

ORIGINAL ARTICLE

What is the key element in the Psychosocial Care Network of a municipality in Minas Gerais?

Qual o elemento central na Rede de Atenção Psicossocial de um município de Minas Gerais?

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ABSTRACT

The objective was to identify, through the Social Network Analysis, the key element of the Psychosocial Care Network of a municipality in Minas Gerais and to establish relationships of such centrality with the profile of workers. Quantitative study carried out with 162 workers. A self-administered questionnaire and a matrix on services were used. Descriptive analysis and Social Network Analysis were performed to calculate the centrality and preparation of the network map. The psychiatric hospital assumed centrality in the studied network. The length of experience in the field, education and care function of the professionals influenced the knowledge of extra-hospital services. It was concluded that the centrality of the psychiatric hospital highlights the need to redefine the care model that supports the practice of professionals. In this sense, it is understood that the densification of workers' social capital and the use of management instruments would contribute to a greater articulation of the Psychosocial Care Network.

Descriptors: Mental Health Services; Patient Care Team; Health; Interdisciplinary Communication.

RESUMO

Objetivou-se identificar, pela Análise de Rede Social, o elemento central da Rede de Atenção Psicossocial de um município de Minas Gerais e estabelecer relações de tal centralidade com o perfil dos trabalhadores. Estudo quantitativo realizado com 162 trabalhadores. Utilizou-se questionário autoaplicável e uma matriz sobre os serviços. Empreendeu-se análise descritiva e a de Rede Social para o cálculo da centralidade e confecção do mapa de redes. O hospital psiquiátrico assumiu centralidade na rede estudada. O tempo de atuação na área, escolaridade e função assistencial dos profissionais exerceram influência em relação ao conhecimento dos serviços extra-hospitalares. Concluiu-se que a centralidade do hospital psiquiátrico assinala a necessidade de ressignificação do modelo de atenção que sustenta a prática dos profissionais. Neste sentido, entende-se que o adensamento do capital social dos trabalhadores e o uso de instrumentos de gestão contribuiriam para maior articulação da Rede de Atenção Psicossocial.

Descritores: Serviços de Saúde Mental; Equipe de Assistência ao Paciente; Saúde; Comunicação Interdisciplinar.

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INTRODUCTION

Current health policies have emphasized the importance of articulating the different services for the effectiveness of comprehensive care. In the field of mental health, national efforts to establish the Psychosocial Care Network (Portuguese acronym: RAPS) are in line with the recommendations of international health agencies for the establishment of community-based services, articulated with the other health and social protection devices of territories^(1,2).

Studies on mental health services and professionals have been widely developed both nationally and internationally. They have analyzed the population coverage of such services and resources⁽³⁾; the question of financing, intersectorality, participation and equity of access⁽⁴⁻⁶⁾; the evaluation of community-based services⁽⁷⁾; assistance flows⁽⁸⁻¹⁰⁾; the training of human resources⁽¹¹⁾; history, theoretical bases and recommendations related to mental health care services and professionals⁽¹²⁻¹⁴⁾.

Therefore, a consolidated body of situational diagnoses, references and recommendations related to services and the mental health network is identified. However, despite the increasing investment in expanding community-based mental health services, several authors⁽⁸⁻¹⁴⁾ have pointed out the issue of articulated functioning and/or in the perspective of the network as a challenge both at the national and international levels⁽¹⁰⁻¹³⁾.

In this sense, there is a gap in studies related to the identification of mental health services that have assumed centrality in the care networks. The Brazilian legislation dealing with such services recommends that the Psychosocial Care Centers assume a key role in the RAPS, acting as coordinators of care. It is considered that such centrality is decisive for better articulation between the various devices and services as well as for guaranteeing access and continuity of care throughout the therapeutic trajectory of users with emotional distress or mental disorder^(2,9,12). In this perspective, the identification of the institutions that have assumed centrality in the networks can contribute both to the understanding of how mental health policies have been implemented in different regions of the country and to improve the interaction between services⁽⁹⁾.

Thus, the objective of the present study was to identify, through the Social Network Analysis, the key element of the RAPS of a municipality in Minas Gerais and to establish relationships of such centrality with the profile of the network's workers.

METHOD

This is an exploratory descriptive study using quantitative approaches.

