

---

---

## THE SHARED CARE IN MENTAL HEALTH AS POTENTIAL OF USER AUTONOMY

Mirla da Silva Lima<sup>1</sup>

Ana Caroline Leite de Aguiar

*AD CAPS of Horizonte and School of Public Health of Ceará (ESP-CE), Horizonte-CE, Brazil*

Mabel Melo Sousa

*Municipal Government of Horizonte, Horizonte-CE, Brazil*

**ABSTRACT.** The care in mental health is permeated by the interchange of knowledge and the co-responsibility between the various actors involved in this process. The general objective of this study was to describe how is the relationship between family and multi-professional group of a General CAPS of the metropolitan area of Ceará, in relation to the shared care in mental health. The research was qualitative, based on participant observation technique with registration in field diary and in the semi-structured interview technique with ten people, among professionals and family members. The study was based by the Hermenêutico-Dialético method. We noticed that there is a relationship of respect and bond between family and professionals and that these individuals see as important the existence of shared care. With regard to the family's participation in the service, we observed a low adherence to the family group and a higher frequency of family as accompanying in individual assistance and in critical moments. We also identified the legitimacy of the relationship between shared care and user autonomy.

**Keywords:** Mental health; caregivers; family; autonomy.

## O CUIDADO COMPARTILHADO EM SAÚDE MENTAL COMO POTENCIAL DE AUTONOMIA DO USUÁRIO

**RESUMO.** O cuidado em saúde mental é permeado pela troca de saberes e pela corresponsabilização entre os diversos atores envolvidos nesse processo. O objetivo geral do estudo consistiu em descrever como se dá a relação entre a família e a equipe multiprofissional de um CAPS Geral da região metropolitana do Ceará, no que se refere ao cuidado compartilhado em saúde mental. A pesquisa teve natureza qualitativa, baseada nas técnicas de observação participante, com registro em diário de campo e de entrevistas semiestruturadas com dez sujeitos, dentre profissionais e familiares. O método Hermenêutico-Dialético alicerçou a análise dos dados. Constatamos, de uma forma geral, uma relação de respeito e de vínculo entre familiares e profissionais, e que estes sujeitos veem como importante a existência do cuidado compartilhado. Quanto à participação da família no serviço, percebemos uma baixa adesão ao grupo de família e uma maior frequência dos familiares como acompanhantes nos atendimentos individuais e nos momentos de crise. Identificamos ainda a legitimidade da relação entre o cuidado compartilhado e a autonomia do usuário.

**Palavras-chave:** Saúde mental; cuidadores; família; autonomia.

## LA ATENCIÓN COMPARTIDA EN SALUD MENTAL COMO POTENCIAL DE AUTONOMIA DEL USUARIO

**RESUMEN.** El cuidado en salud mental está muy permeado por el intercambio de saberes y por la responsabilidad compartida entre los diversos actores implicados en este proceso. El objetivo general del estudio trató de describir cómo se constituye la relación entre la familia y el equipo de profesionales multidisciplinares de un CAPS General de la región metropolitana del Ceará, en lo que se refiere a la atención compartida en la salud mental. La investigación tuvo un carácter cualitativo, utilizando como técnica de recogida de información la observación participante, siendo los datos registrados mediante el diario de campo y entrevistas semiestruturadas con un total de diez participantes, entre profesionales y familiares. Además del comentado, el método hermenéutico-dialéctico nos ha calcado de los retos necesarios hacia el análisis de datos. Hemos

---

<sup>1</sup> *E-mail:* mirli.ma@hotmail.com

constatado, de manera general, una relación de respeto y de vínculo entre la familia y los profesionales, y que, a dichos participantes, les parecen importante la existencia de la atención compartida. Cuanto a la participación de la familia en el servicio, percibimos que estos no participan tanto cuanto la función corresponde a de acompañar, a la persona enferma, en los atendimientos individuales y en los momentos de crisis. Identificamos, aún, la legitimidad de la relación entre la atención compartida y la autonomía.

**Palabras-clave:** Salud mental; cuidadores; familia; autonomía.

---

## Introduction

Reflecting on the Brazilian Mental Health Policies in the current reality shows as necessary the attention to the process of change of the mental health care paradigm, once the model of care that guides this area in contemporaneity underwent social, historical and political changes over time. From a look that punished, isolated and institutionalized the individuals with mental disorders, it was reached a conception of care as right of democratic, humanized and psychosocial character.

The attention to mental health in Brazil underwent several reconstructions from the movement of Psychiatric Reform that, based on the international experiences of psychiatric deinstitutionalization, was intensified from the 1980s, through the sociopolitical struggle and mobilization of a multiplicity of actors, such as social movements, users, families, association of individuals with mental disorders and healthcare professionals. This movement aimed at the transformation and replacement of the hospital-centric model by a new perspective based on humanization, uniqueness and rights of users (Amarante, 1995).

This movement consisted and still consists of a set of transformations of practices, knowledge and values, permeated by impasses, conflicts and challenges, but with new nuances and possibilities (Bisneto, 2009). In this sense, we also highlight the continuous and dialectical character of this process, since in the contemporary reality the struggle is increasingly alive and current.

According to estimates of the World Health Organization (2001), the mental and behavioral disorders affect more than 25% of the world population in some moment of life and one in each four families has at least a member with some mental or behavioral disorder. Besides, it is projected that until 2020, there will be a growth of 15% in the framework of mental disorders.

