Professional practices in psychiatric hospitals: challenges for humanized and comprehensive care

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ABSTRACT

Study model: cross-sectional study with a mixed approach (quantitative and qualitative). **Objective:** to analyze the practices of professionals in psychiatric hospitals in the care of people with mental disorders, with a view to contributing to a humanized and integral approach. **Methodology:** study carried out in two psychiatric hospitals in Rio Grande do Norte, with 60 health professionals as participants. The quantitative data were submitted to statistical software and analyzed through bivariate statistics; and in the qualitative data, the Alceste software treatment and the content analysis technique were used. **Results:** it was observed the predominance of professional practices associated with traditional interventions in the context of the approach performed, reinforced in the two central themes, arising from the qualitative findings, namely: Professional practices in the psychiatric hospital: daily life and policies, and, Barriers and paths to comprehensive and humanized care in psychiatric institutions. **Conclusion:** the professional practices developed within psychiatric institutions point to the biological and individual therapeutic focus, in view of the challenges of articulating a comprehensive and humanized care consistent with the guidelines proposed by the Brazilian psychiatric reform movement**.**

Keywords: Mental health, Human resources, Psychiatric hospital, Mental health services.

INTRODUCTION

The World Health Organization (WHO)[1] marks Mental Health as one of the most neglected areas in the context of international public policies. There are worrying data about the number of cases of mental disorders that affect more than one billion people, in addition to problems such as restricted access to assistance and quality services, the stigma of the disease and history of human rights violations in this field, particularly among developing countries[1-2].

In Brazil, the Mental Health Policy (MHP), driven by the Federal Law 10.216/2001 and the whole struggle of the Psychiatric Reform movement, invests in the process of change in the care of people with mental disorders[3]. The psychosocial care model, more inclusive and community-based, is adopted, replacing the asylum and asylum model[4]. The goal is to guarantee this group access to health services and their free movement around the community and the city.

In recent years, new modalities of health services and devices in the field of mental health have been implemented, such as: the Psychosocial Care Centers, the Therapeutic Residential Service, the Living Together and Culture Centers, the Shelter Unit, among others, which together and in an articulated manner make up the Psychosocial Care Network (PSCN)[4]. The PSCN established criteria for the organization and expansion of out-of-hospital services integrated among the various levels of care in the Unified Health System (UHS), foreseeing the gradual extinction of the psychiatric hospital, reinforcing the aspect of integral and humanized care to users and their families[5].

Psychosocial Care, among advances and setbacks, has favored multi- and interprofessional work, through the adoption of practices based

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on humanization and social reintegration of the user and his family. In the scope of psychosocial care, the planning of actions and health interventions proposed by the professional teams are described and proposed, in an articulated manner, during the elaboration of the singular therapeutic project (STP). The STP is an important tool in the organization of mental health care, because it stimulates the user's self- and co-responsibility in his treatment[6].

In the opposite direction of the reformist propositions, between the years 2017 and 2018, important changes in the previously adopted baseline were instituted[7-8]. It is pointed out, among other aspects, a configuration of PSCN that includes the psychiatric hospital as a care device, even creating mechanisms to increase the cost of psychiatric hospitalization in detriment to the funding of out-of-hospital services such as the Psychosocial Care Center (PSCC), Therapeutic Residential Service, and community centers, among others[8-9].

However, although an increasing volume of referrals of users to the psychiatric hospital is observed, in order to obtain psychiatric evaluation or even hospitalization beds, the invisibility and lack of articulation of the hospital service in the context of care production in the PSCN is pointed out[9]. This fact reflects in the limitation of the exercise of human rights of people with mental disorders, with regard to the right to freedom, health, work, housing and education, in view of the marked institutionalization in this scenario[10].

A study[11], identified flaws in the development of decision making processes and organizational issues, considering: lack of professional preparation; the hegemonic medical relationship, as well as inadequate physical plant and staff dimensioning, as factors that contribute to the increase of risks involving the user in the psychiatric hospital.