The municipality studied is located in the state of Minas Gerais, in the southeastern region of Brazil, and was intentionally selected for being the headquarters of an expanded health region, for having started the implementation of substitute services in the 1990s and for having several points in the network of mental health care. The municipality is one of the 10 most populous in the state, with an estimated 330,000 inhabitants in 2018, according to the Brazilian Institute of Geography and Statistics (IBGE). Of the devices recommended by Ordinance No. 3,088/2011, the only points of care not yet constituted at the time of data collection were the community center and the adult and children and youth reception units⁽²⁾.

The specialized services that comprised the municipal RAPS were: a psychiatric hospital, two adult type II Psychosocial Care Centers (Portuguese acronym: CAPS), one AD III CAPS (Alcohol and drugs), one CAPSi (children and adolescents), five Therapeutic Residential Services (Portuguese acronym: SRTs), a team from the Street Clinic (Portuguese acronym: CR) and a team from the Mental Health Matrix (Portuguese acronym: MSM).

The RAPS had, at the time of data collection, 223 workers, about 54% of whom were health professionals (nurses, nursing assistants and technicians, doctors, pharmacists and physiotherapists); 24%, workers with a support function (cooks, kitchen assistants, general services, administrative assistants, watchmen); and about 21%, psychologists, occupational therapists and social workers.

The involvement of workers with a support function in the research was due to their magnitude (24% of the workforce), the lack of studies with these professionals⁽¹⁵⁾. The involvement of workers with a support function in the research was due to their magnitude (24% of the workforce), the lack of studies with these professionals⁽¹⁶⁾ they have.

To involve the wide range of professions and functions present in the RAPS, the inclusion criteria were: being over 18 years old; work in a mental health institution or program affiliated to the Unified Health System (Portuguese acronym: SUS), regardless of employment relationship, function or education. Workers who were removed from their duties due to health or vacation reasons were excluded from the study.

The recruitment of participants took place in two stages. Initially, the coordinators of the institutions scheduled meetings to present the research. In the case of the Street Clinic and Mental Health Matrix programs, the meeting took place at the Secretariat of Health. Then, there was an individual invitation to participate.

Of the 223 workers, two were on maternity leave, six on vacation and eight on sick leave, resulting in 207 eligible. The percentage of refusal of the eligible was 21.7%. Thus, the study sample was composed of 162 workers.

For the collection of sociodemographic data (gender, age, marital status, color, religion), professional training (education, technical, undergraduate and graduate courses) and work in the health field (institution, function, employment relationship, weekly workload, length of experience in the health field, in the mental health field and in the institution), a self-administered questionnaire, prepared by the team, was used. In addition, a matrix was built with all services on the network so that the participant could signal which of these he/she knew.

The pilot test of the questionnaire involved three workers with different levels of education and indicated difficulties in understanding the nomenclatures related to education levels. To resolve this issue, different nomenclatures related to each level of education were inserted. Example: basic/elementary education/up to 8th grade or 9th grade.

The questionnaires were made available in a sealed envelope at the respective workplaces and returned to the researchers at the agreed time and day. If any clarification was needed, the participant could count on the support of the researchers on those days. The data were transcribed in electronic spreadsheets with double entry. A number was assigned to each participant to ensure confidentiality and anonymity.

Descriptive statistics were used to present the distribution of the absolute and relative frequencies of the data. Social Network Analysis (SNA) was adopted in its sociocentric approach, aiming to encompass the different nodes/services of the RAPS and to analyze the degree of centrality of the services^(9,16,17).

Centrality consists of one of the properties of SNA and is based on the assumption that actors with more links in a network are more likely to circulate or retain information or resources that could be useful to other actors in the network⁽¹⁷⁾. It is understood that the knowledge of a group, service or person is an essential criterion for establishing a link and constitutes one of the elements of its social capital. Like the network, social capital consists of the dynamism of interpersonal relationships within an organization, in this case the mental health network of the municipality in question — this capital is built by the results of such relationships, sometimes hierarchical. In the networks, it is observed that social capital is unevenly distributed due to the different knowledge, values, experiences and relational skills of workers⁽¹⁶⁾. Thus, to analyze the centrality of services, this study relates the profile of the worker with his/her knowledge of the network considering his/her social capital.

The degree of centrality of the elements was analyzed using the Social Network Analysis (SNA) software called Gephi Graph Visualization and Manipulation, version 0.9.2 — an open source relational database

analysis program, which uses a 3D rendering engine to display graphs and network analysis⁽¹⁸⁾. It was used to outline the graph representative of the elements in the studied network.

