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ORIGINAL ARTICLE

THE PRACTICES OF THE NURSE IN PSYCHOSOCIAL CARE: VULNERABILITIES AND PRESENT POTENTIALITIES

A PRÁTICA DO ENFERMEIRO NA ATENÇÃO PSICOSSOCIAL: VULNERABILIDADES E POTENCIALIDADES PRESENTES

LA PRAXIS DE ENFERMERÍA EN LA ATENCIÓN PSICO-SOCIAL: VULNERABILIDADES Y POTENCIALIDADES PRESENTES

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ABSTRACT

Objective: to investigate the praxis of the nurse, the potentialities and vulnerabilities to which this praxis is exposed in Psychosocial Care Centers (CAPS). **Method:** a descriptive study, with a qualitative approach, in which seven nurses working in the CAPS of a capital of the Northeast participated. Data was produced through interviews and the speeches were submitted to the Content Analysis technique. **Results:** therapeutic groups, health education, individual care, home visits, medication administration and fostering were the main activities performed by nurses who consider teamwork a potential for their work. Deficiencies in material resources, transportation and the structure of the service together with low professional qualifications and the weaknesses of the care network were described as vulnerabilities to work. **Conclusion:** identified vulnerabilities interfere with the quality of care provided. **Descriptors:** Nursing; Mental Health Services; Mental Health.

RESUMO

Objetivo: investigar a prática do enfermeiro, as potencialidades e vulnerabilidades a que esta prática está exposta em Centros de Atenção Psicossocial (CAPS). **Método:** estudo descritivo, com abordagem qualitativa, no qual participaram sete enfermeiras atuantes nos CAPS de uma capital do Nordeste. A produção de dados ocorreu por entrevistas e as falas foram submetidas à técnica de Análise de Conteúdo. **Resultados:** grupos terapêuticos, educação em saúde, atendimento individual, visita domiciliar, administração de medicamentos e acolhimento foram as principais atividades realizadas pelas enfermeiras que consideram a atuação em equipe uma potencialidade ao seu trabalho. Deficiências de recursos materiais, transporte e da estrutura do serviço junto a pouca qualificação profissional e às fragilidades da rede de atenção foram descritas como vulnerabilidades para o trabalho. **Conclusão:** as vulnerabilidades identificadas interferem na qualidade da assistência prestada. **Descritores:** Enfermagem; Serviços de Saúde Mental; Saúde Mental.

RESUMEN

Objetivo: investigar la praxis del enfermero, las potencialidades y vulnerabilidades que esta praxis está expuesto en Centros de Atención Psico-Social (CAPS). **Método:** estudio descriptivo con un enfoque cualitativo, en el que participaron siete enfermeras que trabajan en los CAPS de una capital del noreste. La producción de datos se produjo para las entrevistas y las hablas fueron sometidas a la técnica de análisis de contenido. **Resultados:** grupos terapéuticos, educación en la salud, atención individual, visita domiciliar, administración de medicamentos y acogida fueron las principales actividades realizadas por las enfermeras que consideran el trabajo en equipo una potencialidad a su trabajo. Las deficiencias de recursos materiales, estructura de transporte y servicio con poco profesional y las debilidades de la atención de la red fueron descritas como vulnerabilidades para el trabajo. **Conclusión:** las vulnerabilidades identificadas interfieren con la calidad de la asistencia prestada. **Descriptores:** Enfermería; Servicios de Salud Mental; Salud Mental.

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INTRODUCTION

Advances in Mental Health care, achieved by the Psychiatric Reform, have required transformations in the care practices provided by nurses. The praxis is related to the nursing actions involved in the whole of the caring process and involves knowing, as a tool to do that.¹

For years, Brazilian Nursing reproduced practices marked by the French model of psychiatric care in which social isolation and moral treatment were valued. In this model, they committed themselves to maintaining order and discipline in the setting of hospital institutions in which the coercion, vigilance and mortification of the self intrinsically violated the identity of mentally ill people.²

These practices started to present considerable changes from the 40's, when, in the field of nursing theories, Peplau, Travelbee and Misone began to describe the praxis of the profession in the field of Mental Health based on the interpersonal process, which incorporates the help relationship as the focus of care for the suffering person. It was only in 1970, together with the Mental Health workers' movement, that in-depth discussions about the asylum model of care culminate in complaints of ill-treatment, reinforcing the transformations necessary for therapeutic practices.³

These transformations are intensified with the advances in the public policies of Mental Health adopted in the country, since the enactment of law 10216 of 2001, that determines the rights of people in mental suffering, as well as the redirection of the model of psychiatric care.⁴ In this context, the GM/MS Ordinance No. 336/2002, which establishes the Psychosocial Care Centers (CAPS) as a new strategic device for Mental Health care in the community, which is a substitute for psychiatric hospitals, and encourages people who use this service to stay in their own territory, for that, to have, in their basic multiprofessional team, the presence of at least one nurse practitioner.⁵⁻⁶

In addition to the CAPS, the National Mental Health Policy (NMHP), to further implement the ideals of the reform, guides the creation of a Psychosocial Care Network (PCN), stimulating intersectoriality in assisting people suffering from mental suffering through the opening of beds in General Hospitals, basic care and emergency services, implementation of transitional residential services, and benefits granted through deinstitutionalization, strategies such as the