With the creation of the Unified Health System (SUS), the practices of health were redirected in the direction of integral attention, networking and democratization and humanization of the service, elements that guided the formulation of the National Mental Health Policy, which is represented, in the legal sphere, by the Law 10216 (Brazil, 2001).

Several achievements were obtained after the implementation of this Policy. According to the Ministry of Health (2012), there is a progressive reduction in the number of psychiatric hospitals: in 2002, one year after the promulgation of the Law 10216, the costs with psychiatric hospitals corresponded to 75.24% of the resources of the SUS allocated to mental health in Brazil, while in 2011, this percentage decreased to 28.91%. Besides, until 2014, 2129 Centers for Psychosocial Attention (CAPS), 695 Therapeutic Residences, 60 Accommodation Centers, 119 Street Clinics and 800 psychiatric beds in Hospitals were in operation in the country (Ministério da Saúde, 2014).

The present scenario of Mental Health Policy in Brazil is marked by the existence of a Network of Psychosocial Attention (RAPS) composed of services and devices of community level, with focus not only on the assistance, but also on preserving and promoting health. Among the many devices that form the RAPS, CAPS have a role of great importance in systematizing and offering care to the user with mental disorder.

In the context of the State of Ceará, the Ministry of Health (Ministério da Saúde, 2012) points out that, until 2012, there was 106 CAPS, among which 50 were type I, which are destined for municipalities between 20,000 and 70,000 inhabitants, as in the case of the CAPS in the municipality in which the research was carried out.

The CAPS I or General CAPS, as is known, constituted the locus of the research. This service, created in 2001, has around 6000 medical records open and assists primarily persons with severe and persistent mental disorders, but also there is several cases of light and moderate sorrows. In the municipality, there is also a CAPS in Alcohol and other Drugs (CAPS AD), which was established in 2013.

In the psychosocial optics, the exchange of knowledge and experiences and the co-responsibility between the several actors involved in the mental health care process are fundamental for the promotion of citizenship, autonomy and leading role to the user. Among these individuals, the family and the multi-professional team have direct participation in the care and living with the user with mental disorder. The shared care is visualized, thus, as a strategy and a conception directly linked to the mental health nowadays (Pinho, Hernandez, & Kantorski, 2010; Schrank & Olschowsky, 2008).

According to the Law 10216 (Lei n. 10216, 2001), the State is responsible for the development of the mental health policy and for the promotion of health action, which must occur with the participation of the society and family. The family came to be considered a potential link of care and a participant of the process of treatment and psychosocial rehabilitation (Santin & Klafke, 2011). It is worth highlighting the understanding that there is not, in the contemporaneity, a hegemonic model of family, but a plurality of family structures, since biological, emotional and/or bonds of identity (Itaboraí, 2005) can form the families.

The relevance of this study, given by virtue of the fact that the investigation of the relationship between the family and the multi-professional team in regard to the co-responsibility of the care, may bring contributions for a better understanding of the care process performed and conjecture of life of the actors involved, which can also result in new possibilities, ideas and perceptions necessary for the continuous rethinking of the everyday praxis. We also highlight the training process of the Integrated Health Residency (RIS) of the Public Health School of Ceará (ESP-CE), so that it was possible to live daily several situations that cross over the investigation process, since it was established a direct action/relationship with the users, the family, and the other members of the team.

In view of the relevance of the theme, this study had as general objective to describe how is given the relationship between the family and the multi-professional team of a General CAPS of the metropolitan area of Ceara, in relation to the shared care in mental health. For that, we sought to investigate if/how occurs the co-responsibility of the care in the service, identify the vision of the family and team with regard to the participation of the family in the care and understand the meanings that the family and the team attribute to the relationship between the shared care and the user autonomy. We emphasize that this study had as theoretical reference authors such as Amarante (1995), Bisneto (2009), Melman (2006), Minayo (2000, 2007) and Vasconcelos (2010), as well as the current legislation on mental health.

We adopted, with regard to the state-of-the-art, the scientific literature, in which by researching in the Virtual Health Library (VHL), which includes 5 databases on health and using the descriptors "mental health" and "family" in association, we found 339 national articles, from which we choose 37 that correspond more closely to the thematic focus of the study. That is, the selected article versed about the family insertion in devices of mental health and about the mental health care in the psychosocial perspective.

Although some researches deal with, in general terms, the shared care on mental health (Camatta & Schneider, 2009; Dimenstein, Sales, Galvão, & Severo, 2010; Pimenta & Romagnoli, 2008; Pinho et al., 2010; Santin & Klafke, 2011; Schrank & Olschowsky, 2008), studies with specific focus on the relationship between the families and the professionals with regard to the shared care on mental health were not found, based on the opinions of both, as well as in relation to the association between this and the user autonomy, which demonstrates the differential character of the present study and the need to magnify the researches on the above-mentioned theme.

## Method

This study was anchored in the qualitative approach of research. It was opted by the referred perspective by virtue of the fact that it "works with the universe of meanings, reasons, aspirations, beliefs, values and attitudes." (Minayo, 2007, p. 21).

The semi-structured interview and the participant observation were used as techniques of data generation and had the field diary as a complementary resource. The first was chosen for allowing a

greater proximity with the subjects and by virtue of being a more flexible technique about the guidance elaborated. This was composed of six subjective questions that addressed the following points: accomplishment of the care in the service, relationship between family and team, division of roles, family participation in the care, vision about the group of family and user autonomy. The interviews were recorded and transcribed. On the other hand, the participant observation, for allowing, according to Minayo (2007), a direct relationship with the participants, since the observer is part of the observed context, was applied to the study due to our formative experience in Collective Mental Health in the RIS-ESP. In this regard, the locus of the research consisted of a General CAPS of the metropolitan area of Ceará, which was one of the services covered by the Residency.

