Potentialities and fragilities in the route of care for people in crisis in mental health

RESUMO | Objetivo:compreender as potencialidades e fragilidades no atendimento às pessoas em situação de crise em saúde mental na percepção de profissionais da Rede de Atenção Psicossocial. Método:pesquisa qualitativa, com abordagem exploratória, descritiva e retrospectiva, realizada com 628 trabalhadores de nível superior que atuam na Rede de Atenção à Saúde Mental. Os dados foram coletados entre março de 2014 e dezembro de 2015,e analisados entre março e dezembro de 2016através da análise de conteúdo.Resultados:dentre as potencialidades destacam-se a atuação em redes no processo participativo na atenção à saúde mental e redes pessoais como empoderadoras dos trabalhadores. As fragilidades identificadas estavam relacionadas à frágil atuação clínica individual e coletiva, bem como o desafio de tornar concreto o atendimento em rede. Conclusão:O atendimento à crise em saúde mental se sustenta essencialmente no acolhimento e no estabelecimento de vínculo entre o usuário e o serviço de saúde.
Descritores: Saúde Mental; Pessoal de Saúde; Serviços de Saúde Comunitária; Assistência integral a saúde.

ABSTRACT | Objective: to understand the potentialities and weaknesses in the care of people in crisis situation in mental health in the perception of professionals of the Network of Psychosocial Attention. Method: qualitative research, with an exploratory and descriptive approach, performed with 628 higher level workers who work in the Mental Health Care Network. Data were collected between March 2014 and December 2015, and analyzed through content analysis. Results: among the potentialities are the performance in networks in the participatory process in mental health care and personal networks as workers' empowerers. The fragilities identified were related to fragile individual and collective clinical performance, as well as the challenge of making network service concrete. Conclusion: Attention to the crisis in mental health is essentially based on welcoming and establishing a link between the user and the health service.
Keywords: Mental Health; Health Personnel; Community Health Services; Comprehensive Health Care.

RESUMEN | Objetivo: comprenderlas fortalezas y debilidades enlaatención a personas encrisis de salud mental enlapercepción de losprofesionales de laRed de AtenciónPsicosocial. Método: investigacióncualitativa, conabordajeexploratorio y descriptivo, realizada con 628 trabajadores de enseñanza superior que actúanenlaRed de Atención a la Salud Mental. Los datosfueronrecolectados entre marzo de 2014 y diciembre de 2015 y analizados a través delanálisis de contenido. Resultados: entre las potencialidades se destaca laactuaciónen redes enelproceso participativo enlaatención a lasalud mental y las redes personales como empoderadoras de lostrabajadores. Las debilidades identificadas se relacionaronconla frágil actuación clínica individual y colectiva, así como coneldesafío de concretar el cuidado en red. Conclusión: La atención de lacrisis de salud mental se basaesencialmenteenacoger y establecerun vínculo entre el usuario y elservicio de salud.
Palabras claves: Salud mental; Personalsanitario; ServiciosComunitarios de Salud; Atención Integral de la Salud.

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INTRODUCTION

Caring for people from a mental health perspective has undergone changes in the last thirty years, especially in Brazil, from the Sanitary Reform, which mobilized the community to change public policies. People with mental disorders continue to be stigmatized for presenting disruptive behavior in society and its flows and experiences that

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do not fit the standards of most people. Stigma can be considered as an "attribute of social discredit that degrades the person who carries it and that appears due to the discrepancy between two identities" [1], either in virtual social identity, as well as in cultural identity. It is understood that attitudes, feelings, beliefs and behaviors are built from the life and experience of each person, therefore, the stereotyped view can generate discrimination, in some way. [1]

In an attempt to bring health care services closer together to meet the demand of mental health, the need to think about services that are structured in a planned and connected way is evident, so that they can transcend purely epidemiological assistance, but that recognize the individual in his complexity. In this sense, it is necessary to go "beyond traditional epidemiological measures of incidence and prevalence rates to include parameters such as the treatment gap, to assess unmet needs in psychiatry". [2] The perspective of networking, as well as the need to create strategies that can meet the demands of the population that seeks psychosocial care services, perhaps, can respond to these needs, both to expand the scope, as well as to attend to specific situations. The World Health Organization (WHO), in order to address the demands on mental health, launched a Comprehensive Mental Health Action Plan 2013–2020, which aims to offer comprehensive, integrated and responsive mental health and social services in community settings. [2]

