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RESEARCH

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Satisfaction and work overload evaluation of employees' of Psychosocial Care Centers*

Avaliação da satisfação e sobrecarga de trabalho dos trabalhadores dos Centros de Atenção Psicossocial

Evaluación de la satisfacción y sobrecarga de trabajo de los trabajadores de los Centros de Atención Psicosocial

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ABSTRACT

Objective: to evaluate the quality of the services and the satisfaction level of health professionals in relation to the work overload in Psychosocial Care Centers in the municipality of Campina Grande, Paraíba. **Methods:** a quantitative and analytical study. The study included 49 professionals, graduated and technicians. The data were collected between August and September 2014. Data were double entered and its consistency was assessed with "Validate the Epi Info 3.5.4" and "SPSS 17.0". **Results:** temporary work elements were observed, such as instability and vulnerability. Regarding the satisfaction degree relating the security measures, working conditions, PSCC comfort and appearance, contact between the teams, users and family, most workers showed dissatisfied and overloaded at work. **Conclusion:** it has been concluded that there is a need for continuous evaluation and improvement of the working conditions in order to minimize the work overload of the health professionals.

Descriptors: Evaluation, Mental Health, Satisfaction.

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RESUMO

Objetivo: avaliar a qualidade dos serviços e o nível de satisfação dos profissionais de saúde em relação à sobrecarga de trabalho nos Centros de Atenção Psicossocial do município de Campina Grande, Paraíba. **Métodos:** estudo qualitativo, analítico. Participaram do estudo 49 profissionais de saúde de nível superior e médio. Coletaram-se os dados entre agosto e setembro de 2014. Os dados foram duplamente digitados e a consistência avaliada com auxílio do *Validate* do Epi Info 3.5.4 e do SPSS 17.0. **Resultados:** observaram-se elementos do trabalho temporário, como instabilidade e vulnerabilidade. Quanto ao grau de satisfação relativo às condições de trabalho, conforto e aparência dos CAPS, apoio da gestão, a maioria dos profissionais mostrou-se insatisfeita e sobrecarregada no trabalho. **Conclusão:** concluiu-se pela necessidade de avaliação permanente e melhorias das condições de trabalho, de modo a minimizar a sobrecarga de trabalho dos profissionais de saúde.

Descritores: Avaliação, Saúde Mental, Satisfação.

RESUMEN

Meta: se objetivó evaluar la cualidad de los servicios y el nivel de satisfacción de los profesionales de salud en relación a la sobrecarga de trabajo en los Centros de Atención Psicosocial de Campina Grande, Paraíba. **Métodos:** estudio cuantitativo, analítico. Participaron del estudio 49 profesionales de salud de nivel superior y secundario, entre agosto y septiembre de 2014. Los datos fueron evaluados con EpiInfo 3.5.4 y SPSS 17.0. **Resultados:** se observó elementos del trabajo temporario como instabilidad y vulnerabilidad. Cuanto al grado de satisfacción relativa a las medidas de seguridad, condiciones de trabajo, conforto y apariencia de los CAPS, contacto entre los equipos y usuarios y familia, la mayoría de los profesionales se mostró insatisfecho y sobrecargados en el trabajo. **Conclusiones:** se concluyó por la necesidad de evaluación permanente y mejorías de las condiciones de trabajo de modo a minimizar la sobrecarga de trabajo de los profesionales de salud.

Descriptores: Evaluación, Salud Mental, Satisfacción.

