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Original Article

Psychosocial Care Center: daily work and articulation with the network in the pandemic

Centro de Atenção Psicossocial: cotidiano de trabalho e articulação com a rede na pandemia

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ABSTRACT

Objective: to analyze the daily work of a Psychosocial Care Center and its articulation with the Psychosocial Care Network in the context of the COVID-19 pandemic. **Methods**: this is a qualitative study, produced by means of the researcher's diary and semi-structured interviews with nine health professionals, submitted to thematic-categorical content analysis. **Results:** the pandemic revealed failures in the management of services, lack of public investment, and the unpreparedness of professionals, intensifying work fragmentation, network disarticulation, non-assistance, and pre-existing asylum practices. **Conclusion:** the reality of the daily work of psychosocial care services shows that multifaceted actions that consider the complex social process of the psychiatric reform are necessary, especially in the pandemic, seeking the effective institutionalization of the psychosocial care model and the formation of centers of resistance to the established asylum model.

Descriptors: Work; Institutional Practice; Mental Health Services; COVID-19.

RESUMO

Objetivo: analisar o cotidiano do trabalho de um Centro de Atenção Psicossocial e sua articulação com a Rede de Atenção Psicossocial no contexto da pandemia da COVID-19. **Métodos**: trata-se de um estudo qualitativo, produzido por meio do diário do pesquisador e entrevistas semiestruturadas com nove profissionais de saúde, submetidas à análise de conteúdo temático-categorial. **Resultados**: a pandemia revelou falhas na gestão dos serviços, falta de investimentos públicos e o despreparo dos profissionais, intensificando a fragmentação do trabalho, a desarticulação da rede, a desassistência e as práticas manicomiais pré-existentes. **Conclusão**: a realidade do cotidiano de trabalho dos serviços de atenção psicossocial mostra que são necessárias ações multifacetadas que considerem o processo social complexo da reforma psiquiátrica, especialmente, na pandemia, buscando a efetiva institucionalização do modelo de atenção psicossocial e a formação de núcleos de resistência ao modelo manicomial instituído.

Descritores: Trabalho; Prática Institucional; Serviços de Saúde Mental; COVID-19.

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Introduction

Among the advances that the Brazilian Psychiatric Reform, which began in 1980, brought to the care of people with mental disorders and needs arising from the use of alcohol and drugs, the creation of the Psychosocial Care Network stands out, since this was essential for the strengthening of psychosocial care of users and for the decentralization of services, seeking to articulate actions and health services and ensuring individualized, inter-professional, comprehensive, humanized, territorial, and free mental health care focused on ensuring autonomy and social reintegration[1].

Therefore, among the various components of the Psychosocial Care Network, the following stand out: the Family Health Strategy teams that make up the Primary Health Care; the Mobile Emergency Care Service and the Emergency Care Units, in addition to the Psychosocial Care Centers and Polyclinics that, respectively, treat severe and persistent cases and provide outpatient care.

In addition, other health services and community devices also make up the network, such as the Social Assistance Reference Center, Public Ministry, schools, churches, and hospitals[2].

However, despite the strengthening that the Psychosocial Care Network brought to the Brazilian Psychiatric Reform movement, several factors have influenced, in a negative way, the continuity of this movement. Some examples are the various cuts made in the funding of the Unified Health System and the pandemic that further strengthened the risks of discontinuity of mental health care provided by the network, since the services needed to remodel themselves to follow the prevention standards of Coronavirus disease 2019 (COVID-19). At the same time, the services experience a considerable increase in the demand for mental health with the prospect of a worsening in the situation, even after the relaxation or suspension of isolation measures due to the scarcity of resources in the services, worsening of socioeconomic circumstances and others[3].

These remodels have imposed new ways of organizing mental health work, such as the need to reorganize triage and referral flows, the adoption of telehealth and digital interventions, the creation of new means of bonding and support networks, among others, which make the context conducive to understanding the impacts of these changes on mental health care, besides being a potential analyzer for already established practices[4-8].