Homeward Program and therapeutic residences.⁷⁻⁸

In the current model of care for these people, among the activities that must be present in the CAPS are: individual care, is medication, psychotherapeutic or orientation; Therapeutic groups in their various goals; Therapeutic workshops; Home visits; Family care; Initiatives in the community. These activities should be based on the principles of humanization that seeks to diversify the possibilities of receiving and involves an ethical position and care by the professionals who work there and among them, the nurse.⁹

The CAPS services, in the psychosocial care model, seek inclusion through social reintegration, promotion of autonomy of the users of the service and coexistence in society and, for this reason, asks the nurse's preparation for a new way of welcoming and serving in an interdisciplinary team that promote psychosocial rehabilitation. This change also requires, on the part of the nurses, the reflection on the new paradigm proposed by the reform,¹⁰ nevertheless, the effectiveness and strengthening of the model of psychosocial attention in the current Brazilian context occur in a slow and fragile way, considering that the deconstruction of practices in hospitals and psychiatric services for years reproduced, in the logic of exclusion, still requires investments and the provision of an effectively integrated and resolute service network.¹¹

Recent studies reveal that the nurse, in this new model of care, has developed actions of both an administrative, and an assistance nature, although the latter reaches greater prominence. Among the actions are: elaboration of professional scales; medication and stock control of pharmacy; supervision of the nursing team; participation of discussion groups with multiprofessional teams coordination and/or participation in therapeutic groups; reception; counseling and listening; practices; educational visits; nursing consultation; home visits; hygiene and food care; dressing, vital signs verification and outpatient follow-up on addiction detoxification.¹²

Considering such possibilities of nurses acting in mental health services, and the CAPS being the device that presents itself as an opportune and privileged space for both, as well as for the analysis and the exercise of the change of this doing, this research has developed, whose objective was to investigate the praxis of the nurse and the potentialities and vulnerabilities for this praxis in Psychosocial Care Centers (CAPS).

METHOD

A descriptive study, with a qualitative approach, incorporates the question of meaning and intentionality as inherent in acts, relationships, and social structures.¹³

Participants were seven nurses who worked in the Psychosocial Care Centers of a capital of the Brazilian Northeast, at the time this research was performed. The sample considered was the universe of nurses working in these services in the municipality in question. As inclusion criteria were considered: to integrate the professional staff of the CAPS service; to accept to participate in the interview; to reach the accomplishment of the latter. Among the exclusion criteria: being on vacation or working leave in the period of the research. Considering these criteria, there was no exclusion of subjects, and all the nurses in the research universe were interviewed.

In order to approach the subjects, initially, it was noted that, the services were contacted for the possible presentation of the project and scheduling of the interview with the nurses, and then, the interviews were held on the agreed dates.

In order to collect data, the script of a semi-structured interview used by Castro (2007) was used as a tool, in a study in Ribeirão Preto - SP, in the theme similar to the present study.¹⁴

Ethical aspects were considered and observed, and the project was approved by the Human Research Ethics Committee of the Federal University of Alagoas under the protocol number 003038 / 2009-21. All the interviewees signed the Terms of Free and Informed Consent before the interviews began.

During the application of the research instrument, the discourses were recorded in a digital MP3 player and for the analysis of the material. The speeches were initially transcribed in full. Thereafter, repeated floating readings were carried out, in order to explore all the material. Subsequently, the speeches were edited, by extracting the sense nuclei transforming raw data into records units that allowed the understanding of the emerging contents of the speech, thus traversing, the pre-analysis, material exploration and treatment of the results, according to the thematic analysis proposed by Bardin.¹⁵ In order to preserve the confidentiality of the interviewees' names, they will be referred to in their statements as E1, E2 or E n where "n" is the number referring

to the order in which the participant was interviewed.

The units of records were organized in a framework, respecting the sequence of information guided by the objectives, which facilitated the classification analysis of the treated material, where three categories emerged (presented in the results of the article), later interpreted from the theoretical framework of the current policy of the Ministry of Health.⁴

RESULTS

The study participants had seven to nine years of work in CAPS, and six of them were nurses. 85.7% reported that CAPS work was not the first option; 100% of the participants felt unprepared for this work and did not have postgraduate degrees in mental health or related area at the time they were admitted to the service.

In this context, the first category or thematic axis concerns:

♦ Activities developed by nurses in Psychosocial Care Centers

This description was the main topic of the interviews, in which the therapeutic workshops, actions of health education, individual care, medication administration, home visits and reception were evidenced, such as those most commonly performed by the nurses working in the CAPS, under study.

In the therapeutic workshops, one of the main activities developed, took place in a planned way and through different approaches. According to E5:

Every day the workshops are different, today there are three concomitant workshops, each professional has 10 [number of users], the other two are with the other ten. So they are different approaches [...], each professional plans what will be worked on in each workshop. (E5)

Such workshops occur daily and in the presence of at least two or more technicians who, according to her:

The referral technician from each workshop and the co-therapist who helps, but most of the time there are more technicians involved[...] There are four, five[...] The nurse assistant, for example, is always present. (E 5)

The facilitation of therapeutic groups is not exclusively attributed to the Nurse, and should, preferably be carried out in a multiprofessional team, where topics of interest to the community or group of users are addressed, but, the use of no theoretical framework approach is not mentioned.

