

## KNOWLEDGE OF PSYCHOSOCIAL CARE CENTER COORDINATORS ABOUT THE NATIONAL POLICY OF MENTAL HEALTH<sup>1</sup>

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### ABSTRACT

The deinstitutionalization of care in mental health can be compromised if no proper training and understanding of the policy that guides the professionals is achieved. The present study aimed to verify the knowledge of Psychosocial Care Center coordinators in the state of Goiás - Brazil about the National Mental Health Policy. The descriptive-exploratory research, using a qualitative approach, was carried out with 19 coordinators of these services, between January and May 2011. Data were submitted to thematic content analysis counting on the support of the Atlas-ti software. Results show that coordinators have relevant understanding of legal guidelines, especially of social reintegration, family inclusion in care, interdisciplinary work, and articulation of services in a care network. On the other hand, difficulties to implement the policy due to the lack of network devices, the need for qualification and lack of investment in physical, financial and human resources are also pointed out.

**Keywords:** Mental health assistance. Health management. Human resources. Mental health services. Mental health. Psychiatric nursing.

### INTRODUCTION

Several nations of the world saw the rise of the Psychiatric Reform in the 1960s. The movement was born as a way of opposing the asylum-related, medical-based care in Mental Health (MH), proposing alternatives to mental institutions. In Brazil, the Psychiatric Reform was implemented in the 1970s under the influence of theoretical concepts and experiences observed in different countries, aiming to bring a new perspective to the treatment of people with mental illnesses<sup>(1, 2)</sup>.

In such scenario, MH care began to be redirected toward the psychosocial type of care, focusing on a care model that treats people in their social environment. Therefore, the autonomy and subjectivity of individuals are highly valued in the therapeutic proposal, aiming at embracing, supporting and rehabilitating people with mental illness in their own environment<sup>(3, 4)</sup>.

In this new psychosocial care model, to treat means to promote possibilities for people under psychic distress, mental illness and/or alcohol- or drug-related difficulties to be able to live in community, with the highest possible degree of autonomy and without the need for adopting a compulsory ideal behavioral standard. This comprehension reaches far beyond the mere action of diagnosing diseases and prescribing treatments<sup>(3, 5, 6)</sup>.

In Brazil, such premises are supported by the National Mental Health Policy (NMHP), which proposes the creation of an open substitutive service network, community and territory based and grounded on psychosocial care. Such network seeks to offer people with mental disorders an open door to social life, thus promoting a pathway toward citizenship<sup>(1, 7)</sup>.

In the array of substitutive services proposed by the NMHP, Psychosocial Care Centers (CAPS) stand out. These centers are open services provided on a daily basis, which

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promote free access to patients, families and society at large. In order for such guidelines to be consolidated, the healthcare team is expected to present a multidisciplinary approach, aiming at encompassing the patients in their whole being and in their distinct needs<sup>(1, 8)</sup>.

The social responsibility of the CAPS healthcare team represents the basis for the operationalization of an effective change in mental health care. For that purpose, professionals should be even more committed to their work<sup>(1, 4)</sup>.

Nonetheless, the analysis of the MH reality around the country shows that specialized institutions face huge challenges regarding the deinstitutionalization process characterized by difficulties to implement social and family based actions. This process is often seen as a mere dehospitalization procedure, and as such no change whatsoever is observed in the care context<sup>(4, 5)</sup>.

In this regard, the service coordination role is a crucial element in the equation, as the coordination model is closely connected with the instituted care model<sup>(9)</sup>. The level of comprehension of the concept, as well as the attitudes of the coordinators, will directly affect the performance of the services.

The relevant representative function of coordinators should lead them to take responsibility for the conduction of the care team by articulating all necessary support in order to get the work done. Given the importance of such aspects toward the effectiveness of the psychosocial care model, the present study aimed to verify the knowledge of CAPS coordinators located in the countryside of the state of Goiás, Brazil, on the NMHP.

## METHODOLOGY

This descriptive-exploratory research was carried out at CAPS in the countryside of the state of Goiás, which was accredited to work up until December 2010, amounting 22 services offered in 19 cities.

