Rosana Teresa Onocko Campos[I]

Juarez Pereira Furtado[II]

Eduardo Passos[III]

Ana Luiza Ferrer[IV]

Lilian Miranda[IV]

Carlos Alberto Pegolo da Gama[IV]

Evaluation of the network of psychosocial care centers: between collective and mental health

ABSTRACT

OBJECTIVE: To analyze the assistance, management and workers' education models of a network of psychosocial healthcare services (CAPS).

METHODS: This is a qualitative evaluation research, supported by the Gadamerian hermeneutics, carried out in the city of Campinas, Southeastern Brazil, in 2006-2007. Data were collected through 20 focus groups in centers known as CAPS III, with different groups of stakeholders (workers, municipal managers, users, family members and local managers). After the transcription of each group's recorded material, narratives were constructed following Ricoeur's theoretical framework. At the second stage of the focus groups, these narratives were presented to the participants, who could contest, correct and validate them. The preliminary results were discussed in workshops, with the aim of developing a good practice guide in CAPS III.

RESULTS: The study identified strong points and weaknesses concerning the care provided during the crisis, articulation with the primary care network, formulation of therapeutic projects, management and organization in reference teams, educational background and psychological distress.

CONCLUSIONS: The network of psychosocial care centers in Campinas stands out due to its originality in the implementation of six CAPS III and to its efficacy in providing comprehensive assistance to users and family members in the moment of crisis and in rehabilitation. The organization in reference technician and/or team prevails, as well as the development of therapeutic projects. Night teams reduction is the most important problem and the main source of workers' stress. The professionals' education proved to be insufficient to deal with the challenges faced by these services.

DESCRIPTORS: Mental Health Services. Health Personnel. Health Management. Health Care Reform. Qualitative Research. Evaluation Research.

[I] Departamento de Medicina Preventiva e Social. Faculdade de Ciências Médicas. Universidade Estadual de Campinas (UNICAMP). Campinas, SP, Brasil

[II] Universidade Federal de São Paulo. São Paulo, SP, Brasil

[III] Universidade Federal Fluminense. Rio de Janeiro, RJ, Brasil

[IV] Programa de Pós-Graduação em Saúde Coletiva. UNICAMP. Campinas, SP, Brasil

Correspondence:
Rosana Teresa Onocko-Campos
Departamento de Medicina Preventiva e Social
Universidade Estadual de Campinas
Caixa Postal 6111
Cidade Universitária Zeferino Vaz - Barão Geraldo
13081-970 Campinas, SP, Brasil
E-mail: rosanaoc@mpc.com.br

INTRODUCTION

The *centros de atenção psicossocial* (CAPS – psychosocial care centers) are considered strategic services for the organization of the mental health care network within a certain territory and for the consolidation of the Brazilian Psychiatric Reform. Their implementation and qualification have been stimulated by the *Ministério da Saúde* (Brazilian Ministry of Health), in such a way that the number of centers more than doubled in the last five years. In addition, some directives were created to foster the financing and assistance qualification policies.[a]

---

[a] Ministério da Saúde. Relatório de gestão de saúde mental: 2003-2006. Brasília (DF); 2007.

In the condition of public mental health services in the field of collective health,[1,3] they must ensure access, integrality and the ability to solve problems in the provided care, aggregating the different assistance levels (primary, secondary and tertiary) in one single unit, and generating reflections concerning the assistance model and the clinical approach.[10] The complex assistance organization and the subjective impacts on the professionals, typical of the work with psychosis,[7,8] provide CAPS with challenges and the need for constant monitoring and analysis. The institutional aspects of the Psychiatric Reform, updated in the CAPS, present relations between intersubjectivity, management, professional education and clinical approach.[10] Thus, it is necessary to undertake an evaluative approach that takes into account the plurality and interdisciplinarity of such relations.

The present study aimed to analyze the assistance, management and workers' education models of a network of psychosocial care centers.

METHODS

The study is an evaluation research, conducted between 2006-2007, in which we associated themes and categories deriving from collective health, such as management and subjectivity,[11,12] with qualitative, participatory and constructivist evaluation,[2,4,6] in light of the institutionalization of public mental health policies for the new services[3] and of the vicissitudes identified by workers and users in their daily working routine or when attending the services.

The approach was qualitative and the theoretical framework was based on the Gadamerian hermeneutics.[5] The fieldwork was developed in the city of Campinas, Southeastern Brazil, due to the complexity and extent of its mental health system and to its pioneer implementation of six CAPS III (with availability of beds).

