Revista de Enfermagem
do Centro-Oeste Mineiro
2017;7:e1685
DOI: 10.19175/recom.v7i0.1685
www.ufsj.edu.br/recom

RECOM
REVISTA DE ENFERMAGEM DO CENTRO-OESTE MINEIRO

Original Article

QUALIDADE DA ASSISTÊNCIA EM SAÚDE MENTAL: DESENVOLVIMENTO DE UM INSTRUMENTO DE AVALIAÇÃO

CARE QUALITY IN MENTAL HEALTH: DEVELOPMENT OF AN ASSESSMENT INSTRUMENT

CALIDAD DE LA ATENCIÓN EN SALUD MENTAL: DESARROLLO DE UN INSTRUMENTO DE EVALUACIÓN

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RESUMO

Objetivo: desenvolver um instrumento para avaliar a estrutura e o processo da assistência em saúde mental nos centros de atenção psicossocial e buscar evidências de validade de conteúdo. **Método:** estudo transversal, metodológico, com abordagem quantitativa, em duas etapas. Considerou-se a avaliação normativa, a partir de um instrumento de pesquisa (*check-list*). Na verificação dos níveis de concordância e de consistência entre os juízes (n=50), foram aplicados o Coeficiente Kappa e o Índice de Validade de Conteúdo. **Resultados:** a maioria dos juízes era da região Sudeste: enfermeiros, doutores, atuantes na docência e pesquisa. Na rodada 1, dos 40 itens propostos para o instrumento, 13 foram excluídos e 08 sugeridos. Na segunda rodada, dois novos sugeridos. **Conclusão:** a composição do instrumento foi aceita pelos juízes e os índices aplicados mostraram evidências de validade de conteúdo do mesmo.

Descritores: Pesquisa sobre serviços de saúde; Saúde mental; Qualidade da assistência à saúde; Validade social em pesquisa; Serviços de saúde mental.

ABSTRACT

Objective: this study aimed to develop an instrument to evaluate the structure and process of mental health care in Psychosocial Care Centers and to seek evidence of content validity. **Method:** cross-sectional methodological study with quantitative approach in two stages. The normative evaluation of a research instrument (checklist) was carried out. The Kappa coefficient and the Content Validity Index were applied to check the levels of agreement and consistency among judges (n=50). **Results:** most of the judges were from the southeast region: nurses, doctors, active in teaching and research. In phase 1, 13 of the 40 proposed items of the instrument were excluded and 08 suggested. In phase 2, two new items were suggested. **Conclusion:** the composition of the instrument was accepted by judges and the applied indexes indicated evidence of validity of their content.

Descriptors: Health services research; Mental health; Quality of health care; Social validity in research; Mental health services.

RESUMEN

Objetivo: Este estudio tuvo como objetivo desarrollar una herramienta para evaluar la estructura y el proceso de la atención sanitaria prestada en los centros de atención psicosocial y buscar evidencias de validez de contenido. **Método:** Estudio transversal, metodológico con enfoque cuantitativo en dos etapas. Se consideró la evaluación normativa, a partir de un instrumento de investigación (lista de comprobación). En la verificación de los niveles de concordancia y de consistencia entre los jueces (n = 50) se aplicaron el Coeficiente Kappa y el Índice Validez de Contenido. **Resultados:** La mayoría de los jueces eran del Sudeste: los enfermeros, doctores, activos en la docencia y en la investigación. En la fase 1, entre los 40 artículos propuestos, se excluyeron 13 y 08 sugeridos. En la fase 2, dos nuevos fueron sugeridos. **Conclusión**: La composición del instrumento fue aceptado por los jueces y los índices aplicados indican evidencias de la validez de su contenido.

Descriptores: Investigación en servicios de salud; Salud mental; Calidad de la asistencia a la salud; Validez social de la investigación; Servicios de salud mental.

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Como citar este artigo:
Azevedo DM, Salvetti MG, Torres GV. Care quality in mental health: development of an assessment instrument. 2017;7:e1685. [Access_____]; Available in:_____. https://doi.org/10.19175/recom.v7i0.1685

INTRODUCTION

With the creation of substitutive services and the insertion of mental health actions in primary care, promoted by the Brazilian Psychiatric Reform (PR), new therapeutic approaches have been developed with mentally ill people, users of psychoactive substances and their relatives[1,2]. This process of change has stimulated more appropriate forms of care for madness and chemical dependence that affect families and the society.

