

Work and illness risks in Territorial Psychosocial Care: implications for mental health care management

Trabalho e riscos de adoecimento na Atenção Psicossocial Territorial: implicações para a gestão do cuidado em saúde mental

Israel Coutinho Sampaio Lima¹, José Jackson Coelho Sampaio¹, Antonio Rodrigues Ferreira Júnior¹

DOI: 10.1590/0103-11042023139111

ABSTRACT The study aims to analyze precarious work due to working conditions that influence the management of mental health care and occupational health. This single case mixed study was conducted in six Psychosocial Care Centers (CAPS) in a Decentralized Health Sector. The Work and Illness Risks Inventory was applied to a total purposeful sample of 35 workers, 15 of whom participated in the projective interview. Data were processed in SPSS 26.0.0.0 as measures of central tendency and dispersion. The interviews were categorized based on the evaluation axes proposed by the inventory, contextualized, and discussed from Edgar Morin's Complex Thought. The result is critical for most predictors that evaluated the context, human cost, pleasure, distress, and harm related to work in the CAPS. Data illustrated by the workers' narratives describe the precarious work conditions. Local Unified Health System managers quickly incorporated neoliberalism's productivist principles, perpetuating substandard work conditions. Mental health care management processes, funding, and legal occupational and contractual conditions must be reviewed to align with Territorial Psychosocial Care (APT).

KEYWORDS Working conditions. Occupational health. Mental health services.

RESUMO O estudo busca analisar a precarização do trabalho por meio das condições laborais que influenciam a gestão do cuidado em saúde mental e a saúde do trabalhador. Trata-se de estudo de caso único, com abordagem mista, realizado em seis Centros de Atenção Psicossocial (Caps) de Área Descentralizada de Saúde. Aplicou-se o Inventário sobre Trabalho e Riscos de Adoecimento em amostra intencional total de 35 trabalhadores, dos quais, 15 participaram da entrevista projetiva. Os dados foram tratados no SPSS 26.0.0.0, expressos como medidas de tendência central e dispersão. As entrevistas foram categorizadas a partir dos eixos de avaliação propostos pelo inventário, contextualizadas e problematizadas a partir do pensamento complexo de Edgar Morin. O resultado é crítico para a maioria dos preditores que avaliaram o contexto, o custo humano, o prazer, o sofrimento e os danos relacionados ao trabalho nos Caps. Dados ilustrados pelas narrativas dos trabalhadores descrevem as condições do trabalho precário. Princípios produtivistas do neoliberalismo foram incorporados rapidamente pelos gestores locais do Sistema Único de Saúde, tornando a precarização do trabalho uma constante real. É preciso rever os processos de gestão do cuidado em saúde mental, financiamento e condições ocupacionais e contratuais legais, para que se alinhem com a Atenção Psicossocial Territorial (APT).

PALAVRAS-CHAVE Condições de trabalho. Saúde ocupacional. Serviços de saúde mental.

¹Universidade Estadual do Ceará (Uece) - Fortaleza (CE), Brasil.
isracoutinho@hotmail.com



Introduction

The vaunted modernization of labor rights currently in force in many countries, including Brazil, carries some elements that feature precarious work in the face of the loss of rights and social security, scrapping services, low wages, fluid recruitment rules and formats, and the non-guarantee of occupational safety¹, which has been implemented in the Territorial Psychosocial Care (APT) against the logic of building what was intended as a new paradigm for mental health care proposed by the Brazilian Psychiatric Reform Movement (MBRP).

Today, the modernized Consolidation of Labor Laws (CLT) is not aligned with the development of a State policy on mental health, which can offer psychosocial services aimed at the subject-family-caregiver-community in its entirety² and is the foundation for developing work in the APT, through which it seeks to build care through humanizing care, appreciating workers and producing interdisciplinary, community-based creative work, essential for individual and collective mental health². Thus, workers' health has been weakened due to insecure working conditions, especially given the possible psychosocial risks of practices developed in Psychosocial Care Centers (CAPS) services.

If nothing is done, mental health care management as a set of organizational theories and practices, amid the production of non-hierarchical, collaborative, and interdisciplinary work³, will tend to permanent fragmented care, communication, and human relationships. These tend to affect workers and the entire production chain required for implementing APT, which is the interrelationship between the users-family-caregivers-communities-professionals groups. It tends to extreme conditions that foster human body, mind, and soul illness due to the work conditions⁴.

To this end, we should debate this event in permanent dynamics in its agreements and disagreements so that the elements of precarious

work in the APT can be addressed in the real world. Therefore, the mixed and blended complexity of the parts and the constituent whole must be understood in their convergences, divergences, and contradictions⁵⁻⁷. Thus, the study analyzes work precariousness from the working conditions that influence mental health care and occupational health management.

