

Host Process Evaluation in Mental Health in the Midwest of São Paulo: the analysis of the relation between UBS and CAPS¹

Adriano Kasiorowski de Araujo^{Ii}, Oswaldo Yoshimi Tanaka^{II}

^IDepartamento de Práticas em Saúde Pública da Faculdade de Saúde Pública da USP. Av. Dr. Arnaldo, 715. São Paulo, SP, Brasil. 01246-904. <adrianokaraujo@gmail.com>.

^{II}Departamento de Práticas em Saúde pela FSP-USP.

ABSTRACT

This paper reports on the experience of evaluating reception in mental health care in the city of São Paulo-SP. It used interviews with workers from CAPS and UBS. The goal was to understand reception, considering the workers' perception and identifying the bond and network articulation in this process. The method that was used was Philosophical Hermeneutics, to identify which elements of the reception process could be highlighted. The analysis of the narratives was based on three lines of argument: bond, reception, and network articulation. The results emerged in the form of four categories: feeling of *lack*; *mix of models*; primacy of *hard technologies*; and inefficient *integrality*. The discussion showed a relation among these categories, and placed the investment in soft technologies as the center of the debate to overcome the feeling of lack, the mix of models, and for the construction of integrality of care.

Key-words: Evaluation, Mental Health, Reception.

Introduction

Any investigation, of any nature, should emerge from something that troubles the person who intends to make a discovery. Mental Health has always been a very fertile field for discoveries, as it is characterized as an area that raises several questions in those who participate in its universe.

The investigation to which this paper refers is grounded on the very historical process in which the Mental Health services participate (Brasil, 1992, 1986, 1988, 2001a), as it evaluates these services. Health services evaluation has been more and more required in academia and in the health services themselves, as it is a tool that is capable of unveiling problems and identifying solutions (Onocko Campos *et al*, 2008).

¹ This paper is a product of a Master's thesis (Araujo, 2012) that was submitted to and approved by the Ethics Research Committee of the School of Public Health of USP under protocol no. 2235.

The Mental Health field, heir to a history linked to madness and to attempts to deal with it (Foucault, 1978), has produced, in the last 20 years, several changes in the mental health services (Brasil, 2001b, 2002), as a consequence of several movements which have occurred in the Brazilian society and which have caused significant transformations in the conception of mental suffering, and also in the practice that its care demands (Brasil, 2004).

The *Centros de Atenção Psicossocial* (CAPS – Psychosocial Care Centers), health services that were constituted as equipment to substitute the asylum model, centralize the transformations in the area and concentrate workers who demand innovations in the way of providing care (Brasil, 2002, 2004).

Regarding this investigation, what troubled the researcher concerns the practices of the Mental Health workers. These subjects, who dedicate their lives to taking care of people who have some kind of psychological suffering, have their practices wrapped in controversial ideals and realities, between limits and possibilities which are, many times, hard to identify.

These difficulties present themselves in the form of barriers that the workers find to overcome an old model, to escape from the logic that encloses it (Desviat, 1999). In other words, the investigation ponders on the transition between these models: the asylum model, with its own ways of doing; and the anti-asylum one – also called psychosocial, or substitutive, which undertakes different ways of producing health (Costa-Rosa, 2001).

Thus, the study aims to promote a dialog with a mental health network in the West region of the city of São Paulo, in an attempt to understand how the reception process happens in the above-mentioned region.

Reception is focused here as the object of study because it is a device that expresses the transformations that the health services have been undergoing regarding their practices. Therefore, understanding the establishment of reception, as well as the processes that concern it and the workers' perception regarding these phenomena became the objectives of this investigation.

As this is the evaluation of a service, it is important to outline the evaluation perspective shared by this study.

Health evaluation can be considered a process targeted at measurement, comparison and at the expression of a value judgment (Tanaka, Melo, 2001). The last dimension is the one that can be subject to an intersection.

But how does one arrive at a value judgment? Hermeneutics (Gadamer, 2008) can contribute to this discussion as it attributes to language the eminently human characteristic of arriving at such judgment, through the possible mediations that will happen in the world of sharing of the human experience. That is, the value judgment is assumed from the experience that is established with the person that one intends to observe in such judgment. In this sense, the point is not to ascribe the understanding to a methodology, like modern science is used to doing, but to identify the elements that participate in the relations that produce a particular value to a particular subject in a particular context.

