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**Maria Tavares Cavalcanti**[I]

**Catarina Magalhães Dahl**[I]

**Maria Cecilia Araujo de Carvalho**[II]

**Elie Valencia**[III]

# Criteria for admission and continuity of health care in psychosocial healthcare services, City of Rio de Janeiro, Southeastern Brazil

## ABSTRACT

**OBJECTIVE:** To analyze the criteria used by teams for admission, referral and continuity of care among patients of the *Centros de Atenção Psicossocial* (CAPS – Psychosocial Care Centers).

**METHODS:** A qualitative study with participatory evaluation was conducted in three psychosocial healthcare services of the city of Rio de Janeiro, Southeastern Brazil, in 2006. A total of 15 admitted cases and 15 referred cases were selected among the patients admitted for treatment during the six months that preceded the beginning of research. Criteria pointed out by the team to admit patients for treatment or referral were analyzed from structured guidelines. Analysis of continuity of care was based on medical records and information from the team and patients and/or family members themselves, six months after patients were admitted or referred.

**RESULTS:** Patients admitted had psychosis (schizophrenia), history of previous admissions, poor social functioning and a small support network, patients referred had anxiety and depressive disorders, a good level of adherence to outpatient treatment, good social functioning and presence of a social network. In terms of continuity of care, eight out of 27 patients had an unknown destination. In terms of referrals, of the 13 patients referred to the network's outpatient clinics, seven continued in treatment, two returned to the centers and four had an unknown destination.

**CONCLUSIONS:** The centers admit patients who fit into the definition of severe and persistent mental disorder. Continuity of care was pointed out as a problem, probably due to the difficulty in following patients.

**DESCRIPTORS: Mental Disorders, diagnosis. Patient Admission. Continuity of Patient Care. Delivery of Health Care. Mental Health Services. Qualitative Research.**

## INTRODUCTION

The Brazilian psychiatric reform is characterized as essentially public and city-based. It is founded on a healthcare network in the community, comprised by *Centros de Atenção Psicossocial* (CAPS – Psychosocial Care Centers), *Serviços Residenciais Terapêuticos* (SRT – Therapeutic Home Services), community centers, mental health outpatient clinics and general hospitals. The CAPS are strategic interactive centers of this network and of mental health policy, aiming to organize the health care network for people with mental disorders.

[I] Universidade Federal do Rio de Janeiro, Rio de Janeiro, RJ, Brasil

[II] Fundação Oswaldo Cruz. Rio de Janeiro, RJ, Brasil

[III] Columbia University. New York, NY, EUA

**Correspondence:**
Maria Tavares Cavalcanti
Instituto de Psiquiatria da UFRJ
Av. Venceslau Braz, 71 Fundos – Botafogo
22290-140 Rio de Janeiro, RJ, Brasil
E-mail: mariatavarescavalcanti@gmail.com

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The following are among their activities: daily-based clinical care, promotion of social inclusion of people with mental disorders through intersectorial actions and regulation of the gateway to the mental health care network in its operating area, thus supporting primary mental health care.

In the city of Rio de Janeiro, Brazil, the *Programa de Saúde Mental* (Mental Health Program) began in the 1990s through the CAPS and home services, prioritizing actions aimed at care for patients with severe and persistent mental illnesses. In 1995, the *1º Censo da População dos Internos em Hospitais Psiquiátricos* (1st Population Census of Patients Admitted to Psychiatric Hospitals) was held in this city, establishing a policy to change the model from hospital care to community care. In the following year, the city's first CAPS was created in the district of Irajá, thus beginning the CAPS implementation process in areas of the city with serious deficiencies in mental health services.

Currently, there are ten adult CAPS (CAPS II), three child CAPS (CAPSi) and one alcohol and drug CAPS (CAPS ad) operating in this city (accredited and in process of being accredited). In December 2007, 3,246 users were regularly registered with one of the health care network's CAPS II, most of whom were young, of both sexes, aged between 20 and 50 years (predominantly between 30 and 49 years, 63.8%), and diagnosed with schizophrenia spectrum disorders (ICD-10, codes F20-29).[a]

The present study aimed to analyze the criteria used by teams for admission, referrals and continuity of care among patients in the CAPS.

## METHODS

This study followed questions that focused on the CAPS patient, such as: What patient is the CAPS aimed at? What happens when a patient arrives at the CAPS? As regards treatment, what is the patient's treatment destination, beginning with their arrival at the CAPS?