Material and methods

This is a single case study⁸ on the influence of precarious work on mental health care and occupational health management in the APT anchored in methodological triangulation, employing critical, analytical⁹, quantitative/qualitative exploratory techniques, considering its complex, common, and longitudinal nature.

Its setting was six CAPS from the Decentralized Health Sector (ADS) of Crateús, Ceará, Brazil, comprising 11 municipalities, of which five had Caps, namely Crateús, Novo Oriente, Nova Russas, Monsenhor Tabosa, and Tamboril. The demand of clients of other cities – Ararendá, Independência, Iraporanga, Ipueiras, Poranga, and Quiterianópolis – present there is covered by services in neighboring cities, according to intermunicipal agreements or by local Primary Health Care services.

The ADS is a set of municipalities grouped by regional, socioeconomic, and cultural characteristics, which form a Health Region (RS). The Crateús ADS is, therefore, part of RS Norte, with a population size of 300,372 inhabitants in 2022¹⁰.

The study was divided into two stages, meeting the following inclusion criteria: mid-level or higher education-level professionals with at least six months seniority in the CAPS actively participating in these services' mental health care processes. Professionals on vacation, on sick leave, or with conflicts of interest were excluded.

Thus, the Work and Illness Risks Inventory (ITRA) was applied in the first stage. Projective interviews were held in the second stage. Fifty-one questionnaires were distributed in the first stage of the study, making up the 'total sample of CAPS workers' within the inclusion criteria, with (n=35) responses (31% loss). These professionals had the following types of employment relationships: public servants (12), temporary contracts (12), cooperative members (six), residents (three), and CLT contracts (two). This is, therefore, a total 'purposeful sample' organized into two groups:

- Group I – Coordinators (eight participants): five nurses, two social workers, and one psychologist.

- Group II – Healthcare Workers (27 participants): five nurses, nine psychologists, five social workers, two psychiatrists, two occupational therapists, one pharmacist, one pedagogue, and two nursing technicians.

ITRA consists of four scales: the Work Context Assessment Scale (EACT), the Work Human Cost Scale (ECHT), the Work Pleasure and Distress Indicators Scale (EIPST), and the Likert-type Work-Related Harm Assessment Scale (EADRT), developed by Ferreira and Mendes in 2003¹¹, with reissues in 2007¹² and 2008¹³. *Box 1* describes the organization of the ITRA scales.

Box 1. Information table of the Work and Illness Risks Inventory (ITRA) scales

Scale	Description	Values	Results
Work Context Assessment Scale (EACT)	It comprises three factors: work organization, working conditions, and socio-professional relationships.	1 = never 2 = rarely 3 = sometimes 4 = often 5 = always	≥ 3,7 = severe 2,3-3,69 = critical ≤ 2,29 = satisfactory
Work Human Cost Scale (ECHT)	It comprises three factors: physical cost, cognitive cost, and affective cost.	1 = not demanding 2 = little demanding 3 = more or less demanding 4 = quite demanding 5 = totally demanding	≥ 3,7 = severe 2,3-3,69 = critical ≤ 2,29 = satisfactory
Work Pleasure and Distress Indicators Scale (EIPST)	It comprises four factors: professional achievement, freedom of speech, lack of recognition, and lack of freedom of speech.	0 = never 1 = once 2 = twice 3 = three times 4 = four times 5 = five times 6 = six times or more	a) Pleasure experience: ≥ 4,0 = satisfactory 2,1-3,9 = critical ≤ 2,0 = severe b) Distress experience ≥ 2,0 = satisfactory 2,1-3,9 = critical ≤ 4,0 = severe
Work-Related Harm Assessment Scale (EADRT)	It comprises three factors: physical harm, psychological harm, and social harm.	0 = never 1 = once 3 = three times 4 = four times 5 = five times 6 = six times or more	≥ 4,1 = presence of occupational diseases 3,1-4,0 = severe 2,0-3,0 = critical ≤ 1,9 = bearable

Source: Mendes et al.¹² and Ferreira, Mendes¹³.

The inventory was designed based on the dimensions of the life-work interface and the subjectivation of these concrete fields, considering the context, effects, and causes that work implies in life, especially health, affecting workers' way of existing. Thus, the ITRA aims to investigate work and the resulting risks of illness by describing the work, occupational/psychosocial health, and safety contexts. The instrument was validated per Mendes et al.¹².

This article will present the data analysis on the classification of the primary means of the items on the EACT, ECHT, EIPST, and EADRT scales. The factors and predictors were analyzed as satisfactory, critical, or severe. Satisfactory indicates a positive result related to the production of pleasure at work. Critical indicates an average result, an indicator of an extreme situation, with negative costs and work distress, signaling an alert condition and requiring immediate measures in the short and medium term. Severe is a negative result, which produces human costs and work distress. It produces a substantial risk of illness and requires immediate action to address the causes and resolve them¹². Statistical analyses were performed using SPSS 26.0.0.0[®] software, and data were expressed as measures of central tendency and dispersion.

