MENTAL HEALTH CARE MANAGEMENT FROM THE PERSPECTIVE OF THE HEALTH CARE NETWORK

GESTÃO DO CUIDADO NA SAÚDE MENTAL SOB A PERSPECTIVA DA REDE DE ATENÇÃO À SAÚDE

GESTIÓN DEL CUIDADO EN SALUD MENTAL DESDE LA PERSPECTIVA DE LA RED DE ATENCIÓN DE SALUD

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ABSTRACT

The objective of this study was to understand the management of mental health care from the perspective of the health care network. This is a qualitative study that used Grounded Theory (GT) as theoretical reference. The sample consisted of 27 health professionals distributed in three sample groups. Intensive interviews were used to collect data. The collected data were analyzed by means of initial and focused coding and were organized using the NVIVO®10 software for qualitative analysis. Three emergent categories and 11 subcategories were generated. The results showed that mental health care management is permeated by difficulties of communication and articulation between the services that make up the health care network. In order to articulate the health services, the professionals need to improve their knowledge in the area of mental health and put effective matrixing into practice.
Keywords: Comprehensive Health Care; Mental Health; Mental Disorders; Psychiatric Nursing.

RESUMO

O objetivo do estudo foi compreender a gestão do cuidado na saúde mental sob a perspectiva da rede de atenção à saúde. Trata-se de estudo qualitativo que utilizou como referencial teórico a Teoria Fundamentada nos Dados (TFD). A amostra foi composta de 27 profissionais de saúde, distribuídos em três grupos amostrais. Para a coleta de dados foi utilizada a entrevista intensiva. Os dados coletados foram analisados por meio de codificação inicial e focalizada e foram organizados pelo software de análise qualitativa NVIVO®10, em que foram geradas três categorias e 11 subcategorias emergentes. Os resultados evidenciaram que a gestão do cuidado na saúde mental é permeada por dificuldades de comunicação e articulação entre os serviços que compõem a rede de atenção à saúde. Para que haja essa integração entre os serviços de saúde é preciso que os profissionais aprimorem seus conhecimentos na área de saúde mental e coloquem em prática o matriciamento.
Palavras-chave: Assistência Integral à Saúde; Saúde Mental; Transtornos Mentais; Enfermagem Psiquiátrica.

RESUMEN

El presente estudio tiene por objeto analizar la gestión del cuidado en salud mental desde la perspectiva de la red de atención de salud. Se trata de un estudio cualitativo en base a la teoría fundamentada en los datos (TFD). La muestra estaba compuesta por 27 profesionales de salud divididos en tres grupos. La recogida de datos se realizó a través de una entrevista intensiva. Los datos recogidos se analizaron por codificación inicial y focalizada y se organizaron con el software de análisis cualitativa NVIVO®10, en el cual se generaron tres categorías y once subcategorías emergentes. Los resultados ponen en evidencia que hay grandes dificultades de comunicación y articulación entre la gestión del cuidado en salud mental y los servicios que componen la red de atención de salud. Para que de hecho haya integración entre los servicios de salud, los profesionales deberían perfeccionar sus conocimientos en el campo de la salud mental y poner en práctica el apoyo matricial.
Palabras clave: Atención Integral de Salud; Salud Mental; Trastornos Mentales; Enfermería Psiquiátrica.

INTRODUCTION

The current scenario of mental health in Brazil is the result of extensive movements and social discussions about people with mental illness[1] who require better quality medical care. Although the law of Brazilian Psychiatric Reform, on the rights of people with psychological disorders and the reorientation of the care model, was approved more than fifteen years ago, mental health care provision persists challenging; spaces are needed in society to guarantee the reincorporation of patients into society and the respect for their lives.[2,3]

The Brazilian Psychiatric Reform movement favored the creation of an extra-hospital mental health care network where the rights and social reintegration of people with psychic disorders are valued. However, these goals are a daily struggle and the pursuit of an effective and expanded care network has taken decades.[4]

It is with based on this perspective that the *Ministério da Saúde* (BR) instituted the *Rede de Atenção Psicossocial* (RAPS). This network aims to overcome the fragmentation of services and management of the *Sistema Único de Saúde* (SUS), improving its political-institutional functioning in order to respect the diversity of regional contexts, socioeconomic differences, and the population's health needs.[1] Thus, the proposal of the RAPS in the context of care for people with mental disorders adopts a broad, diversified, integrated, articulating and effective perspective in the different points of attention, aiming at the recovery of citizenship and the process of social inclusion.[5]