The difference in the number of services known according to the profile of the participants (education, function performed, institution in which they worked, length of experience in the health field, in the mental health field and in the institution of origin) was calculated through the Mann-Whitney test. The level of significance considered was 5%. Statistical analyses were performed using the Statistical Package for the Social Sciences (SPSS) software, version 24.0.

The research complied with the ethical precepts of Resolution No. 466/2012 of the National Health Council and was approved by the Research Ethics Committee (PCEP) under the CAAE protocol No. 46346415.2.0000.5154.

RESULTS

The average age of the participants was 42.5 years (sd=11.18). Table 1 shows their sociodemographic profile.

Table 1. Sociodemographic profile of the participants. Minas Gerais, Brazil, 2017 (n=162).

Variables	n	%
Gender		
Female	133	82.1
Male	29	17.9
Age range		
Up to 29 years old	19	11.7
From 30 to 59 years	121	74.7
60 years and over	11	6.8
Not informed	11	6.8
Self-referred color		
White/Yellow	104	64.2
Black/Brownish	48	29.6
Not informed	10	6.2
Marital status		
In a stable union	80	49.4
Out of a stable union	79	48.8
Not informed	3	1.8

As shown in Table 1, most participants were between 30 and 59 years old, declared themselves white or yellow, were female and reported being in a stable union.

Table 2 presents the data related to the employment relationship, weekly workload at the institution, exercise of

Table 2. Employment relationship, working hours and experience of study participants. Minas Gerais, Brazil, 2017 (n=162).

Variables	n	%
Employment relationship		
Governed by the Consolidation of Labor Laws/Public servant	126	77.8
Temporary contract	36	22.2
Weekly workload at the institution		
Up to 30 hours	94	58.0
31 hours and more	68	42.0
Perform another activity simultaneously		
Yes	53	32.7
No	109	67.3
Length of experience in the health field		
Up to 5 years	51	31.5
6 years and more	111	68.5
Length of experience in the mental health field		
Up to 5 years	85	52.5
6 years and more	77	47.5
Length of experience at the institution		
Up to 5 years	100	61.7
6 years and more	62	38.3
Place of performance		
Psychiatric hospital	41	25.3
Other mental health services*	121	74.7
Work		
Assistance	124	76.5
Support**/Administrative***	38	23.5
Education		
Incomplete high school	28	17.3
High school	51	31.5
Higher education/Graduate course	83	51.2

*Psychosocial Care Centers; Mental Health Matrix; Street Clinic; Therapeutic Residential Services and specialized board.

**Cooks, kitchen assistants, general services and watchmen.

***Administrator, administrative assistants, social agent and accounting technicians.

simultaneous activity, length of experience at the institution, in health and in the field of mental health.

As shown in Table 2, there was a predominance of workers from community-based mental health services, with a contract governed by the Consolidation of Labor Laws or a public contract, with a weekly workload of up to 30 hours, involved in the assistance, who did not perform simultaneous activities, worked in the health field for over six years, in the field of mental health for less than five years and at the institution for up to five years.

As for education, most had higher education, and the fields of training of these graduates were health (24.6%), social and human (24.1%). Most participants with an undergraduate course did not inform the training area (51.3%). Among the 63 with postgraduate courses, most were specialists (84.1%); 14.3% were masters; and one was a doctor.

In relation to the position of the services in the network, a degree of centrality (in which smaller numbers indicate low centrality and larger numbers, high centrality) of the psychiatric hospital was identified in the value of 1; of the CAPSs, between 0.82 and 0.64; SRTs, 0.45; CR, 0.30; and matrix team, 0.41. Figure 1 shows the graph discriminating the most key elements of the network.

