

## Psychosocial care center workers in Alagoas, Brazil: interstices of new practices

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Psychosocial care centers are one of the main strategies for ensuring mental healthcare within the scope of the Brazilian psychiatric reform and have required considerable numbers of workers involved in new practices. In this study, it was sought to discover how the process of introducing these workers into the services took place, how they are perceived and how they perceive their practices within the new context. This was a qualitative study using the method of thematic oral history, guided by interviews in order to produce data. Thematic analysis was used to discuss the results. From this analysis, four thematic categories emerged: integration with the services; distress among the workers; new care technologies; and precarious employment. The statements indicated that there was a need for care among the workers, taking into considering the demands on them, with the aim that these services might function at their full potential.

Keywords: Mental health. Healthcare workers. Psychosocial care centers. Qualitative research.

### Introduction

With the enactment of Law 10,216 in 2001, known as the Psychiatric Reform Law, Brazil started to change its characteristics in relation to mental health care in an effective way. Some subsequent directives have begun to provide the necessary support for the construction of a network of substitute services that enable the implementation and sustainability of the psychosocial care model.

In 2002, Directive GM 336 adopted the *Centro de Atenção Psicossocial* (CAPS – Psychosocial Care Center) as the new model of care and defined different modalities according to the size and complexity of these services in their territories (CAPS I, CAPS II, CAPS III, CAPSad, CAPSi). Directive SAS 189 included new procedures in psychosocial care. In addition, it amplified

the funding of the new services and instituted different payment modalities, as well as financial incentive to the cities that adhere to the creation of these services in their territories<sup>1</sup>.

The CAPS is a service that is integrated into the network of the SUS (the Brazilian National Health System). It was created during the Brazilian Psychiatric Reform as a substitute for the psychiatric hospital. Open and community-based, it aims to assist people with severe and persistent mental disorder, and it offers care in the clinic and psychosocial rehabilitation perspectives under the logic of territoriality. Care offered in this space must be aligned in an integral and intensive way in order to offer answers to the diverse difficulties presented by users in their daily lives<sup>2</sup>.

To accomplish this, it has a multidisciplinary team engaged in interdisciplinary actions, and it offers individual and group assistance, therapeutic workshops, income generation workshops, playful and sports activities, drug treatment, and family assistance, among other strategies, in order to ensure the construction of a social place to its users and to stimulate their leading role in life<sup>2</sup>.

With the publication of other ministerial directives, which have enhanced and amplified the incentive to its implementation, it was possible to verify a significant increase in this assistance device in the entire national territory, mainly in smaller cities, which has contributed to the interiorization of extra-hospital care.

In the case of the State of Alagoas, the process of construction of a new model of care for people in psychological suffering has important singularities. The number of CAPS in the entire State jumped from 7 in 2004 to 50 at the end of 2012.

It is important to mention that, even with the quantitative growth, it is necessary to invest in the qualification of the existing CAPS services, so that they can represent the model of treatment to be followed and substitute the reference concretely, which are currently the psychiatric hospitals. In fact, the State ranks in second position in Brazil regarding number of psychiatric beds per number of inhabitants<sup>1</sup>.

Today, Alagoas has 880 psychiatric beds in the SUS, distributed across the cities of Maceió and Arapiraca. The capital city of the State (Maceió) has the highest concentration of beds: 760. During the year of 2004, due to Directive GM 52, a programmed and agreed reduction of 40 beds per hospital was performed. Thus, three hospitals were left with 160 beds each and the biggest of them with 280. Only one hospital did not reduce the number of beds because it has had 120 beds since its creation.

In relation to extra-hospital services, in addition to the 50 CAPS (I and II), the State has only one CAPS III, which was inaugurated in 2013 as a reference center in the treatment for alcohol and other drugs, and 8 outpatient clinics specialized in mental health. It does not have Therapeutic Home Services authorized by the Ministry of Health and the number of beneficiaries of the *Programa de Volta para Casa* (Back Home Program) is still very low: only 22. There are no Centers for Conviviality and Culture, either.