In the second stage, participants' adherence was reduced due to work overload, lack of time, non-availability of a restricted location to hold interviews, and fear about recording interviews, which would be recorded by Google Meet in view given content addressed, characterized by one of the respondents as 'politically conflicting' for professionals to remain in employment. Thus, 15 interlocutors participated in this phase, including:

- Group I – Coordinators (five participants): three nurses and two social workers.
- Group II – Healthcare Workers (ten participants): seven psychologists, one nurse, one occupational therapist, and one social worker.

The reduction in participants did not harm the analysis of the event since information saturation was reached, ensuring the quality and reliability of the interviews produced. The analysis occurred by organizing and systematizing statements per the ITRA pre-existing categories, which focus on assessing work organization, working conditions, socio-professional relationships, occupational health, professional achievement, freedom of speech, lack of recognition, and lack of freedom of speech.

Initial stage data were discussed grounded on Edgard Morin's Complexity Theory⁵⁻⁷ based on the critical analysis of the statements and literature relevant to the investigated object. It is, therefore, an active and creative proposal that contextualizes the problem in the face of reflections over uncertainties, incompleteness, and doubts about the objectivity that initially emerges in the observer-researcher's eyes.

This thought proposes to fight against the simplification of the event, which reduces the meanings before the multidimensional object, the non-linear cause-effect proposed by the retroactive circle, the mutual producer-product repercussion from the recursive circle's perspective, in which the aim is to break the event's duality through dialogical thinking, which seeks to promote the reintroduction of knowledge in all knowledge, given the object's historical, political, and social becoming⁵⁻⁷.

The Research Ethics Committee of the State University of Ceará approved the study under CAAE: 46699621.2.0000.5534 and Opinion N^o 4.784.241. The participant's anonymity was preserved through codes corresponding to the letter P= Professional, with the acronym CAPS, and the interview order, as in the following example: (PCAPS1).

Results and discussion

The results with the application of ITRA (n=35) in the EACT (*table 1*) showed a critical illness risk classification for the three factors:

work organization, socio-professional relationships, and working conditions, therefore indicating an extreme situation, with negative costs and distress derived from working in the APT.

The critical risk represented in the predictors underpinning work organization, socio-professional relationships, and working conditions factors of the EACT suggests strong characteristics and elements that represent and are concrete precarious work related to the excessive work pace, pressure to achieve tasks/goals, demand for results, and disrupted actions, with a possible division of labor³ due

to the organizational hierarchy established by local management regarding action planners and executors. This situation contributes to possible hurdles and power struggles and is, therefore, a set of factors escalating the work but not producing APT.

In this context, the organization of work and socio-professional relationships in the APT also suffer from the CAPS working conditions due to insufficient supplies and materials, inadequate and irregular facilities, acoustics, and furniture, which hamper mental health management and affects the occupational health of workers in these services.

Table 1. Classification of the means of the items of ITRA's Work Context Assessment Scale. Fortaleza, Ceará, Brazil, 2023

Scales	Factors	Items	Mean	Standard	Classification
				Deviation	
Work Context Assessment Scale (EACT)	Work Organization	The work pace is excessive	3,26	0,95	critical
		Tasks are completed under pressure of deadlines	2,86	1,22	critical
		There is strong pressure for results	2,97	1,2	critical
		The rules for performing tasks are strict	2,66	1,14	critical
		Performance is monitored	2,74	1,24	critical
		Expected results are unrealistic	2,43	1,14	critical
		Tasks are repetitive	3,23	1,21	critical
		The tasks performed are disrupted	2,86	1,33	critical
	Socio-professional relationships	There is a fine line between the planners and implementers	2,89	1,35	critical
		There are professional disputes in the workplace	2,4	1,58	critical
		Communication between staff is unsatisfactory	2,46	1,29	critical
		Tasks are not clearly defined	2,37	1,35	critical
	Work conditions	The number of people is insufficient to perform the tasks	2,91	1,31	critical
		Lack of time to take rest breaks at work	2,89	1,39	critical
		Working conditions are substandard	2,63	1,24	critical
The physical environment is uncomfortable		2,43	1,22	critical	
There is a lot of noise in the work environment		2,51	1,09	critical	

Table 1. Classification of the means of the items of ITRA's Work Context Assessment Scale. Fortaleza, Ceará, Brazil, 2023

Scales	Factors	Items	Mean	Standard	
				Deviation	Classification
	Work conditions	The existing furniture in the workplace is inadequate	2,6	1,31	critical
		Work tools are insufficient to perform tasks	2,94	1,06	critical
		The equipment required to perform the tasks is precarious	2,43	1,24	critical
		The physical space to perform the work is inadequate	2,4	1,22	critical
		Consumables are insufficient	2,57	1,12	critical

Source: Own elaboration.

