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Centro de Atenção Psicossocial, o cuidado em saúde mental no Distrito Federal, Brasil

Psychosocial Care Center, the mental health care in the Federal District, Brazil

Red de Atención Psicosocial, el cuidado en salud mental en Distrito Federal, Brasil

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RESUMO: Este trabalho objetivou identificar práticas de cuidado realizadas pelos profissionais de saúde mental dos Centros de Atenção Psicossocial (CAPS), na Rede de Atenção Psicossocial do Distrito Federal, tendo por base o modelo psicossocial, preconizado pelas diretrizes políticas de saúde mental. Estudo exploratório, com dados quanti-qualitativos, mediante a realização de entrevistas semiestruturadas, junto a 126 profissionais de saúde de nível superior e médio, em nove CAPS para atendimento de usuários com transtornos mentais e com uso de álcool e outras drogas, realizadas no período maio de 2011 a julho de 2012, após aprovação do Comitê de Ética em Pesquisa da Secretaria de Saúde do DF, parecer nº0081/2010. Os resultados revelam que os profissionais, em sua maioria, são mulheres e adultos jovens, com pouco preparo e experiência na saúde mental, e que, todavia reconhecem o CAPS como dispositivo potente para o modelo psicossocial. Entretanto, referem encontrar desafios relativos à formação básica dos profissionais, preparo especifico e interesse em trabalhar na saúde mental. Referem ainda limites institucionais (inadequadas condições de trabalho, insuficiência numérica e baixa articulação dos serviços RAPS) e falta de priorização da saúde mental, na agenda política local. Conclui-se que os profissionais das equipes de saúde mental que atuam no CAPS têm buscado, na organização do trabalho, superar os

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desafios, buscando o aprendizado de saberes e práticas de saúde para novas formas de produzir o cuidado em saúde mental mais convergente com o modelo psicossocial, preconizado pelas diretrizes políticas nacionais e locais de saúde mental.
Palavras chave: Saúde mental, Serviços de Saúde Mental, Centros de Atenção Psicossocial, Trabalho, Práticas de cuidado em saúde

ABSTRACT: This study aimed to identify the health care practices by professionals of the Psychosocial Care Centers (CAPS), at the Psychosocial Care Network model of the Federal District. Our work has as baseline the psychosocial model, as advocated by the political mental health guidelines. We performed an exploratory study, with quantitative and qualitative data, through semi-structured interviews with 126 health professional with Higher education or High school levels in nine CAPS for users with mental disorders and using alcohol and other drugs. The study was performed from May 2011 to July 2012, after approval by the Research Ethics Committee of the Secretariat of Health of the Federal District, technical advice number 0081/2010. Our results show that the professionals are mostly women and young adults, with little training and experience in mental health. The professionals report to finding challenges related to training, preparation and interest in working in mental health, however, they recognize the CAPS as a powerful device for the psychosocial model. Institutional limits as inadequate working conditions, numerical insufficiency and low articulation of RAPS service, besides the lack of prioritizing mental health in the local political agenda were also mentioned by the interviewees. We conclude that the professionals of the mental health teams in the CAPS have sought to overcome the challenges, learning the health knowledge and practices and exploring new ways of producing the mental health care in line with the psychosocial model, and as recommended by the national and local guidelines of mental health policies.
Key words: Mental health, Mental Health Services, Psychosocial Care Centers, Work, Health Care Practices

RESUMEN: Este trabajo tuvo por objetivo caracterizar las prácticas de cuidado realizadas por los profesionales de salud mental de los Centros de Atención Psicosocial - CAPS, pertenecientes a la Red de Atención Psicosocial del Distrito Federal, en cuanto al modelo psicosocial preconizado por las directrices políticas de salud mental. Estudio exploratorio, con datos cuantitativos y cualitativos, mediante la realización de entrevistas semiestructuradas junto a 126 profesionales de salud de nivel superior y medio en nueve CAPS para atención de usuarios con trastornos mentales y/o con uso de alcohol y otras drogas, realizadas en el período de mayo de 2011 hasta julio de 2012, previa aprobación del Comité de Ética en Investigación de la Secretaría de Salud del DF, dictamen nº 0081/2010. Los resultados revelan que los profesionales, en su mayoría, son mujeres y adultos jóvenes, con poca preparación y experiencia en salud mental. Sin embargo, reconocen el CAPS como dispositivo potente para el modelo psicosocial, pero refieren encontrar desafíos relativos a los profesionales en cuanto a la formación, la preparación y el interés en trabajar en la salud mental, y aún a los límites institucionales, como inadecuadas condiciones de trabajo,

insuficiencia numérica y baja articulación de los servicios RAPS; y la no priorización de la salud mental en la agenda política local. Se concluye que los profesionales de los equipos de salud mental que actúan en los CAPS han buscado en la organización del trabajo superar los desafíos, buscando el aprendizaje de saberes y prácticas de salud para nuevas formas de producir el cuidado en salud mental más convergente con el modelo psicosocial, preconizado por las directrices políticas nacionales y locales de salud mental.
Palabras claves: Salud Mental, Servicios de salud mental, Red de Atención Psicosocial, Trabajo, Prácticas de cuidado de la salud

INTRODUCTION

The psychosocial paradigm brought the possibility to produce new ways of social relation, and new knowledge and practices in the form of conceiving the phenomenon of madness and mental illness. The paradigm positively opposes to the asylum model of mental health care, which was instituted hegemonically in psychiatric institutions and has an emphasis on medicalization, isolation, and segregation of the person who experiences the psychological suffering[1].

