The texture of the collective construction of mental health indicators in Psychosocial Care Centers

A tessitura da construção coletiva de indicadores de saúde mental em Centros de Atenção Psicossocial

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ABSTRACT Psychosocial Care Centers (CAPS) are community services that aim to promote rehabilitation for people with mental suffering. Quality assessment can be measured through mental health indicators, a field that is under development. This study is an experience report that has the discourse objective of the process of collective construction of mental health indicators of a CAPS Adult and CAPS Alcohol and Drugs in a health region of the city of São Paulo, carried out in the period between 2020 and 2021. As a result of these, the work indicators of the process were collectively created: articulation with primary care and crisis care and the specific result indicator for each CAPS: psychosocial rehabilitation. The collaborative construction of the mental health analysis process and the reflection on the indicators-evidence of the potential of the participatory elaboration of the assistance individuals of the work and of each service. It was identified in this construction as the availability of challenges, gap in the training of professionals, course of specific literature and pauses due to the contingencies of the COVID-19 pandemic.

KEYWORDS Mental health. Health status indicators. Mental health services.

RESUMO *Os Centros de Atenção Psicossocial (Caps) são serviços comunitários que visam promover a reabilitação psicossocial para pessoas com sofrimento mental e com problemas recorrentes do consumo prejudicial de Substâncias Psicoativas (SPA). A avaliação da qualidade desses serviços pode ser medida por meio de indicadores de saúde mental, campo em desenvolvimento. Este estudo é um relato de experiência com objetivo de discorrer sobre o processo de construção de indicadores de saúde mental de um Caps Adulto e Caps Álcool e Drogas de uma região de saúde da cidade de São Paulo, realizado no período entre 2020 e 2021. Como resultado desse trabalho, foram criados coletivamente os indicadores de processo: articulação com a atenção primária e atenção à crise e o indicador específico de resultado para cada Caps: reabilitação psicossocial. A construção colaborativa proporcionou a análise e reflexão sobre o processo de trabalho, evidenciou-se a potencialidade da elaboração participativa dos indicadores de saúde mental que impactou na revisão da prática assistencial individual do trabalhador e de cada serviço. Identificou-se desafios nesta construção quanto à disponibilidade de agenda, lacuna na formação dos profissionais, escassez de literatura específica e pausas no percurso devido às contingências da pandemia Covid-19.*

PALAVRAS-CHAVE *Saúde mental. Indicadores básicos de saúde. Serviços de saúde mental.*

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Introduction

The Psychosocial Care Centers (CAPS) are mental health services aimed at serving the population with severe and persistent mental disorders, as well as with needs resulting from the harmful consumption of alcohol and other drugs. They offer assessment care, crisis care, daily and intensive care on a community and territorial basis. They are made up of a multidisciplinary team working in an interdisciplinary way with the aim of promoting psychosocial rehabilitation processes. Thus, they have different modes of operation depending on the scope of the population enrolled in the territory and the profile of this population[1].

These services were implemented in Brazil in the 1990s as one of the products of the consolidation of the Brazilian Psychiatric Reform (RPB), an important social movement composed of mental health workers, family members and users, in the fight for rights and changes to mental health care, previously guided by hospitalization, isolation and violence. As a result of RPB's struggle process, there is a substantial increase in the number of Caps in the country, from 424 in 2002 to 2798 in 2020, an increase of 659.91%[2].

Accordingly, as evidence of a territorial and community-based network, there was a reduction in psychiatric beds in the Unified Health System (SUS), and, in the period between 2002 and 2020, 37,464 beds were reduced. Also, as a stimulus to deinstitutionalization strategies, the Return to Home Program (PVC) showed an increase in the number of beneficiaries between 2003 and 2014, resulting in an increase of 2083.5%. These are some of the data that express advances in the constitution of a substitute network for the asylum model[3].

Thus, as strategic components of the Psychosocial Care Network (RAPS), the CAPS present complex processes of work organization, participation and management, and the organizational arrangement is a daily challenge. Based on the reformulation of the mental health care model, as well as its expansion and maintenance, the literature points out that evaluative processes can serve as an instrument to enhance practices that replace the asylum model, improve work processes and health care[4].