Another activity also mentioned relates to health education, most often focused on topics such as care for the prevention of some diseases, personal cleanliness and good hygiene habits, as exemplified by the following speech:

[...] We started to work with them part of the swine flu, the part of hygiene: basic hand washing, before and after snacking, brushing after lunch [...]. (E4)

The approach of these themes in health education, has become a praxis of the nurse when promoting educational lectures and orientations to the users and family in the assistance. For, as E3 states:

They are more specific [activities][...] I work with them on the hygiene, the bath, how to brush my teeth, how to eat, how to behave. When I work with the mothers I will give lectures on health education, so it becomes more specific for me [...].

Another common practice is to be a reference technician and perform individual care in the form of a nursing consultation. According to E6:

Each user has a reference technician, and periodically performs individual service with the users he or she is referring to and with the family of those users. So, this is the individual care that we perform routinely, is the nursing consultation. I have done with those more severe cases, but this individual care is carried out by all the professionals of higher level following the same line of accomplishment, we try to know what is bothering the patient, what he would like to do in the service. We listened to their complaints, seeking support. (E6)

Another activity concerns the administration of medications. In addition to the distribution of the drugs themselves, nursing acts by making guidelines about posology, adverse effects, among others. The discourses show that it is characterized as a complex activity of care, requesting the contribution of other professionals, as E4 states:

The administration of medicines, which often is not only administered, we talk and guide the family; Because they have the medicines they take at home, they can take care of that medicine, and then we talk to the pharmacy staff. The interesting thing about CAPS is this, it's working as a team, there are things that you do alone, but there are things that are in a group. (E4)

Another activity involving approximation concerns the home visit. The use and appreciation of this resource, although present in most speeches, does not happen frequently. The justifications concern car unavailability. Thus, priority is given to

searching for misconduct and assistance in crisis situations. According to E6:

The home visit is not a routine, because of the lack of transportation, as it is not every day that there is transportation available for the visit. We also carry out the "active search of the cases" that are missing to the service or that they left the treatment without communicating. (E6)

The host was an activity often addressed, for E5:

It is a first listening; in the reception we collect the data, name, age, schooling, date of birth, membership, address and complaint. This is welcome and, together with the host, is the sorting. We research on gestation, such as the health of the gestation of this child or adolescent, psychomotor development, sphincter control, feeding, sleep, if they make use of any medication, if they are accompanied by some other professional. Okay, that's the first part, listen, it's the caller, if it's the first time you're looking for the service [...] It does the reception and the sorting.

Besides these, other activities, infrequent in discourses, were cited, such as: leisure activities such as educational games that seek to work on some cognitive functions. E4 says:

[...] We work on motor coordination, work on memory, perform some games activities. There are also some games, we call the physical educator to participate in these activities, sometimes memory games, competition games that we made with cards, then some games we do to work this out and their frustration with the loss in the game. (E4)

To develop such actions, some aspects of CAPS are valued as enhancers of their work, as presented in the next thematic category.

♦ Potential found for the development of activities in CAPS

Among the mentioned potentials, the possibility of learning and working as a team stands out. For E6, when it happens,

[...] it is a thing that contributes greatly, which greatly enriches the work in CAPS this shared work, so I think teamwork is a key element. (E6)

For E7, the common goal and collaboration favor this interaction:

What makes it easier for us to work for the same thing. If you have difficulty in something, you call the colleague to help you, things flow naturally and one helps the other. (E7)

For nurses interviewed, ways to develop teamwork, such as: sharing knowledge and resources; Have a common goal and; There is a climate of mutual help within the team that enhances the development of its activities.

Brandão TM, Brêda MZ, Nascimento YCML et al.

On the other hand, several factors were reported and, according to the interviewees, make it difficult for the nurses to develop their activities in CAPS, being described in the following thematic category:

♦ Vulnerabilities found for the development of nurses' activities in the CAPS.

The reported vulnerabilities concern the scarcity of material resources; Low-skilled workers in service; Deficiencies in the mental health care network.

The shortage of material resources was widely cited by all interviewees and related to: absence or little availability of own transportation for home visits; transportation of the users of their residences to services and realization of tours and extra-unit leisure activities . E4 says:

We are having a great difficulty in relation to car, transportation, mothers have a great difficulty in transporting the adult autistic people here[...] there are patients that we would necessarily need to do the home visit. (E4)

The shortage of didactic materials, stationery and other materials used in therapeutic workshops and deficiencies in the physical structure of the unit such as: few leisure spaces and impaired infrastructure.

