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# COORDINATION OF THE PSYCHOSOCIAL CARE NETWORK FOR MENTAL HEALTH CRISIS

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**ABSTRACT.** This research aimed to investigate the coordination of the psychosocial care network (RAPS) for mental health crisis care, in its workers' view. It is a descriptive exploratory study with qualitative approach. The study was carried out from 62 portfolios made by the students of the Mental Health Crisis and Urgency Course, who answered the reflective question: "Considering your workplace as a point of RAPS / RUE, describe, reflect and write a text with the synthesis regarding the articulation with the other network points in the reality of your municipality". The data were analyzed according to Thematic Content Analysis method suggested by Bardin, which comprises three phases: Pre - analysis, Material Exploration and Treatment of the Information, inference and interpretation. As a result, three thematic categories were identified: Referral, the traditional way of referring to specialized care, which is associated to a more fragmented care process; Matrix support, the current proposal of collaborative care, a joint strategy that contributes to the complex care demanded by mental health services users; and New strategies for network care, exemplified by meetings or sessions that discuss new ways to enable the network care.

**Keywords**: Mental health; mental health services; crisis intervention.

# ARTICULAÇÃO DA REDE DE ATENÇÃO PSICOSSOCIAL PARA O CUIDADO ÀS CRISES

**RESUMO.** O objetivo deste estudo consistiu em conhecer a articulação entre os pontos da Rede de Atenção Psicossocial (RAPS) no cuidado às situações de crise em saúde mental, na visão dos seus trabalhadores. Trata-se de uma pesquisa exploratória descritiva com abordagem qualitativa. O estudo foi realizado com base em 62 portfólios elaborados pelos alunos do Curso Crise e Urgência em Saúde Mental, respondendo à questão reflexiva: "Considerando seu local de trabalho como ponto da RAPS/RUE, descreva, reflita e elabore uma síntese sobre como se dá a articulação com os demais pontos da rede na realidade do seu município". Os dados foram analisados segundo o método de Análise de Conteúdo Temático de Bardin, que compreende três fases: pré-análise, exploração do material e tratamento das informações, inferência e a interpretação. Os dados resultaram em três categorias temáticas: encaminhamento: modelo tradicional de cuidado, o qual evidenciou o encaminhamento inadequado gerador de um cuidado fragmentado; matriciamento, a proposta atual, que traduz uma estratégia de articulação que contribui para o cuidado prestado ao usuário; e novas estratégias, exemplificado por encontros que abordam novas maneiras de viabilizar o cuidado em rede. Considera-se que a articulação entre os serviços de saúde é de extrema importância para um cuidado humanizado e integral ao usuário. Para tanto, faz-se necessário que os trabalhadores tenham conhecimento da sua rede de apoio, bem como utilizem meios de se integrar à mesma, seja por reuniões, capacitações ou encontros que favoreçam a troca de experiências.

**Palavras-chave:** Saúde mental; serviços de saúde mental; intervenção na crise.

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## COORDINACIÓN DE LA RED DE ATENCIÓN PSICOSOCIAL PARA EL CUIDADO A LA CRISIS

**RESUMEN.** El objectivo de este estudio fue conocer la relación entre los puntos de la Red de Atención Psicosocial para el cuidado de las crisis en salud mental, a la vista de sus trabajadores. Es una investigación exploratoria descriptiva con enfoque cualitativo. El estudio recurrió a 62 carteras realizadas por los estudiantes de la crisis de salud mental y Curso Urgencia que respondió a la pregunta reflexiva: "Teniendo en cuenta su lugar de trabajo como punto de RAPS/RUE, describir, reflexionar y elaborar un resumen de cómo es la relación con los demás puntos de la red en la realidad de su municipio". Los datos se analizaron según el método de análisis de contenido temático sugerido por Bardin, que consta de tres fases: Pre - análisis, exploración y tratamiento de la información, la inferencia e interpretación de lo material. Como resultado se identificaron tres categorías: Referencia, la forma tradicional de hacer referencia a la atención especializada, que se asocia a un proceso de atención más fragmentado; Ayuda matricial: la propuesta de la época, haciendo de esta una estrategia conjunta que contribuya a la atención proporcionada al usuario; y Nuevas estrategias para el cuidado en red, ejemplificadas por las reuniones o sesiones que tratan sobre los nuevos modos de activar el cuidado de la red.

