Care network for children and adolescents in psychic suffering: health promotion actions*

Rede de cuidado a crianças e adolescentes em sofrimento psíquico: ações de promoção à saúde

ORIGINAL ARTICLE

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ABSTRACT: The purpose of this article is to investigate the care network for children and adolescents in psychological suffering and to describe actions aimed at promoting mental health from a territorial intervention. This is a qualitative study based on an action research design whose sample was composed of 6 children and 9 adolescents living in the ascribed territory of four Family Health Units. A semi-structured interview was used, containing socioeconomic and demographic data and the relations in family and care network. The field log was also used for the transcription of the observations of interventions performed at home and in the community, from the perspective of primary health care. Flaws in the achievement of the play and the leisure performance were identified, as well as learning difficulties and behavioral changes; these aspects have been hindered by conflicting family relationships and poor living conditions. It was found that the school and the neighbors, which are the focus of the territorial interventions, are supporting elements in the care network of children and adolescents. Mental health care requires an integrated network with effective tools to promote autonomy and social participation of these subjects.

KEYWORDS: Primary health care; Delivery of health care; Child care; Adolescent health; Mental health; Occupational therapy.

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RESUMO: Este artigo se propõe a investigar a rede de cuidado de crianças e adolescentes em sofrimento psíquico e a descrever ações que visam à promoção da saúde mental, a partir de uma intervenção territorial. Trata-se de um estudo qualitativo, baseado no desenho da pesquisa-ação, cuja amostra foi constituída por seis crianças e nove adolescentes residentes no território adscrito de quatro Unidades de Saúde da Família. Utilizou-se uma entrevista semiestruturada contendo dados socioeconômicos, demográficos, e as relações na rede familiar e de cuidados. Também foi utilizado o diário de campo para transcrição das observações de intervenções realizadas no domicílio e na comunidade, na perspectiva da atenção primária à saúde. Foram identificadas falhas na efetivação do brincar, no desempenho do lazer, dificuldades escolares e alterações comportamentais; tais aspectos têm sido prejudicados por relações familiares conflituosas e precárias condições de vida. Verificou-se que a escola e os vizinhos são elementos de apoio na rede de cuidados das crianças e adolescentes, sendo foco das intervenções territoriais. O cuidado em saúde mental requer uma rede integrada, com ferramentas efetivas para a promoção da autonomia e participação social destes sujeitos.

DESCRITORES: Atenção primária à saúde; Assistência à saúde; Cuidado da criança; Saúde do adolescente; Saúde mental; Terapia Ocupacional.

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INTRODUCTION

A comprehensive mental health system to children and teenagers is built from an extensive care network, which must include services from different sectors capable of providing comprehensive care. Basic health care, education, and social care are strategic sectors in health care policies for children and adolescents, as they contribute to the promotion of health and to the prevention of diseases, in the process related to the identification and supervision of cases. They also enable the population to access the care network[1].

In Brazil, it is estimated that from 10% to 20% of the children and teenage population suffer from mental disorders, and 3% to 4% of those youngsters are estimated to need intensive care. Studies conducted between 1980 and 2006 found prevalence between 12.6% to 35.2% when respondents were the parents or children themselves. When a diagnostic interview was used, that rate ranged from 7% to 12.7%[1-2].

Children and adolescents with mental disorders may have seriously damaged functional performance - that corresponds to an individual's capacity to perform daily tasks in a way that is satisfactory and appropriate for each development stage. In the child population, the difficulty to perform those tasks usually shows through social structure flaws which mainly affect roles regarding playing and studying[3-4].

Therefore, it can be observed that psychic suffering give rise to implications which are not restricted to pathologies from children or adolescents. Therefore, a comprehensive approach which includes users, their families, the community, and supporting services is required. It concerns dealing with serious psychic impairment with collective compromises, in social protection networks. The more collective compromises are extended, the more the vulnerability and social risk of mentally ill children and adolescents decrease. Therefore, they need to have social and affective bonds around them, as a network which allows them to be welcomed, and that is made easier by basic health care professionals[5-6].

One should also take into account that some existing components may worsen the situation, such as low economic income, minimum schooling, lack of family structure, acting as barriers against the participation in health-promoting practices and healthier lifestyles. Thus, the connection between mental health care network and the general health care network - which may comprise health care, education, and social work services - is important and required[7].