Other studies with mental health workers provide results similar to the data in this research. The main problems are associated with the fragile public management of services, which has intense repercussions on work organization, socio-professional relationships, and substandard conditions of services¹⁴⁻¹⁶.

The PCAPS2, PCAPS3, PCAPS5, and PCAPS11 reports bring, as information, the illustration of the materialized predictors (*table 1*) referring to the organization of work and socio-professional relationships experienced on-site at the CAPS.

I went to a meeting at the Public Prosecutor's Office, and she looked at you, CAPS worker, and said: What will CAPS do? What? She had just attended a hearing with family and other services. It's as if the CAPS had to resolve this situation alone. Everyone was there: let's resolve it as a network! Let's join hands, services, family, social assistance, and justice. No, they don't see it that way. (PCAPS2).

The manager doesn't care if you're being crushed or getting sick. He wants you to do it. However, there was another recruited psychologist. We distributed the demands and started groups. Suddenly, he was removed, and our project stopped as I couldn't do it alone [...] His share of the demand returned to me. Intermittent work is very complicated. It affects the progress of the service. (PCAPS3).

People don't understand mental health and want patients to leave CAPS cured. Family members and the manager want us to find a way. The Health Secretary needs to understand the processes: he wants us to work as if we were a Family Health Strategy unit or a hospital [...] He exaggerates demands regarding results. (PCAPS5).

The Residence asks to provide shared care, but management and coordination say no. They force you to provide care; they say that CAPS investment is production, and CAPS will lose funds if you don't produce. The Municipality will not be able to finance CAPS alone. This situation hampers CAPS professionals from going to the field. (PCAPS11).

The reports mentioned above align with the statement by Fidelis et al.¹⁴, based on a study with professionals from CAPS I, CAPS alcohol and other drugs, CAPS children, and CAPS III from a municipality in inland São Paulo. The conditions that should be favorable for the discussion, planning, and development of work from the APT perspective are subverted by neoliberal¹⁴ and biomedical assistentialist² hegemony, which tends to cause instability in the SUS, given production unrelated to the principles of equity and comprehensive care and humanization required by the APT model.

In this context, working conditions indicate an inadequate number of professionals to meet demand, which tends to cause escalated

work due to the contingency of services amid insufficient or non-existent materials for developing work, besides discomfort, noise, and inadequate furniture (*table 1*), discussed by PCAPS1, PCAPS6, PCAPS9, and PCAPS12.

The structure of the building itself is old. It was a massive inconvenience during winter because it rains, and water enters through the roof. We need more rooms. Most of these rooms are unsuitable because the air conditioning is generally not working [...]. The space is small, with few chairs. The occupational therapist needs materials to perform her service; an adapted room is unavailable. The Medical and Statistical Archiving Service (SAME) has many records and needs more space to keep it as it should be. We only have one computer for all employees, systems, and reports. (PCAPS1).

[...] acoustics could be better. Something that could improve is the noise [...] it harms our health [...] and interferes with my work. I must try harder to stay alert, an energy I could save. Patients with extreme sensitivity to noise and phobias come here. (PCAPS6).

The professional psychiatrist has reduced hours. While I and other colleagues work eight hours a day [...], the psychiatrist works three shifts a week. So, many patients are left waiting. First, they go on a waiting list [...], and he will work with the pent-up demand of several days that still needs to be met. It turns out he's not even part of the team. He comes to provide service: diagnose, provide certificates, prescriptions, and referrals. (PCAPS9).

Weak employment contracts imply changing professionals. This ends up breaking the bond with the patient. This relationship of changing professionals is not a good thing: the patient feels abandoned. I have received patients who felt abandoned because the professional left. The patient needs to understand that the professional left for contractual reasons. (PCAPS12).

The statements show recursively⁷ the CAPS public management weaknesses. These, in

turn, trigger some harmful effects on developing mental healthcare management, such as fragile work relationships, which lead to work discontinuity, specialization, and centralization of mental healthcare practices restricted to CAPS; poor understanding of how APT works, which corroborates the insufficient continuing education for managers and other professionals in the territory and health education for family members/caregivers of clients of these services; and poor management of financial resources or deficiency, to adapt the structure, furniture, supplies of the CAPS, besides instability and duality⁷, which are the diverse and precarious types of employment relationships.

