

The journey through mental health crisis care in the city of Rio de Janeiro

O percurso pela atenção à crise em saúde mental na cidade do Rio de Janeiro

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Abstract

The concept of crisis in mental health involves a complex multidimensional formulation, forged in the context of the Brazilian Psychiatric Reform, which is not always taken unequivocally by those involved. However, it is necessary to consider a network capable of providing adequate answers on how to provide care in this situation; thus, networking is an essential condition of this approach. This article discusses the management of the mental health crisis in Psychosocial Care Centers III (CAPS III) in the municipality of Rio de Janeiro, Brazil, from the perspective of central and local health care managers, via semi-structured interviews and analysis based on Giddens' Theory of Structuring. This study found that the municipality of Rio de Janeiro adopts a crisis care model structured into a centralized care network and integrated network, with an emergency network highly integrated with the Psychosocial Attention Network (RAPS), especially with the CAPS III, and the crisis situations are cared for preferably in specific services. Still, from Giddens' perspective, CAPS III have the legitimacy to provide care toward mental health crisis.

Keywords: Crisis Intervention; Psychosocial Care Center; Psychosocial Care; Mental Health; Territory.

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Resumo

O conceito de crise em saúde mental envolve uma complexa formulação multidimensional, forjada no contexto da Reforma Psiquiátrica Brasileira, que nem sempre é tomado de maneira unívoca pelos envolvidos. Contudo, há de se considerar uma rede capaz de dar respostas adequadas sobre como acolher essa situação, de maneira que o trabalho em rede é uma condição essencial dessa abordagem. Este artigo traz a discussão do manejo da crise em saúde mental nos Centros de Atenção Psicossocial III (CAPS III) do município do Rio de Janeiro, Brasil, a partir da perspectiva dos gestores de saúde de nível central e local, realizada por meio de entrevistas semiestruturadas e analisadas com base na Teoria da Estruturação de Giddens. Este trabalho identificou que o Rio de Janeiro apresenta um modelo de atenção à crise estruturado em rede de atenção centralizada e rede integrada, uma vez que apresenta grande integração da rede de urgência com a Rede de Atenção Psicossocial (RAPS), sobretudo com os CAPS III, e as situações de crises são atendidas preferencialmente em serviços específicos para seu atendimento. Ainda assim, pela perspectiva de Giddens, os CAPS III têm legitimidade para cumprir o papel de atenção à crise em saúde mental.

Palavras-chave: Intervenção na Crise; Centro de Atenção Psicossocial; Atenção Psicossocial; Saúde Mental; Território.

Introduction

The concept of mental health crisis involves a complex multidimensional formulation, forged in the context of the Brazilian Psychiatric Reform (BPR), which involves a new way of dealing with and managing this radical experience lived by the subject, dispensing with psychiatric hospitals as therapeutic resources (Campos, 2014).

Although, in the context of crisis, there is an undeniable acute alteration of the subject's psychic functioning, its basis lies in the context of their social network (Campos, 2014): it is produced in a network and disturbs or modifies the individual's relationship with it (Dell'acqua; Mezzina, 2005). Additionally, as the gateway into the mental health care circuit, crisis care is decisive and strategic.

It is important to emphasize that the health care team, users, and their families do not always agree on what a crisis is, nor on the proposals for intervention at this specific time. The sociocultural context in which the individual participates may or may not be favorable to the care strategies, as well as to the institutional ethics in question; thus, all these factors have a direct influence on the type of approach offered (Ferigato; Campos; Ballarin, 2007). Therefore, for crisis management, the sociocultural, historical, and family contexts need to be taken into account by the health care team.

As for crisis care in the context of the BPR, it is necessary to consider a network capable of providing adequate answers on how provide care in this situation; thus, networking is an essential condition of this approach (Dell'acqua; Mezzina, 1991).

Mental health crisis care proves a strategic axis of care in the Psychosocial Care Network (RAPS), as it promotes a change of course in care towards territorial services and non-segregated practices, strengthening the policy of deinstitutionalization. Accordingly, the term "territory" acquires special relevance, precisely in the contrast between hospital-centered services and community-based services. That is because, as argued by Santos (1994), it is the use of territory—rather than territory in its abstract sense—that is in question. In other words, it is a matter of considering the subject's experience in the social, historical, and political field, and it is essential to think that care in the territory

involves, therefore, a real social transformation, in the sense of living with differences (Furtado, 2016).

