ISSN-e [2675-5602]

Global Academic Nursing Journal

ESSAY

Attention to mental health crisis: a theoretical essay

Atención a las crisis de salud mental: un ensayo teórico

Atenção à crise em saúde mental: um ensaio teórico

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How to cite this article:
Souza CNB, Silva GS, Oliveira RMP, Silva BP. Attention to mental health crisis: a theoretical essay. Glob Acad Nurs. 2026;7(1):e538. https://dx.doi.org/10.5935/2675-5602.20200538

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Submission: 01-31-2026
Approval: 03-18-2026

Abstract

The paradigm shift from the psychiatric, asylum-based medical model to the psychosocial care model, centered on the person and the guarantee of their rights, supports the creation of the Psychosocial Care Network, comprised of various care devices, including Psychosocial Care Centers, aiming for comprehensive care for users through community-based and territorial care. Given this paradigmatic shift, considering the concept of crisis becomes fundamental, since there are divergences among professionals and services regarding the definition of what constitutes a mental health crisis and the most appropriate forms of management. Given this scope, this qualitative theoretical essay aims to analyze attention to mental health crises in psychosocial care services and other points of care within the Psychosocial Care Network, guided by the Brazilian National Mental Health Policy. This is a theoretical essay supported by consistent authorial argumentation regarding the phenomenon under study.

Descriptors: Crisis; Mental Health; Psychiatric Reform; Psychosocial Care; SUS; Territory.

Resumén

El cambio de paradigma del modelo psiquiátrico y hospitalario al modelo de atención psicosocial, centrado en la persona y la garantía de sus derechos, impulsa la creación de la Red de Atención Psicosocial, integrada por diversos dispositivos asistenciales, incluidos los Centros de Atención Psicosocial, con el objetivo de brindar una atención integral a los usuarios mediante servicios comunitarios y territoriales. Ante este cambio de paradigma, resulta fundamental considerar el concepto de crisis, dado que existen divergencias entre profesionales y servicios respecto a la definición de lo que constituye una crisis de salud mental y las formas de manejo más apropiadas. En este contexto, este ensayo teórico cualitativo analiza la atención a las crisis de salud mental en los servicios de atención psicosocial y otros puntos de atención dentro de la Red de Atención Psicosocial, guiados por la Política Nacional de Salud Mental de Brasil. Este ensayo teórico se sustenta en una argumentación coherente del autor sobre el fenómeno estudiado.

Descriptores: Crisis; Salud mental; Reforma Psiquiátrica; Atención Psicosocial; SUS; Territorio.

Resumo

A mudança de paradigma do modelo médico psiquiátrico, manicomial, para o modelo de atenção psicossocial, centrado na pessoa e na garantia de seus direitos, sustenta a criação da Rede de Atenção Psicossocial constituída por diversos dispositivos de cuidado, e dentro deles os Centros de Atenção Psicossocial, visando uma atenção integral dos usuários por meio de um cuidado de base comunitária e territorial. Dada essa mudança paradigmática, pensar o conceito de crise torna-se fundamental, visto que há divergências entre profissionais e serviços quanto à definição do que seja crise em saúde mental e às formas de manejo mais adequadas. Dado o escopo, este ensaio teórico de abordagem qualitativa tem por objetivo geral analisar a atenção à crise em saúde mental nos serviços de atenção psicossocial e nos demais pontos de atenção da Rede de Atenção Psicossocial norteada pela Política Nacional de Saúde Mental brasileira. Trata-se de um ensaio teórico sustentado por argumentação autoral e consistente acerca do fenômeno de estudo.

Descritores: Crise; Saúde Mental; Reforma Psiquiátrica; Atenção Psicossocial; SUS; Território.

Introduction

The National Mental Health Policy (PNSM), derived from the Brazilian Sanitary and Psychiatric Reforms (RPB), is supported by Law No. 10,216 of 2001[1], which guarantees protection and rights to people with mental disorders and redirects the model of mental health care, previously medical-psychiatric (asylum-based), man-hospital model, to a psychosocial care model, based on care in freedom, centered on the person and the guarantee of their rights (Table 1).

Chart 1. Models (modes) of care in mental health. Brasília, DF, Brazil, 2025

Features	**Psychiatric medical model** (asylum model)	**Psychosocial care model** (psychosocial approach)
Object	A sick individual - detached from family and society.	A person seen in all their dimensions - the right to a voice. Biological, psychological, social, political, and cultural aspects.
Instruments	Medication - primary treatment for the disease. Medical-psychiatric care. Removal or suppression of symptoms. Pyramidal or vertical care - from the apex to the base.	Work activities, leisure, cooperative workshops, etc. Community service, interdisciplinary team. Horizontal service, subverting the pyramidal or vertical structure.
Purposes	Healing. Normalization.	Social reintegration. Autonomy.

