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ASSESSMENT OF THE STRUCTURE AND PROCESS OF PSYCHOSOCIAL CARE CENTERS OF SOUTHERN BRAZIL[1]

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ABSTRACT
The objective of this article was to evaluate the structure and process of Psychosocial Care Centers from Southern Brazil. It consists of a descriptive study conducted in thirty services, from the results of self-applied questioners to the coordinators. The data collected from May to June of 2006, suffered double typing, cleaning, quality control and the analysis were performed in Epi Info 6.04 software and Stata 7. The results were compared to the Ministry of Health parameters. The analysis indicated that the Psychosocial Care Centers studied, have an adequate physical infrastructure, count in accordance with human resources, and/or higher, with the recommendations. In relation to human resources in duty, it is identified the presence of 100% of psychologists, 93% of psychiatrists and 76.7% of nurses. And when it comes to feeding 94% of services provide at least one meal daily. Only 50% of services operate on the logic of territory. Assessing the services of the study in relation the structure and process we find that they are adapting to the Ministry of Health guidelines for the area of Mental Health, and they point to its sedimentation as health units in the process of psychiatric reform.

Keywords: Mental Health. Rehabilitation. Health Services Evaluation.

INTRODUCTION

The care for a person in mental distress has experienced several changes in the world and Brazilian society. Since the conception of insanity as "bad", a threshold has been reached in which this disorder is recognized as a suffering that needs an extended care in the territory, according to the psychosocial care's logic.

This reasoning reached the various sectors of the social organization, including public health policies, which transformed the model of mental health care in the country, in order to replace a psychiatry centered in the hospital by a care sustained with diversified and communitarian services, from a network perspective[1].

Such reformulation was initially based on the struggle of employees and family and, later, of different sectors of society which, after years of neglect and deprivation of human rights to people in psychiatric distress by mental hospitals, decided to change the way of facing insanity in the everyday life[2].

The proposal took as a model the psychiatric reform consisting on the replacement of mental hospitals by community-based services in network, in order to promote a therapeutic intervention in the individual`s social context[3]. This change in the care model, through an approach focused on promotion and rehabilitation, seeks to break with the segregation model, offering freedom to the person in psychological distress who is under treatment [4].

The Ordinance GM 336/2002[5], as a legislative regulation, is emphasized in the process of psychiatric reform, since it redirects funding for mental health, from a hospital model to a community model. In the same way, it defines and establishes guidelines for the operation of the *Centros de Atenção Psicossocial* [Psychosocial Care Centers] (CAPS), characterizing them as substitutive spaces that provide people in psychological distress with a freedom-based care, seeking to realize psychosocial care in Brazil, founded on the model of the Italian deinstitutionalization.

Considering that assessment is a systematic and objective process, which analyzes the effectiveness of a particular practice from specific goals, aiming to give a new direction to

[1]A study taken from the Assessment of the Psychosocial Care Centers of Southern Brazil (CAPSUL). Announcement Ministry of Science and Technology-CNPq/ Ministry of Health – SCTIE-DECIT/CT-Saude 07/2005

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improve its viability[6], the assessment of the *Centros de Atenção Psicossocial da Região Sul do Brasil* [Psychosocial Care Centers of Southern Brazil] (CAPSUL)[7] was based on the need to assess the CAPS, as new modalities of care, monitoring the work of construction and execution of a public policy supported by knowledge and practices of multi-professional and interdisciplinary staff, engaged in reinserting users in the society and turn the humanization of care into reality.

This article aimed to assess the structure and process of Psychosocial Care Centers of Southern Brazil, based on the data obtained from the coordinators of the services and the Ministry of Health's parameters — among them, the Ordinance GM 336/2002[5].

METHODOLOGY

The assessment of the Psychosocial Care Centers of Southern Brazil (CAPSUL) consisted of two studies, one qualitative and one quantitative. The qualitative study had an epidemiological approach guided by Donabedian [6], in the analysis of the structure, process and result. According to the author, the assessment of the quality of care can guide the exploration directed to the most effective strategies in a process of services restructuration. Accordingly, the quantitative study assessed users, their families, employees and coordinators. In this article, the axis of coordinators is discussed in relation to the process and the structure.

Out of a total of 102 CAPS registered with the Ministry of Health in 2005, in the South of Brazil, a sample of 30 CAPS was randomly drawn, respecting the proportionality of services by state and type of CAPS I or II, resulting in 3 CAPS in Paraná, 9 in Santa Catarina and 18 in Rio Grande do Sul.

