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MULTIPROFESSIONAL WORK AND COMPREHENSIVE CARE IN THE PERCEPTION OF CAPS PROFESSIONALS

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ABSTRACT. This study aimed to verify professionals' perceptions of Psychosocial Care Centers (Centros de Atenção Psicossocial - CAPS) in São Paulo / SP regarding the importance of multiprofessional work in Mental Health for service users and the possible relationships with comprehensive care. The Health and Psychiatric Reforms made comprehensiveness a fundamental principle of health actions, a concept understood through various influences. Twenty-seven higher education professionals were interviewed, and the Content Analysis methodological framework was used. The participants were unclear about integrality care, valuing comprehensiveness and disciplinary integration work concomitantly to tutelage actions that do not favor autonomy. This fact is due to the lack of theoretical knowledge on comprehensiveness issues and the still persistent practice centered on the absence of autonomy and contractuality in the professional-user relationship. The effectiveness of comprehensive care is fundamental to understanding Mental Health users as subjects of rights, an important challenge for Brazilian Psychiatric Reform.

Keywords: Comprehensiveness in health; mental health public policies; services.

TRABALHO MULTIPROFISSIONAL E INTEGRALIDADE DO CUIDADO NA PERCEPÇÃO DOS PROFISSIONAIS DO CAPS

RESUMO. Este estudo teve como objetivo verificar a percepção dos profissionais dos Centros de Atenção Psicossocial (CAPS) de São Paulo/SP da importância do trabalho multiprofissional em saúde mental para os usuários dos serviços e as relações possíveis com a integralidade do cuidado. Com as reformas sanitária e psiquiátrica, a integralidade passou a ser um princípio fundamental das ações de saúde, conceito que vem sendo entendido a partir de diversas influências. Foram entrevistados 27 profissionais de nível superior e utilizado o referencial metodológico da análise de conteúdo. Os participantes não apresentaram clareza sobre a noção de integralidade do cuidado, valorizando a integralidade e o trabalho de integração disciplinar de forma concomitante a ações tutelares e não favorecedoras de autonomia. Tal fato se deve ao pouco conhecimento teórico do tema sobre a integralidade e a prática ainda persistente centrada na falta de autonomia e ausência de contratualidade na relação profissional e usuário. A efetivação da integralidade do cuidado é aspecto fundamental na compreensão dos usuários de saúde mental como sujeitos de direitos, importante desafio à reforma psiquiátrica brasileira.

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Palavras-chave: Integralidade em saúde; políticas públicas de saúde mental; serviços.

TRABAJO MULTIPROFESIONAL Y ATENCIÓN INTEGRAL EN LA PERCEPCIÓN DE PROFESIONALES DE CAPS

RESUMEN. Este estudio tuvo como objetivo verificar la percepción de los profesionales de los Centros de Atención Psicosocial (CAPS) en São Paulo / SP de la importancia del trabajo multiprofesional en Salud Mental para los usuarios del servicio y las posibles relaciones con la atención integral. Con las reformas de salud y psiquiátricas, la integralidad se ha convertido en un principio fundamental de las acciones de salud, un concepto que se ha entendido desde diferentes influencias. Veintisiete profesionales de la educación superior fueron entrevistados y se utilizó el marco metodológico del Análisis de Contenido. Los participantes no tenían claro el concepto de atención integral, valorando el trabajo integral y de integración disciplinaria al mismo tiempo que las acciones tutelares que no favorecen la autonomía. Este hecho se debe a la falta de conocimiento teórico sobre el tema de la exhaustividad y la práctica aún persistente centrada en la falta de autonomía y la ausencia de contractualidad en la relación profesional y de usuario. La efectividad de la atención integral es un aspecto fundamental en la comprensión de los usuarios de salud mental como sujetos de derechos, un desafío importante para la reforma psiquiátrica brasileña.
Palabras clave: Integralidad en salud; políticas públicas de salud mental; servicios.