Source: Silva, 2022[2]. Structured from Costa-Rosa, A. The Psychosocial Mode: a paradigm of practices that substitute the asylum model. In: Amarante, P. (org.). Essays: subjectivity, mental health, society [online]. Rio de Janeiro: Editora Fiocruz; 2000. Collection Madness & Civilization. pp. 141-168.

Models with opposing foundations and actions. And, with this paradigm shift, the Psychosocial Care Network (RAPS) emerges, consisting of various care devices, including the Psychosocial Care Centers (CAPS), aiming for comprehensive care for users through community-based and territorial care[3].

Thus, this care has prioritized social reintegration, user empowerment, bonding, and networking. Within this framework, at least in legal terms, mental health service users, previously stigmatized and excluded, have regained visibility and a sense of humanity.

> *"The goal is to consolidate a diversified, integrated, open, and community-based model of mental health care, whose actions are organized into territorial care networks and work across different sectors to establish bonds and provide support in various spaces within the territory, such as the primary health care unit itself, people's homes, community spaces, and schools"[4:40].*

In analogy to other chronic health conditions, mental disorders, as well as problematic alcohol and other drug use, present seasonal episodes of crisis. According to Dattilio et al.[5], crises have accompanied civilization since the time when human beings began to inhabit the earth, and the term generally evokes many negative life events.

The concept of crisis, particularly in psychosocial care and regarding psychiatric emergencies, still faces differing understandings among various professionals, including those working in mental health. This results in disjointed care for users across different points and healthcare settings. This is because, unlike other forms of illness, mental disorders operate within the complex field of human subjectivity, where available protocols are insufficient and often lead to a lack of assistance in many services. In this context, the Psychosocial Care Network (RAPS) in any territory needs to be fundamentally structured, with qualified multidisciplinary services and assistance, to support psychiatric emergencies and provide users with crisis care as advocated by the current National Mental Health Policy (PNSM) in accordance with its various legal instruments[3].

> *"Building consensus between the logics of urgency and crisis highlights the need to overcome the biomedical model through the articulation of different knowledge and practices and the incorporation of the multiple dimensions contained in these phenomena. Training and, above all, continuing education processes in health for workers who experience the care of crisis and emergency situations are strategic for this articulation and demand joint and continuous efforts from the different levels of management of the system"[6:55].*

The terms crisis, emergency, and psychiatric urgency are often used synonymously. In this context, this essay aims to describe and discuss mental health crisis care in Brazil, starting from the premise that, according to the current National Mental Health Policy (PNSM), this care must primarily occur within the community, supported by family and community resources, and that this assistance should be guided by the guarantee of rights, not their exclusion.

However, this requires a description and discussion of what constitutes a mental health crisis and psychosocial care at the national level to overcome challenges and build pathways so that the municipality, the territory where the researchers of this work operate, can also benefit and offer mental health care grounded in a theoretical perspective applied to the local and regional reality.

Methodology

This is a theoretical essay supported by consistent, original argumentation regarding the phenomenon under study. The methodological approach is based on description, discussion, and logical and dialectical conceptual analysis, in a critical dialogue between the literature on psychoanalytic rehabilitation, mental health, and psychosocial care concerning the phenomenon of crisis.

The Virtual Health Library (VHL), a scientific portal with technical and scientific output from Latin America and the Caribbean, was the main informational resource used to retrieve texts on the topic of this essay. Its selection allowed for a more focused search of Brazilian publications. The retrieved texts were used in writing this essay, along with

seminal texts in the field of mental health and psychosocial care.

For the purpose of organizing the search and retrieval of texts, the PIO[7] strategy was used, in which the problem (P) corresponds to the concept of crisis in mental health; the interest (I) refers to attention to crisis in mental health; and the outcome (O) consists of contributing to and strengthening the debate for a care practice in mental health supported by a theoretical perspective with application to the local and regional reality.

The retrieved texts were read dialogically, allowing for theoretical description, discussion, and logical conceptual analysis of the phenomenon studied. The argumentative structure characterized the current scenario by establishing causal and theoretical links to explain the dynamics of the phenomenon studied and to analyze attention to mental health crises in psychosocial care services and other points of care within the Psychosocial Care Network (RAPS), guided by the National Mental Health Policy (PNSM).