In the instrument, the questions related to aspects of structure and process were prepared from the Ministry of Health's recommendations, which include the Ordinance GM 336/2002[5]. The data were collected by 14 interviewers, previously trained between May 8 and June 20, 2006, coordinated by two supervisors.

The coordinators of the 30 Psychosocial Care Centers (CAPS), of 30 cities in the South of Brazil, answered a self-applied questionnaire that sought to achieve the following specific goals: to identify the structural conditions related to the physical area, human resources, materials and aspects of process, such as service supply and performance within the territory in the CAPS of the South.

The questionnaires were coded by the interviewer, and the data were subjected to double-entry by independent typists, through the software EPI - INFO 6.04. The data were cleaned through the comparison between the two files and the assessment of amplitude errors and consistency. The database was used for necessary corrections, and univariate analyses were performed through the software STATA 7.

The quality control was performed during the application of the instruments of collection: by checking each interviewer at the end of the interview; during the review by supervisors after receiving the questionnaire, during the replication of 5% of the interviews and during the data entry through double-entry, checking and consistency map. The discussion was supported by the Ministry of Health's recommendations, which include the Ordinance GM 336/2002[5], and the current literature. The study was approved by the Ethics Committee of the Faculty of Medicine of the Federal University of Pelotas, having met all the requirements for its approval, according to Letter 074 /2005.

RESULTS AND DISCUSSION

For a better understanding of the data, the results of the structure and process of the Psychosocial Care Centers will be presented and discussed.

Assessment of the structure of the Psychosocial Care Centers

The Article 2 of the Ordinance GM 336/2002 of the Ministry of Health provides that Psychosocial Care Centers must be legal and public, which is in agreement with the result pointed by the 30 coordinators interviewed. In the Article 3, on the independence of the specific physical area of the CAPS of the hospital structure, 100% of the coordinators reported that the services follow this logic.

The Ordinance GM 336/2002 of the Ministry of Health regards the CAPS as substitutive services that primarily care for users with severe and persistent mental disorders, in their territorial area. Also, these devices are distinguished based on their size, complexity and population scope [5, 8-11].

According to the Ordinance GM 336/2002 of the Ministry of Health, in the Article 1, supplemented in the Article 4, CAPS I are psychosocial care services with operational capacity to serve municipalities with a population between 20,000 and 70,000 inhabitants; in turn, CAPS II are psychosocial care services with operational capacity to serve municipalities with populations between 70,000 and 200,000 inhabitants.

The literature reports that these devices should provide users with spaces for mental health care — in conjunction with primary health care and hospitals — and social support, such as work, leisure, shelters, assistance with social security and other rights[3-5, 12].

Knowing that the CAPS should constitute themselves as community services of daily care and operate according to the territory's logic, this study found that, according to the coordinators, 50% of the services do not follow this organization.

In our assessment, such fact is an important limitation that needs to advance. We stress that using the territory, recognizing it beyond the geographical boundary, including its affective, existential, cultural, economic, social, legislative, political, among others dimensions [13], generates objective possibilities for the CAPS to know their surrounding population, establish a bond, work with the logic of health surveillance, in order to meet the needs of the population.

In the paragraph 4.1 f of the Ordinance GM 336/2002, which establishes that the CAPS must operate from 8am to 6pm, in two (2) shifts, during the five weekdays, it is observed, from the data obtained, that only 60% of the services follow this logic. Also, 36.7% operates from 8am to 12pm and from 2pm to 6pm, and 3.7 % from 8am to 11:30am and from 1:30pm to 4:30pm.

Regarding the opening hours of the CAPS, about which it is pointed out that 36.7% of the coordinators and staff serve their clientele from 8am to 12pm and from 2pm to 6pm, this study considers that this interruption, during lunch break, compromises the continuity of the service, especially for those users who may need intensive care. It has to be stressed that the meal time is of utmost importance for the acquisition of healthy habits, whether regarding nutrition, behavior, collective sharing or social life.

Accordingly, it is observed that the CAPS tend to repeat the organization of traditional health units, such as the Basic Health Units (BHU), instead of differentiating themselves, just for having to promote a mental health care that aims to reintegrate people in their normal lives. The logic of these hours of operation is also historically supported, in the first legal regulations of the Brazilian psychosocial care, such as the Ordinance SNAS 224 of January 29, 1992, whose Article 2.1 states that the CAPS/NAPS can structure their operation in one or two shifts of four hours. This determination is updated by the Ordinance GM 336/2002[5] that regulates the hours of operation for the CAPS I and II from 8am to 6pm, in two (2) shifts during the five weekdays.