The psychosocial paradigm, also known as deinstitutionalization[2], emphasizes the citizenship and freedom of the mentally disordered person and was strengthened from the Psychiatric Reform movement, orienting the theoretical-methodological and ideological framework in the formulation of the new political guidelines for mental health care in the world, and mainly from the 90s, in Brazil.

The deinstitutionalization sawed as a "practical work of transformation", that is, a change in the way in which people are treated to transform their suffering and the possibilities of social reproduction in real life[3].

> "the work of deinstitutionalization aimed at rebuilding people as social actors, to prevent them from suffocating under the role, behavior, stereotyped and introjected identity that is the mask that overlaps the identity of the sick. Treating means occupying yourself here and now changing the ways of living and feeling the suffering of the patient, and at the same time transform their daily real life"[4].

The 2011 report World Health Organization – WHO[5] suggests to the countries an increase in the commitment and accountability in the elaboration and implementation of public mental health policies, aiming to "integrating the mental health treatment and services into the overall health system, and especially in primary care". The report also recommends the definition of needs, conditions, services, treatments and strategies for mental health promotion, prevention and rehabilitation, since the population with health problems was historically neglected and excluded

from access to comprehensive health care.

In Brazil, since the adoption of Law 10.216/2016[6], about the rights and protection of mental health users, the State took an incisive role in the restructuring the psychiatric care, favoring the increase of regulations for the gradual implementation of the care model restructuring, and the creation of new community and outpatient services.

Aiming the deinstitutionalization, the Ordinance No. 336/GM[7], of February 19, 2002, creates the Psychosocial Care Centers (CAPS – Centro de Atenção Psicossocial), which are specialized and territorialized community services for the treatment of people with mental disorders and with problems related to the use of alcohol and other drugs, for adult and child-juvenile population, and has the responsibility of ordering the organization of mental health care. To rehabilitation and reintegration of people with mental disorder, coming from psychiatric hospitals or custody, or to those characterized by a situation of serious institutional dependence it was created the Administrative Rule no. 106/2000[8], which provides for Therapeutic Residences, the Law No. 10,708 / 2003[9], which establishes the Coming home Program (Programa De Volta para Casa) and the psychosocial rehabilitation-assistance grant, and the Decree 7,508/2011[10], that organize and integrate the health actions and services in health levels of increasing complexity, to ensure the integrality of health care, confirming the networks of health care – RAS (Redes de Atenção à Saúde), including psychosocial attention. The Ordinance nº 3,088/2011[11] regulates the Network of Psychosocial Attention – RAPS (Rede de Atenção Psicossocial).

The restructuration of the RAPS[11] reaffirms the guidelines for the protection and rights of people with a mental disorder or related to drugs abuse and the treatments in mental health community services. Among the strategic axes are the expansion and qualification of the access to the network of integral attention to mental health, the articulation and integration of intersectoral actions for social reintegration and rehabilitation, through actions of prevention and reduction of damage, ensuring the access, articulation and integration of the health networks in the territory, and qualify the health care through the reception, continuous monitoring and attention to emergencies.

RAPS strategically comprises the CAPS, the assistance in basic care, outpatient services, residential therapeutic services (SRT – Serviços residenciais terapêuticos), Centers for Coexistence and Culture, Reception Unit (UAs – Unidades de Acolhimento) and, beds of integral care (in General Hospitals, in CAPS Mode III). The psychosocial model suggests that the services, in addition to being located near the patient home, should provide a diverse network of health equipment to attend distinct moments of illness, with intersectoral integration, health actions based on the health needs of users of psychiatry and mental health[11]

However, the psychosocial restructuration faces limits in the access of equipment and meeting

the needs of users and their families, but there was significant advances strength the principles of psychiatric reform[12]. The specific investment by the government is an important aspect of increasing coverage capacity of services to mental health problems, which is needing a network of RAPS services, as well as qualified professionals and specialists.

We need to emphasize that the health professionals are essential to deinstitutionalization, both in the exercise of their therapeutic and managerial role, influencing mental health users and the entire network of relationships[3].

> "Therapeutic relationship becomes a source of power that is also used to call responsibility and power to other institutional actors, close or not, local administrators responsible for mental health, technicians responsible local structures, politicians, etc."[3]

Taking this into account, we seek to identify the health practices carried out by the professionals of the Psychosocial Care Centers, to offer subsidies for the improvement of health policies and practices, as well as to the professional training and work organization in mental health and psychiatry.

Therefore, we analyzed the work organization performed by the professionals with High school and Higher education levels that act in the Psychosocial Care Centers with the adult population with mental disorders and with problems related to alcohol and other drugs, of the public network of the Federal District, compared to the national policies of mental health in Brazil.

METHODS

We performed a descriptive and exploratory study, with quantitative and qualitative data to characterize the socio-professional profile of the subjects and the mental health practices developed in the CAPS services of the Federal District.

The combination of descriptive research, allied with exploratory study, describes the characteristics of a given population or phenomenon and provides a new general view of the problem[13].

