Resources, objectives and guidelines in a Psychosocial Care Network structure

Recursos, objetivos e diretrizes na estrutura de uma Rede de Atenção Psicossocial

Recursos, objetivos y directrices en la estructura de una Red de Atención Psicosocial

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ABSTRACT

Objective: 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); tecnológicos, na escassez de fóruns de discussão (p=0,036); humanos, em número de equipes (p=0,258); e 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.
Descritores: 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 actúan en la red Oeste del municipio de São Paulo. Aplicado cuestionarios y análisis estadístico por medio de la prueba 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 el 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, transitory residential care, hospital care, de-institutionalization strategies and Psychosocial Rehabilitation (PR)[1]. 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[1].

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[4]. 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 care 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/solidary housing/culture/art, prevents and/ or there is DR, PR/social inclusion, PTS, intersectoral actions. Service/ core monitors/evaluates the quality of services through effectiveness/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[3] 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 (PSC) 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 solidary 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)
Widower	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(24.5)
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	2(1.7)
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*					0.021
Yes	60(72.3)	24(75.0)	1(14.3)	85(69.7)	
No	13(15.7)	5(15.6)	4(57.1)	22(18.0)	
The person does not know how to inform	10(12.0)	3(9.4)	2(28.6)	15(12.3)	
Project to guide rights and services available in the network					0.381
Yes	64(77.1)	29(90.6)	7(87.5)	100(81.)	
No	8(9.6)	2(6.3)	1(12.5)	11(8.9)	
The person does not know how to inform	11(13.3)	1(3.1)	0(0.0)	12(9.8)	
Access to work, income, and solidary housing project*					0.001
Yes	47(56.6)	26(81.3)	1(12.5)	74(60.2)	
No	23(27.7)	5(15.6)	7(87.5)	35(28.5)	
The person does not know how to inform	13(15.7)	1(3.1)	0(0.0)	14(11.4)	
Access to culture/art projects*					**< 0.001**
Yes	52(63.4)	29(90.6)	0(0.0)	81(66.4)	
No	17(20.7)	2(6.3)	7(87.5)	26(21.3)	
The person does not know how to inform	13(15.9)	1(3.1)	1(12.5)	15(12.3)	
PE about RAPS					0.122
Yes	17(20.5)	12(37.5)	1(12.5)	30(24.4)	
No	66(79.5)	20(62.5)	7(87.5)	93(75.6)	
The person does not know how to inform	0(0.0)	0(0.0)	0(0.0)	0((0.0)	
Monitoring of services offered through quality indicators					0.126
Yes	37(44.6)	17(53.1)	2(25.0)	56(45.5)	
No	27(32.5)	13(40.6)	3(37.5)	43(35.0)	
The person does not know how to inform	19(22.9)	2(6.3)	3(37.5)	24(19.5)	
Program to work on stigma/prejudice*					**< 0.001**
Yes	26(31.3)	22(68.8)	1(12.5)	49(39.8)	
No	34(41.0)	10(31.3)	5(62.5)	49(39.8)	
The person does not know how to inform	23(27.7)	0(0.0)	2(25.0)	25(20.3)	
Space for community to clarify MH issues					0.068
Yes	35(42.2)	17(53.1)	3(37.5)	55(44.7)	
No	33(39.8)	15(46.9)	4(50.0)	52(42.3)	
The person does not know how to inform	15(18.1)	0(0.0)	1(12.5)	16(13.0)	
Drug prevention/DR projects					0.125
Yes	43(53.1)	17(53.1)	1(12.5)	61(50.4)	
No	27(33.3)	13(40.6)	5(62.5)	45(37.2)	
The person does not know how to inform	11(13.6)	2(6.3)	2(25.0)	15(12.4)	
PR/social inclusion project*					0.026
Yes	52(64.2)	28(87.5)	3(37.5)	83(68.6)	
No	18(22.2)	3(9.4)	3(37.5)	24(19.8)	
The person does not know how to inform	11(13.6)	1(3.1)	2(25.0)	14(11.6)	
PTS construction*					0.022
Yes	52(63.4)	29(90.6)	4(50.0)	85(69.7)	
No	15(18.3)	2(6.3)	2(25.0)	19(15.6)	
The person does not know how to inform	15(18.3)	1(3.1)	2(25.0)	18(14.8)	
Intersectoral actions					0.347
Yes	61(74.4)	25(78.1)	44(50.0)	90(73.8)	
No	8(9.8)	4(12.5)	22(25.0)	14(11.5)	
The person does not know how to inform	13(15.9)	3(9.4)	22(25.0)	18(14.8)	
Flow description for user referral in the network					0.564
Yes	41(50.0)	18(56.3)	44(50.0)	63(51.6)	
No	14(17.1)	8(25.0)	22(25.0)	24(19.7)	
The person does not know how to inform	27(32.9)	6(18.8)	22(25.0)	35(28.7)	

