


Experiences in the substitutive network, meanings and therapeutic itineraries of women with a history of psychiatric hospitalization


Kiana Matos Modesto Brito¹

 <https://orcid.org/0000-0002-9415-4494>


Josenaide Engracia dos Santos²

 <https://orcid.org/0000-0002-7712-8470>


João Mendes de Lima Júnior³

 <https://orcid.org/0000-0001-6436-8566>


Thiago Nogueira Silva¹

 <https://orcid.org/0000-0002-8666-8698>

Débora Cristiane da Silva Flores Lino¹

 <https://orcid.org/0000-0003-0080-9873>

Rozemere Cardoso de Souza⁴





 <https://orcid.org/0000-0003-2705-1556>

Objective: to describe meanings, therapeutic itineraries and experiences of women with mental disorders and previous hospitalization history in psychiatric hospitals in relation to the Psychosocial care network. **Methodology:** this is a qualitative study guided by social constructionism according to the Social Psychology approach. Eight women participated in the study through semi-structured interviews, and the contents were analyzed through the construction of meanings based on idea association maps and thematic synthesis.

Results: the meanings given by the participants were grouped into four thematic categories: a) from the crisis(es) to the psychiatric hospital: itineraries of loss, prejudice and mistreatment; b) trajectories in the substitutive network: advances in mental healthcare; c) significant social actors in the deinstitutionalization process; d) challenges to enhance mental healthcare in the territory: what is the place and role of Primary Care? These meanings express advances in psychiatric reform and permanence of the biomedical model in the experiences of the participants in their deinstitutionalization process. **Conclusion:** the meanings produced by female users of mental health services reflect itineraries and social processes related to the conceptions of psychological suffering from the first crisis to the present day. They can serve as a pathway to advances in community-based mental healthcare.

Descriptors: Mental Health; Therapeutic Itinerary; Community Networks; Community Mental Health Services; Healthcare Reform.

How to cite this article

Brito KMM, Santos JE, Lima JM Júnior, Silva TN, Lino DCSF, Souza RC. Experiences in the substitutive network, meanings and therapeutic itineraries of women with a history of psychiatric hospitalization. SMAD, Rev Eletrônica Saúde Mental Álcool Drog. 2023;19:e-196190 [cited   ]. Available from:  <https://doi.org/10.11606/issn.1806-6976.smad.2023.196190>

year month day

URL

¹ Universidade Estadual de Santa Cruz, Ilhéus, BA, Brazil.

² Universidade de Brasília, Faculdade de Ceilândia, Brasília, DF, Brazil.

³ Universidade Federal do Recôncavo Baiano, Centro de Ciências da Saúde, Santo Antônio de Jesus, BA, Brazil.

⁴ Universidade Estadual de Santa Cruz, Departamento de Ciências da Saúde, Ilhéus, BA, Brazil.

Vivências na rede substitutiva, sentidos e itinerários terapêuticos de mulheres com história de internação psiquiátrica

Objetivo: descrever sentidos, itinerários terapêuticos e vivências de mulheres com transtornos mentais e história pregressa de internação em hospitais psiquiátricos em relação à rede de atenção Psicossocial. **Metodologia:** estudo qualitativo, norteado pelo construcionismo social, conforme abordagem da Psicologia Social. Participaram do estudo oito mulheres, por meio da entrevista semiestruturada, cujos conteúdos foram analisados pela construção de sentidos, a partir de mapas de associação de ideias e síntese temática. **Resultados:** os sentidos dados pelas participantes foram agrupados em quatro categorias temáticas: a) da(s) crise(s) ao hospital psiquiátrico: itinerários de perdas, preconceitos e maus-tratos; b) trajetórias na rede substitutiva: avanços no cuidado em Saúde Mental; c) atores sociais significativos no processo de desinstitucionalizar; d) desafios para potencializar o cuidado em Saúde Mental no território: qual o lugar e o papel da Atenção Básica? Esses sentidos expressam avanços da reforma psiquiátrica e permanências do modelo biomédico nas vivências das participantes em seu processo de desinstitucionalização. **Conclusão:** os sentidos produzidos por mulheres usuárias de serviços de saúde mental refletem itinerários e processos sociais relacionados às concepções do sofrimento psíquico da primeira crise aos dias atuais. Podem servir como caminho para avanços no cuidado em saúde mental de base comunitária.

Descritores: Saúde Mental; Itinerário Terapêutico; Rede de Cuidado Comunitário; Serviços Comunitários de Saúde Mental; Reorientação dos Serviços de Saúde.

Experiencias en la red sustitutiva, significados e itinerarios terapêuticos de mujeres con antecedentes de hospitalización psiquiátrica

Objetivo: describir significados, itinerarios terapêuticos y vivencias de mujeres con trastorno mental e historia previa de hospitalización en hospitales psiquiátricos en relación a la red de atención Psicossocial. **Metodología:** estudio cualitativo, orientado por el construcionismo social, según el enfoque de la Psicología Social. Ocho mujeres participaron del estudio, a través de entrevistas semiestructuradas, cuyos contenidos fueron analizados a través de la construcción de significados, a partir de mapas de asociación de ideas y síntesis temática. **Resultados:** los significados dados por los participantes fueron agrupados en cuatro categorías temáticas: a) de la(s) crisis al hospital psiquiátrico: itinerarios de pérdida, prejuicio y maltrato; b) trayectorias en la red sustitutiva: avances en la atención a la salud mental; c) actores sociales significativos en el proceso de desinstitucionalización; d) desafíos para potenciar la atención en Salud Mental en el territorio: ¿cuál es el lugar y el papel de la Atención Primaria? Estos significados expresan avances en la reforma psiquiátrica y permanencia del modelo biomédico en las vivencias de los participantes en su proceso de desinstitucionalización. **Conclusión:** los significados producidos por mujeres usuarias de servicios de salud mental reflejan itinerarios y procesos sociales relacionados con las concepciones del sufrimiento psíquico desde la primera crisis hasta la actualidad. Pueden servir como un camino hacia los avances en la atención de la salud mental basada en la comunidad.

