REME • Rev Min Enferm. 2021;25:e-1416
DOI: 10.5935/1415.2762.20210064

RESEARCH

THE PERCEPTION OF PROFESSIONALS ABOUT MENTAL HEALTH ACTIONS IN THE PSYCHOSOCIAL CARE NETWORK IN BELO HORIZONTE

A PERCEPÇÃO DOS PROFISSIONAIS SOBRE AS AÇÕES DE SAÚDE MENTAL NA REDE DE ATENÇÃO PSICOSSOCIAL EM BELO HORIZONTE

LA PERCEPCIÓN DE LOS PROFESIONALES SOBRE LAS ACCIONES DE SALUD MENTAL EN LA RED DE ATENCIÓN PSICOSOCIAL DE BELO HORIZONTE

Nayara Alacoque Coelho[1]
Jacqueline Nascimento[2]
Barbara Ianca Barreto[2]
Lilian Cristina Rezende[2]
Claudia Maria de Mattos Penna[3]
Maria José Menezes Brito[2]

[1]Prefeitura Municipal de Betim. Betim, MG - Brazil.
[2]Universidade Federal de Minas Gerais -UFMG, Escola de Enfermagem, Departamento de Enfermagem Aplicada - ENA. Belo Horizonte, MG - Brazil.
[3]Universidade Federal de Minas Gerais -UFMG, Escola de Enfermagem, Departamento de Enfermagem Materno Infantil e Saúde Pública - EMI. Belo Horizonte, MG - Brazil.

Corresponding Author: Barbara Ianca Barreto
E-mail: barbaraiancab@gmail.com

Authors' contributions:
Conceptualization: Nayara A. Coelho; Data Collection: Nayara A. Coelho; Funding Acquisition: Maria J. M. Brito; Methodology: Nayara A. Coelho; Maria J. M. Brito; Project Management: Claudia M. M. Penna; Maria J. M. Brito; Supervision: Claudia M. M. Penna; Maria J. M. Brito; Validation: Maria J. M. Brito; Visualization: Jacqueline Nascimento; Barbara I. Barreto; Lilian C. Rezende; Writing – Original Draft Preparation: Jacqueline Nascimento; Barbara I. Barreto; Lilian C. Rezende; Writing - Review and Editing: Nayara A. Coelho; Jacqueline Nascimento; Barbara I. Barreto; Lilian C. Rezende; Maria J. M. Brito.

Funding: Fundação de Amparo à Pesquisa do Estado de Minas Gerais - FAPEMIG. Conselho Nacional de Desenvolvimento Científico e Tecnológico (CNPQ).

Submitted on: 02/01/2021
Aproved on: 11/24/2021

Responsible Editors:
Tânia Couto Machado Chianca
Janaina Soares

ABSTRACT

Objective: to understand the construction of mental health actions in the psychosocial care network of Belo Horizonte, from the view of professionals in a historical perspective Method: this is a qualitative approach based on oral history, and on the Sociologia Compreensiva do Cotidiano (Comprehensive Sociology of Everyday Life). Results: the data are organized into two thematic categories: "The transition of the care model: the creation of CERSAM" and "Difficulties in assisting patients in mental distress". The Reforma Psiquiática (Psychiatric Reform) movement in Belo Horizonte allowed the first CERSAMs to be built based on the ideals of free care and centered on the individual with psychological distress. Furthermore, the growing demand for services was highlighted, followed by weaknesses related to the number of professionals in the health network services, which constitutes care gaps. Conclusion: with the creation of substitute services, improvements were arising from the Psychiatric Reform in Belo Horizonte. Despite this, it is necessary to raise proposals for improving the services of the mental health network, aiming to reduce the burden on professionals, their improvement of primary care services. The culmination will have more integration between them because there will be user-centered care and, consequently, the family.

Keywords: Mental Health; Public Health; Primary Health Care; Patient Care Team.