Despite efforts to effectively change health practices in this area, old and new obstacles emerge in the Brazilian territory: reproduction and attachment to asylum practices in substitutive services; lack of dialogue between basic care and the Center for Psychosocial Care (CAPS); insufficient Psychiatric Urgency/Emergency services (number and problem-solving capability); psychiatric beds in general hospitals with inadequate use; increased use and dependence on drugs; inadequate training of professionals; and absence of actions/programs aimed at mentally ill offenders. Thus, the development of evaluative studies seems timely and pertinent.

Evaluation of health programs, services and technologies has stood out as a State policy in recent years and addressed the need of improving the quality of care, integrating the social rights for public policies of the population[3-5]. As a result, it has been intensified in recent years in parallel to the provision of services, increased costs and the incorporation of technology in the treatment of diseases, particularly on the evaluation of mental health services[6].

The Brazilian Ministry of Health has increased the investments in the evaluation of services and health care. One example is the Evaluation Program for the Qualification of the Unified Health System (SUS). This initiative takes into account the active presence of health managers and professionals, users and families, access to actions and services at all levels of care, with emphasis on mental health services[5].

In recent years, evaluative research in mental health services has increased, representing a natural and necessary movement[7-8]. Since the last decade, the World Health Organization (WHO) has encouraged the development of research and monitoring of mental health services, with indicators of quality of care and assessment of treatment outcomes. The evaluation of mental health services should be a periodic and continuous activity, aiming to identify aspects of care and treatment, of the work process in health, to improve the actions developed[9].

This article defends the perspective that users, family members, health professionals, managers and the whole community should be part of the conduction and evaluation of mental health services and of the quality of care provided[9-10].

Assessment of mental health services and the establishment of indicators of quality of care can help in effective strategies for developing and strengthening the PR. The objective of this study was to create an instrument to evaluate the structure and process of mental health care and to seek evidence of content validity from the perspective of normative health evaluation[11].

METHODS

This is a cross-sectional, methodological study with quantitative approach, developed between August and December 2013, in two stages. In the first stage of the research, the construction of the instrument "Checklist of Health Care Quality in CAPS" (QAS-CAPS) was based on the Brazilian National Mental Health Policy[12-15]. This instrument intends to evaluate the structure and the process of the mental health care in the CAPS, service entrance of this policy.

The structure of the instrument covers relatively constant and essential characteristics of the health care process, including the physical area of the service, human resources, material and financial resources, normative instruments involved in administration, political support and organizational conditions. The process refers to the provision of health care based on conventional technical-scientific standards such as that determined by the National Mental Health Policy of SUS, the use of resources, as well as the recognition of problems and of the care provided[11].

The proposed checklist, in its initial construction with 40 assertive items/assertions (20 for structure and 20 for process), covers the following domains: Physical Structure and Organizational Structure; Therapeutic Process/Activities, Process/Management of Care and Service, Process/Activities of the Community or External to CAPS. After validation of content,

this instrument is intended to be applied through participant observation in CAPS and interview with the service coordinator, with binary response options (absent/present).

In the second stage, judges/experts were contacted by electronic mail in two rounds of the Delphi method. The data collection technique, known as Delphi Method, is considered an important strategy to aggregate ideas and experiences of different people, in an infinite geographic context. In this technique, it is assumed that the collective judgment, based on a structured set of knowledge and experiences, represents much more than the single or individualized opinion of several subjects[16].

The panel of judges was surveyed by consulting the Lattes Platform of the National Council for Scientific and Technological Development (CNPq), through electronic contacts available in published articles and by indication of judges (snowball). As an inclusion criterion, judges should have experience in the area of mental health or health service evaluation for at least one year.

In the first round, Phase 1 of the Delphi Method, 267 judges were invited and 59 accepted to participate and evaluated the research instrument. In the second round, 50 judges evaluated the instrument (85% of return between rounds).

The form for evaluation of the instrument was submitted online (google.docs), followed by the Informed Consent Form (ICF). Each assertion was classified as adequate or inadequate, based on four criteria[17]: Relevance/Pertinence (the item meets the proposed purpose: health assessment); Clarity/Simplicity (the item is understandable and expresses a unique idea); Precision (it is different from others and is not confused with others); Objectivity (item allows a punctual response).