Tanaka[5] points out that evaluation is a technical-political process of power struggle that strategically assists in decision-making in the face of a problem. Since the RPB is a social movement in constant renewal, it becomes relevant to continue articulating the processes of struggle with the most diverse actors. Thus, research centered on clinical practice and technical-political action can contribute as a tool of resistance, production of knowledge and affirmation of the effectiveness of this care model.

In addition to drawing attention to the evaluation as a technical-political process, Tanaka et al.6 highlight that in the Brazilian scenario there is a large production of data in health services, but these are little valued or used for the qualification of care and management. It is understood that, when used in evaluations, the data produced undergo a valuation, which even corroborates the attribution of meaning in the proper completion of these and the possibility of more frequent analyzes in the daily life of the services contemplated here.

It should be noted that, in the field of mental health, the follow-up of the quality of care process, linked to health indicators, is still not widespread and applied. According to Furtado4, the tradition of indicators in mental health is more restricted when compared to other areas, such as primary care and hospital care. Added to this is the strongly ethical and political character of the psychiatric reform and the consequent difficulty in establishing consensus around some parameters and minimum indicators between social actors inserted in different poles.

Regarding the production of evidence about evaluation processes in mental health services,

a literature review[7] identified that most of the studies carried out in Brazil were concentrated in the South and Southeast regions, and the CAPS were the most evaluated services, despite the reduced number of evaluations in services such as the Psychosocial Care Center – Alcohol and Drugs (CAPS-AD) and the Psychosocial Care Center for Children and Adolescents (CAPS-IJ), signaling the need to expand the discussion and develop new studies.

In this sense, the experience report of this work brings as reference the study carried out by Onocko-Campos et al.[8] that presents a set of indicators aimed at monitoring, evaluating and potentially qualifying the CAPS III, developed by the collaboration between evaluators linked to two universities and 58 workers and managers of type III CAPS, in the state of São Paulo. This study marked the beginning of reflection on the process of constructing mental health indicators for CAPS.

Thus, the aim of this study is to discuss the experience of the process of collective construction of mental health indicators for CAPS Adult and CAPS-AD in a health region in the city of São Paulo.

Material and methods

Study type

This is a descriptive, qualitative study, of the experience report type, which is dedicated to describing the experience of workers and managers in the course of building indicators of process and result that can collaborate for the evaluation of substitutive services of the RAPS of the SUS.

Contextualization

In the experience reported here, the construction of indicators emerged as an express need of the management of the partner institution that coordinates CAPS Adult III, CAPS-AD III and CAPS-IJ II. This proposal was developed by the local management collegiate – space occupied by representatives of workers, managers and institutional technical support, and which main objective is communication and exchange of knowledge, analysis of information and decision-making to improve the work processes of the units.

This journey began in the second half of 2020 and ended in the second half of 2021, totaling one year of investment in this work. This experience was developed in two CAPS (Adult CAPS and AD) located in a health region in the city of São Paulo. The territory in which the CAPS are located covers three health districts with high social vulnerability.

Data collection steps

The experiment was organized in six stages. *Table 1* illustrates the creation path common to all services, highlights the stages, objectives and resources used.

Table 1. Indicator construction process common to all services

Steps	Goals	Resources	Responsible
1) Immersion in the theme of indicators.	Acquire and deepen the knowledge on evaluation themes ,focusing on their typologies.	Separate agenda and physical space, computer connected to the internet, zoom platform, class with a specialist from the institution's technical area.	Management Board, Technical area of the partner institution.
2) Data collection and ideas for building indicators in services.	Unite elements of theory with everyday practice combined with the production of meaning for services.	Separate agenda and physical space, computer connected to the internet, zoom platform, group dynamics technique: brainstorm .	Collegiate manager, CAPS -AD and Adult teams.
3) Bibliographic survey on mental health indicators.	Continuity of the immersion process, in addition to identifying studies already carried out and seeking support experiences.	Separate agenda and physical space, computer connected to the internet, zoom platform, search for scientific articles and book chapters published in scientific databases.	Management Board
4) Meeting with invited specialist from the academic area.	Share the path for creating indicators, impressions of the creation process and listen to successful experiences.	Separate agenda and physical space, computer connected to the internet, zoom platform.	Technical area
5) Meeting between the three units.	Share creative processes and define common process and specific indicators, of results, for each service.	Separate agenda and physical space, computer connected to the internet, zoom platform, scientific articles and book chapters.	Management Board
6) Local meeting in each unit.	Definition of local strategies for developing indicators and finalizing the collective path.	Separate agenda and physical space, computer connected to the internet, zoom platform.	Management Board

Source: Own elaboration.

