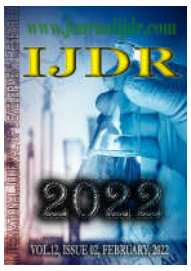
ISSN: 2230-9926

Available online at http://www.journalijdr.com

IJDR

International Journal of Development Research
Vol. 12, Issue, 02, pp. 54128-54133, February, 2022
https://doi.org/10.37118/ijdr.24068.02.2022



RESEARCH ARTICLE OPEN ACCESS

CO-MANAGEMENT, MENTAL HEALTH AND IS ARTICULATION WITH THE PRACTICES PERFORMED IN PRIMARY AND PSYCHOSOCIAL CARE FROM THE PER SPECTIVE OF PROFESSIONALS

Débora Brenda Carneiro de Souza*, Dina Mara Formiga da Silva, Maria SaleteBessa Jorge

Universidade Estadual do Ceará (UECE)

ARTICLE INFO

Article History:

Received 10th December, 2021
Received in revised form
02nd January, 2022
Accepted 26th January, 2022
Published online 26th February, 2022

Key Words:

Co-management, Mental health,
Psychosocial care network,
Health professionals.

****Corresponding author:***
Débora Brenda Carneiro de Souza,

ABSTRACT

Objetivo: The present study aimed to analyze the knowledge of co-management and its articulation with the practices performed in primary health care (PHC) and psychosocial care from the perspective of professionals. This is a qualitative investigation, which used as techniques the snowball interview, also disseminated as snowball sampling "Snowball" and the semi-structured for data collection with PHC professionals and psychosocial care. The data were analyzed from Bardin's thematic category analysis. The predominance of mental health activities was observed, and the perceptions of health professionals about co-management were contemplated within this understanding. Regarding the understanding of the term co-management and its tools, it is understood that professionals expressed their understanding of co-management and cite the tools to do it. Co-management comes as a solution for health spaces because it is a method that is based on the shared and collective construction among the subjects by defining the triple inclusion, considering managers, professionals and users of the service as agents of management.

Copyright © 2022, Débora Brenda Carneiro de Souza et al. *This is an open access article distributed under the Creative Commons Attribution License, which permits unrestricted use, distribution, and reproduction in any medium, provided the original work is properly cited.*

Citation: ***Débora Brenda Carneiro de Souza, Dina Mara Formiga da Silva, Maria SaleteBessa Jorge.*** "Co-management, mental health and is articulation with the practices performed in primary and psychosocial care from the per spective of professionals*", International Journal of Development Research*, 12, (02), 54128-54133.

INTRODUCTION

The mental health panorama in Brazil is a field that has been building over the years, with various forms of expression, so that we will find the most diverse views about the subject, being a devious of the norms of society, a madman who needs to be kept away or a being in its entirety that needs to be understood in its biopsychosocial form 1, 2. Thus, the process of psychiatric reform allowed the madman, a person excluded from society and deprived of his social power, a place of citizen and subject of rights, so that these individuals began to take care of their condition of being and being in society. Concomitantly with the process of psychiatric reform, the health reform movement arose in Brazil, stemming from indignation and discontent with the moment that the country was going through, marked by inequalities, commodification of health, social and economic crises. As a result of the Sanitary Reform, the Federal Constitution of 1988 created the Unified Health System (SUS) and regulated it with Law number 8080 of 1990 in its normative character3. In addition to health as a universal right and the duty of the State to guarantee it in its forms of promotion, protection and recovery, the Constitution also brought to its core the idea of shared management, an aspect that was disseminated and improved in other later policies 4.

Thus, structural and conjunctural factors were associated to mark the premence of a rethinking of health in an enlarged dimension, bringing with it social actors that until recently were not heard, such as the community itself, the users of the health service. With Law No. 8,142 of 1990, the participation of the community in the management of the Unified Health System was expressed3 so that these social actors began to be recognized and validated as essential figures to build and manage health, because they are intrinsically linked to the modes of community health production, because they are the directed focus of care and because they are subjects of co-production of this care.Thus, the population began to be recognized in its full power, assuming an important role, together with health and management professionals, of co-responsible for their health situation.

