The psychosocial rehabilitation as a care strategy: perceptions and practices developed by workers of a mental health service

A reabilitação psicossocial como estratégia de cuidado: percepções e práticas desenvolvidas por trabalhadores de um serviço de saúde mental

ORIGINAL ARTICLE

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ABSTRACT: The actions developed in the Psychosocial Care Centers are confronted with clinical and operational impasses when assessed from the perspective of Psychosocial Rehabilitation. The study, conducted in a CAPS in São Paulo aimed to know how the concept of Psychosocial Rehabilitation is assimilated by its workers, as they relate it to their practices and how they perceive the institution to which they belong to. The methodological approach was qualitative. Study participants were 08 professional workers. For the production of data semi-structured interview was used, and for the analysis the Thematic Analysis technique was used. It was found that the practical conduct of care actions in mental health must be grounded by understanding concerning the nature of the Psychosocial Rehabilitation process. It was also observed that workers perceive critically institutional conducts that prioritize interventions within the service and are little articulated in relation to external contexts. The study suggests that working with the Psychosocial Rehabilitation strategy requires flexibility in facing different challenges, ensuring the community's presence in the process. It also points to the need of creating instruments to monitor and evaluate the services.

KEYWORDS: Mental health; Mental health services; Rehabilitation centers; Health personnel/psychology.

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RESUMO: As ações desenvolvidas nos Centros de Atenção Psicossocial (CAPS) defrontam-se com impasses clínicos e operacionais quando avaliadas sob a perspectiva da Reabilitação Psicossocial. O estudo, desenvolvido em um CAPS da cidade de São Paulo, visou conhecer como o conceito da Reabilitação Psicossocial é assimilado por seus trabalhadores, como estes a relacionam às suas práticas e como a percebem na instituição em que estão inseridos. A abordagem metodológica foi qualitativa. Participaram do estudo oito trabalhadores. Para a produção dos dados foi utilizada a entrevista semiestruturada e para a análise a técnica de Análise Temática. Verificou-se que a condução prática das ações do cuidado em saúde mental deve estar embasada pelo entendimento do que é o processo de Reabilitação Psicossocial. Também se observou que os trabalhadores percebem de forma crítica as condutas institucionais que priorizam intervenções dentro do serviço e pouco articuladas aos contextos externos. O estudo sugere que trabalhar com a estratégia da Reabilitação Psicossocial exige flexibilidade no enfrentamento de diferentes desafios, garantindo a presença da coletividade no processo. Também aponta para a necessidade de elaboração de instrumentos de monitoramento e avaliação dos serviços.

DESCRITORES: Saúde mental; Serviços de saúde mental; Centros de reabilitação; Pessoal de saúde/psicologia.

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INTRODUCTION

The transformation experiences of the Brazilian psychiatric assistance emerged at the end of the 1980s and early 1990s, as the result of claims from social movements and workers movements in the late 1970s, with the redemocratization of the country. Thus, in the city of São Paulo, the first Psychosocial Care Center (CAPS) was opened in 1987 and, in the city of Santos, after the municipal intervention in the Anchieta Nursing home (private psychiatric hospital), the first Psychosocial Care Center (NAPS) was opened in 1989[1].

The Ministry of Health, under influence from the Psychiatric Reform Movement and the experiences in São Paulo and Santos, took over the management of the new care model and proposed mechanisms to make it viable: Ordinance 189/91 changed the funding of actions and services related to mental health and enabled the deployment of new services (CAPS/NAPS, day hospital and psychiatric units in general hospitals). These are some important points in this process: Ordinance 224/92, which regulates the operation of mental health services and supported the regulation of hospital services; Law 10.216, which redirected the mental health care model and, finally; Ordinance 336/02, which extended the scope of services and created own funding mechanisms for the CAPS network[2].

Over the following years, new mental health services were created all over the country, proposing treatments that considered peculiarities and concrete conditions of people seeking care.

In this context, madness is now perceived in its complexity and not by the objectification of psychiatry; citizenship becomes one of the great principles considered, expanding social movements involved in this process, such as family and clients associations, as well as cooperatives and events to enable the construction of new forms of coexistence with society[3].

CAPS centers emerge as a model of services, aiming to provide care to persons with severe and persistent mental disorder, provide care from the perspective of expanded clinical care of and psychosocial rehabilitation, under the logic of territoriality. In these centers, care must be aligned fully and intensively and provide answers to the various needs presented by users in their everyday lives[4].