As regards ethical aspects, the accomplishment of this research followed the criteria of the Resolution 466/12 (Resolução n. 466/12, 2012) and was approved by the Committee on Ethics in Research of the ESP-CE (CEP/ESP) under the Legal Opinion No. 962,978. Besides, the participants were enlightened about the objectives, methodology, guarantee of anonymity, and other relevant information upon authorization and signature of the TCLE (Informed Consent Form).

The subjects, participants of the research were families and professionals of the service. With regard to the former, we interviewed families of users with severe and persistent mental disorders, more specifically, the schizophrenic disorder, once, according to the Ordinance No. 336/GM (Portaria n. 336, 2002), the CAPS have as primary profile of assistance, the disorders of higher complexity. Besides, the interviews were conducted for families of the users monitored, for at least, six months in the service. This period was stipulated due to the perception that, from the practice in the professional routine, after some months of monitoring, there is a greater possibility of systematization of the care, as well as intensification in terms of records of the treatment and a stronger link between the subjects involved in the process of care. In addition to these factors, the choice was for the families in which, in the course of the practical experience, we have already been in touch, as part of the user care, on some occasion. The interviews occurred in the service itself, at the moment that the families, as companions, were waiting for care.

As for the professionals, we interviewed one professional from each category of upper level. According to the aforementioned Ordinance, the technical team of upper level must be composed of a physician with training in mental health, a nurse and three professionals among the following categories: psychologist, social worker, occupational therapist, educator or other professional necessary to the therapeutic project.

It is urgent to highlight that, in the period of the empirical research, the technical board with superior level of the General CAPS studied was formed by two psychiatrists, one clinician with specialization in mental health, one nurse, one social worker, one psychologist and one occupational therapist. The service had also two teams of professionals-residents, composed of the categories of psychology, social service, nursing, occupational therapy and physical education.

To define the amount of subjects interviewed, we used the sampling by saturation, from which, the closing of the sample had as criterion the moment in which the obtained data started to present certain redundancy or repetition (Fontanella, Ricas & Turato, 2008). Thus, ten subjects were interviewed: five relatives and five professionals. With regard to the data analysis and systematization, the followed goal was the hermeneutical/dialectical method. This method, which has its methodological chronology based on sorting, classification/categorization and final analysis of the data, presents as approach the articulation between the critical and the interpretative perspectives, in order to provide a theoretical-critical reflection of the knowledge (Minayo, 2000).

## Results and discussion

The research pointed out three main themes noticed in the speeches of the subjects: co-responsibility of the care in the service; forms of participation of the family in the service; and relationship between shared care and user autonomy. The family members interviewed were

symbolically called F1, F2, F3, F4 and F5, and the professionals received the titles P1, P2, P3, P4 and P5.

### Co-responsibility of the care in the service

Most of the subjects interviewed report to have a good relationship between the family and the team. Most professional stated that, in general, there is a relationship of respect and care between the referred actors. Similarly, all family participants reported that they are very well assisted and that they feel welcomed in the service: *"The users feel welcomed, respected, cared. Even the family members themselves... in a totality, I think it is a good relationship."* (P2); *"I talk to the doctors... I talk, I ask things to them. I feel myself well assisted, they never treat me bad. Everyone is great."* (F2).

We understand that, to occur the care in a truly shared way, is relevant the establishment of a good link between the multi-professional team and the families, which requires openness for a dialogue and exchange of experiences from both sides (Bessa & Waidman, 2013; Colvero, Ide, & Rolim, 2004; Melman, 2006; Pimenta & Romagnoli, 2008; Schrank & Olschowsky, 2008).

A present issue in the speeches of the professionals was the task of the team to enlighten the families about their role in the treatment of the users with mental disorders. In this sense, one of the interviewees argued about the difficulty of working continuously with the families of the users, and others addressed the daily search for the co-responsibility of the care, despite the challenges: *"We try to contact the relative, but due to the dynamics of service, demand and everything else, we cannot insist too much. We insist once, twice, but then, we cannot do this anymore"* (P1); *"When I assist a patient, the family, to me, is always present, they have to participate of the assistance, and we share a lot from the treatment of the user"* (P3).

It is in the routine of the several spaces of promotion and attention to mental health that this involvement must be valued and accomplished. Within the services of mental health, such as the CAPS, such issue should be seen as priority, in order to allow, in the actual plan, the implementation and consolidation of the proposal of deinstitutionalization, in which, according to Vasconcelos (2010), is centered on the total change of the paradigm of knowledge in mental health so that there is a replacement of the psychiatric hospitals with open and community services.

Thus, the CAPS, by having the function of monitoring the cases of severe and persistent mental disorders, act according to the logic of the territory, which implies in the need for an expanded look about the context of life of the users, which encompasses their individual, family, social and community repercussions (Borba, Paes, Guimarães, Labrocini, & Maftum, 2011; Camatta & Schneider, 2009). The community and territorial character of the CAPS means to go beyond the consideration of the geographic space, in view of the perception of relationships, interests, desires and outlined conflicts.

Consequently, we have the duty, as professionals of the mental health services, to accomplish work practices that favor the family inclusion in the strategies of care. Thus, all the activities accomplished can be reasoned in this perspective, such as: groups, individual assistances, accommodations and home visits. The implementation of a co-responsible care and an integral and humanized assistance only occurs fully when instruments that stimulate the interaction between the subjects involved, directly or indirectly, in the psychosocial treatment are created and/or strengthened (Schrank & Olschowsky, 2008)..