The data were collected through 20 focus groups[9] conducted with the stakeholders:[14] 12 groups with workers from each one of the six CAPS, two groups with the municipal mental health collegiate, two groups with the managers of the involved CAPS, two groups with family members of users of the six CAPS, and two groups with users. These groups participated in two stages. In the first, there was a script with discussion-triggering questions, encompassing the themes of interest to the research. The scripts were different in some aspects according to the group of stakeholders. After the transcription of these groups' recorded material, narratives[13] of each one of them were constructed, according to Ricoeur's theoretical framework.[15,16] The narrative construction consisted of the connection of the argumentation nuclei present in the transcribed material, but edited as a story that can be followed in reading.

In the second stage these narratives were presented to the same members of the focus groups, and they could contest them, correct them and validate them. There was an insignificant loss of subjects between stages (three people out of a total of 120).

After the transcription of the material from the second stage of the focus groups, new narratives were constructed. Together with those from the first groups, they were analyzed and became the basis for the workshops in which evaluative parameters and devices were constructed, which occurred subsequently.

The workshops aimed to process the research results. To achieve this, the participation was enlarged, including, besides the groups of stakeholders described for the conduction of the focus groups, workers from other services of the health network, like the *Serviço de Atendimento Móvel de Urgência* (SAMU - Mobile Emergency Care Service), primary care units, conviviality centers, CAPS supervisors, involving approximately 300 participants overall. Thus, we tried to employ a technique for the creation of consensus that would diversify and amplify the participation, and not the already renowned Delphi technique.[17] The objective of our innovation was to radicalize the dialogic pact among the multiple groups of stakeholders involved.

Ten workshops were held in two sessions, divided into the following themes: 1) Conception of CAPS, 2) Individual therapeutic project and group practices, 3) Care provided during the crisis, 4) Workers' professional education and distress, and 5) Management. The theme of CAPS' relationship to the health services network in general cut across all the workshops. In the first session, we presented to the participants a list of problems, controversies and solutions related to each theme that we identified in the focus groups' narratives; the participants elected which ones would need evaluative monitoring. In the second session, the same workshops created evaluative parameters and devices for the monitoring.

The research was approved by the Research Ethics Committee of *Universidade Estadual de Campinas* (Process No. 396/2004). All the participants signed an informed consent form.

ANALYSIS AND DISCUSSION OF RESULTS

Forms of care provided for the user in moments of crisis

The participants evaluated as positive the user's permanence with the same team in moments of crisis, a fact that is permitted by the existence of beds in the CAPS III – an important differential in relation to the hospital model. Users and family members considered

that the mental health network provided comprehensive assistance (especially CAPS and SAMU). The following difficulties were reported: hindrances in the establishment of partnerships with the network as a whole, and receiving and following up patients who are still unknown to the team, mainly at night and on weekends, because in these critical periods only nursing professionals are usually working in shifts at CAPS. Furthermore, the participants reported that the criteria employed to indicate the use of the night bed need to be more objective, as the night bed was used up to the limit or above its capacity during the studied period.

Two opposing conceptions of crisis were indicated: one connected with the emergence of symptoms that must be contained and another that understands the moment as of extreme fragility and as an opportunity for reconstructions. There was no systematic follow-up of users admitted to psychiatric wards outside the CAPS. Users and family members also complained about the disappearance of personal belongings during the use of the night bed.

As evaluative parameters, the participants indicated the periodic verification of the rate of occupation and permanence in the beds, as well as percentages referring to: assistance to patients in crisis without bed occupation, users referred to occupy beds in other services, users with diagnosis of co-morbidity who need intensive follow-up.

As evaluative devices, the participants suggested the creation of a supporting group composed of professionals from the various CAPS that would be called for risk evaluation when a team considers the possibility of referring some user to hospitalization.

The workshops' participants also proposed that the services evaluate the dosage and possible associations between medicines, prescription revision in moments of crisis, evaluation of patients using the night bed, intensification of the follow-up offered to the families, establishment of communication among professionals about the reasons for the use of the bed and for discharge, and sharing with the family the decisions taken during the crisis. Furthermore, it was also proposed that the criteria to refer patients to be hospitalized in other services should be explained, as well as that the follow-up of hospitalizations should be guaranteed. Finally, the participants recommended that the service should be available as home care for patients in crisis.

