Original Article

Object and technologies in the working process of an itinerant team in mental health

Objeto e tecnologias do processo de trabalho de uma equipe itinerante em saúde mental

Objeto e tecnologías del proceso de trabajo de un equipo itinerante en salud mental

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ABSTRACT

Objective: To analyze the work object and the technologies in the working process of a Mental Health Itinerant Team in the attention to drug users.

Methods: Qualitative case study, carried out in a municipality in the South of Brazil. The theoretical framework was the Healthcare Labor Process. The data was collected through participant observation and semi-structured interviews with the professionals of an itinerant team in the year of 2015. For data analysis we used the Thematic Content Analysis.

Results: In the first empirical category - work object - the user is considered as a focus, bringing new challenges in the team's relationship with the network. In the second category - technologies of the work process - potentialities and contradictions of the team work tools are highlighted.

Conclusions: As an innovation in the mental health context, the itinerant team brings real possibilities to reinvent the care for the drug user as well as new institutional challenges.

Keywords: Mental health. Health services reform. Public policies. Drug users.

RESUMO

Objetivo: Analisar o objeto de trabalho e tecnologias do processo de trabalho de uma Equipe Itinerante de Saúde Mental na atenção aos usuários de drogas.

Métodos: Estudo de caso, qualitativo, desenvolvido em um município do Sul do Brasil. O referencial teórico foi o Processo de Trabalho em Saúde. Utilizou-se observação participante e entrevista semiestruturada com os profissionais de uma Equipe Itinerante no ano de 2015. Os dados foram analisados por meio da Análise de Conteúdo Temática.

Resultados: Na primeira categoria empírica – objeto de trabalho – o usuário é considerado como foco, trazendo novos desafios na relação da equipe com a rede. Na segunda categoria – tecnologias do processo de trabalho – são destacadas potencialidades e contradições dos instrumentos de trabalho da equipe.

Conclusões: De modo inovador, a Equipe Itinerante imprime novas possibilidades de cuidado ao usuário de drogas, ao mesmo tempo em que exige novos arranjos institucionais com a rede de saúde mental.

Palavras-chave: Saúde mental. Reforma dos serviços de saúde. Políticas públicas. Usuários de drogas.

RESUMEN

Objetivo: Analizar el objeto de trabajo y las tecnologías del proceso de trabajo de un Equipo Itinerante en Salud Mental en la atención a los usuarios de drogas.

Métodos: Estudio de caso, cualitativo, desarrollado en una ciudad del Sur de Brasil. El referencial teórico fue el Proceso de Trabajo en Salud. Se utilizó observación participante y entrevista semiestructurada con los profesionales de un equipo itinerante en el año 2015. Los datos fueron analizados por medio del Análisis de Contenido Temático.

Resultados: En la primera categoría empírica - objeto de trabajo - el usuario es considerado como foco, trayendo nuevos desafíos en la relación del equipo con la red. En la segunda categoría - tecnologías del proceso de trabajo - se destacan potencialidades y contradicciones de los instrumentos de trabajo del equipo.

Conclusiones: De modo innovador, el equipo itinerante imprime nuevas posibilidades de cuidado al usuario de drogas, aunque traiga nuevos desafíos de promover articulaciones institucionales con la red de salud mental.

Palabras clave: Salud mental. Reforma de los servicios de salud. Políticas públicas. Usuarios de drogas.

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INTRODUCTION

The Third National Mental Health Conference 2001, with the slogan "stop exclusion - dare to care", highlighted the importance of reorienting the mental health care model, addressing the need for itinerant teams in basic health care as a working method for the care of individuals and families[1]. In this sense, itinerancy meets the need to understand a new place for care, i.e. the territory, predicting the movement of professionals to these spaces. For this reason, itinerancy is, in itself, not only a new conceptual approach, but also a technological approach to organize the work in health[2].

The itinerant practices are used for the displacement in the people's living territories, in an active search logic able to attend to vulnerable groups and health care needs of populations that do not adapt to the traditional equipment of care. Among these are: indigenous peoples with nomadic customs, homeless people and drug users, who often do not adapt to traditional clinical protocols[2].

These teams play an important role in the care of people who use drugs, since it is in the territory that the user lives and uses the substance, being necessary for the itinerant health professional to approach this reality and live it as well, in a continuous effort of relationship formation, dialogue and listening. In addition, itinerant teams also coexist as the user's intermediary with society, in order to try to re-signify our view on the subject, still very much based on exclusion, repression, coercion, prejudice and moralization[3].