Introduction

The emergence of the Unified Health System (Sistema Único de Saúde -SUS) in Brazil established healthcare as a duty of the State. In the SUS, comprehensiveness is a principle for the integration of actions in the field of care, health promotion and maintenance, prevention and rehabilitation, healing, harm reduction and palliative care (Portaria nº 2.436, 2017). For Kalichman & Ayres (2016), the principle of comprehensiveness is the most challenging for the implementation of Health Reform since it refers to the form of organization, the knowledge not only of professionals but also of users and the community in their territory, without losing sight of the issue of rights and citizenship when they provide health care.

For Carnut (2017), humanization strategies in the health sector have been used to reduce the weight of hegemonic technicality in healthcare, and their challenge is to promote integrality. Humanization means giving due importance to the user's subjectivity as a priority in relationships with professionals.

In the wake of this, the Psychiatric Reform was responsible for questioning the phenomenon of madness and the hospital-centric model of care, giving rise to the Psychosocial Care Paradigm and the Psychosocial Care Network (Rede de Atenção Psicossocial - RAPS), with the Psychosocial Care Centers (CAPS) as strategic types of equipment (Amarante, 2017). CAPS becomes the structuring equipment of the mental health care model, whose transformation is a complex social process that requires social participation, changing conceptions of care and workers' subjectivity to consolidate new practices (Vasconcelos, Jorge, Catrib, Bezerra & Franco, 2016).

A literature review on the evaluation of CAPS in Brazil pointed to structural weaknesses such as inadequate structures, mainly human resources. In the processes

area, the users lacked normative clarity, with adverse situations between management and fragmented work in teams, causing obstacles to the assumptions of psychiatric reform, uncertainty about therapeutic modalities definition and the use of psychotropic drugs under archaic paradigms. In the results section, social lack of protection appeared, users chronicity, difficulties for user autonomy, and maintenance of asylum paradigms by some professionals (Fleig, 2018).

In a study with CAPS in the city of São Paulo/SP, a dichotomy between ideal discourse and possible practice was verified, highlighting, among other aspects, the overload of professionals approaching outpatient practices (Jafelice & Marcolan, 2018).

Considering the centrality of CAPS and the relevance of the notions of comprehensive care and multiprofessiona work/disciplinary integration for its implementation, this study aims to verify the professional's perception of these services about the importance of multiprofessional work practices in Mental Health for service users and the possible relationships with comprehensiveness care.

Method

This exploratory, descriptive and qualitative study used the methodological framework of Thematic Content Analysis (Bardin, 2017). Data were collected in nine Adult CAPS in all administrative regions of São Paulo/SP city, one unit in the Central-West and two in each other region. Data collection occurred between July and September 2015. The population comprised higher education professionals belonging to the CAPS team. The sample was defined by convenience, with one member of the coordination and two professionals assisting in each service from different professional areas. The inclusion criteria were working at CAPS for at least one year and being a public servant without connection to any Social Health Organization (Organizaçao Social de Saúde -OSS). There were no coordinators in two units with this last criterion due to the scarcity of directly administered Adult CAPS in some territories. The exclusion criterion was to be absent during the data collection.

The interviews were based on four guiding questions, with audio recording and literal transcription for data processing and analysis. The researchers created the data collection instrument with information from the participants and the questions: Describe what you mean by multiprofessional, interdisciplinary and transdisciplinary teamwork in Mental Health; How is multiprofessional teamwork in the service where it operates?; What factors influence the presence/absence of multiprofessional work?; Do you consider that multiprofessional teamwork interferes with the assistance provided to users? How?

The data were analyzed according to the methodological framework of Thematic Content Analysis (Bardin, 2017). In the pre-analysis stage, the interviews were organized, and a floating reading of the data to be analyzed was performed to get first impressions of them. The material obtained had to be read several times to apprehend the central ideas and their meanings.

The interviews were transcribed without omitting data and, to exhaust the interviewees' communication, criteria of representativeness of the investigated universe were used, from homogeneity for the techniques to be used to data obtained, being the same for everyone; relevance, so that the data obtained were in line with the objectives of the study; and exclusivity, so that the data were not used in more than one category (Bardin, 2017).