Although the CAPS virtually represent the only space of care provided for people in psychological suffering in the Psychiatric Reform model, it is possible to state that the numerical

increase in these services has enabled many people to have a new experience of care - people who had just known hospitalization as a form of treatment.

However, the process of transition between models – from an asylum model to a territorial, community-based model – is still fragile, as these models coexist, both as political, ideological, and social forces. It is possible to perceive the emergence of a parallel force that struggles for its space, as an alternative to the asylum power.

A very important issue in this process is that the different operating logic of the provision of care in non-hospital services brings new challenges to the professionals who work in these devices. It requires actors who are committed to a new form of dealing with knowledge and who are capable of articulating specific professional knowledge with the network of knowledge involved in the care system.

Therefore, the CAPS work deals with the entire order of human subjectivity, and it is necessary to institute intense social relationships and to use different therapeutic devices in the psychosocial mode, in which the production of new practices is based on the enlargement of the life possibilities of the subjects assisted there<sup>3</sup>.

The present study is based on the assumption that the analysis of the trajectory of the construction of a new practice in the perspective of its workers offers subsidies to understand this reality. We believe that this understanding enables to recognize limits and to indicate the possibility of new paths.

## **Methodology**

The conduction of a research study based on the understanding, perspective and experience of the actors involved in the investigated phenomenon requests the choice of a method that considers the specificities of the object of study and enables the understanding of the research context and of the dimension of the human experience, as close to reality as possible.

The reality that the study aims to investigate is mental health care. Care is perceived here within a conjuncture of social, political, cultural, ideological and behavioral transformations that have marked mental health in recent years.

These transformations, with their entire historical load, could not be “measured” or reduced to numerical evaluations or statistical data. Our object of study, due to its richness and complexity, needs a view that penetrates transversally the several facets that compose it – its subjects, their histories and experiences, the processes of construction that are involved, their limits and challenges.

To achieve this, the qualitative approach proves to be accurate enough, as it makes a variety of knowledge types and practices converge; knowledge and practices that allow to unveil social processes that are still little known. It values the figure of the subject and their meanings in

the production of results, as it applies to the study of history, of relationships, representations, beliefs, perceptions and opinions - products of humans' interpretations of how they live, feel, think and construct their artifacts and themselves<sup>4</sup>.

The investigation presented here is part of the study entitled "*A saúde mental em Alagoas: trajetória da construção de um novo cuidado*" (Mental health in Alagoas: the trajectory of the construction of a new model of care). Its subjects were users, users' relatives, workers in the CAPS services, public managers and university teachers. In this paper, we present the results referring to the specific study of the workers.

For data production, Oral Thematic History was used, as it corresponds to a more restricted narrative on the part of the subject – a narrative that focuses on a given theme, in which there is commitment to elucidation or to the narrator's opinion about some defined event<sup>5</sup>. Thus, aiming to make the participants' experience and perception emerge, a script with guiding questions to the interviews was employed.

Eight technical workers from four different CAPS in the State of Alagoas participated in the research. These professionals' educational backgrounds varied: 01 Social Worker, 01 Nurse, 02 Psychiatrists, 02 Psychologists and 02 Occupational Therapists.

The interviews were performed in the period between November 2010 and February 2011. All the participants signed a consent document. The research was approved by the Ethics Research Committee of the *Universidade Estadual de Ciências da Saúde de Alagoas*, under no. 1374/2010.

In relation to the analysis of the results, considering the characteristics of the research and of the subjects who lent their knowledge and experience, we decided that the best technique would be Content Analysis, in its modality Thematic Analysis, as it is considered to be appropriate for qualitative studies in the area of health<sup>4</sup>.

