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Desafios e avanços do processo de gestão de um centro de atenção psicossocial de um município do interior do nordeste brasileiro

Challenges and advances in the management process of a psychosocial care center of a countryside municipality of northeast brazil

Desafíos y avances en el proceso de gestión de un centro de atención psicosocial de un municipio del interior del nordeste brasileño

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ABSTRACT

Objective: To analyze the process of work adopted by professionals involved in the management and care of a Psychosocial Care Center and the appropriateness of the physical structure of the unit and the mental health practices. **Methods:** qualitative, descriptive study held at the Psychosocial Care Center, in a city in the countryside of Ceará, Brazil, with nine professionals, between the months of September and October, 2014. We used a semi-structured data collection; data were categorized and analyzed according to Minayo. The authorization was obtained from the CEP-UECE under protocol CAAE: 36971014.0.0000.5534. **Results:** there is a lack of coparticipation between management and workers, shortage of financial resources and inadequate physical structure, which confirms the fragmentation of the work process. **Conclusion:** it is essential that there is an implementation of measures that consolidate the psychiatric reform, and that professionals interrelate in a co-participative way, aiming at the quality of care.

Descriptors: Health management; Mental health; Quality of management.

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RESUMO

Objetivo: Analisar o processo de trabalho adotado por profissionais envolvidos na gestão e assistência de um Centro de Atenção Psicossocial e a adequabilidade da estrutura física da unidade às práticas de saúde mental. **Métodos:** estudo qualitativo, descritivo e exploratório. Realizado no Centro de Atenção Psicossocial, em um município do interior do Ceará, com nove profissionais, entre os meses de setembro e outubro de 2014. Foi utilizado um roteiro semiestruturado para coleta de dados, os quais foram categorizados e analisados conforme Minayo. Obteve-se autorização do CEP-UECE sob protocolo CAAE: 36971014.0.0000.5534. **Resultados:** há ausência de coparticipação entre gestão e profissionais, escassez de recursos financeiros e inadequação da estrutura física, que corrobora para a fragmentação do processo de trabalho. **Conclusão:** é fundamental a implantação de medidas que consolidem a Reforma Psiquiátrica, e que os profissionais se interrelacionem de forma coparticipativa, almejando a qualidade da assistência.

Descritores: Gestão em saúde, Saúde mental, Gestão da qualidade.

RESUMEN

Objetivo: Analizar el proceso de trabajo adoptado por los profesionales implicados en el manejo y cuidado de un Centro de Atención Psicosocial y la adecuación de la estructura física y de las prácticas de la unidad de salud mental. **Métodos:** estudio cualitativo, descriptivo. Realizada en el Centro de Atención Psicosocial, en una ciudad del interior de Ceará, con nueve profesionales, entre los meses de septiembre y octubre de 2014. Se utilizó una hoja de ruta semi-estructurada para la coleta de datos, que son clasificados y analizados según Minayo. La autorización obtenida del CEP-UECE bajo el protocolo CAAE: 36971014.0.0000.5534. **Resultados:** hay falta de participación conjunta entre la dirección y los trabajadores, escasez de recursos financieros y estructura física inadecuada, lo que confirma la fragmentación del proceso de trabajo. **Conclusión:** es esencial la aplicación de medidas que consoliden la reforma psiquiátrica, y que los profesionales se interrelacionan de manera co-participativa, por la calidad de la atención.

Descriptores: Gestión en Salud, Salud Mental, Gestión de la Calidad.

INTRODUCTION

The process of management of the Unified Health System (SUS) connected to the movement of Psychiatric Reform mobilized an important discussion under the ransom of citizenship and autonomy of users of mental health services. It began operating in the 90s, through the National Mental Health Coordination (CORSAM), an agency that inaugurated a new light on the production of mental health regulation.[1]

The Law 10.216/01 is seeking to consolidate a model of open psychosocial and community-based care. Thus, it guarantees to the population free movement in all health services, active participation in society, providing care on the basis of the available resources in the community.[2]

Thus, the Centers for Psychosocial Care (CAPS) are considered strategic services to the network organization of mental health care in a given territory and to the consolidation of the Brazilian Psychiatric Reform. Its implementation and qualification have been encouraged by the Ministry of Health (MS) such that the number of centers has more than doubled in the five past years.[3]