Individual Therapeutic Project (ITP) and Reference Professional/Team

In the evaluation of this theme, ITP was viewed as consolidated in the services, being evaluated periodically, with care being taken not to make it become merely a formality. The work in reference teams was preferred because it allowed and improved the discussion of the cases. Considering the centralization of the follow-up practices on the reference professional, important trust relations could be constituted; however, there could be difficulties in sharing responsibilities for the case. An excessive number of users per reference professional was reported.

As for the evaluative parameters, the participants indicated the periodic verification of the percentage of users who: use other network resources, had their ITP discussed in the last year, were assisted by other professionals, besides their reference technician.

Concerning the evaluative devices, the participants suggested the creation of workshops for workers aiming to present and discuss the work they perform and the theoretical framework they adopt, and workshops targeted at users and family members, aiming to explain about the main medicines that are used and about the forms of service structuring.

Group practices

The participants evaluated that such practices happen in all the CAPS, in many modalities, but they are neither discussed nor supervised among the professionals. The users, in turn, referred to the groups as an important learning and exchange space, while the family members described them as support opportunities, but they would like them to happen at more convenient times, with the presence of their relative's reference technician.

Regarding the evaluative parameters, the participants reported: planning of necessary resources and competences to develop the group practices; the existence of groups for family members and participation criteria, as well as the inclusion of users in the construction and evaluation of the offered groups; mapping of the groups existing inside and outside the CAPS' territory; and the establishment of partnerships with other services of the network in order to create groups.

Evaluative devices were not mentioned.

Management

The evaluation included reports referring to the recognition of the manager's responsibility for the developed clinical approach, the recognition of shift change as an important device of contact with the service's daily routine and the criticism to the fact that the night shifts function similarly to the routines of the psychiatric hospitals. The participants mentioned the inexistence of a career and salary plan, of workers' isonomy and evaluation. The clinical and institutional supervisions, although very valued by the workers, lacked monitoring and evaluation spheres. They reported difficulties in the management of doctors by non-doctors and difficulties deriving from the fact that 24-hour assistance is provided by nursing teams, but not by multidisciplinary teams.

As for evaluative parameters, the participants mentioned the CAPS managers' regular participation in intersector forums, in CAPS' interventions in the territory, in the activities that include family members and the existence of a managerial council and other participatory management arrangements, like the assemblies.

To evaluate the CAPS management, it was also proposed that the services question themselves about the managers' participation in clinical decisions and in the construction of the ITP, about the existence of clinical-institutional supervision, of continuing education, of interdisciplinary care provided in moment of crisis during the night and on weekends, and of the night team's participation in the discussion of the ITP.

Conception of CAPS and articulation with the primary care network

The participants evaluated that some CAPS defined themselves as alternatives to the asylum and others, as substitutes, being different from one another regarding the number of psychiatric hospitalizations they refer. There were also differences concerning the establishment of a partnership with the network (potentialized in the CAPS under the direct management of the municipal health department) and concerning the management of the daily routine (facilitated in the CAPS under the administration of a non-governmental organization, in co-management with the municipal government). The coordinators of primary care units seemed to have a vague and distorted idea of the CAPS' work, independently of the number of patients their unit referred to the Mental Health unit. The studied health agents did not know about the CAPS' function and stated they practiced mental health actions based on common sense.

The participants indicated as evaluative parameter the identification of the number of services that share projects with CAPS, and as evaluative devices: creation of a regular CAPS forum, where these services could share problems and solutions, constitution of local councils in the CAPS and record of the encounters and of the expenses disclosure performed in the services.

About the CAPS' relationship to the network, the workshops proposed that the services should know about the conceptions that the primary care units have of the CAPS' work, should map the users' trajectory across the network until they arrive at CAPS, should adequate the CAPS to Directive no. 336[a] (which regulates the CAPS) and should improve the quality of the food they offer to the users.

Professional education and workers' psychological distress

The participants evaluated as sources of distress: contact with users' madness and social needs, large demand, lack of resources, dialog difficulties with the primary care network, lack of distinction between spaces that are open to users and those that are for workers only, and relationship difficulties in the team in relation to the institutional hierarchy, specially to nursing professionals of technical level.

The organization of the night and weekend shifts was mentioned as the main source of anxiety, as the professionals remain in direct contact with the patients in crisis for long periods of time, making important decisions about the cases all by themselves. Many diseases (hypertension, depression, among others) were associated with somatizations of the distress caused by/at work. Change of shifts, team meetings and supervisions were referred to as forms of helping the workers cope with distress.