Descriptorios: Salud Mental; Ruta Terapêutica; Redes Comunitarias; Servicios Comunitarios de Salud Mental; Reforma de la Atención de Salud.

Introduction

This study emerged in the context of a Family Health Unit where there was a growing demand for problems related to health/mental illness of people in the territory, and the commitment of health professionals to develop therapeutic interventions as part of a Multiprofessional Residency Program in Family Health (*Programa de Residência Multiprofissional em Saúde da Família - PRMSF*). It was addressed to people with a history of psychiatric hospitalization to describe the meanings given by them to the experiences, itineraries, functioning and dynamics of substitutive services.

Services replacing the psychiatric hospital represent advances in the Brazilian Psychiatric Reform (BPR), a process which began in the late 1970s in defense of the rights and care of people with mental disorders within the social space. This process was inspired by the experience of Italian democratic psychiatry, whose policies of social support and legal guarantees promoted the process of closing a large part of asylums in that country, and gave new meaning to the term "deinstitutionalization", in addition to the mechanism of dehospitalization, with the latter understood as the act of discharge from hospital, without proper follow-up of discharged patients from hospitals⁽¹⁾.

Deinstitutionalization is a complex process, which in short aims to deconstruct the asylum model and invent new care forms for people with mental disorders. In addition to administrative or technical restructuring, BPR requires profound cultural changes, such as the social imaginary about mental illness, which implies establishing permanent dialogues with society⁽²⁾.

Treatment in freedom became recognized as a right of people with mental suffering in Brazil through Federal Law No. 10,216 sanctioned in 2001⁽³⁾, and a redirection of the mental healthcare model began. As a result of this, with the Ordinance of the Cabinet of the Minister (GM) of Health No. 3.088/2011⁽⁴⁾, the creation of a network of actions and substitute services to the psychiatric hospital was instituted and regulated. This Psychosocial Care Network (*Rede de Atenção Psicossocial - RAPS*) is aimed at "people with suffering or mental disorders and with needs resulting from the use of crack, alcohol and other drugs, within the scope of the Unified Health System (*Sistema Único de Saúde - SUS*)".

RAPS comprises 18 different services and varied equipment, such as: Psychosocial Care Centers (*Centros de Atenção Psicossocial - CAPS*); Residential Therapeutic Services (*Serviços Residenciais Terapêuticos - SRT*); Coexistence and Culture Centers; Reception Units (*Unidades de Acolhimento - UA*); comprehensive care beds (in General Hospitals and CAPS III), Urgency and Emergency Network and Primary Healthcare services⁽⁵⁾.

The implementation of the RAPS⁽⁴⁾ demands constant and progressive processes of articulation between the

different care points, including the Family Health Strategy (*Estratégia de Saúde da Família - ESF*) and the CAPS in search of proximity between professionals from different services, being understood as a necessary strategy for comprehensive care. Consolidation of the care network implies co-responsibility or shared care which involves users, family members and RAPS workers.

Despite the BPR advances, there are unquestionable challenges for consolidating this reformist process in the country, including implementing care which produces autonomy and protagonism, which places management practices and care directed at people with psychological distress under permanent analysis, and resistance to mental health regression movements in the country⁽⁶⁾.

Other challenges include the growing number of people with mental disorders⁽⁷⁾, the weaknesses in community services resulting from underfunding of mental health policy in the last 10 years⁽⁸⁻⁹⁾, the current movements to dismantle the BPR⁽⁹⁾, for example Technical Note No. 3/2020⁽¹⁰⁾, and more recently the COVID-19 pandemic⁽¹¹⁻¹²⁾.

Given the above, we are encouraged to approach mental health service users with the intention of understanding the meanings constructed about care, services and their experiences considering the deinstitutionalization process. However, from the set of people sought in the territories covered by two ESF teams, it was only possible to identify women. Thus, this study aimed to describe meanings, therapeutic itineraries and experiences of women with mental disorders and previous hospitalization history in psychiatric hospitals in relation to the substitute mental healthcare network.

Methodology

This is a qualitative study from the perspective of social constructionism which has the idea that knowledge produces meanings as its fundamental assumption⁽¹³⁾. This theoretical-methodological framework was chosen as a way of understanding the voices of the research participants, considering intersubjectivity, diversity and plurality of meanings (among other aspects).

From this perspective, meanings comprise the ideas we live with, the categories we use to express these ideas and the concepts we seek to produce in everyday life, which bring with them social positions. The analysis focus is the interpretive or linguistic repertoires used in various dialogical practices, named discursive practices, which make it possible to explain and boost the dynamics of historical transformations⁽¹⁴⁾.

The discursive practices therefore refer to identifying permanencies and mainly the historical ruptures, which in the case of this study are the discourses which break with the asylum culture and open possibilities to expand and qualify the RAPS.

The context of this study was one of the territories of a Family Health Unit (*Unidade de Saúde da Família - USF*) in a municipality in the south of Bahia, Brazil, where two multidisciplinary teams worked; this *USF* assisted approximately 8,229 people, a population corresponding to what regulates Ordinance GM No. 2488/2011⁽¹⁵⁾, which approved the National Primary Care Policy, establishing the review of guidelines and norms for the organization of Primary Care, for the Family Health Strategy (*ESF*) and for the Community Health Agents Program (*Programa de Agentes Comunitários de Saúde - PACS*). The choice of this context was due to the fact that it is where the *PRMSF* is practiced at a public university in this region.

