PSICOLOGIA
EM ESTUDO

ARTICLE 10.4025/psicolestud.v29i1.54679

CARE ARRANGEMENTS ON A PSYCHOSOCIAL CARE NETWORK IN SOUTHERN BRAZIL

Bruno Jardini Maeder [1]**,** Orcid: https://orcid.org/0000-0002-3233-9629
Adriano Furtado Holanda [2]**,** Orcid: https://orcid.org/0000-0002-7171-644X

ABSTRACT. The psychiatric reform is not standard in all Brazilian places, as it depends on different factors such as material, human and cultural aspects of each region. As for its singularity, it is seen as a care arrangement. This article aims to study the psychosocial care network on a regional health department in south Brazil. A descriptive mapping has been performed, following the empirical-phenomenological method. The services described welcome the entire community, people from all walks of life, but when it comes Drug and Alcohol addicted, the approach becomes more challenging. There have been seven care services listed: Hosting, Therapeutic Groups, Workshops, Individual Treatment, Medication usage, Referrals and Support Group Meetings. The approach for care arrangement is related to the creative experiences and human solutions as well as thoughtless and normative practices in the attention of mental suffering.

Keywords: Mental health; psychosocial support systems; mental health service.

ARRANJOS ASSISTENCIAIS EM UMA REDE ATENÇÃO PSICOSSOCIAL NO SUL DO BRASIL

RESUMO. A implementação da reforma psiquiátrica é tema de recorrentes discussões no campo da saúde mental. Essa implementação não é padrão para todas as localidades brasileiras, uma vez que depende dos recursos materiais, humanos e aspectos culturais de cada região. A esta singularidade retoma-se a noção de arranjo assistencial. Este trabalho propôs a conhecer a implementação numa regional de saúde da região Sul. Foi realizado um mapeamento descritivo, seguindo método empírico-fenomenológico. Descrevem-se serviços que acolhem todos os públicos, mas que encontram dificuldades no trabalho com a população usuária de álcool e outras drogas. Foram elencados sete dispositivos assistenciais: acolhimento, grupos terapêuticos, oficinas, atendimentos individuais, uso da medicação, encaminhamentos e reuniões de equipe. Expõe-se a ideia de que a estrutura de um serviço de saúde mental não pode ser estanque. Os arranjos assistências estão relacionados às vivências e soluções criativas e humanas como também práticas irrefletidas e normatizadoras na atenção do sofrimento mental.

Palavras-chave: Saúde mental; sistemas de apoio psicossocial; serviços de saúde mental.

---

[1] Faculdades Pequeno Príncipe (FPP) Curitiba-PR, Brazil – bruno.mader@fpp.edu.br
[2] Universidade Federal do Paraná (UFPR), Curitiba-PR, Brazil – bruno.mader@fpp.edu.br

ARREGLOS ASISTENCIALES EN UNA RED DE APOYO PSICOSOCIAL EN SUR DE BRASIL

RESUMEN. La implementación de la reforma psiquiátrica no se encuentra estandarizada para todas las regiones brasileras, una vez que eso depende de recursos materiales, humanos y de aspectos culturales. Por cuenta de esta singularidad, se retoma la noción de arreglo asistencial. En este trabajo se propone conocer la implementación en una regional de salud de sur de Brasil. Se realizó un mapeo descriptivo, siguiendo el método empírico-fenomenológico. Se describen servicios que acogen a todos los públicos, pero que encuentran dificultades en el trabajo con usuarios de alcohol y drogas. Fueran enumerados siete dispositivos asistenciales: Acogimiento, grupos terapéuticos, talleres, atendimientos individuales, uso de medicación, encaminamientos y reuniones de equipo. Se expone la idea de que la estructura de un servicio de Salud Mental no puede ser hermética. Los arreglos asistenciales están relacionados con las vivencias y soluciones creativas y humanas como también prácticas irreflexivas y normalizadoras en la atención del sufrimiento mental

Palabras clave: Salud mental; sistemas de apoyo psicosocial; servicios de salud mental.

Introduction

The enactment of law 10216 is the legal representation of the reformulation of Mental Health Care in Brazil, the result of a process of national discussions and experiences that began in the late 1960s but which gained shape and relevance with the organization of the Mental Health Workers Movement (in Portuguese, it is best known as ‘Movimento dos Trabalhadores de Saúde Mental’ or MTSM) in the late 70s (Silva, 2014; Amarante & Nunes, 2018). During this period, criticism of psychiatric clinics, isolation, and moral treatment began to have a new proposal for assistance. This legal framework points to the reorientation of services, changing the axis from hospital care to decentralized and territorialized care (Muhl, 2015; Amarante & Nunes, 2018).

The regulation of the shift to treatment in community services was carried out by ministerial ordinances that provide for new service networks and forms of care. However, the transition to assistance was ineffective, and the two models (hospital and territorial) live side by side. The reorganization of public policy and the provision of available services is supported by the discussion about people’s rights and the development of their potential and about the nature of mental disorders with their biological, environmental, or psychological determinants (Almeida Filho, Coelho & Peres, 1999; Silva, 2014; Miliauskas, Faus, Junkes, Rodrigues & Junger, 2019).

