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EVALUATION OF ACCESS AND WELCOMING AT THE CENTER OF PSYCHOSOCIAL ATTENTION

Avaliação do acesso e acolhimento no centro de atenção psicossocial

Evaluación del acceso y acogida en el centro de atención psicosocial

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ABSTRACT

Objective: to evaluate the user's access from the reception process in a Psychosocial Care Center. **Method:** qualitative case study, based on the Fourth Generation Assessment. Data collection took place in 2019, through methods of document analysis, participant observation and interviews based on the Hermeneutic-Dialectical Circle. Ten users, ten family members and nine service professionals participated in the research. For data analysis, the Constant Comparative Method was used. **Results:** the service provides resolute and fast reception, which can reduce psychiatric hospitalizations. It identified the need to break out of outpatient actions in the service, review the user embracement and access process at CAPS and the implementation of permanent education spaces. **Conclusion:** the contributions of this research can support workers and managers to reduce barriers to access and to effect care in specialized and strategic services such as CAPS.

DESCRIPTORS: Health services accessibility; Mental health; Delivery of health care; Health services research; User embracement.

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RESUMO

Objetivo: avaliar o acesso do usuário a partir do processo de acolhimento em um Centro de Atenção Psicossocial. **Método:** estudo qualitativo do tipo estudo de caso, baseado na Avaliação de Quarta Geração. A coleta de dados ocorreu em 2019, através dos métodos de análise documental, observação participante e entrevistas baseadas no Círculo Hermenêutico-Dialético. Participaram da pesquisa dez usuários, dez familiares e nove profissionais do serviço. Para a análise dos dados, foi utilizado o Método Comparativo Constante. **Resultados:** o serviço presta acolhimentos resolutivos e rápidos, podendo diminuir as internações psiquiátricas. Identificou a necessidade de rompimento de ações ambulatoriais no serviço, a revisão do processo de acolhimento e acesso dos usuários no CAPS e a implantação de espaços de educação permanente. **Conclusão:** as contribuições desta pesquisa podem subsidiar trabalhadores e gestores a diminuir as barreiras no acesso e a efetivar o cuidado em serviços especializados e estratégicos como o CAPS.

DESCRITORES: Acesso aos serviços de saúde; Saúde mental; Atenção à saúde; Avaliação de serviços de saúde; Acolhimento.

RESUMEN

Objetivo: evaluar el acceso del usuario desde el proceso de acogida en un Centro de Atención Psicosocial. **Método:** estudio de caso cualitativo, basado en la Evaluación de Cuarta Generación. La recolección de datos ocurrió en 2019, a través de métodos de análisis de documentos, observación participante y entrevistas basadas en el Círculo Hermenéutico-Dialéctico. Participaron de la investigación diez usuarios, diez familiares y nueve profesionales del servicio. Para el análisis de los datos se utilizó el Método Comparativo Constante. **Resultados:** el servicio proporciona una recepción resolutiva y rápida, lo que puede reducir las hospitalizaciones psiquiátricas. Identificó la necesidad de romper con las acciones ambulatorias en el servicio, revisar el proceso de acogida y acceso de los usuarios en los CAPS y la implementación de espacios de educación permanente. **Conclusión:** los aportes de esta investigación pueden apoyar a los trabajadores y gestores a reducir las barreras de acceso y efectuar la atención en servicios especializados y estratégicos como los CAPS.

DESCRIPTORES: Accesibilidad a los servicios de salud; Salud mental; Atención a la salud; Investigación sobre servicios de salud; Acogimiento.

INTRODUCTION

According to the World Health Organization (WHO), health systems still do not respond adequately to mental health care and treatment. In low-middle-income countries, 76% and 85% respectively, of the population in psychological distress do not receive treatment. Poor quality of care is another challenge. Moreover, there is a need for support to access housing, employment, and educational programs, enabling greater citizenship.[1]

In Brazil, access to health care is foreseen in the federal constitution as a right for all and a duty of the state. One of the services that promote this access are the Psychosocial Care Centers (CAPS), which are part of the Psychosocial Care Network (RAPS). These services promote the guarantee of human rights for people in severe and persistent psychological distress. In addition, they organize care in territorial and network-based services, such as the offer of matriciamento actions. Twenty years after the publication of the guidelines for the operation of CAPS, more than 2,200 facilities have been established. The coverage is considered very good, corresponding to 0.86 CAPS/100,000 inhabitants, associated with the reduction of psychiatric hospitalizations in some regions.[2-3]

At the current juncture, CAPS face many challenges to the realization of their proposal, such as the dismantling in public policies (Ordinance n. 3,588, of December 2017, and Technical Note n. 11, of February 2019) that decrease funding for CAPS and other community-based services, encouraging the return of the insane asylum and therapeutic communities. In addition, the difficulty of articulation in care network and integral vision about mental health, making CAPS responsible as the only service for the access to mental health care for the population.[4-6]

