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Welcoming in the psychosocial care network: a descriptive-exploratory study

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ABSTRACT

Objective: To describe the welcoming practices and strategies implemented in the Psychosocial Care Network to individuals experiencing the process of mental illness. **Method**: A descriptive, exploratory, and qualitative study conducted from December 2017 to February2018, with 10 healthcare professionals from the Psychosocial Care Network of a city in theState of Pernambuco. The data were collected by means of a semi-structured interviews, non-participating observation and field diary records, and analyzed according to discursive textual analysis. **Results**: The predominant welcoming practices were qualified listening, bonding and dialogue. Consonance with the National Policy of Humanization and with the model of psychosocial attention was identified. **Conclusion**: Permanent education enables that practices related to the biomedical model are not reproduced. Qualified listening and dialogue are essential to know the patient’s history and to establish a connection with him/her.

Descriptors: User embracement; Health Services; Mental Health; Deinstitutionalization.

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INTRODUCTION

Welcoming is a health care practice defined as a method of communicating, listening and welcoming the populational demands, helping in the search for resoluteness, starting from the reception, appointment booking, delivery of care, and referral or returning. In this sense, welcoming goes beyond the sense of reception and referral, as it includes the entire therapeutic process of the individual[1].

As an operational guideline, welcoming involves the reverse logic of organization and operation of health care services. It is based on the principles of a universal access, resolution of health demands and change in the work processes. It aims to achieve the qualification of relationship between the professional and the patient in the development of a bond. Regarding the manner of working with the patient's health demands, a new method of acting according to the expanded clinic is evident, where care delivery is centered on the patient as a whole and not only on his/her pathology[2].

The National Humanization Policy (*Política Nacional de Humanização* - PNH) or HumanizaSUS, reformulated in 2003 by the Ministry of Health (MS), intensified investments in the humanization of management and care practices, modalities of managing and caring within the settings of the Unified Health System (*Sistema Único de Saúde* - SUS) network[3].

With implementation of the PNH, specific marks were consolidated such as the reduction of waiting lines and time; increased access with welcoming and resolutive care; patients' knowledge about the professionals and health care settings responsible for reference in the area; guarantee of participative management of the units including their professionals and patients; as well as continuing education for professionals[4].

The psychiatric care reform was marked by Law No. 10,216/2001, which provides the rights of mentally ill patients and also redirected the mental health care model. It provided the conditions for the constitution of a Psychosocial Care Network (*Rede de Atenção Psicossocial* - RAPS) composed primarily of community-based and territorial substitute health care settings[5].

The lack of welcoming for persons with mental illnesses by health care professionals working in primary care settings, establishes difficulties in guaranteeing the universality of access and completeness of care that can be identified in several small, medium or large districts. They are often related to the lack of professional qualification to deliver care to this public[1].

People with mental illness have the Family Health Strategy (FHS) as the entrance door to the system and organizer of care; however, welcoming must exist, in all network facilities in an integral and resolutive way. Thus, the relevance of this study is justified by aiming at strengthening the ideals of the PNH, and providing reflection on the act of welcoming that reinforces the professional attitude regarding the care of individuals experiencing mental illnesses.

Considering the above, the study aimed to describe the welcoming practices and strategies implemented in the Psychosocial Care Network to individuals experiencing the process of mental illness.

METHOD

This was a descriptive, exploratory, qualitative study was developed at the RAPS centers in the municipality of Pesqueira, State of Pernambuco, Brazil, between December 2017 and February 2018.

The study sample was composed by health care professionals, who worked in a FHS, two expanded centers for Family Health Support Center and Primary Care (*Núcleos de Apoio à Saúde da Família* - NASF - PC), a Center for Psychosocial Care (CAPS) II, and a Center for Specialties and medium-complexity hospital in the district.

The research participants were selected by convenience. The inclusion criteria were: delivering care to a mentally ill patient during the data collection period; working in the service for at least 6 months, because this is the period required by the professional to be inserted in the work process, in addition to possibly having a better connection with the patients. Ten health care professionals were included, two from each service, with the exception of NASFs - PC, from which one professional was selected from each unit.