The Mental Health Care Model is guided by Ordinance No. 3,088, of December 23, 2011, which creates the Psychosocial Care Network (RAPS - Rede de Atenção Psicossocial), focusing on the individual and his demand, emphasizing community care and social participation in the planning and operationalization of services. However, Ordinance No. 3,588, of December 21, 2017, amends Consolidation Ordinances No. 3 and No. 6, of September 28, 2017, to provide for the Psychosocial Care Network. From this perspective, care guidelines are centered on expanding people's access to services. [3] In the light of Decree No. 7,588 of June 28, 2011, which provides for the organization of the Unified Health System (SUS), health planning, health care and inter-federative articulation, and other measures, structure the network into Health Regions. Such regions are configured in geographic spaces constituted by groupings of neighboring Municipalities, for the creation of collective identities, facilitating the organization, planning and execution of actions and health services. [4]

> "Professionals working in RAPS transit in a context of complexity and uncertainty. It is complex, as it deals with human beings in attention and care in their fragility. It is uncertain, because it considers each human being unique and singular."

The services are organized into points of care that are connected and articulated based on the demands of the users. In psychosocial care, the diversity of care units is notorious, whether primary care, specialized psychosocial care, urgency and emergency, transient residential care, hospital care, as well as deinstitutionalization and psychosocial rehabilitation strategies. [5]

Professionals working in RAPS transit in a context of complexity and uncertainty. It is complex, as it deals with human beings in attention and care in their fragility. It is uncertain, because it considers each human being unique and singular. In this sense, for the development of care in psychosocial care, it is important to recognize a social support network, both for professionals and for service users. [6]

Due to the problem of the continuous need for reflection on mental health care and the configuration of care provided to people in mental distress, the following question emerged for this study: How do RAPS professionals perceive the strengths and weaknesses in caring for people in mental health crisis situations.

In order to answer the guiding question, the following objective was constructed: to understand the strengths and weaknesses in caring for people in mental health crisis situations in the perception of RAPS professionals.

METHOD

Exploratory, descriptive and retrospective research, with a qualitative approach guided by Content Analysis. [7] In this study, public policies related to psychosocial care were used as a theoretical framework.

The study was developed nationwide, with data from a distance course "Crisis and Urgency in Mental Health" at the Federal University of Santa Catarina, with a workload of 100 hours, aimed at updating higher-level health professionals to care for people in crisis situations linked to public health services in Brazil. Data were collected in the period between March 2014 and December 2015, this being the same period of the time frame chosen for the research.

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As inclusion criteria for participation in the study, it was considered: being a regularly enrolled student, having completed the course and having prepared a portfolio on the care provided in situations of crisis and urgency in mental health. As an exclusion criterion used was not having presented the aforementioned portfolio to the course.

Of the graduates, 628 agreed to participate in the research and fully met the inclusion criteria. Study participants were predominantly women with training in psychology, nursing and social assistance, linked to basic health units and CAPS in the Southeast and Northeast regions of the country. The professionals included in this study are: psychologist (267), nurse (189), social worker (82), occupational therapist (55), family doctor (25) and pharmacist (10).

The basic material for the research was a portfolio prepared by the course participant, which contained the following guiding question: What are the situations of crisis and urgency in mental health that occur most frequently in your workplace and how is care provided in these situations? The presentation of the text was free and without character limits. Generally, the material had around 2 pages, containing reports about the course participant's experience as a health professional in their workplace.

Data were organized and analyzed according to the operative proposal of content analysis [7], which can be understood in three phases: the pre-analysis, consists of the organization phase itself, whose objective is to make operational and systematize the initial ideas. Thus, the portfolios were carefully read to obtain a broad understanding of the content described by the participants. The material exploration phase consists of coding the portfolio, where they were exported to a Microsoft Excel spreadsheet for Windows, and a new code was created for each relevant information. The third phase consists of treating the results obtained and interpreting them, that is, the codes are grouped by similarity and difference in content and organized into categories.

