The challenges of comprehensive care in a Psychosocial Care Center and the development of therapeutic projects

OS DESAFIOS DA INTEGRALIDADE EM UM CENTRO DE ATENÇÃO PSICOSSOCIAL E A PRODUÇÃO DE PROJETOS TERAPÊUTICOS

LOS DESAFÍOS DE LA INTEGRALIDAD EN CENTRO DE ATENCIÓN PSICOSOCIAL Y LA PRODUCCIÓN DE PROYECTOS TERAPÉUTICOS

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ABSTRACT

The object of this study is the development of therapeutic projects by the team working in a Psychosocial Care Center (CAPS III). It takes into consideration the creation and expansion process of the Brazilian public health system (SUS) and Psychiatric Reform. In this context, workers are challenged to develop care through an individual therapeutic project that considers the true needs and life context of the people involved. The objective of the study was to analyze and describe the strengths and weaknesses of a to develop the therapeutic projects based on the cartographic model and on the focal group technique. Participants were workers from a CAPS III center from Diadema, São Paulo. By analyzing the data collected through focal groups, the authors found, above all, a rupture between the night and day teams, and a lack of systematic space for conversation to develop and discuss on the therapeutic projects.

DESCRIPTORS

Mental health
Mental Health Services
Deinstitutionalization
Patient care team
Cartography
Psychiatric nursing

RESUMO

Este estudo tem por objeto a produção dos projetos terapêuticos realizados pela equipe de um Centro de Atenção Psicossocial - CAPS III. Considera o processo de criação e expansão do Sistema Único de Saúde - SUS e da Reforma Psiquiátrica do país. Nesse contexto, os trabalhadores têm o desafio de produzir um cuidado a partir de um projeto terapêutico individual que considere as necessidades das pessoas e seu contexto de vida real. O objetivo do estudo foi analisar e descrever as potencialidades e dificuldades da equipe na construção dos projetos terapêuticos tendo como base o método cartográfico e a técnica do grupo focal, do qual participaram trabalhadores de um CAPS III do município de Diadema - SP. Na análise realizada a partir dos dados provenientes das discussões nos grupos focais, identificamos, sobretudo, a cisão entre a equipe noturna e a diurna e a falta de espaços sistemáticos de conversa para elaboração e discussão dos projetos terapêuticos.

DESCRITORES

Saúde mental
Serviços de Saúde Mental
Desinstitucionalização
Equipe de assistência ao paciente
Cartografia
Enfermagem psiquiátrica

RESUMEN

Estudio que objetiva la generación de proyectos terapéuticos realizados por el equipo de un Centro de Atención Psicosocial-CAPS III. Considera el proceso de creación y expansión del Sistema de Salud-SUS y de la Reforma Psiquiátrica del país. En tal contexto, los trabajadores enfrentan el desafío de brindar una atención a partir de un proyecto terapéutico individual, considerando las necesidades personales y su contexto de la vida real. El objetivo fue analizar y describir las potencialidades y dificultades del equipo en la construcción de proyectos terapéuticos. Usó como base el método cartográfico y la técnica de grupo focal. Participaron trabajadores de un CAPS III del municipio de Diadema-SP. En el análisis efectuado a partir de los datos generados en discusiones de los grupos focales, identificamos sobre todo, la escisión entre el equipo nocturno y diurno y la falta de espacios sistemáticos de conversación para elaboración y discusión de proyectos terapéuticos.

DESCRIPTORES

Salud mental
Servicios de Salud Mental
Desinstitucionalización
Grupo de atención al paciente
Cartografía
Enfermería psiquiátrica

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INTRODUCTION

The current mental health policy in Brazil is based on the principles and guidelines of the Unified Health System (SUS) and the Psychiatric Reform (PR).