The care network may be understood in either its structural or in its institutional dimension. In the personal dimension, it is composed of effectively important equipment for families, which establish social bonds and partnerships through those connections. Care networks may be interconnected by health care services, religious institutions, schools, and other services, and it constitutes a social support network which expressively aid families in dealing with adverse situations which arise while care is being provided, and positively reflect in family balance and in the quality of life of members who are involved in that process[7].

The Psychosocial Care Network (RAPS) aims to create, broaden, and organize health care matters to people undergoing mental suffering or disorders, who have needs originating from the abuse of crack, alcohol, and other drugs, in regards to the Brazilian Unified Health Care System - SUS. It presents, as its main goal, to promote health care to more vulnerable groups (children, adolescents, homeless people, and indigenous populations). Despite mental health care being a task for an articulated network of services, such articulation must include resources from communities for those to be considered as true social inclusion spaces in cities, which focus on people with mental disorders[5-6].

According to the Brazilian Ministry of Health[7] the child and teenage mental health care network must comprise several actions and services: mental health actions in the Basic Health Network, Psychosocial Care Centers - CAPSi, outpatient wards, community and cultural centers, access to leisure activities and to schooling.

The Mental Health Care Policy for children and adolescents provides specialized assistance to children undergoing intense psychic suffering in Child and Adolescent Psychosocial Care Centers (CAPSi), which are reference services from the community-based Psychosocial Care Network responsible for a certain geographical territory. They provide services to mentally-ill children and adolescents or to ones with problems arising from alcohol, crack, and abuse from other drugs. CAPSi must share responsibilities with other services from the mental health care network and from the remaining health care equipment in a certain municipality or region. It also develops intersectorial actions with education, judicial, and social care agencies[1,3].

In Primary Health Care, the development of mental health care interventions is built in the everyday routine of talks between professionals and users, in order to create strategies and to build health care. The Brazilian National Basic Health Care Policy sees its Family Health Care

Strategy (ESF) as the gateway for its health care model, and its Family Health Support Center (NASF) as their supporting team in the development of shared actions which promote the extension of clinical practices, support the improvement in its ability to analyze and intervene in the health care problems and needs from the community[6].

Occupational therapists have gained space and consolidated it in programs which deal with community members directly. Prioritizing the social aspect in psychosocial rehabilitation implies leaving rehabilitation centers and brick-and-mortar facilities and creating intervention spaces inside the community itself. Therefore, it must intervene in problems and relationships from the people in the community, understanding the role of activities as an important factor in the emancipation and construction of histories and contexts[5,8].

According to Ribeiro[9] "Occupational therapy cannot only be an intervention instrument" to control and eliminate psychic suffering, it must enable collective life and individual existence to be more interesting, open, and creative".

Occupational therapists are inserted in basic health care through NASF, and they develop actions to prevent and promote health. Those actions make people's independence and social participation easier, considering the diversity of conditions and needs which are present in daily life.

This study aimed to understand the children and adolescent health care network for psychic suffering, and to describe actions which aim to promote and recover mental health, as well as to minimize suffering from a territorial intervention with specific efforts from Occupational Therapy and from family health care teams. The motivation to conduct this study originated from the researchers' knowledge on health care, education, and leisure conditions to the related public, which was obtained from experiences in the project. The researchers used to operate in the field through practical disciplines in the pedagogical syllabus, and they are part of the teaching staff at the Occupational Therapy Course at the Federal University of Pernambuco, with their research subjects being students from that course. The socioeconomic and demographic conditions of that group were identified; as well as their relationships with their families and with the care network and their participation in playful activities at school and in their community.

The research and intervention actions made part of the "Action Research Project: interdisciplinary actions in the care to socially vulnerable people". They were developed by an occupational therapy professor and students of the Occupational Therapy course, regarding primary health care.

METHOD

This is a study with a qualitative approach, which is based on the action research design. This type of research is built in the logics between theory and practice, and it intervenes in real situations, thus producing useful and relevant knowledge[11]. For the action research process to take place, there was an agreement between the respective health care district and the university, in order to establish the research and the actions to promote and protect health, through extension projects which promote those actions. The action research took place as soon as cases were identified, involving and sensitizing professionals to the problem regarding mental health in the territory, and also at the moment the information was collected - as subjects were asked about the health care network, they ended up reflecting on their own life conditions and problems. Then, they were prompted to seek for solutions, which served as the base for care actions which were undertook in a way that both users and professionals were responsible.