The study included all coordinators working in the services throughout the data collection process. One of the CAPS had no coordinator; in one center, the coordinator did not show up for the interview; in another, the coordinator refused

to participate in the study. The total amount of participating coordinators, then, was 19. Data were collected between January and May 2011 by means of two instruments employed by other research processes<sup>(10)</sup>: first, a semi-structured instrument regarding the professiographic profile of coordinators; and second, an interview script counting on guiding questions about the NMHP.

Responses were transcribed and submitted to a thematic content analysis<sup>(11)</sup> aided by the ATLAS-ti software version 6.2. The most quoted words and phrases were codified in order to highlight record units (codes) that complied with the objectives of the research. As transcriptions were codified, context units (quotations) corresponding to excerpts from the interviews, whose frequency may display a series of meanings to the chosen analytical objective, were identified.

Data categorization (families) followed the codification procedure. In this stage, record units were grouped as a result of common characteristics, aiming at condensing the context units whose similarity favored both the analysis and the understanding<sup>(11)</sup>.

It decided to deal with the categories based on a network of elements (network) in the ATLAS.ti, which allowed for the establishment of correlations among record and context units; additionally, they could be visualized in a graphic scheme. Finally, the categories were analyzed and discussed based on specialized literature on this subject.

The subjects' statements depicting each category were codified in the ATLAS.ti, and the quotation reference comprised the number assigned to the subject, followed by the sequential number of the context unit observed in the transcribed report.

All ethical procedures were complied with following the approval of the project by the Research Ethics Committee of the Federal University of Goiás, under protocol number 303/10.

## RESULTS AND DISCUSSION

In the majority of the CAPS, the coordination of services is performed by psychologists (47.4%), followed by nurses (31.6%) and occupational therapists (10.5%). One

coordinator had a degree in public management and one was a physician.

Among the coordinators, 79% were women. The age of the coordinators varied between 22 and 61 years. The length of practice among the MH professionals varied from less than a year to 33 years; 52.6% had worked in the area for a maximum of five years; 5.3% had worked between 5 and 10 years; 26.3%, from 11 to 20 years; and 15.8%, for over 20 years. On the other hand, the length of time dedicated to the coordination of the CAPS varied from one year to nine full years (21%, less than a year; 31.6%, between one and two years; 10.5%, between two and three years; and 36.8%, for more than three years).

It is worth highlighting that most of the services had been implemented for less than five years at the time of data collection. Thus, the coordinators' short amount of time working at the CAPS matches the length of time of the existing services.

Regarding the workload, 15 coordinators worked 40 weekly hours. As for the professional training, of the coordinators who had a specialization degree (68.4%), only 30% were focused on MH.

Wages ranged from R\$ 800 to R\$ 6,000, being the average R\$ 2,583.33. It should be emphasized that during the data collection process the minimum wage in force in the country was R\$ 545. Among the study participants, 68.4% reported they did not receive any bonus resulting from being the service coordinator.

As for the employability issue, 63.2% of the coordinators affirmed to have another job, half of them being related to the MH area. In relation to the labor contract regime, 73.7% of the coordinators were hired under a temporary contract, thus generating insecurity regarding their permanence at the service and a massive turnover rate.

Work conditions identified in the municipalities may be related to the subjectivity of power relations originated in a political-partisan dimension, that is, each change of local government brought new professionals to take up "trust positions", thus interrupting several actions as a result of partisan interests<sup>(12)</sup>. These data are quite relevant, as the human resources

academic background stands out as one of the major challenges toward the consolidation of the Brazilian Psychiatric Reform, whose process demands higher level of technical and theoretical preparation of professionals who are often unmotivated by low wages and/or precarious work contracts<sup>(1, 13)</sup>.

The content analysis of interviews regarding the knowledge of the coordinators on the NMHP enabled us to come up with two thematic categories, as well as their respective subcategories: Knowledge of coordinators on the Psychiatric Reform (Transition from traditional psychiatric care to psychosocial care, and Experiences of coordinators regarding the NMHP); and Mental health care management model (Establishment and articulation of networks, Interdisciplinary work, and Inclusion of the family in the therapeutic project).

### **Knowledge of coordinators on the Psychiatric Reform**

The understanding coordinators have on the NMHP is quite related to the historical construction of the change of the mental health care conception and their professional experiences.