All aspects involving the research are in accordance with Resolution No. 466/2012 of the National Health Council. Project approved by the ethics committee under protocol no. 924.432/2014, CAAE: 39378213.4.0000.0121.

RESULTS

The results will be presented below in two thematic units.

Potentialities in the care provided by professionals in the care of people in a situation of mental health crisis

This category demonstrates the potential of working in networks in the participatory process in mental health care. These networks are considered relevant, as they are analyzed from the perspective of better actions in the form of an integrated health system.

Intersectoral networks as an organizer of the dynamics of care in psychosocial care services (education system, judiciary, public security, social work)

The intersectoral networks that make up the SUS are shared services at the national, state, regional and interstate levels. These institutions in this shared and participatory network interact in a complex way with the presence of mechanisms of social control and agreement between managers, determining the configuration of decision-making of public policies for mental health care.

The network is operationalized and structured from the municipalities and considers territorialization its strategic basis, as we can identify in the speech of a participant when he says that:

> "The Mental Health Network of this municipality has been building another possible care, based on territories that make sense to people, considering other gateways for users with psychological distress. The crisis, previously contained in the Hospital, is now expressed in other spaces, and the workers in this network have sought to learn to welcome the subjectivity of these unique moments" (43).

The network also consists of reaching other sectors and support services so that care can be effective and resolute:

> "What we have seen that has contributed a lot to the monitoring and observation of the cases more frequently is the construction of the care network involving different actors – PSF – CAPS – CREAS – Education, always aiming to see the subject in its entirety and understanding that relationships are established in different ways (458).

Transversality is fundamental in all health spaces and services, so that crisis care can develop into a continuous flow of care, as observed in the speech:

> "By understanding all these difficulties that involve the dynamics of care in crisis and urgency, professionals have tried their best to work on strengthening and articulating the network, so that the service can effectively reach patients and families" (277).

Comprehensive care is a prerogative in assisting people in crisis in the transition between health services, in this sense, communication is configured as a fundamental strategy for care, according to the statements:

> "communication between the hospital and the municipality of origin with the health network, mental health and social assistance programs (383). In this communication, the other

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> services mentioned above also communicate, facilitating comprehensive care in mental health" (546).

Still, comprehensiveness is often an approach associated with comprehensive, humanized and quality treatment and welcoming the person in crisis, according to the speech:

> "it is of paramount importance that from CHAs to managers be able to provide comprehensive and humanized assistance to patients with mental disorders" (426).

Assistance and humanity seeks the practice of a service based on universality, equality and equity in assistance, these basic doctrinal principles that confer legitimacy to the SUS, according to the report:

> "I try to practice the universality that is the guarantee of health care by the system, to each and every citizen; and equity, which is considered equality in health care, with actions and services prioritized based on risk situations, living conditions and the health of certain individuals and population groups" (314).

It is also added that a humanized service presupposes the union of an ethical, respectful behavior based on dialogue, seeking to understand feelings and emotions in the attention to the user in crisis, according to the speech:

> "The approach prioritizes respect for the user and resolving the situation through dialogue, negotiation and demonstration of empathy" (387).

> In emergency situations, the team works closely together, practically everyone gets involved to provide humane and safe care. (739)

Therefore, it is possible to verify that the intersectoral networks constitute shared services between the national, state, regional and interstate spheres. These networks are fundamentally based on transversality, which seeks a degree of contact and communication between people and groups forming a network, without hierarchy, reinforcing quality psychosocial care, based on comprehensive care.

Multidisciplinary and multidisciplinary teamwork

Work in mental health has some particularities, one of which is multidisciplinary and multiprofessional, professionals in different areas and specialties for better practice in the care of people in crisis situations, according to the following speech:

> "[...] the multidisciplinary team works together, seeking to provide individual and collective spaces for listening and guidance to adolescents so that they can verbalize their anguishes, as well as having support to think about changes and actually implement them". (719)

Including, integrated work is present in the team. Integration is important for the care of people in crises, this practice plays a role in establishing the best care, as mentioned in the next speech:

> "the CAPSi team works in a well--integrated way (719). Seeking not to limit drug therapy, in the medical-centered model, but to welcome not only the patient, but the family members, seeking to interact with RAPS partners." (110)

RAPS workers mention the importance of professional qualification for maintaining the quality of care, also, so that they can act with more resolution in the services in which they work. For this, they point out that in-service education is still a reality in the daily lives of the teams, even considering the broader and more comprehensive permanent education. The expressions of permanent education and continuing education were used in a broader perspective of in-service education.

