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ORIGINAL ARTICLE

INTENTIONS OF COMMUNITY HEALTH AGENTS ON THE MENTAL HEALTH ACTIONS

INTENÇÕES DE AGENTES COMUNITÁRIOS DE SAÚDE SOBRE AS AÇÕES DE SAÚDE MENTAL

INTENCIONES DE AGENTES COMUNITARIOS DE SALUD SOBRE LAS ACCIONES DE SALUD MENTAL

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ABSTRACT

Objective: to understand the intentions of the Community Health Agents (CHA) on mental health actions in the Family Health Strategy (FHS). ***Method***: qualitative study, supported on the references of phenomenological sociology. Semi-structured interviews were conducted with 10 CHA of two Porto Alegre FHS units *RS, Brazil, in 2010. The comprehensive analysis for the interpretation of concrete category was used to improve the patients´ life situation. ***Results***: the main mental health actions undertaken were listening, guiding, home visits, identify and track cases, and refer to the unit of the FHS and other services outside the area. The relational aspect of actions appears as a key element to all of them. ***Conclusion***: CHA intends to improve the patients´ life situation when performing the mental health services, especially through an inter-subjective relationship with patients and families. ***Descriptors***: Mental Health; Primary Health Care; Family Health Program; Family; Nursing.

RESUMO

Objetivo: compreender as intenções de Agentes Comunitários de Saúde (ACS) sobre as ações de saúde mental na Estratégia Saúde da Família (ESF). ***Método:*** estudo de abordagem qualitativa, apoiada no referencial da Sociologia fenomenológica. Foram realizadas entrevistas semiestruturadas com 10 ACS de duas unidades de ESF de Porto Alegre/RS, Brasil, em 2010. Utilizou-se a análise compreensiva para a interpretação da categoria concreta melhorar a situação de vida do usuário. ***Resultados:*** as principais ações de saúde mental realizadas foram escutar, orientar, realizar visita domiciliar, identificar e acompanhar casos, bem como encaminhar para a unidade da ESF e outros serviços fora da área. O aspecto relacional das ações aparece como um elemento fundamental a todas elas. ***Conclusão:*** o ACS tem a intenção de melhorar a situação de vida do usuário ao realizar ações de saúde mental, principalmente por meio de uma relação intersubjetiva com os usuários e famílias. ***Descritores:*** Saúde Mental; Atenção Primária à Saúde; Programa Saúde da Família; Família; Enfermagem.

RESUMEN

Objetivo: comprender las intenciones de Agentes Comunitarios de Salud (ACS) sobre las acciones de salud mental en la Estrategia Salud de la Familia (ESF). ***Método:*** estudio de enfoque cualitativo, apoyado en el referencial de la Sociología fenomenológica. Fueron realizadas entrevistas semiestruturadas con 10 ACS de dos unidades de ESF de Porto Alegre *RS, Brasil, en 2010. Se utilizo un análisis comprensivo para la interpretación de la categoría concreta para mejorar la situación de vida del paciente. ***Resultados:*** las principales acciones de salud mental realizadas fueron escuchar, orientar, realizar visita domiciliar, identificar y acompañar casos, y encaminar para la unidad de la ESF y otros servicios fuera del área. El aspecto relacional de las acciones aparece como un elemento fundamental a todas ellas. ***Conclusión:*** el ACS tiene la intención de mejorar la situación de vida del paciente al realizar acciones de salud mental, sobre todo por medio de una relación intersubjetiva con los pacientes y familias. ***Descriptores:*** Salud Mental; Atención Primaria de Salud; Programa de Salud Familiar; Familia; Enfermería.

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INTRODUCTION

The Family Health Strategy (FHS) guides the reorientation of the health care model in Brazil, to overcoming the traditional model, centered on the disease and the hospital, to a model focused on the patient and a diversified service network, which is operated according to the demands and needs of the patient.