Note: PR- Psychosocial Rehabilitation; MH - Mental Health; DR - Damage Reduction; PTS - Single Therapeutic Project (PTS - Projeto Terapêutico Singular); PE - Permanent Education; *It 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.)	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)	
Technological	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)	

Table 3 (concluded)

Technological	Biomedical approach to the detriment of the biopsychosocial approach	Agreement	45(54.2)	14(43.8)	5(62.5)	64(52.0)	0.501
		Neutral	14(16.9)	4(12.5)	0(0)	18(14.6)	
		Disagreement	24(28.9)	14(43.8)	3(37.5)	41(33.3)	
	Satisfactory/therapeutic viability/management of the crisis along the PSC lines	Agreement	53(63.9)	15(46.9)	6(75.0)	74(60.2)	0.315
		Neutral	11(13.3)	4(12.5)	0(0)	15(12.2)	
		Disagreement	19(22.9)	13(40.6)	2(25.0)	34(27.6)	
Human	Composition of teams (number of professionals)	Agreement	64(78.0)	30(93.8)	8(100)	102(83.6)	0.258
		Neutral	5(6.1)	1(3.1)	0(0)	6(4.9)	
		Disagreement	13(15.9)	1(3.1)	0(0)	14(11.5)	
Financial	Insufficient material/inputs/financial resources	Agreement	54(65.1)	27(84.4)	4(50.0)	85(69.1)	0.159
		Neutral	10(12.0)	1(3.1)	1(12.5)	12 (9.8)	
		Disagreement	19(22.9)	4(12.5)	3(37.5)	26(21.1)	

Note: PR - Psychosocial Rehabilitation; MH -Mental Health; PE- Permanent Education; PSC - Psychosocial Care; CL- Care Lines; RAPS - Psychosocial Care Network (Rede de Atenção Psicossocial); * It presents statistical significance.

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[8]. 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[9], 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 exacerbation of psychopathological symptoms, it demands PSC care[10]. 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[11].

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]. 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]. 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 the 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.

FUNDING

REFERENCES

1. Ministério da Saúde (BR). Portaria nº. 3088, de 23 de dezembro de 2011. Institui a Rede de Atenção Psicossocial para pessoas com sofrimento ou transtorno mental e com necessidades decorrentes do uso de crack, álcool e outras drogas, no âmbito do Sistema Único de Saúde [Internet]. Brasília: Ministério da Saúde; 2011 [cited 2016 Dec 12]. Available from: http://bvsms.saude.gov.br/bvs/saudelegis/gm/2011/prt3088_23_12_2011_rep.html

2. Mendes EV. As redes de atenção à saúde. Ciênc Saúde Colet. 2010;15(5):2297-305. doi: 10.1590/S1413-81232010000500005

3. Ministério da Saúde (BR). Portaria nº 4.279, de 30 de dezembro de 2010. Estabelece diretrizes para a organização da Rede de Atenção à Saúde no âmbito do Sistema Único de Saúde (SUS) [Internet]. Brasília: Ministério da Saúde; 2010 [cited 2016 Dec 10]. Available from: http://bvsms.saude.gov.br/bvs/saudelegis/gm/2010/prt4279_30_12_2010.html

4. Ministério da Saúde (BR). Secretaria de Atenção à Saúde. Departamento de Atenção Especializada e Temática. Linha de cuidado para a atenção às pessoas com transtornos do espectro do autismo e suas famílias na Rede de Atenção Psicossocial do Sistema Único de Saúde [Internet]. Brasília: Ministério da Saúde; 2015 [cited 2016 Dec 10]. Available from: http://bvsms.saude.gov.br/bvs/publicacoes/linha_cuidado_atencao_pessoas_transtorno.pdf

5. Nóbrega MPSS, Domingos AM, Silveira ASA, Santos JC. Weaving the West Psychosocial Care Network of the municipality of São Paulo. Rev Bras Enferm [Internet]. 2017;70(5):965-72. [Thematic Edition "Good practices and fundamentals of Nursing work in the construction of a democratic society"] doi: 10.1590/0034-7167-2016-0566

6. Nóbrega MPSS, Silva GBF, Sena ACR. Psychosocial rehabilitation in the west network of the municipality of São Paulo: potentialities and challenges. Rev Gaúcha Enferm. 2018;39:e2017-0231. doi: 10.1590/1983-1447.2018.2017-0231

7. Moreira MIB, Onocko-Campos RT. Mental health care actions in the psychosocial care network viewed by users. Saúde Soc. 2017;26(2):462-74. doi: 10.1590/s0104-129020171711548