This study was realized in a subset of the RAPS network, comprising of nine CAPS from the mental health care network of the Federal District Health Department - SES/DF. CAPS were focused on adult population assistance. Three CAPS are from modality II, and they aim the care of people with mental disorder, located in the administrative cities Paranoá, Taguatinga, and Samambaia. And, six CAPS, which attend users with alcohol and other drugs abuse: five are CAPS II, located at the cities of Brasília, Ceilândia Guará, Itapoã and Santa Maria, and one CAPS III, the CAPSad

Rodoviária located in the city of Brasília.

We studied 126 health professionals, of which 92 have Higher education level, and 34 have only the High school level. From the professionals with High school levels, two were administrative technicians, and one was a social action agent. Included in the sample were the active health professionals, belonging to the professional staff, who was in charge of the assisting service to users and their families, independently of the time in the CAPS.

Data collection was carried out from May 2011 to July 2012, through interviews using a semi-structured script, validated at the coordinating center responsible for multicentric research. The professionals were contacted in person, and the interviews scheduled previously and held on site. The participants were asked to sign the Free and Informed Consent Term, and also, the acceptance for audio recording.

Before data collection, the research team aligned the instruments. The entry into the field started with a simple observation, resulting in a brief description of the services regarding their organization, quantitative of workers, professional category, and the modalities of the practices developed.

For the quantitative data analysis, we realized a descriptive method, using simple statistics. Qualitative data were object of analytical treatment aiming the contextualization and reflection of the meanings attributed by the professionals in the descriptions about the organization of the services and the practices performed, as well as, the description of the adequacy of the policies developed in the CAPS, in the set of local and national results, based on the literature on the subject.

ETHICAL ASPECTS: This study is part of a multicenter research project entitled "Roles and functions of Professionals of Mental Health Services and Policies - OPS/2003 Project". The project is coordinated by the Professor Antônia Regina Ferreira Furegato, Nursing School of Ribeirão Preto/University of São Paulo, and approved by the Ethics Committee of the Clinical Hospital of the Medical School of Ribeirão Preto - USP (HCRP Process nº 13282/2005)[14]. The research was also approved by the Research Ethics Committee of FEPECS, of the Health Department of the Federal District - SES/DF, opinion no. 0081/2010, replicated in the Federal District, with financial support from FAPDF, Public Notice PPSUS 013/2010. The project and its approval protocol were presented to the Mental Health Coordination, Health and Management Secretariat of the CAPS services of the DF mental health network. The interviewees were invited to participate in the study, received the guidelines and clarification of doubts regarding the study, ensuring confidentiality and their anonymity, according to Resolution of the National Health Council No. 196/1996.

RESULTS AND DISCUSSION

1 – The Psychosocial Attention Network in Federal District

The creation and expansion of a substitutive network in the Federal District, with a territorial and decentralized basis, has taken place in a late and slower way, composed mainly for CAPS. The first CAPS was inaugurated only in 2004, aiming the care of people with alcohol and drug problems, and services such as the residential therapeutic service are missing. According to the Mental Health Plan of the Federal District, 2011-2015[15], there was a need to expand the network, with the projection of 46 CAPS and 11 therapeutic residences by 2016.

Hospitalizations, in situations of crisis and emergency, are done primarily at the São Vicente de Paulo Hospital - HSVP, a traditional specialized unit located in Taguatinga, which receives many criticisms for perpetuating the asylum psychiatric model for intervention in crisis[16,17]. The Unit of Psychiatry – UP, a building in an independent area in the Base Hospital of Federal District – HBDF, is the local of reference for clinical comorbidity. The professionals report that there are hospital beds for mental health users in other Hospitals, but the users usually undergo an evaluation and are immediately referred to the specialist hospital, HSVP or UP/HBDF. The Maternal-Child Hospital of Brasília (HMIB - Hospital Materno Infantil de Brasília) or the UP/HBDF are the reference hospitals for child-juvenile hospitalizations in mental health.

The network of specialized services of the CAPS modality consists of 18 services. For adult care, seven CAPSads for the treatment of user of alcohol and other drugs, of which four are in modality II, located in Itapoã, Guará, Santa Maria, and Sobradinho, and three are modality III, located in Brasília, Ceilândia, and Samambaia. For the treatment of mental disorder persons, there are seven CAPS: five CAPS II, in the cities of Brasília, Paranoá, Planaltina, Taguatinga, and Riacho Fundo, on CAPS II at Samambaia and the last CAPS opened was in Brazlândia on 03/07/2018. For child-juvenile, there are four CAPSi, located at Brasília, Recanto das Emas, Sobradinho, and Taguatinga. Several CAPS unities have a precarious or inadequate physical area for the development of therapeutic activities.

The CAPS network at Federal District covers 0.62 by 100 thousand inhabitants, considered good, according to parameters of the Ministry of Health. However, there is a low coverage in the south, west, and south-central health regions, with parameters between 0.20 and 0.34 by 100 thousand inhabitants[18]. Likewise, there is a small number of Family Support Unit teams (Núcleos de Apoio Familiar) for the whole DF.

People with alcohol and other drug complications, clinical worsening, or requiring moderate or severe detoxification are directed to emergencies and referral beds in the general hospitals closest to home. Light and moderate detoxification is also done in CAPSad III. Agreements and accreditation are also signed between State Department of Health of the Federal District (SES - Secretaria

Estadual de Saúde) and the therapeutic communities aiming the bed occupancy. Other intervention strategy actions are realized by the teams of the Offices on the Street, which are articulated to the Reception Units for attention to the population in a situation of social vulnerability and the Centers for Attention to Street Population.