As for the meals, the Ordinance provides that the users attending the CAPS in one shift (4 hours) will receive a daily meal, and those assisted in two shifts (8 hours) will receive two daily meals. In the analysis of the questionnaires, 93.33% of the services offer meals, 73.08% provides a breakfast, 37.5 % a morning snack, 88.89 % serves lunch and 96.43 % an afternoon snack.

According to the coordinators, none of the CAPS I and II investigated offers dinner and evening snack, which is justified by the hours of operation, in accordance with the Ordinance GM 336/2002 of the Ministry of Health and the type of CAPS. Also, only 10% of the CAPS has a special menu for hypertensive patients and 23.3% for diabetic patients.

The ministerial regulation sets a minimum staff for the operation of the CAPS I, for the care of twenty (20) to thirty (30) users under intensive care per shift; in turn, the CAPS II must serve thirty (30) to 45 (forty five) users in intensive care per shift. In comparison with the data obtained, there is:

Table 1 – Distribution of the human resources of the CAPS of Southern Brazil, according to the coordinators, Brazil, 2006*

Professional	Number (p)	Percentage
General Practitioner (1-2)	12	40%
Psychiatrist (1-4)	28	93.3%
General Nurse (1-2)	23	76.7%
Nurse trained in Mental Health (1-2)	8	26.6%
Psychologist (1-7)	30	100%
Social worker (1-2)	26	86.7%
Occupational Therapist (1-4)	19	63.3%
Educator (1-3)	8	26.6%
Tec./Aux. Nurses (1-5)	25	83.3%
Administrative Technician (1-4)	23	76.6%
Educational/Occupational Technician (1)	5	16.7%
Artisan (1-3)	9	30%

*Professionals listed in accordance with the Ordinance GM 336/2002 of the Ministry of Health

Source: CAPSUL, 2006.

With regard to human resources, specifically physicians, according to the Ordinance GM 336/2002, the CAPS I must count with physician trained in mental health and the CAPS II with a psychiatrist. The present study observed the presence of psychiatrists in 93.3% of the CAPS, which numerically extrapolates the requirements of the Ordinance. However, as for the workload, since most CAPS count with psychiatrists, and the others with general practitioners, the time this professional effectively works, as well as the other professionals in this scope, has not been assessed.

Regarding nurses, there should be 50% of general nurses (CAPS I) and 50% of nurses trained in mental health (CAPS II). This study verified that 76.7 % of the services have one or two nurses, while only 26.8 % have a nurse trained in mental health. It should be also emphasized the category of psychologists, who stand out among the other professionals, since there is 100% of psychologists in the CAPS (1-7 professionals per service).

In relation to the physical structure, approximately 36.7 % of the coordinators are unaware of the physical area of the services they coordinate. Among the 19 CAPS that referred physical area, the figures showed an average of 287.48 m^2, ranging between 170 m^2 and 658.44m^2. Among the coordinators, 40 % reported that the number of rooms meets the services demand.

As for the physical space to hold structured and equipped workshops in the CAPS of the South, the coordinators responded that, in their services, 63.3 % is appropriate. Table 2 displays the distribution of available rooms in the CAPS, according to their purpose.

About the adequacy of the physical infrastructure for people with special needs, in the 30 services studied, only 33.3 % have an adequate infrastructure, which is confirmed by the presence of ramp in only 40% of the CAPS. Still about the structure, according to the coordinators, 83.3 % of the CAPS have a patio, 46.7 % count with a vegetable garden, 67.7 % have a yard, 20% have an area for activities and 16.7 % have a covered outside area in the physical space of the service.

Table 2 – Availability of rooms for activities, according to the coordinators, in the CAPS of Southern Brazil, 2006.

Rooms	Number (p)	Percentage (%)
Room for collective and individual care (3-12)	30	100%
Room for individual care (1-7)	30	100%
Room for collective activities (1-5)	30	100%
Rooms for nursing/procedures (1-2)	28	93.3%
Bed (1-3)	18	59.9%
Bathroom (1-7)	30	100%
Kitchen (1)	30	100%
Dining Hall (1-2)	28	93.3%

Source: CAPSUL, 2006.

It is known that the physical space influences the care provided. In this sense, the environment of the physical space is understood as a place for social, professional and interpersonal relations that provide a warm, resolutive and human care. The ambience in the architecture of the spaces of health goes beyond technical, simple and formal composition of the environments and considers the situations that are constructed. (14).

According to the Ministry of Health's guidelines, the minimum physical structure in which CAPS must operate includes: rooms for individual activities (consultations, interviews, therapies), rooms for group activities, living space, workshops; dining hall; toilets; outdoor area for workshops, recreation and sports. In the quantitative study on the assessment of the CAPS of southern Brazil, according to the coordinators, the services analyzed have these spaces in their physical structure.