The FHS is a fair policy in the sense that seeks to reduce socioeconomic differences in access to health services the primary care.[1] The FHS comes as a government strategy for the restructuring of primary health care and health care models of the Single Health System (SUS). An innovative feature of the FHS is its emphasis on the reorganization of clinical primary care focused on families and communities by integrating health promotion, prevention and attention to public health.[2] In this context, the Community Health Agent (CHA) appears as a promoter of care in the territory, the main prerogative to favor the link between health services and the people of the geographical area covered by him.

The actions in the mental health area in primary care are being reshaped and made more widely in recent years. However, the CHA has not demonstrated the acquisition of broader perceptions of mental health and psychological distress for their daily practice.[3]

In addition to the mental health issues facing the CHA, the problems that he tries to live in the area (substandard housing, scarce public services and high vulnerability of the population) are intensified in contact with people in distress situation and social vulnerability.[4]

The CHA is viewed as a strategic professional in the context of the FHS, particularly in the mental health area because he knows part of the story of the families in the community. Thus, he tries to deal more continuously with cases of greater vulnerability[(5)]; he lives close to the patients and has gained experience in identifying the disease and the changes in behavior of people in their day-to-day[6]; he knows cases of drug users accompanying them through home visits and other activities[7]; and he has sensitivity and skills to deal with everyday situations, which go beyond health issues, often using the use of soft technologies - receptiveness and bond - even if sometimes happen in a fragmented way.[8] With this, the CHA and the FHS professionals are intended to meet the needs expressed by patients acting on their health conditions, reflecting the improved quality of life.[8]

It is common to note that there are potential resources to be used in the FHS that is not yet recognized in some contexts, such as mental health resources in the mental health actions may include: monitoring, involvement and availability; recognition of the health needs of the patient, families and communities; prevention efforts and partnership with specialized services; the ability to listen and dialogue; providing assistance in situations of risk and; the building of trust and respect bonds. This invisibility has reinforced the sense of failure, impotence and incapacity for mental health care in the FHS.[6]

These aspects reveal the need for convergence of knowledge, both popular as scientific, for the effectiveness of mental health policies, especially in primary care[1] enhancing dialogue between popular knowledge and scientific knowledge, and dialogue between very different experiences of life.[9]

The role of the CHA has an important contribution to the mental health care within the FHS since he deals with situations of life. In addition to epidemiological and programmatic actions in health, given from their health surveillance role, the CHAs perform many actions in favor of health promotion in general and mental. Faced with this, it is important to investigate the CHA intention to carry out mental health activities in their day-to-day work. Such research can broaden and deepen the understanding of mental health actions in the context of the FHS and reveal the reasons why the CHA perform these actions in their day-to-day work.

OBJECTIVE

- To understand the intentions of the Community Health Agents (CHA) on mental health actions in the Family Health Strategy (FHS).

METHOD

A qualitative study using the phenomenological sociology reference of Alfred Schutz, which allows the understanding of the meaning of social action for individuals who perform it, revealing their motivations, the reasons for their actions. A perspective that can only be expressed by actor action as an action in progress or to the future is possible to reveal the reasons for his action; that is their intention to do it in the social world.

From the identification of action reasons, there are typical characteristics of this action of a group of individuals who share similar characteristics within the context of the social world. This description is set in the typical action[10] of these subjects, showing the essence of the meaning of their actions in relation to the phenomenon, which in this study they are the CHA intentions regarding the mental health services.

This study was conducted in two FHS units located in Porto Alegre; the Rio Grande do Sul. Semi-structured interviews were conducted with 10 CHAs in May and June 2010, using the guiding questions: What actions for mental health are you developing in FHS? What is intended with these actions? Subjects were included who were part of the functional service reference and were acting in it for at least six months.

All participants signed a consent form before the interview. This study was approved by the Ethics in Research of the Municipal of Porto Alegre Health Committee (number 001.015735.10.9).