This way of inclusion of new subjects in management processes is known as shared management or co-management, a term forged by Campos5 that addresses aspects of a shared management among the various social actors and brings the importance of this project to the production and construction of the subject, giving him greater freedom, reflexive capacity and autonomy, fundamental pillars when we talk about this subject who constitutes as a user of mental health services.The literature on health management follows two parallel aspects — the Paradigm of Collective Health for the Public Sector and the Paradigm of Administration for the Private Sector — with

rare interfaces, thus mimetizing practices in this field. We highlight the National Policy for Humanization of Care and Management of the SUS, which aims at the interface between the ways of producing health and the ways of managing work processes, between care and management, between clinic and politics, between health production, among others. Management causes innovations in management practices and health production practices, highlighting the different collectives/teams involved in these practices the challenge of overcoming limits and experimenting with new ways of organizing services and new modes of production and circulation of power6. In this sense, the management model that the National Humanization Policy (NHP) proposes is centered on teamwork, collective construction (planning who performs) and collective spaces that ensure that power is actually shared, through collectively constructed analyses, decisions and evaluations6.

In relation to the context that this study takes place, it is also necessary to contextualize the network, since the SUS is organized under the lines of Health Care Networks (RAS), that is, "health actions and services are organized in regionalized and hierarchical care networks, in order to ensure comprehensive care to the population and avoid fragmentation of health actions"7. It is in this network that the field and its interfaces of this research work stand out, in which it focuses on the work of network health professionals in the Family Health Strategy (ESF), the Extended Family Health Center (NASF) and the Psychosocial Care Center (CAPS-GENERAL). The ESF is characterized by a work located in the territory, focusing on the family system and its relations with culture and society. Professional conduct aims to rescue the multiple dimensions of health and seeks to produce care in a relational way8. The NASF was created by the Ministry of Health in 2008 with the main objective of supporting the insertion of the ESF in the territory and amplifying the coverage of primary care actions, proposing to co-responsibility and integrated management of care (through interdisciplinary care) in order to agree therapeutic projects that involve users and family members as participants of this collective construction.

The professionals of this team will be available to promote permanent education, actions to promote integrality and territorial organization of health services. On the tangent of mental health, the ordinance recommends that each NASF can count on at least one mental health professional, being this psychologist, psychiatrist or occupational therapist9,10. Finally, the CAPS-General, which recommends being a community-based service, focusing on treatment for people suffering from severe and/or persistent mental disorders, aiming at social reintegration, through interdisciplinary care and clinical follow-up, in order to strengthen the exercise of autonomy, civil rights and social bonds11. In view of all the above, there are the following questions: What knowledge, practices and shared perspectives are being built in the psychosocial care network about co-management? How can these actions have repercussions on the functioning dynamics of the ESF, NASF and CAPS-GERAL?It is believed that this study will serve to provide a reflection on co-management in health services, subsidize the production of knowledge and the implementation of shared practices on co-management in mental health, through the proposition of a virtual guide for health professionals, in order to contribute to the empowerment of users of the health service, in addition to filling a gap in the knowledge observed during the review of published studies. Thus, the objective was to analyze the knowledge of co-management and its articulation with the practices performed in primary health and psychosocial care from the perspective of professionals.

METHOD

The study is part of the master's research entitled: Construction and validation of a virtual guide on co-management in mental health: shared knowledge and practices of professionals in primary health and psychosocial care. It is a qualitative investigation whose purpose was to identify the disagreements and reciprocities present in the subjects' statements, according to the precepts of Bardin's thematic category analysis12.We chose to use the snowball technique, also published as snowball sampling "Snowball" for the collection of interviews with health professionals13. Following this technique, the first interview took place through the contact of the researcher, via telephone, with a psychologist from regional VIII, who indicated other health professionals with the same profile as the subject of the reference chain. This professional was one of the seeds that started the snowball process, because from it it was possible to reach other professionals, indicated according to their consideration of meeting the requirements of the target population. From there, the wave process14 began, which reverberated until the sample was closed, because it reached the point where the contacts did not indicate more new people.It is noteworthy that not all indicated accepted to participate in the research, many refused claiming lack of time and that the service was demanding a lot (especially the professionals of the health posts, who were focused on the vaccination campaigns of covid-19).

Others did not want to participate because they did not feel safe with the questions, claimed to be an unknown topic and because it was open questions, making it difficult to join the research.The inclusion criteria of the participants were: having complete higher education, of various degrees, working in the Psychosocial Care Network of Fortaleza, including the general CAPS, the ESF and the NASF. Have at least six months of work in the health service, be linked to one of the health devices (CAPS or Health Center) through competition or public selection and are in practice of work activities at the time of collection. All subjects investigated during the research, in the period from January to July 2021, were 16, one doctor, two psychologists, two nurses, three social workers and one occupational therapist of the general CAPS; three nurses and a dentist from the ESF; and two occupational therapists and a PSYCHOLOGIST from the NASF. The interviews ended when the new participants of the research began to bring repeated contents. Another collection technique used was the semi-structured interview with questions that guide and lead to the achievement of the objective of this research. Also using the free observation of both the interviewees' posture and the field of collection12. The interviews took place at the first moment, through a virtual environment, due to social isolation and restrictive contact measures established in the city of Fortaleza, Ceará due to the Covid-19 pandemic. It is understood by means or virtual environment everything that involves the internet, such as e-mails electronic sites; the phone, such as audio, video, or mobile apps; as well as applications that use the internet media, not involving the face-to-face form, which is the contact made through the use of technologies that does not cover the physical presence of the researcher and the research participants15.

