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INTEGRATIVE LITERATURE REVIEW

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Intersectoral Actions for Mental Health: An Integrative Review

Ações de Intersetorialidade em Saúde Mental: Uma Revisão Integrativa

Acciones Intersectoriales en Salud Mental: Una Revisión Integradora

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ABSTRACT

Objective: The study's purpose has been to identify in scientific literature the intersectoral actions developed in the mental health field. **Methods:** It is an integrative review that was performed by searching in both *LILACS* and MEDLINE databases for publications between January 2005 and August 2015. There were found 1,027 publications, 28 of which met the inclusion criteria. We evidenced some intersectoral actions that were categorized as follows: interventions in school/educational institutions; educational activities; partnerships with NGOs; discussion forums; social benefits; inclusive actions at work; interventions in the community; home interaction; religious care institutions; and leisure. Results: Through data analysis, it was possible to observe the importance of intersectoral actions in social inclusion, and also the decentralization of care to other services, places and sectors. Nonetheless, it is still necessary to discuss this process, once it is not only to include other spaces, rather to stimulate and to develop the communication between health, social assistance, work, and education. **Conclusion:** The challenge of consolidating intersectoriality lies on building an articulation between different sectors and shared responsibilities for mental health cases.

Descriptors: Mental Health, Integrality in Health, Intersectoral Collaboration.

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RESUMO

Objetivo: Identificar na literatura científica as açes intersetoriais desenvolvidas em saúde mental. **Métodos:** Revisão integrativa realizada nas bases de dados LILACS e MEDLINE, entre janeiro de 2005 a agosto de 2015. Foram encontradas 1027 publicações, das quais 28 atenderam aos critérios de inclusão. Na análise dos dados, evidenciamos ações intersetoriais que foram categorizadas em: intervenções na escola/instituição de ensino; ações educativas; parcerias com ONGs; fóruns de discussões; subsídios sociais; ações de inclusão no trabalho; intervenções na comunidade; intervenção domiciliar; acolhimento das instituições religiosas; e lazer. **Resultados:** Observa-se a importância das ações intersetoriais na inclusão social com a descentralização do cuidado para outros serviços e dispositivos. No entanto, é necessário problematizar que esse processo não é somente incluir outros espaços, e sim, estimular e desenvolver a comunicação entre eles. **Conclusão:** O desafio da consolidação da intersetorialidade é que haja a articulação entre diversos setores e a responsabilização compartilhada da rede.

Descritores: Saúde Mental, Integralidade em Saúde, Ação Intersetorial.

RESUMEN

Objetivo: Identificar en la literatura científica acciones intersectoriales desarrolladas en la salud mental. **Métodos:** Revisión de las bases de datos LILACS y MEDLINE para publicaciones entre enero de 2005 y agosto de 2015. Hemos encontrado 1027 publicaciones, 28 cumplieron los criterios del inclusión. Las acciones intersectoriales encontradas fueron categorizadas como: intervenciones en la escuela/instituciones educativas; actividades educacionales; asociaciones con ONGs; Foros de discusión; beneficios sociales; acciones inclusivas en el trabajo; intervenciones en la comunidad; intervenciones domiciliarias; instituciones del cuidado religioso; y ocio. **Resultados:** Las acciones intersectoriales son importantes en la inclusión social, la descentralización de la atención a otros servicios, lugares y sectores. Todavía es necesario discutir este proceso, para incluir otros espacios, sino para estimular y desarrollar la comunicación entre salud, asistencia social, trabajo y educación. **Conclusión:** El desafío de consolidar la intersectorialidad es construir una articulación entre los diferentes sectores y responsabilidades responsabilidades compartidas en salud mental.

Descriptores: Salud Mental, Integralidad en Salud, Colaboración Intersectorial.

