Mental health cages

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ABSTRACT
Socio-educational practices in health promotion as training tactics, sensitization and reflection on the management of primary care health professionals with patients in psychological distress and mental disorders. This is an "Experience Report" developed by the Social Service of the multidisciplinary team of the basic health unit, in the model of care of the family health strategy. It discusses the advocacy of the rights of people in psychic suffering and mental disorders and discusses the "taboos" in the initial reception and management of primary care professionals, thinking from the changes in the psychosocial care network in the light of the anti-asylum movement. The results show a resistance of professionals with a weakened bias towards the stigmatization of mental health demands and psychosocial management of these patients. This project reinforces the need for continuing education in primary care as a training and awareness strategy as a means of learning and professional qualification.

Keywords: Social work, Mental disorder, Primary care.

1 INTRODUCTION

This project was designed and elaborated based on the demand observed in the environment of the basic health unit, and on reports brought by the patients assisted in relation to the initial reception at the UBS. Some patients and family members verbalize a feeling of discomfort and sometimes stigmatization as a result of the behavior in the initial welcoming act of the professionals in general at the UBS.

> We imagine that sometimes every health professional has felt insecure, surprised or unsure of how to act as soon as they identified a mental health demand. We also believe that it is likely that in some of these situations the professional feels like improvising, or using intuition and common sense. (MINISTRY OF HEALTH, p.23, 2013).

Despite the advances in the legislation that refers to the health care network and care flows for patients in psychological distress and mental disorders, we can still observe some "taboos" that intrinsically generate resistance to the care of patients in primary health care. Such situations leave patients more fragile and vulnerable to situations that can cause exposure to risks and generate conflicts/violence.

But how to link the patient to the basic health unit, if his initial reception is causing suffering both to him and to the UBS professional himself, who does not have adequate management to feel safe and able to welcome the patient, how to mediate this relationship precisely to avoid situations of risk and conflicts.

According to the primary care booklet 34, initial reception is essential for this relationship to be established:

> The embracement provided in the health units is a device for the formation of bonds and the practice of care between the professional and the user. In a first conversation, through welcoming, the health

> unit team can already offer a space to listen to users and families, so that they feel safe and calm to express their afflictions, doubts and anguish, knowing then that the UBS is available to welcome, monitor and, if the case requires, care in a shared way with other services. (BRASIL, 2013, p.25).

The reformulation of mental health has brought changes in public policies and health care models in the context of user care, with the objective of combating stigma and exclusion by expanding the social context of these patients in the context of comprehensive care and in the construction of the psychosocial care network with the bias of the liberating character, broadening the systemic view and reinserting the person in psychic suffering and mental disorder into society with perspectives of developing autonomy in their own lives, thus giving these patients back the right to social life, reintegration into the family environment, the labor market and interaction with health care services and the intersectoral network.

> ORDINANCE NO. 3,088, OF DECEMBER 23, 2011(*), establishes the Psychosocial Care Network for people with mental suffering or disorder and with needs resulting from the use of crack, alcohol and other drugs, within the scope of the Unified Health System (SUS).
> Art. 1 to the establishment of the Psychosocial Care Network, whose purpose is the creation, expansion and articulation of health care points for people with mental suffering or disorder and with needs resulting from the use of crack, alcohol and other drugs, within the scope of the Unified Health System (SUS). (BRAZIL, 2011).
> § 1 The Basic Health Unit, referred to in item I of this article, as a point of attention of the Psychosocial Care Network, is responsible for developing actions to promote mental health, prevention and care of mental disorders, harm reduction actions and care for people with needs resulting from crack use, alcohol and other drugs, shared, whenever necessary, with the other points of the network.

In article 5 of the same ordinance that establishes the Psychosocial Care Network, the basic health unit is one of the points of care supported and matrixed by the NASF teams, today after a restructuring of the policy, the NASF teams - Family Health Support Center are no longer part of the primary care that is supported by a Multiprofessional team.

> This service was guaranteed by the Health Support Center (NASF), created in 2008, but was dismantled by the last administration. The lack of funding from the last government so that states and municipalities could keep the teams organized and functioning caused a lack of assistance, especially in the most vulnerable regions of Brazil. With the reconstruction and reformulation of this strategy, now called eMulti, the expectation is that 4,000 multiprofessional teams will once again organize themselves and provide this care throughout the country.
> "eMulti resumes, innovates and strengthens multiprofessional care in Primary Care, based on the experience of the NASF, which was a structuring part of the SUS. This resumption is one of the priorities for health in President Lula's government, in addition to having been a demand of municipal and state managers. We are rebuilding assistance, comprehensive care, rescuing access to health for Brazilians", reinforced the executive secretary of the Ministry of Health, Swedenberger Barbosa.
> The resumption of multidisciplinary teams is essential to ensure comprehensive care for the population, increasing the resolution of health problems in Primary Care, since Brazilians will have access to specialized care in Basic Health Units. (BRAZIL, 2023)

The reformulation of the care policy and care strategy for patients with psychological distress and mental disorders brought a challenge in the process of work and health care for primary care professionals.

