

Andréia de Fátima Nascimento¹

Ana Tereza Costa Galvanese^{II}

Evaluation of psychosocial healthcare services in the city of São Paulo, Southeastern Brazil

ABSTRACT

OBJECTIVE: To describe infrastructure, human resources, and care approaches in psychosocial healthcare services.

METHODS: Descriptive study including 21 psychosocial healthcare services for adults affiliated to the local health department in the city of São Paulo, Southeastern Brazil, conducted between 2007 and 2008. Information about infrastructure of facilities, human resources available and patient care was collected using a standardized instrument. There were performed descriptive data analysis and chi-square test to test the association between care activities and service source and location.

RESULTS: Ten services were first created as outpatient clinics and later adapted, eight were day hospitals and only three were created as psychosocial healthcare services. None of them was open 24 hours a day. Half of them were located in rented buildings with inadequate infrastructure especially for group activities. Staff composition was very different among services, with emphasis on on-site group activities and little integration to other health services. All services provided mostly arts and cultural activities. Earlier outpatient services provided mainly craft activities and former day-hospitals offered mostly psychophysical integration activities. The profile of activities varied according to the geographical distribution of services.

CONCLUSIONS: Current heterogeneous character of psychosocial healthcare services seems associated to the history of mental health care programs that have been implemented in São Paulo since 1980s and to social, economic and cultural differences in different areas of the city. Different psychosocial care approaches were found ranging from on-site care with little integration with other health services to services that refer their users to other services after symptoms become stable in an attempt to create a network of mental health care.

DESCRIPTORS: Mental Health Services. Structure of Services. Health Personnel. Material Resources in Health. Health Resources. Health Care Level. Mental Health.

¹ Departamento de Medicina Social. Faculdade de Ciências Médicas da Santa Casa de São Paulo. São Paulo, SP, Brasil

^{II} Departamento de Medicina Preventiva. Faculdade de Medicina. Universidade de São Paulo. São Paulo, SP, Brasil

Correspondence:

Andréia de Fátima Nascimento
R. Cesário Motta Júnior, 61
6º andar – sala 11 – Vila Buarque
01221-020 São Paulo, SP, Brasil
E-mail: andreiafn@yahoo.com.br

Received: 11/19/2008
Revised: 04/23/2009
Approved: 04/30/2009

INTRODUCTION

The first psychosocial healthcare service (CAPS) in Brazil was created in the city of São Paulo in March 1987 on account of the country's political redemocratization and a process of re-examination of conceptual framework models. New conceptual frameworks brought about the introduction of new mental care and financing models that gained momentum in Latin American and especially in Brazil⁷ in the late 1980s. In 1989 the Psychosocial Healthcare Centers were established in Santos.⁴ They were directly originated from the

Basaglian tradition of deconstructing the asylum model, which has influenced the establishment of CAPS as the building blocks of care for patients with severe chronic mental conditions in the community.

The *Ministério da Saúde* (Brazilian Ministry of Health) Decree No. 224 of January 29, 1992 established the roles of partial hospitalization services and CAPS.^a Decree No. 336/GM^b (02/19/2002) established that CAPS should focus their care actions on adults, children, and adolescents with severe chronic mental conditions, and substance abuse. CAPS for adult care should include the following types of services: CAPS I, CAPS, II and CAPS III, from lower to higher complexity/size and population coverage.^b These three types of public services have the same role and their priority should be to provide care to patients with severe chronic mental disorders in their community on an intensive, semi-intensive or non-intensive basis. Day hospitals are not mentioned in this decree. There has been a considerable growth of CAPS over the last two decades. In July 2006, there were 1,220 specialized mental rehabilitation services in Brazil.^c In October 2008, the state of São Paulo had 196 CAPS, of which 48 were CAPS I, 64 CAPS II, 17 CAPS III, 22 CAPSi (for children and adolescents), and 45 CAPSad (for substance abuse treatment).^d The city of São Paulo, in February 2009, had 53 CAPS affiliated to the city health department, of which 25 were CAPS for adults, 16 CAPSad, and 12 CAPSi.^e

The most recent Brazilian studies assessing quality of mental health services, especially CAPS, have focused on the implementation of these services⁸ or they are qualitative studies evaluating a single service.⁶ Few studies have developed instruments to assess these services regarding satisfaction of users and family with care provided,² and others have focused on characterizing CAPS clientele.¹