INTRODUCTION

The concept of Health and quality of life encompasses different social factors as its determinants: schooling, work, income, environment, living conditions and social equity. In mental health, it is no different, and it is also necessary to incorporate the search for autonomy and social inclusion.[1,2]

To account for the multiple factors involved in mental health, the health system needs to be organized in networks that articulate different sectors of society, such as schools, community centers and health institutions, in order to think about integral care, citizenship and social reintegration. The idea is to create networks of services, mechanisms and resources of different dimensions, thinking about user access, interdisciplinary practices, coping with prejudice and exclusion.[3]

It is impossible to detach from this discussion the concept of intersectorality that is the articulation of the different organs and sectors of society, emerging as a fundamental piece for the achievement of integrality in health care. When we treat the individual as a whole, we need the system to work in an articulated way.[1]

Intersectoriality is a process that requires the permanent interaction between the different segments such as education, culture, housing, health, social assistance, since it interferes in social and subjective production, producing effects on the ways of being and acting of workers, users and organizations. These modes prioritize the creation of spaces for communication, interdisciplinary work, community participation in the solution of conflicts.[4]

The idea of networks is that of connection, links, complementary actions, horizontal relations between partners, service interdependence, to guarantee the integrality to social segments vulnerabilities or at risk. These actions are still challenging, since there is network fragmentation, discontinuity of care, communication difficulty between sectors, care centered in some services, based on an immediacy and centralizing model that sees the disease and not all the issues that involve the subject.[4]

Integrity is a principle of the *Sistema Único de Saúde (SUS)* [Unified Health System] that reveals the observation of the various dimensions of the human being in care, being them biological, cultural, social, political and life. This principle guides the need for policies and actions that can meet the complexity and needs of access and care actions, building the urgency of intersectoral networks.[5]

Bearing the aforesaid in mind, this study proposes to identify in the scientific literature the actions of intersectoriality are realized in mental health. The choice of this topic is justified because it is current in public policies, it is necessary to know what has been done as intersectoral actions and their repercussions, this will help us to think this concept in practice inside and outside services, its importance in care, and may serve as a basis for thinking about new strategies of intersectoral articulation that favor the reinsertion of the individual with psychological suffering in society.

METHODS

It is an integrative review of the literature that is a specific review method of synthesis of existing empirical or theoretical literature to provide a more comprehensive understanding of a specific phenomenon or a health problem, aiming to contribute to the development of theory and applicability for the practice and for directives.[6] Herein, the five stages were used, being the definition of the problem, the research in the literature, the evaluation of the data, the analysis of the data and the presentation of the data. In the first stage, we defined as objective to identify the intersectoral actions carried out in mental health, considering at present its repercussion/relevance in the implementation of care practice.

During the second stage, the Medical Literature Analysis and Retrieval System Online databases (MEDLINE) and *Literatura Latino-Americana e do Caribe em Ciências da Saúde (LILACS)* [Latin-American and Caribbean Literature in Health Sciences] were used. The following criteria were used to guide the search, selection and inclusion of articles for review: a) studies that fit into the proposed theme: intersectoral actions in mental health; b) theses and dissertations with full text available online; c) articles published in Portuguese, English, and Spanish, in national and international journals, covering the period from January 2005 to August 2015; d) articles with full text indexed in the bases previously mentioned; e) combinations of the descriptors included in the list of Health Sciences Descriptors (DeCS), Intersectoral Action, and Mental Health were used in *LILACS*. In MEDLINE, the Medical Subject Headings (MeSH) combinations were used: Mental Health, Mental Health Services and Community-Institutional Relations.

The criteria for exclusion of articles used were the following: a) not answer the guiding question; b) publications of the type reflection, bibliographical and integrative review, summaries, comments, books, interviews, editorials, government publications, project and study protocol. The descriptors were combined in pairs, totaling three combinations of DeCS and three combinations of MeSH.

After the crossings of descriptors, there were 925 publications in MEDLINE and 102 in *LILACS*. In this stage, 46 publications were selected, 37 of which were indexed in the MEDLINE database in the English language and nine indexed in *LILACS* in the Portuguese language. The searches occurred over the period from August 9th to September 30th, 2015. In the data evaluation stage, a detailed reading of the 46 chosen publications was made. During this stage, 11 publications indexed in MEDLINE and nine indexed in *LILACS* did not respond to the guiding question and were excluded from the study. We thus totaled 28 publications, 26 of MEDLINE and two of *LILACS*.