The E2 nurse resents the restriction of physical space and how the lack of material resources and the low diversity of these resources make the routine tedious. According to her, what limits the work, is the lack of resource, not having the physical space to develop other activities with them [...]. E2 further complements:

Here everything is very scarce, [...]. Sometimes, you have to improvise, use one side of the card, the other week you have to use the other side, there is no other card to use [...] We do not have a puppet, there are no other resources that can work in a more qualified way, the routine is kind of tedious for them and it is for us too, that is only what it has to offer, so that is what limits my work, I think that of a lot of people here too. (E2)

In the scenarios in which this research was carried out, environments with aspects of neglect and poor structure can promote malaise in users and decrease the motivation of the professionals working in these scenarios. Aspects perceived in E3's speech when he/she says

Nowadays, what we are asking for more, is to make this reform, which although it seems great, I think the aspect of the health unit is also very important, then you arrive in a place where things are broken, and the

The practices of the nurse in psychosocial...

people who arrive with this problem [...] it should be a beautiful, attractive, colorful place. (E3)

Another difficulty concerns the poor qualification of workers for typical CAPS activities. For E6, it is necessary to invest in permanent education. She says:

[...] it is something that I miss, which would also help a lot in the performance of the work, we have struggled trying to make groups of studies of discussion of clinical cases, elaboration of the unique therapeutic projects in the team and we cannot, we encounters barriers. So, I think continuing education in services would be something that would help. (E6)

The consequences of low qualification of human resources can be reinforced by the deficiencies of the mental health care network that is insufficient and unsuccessful in the discourses of these subjects.

For E6,

The distance between mental health and basic care, mainly, but with other areas as well, is a major obstacle for our service, lacking an integrated and integral network of attention to the user. (E6)

Regarding the incompleteness of the network and its difficulties of functioning, the nurses are dissatisfied with the flow of care and report several cases that would need other devices that should be present in the network of Mental Health, care so that the attention in CAPS is improved.

E4, in dealing with this matter, says that:

[...] it needs to give a to flow patients who are discharged or who do not need CAPS care for the unit, but there is no way, then the CAPS will end up being overloaded. (E4)

These are, in summary, the vulnerabilities pointed out by these nurses that can compromise the integrality and negatively affect the quality of care provided in CAPS.

DISCUSSION

The characterization of the nurses participating in the study showed that only one of the seven interviewees initially opted for the work in CAPS. The others, approved in public care, were not offered other service options, being mostly, the choice motivated by factors not related to affinity or interest in working in the area of mental health, data that are confirmed in other studies.¹⁶

The study also showed that the lack of knowledge of these nurses about the principles and objectives of the Psychiatric Reform reflect on the quality of care provided in mental health, reproducing, in most cases,

a care based on the asylum model that little stimulates the therapeutic and social inclusion.¹⁶

The limitation of the knowledge of these nurses on the changes required in the attention to mental health and conquered by the process of Psychiatric Reform has also reflected in the description of the actions developed by them. In the context of CAPS, the study points out that there is great difficulty in describing praxis, since these services were recently instituted and are in constant transformation.¹⁰

Research points out divergences in the opinion of nurses working in CAPS regarding the actions developed by them. While one group reported difficulty in identifying the role of nurses in the extra-hospital space and credited nurses with care for clinical aspects such as food, hygiene and medication administration, very frequent in the hospital routine, the other part of the interviewed nurses demonstrated they recognize the role of the nurse even in actions that are not exclusive to the profession and that could be performed by other team professionals in the CAPS. This group also referred to the therapeutic relationship as being a health care attributed to the nurse.¹⁶

Among the activities carried out by the nurses at the CAPS under study, therapeutic groups and workshops, health education, individual care, medication administration, home visits and patient care were considered as non-exclusive to the nursing professional, but are most of them.

When conducting therapeutic workshops, it is evident, in the speeches, that this activity, although developed routinely and with prior planning, does not mention the use of flexible planning or a theoretical-practical reference for such an approach. The implementation of these activities should be based on knowledge acquired from graduation to complementary formations, and should also seek guidance in the manuals of the Ministry of Health that guide the practices in CAPS.¹⁷⁻⁸

Studies have shown that using a group theory, whether by Pichon, Rogers, Moreno, Yalom or other theorists, even in an "adaptive manner", is essential for group intervention. It is possible to facilitate therapeutic groups based on a theory, even if they are not configured as psychotherapeutic. A group activity should not be performed intuitively, without adequate understanding of group facilitation. Nurses should be encouraged to use group theories from academic training, and continually trained in lifelong education.¹⁸

In addition to the therapeutic workshops, health education actions are among the main activities reported by the nurses and it seems that these are the actions considered of greater domain for the nursing professionals. However, there are still focused actions for the prevention of specific diseases and not for the production of life, as directed by the Expanded Clinic.¹⁹

Educational workshops are carried out as a strategy for nursing care in CAPS. Among the topics covered, contents on healthy eating, alcoholism, sexual health, diabetes, hypertension and oral health are common. In order to address these issues, nursing uses group dynamics, educational games and thematic experiences. In addition to the topics cited, coexistence and self-esteem are worked on in the educational moments.²⁰

It is important to emphasize that work on the prevention of injuries and self-care is indispensable, but, should not be limited to the only actions of health education. Nurses need to deepen actions that go beyond routine self-care activities and campaigns to reduce the prevalence rates of some diseases.

In addition to the educational actions that occur in collective activities using group methodologies, games and dynamics, individual attendances were also listed among the nurse's praxis.

Described as an individualized moment of care, where therapeutic strategies are traced or evaluated, it is also cited as a form of care in the clinical interurrences between them, the crisis, the nurse working in CAPS, has adopted in their professional practice, individual care as a tool to qualify their care and put into practice the nursing consultation aimed at planning care based on the establishment and evaluation of therapeutic strategies.

