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REVIEW

Working processes of professionals at Psychosocial Care Centers (CAPS): an integrative review

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Abstract *This is an integrative review of the literature on the working processes of professionals staffing the Psychosocial Care Centers (CAPS), reflecting on service practices, in particular social reinsertion of service users from the bio-psychosocial perspective. The literature review aims to show how working processes are being developed by CAPS professionals, and the repercussions for service users. This literature review used the Lilacs, SciELO and PubMed databases in Portuguese, English and Spanish, selecting 57 articles that were analyzed and organized using an Excel spreadsheet. This study revealed shortcomings in the amount and quality of physical, human and material resources, a fragile mental health network, and dissonances in the care provided to users and their families, reducing the quality of the working processes. The outcomes mentioned most often were intake, unique therapeutic project and territory as dissonant components of the de-institutionalization proposal. This work combines the experience and knowledge of professionals across the country, with score to guide the re-direction of care practices.*

Key words *Mental health, Community mental health services, Mental health services, Process evaluation*

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Introduction

Given the current psychiatric hospital model, which resulted in Law 10,216/2001, known as the Psychiatric Reform Law, which governs the National Mental Health Policy (NMHP), the emphasis is on care using substitute, community-based services, with visits and the social reinsertion of people with mental disease[1].

In light of the psychosocial care model, Psychosocial Care Centers (CAPS) were created, which differ from each other depending on the clientele served (mental disorders, alcohol and other drugs, and youth and children). These are ranked by increasing order of complexity and populational scope[2].

Such services have their own culture, and the working processes are developed by multi-professional teams. They offer diversified activities, including individual and group care. The family is considered an essential component of treatment, receiving specific care and free access to the service as required[3-5].

In the NMHP rationale, serving all users is one of the major challenges facing area professionals, given the shortage of service resources, which has a direct impact on their working processes.

Seeking to give visibility to this theme, this article describes the output of the working processes performed by CAPS professionals, according to NMHP guidelines.

Methodology

We opted for an integrative review, an important tool to communicate study results, providing a summary of the knowledge produced and providing subsidies for improved healthcare. This process could make it easier to incorporate evidence, making the transfer of knowledge more agile to re-direct the care practices.

The purpose of this methodology is to combine and summarize the results of studies on a given theme in a systematic and ordered way, contributing to deeper knowledge of the theme under investigation.

The literature survey was done in July 2014 used the Lilacs, Scielo and PubMed databases, as these are the most widely used in the field of healthcare. We looked at articles published in Portuguese, English and Spanish between 2001 and 2014. We used 2001 as the starting year as it coincides with the Brazilian Psychiatric Reform Law. We used the following keywords in English and Portuguese: mental health, CAPS, working processes, Substitute services in mental health, community services in mental health, as well as the Boolean operator AND for combinations of these groups of words.

As a result, we included articles addressing the working processes used by those providing care, developed exclusively at the CAPS.

We excluded monographies, dissertations and theses, as it would be impractical to analyze them systematically. We also excluded reflexional and review articles, and those dealing with the experiences of a single category of professionals, as the object of this study was the work of the Psychosocial Care team.

A first cut of the articles looked at the titles and abstracts, using the key words mentioned above. When the title and/or abstract were not informative enough we looked at the entire article, trying not to leave important studies out of this integrative review.

After eliminating all the duplicate abstracts, a careful reading of the other articles revealed 153 papers that we read in their entirety, excluding 96 that did not meet the objectives of this article.

We reiterate that the entire data capture process was performed by two researchers who searched the databases independently, using the same criteria. After discussing the previous analyses, we took 57 articles and organized them in an Excel spreadsheet by year the study was performed, author, year of publication, outcome and method. After this we submitted the results to a third researcher.

Results and discussion

Data was organized using the working themes and processes in the articles analyzed, and grouped into three categories and 18 sub-categories, representing the outcomes mentioned by the authors (Chart 1).