The social isolation determined by the state government made it difficult to access the research field, which enhanced the search for the online solution. With the gradual return of activities and the reduction of risks of contagion by the new coronavirus, the interviews could take place in person, enabling a contact with the very field of action of health professionals. The end of the interviews occurred when the new names indicated by health professionals did not add new information to the analysis board, making the content of the interviews repeated. For the analysis, the three phases of the Thematic Category analysis proposed by Bardin16 were used, defined as a set of communications analysis techniques that uses systematic and objective procedures for describing the content of messages in three phases: Pre-analysis; Exploitation of the material; Treatment of Results, Inference and Interpretation.This research was approved by the Research Ethics Committee (CEP) of the State University of Ceara (UECE) and approved with protocol number 2,853,335 The interviewed subjects had access to the Free and Informed Consent Form in which they presented information about the research, possible damages and benefits, as well as the guarantee of anonymity, accordance with ethical principles, according to Resolution 466/2012 of the National Health Council17. The consent form was signed in two ways by all subjects who chose to participate in the research.

RESULT AND DISCUSSION

For Creswell18 the data analysis process involves extracting sense from the data, preparing, conducting different analyses and going deeper and deeper into the process of understanding the data. Below is the picture with the profile of the professionals interviewed separated according to the units of activity (CAPS, ESF and NASF), with the area of training, profession, regional that operates and the time of operation in the service.

Quadro 1. Atribuições de cada entrevistado do CAPS

Entrevistado	Formação	Profissão	Regionais	Tempo de atuação
E1	Pós-graduação	Médico(a)	VI	Nãoatribuído
E2	Pós-graduação	Assistente social	VI	Nãoatribuído
E4	Pós-graduação	Enfermeiro(a)	VIII	1 - 5 anos
E5	Mestrado	Psicólogo(a)	VIII	+ 15 anos

Fonte: Nvivo (2021).

Quadro 2. Atribuições de cada entrevistado da ESF

Entrevistado	**Formação**	**Profissão**	**Regionais**	**Tempo de atuação**
E3	Mestrado	Enfermeiro (a)	IV	+ 15 anos

Fonte: Nvivo (2021).

Quadro 3. Atribuições de cada entrevistado da NASF

Entrevistado	Formação	Profissão	Regionais	Tempo de atuação
11	Pós-graduação	Terapeutaocupacional	III	+ 15 anos
13	Pós-graduação	Terapeutaocupacional	VI	10 - 15 anos
14	Pós-graduação	Psicólogo (a)	VIII	+ 6 meses - 1 ano

Fonte: Nvivo (2021).

The results presented in the table correspond to the survey of the interviews inserted in the Nvivo software12, as well as the analysis and reflections of the contents of the interviews that are exposed below. The predominance of mental health activities is perceived, and the perceptions of health professionals about co-management are contemplated within this understanding. Regarding the understanding of the term co-management and its tools, it is understood that those who professionals expressed their understanding of co-management and cited what were the tools to do it, however much that not all those that were actually mentioned fit as a co-management tool, as an example the medical record.According to the interviewee, one can understand the logic used to justify the medical records as a tool of co-management, since: [...] the electronic medical record is a photograph of the patient, all his visits, they are placed in the electronic medical records, regardless of the professional who attends him, it is the nurse, it is the doctor, it is the technician, so the whole history of the patient is there and the medical record is also important because of the references, if this medical record was fed correctly, we could get feedback through the medical records, by counter-reference, but even so, there is still a lot that we observe in the medical records, so the medical record would be an interesting tool because, if the patient was new to me, but he had a history in his medical records, I would have how to get this history from him and get to know this patient a little more, their difficulties, the moments within mental health and also the question of reference (E3).However, when searching the literature on the medical records as a co-management tool, nothing was found that is based on this finding.