The public transportation is available for all CAPS localities, but as the cover of the CAPS is broad, some users have a difficulty of displacement.

The work dimension is marked in the life of the mental health patients in function of the damages resulting from the psychic illness, which causes the need to discuss the conception of psychosocial rehabilitation as a factor of autonomy, social inclusion, and citizenship. The work in the field of mental health requires establishing a network of community and intersectoral support: health, work and employment, education, social assistance and art and culture. Inspired by the principles of solidarity economy, social cooperativism and associativism[19], the investigated CAPS developed initiatives to generate work and income, but in a more empirical and fragile way, since professionals report difficulty in financial support and time, given the low number of professionals, to meet the necessary community articulations and enhance the professionalization. The financial surplus is distributed for maintenance of the workshops and the users involved.

The income-generating initiatives are diverse, such as crafts, mosaic, bazaar, customization, automation, community garden, music group, choir, cooking, and others. The commercialization of the products made in some of these workshops is realized at the Fair of the Tower, important tourist space in Brasilia, with the participation of artisans users and professionals.

Bürke and Bianchessi[20] discuss the importance of work towards the social inclusion of mental health users. The capitalist mode of production demands a more competitive and qualified professional, having an excluder character for a large contingent of the population with mental problems, which, for the most part, are vulnerable to social conditions. Besides, the majority of people with mental disorders receive financial support from the government that prevents them from have a formal work.

In this sense, local management has brought to the political agenda the need to strengthen the strategies of work as a factor of social inclusion based on principles of solidarity economy, work, cooperativism, and income generation[18, 21]. The Mental Health Observatory of the University of Brasilia, located in the Nucleus of Public Health Studies, has conducted a sensitization and articulation movement of the CAPS since 2017, to problematize the importance of work as a factor of sense production and social inclusion. Besides, have the initiative to offer intervention actions of developmental and participative processes, involving the segments of professionals, users and families and other sectors, supported by the principles of solidarity economy and community

treatment[22].

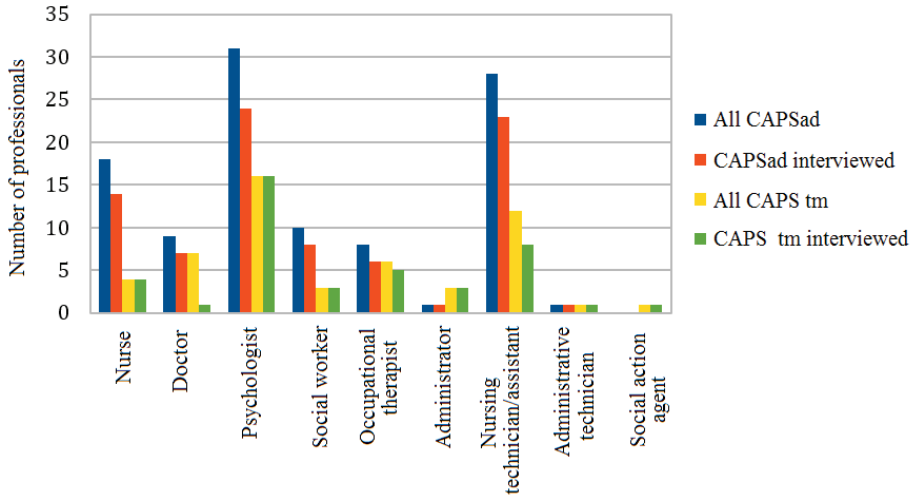
2 - Socioprofessional characterization of health professionals working in CAPS

The professional's profile is analyzed to understand the internal organization and work processes of the CAPS.

From the 159 professionals that work across the CAPS network, approximately 80% participated in the research, allowing to infer that the presented results expressed in a significant way the reality. This representation is not only related to the number of interviews, but also to the diversity of professional categories that participated in the study. The same number of professionals of the distinct categories were interviewed, which reinforces the credibility of the research.

At the CAPSs from Federal District, there is a professional diversification with the participation of social workers, nurses, doctors, psychologists, nursing technicians and occupational therapists. There are also professionals whose positions are not directly related to assistance but participate in assistance activities, such as the administrative staff (Graph 1).

Graph 1 - Distribution of the 159 professionals from the 9 CAPS, participants of the research, by professional category of Higher education and High school levels. 2012, Federal District.

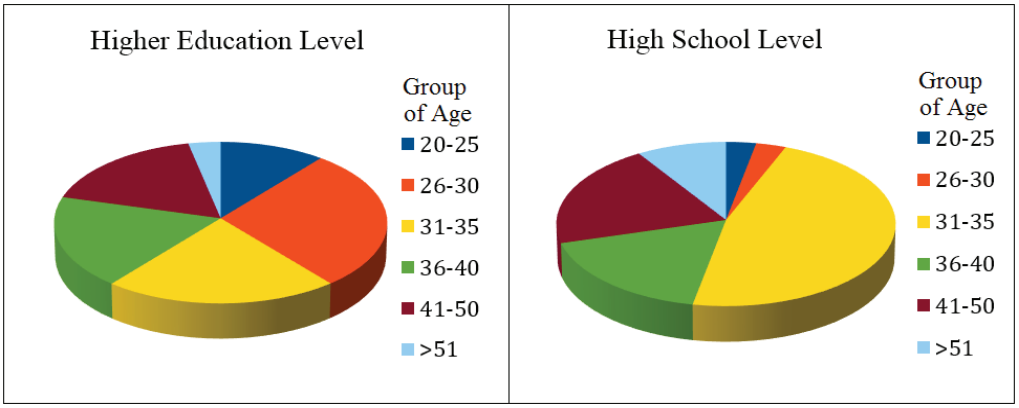


Gender and age were also studied and tend to reproduce the relationships experienced in the social system in the workplace. We found a predominance of women in both categories of High school (83.6%) and Higher education (88%) levels of professions. The results show that care professions are still predominantly composed of women. The historical construction of behaviors classified today as mental disorders are anchored to the care exercised by women since the dawn of humanity.