Psychiatric Reform has as basic ordinance the GM/MS No. 336 of 2002, which establishes arrangements for CAPS's services and sets its remuneration by the High Complexity/Cost of Outpatient Procedures Authorization System (APAC) and it is financed by the Strategic Actions and Compensation Fund (FAEC) that was substantial in the expansion and consolidation of the model.[4]

The growth of CAPS began timidly in the country since its establishment had been competing with other devices on the financial budget of the municipalities. In 1996, Brazil had 154 CAPS, increasing to 1,620 CAPS deployed in 2010, with coverage of 0.66 per 100,000 inhabitants. The funding through FAEC assured municipalities the necessary financial resources for the development and maintenance of the services in its territory, by the expansion of resources over the budget.[1,5]

Thus, the gears of the dismantling of a mental institution concurrently with the installation of a territorial network are key questions posed in the discussion of mental health in the National Health System, as it requires the methodological design of integrated management, therapeutic strategies and social interventions, connected directly to users.[6]

The focus of mental health care, which lays on the professionals, requires the ability to work in teams, with some subjective predisposition to make and receive criticism for making shared decisions. Thus, there is a need to recognize the interdependence of individuals and organizations, which allows assistance to individuals in psychological distress to be full and resolutive.[7]

It requires managers and a multidisciplinary care team to know the regional epidemiological characteristics of the psychosocial care network, as well as its resources, dynamics, weaknesses and powers, besides knowing about the issues involving mental health policy as their paradigms and management tools, contingent over demand to be absorbed and accepted, manager accountability regarding the management process which involves prioritizing actions, through resource coordination in order to build effective responses, and to promote the institutionalization and integration of the health network, making it accessible, interconnected, universal and resolutive.[6]

Facing this reality, this study is justified by the intrinsic need to seek real significance on the scenario in which public policies on mental health operationalize.

It had as an objective to analyze the working process adopted by professionals involved in the management and care of a Psychosocial Care Center and the appropriateness of the physical structure of the unit to the mental health practices of a city in the countryside of Ceará.

METHODS

This is a qualitative and descriptive study. It was held in a CAPS I, in a city of reference to Sertões de Crateús-Ceará, with a population of 72,812 inhabitants, which supports four surrounding municipalities, totaling 156.25 inhabitants, according to data from the Brazilian Institute of Geography and Statistics (IBGE)[8] this unit had six thousand registered users.

The selection of subjects was guided by the following inclusion criteria: professionals with superior education who have exercised mental health management or care in the Psychosocial Care Center I, previously contacted and interviewed at the facility that they were inserted. The exclusion criteria were: professionals with secondary education and substitutes inserted or not in this service.

The study subjects were nine professional who exercised care and management activities in that center, such as: unit coordinator and superior education professionals: doctor, nurse, social worker, occupational therapist, psychologist, and multi-professional residents in mental health. The data were collected between September and October 2014, through a semi-structured interview, in which the first step was the characterization of the study subject with closed questions, the second stage was open questions, which were recorded in an MP3 player.

The interviewees' statements were heard, transcribed and organized according to the similarity of the content, so that allowed a better understanding of the meanings, sought in the research objectives, and these statements were categorized, analyzed and interpreted as in Minayo.[9] The following categories were built: challenges and advances in the work processes; and problems and advantages of the structure.

The study was authorized by the Ethics Committee of the State University of Ceará by CAAE protocol: 36971014.0.0000.5534, as established by the National Council of Health's[10] Resolution No. 466/2012.

RESULTS AND DISCUSSION

Characteristics of study subjects

Regarding the nine respondents only one was male, four had ages ranging from 26 to 28 years-old, and five subjects were between 32-38 years-old. With regard to marital status, five were single and four were married. Concerning the professional qualification, one was graduated in medicine and specialized in Occupational Medicine and Mental Health; two were graduated in Occupational Therapy, with specialization in gerontology and Child Development; two in Psychology, with a specialization in Community Interventions and Public Policy, one in Neuropsychology and Cognitive Behavioral Therapy; three in Social Work with specialization in Mental Health; two in Nursing, both specialized in mental health, and there was no health management experts among the study subjects.

