

Network articulation practices in psychosocial care: what challenges do professionals face in *matriciar*, meeting, and referring?

Práticas de articulação de rede na atenção psicossocial: quais desafios enfrentam os profissionais para matriciar, reunir-se e encaminhar? (abstract: p. 17)

Prácticas de articulación de red en la atención psicossocial: ¿Cuáles son los desafíos enfrentados por los profesionales para realizar el apoyo matricial, reunirse y derivar? (resumen: p. 17)

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This study aimed to explore the network articulation practices developed by professionals working in two points of the Psychosocial Care Network in the Federal District: The Psychosocial Care Centers for Alcohol and Other Drugs and the Basic Health Units, covering seven existing health regions, highlighting the strategies used, as well as the difficulties and challenges that cross its effective implementation following the Psychosocial Care model. This research uses a qualitative and exploratory approach, using intra-method triangulation with 36 participants and adopting Bardin's content analysis. A lack of infrastructure and inputs was identified to build the matrix support practices, meetings with the network, and referrals satisfactorily according to the participant's perspective. However, intervention and health promotion strategies emerged to strengthen Psychosocial Care.

Keywords: Psychosocial care. Network articulation. Primary health care. Mental health services.

Introduction

One of the significant milestones of the Brazilian Psychiatric Reform (BPR) movement was the approval of Law No. 10.216/2001. This law aimed to reorient the care model for people with mental disorders and their families, as well as to build care practices through the creation and strengthening of services that replace mental institutions, based on care in freedom and a territorial basis. The Brazilian experience of implementing a Mental Health (MH) care model in line with the paradigms of the BPR shows a new social place for mental disorders, guided by the Psychosocial Care (PC) model. This model, which makes the center of care the person in their different spheres in a socio-community context^{1,2}, is particularly relevant in the context of our study's location, the Federal District of Brazil.

The Psychosocial Care Network (RAPS) establishes the points of care in the Brazilian National Health System (SUS) – Brazil's universal and public health system – for comprehensive and humanized care for people with mental disorders and substance use disorders. RAPS has regional management and an open, community-based model of care, guaranteeing freedom and social coexistence through services, the community, and the territory. It is structured around the following points of care: Primary Health Care (PHC) – Primary Care Units (UBS) and the Expanded Family Health Center (NASF) – Strategic PC – different types of Psychosocial Care Centers (CAPS), which can be for the care of mental disorders or substance use disorders (alcohol and other drugs – AD) in adults or children – Urgent and emergency care, Home Care, Reception Units and Hospital Care^{3,4}.

For Avelar & Malfitano⁵, network care can be understood as:

[...] a working tool, or a strategy, that promotes interaction between social actors in the same territory, with the central objective of making the rights of the population effective and should be guided by what is recommended in public policy. (p. 3204)

This understanding is in line with the proposal of the PC model, integrating SUS services, promoting comprehensive care for people with mental and substance use disorders and their families, encouraging professionals to work together, and articulating the most diverse points of care^{4,5}.

Therefore, networking retains a relational character between its actors and is an extremely important light technology. Merhy et al.⁶ present light technology as a strategy for relational processes between health professionals, users, and their families, individually or collectively, with care based on listening, welcoming, dialog, bonding, and meeting one another, in the act, a living work.

Studies in Brazil have discussed the importance and challenges faced in implementing network care coordination practices between the various points of care in the RAPS. Fonseca and Gallassi⁷ discuss the extramural practices



developed by professionals working in the CAPS-AD of the Federal District (DF), pointing out that there are still few care actions outside the physical structure of the services, and even though there are extramural activities, they occur on an occasional and temporary basis. Gama et al.⁸ discuss how mental health demands are dealt with in primary health care in the state of Minas Gerais (MG) and identify problems in the organization and articulation of the RAPS, which hindered care practices in line with the paradigms of the BPR. Sampaio and Bispo Júnior⁴ evaluated the structure and practices of mental health care coordination in Bahia. They identified a fragmented network, with centralization in specialist services, lack of established flows, insufficient structure and communication difficulties with primary care and other points of care.

In this sense, this study set out to explore and characterize the network articulation practices developed by professionals working in two specific points of the RAPS - the CAPS-AD and the UBS - highlighting which strategies are used, as well as the difficulties and challenges that cross their implementation following the PC model.