**Palabras-clave**: Salud mental; servicios de salud mental; intervención en la crisis.

## Introduction

In Brazil, the Federal Constitution of 1988 presents health care as a right of all citizens and an obligation of the State; it was the result of an intense and important social mobilization towards the enlargement of the access to citizenship in the country. Aiming at improving the constitutional determination and regulating the set of actions and services performed, by bodies, institutions and foundations kept by the Public Power and aiming to unify the different actions, programs and health care services, the *Sistema Único de Saúde* (Unified Health System – SUS), by means of the Law number 8.080 dating from 1990 (Fountora & Mayer, 2006).

SUS construction is guided by the following principles: Universality, which assures health care attention by part of the system to every citizen; this way, the individual has the right to access all the health services; Equality, which aims to assure actions and services to all the levels according to the complexity of each case, regardless of who the individual is, once, for SUS, everyone must be treated equally; Integrality, which consists of the integration of preventive, curative, individual and collective actions. It means that health care actions must be integrated and aim at the prevention and the cure of the disease, and the individual must be integrally assisted, not in a fragmented way (Fountora & Mayer, 2006).

On the other hand, since the end of World War II, in many countries around the world, several movements aiming at the re-orientation of the model of health care attention started to be structured. In Brazil, those movements shaped at the end of the 1970s, associated with the struggle for the country's re-democratization; they defended the idea that people who suffer from mental disorders have the right to be cared for in liberty, in opposition to the asylum logics, predominant in health care actions and services offered at that time. During several years, that ideal was the origin of many questions and changes whose goal was assuring the rights of that particularly vulnerable population. It generated what was called the Psychiatric Reformation Movement (Amarante, 2008).

In March 27 of 2001, the Law n. 10.216/2001 was promulgated; it is also known as Psychiatric Reformation Law, which represented a significant advance in the legal assurance of the ideals of the Brazilian anti-asylum movement. That law embraces the rights and the protection of people with mental disorders, recognizing them as citizens and regulating their relations with health and law professionals, as well as with the society and with the State (Lei n. 10.216, 2001).

The recent Brazilian mental health policy is recognized by international agencies, such as Pan-American Health Organization (PAHO) and World Health Organization (WHO). It has as its guideline the deinstitutionalization of people with mental disorders, substituting the centrality of psychiatric hospitals for a wide network of services, such as the psychosocial care centers (*Centros de Atenção Psicossocial - CAPS*), Community Centers, Therapeutic Home Care Services and psychiatric wards in general hospitals, among others (Amarante, 2008).

More recently, the recognition of the change on the epidemiological illness profile in the country and the necessity to assure the integrality of care in different levels of health care, among other reasons, boosted the organization to offer health actions and services by SUS, by means of the care networks. The *Redes de Atenção à Saúde* (Health Care Networks - RAS) “are organizing adjustments of health actions and services, of different technological densities which, integrated by means of technical, logistic and management support systems, aim to assure the integrality of the care” (Portaria n. 4.279, 2010 p. 2, free translation). Some thematic networks have been established, such as *Rede Cegonha* (Stork Network); *Rede de Atenção às Urgências e Emergências* (Urgency and Emergency Care Network - RUE); *Rede de Atenção às Doenças e Condições Crônicas* (Cronic Conditions and Diseases Care Network); *Rede de Cuidado à Pessoa com Deficiência* (Care Network for People with Disabilities); and the *Rede de Atenção Psicossocial* (Psychosocial Care Network - RAPS) (Ministério da Saúde, 2012).

RAPS, instituted by the Ordinance n. 3.088, dating from December 23, 2011, establishes the points of health care for the assistance of people with mental disorders and necessities caused by the abuse of alcohol and other drugs. It is constituted by the following components: *Unidade Básica de Saúde* (Primary Health Care Unit; Teams of Primary Care for Specific Populations and Community centers); *Centro Especializado de Atenção Psicosocial* (Psychosocial Care Center - CAPS); Urgency and Emergency Care (SAMU, Stabilization Room, 24-hour UPA, Urgency/Emergency Room, Primary Health Care Units and others); Transitory Home Care Assistance (Shelter Unit and Home Care Assistance); Hospital care (Specialized Nursing in general hospital, Reference Hospital Service (SHR); Deinstitutionalization strategies (Therapeutic Home care Services (SRT) and *Programa de Volta para Casa* (Back Home Program - PVC) and psychosocial rehabilitation (Portaria n. 3.088, 2011).