In the transcriptions of the audio-recorded content, the factual elements of communication ('linguistic canes') proper to oral language present in the interviews were subtracted, the most common of which were: 'like', 'right', 'like that', 'I', 'then', 'there', 'okay', etc. The names of the people and services mentioned have been changed to preserve the identity of the professionals who collaborated with the study.

When exploring the material, coding, categorization, decomposition or enumeration operations were applied, considering the rules previously formulated (Bardin, 2017). For the convenience of the researchers, quantitative analysis, called enumeration and based on the frequency of appearance of certain elements of the message, was not performed in this study.

The speeches were cut to build registration units, the units of meaning that were through themes, which is the unit of meaning of a text and considered the study's objective. The decomposition was characterized by the choice of recording units and involved the content considered the base unit in the search for categorization (Bardin, 2017).

Categorization was done to classify elements that constitute a set by differentiation and, then, by regrouping according to genre (analogy), with criteria previously defined by the study's objectives. The categories were organized by a group of elements (registration units) under a generic title, and this grouping was carried out based on the common characteristics of the elements. Semantic, syntactic, lexical and expressive were used as categorization criteria (Bardin, 2017). The categorized data were related to the theoretical framework and objectives that support the research.

The excerpts of answers to the questions are identified by the letter P (an acronym for participant) followed by the number corresponding to the order in which the interviews were conducted.

The research project received a favorable opinion from the corresponding Ethics Committees in April and May 2015 under CAAE nº 43383515.6.0000.5505 and nº 43383515.6.3001.0086. CAPS managers signed authorization letters; all participants signed the Free and Informed Consent Form (FICT).

Results and discussion

Twenty-seven professionals were interviewed in eight CAPS II and one CAPS III. Two were psychiatrists, one pharmacist, two occupational therapists, six social workers and nine psychologists. Three participants were male, and twenty-four were female. The participants ranged from 28 to 64 years old, averaging 45. Working in the health unit was from 1 to 19 years, with an average of 10 years, and the professionals' graduation time varied from 4 to 35 years, averaging 18.

Multiprofessional work in Mental Health was considered a possibility of offering comprehensive healthcare to the user by 10 interviewees. Despite this, attention was drawn to the different ways of understanding comprehensiveness and putting it into practice in everyday services based on tutelage care proposals to the detriment of the production of autonomy:

> You should pay attention to the entire subject, not just the mental or medication part [...]. Looking at the subject in its entirety, even it will never be totality, but at least it is a more integrated work than [...] where there is no listening to other things than the specific object. Here, there is the possibility of a more complete and integral listening of the subject [...] (P17).

> If it can be [...] constructed collectively, with the different sciences and knowledge, I think the comprehensiveness of care becomes more concise. [...] You can achieve... I don't know if comprehensive care, but the closest thing to that, [...] more dignified care. If you take the strict sense of integral concept, [...] it is impossible in any area. I'll be able to take care of some things as long as he allows me, as much as I can access and as long as I can. [...] Comprehensive care is a [...] very strong word. I don't know if this exists [...] (P20).

Among the principles guiding the reconstruction of the Brazilian health system, comprehensiveness can be considered the most difficult to define and the most challenging for effectively consolidating SUS commitments. The lack of a conception of what 'integrality' means can be understood as an obstacle or a power since its precise definition could end up closing off other possible meanings (Machado, Monteiro, Queiroz, Vieira & Barroso, 2007).

Comprehensiveness, more than a SUS guideline, is a 'fighting flag' for the values of a more just and supportive society and can be taken as a guiding principle for practices and the organization of work and health policies. In all its senses, it suggests the refusal of reductionism and the objectification of subjects, with an openness to dialogue. It is only effective in subject-subject and not subject-object relationships in the practices and organization of health services. Furthermore, comprehensiveness is linked to the universal right to meet health needs (Mattos, 2006).

Comprehensiveness is understood in the care of people and communities concerning historical, social and political subjects, which are linked to the family context, the environment and the society in which they are inserted (Machado et al., 2007):

> Access to more comprehensive, complete treatment, because although we don't deal with clinical issues, we identify, guide [...]. We talk about medication, his relationship with his family, his body, what he eats, whether he goes to the theater, [...] topics not specific to Mental Health (P16).