Individual care brings the nurse closer to the person cared for, building bonds through therapeutic relationships. When this bond becomes deep and resolute, the professional tends to be the reference technician (RT) for the person cared for.

The individual care is between the nursing praxis in the CAPS, be it in orientation, or therapeutic care, when using the tools of psychotherapy. A member of the service user's family that needs this type of approach must also be serviced individually.⁴

Even though it happens with the concern to raise the individual demands of care and that intervention strategies are defined and that, this way, it is configured as a nursing consultation, the individual care described by

the interviewees does not refer to the use of the singular therapeutic project (STP), a tool that must be implemented in the care provided in CAPS and that has the reference technician as the main responsible for its implementation and updating.²¹

Since the STP is a set of therapeutic actions and described as a strategic tool, valued by the ministerial manuals that guide the production of mental health care, it must be constructed in a shared way between the user, his/her family and the interdisciplinary team, seeking the continuous reflection of the possibilities that enhance their autonomy and social reintegration.²²⁻³

Faced with this ministerial orientation on the singularly planned attention to the user, should the nurse, who works in CAPS and who performs the role of reference technician for a significant number of users, reflect on their practice in approach or individual empowering care by weighing the important tool that is the STP and work to implement it along with the other team members.

The singular therapeutic project, as a tool, to stimulate the specific care of the user in its context, reinforces the actions of the Ministerial Policy of psychosocial rehabilitation where the disease ceases to be the center of attention and the resources of the individual and his social network constitutes the major part. However, even without overvaluation, attention to clinical issues should not be overlooked. Guidelines on the disease, information on the correct use of medications and their adverse effects on the suffering person and their family are of paramount importance.¹⁰

The nurses emphasize, among their actions in the CAPS, the administration of medicines, occurring, at that moment, besides the delivery of the medications, the realization of guidelines. They count on the help of other health professionals such as the pharmacist, for example. Although it is a nursing action more focused on the clinical aspect, as in the care that was initially provided to the institutionalized patients, it is an important action in the attention to people, especially when it involves the interdisciplinary action and the empowerment of the subject, when knowing more about the treatment.

Not that these clinical actions should not exist, but that these incorporate a new image. Medication guidelines are indispensable. Therefore, they do not need to be identified as the only nursing actions that should be performed in an institutionalized environment.

For the Ministry of Health (2004), even organizing a medication distribution routine and advising users and family members on their acquisition and administration, it is necessary to observe the differentiated, use and according to the diagnosis and the therapeutic project of each one .. Thus, the administration of medicine expands beyond the technique: it has become a relief action, and; also, of approximation with the pain, with the life and the history of each one.

In this logic of attention, proposed by the National Mental Health Policy. where the community and its devices should be seen as the main scenario and not only the CAPS service, actions outside it should be stimulated. So, the home visit is a relevant strategy that allows the approximation and knowledge of the user's family context and which is described as an action developed by the nurses.^{5,24}

In the interviewees' speeches, it does not occur more frequently due to poor availability of transportation, but they understand that the home visit allows the approach of the "service" to the home. The "exit" of the CAPS to the place where the user resides, allows the visualization of social resources that exist in the vicinity and that may be useful in planning care for them. In this sense, the lack of transportation, by hindering the psychosocial attention in the habitat scenario, distances the family from the rehabilitation process and reduces the concrete possibilities of insertion and reception of the user in their social environment.

Also in this panorama of attention to mental health, based on the principles of psychosocial rehabilitation, where it is necessary to join forces to minimize the prejudice of society towards people in psychological distress, reception, another essential tool to this process, as well as others already described and brought by the process of psychiatric reform, must be thought of as a concept.¹⁹

Reception was very present in the nurses' speeches participating in the research, however, they described the reception, most often, as a way to receive the person in psychic suffering or their relatives when they first arrived in the CAPS. A certain mixture is identified here in the understanding about reception, once they understand that the reception takes place at the arrival of the user and, that, anamnesis, the physical examination, the choice of therapeutic treatment and other actions related to the nursing consultation and screening occur.

In the literature, consonant with the proposals of the Ministry of Health regarding the theme host, the latter is often confused as an isolated action of reception that should have its concept expanded as a strategy, tool or technology of care that seeks the transformation in the process of health work and the guarantee of access to humanized services, as well as attendance and resolution to the demands presented by the people and shared responsibility of these needs by health professionals.²⁵

Thus, welcoming becomes an ethical prerequisite, a way of being before each user that extends beyond their arrival in service and, beyond the walls, involving the whole process of psychosocial attention.²⁵ Within this sense, only one of the seven nurses interviewed mentioned the accomplishment of the reception in their speech.

In summary, these were the main activities described by the nurses interviewed. What we conclude is that despite the characteristics of this new mental health device, such activities demand expansion and are still far from the meaning of the psychosocial rehabilitation that the CAPS proposes. On factors favorable to nursing praxis in CAPS, it was common in the speeches to highlight the performance in the team. The interaction between the different knowledges, by the common goal, achievement was reported as a great empowering factor.