Method

This is a qualitative, exploratory and descriptive study carried out between May 2022 and January 2023. It included health professionals working in CAPS-AD and UBS in the seven health regions of the DF. The CAPS-AD is an open-door service with a multidisciplinary team, specifically for comprehensive and continuous care for people with substance use disorders, seeking to provide social reintegration and strengthen family and territorial ties⁹. The UBS is people's gateway to the SUS, whose function is to promote comprehensive health care for the population in its territory. It has Family Health Strategy (ESF) teams, made up of a doctor, nurse, nursing technician and community health agents, oral health teams, made up of a dentist and an oral health technician, and NASE, made up of specialists who provide matrix support/technical pedagogical support to the primary care teams and direct assistance to users^{10,11}.

The DF is located in the Midwest region of Brazil. It has a population of 3,094,325 inhabitants spread over 33 administrative regions (ARs)¹² – equivalent to “neighborhoods” – with Brasília being the third most populous city in the country (IBGE/2021)¹³. These ARs are grouped into seven health regions, according to geographical and epidemiological layout, and have health services of different complexities (primary care, medium and high complexity)¹⁴. The matrix support activities are articulated between the health regions and their superintendencies so that they jointly have administrative and shared attributions with the other social actors in the network. Still, there is no common schedule or methodology. Each health region in the DF draws up its matrix support actions according to the demand and specificities of its catchment area¹⁴.

The inclusion criteria for the study were: (i) working in a CAPS-AD or UBS in the DF, (ii) being over 18, and (iii) agreeing to take part in the study. At least two professionals from each health region were included, one of whom worked in a UBS and the other in a CAPS-AD, sharing the same health region to explore the dynamics of network articulation in each of the seven regions.



The strategy used to collect the data was intra-method triangulation¹⁵, using two techniques: a semi-structured synchronous interview and a structured asynchronous interview, conducted virtually and focusing on the relationship between the UBS and CAPS-AD. For the semi-structured interview, the following trigger themes were used: the strategies used to weave the network, the existing difficulties for dialog between the two points of care in the RAPS, and actions to expand the network. The structured interview dealt with sociodemographic aspects, perceptions of networking and the practices used to create networks, and what strategies are being used to continue this work. The aim of choosing these different interview methods was to offer different opportunities for the interviewees to reflect and contribute, either by speaking or by writing, and thus capture the perceptions of these professionals more fully. This is because some may feel uncomfortable explaining difficulties and problems at work when interviewed live and do so in written form. In addition, intra-method triangulation in the data analysis process provided greater support for structuring categories based on themes that recurred and were consolidated throughout the speeches.

The data was analyzed using the content analysis technique guided by Bardin¹⁶, covering three stages: (1) pre-analysis of the material collected, carried out by carefully reading and re-reading the transcripts of both interviews to systematize and get closer to the findings to be analyzed; (2) the elaboration of the thematic axes which took place through the repetition and relevance of the material; given the objectives of the study, a cut was made in registration units and the practices of i) matrix support; ii) meetings with the network; and iii) referral, discussed concomitantly, were classified into a single thematic axis. Finally, (3) treatment, inference and interpretation of the material collected.

The research was approved by the Research Ethics Committee of the University of Brasília (CAAE: 53345921.7.0000.8093), and the Foundation for Teaching and Research in Health Sciences of the Federal District (CAAE: 53345921.7.3001.5553). All participants signed the Informed Consent Form virtually.

Results and discussion

Thirty-six professionals were interviewed, 18 working in UBS and 18 working in CAPS AD, representing the seven health regions of the Federal District, with a predominance of females (33). The age range varied between 29 and 53 years, with the majority (20) in their 30s and 40s. The participants' predominant length of time worked at CAPS AD was between 6 months and 17 years, and at UBS, it was between 5 months and 17 years. The CAPS AD interviewed 6 occupational therapists, 4 psychologists, 4 nursing technicians, 3 nurses and 1 social worker. From the UBS, 7 occupational therapists, 3 nurses, 2 nutritionists, 2 social workers, 2 physicians, 1 psychologist, and 1 physiotherapist participated. No community health agents participated in the interviews, as the matrix support activities they carry out



are only between the NASF and the ESF team, not between other points of care, such as the CAPS (Frame 1).

