Mental health care based on the psychosocial model: reports of relatives and persons with mental disorders*

ASSISTÊNCIA EM SAÚDE MENTAL SUSTENTADA NO MODELO PSICOSSOCIAL: NARRATIVAS DE FAMILIARES E PESSOAS COM TRANSTORNO MENTAL

ATENCIÓN EN SALUD MENTAL BASADA EN EL MODELO PSICOSOCIAL: TESTIMONIOS DE FAMILIARES Y PERSONAS CON TRANSTORNO MENTAL

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ABSTRACT

This study was performed in 2009 in Curitiba, using the thematic oral history technique. The participants were eight individuals from three different families who had one relative suffering from a mental disorder. The objective of the study was to describe the perception of relatives and persons with mental disorders regarding mental healthcare based on the psychosocial model. The data were obtained through semi-structured interviews, which were then analyzed and organized descriptively. The participants opined that extra-hospital services such as the Psychosocial Care Center and mental health outpatient clinics are innovative strategies. They described receiving assistance from a multidisciplinary team, the mediation of family conflicts, and the principle of territoriality. They highlighted that the individual with a mental disorder is followed by the Basic Health Unit and emphasized the importance of mental health network connections. They believe that including the family in the treatment regime improves family relationships and their acceptance of the disease.

DESCRIPTORS

Mental disorders
Family
Mental Health Services
Psychiatric nursing

RESUMO

Esta pesquisa foi realizada com o método da história oral temática e desenvolvida no ano de 2009, em Curitiba, com oito colaboradores pertencentes a três famílias que tinham um integrante com transtorno mental. O objetivo do estudo foi descrever a percepção de familiares e de portadores de transtorno mental sobre a assistência em saúde mental sustentada no modelo psicossocial. Os dados foram obtidos por meio de entrevista semiestruturada, analisados e apresentados de maneira descritiva. Os colaboradores consideraram os serviços extra-hospitalares, como o Centro de Atenção Psicossocial e os ambulatórios de saúde mental, estratégias inovadoras, e mencionaram o atendimento por equipe multiprofissional, a mediação de conflitos familiares e o princípio de territorialidade. Destacaram o acompanhamento do portador de transtorno mental pela Unidade Básica de Saúde e ressaltaram a importância das associações na rede de saúde mental. Atribuíram à inclusão da família no tratamento a melhora na relação familiar e a aceitação da doença.

DESCRITORES

Transtornos mentais
Família
Serviços de Saúde Mental
Enfermagem psiquiátrica

RESUMEN

Investigación según metodología de historia oral temática, desarrollada durante 2009 en Curitiba, con ocho colaboradores pertenecientes a tres familias con un miembro padeciendo transtorno mental. Se objetivó describir la percepción de familiares y portadores de transtorno mental sobre la atención de salud mental basada en el modelo psicosocial. Datos recabados mediante entrevista semiestructurada, analizados y presentados de modo descriptivo. Los colaboradores consideraron estrategias innovadoras a los servicios extrahospitalarios como el Centro de Atención Psicosocial y ambulatorios de salud mental, mencionaron la atención por parte de equipo multidisciplinario, la mediación de conflictos familiares y el principio de territorialidad. Destacaron el seguimiento del portador de transtorno mental por la Unidad Básica de Salud y resaltaron la importancia de las asociaciones en la red de salud mental. Atribuyeron la mejora de las relaciones familiares y la aceptación del padecimiento a la inclusión de la familia en el tratamiento.

DESCRIPTORES

Trastornos mentales
Familia
Servicios de Salud Mental
Enfermería psiquiátrica

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INTRODUCTION

The hospital-centered model, characterized by overcrowded mental institutions, segregation, guardianship, and therapeutic processes grounded on the lack of care and ill treatment of mentally disabled individuals received deserved criticism after the end of World War 2. Mental institutions at that time were even compared to concentration camps, given the institutions' precarious care and disrespect of human rights(1).

This reality demanded a reformulation of care practices and provoked the proposition of a new model towards caring for the mentally ill: the psychosocial model. However, the consolidation of this model involves the deconstruction of long-held ideas and ways of thinking about mental health, as well as the transformation of practices and manners of speech that continue to reinforce the disease's object-based character. The rationalist, reductionist, problem-solving-based paradigm still shapes our social relationships. Therefore, the deconstruction of the physical structure of mental institutions, together with its institutionalization-centered myths and archaic ways of performing and thinking, must be changed for the collective good(2-3).