In this context, 17 people with a history of psychiatric hospitalization were identified, of which 8 (eight) women who met the following inclusion criteria participated in this study: a) having a previous psychiatric hospitalization history; b) gave consent to participate in the research. Psychiatric hospitalization in this study was considered to be the stay in a psychiatric hospital for any period. People who did not have conditions for effective verbal communication and those under 18 years of age were excluded from the sample.

Data were collected from October 1, 2019 to January 24, 2020, based on the following steps and research instruments: a) survey of people with mental disorders, and among them, those with a psychiatric hospitalization history; b) home visits to invite them to participate in the study, and obtaining the Informed Consent Form – ICF; c) completion of the form of sociodemographic characteristics, therapeutic itinerary of the participants; and d) conducting semi-structured interviews. The study had collaboration of the Community Health Agents of the unit in all stages, with the last one being to schedule the interviews.

The interviews were carried out at the interviewees' homes, as well as at the reference *USF*. Spaces with a reasonable guarantee of privacy, silence and minimum conditions to produce dialogues were sought. The data collection moment was understood as a discursive practice^(13,16), which allowed dialogues with the interviewees in a relaxed way, thereby allowing maximum freedom of expression through words in both terms of relationships and in terms of their speeches.

The interview followed a script with the following guiding questions: talk about your life story in the search

for mental health treatment, when was your first and last psychiatric hospitalization? If you had to sum it up in one word, what would you say about these admissions? Do you currently attend any service to take care of your mental health? Which one(s)? What can you say about them? If you had to sum it up in one word, what would you say about your care in these services? In addition to these services, are there places, groups or people that help you? Tell me about them. What events at work, at home and/or in the community where you live would help you today in your mental healthcare? The duration of each interview ranged from 30 minutes to 1 hour and 20 minutes.

The contents emerging from the interviews were recorded and transcribed for data analysis, followed by elaborating idea association maps⁽¹⁷⁾ and thematic synthesis to describe the meanings, itineraries and experiences of the interviewees in the psychosocial care network. Numbers were used to reference the participants to ensure anonymity.

The idea association map is a table and has the interpretive repertoires as an analysis category, which define the terms, concepts, commonplaces and figures of speech that demarcate the list of possibilities for the construction of meanings⁽¹⁷⁾. Therefore, it is a visualization instrument with a double objective: to support the interpretation process and to facilitate communication of the steps underlying the interpretation process, making it possible to show what happened when certain questions were asked or some comments were made.

As shown in Figure 1, the MS Word data processor was used to build the maps. Excerpts from the content emerging from the interviews were cut from the transcripts and pasted into three maps for each participant (respecting the sequence of statements) in columns corresponding to the following categories and subcategories related to the research objectives:

Map 1 - The disease: how they name it, how they describe the onset (places and situations involved), how they explain it, what others say.

Map 2 - Therapeutic itinerary – from community management to psychiatric hospitalizations: initial treatment paths, psychiatric hospitalization.

Map 3 - Trajectories in the substitutive network or *RAPS*: services attended, how they name and describe care, about family and possible support network, challenges.

How it is named	How do you describe the beginning (places and situations involved)	How is it explained	What others say
Psychiatric crises	<i>When I started to present (symptoms) I was 16 years old and from 16 to 19 years old I had exactly 5 crises, but in the fifth crisis I had a medical intervention and I had to be hospitalized, in this case at the base hospital...</i>		<i>... people said it was a spirit ...</i>

Figure 1 – Idea association map: the disease

The Consolidated Criteria For Reporting Qualitative Research (COREQ) was also used to guide the data exposition from this study, which is a 32-item checklist for interviews and focus groups⁽¹⁸⁾. This study complied with all ethical aspects of research with human beings, according to guidelines from the *Resolução do Conselho Nacional de Saúde (CNS) 510/2016*⁽¹⁹⁾.

Results

The participants of this study were women, aged between 35 and 64 years, had mostly incomplete primary education, and self-declared evangelicals. Regarding income, they were beneficiaries or retired and two had no occupation and no income (Figure 2).

Participant	Gender	Age	Religion	Education	Occupation	Income
P1	F	64	Evangelical	5 th grade	Homemaker	Retired
P2	F	40	Evangelical	High school	Homemaker	BPC*
P3	F	44	Evangelical	5 th grade	Homemaker	BPC*
P4	F	43	Evangelical	Illiterate	No occupation	No income
P5	F	35	Catholic	6 th grade	No occupation	No income
P6	F	54	Adventist	High school	Homemaker	BPC*
P7	F	51	Evangelical	7 th grade	Homemaker	Retired
P8	F	57	Evangelical	2 nd grade	Homemaker	BPC*

*BPC = Continuing Provision Benefit (*Benefício de Prestação Continuada*)

Figure 2 – Sociodemographic characteristics of the investigated participants

Table 1 presents a brief psychiatric history of these women, all diagnosed with “schizophrenia”. Most had the first crisis aged between 16 and 31 years and history of 5 or more psychiatric hospitalizations. The length of stay ranged from 7 days to 1 year. One participant did not remember the time she was hospitalized. After hospital

discharge, they were referred to the extra-hospital health system; only one of them reported having difficulty accessing it.

Of the 8 participants, 6 were being assisted by some RAPS service, namely: psychosocial outpatient clinic, CAPS – II, USF or Polyclinic.