Results and Discussion

The Historical Trajectory of the Gaze Upon Madness

According to Fialho[6], the concept of Madness and the various proposals for its approach were constructed historically and socially over centuries, varying according to the temporal, social and cultural context. The historical trajectory of madness from its origins to the promulgation of the RPB Law is marked by intense struggles and militant movements that spanned different historical periods.

In this sense, social crises, such as wars, revolutions, and advances in scientific knowledge in the field of health have exerted significant influences on the emergence of these transformations in the field of mental health. As Nunes et al.[8] state, historical precedents show that society's own conception of madness tends to change during periods of crisis.

In ancient times, mental illness was believed to be caused by supernatural phenomena such as possession and divine punishment. According to Melo and Veloso[9:12], "[...] this phenomenon was not always called madness. Before the 15th century, it was understood as possession, and people considered 'mad' circulated through the cities imbued with a sacred character." These authors emphasize that, during this period, the figure of the madman in urban centers was common, and they were seen as beings blessed or cursed by the gods.

This scenario began to change around the 16th century, when madness became associated with social disorder. From the 17th century onwards, the isolation of people considered insane - "madmen," the unemployed, beggars, and "vagrants" - intensified through the internment of those deemed unproductive, driven by the belief that this practice would cure them to the point of making them functional again. However, in the following two centuries, with the emergence of psychiatry as a medical specialty, the perspective on madness adopted a new paradigm, as mentioned by Melo and Veloso[9:153]:

> *"The 19th century was a time marked by the emergence of the asylum as a place dedicated to treating mental alienation, as classified by Pinel. Furthermore, with the advent of the natural sciences, the prevailing understanding of that era found coherence in brain structures to conceive of madness as a "mental illness".*

According to these authors, during this period, institutionalization gained moral, therapeutic, and epistemological legitimacy through the perception of control over people in psychic crisis. According to Fialho[6], the 20th century was marked by the expansion of asylums, which were increasingly overcrowded during a critical post-World War II period. Here, the view of these people as subjects of rights began very gradually, and asylums came to be compared to Nazi concentration camps, causing social discomfort, in contrast to the large number of young people who had survived the war with serious psychological damage. These situations made mental health a fertile ground for the emergence of new paradigms on the world stage, opposing the hospital-centric model and seeking transformations in the concepts and ways of dealing with madness. With this, a movement called anti-psychiatry began, mainly in Europe, which would culminate years later in the RPB (Revolutionary Psychological Movement).

The manifestations of the Brazilian Anti-Asylum Movement (RPB) began in the 1970s. This movement was directly associated with the political context experienced by the country, marked by the process of redemocratization. Furthermore, it was influenced by transformations in care practices developed in Europe, especially in Italy, as well as by the studies of Basaglia and collaborators. Boni et al.[10:10,11] state that "[...] an important characteristic of the anti-asylum movement in Brazil was to highlight the violent nature of the asylum model, in relation to users and human rights, and its inability to serve the care of people with mental suffering." Also driven by the Brazilian Sanitary Reform movement, the debate on changing the care model progressively strengthened in the national context.

Currently, the approach to mental illness is framed within a legal framework based on the principles of care in freedom, with a territorial focus and the support of a care network. This framework proposes the end of asylums as a form of crisis care, enabling the extension of users' rights, aiming at the reconstruction of their citizenship and social reintegration. Over the last 20 years, this law has brought significant progress, with a substantial reduction in asylum-based care, expanding the alternative network of mental health services and psychosocial care. As Moreira and Kyrillos Neto[11] state, this new model aims to articulate this psychosocial care network with a view to the social inclusion of the user, facilitating their connection with family and society through outpatient treatment and resocialization activities, with the CAPS (Psychosocial Care Center) at the center of this network as the main articulator of care.

In this sense, it is fundamental to point out that the focus on individuals experiencing mental distress must be on recognizing them as subjects of rights and responsibilities, protagonists of their own history. These are individuals who need to be cared for in freedom, within their own territory,

with dignity and respect for their fundamental rights. From this perspective, it is important to reflect on the role of alternative services within the Psychosocial Care Network (RAPS) in the face of mental health crises, in their interaction with territorial and community-based care, as foreseen in Brazilian legal instruments, laws, and regulations.