Taking this as a focus, some components can be considered crucial for mental health crisis care. Among them, it is worth noting Psychosocial Care Centers mode III (CAPS III), due to their capability to care for crises and avoid hospitalizations in psychiatric hospitals. These facilities have specific formal resources for crisis care and 24-hour service, which makes them strategic for the apprehension of modes of care and resolution of mental health crises, especially because they are recognized as services that, supposedly, provide satisfactory care in these situations.

However, crisis management is still a challenge and possibly the main issue faced by mental health care teams and services, especially in CAPS, which have seen increased demand for crisis care and resolution (Dimenstein et al., 2012).

This article discusses mental health crisis management in CAPS III in the municipality of Rio de Janeiro, Brazil, from the perspective of central and local health care managers.

Methodology

This is a descriptive and exploratory qualitative research (Deslauriers; Kérisit, 2010), the result of a doctoral thesis prepared between 2018 and 2022 and proposed to think about mental health crisis care in the municipality of Rio de Janeiro—considering the structure and functioning of the RAPS, the services that are used to intervene in these situations and which are references for them, in addition to the crisis resolution potential of CAPS III.

To this end, semi-structured interviews were carried out in a virtual environment due to the period of social isolation imposed by the COVID-19 pandemic. The interviews were based on two guides: the first, directed to the central management, identified as CM, seeking to gather information on the structuring, planning, conceptions and functioning of crisis care in RAPS in the municipality of Rio de Janeiro; and the second, aimed at local managers—coordinators of all CAPS III identified as LM—which had as axes the conceptions and management of crisis in CAPS III.

The study had 21 participants, managers of CAPS III in the city of Rio de Janeiro, in addition to the team

of the city's mental health superintendence, between the second half of 2020 and the first half of 2021.

At the time, there were eight CAPS operating in mode III in the city of Rio de Janeiro: CAPS III Manoel de Barros, CAPS III João Ferreira Filho, CAPS III EAT Severino dos Santos, CAPS III Clarice Lispector, CAPS III Fernando Diniz, CAPS III Franco Basaglia, CAPS III Maria do Socorro Santos, and CAPS III Arthur Bispo do Rosário.

The interviews were submitted to content analysis compared to the theoretical framework of Anthony Giddens, more specifically the Theory of Structuring (TE) (O'Dwyer, 2015; O'Dwyer; Mattos, 2010). The use of individual interviews allowed for mapping the practices of CAPS III in a psychosocial care network, whose actions are influenced by the singularities of the territory and the perceptions of crisis of the subjects who work in them.

The research followed ethical standards, being approved by two Research Ethics Committees under opinions No. 5,533,776 and No. 4,046,876.

Results and discussion

Crisis planning – central level

In 2015, the superintendence of mental health of the municipality of Rio de Janeiro created a Working Group (WG) on Crisis Care, with a permanent education character, in all CAPS—with particular attention to CAPS III—so that the mental health of the municipality could advance more vigorously in reducing psychiatric hospital beds and expanding territorial care.

In interviews, managers recognize the importance of crisis care, which, “*along with deinstitutionalization, is the great pillar of psychosocial care*” (GC4), being “*a transversal theme to all actions in mental health care*” (GC1).

The reduction in the number of long-term psychiatric hospitalizations in Rio de Janeiro—from 9,808 in January 2015 to 4,553 in September 2018 (Matos, 2019)—confirms the success of the conduct that the mental health coordination of the municipality adopted in relation to the crises.

Since 2015, there has been much progress as to the technical and organizational planning of crisis care,

in order to transform the mode of operation of RAPS. As an example, the regionalization of this type of care is no longer linked to hospital services, that is, it is now connected to psychosocial care, and not simply linked to the hospital service.

For this to happen, the first action of the superintendence was to divide the RAPS into three large territorial blocks—North, Center-South and West zones—due to their territorial extension and large population concentration.

Another fundamental step was the inclusion of urgent care for people in mental health crisis in the emergency medical clinic, ending emergency rooms within psychiatric hospitals. This action is related to the understanding that the crisis needs to be apprehended in a larger context, which involves the general practice dimension and not just psychic aspects. This measure is underlain by the unpredictability inherent to psychosocial crises, which may necessitate rapid interventions, but which would in no way justify the permanence of this service in an psychiatric hospital setting, in addition to their complex character, requiring a response associated to the comprehensiveness of care.