In order to point out the articles and their outcomes, Table 1 shows the frequency at which they appear in the 57 publications analyzed

We found that all the studies used a qualitative approach, while 38.6% referred to questions related to CAPS practices. The outlook in terms of Territoriality and Intake PNSM/Care were the most frequent, followed by the Unique Therapy Project.

Up until 2007, few publications mentioned CAPS working processes. Most of these appeared between 2009 and 2012, declining sharply in

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Chart 1. Working process categories and outlooks.

Category	Outoput
Factors that intervene in working processes	• Inadequate materials and physical infrastructure • Insufficient training for the job • Precarious link with the service and low wages • Difficulty handling teamwork • Continued hegemony of the medical specialty • Medicalized care
Practices developed by the CAPS	• Intake/care • Unique Therapeutic Project • Technical reference • Therapy groups and workshops • Matrix Support • Home Visits • Family service • Handling crisis situations • Reinsertion in the job market • Team Meetings and Assemblies
Dissonances in the de-institutionalization proposal	• Ineffective network articulation • Institutionalization within CAPS

Table 1. List of articles analyzed and their outcome.

Categories	Outcomes	Frequency (n)	%
Factors that intervene in working processes	Inadequate materials and physical infrastructure	13	22.8
	Insufficient training for the job	10	17.5
	Precarious link with the service and low wages	5	8.8
	Difficulty handling teamwork	8	14
	Continued hegemony of the medical specialty	9	15.8
	Medicalized care	7	12.3
Practices developed by the CAPS	Receiving/care	21	36.8
	Unique Therapeutic Project	16	28
	Therapy groups and workshops	5	8.8
	Therapy groups and workshops	15	26.3
	Matrix Support	5	8.8
	Family service	8	14
	Home Visits	5	8.8
	Handling crisis situations	6	10.5
	Reinsertion in the job market	5	8.8
	Team Meetings and Assemblies	8	14
Dissonances in the de-institutionalization proposal	Territoriality	22	38.6
	Institutionalization	14	24.5

2013 and 2014, although the last year is not yet complete.

There is a significant difference by study geography. The south, southeast and northeast publish more on the theme, with 16, 13 and 11 articles respectively. Only 3 and 1 articles respectively were published in the middle-west and north.

Considering that the three categories emerging from an analysis of the articles made important contributions to identifying the working processes of the CAPS, the content they submitted will be detailed, in an attempt to learn specifically what they were about.

Factors that intervene in working processes

Publications on the factors that intervene in CAPS working processes signal the difficulties normally linked to a shortage of materials and physical infrastructure for the workshops[6,7]. They also reveal a shortage of human resources compatible with the needs of the service, professional turnover, disordered files, and long working hours[8-10]

Rearrangements made by professionals to overcome the absence of the tools they need to do their jobs affect their job stisfaction or, in other words, their satisfaction in providing care[11], and also compromises planning from the psychosocial perspective[12].

Poor or limited training for working in community services is also listed as an issue that makes the working processes harder. To provide care under the psychosocial model, training should focus on the social reinsertion of users, with a strong position against putting these individuals in psychiatric institutions[7,10]. Many professionals working in the CAPS were trained under the previous care model. Consequently, they have problems doing their jobs based on psychosocial care[13].

The reality in this country shows a need to train mental health human resources[14], which often does not happen due to a shortage of funding[12]. Lack of awareness of the role of CAPS is an obstacle to the progress of Psychiatric Reform, making comprehensive care difficult and reducing the changes in the care model to the simple opening of new services. Professionals must believe in, and defend the psychosocial model[15,16].

Other elements that impact working processes are also addressed in the literature. These include the precarious nature of the employment bond (temporary contracts), limited or no experience in mental health[17], and low wages[15], discouraging care and investment in professional training[18]. Such conditions can result in professionals who are not prepared to care for the users of this service, often leading to feelings of frustration and guilt among workers[19].

Medical hegemony and medicalized care were mentioned as outcomes, suggesting these are factors that often make it difficult or impossible to implement the working processes of multidisciplinary teams in the alternative services, from the point of view of psychosocial care.