The Kappa coefficient (k) was applied to check the levels of agreement and consistency (reliability) among judges. The Content Validity Index (CVI) was used to measure the proportion or percentage of judges who agreed or disagreed with the items of the instrument[18-19].

The analysis of retention of items in the instrument adopted the Kappa Index ≥ 0.70 and the Content Validity Index (CVI) ≥ 0.80 in the first round, and Kappa ≥ 0.80 and CVI ≥ 0.90, in the second round. The agreement indices admitted in this research (Kappa and CVI) are considered good or excellent by some researchers[18,20].

The items that did not reach the established Kappa and CVI scores were excluded; otherwise their permanence was justified with support on the literature. Judges also had the option of including suggestions for correction and modification of items of the instrument.

The research was approved by the Ethics and Research Committee of the Federal University of Grande do Norte (CEP-UFRN/CAAE - 12288313.8.0000.5292), respecting the normalization of Resolution 466/2012, regarding the ethical aspects of the research involving human beings in Brazil. The data were coded and tabulated in an electronic spreadsheet (Excel software) and analyzed through the SPSS statistical program for descriptive statistics. After the analysis, the instruments were reformulated according to the results of the Kappa and IVC indices, including the suggestions given by the judges.

RESULTS AND DISCUSSION

The analysis of the characteristics of the judges showed that the majority were female (78%), aged between 36 and 55 years (54%), residents in the Southeast region (40%), with PhD degree (70%), nurses (54%), and acting in teaching and research (86%). It was also observed that in the case of 54% of the judges more than 14 years had elapsed after completing training, 40% worked in the area of mental health, between seven and sixteen years, and 46% in health evaluation, between five and fourteen years.

Table 1 presents the judgment in the two rounds of the Delphi method, related to the evaluated instrument.

Table 1 – Judgment of the research instrument "Checklist of Health Care Quality in CAPS". Natal, Rio Grande do Norte, 2013.

Number of items	1rst round	2nd round
Initial items	40	35
Excluded items	13	00
New items	08	02
Total	**35**	**37**

Source: Research data.

The construction of instruments to evaluate mental health care seems to follow the changes that have occurred in the last two decades, with the reversal of the health care model, from an asylum to a psychosocial model. Studies published on specific mental health assessment instruments have addressed professional satisfaction and overload[21], and user and family satisfaction[22-23]. The precursor WHO-SATIS, an instrument designed by the WHO to measure the satisfaction of users, family and professionals, with mental health services[24] is also worthy of note.

The proposal of this research presents a similar path and at the same time, different from the abovementioned authors. First, it represents an evaluative demand of the PR itself experienced in the country, with CAPS as the main substitutive service. Second, it seeks to establish direct and interdependent relationships between structure and process in the quality of mental health care of this service. Third, it arises from the concern to investigate the quality of care in a health region (population estimated at 290 thousand inhabitants), which in 2005 had the only existing psychiatric hospital closed[25].

Regarding the characterization of the judges, there was a proportional participation among professionals from the Northeast, Southeast and South regions. The last ones are responsible for most of the national production on the area, for the presence of universities and research centers pioneering in the field of mental health and evaluation of services.

Training of professionals in different health areas (nursing, medicine, psychology, social work and occupational therapy), contemplating the interdisciplinary and multiprofessional character of mental health, and their action in teaching and research settings, as well as a training time long enough to experience the emergence and the background of the PR, provide a framework of experts aligned to the proposal of this study.

Table 2 shows the assertions regarding the structure that did not reach the Kappa and/or CVI scores established for maintenance in the instrument, according to the evaluation of judges (round 1) and the methodology used, followed by the justification for permanence or not in the next round.

Table 2 - Judgment of assertions considered inadequate, their evaluation indices and justification for permanence in the instrument. Natal, Rio Grande do Norte, 2013.

Domains and Assertions (Round 1)	Kappa	CVI	Suggestions of judges	Approval of the researcher	Justification
Organizational structure					
Visual signaling and Service Flow	0.61 (Clarity) 0.68 (Relevance)	0.74 (Clarity)	Exclude	Yes	It is not mentioned in the official documents of the National Mental Health Policy[13,15].
Working Hours Composition of the Technical Team Number of users served per day – Provision of meal	≤0.67 (Clarity) ≤0.68 (Relevance)	≥0.82	Exclude and integrate characterization variables of the CAPS	Yes	Although mentioned in the official documents[13,15], it is agreed that they should integrate the characterization of the CAPS.
Disposal of Contaminated Material	0.65 (Relevance) 0.73 (Clarity)	0.81	Exclude	Yes	It does not fit into the structure domains chosen to compose the instrument.
Clinical-Social Record	0.65 (Clarity)	0.77 (Clarity)	Exclude	No	Renamed to Transdisciplinary Record, according to literature[26].
Physical structure					
Room for collective service	0.67 (Clarity)	0.79 (Clarity)	Exclude	No	It is part of the Manual of Physical Structure of Mental Health Services[15].

