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ARTICULATION BETWEEN MATRIX SUPPORT IN MENTAL HEALTH AND HEALTH CARE NETWORK[1]

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ABSTRACT. This research had as objective to investigate the matrix support in mental health in Primary Health Care and the articulation with the Health Care Networks. This is a qualitative research conducted with matrix supporters, such as psychologists and psychiatrists. The instruments used were semi-structured interviews and focus groups. Content analysis in the thematic modality was used to treat data. The results show the personalized relationships and the work style of the teams as immaterial resources that sustain the work; the strength of matrix support in Family Health Units; the need for systematic longitudinal support; and coordination as a facilitating factor for decentralization in mental health. The results also show the existence of three types of networks - centralized, decentralized and distributed. We conclude that the immaterial networks constructed in the communities through the relations and interactions established between professionals and users overlap with the established formal networks and present potential life production.
Keywords: Mental health, primary health care; matrix support.

ARTICULAÇÃO ENTRE APOIO MATRICIAL EM SAÚDE MENTAL E REDES DE ATENÇÃO À SAÚDE

RESUMO. Esta pesquisa teve como objetivo investigar o apoio matricial em saúde mental na Atenção Primária à Saúde e a articulação às Redes de Atenção à Saúde. Trata-se de uma pesquisa qualitativa realizada com apoiadores matriciais, tais como psicólogos e psiquiatras. Os instrumentos utilizados foram entrevistas semiestruturadas e grupo focal. Para o tratamento dos dados utilizou-se a análise de conteúdo na modalidade temática. Os resultados evidenciam as relações personalizadas e o estilo de trabalho das equipes como recursos imateriais que sustentam o trabalho; a potência do apoio matricial em Unidades de Saúde da Família; a necessidade de apoio sistemático longitudinal; a coordenação como um fator facilitador à descentralização em saúde mental. Os resultados mostram, também, a existência de três tipos de redes - centralizada, descentralizada e distribuída. Conclui-se que as redes imateriais construídas nas comunidades, por meio das relações e interações estabelecidas entre profissionais e usuários, sobrepõem-se às redes formais instituídas e apresentam potência de produção de vida.
Palavras-chave: Saúde mental; atenção primária à saúde; apoio matricial.

ARTICULACIÓN ENTRE APOYO MATRICIAL EN SALUD MENTAL Y LAS REDES DE ATENCIÓN A LA SALUD

RESUMEN. Esta investigación tuvo como objetivo investigar el apoyo matricial en la salud mental en la atención primaria y el enlace de las Redes de Servicios de Salud. Se trata de un estudio cualitativo realizado con los *matriciadores*, como psicólogos y psiquiatras. Los instrumentos utilizados fueron entrevistas semiestructuradas y grupos focales. Para el tratamiento de los datos se utilizó el análisis de contenido en la modalidad temática. Los resultados muestran las relaciones personalizadas y el estilo de trabajo de los equipos y los recursos inmateriales que sustentan el trabajo; la potencia del soporte matricial en las Unidades de Salud Familiar; la necesidad de soporte longitudinal sistemático; la coordinación como factor que facilita la descentralización de los cuidados en salud mental. Los resultados también muestran la existencia de tres tipos de redes - centralizados, descentralizados y distribuidos.

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Llegamos a la conclusión de que las redes inmateriales construidas en las comunidades, por intermedio de las relaciones e interacciones establecidas entre los profesionales y los usuarios, tienen prioridad sobre las redes formales establecidos y vida actual de producción de vida.
Palabras-clave: Salud mental; atención primaria de salud; apoyo matricial

Introduction

This study aimed to investigate the matrix support in mental health in Primary Health Care (PHC) and its articulation with Health Care Networks (HCN). Fragmented hegemonic health care systems are organized as isolated and incommunicable points of health care with a tendency to return to acute conditions. While integrated systems tend to act on acute and chronic conditions, fragmented systems, organized in hierarchical structures (primary, medium and high complexity care) are unable to provide continuous and comprehensive attention to the population (Mendes, 2011). This situation is even more deleterious in the area of mental health because of the simultaneous occurrence of acute conditions and exacerbation of chronic mental disorders, besides clinical comorbidities.