NTRODUCTION

The Brazilian Psychiatric Reform began in the late 70s of the twentieth century with the Movement of Workers in Mental Health, known as the Antimanicomial Struggle Movement. Influenced by the Italian transformation model, the Brazilian Antimanicomial Struggle Movement pointed to deinstitutionalization as a fundamental premise in the reorganization of services and mental health practices.[1]

The National Mental Health Policy, present in Brazil, aims to progressively reduce beds in psychiatric hospitals, expanding, qualifying and strengthening the extra-hospital network through the implementation of substitutive services such as: Psychosocial Care Centers (PSCC), Therapeutic Residential Services (TRSs) and Psychiatric Units in General Hospitals (PUGH) - including mental health actions in primary care, implementation of comprehensive care policy for alcohol and other drug users, Back to Home Program, among others.[2]

The shift in the care of psychiatric patients from the hospital context to community-based services aimed at social reintegration, reduced hospitalizations, adherence to treatment and the fulfillment of patients' clinical and non-clinical needs, in a way that promotes their quality of life.[3] The psychosocial model involves collective practices, horizontality of relationships, family and user participation in treatment, emphasizing on social reintegration and the conception of psychosocial rehabilitation.

This transformation, in many moments, is experienced by the PSCC worker as a factor of pleasure and/or suffering at work.[4]

In observing the presented context, it is verified that the work in mental health represents great challenges, due to its complexity; these challenges include several interfaces, ranging from the restructuring of services to the quality of care provided, to working relationships and to the adoption of new knowledge, technologies and work methodologies.[5]

Overload and dissatisfaction can affect the general health of the worker, including its mental health, and can cause damages not only in its professional life, but also in social and behavioral aspects,[6] especially since one deals with suffering and madness on a daily basis, which makes the environment permeated by intense subjective and intersubjective production.[5]

In addition, authors point out that mental health practices in health services coexist with increasing productivity pressure in an extremely competitive environment in which the individual must always be ready to change and adapt to the demands of the market.[7] Thus, tensions and advances in services arise, which are in constant transformation, as new experiences and practices are reformulated and reinvented.[8]

In view of these issues and also in view of the process of reorganization of the UHS and the mental health care network, several authors have already appraised the PSCC evaluation process with the purpose of evaluating the functioning of these services taking into consideration its physical structure, human resources, working conditions, satisfaction and overload of the health professional, among others.[9] From this perspective, satisfaction studies can contribute to the institutionalization of evaluation and reorganization of services, besides being a tool for the participation of health professionals.[10]

Understanding the influence of the work organization on the quality of life, mental health, physical weariness and illnesses of workers becomes essential for understanding and intervening in work situations that can lead to various forms of suffering, illnesses and exclusion.

It is assumed that the structure and the work process of the PSCC interfere with the satisfaction, work conditions and workload of the professionals. Based on this proposition, the main objective of this article is to evaluate the quality of services and the level of satisfaction and overload of health professionals in relation to the work developed in Psychosocial Care Centers.

METHODS

A qualitative study, conducted in Campina Grande, a municipality located in the state of Paraíba. The city's extra hospital network of mental health services has eight PSCC (one PSCC AD, two PSCC I, one PSCC II, one PSCC III and three PSCCi), one Coexistence Center and six Therapeutic Residences. Five PSCC were selected based on the administrative division of the municipality. Two of these substitutive services are classified as type I; One of type II and one of III, in addition to a PSCC AD. The two substitute services of the PSCC I modality are located in the sanitary districts of Galante and São José da Mata, being a reference for three surrounding municipalities within the state of Paraíba: Fagundes, Puxinanã and Boa Vista.

The data were collected between August and September 2014, from a population of 56, with a sample of 49 health professionals (college degree, technicians and caregivers), determined by probabilistic sampling with proportional allocation. To be included in the study, they should meet the following criteria: to have completed their training for at least one year; to have been working at the PSCC for at least six months and to have been active at the time of data collection. Were excluded health professionals who, in addition to the PSCC, worked in other substitutive services, such as therapeutic residences, psychiatric emergencies and others; professionals that performed activities other than the direct care of the institution's user, such as administrative area, general services and patrimonial guards, and also those who refused to sign the Free and Informed Consent Term.

A self-administered questionnaire was used as a data collection instrument with questions directed to the research objectives, based on a questionnaire validated and adjusted to this purpose.[11] The contact with the health professionals was made in the service and the questionnaire was applied in private rooms at the PSCC, according to the participants' preference.