The interviews were recorded and transcribed for analysis and interpretation, and the closure of conducting new interviews took place at the time was observed saturation characterized by the repetition of the answers of respondents. To preserve their anonymity the letter "A" was used followed by sequential number according to the interviews (A1 to A10).

For the organization, categorization and phenomenological analysis of the results, the following steps were used[11-2]: a sequential, detailed and exhaustive reading of the interviews, trying to identify the significance of the action units, grouping them according to their similarities, configured in specific categories of lived action. This process, from the emergence of meanings of the action and identification of experienced concrete categories of action, involving the identification of the reasons for the subjects to perform mental health actions in the FHS, converging to the description of the typical characteristics of the significance of the action (the typical action of the CHA).

RESULTS AND DISCUSSION

Analyzing the experience of the CHA in the phenomenon under study, it was possible to identify the mental health services expressed by them in the FHS, such as listening, guiding and monitoring; home visits, identify cases, refer to the health unit and other health services. These actions appear intermixed with their intentions in performing them, thus revealing the significance of these actions. Thus, it is apprehended that the reasons for the CHA, is essentially the typical intention of improving the patients´ life situation through different actions by setting up as the particular type of study, presented below.

♦ Improving the patients' life situation

In general, it is understood that the intention of the CHA aims to provide the patients space to talk about their troubles, offering treatment and improving their situation of social life and health. In this study, the CHAs consider listening to an important mental health action, which takes place at home and in the street, this because they have "more time to work on the street" compared to other FHS professionals.

> *As an agent, there is more time to work on the street, so I think we do a lot of things [...]. More frequent visits. (A1)*
>
> *I first signal the most serious problems, so I do these, then I make the most of the day-to-day [...]. So the visit I usually do it. (A2)*
>
> *Mental health work we do is almost the same thing you do for others because we do visit for them even if they have a mental problem. (A3)*
>
> *Along the residence, I am more as a listener. (A4)*
>
> *Usually, we come to the house and ask how the person is feeling. (A5)*

Listening to the people and carrying out home visits are the main mental health actions carried out by the CHA. Home visits are carried out monthly for each family and, as the CHA notes situations involving risks for the patient, when with some families with members in psychological distress, he establishes priorities to accomplish them.

The home visit is a more common activity of CHAs favoring the professional to build a dialogue with the patient, to meet the family's needs and assist in solving the identified problems, especially when the family faces some difficulty, requiring professional listening, guidance and information to minimize the problems highlighted.[8]

This care action allows the professional circling often in the "world" in which the family lives,[8] strengthening the joint of the CHA between the health team and the community. Also, being in frequent contact with families, on the street or in their homes, benefits the work of surveillance and health promotion, especially of individuals and families in vulnerable situations, as often happens when there is psychological distress.

During the home visit, the relationship built between the patient and the health

professional in a dimension of listening and exchanges gains space for strengthening the receptiveness and bond based on technologies in health.[8]

The CHAs listen with the intention of encouraging moments for the patient talks and relieves his anxieties by exposing his problems and difficulties experienced. Being available for the patients, trying to understand them, contribute to the improvement of their situation.

> *You start talking and let them talk; we listen to them first, and sometimes when we leave, they are now much more peaceful, much relieved. (A2)*
>
> *We will visit them [...] see the situation, type of house, the house, see how the experience of it, the food, where he gets it and how he prepares it. (A3)*
>
> *When I hear them, I think it is an outlet for them [...] feel better talking, exposing the problems. (A4)*
>
> *The fact of you being someone who gives attention seems to help the person to unload some of that anxiety, that difficulty [...] it makes a difference having someone listen and to understand or try to understand. [...] Listen to the patient and try to soften. In any context, not only in mental health, if you have a sick family member around, the whole family and neighbors have just achieved. (A8)*

It is common to note that in the CHA work, listening proves to be more important than to have health information at any given time. This often occurs with people who manifest need and expect someone to listen and offer them simple and meaningful advice to alleviate their anguish and suffering. It is, therefore, important that the CHA performs educational and preventive actions in the community, but also listening actions and dialogue, and working towards the host and the construction bond.[8]

Being available for the other, being open to an inter-subjective relationship, prints this relationship an authentic character of interest to the CHA by the experienced situation of the user. Thus, it is evident that the CHA intends to provide the patient with space for a direct social relationship, the face to face,[10] because they share experiences in the same space (home and/or street) and one point of their life.