Comprehensiveness can be seen as a social action with a view to democratic and civic interaction among the various agents who work in health practice in a multiprofessional way, at the levels of care of SUS, due to the close relationship among treatment, health promotion and prevention (Alves, 2017).

Universality, equity and integrality are three mutually referring notions, each calling the others to achieve pragmatism with utopia. However, comprehensiveness best addresses the challenge of realizing the values of justice, democracy and effective access to Health to the intimacy of the technological core of these practices. This happens because, more than guaranteeing access for all (universality) and agreeing with everyone on what each person needs (equity), comprehensiveness responds to the challenge of knowing and doing 'what' and 'how' can be achieved in health for respond universally to each person's demands (Ayres, 2009).

Comprehensiveness in health dialogues with the challenge of producing, universally and equitably, not only treatment, prevention and recovery of health, but, indeed, care. The reference to care indicates the intentions of the principle of integrality, drawing attention to the richness of needs, purposes, articulations and interactions required in Health work, understood as a resource of and for people to fulfill themselves as full subjects. When noticing the strong presence of the terms 'integral care' and 'comprehensiveness of care' in the Health field, it highlights that 'comprehensiveness is about care, as care can only be integral'. Given these perspectives, health needs are understood beyond the language of biomedical sciences and can be individualized and filled with meanings, which requires producing and doing differently (Ayres, 2006).

In this sense, vertical integration is required for the comprehensiveness approach among primary, secondary and tertiary care, and horizontal among health promotion, protection and recovery. Enriching these needs also requires that the biomedical sphere be articulated with each other and other actions, resulting in multi, inter and transdisciplinarity and intersectoriality. There is also no way of reconstructing needs and resources without transforming relationships, so there is no comprehensiveness without strengthening the dialogue between the subjects involved in health practices, both between professionals and users and between professionals and each other, so that care does not occur without intersubjectivity (Ayres, 2006).

Beyond reorganizing knowledge and inter-relationships, it is necessary to tackle the restructuring of health establishments through the articulation of these services and the reformulation of professionals' practices within their teams, with the reordering of multiprofessional work among the teams being a necessary achievement for comprehensiveness (Furtado, 2009).

The participants in this study considered disciplinary integration work as a possibility of sharing care among team members and 'sharing the load', producing more supported practices, and enhancing learning:

> "There is much knowledge that complements my practice. I have greater support if I have doubts [...]" (P16).
>
> It takes the burden off a citizen. It's difficult to take care of someone alone. [...] A citizen with social, psychiatric, and family problems and wants to deal with it all alone. [...] Working in a multi-way, we can share the load, [...] we can count on someone (P1).

Understanding that comprehensiveness care occurs in different dimensions, the notions of 'expanded comprehensiveness' and 'focused comprehensiveness' are suggested, the first referring, from a macro perspective to the articulation of each piece of equipment to the extensive network of services and institutions; and the second, the result of the confluence of the diverse knowledge of the multiprofessional team in the space of each health service (Cecílio, 2006):

"It could be more, if in addition to the multiprofessional aspect there was an intersectoral one, [...] the issue of work, education, social rights [...]" (P17).

The Ministério da Saúde (2004) highlights that transdisciplinary work is guided by common sense, which crosses and modifies the various professional practices to approach the integral human being, also understanding that fragmented actions restrict work to a small portion of the therapeutic process, which can produce alienation and demotivation in workers, given the loss of the global dimension of the user's health:

> A professional trained with a hyper-specializing vision [...] ends up having a notion that he doesn't need other areas. [...] 'I don't need to know anything else, I'll just take care of this', when, in fact, the human being is an entirety [...] Anyone who only sees a little piece doesn't understand the production of the whole. This posture is very serious in Mental Health because all illnesses involve the entire being, not just a little piece (P7, authors emphasis).

