Resources, objectives and guidelines in a Psychosocial Care Network structure

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ABSTRACT
Objectives: to analyze a Psychosocial Care Network structure, based on the compromise of its resources and meeting objectives and guidelines recommended in Ordinance 3,088/2011. Method: an empirical, quantitative study with 123 primary care professionals, psychosocial and emergency care, who work at Western Network of the city of São Paulo. Questionnaires and statistical analysis were applied through the Exact Fisher’s test with 5% significance considering p<0.05. Results: there is compromise of physical resources in the absence of mental health beds in a general hospital (p=0.047); of technological resources in the lack of discussion forums (p=0.036); of human resources in number of teams (p=0.258); and of financial resources (p=0.159). Psychosocial care is the one that most meets the objectives and guidelines. Conclusion: there are insufficient physical, technological, human, and financial resources for the work articulated in the three care modalities that are heterogeneous in terms of meeting the objectives and guidelines. Descriptors: Mental Health Assistance; Health Services Accessibility; Comprehensive Health Care; Mental Health; Health Policy.

RESUMO
Objetivo: analisar a estrutura de uma Rede de Atenção Psicossocial, a partir do comprometimento de seus recursos e do cumprimento de objetivos e diretrizes preconizados na Portaria 3.088/2011. Método: estudo empírico, quantitativo, com 123 profissionais da atenção básica, atenção psicossocial e atenção de emergência, que atuam na Rede Oeste do município de São Paulo. Aplicados questionários e análise estatística por meio do teste de Fisher com significância de 5% considerando p<0.05. Resultados: há comprometimento dos recursos físicos na falta leitos de saúde mental em hospital geral (p=0.047); de recursos tecnológicos, na escassez de fóruns de discussão (p=0.036); de recursos humanos, em número de equipes (p=0.258); e de recursos financeiros (p=0.159). A atenção psicossocial é a que mais os cumpre os objetivos e diretrizes. Conclusão: não há recursos físicos, tecnológicos, humanos e financeiros suficientes para o trabalho articulado nas três modalidades de atenção, e as mesmas são heterogêneas quanto ao cumprimento dos objetivos e diretrizes. Descriptores: Assistência à Saúde Mental; Serviços de Saúde Mental; Assistência Integral à Saúde; Saúde Mental; Política de Saúde.

RESUMEN
Objetivo: analizar la estructura de una Red de Atención Psicosocial a partir del compromiso de sus recursos y del cumplimiento de objetivos y directrices preconizados en la Ordenanza 3.088/2011. Método: estudio empírico, cuantitativo, con 123 profesionales de la atención básica, atención psicosocial y atención de emergencia, que atuaron en la Red Oeste del municipio de São Paulo. Aplicado cuestionarios y análisis estadístico por medio del test de Fisher con significancia del 5% considerando p<0.05. Resultados: hay comprometimiento de los recursos físicos, en ausencia de lechos de salud mental en hospital general (p=0.047); tecnológicos, en la escasez de foros de discusión (p=0.036); humanos, en número de equipos (p=0.258); y financieros (p=0.159). La atención psicosocial es la que más los cumple los objetivos y directrices. Conclusión: no hay recursos físicos, tecnológicos, humanos y financieros suficientes para el trabajo articulado en las tres modalidades de atención, y las mismas son heterogéneas en cuanto al cumplimiento de los objetivos y directrices. Descriptores: Atención a la Salud Mental; Servicios de Salud Mental; Atención Integral de Salud; Salud Mental; Política de Salud.
INTRODUCTION

Since the enactment of Law 10.216/2001, which guides a new care model for people with mental disorders, Mental Health (MH) care in Brazil has been undergoing major transformations. Currently, this field is focused on the qualification, expansion and strengthening of the Psychosocial Care Network (RAPS) established by Ordinance 3.088/2011(1) as a political process of consolidation expression of the Psychiatric Reform and National Mental Health Policy (PNSM).

In this sense, MH care is guided by the perspective of Health Care Networks (RAS), which directs it through clinical and organizational guidelines. RAS implementation has been encouraged since 2011. To date, some thematic RAS have been instituted, such as maternal and child health networks, chronic diseases, urgency and emergency, and psychosocial care. RAS are service organizations linked by a single mission, with cooperative and interdependent purposes and actions, aiming to offer comprehensive care, with different degrees of complexity to different demands, from the simplest to the most complex(2).