The expansion of the degree of familiarity in this relationship between the subjects is favored by the fact that CHA is a resident of the area in which he works because, they know, experience and possibly share values, beliefs, languages, traditions and customs of the majority of people in that community in which they lives.

The phenomenological sociology shows that the mere hearing conducted by CHAs turns into an authentic listening to the patients because this intersubjective relationship he perceives, in a personal way, the terms of the experiences of patients as well as their expressed demands. Attracting patients´ uniqueness of nuances allows CHA to identify their needs and establish an empathic process with the intention of understanding the situation experienced by the other and then act on it.

This familiarity in the face to face relationship implies that enhances mutual apprehension of subjectivities involved[10], allowing recognition and understanding of the needs expressed by the patients. This relationship allows the seizure of the other in their individuality, experienced in the form of a relationship of *we*[10], the opposite of indifference to each other.

Although the listening is recognized as a mental health action used by the CHA, there are lines which are reflected some frustration with it, weakening its power as care action, and revealing ambiguity about its importance.

> *In addition to listening and guide, I know, I have no other action. (A1)*
>
> *As agents we do not have much to do [...] is basically to listen to them. (A2)*
>
> *All I have to offer is to encourage conversation. (A6)*
>
> *It is what we provide only guidance and conversation. (A8)*

Often the relational aspect of the CHA work generates wear, especially in situations where he feels affected by what he heard from the patient and family, without having been able to resolve the questions raised by them.[4] Many times, this situation affects negatively the results achieved by listening, which ends up being underestimated by the CHA.

In this way, knowing how to listen to people and have time for this, enriches the CHA work and value their profession.[8] Therefore, it is important to discuss ways to enhance this listening and make it more efficient in the CHA routine, since he uses this form of communication as the primary means of interaction with others. Among other possibilities therapeutic communication and social skills training can contribute to this professional development since these references structured social interaction techniques for a more assertive human relationship.

On the other hand, while the CHA recognizes listening as an action that alleviates unpleasant feelings experienced by the patients, he ignores when he observes that it is not as effective as he would like.

> *I would like to settle, solve their problems [...]. That's my goal, trying to solve and find the way out for them. (A4)*

It is common to observe that the CHA listens to the problems of patients and families and almost always finds it difficult to devise strategies that can be resolutive[8], often feeling overwhelmed by situations that cannot solve on their own.[4] This feeling of dissatisfaction causes the CHA feeling unprepared to deal with the patient because the listening offered does not seem to be sufficient to provide the improvement of the patient´s situation, as they like.

The CHA is an FHS team member that does not have specific training in health, which justifies the need for the introductory course for their work. However, it does not invalidate the need for specific training (technical course) given the complexity the work done in the territory.[9]

Interventions in the mental health area has been transformed in recent years towards the meanings of Psychosocial Attention (attention to the subject in psychological distress and strengthening a care network), but CHA perceptions are still guided in the popular imagination of the asylum model (disease/ill and psychiatric hospital), the broader concept of mental health poorly understood and applied in daily practice.[3] This occurs even in situations where the CHA recognizes the difficulty of putting into practice the knowledge acquired in courses, training, and continuing education activities in the mental health area.[9]

To question the actions of mental health used by the CHA in the territory involves expanding the discussion beyond the technical dimension of work, also incorporating other dimensions, such as policy and management. This appears in a study[9] to recommend that the CHA understands the model of mental health care (humanization, completeness, and inter-sectoral work), health policy, planning, information and health education; for the discussion of these issues have generated changes, both about work and about his own life.[9]