Professionals who were not exercising their work activities due to vacation, medical or maternity leaves were excluded. The project was approved by the Research Ethics Committee of the Hematology and Hemotherapy Foundation of Pernambuco, and received a favorable opinion nº 1,803,905.

Data collection occurred by means of semi-structured individual interviews, non-participating observation and field diary records. The interview and observation guides were prepared based on the theoretical framework of the PNH. They were submitted to a pre-test in order to analyze language clarity and reproducibility by administering them to health care professionals in the SUS network who are not part of the study sample.

The semi-structured interview guide was composed of questions dealing with ten dimensions related to professional understanding about welcoming, including how the patient was received, general aspects of this practice and socio-demographic conditions (function, length of service, professional qualification). The observational script was composed by the dimension of how the patient was welcomed.

As for the practice of welcoming, in both instruments a checklist consisting of seven aspects to be addressed was available: Do you call the patient by name? Do you establish a dialogue with him/her? Do you explain the procedure that will be performed? Do you try to know how the patient is doing? Do you clarify the patient/family regarding doubts? Do you use simple and clear language? Do you worry about the next appointment? These parameters were grouped according to the answers provided by the interviewees and the observation by the researcher and considered as adequate, partially adequate and inadequate behavior to the SUS patient service.

The data collection in CAPS II, NASFs-PC and FHS was performed after previous scheduling with the team. For CAPS II and NASF-PC the observation occurred in the CAPS itself, during the professional care delivery to the patients, and then the interview was performed. In the FHS, the observation of a service occurred in the center itself, however, the next observation, as well as that of the

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other NASF-PC team, was performed via home visit. In the hospital center and in the specialty center, the team's work process was observed while waiting for the patient with mental illness care. At the end of the care provided, the interviews were administered. In all these contexts, the observations and interviews were only performed after the Free and Informed Consent Term was read and signed by both, the patient and the health care professional.

The data collected from the interviews and non-participating observation were complemented by records from the researcher's field-diary. To preserve the anonymity of the interviewed professionals, codes were used to identify them in the text (E1, E2...).

The data analysis occurred using the ATLAS.ti® version 8, a free demo software. The content analysis of the interviews was performed by means of the discursive textual analysis method, which includes elements of traditional content analysis and discourse analysis, representing a hermeneutical interpretive movement[6]. The first step included the process of disassembling the texts, followed by data codification. The codes were used as classification devices at different levels of abstraction, in order to create sets of related information units for comparison purposes. The last step involved the development of meaning networks among the codes, which facilitated the formulation of analytical categories[6].

It was possible to elaborate eight codes that composed the meaning network (Network View), which expresses discursive relationships about the practices and strategies of welcoming: "Concept of welcoming"; "Welcoming practices and strategies"; "Important aspects in the care delivery"; "Evaluation of care"; "Limiting aspects of care"; "Partnerships between the RAPS centers"; "Knowledge of patients about health care settings and RAPS professionals" and "Professional/patient relationship".

Subsequently the codes were grouped to form the following analytical categories: "I. Concept of welcoming", "II. Practices and strategies of welcoming" and "III. Care management". These categories were used as thematic axes for composition of metatext that elucidates new discursive relationships between the different codes[6].

RESULTS

Of the ten professionals participating in the study, one was a Community Health Agent (CHA), one nurse, one physiotherapist, two physicians, one nutritionist, two psychologists and two nursing technicians. Only three had specialist degrees, two in mental health and one in family and community medicine; four attended short courses in mental health and the other three had no complementary education in mental health. The time they worked in the field ranged from 2 to 35 years.