The need to integrate the mental health agenda in Non-communicable Chronic Diseases (NCCD) has been advocated in different fora such as the World Health Assembly (World Health Assembly, 2012), and publications (Ngo et al., 2013; World Health Organization, 2013; Patel et al., 2013). It results from the understanding and scientific evidence that people live with both physical and mental illnesses throughout life and that they influence each other (Ngo et al., 2013; World Health Organization, 2013). The data indicate that people with major depression and schizophrenia have 40% to 60% more chances of dying prematurely than the general population, due to lack of attention to physical problems such as cancer, cardiovascular diseases, diabetes and HIV infection (World Health Organization, 2013).

Despitethe evidence and studies (Prince et al., 2007; Becker & Kleiman, 2013) showing the relationship between NCCD and mental disorders, the latter remain in the void, waiting for a global agenda to give them visibility. In May 2013, the World Health Assembly of the World Health Organization approved the *Comprehensive Mental Health Action Plan* 2013-2020 (World Health Organization, 2013). In this document there is the recognition that people with chronic conditions are more likely to develop some mental disorder. This document is perhaps the first step towards making the need for integration of NCCD and mental health visible.

On the other hand, there are also numerous structural difficulties in the PHC and in the HCN regarding the difficulty of services to assume the responsibility for people rather than for diseases and procedures, whether acute or chronic. This difficulty is related to the objectives of the services and, above all, to the contracts that are established with the services. Alves (2011) recognizes that among the challenges of the psychiatric reform in the country is the articulation in the network, the evaluation of the quality of the services offered and the rigorous documentation of the innovative practices.

In Brazil, initiatives such as matrix support in mental health in Primary Health Care (PHC), the institution of the many HCN and PCN aims to decentralize care and promote networking through intersectoral actions with a view to the integrality of care (Departamento de Atenção Básica, 2012). The objective of the matrix support is to provide assistance and technical-pedagogical support to the reference teams. This involves the shared construction of health guidelines between referral professionals and specialists who provide the matrix support. Both matrix support and the reference team include organizational arrangements and a methodology for health work management that aim at clinic expansion and dialogic interaction between different specialties and professions (Campos & Domitti, 2007).

The HCN comprises polyarchic organizations of health service groups linked by a single mission, common objectives and cooperative and interdependent action through the provision of continuous and integral services to a given population and with sanitary and economic responsibilities towards this population. One of the characteristics of the networks concerns the fact that the coordination is carried out by the PHC (Mendes, 2011). Thus, with the objective of overcoming the fragmentation of attention, specialists in the HCN model act as supporters and consultants for PHC teams (Mendes, 2011).

The Psychosocial Care Network (PCN) is one of the priority networks for the Ministry of Health. Among the guidelines of the network are the respect for human rights; the promotion of equity through recognition of social determinants of health; the guarantee of access, through comprehensive care, under the logic of interdisciplinarity; the emphasis on community-based and territorial services; and the establishment of intersectoral actions to guarantee the integrality of care (Departamento de Atenção Básica, 2012)**.** In this perspective, matrix support represents an important tool for the decentralization of mental health care, promotion of equity and integrality through articulation and integration of health networks in the territory, qualifying care and providing continuous follow-up and attention to urgencies (Portaria nº 3.088, 2011). Thus, the present study intends to contribute to the discussions about the implementation of this methodology of work, the unfoldings for the network care and the different established network configurations.

Method

This is a descriptive-analytical research with qualitative approach. The participants were professional specialists (two psychologists and four psychiatrists) who worked in the matrix support for mental health of Gravataí/RS, Brazil. According to the inclusion criteria of matrix supporters, those who had been acting in the mental health support for at least two years were selected, regardless of the intervention modality (case discussion, supervision or joint attendance; specific care or interventions of the supporter with subsequent care by the referral team). Based on these criteria, one professional was excluded from the survey.

Located in the metropolitan area of Porto Alegre, Gravataí is an economically important city by having the sixth largest Gross Domestic Product (GDP) and the sixth largest population in the State, with about 255,660 thousand inhabitants. In 2006, the municipality qualified for the term of commitment for health care management. The Primary Care network is made up of 26 Health Units, of which 12 are Family Health Units (FHU) and 14 are Basic Health Units (BHU). In 1997, the process of decentralization in mental health began. In that year, some psychosocial care center (PCC) professionals, under the coordination of a psychologist, began to make periodic visits to the various BHU for discussion of clinical cases. Instead of a bureaucratic and impersonal counter-referral system, a personalized work was carried out with PHC professionals. Also in that year, group meetings in the community were established and from 2007 onwards, the matrix support in mental health.