The testimonies were analyzed with the aim of identifying recurrences and singularities in the trajectories of the interviewed subjects' exercise of work, so that possible intersections between their histories and perceptions related to the new practices performed in the CAPS could be identified. Thus, the analysis of the testimonies promoted a reorganization in thematic categories.

## **Results and discussion**

As the considerations that emerged through the interviews were weaved, the process of data analysis started. It approached specific issues of the beginning of the interviewees' histories as professionals, their entrance into the CAPS, their achievements, their frustrations, sufferings and needs connected with the new practice. Thus, the first thematic category was outlined:

## Insertion in the Services

The complexity generated in the new forms of care requires that the services start incorporating every type of contradiction and demand into their operation. In this sense, one of the first contradictions detected in our research was in the discourses of the majority of the interviewed workers, who revealed a significant lack of training to the practice that is required in the daily routine of the services when they started working at the CAPS:

“We come without training... How am I going to deal with this patient, how are we supposed to do it? What should I do? How do I speak to him? How do I approach the family? How do we solve this situation? So, we gradually acquire experience with our colleagues, but there is no training ...”. (W2)

“When I arrived at the Department and they told me that I would work at a CAPS, I was surprised because up to that moment I had known very little. I was trained for two days, but I knew almost nothing”. (W8)

The lack of experience and the absence of specific education to work at the CAPS may create a distance between the subjects who work there and the basic assumptions of psychosocial care, foundations that are extremely necessary in the mental health care services, governed under the aegis of the Psychiatric Reform.

The professionals' little experience is understood, in the interviewees' discourse, as fragilization of the provided care:

“[...] if there's no supervision, a better monitoring of the team in which it's prepared to struggle, bringing the proposals to be discussed based on laws, we'll end up having mini-hospitals and we can't let this happen”. (W3)

“The instruments that replace the psychiatric hospital leave a lot to be desired even in terms of human resources, education, qualification, and in fact, a large number of psychiatrists don't know how to work in the CAPS”. (W5)

Studies<sup>6,7</sup> have shown large gaps between workers' education and the practical demands in the CAPS. The gaps have revealed the workers' difficulty in reconciling their theoretical learning with the daily challenges that the new mental health care incites.

This indicates that the university courses that have health education can play a significant role in the strengthening of these spaces if they include, in their pedagogical programs, learning and assistance in these new perspectives of care, rather than only reproducing the maintenance of

a traditional knowledge that is coherent with the biomedical model of care, which focuses on the individual in his illness.

Another path to be pointed is the involvement of Universities in the new mental health proposals through the construction of partnerships between the teaching institutions and the services. It is necessary to invest in the education of professionals in this new model.

It is known that the teaching activities developed in the services collaborate both with the institution professionals' recycling and with the education of the new professionals who will soon arrive in the work field. These partnerships play an important role in the process of constant reformulation of mental health care, as they guarantee the continuous questioning of the practices, the reduction in the distance to the theoretical field, and the non-crystallization of postures. Furthermore, by means of this contact, they enable the emergence of innovative ideas that can result in experiences that aggregate the theoretical field and the practical one<sup>8</sup>.

Permanent Health Education also is a fundamental strategy to ensure the incorporation, by the CAPS workers, of the changes required in the new mental health practices and policies, as it contributes to the qualification of their daily actions in the services.

In addition to these aspects, another important issue that emerged from the discourses was the way in which the workers were included in the services:

"I passed a competitive examination and I came to the city. And here, I was placed in this service. Nobody tells you where you're going... Was it Health? Then you go to the CAPS... [...] We don't choose, we can't choose where to go... I was placed here". (W1)

"I think that everybody... and in fact, I've checked with the professionals, everybody who gets to know that is going to work in mental health takes fright. I also took fright, because I didn't know how the work was, how it functioned". (W2)

"In 70% of the CAPS, what happens is this: you pass a competitive examination and you have to be located somewhere and the CAPS is one more place. You have to... to work. This happened to me, right, and this possibility of working in mental health scared me a lot". (W6)

The professionals' relationship with their workplaces should be based on identification with the proposals, desire to contribute, and mutual choices of real partnerships. In the mental health area, within the public services that substitute the psychiatric hospitals, we can add to this: political and ethical commitment to the proposal of deinstitutionalization. In this study, we verified that, in the majority of cases, this does not occur, which makes us infer that this condition can contribute to the emergence of stress, anguish and frustration among the workers.