The mental health reform movement, as a catalyst for a process of model change in mental health that does not detract from this reality, offers us a possibility of epistemological rupture with these traditional models. By promoting initiatives and innovative experiences of counter-hegemonic care, the itinerant teams emerge among them[4].

In this sense, the relevance of these teams in the composition of the mental health care network is highlighted, not only through the consolidation of new public policies in the sector, but also in the sense of establishing a social and sanitary commitment with people and their places of life and experience. This means that teams need continually to develop strategies able to focus on care in the territory, involving care relationships among different sectors, services, and actors.

Thereby, in 2014, the mental health management of the studied municipality invested in the composition of an itinerant mental health team, responsible for receiving and monitoring the legal proceedings in the area. Among them, there are also problems related to drug use. The mentioned team was created as an initiative to reduce the judicialization of mental health and to promote the approximation with the judiciary sector, in order to widen the eyes of justice in relation to care and to foster intersectoral connectivity[5].

As it is an innovation in the local context, it was aimed to know the object and the technologies present in the daily work of this itinerant team in particular. According to this, the guiding question of the study was: What work object and care technologies are present in the working process of a mental health itinerant team in the care to drug users?

METHOD

Qualitative study approach of case study type, guided by the theoretical framework of the health work process(6-7). The working process is modified according to the society organization. In the Marxist conception, capitalism is responsible for organizing the labor process into three distinct elements: **"the activity proper to an end**, i.e. the work itself; **the matter to which the work applies**, the object of work; and the **means of labor**, the instruments of labor"[6].

The object may be natural or a raw material, but the object will only be considered a work object when the man has a destiny in mind for it. The means of work is a complex and necessary set of things with different chemical, physical and mechanical properties that the worker uses, between himself and the object, to perform his work. Finally, the product will be the result of the idea that the man operated. Thus, when concluding the process, the man will have a material of nature adapted to his needs by changing the object[6].

In the health area, the work process is essential for human survival, being its production not material, because it does not result in a marketable production and occurs at the moment of the action, since the product is inseparable from the process of its formation. The object of health work is the individual or healthy or sick groups with different needs, for which technologies are destined, marked by their technical and social dimensions. The technologies, placed into action, generate purposes, which would be the result of the work process, or the object itself transformed by the act of creation and human action by the work[7].

This study was performed with a mental health itinerant team from a municipality in the Southern Brazil. The itinerant team was composed of four professionals: three psychologists and a helper. As the exclusion criterion was to be absent by sick leave and/or to be on vacation during data collection, one participant was excluded. Thus, this study was attended by three professionals.

Data collection occurred through the use of participant observation techniques and semi-structured interviews. Participant observation was performed between July and September 2015, on different days of the week. Among the followed activities, stands out: home visits, active search, case discussions in the health services and monitoring of the team in the writing of answers to cases analyzed for the public prosecution. The observations totaled 180 h. The semi-structured interview was performed at the end of September 2015. All interviews were recorded and then fully transcribed for analysis.

To perform the data analysis, the "thematic content analysis" was used, which is composed of three stages: pre-analysis, material exploration and treatment of results. In the first stage, the floating and exhaustive reading of all the material was performed to sensitize the empirical content. In the second stage, it was performed the separation of common fragments and sections, identified as "information units", which, together, gave rise to the units of meaning. Finally, in the third stage, an interpretative synthesis of the units of meaning was performed, which derived the empirical categories of the study[8].

From the data treatment, two empirical categories emerged: 1) work object of the mental health itinerant team and 2) care technologies in the work process of the mental health itinerant team.

The research contemplated the bioethical prerogatives, according to Resolution nº 466 of December 12, 2012, of the National health council. The approval was obtained from the Research Ethics Committee of the Federal University of Rio Grande do Sul in July 2015 (opinion number 1,144,089). The study participants signed the free and informed consent term and were identified with the letter T of worker ("*Trabalhador*", in Portuguese), for example, T01, T02. The excerpts from the field diary were represented by the acronym DC.

RESULTS AND DISCUSSION

Work object of the mental health itinerant team

The work of the itinerant team is new in the studied reality, and perhaps unpublished, because it was created to meet the urgent demands of the municipality - to reduce the judicialization of mental health. Thus, for being a new work, it gave rise to doubts among workers in relaion to nature, to the conception of work and to the role of the team in the context of the psychosocial attention network.