The psychosocial model is based on the premise that the effective transformation of reality, where speech, analysis and practice are integrated, grounds the construction of knowledge(2-3). The model is guided by the presuppositions of Brazilian psychiatric reform, which upholds the transformations applied to the theoretical-care-based, juridical-political, technical-care-based and social-cultural fields of mental health care(1,4).

...the implementation and the consolidation of the psychosocial model in Brazil has taken place at a slow pace. The model is still incipient, as it involves rethinking the way traditional psychiatric care...

The theoretical-care-based field has been elaborated on the construction of the existence-suffering concept, as opposed to the disease-cure binomial. This concept questions the subject-object correlation and places the subject in the forefront of care interventions. The practices supported by the psychosocial model embody the subjects' embracement/acceptance, care, emancipation, autonomy and contractual powers(4).

The approval of Federal Law number 10.216 and other legal entities that normalized substitutive services and reoriented mental health care brought clear advancements in the country's juridical-political field. The law also promoted the creation of social control and the organization of supervising commissions comprised of family members and technicians, as well as the participation of the whole community by means of local and state Health Councils(1,4).

In the technical-care-based dimension, this improvement is clearly seen in the construction of a service-based network aimed at becoming real environments favoring sociability, embracement, care and social relationships, no longer associated with repression, surveillance and punishment. The institution now stands out as a place for dialogue and conversation. These services must be carried out by a multidisciplinary team, whose practice must be grounded on the principle of comprehensiveness and based on concepts of networking, territorialization, intersectoral collaboration, social participation and democracy; in other words, an open, articulated service network focused on primary care and on the resources available in the community(1,4).

Innovative strategies carried out by community-based groups/teams for the treatment and embracement of mental illness sufferers, such as the CAPS Psychosocial Care Centers, the Sociability Centers and the Therapeutic Residential Services (TRS), as well as the General Hospital's Psychiatric Units (GHPU), can now be observed throughout the nation. These strategies are aimed at tackling the challenges related to the search for new care strategies and the humanization of relationships among mental illness sufferers, their families and society at large, grounded on the principles of inclusion and respect for human rights(3,5).

The activities proposed by the social-cultural field are related to the transformation of the collective imagination surrounding mental illness. Within this context, the institution is now considered to be a place of freedom, and not one of surveillance and/or violence, and the mental illness sufferer once considered as dangerous and incapable is now viewed as a citizen with the same rights as all citizens(4).

However, the implementation and the consolidation of the psychosocial model in Brazil has taken place at a slow pace. The model is still incipient, as it involves rethinking the way traditional psychiatric care has been carried out for many years, as well as offering a true mental healthcare network in which services are complimentary, articulated and organized(2). One study(5) concluded that this service network is still under the process of construction and still lacks expansion into extra-hospital infrastructure, stimulus for professional qualification, disconnection with any type of prejudice and improvement of people's access to services.

Bearing the above in mind, research regarding this matter is justified by the current transformation experienced within the mental healthcare field, in addition to all of the present discussions about the ways of conceiving, working, thinking and relating to the phenomenon of mental illness.

Hence, this present study aims to describe the perception of family members and mental illness sufferers regarding the concept of mental healthcare grounded on the psychosocial model.

METHODOLOGY

This qualitative-based research approached by the Thematic Oral History methodology was carried out in the Curitiba, Paraná, and Metropolitan areas during the year 2009 with families that had a mentally ill member.

The selection of participants took into account the defining guidelines of *how to conduct research*, based on the Oral History methodology. These guidelines also oriented the interviews. Steps consist of establishing the destiny community, the colony and the network(6:54).

The destiny community is determined by the common, intensely experienced circumstances that bring people together, as well as their relevant consequences, which inevitably end up imposing changes in the group's dynamics(6). In terms of this research, the destiny community is represented by the families that have experienced the treatment of a mentally ill member under the perspective of the psychosocial model.

The colony is the first division of the destiny community, and its objective is to facilitate the understanding of the whole picture and make the implementation of the study feasible(6). Thus, the colony is represented in this research by the families that experienced the treatment of a mentally ill member under the perspective of the psychosocial model and resided in the Curitiba and Metro areas.