The National Mental Health Policy has broken with the model centered exclusively on the physician, including professionals from several health related areas[20]. With this change come difficulties in teamwork, communication and even a lack of communication among the professionals involved[21].

The persistence of medical hegemony is perceived as over-valuation of medical knowledge, to the detriment of knowledge in other areas. Traditional medicine gives physicians social prestige[20,21], further reinforced by the fact that often, access to the multi-professional team requires a referral, so care continues to depend on a psychiatric consult before other forms of care can be provided. This situation is a strong contributor to the waiting lines and medicalized care[22], widely discussed in the literature and often mentioned as one of the major hurdles of the Psychiatric Reform.

Professionals, users and family members admit that failure to adhere to drug treatment means failure to adhere to treatment, and resolution is left up to medication only. In this regard, medical treatment is considered absolutely essential, while psychosocial rehabilitation is under-valued and viewed only as a possibility[20,23].

This analysis reveals a need to overcome the biomedical and mental hospital models, still prevalent in mental health situations[23].

Practices developed by the CAPS

Intake, which presumes qualified listening and bonding, was the most frequent outcome in articles published in the past five years and included in our analysis. It addresses the essence and skills for its true value, surpassing the concept of screening. Intake is associated with a warmer tone at first contact[24]. Patient intake or welcome is viewed as an intervention tool characterized as being inclusive, one where professionals listen to the needs that emerge from the life histories and circumstances experienced by users and their families[25-27].

Intake, in terms of valuing the knowledge held by the other, implies in producing a therapeutic effect in subjects who are in the throes of psychiatric suffering, favoring an understanding of their demands[27,28], providing relief and developing a relationship of care and support[29].

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It also enables building trust-based relationships between workers and users, based on developing bonds of affection, and gradually building other links as achievements, facilitating treatment and favoring the relationship between users and the healthcare team[11,26].

Intake and bonding must involve the family, which starts to view CAPS as a suitable resource to meet their needs and those of their family members[30].

Viewed as interdependent tools, intake, listening and bonding only work if the team is committed[25]. Thus, the CAPS should also enable communication and the exchange of information, considering the subjectivities of each one, where the challenge is to meet the unique demands of the individual within the collective environment[20].

The third outcome mentioned most often among the articles we reviewed was the Unique Therapy Project, considered a care guideline. This must be developed together with the user, as a strategy of co-responsibility and stimulus to the person's autonomy, enabling people to recover their identity and self-esteem, and the power to enter into a contract, based on the life project of each one[31]. The UTP seeks to create actions that address the inabilities, needs, fears, anxieties and dreams that enable people to retake the reigns of their own lives[26].

From time to time, it is essential that the team discuss among itself and check with the user and his/her family members to adjust any emerging needs[32].

Camatta and Schneider's[33] study of family members found that they did not recognize the UTP as a team effort, questioning if they were included in designing and developing the therapeutic proposal.

Figueiró and Dimenstein[34] mentioned the rigid structure of the service as a UTP dissonance, where workshop planning and strategy rescheduling is something done only by the technical team, thus voiding user ability to think about their day-to-day lives and their treatment, and manage their very existence.

Working together with the user and family members to develop the therapeutic process is monitored by the technical reference or reference team, and is led by professionals who are in constant dialog with the various social players, enabling bonds and establishing accountability across healthcare services and the user's relationship network. The reference emerges as a strong influencer of the behavior of users and family members, and actually mediates some situations[35].

These publications discuss their performance and how, at times, professionals institutionalize care, confusing the role of reference with that of guardian. One must be careful not to establish a relationship of dominance over the subject, lest one risk applying controlling practices[36].

The model of a reference team shifts the focus from a single individual to a group of technicians. It is considered an advantage, as it enables more comprehensive care such as inter-disciplinary discussions, avoids centralizing the case in a single individual, shares responsibility and helps users expand their emotional ties[21,36].