Participatory evaluation with CAPS professionals was the method used, where "researchers collaborate, in an integrated way, with individuals, groups or communities that play a role in the program under evaluation" (Cousins & Whitmore,[3] 1998) and the evaluation course may change with the discovery of factors that were not foreseen in the beginning (Guba & Lincoln, 1989).[4] This participation occurred in two distinct forms: 1 – weekly service team meetings to collect data; 2 – every three months, meetings of the advisory council, constituted by researchers and one representative of each CAPS II of the city to share research directions, validate data and discuss future referrals.

The following methodological steps were performed:

1. notice of meeting to the advisory council and definition of the service(s) to be used as object of investigation. A total of three older CAPS were selected, whose teams volunteered for the investigation. Teams had 36 professionals on average, of which half was comprised by health professionals with higher education (psychiatrists, psychologists, nurses, social workers, occupational therapists, music therapists), while the other half included mid-level professionals from the areas of health, support and management;

2 completion of a form with data on service structure, process and mission, during one team meeting;

3. random selection of five patients admitted to the CAPS for treatment and five patients referred to the health care network by each of the three CAPS studied, totaling 30 randomly selected patients, 15 admitted to the CAPS for treatment and 15 referred to the health care network by the CAPS. This random selection was based on the universe of all patients admitted for treatment in the CAPS or referred to the health care network for treatment by the CAPS during the six months that preceded the beginning of research;

4. discussion of each case randomly selected during team meetings, using guidelines that sought information about who referred the patient to the CAPS, who received them in the CAPS, the reason for the first visit, the diagnostic impression and the referral given to the case;

5. return to the CAPS six months after random selection to find out the treatment destination of patients initially admitted and referred, using a survey on medical records, information about the team and the patients and/or family members themselves.

Team meetings were recorded and transcribed and their contents analyzed.

The study was approved by the Research Ethics Committee of *Instituto de Psiquiatria do Rio de Janeiro* (Rio de Janeiro Institute of Psychiatry).

## RESULT ANALYSIS AND DISCUSSION

Of all the 30 cases randomly selected, three were excluded from the final sample as they had not been resolved (patients had been included into the groups of those registered with or referred by the CAPS, even though they were found not to belong to such groups in a subsequent analysis). Thus, it was not possible to place

[a] Terto A, Sávio D, Almeida N, Processi V, organizadores. Relatório técnico dos centros de atenção psicossocial (CAPS II) da Secretaria Municipal de Saúde – SMS/RJ. Rio de Janeiro: Instituto Franco Basaglia; 2008.

them in any of the two outcome groups – admitted to the CAPS for treatment or referred for treatment in the health network. Of all the 27 remaining patients, 13 were referred to the health network and 14 to the CAPS.

At the first visit to the CAPS, there were different concepts of service objectives and target client composition. However, the three teams studied agreed on the CAPS being the most appropriate place to welcome "seriously ill" clients.

The reasons alleged by the service teams to admit 14 patients in the CAPS were as follows: previous classification as "schizophrenic" and/or "severely psychotic" (n=7); lack of a social network, causing one to be isolated and have difficulty in interacting socially (n=5); history of several psychiatric hospitalizations (n=3); presence of "moderate to severe mental retardation" (n=2); presence of "impoverishment" (n=2); lack of appropriate institutions in the network (n=2); presence of "resistance to outpatient treatment" (n=2); previous referral by another CAPS (n=2); de-institutionalization (patients of the CAPS area who had had long psychiatric hospitalizations (n=2); presence of "change of behavior and refusal to leave home" (n=1); and "non-adherence to drug treatment" (n=1). More than one reason could be assumed for the same patient.

As regards the 13 patients referred, the following criteria were used: diagnosis of "dissociative disorder" (n=1), "fear" (n=1), "irritability" (n=1), "depression" (n=1), "epilepsy" (n=1), "mood disorder" (n=1), as well as good adherence to previous outpatient treatment (n=9) and good family support (n=3). All patients were referred to psychiatric/mental health services in outpatient clinics of health centers, except for one who was referred to a center specialized in psychogeriatrics (a case of alcoholic dementia).

As regards continuity of care six months after the decision of admission or referral of patient, of the 14 patients admitted to the CAPS, five remained in treatment, five were referred to a different place of treatment in the health network and four had an unknown treatment destination (without any medical record information for at least six months before this consultation and without a successful attempt of contact – usually by telephone – with the patient and/or the family).