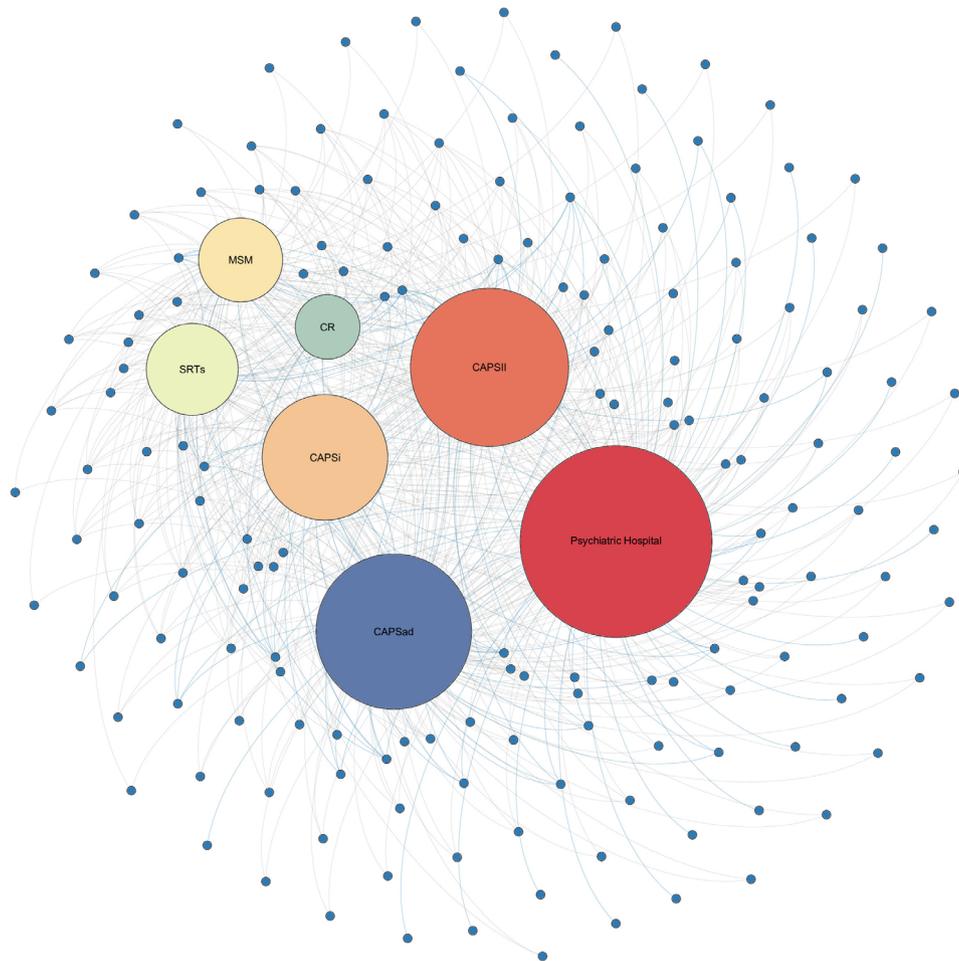
The average number of mental health services known by the participants was 5.1 (sd=2.70; median 5). On average, 44.6% of workers in community-based services reported not knowing the other community-based services in the network; and 17.3% of workers in these services were unaware of the psychiatric hospital. Among workers in the psychiatric hospital, 66.3% were unaware of the other services.

About 60.5% of workers who performed support activities, 41.2% of health workers and 17.5% of psychologists and occupational therapists were unaware of one or more of the other services; and only 14.2% of the professionals knew all the services of the network.

It was identified that workers who have been working for longer in the health field and/or in the mental health field knew more services than those who had been working for less time (Graphic 1).

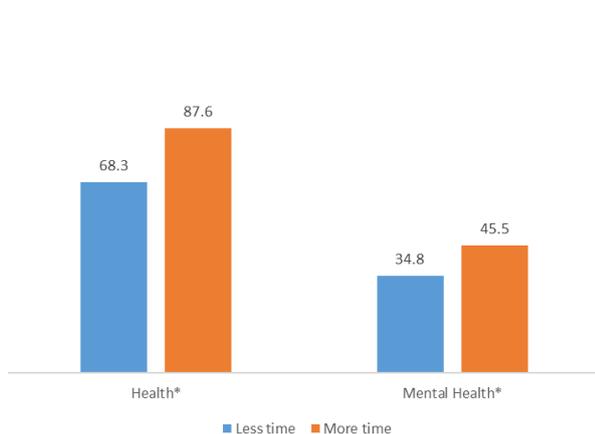
Regarding education, it was found that workers with higher education (n=83) knew more points of care in the RAPS than those who had an average or lower education level (n=79) (Rank average, respectively 103.8 and 58.1; p=0.000).

Regarding the performance of the participants, it was identified that the assistance workers knew more services than those who performed administrative or support activities. In addition, the psychiatric hospital workers knew less services than those who worked in community-based services (Graphic 2).