Psychosocial rehabilitation is understood here according to the perspective of Saraceno[5,6], as a process of reconstruction, exercise of citizenship and contractuality in the everyday life situations of clients of mental health services. In this sense, rehabilitative measures isolated from the clients' social and significance contexts (whether actual or symbolic) are not consistent with this perspective, as well as actions that do not allow internal and external integration of services, ensuring the permeability of these and flexibility in the organization of work processes[5,6].

Although, conceptually, CAPS represents one of the major operators of the innovative practices for transforming the life of people with psychological distress, with psychosocial rehabilitation being the strategy used to achieve this goal, further knowledge on the practices conducted in such services must be obtained.

In recent years, the implementation of CAPS in the entire country is faced with major clinical and operational dilemmas, because even inside the cutting-edge services old practices of psychiatrization can be found that imprison the individual, bringing isolation from the social environment, reinforcing the exclusionary character[7].

In this sense, studies[8,9] have pointed out the need for coordination of technical actions carried out in the wake of clinical care, with initiatives aiming at reinserting the individuals into their territory, their family, and community.

Therefore, current mental health care strategies trigger in the CAPS multidisciplinary teams the need of restructuring considering new intervention proposals. Thus, this study aims to reflect on these issues, taking psychosocial rehabilitation as a fundamental axis.

It is believed that the knowledge of how the concept of psychosocial rehabilitation is being assimilated by mental health professionals, how they relate it to their practices and how they perceive it in the institution to which they belong – objectives of this study –, can support the best application of this concept in the care of people suffering from mental disorders, problematizing this issue, differentiating theoretical knowledge from practical exercise of psychosocial rehabilitation in everyday services.

METHODS

In order to conduct the study, all ethical criteria were considered, and the research was previously approved by the Research Ethics Committee of the University of São Paulo School of Nursing under number 311/2003.

The methodology chosen for the development of the research was the qualitative approach. CAPSII workers were interviewed at the city of São Paulo, which were part of a mental health care network composed of psychiatric beds in general hospitals and the Centro de

Convivência e Cooperativa [Coexistence and Cooperation Center], integrated in a teaching program organized with universities.

The service workers were informed of the research in a routine meeting of the institution, in which both higher education and high school education professionals participated. The objectives of the study were presented and all were invited to participate. Individuals were approached and a day and time suitable for the individual interview was scheduled for those who indicated interest and met the following inclusion criteria: having worked in the service for six months or more and being directly involved in activities (individual and/or in group) offered to clients of CAPS.

Semi-structured interview was used as a tool to obtain data, based on a single questionnaire, prepared by the researchers, which enabled addressing issues considered important in relation to the theme. Interviews were recorded with permission of the participants.

To analyze the data, we used thematic analysis. All interviews were transcribed and, subsequently, the initial reading step was performed. Then the interviews were coded and categorized. This process of analyzing results allowed for the construction of inferences and the interpretation of interviews. Therefore, the different steps of analysis were followed: pre-analysis, material exploration, and treatment of results[10].

PRESENTATION AND DISCUSSION OF RESULTS

Eight professionals of the service who were directly involved in assisting users participated in the study, five having higher education (two occupational therapists, two psychologists, and one psychiatrist) and three having technical training (three nursing assistants), totaling eight interviews. All participants were female and the average age was 42 and a half years, with a minimum of 31 and a maximum of 62 years.

Regarding the characterization of the workers interviewed according to length of service, the study found that the average length of service in mental health was 11 years and three months, and the specific length of service in the CAPSII center in which the survey was conducted was five years and two months.

The three theme categories that emerged from the analysis of the interviews were: the concept of psychosocial rehabilitation; psychosocial rehabilitation practices; and the challenges in the field of psychosocial rehabilitation. Below, we present each category with its possible inferences and interpretations.

The concept of psychosocial rehabilitation

Recovering the possible autonomy and expanding social exchange opportunities – whether affective, material, or symbolic –, meant, for the interviewees, the hallmark of that which is considered the psychosocial rehabilitation process.

> *"I think it is a process that aims to promote inclusion of people with a mental illness in community things, to foster coexistence, living together, to prepare the individual so that he can manage to participate in community things" (Int. 6).*

> *"[...] simply being, once again, able to do things like writing, calculating, being able to talk, to go to a movie, doing the simplest things, if they achieve it, I think this is a psychosocial rehabilitation" (Int. 2).*

Psychosocial rehabilitation is defined as a set of strategies to bring increased opportunities for exchange of resources and affections, a process that necessarily involves opening a space of negotiation with clients, their families, for the surrounding community and the services involved in their treatment. Thus, this concept can be expanded as a process that allows and encourages social inclusion and the development of potential that was recessed while living with psychological distress[11].