Data analysis followed the operationalization of the three stages of the thematic analysis.[12] The first stage or pre-analysis consisted of the exhaustive reading of the interviews (floating reading), followed by the organization of the material (constitution of the corpus) and the formulation of hypotheses. The second stage involved the exploration of the material, in which the raw data was coded. Finally, the treatment of the results and interpretation was performed, presenting them in thematic units. The analysis and interpretation of the data allowed the recognition of structures of relevance, converging in the identification of primary codes and code groups, which allowed the construction of five thematic units, presented with textual parts.

In order to meet the ethical aspects in research with human beings, this study followed the requirements of Resolution 466/2012 of the National Health Council of the Ministry of Health, submitted and approved by the Research Ethics Committee of the Federal University of Rio Grande do Norte (CEP/UFRN), Protocol No. 719,435, 05/30/2014; CAAE: 30409814.30000.5537. To guarantee the confidentiality and anonymity of the participants, the workers were identified by the initial letters of the category, such as: (N) nurse, (NT) nursing technician and (SW) social worker, (PED) pedagogue, (PHY) physiotherapist, followed by numbering, numerical sequence, as they were collected.

RESULTS AND DISCUSSION

The sample consisted of 27 graduated professionals (six nurses, seven psychologists, three social workers, a pharmacist, a speech therapist, two physical education professionals, six pedagogues and a physiotherapist) and 22 technicians (18 nursing technicians and three caregivers), accounting for 49 subjects in total.

In this study, were observed a higher percentage of females (91.8%) and with no companion (51.0%). The distribution by age group showed a predominance of professionals between 30 and 39 years (57.1%), followed by 40 to 49 (18.4%), 20 to 29 (16.3%) and 50 to 59 (8, 2%). The majority had between 11 and 20 years of study (79.4%); of which 42.9% had completed graduate studies.

With regard to working conditions, the work relation most prevalent were the Consolidation of Labor Laws (CLL) or temporary/emergency contract 38(77.6%). The majority worked 40 hours a week 37(75.5%) and earned a salary equal to or less than one thousand reais 24(50.0%). Regarding working time, 38.8% work in PSCC between six and 10 years, and 23(46.9%) have been in the PSCC where they are currently leased for more than five years. Of the total, 27(55.1%) work in places other than PSCC.

In the qualitative analysis, when considering the factors related to the working conditions of the PSCC from the point of view of health workers, three sense nuclei were identified: the overload of work in the PSCC, the commitment of the management and the organization of the flow of care.

The discussion of the results will be carried out considering the identified nuclei of meaning, highlighting the speeches of the research subjects.

Work overload in the PSCC

The analysis of the discourses showed the existence of overload in the work of health workers of the PSCC, derived from both inadequate working conditions (insufficient personal distribution, lack of material) and work organization that includes the prescribed operative mode. This reality can be demonstrated in the following discursive manifestations in relation to the aspects that contribute to the overload, such as: "The responsibilities that the service demands, a significant number of assignments and a decrease in the number of professionals in the sector" (PSY 20); "Precarious work conditions, sometimes lacking material for workshops" (N 23);

"Doing activities that are not my responsibility (reception, secretary)" (NT 16); "The number of health professionals is not sufficient to meet the demand at the PSCC" (PED 10). The accumulation of functions per health professional weakens and interrupts the initiatives of formation of bonds between workers and users, providing obstacles to the effectiveness of the performance of health actions. Added to these factors is the daily contact with people in psychological distress, constituting a scenario that reflects on the satisfaction and, consequently, on the well-being and mental health of the worker, with a perceived influence on the quality of the care provided to the users and, therefore, of services.[13]

Such statements corroborate with the data observed in other studies developed with the professionals of the substitutive services in mental health. Among the reasons for dissatisfaction, there are complaints about the lack of human and material resources in the services,[14-5] such as lack of personnel and adequate facilities, of materials for the realization of workshops, of a vehicle for home visits, of food for the meals of the patients. It is noteworthy that those aspects that generate overload and dissatisfaction, regarding the quality of services offered, are those that do not depend directly on the performance of the professionals interviewed.