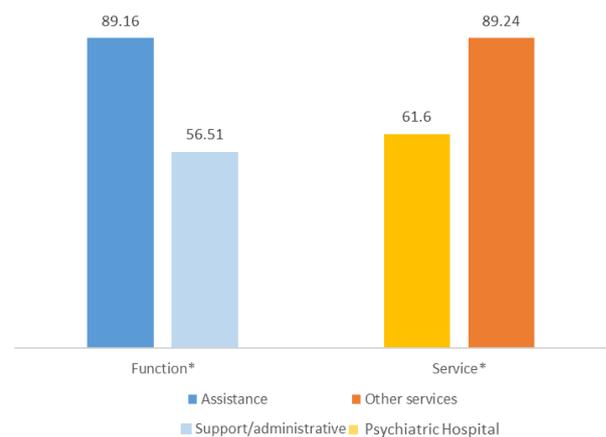


CAPSII: Psychosocial Care Centers; CAPSi: Psychosocial Care Centers (children and adolescents); CAPSAd: Psychosocial Care Centers (Alcohol and drugs); MSM: Mental Health Matrix; CR: Street Clinic; SRTs: Residential Services and specialized board. Note: the size of the circles corresponds to the degree of centrality. The services reported by professionals from community-based services were identified by the gray edges; and those of the psychiatric hospital, for the blue edges.

Figure 1. Graph representing the centrality of the network elements.



Graphic 1. Average rank of professionals' knowledge about services according to time in the health and mental health field (* $p < 0.03$), interior of Minas Gerais, $n=162$.



Graphic 2. Average rank of professionals' knowledge about network services according to function ($p=0.000$) and service in which they work ($p=0.002$), interior of Minas Gerais, $n=162$.

DISCUSSION

Most of the participants were young-adult, had a formal job, a 30-hour workload, did not perform simultaneous activities, had experience in the mental health field and a graduate course.

The psychiatric hospital revealed itself as a key element of the Psychosocial Care Network followed by the CAPSs. The matrix teams, SRTs and Street Clinic were in a less centralized position according to the analyses undertaken.

Most workers in community-based services mentioned the psychiatric hospital. However, most of them (44.6%) were unaware of the other extra-hospital services in the territory. In addition, such services were also unknown to almost 70% of workers at the psychiatric hospital.

The percentage of participants who knew all the studied RAPS devices was very low (14.2%). The lack of knowledge of the RAPS points was also verified in other studies^(10,19). Internationally, problems are reported in relation to knowledge about existing institutions, services offered and forms of access, which has motivated large initiatives for mapping networks and making information available to workers, the community and policy makers⁽²⁰⁾.

The results suggest that the length of experience in the field, the level of education and the assistance function are characteristics of the profile of the participants who exercised influence in relation to the knowledge of the other services. In addition to the profile of workers, in daily services, networking can be affected by a number of factors, such as: professional training permeated by the biomedical medical model; deficit in human resources; work overload; inadequate funding, infrastructure and communication tools; limited ownership of mental health guidelines and policies; excessive bureaucratization; and scarcity of opportunities for continuing education⁽⁸⁻¹⁰⁾.

Considering that the degree of centrality is related to the element's influence on the network and to the potential for articulation and dissemination of resources and information⁽¹⁷⁾, it appears that the analyzed network, although it has an expressive number of health devices advocated by current mental health policies, faces a basic challenge: workers' knowledge of institutions. This is a basic requirement to ensure the sustainability of psychosocial rehabilitation proposals and has a direct impact on the ability to articulate, as the mutual recognition of social actors is a key element for the establishment and maintenance of bonds⁽¹⁶⁾.

It is worth mentioning that the treatment offered in psychiatric hospitals aims at remission and stabilization of symptoms through medication and continuous supervision by the team. In contrast, the emphasis of extra-hospital services is on reintegrating the user into society through the implementation of opportunities/spaces for the exercise of citizenship, regardless of the individual's subjective structure,

making interdisciplinary efforts to guarantee his/her right to housing, work and leisure⁽²¹⁾.

The centrality of the psychiatric hospital, as the main result of the present study, refers to the difficulty of professionals to work towards the transcendence of care based only on medical diagnosis and hospital treatment. This corroborates previous studies that suggest the existence of a "psychiatric hospital memory", that is, in which the practice turns more towards curative models than the need to stimulate autonomy and ways of living in the world in a unique way^(12,19). Such centrality reinforces the importance of returning to the radical nature of psychiatric reform not only in replacing the psychiatric hospital with territorial services, but also in building institutions and models of care based on people's life contexts^(9,12).

The level of adherence to the psychosocial practices of mental health teams is not easy to measure. However, the importance of sharing care among professionals in the services that make up the RAPS is an essential factor for the differentiation of "a set of services" from "a network of services".