The municipality's secondary mental health network is composed of three PCC: PCC II (care for adults with severe and persistent mental disorders), PCC ad (care for disorders resulting from use and dependence of psychoactive substances) and PCCi (care for children and adolescents with mental disorders). In the tertiary care, there is an emergency service in the municipality with psychiatric beds for observation and brief hospitalization and beds for mental health hospitalization in the general hospital.

The instruments used were semi-structured interviews (Minayo, 2010) and the focus group (FG) (Barbour, 2009). The choice of these two research methods was due to different perspectives, *insights* of work processes, as well as inconsistencies and contradictions. For both semi-structured and FG interviews, a script was drawn up. First, all the semi-structured interviews were carried out and then the FG. The databases were analyzed individually first, through an exhaustive reading of the texts according to the analytical proposal described below. After this first move, data obtained from the two techniques were triangulated.

The content analysis technique in the thematic modality (Minayo, 2010), including ordering, classification and final analysis of the data, was used to analyze the data. The ordering of the data consisted in the transcription of the interviews; re-reading of the material; and organization of the reports in a certain order, according to the analytical proposal. The next step, the classification of the data, was operationalized by the horizontal and repeated reading of the texts aiming to seize the "relevant structures" of social actors (Minayo, 2010, pp. 357-358). In these structures are contained the interviewees' central ideas on the subject, from which the empirical categories emerged. The final analysis and discussion of the data was made in the light of recent scientific evidence at national and international level.

The research was submitted and approved by the Research Ethics Committee of the Pontifical Catholic University of Rio Grande do Sul, under nº 304. 227. All interviewees signed the Informed Consent Term (IFT). Participants will be identified by letters and numbers in order to preserve anonymity (AM1, AM2, AM3...).

Results and discussion

The extended interaction field of the AM, that is, the space of articulation with the Health Care Network and the Psychosocial Care Network; the coordination; the decentralization and the systematic longitudinal support and different network configurations, will be discussed in the thematic areas.

Matrix support and operational aspects of networking

The interviews evidenced that the current configuration of the AM was preceded by the decentralization of the therapeutic groups in the territory. These groups were and continue to be coordinated by a psychologist who also took on the task of locating other mental health professionals to form a team of supporters. The participants recognize that there are separate but complementary activities. We can understand from this that there is a focus on operational aspects and also on immaterial resources, to get to know and interact with people from different places in the network. The participant explains how the matrix support operation in PHC occurs:

> *We first get in contact with all the units, we have one general meeting per semester, in which the professionals, usually the coordinators and the doctors, participate and this meeting usually takes place in the PCCII. Then the dates and places of the meetings are defined, usually these meetings happen in the units so that the professionals can get to know each other and at the same time they can interact* (AM1).

The various HCN are composed of three elements: the population, the operational structure and the health care model. The first element, the population, is the raison d'être of the networks, and it must be known and registered by the PHC, with the knowledge of groups at socio-sanitary risk. For Mendes (2010), the knowledge of the population of a given HCN involves a complex process and implies territorialization; the registration of families; the classification of families according to socio-sanitary risks; the linking of families to the PHC unit; the identification of subpopulations with risk factors (psychobiological risks, such as hypertension, depression); the identification of subpopulations with health conditions based on degrees of risk (e.g. low risk, medium risk, high risk, very high risk and/or comorbidities); and the identification of subpopulations with very complex health conditions. The second constituent, the operational structure, consists of the network nodes and the material and immaterial resources communicated by these different nodes. It is divided into five components: the communication center, the Primary Health Care; the secondary and tertiary points of attention; the support systems; the logistics systems; and the HCN governance system (Mendes, 2010).