Access involves political, socioeconomic, network organizational, technical, and symbolic dimensions, as well as the adoption of working tools, such as the reception. The embracement is a care practice that should be present in the relationships that permeate the encounter of workers with users, materialized in qualified listening, in the recognition of the other, of their health needs, their experiences, and their suffering in the co-responsibility for care, in the bond, and commitment in the search for autonomy.[7-8]

Scientific studies point to the welcoming in CAPS as being resolutive in the access and adherence to treatment. However, they highlight the difficulty for the continuity of care, due to problems in the construction of therapeutic projects linked to factors such as lack of bonding with professionals, listening to the real needs of the user, accountability for the cases, and violent practices. Such difficulties contribute to the maintenance of the existing gap between the demands for care and the supply in mental health.[9-10]

Thus, the study is justified by the challenge of ensuring full access to health care as a Brazilian constitutional right. The objective is to evaluate the user's access from the reception process in a Psychosocial Care Center.

METHODS

A qualitative case study based on the theoretical and methodological framework of the Fourth Generation Evaluation. This evaluation framework is constructivist and responsive, focused on the needs of stakeholders. It is an evaluation that uses a hermeneutic-dialectic process of negotiation and interaction between the researcher and the stakeholders, based on the daily constructions of people involved and/or affected by the evaluation process and willing to participate.[11-12]

The study was carried out in a small town in the southern region of the state of Rio Grande do Sul, with 25,462 inhabitants. The research was developed in a type I Psychosocial Care Center, opened in 2002 and operating from Monday to Friday, between 8am and 6pm, and it was the only specialized service in the RAPS of the municipality at the time of the study.

Twenty-nine individuals participated in this study, including nine workers, ten users, and ten family members. The workers had the following inclusion criteria: having a bond of at least three months with the service and allowing the dissemination of research data (for all participants). The exclusion criteria was being on vacation and/or sick leave, one professional did not participate in the interview stage. The inclusion criteria for users were: being attending CAPS at the time of data collection and being able to communicate. The family members had the following inclusion criteria: people who accompanied or had already accompanied a relative undergoing treatment in CAPS.

The research data collection was conducted during the first semester of 2019. The research methods were document analysis – a technique that allows searching for precise information in several documents selected to compose a research.[13] Participant observation – a fundamental technique for a research of social interaction, of understanding the actions of subjects.[14] The participant observation stage totaled 118 hours with recording in field diaries. The dialectic hermeneutic circle was used with the interviews and the Constant Comparative Method of data analysis. This method guides that the processes of data collection and analysis be concomitant.[11]

The interviews with all the interest groups were guided by the Hermeneutic-Dialectic Circle. Initially, an emblematic person of each interest group is chosen, called respondent 1 (R1), to whom an interview script was applied with open questions about the operation of the service and their impressions about the access to mental health care in the Psychosocial Care Center. This interview was analyzed in its entirety to identify some important themes for the research objectives and some initial constructs, giving rise to construct C1. These were systematized and saved to be asked to respondent 2 (R2). For R2, the questions from the original script were applied again, and afterwards he was invited to make considerations about the themes arising from construct 1 (C1). Thus, from the analysis of R2's interview emerged information about his considerations and criticism of the demands and constructs of the first respondent (C1), and another formulation was built, with more elaborate and sophisticated information, based on two sources. This process was repeated with the other participants in each interest group, respecting values, ideas, and conceptions.[11-12]

The interviews were conducted individually, recorded, and transcribed in full. To ensure anonymity, the interviewees were identified with the following letters: F for family members, P for workers, and U for users, along with the number corresponding to the order of the interview. The research followed the ethical precepts guaranteed by Resolution n. 466, of December 12, 2012, and approved by the research ethics committee of the Federal University of Rio Grande do Sul, under opinion 3,110,415, CAAE: 04070818.0.0000.5347, on January 17, 2019.

RESULTS

The service under study offers individual care, activities in therapeutic workshops, therapeutic group directed to people with use and/or abuse of psychoactive substances, home visits, and matrix support for Primary Health Care.

The participants related the welcoming service to aspects such as good receptivity, agility in the service, and improvement in the biopsychosocial conditions. Besides being a service that contributes to the reduction of admissions in psychiatric hospitals.