Thus, the result that we intend to achieve with hermeneutics does not aim at absolute truth, but at getting close to reality. The value of evaluation or, in the hermeneutical conception, the validity of the knowledge that emerges is placed on the relationship that the interpreter establishes with the thing – his object of analysis, starting from his previous knowledge in a dialectical movement with what is enunciated by this object.

According to this conception, our intention is to question the subjects who participate in the work process about the investigated theme and the possible answers are placed in

suspension of meaning, so that the new, or the judgment, can be issued. It is important to bear in mind that we should always view this judgment as an approximation that takes place in a particular time and space, and it can always be “re-questioned”.

Ayres (2008) argues that health evaluation should focus on the practical dimension of everyday life, that is, the microscopic and non-macroscopic relations in the routine of healthcare. To this author, evaluating according to hermeneutics means considering that language is dialog. It is a way of participating in the lived world; the essence of dialog is in the dialectics of question and answer; and the truth would be reached by means of the fusion of horizons.

To achieve this, it is necessary to employ the concept of hermeneutical application which, according to the author, is the very theme of the conversation that takes place (Ayres, 2008). In the specific case of this research, the theme is reception and this is the element that triggers the questionings.

When we read notes on the theme proposed here, reception, and identify it as a process that is capable of changing the health assistance model (Franco, Bueno and Merhy, 1999), we notice that these characteristics are present and have the potential of getting close to the reality based on the proposed application, that is, to understand how reception has been happening in a particular region, which is composed of specific health services and provides assistance with peculiar characteristics.

All these specificities offer a unique design and carry a singularity in the apprehension of their truth. At the same time, they have the power to, based on this singular dimension, open itself to the universal dimension in the form of language (Gadamer, 2008); thus, it is possible to arrive at the validity of the evaluation.

The word “reception” has been frequently used in the daily routine of the health services; however, when we read some studies about the matter, we soon realize that this word has been utilized to designate work processes whose way of operating is similar to what is known as screening, as Cunha and Vieira-da-Silva (2010), Souza (2008) and Campos (1998) argue. Although the vocabulary used by the professionals has changed, the action continues to be mediated by a logic of different principles.

The difference in principles can be evidenced by the discussion about what is wanted with one or the other modality of intervention. That is, the user who goes to the health service in order to receive assistance does it driven by his health problem. The professional who receives him and, above all, the way in which this professional receives the user, does it mediated by what he can do in health.

After the 8th National Health Conference (Brasil, 1986), established as the historical benchmark of the construction of the Brazilian National Health System (SUS), the principles of public health as the right of all and in defense of life were defined. These principles directly imply operational alterations concerning work in the health area.

It is important to highlight that in this conference it was debated that, to fulfill these principles, new parameters should be constructed and the paradigms which health uses should be altered. Regarding these transformations, the discussion about the technologies related to the practices that happen inside the care network becomes important.

The concept of technologies that has been adopted refers to an intentional action in the world mediated by a rationality (Franco, Merhy, 2003). According to this understanding, the technologies would be capable of capturing the objects and transforming them into goods/products (Merhy et al, 1997); in the case of health, the very cure of the problems would be their product, or the symbolic elements deriving from the relationships established between the services’ professionals and users.

To Merhy (1997), there is a difference between dead work, whose products are finished – for example, medications or procedures - and the Live Work in Act, which takes place in the relation that is established – it would be the work that “happens while it happens”, mediated by the agents’ action and being always new and creative.

According to this approach, there would be three ways in which the work process presents itself: hard technologies, which are technological equipment, organizational norms and structures; soft-hard technologies, which concern the structured knowledge; and soft technologies, which are basically relationship technology, which produces bonds, empowerment and reception.

Thus, screening represents a specific modality of providing health care, linked to the logic of the hegemonic medical knowledge (Franco, Merhy, 2005), which has become, with the advance of the capital, more and more dependent on hard technologies and encloses health assistance in drug prescriptions, the production of examinations and referrals to specialists. Thus, medical knowledge views the services’ users as biological organisms and their health problems as objects of a knowledge that has been increasingly segmented (Ayres, 2002).