Table 1 - Demonstration of some clinical characteristics of the participants. Itabuna, BA, Brazil, 2019-2020

Clinical characteristics	N
First crisis (age)	
16-31 years	05
32-47 years	03
Diagnosis	
Schizophrenia	08
Number of hospitalizations	
01	03
05 or more	05
Hospitalization time	
1 week	01
2 weeks to 1 month	01
1 month to 6 months	03
6 months to 1 year	02
Did not remember	01
Care by RAPS*	
Yes	06
No	02
Difficulty to access	
Yes	01
No	06
Did not know	01

*RAPS (*Rede de Atenção Psicossocial*) = Psychosocial Care Network

Considering the interpretative repertoires used by the participants regarding the previous hospitalization history in psychiatric hospitals and treatment in the substitutive network in the context of the *ESF*, the following themes describe the meanings, itineraries

and experiences related to mental healthcare. Thus, in order to organize the disposition of the participants' speeches, Figure 3 shows the testimonies of each participant according to the thematic category to which it was assigned:

Theme	Interpretive repertoires used by participants
<p>From the crisis(es) to the psychiatric hospital: itineraries of loss, prejudice and mistreatment</p>	<p>... After you have all these problems, you are unable to lead a normal life, you don't have one (...) you're unbalanced... Really disturbed. (Participant 3); She (mother) says I'm crazy and I'm really no good. (Participant 7); I got very nervous (...) and then when I had a crisis I couldn't and I didn't work anymore (...) (Participant 1).</p> <p>(You already told me that you worked a lot, with many things and your husband didn't work, right?) - He only made me mistreat that miserable man. (Participant 1); ... Only God knows if she is my mother because she treats me worse than certain stepmothers ... all this helps to make me get depressed, nervous, depressed. (Participant 7).</p> <p>It was hell because of the mistreatment, I remember the nurses calling us sluts. (Participant 3); Human beings cannot be treated like animals in that way. (Participant 2); There it was like a jail, locked in a small room and left there. (Participant 4); The hospital was a filthy environment. The boys did the cleaning, but the women excreted on the floor (...) it was a hell of a mess. (Participant 6); In terms of drinking from water to food, I thought it was unethical and impolite to give everyone water in the same glass (...) I stayed 3 days in a small room, trapped, tied up and they sedated me... (Participant 8). (What did you do during the day at the hospital?) - I didn't do anything, I just lay down, sitting in the cafeteria, there wasn't much to do. (Participant 6).</p> <p>It is a mental illness, of the brain and needs to be treated with medication so that the person can have a better quality of life. (Participant 2); My husband who hospitalized me, I can't even tell you why, I fell into a crisis, he thought I wasn't in a crisis, but he thought because he took care of me. He admitted me! Then I was hospitalized! (Participant 1); today I already understand the importance of medication, I have no more problems sleeping. (Participant 3).</p> <p>My father took me to a pastor's house first and these people prayed a lot in my presence and I remember they held my head telling the demon to leave. (Participant 3); I had this disturbance, then I called the pastor to say a prayer because it could be a bad thing. (Participant 6); (Do you still see angels?) - I see them right away and when I see them I go to pray because I'm afraid. (Participant 4).</p>
<p>Trajectories in the substitutive network: Advances in mental healthcare</p>	<p>CAPS* is an inclusion where there is the part of therapy, psychiatric care, nurses and psychologists. (Participant 2); In the psychosocial clinic I feel love for Dr. "N". At ASDITA†, I like the physical activities and here at the unit, I like the meetings with you, which are great. (Participant 1); I like CAPS* because they treat me much better than my own family. (Participant 7). After the psychosocial clinic left the hospital in Base, I didn't go there anymore. Everything closes and it's a hell of a fight that makes access difficult. (Participant 5); Here at the health center it's good, but we could have more access to the doctor because there are a lot of people and not many professionals. (Participant 2).</p>
<p>Significant social actors in the deinstitutionalization process</p>	<p>I have a brother who helped me a lot, he really helped me and my mother. (Participant 3); if my daughter had been there, she wouldn't have let me be admitted to the hospital, because she knows how to take care of me (Participant 4); if I didn't have the support of my family I don't think I would have the strength to overcome it. (Participant 8).</p> <p>The only space I go to regularly is the church because for me it's like you, the psychologist, because that's where I let go (...) talking to God is the best thing for me. (Participant 8); the church also treats me well, but there are many things in these churches, you know how human beings are (...) they make jokes about me. (Participant 7).</p> <p>After the community health agent came to my house and said to my mother: - take your daughter there to the unit because the CAPS nurse is registering people who have mental disabilities to undergo treatment at the CAPS* and not be hospitalized anymore. (Participant 7).</p>
<p>Challenges to enhance Mental Healthcare in the Brazilian territory: What is the place and role of Primary Care?</p>	<p>I think there should be groups like there are on narcotics, there should be one on Mental Health that listens to us weekly so we can meet and talk about what the person needs, about what happened (...) I think that in addition to church should have a space for you to go, for you to socialize. (Participant 2); the community could continue with the meetings (referring to the group formed by the resident of this study) with you here in the unit. (Participant 1).</p>

*CAPS (Centro de Atenção Psicossocial) = Psychosocial Care Center; †ASDITA (Associação dos Diabéticos de Itabuna) = Diabetic Association of Itabuna, BA, Brazil

Figure 3 – Themes and examples of interpretative repertoires used by the participants in the process of producing meanings about the experiences, itineraries and services of the Psychosocial Care Network

Discussion

The analysis of the research data was elaborated descriptively and presented in topics according to the themes defined in Table 4, and the interweaving between the corresponding linguistic repertoires, the investigated literature on the theme and the interpretation by these researchers, as follows:

From the crisis(es) to the psychiatric hospital: itineraries of loss, prejudice and mistreatment

The terms "mental illness", "crazy", "mentally ill", "abnormal", "unbalanced" and "disturbed" are among the repertoires most used by the participants to name mental illness, all of them marked by negativity. In this negativity, madness was maintained by a set of devices that sought its control and/or social isolation⁽²⁰⁾.