Similarly, studies—such as those of Barros, Tung and Mari (2010) and Sousa, Silva and Oliveira (2010)—indicate the inclusion of mental health in the medical clinic as an important step for accurate diagnostic evaluation and proper management of the clinical and psychological condition of users, considering that general emergencies have appropriate diagnostic resources for the detection of organic disorders that may be causing the psychiatric disorder.

The urgency and emergency network of Rio de Janeiro consists of Emergency Care Units (*Unidade de Pronto Atendimento* - UPA), Regional Emergency Coordinations (*Coordenação de Emergência Regional* - CER), and hospitals for major emergencies, in addition to the Mobile Emergency Care Service (*Serviço de Atendimento Móvel de Urgência* - SAMU). Each of these services has a specific role in the network and serves different user profiles.

As for mental health crisis care, CERs acquire greater importance, due to their partnership with CAPS III, because of the existence of a “*mental health sector*” (GC2) and the demand for the service by users in crisis. At the time of the study, the municipality of Rio de Janeiro had seven CERs: Centro, Barra da Tijuca,

Leblon, Ilha do Governador, Santa Cruz, Realengo, and Campo Grande.

The other ongoing actions continue to be the closure of psychiatric hospitals and the expansion of CAPS III, in addition to the transformation of all CAPS mode II into CAPS III. Currently, there is only one Municipal Psychiatric Institute in operation in the municipality—both the Nise da Silveira and Colônia Juliano Moreira institutions had their cycles closed by October 2022.

Crisis arrival point

In general, mental health crises can reach the health care system in the municipality of Rio de Janeiro through some points, namely: Primary Health Care (PHC), psychiatric emergency services, CERs, and CAPS III.

The interviews showed the existence of two flows of care, which establish two care regimes. For those who are already CAPS III users and are in a relationship of care with professionals of the service, there is a certain course within RAPS that does not necessarily go through emergency care. However, even if the user has some contact with a CER or psychiatric emergency service, having a relationship with professionals of territorial services facilitates and speeds up their access to CAPS. On the other hand, not being a user already recognized by CAPS III implies greater possibilities of being cared for in the hospital facility, since not having a relationship with the service technicians reduces the chance of faster care in the territorial services.

It is evident here the dimension of care and benefits arising from the relationships established between users and health care professionals in a clinic that proposes the adoption of an expanded perspective, in which it is not enough to focus only on the disease (Campos, 2000; 2015). It is necessary to consider health issues and life situations that result in vulnerability for people. In any case, it is necessary to consider this asymmetry of itineraries with regard to equity and comprehensiveness of care.

According to Oliveira and Szapiro (2020), the expanded clinic advocates a unique clinic, which considers each case as unique while dialoguing and critically incorporating other knowledges and guidelines, involving issues such as bonding, resolvability, and accountability (Bonfada et al., 2012).

Thus, it is precisely the quality of the care that users receive in the services that favors the bonding and impacts their journeys through the RAPS, either on the side of technicians who make referrals, or on the side of patients who demand care. Services alone do not guarantee care; what makes the difference is the work conducted by professionals when dealing with people, as can be seen in the interviews.

Even if the CAPS user does not arrive at the service, the team is responsible for their follow-up in the RAPS, thus maintaining continuous care.

Usually, when they don't seek it, it's because there was something like an unrest, something more aggressive that happened at night, or that the family has some difficulty taking them there, then they call the SAMU service. If we have a place available in the care, we say: We have a place available in the care, we make an evaluation with them, then they can already be transferred to us. (GL3)

Networking, especially at the interface with primary health care, emerges as an extremely significant factor for the detection of crises in the territory and for the construction of alternatives to psychiatric hospitalization. Community agents are fundamental for early recognition and intervention in crises in the territory, including people who have never been to a mental health care service, often allowing for the use of CAPS III beds to be dispensed with.

Usually, people who are not users of the service and who go into crisis seek emergency services—whether psychiatric or CER—as can be seen in the excerpt of the interview granted by GL2:

They usually resort to the emergency service [...] The CER located at Barra. Because, generally, it is a call from SAMU and then SAMU, it works with the guidelines already given by the firefighter commander, with guidelines already given for emergencies. This is built together with the Superintendence of Mental Health, also. (GL2)

There are even situations where CAPS III itself refers users that are not registered with the service to the emergency service or CER.