On the other hand, reception, in this panorama, starts to be discussed as an operational guideline (Franco, Bueno and Merhy, 1999), that is, it has potential to transform these paradigms, as it tries to concentrate these principles on the concreteness of the services’ daily routine, focusing on soft technology.

Franco, Bueno and Merhy (1999) understand reception as an intercessional space that produces a relationship of hearing and accountability. The former guarantees the formation of a bond with the user and the latter can be translated as the commitment to the intervention projects that will emerge from this relationship. Thus, it is through this space that the worker will use his technology, his knowledge, and the user will see himself as the subject of the production of his health and not as a mere object of an impersonal knowledge.

The penetration of these principles in the reality of the health services beyond the change in the nomenclature of old practices, producing an effective transformation in the services, is a process that needs to be explored and understood.

The problem of the alteration in language without the correspondent alteration in the practices, or the difficulties faced by the services to implement the reception process so as to produce health in a more resolvable, integral, economic and humanized way, have become urgent needs in public health.

Method

Based on these perspectives, the study constructed a methodological path that established three stages which were called spins, in allusion to the hermeneutical circle that substantiates the treatment of the data.

This is a study that deals with secondary data, that is, data were collected in another moment, in a previous research that was carried out in 2006. The data were constructed in the form of narratives, based on the following question: how is the mental health service in which you work? This question was asked to six professionals of three different services: one nursing assistant and one general practitioner of one *Unidade Básica de Saúde* (UBS – Primary Care Unit) that does not have a mental health team; one psychologist and one psychiatrist of one UBS that has a mental health team; and finally, one psychologist and one psychiatrist of the *Centro de Atenção Psicossocial* (CAPS – Psychosocial Care Center) for adults of the region.

The First Spin – the construction of the lines of argument. It started from the reports. It was possible to construct three lines of argument. Based on the notion of fusion of horizons (Gadamer, 2008), the narratives about reception were questioned. As we start from the principle (previous conception) according to which reception would be an intercessional space (Franco, Bueno and Merhy, 1999) in which there is a relation among subjectivities, the element *bond* became an important analyzer of this aspect, because the links among the subjects involved are located in it. Another facet of reception was considered when it is described as an operational guideline of the service (Franco, Bueno and Merhy, 1999), that is, as a tool that is capable of reorganizing the care network. Thus, network articulation was established as another element of analysis. Therefore, the first contact with the reports guides the interpretation by means of these three lines of argument: bond, reception and network articulation.

The first visit to the data being questioned, as a whole, by the lines of argument directed the study to the reconstruction of the narratives, initially in an individualized way, report by report.

This stage was predominantly interrogative, that is, several questionings to the data are constructed, creating a debate with them and complying with the premise according to which understanding never is a merely reproductive behavior, but also, and always, a productive behavior (Gadamer, 2008). Thus, a shock is promoted and it produces something new based on the questions guided by the lines of argument.

This shock happens during the dialog with the data, as the need to compare them to theoretical presuppositions is gradually outlined, which enables the narratives to remain open to the questions that are raised. This makes this stage be marked by a very frequent presence of the discourses, in the exact way in which they are expressed by the subjects. Second Spin – the search for univocality. This second moment was permitted by the openness caused by the previous stage. In this stage of the interpretation process, the path heads to the settlement of the issues that were presented, in the search for an understanding about how the approached elements are applied to the local reality.

This stage of the interpretation was based on the attempt to answer the several questions raised in the previous stage. The lines of argument continued to guide the analysis, but not through the parts anymore; rather, in the search for a univocality of the data, that is, bringing the discourse to the network as a whole, and in relation. With this, some aspects that were questioned and compared to theories became more explicit or – in consonance with hermeneutics – stood out in the process.

To Gadamer (2008), being able to see beyond depends on the relation in which the horizons are placed, and based on this process, understanding becomes possible.

The dialog between the data and the interpreter produced the emergence of points that had neither been seen nor perceived previously. And these points were considered what was conserved in the process of production of the hermeneutical work. Thus, it was possible to take these new elements to the discussion of the results so as to enhance them in the next stage, which was considered the last stage of the interpretative process.