Such meanings interfere in the care offered by the comprehensive health network, as they characterize appointments which come from the history of the asylum, built over time as a flaw that the person presented in their behavior towards society, thus being outside the expectations expected for social living together. This results in the isolation and social exclusion of people with a history of mental disorders, and even today, implications like these are present in everyday life where the subject is seen and treated as an object⁽²¹⁾.

The term "nervous" was also recurrent in the participants' speeches. This term similarly originates from the biomedical model, and excludes psychosocial aspects from illness, meaning the processes through which social relations, history, and culture include and subordinate the biological. It also explains what is called the medicalization of life, a process which extends nowadays⁽²²⁾. Disease production occurs at the collective level and therefore the study of the health-disease process cannot be detached from the social context in which it is inserted⁽²³⁾.

This psychosocial dimension can explain the use of repertoires by the participants in this study about the meanings given to the onset of mental illness. They reported life moments of great stress, conflicts in love relationships and family relationships. At the time of these interurrences, the psychiatric hospital was reported as the main place of "choice" for "treatment" of the first crisis(es), but it is worth mentioning that there was no care network in the period in which the first crises manifested signs of suffering psychologically; the psychiatric hospital was one of the only care options in the public healthcare network. The meanings constructed for this trajectory of the participants characterize these institutions as inhumane spaces, excluding and medicalized practices.

Spirituality was also presented as one of the first paths in the care trajectory after outbreak episodes

of the participants, explained by repertoires similar to "divine evil" and "spiritual illness". In the history of mental illness, spirituality has always been present in the links between care concepts and practices with different implications, involving guilt, the image of madness as famous figures, and more recently a care dimension⁽²⁴⁾.

Therefore, the meanings given to mental illness describe the suffering they were subjected to at the beginning and throughout their life history. In turn, medical care and medication, as central elements in many statements, imply the hegemony of the classical psychiatry model which reduces the complexity of life and the mental health/illness process and the relationship with differences.

The BPR process based on the psychosocial care model, life possibilities and care in freedom for the participants emerged with deinstitutionalization, which are described in the following topics, and challenges for their social reintegration and for overcoming the model asylum in the contexts studied still persist even today.

Trajectories in the substitutive network: Advances in mental healthcare

The itineraries of the participants in *RAPS* services are highlighted in this topic. Itineraries understood as their experiences in seeking treatment of their afflictions and which elements influence their choices in this path⁽²⁵⁾, meaning without removing them from their environment.

The itineraries in this study regarding substitutive services after hospital discharge occurred in the various *RAPS* devices, making it possible to care for the person with mental suffering in community-based services. Therefore, they describe psychosocial care aspects, considering biopsychosocial, cultural and spiritual factors in the use of different care technologies. The integration of the individual as the subject of his/her history, the incorporation of the family in the therapeutic path, the community and the multi and interdisciplinary teams are also considered as support systems within the interventions that provide comprehensive care to the individual⁽²⁶⁾.

The narratives produced speak of well-being, associated with implementing new care devices; incorporating new technologies; and reorganizing work processes; to the conformation of networks; in addition to articulating and complementing existing services and sectors⁽²⁷⁾. They confirm the advances in mental health over the last 20 years, a period in which community services, such as *CAPS*, began to receive more resources than psychiatric hospitals⁽⁶⁾.

The meanings also express some of the challenges of the participants' deinstitutionalization process, as explained by losses and/or daily difficulties: access to services in a general hospital, access and continuity of Primary Healthcare (PHC) services, demands for service

improvements provided by new devices. Such challenges imply (among other social processes): thinking about the mental healthcare network to meet the complex needs and demands of its users, based on the principles of the *SUS*, among which universality, comprehensiveness, equality and social participation stand out⁽²⁸⁾; overcoming the logic of “referring” PHC professionals to specialized mental health services, inconsistent with the ideals of the BPR⁽²⁹⁾.

Thus, the services which compose the *RAPS* need constant revision and criticism, so that they become welcoming places instead of serving for another type of social exclusion. In this sense, the necessary and permanent concern with the quality of community-based services stands out, in addition to the instrumentalization of health and mental health workers and users, and the awareness of managers who are co-responsible for healthcare⁽³⁰⁾.

Significant social actors in the deinstitutionalization process

The most significant social actors for the participants’ social reintegration process were the family, religious groups and Community Health Agents (*Agentes Comunitários da Saúde - ACS*). Interpretative repertoires linked by affective ties stood out regarding the family. Family support is very important, and even more so during treatment, but this role in dealing with the subject in mental distress is not easy, as there are several feelings that the family can present in this situation, such as guilt, prejudice and incapacity.

The search for psychiatric hospitalization is often due to family exhaustion in living with the person with a mental disorder, so that caregivers can regain strength, protecting individuals from mistreatment, even if they are unconscious due to family exhaustion⁽³¹⁾. The family – included through kinship or emotional ties – needs support in exercising mental healthcare, remembering that they are often also victims of prejudice and lacking in resources⁽³¹⁻³²⁾.

The church was also described as an important support network for the participants. Although still with reports linked to deficit, religiosity appears more as a motivational factor in people’s lives which reflects hope as being extremely important in the health-disease-care process. Despite the increasing recognition of the importance of religiosity for health, most health professionals have not received training to deal with this issue, which has created gaps between the care provided and knowledge about the importance that religion represents in the lives of patients⁽³³⁾.

