

The profile and professional practice of nurses in a psychosocial care services*

O PERFIL E A AÇÃO PROFISSIONAL DA(O) ENFERMEIRA(O) NO CENTRO DE ATENÇÃO PSICOSSOCIAL

EL PERFIL Y LA ACTUACION PROFESIONAL DEL ENFERMERO/A EN EL CENTRO DE ATENCIÓN PSICOSOCIAL

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ABSTRACT

This qualitative study was performed with fourteen nurses of eleven psychosocial care services. The objectives of the study were the following: to characterize the professional profile of the nurses who work in community psychiatric services and to verify those nurses' practice according to the current model of mental health care. Results: there was a prevalence of females; most had over 10 years since their graduation; their entrance in the mental health area is late and is associated with the lack of job opportunities and the fact that the service is close to their home. One part of the nurses found it difficult to define their work at an extra-hospital environment. On the other hand, another group of nurses believes that the nursing work in mental health services is flexible and it is shared with other workers of the multidisciplinary team. Low salaries, poor infrastructure and the lack of team member acknowledgement generate dissatisfaction at work. The Brazilian Psychiatric Reform is associated with dehospitalization.

KEY WORDS

Psychiatric nursing.
Nurse's role.
Mental Health Services.

RESUMO

Trata-se de um estudo qualitativo, envolvendo quatorze enfermeiros de onze Centros de Atenção Psicossocial. Os objetivos do estudo são: caracterizar o perfil profissional do enfermeiro que trabalha no CAPS, e verificar as ações desse profissional no atual modelo de assistência à saúde mental. Resultados: o sexo feminino prevalece; a maioria é formada há mais de 10 anos; a inserção na área de saúde mental se dá tardiamente, e está associada à falta de opção de trabalho e proximidade do serviço com a residência do profissional. Uma parcela demonstra dificuldade para definir sua função num serviço extra-hospitalar. Outra parcela acredita que a ação no CAPS é flexível e identifica um saber que pode ser compartilhado com a equipe multiprofissional. Baixos salários, infraestrutura deficiente e falta de reconhecimento pelos membros da equipe produzem insatisfação no trabalho. A Reforma Psiquiátrica é associada à desospitalização.

DESCRITORES

Enfermagem psiquiátrica.
Papel do profissional de enfermagem.
Serviços de Saúde Mental.

RESUMEN

Se trata de un estudio cualitativo que tiene como sujetos de análisis a catorce enfermeros de once Centros de Atención Psicossocial de la ciudad de São Paulo (Brasil). El objetivo del estudio es caracterizar el perfil profesional del enfermero/a que desempeña sus funciones en un CAPS y verificar sus acciones en el modelo vigente de asistencia a la salud mental. Los datos fueron recogidos a través de entrevistas, empleándose las premisas de Bourdieu. Resultados: prevalece el sexo femenino, la mayoría está graduada hace más de diez años, la inserción en el área de salud mental se produce en forma tardía y está asociada a la falta de opciones de trabajo y a la cercanía del servicio con el domicilio del profesional. Una parte de los entrevistados muestra dificultad para definir su función en un servicio extra hospitalario. Otra parte cree que el trabajo en el CAPS es flexible, e identifica un saber que puede ser compartido con el equipo multidisciplinario. Bajos salarios, infraestructura deficiente y falta de reconocimiento por parte de los miembros del equipo producen insatisfacción en el trabajo. La Reforma Psiquiátrica está asociada a la deshospitalización.

DESCRIPTORES

Enfermería psiquiátrica.
Rol de la enfermera.
Servicios de Salud Mental.

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INTRODUCTION

Until the 1970s, in the 20th century, Brazilian psychiatry worked according to a mental hospital model and the assistance to the patients was focused on a traditional medical model with hegemony of the psychiatric hospitalization taken as synonymous to treatment. Such conjuncture has changed as a result of the implementation and consolidation of the Brazilian Healthcare System (SUS)⁽¹⁾ and public mental health policies built by the organization of workers, users and family members together with non-governmental organizations under the responsibility of the Ministry for the Health by means of laws and ordinances⁽²⁾.