### **Transition from traditional psychiatric care to psychosocial care**

The work experience on the hospital-centered model enabled the majority of coordinators to apprehend the objectives of the NMHP, as they were able to compare the traditional care model to the psychosocial care model.

We have evolved a lot by assimilating and executing the Psychiatric Reform in a very proper way. I think we'll turn out fine. I experienced both realities and now I look very positively at this new care proposal (14:28).

I understand that we are on the right path. I think that the exclusion has not helped any of us. I used to work in a closed institution with 400 patients that stayed there for two whole years and never got out, unless the situation was politically handled. I have never heard of a patient that was discharged under the protocols. (4:20).

The statements above allow us to reflect on the treatment offered by the asylum-based model, which favored the exclusion of patients. In order to guarantee the advancement of the reform, it is important that professionals defend

care models different from the previous ones, so that the psychosocial proposal is not reduced to a mere launch of new services. The professionals who were active militants for the change may show more flexibility toward recognizing the advances proposed by the NMHP<sup>(6)</sup>.

The promotion of social reinsertion by means of the work in the patient's territory has been deemed by the coordinators to be a top priority toward the effectiveness of the NMHP.

What I now understand is that the Mental Health priority is to care for people under psychic distress in a free, community-based environment, that is, in the community. It's a non-exclusionary model. (4:1)

Four coordinators viewed the Psychiatric Reform as merely the non-hospitalization of patients with mental disorders. In this sense, the deinstitutionalization is understood as a mere dehospitalization, meaning to remove people from the asylum-based context, with no previous structure in the community to care for them<sup>(14)</sup>.

A series of services still focus on the biomedical logic, thus subjecting the professional team to a care regime that weakens the complex dimension of the mental disorder. Instead of "including" to "set free", the services usually "include" to "treat", as if care was expected to be rendered only in the service itself, and not otherwise<sup>(3)</sup>.

Deinstitutionalization. This should be our top priority, as the psychiatric reform advocates the absence of the hospitalization process, so that patients are not kept in the hospital. But, in a general perspective, we know we do not count on any framework that could prevent this from happening. (19:1).

It is important to understand that the psychosocial model that involves the dehospitalization practice also includes other practices that it make possible to reinsert patients into their social environment<sup>(5)</sup>.

So, the dehospitalization process means to cope with social infrastructure issues, wiping out the stigmas mental health patients suffer from and breaking through prejudices by carrying out a really effective work of social reinsertion. (8:1)

Although the report makes use of the term "dehospitalization", its content actually brings

about the deinstitutionalization concept, which is related to an ethical process of rescuing citizens' rights in a dimension that opposes stigma, exclusion and violence<sup>(14)</sup>.

It is worth highlighting that the participants in this study did not make any conceptual distinction between deinstitutionalization and dehospitalization, usually applying both terms as if they were synonyms. The representation of the psychiatric reform movement is perceived by many professionals as a mere change in the locus of the institution, without clarifying what such procedure represents<sup>(1)</sup>. On the other hand, several coordinators address the deinstitutionalization as the major proposal of the NMHP. The appropriation of this knowledge is crucial toward the development of a comprehensive care to patients, aiming at generating their social reinsertion by the taking their needs and their families' needs into account.

### **Experiences of coordinators regarding the NMHP**

The experience of the coordinators in the substitutive services has granted them the opportunity to draw closer to the orientations of the NMHP, thus allowing them to experience the construction process of the proposed model.

I've been working with this new model since 2002. I see that some patients do achieve their social reinsertion. I also see that depression can be cured, and schizophrenia may be controlled. We're on the right path toward breaking stereotypes. (4:22)

We have been advancing, I can't say that we're stuck on level zero. We still have lots to do, but we are surely advancing. (3:18)

On the other hand, we find the report of a coordinator who understood the NMHP as a type of social exclusion to the less favored classes toward MH care:

The doctor (a psychiatrist at the CAPS) nailed it. She said that the psychiatric reform here in Brazil was made for poor people to be hospitalized. Because the rich who have people with mental disorders in their families can afford paying for a hospital, but what about the poor ones? What are we supposed to do with the poor people? (11:3)

This statement is utterly directed to the valorization of the asylum model and

summarizes the deinstitutionalization logic as a proposal to organize the administrative nature of cost reduction to the public coffers, and not to bring about a real care change. Such statement, coming from a CAPS coordinator, should concern us, as his understanding may dislocate the intentionality of the social reinsertion promotion activities aimed at preventing hospitalization processes.