Source: Research data.

The four new items suggested by the judges in this round were related to the physical structure: division of the item "accessibility" into "internal accessibility" and "external accessibility"; "inner space of coexistence", "collective room with individual accommodations" and

"coordination/administrative room". The last three comply with the normative provisions of the National Mental Health Policy[15,27].

The exclusion of the items "signaling and service flow" and "disposal of contaminated material" was agreed among judges because they are little to do with the characteristics of the other items of the instrument. The insertion of the three items related to the physical structure ("inner space of coexistence", "collective room with individual accommodations" and "coordination/administrative room") is supported by literature[15].

We agree with the judges with respect to the division of the items "transdisciplinary record" and "UTP" because these are two distinct, although complementary, organizational/clinical instruments. The transdisciplinary record favors teamwork and professional dialogue, stimulates the exchange of knowledge, between users and family members, and develops the production of bonds and the strengthening of the sense of group. The transdisciplinary record must be shared, with updated and comprehensible information to the entire team, so as to facilitate the development of UTP[28].

The UTP represents a set of proposals on articulated therapeutic behaviors, involving an individual or collective subject (family), as a result of the collective discussion of the technical team of the service originally idealized in mental health. It aims at singularity and difference as central articulating elements of the health-disease process[29].

Regarding the Process, Table 3 shows the assertions that did not meet the Kappa and/or CVI scores for retention in the instrument, according to round 1, and justifications for retention.

Table 3 - Judgment of assertions considered inadequate, their evaluation indices, and justifications for retention in the instrument related to the Process. Natal, Rio Grande do Norte, 2013.

Domains and Assertions (1rst round)	**Kappa**	**CVI**	**Suggestios of judges**	**Approval of researcher**	**Justification**
Therapeutic Process/Activities					
Individual Family assistance	0.69 (Clarity)	0.85	Exclude	Yes	The assertion is part of official documents[13,15], now is part of two new items.
Therapeutic listening	0.58 (Clarity) 0.63 (Precision)	0.71 (Clarity) 0.76 (Precisio)	Exclude	Yes	The assertion contemplates the description of hosting proposed by SUS[30] which is already part of another item in the instrument.
Spontaneous Demand Service	0.68 (Clarity) 0.69 (Precision)	0.75 (Clarity)	Exclude	Yes	The assertion became part of a new item on Hosting[15,27]
Hosting	0.61 (Clarity) 0.69 (Precision)	0.75 (Clarity)	Exclude	No	The assertion is part of official documents[15,27]
Users, Family and Technical Assembly	0.65 (Clarity)	0.77 (Clarity)	Exclude	No	The assertion is part of official documents[15,27]
Process / Management Of Care and Service					
Classification of users in CAPS	0.68 (Relevance) 0.7(Precision)	0.8	Exclude	Yes	Inexistent, according to official documents of the Ministry of Health[15,27]
Unique Therapeutic Project (UTP)	0.69 (Clarity)	0.83	Exclude	Yes	The assertion demonstrates better relevance in the first part of the Checklist (Organizational Structure)
Evaluation and Monitoring of CAPS	0.65 (Precision)	0.78 (Clarity)	Exclude	Yes	The assertion is contemplated in Structure[31]
Active search for users	0.69(Clarity) 0.68 (Precision)	0.6 (Precision)	Exclude	Yes	The assertion includes an item of Therapeutic Process/Activities (Home Visit).

Source: Research data.

The judges suggested four new items, from a subdivision of two items, as specified in the justification, related to Therapeutic Process/Activities ("individual care for family members" and "collective care for family members") and Process/Management of Care and Service (“spontaneous demand service" and "night/day care"), all referenced in the ministerial literature[13,15,27]. In the domain of Process/Activities of the Community or External to CAPS, all the items obtained indices above the pre-established scores and, therefore, did not undergo modifications.

