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RESEARSH

PROFESSIONAL PRACTICE IN MENTAL HEALTH IN PSYCHOSOCIAL CARE CENTERS DURING THE COVID-19 PANDEMIC

PRÁTICA PROFISSIONAL EM SAÚDE MENTAL EM CENTROS DE ATENÇÃO PSICOSSOCIAL DURANTE A PANDEMIA DA COVID-19

PRÁCTICA PROFESIONAL EN SALUD MENTAL EN CENTROS DE ATENCIÓN PSICOSOCIAL DURANTE LA PANDEMIA DE COVID-19

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ABSTRACT

Objective: to understand the professional practice of mental health care carried out in Psychosocial Care Centers during the COVID-19 pandemic. **Method**: qualitative descriptive-exploratory research was carried out in four Psychosocial Care Centers (CAPS) in the interior of Rio Grande do Sul, between August and November 2021, with the participation of 18 professionals who worked during the COVID-19 pandemic. The technique used for data collection was the semi-structured interview, with visual representation through a word cloud. The data was analyzed using Thematic Analysis. **Results**: in the first category, "Impacts of the COVID-19 pandemic on professional practices in Psychosocial Care Centers", the main impacts were identified as changes in the CAPS routine and the need to adapt mental health care activities accordingly with the demands imposed by the pandemic. In the second category, "Mental health care practices during the COVID-19 pandemic", non-face-to-face mental health care practices were identified, using digital devices, in addition to face-to-face demands, to ensure the continuity of mental health care, with additional care to avoid contamination of CAPS professionals and users. **Conclusion**: during the COVID-19 pandemic, professional mental health care practices underwent changes due to the precautions adopted to avoid contamination by the virus. In this way, practices in CAPS were adapted with the use of technological devices, revealing difficulties both in the structure of services and in the social issues of users served in CAPS.
Keywords: Professional Practice; COVID-19; Mental health; Nursing Care; Occupational Health; Nursing.

RESUMO

Objetivo*: compreender a prática profissional de cuidados em saúde mental realizada nos Centros de Atenção Psicossocial durante a pandemia da COVID-19.* ***Método****: realizou-se uma pesquisa qualitativa descritiva-exploratória em quatro Centros de Atenção Psicossocial (CAPS) do interior do Rio Grande do Sul, entre agosto e novembro de 2021, com a participação de 18 profissionais que atuaram durante a pandemia da COVID-19. A técnica utilizada para a coleta de dados foi a entrevista semiestruturada, com representação visual por meio de nuvem de palavras. Os dados foram analisados por meio da Análise Temática.* ***Resultados****: na primeira categoria, "Impactos da pandemia da COVID-19 nas práticas profissionais nos Centros de Atenção Psicossocial", identificaram-se como principais impactos a modificação na rotina dos CAPS e a necessidade de adaptação das atividades de cuidados em saúde mental de acordo com as demandas impostas pela pandemia. Na segunda categoria, "Práticas de cuidados em saúde mental durante a pandemia da COVID-19", foram identificadas práticas de atendimento não presencial em saúde mental, utilizando dispositivos digitais, além das demandas presenciais, para garantir a continuidade da assistência em saúde mental, com cuidados adicionais para evitar a contaminação dos profissionais e usuários dos CAPS.* ***Conclusão****: durante a pandemia da COVID-19, as práticas profissionais de cuidados em saúde mental sofreram alterações devido às precauções adotadas para evitar a contaminação pelo vírus. Dessa forma, as práticas nos CAPS foram adaptadas com a utilização de dispositivos tecnológicos, revelando dificuldades tanto na estrutura dos serviços quanto nas questões sociais dos usuários atendidos nos CAPS.*
Palavras-chave: *Prática Profissional; COVID-19; Saúde Mental; Cuidados de Enfermagem; Saúde do Trabalhador; Enfermagem.*

RESUMEN

Objetivo*: comprender la práctica profesional de cuidados en salud mental realizada en los Centros de Atención Psicosocial durante la pandemia de COVID-19.* ***Método****: se llevó a cabo una investigación cualitativa descriptiva-exploratoria en cuatro Centros de Atención Psicosocial (CAPS) en el interior de Rio Grande do Sul, entre agosto y noviembre de 2021, con la participación de 18 profesionales que actuaron durante la pandemia de COVID-19. La técnica utilizada para la recolección de datos fue la entrevista semiestructurada, con representación visual mediante nube de palabras. Los datos fueron analizados a través del Análisis Temático.* ***Resultados****: en la primera categoría, "Impactos de la pandemia de COVID-19 en las prácticas profesionales en los Centros de Atención Psicosocial", se identificaron como principales impactos la modificación en la rutina de los CAPS y la necesidad de adaptar las actividades de cuidados en salud mental de acuerdo con las demandas impuestas por la pandemia. En la segunda categoría, "Prácticas de cuidados en salud mental durante la pandemia de COVID-19", se identificaron prácticas de atención no presencial en salud mental utilizando dispositivos digitales, además de las demandas presenciales, para garantizar la continuidad de la asistencia en salud mental, con*