In the following reports, it is possible to verify that the work object of the team seems to be the user, and the answers given to the Public Prosecutor's Office are a consequence of the developed actions, resulting from the meeting between user and worker:

> *[...] The main response that we have to have is in relation to the care of the user, so the response to the [Public] Prosecutor's Office is a consequence of this [...] is our user of mental health, of course that the itinerant team is not the reference , it will not be the reference of care .[...] but an articulated work, in a work sometimes of support of the CAPS you have and you can realize that such user is also yours [...] (T03).*

> *[...] The idea is that it is possible to follow-up what is being executed, how care is being taken [...] But, the follow-up is another way; we keep in touch with the service, from what I see as a work almost of matrixing, perhaps, of the legal issue [...] (T02).*

The precise action in the work is not evaluated from a specific demand, but thought while strategy of continuity, to follow-up the user's case. Moreover, in fact, the work of this mental health team resembles the matrixing teams, even if the focus is to reduce processes that judicialize health demands, since it requires continuous/recurrent and deep movements in relationships with the reference services.

Therefore, this team, whose work object is the user, triggers the workers to think and to execute strategies that enable the continuation of care to the user in the specialized services, in partnership with the itinerant team:

> *[...] It is the CAPS' attribution, a higher responsibility, yes, but if the itinerant was created in order to reduce the judicialization, then it is not only for new cases, not only bringing to the reception, it is to bring to the 'rehost', to think together with CAPS the care of that user, which is a guide to, finally, think of ways and strategies to avoid that this family will soon enter a process [...] (T03).*

The psychosocial care centers (CAPS) are constantly referenced by the staff of the itinerant team, especially because these devices are the main components of the specialized network of mental health care. However, it is necessary to be attentive and to perform other institutional partnerships, inside and outside the health sector.

In this sense, the Brazilian mental health reform process highlights the network as an important conceptual operator of changes and predicts that care actions need to be performed in networks. Therefore, the psychosocial model of mental health care highlights the formal and informal

networks of individuals and family as guiding for the community-centered care[9].

Thus, it is understood that the unfolding of the team's work process should be guided to the construction of care networks, expanding beyond the CAPS. And, although the CAPS is the reference for drawing the drug user care trajectories for services, the itinerant team must pay attention to the principles of network articulation that are based on reformist assumptions, always appreciating dialogue and shared work with different community-based services, as the following testimony points out:

> *[...] It does not make much sense an itinerant team's work that is only punctual, that is only marked by the relationship with the legal sector. It seems to me that it would have almost no relationship to care, something very far away. So I guess trying to get closer and making that relationship with the service, trying to think as a team that in some ways is an attachment of each CAPS, I think the possibilities are very different, the care is very different [...] (T02).*

Mental health care interventions for drug users require intersectoral follow-up, involving education, health, justice, social assistance, non-governmental organizations, and others. As this work is complex and mutant, to insert the user is to always be accompanying and doing a collective work in search of new pleasures and satisfactions that can replace what drugs and trafficking provide for the individual[10].

Thus, the itinerant team's work brings wealth to the local mental health policies, since it enables the constant meeting of health workers with users in their living spaces, in their territory. However, in relation to the role of this service, there are divergences of conceptions, mainly in relation to technical responsibilities. The team seems to be clear that the object of health work is the user, but ends up making the CAPS responsible for this care, such as for specialized services:

> *[...] I understand that it is an assignment of the CAPS, to work with this family and this awareness [...] to build these other forms of care with this family and the mark that a psychiatric hospitalization remains for a 15-year-old boy, this is an assignment of the CAPS in my understanding [...] (T01).*

> *[...] Our proposal for mental health care is the CAPS, it is the care in the territory [...] it implies relationship, continuity of care, several values, principles that we understand that a CAPS team has more possibility to do, considering that the itinerant team will do something more precise, to access that user, to make an intervention, to evaluate according to the request of the process, to respond and will not continue that care [...] itinerant will focus on the legal issue [...] (T02).*

Therefore, the care does not seem to be a function of the itinerant team, but rather of the reference services, since the team must respond to health legal proceedings. According to T01, for example, it is the responsibility of the reference service to take care of the user and the family, creating relationship strategies in the services. Therefore, to carry out the care of the user, the workers understand that it requires contractuality, continuity, longitudinality, and other characteristics that CAPS offers with full ownership.