There are many issues involving the implementation of CAPS designed as a “synthesis service” gathering together all different levels of care in a single unit within local health systems. It is important to assess how adequate CAPS setting is for mental health rehabilitation in the community and to what extent these services may be deviating from their original role and becoming outpatient services that provide extensive care to chronically ill patients. Mbaya et al⁵ (1998) conducted a one-day survey in ten day hospitals in the

United Kingdom and found that, although most services were originally described as focused on mental health rehabilitation, in fact more than half of their patients with psychotic disorders received psychotherapy but were not enrolled in rehabilitation programs.

The city of São Paulo has a peculiar history regarding care of patients with severe chronic mental illnesses. In the 1980s, the State Health Department promoted the expansion of outpatient mental care clinics. In 1987, the first CAPS in Brazil was created in the city of São Paulo and became a landmark as a care option to replace the almost all exclusive approach of hospital treatment. In the early 1990s, a new mental care model was implemented in the city. Attention to patients with severe mental conditions would be provided preferentially at day hospitals during crises and at outpatient clinics for disease follow-up. Mental rehabilitation activities would be carried out preferentially at the Centers for Socialization and Cooperatives (CECCO). The introduction of the Health Care Plan (PAS) by the mid-1990s completely ruined this mental health program: day hospitals and CECCOs continued to exist but they operated as isolated units with no connection between them. Starting from 2002, with local strengthening of the *Sistema Único de Saúde* (SUS – National Brazilian Health Care System), there has been an increasing number of CAPS in São Paulo.

In the light of that, in parallel to the recent restructuring of SUS and mental care services in the city of São Paulo, the objective of the present study was to describe CAPS operation as for their physical infrastructure, human resources, and activities.

PROCEDURES FOR ANALYSIS

A study on the CAPS infrastructure and activities provided as part of adult patient care was conducted in the city of São Paulo, Southeastern Brazil, in coordination with the city's Health Department. Twenty-one out of 22 CAPS I and II operating by December 2007 participated in the study (one CAPS refused to participate). Five CAPS were located in the north area of the city, two in the south, four in the midwest, five in the east, and five in the south. There were no CAPS III. The study was based on guiding principles proposing the evaluation of three dimensions: infrastructure, process, and results.³ Ethnographic observations and semi-

^a Ministério da Saúde. Decree No. 224, pf January 29, 1992. Establishes guidelines and regulations for mental health care. *Diario Oficial Uniao*. 30 Jan. 1992; Seção 1;1168.

^b Ministério da Saúde. Legislação em saúde mental. 2. ed. Brasília; 2002.

^c Cadastro Nacional de Estabelecimento de Saúde. Brasília; 2006 [updated 2006 Jul 01; cited 2006 Jul 14]. Available from: <http://cnes.datasus.gov.br>

^d Ministério da Saúde. Número de Centros de Atenção Psicossocial (CAPS) por tipo e UF e indicador CAPS/100.000 habitantes – Brasil, 31 de outubro de 2008. Brasília; 2008 [cited 2009 Feb 23]. Available from: http://portal.saude.gov.br/portal/arquivos/pdf/caps_por_uf_e_tipo_31_outubro_2008.pdf

^e Health Department of the City of São Paulo. Relação das unidades da Secretaria Municipal de Saúde por Coordenadoria Regional de Saúde e Supervisão Técnica de Saúde do Município de São Paulo. São Paulo; 2009 [cited 2009 Apr 20]. Available from: http://ww2.prefeitura.sp.gov.br/arquivos/secretarias/saude/organizacao/0005/Unid_Munic_Saude_SupervisaoTecnica.pdf

structured interviews with service staff were carried out to assess care processes. A cohort study including users receiving intensive care, i. e., who went to the CAPS three or more times per week, was conducted to evaluate results.^a Data were collected at each service using a standard questionnaire with questions about physical infrastructure of facilities, human resources, admission, follow-up, and discharge protocols, and activities provided in-site and outside CAPS. The data collection instrument was completed by the study team with information provided by service managers or a professional staff person during the week of ethnographic observation. Data were double entered using EpiData software and then checked for consistency. Data was collected from April 2007 to April 2008. All activities provided at CAPS were grouped into empirical categories constructed over the study based on their approaches and purposes. A descriptive analysis was carried out and the chi-square test was performed to test the association between CAPS activities and service background and location.