Third Spin – the highlight. This stage received the name of discussion of results, as it evidenced what remained open during the entire research. Instead of exhausting them, the path of the thought erected in the research allowed to bring them to light or to give them shape.

The results were constructed in the form of four categories, and this construction is due to the possibility that they function as analyzers of the network, that is, elements that are capable of pointing at similar characteristics in other regions and services. Thus, they fulfill the objective of the interpretation, which is to promote a closer contact with reality.

Discussion and Results

The analysis enabled to notice that the interviewed professionals' practices are distant from what has been recommended for health services that are receptive, responsible and which promote the integrality of users' care. Also, that this distance is directly connected with the absence or presence of mental health teams in the services, which shows the contribution that a model that is different from the hegemonic one can bring to the care network.

The analysis attempted to compare the paradigms implicit in these characteristics and in this way some elements emerged from the investigation and from the dialog undertaken with the data. They are:

- a) lack;
- b) mix;
- c) technologies;
- and d) integrality.

We decided to expose the data in the form of categories and these are displayed here according to their order of emergence during the discussion. However, it is understood that there is a relation among the phenomena in the daily routine of the service; thus, bond, reception and network articulation constitute important elements to consider, in terms of application.

Lacks

As the work advanced in the search for the understanding of the object in study, the sensation that in the several discourses there was a kind of lack reported by the professionals emerged. In certain moments, the interviewees tried to give shape to these phenomena. We present below three examples extracted from the reports of distinct professionals that point to this attempt, each one from one health equipment; UBS A, without mental health team; UBS B, with mental health team; and the CAPS, respectively:

“Before the service had an ambulance, he used his own car” (Nursing assistant).

During the time he worked [...] as an emergently hired employee at the CAPS, the doctor assisted many patients who live in the region of UBS X and UBS Y (which don't have Mental Health). He continued to assist them when he started working at UBS B. Due to this, his agenda is open also to patients from these units. They are not enrolled at UBS B, they don't have medical records, the assistance is registered in separate sheets, and all their other assistances are performed in the unit near their residence (Psychiatrist).

“There are not enough professionals [...] to treat the CAPS patients and the Outpatient Clinic's patients. Especially the first group doesn't receive the necessary care” (Psychologist).

These attempts emerge in the discourses as lack of human resources and materials, communicative difficulties, incoherence among professionals or units, etc.

This reasoning led to the understanding of a structural lack concerning the network that was gradually being outlined according to the erected argumentations.

The theoretical framework that was adopted did not enable to find related elements that could be confronted, or even concepts that could subsidize the understanding of these occurrences. In this sense, the context in which these lacks are manifested regards the work that is included in an institution, a health service, composed of professionals from this area. If these subjects start to be understood as integrating a group and we employ Psychoanalysis to reflect on this network as the place of lacks, some notes can be constructed in the search for elucidation of the above-mentioned phenomenon.

When we question the meaning, the objective or the reason for the existence of a health service, a very common answer can be given: it serves to take care of people's health. If the lacks are repeated many times by the professionals, we understand that its intention, of taking care of health, has not been met.

In *Psicologia de Grupo e Análise do Ego* (Group Psychology and the Analysis of the Ego), Freud (2006) approaches how groups are capable of organizing themselves around an authority, which can be represented by a person, a sector, or an idea. Moreover, this authority has the function of, due to its ambivalent character, offering fear and protection at the same time, in order to maintain all the individuals under its control, with individual desire inhibited in its goal.

The inhibited desire does not guarantee that satisfaction is achieved, but it reproduces the promise that this is possible. In other words, everybody acts submitted to the authority's voice, and in this case, care production remains in the absence (lack) of the fulfillment of the desire.

Thus, the hard technologies present themselves as the authority that offers true protection **a priori** (Gadamer, 2008), generating the maintenance/reproduction of the model centered on the doctor and on procedures (Franco, Merhy, 2005).

Freud (2006) considers that the individual, when included in a group, starts to share its ideal and submits to the idea that is preponderant there. This individual "only needs to provide an impression of greater strength [...]"²(Freud, 2006, p.139).

And, in this sense, the study showed how the hard technologies still maintained their strength over the care network, which is entirely organized according to this paradigm, identified in the reports of the professionals of the different analyzed units.