The opinions about the psychiatric hospitalization processes are still very much diluted. If the demands of the families are taken into account, this type of procedure is sometimes required. On the other hand, it is also understood that, although they are needed in some cases, hospitalization processes may result in a deterioration of both the patient's clinical status and his return to the social environment<sup>(1)</sup>.

However, it is widely known that, whenever necessary, hospitalization processes should occur in adequate spaces, such as nursing wards in general hospitals, beds in CAPS III, CAPS III AD, and emergency care units<sup>(15)</sup>.

It should be highlighted, nevertheless, that such understand may express an approach that may be incorporated to the practice of many CAPS professionals who also disbelieve the actions they undertake themselves, thus incorrectly misplacing the focus on disease management and missing that type of health care that values the healthy aspects of the person who is cared for.

Part of the statements signaled the distance between the planning/management of action and the care context, often misguided by political issues.

I don't know if the other professionals also feel it, but there is a gap between the elaboration and consolidation of a healthcare policy and what really goes on in the real life. To work behind a desk, enjoying the air conditioning, with just a pen in your hand and figuring out if this or that would fit, is quite easy. Now, reality is quite distant from what one thinks about in an office. (7:19)

The advances in the implementation of the NMHP in recent years are undeniable; however, they are perceived as insufficient in the daily practice, given the magnitude of the problem and the isolation of several regions of the country, especially the countryside areas distant from

capitals and metropolitan areas<sup>(16)</sup>.

The CAPS coordinators in the countryside of the state of Goiás also perceived a certain degree of fragility in the operationalization of the measures proposed by the NMHP. There are serious problems related to professional training and physical structure of services, which actually complicates the development of the work as recommended.

In my opinion, the procedures need to be reorganized. The idea is awesome, the guidelines are very good, I just think the professional training processes have to be adequate to this issue [...] (6:27)

As a healthcare area that counts on so fresh policy undergoing an expansion and consolidation process, the MH area often does not receive the deserved attention, thus resulting in low amounts of investments in resources and precarious work conditions<sup>(13)</sup>.

It is essential that there be investments for physical and material resources, as well as qualification and continued education for MH service workers, so that they are able to institutionalize the construction of new care practices aimed at improving life conditions and social reinsertion of MH patients.

### **Mental health care management model**

This category addresses the fundamental concepts that are necessary toward the implementation of the psychosocial model contained in the statements of the coordinators.

### **Establishment and articulation of the network**

The creation of a Psychosocial Care Network (PCN) is listed as one of the recommendations of the NMHP, counting on territorialized services and based on a psychosocial care approach<sup>(15)</sup>. The articulation of the network expands the possibility of reinserting patients into the various social spaces, thus providing them with care in all complexity levels.

Although the ordinance that created the PCN<sup>(15)</sup> had not yet been issued at the time of data collection, the CAPS coordinators already understood the need for the network and identified the existence of a series of mechanisms composing it.

The planning process needs to address the coverage, starting in the NASF structures and coming to the CAPS, at the outpatient area, at the

basic care, at the street clinics, at therapeutic institutions [...] (1:26)

The articulation between the CAPS and the Family Health Strategy (FHS) is equally valued by the professionals.

CAPS are actually the entrance door. But, in my mind, the entrance door will always be primary care. Here's where cases are detected, where they occur by means of the health community agents, who identify the problems right in the spot, in the homes and refer the families to the CAPS, whenever the CAPS should be involved, of course. (1:15)

However, the professionals working in primary care are unprepared to cope with the psychic distress and the subjective needs of people, and their actions are generally bound to the reproduction of receipts and referrals to other specialized services<sup>(2, 4, 17)</sup>. In the face of this reality and taking into account the intense requirements in this healthcare area, primary care teams need to receive proper training and supervision, aiming at meeting all demands related to the citizens' MH<sup>(4, 17, 18)</sup>.