Networks composed of health teams and health institutions can be articulated by connecting basic health units to emergency services or hospitals. In short, the paths to be travelled are triggered according to each case and defined by the needs of the users and by the resources available for their care.[6] Services that work for the benefit of people with mental disorders need to be articulated in a horizontal work process, guaranteeing mental health care in all points of attention of SUS.[7] However, mental health care still lacks strategies capable of proposing solutions to the obstacles that arise in daily routine. Professionals committed and with the ability to deal with eventualities and challenges arising in this field are sorely needed.[2]

However, the availability of health services and actions alone does not guarantee that care will, in fact, be comprehensive and troubleshooting. Elements such as management models can help in the effectiveness of the care network, to direct the steps of managers and health professionals and consequently improve the care provided to users.[8] In the search for comprehensive care through the RAPS, it is important to highlight health care management as an important tool to aid in this construction.

Health care management can be defined as the use of technologies that take into account human individuality in the promotion of more security and autonomy for the well-being of users. To that end, health care management is anchored in six multiple dimensions, namely: individual, family, professional, organizational, systemic and societal dimension. Each dimension has a particularity, but there are connections between the various dimensions that produce a complex network of contact points, shortcuts, collateral paths and possibilities more or less visible and/or controlled by workers and managers.[9]

In the field of mental health, care management has faced barriers that jeopardize its solidification, resulting in instability in the articulation between services and in the implementation of qualitative care practices.[5] Associated with this, concern and questioning with the quality of care people with mental suffering have been intensified. Such questioning stimulates the reconfiguration of the methodological and conceptual bases of care management and promotes the expansion of therapeutic actions and activities, shared with other health care services.[10]

In this context, taking into account the importance of care management for the implementation of the psychosocial care network, this study aimed to understand the management of mental health care from the perspective of the health care network.

METHODS

This is a qualitative study based on the theoretical reference of Grounded Theory (GT).[11]

The municipality where the study was conducted is located in the south of the state of Santa Catarina. It has a population of approximately 29,000 inhabitants,[12] eight teams of the *Núcleo de Apoio à Saúde da Família*, *Centro de Atenção Psicossocial*, *Clínica Materno-Infantil*, *Saúde do Homem*, *Policlínica de Atendimento Municipal* and a General Hospital as municipal reference.

Following the methodology of GT, the participants of the research were indicated based on the realization of the study, by means of the composition of a theoretical sample consisting of the inclusion of different subjects to refine and to increase the categories that appear throughout the study. Three sampling groups composed the theoretical sampling, making up the total of 27 participants, defined with basis on the circularity of the data and on the constant comparative method.

The first group consisted of 17 professionals (P1- P17) who worked in the *Estratégia de Saúde da Família* (ESF) and *Núcleo de Apoio à Saúde da Família* (NASF) in the city studied. They were four nurses, four physicians, four nursing technicians, one psychologist, one nutritionist, one physical educator, one pedagogue and one physical therapist. It was decided to start with ESF and NASF professionals because the ESF is commonly classified as the gateway to the health care network of the SUS.

As the interviews took place and the respective sample group analyses progressed, relevant facts were persistent in some interviews, among them the accumulation of statements about the role of the *Centro de Atenção Psicossocial (CAPS)* for the care of mental health users. This factor triggered the formation of the second sample group, composed of five professionals (P18 - P22) who worked in the CAPS, who consisted of one nurse, one psychiatrist, one nursing technician, one psychologist, and one social worker.

During the analysis of these interviews, it was relevant to identify that the hospital is the service that serves mental health users in case of psychiatric emergencies. Based on this observation, a third sample group was created, composed of five professionals (P23-P27) who worked in the emergency unit of a general hospital; they were two nurses, two nursing technicians and one physician.

The size of the theoretical sample was determined based on theoretical saturation of data, as recommended by the method.[11] The inclusion criterion for composition of the sample groups was the existence of professional experience in the provision of care for people with psychic disorders.