All service teams were informed about the study objectives and procedures and service managers agreed with the participation of their facility in the study. The study was approved by the Research Ethics Committee of the Health Department of the City of São Paulo (Protocol No. 0306/06 – CEP/SMS).

ANALYSIS AND DISCUSSION OF RESULTS

Of 21 CAPS studied, ten were originally established as outpatient clinics (four located in the north area of the city), eight were originally psychiatric day hospitals (three located in the east area) and only three were CAPS. The background of services was quite mixed; some went through all three different types of organization and others were created from the merger or splitting of preexisting services.

Physical infrastructure

Eleven CAPS operated in rented buildings (houses); some buildings had inadequate room distribution as well as in-site access areas. All other CAPS operated in the city's Health Department buildings. CAPS that were originally outpatient clinics operated in large buildings with many offices for individual consultations and few adequate rooms for group activities while others operated in adapted rented houses with limited space. Eleven CAPS operated in two-storey buildings and ten of them did not have access for people with special needs. Only two CAPS had semi-industrial size kitchens where income generation activities were developed; all the rest had only regular-size home

kitchens. The number of offices ranged from one to seven (median = 2); the number of rooms for group activities/workshops ranged from one to six (median = 3); and the number of rooms for management ranged from one to four (median = 2). All CAPS had room for outdoor activities and 17 of them had a special room for providing care during crisis.

All services kept patient records and other information and patient records were completely legible in 14 CAPS. Some services had daily records of users' attendance to CAPS and their involvement in activities and others had only specific records including first consultation, management, changes of treatment plan, and description of crisis.

Human resources

Many different professionals worked in the capacity of service manager: psychologists (in 11 CAPS), psychiatrists (in four), occupational therapists (in four), social workers (in one), and nurse (in one). Four CAPS did not have occupational therapists and two CAPS did not have social workers in their staff. Eleven CAPS had at least one pharmacist in their staff. All CAPS had at least one psychiatrist, although in one CAPS there was only one psychiatrist who worked in the capacity of manager and was in charge of all patient consultations. More than half of CAPS had at least four psychologists in their team and the mean number of nursing providers (assistants, aids, and specialists) was six per service (Figure 1). In only one CAPS a psychiatrist worked in the capacity of manager and most providers were females.

Only seven CAPS had professional supervision. Team meetings were carried out on a weekly basis except in three CAPS where these meetings were on a daily basis.

Types of care

Seventeen CAPS provided care to walk-in patients and referrals, and all the remaining services provided care only to patients referred from other services. As for referrals, 14 CAPS had one provider in charge of referrals and three CAPS had a small team of providers in charge of referrals. Users' meetings took place at 16 CAPS. Treatment plans at five CAPS did not include a discharge protocol. At six CAPS users were discharged but these facilities were their reference service and they could be seen at the service without having to go through triage. At six services users were discharged and referred to primary care units. Understaffing of mental health providers and inadequate referral system were the main difficulties pointed out as preventing user discharge from the service.

^a Nascimento AF. Percorrer e conhecer: como são os Centros de Atenção Psicossocial do Município de São Paulo. Cadernos Brasileiros de Saúde Mental (Anais do I Congresso Brasileiro de Saúde Mental) 2009; 1(1). [cited 2009 Apr 20] Available from: <http://www.congressodesaudeamental.ufsc.br/>