In general, the psychiatric hospital is required to rethink its management and practice beyond an eminently technical and disciplining knowledge. To this end, we emphasize the political support from managers as an essential element for strengthening the mental health care model proposed by the RP[12-13]. It is understood that the psychiatric reform process implied the rethinking of the traditional care model by linking mental health and promoting the social inclusion of people with mental disorders with their differences and singularities, whose practices require specific knowledge, techniques and skills, with investments in training and qualification processes among educational institutions[14-15].

In broadening the debate around the qualification of mental health care offered among Brazilian services, the question is: what are the practices of mental health professionals in psychiatric hospitals? Thus, the study aims to analyze the practices of professionals in psychiatric institutions in the care of people with mental disorders, with a view to contributing to the humanized and integral approach.

METHODOLOGY

This is a cross-sectional study with a mixed approach. The mixed method encompasses both quantitative and qualitative approaches[16]. Quantitative and qualitative data were collected concurrently and then convergences, differences, and combinations between them were identified. These two approaches were linked by the data triangulation technique[16].

The study sites were two public psychiatric hospitals (PH) of reference in the state of Rio Grande do Norte (RN). PH I is located in the capital city, being a reference institution in medium complexity mental health care and PH II is located in the western region, serving a public predominantly in the adult age group[17], both located in strategic geographic regions (the largest municipalities in terms of population.

The participants were senior level professionals selected through convenience sampling of the consecutive type. Inclusion criteria were: to be senior level professionals, with a minimum of six months of effective employment in the institution and weekly workload of 20 hours, in addition to participating directly in care and/or activities with patients and families. And, as exclusion criteria, professionals on leave or vacation during the collection period. The target population was 95 professionals, and, adopting a margin of error of 8%[18], the final sample of 60 participants was reached.

The research instrument was a self-administered questionnaire[19], encompassing questions about the socioeconomic profile and educational background of the participants, about the teams' professional care (individual, family and group) and the mental health policy, distributed in multiple choice and open questions.

Data collection took place from June 2017 to November 2018. Initially, the managers of each psychiatric hospital were contacted, explaining them about the research. Upon their acceptance, the delivery of the questionnaires was scheduled at the workplace during off-peak shifts, in a reserved room of each service, after signing the Free and Informed Consent Term. Orientation about the questionnaire was reinforced individually.

In the quantitative stage, the data obtained were processed in the Excel program, version 2010, checking for possible typing errors and exported and tabulated in the statistical software SPSS version 20.0. For data analysis we used simple and bivariate statistics, adopting the significance level $p<0.05$. And, in the qualitative stage, the data were categorized with the support of the Alceste software, followed by Bardin's content analysis technique in its respective stages: pre-analysis, exploration of the material or coding and treatment of results, including inference and interpretation[20].

In compliance with the ethical precepts, the national and international standards for research involving human beings were met, with a favorable opinion from the Research Ethics Committee of the Federal University of Rio Grande do Norte under number 508.430, CAAE: 25851913.7.0000.5537.

RESULTS

The higher level professionals of the two psychiatric hospitals were predominantly female (91.8%), nurses (36.7%), aged between 50 and 59 years (42.9%), graduated between 1975 and 1999 (37.3%); of these, 21.4% had a specialization in mental health and 58% started in the area between 1975 and 1999 (Table 1).

Table 1

Socioeconomic and training profile of professionals. Rio Grande do Norte, 2018.