Data were collected in August and September 2015 through an intensive interview.[11] The interviews were conducted individually at sites of the participants' preference and followed a script with open questions related to care management in the psychosocial care network. The interviews were transcribed verbatim in a Microsoft Office Word® document. The average duration of the interviews was 30 minutes, and they generated approximately 128 transcribed pages.

Two coding steps were used in data analysis: initial and focused. The initial coding consists of dividing and naming each segment of the data with codes that express the meanings present in the respondents' speeches. In the focused coding, the most significant or frequent initial codes are classified, integrated, synthesized and organized into subcategories and categories until the central phenomenon or central category of the research is identified. The phenomenon is the central idea on which a set of actions or interactions is adopted by people.[11] The NVIVO®10 software for qualitative analysis was used to organize and categorize the data.

Ethical aspects were respected according to Resolution 466 of December 12, 2012, of the *Conselho Nacional de Saúde* (BR). The study was approved by the *Comitê de Ética em Pesquisa* (CEP), under Opinion nº 1.125.508. The participants consented with the interviews by signing the *Termo de Consentimento Livre e Esclarecido Informado* (TCLE) after receiving explanations of the objectives and methods of the study. The statements obtained were identified with the letter "P" of professionals, associated with numbers that corresponded to the order of interviews.

RESULTS

The three categories and respective subcategories that emerged from the data analysis are presented in Table 1. Based on the interconnection of categories, the following phenomenon was obtained: "articulating the multiple dimensions of the management of care for people with mental disorders in the psychosocial care network". Each category is described below.

Table 1 - Categories, subcategories and phenomenon of the study

Categories/subcategories
Describing the individual and family dimension of the management of care for people with mental disorders
1. Choosing the type of health service to seek treatment 2. Suffering prejudice for having a family member with mental disorder 3. Realizing the need to offer support to family members of people with mental disorders 4. Understanding the cause of mental disorders as a social issue
Developing the professional and organizational dimension of care management in different points of the health care network
5. Seeing the FHS as gateway and as responsible for health prevention and promotion 6. Assisting people with mild mental disorders in the FHS, severe mental disorders in the PCC, and emergencies in the hospital 7. Facing challenges in the work with people with mental disorders 8. Minimizing psychiatric hospitalizations through the PCC
Developing the systemic and societal dimension of the management of care for people with mental disorders
9. Building a network of mental health care in the municipality 10. Perceiving the articulation of services in the care for people with mental disorders 11. Referring people with mental disorders to different points in the network
PHENOMENON Articulating the multiple dimensions of the management of care for people with mental disorders in the psychosocial care network

The first category, "Describing the individual and family dimension of the management of care for people with mental disorders", revealed aspects experienced by the professionals during mental health care.

Although primary care is referred to as the gateway to the SUS, many people end up going to other services to receive initial care, even if the problem does not represent an emergency or urgency. In mental health this process is not averse; people with the CAPS mental disorders have not always sought care in the *Estratégia de Saúde da Família*, making or hospital emergency units the initial alternatives.

> [...] *these mental patients do not always seek the FHS because they often go straight to secondary care, in this case, the CAPS* [...] (P10).

Having a family member with a mental disorder is challenging because, besides having to deal with all the problems

caused by the mental illness, they still have to face the prejudice of society. In this sense, the professionals realize the need to offer care not only for the person with mental disorder, but also for the whole family.

> […] *we need to support these relatives, because, in fact, I think they are the ones who suffer the most and this goes unnoticed. Sometimes we try to treat this patient with medicine or we give support in case of psychotic outbreak, but the relatives are the ones who suffer the most, and they end up not receiving professional help* (P3).

> *We know there's prejudice, I know because I've been through it; my brother has schizophrenia, and it's very difficult to deal with this. The way people look at him, people call him crazy, and so on. It hurts a lot. Relatives do not like this treatment, because it's not an issue of madness there, it's not something he wants, do you understand?* (P26).

When assisting varied range of people with mental disorders, the health professionals realized that, sometimes, social issues are triggers of this problem, making the treatment further complex.