Furthermore, this feeling of not belonging to the mental health area or the posture of non-commitment to the presuppositions of the Psychiatric Reform can result in actions that affect the

service negatively, and also the users and their relatives: workshops that focus only on production, and not on what they produce concretely in terms of the singularity of each user; groups that function as banalized spaces, without clarity of their objectives and of their meaning to each user; family groups in which the relatives are constrained to expose themselves before others regarding their most intimate and hurtful aspects<sup>9</sup>.

It is important to focus on the subjectivity of those who provide care. It is necessary to ask ourselves how they are included in the services, how they feel when they are working with severe psychological suffering, and about their availability to work in an interdisciplinary way with actions in the territory, in the perspective of psychosocial rehabilitation.

The answer to these issues may explain the difference between services that place the subject as the focus of their actions and services that place the disease as the focus. Recognizing these hindrances and deepening the reflections on this reality in order to improve the service by means of the qualification of its workers is fundamental in order to avoid postures and conducts that endanger the intended process of transformation of mental health care.

It is interesting and encouraging to note that, although the discourses above express this grave reality, the same professionals recognize that it is necessary to be included in the new proposals of care, and many professionals mention changes that have occurred with the development of their practices and experiences:

“What motivates me today is to really know this policy better and make my contribution. To contribute here with the city, in my area, so that this policy functions in the way it must function”. (W2)

“I think this is the first issue: to have committed professionals who may not have the knowledge, but knowledge can be learned and enhanced. But ethical commitment, either you have it or you don't”. (W4)

We can assume that the discourses above show the desire of internal changes towards a qualified posture concerning the care provided for the user of the service. Many times, even though this posture lacks technical knowledge, it intends to construct alternative and substitutive practices.

When Foucault<sup>10</sup> discusses the construction of knowledge, he states that there is knowledge that is independent of science, but there is no knowledge without a defined discursive practice. In this sense, our interviewees seem to be discovering this path in the construction of their knowledge.

## Worker's suffering

An important fact that we should consider is that the workers themselves start needing care. As it has been shown by other researchers in the area, there is a strong incidence of reports on suffering, exhaustion, fear, coming from a daily routine that is inhabited by intense demands of care<sup>11,12</sup>.

The discourses below corroborate the idea of the need to have a closer look at this worker:

"We support each other a lot, precisely to avoid getting ill too, because we expose ourselves a lot, you know, it's an environment where we really expose ourselves...". (W1)

"We see the professional getting ill, not because he wants it... when things get really tough we get sick, as the blood pressure increases, the diabetes increases, everything increases... like a defense mechanism". (W7)

The transformations of care in the new context of mental health generate impasses, uncertainties, conflicts and anxiety, which are felt on a daily basis by the worker. The substitution of the asylum practice for a practice that is still being formed produces different feelings.

Unlike the asylum relations, which are marked by a distance among professionals, patients and their relatives, the relationships established in services like the CAPS stimulate intersubjective exchanges that produce tensions.

In addition to these aspects, we can cite others that have been pointed as factors that hinder the exercise of professional practice: undervaluation of mental health as a working area; the existence of different discursive formations; the contradictions produced by the richness of creation and inventiveness that the CAPS provide and the lack of investment, which imposes limits and overloads the worker; professional education, which still follows the clinical-biological model, in opposition to the need of the practice in the perspective of psychosocial care<sup>13,14</sup>.