Some scenarios of the exercise of this process were mentioned by the survey participants:

> *"I see psychosocial rehabilitation as part of life, social life, family life, the total life of the individual, being able to work, to have fun and to get along with people again" (Int. 2).*

> *"I think of rehabilitation as a work meant to get the patient back to the professional life, to get a job, to have income" (Int. 3).*

The excerpts show that the idea and practice developed are consistent with theoretical concepts that guide the psychosocial rehabilitation, even if such concepts are not referenced, confirming other studies that showed that the construction of the meaning of psychosocial rehabilitation is accomplished in the everyday experience[9].

However, some conceptions mentioned are remarkable for showing a reductionist view of the objectives of psychosocial rehabilitation:

> *"I believe it is a recovery, I don't know to what extent, but it surely is a recovery, because it's a return to being as normal as it is possible to that person, sometimes it's not all that it was, but it's as normal as it can seem" (Int. 2).*

> *"It will serve for them to be inserted in this world that we say is normal, because we ourselves consider them abnormal, to me rehabilitation means to be included, together, within the concept of society that we live, not being excluded" (Int. 5).*

> *"There are patients who are having their first crisis or have not been mentally ill for a long time, but they're already out of the context of normality" (Int. 5).*

It is interesting to detect that the issue of normality, or rather, the return of normal state, was part of several interviews, included in the objectives to be achieved through psychosocial rehabilitation.

Canguilhem[12], in a study on the concept of normal and pathological, brings the concept of normativity, which would be the ability to establish new standards and not the state of compliance with established norms.

Aguiar[13], in analyzing the proposals by Canguilhem[12], affirms that to be normative would be to have the ability to create standards for oneself whenever necessary and not to be within the expected standards. Thus, what characterizes a pathological state would be the reduction of normativity, that is, when the ability to face the challenges imposed by the environment is reduced.

From this perspective, it can be said that treating mental health according to the propositions of psychosocial rehabilitation should not be to normalize, but rather to used all possible means to stop or mitigate the process that restricts a person's normativity[13].

For this to be possible, we must point out that all caring practice must be linked to a conceptual framework, and advance in the construction of guiding concepts, even if such concepts are obtained often through their own references, built in daily practices.

Thus, the idea of a theoretical construction is not opposed to the idea of practical exercise, but may be a result therefrom. Saraceno[14] indicates that the practice of psychosocial rehabilitation awaits its theoretical construction and points out that this fact must not generate a hurry, because by wanting to accelerate this process we can also risk building theories that are not articulated with the possible practice.

However, some concerns in this field are perceived in the interviewees:

> *"[...] nowadays, I have been perceiving some detailing in this process because I think there are some deeper discussions, concerning the nature of rehabilitation, its symbolic meaning, how it relates to the world, that this is not something detached from the theoretical work proposals, that this is a theoretical foundation" (Int. 1).*

> *"[...] I don't think we're at the beginning of this story, I even think to a lot of people promote psychosocial rehabilitation, that they have a much broader view of the work, but they don't know what they are doing, they don't connect, I think there's, let's say, a production of very interesting things here and often detached from a concept and then, poorly utilized" (Int. 7).*

It is understood, based on the excerpts presented, that there is a need for a practical conduct founded on theory and, therefore, imbued with an understanding of the process of Psychosocial Rehabilitation and how it can be articulated in mental health care actions.

Furthermore, other difficulties can be identified in the interviews:

> *"I realize that the clinical area has more support, because you have a much more well-designed framework, much longer, a long theoretical history on which to base actions, on the other hand, in rehabilitation, I think the ideas are relatively much newer and have people who are working in it more doubtful, because it's all very experimental, people find themselves outside their traditional professional role" (Int. 1).*

> *"I think this is a challenge of our practice, I think we will never have a ready answer, so I think it is a process that is being built here in this CAPS, I think in all of them and we are trying to approach that, actually, according to the needs of each patient, because psychosocial rehabilitation cannot be understood as a standardized set of practices, in which we will offer a standardized service, that's not possible, because patients are very complex, mental disorder is very*

complex, it involves several things, social things, we deal with social things, economic things, emotional things, familiar things, there are several things involved" (Int. 6).

Psychosocial rehabilitation brings this question concerning the practice, removing professionals from the comfort zone of a strict clinical practice – understood as the perspective in relation to the disease – and puts them in the field of an extended therapeutic action – in which the relationship is based on qualified attention to the individual and to what this individual regards as important for his treatment, for his social relations and exchanges, finally, for his life.