The exclusion of the item "classification of CAPS users" is relevant because from 2012 onwards, the Ministry of Health no longer takes into account the treatment regimes of CAPS users (non-intensive, semi-intensive and intensive), motivated by the redirection of the procedure payment table in the CAPS[27].

The item "evaluation and monitoring" covers the assertion related to clinical-institutional supervision, present in the Organizational Structure of the instrument. Such supervision is understood as the work of a mental health professional external to the CAPS technical team, with recognized theoretical and practical training, who will assist the staff of the service for three or four hours a week, advising and accompanying the work carried out, with special focus in the UTP of the users[32].

The items "therapeutic listening" and "spontaneous demand" were included in the item "hosting" because the National Humanization Policy (Humaniza SUS) considers listening and meeting the demand are integral elements of the reception, understanding it as a way of developing the work processes in health, capable of attending those who seek the health services, adopting a posture that welcomes, listens and gives more adequate responses to users[29].

In round 2, two new items were added at suggestion of judges. One of them was related to the Organizational Structure domain: division of the item "transdisciplinary record", which included the unique therapeutic project (UTP) into "transdisciplinary record" and "singular therapeutic project". In addition to this, the item "institutional therapeutic project" (ITP) was suggested by 18 judges; this suggestions was accepted and included in the instrument, supported by the creation of the services itself, since no request for new CAPS in the Ministry of Health is possible without this document. It represents the central purpose of CAPS, its goals, physical structure, health team, services and health actions offered, the clientele to be served.

Thus, the proposed instrument (Figure 1/Checklist QAS-CAPS) ended up in the last round with 20 items for structure and 17 for process, totaling 37 items to analyze the quality of health care in the CAPS.

Figure 1 - Checklist of the Health Care Quality in CAPS (A-Structure and B-Process)

A. STRUCTURE	**Response option**	
Domain A.1 Physical Structure (Expected Score 0 to 14) The CAPS has:	**Yes (1)**	**No (0)**
A.1.1 - at least two individualized meeting rooms (Spaces for reception, consultations, interviews, therapies, guidelines), to guarantee privacy to users, family members and professional staff.		
A.1.2- at least two collective activities rooms (Spaces for attending groups, development of therapeutic workshops, meetings. Use of users, family and professional staff).		
A.1.3- reception hall (Space where the first contact of the user and/or their relatives/companions and the service takes place. It represents an accessible and cozy space, with seats to accommodate the people who arrive at the service).		
A.1.4- administrative room (space for use and demands of the service coordination/management).		
A.1.5- dining hall (space for handling and preparing food).		
A.1.6- cafeteria (space for meals of users and professional staff, open all day long, consisting in a pleasant place of coexistence and exchanges).		
A.1.7- INTERNAL living space (environment for informal meetings between users, family and CAPS workers, as well as visitors, people from the community or the psychosocial network, to promote the circulation of people, exchange of experiences and informal conversations).		
A.1.8 - EXTERNAL space of coexistence (Open space of circulation of people, for individual and collective activities. Ventilated area where users, family, visitors and the professional staff can share moments in groups or alone).		
A.1.9- EXTERNAL accessibility for people with disabilities, with difficulties of locomotion and on stretchers.		
A.1.10 - INTERNAL accessibility for people with disabilities, with difficulties of locomotion and on		