In the past two decades the Psychiatric Reform Movement in Brazil has started to criticize the violent way patients were treated at asylums and that led to the first attempts to humanize such spaces, which coincided with the opening and redemocratization movement of the Brazilian society. In the 1st. National Conference of Mental Health in 1987, discussions gathered strength and that same year the 2nd. National Congress of Mental Health Workers was held in Bauru, when changes in the theoretical and ethical premises of psychiatric assistance were ratified.

Therefore, in the end of the 1980s and early in the 1990s, experiences to transform psychiatric assistance emerged, the creation of community psychiatric services such as the Centers of Psychosocial Care (CAPS/ NAPS) among them. These new services were funded by the Ministry for the Health and regulated by Administrative Rule / SNAS No. 189 of November 19th, 1991 and Administrative Rule / SNAS No. 224 of January 29th, 1992⁽³⁾.

The Psychiatric Reform advocates the transformation of the mental health assistance model and the construction of a new social status for mentally-challenged individuals, that of a citizen. It does not intend to eliminate clinical treatment for mental conditions, but to eliminate hospitalization as a means of social exclusion of mentally-challenged individuals. For such purpose, it proposes the replacement of the mental hospital model by the creation of a territorial psychosocial care service network based on the community guaranteed by Administrative Rule / GM No. 336 of February 19th, 2002⁽³⁾.

Therefore,

the new guidance of the assistance model has imposed gradual and increasing implementation of a care network whose organization requires a complex structure and articulated community services and territorial, cultural and social resources, mental health wards in general hospitals, therapeutic homes and social cooperatives⁽⁴⁾.

The practical transformation of how mentally-challenged individuals should be treated is understood as a set of indirect and immediate strategies facing the problem of suffering so that emphasis was not placed on the health-disease process any longer, but on patients' social production/reproduction project.

Within that context teamwork has fundamental importance. Psychiatric patients are no longer an exclusive object of intervention of the medical practice and are now seen as the subject and agent in their own treatment; so, they *start to demand other therapeutic instruments-projects, intervention strategies, and they are now redesigned by those instruments*⁽⁵⁾. According to this new care model, service users count on interdisciplinary teams for therapeutic follow-up.

An interdisciplinary team is understood as

a group of agents operating with different skills by means of several instruments, where practices are combined and interact with each other, and common objects are identified and there is a trend towards horizontal power relations among the areas of knowledge enabling mutual enhancement of the professionals involved⁽⁶⁾.

Therefore, the more therapeutic and social devices are open and flexible, the more efficient non-hospitalization practices are, once the Centers of Psychosocial Care

are not only a physical environment where patients are left, but also social place where work, leisure, culture and rights are present and, more than that, work as clinical strategies of social inclusion and cultural intervention inasmuch as they favor experimentations different from those traditionally known by the population, which is the place of the sick, the impotent, the incapable of being an agent⁽⁶⁾.

Therefore, with the emergence of open mental health services it was necessary to reorganize the working processes and, consequently, the institutional therapeutic project. In this regard, it is also up to the nursing team to move away from the medical-focused attention and take over a therapeutic stance under a humane and professional autonomy approach⁽⁷⁾.

On the other hand, studies have shown that healthcare providers in general think it difficult to be included in this new assistance model so that the work currently done in the open psychiatric care services is far from that proposed by the guidelines of the Psychiatric Reform, once the changes made so far have been mostly mirrored

in external logic, equipment visibility, keeping not only custodial practices and those limited to the medical-psychiatric model, but also, what is worse, adhering to unethical and inhumane practices questioned by the very psychiatric medical knowledge duly constituted⁽⁶⁾.

So, despite all advances in mental health, *the work done is still very far from inclusion (even therapeutic, perhaps social), citizenship and autonomy of the subject/user*⁽⁵⁾.

This study addresses particularly the insertion of the nurse into the healthcare production process proposed by the Psychiatric Reform and the reorientation of the assistance model consolidated by Law 10.216/2001 in the Centers of Psychosocial Care once

the working process is determined by the need of transformation and overcoming a given situation towards a pur-

pose. These needs are individual and at the same time collective once they configure themselves historically and socially⁽⁸⁾.