The traditional clinical practice tends to turn the patient into an inert object, dealing only with the disease; a more comprehensive clinical practice opposes this approach, addressing an individual's social and subjective dimension, valuing the therapeutic power of listening and talking, in the construction and expansion of this individual's autonomy level[15].

Therefore, the concept of psychosocial rehabilitation should be aligned to those practices performed in the comprehensive clinical practice, hence complexity being a key concept in this process, because its understanding requires constant rethinking of the roles played by rehabilitation professionals, calling into question and problematizing the sphere in which mental health care should be: a sphere of conflict, confrontation and contradiction. Also a sphere of constant change, as this complexity refers to the care offered to individuals, people within the collectivity[3].

Psychosocial rehabilitation practices

The thinking and rethinking of practices, understanding rehabilitation as a process, identifying the instruments used and how they relate to the rehabilitation, form a set of practices that are perceived by the professionals interviewed.

"[...] I started thinking this matter of rehabilitation in the practice, with patients, I started to see that rehabilitation was something, let's say, natural, a consequence of a more humane treatment" (Int. 6).

"[...] now I can only think of psychosocial rehabilitation when I think of what it promotes rather than what we do to promote it, because what we do to promote it can be psychotherapy, it can be a workshop, it can be walking, I think it has to be an action that promotes it, and sometimes it is simply a service, the person comes, changes an attitude, then promotes a change. I think it is about promoting changes with a view to achieving quality" (Int. 7).

Several strategies are mentioned as facilitators of the psychosocial rehabilitation process:

"[...] when we offer a treatment that comprises medications, psychotherapies, and also workshops, we are taking care of these things, we are trying to encourage a return, so that the person can regain the citizenship" (Int. 6).

"The workshop has an important role in rehabilitation in this thing of exchange, of coexistence; these are patients with many years of disease and I think that this is a space where this exchange is enabled, the exchange of affection, the exchange of knowledge, exchange of experience, exchange of life, you know, all kinds of exchange, I think that this is something of rehabilitation, being able to have this power to exchange, to talk about yourself, trying to establish a connection with life outside the institution" (Int. 8).

We observed, in relation to the respondents, a tendency to consider the therapeutic workshops as the most well-defined space for them to be conducted, as they are a space that gives opportunity for exchanges. The device defined as *workshop* has been used to describe a wide range of therapeutic and extra-therapeutic experiences referring to the idea of production and from this to the idea of production of subjectivity, since new ways of relationship, new existential spaces, and new spaces for expression are devised and experienced in these spaces[16].

Research carried out in other CAPS considered the group space and the workshops as rich spaces, potentially creative, that operate aiming at psychosocial rehabilitation[17-19].

Therefore, they should not be used for the purpose of occupation nor aesthetic or productivity requirements, let alone as a group of persons without clear objectives as to why they are there and what is the intention. They shall be construed as medical devices that have at their core the reference of articulation of the socio-political dimension with the dimension of subjectivity and, transversely, they are accompanied by an ethical dimension regulating them operationally[20].

These dimensions, related to the staff's commitment in relation to the propositions of psychosocial rehabilitation, can determine if this strategy has the creative potential to effectively transform the individuals involved, offering them real spaces for exchange, or whether it is just another regulatory space, which molds the participants according to the wishes of the responsible professionals or according to institutional needs – the history of psychiatry has countless examples of this last use.

Recovery of citizenship was also appointed as expected result from practices developed by the psychosocial rehabilitation process. However, one must understand that such citizenship claimed by the new mental health care perspectives has no correspondence to the citizensship sought by social movements – which seek the mere granting of rights. Citizenship as referenced by Saraceno[6], among many other technical-political articulators involved in the process of theoretical and practical construction of Psychosocial Rehabilitation, is part of the set that Santos[21] defines as New Social Movements (NSM) and focuses on establishing the subjectivity in relation to this citizenship: its means of oppression and exclusion require a comprehensive restructuring of the processes of socialization and cultural inculcation and of the development models.

Thus, understanding that mental health care is organized in new exercises and new forms of citizenship and construction of rights in society, the aforementioned authors point out that the exercise of citizenship promotes the (re)conduct of social relations and rights that were denied to the mentally ill throughout their history of imposed imprisonment. Psychosocial rehabilitation, in this case, may be one of the strategies to achieve this (re) conduct.

The challenges in the field of psychosocial rehabilitation

Professionals and services involved in mental health care within the psychosocial rehabilitation proposal develop and implement their practices within a routine that present different challenges: the need for coordination between technical and policy practices to combat the exclusion of individuals attended and of mental health itself, which always seems to be out of the priorities of the bodies that establish guidelines for the operation of practices and construction of health services.