The third element, the health care model, organizes the networks of health systems according to a certain time and in a given society, defined according to the prevailing view of health, demographic and epidemiological situations and social determinants of health. The various HCN can improve clinical quality, health outcomes, user satisfaction, and reduce the costs of health care systems (Mendes, 2010). Empirical data bring a wide perspective of the intervention of the specialists in the matrix support, as AM3 reports: *"In addition to the participation of other professionals, the differentiated knowledge in relation to the users, it is also to get out of the scope of the sign and symptom of mental illness and know that there is a much greater repercussion in their social, family, work aspects..."*.

The previous speech shows that the interventions transcend the biomedical model, unlike what was pointed out in another research (Pegoraro, Cassimiro, & Leão, 2014) that showed that the matrix support investigated in reality is centered on the psychiatrist and in the perspective of the biomedical care model, without the intervention of other PCC professionals. The study revealed the professional intervention on the disease to the detriment of the joint elaboration of strategies by different actors for the use of different resources in the community. The care model expected for integrated networks is

one where the care is centered on the person, family and community; these are defined as secondary attributes of attention networks (Organização Panamericana da Saúde, 2011).

The data show that besides the work carried out in the AM, therapeutic groups in the community provide the framework for an informal network that recall paradigms that depart from the biomedical model centered on the disease and the harm and work along with the paradigm of life production of subjects. This network supports modes of subjectification anchored in the care, constitution and co-emergence of singular contexts, by increasing the contractual power of users. Thus, the matrix support in mental health implied in the work carried out in the PHC through cooperative and interdependent, longitudinal and integral action towards a specific population can impact the life of the people who seek help in the professionals and consequently in the health outcomes.

Specifically the area of mental health is dependent on light and light-hard technologies (Merhy, 2005) and immaterial resources (Thornicroft & Tansella, 1999). Different authors, through different constructions, have defended the immaterial elements in the work processes. Merhy (2005) sustains light, relational technologies; Thornicroft and Tansella (1999) emphasize *invisible inputs* resources; Saraceno (1999) addresses the *style of lavoro* of the teams with a high affective, intellectual and organizational consumption. Venturini (2010) advocates the power of human resources to support informal networks in community spaces.

Some participants did the training in community health; however, an issue addressed by them concerns the inclusion of the theme matrix support in the training of professionals. "*I think it's very important for the academic training, for us to work with the matrix support"* (AM5). Another supporter brings the perspective of training associated with the public health bias. "*So, I would start with the issue of training, of being able to look at the patient in the public health sector; during my whole life, I dedicated a lot of time to public health, to public health issues*" (AM6). This is a relevant issue because it ultimately concerns the characteristics, specificities and attitudes desirable for the support function.

The analyses carried out in this study showed that immaterial elements support the proposal of the matrix support. These elements appear in different ways: internal support relationships of the working group itself, anchored in care; personalized relationships with reference teams; the affectivity, the different theoretical aspects of the professionals that, instead of being an impediment, provide different looks of the object; respect for the opinion of others. These are some specificities of the group studied. Thus, we can infer that the work developed in the matrix support needs to take into account such elements, with a view to overcoming the bureaucratization of work processes. It was also possible to observe the existence of nodes to be untied, such as, for example, the need to involve the PCC and the management in the articulation of the network.

Health Care Network and Psychosocial Care Network

The components of the PCN are the basic health units and the specialized psychosocial care (Portaria nº 3.088, 2011). The PCN is one of the HCN that has been designated, through a tripartite agreement, as one of the priority thematic networks. The interviews show that the understanding of the service network is fundamental for matrix support, for the movement of both supporters and users. *"By having an idea of the whole, I have an idea of the PCC, I have an idea of the Urgency and Emergency Service, I have an idea of the FHS and the BHU, that is, I can see the integrality of the network"* (AM6). This result finds resonance in another study (Bonfim, Bastos, Góis, & Tófoli, 2013) that endorses the need for the supporter to have a comprehensive understanding of the health network and of the complexity of mental disorders, as well as other skills still under construction.

The professionals reported that not only light cases are taken care of in the matrix support, but also more serious situations. These situations, when referenced to PCC or to hospitalization, are the result of risks (self-inflicted and hetero-inflicted aggression, neglect, social risk) and not of the primary diagnosis. The participants understand that matrix support implies co-responsibility and co-management of the case. Thus, referral to a specialized service is performed when the person will benefit from it. In the traditional model of reference and counter-reference, movements of unaccountability usually occur, whereas the matrix support logic demands co-management and co-responsibility. In this way, the possibilities of interventions for serious mental disorders are widened.