Merhy<sup>12</sup> discusses the sadness, suffering and exhaustion reported by teams of mental health workers. The author proposes the institution of arrangements that are self-managed by the workers as part of their daily routine. These arrangements would allow them to reorganize these feelings, to have a fresh attitude towards new opportunities, and to view happiness as an indicator of the struggle against these feelings and as an analyzer of their practices.

To bet on the construction of working processes that produce care for users and care for caregivers is vital in this route. This enables to vivify the health work that bets on the construction of the qualification of lives<sup>12</sup>.

Therefore, so that this new model of care can be recognized in welcoming postures, qualified hearing, and in actions of inclusion and rehabilitation, the creation of strategies and



initiatives that generate relief and happiness also to their executors is more than urgent, so that solutions like the one mentioned below are avoided:

“[...] I've been thinking about this. It's not easy to deal with mental illness. We put what is ours at the moment; as it's very hard, I believe that some professionals protect themselves and each one will protect himself in the way he can. I know I can't criticize anyone because I also protect myself when I can't handle it. Some protect themselves more; some, less. Those who live inside the rooms must protect themselves, there's no doubt about that”. (W7)

The construction of work committed to the provision of care for people must pay attention to the production of care not only in one of its spheres; rather, it must be attentive to the creation of internal potentialities that meet its several types of needs and possibilities in the production of the subjectivities of all the actors.

It is known that the positive results of a service such as the CAPS are also directly related to the satisfaction of and to the attention given to the needs of its workers; therefore, it is not possible to achieve the intended quality in assistance if strategies are not adopted by the team and by the managers in order to face these issues<sup>15</sup>.

### **New care technologies**

So that these new spaces can act with the expected power, it is necessary that the people who make them exist as therapeutic spaces, welcoming spaces, care provision spaces, that is, their workers, are aligned with this strength of resources.

To some of our interviewees, this strength is only possible by means of the use of new working tools.

“In the CAPS, the patient has direct contact with all the professionals who are part of the service [...] the professionals' relationship with the family has also become closer, so the work is facilitated, as well as the monitoring of these patients...”. (W2)

“I believe that it's a team, a team that has integration, in which everybody really speaks the same language concerning the proposal, and everybody has the same views. It's where, today, we use the issue of welcoming, the gateway, this is a strong point of the CAPS...”. (W3)

“I enjoy the team, the form of work of the Psychiatric Reform, when diverse health professionals act together. This obviously brings benefits to the patient. I situate myself as a participant in this new view because I accept this interdisciplinarity”. (W5)

The new mental health care provides its workers with a framework of new technologies: teamwork, interdisciplinarity, welcoming techniques and closeness to the family, among others that were cited by our interviewees.

The psychosocial field presupposes an integrated action of the team based on principles of solidarity, welcoming, and cooperation towards the production of health and care compatible with users' needs<sup>16</sup>.

The raw material to deal with the new health practices is the daily routine of the relationships between professionals and users. The knowledge accumulated by the several areas present in one service enriches its workers' practices and qualifies them for an integral approach to the users in all their dimensions – biological, sociocultural, psychological, among others<sup>17</sup>.

At this moment, it is worth studying thoroughly the ideas that Merhy<sup>18</sup> has developed about health workers and their knowledge and technological actions. Firstly, the author states that the purpose of any health action is to produce the act of providing care; thus, the health technologies that produce care are configured from arrangements between material and non-material dimensions of the health action. These dimensions are expressed in technological territories that Merhy calls soft, soft-hard and hard.

To better understand these care technologies, Merhy<sup>18</sup> uses the idea of the encounter between the professional and the user and the notion of their suitcases as boxes of technological tools that are necessary to produce care in this intersection process. The hard technology suitcase is connected with the professional's hand and contains concrete materials, such as stethoscope, ultrasound scanner. The soft-hard technology suitcase is connected with his head and contains well-structured knowledge, such as the clinic and epidemiology. Finally, the soft technology suitcase is present in the relational space between worker and user, and it is different from the others because it has materiality only in act and it is implied in the production of relationships between two subjects.