In order to analyze the data, we developed a collection tool to guide what should be observed in the article as the identification data, objectives, methodology, results and conclusions, in order to organize and categorize the information found in the articles. The presentation of the data was organized through a synoptic table with the publications selected for the study with the title, authors, country and year. The ethical aspects were observed preserving the idea of the referenced authors and giving the due credits in order to maintain the intellectual property rights of the same ones.

RESULTS AND DISCUSSION

There were considered 28 articles to compose the integrative review, according to the inclusion and exclusion criteria. It can be observed that most publications (92.85%) are indexed in the MEDLINE database. The prevalence of medical professionals (39.29%) occurred in ten of these psychiatrists, followed by psychologists (28.57%) and nurses (14.29%).

According to the Synoptic Frame (**Figure 1**), it is observed that the highest concentration of publications was in the years 2008 and 2009, totaling (46.43%) of the publications. The distribution of publications according to the countries where the studies took place, it was observed that the majority of the studies were conducted in the United States of America (53.57%), followed by Brazil and the United Kingdom (14.29%); Australia (7.14%); South Africa, Russia and Canada (3.57%), totaling 28 publications selected for this study.

P.C.*	Author(s)	Year	Title	Country
P1	Cristina A Iizuka et al.	2014	The FRIENDS Emotional Health Program dor Minoritty Groups at Risk	Australia
P2	Sarah Skeen et al.	2010	Mental health is everybody's business: Roles for an intersectoral approach in South Africa	South Africa
P3	Jeff J. Guo, Terrance J. Wade, Kathryn N. Keller	2008	Impact of School-based Health Centers on Students with Mental Health Problems	USA
P4	Rachel Jenkins et al.	2007	Mental health reform in the Russian Federation: an integrated approach to achieve social inclusion and recovery	Russia
P5	Sandra Scivoletto et al.	2014	Global Mental Health Reforms: challenges in developing a community-based program for maltreated children and adolescents in Brazil.	Brazil
P6	Alan Pringle	2009	The growing role of football as a vehicle for interventions in mental health	United Kingdom
P7	Jessica Young Brown, Micah L. McCreary	2014	Pastors' Counseling Practices and Mental Health Services: implications for African American Mental Health.	USA
P8	Ellen J. Teng, Lois C. Friedman	2009	Increasing mental health awareness and appropriate service use in older Chinese Americans: a pilot intervention.	USA
P9	Maria L. C. de Oliveira et al.	2008	Counseling Brazilian Undergraduate students: 17 years of campus mental health service.	Brazil
P10	JoAnn E. Kirchner et al.	2007	Blending Education, Research, and service missions: The Arkansas Model	USA
P11	Robert A. FOX, Ryan J. Mattek, Brittany L. Gresl	2012	Evaluation of a University-Community Partnership to provide home-based, mental health services for children from families living in poverty.	USA
P12	Kate V. Hardy et al.	2011	Filling the implementation Gap: a community-academic partnership approach to early intervention in psychosis.	USA
P13	Jaleel Abdul-Adil et al.	2009	University-community mental health center collaboration: encouraging the dissemination of empirically-based treatment and practice	USA
P14	David A. Bartsch e Vicki K. Rodgers	2009	Senior reach outcomes in comparison with the Spokane gatekeeper program	USA
P15	Michael A. Southam-Gerow, Shannon E. Hourigan, Robert B. Allin Jr.	2009	Adapting Evidence-based mental health treatments in community setting: preliminary results from a partnership approach.	USA
P16	Ben Assan et al.	2008	The Adolescent Intensive Management Team: an intensive outreach mental health service for high-risk adolescents.	Australia
P17	Kimberly M. Jones et al.	2008	Community and scholars unifying for recovery.	USA
P18	Laurie A. Lindamer et al.	2008	Improving care for older persons with schizophrenia through an academic-community partnership	USA
P19	Richard Spoth et al.	2007	Toward dissemination of evidence-based family interventions: maintenance of community-based partnership recruitment results and associated factors.	USA
P20	Ashley Wennerstrom et al.	2011	Community-based participatory development of a community health worker mental health outreach role to extend collaborative care in post-Katrina New Orleans	USA
P21	Dee Howarth	2013	Camaraderie, tea...and laughter.	United Kingdom
P22	Catriona Hutcheson et al.	2009	Developing community-based activities for inpatients in a mental health hospital.	United Kingdom
P23	Gail L. McVey et al.	2005	A community-based training program for eating disorders and its contribution to aprovincial network of specialized services	Canada
P24	Michel A. de Arellano et al.	2005	Community outreach program for child victims of traumatic events	USA
P25	Lajhvir Rellon	2009	Rules of engagement: reaching out to communities	England
P26	Sharon Sousa, Christine Frizzell	2005	The power of friendship: the compeer program at the University os Massachusetts Dartmouth	USA
P27	Ana Paula Freitas Guljor	2013	O fechamento do hospital Psiquiátrico e o processo de desinstitucionalização no município de Paracambi: um estudo de caso.	Brazil
P28	Elisabete Ferreira Mângia e Priscila Mitie Yasutaki	2008	Itinerários terapêuticos e novos serviços de saúde mental.	Brazil