Among the practices developed at the CAPS, publications focus on group activities and workshops, demonstrating an interest in analyzing their efficacy as therapy.

A study of users found that the group is considered a place to get support, where people discuss the need to help themselves and ask for support as necessary. The recommendations shared in the group contribute to increasing the value of a positive mindset among its members and how they position themselves in the world[37]. On the other hand, among care-givers, workshops are viewed leisure, although they have a degree of understanding of their therapeutic value[20].

The fact that groups and workshops do not take into account subject ability to symbolize and develop is a source of disquiet, as these become merely operational and populated by users with no desire to participate[34].

Activities should not be considered something merely to pass the time, but as important spaces to work on concentration, creativity and the anxieties of the individual or group. Thus, they should extend into the socioeconomic field, as opportunities for learning artisanal techniques that may later be used to generate income[38].

Vocational workshops are associated with social inclusion in the sense of Psychosocial Rehabilitation, as they promote a change in the social role of the users by providing them with tools to produce and sell their wares independently[39].

Tavares[40] listed a number of possible artistic groups and workshops, believing them to be powerful therapeutic tools as they favor user communication and the exchange of affection, enabling them to express emotions and feelings. They also foster rehabilitation, provide new experiences and enable subjective construction.

The CAPS art and culture workshop have just such a role, as they are therapeutic devices capa-

ble providing not only mental health, but an area where users can be together and integrate with society, resulting in partnerships with cultural spaces in the region, where participants work on themes related to their desires, projects and creations, recognizing themselves as creative, competent and productive individuals[41].

The matrix outcome was found as the main object of study in publications after 2010, not being found before this period.

Matrix support is a practice where the mental health team supports the Family Health team, promoting the horizontal articulation of specialized services for deeper interlocution between healthcare services, providing increased capillarity to mental health activities within the region, articulating with other social sectors[23].

Chiavagatti et al.[42] found that this articulation consists basically of team supervision and training, as well as a system of references and counter-references, often masked behind the logic of referrals.

He we point to the fact that for this matrix system to be effective, dialog networks must be created, covering all the services in the care network. This is the responsibility of the workers, and also requires effort and involvement of government managers to make the NMHP effective[27].

Home visits (HV) are a tool within matrix support that can be used together with the Family Health and CAPS teams. As a care device, home visits tend to strengthen links and build bridges between subjects, services and society. Although mentioned in only 5 of the articles selected, it is considered an important therapeutic mechanism, allowing the professionals to understand family dynamics and how the user is inserted into the family. It also provides family support, valuing the family as part of treatment, and may even improve any conflicts that may exist within families[16,30].

The literature does not question the importance of family involvement in the proposed therapy, and considers it to be a backup to bear the burden of mental suffering, stressing that many times the family is also responsible for the success of the therapy. User reinsertion in the community and resumption of day-to-day activities are facilitated when family members believe in the improvement of the user's health.

Wetzel et al.[43] defend the family as the care unit. Its inclusion is essential for the proposed psychosocial rehabilitation, requiring that the team be responsible for the family as well, as it is equally affected by the disease condition. However, family members are still absent from the service activities. This may be related to difficulties accepting responsibility for the treatment, justified by the feeling of being overburdened by the users[3].

One must view the family as a partner in addressing and experiencing mental illness beyond the confines of the hospital, avoiding fragmentation of care, and facilitating continuity and complicity among those involved in all possible social spaces, in line with the psychosocial proposal of rehabilitation[44,45].

Before including the family in the treatment, it must be fully aware of its biographical situation. Understanding the family history may be a powerful strategy for the CAPS mental health team, and could enable facing the adversities imposed on day-to-day activities, allowing them to tread a less painful path and overcome moments of crisis[33].

Handling crisis situations was mentioned in some of the articles, and has a direct impact on quality of life, as intense suffering leads to the de-structuring of psychiatric, family and social life, leading to a break with the socially accepted reality. Moments of crisis are not limited to the acute phase, when all symptoms are present, but are a complex moment involving the existence of the subject and his/her family, social, relationship and emotional issues. Therefore, one must listen to express the subjectivities, and interventions to provide tools so the person may respond to the situations that trigger a crisis[46].

