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Beyond the consultation and the medication: collective activities and resocialization in a CAPS I

Além da consulta e do medicamento: atividades coletivas e de ressocialização em um CAPS I

Más allá de la consulta y la medicación: actividades colectivas y de resocialización en un CAPS

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ABSTRACT

Objective: to evaluate the collective and resocialization activities developed in a CAPS I, from the perspective of users, family members and service professionals.

Method: evaluative research, anchored in the theoretical-methodological framework of the Fourth Generation Evaluation, conducted with 11 users, six family members and 10 professionals from a Psychosocial Care Center I. It took place from September 2021 to August 2022, using prior ethnography, interviews and negotiation, with data analysis using the Constant Comparative Method.

Results: participants pointed out that therapeutic workshops, support groups and collective meetings are held, which take place mainly in the physical space of the service, with adequate operationalization and frequency, facilitated by the professionals' attitude and the provision of transportation and food. It was assessed that these actions had an impact on the psychosocial care offered, resulting in treatment adherence, improved interpersonal relationships within the service and community, emergence of positive feelings, social inclusion and support for coping with difficulties. The challenges are the support group schedule and the participation of children and adolescents.

Final considerations: collective and resocialization activities were evaluated as essential for the psychosocial care offered at CAPS, providing significant benefits to users, promoting interaction, social inclusion, interpersonal relationships and coping with adversities.

Descriptors: Health services evaluation. Mental health services. Nursing. Psychiatric rehabilitation. Self-Help groups.

RESUMO

Objetivo: avaliar as atividades coletivas e de ressocialização desenvolvidas em um CAPS I, na ótica dos usuários, familiares e profissionais do serviço.

Método: pesquisa avaliativa, ancorada no referencial teórico-metodológico da Avaliação de Quarta Geração, realizada com 11 usuários, seis familiares e 10 profissionais de um Centro de Atenção Psicossocial I. Ocorreu de setembro/2021 a agosto/2022, utilizando etnografia prévia, entrevista e negociação, com análise de dados pelo Método Comparativo Constante.

Resultados: os participantes apontaram que são realizadas oficinas terapêuticas, grupo de apoio e encontros coletivos, que ocorrem, principalmente, no espaço físico do serviço, com operacionalização e frequência adequadas, facilitadas pela postura dos profissionais e pela oferta de transporte e alimentação. Avaliou-se que essas ações impactaram no cuidado psicossocial ofertado, resultando na adesão ao tratamento, melhora do relacionamento interpessoal no serviço e na comunidade, surgimento de sentimentos positivos, inclusão social e apoio para o enfrentamento de dificuldades. Seus desafios são o horário de realização do grupo de apoio e a participação de crianças e adolescentes.

Considerações finais: as atividades coletivas e de ressocialização foram avaliadas como essenciais para o cuidado psicossocial oferecido no CAPS, proporcionando benefícios significativos aos usuários, promovendo interação, inclusão social, relacionamento interpessoal e enfrentamento de adversidades.

Descritores: Avaliação em saúde. Serviços de saúde mental. Enfermagem. Reabilitação psiquiátrica. Grupos de autoajuda.

RESUMEN

Objetivo: evaluar las actividades colectivas y de resocialización desarrolladas en un CAPS I, desde la perspectiva de usuarios, familiares y profesionales del servicio.

Método: investigación evaluativa, anclada en el marco teórico-metodológico de la Evaluación de Cuarta Generación, realizada con 11 usuarios, seis familiares y 10 profesionales de un Centro de Atención Psicosocial I. Se desarrolló de septiembre/2021 a agosto/2022, utilizando etnografía previa, entrevistas y negociación, con análisis de datos mediante el Método Comparativo Constante.

Resultados: los participantes señalaron que se realizan talleres terapéuticos, grupos de apoyo y reuniones colectivas, que se desarrollan principalmente en el espacio físico del servicio, con adecuada operacionalización y frecuencia, facilitadas por la actitud de los profesionales y la provisión de transporte y alimentación. Se evaluó que estas acciones tuvieron impacto en la atención psicosocial ofrecida, resultando en adherencia al tratamiento, mejora de las relaciones interpersonales en el servicio y en la comunidad, aparición de sentimientos positivos, inclusión social y apoyo para afrontar las dificultades. Los desafíos son el horario grupal y la participación de niños/adolescentes.

Consideraciones finales: las actividades colectivas y de resocialización fueron evaluadas como esenciales para la atención psicosocial ofrecida en el CAPS, proporcionando beneficios significativos a los usuarios, promoviendo la interacción, la inclusión social, las relaciones interpersonales y el enfrentamiento de las adversidades.

Descriptores: Evaluación en salud. Servicios de salud mental. Enfermería. Rehabilitación psiquiátrica. Grupos de Autoayuda.

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INTRODUCTION

Psychosocial rehabilitation and resocialization of people with mental disorders are objectives of mental health care, prioritized by the Brazilian Psychiatric Reform (*Reforma Psiquiátrica Brasileira* – RPB). Psychosocial rehabilitation of an individual is understood as the reorganization, contracting and exercise of citizenship that involve the social, family and work areas of their life, strengthening the social exchanges that occur in their daily lives[1]. Reintegration, on the other hand, is considered in this text as synonymous with social inclusion and social reintegration, is based on the presence of the individual in society and their coexistence with it and its spaces, as opposed to the social exclusion, segregation and marginalization commonly experienced by people with mental disorders[2].

The Psychosocial Care Centers (*Centros de Atenção Psicossocial* – CAPS), in their various modalities, are services that operationalize the RPB and, therefore, must develop actions that promote psychosocial rehabilitation and resocialization. These include collective activities, such as support groups and therapeutic workshops, which have been identified as one of the most important actions in the new mental health care model. These activities are developed in search of autonomy, interaction and negotiation among individuals, and are spaces for acceptance and belonging[3].