Concept of welcoming

The concept of welcoming, as a relationship of commitment, bonding and trusting between health care professionals and the patient was predominant:

> *[...] It's having a very receptive, affectionate view of the person who is approaching you; trying to make them feel comfortable and*

> *trying to give them confidence, that you are there to welcome them, you are only there to welcome them and nothing else, that the space is all theirs, that the attention is all theirs, that they are the priority.* (E3)

However, the concept of welcoming is often confused with the patient welcoming or screening in the health care setting:

> *[...] It's in the first contact I have with the patient to determine what kind of service I will be able to offer to that person [...] door entry, owning the health care service with the community or with the individual.* (E7)

Welcoming practices and strategies

In order to analyze how the patient experiencing the process of mental illness was welcomed by the health professional in the RAPS, the questions were grouped to serve as comparative parameters between the behavior during delivering of care to the SUS patient and the professional response to the interview (Figure 1).

Among the study participants, five had their perception consistent with their attitudes in all aspects observed and recorded in the checklist, having their behavior considered appropriate.

In contrast, three participants had their conduct partially consistent with their response. It was not possible to observe the professional E3 in some aspects, such as: whether the professional explained the procedure performed, whether she answered the patient's or the family member's doubts and whether she was concerned with the next appointment. These aspects were not observed, as it was not possible to enter the office at the time of the appointment due to the professional confidentiality. Therefore, the other factors were observed at the time the reception was performed.

The failure to obtain these data reflects the *Ethos* of the professional, as well as the researcher, because the professional confidentiality was respected and associated to the bioethical principles of autonomy and not maleficence.

Study participant	Do you develop welcoming practices?	
	Interviewee's response	Researcher's observation
E1	YES	YES
E2	YES	YES
E3	YES	PARTIALLY
E4	YES	NOT OBSERVED
E5	YES	YES
E6	YES	PARTIALLY
E7	YES	YES
E8	YES	NO
E9	YES	YES
E10	YES	PARTIALLY

Figure 1 - Development of welcoming practices by RAPS health professionals to the mentally ill patient. Pesqueira, PB, Brazil, 2018
Source: Elaborated by the authors, 2018.

The professional E6 also had her/his conduct partially correlated to her answer: she/he did not call the person by name nor did she attempt to know how he was doing. Finally, the professional E10 did not call the person by name, nor did she/he try to find out how he or she was doing, nor did she/he try to explain any doubts the person or the family had.

Only E8 did not have attitude consistent with answers in almost all aspects, having her/his behavior considered inadequate, because she/he only sought to know how the patient felt while administering the medication. This fact observed during the care provided by the professional is not in accordance with the PNH or with the ethical principles that regulate the health professions. However, many times these attitudes are enhanced by the high demand of the service, in which the professional provide care combined with fatigue, can cause losses to a qualified care.

In the following statement it is noted that, in the welcoming practice, all emphasis is given to the patient, without excluding the family as a direct participant in his/her care process:

> *[...] we sit down and we listen to the patient, we listen to the family member, sometimes the patient doesn't want to come, but the family is coming and we welcome the family [...].* (E2)

The practice of welcoming the participants most often stated was listening:

> *[..] Listening without judging and not emphasizing diagnosis [...] but in the patient care, that each professional has a different strategy of action and within the SUS we understood as the Singular Therapeutic Project (Projeto Terapêutico Singular - PTS), right? For us, this also needs to be important, and I think that interdisciplinarity is very fundamental* [...]. (E4)

Listening is a primary tool, because it is used to outline an intervention plan for the patient, as well as to establish dialogue and a link between the patient and the healthcare professional.

The care provided by professional E4 is centered on the person with mental illness and its peculiarities, and in this sense, she mentioned the PTS, an instrument of expanded clinic, one of the guidelines of the PNH.

The professional/patient bond was evident in many cases, such as the care provided by E9. The professional had already established the bond with the patient and made several questions about the health situation, performance of physical exercises that she had proposed in the last attendance, asked to see the tests and referred her to another service, with the elucidation of doubts and assisting her in the social reinsertion after the trauma suffered. The study showed that the participant's attitude follows the PNH and the psychosocial care model, as it listens to the patient without judgment, explains the existing doubts about health care settings and does not focus on the pathology, seeing the patient as a whole and respecting his/her autonomy.