Frame 1. Distribution of participants according to the characteristics of the health region of the DF where they work and their professional training (n=36)^{12,14}.

Health Region	Population	ARs covered	Number of CAPS	Number of UBS	CAPS-AD Participants	UBS Participants
Central Region (RC)	436.912	7	3 (1 AD)	10	- Occupational Therapist (OT) - Nurse	- Nurse - Nutritionist
Central-South Region (RCS)	315.342	8	2 (1 AD)	19	-OT (2)	- OT (2)
Northern Region (RN)	378.729	4	3 (1 AD)	34	- Nurse - Psychologist -OT	- Nutritionist - OT
South Region (RSL)	290.226	2	1 AD	22	- Nurse - Nursing Tech (2)	- Physiotherapist - Physician
West Region (RO)	526.871	2	2 (1 AD)	6	-Social worker - Psychologist	- Social worker (2) - OT (2)
East Region (RL)	231.167	4	2 (1 AD)	28	- Nursing Tech (2) -OT	- Nurse - Psychologist -TO
Southwest Region (RS)	792.962	5	5 (1 AD)	34	-OT - Psychologist (2)	- OT -Physician - Nurse

The interviewees' accounts were named according to i) the form of participation, semi-structured interview (ES) and structured interview (EE); ii) the order of participation, from (01) to (36); iii) professionals working in the UBS/Primary Health Care (PHC) and CAPS-AD (AD); and iv) health regions: Central Region (RC), Central-South Region (RCS), North Region (RN), South Region (RSL), East Region (RL), West Region (RO) and Southwest Region (RS).

The data collected was grouped into two broad thematic categories: the first portrays seven obstacles that challenge the implementation of networking practices to strengthen PC in the DF, and the second points to three strategies that can change this reality, presented below.

The challenges of weaving the network: common perceptions of CAPS AD and UBS workers from the seven Health Regions of the Federal District

The functioning of an articulated network between the different points of care in the RAPS depends on investment inflows, resources, and work processes that can break down the barriers that hinder and limit this practice. Although each health region has its own particularities, there were difficulties and challenges in common. In this sense, seven obstacles were identified that challenge the implementation of network articulation practices to strengthen PC and BPR:



1) Lack of matrix meetings

The participants pointed to matrix support meetings as an extremely important strategy for strengthening primary care. However, three main points make matrix support difficult: the lack of a prior schedule, the lack of planning for how these meetings will be held, and the lack of understanding among managers and professionals about this practice:

They happen on demand, I wish we could have a schedule. (ES.15/AD-RL)

There is still no structured flow, no planning due to people not knowing what matrix support is. (ES.03/AD-RCS)

Managers don't understand the importance of matrix support [...] when they don't understand the idea of matrix support, it becomes very difficult. (ES.03/AD-RCS)

The difficulties mentioned in this study have also been identified in others in Brazil¹⁷⁻²¹. Matrix support is a joint action between primary care and CAPS AD and is seen as an important strategy for promoting health and strengthening PHC and BPR. However, the lack of understanding or knowledge about matrix support and its objectives leads to an unwillingness on the part of professionals and the management itself to dedicate themselves to and encourage this practice. So, there is little effort to organize an agenda, plan actions in advance, and engage professionals. Encouraging actions that inform and stimulate teams to adopt matrix support practices can be an effective strategy for articulating the network and solving more cases.

2) Lack of a flow for referral and counter-referral cases

Participants say that users are referred via *WhatsApp*, email, SEI (Electronic Information System) and a physical referral form delivered by hand. The lack of criteria and guidelines to carry out this flow has an impact on case follow-up:

I've already received a sheet like this: patient should go to the Basic Health Unit, that's all there was, there was no prescription, there was nothing, we didn't know anything, he didn't know anything either, the family didn't know anything, so it's a real failure, of this management that doesn't talk, and then it's the citizen who is left without proper assistance, regardless of the form of management. (ES.09/PHC-RO)

Sometimes we put paper in the patient's hand, and they disappear, or the professional on the other side doesn't take much notice. In the SEI, it's registered, and that UBS professional will have to receive the patient; he is aware that he will have to attend to that patient. This conversation is sorely lacking, that matrix support would help a lot, that the chemically dependent



patient is unstable, that they may relapse and need to come to CAPS-AD again and it's fine, send them back to us. (ES.03/AD-RCS)

National studies^{22,23} discuss the weaknesses of continuity of care between PHC and the other points of care in the RAPS, pointing to the need to improve effective communication between the different levels of care with the potential to disseminate case information. In this way, the referral and counter-referral system within the RAPS is strengthened to corroborate shared care actions involving users, their families and health professionals, following the assumptions of the PC model.