However, it has been recommended to overcome the traditional ways of professional training processes, usually supported only in identifying and correcting flaws in the work process emphasizing the error and unconformity in favor of a working logic with groups adopting a listening sensitive to the resources already possessed by the team, their qualities and success and stories of overcoming, rather than strengthen their weaknesses and failures. It is understood that helping the team in recognizing and naming resources and skills hitherto not recognized as such from their narrative possibilities; there is a view to transforming realities experienced as problematic and challenging, favoring the help to patients extending their narratives and building new ways of relating to the everyday problems.[6]

CHA qualification of the importance of their work in general and specific reference for mental health, and about the impact of their actions on people´s lives, no matter how specific they may be, need to be recognized and valued by the FHS team. This is because the improvement of their work takes place continuously and must be articulated to the FHS staff and other services within and outside the health sector, for, in a shared and cooperative attitude, to respond concretely to the complexity of the needs of people in psychological distress.

Contact with people provides opportunities to CHA listening, knowing and identifying cases and/or situations involving psychological distress and mental disorders. This identification occurs by collecting data and information that is communicated to the FHS team in the formal moments (team meetings) and informal moments (any time of daily work).

> *[...] Collecting data, providing information [...]. I see that is too much, you are at risk, go to the emergency [psychiatric] the health center to have the first call. (A1)*
>
> *[...] we go to visit [...] communicating the FHS team [...] invite to go to the health center, notifying the family for him to take it [...] we bring the meeting Friday, or if not, already brings to the nurse, the doctor. (A3)*
>
> *We come to talk to the doctor [...]. The nurse goes with us to the place [...] If it's a weekend calls for the direct lead to the heaçth center. (A5)*
>
> *Our job is to identify what is going on [...]. I step to the team [...] I reported for X [nurse] and she had an appointment for Z [medical]. (A7)*
>
> *Sometimes we see the need and sends them to the emergency. (A8)*

Thus, during the meetings between the patient and the CHA, it is established an attentive listening, allowing identify cases that require the team´s attention, then being communicated, especially to the doctor and the nurse, or even sending them to the service

at the FHS and other health services, according to the view of the CHA.

The ability to identify the subjects and meet more closely the cases of psychological distress are important features of the CHA about mental health care in the FHS, taking him to act empirically and to request assistance from the FHS professionals.[13]

Family members are activated and engaged by the CHA especially in times of patients referrals to the BHU or other health services, emphasizing their intention to offer treatment to the patient, through actions in the area of FHS (such as listening, guidance, case management, home visits and referral to the FHS team) and outside the area, mainly by referral to other health services.

Referrals to other services occur when the CHA notes the need and the risk presented by the patient, especially on the weekend when the BHU is closed. Often, when patients and their families face some difficulty related to health problems in general and mental health, the CHA is sought, as he recognizes as a different subject in that context, act in a health service and serve as a reference for them.

This search also occurs due to bond and trust built between them, through an inter-subjective relationship of familiarity[10], where there is proximity, listening, and recognition of the lived experience of patients and their families. The proximity allows people to monitor closely their difficulties (physical and emotional) experienced, working as a lifeguard in many situations, and prevent their escalation. This is only possible when they know the people they care and won the recognition.[6]

While care technology, bonding favors proximity and strengthens the working relationship between the CHA and the family, making the patients feel more confident to report the difficulties and risks they are exposed, allowing they to be serviced in their entirety. This bond can be understood as a relationship of friendship, trust, responsibility and commitment established with most families.[8] Through this bond, the CHA perceives situations of suffering and can carry out their actions, by improving listening and referrals, revealing their potential.[4]

The CHA is a professional who is closest to the population, because he resides in the same neighborhood, serving as a link between the community and the health service. He establishes a relationship with the community, possibly feeling being valued, particularly by ensuring the community health and being as a reference for people[14], helping them to overcome situations of suffering faced by them.