The network is the subdivision of the colony and it must be plural. It is believed that the internal differences observed in a group expose diversified ways of understanding a given phenomenon(6). In this research, the network is comprised of families (the *family* here is to be understood as the people surrounding the mental illness sufferer referred to and deemed to be his family) that experienced the treatment of mental illness sufferers prior to 1980, or from 1980 to 1994, and who live in the Curitiba and Metro areas.

In order to establish the network of participants according to the adopted methodology, the coordinators of two associations of families, as well as mental illness sufferers, were contacted and asked to identify participants that would comply with the inclusion criteria. Thus, the included participants – three families, totaling eight participants - were invited and agreed to take part in the research, as shown in Chart 1.

Chart 1 – Characterization of participants - Curitiba, 2009

Families	Members	Age	Age of 1st crisis / year	Marital Status	Participant code
Family 1	Mother Father Sister Eduarda*	61 years 72 years 38 years 40 years	19 years/ 1985	Married Married Married Single	F1Mother F1Father F1Sister F1Eduarda
Family 2	Mother Paulo*	67 years 38 years	23 years/ 1994	Widow Single	F2Mother F2Paulo
Family 3	Mother Gustavo*	66 years 47 years	17 years/ 1982	Widow Single	F3Mother F3Gustavo

* Fictitious names

The inclusion criteria of participants were as follows: families with at least one mental illness sufferer who became ill prior to the 1980's, when a series of occurrences marked the beginning of the psychiatric reform process in the country, up to approximately 1994, when a mental health care network guided by psychosocial principles was effectively established. The family members must have followed the treatment trajectory of the mental illness sufferer, be regarded by the mentally ill family member as their *family* and be over 18 years of age. Those who agreed to take part in the research signed the Free and Informed Consent Form and were instructed as to the goals of the study, as well as the adopted methodology, thus complying with the ethical guidelines advocated by Resolution 196/96 of the National Health Council.

The selection of this time interval is utterly justified, as the authors believe that those who experienced the hospital-centered care model would be able to describe effectively the care received and could thus point out the changes which occurred after the implementation of psychiatric reform.

The project was approved by the Research Ethics Committee of the Federal University of Paraná (UFPR) Healthcare Sciences Department under registration CEP/SD: 617.154.08.09; CAAE 3168.0.000.091-08.

The data were collected from semi-structured interviews guided by a script comprised of identification information regarding the participants, along with two open-ended questions: *How do you perceive the treatment your family member currently receives in the mental healthcare field?* The family's mental illness sufferer was also approached with the following question: *How do you perceive the treatment you receive in the mental healthcare institution?*

The interviews were carried out in accordance with the free time of each participant, and in the places indicated by them (at the Associations or in their own homes). Prior to the beginning of the interview, each participant was asked whether or not they would like to talk about their history in front of or away from the other family members. Some preferred to be individually interviewed; others decided to be interviewed together with other family members. This procedure was utilized with all the participants of the research. In all, five interviews were recorded on cassette tapes (Chart 2) in the period between April and June 2009. Each interview lasted an average of one hour.

Chart 2 – Identification of the interviews carried out with the participants of the study - Curitiba, 2009

Family	Type of interview (collective or individual)	Place
Family 1	1st interview: carried out with the Mother. 2nd interview: carried out with Eduarda, mentally ill family member. 3rd interview: carried out collectively with the Mother, the Father and Eduarda's sister.	Association Home Home
Family 2	4th interview: carried out with Paulo together with his Mother	Association
Family 3	5th interview: carried out with Gustavo together with his Mother.	Association

Each interview was transcribed, contextualized and transcribed according to the oral history's methodological guidelines. The transcription process involved the conversion of the oral history to a written history, exactly as the interviewee stated. The contextualization process refined the material in order to achieve a *cleaner* text. In this phase, the *vital tone* of the interview (Chart 3) – the essence, or the core message that the participant expressed in his narrative - was identified. This process determines what can and cannot be excluded from the text. In the transcreation phase, the text was recreated following a logical rationale validated by each participant, in order to avoid altering the meanings of their narratives. Participants should be able to identify themselves within the results of the text. Such a feature grants quality to the final text(6).

