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Challenges in the work of the nurse in the Psychosocial Care Network: an exploratory-descriptive study

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ABSTRACT

Aim: identify factors and obstacles that interfere in the nurses' work process in the Psychosocial Care Network. **Method:** an exploratory-descriptive study conducted in the period from October to December 2017, in the components of the Psychosocial Care Network of a district health management in Porto Alegre, RS, Brazil. Twelve nurses participated by means of a semi-structured interview. The information was transcribed and submitted to content analysis in the thematic modality. **Results:** Two thematic categories emerged from the analysis: Work Environment and Obstacles to the Performance of Work. **Discussion:** violence, poverty, structural scrapping, barriers to urban mobility, demotivation, queuing and work overload, form a poor health system for the poor, producing discontent in nurses, since the needs of users and workers to perform care are disregarded. **Conclusion:** each problem is considered as the cause or consequence of the identified difficulties. Humanized care must come from the destabilization to face the hostile reality.

Descriptors: Psychiatric Nursing; Work conditions; Nurses; Nursing care; Mental health; Community Networks.

INTRODUCTION

The mental health care based on the integrality guideline, with the consolidation of the Brazilian Psychiatric Reform (RPB, acronym in Portuguese), is directed towards the subject in the territory and in freedom, proposing services that are opposed to the traditional psychiatry that isolated and excluded the subjects considered crazy inside asylums[1].

By promoting free mental health care in the territory, the workers aim to build a bond with users that makes it possible to prevent the worsening of mental disorder, reduce the number of acute attacks and reduce symptoms, promoting both rehabilitation and promotion of mental health through stimuli for users to exercise their role as citizens, their autonomy, empowerment, and self-care. Thus, mental health users achieve a better social participation, interacting with the other elements of the territory[2].

Mental health services, replacing the asylum model, aim to work in a joint called the Psychosocial Care Network (RAPS, acronym in Portuguese), which is made up of different primary, secondary and tertiary health care services, and takes on the Centers of Psychosocial Attention (CAPS, acronym in Portuguese) as strategic articulators[3].

However, workers perceive that the articulation between mental health services is a complex challenge and its non-effectiveness has consequences for users and workers.

The lack of articulation and deficiencies present in the RAPS were identified as causing dissatisfaction and suffering at work, in a study carried out with mental health nurses. These revealed how much anxiety exists in the face of unmet expectations due to the access difficulties that users and their families face in primary health care during CAPS discharge plans, impairing the resilience and agility necessary for good care and assistance to users; and the difficulty of breaking the paradigm of traditional psychiatry in health institutions and in nursing care itself[4].

Considering this contextualization, the reflection and the deepening of the questions related to the work of nurses in the RAPS are pertinent, focusing attention on the contributions of this work to the strengthening of the network, since the care in freedom in the mental health is in permanent tension with institutions of the psychiatry that lost part of the power after RPB. Thus, this study was delineated from the following research question: What are the elements of the territory that interfere in the nurses' work process in RAPS? Aiming to answer such questioning, the objective was to identify factors and obstacles that interfere in the nurses' work process in RAPS.

METHOD

This is an exploratory-descriptive study using a qualitative approach[5]. The scenario of this research was composed by RAPS points of attention, located in a territory governed by a Health District (DS, acronym in Portuguese) management in the city of Porto Alegre, RS, Brazil, in which there were nurses in the team: eight Primary Care Health Units, one Adult Mental Health Team (ESMA, acronym in Portuguese), one CAPS II, one CAPS Alcohol and Drugs (CAPSad, acronym in Portuguese) and one Emergency Care Unit (UPA, acronym in Portuguese).

The selection of the participants was done intentionally, by inviting the nurses assigned to the health services that were the setting for this research. Twelve nurses were included in the study, which included: working for at least three months in the service, excluding those who were away from work because of vacations or leave.

The selection of the participants is justified in the trait of the qualitative research techniques that adopts a style of research that prefers the deepening of the detail to the reconstruction of the whole; therefore, it is a methodological choice that guides the complexity of the phenomenon, attributed to the ontological proximity between the researcher and the researcher. For this, the qualitative research follows the path of the reduction of the extension of the phenomenon and the focus in few cases, of which it is proposed to identify and represent the smallest details[6].

The information was collected from October to December of 2017 through a semi-structured interview, in which the interviewee has the possibility of discussing the subject without being bound by the question asked[5].

