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## PSYCHOSOCIAL CARE CENTERS: WORK OFFERED COMPARED TO LEGISLATION<sup>1</sup>

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**ABSTRACT.** Psychosocial Care Centers were developed as an alternative to the asylum model of mental health care predominant in psychiatric hospitals. The evaluation of service delivery is essential for ensuring quality of care and achieving the goals of the Brazilian psychiatric reform. In view of the above, this study aims to assess and describe the psychosocial treatment provided by four Psychosocial Care Centers in a municipality in the northeast of Brazil. The study used a qualitative research design and methodological triangulation based on documentary analysis of existing legislation and a thematic analysis (Minayo, 2009) of interviews conducted with managers of the centers with the aid of the software package QDA Miner. The findings show that the work processes in place in the centers investigated by this study are grounded in the asylum model of mental health care and a doctor-centered and psychopharmacological approach. This in turn hinders the services' capacity to plan activities focusing on users' rights. With respect to the therapeutic plan, the findings show that there is a gap between the daily practice of health professionals and the standards and regulations envisaged by the legislation.

**Keywords:** Public health; psychosocial care centers; health evaluation.

## CENTROS DE ATENCIÓN PSICOSOCIAL: COMPARACIÓN ENTRE EL TRABAJO OFRECIDO Y LA LEGISLACIÓN

**RESUMEN.** Los Centros de Atención Psicosocial fueron idealizados para reemplazar las prácticas asilares predominantes en los hospitales psiquiátricos. La evaluación de las prácticas realizadas en dichos servicios se torna fundamental para intentar dar garantías sobre la calidad del cuidado ofrecido a los usuarios y alcanzar los objetivos del movimiento de Reforma Psiquiátrica brasileña. Teniendo en cuenta estos aspectos, el objetivo es describir y analizar el tratamiento psicosocial ofrecido en cuatro Centros de Atención Psicosocial de una ciudad en el noreste de Brasil. Se trata de una investigación cualitativa de triangulación metodológica que utilizó el análisis documental de la legislación vigente y el análisis de contenido temático (Minayo, 2009) de las entrevistas realizadas con profesionales de los servicios, con la ayuda del software QDA MINER. Fue observado que los procesos de trabajo se apoyan en pilares asilares: atención centrada en el médico y prescripción psicofarmacológica, así como también la dificultad de los servicios en llevar a cabo actividades en el territorio y centradas en los derechos de los usuarios. Sobre el plan de cuidados se percibe un distanciamiento entre las prácticas diarias de los profesionales y las normativas postuladas.

**Palabras-clave:** Salud colectiva; centros de atención psicosocial; evaluación en salud.

## CENTROS DE ATENÇÃO PSICOSSOCIAL: O TRABALHO OFERTADO COMPARADO COM A LEGISLAÇÃO

**RESUMO.** Os Centros de Atenção Psicossocial foram idealizados para substituir as práticas asilares predominantes nos hospitais psiquiátricos. A avaliação das práticas realizadas nesses serviços tornou-se fundamental na tentativa de garantir a qualidade da assistência ofertada aos usuários e de alcançar as

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metas do movimento da Reforma Psiquiátrica brasileira. Considerando tais aspectos o objetivo é descrever e analisar o tratamento psicossocial oferecido em quatro centros de atenção psicossocial de um município do nordeste brasileiro. Trata-se de uma pesquisa qualitativa de triangulação metodológica que utilizou a análise documental da legislação vigente e a análise de conteúdo temático (Minayo, 2009) de entrevistas realizadas com profissionais dos serviços, com auxílio do software QDA MINER. Observaram-se processos de trabalho apoiados em pilares asilares: médico centrado e psicofarmacológico e dificuldade dos serviços em planejar ações desenvolvidas no território e focadas nos direitos dos usuários. No plano do cuidado foi percebido o distanciamento entre as práticas cotidianas dos profissionais e as normativas postuladas.