In this sense, studies that aim to analyze the effects of the pandemic on the daily work of the mental health service and its articulation with the other devices of the network, in order to identify the deficiencies and potentialities revealed and/or intensified by the pandemic, will allow us to reflect on the instituted and instituting movements that occurred in the specialized services of the Psychosocial Care Network during the pandemic context, so that we can propose/establish practices more aligned to psychosocial care in moments of crisis such as this. Thus, this study aimed to analyze the daily work of a Psychosocial Care Center and its articulation with the Psychosocial Care Network in the context of the COVID-19 pandemic.

Methods

This is a qualitative study, which was developed according to the Consolidated Criteria for Reporting Qualitative Studies (COREQ) for qualitative research. Qualitative research is chosen when one considers it necessary to understand the multiplicity and subjectivity of reality through the experiences and perceptions of the individuals involved[9].

The sample was intentionally defined, seeking to reach data saturation. The inclusion criteria were being a professional in-patient care or service management and being professionally active during the data collection period. Professionals on medical or other leave of absence and those who refused to participate were excluded.

As a data collection method, we chose participant observation and semi-structured interview, both

conducted face-to-face by a master's student during the last semester of 2020 in a type I Psychosocial Care Center of a Brazilian capital, which is the main mental health service in the city.

Participant observation was initiated in July 2020, four months before the interviews began, with the aim of bringing the participants and the researcher closer together[6,10] to collect observational information regarding institutional practice, the organization of work, and the culture of the service. The researcher's perceptions were recorded in a diary, used as a source of data[10].

The interviews took place in a private place, only in the presence of the researcher. They lasted an average of 50 minutes each, being recorded by electronic recorder and later transcribed by converting the speech into electronic text on a computer (Word Office 2016), with prior authorization from the participants.

The following guiding questions comprised the interview script: How has the teamwork routine been in the unit during the pandemic of COVID-19? How have you maintained the care and follow-up of users in the context of the pandemic? What situations of mental suffering have you attended to most frequently in the last few days and the main care/interventions performed? What has changed in your professional practice and in your relationship with other professionals that attend users during the pandemic? What do you imagine will change and what will be maintained in your practice and in your interaction with other professionals when the pandemic is over?

The results were submitted to the thematic--categorical content analysis technique, consisting of a sequence of three chronological steps: pre-analysis, material exploration and treatment of results. The coding process was developed according to the research objectives and organized by the creation of registration units, context units and categories, respecting the criteria of homogeneity, mutual exclusion, relevance, objectivity, fidelity, and productivity[11].

We used as theoretical-conceptual reference the Model of Psychosocial Care, in view of the historical process of the psychiatric reform in Brazil[1-2] and some concepts of Institutional Analysis, namely: analyzer, institution, instituted and instituting that consider the institution as an articulation between what is established (instituted) and the social movements and events that can support or discuss what is already set as a norm (instituting) and the analyzer that is an event capable of bringing to light what is hidden in the institutional practices, revealing the institutions[12].

The research was submitted and approved by the Research Ethics Committee under opinion number 4,199,950/2020 and complied with all national and international ethical resolutions regarding the development of research with human beings. In addition, the recommendations for prevention of COVID-19 were followed throughout the research. To ensure anonymity, the speeches were randomly identified with the letter P followed by cardinal numbers.

Results

Of the 24 workers at the Psychosocial Care Center, only 11 were professionally active during the period of data collection. Nine professionals participated in the study whose categories were: two nurses, two psychologists, three social workers, one pharmacist, and one journalist, who acted as manager of the service.

From the content-thematic analysis of the participants' speeches and the researcher's diary, three categories were formed, namely: Analyzers: changes imposed by the pandemic of COVID-19; Old news: what does the pandemic intensify and reveal to us? (De)articulation of the Psychosocial Care Network.