Conceptions of Crisis in Dispute

Currently, the definition of a mental health crisis remains a field of intense conceptual debate. This is because, for some authors who defend the biomedical model, this crisis is directly associated with the signs and symptoms of people experiencing emotional imbalances and psychotic episodes. Consequently, this view imposes a bias of dangerousness on the person in crisis. In contrast, the psychosocial care model proposes a break with this logic, understanding the crisis as a moment of profound subjectivity and an opportunity to reorganize the subject's existence within their own territory, as Amarante points out[12:82,83]:

> *"Addressing a crisis represents one of the most difficult and strategic aspects. In the classic model of psychiatry, a crisis is understood as a situation of serious dysfunction that occurs exclusively as a result of illness. [...] In contrast, in the context of mental health and psychosocial care, a crisis is understood as the result of a series of factors involving third parties, whether family members, neighbors, friends, or even strangers. [...] In short, a situation that is more social than purely biological or psychological. For this reason, it is also a social process".*

However, it is necessary to reflect on the significant theoretical and practical divergences surrounding crisis care in mental health and how to manage them in the services of the Psychosocial Care Network (RAPS) and in the various points of the intersectoral network, where there is still an antagonistic tension regarding the existence and/or permanence, or even the combination of these very divergent care models: captive care and/or liberated care, the asylum and/or the community, the biomedical and/or the biopsychosocial. This dichotomy is still challenging and subject to social resistance, demanding a theoretical framework and a sense of humanity from those who address it.

> *"[...] attention to crisis takes on special significance as it proposes new terminologies, strategies, changes in institutional organization and care practices, in contrast to a set of discourses and practices produced and addressed within psychiatric hospitals. A mental health crisis corresponds to psychiatric cases considered acute, with reference to the intensity, frequency, and severity of symptoms, in a historical correspondence between severity, dangerousness, and psychiatric hospitalization. In this sense, the acute nature, the notion of risk, the need for immediate intervention, and severity define the institutional space of care"[13:596].*

Therefore, understanding that there are different crises within their different paradigms is complex, but fundamental for providing biopsychosocial care. According to Dias[13:596], "[...] attention to mental health crises is the name given to a set of care practices developed within the community-based care model and carried out with users in situations considered acute and severe".

Another aspect to be considered is that psychiatry and the biomedical model still influence the care and attention given to mental health crises, even in current psychosocial rehabilitation settings, where crises continue to be associated with various diagnoses and signs and symptoms. Coutinho et al.[14:2] emphasize that "the health team, users, and their families do not always agree on what constitutes a crisis, nor on the proposed interventions at that specific moment.

In this context, a family member arrives at the service requesting intervention for a user in crisis. However, when the team provides care, they identify that the user is actually suffering from a family conflict, or the team attends to the user, but the doctor does not see the individual in crisis. Furthermore, there are numerous early referrals from Primary Health Care Units (PHCUs) to CAPS (Psychosocial Care Centers) for crisis intervention, but the teams fail to identify the urgency initially reported.

This misalignment between services and different professionals in their perception of this crisis speaks volumes about the intertwining of management and professionals in understanding the topic, not as a personal interest, but as a way of appropriating their work subject and reflecting this in providing qualified care within the framework of the Brazilian Unified Health System (SUS). It is not expected that family members and/or caregivers will master the topic with dexterity, but that the teams and services providing care are definitely minimally prepared to address this condition. However, in practice, what has been observed are services within the Psychosocial Care Network (RAPS) that are not familiar with the subject matter and lack the necessary ethical detachment from their personal projections. Because of this, practices that contradict those proposed in the National Mental Health Policy (PNSM), such as freedom or isolation for these cases, still prevail.

It is further emphasized that in a mental health crisis, the individual's subjective maladjustment is not resolved solely by stabilizing signs and symptoms, and should not occur only within the scope of CAPS (Psychosocial Care Centers), since intervention at the core of the individual's psychic suffering becomes imperative for effective and comprehensive care. Therefore, managing a mental health crisis is a process of negotiating meanings. For care to be effective, it is necessary to align what each party understands by "crisis" to avoid both negligence and unnecessary medicalization of social or family problems. That is to say, a mental health crisis is not just a medical act.

However, these disputes regarding the management of mental health crises have led to a contradictory element concerning the centrality of the user. If, on the one hand, this crisis in the biomedical model centers care on signs, symptoms, and their exacerbation, prioritizing a diagnosis over the person and a potential for risk and dangerousness, causing assistance for these cases to be relegated to various forms of restraint and hospitalizations; on the other hand, in psychosocial care, it is understood as a complex phenomenon of rupture derived from the biopsychosocial issues of the individual, whose direction of care implies welcoming, bonding, and an

Individual Therapeutic Project (ITP) in freedom, aiming to avoid the chronicity of the illness and the person at the moment they find themselves.