> *The patients themselves are mostly sad, and we see that it is actually a social problem. So, it is the family environment that has a problem, it's a problem at work, it's a lack of money, and then everything turns to depression, anxiety and they think medicine will solve. So, basically the vast majority is this way. Some have disorders that need to be followed up, but the vast majority of patients you realize that it is a social problem rather than a psychiatric problem; I'm not saying that it is not psychiatric, right, but the social problem itself leads to discouragement and everything else. Then, the patient takes a pill and he will feel better; unfortunately this is not true* (P8).

> *Most of them, nowadays, with this rush of modern world; it is generalized anxious disorder, anxiety disorder, then it comes depression; people often confuse sadness with depression. There are several aspects, from schizophrenia to a simple sadness or mourning for losing a loved one, something similar* (P11).

The second category, "Developing the professional and organizational dimension of care management in different points of the health care network", revealed the professional and organizational dynamics for the implementation of care management.

Health professionals perceived the *ESF* as the genitor and responsible for actions to promote health and prevent illnesses. This would be the gateway for mental health users in the SUS,

as well as responsible for avoiding the onset and/or aggravation of existing mental disorders.

> *The role of primary care is very important; it is the embracement, it is the gateway. They will look for the basic health unit near their house, and sometimes they create this bond with the nurses, with the nursing technique, where they seek this support, with the physician; this initial support is very interesting* (P11).

To better organize the care, a hierarchy of care measures was established within the health care network, with the ESF being responsible for the care of mild mental disorders, the for the most severe cases, and the general hospital for psychiatric emergencies.

> *So here at the ESF, when patients ask us for help, we embrace them, try to welcome them, try to talk in the first moment, see what they need. Sometimes a good conversation is enough to help. Of course, they are usually milder cases* […] (P5).

> […] *the profile of CAPS patients of high complexity, schizophrenic patients, patients with personality disorder, patients with bipolar mood and severe depression; the other condition we leave for the Family Health Strategy or Psychiatry Outpatient Clinic* (P21).

> *The role of the hospital is the initial care during the emergencies, psychotic outbreaks, the first care measure is to provide the necessary support for the survival of that patient* (P23).

Professionals who work in the *ESF* and general hospital indicated that care for people with mental disorders is permeated by adversity. Overwork, lack of training in mental health, and inadequate physical structure were cited as the main difficulties faced to provide quality care.

> *I do not know how to deal with psychiatric patients, I do not know what to say, sometimes they come here and you see that they are patients who have a psychiatric problem, depression. Regardless of anything I say: calm down, it'll be all right! But anybody can say that. As a health professional, I am not prepared to talk to the patient* […] (P7).

> *We have so many activities to do that there is not much time left, and these patients need time to talk, time for a good embracement* (P3).

> *In the emergency unit we do not have a specific physical space to attend patients with mental disorders. They end up being attended together with the other patients* […] (P25).

Professionals working at the *CAPS* usually have some specialization in this area and this make them feel prepared to deal with this group. The *CAPS* develops a series of activities with these users and offers professional support in order to alleviate the symptoms and help these patients to re-enter society, especially after hospitalization in psychiatric hospitals.

> *[…] from the moment the patient goes through embracement, we insert him into a CAPS group so that he will participate in the groups. We have the group of crafts, group of garden therapy, music therapy, groups of people with drug dependency, the family support group, we have several groups, groups of psychotherapy (P21).*

> *That's why the openness of the CAPS. The CAPS is o Centro de Atenção Psicossocial that the government actually launched to try to reduce hospitalizations and try to insert more psychiatric patients into society (P19).*

The third category, "Developing the systemic and societal dimension of the management of care for people with mental disorders", approaches the organization of the systemic and societal dynamics that make up the management of care for people with mental disorders.

The creation of some health services such as *CAPS* and the *Núcleo de Apoio à Saúde da Familia (NASF)* represented an advance for the implementation of SUS principles, especially equity and comprehensiveness. After the creation of these services, the professionals perceived a greater involvement between the different points of attention with the matrixing, representing a moment when the municipality began to discuss and to work in network.

> *[…] we are always matrixing; we do the matrixing, that is, this exchange of information. We follow how the patients are going, how is the therapeutic plan of these patients going on. Sometimes the ESF always has more information to give about these patients. It is the strategy that is there day by day, the community agents, nurses, nursing technicians, you know, the family history (P18).*

> *We have a very good relationship with network services, programs that are popping up all out there like CAPS and NASF, they are coming just to contribute (P6).*

Despite the improved interaction between the services that make up the network, communication difficulties still persist, mainly in the referral of users to different services.