Variables	N	%
Sex*		
Female	52	91.8
Male	4	8.2
Total	56	100
Age group (years)*		
30 to 39	6	17.1
40 to 49	12	34.4
50 to 59	15	42.9
More than 60	2	5.6
Total	35	100
Professional categories		
Nurse	22	37
Doctor	3	5
Psychologist	15	25
Occupational therapist	9	15
Social worker	9	15
Physical educator	2	3
Total	60	60
Graduated (year)*		
1975-1999	34	57.6
2000-2014	25	32.4
Total	59	100
Post-graduation and refresher courses*		
Mental Health Specialization	12	21.4
Upgrading/training and others	28	62.5
Master's/PhD	3	5.4
No	6	10.7
Total	49	100
Start in mental health (year)*		
1975-1999	34	58
2000-2014	25	42
Total	59	100

*Absent data

Table 2 shows the practices developed by health professionals, structured under three levels of care, namely: individual, family, and group care. In individual care, it is observed that it is made optional and not a guideline. An association was found between those who do not follow the user's therapeutic project, associated with those who do not perform physical and hygiene care ($p=0.019$); and in the orientations about sleep ($p=0.001$).

Table 2

Practices of professionals who design individual therapeutic project by level of individual, family and group care. Rio Grande do Norte, 2018.

Individual Therapeutic Project						
Developed practices	Elaborates		Does not elaborate		X^2	p value
	n	%	N	%		
Individual care						
Physical care and hygiene						
Yes	5	25	15	75	1.71	0.019
No	3	10.7	25	89.3		
Sleep						
Yes	6	46	1	53.8	11.1	0.001
No	2	5.7	33	94.3		
Family care						
Observation						
Yes	5	23.8	16	76.2	7.34	0.039
No	3	13.6	19	86.4		
Crisis consultation						
Yes	6	24	19	76	1.14	0.028
No	2	11.1	16	88.9		
Group care						
Annotation						
Yes	6	28.6	15	71.4	2.68	0.010
No	1	6.7	14	93.3		
Recreation						
Yes	6	26.1	17	73.9	1.79	0.018
No	1	7.7	12	92.3		

In family care, there is an association between professionals following the patient's individual therapeutic project and an increase in family care in moments of crisis (p=0.028); group care with note taking (p= 0.01) and with recreation (p=0.018) (Table 2).

In Table 3, an association was found between the institution complying with the doctrinal and operational requirements of the Mental Health Policy with the performance of individual care alone and shared with other professionals of the team (p=0.012); however, the same results were not found when compared with family and group care (Table 3).

The data report obtained through the corpus of the professionals' answers to the questionnaire generated five distinct classes, being used in this study classes 1 and 5 that specifically addressed the practices of health professionals in psychiatric hospitals. By systematically reading the excerpts selected in the classes and following the categorical analysis technique, two central themes and their respective subthemes were established: Theme I) Professional practices in psychiatric hospitals: daily life and policies, and, The scenario of practices and Professional daily life and the dissonance of the national policy; Theme II) Obstacles and paths for the integral and humanized care in the psychiatric hospital, and, Main obstacles and Glimpsing paths (Chart I).

Table 3

Practices of professionals in institutions that follow the Mental Health Policy and how they provide care at the individual, group and family levels**.** Rio Grande do Norte, 2018.

Mental Health Policy in the institution						
How you provide care	Doesn´t follow		Follows		x^2	p value
	N	%	N	%		
Individual						
Alone and/or with another professional	6	30	14	70	6.27	0.012
I don't do it	2	5.6	34	94		
Familiar						
Alone and/or with another professional	7	14.9	40	85.1	3.15	0.076
I don't do it	3	42.9	4	57.1		
Group						
Alone and/or with another professional	6	15	34	85	0.998	0.318
I don't do it	4	26.7	11	73.3		

Chart 1

Themes and sub-themes of the study and the main excerpts of the health professionals' speeches