The evaluative parameter that was indicated was the percentage of workers involved with some type of professional formation, as well as of those who receive subsidies from the institution to undertake it.

Among the aspects proposed to be taken into account in the service's evaluation, there were participants who highlighted the importance of reflecting on the existence and duration of the team's meetings, the participation of all in the collective decisions, the dialog between the diverse clinical approaches, the strategies used to receive and follow up users, the existence, regularity and guarantee of supervisions financing, adapting the language used in the supervision to the several members of the team, as well as the language's capacity to trigger a self-questioning in the team and to discuss the ITP.

The workshops also proposed: to stimulate the performance of the change of shift between the day and night teams, to question the paradigm that sustains the night work, to check the coherence between the day and night teams regarding the criteria used to indicate the use of night bed and to reflect on the possibility that the night team participates in the team's meetings, having its questions taken into account. In addition, they highlighted the need for high-quality qualifications with transparent admission criteria when they are financed by the public power, for management's flexibility so that workers can participate in permanent education processes, and for support so that the professionals can also become educators, transmitting their experience.

FINAL REMARKS AND RECOMMENDATIONS

In Campinas, the expansion of the CAPS network occurred due to the effort and courage of managers and workers with different qualifications. This expansion

---

[a] Ministério da Saúde. Legislação em saúde mental. 2. ed. Brasília; 2002.

produced: rehabilitation, follow-up in the community environment, increased autonomy and effective replacement of the model centered on the psychiatric hospital. This effect of the public mental health policies cannot be disregarded in the discussion about resources.

The fragilities observed in the mental health network of Campinas point to the need of offering normative elements that enable to extend the night and weekend assistance to the multiprofessional team as a whole. Otherwise, the CAPS III may repeat the day/night fragmentation, something that occurred in the psychiatric hospital. In Campinas, the fact that doctors are working in shifts at distance (SAMU) is, on the one hand, a source of backup to the network as a whole and, on the other hand, a source of intense distress when patients are unknown to the teams or when they have associated non-psychiatric clinical problems.

Some recommendations can be formulated based on the findings of our investigation and we offer them as a subsidy to the necessary and permanent reformulation of the public policies of the area:

- it is necessary to expand the specialization courses and to redefine the curricular plans of many health professions;

- it is important to define career and salary plans, selection processes and stability norms that allow to qualify and to recover the necessary isonomy in the work at the CAPS;

- the CAPS professionals' continuing education should be stimulated. Regarding this, the clinical-institutional supervisions are scarce and there is the risk that they become a space of "knowledge-power" that operates on the teams, totally distant from the local management;

- the stimulus to and strengthening of democratic management and managers' education must also be considered: after all, the local manager is in charge of the management of the CAPS clinical approach, of its relationship to the health network as a whole and of the multiprofessional team itself;

- users and family members should receive more information from the public health services in relation to diseases, treatments and medicines, strengthening their participation and autonomy;

- it is important to debate the theme of the entrance door to the CAPS and of their insertion in the territory. Family members and users highlight that the services must be flexible, adapted to their possibilities, so that they can assist patients during emergencies: meetings' timetable, care provided at home during the crisis, for example;

- the CAPS are part of an efficient mental health policy targeted at patients with very serious psychosis and neurosis who have or have not been admitted to asylums. This policy must be extended and sustained, and its viability must be ensured in terms of resources, qualification and hiring of personnel;

- it is necessary to design a public policy focusing on other prevailing mental health problems, characterizing other types of subjective crises: violence, somatizations, depression, drug addiction, among others, so as to define the roles and profiles of the many spheres involved in mental health assistance.

In our research, CAPS proved to be a rich field in terms of practices and systematizations that indicate consolidated advances regarding the service's organization. The inclusion of workers, family members and users both in the focus groups and in the workshops potentialized the participatory research devices and provided the material produced in them with an emphasis on diversity, respect for difference, and recognition of life expertise, not only of academia or services management.

The study's methodological innovation is in the utilization of the narrative approach in the treatment of the material produced by the focus groups, as well as in the subsequent participatory handling of such texts, with the extraction of the argumentation nuclei and their transformation, in the workshops, into indicators and analyzers. These innovations were brought about by the researchers' interest[5] in producing dialogic interventions and also by the very research object, as there are still few studies about the "black boxes" of the work processes at CAPS.

The exploration of the narratives enabled the emergence of stories "not-yet-told"[15]. With this choice, we intended not only to tell a unique, chronologically arranged story, but, above all, to understand the work processes and the exchanges that occur in the daily routine of the CAPS.