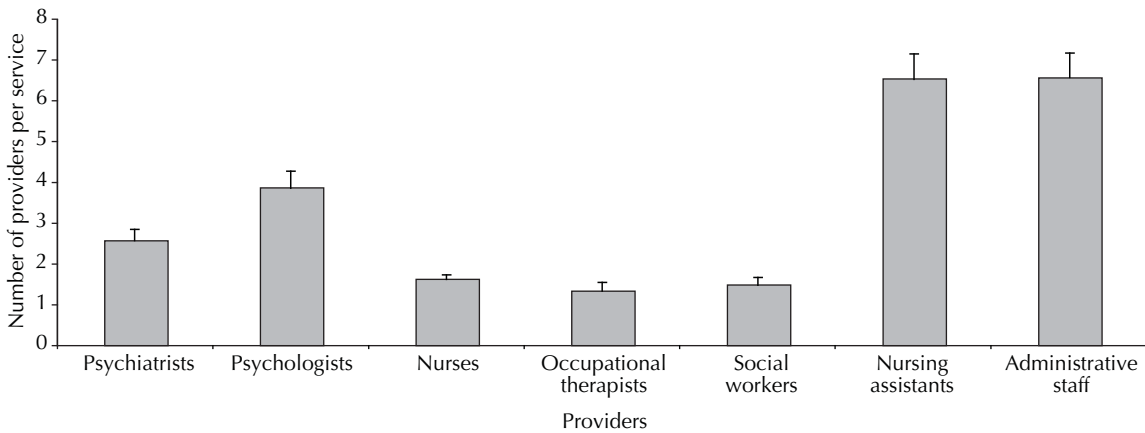


Figure 1. Means and standard errors of the number of providers at psychosocial healthcare services. City of São Paulo, Southeastern Brazil, 2007-2008.

A wide variety of activities were provided at CAPS. The main types were: in-site group activities; group activities developed outside CAPS (in the community); individual clinical consultations; individual therapy sessions; family consultations; home visits; follow-up care; and organizational activities.

In all CAPS, during the study period, there were seen 457 in-site group activities categorized as follows: arts and culture (arts, cultural, body expression, and music activities); psychotherapy (including verbal groups and other types of psychotherapy, clinical/therapy group follow-up, and community therapy); socialization-related activities (reunions, outing groups, and other support groups, play activities, and social gatherings); craftwork; income generation; physical and psychophysical integration activities; daily life activities (self-care, cooking, vegetable gardening, and gardening); and other mixed groups (age-specific, citizen's rights, and others).

The type of activities provided was associated with CAPS original background (Figure 2). The majority of activities offered at CAPS are arts and culture; however, services that were originally outpatient clinics offer mostly craftwork activities and services that were day hospitals offer mostly psychophysical activities ($p=0.02$). There were also seen different types of activities by city area: in the north area most were craftwork and in the south most were socialization activities (Table; $p<0.001$). In all CAPS, more than 20% of group activities were arts and culture.

There were seen 41 group activities involving the community in the CAPS area of coverage, of which 31 were physical and/or socialization activities and ten were cultural activities. They were generally carried out at CECCOS, local clubs, cultural centers, and libraries.

GENERAL CONSIDERATIONS

CAPS for adult care affiliated to the city's Health Department showed diverse organization and operation characteristics. As for infrastructure, facilities were quite different physically. Team staff also comprised many different providers; some services had mostly psychologists and others had providers with diverse backgrounds. The *Ministério da Saúde* Decree 336^a establishes that CAPS II team should consist of at least one clinical psychiatrist, one mental health nurse, four licensed providers including psychologists, social workers, nurses, occupational therapists, educators, or other providers involved with mental health care; and six mid-level staff including nursing assistants, and administrative, education, and craftwork staff. It can be noted that the mean number of psychiatrists at CHMS is well above the recommended as well as the total number of other licensed providers (especially psychologists). The number of mid-level staff was also well above the recommended minimum.

There was also a variety of in-site group activities. In some CAPS, these activities were mostly craftwork workshops (sewing, crochet, upholstery); in other services these workshops focused on psychophysical activities (lian gong, tai chi) and or psychotherapy approaches. The different profiles of activities may be due to local area differences and different socioeconomic conditions of the community where CAPS are located and the availability of health, leisure, sports, and culture resources in the area. In addition, service background also influenced the approaches used at services. Services that were originally outpatient clinics in 1980s and then became CAPS put an emphasis on craftwork activities, which have been traditionally included as part of care of stable patients with severe chronic mental illnesses. Services originally created

^a Ministério da Saúde. Legislação em saúde mental. 2. ed. Brasília; 2002.