For ideal functioning, there is a need for attributes, such as physical resources, number of devices adapted to the territory demand that must provide promotion, prevention, diagnosis, treatment and articulation of components for case management and rehabilitation. Technological resources are needed, such as the integrated information system that links all the components of the network with broad intersectorial action and existence of coordination mechanisms, continuity of care and care integration. There is also a need for financial resources aligned with the purposes of the network, in addition to sufficient, competent and applied human resources(2-3).

RAPS aims to ensure people with suffering or mental disorder and the needs arising from the use of crack, alcohol and other drugs, as well as a comprehensive and humanized care. RAPS has regional management and comes with the perspective of consolidating an open community-based care model, guaranteeing people with mental disorders’ freedom of movement through services, community and city. It consists of 07 components that comprise a set of actions/services or points of care, among them primary health care, specialized psychosocial care, urgent/emergency care, tertiary residential care, hospital care, de-institutionalization strategies and Psychosocial Rehabilitation (PR)(3). Among the RAPS’ general objectives are expansion of the population’s access to psychosocial care, promotion of access to points of care of the target population and their family, and guarantee of their articulation and integration. Thus, there is provision of qualified care through reception, continuous follow-up and attention to urgencies with the proposition of paradigm of exclusion/segregation of people with mental disorders transformation to a new way of looking, listening and caring for the person psychic with mental disorder, reinventing the practice of work sustained in the psychosocial model(4).

In order to meet these objectives, RAPS actions are anchored in twelve guidelines: respect for human rights; guarantee of autonomy and freedom of the people; equity promotion; recognition of social determinants of health; action in combating stigma and prejudice; access and quality of services; offering comprehensive, multidisciplinary and interdisciplinary care; Permanent Education (PE) for all professionals; humanized assistance focused on people’s needs; diversity of care strategies and Harm Reduction (HR) that favor social inclusion and user autonomy. Thus, it is necessary that the services act with central axis the construction of the Single Therapeutic Project (PTS)(1).

RAPS work should be delineated through Care Lines (CL), which are based on clinical guidelines and define the ways in which the services available in a particular territory and health practices are articulated. In this way, ethical-technical-political principles are validated for the organization of the points of care, being possible to subsidize strategies to reach a qualified care, according to the complexity and technological density that care requires(5). Likewise, in order to configure CL, workers must be moved among themselves and with other work devices.

Considering the particularities of an RAS, a recent qualitative research on the functioning of RAPS, from professionals/users’ perspective, evidenced deficits in relation to communication among network points, lack of Regulatory Flows (RF) to conduct referrals, human/physical/structural resources(5-6), simplifying paradigms in listening to psychic suffering. In addition, there is implementation of MH actions in primary and in different network points, in addition to limited access by users to them, lack of articulation and effectiveness of integrated care in services, and centralization of care in specialized services(7).

Considering the challenges of networking and deepening of possible determinants of its reality, this article has as central theme structure of Primary Health Care components, specialized psychosocial care and urgent/emergency care of a specific RAPS. This article has as research questions: what is the structure of these components to meet the objectives/guidelines established by Ordinance 3.088/2011? What attributes are impacting its operation? In addition, considering that RAPS is a policy in expansion, it needs continuous evaluations. Therefore, this study intends to provide perspectives that foster the needs judgment that subsidize MH care qualification in the healthcare network care model.

OBJECTIVE

To analyze a RAPS structure, based on the compromise of its resources and meeting objectives and guidelines recommended in Ordinance 3.088/2011.

METHOD

Ethical aspects

The project approved by the Research Ethics Committee of the USP Nursing School and the Municipal Health Department of São Paulo, according to Resolution 466/2012 of the Brazilian National Health Board. All participants signed a Consent Form.

Type of study

This is an empirical and quantitative study.

Methodological procedures

Study setting

Of the 25 points of care that make up the RAPS of the Western Coordination of the city of São Paulo, they were part of the 23:10 Basic
Health Units (BHU), 04 with MH team, composed by occupational therapist, psychiatrist, and psychologist. The others have support from 03 Family Health Support Centers (NASF); 5 Psychosocial Care Centers (CAPS) - 2 CAPS II adult, 1 CAPS II alcohol/drugs, 1 CAPS II child-juvenile, 1 CAPS III adult; 1 PS - Psychiatric Emergency Sector (PS) with 9 beds (the network does not have psychiatric beds in a general hospital); 1 Coexistence and Cooperative Center (CECCO); 2 Therapeutic Residential Services (SRT), 1 mixed/1 fem; 2 Street Outreach Office Team (SOO) with shared/integrated actions to NASF points and 2 teams. The services that did not participate claimed to be impeding the teams’ agenda: 1 CAPS II alcohol/drugs and 4 BHU (1 of them with a MH team and 03 traditional).