Care management

The care management will be analyzed under the limiting aspects of care, partnerships

between the RAPS centers and patients' knowledge about the RAPS health care settings and professionals.

The professional E1 was accompanied during appointments that were initiated with questionings of how the patient was feeling, and others resulting from this initial approach. Most of the appointments were concluded with the prescription of medications, as the patients went to the appointments specifically for that purpose. The excessive demand of patients and accumulation of work contracts may have compromised the quality of the examinations, as they were performed in a very fast and automatic manner.

Regarding the question of the limiting aspects of care, it was mentioned that the rotation of professionals compromises the establishment of bonding, as in the case of professional E9, who would be joining a different team, jeopardizing the continuity of care. However, issues such as lack of infrastructure and lack of material resources were predominant. This can be evidenced in the following statements:

> *Unfortunately one difficulty we have is the structure issue [...] as for confidentiality, it's little impaired sometimes, now it's better, but before someone from the outside could hear what we said, the sound is not sealed, if someone speaks louder, it suddenly comes out [...].* (E3)

> *[...] a room [...] where better instruments would be available [...] more specific instruments, letters, games are necessary [...].* (E4)

Not only physical structure aspects, but also material resources were emphasized and these factors, according to the interviewees, end up making it difficult to provide qualified care.

With regard to patient' knowledge about the professionals and health care settings available at RAPS, the interviewee E7 emphasizes the strain during the shift by attending to demands that should not be met in the emergency service:

> *No [...] because if they knew they should go to the health center, CAPS, NASF, they would not come here to ask for a prescription, or a referral, for a chronic disease that is not decompensated [...] even here we see very few urgent or emergency cases. What are most stressful during the shift, what consumes most resources are patients who have a primary care profile.* (E7)

Another professional diverges from the previous interviewee by stating that the patients are knowledgeable of the professionals and health care settings existing in RAPS:

> *Yes, they prefer to go to the Reference Center for Social Care (Centro de Referência de Assistência Social- CRAS) and to the hospital sometimes; they don't like to go to the primary care, I've been working with them about that [...] but they don't feel very comfortable about going to the primary care, because they weren't very well received by the population. [...].* (E2)

When asked about specific welcoming practices and strategies for people with mental illness, seven participants reported that there was no specific pattern to these users. They stated that welcoming practices are the same for all patients. However, when asked about important aspects of caring for these people, they mentioned several factors that corroborate the PNH.

DISCUSSION

The welcoming comprises reception and screening, however, it goes beyond these moments, composing the whole period of coexistence between the team and the patients[2]. The welcoming is organized in a collective manner and aims to establish relationships of commitment, bonding and trusting between the health care teams and their patients[4]. It is often confused with the reception or screening of the individual and understood in various formats (door entry, immediate care), which go beyond the limit of the concept itself[7].

Both specialization and complementary education are of extreme relevance, especially when the professional delivers care to people who are mentally ill. The process of qualification in mental health is of great contributions, which provides professionals with more confidence to deliver quality support to this population. One of the marks to be reached by the PNH is permanent professional education, and the managers are responsible for analyzing the updating demands and offering the necessary qualification for the teams[5].

In health care settings, welcoming is considered a light technology, which has a great influence on the work process. It represents a strategy of change. Through the relationships established between professionals, patients and family members, it is possible to provide care with quality, according to the patient's need in a humanized manner[8].

In this context, the respect for the individual's autonomy reinforces the bond between professional and patient[9]. It contributes to overcome difficulties encountered in the public hospital health care settings, where professionals experience work overload due to a reduced number of professionals in face of a high demand for care, resulting in low quality care[10].

In the mental health field, from the deinstitutionalization process, the family assumed the main care provider for these individuals. Thus, the entire therapeutic process occurs in community-based health care settings, where teams try to give all the necessary support to the individual with mental distress and their relatives[11].

In this perspective, the professional must be resolute when confronted with the complaints raised by the individuals and demonstrate an attitude of co-responsibility with their treatment, considering their family and historical background. Before organizing any intervention, it is necessary to be attentive to what the patient presents[12].