This moments requires intense support and responsible and human care that respects individuality and values subjectivity. The approach should also include, in addition to the empathetic professional/user relationship, concerns with the environment and with making it safe for all those involved[46].

A study by Lima et al.[47] showed that during a crisis, the solution of choice is psychiatric hospitalization, often mediated by the police. This practice is questionable, as a solid bond and listening to the subject may enable stabilizing the critical situation without the mandatory use of medication or even police force.

Here we realize the feeling of danger present in the social imaginary and among some professionals makes it harder to properly address the crisis. One must abandon the rationale that considers the mentally ill as a threat[46].

There is a need to invest in training so that the CAPS may handle crises, introducing technologies for expanded clinical activities so that

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users and their families may have support at these times. Professionals recognize they are not prepared, which in turn generates a sense of insecurity, fear and difficulty when working, as CAPS users may, at any time, enter a crisis[48,49].

Lima et al.[47] also address other aspects that make it harder to handle crises, such as the lack of backup and the resistance of other healthcare facilities to receive users [of mental health services] at these times, no institutional capacity to meet the demand for psychotherapy, and material and/or emotional shortcomings of the families. Failure to be responsible for [support during] crises may result in users being referred to psychiatric hospitals, which in turn could result in CAPS becoming a supplementary and parallel facility to these institutions, rather than a repacement[48].

Here we point out the crisis handling experience under partial hospitalization described by Willrich et al.[50], where users in crisis spend the night at a General Hospital and during the day are followed by the CAPS, as services qualified to handle urgencies and accept users in crisis, as recommended by the National Mental Health Policy.

The importance and advantages of work for individuals were also addressed in three of the articles included in the study. Work is an element of social inclusion, it implies in exercising citizenship and insertion in the job market, unlike humanist or care and therapy activities. The experience of generating income has been shown as one way to intervene on the aspect of work in the context of social inclusion, although it is not viewed as a target, as healthcare professionals believe it is not their provenance to promote activities in this area[51].

Given the difficulty inserting service users in the formal job market, the Brazilian psychiatric reform created protected work as one more therapeutic resource aimed at socialization, expression and social insertion with vocational workshops[52].

Thus, productive activity is not the goal of treatment, but an instrument of intervention that seeks to add quality to the transformed life, to the extent that work acquires a meaning as an articulator with the world, related to access to citizenship. A subject who works is paid at the end of the month, must keep certain hours and enters into new social relationships that indicate internal change, learning and an intense experience of facing difficulties[53].

The question of work must be recovered, articulating clinical practice with an understanding of work as a right and a concrete proposal for social reinsertion, in addition to the physical space of CAPS[54].

Finally, in light of the practices developed by the CAPS, team meetings were suggested in the literature as a formal moment of the technical team to coordinate efforts. Not only because they happen regularly, but because they bring together all the technical staff, fostering discussions that result in organizational arrangements regarding the activities to be performed[21]. This is an area of interdisciplinary work and a location for dialog and discussion among the different professionals, seeking interactions without any loss of specificity, enabling a broader view of mental health[11].

Assemblies on the other hand, are a space where users, family members, professionals and members of the community can openly comment on matters related to the service, enabling social reintegration and participation[6,38].

Dissonance in the de-institutionalization proposal

Most (63.1%) of the publications addressed the dissonances regarding de-institutionalization and chronicity in Mental Health, reiterating the difficulties regarding territory, which clashes directly with the principles of the Psychiatric Reform.

Territoriality means articulating the service with different purposes to help social reinsertion. In articulating the concept of network and comprehensive care, we find that mental health itself is part of a broad set of actions that include Primary Care, reference teams, matrix support, equity, intersectorality and community involvement. Thus, the mental healthcare network also depends on the progress made in each region[11]

The literature shows that this is relevant to the issue that involves matters of territory, which directly interfere in CAPS working processes. The lack or limited training of social networks makes it hard to create inter-sector efforts, resulting in insufficient territory activities[16,55,56].