> *I was well received, I was well received, and it was very good, and today I see how much I improved with this.* [...] *And I said that I needed, that I tried to commit suicide, I wanted to take my life, and they succeeded, I arrived here very bad* [...]. (U7)

> *There (psychiatric hospital) I was hospitalized a few times, then it changed, they tried private, then the money was no longer available, then I started to go to the clinics to get a prescription, then to CAPS [...]. It was wonderful. Then I started to come, get informed. I was at home or at the Spirit (psychiatric hospital). Then one of my father's neighbors [...] said "no, the CAPS is very good" [...]. Then we went there and it was solved* (U6)

> *The reception was excellent, we, at the time I made contact, he was still hospitalized, I explained the whole situation, and the next day he was discharged I took him there, since he arrived at the reception, the attention from professionals.* [...] *The team has always been extremely careful, affectionate, very responsible.* (F1)

> *He feels the importance of CAPS, that when he is unwell, when he has to look for help, he always speaks very well, that, I think, they hold him. CAPS helps him to hold on. As much in work, in handicrafts, as in the consultation with the psychologist.* (F2)

Regarding the challenges, we point out the difficulty of access to individual consultations and the reception of other professionals, in addition to the therapeutic workshops.

The doctor, when we needed, we were attended almost right after, [...]. *So he attended to us first, before attending to those who come from the street* [...]. *And now it has taken longer, a lot of time, because there are many people that don't participate in the workshops, they are left out,* [...] *I think they lost their preference, because I think there are many people that they give prescriptions for.* (U9)

Sometimes it seems that the patients of the house, that we call, that are the ones that attend, are forgotten between those that attend the workshops and the reception. To sum it up, there is this difficulty of access to the middle of an individual consultation, of a reception, of the other professionals. (P3)

Another challenge identified by the team is the access to the service only for prescription renewal and medical care of users in outpatient treatment.

There are patients that I don't know, I know the patients that attend the house, or some cases that are passed on to me, but there are other patients that have already passed on to me, that for me it is news even that that person is a patient, because it is outpatient. [...] *people who come only for these consultations, with the psychiatrist or with the clinical doctor.* (P4)

The doctors complain a lot, that sometimes they make a direct appointment and this patient hasn't had any consultation before, hasn't talked to any employee, hasn't been through any reception [...]. (P5)

Yes, it is a big problem [...] *we separate some medical records and there are some people who come only to get the prescription, and we have been trying to pull the user* [...] *it is a time invested in this delivery of prescriptions and it becomes a difficulty, these people are accessing in a certain way, but only the prescriptions.* (P6)

Behind the "half door" there is a small line with about four people, a user takes the prescription and says to the intern "I am sick and I need an appointment with the doctor". And the intern herself makes the appointment with the general practitioner and the user seems to leave satisfied. (DC)

For the team, it is necessary to rethink the welcoming process, in order to meet all the people who seek CAPS, as well as to offer continuing education processes for the team.

The reception starts at the reception, the interns are very willing, but I think no one trains the girls to receive people there, they don't know how to handle anything, I'm not saying they are therapists, but it starts there, at the reception desk. (P1)

[...] *there are people that, even in health, come here and never did a reception, and how do you do this reception? So we should have this preparation of the team, I don't know if it is a course, but things from outside that come and add to it.* (P2)

There always come those that come directly, those that someone said! But I believe that we have to take a closer look at this, because some you end up welcoming, only that sometimes you welcome the one who makes a scandal in front of you, and the one who accepts it well ends up leaving. And I think that sometimes we have to police ourselves a little, I have already policed myself. Sometimes I have sent him away and I was thinking "why would he come here, what wasn't he feeling? (P3)

DISCUSSION

Hosting is a fundamental health work tool/instrument for mental health care. Welcoming means understanding the human being as a whole, shifting the gaze from an exclusively biomedical idea, which focuses on signs and symptoms and diagnoses of mental illness, to the human being's experience of suffering and complex life issues, which are social, cultural, relational, and contextual.[15]

CAPS provides a welcoming that is resolute, agile, and based on accountability. Moreover, through the statements of U6 and F2, it is possible to realize that the team contributes to the care in freedom of users, inserting them in therapeutic activities, managing crisis situations, and avoiding unnecessary hospitalizations.

The offer of therapeutic activities in territorial services comes from the psychosocial model, in which new care possibilities are valued through art, culture, interaction, and listening. This model opposes the asylum model, which had its origins with physician Philip Pinel, who understood madness only as an illness that should be treated in the psychiatric hospital, through disciplinary actions such as isolation, imprisonment, straitjacketing, and medicalization, in order to normalize the sick.[16-17]

The psychosocial care model criticizes the traditional paradigm of psychiatry, questioning the concept of mental illness and the asylum as a place of treatment. In the psychosocial model, there are new care possibilities and different views for mental health, with care actions offered in a network and in substitutive services, such as CAPS, especially through the welcoming, listening, and understanding of health-disease experiences and social inclusion.[17] In a study carried out in a city in the interior of Rio Grande do Sul, in a CAPS, it was found that this service is effective, and that through group and individual actions, it reduces psychiatric hospitalizations.[18]

In the context of the study, it was identified that some users and professionals criticized the difficulties of access faced by users that assiduously attend CAPS, "house users", as they are called by the participants. The research reveals that "house users" have difficulty in accessing the reception and care with specialized professionals such as doctors, psychologists, and other professionals, as highlighted by P3 and U7.