In steps 1, 2 and 3, the first stage was to identify the critical points in the routine of services, the practical use of indicators and their feasibility. Accessing the barriers for carrying out this task required the involvement of the different actors in this process, in order to capture the aspects that indicated the real need for services, with the objective of ensuring the use of indicators in clinical practice and not just compliance with the institutional request.

To support the discussion and decision, in step 2, data from the partner institution's information system were used with the demonstration and construction of a possible calculation formula for these indicators. One of the analyzed data was the crisis care, raising the debate about the crisis care services handled in the CAPS and the services referred to the urgency and emergency network.

In step 4, there was a meeting with a researcher in this area who provided the deepening of the theme and the sharing of knowledge on the process of creating service indicators. In steps 5 and 6, the use of two process indicators common to the three services and a specific result indicator for each CAPS were defined.

It is important to emphasize that the steps were not built a priori, they were all part of the identification of needs that occurred at each meeting.

Results

The task was well received even in the face of the challenge of the institutional request and its great complexity, as services had never before addressed something similar; the identification of the need to go deeper into the subject was unanimously identified in order to make it possible to build indicators that would actually contribute to the fields of action. An institutional collaborative partnership was then created between the two services for the production of common mental health indicators, but guaranteeing collective spaces for local dialogues to address the specificity of each unit, with the intention of contemplating the evaluation of the care provided. The urgency of training gave rise to the need to accumulate specific knowledge with researchers who experience this process.

The construction of theoretical/practical knowledge was facilitated by a specialist from the technical area of the institution on indicators and their use in the health area. The types, calculation formulas and construction of their definitions were discussed. After this meeting, a specialist from the academic field was invited to report on her experiences and successful research with the construction of specific mental health indicators. From the contact with the specialist, it was decided to continue the training process that consisted of a survey of the literature in the area, in order to support the construction of the indicators. As a result of the collaborative partnership, two process-type indicators were created, common to the two CAPS, and a result-type indicator for each.

We used as a reference Donabedian cited by Tanaka[9], who classified the indicators as follows: Structure, Process and Result indicators. By definition, process indicators relate to the analysis of the set of activities developed during the provision of care, relating categories such as performance, energy, strength and work; outcome indicators, on the other hand, are related to direct events in users and signal changes (desirable or undesirable) in the health status of individuals or populations.

The chosen process indicators were: articulation with Primary Health Care (PHC) and crisis care, presented with the calculation formula in *figures 1 and 2* below. The perspective of articulation with the PHC was defined based on the use of local data in order to analyze shared practice as a strengthening of network care, since the literature indicates the effectiveness of collaborative and shared practices in health care management through a pedagogical-therapeutic proposal[10].

Figure 1. Formula for calculating the articulation indicator with APS

$$\frac{\text{Number of shared services}}{\text{Number of matrix actions}}$$

Source: Own elaboration.

Figure 2. Crisis attention indicator calculation formula

$$\frac{\text{Number of users in a crisis situation that were referred}}{\text{Total number of users in a crisis situation}}$$

Source: Onocko-Campos et al.[8].

In the Adult CAPS, for example, a documental analysis was carried out which contains the description of matrix actions with the Basic Health Units (UBS). In 2020, there was a tendency to use case discussion as a priority in matrix support strategy, to the detriment of shared actions. We obtained a comparison of 215 case discussion actions, such as telephone calls or face-to-face meetings, and 57 shared actions, such as consultations and home visits.

Next, the construction process of specific outcome indicators for each health service will be reported.

Adult CAPS

At Adult CAPS, the process began with the management committee, using the brainstorming technique with the objective of providing a space to all those involved in the process to speak freely, in order to clarify professional practices. The committee was composed of the unit manager, the senior nurse, a psychologist, an occupational therapist, an institutional supporter, a nurse and two nursing technicians. Subsequently, the committee was divided into pairs of professionals to collect and analyze the data that supported the situational diagnosis carried out in the daily routine of the service. Finally, the discussion was extended with the presentation of data in two meetings, the definition of points of intervention and the creation of the indicator. This form of organization encouraged the active participation of all members of the collegiate, in addition to the deepening and theoretical alignment on psychosocial rehabilitation and health indicators.