Pinho et al.[16] describe how professionals realize the contradictory situation of the CAPS in their territory, as the service was born in the community, but is not at all close to it. The literature also states that the workers are responsible for being limited to the internal spaces of the service.

Although the purpose of CAPS was to replace psychiatric hospitals so as not to reproduce the traditional care model, these services also have mechanisms for institutionalization. Merely

opening a service within a given territory will not lead to de-institutionalization of the practices involved in the culture of mental hospitals, but rather the nature of the activities it provides. Wetzel et al.[48] coined the term enCAPSulated to address the danger of reproducing old practices in these new healthcare devices. Some studies discuss the reasons for this situation as an attempt to protect users of the challenges imposed by society[55,57].

There are challenges and obstacles for social insertion. These are overcome as actions are no longer performed exclusively inside CAPS, remembering that the inclusive process starts outside its walls[58].

Another institutionalizing mechanism mentioned in some studies was failure to subscribe to the UTP discharge project. Discharge should not be viewed as absence of care, but as the possibility to articulate with network services that can meet user needs when the intensive services provided by the CAPS is not required. It essential to discuss the benefits and opportunities users will find when they are discharged, and that this is an achievement of their rehabilitation process[48,59].

Awareness and critique of institutionalization processes by professionals is a necessary element of change in the process of transforming the mental health model[57].

Studies reveal that the CAPS should navigate the community spaces, as this will further de-mystify the figure of a person with mental illness and show they can remain outside the institutional walls. This will also allow those with mental illness to become familiar with the resources and demands of the community, and encourage society to get to know him or her[56,60].

This inclusion strategy helps the subject address his/her fears and shames, with the discrimination they are subject to. Society must learn to live with these users in the street and understand them in their uniqueness, without excluding them. This will favor autonomy and mitigate the risk of a new chronic situation.

Clearly the CAPS, via teamwork, has achieved concrete results, reducing crises and psychiatric hospitalizations[61].

Final considerations

This effort goes beyond listing the working processes of the CAPS in the past 13 years. Because of their integrative nature, the CAPS in Brazil combine the experience and professional knowledge disseminated across the entire countries, and guidelines for redirecting care practices.

Working processes were assessed based on care reports that reflect the activities performed in providing mental healthcare, and the development of the intervening care factors. The integrated articles analyzed in this study use a qualitative approach, giving voice to mental health authors, be they users, family members or professionals.

These studies suggest additional scientific publications on the theme of home visits, assembly and team meetings, technical references, reinsertion through work and matrix support. These are important tools in psychosocial care. We reiterate that matrix support is an emerging theme that explains the limited number of publications and points to the need for research.

Poor professional training, precarious employment bonds and low wages are the norm across many mental health services in Brazil, and are mentioned in several articles as factors that discourage professionals. This reality demands scientific and financial investment in the working teams, so that they are motivated by the NMHP proposal, and are able to expand the discussion of how to improve care and reflect on the working processes developed.

Family members and users evaluate the Psychosocial Care Centers in a positive manner, showing that the NMHP is achieving its goals. The experiences reported by mental health authors are said to be transforming, towards independent living and inclusion in society. However, there is much to be perfected in this inclusion process. In particular, reinsertion through work and the articulation and effectiveness of Psychosocial Care Network, integrating all healthcare services to better care for mental health users and their families.

This review shows shortcomings in the working processes that must be considered by service

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professionals and management, such as higher value of the CAPS psychosocial activities to enable deconstructing medicalized care, developing a matrix system and investing in studies that reveal the realities of mental health in Brazil.

Collaborations

ES Pinho and ACS Souza: design and data analysis and interpretation; drafting the article and final approval of the version for publication. E Esperidião: relevant critical review of the intellectual content and final approval of the version for publication.

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