Unlike the Health Councils, there is literature that proves this body as an essential tool for co-management through the formulation, supervision and evaluation of public management, controlling and proposing public policies for the various health spaces19. There is in the speech of the professionals the demarcation between what is expected and what is possible to accomplish in daily practice, in these moments, in which the professional is talking about his possible and real practice, in his way of doing that integrates what is expected by him and the possible of the field, which is, as is punctuated by Franco and Merhy20, subjectivity as a dimension of the mode of production of care, a care that is unique, which is revealed in the context of micropolitics, the scope in which the territories are manufactured existences21. The production of health care is a work of high complexity, multiple, interdisciplinary, intersectoral and interprofessional, directed in order to provide gains in autonomy and better quality of life to users, through promotion, prevention, treatment and rehabilitation, provided continuously and integrally through the lines of care. Feuerwerker21 writes that using the production of new ways of caring for health, added to essential elements such as substitutivity and deinstitutionalization, to guide the work alliance of the teams. The work processes within the health teams, are also revived by the effective and punctual communication on the part of the manager or users interacting connected to each other. Thus, the line of care is established in the continuous access of the service, from the moment that begins the user-service relationship and that has as stage its entrance door, in which users receive the reception and are directed to the specialty and or the integral service of their needs that receives the reference of the need for the assistance of users and also makes its against the case that should be appropriate. It should be observed that the current work of mental health care is directed by a multidisciplinary team, disjointed from the strictly medicalocentric standard of accountability of the old days. Well, I as a psychiatrist, I work here, mainly right, analyzing each, each case, seeing psychiatric diagnoses, starting the treatment whether pharmacological or non-pharmacological, referring to other professionals also trained right from the multidisciplinary team [...] well, patients come to me after a reception consultation right, the professional does the reception, sees more or less as is the case, profile of the patient and brand, schedule the consultation to me right, and then I do, i evaluate, I see the issue of diagnosis and everything, See if the patient has profile to be accompanied by caps or if he can be referred, for example, to basic health unit right, to another type of service right, then it is usually after the reception (E1).

E1 explains the flow necessary for the user to enter the consultation by the specialist, stresses that it is only performed after the reception. The act of welcoming is a commitment to respond to the demands of users seeking health services. In the field of Public Health, Welcoming is a guideline of the National Humanization Policy (NHP), being a way to operate health work processes, seen as a device for intervention in quality listening and bond building, ensuring access with accountability and resolution, with activation of knowledge sharing networks.Yes, comes many patients referred from the emergency of the Mental Hospital mainly, so it turns out that comes a lot, we have a relationship so very close and especially with the emergency hospital, in the mental hospital and also with the basic health units we are always doing this counter-reference right. As it's all through the system, right, by the electronic medical records, it

made it a lot easier, so everything is now through the electronic medical records, we do the communication. With the Mental Hospital unfortunately not, because since it is State the medical records is different, usually we make the same hand the letter, when we need, a more urgent case, we make the call (E1).In this discourse, there are also inappropriate incidences of referrals received by the CAPS, which generates a waste of time and dissatisfaction on the part of the user. Well, I'm a social worker right, so I participate in the receptions, have the days, certain days of reception, I make social service services that are the specific guidelines, I do a lot of home visits, I do home visits together with the doctor right, and some home visits requested by the law agencies, public prosecutors, CREAS, Pop Center, and from these visits we are trying to build some reports, some solutions, possible solutions and everything. We are also participating in matrix support, we are matriciando some posts (E2). It was recorded that the interviewee focuses on emphasizing the practice of matrix support and continuing education as facilitating tools for improving the service, as well as the need for timely reception with a measure of the resolution of the repressed demand in the daily work process.

The matrix ization is basically like clinical case, presents, the doctor is with a doubt in certain driving, does not know what else to do, exhausted there the ability of him to try to , of limir right that issue, and then we go and act on it right, then there is also the part of permanent education right, sometimes the patient does not come, sometimes it is a day like this 'no, we just wanted to discuss the case, patient will not come' and then we do the right case discussion, without the patient coming. Often the patient comes, he invites the patient, the patient reports, he exposes, the doctor exposes the case to us, we talk, has a preview and then talks to the patient, enters the patient, he is presented to the team, then the patient leaves and we will discuss the patient's conduct, conducting the case, then there is case that sometimes you look 'no, this here friend, it's way to the Caps' and then already in time we already get the joints to be able to make an appointment, so it is not so difficult because here there is a limit, it is not that there is a limit is because we have a lot of demand right, a lot of demand right, so we have a lot of demand and we are not an emergency service, the emergency service it works directly, it has a profile of receiving at any time, at any time, we have our limitations and the Municipal Health Department says "it is not to let any patient return without being heard" only that reaches the limit of the professional right, then so sometimes will arrive patient who will come ten o'clock in the morning (E2).