The proposed model change presents technologies, strategies, services, devices, and techniques to compose the model that would replace traditional psychiatry. Ballarin, Carvalho, Ferigato, Miranda and Magaldi (2011) find an interesting semantic solution when grouping them as ‘care arrangements’. In addition to the services that make up the network, such arrangements consist of actions that professionals use in their work. Highlighting this professional participation, the replacement of the care model does not occur simply by replacing the hospital with CAPS and other substitute services. The reform is not linked only to the place or health equipment where the person with a mental disorder is embraced (Macedo, Abreu, Fontenele & Dimenstein, 2017).

Mental Health Care services and, more specifically, those that make up Psychosocial Care imply an open stance towards psychological suffering that goes beyond the legal designation that supports them. In this scenario, the professional's performance is a key element. When services and policies are implemented as imposed packages, that is, designated a priori without the participation of professionals in this construction, it is not clear to the mental health worker the rules and limits of practice, which generate confusion and insecurity (Silva, Aciole & Lancman, 2017; Lima, & Guimarães, 2019).

In this sense, the performance and development of professionals gain a certain protagonism. Unlike the provision of substitute services by the state and its regulation, professional performance has a certain uniqueness. Merhy & Franco (2003) point out this distinction when conceptualizing this development as technological. While the first would be a hard technology (due to its immutability), aspects such as reception and bonding would be light technologies, as they "[…] relate to the unique way in which each professional applies their knowledge to produce care" (p. 138).

This research analyzed and described the Mental Health Care Network in a regional health division in a state in southern Brazil. Studies on health policies are commonly linked to epidemiological thinking, which addresses the distribution and determining factors of illnesses, damage to health, and events associated with collective health (Rouquayrol, 2012). However, health, in addition to objective aspects, such as disease classification and statistics from epidemiological research, is also composed of a subjective dimension whose model object is heuristic (Almeida Filho, 2000) and, therefore, subject to qualitative and phenomenological analysis (Mäder, Holanda & Costa, 2019).

We consider clinical practice, 'making Health', as a lived process, a dialogue with humans, in which technical and personal aspects of professionals are at stake, together with the treatment and care for people with mental disorders. In this way, the production of a care network will go beyond legal designations and provision of services through the effective communication between its components, that is, through the experience of professionals working clinically and in a network.

Thus, the object of the researcher or mental health worker is not alien to them. In other words, in their care work, professionals have the challenge of developing strengths and weaknesses and promoting their own mental health. Furthermore, by understanding that "[…] the concept of mental health is linked to an emancipatory agenda for the subject, of an unavoidably political nature" (Almeida Filho et al., 1999, p. 123), we indicate that the professional's understanding of their work is a determinant of the performance of public policy.

Method

Our study was structured as descriptive mapping, which allows us to understand a network of services through the experience of the professionals who make it up. Mapping can be carried out in three stages: the design of a project, the one in which the data is collected, and the next in which they are described, organized, and interpreted. For data collection, the experiences of professionals in the Psychosocial Care network, semi-structured interviews were used, recorded, and transcribed. The analysis carried out using the empirical phenomenological method, consists of, after knowing all the material, categorizing the experiences of the participants into units of meaning, expressing the psychological understanding contained in these units, and, finally, synthesizing them, attributing a vision of the whole to the reader (Mäder et al., 2019).

The research proposed to go into the field to find out and describe the composition of this care network and its care arrangements in a specific regional health division. To this end, the network of services, devices, and professionals in this region was mapped. A network, beyond its legal designation, was understood as a process of communication and cooperation between services and professionals. For the research, reference mental health services for each of the municipalities in the region were taken as a basis. Muhl (2015) presents this regional health division and its services in depth.

Out of the 31 professionals who made up the network, we had the participation of 27 (eight psychologists, four social workers, four occupational therapists, three nurses, three psychiatrists, two nursing technicians, one office worker, one pedagogue, and one intern of social services) of six services (four CAPS I, one Mental Health Outpatient Clinic, and one hospital). Some services had professionals for administrative and general service functions that were not included in the sample.

The research was approved by the Research Ethics Committee of the Health Sciences Sector of the Federal University of Paraná – SCS-UFPR, opinion 896,740, on 12/02/2014.

Results

1. The profile of professionals and services

The professionals participating in the study are mostly female (78%), coming from six higher education areas and two high school areas. We noted that 44% (12 professionals) completed a graduate program in the mental health area. Most professionals are young adults (20-29 years old) or adults (30-49 years old). Although the majority (19 or 70%) graduated more than six years ago, 15 (62%) have been in the services for less than two years. This short period of integration into services can be attributed to the recent inauguration of most of the equipment or recent changes in the team.