Chart 3 – Vital tones of the interviews - Curitiba, 2009

Interviews	Vital tone
F1Mother	The Primary Healthcare Unit has been caring for my daughter and they are now visiting us at home, something they did not do in the past, and that's good. But I see the lack of available appointments in the mental healthcare's outpatient department as a major difficulty.
F2Paulo and F2Mother	I have been admitted nine times. Just recently I have been able to attend the CAPS, then the outpatient department and later the Association. All these resources were crucial in keeping me stable. He had to be constantly admitted, it was very difficult. For a while, I searched for a type of service that could help him. When we came across the CAPS in 2003, everything changed. He then started to improve and did not need to be admitted again.
F3Mother and F3Gustavo	I used to be admitted over and over again. I believe now that mental illness sufferers should be treated in quite a different way. Most of the therapeutic processes lacked criteria; it was sort of forced on you. Our lives were like hell. After he started taking part in the Psychosocial Care Center (CAPS), we started accepting and understanding the disease. It's been eight years now since he was admitted for the last time.

RESULTS

Data collected from the interviews were analyzed and are descriptively presented. In order to demonstrate how the mental healthcare treatment offered to family members differed following Brazilian psychiatric reform, as perceived by the participants, this study highlights some excerpts of the interviews. Chart 3 shows the vital tone understood from each interview, the narratives of which have been exemplified in this paper.

From the perspective of the participants, the CAPS, the outpatient department, the family associations and the patients are the components that make up the service and the mental health support network. This network, in their view, relates both to the changes that have occurred in health care due to psychiatric reform, the inclusion of primary care and embracement of mental illness sufferers.

> He was admitted nine times. During his worst crisis, I asked God to enlighten me, so that I could find a way to help him understand that he should adhere to the recommended treatment. I followed some news on the television and radio, where they explained that if the person correctly took his medicine he could live a normal life, and that's what I dreamed for him (…) My goodness! One day, a friend of mine that knew a lady who was being treated at the CAPS introduced me to the center. After finding the CAPS, things started to improve. (...) I started attending the Association together with Paulo, because there was a time when he did not want to go there anymore. I told him, 'You cannot quit. If you just stay at home you will get worse, you won't do anything, you can't do this'. I had already participated in the CAPS's workshop and I told him, 'Let's go, both of us, to the association. I want to learn new things.' (…) That's when I started taking part in the association (F2Mother).
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> At the CAPS I was told about the Association. The nurses took me there. Then, I came and I met the president of the Association and started to participate. (…) Well, that was it. I was admitted to a psychiatric hospital, and then I attended the CAPS. Now I attend the Association and the outpatient department (F2 Paulo).
>
> One day, Eduarda was visited by someone from the Primary Healthcare Unit (PHU) in her home. The team was comprised of the doctor, the nurse and the social assistant. I was very glad, because throughout the whole time Eduarda was in treatment I had never seen a healthcare unit member make a home visit. Wow! That was the first time that a Primary Healthcare Unit provided us with support. It's ok now, because if anything happens, they are aware of her situation. This PHU does not have a psychiatrist, but they are supplying Eduarda with the medications she needs (F1Mother).

F1Mother alludes to the outpatient department, but also criticizes the scarcity of available appointments and the delays in receiving care for her daughter:

> (...) then they said that they would refer her to the outpatient department twice a month. But, so far a vacancy has not yet opened up. You see, that was in March. We are now in July and they have not given her an appointment date yet. I believe that if a vacancy finally becomes available in the outpatient department, she will go (F1Mother).

Participants related the decision to take part in treatment and the reduction in number of admissions to psychiatric institutions with the dynamics of the mental healthcare services, such as the Psychosocial Care Centers (CAPS). They also stated that replacement service patients are followed up by a multidisciplinary team, complying with the guidelines of treatment based on a personalized therapeutic program; they participate in several therapeutic activities and understand that this mental healthcare model complies with the principle of territoriality, as can be observed in the following narratives:

> This was the last time he was admitted to a program. It's been eight years since he started treatment with the CAPS. He was one of the first patients to take part in the CAPS Curitiba, he was one of the original patients in the program there (…) I can affirm that those changes worked for the good. I attended the CAPS meetings, I saw their work, what they did there, and everything was done in the open for everyone to see. He made a mosaic shark that won an award in São Paulo. It was very good for him to be at the CAPS (…) We made friends there and those friendships persist today. It's been really good. (F3Mother).