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cuidados adicionales para evitar la contaminación de los profesionales y usuarios de los CAPS. ***Conclusión****: durante la pandemia de COVID-19, las prácticas profesionales de cuidados en salud mental experimentaron cambios debido a las precauciones adoptadas para evitar la contaminación por el virus. De esta forma, las prácticas en los CAPS se adaptaron con el uso de dispositivos tecnológicos, revelando dificultades tanto en la estructura de los servicios como en las cuestiones sociales de los usuarios atendidos en los CAPS.*

Palabras clave: *Práctica Profesional; COVID-19; Salud Mental; Atención de Enfermería; Salud Laboral; Enfermería.*

INTRODUCTION

Care for people with mental disorders has historically had a hospital-centric and hygienist character, centered on the disease, with violent practices that did not consider the subjectivities of those on the margins of society, resulting in exclusion and silencing[1]. These practices were questioned in Italy in the 1960s, a period in which Democratic Psychiatry questioned psychiatric care, proposing the end of hospices and the strengthening of the psychosocial approach. In other words, health care is understood as a complex and constantly changing social process, involving the person and their social relationships[2].

Influenced by the Italian experience, in Brazil, the historical transition that led to changes in mental health care practices had as its main milestone the Psychiatric Reform movement in the 1970s, which called for care in freedom that perceived people with mental disorders as subject of the right to be cared for in the territory[3]. Thus, instead of hospitalization and prison, health services organized as a network were developed, replacing the hospice model, and based on welcoming, listening and solidarity as principles.

In this sense, in accordance with the Psychiatric Reform Law, as of Ordinance N°. 3,088 of 2011, the Psychosocial Care Network (PCN) was established to organize the network of services that provide care to people in distress or with mental disorders. and with needs related to the use of crack, alcohol, and other drugs, within the scope of the Unified Health System (*Sistema Único de Saúde, SUS*). The guidelines, objectives and services that make up the mental health network were defined, including the Psychosocial Care Centers (*Centro de Atenção Psicossocial*, CAPS)[4].

The mental health care provided at CAPS is characterized by welcoming people with mental disorders and their families, through groups and therapeutic projects(4). However, with the emergence of the Coronavirus Disease 2019 (COVID-19) pandemic, the CAPS routine underwent changes, with restrictions on individual care and group activities, in order to avoid crowds and follow health protocols[5].

According to a survey carried out by the World Health Organization (WHO), one third (33%) of countries had total or partial interruptions in at least 75% of interventions and services related to mental health between June and August 2020[6]. Furthermore, there was a 25% increase in demand for psychiatric care in the country during the COVID-19 pandemic. On average, 67.8% of mental health professionals had new users during this period, and around 90% of them noticed a worsening in their users' psychiatric conditions. As a result, there were a large number of people who needed mental health care in the various PCN services[7-8].

In this context, in the area of mental health, the pandemic brought the challenge of restructuring care in order to meet the health needs of users, considering both existing demands and those resulting from the pandemic[9]. Given this, it is important to discuss mental health care as a professional practice, since this practice results from collective and cooperative work, taking into account technical and social issues determined by a specific historical context[10].

Professional practice is a movement that occurs in conjunction with the reality experienced by workers, aiming to build work projects. This practice is based on cooperative and collective approaches, which acquired both individual and collective meaning through ethical guidelines[11-12].

Furthermore, in the context of mental health, understanding the practice goes beyond the technical dimension determined by medical/hospital knowledge. Given this, the following research question arises: How are professional practices being developed in mental health care in Psychosocial Care Centers during the COVID-19 pandemic? Therefore, the objective of this study is to understand the professional practice of mental health.