The following reports demonstrate the daily lives of professionals with permanent education:

> "In Management, we at least try to propose permanent education actions to somehow cooperate with these services until the context improves (190). I have sought to strengthen permanent education inside and outside the service so that everyone understands that the crisis is our responsibility (23).

Continuing education has the potential to resolve specific situations of theoretical weakness on certain professional aspects, but continuing education can contribute to citizenship education, to life. The following reports corroborate this idea:

> "We work a lot with continuing education, especially with the nursing team who are always at the forefront of this situation". (300)

> "I believe that more and more permanent training is needed for FHS professionals to work with users in psychosocial distress." (206)

It consists of an articulation between different secretariats: sports, culture and social assistance and education. This category, reference to the various services that optimize and streamline care, achieving quality in crisis care, between the national, state and municipal levels, regarding the organization of health care networks.

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It is noteworthy that these institutions in this shared and participatory network interact in a complex way with the presence of mechanisms of social control and agreement between managers, determining the configuration of decision-making of public policies for psychosocial care.

Personal networks as empowering subjects working in the psychosocial care network

The team that works in psychosocial care considers some everyday situations as a possibility of empowerment, among them dialogue, welcoming, listening, respect and bonding with users, these conditions are characterized as empowering professionals in their daily professional practice.

This category seeks the factors that fluency in the care of psychosocial service users by the team, according to the following statements:

> "the approach prioritizes respect for the user and resolving the situation through dialogue, negotiation and demonstration of empathy. (387). I believe that presence and empathy can be potential at the time of crises, subjects need people who understand and are available to be by their side". (470)

Another form of dialogue mentioned between users and the team, which has a potentiating impact on care, are the assemblies developed by the reference teams, which favor open dialogue and decision-making, as mentioned by the participants:

> "We also hold, but without a determined frequency, meetings with the presence of professionals and patients on a day-to-day basis, the so-called "assemblies", to chat about the most diverse subjects, from diagnosis, medication, exchange of experiences to administrative issues that directly involve them, so that, while the subject takes over the place and the decisions to be taken, he also empowers himself, starting to act as the subject of the treatment." (456)

In order to provide effective care for people in crisis, the team demonstrates:

> "He is co-responsible for the cases and we organize ourselves to handle the situations in the best possible way, respecting our limits and possibilities for action." (726)

The bond between the team and the person in crisis is fundamental for the maintenance of the conditions that involve the therapy and, as well as the follow-up of the actions of this care. In this sense, it is observed that:

> "The bond is a very powerful "ally" in these moments. It is worked on throughout the Caps follow-up process, so in these situations, communication is facilitated by it. If you are a new user, you are welcomed by the shift." (727)

Considering dialogue, welcoming, listening, respect and bonding as essential conditions for valuing the suffering subject. Because, before the perspective of illness and disorder, there is a human being whose health condition is shaken.

> "valuing the subject in crisis implies taking into account his condition as a human being [...], it means respecting his time, his individuality and uniqueness". (447)

In view of the above, the empowerment of the subjects is potentialization based on dialogue, bonding, acceptance and respect. These practices provide commitment to the transformation of the reality of workers in the psychosocial care network. It even mobilizes people to become aware of their situation in psychosocial care.

Difficulties in the care provided by professionals in the care of people in a situation of mental health crisis

This category seeks to reflect on the difficulties encountered by professionals in providing care to people in mental health crises. To this end, it addresses the professional barriers facing the disarticulation of Health Care Networks, describes the repercussions experienced by the multidisciplinary team in the face of health service problems, as well as the fragile aspects in the individual approach to crisis care.