Mix

As in the case of the lacks, the term mix is not a theoretical or technical concept, but a word with the potential to represent a phenomenon that is present in the studied network.

The conception of Psychiatric Reform brings in its wake a historical process marked by an attempt of change from a model of care for mental suffering, escaping from the hospital-centered logic, to the model of care provided for the user in his region, investing in his autonomy and sociability, as can be verified in the theme of the 3rd Mental Health Conference (Brasil, 2001a), which is "yes, we must provide care; no, we should not exclude".

However, the network shows that there is truly a mix between the models: the old one, which maintains its primacy over medical assistance and all the procedures related to it, and the new one, substitutive.

In the analyzed CAPS, this mix was more evident - not by chance, as this equipment was designed and implemented with the purpose of being the "substitute" device for the

² This quotation was translated into English for the purposes of this paper.

psychiatric hospital. Thus, it has become the service that carries the two models mixed in it, as a moment of this substitution process that is intended to be applied. This situation is identified in the report of the CAPS professional:

After Directive 336, the CAPS was regulated as the reference for all Mental Health cases. Since then, the team has felt obliged to maintain the 'door open', and to ensure at least the first hearing to the demand it receives (Psychologist).

It can be verified in the extract above that the "open door" is not a moment of the provided care that has the user as the center, but an external legal obligation that is superimposed on the service's dynamics.

This mix has been debated as what has been theoretically called technological transition in the transformation of the mental health care models, as a product of the invisible fight that happens between the hegemonic asylum view and the counter-hegemonic anti-asylum one.

Nevertheless, technological transition implies a social, cultural, political and subjective investment in the technological nucleus, with the aim of making it become *soft* and *dependent* (Franco, Merhy, 2003); and this commitment was not verified in the analyzed network. For this reason, the *mix* was viewed as a phenomenon that is typical of the co-existence of two models. The counter-hegemonic one was implemented in a normative way, not as an institutional investment.

Technologies

The discussion about technologies in the work process analyzed here has imported from the model of Life Defense the conceptions to debate the network's practices. This adoption happened through the understanding that the model mentioned above has underlying elements of the Sanitary Reform (Brasil, 1986), just like the Psychiatric Reform (Brasil, 2001b). With this perspective, the study adhered to the theoretical notes that identify the need to invest in soft technologies as a possible solution for questions like the lack and the mix described above; in the first case, because it would increase the worker's strength and freedom (with decision-making power); and, in the second case, because it would aim at changing the technological nucleus.

Although soft technologies present themselves as an instrument capable of promoting significant changes in the care network, so as to increase the coefficient of bond and accountability, produce more receptive services and work in favor of the integrality of care (Franco, Bueno and Merhy, 1999), they still have fragilities, mainly when we think about their penetration in the health practices, after more than a decade of the creation of the Brazilian National Health System (SUS). And there is much to be developed in order to overcome the lacks and mixes that their implementation causes on the care model and on the practices inserted in it.

Integrality

The network analyzed here can be compared to an archipelago composed of islands whose only common characteristic is their location in the same region, but with no communication among them.

The presentation of this network can be expressed according to its distance in relation to what is recommended by the guidelines of the Psychiatric Reform.

The most distant unit, UBS A, is, according to reports, a place where procedures stiffened by the norms and the technical tradition predominate. For example, when the user arrives with a mental health complaint, the indication that the professionals have is to refer him to the local emergency service, the place where the decisions are made.

This procedure was reported by both the interviewed workers, the nursing assistant, who reproduces the discourse of the order: “users with mental health problems must be referred to the emergency service”; and the general practitioner, who uses the technical knowledge to justify the procedure: “knowledge of mental health is attributed to psychiatry”.

The only network that is configured, based on the discourses, is the flow from UBS A to the Emergency Service, without other communications.

At UBS B, a possible divergence was identified between the work of the doctor and of his unit colleague, the psychologist, as the former maintains the primacy of the emergency service, while the latter heads towards the CAPS. However, this divergence is clarified when we understand the work process inside the UBS.

According to the psychiatrist, UBS B has the following flow: it receives patients from *Hospital Central* and from *Hospital Universitário* through appointments. After an evaluation, if the user is unknown, he is referred to the emergency service and this service decides if the user is referred to the CAPS or to a hospital. If the user is known and according to the need evaluated by the doctor, he is referred to psychotherapy with the Psychologist of the UBS, or directly to the CAPS. Therefore, the Emergency Service continues to be the decision-making center.