Theme I - Professional practices in the psychiatric hospital: daily life and policies	
The practice scenario	Professional daily life and the dissonance of national politics
Preparation and administration of medications; nursing care directly to the patient [Nurse 19]. Administration of medications, vital signs, physical and hygienic care, promoting comfort [Nurse 4]. Reception, individual care, group care, family care, referrals, contacts with municipal services, home visits, workshops and daily activities [Soc. Work.] Dispensing of medication, therapeutic workshops, administration of medication, performing dressings, orienting users and family members [Nurse 11]..	There are still incipient practices, by some teams, in line with the precepts of the Brazilian Psychiatric Reform [Psy. 16]. There is no therapeutic project of the institution that follows the National Policy, so it does not follow [Occup. Ther. 23]. Professionals plastered to the old system [Occup. Ther. 16]. The internal political issues of the institution cause the psychiatric reform not to flow [Phys. educ. 03].
Theme II - Obstacles and paths for integral and humanized care in psychiatric institutions	
Main Obstacles	Glimpsing Paths
It still remains as a large psychiatric hospital with long hospitalizations [Nurse 5]. There are still conservative and authoritarian practices in the way of attending the sick people, prevailing prejudice, isolation [Psych. 9] There is no effective network work [Nurse 11]. Lacks support and incentive from the government [Nurse 14]. Lack of human resources [Nurse 6]. Follows some guidelines, however not actively [Nurse 8]. Needs a better knowledge of this Policy [Occup. Ther. 22].	It is fundamental to be up to date with mental health policies for a better therapy [Nurse 3]. Implement the therapeutic project, discuss with patients and family, etc. [Nurse 6] Resocialize the patient and guide the treatment at the outpatient level [Psych. 16] To work on the subject suffering from mental disorder as a person in order to guarantee citizenship rights [Psych. 16]. To provide a better quality of life for patients and their families [Soc. Work. 16]. To improve and optimize through the proposed physical activities [Physical Ed. 16].

DISCUSSION

In Brazil, it is observed that Nursing currently stands out as the largest contingent of professionals in health work, with predominantly women working in the UHS service network; and, among hospital services, with 60% of occupied positions[21]. Accordingly, the professional profile found in this study was that of nurses with a long trajectory in mental health, having graduated in a period before the changes in the psychosocial model.

Although the movement for psychiatric reform has partly followed the historical process of health reform, there is a gap between them, even though some progress has been made in the field of mental health[12]. The most significant changes are attributed to the Reform Law of 2001[3]. The result is that after this legal provision, the training process, skills and competencies had to be adapted, based on changes in the practice scenario and new care strategies adopted in recent years[7, 14-15].

Thus, in the context of professional training, curricular reforms have been identified in health courses (nursing, psychology, medicine, and others), requiring the incorporation of the theme and the debate around the new national mental health policy, expansion of the theoretical and practical workload in mental health/psychiatry, greater experience of students in PSCN services, among others[13, 22].

Considering the current needs and demands in the psychosocial field, on the one hand, the profile of the participants shows a low percentage of professionals who have completed training and specialization in this area. On the other hand, there are still few investments in the field of government policies aimed at professional training and qualification, especially in the psychiatric hospital[23].

It is understood that continuing education in mental health is a fundamental requirement to work in these services[13-14]. Particularly among professionals working in hospitals, where the biomedical and conventional model of user care predominates, it is important to give new meaning to the spaces for discussion and integration among the team, whether for discussing cases or planning other training and updating activities in the area[15 , 24].

With regard to the professional practices in the psychiatric hospital, associations were found, in individual care, between who follows the therapeutic project of the user and the physical and hygiene care and sleep orientations performed by professionals. In part, this finding refers to the strong presence of care based on actions with a predominantly care focus, with historical remnants of the traditional psychiatric model, particularly recognizing the role of psychiatric nursing in this scenario (most professionals in the study), paying attention to body care and sleep[9]. Studies have identified that the actions performed individually by these professionals are mostly of a care nature, followed by educational and managerial ones[15,25].

