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User Embracement in Practices Care in Psychosocial Care Centers the Perspective of Local Managers

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Abstract

Introduction: Psychosocial care centres (CAPS), strategic IN articulation of psychosocial care network and health system gateway, propose to the reorganization of health practices, by adopting a new ethic of care, based on respect to the singularity of the subjects and in the reception to the health needs of the users. Reception is a device for transforming practices and humanizing health care.

Objective: To analyse the operation of the host users of CAPS from the perspective of local coordinators in Fortaleza, Ceará, Brazil.

Method: Qualitative research with case study design, performed with CAPS coordinators of the city of Fortaleza, Ceará, Brazil. Data were collected through semi-structured interviews and observation, being submitted to the analysis of thematic content.

Results: The host constituted innovative device in mental health practices, as triggered the construction of new ways of dealing with the subject in psychological distress, by incorporating technologies such as qualified listening, building autonomy, with attention focused on the user. Provided a reorientation of work and service processes, requesting the articulation for network care. In addition, it was configured as a strategy for humanization in the CAPS. Was presen-

ted, however, operational difficulties related to the environment and to the effectiveness of the network of attention.

Conclusions: The host device configured for reorienting health practices, enhancing the consolidation of psychosocial care model, with humanization and increased solvability. However, challenges remain to be overcome, related to the environment and to the effectiveness of the network of care.

Keywords
User Embracement; Mental Health Services; Mental Health; Health Management.

Introduction

In the last three decades, Brazilian mental health policies have prioritized the establishment of a network of substitutive services to psychiatric hospitals, currently called the Psychosocial Care Network. Among its points of attention, the Family Health Strategy (FHS) and the Psychosocial Care Centres (CAPS) demarcate an interface between mental health and collective health, being considered strategic in the reorientation of the care model. As public health services, SUS members must act to materialize the principles that guide this system, guaranteeing universality, equity, integrity, decentralization, democratic participation of the different actors (managers, workers, users and their families) and the solubility of the assistance.

According to their strategic character, they assume a central position in the articulation of the care network, constituting the gateway to the health system. Should, therefore, act to establish integration between the three health care levels, the local routing policies and mental health programs and the promotion of continuous reflections on the work of the management model, care model and clinical Operated in their daily lives [1, 2, 3, 4].

In the context of internal sector reforms, driven by the Brazilian Psychiatric Reform Movement, the CAPS propose to reorganize the mental health services network, making the implementation of substitutive services a priority on the political agenda and adopting a new ethic and aesthetic of the care, based on respect for the singularity of the subject, in the struggle for social reintegration and in the construction of the citizenship of those with mental disorders, with a view to the implementation of the psychosocial care model.

At the heart of this process is the incorporation of some technologies to subsidize the new care management and production arrangements, which have the potential to organize a new group and the formation of spaces that incorporate subjectivity in the relationship between the different subjects. We refer to the light technologies, represented by those inscribed in the field of relations, such as reception, bonding, autonomy and co-responsibility. Thus, care practices in mental health move from disease to approach the subject in its multiple dimensions and needs [5].

In these terms, care can be understood as an interaction between two subjects, with the aim of alleviating suffering or achieving a well being, always mediated by knowledge specifically aimed at this purpose. It should take into consideration the ways of walking the life of the different subjects, with a view to enhancing the development of happiness projects [6].

Thus, it is understood that the production of care occurs in the encounter between worker and user, within the health work process, allowing a negotiation game between supply and demand for

care. It is in this space, considered as intercessor, where the users present their demands for care and the workers recognize the health needs, having to attend them with a certain coefficient of autonomy and solvency, in which the reception is located [5].

In the context of the CAPS, considering the demands for humanization of attention to the subject in psychological distress, as an alternative to the asylum model, the reception is implemented as a device that represents an ethical-political and aesthetic commitment with another in health practices. It integrates the set of guidelines of the National Humanization Policy, being expressed as a techno-assistance action that presupposes changes in the relations between workers-users and their social networks, based on respect for the singularities of the subject, which implies the adoption of technical, ethical, solidarity, humanitarian and political parameters and, based on which the user is recognized as co-responsible in the process of health production [7].

