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ARTICLE

Validation of the Continuing Health Education Policy logical model in the Psychosocial Care Centers

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Abstract *The study aims to describe the validation process of the Continuing Health Education Policy (PEPS) logical model in the Psychosocial Care Centers (CAPS) in Barreiras, Bahia, Brazil. In two rounds, this evaluability study on specialists distributed in the health training four-square model, including management, education/research, service, and social control, was conducted through the Delphi consensus technique. The items were consensual when they reached more than 80% of agreement among the participants, confirmed by the analysis of the median and the interval between the first and the third quartiles. The results reflect the validated logical model content in five technical components: Planning, Political Articulation, Coordination, Technical Qualification, and Live Work in Care Production. The structure and processes required to carry out the EPS actions at the CAPS and the expected results in the short, medium, and long terms were described in the logical model. Validating the operational aspect of the intervention contributes to organizing and adopting operability and fertility criteria in a formative assessment that aims to strengthen the practices of an educational policy in mental health toward comprehensive care.*

Key words *Continuing education, Health policies, Validation studies, Mental health, Mental health services*

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Introduction

Health work is loaded with subjectivity in its relational essence and adds the use of technologies during the health-disease-care process[1]. It is not a simple, unidirectional, positivist, or superficial process[2] when looking at mental health care. It does not follow the path of symptoms-diagnosis-therapy-cure because the symptom circulates and is never eliminated[3]. Its object of intervention requires transformations in the organization of services[4].

Regarding mental health care services, the Psychosocial Care Network (RAPS) mission is to articulate the different points of health care for people with distress, mental disorder, or drug use, as follows: Primary Health Care (PHC), in which the PHC Units (UBS), Extended Family Health Centers, Street offices and Recreational and Culture Centers are allocated; Specialized Care, with Psychosocial Care Centers (CAPS) in their modalities; Urgent and Emergency Care; Transient Home Care; Hospital Care; and Deinstitutionalization Strategies such as Home Therapy Services and the *Volta para Casa* (Back Home) Program[4].

The training of professionals to work in mental health services is in constant construction due to the challenges of the Anti-asylum Struggle, Deinstitutionalization, Psychosocial Care, and frequent attacks on the Brazilian Psychiatric Reform (RPB)[5,6]. Labor management and health education deserve much attention from managers and institutions to meet the needs of the population[7]. As a policy, work management allows us to think strategically and ensure the primary requirements for valuing health professionals, and the qualification of health workers is an essential strategy for strengthening the Unified Health System (SUS), which far exceeds the search for diagnoses, care, treatment, prognosis, etiology and prophylaxis of diseases and illnesses[8].

It is crucial to develop conditions to meet the health needs of people, groups, and populations, sectoral management, and social health control[9]. Thus, we can resize the development of people's autonomy and the influence on the formulation of care policies. Continuing Health Education (EPS) is a tool for transforming practices in the daily life of health services[10]. Its primary principle for training health professionals[11] is the National Continuing Health Education Policy (PNEPS). In this sense, the PNEPS provides that evaluation processes can follow the EPS action design stages, the analysis of results, and the formulation of a value judgment about the scope of the formulated purposes[12].

An integrative review by Mattos et al.[13] points out the need for continuing education actions in the CAPS and the perpetuation of practices geared to the traditional and fragmented model of health actions, which hampers the inclusion of psychosocial practices in the setting of public health policies. In this context, the evaluation is a device that contributes to the renewal of health services and programs, where the EPS practices and developing groups with higher horizontality stand out. This strategy attaches the evaluation of the commitment to intervene in a particular reality[14].

Thus, evaluation processes acquire fundamental political functions by developing instruments that overcome traditional hospital models[15]. Few evaluation initiatives that include mental health services[16,17] are available within the SUS management. Evaluability studies involving the training four-square model (management, education/research, service, and social control) and whose references are the attributes of CAPs to evaluate the EPS were not identified in the literature. The evaluability study can be used as a pre-assessment at some stage of developing a program and throughout its cycle[18].

In the meantime, it enhances the likelihood of assessing which results are helpful for the program and the professionals involved. The stages of the evaluability plan include a) documentary analysis to clarify the program's objectives and goals; b) interview with key informants; c) modeling the intervention; d) hosting the workshop to agree with the logical model with those interested; and e) formulating evaluative questions[19]. In this context, it is noteworthy that modeling the Continuing Health Education Policy (PEPS) developed in the CAPS in Brazilian settings facilitates understanding the initiative in its rationality and logical chain from the operationalization of intervention and the essential components of the policy and its surrounding context[20].

Understanding the relevance of promoting staff training spaces that allow workers to advance the transformation of daily practices and institutionalize the assessment of care and work processes developed in the CAPS to produce a change in formation, we should recognize the need for new "toolboxes" for knowledge production[21]. This action allows feedback to reverse or minimize the obstacles and enhance the care provided[22]. Thus, this study aims to describe the validation of the PEPS logical model in the CAPS in Barreiras, Bahia, Brazil.

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Methods

This evaluability study for validating the PEPS logical model in the CAPS in Barreiras, Bahia, Brazil. The CAPS surveyed were CAPS II and CAPS Alcohol and Drugs (CAPS AD). This course was supported by a mixed approach[23], using quantitative and qualitative techniques. The research is one of the stages of a doctoral thesis that addresses EPS actions in the CAPS from a participatory perspective.

The logical model (LM) is a tool to systematize and communicate the causal relationships between available resources, activities performed, and expected intervention results[20]. Expressed through a graphic design, it explains the sequence of events with a synthesis of the main components of the intervention[20]. The LM does not pretend to be a universally applicable truth, especially regarding Brazilian municipalities' social, economic, and cultural diversity. Therefore, it is essential to incorporate new information and viewpoints about convictions, experiences, and knowledge[24] in the modeling to increase the internal validity of the model itself and strengthen the analytical replication of this case study and research designs that depart from theory to empiria[20,25].

The preparation of the LM considered the implementation of the PNEPS from 2007, a period of reformulation of the policy guidelines through the Ministry of Health Ordinance (MS) n° 1.996/2007[11]. Official documents referring to the Municipal and State Management process of the SUS, represented by the Municipal Health Plan, State Health Plan, the Annual Municipal Management Report, the Annual State Management Report, the Regionalization Master Plan of the State of Bahia and State Continuing Health Education Plan. We performed a bibliographic review[13], referring to the intervention and documentary analysis to understand and identify its objectives and activities in Ordinance MS N° 1.174/2005[26], Ordinance MS n° 854/2012[27], Technical Note MS n° 11/ 2019[28], and PNEPS[11] to build the LM. The intervention was described and delimited through a data extraction roadmap, and aspects of thematic content analysis were used for document analysis[29] and the identification of the technical components of the intervention.