Overload and dissatisfaction can affect the general health of the worker, including its mental health, and cause damages not only in his professional life but also in social and behavioral aspects,[6] especially because one deals daily with suffering and madness, which makes the environment permeated by intense subjective and intersubjective production.[5]

Another perception presented by health workers is the association of the overload with the number of work contracts, low salary and exorbitant working hours. The following excerpts better illustrate this consideration: "I work in more than two mental health services. The fact that I have to commute from one service to another is an overload, it is very tiring! "(PHAR 49); "For the lack of human resources to share the demand for care. Low salary and exhaustive workload (ST 3)"; "Many assignments. Besides, a 40-hour working journey"(E11).

PSCC work is often considered demanding and exhausting by many professionals who participated in the study. Such a situation, in addition to generating weariness, can increase insecurity on the part of the workers and of the population in relation to the services provided.

The result of the present study is in tune with those of the study carried out with professionals of the Family Health Strategy, which pointed out the following situations as factors of attrition related to the organization and the work process: shortage of personnel, lack of material resources, work overload, lack of autonomy, interpersonal relationship, devaluation, low salaries, great responsibility and emotional overload.[16]

It is evident that the demands of health workers are numerous. In addition, insufficient remuneration may be responsible for the need to maintain another working contract. It is known that it is indispensable to broaden the look on working conditions, salary valorization, among others. Studies state that underpaid compensation may be responsible for the need to maintain another work contract, which causes the worker to sacrifice his/her rest and leisure time to keep more than one job.[17]

In this sense, in using the proposed Human Resources policy as one of the structuring axes of the UHS, work management must seek the appreciation of the work and of the worker; the treatment of conflicts of interest; the humanization of labor relations, which should become a management agenda in order to revert the working conditions that compromise both the quality of the services produced and the worker's quality of life.[18]

Management commitment

The study participants emphasized the need for a more participatory management follow-up in relation to the PSCC work, with clinical supervision of health professionals, investment in infrastructure, among others. The following statements of the study participants point to the difficulties faced regarding the service, that deserve attention and actions to which they are legally entitled, although they are not respected by the management: "With the right destination of the funds. With infrastructural organization and work material resources ... With clinical and institutional supervision with the discussion of cases and therapeutic projects in the meetings "(PED 37); " The management could give more professional recognition, invest in infrastructure, financial investment, financial valorization of the professional, increase of human resources for better care" (N 29).

The hegemonic managerial rationality pursues the utopia of reducing the subject who works to an object, to a malleable resource according to the planning and programs defined by the management or by "who understands the subject", in general, specialists who think and plan far from the space where the work is carried out.[19] It is noticed that there are many obstacles faced by health professionals in the day-to-day life of PSCC, due to the great demand for care, poor working conditions and limitations of teamwork, in view of the lack of clinical supervision of the health professionals, of discussion of clinical cases, among others.

Similar findings were found in a study carried out in Fortaleza, Ceará, where workers reported: unsatisfactory working conditions from the point of view of physical facilities, with small and/or inadequate spaces for the development of activities, shortage of materials and equipment, shortage of professionals leading to the formation of small teams and work overload, low wages and precarious employment relations, with insufficient in-service training.[5]

The performance of the mental health team in substitutive services has been marked by advances in the construction of

the psychosocial care model, but marked by the emergence of contradictions and a large problem intrinsic to the process of implanting these equipments, with repercussion in the work process configuration, in the relations between the different actors, in the satisfaction and in the workers pleasure/suffering dynamic.[20]

In this regard, the study participants emphatically pointed out the disregard of the management in the hiring process of health professionals to work in the PSCC, as can be identified in the speeches: "The Health Department should be more careful about who it hires, especially in the mental health demand, since there are many professionals who do not even know what PSYCHIATRIC REFORM is "(professional emphasis) (N 28); "Leaving party politics aside, focusing on service. In addition, investing in capacity building and improving the physical structure "(PSY 13).