How could one develop a therapeutic project with fragile work relationships that may last less than twelve months? The therapeutic processes consolidated by APT knowingly aim to rebuild the autonomy and citizenship of CAPS clients through individual and collective actions to re-establish mental and physical health amid their socioeconomic conditions², on a pathway that seeks to project a new conscious, autonomous, and self-producing becoming.

We understand that the central cause from the viewpoint of the retroactive circle⁷ includes neoliberal principles, relaxing employment contracts, and reducing financing of SUS public services, according to the private market rules, which tend to require high production with a minimum commitment of resources⁴. Along this path, the constant becomes escalating work processes to meet the goal of high production (appointments, prescriptions, referrals, and certificates), assigning significant exchange value regarding the low production of mental health.

When analyzing the ECHT, we note that it had a critical risk classification for the affective, cognitive, and physical cost factors (*table 2*), indicating an extreme situation with negative cost and labor distress. Such results signal a warning when compared with data from the application of ECHT to nursing

workers in a reference psychiatric hospital in Teresina, Piauí¹⁷.

The affective and physical costs were satisfactory in the study in question. Only the cognitive cost was considered a critical risk due to the work complexity with clients with severe conditions, chronic situations, or who have been hospitalized for a long time¹⁷. It warns that this precisely occurs because this service originates from and is instead aligned with the Classical Asylum and Psychiatric

models²: the former is focused on the exclusion and marginalization of untreated clients; the latter centralizes mental illness in the face of biomedical-assistentialist and curative practices, which oppose the APT model, considered innovative and original because it stemmed from the community that formed the MBRP, which established the CAPS in its various classifications, as a replacement model for the hospital-centric/asylum model.

Table 2. Classification of the means of the items of ITRA's Work Human Cost Scale. Fortaleza, Ceará, Brazil, 2023

Scales	Factors	Items	Standard		Classification
			Mean	Deviation	
Work Human Cost Scale (ECHT)	Affective cost	Keeping emotions under control	3,46	1,24	Critical
		Dealing with contradictory instructions	2,37	1,21	Critical
		Having emotional costs	2,8	1,28	Critical
		Being forced to deal with the aggressiveness of others	2,54	1,4	Critical
		Disguising own feelings	2,8	1,45	Critical
		Having to be nice to others	2,37	1,52	Critical
	Cognitive cost	Having to solve problems	3,46	1,4	Critical
		Being forced to deal with unforeseen events	3,17	1,2	Critical
		Predicting events	2,37	1,19	Critical
		Using the memory	3,4	1,35	Critical
		Having intellectual challenges	3,03	1,38	Critical
		Making mental effort	3,2	1,51	Critical
		Having mental concentration	3,57	1,42	Critical
	Using creativity	3,74	1,15	Critical	
	Physical cost	Using vision continuously	3,03	1,44	Critical

Source: Own elaboration.

The PCAPS4, PCAPS7, and PCAPS13 reports discuss the implication of the affective, cognitive, and physical cost factors in their lives as CAPS workers.

Work makes us sick; it saddens us in some ongoing situations. I was working in reception, and a patient arrived looking for medication. She cursed me

because of the lack of medicines. I do so much for the service and this patient. The patient doesn't recognize it and doesn't see it. The medication issue is management. (PCAPS7).

Management often asks the CAPS team to carry out non-CAPS activities, such as how to support other campaigns that CAPS could develop, but

in another way, like the Pink October campaign. They put us on the street and the radio, and we do everything. However, that ends up shifting the focus. I already said, 'Let's work on health campaigns, not as support, but work with our public'. We often see ourselves performing actions that are not part of the CAPS at the request of the Health Secretariat. It generates moral and ethical stress. It makes sense that, while I'm doing this, I'm not doing a therapeutic group, serving a family, improving a patient, not prioritizing what I know should be prioritized. (PCAPS13).

I'm currently more into child labor [...] despite the lack of material [...]. I bring the material, which makes me stressed and irritated [...]. I saw that there was no point; I would get sick and would go crazy. It wouldn't solve the problem. Now, I bring the material to do quality work. (PCAPS4).

Given the statements, we can deduce that, even with the implementation of an APT network from scratch, in this ADS in Crateús, Ceará, Brazil, where psychiatric hospitals never existed, implementing the APT through the CAPS faces hurdles that do not substantially favor political and social acceptance of

the ideal ways to manage mental healthcare to produce authentic and positive impacts for the APT.

We see a clear overlap of actions repelling each other but coexisting in a predatory manner within the same system, given the struggle waged by the APT against the hegemony of the old models, such as the Classical Asylum and Psychiatry models. This factor was also reported in the study by Feitosa et al.¹⁸ on the models and paradigms guiding multidisciplinary work in CAPS in a Brazilian municipality, strongly associated with the understanding of public, curative, and medication-related health, which marginalizes and causes dependence¹⁹ in clients of such services.

