

## Violence social representations and teaching strategies used by undergraduate nursing professors

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### ABSTRACT

The discharge in mental health services has a psychosocial rehabilitation connotation and articulation with network devices to promote continued attention in the territory. The aim was to assess the discharge process of users in Psychosocial Attention Centers (CAPS). A qualitative and evaluative study, based on the Fourth Generation Assessment. It was conducted in a CAPS II in Santa Catarina, with 17 workers, 14 family members and, five users, in 2014. We used the Constant Comparative Method to analyze the data. We comprehended the discharge process as an important psychosocial rehabilitation process, promoting care in the life territory of users. Our study question of admissions being chronic in CAPS, as services, should not keep accompanying users for long periods of time, but to be transitory, allowing care to get stronger in other points of the network, narrowing links with the primary attention and with the other social equipment from the territory.

**Descriptors:** Patient Discharge; Mental Health; Health Evaluation; Mental Health Services; Psychiatric Nursing.

### INTRODUCTION

The discharge theme in mental health accompanies modifications in the assistance model. Its definition still is strongly linked to the hospital model and its ideal for a cure. However, discharge, in our study, is connected to the psychosocial attention context, which separates it from the biological meaning, which refers to the cure of the psychiatric pathology. Here, the discharge has the connotation of psychosocial rehabilitation, production of life and articulation with many devices in the health network to promote continued attention to the user in the territory. According to few studies<sup>(1-5)</sup> one of the fundamental points to advance in the discharge process is the presence of a flexible, agile and resolute network, which gives

support to the user when discharged. Therefore, it is important to occur the planning of the discharge process, in a way that the subject can access the network according to his specific need, and this is the fundamental point for de-institutionalization<sup>(5)</sup>.

In this sense, the Mental Health Commission of New Zealand pointed few strategies to develop mental health services, within them, the improvement of flows between primary and specialized services, which is needed to keep the focus on rehabilitation, promoting integration in the network, efficiently providing provision of services. These actions should be present in all network, and not only in one service. For that, teams should promote the discharge of users from specialized services, strengthening the construction of partnerships and relationships in all network points. It intends to guarantee an effective transition of the subject once users who are not able to bind to teams to which they are transferred have more difficulty to adhere to treatment after discharge<sup>(6-8)</sup>.

Therefore, the promotion and to reinforce the bond between teams is important to broaden access, dialogue and responsabilization for mental health demands. At the moment that the network is articulated, with qualified attention for all points, professionals, as well as, users will feel safer to promote the discharge; allowing individuals with psychic disorders to receive care in their life territories, breaking the stigma that mental health attention occurs only in specialized services.

It is important for the user to be clear about opportunities and benefits that discharge will provide, allowing to build new bonds with people and services, broadening the social network. Practices focused on the user's autonomy should be present in the daily routine of CAPS teams, and the discharge as a resource contributes to users in taking their lives back independently.

Considering the discharge process phenomenon in the psychosocial context, it needs to be understood and deepened. Therefore, our study aimed to assess the discharge process of users of a Psychosocial Attention Center.

## METHODS

Qualitative research with evaluative characteristic, case study type, and it is a cut of the research Assessment of Psychosocial Attention Centers from the South Region of Brazil, in its first and second edition (CAPSUL I and II)<sup>(9-10)</sup>.

The present study had the fourth generation assessment as methodological referential, which can be defined as an assessment model with questions, requests, and worries of groups of interest. They serve as organizational focuses and, they are implemented according to methodological precepts of constructivist investigation<sup>(11)</sup>.

The fourth generation assessment constitutes a 12-step flow to develop the evaluative process. The first step is to hire, that is, to make the formal contract with the participant or institution, in our case, with the CAPS. The 2<sup>nd</sup> is to organize, aiming to select and train researchers, to organize the logistics and, the fieldwork. In the 3<sup>rd</sup> step, we try to identify groups of interest and also to elaborate strategies to search for

participants. The 4<sup>th</sup> step is defined by the generation of conjunct constructions in the groups, through the creation of hermeneutical circles. The 5<sup>th</sup> step aims to broaden the conjunct constructions of interested people using new information, and it is possible to use documental information and also to interact with interviews and the observation data. The 6<sup>th</sup> step tries to select non-resolved questions, separating them as components of a case report. The 7<sup>th</sup> foresees to prioritize non-resolved questions. The 8<sup>th</sup> step is the collection of information, with the objective to increase the level of clarity. The 9<sup>th</sup> step aims to prepare the agenda for negotiation, and, the 10<sup>th</sup>, to negotiate. The 11<sup>th</sup> step aims to advertise the results. And, the 12<sup>th</sup> step is the Data Recycling, that aims to recycle the process as a whole<sup>(11)</sup>.