METHODOLOGY

This study was conducted in a municipality in the central region of Rio Grande do Sul (RS) and used a qualitative, descriptive and exploratory approach[13]. The Consolidated Criteria for Reporting Qualitative Research (COREQ) guidelines were followed for the preparation and description of the study. The municipality in question has an average population of 280 thousand inhabitants and has four CAPS. They are a CAPS II, which deals with people with serious mental disorders; two CAPS II AD, which serve people with disorders caused by the abusive use of alcohol and other drugs; and a CAPSi, which assists children and adolescents with mental disorders.

These CAPS are coordinated by the 4th Regional Health Coordination[14].

The study participants were professionals who worked at CAPS during the COVID-19 pandemic. The inclusion criteria were being a professional with a higher, secondary, or fundamental educational level; be a professional in the Integrated Multidisciplinary Residency Program in Mental Health *(Programa de Residência Multiprofissional Integrada em Saúde Mental*, PRMISM); and working at CAPS in mental health during the COVID-19 pandemic, period in which the data was collected. Professionals who were on vacation, leave (health or premium) or any other type of absence from work during the data collection period were excluded. After applying these criteria, 18 participants were selected: six psychologists, three social workers, two nurses, a physiotherapist, a physical educator, a pedagogue, a psychiatrist, an occupational therapist, a mental health technician and a Nursing technician. All invited professionals agreed to participate.

Data collection was carried out between August and November 2021, through semi-structured interviews, which combine open and closed questions. This approach allows interviewees to express their perceptions on the researched topic, in addition to answering questions[13]. The initial question was the following: What mental health care practices were carried out in CAPS before the pandemic?

The interviews were scheduled in advance by telephone, on dates and times convenient for the professionals, according to their availability. Before the interviews, authorization was requested from those responsible and a room was reserved in the service that offered an airy environment and privacy, ensuring subjects' confidence, freedom and safety to express themselves. The interviews began with a review of the type of research in progress and its objectives, to ensure that the professional clearly understood the study in which they were participating. The interviews were carried out by the responsible researcher, a nurse specialized in data collection through interviews.

The interviews were individual and recorded on an mp3 audio recorder to facilitate later transcription. All interviewee expressions were maintained as spoken, and punctuation was used to reflect phrases, pauses, and silences. A specific time was not established for each interview, as the willingness and availability of the interviewee to share their experiences and professional practice in the service was considered. The duration of the interviews varied from 12 to 60 minutes. All necessary precautions were taken to prevent the transmission of the SARS-CoV-2 coronavirus, including the appropriate use of a mask, provision of alcohol gel and two meters between the researcher and the interviewee. This step was completed when the interviews comprehensively addressed the multiple dimensions of the phenomenon studied, with the aim of guaranteeing the quality of actions and interactions throughout the process[15].

Data analysis was based on the thematic analysis technique, which considers both the context and the empirical data of the study. Thematic analysis includes three steps: pre-analysis, exploration of the material and treatment of results, and interpretation.

In the pre-analysis step, an initial reading of the interviews was carried out to organize the material to be analyzed (corpus). It was found that the content addressed the research question, presented specific characteristics of CAPS (studied context), was homogeneous and was aligned with the objective of the study. Furthermore, recording units and context units were identified with the help of NVivo12 software, according to the object of study.

During the step of exploration of the material, an in-depth reading of the corpus of analysis was carried out to understand the core of the text. Based on this, relevant recording and context units identified in the pre-analysis were reviewed and grouped by similarity. In processing the results and interpretation step, the raw material was analyzed, and inferences were made based on the interrelationship with the relevant literature. To make data analysis more sophisticated, the word cloud was used as a tool. This technique consists of creating a figure made up of different words, based on their frequency of use in the text. The word cloud was created with the help of NVivo12 software.

The present study followed the ethical precepts established by the standards for research with human beings, according to Resolution 466/2012, and was approved by the Research Ethics Committee, through opinion report number 4,844,724 issued on July 13, 2021. Subjects signed the Free and Informed Consent Form (ICF) in two copies, and to guarantee anonymity, professionals were identified using the letter "P" followed by arabic numbers, following the interviews (P1, P2, P3 ... P18).

RESULTS

After analyzing the interviews, the following categories emerged: Challenges of the COVID-19 pandemic in professional practices in CAPS and mental health care practices during the COVID-19 pandemic.