It is observed in the discursive manifestations, that the list of services falls far short of the necessity, especially with regard to the recruitment and selection of personnel for mental health care. The situation is aggravated by the fact that the statements depict an organizational model in which the inevitable departmentalization stipulates a command and a vertical management line that induces the fragmentation of the work process.[21]

In this way, we can understand that the construction of these actions becomes a great challenge considering that the initial relations are fragile and the process of construction of a new proposal, that must be agreed between different actors (manager, worker and users), presupposes a negotiation which involves the assumption of responsibilities and the sharing of tasks that are not always easy to handle.[22-3]

The misunderstanding of the management team regarding the work process and attributions of the health professionals was another difficulty reported by the study participants. It is possible, in some situations, to perceive a divergence regarding the work process of the team and the management model.

As presented in the following excerpt, in which the health professional describes recognizing and prioritizing the demands that arise in the work environment, although, it does not have competence and support of the management team to solve the problems. The following passage illustrates this discussion: "I believe there are issues that do not depend on me to solve. In fact, I am distressed by the fact that I want to do some things and I cannot, I'm dependent on people who do not care about the service "(N 28).

Another relevant aspect to the organization of the management of the health services system concerns the decisions of the manager on the health actions to be developed, taking into account the opinion of the team on the needs of the users. The anguish and insecurity brought by the professionals can be read as being specific to the work in contact with the suffering, but it also expresses certain want of protection of these professionals by the lack of theoretical and technical resources for the work.[24]

This situation results in obstacles to humanized care since this activity is faced with situations that depend on the political will of other hierarchically superior professionals. Thus, the need to (re)think strategies in the healthcare process of users with mental disorder is emphasized since such attention devices need to be constantly evaluated, so that it is not lost in its characteristics and so that the psychiatric reform can reach its ends properly.[25]

Also important is the expansion and qualification of the team supervision, inclusion of discussions and planning instances in the daily services, as well as decentralized and democratic management processes.[26] Permanent Education is, therefore, an important instrument for the evaluation, regulation and follow-up in the health sector, once it is established as a possible strategy in the restructuring of services, based on the analysis of the social and economic determinants, but, above all, on the values and concepts of the professionals.

Organization of the service flow

The study participants point out that the network is fragile, not offering other devices for psychosocial attention. Regarding the organization of the assistance network of the municipality, this is how the professionals are positioned: "With the organization of the assistance network of the municipality to attend to light and stabilized cases which are in the PSCC without any need" (PED 37); "Organization of reference and counter-reference flow and better integration with the Family Health Strategy" (NT 35).

It is observed that the lack of flexibility in the dynamics of the care increases the risk of structures becoming embedded, so that the user is not able to circulate in the health care network and, consequently, is impaired with respect to its mental health and its rights as a citizen.

The need for a reorganization of health services is therefore considered, since the foundations of the Unified Health System still doesn't seem to be incorporated into the organization of the system and, consequently, into the actions of professionals who work in this context[27]. The fragmented network of attention has, as a consequence, the "abandonment" of the community, because when selecting problems based on a specialty, or worse, according to a type of "mental illness", people are abandoned to themselves, and their experiences are often problematized.[27]

Faced with this, it is necessary to think about the continuity of care to the user in the community in a more committed way, in a manner that this process is not limited to the performance of each team professional, who individually, seeks the resolution of the demands.[26] It

is necessary to move from a supply management model to a population health management model. The first is a management model that is incompatible with the generation of value for users because it focuses on the provision of services and not on the needs of the user population.[28]

Another important challenge is to implement mental health teams in basic health units and family health units, qualified to meet this type of demand. The deep knowledge on the population that uses a health care system is the basic element that makes it possible to break with the supply-based management characteristic of fragmented systems and to establish a management based on the health needs of the population or population-based management, an essential element of the Health Care Networks (RCN).[28]

In addition, there is a need to increase the number of beds in general hospitals for the hospitalization of people when the symptoms of mental illness become more acute, observing protocols of entry and exit in each care service so that the user and the treatment are not lost In the middle of the course.[29]

CONCLUSION

The present study made possible an evaluation of five PSCC from the perspective of health professionals. It was observed from the results, a precarious work mediated by the instability and vulnerability due to temporary work. In addition, the results show dissatisfaction and overload of health professionals related to precarious working conditions in PSCC, to the comfort and the appearance of the PSCC, to support of municipal management, among others.