In the context of individual care to the user, beyond the interventions aimed at the biological body itself, it is known that the adoption of other psychosocial care technologies, such as qualified listening, bonding, multi-professional consultation, among others, become valuable in the process of improving the user's condition and, consequently, his/her discharge from the service in crisis conditions and continuity in the PSCN devices[6,26]. Based on this prerogative, the elaboration and discussion of the therapeutic project favors a greater approximation between the team and the user, making possible a greater adherence to treatment[5].

The family-oriented approach and care among mental health services constitutes a great challenge for the work of professionals[28]. Among the psychiatric hospitals studied, the crisis consultation is pointed out as the main intervention involving the family. It is understood that the crisis consultation is configured as a specific case of psychiatric emergency that requires from the team a brief intervention strategy focused on the event, in order to prevent its progression and situations of harm for the user and those close to him/her[26-28].

It should also be noted that during hospitalization, the family-user-service interaction happens occasionally, only at specific moments of the visit or when requested[27]. This aspect, in some cases, can cause difficulties in getting used to the service or even the fear of abandonment and social solitude in this period[28].

Although the proposed changes for the situations of hospitalization are considered, which have become preoconized only in necessary cases and have a shorter duration of time, the family support articulated to the professional performance contributes to the best approach to be taken in the definition and execution stage of the user's therapeutic project[6]. This articulation brings important clues in the broad evaluation of the case, contributing to strengthen the sense of confidence and self-esteem of that person[6,23]. However, it is verified the lack of preparation and/or psychological wear of the family in dealing with specific situations, or even for not knowing their active role in the therapeutic process[28].

In the group care developed by the professionals, recreational activity with users stands out as the main collective intervention, following the proposed therapeutic project. The recreational activity has been an important space for socializing and sociability during the hospitalization period[26]. It is recognized that hospitals have a large physical structure and, even in a timid way, maintain a schedule of recreational activities and commemorative dates in this format, a fact that also reflects the presence of the physical educator.

Among the services that have a physical educator, it is possible to develop activities and exercises geared to the needs of users, going beyond the recreational and entertainment space that involves recreational activity. The literature has shown a positive association of high levels of recreational and physical activities with good mental health, even being recommended in some forms of treatment[26].

In the last years, the Mental Health Policy has expanded its constitution bases and intervention focus, through the need to reaffirm its strategic role in the deinstitutionalization process and in the rescue of the human rights of people with mental disorders[29]. From this perspective, in recent years, the implementation of strategies and legal and juridical devices in the psychosocial field have been pointed out, in order to guarantee their adoption among states and municipalities[12].

It was evidenced that the (MHP), determined by Federal Law 10,216[3], which redirects the mental health care model has little influence among the psychiatric institutions surveyed, considering the three levels of care provided, whether individual, group or family. An association was found between the care provided alone and with another professional and the institution that follows the MHP.

In part, this reality is related to the care focused on the specialized care provided in psychiatric hospitals, given the few advances in the way of assisting people with mental disorders and their families, and the lack of investment in multi- and interprofessional work[9]. Traditionally, the psychiatric hospital represents a complex historical and social organization that currently occupies a critical place in the process of mental health care production, considering the therapeutics developed that, in part, disregards the user in his/her singularity, focusing more on the disease[12].

It is agreed that there is a centralization of power and devaluation of professionals in the organizational context, even with the existence of some collaboration at work[23,25]. This observation refers to the challenge of transforming mental health care into a deinstitutionalized practice that requires the construction of new ways of caring for users. It is also mentioned, in many realities, the lack of preparation or qualification of professionals in the mental health field[13,23].

One can notice changes in the field of training and professional performance in psychosocial care with the expansion of training courses and the opening of multiprofessional residencies in mental health and psychosocial care, among others[22]. However, there are still obstacles to be overcome, such as the little emphasis on mental health/psychiatry topics among undergraduate health courses, the lack of incentive for the realization of practical and teaching activities among the devices of the PSCN, as well as the lack of financial investments for the implementation of continuing education activities aimed at service professionals[14-15].