Studies have shown that the implementation of therapeutic workshops and groups in CAPS is not standardized and does not always fully align with psychosocial care, being influenced by the concepts, knowledge, skills and disposition of the professionals who coordinate them, as well as by the availability of physical and material resources. These factors can bring them closer to or distance away from what is proposed in the RPB[4–6].

In many services, workshops and groups are organized without considering the Singular Therapeutic Project (*Projeto Terapêutico Singular* – PTS) of each user and aim to produce something material[5], being normally intended for individuals with the same mental disorder diagnosis and covering a range of activities, such as crafts, gardening, computing and physical exercise, promoting the interest of users in participating[6].

Beyond these activities, those that encourage the user to coexist with the territory and society, aiming at their resocialization, should also be part of the daily routine of the CAPS. This is necessary because, besides facilitating the exercise of citizenship, they have the potential to reduce stigma and contribute to the protagonism of users in their lives and treatment[3].

The literature shows that actions aimed at social reintegration of users have occurred in CAPS, but they are still discreet and sporadic. It is necessary to intensify the work outside the services, so that people with mental disorders become familiar with the environments and culture in which they are inserted and increase their circulation in spaces that are beyond the CAPS structure[7].

Collective and resocialization actions in CAPS should involve, besides users, their families, since both are subjects of mental health care and co-responsible for its success, along with the team, according to the psychosocial paradigm. When the relationship between the CAPS team and the family is based on support, guidance, respect and address the family needs and demands, home care and social inclusion of the user are improved[8]. Thus, the CAPS team needs, in their daily actions, to bring them closer to the service and assistance to the user, promoting their participation in consultations, groups, meetings, construction of the PTS and other activities carried out[9].

Based on the importance of collective and resocialization actions in mental health care provided by CAPS, and considering the scenario of their implementation in these locations, as evidenced in the cited studies[4–7], it is expected that the services implement and consolidate these practices in a consistent and innovative manner, adapting them to what is proposed in the RPB and to psychosocial care. Even though they are practices contemplated in the RPB and recommended as a way of meeting its guidelines, it is not possible to state that they have been carried out adequately.

Considering that collective and resocialization actions are essential to promote citizenship, psychosocial rehabilitation and reintegration into society, as recommended in the psychosocial paradigm, it is essential to understand how they are conducted and perceived by professionals, users and family members. Thus, the research is justified by the need to improve the interventions carried out in CAPS, ensuring that they are aligned with the principles of RPB, since by comprehensively and participatively evaluating the actions, the goal is to contribute to the qualification of mental health care and to promote the protagonism and social inclusion of people with mental disorders.

Therefore, this study aimed to answer the question: how are the actions aimed at the collective and resocialization in a CAPS evaluated by users, family members and professionals? And its objective was to evaluate the collective and resocialization activities developed in a CAPS I, from the perspective of users, family members and service professionals.

METHOD

This is a case study, with a qualitative approach, guided by the Consolidated Criteria for Reporting Qualitative

Research (COREQ)[10]. It is based on the theoretical-methodological framework of the Fourth Generation Evaluation (FGE), which follows the constructivist paradigm and the hermeneutic-dialectical process[11].

The FGE is one of the qualitative evaluation performed in health services, where the Claims, Concerns and Issues (CCI) of the participants determine what should be addressed. Participants include various interest groups who may be directly or indirectly impacted by the evaluation object and/or the evaluation itself[11].

The constructivist paradigm states that realities are mental social constructions and reconstructions, created from the interpretation of facts, and proposes that the result of a study emerges from the interaction between participants, being hermeneutic and dialectical. In the FGE, the interaction and negotiation among stakeholders allows the validation of the emerging information, making the evaluation responsive to the CCI identified[11].

The study was conducted in a CAPS I, located in the municipality of Nova Esperança, state of Paraná, which is part of the 15th Health Region and the Northwest Macroregion of the state. The municipality has a population of 26,585 inhabitants according to the 2022 Census, and it has an area of 401.587 km^2.

The municipal health network has seven Basic Health Units (*Unidades Básicas de Saúde* – UBS), a polyclinic, a CAPS I, a physiotherapy clinic, a Health Academy, a Municipal Hospital with an Emergency Care service, a base of the Regional Mobile Emergency Care Service (*Serviço Móvel de Atendimento as Urgências* – SAMU), and a municipal laboratory.

In the municipality, mental health care is provided by UBS, CAPS I, and a psychiatry and psychology outpatient clinic. Individuals in crisis or who require short-term hospitalization due to mental disorders are treated at the Emergency Care Unit and Municipal Hospital, and are transferred to services in other municipalities when require longer hospitalizations.

CAPS I serves approximately 380 users per month, with severe mental illness and/or alcohol and other drug use, including children and adolescents. Its multiprofessional team is consists of psychiatrists, psychologists, nurse, social worker, social educator, artisan, occupational therapists and a service coordinator, totaling 13 professionals. It also has an administrative assistant, a janitor, a cook and a driver. It operates from Monday to Friday, from 7:30 am to 5:00 pm, offering consultations, individual and group sessions, and home visits, accepting both spontaneous demands and referrals from other services.

The choice of a CAPS I as a study location is justified because it is the most widely implemented modality in the region and in Brazil and because it serves a broad public with diverse mental health needs, stemming from persistent mental illness and the use of alcohol and/or other drugs, including children and adolescents. Furthermore, the service was selected for convenience, since, prior to the development of the research, the researcher worked in the management of the municipality where the CAPS is located and had occasional contact with it, which stimulated interest in learning about the local reality. It is important to note, however, that the researcher had never worked in the service and that, at the time of data collection, had been out of contact with the research site for over 3 years, with no conflict of interest.

The study participants were 10 professionals, 11 users and six family members. The professionals were included according to the following criteria: having worked in the service for at least six months and providing direct assistance to the user and family. The exclusion criterion for this group was being absent from the service during the data collection period for any reason.

The participating users met the criteria of being over 18 years old and having received care at the CAPS in the last three months. For family members, they were being 18 years old or older, being a family member of a user who had been treated at the service in the last three months and living with the user. The exclusion criteria for both were being in crisis at the time of data collection and having cognitive impairment, according to the Mini-Mental State Examination, applied by the researcher[12].