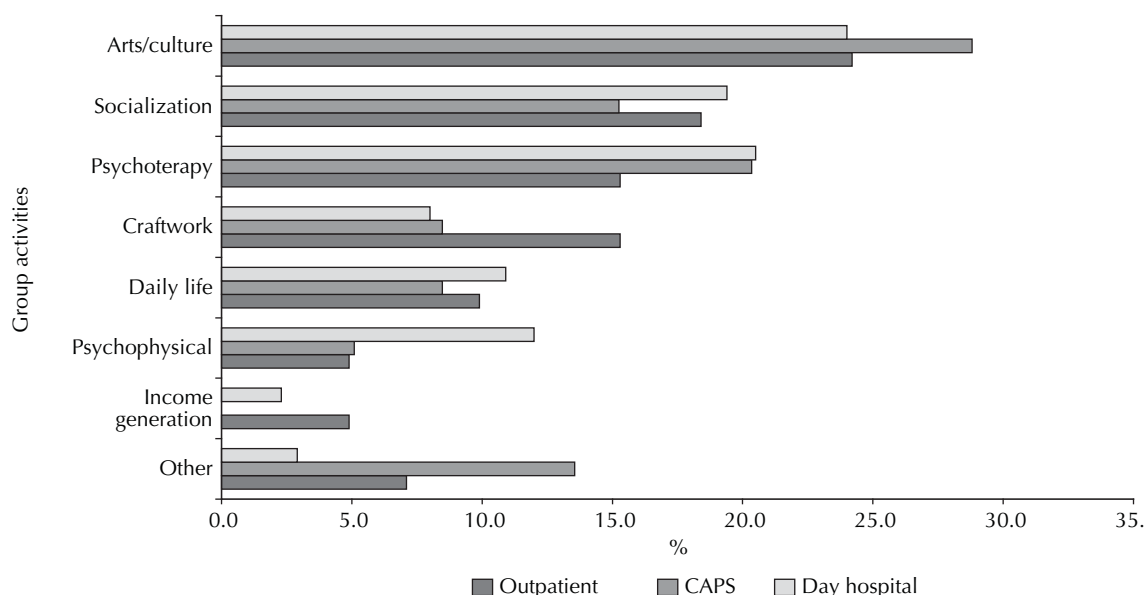


Figure 2. In-site group activities provided at psychosocial healthcare services, by service background. City of São Paulo, Southeastern Brazil, 2007-2008.

as day hospitals continued to provide many activities based on psychophysical approaches, which can be provided during crisis when patients have marked disorganization. CAPS in the city of São Paulo do not have a linear common development: some services were outpatient clinics until 2002 and became CAPS; others were day hospitals or were created from the merger of day hospitals and outpatient clinics, and others resulted from the splitting of other services. In many instances the transition from the original model of operation (outpatient clinic or day hospital) has been incomplete. Many staff persons still answered the phone by saying “day hospital” or “mental care outpatient clinic” and the same is true for the signs at the front of the facility.

Another major factor explaining the diversity of activities provided at CAPS is that they are developed and implemented based on provider’s skills and preferences, as reported by managers or other professional staff when they were asked about CAPS objectives and methods. While non-standard activities can offer room for creativity and customized approach, they can paradoxically create a significant gap between what is offered by the service and what users need. Services providing many handmade activities (e.g., craftwork) may not be as attractive to young people and males who are culturally not interested in this kind of work. On the other hand, services focusing on group psychotherapy approaches can be disappointing to those looking for an occupation or inclusion in other daily life settings.

Table. In-site group activities provided at psychosocial healthcare services, by city area. City of São Paulo, Southeastern Brazil, 2007-2008.

Activity	City area											
	North		Midwest		South		East		Southeast		São Paulo	
	n	%	n	%	n	%	n	%	n	%	n	%
Arts/culture	30	21.9	21	24.7	9	23.7	25	27.5	28	26.4	113	24.7
Craftwork	25	18.3	5	5.9	2	5.3	7	7.7	14	13.2	53	11.6
Daily life	18	13.1	8	9.4	4	10.5	6	6.6	10	9.4	46	10.1
Income generation	10	7.3	2	2.3	0	0.0	1	1.1	2	1.9	15	3.3
Psychophysical	7	5.1	12	14.2	2	5.3	4	4.4	10	9.4	35	7.7
Psychotherapy	10	7.3	24	28.2	5	13.2	22	24.2	21	19.9	82	17.9
Socialization	29	21.2	7	8.2	13	34.2	21	23.1	14	13.2	84	18.4
Other	8	5.8	6	7.1	3	7.8	5	5.4	7	6.6	29	6.3
Total	137	100.0	85	100.0	38	100.0	91	100.0	106	100.0	457	100.0