**Data source**

The inclusion criteria were to be a graduated health professional, to work in the clinic or management and to agree with the collected data publication. The exclusion criteria were to be on vacation/leave at the time of data collection. It was not possible for the participation of mid-level professionals, since logistics did not allow. In the Brazilian National Registry of Health Facilities, there were 263 professionals working at Western RAPS. Based on the 7% margin of error, the final sample was 119, with a total of 123 professionals.

**Collection and organization of data**

Collection was carried out from January to November 2016, with a self-administered questionnaire prepared by the authors, and submitted to a pre-test with 05 professionals, and then excluded. The socio-demographic data were age, gender, marital status, training, working length with MH, service performance, workload, service function. The application of RAPS guidelines/objectives (answers “Yes”; “No” and “I do not know”) are: service/core has or articulates in a project of health promotion for vulnerable groups, guiding rights, accessing work/income/social housing/culture/art, prevents and/or there is DR, PR/social inclusion, PTS, intersectoral actions. Service/core monitors/evaluates the quality of services through effective-ness/resolution indicators, works stigma/prejudice, provides space for community to clarify MH issues and participation in PE.

Network resources compromise, by Likert scale, with variation of -1 to +1 values: “I agree” (value = -1), “Neutral” (value = 0), “I disagree” (value = +1), was based on Ordinance 3,088 of RAPS(1), Ordinance 4,279 of RAS(2) and Mendes’ framework(2). RAS construction must be anchored in fundamentals such as: availability of resources, quality and access; horizontal and vertical integration between points; defined health territories; levels of health care; team composition (number of professionals); training and PE processes; existence of CL and guidelines on crisis management. It was considered as compliance with the guidelines/objectives equanimity of positive results on the operation and availability of resources in the three modalities, and as compromise, evaluation carried out by service professionals(2-3).

**Data analysis**

The Statistical Package for the Social Sciences (SPSS) version 22 was used to determine the frequency distribution among the identified variables, with 95% confidence level and Fisher’s exact test. It presented significance between the results when p value is <0.05. To order the presentation of the results, the RAPS components were organized according to their care modalities: Primary Care (PC) - BHU, CECCO, NASF and CR; Psychosocial Care (PCS) CAPS and SRT; and Emergency Care (EC), Emergency/Psychiatric Emergency Service. Resources were grouped into physical, technological, human and financial.

**RESULTS**

The sample was composed mainly by BHU (55.5%) and CAPS (24.5%) professionals. Psychologists predominate (24.4%), followed by nurses (22.9%), physicians (20.3%), and occupational therapists (10.6%) (Table 1).

Table 2 shows that part of the objectives/guidelines is not carried out equally among the three modalities showing weak compliance with the legislation in question.

As for the development of access to work, income and solidarity housing/PR projects - social inclusion/construction of the PTS, there is greater performance of PSC, followed by PC. In relation to access to culture/art and programs projects to work on stigma/prejudice, there is significance between the three modalities, since there is greater performance of the PSC in detriment of the PC and EC. EC showed less emphasis on both proposals, with emphasis on culture/art in which it does not develop any project.

There is agreement regarding noncompliance among the modalities regarding monitoring of services offered through quality indicators and DR/drug prevention projects, with EC presenting the least involvement. In the investigated variables, except in PE activity on RAPS, a significant portion of professionals of the three modalities are not aware of the application of the objectives/guidelines described in Ordinance 3,088/2011 (Table 2).

Table 3 shows that among the physical resources of the three modalities, the operating structure of the service, inadequate physical area and rooms for care, and the lack of MH beds in a general hospital are considered compromised in all modalities. The latter was the most committed, from the perspective of PSC and EC professionals. Regarding the absence/insufficient number/distribution of services in the territory, it was evaluated as a resource compromised in all modalities.