The Community Health Agents (*ACS*) and other *ESF* workers also mean support in the territory, and seem to fulfill the mission for which they were responsible, acting as mediators and in the dialogue between the team and the

community. The *ACS* was often the main way of accessing health and quality of life programs for the participants in contexts of poor or more remote communities.

This communication with workers in the basic health network also meant help in adhering to the *CAPS*, resulting in a reduction in the number of subsequent hospitalizations. The insertion of mental health actions in public health means to boost the deinstitutionalization process through more appropriate care forms for people with mental problems in their family, social and cultural contexts^(27,34).

Challenges to enhance Mental Healthcare in the Brazilian territory: What is the place and role of Primary Care?

Considering that the *ESF* implies an affective relationship with the assisted community, the involvement with individual, collective and social issues is fundamental in the routines of health professionals, as described in the previous topic. This affective phenomenon that occurs in this strategy links the parties, being important for monitoring and solving the health needs of users. However, there were few statements about this type of relationship in this study, and there were also almost zero frequency of statements in relation to the articulation of the *ESF* and the substitute services.

The population enrolled by the Primary Healthcare (PHC) team and Family Health Strategy ranges from 2,000 to 3,500 people, located within their territory, guaranteeing the principles and guidelines of PHC⁽³⁴⁾. The inclusion of mental health actions in the *ESF* is advocated by the Brazilian Ministry of Health, and constitutes the very essence of the deinstitutionalization process; in addition, it must transpose the actions of the biomedical model, and be centered on the disease through an approach that articulates treatment, psychosocial rehabilitation, expanded clinical and individualized therapeutic projects⁽³⁰⁾.

Thus, the challenges of mental health in PHC described in the literature and also identified in this study are the following: establishing articulation with specialized extra-hospital care devices, working in an intersectoral way, with the implementation of matrix support and formulating Individualized Therapeutic Projects (*Projetos Terapêuticos Singular - PTS*), aiming at greater resolution of mental health demands.

In the meanings given by the participants of this study, the failures and lacks for the articulation between mental health and primary healthcare can be understood as “projects which come to be”⁽³⁵⁾, to understand the challenges of public health. In this case, the fundamental principles⁽²¹⁾ are: notion of territory, organization of mental healthcare in a network, intersectorality, psychosocial rehabilitation; multiprofessionality/interdisciplinarity,

deinstitutionalization, promotion of citizenship of users and construction of the possible autonomy of users and family members, enabling greater social inclusion throughout the Brazilian territory by inserting users and groups and different works carried out in the community.

The reality of the social determinants in the Brazilian territory which directly interfere in the health-disease-care process of its community needs to be taken into account all its potentialities and difficulties to offer activities related to health promotion and disease prevention.

The continuous investment in the instrumentalization of professionals to leverage the inclusion of mental healthcare in the *SUS* with a view to reversing the care model is also a permanent challenge, with training and appropriation of expanded clinical concepts of the *ESF* professionals being fundamental for a paradigm change⁽³⁰⁾. In this sense, matrix support cannot end⁽³⁴⁾; on the contrary, it should encourage subsidies for inventing/creating mental healthcare alternatives in the territory, which even value the subjects in their ideas, as described by the participants in this study.

Thus, this study produced meanings about the experiences of people with mental disorders in *EFS* territories about mental illness and therapeutic itineraries from the hospital to substitute services. From the challenges, there is the alternative of contributing to the *EFS* teams in formulating and strengthening different care possibilities for this specific public, aiming at changing the care model from the biomedical to the psychosocial in the ways of demedicalizing mental health suffering and better quality of life.

The limitations of this study refer to the lack of information regarding the situations experienced by people without conditions for effective verbal communication at the time of data collection, and also the scarcity of content about the relationships between the participants and the *ESF* professionals. Thus, for both situations and with a view to expanding listening to other important social actors of care in the territory, studies are suggested that include family members and family health workers, and also instruments which can better explore the relationships or absence of these between people with some kind of psychological suffering and the *ESF* team.

Conclusion

In this study, we evidenced the social production of speeches and meanings of people with mental disorders with a previous psychiatric hospitalization history about mental illness, the psychiatric hospital and the de-institutionalization process through idea association maps. During the reflection of the speeches presented by the research participants, we were able to understand advances in BPR and also the permanence of the biomedical model, which is culturally impregnated

in professional health practices and in the experiences of users at its different levels, whether primary, secondary or tertiary.

Despite the advances achieved in the mental health area in recent decades, unquestionable challenges are present in order to consolidate this reformist process in our country, with the effectiveness of care that produces autonomy and protagonism being among them, and which places our management and care practices under permanent analysis.

Thus, this study can contribute to adding efforts to the deinstitutionalization process based on the evidence of gains in the BPR process, and understanding the dynamics of relationships between people with mental disorders, substitutive services and the *ESF* in order to subsidize movements and ways to strengthen the *RAPS* and reduce the usage of psychiatric hospitals.