In our study, we developed the Data Recycling, which allows the researcher to deal with issues brought by other cycles, trying to deepen information, the questions, and concerns of the previous assessment processes<sup>(12)</sup>.

Initially, we analyzed the two CAPSUL study editions, which provided aids to assess questions involving discharge processes of CAPS users in the years when they were developed, 2006 and 2011. Based on analyses of interviews with users, family members and CAPS teams, and still, on field diaries contemplating service observations, we defined and organized the Data Recycling step.

We developed the study at CAPS II of a large city in the state of Santa Catarina. Three researchers collected data, and they observed the service, registered observations in field diaries and, conducted Data Recycling Groups (DRG). This step occurred in April of 2014, during two weeks in the field. In the first one, they performed field observations, registries in the field diaries, totalizing 100 hours of observation; in the second week, they conducted DRG, introducing questions regarding the discharge process identified on databases from CAPSUL I and II, and the observations from the first step of the Recycling week.

To guarantee the anonymity of participant's identity, we identified information according to the following sources: Field Diary of Data Recycling (example: FD1DR), numbered from one to three, referring the three researchers. We identified Data Recycling Groups by the initial letter of the respective group of interest (DRGU: users; DRGFM: family members; DRGW: workers).

The DRG's lasted approximately two hours, with the participation of three researchers, and of each participating group: users, family members, and team workers, separately. We performed them in workshop rooms and groups of CAPS II. One researcher conducted each group, while others were making registries in their Field Diaries. We used a multimedia projector and a notebook to present the questions introduced to the group. The meetings were audio recorded, and after transcribed by the researcher.

We conducted the data analysis using the Constant Comparative Method<sup>(13)</sup>, which allows analyzing data simultaneously to its collection. It presents two distinct steps: the first consists of identifying the information units, which serve to define categories, and we obtain them through the collection of empirical material. The second consists of categorizing aimed to aggregate all units that are related to the same content in temporary categories, aiming at the internal consistency of categories.

We identified three thematic categories: Permanence time in CAPS; Prepare for discharge and Care

continuity in the territory. And the central empirical category: Discharge Process. For the present study, we opted to present a cut of the results, in what refers to the comprehension of discharge as care transfer.

The Data Recycling step was approved by the Ethics in Research Committee of the Medical Faculty of Universidade Federal de Pelotas (Protocol nº 750.144, 2014). We respected the ethic norms of research with human beings, according to the Resolution 466/2012 from the Brazilian National Health Council of the Health Ministry<sup>(15)</sup>.

## RESULTS

Understanding that there is no mental health consensus to use the term discharge for users, we opted to present our study results from the approach assessment from users, family members, and CAPS professionals, comprehending and using the term discharge as “Care transfer”. Study participants indicated this conception of discharge as the closest definition to what they want to translate the term “discharge” for the mental health field, discharge from CAPS, specifically in this case.

### Care transfer: a new comprehension about discharge

Professionals question the term “ discharge” from CAPS:

*I think that the discharge [...] I think that from all of us here, from mental health, it is a thing that does not exist, even because it is a disease that needs to be treated in the long term (DRGW).*

*We refer to the discharge meaning when the person is cured (DRGW).*

Therefore, the definition proposed by CAPS workers arise: care transfer:

*To me, discharge is the transfer of care (DGRW).*

*Also to me, to the Basic Health Unit (BHU) and for life, for the both (DGRW).*

*I see it this way, for few, the discharge is about the meaning of life, to return to work, to leave here and build a life outside here (DGRW).*

*For few, I see as not stigmatizing him as “ he has a mental disorder, he is going to stay his whole life at CAPS” . He is stable, but will not be able to go back to work, but he does not handle other activities, but not even because of this he needs to stay inside CAPS as it was in the psychiatric hospital! Because I see that families still have this difficulty, and even many professionals, that simply substituted the psychiatric hospital for the CAPS. He left the hospital, but he needs to stay inside CAPS (DGRW).*