Most professionals (16) work exclusively in the services surveyed. Those with other employment relationships work in private practices, other health services, or therapeutic communities, and one professional works as a professor in higher education. All psychiatrists work in other services. Unlike other professions, psychiatrists are the only professionals who work in more than one of the services surveyed.

2. Welcoming the assisted population

The services researched are a reference in mental health for their municipalities. CAPS are all type I and, according to regulations, receive all audiences (mental disorders, alcohol, and other drug addicts, children, young, adults, and the elderly). Hospital services (outpatient clinic and inpatient beds) accommodate all ages, depending on their clinical condition.

There is a common concern among services to identify the public that should be received and will benefit from the attention provided by CAPS and distinguish them from those who should be referred or hosted by other services in the network. This is due to the reason for organizing demand and the service's capacity to provide care and treatment. The phrases that identify "[…] patients who are not from CAPS" (P6) and/or that "[…] the case is evaluated as to whether it belongs to CAPS" (P17) are symbolic.

In the case of adult users, a ‘CAPS patient’ is one who has a severe mental disorder with loss of the capacity for daily activities, interpersonal relationships, and social isolation or who presents positive crisis symptoms.

There is also an audience of alcohol and other drug addicts. In this case, the ‘CAPS patient’ is the one who is motivated to stop using it, who does not use it during treatment, and who constantly requires hospitalization

Among young people, there is a difference in the reception of users referred by the care network and those referred by the judicial power. This difference is due to how the adolescent is linked to the service. Since CAPS is an open service, it is difficult to work with a user who does not want to attend the service.

Hosting different audiences is a central feature of the services, especially CAPS I. This diversity influences the organization of services: there is a concern not to mix audiences and to offer specific activities for each group.

3. Care arrangements – specialized psychosocial care devices

The structuring of services and their therapeutic provision are supported, in addition to ministerial regulations, on material resources made available by management and human resources. The care arrangements promoted by the services are based on the qualifications and disposition of their professionals; the organization of the provision of groups and services are reflections of the professionals’ notion of suffering and pathology and their ability to accept these issues.

Hospital services show a traditional organization centered on the disease and the physician-patient relationship, with scheduled appointments or visits to hospital beds, and do not offer group care or recreational activities. Attention is restricted to ‘individual care’ and ‘medication’ administration.

CAPS has a higher diversity of care (to the user, their family, and the care network). We observed five assistance offers in all CAPS services, although each in its own way: user embracement, therapeutic groups, individual treatment, workshops, and medication. When we pay attention to the structure of the service schedule, it is still possible to observe a specific time for team meetings, which is essential for service functioning.

It is worth paying attention to arrangements or offers not included in the schedule of activities but mentioned decisively in data collection. We highlight referrals and dialogues with other services but also reports of spontaneous activities that do not occur with a scheduled appointment. These activities are relational and linked to a specific need: help with personal hygiene, basic care for users, and during meal times.

User Embracement is identified in two ways: the moment of arrival and reception of the user at CAPS and the act of accepting and admitting the user to the service. The moment the user arrives at CAPS is carried out differently in each service. At CAPS A, all receptions are carried out by the same professional, the coordinator. At CAPS B, reception is administrative with filling out a form and subsequent attention from assistance professionals. At CAPS C, reception is carried out by professionals by appointment. In CAPS D, it is done by any professional with higher education at any time of search.

The user embracement has a double function: first, an initial assessment of the user, and the second comes from the notion that the CAPS is not a simple outpatient clinic but a place to establish bonds and relationships. Despite different forms of action, services have in common the duty to know the user as a whole and include them in the available activities. Although the reception is carried out by only one professional, all services decide as a team on the inclusion into the service and the activities for each user. The formulation of the Singular Therapeutic Plan, as guided by the Ministry of Health (Ministério da Saúde, 2007), was not reported.

‘Therapeutic groups’ are central activities in the functioning of CAPS; however, each service uses this device differently. The selection of group participants and their objectives are the main characteristics of these activities. In general, the selection of participants is made based on diagnosis. The organization of assistance as a whole follows this pattern. We observed that users selected by diagnosis have a scheduled day to attend CAPS, except in cases of need and greater attention. Two quotes from participants exemplify this trend as

> We assemble in separate groups, there is no way to mix either. Come here and we serve all types. Schizophrenia [...] bipolarity, it goes all the way to drug addiction, alcoholism, then [...] all kinds of disorders and chemical dependencies (P3).
>
> We have the mental disorders group on Monday, the family group on Tuesday, the depression group on Wednesday and the chemical dependency group on Thursday. The group that is walking slowly is the teenagers (P3).

At each CAPS, the groups serve different purposes. They can be psychotherapeutic (with an emphasis on group psychotherapy), guidance (such as organizing routine and medication), or in a more comprehensive way, such as conversation circles or free activities. Therapeutic groups are led by psychologists, social workers, and occupational therapists. Nurses and physicians did not report carrying out these activities. Except for CAPS C, all CAPS have a group of family members. This activity has a lower frequency than the others (once a month) and aims to bring people closer and provide guidance. The use of groups can be enhanced by the attentive and clinical eye of professionals. In one of the CAPS, upon self-criticism and self-evaluation, professionals were inventive and created new possibilities. When they realized that CAPS was having difficulties discharging patients, they decided to think about this. They then held a discharge preparation group, where relationships without CAPS and life activities were worked on.