The study was conducted with children and adolescents with psychic suffering histories and their family members. All participants had records in four health care units in Health Care District IV, which refers to Recife city, in the state of Pernambuco.

In order to subjects to be identified in the community, Community Health Care Agents (ACS) were sensitized and trained through brochures and lectures containing information regarding the characteristics and peculiarities of childhood and adolescent mental suffering, as well as risk and vulnerability situations for the installation of suffering profiles in the future. Training took place in two meetings at the Family Health Care Unit, which were part of the research project proposal. At those times, it was possible to clarify the doubts the ACS had regarding possible cases which were detected in their micro-areas.

The data were collected from households and community spaces which were selected for the territorial interventions between September 2012 and April 2013. In order to do that, a semi-structured interview containing socioeconomic and demographic data was conducted. It also contained the relationships in family and care networks.

The data on socioeconomic and demographic aspects were collected from the responsible family members, and they were then systematized for characterizing and describing subjects. Questions regarding the relationships

in the family and care network, in turn, were answered by the children and adolescents and represented in an ecomap. Then, the individual flowcharts of all subjects were compared and analyzed, and a single ecomap was built, one which was representative of most relationships.

An ecomap was chosen as it is a useful instrument to evaluate family relationships with the social environment. It is represented by diagrams which are interconnected by a circle in the middle representing their family or individuals themselves, by the flow of relationships, and by the probability for social relationships in the family, the strength of such bonds, and the impacts on the family and the quality of that bond. Studying the ecomap enables the analysis of the possibilities for acting according to developed activities and the social networks involved in the daily lives of families[12].

The information from the interview and the observations during residential visits supported the interventions in the territory.

The guidelines from the Family Health Care Support Center (NASF) were used as reference for the interventions. In this perspective, households were visited for listening to health care demands. Then, the ecomaps of users were built, so actions could be directed. The interventions for instructing teachers, discussing cases, adapting textbooks at schools were also part of the actions, in order to create strategies to improve school performance from the studied population[10].

A field journal was developed to describe the observations from conducted interventions in households and at the community, in order to guide the planning of care actions. The findings on the routines and relationships of children and adolescents were classified according to the characterization of subjects, care networks, and family relationships, and the conducted interventions were discussed based on the scientific bibliography survey results.

As those are vulnerable populations, both due to their diagnostic possibilities and to the fact that subjects are not legally autonomous to decide their participation in the research, free and informed consent forms were signed both by the subjects and their legal guardians. The research part of the project was approved by UFPE's Research Ethics Committee, under the CAEE no. 02666512.6.0000.5208, on July 23, 2012.

RESULTS AND DISCUSSION

Initially, the characterization of subjects will be presented, according to their socioeconomic and demographic conditions. Then, the care network and family relationships are presented through the ecomap. Afterwards, the intervention process in the territory is described.

Population characterization

This study included children and adolescents who were sent by Community Health Care Agents (ACS), as the former were at social risk and vulnerability, had behavioral problems, difficulty in learning, and conflicting relationships with their families and community. The studied group comprised 15 subjects aged between 6 and 17 years. Out of those, 10 are males and 5 are females - 9 of them are adolescents.

According to Poeta and Rosa Neto[13], adolescence predispose the onset of symptoms and mental disorder profiles. That is known to be a period marked by constant psychic transformations and internal conflicts, including at school. However, the intensity and the history of suffering, the context in which it takes place, the atmosphere in those youngsters' lives, as well as their and their caretakers' individual characteristics are factors which characterize their damaged mental health[14].

Fourteen of the subjects attended school, mainly in regular classes and institutions. Subjects performed school activities in regular groups, and thus underwent difficulties and conflicts arising from their psychic suffering and stigma. However, they also experienced the opportunity of being socially included and interacting with their peers in an environment where one can frequently find stimuli for a healthy development.

The socioeconomic levels of families were predominantly slow - families earned one minimum wage per month. In 13 cases, families had no formal employment relationships. Such situation has been pointed out in the literature as a risk factor for mental health. Being born at poverty, as well as living in psychological unfavorable environment are high risk conditions for people's mental health, and some individuals cannot develop the skills for a good psychoemotional development[15].