Host is considered as a device, insofar as it can be configured as an agent of creative, conservative or destructive potentialities, or even weak and dynamic lines that carry individual and collective territories of content and expression. Thus, within the territories where mental health practices are engendered, the agency may reproduce, maintain or transform the intervention spaces of these practices [8].

It can also be considered that the reception involves three dimensions: posture, technique and reorientation of work processes. Regarding posture, we consider the relational aspects, present since the reception of health services and permeates all spaces of health production, considering the attitude of workers in receiving, listening and attending to the demands of users, which implies confidence and bonding, which are configured as determinants in the humanization of care. It also concerns the workers' relations between them, which must be based on democracy, with a view to participation and co-responsibility in decision-making processes. In the technical dimension, the articulation of knowledge is included in the instrumentalization of actions and procedures in response to users' demands, seeking to overcome the fragmentation of care. The last dimension, reorientation of the work process and the service, implies in the clinical conception, based on the user-centred model, which surpasses the screening protocols [9].

In this way, the reception can be configured as a possibility to generate new health practices, through the establishment of a new ethics of care, based on respect for differences and building solidarity bonds between managers, workers and users, with a view to humanization. In this sense, there is an innovation in the production of health in the substitutive services of mental health, expressed in tensions, ruptures and transition with the instituted paradigm. Innovations are based on social and historically constructed knowledge and practices based on the interaction between subjects in their everyday practices in institutions [10].

Thus, the objective of this study was to analyse the operationalization of the reception to CAPS users of the Municipality of Fortaleza, from the perspective of the local coordinators.

Method

In this essay, the object of analysis is a social phenomenon, inscribed in the relations and practices of mental health, that is, the reception to the users in CAPS, general modality. It is understood that the reception is configured as social and institutional practice, in which there are objective and subjective aspects, conforming a dynamic context of relations, actors and institutions, demarcating a singular reality with intense subjective production, not objectifiable, that is, can not be translated into numbers. Thus, for this research, a single case study design was chosen, with a qualitative approach, a critical-reflexive perspective [11, 12].

Six CAPS constituted the empirical field of the study, general modality, located in the Municipality of Fortaleza, Ceará, Brazil. The municipality has 14 CAPS, which six of them are general, six CAPSad - for attention to alcohol and other drug users, and two CAPSi, for children and adolescents. Depending on the design of the study, it was decided to carry out the research only in the six general CAPS, considering that, among them, the first three services of this nature were implemented, they were responsible for coordinating the matrix support in mental health, besides of more users in follow-up.

The qualitative sample of the study was composed of six occupants of the coordinating posts of the CAPS, considered key informants, due to the subjective accumulation in relation to the object in question, given the experience In the administrative functions, by means of the direct action in the organization of the services, particularly in the implantation of the host. At the time of the study, female subjects, ranging in age from 34 to 57 years, performed all coordination of these CAPS. In relation to training, they were two social workers, a pedagogue, a psychologist, a pharmacist and an occupational therapist, accumulating CAPS coordination experience, ranging from six months to two years.

The data were collected through a semi-structured interview and free observation of the host in the CAPS. The interview was conducted based on a guiding script, with questions related to the scheduling and reception of the users of the service. They were carried out in the work environment, guaranteeing the privacy during the interview. Each interview lasted an average of 40 minutes, being recorded on audio equipment and completely transcribed, in order to ensure the reliability of the information.

The empirical material was processed and analysed based on Content Analysis, thematic modality, with the perspective of overcoming interpretation at the level of common sense and subjectivism, in order to achieve greater depth and criticality in relation to the object in apprehension [12]. Thus, the following themes have been identified: Home as a device for innovation in mental health practices; Acceptance as a device for humanization of mental health practices; Reception as a device for reorganization of CAPS and health care network; Reception in the CAPS: ambience and operational difficulties.

The research was submitted to the Research Ethics Committee of the State University of Ceará, and was approved with an opinion substantiated in Case No. 10030848-1. All the participants expressed their consent for insertion in the research, by signing the Term of Free and Informed Consent.