The professionals' coping with the (dis) articulation of the Health Care Networks

The articulation between the different devices of the Health Care Network is described by professionals as a fragile element, since dialogue is considered difficult between primary care, specialized mental health services, hospital care and urgency and emergency services, even having repercussions in other sectors, such as Social Assistance.

Some of the reasons identified for the lack of articulation is the dependence of the political will of local management on mental health care, in particular, for crisis care. Another point that can be highlighted is the difficulty faced in implementing the Psychosocial Care model, as provided for in public policies. The adaptations and denials received mean that, for example, beds for comprehensive mental health care in general hospitals, a fundamental device to offer support to CAPS, are not a reality in several regions of the country, with this, unjustified psychiatric hospitalizations are not avoided.

In this context it is possible to observe that:

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> "There is a difficulty in articulating the network in the sense that the UBS welcome this user. Today, the user is eventually referred to the CAPS, regardless of the level of severity of the case, that is, there is a lack of responsibility of the services in the care of the person with psychological distress." (193)

The relationship between professionals from different health devices, especially those linked to the Urgency and Emergency Network, generates dissatisfaction in some workers. Psychiatric urgencies are often not addressed in the way they should be by other teams, requiring the intervention of CAPS professionals to manage the situation in partnership with Public Security and Firefighters.

> "Although we identify clinical urgencies, we have many difficulties with SAMU professionals, or even the hospital in which SAMU regulates, to look at the clinical needs of this subject. Most of the time, he is medicated and discharged, without any evaluation of his clinical status and forwarded to CAPS AD." (521)

With regard to the structuring of the RAPS, professionals experience a lack of regulation of cases, that is, there is no care network that guides which service the user should be referred to. It is noteworthy that there are health districts that do not have CAPS, although they have a regulatory role in the mental health of a municipality, such a situation added to all the fragility of the network, the assistance offered to the user is compromised, as well as the logic of continuity of care.

> "We face another very serious problem, difficulty in the regulation center. Sometimes there is no bed available and you have to stay with the patient in the unit without support. Sad reality!" (591)

> "We don't have other supports, beds in a general hospital and therapeutic residences. What has been happening and what worries us is the recurrence of the crisis and cases that need more attention and care from the team, a fact that justifies the impotence of the RAPS network". (608)

Other aspects that have an impact on RAPS involving resource management are the interruption, at some point, of the user's therapy due to the fragility of the services and, mainly, the lack of the necessary tools to effectively carry out the work with the user in crisis. The fact that some points in the network also do not carry out their role makes it difficult to solve and progress in crisis situations that arise in the daily work of mental health.

So the user is seen as "from the CAPS" and not from the network. Services and professionals want to abstain from this responsibility, which belongs to the entire psychosocial network, which includes the hospital and the FHS teams. When he arrives at the municipal hospital and hospitalization is necessary, it is difficult to get a bed in the capital. (408)

> "I see that although the current movement is towards the decentralization of services, there is still a need to break the crystallizations around care for people with psychological distress in my municipality." (193)

Still, prejudice and stigma are part of the network professionals themselves. This process means that the RAS is not consolidated, causing suffering not only for the user, but also for the teams that face the demands in the territory as best they can.

Repercussions experienced by the multidisciplinary team in the face of health service problems

The multidisciplinary health team promotes care at the RAPS service points and should be responsible for crisis care. This understanding is a consensus among the professionals addressed, however, the need to adapt the number of professionals and their qualification to work in psychosocial care is highlighted.

The turnover of the team, considering the high number of professionals hired, has an impact on the lack of employees and the families' resistance to accepting treatment with professionals who are unable to develop a bond with the user. Still, given the internal demands of other work to be carried out in the health service (medication, patient care, organization of the unit), professionals perceive that the inadequacy of the number of employees compromises the active search for patients in crisis at home and the continuous monitoring of cases.

> "[...] our service has only one psychiatrist, yes, a single professional, who, in addition to the technical meeting, has a shift to provide reports (great demand from our CAPS) and two shifts for consultations." (332)

Another difficulty for the teams is the decrease in the supply of community services and CAPS, especially in the night shift. Many municipalities do not offer night care. Under these conditions, the team advises the patient to return home, even knowing that it would not be the most appropriate conduct for the case. In some situations, referral to the hospital context is unavoidable, which overwhelms community service workers, mainly because they refer patients only when they are driven by the ambulance driver and a nursing professional. However, still on the issue, professionals point out that the lack of clarity about the concept of crisis in mental

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health generates numerous obstacles, even when services are subject to the same municipal management.