Although their parents have been mentioned as being the main responsible people for the children and adolescents, grandparents, especially the maternal ones, were found to be the main supporters and caregivers. In cases in which other people were the children's or adolescents' legal guardians, grandparents were seen as the main source of support to parents who needed to work in order to ensure the family income, or even because they felt they were also responsible for taking care of their grandchildren[16].

Care network and family relationships

The ecomap analysis (Figure 1), shows how week the relationship between users and specialized care services is, and how strong the users' relationship with Family Health Care Units (USF) is. The strong relationship established with the USF points towards the effectiveness of the Basic Health Care actions, as recommended by SUS, when it implemented its Family Health Care Program, intending to humanize health care practices through a bond between health care professionals and the population. [17] The Family Health Care Strategy has been recognized as a successful policy because it allows users to be closer to the professionals from health care units, as those are essentially knowledgeable on local and regional needs and on the network facilities which are able to meet those demands, which favors the solving of difficulties that are found in the territory[18,19].

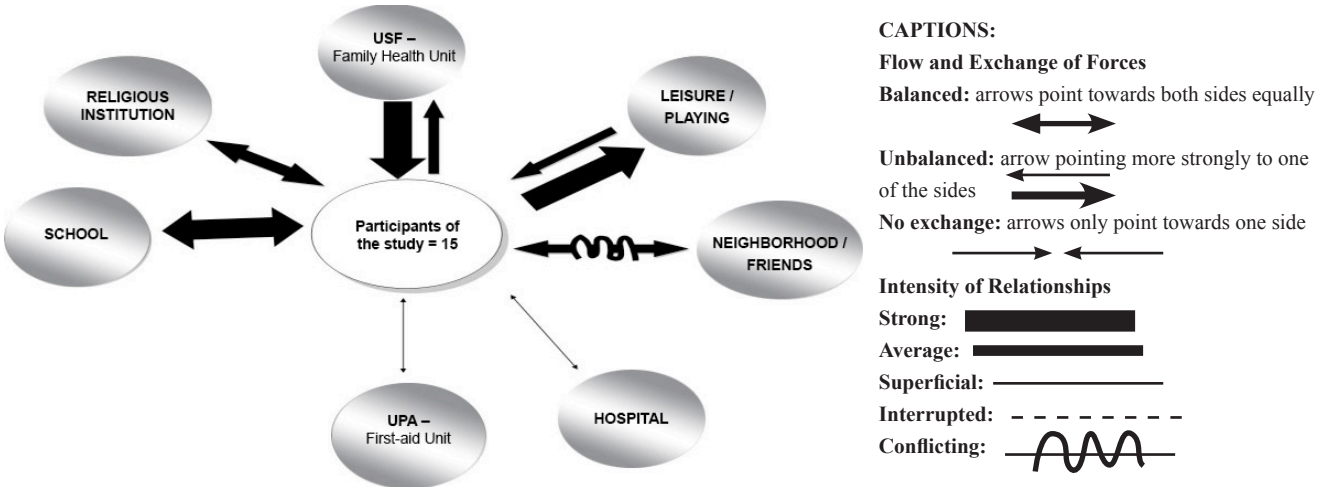

Figure 1 – Ecomap of the subjects' care network

Activities such as playing were not experienced much by children and adolescents. The little space they had available and violence were pointed out by their guardians as factors which get in the way of those activities.

To Motta and Enumo[20], children, while playing, change the environment they are currently at, getting it closer to an idealized reality, which may have a very positive effect as compared to just facing their realities. With that, the very recreational activity, which is free and disinterested, has a positive effect, when one sees everything that supports the promotion of children's wellness as favorable. During playful activities, actions become more revealing than unsaid words, once this act is filled with a symbolic content, in which children reacquire conceptions. Besides that, playful activities create possibilities for the unconscious mind to express itself through psychomotor and sensory development. The constraints found prevented subjects from developing skills regarding their development stages.

The relationships with their neighborhoods and friends are pointed out by subjects as a solid relationship which offers permanent support to the studied population. When families do not have a supporting network, difficulties are added to those in their daily lives, as people who are going through times of suffering expect to be able to have support, regardless if it comes from neighbors, their communities, church, among others. Thus, it is fundamental to extend the intervention to their neighborhoods, as those are understood to be an important resource for the mentally ill child and adolescent care network, as the Ministry of Health establishes when it mentions guidelines for Primary Health Care actions. Care actions must go beyond the family nucleus in order to maintain and strengthen family and community bonds. [10,21]

In regards to the family relationship study (Figure 2), families were identified to inspire strong bonds among these children and adolescents. In turn, several internal family conflicts and many symptoms reported by the subjects may be related to troubled family dynamics, which even include episodes of violence.