Sampling was by convenience and adopted having academic experience or professional practice with EPS or mental health in Barreiras or the State of Bahia as an inclusion criterion to achieve consensus. Twenty experts representing management, education/research, service, and social control were selected and invited to participate in the study, as follows: a municipal mental health coordinator; ten CAPS health professionals; five representatives of higher education institutions (IES) (teachers and researchers); a representative of the technical area of mental health of the Regional Health Center; a representative of the Care Management Directorate of the Health Secretariat of the State of Bahia (SESAB); and two patient representatives in the Municipal Health Council. In the first contact, we explained the study's objective, the technique to be used, and the importance of participation. One of the twenty selected experts refused to participate in the survey.

Figure 1 presents the steps of the LM construction and validation process. In the first round, held in September 2020, (1) an introductory text on the study objectives, (2) the Informed Consent Form, (3) the described modeling of the intervention in the evaluation process, (4) the first version of LM of the PEPS in the CAPS in Barreiras (Figure 2), and (5) the instructions for completing the instrument and returning the material were made available.

The second instrument was sent in October 2020 only to the 19 participants who responded to the first instrument. The document consisted of a brief consolidation of the first instrument, with (1) the description of the LM incorporating the first round's inputs and (2) the modified visual scheme, and (3) an instrument for analyzing the relevance of the items (Figure 1). Regarding the PEPS in the municipal CAPS, a part of the theory was presented through the LM concerning structure, process, and results to be analyzed and classified by experts regarding relevance to items, into "yes" or "no", and regarding the relevance of the items, through Likert scale (Figure 1). The first research instrument was organized into nine blocks, 1 referring to resources, 2, 3, 4, 5, and 6 to activities, and 7, 8, and 9 to short-, medium- and long-term results.

The following components related to PEPS in the CAPS were defined and inserted in the LM: planning, political articulation, coordination, technical qualification, and live work in care production. The "Planning" component comprises documents and plans that must be prepared by the stakeholders and the institutions involved in the planning and implementation of the PEPS in the CAPS.

The "political articulation" component refers to the existence of structured stakeholders and institutions responsible for the EPS in the

CAPS, which are articulated with each other in a collaborative network for developing the policy. The "coordination" component addresses the availability and use of resources for developing the PEPS in the CAPS. The "technical qualification" component comprises guidance and actions for developing health education. The "live work in care production" component comprises the alignment between the stakeholders involved to reorient conceptions about the health space, the production of meanings, and their interrelationships.

In the first round, the 19 completed and returned instruments were encoded, and the answers were entered in a Microsoft Excel spreadsheet. The data were then analyzed through descriptive statistics before being presented in the next round. There was consensus on the item that received at least 80% of the votes "yes" in the relevance aspect[23,24]. In this first round, the participants judged the relevance of each item and could suggest and freely discuss the subject if they disagreed with what was presented. The participants' suggestions were submitted to a qualitative analysis using thematic content analysis aspects[29]. The irrelevant items were reformulated or excluded, and the considerations of the participants were listed and categorized, resulting in the inclusion or reformulation of the items in the second instrument (Figure 1).

In the second round, participants were asked to analyze the visual scheme again and their de-

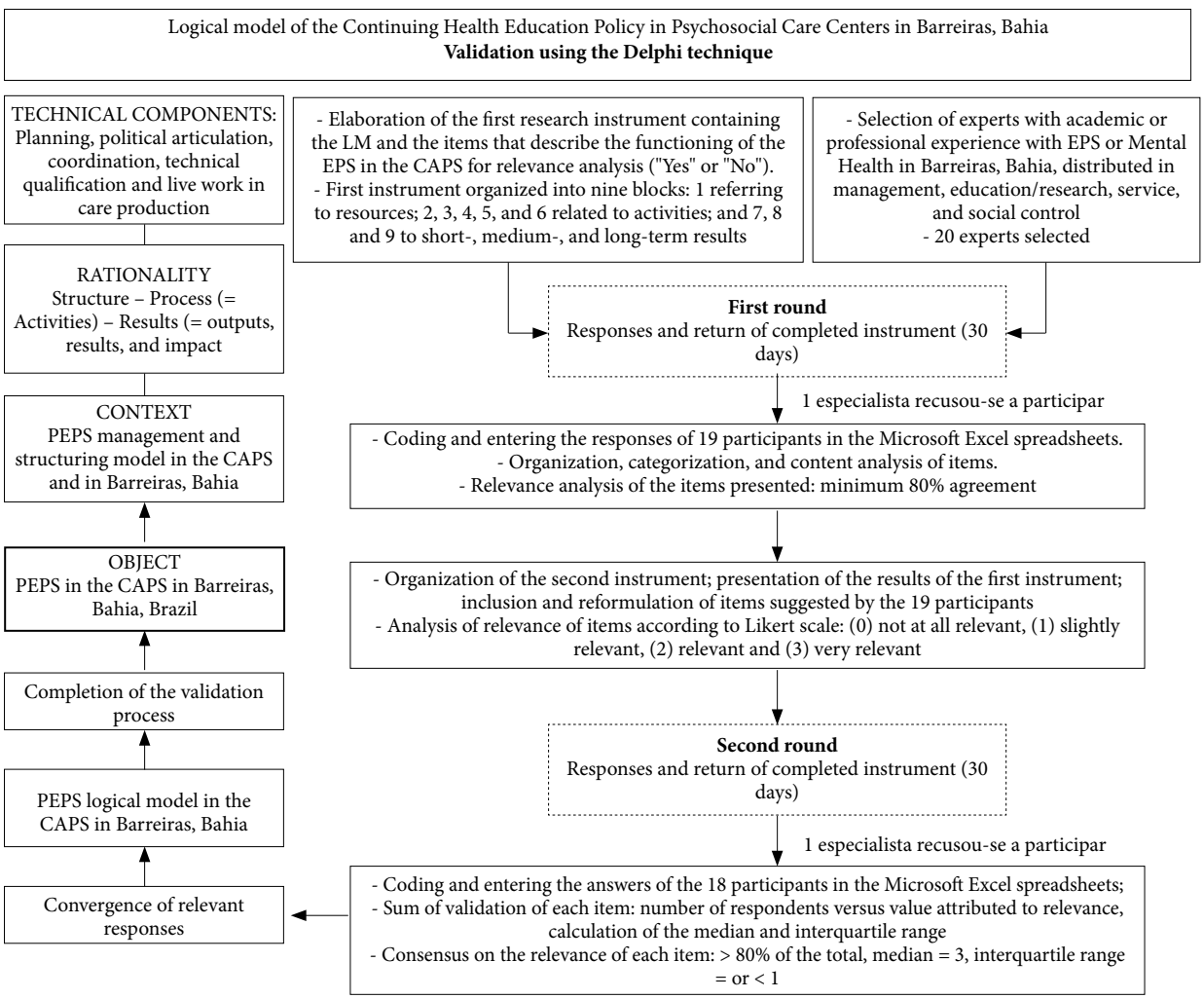

Figure 1. Validation process of the PEPS logical model in the CAPS. Barreiras, Bahia, Brazil, 2020.