**Palavras-chave:** Saúde coletiva; centros de atenção psicossocial; avaliação em saúde.

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## Introduction

Psychosocial Care Centers (*Centro de Atenção Psicossocial* - CAPS) play a strategic role in consolidating changes to mental health services aimed at promoting the social inclusion of users of the Unified Health System (*Sistema Único de Saúde* - SUS) who suffer from some form of mental disorder. The use of the word “user” in this paper, instead of “patient”, reflects our understanding of the concept of health as a human and social right regulated by relations of citizenship. The concept of user embraces not only the biological perspective on health, but also psychosocial aspects. It encompasses the individual in all his/her dimensions, regardless of the presence or absence of illness, and refers to the person who is receiving treatment and preventive health care (Saito, Zoboli, Schweitzer, & Maeda, 2013). In this sense, users exercise their rights to access health services.

Article 196 of the Brazilian Constitution, promulgated in 1988, establishes that “health is the right of all persons and the duty of the state”. While the constitution outlines the guiding principles for health care delivery under the Unified Health System, law 8080, promulgated in 1990, details how the system should operate in practice (Ministério da Saúde, 2004). The broad definition adopted by Article 3 suggests that various factors determine and influence health: the physical environment (geographic conditions, water, food and diet, type of dwelling, etc.); the socioeconomic and cultural environment (occupation, income, level of education, etc.); physical factors (age, sex, genetic inheritance, etc.); and access to health care services aimed at the promotion, protection and recovery of health. In order to fulfill its responsibility to ensure healthcare for all, the government formulates and implements economic and social policies, including a series of plans, programs, and projects, aimed at reforming the health system in order to ensure universal access to comprehensive health care actions and services.

This new care model, which replaced the hospital-centered model, emerged in Brazil within a context of reforms. The reform process was influenced internationally by the Regional Conference on Restructuring Psychiatric care in Latin America, attended by Argentina, Chile, Mexico, Uruguay, and Nicaragua (Declaration of Caracas, 1990), and at country level by the First and Second National Conferences on Mental Health (*Conferência Nacional de Saúde Mental* – CNSM), held in 1987 and 1992, and by the IX National Health Conference. The latter was a milestone in Psychiatric Reform in Brazil, since it led to the decentralization of the health service and the adoption of concepts such as territory, the regionalization of health actions, and equity, which made up the ideology behind the health reform. These were the actions that made the shift from the hospital-centric model truly possible (Ministério da Saúde, 2005).

According to Yassui (2006), it is impossible to think of psychiatric reform as being detached from the overall health reform movement and international movements seeking changes to overcome the shortcomings of the asylum model. At national level, the underlying principles of psychiatric reform, understood as a set of changes in knowledge, practices, and social and cultural values were manifested in the National Policy on Mental Health, Alcohol and Other Drugs (*Política Nacional de Saúde Mental, Álcool e outras Drogas*).

In 2001, Law N° 10.216 (Ministério da Saúde, 2004) was created, which protects the rights of persons suffering from mental disorders and reorients the mental health care model. Considerable progress in this area has subsequently been made, including the implementation of a network of substitute services

to provide care for people suffering from mental disorders or from the use of alcohol and other drugs. Ten years later, the Psychosocial Care Network (*Rede de Atenção Psicossocial* - RAPS) was created by Decree 3088 (Decree 3088) (Portaria 3088, 2011). The CAPS are the main pillars of this network and play a key role in service delivery.

The CAPS were one of the fruits of the abovementioned reorganization of mental health services, originating in 1987 when the first intermediate care facility between a psychiatric hospital and mental health outpatient clinic was created. They were officially legitimized as a daily service, organized on a geographical basis, by Ministerial Decree 336 (Decree 336) published in 2002 (Ministério da Saúde, 2004). This decree provided for the incorporation of the family, community, and the institutions involved in the implementation of the government's mental health strategy into the functional structure of these essentially extra-hospital facilities, through the provision of continuing education for staff and interns and university extension and research projects (Costa-Rosa, Luzio, & Yasuí, 2001). The Ministerial Decree 336 (Ministério da Saúde, 2004) describes three different types of facilities and different modalities: CAPS I, CAPS II, and CAPS III, and the modalities Mental Disorders (MD) and Alcohol and Drugs (AD) defined according to size/complexity and population coverage. The type of treatment offered by the facilities is either daily/intensive, weekly/semi-intensive, or monthly/nonintensive. The CAPS III MD offer a 24-hour service and beds are available for service users suffering from mental disorders in crisis; while the CAPS III AD offer detoxification facilities and provide overnight stay, including on national holidays and weekends.