The urgency and emergency care points of RAPS are responsible for receiving, classifying the risk and taking care of people under suffering or mental disorders as well as the necessities caused by the use of crack, alcohol and other drugs. These points of health care must be integrated with the CAPS, which assist and care for people in the second acute phase of mental suffering/disorder as a result of alcohol and other drugs; whenever a hospital admission or transitory home care services is necessary, CAPS must integrate and coordinate the care (Portaria n. 3.088, 2011).

According to Franco (2006), in the operation of care networks, the ones divided into diverse units or health levels (family health team, basic unit, specialty services and hospital network), it can be observed that the professionals work, communicating mutually, characterizing the network operation. This way, it can be said that the networks are inherent to way the care is produced, regardless of the level in which it occurs. The establishment and the operation of an articulated service network that meets the needs of the person under psychic suffering, mainly in crisis, depend on the professionals’ capacities and on the services offered by the network, aiming at the improvement of the technical quality, the equality and the continuation of the care in relation to people with serious and persistent mental disorder (Fialho, 2014).

A crisis situation can be defined and/or understood as a “serious suffering, caused by diverse reasons, clinical ones and related to alcohol and other drugs, which can become more intense and frequent, causing a break of the support social network and processes of social incapacitation and invalidation” (Souza, 2008, p. 111, free translation).

From that context of renewing and innovative policies and the recent implementation of Ordinance n. 3.088, dating from December 23, 2011, it can be noticed that there is a lack of data that demonstrate the application and the efficacy of the integration among the diverse points of RAPS for the care to mental health crisis situations, according to the policy instituted. By knowing about the existence and the ways of integration among the diverse points of health care to people with mental suffering/disorders and with necessities caused by the use of alcohol and other drugs in Brazil, it would be possible improve the assistance system. It would also allow the identification of more fragile points, and therefore adjust them, in order to standardize and optimize the assistance in all the network points. Besides being a subject rarely dealt with because of the fact that the policies are still being established, this study will contribute to health public system, allowing the development of improvements and guiding the establishment of the policies.

The present study aims at knowing the integration among the RAPS points in the mental health crisis situations, from the point of view of its workers.

## Method

It is a descriptive exploratory study with qualitative approach. It was carried out based upon the materials produced by the students of the Mental Health Crisis and Urgency Course. It is a professional updating course, with the duration of 100 hours, carried out in 90 days, completely at distance. The course was developed in four modules, within their respective teaching units: Introduction to the Course; Fundamentals of the Psychosocial Care to the Mental Health Crisis and Urgency; Organization of Psychosocial Care to the Crises in the Care Network; The Care of People in Crisis and Urgency Situations within the Perspective of Psychosocial Care.

For that distance course, the students had tools and materials available for their learning: Content in PDF, Online Content; Online Forum; Chat, Portfolio and Interactive Evaluative Exercise. For this study, we have used the portfolio, which, according to Corrêa (2007), is the sum of parts of a work carried out by the student along the course, totally or partially. In general, this tool is used for the analysis of the student’s development, for it can have texts and other materials produced in every stage of the course. The Crisis Course Portfolio is formed by the answers referring to four reflective questions, owing evidence to each student’s considerations on their reality, relating them to the content developed in each module.

The target public of this study were the 429 students of the first edition of the Mental Health Crisis and Urgency Course, all of them being workers at RAPS, educated at graduation level, acting in the scope of mental health at SUS and living in different regions of Brazil, selected by the Health Ministry.

For the inclusion criteria, were determined: being regularly enrolled in the Course and having answered the four reflective questions that composed the portfolio. As exclusion criterion, was considered: having given up of the course before it finished. From the 429 students who started the course, 56 gave up and 302 met the criteria. A number of 156 out of those 302 agreed to participate of the research, after reading the free and informed consent term.

The data collection was carried out in the period from September 24 to October 26, 2015. The answers to reflective question 3 were used: “Considering your workplace as a RAPS/RUE point, describe, reflect and write a synthesis on how occurs the integration with other network points in your municipality.”

The data were organized and analyzed according to the Thematic Content Analysis suggested by Bardin (2011). It comprehends three phases: Pre-analysis, Material Exploration and Treatment of Information, inference and interpretation.

In the pre-analysis phase, the material was organized with the printing of the portfolio, followed by the fluctuating reading of them, in order to systematize the initial ideas. After that, we carried out an exhaustive reading, allowing us to create a database, where the mostly repeated reports were present. The description of 62 portfolios were used, because from then on, they started to repeat.

In the material exploration phase, it was possible to group the elements according to each main theme, creating, posteriorly, three analysis categories.