3) Lack of a unified medical records system for all RAPS points of care to monitor cases

Participants say that in addition to the referral and counter-referral not having a pre-established flow, once users have been referred, they cannot monitor whether or not the person is being attended to via a unified electronic medical record system. This information is usually gathered by communicating with the user themselves or by contacting a professional from the other service who is part of their personal support network:

Networking requires a lot of flexibility, right? We need to maintain good relations all the time, it often ends up being too personal and not institutional. (ES.02/AD-RN)

We can't keep track of whether he's gone, whether he hasn't, precisely because we don't have a system, if we did, we could just log in and see if he's been received by the other service; it would be easier, but we don't have one. (ES.14/AD-RC)

National studies^{24,25} discuss the implementation of the electronic medical record of the SUS (e-SUS) in primary care, pointing out that incorporating e-SUS can optimize work processes. However, they point out that some aspects need to be improved to break down inconsistencies in the quality of information in the system. e-SUS was seen as an interventional strategy to overcome barriers and weave the network:

e-SUS is a very good system, and it is complete. Everyone can use it for free, not just primary care. There's no doubt about it, it's about putting in a system that would be unified for everyone. (ES.06/PHC-RSL)

4) Lack of telephone and telephone system in services

The practice of networking is once again impacted by communication barriers between services due to the lack of a telephone and an institutional telephone system, according to the study participants:



There is also the difficulty of having institutional contacts, often using the personal contacts of professionals. (EE.02/AD-RC)

We also have an informal network, this network of professionals. We have the contact information of the institution's server, and we make contact by WhatsApp; it has worked a lot. (ES.05/AD-RN)

Sheridan and collaborators²⁶ discuss the implementation of telehealth tools in MH services worldwide and point to the increased use of applications for individual and group consultations and team meetings. These tools have enabled continuity of care, keeping alive activities that could have been extinguished in the context of the Covid-19 pandemic.

5) Lack of driver and car to travel between RAPS points of care

Participants from services located in more extensive health regions and serving rural areas were the ones who most pointed out the problem of the lack of a car and driver, especially to hold matrix meetings with more distant units:

The barriers encountered are limited transportation to the units, so we mainly use online resources to discuss and monitor cases. (EE.02/AD-RC)

The barriers encountered are limited transportation to get to the units. (EE.02/AD-RC)

According to Santos²⁷, residents of rural areas suffer from barriers to accessing mental health care due to existing weaknesses in RAPS services, such as weak human resources for health promotion and prevention work, structural resources for transportation and communication, and financial shortages and technologies that bring teams closer to rural areas, highlighting the need for these aspects to be prioritized to facilitate and expand access to health care for residents of rural areas. An international study²⁸ pointed to a high prevalence of alcohol and other drug use in rural populations and poor access to MH services for the care of this problem, highlighting not only the socioeconomic inequality between rural dwellers compared to those living in the city but also the difficulty in accessing health services.

6) Lack of time and schedule to carry out networking activities

Many of the participants mentioned that the main focus of the services is to meet the demand there, and going outside to take part in network meetings or matrix meetings, for example, is not seen as a priority and ends up taking a back seat:

They do it at least once a month, but to fulfill the productivity issue, we know the importance and relevance, but the service has not been able to do it. (ES.01/AD-RS)



I think that before the pandemic, it was already like this; this is a difficulty that we have had for a long time in the service. (ES.04/AD-RS)

According to Martinhago and Oliveira²⁹, the lack of intersectoral actions hampers and restricts mental health care, stiffening network and intersectoral articulation practices, with uniprofessional and unisectoral care prevailing. The importance of knowing about existing activities in the network and in the territory allows users to participate socially in different devices, such as schools, churches, community and cultural groups, which are extramural practices that are favorable to what is recommended by the PC model.

