

Evaluation of a Psychosocial Care Center in Foz do Iguaçu, Brazil

AVALIAÇÃO DE UM CENTRO DE ATENÇÃO PSICOSSOCIAL:
A REALIDADE EM FOZ DO IGUAÇU

EVALUACIÓN DE UN CENTRO DE ATENCIÓN PSICOSSOCIAL:
LA REALIDAD EN FOZ DEL IGUAÇU, BRASIL

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ABSTRACT

This is an excerpt of the study An evaluation of the Psychosocial Care Centers in Southern Brazil. The objective is to evaluate the ambience of a Level II Psychosocial Care Center (CAPS, abbreviation in Portuguese) as a place for comfort. This case-study was performed using a qualitative approach and the Fourth Generation Evaluation. The following was used for data collection: interviews with 10 professionals from the health team, 11 patients, and 11 relatives, and 297 hours of field observation. The closed door and the reduced team had repercussions on the work process at the Care Center. These critical nodes have a direct effect on the ambience, producing tension and antagonism in services such as CAPS. The presented issues are themes that demonstrate the commitment to a healthy environment, which implies comfort and subjectivity in the work at CAPS.

KEY WORDS

Health evaluation.
Mental health.
Mental Health Services.

RESUMO

Trata-se de um recorte da pesquisa Avaliação dos Centros de Atenção Psicossocial da Região Sul do Brasil. Temos o objetivo de avaliar a ambiência enquanto espaço de conforto e subjetividade em um Centro de Atenção Psicossocial II (CAPS). Pesquisa qualitativa, tipo estudo de caso, que utilizou a Avaliação de Quarta Geração. Os instrumentos de coleta de dados foram: entrevistas com dez profissionais da equipe, 11 usuários e 11 familiares e 297 horas de observação de campo. A porta fechada e a equipe reduzida foram problematizadas, ocasionando repercussões no processo de trabalho do serviço. Esses nós críticos interferem diretamente na ambiência e consistem em tensão e antagonismo às proposições de um serviço como CAPS. Identificamos que as questões apresentadas são temas que demonstram o compromisso com um ambiente saudável, que considera o conforto e a subjetividade no trabalho do CAPS.

DESCRIPTORIOS

Health evaluation.
Mental health.
Mental Health Services.

RESUMEN

Se trata de una parte de la investigación Evaluación de los Centros de Atención Psicossocial de la Región Sul del Brasil. Tenemos el objetivo de evaluar el ambiente en cuanto espacio de confort y subjetividad en un Centro de Atención Psicossocial II. Investigación cualitativa, tipo estudio de caso, que utilizó la Evaluación de Cuarta Generación. Los instrumentos de recolección de datos fueron: entrevistas con diez profesionales del equipo, 11 usuarios y 11 familiares y 297 horas de observación de campo. A puerta cerrada y con equipo reducido fueron problematizadas, ocasionando repercusiones en el proceso de trabajo del servicio. Estos nudos críticos interfieren directamente en el ambiente y consisten en tensión y antagonismo a las proposiciones de un servicio como el CAPS. Identificamos que las cuestiones presentadas son temas que demuestran el compromiso con un ambiente saludable, que considera el confort y la subjetividad en el trabajo del CAPS.

DESCRIPTORIOS

Evaluación en salud.
Salud mental.
Servicios de salud mental.

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INTRODUCTION

The Psychiatric Reform Movement, which started in Brazil in the 1970s, made it possible to build new ways of providing mental healthcare. The implantation of substitute services to replace psychiatric hospitals, which make up the integral healthcare network in mental care, has transformed care delivery, aiming at the social reinsertion of mental care users and the recovery of their autonomy.

Among the services that make up the substitute network, we highlight the Psychosocial Care Centers - Centros de Atenção Psicossocial (CAPS), services that provide daily care by developing activities with the participation of users, their families and the community. These services have demonstrated their efficacy to replace long-term hospitalizations with treatments that do not isolate users from their families or the community. Instead, patients are involved in care procedures, providing them with the necessary attention, aiding in the rehabilitation and social reinsertion of people in mental suffering⁽¹⁾.