By analyzing the time of academic training, it ranged from one to ten years and six months, and the time in the unit ranged from six months to seven years. Regarding the total study subjects, one had a management position, three were residents and the others exercised care positions. The monthly income of the professionals involved at the study presented as it follows: seven professionals received three to four times the minimum wage, one professional received five to seven minimum wages and one professional received over seven minimum wages. From the analysis and discussion of the categories that emerged from the interviewees' statements, one can understand the challenges and advances the management process of the Psychosocial Care Center.

Challenges and advances in the work processes

This category covers the work process based upon challenges and progress on the dimension that forms the basis of work processes, be they financial, provision of human resources, perspective on the interdisciplinary interrelation between healthcare and management staff, professional training, which can be understood in this study as a professional development.

In this context, the approach to the management and use of funding for mental health has suffered depreciation of political interest, which directly affects labor and structural processes to provide inputs and basic human resources for the satisfactory operation of CAPS.[11] Following the given lines:

> *"The Federal resource is minimal. There are 28 thousand to keep the payroll of the professionals, keep the groups, feed users, it is not enough, the counterpart is that the municipality has to maintain [...]." (05G)*

> *"[...] as for the money, it also depends on the interest of the managers and coordinators [...] there are funds that the Ministry make available, but the city, the managers and the employees have a lack of interest in directing these projects [...]." (03A)*

The amount of the financing of CAPS I, exposed in one of the reports, is confirmed in the Ordinance No. 3089 of December 23TH 2011, which establishes in its article 1 the fixed value credited for CAPS by the Ministry of Health, for the costing of psychosocial care actions, as described below: CAPS I R$ 28,305.00; CAPS II R$ 33,086.25; CAPS III R$ 84,134.00; and CAPS AD III R$ 105.000,00.[12]

Given the above, the underfunding scenario on financial transfers by the Union is strongly suggestive, leaving it to the municipal management to afford the amount of expenditure and budgetary costs that enable the basic operation of the Psychosocial Care Center.

It is understood, as discussed in the reports, that it is an arduous task for the city to maintain the cost structure for human resources, supplies and maintenance of CAPS. If we

consider that in a hypothetical situation the amount spent by the Union could hardly meet the payroll, the municipal management in this scenario is more likely to have difficulties in funding professional payroll and other features inherent to the minimum operation of the unit.

Thus, the intrinsic analysis of the overlapping reports about the reality already mentioned by Sampaio et al.[13] brings us to the political neglect on the recast of the new replacement network in mental health, in which the Union, who ideologically encouraged the opening and dissemination of the CAPS throughout Brazil, does not give the necessary contribution to municipal managers, who have difficulties to cope with the budget on health. The agreed and scheduled budget for a particular health service cannot be used or transferred to units that have less financial capital, and if it does, it will incur in administrative misconduct.

Another primate point observed in the statements concerns the acquisition of extra funding for the management through the development of therapeutic projects. It has little grip of the health management, even of the professionals. This lack of interest may be related to the lack of co-participative interrelation between management and assistance professionals. Thus, the indirect observation made by the researcher on the efforts provided by the municipal administration in trying to keep running CAPS is relevant, even with limited financial resources.

Other important aspects along with the financial resources are human resources and quality of health work management. This work process according to Jorge et al.[14] is seen as producer and product of the working conditions in which social actors are inserted.

It becomes a major challenge for the management of health services to envision a set of demands and needs, in a perspective that considers the interests of the community, the needs of users and the various health labor segments.[15]

The following reports demonstrate at its core the aspects of the adequacy of the professional service, compliance with the working hours, human resources deficit, confrontation with the biomedical model and demand exceeding the capacity to be supplied.