Results

According to the CAPS managers in Fortaleza, Ceará, Brazil, the reception can be understood in different dimensions, on the basis of which the thematic axes expressed in the sequence were structured.

Acceptance as a device for innovation in mental health practices

It is evident that the implementation of the CAPS host is an innovative experience, insofar as it reorients the care processes, as shown in **Table 1**. In these terms, managers seem to establish manage-

Table 1. Speeches of the local managers about the host as innovation in mental health practices. Fortaleza, Ceará, Brazil, 2016.

Manager	
F	The people here in the CAPS do everything to not hospitalize because it is within politics. So, we welcome the user, so that he is being treated here and does not need hospitalization
C	Many things are built from listening. [...] Then we make the whole process of building autonomy, care, welcome. When it restructures, it walks along with the team in the choice of their activities
A	The host does not replace the query. So our proposal of organizing the host is discussed in the team

rial processes aimed at breaking with the attention paradigm mental health, focusing on disease-centred professional medical and psychiatric hospital as a privileged *locus* of intervention. For this, the production of care is shared by the team, considering the resources of the territory and occurs mediated by the use of technologies, such as qualified listening, welcoming and building autonomy, with a view to avoid hospitalization in psychiatric hospitals.

As evidenced by the CAPS observation, the local manager accumulates the managerial and health care functions, also participating in the reception. In fact, meetings are held in which the team undertakes analyses and proposes interventions before the problems related to reception in a perspective of co-responsibility of all workers.

Acceptance as a device for the humanization of mental health practices

The CAPS managers of Fortaleza, as expressed in the statements reproduced in **Table 2**, consider the operationalization of the host as an agent capable of materializing humanization in the practices of mental health care. To this end, they recognize that the host involves relational dimension expressed in the sensitivity to the user's demand with a view to the adequate response to their need for care. Thus, they defend the idea that the reception should be transversal in all spaces of the CAPS, expressed in humanistic attitudes, which is object of analysis in the discussions of the team about the work process, with a view to qualify the processes of care.

Table 2. Speeches of the local managers about the host as a humanization device for mental health practices. Fortaleza, Ceará, Brazil, 2016.

Manager	
B	Humanizing is you treating people, having the care and sensitivity to perceive the best way to care when they arrive at the service, is to welcome
D	Humanization and reception have to have capillarity, they have to be a practice in all spaces of the service, you do not do it by decree, it is attitude.
E	We work on humanization by improving the reception. We had a discussion about humanization and a re-evaluation of the reception

Reception as a device for reorganization of CAPS and health care network

According to the managers' statements, shown in **Table 3**, the host is a device whose operationalization requires the reorganization of work and service processes, insofar as it seems to materialize a user-centred model in which the team organizes itself for a production of care oriented to meet the specific health needs of users, which implies the on-going discussion and reflection on the organization of the CAPS and the work of the team before the demands for health care.

Table 3. Speeches of the local managers on the host as reorganization device of the CAPS and network articulation. Fortaleza, Ceará, Brazil, 2016.

Manager	
F	It is a gateway, it is time to really welcome the person, a qualified listening is necessary because the person is coming with a demand that is urgent for the person at that time. This is a very important service because it is not the day the user is dialled, but the person came because he is in need of care [...].
E	The issues of organization of the CAPS are discussed, for example, how is the demand of the host, what is happening in the reception. This reorganizes the team's work.
B	Sometimes there are people with a demand that is more clinical, so we see which is the place (basic health unit) closer to her house, we call and try to dial, informs that the person is here and tries to define what the best day for her to go
C	If the person came and does not have a care profile here at the CAPS, we make the welcome, [...] we also try to make the referrals due, but always looking to schedule to ensure care in the other unit, so that the patient does not leave without being attended.

Considering that the CAPS is the gateway to the mental health network, therefore, with the possibility of access by spontaneous demand, besides the users who do not attend the scheduled care, requesting reception, it is also evident that there is demand of users with health needs, whose response does not constitute the assistance profile of this service. In these cases, they seek to establish the articulation of social networks of support and health care, as well as the establishment of user flows, with a view to the production of care, with team co-responsibility.