In this exploratory-descriptive study, the content analysis of the interviews was used in light of the Work Process and Work Psychodynamics framework[7-8]. It was decided to analyze, according to the thematic modality, whose purpose is to discover the nuclei of comprehension that make up the speeches of the interviewees. This type of analysis is divided into three stages: pre-analysis; exploitation of the material; and data processing, inference and interpretation[5]. The pre-analysis occurred with the reading and conference of the textual transcript of the interview audios. Each transcript was cataloged in the Nvivo 11 software and, from it, the registration units and context units were selected. In the exploration of the material, the categorization took place trying to aggregate each unit of context in nuclei of understanding, forming, thus, the thematic categories. And, finally, in the treatment of the results obtained, the categorization of information produced through the Nvivo 11 was exported to a Microsoft Excel worksheet, allowing its interpretation in the light of the theoretical reference.

Pursuant to Resolution 466/12, ethical considerations were observed, and this study was approved by the Research Ethics Committee of the Municipal Secretariat of Porto Alegre under opinion No. 2.311.407, in October 2017.

RESULTS

Based on the content analysis of the information, two thematic categories emerged: Work Environment and Obstacles for the Performance of Work.

Workplace

This thematic category addresses the relationship of nurses to their work environment: the territory where professionals carry out their network work process.

One of the characteristics present in the territory that interferes in the work is the **urban violence**.

> Sometimes users do not come because of violence. Because sometimes the area where you live is closed, you had a shootout. [E3]

> There is no way you can be inserted in it without suffering violence. Imagine if you wake up in the middle of the night listening to a shot. It's violence. (...) They are victims of violence every day. [E7]

And this violence does not interfere only with work outside the walls, but also with the internal work in the unit.

> There was a woman whose son was killed in the drug traffic; not only killed, he was quartered. [E3]

> There were only two people to perform bandage on the unit that morning: one who had taken a stray bullet and a pregnant girl who had injured herself by fleeing the shooting. [E12]

Violence in the work environment sometimes originates from a conflicting interaction between nurse and user.

> The team has already had some traumas, but with the organization of care, this has never happened again. I've been talking to the team about not hampering mental health patient access. [E5]

> Users think it's our fault; if some input is missing, if everything is missing. So this type of verbal violence always occurs. [E11]

The patient, especially the psychiatric patient, has a very small limit to hear "no" and, unfortunately, they arrive here 10 or 11 o'clock in the morning, when all the reception vacancies have already been filled by children with fever and other more serious health cases. [E7]

The relationship between violence and the **social condition of poverty** of the population of the territory is observed by the nurses of the DS studied.

> It's our most vulnerable area. These are cases of children with trauma after witnessing homicides, waking up in the middle of the night with the shooting. [E7]

> We serve a very poor population. There are various issues of violence; sometimes sexual abuse. [E11]

The demands of the users are directly related to the vulnerable condition in which they are inserted.

> Most patients are very vulnerable (...). Even the clothes we have to fight to get. [E1]

> It's a completely vulnerable zone. We have users whose problem is purely social and we are very careful not to medicate in these cases. [E2]

There is also a process of **scrapping the structure** of the public health services provided by the management.

> It's a place with three tables. Three patients are being treated at the same time. The person usually can't expose much (...). You have no privacy whatsoever. [E1]

> I don't have a handrail on all the stairs; I don't have a non-slip on the stairs; it's very sloppy; the situation is very sad. [E2]

Obstacles to the performance of work

Barriers to urban mobility are identified as barriers to networking.

> The greatest difficulty is that we do not have a car to do things, so there is a lack of resources. [E2]

> We must have a car. The car is one of the things that holds us pretty much; I think the matrix support had to come from the unit. [E3]

Health service users also find it difficult to use public transportation due to the value of the fare.

> The CAPS is near here, you can walk (...). But the health center is a little further, so sometimes they don't have a ticket, you know? Then things get complicated. [E11]

> Patients' access to the CAPS or any other sector of the network is very complicated. Many have no way to get there, no bus fare or they don't go for various other reasons. [E4]

One of the proposals that is being conveyed among network professionals is the division of the territory of comprehensiveness between the teams of the matrix support.

> We think about dividing the territory in half. We can have the closer half. [E2]

> It is a very large district (...). We started picking up this side to make it easier for the user to move. [E3]

Demotivation is also pointed as an obstacle and it is tied to a feeling of sadness in the nurses.

> And what makes me sadder is that when I worked in X, which was a public--private partnership, I couldn't open the door if something was missing and here, we all lack everything. [E2]

> I'm tired of working here; I've even asked to leave (...). Most patients who come here don't want to improve. [E10]

The **waiting queue** for care, also identified as an obstacle, occurs through the phenomenon of repressed demand of cases not discussed in the matrix-based strategies and not hosted by mental health services that operate with closed doors.

> I think children are an issue that we need to improve (...). But it is not us; the network has to expand in order to be able to handle all the demand. [E8]

> I have my folder with 10 cases and I can pass four (in the matrix support). So we have a very large pent-up demand. [E5]

It is also formed the queue of the users who have already been discussed in the mutual consultation of the matrix support and who remain waiting for a place in the agenda of the hosting of the mental health services.