The EIPST had a satisfactory risk classification related to work pleasure. Thus, it was a positive result associated with the dialogued production of work between the members of the CAPS teams. Concerning the appreciation and recognition factor, the illness risk classification was critical. Both professional burnout and lack of recognition had critical risks (*table 3*) and were characterized as extreme situations due to the negative cost and work distress.

Table 3. Classification of the means of the items of ITRA's Work Pleasure and Distress Indicators Scale. Fortaleza, Ceará, Brazil, 2023

Scales	Factors	Items	Mean	Standard		
				Deviation	Classification	
Work Pleasure and Distress Indicators Scale (EIPST)	Work pleasure	Freedom	Freedom with management to negotiate my needs	4,26	1,85	Satisfactory
			Freedom to talk about my work with colleagues	4,51	1,69	Satisfactory
			Solidarity among peers	4,89	1,39	Satisfactory
			Trust among peers	4,2	1,78	Satisfactory
			Freedom to express my opinions in the workplace	4,69	1,32	Satisfactory
			Freedom to use my creativity	5,09	1,15	Satisfactory
			Freedom to talk about my work with the bosses	4,49	1,6	Satisfactory
			Cooperation among peers	4,66	1,28	Satisfactory

Table 3. Classification of the means of the items of ITRA's Work Pleasure and Distress Indicators Scale. Fortaleza, Ceará, Brazil, 2023

Scales	Factors	Items	Mean	Standard			
				Deviation	Classification		
Work Pleasure and Distress Indicators Scale (EIPST)	Work pleasure	Professional achievement	Satisfaction	4,77	1,4	Satisfactory	
			Motivation	4,37	1,63	Satisfactory	
			Proud of what I do	5,34	1,21	Satisfactory	
			Well-being	4,4	1,58	Satisfactory	
			Professional achievement	4,74	1,34	Satisfatório	
			Appreciation	3,69	1,83	Critical	
			Recognition	3,46	2,06	Critical	
	Work distress	Professional burnout	Emotional exhaustion	3,49	2,13	Critical	
			Stress	3,63	2,07	Critical	
			Unsatisfaction	2,37	1,88	Critical	
			Overload	3,4	2,19	Critical	
			Frustration	2,83	2,04	Critical	
			Insecurity	2,54	2,13	Critical	
			Fear	2,14	1,99	Critical	
			Lack of recognition	Lack of recognition of my effort	2,31	2,15	Critical
				Lack of recognition of my performance	2,17	2,04	Critical
Depreciation	2,26	1,95		Critical			
		Outrage	2,29	1,9	Critical		

Source: Own elaboration.

Pleasure at work related to freedom and professional fulfillment was correlated in studies by Fidelis et al.¹⁴ and Trevisan et al.¹⁵, mainly with the excellent relationship and integration between team members, who tend to produce collective work in a given way, considering the professionals' sensitivity to understanding the problems faced by their peers in the face of CAPS clients' needs and issues.

Based on recursive thinking⁷, we understand that this work form is close to what is desired as APT, as it favors shared management and interdisciplinarity, as shown by PCAPS10 and PCAPS14.

[...] There is much dialogue with the current coordinator, a whole issue considered so that you are well. He has that perspective and is a partner. As a coordinator who knows CAPS comes in and

familiarizes with the health structure with a modern mindset. He treats the client as a person with rights, making us more comfortable. (PCAPS10).

Interdisciplinary group work is positive. It flows better; we interact more with patients, and our peers collaborate whenever we need individual care. You call, they come, they are available to work with you, depending on your needs. We feel safer making some decisions, even regarding the service. (PCAPS14).

Appreciation and recognition tend to be unsatisfactory due to the effects caused by professional burnout and lack of recognition, which generate work distress from work overload and the devaluated mental health production developed by CAPS workers. These effects were reported in studies with CAPS

professionals by Fidelis et al.¹⁴ and Trevisan et al.¹⁵, and can be better illustrated in the reports of PCAPS11 and PCAPS15.

[...] The doctor doesn't punch the clock at CAPS, and we must. If he earns ten times more than me, how do we feel? The coordinator needs to fill in the doctor's hours. Why the pressure on mine? Why can one do it and the other not? Despite this, the CAPS team has a good relationship with professionals and the coordination office. There is no gossip or anyone wanting to take each other down. What makes us sick is work overload, devaluation, and lack of recognition. (PCAPS8).

I felt very distressed because of the pressure: people demand care because we have a huge demand. People demand it because their sons are autistic... Our hands are tied for a demand like this, with people pressuring us. We try to do our best to serve everyone but find ourselves in a desperate situation. (PCAPS15).