In 2011, through Decree 3088 (Portaria 3088, 2011), which instituted the RAPS, aimed at creating, extending, and coordinating the SUS's mental health care network, the CAPS were recognized as specialist centers for psychosocial care. However, despite being considered a major social achievement, Bandeira, Pitta, and Mercier (1999) highlight a number of deficiencies that affect the capacity of these services to help patients live satisfactorily in the community. International and national organizations such as the World Health Organization (WHO) and Ministry of Health have proposed ongoing evaluations and the development of indicators to assess the effectiveness of substitute services.

The majority of studies in Brazil focus on the South and Southeast Regions and assess work processes and care delivery (Silva, Melo, & Esperidião, 2012). Some authors have confirmed that, despite daily challenges, health professionals manage to deliver quality services that result in positive outcomes (Mielke, Kantorski, Jardim, & Olschowski, 2009). Many others have observed that, although some of the activities and principles embodied by the psychiatric reform can be found in the substitute services, there continues to be an emphasis on doctor-centered activities, which are a far cry from reformist principles (Duarte, Nasi, Camatta, & Scheneider, 2012). Considering that evaluation is essential for ensuring quality of care and achieving the goals of the psychiatric reform in Brazil and the lack of data on the situation in the country's Northeast Region, this work aims to characterize the treatment provided to adult users of four psychosocial care centers located in a municipality in the northeast of Brazil and explore whether services are being delivered in accordance with current mental health regulations.

## Methodology

This work outlines the preliminary results of a qualitative study conducted as part of a doctoral thesis research project<sup>3</sup>. Field work was undertaken in a municipality that has a population of approximately 800,000 people and a psychosocial care network made up of four adult CAPS, one child CAPS, one Mental Health Outpatient Center, two Therapeutic Residences (*Residências Terapêuticas*), three Family Health Support Nucleus, three Street Consulting Room teams (*Equipes de Consultório na Rua*), six beds in the general hospital, and a mobile emergency care service. The study encompasses the four adult CAPS denominated services 1, 2, 3, and 4 in accordance with the description below (Table 1).

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<sup>3</sup> PhD thesis currently being undertaken by the first author under the supervision of the second author and co-supervision of the third author.

**Table 1.** Description of the services assessed (S1, S2, S3, and S4)

Characteristic s	S1	S2	S3	S4
Type of Service	Mental disorders, overnight stay for users in crisis	Mental disorders	Alcohol and other drugs, overnight stay for users in crisis	Alcohol and other drugs
Active users	108	62	142	80

Source: Study findings

A documental analysis was carried out of relevant laws, decrees, and other secondary sources of information (Minayo, 2009) in order to provide a normative characterization of comprehensive treatment based on the following dimensions: direct actions; and indirect actions. Primary data sources consisted of four semi-structured interviews conducted with the managers of the CAPS. The interviews were conducted by the first author, lasted for between 60 and 120 minutes, and were recorded and transcribed in full. The data was systematized using the software package QDA Miner Lite V 1.4.3 (Hernández, 2008). Thematic analysis was then conducted in the following stages (Minayo, 2009): prior analysis through the reading and re-reading of the text and the interpretation and organization of the content into clusters of meaning; coding consisted of identifying words and expressions that enabled the organization of categories and the final analysis of the results. The categories of analysis, based on the words of the informants, were divided into three main areas: actions carried out; actions not carried out; and difficulties in carrying out actions. The research project was approved by the Research Ethics Committee of the Federal University of Rio Grande do Norte (Approval number 510825/2014) and all participants signed an informed consent form.

## Results and discussion

Material relevant to the research objectives was selected for analysis based upon the reading of the Mental Health Law and 18 relevant decrees created by the Ministry of Health after its promulgation. Decrees that did not address the characteristics of the treatment provided by the CAPS or that focused on funding were excluded, except Decree 130/2012 (Decree130) (Portaria 130, 2012), which redefines the CAPS III AD and includes provisions relating to funding. The analysis identified the normative features of comprehensive treatment under the following dimensions: direct actions, understood as those actions that are the responsibility of health professionals, either individually or as a team, and have a direct effect on the user (Table 2); and indirect actions, understood as actions related to operational aspects and institutional dynamics, where responsibility is shared between service managers, the health team, and other institutions that indirectly affect users.