The practices of the SUS, resulting from a long route of political and institutional changes, go through a process of constant reformulations. One of the major challenges nowadays is integrated work among services, actions and professional knowledge. Thus, in services' specific areas, the commitment needs to prevail to listen to the users as well as possible, welcoming their singularities through interdisciplinary work; besides, articulation among different health equipment and other institutions is important, such as Schools, Neighborhood Associations, Cultural Centers etc., so that workers can offer the best possible alternatives for people's true needs[1].

Another fundamental change to achieve comprehensive care refers to many health professionals' practice which, still rooted in traditional parameters, contain the physician as the main actor in care practices, split from disease care[2].

In the same sense, but in the mental health area and in the Psychiatric Reform context, a paradigm transformation is intended, in which actions consider people as protagonists of processes that aim for sociability and the production of life and citizenship. In this perspective, the object of the intervention is no longer the cure of the psychiatric illness, but people's needs, putting them forward as active subjects in the construction of solutions to their problems[3-4].

The PR, based on the deinstitutionalization principles of the Italian mental health care reformulation experiences, the *Italian Democratic Psychiatry*, considers that overcoming the psychiatric paradigm involves dismantling not only hospitals, but all power relations in the context of the disease objects, which can even be found in territorial services[5].

For this deinstitutionalization process not to be simply characterized by *dehospitalization*, in which patients are transformed from asylum to extra-asylum abandonment, a specialist suggests the *Psychosocial Rehabilitation* practice[6]. This approach presupposes the opening of negotiation spaces between patients and the environment they live in, so as to develop people's contract power in living, social network and workspaces.

In Brazil, based on two emblematic experiences at the *Psychosocial Care Center (CAPS) Prof. Luiz da Rocha Cerqueira* in São Paulo, in 1987, and the *Psychosocial Care Nucleus (NAPS)* in Santos, in 1989, different experiences emerged of practices that went against conventional psychiatric treatment. Especially after the experience in Santos, in which, for the first time in Brazil, the asylum apparatus was replaced by a mental health service, the Ministry of Health set rules to establish this kind of services[7].

Today, the national mental health policy determines on decentralized care, including families and communities' active participation. Through the set-up of extra-hospital devices, a service and action network is composed which should cover the complexity of people's needs. Thus, in Decree 336/02, the CAPS emerge as the central axis of mental health practices and can be constituted, according to their capacity and complexity, as CAPS I, CAPS II o CAPS III[8].

At these services, professionals face the challenge of composing care based on an *Individual Therapeutic Project* that takes into account users' singular history, offering answers that can resize their life situation. By broadening relationship and exchange spaces, the therapeutic projects constitute an instrument to improve living conditions and recover autonomy. Thus, it should not only be limited to institutional spaces, but expand into the places of subjects' circulation and social participation[9].

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In view of the complexity of this action, it is essential for therapeutic projects to be constructed and periodically reconstructed and reassessed, involving users and relatives, departing from group discussions among all interdisciplinary team professionals. Thus, through dialogue and mutual understanding, the relation among the different interventions and interaction among professionals from different areas can be established, contributing to the accomplishment of more integrated practices that lead to truly transformative actions[10-11].

In view of the entire scenario presented here, the authors inquire how mental health service teams are constructing therapeutic projects. Hence, with a view to contributing in the context of the current transformations that orient the ongoing Psychiatric Reform in Brazil, a study is justified which permits understanding the main challenges and potentials in CAPS III workers' construction of therapeutic projects.

METHOD

The study was performed at a CAPS III located in Diadema, a city in the Metropolitan region of São Paulo. There were about 389,000[a] inhabitants and, at the time of research, three Adult CAPS III; one Child CAPS I and one Alcohol and Drugs CAPS I.

[a] Source: SEADE data, 2007.

As regional institutions, each CAPS III is named according to the coverage region, thus: CAPS III Center, CAPS III South and CAPS III East, the latter of which served as the place of study.