> *We expect the best for all, to recover and to be treated. (A3)*
>
> *I hope they have adequate care. [...] I hope you can help in any way. (A6)*
>
> *They [people with mental illness] can make the right treatment. (A9)*

With these actions, the CHA intends to provide patients with treatment appropriate in both FHS and specialized services, compared to the identified needs of patients which require a careful approach that spill over the FHS team response capabilities and planning services.

The CHA strategic role is the search for a better Single Health System and a more fair society, translated by their community desire for change where they live, through practices aimed at improving the lives of the local population, which is also the life of the CHA.[15-6] By sharing the geographic and existential territory of that community, the CHA favors the production link.[7]

It is observed that the use of themselves is the main CHA working tool, which seeks to achieve their intentions by conducting mental health actions eminently intersubjective character among which stand listening, home visits and orientation/counseling.

Thus, the willingness to establish a relationship face to face intersubjectively is constantly required to CHA in their daily work. In phenomenological sociology, this requirement demands to mobilize their stock of knowledge at hand[(10)], given from his biographical situation, emerging from the lived experience and knowledge accumulated throughout life, at that time and context, design and carry out actions order to help the user improve their life situation.

Overall, the improvement desired by the CHA in this study relates to aspects of health and social. In the context of health, he hopes to prevent user crises, avoiding that endangers their physical integrity by monitoring the use of medications and the frequency consultations at FHS.

> *Checking medications, if they are not taking wrong, see how long does that person was consulted. (A2)*
>
> *Always be looking for help before the worst happens, anticipate things. (A5)*
>
> *Medication guide as to the frequency, schedule, and track how's the prescription. (A8)*
>
> *Monitoring, see if they are taking the right medication if they are not missing. (A9)*

The professionals of the FHS, including the CHA work hard to build bonds of trust and

respect as resources for mental health care, involving monitoring the health status of patients and the use of psychotropic medication.[6] CHA insertion in the community every day allows knowing the reality of life, committing him to seek the improvement of health conditions in her community, thus impacting on quality of life.[8]

In the social, the CHA hopes to minimize problems related to drug use and the world of crime, improving relationships between family members, and promoting sociability among people, hiking, and groups.

> *Giving better quality [of life] so that they can live a little better. For example, leaving more room, going on a walk, going on a tour, bringing them to the group [...] is a way for them to leave the house to talk to other people. (A2)*
>
> *There, if we can [...] take two or three a bad thing, drug addiction, drink, bad way, of the criminal world, for us is a victory. (A7)*
>
> *We try to seek agreement among them because it has a lot of friction within families. (A8)*

In the context of the FHS, the CHA also intends to their mental health actions mediate relationships between family members, and promote the construction of autonomy of patients.[4] This mediation is especially true in family conflict situations, where the CHA plays an intermediary role in the resolution of the conflict, even if no specific training for this, often relying on their life experience and the experiences of daily work.

The autonomy of patients is also sought by the CHA, as they provide these spaces of socialization, seeking to break with social isolation, and to prevent or minimize the use of drugs and involvement in situations of violence, crime, and trafficking.

In situations involving the care of drug users in the FHS, for example, it is necessary to diversify the supply of actions and activities that promote continuity of care at this level of attention, as well as establishing partnerships with other sectors, providing opportunities strategies, social (re) integration of patients (further education, professional training, conducting courses) in a broader, interdisciplinary dimension.[7]

Although important initiatives for the care of people in the community, these actions still need to be diversified within the FHS, expanded and articulated to other departments and sectors of society beyond the health sector, such as education, culture, sports, among others. This construction should be consolidated in the micro-scope of work in the FHS team, founded by the epidemiological profile of health indicators, and above all the need and desires of people who should read this carefully.

