

Mental Health Network: A Narrative Review Study of the Integration Assistance Mechanisms at the Brazilian National Health System

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Abstract

The fragmentation of health systems has presented as one of the biggest problems for the establishment of an integral attention and for guaranteeing the longitudinality of care. In Brazil, the mental health policy has changed its model of care, over the years, reversing a strictly hospital centered care, to integrate different services. Through the method of narrative revision the present article aims to analyze the mechanisms used in the mental health's attention care. The review points out that mental health presents several integration mechanisms in the macro (systemic), meso (institutional) and micro (clinical). Was identified an expansion of the health care network and new forms of organization and police of training, however the system is underfunded and needs improvement in primary care and evaluation mechanisms? The services are organized with integration practice, related to urgency and matrix support teams. The clinic has supervisory experiences, and multidisciplinary teams. These levels can be transported and integrated into the health care network, to improve the care's integration process.

Keywords: Mental Health; Health Care Reform; Public Health; Health Policy.

1. Introduction

1.1 Health Care Network (RAS)

The organization of health care by networking originates since the Dawson Report, in the beginning of the past century; However, its effective organization applied to health systems is recent, starting in the 1990 's in some countries in Europe. It is an organization of the system which attempts to overcome its fragmentation, seeking better efficiency and efficacy among the various points of care which comprise the health care network (Mendes, 2009). The new epidemiological profile, with an expressive increase in chronic diseases and patients with multiple pathological conditions, poses even more difficulty to implant an integrated system in which the focus is on the user and the primary care is the coordinator and organizer of assistance (Vargas, Lorenzo, Calpe & Núñez, 2005) Health systems were developed and organized in hierarchical systems, divided in levels of care which reflect different degrees of technological density incorporated into the procedures which develop in each level.

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This systemic organization favoured the health system fragmentation and was not able to guarantee the necessary continuity of care (Cecilio, 1997). In light of integrating the system, and examples which have been happening around the world, Latin American countries have been transforming their organization model. Brazil, by means of the Unified Public Health System (SUS), has sought to organize the Health Care Networks (RAS), which are organizational health action and service have. Said have present points of care, integrated by means of diagnostic and therapeutic support, logistic systems and those of management, in order to guarantee the care completeness in any given territory, irrespective of the technological density of the procedures or specific focuses on any pathology, or life cycle stage (Mendes, 2009).

The integration process seeks to overcome the historical process of fragmentation (Silva, 2011; Conill & Fausto, 2012) and it is in the SUS agenda since its creation. We have identified the preoccupation on part of the Ministry of Health and other federal entities with the objective of formulating orientation and legal conditions for the creation of the Networks (BRASIL, 2006).

The Organizational Contract of Public Action on Health (COAP) (BRASIL, 2011), defines and implements key aspects for the integration of the system, also grant the financial support to an integrated and regional care model, which seeks to induce interfederal Vida, and consequently, integrate the system. The issue of regionalization gains importance in the centre of orientation standards of the health system and in the political agenda of health administration (BRASIL, 2006).

Hartz and Contandriopoulos (2004) discuss the integration of the system and affirm that when the term "network" is discussed, there is a point of view which refers to the organizational structure and another related to the dynamics of the social actors involved. We can look more thoroughly at the subject and claim that when we evaluate the extent of the integration of the system, we should consider not only the articulation between its units but also the integration processes of the teams and professional practice in these services.

The integration mechanisms of assistance in Brazil, when compared to universal health systems in countries as Spain and England, are still incipient (Mendes, 2009), in a systemic context of underfinancing, selective primary care and a mismatch in the process of the administrative decentralization among united entities. Although, it is possible to note various strategies related to programmes and services, although, still focused on cities or health regions. The adoption of the Family Health Strategy as an organizational model for the Primary Health Care has shown positive impacts on the coordination of assistance and consequently a better integration between teams and between services (Conill & Fausto, 2012; Mendes, 2012).

The current study will focus on the mental health care network, also known as thematic network of mental health. It is important to highlight that isolating but one specialty is the most effective approach in order to plan or study it, and from that, identify some peculiar and specific issues of the problem and better understand it. In everyday life, they are interdependent and overlap in many aspects. A brief presentation of the Mental Health care network will be made, and also the results of the study.