Regarding the care rooms listed in Table 2, it is observed that the CAPS are working with groups, workshops and not only individual services, which characterizes them as community health services seeking to expand and optimize the instruments of work.

As for the use of other community spaces by the CAPS, the coordinators declared that, in 18 of the 30 services, there are activities developed in the territory. This inclusion is distributed as follows: gymnasium and sports court (50%), ballrooms (36.7%), art studio (13.3%), *Gaucho* Traditions Center/CTG (6.7%) and gym (3.3%).

Thinking of the conjunction with the territory, 70% of the coordinators reported that there are formal or informal relationships with different sectors and services of society: basic network — 96.7%; other instances of articulation, health services (Emergency Rooms, General Hospital, Secure Hospital, Psychiatric Hospital, *Serviço de Atendimento Móvel de Urgência* [Mobile Emergency Service] SAMU, Basic Health Units (BHU), other Psychosocial Care Centers (CAPS), *Estratégia Saúde da Família* [Family Health Strategy] (ESF), *Programa de Agentes Comunitários de Saúde* [Program of Community Health Agents] (PACS) and matrix staffs) — 30 %; public and private institutions *Instituto Nacional do Seguro Social* (National Institute for Social Security] (INSS), Guardianship Council, Forum, Prosecutor, Military Police, Judiciary, State Secretary of Health, Secretary of Social Service, City Council, Municipal Commission for Mental Health, Municipal Health Council, District Health Council, Secretary of Housing, and other secretaries, universities, schools, technical courses, Professionalization Network: *Serviço Nacional do Comércio* [National Service for Business Training] (SESC), *Serviço Nacional de Aprendizagem Industrial* [National Service for Industrial Training] (Senai), *Sistema Nacional de Emprego* [National System of Employment] (SINE); Clubs in general) — 36.7%.

When it comes to the mechanisms to prevent admissions to psychiatric hospitals, 20 services (66.7%) reported that they put such strategies into practice, and the places to which critical patients are referred are: emergency rooms (20%), general hospital (16.7%) and psychiatric emergency (6.7%).

Also, 100% of the Secretaries of Health and/or the CAPS, provide the prescribed medications (psychotropic), and the most

distributed drugs are: 100 % (Chlorpromazine; Haloperidol, Carbamazepine, Amitriptyline; Biperiden), from 93.3% to 96.7% (Phenobarbital, Phenytoin, Diazepam, Lithium Carbonate, Promethazine, Imipramine).

Assessment of the process of the Psychosocial Care Centers

The Article 4 of the Ordinance GM 336/2002 cites activities that must be offered in the CAPS, namely: individual care (medication, psychotherapy, orientation, among others); group care (psychotherapy, operative group, activities for social support, among others); care in therapeutic rooms run by a professional with higher education or technical course, home visits, family care, community activities focusing on the patients' integration in the community and their insertion in their family and society. In the assessment of the Psychosocial Care Centers of Southern Brazil, the coordinators pointed the following activities (Table 3).

Table 3 - Services offered by the CAPS of Southern Brazil, 2006*.

Proposed Activity	Number (p)	Percentage (%)
Individual care in the service	30	100%
Individual care at home	28	93,3%
Psychotherapeutic individual care	30	100%
Psychotherapeutic group care	22	81.48%
Group care by operative group	21	80.77%
Group care with activities for social support (Citizenship/Education/Fam.)	4	13.3%
Care in therapeutic rooms	30	100%
Care for family orientation	29	96.67%
Group care for families	23	76.67%
Assemblies	21	71%
Home visit	29	96.7%

*Activities proposed by the Ordinance GM 336/2002 of the Ministry of Health

Source: CAPSUL, 2006.

Still according to the coordinators, the main therapeutic workshops held in the services are: arts (86.7%), hygiene and special care (80%), music (63.3%), income generation (56.7%), dance (46.7%), study/culture/communication (26.7%) and exercises/touring/fun (13.3%). A total of 90% of the services (20) count with transportation for these activities.

With respect to family care, the coordinators point out the work with group of relatives, making explicit their approaches: space for discussion on how to deal with the user (73.3%); the treatment of the user (73.3%); emphasis on psychological support encouraging interaction between family and user (76.67%); the pathology of the user (70%).