A qualitative research[12] was accomplished, guided by the map analysis method, which intends monitor and investigate a production process, instead of merely representing an object like on a map[13]. This method considers that, based on the habitation of a territory and involvement in the world surrounding the research space, the processing of information about that place is organized, which already constitutes a learning process for the cartographer himself.

Therefore, through subsequent visits and contact with CAPS III East, all impressions that started to emerge from the meetings with professionals and users were reported in a field diary. These reports were not only based on objective analyses. Instead, the researcher intended to capture and describe everything that happened at the level of strengths and affection. Thus, this represented not only a bureaucratic moment of data recording, but even demanded some degree of refuge, so as to be able to talk from *within* and *about* this experience[14].

With a view to reflecting the multiple dimensions of the study problem, based on the Focus Group technique[15], workers from the *day* and *night* shift participated in the research. Three groups were held with the day team and two with the night team, conducted through a pre-elaborated script[16]. During these meetings, three cases were discussed the participants had chosen (in this context, a case is considered as the history of a subject experiencing psychic suffering and receiving care from the CAPS team).

The analysis was based on data resulting from the workers' discussions in the focus groups and, in this paper, the results of the analysis of groups held with the *night* team are presented.

It should be highlighted that, to reach this process, approval for the study was obtained from the Institutional Review Board at the University of São Paulo School of Nursing (process No 831/2009), and also from the Mental Health Coordination and the Ethics Committee at the Diadema Municipal Government School of Health. Together with the professionals who were willing to participate, the date and time for group meetings was scheduled, which were held at the place of study. After understanding and agreeing with the research, the participants signed two copies of the Informed Consent Term, one for the researcher and one for the participant. This procedure guaranteed the recording and transcription of the groups, as well as data analysis and dissemination in scientific publications. To guarantee secrecy to participants and users mentioned in the study, fictitious names were used, which the researcher had randomly chosen. Discourse transcripts will be presented exactly as the participants pronounced them, including Portuguese language errors and mistaken habits.

The study context and service functioning

Located at an old house the municipal government rents, a multidisciplinary team was present at CAPS III East, including: 6 nursing auxiliaries; 18 nursing technicians; 2 social workers; 1 physical educator; 6 nurses; 1 psychiatric physician; 4 psychologists (one of whom coordinated the unit); 2 occupational therapists, besides administrative support, reception and cleaning professionals.

The service receives adults diagnosed with severe neuroses and psychoses, in an *open door* regimen, i.e. without a waiting list. Patients can get to the service spontaneously or be forwarded by other regional services, including Primary Healthcare Units and the Central Emergency Service.

During the research period, 650 patients were registered, functioning 24 hours, seven days per week, with 4 female, 4 male and 2 extra beds for rest and observation.

At daytime, from Monday to Friday, the service received patients in an intensive, semi-intensive and non-intensive treatment regimen[8], offering individual or group listening to family members and users, community therapy, home visits, as well as artistic, sports, cultural and leisure workshops. Every week, an assembly was held, involving users, relatives and workers, discussing suggestions to improve care at the service. One or more professionals coordinated these activities.

A higher education professional (psychologist, nurse, occupational therapist etc.) and a nursing technician welcomed all new cases and problems, who remained available at the *door duty*. Procedures performed were described in the *duty book*, where the nursing team's notes were also shared. At noon, all professionals stopped their activities and the *shift change meeting* was held, where cases attended by the door duty, changes in certain patients' therapeutic projects, information about users who stayed for night hospitality, description of home visits, among others. Some of the conducts decided on during the meeting were also written down in the duty book.

Besides this daily meeting, every week, a *general team meeting* was held. On that occasion, classes were also offered in the Permanent Education Program. Besides training, this Program was also aimed at integrating different professionals and shifts.

At weekends, only the nursing team worked; no workshops or activities were held and only those users stayed at the service who were under observation in the available beds for night hospitality.

Only nursing team professionals worked during the night period as well. These professionals did not participate in activities and meetings that happened during

the day and, thus, patient information was transmitted through the duty book and verbally when the nursing shift changed from the day to the night team; some of them obtained further information during occasional overtime and participated in daytime meetings or when notes were made in the patients' files.