In this discussion, it should be added that current health policies recommend that primary care services should be a reference for care, due to their strategic position in the territories. Thus, in the context of mental health, the CAPS would have a key role both in the articulation of the RAPS and in mental health actions in the scope of primary care^(9,22). Based on these assertions, it was expected that extra-hospital services would assume greater centrality in the studied network. Carrying out the coordination of care in the territories is one of the main challenges for deinstitutionalization and can occur in an institutional/formal way and in an instituting way, through interconnections built by the actors of the network^(10,19). In this sense, research on the interactions between the actors and the strategies engendered in the daily routine of services for the continuity of care and sharing of responsibilities are essential^(10,19,22).

Matrix support as a device of the expanded clinic proposes care, joint visits, interventions in the territory and case discussions between both teams, overcoming the curative specialist logic, vertically hierarchical and bureaucratic, based on reference and counter-reference. The network care policy implies the sharing of cases with the teams responsible for care, with the user and with the community involved. Thus, the important role of such a program is understood in strengthening the exchange and articulation of the efforts of different services for mental health care in a network perspective, as recommended by a previous study⁽²³⁾.

Given the wide range of mental health services in the municipality studied, it appears that the difficulty in providing assistance goes beyond the need for new services, but also encompasses the demand for more active participation by

workers, as well as institutional investments to facilitate the articulation of these services⁽²⁴⁾.

In this sense, the knowledge of the territory by the mental health teams both regarding the service structure and the affective relationships of users with their family and the surrounding community are essential for the joint construction of projects that guarantee the access of individuals to the different devices of the network^(24,25) and strengthen communication between professionals in the intra/intersectoral network, enabling strategies for the psychosocial rehabilitation of users in a more effective way^(24,25).

It is noteworthy that the ignorance of the community network by most professionals is certainly not related only to the profile of the participants, but also to the potential and technical capacity of the teams and management to provide more articulated and interprofessional actions. That is, the synergistic communication between the different points of care as well as the knowledge of the services of the formal and informal social assistance network would contribute to more articulated actions and, consequently, to the consolidation of the RAPS⁽²⁵⁾.

In this line, it is understood that matrix support alone is not enough to overcome the numerous difficulties in operationalizing services with internal and external network partners⁽²⁶⁾. Recognizing the territory, the partnerships that the services can make with each other, and fighting for investments in these services and in the development of the existing networks is as important as the creation of new devices. This is because, as discussed, there is a notable demand for the purpose of extra-hospital services to be substituted for hospital-only care, and such an achievement would be facilitated through more transversal actions considering all the devices of the social assistance network.

Thus, the results found contribute to the identification of the challenges posed to the deinstitutionalization of mental health care, especially with regard to networking and the place still occupied by psychiatric hospitals. The lack of knowledge of specialized mental health institutions by RAPS workers reveals weaknesses in their ability to exercise advocacy proposed in international guidelines and national policies. Further studies are needed to assess how co-responsibility and care sharing have occurred, given the low number of study participants who knew all the points in the network.

It is worth considering the limitations of the present study. One of them refers to the incorporation of other dimensions to the analysis, especially with regard to the relationships between each of the RAPS nodes and of these nodes with other formal or informal services existing in the territories, which would allow to explore the potential of the SNA and expand the analysis of psychosocial rehabilitation. Another limitation is the importance of understanding the specificities of implementing mental health policy at the municipal level to

deepen the analysis. It is understood that the results found can contribute to the design of new research on the topic.

CONCLUSION

The professional profile of network workers suggests that the length of experience in the field, the level of education and the care function are characteristics correlated with the knowledge of the services that make up the RAPS.

Considering that the current mental health policy proposes the replacement of hospital-only care with community-based services, comprising the CAPS as the main articulator of the RAPS, it was expected that extra-hospital services would be appointed more frequently by the participants of the present study. However, the key element identified was the psychiatric hospital.

It is noteworthy that the identification of the psychiatric hospital as a key element of the network highlights the need to redefine the care model that supports the practice of professionals, as well as the low knowledge of community services requires the expansion of the technical capacity of the teams and management.

The densification of workers' social capital and the use of management instruments would contribute to a greater articulation of the RAPS. In this sense, it is essential that workers make efforts to get to know the services of the formal and informal social assistance network and use the existing management tools, namely, matrix support, reference professional, unique therapeutic project and expanded clinic, which they would enable synergistic communication between the different points of care, contributing to more articulated actions and, in turn, to the consolidation of the network.

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