Challenges in the performance and development of the work process that now advocates a systemic and expanded look at mental health with limitations of the technical conditions and qualification for the management and constitution of the care process for these patients, is still a long way to go.

> In the proposal of Permanent Education in Health, the change in the strategies of organization and the exercise of care, management, participation or training is built in the practice of teams, workers and partners, and must consider the need to implement relevant, quality and problem-solving work. The demands for qualification or specialization are demands for the promotion of thought and action. (BRAZIL, 2014.)

This article emphasizes the need for continuing education and daily qualification in the trajectory of primary care collaborators in order to outline good perspectives for the care and reception of these patients, but it is still a challenging path.

2 METHOD

This is a descriptive study, based on an "experience report" of the experience of social work in primary health care.

2.1 PARTICIPANTS

All employees who were present at the health unit participated in this action, with a total of ***135 employees*** aged from 18 to 69 years old, divided into four groups at different times, with workshops of approximately 2 hours.

2.2 INSTRUMENTS

A questionnaire of questions with a semi-structured script was applied, with the objective of collecting data on social situations in the work environment, in social life and in the personal relationship with patients in a state of psychological distress and mental disorder.

Table 1. Questionnaire applied with semi-structured questions.

Question 1.	Question 2.	Question 3.	Question 4.	Question 5.	Question 6.	Question 7.	Question 8.
Do you believe you should stay away from people with mental disorders? YES ( ) DON'T ( )	**Do people with mental disorders pose a risk to everyone? YES ( ) DON'T ( )**	**Would you work with people with mental disorders? YES ( ) DON'T ( )**	**Would you mind having them as your neighbors? YES ( ) DON'T ( )**	**Would you mind living with people with mental disorders? YES ( ) DON'T ( )**	**Would you mind having them as friends? YES ( ) DON'T ( )**	**If a family member had an affective relationship with a person with a mental disorder, would you mind? YES ( ) DON'T ( )**	**People with mental disorders are unable to work. Do you agree?**

2.3 MATERIALS

The activity was carried out in the external area of the UBS, which is a garden with a cover and support of multimedia equipment. Employees were arranged sitting in circles.

The resources used were from a Power point presentation, playful videos, group dynamics, flip chart, paper, felt-tip pens and bibliographic materials about the current law.

2.4 PROCEDURE

The methodological path was traced from the presentation of an expository class of contents about asylum hospitals, (Brazilian holocaust) movement of the anti-asylum struggle, followed by a conversation circle with sharing of experiences and reflections on the initial reception of these patients in the UBS and presentation of the psychosocial care network, flows and referrals. And for closing, the participants prepared the construction of posters with the care map of the psychosocial and intersectoral care network and the importance of promoting mental health care. Subsequently, the questionnaire was applied with semi-structured questions.

Among these moments, we highlight the playful dynamics of the "cage". The cage symbolized asylum hospitals, so each of the employees was given a bird in the shape of cardboard and we left the participants free so that at the end of the activity, they could choose whether or not to leave the bird in the "cage".

3 RESULTS

All the results of the script of questions were analyzed together and not by age group, the contents were analyzed through a protocol segmented into categories of analysis.

A total of 135 health professionals (nurses, physicians, multidisciplinary staff, administrative staff, cleaning professionals and nursing assistants) ***answered the questionnaire***. We will present together and then we will present the analysis of the answers to the questionnaire applied.

Regarding question 1, we had 130 health professionals who answered that "***no***" it is necessary to keep people with mental disorders away and 05 answered that **"yes",** they should stay away.

Subsequently, in response to question 2, 128 professionals answered that patients "***no***" pose a risk to everyone and 07 employees answered that ***"yes",*** they pose a risk.

Continuing the questionnaire, in question 3, we noticed that 19 employees answered that they would ***"no***" work with people with mental disorders and 116 employees answered that they ***would work*** "yes".

In question 4, 119 participants answered that "**yes",** they would mind having people with mental disorders as neighbors and only 16 answered that they would **"not"** mind.

In reference to question 5, 121 participants indicated that "yes" they would mind living with patients with mental disorders and only 14 said they would "**no"** mind.

When asked in question 6 if the participants would mind having friends with mental disorders, 122 employees answered that ***"yes***" they would mind and 13 answered that they would ***"no"*** mind having them as friends.