At the time of research, each night team shift included four nursing technicians and two nurses, who worked 12x36-hour shifts (from 19h00min till 07h00min). Two of these nurses and two nursing technicians participated in the study.

RESULTS AND DISCUSSION

The workers decided to discuss a case that anguished them, and which they considered *stuck and successless* (ACI)[b], due to the long period this patient had spent in night hospitality, who had already taken about a year.

Initially, the workers were willing to read the file and get information from the day team, so as to support the discussion with further details on the user's history.

This fact aroused the researcher's attention, as it appointed that, in this work process, it was the day team that obtained information on patients' lives, and that it was only based on this opportunity that these professionals were able to discuss and seek further data about the user:

> where the therapeutic projects are discussed, where something is done, right, the projects, they are always executed during daytime...(Tiago).

To construct the user's history, although the workers found data described by the Reference Technician (RT)[c] and physician in his file, they said they could not find notes on other professionals' interventions and, despite acknowledging their colleagues' efforts, they questioned the existence of a therapeutic project shared among all team members:

> And, like, there is no project like, for me there's no project, because when there's a project each interdisciplinary team member puts it there! Puts it there! It evolves there, I'm a psychologist I'm going to evolve... She's an OT she's gonna do an activity with him, she's going to evolve, right, community therapy, physical exercise, is he going? Does he participate? Does he play soccer? Does he play basketball? Does he go for a walk? You can't see it in the file... (Francisco).

The deficient file records can be due to different reasons: either the patient did not participate in activities, or professionals, in view of different demands, did not have time available to make the notes; in short, the question remains. The researchers suppose, however, that this fact contributes to hamper the circulation of information and interventions performed with the patient: which worked out and which did not, which deserved investment or not. And, what is more: the researchers believe that the lack of records by professionals can also hamper the reference technician's task in the composition and systematic reassessment of therapeutic projects[8].

Moreover, medical information about diagnosis, signs and symptoms particularly serve to establish psychopharmacological intervention strategies, but data on the family, social context and any other information other team members observe can collaborate towards a more articulated intervention strategy[17].

Thus, as they do not participate in team meetings that happen during the day, professionals working at night do not have sufficient data about the users staying in night hospitality, who consequently need more intensive care. Despite using the duty book, the participants declared that the notes only included information about punctual decisions on conducts involving certain patients. Some participants revealed that they preferred the former system of notes used at the CAPS which, according to them, contained the most complete register of meetings, describing the professionals' opinions in further detail so that, thus, they felt more integrated in the work:

> At first there were two, I for one thought that was much better, because there was one book with proceedings on shift transfers, so we arrived at night, got the book and read the entire shift transfer! So we knew about anything new that had happened, what the team had discussed, suggested, we ended up playing somewhat of a bigger role, right, more passively, but at least we were informed about what was happening... (Glória).

The professionals remembered an experience they considered successful with another patient, in which a former CAPS director went to the night shifts to talk to the team about her therapeutic project. According to them, they used to feel they participated more effectively.

At that time, however, institutional attempts towards integration between shifts were fruitless as, according to the workers, they were not able to attend the training sessions held during the day, as they were involved in other activities at that time. Thus, as an alternative, they suggested that a team member could go to the night shifts and discuss the therapeutic projects for the most difficult cases, as they believe that, based on their observation of and interaction with patients, they can also cooperate with the construction of these projects.

According to the testimonies, the workers feel a strong work *rupture* (ACI) between the day and night teams, considering that a possible dialogue between professionals from different shifts can contribute to compose more converging actions as, in view of the complex cases attended

[b] ACI - According to Collected Information

[c] Reference Technician (RT) is the team professional who will monitor the therapeutic project together with the user, defining the frequency and activities the patient will participate in. He/she also contacts the family and periodically assesses the established objectives[8].

at the CAPS, the mere juxtaposition of different professionals, often performing diverging actions, may can guarantee better care[18].