This difficulty faced, leads to the need to rethink the proposal of CAPS, since the monitoring of the person in the service depends on their social and health needs and not on the fact of

being a new or old user, which may indicate the need for training of professionals, family members, and users to understand this care and organization of the flow inside and outside the service. Another important point is to strengthen the role of Primary Health Care as the gateway to RAPS, offering matrix support for professionals to make referrals consistent with the role of CAPS and offer mental health care in primary care.

If there is no strengthened and qualified primary care for mental health care, CAPS can be overloaded and face structural and human barriers to develop its work. Or even prioritize biomedical and outpatient actions focused on the disease, symptoms, and the provision of pharmacological prescriptions that go against the proposal of the service: welcoming, bonding, interdisciplinary construction, and autonomy of users.

This logic of prescription renewal and outpatient care has been happening in the service and is problematized by the professionals. It is noticed that the access to the service is often restricted to the supply of pharmacological prescriptions, without an adequate follow-up and evaluation of each case. This organization, besides not being in accordance with the service proposal, generates difficulties for the team, such as the time invested by the professionals occupied directly with this task.

In this sense, although the advances produced by the psychosocial mode paradigm have brought a complex understanding in relation to mental suffering, the clinical conception is still influenced by the biomedical paradigm – based on psychopathological pictures, symptom evaluations, and drug interventions.[17,19-20] That is, the strength of the biomedical model is present and promotes reduced interventions that are distant from the real care needs of the subjects.

Outpatient care is also perceived in the service from the centrality of care in the figure of the physician. From this flow, an overload of the physician is observed, and the collective construction of therapeutic projects and the participation of the professional in other activities of the service are not visualized. Another scientific study also identified a possible overload of the physician, due to the high level of medicalization, individual consultations, and provision of prescriptions, which hindered the participation of the professional in other activities in the service and in the territory, reinforcing the biomedical model.[20]

In another study, carried out in a CAPS III, failures were also identified in the welcoming process in relation to the understanding of psychological suffering and whether the multifactorial dimension involving lack of social support, unemployment, loneliness, and neglect, as well as problems with the side effects of medications, fragility in the establishment of a bond, failures in the construction of a PTS that considered the user's abilities, possibilities, challenges, and interests. The care was focused on the psychiatrist and the medications.[5]

From this perspective, the professionals revealed necessary and ongoing movements in the service in order to break the barriers of access in the welcoming process. For P3, it is necessary to listen to the user, breaking with casted flows that force the user to seek primary care to be received by the CAPS technical team.

As possible paths to qualify the access and welcoming, the professionals point to the need for continuing education processes within CAPS that include all professionals, since the welcoming starts at the reception desk of the service. P1 pointed out that it is necessary to welcome the new professional offering information about psychosocial care, about the actions offered and about the welcoming process, providing better conditions for the professional to provide care.

The scientific literature points to the need to institute processes of continuing education and professional qualification as a way to advance in effective care practices and in line with the psychosocial model, avoiding the manicomial discourses and practices in substitutive mental health services.[9,17-20] It is understood that it is necessary to innovate in processes of continuing education in CAPS and RAPS, and it is up to professionals and managers to take on the commitment to activate training spaces, identify partners in the intersectoral network, and maintain continuing education as part of the work activities.

CONCLUDING REMARKS

This research highlighted the need for permanent review of the processes of embracement in the access of users to CAPS in order to strengthen care practices focused on the subject, on their health needs, and on the assumptions of the psychosocial paradigm. The users and family members approached the importance of the welcoming process as resolutive, fast, and powerful for the reduction of psychiatric hospitalizations.

From the perspective of the challenges, we identified actions focused on the biomedical and ambulatory model, with little investment in interdisciplinary resources. It was also identified movements to break the chains of the hospitalization process and the need for spaces for continuing education for the team to perform more effective care focused on interdisciplinary and networked actions.

Finally, the contributions of this research can support workers and managers to eliminate possible barriers to access and to implement mental health care as a human right in specialized and strategic services such as CAPS, which offers treatment and social inclusion in line with the assumptions of the Brazilian Psychiatric Reform. Thus, it is necessary to understand the processes of care as dynamic, political, social, and cultural, arising from a scenario marked by advances and setbacks, being necessary to constantly review the ways of welcoming and ensuring access to services offered by CAPS.

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