> I contacted the CAPS, we were interviewed and he agreed to be treated. Thank God! That's when I began to feel some relief! He was never again admitted and is now taking the medicine accordingly. He started participating in the CAPS. He used to go every morning and got back home in the afternoon. They provided general care and medical follow up, as well as a psychologist, social assistant and occupational therapist. He began to attend the therapies. That was a relief. I was looking for a service like this for a long time (...) They provided family care, I was always present at the meetings. They scheduled special programs along with the multidisciplinary team. There were several professionals caring for him and they offered him many activities so that he could keep his mind busy. It was very good. I always tried to support him (F2Mother).

> As soon as I left the hospital, my mother introduced me to the CAPS. I did not want to attend it in the beginning. I didn't know what it was. I even told my mother that I did not want to go, but I ended up going there and I'm still there so far, taking care of myself. The CAPS was very good. They had other patients, and we carried out various activities. The lunch they offered us was very good. In the afternoon we had some activities with the educator and the occupational therapist, such as drawing, reading, and gardening. I attended the CAPS from 2003 through to 2004. During this period, they created a system – I can't say if it was a local or state program. The system would transfer any patient attending the CAPS in Curitiba if their home town had a local CAPS. For instance, if a CAPS was launched in [name of a municipality in the Curitiba Metro Area], the patients who used to attend a CAPS in Curitiba had to be transferred. In 2004, I was discharged from the CAPS and referred to the outpatient department. But, as my home town did not have an outpatient facility, I was asked to keep attending the activities at the CAPS. After I was transferred, I had appointments with the psychiatrist in [name of a city in the Curitiba Metro Area] and attended the CAPS once a month. I did this because my city did not have an outpatient facility. (F2Paulo)

> I enjoyed attending the CAPS. I used to take part in activities such as gardening, backing, and playing soccer. On Wednesdays we had theater classes. Activities were well distributed. In addition, each one of us had a personal therapeutic project. Some were involved in gardening; others took care of the kitchen, while others would go shopping at the market. They allowed us to go shopping. I used to stay at the CAPS from 8 a.m. until 4 p.m. I felt good there. I preferred the CAPS rather than being admitted to a psychiatric institution, where I did not feel happy at all, where things were forced on you, where everything was carelessly done (F3Gustavo).

The participants affirmed that the environment shared by both the mental illness sufferer and his family prior to the beginning of treatment at the CAPS was unbearable and was permeated by continuous arguments and struggles. The family was not able to understand neither the disease nor the behavior of the individual suffering from mental illness. However, as soon as the families began to participate in the meetings offered by the substitutive services their sociability level improved, as they started becoming educated and oriented regarding the disease, and also began to share experiences. From this point onwards, they began to accept and understand the behavior and the appropriate way to live with the individual suffering from mental illness.

The participants also explained that the major contribution of the psychosocial model to their lives was the improvement of their sociability levels from the moment they understood and accepted the disease, through teaching and conflict management.

> (...) Prior to attending the CAPS, while he was sick our lives were like hell. We just fought because we thought that he was a mean person. My husband thought he was just bad, and I thought so, too. Then his dad passed away and he started attending the CAPS. They called us [family] to participate in some meetings. The meetings were held every week. That's where we – me and my other son – learned how to treat him properly. In the mental institution they didn't say a word in the family gatherings. They didn't explain anything, just asked us about his behavior during the family leaves and whether he was doing okay. When he had family leaves, when he started getting sick, oh my

> goodness! They fought, but they only fought with each other. They did not beat each other, he has never been violent, but he argued a lot with his brother. Hell of a fight! No one at home could understand Gustavo's problem. (...) That's when we started attending the CAPS meetings, me and his brother. We would go there and, they would teach us there, they talked to us. Then, we began to accept his disease, to understand that he was sick. Now our life is wonderful, we live in harmony. It was like hell before (…) When my other son started attending the meetings he began to understand everything about the disease; we started understanding each other's problems and how they should be treated. I can certainly say that the major advantage of these services has been the understanding of the disease. (F3Mother).