> *"There is a professional staff deficit [...] the doctor only meets patients twice a week in the afternoon [...] there are professionals who do not start on time, from superior education to secondary education ones, because there is the political part, that works for some and for others, it discourages to try to do some serious work [...] and others that come from public tenders do not comply with the institution's schedule [...]." (03A)*

> *"Really after the residents arrived, we saw that it supplied some of the demand, but we still see that the demand is not fully achieved yet [...] here we are missing doctors, the doctor can only meet with patients at two p.m.[...] there is a waiting list [...]." (07B)*

Health work, as observed, is marked by the history of the professions that have obtained a definition of their field of competence and actions that strengthen the division of labor and the creation of a boundary between the groups.[15]

The taken approach shows the dissatisfaction of members of the multidisciplinary team on the prioritization of personal relationships that diminishes compliance with standards established in a group as a whole. The working process should be disentangled from the informal practice of favors exchange and must be crafted in a full and unanimous way by all who compound the team, so that we can avoid friction.

The demotivation in this situation may arise as a reaction to professional favoring conditions for some, as well as the lack of resoluteness of the system to meet repressed demand. The work overload due to user demand can be met in part by the implementation of therapeutic residence, which brought superior education professionals to the health service, but such a measure is not enough to resolve the problem since the lack of medical professionals is quoted in an emphatic manner.

Faced with this increased workload, it is necessary to demonstrate the minimum team required for the operation of a CAPSI, according to the Ministry of Health[16]: 1 psychiatrist or doctor trained in mental health; 1 nurse; 3 graduated professional of other professional categories: psychologist, social worker, occupational therapist, pedagogue or other professional required for the therapeutic project; 4 secondary education professionals: nursing technician and/or assistant, administrative technician, educational technician and artisan. It should operate from Monday to Friday from 8:00 to 18:00, according to the Decree 336/2012.

In this context, a mismatch between human resources policies that are being implemented by public administration and its operationalization at the local level emerges. That is, political practices are still developed timidly, under the friction between the interests of society and those imposed by the economy. Facing this scenario, a more intensive implementation of what is proposed, compared to what is operationalized is urgently needed.[14]

On the other hand, the Psychosocial Care is clearly a political, management and counterhegemonic care proposal. However, the achievements of the laws of the Psychiatric Reform and the substitutive services indicate the existence of abundant medicalized approaches to care.[6]

One can envision in the units of meaning that there is a deficit in the service, which is related to the lack of medical professionals, and that such an exercise is still impregnated with the biomedical model, which has as the main profession the medicine and its medicalized exercise.

It is under this perspective that there is a consensus in the health bibliography, especially in the discussion on the SUS, that it is necessary to review the doctor's hegemony in

health work and move towards interdisciplinary practices to increase the quality of health care. The doctor and other health professionals' work should be conceived as part of a complex and multifactorial whole, since to centralize the work on the doctor is a paradox that contributes to the maintenance of a care model uncompromised with the user and centered in the procedure as a way which would constitute a new act in health.[15]

It is necessary to stress that the psychosocial model considers the political and biopsychossociocultural factors specifically in the genesis and treatment of the suffering. The means considered for therapeutic work include psychotherapies, socioterapies, laborterapies and medication when necessary.[17]

Therefore, it aims at the appreciation of the work by the reinterpretation of the pillars and processes of the relations with the transformation of forms of sociability involving workers, managers and users in their everyday experience of production, organization and conduction of health services, in order to change the models of management.[11] It is about the multidisciplinary and interdisciplinary perspective among professionals involved in the care and the management that the following statement is presented:

> *"Here inside the unit, I believe that professionals have free access to each other [...] now with the therapeutic residence it has improved a lot [...] I think that it opened the door more, to talk, discuss cases. We came back to do the study of patients, case studies, making treatment plans, set goals [...] with the coordination we have a free access, of talking, of pointing out something we're not having results. As for the health department, I do not see that much opening [...]." (01L)*

Following the line of reasoning that unveils a barrier between the professions, it can be inferred that the relationships in this health service were fragmented and impersonal, focused on the maintenance of their own jobs and struggle for individual space. This route was broken by the insertion of therapeutic residence, which promoted dialogue among professionals, promoting free and responsive personal relationships, which used a strategy the case study, goals planning and treatment plans, as well as a discussion of personal relationships. It has favored the improvement and interconnection of interdisciplinary processes.