**Table 2.** Direct actions envisaged by the legislation for the operation of the CAPS

Direct actions	Decree 336/2002			Decree 130/2012
	CAPS			
	II MD	II AD	III MD	III AD
Intensive, semi-intensive, or nonintensive treatment regimes	X	X	X	
Individual care (medication, psychotherapy, counseling, etc.)	X	X	X	X
Group care (psychotherapy, operative groups, social support activities, etc.)	X	X	X	X
Therapeutic workshops coordinated by health professionals with secondary or higher education	X	X	X	X
Home visits/care	X	X	X	X
Family care	X	X	X	X <sup>a</sup>
Community activities focused on integrating the person suffering from mental illness into the community and family and social integration	X	X	X	X <sup>b</sup>
Weekly user meetings				X
Meals (1, 2 or 4 times a day)	X	X	X	X
Overnight stay, public holidays, and weekends			X	X
Disintoxication		X		X <sup>c</sup>

Source. Study findings

<sup>a</sup>Individual and group <sup>b</sup>Includes the expression "psychosocial rehabilitation activities" <sup>c</sup>Includes the expression "provision of combined and dispensed medication"

With respect to the data obtained from the interviews, the constituent elements of treatment provided by the CAPS were classified into three categories: actions carried out; actions not carried out (Table 3); and difficulties that result in actions not being carried out.

**Table 3.** Actions carried out and not carried out in the services investigated by the study (S1, S2, S3, and S4)

Actions	S1	S2	S3	S4
PTS	No	Yes	No	No
Treatment regime	Yes	Yes	Yes	Yes
Individual care				
Yes	Yes	Yes	Yes	Yes
Psychological	No	No	No	Yes
Social Work	Yes	Yes	Yes	Yes
Group care				
Psychotherapy	No	Yes	Yes	Yes
Operative groups	No	Yes	Yes	Yes
Therapeutic workshops	Yes	Yes	Yes	Yes
Social support activities				
Home visits	No	Yes	No	No
Family care	Partially	Yes	Partially	Yes
Community activities (rehabilitation, reintegration)	Partially	Yes	Partially	Partially
Overnight stay (crisis patients)	Partially	Not applicable	Partially	Not applicable
User meetings	Yes	Yes	No	No
Supervision and primary care capacity building (Matrix Support)	No	Yes	No	No

Source: Study findings

### Actions that make up the treatment provided by the caps

It is important to highlight that although the Mental Health Law does not cite the CAPS as a mechanism, a clear reference is made to the functional aspects of service provision in Article 2, which

refers to the field of mental health and the right to treatment, preferentially through community mental health services. Thus, Law 10.216 (Ministério da Saúde, 2004) does not clearly stipulate the specific actions that should make up the treatment provided by the CAPS.

The item of legislation that provides the clearest indication of the type of treatment that should be provided by the CAPS, which it calls "care provision" (*"assistência ofertada"*), is Decree 336<sup>4</sup>. Understood as direct actions (Table 2), this dimension includes the following activities: a) individual care (medication, psychotherapy, counseling, etc.); b) group care (psychotherapy, operative groups, social support activities, etc.); c) therapeutic workshops; d) home visits; e) family care; f) community activities focused on integrating the patient into the community and social and family integration; g) meals proportional to the length of stay; h) overnight stay for rest or observation, including on national holidays and weekends in the case of the CAPS III.

With respect to indirect actions directed at ensuring that the CAPS have the necessary capacity to provide treatment services, one of the paragraphs of Decree 3088 (Portaria 3088, 2011) suggests that work shall be carried out primarily in collective settings (groups, user meetings, daily team meetings) and coordinated with the activities of other care centers that make up the RAPS and other networks. It also suggests that care should be developed through the Single Therapeutic Plan (*Projeto Terapêutico Singular* - PTS) and shall include the health team, user, and his/her family, and that the CAPS or primary care mechanisms shall undertake the responsibility for providing care, ensuring an ongoing process of co-management and follow-up of cases over time (Matrix Support). Tailored to the needs of each user and based on the use of "technology of relations", the PTS is the basis of any intervention, since by considering the user's way of understanding life, singularity and subjectivity, it consists of a democratic and horizontal interaction between the social actors participating in the care process (workers/users/family) (Merhy, 1997).