In view of this scenario, the purpose of this research is to help understanding nurses' work in the mental health field, the commitment of such healthcare provider to the mental health production process, as well as how they understand the reason why they should take certain attitudes instead of others. What is their object of interest, the patient or the mental disorder? Do their actions address their caring tasks or are they still limited to just administrative tasks?

The object of investigation of this article is nursing agents' actions at an upper level in mental health today.

OBJECTIVE

The objectives of the study are to characterize the professional profile of graduated nurses who work in Centers of Psychosocial Care and to check nurses' work within the current model of assistance to mental health.

METHOD

This paper is based on theoretical principles in the psychosocial field and psychosocial rehabilitation proposed by Benedetto, Saraceno⁽⁹⁾ according to the dispositions in Law No. 10.216/2001 which *disposes on protection and rights mentally-challenged people and redirects the assistance model in mental health*⁽³⁾.

This is a qualitative study involving 14 nurses working in Centers of Psychosocial Care (CAPS) II in the city of São Paulo from October 2003 to February 2004. As recommended by the Ethics Committee on Research of the Municipal Department of Health of São Paulo, healthcare coordinators of the Health Districts, who were informed about the study, agreed with it and informed the unit managers. After obtaining service managers' consent, nurses were contacted and they agreed to join the study. Interviews were schedule and conducted from December 2003 to February 2004.

According to the data provided by COGEST in September 2003 there were 17 Centers of Psychosocial Care - CAPS II - registered in the Ministry for the Health in the city of São Paulo. Out of those 17 centers, 16 were contacted and 01 could not be reached because no phone number was available during the whole period when the research subjects were selected.

Among the centers contacted, 02 of them did not fit in the research selection criteria as they have no graduated nurses and 03 of them were excluded because their nurses were not available to participate in the study at the time scheduled to collect data. Therefore, 15 nurses were previously selected according to their availability to participate in data collection. Among them 14 became research sub-

jects after agreeing to participate in the study and signing an informed consent form. A male nurse refused to participate in the study.

The research was approved by the Ethics Committee on Research of the School of Nursing of University of São Paulo (Proceeding No. 321/2003) and the Ethics Committee on Research of the Municipal Department for the Health of São Paulo (Proceeding No. 149/2003).

The instrument chosen to collect data was a semi-structured interview, i.e., an interview combining open and closed questions *where the interviewee has the possibility of talking about the theme proposed without answers or conditions preset by interviewer*⁽¹⁰⁾. For that purpose, premises proposed by Bourdieu were used where identifying interviewer's stance before interviewees influences the interview's outcome. Still according to the author, through a subject's speech we can reach the universal speech of subjects inserted in the same group, thus making sure that qualitative researches are representative once, according to the author, there is a trend towards reproducing subjects' speeches when they are inserted in the same system under similar conditions to which they are subject⁽¹¹⁾.

RESULTS AND DISCUSSION

On characterizing the professional profile of the nurses interviewed

As to the age range, most nurses interviewed were women (78.54%) and are at least 40 years old; and the youngest nurse was 34 years old, while the oldest was 63 years old.

As to how long ago they had graduated, time interval varies from 06 to 26 years, most of the nurses having graduated at least 10 years earlier, (92.82%). Nevertheless, only a few nurses had a post-graduation degree in mental health (21.42%).

Monthly income of the nurses interviewed varied from 04 to 33 minimum salaries, whose amount when data were collected corresponded to 240.00 Reais, and half of the nurses interviewed earned no more than 09 minimum salaries.

As to working hours, 06 nurses (43%) worked 60 hours or more per week.

On the work of graduated nurses in the Center of Psychosocial Care II

Work in the mental health area

The investigation about professional experience in mental health reported that out of the 14 nurses interviewed, 12 (85.78%) did not work in this field since the beginning:

No. initially I worked in the hospital area for about 11 years.

No, I had never worked in the mental health area. This is my first time".

No, I graduated 14 years ago, but I have always worked in the ER.

Only 02 (14.28%) reported having made such a choice, as shown by the following statement:

I have always worked in this area. I was a nursing assistant and worked in a psychiatric hospital, and then I became an auxiliary nurse...