When the psychologist’s discourse was analyzed, we realized that he omits the Emergency Service and establishes a very rich communication with other resources, giving the impression that he tries to provide integral care.

Conversations happen more frequently at this unit, which denotes that the Psychiatric Reform perspective has advanced on the network. It is not capable yet of overcoming the old model, but it has been causing considerable alterations to it. The flow happens in the following way: from the UBS to the CAPS through telephone contact; from the UBS to the CAPS ad, when the case is drug dependence; from the UBS to the psychotherapy clinic of the University; from the UBS to the Outpatient Specialty Clinic; from the UBS to other community resources, like NGOs, CECCO, workshops, etc.

Unlike the first UBS, therefore, this unit is more communicative and offers more possibilities of conviviality spaces and health production with production of subjectivity.

The CAPS’ flow is described in the following way by the psychiatrist: it receives referrals from the local Emergency Service, which is the decision-making center, as we have already mentioned. It also receives users referred by other emergency services. The UBS also refer patients to the CAPS; nevertheless, the analysis of the verified lacks show that the UBS that refer mental health patients possibly are those which have mental health teams, because UBS A explains that the norm is to refer patients to the Emergency Service in the first place.

At the CAPS, there is what the doctor calls screening, in which he participates and, according to an evaluation, refers the patient. This evaluation takes the user to treatments offered at that service or, in other cases, to the psychology clinic of the university, or to the UBS or other services in the region.

The psychologist, in turn, defines the network in the following way: he receives the referrals and, according to the seriousness verified by the description of the case, he takes the user to reception, which is in group and is targeted at mild cases; or to screening, which is carried out individually and is reserved for more serious cases. This

second form of reception has the doctor's participation and it is possibly the same procedure described above, with the same name.

If the users are not included for treatment at the CAPS, they are referred to the UBS of reference or to the University's clinic, or even to other resources in the region, like CECCO, community therapy, other places where there is psychotherapy, NGOs, courses, workshops, etc.

In this unit, it is possible to notice that both descriptions coincide and, although we can question the way in which they are performed and the paradigm that inspires them, this coincidence denotes greater communication among the actors involved. It is possible to say that the coincidence is a product of communication, as the service has established a dynamics that has been respected by the team.

Concerning the communication and the need of dialog among the actors involved, it is interesting to perceive that the flow described here is very similar to that of UBS B, which has a mental health team. This similarity, when concerning the communicative question of the network, offers evidence that the work of interrelation between the CAPS and UBS B services, mediated by language, is responsible for the user's safe transit in the network (Franco, Merhy, 2003).

The higher communicative incidence places the worker as the fundamental agent in the constitution of care and in the search for its integrality.

We used as a metaphor of the analyzed network its similarity to an archipelago, containing islands separated by the specialties, which remain close, but without communication. But when we look at the workers' potential to reduce this distance through communication, we notice that it is the conducting element, or the line that establishes the tie among the services to seek for resolvability. This communicative tie, which is exclusively understood as soft technology, emerges as the element that is capable of promoting the integrality of this non-communicative network.

The hegemonic medical view, producer of procedures and consumer of technological inputs, impoverishes the clinic and reduces it to the performance of examinations, drug prescriptions and referrals to specialty services. This scarce use of the clinical possibilities minimizes resolvability at the UBS and reproduces, in the case of mental health, the asylum logic, in consonance with the paradigm of the search for specialties.

The CAPS in question is viewed by the other services in the network as a psychiatric hospital, concentrating all the mental health cases, although its team has presented some qualitative advances.

The coexistence of more than one model was presented as a central point in the difficulties to establish bonds, to institute reception according to the guidelines of the Ministry of Health, and to articulate the network based on resolvability and integrality.

We also identified that this coexistence enables counter-hegemonic or instituting initiatives, or even technological transition initiatives. The hard technologies clearly present a limit concerning the promotion of the services' integrality, as they are based on the reproduction of a model that does not place the user as the center of the performed work. The investment in communication and in spaces for dialog can be the tool that is capable of building the necessary bridges among the islands of the network under analysis, enabling the user's safe and caring transit among them.