In the health field, concepts such as interdisciplinarity, completeness, territoriality, networking and social incentive to participation are part of the public policy agenda. Thus, preventive and health promotion actions take into account the complexity of care that is everyone's responsibility, and each worker/service must find his place in this network[11].

Here is an interesting question in relation to the itinerant team: its place in this network is to dialogue with the judiciary sector, promoting the care of the user in this sector:

> *[...] I think it depends, if you want to follow-up the therapy of the user's treatment, maybe if you want to be a part of this therapy, it may not be the time to work on the itinerant, but if you want to participate and take care of this user along with the judiciary. Sometimes are details of answers, [...] are subtleties that are another way of caring, you know, that is to show to this person that also has other ways [...] (T01).*

The role of the worker in the team is not a continuation of the actions directed to the user, but to propose other ways of care along with the judiciary sector. It is a great technical exercise of articulation, in order to avoid only the operational work of responding to the demands of the judiciary. It should be noted that the judiciary is part of the network of mental health care and the search for this service is also to find treatment measures.

The work in the itinerant team is challenging, because it is something new, being expected doubts regarding the work in this differentiated composition. Thus, the constant discussion about intra- and intersectoral articulation strategies, facing the communication difficulties, besides the role of workers in this scenario, brings new possibilities for producing mental health practices articulated with local reality.

Care technologies in the work object of the mental health itinerant team

To discuss the technologies of the work process, it is necessary to understand that these are not only equipment/instruments/tools involved in the actions, but a technological know-how and a *modus operandi* that gives sense to what will or will not be the "instrumental reason" of the equipment(12).

It is necessary to know how to use the technologies of work and to be clear what the aim of its use, and what its purpose. This is because it is not enough to know how to use the technical instruments, but it is necessary to know how to operate in order to perform interventions aimed at integrality in health. Thus, the working tools used by the itinerant team in the care of drug users are: Referral guidelines, home visit and psychiatric internment.

Referral guidelines

The referral guideline originated from an agreement between the health and judiciary sectors. The Public Prosecutor's Office directs the user to the mental health services to be hosted and accompanied through the referred guideline. This is a way of making the health sector responsible for care, avoiding the opening of legal proceedings.

In the referral guideline are described: guide number, issuer (public defender) and the recipient (Municipal Secretariat of Health). The service name may or may not appear in the guideline. The subject is also present, which often is evaluation and treatment in mental health. Finally, an orientation to the mental health service to inform the Public Defender in spite of the care and the performed conducts.

The referral guideline is an important working tool for the mental health services and the itinerant team, since they can avoid health judicialization processes (such as compulsory hospitalizations) and promote the rational use of therapeutic actions available in the municipality:

> *[...] guidelines are not lawsuits, they are different things, the guides seem to be something as a control, of a care in the sense that mental health takes more responsibility for its demands, not that it did not take responsibility before, but the intention is to be more focused, closer and more affectionate, avoiding the creation of lawsuits [...] (T02).*

> *[...] The guideline will bring a monitoring along with the Public Prosecutor's Office. It would be something that usually says that would be done before a process, I think also in terms of service management, the guide costs far less to the municipality than an open lawsuit here, which generates a lot of cost whereas the guideline does not. In terms of care, I think the guideline also makes it easier for us to have a monitoring and a closer or maybe even more qualified approach [...] (T03).*

This tool helps families to know about the mental health services available to care for the drug user, since many people do not identify them as a space for health care. Thus, the judiciary sector becomes a gateway to promote care, while also promoting the dissemination of mental health services to the community.

The implementation of the referral guideline facilitated the networking in a more logical and effective way, avoiding the opening of onerous lawsuits to the public sector. It is considered that this articulation responds to a need to improve care management, making the network to move, because it has become an enforceable judicial decision in an active problematization artifice for the care of the user. However, on the other side of this articulation is the family of the drug user, who receives the guideline and needs to follow-up that flow.

In the studied municipality, this family's co-responsibility flow comprises the following process: the family searches for the judiciary system and receives the referral guideline. Then, they must activate the health system. From the moment the guideline arrives at the referral service (usually a CAPS), professionals need to create strategies to link the user to the service, and if the referral service cannot perform the user's insertion, the itinerant team should perform the active search of the user and the family.