FINAL REMARKS

The convergence of the reasons for the CHA group expressed in the concrete category of living improve the patients´ life situation, revealing the significance of the action, becoming like the typical action, namely intentionality in common the CHA to perform mental health actions in the FHS. Therefore, typically, when the CHA group performs listening, guidance, monitoring and home visits; when identifying cases and refer them to the unity of the FHS or other health services, the group's intentionality improves the patients´ life situation, welcoming them in times of suffering, offering treatment inside and outside the FHS for improving their health status (preventing crises, monitoring the use of drugs and frequency consultations) and their social situation (trying to minimize problems related to drug use and the world of crime).

Thus, this study achieved its objective to understand the CHA intentions to conduct mental health actions in the FHS, by identifying the meaning of the action and typical description of the ACS group action, showing his usual intention to hold such actions.

These mental health actions encompassed: listening, guiding, making home visits, identify and track cases, and refer to the FHS unit and other services outside the area. The relational character of the actions appears as a fundamental aspect to all of them, especially in the actions of listening, guiding and conducting home visits, because they involve the greater availability of CHA to relate socially with patients and families.

Listening and home visits are the main mental health actions carried out by the CHA. However, listening proved ambiguously to the CHA, in that it recognizes as an action that alleviates unpleasant feelings experienced by patients, but at the same time, it is not as effective as they like. This situation has generated frustration and dissatisfaction feeling in CHA, causing him to feel unprepared to deal with the patient, so that, in fact, promote the improvement of their living situation.

It is necessary to invest in the development of relational skills of the CHA since the use routinely in their work, as demonstrated in the study, with the intention of a) favoring moments of confidences and minimize user suffering; b) understanding the family history

of life; c) recognizing the health needs of the family; d) providing a better response to the health demands of users and family.

The CHA intends to improve the patients´ life situation when performing the mental health services, especially through an inter-subjective relationship with patients and families. This study reflects the understanding of a social group in a given context, and can be compared to other similar contexts, with no claim to generalize their findings. These findings raise the further studies on how this interaction takes place on the day-to-day through other data collection techniques such as observation and focus groups to capture nuances of this relationship that the interview does not reveal.

REFERENCES

1. Andrade MV, Noronha K, Barbosa ACQ, Rocha TAH, Silva NC, Calazans JA et al. A equidade na cobertura da Estratégia Saúde da Família em Minas Gerais, Brasil. Cad Saúde Pública [Internet]. 2015 [cited 2015 Jan 20];31(6):1175-87. Available from: http://www.scielosp.org/scielo.php?script=sci_arttext&pid=S0102-311X2015000601175

2. Paim JS, Travassos CMR, Almeida CM, Bahia L, Macinko J. The Brazilian health system: history, advances, and challenges. Lancet [Internet]. 2011[cited 2015 Jan 20];377:1778-97. Available from: http://www.sciencedirect.com/science/article/pii/S0140673611600548

3. Cabral TMN, Albuquerque PC. Saúde mental sob a ótica de Agentes Comunitários de Saúde: a percepção de quem cuida. Saúde Debate [Internet]. 2015 [cited 2015 Jan 20];39(104):159-71. Available from: http://www.scielo.br/pdf/sdeb/v39n104/0103-1104-sdeb-39-104-00159.pdf

4. Moura RFS, Silva CRC. Saúde Mental na Atenção Básica: Sentidos Atribuídos pelos Agentes Comunitários de Saúde. Psicologia: ciência e profissão [Internet]. 2015 [cited 2015 Jan 20];35(1):199-210. Available from: http://www.scielo.br/scielo.php?script=sci_arttext&pid=S1414-98932015000100199

5. Nunes M, Jucá VJ, Valentim CPB. Ações de saúde mental no Programa Saúde da família: confluências e dissonâncias das práticas com os princípios das reformas psiquiátrica e sanitária. Cad Saúde pública [Internet]. 2007 [cited 2015 Jan 20];23(10):2375-84. Available from: http://www.scielo.br/pdf/csp/v23n10/12.pdf