> *But situations that we find, we refer the patient to the CAPS, and when he gets there, no, this patient does not meet the CAPS profile. Then, he returns to the ESF, and the patient keeps wandering […] (P9).*

By articulating the categories and subcategories, combining reflective thinking about the event studied, the phenomenon "Articulating the multiple dimensions of the management of care for people with mental disorders in the psychosocial care network" was obtained. Figure 1 represents the interaction of the categories with the phenomenon.
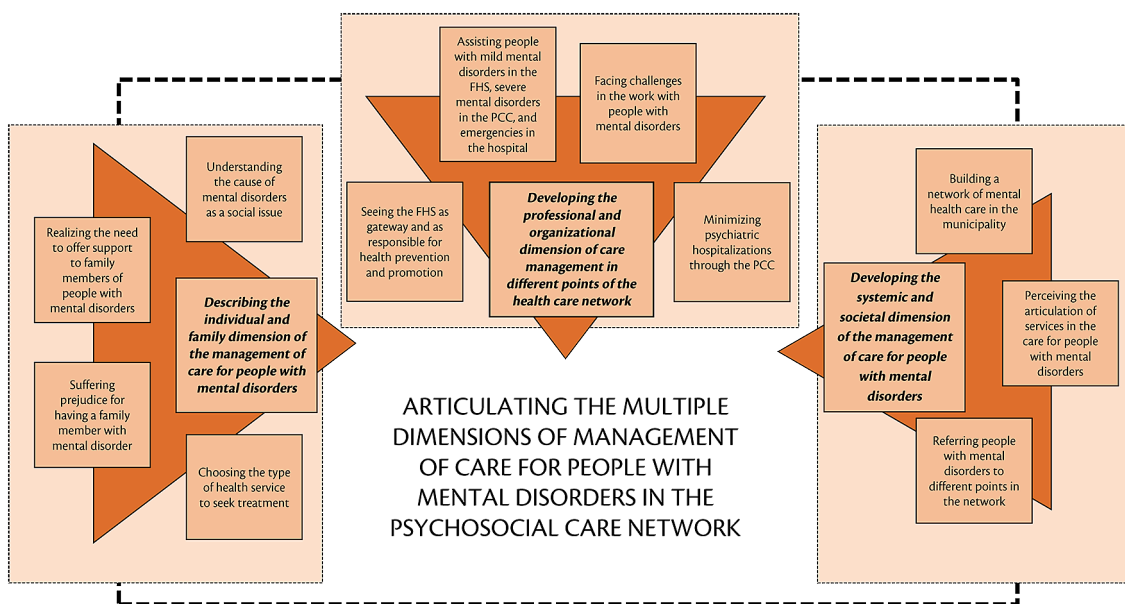

Figure 1 - Flowchart representing the phenomenon and its categories.

DISCUSSION

Mental health care in Brazil has undergone changes in its context in the last decades, in the provision of care, mainly mediated by the transformations that have occurred with the Psychiatric Reform. Since then, a new model of care has been inserted in the scenario of mental health, breaking with the practice traditionally institutionalized and exclusively focused on the treatment of mental illness.[13]

Primary health care (PHC) is characterized in the Brazilian scenario as the main gateway to health care in the SUS, including mental health care. PHC should be considered the center of communication between health care levels, ordering the referral and counter-referral at the primary, secondary and tertiary levels.[14] In contrast, data found in this study revealed that users rarely use the PHC for initial treatment of their health condition, compromising their treatment from the outset and making it difficult to provide comprehensive and troubleshooting care within the health care network.