Since substitute services are fairly new and propose transformations in mental care, oriented according to territorialized care, they need to assess the development of their activities according to their own actors: users, relatives, professionals, among others.

Assessment is used to validate psychosocial practices in mental healthcare, by understanding their importance within service routine and considering the complexity of the object of mental care⁽²⁾.

As such, studies on the satisfaction of users and relatives with mental care services have been developed in Brazilian cities, as part of the Multicenter Project of Quality Assessment of Mental Healthcare Services⁽³⁾. Likewise, studies directed at the satisfaction and overload of professionals in these services have encouraged research in the area of healthcare assessment, in order to re-structure the work processes⁽⁴⁾.

With that in mind, the study named Assessment of Psychosocial Care Centers in the South of Brazil - Centros de Atenção Psicossocial da Região Sul do Brasil (CAPSUL) was developed, funded by the CNPq and the Ministry of Health, in a partnership between Universidade Federal de Pelotas (UFPEL), Universidade Federal do Rio Grande do Sul (UFRGS) and Universidade do Oeste do Paraná (UNIOESTE).

The qualitative study was performed in five CAPS in the three states, based on their actors: users, relatives and professionals.

Among the markers in the qualitative analysis of the assessment process, we highlight the ambience, which refers to the treatment given to the physical space, understood as a social, professional and interpersonal space that

provides welcoming, problem-solving and humane care⁽⁵⁾. Such a concept proposes strategies that attempt to qualify the healthcare working process, facilitating its promotion.

The ambience in healthcare spaces is configured beyond the simple and formal technical composition of environments, considering the situations that are built. That means that healthcare services are built in certain spaces, within a certain time, and experienced by a range of people, with their own cultural values and social relationships⁽⁵⁾.

In the CAPS, this concept appears as a tool that seeks to empower the process of psychosocial rehabilitation, since we understand that an environment focused on comfort and production of subjectivities can favor spaces of freedom, autonomy and citizenship.

This article presents partial results from a case study, addressing the aspects that involve ambience.

GOALS

The Psychosocial Care Centers - Centros de Atenção Psicossocial (CAPS) have demonstrated their efficacy to replace long-term hospitalizations with treatments that do not isolate users from their families or the community.

To assess ambience as a space of comfort and subjectivity in a Psychosocial Care Center II in the city of Foz do Iguaçu.

AMBIENCE

The concept of ambience refers to the architecturally organized space that constitutes a physical, aesthetic and moral environment appropriate for any human activity⁽⁶⁾.

The world started to reformulate its comprehension about this topic with the concept developed by the World Health Organization after World War II, where health is not only the absence of disease.

During the VIII National Health Conference in Brazil, held in March 1986, the expanded concept of health was elaborated. This new concept involves the conditions of housing, education, income, diet, environment, work, transportation, employability, leisure, liberties, access to and possession of land and access to healthcare⁽⁷⁾. Health is not uniquely related to clinical care any longer, but covers psychological, emotional, social, environmental, economic, cultural and biological aspects.

The expansion of the concept of health implied the creation of another concept - that of health promotion, understood as the process of enabling the community to improve the quality of life and health, taking active part in this process. In November 1986, the First International Health Promotion Conference was held in Ottawa (Canada), resulting in the Ottawa Charter, which presents the creation of environments that are favorable to health, among others. As such, it justifies the importance of healthy public policies in every sector, not only in healthcare. This shows

there is an understanding that the constitution of the physical environment interferes directly in people's social relations and conditions of life⁽⁸⁾.

The Declaration of Sundsvall, the result of the Third International Health Promotion Conference, held in 1991 in Sweden, defined that the term *favorable environments* refers to physical and social aspects, involving people and reaching spaces like the community, households, work and leisure, as well as structures that determine access to resources for living, such as decision making⁽⁹⁾.

With this information, environment and health can be called inseparable, correlated and interdependent terms and, as such, need to be structured and organized together. Ambience in healthcare aims to qualify healthcare environments, resulting in improvements in quality of life and the health of people.