By detecting a health problem of the user, the team professional, who has the ability, can already start a therapeutic project and multiply his rhizomatic network in work processes that may arise soon after different ways, whether with other professionals, other health services, local relations or at a distance, agreed or not. And because they exist, they operate for the production of care22. Through matrix support, health professionals treat users' difficulties through a proposal for joint pedagogical and therapeutic intervention, shared construction with other areas of knowledge; they are in tune with the multiple devices of the care network, and contribute to the collective construction of care and care. from interconsultations, meetings, case discussion, among others. Here in these narratives it was possible to evidence the act of matrix support production, also implying the co-management guideline, which, through the sharing of strategies, knowledge and care, provide opportunities for teamwork and strengthen the bond between them, deinstitutionalizing mental health with their way of acting. In this report, the interviewee informs the execution of the practice of conversation wheels, and the modalities of co-digesting that takes place in the service are verified. However, it focuses once again on the ignorance of the theme of co-management and or management shared by professionals, however it is possible to perceive the use of cogestive strategies at work. Health work is based on meetings between workers and these with users. Describes that even with this activity in progress, the user is served promptly. In this speech we can verify the importance attributed to the user in order to ensure the demand for their needs. Studies reveal that users of health services seek qualified professionals, committed, prepared to listen to them and perform a welcoming communication, with the valorization of discourses and that has problem-solving capacity for their needs23,24. Yes, but so, the fact that the wheel happens does not mean to say if a patient arrives here we will not meet, one will leave the wheel and will attend, we have a schedule at least semiannual of the subjects that we do on the wheel, such as reading articles, discussion of cases, political discussion, health care policy right, has the reports, we also have our 'taking care of the caregiver' that is always on the last, last day of the month, which does not happen outside the service, happens here and it is in these team meetings that we do planning activities of the team, caps so, activities related to Christmas, activities related to May 18, understood, is at that moment (E2).

In Ordinance No. 3,088 of the Ministry of Health, Raps should be structured with the continuous flow of care, promoting the performance of professionals in the territory, since they are close to families and communities25. The new proposals for intervention with the subject in psychological distress no longer aim at hospitalization, but rather the type of treatment that preserves their social, family coexistence, and their territory of origin.I think it goes through listening, legitimizing what the person is feeling, is bringing you, is often this patient who comes here, this user who comes here he is not a serious persistent that is the focus of us, but he needs to be heard and even if it is not, because so, we can not also is putting a person who within the service, without, without that person is with the profile of the service but he has the right to be heard right, be heard, be answered in some demand, often happens that the patient he is not, he is with a crisis of anxiety right, anxiety for something, often the history of covid happens and everything, but it is still not a chronic case and then we have to take this care, it is not only deny the service, it is also trying to welcome, it often happens that I listen, i listen, i try to see in some way, with some doctor, some kind of conduct that can be established there at that moment and that it can be referenced and well referenced to primary care unit (E2).[...] the team is extremely responsible, it is... I know that the demand is huge, we try to make a care with a lot of zeal, we have complaints we have, we have complaints on account of a network that she, she has great difficulties, but so, I believe that we seek to listen, seek to take care, the biggest complaints that have is a remedy that is missing, is a patient who is, sometimes he's at the health center but then he doesn't, he knows that in the Post there is a flow but then he does not want to follow this flow of the Post, then he finds it easier to get here as we welcome, so he thinks it's easier to get here and putting the pressure to get his recipe, when you go to see, look at the medical test, patient had just passed the health center, the patient who has the mental health problem, he is a little complicated to understand, exalts himself right, and then we have to have a lot of patience in relation to this right (E2).

This bond has always been positive, because so in the nursing part, for example, I will specify in the nursing consultation, this link is very positive because we do not only evaluate the mental health part, but other demands as well, so there is always this link with the health center because we have had cases of the people identifying pregnancy in the nursing consultation, even have a project of mouth, nothing on paper yet, to do mental health training for community health agent, because despite being positive we have a lot of difficulty referrals that come from there to here. There are situations, we know that the CAPS is for severe cases, very serious and the mildest is to stay in primary care, but we receive a lot of referral of mild cases, mild anxiety for coming ... coming from the... primary care for CAPS. And there is this bond that we need to strengthen what is really the case of primary care, which is really the case for the psychosocial care center, but in the midst of all these difficulties it is positive, we have a very good bond with the unit, with primary care, especially referrals, demands that are there, or from there to here right (E4). What is possible to apprehend from these statements is the production of living work in action, which is developed through the care produced beyond the bureaucratic mode expected of health professionals. Through welcoming, bonding, encouraging autonomy, the "lifelines" that are established in the flows circulating between professional-users,

professionals-professionalsare configured20. However, it was also observed in the interviews the configuration of the "death lines" within the health service, affecting the power to act of the professionals who are present there20. It is perceived through these two explanations that follow about the work overload of professionals, an occurrence that can trigger a breakdown of the network, the withdrawal of care to be provided intersectoral and the intensification of unnecessary referral to other health units.

