Saúde e Sociedade
ISSN: 0104-1290
ISSN: 1984-0470
Faculdade de Saúde Pública, Universidade de São Paulo.
Associação Paulista de Saúde Pública.

Bermudez, Karina Moraes; Siqueira-Batista, Rodrigo
"Um monte de buracos amarrados com barbantes": o conceito de rede para os profissionais da saúde mental1
Saúde e Sociedade, vol. 26, núm. 4, 2017, Outubro-Dezembro, pp. 904-919
Faculdade de Saúde Pública, Universidade de São Paulo. Associação Paulista de Saúde Pública.

DOI: 10.1590/S0104-12902017170298

"Many holes tied together with ropes": the concept of network for mental health professionals[1]

"Um monte de buracos amarrados com barbantes": o conceito de rede para os profissionais da saúde mental

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Abstract

This study aimed to analyze the meanings attributed to the concept of network of care by health professionals and identify how they change it into living work in the production of care. This study used a qualitative approach, with interviews mediated by the use of problem situations with professionals from different levels of care provided to patients with mental disorders. Data were evaluated using Bardin's content analysis and, from the thematic analysis, three categories were defined: (1) meanings of a network of care - concept and characteristics; (2) operating means for the construction of a network of care - practice construction; and (3) proposals to minimize the challenges and consolidate a network of care. From these, the following subcategories were identified: networking; support networks; conflict; continuity of care; integral care; shared care; training process; broad discussion; and work organization. This study concluded mental health professionals express different concepts of network and, therefore, act differently when producing care, even though they observe the same normative guideline. Access fragmentation and barriers to access were also observed, which hinders the patient's use of the network of care.

Keywords: Mental Health; Integrality; Normative Guidelines.

1 This study was supported by the National Council for Scientific and Technological Development (CNPq) and the Research Program of the Faculdade Dinâmica do Vale do Piranga (Proapp/Fadip).

DOI 10.1590/S0104-12902017170298

Resumo

Este trabalho objetivou analisar os sentidos que são atribuídos ao conceito de rede de atenção pelos profissionais de saúde e identificar como eles o transformam em trabalho vivo na produção do cuidado. A investigação foi de abordagem qualitativa, com entrevistas mediadas pelo uso de situações-problema com profissionais de diferentes níveis de atenção aos pacientes com transtorno mental. Os dados foram apreciados pela análise de conteúdo de Bardin e, da análise temática, emergiram três categorias: (1) sentidos de uma rede de cuidado – conceituação e características; (2) meios operadores para a construção de uma rede de cuidados – construção da prática; e (3) propostas para minimização das dificuldades e efetivação de uma rede de cuidados. Delas, por fim, surgiram as seguintes subcategorias: trabalho em rede; redes de apoio; conflito; continuidade do cuidado; assistência integral; cuidado compartilhado; processo de formação; espaços amplos de discussão; e organização do trabalho. Desse modo, foi possível concluir que os profissionais expressam diferentes conceitos de rede e, com isso, agem de modo singular na produção do cuidado, mesmo estando sob a mesma diretriz normativa. Foram identificadas, também, uma fragmentação do acesso e barreiras a ele, o que dificulta a trajetória do paciente pela rede assistencial.

Palavras-chave: Saúde Mental; Integralidade; Diretrizes Normativas.

Introduction

Over the last two decades, there has been a significant reorientation of the attention provided to patients with mental disorders, given the creation and expansion of care services, seeking to replace a hospital-centered logic with a psychosocial care model, diversifying the types of therapy and creating new scenarios of care provision (Amarante, 2007). The possibilities of thinking and caring in the field of mental health have increased, including the creation of a **network** of services to provide proper care and attention and engage the patients themselves, their families, the territory, health professionals, administrators and the community.

The idea of Health Care Networks (RAS – *Redes de Atenção à Saúde*) has been largely discussed and questioned within the scope of the Brazilian National Health System (SUS – *Sistema Único de Saúde*) and in the daily services of the area. However, the concept of service networks is not new. It dates back to the 1920s, when the Dawson Report was developed in the United Kingdom. This document proposed the organization of regional health systems so that services could adopt a new and expanded arrangement, distributed in such a way that the needs of the (target/ascribed) population were efficiently fulfilled by adopting combined actions (Dawson, 1964).

In more recent considerations, Mendes (2011) referred to the characteristics of an integrated network and the effects of disintegration. In general, the RAS perspective attempts to detach from the hierarchical concept and shows the networks as polyarchical formations, that is, in a cooperative, horizontal relation, but respecting the differences in the technological densities. It is no longer concerned about who controls who, who reports to whom. The reference that guides care leaves the required complexity and focuses on patients and their needs. After that, and with a more flexible model, new schemes may be considered and drawn within the health care system.