Ambience has three main axes: comfort, subjectivity and the work process⁽⁵⁾.

The axis of comfort refers to the components of the environment, such as morphology (shapes, dimensions and volumes), light (intensity, nature, incidence, quality and quantity), smells, sounds (machine noise, music, shouting), synesthesia (perception of space) and colors, which can act as modifiers and qualifiers of space. Airy, clean, well-lit rooms painted with soft, likable colors are elements that could facilitate the development of therapeutic group activities, for example.

Also, regarding comfort, there is privacy and individuality. Privacy means respecting the intimacy of healthcare service users, using dry walls, curtains, furniture and keeping doors closed during appointments. Individuality consists in understanding that each user is different from others, with his/her own life histories, coming from specific and characteristic social spaces. Creating environments that will enable users to welcome their social networks, for example, will permit the preservation of the individual identity of those users.

The second axis considers that ambience is a space for the encounter of subjects, resulting in the production of new subjectivities. A new ambience results in a process of reflection that covers the practices, ways and knowledge developed within that space, which will enable the construction of new situations, resulting in the change of this environment through actions.

The production of the subjects incorporates all of those who take part in healthcare, especially those who deal with the user directly, since they can detail what contributes and what hinders the development of activities. Adequate spatial arrangement is fundamental for the work process to flow as desired.

The last axis says that ambience is the facilitator of change in the work process, as an auxiliary instrument in the construction of the spaces desired by healthcare workers and users.

METHOD

This is a case-study research, an empirical investigation addressing a contemporary phenomenon within its real life context, especially when the boundaries between the phenomenon and the context are not clearly defined. The case study investigation attempts to apprehend a situation that is technically unique according to several sources of evidence, with the data converging in a triangle, and benefiting from the prior development of theoretical proposals, which aim to conduct data collection and analysis. The execution of case studies in research focused on assessment evidences their potential to describe the real context where the intervention happens and their ability to explore specific situations, identifying inter-relations between the precepts and the concrete practices of services and programs within the studied reality⁽¹⁰⁾.

The study was developed according to the quantitative assessment of the CAPSUL research, which used Fourth Generation Assessment⁽¹¹⁻¹²⁾. This method is based on a constructivist and responsive assessment, with a hermeneutic-dialectic approach.

In responsive assessment, different groups of interest identify the demands, concerns and issues of the object to be assessed.

The researcher should identify the different groups of interest involved in the phenomenon to be evaluated. After that, the Hermeneutic Dialectic Circle should be elaborated with each group of interest⁽¹¹⁾.

The Hermeneutic Dialectic Circle is used in Fourth Generation Assessment as a way to reach a constructivist and participative character. It is hermeneutic because it has an interpretative nature, and dialectic because it results in comparing and contrasting different points of view, aiming at a high level of synthesis⁽¹¹⁾.

The CAPSUL research identified three groups of interest: workers, users and their relatives.

The CAPSUL research was approved by the Review Board of Faculdade de Medicina da Universidade Federal de Pelotas, file #068/2006. The study field was the Psychosocial Care Center II Flávio Dantas de Araújo, located in the city of Foz do Iguaçu, Paraná. The choice was intentional, considering the availability of groups to participate in the assessment proposal, adequacy to the norms defined by Regulation #336/2002⁽¹³⁾ and because it was a CAPS in the process of consolidation in the state of Paraná.

Ten staff professionals, 11 users and 11 relatives took part in the study by signing a term of consent, according to Resolution 196/1996 by the National Health Council⁽¹⁴⁾.

Data collection occurred in November and December, 2006, with 297 hours of observation and individual interviews, according to the principles of the Hermeneutic Dialectic Circle.

Data analysis occurred concomitantly to the collection, resulting in a pre-analysis, identifying the thematic axes discussed in the negotiation with the groups of interest. These data were transcribed and organized in central thematic units. Markers were then established based on these units, understood as categories abstracted from the empirical data. Ambience was the category that emerged from the structure marker, and will be discussed next.

RESULTS

The Psychosocial Care Center Flávio Dantas de Araújo (CAPS II) started its activities in 2004 in the same building occupied by the mental care outpatient clinic, rented by the town hall.