The ability to listen to people is considered of utmost importance, as being listened makes the individual feel respected in the professional-patient communication. The professional communication skills can contribute to the development of a bond with the patient, as the communicative resources are considered relevant to their life history and world perception[13].

Patients should work closely with health care professionals to outline their care plan. The principle of shared decision-making favors the patients of health care settings to take responsibility together with the team to achieve their goals[14].

The practice of welcoming is present in all relationships of care, in the union between health care professionals and patients, in the acts of receiving and listening to individuals, and can occur in several manners, according to each professional scenario[7].

Bonding is a decisive instrument in the relationship between the health care professional and the patient, as it brings along the idea of the patient as an autonomous subject, participant in the health care process, and enables the responsibility agreed upon and shared[5].

In this sense, in order to achieve the goals agreed upon during the therapeutic process, one of the indispensable strategies is the bond established between patients and the health team, so that they can work together and ensure that the strategies and care interventions outlined are in accordance with the needs of the patient[15].

In order for welcoming to be an inseparable practice in health care at all levels of complexity, it is necessary to have adequate staff sizing so that the appointments and care are not performed in a hurry, and so that they are not centralized in the prescription of medication[16].

Other aspects can be explored, such as the individual and social needs of the patient, which could be prioritized in the assistance[17].

In addition to this, other factors limit the quality of care, such as the shortage of material and didactic resources, which end up bringing losses in the performance of therapeutic workshops, in addition to the inadequate physical structure of the health care settings[18].

A study conducted in Minas Gerais reinforces that the more effective the basic care, the lower the hospitals flow. Therefore, the adequacy of demand in each level of health care stimulates an environment to the development of welcoming practices. According to their characteristics, primary health care settings would be the most appropriate to assume responsibility for coordinating the individual's therapeutic process. Acting as an entry door, coordination strategies can be determined based on effective communication between levels of care. In this sense, the information is presented in a beneficial manner for the patient and satisfactory for professionals[19].

The FHS is considered relevant for creating forms of relating people to various dimensions of health, including mental health. Therefore, it is necessary to work to deconstruct negative thoughts and stigmatizing conceptions of many patients and professionals about mental illness, considering that the right to enjoy the health care service belongs to everyone[5].

There are some obstacles of primary care to accomplish this role, and among them, the weakness in the qualification of some professionals who work at this level of care, because they often have not been capacitated to work with this demand, providing low quality care.

In the hospital context, a strategy was developed to reach one of the goals that PNH aims to achieve, which is the organization

of the waiting list. In addition to proposing priority order of care, the Welcoming with Risk Assessment and Classification (*Acolhimento com Avaliação e Classificação de Risco* - AACR) is a dynamic process of identifying patients who require immediate care, according to their severity condition and not in order of arrival as was previously the case in the emergency health care settings [20].

The AACR is under implementation in the hospital service that is integrated in the research, which is important both for the population and for the professionals, who will be able to provide immediate care to people with a higher degree of criticality, acting in accordance with the SUS principle of equity.

CONCLUSION

The practices and strategies of welcoming patients with mental illness that were identified in the RAPS, in the city where the study was conducted, are mostly in line with the PNH and the psychosocial care model. These practices are fundamental for qualified care. Although there are still attitudes focused on the biomedical model, this was not the predominant practice in the present study.

Professionals do not have a specific standard of care to be followed in delivering care to people with mental illness. However, their behaviors are humanized and for that they use the tools of qualified listening and dialogue, which are important to know the trajectory of the patient and with that establish a bond with them.

Managers should cooperate more with the health care professionals who work in these health care settings, especially regarding physical structure, material resources and qualification, because working with the mental health demand requires the teams to be updated, so that they do not reproduce practices that are contrary to the principles of psychiatric reform.

It is also necessary to analyze possibilities of redirecting the teams' work process that contemplate strategies to reduce the excessive demand on health care settings, among others, because the overload of professionals often makes it impossible to provide qualified care.

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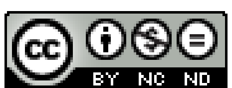

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