P7 also highlighted the importance of contact with disciplinary integration proposals since graduation, observed in the literature under the bias of the need for learning strategies that enhance dialogue, exchange and transdisciplinarity based on the user as the centrality of health actions (Machado et al., 2007; Jafelice & Marcolan, 2017):

"So I think this concept is a little more complicated and relates to the education of health professionals" (P7).

Since comprehensiveness is related to the refusal of reductionism, the Expanded Clinic can be considered a tool for articulating and including different approaches and disciplines, understanding that people are not limited to expressing the diseases they are affected, which justifies the need to approach singularities (Mattos, 2006; Campos, 1999; Ministério da Saúde, 2009). This clinical modality seeks to integrate different perspectives to effectively manage health work, necessarily multiprofessional (Ministério da Saúde, 2009). Its main axes are a broader understanding of the health-disease process; the shared construction of diagnoses and therapies (whether among the health team, health and intersectoral services and users); the broadening of the 'object of work', considered as people or groups of people, for all health professions; the transformation of the 'means' or work instruments, with transversal communication within and among teams and relational techniques for sharing (the ability to listen to others and oneself, to criticize automatic behaviors, to deal with the expression of social and subjective problems); and support for health professionals, with instruments to help them deal with difficulties and positive and negative identifications, for example (Ministério da Saúde, 2009).

Conceived by Campos (1999), the expanded and shared clinic seeks to construct clinical work as a 'neo-craft' based on reorganizing and enhancing macro and micro sanitary responsibility. To this end, it is necessary to broaden the 'object of work' of the clinic, considering that health problems are embodied in subjects, with the main necessary expansions being the 'clinic of the subject', the purpose of this type of work, which becomes expanding the degree of autonomy of the subjects; and the means of intervention, with the valorization of the therapeutic power of listening and speaking (Campos & Amaral, 2007).

In line with these perceptions, P15 highlighted difficulties in working in a multiprofessional team at CAPS:

> You lose a bit of depth about the client. I got to know patients better when attending to them individually [...] on the other hand, you can [...] broaden your perception and sometimes see what a Basic Unit professional can't manage due to the various professionals looking at and studying that user. [...] The inconvenience [...] is that we look too horizontally and can deepen less vertically. [...] I don't think the lack of deepening has anything to do with the multiprofessional team. It has to do with the work scheme. When everyone is responsible, no one is totally responsible for that user. However, if you have a patient who depends a lot on you, you will be much more committed than if you have some patients that many people assist. There are too many people to attend but not enough professionals. It hinders a lot, but it's not the team that interferes. It's the way CAPS works. Most patients have no individual follow-up; it's more in groups. [...] (P15).

It seems possible to raise the hypothesis that the reduced vertical depth referred to by P15 is, in fact, due to the excessive demands imposed on the CAPS teams, with a large number of weekly activities, which may mean little knowledge of the users, and Singular Therapeutic Projects (STP) reduced to 'menu of activities', which make it impossible to effectively approach all users, among other difficulties and not necessarily disciplinary integration proposals (Ramminger & Brito, 2011).

Going further, P4 and P13 highlighted the importance of involving users in their care, associating disciplinary integration proposals with the possibility of building citizenship, responsibility and empowerment, as opposed to tutelage proposals, which can maintain the asylum logic in CAPS:

> According to a CAPS proposal, multiprofessional work interferes with this issue of citizenship, the user's responsibility. The user's responsibility is not only to take medication. [...] Working on this issue of responsibility, of ownership concerning life decisions. [...] Very tutelage interdisciplinary proposals may still exist, but I don't think so within the CAPS. [...] It impacts the user's attitude, [...] also how you

> approach a suffering individual, whether you blame him or not, whether you tutor him more or not [...] (P4).