7) Lack of human resources to carry out networking actions

The participants see the network articulation actions as an important strategy for strengthening PC and BPR. However, in addition to the lack of a timetable, planning and understanding of the actions (obstacle 1), many PHC and CAPS teams are precarious due to the lack of human resources - aggravated by the Covid-19 pandemic - which has triggered a work overload directly influencing the availability of participation in matrix support activities.

We know that the CAPS are outdated, as are almost all sectors of the Health Department, at least the CAPS that do [matrix support], which are references for my unit, have a very large flow of alternating professionals. (ES.08/PHC-RO)

Lack of available professionals and availability of schedules. (EE.12/AD-RSL)

I even realize a lack of interest in this link between CAPS and primary care. I don't judge either, everyone is very overloaded, we're overloaded, CAPS is certainly overloaded too. (ES.06/PHC-RSL)

National studies have discussed the setbacks in mental health, and drug policies in Brazil since 2016, with significant disinvestment in CAPS and greater investment in private long-term and religiously-oriented services, such as therapeutic communities^{30,31}. This scenario of the precariousness of public health services and their workers has been aggravated by the Covid-19 pandemic, both because of the increase in demand and because of the coverage of colleagues who have been absent due to the disease, with a significant impact on their mental health. Teixeira et al.³² conducted a study in Brazil during the pandemic and found problems affecting health workers, including the deterioration of services and the precariousness of the PHC workforce. Miranda et al.³³ identified almost identical impacts on mental health and the use of alcohol and other drugs among PHC workers in the Federal District during the Covid-19 pandemic, regardless of socioeconomic status (more or less vulnerable) and the number of cases and deaths



in the regions where they worked. In addition, they emphasized that the lack of support and leadership from the federal government and the distance from family and friends during the pandemic contributed to these professionals' negative manifestations of MH issues.

Strategies for weaving the network: common perceptions of CAPS AD and UBS workers from the seven Health Regions of the Federal District

Although there is a lack of infrastructure, human resources and supplies for network articulation practices to be carried out satisfactorily in the view of the participants, these professionals also suggest interventional and health promotion strategies to seek improvements, such as:

1) Creation of an online portfolio with a complete network menu to be shared among all points of care

An online portfolio of network data: contact, type of service, type of access. I would also make political and management links, with the support of universities as facilitators for ongoing education on the subject and to encourage the creation of links and flows. (EE.01/AD-RL)

A Brazilian experience that meets this strategy was creating a *website* entitled "Portfolio of Inspiring Practices in Psychosocial Care" bringing together reports and illustrative media of innovative experiences in PHC between 2015 and 2020. The actions featured psychosocial approaches to welcoming, caring and empowering life, including thematic video lessons on different fields of knowledge given by specialists, encouraging the dissemination of actions that seek to strengthen the PC model³⁴.

2) Creation of continuing and permanent education programs, as well as partnerships with medical and multi-professional residency programs

The strategy of permanent education with the team, so that the team understands the importance of intersectoral education. (ES.14/AD-RC)

The MH residency program has been another means that has facilitated communication and networking. As the program encompasses most of the components of the RAPS and I am part of it, the resident professionals are available for collective construction, discussions and other important actions, being a current tool for integration. (EE.6/PHC-RS)



The MH residency programs in Brazil are a great asset for strengthening care. The direct insertion of recently graduated professionals with different health backgrounds into care enables them to learn and exchange knowledge with professionals working in the services. This is a strong instrument for network articulation between the points of care where they are inserted and providing guidance and matrix support for the PHC teams³⁵.

In the studies by Nóbrega et al.³⁶, Silva et al.³⁷ and Santos et al.³⁸, the lack of human resources, investments in adequate equipment and continuing education actions were considered major obstacles to effective networking. This reinforces that investing in continuing and permanent education strategies, integrating the electronic medical records system, having the service's own telephone system, and investing in transportation are essential strategies for expanding and consolidating the dialog between the RAPS points of care.

3) Raise awareness among managers and PHC professionals about the importance of matrix support, demystifying the idea that it is a work overload or a secondary priority

Managers don't understand the importance of matrix support, it's not up to us to go there and ask if they want it, it has to be demanded from the unit, because they often see it as another work overload when they don't understand the idea of matrix support, it becomes very difficult. (ES.03/AD-RCS)

At the moment, I think things at the management level need to be better structured to achieve a better dialog. Services need to be less overloaded so that people have the mental space to dedicate themselves to this sharing. It's my perception everyone is very overloaded, so proposing anything new is difficult. (ES.13/AD-RO)

The literature points to extramural practices as necessary and fundamental for strengthening primary care⁷. Care actions outside the physical structure of the services – including matrix support – are scarce and are still being implemented and consolidated. Although such activities occur, they are not systematic and continuous, demonstrating the need for managers to incorporate them as a strategic guideline for MH care.