In the third and last phase, there was the treatment, inference and interpretation of the results. It was verified the relevance of each piece of information for the analysis, separating the reports that were more highlighted. Concomitantly, we reflected on the data exposed; posteriorly, they were compared to the literature produced regarding the theme.

The project was approved by the Ethics Committee for Researches with Human Beings of Santa Catarina Federal University, with the Opinion Document n. 924,432/2014, meeting the Resolution n. 466/2012. In order to assure the anonymity, the participants were identified by letters and numbers, according to the following order: E1A1 – First edition of the course, Student number 1, until all the students were identified up to E1A156. It is important to remark that letter A stands for aluno, the Brazilian Portuguese word for “student”.

## Results e discussion

From the reading of the portfolios, it was possible to identify the participants’ profile, as well as the RAPS point and the Brazilian region where the participants of the study work.

**Table 1 – Profile of the participants of the study**

| Variable | % |
|---|---|
| **Gender** | |
| Male | 19.2 |
| Female | 80.8 |
| **Age** | |
| 22-31 years old | 29.5 |
| 32-41 years old | 37.2 |
| 42-51 years old | 23.7 |
| 52-61 years old | 9.6 |
| **Job** | |
| Psychologist | 38.5 |
| Nurse | 28.2 |
| Social Assistant | 14.1 |
| Occupational Therapist | 8.3 |
| Physician | 5.2 |
| Others | 5.7 |
| **RAPS point** | |
| CAPS | 72.5 |
| General Hospital | 8.3 |
| UBS | 7.1 |
| Others | 12.1 |
| **Region** | |
| Northeast | 30.1 |
| Southeast | 28.2 |
| Midwest | 17.3 |
| South | 12.2 |
| North | 12.2 |

Source: study data, 2014

It was possible to notice that most participants were women, from the northeast region of Brazil. The most common jobs were psychologists and nurses. Most participants of this study worked at CAPS.

By means of the reflective question, the participants described how occurs the integration among the network points of care in mental health crisis situations. The answers were analyzed and organized in three categories: Referral: traditional care model; Matrix support: the current proposal; and New strategies for the network care.

**Referral: traditional care model**

The referral was described by the study participants as a usual practice. Generally, the users that look for the service having some kind of psychic suffering are directed to their reference unit or CAPS. The participant E1A4 claims that *"The patients who are leaving hospital admissions, who live in our town, are usually directed and assisted at CAPS…"*.

A study carried out by Quinderé, Jorge, Nogueira, Costa and Vasconcelos (2013) evidenced that the professionals precipitate to direct the cases of elementary care to CAPS, because, many times, they are insecure at assisting the cases related to mental health, even the least serious ones, because they feel unable to care for those patients. This way, most cases that could be assisted at the primary level ends up overloading the CAPS, compromising the access and the assistance of people under more serious situations.

That referral is usually carried out in a precarious way, by means of a simple phone call or form; the professional who realizes the referral depends on the goodwill of the one who assists the patient. Delfini and Reis (2012), in their study, verified that most part of the referrals performed by the *Estratégia de Saúde da Família* (Family Health Strategy) or CAPS occurs by phone, and this contact often happens as a way to verify if there are empty places. Where there is not any contact among the professionals, the user is directly referred from a place to another for assistance, and, many times, they end up without any assistance for their suffering.

When the referral is carried out by means of a form, the latter is “considered as being ineffective, for it is not organized in a way that allows that important information is passed on among the teams... this way, the information and the users get lost within the system, resulting in a lack of problem solving” (Paes, Schimith, Barbosa, & Righi, 2013, p. 400, free translation).

> *I try to integrate the professionals when I need other services (PA, SAMU, ESF and others), i.e., performing the referral of a user always depends on having a friend/acquaintance, and yet, by telephone; I realize that the integration and the interaction among people does not really occur* (E1A31).

It can be noticed, from the participants’ reports, that the referral occurs so the case/user is put ahead, as a way of getting rid of the responsibility or for believing that they are not able to solve that situation, causing insecurity to perform the procedure.

> *The mental health team, including the professionals of CAPS and of NASF, are always concerned about the dialogue, among the points, with network discussions, but I believe that we never reach the main objective of the networking. The practice of “putting the case ahead” is still kept* (E1A53).

In another study, the professionals report that one of the causes for the inappropriate referrals is the fact that the professionals themselves do not listen properly to the user; this way, the user’s real necessity is not met; what the service has to offer is also not shown before the referral, causing a “come and go” of the individual through the services (Gonzaga & Nakamura, 2015).