*P.C. Publication Code.

Figure 1 – Synoptic frame.

With regards to the intersectoral actions found in the literature, it was decided to present them in a grouped manner, using the division by themes according to **Table 1**.

Table 1 - Distribution of the publications by the category of identified intersectoral actions.

Category of the identified action	Publication code
Interventions in school/educational institution	P1, P3, P9, P10, P24
Educational actions	P1, P4, P10, P14, P20, P23, P25, P27
Partnerships with NGOs	P2, P4
Discussion forums	P2, P6
Social benefits (pensions, housing, health)	P2, P4, P5, P9, P11, P16, P27
Inclusive actions at work	P4, P22, P25, P28
Interventions in the community	P4, P5, P6, P12, P13, P15, P17, P18, P19, P20, P21, P24, P26
Home interaction	P11, P24
Religious care institutions	P7, P8, P28
Leisure	P6, P22, P25, P27

Most of the articles come from the MEDLINE database, which may be from journals in more than 70 countries on different continents, while *LILACS* only covers journals from Latin America and the Caribbean. This characteristic leads us to think that intersectoriality in mental health has been explored and described worldwide. However, despite the current debates, it has been little worked in studies, since the analysis of the articles allowed to identify that there is a concentration of publications on this subject between the years 2008 and 2009, being still necessary the incentive to its study.

In relation to the hegemony of publications and studies conducted in developed countries, emphasizing the United States of America, it is understood that there is a culture of research strongly consolidated in these countries, a fact that justifies the expressive number of articles found. In Brazil, it is believed that the researches were given greater visibility and fomented, as the policies of incentive were built the networks resulting from the Health Reform and the need to build intersectoral policies.

The networks of health care that focus on preventive and curative actions, integration of a diversity of services and intersectoral work, are necessary and discussed models from the 90's, questioning the bureaucratic and hegemonic model, based on hierarchical pyramids and models of health that are focused only on the solution of signs and symptoms.7 Hence, observing a context of social complexities, it was necessary to think of networks of flexible structures open to the work of different levels of attention, professionals, and decentralization of care.

Given this context, the intersectoriality is constructed by intersectoral actions by which they are presented in the selected articles (**Figure 1**). The intersectoral actions identified in the integrative review were gathered according to **Table 1**, and are discussed below:

Intersectoral actions of interventions in the school/educational institution

It is observed the importance of the school environment and also of the university in the prevention and promotion of health, being these local spaces necessary for carrying out actions in health and mental health.

The studies P1, P3 and P24 show examples of intersectoral actions carried out within the scope of teaching. Among them is a health education program, carried out during the period of P1, the implementation of health centers within schools, intersectoral actions in P3; and the behavioral and cognitive-behavioral approaches provided by home and school services for the care of children with trauma related to emotional/behavioral problems reported in P24.