The circulation through the different services of the territory is in practice incorporated by the team. *"The Center for the Elderly that give assistance there to the mother of a patient who is here at the PCC, and with this conversation we can find out everything that happens within a family and draw a goal together...".* (AM3). The establishment of therapeutic proposals with professionals of other services of the network qualifies the doing, provides situational diagnoses and widens the scope of the work of specialists and generalists.

> *These meetings beyond the units take place in the Urgency and Emergency Service, in the Elderly Home, in the Municipal Polyclinic, in the Quality of Life Center, in PCC ad, in the Center for Child and Family Care, so that all those demands that we have of needs, and that more professionals be able to contribute, so that we can see it 'in loco'..."* (AM1).

The previous speech corroborates the construction of Mendes (2010), who argues that other basic contents of the various HCN include: a constant exchange of resources; the non-establishment of hierarchy among the different components and points of health care; a continuous care at the primary, secondary and tertiary levels; integral attention with promotion, prevention, curative, caring, rehabilitation and palliative interventions; focus on the complete cycle of a health condition and generating value for the population (Mendes, 2010). A dynamic implemented in matrix support consists in the meetings taking place in different services of the network. This allows a constant exchange of human resources and the construction of new knowledge based on the situations discussed between the teams and the supporters. Processes of support to the distress brought by the BHU and FHS professionals in the case of severe patients, besides the training and permanent education of professionals, also occur there. This is one of the functions of matrix support, by expanding the repertoire of technical interventions.

> *The qualification in recognition of situations, when you see a situation of a patient with mood disorder, and after that another situation similar to this, you can identify basic issues, signs and symptoms, plan a better treatment, thus, there is an organization that is more appropriate for the learning, in fact, focused on training and not only on demand* (AM2).

Besides a formal network, there is the systematic construction of a symbolic network centered on people suffering from mental disorders and their surroundings, mediated by specialist and general practitioners. This symbolic network, sustained not only by professionals, but fundamentally by the participants of the groups in the community, was discussed in the FG. That is, these networks that were gradually built in the territory present the potential to produce health.

> *So, when the person realizes that she can build not only the change of her suffering from a medication... there is a greater desire for life and together they can build a larger collective of social change because they are being heard* (AM4 FG).

Decree nº 3,088 of December 23, 2011, establishes the Psychosocial Care Network (PCN) for people with mental disorders and with necessities arising from the use of crack, alcohol and other drugs within the Unified Health System (SUS). This network should integrate the different modalities of care into mental health within the scope of the SUS and should be constituted by: basic health care; street practice teams; Coexistence Centers; PCC; urgency and emergency care; Home Care Services; Family Health Care Centers (FHCC); and the reference hospital service (Portaria nº 3.088, 2011).

> *Thus, the articulated process is this, from the tip to the hospitalization, if it is the case, when we forward the patient from here, and after that then the return to the PCC, the PCC ad, the PCCII, in order to continue the hospitalization process, the service and the new reference to its unit of origin; this is the process of articulation that I see* (AM6).

Mental health actions are mentioned by supporters as occurring in different network services - in the PHC, in the PCC (II, ad and infantile), in the emergency service, in the center of the elderly. This refers to a dynamic process, due to the turnover of professionals, which generates the need for new investments to raise awareness towards the proposal presented by the supporters. That is, there is a need to redo the points in the network through the changes of the BHU and FHS teams.

In the study, it could be seen that the matrix support developed in the PHC and the community groups, through an interdisciplinary work, has potential for promotion, prevention, care and treatment actions. However, the participants recognize that the matrix support in traditional BHUs, in some cases, serves to meet the demand in mental health. The work carried out in the FHS, on the other hand, allows joint planning to be carried out. This is due to the different modes of operation, organizational structure and human resources of these units. Despite the difficulties, the supporters decided in favor of maintaining the matrix support in the BHUs, in the possible model, since these units have gradually been transformed into FHS.