RESUMO

Objetivo: compreender a construção das ações de saúde mental na rede de atenção psicossocial de Belo Horizonte, sob a ótica dos profissionais em uma perspectiva histórica Método: trata-se de uma abordagem qualitativa baseada na história oral, fundamentada na Sociologia Compreensiva do Cotidiano. Resultados: os dados encontram-se organizados em duas categorias temáticas: "A transição do modelo de cuidado: criação dos CERSAM" e "Dificuldades para a assistência ao paciente em sofrimento mental". O movimento da Reforma Psiquiátrica em Belo Horizonte permitiu que os primeiros CERSAMs fossem construídos pautados nos ideais do cuidar em liberdade e centrados no indivíduo com sofrimento psíquico. Ademais, destacou-se a crescente procura pelos serviços seguidos de fragilidades relacionadas ao quantitativo de profissionais nos serviços da rede de saúde, o que constitui lacunas assistenciais. Conclusão: com a criação de serviços substitutivos, pode-se afirmar que houve melhorias advindas da Reforma Psiquiátrica em Belo Horizonte. Apesar disso, é necessário levantar propostas de aperfeiçoamento dos serviços da rede de saúde mental, visando diminuir a sobrecarga dos profissionais, seu aperfeiçoamento e a melhoria dos serviços da atenção primária. O ponto culminante será mais integração entre eles, porque haverá assistência centrada no usuário e, consequentemente, na família.

Palavras-chave: Saúde Mental; Saúde Pública; Atenção Primária à Saúde; Equipe de Assistência ao Paciente.

RESUMEN

Objetivo: comprender la construcción de acciones de salud mental en la red de atención psicosocial de Belo Horizonte, desde la perspectiva de los profesionales en una perspectiva histórica. Método: se trata de un abordaje cualitativo basado en la historia oral, fundamentada en la Sociología Integral Cotidiana. Resultados: los datos se organizan en dos categorías temáticas: "La transición del modelo asistencial: creación del CERSAM" y "Dificultades en la atención al paciente en sufrimiento mental". El movimiento de Reforma Psiquiátrica en Belo Horizonte permitió construir los primeros CERSAM basados en los ideales de atención en libertad y centrados en el individuo con sufrimiento psicológico. Además, se destacó la creciente demanda de servicios, seguida de debilidades relacionadas con el número de profesionales en los servicios de la red de salud, lo que constituye brechas de atención. Conclusión: con la creación de servicios sustitutos se puede decir que hubo mejoras derivadas de la Reforma Psiquiátrica en Belo Horizonte. A pesar de ello, es necesario plantear propuestas de mejora de los servicios de la red de salud mental, con el objetivo de reducir la carga de los profesionales, su mejora y la mejora de los servicios de atención primaria. La culminación será una mayor integración entre ellos, porque habrá una atención centrada en el usuario y, en consecuencia, en la familia.

Palabras clave: Salud Mental; Salud Pública; Atención Primaria de Salud; Grupo de Atención al Paciente.

How to cite this article:
Coelho NA, Nascimento J, Barreto BI, Rezende LC, Penna CMM, Brito MJM. The perception of professionals about mental health actions in the psychosocial care network in Belo Horizonte. REME - Rev Min Enferm. 2021[cited_____ ___ __];25:e-1416. Available from: _____
DOI: 10.5935/1415.2762.20210064

INTRODUCTION

Mental health care has undergone changes and improvements over the years, as well as the conception of the "crazy person" for society. People in mental suffering were stigmatized by society, excluded, and discriminated against for threatening the social order. Often, the "crazy people" were incarcerated in prisons or inmates in special cells of the Santas Casas de Misericórdia.

At the end of the 1970s, there were struggles for the democratization of health, accepting new public mental health policies that led to the beginning of the transition from the hospital-centric to community care model.[2] With the health reform, which culminated in the construction of the Unified Health System (Sistema Único de Saúde - SUS) guaranteeing comprehensive care to all Brazilian citizens, mental health care also advanced with the Psychiatric Reform (Reforma Psiquiátrica), which reached new ways of caring and conducting care for people with mental suffering in the health service network.[3]

The enactment of Law 10,216 of April 10, 2001, which provides for the protection and rights of people with mental disorders, sought to regulate the rights of people with mental care needs, abolishing asylums and seeking to include people in society with care in basic units and Psychosocial Care Centers (Centros de Atenção Psicossocial - CAPS).[4]

The new way of providing care finished with the traditional model and moved towards person-centered care, in the understanding of the sociocultural context, with practices aimed at the social health needs of the individual and the community. The care for people in mental suffering in this new logic of care provision is installed in health care networks for comprehensive care and the construction of links to ensure access, reception, and humanized listening following the principles and guidelines of the SUS, directed to individuals, family, and community.[5]

From this perspective, there is the Family Health Strategy (Estratégia Saúde da Família - ESF), within the Primary Health Care (Atenção Primária à Saúde - APS), which focuses on comprehensive and equitable care, disease prevention, health promotion, rehabilitation, and healing of individual and community assigned to a delimited territory, being the priority gateway for patients.[6] The work of the ESF team seeks to articulate substitutive and specialized services in mental health. The proposal to work in a health care network favors that care is carried out and designed by trained professionals located in different physical spaces, specialists, and generalists, requiring a dialogical-dialectical construction that allows for the integration of these services.