The technological resources used were inadequate training/absence of EP processes, aiming at the qualification of care and support to the professional/worker; effective communication among professionals; the lack of integration between the components of RAPS; constitution of social network to include users in the community; qualification of MH practices and services are compromised in all modalities. CL and protocols are compromised resources in the PC and in the EC, where the latter stands out most. Regarding the involvement in discussion forums, participation is low among PC and EC professionals. The viability/satisfactory/therapeutic management of the crisis along the lines of PSC, outside the circuit of psychiatric hospitalizations in hospitals, is not only compromised in the PSC. Among human resources, the composition of the teams, number of professionals, is emphasized as a resource compromised in all modalities. Regarding financials, PSC stands out more than the other modalities in this question (Table 3).
### Table 1 - Training and occupational sociodemographic profiles of the situation of interviewees, São Paulo, São Paulo, Brazil, 2016 (N=123)

| Variables                      | n (%)       |
|--------------------------------|-------------|
| Gender                         |             |
| Male                           | 26 (21.1)   |
| Female                         | 97 (78.9)   |
| Marital status                 |             |
| Single                         | 38 (30.9)   |
| Married                        | 58 (47.2)   |
| Stable Union                   | 5 (4.1)     |
| Divorced                       | 21 (17.1)   |
| Widow                          | 1 (0.8)     |
| Training                       |             |
| Psychologist                   | 30 (24.4)   |
| Occupational therapist         | 13 (10.6)   |
| Nurse                          | 28 (22.8)   |
| Physician                      | 25 (20.3)   |
| Social work                    | 12 (9.8)    |
| Physiotherapist                | 5 (4.1)     |
| Others                         | 10 (8.1)    |
| Training length                |             |
| < 1 year                       | 2 (1.7)     |
| 1 - 5 years                    | 11 (9.1)    |
| 5 a 10 years                   | 25 (20.7)   |
| 10 - 20 years                  | 22 (18.2)   |
| > 20 years                     | 61 (50.4)   |
| Graduate                       |             |
| Specialization                 | 96 (86.5)   |
| Master                         | 12 (10.8)   |
| Doctorate                      | 3 (2.7)     |
| Mental Health working length   |             |
| < 1 year                       | 11 (9.7)    |
| 1 - 5 years                    | 21 (18.6)   |
| 5 a 10 years                   | 20 (17.7)   |
| 10 - 20 years                  | 23 (20.4)   |
| > 20 years                     | 38 (33.6)   |
| Service length                 |             |
| < 1 year                       | 29 (23.6)   |
| 1 - 5 years                    | 35 (28.5)   |
| 5 a 10 years                   | 17 (13.8)   |
| 10 - 20 years                  | 34 (27.6)   |
| > 20 years                     | 8 (6.5)     |
| Workload                       |             |
| 44h                            | 7 (5.7)     |
| 40h                            | 53 (43.4)   |
| 36h                            | 9 (7.4)     |
| 30h                            | 24 (19.7)   |
| 20h                            | 22 (18.0)   |
| Others                         | 7 (5.7)     |
| Service in which the professional operates | |
| BHU                            | 55 (55.5)   |
| CAPS                           | 43 (42.5)   |
| CECCO                          | 6 (4.9)     |
| Psychiatric Emergency          | 8 (6.5)     |
| NASF                           | 4 (3.2)     |
| Street Outreach Office         | 5 (4.0)     |
| Therapeutic Residency          | 2 (1.6)     |
| Function in servisse           |             |
| Assistance/Technical           | 106 (87.6)  |
| Supervision                    | 21 (17.1)   |
| Management                     | 13 (10.7)   |
| Total                          | 123 (100)   |

Note: * pharmacists, dentists, nutritionists and speech therapists.

### Table 2 - Compliance with Psychosocial Care Network objectives/guidelines by care model, São Paulo, São Paulo, Brazil, 2016