Several, countless, I think that one of these challenges is the overload, the overload, the lack of supplies for us to perform activities, I'll give as an example itself right, I've been here as a professional Nurse alone several times, so, there is the.. has several is.. there are several activities that nurses can perform, there is still this doubt even without deception the COFEN raised a question about this, the role of the nurse in mental health. Because it was very blurry, it's.. what was the function, but there are several activities that are performed, a range, the therapeutic group, home visits, the nursing consultation that was initially a resistance of patients understand what was this nursing consultation, break a little of that idea of leaving a consultation but I have to have a prescription, so there is a difficulty because I am alone, not only in this unit, everyone goes through this difficulty, today I have another nurse with me, but being alone I had difficulty attending an outpatient clinic here, the procedure room, turning around in reception, that I can not fail to do the reception of patients, nursing consultation, create therapeutic groups and even alone gave to do this but wanting or not I was unwatching other things, then there is this difficulty of a very large demand for few professionals (E4).Merhy26 describes that the management of health networks has a self-managed character, and therefore the execution of living work has a remarkable presentation and freedom in production processes. Thus, Franco and Merhy20 argue that any team member is able to produce other bonds, projecting "lines of care" in different positions. The decision-making of the workers determines the favorof the rescue of this network, because the living work in action allows them to conceive actions of health care productions. Challenges? Finish building this network right? Because instead of finishing building the network, the network was being strangled, cut, closed right? And then, for example: you have a 24 hours that instead of having been expanded another 24 hours, you closed 24 hours that you had working, so today, we are obliged when a person needs hospitalization, because people still need hospitalization, does not mean that it needs to be in the manicomiais conditions right? But people will need monitoring, medication adhering, stabilization, then you force yourself to go to Messejana and many of the users no longer want to go to Messejana, they want the 24 hours and the 24 hours is closed (E5).

Performing health work requires workers a high degree of perception of the demands presented by users. The Discourse of E5 connotes the concern with the impaired quality of the care provided and with scarce logistic spaces of accommodation that meet the user's expectations. It makes many references of services and modalities of well-articulated work processes that existed in the service and that no longer exist, disadvantaged over the years due to lack of structure, support and intense turnover of professionals. The interviewee's great dissatisfaction is clearly perceived.It is believed that the professional who is inserted in a fragmented work process, worn out and deconstructed due to lack of organization, needs efforts to adapt to this work. However, all this may not be enough to maintain satisfaction with the contents of the work to avoid possible suffering.The degree of satisfaction with work has a direct effect on productivity, performance, absenteeism, turnover, citizenship, health and well-being, life satisfaction and customer satisfaction27.[...] No, it's not organized at the moment, is it? At the moment it is not, in 17 years we have seen this organization, but at the moment it is disorganized, primary care it was scrapped also, in fact, deconstructed, who is scrapped is mental health, so it was deconstructed so this deconstruction is clear that will splash on us, so we have had matrix support working, we already had teams composed of professionals from each caps of the territory of 4, for example: there was a team and in this team had general, ad and children in the same team and once a month they were responsible for x posts and the other and the other, so there were 4 teams responsible for the posts, and that monthly you went and that had conversations, and that you didn't necessarily have doctors on these teams, there were other professionals, discussed there about mental health cases and we knew who was from here who was there, who was who was referred from there to here, when they needed an evaluation of the psychiatrist they made this reference, made this request, if the person really could be accompanied there, the doctor attended, made a report forwarded and then we kept following us also experienced at that same time, yes, there were these teams that monthly did these discussions and in parallel we had the occupational therapist who was implementing groups is... with professionals who were sensitive in these posts, in these health units for example here is a nurse, here and a person of the nasf, and so we were monitoring then had, I think had in the oak valdevino, had in the... in the other now I do not remember the name, but, yes, in one was group with mothers, another was group of women, another was groups that depended a lot on the territory of the need for that post, she implanted, did is ... Embroidery workshop, crochet and so, and then went deploying, implanted left the staff taking care and she left, that the intention was just this, deploy and leave so we had all this and we were retreating for lack of structure, support, turnover, right? And then a lot of people left that they experienced it, so you have to start all over again, but if management doesn't buy this idea, just us talking will work? Today we are again trying to negotiate with primary care again, so at the moment we do not have this flow, of course, no, some that are from this time forwards we evaluate and go, but I do not see a flow (E5).