When considering intersectoral actions in higher education institutions, study P9 presents the experience of a service that offers psychotherapy and emergency care for undergraduate and graduate students of a university in *São Paulo*. According to the study, the students attending the Psychological and Psychiatric Assistance to the Student (SAPPE) are mostly low-income students who have presented Mental Health issues, requiring university looks.

It is noted that professionals use these spaces to create/propose health care, this can provide the ease of access and adherence by the users. Nevertheless, it is important to consider that these strategies in the creation of intersectoral networks should expand beyond centers or practices within schools and universities, or simply interventions in some periods of time in these places. In expanding the intersectoriality debate, its actions should be shared among health professionals, teachers, families, and social actors, making the school and university a partner in a health and service network that goes beyond a traditional clinic.

Intersectoral actions of educational interventions

The studies P1 and P25 bring the importance of the figure of the promoters of spaces of discussion and learning. In P1 the teacher is the driver of the emotional health prevention programs of schoolchildren, thus making their training a cost-effective way of promoting mental health in schoolchildren. Instead, study P25 presents actions in which nurses and human resources employees are responsible for the action since they have the characteristic of going to schools to develop young people's awareness and understanding of mental health issues, and in addition they present the services available in the network, which was also saw in P10.

Considering the actions carried out, we highlight in P23 the experience of workshops on body image and the identification of students at risk of eating disorders, in order to refer them to specialized services in the community. On the other hand, the educational actions as professional training studies P4, P20 and P27 presented the logic of the training of professionals as a form of intersectoral actions. In P4, it is demonstrated that the specialized training program has helped to promote lasting changes in practice by creating a critical mass of professionals capable of providing multidisciplinary evaluation and treatment. This idea is also worked on in P27 that addresses the strategies of training and qualification of professionals in partnership with a university.

In this same line of thought, P20 describes the development of a training program for Community Health Agents (CHAs), whose purpose is to enable CHAs in the active search as a complement to collaborative care for depression. The main goal of the action is to reduce the disparities in access and quality of services for depression and posttraumatic stress disorder in the population of New Orleans following the 2005 Hurricane Katrina disaster. During the implementation of the program, the CHAs revealed lack of services for the vulnerable population, frustration with the lack of capacity to meet the financial needs of the population, concern with capacity, resources, and infrastructure for mental health services.

Given this context, it is important to consider that intersectoral actions should be considered beyond changing spaces, that is, taking care of the health service and letting the school and community be responsible for Mental Health activities. This process should be more complex, it is important to think about how to strengthen communication between services and devices, so that both are not isolated in the responsibility for health care, but rather that there is a sharing of experiences, cases, the creation of projects and co-responsibility for care.

Intersectoral actions of partnership Interventions with Nongovernmental Organizations (NGOs)

Nowadays, a NGO is understood as a group of non-profit voluntary citizens, organized locally, nationally or internationally. NGOs carry out a variety of humanitarian services and functions, bring citizens' concerns to governments, monitor policies and encourage political participation at the community level. They provide analysis and expertise, serving as an early warning mechanism, and help monitor and implement international agreements.[8,9]

In the P2 study, early childhood intervention services, the provision of social subsidies, the development of poverty reduction programs, and the rehabilitation of drug use are said to be easy to access when partnering and funding NGOs "In P4 the study presents actions that cover projects beyond the health issue, such as housing and employment projects in a region of Russia.

We can see in the studies presented that NGOs bring integration with social assistance, as they assume a role of mediators between the population and different sectors of government and society, and thus are important in the construction of intersectoral actions. However, it is necessary to point out that the state needs to be frequently called upon to assume its responsibilities in the creation, strengthening and expansion of Public Policies of intersectoriality and integrality.

Intersectoral actions of forums and discussions

In the P2 study, a national forum on forensic psychiatry was reported in South Africa with the South African Police Services (SAPS), the Department of Justice and the Department of Correctional Services. According to the authors, such intersectoral collaborations are the exception rather than the rule in the country in question. In P6 a forum is described to discuss questions about the use of football in mental health. The author argues that it is necessary to develop deep and sustained partnerships between the world of football and the world of mental health care as a potent activity for leisure, inclusion, and demystification of madness.