| Objectives and Guidelines                                      | Primary Care n (%) | Psychosocial Care n (%) | Emergency Care n (%) | Total n (%) | p value |
|---------------------------------------------------------------|--------------------|-------------------------|----------------------|-------------|---------|
| Health promotion project for vulnerable groups*              | Yes 60 (72.3)      | 24 (75.0)               | 1 (14.3)             | 85 (69.7)   | 0.021   |
| Project to guide rights and services available in the network| Yes 64 (77.1)      | 29 (90.6)               | 7 (87.5)             | 100 (81)    | 0.381   |
| Access to culture/art projects*                              | Yes 52 (63.4)      | 29 (90.6)               | 0 (0.0)              | 81 (66.4)   | < 0.001 |
| Monitoring of services offered through quality indicators     | Yes 37 (44.6)      | 17 (53.1)               | 2 (25.0)             | 56 (45.5)   | 0.126   |
| Program to work on stigma/prejudice*                         | Yes 26 (31.3)      | 22 (68.8)               | 1 (12.5)             | 49 (39.8)   | < 0.001 |
| Drug prevention/DR projects                                  | Yes 43 (53.1)      | 17 (53.1)               | 1 (12.5)             | 61 (50.4)   | 0.125   |
| PR/social inclusion project*                                  | Yes 27 (33.3)      | 13 (40.6)               | 5 (62.5)             | 45 (37.2)   | 0.026   |
| PTS construction*                                            | Yes 52 (63.4)      | 29 (90.6)               | 4 (50.0)             | 85 (69.7)   | 0.022   |
| Flow description for user referral in the network             | Yes 41 (50.0)      | 18 (56.3)               | 4 (50.0)             | 63 (51.6)   | 0.564   |

Note: PR - Psychosocial Rehabilitation; MH - Mental Health; DR - Damage Reduction; PTS - Single Therapeutic Project (PTS - Projeto Terapêutico Singular); PE - Permanent Education; *p presents statistical significance.
Table 3 - Compromise of resources in Psychosocial Care Network, São Paulo, São Paulo, Brazil, 2016

