250 patients attended by CAPS, ten were there, five being selected subjects. The selection criteria was to mental illness patients, so those who were diagnosed with schizophrenia were prioritized - seven patients, those who had records family problems described by some professionally - five cases.

Therefore, it was sought to work with the families of these patients with the service staff. The option to work with the family was due to the need of these individuals being prepared to face the various situations that may arise as result of the disorder, and their longer life experiences. The difficulty showing affection, lack of dialogue and impulsive actions are factors presented by patients with mental suffering.

The fear, anxieties and concerns experienced by their family members occurred by explosive behaviors and figure in this context. As a result, the lack of understanding of the disease and its consequences entails movement away from friends, family and relatives, which perpetuates the stigma and prejudice against the subject afflicted with mental disorder.¹

To work with the families of patients with schizophrenia the third action of the extension project was the need to conduct home visits to meet the singularities experienced by these subjects.

A home visit in the context of mental health configured as an approximation tool between professionals and family allowing the construction of ties and trust to subsidize the doubts, desires and needs of these individuals forward to the inherent issues of patients with mental disorders.

The home visit allows health professionals to understand the reality and the home context, whether the physical structure and material or intra-family personal relationships. It enables professionals to build activities that encourage patients' participation in the health-disease process. It is important to minimize or even eliminate the factors that endanger their health and their families.¹⁵

A study in Paraná revealed that health professionals do not guide and/or inform family members about the disease and its treatment. Then, the family is a challenge to serve as co-participant in the care process, since knowledge, commitment and family involvement in the treatment is needed, and in most cases professionals do not seek to

clarify the family about the particularities affecting his relatives.¹⁶

To carry out this activity, the extension participants invited professionals of CAPS, however the professional moving difficulties are presented as an obstacle that interferes with effective actions for patients and their families. The absence of a means of transport hinders the team access to residences. Thus, these visits occur only when management agree to be timely, providing transportation to the team. The lack of support from management is noticed that determines the multidisciplinary team their subordination limiting the activities of the service.

The lack of articulation between the CAPS and the management is unsatisfactory for the patient service with mental disease, given that home visits favors the construction of coping strategies for the challenges that the disease can provide to the patient/family/service.

From this perspective, it is observed that the difficulties in health services, especially in the field of mental health, are due to the difference in public policy management, administrative management of the institution and management of clinical actions developed in the health equipment. The lack of conciliation between the triad is the antagonism of interests between demand of the subject, health workers and public managers.⁴

Another difficulty identified in the execution of home actions was the non-existent matrix support in the mental health service. The matrix is understood as an arrangement that proposes to reformulate the way of organization of services seeking to increase the degree of resoluteness in health actions, through a network of co-responsibility between the different sectors of primary care.¹⁷

The matrix is a guided device in integrated pact of resolutions, allowing professionals building a comprehensive health care through innovative practices and multidisciplinary activities, besides providing the participation of patients and family during the therapeutic process, in view of the flows assistance that are articulated by CAPS and the ESF (Family Health Strategy).¹⁸

The CAPS has no connection with the teams of the country's Family Health Strategy - ESF causing a gap in the intersectoral actions necessary for patients' access to these services. The work carried out by mental health professionals do not understand the

essential territoriality of actions to the knowledge of the CAPS area of coverage.

Given the difficulties to carry out interventions outside the service area, participants developed a fourth action, the development of PTS of five selected subjects, in view of the absence of this instrument in CAPS.

The PTS is a device developed by the entire multidisciplinary team based on health needs of each patient, not excluding their opinions, their dreams, and their lives' project. It is something unique and individualized, democratic and horizontal interaction between worker/patient/family, strengthening the health/mental process of the carrier disease suffering.¹⁹

With this proposal, there were families of patients visited and developed PTS from the special circumstances of each individual, valuing their subjectivities and building a guided planning in care as a key element and practices that foster responsibility to the individual with psychological and mental suffering. Thus, establishing a rehabilitation that addresses the three dimensions of human life: home, work and leisure.

Thus, the PTS contained proposed interventions in the family environment together with the patient. Made with therapeutic goals to be achieved between patient/professionals and finally with evaluation of results proposing to understand the concerns of the multidisciplinary team.