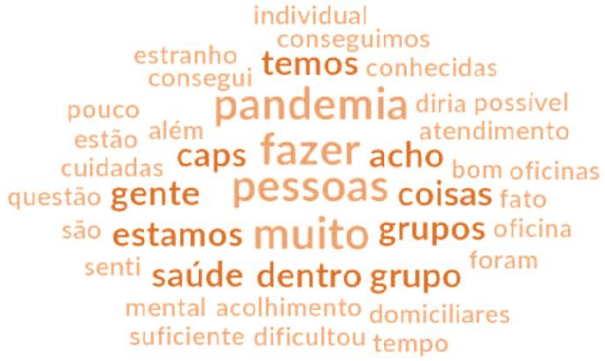
Impacts of the COVID-19 pandemic in professional practices in CAPS

The word cloud consists of grouping and graphically organizing words based on their frequency, which emerged as keywords in this category (Figure 1).).

> *With the pandemic, we closed daytime reception; groups, home visits decreased considerably, only in extreme cases; and then, individual services remained, but reduced; many patients stopped coming because of the pandemic* (P14).

The reorganization of practices was described as a process in which there was no adequate support in relation to the guidelines, and the importance of the empirical approach in practices in CAPS.

Figure 1 – Word cloud referring to category 1. *Santa Maria*, RS, Brazil, 2021.



> *At first we pushed everyone away. Now, not so much! We learn over time. Time was our school. We saw that it wouldn't hurt to bring them with the necessary care* (P8).

> *I think what made it difficult was the access to people. When the pandemic started, the Executive (the government) itself and the health organizations didn't really know what to say, people isolate themselves* (P9).

The reorganization of practices was described as a process in which there was no adequate support in relation to the guidelines, and the importance of the empirical approach in practices in CAPS.

> *A strangeness arises when they are not here for it is very strange. There were times when we came to work and we spent more time on theory, reading, writing, doing study groups, filling out medical records, of course, a lot on the phone, monitoring from a distance, but it's very strange. It deprived us a little of being in the city space, because one of the things at CAPS is to resocialize, to return to society those who are trapped by a pathology and everything else... and that was no longer possible* (P1).

> *I felt like I was able to follow-up a certain user, I could understand him/her more... meeting as a group (of people) it's good, but in the group, they don't share personal issues in depth, in the individual service they managed to share more (personal) issues, I was able to approach more to them, I felt that was good* (P10).

The change in group activities is a point highlighted by professionals, as many mention the importance and lack of this activity.

> *We do as much as we can, within that (a certain situation)... of the person who needs listening, guidance... what we can handle with individual care. However, the issue that needed the group, the activity... for sometimes, it is not the issue of the workshop. The fact of doing a workshop, but the fact of living with other people, exchanging ideas and experiences who have the same problem as the other, in that sense we lost a little* (P11).

As time passed during the pandemic, we looked for practices that more closely matched those of the pre-pandemic period.

> *And the groups, workshops, and home visits we are resuming... we resume when there is a car available... within what we can do we are trying, I'm not saying it's enough and I don't know if one day it will be, but within what we can we are trying to do* (P5).

This process of resuming practices involves the need for professionals to feel safe to work in the context of the pandemic, when there was concern not only about users, but also about the exposure and impacts of the pandemic on professionals.

> *One thing that made it difficult was the protocols for distancing and distancing from people, the fear generated by the pandemic, the illness of people we know, the loss of people we know. So, there were obstacles to activities at CAPS. But we had to adapt so that people felt cared for even with these obstacles. That was our challenge! How to make people feel cared for even in a different way* (P18).

Even with the significant changes in practices, the models adopted were considered adequate within the professionals' possibilities.

> *I think they are adequate, but I think they are not enough. In addition to the pandemic, we have the difficulty of being closer to the territory, and when we work with users of alcohol and other drugs this is fundamental, having this greater proximity. We have tried to keep the workshops and groups feeding people, with open reception. We tried; I wouldn't say it's enough. I would say it is adequate* (P5).

However, practices at CAPS are just one of the issues that address the demands of mental health users. These are practices that reinforce the importance of professionals' work at CAPS.

> *I think that mental health goes far beyond practices within CAPS, it depends on public policies and social assistance. Anyway, so many other issues, we don't have CAPS III and if we did, there's a lot of possibility of it becoming a hostel or a mental health outpatient clinic* (P7).

Mental health care practices during the COVID-19 pandemic

Next, the cloud of words that make up the second category of the study is presented. The words are arranged randomly, highlighting those that were mentioned most frequently by the interlocutors (Figure 2).

As the pandemic evolved, more and more questions related to care and restrictions arose. This led professionals to adopt new practices to guarantee assistance to users, considering the uniqueness of each one. These activities aimed to take care of users' health, avoiding their exposure to the pandemic and preventing them from circulating in public places, allowing them to receive care at home.