In one of the services, a participant created a group activity based on another view of patients. The selection of group members was not based on the pathology but because of something some users had in common: parenthood. The professional used the need to prepare a final paper for a graduate program in mental health to carry out an intervention project at the CAPS where she works. Based on the technical opportunity, the professional used her clinical insights and personal creativity to create an attention device. She noted the need to work with adult users’ parent-child relationships. In addition to the diagnosis, it was possible to embrace these people’s relationships with their children. In this way, the subjects are valued and not the disorder.

> This came from an observation I made here in the service department, right? In this group, I work with them on the issue of limits, of affection […] It is more preventive work, taking into account that they [children of people with mental disorders] are likely to also develop some type of disorder. So, this is a more focus group to talk about family relationships, more specifically parents and children (P8).

‘Individual treatment’ is mentioned in all services and is used for evaluation. On an ongoing basis, individual care is provided by psychiatrists, nurses, and psychologists. The psychiatric consultation follows the outpatient model, a time for the patient to talk about what is happening and for the psychiatrist to evaluate. Nurses’ care is a complement to biomedical work. In addition to assessment, there is individual monitoring for therapeutic purposes. Unlike outpatient clinics, where the focus is individual and progressive, individual treatment is complementary to group work and intended for those who are not yet able to participate in groups or for those who need greater attention than provided by the group.

‘Workshops’ are group work proposals with different objectives from therapeutic groups and represent an alternative, creative proposal mediated by a central activity. In the services researched, we observed the offer of painting, crafts, and crochet workshops; computing; vegetable garden; water aerobics in the pool; and walking and stretching. Some of these workshops are performed in partnership with other institutions and services. If, on the one hand, they are linked to the figure of a craftsman or artist, on the other, they can also be performed by other professionals (occupational therapists, social workers, nurses, and volunteers described workshop actions in our sample).

The provision of these activities depends on the theoretical knowledge, technical skills, and personal willingness of professionals and the availability of material resources by the service, the municipal administration, or the community.

> Go after it! It's all like that, we go after it. Partnerships, partnership with the union, we have the farm here at our disposal, everything is a partnership. Culture, agriculture people come here, donate the land, donate the seedlings (P21).

> I have been trying to develop work, as general attention. [...] Identifying possible health problems in general. [...] I see the issue of their motor skills when working on stretching, walking, exercise, and aerobics. [...] So, but they accept it well, they adhere well. It’s very interesting (P20).

On the other hand, when a professional does not have the ability or willingness to work in groups, there is difficulty in the evolution of the process.

> [I] used to form a group [...] but I saw that it wasn’t evolving much. Because there was no way to create a dynamic, because it’s not my area, right? So, we found it more viable to visit all the groups, asking how the medication was organized, how the consultations with the psychiatrist were going, which is now much more viable (P2).

Prescription, routine, and use of ‘medication’ are central concerns in CAPS activity. Prescription is the exclusive function of the psychiatrist, while the routine and organization of use are divided among other professionals, especially nurses. Users with greater difficulties in understanding or organizing their routine receive more constant and closer individualized attention, sometimes with daily care.

The supply of medications by the municipality is constant. There is greater difficulty linked to the variety of medicines, and bureaucracy for those provided by the State Secretariat; however, in the end, medications are accessed.

> We have several classes of medicines. Here I have two antidepressants, two mood stabilizers, and one anxiolytic. Not that it doesn’t work, it solves it, but what about that patient who has already used it and it didn’t solve it? We would need to try other classes of medicines to try to get benefits and see if the patient has any improvement, [...] and the patient has to buy them. But in general, access is not difficult but unfortunately, we have this restriction on drug classes (P27).

Users with greater resourcefulness in dealing with these issues receive more autonomy in this care and in conducting their process. Care with medication reflects self-care and understanding symptoms and suffering.

> Every patient who goes into crisis, you can look at the medication: they stopped taking it [...]. Everyone, everyone. 100%. Why do they stop taking it? Because I always tell them: ‘guys, when you see that you look great, it’s because you’re combining medication and therapy very well. Then, all those symptoms disappear, and you think the disease is gone’. Unfortunately, mental illness is a chronic illness. It has control, but there is no cure (P6).

The medication care process is a concrete and observable factor to evaluate the way a user takes care of themselves. There is a perception that CAPS fulfills its role when a user can manage medication and their relationships without the constant presence of the team.

> A patient who is stabilized has been here for more than one stable period, whether due to more severe depression or perhaps an anxiety disorder, if this patient has not presented any change in the condition within a year, they are referred to a health unit to give continuity of treatment (P20).