Four important dimensions stand out in the professional work at the CAPS: the integrality; the proposal of constant search for psychosocial rehabilitation, insertion, autonomy and identity so that there is no risk that the CAPS be reproducers of the mental asylum logic; the assistance to attacks and acute conditions under the patterns of the expanded clinic; and the essentiality of the family inclusion (Wetzel, Kantorski, Olschowsky, Schneider, & Camatta, 2011).

In this sense, the fact that the interviewed family members are apparently aware of this co-responsibility, attracted our attention, since they referred to the need for family support and relationship of the family with the mental health service: *"On weekends at home, we monitor the patient in the same way that he leaves here [from CAPS]. I am all the time guided by the CAPS"* (F3); *"If there were no CAPS, it would be difficult because, whatever happens, I call here, come here and put some things in*

order... *I am the one who gives the medicine. I help feeding. I always have care with this*" (F4); *"The treatment has to come from us two. The CAPS plays its role and you [the family member] has to do at home"* (F5).

Based on the opinions of the participants and in the professional experience in the service, we observe that many families seek to be close to the device and they establish a relationship of partnership with the team. Nevertheless, there are many cases in which the families are still not sensitized about their role in the care and that, by presenting difficulties to handle the situation of illness in the family environment, deposit in the service all the expectations of solving of problems come from the psychosocial fragility condition. Some subjects pointed out some features on this question: *"The CAPS did the work thus far; from now on it is up to the family. However, sometimes, the family do not want to take very seriously the work, they want that the CAPS to assume a part that is not its job."* (P5); *"I realize that many family members bring many difficulties here, they place the responsibility on the CAPS. For some, because we are here and we witness, there is no way not to witness"* (F1).

We stress the shared care as an efficient strategy of care to the user with mental disorder, especially in the most serious cases. As, in these cases, the therapeutic monitoring, in general, occurs for long periods of time, by virtue of its complexity, and when the attention to the user is jointly accomplished, this is more strengthened and the care has greater chance to occur longitudinally and integrally.

### Forms of participation of the family in the service

The consideration of the importance of the care to occur in a shared way, brings light to the discussion with other thematic referred to in the speeches analyzed, in particular, the forms of participation of the family in the service. The interviews accomplished and the participant observation allowed us to notice that, in most of the time, the presence of the family member as companion of the user at the researched CAPS happens in the occasions of individual assistances. It was also possible to notice that, it is common the family members to seek the service in moments of increased vulnerability, and this may be arise from several degrees of factors, in such a way that, as the situation is stabilized, many family members begin to attend the device sporadically: *"What I feel here, also happens a lot, not to everyone, but happens: the user arrives here, we orient and the user gets better, then the family think that it is no longer necessary to be here"* (P2); *"They accompany in the assistance, or seek assistance when the person is having an attack. I see a lot of this"* (P4); *"If I need therefore of anything from here at the CAPS, I simply come here, talk and they help me"* (F3).

We can see, thus, the pertinence of the idea that it is common that the family members to need the professional support at times of crisis, since these families many times are not and/or do not feel prepared to handle the difficulties. Besides, it is indispensable that these people receive guidance on the repercussions that a serious disorder may have, because, the more informed they are, the more are the chances to understand that their presence in the mental health service goes beyond a one-off request for assistance and is configured in a partnership that must be implemented both at the stages of instability and at the stages of equilibrium (Almeida, Schal, Martins, & Modena, 2010; Sant'ana, Pereira, Borenstein, & Silva, 2011).

In the device studied, there is a group of family that was created just after the opening of the CAPS; however, this activity was deactivated in some moments in the history of the institution, due to the low adhesion of the families. In the period of the field research, the group was held weekly, being reactivated two years ago, through a joint work between the service team and the professionals-residents. When questioned about the participation in the group of family, the family members affirmed not to have the habit to participate in it. Three respondents said that they knew about the existence of the activity and two reported unawareness: *"Someone has already said, has asked to us to participate, but that is what I am saying: the difficulty of time. Today, for instance, I had to be absent from work to come"* (F1); *"I have never participated in the group. I do not remember anybody talking about this group."* (F2); *"I was participating when I had more time, but now, I do not have"* (F3).

Many families of users with mental disorder go through situations of overload, whether of emotional, physical or financial order, of which some examples are: limited time availability, losses in the social relationships, economic difficulty, development of symptoms of emotional distress, accumulation of tasks, detriment of the professional performance and impairment of the leisure and self-care (Almeida et al., 2010; Bessa & Waidman, 2013; Cavalheri, 2010; Santin & Klafke, 2011). The practical experience of facilitation of the group of family allowed us to identify that, although, in many cases, the family members are aware with respect to the relevance of the group, different factors hinder the systematic participation of these subjects at the referred space:

The possibility to observe, in the context of a research, the dynamics of the families in the service allowed to realize, concretely, the difficulties felt during the meetings of the group of family. It was possible to identify that the family members were, mostly, hurried, tired and even worried about the volume of daily chores that they had to handle on that day. The brief speech of a participant, in an informal chat before the interview, was quite striking. She expressed that she had only appeared at the CAPS on that day because there was no other person available to accompany her sister, but that she was very concerned, because she still had to make lunch when she got home, so that the children could eat when they got home from the school. In the same way as her, many family members cannot handle several daily tasks well, including the care to the user, and they feel overcharged, which makes difficult the presence in the group (Field Diary).