Finally, the need to deepen the issues raised was explored, expanding the discussion to the context of Mental Healthcare, it implies a shared responsibility of managers, workers, users and educational institutions for the construction of a humanized and efficient health system.

From the reflections carried out in this study, it is suggested as a management priority: to guarantee the basic structure necessary for the development of actions, which involves adequate facilities, material resources, transportation and professionals, among others; to review the hiring criteria for mental health care professionals; to organize flow of care, as directed by Administrative Rule no. 4,279 that guides the organization of health care networks within the SUS and Decree n. 7.508/11, surpassing a purely biological approach to an integral approach; to invest in the realization of Permanent Education in Health Programs and in the offer of incentives for the professionals that work in the network of Mental Health Attention and to provide spaces for reflection on the daily practice, avoiding that the services develop activities according to which each professional believes to be correct.

REFERENCES

1. Hirdes A. A reforma psiquiátrica no Brasil: uma (re)visão. Cien Saude Coletiva. 2009;14(1):297-305.
2. Barros S, Salles M. Gestão da atenção à saúde mental no Sistema Único de Saúde. Rev Esc Enferm USP. 2011;45(2):1780-5.
3. Leal RMAC, Bandeira MB, Azevedo KRN. Avaliação da qualidade de um serviço desaúde mental na perspectiva do trabalhador: satisfação, sobrecarga e condições de trabalho dos profissionais. Universidade Federal de São João elRei, São João del Rei – MG – Brasil; Psicologia: teoria e prática. 2012; 14(1):1525.
4. Glanzner CH, Olschowsky A, Kantorski LP. O trabalho como fonte de prazer: avaliação da equipe de um Centro de Atenção Psicossocial. Rev Esc Enferm USP. 2011; 45(3):716-21.
5. Guimarães JMX, Jorge MSB, Assis MMA. (In)satisfação com o trabalho em saúde mental: um estudo em Centros de Atenção Psicossocial.Cien Saude Coletiva. 2011; 16(4):2145-54.
6. Rebouças D, Legay LF, Abelha L. Satisfação com o trabalho e impacto causado nos profissionais de serviço de saúde mental. Rev Saude Publica. 2007; 41(2):244-50.
7. Vasconselos A, Faria JH. Saúde mental no trabalho: contradições e limites. Psicol Soc. 2008; 20(3):453-64.
8. Guedes AC, Kantorski LP, Coimbra VCCC, Olschowsky AC, Jandro MC, Cantarelli KJ. Tratamento em liberdade: pontos de tensionamento e avanço no centro de atenção psicossocial. Rev Enferm UFSM. 2014; 4(1):133-43.
9. Nascimento AF, Galvanese ATC. Avaliação da estrutura dos centros de atenção psicossocial do município de São Paulo, SP. Rev Saude Publica. 2009; 43(1):8-15.
10. Kantorski LP, Coimbra VCC, Silva EF, Guedes AC, Cortes JM, Santos F. Avaliação qualitativa de ambiência num Centro de Atenção Psicossocial. Cien Saude Coletiva. 2011; 16(4):2059-66.
11. CAPSUL. Avaliação dos CAPS da Região Sul do Brasil: Relatório/ Conselho Nacional de Desenvolvimento Científico e Tecnológico – CNPq. Ministério da Saúde; Coordenação Luciane Prado Kantorski. Pelotas; 2007. p.437.
12. Minayo MCS. O desafio do conhecimento: pesquisa qualitativa em saúde. 11. ed. São Paulo (SP): Abrasco; 2008.
13. Bandeira M, Ishara S, Zuardi AW. Satisfação e sobrecarga de profissionais de saúde mental: validade de construto das escalas Satis-BR e Impacto-BR. J Bras Psiquiatr. 2007; 56(4):280-6.
14. Alves HMC, Dourado LBR, Côrtes VN. A influência dos vínculos organizacionais na consolidação dos Centros de Atenção Psicossociais. Cien Saude Coletiva. 2013; 18(10):2965-75.
15. Athayde V, Hennington EA. A saúde mental dos profissionais de um Centro de Atenção Psicossocial. Physis. 2012; 22(3):983-1001.
16. Valeretto FA, Alves DF. Fatores desencadeadores do estresse ocupacional e da síndrome de Burnout em enfermeiros. Revista Saude Fisica & Mental - UNIABE, Rio de Janeiro. 2013; 3(2):1-11.
17. Mauro MYC, Paz AF, Mauro CCC, Pinheiro MAS, Silva VG. Condições de trabalho da enfermagem nas enfermarias de um hospital universitário. Rev Enferm. 2010 Apr-Jun; 14(1):13-8.
18. Ministério da Saúde (BR); Secretaria de Atenção à Saúde; DAPES; Coordenação Geral de Saúde Mental, Álcool e Outras Drogas. Saúde Mental no SUS: as novas fronteiras da Reforma Psiquiátrica. Relatório de Gestão 2007-2010. Ministério da Saúde: Brasília. January, 2011.
19. Campos GWS. Cogestão e neoartesanato: elementos conceituais para repensar o trabalho em saúde combinando responsabilidade e autonomia. Cien Saude Coletiva. 2010; 15(5):2337-44.
20. Sampaio JJC, Guimaraes JMX, Carneiro C, Garcia Filho C. O trabalho em serviços de saúde mental no contexto da reforma psiquiátrica: um desafio técnico, político e ético. Cien Saude Coletiva. 2011; 16(12):4685-94.
21. Campos GWS, Domitti ACI. Apoio matricial e equipe de referência: uma metodologia para gestão do trabalho interdisciplinar em saúde. Cad Saude Publica. 2007; 23(2):399-407.