Regarding the individual and family dimension of the management of care for persons with mental disorders, the presence of a family member has important consequences, not only related to the disease, but also to the social context, derived from prejudices that individuals and their families need to face. This dimension of analysis corroborates the results of a study that evaluated the resilience of health teams in the care of people with mental disorders.[15] Despite the advances arising from the Psychiatric Reform and the updating of public policies related to mental health, negative social representations on people with mental disorders are still present in the different segments of society.[15]

A study carried out in the state of Rio Grande do Sul aimed at understanding the expectations of family members of patients with mental disorders regarding the actions performed by the ESF presented the need for family insertion in the mental health care of patients. The study revealed that by providing support for the guidance of their lives, the effectiveness of mental health care will be increased, minimizing undesirable consequences in families who have a member with mental disorder.[16]

Regarding comprehensive care in the context of mental health, the results pointed out that professionals recognize this practice as a complex and multifaceted process. Sometimes the social situations experienced are mediators of the mental disorders in people and are included in the set of factors listed by the World Health Organization as influencing the onset of mental disorders in the population. Their development is linked to the inability of a person to administrate his thoughts, emotions and social interactions. Moreover, the social, cultural, economic, environmental, working and housing conditions and community issues can interfere with the mental health of any individual and conduce to the development of mental dis-

orders.[17] Working in this setting requires skills to deal with the human being, in view of the need to understand him considering the multiple aspects that influence the development of mental disorders.[18]

Regarding the professional and organizational dimension of care management in different points of the health care network, the professionals considered the ESF as responsible for developing actions to avoid the onset and aggravation of mental disorders. In addition, they considered that the hierarchy of work from the point of view of the care network represents a predictor for the achievement of comprehensiveness in mental health. A study carried out in the South of Brazil showed that the ESF represents an important space for promoting mental health care since it has territoriality and the family as its focus of care. However, ESF teams are often restricted to reproducing the biomedical care model when it comes to mental health, jeopardizing the quality of the actions that could be developed.[16]

In the scenario of this study, users with severe clinical conditions were monitored by the CAPS, while those with acute conditions were referred for care in the emergency unit of the general hospital. The profile of the users that made up the population served by the CAPS was evaluated in a study carried out in the Northeast of Brazil whose results showed that they are people with severe mental disorders or people with severe psychic impairment. This is in line with the findings of the present study. The CAPS should be considered as a substitute service that aims to guarantee daily clinical care, avoiding hospitalizations and promoting the reinsertion of its patients in the social environment.[19]

Users with mental disorders or with severe psychic impairment experience critical moments that sometimes coincide with the onset of an outbreak. At such moments, users are directed to hospitals to receive care. In fact, acute mental health situations must be addressed by general hospitals that are part of the health care network, through the implementation and qualification of psychiatric beds and the provision of psychiatric emergency services.[20-21]

However, there are difficulties in this work when it comes to assisting users with mental disorders outside the psychosocial care service. Other studies[15,22] found that the professionals claimed not knowing what to say or to ask, and they had fears that the condition of the patient progressed to worse or they understood that this field of knowledge was not available to them. Many of the professionals developed competencies to care for people in mental health based on their own professional experience.[15,22]

In the systemic and societal dimension of the management of care for people with mental disorders in this study, the professionals recognized that the joint work of the different services favored the practice of comprehensive and troubleshooting mental health care. Despite this progress, there were still difficulties of communication and access between the different points of

the network. The articulated work in health care networks must have communication, and must have unilateral and interconnected care services. The paths to be travelled in the network must be activated according to each case and must be based on the needs of users and on the resources available for their care.[6]

Effective and comprehensive care depends, in large part, on the shared construction of a pedagogical-therapeutic interventions, which is called matrixing. Correct matrixing requires professionals to have both pedagogical and managerial skills that favor the construction of spaces for collective and democratic dialogues. Without these competencies, the reorganization of the work process and the transformation of care practices guided by this principle become fragile and the a network cannot be firmly established after created.[23-24]

Inadequate access to mental health services has resulted in the worsening of the mental health status of people with mental disorders and thus contributed to high rates of suicide in the United States.[25] These considerations indicate the need to strengthen health care networks, regarding mental health, aiming at improving access conditions and guaranteeing comprehensive care practices, avoiding the worsening of the psychiatric disorder.

CONCLUSION

The present study made it possible to understand the management of care for mentally ill people, thus contributing to the recognition of fragilities and potentialities of the Psychosocial Care Network and its effects on society, family members, professionals and also on the people mental disorders.

Integration between health care networks needs to be improved and this is possible, especially with the practice of matrixing, as well as by training professionals in mental health, and integrating the services that make up such networks.