Source: Authors.

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scription and respond to the relevance of the instrument items in the nine blocks. The relevance level was assigned to each item, based on the four-point Likert scale, to determine its relevance value: (0) not at all relevant; (1) slightly relevant; (2) relevant; and (3) very relevant. The data were entered into the Statistical Packages for the Social Sciences (SPSS) software, version 21. Then, the descriptive analysis was performed, calculating the sum, median, and interquartile range of items. There was consensus on the relevance of items whose final scores reached more than 80% of the maximum available value and had a high level of agreement, confirmed by the analysis of the median response and interquartile range[23,24].

A period of 30 days was established in the first and second rounds to return the instruments duly completed, and the participants answered on time and sent the signed ICF with the instruments. The final result of the validation process was sent to participants to inform them. The Research Ethics Committee of the Federal University of Western Bahia approved this project under Opinion n° 4.022.337, of May 12, 2020.

Results

Using the two-round Delphi consensus technique, this study achieved the consensus of the relevance analysis and relevance of each LM item by experts, organized in nine blocks on structure, process, and results related to the PEPS in the CAPS in Barreiras, Bahia, Brazil. Nineteen of the 20 experts initially selected participated in the first round and 18 in the second round, representing all groups: management; education/research; service; and social control.

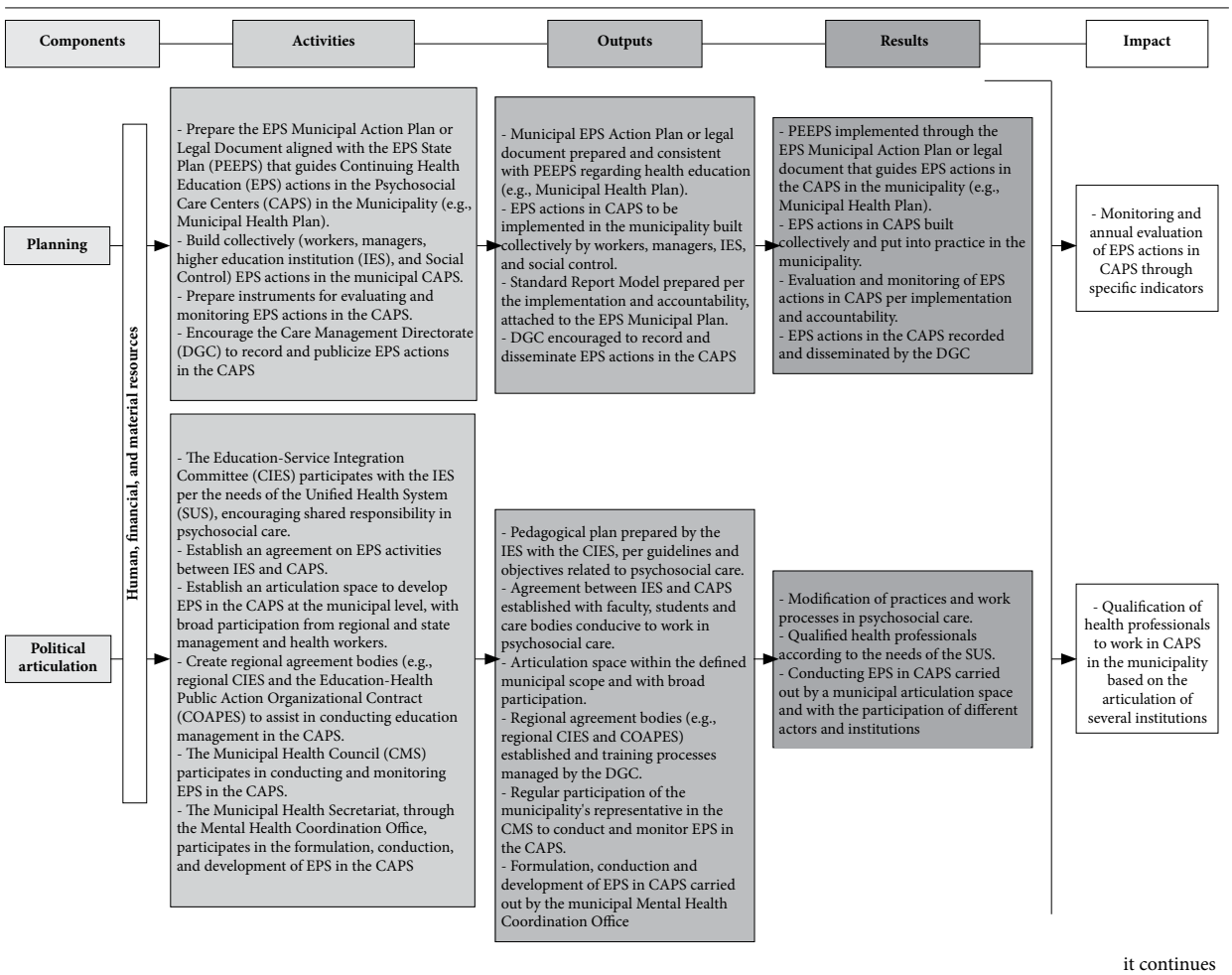

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Figure 2. Preliminary logical model of PEPS in the CAPS. Barreiras, Bahia, Brazil, 2020.