The practice of referral in which the user is “pushed” from a service to another translates the care fragmentation, reducing possibilities and causing the lack of responsibility for the cases and for the subjects (Delfini & Reis, 2012). This kind of referral does not contribute to the full care, and is against the Ordinance n. 3.088, dating from December 23, 2011, once, that way, there is not the creation of ties, or networking (Paes et al., 2013).

Therefore, it is evident that the referral action mentioned by some professionals does not relate to a good integration strategy among the services, for it does not allow a work that integrates all the professionals involved. The referral performed in a non-shared way causes the user who needs assistance to go through many health care services, without receiving adequate assistance in any of them. Ideally, the professional who performs the referral should include him/herself in the process, taking the responsibility and sharing the case, making the services function in network (Ministério da Saúde, 2005).

This way, the *Política Nacional de Humanização* (Humanization National Policy) (Ministério da Saúde, 2007) proposes a new care model that is based upon the necessities of each user, carried out by a multidisciplinary team, escaping from the logics of the referral and favoring the co-responsibility of all involved in the process.

## Matrix support: the current proposal

The necessity of mental health care is transversal to the different levels of health care; it is necessary and indispensable that the professionals act on the primary health care take responsibility on part of that care, even if it is by means of support or supervision of specialists (Reilly, Planner, Hann, Reeves, Nazareth, & Lester, 2010; Sved-Williams & Poulton, 2010).

The matrix support (AM) was mentioned by the participants as an articulation form that has been working positively up to the moment, such as participant E1A24 affirms: *"The integration on the scope of the UBS's and the assistance gadgets happens specially by means of the supportive matrix to the cases, space where it has been possible to construct the cases jointly, by means of various views."*

"Matrix support is a new way to produce health care in which two or more teams, in a process of shared constructing, create a pedagogic and therapeutic intervention proposal" (Chiaverin, 2011, p. 13, free translation). This proposal aims at transforming the old logics of the health systems (referrals, reference and counter-reference, protocols and regulation centers) The Matrix Support works as a technical support for the construction of therapeutic projects (Chiaverin, 2011).

By means of Matrix Support, there are discussions of the most complex cases and the construction of singular therapeutic projects, in which the professionals involved address the best ways to care for the users. They believe that, this way, there is sharing of knowledge and experiences that contribute to the care given to the user, as well as strengthening of the support network.

> *We can carry out the matrix support with the basic care, in the sense of sharing the cases and not performing the referral. We have meetings of matrix support with the health care team that covers the territory of those users, every fifteen days. But I notice some difficulty, for most of part PSFs do not have a NASF team to contribute with the discussion* (E1A60).

By means of the Matrix Support, it is possible to increase the offer of actions carried out in the process of the user's care, once the reference team and the matrix support are co-responsible for the case, providing an exchange of knowledge that will contribute for the construction of a singular therapeutic project (Delfini & Reis, 2012). In the meetings provided by the matrix support, new possibilities are offered by means of the dialogical work, deconstruction the work type focused on the procedure and on the individual practice centered on the disease. Regarding this theme, we highlight the subject's speech that points out the collective work at the construction of the therapeutic project, gathering the multidisciplinary knowledge and practice (Vasconcelos, Jorge, Pinto, Pinto, Simões, & Maia Neto, 2012).

From the participants' answers, it could be noticed the evidence that the matrix support is a good integration strategy, for it contributes to the care of the user, besides providing the integration of the teams. The AM proposal diverges from centralizing practices, which stiffen the heath care professionals' work, going beyond the actions guided form protocols and procedures more and more specialized, which deviate the health attention action from its biggest aim: producing care. The suggestion of interconnected health care practices, interacting in the routine of the service, connecting various knowledges and being placed in the complexity levels of the health care system, favors the co-responsibility among the professionals and the solving of problems at the assistance (Vasconcelos et al., 2012, p. 171).

The matrix support intends, therefore, to "increase the possibilities to carry out a more humanized assistance, with the provision of a set of resources that aim at the treatment focused on the subject and his/her social ties, besides favoring the integration among different specialties and professions" (Feitosa, Silva, Silveira, & Santos Junior, 2012, p. 51, free translation). The matrix support practice can contribute to the reduction of inadequate referrals of the users due to the presence of a specialized team, which can solve the problems of the cases (Pegoraro, Cassimiro, & Leão, 2014).

This way, it seems notorious, that the matrix support is a strategy used by the RAPS workers in order to provide the integration of the health care services. Moreover, the workers and the services have searched new ways to be integrated to overcome the limitations faced.