The *ESF*, the *NASF*, the *CAPS* and the hospitals are the main services that make up the psychosocial care network. Despite advances in care for the mentally ill, difficulties in the articulation between these services were observed.

It should be emphasized that the present study presented limitations because it was carried out in a single context, preventing the generalization of the phenomenon to other realities. However, studies on the management of mental health care are scarce. Further research in this area is therefore recommended, particularly comparing the construction and articulation of the health care network in small and large municipalities.

REFERENCES

1. Macedo JP, Abreu MM, Fontenele MG, Dimenstein M. The regionalization of mental health and new challenges of the Psychiatric Reform in Brazil. Saúde Soc. 2017[cited 2017 Aug 27];26(1):155-70. Available from: http://dx.doi.org/10.1590/s0104-12902017165827.

2. Eslabão AD, Coimbra VCC, Kantorski LP, Guedes AC, Nunes CK, Demarco DA. Beyond mental health's network: between challenges and potentialities. Rev Pesqui Cuid Fundam online. 2017[cited 2017 Aug 27];9(1):85-91. Available from: http://dx.doi.org/10.9789/2175-5361.2017.v9i1.85-91.

3. Borba LO, Maftum MA, Vayego SA, Kalinke LP, Ferreira ACZ, Capistrano FC. The mental disorder profile of patients treated at the center for psychosocial care (CAPS). REME - Rev Min Enferm. 2017[cited 2018 Aug 07];21(e-1010):1-8. Available from: http://dx.doi.org/10.5935/1415-2762.20170020.

4. Eslabão AD, Coimbra VCC, Kantorski LP, Pinho LB, Santos EO. Mental health care network: the views of coordinators of the Family Health Strategy (FHS). Rev Gaúcha Enferm. 2017[cited 2017 Aug 27];38(1):1-8. Available from: http://dx.doi.org/10.1590/1983-1447.2017.01.60973.

5. Nóbrega MPSS, Domingos AM, Silveira ASA, Santos JC. Weaving the west psychosocial care network of the municipality of São Paulo. Rev Bras Enferm. 2017[cited 2018 Aug 27];70(5):1016-23. Available from: http://dx.doi.org/10.1590/0034-7167-2016-0566.

6. Quinderé PHD, Jorge MSB, Franco TB. Rede de Atenção Psicossocial: qual o lugar da saúde mental?Physis. 2014[cited 2017 Aug 27];24(1):253-71. Available from: http://dx.doi.org/10.1590/S0103-73312014000100014.

7. Lima M, Dimenstein M. O apoio matricial em saúde mental: uma ferramenta apoiadora da atenção à crise. Interface (Botucatu). 2016[cited 2017 Aug 27];20(58):625-35. Available from: http://dx.doi.org/10.1590/1807-57622015.0389.

8. Ministério da Saúde (BR). Portaria GM/MS nº 4.279, de 30 de dezembro de 2010. Estabelece as diretrizes para a organização da Rede de Atenção a Saúde no âmbito do SUS. Brasília: Ministério da Saúde; 2010.

9. Cecílio LCO. Theoretical and conceptual notes on evaluative processes taking the multiple dimensions of healthcare management into account. Interface (Botucatu). 2011[cited 2017 Aug 27];15(37):589-9. Available from: https://dx.doi.org/10.1590/S1414-32832011000200021.

10. Santos RCA, Pessoas Junior JM, Miranda FAN. Psychosocial care network: adequacy froles and functions performed by professional. Rev Gaúcha Enferm. 2018[cited 2017 Aug 27];39(1):1-18. Available from: http://dx.doi.org/10.1590/1983-1447.2018.57448.

11. Santos JLG, Erdmann AL, Sousa FGM, Lanzoni GMM, Melo ALSF, Leite JL. Methodological perspectives in the use of grounded theory in nursing and health research. Esc Anna Nery Rev Enferm. 2016[cited 2017 Aug 27];20(3):1-8. Available from: http://dx.doi.org/10.5935/1414-8145.20160056.

12. Instituto Brasileiro de Geografia e Estatística (IBGE). Santa Catarina (SC): IBGE; 2010. [cited 2017 Aug 27]. Available from: http://cod.ibge.gov.br/omb.