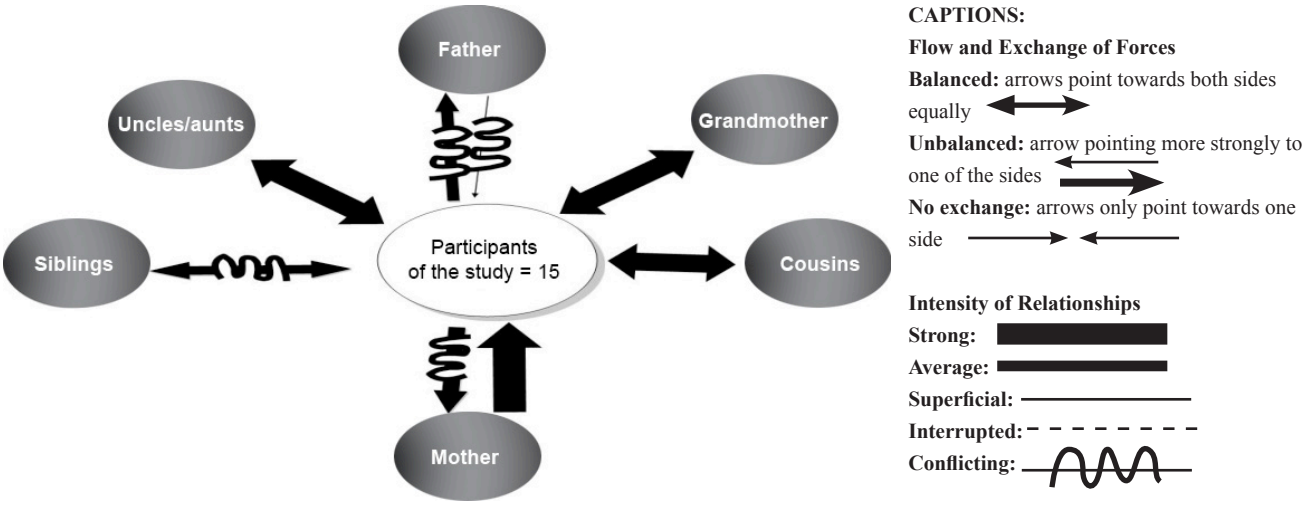

Figure 2 – Ecomap of Family Relationships

In this context, the domestic environment becomes potentially weakened for healthy development during childhood and adolescence, as families serve as models for children to learn behavioral and social patterns. Thus, when episodes of violence exist, the family acts as a negative model, generating behaviors which are harmful to social interaction and to the children and adolescents who see those practices in their daily lives[16].

Many users were also observed to keep superficial relationships with their fathers, which may be related to the little, low quality care they provided. That is justified by some as "lack of time due to excess work". When relationships existed, they were predominantly conflicting. The lack of a father figure in the daily life of a family leads mothers to be overburden, and that gets in the way of activities related to education and emotional support. That may lead to an increased risk of school, behavioral, and emotional problems[22].

Interventions in the Territory

The occupational therapist responsible for the research and eight students from UFPE's Occupational Therapy course - who were part of the research group - participated in the interventions. The interventions focused on including the child or adolescent in the territory, with aims to social participation and autonomy. In order to do that, the support services in the care network had been mapped and contacted. In order to better support the children and their families, matrix actions were conducted with the CAPSi and USF at corresponding areas, for discussing the cases and taking required measures (Chart 1). When difficulties in the access to recreation were noticed and when the damage that leads to development was understood, it was possible to create a community toy library in partnership with the local USF. The community organized itself to implement it. According to the Ministry of Health[10], Family Health Care Teams are responsible for fostering the creation of social inclusion spaces which are rich in stimuli, with actions which extend the social relevance feeling, through actions regarding educational and leisure practices.

When interpersonal relationships were identified to be conflicting, one of the main intervention targets was to strengthen family bonds (Chart 1). The lack of structure in family relationships many times led to an atmosphere that was surrounded by misunderstood and negative feelings among their members, which made difficulties more serious and had impacts in the subjects' self-esteem.