Analyzers: changes imposed by the pandemic of COVID-19

The professionals highlighted some changes in demand during the pandemic as the increase in cases

of anxiety, depressive symptoms, and suicidal behavior. The number of patients in whom social vulnerability may have exacerbated mental suffering also increased: *We noticed an increase in cases, especially suicide attempts and new cases of depression* (P1). *Look, I attended some cases of anxiety, depression, schizophrenia, and of people who had COVID-19 and, even after the cure, are no longer presenting symptoms of COVID-19, but were left with anxious symptoms* (P5). *A lot of patients are showing up with issues of economic and social vulnerability and mild anxiety* (P9).

To adapt to the hygiene measures imposed by the pandemic, professionals adopted actions to prevent professionals and users from getting sick, but the fear of contagion and the need for distance interrupted multiple therapeutic actions and strategies for inter-professional and intersectoral work: *We stopped a few weeks with the case studies so that there would be no crowding* (P3). *We tried to space the appointments so as not to have too many people at the reception, give sometime between one person and another to air the room a little and clean it* (P8). *Patient follow-up suffered losses because the groups were suspended, the family meetings are suspended and the visits were also restricted, only the phone calls* (P9). *The professionals kept their masks on all the time, performing frequent hand hygiene and keeping their distance. There was also, at the entrance of the service, a notice about the mandatory use of mask and hand washing* (Researcher's diary - June 2020).

To continue the assistance, telephone contact was adopted as the only strategy to follow up stable users or those who were already followed by the service before COVID-19. However, new users who sought the Psychosocial Care Center for the first time during the pandemic were not included in this strategy and began to be assisted by fitting them into the waiting line: *These older patients are closely followed by their referral technician, by telephone contact* (P2). *You call and the patient doesn't answer. Sometimes there are three contacts, and nobody answers* (P3). *And now, in August, the doctor started to alternate the new cases with the cases that were already being followed up* (P5).

In face-to-face appointments, previously scheduled by the receptionist, the team prioritized users with more severe psychopathological conditions such as: suicidal ideation or inadequate medication adherence: *We are giving priority for medical consultation to those who cannot afford to stand in line waiting, something very urgent* (P3). *The extremely severe patients are those who, besides having suicidal ideation, are planning how to commit suicide* (P4). *We started to prioritize some more severe cases, some patients already adapted to the medication, more stable, were put on stand-by* (P8). *Most of the behaviors were schedules for psychological care, with social workers and doctors* (Researcher's diary - Aug. 2020).

Old news: what does the pandemic intensify and reveal to us?

The workers mentioned difficulties in maintaining face-to-face care due to the fear of professionals and users, the reduction in the number of consultations, the suspension of group and individual activities, and the lack of Personal Protection Equipment. The confusion between the concepts of welcoming patients and first consultation also drew attention in the answers: *At the beginning of the pandemic, we started to welcome patients by appointment. The person would call, and we would follow a schedule of three appointments a day, no more than that. Before the pandemic, if 10 people came, we had to receive 10 people* (P4). *We became afraid of getting sick and, because of that, the patients moved away from the service, and we moved away from the patients. So, we need to look for strategies to work that way, overcoming the fear of attending* (P5). *The municipal health department was not prepared to provide the protective equipment, it took a long time for them to get here* (P9). *One of the professionals reported that in the first 15 days after the first cases of COVID-19 in the municipality, the individual consultations were suspended. Visits were restricted during the entire period of data collection, so that I was informed of only one urgent case, where two attempts to visit were made* (Researcher's diary - Sept. 2020).

The speeches expose the professionals' knowledge limitations and the lack of training and continuing education actions in health*: For me, care in the territory is the scope of the service* (P2). *The psychosocial care network consists of five Psychosocial Care Centers. There are five psychosocial care networks* (P3). *In my view, the Psychosocial Care Center should not provide outbreak care* (P7). *It has no training* (P4).