Thus, in this battle of egos, the individual who previously had rights continues to be socially excluded, perceiving that everyone knows what is best for them except themselves. In this way, yet another person remains socially invisible and loses their status as a citizen. For the user, this process also becomes a struggle for dignified healthcare, like any other illness, for autonomy, for social spaces, for acceptance and freedom, not only of the body but also of choices, and for validation of how they express their desire to be cared for.

In this context, it is worth reflecting on the need to broaden and reconcile the subjective care of the person with the objective care of their lives, understanding that the causes of a mental health crisis involve subjective issues linked to daily objective issues, which can be interpreted from basic rights such as food, housing and freedom, to the provision of sufficient and adequate spaces for their mental health care and how this is absorbed by people and transformed into daily suffering. However, it is important to point out that effective attention to mental health crises demands an evolution in the thinking of professionals in their respective services regarding mental health as a public policy. This requires complex and creative approaches to this attention, and this will be promoted through continuous and concrete spaces for continuing education that foster the reorganization of the Health Care Network (RAS), with emphasis here on the Psychosocial Care Network (RAPS), based on the territorial conditions of each region. This aims to find the best way to manage cases, especially when there is an incomplete substitute network with incongruities in intervention, and to expand and strengthen the care network to overcome fragmented care within the RAPS. This can be achieved through the matrix support and articulation of cases between the different levels of health care that the person goes through, such as CAPS (Psychosocial Care Centers), General Hospitals, and UBSs (Basic Health Units), promoting continuity of care and preventing future crises, with priority given to recurrent cases.

Weaknesses of the Psychosocial Care Network in Crisis Management

The Unified Health System (SUS), according to its legislation, is organized so that its services are provided in a regionalized manner. To this end, this policy is established within territories through care networks, which aim to provide comprehensive care in the person's area of origin, through the coordination and direction of this health care[15]. Currently, the Health Care Networks (RAS) of the SUS (Brazilian Unified Health System) are comprised of the Alyne Network, the Emergency and Urgent Care Network (RUE), the Psychosocial Care Network (RAPS), the Care Network for People with Disabilities, and the Health Care Network for People with Chronic Diseases[16].

In this operational logic, the networks fulfill the function of organizing healthcare by segments, but their integration is fundamental for comprehensive care to occur. Thus, it is understood that they can operate in different ways, where some tend to be closer to people's lives, and others not so much, and that it is in the most complex scenarios, such as in a mental health crisis, that these networks, through their territories, are required to provide equally complex and creative responses to different cases.

Therefore, one point to highlight regarding this mental health crisis care is networking. It is fundamental that there is understanding and consensus that the level of complexity of mental health work exists and requires shared action among various public policies, since the exclusive action of CAPS (Psychosocial Care Centers) is not sufficient to provide this care with the quality that a mental health crisis demands.

> *"The premise is that there is no single piece of equipment or even a healthcare team considered self-sufficient in providing care. Due to the high complexity of health problems, generally involving various fields of knowledge, the inherent interdisciplinarity of health issues, and the multiplicity of social actors involved in management and care, networks become a prerequisite for their functioning, and are therefore inherent to work focused on healthcare"*[17:254].

However, what is observed in the laws and regulations contradicts the practice of providing isolated care, with teams and services offering fragmented assistance and responses disconnected from a network-based approach. Following this logic, Onocko-Campos et al.[18] corroborate that chronic underfunding and weaknesses in the management of the Psychosocial Care Network (RAPS) accentuate the structural limitations of the services, hindering the consolidation of territorial care that is truly effective and comprehensive.

In turn, valuing professionals and teams, whether through decent salaries, training, and supportive spaces for caregivers, needs to be a key point, as it also highlights the weaknesses of this network. It must be said that being a caregiver in the context of mental health involves many personal challenges and struggles for professionals. In their daily work, staff members become ill and often suffer psychologically due to the complexity required for that care, and, working directly in the SUS (Brazilian Public Health System), they do not always - just like users in crisis - receive prompt care. The lack of targeted assistance for caregivers during their own illnesses results in neglect and prejudice not only towards mental health service users but also towards professional caregivers.