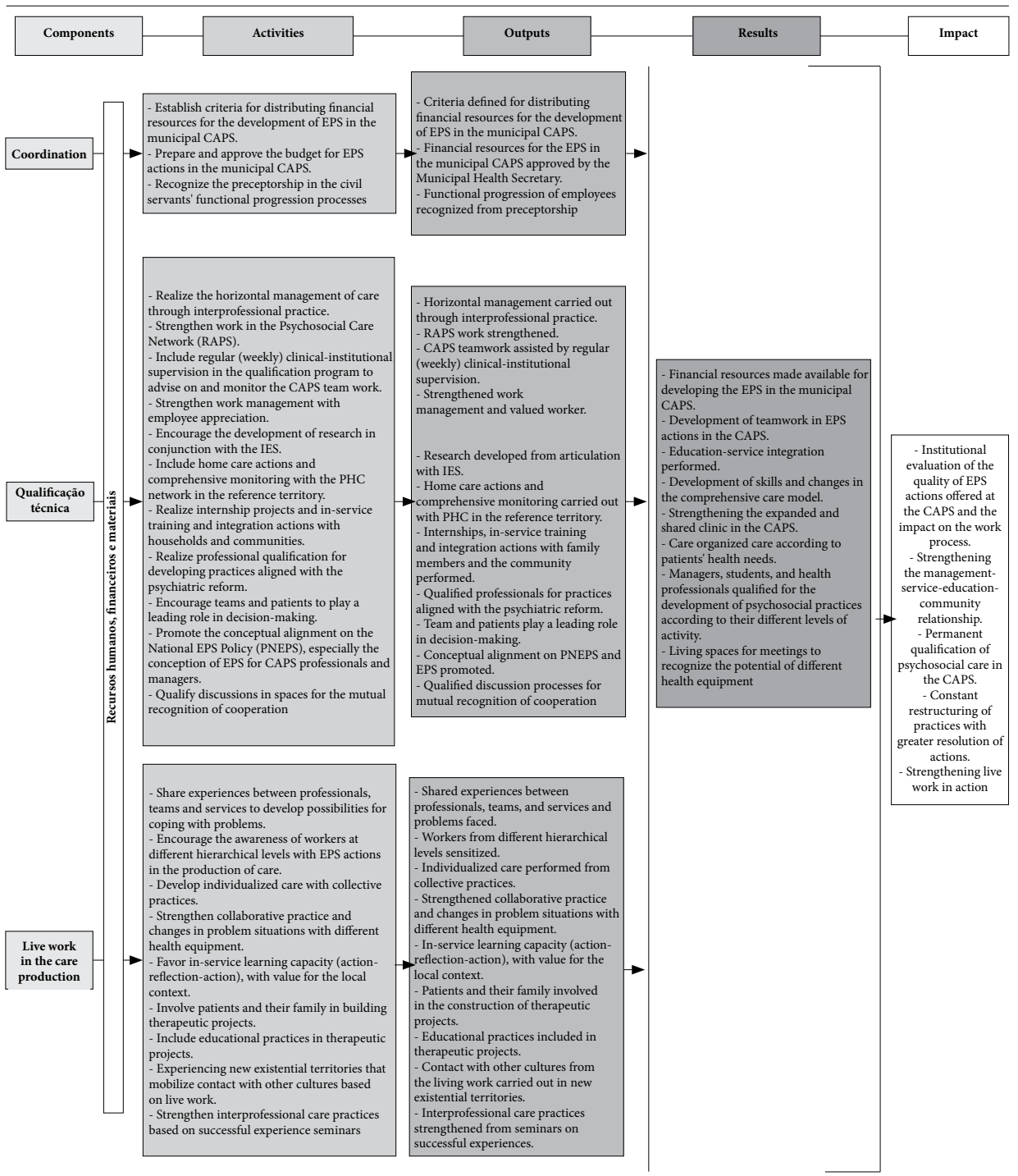

Figure 2. Preliminary logical model of PEPS in the CAPS. Barreiras, Bahia, Brazil, 2020.

EPS: Continuing Health Education; PEEPS: EPS State Plan; CAPS: Psychosocial Care Center; IES: Higher Education Institution; DGC: Care Management Directorate; CIES: Education-Service Integration Committee; SUS: Unified Health System; COAPES: Education-Health Public Action Organizational Contract; CMS: Municipal Health Council; RAPS: Psychosocial Care Network; PNEPS: National Continuing Health Education Policy.

Source: Authors.

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Regarding the analyzed items, those related to PEPS resources in the CAPS obtained the following values regarding the total sum reached, the median and interquartile range, respectively: 54, 3, 0 (human resources); 51, 3, 0 (financial resources); 49, 3, 0 (material resources). Table 1 presents the items related to the processes, represented by the activities and their respective outputs, organized into five technical components: planning, political articulation, coordination, technical qualification, and live work in care production.

The marking in Table 1 corresponds to the item considered irrelevant by the participants, that is, the one that reached the sum of points ≤ 43.2 points, confirmed by the median < 3 and interquartile range ≥ 1, and this item was reformulated in the final LM since it was considered relevant concerning PEPS activities in the municipal CAPS. Table 2 shows the items related to the results and impacts of PEPS in the CAPS in the municipality of Barreiras, Bahia.

Applying the Delphi consensus technique with the experts modified the initial LM and allowed a better understanding of the essential components of the policy in the local context. In the first round, based on experts' contributions regarding the items' pertinence, the items related to activities, outputs, and results of all the components closest to local governance in conducting the PEPS in CAPS were included and reformulated.

In the second round, the experts considered all items related to the structure relevant. Of the items related to the technical component of Political Articulation concerning outputs, the item referring to instances of regional agreement such as the Education-Service Integration Committee (CIES) and the Education-Health Public Action Organizational Contract (COAPES) established in conducting education in the CAPS, were not considered relevant. All items referring to the results and impact of the five technical components were considered relevant by the experts.

Finally, Figure 3 presents the PEPS LM in the CAPS in Barreiras, Bahia, validated through the Delphi consensus technique, structured according to the triad structure, process, and result, according to five components (planning, political articulation, coordination, technical qualification, and live work in care production). At the end of the validation process, we noticed that the main changes made to the LM consisted of including items that reflect the structuring, conduction, and participation of the PEPS in the municipal CAPS and, consequently, its structuring at the state and regional levels.

Discussion

The adequate evaluation of the PEPS in the CAPS requires building its LM. Its design consists of the first step for planning the evaluation with the understanding of the intervention's operationalization[20]. In this context, this PEPS evaluability study sheds light on its structure, operationalization, and direction in achieving the intended results and impacts on the qualification of professionals in the CAPS. In the context of this research, the LM stands out as a potentially helpful instrument for organizing training in the CAPS as a public policy that allows building local and regional spaces with the capacity to increase the qualification of health teams and their intersectoral partners. However, the setting is scarcely explored, and studies have yet to influence its macropolitical context[30]. The components of structure, process, and results that guided the LM elaboration will also drive the discussion of the results of this study.