We realized that, despite some discursive divergences, the workers could identify many common problems and the need for joint strategies to face them. Today, a forum for CAPS workers is being created in Campinas, which will be an innovation in the mental health work process, and to which our research has contributed. Gadamer[5] says that, when one succeeds in understanding, he/she always understands in a different, and consequently productive, way.

It has been traditionally stated that qualitative research does not produce explanations, but interpretations that amplify our understanding of the object under study. Its possible generalizations are not in the level of empiricism, but in the theoretical-conceptual one.

In this sense, we hope that the consensuses about the analyzers, indicators and parameters for a CAPS III network can be useful to other researchers and to the managers of SUS (Brazil's National Health System) in their local and federal spheres.

Our study of a municipal CAPS III network is original, in view of the recent implementation of these services in Brazil and because we have neither similar services in the international bibliography, nor other studies published in the Brazilian context. The CAPS III proposal for treating the crises away from the psychiatric hospital is of interest to other national health systems that are concerned about the improvement in mental health assistance.

Evidently, our understanding presents marks that are characteristic of Campinas' mental health network and of its historical and social formation. However, our evaluative approach, inspired by fourth generation evaluation,[6] allowed us to apprehend the CAPS practices in their complexity, composed of several opinions and versions in which what is important is not to discover which one is true; rather, as all of them are true, they express a singular positioning in the historical-social field. Thus, instead of talking about possible biases, we should talk about the limits of our investigation, limits given by the methodology that prioritized the understanding rather than objective description, and the production of participatory consensuses rather than the production of neutral truths.

REFERENCES

1. Delgado PG, Gomes MPC, Coutinho ESF. Novos rumos nas políticas de saúde mental no Brasil. *Cad Saude Publica*. 2001;17(3):452-3. DOI:10.1590/S0102-311X2001000300001

2. Furtado JP. Um método construtivista para a avaliação em saúde. *Cienc Saude Coletiva*. 2001;6(1):165-82. DOI:10.1590/S1413-81232001000100014

3. Furtado JP, Onocko Campos R. A transposição das políticas de saúde mental no Brasil para a prática nos novos serviços. *Rev Latinoam Psicopatol Fundam*. 2005;8(1):109-22.

4. Furtado JP. Avaliação para o conhecimento e a transformação. In: Bosi ML, Mercado F. Avaliação qualitativa em saúde. Rio de Janeiro: Vozes; 2006. p. 191-206.

5. Gadamer HG. Verdade e método: traços fundamentais de uma hermenêutica filosófica. Petrópolis: Vozes; 1997.

6. Guba EG, Lincoln YS. Fourth generation evaluation. Newbury Park: Sage; 1989.

7. Kaës R. Realidade psíquica e sofrimento nas instituições. In: Kaës R, Bleger J, Enriquez E, Fornani F, Fustier P. A instituição e as instituições. São Paulo: Casa do Psicólogo; 1991.

8. Marazina I. Trabalhador da saúde mental: encruzilhada da loucura. *SaudeLoucura*. 1991;1(1):69-74.

9. Morgan DL. Focus groups as qualitative research. Thousand Oaks: Sage; 1997.

10. Onocko Campos R. Clínica: a palavra negada: sobre as práticas clínicas nos serviços substitutivos de saúde mental. *Saude Debate*. 2001;25(58):98-111.

11. Onocko Campos R. La gestion: espace d'interevention, d'analyse et de especificités techniques. *Rev Prat Cah Med Utop*. 2003;2(1):139-54.

12. Onocko Campos R. O planejamento no labirinto: uma viagem hermenêutica. São Paulo: Hucitec; 2003.

13. Onocko Campos R. O encontro trabalhador-usuário na atenção à saúde: uma contribuição da narrativa psicanalítica ao tema do sujeito na saúde coletiva. *Cien Saude Coletiva*. 2005;10(3):573-83. DOI: 10.1590/S1413-81232005000300015

14. Patton MQ. Utilization-focused evaluation. Beverly Hills: Sage; 1997.

15. Ricoeur P. Interpretação e ideologias. Rio de Janeiro: Francisco Alves; 1990.

16. Ricoeur P. Tempo e narrativa. Campinas: Papirus; 1994. v.1.

17. Wright JTC, Giovinazzo RA. Delphi: uma ferramenta de apoio ao planejamento prospectivo. *Cad Pesq Admin*. 2000;1(12):55-65.