> After he started attending the CAPS, everything began to get better. They met frequently there. I never missed the family gatherings and was always present and supportive of the celebrations. The CAPS showed us each others' situations, everybody tells their stories, talks about their problems, and they explained the issues of the disease, what we had to do. Wow! It was wonderful! (...) It's quite a difficult situation, but I always tried to help him (...) I remember a conversation in which Paulo said that I did not love him, that I admitted him to the hospital because I did not love him. At one of the CAPS meetings I told him, 'I do love you, if I didn't I wouldn't be here providing you with full support. I take you to the hospital because I love you and I don't want to see you on the streets like a beggar, abandoned, suffering, and the only way I could help you was admitting you, because I know that you will be cared for there. It's not that I don't love you'. He seems to understand it better now. (F2Mother)

DISCUSSION

It is possible to relate the satisfaction of both Paulo and his mother with the existence of the substitutive service of the CAPS in their statements. The first Brazilian CAPS – the CAPS Professor Luiz da Rocha Cerqueira, located in São Paulo – was launched in 1987. The experience was later replicated in several cities throughout around Brazil(3). Adhering to the substitutive service model, the Psychosocial Care Centers are open, community-based services maintained by the Unified Health System (UHS) and regulated by Decree 336 of February 19, 2002, which established the guidelines for their operation(7).

The CAPS is held responsible for the acceptance of 100% of mental illness sufferers, especially those with severe, persistent disorders within its territorial boundary, ensuring that responsible, well-trained professionals take part in the activities of the unit and create an embracing environment. This strategic apparatus must coordinate the application of clinical resources, including medication, housing, employment and leisure by means of timely care and psychosocial rehabilitation programs. The CAPSs must aim at rendering daily care to mental illness sufferers, promoting the patients' social reinsertion through intersectoral interventions comprised of education, work, sports, culture and leisure activities(7). These activities are strategies toward the organization of the mental healthcare network, aiming to ease the entrance to the mental healthcare network within the territorial boundary, and to be held accountable for the supervision of mental healthcare in the primary care service(7).

In its turn, the Mental Healthcare Outpatient Department, mentioned by F2Paulo, is a reference to countless psychiatric and psychological appointments. However, its resolution has shown very unsatisfactory results, producing huge waiting lists and lacking effective coordination with the rest of the healthcare network(8). Therefore, the operating mode of the Mental Healthcare Outpatient Department must be reformulated, and its role in the mental healthcare network must be reassessed. This finding corroborates the statement of Participant F1Mother, who mentioned that her mentally ill daughter had been waiting for three months for an appointment in the mental healthcare outpatient service.

It is also worth highlighting that only one of the participants mentioned the follow-up provided by the Primary Healthcare Unit (PHU), which may indicate a challenge to the new mental healthcare model: the articulation between mental healthcare and primary care.

In this sense, if the strategies of group-based assistance, follow-up of the clinical status, home visits, family-based assistance, education, opportunities for dialogue, community-based partnerships and care of the mental illness sufferers within their territorial boundaries based on the matrix support are embodied by the primary healthcare work agenda, this may allow for its coordination with mental healthcare and facilitate the social reinsertion of the mental illness sufferer(9).

Psychosocial care is expected to be organized as a network. In this sense, it is indispensable to integrate the various apparatuses operating within the territorial boundary by interconnecting a series of initiatives and social players that eventually intersect in the process. The PHU is now considered to be a complex service-rendering entity, as it embraces the family in crisis and social relationships. In this sense, the PHU enjoys a privileged place in the construction and guidance of the logic of this new way of caring(1,7).

It should be highlighted that the primary care network has a tremendous potential to identify complaints concerning the various ways in which problems are detected, as well as offer treatment at the primary care facility or referral of patients to specialized services(10).

The participants deemed the Associations of Family Members and Mentally Ill People to be useful and relevant environments for the socializing and joint activities of the families. As an example, among many others all around the country, we highlight the Franco Basaglia

Association, which seeks to provide opportunities for an all-embracing participation of family members by means of cultural, leisure and income generation activities. Thus, these initiatives are permeated with values and meanings that involve people, professionals, volunteers, patients and family members, thus corroborating the statements of both F2Mother and F2Paulo(11).

The received and perceived social support provided by individuals is essential for the maintenance of the mental healthcare network. A strengthened network contributes to social reinsertion and helps individuals to cope with adverse and harmful situations, such as those emerging from having a chronic disease(12).