1.2 The Mental Health Network in SUS

Subsequent to the long struggle for political and social changes in the form of treatment in relation to patients suffering from mental disorders, Brazil claimed that, as a model of assistance, an organization focused on territorial services, which seeks to put aside hospitalization in psychiatric hospitals and monovalent offer longitudinal care, focused on the users and their territories (Trapé, 2010).

The organization of models of mental health assistance, de-emphasizing community services predates SUS. Examples are found in various cities since the end of the 1980 's (Braga Campos, 2000), with clinical organizational strategies and administrative strategies that had been implanted and evaluated (Onocko Campos et al. 2011; 2012). Although, only after the promulgation of Law 10,216 (BRASIL, 2001), also known as "Law of the Psychiatric Reform", that it was possible to implant the National Mental Health policy.

This change process was based on Federal financial incentive granted to municipalities, for the implantation of a range of services with the purpose of surpassing the centrality of the psychiatric hospital: Psychosocial Care Centres (CAPS, adults, children and adolescents, and Alcohol and other drugs), Residency, Community Therapeutic Centres, Workshops and Psychiatric Infirmaries in General Hospitals.

The development of actions in the Primary care (APS) is also expected, since it is the unit of care which structures our system by means of the support of reference services (CAPS and Ambulatory Units) and Family Health Support Units (NASF) (Barros & Salles, 2011). The mental health policy implantation evaluations show improvement and expansion in process (Onocko Campos et. al. 2009). It can be stated, after more than 20 years after the creation of SUS that mental health, grounded on the Brazilian Psychiatric Reform movement has been showing to be a well succeeded policy sector (Alves, Silva & Costa, 2012), but faces great challenges before the structural problems in SUS as in specific issues in its field (Pitta, 2011).

The goal of this article is to analyze the mechanisms of assistance integration present within the mental health network, considering from public policy initiatives, which propose induction devices, to the different forms of institutional organization and clinical practices that further the integration. The following question is sought to be answered: which are the mechanisms of assistance integration present within the Brazilian Mental Health Network? To simplify the organization of the elements to be analyzed, we resorted to some authors who put forward analytical dimensions on the RAS mark.

1.3 Analytical Dimensions of the Health Care Networks

Garcia (2001) defines management models from dimensions which give direction to different responsibilities in different fields. In the macro dimension there would be responsibility of the Government to allocate funds, offer and organize services according to orientation policies; in the meso level, or institutional management level, there would be responsibility of the services involved in health care and their strategies to meet the policy objectives; and in the micro-level, or clinical management, professional responsibility can be observed, in which the clinical handling decisions will be responsible for a large part of teamwork resources and strategies.

Based on such elements, the reference of analysis makes defining the integration mechanisms of assistance in distinct, complimentary and interdependent dimensions (macro (systemic), meso (institutional) and micro (clinical management)) possible. These dimensions, when put together, allow qualification of the processes and consequently, better organization of the network.

2. Method

The current study made use of the Narrative Review the work methodology. We understand that the issue in question does not count on sufficient systematic productions in order to produce, for example, the systematic review (Rother, 2007). The chosen methodology permits discussion and technical-reflexive specifications, introduction to new narrative structures and theoretical and conceptual constructions. The goal is to describe and discuss "the state of the art" of the subject in question from the theoretical and conceptual perspective, thereby seek to amplify the field of analysis on the topic and deepen the thoughts incorporating various analytical perspectives (Gadamer, 1997; Campos & Furtado, 2008). For the development of the study, the search was made in the LILACS database, with the descriptor as "mental health", aside from governmental documents. The research used a fragment of the past 10 years, (March 2004 to February 2014) of production in Brazil and found 3594 products. From these findings the large part of the material was deleted.

The first exclusion criterion was of the *form*: master and doctorate theses were discarded, among other documents, leaving only articles in indexed magazines (2712 articles). The second criterion was *access*: only articles with full online access were included. The third criterion was of the *field*: only articles with an analytical field of Brazilian public policies (617 articles). At the end of this selection, their titles and, afterwards, their summaries were read in light of the last exclusion criterion, the *subject*: Based on this filter, articles which were pertinent to the theoretical mark of the Health Care Networks presented, leaving 33 articles for analysis. This procedure was performed by two independent readers.