Reception at CAPS: ambience and operational difficulties

The operation of the host in the CAPS, besides the organization of the team for its effectiveness, requires the availability of spaces and adequate physical structure. Such an understanding refers to the concept of ambience. Considering that the six CAPS, general modality, in the Municipality of Fortaleza, Ceará, Brazil, operate in residential properties, which are adapted for its operation, in the perspective of preserving by social inclusion in the territory, its infrastructure is quite heterogeneous. Only two CAPS were found with good maintenance and preservation, since they were reformed. The other four were without adequate maintenance, with poor infrastructure. All, however, had insufficient physical space to carry out all their activities, given the growth of demand and users in follow-up.

According to the managers, as shown in **Table 4**, the ambience of some CAPS is an aspect that hinders the operationability of the host, since it does not meet the requirements of comfort and space for the production of subjectivities, since it does not allow meetings with privacy, as well as does not favour the execution of team work.

In addition, another difficulty that interferes with the execution of the host is the lack of a computerized system to process schedules of consultations/referrals to other health specialties, as implemented in the basic attention of the municipality. Thus, CAPS teams have no way of ensuring and monitoring their users' schedules at other levels of attention.

Table 4. Speeches of the local managers about the ambience and operational difficulties of the host in CAPS. Fortaleza, Ceará, Brazil, 2016.

Manager	
B	We have the problem of lack of space. The CAPS is well structured, with air-conditioned rooms and well-kept furniture, but the space would need to be improved without rooms so that professionals can attend at certain times. But the atmosphere is pleasant, it has been thought of so that it is cozy
F	The reception is done in the corridors, where people do not have privacy and this is important because the person is telling their problem. [...] Often the person does not want to talk because of shame; there are people on the side. Then our host becomes inadequate
A	We have difficulties in guaranteeing service in other specialties when we refer users. Nor do we have system to refer to the user as that of basic attention

Discussion

The analysis undertaken in this study takes as its main substrate the interpretation of local managers in relation to their experience of operationalizing the host to CAPS users. Initially, the reflection falls on two central aspects in mental health care, namely, the change in the care model and the humanization of mental health care/management, which constitute the demands of the Brazilian Psychiatric Reform Movement, which seeks to materialize in the scope of the current public health policies in Brazil. It can be considered that CAPS and host express relatively recently applied strategies in the implementation of such policies, which, in their interconnection, potentiate the consolidation of the network of substitutive services to the psychiatric hospital. It is, therefore, the reception a fundamental premise of care for

people in psychological distress in this modality of health services.

The results of this study point to the fact that operating host processes in the CAPS constitutes innovation, since it potentiates the reorientation of the model of attention to mental health, in which there is displacement of the object of care of the disease to the subject, radically changing the way of dealing with the subject in psychic suffering, whose purpose is no longer the mere remission of symptoms, but attention to human needs and the mediation of life projects. Therefore, a new ethic of care is established, based on psychosocial rehabilitation, whose greater expression is concretized in the deconstruction of the manicomial apparatus and in the (re)invention of practices that consider alterities. Accordingly, evaluative studies in the field of psychosocial care consider the reception as an innovative practice, in that it is presented as the basis of mental health actions, respecting differences, fostering the creation of new ways to act and intervene in team [13, 14, 15].

Nonetheless, it should be pointed out that not only the implantation of care services and devices in the context of psychiatric reform are enough to make the necessary change, because it also requires the constitution of proactive and ethically and politically committed individuals with the innovation of practices.

The findings of this study raise the idea that the reception is a device that contributes to the humanization of the care of the subject with psychic suffering. To that end, the managers committed themselves to reassess it permanently through the discussion with the team, with a view to improving and qualifying health care in the CAPS. Similarly, it was also recognized as a humanization strategy in the CAPS located in the metropolitan region of Porto Alegre, Rio Grande do Sul, Brazil, where its implementation triggered a break with the so-called technocratic practices in health care, through the adoption of a professional attitude that expresses ethical-political commitment with the other in its uniqueness and with the change in health practices [16].