Regarding the limitations of the study, the cross-sectional nature and the disproportion in the representation of professional categories are pointed out. However, the quality of the findings demonstrates the value of the investigation and the importance of deepening the causal relationship between the Brazilian mental health policy and the challenges of the psychiatric hospital as to the training and qualification of the multi-

professional team in the construction of new ways of caring for the mentally ill.

CONCLUSION

In the transience of recent changes in mental health care in Brazil, it is observed that the professional practices in the psychiatric hospital setting, whether at the individual, family, or group level, point to the biomedical therapeutic and curative focus in mental health care, possibly reflected in the participants' training profile. Few advances or initiatives aimed at integral and humanized care to the person with mental disorder and his/her family were identified.

The study brings to the debate the need to rethink the care practices of the multiprofessional team in the psychiatric hospital in the context of health care actions developed, whether through embracement, self-care, or health education, qualifying them to the exercise of autonomy and freedom of the human being who experiences mental illness, in their life wishes and clinical perspectives. The need for greater financial and human resource investments in the area is recognized, in order to strengthen the implementation of the guidelines recommended by the Brazilian psychiatric reform and the provision of public policies in psychosocial care.

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REFERENCES

1. World Health Organization. Mental health: strengthening our response. 2016.
2. Organização Mundial da Saúde. Saúde mental. Brasília: OMS; 2020.
3. Brasil. Lei nº 10.216, de 06 de abril de 2001. Dispõe sobre a proteção e os direitos das pessoas portadoras de transtornos mentais redireciona o modelo assistencial em saúde mental. In: Diário Oficial da União. Brasília; 2001.
4. Brasil. Portaria n. 3.088, de 23 de dezembro de 2011. Institui a Rede de Atenção Psicossocial para pessoas com sofrimento ou transtorno mental e com necessidades decorrentes do uso de crack, álcool e outras drogas, no âmbito do Sistema Único de Saúde (SUS). Diário Oficial da República Federativa do Brasil; 2013.
5. Moreira DJ, Bosi MLM. Qualidade do cuidado na Rede de Atenção Psicossocial: experiências de usuários no Nordeste do Brasil. Physis. 2019; 29(2): e290205.
6. Baptista JA, Camatta MW, Filippon PG, Schneider JF. Singular therapeutic project in mental health: na integrative review. Rev Bras Enferm. 2020 ; 73(2):e20180508.
7. Brasil. Ministério da Saúde. Portaria no 3.588, de 21 de dezembro de 2017. Altera as Portarias Consolidação no 3 e no 6, de 22 dezembro de 2017, para dispor sobre a RAPS, e dá outras providências. In: Diário Oficial da União. Brasília; 2017.
8. Brasil. Ministério da Saúde. Nota técnica nº 11/2019 de 04 de fevereiro de 2019. Esclarecimentos sobre as mudanças na Política Nacional de Saúde Mental e nas Diretrizes da Política Nacional sobre Drogas. Brasília: CGMAD/DAPES/SAS/MS; 2019.
9. Sousa FSP, Jorge MBS. O retorno da centralidade do hospital psiquiátrico: retrocessos recentes na política de saúde mental. Trab. educ. saúde. 2019; 17(1):e0017201.
10. Souza DS, Arena VCA, Carrara BS, Moll MF, Mendes IAC. Exercício dos direitos humanos de pessoas institucionalizadas: percepção de profissionais de hospitais psiquiátricos. Rev. Bras. Enferm. 2020; 73 (1): e20180519.
11. Toledo VS, Oliveira A, Pacheco I, Garcia APRF. Psychiatric patient safety: nursing team perception. Rev enferm UFPE on line. 2019;13:e242325.
12. Nunes MO, Lima Júnior JM, Portugal CM, Torrenté M. Reforma e contrarreforma psiquiátrica: análise de uma crise sociopolítica e sanitária a nível nacional e regional. Ciên saúde coletiva. 2019; 24(12):4489-4498.
13. Santos RCA, Pessoa Júnior JM, Miranda FAN. Rede de atenção psicossocial: adequação dos papéis e funções desempenhados pelos profissionais. Rev Gaúcha Enferm. 2018; 39, e5744.
14. Mota AS, Silva ALA, Souza AC. Educação permanente: Práticas e processos da enfermagem em saúde mental. Rev. port. enferm. saúde mental. 2016; (spe4): 9-16.
15. Pinho ES, Souza ACS, Esperidião E. Processos de trabalho dos profissionais dos Centros de Atenção Psicossocial: revisão integrativa. Ciên saúde coletiva. 2018; 23(1), 141-152.
16. Creswell JW, Clark VLP. Pesquisa de métodos mistos. 2. ed. Porto Alegre: Penso; 2013.
17. Brasil. Ministério da Saúde. Cadastro Nacional de Estabelecimentos de Saúde - CNES.
18. Barbetta PA. Estatística Aplicada às Ciências Sociais. Santa Catarina (SC): Editora UFSC; 2007.