Another aspect is the dichotomy that translates into different network arrangements, even within the RAPS (Psychosocial Care Network), with one model being decentralized and territorial, and the other being centralized and hospital-centric with residual practices. The first, ideal for psychosocial care, where crisis management should be prioritized in territorially based substitute services, such as CAPS (Psychosocial Care Centers), including their inpatient beds (CAPS III), where care begins and continues as much as possible within the user's territory, with hospital backup in a General Hospital only for cases of extreme need and for a short time. The CAPS acts as the coordinator of care, and this system self-regulates through the shared PTS (Therapeutic

Project) and the articulation of the RAPS points. In the second model, there is a difficulty or denial of the capacity of substitute services (CAPS, APS) to manage the crisis, and this is displaced to the emergency and urgent care network (General Hospitals, emergency services) or even to the psychiatric hospital (although this should be progressively replaced), which becomes the main place of attention for the crisis. The system is regulated by the availability of inpatient beds, and care becomes less linked to the territory.

> *"Given this, the topic of crisis intervention is an area with contradictions: on the one hand, mental health is structured based on frameworks guided by inclusion, bonding, knowledge of the subject's history and contexts, valuing subjective aspects, and respecting the temporality of the crisis. On the other hand, in the emergency sector, objectivity and pragmatism of punctual interventions predominate, including the optimization of time spent and equipment for the intervention. Similarly, the emergency and urgent care area develops the technical formalization of its practices, especially in the form of protocols. In the psychosocial approach, the singularity of interventions is prioritized based on the evaluation of each case"*[13:596].

Thus, these theoretical and practical divergences generate impacts on the Psychosocial Care Network (RAPS) and on care, and are especially evident in crisis management, generating conflicts between the ideal and the actual, and are reflected in the way mental health services handle these crises. Ordinance No. 3,088/2011[3] stipulates that the ideal role of the CAPS (Psychosocial Care Center) is to be the focal point and coordinator of care during a crisis, offering intensive support and daytime care, and nighttime care in the case of CAPS III, to avoid hospitalization. However, the difficulty in maintaining 24-hour care, especially in CAPS I and II, leads to premature referral to urgent and emergency services, hindering the network care strategy and prioritizing emergency care instead of continuous psychosocial assistance.

In Primary Health Care (PHC), ideally this point of care should be the first to identify the risk early and initiate management in the territory, with matrix support from the mental health team of the CAPS, as pointed out by Coutinho et al.[14:5], in which "[...] networking, especially at the interface with primary care, emerges as an extremely significant factor for the detection of the crisis in the territory and for the construction of alternatives to psychiatric hospitalization".

However, historically, primary health care teams have faced difficulties in managing people with mental disorders, especially during crises, resulting in direct and often unnecessary referrals to emergency services and CAPS (Psychosocial Care Centers), thus overloading these points in the network. Therefore, each point in this network must be organized for intervention in crisis situations.

> *"The patient in crisis, even when referred to the CAPS (Psychosocial Care Center) or any point in the emergency network, continues to belong to the area covered by a specific Family Health Strategy team, which is jointly responsible for them, needing to stay informed about their condition while they are in another service, or assume their part in their treatment after discharge"*[6:38].

In the RUE (Emergency Care Network), it is essential that it offers qualified clinical and psychiatric support in mental health beds through General Hospitals, with brief and necessary hospitalizations, focusing on stabilization and rapid referral/return to territorial services. However, the scarcity of beds and qualified teams, coupled with pressure from families, users, and professionals themselves for the rapid referral of users in crisis, contributes to the repetition of asylum-like practices, which further disorganizes territorial care and the bond with those who care - family members and professionals - and with the services that receive them.

In short, the main theoretical divergence is between crisis as an opportunity for transformation (psychosocial approach) versus crisis as a danger to be contained and isolated (asylum/biomedical approach). This dispute manifests itself in practice as a constant challenge to ensure that decentralized and community-based care prevails over the tendency to centralize care in hospitals and emergency rooms.

Therefore, one of the main challenges is to make the Psychosocial Care Network (RAPS) function and promote psychosocial care in different territories and at different points within this network during times of crisis, since it is precisely at this moment that the network tends to show its weaknesses and also its "crises" in this care. However, it is important that the Unified Health System (SUS) offers both equipment and qualified assistance that results in agility and effectiveness in the care of people in mental crisis, since lack of assistance or inefficient assistance leads to the worsening of the condition and, consequently, more problems for the sick person and those who care for them. The controversy surrounding this generates fragility and fragmentation of the care network and, consequently, multiple questions and doubts about the hospital-centric model to the detriment of the efficiency of psychosocial care.

Given the situation, the existence of continuing education spaces within health services, not only for those specializing in mental health, clinical-institutional supervision, and matrix support for the RAS and RUE are possible and necessary strategies to minimize the impacts that different understandings of mental health crisis have caused and, with this, try to reverberate in the care of people in crisis also in the different territories and points of this network.