We observed that a significant amount of workers are young adults, both at the upper and middle levels, although High school professionals are in a slightly higher age range (Graph 2).

At the State Department of Health of Federal District, the teams are composed of professionals who have performed general examinations, except for the medical categories, which are hired by specialty. The location of work is freely chosen as long as there is a vacancy available.

Graph 2 – Distribution of interviewed professionals with High school and Higher education levels, at the CAPS, by age. 2012, Federal District, Brazil.



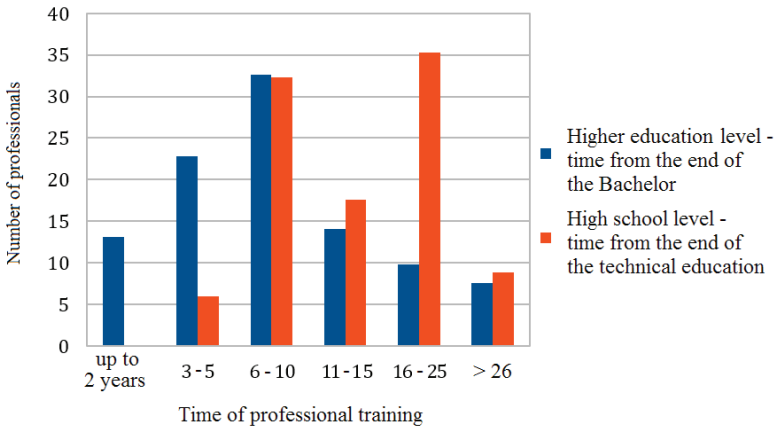
The amount of time from the end of Bachelor's degree or High school and the search for professional qualification are variables that affect the organization of work processes since they come with reflexive mobilizing and transformation referents. We observe that the majority of workers with Higher education level have up to ten years of formation (Graph 3), which means a recent professional trajectory. On the other hand, slightly more than 60% of the professionals with High school level have more than ten years of technical level completion, configuring professionals with more experience time. It is assumed that this time requires a differentiated look at the knowledge and skills required in the field of mental health, to realize health care whose paradigm is governed by the principles of the psychosocial approach.

The psychosocial paradigm, as a guide for the formation and performance of mental health professionals, requires that theoretical and practical aspects be experienced to compose the skills and abilities needed for organizing the health care.

The vast majority of interviewed considered that the training during undergraduate or technical education was not satisfactory, evaluating it as deficient or partially deficient and that the learning was developed in the daily work.

The professionals showed interest to continue the professional training through *stricto-sensu* and *lato-sensu* post-graduation, and in the realization of short courses (Graph 4).

Graph 3- Percentage of professionals interviewed in the CAPS of the DF, with High Education and High school levels positions, regarding the time of professional training. 2012, Federal District.



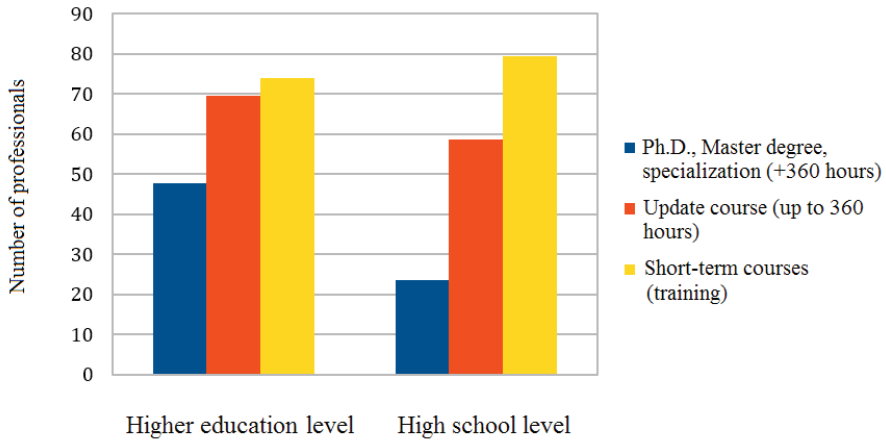
There is a significant number of Higher education professionals with postgraduation (47.8%) (Graph 4). The *lato-sensu* modality (Specialization) of qualification was more frequent than stricto-sensu (Ph.D. and master courses), but there were several professionals with a master degree and few with a Ph.D. degree. The professionals with specialization degree related that the theoretical approach was prevalent during the course, but that they also had the approach of case studies and few mentioned the healthcare approach. These indicators show the reflection of the lack of training focused on the concrete experiences that perform in the workplace.

Several professionals that work in High school level position also have undergraduate courses completed (about 47%) or in progress, in the areas of Nursing, Social Work, Physical Education, Administration, Law, Pedagogy, among others. Graduates in other areas expressed an interest in staying connected to the health field. In this group, we verified that some had done or were doing specialization.