In order to offer singular care to the user situation discussed in the group, the workers presented different suggestions regarding the concerns they felt, like greater investment in interventions involving the patient's relatives for example, which the reference technician was already starting to do at that time, but which in their opinion could be intensified with support from other team members, enhancing the number of home interventions.

They also suggested offering individual care to the patient's mother; they reported that they even tried to offer listening, but were afraid that, in this process, contents would appear which they technically would not be able to take care of, recommending that some more specialized professional would perform this intervention:

> We will have to work with her... and it's not 'we', I think that will depend on the competency, each person has her own. I think I cannot make things crop up, say 'I'll visit her at night' and I'll crop something up in her which I won't be able to treat (Estela).

The parceled work organization the participant recommends, however, can fix a worker in a certain phase of the therapeutic project and, therefore, this superspecialization, without integrated work among interdisciplinary team members, makes workers get alienated from the work object and lose contact with the end product of their activity, which is the improvement of users' living conditions[19].

Based on these considerations, the researchers assess that, if these professionals' work process contained more systematic spaces for conversation about the users' therapeutic projects and life history, they could feel more at ease to go beyond their professional particularities, advancing towards a less compartmentalized and more shared and inventive practice.

It is underlined that the main issue was not if the team was conducting this case well or not because, despite the discussion, no deeper knowledge on why the patient continued in night hospitality was possible; after all, in such a complex situation, the case reference technician could be taking into account other issues, which were not exposed at that time.

It is fundamental, however, to heed this work process as a whole because, in view of these concerns, the night team has no room for exchange and remains alienated from the user intervention process. On this occasion to talk about this story, they presented creative suggestions that could be attempted with this patient. After all, at a CAPS III, should these workers' functions continue the same as in psychiatric hospitals, where they basically take care of institutional order and medication interventions?

CONCLUSION

This is a period of rupture with the hegemonic model, in which work especially aims to cure diseases, towards the construction of new practices and services. Hence, the implantation of CAPS III is still going through a construction and maturing process. The psychosocial care model based on the premises of the Psychiatric Reform is being consolidated in this new equipment. From this perspective, based on interdisciplinary work, these people's reinsertion in their territory, their family and community is considered.

Thus, professionals face the challenges of constructing another care type, starting from *individual therapeutic projects*, considering aspects beyond the *disease*, which often are not taught and valued in courses and colleges.

Based on the study results, it can be identified that the main challenges these professionals face in the construction of therapeutic projects are: constitution of actual integrality among different team professionals and shifts; organization of systematic spaces for project construction and reassessment involving all team members, and stricter records on professionals' interventions in the patient files, so as to facilitate information circulation among professionals.

The deficient integration with night workers can impair daily care and the construction process of these users' therapeutic projects. These professionals deal with severe patients in crisis every day, often without knowing further details about their history and therapeutic project. When they looked for this information in the file and duty book, they considered the data insufficient and, thus, can continue stuck to more mechanical interventions, such as merely offering dinner, administering medication and preventing *flights*, actions similar to what happens in an asylum.

The night team professionals provided different suggestions for the discussed patient situation, but had no way of sharing them and did not know whether they day team was already performing some interventions.

Despite these challenges though, workers made efforts to construct work permeated by the goals of psychological rehabilitation and many questioned issues that are considered flaws in this work process, which evidences these professionals' power.

Finally, knowing that this knowledge production is not exhausted in this study, the researchers do not intend to offer final answers and solutions for the challenges mapped in the study. It is important, though, to suggest that workers can collectively construct the possibility of rooms for dialogue. This makes it easier for the team to actually constitute, more than a group of people, a team with integrated activities. Thus, the continuous construction of therapeutic projects can be further shared, contributing to the invention of a new care representation, which offers individualized and creative actions in crisis and vulnerability situations.

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