The data from the researcher's diary show that

there is hierarchy in the team and medication is the main therapeutic method. The non-use of the Single Therapeutic Project, even before the pandemic, reinforces the perception of fragmentation and non-participation of the patient in care: *For example, a patient who uses psychoactive substances is not a profile patient here. So, we already make the referral to the Psychosocial Care Center for alcohol and drugs* (P1). *Employees running and articulating to separate medical records, print prescriptions and ensure the renewal of prescriptions of users with the psychiatrist* (Diary of the researcher - July 2020). *The professionals expressed general annoyance with a call made by the psychiatrist, in which the doctor asked to be printed, in advance, the prescriptions they would have to sign the next day* (Researcher's diary - Aug. 2020). *I have no recollection of witnessing or following the mention of the term "Projeto Terapêutico Singular" ("singular therapeutic project") or discussion for the formulation of a robust project proposal* (Researcher's diary - Sept. 2020).

The organization adopted by the team during the pandemic reinforced this work fragmentation. Some professionals highlighted the overload of tasks, due to the attendance strategies: *I managed to answer about 22 phone calls, in a single day, during this period of isolation and pandemic* (P4). *In the lockdown, we were on a schedule and some colleagues got sick from COVID-19. We drifted apart a bit* (P9). *I realize that the psychologist does office work, the social worker does the listening and referrals, and the nursing professionals do orientation* (Researcher´s diary - Aug. 2020).

(Dis)articulation of the Psychosocial Care Network

Some professionals recognize the importance of intersectionality, but most tend to limit the network to the referral and flow of the user's itinerary, with little appreciation of territorial care and articulation of the actions and agents involved: *Networking is very good. Because the nurse there is seeing everything that is happening. Sometimes, one of our patients we didn't see, they notice something that is happening there and call us here* (P3). *If I do not know how the network works, I do not know how to refer these patients* (P6). *We manage to trigger the services through referrals to the network* (P7).

On one hand, there is a certain difficulty in recognizing the role of the service in the care of crises of psychic disorganization. On the other hand, there is no investment in physical structure and material for this care to happen: *As the care here is scheduled and we are short of doctors, so the family member is asked to take this patient in crisis to the Emergency Care Unit* (P4). *In my view, the Psychosocial Care Center really shouldn't provide care for outbursts, for people in crisis* (P7). *The unit does not have a pharmacy on its premises and does not have a psychiatrist to provide back-up medication when needed. The Psychosocial Care Center is charged to provide support in crisis and outbreak situations (as recommended by its operation), but it does not have the necessary support and structure to do so* (Researcher's diary - July 2020).

Given the lack of organization of the service for crisis care, hospitalization becomes one of the main alternatives for these patients and, with the pandemic saturation of the network, some users are left unattended: *In case of a crisis, call the Mobile Emergency Care Service, take it to the Emergency Care Unit, which is the place for this care. Then, it is necessary to request the regulation there at Adalto Botelho and he is on a waiting list to be hospitalized* (P1). *One patient came to the service accompanied by family members and was in crisis (possible psychotic break). There was no doctor, no previous prescription, and no medications in the unit. The team's conduct was to call the Mobile Emergency Care Service, but it manifested that it had priorities for care of COVID-19 and did not provide backup* (Researcher's diary - June 2020). *In one of the medical records a patient presented with a disorganized condition. The family was guided by the team to call the Mobile Emergency Care Service and seek hospitalization in a possible crisis, not being clear if the possibilities of interventions, prior to hospitalization, had been exhausted or if she presented risk to herself or others* (Researcher's diary - Jul. 2020).