As to the insertion in the mental health area, 08 interviewees (57.12%) answered they were not interested in working in that area and they only did it because they had no better options and one of the most important criteria in their decision was the proximity to their home:

I took the official exam. It was not a choice. I only chose the place where I would like to work. It was because of the area, the territory, because I live nearby.

I first arrived here by chance; there was an opening so I was invited to work here. I had never worked in mental health before and I was kind of afraid, but I came anyway.

I chose here because there was an opening [...] I did not have many choices... I kind of accepted the job because I had no other option, but I would rather work at a hospital.

Differently from 06 other interviewees (42.84), who related their work in the mental health area because they had a chance, not because they lacked it:

I started to get interested in the area, my previous experience encouraged me to join the area [...]; we build a life story, in our work, which leads us to study, go deeper, learn, and then I felt more inclined to work in the mental health area.

I have always liked it; this is something that always drew my attention. Psychiatry is a more special care. They are patients who need you more.

Health actions taken by graduated nurses

About nurses' activities in the Centers for Psychosocial Care, according to the interviewees, this is a very broad field covering activities of an administrative and assistance nature. The administrative activities mentioned more often were drugs and pharmacy inventory control; nursing team supervision and guidance; participating in group discussions with the multi-professional team; scheduling shifts and helping managing services:

I manage the services, provide internal training about some specific matters in the nursing area; I control pharmacy inventory; I order drugs, check demand and update the inventory.

Activities that nurses are supposed to do, such as supervising nursing auxiliaries and scheduling shifts.

Assistance activities were more highlighted: participating in therapeutic groups with users and relatives; welcoming and listening to the patient; nursing consultation and home visits; hygiene and food and doing tests:

I participate in therapeutic groups, educational groups, case discussion with the team, with psychologists, psychiatrists, T.O. I make nursing consultations, apply the systematization when a patient is admitted. I do the weekly nursing prescription. I evaluate patients.

Blood collection, therapeutic groups, journal groups, dance group, reunion group and medication group. I also follow up food, hygiene and rest.

Another relevant piece of information about nurses' work in the Centers for Psychosocial Care revealed that some interviewees believed that their activities are completely unrelated to nurses' competences; the activities closer to nurses' field of work are supervising the nursing team, patients and the institution, controlling drugs and applying the SAE:

Most services are unrelated to nursing. What is linked to nursing is the SAE [...] here, in my opinion, it is all about supervising nursing assistants.

Supervising the personnel ministering drugs, nursing personnel, patients.

What we can see in this subgroup of interviewees is that they find it difficult to outline their function in the health-care production process in an extra-hospital service. That is so because their concept of being a nurse is linked to the hospital practice, what makes nurses distort their professional identity:

Almost nothing belongs to the nurse except for the shift; we record patients' story and that is what we do anywhere, in the hospital, in the healthcare area. But, as to the rest, as I told you, in a hospital we do not work as a group, with this stuff, there who works more is T.O. There is a little nursing, a little, and that is something we do not use inside the hospital.

On the other side there are the nurses who believe that their actions are consistent with the skills of a nurse. They believe that there is more flexibility in the actions of the professionals in a multi-professional team. They identify a specific capacity associated to an activity proper of a nurse that can be shared:

It is hard to separate what is nursing from what is not. In mental health I see that everyone does a little bit of everything, but there are not many specific things that are or are not nursing. Everything related to nursing refers to interpersonal relationships and communications, fostering a therapeutic environment, therapeutic communication, interpersonal relationship, building bonds, based on that, I guess. Now, something specific, I do not see that.

Here there is no such discrimination, such difference that you find as rigid as in hospitals. That thing of a nurse's role, social service, the doctor, TO. I think that this is our role, the team's role, here we can do everything together.

In this subgroup of interviewees, nurses mentioned as typical tasks of the nurse: therapeutic relationship, nursing

consultations with patients and their relatives and activities in therapeutic groups, besides the already mentioned supervision and qualification of the nursing team, and such activities are exemplified in the following answers:

As care is provided here, then here everything is about nursing in all sectors.

Workshops, therapeutic relationship, and intervention in crisis situation [...] we can provide counseling to the family, if we are qualified to do it.