> "[...] We lack a way to shelter this patient in crisis during the night, since the patient in crisis sometimes has to return to his home during the night, because he has nowhere to be sheltered during the night. Because the only hospital in the city does not welcome our patients in crisis." (513)

> "[...] The transport of this user to the municipal hospital is also a difficulty. On several occasions the ambulance is not made available, as they argue that an emergency may arise, when this case is an emergency and is not seen that way."(408)

Considering the important clinical performance of the team with the patient in crisis, some professionals point out that sometimes they only mediate between family members and health services, that is, with low power of intervention. The active presence of family members in the search for care at various points in the network and, without an effective response, worries some professionals who question themselves as a health team.

> "There is no qualitative approach, [the team] only play the role of mediators between the family members and the services. The CAPS presents fragility of material and human resources. In the case of people who are not users of the service and arrive in a crisis situation, they have often been referred, through family members, to the psychiatric emergency of reference in the state located in a neighboring municipality, approximately 30 kilometers away. [...] causing intense anguish and impotence of the technician/s who carried out the reception due to the impossibility of carrying out new enrollments." (8)

Part of the problems signaled here has an interface with the difficulty of adapting the health team to break with the hegemonic biomedical model. Professionals perceive that this has important implications in the relationships with the user, with the family and in the integration of the team.

> "[...] I also perceive the need for changes in work processes regarding crisis and emergency response, as there is no consensus in the team. Some professionals do not consider the subjective dimension of the crisis, offering drug therapy as the main strategy to deal with these cases. Our CAPS has hospitalization as its "flagship", demonstrating a model based on biomedicine. Thus, it is common that there is no interdisciplinarity, but the compartment of each knowledge." (193)

In this way, the discussion of cases is replaced by individual care, the therapeutic plan ceases to articulate the different knowledge and perspectives on the process experienced by the user in crisis,

positioning being maintained indifferent to the user's participation in their treatment, since the professional dominates the knowledge and dictates the rules.

Fragile aspects in the individual approach to crisis response

Professionals point out the fragile connection of users who have experienced an episode of mental health crisis to the service and compliance with the singular therapeutic plan, which may include carrying out other consultations, exams, correct adherence to drug treatment, unpreparedness to deal with another human being in psychic imbalance. Both Primary Health Care (PHC) and Emergency Care Unit (UPA) professionals have similar confrontations in the individual approach to these situations, revealing feelings of fear and impotence, according to the reports:

> "[...] I believe that there is a great lack of professional preparation in the management of such occurrences, which leaves much to be desired at the moment. I often feel that we are powerless in the face of such occurrences, as we do not have human resources trained to adequately approach the UAPS." (204)

In this way, many professionals reported feeling lost and not knowing how to react in the face of an unexpected crisis, forgetting the humanization in handling the situation and that the user in crisis is the same as before. The success of the approach will depend a lot on how the professional positions himself before, during and after the service, since the user's perception in relation to the reception and handling of his case is decisive for the creation of a bond. This practice is observed below:

> "[...] So often the containment is done with the help of family members and neighbors who show solidarity. They try to help, but it often hurts, because they are not prepared in physical restraint, they do not know how to approach it correctly". (408)

With regard to the humanization of care, the fragile involvement of the professional with the user's family is understood as a difficult element. The professionals reveal that there are families that are not co-responsible for care, not following the guidelines. In these processes, the lack of preparation to deal with complex care, which goes beyond the biological dimension, makes the professional move away from the detailed investigation of the user's

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past history, which elements enhance their emotional imbalance, which situations cause stress. Such individual conducts are perceived and considered harmful for the service to the user in crisis.

> "The absence of family participation may be one of the causes of the psychotic outbreaks that have occurred in the municipality." (380)

Added to this issue, the high demand for mental health at health care points is a confrontation that is often postponed by the team, considering, among other reasons, the lack of preparation for clinical care. To this end, professionals are eager for qualifications and training in dealing with urgencies and emergencies in mental health.