| RAPS resources |         | Primary Care n (%) | Psychosocial Care n (%) | Emergency Care n (%) | Total n (%) | \( p \) value |
|----------------|---------|---------------------|-------------------------|----------------------|-------------|--------------|
| **Physical**   |         |                     |                         |                      |             |              |
| Structure for service functioning (inadequate physical area and care rooms) | Agreement | 57(68.8) | 25(78.1) | 6(75.0) | 88(71.5) | 0.712 |
|                | Neutral | 9(10.8) | 1(3.1) | 0(0) | 10(8.1) |              |
|                | Disagreement | 17(20.0) | 6(18.8) | 2(25.0) | 25(20.3) |              |
| Lack of MH beds in general hospitals* | Agreement | 52(62.0) | 28(87.5) | 7(87.5) | 87(70.7) | 0.047 |
|                | Neutral | 18(21.7) | 1(3.1) | 1(12.5) | 20(16.3) |              |
|                | Disagreement | 13(15.7) | 3(9.4) | 0(0) | 16(13.0) |              |
| Accessibility issues/open door | Agreement | 48(57.8) | 12(37.5) | 6(75.0) | 66(53.7) | 0.130 |
|                | Neutral | 7(8.4) | 6(18.8) | 1(12.5) | 14(11.4) |              |
|                | Disagreement | 28(33.7) | 14(43.8) | 1(12.5) | 43(35.0) |              |
| Absence/insufficient number of MH care services in the territory | Agreement | 66(79.5) | 23(71.9) | 6(75.0) | 95(77.2) | 0.691 |
|                | Neutral | 6(7.2) | 2(6.3) | 0(0) | 8(6.5) |              |
|                | Disagreement | 11(13.3) | 7(21.9) | 2(25.0) | 20(16.3) |              |
| Provision of services in the territory | Agreement | 47(57.3) | 16(50.0) | 1(12.5) | 64(52.5) | 0.127 |
|                | Neutral | 13(15.9) | 7(21.9) | 3(37.5) | 23(18.9) |              |
|                | Disagreement | 22(26.8) | 9(28.1) | 4(50.0) | 35(28.7) |              |
| Articulation among network services | Agreement | 56(67.5) | 21(65.6) | 4(50.0) | 81(65.9) | 0.441 |
|                | Neutral | 5(6.0) | 4(12.5) | 0(0) | 9(7.3) |              |
|                | Disagreement | 22(26.5) | 7(21.9) | 4(50.0) | 33(26.8) |              |
| Inadequate training and absence of PE processes aiming at care qualification | Agreement | 58(69.9) | 24(75.0) | 6(75.0) | 88(71.5) | 0.953 |
|                | Neutral | 8(9.6) | 3(9.4) | 0(0) | 11(8.9) |              |
|                | Disagreement | 17(20.5) | 5(15.6) | 2(25.0) | 24(19.5) |              |
| Inadequate training and absence of PE processes aiming at professional/worker support | Agreement | 59(71.1) | 22(68.8) | 7(87.5) | 88(71.5) | 0.975 |
|                | Neutral | 8(9.6) | 3(9.4) | 0(0) | 11(8.9) |              |
|                | Disagreement | 16(19.3) | 7(21.9) | 1(12.5) | 24(19.5) |              |
| RAPS discussion forum* | Agreement | 55(67.1) | 13(40.6) | 5(62.5) | 73(59.8) | 0.036 |
|                | Neutral | 0(0) | 0(0) | 0(0) | 0(0) |              |
|                | Disagreement | 27(32.9) | 19(59.4) | 3(37.5) | 49(40.2) |              |
| Effective communication among professionals working in the network | Agreement | 58(69.9) | 21(65.6) | 5(62.5) | 84(68.3) | 0.533 |
|                | Neutral | 4(4.8) | 4(12.5) | 0(0) | 8(6.5) |              |
|                | Disagreement | 21(25.3) | 7(21.9) | 3(37.5) | 31(25.2) |              |
| Complexity of MH needs | Agreement | 55(66.3) | 19(59.4) | 5(62.5) | 79(64.2) | 0.614 |
|                | Neutral | 10(12.0) | 6(18.8) | 0(0) | 16(13.0) |              |
|                | Disagreement | 18(21.7) | 7(21.9) | 3(37.5) | 28(22.8) |              |
| Continuous compromise of the professionals in the construction of new ways of dealing with the psychological/emotional suffering | Agreement | 54(65.1) | 16(50.0) | 5(62.5) | 75(61.0) | 0.295 |
|                | Neutral | 4(4.8) | 5(15.6) | 0(0) | 9(7.3) |              |
|                | Disagreement | 25(30.1) | 11(34.4) | 3(37.5) | 39(31.7) |              |
| Lack of integration of RAPS components | Agreement | 58(69.9) | 22(68.8) | 6(75.0) | 86(69.9) | 0.969 |
|                | Neutral | 5(6.0) | 3(9.4) | 0(0) | 8(6.5) |              |
|                | Disagreement | 20(24.1) | 7(21.9) | 2(25.0) | 29(23.6) |              |
| Lack of agreement between the points of health care in the territory | Agreement | 53(63.9) | 16(50.0) | 4(50.0) | 73(59.3) | 0.410 |
|                | Neutral | 9(10.8) | 4(12.5) | 0(0) | 13(10.6) |              |
|                | Disagreement | 21(25.3) | 12(37.5) | 4(50.0) | 37(30.1) |              |
| Social support network for inclusion of users in the community | Agreement | 64(77.1) | 24(75.0) | 6(75.0) | 94(76.4) | 0.813 |
|                | Neutral | 11(13.3) | 4(12.5) | 2(25.0) | 17(13.8) |              |
|                | Disagreement | 8(9.6) | 4(12.5) | 0(0) | 12(9.8) |              |
| CL and protocols | Agreement | 42(51.2) | 12(37.5) | 6(75.0) | 60(49.2) | 0.293 |
|                | Neutral | 10(12.2) | 4(12.5) | 1(12.5) | 15(12.3) |              |
|                | Disagreement | 30(36.6) | 16(50.0) | 1(12.5) | 47(38.5) |              |
| Responsibility of professional with user | Agreement | 36(43.4) | 11(34.4) | 4(50.0) | 51(41.5) | 0.826 |
|                | Neutral | 10(12.0) | 4(12.5) | 0(0) | 14(11.4) |              |
|                | Disagreement | 37(44.6) | 17(53.1) | 4(50.0) | 58(47.2) |              |
| Qualification of MH practices and services | Agreement | 45(54.2) | 17(53.1) | 5(62.5) | 67(54.5) | 0.738 |
|                | Neutral | 15(18.1) | 3(9.4) | 1(12.5) | 19(15.4) |              |
|                | Disagreement | 23(27.7) | 12(37.5) | 2(25.0) | 37(30.1) |              |

To be continued
DISCUSSION

The findings demonstrated that professionals present training length and a long-standing trajectory in the field of MH, which allows them to make a careful evaluation regarding the reality of MH care offered in this RAPS. Although more than half of these professionals have worked for less than five years at the points of care, it brings with it parameters of operation of other networks to contextualize and contrast different organizational arrangements for work, as well as the follow-up of a policy still incipient. It should be noted that professionals present a mixed work contract, in a Single Legal Regime of public servants and/or Consolidation of Labor Laws, and act in direct and indirect management services. In São Paulo, the RAPS agreement began in 2013 and diagnosed the need to review and implement changes in order to align with the new policy, emphasizing care; PE; construction and service reforms; hospital medical equipment/furniture; costing; intersectoral actions; health promotion. However, the current reality, through the present study, indicates that such measures were not sufficiently achieved, since the professionals failed to perceive them.