CAPS III should be open all day, seven days a week, able to attend to crises (Brasil, 2002; Brasil, 2004). However, this does not apply to all services in the city of Rio de Janeiro, especially after five o'clock in the afternoon, when there are no psychiatrists available to evaluate new users.

In this sense, the 24-hour flow occurs in partnership with emergency services. The use of WhatsApp® for constant communication with CAPS managers and emergency professionals often allows for hospitalizations not to occur and patients to be referred to CAPS III according to the program area.

[...] we have a crisis group (WhatsApp®) in the territory of the entire municipality. All CAPS, emergency services and such. And there is the RAPS group, which is only of the 3.1. So, we get to know ASAP, if they show in the Asylum, the Asylum informs us: Folks, John Doe, Jane Doe showed up in the emergency room, they're here with us. (GL9)

However, this crisis monitoring group sometimes does not work and the patient ends up being hospitalized.

What happens is, sometimes, this flow with CER Barra, that we have the group, sometimes, it fails. Then I learn that the guy was taken to CER Barra, and they referred him to Manfredini, for example, but this has been very rare to happen. We'll go there immediately, take the guy from Manfredini and put him inside the CAPS. (GL7)

The analysis of what was discursively expressed by the participants of this study shows, as facilitating factors for crisis management, the sharing of cases and night care beds between CAPS III, the inclusion of mental health in CERs and WhatsApp® groups.

In view of the above, it is worth noting the awareness and critical capacity of managers, when they perceive flaws in the system and devise suggestions for improvements to crisis care in Rio de Janeiro. Giddens (1984) emphasizes this capacity of the “agent,” who, through their knowability, reflects on the context in which they live.

The coordination between CAPS III, CERs and psychiatric emergency services constitutes points of

power and resistance for effective operation of the RAPS network. Moreover, CERS end up being an emergency service in a network of other RAPS services, fulfilling the function of being a reference in differentiated crisis care, being situated at the forefront of the traditional hospital structure and psychiatric emergency services and proving essential for crisis care in Rio de Janeiro.

In this regard, it is known that the disorganization of entry points and the lack of defined and recognized exit points and referral flows contribute to impair the processes of decentralization and connection between mental health care points (Sampaio; Bispo Júnior, 2021). Therefore, in the RAPS of the municipality of Rio de Janeiro, crisis care occurs in the same ways that support its difficulties, because, on the one hand, it exhibits network integration and efficiency in referring users in crisis to territorial services, on the other hand, it highlights the inefficiency of CAPS III as a device for crisis care.

Procedures in case of crisis in CAPS

Mental health care vacancies represent the major differential factor in the CAPS III service, since they are one of the possibilities to avoid hospitalization in a psychiatric institution setting. In this regard, it is observed that the approach to patients in crisis in CAPS III does not appear homogeneous in all services, which shows the lack of a care service protocol.

All respondents talk about more general “work guidelines” given by the superintendence of mental health as to providing crisis care in CAPS III and avoid hospitalization. As a result, services end up caring for and conducting the crisis according to their own physical and relational resources.

The interviews show that there are two ways of organizing the technical team for the first crisis care or service in CAPS between 8 am and 5 pm: by mini-teams or by rotation of shifts.

The mini-teams can be divided according to the family health teams of their territory, or even through groups of professionals from different fields (psychology, nursing, occupational therapy, among others). On-duty teams are usually established only by the schedule of professionals assigned to the care function on a given day of the week.

In the mini-team mode, the professional who provides the first care will not necessarily be responsible for the

user in the long term, because the patient’s reference is the person who is closest to them. According to this logic, when a service user arrives in crisis at the CAPS, this professional is called to provide care.

Daytime care or first-time care, organized by on-call teams, will generate, after this first service, the assignment of a reference technician who will be responsible for this user. The fact that the on-call professional necessarily has to take the place of a reference technician for the user who is arriving at the CAPS sometimes promotes a flight reaction on the part of the professional. In an interview, the manager said that: “*No one wants to be on duty, because they know they will need to absorb new patients of the service*” (GL1).

When comparing the two current models of organization of CAPS III teams to care for users, it seems that organization in mini-teams enables better care, since it provides the possibility of creating a bond with more than one technician, expanding (more consistently) the possibilities of care.