And still in the questionnaire track, in question 7, we observed that 87 of the participants answered that "***yes",*** they would mind if someone in the family had an affective relationship with people with mental disorders, and 48 answered that they "***no"*** minded.

Finally, in answer 8, 26 employees agreed that "***yes",*** people with mental disorders are incapable of developing work activities and 109 said that they "***no"*** agree.

Thus, in order to continue our debate and reflections on mental health, it is necessary to "overcome the asylum mode from the realization of freedom" (Nicácio and Campos, 2007). In the dynamics of the "cage" we had 05 birds that were caged at the end of the activity, below we will bring the discussions of the employees.

Some professionals reported that they understand that: "'severe' patients should be kept in hospitalizations without the right to hospital discharge, because family members have no way to maintain care and believe that the patient would not remain stable outside the hospitalization environment".

> How many requests for "Get me out of here!" are still needed? "The processes of 'anesthetization' of our listening, of producing indifference towards the other, have produced in us the deceptive sensation of safeguarding, of protection from suffering" (BRASIL, 2008, p. 12).

Others reported that: "they are afraid to welcome patients with psychic suffering and mental disorders, because they are usually aggressive and do not listen".

Some professionals pointed out that: "they find it difficult to differentiate between patients with mental disorders and people who use illicit substances and who are afraid of suffering some type of violence". There were also reports that: "mental health is difficult to manage, to refer to the service network and to care". In this exchange of experiences and ideas, the collaborators said that: "there is prejudice in relation to these patients, that they are excluded and seen as incapable, yes, and this is sometimes unconscious". There were others who: "understood the issue of asylum hospitals as a place of torture and were sensitized", some professionals "believe that every patient has the right to live in the family environment and to be treated by the psychosocial care network". A good number of the health professionals present there did not know the history of asylum hospitals and did not understand the anti-asylum movement.

4 FINAL THOUGHTS

The experience in this activity was crossed by an intrinsic resistance to the understanding of mental health in the current way, in which the sick subjects must be taken for autonomy and protagonism of their own lives.

It is almost automatic that when we enter the debate on the care of patients in psychic suffering and mental disorders, society in its conservative mold directs its ideas to asylum "care" in places where these people remain hospitalized and socially excluded. Thinking of these patients as people who move in all social spaces still generates a discomfort that we can call "taboo", because the existential fear that something could happen to them and there are third parties due to their health condition is almost inevitable for the majority of the population.

It seems to us that there is a difficulty for health professionals in primary care to manage the reception/care of patients who present psychic suffering and mental disorders, certain that it is a challenge from the proposed changes in the psychosocial care model, requiring a daily immersion in the light of the clarifications of continuing education, an essential action for health professionals to feel qualified to welcome and manage the care of the patients. Patients.

But there is also intrinsically a socially instilled prejudice that needs to be disseminated, especially in public health environments, it is very common in some cases to have a counter-transfer of professionals in relation to the patients served, and in these cases the transfer of values, customs, fears and prejudices that directly and indirectly affect the work process, and overrides professional ethics, leaving it in the background.

> The meaning, the sense, the feelings aroused are different according to the experience of each one and their family history. This often hinders the perception and understanding of health professionals

> (...), because their individual, cultural and social references are different. Looking, listening, observing, perceiving and understanding the diversity of the way of living in the family are strongly influenced by the conceptions of family, beliefs and values of each professional, but these cultural and communication barriers can be faced from an approach that favors reflection, dialogue, listening and welcoming of the user. (BRASIL, 2013, p.63)

Based on the answers to the questionnaire applied, the health professionals manifested a greater challenge in living with, or maintaining affective relationships with people with psychic suffering and mental disorders, having them as friends, neighbors or seeing them in a loving relationship with a family member seemed to be something that would not bring tranquility.

Most participants understand that people with mental disorders are able to perform work activities and are not incapable of doing so. And having them as co-workers and living in the same environment is not something that brings discomfort.

The results showed the presence of the limitation of the management and care in mental health of primary care professionals, and how there is still an absence of elements of qualification of care and coverage of activities of a nature of permanent education of a psychosocial nature for the awareness, sensitization and accountability of this care without prejudice and, in addition, There is still a need to dissolve the prejudice against welcoming such patients, whether due to the bias of social risk or the bias of lack of knowledge.

The strengthening of the psychosocial care network and the intersectoral network in the matrix support and reception of patients is something that comes to engage the management and development of the work process.

Taking this reflection on the management and initial reception of patients with psychic suffering and mental disorders in primary health care is something extremely relevant and current in our society, in view of the existence of resistance in this care instilled in prejudices and axillary molds.

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