Pinto et al. (2011) highlighted soft technologies as fundamental elements for Psychosocial Rehabilitation, considering the horizontal and democratic interaction among user, worker and family, operated by professionals in the formation of affective bonds, inducing responsibility on the part of the subjects, by proposing the direction of care based on ethics, autonomy, the rescue of citizenship, subjectivation and social inclusion. In addition to the user being able to "[…] appropriate the service […]", CAPS needs to be "[…] places of passage" (P13) so that there can be continuity of care in other types of equipment, which refers to the delicate border between bonding and dependence on the service, which should be critically problematized:

> We even find the patients here difficult to establish in the network and bond with them because they feel very safe here. Even though the care isn't provided as you expected, [...] they've become very attached and manage to stay stabilized. [...] We didn't accept their basic transfer to other places long ago. Over the last few months, we've been working on this [...], establishing a relationship with the patient and removing some of the dependency. [...] You must be included in your family, Brazil, and the municipality (P5).

Unlike dependency, the notion of 'bonding' refers to the construction of encounters that favor richer, more plural intersubjectivities and enhance sharing, which allows for true co-responsibility for the production of care between the user and the team (Ayres, 2009). Kantorski et al. (2010) highlight the importance of CAPS being an intermediary space that enables users to perform autonomous activities, favoring social reintegration and the possibility of moving on to conquer new spaces in society. For these authors, autonomy is marked by the moment people can live with their problems with less need for the service's assistance devices. In the speeches of some participants, however, the CAPS team seemed to take full responsibility for the expanded attention (Kantorski et al., 2010):

> The user can have all [...], ten professional categories discussing a project. [...] If well stimulated, this is a work of excellence. Based on my problem, I can get someone thinking about my civil, social, cultural, and health situation [...] You can only achieve comprehensiveness by looking at things from an interdisciplinary perspective. [...] If he doesn't have any documents, we (the CAPS team) are the ones who have to look for them; if he doesn't have any benefits, we're the ones who have to look for them [...], if he's never been around the city, we're the ones who have to take him to places and teach him how he goes [...] how he can do it on his own. [...] That's comprehensiveness (P22).

In these discourses, there seems to be no space for sharing care with users, family members, the community or even other network services, which are solely the CAPS team's responsibility, leading to the question of whether these practices produce autonomy and expansion of the contractual power of users:

> The person who presents great suffering has the contribution of various knowledge to provide improvement or a more positive response to treatment. [...] We have had very positive statements from the patient about feeling welcomed and cared for, and this creates great difficulty when transferring the patient to the network; much resistance occurs because, unfortunately, he knows how the service is organized out there and that he will leave a service where he is assisted entirely (P13).

Merhy (2004) considers caring paradoxical, capable of imprisoning or liberating. According to the author, it is necessary to differentiate between 'tutelage with a castrating effect' and 'autonomizing tutelage' regarding the State's guardianship over individuals. The former is responsible for the expropriation of subjects' 'self-walks', their desires and movements producing paths that invest in the world to take it as their own, while the latter

brings about liberation from itself, with a complex movement from which dependence generates liberation (Merhy, 2004). To this end, they move towards creating a liberating process at the same time as the public process of establishing responsibilities, demanding that desires are implicated in each other in cooperative and contractualized movements, allowing the living movement of one subject to awaken the production of life in another. In this sense, health is understood as people's ability to build networks supporting and producing life, so autonomy becomes the multiplication of autonomy networks (Merhy, 2004).

By seeking to be responsible for the totality of the user's demands in a non-shared way, the CAPS teams end up creating tutelage relationships with a castrating effect, giving voice only to the worker and leaving the user's health needs in a configuration of lack, determined from outside inwards, and not positivity, a process defined by the agents in action (Merhy, 2004). Even though it may be believed that this form of care produces health, Merhy (2004) warns of the fact that this process does not allow the qualification of living nor gains in autonomy in the user's ways of ‘movement of life that produces life’, what is considered by it as health.

In addition to being distant from the proposals of the Psychiatric Reform, this form of ‘tutelage’ work also seems ineffective in the reality of services, which have to deal with many users to serve and the precariousness of working in a health service network and intersectoral, which is a significant challenge for comprehensiveness care. It is possible to notice the lack of appropriation by some interviewees in this study of fundamental elements and discussions for the construction of the SUS, with answers distanced from the practice of services and even empty of meaning and problematizations.