It is also worth highlighting that the articulation between CAPS and primary care needs to be more evidenced by actions that meet the demands of the suffering people who look for help in both services than by the principles of the model<sup>(2, 18)</sup>. The network logic is also expressed in the social environment by means of several articulations and partnerships that provide people with care in the communities and within the context they are inserted<sup>(19)</sup>.

Among the challenges to organize the network, the coordinators emphasize intersectoriality as an essential presupposition toward the effectiveness of the actions proposed by the NMHP. Intersectoriality is recognized as one of the mechanisms that favor social reinsertion, as it proposes the articulation of specialized services with other healthcare services and social amenities.

I think the network can't be limited to the health care. It has to be intersectorial. Therefore, we should search for other means, such as partnerships within the district, strengthening connections with entities other than those of the public sector. (6:8)

Nonetheless, the coordinators point out several difficulties to articulate the network

services, such as lack of knowledge of the MH care object, lack of services to effectively create the network, and lack of communication among them.

The coordinators also highlighted the need for beds in the mental health area in general hospitals aimed at the consolidation of the MH care network, as the state of Goiás lacks these types of bed everywhere up to the present moment.

In practice, we face countless situations in which the hospitalization process is a necessary step. (17:4)

In general hospitals, care must be carried out in specialized mental healthcare nursing wards, counting on a multidisciplinary professional team and based on an interdisciplinary approach. The care offered must be articulated with the Individual Therapeutic Project developed by the patient reference service, and the hospitalization process should be for only a short period of time, up until the patient reaches clinical stability<sup>(20)</sup>.

### **Interdisciplinary work**

Mental health services deal with multidisciplinary teams, thus enabling different sociability perspectives, as they count on professionals originated in the traditional healthcare team (physicians, nurses and psychologists) and professionals from other areas, such as art-therapists, educators, social assistants, pharmacists, physical therapists and occupational therapists.

The comprehension of the interdisciplinary framework of MH actions allows professionals at the CAPS to contribute to the construction of the therapeutic project, thus favoring knowledge exchange processes toward a comprehensive approach of subjects. Even so, interdisciplinarity in the treatment proceeding is not always easily achieved due to its high complexity and the distinct understanding professionals have of the concept while building therapeutic actions to the patients assisted by the services.

I think that in the therapeutic project, bearing in mind the needs of the patient, you can put together a therapeutic project and after that you will know what is the contribution of each professional. (6:9)

Although the specificities of the occupations are recognized toward the development of interdisciplinary work, the coordinators consider that there has to be a conjoint action. The various specialties should share and exchange experiences in the search of solutions to common problems throughout the development of the therapeutic project. The interdisciplinary work is pointed out by healthcare professionals as the only way the results and objectives recommended by the Psychiatric Reform can be achieved<sup>(16)</sup>.

### **The inclusion of the family in the therapeutic project**

The insertion of the family into the therapeutic project was another issue raised by the coordinators, showing that they apprehend the dimension of the family context inclusion, in accordance with the recommendations of the NMHP. The knowledge of the family structure allows for a broader understanding of the patient's problem; additionally, the patient's personal dynamics in face of the difficulties can be fully addressed. Such characteristic can determine the social reinsertion process initiated in the family environment. It is important that spaces be created for families to perceive themselves as relevant players in the care project. Their adherence to the project must take place in an environment of negotiation, and this is a strong challenge for CAPS professionals<sup>(20)</sup>.

We do not count on the support of the family. The family comes and dumps the patients here on their own. And then, regardless the number of meetings we have with the family, in spite of all the notes we send them, no matter how many times we visit their home [...] the family thinks like this, "No, I'll leave him/her there, they have to take care of him/her". (16:13)

The reports highlight how much families still stigmatize patients, as well as how hard it is for them to accept the patients' condition. This problem may be minimally relieved if the family were inserted into the treatment process, enabling them to recognize the patient's qualities, skills and limitations, exactly like any other human being. Professionals should also pay attention to the family's sickening process as a legitimate trait in face of the heavy burden resulting from

dealing with that special family member and his/her social life limitations.