stretchers.		
A.1.11- MALE bathroom with shower, toilet adapted for people with disabilities, for use of users, family members/companions and professionals of the service.		
A.1.12- FEMALE bathroom with shower, toilet adapted for people with disabilities, for the use of users, family members/companions and professionals of the service.		
A.1.13 - medicine application room/nursing station (space with bench for preparation of medication, sink and cabinets for storage of medicines).		
A.1.14- collective room with individual accommodation for day/night care (CAPS I and II, two beds, CAPS III, eight beds distributed into more than one room).		
Domain A.2 Organizational Structure (Expected Score 0 to 6) About CAPS:	**Yes (1)**	**No (0)**
A.2.1- It has a weekly schedule, to forecast activities involving users, family and professional staff.		
A.2.2- It has an Institutional Therapeutic Project (ITP).		
A.2.3- In it, each user has a transdisciplinary record for notes of team professionals.		
A.2.4- In it, each user has a Unique Therapeutic Project (UTP) to monitor clinical and psychosocial conditions.		
A.2.5- It distributes every month psychotropic medication to its users for daily pharmacological treatment.		
A.2.6 The technical team receives weekly external supervision for clinical-institutional matters (Decree GM Nº 1.174).		
FINAL Score (0 to 20)		
B. PROCESS	**Response option**	
Domain B.1 Therapeutic Process/Activities (Expected Score 0 to 5) CAPS performs:	**Yes (1)**	**No (0)**
B.1.1- Body Practice Workshops at weekly basis (activities that aim at corporal perception, self-image and psychomotor coordination of users).		
B.1.2- Expressive and Communicative Workshops at weekly basis (activities that aim at expanding the communicative and expressive repertoire of users).		
B.1.3- home care (home visit), to understand the context and relations of users/families, and case follow-up.		
B.1.4- family care (INDIVIDUAL actions that aim at participation and co-responsibility in the attention to the health of the users, besides needs in the health process of family members).		
B.1.5 - family group at least once a month (COLLECTIVE/GROUP action to share experiences, information and therapeutic function).		
Domain B.2 Process/Management of Care and Service (Expected Score 0 to 7) CAPS performs:	**Yes (1)**	**No (0)**
B.2.1 - initial reception of users and/or family members by SPONTANEOUS demand.		
B.2.2 - initial reception of users and/or family members on REFERENCED demand.		
B.2.3 - night/day hosting (hospitality action as a UTP resource that aims to retake/rescue and resize interpersonal relationships, family and/or community living).		
B.2.4 - every user has a Reference Technician (RT).		
B.2.5 - at least once a month, some strategy for teaming with the Psychosocial Care Network (RAPS): basic care (FHS and NASF), urgency and emergency, general hospital referral services for discussion of cases and of work process, shared care and health actions in the territory.		
B.2.6 - At least once a month, Assembly of Users, Family members and Technicians (participation in the service management process and strengthening of the protagonism, appropriation and defense of rights/duties of all involved).		
B.2.7- WEEKLY meetings with their professionals, aiming at the discussion/resolution of administrative problems, operation of the service, discussion of cases.		
Domain B.3 Process/activities of the community or external to CAPS (Expected Score 0 to 5)	**Yes (1)**	**No (0)**
B.3.1 The CAPS is articulated with components of the INTERSECTORIAL service network (Schools, Reference Center in Social Assistance-CRAS, Specialized Reference Center-CREAS, etc.) for active search, shared care and intersectoral actions in the territory.		
B.3.2 It promotes some Employment and Income Generating Activity or articulates with Solidary Economy Networks, Cooperatives.		
B.3.3 It carries out, at least once a month, Community Activity external to the service (city tour, visit to public spaces, events, etc.) aiming at the use of different social spaces by users.		
B.3.4 The CAPS celebrates in its physical space festivities in commemorative dates (carnival, antimanicomial fight, June festivities, mothers'/fathers' day, Christmas/new year...).		
B.3.5 In the last year, the Municipal/State Health Department developed at least one strategy of Permanent Health Education (PHE) aimed at CAPS workers.		
FINAL Score (0 to 17)		

FINAL CONSIDERATIONS

It was possible to develop an instrument to evaluate the structure and process of mental health care in CAPS, based on the National Mental Health Policy. The suggestions of judges allowed to improve the initially proposed instrument and the indices obtained indicated evidence of validity of content. This initiative presents as strong points the opening of new possibilities for reflection on the PR process in Brazil, besides the easy applicability and interpretation. As weak points, the limitations of normative evaluation and the impossibility of capturing all the evaluative dimensions of the health structure and process are noteworthy.

The Checklist "QAS-CAPS" is not intended to be unique or complete. Its use represents the possibility to using evaluation as an aid in the diagnosis of the CAPS network, besides the need of application in different scenarios (CAPS) to test its internal validity, along with new related studies. It is understood that such fragilities potentially strengthen and challenge the understanding of an area of knowledge (mental health) that demands plurality and diversity of experiences *per se*.

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Note: This article represents part of the PhD Thesis defended in August 2014, Graduate Program in Health Sciences (PPGCSa), Federal University of Rio Grande do Norte (UFRN). The research received encouragement through a PhD scholarship from CAPES and Pro-Rectory of Research and Post-Graduation from the State University of Rio Grande do Norte (UERN).

Received in: 23/12/2016
Approved in: 17/10/2017

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