The psychosocial rehabilitation indicator was chosen by CAPS Adult based on the need for workers to look at the therapeutic path in the historical series of the service itself, in addition to analyzing whether there was an expansion in the dimensions of the subject's spheres of life.

The professionals' perception of the scarce use of clinical tools for evaluating and satisfying users and families regarding treatment at this service was discussed.

The formula for calculating the effectiveness of psychosocial rehabilitation processes was designed as a result indicator. Dimensions to be measured were indicated, such as work, criticism about health conditions, housing, relationships, citizenship and composition of the social/community network, according to *figure 3*.

Figure 3. Calculation formula for the CAPS Adult psychosocial rehabilitation indicator

$$\frac{\text{Number of users who achieved the results os the proposed actions according to selected dimensions}}{\text{Number of users who achieved at least two dimensions of care out of the three selected}}$$

Source: Own elaboration.

Dimensions of care

1. Housing: actions carried out related to Activities of Daily Living in the personal and environmental scope, in addition to how they relate to their peers and family.

2. Work: ability to carry out actions to generate income and improve the quality of life and funding of basic needs.

3. Social network: way in which the user transits through the territory, relates to the environment and other people, leisure activities and well-being.

Initially, the need to make changes and reformulations in the formatting of the Single Therapeutic Project (PTS) in the information system was highlighted, in order to describe data on the dimensions mentioned above. In this way, meetings were held with technicians responsible for formatting the information system with the intention of including questions, boxes, temporal comparisons and even indices to compute data on the dimensions.

So far, there has been no progress in the active construction of the CAPS indicator process due to the creation of a healthcare contingency plan, in view of the territory's needs during the COVID-19 pandemic.

CAPS-AD

The choice of the CAPS-AD result indicator was based on the meetings of the unit's management committee, which at the time was composed of the unit's coordinator, the technically responsible nurse, two occupational therapists, a social worker and an administrative assistant.

Several topics were raised and considered important, such as: Street CAPS actions; harm reduction practices; crisis assistance; collaborative and intersectoral care and promotion of contractuality. This group, anchored by the theoretical framework of psychosocial rehabilitation, chose to focus on assessments that would be able to indicate whether this service is fulfilling its ethical, technical and political mandate as an operator of mental health policies.

To this end, the following question was delimited: 'Is the CAPS-AD care offer capable of contributing to the expansion of the contractual capacity of the monitored users?'. From the construction of the question, the collegiate began an investigation into psychosocial rehabilitation and contractual power. An online document was created and shared with all the people involved in the process and, from then on, the theoretical framework began to be defined. In this document, clippings of scientific productions were inserted that guided the construction of the indicator, from the perspective of psychosocial rehabilitation[11,12].

With the clarity of the theoretical framework of psychosocial rehabilitation, autonomy and contractual power, the group committed itself to building an instrument that would contribute to capturing data, since the existing data in the information system were not capable of measuring this construct. The instrument was built by pairs of professionals and later, three meetings with the entire management collegiate were necessary for adjustments, such as the use of accessible language to reach service users.

The choice was made to incorporate sociodemographic data into the instrument that dealt with aspects of the social determination of the health and disease process so that the data analysis was more robust and complete.

The instrument was divided into three axes: address with 07 items, social network with 18 items and work with 08 items, thus totaling a questionnaire with 33 items. All utterances were written in the affirmative, in the present tense of the indicative. The answers will be measured using a likert-type scale, where the option that most closely matches/identifies the user's situation at that moment will be marked with an 'x', with the options: 'I really don't agree', 'I don't agree', 'indifferent', 'agree' and 'agree a lot'.

The application will be given to users who have recently arrived at the service and are in their first service to build a PTS. After six months, the same instrument will be applied to users who remain in follow-up. The evaluation criterion will be the comparison of the user with himself, as shown in *figure 4*.

Figure 4. CAPS-AD psychosocial rehabilitation indicator calculation formula

$$\frac{\text{user score when starting treatment}}{\text{user score after six months of treatment}}$$

Source: Own elaboration.