Improving the user's living conditions and symptoms is a major reason for making referrals or contacting other services. In addition to discharge, social vulnerability, clinical conditions, or care for crises represent referral needs. There are few interactions with other services, such as meetings or matrix support. In particular, when there is a need for hospital admission, communication with hospital services is zero. Communication or joint construction with other services is more used in difficult cases to manage that challenge the team or whose problems cannot be developed by CAPS alone, which organizes its attention according to the demands of users in the service. In this way, the organization of the service with a timetable and planned activities, on the one hand, facilitates the organization of the service, but, on the other, it makes the relationship and connection of services difficult.

> There are a lot of meetings […] they come here more than we go there because they don't have a service schedule. We have kind of… It's all timed (P6).

The organization of the service on a timetable has a space for team meetings. All CAPS have a moment to discuss cases and 'team meetings'. The meeting is seen as a special moment for the team as a space for training, organicity, evaluation of cases, and decisions on conduct among the team. This moment of cooperation takes place in all CAPS researched. We emphasize that there is a time set out in the service timetable, which, on the one hand, obliges everyone to be present and, on the other hand, provides an opportunity for the meeting. This effort to delimit and guarantee the meeting space contrasts with the difficulty of meeting (or even exchanging) with other services on the network, where there is no pre-arrangement in a timetable, which is not within the time limit, as P6 said.

The care offered by CAPS is not restricted to activities that can be organized on a timetable or based on the prescription and management of medication. CAPS is a place for establishing bonds, both for users and workers.

In this process, 'coordination' is fundamental to the progress of CAPS activities. The coordinator maintains political relations with management, accounts for administrative and human management, and, on some occasions, acts as a technical supervisor for others. The coordinator needs to mediate conflicts or disagreements between the team, interact, and motivate professionals to truly feel like a team. In the case of our sample, the coordinators continue assisting and are often willing to take on the most difficult cases. Furthermore, the coordinator needs to give autonomy to the professionals' work while at the same time providing unity and characteristics specific to the work. She is the coordinator who feels the team's limits and serves as a support point for the team's decisions.

> [The workshop], in fact, is to materialize their rehabilitation. When the coordinator asked me to take it on, I said: 'Can I do it the way I see it?' She replied: 'You can' […] [today, the workshop] It's beautiful! A sign that our group is great (P22).

> And even, sometimes, wow, because we create a bond, and it becomes like that, so much so that you see, the coordinator, especially. She admits patients that theoretically she could not because the patient arrives here very ill; she says there is no way to abandon this patient, and we will have to treat them (P8).

Discussion

The work of CAPS is seen as a process with an important effect on the lives of its users. Therapeutic activities (groups, individual sessions, and workshops) have a primary function providing opportunities for catharsis, relaxation, creativity, knowledge, and self-perception. Medication has an important effect, as it provides stabilization of symptoms, but also knowledge of its function and its effects on users' lives.

Discharge is related to the stabilization of a patient's symptoms and the ability to take care of their own medication. Admission in the service is related to cases in which users are in intense suffering, have functional disorganization, or are chronically affected by previous treatments. However, it is possible to perceive that monitoring for users of alcohol and other drugs is not as effective as for users with other mental disorders. It is noted, in the participants' speech, that there is an understanding that mental disorder is a condition, something that does not go away and that one must live with; as for users of alcohol and other drugs, abstinence is central to care. In some cases, it is expected that the user has already suspended use to be included in the service (for maintenance), in others the user would need to show motivation to suspend use. In this case, it is worth asking, if CAPS does not accept the suffering of a user who is not clear about abstinence, which other service will accept them?

If, on the one hand, we do not observe, in any service, care based on the harm reduction strategy, on the other hand, we note that the number of requests for hospitalization in cases of alcohol and other drug addicts is higher than for people with other mental disorders. If there is a notion that drug users should not have contact with drugs, hospitalization fulfills this objective with some success.

> The majority [of users who require hospitalization] are cases of chemical dependency. Very little disturbance, we have managed to keep them here in stabilized condition at CAPS (P21).
>
> [We serve] drug addicts, but […] the drug addict who comes and goes, comes and goes, is not a permanent client of the service due to these relapses, sometimes they want treatment, sometimes they don't (P5).

The difficulty in following the follow-up suggested by the team is not restricted to drug users. Not wanting treatment, not wanting to leave CAPS, or showing some resistance to improving symptoms are important issues that impose impasses on services. These cases go against the idea of health as complete physical, mental, and social well-being. The objectives of treatment, according to professionals' reports, are to increase self-esteem, and psychosocial reintegration, work on adherence to treatment, and suppress symptoms. Now, what can or should professionals do with users who do not want to achieve the treatment objective?