Workers comprehend the care transfer surpassing the user referral to another service but refers to transfer to life so that the person can return to daily activities:

*But there is a difference in not being encapsulated and to be disconnected from the service. Because many times, the discharge means “ let’s cross the subject out of the map” . But at least he is not encapsulated, the subject is included, he can be included, he is included, but he is not encapsulated (DGRW).*

There is a clear positioning that CAPS should be transitory in the user’s life:

*CAPS is not a place to stay. When the user is stable, goes to the territory.*

*Change of the term “ discharge” – when you say discharge, the user thinks to be free from treatment (FD1DR).*

For the transition between the mental health service and the primary attention, it is necessary to have a dialogue between the teams and to include the user in this process:

*When I was prepared for discharge here, but outside I was being accompanied in the BHU, and I was doing workshops occupations there too, until a certain time. I was not like, take me from here and go home and take medication alone. There was an accompaniment by the BHU closer to home (DGRU).*

And for the care transfer to be possible, it is important to have the family engaged in care:

*I think that we need to improve a lot the family inclusion issue, I think that in the attention, in the treatment here, and especially when going to discharge. We note that when there is a family being part of the treatment here, coming to CAPS for the family meetings, then when you perform the discharge process, the family has comprehension of the disease, the family notes that and it facilitates a lot to care for this user at home, they will care for the medication, it will always have a person to be as the caregiver (DGRW).*

*So, the family participation is fundamental (DGRW).*

*We see the patients discharged, that have their family situation very round-up, they hardly come back (DGRW).*

*Those who participate in the therapeutic process as a whole makes a huge difference. Huge! Hardly comes back [...] And those who we know, they are discharged, and there are not even six months passed, and the patient is back here. One year maximum! (DGRW).*

*It is a great emotion when the patient is discharged, especially like my son who stayed a long time. Discharging him was impossible. He would not leave the crisis; It was very difficult until the regulated the medication (DGRFM). My son stayed in CAPS for eight years. [...] He always accepted, he takes the medication always correctly [...], and after eight years he was discharged. Today he is free; I am very emotional. [...] My son is at home for a good while, and he did not need more admissions [...] he has the therapy there at the BHU (DGRFM).*

According to the users' GRDs, one of the impeding factors for discharge was the interruption of the medication treatment:

*One thing that might prevent discharge is not to do the correct treatment, to start not taking the medication [...] Because if doing the correct treatment and if having a good accompaniment, inside here, as well as, from the family outside, it helps a lot (DGRU).*

As a counterpoint, in many situations, the person who demonstrates insecurities to promote the care transfer of users is the CAPS team, as they are afraid to transfer them:

*I think they have to get out; I don't think it is healthy to stay in CAPS. How many times it happens, adequated, but continued staying inside here, without us noticing, it is not healthy, but it happens a lot that they stay years and years here. There are family members who want that; this is not an asylum, you can't turn here into a mini asylum, they have a home, we have to be providing that, this family conviviality and not the opposite (FD1DR).*

One exit mentioned by workers for the territorial insertion of users is the creation of a conviviality center in the community. It is evaluated as an important device to potentialize care transfers and, besides

that, it extrapolates the referral logic to health services only.

*We start to perceive some holes in the network, because, for example, we don't have a conviviality center, where they feel a bit safe, to free CAPS a little bit, but to leave for the conviviality center. But we just have one therapeutic residence in the city; we don't have a conviviality center (DGRW).*

Through the analysis of results, we assess that CAPS users discharge should not be only connected to the referral to another health service, and it is comprehended as care transfer, that can be done to the BHU, to another service, to the community, and life.

CAPS should be a transitory service for users and not a place for long stays, and at the moment when they are stable, they should follow their trajectory in other points of the health and social networks.

Dialogue is important to users, their family members and the health teams, so all are engaged in the discharge process, and they feel safe regarding the flows in the territory.

## DISCUSSION

Care transfer constitutes of a new comprehension about the discharge of mental health users. Participants from our study problematized this question, as they comprehend that when using the term "discharge", they refer to the meaning of cure. And being discharged in the mental health field surpasses this comprehension, as care in this context should be longitudinal, in networks and different health services and other institutions, beyond the conception that only specialized services contemplate mental health.