> *We had to design other activities due to the obstacle of activities that involved a larger crowd... they were adapted by virtual activities, as well as attempts at virtual groups, attempts at monitoring users via telephone, WhatsApp, video calls, event activities migrated to the virtual, health events, networking meetings.* [...] *So, there was an important change during this period, the insertion of other care technologies* (P18).

Figure 2 – Word cloud referring to category 2. *Santa Maria*, RS, Brazil, 2021.

As the pandemic evolved, more and more questions related to care and restrictions arose. This led professionals to adopt new practices to guarantee assistance to users, considering the uniqueness of each one. These activities aimed to take care of users' health, avoiding their exposure to the pandemic and preventing them from circulating in public places, allowing them to receive care at home.

> *I participated in hearings. Then, there were hearings where the internet didn't work! Then they said: we're going to have to do it in person. Then, we had to "transmute" to the forum* (P8).

However, the use of new technologies during the pandemic brings to the fore the discussion about the social reality in which users are involved and how they access technology, the skills to use it and the CAPS care offers. Different factors may be associated with the benefits of these practices for users, but the impact is heterogeneous across the group:

> *We use other tools, such as WhatsApp, technologies that allow us to get closer to users. This is one of the things that changed, but not much, because we know that there is also an audience that can access it, but most of us cannot...* (P9).

> *I kept attending some of them via telephone contact, the vast majority, at least of those I serve, those who can afford it (to have a telephone), do not have skills with technology, for example, video calls, WhatsApp... So, it was more by phone call... the public that we attend doesn't stay with the same phone number for a month. They are always in a rotation, they*

> *change a lot in smokers, they lose devices a lot, not everyone has internet, they don't have the financial means to have it and those who do are often older people who have difficulties dealing with technology* [...] (P14).

The use of technologies was not just a challenge for user access. The existing demand brought to light the issue of difficulty in finding the necessary material for professionals to maintain their care practices. As a result, the use of private materials in consultations was identified.

> *What made it easier for us, for the service, that I realized, was one of the things that helped - the inclusion of cell phones in the service - to be able to have this communication, which initially, in the first months, we didn't have. Then, I had to use my personal phone. Still, sometimes, you should use it. But now, there's the service, you can get better communication* (P4).

> *We tried, but it didn't work out very well. First, there was no Wi-Fi, we couldn't access Google Meet. So, we thought about a WhatsApp group, it didn't work out because we didn't have Wi-Fi here... so, we had to do it at home, but no one felt comfortable. We were not allowed to work from home, we would have to go home to hold the meeting, it was also a conflict trigger* (P5).

However, this practice brings with it exposure to professionals, as demands may arise outside office hours, requiring professional intervention.

> *If he can't come, he can call via WhatsApp, I avoid giving my private address, we have one (mobile device) here... I don't know, people use it, I've never held a meeting, but people do. Some services, like that, but it has more to do with their way to do things* (P9).

Another considerable challenge in caring for new technologies was the fact that the user was not present during the care. This created difficult situations to deal with. This brings back the discussion about a technology that both brings us closer and further away. On the one hand, there is the possibility of communicating with the person, on the other hand, there is the loss of physical contact.

> We had the possibility of attending online, video calls in *individual consultations with autistic people, especially with me it didn't happen, they didn't want to, they didn't talk, they couldn't see. It's very important to be a face-to-face consultation, to get the materials, to paint, to sew. Attending a patient doesn't just happen in conversation, just in speech, it's complicated not being present, not having the material* [...] (P1).

> *I had a patient who was complicated because I couldn't help via WhatsApp. He had suicidal ideation at home, I couldn't call SAMU because I wasn't there. At that point, it was frustrating for me because I felt like I couldn't help at all* (P10).

Even in the face of the challenges brought about using new technologies during the pandemic, positive experiences were reported that raise the question of their use in scenarios with or without a pandemic.

> *Perhaps, in the coming months, next year, things will improve with these tools that have now been included in the pandemic, digital media, which were almost not used before, will be another tool in addition to individual care that takes place in the service. This, I think will be a potential to add, it will be something that will not be removed, this from digital media, whatever it is, health or not* (P4).

DISCUSSION

To understand the dynamics of CAPS care, it is important to know the reality faced by mental health professionals. The health system has been weakened due to neoliberal policies in Brazil, which affects the appreciation and salaries of these professionals, harming their mental health[16]. Precarious working conditions already existed before the pandemic and the pandemic only highlighted these problems[17]. CAPS is recognized as a meeting space where users can interact freely with other subjects, including other users and professionals, without the fear of suffering prejudice due to mental disorders[18]. Therefore, CAPS is a service in which face-to-face activities play a fundamental role in mental health care.