The lack of or deficient actions that seek to appreciate and recognize workers for their

commitment and dedication to the service provided in mental healthcare were also reported in studies by Fidelis et al. (2021)¹⁴, Trevisan, Haas, and Castro (2019)¹⁵, Sousa et al. (2018)¹⁷, and Feitosa et al. (2022)¹⁸, when considering the density and complexity of the type of occupation. Working conditions tend to increase emotional burnout, stress, dissatisfaction, overload, frustration, fear, and indignation in the face of contradictory and antagonistic conduct against the APT model, which should be implemented by SUS management in its entirety.

Finally, the EADRT analysis had a severe risk classification for the headache item, suggesting occupational disease risk, which requires immediate action on the causes to eliminate or relieve the effects. The other items of the physical, social, and psychological damage factors were classified as critical risk, which results in negative costs and distress correlated to the work performed in the CAPS (table 4).

Table 4. Classification of the means of the items of ITRA's Work-Related Harm Assessment Scale. Fortaleza, Ceará, Brazil, 2023

Scales	Factors	Items	Mean	Standard Deviation	Classification
Work-Related Harm Assessment Scale (EADRT)	Physical harm	Body pain	2,66	2,07	Critical
		Headache	3,17	2,16	Severe
		Back pain	3	2,01	Critical
		Sleeping disorders	2,94	2,22	Critical
	Social harm	Willingness to be alone	2	2,34	Critical
	Psychological harm	Sadness	2,11	2,05	Critical

Source: Own elaboration.

As seen in the studies by Trevisan et al.¹⁵ and Sousa et al.¹⁷, health problems arising from working in mental health services are frequent, leading to psychological illness, represented by sadness, dullness, anxiety, and physical harm, such as headache, muscle/joint pain, sleep

disorders, which affect workers' social and family routine, due to their desire to be alone and isolated. Next, the reports from PCAPS2, PCAPS3, PCAPS9, and PCAPS11 discuss physical, social, and psychological harm, shown in table 4, derived from work in the CAPS.

I never thought about submitting to psychotherapy because of work. I had to take a sleep-inducer. My mind was working a mile a minute. It's mental, but it affects the physical. I felt pain in my limbs, head, back, and neck. It consumes you in a way that you don't realize [...] I no longer had a life. (PCAPS2).

It's that thing... coming to work sick is normal. If I get sick, I have to come in sick. I'm burdened with self-harm and attempted suicide demands. I feel worn out most days, without the strength to listen to anything else, due to the excessive amount of calls. The work environment is heavy, and that is sickening. (PCAPS3).

I currently work, and we pretend everything is fine. Everyone is pretending that everything is fine. However, the professionals are sick, with physical problems and low immune systems due to work. The amount of work we have due to the low resolution, which generates a feeling of frustration and does not depend only on us, relies more on network factors, managers, and socioeconomic implications. (PCAPS9).

I see illness as a result of work overload, which manifests through medical certificates. We have medical certificates due to stress, hypertension, and high blood sugar levels, compounded by work issues, making me ill. I had to put in a certificate to rest and escape it all. (PCAPS11).

At this point, reintroducing all knowledge in discussing reflection-action⁵⁻⁷, we understand that substandard working conditions in the APT in the studied setting have affected the development of the productive mental health processes of the CAPS and possibly harmed workers' occupational health. Moreover, this is precisely due to the ambiguity and contradictions promoted by neoliberal productivist principles that undermine APT work. First, by superimposing the actions of old, retrograde models on the new progressive ones in the face of underfunding and scrapping.

Conclusions

In this context, implementing CAPS has yet to facilitate work processes aligned with the APT model entirely. Its mental health care management ways are subverted by political and social non-acceptance, non-addicted to old models, which tends to affect the fragmented actions and the deficient structure, insufficient supplies/human resources for the CAPS, and workers' illness.

We observe that the model tended to be amorphous rather than hybrid in the CAPS of this region, with different employment relationships among public servants, temporary contractors, or cooperative members, which continue in their isolated cores under the productivist principles of neoliberalism quickly incorporated by local SUS managers, preserving substandard work, which distances itself from SUS principles of universality, comprehensiveness, and equity of care. Furthermore, workers' appreciation should have been remembered.

It is urgent, therefore, to implement the National Humanization Policy as an innovative strategy to improve the organizational and structural conditions of the SUS network, the recognition of its workforce, and the review of mental health care management processes, financing, and legal occupational and contractual conditions to align with the APT.

The sample size is the limitation of this study. However, all CAPS professionals in the municipalities were invited to participate. The interviews allowed greater solidity for data interpretation, discussion, and understanding.