The participation in courses of updating was also significant. The most common themes for short courses were in mental health, drugs, and chemical dependency, health care reception, family health, health promotion, STD and HIV prevention, adolescence, human rights, sexuality and health management.

Although the professionals have a propitious knowledge, they report difficulties to integrate theory to the practice of the psychosocial paradigm in everyday life. The difficulties are related to the limited experience during undergraduate studies with the population with a mental disorder and/or with alcohol and other drugs abuse, besides of the hegemonic logic of the asylum model during the study.

Graph 4 - Distribution of professionals with High school and Higher Education levels at the CAPS, FD, regarding their qualification for work. 2012, Federal District.



The interviewed report the need for public policies specifics for the training of human resources to work in RAPS, either by multiprofessional residences, post-graduation or other modality of qualification of the management and intervention processes in mental health. The clinical-institutional supervision is an example of a device that can promote changes in the psychosocial approach in the team, services, and workers[23].

The clinical-institutional supervision is a qualification program for CAPS services, with a financial incentive forecast, and is defined in Administrative Rule No. 1,174, dated July 7, 2005[24],

> "the work of a mental health professional outside the professional staff of the CAPS, with proven theoretical and practical qualification, who will work with the service team for at least 3 to 4 hours per week, in order to advise, discuss and follow up the work carried out by the team, the therapeutic project of the service and the users, institutional and management issues of the CAPS and other issues relevant to the quality of health care performed"[24].

There is a need to reinforce permanent education processes for the principles of practices that stimulate a new place for the person suffering from mental suffering, based on subjectivity, citizenship, and human rights. The formation of knowledge in the field of health must bet on more autonomous and competent professionals such that they become technical and political subjects in the implantation of management and care practices that will consolidate the psychosocial approach in the daily life of the services - integral attention to the users, management for the teamwork and the offer of activities in line with the guidelines of the national policies for mental health care in the SUS/DF.

We verified that most of the professionals working at CAPSad and CAPStm have professional experience of up to three years in the area of mental health. This panorama shows that the CAPS of the DF is a recent device, differentiated from traditional specialized services in mental health, being a space to create and reinvent work arrangements and care practices that give meaning and values to work in the psychosocial approach.

The number of Higher-level professionals that report work in a second job is significant (58.7%). Few professionals of High school level position have a second job (26.5%), possibly because they have a 40-hour working day. Although the salary is higher than the national average, the professionals justify the need for a second job to improve the quality of life. The health care professionals are allowed, by law, to accumulate two jobs since respecting the total workload of 60 hours per week. Thus, the same worker can have two enrollments in the Department of Health of the Federal District or in another institution, which is not uncommon to be found in professionals of higher education.

The working time, duration, distribution/flexibility, and intensity have followed the changes in the world of work since the 1980s and 1990s and are increasingly present in workers' daily lives. Studies indicate that "the increase in the intensity of the time of work is directly related to the growth of manifestations of physical, psychological and emotional illness of workers"[25].

Among the professionals with the Higher education interviewed, almost half said having held managerial positions in some mental health unit. Few professionals with the High school reported had held administrative positions, but for a short time. Some nursing technicians reported that many of the busy management positions occurred in private clinics.

3 – The organization of work and healthcare practices carried out by professionals in the CAPS regarding the adequacy to the National Mental Health Policy

The professionals emphasized the importance of CAPS as a strategic device for paradigm shifting from the traditional approach, centered on the knowledge of psychiatry, to the psychosocial approach. They also reported that they follow partially or do not follow the national mental health policy.

The main difficulties pointed out by professionals are related to professional dimensions and to institutional, political, financial, human resources, material or infrastructure limits. These two last difficulties are perceived more sharply in CAPS services with a recent creation time, which are still in the implementation phase.

The little technical-assistance preparation is cited as a professional limitation, besides the low

motivation and differentiated interest for the work in mental health among the members of the work team. They identify that there are professionals who are dedicated to advancing the organization of work and health practices in the psycho-social logic, however there several workers that do not dedicated to doing the work in an engaged way and shared responsibility.

According to the professionals, the weekly team meetings, with the participation of all professionals, are a strategy adopted in all CAPS that foster interpersonal communication, making adjustments in the work process, and agreement for team work. Therefore, in assessing the adequacy of work team relationships, they recognize the learning to share and respect knowledge from different professional areas, which is a continuous and not easy process, involving everyone to integrate and use that space positively for pedagogical processes and work organization.

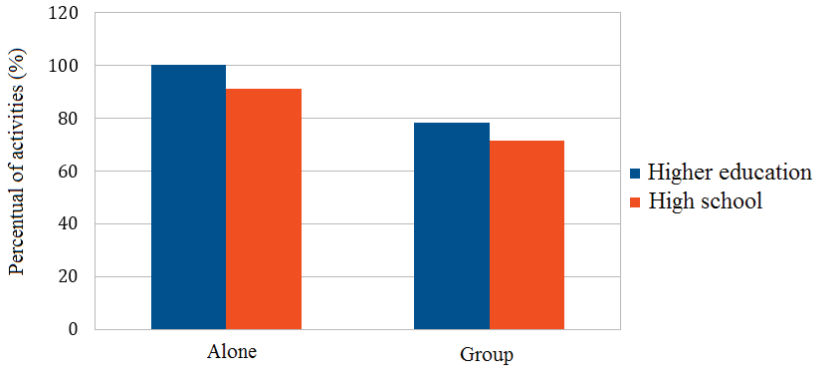
The professionals admit that the meeting with all professionals allows advances to experience greater horizontality in the work relations, and practices adjusted to the national and local politics. They emphasize that they seek, in the organization of teamwork, to act more in the logic of integration, striving for the articulation of the actions and interactions of the agents, according to the organizational model presented by Peduzzi[26].