Two dimensions were identified in Decree 130 (Portaria 130, 2012): how the service works, denominated "operational features"; and the treatment itself, denominated "comprehensive care". It is interesting to note that four points of action totally coincided between Decree 336 (Ministério da Saúde, 2004) and Decree 130 (Portaria 130, 2012): group care, therapeutic workshops, meals proportional to length of stay, and overnight stay. Partial coincidence, resulting from the addition of a word that broadens the objective or provides greater precision, was observed for two points of actions: "home visits", called "home visits and care"; and "family care", referred to as "family, individual, and group care". A sub-dimension was identified for "individual care" that specified whether the action consisted in medication, psychotherapy, or counseling. In this case, Decree 130 (Portaria 130, 2012) maintained the same point of action but replaced the specification "medication" with "provision of combined and dispensed medication".

A second sub-dimension was identified for "community activities", replaced in Decree 130 (Portaria 130, 2012) by "social rehabilitation activities". While Decree 336 (Ministério da Saúde, 2004) focused on the integration of the user in the community and social and family integration, Decree 130 (Portaria 130, 2012) referred to actions specifically related to rescue and building autonomy: literacy or educational integration, access culture, daily money management, self-care, medication management, and inclusion through work and widening social networks. This sub-dimension emerged after introducing a new objective of action: encourage users and family members to promote social participation, through activities such as weekly meetings, promotion activities, promoting the dissemination and discussion of public policies and rights. It is important to remember that Decree 130 (Portaria 130, 2012) regulates actions that were already undertaken, or avoided, within the services investigated by this study, based more on ideological issues than on structural concerns.

It is our understanding that, while Decree 130 (Portaria 130, 2012) does not address treatment modalities and Decree 336 (Ministério da Saúde, 2004) fails to mention user meetings as an action in the CAPS MD, thus showing that they could be improved and adapted to the real needs of users, we noted that they provide for the provision of comprehensive care through a suite of direct and indirect actions performed at individual or group level by a team of professionals working in the CAPS in coordination

<sup>4</sup> Decree 224, which was published in 1992 (Ministério da Saúde, 2004) and regulates the operation of the CAPS, was not included in this study since we opted to analyze legislation produced after the promulgation of Law 20.216/2001.

with other RAPS mechanisms and other care networks directed at providing consensual treatment to those who require it. "Consensual treatment" involves the active participation of the user in the elaboration of his/her own PTS, as opposed to the formal or tacit acceptance of a predetermined plan. Furthermore, we believe that the treatment provided by the CAPS should correspond to the PTS or be based on elements of the latter that could be even more far-reaching. Furthermore, the legislation provides that CAPS should adopt a treatment approach that is in line with that proposed by Cecilio and Merhy (2003) and thus capable of providing comprehensive care (health care and promotion, including the prevention of the occurrence and aggravation of the illness).

### **Actions carried out, actions not carried out, and difficulties in carrying out actions**

To complement the above discussion and bearing in mind that the treatment provided through the RAPS as a whole and the CAPS in particular should be structured around the elaboration of a PTS as a core element of any intervention, this section is dedicated to the analysis of this instrument.

Decree 3088 (Portaria 3088, 2011) provides that care provided under the CAPS shall be delivered based on a PTS elaborated with the participation of the health team, user, and family. Despite the importance of this instrument, it was found that in the majority of the services assessed by this study actions were undertaken without reference to the plan: *"the activity [PTS] was not established as... routine"* (S1) and *"considering the elaboration of the PTS, which is urgent and necessary. But the doctor that developed it doesn't work there anymore"* (S3). In certain cases the PTS was confused with other instruments such as the Therapeutic Contract, where the user was advised of the rules and norms at the beginning of the treatment in addition to explaining *"all that is part of the PTS, especially the question of absences"* (S4).