This explanation helps us to understand the importance of the use of soft technologies in user-centered care processes. In the case of care provided at the CAPS, the product of these soft technologies are also the encounters, which should be perceived as continuous acts of care: encounters of professionals with users, of users with users, of professionals with users' relatives, of relatives with users, of relatives with other relatives, of professionals with professionals.

The discourses below illustrate this importance:

“We have to do a little bit of everything, so we learn the patient's need and bearing this need in mind we start working so as to help”. (W1)

“The CAPS has a fantastic richness due to the multiplicity, because you don't add in the CAPS, you potentialize”. (W4)

It is in the encounters that the needs, demands, desires and opinions of those who must be in the centrality of care are learned.

The professionals' perception of the importance of the use of these new technologies can make the services offer more effective care, targeted at the relief of suffering, the production of individual and collective subjectivities, and the development of sociabilities. Moreover, such care would potentialize the patients assisted by them.

Therefore, to these workers, the need to improve the care-related knowhow is evident:

"[...] all the professionals need this... need to receive qualification, to improve within the area, as we, in a certain way, are placed in the service with no qualifications at all. In fact, we learn in our daily routine". (W2)

"We need supervision, we need someone to monitor us, to charge us, to demand, to supervise, to see if the service is really operating well, right? Because we feel that the CAPS are there, but some of them are idle...". (W3)

This is a complex trajectory, mainly because only recently have these professionals started to think about these new propositions. The numerical growth of these services in Alagoas is a new fact and, because of this, their professionals are still trying to discover intervention paths that can offer the promotion of life and health.

### **Precarious work**

Many professionals mentioned they do not have time to dedicate themselves to the care offered, which would justify the fragility pointed in the conducts performed at the CAPS:

"Because it's very simple for me to evolve alone, but this doesn't solve the problem, it's no use, right? It's not a proposal to the patient, it's not of the CAPS... If I want to make this patient become the best he can be, I need to evolve in a group. But we don't have time". (W4)

"[...] there's no time to provide a more accurate assistance. The question isn't institutional; it's personal". (W5)

The discourses above illustrate that lack of time has severe consequences in the service. Many workers perceive that the small period of time they spend at the CAPS is a reflection of the low salaries that are offered and of their need to have many jobs. Thus, it can be seen that the number of hours the professionals were hired to work is different from the number of hours during which they really work:

"I'd like to have available time... Why don't I have available time? Because they don't pay for this..." (W4)

"[...] the professional ends up having many jobs and he can't participate in the CAPS actions because he works at other places..."; (W5)

The fact that workers in the same team have other jobs generates many types of dissatisfactions and managerial difficulties. Teamwork is negatively affected:

"[...] professionals who work for a very short period of time... nobody meets anyone, and then, it really... I think it's schizoid, it's impossible to discuss the patients' cases. This is a very serious bias of the CAPS in Alagoas. [...] I think that the minimum team is too minimum. Besides, they don't work during the minimum hours that the minimum team must work". (W4)

"I think that, many times, this lack of time happens because the team doesn't speak the same language. The team's interests are different, one professional's view of the CAPS users is different from another professional's view, and when the situation becomes tough and we can't handle it, we really want that the patients are hospitalized". (W7)

And the care that is received becomes even more fragile:

"When will the patient become the priority? When the technician knows what to do with each patient. When the technician understands that the patient is the priority. It's not the form that I fill in, it's not who gets better, who doesn't... The priority is the patient. And for the patient to become the priority, I have to have time to assist, develop, assist, develop, discuss, assist, develop, discuss within the group... With the number of hours that we have here in Alagoas, I think it's impossible". (W4)

In the State's capital city, the teams' structure is better defined, as a significant number of workers have passed the competitive examination; however, in the interior of the State, some workers provides services, others are appointed – which means political indication – and only a small part has passed the competitive examination. The inexistence of a plan of jobs and salaries and the absence of isonomy cause a large turnover, lack of bonds and lack of motivation at the workplace.