We highlight the relevance of structural components for developing the PEPS in the CAPS since they provide fundamental requirements for its operation, such as physical, human, and material resources. Infrastructure must result from a multisectoral effort with health to develop or continue to multiply and apply the EPS[31] to successfully develop the policy, planning, material, managerial, and human and financial resources. In the context of the CAPS, ambiance arises within a broader theoretical orientation, which refers to the treatment given to the physical setting that is a social, professional, and interpersonal relationship space, which provides welcoming, resolute, and human care[32].

Therefore, this validation process moves toward breaking the illness processes created by institutionalization[33]. Planning, political articulation, coordination, technical qualification, and live work in care production technical components were all considered relevant. In the technical component of planning, intersectoriality is a dimension valued in public policies. It contributes to articulating knowledge and experiences for planning and evaluating policies, programs, and projects to ensure cooperative results in complex situations[34]. In this path, the political articulation component was fundamental for developing the EPS Policy in the CAPS. It shows the

Table 1. Items related to the activities and respective outputs for the PEPS in the CAPS in the municipality distributed by total points, median and interquartile range. Barreiras, Bahia, Brazil, 2020.

Technical component	Activities to be performed	Total points	Median	Interquartile range	Outputs	Total points	Median	Interquartile range
Planning	Elaborate the EPS Municipal Action Plan or legal document that guides the EPS actions in the Psychosocial Care Centers (CAPS) in the municipality.	50	3	0	EPS Municipal Action Plan or legal document elaborated and coherent with the PEEPS regarding health education (e.g., Municipal Health Plan).	51	3	0
	EPS State Plan (PEEPS).	45	3	1				
	Build collectively (workers, managers, Higher Education Institution (IES), and social control) EPS actions in the municipal CAPS.	52	3	0	EPS actions in the CAPS to be implemented in the municipality, built collectively by workers, managers, EIS, and social control.	50	3	0
	Elaborate instruments for evaluating and monitoring EPS actions in the CAPS.	51	3	0	Standard report model prepared according to implementation and accountability, attached to the Municipal EPS Plan.	49	3	0
	Create a schedule of training and qualification workshops by the mental health technical team of the State Health Secretariat of Bahia (SESAB) for the CAPS.	51	3	0	Schedule of training and qualification workshops established by the SESAB mental health technician for the CAPS.	51	3	0
Political articulation	Promote articulation with the IES along with the Education-Service Integration Committee (CIES) in the construction of political-pedagogical plans in undergraduate and graduate health courses, according to the needs of the Unified Health System (SUS), encouraging a stance of shared responsibility in the psychosocial care.	51	3	0	Political-pedagogical plan prepared by the IES together with the CIES, according to guidelines and objectives related to the SUS and psychosocial care.	49	3	1
	Establish an agreement on EPS activities in the CAPS between the IES and the Municipal Health Secretariat (SMS).	51	3	0	Agreement of EPS activities in CAPS between HEIs and SMS instituted with faculty, students and assistance conducive to work in psychosocial care.	50	3	0

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diversity of social stakeholders, the challenges, and the need for negotiation and political agreement. The EPS logic is decentralized, bottom-up, multidisciplinary, and transdisciplinary since the PNEPS management is shared[9].

The inter-institutional articulation breaks the rule of single and hierarchical verticality of organizational flows. In the meantime, with the Administrative Reform in Bahia in 2014, the Regional Health Directorates (DIRES) were extinguished, and the Regional Health Centers (NRS) were established. The latter became responsible for centralizing regional management[35]. In Brazil, health regionalization is an organizational strategy supported by SUS guidelines and manifests the need to establish healthcare networks in a complex political process involving different stakeholders[36]. In the context of maintenance and municipal leadership and, simultaneously, strengthening of interdependence relationships

Table 1. Items related to the activities and respective outputs for the PEPS in the CAPS in the municipality distributed by total points, median and interquartile range. Barreiras, Bahia, Brazil, 2020.

Technical component	Activities to be performed	Total points	Median	Interquartile range	Outputs	Total points	Median	Interquartile range
Political articulation	Establish an agreement on EPS activities in regional spaces between the Regional Interagency Committee (CIR) and the Regional Health Center (NRS) in conducting the EPS, including the CAPS	47	3	1	Agreement on EPS activities in regional spaces between the CIR and NRS in conducting the EPS that includes the CAPS	47	3	1
	Establish the EPS Center at the municipal level as a training space for workers to guide EPS actions in the CAPS	48	3	1	EPS center established at the municipal level as a training space for workers to guide EPS actions in the CAPS	49	3	0
	Create regional agreement bodies (e.g., regional CIES and the Education-Health Public Action Organizational Contract (COAPES) to assist in conducting education management in the CAPS	46	3	1	Regional agreement bodies (e.g., regional CIES and COAPES) established in conducting education in the CAPS	42	2,5	1
	Establish monitoring of EPS actions, including the CAPS, by the Municipal Health Council (CMS)	48	3	1	Monitoring EPS actions by CMS representatives, including the CAPS	46	3	1
	Establish the participation of the Municipal Health Secretariat through the Mental Health Coordination in	52	3	0	Formulation, conduction and development of the EPS, including the CAPS, conducted by the municipal Mental Health Coordination	51	3	0
Coordination	Establish criteria for distributing financial resources for the development of the municipal EPS, including the CAPS	48	3	1	Criteria defined for the distribution of financial resources for developing the municipal EPS, including the CAPS	46	3	1
	Prepare and approve a budget for municipal EPS actions, including CAPS	49	3	0	Financial resources for the municipal EPS, including CAPS, approved by the municipal health secretary	50	3	0
	Recognize preceptorship in the civil servants' functional progression processes	48	3	0	Functional progression of employees recognized from preceptorship	51	3	0

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and shared health responsibility, in this study, the Regional Interagency Committee (CIR) is a potential forum for discussing and building inducing strategies to advance deinstitutionalization and non-institutionalization and the inexistence of mental health care gaps[37].

The coordination component's activities encourage, monitor, and strengthen the qualification of health workers. PNEPS funding decentralization, a shared responsibility, stumbles upon obstacles, as the "public machine" operates well within health actions and "gets stuck" when they are education actions[38]. Thus, to recover the funding flow and strengthen the PNEPS through transfers of resources from the Ministry of Health, Ordinance n° 3.194 of November 28, 2017[39], provides for the Program for Strengthening EPS Practices in the SUS. Thus, around R$ 70 million were transferred to states and municipalities to conduct educational activities, observing regional and local needs[40].

In the technical qualification component, the EPS and interprofessional education (EIP) are chosen to overcome the asylum model, de-

Table 1. Items related to the activities and respective outputs for the PEPS in the CAPS in the municipality distributed by total points, median and interquartile range. Barreiras, Bahia, Brazil, 2020.