It is highlighted that the eligibility criteria were applied after the participant indication, during the Hermeneutic-Dialectic Circle (HDC), according to the FGE method. Therefore, all those indicated by the HDC met the inclusion criteria and did not have the exclusion criteria. After the inclusion of the participant, there was no refusal, withdrawal or exclusion of those who were invited to participate, indicated in the HDC.

Data collection was conducted by the main researcher/author, who was a nurse, a doctoral student in nursing and worked professionally as a professor at a public university. Despite having more than 10 years of experience with qualitative research, the researcher was trained by a doctor with expertise in FGE, to apply the methodological framework. In the first contact with the participants, the researcher presented her credentials, the personal and professional reasons why she was interested in the study topic and the reason for developing the research, as a requirement of the doctoral program.

Considering all its stages, data collection took place from September 2021 to August 2022, after the researcher contacted the service, to present the research and establish

the agreement to remain in the field. It began with the preliminary ethnography, which included non-participant observation at the CAPS, lasting 95 hours, covering all days and periods of care.

The observation was conducted using a script containing the aspects necessary to fully understand the service, such as its structure, resources, routines and existing processes. A field diary was used to record, comment and reflect on the observation. At the end of this stage, it was possible to learn about and monitor the services offered, the dynamics of the service, and the established flows, as well as to promote interaction between the researcher and potential participants.

The information obtained at this stage contributed to equipping the researcher with the knowledge necessary to analyze the interviews and assist in the process of emergence of the constructions and results, as well as being used in moments to foster joint construction and reflections in the HDC.

Next, semi-structured individual interviews were conducted. The users and professionals indicated in the HDC were approached individually at the end of their CAPS service; home visits were made to family members, together with the service team. During this approach, the study was introduced and an invitation to participate was made, with a scheduling of the day and time for the interview.

A single interview was conducted with each participant. They took place at the service, for users and professionals, and at the family members' homes, always in a location that ensured privacy and confidentiality, with only the participant and the researcher present. They were conducted with the following initial trigger questions: What is the CAPS service like? What are the service's strengths and weaknesses? These questions were derived from those indicated by the FGE method, with adjustments related to the evaluation object, so a pilot test was not deemed necessary.

A HDC was conducted for each interest group. The HDC of users started with one of the individuals who has been receiving follow-up at the service since its inception. The first HDC professional was the oldest at CAPS. The HDC for family members began with a family that had considerable participation in the treatment, according to the multiprofessional team.

The HDC continued with the interviewee indicating the next participant, as established in the FGE, so that at the end of the interview, the interviewee was asked who they would indicate as the next participant, without the researcher having any interference in their choice. Based on this indication, the inclusion and exclusion criteria were applied and an invitation to participate was made.

The constructions arising from the interview analysis generated questions to be answered by the next participants. Thus, in addition to the initial questions, they answered those that were incorporated into the interview script, arising from previous constructions. The questions were gradually included in the script, during the HDC, so that in the end, the users group answered 24 questions; the family members group answered 26 questions; and the professionals group answered 41 questions. These questions refer to the topics of the final construction of each HDC, shown in Chart 1.

The HDC was interrupted when the constructions obtained were redundant, and did not add new information or change the existing constructions[11]. With this, the HDC were finalized, and no family member and user belonged to the same family.

Each interview lasted about 46 minutes, with the shortest lasting 10 minutes and the longest lasting 2 hours and 3 minutes. They were audio-recorded with a smartphone, with participant consent, and transcribed with adaptations, excluding language defects and speech errors, without changing their meaning.

A negotiation session took place in each completed HDC, separately. This session aimed to provide the FGE and the constructions that emerged from the interviews available to the participants, so that they could discuss and delve deeper into them and define what would be consensually considered the outcome of the study.

For this review, the content was provided in printed material for each participant and presented with the support of a digital projector. At this time, the participant also received the transcript of their interview, for reading, completion and corrections. Not all participants attended the negotiations, which does not invalidate the process, since there is no minimum number of attendees required[11]. Among those who were absent, only the professional provided a justification.

The topics discussed in the negotiation of each HDC, which include the constructions and FGEs, the duration of the session and the number of attendees are presented in Chart 1.

The field diary was used again at this stage to record field notes, inserted at the end of the interviews and negotiation sessions.

The data were analyzed using the Constant Comparative Method, which allows for the analysis of one interview before the next, making it possible to conduct the HDC and jointly construct the research results, which are inherent to the FGE. For this, the relevant paragraphs or sentences, called information units were identified, which led to the creation of provisional categories, when they were coded and grouped according to their content[11]. The information from the field diary, arising from the previous ethnography

Chart 1 – Number of participants, session duration, and topics discussed in the negotiation held with participants of each HDC. Nova Esperança, Paraná, Brazil. 2023.

HDC	Participants	Session duration	Topics discussed in the negotiation session	
			Common to HDC	Specific to HDC
Professionals	09	1 hour and 31 minutes	• Assistance at CAPS and the results of its actions • Physical structure • Multiprofessional team • Service resources • Family assistance • CAPS and RAPS	• Material and financial resources • Humanization at CAPS • Communication and interpersonal relationships • Work and organizational process
Family members	04	1 hour and 27 minutes		• Access and adherence to treatment at the service
Users	08	1 hour and 55 minutes		• Quality of care • Impact of care • Comprehensiveness of care • Environment • Social Control

HDC – Hermeneutic-Dialectical Circle; CAPS – Psychosocial Care Center; RAPS – Psychosocial Care Network
Source: The authors.

and interviews, was also considered in this analysis, allowing for the contrasting, complementing or deepening of the emerging constructions.

The provisional categories were assessed and validated in the negotiation sessions, with a high degree of consensus among participants. Since there were no changes in the provisional categories, they became the definitive categories of this study, as provided in FGE[11].