CAPS managers and professional staff reported mainly in-site activities. Activities provided outside CAPS and family activities were often not considered “CAPS activities.” Organizational activities (e.g., team, mental care, and board of directors meetings, and participation in mental health forums) were not included in the schedule of activities at most services. These activities are most likely not recognized as work or they are not considered to have the same relevance. It may indicate that services are more concerned with what goes on within their facilities in detriment of their inclusion in the community area. Few CAPS had common activities and most treatment plans involved only in-site activities

Many professional staff reported difficult coordination between mental health and rehabilitation services and other health resources as a major obstacle to patient discharge. Divergence was seen between services regarding discharge after patient follow-up at CAPS and again it can be observed the overlapping of care models. Some CAPS had taken up the position of “synthesis service,” where users would always be

provided care regardless of the level of care required and would not ever be discharged. But other CAPS were concerned about patient discharge and referral to other services was considered during the development of the treatment plan at admission. They prioritized care during crisis or symptom exacerbation using an approach similar to that of day hospitals. The availability of only 22 CAPS for adult care in a city with nearly 10 million people make the idea of CAPS as “synthesis service” quite unfeasible because they are always operating over the limit. The overall poor condition of all other mental health resources in the city (understaffing of mental health providers, inexistence of admission and user referral systems) make it difficult or either unfeasible follow-up of users outside CAPS. It is a deadlock situation that service teams must resolve.

It is expected that the analysis of information obtained from ethnography observations of services and interviews with professional staff can help further understanding the different proposed models of CAPS implemented in the city of São Paulo.

REFERENCES

1. Andreoli SB, Ronchetti SSB, Miranda ALP, Bezerra CRM, Magalhães CCPB, Martin D, Pinto RMF. Utilização dos Centros de Atenção Psicossocial (CAPS) na cidade de Santos, São Paulo, Brasil. *Cad Saude Publica*. 2004; 20(3): 836-44. DOI: 10.1590/S0102-311X2004000300021
2. Bandeira M, Pitta AMF, Mercier C. Escalas da OMS de avaliação da satisfação e da sobrecarga em serviços de saúde mental: qualidades psicométricas da versão brasileira. *J Bras Psiquiatr*. 1999;48(6):33-44.
3. Donabedian A. The seven pillars of quality. *Arch Pathol Lab Med*. 1990;114(11): 1115-8.
4. Lancetti A, Kinoshita RT. Sistema de Saúde Mental da Prefeitura de Santos. In: Kalil MEX, organizador. Saúde Mental e Cidadania no Contexto dos Sistemas Locais de Saúde. São Paulo: HUCITEC; 1992. p.232-7.
5. Mbaye P, Creed F, Tomenson B. The different uses of day hospitals. *Acta Psychiatr Scand*. 1998;98(4):283-7. DOI:10.1111/j.1600-0447.1998.tb10085.x
6. Mostazo RR, Kirschbaum DIR. Usuários de um centro de atenção psicossocial: estudo de suas representações sociais acerca de tratamento psiquiátrico. *Rev Latino-Am Enfermagem*. 2003;11(6):786-91. DOI: 10.1590/S0104-11692003000600013
7. Onocko-Campos RT, Furtado JP. Entre a saúde coletiva e a saúde mental: um instrumental metodológico para avaliação da rede de Centros de Atenção Psicossocial (CAPS) do Sistema Único de Saúde. *Cad Saude Publica*. 2006; 22(5):1053-62. DOI: 10.1590/S0102-311X2006000500018
8. Ribeiro SL. A criação do Centro de Atenção Psicossocial Espaço Vivo. *Psicol Cienc Prof*. 2004;24(3):92-9.

Research funded by the *Ministério da Saúde* (Brazilian Ministry of Health) and *Conselho Nacional de Desenvolvimento Científico e Tecnológico* (CNPq – Proc. nº 554513/2005-6).

This article underwent the peer review process adopted for any other manuscript submitted to this journal, with anonymity guaranteed for both authors and reviewers. Editors and reviewers declare that there are no conflicts of interest that could affect their judgment with respect to this article.

The authors declare that there are no conflicts of interest.