More than half of the health professionals stated that the CAPS partially comply the national policy guidelines for mental health care. This is because are many institutional limits that avoid the governability by the professionals, overwhelming the organicity of the work in the CAPS and compromises the access and the integrality of the attention to the users of mental health. Even with the efforts of mental health coordination for RAPS advances in the Federal District, there are several external limits reported: the numerical insufficiency of CAPS and other network care devices of the Psychosocial Care Network; the low articulation of the Psychosocial Care Network - hospital network, basic care, urgency and emergency services, and rehabilitation devices; inadequate working conditions; low management valuation in prioritizing mental health care in the local political agenda.

We observed in the services as well as in the professionals' reports that is a congruence of information about the care practices developed in the CAPS, in order to comply the recommendations of Ordinance No. 336/GM[7]. There is a varied offer of individual and group visits and continued assistance. The group modality is prioritized by the different modalities of therapeutic workshops: expressive, educational, motor, yoga, crochet, hiking, garden, newspaper, paper art, embroidery, mosaic, capoeira, body therapy, community groups, and community activities such as commemorative and festive events, assemblies among others. The activities can be modified depending on the users and staff of the institution. Individual psychotherapy and group continued assistance for patients and their families.

It is evident in the organization of the work of the professionals of the CAPS that, despite the diversity of group activities, still there is the realization of individual interventions, as pointed by the interviewed. This case minimally depicts two angles that can be understood in different ways. If, on the one hand, it can imply that the focus continues on individual activities, on the other hand it can represent a significant advance in the reorganization of all activities. While focusing on the individual, collective activities are presented as part of the assistance provided in CAPS.

Graph 5 - Percentage of individual and group activities carried out by professionals at the Higher Education and High school levels of the CAPS of the Federal District. 2012. Federal District



According to Costa Rosa, the psychosocial approach requires the problematization of the political-ideological and ethical dimensions of the health model and the practices developed in the therapeutic action, for a redefinition of the object and the ways of work, in the organization of the multi-professional work. The problematization is vital to break the logic of the technical division of labor based on the vertical, uniprofessional model, centered and fragmented (asylum mode) to advance in horizontal models in order to "*favor conceptions of the object focused on multiple knowledge, ... and for therapeutic relations in which practice horizontal intersubjectivity, bases for singularization*"[1].

Professionals reported the participation in the elaboration of the Unique Therapeutic Project (Projeto Terapêutico Singular), referring local arrangements of reference technician appointment with a set of users, and usually, the team meetings seek to discuss the more complicated cases.

Reception activities are realized mainly by scheduling, according to the organization of each service, justified by the high demand and scope of the territory, and several CAPS have a waiting list, and the users may take weeks or even months to have access to the service.

In general, few professionals reported a fluidity to perform the matrix support and to promote

the integration with the basic attention and networking of social and communitarian resources. The home visit, active search and community events still have a fragile organization in the speech of the professionals. Among the most cited factors that difficult the approach and dialogue in basic care, are the insufficiency of staff, the lack of transportation and the overload of demand.

Among the guidelines, CAPS is expected to be a regulator of attention in the territories of action and responsible for searching integration strategies between mental health and primary care. This is a priority guideline in the policy of mental health care and can be strengthened by the provision of matrix support in order to reduce the demand for specialized services, as they can expand the competencies for mental health care and the definition of responsibilities, in a shared way, taking in to account the lack of established health systems in several countries and localities[27].

> "the matrix support as an organizational arrangement of technical assistance to the primary care services is the main strategy of qualification of the ESF to meet the mental health demands of the population. A specialized team responsible for matrix support shares cases with family health teams, through joint case discussions, joint interventions with families and communities or shared care"[27].

The fragility of the integration of the CAPS with the Basic Attention raises an critical reflection of the psychosocial approach to takes place in the territory. Thus, it is worth questioning how much the professionals of the CAPS have considered the macro-institutional issues as a determinant and limiting for the development of the extended care, restricting the CAPS to a technical assistance role of providing healthcare in the institutional space. Without the problematization, the professionals releasing themselves as political actors for articulations for full access to health and citizenship of this clientele and its implications.

Therefore, CAPS having as function the reiteration of the treatment in freedom and the citizenship valuation may not pay attention "*to the risks of institutionalization or the new chronicles in the spaces of the CAPS that can reinforce a relationship of dependence of the users in relation to these services* "[28].

The participation of family members is an important guideline in the treatment, psychosocial rehabilitation and social inclusion of users with mental disorders and problems related to the use of alcohol and other drugs. Therefore, the family must be considered as a central support device in the care of the person and the relationship with society for processes of resignification of the madness, the prejudices, and associated stigmas. The family needs to be regarded as

> an ally, a partner in the process of psychosocial rehabilitation of the user.