6. Ribeiro MOP, Caccia-Bava MCGG, Guanaes-Lorenzi C. Atenção à saúde mental na estratégia saúde da família: recursos não reconhecidos. Psicologia USP [Internet]. 2013 [cited 2015 Jan 20];24(3):369-90. Available from: http://www.scielo.br/scielo.php?script=sci_arttext&pid=S0103-65642013000300002

7. Schneider JF, Roos CM, Olschowsky A, Pinho LB, Camatta MW, Wetzel C. Atendimento a usuários de drogas na perspectiva dos profissionais da estratégia saúde da família. Texto Contexto Enferm [Internet]. 2013 [cited 2015 Jan 20];22(3):654-61. Available from: http://www.scielo.br/scielo.php?pid=S0104-07072013000300011&script=sci_arttext

8. Carli R, Costa MC, Silva EB, Resta DG, Colomé ICS. Acolhimento e vínculo nas concepções e práticas dos agentes comunitários de saúde. Texto Contexto Enferm [Internet]. 2014 [cited 2015 Jan 20];23(3):626-32. Available from: http://www.scielo.br/pdf/tce/v23n3/pt_0104-0707-tce-23-03-00626.pdf

9. Bornstein VJ, David HMSL. Contribuições da formação técnica do agente comunitário de saúde para odesenvolvimento do trabalho da equipe saúde da família. Trab Educ Saúde [Internet]. 2014 [cited 2015 Jan 20];12(1):107-128. Available from: http://www.scielo.br/scielo.php?script=sci_arttext&pid=S1981-77462014000100007

10. Schutz A. Sobre fenomenologia e relações sociais: textos escolhidos de Alfred Schutz. Rio de Janeiro: Vozes; 2012.

11. Machineski GG, Schneider JF, Camatta MW. The experience lived by clients' family members of a child psychosocial care center. Rev Gaúcha Enferm [Internet]. 2013 [cited 2015 Jan 20];34(1):126-32. Available from: http://www.scielo.br/scielo.php?script=sci_arttext&pid=S1983-14472013000100016

12. Jesus MCP, Capalbo C, Merighi MAB, Oliveira DM, Tocantins FR, Rodrigues BMRD et al. A fenomenologia social de Alfred Schütz e sua contribuição para a enfermagem. Rev Esc Enferm USP [Internet]. 2013 [cited 2015 Jan 20];47(3):736-41. Available from: http://www.scielo.br/scielo.php?pid=S0080-62342013000300736&script=sci_arttext

13. Consoli GL, Hirdes A, Costa JS. Saúde mental nos municípios do Alto Uruguai, RS, Brasil: um diagnóstico da reforma psiquiátrica. Cienc Saúde colet [Internet]. 2009 [cited 2015 Jan 20];14(1):117-28. Available from: http://www.scielo.br/scielo.php?pid=S1413-81232009000100017&script=sci_arttext

14. Jucá VJS, Nunes MO, Barreto SG. Programa de Saúde da Família e Saúde Mental: impasses e desafios na construção da rede. Cienc Saúde colet [Internet]. 2009 [cited 2015 Jan

20];14(1):173-82. Available from: http://www.scielo.br/scielo.php?script=sci_arttext&pid=S1413-81232009000100023

15. Menegussi JM, Ogata MN, Rosalini MHP. O agente comunitário de saúde como morador, trabalhador e usuário em São Carlos, São Paulo. Trab Educ Saúde [Internet]. 2014 [cited 2015 Jan 20];12(1):87-106. Available from: http://www.scielo.br/scielo.php?script=sci_arttext&pid=S1981-77462014000100006

16. Canário DDRC, Costa e Silva SP, Costa FM. Knowledge and practices of community health agents about hansen's disease. J Nurs UFPE on line [Internet]. 2013 [cited 2015 Jan 20];8(1):1-7. Available from: http://www.revista.ufpe.br/revistaenfermagem/index.php/revista/article/viewFile/4952/pdf_4369

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