Approaching the patient, mitigating mental suffering of that person by means of workshops, psychic restructuring of that patient, bringing him to reality.

As to the reason why care is provided, some interviewees stated that they like working in the mental health area or in healthcare area:

I do what I like, I like working in the health area, any area is good for me, I have always thought it nice.

I like doing it, I like everything I do. I believe that this is because I like the mental health area, I study, I invest. And because I work with what I like, it is pleasurable, very involving.

On the other hand, 04 (28.56%) reported they also acted because they had to in certain circumstances and not because they liked it, but because this is an imposition of the system, the Regional Nursing Council (COREN):

I do what I have to do because otherwise I would not fit in this system. I do some of what I have to do. There are some things that I think I should do, but I do not like doing them and there are things I really enjoy doing and I do them. The reason is that I am inside a social order of things, a phallic order, I'm not outside of it, yet.

I do here what I should do and what I like, what the COREN requires.

As to professional satisfaction of the nurses interviewed, 05 (35.70%) reported significant satisfaction and did not report any obstacles to their work:

I do what I like... I left the Family Healthcare Program where I earned almost four thousand reais to work here for one thousand.

I like working here very much... being with them, talking to them, seeing them making progress. Particularly when you see a patient being discharged, after he came here disoriented, confused and you see he is leaving feeling fine, I think it is great.

The 09 remaining nurses (64.26%) answered they were happy, but reported some obstacles preventing them from achieving an even greater satisfaction, such as low salaries, lack of incentives and infrastructure, lack of acknowledgement by the other team members, lack of deeper knowledge in the mental health area and also relative inadequacy to the new model of mental health assistance:

There is a political context influencing everything; many things cause dissatisfaction to those who could experience a different time, I would be very happy if that policy were kept, if we had support... satisfaction depends on what you feel, individually.

I am happy for working here, but I think that the unit could have a greater and better dynamics, more professionals, for the patients [...] to be reinserted in the society.

The only thing I do not like is my salary. Considering what we have to invest, there is no return.

I am happy with my job, I like what I do, despite a lot of problems. Whenever you are doing something, involved with a patient, they ask you to do something else, they block you: your role is different, it is a matter of hygiene, food. It does involve other things, but that is not all.

Nurses' knowledge of the Psychiatric Reform

As to the nurses' knowledge of the Psychiatric Reform, the interview disclosed a set of heterogeneous answers, so they were divided into three subgroups. Nine interviewees (64.26%) associated the Psychiatric Reform to a change in the assistance model targeting on ending hospitalization of psychiatric patients together with the creation of open psychiatric assistance services, which allows patients to have more contact with their families and to be more integrated with the society:

They used to put patients at hospitals' basement... it is getting much better, now this last reform is no longer admitting patients in hospitals...patients stay in the hospital during the day and go back to their family.

We could vivify models before [...] I could see what meant a patient who stays in a hospital for his entire life, or loses his life because he had been admitted,, abandoned by the family and then I could act after ten years. Virtually in another history, another model. Where people could stay without being in exile.

I have always worked in the ER and all ERs have a psychiatric ward.

I was a reference in psychiatry, psychiatric emergency [...] but experience I had there in psychiatry was very poor... they had sexual intercourse inside the hospital and were actually deposited there [...] I started to work here when it was a Day Hospital and today it is a Center of Psychosocial Care, and I think this is the elite.

Other 04 nurses interviewed (28.56%) said that the Psychiatric Reform covers a historical and political context targeting on a deep change in the assistance provided to psychiatric patients, including building a supporting network for patients, creating new models such as the Centers of Psychosocial Care and therapeutic homes, besides changing the approach to such patients by using other instruments:

Reform was what I started learning when I got here in the Psychosocial Care, that is a political discussion in the senate,

laws, Paulo Delgado, but what we see is that the Reform is made in daily life, in the same things, small decisions.

From what I read, they go back to the end of the 1970s, the 1980s, together with the challenges against the military government, in the health area too, one also had a different view of what a psychiatric assistance should be. People fought for the Brazilian Healthcare System and within that context, for the Psychiatric Reform which advocates that there should be even fewer hospitals where patients are *deposited*, supported by the Centers of Psychosocial Care, therapeutic homes, etc.