In accordance with the aforementioned, the professionals interviewed mentioned, in their majority, a low adhesion of the family members to the group. In this perspective, several possible causes were enumerated by the team to justify this fact, such as: the difficulty to understand about the meaning of these spaces of care; the low level of schooling of the user population; the family overload; the fragility in sensitizing by the team; the brief team discussions about the theme of the family on the occasions of the meetings; the individualist character of the current society; and the working hours of the family members coinciding with the routine of operation of the service.

We understand as being of great importance the viability of spaces of care, socialization and support to the families, once the exchange of experiences and knowledge can bring positive repercussions to all subjects involved in the treatment. We highlight, mainly, which the participants were unanimous with respect to the relevance of activities focused on the relatives of the users, such as the group of family. All interviewees, including the family members who affirmed that they have never participated in the group, exposed favorable and positive opinions about the existence and continuity of this activity: "*The group is very necessary, because we cannot deal with the user without the presence of the family*" (P3); It is important to have a family attention, so that they can understand the situation, be able to discern what to do or not" (F2).

Santin and Klafke (2011, p. 157) reiterate the essentiality of the group of family in the services, such as the CAPS, since this type of activity "can operate as a space of welcoming of life experiences of its participants".

With regard to the conduction of referrals, guidance and clarifications regarding the group of family, the professionals stated that generally they speak about the activity during their assistances, but they hardly record in the user card or perform a more directive referral: "*I never referred, I never took notes, but I only spoke... but not about the fact of referring.*" (P1).

We believe that the information record can be an efficient dissemination tool, since this allows the family member to organize himself better. We also visualize that the question of the adhesion of families, not only to the group, but also to the service as a whole, consists of a multifactorial challenge that requires a more detailed planning of the practices of care with a view to the expansion of the dissemination and sensitization on the mental healthcare policy and its interfaces with the local situation. The challenge is, therefore, collective and makes necessary the involvement of the family members and users themselves. Many authors, under this angle, address the relevance of the dissemination and/or information strategies (Cavalheri, 2010; Dimenstein et al., 2010; Sant'ana et al., 2011).

It thus calls for the need to sensitize the user population to the fact that the families are not merely companions of the user with mental disorder and their presence in the mental health device must go far

beyond the moments of individual assistance. It is fundamental that the family members feel pertaining to the service understand the extent of the psychosocial context and consider the professionals as partners, in order to implement the mental healthcare. The strengthening of the means of sensitization and dissemination is indispensable as, despite the family members had highlighted the importance of the group of family, they admitted not to participate of this frequently and effectively. It is necessary, therefore, to build a strong bridge between the speech dimensions and the practical reality, in order to overcome this duality.

A strategy that started to be used in the device studied is the assembly of users and families, which was implemented about 6 months ago and that has presented a good adhesion and satisfactory results. The assembly has bimonthly periodicity and is facilitated by all the professionals of the service, counting, generally, on the presence of the unit managers. The planning and execution of this initiative are fruits of the collective action between the members of the CAPS and the Residency, so that, when consisting of a tool of social participation and political empowerment, this activity has the potential to strengthen the links and expand information.

### **Relationship between shared care and user autonomy**

The third theme pointed out was the relationship between shared care and user autonomy. All professionals stated to realize the existence of this relationship when stressing the home, the family environment as a potential space of care and psychosocial rehabilitation; when envisioning a higher possibility to get better and expand the autonomy when the family and the mental health service are acting together; and when reinforcing the importance of the team to work on this co-responsibility in a continuous and permanent form: "We can achieve until a certain point, but the full empowerment of the patient, the stabilization of the condition I think nobody can achieve it alone" (P1). "If we do not work in that direction [shared care], I think that we will also not be, I should say, vehicle for this possibility of this prominence to happen, for this user be autonomous, but always emphasizing that this is a process" (P2).

The attention in mental health aims, thus, the expansion of the possibilities of socio-community coexistence, the social inclusion and the promotion of autonomy, citizenship, prominence and emancipation of the user. For this purpose, the construction and the collective accomplishment of welcome actions, care and encouragement to the participation in the most diverse social support networks are necessary (Dimenstein et al., 2010). Besides, the joint responsibility between family and service requires the redirection of practices and the commitment to construct a collective and promoter care of the user autonomy and the regain of his space in society (Schrank & Olschowsky, 2008).

The professionals also reinforced the fact that, when we speak about severe and persistent mental disorders, which consisted of the focus of the study and that have, in general, greater psychosocial complexity, the autonomy level is very relative, so that, depending on the degree of commitment of the user, small daily achievements can have a great meaning to the person with mental disorder and his family and to the service.

It is of utmost relevance to work on, therefore, in the course of the professional practices, the potentialities and limits of each subject, since each individual has his particularities and needs, not forgetting, however, elements such as link, sociability, collective construction and family, social and community bonds: "*In the case of patients that have limitations, the families do as far as they can do to this patient... Within his limitations, we can see the autonomy and the family contributing*" (P3).

Despite the limitations inherent to the most severe mental disorders, the individuals with this type of illness must be seen, having as lens the humanized and global view of health, as a being of possibilities. The relationships that these users establish with the persons and other elements around them can contribute significantly to this reality. The shared care has, thus, a great emancipatory potential, which denotes as legitimate the appreciation of a participatory culture inside the mental health institutions and in all the conjecture of life of the subjects (Borba et al., 2011).