In these terms, the host represents a light technology, that agency processes of listening, bonding and autonomy, with co-responsibility between workers and users. Qualified listening, therefore, permeates the warm practices, a strategy that makes it possible to identify the demands of users, as well as building links in the development of therapeutic projects. In this sense, listening is pointed out as a space of attention, understanding and availability in the worker and user relationship in the CAPS, which requires trusts and respect for singularities. When done properly, it can provide relief from suffering. On the other hand, its realization in a disrespectful and non-welcoming way of user needs may lead to the breaking of ties and frustrations in the relationship between the subjects in the care process [17, 18].

Regarding the construction of autonomy, as unfolding of the reception, as can be evidenced in the speeches, ruptures occur with the discourse and hegemonic practice in mental health, breaking the prescriptive disciplinary logic, as the user is encouraged to become protagonist of their care process, sharing the choices regarding the therapeutic actions and the best conditions of coexistence with their suffering [19, 20].

According to the managers interviewed, the operationalization of the reception implied a reorganization of the work processes of the team, which is only possible when the workers reflect critically about the services they offer and the ways they deal with the health needs of the population [7]. In CAPS under review, according to the observation made during the research, the team is responsible for listening and for the establishment of responses to user needs, considering the "menu" of actions and internal services, as well as what is available in health care network, seeking to take responsibility for the guarantee of care. In this sense, there seems

to be directionality for the supply to move from the centrality in the physician, to be conformed according to the capacity of intervention of the multiprofessional team.

The discussion about the ways in which the workers perform the reception, as well as establish the offerings of care, implies an increase in the clinical capacity of the team to listen, recognize risks and vulnerabilities, promote interventions, and may even materialize processes of "de-medicalization" when this is not restricted to an emergency room doctor. Is recognized, therefore, the fact that the host leverages an expanded approach to health problems, avoiding one biologist approach and the unnecessary "medicalization [21].

In addition, it can be considered that such a way of operating the host in the CAPS exceeded the logic of screening, since it is not restricted to the evaluation of signs and symptoms and/or order of arrival, depending on the availability of vacancies of each professional, the doctor. According to the managers, it is sought to develop the decoding of health needs and accountability with the access of users.

In these terms, there is a reorganization of the work processes, being necessary the team to have availability and flexibility of agenda, so that the multiprofessional team stays in the rear to attend to the cases considered urgent, directed by the workers who perform the reception, with a view to conferring greater solvability. It is worth noting that all the professionals of higher level participate in the weekly scale of accomplishment of the host, except the doctor, who acts in the support to the team to immediately attend the users in situation of crisis. This circumstance is justified by the high demand of users in the CAPS who need medical consultations and by the reduced number of these professionals in the service. So the team is driven to increase the solvability capacity model based on user-centred, by offering programs and services guided by the psychosocial approach, an interdisciplinary perspective, as advocated It is noted the argument that, similarly historically registers the lack of doctors in the host in different health services, based on the same reasons presented here [22, 24].

It was evidenced that the team, in assuming responsibility for the access of all users, based on psychosocial attention, considering the multiple dimensions and health needs of the subject, seeks to develop strategies to ensure the integrality of care, which Implies the establishment of care flows through the articulation of the mental health care network. In this sense, it was necessary to demarcate reference and counter-referral mechanisms among health services in their different levels of complexity. CAPS is understood as strategic in the psychosocial care network, which denotes its primary function as articulator of services and actions in the territory. In this study, we identified the fact that the main articulation occurs with the FHS teams, through referrals often made by telephone.

Managers, however, find it difficult to refer to other services, especially in the area of specialized secondary and tertiary care. Here it is expressed the idea that the implantation of health care networks in the Municipality represented an instituting process with weaknesses in the system and in the mechanisms of reference and counterreference implanted, including in relation to basic care, with which there is a greater articulation of CAPS, either via referrals or matrix support strategy. The guarantee of the care network, particularly when users require care in other medical specialties, is an action to challenge host, therefore, the construction of comprehensive care in the CAPS study.