For data organization and presentation, the MAXQDA software was used, which enabled to consider the occurrence of terms and expressions in the interviews. The audio files from the data collection were destroyed after the negotiation session; the transcription of these files, processed to ensure secrecy and confidentiality, were stored on digital media, protected by passwords, with access only by the main researcher, who will retain the files for 5 years.

This research was approved by the Research Ethics Committee of the *Universidade Estadual de Maringá* and complied with all ethical principles involving studies with human beings, in accordance with Resolutions 466/2012 and 510/2016 of the National Health Council. After clarifying the research objective and method, as well as the potential risks and benefits, all participants signed the Informed Consent Form.

Participants' names were replaced to ensure anonymity. The letter "U" was used for users, "P" for professionals and "F" for family members, followed by a sequential number, according to the order of the interviews conducted in each HDC.

RESULTS

The study involved users aged between 34 and 67 years old, who attended the CAPS for a period ranging from two to 14 years, attending weekly for group activities and individual consultations. Among the participants, nine attended therapeutic workshops, while two were part of a support group for users of psychoactive substances. Additionally, two users were undergoing psychotherapy treatment.

Most users were female, with diagnoses of depressive disorder, bipolar affective disorder, schizophrenia, mental and behavioral disorder due to alcohol use, and mental and behavioral disorder due to cannabinoid use.

The participating family members were aged between 25 and 79 years old and accompanied their relatives to CAPS for a period ranging from four to 10 years, for individual and crisis-oriented care, as well as occasionally attending family meetings at the service. These family members were mothers, fathers, sisters, daughters or spouses of CAPS users, and

whose family members had been diagnosed with schizophrenia, depression and use of psychoactive substances, which required them to attend weekly collective activities and periodic psychiatric consultations.

The professionals involved were aged between 29 and 58 years old and worked as psychologists, artisan, occupational therapist, nurse, administrative assistant, social educator, social worker and psychiatrist. The length of time these professionals had worked at the service ranged from one year and three months to 14 years, corresponding to the time the CAPS had been operating. Most were women and experts in mental health.

By observing the service, it was identified that the collective activities developed at the CAPS were therapeutic workshops, support groups and collective meetings aimed at coexistence and resocialization. Therapeutic workshops occurred daily, in the morning and afternoon, except Monday mornings, which were reserved for the support group for psychoactive substance users.

In each workshop or group, there were approximately 10 participants who met weekly, lasting two hours, with each user participating in only one workshop or group. Four workshops were for children and adolescents, one for adult men and four for adult women. Only one group was conducted for psychoactive substance users, regardless of gender.

In addition to the workshops and groups, the service periodically organized other collective activities, such as monthly lunches, themed parties and outings, in which all users could participate, allowing individuals from different workshops and groups to meet. Additionally, "little fairs" were held in front of a city supermarket to sell the products made in the workshops, with the funds obtained used to promote paid outings to places like water parks, cinemas, and exhibitions.

The workshops were led by two artisans and a social educator, while the support group was facilitated by the occupational therapist, who was replaced by a psychologist during her vacations. Other professionals, mainly psychologists, attended the workshops, but were not responsible for the activity. The organization of the lunches, parties and outings was the responsibility of the social worker, the artisans and the social educator, with the participation of other professionals on the team, including the nurse, who took turns between the activities and the CAPS care.

The analysis performed through the constant comparative method revealed two categories: the first related to collective and resocialization activities in the perception of users, family members and professionals, and the second related to the contributions of these activities to the rehabilitation and psychosocial care of patients.

1 – Collective and resocialization activities in the perception of users, family members and professionals

The participants evaluated the collective and resocialization activities conducted by the CAPS, highlighting the characteristics of each one, their potentialities and challenges. A predominant focus was observed on the activities conducted within the physical space of the service, directed exclusively to users.

> *She goes to the workshop every week and participates in the lunches, parties and outings organized by CAPS. These activities are only for the patients there.* (F5)
>
> *I come to the group of dependents and always participate in the activities with all the patients. Most of them happen here, but every three months or so, we go to other places.* (U11)
>
> *We hold the little fairs in front of the supermarket, about three times a year, to sell the products produced in the workshops. Users take care of it, with team supervision.* (P8)

The analysis of the workshops, organized by groups of users with similar characteristics, such as gender, age, skills and diagnoses, revealed that they were effective in meeting the interests and preferences of the participants, in addition to being aligned with the proposed therapy. The options offered, such as manual activities, games and the use of technology, were well received. On the other hand, the support group focused on listening and encouraging abstinence, proving to be an important tool in the therapeutic process.

> *The workshops are tailored to the patients, who are separated according to what they like and what needs to be worked on in the treatment.* (P10)
>
> *There are workshops just for children and adolescents. They like different things from us, adults. I think it is important to better meet their needs.* (U9)
>
> *There are many crafts to do there: embroidery, crochet, painting... Men also like to play dominoes or ball games on the court, use the computer and chat.* (F2)
>
> *Coming to the group gives us strength to continue without using or drinking. We can interact, talk about how we resisted our desires, and serve as an encouragement and example to the other.* (U10)

When evaluating the participants' opinions, family members suggested reviewing the duration and frequency of the workshops, while users and professionals considered them

sufficient. As for the other resocialization actions, participants considered adequate. In addition, there was a consensus among them about the need to reschedule the timing of the dependents group.

> *The workshop, once a week, is not enough. It could go more often or stay there longer. I believe it would improve things.* (F6)
>
> *Once a week is fine, otherwise it starts to interfere with our home life.* (U1)
>
> *We would need to reconsider the schedule for the support group, which takes place during business hours, to favor participation. The frequency of the groups and workshops is adequate to the needs of the users we have here.* (P3)

It is important to highlight that the professionals identified planning workshops with children and adolescents as a challenge, due to the difficulty in engaging them in the proposed activities, attributing this to a lack of knowledge and training.

> *We started monitoring children and adolescents in the workshops four years ago, but we have not had any training for this. We don't know how to act with them, what to do to improve participation, which is low, especially in the workshops.* (P2)

The provision of transportation, the offer of snacks and/or meals and the attitude of the professionals responsible for the collective activities and resocialization were evaluated by the participants as facilitators, since they made attending and staying at the activities more welcoming and adequate to their care needs, reducing the factors that could hinder their participation.