References

1. Amarante PDC. O homem e a serpente: outras histórias para a loucura e a psiquiatria. 1. ed. Rio de Janeiro: Editora IMS/UERJ/Cepesc/Abrasco; 2005.
2. Amarante PDC; Guljor AP. Reforma psiquiátrica e desinstitucionalização: a (re) construção da demanda no corpo social. In: Mattos RA, Pinheiro R, orgs. Construção social da demanda. Rio de Janeiro: IMS/UERJ/Cepesc/Abrasco; 2005.
3. Brasil. Lei nº 10.216 de 6 de abril de 2001. Dispõe sobre a proteção e os direitos das pessoas portadoras de transtornos mentais e redireciona o modelo assistencial em saúde mental [Internet]. Diário Oficial da União, 06 abr. 2001 [cited 2022 Mar 31]. Available from: <https://www2.camara.leg.br/legin/fed/lei/2001/lei-10216-6-abril-2001-364458-publicacaooriginal-1-pl.html>
4. Brasil. Portaria nº 3.088 de 23 de dezembro de 2011. Institui a Rede de Atenção Psicossocial para pessoas com sofrimento ou transtorno mental [Internet]. Diário Oficial da União, 26 dez. 2011 [cited 2022 Feb 10]. Available from: https://bvsms.saude.gov.br/bvs/saudelegis/gm/2011/prt3088_23_12_2011_rep.html
5. Brasil. Portaria nº 2.840 de 29 de dezembro de 2014. Cria o programa de desinstitucionalização integrante dos componentes e estratégias de desinstitucionalização da rede de atenção psicossocial (RAPS), no âmbito do sistema único de saúde (SUS), e institui o respectivo incentivo financeiro de custeio mensal [Internet]. Diário Oficial da União, 29 dez. 2014 [cited 2022 Mar 31]. Available from: <https://pesquisa.in.gov.br/imprensa/jsp/visualiza/index.jsp?data=30/12/2014&jornal=1&pagina=54&totalArquivos=128>
6. Onocko-Campos RT. Saúde mental no Brasil: avanços, retrocessos e desafios. Cad Saude Pública. 2019;35(11):1-5. <https://doi.org/10.1590/0102-311X00156119>

7. Delgado PG, Schechtman A, Weber R, Amstalden AF, Bonavigo E, Cordeiro F, et al. Reforma psiquiátrica e política de saúde mental no Brasil. In: Mello MF, Mello AAF, Kohn R, organizators. *Epidemiologia da saúde mental no Brasil*. Porto Alegre: Artmed; 2007.
8. Trapé TL, Campos RO. Modelo de atenção à saúde mental do Brasil: análise do financiamento, governança e mecanismos de avaliação. *Rev Saude Publica*. 2017;51(19):1-8. <https://doi.org/10.1590/s1518-8787.2017051006059>
9. Cruz NFO, Gonçalves RW, Delgado PGG. Retrocesso da Reforma Psiquiátrica: o desmonte da política nacional de saúde mental brasileira de 2016 a 2019. *Trabalho Educ Saude*. 2020;18(3):1-20. <https://doi.org/10.1590/1981-7746-sol00285>
10. Ministério da Saúde, Secretaria de Atenção Primária à Saúde, Departamento de Saúde da Família (BR). Nota Técnica Nº 3, de 28 de janeiro de 2020 [Internet]. Brasília: Ministério da Saúde; 2020 [cited 2022 Mar 31]. Available from: <https://www.conasems.org.br/wp-content/uploads/2020/01/NT-NASF-AB-e-Previne-Brasil.pdf>
11. Lima RC. Distanciamento e isolamento sociais pela Covid-19 no Brasil: impactos na saúde mental. *Physis*. 2020;30(2):1-10. <https://doi.org/10.1590/S0103-73312020300214>
12. Faro A, Bahiano MA, Nakano TC, Reis C, Silva BFP, Vitti LS. Covid – 19 e saúde mental: a emergência do cuidado. *Estud Psicol*. 2020;37:1-14. <https://doi.org/10.1590/1982-0275202037e200074>
13. Spink MJ, org. *Práticas discursivas e produção de sentidos no cotidiano: aproximações teóricas e metodológicas*. São Paulo: Editora Cortez; 1999.
14. Spink MJ, Medrado B. Produção de sentidos no cotidiano: uma abordagem teórico-metodológica para análise das práticas discursivas. In: Spink MJ, org. *Práticas discursivas e produção de sentidos no cotidiano: aproximações teóricas e metodológicas*. São Paulo: Editora Cortez; 1999. p. 41-61.
15. Brasil. Portaria nº 2.488 de 21 de outubro de 2011. Aprova a Política Nacional de Atenção Básica, estabelecendo a revisão de diretrizes e normas para a organização da atenção básica, para a estratégia saúde da família (ESF) e o programa de agentes comunitários de saúde (PACS) [Internet]. *Diário Oficial da União*, 24 out. 2011 [cited 2022 Mar 31]. Available from: https://bvsmms.saude.gov.br/bvs/saudelegis/gm/2011/prt2488_21_10_2011.html
16. Rosa AR, Tureta C, Mozar JB. Práticas discursivas e produção de sentidos nos estudos organizacionais: a contribuição do construcionismo social. *Contextus* [Internet]. 2006 [cited 2022 Mar 31];4(1):41-2. Available from: <http://www.periodicos.ufc.br/contextus/article/view/32073>
17. Spink MJ, Lima H. Rigor e visibilidade: a explicitação dos passos da interpretação. In: Spink MJ, org. *Práticas discursivas e produção de sentidos no cotidiano: aproximações teóricas e metodológicas*. São Paulo: Editora Cortez; 1999. p. 93-121.
18. Souza VRS, Marziale MHP, Silva GTR, Nascimento PL. Translation and validation into Brazilian Portuguese and assessment of the COREQ checklist. *Acta Paul Enferm*. 2021;34:1-9. <https://doi.org/10.37689/acta-ape/2021AO02631>
19. Brasil. Resolução nº 510, de 7 de abril de 2016. Trata sobre as diretrizes e normas regulamentadoras de pesquisa em ciências humanas e sociais [Internet]. *Diário Oficial da União*, 24 mai. 2016 [cited 2022 Mar 31]. Available from: <http://conselho.saude.gov.br/resolucoes/2016/Reso510.pdf>
20. Foucault MR. *A ciência e o saber*. 3. ed. Rio de Janeiro: Editora Zahar; 2007.
21. Amarante PDC. *Saúde Mental e atenção psicossocial*. 4. ed. Rio de Janeiro: Editora Fiocruz; 2015.
22. Tesser CD, org. *Medicalização social e atenção à saúde no SUS*. 1. ed. São Paulo: Editora Hucitec; 2006.
23. Breilh J. *Epidemiologia crítica: ciência emancipadora e interculturalidade*. Rio de Janeiro: Fiocruz; 2006.
24. Monteiro DD, Reichow JRC, Sais EF, Fernandes FS. *Espiritualidade/religiosidade e saúde mental no Brasil: uma revisão*. *Bol Acad Paul Psicol* [Internet]. 2020 [cited 2022 Mar 31];40(98):129-39. Available from: http://pepsic.bvsalud.org/scielo.php?script=sci_arttext&pid=S1415-711X2020000100014&lng=pt&nrm=iso
25. Mângia EF, Muramoto MT. *Itinerários terapêuticos e construção de projetos terapêuticos cuidadores*. *Rev Ter Ocup Univ São Paulo*. 2008;19(3):176-82.
26. Valladares ACA, Lappann-Botti NC, Mello R, Kantorski LP, Scatena MCM. *Reabilitação psicossocial através das oficinas terapêuticas e/ou cooperativas sociais*. *Rev Eletr Enferm* [Internet]. 2003 [cited 2021 Nov 14];5(1):4-9. Available from: <https://revistas.ufg.br/fen/article/view/768/851>
27. Santos RC. *Saúde todo dia: uma construção coletiva*. São Paulo: Hucitec; 2006.
28. Conselho Nacional de Saúde (BR). *Documento Orientador da 5ª Conferência Nacional de Saúde Mental* [Internet]. Brasília: CNS; 2021 [cited 2022 Mar 31]. Available from: http://conselho.saude.gov.br/images/5cnsn/doc/documento_orientador_5CNSM.pdf
29. Rosa DCJ, Lima DM, Peres RS. *Saúde mental na Atenção Primária: (des)encontros entre enfermeiros e pacientes com diagnóstico de esquizofrenia*. *SMAD, Rev Eletrônica Saúde Mental Álcool Drog* [Internet]. 2021 [cited 2022 Mar 21];17(4):83-91. Available from: <https://www.revistas.usp.br/smad/article/view/176976/179325>
30. Hirdes A. *A Reforma Psiquiátrica no Brasil: uma (re)visão*. *Cienc Saude Colet* [Internet]. 2009 [cited 2020 Feb 15];14(1):297-305. Available from: <http://www.cienciaesaudecoletiva.com.br/>