The service has a daily average demand of 90 people, with a total of 180 registered users. Access is granted at the mental care outpatient clinic after an interview is scheduled with one of the technicians of the service. This is an admission interview, an anamnesis, defined by the staff as welcoming.

Individual service is not systematized at the CAPS Flávio Dantas de Araújo, occurring at random, at the moment of the initial assessment and according to the users' requests.

Likewise, the reference technician is not defined, but depends on which professional is responsible for coordinating the two operative groups that occur every day as the first activity of the service, during which the users and the team address feelings, difficulties and activities of the day. Therefore, each professional would have about 14 users under his/her responsibility. However, it is not clear for users whom their reference technician would be, with the same occurring for the CAPS team.

Also, there is no individual therapeutic project (ITP) at the CAPS. However, space for that is available on the initial assessment form, which has been used to indicate the participation of the user in certain workshops.

In the assessment process, the three groups of interest brought questions about ambience, characterizing the environment as a clean and likable space, but with excess heat, drips in the ceiling and the need for renovation in the building. The need for human and material resources to handle the functioning and execution of CAPS activities was also evidenced. The food provided has good quality, and the availability of medication is considered positive, aiding in the treatment.

The locked door policy at the service and a small team was mentioned as a problem in the three groups of interest, causing important repercussions in the work process.

The Psychosocial Care Center Flávio Dantas de Araújo (CAPS II) shares its physical space with the mental care outpatient clinic. The division between both services is a glass door that remains closed and locked. Only workers and CAPS users have access to it.

The issue of the locked door is a relevant aspect in the organization of the service. On the one hand, it causes discomfort (for professionals, users and relatives) but, on the other hand, it is understood as a measure of safety for users.

Oh, this part (the door), I think it would be better to leave it open, because we don't need to wait out here when we arrive [...] F(5)8.

I think the CAPS door should remain closed so they don't escape, so that there won't be problems like that time when people run away U(5)5.

They started discussing the CAPS' locked door in the staff meeting [...] keep it locked or not? The question comes after considering the users' rights of coming and going. [...] about the user screaming that he wanted to leave, yesterday [...] The nurse thinks he has the right to come and go, feels bad about the locked door. The social worker states that they had to lock the door due to the occurrences, so that they could avoid problems with the users with more serious problems O(5)5.

CAPS is a daily care service, providing unrestrained healthcare service, understanding that the user is primarily a citizen with rights and duties⁽¹⁵⁾. Therefore, the doors of the service should remain open for people to enter and leave the facility, respecting the subjectivity and decisions of those who are or arrive there. That will imply a paradigmatic change of attitude about the view the teams have about people with a mental disease diagnosis, i.e. seeing the person as capable of choosing and voicing opinions about his or her treatment, as well as how to live life.

Liberty appears as a core practice in psychosocial care, characterizing the work at the CAPS as a space that allows for movement, opposed to reclusion, preserving the rights of actors to come and go, walk and move around in their subjectivity and options in the many walks of life.

Surely, certain users who are in critical and/or acute conditions need intensified care, where the professional should be nearby, providing orientation and facilitating their actions in order to provide an environment with more protection. This protection does not occur by locking doors; on the contrary, this aspect transmits the imprisonment of madness and its social exclusion. At the CAPS, this closer monitoring of the user is usually hindered, since the team is small and is always involved with the workshops, group activities and other events planned for the daily routine of the service.

Working with an open-door policy, in addition to guaranteeing freedom as a therapeutic factor of treatment, would facilitate the access of the community to engage in this process, in which such inclusion and partnership are predicted.

Access through an open door should be used as a facilitating and integrating strategy for mental healthcare teams, bringing them closer to the territory. An open CAPS is a

space of communication and relationship, in which a range of routes and flows to produce citizenship in and out of the service should be built, thus promoting contact between people and the city, and bringing new perspectives about the crazy person and madness.