Considering that the performance/management of human resources impacts the quality of attention and user satisfaction, it was detected that these are the most committed, constituting a critical node that requires immediate interventions not to break the follow-up of the RAPS guidelines. Among these, team re-adaptation and professional qualification, definition of protocols, routines and RF that improve assistance in network points, evaluation of the wear and strengthening of the worker, listening to their needs and recognizing their potentialities, reviewing the conditions for full exercise of the praxis from logistics, physical structure, inputs, materials, and equipment. In line with the current Brazilian economic reality and the underfunding of SUS (Brazilian unified Health System), there is a shortage of financial resources to purchase materials/inputs that directly entail assistance. Surely, these resources alone are not sufficient to meet the demands of the population if there is no administrative coherence of the same.

Since MH financing is small and the governance process gives autonomy to municipalities on how to apply them, it is necessary to revise and change this logic, since it impairs work processes and co-responsibility with PNSM. When resources are not applied in a balanced way, depending on the specifics of each point of care, the good performance and continuity in the services are compromised. It is also necessary for managers to broaden their understanding of how assistance is provided in loco and to be able to apply financial resources according to the actual needs of the population.

As to the physical resources of Western RAPS, absence, insufficient number and poor disposition of the services have implied accessibility and incapacitated adequate responses to the needs of the attached population. Network still faces difficulties regarding the lack of beds of psychiatry in a general hospital that, according to the RAPS Ordinance, are intended to include short-term psychiatric hospitalizations, crisis management, with a view to avoiding its recurrence and the long stay in the EC.

Considering that the crisis is a singular and disruptive experience of the existential process and not only the presence of psychopathological symptoms, it demands PSC care. In the Western RAPS, the management of the crisis in this model is a difficulty for PC and EC, possibly because the psychosocial perspective was not fully incorporated by professionals. This represents a circumstance involving the complexity of the demands of MH and the focus still given to the biomedical model. Transforming this care logic requires that these modalities be articulated with the RAPS propositions and construct strategies to deal with the needs of people with mental distress/mental disorder. Thus, their experiences were supported by understanding their magnitude, not only on the premise of eliminating symptoms.

Moreover, it has been found that in terms of technological resources, effective communication among professionals and the ongoing compromise to building new ways of dealing with psychic/emotional suffering are presented as fragile aspects of the network. This compromises MH focus on people’s needs and the diversification of care strategies. Strengthening this communication will enable Western RAPS to conduct longitudinal, comprehensive and qualified care, and in dealing with psychic suffering/mental disorder in this perspective, the psychosocial model is promoted in detriment of the asylum model.
In line with this reality, PC and EC professionals rarely participate in discussion forums on RAPS. As guided by article thirteen of the Ordinance, encouraging the creation of forums can be a possible means for the reversion of this framework since they represent a fertile space of exchange, appropriation on the components of the network and close ties between professionals, with citizen participation. Therefore, when promoting forums, PE is necessary in the face of the complexity and constant changes in social practice of workers(12).

Although there are difficulties in relation to the articulation of the network services, it is verified that PC and PSC are able to articulate and establish PR actions in the territory, fulfilling the guidelines established in the ordinance. By acting more closely and longitudinally with users, these two modalities play an important role in these actions, as they offer access to experiences, skills, autonomy and give users the opportunity to make choices(13). On the other hand, EC, because it provides care directed to crisis situations, does not emphasize rehabilitation actions, which does not rule out the compromise to articulate with other components to develop them, to expand and qualify access, including even promotion actions and health prevention.

As an axis of the PR Strategy, projects for access to work and income are developed through Solidary Economy, and contribute to reinsertion and reestablishment of the individual's contractual power, benefiting their inclusion, autonomy and citizenship, as well as strengthening the user-user and professional-user bond(14,15). Operationalization of this strategy cooperates for construction of subjectivity and makes it possible to open avenues for the resumption of citizenship(6). At the Western RAPS, these projects, along with culture/art projects and programs that work on stigma/prejudice are fragile in PC and completely out of phase in EC, and are mostly met by the PSC, which has CAPS.