> "The greatest demand for user embracement is from users and family members who need guidance on how the network works, and from network workers who need guidance on the role of the service in the network. Limitation of personnel, workload and technical training." (381)

In this way, the professionals point out that the permanent health education of the different points of the RAS must consider the need not only verbalized by each worker in their daily lives, but also manifested by the low resolution in the care of patients in crisis in mental health.

DISCUSSION

In a context of reformulation of the care model structured in networks and considering the complexity of mental health care, processes of reflection on practice and work dynamics are essential to monitor both the implementation of RAPS and its repercussions on care.

Expanding the number of devices and strengthening the articulation of health care points for people with suffering, mental disorders and/or drug users was an important gain for the Psychiatric Reform. With devices organized at different levels of care, the expansion of the specialized services that make up the RAPS stands out, which at the end of 2016 had 2340 CAPS of all types throughout the national territory. (8) Another important collaborating factor supporting this model of care was the internalization of mental health care for medium and small-sized municipalities, with a consequent increase in PHC participation and decentralization of psychosocial care beds.[9]

The offer of qualified conditions for health professionals, envision having a positive impact on the care and monitoring of patients in mental health crisis. However, the contrasting perception of workers about the structuring and implementation of RAPS emerges from the territorial diversity in different regions and from the socioeconomic inequality present in a country of continental dimensions such as Brazil. [9]

Also considering aspects related to the local management of financial resources and contracts between municipalities and health regions, they have a significant impact on the organization in the flow of care and on the way in which professionals will provide care for patients in crisis, as well as make the patient and family empowered for their treatment. The understanding that professionals are essential for this process was demonstrated in the mental health care network in the municipality of Sobral (CE), in which the connection flows, that is, the modes of functioning of the networks operate by virtue of the action of the workers, who perceive themselves as protagonists in the care process, enhancing the shared and articulated movements among themselves. [10]

Even if human potential promotes changes and consolidates processes, "assistance gaps" at various points of care generate fragility in the coverage of the service network. A study developed from national databases found that the inequality of conditions in different regions is related to disparities in the provision of services, physical infrastructure and human resources. [9] Such barriers, which negatively impact networking, essentially affect access to services and the professionals' ability to solve problems. Thus, the substitutive strategies and the deinstitutionalization process, despite the difficulties presented, prove to be more humane and effective when compared to the traditional model. [11]

Mental health care particularly, among the health areas, is the one that has a strong prerogative of multidisciplinary and interdisciplinary work. The psychosocial approach presumes in essence the involvement of different areas of knowledge, in addition to integrated actions, which involve different care networks such as: social, legal, educational, cultural, public safety, which together act in favor of the person in mental suffering and his family.

The WHO already mentioned that there must be a strong relationship between primary care professionals and mental health care, and that these professionals are able to recognize the person's suffering. However, the importance of continuing education for these professionals is highlighted. An effective education process should emphasize care for the person, and not their disease, from the perspective of the subject's expanded clinic, deconstructing the biological and biomedical strategies of mental health care. [12]

One of the most important strategies implemented by the Ministry of Health with regard to psychosocial care is the constitution of a multidisciplinary team that operates locally and regionally in a territorialized perspective. In this context, the team is one of the main responsible for the proper functioning of health services, especially those linked to RAPS. [12]

In this perspective, the team constitutes a key and central element in the context of psychosocial care, especially because it provides the person undergoing treatment with the construction of their autonomy, using unique intervention strategies as the-

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rapeutic elements that value human beings in their particularity, in a new model of care that favors interdisciplinarity. [13]

In this approach, interdisciplinarity seeks theoretical and practical integration in different areas of knowledge. Interdisciplinarity, from the perspective of the team, establishes a reciprocal relationship that will promote dialogue between all those who participate in mental health care. This perspective encompasses promotion, prevention, care and social reintegration. [14]

The different knowledge involved in care must consider horizontalization based on the relationships between professionals and specific actions in interdisciplinary areas, overcoming the simple transfer of knowledge. [15] Interdisciplinary actions transcend the simplistic thinking arising from the health-disease process as a prerogative of cause-effect and start to consider the individual in his entirety, demanding from the health team the understanding of the human condition beyond the disease. [16]