The open-door policy assumes a connotation of building bonds and responsibility with users and relatives, inserting, welcoming, and especially eliminating the exclusion of those who are inside and those who must stay outside. The intention is to build partnerships and new subjectivities, not through isolation, but by seeking a more responsible mental care, through less painful and stigmatizing practices.

The concept of ambience also refers to social, professional and relational spaces between the team, users and relatives, which reflect in the work process. Therefore, the small number of human resources of the CAPS Flávio Dantas de Araújo is seen as another difficulty faced in its organization.

The service had 23 professionals from different backgrounds, 18 of whom officially worked for the outpatient clinic. However, in the assessment process, the CAPS Flávio Dantas de Araújo was observed to have a fixed team in its daily schedule, with five professionals: one nurse, one nursing auxiliary, two psychologists and one social worker.

The CAPS has a psychiatrist who also works in the mental care outpatient clinic. This professional is not exclusive to the service, being available to coordinate the general meeting every Wednesday, having appointments with scheduled users and participating in staff meetings every other Friday. There are also two interns in the team - one studying Psychology and another Physical Education - who are paid for their services, develop administrative activities and coordinate workshops at the facility. Three aides, who also work for the mental care outpatient clinic, provide support and janitorial services.

The number of professionals at the CAPS is not in accordance with the minimum staff requirements for a CAPS II, as proposed by Regulation 336/02. By law, a CAPS team should contain the following professionals: one psychiatrist; one nurse with a mental healthcare background; four college-level professionals (psychologist, social worker, nurse, occupational therapist, teacher, among others), who may be necessary for the therapeutic project; and six technical-level professionals (nursing auxiliaries or technicians, administrative technician, educational technician and artisan)⁽¹³⁾.

The small number of professionals at the studied CAPS is a problem that interferes in the services provided, as the organization of daily activities for the large demands of users per day causes discomfort in the groups of interest. The daily service demand averages at 80 to 90 users per shift. As such, the team has a feeling that they are providing low-quality services, and the users and relatives perceive that the workers are overburdened by the service.

It is worth noting that the CAPS team was not sure about how the intensive modality of care and team composition worked, which was clarified by the proposal to assess compliance with Regulation 336/2002 (13). The professionals considered that the users included in this modality should be at the service in both daily turns, every day of the week, resulting in the swelling of the service. This phenomenon is also related to other aggravations, such as the weakened structure of the mental healthcare network in the city and failure to discharge patients from the service. As for the small team, internal and external management issues of the service were addressed, focusing on hiring more human resources as dictated by law, resulting in more comfort for the users, relatives and the team in the implementation of a welcoming work proposal, committed to psychosocial care.

The high demand and the small team are seen as a conundrum, going beyond simple technical and formal compositions of the environment, being experienced as concerns for the relationships established there, which are perceived in the following reports:

I believe that more professionals, more and more, to help these people who need them, would be very good [...] I still think there aren't enough, sometimes they have a lot to do because the place is crowded F(5)1.

Some patients need more care. That's when we see that the place is understaffed [...] If there were more people working, it would be possible to work better, because I think the work we do here is very interesting. If we had more staff, the treatment of the patients would be way better E(5)9.

Look, what this place needs is more human material, more people to work, because a lot of people seek this place out and there's not many people to work here U(5)9.

A small team results in having a professional take on several functions within the service so that it can maintain its activities. This overburdens the professionals with work and interferes in the quality of the service provided. Work overburdening may result in professionals becoming sick, a concern that is present in the daily routine of this service.

A strategy of staff meetings could possibly prevent this situation of falling ill and lack of motivation. At these moments, the professionals can share their concerns and anxieties, as well as the successful services provided and activities executed⁽¹⁶⁾. Those are the moments to re-think and reorganize their work at the service, as well as the emotional aspects of these caregivers. For this reason, staff meetings should be considered a priority.

The small number of healthcare professionals in the team also hinders the quality of the service.

[...] If there were more people working here, I think that the service would be better. It would be better if there were more people, more professionals U(5)3.