The family members interviewed did not establish in their speeches a direct and express relationship between the shared care and the user autonomy, but they identified that, as already



explained before, both the family and the service play a role in the treatment and brought real examples that from the process of care, the users had, considering their limitations, significant advances in relation to the autonomy: "At the beginning, I had to give the medicine. Now she [the user] is taking by herself... I had to bath her. Now, I had not. Bathing, changing clothes, now, she can do by herself" (F2); "When he gets better, he goes out alone. He is studying, he was going to swim, but he stopped some days ago" (F3).

In this sense, some professionals referred to the need of having balance and reasonableness in the accomplishment of the care, in such a way that the user is not treated with negligence and/or indifference, but also that he does not have an excessive protection that prevent him to develop or expand the skills and knowledge: "when there is a family present with a degree of equilibrium, it is very important for the question of autonomy. Without protecting and abandoning a lot" (P5).

The participant subjects also commented on the specificity of the care in mental health, emphasizing that this area should be seen with an expanded look, once it encompasses a series of constraints and dimensions, which makes the co-responsibility and the relationship between the many actors involved, a task even more challenging, rich and rewarding: "The mental health brings this overview of life, contexts, society, family, biological, all together. So it is a care extremely delicate and nothing can be undervalued." (P1); "It is a thing that nobody has to have prejudice because it is an illness, isn't it?... If you have diabetes or high blood pressure, but your conscience is well, is different. The basis of everything is the brain." (F5).

The mental health, in its psychosocial perspective, encompasses, therefore, not only the biological aspects of the individuals, but also all the context of social, cultural, political and relational implications experienced by the users with mental disorders and their families.

Therefore, the psychosocial view seeks to see no more the disease and symptoms in isolation, since it considers the social environment in which the persons are inserted (Mello & Furegato, 2008).

This conception expresses the network activities as a fundamental tool for the effectiveness of the psychosocial paradigm. A strategic point in the network is the Primary Care, by virtue of its strong territorial character and of proximity with the user population. The participant observation and the analysis of the speeches led us to the concern that, in the studied reality, the networking still consists of a challenge and, although many steps have already been taken in the direction of this approximation process, including the process of Residency, the strengthening and the systematization of these connections and extramural care sharing are necessary.

It is showed, therefore, that the acting in networks is a *sine qua non* condition for the completeness of the care. In this respect, the professionals interviewed reported the importance of acting jointly and intersectorally: "This care crosses so many other possibilities of insertion, of care indeed, which can be performed in a health center or in another space such as a NGO" (P2); "If the care is shared, it will occur less frequently in the service. If he has the support in the network, in the community, he will depend less on the service. He will can live; he will be able to work" (P4).

It is undeniable the role of the CAPS as a space of reference and welcome in mental health, but they have to create and consolidate intersectoral partnerships, which "require the territory to be sketched with bridges built with solid materials and, at the same time, permeable to different forms of circulation of the population" (Miranda, Oliveira, & Santos, 2014, p. 594). According to this definition, it is aimed to break with the spatial boundaries of the service, in order to ensure a full and democratic attention to the individuals.

We defend, in view of this, which the tripod: user, family and service, which is inserted in community and social links, has a great capacity to promote the autonomy and prominence of the user, in such a way that, for the user can feel empowered and protagonist of his own trajectory, it is important to have a solid basis of care and a intertwined web of bonds, affections and subjectivities. It is necessary, therefore, which all subjects involved in the dynamics of the care can be heard and invited daily to participate of this process, including and mainly, the users themselves.

## Final considerations

From this study, which was elaborated in the context of the formative experience of the Multi-professional Residency in Collective Mental Health, we made some reflections on the relationship between the families and the professionals of a General CAPS, within the scope of the shared care. Through interviews and participant observation, we sought to understand the dynamics of the care performed by the aforementioned actors, having as goal the mental health in an expanded context of promotion of life and subjectivity.

We found that, in the general, there is a relationship of respect and bonds between the family members and the professionals of the studied service and that the subjects demonstrated the perception of the importance to accomplish the shared care. We visualized, therefore, which many families act in fact as partners of the multi-professional team, however, it is valid the proviso that there are cases in which it is noticed a relative distancing between the service and the family, which denotes the need of the mental health work to be based on a permanent relationship of approximation, information and dialogue with the users and their families.

As for the forms of participation of the families in the device, we noticed a low adherence to the group of family and a higher frequency of the families on the occasion of the individual assistances while companions, as well as in moments of intensification of the psychosocial condition and/or of the user crisis. Despite this, we verified and corroborated the unanimous view of the interviewees on the relevance of activities intended for the support and care of the families.

We also identified the legitimacy of the relationship between the shared care and the user autonomy. Thus, when the care is built through an eye of collectivity and sharing, the possibilities of strengthening of the processes of autonomy and empowerment are largely expanded.

Due to the above considerations, we observe that the mental health care is not managed unilaterally. On the contrary, it is permeated by multiple dimensions and implications and involve not only the user, his family and the mental health service, but also the community, the other intersectoral and health devices, in which the Primary Care is a strategic point, in addition to the society as a whole.

This study lists, therefore, the need to expand the debate on the studied theme, since it was not possible the study with a large number of subjects by virtue of a time limitation. In contrast, there were contributions for the improvement of the care at the General CAPS, locus of this research and Residency; for the intensification of the debate about the shared care in mental health as a potential for autonomy and; also for the daily dialectical thinking-doing of all professional categories mentioned in this research, once the realization of this shared care, here emphasized, qualifies the performance of the entire team of health workers (which the mental health, inexorably, is part), independent of where they are allotted and which specific training they bring.