And at last it was also possible to find one of the interviewees (07.14%) who said he knew nothing about the Psychiatric Reform, but he ended up by associating it to the prohibition of straitjackets, as shows the following speech:

I do not know anything about the Reform [...] that I know because when I worked in a ER it was emphasized, that a straitjacket could not be used [...] it is something very aggressive, I think it is very interesting to stop using straitjackets, I think that with dialog and drugs you can do more... of course in some cases there is no other way, one has to restrain patients mechanically, but it was like that. I was told he was crazy and then I had to use a straitjacket.

FINAL CONSIDERATIONS

The characterization of the profile and professional work of the 14 graduated nurses in psychosocial care centers has shown that most of them are in the age group above 40 years old. Among them, only 02 chose the mental health area and worked predominantly in that area, and this information has been corroborated in other studies^(7,12). The reason why nurses entered the mental health area later is associated to a lack of better options and the criteria that weighed in that choice, even if later, is the proximity to their homes. Such rejection to the mental health field seems to be the remains of the institutionalization period.

The study shows that females prevail, thus confirming the trend in the profession. The fact that 13 of the research subjects graduated more than 10 years ago draws the attention, and also that although they are experienced in nursing area, it does not obligatorily reflect on their current job, once out of these 13 nurses, 12 entered in the mental health area at some point later in their professional career.

The reason why nurses do not seek professional improvement has not been directly investigated, but according to some reports, their lack of interest in attending post-graduation is associated to old age and to the cost effectiveness of that investment. Moreover, there is a clear exhaustion caused by working multiple shifts and a low remuneration. This process makes nurses feel empty, thus causing negative changes in their behavior towards their managers, colleagues and tasks, and also causing problems in interpersonal relationships, absenteeism and requests

for transfers in sector, tasks or functions⁽¹³⁾, and may lead to a bad performance as a whole.

Centers of Psychosocial Care II's nurses do administrative tasks, predominantly controlling psychotropic pharmaceuticals and supervising the nursing team. They define as assistance activities the promotion of patients' wellbeing, hygiene and food, doing tests and controlling drugs' effects. And actions oriented towards promoting patients' psychological well-being by using therapeutic communication and therapeutic groups are frequently mentioned.

The investigation focused on the concept of the nursing work done by nurses working in open units for mental health. Nurses understand activities proper of nursing in a very interesting and heterogeneous way. Some nurses interviewed seem to feel insecure to work in a field that does not follow the hospital model and believe that the work proper of a nurse is that that can be also reproduced in a hospital, such as supervising the nursing team, paying attention to drugs' effects, meeting some patients' basic needs such as food, hygiene and rest. This subgroup evidences some difficulties in defining their function in the process of producing healthcare in an extra-hospital unit

Other nurses believe that the work in Centers of Psychosocial Care is consistent with the actions of a nurse because there actions of the professionals composing the multi-professional team are flexible and they understand that activities proper of a nurse are not necessarily specific activities and they may be shared. This subgroup mentioned the therapeutic relationship as nurses' typical healthcare actions.

Most say that the reason why they provide mental health assistance is because they like taking care of people and present justifications that come close to the speech historically built where nursing is associated to charity and abnegation. Nurses who are not happy with their jobs list low salaries, defective infrastructure and lack of acknowledgment by the other team members as the main reasons.

The knowledge of the nurses of the Centers of Psychosocial Care of the Psychiatric Reform, according to them, is limited, associated with the end to the lengthy hospitalization process of psychiatric patients and the creation of alternative services. The lack of knowledge of the Psychiatric Reform is an important factor when associated to the quality of the assistance provided by such professionals, a piece of information also found out in another study⁽¹²⁾. It is noteworthy the fact that the very nurses who recognize and support such an important movement dealing with the organization of the work and reorientation of the assistance mode, do not seem interested or involved in it.

We understand that professional actions in the healthcare field are determined by several factors related to nurses' education, to their personal characteristics and the circumstances in the very society. Therefore, it is extremely important that nurses obtain competences and

skills to meet the population's needs based on their own knowledge, thus building their place in the healthcare pro-

duction process in order to be able to interact with the remaining professionals in the healthcare area.

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