> *The professionals are very pleasant. They always encourage and respect their choices and limitations. They support and guide them whenever necessary, never giving up on them.* (F4)
>
> *When we take users to other locations, t the accompanying professionals are very involved and careful.* (P4)
>
> *The CAPS has snacks and lunches, which are very tasty and give us a chance to talk and have fun. There is also a van that picks us up and takes us home whenever there are workshops, lunches and parties. This encourages and enables our participation in the activities, because many families can't afford it.* (U8)

Despite the professionals' attitude, not all team members are present at these moments, and the planning and execution of these activities are the responsibility of the artisans, social educator, occupational therapist and social worker, and may involve other professionals occasionally. Nurses are one of the professionals who rarely participate in these moments, as they understand that the specific professional duties be a priority.

> *Not all professionals on the team are responsible for developing or monitoring group activities, but one or another always attends workshops and goes on outings. Nurses are the professionals who participate the least, because they are occupied doing their duties at the CAPS and says they cannot participate. (P8)*

It was observed that collective and resocialization activities were directed at users and mainly conducted in the CAPS space, meeting the needs of different groups. However, some points needed to be reviewed to improve the efficiency of the activities.

2 – Contributions of collective and resocialization activities to psychosocial care

The collective and resocialization activities had a significant impact on the psychosocial care provided to participants, positively influencing treatment in several ways. The interaction between individuals during these activities promoted the generation of positive feelings, social inclusion, the development of interpersonal relationships, and the ability to cope with difficulties.

A relevant point was the team's approach to users and the consolidation of the treatment offered at CAPS, through support, welcoming and establishment of bonds, which favored the participants' adherence.

> *These moments help a lot in the treatment, because she is there more frequently and is closer to the professionals. The team can see how she is doing and if the treatment is effective.* (F3)
>
> *It was the group that helped me stop drinking. Just consultations and medication weren't enough.* (U11)
>
> *We provide reception, a bond between us and the users, and that's why they don't leave the treatment.* (P6)

Additionally, these places were perceived as environments conducive to coexistence and exchange between

users and the community, fostering the emergence of favorable emotions.

> *When she goes to the workshops and outings, she has more contact with other people, and is happier. She returns much more excited.* (F1)
>
> *We interact with people, talk to people we didn't talk to before, meet new people.* (U2)
>
> *At the little fairs, users are highly praised because they do beautiful things. They love it, they feel productive. They can earn money with what they know how to do.* (P5)

The inclusion of users in society was recognized as one of the main achievements of the resocialization activities. Participation in everyday situations allowed them to realize the importance of these experiences for their personal growth. Besides, the presence of users in the community resulted in more positive interaction between them, with greater acceptance by the public and a significant reduction in social isolation, fear and shame.

> *When we go on outings, we see that we are normal, that we can go to these places without fear or shame.* (U6)
>
> *Just by going to places with more people, he has started to interact better with the community. He has improved his ability to go to the supermarket or an ice cream shop, because he didn't feel safe doing that.* (F4)

Interaction with society on outings is very important, both to work through the situations that arise and for them to get to know how these environments work. And the locals also learn to deal with them, they start to accept them better. (P7)

Participants recognized that the collective and resocialization activities had a positive impact on their lives, helping them deal with challenges, such as relationships with family members and overcoming losses. They highlighted that these initiatives were essential for developing interpersonal skills and strengthening the emotional support needed to face their difficulties.

> *In the workshop, it is common for us to talk, share personal life experiences, ask for and give advice on how to deal with problems, with family members. They open up about feelings. This helps to resolve the difficulties that arise.* (P2)
>
> *When my mother died, I came to the activities, and that was great, it helped me to overcome. Both the professionals and colleagues help with the difficult things in life.* (U3)

It is evident that collective and resocialization activities are essential in the psychosocial care of CAPS, strengthening bonds, promoting social inclusion and helping in the recovery of participants. These practices have a positive impact on treatments, stimulate interpersonal relationships and offer emotional support, highlighting the importance of a humanized approach to the well-being of the individuals.

DISCUSSION

When faced with the existence of various collective and resocialization activities, which promote psychosocial rehabilitation and social reintegration, according to the concepts already presented[1–2], it is necessary to consider that the service has sought to meet the principles of the RPB, in which psychosocial and community care tends to be established, moving away from care centered on medical care and medicalization.

Collective activities are in line with the new approach to mental health care, allowing users and their families to socialize and participate in the community, while reclaiming and exercising their autonomy and agency. However, there is no standardization of how these activities should be conducted in mental health services, and the team is responsible for planning, organizing, and implementing these activities.

The literature has shown that therapeutic workshops and support groups are the most common collective activities in CAPS, with weekly frequency and aimed on different objectives, consistent with the result found in our research[13]. Since workshops were indicated as actions carried out in CAPS, their different forms and structures can be used.

In Brazil, the types of workshops have been standardized as expressive, which focus on individual expression through arts, body, words, and music; income-generating workshops, which aim to train users to produce something that gives them a financial return; and literacy, which aim to develop or improve users' reading and writing skills, contributing to their literacy[14].

In the studied service, the two types of workshops most common in the country occur, according to a review of group activities conducted in CAPS[13]. Literacy workshops should be encouraged, since they can address the low educational levels, which is common among CAPS users, and stimulate social reintegration, since there is a direct relationship between education, occupation and formal work among users[15].

As shown in the results, it is possible to understand that offering different options of activities in the workshops allows meeting the different needs and interests of users, which

change according to gender, age, clinical condition and individual preferences. Thus, the groups and workshops respond more directly to the PTS and the preferences of users, corroborating what was pointed out in the study[6].

Regarding the only group developed in the service, which is presented as a space for listening and support for users of psychoactive substances, it is worth noting that its method is in line with the best practices for assisting this group. In these activities, priority is given to welcoming, establishing bonds, harm reduction and comprehensive care for drug dependents, without discrimination or judgment[16].