However, eventually, this becomes an additional charge to the family member to take more responsibility for care:

> *[...] The worker says she paid a visit to the [name of the young woman], a drug user, and said that her mother said she would bring the girl to the service. She notes her mother did not know how the guidelines worked, she said she thought she was going to help her daughter, but that she realizes a big charge for the girl to do the treatment in the service. Moreover, the mother states that she cannot take her daughter because she does not accept treatment and needs to work [...] (DC).*

Many families, unknowingly dealing with the issue of drug use, seek the judiciary sector to solve the problem, but depending on the family member's exhaustion, the family member may not want to get involved in the care. This issue has already been debated in some studies[13-15], which bring not only the lack of involvement of the fami-

ly member, a partner in this process, but also the need to relativize this responsibility, since drug use is a complex phenomenon, brings important repercussions on family functioning, besides suffering, overloading of care and emotional exhaustion.

Family participation in treatment is very important and is well received by workers, but some health care workers tend to make family members responsible for care. Thus, it is necessary to invest in debates to prevent the success of therapy from being put in charge of such participation, as this could give the family extra responsibility for successes or failures in interventions[16].

Thereby, professionals put themselves in a resigned position that they "did their best" and may end up transferring the responsibility for therapy failure in family. When transferring the responsibility to the family, they form a circuit that begins and ends in the team, since the workers blame the family for their withdrawal from the therapy, but are implicitly blamed for the lack of knowledge and care of this same family unit[16].

Faced with this situation, many families may request the cancellation of the referral guideline, so there are no additional pressures from the health teams. Therefore, it is considered necessary and crucial to dimension the qualitative issues that contemplate the singularity of each situation, in order to not hamper the workflow and to bring the family as a true partner for the treatment, considering its difficulties, potentialities and limitations.

Home visit

The home visit is a working tool that reveals a universe of information about the user and their living conditions, enabling the worker to interact in the family and social environment, knowing their daily life, culture, beliefs and customs. This tool provides enriching experiences for workers, users and families[17].

In the context of the itinerant team, the home visit is the first contact between workers, users and family members, an arrangement whose result should be based on a therapeutic intervention that responds to the judiciary, but which also brings more precise answers to the user or family problems. The itinerant team understands that the home visit should be in conjunction with the reference service workers, e.g. the CAPS AD, and there is a great effort of the workers involved in this regard:

> *[...] I think it is very valuable when you can go until the user, you know, and this is what we have brought more and more to CAPS. Well, we go to the user, we know the context in loco of his situation, I think the house, the place where the person lives says a lot from him too [...] (T03).*
> *[...] [elderly's name] is elderly caregiver of the mother who has Alzheimer's and the child who is a drug user and has tuberculosis, without clinical treatment. The case of the [elderly's name] arrived for the itinerant team as a request for psychological and clinical evaluation for her mother, but when we go to the family home, she reports that she wants to take her mother to a nursing home, because she is tired taking care of her and her son. [elderly's name] reported on the first visit that has already filed a legal proceeding for treatment and hospitalization of the child too [...] (DC).*

It is possible to realize that, besides the legal proceeding, the importance of the relationship construction, the hosting relation, the aid and the respect to the subject and its history of life is made possible. Thus, the scenario of a home visit is challenging, since delicate life situations are evidenced, demanding sensitivity, care and attention of the workers. In the home visit, the knowledge of the user and the family is performed, making it possible to strengthen relationships among all the involved subjects and to construct therapeutic plans that will meet the reality of people's lives. For the professional, it is possible to seek for the prevention, promotion, care and rehabilitation of diseases and injuries[17].

However, there is a dilemma with the itinerant team. The fact of representing two sectors (health and judiciary) seems to interfere in the meeting time between the worker and the user. Getting to the home of an individual with a legal proceeding can also generate yearning and mistrust. The visit to the home of a user exemplifies this situation a little:

> *[...] A professional of the itinerant team arrives from a home visit, held in conjunction with the infant CAPS, and begins to tell how was the intervention with a teenager. The legal proceeding was moved by the boy's mother. On arriving at the boy's house, the mother and him were fighting, and when the young man saw the team ran into the bathroom and locked himself [...] (DC).*

The challenges of the team become higher, because workers need to mediate situations of family conflict and build a communication bridge with users and the family in favor of care, while expecting that the union of the health and judiciary sectors can actually contribute to diminish fears and mistrust. It is observed the need of health and justice teams to discuss the image present in society in relation to the judicial sector, which can delegate and order, but can also be a possible supporter in care.