People are capable of reaching people through language. Every conversation presupposes a common language, or better still, every conversation generates a common language (Gadamer, 2008). If to integrate means to unite, language is the means that promotes the union, transforming the several services that compose a network of care into a tangle, whose main objective is provide care for the user.

The study showed that where there are more language-mediated exchanges among professionals, the greater the service's unity and its communication with the other resources of the network, that is, the greater the integrality of care.

Language is what underlies the soft, relational technologies, as they aim at the creation of spaces for talking and exchanging knowledge. This would reduce the lacks, because it would satisfy the desire of care; the common language would reduce the mixes, as they are a product of the coexistence of at least two models, with different languages, but searching for fusion, unity.

Conclusions

In light of the power that was identified concerning the reception process, the research established that its general objective was to evaluate the application of reception in a particular region of the municipality of São Paulo.

And, because it is a specific field – Mental Health -, the evaluative investigation focused on the UBS and on the CAPS of that region. Thus, we tried to understand how the professionals perceive their practices in these health units.

Evaluation in the health services was approached as the expression of value judgments; in this case, regarding the reception process. To achieve this, we traveled the methodological path of Philosophical Hermeneutics, as this approach is an adequate way of fulfilling the objectives.

Concerning reception in the studied services, it was linked to another work process that represents the model centered on the doctor and his procedures: screening. A bibliographic review had been carried out previously and some studies showed that these two practices are thought to have similarities. The research showed similar results concerning this theme, with the complicating element that, in some units, screening was applied and, at the same time, was called reception, without altering significantly the practices: it did not enable a space for speaking, it did not reorganize the care network and there was no investment in bonds with users.

Thus, the research started with the analysis of the narratives produced by the question: how is the mental health service? And it took a path marked by questioning the collected data, following the conducting wires: bond, reception and network articulation. This path needed to be confronted with theories and arguments about the health practices, producing the hermeneutical circles, in which one transits many times by the same object. And, in this path, some highlights could be constructed.

Some elements came to light as approximate answers to the question above. In short, the study showed that the health services of the analyzed region produce a sensation of **lack**; they coexist with a **mix of models**; they maintain **hard technologies** in health production; and they are not efficient concerning **integrality**.

Thus, the research presented a portrait of how reception and the other elements participating in this process could be applied in that region and in that historical moment. It is important to emphasize that, although the investigation has been grounded on the ethical principle of qualitative research according to which the description of the processes for handling data should be clear and reliable, a limit should be mentioned, and it regards the time when the data were collected – the year of 2006 -, and the temporal distance for their analysis.

Philosophical Hermeneutics enables a rich dialog with materials from any time, but it understands that it is in the very process of interpretation that the object can be updated.

In this sense, we understand that the results presented here have the potential of being confronted in future research, and they can amplify the investigation on the theme of reception if they are considered as elements that participate in it.

Collaborators

Araujo and Tanaka worked together in the conception, outline, analysis, data interpretation and writing of the paper.

References

AYRES, J.R.C.M. **Conceptos y prácticas en salud pública: algunas reflexiones.** Fac. Nac. Salud Pública. Medellín, Colombia; 2002.

_____. **Hermenêutica, Conhecimento e Práticas de Saúde, a Propósito da Avaliação.** In: ONOCKO CAMPOS, R.T. et al. (Orgs.). **Pesquisa Avaliativa em Saúde Mental: desenho participativo e efeitos da narratividade.** São Paulo: Ed. Hucitec, 2008. p. 27-67.

Araujo, A. K. **Avaliação em Saúde Mental: o processo de acolhimento.** São Paulo [s/p], 2012.

Brasil. **I Conferência de Saúde Mental.** Ministério da Saúde. Brasília, 1988.

_____. **II Conferência de Saúde Mental.** Ministério da Saúde. Brasília, 1992.

_____. **III Conferência de Saúde Mental.** Ministério da Saúde. Brasília, 2001a.

_____. **8ª Conferência de Saúde.** Ministério da Saúde. Brasília, 1986.

_____. Presidência da República. Lei 10.216 de 6 de abril de 2001. Dispõe sobre a proteção e os direitos das pessoas portadoras de transtornos mentais e redireciona o modelo assistencial em saúde mental. In: Conferência Nacional de Saúde Mental, 3., 2001, Brasília. **Caderno Informativo.** Brasília: Ministério da Saúde, 2001. p.58-62.