When the nurse practitioner performs actions common to other professionals of the team facilitates the shared action that allows the exchange of knowledge, however, this practice may mistake the nurse to perform activities unique to another profession, performing something that they have no dominion over. Therefore, it is necessary to redouble the care so that nurses do not risk taking actions for which they have not been able to compromise, the assistance to the user.¹⁰

Teamwork, as well as the interpersonal relationship with this team and the support of the coordination of the services, is reported as a potentiator of nursing work. It is also important to accept, this coordination, by the demands and suggestions given by the nurses to guide and plan the operation of the CAPS. The union of efforts of the components of a team has the power to transform the practices, the form of service and reduce the vices based on an old model that still is remarkable in the assistance in CAPS.⁸

Linked to professional training, is also essential the affinity and interest in acting in the area of mental health. It implies the

ability to develop relational tools such as listening, welcoming, bonding, and availability to the other's own who are identified with the mental health area.²⁶

In contrast to the potential for nurses' work in CAPS, the scarcity of material resources, deficiencies in the physical structure and transportation available for the visits, poor professional qualification and the fragility in the mental health care network are identified as vulnerabilities that make it difficult for the nurses to work in the CAPS. Studies show that among the reasons for dissatisfaction with work in CAPS appear: as the deficiency of physical structures and lack of recognition among other professionals.¹⁶

Researches show that the lack of material and structural resources are pointed out as factors that hamper nursing work by most nurses working in CAPS, and that the inadequacy of the environment and shortage of resources for workshops are also indicated as causes of dissatisfaction in the workplace by these professionals.⁸

For the Ministry of Health (2007), the CAPS, as meeting space, should "favor the production of new subjectivities; make the reflexive process possible, guaranteeing the construction of actions from the integrality and the inclusion, in the perspective of equity". And, in this sense, become cozy in its physical structure and in its intra and intersubjective aspects.²³

In addition to the material aspects, the few capacities for the nurses' work in the area of mental health as vulnerabilities to their work in this context were mentioned. Through the brief description of the interviewees, it was noticed that there was no previous preparation for them to start work in CAPS, even though none of the participants had specialization in the area of mental health. The training, courses and trainings that arise in some of the statements are often carried out at the initiative and cost of the nurses themselves, which reflects the need for greater investments, by the managers, in the qualification of these professionals to perform, with higher quality, in the services in which they work.

In a survey conducted in 2011, where nurses working at CAPSad in the city of São Paulo were interviewed, it was verified that most of the subjects had no specialization in mental health, considered the knowledge offered during graduation insufficient and did not feel prepared to act in these services in the context of psychiatric reform. These subjects, sought, their own improvement through reading material published in the

Brandão TM, Brêda MZ, Nascimento YCML et al.

The practices of the nurse in psychosocial...

mainstream media, exchanging experiences with other professionals, and based their practices on previous experiences of similar services. This autonomy, in the search for information - on its own - carries the risk of training through non-scientific knowledge, and that end up compromising the quality of care provided to users.²⁷

Another factor that compromises patient care and which was also mentioned in nurses' discourses, as a vulnerability that interferes with work, was the fragility of the mental health care network described as a deficiency in the articulation of services. It exemplifies, in the speeches, the little interaction of the service with the basic attention and with other services of greater complexity.

In 2011, the Psychosocial Care Network (PCN) was created to increase integration among the various points of health care, seeking to build integral care and greater access to people suffering from mental illness due to mental disorders or harmful use of crack, alcohol and other drugs. With PCN, health services of different levels of care begin to interact with specific mental health services to meet the demands of their users.⁷

In practice, the psychosocial care network is in a slow process of development and needs to be expanded, especially in the infrastructure and implantation of out-of-hospital services, requiring even greater incentives for professional qualification, management of existing bias and guarantee of better access to services.

Currently, according to information from the Mental Health Municipal Program, Maceió has five CAPS: one for alcohol and other drugs, one for children and three for type II. It has seven Basic Health Units, with psychological and psychiatric care, distributed in the seven Sanitary Districts of the city and four psychiatric hospitals; six offices on the street and; twenty-two users benefited by the Homeward Program. A network of mental health that is still insufficient to meet a population that borders one million inhabitants (exactly 932,748 inhabitants) and which demands therapeutic residences, passage homes, social centers, psychiatric beds in general hospitals, CAPS type III and one coverage of the family health strategy.²⁸

Little has also been described about interventions and care with family members. Studies point to the great interference in the physical and mental health, the quality of life and social interaction of the family members who care for people with mental disorders, even though they are treated at CAPS, and it

is necessary to plan and perform care for these family caregivers.²⁹

The reports confirm that the strategies present in the network and "available" in the Brazilian capital where the study was developed, such as outpatient services and CAPS, have not been able to meet the demands and needs of people in psychological distress, it is necessary to include other strategies and create other devices when the path one wishes to follow is that of the integrality and quality of psychosocial attention.

CONCLUSION

The nurse is among the minimum staff required for the implementation of any CAPS modality. In this context, it is assumed that the Nursing practice, especially of the nurse practitioner, must be interdisciplinary and competent for psychosocial care, which involves the knowledge of the objectives of the CAPS in the new policy of attention to mental health and the specifics inherent in this field.

In this sense, the activities developed such as: individual service to the user and family; Distribution, administration and orientation of medicines, among others; still retain characteristics of the model centered in the psychiatric hospital, in which the adequacy of behaviors such as hygiene, feeding and medication are the key to its performance. This is confirmed, through the almost imperceptible reporting of activities outside the CAPS, for example.