In this way, to ensure the effectiveness of care, the integration of services is constituted as a way to promote reception and listening to people with mental disorders.[7] This is equivalent to the provision of humanized and comprehensive care, that is, one that does not return only for psychic issues, but also for social, mental, and physical problems.

Therefore, it is based on the assumption that integration must be established in a dialogical way between health services to ensure equity and comprehensiveness of health care for people in mental suffering. Given the above, this study aimed to understand the construction of mental health actions in the psychosocial care network in Belo Horizonte, from the perspective of professionals in a historical perspective.

METHOD

This is a study of oral history based on the perspective of Comprehensive Sociology of Everyday Life (Sociologia Compreensiva do Cotidiano) with a qualitative approach. Qualitative research enables to visualize the object of study considering its conditions, its specificity, and the relationships that permeate it, allowing it to be analyzed and interpreted, incorporating the meaning and intention of the subjects and their established interrelationships.[8]

It is a methodological outline of the oral history (OH) based on the perspective of the Comprehensive Sociology of Everyday Life.[9] Such outline is presented as social stories, from the perspective of its actors and their relations with the studied universe, and allows revealing their experiences through the reports of the participants. Oral history enables to emerge from memory situations related to daily life from memories in the definition of a social place and the built interpersonal relationships.[9]

The setting of this study was composed of eight Mental Health Reference Centers (Centros de Referência em Saúde Mental - CERSAM) in the Northeast, Pampulha, West, East, Barreiro, Venda Nova and Northwest regions and nine basic health units in Belo Horizonte, MG. In this capital, the CAPS are called CERSAM. The CERSAMs operate in different regions, supplying the entire city, from 7:00 am to 7:00 pm, every day of the week. The logic of operation occurs by spontaneous demand and by referral from other services in the network.[10] The choice of services was made at random, through a draw.

The participants were two doctors, six nurses, two Nursing technicians, five psychologists, two social workers, and two occupational therapists, with an average time of experience in care between three and 32 years, on the date of the interviews.

The inclusion criterion was the inclusion of at least one representative of CERSAM and UBS for each region. The exclusion criteria were professionals who worked for less than two years in health services to ensure that their experience in the services would enable the achievement of the proposed objectives.

Data collection took place through individual interviews guided by a semi-structured script. The guiding questions were: the perception of the changes that took place in mental health services, as well as the participation in this process and how the integration of actions in CERSAMs and UBS occurs. The interviews were carried out from February to June 2017, with an average duration of 75 minutes. To ensure the anonymity of the participants, they were identified by their professional training, followed by the letters C - CERSAM and U - UBS and the time of experience in the services in numerical representation (for example nurse CERSAM: EC nº; UBS Nursing technician: TEU nº; psychologist CERSAM: PSIC nº; social worker UBS: ASU nº; occupational therapist CERSAM: TOC nº).

We carried out the analysis according to Bardin's proposal, known as content analysis, which takes place in three chronological stages.[11] The first is the pre-analysis, which involves a "floating" and exhaustive reading of the collected and organized documents, forming the documental corpus of the research. The second phase is the exploration of the material when the coding, classification, and categorization units are defined. Finally, the last step is the treatment of results, when inferences and interpretations of these results are made to make them significant, as they are based on discussions based on the literature.[12]

The research was approved by the Research Ethics Committee (Comitê de Ética em Pesquisa) of the Universidade Federal de Minas Gerais (COEP/UFMG) and by the Municipal Health Department of Belo Horizonte (Secretaria Municipal de Saúde de Belo Horizonte) (Opinion nº 1.840.619). Participants authorized the disclosure of their testimonies by signing the Informed Consent Term (ICF) voluntarily, being aware of the possible discomforts, risks, and benefits that could result from the research.

RESULTS

During the data analysis, we created two thematic categories. The first category addresses the transition of the care model, culminating in the creation of CERSAMs and territorialization. The second category shows the difficulties identified by professionals to care for patients in mental suffering.

The transition of the care model: the creation of CERSAMs

The creation of CERSAM in Belo Horizonte took place gradually, regionally, and based on the logic of care in the territory and articulation with the APS. Initially, CERSAM depended on psychiatric hospitals for night care. After transitioning to its expanded functioning, it began offering overnight hospitalization for those requiring short stays.