Here it is important to return to the role of attention, reception, and diagnosis. What does 'not wanting to get better' refer to, about the pathology and the user's position about themselves and the world? Some participants point to a relationship with the INSS medical examination: improving means losing the benefits. Another possibility is users who do not want to get better because upon being discharged from CAPS, they would lose their only place to live. There are cases in which it is a specific manifestation of psychopathology. Now, what, after all, does the experience of 'suffering' consist of? "Getting closer to pathology, describing it in its entirety, facing it as a reality, implies facing human suffering – not as an object alien to us, but as a concrete reality – in its clarity and its deepest rawness" (Holanda, 2017, p. 173).

When a healthcare professional deals with suffering, with a pathology that ‘doesn’t get better’, their own dexterity and capacity (and that of the team) are put to the test. Associated with this is the satisfaction that the professional gains from work. It is at this point, in this node of mental health care, that professionals assume a leading role that involves technical, ethical, and personal aspects, in addition to that proposed by ministerial decrees.

Yasui, Luzio and Amarante (2018) point out the need for daily effort by professionals to free themselves from the traps of biomedical, prescriptive, and alienating models that insist on returning to psychosocial care.

We present another example: a psychiatrist points out the need not to be in a hurry to close a diagnosis, use the information they collect, and be creative in gathering information. To develop a boy’s diagnosis, he was asked, during the second consultation, to write a newspaper about his life. With this information, a diagnosis was made after a month of care.

The active participation of professionals from a CAPS, from a mental health service, goes beyond legal and bureaucratic guidelines. The role of the coordinator is another example, as she is the one who provides the service with organicity, balance, and speed of care processes. She centralizes the information and has to have a view of the whole. She is the one who will represent the service vis-à-vis municipal management and mediate institutional relations. We could say – following the designation proposed by Merhy & Franco (2003) – that the coordinator needs to deal more frequently with ‘hard’ and ‘light-hard’ technologies than other professionals. It is based on the success of this mediation that the service can safely carry out the ‘light’ tasks. Light, relational technologies can be exemplified by welcoming, bonding, autonomy, and accountability. These actions of coexistence and dealing with users depend on the personal disposition and will of the professionals. The perspective of care and reception has a greater ethical and human dimension than a technical and formal issue (Romanini, Guareschi & Roso, 2017)

> In fact, we work more for consistency than for rules. We certainly have the rule, but we use common sense more than the rule itself. [...] in this dialogue, I realize that this person really is someone to be cared for here at CAPS, I have no reason to tell the person to walk this via crucis (P25).

In addition to the technical dimension, there is the personal dimension, which is quite relevant to the success of a CAPS. These dimensions are often mixed, after all, each person’s professional project is also personal. In this case, technical development needs to be part of the routine.

> We have a project here at CAPS, each professional has a project, which ranges from formulation to general services. Each professional has a project and my project is precisely this: developing the group’s issue (P1).

The professional’s perception and donation are fundamental factors for new strategies to emerge and for care work not to become a time-consuming reproduction of technical obligations.

In these examples, we can observe that professionals who offer assistance experience difficulties and advances together with their users. By investing time and dedication to work, they take personal satisfaction from the results. Likewise, when results do not turn out as expected or are in some way obstructed, professionals feel frustration and discouragement in the process. Working to promote the rights of people with mental disorders involves straining the relationships of professionals who do not know or are resistant to dealing with this population.

> I think we do everything possible and impossible to make it work better [...]. But we have an immense desire and we put into practice everything we want. We don't know if it will work, but we'll do it (P10).
>
> We, CAPS professionals, need to be very careful with our mental health. But we end up changing our own profile at work, in the team, we went through some changes even at work itself, and we become a different team from where we are (P23).

In addition to promoting rights, when caring for people with mental disorders, we work with people's subjectivity, with learning, and growth. Just like users, professionals face, in addition to technical issues, their personal difficulties. In this way, working with mental suffering requires a certain degree of tolerance for one's anguish and openness to development.

> This case of this boy really touched me here and several ideas came up (P17).
>
> I had to learn a lot here [...] I thought I had to help everyone [...] I learned to say no at times (P7).

In this work that puts professionals in the face of technical and personal impasses, the answer does not just come from protocols or manuals. Here we see an impasse on the path of making health and, more precisely in this case, making mental health. There is a requirement to improve the user's life, reduce their suffering, and promote their well-being. However, there are technical and administrative requirements in assisting the user, offering groups, services, progress in medical records, and documenting actions, so that it is possible to fall into the trap that, by doing this, the objective of mental health is already reached.

If the objective of mental health policy is not to standardize individuals, but to respect and promote singularities, we find in Saraceno (1996, p. 151) that psychosocial rehabilitation "[…] is not a process to adapt the weak to the game of the strong. But on the contrary, rehabilitation is a process so that the rules can be changed so that the strong can live and coexist in the same scenario as the weak".