The analyzed text fragment highlights the coexistence of antagonistic paradigms within the Psychosocial Care Network (RAPS), revealing that the transition from the asylum model to the psychosocial model is not a linear process but a continuous dispute over care arrangements. On one hand, there is the territorial and decentralized model, aligned with the principles of the Brazilian Psychosocial Network (RPB), in which the CAPS - especially CAPS III - assumes the role of network organizer. In this arrangement, crisis is understood as a phenomenon to be managed in the community, using the Therapeutic Project (PTS) as an integration tool and the general hospital as a temporary backup. The effectiveness of this model lies in maintaining social ties and the subjectivity of the

individual, ensuring that care does not become detached from the user's territory of existence.

Conversely, the text warns of the persistence of a hospital-centric and centralized model, which emerges from the difficulty or denial of the problem-solving capacity of alternative services and primary health care in crisis situations. This residual logic shifts the focus of attention to the crisis management system and the psychiatric hospital, re-enacting practices that prioritize hospitalization over social inclusion. From this perspective, the regulation of the system ceases to be guided by the clinical and social needs of the individual and becomes dictated by the availability of beds, resulting in fragmented and deterritorialized care. Therefore, this analysis suggests that strengthening the Psychosocial Care Network depends on overcoming this dichotomy, requiring community-based services to reaffirm their technical and political competence in crisis management to avoid a regression to the logic of exclusion.

Strategies for Territorial Care

Psychosocial care focused on crisis management must break with the fragmented logic of the biomedical model, shifting the focus from symptoms to the wholeness of the individual and the guarantee of their rights. Historically, individuals in crisis have faced invisibility and loss of subjectivity under the pretext of care. In the context of the Brazilian Psychosocial Care Network (RPB) and the National Mental Health Policy (PNSM), territorial strategies emerge as essential tools to guarantee humanized care that recognizes the individual's vulnerability without depriving them of their citizenship.

Therefore, countering this logic of care requires listening to the person in their subjectivity, validating their speech and interests, establishing a bond, building integrated care within the territory with support in establishing self-knowledge that allows the development of self-care and autonomy as an alternative for crisis prevention and empowerment in the choices that will affect their life and care.

Given the varying levels of intensity of crises, the bond emerges as one of the main strategies for providing care to the person beyond illness. It arises in the service as a reflection of social and productive relationships and needs to be viewed also because of a debilitating social organization linked to the emotional resources of individuals in their various life contexts, expressing itself in an individual and singular crisis derived from and reproduced as a consequence of a collective crisis. Boni et al.[10:11] portray this well in their study, highlighting the role of the asylum within a society, when they state that "[...] the asylum presents itself as a response to the expressions of social contradictions produced by capitalist relations. A response that, as is known, reiterates and reproduces processes of oppression and violence, aggravating psychic suffering".

In times of health crisis, particularly in mental health, services must be organized with a user-centered approach, based on their needs, priorities, and life plans, with the involvement of their families and caregivers. Effective care will only occur when these characteristics prevail over the anxieties of professionals, management, and services. Psychosocial care and comprehensive attention, as advocated by the Brazilian Psychosocial Care Network (RPB), the National Mental Health Policy (PNSM), and the Unified Health System (SUS), cannot be provided without addressing the user as a person with rights and individuality.

In this context, the definition of the role of institutions in addressing mental health crises, from a theoretical, ethical, and technical standpoint, has often proven flawed and fragile. This has directed care and shaped the various professionals and services that comprise not only the Psychosocial Care Network (RAPS), which works directly with mental health service users, but is also reflected in the different professionals and services of the intersectoral network.

Given this attention, the construction of a care plan before, during, and after a crisis is a tool that gains relevance. The PTS (Personalized Treatment Plan), as well as a Crisis Plan, are useful tools that have been used in CAPS (Psychosocial Care Centers). In this context, conducting risk assessments is important because it guides the management of the user in these events, aiming to reduce bureaucracy and avoid barriers to user access to different services, especially during moments of personal instability caused by the crisis. In this understanding, Merhy et al.[19:82] indicate:

> *"[...] a therapeutic project is never finished, completed, but is dynamic and is always under construction and permanent evaluation. [...] If a proposal didn't work, if the care didn't happen, it's worth discussing again whether the PTS as it is makes sense and for whom it makes sense, and whether the ways to make it move forward could be different. And change direction".*

Often, professionals become frustrated when users discontinue their treatment plan because they fail to understand the inherent dynamism inherent in each individual's uniqueness. By insisting on long-term interventions when the context only allows for short-term solutions, they mistakenly end up blaming the individual for the plan's failure.