The majority of collective activities are conducted within the walls and involve only users, which corroborates data from the literature[13]. However, it is worth noting that those that occur in the community space are present in the study service at least once every three months, which demonstrates a tendency to use the territory during CAPS actions.

Despite their potential, external activities are still not highlighted in mental health services, are not carried out routinely, in a way that effectively inserts users into the social context in which they find themselves. One of the reasons for this is that they require greater involvement and time from the team for their planning and execution. As a result, there is a tendency to prefer internal activities, which are less laborious and more predictable[17].

It is worth noting that the service studied has sought to involve users in family routines, alternating days of collective activities with those intended for them to stay at home, which is well evaluated by them. However, there is no family participation in collective activities, which is considered an instrument to enhance social rehabilitation and resocialization, as demonstrated in studies conducted in Uganda[18] and Pakistan[19].

Family dissatisfaction with the frequency of groups and workshops also highlights their absence in the construction and implementation of the PTS, which causes a lack of understanding of how care is organized and drives the desire for its centralization in the CAPS. It is important to note that the actions of the mental health service need to be in consensus with the PTS, which must consider the interests, aspirations and possibilities of users and family members, since this may directly impact the management and quality of their life and health[20].

The organization of the service is related to facilitating factors for carrying out collective and resocialization actions, such as the provision of food and transportation to users. They promote users' citizenship and their access to basic rights, enabling their participation in activities[16].

Despite the potential benefits identified by the interviewees, one suggestion was made: to change the support group schedule in order to improve access and adherence by users of psychoactive substances. The lack of organizational accessibility, related to how the service is organized to serve users, is one of the main reasons that hinders access and permanence in the CAPS, according to a study with crack users[21].

The challenge cited by professionals is related to the care provided to children and adolescents at the facility. Developing actions for the broad public of CAPS I, with different ages, diagnoses and demands, requires that the team be constantly trained. For this, Permanent Health Education (*Educação Permanente em Saúde* – EPS) must be implemented and strengthened as an institutional policy, qualifying the team to meet the premises of psychosocial care [22].

The participation of children and adolescents in collective activities does not only result from professional training and how they are conducted, as there is interference from their interests, availability, personal characteristics and aspects of the mental disorder[4–5].It is also impacted by commitments to school, health services, friends and leisure, and by the tasks of family members who accompany them to CAPS.

A systematic review and meta-analysis study highlighted that interventions involving the practice of physical activity are seen as interesting by children and adolescents with depression and/or another diagnosis of mental disorder, in addition to being beneficial for this group, and should be encouraged in mental health services[23].

Regarding professional monitoring in group activities, it was pointed out that their attitude is one of the service's strengths. The contact and shared responsibility of professionals play a fundamental role in prevention and early intervention in crises. Additionally, the team can activate other resources necessary to improve the clinical condition and ensure the user's stabilization[24].

A team that promotes support, bonding and welcoming across its actions was also a reason for satisfaction and adherence to treatment in other mental health services[16,25]. This adherence is also influenced by the relationships built within the group, the quality of the activities offered and how the user feels when attending the service. By resolving conflicts and producing positive experiences, the team ensures users better coexistence and development as individuals[4].

It is worth mention that there is no regulation that prevents any CAPS health professional from carrying out group activities with users and family members. However, these activities commonly become the responsibility of some, while

others are less involved. For adequate care, professionals need skills, knowledge, and attitudes to conduct collective actions effectively[4].

The evaluation showed that nurses have been little involved in collective and resocialization activities, participating sporadically in lunches, parties and outings. In this sense, COFEN Resolution 678/2021 stands out, which regulates the work of the nursing team in Mental Health and Psychiatric Nursing, highlighting the skills of these professionals in providing care in groups with users and family members, as well as leading and coordinating therapeutic groups[26].

Also in the context of nursing, a study[27] demonstrated flaws in professional training, which leads nurses to have attitudes that are not consistent with the psychosocial paradigm during their practice, both in individual and collective activities. This underscores the importance of EPS as a way to align nursing care and ensure that nurses are responsible for caring for individuals with mental disorders, addressing their needs[27].

For users of psychoactive substances, collective actions promote a support network, which they often do not have outside of service, where they face discrimination and disbelief[16]. Even mental health service professionals may be less tolerant of people with mental disorders when they are outside their work environment, resulting in discrimination and social distancing, as demonstrated in a study conducted in the United Arab Emirates[28].

Helping each other, promoting acceptance of differences and bringing people together to share experiences are the goals of support groups. Besides the groups, other collective activities also provide spaces for coexistence and interaction between individuals, which impact social reintegration. In these activities, exchanges and recognition of oneself and others occur, both within the CAPS and with the external population[4]. This exercise is necessary for users to develop interpersonal relationships and the characteristics needed for positive interaction within the service and the community[13].

The interaction with individuals outside the CAPS that occurs at the "little fairs", when selling what is made in the workshops, promotes in users a feeling of appreciation and being productive, contradicting the discriminatory conception that people have of individuals with mental disorders or drug abuse. Knowing how to produce is a means of generating income, a principle necessary to grant users greater freedom, empowerment, and autonomy, as well as to reintegrate them socially, promote citizenship, and contribute to therapeutic goals[29].

Another contribution presented by the participants was that collective activities outside the facility encourage the inclusion of users in social spaces. These activities promote citizenship and psychosocial rehabilitation and should be prioritized by services[16].

Being in community spaces allows CAPS users to reaffirm their normality as members of a society made up of diverse individuals. As a result, self-discrimination, fear of prejudice and rejection tend to decrease, which changes the way users deal with social spaces. It then becomes a challenge for mental health services to promote actions that help users feel they belong to social spaces and encourage them to frequent these spaces[16], as well as equipping them to feel safe in these places[17].