Of all the 13 patients referred to the mental health care network, seven remained in treatment in the outpatient network, two returned to the CAPS for treatment and four had an unknown treatment destination (without any medical record information for at least six months before this consultation and without a successful attempt of contact – usually by telephone – with the patient and/or the family).

Admission or referral of patients in the three CAPS of the city of Rio de Janeiro health network was based on an interaction of five aspects – diagnosis, symptomatology, prognosis indicators, social support/autonomy, and health service network available – described as follows:

- diagnosis – as an example, while diagnoses of schizophrenia tend to lead to admission to the CAPS for treatment, diagnoses of mild dissociative, anxiety or depressive disorders tend to lead to referrals to the health network;
- symptomatology – patients with severe psychosis or major negative symptomatology (impoverishment) tend to be admitted, while stabilized patients, without psychotic symptomatology at the moment, tend to be referred;
- better or worse prognosis – history of innumerable previous hospitalizations, alcohol and drug use, non-adherence to outpatient treatment tend to lead to patient admission. Good clinical treatment response, stabilization with treatment, good adherence to drug treatment and good adherence to outpatient clinic tend to lead to patient referral;
- level of social support/patient autonomy – withdrawal from family, social withdrawal, leaving the penitentiary system or discharge after long hospitalization (de-institutionalization) lead to admission, while good social and family support and good autonomy lead to referrals;
- structure of the health network itself – absence of network services to follow up patients or the unavailability of vacancies lead to admission, regardless of the patient's diagnosis or symptomatic and support situation at the moment.

There is no consensus in the literature on the definition for a patient with severe and persistent mental illness (SPMI). However, the *Ministério da Saúde* (Brazilian Ministry of Health) decrees classify a patient with SPMI as eligible for the CAPS (Ministerial Decree 224/MS and 336/MS).[a]

A review article by Schinnar et al[11] (1990) shows 17 definitions of SPMI throughout the 1980s. The National Institute of Mental Health (NIMH)[11] definition was formulated by a work group instituted in 1987, aiming to reach a consensus on SPMI. The definition is based on three aspects: a) confirmation of diagnoses of non-organic psychosis or personality disorder; b) incapacities (assessed with the Global Assessment of Function – GAF)[11] that show at least three of the following dysfunctions – social behavior requiring intervention by the health or law system, mild damage to daily life activities or basic needs, moderate deficit

[a] Ministério da Saúde. Portaria nº. 224, de 29 de janeiro de 1992. Estabelece diretrizes e normas para o atendimento em Saúde Mental. *Diario Oficial Uniao.* 30 jan. 1992; Seção 1;1168.

in work performance, moderate deficit in performances not associated with work; c) duration, in which the history of mental disease for two years or treatment for two years or longer is considered.

In 2000, Ruggeri et al[10] presented and tested a second NIHM definition of SPMI, considered broad, as it includes two criteria from the narrow definition – incapacities and duration –, excluding the diagnosis dimension.

Ruggeri et al[10] concluded that the narrow definition of SPMI does not include a great proportion of patients if the criteria of duration of contact with services and incapacity (broader definition) are used exclusively. By applying the broad definition, these authors found that 58% of patients in the sample had a diagnosis of psychosis and 42% did not. What remains in question is the legitimacy of disregarding a great proportion of patients when planning services for those with SPMI. In the exploratory data analysis, the non-psychosis diagnoses that appeared more frequently were the personality disorders, alcoholism and use of other drugs.[11]

As regards the two NIMH definitions (narrow and broad)[10,11] it is possible to affirm that CAPS professionals used part of the narrow definition, based on the diagnosis (especially schizophrenia spectrum disorders) and incapacity (GAF≤ 50, once the GAF considers aspects of symptomatology, prognosis indicators, social support and autonomy). Among CAPS professionals, there is no formal reference to duration of treatment, even though speech and medical record visits indicate patients with a long history of psychiatric treatment and several previous hospitalizations. On the one hand, there is no systematization of these criteria, while, on the other, the literature shows that the question of diagnosis may limit the inclusion of a substantial number of patients considered to have SPMI, when the broad definition is used.[10] In Brazil, there are two types of services for adults with SPMI: the CAPS II and the CAPSad. It is possible that the CAPS are selecting patients based on the narrow definition of SPMI (diagnosis of psychosis), whereas the CAPSad select patients who are alcoholics and use other drugs. Regardless, the question remains about where people with personality disorders without comorbidity with drug and alcohol use are treated.