8. São Paulo (Município). Prefeitura do Município de São Paulo. Rede de Atenção Psicossocial. Proposta de Adesão - RAAS 06 [Internet]. São Paulo; 2013 [cited 2018 Jul 24]. Available from: http://www.prefeitura.sp.gov.br/cidade/secretarias/upload/saude/RAPS04112013.pdf

9. Santos AM, Giovanella L. Regional governance: strategies and disputes in health region management. Rev Saúde Pública. 2014;48(4):622-31. doi: 10.1590/S0034-8910.2014048005045

10. Zeferino MT, Cartana MHF, Fialho MB, Huber MZ, Bertoncello KCG. Health workers' perception on crisis care in the Psychosocial Care Network. Esc Anna Nery 2016;20(3):e20160059. doi: 10.5935/1414-8145.2016005911

11. Quinderé PHD, Jorge MSB, Franco TB. Rede de Atenção Psicossocial: qual o lugar da saúde mental? Physis. 2014;24(1):253-71. doi: 10.1590/S0103-73312014000100014

12. Martins JRT, Alexandre BGP, Oliveira VC, Viegas SMF. Permanent education in the vaccination room: what is the reality?. Rev Bras Enferm [Internet]. 2018;71(Suppl 1):668-76. [Thematic Issue: Contributions and challenges of nursing practices in collective health] doi: 10.1590/0034-7167-2017-056013

13. Bezerra e Silva ML, Dimenstein MDB. Manejo da crise: encaminhamento e internação psiquiátrica em questão. Arq Bras Psicol. 2014 [cited 2016 Dec 18];66(3):31-46. Available from: http://pepsic.bvsalud.org/scielo.php?script=sci_arttext&pid=S1809-52672014000300004

14. Pedroza AP, Oliveira FB, Fortunato ML, Soares PFC. Articulação saúde mental e economia solidária: relato de projeto de inclusão social. Rev Rene. 2012 [cited 2016 Dec 15];13(2):454-62. Available from: http://www.periodicos.ufc.br/rene/article/view/3955/pdf

15. Inglez-Dias AI, Ribeiro JM, Bastos FI, Page K. Políticas de redução de danos no Brasil: contribuições de um programa norte-americano. Ciênc Saúde Colet. 2014;19(1):147-58. doi: 10.1590/1413-81232014191.1778

16. Jorge MSB, Diniz AM, Lima LL, Penha JC. Matrix support, individual therapeutic project and prodution in mental health care. Texto Contexto

Enferm. 2015;24(1):112-20. doi: 10.1590/0104-07072015002430013

17. Malta DC, Merhy EE. O percurso da linha do cuidado sob a perspectiva das doenças crônicas não transmissíveis. Interface (Botucatu). 2010;14(34):593-605. doi: 10.1590/S1414-32832010005000010

18. Santos JC, Barros S, Huxley PJ. Social Inclusion of the people with mental health issues: compare international results. Int J Soc Psychiatr. 2018;64(4):1-7. doi: 10.1177/0020764018763941

19. Silva MLB, Dimenstein MDB. Manejo da crise: encaminhamento e internação psiquiátrica em questão. Arq Bras Psicol [Internet]. 2014 [cited 2017 Nov 11];66(3):31-46. Available from: http://pepsic.bvsalud.org/scielo.php?script=sci_arttext&pid=S1809-52672014000300004&lng=pt

20. Goldberg SE, Whittamore KH, Pollock K, Harwood RH, Gladman JRF. Caring for cognitively impaired older patients in the general hospital: a qualitative analysis of similarities and differences between a specialist Medical and Mental Health Unit and standard care wards. Int J Nurs Stud. 2014;51(10):1332-43. doi: 10.1016/j.ijnurstu.2014.02.002

21. Alves PF, Kantorski LP, Coimbra VCC, Oliveira MM, Silveira KL. Indicadores qualitativos de satisfação em saúde mental. Saúde Debate. 2017;41(spe):50-9. doi: 10.1590/0103-11042017s05

22. Montenegro H, Holder R, Ramagem C, Urrutia S, Fabrega R, Cruz M, et al. Combating health care fragmentation through integrated health service delivery networks in the Americas: lessons learned. Int J Integr Care. 2011;11(Suppl):e100. Available from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3184820/

23. Protasio APL, Silva PB, Lima EC, Gomes LB, Machado LS, Valença AMG. Avaliação do sistema de referência e contrarreferência do estado da Paraíba segundo os profissionais da Atenção Básica no contexto do 1º ciclo de Avaliação Externa do PMAQ-AB. Saúde Debate. 2014;38(spe):209-20. doi: 10.5935/0103-1104.2014S016