S2 highlights the importance of the instrument: *"treatment based on a PTS, comprising various unidisciplinary, multidisciplinary and interdisciplinary interventions that converge towards a single objective: social reintegration"* (S2). These statements are important since they are based on an a priori assumption of the existence of a PTS and show that the informant views care from a different perspective, whereby he/she perceives the importance of comprehensive treatment over therapeutic medication. From this perspective, it is of utmost importance that the reintegration of the user should work from the inside out of the service to avoid making the anti-reformist mistake of thinking that users should be rehabilitated from within the walls of the center: *"We view PTS in a more comprehensive manner, since treatment is not only medication"* (S2) and *"we really work towards the goal of reintegration. When we organize the PTS for a specific case, we always consider involving the person in activities that are not specifically within the service. Thus the idea of reintegration from the inside out"* (S2).

However, despite the above emphasis, difficulties were observed in terms of teams' capacity to ensure users attend meetings held specifically to discuss the therapeutic plan. As a result, the use of the PTS does not necessarily ensure quality, suggesting routine compliance with protocol to meet external requirements. These dynamics of the majority of services (mis)guided by the PTS beg a number of questions regarding the model for delivering health care services and parameters that would otherwise be used to decide the course of treatment without regard to the user's and family's right to participation.

With respect to individual care, the Ministry of Health cites medical care, psychotherapy, and counseling (Ministério da Saúde, 2013). It was observed that all the services provided psychiatric medical care (and clinical care in the case of the CAPS-AD) and that users received counseling from a social worker. Individual psychotherapy was not provided in the majority of services, despite being included in the legislation. Individual interventions performed by a psychologist seem to have been replaced by "active listening" (S1, S2, S3) by team members, whether or not they are psychologists. Service 4 was favorable to continuing this practice, alleging that it was possible to continue with short-term psychotherapy, which is seen as necessary and has been proven to be effective, without compromising psychosocial-based group activities. This suggests a lack of knowledge on the part of the interviewees regarding both active listening and the reach of psychological interventions. While active listening may be considered a "light technology" (Merhy, 1997) based on establishing a dialogic relationship and developing bonds and a welcoming environment, its aim is to ensure that the health worker is open to

understanding the user's real health needs. By no means can it replace individual or group psychotherapy, which is of undeniable value in the field of mental health.

With reference to group care, the Ministry of Health cites therapeutic mechanisms such as group psychotherapy, operative groups, and social support activities, including home visits and user meetings. The findings show that group psychotherapy was performed in all services except S1. The fact that this center is practically fully dedicated to caring for users suffering a mental health crisis, overnight stay, and referral of cases to group activities outside the center may partially explain why group psychotherapy is not performed at this center. The lack of group psychotherapy may also be due to the theoretical approach adopted by the psychologists who work at the center and their preference for "one-to-one" individual contact.

It is likely that actions involving operative groups (OG) were also not undertaken in this center for the same reasons mentioned above. Although the operative group technique was applied in the other services, a number of differences and inconsistencies were observed as to the understanding of the concept: *"it's a moment reserved for scheduling: whether they need a medication, an appointment with the psychiatrist and that sort of thing"* (S3). Apart from the lack of knowledge of GO shown by the above statement, it was observed that the objectives of the treatment provided by S4 are not totally in line with the objectives of the service, revealing a paternalistic and tutorial approach that consists of asking users on Fridays what they are going to do on the weekend, recording the answers and checking the level of compliance between what was planned and what was achieved. This technique, systematized by the Argentinean psychiatrist Pichón-Rivière, has the potential to transform reality and provides an important setting for developing bonds, promoting identification and differentiation, and working with the subjectivity and singularity of each group member (Bastos, 2010). Inexistent in S1 and void of signification in S3 and S4, the findings show that, due to its features, GO is able to redefine relational settings and expand ways of producing "health acts" (Merhy, 2003) and is a suitable tool for implementing the PTS since it provides, among other things, a setting where users can develop bonds and exchange experiences. The metamorphosis and absence of this technique in the CAPS reveals tension between restrictive tutelary actions and liberating actions that restore citizens' rights, which acts as an obstacle to comprehensiveness.