Technical component	Activities to be performed	Total points	Median	Interquartile range	Outputs	Total points	Median	Interquartile range
Coordination	Provide exchange of mental health coordination office with mental health services in other municipalities	50	3	0	Intermunicipal exchange of mental health coordination offices in place	49	3	1
	Establish the attributions of the Mental Health Coordination Office and the Mental Health Services Coordination Office at the municipal level	48	3	0	Attributions of the mental health coordination office and the mental health services coordination office established without overlapping	51	3	0
Technical qualification	Conducting the horizontal management of care through interprofessional practice.	50	3	0	Horizontal management of care carried out through interprofessional practice.	51	3	0
	Strengthen work in the Psychosocial Care Network (RAPS).	52	3	0	Work at the RAPS strengthened.	54	3	0
	Include regular clinical-institutional supervision in the qualification program to advise and monitor the CAPS team's work.	53	3	0	Teamwork in the CAPS assisted by regular clinical-institutional supervision.	49	3	1
	Strengthen work management with employee appreciation.	54	3	0	Strengthened work management and valued worker.	53	3	0
	Encourage the development of research in conjunction with the IES.	48	3	1	Research developed from the articulation with the IES.	51	3	0
	Include home care actions and comprehensive follow-up with the PHC network in the reference territory.	51	3	0	Home care actions and comprehensive monitoring performed with PHC in the reference territory.	52	3	0
	Conduct internship projects and in-service training and integration actions with families and communities.	51	3	0	Internships, in-service training and integration actions with family members and the community conducted.	50	3	0
	Conduct professional qualification for developing practices aligned with the psychiatric reform.	50	3	0	Professionals qualified for practices aligned with the psychiatric reform.	51	3	0

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construct individualized, fragmented, mechanized practices, and build mental health care. The CAPS need a new work and care type, challenging the teams, as most professionals need to be trained in the psychosocial care paradigm[41]. This situation requires training strategies such as EIP, which enable building learning through the interaction of subjects with their knowledge, feelings, attitudes, beliefs, and customs based on democratized relationships[42]. Moreover, we highlight the fragility of academic training and the need to resume reflection on the EPS concept. Thus, total appropriation of its concept is relevant, proposing its alignment, which facilitates managing and planning EPS actions[43].

The final technical component, live work in care production, highlights items that must be supported by a commitment that it is possible to make a difference, even in situations where, in principle, nothing moves. The team moves towards thinking about another way to act, mobilizing affections, creating deviations, and other unthinkable care possibilities[44]. Negotiation occurs through mutual affectations in the territory of caring actions. This territory is influenced by live work in action[45], which takes on a leading

Table 1. Items related to the activities and respective outputs for the PEPS in the CAPS in the municipality distributed by total points, median and interquartile range. Barreiras, Bahia, Brazil, 2020.

Technical component	Activities to be performed	Total points	Median	Interquartile range	Outputs	Total points	Median	Interquartile range
Technical qualification	Encourage teams and users to play a leading role in decision-making.	49	3	0	Team and users playing a leading role in decision-making.	51	3	0
	Promote conceptual alignment on the National EPS Policy (PNEPS), especially the conception of EPS for CAPS professionals and managers.	48	3	0	Conceptual alignment on the PNEPS and EPS promoted.	46	3	1
	Qualify discussion processes in spaces for the mutual recognition of cooperation.	46	3	1	Qualified discussion processes for mutual recognition of cooperation.	48	3	0
Live work in care production	Sharing experiences among professionals, the community, teams and services to develop possibilities for addressing issues	52	3	0	Experiences between professionals, community teams and services shared, and problems faced	51	3	0
	Encourage the awareness of workers at different hierarchical levels with EPS actions in care production	50	3	0	Workers from different hierarchical levels sensitized	50	3	0
	Develop individualized care with group practices	51	3	0	Individualized service performed from group practices	50	3	0
	Strengthen collaborative practice and changes in problem situations with different equipment from an intersectoral perspective	49	3	0	Strengthened collaborative practice and changes in problem situations performed with different equipment from an intersectoral perspective	47	3	1
	Favor in-service learning capacity (action-reflection-action), with value for the local context	51	3	0	In-service learning capacity (action-reflection-action) performed, with value for the local context	52	3	0
	Involve the user and his family in the construction of therapeutic projects	53	3	0	Users and their family involved in the construction of therapeutic projects	51	3	0
Live work in care production	Include educational practices in therapeutic projects	53	3	0	Educational practices included in therapeutic projects	49	3	0
	Experiencing new existential territories that demystify deinstitutionalization and deprivation of liberty in the CAPS	50	3	0	New existential territories established that demystify deinstitutionalization and deprivation of liberty in the CAPS	50	3	0
	Strengthen interprofessional care practices based on successful experience seminars	50	3	0	Interprofessional care practices strengthened from seminars on successful experiences	51	3	0

Source: Authors.

role in the work process and takes on different shapes based on the user's need and the worker's offer in an intense movement that accompanies birth or death[46].

Thus, good encounters generate happy passions and favor and expand the potency of action between the bodies whose relationship is one of composition. On the other hand, bad encounters

Table 2. Items related to the results and impact of the PEPS in the municipal CAPS, distributed according to total points, median, and interquartile range. Barreiras, Bahia, Brazil, 2020.

Technical component	Results	Total points	Median	Interquartile range
Planning	PEEPS implemented through the Municipal EPS Action Plan or legal document that guides the EPS actions in the municipal CAPS (e.g., Municipal Health Plan).	49	3	0
	EPS actions in the CAPS built collectively and put into practice in the municipality.	51	3	0
	Evaluation and monitoring of EPS actions in CAPS performed according to implementation and accountability.	49	3	0
	Support from the mental health technical team in the qualification of the CAPS.	52	3	0
Political articulation	Modification of practices and work processes in psychosocial care.	47	3	1
	Qualified health professionals according to the needs of the SUS.	53	3	0
	Conducting and developing the EPS, including the CAPS, performed by a regional and municipal articulation space and with the participation of different stakeholders and institutions.	48	3	0
Coordination, technical qualification, and live work in care production	Financial resources made available for developing the EPS in the municipal CAPS.	51	3	0
	Development of teamwork in the EPS actions in the CAPS.	50	3	0
	Education-service integration performed.	48	3	1
	Development of skills and changes in the care model for comprehensive care.	48	3	1
	Strengthening of the expanded and shared clinic in the CAPS.	52	3	0
	Care organized according to the users' health needs.	53	3	0
	Managers, students, and health professionals qualified for the development of psychosocial practices, according to their different activity levels.	51	3	0
	Live spaces for meetings with other cultures to recognize the potential in different situations.	48	3	1
Impact	Monitoring, promotion, and annual evaluation of EPS actions in the CAPS, through specific indicators.	49	3	1
	Participatory management of curricular and extracurricular activities in undergraduate and graduate health courses.	43	3	1
	Qualification of health professionals to work in the municipal CAPS based on the articulation of several institutions.	51	3	0
	Institutional evaluation of the quality of EPS actions offered in the CAPS and of the impact on the work process.	49	3	0
	Strengthening the management-service-education-community relationship.	52	3	0
	Continuing qualification of psychosocial care in CAPS.	51	3	0
	Constant restructuring of intersectoral practices with greater resolution of actions in health, justice, education, culture, and social assistance.	50	3	0
	Strengthening live work in action through interprofessionality and deinstitutionalization of care in the CAPS.	49	3	0

Source: Authors.