> Psychosocial attention, coupled with the protagonism of families, facilitate the social reinsertion of the user and the promotion of the health of the family nucleus, considering the personal, biological, social, and political dimensions that involve daily life[29]

The professionals interviewed report to perform the "family care" most of the time together with another professional, walking towards a practice that indicates co-responsibility among the members of the team. However, the family care need be expanded, since some professionals reported not doing any attention to the family.

The predominant approach in the family care is the systemic approach. Other criteria cited primarily by psychologists, and to a lesser extent, some psychiatrists were cognitive, psychoanalytic, pichonian, gestalt, behavioral, cognitive-behavioral and psychoeducation. Other Higher education professional categories more commonly referred to the self-help and reception approaches.

The document "Saúde mental no SUS: os Centros de Atenção Psicossocial" reinforces that psychosocial care services should invest in family care, through nuclear and family care, individualized care, home visits, teaching, learning and leisure activities, empowerment of community actions, seeking the integration of service and users, in the perspective of participation and social organization of the family, community and society as a whole[30].

We registered the presence of the social movement ASSIM - Association of friends of mental health, with active participation in the discussion of mental health issues and discussion forums on the challenges of mental health policy. The ASSIM is an extra associative organization to CAPS.

The creation of movements from this nature in the different territories can initially be supported by mental health professionals in family intervention practices, which should be understood in their complexity, intending to their empowerment and higher demand for respect to the principles of citizenship and human rights.

The majority of interviewed affirm to promotes actions for the autonomy of the users during their stay in the CAPS, while a significant number of professionals say do not prepare the patients to be discharged from the care. That is, there is no understanding that actions for autonomy are preparatory to discharge. The non-establishment of this relationship instigates to think if the actions for the autonomy effectively walk to reach that goal so that the discharge is a natural consequence of the process. It is also understood that the discharge is seen as a punctual action and not as the result of a process in which the users become able to develop abilities that allow them to participate actively in the society[31].

The autonomy understood as the production of subjectivities, whether in the relations between health professionals and users and between users and other social networks, is a construction process in which there is a search for protagonist participation in the production of meanings in the development of practices of the substitutive services. Thus, the psychosocial approach, besides problematizing the historical relations developed in asylum institutions, as well as segregation and exclusion, offers subsidies that lead to another way of producing health.

The professionals recognize themselves as important institutional actors to change and concretize the technical-assistance and ideological conception of the CAPS device of the psychosocial model. However, they are not free of conflicts of different natures in the search for a hegemonic treatment in the community perspective, which permeate the heterogeneous training of professionals, the logic of specialties in work in mental health, and the centrality of care in the needs of the users to go beyond the institutional limits already mentioned. But, the strategy of bringing these issues to the discussion in the organization of teamwork has allowed advancing in knowledge and practices of care in greater consonance with the psychosocial model and, consequently, with the national political guidelines of attention to mental health.

The CAPS are considered recent devices in the DF. The health professionals are in the construction of a work process different from the traditional approach, adopting the freedom, the autonomy and the citizenship of the users as guiding aspects of the work process. Therefore, it is appropriate to bring to the discussion of CAPS health teams the purpose of therapeutic work in the process of deinstitutionalization.

FINAL CONSIDERATIONS

Our results allow increasing the understanding of the care strategies and practices that have shaped the work of health professionals in the Psychosocial Care Centers - CAPS, and the challenges faced by them to adapt to the psychosocial model advocated by the Mental Health Care Policy.

The professionals evidenced the effort made to give concreteness to the psychosocial model in the interpersonal relationships for the construction of teamwork, the search for better professional technical preparation and the relationship of care with the user mental health with an emphasis on autonomy, participation, and citizenship. However, the professionals affirm that the advances are not more significant due to the precarious physical, material and economic conditions of the CAPS and to the macro-structural limits that avoid the compliance of the National Policies

guidelines to the integral attention to mental health. The difficulties involve the need to create and expand health equipment aiming the conformation of the points of the psychosocial care network to cover the health regions. The expansions of the health equipment are in the midst of the problems and political conflicts to affirming the SUS and to increase access and the integrality of health care in the set of social politics.

There is a need for investment in professional training to work in the field of mental health. In general, the mental health professionals of the CAPS report an inadequate preparation in training, often occurring empirically in the daily practice of the work, which refers to the need for investments in lifelong education.

However, despite the institutional and professional limits, the CAPS are recognized and valued by professionals in general, as a differential center of services, powerful and substitutive to the asylum mode. The professionals highlight the importance of the CAPS in meeting the needs of users and their families for a comprehensive mental health care, but find limits on the articulation with others sectors and the community.

The professionals perceive themselves in the process of continuous and progressive construction of learning and re-signification to change the hospital-centered asylum model for the psychosocial model conception. The acquisition of knowledge and practices allow affirming the CAPS as a new space of care for the mental health users in seeking to institute care productions with an emphasis on the values of freedom and citizenship of users.

Therefore, we could see in the institutional practices developed by the professionals in the CAPS, the strengths and weaknesses that are in transition and identity formation for new knowledge, practices, and values in social relations. The new knowledge allows advancing the objective characterization of the psychosocial model hegemonically instituted.

Our finds reveal important aspects about the role of health professionals in the organization of mental health care in the Federal District, as well as the need of better strategies in the scope of management and organization of work to progress in the qualification of the psychosocial care. However, it is necessary to consider further studies, aiming a greater monitoring of the management system, indicators of mental health, financial resources applied, access and effectiveness of the network and other variables involved for comprehensive care for mental health users.

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