Discussing the activities developed by the CAPS for family care, this investigation observed that the services work with the family focused on the care for the person in psychological distress, pushing aside specific demands, suffering and burden of the family. Thus, the family, instead of being equally considered as the protagonist in this process, is seen as a tool for the extension of care for the one who suffers psychologically, limiting the possibility to look at this family and their experiences derived from this psychological distress.

In this sense, it is necessary to advance the practices of care for the families of people in psychological distress, recognizing them, firstly, as individuals, and not just caregivers, weaving

other dialogues to bring about an effective health [15-17].

FINAL CONSIDERATIONS

From the data analysis of the structure of the CAPS of southern Brazil, having as an assessment parameter the Ministry of Health's regulation, such as the Ordinance GM 336/2002, it can be stated that the Psychosocial Care Centers assessed are adequate with respect to their physical structure and human resources. Regarding the process, the care for the users proved efficient, but the family care still needs to be focused on the caregiver. Thus, most of the services studied are in accordance with the guidelines of the National Coordination for Mental Health, of the Ministry of Health, which regards psychosocial care as a way to care for and treat the person in psychological distress in the Brazilian territory.

It is noteworthy that the existing Ordinances and Laws that regulate mental health, with a view to the Psychiatric Reform and psychosocial care, are more recent than the *Sistema Único de Saúde* [Unified Health System] (SUS); however, point to the sedimentation of their services, rethinking their practices, in order to improve the care provided to people in psychological distress, thus qualifying the health of the population as a whole.

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AVALIAÇÃO DE ESTRUTURA E PROCESSO DOS CENTROS DE ATENÇÃO PSICOSSOCIAL DA REGIÃO SUL DO BRASIL

RESUMO

O objetivo deste artigo foi avaliar a estrutura e processo de Centros de Atenção Psicossocial da Região Sul do Brasil. Consiste em um estudo descritivo realizado em trinta serviços a partir dos resultados obtidos dos questionários autoaplicados aos coordenadores. Os dados coletados de maio a junho de 2006 sofreram dupla digitação, limpeza, controle de qualidade e as análises foram realizadas nos softwares Epi Info 6.04 e Stata 7. Os resultados foram comparados aos parâmetros do Ministério da Saúde. A análise indicou que os Centros de Atenção Psicossocial estudados têm uma estrutura física adequada, contam com recursos humanos de acordo, e/ou superior, com o preconizado. Em relação aos recursos humanos, identifica-se, nos serviços, a presença de 100% de psicólogos, 93% de psiquiatras, e 76,7% de enfermeiros. No que se refere à alimentação, 94% dos serviços disponibilizam, ao menos, uma refeição diária. E apenas 50% dos serviços funcionam segundo a lógica do território. Avaliando os serviços do estudo em relação à estrutura e processo, concluímos que estes estão se adequando às diretrizes do Ministério da Saúde para a área temática de Saúde Mental, e apontam para sua sedimentação enquanto unidades de saúde dentro do processo de reforma psiquiátrica.

Palavras-chave: Saúde Mental. Reabilitação. Avaliação de Serviços de Saúde.

ANÁLISIS DE LA ESTRUCTURA Y LOS PROCESOS DE LOS CENTROS DE ATENCIÓN PSICOSOCIAL DE LA REGIÓN SUR DE BRASIL

RESUMEN

El objetivo de este artículo fue el de evaluar la estructura y el proceso de Centros de Atención Psicosocial de la Región Sur de Brasil. Consiste en un estudio descriptivo realizado en treinta servicios a partir de los resultados obtenidos de los cuestionarios auto-aplicados a los coordinadores. Los datos recolectados de mayo a junio de 2006 sufrieron doble digitación, limpieza, control de calidad y los análisis fueron realizados en los softwares Epi Info 6.04 y Stata 7. Los resultados fueron comparados a los parámetros del Ministerio de la Salud. El análisis indicó que los Centros de Atención Psicosocial estudiados tienen una estructura física adecuada, cuentan con recursos humanos de acuerdo, y/o superior, con lo preconizado. En relación a los recursos humanos, se identifica, en los servicios, la presencia de 100% de psicólogos, 93% de psiquiatras y 76,7% de enfermeros. En lo que se refiere a la alimentación, 94% de los servicios disponen, al menos, una comida diaria. Y sólo 50% de los servicios funcionan según la lógica del territorio. Evaluando los servicios del estudio en relación a la estructura y proceso, concluimos que éstos están adecuándose a las directrices del Ministerio de la Salud para el

área temática de Salud Mental, y apuntan para su sedimentación como unidades de salud dentro del proceso de reforma psiquiátrica.

Palabras clave: Salud Mental. Rehabilitación. Evaluación de Servicios de Salud.

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