The family is not yet cared for, it lacks structure and support. So, I believe that a specific strategy has to be set toward assisting the family. (9:11)

The psychic distress of a family member tends to expand to all other members. If the family is not provided with a specific type of care, the results of such dynamics can be devastating. The care toward the family and its social environment produces more positive outcomes than those only bound to treat the disease. Conjoint work enriches the health practice and demystifies prejudices.

### **FINAL CONSIDERATIONS**

The healthcare actions proposed by the NMHP demands that CAPS coordinators be prepared to cope with the Brazilian care context, in which patients have to be embraced by a multidisciplinary, collective work toward their psychosocial rehabilitation.

Although the coordinators recognize the principles of the NMHP and have an assertive comprehension of its recommendations, a certain gap between theory and practice still remains in the CAPS located in the countryside of the state of Goiás.

Such perspective stresses the fact that knowledge itself is not enough to change practices. In addition to following up the development of the work, managerial spheres should invest in supervision, continued training and partnerships with other services and social amenities.

The present study shows that CAPS coordinators pointed out the insufficiency of governmental investments in their work, which makes continued and permanent education unfeasible for the professionals inserted into the psychosocial care context.

Finally, the work carried out by the authors of this research at the Mental Health services and the MH State Department ended up unleashing a series of initiatives on the part of the state government aimed at providing the coordinators with support toward the implementation of psychosocial care in their cities. The development of this study enabled us to draw the

academic thought to the service care logic, thus maintaining their specificities and, above all, the convergence of expertise.

## CONHECIMENTO DOS COORDENADORES DE CENTROS DE ATENÇÃO PSICOSSOCIAL SOBRE POLÍTICA NACIONAL DE SAÚDE MENTAL

### RESUMO

O processo de desinstitucionalização da assistência em Saúde Mental pode ficar comprometido se não houver a adequada formação e compreensão da política que o norteia pelos profissionais da área. O objetivo deste trabalho foi verificar o conhecimento dos coordenadores de Centros de Atenção Psicossocial do interior do Estado de Goiás sobre a Política Nacional de Saúde Mental. Trata-se de uma pesquisa descritivo-exploratória de abordagem qualitativa realizada com 19 coordenadores desses serviços, no período de janeiro a maio de 2011. Os dados foram submetidos à análise temática de conteúdo com o auxílio do *software* ATLAS-ti. Considerou-se que os coordenadores possuem compreensão pertinente às orientações legais, destacando-se a reinserção social, inclusão da família na assistência, o trabalho interdisciplinar e a articulação dos serviços em uma rede de assistência. Em contrapartida, apontam-se dificuldades para implementar a política, devido à carência de dispositivos na rede, à necessidade de qualificação e à falta de investimentos em recursos físicos, financeiros e humanos.

**Palavras-chave:** Assistência em saúde mental. Gestão em saúde. Recursos humanos. Serviços de saúde mental. Saúde mental. Enfermagem psiquiátrica.

## CONOCIMIENTO DE LOS COORDENADORES DE CENTROS DE ATENCIÓN PSICOSOCIAL SOBRE LA POLÍTICA NACIONAL SALUD MENTAL

### RESUMEN

El proceso de desinstitucionalización de la atención en Salud Mental puede quedar comprometido si no haya, por parte de los profesionales del área, la formación adecuada y la comprensión de la política que lo guía. El objetivo de este trabajo fue verificar el conocimiento de los coordinadores de Centros de Atención Psicossocial del interior del Estado de Goiás - Brasil, sobre la Política Nacional de Salud Mental. Se trata de una investigación descriptivo-exploratoria con enfoque cualitativo realizada con 19 coordinadores de estos servicios, en el periodo de enero a mayo de 2011. Los datos fueron sometidos al análisis temático de contenido con la ayuda de *software* ATLAS-ti. Se consideró que los coordinadores poseen comprensión pertinente a las orientaciones legales, destacándose la reinserción social, la inclusión de la familia en la atención, el trabajo interdisciplinario y la articulación de los servicios en una red de atención. Por otro lado, se señalan dificultades para aplicar la política, debido a la falta de dispositivos en la red, a la necesidad de cualificación y a la falta de inversión en recursos físicos, financieros y humanos.

**Palabras clave:** Atención en salud mental. Gestión en salud. Recursos humanos. Servicios de salud mental. Salud mental. Enfermería Psiquiátrica.

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