Therapeutic workshops (TW), held on a daily basis by one or more health professionals or monitors, are aimed at bringing disintegrated and isolated individuals who are suffering from a crisis back to the social environment through psychosocial rehabilitation. Workshops are valuable technologies through which work and artistic expression provide settings for interaction and socialization, (re)construction and (re)integration, as individuals are free to express themselves and face their fears and insecurity. Therapeutic workshops are held, to a greater or lesser extent, in the majority of the services (S1, S2, S3). The staff of S1 hold dance, painting, and handicraft workshops outside the center, made possible through a partnership with the Federal Education Institute (*Instituto Federal de Ensino*), which provides the physical space and material resources. This initiative, made possible by intersectoral agreements, promotes the inclusion of users in new and destigmatized contexts. In S2, the workshops, whose main aim seems to be the reintegration of users, are held internally. The terms inclusion and resocialization were employed to reflect the scope of the expression reintegration: *"Just because he/she [the user] is inside the service doesn't mean that he/she is not going to be resocialized; we understand that resocialization goes beyond that and that we can also do it from here inside..."* (S2).

The therapeutic workshops are attended by users undergoing intensive, semi-intensive, and nonintensive treatment, showing that there is a lack of planning of these actions for the users receiving treatment at S1 and S3, since these CAPS III receive users suffering from crisis on an overnight basis. It is understood that access to therapeutic workshops is a right and should be guaranteed to users whether or not they are in crisis, since the involvement of users in this type of activity plays a crucial role in recovery and overcoming the crisis.

One of the social support activities identified by the study was home visits, understood as a set of activities directed at health care and education (Mattos, 1995). Home visits give professionals the opportunity to justify interventions based on first-hand experiences gained through their interactions with the user's family. Home visits carried out from S1 were associated with the social worker, as if this function was restricted to this professional. Consequently, the recent incorporation of a new social worker created



a number of expectations: *"We are going to resume them.... The arrival of a social worker has provided us with oxygen"* (S1). Some authors confirm that home visits bring families and the health team closer together and increase their participation in mental health care (Schrank and Olschowsky, 2007). However, despite their importance and potential, home visits are not effectively carried out in the majority of the services.

The family care envisaged by mental health policy should offer support to help the family perform their functions and responsibilities in providing care for people with mental disorders. Family care is regulated by Articles 2 and 3 of Law 10.216/2001 (Ministério da Saúde, 2004), which reflect a paradigm shift from approaches that blamed the family for the illness. The paradigm shift from the institutional model to deinstitutionalization does not seek to neglect users; rather, it seeks to provide community services aimed at providing their families with the necessary care and support (Amarante, 2003). However, our findings show major differences in understanding of the concept of family care among the informants.

S1 and S3 provide "listening to the family" services according to demand; that is, when the family requests the service, which leads us to the same questions raised above regarding "active listening versus psychological intervention". S2 performs monthly actions based on the psychosocial educational assumption that *"you learn how to care by caring"* (S2) and therefore it is necessary to care for the person who is caring for someone. Thus, family members are considered partners in the care process, a clear example of Extended Care (Campos, 2003), which promotes the welfare of family members through helping them to socialize their difficulties and coping strategies. Service 4 promotes a family members group, which is open to anyone living in the sphere of the center's responsibility who has a family member suffering from alcohol or drug-related disorders.

The differences observed between the services could be associated with the theoretical frame of reference adopted by our informants, which realizes or limits the potential of this measure and thus has a positive or negative impact on the treatment depending on the type of care delivered to the users. We defend that this type of care should be provided regardless of the theoretical frame of reference, since in order to provide care to the patient's family the professional should feel secure and conscious of the fact that working with families is not a static process; families are dynamic in nature and shift according to cycles and have their own rhythm of life and story (Waidman & Elsen, 2006).

With respect to community activities, significant differences were observed between Decree 336/2002 (Ministério da Saúde, 2004) and Decree 130/2012 (Portaria 130, 2012). In the former, which addresses CAPS in general, these activities are aimed at integrating the user into the community and promoting social and family integration, while the latter adopts the term 'social rehabilitation activities' instead of 'community activities' and outlines the need to encourage users and their families to play an effective role in the care process by participating in social activities, weekly meetings, health promotion activities, the dissemination and discussion of public policies, and the protection of their rights. This implies overcoming boundaries: while the services may offer security and protection to health professionals and service users, there is often a lack of willingness on the part of the former to break down the internal barriers that prevent them from venturing beyond the center's walls to coordinate actions with other mechanisms in the search to provide comprehensive treatment, as well as a tendency to reinforce the asylum mentality of self-sufficiency and isolation: *"For some users, this continues to be the best place to be (...) this space..., for them, represents security"* (S1). Venturing outside the center's walls with users or accompanying their movements throughout the network are not practices adopted in services 1, 3, and 4, showing that health professionals tend to feel more comfortable performing actions within the center's walls. In the case of service 1, which offers workshops outside the center, only three health professionals identified with this type of intervention and were willing to perform these activities. We also observed differences between the expectations of our informants with respect to the possibility of rehabilitation among users, showing that the prognosis was generally better for persons suffering from substance abuse than those suffering from mental disorders, since *"(...) not everyone manages to get over that hurdle"* (S1). It is important to highlight that the conceptual differences observed between the interviewees always lead to methodological differences between practices and work processes that end up affecting treatment.