In this understanding, a study conducted in São Paulo pointed out that the treatment project is a structured process related to care management and planning aspects involving knowledge, ways of acting and health technologies that provide caregivers actions, meeting certain health requirements. These actions aim to humanize the care to the patient with mental suffering and enabling their socialization.²⁰

After PTS formulation, planning was presented to the multidisciplinary team of CAPS, discussing all proposals actions and inserting them on the new demands of selected patients. Then, it was realized that this action was well accepted by professionals, as established priorities and effective actions to patients.

The results of this action are considered good, considering that the professionals did not have planned actions, whose interventions were just focused on drug therapy and care not directed to autonomous actions of the patients' rehabilitation.

The rehabilitation of mental suffering is an enlarged action presented as a set of strategies aimed at increasing the ability to exchanges and to value subjectivity. For the realization of this process, it is essential to the individual be reinserted in society. Reintegration is the resumption of autonomy and citizenship when a person conquer his freedom and exercise subjectivity, circulating in city spaces and promoting new social relationships.²¹

Finally, the fifth action understood the need for new strategies to work with both patients and with professionals and family, extension participants solved through the study rounds inserting the Community Therapy (CT) in the daily actions developed by CAPS. For this, from the project coordinator experience, it was necessary to reflect, discuss and learn the proposed theme in order to provide the subject of the service a healthy and consistent interaction with their moral values and customs.

CT is understood as a complementary practice that is within the community from the participation of various areas that comprise forming a network of knowledge that enables by unpredictability and creativity dialogue problems, concerns and solutions inherent to all individuals who are inserted in this activity.¹⁰

Through CT, it is sought to perform an individual suffering reflection caused by the stressful situations or any others that interfere with their health condition. In that sense, it is sought to promote health in collective places, valuing the life stories of individuals, the restoration of self-esteem and self-confidence, rescuing the identity, allowing the individual to become autonomous and independent and to promote awareness of the difficulties and possibilities of solving through local skills.^{10,21}

Participants performed the CT in CAPS as an action that would strengthen relationships between professionals, family members and patients entered in CAPS. First, the reception with music and presentation of the participants was done. Then, the community therapist realized the dynamics of transformation through butterflies figures encouraging reflection on the challenges, problems, difficulties and obstacles that are faced in everyday life of each subject. After, there was reading a poem that sparked concerns about the contributions the participants as subjects of change has made actions that transform the reality around them. Finally, the circle training with the link of practitioners through the embrace

encouraged the relevance of each other in the life of each individual and how a simple act strengthens people's lives.

CT offers a look back to the collective, stimulating the recovery of citizenship and encouraging the empowerment process. It is a space based on the sharing of experiences, allowing them to build social networks to promote the life, culture and the appreciation of each individual's skills. The therapy meetings weave support networks and awaken change possibilities.²²

Given the above, to address this issue in CAPS was essential to support the development of new participatory methodologies in this space, although this action represents a new approach for patients, families and professionals, it was also characterized as an approaching tool between patient/family/service.

It is necessary to show that the invisibility of this family service is a challenge for professionals, given the need to build strategies to meet this relative who suffers mentally along with his family.

Promoting extension actions in the context of mental health corroborates the challenges facing the anti-asylum model proposing the autonomy and independence of the subjects favoring their inclusion in the community and strengthen the construction of links between patient/family/service, enabling the professional future reflect on the particularities health services and introducing the university in community spaces providing the exchange of knowledge and expertise stimulating the autonomy of the individual.

CONCLUSION

This extension action proposed to help and encourage changes needed in this area assisting practices in mental health. However, most professionals justify its difficulty to work with psychosocial care due to lack of inputs, incentives of managers, in addition to knowledge deficit, due to failures in the training process, which implies the lack of preparation and poor working conditions.

The change process becomes complex, reducing the possibility of professionals perceive as subjects of their work and consequently also share responsibility for quality of care offered to patients of that institution. In this condition, it is unlikely a rise of care and skilled attendance for all patients supported by this support network.

CAPS constitutes a support space and support to patients and families in psychological distress, implying constant

demands of intellectual investment, financial, which must be commitment and practical skills with regard to mental health, as well as understanding the importance of multidisciplinary work as facilitator of the work process and health care multiplier.

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