Coordination in Health Care Networks

In the study, the coordination of the matrix support is on the hands of a CAPS psychologist who is integrant of the different services, and performs the articulations between the different PHC groups where support is provided, as well as in the relationship with other specialist colleagues. That is, there is an intensification of the possible relationships between the different protagonists of the process, with personal enrichment of all involved. Mendes (2011) argues that the coordination has a greater importance in the HCN because without it, all the other attributes, the first contact, the longitudinality and the integrality would be hampered. It is through the PHC coordination that the flows and counter-flows are ordered at the various levels of a given HCN.

Some personal characteristics of the coordinator that facilitate the process of matrix support in the PHC can be deduced from the reports of the professionals: the movement through the different places and the explanation of the proposal of work, the articulations made person to person, the capacity to aggregate people around a common goal, group motivation, respect for different opinions, and the ability to mediate conflicts and to build consensus. The recognition of this coordination by the peers, by the general practitioners, as well as the need to strengthen their role with the management and political authorities, was reported in the interviews and FGs.

Leadership in mental health has been pointed out in other studies (Eaton et al., 2011; Kakuma et al., 2011; Benzer et al., 2012) as one of the barriers to decentralization in mental health, when nonexistent, or as a facilitator, when present. Leadership is conceptualized as the ability to cultivate vision and values that can be shared with others, to initiate and guide actions in a group or organization, to build and sustain trust (World Health Organization, 2005). "*He (leader) had a good movement, he was also able to explain and discuss the* matrix support *in the teams... he can clearly explain how and what the process is, how the* matrix gives support *... "* (AM4).

The logic of "reasoning with the feet" (Venturini, 2010: 478), which means to know and to cross the community, to live in the daily life the "laboratory of life" of people and their stories, is also evident in the speeches. One of the participants has two formations - psychiatrist and sanitarist, and reports that:

> *This public health issue has allowed me to develop a different look, to be able to look at the issue of mental illness effectively within the public context... thus, I need to be passing in the places, talking to people, trying to understand* (AM6).

The speeches show that the proposal of the matrix support transcends the process and place the people involved in the work in the centrality. That is, there is a tendency to personalize the relationships through interaction and dialogical processes that are established among the people involved. Regardless of the training or specialty, people are known by name. It is noted that, in addition to the care provided to the user, there is a personalization of relationships within the team, and between these and the environment, generating personal enrichment, besides professional exchanges. From this, a central issue for matrix support in the PHC emerges in the study, namely, the focus not only on the process, but primarily on the interactions between people who operationalize the process.

> *This way you know the people, the subjects that are involved in the care of that user; thus, these articulations are made in the day to day contact, in the communication, in the understanding of a bigger proposal to know not only what is done, the process, but also the people involved in this process* (AM1).

This finding is corroborated by Venturini (2010): "The answer is to abandon the idea of working with and between institutions; the secret is to work with people, with their subjectivity, with people who live and work in the institutions". (p. 478). On the other hand, with regard to the coordination of the network care, a study carried out in four capitals showed that the main difficulties are the restricted flow of information about the patients and the lack of sharing of responsibility between the different levels of care regarding the assistance given to the patient. The authors acknowledge that the sharing of responsibilities will only be possible through the implementation of effective mechanisms of communication between different levels of care and the creation of spaces for professional coexistence between different professionals (Organização Panamericana da Saúde, 2011).

The matrix support in mental health in PHC demands the weaving of a network of people and services and implies the construction of an interdisciplinary work process through the convergence of an ideal, the decentralization of mental health care. In the study, this convergence of ideas, and, above all, ideals about decentralization in mental health, helps in coping with challenges and overcoming obstacles and subsidizes the actions of professionals. Thus, the interaction between professionals gives origin to dialogical processes that allow the creation of joint work platforms, not only restricted to the teams and supporters of each FHS or BHU, but also among the different PHC teams.

Decentralization and systematic longitudinal support

Decentralization in mental health (groups and matrix support) did not result from a management demand (Secretary of Health), but from the conviction of a group of professionals and their internal arrangements. This protagonism supported the proposal in the management changes. Among the motivating factors of the supporters is the understanding that the territory is the place par excellence for promotion and care in mental health. The idea that there is a systematic need to raise awareness among managers, at every change of government, prevails in the speeches. This is due to the vicissitudes of political, technical and managerial nature to which the professionals are exposed. In that sense, it is the recognition that, despite the different forces at stake, matrix support was maintained because of the desire and the protagonism of the supporters.