When society interacts with CAPS users in public spaces, it begins to betterdeal with them, since it normalizes their presence and learns about their particularities, reducing stigma and fear. It also allows locals to perceive what needs to be improved in order to serve them adequately, especially when it comes to environments with paid entry or intended for consumption, which are the most available and structured for outings and collective meetings[17].

Community involvement in the search for psychosocial rehabilitation and resocialization is an important tool for successful experiences, as demonstrated in studies with community mental health services in Myanmar and China. In these services, the community and health professionals work to provide housing, education and employment to people with mental disorders, to encourage their employment and understanding of their rights. To this end, the service, its users and their families participate in local development and political dialogues[30].

Finally, collective and resocialization activities are pointed out as a means of developing users' skills to deal with everyday situations involving difficulties and losses. Shared experiences, dialogue and learning that arise in the collective enable users to change the way they deal with friends, family members and the community, strengthening relationships and addressing problems experienced[13].

The results of this study have the potential to contribute to health care in mental health services and support innovations that involve the organization and implementation for the collective and resocialization, as they demonstrate that they can be developed with quality and with effective results. Furthermore, they can support management decisions to expand and solidify these actions in the environment outside the CAPS and strengthen the service in psychosocial care and in the psychosocial care network.

For nursing practice, the findings of this study highlight the need to modify training and encourage the qualification of nursing professionals, to better prepare them to work in mental health services, according to the precepts of psychosocial care, and particularly in the execution of collective and

resocialization activities. Additionally, they highlight the need for a change in professional attitude, so that nurses assume their role in management and nursing care that includes these activities, having an effective role in the multiprofessional team and in actions that are not exclusive to their profession, ensuring the quality of psychosocial care offered to users.

The limitations of this study include its development in only one CAPS I, and the fact that the sample does not represent all types of users, family members and professionals within the CAPS. However, during the study, no distortions were found in the participant selection processes, in the data collection and interpretation, or result analysis that could negatively influence the validity and reliability of the results or generate biases.

It is recommended that studies based on the FGE to be carried out in CAPS of other types, aiming to expand knowledge on how collective and resocialization activities have been developed when the team has a larger number of professionals (CAPS II and CAPS III) and when the service is targeted at only one specific group, as occurs in the CAPS for alcohol and drugs and in the CAPS for children and adolescents.

FINAL CONSIDERATIONS

Collective and resocialization activities were evaluated as essential for the psychosocial care offered in the CAPS, providing significant benefits for the participants, promoting interaction, social inclusion, interpersonal relationships and coping with adversities. Therapeutic workshops, support groups and collective meetings conducted by mental health services promote autonomy and protagonism, and encourage social reintegration and psychosocial rehabilitation, meeting the varied needs of users and the principles of the RPB.

Interaction with the community, valuing work and promoting citizenship are fundamental aspects, challenging mental health services to strengthen social inclusion. Engagement in these activities helps users deal with daily challenges and consolidate their interpersonal relationships, contributing to a positive transformation, aligned with the psychosocial paradigm. Nurses play a discreet role in the planning, execution and evaluation of collective and resocialization activities at CAPS, and it is important to modify their agency.

By performing a fourth generation evaluation at CAPS, it is possible to more broadly identify users' needs, potentialities, social demands, and possibilities for integration into society. This contributes to individualized care planning that is appropriate to each person specificities, promoting a humanized and user-centered approach.

REFERENCES

1. Saraceno B. Reabilitação psicossocial: uma estratégia para a passagem do milênio. In: Pitta AMF, organizador. Reabilitação psicossocial no Brasil. São Paulo: Hucitec; 2016. p. 19-26
2. Sanches LR, Vecchia MD. Reabilitação psicossocial e inclusão social de pessoas com problemas decorrentes do uso de álcool e outras drogas: impasses e desafios. Interface. 2020;24:e200239. https://doi.org/10.1590/interface.200239
3. Aires JSF, Vianna K, Tsallis A. Oficinas terapêuticas em saúde mental: pesquisando COM a Teoria Ator-Rede. Fractal, Rev Psicol. 2022;33(3):212-7. https://doi.org/10.22409/1984-0292/v33i3/5986
4. Nunes FC, Sousa JM, Pinho ES, Caixeta CC, Barbosa MA, Costa AP. Fatores impulsores e restritivos da prática com grupos em serviços comunitários de atenção psicossocial. Ciênc saúde coletiva. 2022;27(1):183-92. https://doi.org/10.1590/1413-81232022271.19992021
5. Oliveira ALM, Peres RS. As oficinas terapêuticas e a lógica do cuidado psicossocial: concepções dos(as) coordenadores(as). Psicol Cienc Prof. 2021;41(spe4):e204609. https://doi.org/10.1590/1982-3703003204609
6. Maeder BJ, Holanda AF. Arranjos assistenciais em uma Rede Atenção Psicossocial no sul do Brasil. Psicol Estud. 2024;29:e54679. https://doi.org/10.4025/psicolestud.v29i1.54679
7. Stracini MM, Moreira MIB. Os sentidos do morar sob a ótica dos usuários dos Centros de Atenção Psicossocial: experimentações do viver na cidade de Santos, São Paulo, Brasil. Ciênc Saúde Coletiva. 2022;27(1):69–78. https://doi.org/10.1590/1413-81232022271.19462021
8. Pini JS, Nacamura PAB, Harmuch C, Costa MAR, Giacon-Arruda BCC, Radovanovic CAT, et al. Assessment of the Psychosocial Care Center multidisciplinary team from users' and family members' perspective. Rev Bras Enferm. 2023;76(3):e20220645. https://doi.org/10.1590/0034-7167-2022-0645
9. Silva AP, Soares PFC, Costa ES, Silva LGS, Silva RG, Braga LS. O cuidado a pessoa em sofrimento mental: sob a ótica dos familiares. Nursing. 2021;24(281):6280-9. https://doi.org/10.36489/nursing.2021v24i281p6280-6289
10. Souza VRS, Marziale MHP, Silva GTR, Nascimento PL. Tradução e validação para a língua portuguesa e avaliação do guia COREQ. Acta Paul Enferm. 2021;34:eAPE02631. https://doi.org/10.37689/acta-ape/2021AO02631
11. Guba EG, Lincoln YS. Avaliação de Quarta Geração. Campinas-SP: Editora Unicamp; 2011.
12. Bertolucci PHF, Brucki SMD, Campacci SR, Juliano Y. O Mini-Exame do Estado Mental em uma população geral: impacto da escolaridade. Arq Neuro-Psiquiatr. 1994;52(1):1-7. https://doi.org/10.1590/S0004-282X1994000100001
13. Menezes GP, Pegoraro RF. Panorama das atividades grupais desenvolvidas em centros de atenção psicossocial (2006–2016). Psicol, Ciênc Prof. 2019;39:e189050. https://doi.org/10.1590/1982-3703003189050
14. Ministério da Saúde (BR), Secretaria de Atenção à Saúde, Departamento de Ações Programáticas Estratégicas. Saúde mental no SUS: os centros de atenção psicossocial [Internet]. Brasília, DF: Ministério da Saúde; 2004 [cited 2023 Jun 29]. Available from: http://www.ccs.saude.gov.br/saude_mental/pdf/sm_sus.pdf