> (...) Barreiro was the region of Belo Horizonte that most people were hospitalized, in Galba, in Raul Soares, that's why it started in Barreiro, then CERSAM Barreiro was the first (EC23).

> The east was created, then it was a sequence of CERSAM (...). We still had the help of hospitals for the night. So, sometimes, we needed to make contact with Raul or Galba, to host them at night. The other day, we would look for the patients, because we didn't have a night bed and there was no way to sleep with the family (EC23).

CERSAM professionals meet weekly to discuss cases and the facilities and difficulties found in the daily services, which are supervised by a specialist. This was the condition for having a CERSAM in the region. EC15 reports that, over time, other professionals arrived, such as supervisors better prepared for the activity.

> Supervisions have always been something of a condition for CERSAM to open up. In the beginning, there were psychoanalysts, but like that, which today is not even close, later on, came more prepared people, more important people, and supervised us (EC15).

Before the psychiatric reform, the UBS did not assist patients with psychological distress. The de-hospitalization process gave rise to new perspectives of care, as well as new confrontations and challenges for professionals in these units.

Since the ESF is recommended to be the patient's gateway, the first contact must be at the UBS. The UBS teams, together with the substitute and specialized mental health services, must organize the flow of patients in the territory.

ASU31 reports the transition and patient demand for the service, making APS a reference for first contact.

> As people searched for A unit, it began to change. People began to be aware of the service. I think they went to hospitals, and hospitals explained to them about the care they were getting here at the unit (ASU31).

The most effective connection of people in psychological distress in the UBS occurred later, with the implementation of the ESF. According to EU15, the reception of patients in mental distress in the units was not easy, there was unpreparedness and resistance from the team, which, over time, became more prepared to carry out the care.

> Then the ESF came and it started to link up little by little, it was not easy, because everyone was afraid to care for the mentally ill. Everyone was terrified of them, interesting that today it is so easy to serve them. Very peaceful! (EU15).

The structure of the provision of regionalized assistance is a facilitator of the work process and integration with RAPS services. As reported by the participants, regionalization was a facilitator for the transition of care due to the flow of care for patients in mental distress.

> Now, I receive the patient, I welcome him, I'm on duty, I host him and if I think he needs to be monitored at CERSAM, to have a follow-up with the technical reference, I go to his microregion and insert him there. In this micro-region there are the names of the professionals, I'm following the list, you know? The first person on the list will receive the patient, I make the appointment for that person in their region (EC15).

> We had no contact with the UBS professional because there were several health units. When we started to participate in microregions, we have an area of activity that is more defined, you get to know the professionals who work better, you discuss cases more, it's much easier. Before the regionalization, it was complicated (PSIC21).

However, despite the patient's de-hospitalization, the organization of RAPS and regionalization were not enough to break the stigma of mental health since care remains fragmented in body and mind. EC23 confirms this fragmentation, identifying a prejudiced and reductionist service in UBS and the emergency care unit (unidade de pronto-atendimento - UPA), contrary to SUS principles. The participant indicates a justification for the absence of comprehensive care, such as the lack of professional time in these units.

> First, because there is a great lack of interest, a prejudice with mental health by the UBS teams. He said he's crazy, there's nothing else, another pain. The crazy person has no pain. His question is all about mental health, about Psychiatry. So, I think that there is still a lot, in the basic unit and the UPA. This is a fact, and when the patient doesn't bother them, they don't really have any interest, and there's another thing too, which is time, they (FHS professionals) don't have time (EC23).

Despite the de-hospitalization of patients with mental suffering and the implementation of humanized care, the transition of the model still did not guarantee a comprehensive approach to care, as reinforced in the professionals' discourse. The need to understand and reinforce the comprehensiveness of health practices and actions is highlighted, as well as the integration of services in RAPS.

Difficulties for patient care in mental distress

The testimonies of the participants revealed difficulties that impede the effectiveness of comprehensive care. In the view of EU31, there are real "holes" in RAPS, because they cannot meet all the incoming demand. Because of this, they need to schedule assistance for severe psychotic cases.

> Because today, the boy has a learning disability, the school sends him to the health center to try to find a psychologist, and that's not how it is. We cannot do it. Because it requires work that is often familiar, which perhaps is the work of a psychopedagogist. I don't have time to do this, nor the PSF doctor has time, we don't have time to work with this universe, this universe is a hole. Because the clinic's psychologist and psychiatrist are taking neurotics and psychotics at the clinic, this boy is not a case of hospitalization, neither for CERSAM Dia nor for the hospital, he's free in the network (EU31).