Another aspect highlighted by the statements of participants F3Mother and F2Mother concerns the adherence to treatment and the reduction in number of admissions to psychiatric institutions owing to substitutive services such as the CAPSs. The statements endorse the findings of the literature, which affirm that the implementation and expansion of community-based healthcare services allow for the interruption in the cycle of admissions, as these services embody actions that aid individuals in the development of new abilities in their search for autonomy and enhancement of contractual powers(13).

A study revealed that some patients receiving substitutive services no longer required admission to psychiatric institutions. Others experienced relapses requiring readmission; however, admissions were less frequent than in the period prior to receiving treatment at the CAPS. Had patients had access to this type of service earlier, a series of admissions may have been avoided(14).

The patient care provided by the CAPS is carried out by a multidisciplinary team. Patients must be provided with a personalized therapeutic plan that is capable of meeting their needs. Group and personal care, therapeutic workshops, physical activities, leisure activities, literacy-based activities, income generating activities, community-based activities and assemblies or meetings aimed at organizing the services, in addition to the provision of medication deemed to play a major role in the treatment, are other interventions included in the CAPS. In all of these activities the family is viewed as the fundamental player in the intended restructuring process. The family is provided with specific care and embraced in all situations(7,15).

Artistic and handiwork activities carried out in the therapeutic workshops are possible ways of socializing mentally ill people. Dance, music, arts, cooking and carpentry are some of the activities, among many other group-centered activities of this nature, which provide patients with opportunities to interact with other patients. In addition to stimulating and preparing them to enter the labor market, these activities allow patients to regain control over their own actions and discover new abilities in their search for independence(15).

The above-mentioned perspective is corroborated by F2Mother's statement:

> We received family care, attended the assemblies- I was always there. We were assisted by the multidisciplinary team, and several professionals assisted him. There were many activities for him to do to keep his mind busy. It was very good.

F2Paulo said:

> The CAPS was very good. They had other patients, we carried out various activities, and the lunch they offered us was very good. In the afternoon we had some activities with the educator and the occupational therapist, such as drawing, reading, and gardening.

F3Gustavo stated:

> I enjoyed attending the CAPS. I used to take part in activities such as gardening, backing, and soccer playing. On Wednesdays we had theater classes. Activities were well distributed. We were assisted by a multidisciplinary team.

Moreover, the substitutive services ought to meet the demand for these services, respecting the principle of territoriality, or the idea of territory, which extends beyond the geographical space, although location is an important element in the characterization of territoriality. However, within the psychosocial context, *it is fundamentally built by the people who live in it, with their conflicts, interests, friends, neighbors, family, institutions, and lifestyle (church, groups, school, work)*(1,7). This standpoint corroborates F2Paulo's reference regarding the transfer of his treatment from the Curitiba CAPS to the CAPS in his home town.

A study carried out with nursing professionals from the CAPS shows that the nurses perceived the Center's services as a turning point in mental healthcare practice, as they were able to go beyond the required technical interventions and get closer to the patients. The nurses also voiced approval of to the composition and work of the team, the inclusion of the patient in his own therapeutic plan and the responsibility shared by the patient in the treatment process and the organization of the service. They reported that the CAPS contributes far more to the mental patient's recovery and social reinsertion process than the psychiatric hospital ever did(16). This finding ratifies F3Gustavo's statement: *I preferred the CAPS rather than being admitted to a psychiatric institution, where I did not feel good at all*.

In light of the above-mentioned perspective, we can infer that the dynamics/role of substitutive services such as the CAPSs surpass the expectations of both the patients and their families. However, it is worth noting that such a large transformation requires professionals to change their attitude by reflecting on their practice. The care provided within the psychosocial model's scope demands that nurses leave behind their hierarchical position as knowledge and power holders and take on a parallel position. This change presupposes the development of a relationship with the mental illness sufferer, understanding that the human being behind the disease is full of potential, relationship possibilities and subjectivity. This change requires professionals to comprehend the power that mental illness sufferers have to restructure their lives. Patients must be viewed as subjects of suffering within their social relationships(14-16).

The participants in this research affirmed that one of the major advances in the psychosocial care model had been the inclusion of the family in the treatment process. In the new model, families do not play the roles of guilty victims or mere informants. This model requires the substitutive services to reformulate the family-based approach. Hence, the services must provide a negotiation space, so that families realize that they are subjects in a project of healing; thus far, the caregiving practice is still very centered on the patient and excludes the family from planned interventions(14).