The professionals highlight the refusal of patients in other services and the lack of counter-reference as a factor that contributes to the disarticulation of the network, non-assistance, and overload of the service. The lack of training and the stigma of mental health were pointed out as the cause of the problem: *It doesn't matter if there is a pandemic or not... it's difficult! We don't have a counter-reference. You end up with a stable patient here because there is nowhere to refer* (P1). *Patients come to the clinic, and they say: No, not here, come back! But I think that is because they have no knowledge, a training course is very rare* (P4). *The mental health patient has a stigma, even in other services. They say: Oh no! The patient is yours* (P9).

The lack of human resources, especially of doctors and the overload of the network are used as justification for the refusal of patients, showing the centralization in medicine as well as the poor structure in the teams. The professionals point out the worsening of this picture during the pandemic: *Generally, there is a lack of doctors, especially in the polyclinics. There is never a psychiatrist, there is always none. So, we send them, and the patient is left without treatment* (P4). *We have a lot of difficulty. Sometimes we refer the patient to the outpatient clinic, and he also has a long queue* (P5). *During the pandemic, the articulation decreased. We have not referred many patients because COVID-19 overloaded the emergency service, overloaded the basic unit, and therefore overloaded the Psychosocial Care Center* (P8).

Discussion

As limitations of the study, we consider the characteristics of the sample, since it was not possible to consolidate the strategy of data saturation - since the study was conducted in a single service and not all professionals could be included - which does not allow the generalization of the results, highlighting the need for further research that can enhance the advancement in the discussions pointed out by this study. However, it is considered that this study can contribute to the analysis of the impacts of the pandemic on mental health care and raise questions about the institutionalization patterns of the Brazilian Psychiatric Reform.

The impacts caused by the pandemic have considerably compromised mental health. These are directly related to the change in demand described by professionals in this study, such as: anxiety peaks, depressive mood and, especially, worsening of pre-existing sufferings in people with previous diagnoses[3]. In addition, it is necessary to consider that the situation of socioeconomic vulnerability and food insecurity has been growing every day in Brazil during the pandemic, which severely contributes to the weakening of the mental health of citizens[13].

Thus, to continue the assistance and protect professionals, patients, and families, the team interrupted the group activities, limited the number of face-to-face visits, and adopted telephone contact for active search, welcoming, and follow-up of patients who were already being assisted by the team before the pandemic, which corroborates other studies conducted in specialized services[7-8].

However, these new practices end up generating a fragmentation of work, overload to professionals, limitation of therapeutic involvement, besides running into the high turnover of numbers[4,8]. Therefore, as an alternative, they could have kept the visits and other activities in open spaces, with distance and use of masks, besides trying other forms of care, such as telehealth[4].

In addition, the team started not to welcome people who sought the service for the first time, prioritizing face-to-face care to patients considered as "more severe", not making clear the criteria/instruments applied for this classification. It is noteworthy that these failures in work reorganization intensified during the pandemic, presenting the therapeutic gap already established in the network, since it increased the difficulty of access of people with mental disorders to appropriate services and care, potentiating their suffering[14].

Added to this therapeutic gap is the suffering experienced by professionals due to the fear of getting infected, the lack of social support, and the lack of resources and physical structure, such as the unavailability of computers, internet in the unit, and the scarcity of personal protective equipment, which increases the levels of stress in the team and further hinders the continuity and quality of patient care[3,8,15].

Other data from the researcher's diary pointed to the existence of other problems already established before the pandemic in the daily life of the Psychosocial Care Center and in the articulation with the other services of the Psychosocial Care Network, which also directly contributed to this therapeutic gap. This

could be observed to the extent that the role of the devices was not recognized in the assistance to users in a manner consistent with psychosocial care and that were intensified by the pandemic with its potential to aggravate these pre-existing limitations[15-17].

The lack of investment by the government in physical structure/resources and the poor management of the mental health service discourages professionals who, most of the time, do not have the proper means to perform their duties. The disorganization caused/evidenced by the pandemic has exposed the deficiencies of management, reinforcing the need for investment in physical structure and personal qualification through strategies aimed at the joint construction of knowledge and continuing education in health, since the critical awareness about the elements that involve psychosocial care is essential for good assistance[17-19].