13. Silva NS, Esperidião E, Cavalcante ACG, Souza ACS, Silva KKC. Development of human resources for work in mental health services. Texto Contexto Enferm. 2013[cited 2017 Aug 27];22(4):1142-51. Available from: http://dx.doi.org/10.1590/S0104-07072013000400033.

14. Cunha KS, Erdmann AL, Higashi GDC, Baggio MA, Kahl C, Koerich C. Myocardial revascularization: unveiling strategies in reference and counter reference in primary health care. Rev Baiana Enferm. 2016[cited 2017 Aug 27];30(1):295-304. Available from: http://dx.doi.org/10.18471/rbe.v1i1.16039.

15. Brolese DF, Lessa G, Santos JLG, Mendes JS, Cunha KS, Rodrigues J. Resilienceofthehealthteam in caring for peoplewith mental disorders in apsychiatric hospital. Rev Esc Enferm USP. 2017[cited 2017 Aug 27];(51):1-8. Available from: http://dx.doi.org/10.1590/S1980-220X2016026003230.

16. Camatta MW, Tocantins FR, Schneider JF. Mental health actions in Family Health Strategy: family expectations. Esc Anna Nery Rev Enferm. 2016[cited 2017 Aug 27];20(2):281-8. Available from: http://dx.doi.org/10.5935/1414-8145.20160038.

17. Pinto ACS, Luna IT, Silva AA, Pinheiro PNC, Braga VAB, Souza AMA. Risk factors associated with mental health issues in adolescents: a integrative review. Rev Esc Enferm USP. 2014[cited 2017 Aug 27];48(3):555-64. Available from: http://dx.doi.org/10.1590/S0080-623420140000300022.

18. Macedo JQ, Lima HP, Alves MDS, Luis MAV, Braga Violante AB. Practices in mental health services: interface with professionals' satisfaction. Texto

Contexto Enferm. 2013[cited 2017 Aug 27];22(4):999-1006. Available from: http://dx.doi.org/10.1590/S0104-07072013000400016.

19. Cruz LS, Carmo DC, Sacramento DMS, Almeida MSP, Silveira HF, Ribeiro Junior HL. Profile of patients with mental disorders assisted in the center for psychosocial care in the city of Candeias, Bahia, Brazil. Rev Bras Ciênc Saúde. 2016[cited 2017 Aug 27];20(2):93-8. Available from: http://dx.doi.org/10.4034/RBCS.2016.20.02.01.

20. Almeida AB, Nascimento ERP, Rodrigues J, Schweitzer G. Intervention in situations of psychic crisis: challenges and suggestions of a prehospital care staff. Rev Bras Enferm. 2014[cited 2017 Aug 27];67(5):708-14. Available from: http://dx.doi.org/10.1590/0034-7167.2014670506.

21. Paes LG, Schimith MD, Barbosa TM, Righi LB. Mental health care network from the view of health service coordinators. Trab Educ Saúde. 2013[cited 2017 Aug 27];11(2):395-409. Available from: http://dx.doi.org/10.1590/S1981-77462013000200008.

22. Zeferino MT, Cartana MHF, Fialho MB, Huber MZ, Bertoncello KCG. Health workers' perception on crisis care in the Psychosocial Care Network. Esc Anna Nery Rev Enferm. 2016[cited 2017 Aug 27];20(3):1-7. Available from: http://dx.doi.org/10.5935/1414-8145.20160059.

23. Ferreira TPS, Sampaio J, Souza ACN, Oliveira DL, Gomes LB. Care production in Mental Health: the challenges beyond institutional walls. Interface (Botucatu). 2017[cited 2017 Aug 27];21(61):373-84. Available from: http://dx.doi.org/10.1590/1807-57622016.0139.

24. Romera AA, Barrêto AJR, Pinheiro PGOD, Adário KDO, Sá LD. Speech of nurse managers related to conditions that (dis)favor the control of tuberculosis in the elderly. Rev Gaúcha Enferm. 2016[cited 2017 June 20];37(4):1-8. Available from: http://dx.doi.org/10.1590/1983-1447.2016.04.57327.

25. Hester RD. Lack of access to mental health services contributing to the high suicide rates among veterans. Int J Ment Health Syst. 2017[cited 2018 June 20];11(47):1-4. Available from: http://dx.doi.org/10.1186/s13033-017-0154-2.