A study carried out with nurses who work in psychosocial care found that professionals in general have difficulties to include themselves in a model arising from the psychiatric reform, since open services have a characteristic in care that is different from the previous proposal linked to hospital care. The study also addresses the difficulties that professional nurses have in defining their role in the extra-hospital network, sometimes representing a certain distortion in their professional identity. [13]

The same study also points out the level of satisfaction of nurses who, surprisingly, consider themselves satisfied despite low wages, lack of recognition, the lack of incentives, the precarious infrastructure and difficulties regarding specific knowledge in the area of mental health that would qualify the care. It is considered essential to propose permanent education programs made available and built collectively, capable of equipping the professionals of the health team. [13]

In the psychosocial care network, empowerment is sought as a constructive process between workers and people, which means commitment to the fight for equity. According to WHO, empowerment is based on four pillars: understanding their role; acquisition of sufficient knowledge to engage in health care; skills and facilitation in living with the context they experience. [17]

> “Participatory practices enhance care for people in crisis, even in the face of obstacles related to fragile individual and collective clinical performance, as well as the challenge of making network care concrete.”

In the health sector, a context in which the hegemony of hierarchical relationships between professions and the overlapping of medical knowledge is experienced, the understanding presented by nursing professionals about the concept of empowerment is revealed in opposition to the instituted dynamics and potentiator of changes. As a synonym of shared power and promoter of individual and collective transformations, empowerment is fostered by training and the exercise of expanded clinical practice. However, in the care and contact with the drug user, the fragile empowerment of some nursing professionals was revealed, evidencing a contradiction in the way of welcoming these professionals, which can hinder the constitution of living care networks. [18]

From this perspective, empowerment in the network is envisioned in the reception, imprinting its value and potential in establishing a link between the user and the health service, with the resolvability of the service and with the adequacy of the service to the needs of the users. However, the user is part of other networks, in addition to this one structured in health services offered by RAPS.

Social support networks perform functions such as emotional support, social companionship, and cognitive guidance [19] in addition to being considered indispensable for living in society. Its structural characteristics include size, density, composition, dispersion and homogeneity/heterogeneity. Among them, it should be noted that the most effective networks are those of medium size, between 8 and 10 members, as very small networks tend to overload members in times of crisis. Density concerns the quality of relationships and is an important influencer on the subject. Other elements that can facilitate exchanges or tensions in the network are the context of the relationship and the degree of intimacy, as well as the different characteristics of the members, such as age, gender, culture, social and economic level. [20] In this sense, RAPS constitutes a network of conversations that permeates all moments of the user's encounter and their networks with health professionals and their care flows.

Amidst the articulation, interaction and overlapping of networks, dialogue and conversation have been identified as the substance of health work. Reception then becomes a central dimension in everyday practices, integrating those involved in dif-

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ferent care spaces, ranging from the home context to the device of greater technological complexity. [21] Still, with regard to crisis care, welcoming, specifically, expands the possibilities of safe transit through the network, since the mental health care process is sometimes stigmatized and reduced to violence and medicalization.

Thus, when health professionals understand their attribution as mediators of propulsive processes of empowerment in health, they offer users spaces for dialogue aimed at interrupting processes of impotence and dependence and seeking more autonomy, engagement, co-responsibility and initiative for conducting their lives. [17]

CONCLUSION

This study points out the potential of articulated work between primary health care and mental health services, based on a participatory and comprehensive network between users and the team, seeking to enhance and strengthen psychosocial care. Participatory practices enhance care for people in crisis, even in the face of obstacles related to fragile individual and collective clinical performance, as well as the challenge of making network care concrete.

It is necessary to enable crisis care in a universal, equitable, comprehensive and quality way, which is essentially based on welcoming and establishing a link between the user and the health service. However, the resoluteness of care starts with adapting the service to the needs of users, expanding the technical capacity of professionals and recognizing the complex structure of health organized in networks.

Thus, it is recommended to carry out future investigations that include professionals, managers and users, in order to broaden the understanding of the elements that positively impact and the strategies to consolidate the RAPS in Brazil.

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