Another problem established and revealed by the researcher's diary and the speeches of professionals was the hierarchization within the team through the overvaluation of medical practice and medicalization that is important in the organizational culture of the components of the psychosocial care network and is contrary to the objectives of psychosocial care, since it limits the inter-professional care, fragmenting the care. This fact contributes to the team's organization into a group, where the work is developed without sharing decisions and monitoring of patients, undermining the continuity of care[2,15,20].

The scarcity of inter-professional and intersectoral strategies such as that achieved through the Singular Therapeutic Project, case studies, and counter-referral are symptoms of this fragmentation and unpreparedness that exist throughout the psychosocial care network. The gaps in the professionals' knowledge about the articulation of the network, territorial care, and about the attributions of their own professions and devices prevent a comprehensive, interprofessional, territorial, and free assistance, since it generates refusals of patients, errors, and inefficiency in the articulation of services - such as unnecessary referrals for hospitalizations - and limitations on the actions of professionals who reinforce the biomedical-psychiatric model[17,20].

These problems also seem to be part of the institutional practice of other network services, which ignore their role in psychosocial care, keep the focus on medicalization and control of the bodies, and dispense interprofessional work tools and promotion of autonomy[17].

It is noteworthy that the disarticulation of the psychosocial care network is a chronic problem that is largely caused by the unpreparedness of professionals and the lack of investment in human and technological resources, as previously mentioned[8,17]. But, despite being a previously established problem, the pandemic intensified the disarticulation of the psychosocial care network by the closing, overcrowding, and relocation of services for the care of COVID-19, while it highlighted the need for care in the territory and the strengthening of interpersonal relationships[7,17].

However, the pandemic, as well as other periods of crisis, serves not only as a potential analyzer of the institution (in this case, of the psychosocial care model instituted in the device Psychosocial Care Center), but can also be the engine to question the place of mental health in society, the power relations and the practices instituted in the services, to generate transformative instituting forces[5,12].

This type of movement becomes essential, considering the context of setbacks in the national mental health policy, facing a movement that stresses and weakens care[1]. But, for this to be reversed, it is necessary to recognize that the institution is involved in tensions between the instituted and instituting model, being marked by advances and setbacks, and the psychiatric reform, as an instituting movement, is a complex social process, imbued with four dimensions (theoretical-conceptual, technical-assistance, legal-political and sociocultural)[1,5].

Faced with this complexity, multifaceted actions are required, with the main objective of breaking with the instituted asylum and resisting these forces

that weaken the psychosocial care[2,17]. Resistance is a collective responsibility and can be put into practice through public investments, discussions in community devices, inclusion of inter-professionalism in the graduations and continuing education in health, with valorization of previous knowledge, reinforcing the positive points and seeking to institute a new mental health practice, far from the asylum ties[17-20].

Conclusion

The study allowed an analysis of the daily work and articulation of a Psychosocial Care Center with the Psychosocial Care Network during the pandemic, showing the difficulties of the team in the (re)organization of the actions offered by the Center, but mainly pointing to the crisis of COVID-19 as an analyzing factor that exposes and reinforces previously instituted problems in the service, such as the lack of investment in material and human resources, the disarticulation of the network, the hierarchization, and the lack of interprofessional strategies in the team. This fact reveals the failures in the institutionalization and implementation of the psychosocial care model, as part of the psychiatric reform movement.

Authors' Contribution

Conception and design of the study, data analysis and interpretation: Rezio LA.

Analysis and interpretation of data, writing of the article, review, and approval of the final version to be published: Silvano AD.

Performed the data collection, analysis, and interpretation: Martins FA.

Analysis and interpretation of data, review, and approval of the final version to be published: Bittencourt MN, Cebalho MTO, Silva AKL.

Writing, relevant critical review of the intellectual content, and approval of the final version to be published: Borges FA.

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