To perform a job, there is a prescription consisting of a defined goal, as well as rules and procedures relating to the expected results and how to get it. The prescription is made by the institution, but also by the worker himself, individually or in groups. The real work means the activity carried out and also what is evaluated in uncertainty, discarded with sorrow or suffering through the debate of rules always present.[15]

In this analysis, it can be seen that the relationship between professionals and coordination unit is mild. However, in relation to the municipal health management, there is no approach and co-participation on actions to be developed, creating an interdisciplinary split between manager and healthcare professionals. The subjects see this relationship as order, and infer the importance of leadership as a positive feature for the development of the personnel management.

The promotion of co-management is important, through respect from the institution to the views of the staff, the incentive from the institution for the employee to participate in decision making, the effectiveness of internal communication vehicles and transparency of relations expressed by honesty.[14]

The failure in the relationship between healthcare professionals and managers can also be seen in the study by Oliveira[18] where the lack of therapeutic freedom, disagreement between the service management policies and bureaucracy, interfered on the quality and satisfaction of care provided to users. Thus, it is necessary that the services present a unified and clear management with qualified professionals to assist in effective interventions to meet the professionals and users demand of the service.

It is about professional training that it is necessary to analyze the perspectives of health professionals, for the encouragement of practices which, may be implied, support the enhancement of the professional, which makes a clear and effective efficiency. It is noticed that there is a lack of training for the subjective and practical aspects of care in mental health:

> *"There is no training or practical education here in the city. Recently, the residents brought new forms of care, to intervene in the user's life [...] they are the ones making a difference here." (02E)*

> *"We don't have continuing education [...] we don't go out to take courses, for what I see it is a failure of state mental health, we receive almost nothing. Then I see that the fault is not so much of the city, but of the Ministry and of the State. When we know something, we learned it in a congress, who 'pays' is us [...]." (06Z)*

Oliveira et al.[18] stress that professionals should be trained to act as a connecting link between service and users as well as between the family and the community. This sense is founded according to the Ministry of Health[11] in Decree 3,088/2011 that provides management strategies to promote the continuing education of professionals.

The fragility over the continuing education, permanent or professional qualification processes is evident and clear here. The training is found as a unitary act, an individual search for knowledge, and there are no public incentives to do so. The Ministry of Health and state health management were cited as institutions that could facilitate such qualification process, exempting partly the responsibility of

the municipal administration. The insertion of therapeutic residence program is inferred again as important, as it promotes the development of studies within the Psychosocial Care Center, which will encourage the continuing education of the study subjects.

Thus, the production process requires ongoing training of the workforce, in a perspective of constant technical competence improvement. It requires skills development directed to the group work and the satisfaction of users as fundamental requirements for the workers' profile. Because, in mental health services, with regard to the qualification, there seems to be a requirement for specific training due to the reorganization of the care model, which imposes a new logic of training for workers. However, reality shows the gap between what is proposed and what is done in management of human resources at SUS.[14]

Structural problems and advantages

In this category it will be addressed with a dynamic approach, the problems and advantages of the physical structure, regarding the perception of the professionals working in the care and management of CAPS, as for the suitability, quality and maintenance of the physical area in which the unit was deployed as the following statements:

> *"The CAPSI project was implemented and adapted to the former Municipal Secretary of Health [...] it should have an air-conditioned auditorium, a room for therapeutic activities. We have the space, but it is not suitable to work in the evening hours, because it is very hot [...] it should be a more pleasant space, one that doesn't have that strong painting. Those are not sensitive colors for users." (05G)*

> *"[...] it is a segregating space. Closed rooms, which unfortunately turns to the madhouse and isolated practices, right? [...] it is as if each employee had their home, perhaps if it had fewer rooms the professionals would stay closer." (08W)*

As it was noted, in the views of the respondents, there is a inadaptability of the physical structure to the needs of the care and management team of the unit, stressed by lack of air conditioning in the auditorium, which prevents the development of therapeutic activities during the afternoon, deficit of rooms and/or multidisciplinary rooms, which implies directly on the multidisciplinary and interdisciplinary care.

There is a disharmony of the colors of the unit, disproving the precepts of the host, which must be harmonious and friendly for users, families and professionals; beyond the space architecture in which the service is displayed, it possibly requires a structure possessing a rounded system, which would favor human contact.