Through this research, it was identified that the nurses working in the CAPS of a northeastern capital, lack mental health training, so that they can expand, qualify and direct their activities for the purpose of psychosocial rehabilitation.

In order to implement the paradigm transition, the CAPS proposal has favored and challenged these nurses for the development of teamwork, and, in turn, has requested the involvement of the family and other social networks in the caring process. Considering the vulnerabilities that interfere with the work of these nurses, such as: the lack of physical resources and physical structure; transportation unavailability; little qualification and preparation for the area, and incompleteness of the network of mental health, psychosocial attention points that, for this transition, it makes the creation of spaces of exchange and knowledge in the service necessary; investment in the training of professionals, as well as increase, expansion

and diversification of the current network of mental health care in the city in question.

Describing the activities that nurses have performed in the CAPS, as well as the potentials and the vulnerabilities present, provides subsidies for the discussion of nursing actions appropriate to the field of psychosocial care and the necessary minimum requirements that can make CAPS a new space of mental health care. New possibilities of attention and new spaces of action in nursing, beyond the infirmary and the walls of the CAPS, exist and can be explored.

REFERENCES

1. Vale EG, Pagliuca LMF, Quirino RHR. Knowledges and nursing praxis. Esc Anna Nery Rev Enferm [Internet]. 2009 [cited 2015 Feb 10];13(1):174-80. Available from: <http://www.scielo.br/pdf/ean/v13n1/v13n1a24.pdf>
2. Goffman, E. Manicônios, Prisões e Conventos, São Paulo, Perspectiva, 2008.
3. Esperidiao E, Silva N, Caixeta CC e Rodrigues J. A Enfermagem Psiquiátrica, a ABEn e o Departamento Científico de Enfermagem Psiquiátrica e Saúde Mental: avanços e desafios. Rev bras enferm [Internet]. 2013 [cited 2015 Feb 11] 66:171-6. Available from: <http://www.scielo.br/pdf/reben/v66nspe/v66nspea22.pdf>
4. Brasil. Ministério da Saúde. Secretaria de Atenção à Saúde. Departamento de Ações Programáticas Estratégicas. Saúde mental no SUS: os centros de atenção psicossocial / Ministério da Saúde, Secretaria de Atenção à Saúde, Departamento de Ações Programáticas Estratégicas. - Brasília: Ministério da Saúde; 2004.
5. Brasil. Portaria/GM n. 336, de 19 de fevereiro de 2002. Define e estabelece diretrizes para o funcionamento dos Centros de Atenção Psicossocial. Diário Oficial da República Federativa do Brasil. Brasília, 17 set. 2004b. Seção 1:51.
6. Vargas D, Duarte FAB. Enfermeiros dos centros de atenção psicossocial em álcool e drogas (caps ad): a formação e a busca pelo conhecimento específico da área. Texto Contexto Enferm [Internet]. 2011 [cited 2015 Feb 12];20(1):119-26. Available from: <http://www.scielo.br/pdf/tce/v20n1/14.pdf>
7. Brasil, Ministério da Saúde, portaria nº 3.088, de 23 de dezembro de 2011. Institui a Rede de Atenção Psicossocial para pessoas com sofrimento ou transtorno mental e com necessidades decorrentes do uso de crack, álcool e outras drogas, no âmbito do Sistema Único de Saúde (SUS).
8. Silva N, Esperidiao E, Caixeta CC e Rodrigues J. Percepção de enfermeiros sobre aspectos facilitadores e dificultadores de sua prática nos serviços de saúde mental. Rev bras enferm [Internet]. 2013 [cited 2015 Feb 14];66(5):745-52. Available from: <http://www.scielo.br/pdf/reben/v66n5/16.pdf>
9. Feitosa KMA, Silva T, Silveira MFA, Santos Junior HPO. (Re) construção das práticas em saúde mental: compreensão dos profissionais sobre o processo de desinstitucionalização. Psicologia: teoria e prática [Internet]. 2012 [cited 2015 Feb 14];14(1):40-54. Available from: <http://pepsic.bvsalud.org/pdf/ptp/v14n1/v14n1a04.pdf>
10. Soares RD, Villela JC, Borba LO, Brusamarello T, Maftum MA. O papel da equipe de enfermagem no Centro de Atenção Psicossocial. Esc Anna Nery [Internet]. 2011 [cited 2014 Feb 15]; 15 (1):110-15. Available from: <http://www.revistas.usp.br/reeusp/article/view/52830/0>
11. Borba LO, Guimarães AN, Mazza VA, Maftum MA. Mental health care based on the psychosocial model: reports of relatives and persons with mental disorders. Rev Esc Enferm USP [Internet]. 2012 [cited 2015 Feb 15]; 46(6):[about 5 p.]. Available from: <http://www.revistas.usp.br/reeusp/article/view/52830/0>
12. Spadini LS, Souza MCBME. O preparo de enfermeiros que atuam em grupos na área de saúde mental e psiquiatria. Esc Anna Nery [Internet]. 2010 [cited 2015 Feb 15];14(2):[about 5 p.]. Available from: <http://www.scielo.br/pdf/ean/v14n2/19.pdf>
13. Minayo MCS. O desafio do conhecimento: pesquisa qualitativa em saúde. 11th ed. São Paulo: Hucitec; 2010.
14. Castro T M. Atuação do enfermeiro em Centro de Atenção Psicossocial. Ribeirão Preto: EERP - USP, 2007. 114 p.
15. Bardin L. Análise de Conteúdo. Lisboa: Edições 70 Lda; 2009.
16. Dias CB, Silva AL. O perfil e a ação profissional da(o) enfermeira(o) no Centro de Atenção Psicossocial. Rev Esc Enferm USP [Internet]. 2010 [cited 2015 Feb 18];44(2):469-75. Available from: <http://www.scielo.br/pdf/reeusp/v44n2/32>
17. Bourguignon LN, Guimaraes ES, Siqueira MN. A atuação do enfermeiro em grupos terapêuticos dos CAPSad do estado do espírito santo. Cogitare [Internet]. 2010 [cited 2015