## References

- Almeida, M. M., Schal, V. T., Martins, A. M., & Modena, C. M. (2010). A sobrecarga de cuidadores de pacientes com esquizofrenia. *Revista Psiquiatria*, 32(3), 73-79. Recuperado em 28 de abril, 2015, de <http://www.scielo.br/pdf/rprs/v32n3/1312.pdf>.
- Amarante, P. (Coord.). (1995). *Loucos pela vida: a trajetória da reforma psiquiátrica no Brasil* (2a ed.). Rio de Janeiro: Fiocruz.
- Bessa, J. B. & Waidman, M. A. P. (2013). Família da pessoa com transtorno mental e suas necessidades na assistência psiquiátrica. *Texto Contexto Enfermagem*, 22(1), 61-70. Recuperado em 30 de abril, de 2015, de [http://www.scielo.br/pdf/tce/v22n1/pt\\_08.pdf](http://www.scielo.br/pdf/tce/v22n1/pt_08.pdf).
- Bisneto, J. A. (2009). *Serviço social e saúde mental: uma análise institucional da prática* (2a ed.). São Paulo: Cortez.
- Borba, L. O., Paes, M. R., Guimarães, A. N., Labrocini, L. M., & Maftum, M. A. (2011). A família e o portador de transtorno mental: dinâmica e sua relação familiar. *Revista da escola de enfermagem*, 45(2), 442-449. Recuperado em 28 de abril, de 2015, de <http://www.scielo.br/pdf/reeusp/v45n2/v45n2a19.pdf>.
- Camatta, M. W. & Schneider, J. F. (2009). A visão da família sobre o trabalho de profissionais de saúde mental de um centro de atenção psicossocial. *Escola Anna Nery*, 13(3), 477-484. Recuperado em 27 de abril, de 2015, de <http://www.scielo.br/pdf/ean/v13n3/v13n3a04.pdf>.
- Cavalheri, S. C. (2010). Transformações do modelo assistencial em saúde mental e seu impacto na família. *Revista Brasileira de enfermagem*, 63(1), 51-57. Recuperado em 04 de maio, de 2015, de <http://www.scielo.br/pdf/reben/v63n1/v63n1a09.pdf>.