_____. Ministério da Saúde. Portaria nº. 336, de 19 de fevereiro de 2002. **Estabelece as modalidades de serviços nos Centros de Atenção Psicossocial (CAPS), definidas por ordem crescente de porte/complexidade e abrangência populacional.** Brasília: Ministério da Saúde, 2002.

_____. **Saúde Mental no SUS: os centros de atenção psicossocial.** Brasília; 2004.

CAMPOS, G.W.S. **O anti-Taylor: um método para co-governar instituições de saúde produzindo liberdade e compromisso.** Cad. Saúde Pública, v.14, n.4, p. 863-870, outubro, 1998.

COSTA-ROSA, A. da.; LUZIO, C.A. YASUI, S. **As Conferências de Saúde Mental e as Premissas do Modo Psicossocial.** Rev. Saúde em Debate. Rio de Janeiro, v.25 n.58, p.12-25, 2001.

CUNHA, A.B.O.; VIEIRA-DA-SILVA, L.M. **Acessibilidade aos serviços de saúde em um município do Estado da Bahia, Brasil, em gestão plena do sistema.** Cad. Saúde Pública, vol.26, no.4, p. 725-737, abr, 2010.

DESVIAT, M. **A Reforma Psiquiátrica.** Rio de Janeiro: Fiocruz, 1999.

FOUCAULT, M. **História da Loucura.** São Paulo: Perspectiva S.A., 1978.

FRANCO, T.B.; BUENO, W.S.; MERHY, E.E. **O acolhimento e os processos de trabalho em saúde:** o caso de Betim, Minas Gerais, Brasil. Cad. Saúde Pública, v.15, n.2, p. 345-353, abr-jun, 1999.

FRANCO, T.B.; MERHY, E.E. **Produção Imaginária da Demanda.** In: PINHEIRO, R. & MATTOS, R.A. (Orgs). **Construção Social da Demanda:** direito à saúde, trabalho em equipe, participação e espaços públicos. Rio de Janeiro: IMS/UERJ-CEPESC-ABRASCO, [s/p.], 2005.

FRANCO, T.B.; MERHY, E.E. **Por uma Composição Técnica do Trabalho centrada no campo relacional e nas tecnologias leves.** *Saúde em Debate*, v. 27, n. 65, pp. 316-23, Set/Dez; 2003.

FREUD, S. **Psicologia de Grupo e Análise do Ego.** Vol. XVIII. Rio de Janeiro: Imago, p. 77-157, 2006.

GADAMER, H.G. **Verdade e Método I:** traços fundamentais de uma hermenêutica filosófica. 10ª ed. Petrópolis: Vozes, 2008.

MERHY, E.E. **et al. Em Busca de Ferramentas Analisadoras das tecnologias em Saúde:** a Informação e o Dia a Dia de um Serviço, Interrogando e Gerindo o Trabalho em Saúde. In: MERHY, E.E. & ONOCKO CAMPOS, R.T. (Orgs). **Agir em Saúde.** Um Desafio para o Público, São Paulo: Hucitec; 1997. p. 113-150.

ONOCKO CAMPOS, R.T. **et al. (Orgs.). Pesquisa Avaliativa em Saúde Mental:** desenho participativo e efeitos da narratividade. São Paulo: Hucitec, 2008.

SOUZA, E.C.F. **et al. Acesso e acolhimento na atenção básica:** uma análise da percepção dos usuários e profissionais de saúde. Cad. Saúde Pública, v.24, n.1, p. 100-110, 2008.

TANAKA, O.Y.; MELO, C. **Avaliação de programas de saúde do adolescente:** um modo de fazer. São Paulo: Edusp, 2001.

ⁱ Departamento de Práticas em Saúde Pública da Faculdade de Saúde Pública da USP. Av. Dr. Arnaldo, 715. São Paulo, SP, Brasil. 01246-904.

Translated by Carolina Siqueira Muniz Ventura.

Translation from **Interface - Comunicação, Saúde, Educação**, Botucatu, v.16, n. 43, p. 917-928, 2012.