The lack of integration among team members and the lack of support for the development of such work actions with management support, physical space, financial resources, continuing education, work overload, and professional devaluation are factors related to workers' dissatisfaction. Given the multiple changes in the field of mental health resulting from the changes that have happened along the path evidenced by the psychiatric reform and its repercussion of improvements in the current context, the researcher collected statements from health professionals in the context of knowledge about health co-management, their practices and conducting their work processes and through their answers, present their statements and describe the real situation of this scenario. The Ministry of Health adopted co-management as a new form of management, because it advocates the participation of health workers in the management of services and professional valorization, for the development of democratic management strengthening labor relations28,29. For the National Humanization Policy, co-management is equivalent to participatory management, being considered as a new way of acting in health, recommending the method of triple inclusion of social actors (manager, worker and user)11.It is understood that the innovative management modality aggregates and strengthens the constitutional rights of the SUS health user by the power of participation, learning and decision in the work processes of their health units, in view of the better results obtained compared to the vertical model that is still found in health teams and services, although it is still a challenge in the SUS.In this context, it is expected to know the perception of health professionals of the health units referred to here, about co-management/ shared management in the city of Fortaleza, because they are multidisciplinary teams and who face the daily challenge of experiencing work processes and participating in decision-making to improve the user's mental health care.

CONCLUSION

This study enables the production of subjects who fight for the construction of the SUS. This is because autonomy and reflexive capacity over their condition of being subject is also a way of participating in management, being an opportunity for health professionals to recognize both their place as a manager, as well as that of responsible for the co-production and empowerment of users as a social actor in this environment. The interviews provided the identification of the understandings of health professionals from the

ESF, NASF and CAPS-GERAL about the term co-management and the tools capable of producing this method in practice. Although the term was unknown to most interviewees, it was possible to glimpse the existence of shared management as the professionals described their practices. The interviews led to the identification of the weaknesses of theoretical knowledge about co-management in mental health, so that the virtual educational guide was constructed in order to reduce this gap for professionals working in health units. The limit of this study is the non-inclusion of listening to users of health services, bringing in the analysis, only the voice of the health professional, which bring their crossed way of seeing their relationship with the community. Considering the proposal of co-management and the need for users to engage in these collective management spaces, as well defended throughout the discussion of this study, it is indicated the imprescindibility of new studies that contemplate the understanding of users about this theme. It is suggested to conduct new studies with a view to understanding and the perception of the manager and the user about co-management in health spaces. Therefore, it emerges as a suggestion for the continuity of this research, the addition of the view of the manager and the user, as members of this triple inclusion of co-management, as well as the pertinence in validating the guide with the target pubic (health professionals), since due to the time for the timely development of completion of this research, such action was not possible.It is expected that this research can enable discussions that produce practical arguments on how to execute the promotion of a participatory and cogestive culture of management through the implementation of the Virtual Educational Guide as a possibility to work on the relationships and the context in which the health professional is inserted.