CAPS stand out as a safe environment by offering a protected area of social interaction of users, where these, familiar and embraced in their needs, do not deal with adverse situations related to socializing, such as exclusion, prejudice and discrimination(14,15). Due to concentration of daily activities within the CAPS, it is necessary to encourage territory appropriation by users, allowing experimentation of new menus in community living(6). However, there is a need for intersectorial actions in Western RAPS, which promote access to culture/art to users and is not restricted to the CAPS space. It allows access to other services available in the city, such as CECCOs, thereby favoring circulation by the city and the autonomy(6).

Western RAPS has not yet consolidated itself in the development of DR/drug prevention projects, a fact that is in line with the Brazilian reality, which is also incipient. Such practice guarantees the subject’s right to choices and responsibility over his or her life, and loosens methods to understand population involved with drugs’ universality(15). Empowering it is fundamental to meeting the Brazilian drug policy proposition. With regard to the feasibility of PTS, a device that allows appropriation of living conditions and users’ needs and enables full care(16), it is fundamental that the network establish CL. Except in the PSC, one has as a technological resource compromised, indicating a gap between what is planned and performed in terms of care. In addition, the Health Information System is fragile, which represents an important technological vulnerability, with information carried through physical files, sometimes incomplete, and team meetings with conflicting experiences. As effective communication among professionals has been considered a compromised resource, decision-making and better conduct can compromise PTS.

CL is fostered by resources/inputs, technologies that users will use during the assistance process, and should work in a systemic way, operating with several services, starting with user input anywhere in the network(17). Since, according to the PTS, user circulates through points of care of the territory, if there is no CL that systematize his itinerary, there is a risk that he will lose in his therapeutic path. In addition, interventions become de facto therapeutic when all the actors involved benefit(18). In the Western RAPS, there is no uniformity regarding the existence of RF described between RAPS points, which promotes the construction of partnership and co-responsibility for care demands of the subjects as existences-suffering and that boost comprehensive care(19-20).

From the perspective of management, a significant number of professionals are unaware of the existence of monitoring through quality indicators, evidencing the need to appropriate the administrative aspects of the services. Based on these, it is possible to verify if actions developed have repercussion in assistance and if the obtained results help in the review of processes. Likewise, it is important to consider that the indicators consider a quantitative/qualitative understanding, which provides information about the effectiveness of the offered services, and that values the singularity and user individuality, putting it at the center of evaluation processes(21). This may be a challenge for the services in this field.

Efficient coordination among the components of a health care network leads to quality and continuity of care as well as efficiency in the use of resources(22), orchestration that is configured as the main point of (re)ordering and structuring a RAS(23). In view of the present setting, with the physical/human/technological/financial resources involved, difficulties to meet the objectives/guidelines of RAPS Ordinance 3,088/2011 intensify. In addition, it is only through exchange of resources, cooperation, integration and interdependence among the devices of a network that health care continuum and continuity of care are promoted(2).

Study limitations
Photograph of a single setting that precludes comparative analysis with other points of care and evaluation of the city’s RAPS governance.

Contributions to Mental Health Public Policies
Some recommendations were made to solidify Western RAPS: investment in discussion forums to strengthen compromise of cooperation between professionals/devices; re-training of the teams, intensifying PE, because professional alternation is something dynamic and everyone needs to speak the same language/maintain the thinning of their organization; to institute beds of psychiatry in general hospitals in existing services/territory or extend agreements with other networks; to integrate PC with
PSC; to involve care professionals in management activities to improve cooperation of processes and, finally, to extend the psychosocial approach at EC.

CONCLUSION

The Western RAPS structure of São Paulo does not fully own the physical, technological, human and financial resources to sustain the work in an articulated way, not fulfilling satisfactorily the objectives/guidelines listed in Ordinance 3,088/2011. PSC fulfills the objectives/guidelines more positively in the context of crisis management under PSC, PR projects and PTS leadership, even with the fragility of resources. PC and EC do not satisfactorily fulfill the objectives/guidelines regarding participation in discussion forums, promotion of culture/art projects/reduction of stigmas/prejudices, PTS and crisis management under PSC. It is emphasized that PC is able to perform PR in conjunction with PSC. The network’s fragility in sustaining MH care provision to the circumscribed population is evident, underscoring the explicit need for more investments. Western RAPS is progressing steadily, and has great potential to be reconfigured. This research contributes to fostering discussions and influencing macro-political influences on the functioning of this and other RAPS.

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