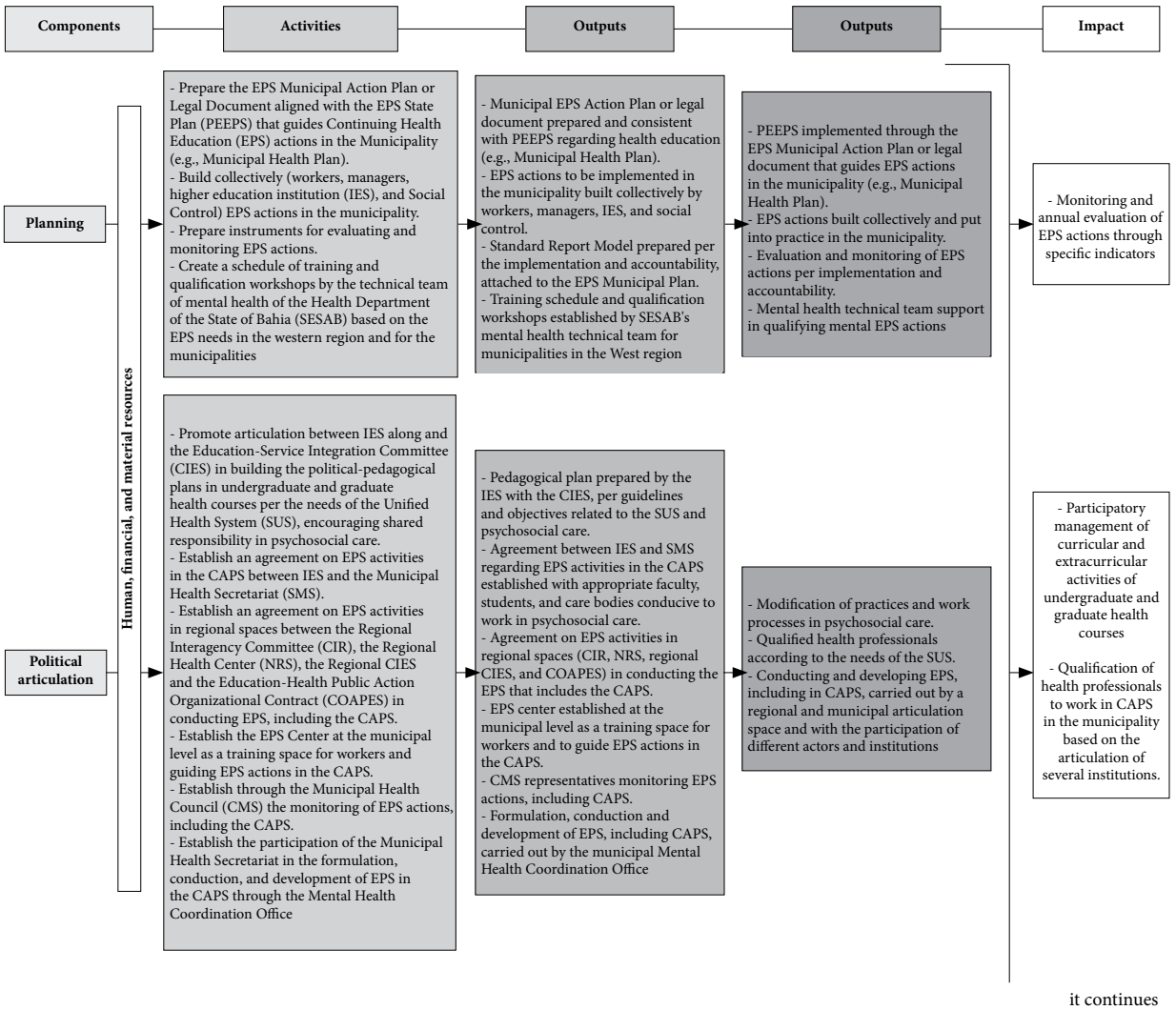

Figure 3. Final logical model of PEPS in the CAPS. Barreiras, Bahia, Brazil, 2020.

generate sad passions in which the potency of one is opposed to the other[47]. Deleuze[48] explains that actions are active affections. Through them, we know the constitutive relationships between bodies; what is pleasing or displeasing, and, therefore, the actions would generate ideas adequate to our reality. Thus, the items of each technical component described in this LM contribute toward PNEPS being adjusted to local contexts[23]. From this perspective, health work reveals that its reorganization must also include implementing educational and training processes. EPS is a valuable strategy for reorganizing network services and building participative management.

The intended objectives of the intervention were presented as outputs, results, and impacts, which refer to short-, medium- and long-term results, respectively. Regarding outputs, almost all items were considered relevant by experts, except for regional agreement bodies such as the regional CIES and COAPES in conducting the EPS in the CAPS. Some states carried out in several Brazilian states report deficiencies in physical space and logistical support to ensure the functioning of the CIES, besides the inexistent EPS sector in the organization chart of the State Health Secretariats and the lack of resources (personnel, per diem, transportation) for the EPS actions[38,40,49]. However, the proposals in PNEPS[11] aim to encourage regional policy management and inter-institutional participation through the CIES and reflect on the articulation between the