Some interviewed professionals and managers, even if without realizing it, ended up approaching, in their responses, tutelage practices with a castrating effect, which keep CAPS users as objects of the team's knowledge and policies without being able to constitute themselves as subjects, placing in the world (Merhy, 2004). One cannot ignore the risk that discourses and teams that seek to deal with all aspects of users' lives in a single service end up approaching the asylum logic and ‘total institutions’, which, even with therapeutic claims, end up dehumanizing the people with mental suffering and objectify them in medical and psychological knowledge, repeating precisely the mechanisms that substitutive services seek to overcome (Goffman, 2013). From this perspective, being anti-asylum is betting on autopoietic care, being the force that builds the meaning of living, in other words, the ‘movement of life that produces life’:

> It is also a great trap, this story of everyone saying they can handle everything. It's a potential, but it's a great risk because it's easy, especially with very serious patients, for us to repeat [...], to become a ‘total institution’, like a mental asylum. If we let them, some patients will say that we are their family and they [...] would do anything here. [...] It transmits this image to users, which they often call a ‘medical board’ [...]. It gives the idea of completeness even, which doesn't exist [...] As if you could have all eyes in the same place, and I don't believe that's possible. [...] It's possible to broaden this listening, but not that it's total, because if the subject doesn't listen, it goes against our other principle, that the multi is not just here inside, that we believe in networking. [...] It ends up becoming a ‘total institution’ (P17, author’s emphasis).

P17 also pointed out that disciplinary integration and comprehensiveness care are processes that also need to occur outside the walls of these services, at other points in the health and intersectoral network and in city spaces so that users can move around and appropriate other roles and ways of being in life. These aspects draw attention, beyond the field of Mental Health, to a certain contemporary tendency to delegate care and relationships

(especially when they ‘demand hard-working’) to institutions, which can also be visible in asylums and schools, which can be related to the individualism and productive logic present in capitalism - without it being possible in this space to deepen this discussion.

Próchno & Bessa (2016) state that the model of psychosocial care, under the assumptions of Psychiatric Reform, undergoes transformations and receives questions, of which the practice ordered by a local logic and prevalence of the act over the function stands out, resulting in silencing of the subject.

Final considerations

The importance of multi, inter and trans-professional teamwork proposals in Mental Health could be problematized by the interviewees concerning the notion of comprehensiveness care, a principle dear to the SUS and complex in its practical apprehension, especially when considering the delicate border between tutelage and production of autonomy, or even ‘total institutions’.

This discussion seems to be little present in the daily lives of the teams, who tend to understand integrality within the simplicity of ‘taking care of all aspects of the subject's life’, which is neither possible nor desirable, especially given the difficulties experienced by the CAPS types of equipment in the country. The very guideline of comprehensiveness takes up the aspect of humanity and subjectivity in health care, valuing people in their complexity and different types of knowledge, which gain equal weight.

It is also considered important for this research to have been conducted in the city of São Paulo/SP and, more than that, to have been able to cover all its health regions, problematizing the complexity of talking about Psychiatric Reform and the implementation of RAPS in the largest city in the country, marked by a political history that was not always favorable to this model of care. Perhaps also for this reason, it stands out that it is an under-researched territory, especially in comparison to its population and academic and financial importance in Brazil, which increases the relevance of this study.

The challenges highlighted in this study do not seem exclusive to the services researched, which justifies the importance of dialogue with difficulties experienced throughout the country in implementing RAPS and approaching the assumptions of Psychiatric Reform. The criticisms and problematizations presented here point to the need for more discussions and spaces to rethink practices, with the expectation that they will be an opportunity for new questions and studies. Expanding research and bringing closer the daily lives of teams that work from the perspective of disciplinary integration is a fundamental tool for implementing the SUS and the values of Psychiatric Reform.

Psychiatric Reform has greatly advanced its Mental Health assistance objectives, such as losing the hegemony of hospitalization and creating service networks in the community. However, it still lacks the strength to empower users as subjects of rights, effectively autonomous and citizens. In this context, implementing the principle of comprehensiveness of care is a fundamental aspect.

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