15. Campos IO, Cruz DMC, Magalhães YB, Rodrigues DS. Escolaridade, trabalho, renda e saúde mental: um estudo retrospectivo e de associação com usuários de um Centro de Atenção Psicossocial. Physis. 2021;31(3):e310319. https://doi.org/10.1590/S0103-73312021310319
16. Machado AR, Modena CM, Luz ZMP. Das proposições da política às práticas dos serviços: há novidades nos Centros de Atenção Psicossocial Álcool e Drogas?. Physis. 2020;30(1):e300118. https://doi.org/10.1590/S0103-73312020300118
17. Bongiovanni J, Silva RAN. Desafios da desinstitucionalização no contexto dos serviços substitutivos de saúde mental. Psicol Soc. 2019;31:e190259. https://doi.org/10.1590/1807-0310/2019v31190259
18. Alinaitwe R, Seggane M, Turiho A, Bird V, Priebe S, Sewankambo N. Family Psycho-Social Involvement Intervention for severe mental illness in Uganda. S Afr J Psychiatr. 2024;30:2138. https://doi.org/10.4102/sajpsychiatry.v30i0.2138
19. Saleem S, Baig A, Sajun S, Bird V, Priebe S, Pasha A. Uma exploração de métodos mistos do papel de grupos multifamiliares no tratamento comunitário de pacientes com depressão e ansiedade no Paquistão. Int J Ment Health Syst. 2021;15:1–8. https://doi.org/10.1186/s13033-021-00500-z
20. Baptista JÁ, Camatta MW, Filippon PG, Schneider JF. Singular therapeutic project in mental health: an integrative review. Rev Bras Enferm. 2020;73(2):e20180508. https://doi.org/10.1590/0034-7167-2018-0508
21. Vernaglia TVC, Cruz MS, Peres S. O acesso ao tratamento de usuárias de crack sob a perspectiva dos profissionais de saúde. Saúde Debate. 2020;44(spe3):184–97. https://doi.org/10.1590/0103-11042020E316
22. Mattos MP, Campos HMN, Gomes DR, Ferreira L, Carvalho RB, Esposti CDD. Educação Permanente em Saúde nos Centros de Atenção Psicossocial: revisão integrativa da literatura. Saúde Debate. 2020;44(127):1277–99. https://doi.org/10.1590/0103-1104202012724
23. Recchia F, Bernal JDK, Fong DY, Wong SHS, Chung PK, Chan DKC, et al. Physical Activity interventions to alleviate depressive symptoms in children and adolescents: a systematic review and meta-analysis. JAMA Pediatr. 2023;177(2):132-40. https://doi.org/10.1001/jamapediatrics.2022.5090
24. Constantinidis TC, Belotti M, Taño BL, Silva CM, Leão A. Processo de produção de cuidado à crise em Rede de Atenção Psicossocial. Psicol Pesq. 2021;15(2):e29302. https://doi.org/10.34019/1982-1247.2021.v15.29302
25. Nacamura PAB, Salci MA, Coimbra VCC, Jaques AE, Piratelli Filho MB, Pini JS, et al. Fourth-generation evaluation in an Alcohol and Drugs Psychosocial Care Center. Esc Anna Nery. 2022;26:e20210302. https://doi.org/10.1590/2177-9465-EAN-2021-0302
26. Conselho Federal de Enfermagem (Cofen). Resolução COFEN nº 678/201, de 19 de agosto de 2021. Aprova a atuação da Equipe de Enfermagem em Saúde Mental e em Enfermagem Psiquiátrica [Internet]. 2021 [cited 2023 Jul 18]. Available from: https://www.cofen.gov.br/resolucao-cofen-no-678-2021/
27. Nóbrega MPSS, Fernandes CSNN, Zerbetto SR, Sampaio FMC, Carvalho JC, Chaves SCS. Primary health care nurses: attitudes towards the person with mental disorder. Rev Gaúcha Enferm. 2021;42:e20200088. https://doi.org/10.1590/1983-1447.2021.20200088
28. Abdulla A, Webb HC, Mahmmod Y, Dalky HF. Beliefs and attitudes of health care professionals toward mental health services users' rights: a cross-sectional study from the United Arab Emirates. J Multidiscip Healthc. 2022;15:2177-88. https://doi.org/10.2147/JMDH.S379041
29. Silva VC, Kowalczuk L, Moeller AG, Paz AA, Viana ACW. Geração de trabalho e renda para indivíduos com transtorno mental: revisão integrativa. Rev Recien. 2022;12(37):186-95. https://doi.org/10.24276/rrecien2022.12.37.186-195
30. Organização Pan-Americana da Saúde (OPAS). Orientações sobre serviços comunitários de saúde mental: promoção de abordagens centradas na pessoa e baseadas em direitos. Brasília: OPAS; 2022. https://doi.org/10.37774/9789275726440

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