Technical knowledge to conduct psychosocial care clinic and the functioning of the network is fundamental for there to be coordination and integration between services, whether in general health, or just in mental health (Vieira et al., 2020). Following this premise, health care services would be committed to the population to provide the best possible outcome, seeking to meet the demands of users even if they do not have a ready solution, defining it with the existing services in the care network, whether they are primary health care or not. This coordination occurs through “living networks” constituted of different people in daily routine (Merhy et al., 2014).

As discussed in the previous section, the absence of medical professionals may prove an obstacle to crisis care. However, for some interlocutors, this absence is absolutely fundamental in this initial care, so the logic of medicalization of illness is reversed.

We don't have doctors there, because otherwise it turns the CAPS into a psychiatric emergency service. People already seek CAPS as a place that has a doctor. So, people come looking for the doctor, looking for a prescription. (GL13)

According to Moreira, Torrenté and Jucá (2018), in mental health crisis care, the care service must be offered

in order to ensure the subject receives comprehensive care and qualified listening. This implies the recognition of psychic suffering as a subjective experience, in order to consider its context of origin, as well as the uniqueness of the subject, their potential and way of life in the conduct of the provision of care.

To this end, knowledge relationships must be thought of by interdisciplinary logic, with the purpose of greater horizontality between actors and knowledge, with a view to the well-being of the user. Actions must be operationalized by technologies capable of ensuring psychosocial rehabilitation, such as bonding, care, autonomy and protagonism of the subject (Mehry; Franco, 2003).

In a general sense, all CAPS III professionals are involved in crisis care, although the design of the first service varies depending on the type of regime adopted by the service (mini-teams or on-duty shift).

However, not all services have a medical professional on a daily basis. This fact means that patients who are not users of the services have to be redirected to emergency services before being admitted, especially in the preliminary care beds. Then, there is an obstacle between the interdisciplinary logic of crisis care and the professional, who can legally admit a person for hospitalization.

Physicians and drug prescriptions are constituent parts of the team and intervention actions in CAPS III and, therefore, need to be available to users who arrive at the service. Prescription becomes medicalization when it is used to reproduce control and guardianship measures—that is, when there is no contractuality, and only the silencing of psychological suffering, making it difficult for the subject to build ways to signify and deal with it (Zeferino, 2015).

For Giddens (1984), the agents' actions can have intentional or unintended consequences—the flow of action continuously produces consequences that were not in the actors' intentions. Agents, in Theory of Structuring, as much as they are aware of their practices, cannot control all consequences of their actions. The consequences, then, generate unpredictability and feed back the unrecognized conditions of the action, and influence the actions of other agents. That is, since users do not find medical care, because territorial services are often unable to provide it, they need to resort to other services.

Crisis care in CAPS III during nighttime has very different characteristics in relation to that provided during daytime, when the medical professional is available. It should be noted here that this aspect refers to users who are not yet included as CAPS users, because, once patients are part of the system and known to the physician, the drug guidelines can be provided even in the absence of the professional, who can be accessed remotely.

Following this reasoning, the mode of organization of the team to receive users in the service is related to that which directs the operation of the service in general:

At the start-of-shift meeting, we talk about the night of patients under care, if they slept, or if they did not sleep, if they are well, if the medication is having an effect, or if it is not having an effect. And that's the kickoff of the day. And from there we already see how we will deal with the crises on that day. [...] At the end of the day, we have the end-of-shift meeting, where we also say what has improved, what has not improved. The team that is beginning on-duty shift, what possibilities they will have at night, what was taken out of direction during the day. (GL11)

The intervention will be designed according to each case, understanding that night care is not the only intervention strategy in the crisis.

It depends a lot on each situation... not necessarily the crisis will need to be referred to the crisis care admission. That will depend a lot on what support the user has, on what network we can build. Oftentimes, we deal with crisis situations in our own territory that don't necessarily need to reach the CAPS. (GL12)

The excerpt from the interview granted by GL12 reiterates the lack of minimally normative direction for crisis care that least impacts the variability of care, but which is still a clinic that places the disease in parentheses. For Campos (2001), placing the disease in parentheses means bringing the user to focus, rather than denying the disease.

For Lancetti (2016), one of the major obstacles faced by CAPS is the centralization in themselves and their little openness to the territory. This can be translated into strict requirements as to profiles

for admission to treatment or inflexible routines, making it very difficult to access the service.