Discussion

The institutional proposal is in line with the shortcomings expressed in the literature, which identifies a gap with regard to the creation of mental health indicators as part of the service evaluation process.

The initiative and resources mobilized so that the workers could build the indicators served as a guide for practices and approximation of actions. The collaborative meeting with workers from different services was also powerful, as one of the effects of the process was the articulation between the two CAPS, generating recognition of the work processes of each service, of the different mental health clinics, thus collaborating for the strengthening of RAPS in this territory. Partnerships and collaboration networks are present in different contexts, such as academic, scientific, corporate and personal, which aim at exchanging information. In them, social actors engage together, even if they are in different locations, work in an interconnected way and share ideas and propositions in a team/community/network[13-15].

The issue of praxis in this construction was elucidated, as a unit between theoretical and practical activity, in a dynamic and dialectical way. As Demo16 points out, the practice is concrete and historical, and in this way it is committed to reality, bringing new dimensions to scientific knowledge, since

We do not exhaust reality, nor do we have the truth in our hands; we are just researchers and social actors, people who doubt, who make mistakes, who misrepresent, but who, knowing this, want to reduce the mistake[16(103)].

Along the way, there were difficulties in organizing agendas for collective meetings to deepen the theme and allocate time for individual study. Thus, the workers involved in this process needed to spend an extra workload. By way of comparison, in the study by Onocko-Campos et al.[8], professionals from a CAPS III prepared themselves in a 120-hour course to compose the process of developing health indicators.

It was found that, among the professionals involved, there was a reduced accumulation of knowledge on the topic of indicators. It was observed that those who obtained some knowledge were due to approximations with research programs such as multi professional residencies and graduate programs. Allied to this, there was a lack of publications that are intended to measure specific results of the clinic of each service. So, it was necessary and decisive to achieve the proposed task to deepen knowledge and resume the theoretical dimension in daily practice.

In this sense, it is necessary to highlight the need to expand Continuing Education (CE) actions aimed at transforming professional practices based on critical reflection on real problems[17]. Assis[18] reflects on the importance of CE actions carried out within the scope of

the SUS for the qualification, awareness and best practices of professionals. The construction of this knowledge and the proposal of CE actions also show the importance of participatory management spaces that allow dialogical exchanges, which was understood as a positive point in the experience reported here.

The need for continuity of this process is indicated with future readings and analyzes of the indicators, so that it is possible to measure processes, formalize data and generate evaluations that direct or redirect strategies allied to the health needs of the population and existing resources. In this way, it is understood that the evaluation based on the constructed indicators can help to make each equipment closer to its reason for being, exercising its political and assistance role in RAPS. This possible design points to the potentialization and systematization of a culture of research and evaluation within the services and, in a macro-political view, the expansion of evaluative research in the field of mental health.

Another relevant and innovative aspect is the use of indicators in clinical practice for PTS management and evaluation, together with the user, of the historical series of their path in the network. It is believed that the use of indicators will make it possible to reflect on the potential, advances and achievements of users, as well as signaling necessary points for the qualification of care practices.

It is expected that, with the use of the results shown by the indicators, the monitoring of the functioning of the CAPS will be qualified, since currently the evaluations are based mainly on quantitative data, such as the number of procedures performed. This form of evaluation is due to the current tendency to apply tools commonly used in private services, with mercantilist logic, with the results achieved associated with benefits or penalties according to the performance of each organization or each worker[19]. The association of other neoliberal characteristics has direct consequences on the experience of workers in these institutions, whether on work relations or on the organization of work processes, which may affect the quality of the service provided[20].

A breakthrough that took place in August 2012 was the change in the CAPS procedure table based on Ordinance No. 854, Brasil[21], which defines the use of the Record of Outpatient Health Actions (RAAS) instrument in psychosocial care. This ordinance qualifies the information related to the services provided by the CAPS, based on a care network with an emphasis on rehabilitation and social reintegration. It included as a procedure several actions already carried out in the routine of the service, such as: promotion of contractuality in the territory; psychosocial rehabilitation actions; strengthening of protagonism; matrix support; and harm reduction actions and articulation of intra and intersectoral networks[18].