Previous studies (Phelan 2001,[9] Parabiaghi 2006[7]) are controversial in terms of the benefits of this systematization of patient inclusion criteria in the CAPS, according to the NIMH[11] broad definition. However, the present study indicates that this could be an interesting development.

The fact that no information about the destination and/or treatment of eight (29.6%) of the 27 patients could be identified indicates the need to improve CAPS patient follow-up.

Brazilian studies, such as the one by Melo & Guimarães[6] (2005), report an even higher rate of abandonment of treatment in the CAPS. In a review of 295 medical reports in the city of Belo Horizonte, Southeastern Brazil, the authors found a 39.2% rate of abandonment of treatment. Pelisoli & Moreira[8] (2005) found a 54% rate of no return to treatment among patients who had their first consultation in the CAPS of the city of Osório, Southern Brazil.

In the international literature, systematic review performed by Simmonds et al[12] (2001) found a 33% rate of abandonment of treatment among patients receiving care by a mental health community team. Community care is offered by multidisciplinary teams located out of the hospital area and gathers interventions aimed at specific needs of patients, similarly to Brazilian CAPS.

## FINAL CONSIDERATIONS

According to what has been previously mentioned, the CAPS are area-based services including several functions, from the follow-up of patients with SPMI to mental health network organization in their area of coverage. This diversity is inherent in a service with characteristics of psychosocial care in the area. However, in a major city such as Rio de Janeiro, this logic of functioning in the area would imply a structured and well-integrated mental health care network, especially in terms of primary care. None of the 27 cases studied showed integration with the *Programa de Saúde da Família* (PSF – Family Health Program) or the *Programa de Agentes Comunitários de Saúde* (Community Health Agent Program), even though the *Ministério da Saúde* had foreseen such interaction in a recent decree.[a]

In addition, the absence of other mental health services in the area which can include patients who do not need treatment in the CAPS is an important problem in the city. The mental health service network and family health team coverage (primary care) are insufficient for the population density, thus causing the health services available to be overloaded. The *Ministério da Saúde* established the 1 CAPS/100,000 inhabitant index, whose satisfactory coverage is between 0.46 and 0.60. The state of Rio de Janeiro shows an index between 0.31 and 0.45 and the city of Rio de Janeiro, with 13 CAPS for 6 million inhabitants,[b] shows that it lacks at least 17 CAPS, considering the coverage for

[a] Ministério da Saúde. Portaria nº. 154, de 24 de janeiro de 2008. Cria os núcleos de apoio à saúde da família – NASF. *Diario Oficial Uniao*. 04 mar 2008; Seção 1:28-42.

[b] Instituto Brasileiro de Geografia e Estatística. Revisão 2004 de projeção da população. Brasília; 2004. [cited 2009 Jun 19]. Available from: www.ibge.gov.br /cidadesat/

an area with between 150,000 and 200,000 inhabitants, recommended by Thornicroft & Tansella, and cited by Andreoli et al[1] (2004).

Besides the number of services, there is the question of the patient follow-up methodology itself in the community.

The international literature points to a professional, not necessarily with higher education, who is a case manager and follows the patient in the community (family, work, study, treatment), facilitating their connections with and inclusion into the treatment system of the primary care network and/or the CAPS (Bandeira et al,[2] 1998; Machado et al,[5] 2007).

A CAPS reference technician could not play the role of case manager for the patient; instead, they interact with services and basic needs. This is because they are already overloaded with the number of patients they follow up. Thus, if they are also in charge of the interaction between this patient and his formal and informal support network in the area, it will be difficult for them to care for those who are under their responsibility in the CAPS. As a result, the present study reveals the lack of a professional who integrates the CAPS with its territory, responsible for the work with the patient, his interactions (family, friends, activities that the patient may have, and adherence to medication, for example) and his connection with the CAPS. This professional may be the community health agent of PSF teams, once the presence of mental health professionals, including psychiatrists, is foreseen by a recen *Ministério da Saúde* decree, establishing the *Núcleos de Apoio à Saúde da Família* (NASF – Family Health Support Centers).[a] Findings from this study show that, in a major urban center such as Rio de Janeiro, it is not feasible for a CAPS professional to be responsible for care both in the service and in the community in a satisfactory way.

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[a] Ministério da Saúde. Portaria no. 154, de 24 de janeiro de 2008. Cria os núcleos de apoio à saúde da família – NASF. *Diario Oficial União*. 04 mar 2008; Seção 1:28-42.

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