As the study is on the subject which directly involves the organization of governmental Public Policies, therefore, laws, Ordinance, and documents of the Ministry of Health with regards to Mental Health were included. This material was organized by subject, which will be presented based on the dimensions previously discussed.

3. Results And Discussion

3.1 Macro Dimension (Systemic)

3.1.1 Psychosocial Care Network (RAPS)

The Ministerial Ordinance 3088 (BRASIL, 2011a) was instituted as the organizational proposal towards mental health service, which creates and regulates the Psychosocial Care Network (RAPS), establishing guidelines, objectives and components for the network focused on mental health care. It reaffirms the model focusing on territorial services substituting the psychiatric hospital. In this respect, the policy induces the expansion of attention points and the creation of regional plans, offering deployment methodology for inter-municipal pacts.

It's too early and the subsidy is not sufficient to determine if this model, based on a vertical and sectoral action, will make mental health care more integrated. If on the one hand the thematic networks, which refer to older "health programs", seek to offer answers to the specificity of a current health problem, on the other hand, incur the risk of maintaining parallel and fragmented actions, being the exact opposite to what the RAS organization proposes.

3.1.2 Mental Health Policy for Primary Health Care (APS)

In a model of care designed in network, as discussed, the APS has a priority function. It works as a gateway and has a structuring function in the system, with population and territory attached, geographical proximity between users and services and multiprofessional teams which, when well organized, configure efficaciousness in 85% of cases (Starfield, 2002). The APS serves as a mediator between the user and the other assistance levels, therefore, in addition to the communication between services be the most perfect possible, units have to meet the full range of users seeking assistance and to be the reference of cases: when the APS works, the system becomes integrated.

Since the beginning of the process of Psychiatric Reform, political forces were intended to the closure of psychiatric hospitals, which occupied the centrality of mental health policy prior to SUS. The substitute services were broadened, mainly intended for severe and persistent cases. Meanwhile, specific policies for mental health on APS are still incipient, primarily for moderate and mild cases, and in many places a disclaiming process of the APS, swelling in CAPS, unnecessary hospitalizations culminated in a process of non-assistance (Figueiredo & Onocko Campos, 2009; Onocko Campos et al. 2012). The lack of integration between the replacement equipment and APS was identified. The lack of professional training carries a series of inadequate postures such as: standardizing and hospital centred actions; discriminatory actions, infantilization; medicalization of psychic suffering, among others (Gama & Onocko Campos, 2011; Onocko Campos et al. 2011).

Seeking to overcome this fragmentation, an ordinance was launched, which creates multidisciplinary teams to support family health teams, with the indication of a mental health professional. The NASF has the main objectives of strengthening of APS in coordinating assistance, proposing to review the practices of referral to a longitudinal care organization (BRASIL, 2008).

Before the creation of the NASF, many municipalities had mental health professionals composing teams in APS. However, without a policy that set the direction these professionals should follow, there is a risk of compartmentalization of the care and of being seen as "experts" within the units. However, when there is a clear policy, practices consistent with the expanded clinic model, teamwork, assistance for mild and moderate cases, shared responsibility of cases with other professionals and link to define the flows with the reference services, fixed teams are potent and could be incorporated into the assistencial model.

3.1.3 Financing

In Brazil there is a real growth in spending on mental health since 2001 (Gonçalves, Vieira & Delgado, 2011). But its percentage on the total amount destined to public health is still short of the indicated. In the face of the systemic underfunding of the SUS, mental health is only assured with only 2.3% of the Federal Health Budget, while the World Health Organization estimates that, because of the high prevalence and complexity, this value should be around 5% (Barros & Salles, 2011). It is important to note that the financial services increment of average complexity, in relation to hospital resources, is a path to integration assistance (Almeida, Giovanella, Mendonça & Escorel, 2010), since lower density technological services, when organized, tend to articulate better networking, have a longitudinal patient-centred care and allow only necessary cases reach hospital attention (Vazquez, 2009).