The flows established in the network are the matrix support in days and at times previously agreed; the different groups in the community, coordinated by psychologists; the telephone contacts in situations of urgency or doubt and the reference system for specialized services (PCC, hospitalization) when it is impossible to maintain the person in outpatient care. The participants understand that matrix support implies co-responsibility and co-management of the case. Thus, referral to a specialized service is performed when the person will benefit from it. *"... the idea of passing on the care is the idea that if I'm forwarding someone to another service, it's because I think that person will effectively benefit from that action. But if I'm just passing on the responsibility, that is a problem"* (AM6). In other words, referral to secondary or tertiary care should be foreseen in matrix support, provided that it is supported by a logic of maintenance of bond and longitudinal monitoring.

Research carried out focusing on the construction of mental health interventions in *Low and Middle-Income* Countries (LMICS), based on training and supervision of lay councilors and supervisors concluded that continuous (systematic) support is essential for the maintenance of interventions in PHC (Murray et al., 2011). These findings are in line with other studies that focus on severe mental disorders (Minoletti, Rojas, & Horvitz-Lennon, 2012; Prates, Garcia, & Moreno, 2013). The continuity of the contact is fundamental for the operationalization of the work process, as well as for the effectiveness of the interventions. Mendes (2011) points to "evidences that show that the performance of specialists only adds value to people when they personally know and work together with the generalists" (p.108). This assertion finds resonance in the speech of AM4: *"... if there was* matrix support *and then this slowed down, I think it would not work, the support has to be continuous".* Another participant points out: *"It is a process because there is a beginning, an intermediate point, and there is no end"* (AM3).

It was noticed in the FG that there are tensions that related to the lack of understanding of the work process by the management, especially in that specialized professionals do not assist a significant number of users. There is an assessment of the number of people served and the lack of understanding that matrix support may reduce referrals to specialized services. Other issues involve the

lack of structural conditions for work, and the feeling of non-appreciation and non-recognition of the work developed by the supporters on the part of managers. "*And another thing that also limits the work of the matrix support is sometimes the managers who do not understand that the work that happens outdoors is as important as that carried out within four walls"* (AM1). *"*Usually, in a BHU, we deal more often with demand, thus the professional has no time available for discussion and this is something that happens in the FHS, a space and a timetable destined... " (AM2). *"There has to be motivation in order that it (the management) understands the importance of matricial support and believes that it is possible to contemplate the demands of mental suffering in the basic unit and with enough time for this to happen, with due acknowledgement of the managers"* (AM3).

The FG discussed the difficulties of the PCC as articulator of the picossocial network. The discussion was based on the following arguments: the PCC should be the aggregating place of actions, but this space does not exist for the articulations of the group, neither is this place the broader scenario of mental health of the municipality; the absence of participation of the mental health coordinator in activities of the matrix support; the need to reduce the distance between BHU and the FHS and the specialized service, which to some extent is reinforced by matrix support by the issue of lack of free access of people to the PCC. Obstacles to referral to the PCC occur because the reference professional needs the endorsement of the supporter, or needs to be carried out by him. *"They (patients) arrive in the counter and sometimes the person does not answer: 'Why did not they give me a good assistance, if there in the BHU X they assisted me well?'"* (AM 4 FG). Another supporter noted that "*the counter is more a wall than a counter"* (AM 1 FG).

It can be concluded that there is a need to work on the deinstitutionalization of the PCC and articulate it effectively in the network. It should be noted that authors and official documents have different perspectives on the role of CAPS in the network. While some argue that PCC should be the articulator of the network (Dimeinstein et al., 2009), others say that coordination, including decentralization through AM, must be from PHC (Mendes, 2010; (Portaria nº 3.088, 2011). Other authors note that PHC does not yet have the necessary conditions to do so (Cecílio et al., 2012). These different perspectives are evidenced in the fragmented practices and in the difficulty of articulating the network in the Brazilian municipalities.

As for the operational structure of the networks, Mendes (2010) argues that, from the perspective of polyarchic networks, there are no relations of what is primordial or subordinated, characteristics of hierarchical networks. However, in the practice, a valuation of the specialties is observed, corroborated by the hegemony of the specialized work over that of the generalist, and of specialty services on PHC. This relationship of subordination correlates with social, cultural, and economic values. Depending on how the communication and co-operation contracts happen between the network's points, if this trend is not addressed, it is strengthened and updated.