Parallel to this advance, what has been sustaining the agenda organization, clinical decision-making, the evaluation of professionals and the service, with an important impact on the daily lives of professionals, is linked, in large part, to the institutional analysis by number of procedures carried out by the RAAS.

There is a need to explore the number of procedures concomitant with health indicators, with the objective of producing an analysis of the impact of the service on the territory, the effective change in the care model that surpasses the quantitative production and manages to demonstrate the impact of psychosocial rehabilitation.

Psychosocial rehabilitation, according to Saraceno[12], is understood from the idea of rebuilding the full exercise of citizenship and social contractuality in its three scenarios: home, work and social network. Contractuality will be determined, first, by the relationship established between users and the professionals who serve them, and then by the ability to develop projects, that is, practical actions that modify the concrete conditions of life in which goods and values are produced and exchanged,

provoking the construction of new networks and new relationships between social actors and the social network[22].

The complexity of this intervention is not limited to just one point of attention within RAPS, nor will it be represented by one procedure/action. It summons all the actors involved in the creation of a set of intersectoral 'assessments' that guarantee a more reliable reading of the impact on the user, service and territory. Therefore, what is intended here is to contribute to the complexification of the current way of evaluating mental health services based on clinical practice.

It is important to point out that this process of building local indicators had considerable pauses in 2020 – 2021, due to the new configuration of services. This configuration resulted from the creation of a healthcare contingency plan, in view of the needs of the territory during the COVID-19 pandemic, and agreed between the Health Department and the Regional Coordination of Mental Health of São Paulo. The Caps were reconfigured for a psychiatric hospitalization service, since the general hospitals and Emergency Care Units (UPA) in the territory were exclusively destined for COVID-19. The new scenario provoked a change in the scope of services and in the performance of professionals and caused the active construction of the process of CAPS indicators to be put on pause.

Final considerations

The process of building indicators showed gaps in the training of professionals with regard to: typology of indicators, relationship between indicators and professional practice, how to build an indicator, state of the art of indicators in mental health and how to measure what is intended with the indicator. Thus, one way to reduce the gap found was to guarantee permanent education for the participants of the management collegiate. Although this permanent education was not comprehensive for all service professionals, it was important for understanding and implication in the demand.

Even though the specific permanent education process on indicators was restricted to some workers, there were developments that affected the team in order to identify the need for training processes involving topics such as gender identity, psychosocial rehabilitation and race/color. Another factor highlighted during the process was the scarcity of publications related to this topic, especially materials on outcome indicators. This, combined with the gap in the training of professionals, made the journey more difficult and time consuming.

The analysis of the care practice, provoked by the trajectory of approximation with the indicators, favored the team to understand that sometimes the work process becomes mechanized, thus producing a distancing from the understanding of the needs of the subjects and their territories and the simplification of certain attributions of the clinics, such as psychosocial rehabilitation, understanding of the health and disease process, construction of an expanded PTS, promotion of contractuality, matrix support, among others.

Mechanization, combined with the simplification of care practice, tends to generate automatic responses that approach the offer of services focused on the individual and on the selection of activities that can compose the PTS from the 'menu' offered by the equipment. Thus, the multiple estrangements provoked by this process were understood as tensioners of changes, both in the individual practice of each worker and in the services as a whole.

One obstacle was the need to spend extra hours of work, thus placing this task as an additional demand for care professionals. However, it is understood that care professionals can also manage, increasing the meaning of everyday practice and thus reducing the distance between 'who thinks' and 'who does'[23].

It was found that there is still no well-established equation between the relationship of providing care and management. Therefore, the way in which services are organized today

does not favor involvement in management processes and the maintenance of care practices without causing harm to users and wear and tear to workers.

It is considered that by being part of this elaboration, the professionals stressed the creation of a participatory and horizontal process, which did not cease to be conflicting and permeated by power relations.

The construction of process indicators for crisis care and matrix support and psychosocial rehabilitation results tend to generate evaluations of services in order to bring them closer to their ethical, technical and political mandates, such as mental health services based on the principles fundamental aspects of SUS and RAPS.

The aim of this work is to stimulate the unique construction of services such as the CAPS with regard to participatory processes of management and organization of work processes, as well as to support the use of indicators for a critical and problematizing assessment of obstacles in the implementation and completion of this care model.

Collaborators

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