Feb 19];15(3):467-73. Available from: <http://ojs.c3sl.ufpr.br/ojs/index.php/cogitare/article/view/18889/12198>

18. dos Santos MCA, Nascimento YCML, Brêda M Z, Luca LCG. Mudanças percebidas por familiares de crianças/adolescentes em sofrimento mental que participam de grupos operativos. Revista Eletrônica de Enfermagem [Internet]. 2014 [cited 2015 Feb 19];16(3):652-61. Available from: <http://www.fen.ufg.br/revista/v16/n3/pdf/v16n3a21.pdf>

19. Brasil. Ministério da Saúde. Secretaria de Atenção à Saúde. Política Nacional de Humanização da Atenção e Gestão do SUS. Clínica ampliada e compartilhada / Ministério da Saúde, Secretaria de Atenção à Saúde, Política Nacional de Humanização da Atenção e Gestão do SUS. - Brasília : Ministério da Saúde, 2009. 64 p.

20. Cotta EM. Oficina Bem Viver: Construção de tecnologias e significados de educação em saúde na área da saúde mental. Rev Eletrônica Saúde Mental Álcool Drog. [Internet]. 2010 [cited 2015 Feb 19];6:471-92. Available from: <http://www.revistas.usp.br/smad/article/view/38728/41581>

21. Silva EA, Costa II. O profissional de referência em Saúde Mental: das responsabilizações ao sofrimento psíquico. Rev Latino-Am Psicopatol Fundam [Internet]. 2010, [cited 2015 Feb 19];13(4):635-47. Available from: <http://www.scielo.br/pdf/rlpf/v13n4/07.pdf>

22. Boccardo ACS, Zane FC, Rodrigues S, Mângia EF. O projeto terapêutico singular como estratégia de organização do cuidado nos serviços de saúde mental. Rev Ter Ocup Univ São Paulo [Internet]. 2011 [cited 2015 Feb 21];22(1):85-92. Available from: <http://pesquisa.bvsalud.org/portal/resource/pt/lil-657279>

23. Brasil. Ministério da Saúde. Equipe ampliada, equipe de referência e projeto terapêutico singular. 2nd ed. Série textos básicos de saúde. Brasília, DF; 2007.

24. Kebian LVA, Acioli S. Visita domiciliar: espaço de práticas de cuidado do enfermeiro e do agente comunitário de saúde. Rev enferm UERJ [Internet]. 2011 [cited 2015 Feb 22];19(3):403-9. Available from: <http://www.facenf.uerj.br/v19n3/v19n3a11.pdf>

25. Mitre SM, Andrade ELG, Cotta RMM. Avanços e desafios do acolhimento na operacionalização e qualificação do Sistema Único de Saúde na Atenção Primária: um resgate da produção bibliográfica do Brasil.

Ciência e Saúde Coletiva [Internet]. 2012 [cited 2015 Feb 24];17(8):2071-85. Available from:

<http://www.scielo.br/pdf/csc/v17n8/18.pdf>

26. Silva NS, Esperidião E, Cavalcante ACG, Souza ACS, Silva KKC. Desenvolvimento de recursos humanos para atuar nos Serviços de saúde mental. Texto Contexto Enferm [Internet]. 2013 [cited 2015 Feb 24];22(4):1142-51. Available from: <http://www.scielo.br/pdf/tce/v22n4/33.pdf>

27. Vargas D, Oliveira MAF; Duarte, FAB. Psychosocial care Center for Alcohol and Drugs (CAPS ad): nursing insertion and practices in São Paulo City, Brazil. Rev Latino-Am Enfermagem [Internet]. 2011 [cited 2015 Feb 25];19(1):[about 5 p] Available from: http://www.scielo.br/pdf/rlae/v19n1/pt_16.pdf

28. Instituto Brasileiro de Geografia e Estatística [Internet]. IBGE, 2014 [cited 2015 may 04]. Available from: <http://www.cidades.ibge.gov.br/xtras/perfil.php?lang=&codmun=270430>

29. Beuter M, Rossi JR, Neves ET, Brondani MC. A sobrecarga do familiar no cuidado domiciliar. J Nurs UFPE on line [Internet]. 2009 [cited 2015 May 04];3(3):687-93. Available from: http://www.revista.ufpe.br/revistaenfermagem/index.php/revista/article/viewFile/181/pdf_918

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