When the care transfer is conducted in the CAPS for primary attention, it is important to have a dialogue between the teams, so the user safely transits between services. At the measure that the teams keep the co-responsibility for their user's demands, they learn about their live's histories, context and social network, their fragilities, needs, as well as, their potentials, and they will be able to give integral support to the user, surpassing the health issues.

The user can be afraid to be transferred from one service to another when not feeling safe regarding the provision of their needs. A study conducted in Dublin with 150 psychiatric patients attended in a mental health community center pointed that 98% of them preferred to go to a specialized psychiatric service, even when stable in their treatment. It occurs due to the fear of not receiving adequate psychiatric attention, which can significantly restrain the capacity of specialized mental health teams to have new primary care referrals<sup>(8)</sup>.

In a study conducted in Japan, another aspect indicating a barrier to discharge is the lack of accompaniment during the transition of the hospital discharge from the psychiatric ward to the continuity of community mental health care, and it can increase the probability of crisis recurrence or re-admission in hospital services<sup>(1)</sup>.

The transfer of mental health care advances to the health sector, it is a discharge for life, when the user can choose where he wants his trajectory in the territory to continue, with possibilities to return to their

daily activities that were interrupted with the crisis experience. Thus, it is important for workers, users and family members to have in mind that CAPS is a strategical service for attention when the user is not stable in their clinical case, and during other moments of existence, the user can transit in other places, therefore, avoiding it to become chronic.

The CAPS needs to be constantly questioned about the fact of being a place of insertion, psychosocial rehabilitation and of autonomy rescue, in contrary, there is the risk to reproduce in their interior the same chronic characteristic as the psychiatric hospital<sup>(15)</sup>.

There is the need beyond the theoretical comprehension of the territory, to surpass the barriers of the difference of the social place inhabited by individuals involved in the clinic, having the concept that this is a product of social relations which users are protagonists. The CAPS inserted and constituted as a territory should remain alert to not become a distinct territory, on the side<sup>(16)</sup>. Users should be the focus of any care transfer<sup>(17)</sup>.

Still, family members participative in the treatment continuity, compromised with the emotional and affectionate support to users, are fundamental partners to promotion and maintenance of the discharge. However, one of the challenges of the CAPS team is the constitution of a contract in which family members can feel like actors in a project in a way that this adherence involves promoting a space for negotiation<sup>(15)</sup>.

According to participants' testimonials, one of the barrier factors for the care transfer consists of interrupting the medication treatment, due to the patient feeling cured and, therefore, to suspend the use of psychotropic drugs.

Another impeding factor is the insecurity of workers, users, and family members to promote and to accept the care transfer, which leads CAPS to become a mini asylum, as the workers in this study referred.

It is important for the care transfer to promote the link between the user and territorial spaces: school, neighborhood's associations, leisure spaces, among others so the user can explore other possibilities in life.

The conception of mental health discharge, indicated by participants as "care transfer", is the possibility that most converge to contemplate the subjectivity and integrality of mental health actions, which surpass the health sector, and advance to the territory. The term care transfer gives the idea of longitudinal, accountability, and movement in the health network and social network of users.

## CONCLUSION

The care transfer is an important marker to consolidate the psychosocial attention, as it allows users to advance in their trajectories in the network autonomously and as citizens.

About the referrals in care transfer, it is not possible to formalize a flow of transfers to a unique and uniform territory, as the actions to exit the CAPS should agree with the experience and moment of each user.

Although the CAPS are strategical in mental health care, they should not be services that keep users in continuous and long-term accompaniment; they should be transitory, allowing the strengthening of care in other points of the network, strengthening the bond with the primary attention and with all other social

equipment of the territory.

Our study points as an advance in the possibility to discuss and problematize questions involving the discharge of mental health users, comprehended in this study as care transfer. And also, the question of chronicity of users inside CAPS, when discharge from service is not promoted.

In Brazil, publications about this theme are lacking, and there is a need for new studies about the discharge of users from mental health services and about the consequences of keeping users in continuous accompaniment in the CAPS; without providing other devices, which will point to limits and challenges to break the logic that mental health can only be contemplated by specialized services, thus, strengthening the deinstitutionalization and good practices in mental health.

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