We believe that it is not possible to transform mental health assistance into care that focuses on the construction of subject-centered therapeutic projects -care that aims at the (re)construction of citizenship by means of rehabilitating practices and that involves diverse actors in this purpose -, if the main actors of this care – the workers – are not committed to this action.

However, the precariousness exposed in the discourses about the work relationships in the service is also present in the structures of the service itself. Many interviewees talked about the lacks noticed in the daily routine of the CAPS:

"[...] there's still no budget for the OT workshops; she does it by her own efforts, she creates techniques and applies them. So, within the minimum, I think that much is done. But according to the proposal of what the CAPS should be, almost nothing is done". (W4)

"Many times, we buy things with our own money... I feel better taking my money to buy stuff than saying, 'I won't do it because there's no material'; my head would hurt more... the only thing I can do is to pay for the things myself and not to sulk if I really mean to do something with them". (W7)

These lacks are justified in the interviewees' own discourse, when they mention lack of investment in the new propositions that are required in the daily routine of the mental health practices in the CAPS:

"We could have investments and I mean financial investment. Sometimes, they don't hire, no, not hire, they don't open competitive examinations, so they don't have new employees...". (W1)

"I think that a negative point is this question of the managers: health manager, municipal manager, state manager, of not investing in the things that are really needed". (W2)

"For a CAPS to function, for any service to function, it is necessary to invest in it. And if there are no qualifications, if the necessary investment is not made, the proposal is interrupted...". (W3)

Many studies<sup>19,20</sup> have shown lack of investments in mental health services, and have indicated that the municipal managements do not adhere, in an integral way, to the proposals of the Ministry of Health. The consequence of this are services with precarious physical structures, lack of material for therapeutic interventions, as well as teams with little investment in terms of qualifications and training actions.

### **Final remarks**

We consider that the transformations in the models of mental health care must go beyond the implementation and amplification of the service networks: they must lead to another

knowledge that requires flexible actions and individual and collective changes of all those involved in this process.

To achieve this, care provided for the worker must be indicated as an urgent and continuous need, so that the CAPS can work in full potential.

It is not possible to ignore that the exposure to daily situations of stress can make these workers become ill. As it was analyzed in our study, the majority of them perceive that there is lack of training to exercise the practice in these services. This causes insecurity to act and results in the construction of defense mechanisms that reduce the qualitative capacity of their work.

Therefore, it is necessary to invest in continuous qualifications and in clinical-institutional supervisions in all the CAPS, to guarantee that these professionals can be heard and that their needs can be met within a daily routine marked by care provided for mental suffering.

The higher education institutions, besides promoting curricular reformulations and the practical inclusion in the new models of care, can contribute by formulating advancement courses and specializations in the proposals for the Permanent Education of these workers.

Another very important aspect is that work in mental health must be valued, with salaries that stimulate the professionals' dedication and allow them to engage in intersectoral actions. Thus, he will be able to participate in the creation of therapeutic spaces and continuous care, enabling, on a daily basis, the users' interlocution with the collectivity.

The spaces offered for the provision of care should also be spaces of life, with adequate physical structures that stimulate the desire of being in that place and foster feelings of happiness and wellbeing, so that the environment itself facilitates the generation of creative stimuli and not the contrary – in our investigation, we could notice that inadequate places and the scarcity of materials for the development of the practices that are necessary to perform high-quality work have mistreated workers and users.

The new model of care introduced by the Brazilian Psychiatric Reform, that of psychosocial care, brings to the workers' daily practice new intervention fronts, and opens paths for more democratic relationships, in which subjects who receive care and subjects who provide care have competences that intertwine. It is within this relational space that knowledge and practices are gradually composed.

In this sense, the CAPS must function as a catalyst for this potential, providing spaces for continuous exchanges and for the strengthening of collective work in the valuation of the new forms of providing care.

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