19. Furegato ARF, Osinaga VLM, Galera SAF, Pillon SC. Avaliação de instrumento para diagnóstico de atividades dos profissionais de saúde mental: estudo piloto. Cad Bras Saúde Mental. 2010; 2(3): 22-37.

20. Bardin L. Análise de conteúdo. Lisboa (PT): Edições 70; 2009.

21. Arcêncio, RA. Nursing as the profession of the future and the foundation of universal health systems. Rev Latino-Am Enfermagem. 2018;26:e3063.

22. Emerich F, Onocko-Campos R. Formação para o trabalho em Saúde Mental: reflexões a partir das concepções de Sujeito, Coletivo e Instituição. Interface (Botucatu). 2019; 23, e170521.

23. Rocha FLR., Gaioli CCLO, Camelo SHH, Mininel VA, Vegro TC. Cultura organizacional de um hospital psiquiátrico e resiliência dos trabalhadores de enfermagem. Rev Bras Enferm. 2016; 69(5), 817-824.

24. Maftum MA, Pagliace AGS, Borba LO, Brusamarello T, Czarnobay J. Mudanças ocorridas na prática profissional na área da saúde mental frente à reforma psiquiátrica brasileira na visão da equipe de enfermagem. Rev. Pesqui. (Univ. Fed. Estado Rio J., Online). 2017; 9(2):309-314.

25. Cunha VCA, Galera, SAF. Perfil das equipes dos centros de atenção psicossocial de uma região do estado de minas gerais. Arq. ciências saúde. 2016; 23(1) 32-36.

26. Franzmann UT, Kantorski LP, Jardim VMR, Treichel CAS, Oliveira MM, Pavani FM. Fatores associados à percepção de melhora por usuários de Centros de Atenção Psicossocial do Sul do Brasil. Cad Saúde Pública. 2017; 33(7): e00085216.

27. Silva EV, Ribeiro MC, Souza MCS. O cuidado e os processos de trabalho em um hospital de custódia e tratamento psiquiátrico sob a perspectiva de seus trabalhadores. Cad. Bras. Ter. Ocup. 2018; 26(2): 315-327.

28. Ely GZ, Terra MG, Silva AA, Freitas FF, Leite MT, Brum BN. Percepções do ser humano internado em unidade psiquiátrica sobre o viver com doença mental. Texto & contexto enferm. 2017; 26(3):e0280016.

29. Almeida JMC. Política de saúde mental no Brasil: o que está em jogo nas mudanças em curso. Cad. Saúde Pública. 2019; 35(11): e00129519.

Contribution:

JMPJr - Substantial contribution to the study design or data interpretation; Participation in the writing of the draft; and Participation in the review and approval of the final version

FSC - Contribution in the interpretation of the data; and Participation in the review and approval of the final version

ESC - Contribution to the analysis and final revision

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