The studies demonstrate that forums have the potential to raise awareness of mental health issues in different governmental spheres and sectors of society, are important tools for intersectoral actions to be established and strengthened, aiming at integrality in health.

Intersectoral actions of social subsidy interventions

P2, P4, P11 and P27 mention the establishment of housing, such as the creation of shelters, social housing, and Therapeutic Homes, which favor and support the process of deinstitutionalization of patients with mental health issues. Among these, only P2 pointed out that sectors such as work, housing, and transportation have not been involved with mental health issues.

Considering the studies that involve some action between two services/agencies providing social subsidies are: study P5, which presents a partnership between university and community, providing school, family and social reintegration agencies and, when necessary, maintaining links active with Juvenile Court; and study P9, which presents a partnership between university agencies that help students meet their financial and academic needs. This strategy has contributed to the reduction in the abandonment of the course since the profile of the students served is of low income.

In this sense, P16 reports the action of an active search team and case management with high-risk adolescents and difficult adherence to mental health treatments. The team is linked to the mental health service for children and adolescents and funded by the Department of social work in Melbourne, Australia.

Socio-cultural factors have an effect on the course of the disease and the outcome of the treatments; so, it is not possible to restrict mental health to a narrow model of mental disorders by focusing only on psychiatric symptoms since health care requires thinking social benefits and living conditions.[1]

Intersectoral actions of inclusive interventions at work

Among the intersectoral actions focused on work is the study P4, which defends the need to define the roles and responsibilities of the Department of Labor in the development of skills, vocational training opportunities and career planning for people with intellectual and mental disabilities.

On the other hand, studies P22 and P25 report social inclusion programs for patients in a psychiatric hospital;

and employment and volunteer programs as a way to engage the local community in mental health issues. Already in P28 mentions the courses of professional qualification. Programs can help to rebuild patients' self-esteem and confidence, helping to reduce hospital admissions and improve their quality of life.[10] P25 advocates the engagement of different sectors of society as essential for the success of integrality in mental health.

Intersectoral actions in this field strengthen integral health care, as they provide resources for individuals to achieve social and economic integration in the environment in which they live. Thus, the work brings a sense of belonging, autonomy, and appreciation to people facing mental health problems. Being that the articulation with this sector is an important tool to qualify attention in mental health since work in the present time is considered as a value for inclusion in society.[11,12]

Intersectoral actions of community interventions

P5, P12, P13, P15 and P26 presented a university-community partnership through community-based, sustainable programs, prevention and intervention programs that helped find new ways to include the family in the health-disease-care process. In relation to other ways presented that promoted intersectoral actions in the community were through research, such as: the creation of a research project in partnership between researchers, academics and a group of people diagnosed with psychiatric disorders in P17; community-based participatory research and cultural exchange theory to create a research partnership between the Mental Health service at P18.

Other actions that do not include the university-research axis were also identified as the development of an action model for collaborative care for depression performed by community health agents in P20; a mental health education work in partnership between schools and community with a community recruitment team at P19; a program that provides home and school treatment services to address trauma-related emotional and behavioral problems in children in P24; a program whose purpose is to bring together individuals and groups who wish to help people facing mental illness in a relationship of friendship and fellowship in P26; weekly meetings for older men with mild to moderate mental health needs in a specially built shed in P21; the use of football stadiums as a space for P6 mental health interventions and ultimately actions to facilitate mental health reform in a region of Russia using systematic approaches to policy design and implementation presented in the P4 study.

Intersectoral actions of home interventions

P14 brings a program aimed at working in the community, including social actors such as restaurant employees acting like drivers, as well as health professionals. This program aimed at working with seniors giving the possibility of common people to identify and refer "acquaintances, friends, and people of the community with health risks.

On the other hand, P11 and P24 address interventions at home, where they bring programs that aim to change the behavior and emotional problems of children, the improvement in the father and son relationship and the instrumentalisation of parents to care for their children. The presented strategies range from jokes, observations of behaviors different from the common, and techniques of children approaching. It was observed that these programs aided in the professional's relationship with the family, placing the family as an essential member in the progress of the children.