It is observed that macro structural actions have induced the desired network model. An example of this is the impulsion of the number of CAPS open after the promulgation of Ordinance 336 (BRASIL, 2002) (410% growth in the last 10 years). This increase has made, since 2006, the expenses on replacement services to exceed the direct expenses on hospital beds, which was drastically reduced (37% in 10 years) (BRASIL, 2012). However, a disparity between the types of services created should be noted: the 24-hour CAPS, type III, increased less than type I and type II in large municipalities, where the Ordinance stimulates them, and are today only 68 throughout Brazil (BRASIL, 2012). To Costa et al. (2011), there are more than one piece of data that demonstrate the inability of municipalities to deploy the policy, it is a systemic failure of the Brazilian State, which "severely affects the substitutionary strategy from hospitalization in psychiatric hospital by force of federal responsibility with low this agenda" (p. 4613).

3.1.4 Systematic Evaluation

The field of evaluation has been consolidated in two spaces: the academic and bureaucratic (Furtado, 2013), marked by differences between the productions performed by research groups in universities (academic) and by governmental entities (bureaucratic). Government-induced processes tend to have a lower plasticity and autonomy. On the other hand, the possibility of application of the knowledge generated from its results is greater. In the governmental area, two initiatives have been implemented at a national level, aiming at assessing the health network: the IDSUS (SUS Performance Index) and the PMAQ (National Program for Improving Access and Quality of Primary Health Care). In them, it was observed that a number of indicators applied to a service, or a network of services that, with different purposes, try to induce practices and evaluate the health system. In the composition of the IDSUS there is no indicator related to the field of mental health, while in the PMAQ four-related indicators were incorporated. However the single focus and priority is the use of psychoactive substances, which does not encompass the complexity of mental health practices and the organisation of their services, not even its own policy of expansion of services developed by SUS in recent years.

The indicators published in annual documents released by the Ministry of Health (BRASIL, 2012) refer to structure and some results, using government databases. The assessment based on indicators that could induce good practices (Furtado & Onocko Campos, 2008) to the qualification and suitability in the processes of organization and services between departments is a field to be explored. However, there are recent studies still not incorporated by public policy. Within the academic study of Furtado, Onocko Campos, Moreira e Trapé (2013), conducted with 46% of the CAPS type III of Brazil, which with participatory methodology defined a range of process indicators, structure and result to be applied in the units.

3.1.5 Training

Within the governmental scope, two things stand out as structural policies for training, with goals to qualify the networking and support the integration of the SUS: the work education program for health (PET health) and the National Policy of permanent education in health (PNEPS). PET-Health (BRASIL, 2008a) fosters projects that have the interface: University health services, and covers different thematic lines related to SUS. The few analyzed experiences in mental health show impact on professional practices, service dynamics and academic education (Onocko Campos, Trapé, Kores, Bello e Dorigatti, 2012). The PNEPS (BRASIL, 2007) aims to change work processes and promote the integration and the development of professionals from a multidisciplinary vision, interdisciplinary and intersectoral work. It proposes the identification of needs and requirements of the system and the development of educational initiatives that value the reflection and the rapprochement between the theoretical discussions and the reality of the services (Ceccim, 2005).

In addition to the theoretical constructions, more studies that evaluate how these actions have been implemented and their impact are necessary.

3.2 Meso Dimension (Institutional)

3.2.1 Matrix support

The actions in partnership between the CAPS and the APS are diverse, with centrality yet in CAPS (Dimenstein et al. 2009) figure.

The non-responsibility of mental health cases by the APS may be related to the lack of preparation of professionals in dealing with mental distress (Jucá, Nunes & Barreto, 2009), which determines the centrality of mental health actions in specialized services (Lucchese, Oliveira, Conciani & Marcon-2009).

As an alternative to integration, one of the widely used arrangements between matrix technical support is (Campos, 1999; Campos & Domitti, 2007; Morais & Tanaka, 2012:). It allows, in addition to the cooperation between different levels of attention, a technical-pedagogic process, where the binding between the expert and the team of APS can promote exchange of knowledge, joint driving cases and qualification of referrals, seeking to overcome fragmentation assistance (Pinto et al. 2012).

We have identified in literature two models of organization of the matrix support teams: that which is linked to a specific mental health attention and matrix units steering wheels, without ties to any production unit (Tófoli & Fortes, 2007). It is noteworthy that they are complementary and not contradictory models. In the first, in which the professional reference unit moves to the APS unit, the flow is more integrated, once the "matrix" team has autonomy to agree jointly on the priority cases, define the best offer from the need of the user and access the agenda of professionals directly.