Network configurations

For the discussion of the different network configurations established in the researched reality, a theoretical contribution was sought in Ugarti (2008). According to the configuration constructed by this author, it is evident the existence, in the city under study, of three types of networks: centralized, decentralized and distributed. The centralized network, through a established formal system of reference and counter-reference; the decentralized network, through matrix support in mental health and the distributed network. This latter is operationalized through the organizational arrangements of the systematic meetings of the matrix support in different points of the network. Therapeutic groups in the community also play a role here. They allow participants to circulate in different groups in the territory, without the imperative of being attached to a particular location. The SUS is configured in a decentralized but hierarchical network. In this research, the design of other network configurations is rooted in immaterial resources - in relationships established between people (generalists, supporters and users). Thus, the different types of networks are manifested in the work and relationships established in the field. These arrangements are built on the micro-politics of vivid health work (Merhy, 2005).

The research shows that the formal network, especially with respect to the specialized service, the PCC, presents weaknesses. These result, as already identified by Dimenstein et al. (2009), from the operation in an out-patient *modus operandi*, with little insertion in the territory, permeated by a disciplinary functioning (if the patient misses X consultations, he misses the vacancy). *"There is a very interesting situation there (PCC), I'm on vacation now, all groups worked, except the PCC, do you understand? This inconsistency is very complicated."* (AM4 FG). However, there is a symbolic network that permeates the relations between specialists, generalists and users. It can be inferred that this immaterial network supports the specialist and generalist professionals in mental health decentralization.

The analysis of the empirical material allows inferring that the matrix support in mental health facilitates the configuration of non-regulatory networks in the territory, where the weight of services is relativized. The networks built in the territory come to the meeting of a project to promote life, the weaving of new relations and interactions between people. The results show the concern to broaden the existential, relational, affective and geographical scenarios of the people. Thus, the central question is to resignify the experiences of suffering, to strengthen the support networks and the production of sense for life.

Final considerations

We conclude that there are different organizational arrangements between the reference teams and the supporters, according to the different realities - BHU or FHU. These different tasks, evidenced as potent factors in the FHS, come from the teams formed by different professional categories; from the link between professionals and users; from the personalized relationship with general practitioners of longitudinality; and from the characteristics of the professionals. Among the other reasons listed are the interdisciplinary work and the incorporation of "matrix logic" by professionals.

The complexity of the process stems from the need to systematically redo formal network points. One challenge concerns the elimination of barriers to access the referral of patients imposed by the PCC coordination, on the grounds that there is matrix support. This work methodology will reduce referrals from patients to specialized services. However, there will still be a need to refer some patients to secondary or tertiary care services. Another challenge points to the need for management to provide objective and subjective conditions for the implementation of matrix support.

The results show that there is a genuine interest of the supporters in decentralization, despite the obstacles of several orders. It was noticeable that they themselves experienced the deinstitutionalization and the possibility of creative interventions in the territory. In this sense, the possibilities are extended not only for people with mental disorders, and also the professionals are affected by the co-constitution of singular contexts of interaction with generalists in PHC. Thus, in addition to the basic guidelines and the different forms of operationalization of the matrix support, it was possible to analyze the singular unfolding that this process provides in the studied reality.

The research shows that the central issue stems not only from the process, but from the people involved in it, in short, from immaterial resources. This observation points to the fact that matrix support and network articulation are essentially dependent on relational technologies, communication, the work style of those involved, and interdisciplinarity. The human networks that are constructed in daily life, as the study shows, overlap and enhance the established formal networks, but do not ignore them. These networks, supported by people, speak of a know-how directed to the production of a sense of life and a reduction of human suffering in the territory.

The research also revealed the possibilities of action of psychologists and other professionals working in the field of mental health in Brazil. Among the different challenges are the issue of training to work in PHC; the characteristics and attributes desirable for the work; the adoption of new epistemological perspectives; the incorporation of supervision and support as a working tool; the extension of disciplinary competences; the formation of multidisciplinary teams in the conduction and co-management of the interventions, which calls for an interdisciplinary work. In this sense, there are no "ready" supporters, but they become such in the relational work in action.

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