Psychiatric internment

Historical roots point to psychiatric internment as a care modality in mental health. From the Pinelian origins, internment is observed as a possibility to better understand the process of development of mental illness[18]. Much questioned currently, with the restructuring of the assistance from the reformist principles and, especially, when performed in the psychiatric hospital, the psychiatric internment in psychiatric hospitals was also used as a device of punishment and incarceration.

In Brazil, psychiatric internment had its regulation revised with Law 10,216 of 2001. This can be of three types: voluntary internment, with the consent of the user; involuntary internment, without the consent of the user and requested by third parties, such as the family; and compulsory internment, determined by Justice. In the latter case, compulsory internment must be approved by the judicial authority, when requested by the health team, and cannot be configured as long-term internment.

In the case of the municipality, the itinerant team faces daily requests for compulsory internment, also bringing challenges to the workers, because they are usually requested by family members who seek a *priori* the judiciary:

> *[...] I think it's in the matter that you can actually think, you know it will be good for this user [...] it's very good when you realize that you can offer something that really comes to meet people's health, because you take a person tied to the hospital without this need, I do not believe that this can be therapeutic [...] (T01).*

In this sense, the municipality has a very peculiar construction regarding the use of psychiatric internment as a technology of mental health care. In a study performed in the same municipality, it was observed the concern of mental health management to guarantee other modes of out-of-hospital care, leaving internment as the last alternative to be performed and, when necessary, conditioned to a rigorous assessment by CAPS workers[19].

Incorporating this functioning logic, the itinerant team is in the dilemma between recognizing the necessity of internment based on the exhaustion of other care possibilities in the network and, on the other hand, the difficulty of accessing this modality of care against the unavailability of bed and infrastructure.

Thus, what brought most reflections to the team is to admit that "internment is part of the care" for themselves and for the network. This, in the course of professional practice, faces the network barriers:

> *[...] It is always very difficult for the team when we realize that, no, this person needs to be interned! For the teams as a whole, for the itinerant, for CAPS [...]. It has arrived at a certain user, if I was not mistaken, it was from CAPSi, it has drawn the conclusion that such teenager needed to be interned, and then you will make contact, articulate the network and did not find vacancy in the hospital of the city, and there what will you do? [...] (T03).*

In this way, it is necessary to look at internment as a care tool that, if well used, brings benefits to the users, being necessary to remove the fear of considering any internment as a punitive measure, even when they come from the judiciary. The itinerant team, as observed in the speeches, has pointed out its concern regarding the spaces of discussion for not performing internment in an iatrogenic way, and without careful evaluation from the involved network workers.

On the other hand, the team has difficulty to access the network when there is a need to perform a psychiatric internment. Here are shown some gaps, among them the difficulty of obtaining a psychiatric bed in the general hospital of the municipality and the availability of an ambulance to conduct the user to the health service.

These difficulties are anxiogenic to the workers from the itinerant team, and unnecessarily expose the drug user and his family. Some studies already point out this issue[20-21]. Therefore, in order to perform network movements, the participation of all workers involved in care, whether in the health sector or in other sectors, should be encouraged.

CONCLUSION

The workers identify the user as work object and the purpose, for some participants, is the care as a therapeutic action, being the response to the Public Prosecutor's Office a consequence of actions that may promote a decrease in the opening of new legal proceedings. In the face of this conception, the team itself proposes the use of technological tools that allow us to analyze the work process, always taking into consideration its role in the construction of care and network arrangements.

The referral guideline, while one of these work instruments, was created by the mental health management of the municipality and is something innovative in the practice of health, but it is necessary to know how to use it without transferring to the family a responsibility of care that is mainly from the health team.

In the case of the home visit, it is pointed to the emergence of delicate life situations, requiring greater participa-

tion of the itinerant team in the mediation of conflicts and meeting of solutions in partnership.

Regarding psychiatric internment, within the shelf of the itinerant team, it is important to emphasize that it should be perceived as a possibility of treatment in the care, so that the team has guaranteed access to the beds in general hospitals, when necessary, in order to provide movements in the network.

Finally, as an innovation in the context of mental health, the itinerant team has brought concrete possibilities for reinventing care, where sharing experiences is fundamental and reinforce the urgency of intersectoral partnerships in the field of mental health.

Despite the importance of the study to understand locoregional reality, one of the limitations is that it is not possible to compare other similar experiences, with which we could have greater subsidies to understand and analyze the work processes. Thus, we suggest new studies that address the work process in the field of mental health, especially analyzing how these innovative experiences actually materialize in the daily life of care practices.

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