Another difficulty identified by TOC15, which reports that it is a "hole" in the network, are cases related to self-extermination. According to the participant, the teams recognize these cases as mild; therefore, due to the high demand at the units, they do not provide satisfactory service.

> There are some holes, for example, the priority of UBS is the psychotic and severe neurotic. Neurotics and self-extermination attempt that are lighter for them, those who take a lot of medicine or those who say: "I want to die if my husband doesn't come back".

> In these cases, UBS has cannot take care of and not even we here at CERSAM will take care of them. There are times when I even send them to the Psychology Service at the universities or I see if the person has any conditions to pay and I send them (TOC15).

Difficulties in the regionalization were highlighted, such as the creation of bonds and the referral of patients to other reference units. This difficulty is related to the bond established in the reception of patients, as reported by TOC15 that when establishing a bond with the patient, it is difficult to refer them to the unit in the region they belong.

> The patient who is very depressed, had a severe self-extermination feeling, something like that, I end up creating a bond with him, I try to tie it somehow so that he's coming back, I end up staying with him. Because I find it difficult, after you welcome the patient, to create a bond and say that he will be referred to another unit. He says: "I'm not going to someone else; I've already told you everything". So, there is this difficulty too (TOC15).

Another difficulty detected was the absence of establishing flows and offering services that encompass the complexity of mental health care. This fact triggers feelings of frustration for APS professionals, who are faced with the demand and unresolved cases, which remain unattended.

> I can't send him to CERSAM because it's not a case with CERSAM, I can't send him to the hospital because I don't have this flow, but he is here, he is knocking on my door (EU25).

Matrix support and the possibility of participating in meetings between the services were also mentioned as difficulties in integrating into the network. EC23 says that there needs to be managerial support to make the professional available for the meetings, which he says is essential for the integration of professionals on behalf of the patient. TOC14 lists the weaknesses in matrix support.

> As I was telling you, you need a managed wish. What does this manager have to do? To enable the professional to go where the people are, to free up the workload to be able to be present at the UBS meeting. I went and liked it a lot. Because I saw things happening, I saw it was important. I felt how important this is for the patient, the effectiveness and quality of the work we provide when we manage to do this interaction (EC23).

> This has to come from the district as well if we have to leave the UBS every time by calling and asking what day is your matrix support because matrix support changes (TOC14).

The difficulties mentioned by the participants as "holes" in the services compromise the integration of mental health actions in the network and negatively impact the provision of care for patients and their families. For a change, it is essential to reorganize the way of working, train professionals, and create a network of dialogues between services. The current organization of workflows, the unavailability of professionals to travel and the lack of time for meetings interfere in the feasibility of building the care network based on dialogue and interprofessional exchange. This both negatively affects the results, as it triggers a feeling of frustration and incapacity by the professional in providing care.

DISCUSSION

The psychiatric reform movement allowed the CERSAMs in Belo Horizonte to be guided by the ideals of care in freedom, centered on the individual with psychological distress and their family. In other words, based on comprehensive and humanized care, carried out in an equitable and organized manner in the territory.

For mental health care, the UBS of Belo Horizonte is composed of family health teams and a mental health service, consisting of psychologists.[13] Currently, Belo Horizonte has 148 UBS distributed among nine regional health districts. Each of them has a mental health team that has a psychologist working directly in matrix support to the family health teams. Psychiatrists are allocated to the NASF team and meet the demand of more than one basic health unit.[14] This reality compromises care, as the mental health team at the UBS is unable to support all the cases contained in the territory. In this way, these teams are faced, in their daily lives, with a high number of cases that they cannot continue, at least not with quality care.

There is a lack of preparation of many professionals working in primary care to work with the demands of mental health. The APS has several potentials regarding the reception of mental health demands. It emphasizes the ability to serve the individual integrally, as a holistic human being, being an open gateway to access to health, decentralized medical care, and allowing the professional to monitor the patient in the network.[15]

For the implementation of actions in APS, it is necessary that teams understand and use the knowledge they have of the territory, being trained to develop extramural work in partnership with the various equipment in that territory.