In this sense, the mental healthcare community-based care services must include interventions that are directed at family members and commit to the construction of social insertion projects, respecting individual possibilities and the principles of citizenship that are able to minimize the stigma of mental illness and promote quality of life and social inclusion of sufferers(7).

The involvement of family and society in the treatment of mental illness sufferers enables deinstitutionalization, as it allows for the construction of a new social structure in which the differences and the individual personalities of each subject are understood and respected. Nonetheless, in order to make this a reality, families must be provided with the necessary tools so that they are capable of contributing toward the maintenance of the mental illness sufferer in terms of extra-hospital services. In their turn, these services must be open to conflict and negotiation(17).

In order to elaborate their feelings, reorganize and reorder their roles within the reality of the illness, families need to receive guidance and support. This means that they must receive adequate information from the professionals concerning the symptoms, the causes of the psychic suffering, treatment models, the approach to the disease and sociability patterns. Whenever the treatment is allied to an experience exchange platform, it favors and improves the family's emotional stability, as well as its understanding regarding the complexity of the illness, and makes possible the sharing/creation of effective strategies to cope with the situation(11,17-19). Thus, F3Mother's narrative, which described the understanding of the family regarding the mental disorder as explained in the CAPS's family meetings as being the most relevant contribution of the psychosocial model following psychiatric reform, is corroborated by literature.

In this way, the new national mental health treatment and care guidelines require healthcare professionals to be prepared to meet the demands and elaborate family-focused issues. Their work, notwithstanding, does not occur in a linear, unidirectional basis, but must be shared, all-inclusive, respectful and willing to offer qualified care that goes beyond the technicist logic that prevailed up to the beginning of the 1980's(17-18).

F2Mother and F3Mother's statements regarding the inclusion of the family into the treatment plan clearly show that the organization of family meetings, assemblies and celebrations are effective strategies toward achieving that goal. This is ratified by a study that illuminates some possible family insertion and care strategies in the new mental healthcare model; for instance, the family group, individual care, the home visit, the participation in assemblies of patients and the other events promoted by the services(20).

Under this perspective, the reality of the family dynamics can be identified and more precise interventions can be brought about, providing the family with the opportunity to express feelings, share experiences, solve problems, and feel supported and cared for, as well as get acquainted with the activities promoted by the service and the therapeutic possibilities made available to them(19-22).

Another relevant quote referred to the substitutive service as a space for managing conflicts. Participant F2Paulo believed that his mother did not love him. Following a dialogue mediated by one of the CAPS's professionals, the conflict was managed and negotiated. The mother-son relationship was greatly improved.

Therefore, the promotion of a place to socialize and manage conflict turns the psychosocial model into a complex process that is not restricted to the restructuring and transformation of services. The new model also encompasses other core objectives, such as the need to transform and overcome the paradigm of the mental institution by means of the implementation of actions and strategies that outshine its institutionalized status(1).

CONCLUSION

In order to comply with the presuppositions of the psychosocial model, institutional care must be grounded on extra-hospital, community-based services that can offer patients opportunities to exercise citizenship, autonomy and social reinsertion, and that can also include families and the society in the discussions concerning the changes proposed by psychiatric reform. All of these aspects were reported by most of the participants, who equated them with progress in the treatment model of mental illness sufferers.

Another relevant consideration relates to a paradigm change in mental healthcare, demanding healthcare professionals at large to reflect upon their actions, as the work provided in this specialty requires the involvement of an interdisciplinary team. In order to make this happen, professionals should be trained to embrace and elaborate intervention strategies that are capable of absorbing the realities of both families and mental illness patients individually.

In addition to their training, healthcare professionals should be aware of and debate the psychosocial model in all undergraduate courses related to the healthcare field. The expanded comprehension of mental disorders is built on the concrete reality in which the mental illness sufferer and his family stand out as important players in all healthcare services. They must be seen as the objects of constant, high quality care.

The expansion of healthcare services, such as the Psychosocial Care Centers, mental health outpatient departments and psychiatric units in general hospitals is an urgent demand in the consolidation of the psychosocial-based care. These healthcare services are to be understood as substitutive, not complimentary to, the psychiatric institution.

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