REFERENCES

1. Amarante P. Loucos pela vida: a trajetória da reforma psiquiátrica no Brasil. Rio de Janeiro: Fiocruz, 1996.
2. Sampaio JJC et al. Working in mental health services in the context of Brazilian psychiatric reform: a technical, political and ethical challenge. Ciência & Saúde Coletiva, v. 16, p. 4685-4694, 2011.
3. Ministério da Saúde. I Conferência Nacional de Saúde Mental: relatório final. Brasília: Ministério da Saúde, 1988.
4. Souto LRFl, Oliveira MHB. The Brazilian Sanitary Reform Movement: a civilizatory project of alternative globalization and construction of a post-abyssal thought. Saúde em Debate, v. 40, p. 204-218, 2016.
5. Campos GWS. Public health and collective health: field and core area for knowledge and practice. Ciência & Saúde Coletiva, v. 5, p. 219-230, 2000.
6. Ministério da Saúde. Secretaria de Atenção à Saúde. Política Nacional de Humanização da Atenção e Gestão do SUS. Gestão participativa e cogestão. Brasília: Ministério da Saúde, 2009.
7. Ministério da Saúde. Secretaria de Vigilância em Saúde. Secretaria de Atenção à Saúde. Política Nacional de Promoção da Saúde / Ministério da Saúde, Secretaria de Vigilância em Saúde, Secretaria de Atenção à Saúde. – 3. ed. – Brasília : Ministério da Saúde, 2010. 60 p. – (Série B. Textos Básicos de Saúde) (Série Pactos pela Saúde 2006; v. 7).
8. Camargo-borges C, Cardoso C. Psychology and the family health care strategy: combining knowledges and practices. Psicologia & Sociedade, v. 17, p. 26-32, 2005.
9. Ministério da Saúde. Secretaria de Atenção à Saúde. Núcleo Técnico da Política Nacional de Humanização. HumanizaSUS: documento base para gestores e trabalhadores do SUS. 4. ed. Brasília: MS, 2008.
10. Eichenberg JF, Bernardi A B. A prática do psicólogo na atenção básica em saúde mental: uma proposta da clínica ampliada. 2016. 26f. Trabalho de Conclusão de Curso (Especialização em Saúde Menta) – Centro Universitário para o Desenvolvimento do Alto Vale do Itajaí (Unidavi), Santa Catarina, 2016.
11. Ministério da Saúde. Secretaria-Executiva. Núcleo Técnico da Política Nacional de Humanização. HumanizaSUS: Política Nacional de Humanização: a humanização como eixo norteador das práticas de atenção e gestão em todas as instâncias do SUS / Ministério da Saúde, SecretariaExecutiva, Núcleo Técnico da Política Nacional de Humanização. – Brasília: Ministério da Saúde, 2004. 20 p.: il. – (Série B. Textos Básicos de Saúde).
12. Minayo MCS. O desafio do conhecimento: pesquisa qualitativa em saúde. 13. ed. São Paulo: Hucitec, 2013.
13. Biernacki P, Waldorf D. Snowball sampling: Problems and techniques of chain referral sampling. Sociological methods & research, v. 10, n. 2, p. 141-163, 1981.
14. Berg S, Snowball S. In: Kotz, S.; Johnson, N. L. Encyclopedia of statistical sciences. New York: *John Wiley* and *Sons*, 1988. p. 528-532
15. Ministério da Saúde. Resolução CNS n. 466, de 12 de dezembro de 2012. Aprova as diretrizes e normas regulamentadoras de pesquisas envolvendo seres humanos e revoga as Resoluções CNS nos. 196/96, 303/2000 e 404/2008. Diário Oficial da União, Brasília, DF, 13 jun. 2013.
16. Bardin L. Análise de conteúdo.Lisboa: Edições 70, 2010. p. 281
17. Ministério da Saúde. Conselhos de saúde: a responsabilidade do controle social democrático do SUS. 2. ed. Brasília: Ministério da Saúde, 2013.
18. Creswell JW. Projeto de pesquisa: métodos qualitativo, quantitativo e misto; 3 ed. Porto Alegre: ARTMED, 2010.
19. Ministério da Saúde. Secretaria de Atenção à Saúde. Departamento de Atenção Básica. Saúde Mental. Cadernos de Atenção Básica, n. 34. Brasília: Ministério da Saúde, 2013. 176 p.
20. Franco TB, Merhy EE. Trabalho Produção do Cuidado e Subjetividade em Saúde. São Paulo: Hucitec, 2013.
21. Feuerwerker LCM, Merhy EE. Governamentalidade, governo da vida e análise de políticas. Interface (Botucatu, Online). No prelo, 2019.
22. Franco TB. Processos de trabalho e transição tecnológica na saúde: um olhar a partir do cartão nacional de saúde. 2003. Tese (Doutorado em Saúde Pública) - Faculdade de Medicina, Universidade Estadual de Campinas, Campinas, 2003.
23. Hoyos HPA, Cardona RMA. Correa SD. Humanizar los contextos de salud, cuestión de liderazgo. Investigación y Educación en Enfermería Medellín, v. 26, n. 2, p. 218-225, Sept. 2008.
24. Oliveira GN. O Projeto Terapêutico Singular. *In*: Campos, GWS; Guerreiro, André Vinicius Pires. (Orgs.). Manual de práticas de atenção básica: saúde ampliada e compartilhada. São Paulo: Aderaldo & Rothschild, 2008.
25. Ministério da Saúde. Portaria GM n. 2.488, 21 de outubro de 2011. Aprova a Política Nacional de Atenção Básica, estabelecendo a revisão de diretrizes e normas para a organização da Atenção Básica, para a Estratégia Saúde da Família (ESF) e o Programa de Agentes Comunitários de Saúde (PACS). Brasília: Ministério da Saúde, 2011.
26. Merhy EE. Saúde: A Cartografia do Trabalho Vivo; São Paulo, Hucitec, 2002.
27. Malta DC et al. A implementação das prioridades da Política Nacional de Promoção da Saúde, um balanço, 2006 a 2014. Ciência & Saúde Coletiva [online]. 2014, v. 19, n. 11
28. Ministério da Saúde. Secretaria Executiva. Subsecretaria de Planejamento e Orçamento. Plano Nacional de Saúde: um pacto pela saúde no Brasil: síntese. Brasília: Ministério da Saúde, 2005.
29. Campos GWS. Democratic management and new craft: concepts to rethink integration between autonomy and responsibility in health work. Ciencia & Saúde Coletiva, v. 15, n. 5, p. 2337-2344, 2010.

****