Psychosocial care is a process of care and follow-up in which uniqueness is a product of resistance, whose goals are related to providing new possibilities for living and creating (Yasui et al., 2018)

In this scenario, considering the proposition presented above that the concept of mental health implies an 'emancipatory agenda for the subject, of an irrevocably political nature', the actions of professionals, if they are merely protocol, would aim to place the user in an adapted, standardized position. According to Canguilhem (2007), normalization is the expression of how a historical society relates to its structure, even if there is no awareness on the part of individuals. Mental health professionals are not exempt from having to deal with their limits and their way of dealing with the structure, at the risk of becoming a bureaucrat. In this sense, it is not surprising that models of normalization and standardization find echo in the work of CAPS, given that there is always a need to renew perspectives for a critical understanding of the system, the ways of understanding pathology and professional actions (Krachenski, 2019).

In this sense, Holanda (2017) distinguishes two positions of human nature that can be compared: freedom and slavery. Slavery, in this case, is not linked to shackles and chains; we are talking about someone who is alienated from themselves and dependent on external models to guide their judgment and actions. In mental health, slavery is comparable to the bureaucrat's stance, who seeks to repeat the same model to everyone and himself; which strives to offer groups, workshops, and get-togethers, but the experience or suffering of those who are vulnerable is not accessed. For Portugal, Mezza and Nunes (2018), psychosocial care involves opening up ('putting it in parentheses') to a point outside the clinic, through a dialectical movement between the clinic and everyday life that enriches care.

For Delgado (2011), the change in the mental health model occurs when professionals share the pain of others as if it were their own.

> The necessary psychiatric reform will only be carried out by professionals and managers who are relics and have full dedication to others, seeing the pain of others as if it were their own pain. Willing to criticize themselves and review positions, as there is no battle won or vigor that does not cool down among informed and free people (Delgado, 2011, p. 4706).

Working in mental health places us facing a constant resumption. Freedom should not be equated with the achievement and satisfaction of desires, with the arrival of an end, but precisely with the self-recognition capacity. After all, "[...] it is painful, it is tiring, it is laborious to be free. Freedom is not a state of mind, but a human condition; and as such, it cannot 'be' conquered, but must 'be' continually conquered" (Holanda, 2017, p. 166). If, in mental health, we talk about co-responsibility, it is precisely in this sense: professionals and users jointly assume the continuous task of being free and creative, assuming suffering as a human condition, but with the possibility of understanding and growth.

Final considerations

The advance represented by law 10,216 and the social movement that supports it is not limited to a change in the place where 'madness' is treated, but a change in the place of the 'insane person' in society. Reaffirming suffering and freedom as human conditions, this place has to be continually 'revisited'.

It is necessary to know the care arrangements found by professionals who take on the responsibility of working with mental health. The description of the devices used in the services aims to understand how this organization works. We were able to find watertight and creative ways in all services. We find humane and creative solutions as well as thoughtless practices crystallized in attention to mental suffering.

In this sense, we also point out the difference between the understanding of treatment objectives between alcohol and drug addicts and users with other mental disorders. If, on the one hand, professionals, in general, see mental disorders as something chronic that the person needs to know and live with within their uniqueness, on the other, they see the objective of providing care to users of alcohol and other drugs in a generic way: interruption of use. Wouldn't it be the case, in the same way, to know the need for use for each person individually?

Finally, without detracting from the need for quantitative research that has the disease as its object, we return to the heuristic nature of the object in mental health, highlighting its importance. When we view health as a right, it is convenient to awaken curiosity about its subjective dimension in other areas of health, such as mental health.

References

Almeida Filho, N. (2000). O conceito de saúde: ponto-cego da epidemiologia? *Revista Brasileira de Epidemiologia, 3*(1-3), 4-20. https://doi.org/10.1590/S1415-790X2000000100002

Almeida Filho, N., Coelho M. T. A., & Peres M. F. T. (1999). O conceito de saúde mental. *Revista USP, 43,* 100-125. https://doi.org/10.11606/issn.2316-9036.v0i43p100-125

Amarante, P., & Nunes, M. O. (2018). A reforma psiquiátrica no SUS e a luta por uma sociedade sem manicômios. *Ciência & Saúde Coletiva, 23*(6), 2067-2074. https://doi.org/10.1590/1413-81232018236.07082018

Ballarin M. L. G. S., Carvalho, F. B., Ferigato, S. H., Miranda, I. M. S., & Magaldi C. C. (2011) Centro de atenção psicossocial: convergência entre saúde mental e coletiva. *Psicologia em Estudo, 16*(4), 603-611. https://doi.org/10.1590/S1413-73722011000400011

Canguilhem, G. (2007). *O normal e o patológico* (6a ed.). Rio de Janeiro, RJ: Forense Universitária.

Delgado, P. G. G. (2011) Democracia e reforma psiquiátrica no Brasil. *Ciência & Saúde Coletiva, 16* (12), 4701-4706. https://doi.org/10.1590/S1413-81232011001300019

Holanda, A. F. (2017). Loucura, exotismo e diversidade: revisitando um olhar antropo-fenomenológico. In N. J. Faria, & A. F. Holanda. *Saúde mental, sofrimento e cuidado: fenomenologia do adoecer e do cuidar* (p. 155-190). Curitiba: Juruá.