The most significant challenge for RAPS in Rio de Janeiro may be to structure a care policy that considers the idiosyncrasies (of users, of the territory and of the very manifestations of the crisis) without being merely determined by them. In this sense, the perspective of the line of care, as a strategy of territorial accountability, can be a tactic to introduce new answers. Thus, the concept of line of care could be a guiding perspective for comprehensive care, involving continuous follow-up and joint care response, through a pact that mobilizes all actors that control care services and resources.

The permanence or not of the user in the service may be related to the evaluation of the service's capacity to deal with a given clinical/symptomatic situation, or even due to the absence of places for care.

With regard to the nature of the interventions that technicians operate in the services, according to the respondents, they can be highly varied, ranging from circulation around the service, writing and drawing workshops as therapeutic resources, individual care, to the use of medication. In general, the mark of the territorial and collective character is evident in the approaches. Thus, the expansion of the perspective on the social context in which the subject in crisis participates enables a greater understanding of this phenomenon, in addition to opening a range of possibilities of coordination for care.

These modes of intervention operated in CAPS III are consistent with a conception of crisis management that considers and includes all its complexity, relying on the possibilities of using varied, non-invasive resources that emerge in the follow-up of the subject in crisis, considering guidelines and the construction of a bond (Tranquilli, 2017).

Crisis management strategies in the pandemic

Faced with a profound global public health crisis, with obvious and expected impacts on the mental health of the population, the services specialized in managing this demand had as challenges the production of territorial care and compliance with social distancing measures and all other contingencies of the pandemic (Costa et al., 2020).

Thus, the superintendence of mental health of Rio de Janeiro established guidelines for services on March 18, 2020, based on a technical note, SMS Resolution No. 4333 (Rio de Janeiro, 2020), which listed some conditions for the operation of the care service units.

The mental health crisis in the pandemic is a recent topic and the literature on it is still scarce. In any case, data from this study indicated that the measures adopted by CAPS III in the municipality of Rio de Janeiro, based on the technical note, were the same as those found by Silva et al. (2022) and Barbosa et al. (2020). In general, the note in question provided for the organization of the internal structure and routine, but, above all, for the organization of care. The collective activities were suspended, and the therapeutic projects revisited, in order to determine the possibility of reducing the stay in CAPS. The dispensation of medication was changed, so users could obtain larger amounts, in addition to the introduction of electronic prescription and home delivery of medicines subject to special control.

Aiming at guaranteeing care, follow-up and strengthening of the bond with users, the professionals developed a form of remote intervention—through telephone calls—to guarantee therapeutic care and drug monitoring, in addition to active search for users who had been absent from the service. Such actions were carried out not only by the reference professionals who were in the services, but also by those who had been given a leave of absence because they were more susceptible to presenting severe cases of COVID-19. In addition, team supervision and matrix support also assumed a remote character.

Minervino et al. (2020) support, based on international studies published between 2010 and 2020, the effectiveness of telemedicine in mental health care as a worldwide therapeutic resource, with a view to avoiding contamination by COVID-19, especially in times of social isolation.

According to Barbosa et al. (2020), the use of technologies such as telephone calls, video calls or WhatsApp® messages enables thinking about the organization of the routine of services and the management of critical (and sometimes unexpected) situations based on the strength of the bond that is maintained with users, placing them at the forefront in their mental health care.

The possibility of maintaining this innovation in psychosocial care seemed feasible, although it is not possible for some CAPS III, due to the severity of patients' mental disorders and the poverty of the population, which would make the access to virtual communication impossible.

The SMS Resolution No. 4333 also provided that services would need to be carried out in person at the service unit. However, the services should be conducted in an open space and users who arrived at the CAPS would need to be received by a nursing professional to perform basic screening for Influenza-like illness. In case of need for urgent care, home visits should be evaluated, together with primary health care.

Evidently, all these guidelines of the superintendence were being adjusted to the reality of each unit and, therefore, they were not always complied with—and some important observations in this regard should be noted.

It was recommended that they informed users on the protective and isolation measures that had been prescribed to the general population, such as hand hygiene, use of a mask and social distancing.