However, some improvements are required for qualification of support teams. The profile of the hired professional does not meet the need and complexity of practice, demonstrating a lack of qualification (Andrade et al. 2012). There is an understanding on the part of the APS team that the "matrix" professional is an expert of only assistive purposes, not enabling the co-management⁵² and making the shared building process of the cases simply reproduce the hegemonic and fragmented model (Sampaio, 2012).

3.2.2 Urgency and emergency

The management of crisis situations in users with mental disorder has been an object of constant debate in the process of reform of mental health practices (Ferigato, Onocko Campos & Ballarin, 2008). The CAPS type III is the privileged space to deal with crisis by having features such as rear bed and a 24-hour team nonstop, but these services are still insufficient in Brazil as discussed.

Psychiatric Emergency Services (SEPs) can reduce the admission of new cases to the hospital, being efficacious and precluding unnecessary hospitalizations (Del-Ben et al. 1999; França, 2005; Barros, Tung & Mari, 2010). When hospitalization is necessary, the existence of a vacancy regulating central that sets the flows based on clinical criteria, shows itself potent in qualifying this demand (Souza, nd). They rely on specialized professionals for evaluation with different modeling: teams linked to Mobile Emergency Care Service (SAMU) (Bonfada e Guimarães, 2012); regulatory services connected to the network or regional character; with a professional at a distance, and are also a team support space, both for the APS and the CAPS.

The hospitalization in General Hospital, different from monovalent ones, shows itself to be effective for various clinical cases (abstinence, Comorbidities, etc...) (BRASIL, 2001) and can cooperate with the SEPs. There is a conflicting risk of this equipment taking up the role of the gateway to the network, reproducing the fragmentation and centrality of the hospital-centred model, which is of little efficiency. However, when the substitute network works, it prepares for demand, reduces the flow in emergencies, decreases the cost and becomes the articulator of care.

3.3 Micro Dimension (Clinical Management)

3.3.1 Institutional Clinical Supervision

Institutional clinical supervision suggests broadening the conception of the clinic as something with dimensions that exceed the symptom, but also incorporate the clinic *stricto sensu*. According to Onocko Campos (2012) institutional clinical supervision must be the space of fundamental content analysis of a team that is, at the same time, both institutional and clinical, since the discussion of clinical cases or therapeutic projects are intrinsically linked to the institutional relations and vice versa (Ferigato e Diaz, 2013). It is organized as a catalyst arrangement of the network, which supports teams facing adversity in relation to the working process, the intensity of the mental health clinic and its direct relationship with the suffering with psychological repercussions on workers (Ballarin et al. 2011). It is a protected space to organize clinical practice, since the process of work in the same unit can be compartmentalized and reproduce the fragmentation discussed previously.

3.3.2 Reference Teams

We can define the concept of Reference Team (Campos & Domitti, 2007) as a range of diverse professionals that link to a territory, with a number of users under their responsibility, and relate to the APS teams responsible for the same population, facilitating the process of bonding and construction of therapeutic projects (Furtado,2007). It is a form of including the users, induce interdisciplinary work (Miranda & Onocko Campos, 2010), to bring the attention points in clinical discussions closer and facilitate contact with the APS, by making the relationship more customized and enabling the flow debureaucratization.

4. Conclusion

In this paper, we seek to identify mechanisms of assistance integration, which when embedded, help break away from the chronic state of fragmentation of health care.

A broad and heterogeneous territory as Brazil, the actions and the forms of organization of the network will always be marked by peculiarities. The mechanisms discussed here make up the network of services to some municipalities and regions for years, but that doesn't translate into organizational models of the system. As successful that some mechanisms seem to report, structural problems as underfunding and constant change of management do not allow the sustainability of these practices in areas that they have been deployed.

The articles reviewed showed some successful examples and characterize the continued efforts in the area of mental health in promoting an integrated management, within a scenario beneficial to its fragmentation. The examples discussed offer subsidies that can be incorporated into various fields. When we set out to analyze the mechanisms of assistance integration by a longitudinal network clipping, we used to think we'd find elements that constitute other areas. In addition, mental health, for considering subjective aspects, which are inherent to their object of study and practice, shows to be a privileged area to design and deploy mechanisms both in the organization of the network, as in clinical practice, which showed potent and can be incorporated into health care Networks.

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