## New strategies for the network care

Many professionals reported diverse forms of integration, such as referrals and matrix support. However, what most called our attention was the arise of new strategies of integration among the services regarding mental health crisis situation.

Currently, it is clear that, for an effective integration among the services concerning mental health care, it is necessary a solid action among the health care teams; they must be integrated and well equipped. They also must have a good understanding of the functioning of the health care system, what may not occur, due to the lack of training, or even to the worker's resistance to adapt to the proposed changes. In order to make the integration among the services and the professionals a reality, it is indispensable the use of alternatives that allow the exchange of information and qualification of the professionals (Paes et al., 2013).

Meetings among the services were described by the participants; in them, the mental health care is discussed, as well as how each point plays its role, allowing everyone to know how the service works.

> *In the last four months we had our two first meetings of RAPS with the participation of different services (Mental Health/Family Health/Woman's Health/The Elderly's Health/ Education Area/Social Department, among other offices),with the participation of workers, users and users' families. In those meetings, we are able to present how the work of each service is carried out and discuss strategies to improve the network "communication"* (E1A1).

> *We have monthly meetings with the CAPS and the Atenção Básica; also once a moth the continuing education meetings occur in the territories, where various segments gather. It's a great opportunity to talk and clarify what the mental health care is, as well as to understand the other services* (E1A40).

The meetings to discuss mental health care have as their main goal knowing the network and the services and people that compose it, in order to discuss it and suggest strategies to deal with the health care reality presented. This network in under construction process, seeking to improve the integration among the services and, consequently, to qualify the assistance by means of the realization of meetings to discuss mental health care, known as *saúde mental na roda* (mental health under discussion) (Paes et al., 2013).

The participants reported that they are part of online spaces, where health care managers and workers meet to exchange information and share experiences about their work routine. Those spaces are called *Comunidades de Práticas* (Practice Communities) (Comunidade de Práticas, 2015), and, according to the experiences reported, it is possible to notice examples of those new strategies:

> Those meetings allow the technical an theoretical improvement by means of discussions of cases, planning and realization of Workshops, Meetings and Training courses to the teams of basic care, promotion of education regarding health care by means of the elaboration of information leaflets with relevant themes concerning mental health, involving professionals, users and the community, looks for partnerships for organizing the services and elaborating projects (...)The *Programa Bem Viver* [Living Well Program] is, today, a reference space for people with mental disorder, community and microregion. By means of this program, it was possible to organize the assistance to mental health and establish a care network within the municipalities (Fonseca, Carvalho, Azevedo, & Silva, 2015).

There are, still, meetings in which ways of caring and constructing a network performance are addressed. Those meetings have the participation of various RAPS representatives, as well as of the community, churches, education.

> *We started to integrate inter-sectorial meetings with the presence of the following network points: Mental Health (CAPS AD, IA, II and First aid centers),* Atenção Básica *(Basic Care - various programs:, women's, men's child health etc), Emergency and Urgency Network (SAMU, City Hospital, State Hospital, UPA), CEAME (service of inclusive education), Military Police, Fire Department, Civil Police, Services of the Work and Social Development City Offices (CRAS, CREAS, High Complexity) and Brazilian Child Protective Service. Those meetings became very productive, connecting the services of the mental health care, dealing with stigmas, prejudice, and the idea of CAPS as a total institution* (E1A38).

> *With the other network care points, there are the work groups; each of them deals with one aspect of the Mental Health Care, together with the services of Social Assistance of the municipality, allowing the interaction of the network professionals. Those groups gather in periodical meetings, in which the cases are discussed; after that, strategies are elaborated, in order to enable the treatment/accompaniment by the network components, in a synchronized way* (E1A46).

Some professionals of mental health care highlight the sectorial and intersectorial meetings that occur in their municipalities, in which the actions are planned and performed according to the discussion of cases and their problematization in the network, developing strategies that allow the integration among the health care services. This way, those professionals notice that this form of integration with the network has been successful in the scope of mental health care (Cunha & Sousa, 2015).

In his experience report, Giasson (2015) affirms that the reflection on the fragmented care actions that had been performed allowed a new integration strategy that was according to the RAPS presuppositions. In February of 2014, the *Rede de Atenção Psicossocial Intersetorial* (Intersectorial Psychosocial Care Network - RAPI), was established, in order to allow the contact among the network professionals. This way, there is a monthly meeting, in which the professionals discuss cases previously chosen and plan actions to prevent violence and to promote health care, as well as life quality. Those meetings have the participation of health care and education professionals, CRAS and CREAS, Child Protective Services and others, depending on the demand. For the worker, that practice favored the work process, which benefits the worker and, mainly, the user.