Professional, family and community training and instrumentation through courses and training has been a form of intersectoral approach, with the importance of environments for reflection and construction of a collective work, however, it is necessary to point out that intersectoral actions must be reflected intersectoral network, formed of diverse sectors, services and places of care, in a way to articulate these places, and the great challenge is still to create integrated and not only isolated actions, such as, new techniques, little contextualizing and knowing these sectors.

Intersectoral actions of welcoming interventions towards religious care institutions

Study P7 investigates the perceptions and practices of pastors with regards to the mental health within their churches. Among the actions undertaken by the pastors were counseling, recognition of behavioral and emotional changes in church members, and referral of a member to an external source of mental health services. It was noted that for effective collaboration between the church and mental health services, there should be a working relationship between clergy and mental health professionals based on mutual trust and respect.

In P8, a community intervention is presented to sensitize the elderly to mental health issues and the available resources. In the study, members of a community church received a didactic presentation and answered a questionnaire regarding their preferences for seeking help before and after the intervention. The results suggest that the intervention successfully increased knowledge about mental health and adequate resources by the elderly.

In P28 there is the observation that faith is an important aspect in the therapeutic trajectory of the interlocutors. The approach of the life trajectories of the interviewees shows that social networks have an active participation in the definition, management, and creation of strategies of interaction with the disease.

There are three different approaches involving religious institutions: (1) the involvement of pastors who confers a close eye on the individual in psychological distress; (2) The intervention within the institution for the purpose of educating its members on mental health issues, and (3) The importance of religious institutions and faith as something

capable of strengthening and supporting the user in mental health. In different ways, the welcoming of religious institutions shows itself capable of involving and sensitizing leaders, members, and users in mental health issues. Understanding that mental health is not restricted to the "health sector" or the formal networks of public policies, and can also count on networks that reinforce spirituality and religiosity.

Intersectoral actions of leisure interventions

Intersectoral actions of leisure interventions go across sports, cultural and entrepreneurship activities. For instance, the P6 study outlined some mental health strategies with soccer clubs where people with mental health problems had the opportunity to join traditional groups, make friends, and develop better relationships with family members. In P22 and P27 there is the development of a program that promotes social inclusion from cultural activities such as dance, theater, music, photography, arts, crafts and cinema workshops.

Concerning the entrepreneurship actions, a P25 study was identified that inserts some innovative ways in which a foundation has been involved with local communities, extending the commitment of local companies to help eliminate stigma, remove barriers and create opportunities for users mental health. And study P27 also describes a community radio set up to discuss with the community a new approach to insanity, in which cadres were drawn up by deinstitutionalized patients themselves.

It is observed that leisure activities provide social inclusion and consequent demystification of insanity in society, bringing a sense of value and belonging. Through playfulness, everyone involved in these actions can experience moments of pleasure and integration, contributing to mental health.

CONCLUSIONS

This study found, in the national and international literature, a diversity of actions considered intersectoral, by which we organize in categories of analysis: interventions in school/educational institutions; educational activities; partnerships with NGOs; discussion forums; social benefits; inclusive actions at work; interventions in the community; home interaction; religious care institutions; and leisure.

Throughout the text, we seek to present and problematize intersectoral actions and the concept of intersectoriality, understanding that this process is not only to include other spaces for care but to stimulate and develop communication between health places, social assistance, work, leisure, education.

We believe that the greatest challenge of consolidating intersectorality is that there is such articulation between different sectors, broad communication and shared responsibility for mental health cases. For this, it is important the professional and social formation aiming to comprehend that health and integrality go beyond the absence of illnesses and point resolution of signs and symptoms, it covers the quality of life and the broad need of the subject, in other words, it involves work, food, care, leisure, religion, dwelling.

Hence, this work aimed to bring a review of what we have in the context of intersectoral actions in the world, subsidizing the need for investment in research on the subject. It is important that our public policies involve different services/spaces of society collaborating beyond the health sector, so we can envisage in the future the consolidation of comprehensive networks of mental health care.

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