This context, groups are light care practices at CAPS and are effective in caring for and socializing users. These activities occur mainly in person and may also involve family members and take place in different settings outside of CAPS. It is a space for coexistence and therapeutic exchanges. The importance of a service in which users feel safe and free to express themselves, without prejudice, is evident in face-to-face experiences, making it a reference place for treatment, without access barriers[19].

The pandemic required distancing and a reduction in face-to-face services, which resulted in significant changes to the routine of professionals within CAPS. This caused frustration as it seemed they were unable to help people

effectively. This difficulty goes against the importance of prioritizing collective actions in professional mental health practice[20-21]. The social distancing caused by the pandemic was repeatedly highlighted as a factor that negatively impacted the routine of healthcare professionals, as well as the general population. These professionals are social beings by nature and need interaction[22]. Although attenuated symptoms of depression, anxiety, anguish and changes in sleep patterns have been observed in professionals who work directly with patients with COVID-19, these symptoms are also reported by all professionals who work in the healthcare field, including healthcare professionals at CAPS[23]. In professional practice during the pandemic, there was a risk of professionals becoming a source of contamination for people close to them. This led professionals to adopt isolationist behavior to preserve people's health. However, this situation also made professionals mentally vulnerable, causing feelings of guilt to recur[22,24].

Even with professionals following prevention guidelines and understanding aspects related to the virus, fear was still reported, especially by those who considered themselves more vulnerable. This raises the issue of a lack of understanding about whether they fit into a risk group or not[25]. In the professionals' statements, it is evident that fear regarding the pandemic persists over time. Considering that professional practice already requires physical, social and emotional effort, this fear can be mitigated by the reality experienced[26].

With the risks and changes in daily practices, the use of technological devices for care through digital activities has become a possibility and a challenge. This also raises reflections on the fact that many users do not have access or skills necessary to use technologies[24]. Online care proved to be a quick intervention in the context of mental health care, with less waiting time compared to face-to-face approaches. This allowed people to express feelings such as sadness, fear and anxiety related to the pandemic[27].

Among the challenges of the pandemic, there was a need to adapt to emerging models of care to guarantee the continuation of care[24]. This change resulted in a lack of support, bringing insecurity to professional practice and compromising the quality of care provided. feeling of devaluation is also present in everyday life due to increased demand and reduced resources, which increases suffering in professional practice[16,22-23].

The inadequate environment for remote care poses a risk to the health of professionals. It is important to highlight the mental overload, the inadequate height of the devices, the inadequate table and the body pain related to posture while using the devices[28]. It is necessary to understand that the use of technological devices was not part of the reality of assistance provided previously in CAPS, as there was a different focus on the practices carried out. In addition to the difficulties related to the use of technologies by professionals, there is also the social context of users served at CAPS. During the pandemic, the negative effects on the population's mental health may be more pronounced in people with social vulnerabilities and/or with some previous psychological distress. This reality raises the debate about access to services for a population that already faces daily barriers in society. There is oppression of people with mental disorders in a segregationist sociocultural scenario, where public policies fail about the rights of these individuals[29].

The pandemic has brought to light the need to discuss care with professionals who care for people, and it is important to strengthen work processes and promote adequate and efficient communication within the health network. Collective spaces are also needed for discussion and welcoming professionals. Regarding the limitations of the research, it is noteworthy that the data were collected during the COVID-19 pandemic, a period in which healthcare professionals were under stress and overload. Furthermore, the topic has not been fully explored, suggesting that more research needs to be carried out to investigate other aspects of professional practice. Other data collection and analysis techniques can be used. about contributions to the Nursing field. This research raised questions that were relevant in professional work during the COVID-19 pandemic. Nursing plays a crucial role in mental health teams and is an essential profession in front-line care.

FINAL CONSIDERATIONS

During the COVID-19 pandemic, professional mental health care practices were reduced, with fewer face-to--face services, and there was the challenge of incorporating technological devices to provide remote care. This brought challenges to mental healthcare professionals and services, exposing difficulties in assistance and raising discussions about the reality of users and their access to these devices.

In this context, practices using digital devices were observed, which demonstrated the potential to care for CAPS users. These technologies already existed but were little or not used. However, these practices have also sparked debates about how these tools can approach the

care of individuals who are often in situations of social vulnerability.

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