It is important to highlight that the managers play a fundamental role in this innovation process at the mental health care, being necessary that various sectors are integrated in order to effectuate a “humanized mental health care service, problem-solving, and based upon the promotion of health and life quality of the users and their families” (Paes et al., 2013, p. 407, free translation).

From the reports, it was possible to notice that the referral practice is outdated and does not offer a proper integration among the services. However, as an alternative, the matrix support meetings occur, providing discussions of the most complex cases and the sharing of knowledge by a multiprofessional team, in order to offer a more humanized service to the user. Nevertheless, there are still various obstacles to networking, and, besides that, the new strategies appear to make this process possible.

## Final considerations

The integration among health care services is extremely important for the creation of a humanized and full care to the user, mainly regarding the mental health field. Despite the fact that this study deals only with the view of the workers that participated of the Mental Health Crisis and Urgency Course, it was posible to notice which strategies those RAPS workers, who work in many regions of Brazil, use to favor the integration among the network points. It was also possible to identify the points of more fragility and the ones that, in spite of the difficulties found, search other ways to perform the care.

Regardless of the fact that non-shared referral and matrix support practices are still very commonly used, it is possible to verify that the workers and the managers are more and more worried about designing new strategies. These allow a quality care, providing meetings in which the professionals discuss new ways to assist the individual under psychic suffering, also creating ways for the work to be integrated in the network.

Thus, it was possible to notice different integration forms among the various RAPS points for the care of mental health crisis situations. For that, it is necessary for the workers to know their supporting network and to use ways to be integrated to it, by means of meetings, training courses or other gatherings that provide the experiences exchange.

## References


Amarante, P. (2008). Saúde mental, desinstitucionalização e novas estratégias de cuidado. In L. Giovanella, S. Escorel & L. V. C. Lobato (Orgs.), *Políticas e sistemas de saúde no Brasil* (pp. 735-759). Rio de Janeiro: FIOCRUZ – CEBES.

Bardin, L. (2011). *Análise de conteúdo*. São Paulo: Edições 70.

Chiaverini, D. H. (Org.) (2011). *Guia prático de matriciamento em saúde mental*. Brasília: Ministério da Saúde, *Centro de Estudo e Pesquisa em Saúde Coletiva*, 236 p.

Comunidade de Práticas (2015). *Sobre a Comunidade de Práticas*. Recuperado em 15 de novembro, de 2015, de https://cursos.atencaobasica.org.br/sobre.

Corrêa, J. (2007). *Educação à distância: orientações metodológicas.* Porto alegre: Artmed.

Cunha, R. G., & Sousa, T. A. (2015). *Saúde mental – Uberlândia/setor sul: experiência de articulação com a rede de atenção à saúde.* Recuperado em 14 novembro, de 2015, de https://novo.atencaobasica.org.br/relato/1071.

Delfini, P. S. S., & Reis, A. O. A. (2012). Articulação entre serviços públicos de saúde nos cuidados voltados à saúde mental infantojuvenil. *Cadernos de Saúde Pública, 28* (2), 357-366 Recuperado em 09 de novembro, de 2015, de http://www.scielosp.org/pdf/csp/v28n2/14.pdf.

Feitosa, K. M. A., Silva, T., Silveira, M. F. A., & Santos Júnior, H. P. O. (2012). (Re)construção das práticas em saúde mental: compreensão dos profissionais sobre o processo de desinstitucionalização. *Psicologia: Teoria e Prática, 14* (1), 40-54.

Fialho, M. B. (2014). Contexto histórico e concepções teóricas da crise e urgência em saúde mental. In M. T. Zeferino, J. Rodrigues & J. T. Assis (Orgs), *Crise e Urgência em Saúde Mental: fundamentos da atenção à crise e urgência em saúde mental* (pp. 11-22). Florianópolis.

Fonseca, M. L. S., Carvalho, M. L. R., Azevedo, T. M., & Silva, L. A. (2015). *Bem Viver: construindo novas possibilidades em Saúde Mental.* Recuperado em 14 novembro, de 2015, de https://novo.atencaobasica.org.br/relato/4159.