It is important to point out that the territorialization of care must prevail in order for psychosocial care to occur. Thus, this care needs to begin, preferably, in the territory, at home and on the street, and not only in hospital settings or only within CAPS (Psychosocial Care Centers), as Lancetti points out[20:46], where "[...] one of the great obstacles of CAPS is their self-centeredness and their lack of openness to the territory". Therefore, at any point in the network, priority should be given to promoting care in freedom and community reintegration.

Furthermore, this process requires providing support and connection, as these are essential soft care technologies for crisis management and the construction of individual-centered care plans. According to Merhy et al.[19:42], "[...] we are centrally using soft technologies when we approach the 'singularity' of the subject I am caring for." In short, the promotion of mental health care must be rooted throughout the territory, demanding an intersectoral and community-based approach, guaranteeing comprehensiveness and accessibility for all users.

> *"[...] If we are committed to a clinic that welcomes, builds relationships with, and monitors the user's care, it needs therapeutic projects that ensure the user's needs are met, or rather, that also express the presence of the other's knowledge about themselves, and not just our professional knowledge. In this sense, we would have a shared management of the clinic between the health professional and the user-citizen"*[19:26].

In this sense, comprehensive care requires the involvement of different categories of professionals and different public policies, whose theoretical-methodological and practical knowledge needs to be aligned with the precepts of the RPB (Regionalized Psychosocial Care), so that inter- and transdisciplinary psychosocial care can manifest itself and favor the expansion of the offer of care in freedom, community-based and linked to the individual and collective needs of these people, and that is in constant progress against the biomedical model.

Final Considerations

It is evident, therefore, that after more than two decades of RPB (Regionalized Psychosocial Care Network), the RAPS (Psychosocial Care Network) and the different networks of the SUS (Unified Health System) have still been operating in a fragmented and incomplete manner. There is a lack of integration between services and professionals in assisting with crisis situations, and especially in the continuity of care for these individuals in the post-crisis period in a preventive way. This aspect, in addition to the crisis itself, is one of the main contemporary challenges for those working in mental health and psychosocial care, seeking to provide care that reflects the previous crisis and allows for the establishment of strategies to prevent future crises. It is observed that institutions, in isolation, have attempted to provide a rapid response to crisis events, but have been ineffective in interventions during periods of user stability.

It is understood, therefore, that in the field of mental health and psychosocial care, one of the main contemporary challenges is the effective operationalization of the Psychosocial Care Network (RAPS) in the territories, so that the points of care act in an integrated way during a crisis. It is precisely in the exacerbation of suffering that the network tends to expose its structural and conceptual weaknesses. However, the difficulties of the services also extend to periods of user stability. Frequently, a "loosening" of follow-up is observed when acute symptoms subside, resulting in purely reactive assistance. The network, often guided by the logic of urgency, finds it difficult to sustain continuous and preventive care in the territory, which can lead to the depletion of social support and the discontinuity of therapeutic projects, invariably precipitating new episodes of crisis.

Coupled with this is the precariousness of the State in expanding resources, funding, and investments in public mental health policy, both in services and teams, as well as in the network that comprises it, and in other public policies, such as Social Assistance, Education, Culture, Sports, and Leisure. The expansion of these policies would not be for the extension of health care, but rather to qualify and expand this assistance for people in their various spheres of life, since these areas also have the potential to promote health and quality of life, which in turn reflects on people's mental health and consequently on health services, specifically those specialized in mental health.

Therefore, this essay demonstrated that the effectiveness of networked care in mental health fundamentally depends on overcoming the biomedical view of crisis and consolidating territorial practices. It emphasizes that the biomedical network is a continuous process, and that "crisis" should not be seen as a problem to be resolved, but as a life moment that requires a supportive and non-repressive network. Each crisis is unique, even for the user themselves, and this perspective will guide the care provided to the individual. Thus, further practical studies on the implementation of these networks are necessary, as well as ongoing discussions on effective crisis interventions as an important and relevant issue in mental health.

It is concluded that strengthening continuing education in services plays a fundamental role in resolving theoretical and practical conflicts regarding the care of users in mental health crises. This will allow for the demystification of users with mental disorders and their crises, the perceived dangerousness of these individuals, and the qualification of teams and services to meet this demand within the community and across networks. This is because services and these networks are formed by people to people providing care and people being cared for - within their particularities. Therefore, strengthening and qualifying the people who provide care will result in a strong and qualified network for the care of people experiencing mental distress and crisis.

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