[...] I wish there could be more service, or an employee that could be less busy, so that, whenever there is a workshop, he or she could check on those people who are walking around and not working F(5)6.

it would be good to have (more professionals) around, because that overburdening would not exist, or that pressure to have them see everyone at the same time [...] But there's a lot of patients who require longer healthcare sessions, or more patience. That keeps the professional really busy at that time F(5)2.

The issue of a high demand versus a small team and its consequences involves several aspects that interfere in the quality of the mental healthcare service, such as: availability of time and qualification of the team, adequate physical structure, satisfaction of those involved in the care and favorable work conditions. As such, the work process at the CAPS is concentrated in a more technical procedure, based on the biological model of healthcare and hindering more comprehensive healthcare actions, as one of the precepts of psychosocial rehabilitation.

Mental healthcare policies and institutions responsible for the city of Foz do Iguaçu should prioritize this problem.

One of the ways to assure the quality of healthcare work is to adequately combine professional autonomy with workers' responsibility. All processes that limit the capacity to solve problems at work cause alienation and lack of commitment with health promotion.

Therefore, the CAPS teams consist of several actors, who invent other ways of functioning, organizing and articulating mental healthcare in their daily routine, considering the construction of healthy environments as well.

FINAL CONSIDERATIONS

Health is no longer related exclusively to clinical care, but covers psychological, emotional, social, environmental, economic, cultural and biological aspects as well.

Ambience is characterized as a therapy, incorporating aspects related to physical structure, human resources and social work relations in the search for comfort and quality, perceived as some of the core concerns in the work performed at the CAPS Flávio Dantas de Araújo at the moment of the assessment.

The small team is considered to be the main critical knot, since the service was registered as having 23 professionals from different backgrounds. Of these, 18 are registered in the outpatient clinic. In the CAPS studied, the fixed team consists of five professionals, which causes the daily conundrum: high demand versus small team.

It should be noted that the CAPS team did not have a clear idea of how the intensive healthcare modality should work, which was clarified by the assessment proposal.

On the other hand, this team sees that this problem interferes with work at the CAPS, and its consequences involve several aspects related to the quality of the mental healthcare, such as limitation of the individual service, development of the ITP, having a professional assume several activities and functions without having time to organize or articulate partnerships for internal and external management.

Such fact overburdens the workers, and this is reflected in the service provided, since it is often characterized as a technical procedure based on the biological healthcare model. More comprehensive healthcare actions, which are the precepts of the psychosocial rehabilitation, are thus hindered.

The issues related to human resources represent a critical component for outlining new paradigms in the work process at the CAPS, and should be prioritized by mental healthcare policies and institutions responsible for the city of Foz do Iguaçu, since the performance of any organization depends on its staff.

This service develops its activities in a rented building, shared with the municipal mental care outpatient clinic. A glass door that remains closed and locked divides the two services. Only the CAPS staff and users have access to it.

The closed-door policy at the CAPS is an issue of debate, since this is a daily care service with freedom as one of its precepts. The doors should remain open to allow people to come and go, which implies and was assessed as a paradigmatic change of attitude, where the subjectivity and decisions of those who are or arrive there should be considered.

Also, it was observed that some users needed to receive more attention, so that the professionals could be closer, providing orientation and facilitating their actions to provide an environment with better protection. Such protection does not occur by closing and locking doors; on the contrary, it brought the imprisonment of madness and its social exclusion.

In the CAPS, this closer monitoring of the users is hindered, as the team is small and is always involved in workshops, group activities and other events planned for daily service routine.

This routine has not been easy, but is always seen as a social and political commitment for the consolidation of the Psychiatric Reform. Work at the CAPS, regardless of its many conditioning factors, human and material resources, physical space, healthcare policies, relations between professionals, users and families, has been happening as an experience that considers the range of actions developed there, i.e. a type of work that considers the life of people.

The relations between the staff, users and families are seen as being at the core of the mental healthcare, being either capable of providing change in the evolution of the mental condition or not, since the intervention is built upon the complex articulation among the many actors⁽¹⁷⁾.

In this sense, it should be noted that such issues are observed in the assessment process and demonstrate the

commitment with a healthy environment that considers comfort and subjectivity in CAPS work.

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