Collaborators

Lima ICS (0000-0002-1929-6142)* contributed to the preparation, conception, and design of the work; and acquisition and analysis of information for the work. Sampaio JJC (0000-0003-4364-524X)* contributed to the

conception of the work, critical review of the relevant intellectual content, and final approval of the version to be published. Ferreira

Júnior AR (0000-0002-1057-8688)* contributed to the critical review of the relevant intellectual content. ■

References

1. Standing G. O precariado: a nova classe perigosa. 1. ed. Belo Horizonte: Autêntica Editora; 2019.
2. Sampaio JJC, Guimarães JMX, Abreu LM. Supervisão clínico-institucional e a organização da atenção psicossocial no Ceará. 2. ed. Fortaleza: EdUECE; 2019.
3. Guimarães JMX. Inovação e gestão em serviços de saúde mental: incorporação de tecnologias e reinvenção no cotidiano dos Centros de Atenção Psicossocial. [tese]. Fortaleza: Universidade Estadual do Ceará; 2012.
4. Casulo AC, Silveira C, Alves G, et al. Precarização do trabalho e saúde mental: o Brasil da era neoliberal. Bauru: Canal 6; 2018.
5. Morin E. A cabeça bem-feita: repensar a reforma e reformar o pensamento. 20. ed. Rio de Janeiro: Bertrand Brasil; 2000.
6. Morin E. Ciência com consciência. 6. ed. Rio de Janeiro: Bertrand Brasil; 2002.
7. Morin E. Introdução ao pensamento complexo. 5. ed. Porto Alegre: Sulina; 2015.
8. Yin RK. Estudo de caso: planejamento e métodos. 5. ed. Porto Alegre: Bookman; 2015.
9. Minayo MCS, Souza ER, Constantino P, et al. Métodos, técnicas e relações em triangulação. In: Minayo MCS, Assis SG, Souza ER, organizadores. Avaliação por triangulação de métodos: abordagem de programas sociais. Rio de Janeiro: Editora FIOCRUZ; 2005. p. 71-103.
10. Instituto Brasileiro de Geografia e Estatística. Censo estimado dos municípios Ararendá, Independência, Ipaoranga, Ipueiras, Poranga e Quiterianópolis, Crateús, Monsenhor Tabosa, Novo Oriente, Nova Russas e Tamboril, para o ano de 2022.
11. Ferreira MC, Mendes AM. Trabalho e riscos de adoecimento: o caso dos auditores fiscais da Previdência Social brasileira. Brasília, DF: Edições LPA/FENAFISP; 2003.
12. Mendes AM, Ferreira MC, Cruz RM. Inventário sobre Trabalho e Riscos de Adoecimento – ITRA: Instrumento auxiliar de diagnóstico de indicadores críticos no trabalho. In: Mendes AM, editora. Psicodinâmica do Trabalho: teoria, método e pesquisas. São Paulo: Casa do Psicólogo; 2007. p. 111-26.
13. Ferreira MC, Mendes AM. Contexto de Trabalho. In: Siqueira MMM, organizadora. Medidas de comportamento organizacional: ferramentas de diagnósticos e gestão. Porto Alegre: Artmed; 2008. p. 111-23.
14. Fidelis FAM, Barbosa GC, Corrente JE, et al. Satisfação e sobrecarga na atuação de profissionais em saúde mental. Esc Anna Nery Rev. Enferm. 2021; 25(3):1-5.
15. Trevisan E, Haas VJ, Castro SS. Satisfaction and work overload at Psychosocial Care Centers – Alcohol and Drugs in the Minas Triangle region, Brazil. Rev. Bras. Med. Trab. 2019; 17(4):511-20.

*Orcid (Open Researcher and Contributor ID).

16. Leal RMAC, Bandeira MB, Azevedo KRN. Avaliação da qualidade de um serviço de saúde mental na perspectiva do trabalhador: satisfação, sobrecarga e condições de trabalho dos profissionais. *Psicol. Teor. prá.* 2012; 14(1):15-25.
17. Sousa KHJF, Lopes DP, Nogueira MLF, et al. Risco de adoecimento e custo humano em um hospital psiquiátrico. *Esc. Anna Nery Rev. Enferm.* 2018; 22(2):1-9.
18. Feitosa JBA, Lima ICS, Santos SD, et al. Modelos e paradigmas orientadores do trabalho multiprofissional em Centros de Atenção Psicossocial em um município brasileiro. *Rev. port. enferm. saúde mental.* 2022; (28):8-27.
19. Viana GV, Cavalcante ASP, Marinho MNASB, et al. El ser autónomo y/o dependiente en la mirada de los usuarios de atención psicosocial frente al consumo de alcohol y drogas. *Enferm. Comunitaria.* 2022; 18(supl):e14066.

Received on 05/16/2023

Approved on 08/24/2023

Conflict of interests: non-existent

Financial support: non-existent