The reference established by the organization of the territory enables the establishment of a flow and the creation of a bond, as the singularities of the families in that region are known closely, as well as the social sphere. There is a need to expand access through a multisectoral and networked approach that involves all components of RAPS.[16] In this context, the creation of links represents the possibility of spaces for exchanges necessary for mental health care.[17]

The testimonies of APS professionals about the public reveal a high number of consultations and a diversity of cases, which range from physical and mental illnesses at all stages of life. However, in daily life, there was an overload of APS professionals, their unpreparedness in dealing with psychiatric issues, and the difficulty of referring patients, which resulted in a worsening of conditions considered initially mild. This fact reinforces the idea that the patient with psychological distress is exclusive to the specialized service. Thus, the stereotyped image that characterizes people in mental suffering and that only specialized services can meet appears in the ideology.[16] Thus, the logic of fragmentation of care, which is the mind and body dichotomy, is reproduced. Integration between RAPS services is essential, through understanding the weaknesses and training needs of professionals to meet the diversity of demands both in APS and in CERSAMs.[18] Professionals need to identify and understand social health needs, seeking extramural means to act and transform their practice so that, together, the team and patients can solve problems, promoting humanized care and strengthening the relationship, bonds of trust.[19]

In this sense, there is a need to encourage intercession between the services that make up the RAPS, following the model of care networks, guided by the territorialization and transversal performance of services, seeking to strengthen the bonds and reception of this patient. The approximation of family health teams and professionals from the mental health network services contributes to the insertion of actions and resolute care strategies in the care network.[20] After all, the conducting element for the resolution of RAPS is communication and dialogue on the network. For mental health, matrix support offered by NASFs can enhance the approach and conduct of diagnostic and therapeutic clarification, strengthen the construction of singular and collective therapeutic projects, structure psychosocial interventions in primary care and promote integration between specialized services.[21]

In general, it is necessary to strengthen public mental health policies, which include the commitment of managers to the expansion of mental health in primary care; the creation of guidelines for mental health actions; the promotion of conditions for the implementation of mental health by hiring specialists, as well as qualifying general practitioners to join the network.[22,23]

To promote integration between professionals from different services and strengthen the actions proposed in the policy, the strategy is matrix support, as a new way of producing health, through the shared construction of intervention proposals.[24] This model aims to transform the way of knowing and doing in health, breaking the traditional logic. There are several challenges to materialize the matrix between them: the organization of services, the break with the biomedical model, and intersectoral communication, which interfere in the flow and affect the resoluteness of actions.[25]

Projects for team integration must be mediated by dialogic constructions, within the theoretical-practical reference of comprehensiveness and expanded actions beyond the disease, and by understanding reality, bringing together the existential experiences resulting from mental illness.[26]

We also can emphasize the need to broaden the debate on forms of resistance to the dismantling of the Política Nacional de Saúde Mental (Política Nacional de Saúde Mental). The approval of Resolution number 32 of 2017 is a setback to anti-asylum practices.[27] The reinsertion of the psychiatric hospital as a component of the RAPS, proposed in the first article, in addition to showing its more significant funding, acts in a way that diverges from the aforementioned legislation, which advocates care in the territory and community-based services, highlighting the transfer of inpatients to the extra-hospital network and the progressive closure of these beds.

There is a trend towards a stagnation in the pace of implementation of investments in community-based services, which goes against the need for integration between the services of the RAPs, as we discussed in this study.

FINAL CONSIDERATIONS

This study used the oral history method which, through a qualitative approach, enabled us to understand the view of professionals about their actions in mental health in the transition from the model in the city of Belo Horizonte.

The results showed that there were great advances in the transition from the model in Belo Horizonte and professionals understand the care model and make efforts in their actions so that there is integration between the services in the network. However, there are still many difficulties to be overcome, conceptualized by them as "holes". They are obstacles that permeate the lack of training in the case of management in mental health, the great demand in daily work, the lack of support in associated management the absence of flows, and ineffective communication between services. The findings indicate the need to evaluate the practices carried out to solve problems related to the organization of the flow and effective communication between services to legitimize the shared construction with the effective participation of all involved.

The limitations of this paper are the choice of the components of the care network, making it necessary an expanded approach to the services that make up the network, such as the inclusion of service patients, who are essential actors for the integration of practices and knowledge in health. Therefore, we indicate further studies considering the different levels of care in the city and the care management and specificities of this care.

From this perspective, it is important to promote dialogue between services, especially by managers, for the integration of actions in the network and that can propose changes in practices consistent with the needs of individuals and their families, seeking the effective implementation of the model of psychosocial care. It is also essential to consider the subjectivity and uniqueness for the continuity of care, enabling the construction of new knowledge and practices that allow the integrality and resoluteness of care.

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