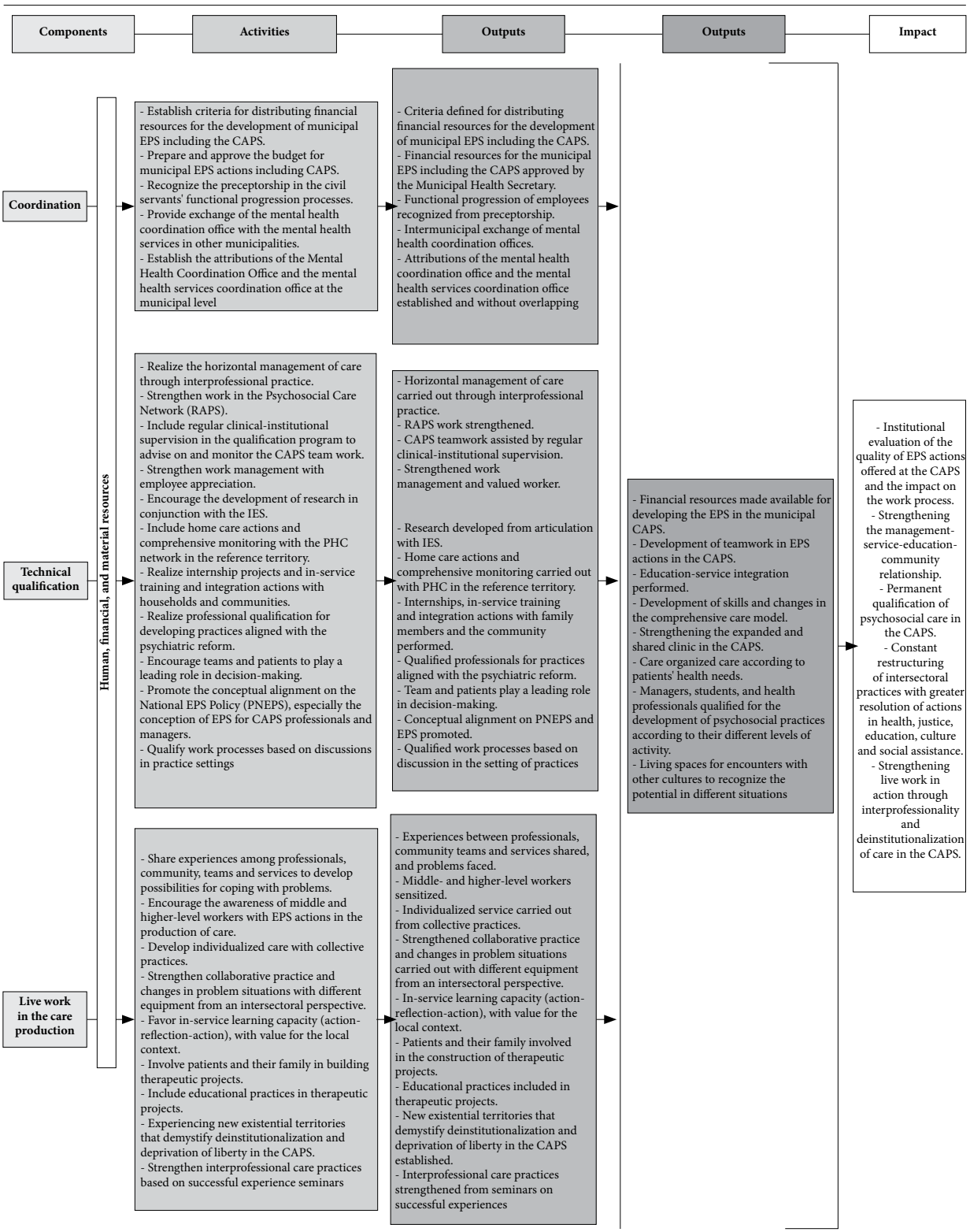

Figure 3. Final logical model of PEPS in the CAPS. Barreiras, Bahia, Brazil, 2020.

EPS: Continuing Health Education; PEPS: EPS State Plan; CAPS: Psychosocial Care Center; IES: Higher Education Institution; CIES: Education-Service Integration Committee; SUS: Unified Health System; COAPES: Education-Health Public Action Organizational Contract; CMS: Municipal Health Council; RAPS: Psychosocial Care Network; PNEPS: National Continuing Health Education Policy; CIR: Regional Interagency Committee; NRS: Regional Health Center; and SESAB: Bahia State Health Secretariat.

Source: Authors.

several institutions that comprise the EPS[9] four-square model.

Establishing the regional CIES as a member of the local COAPES management committee[40] is recommended to strengthen the PNEPS. COAPES is a continuous articulation instrument that signals the intentionality of several stakeholders in building an educational model that values the education-service-community integration required for health undergraduate and residency courses[50]. It proposes a flow to guide and formalize intersectoral and interinstitutional relationships. Its adoption shows several advantages for states, municipalities, IES, workers, and students, as it qualifies them for the SUS demands and collaborates for its improvement[40,50]. COAPES should transcend the bureaucratic limits and develop a permanent negotiation to defend the qualification of care and training in the SUS in articulation with the EPS premises[51].

All items referring to the results and impact of the EPS Policy on the CAPS in Barreiras, Bahia, were relevant. When recognizing the potential of education in transforming practices, a vital competency is developing pedagogical methodologies that allow dialogical relationships and broaden the perspective of changing practices and organizing services[42,52]. Constructivist training in SUS management was identified as a catalyst for this process[52,53]. Despite this indication, we should reinforce that the EPS process for training in mental health to work in the CAPS must be concomitantly guided by the RPB principles. Thus, workers should rethink their care practices since they are not only human "resources" or inputs, and care production is not alien to the subjective dimension of work[54].

The items in the final LM presented in this study show the multiple and complex factors and relationships involving PEPS in the CAPS. Only two rounds were necessary for this study due to the high consensus among experts. The expected loss in the validation study in the first round was 30% to 50% and 20% to 30% in the second round[23,55]. Thus, the validation of internal consistency was intact, as the loss was only 5% in both rounds.

Final considerations

This evaluability study presented the validation process of the LM referring to the EPS Policy in the CAPS in Barreiras, Bahia, Brazil. The LM design shed light on how the intervention was conducted, understood the PEPS as a valuable tool in mental health training, and agreed on the possible development of the intervention. The collective construction with experts distributed in the four-square model for health education through the Delphi consensus technique was essential. It is an important step in the involvement of potential stakeholders in the evaluation process to strengthen the management of policy education at the local level. Furthermore, the validated LM can be revised and applied in other contexts if they fulfill the necessary adaptations and influences related to the intervention.

Developing the PEPS in the CAPS is essential to avoid bureaucratization and inefficient clinical practices. Operability and fertility criteria were adopted in a formative evaluation to strengthen mental health practices toward comprehensive care. This research aims to guide future investigations in the planning and evaluating mental health training policies and qualify care in different RPB settings.

Collaborations

MP Mattos, L Ferreira, CDD Espoti, and DR Gomes worked on the conception, design, analysis, and interpretation of data, drafting and critical review of the article, and approval of the version to be published.

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