Fontoura, R. T., & Mayer, C. N. (2006). Uma breve reflexão sobre a integralidade. *Revista Brasileira de Enfermagem, 59* (4), 532-537. Recuperado em 18 de maio, de 2015, de http://www.scielo.br/pdf/reben/v59n4/a11v59n4.pdf.

Franco, T. B. (2006). As redes na micropolítica do processo de trabalho em saúde. In R. Pinheiro & R. A. Matos (Orgs.), *Gestão em redes* (pp. 459-474). Rio de Janeiro: LAPPIS-IMS/UERJ-ABRASCO.

Giasson, F. (2015). *Rede de Atenção Psicossocial Intersetorial - Evoluindo a partir da RAPS.* Recuperado em: 14 novembro, 2015, de https://novo.atencaobasica.org.br/relato/ 4519.

Gonzaga, N., & Nakamura, E. (2015). Os significados dos encaminhamentos feitos aos CAPS III de Santos: a visão dos profissionais. *Saúde e Sociedade, 24* (1), 232-243.

*Lei n.º 10.216, de 06 de abril de 2001*. (2001, 06 de abril). Dispõe sobre a proteção e os direitos das pessoas portadoras de transtornos mentais e redireciona o modelo assistencial em saúde mental. Brasília, DF: Ministério da Saúde.

Ministério da Saúde. (2007). *Política Nacional de Humanização* (PNH): documento base para gestores e trabalhadores do SUS (4a ed.). Brasília: Ministério da Saúde.

Ministério da Saúde (2012). *Portal da saúde*. Brasília: Ministério da Saúde. Recuperado em 25 maio, 2015, de http://dab.saude.gov.br/portaldab/smp_ras.php?conteudo= rede_proprietaria

Ministério da Saúde. (2015). *Caminhos para uma política de saúde mental infanto-juvenil.* Brasília: Ministério da Saúde: Secretaria de Atenção à Saúde - Departamento de Ações Programáticas Estratégicas,.

Paes, L. G., Schimith, M. D., Barbosa, T. M., & Righi, L. B. (2013). Rede de atenção em saúde mental na perspectiva dos coordenadores de serviços de saúde. *Trabalho, Educação e Saúde, 11* (2), 395-309. Recuperado em 09 de novembro, 2015, de http://www.scielo.br/pdf/tes/v11n2/a08v11n2.pdf.

Pegoraro, R. F., Cassimiro, T. J. L., & Leão, N. C. (2014). Matriciamento em saúde mental segundo profissionais da estratégia da saúde da família. *Psicologia em Estudo, 19* (4), 621-631.

*Portaria nº 4.279, de 30 de dezembro de 2010.* (2010, 30 de dezembro). Estabelece diretrizes para a organização da Rede de Atenção à Saúde no âmbito do Sistema Único de Saúde. Brasília, DF: Ministério da Saúde.

*Portaria nº 3.088, de 23 de Dezembro de 2011*. (2011, 23 de dezembro). Institui a Rede de Atenção Psicossocial para pessoas com sofrimento ou transtorno mental e com necessidades decorrentes do uso de álcool, crack e outras drogas, no âmbito do Sistema Único de Saúde. Brasília, DF: Ministério da Saúde.

Quinderé, P. H. D., Jorge, M. S. B., Nogueira, M. S. L., Costa, L. F. A., & Vasconcelos, M. G. F. (2013). Acessibilidade e resolubilidade da assistência em saúde mental: a experiência do apoio matricial. *Ciência & Saúde Coletiva, 7* (18), 2157-2166.

Reilly, S., Planner, C., Hann, M., Reeves, D., Nazareth, I., & Lester, H. (2012). The role of primary care in service provision for people with severe mental illness in the United Kingdom. *PLoS ONE , 7* (5), 1-10.

Souza, P. J. C. (2008). Resposta à crise: a experiência de Belo Horizonte. *Política de Saúde Mental de Belo Horizonte: o cotidiano de uma utopia.* Belo Horizonte: Secretaria Municipal de Saúde.

Sved-Williams, A., & Poulton, J. (2010). Primary care mental health consultation-liaison: a connecting system for private psychiatrists and general practitioners. *Australasian Psychiatry, 18* (2), 125-129

Vasconcelos, M. G. F., Jorge, M. S. B., Pinto, A. G. A., Pinto, D. M., Simões, E. C. P., & Maia Neto, J. P. (2012). Práticas inovadoras de saúde mental na atenção básica: apoio matricial na redefinição do processo de trabalho em saúde. *Cadernos Brasileiro de Saúde Mental, 4* (8), 166-175.

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