- Colvero, L. A., Ide, C. A. C., & Rolim, M. A. (2004). Família e doença mental: a difícil convivência com a diferença. *Revista da escola de enfermagem*, 38(2), 197-205. Recuperado em 29 de abril, de 2015, de <http://www.scielo.br/pdf/reeusp/v38n2/11.pdf>.
- Dimenstein, M., Sales, A. L., Galvão, E., & Severo, A. K. (2010). Estratégia da atenção psicossocial e participação da família no cuidado em saúde mental. *Physis*, 20(4), 1209-1226. Recuperado em 28 de abril, de 2015, de <http://www.scielo.br/pdf/physis/v20n4/a08v20n4.pdf>.
- Fontanella, B. J. B., Ricas, J., & Turato, E. R. (2008). Amostragem por saturação em pesquisas qualitativas em saúde: contribuições teóricas. *Caderno Saúde Pública*, 24(1), 17-27. Recuperado em 29 de abril, de 2015, de [http://www.scielo.br/scielo.php?script=sci\\_arttext&pid=S0102-311X2008000100003](http://www.scielo.br/scielo.php?script=sci_arttext&pid=S0102-311X2008000100003).
- Instituto Brasileiro de Geografia e Estatística [IBGE] (2010). *Ceará – CE*. IBGE. Recuperado em 30 de abril, 2015, de [http://www.cidades.ibge.gov.br/download/mapa\\_e\\_municipios.php?lang=&uf=ce](http://www.cidades.ibge.gov.br/download/mapa_e_municipios.php?lang=&uf=ce).
- Itaborai, N. R. (2005). A proteção social da família brasileira contemporânea: reflexões sobre a dimensão simbólica das políticas públicas. *Anais do Seminário As Famílias e as Políticas Públicas no Brasil*. Belo Horizonte. Recuperado em 04 de maio, de 2015, de <http://www.abep.nepo.unicamp.br/docs/anais/outros/FamPolPublicas/Nathalieltaborai.pdf>.
- Lei nº 10.216, de 6 de abril de 2001 (2001, 6 de abril). *Dispõe sobre a proteção e os direitos das pessoas portadoras de transtornos mentais e redireciona o modelo assistencial em saúde mental*. Brasília: Presidência da República. Recuperado em 14 de abril, de 2015, de [http://www.planalto.gov.br/ccivil\\_03/leis/leis\\_2001/l10216.htm](http://www.planalto.gov.br/ccivil_03/leis/leis_2001/l10216.htm).
- Mello, R. & Furegato, A. R. F. (2008). Representações de usuários, familiares e profissionais acerca de um centro de atenção psicossocial. *Escola Anna Nery*, 12(3), 457-464. Recuperado em 13 de maio, 2015, de <http://www.scielo.br/pdf/ean/v12n3/v12n3a10.pdf>.
- Melman, J. (2006). *Família e doença mental: repensando a relação entre profissionais de saúde e familiares*. São Paulo: Escrituras Editora.
- Minayo, M. C. S. (2000). *O desafio do conhecimento: pesquisa qualitativa em saúde* (7a ed.). São Paulo: Hucitec, Rio de Janeiro: Abrasco.
- Minayo, M. C. S. (Org.). (2007). *Pesquisa social: teoria, método e criatividade* (25a ed.). Petrópolis: Vozes.
- Ministério da Saúde (2012). *Saúde mental em dados 11*. Brasília: Ministério da Saúde. Recuperado em 16 de abril, de 2015, de <http://psiquiatriabh.com.br/wp/wp-content/uploads/2015/01/Dados-da-rede-assistencial-brasileira-2012-Ministerio-da-Saude.pdf>.
- Ministério da Saúde (2014). *Esclarecimento sobre leitos no SUS*. Brasília: Ministério da Saúde. Recuperado em 16 de abril, de 2015 de <http://portalsaude.saude.gov.br/index.php/cidadao/principal/agencia-saude/15145-esclarecimento-sobre-leitos-no-sus>.
- Miranda, L., Oliveira, T. F. K., & Santos, C. B. T. (2014). Estudo de uma Rede de Atenção Psicossocial: Paradoxos e Efeitos da Precariedade. *Psicologia, ciência e profissão*, 34(3), 592-611. Recuperado em 30 de abril, de 2015, de <http://www.scielo.br/pdf/pcp/v34n3/1982-3703-34-03-0592.pdf>.
- Organização Mundial da Saúde (2001). *Relatório sobre a saúde no mundo 2001 – Saúde mental: nova concepção, nova esperança*. Suíça: Organização Mundial da Saúde. Recuperado em 28 de abril, de 2015, de <http://www.abebe.org.br/wp-content/uploads/oms2001.pdf>.
- Pimenta, E. S.; Romagnoli, R. C. (2008). A relação com as famílias no tratamento dos portadores de transtorno mental realizado no Centro de Atenção Psicossocial. *Pesquisas e Práticas Psicossociais*, 3(1), 75-84. Recuperado em 07 de janeiro, de 2016, de [http://www.ufsj.edu.br/portal2-repositorio/File/revistalapip/volume3\\_n1/pdf/Pimenta\\_Romagnoli.pdf](http://www.ufsj.edu.br/portal2-repositorio/File/revistalapip/volume3_n1/pdf/Pimenta_Romagnoli.pdf).
- Pinho, L. B., Hernandez, A. M. B., & Kantorski, L. P. (2010). Reforma psiquiátrica, trabalhadores de saúde mental e a "parceria" da família: o discurso do distanciamento. *Interface (Botucatu)*, 14(32), 103-113. Recuperado em 28 de abril, de 2015, de <http://www.scielo.br/pdf/icse/v14n32/09.pdf>.
- Portaria nº 336, de 19 de fevereiro de 2002 (2002, 19 de fevereiro). *Estabelece CAPS I, CAPS II, CAPS III, CAPS i II e CAPS ad II*. Brasília. Recuperado em 14 de abril, de 2015, de [http://dtr2004.saude.gov.br/susdeaz/legislacao/arquivo/39\\_Portaria\\_336\\_de\\_19\\_02\\_2002.pdf](http://dtr2004.saude.gov.br/susdeaz/legislacao/arquivo/39_Portaria_336_de_19_02_2002.pdf).
- Resolução nº 466, de 12 de dezembro de 2012 (2012, 12 de dezembro). *Resolução nº 466, de 12 de dezembro de 2012*. Brasília: Ministério da Saúde. Ministro de Estado da Saúde. Recuperado em 07 de maio, de 2015, de <http://conselho.saude.gov.br/resolucoes/2012/Reso466.pdf>.
- Sant'ana, M. M., Pereira, V. P., Borenstein, M. S., & Silva, A. L. (2011). O significado de ser familiar cuidador do portador de transtorno mental. *Texto Contexto Enfermagem*, 20(1), 50-58. Recuperado em 29 de abril, de 2015, de <http://www.scielo.br/pdf/tce/v20n1/06.pdf>.
- Santin, G. & Klafke, T. E. (2011). A família e o cuidado em saúde mental. *Barbarói*, 34, 146-160. Recuperado em 07 de janeiro, de 2016, de <http://online.unisc.br/seer/index.php/barbaroi/article/viewFile/1643/1567>.
- Schrank, G. & Olschowsky, A. (2008). O Centro de Atenção Psicossocial e as estratégias para inserção da família. *Revista escola de enfermagem*, 42(1), 127-134. Recuperado em 29 de abril, de 2015, de <http://www.scielo.br/pdf/reeusp/v42n1/17.pdf>.
- Vasconcelos, E. M. (Org.). (2010). *Saúde mental e serviço social: o desafio da subjetividade e da interdisciplinaridade* (5a ed.). São Paulo: Cortez.
- Wetzel, C., Kantorski, L. P., Olschowsky, A., Schneider, J. F., & Camatta, M. W. (2011). Dimensões do objeto de trabalho em um Centro de Atenção Psicossocial. *Ciência saúde coletiva*, 16(4), 2133-2143. Recuperado em 28 de abril, de 2015, de <http://www.scielo.br/pdf/csc/v16n4/v16n4a13.pdf>.

*Received: Jun. 29, 2015*  
*Approved: Jan. 20, 2016*

---

*Mirla da Silva Lima:* Social Worker by the State University of Ceará, residency in Collective Mental Health by the Public Health School of Ceará (ESP-CE).

*Ana Caroline Leite de Aguiar:* Psychologist by the Federal University of Ceará, specialist in Mental Health by the State University of Ceará, psychologist of the an AD CAPS of the metropolitan area-CE, preceptress of Psychology of Integrated Residency in Health (ESP-CE), actuation in Clinical Psychology in the private sector.

*Mabel Melo Sousa:* Psychologist by the Federal University of Ceará, master's degree in Psychology by the Federal University of Ceará, specialist in Family Health by the ESP-CE, specialist in Family by the Unifor.