In the interviews conducted with the staff, for example, it is evident a feeling that the work required to effectively promote changes seems to depend on the goodwill of the professionals rather than in governmental practices and guidelines.

> *"It seems to me that regardless of the mental health policy in the municipality, which currently is absolutely absent, the unit gradually recovers, proposing new things, which result from the training of the professionals, however, not from outside, if we followed the muncipality policy we would be lost because it has not been clearly established so far" (Int. 1).*

> *"[...] this is a very symbolic work, because people try to do, we have no resources, no money, there's no way you can teach a profession to a person without having actual resources, I think we keep struggling, trying to do, we have the jewelry shop, sewing shop, I think I can even do this for real, but I think we are still very restricted, we stay mostly in the unit, we can't get it out, but I think we lack a lot of resources, a lotta things of actual courses, meant to do this for real, I think this is just an attempt" (Int. 3).*

These observations lead us to think about the dual nature of CAPS and its staff: they have a therapeutic function focused on the subjective dynamic of suffering; however, they also devise and organize actions in mental health care, aiming at the completeness of these actions, coordination of resources, system structuring[22].

The question is how to integrate these roles or how to assume the clinical-policy interface to guide their actions?

Assuming an open position to try different practices, coupled with the adoption of a permanent critical attitude and the acceptance of models that still seek theoretical foundation, can help professionals to see themselves also as constructors of this new paradigm and, thus, instead of feeling away from this process, taking ownership of it in the construction of a new professional identity: as rehabilitators.

The question of the place of the exercise of rehabilitation is also raised by the interviewees as a criticism in relation to the institution's conduct that often prioritize interventions only within the service, seldom establishing a connection with the community, the family, etc.:

> *"I think this has to be an example, I think the workshop should not end here in Caps, I think it has to be a means*

to bring possibilities of a person leaving and being able to establish bonds when out there" (Int. 5).

"in the institution we manage to foster coexistence, stimulate activities, to improve a little all of this (...) but we should think a little more about this issue focused on the social, on the community, how he could be interacting out of here" (Int. 8).

The service's capacity and tendency to absorb the surrounding knowledge and resources, as stated earlier, is a key differentiator for assessing whether it is integrated externally or not[11]. In this sense, the community should be present as an inexhaustible source of existing and potential resources, both human and material, which includes the client's family as part of this community to which the service should relate permanently.

Often what happens within the services is the institutionalization of professionals, who have difficulty to leave the usual field of institutional practice and face the challenge of an innovative practice, often uncertain, and apparently or potentially less secure.

However, for these professionals, inserted in the substitutive services, there is a pressing need of understanding that deinstitutionalizing their clients is not possible without the presence of the institution in the community. Thus, we must understand that the sustainability strategy for substitute services involves inserting the institution in the community, distinguishing it as a complex reality, which expresses contrasting interests and that, therefore, it is up to the professionals the role of interlocutors for their clients, to generate ongoing alliances and conflicts within this territory[6].

Importantly, this dialogue should be temporary, the professionals must lend their contractual power to the extent that users are having difficulty in interacting with the social sphere; however, the aim of this dialogue is to promote the ability of individuals so they become increasingly autonomous in such interaction.

CONSIDERATIONS

The study suggests that Psychosocial Rehabilitation requires flexibility from the staff in their actions and a new attitude towards clients, in which the objectives to be achieved must be connected to the singularity of each individual, respecting their wishes and investing in their real potential.

Its practice has been constructed daily in the exercise of mental health care and, despite its theoretical elaboration still being fragile, this fact does not preclude its execution, but highlights the need for better basis so actions can have more clear directions within teams, of services and public policies.

It is important to understand that comprehending the complexity of the action in mental health care in services is needed to instigate discussions, concerns, and to challenge those that arise as promoters of Psychosocial Rehabilitation, supported by an ethical, theoretical, clinical and political axis that not only admits but requires that uncertainties be part of the work, ensuring the continuous search for answers that are continuously transformed through the differences of each individual attended.

Thus, mental health care professionals, involved in the new actions of psychosocial care, should be able to cope with their different challenges, ensuring the community's presence in the Psychosocial Rehabilitation process.

Finally, we must point out that, although the study is related to only one service, it is known that this situation presents itself similarly in other locations. Therefore, we indicates the need for the development of systematic tools for monitoring and evaluation to facilitate the production of information on the operation of the CAPS units, enabling the teams to create technical and political strategies for dealing with specific issues, as well as the planning of operational arrangements that allow for the daily challenges of services to be overcome and for the proposals of Psychosocial Rehabilitation to be implemented.

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