According to Vieira and Sá[21,23], the effects from therapeutic interventions have better results when family members are inserted into the therapeutic central in a central role. From that point on, families were asked to create coexistence agreements, in regards to organizing routines and performing self-expressive activities. Besides that, educational materials were prepared, and they contained instructions to legal guardians on how to stimulate their children and how important it is to establish affectionate relationships with them.

During interviews, family members reported complaints on the subjects' school and social performances. With that, during visits, the occupational therapist as the

children/adolescents' school material, in order to check their progress regarding school activities. For those who needed further support, as they had sight problems or hyperactivity - which made it hard for them to properly perceive their school material, adaptations were made and instructions were given for them to make the most of it. They were asked to set aside spaces and times for studying at home, in order to establish study routines and stimulate parents to take part in it. Many of the studied children and adolescents' legal guardians had low education levels, and that was a factor which made it hard for them to take part in their children's school activities[16].

Chart 1 – Description of conducted interventions in the territory of Recife, PE, Brazil 2013

Interventions in the care network
Mapping of support devices and articulation between these services;
Referral to specialized services;
Matrix actions with CAPSi and USF;
Project focused on the creation of a community toy-library;
Interventions at home
Strengthening family bonds;
Creation of sociability agreements;
Stimulating the routine organization;
Implementation of self-expressive activities;
Creating education materials for children estimulation;
Checking performance at school;
Adaptations for school supplies, guidance for pedagogical achievement.
Interventions within school context
Guidance provided about how to identify and deal with children and adolescents under psychic suffering;
Strategies provided for activities for learning assistance;
Discussion of cases and actions planning;
Workshops on sense perception and sensorial experiences.

School, albeit not being the only space for that, is a place established to promote formal learning. Its role is not only restricted to systematic learning and teaching processes, but it is also an important space for exchange, and transmission of social and cultural values. The student's occupational role is generally defined by their school, and by the laws that govern school operations. Therefore, that institution becomes a social system in which children learn rules of conduct and academic skills[23].

In that perspective, the need for actions to be also extended to the school environment was observed, in order to provide children and adolescents with full care regarding all areas in their occupational development (Chart 1). The importance of developing a project with educators, students, parents, and the community is highlighted, and it should also be extended beyond the school space, whose purpose is to cooperate with the learning process, socialization, and with students knowing their rights and duties as citizens[23].

Thus, intersectorial actions are required to include health care and education actions. At school, Occupational Therapy focuses on improving children's abilities to register, process, and integrate information through direct intervention, as well as to adopt compensatory environmental strategies, in order that children can minimize their difficulties and enhance their potentials[10,23].

During interventions, the discrepancy between perceptual-cognitive skills of children/adolescents and what they were offered by schools was noticed. Some of their teachers reported not being prepared to teach to such public, which makes these professionals feel anguished and incapable. Based on the findings, the interventions that were conducted at schools provided teachers with guidance on how to identify and deal with mentally-ill students, and consequently with their difficulties understanding pedagogical activities. They also indicated different possibilities and strategies to make it easier for students to learn and get interested by the syllabi. Workshops were

also conducted with teachers on sensory perception and experiences, for them to understand the positive effects sensory stimulation could cause in learning, and to improve their students' participation in the classroom.

CONCLUSION

During the study, the applicability and effectiveness of some tools which may be used by primary health care professionals were verified. They include the following: conduction of health-promoting practices and development of clinical actions, as well as the articulation and mapping of facilities in the network and of collective strategies that are conducted at schools, homes, and in other community spaces which serve as facilities which support and promote health.

It was also possible to find needs for the conduction of playful activities, the school-related difficulties in most cases, and the conflicting family relationships which hinder the healthy development of that population. Most subjects were noticed to live with few rights assured, once they do not have access to proper sanitation infrastructure, regular housing, leisure activities, specialized health care services, or efficient means of transportation.

The reality of conflicting family settings and relationships has led to missing references for children and adolescents, who are starting their lives and beginning to discover the world and their identities. Thus, they end up expressing negative feelings through attitudes and behaviors - they even get sick. Family is known to be the first and main social institution which is responsible for the formation of children's personalities. A flaw in that relationship leads to worsened psychic conditions for children. Thus, extending actions to family members is fundamental, with aims to improve family and community bonds, so all of them can feel they are also responsible in their care processes.

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