According to Decree 3,088/2011, which provided the basis for the planning of construction projects, renovation and expansion of the physical structure, the environments of Psychosocial Care Network (RAPS), which constitute a key operational base to ensure the quality of care and the users-teams-territory relationships, should promote relations and work processes in line with the guidelines and objectives of the network in mental health characterized by humane, community-based and territorial care, substitutive to the asylum model, by the respect for human rights, autonomy and freedom of the people.[19]

It is clear that the unveiled context is due to the shy ideological, political and professional endowment on development, cutting and prioritization of substitutive mental health services, and that these problems are emerging in the everyday of health teams. Since the very implementation of this Psychosocial Care network is not being posed as a priority in the public budgets, which directly reflects on the structure of institutions and the working conditions of the team.[11]

Therefore, in understanding the dialectical unity of the analyzed reports one can denote that the managing political construction which expresses interest and supports the implementation of a CAPS does not conform to the assumptions of psychiatric reform, which instituted socialization, breaking barriers, humanization with a branch for the structural conditions under which future psychosocial unit would be deployed. There is an expressed notoriety in the inadequacy of the physical area and the components that are necessary for the proper functioning and development of practices aimed at socialization and demystification of madness.

The inadequacy of the physical facilities can also be observed in another study that addressed the dissatisfaction with the work in mental health in a CAPS in Fortaleza, which exposes the poor working conditions in addition to the difficulties in developing therapeutic activities in small and inadequate spaces.[11]

The guidelines for the development of construction, renovation and expansion of the CAPS projects are described in the Manual of Physical Structure of these units according to the Ministry of Health[19]. They should have at least the following environments: reception, individualized care rooms, collective activity rooms, living room, bathrooms with shower and toilet adapted for the disabled, nursing station, administrative room, meeting room, storeroom, dining room, kitchen, bathroom with dressing room for employees, deposit of cleaning supplies, linen room, waste containers (garbage) and external storage for solid waste, outdoor area for loading and unloading of ambulance and external area of coexistence.

As noted in the Physical Structure Manual of Psychosocial Care Centers, the architectural spatial conformation of these health facilities are built collectively, with no apparent segregation or isolated professional groups. Contrary to the organization's existing physical structure featured in the

study's scenario, where professionals protect themselves in their offices, performing fragmented and isolated care as noted in the reports above, which tends to segregate and difficult interpersonal relationships and the exchange of knowledge.

The benefits derived from the significance of the analyzed context are few, the quality of the amplitude of the structure is pointed out, which is broken by the great demand of users and professionals working in the unit, corroborating to its inadequacy. For the management, the readjustment of a health service, for example, the Psychosocial Care Center in a space in which it was constituted an administrative body can be configured as an advantage since the unit was already solidified. However, this solidification constituted a segregated model, which does not meet the bias of the Psychiatric Reform, which works with human beings in a community.

CONCLUSION

The context unveiled in this study shows that there is a lack of compliance in the harmony of the physical structure, due to the inadequacy of the unity's architecture, which predisposes the individualization of relations, with the need for multidisciplinary environments for collective practices, properly conditioned, and in harmony with the colors of the unity. Such deconstruction ultimately does not meet the needs of the healthcare team and the population.

As for the work process, the scenario is suggestive of underfunding in which the municipality has to bear most of the costs, and the Union has a timid participation. The interdisciplinary relationship between healthcare and management professionals is unveiled as a failure, due to the lack of co-management. There is unconformity in the compliance of the weekly working hours among the professionals, linked to the informal practice of exchanging favors, and the regulation of the working day by Class Councils.

These deficits corroborate to a possible work overload, adding to a large user demand and the lack of medical professionals. It is clear that the inclusion of permanent learning developed in this study through the therapeutic residence in Mental Health has brought a positive impact because it has become critical to the conformity of multi-professional relations, through the critical and methodological development of the subject-work relationship. It motivates the professionals to seek co-participative initiatives within the labor niche in which they are.

Thus, we see the need to implement measures to consolidate the Psychiatric Reform, which works with the public health collectiveness. Members who are part of the healthcare and the management are inter-related in a co-participative way, aiming the quality of the care provided. It is suggested that managers develop monthly meetings with the coordinators and professionals involved in health services, so they can know the nodes of CAPS, promoting debates and action planning that can improve the performance of the quality of care.

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