It is worth noting that this problem is common in another municipality, located in the south of Brazil, where the coordinators, pointing out the mental health network in a state of construction, presented assistance flows based on referrals, in which the continuity of cases resolution is A concern of the worker, with weaknesses in the articulation between services, including with the FHS. This situation

configures poor connectivity of the network, with fragmentation of care, which implies reduction of solvency, despite the efforts to qualify services and care processes [25, 26].

The developer's importance is determining health promotional actions in order to promote quality of life of the population. These actions can be developed between ESF and NASF [27].

Regarding the ambience, pointed out as an aspect that negatively compromises the operation of the host in the studied CAPS, it can be considered to represent a device for qualification and humanization of health services. It is related to the treatment granted to the physical space, in its social, professional and interpersonal relationships, which provide welcoming, resolute and human attention. In the context of implementing the guidelines of the National Humanization Policy, such as the CAPS in the period of this study, it should be considered that the ambience in the architecture of health services goes beyond the technical, simple and formal composition of the environments, as it involves situations Constituted in the daily life, experienced by groups of people with their cultural values and social relations. Thus, it involves three axes: space with comfort, focusing on privacy and individuality, considering the environmental elements that interact with people (colour, smell, sound, lighting, availability of seats, among others); Space of production of subjectivities, focusing on the encounter between the subjects and reflection on the work process; And space that favours the work, with focus on the optimization of resources, humanized and resolute service [28].

In general, when considering aspects such as facilities, physical environment and materials and equipment, it can be said that the precariousness of health care facilities is recurrent, especially in relation to the size and layout of rooms, ventilation and physical conservation, common in the context of primary care, but there are also the CAPS of Fortaleza [29, 30].

Different results of these were found in Alegrete, Rio Grande do Sul, Brazil, CAPS, where the environment was evaluated positively, when workers, users and their relatives pointed out that the space is pleasant, well ventilated, with rooms customized, decorated and painted in different colours. In addition, comfort, privacy and individuality were considered satisfactory [31].

In view of the above, it can be considered that CAPS managers indicate that the host is a powerful device to operate changes in the processes of production of mental health care, by promoting reorganization of work processes and reorientation of the care model. On the other hand, its operation is hampered by aspects internal and external to the CAPS, such as the environment and the effective integration of the care network.

Conclusions

The analysis of the operationalization of the host in the CAPS, from the perspective of the managers, allowed to characterize it as a social practice with potential to operate changes in the health production process, depending on the critical reflection performed permanently, shared with the staff.

In this sense, the host constitutes a device capable of promoting innovation in health practices, which resides in the (re) invention of health, insofar as it potentiates the displacement of the historically constructed object of care from the disease to the subject, considering its human needs, Which contributes to the reorientation of the attention model, in the perspective of making it user-centred. In these terms, it establishes a new ethic of care based on alterity and psychosocial attention.

The implementation of the host set up space for qualified listening and construction of autonomy in care processes, as well as reflection on the work processes and organization of CAPS. Thus helps the consolidation of the psychosocial care model, with humanization and increased solvability.

Paradoxically, to demarcate flows for attention to the health needs of users in their search for care, can not fully carry out the joint care network to mental health, for reasons external to the CAPS, that go beyond the sphere of team skills; among these, the lack of integrated system of reference and counter between the different levels of complexity of the health system. This situation, coupled with the inadequacy of ambience, is a challenge that stands the operationalization of the host.

In this way, it defends the argument that it is necessary to expand the capabilities of the host, recognizing the inseparability between management and health care, for the qualification of health practices orders the implementation of management models that create possible conditions for its implementation.

So, seems essential to tackle the existing challenges expressed by the municipal management, which involves investments in infrastructure to improve the internal ambience of CAPS, and the establishment of strategies for the effective construction of the mental health network, which They extend from the expansion of supply, through the implementation of services to the activation flows that connect the different services, through effective communication networks with a view to comprehensive health care.

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