The objective of user meetings is to involve users in the day-to-day management of the center. In this respect, it is essential that they feel jointly responsible for the management of the space they use and the

treatment they receive (Camargo, 2004). User meetings therefore promote more horizontal relations of power when it comes to treatment, which is in line with the objectives of the social rehabilitation process. Holding effective user meetings in S1 and S2 seems to safeguard the full exercise of the rights of users and their families. As a mechanism, meetings have played an important role in the analysis of institutions and health service delivery: *"It is a moment of information; very rich, of sharing. And also very political, because we listen to the users' opinions regarding our services; it's also a moment to hear criticism and receive compliments."* (S1). However, despite the provisions of Article 7, section II of Decree 3088 (Portaria 3088, 2011), and Article 6, section 9 of Decree 130 (Portaria 130, 2012) specifically addressing AD, meetings are not held in services 3 and 4: *"In August [2014] it'll be two years since we have held a meeting"* (S4). It is important to highlight that this situation is specific to this center, which was closed due to technical shortcomings and whose services were interrupted for over a year before being reopened six months before the interview; during which time, no meeting had been held.

Matrix Support (*Apoyo Matricial*) is a task management methodology developed by Campos and Domitti (2007) that seeks to promote interaction and exchange of knowledge between professionals working in different care services. It promotes communication between health professionals working in the network and ensures that primary health care teams and CAPS teams work together to deliver comprehensive care, thus increasing the possibility of achieving Extended Care, providing different types of services (appointments, home visits, therapeutic workshops, recreational activities, work, income-generating activities, socialization-reintegration, etc.), and making it possible to care for the different needs that emerge throughout the course of mental illness.

We observed that the interviewees have little knowledge about Matrix Support and, except for S2, which coordinates actions with the primary health service through the Family Health Support Unit, it is not implemented in the CAPS investigated by this study. We believe that the difficulties in coordinating actions between CAPS, primary health care services, and other institutional bodies (intersectorality), and even relationship and communication problems identified among people working in the services, could be eased through the implementation of Matrix Support. Another aspect that should be highlighted is that its implementation would not reinforce the current dependence of users on the CAPS, as in the case of S4, where users attend the center to be seen by the psychiatrist and receive medication: *"We have already discharged him and now he is on monitored discharge due to the lack of matrix support"*. On the other hand, the isolation of services 1, 3, and 4 is particularly relevant, evidenced by the reluctance to implement a care mechanism in line with the objectives of the mental health law, which has been proven to be effective in providing comprehensive care and guarantees co-management and the joint provision of specialized and primary care.

## Final considerations

In the services dedicated to caring for users suffering a mental health crisis, the ambulatory model is predominant, bearing similarities to the conventional approach to mental health care adopted before the reform and limited to psychiatric evaluation and medication. This situation is associated with the fragile knowledge of the majority of health professionals regarding the legal, theoretical and practical frameworks governing the field of mental health care and the current mechanisms to ensure the provision of quality comprehensive care and work process management grounded in the asylum model of mental health care and doctor-centered and psychopharmacological approach, which in turn hinders the services' capacity to plan activities focusing on users' rights. The findings show that there is a gap between the daily practice of health professionals and the standards and regulations envisaged by the legislation. We consider it necessary to carry out strategic planning (Onocko-Campos, 2001) and the clinical and institutional supervision (Alvarez, 2014) of work processes in the context of the CAPS in order to contribute towards the effective elaboration of the PTS and the provision of quality comprehensive treatment. Study limitations include the interview sample size. Further research is recommended to include the rest of the health team and explore their perceptions of the principles underlying psychiatric reform.

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