> We have a waiting line that is a little bit big; it takes a month for people to come in as soon as they come here (to the hosting). [E2]

> The EESCA (Specialized Team on Child and Adolescent Health, acronym in Portuguese) has the agenda long ahead. Our agenda is also for a far future. [E3]

This queue also results in part from the difficulty of displacement in the territory.

> I enrolled 25 children in 2016 and nine didn't attend. They return to the unit. And then you do the same thing; you wait for a long time in the waiting queue. [E12]

The **work overload** to which nurses feel subjected is also an obstacle. It is attributed to three factors. The first is insufficient human resources.

> The problem is overcrowding and lack of staff in the nursing team, technicians. [E1]

> I think we need doctors, nurses, and technicians too; there is the lack of professionals as a whole. We don't have community health agents. [E6]

The second factor of work overload is the lack of time to meet with the team and plan the care that will be performed.

> If perhaps we had more time to organize actions, to discuss these matters, things we don't have (...). We are drowned in this spontaneous demand for patient care. [E4]

> The problem of primary health care is that it ended up receiving a very large overload of demands (...). So there id a high demand. [E5]

The third factor is the perception that there is a gap in the dimensioning of the coverage area of the basic health care teams.

> Our territory has more than 10 thousand inhabitants. There are several condominiums being built here. So this is also a complication. [E5]

> The size of the population here is underestimated. We have a team that would serve a maximum of eight thousand people, but there are more than 15 thousand. [E6]

DISCUSSION

The territory is understood as the **work environment** of nurses in the RAPS, because in this space of organization of social life these professionals think and act on the freedom of care for the mental health user, even if their relation with the interfering factors make it difficult to conduct the actions in the work process[9].

Urban violence interferes in the nurses' work process, configuring a barrier of territorial access. The closure of some regions of the territories due to shootings prevents users from accessing services and compromises some actions of professionals, such as home visits and educational practices, resulting in the discontinuity of mental health care[10].

Violence is also perceived in the conflicts between nurses and users, since they feel that their demands for attention are not met as expected and/or desired within the nurses' work planning. The demands of mental health users do not adapt, for example, to host hours restrictions. The difficulty for nurses increases with the users who transform frustration into aggression, reproducing the situations of violence with which they live in the territory.

In addition, a study pointed out that the work involves issues related to communication and the experience of interpersonal and intergroup dynamics that, when impaired, generates weakening of the link between users and professionals[11].

In the poor territories there is a population highly exposed to self-reported violence and, in these areas, exposure is even higher in

socioeconomically unfavorable populations, in men, and in blacks, thus showing the link between urban violence and poverty[12].

The violence to which users in **social conditions of poverty** are vulnerable aggravates the psychic aspects, since experiencing one or several situations of violence develops in the users symptoms suggestive of mental disorders. From this, nurses need to think about their work process in an extended perspective, considering the living conditions of the users in their living quarters, thus breaking with the reductionism that understands health as absence of disease[10].

These aspects are directly related to the national political system. In Brazil, formal democracy is recent, citizenship is incipient, and the party political system has little engagement to overcome situations of vulnerability. The financial and structural resources of the Unified Health System (SUS, acronym in Portuguese) are selective and become a policy of compensation and limited access directed to the poorest social classes of the population. Thus, there is a segmentation of the population of poor individuals who only resort to the public service of the SUS and there are those who have health plans or pay private services directly, as there is a government support to health insurance clients through tax exemption of the income tax[13].

The workers of the SUS public health services, in this way, follow the compensatory health policy implemented by the State in response to the vulnerability present in the territories, that is, a poor SUS for the poor. Working in this logic produces a feeling of discontent in nurses, since the **scrapping of the structure** interferes in the need for privacy and accessibility to the physical structure to perform health care. This contesto leads nurses to readapt the care they had planned to perform with the user, eventually limiting the potentiality of the work.

The professionals of the matrix-based strategies also do not have support of the management for the **displacement** to the separated basic units and health of the family to carry out some shared activity, such as consultation and joint domiciliary visit. As the duration of the consultation period extends throughout the shift, it can be said that primary care nurses use the resources of the transport voucher, received at the beginning of the month, to move to the place where the mutual consultation of the matrix support occurs, as this will be their momentary place of work. In the case of nurses of matrix-based strategies, if they move to the basic units they will be using the value of the transportation voucher offered by the municipality only in the first displacement, in the others they would be using the resources of their own salary. Thus, the nurses of the matrix support only move to the units that are at a distance that can be traversed walking.

Since the implementation of SUS, municipalities have been the ones that have expanded the most in terms of health investments, with proportional reduction of the federal level; however, the municipal sphere of government is strangled in its ability to increase financial resources, especially in the financial crisis of capitalism, since the SUS cannot be built alone[14].