[...] some say it is nothing like that, that there is no coronavirus, that the coronavirus does not infect you. We have one there who says he is God, he is being cared for, and that because he is God, nothing happens to him. So, he doesn't need a mask. (GL3)

This finding corroborates the statements of Minervino et al. (2020) about mental health services being more conducive to contamination by the coronavirus, both because the way CAPS operates—by prioritizing social interaction—and because of the difficulty for patients to understand the need for a mask and hand hygiene. This is compounded by aspects related to the very situation of mental suffering. Therefore, the implementation of this protocol depended, in large part, on the patients' psychic state.

Although collective activities and most in-person services had been interrupted, crisis care had continued since the beginning of the pandemic, due to the impossibility of its interruption and the expectation that the pandemic would more severely impact people under mental suffering. Thus, institutional adjustments had to be made, such as the provisional creation of a COVID-19 ward for crisis care.

The 2020 SMS Resolution No. 4333 provided specific guidelines for the organization of CAPS III, such as the reorganization of nighttime care spaces and the monitoring of cases with respiratory symptoms, with due preventive measures regarding the exposure of the team and other users.

As the pandemic progressed, the service units understood how to manage these crisis and COVID-19 situations, creating alternatives for patients to remain in CAPS III. It was necessary to create strategies to deal with users who were in the nighttime care and had flu-like symptoms. After the 90 days of the technical note, the changes that remained in the services were basically the suspension of collective activities and the suspension or adaptation of home visits or trips to the territory.

In general, there was a lack of homogeneity in services during the pandemic, related to existing structural deficiencies, such as the physical and human resources of each service. However, all CAPS III had access to Personal Protective Equipment (PPE) material, both for the technical team and for users.

It was precisely this period of distancing that highlighted the power of physical coexistence between professionals and users—and also between users themselves—in the daily routine of CAPS. In addition, it was evident how this coexistence mitigates suffering, enables the singular and collective construction in the lives of each one and reinforces the place of CAPS as a reference of service and care for users and family members, which can be seen in the maintenance of bonds through remote care.

Final considerations

This study found that the municipality of Rio de Janeiro adopts a crisis care model structured into a centralized care network and integrated network, since the emergency network is highly integrated with the Psychosocial Care Network (RAPS), especially with CAPS III, and crisis situations are cared for preferably in specific services. Accordingly, CERs constitute central devices so crisis care does not result in one-off services nor isolation for long periods, clearly being part of the therapeutic project, since they establish a partnership with CAPS III for

quick identification of users by program area and for referral to territorial services. Thus, it was possible to significantly change the route of users in crisis from psychiatric institutions to territorial services.

Both the introduction of psychiatric emergency services in CERs and crisis groups in WhatsApp[®] were absolutely essential for the success of this care outside psychiatric institution settings, as they enable a good integration with the emergency network and ensure that professionals in CAPS III units will be referred clinically “stable” users. Thus, similar measures may promote integration with the emergency network in other municipalities.

Although the superintendence gave the team a direction of work, in practice, the conducts proved to be heterogeneous. This may be related to several factors, such as: varied conceptions about the phenomenon, territorial issues, technical and structural composition of services and devices available in each program area, lack of more systematic guidance, etc. Despite all the complexity of the crisis experience and the reliance on the use of varied, non-invasive and non-reductionist resources, there is a lack of more specific guidelines that order the flows.

Much has already been accomplished and proposed for mental health care and, throughout the BPR process, several advances have been achieved. Health professionals are responsible for providing quality care with an emphasis on continuous care and follow-up, using RAPS devices. Managers should understand the deinstitutionalization process, providing collective spaces for the exchange of knowledge and workshops that work on the new concepts of networking, thus contributing to change the work process of the teams.

In this sense, the use of allocative and authoritative resources—as named by Giddens (1984)—produced reflective monitoring in managers. The mobilization of these resources showed how underfunding is still a serious problem in mental health care.

Still, from Giddens’ perspective, CAPS III have the legitimacy to provide mental health crisis care. Managers make the best use of the insufficient resources available for service. There is a push with regard to human resources and access to beds.

Finally, new services, especially CAPS III, require trained professionals to operate within new strategies. The

care model reformulation processing will not occur only by normative measures, but, fundamentally, by disruptions in microspaces and deconstruction of the psychiatric institution model, strongly rooted in professionals and common sense. To this end, it is essential to build a clinical practice with multidisciplinary work and provision of care that is adjusted to the specificity of the demand and creates possibilities of life, enabling the inclusion of these individuals in a society that can see insanity as just another way of existing.

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