22. Yasui S. CAPS: estratégia de produção de cuidado e de bons encontros. In: Pinheiro R, Guljor AP, Silva Junior AG, Mattos RA. (ed.). Desinstitucionalização da saúde mental: contribuições para estudos avaliativos. 1. ed., CEPESC-IMS/UERJ-ABRASCO, Rio de Janeiro, 284, 2007.
23. Peduzzi M. Trabalho em equipe de saúde da perspectiva de gerentes de serviços de saúde: possibilidades da prática comunicativa orientada pelas necessidades de saúde dos usuários e da população [Tese]. São Paulo (SP): Escola de Enfermagem da Universidade de São Paulo, 2007.
24. Figueiredo MD, Campos RO. Saúde Mental na atenção básica à saúde de Campinas, SP: uma rede ou um emaranhado? Cien Saude Coletiva. 2009; 14(1):129-38.
25. Santos junior HPO, Silveira MF. A. Práticas de cuidados produzidas no serviço de residências terapêuticas: percorrendo os trilhos de retorno à sociedade. Rev Esc Enferm. 2009; 43(4):788-95.
26. Lapischies SRC, Jardim VMR, Kantorski LP. Fatores associados à satisfação no trabalho em Centros de Atenção Psicossocial. Rev Latino-Am Enferm. 2014; 22(6):950-8.
27. Machado, LM, Colomé JS, Beck CLC. Estratégia de Saúde da Família e o sistema de referência e de contrareferência: um desafio a ser enfrentado. Rev Enferm UFSM. 2011; 1(1):31-40.
28. Mendes EV. A construção social da atenção primária à saúde. Conselho Nacional de Secretários de Saúde – CONASS, 2015. 193 p.: il. ISBN: 978-85-8071-034-2
29. Martins RV, Rossetto M, Sartori QDN, Pinto EC, Van Der Sand ICP, Hildebrandt LM. Ações de saúde mental na região norte do Rio Grande do Sul, Brasil. Rev Gaucha Enferm. Porto Alegre (RS) 2012 mar; 33(1):11-8.

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