artigos/a-reforma-psiquiatrica-no-brasil-uma-revisao/1241?id=1241

31. Soares CB. Família e Desinstitucionalização: impacto da representação social e da sobrecarga familiar [Thesis]. Goiânia: Universidade Católica de Goiás; 2003.
32. Souza RC, Scatena MCM. Produção de sentidos acerca da família que convive com o doente mental. Rev. Latino-Am. Enfermagem. 2005;13(2):173-9. <https://doi.org/10.1590/S0104-11692005000200007>
33. Almeida AM. Espiritualidade e saúde mental: o desafio de reconhecer e integrar a espiritualidade no cuidado com nossos pacientes. Zen Review [Internet]. 2010 [cited 2014 May 14];01(esp):1-6. Available from: <http://www.hoje.org.br/arq/artigos/Espiritual1.pdf>
34. Bonfim IG, Bastos NE, Góis CWL, Tófoli LF. Apoio Matricial em Saúde Mental na atenção primária à saúde: uma análise da produção científica e documental. Interface (Botucatu). 2013;17(45):287-300. <https://doi.org/10.1590/S1414-32832013005000012>
35. Paim JA. A crise da saúde pública e a utopia da saúde coletiva. Salvador: Casa da Saúde; 2019.

Authors' contribution


Study concept and design: Kiana Matos Modesto Brito, Rozemere Cardoso de Souza. **Obtaining data:** Kiana Matos Modesto Brito, Rozemere Cardoso de Souza. **Data analysis and interpretation:** Kiana Matos Modesto Brito, Rozemere Cardoso de Souza, Josenaide Engracia dos Santos, Thiago Nogueira Silva, João Mendes de Lima Júnior, Débora Cristiane da Silva Flores Lino. **Drafting the manuscript:** Kiana Matos Modesto Brito, Rozemere Cardoso de Souza, Thiago Nogueira da Silva, João Mendes de Lima Júnior. **Critical review of the manuscript as to its relevant intellectual content:** Josenaide Engracia dos Santos, Débora Cristiane da Silva Flores Lino, João Mendes de Lima Júnior, Rozemere Cardoso de Souza.

All authors approved the final version of the text.

Conflict of interest: the authors have declared that there is no conflict of interest.

Received: March 31st 2022

Accepted: Apr 5th 2023

Corresponding Author:
Rozemere Cardoso de Souza
E-mail: rcsouza@uesc.br
 <https://orcid.org/0000-0003-2705-1556>

Copyright © 2023 SMAD, Rev. Eletrônica Saúde Mental Álcool Drog.
This is an Open Access article distributed under the terms of the Creative Commons CC BY.

This license lets others distribute, remix, tweak, and build upon your work, even commercially, as long as they credit you for the original creation. This is the most accommodating of licenses offered. Recommended for maximum dissemination and use of licensed materials.