Acquisitions of hard technologies necessary for the functioning of secondary and tertiary health care services are greater than investments in primary health care; therefore, mental health care in the territory has a smaller impact on the government budget. In this way, it is possible to meet the social and health needs of the community, ensuring the access of users to RAPS health services, through

public managers that direct the investments needed to promote care in basic care, where expenses are less costly, without losing the quality of care[15].

Demotivation is a factor of suffering in the work and an obstacle when the professional does not glimpse possibilities of a transformation in the routine that disturbs to him; however, according to the Dejourian approach[8], this feeling can be a driving factor for creativity at work, modifying stagnant elements, improving the product of the work process and, ultimately, causing pleasure.

Thus, the focus of the Dejourian analysis does not only address pleasure-suffering at work, but the way in which the worker particularizes the experiences (including the death of the users) and uses individual and collective defensive strategies to overcome the situation[16].

The **waiting queue** is a product of the difficulty of access, either by the restrictions in the hosting or by the difficulty of the user to go to the health unit. There are limitations in the context of the district and municipal territory that require the professionals of the Specialized Psychosocial Care an adaptation of the host. Users are welcomed through a time limitation, after the cases are discussed at the matrix-based strategies or within 30 days after discharge from the UPA or hospital. The difficulty of the user to go to the health unit, due to lack of resources to pay the public transportation fare, ends up causing abandonment and thus returns to the case discussion queue in the mutual consultation.

Absenteeism in the specialized service is at the same time the cause and consequence of the increase in the queue: this is because end-of-the-line users could fill the vacancy of the offenders, facilitating access to the health service, and this is because long wait time makes the user forget or dismiss the scheduled specialized service.

In an attempt to alleviate the consequences of absenteeism, one technique tested in an outpatient clinic was to make appointments for a larger number of users than the number of available times for that day (a method known as overbooking and already used by airlines and restaurants in Brazil) and warn users through a phone call or text message before the date of the consultation[17].

The technique is successful in reducing the number of unused service spaces, but it is not decisive for those who fail to return to the end of the queue. Perhaps this can be an experience to be tested in the health services and verify whether its results have repercussions in the decrease of the waiting queues.

Work overload interferes by blocking nurses in a cycle of suffering because the cycle begins with insufficient planning for care actions, perceived work overload increases by disorganization to satisfy demand and thus the cycle resumes with the reduction of the time to carry out planning.

When the worker has used all the forms he had to know and power in the organization of work, when he cannot change his task, when there is certainty that the degree of dissatisfaction cannot be reduced, the beginning of suffering is sealed. Therefore, suffering begins when there is a block in the subject-organization relationship of work[18].

A work is considered to be fatiguing if it opposes the reduction of the psychic charge; if it allows this decrease, it is balancing. In fragmented work, there is no room for phantasmatic activity (instinctual evaluation of reality) and thus imaginary capacities are not used in order to contribute to the formation of a sense of pleasure and the means of psychic discharge is blocked. Thus the accumulation of

psychic energy takes place, becoming a source of tension and suffering, and in the fatiguing work the psychic load can grow until fatigue, lack of energy and pathology appear[19].

Nurses perceive their work as fatiguing and point out as a cause the presence of a population in the area of coverage that is greater than the conditions of care offered by the team.

CONCLUSION

Urban violence, the social condition of poverty, the scrapping of the structure, barriers to urban mobility, demotivation, waiting queues, and work overload are factors and obstacles present in the health services that were scenarios of the study and that interfere in the ways of thinking and acting on the nurses' work process in relation to mental health. Moreover, consequently, they interfere negatively in the construction of the RAPS.

Each problem can be considered to be the cause or consequence of the other difficulties also identified. Thus, interventions aimed at only one of these impasses do not result in benefits for the production of life and mental health care in the territory. Equally, it is not advantageous for mental health care to try to hide the sufferings caused by these factors, retreating to asylum public policies; institutionalizing the feelings of users and workers; and producing care only in closed units, such as hospital care units and therapeutic communities.

The nurses' creative effort to produce a humanized care in mental health in the territory, and to seek the strengthening of the RAPS, must come from the destabilization to face a hostile reality, characterizing this movement as a real battle to overcome the mishaps and obtain an improvement in the service network produced in the territory.

As a limitation of the study it is highlighted the impossibility of including the other RAPS components in the study (Hospital Attention, Residential Attention of Transitory Character, Strategies of Deinstitutionalization, and Psychosocial Rehabilitation) due to the absence of these services in the DS.

It is suggested to conduct research that has as a theme the work process of nursing teams in mental health and that uses the triangulation of data. Participant observation combined with other research techniques, such as interview, for example, can make the dialogue and the deepening of the results ever richer, making new discoveries about the studied phenomena.

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