The interventional and health promotion strategies pointed out by the participants could alleviate many of the difficulties presented. Even though each health region has its own particularities, the challenges are quite common among them, and adopting such strategies would benefit everyone. Networking practices are congruent with live work, and it is necessary to provide spaces for dialog and active participation between all the parties involved, workers from different specialties, users, families and managers. Adopting such practices could directly impact case resolution, reduce work overload and mitigate the lack of resources for care under the PC model.



Conclusion

The study's methodological design was qualitative, with an exploratory and descriptive approach. It did not set out to exhaust the proposed theme but to contribute to thinking about the challenges faced by CAPS AD and UBS teams in network articulations, focusing on strengthening and resolving MH practices following the paradigms of BPR, PHC and PC.

From this perspective, it is understood that the existing obstacles discussed in this study need to be addressed so that the BPR paradigm and the PC model can move forward, develop and be strengthened through the active participation of CAPS and UBS professionals in the construction of MH care actions. In addition, the interventional and health promotion strategies identified by the participants may be implemented in the Federal District's health network to strengthen care in the context of PC.

Further studies involving service users, family members, and managers are suggested to broaden the understanding of the challenges in building network articulation practices between primary care services and MH, alcohol, and other drug services.



Authors' contribution

Both authors actively participated in all stages of preparing the manuscript.

Acknowledgments

Both authors thank the participating health professionals who gave up their time to contribute to this very relevant discussion.

Conflict of interest

Both authors have no conflict of interest to declare.

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Editor

Simone Mainieri Paulon

Associated editor

Alberto Rodolfo Velzi Diaz

Translator

Andrea Donatti Gallassi

Submitted on

01/12/24

Approved on

05/01/24

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Este estudo se propôs a explorar as práticas de articulação de rede desenvolvidas pelos profissionais atuantes em dois pontos da Rede de Atenção Psicossocial do Distrito Federal: os Centros de Atenção Psicossocial Álcool e outras Drogas e as Unidades Básicas de Saúde, abrangendo as sete regiões de saúde existentes, evidenciando as estratégias utilizadas, bem como as dificuldades e os desafios que atravessam sua implementação à luz do modelo de Atenção Psicossocial (AP). Trata-se de uma pesquisa com abordagem qualitativa e enfoque exploratório com 36 participantes entrevistados; utilizou-se a triangulação intramétodo e adotou-se a análise de conteúdo de Bardin. Identificaram-se a falta de infraestrutura e de insumos para tecer as práticas de matriciamento, reuniões com a rede e encaminhamentos de forma satisfatória, conforme a perspectiva dos participantes. Contudo, surgiram estratégias interventivas e de promoção de saúde para o fortalecimento da AP.

Palavras-chave: Atenção psicossocial. Articulação de rede. Atenção básica. Centro de atenção psicossocial.

La propuesta de este estudio es explorar las prácticas de articulación de red desarrolladas por los profesionales actuantes en dos puntos de la Red de Atención Psicosocial del Distrito Federal: los Centros de Atención Psicosocial Alcohol y otras Drogas y las Unidades Básicas de Salud, incluyendo las siete regiones de salud existentes, poniendo en evidencia las estrategias utilizadas, así como las dificultades y los retos presentes en su implementación a la luz del modelo de Atención Psicosocial (AP). Se trata de una encuesta con abordaje cualitativo y enfoque exploratorio con 36 participantes entrevistados; se utilizó la triangulación intramétodo y se adoptó el análisis de contenido de Bardin. Se identificó la falta de infraestructura y de insumos para tejer las prácticas de apoyo matricial, reuniones con la red y derivaciones de forma satisfactoria, conforme la perspectiva de los participantes; no obstante, surgieron estrategias de intervención y de promoción de la salud para el fortalecimiento de la AP.

Palabras clave: Atención psicossocial. Articulación de red. Atención básica. Centro de atención psicossocial.