Krachenski, N. B. (2019). *A experiência de profissionais de um CAPS a partir de uma proposta de atenção em saúde mental em primeiras crises* (Dissertação de Mestrado em Psicologia). Universidade Federal do Paraná, Curitiba.

Lima, D. K. R. R., & Guimarães, J. (2019). Articulação da Rede de Atenção Psicossocial e continuidade do cuidado em território: problematizando possíveis relações. *Physis: Revista de Saúde Coletiva, 29*(3), e290310. https://doi.org/10.1590/s0103-73312019290310

Lima, M., & Dimenstein, M. (2016). O apoio matricial em saúde mental: uma ferramenta apoiadora da atenção à crise. *Interface - Comunicação, Saúde, Educação, 20*(58), 625-635. https://doi.org/10.1590/1807-57622015.0389

Macedo, J. P., Abreu, M. M., Fontenele, M. G., & Dimenstein, M. (2017). A regionalização da saúde mental e os novos desafios da Reforma Psiquiátrica brasileira. *Saúde e Sociedade, 26*(1), 155-170. https://doi.org/10.1590/s0104-12902017165827

Mäder, B. J.; Holanda, A. F. & Costa, I. I. (2019). Qualitative and phenomenological research in mental health: Mapping as a proposed descriptive method. *Psicologia, Teoria e Pesquisa, 35*, e35439. doi: https://dx.doi.org/10.1590/0102.3772e35439P

Martins, A. G. (2017). A noção de crise no campo da saúde mental: saberes e práticas em um centro de atenção psicossocial. *Mental, 11*(20), 226-242. Recuperado de: http://pepsic.bvsalud.org/scielo.php?script=sci_arttext&pid=S1679-44272017000100012&lng=pt&tlng=pt

Merhy, E. E. & Franco, T. B. (2003). Por uma composição técnica do trabalho centrada nas tecnologias leves e no campo relacional. *Saúde em Debate, 27*(65), 316-23. Recuperado de: https://www.pucsp.br/prosaude/downloads/territorio/composicao_tecnica_do_trabalho_emerson_merhy_tulio_franco.pdf

Miliauskas, C. R, Faus, D. P., Junkes, L., Rodrigues, R. B., & Junger, W. (2019). Associação entre internações psiquiátricas, cobertura de CAPS e atenção básica em regiões metropolitanas do RJ e SP, Brasil. *Ciência & Saúde Coletiva, 24*(5), 1935-1944. https://doi.org/10.1590/1413-81232018245.18862017

Ministério da Saúde. (2007). *Clínica ampliada, equipe de referência e projeto terapêutico singular.* Brasília, DF. Recuperado de: http://bvsms.saude.gov.br/bvs/publicacoes/clinica_ampliada_2ed.pdf

Muhl, C. (2015) A atuação do psicólogo na Rede de Atenção Psicossocial: um estudo fenomenológico na Regional de Saúde do litoral do Paraná (Dissertação de Mestrado). Programa de Pós-Graduação em Psicologia, Universidade Federal do Paraná, Curitiba.

Portugal, C. M., Mezza, M., & Nunes, M. (2018). A clínica entre parênteses: reflexões sobre o papel da arte e da militância na vida de usuários de saúde mental. *Physis: Revista de Saúde Coletiva, 28*(2), e280211. .https://doi.org/10.1590/s0103-73312018280211

Romanini, M., Guareschi, P. A., e& Roso, A. (2017). O conceito de acolhimento em ato: reflexões a partir dos encontros com usuários e profissionais da rede. *Saúde em Debate, 41*(113), 486-499. https://doi.org/10.1590/0103-1104201711311

Rouquayrol, M. Z. (2012) Contribuição da epidemiologia. In G. W. S. Campos. *Tratado de saúde coletiva* (2a. ed. rev. aum.). São Paulo, SP: Hucitec.

Silva, G. B. (2014). *A legislação em saúde mental no Brasil (1841-2001): trajeto da consolidação de um modelo de atenção* (Dissertação de Mestrado). Programa de Pós-Graduação em Psicologia, Universidade Federal do Paraná, Curitiba.

Saraceno, B. (1996). Reabilitação psicossocial: uma estratégia para a passagem do milênio. In A. M. F. Pitta (Org.), *Reabilitação psicossocial no Brasil* (p. 13-18). São Paulo, SP: Hucitec.

Silva, J. D. G., Aciole, G. G., & Lancman, S. (2017). Ambivalências no cuidado em saúde mental: a ‘loucura’ do trabalho e a saúde dos trabalhadores: um estudo de caso da clínica do trabalho. *Interface - Comunicação, Saúde, Educação*, 21(63), 881-892. https://doi.org/10.1590/1807-57622016.0559.

Yasui, S., Luzio, C. A., & Amarante, P. (2018). Atenção psicossocial e atenção básica: a vida como ela é no território. *Revista Polis e Psique, 8*(1), 173-190. https://dx.doi.org/10.22456/2238-152X.80426

Recebido em 09/07/2020
Aceito em 05/06/2021