According to the Ministry of Health, the RAS implementation leads to increased effectiveness in health production and improved efficiency of health management at the regional level, and it contributes to the progress of SUS consolidation process (Brazil, 2010). In this sense, on December 23, 2011, through ministerial directive nº 3.088, the Psychosocial Care Network was created, aiming to develop, expand and articulate health care centers for people with mental suffering or disorder and needs arising from the use of crack, alcohol and other drugs, in the scope of SUS. The creation of a normative definition, ministerial directives and decrees is not enough for a network to be established. Based on the need expressed by the patient, and according to the thematic network of care, the centers are dynamically developed and defined, based on a joint sanitary responsibility, cooperative actions and proactivity.

Considering the above, this study aims to present the operationalization of a network of care. The networks do not exist by themselves.

Rovere (1999) points out that this idea includes the emotional dimension of embracing the hospital and mentions two comprehensive networks: **intellectual** and **emotional**. He also says that networks are types of multicenter, relational, contractual and non-hierarchical articulation. He extends the concept to include institutions where people work, whether patients or professionals; places where people greet each other, where one knows what happens to the other: this is what creates networks, creates support mechanisms in terms of our composition as subjects.

Thus, in addition to the network as a type of administrative organization, the concept involves the connection between people, but not between institutions or computers. The people are connected here, creating multiple nodes, not a specific place, but points of articulation of higher or lower density, allowing flexible responses to different needs (Rovere, 1999).

From this conceptual understanding, the political and administrative guidelines indicate the consolidation of an expanded health care network that, despite its fragilities, shows some progress. The field of care for patients with mental disorders has changed with the implementation of these guidelines and regulations of differentiated treatment dispositifs **(apparatuses)**, considering health prevention and promotion, created over time.

Standards are important and allow work direction, but in the act of providing care, direction is also provided by the professional. The intention is to consider networks as a process of construction, of articulation, of flows between people, whether professionals, teams or patients in the territory. In this context, the concept of network has the purpose to drive transformations in care practices and institutional structures.

Health professionals play a critical role in care provision actions, in terms of integrality. Therefore, despite the recognition of RAS (Brazil, 2010) and the Psychosocial Care Network (Raps) (Brazil, 2013a) for strengthening mental health policies, it is also important to show the potential of a network by understanding professionals working in health services. The intention is to point out the multiplicity of connections created in a network of care, which is constructed, deconstructed and reconstructed by these professionals.

The networks do not exist by themselves. These are real networks of everyday life, which produce interesting movements, involving all agents of the process – patients, workers and managers –, each with interests that are more or less clearly defined (Cecílio et al., 2012).

However, if it is feasible to consider the network as a guideline, it can constitute an operator based on apparatuses, which, in turn, can be understood as the way according to which various elements relate to each other to achieve a certain purpose and produce something to address an issue, a desire, or generate surprise (Foucault, 2012). In this perspective, the services are strategic apparatuses of care, which should be comprehensive and expanded, so that they are able to address the complexity of emerging demands. The concept of apparatus is always linked with the power game, that is, it joins the instances of power and knowledge. It is a term used in the attempt to

> outline a clearly **heterogeneous** group that encompasses discourses, institutions, architectural organizations, regulatory decisions, laws, administrative measures, scientific statements, philosophical, moral, philanthropic propositions.

 DOI 10.1590/S0104-12902017170298

> The apparatus is the network that can be established between these elements. (Foucault, 2012, p. 364-365)

However, once established, the apparatus is not static and inflexible, it is **dynamic**. When generalizing the class of Foucaultian *dispositif*, Agamben defines it "as anything that somehow has the ability to capture, guide, determine, intercept, shape, control and ensure the gestures, conducts, opinions and discourses of living beings" (Agamben, 2009, p. 40-41).

But to what networks and apparatuses is this study related? As already mentioned, the organization and the number of existing services will not be analyzed. Emphasis will be placed on the fabric of a network, the nodes established among the professionals that bind them in the perspective of care production. A network is woven in the articulation of those who constitute it. Therefore, it proposes a reflection on how the network articulation has happened in the daily routine of health services. Based on these considerations, the scope of this article is to analyze the meanings attributed to the construction of a network of care provided to people with mental disorders, from the point of view of health professionals.

Methods

This qualitative study was conducted from October to December 2016 in a municipality of the metropolitan region of Rio de Janeiro. The health network of the studied municipality comprises services of different complexities, classified as: emergency and urgent services; hospitals; polyclinic; primary health care (PHC) units; and mental health program. This composition precedes the publication of Raps in 2011. This study focused on four health services: an adult psychosocial care center II (Caps); an expanded mental health outpatient clinic; a psychiatric emergency service at a hospital; and a PHC unit.

Semi-structured interviews addressing problem situations (Ferreira, Silva Júnior and Siqueira-Batista, 2015) were used to collect data. At the end of these situations, a guiding question was presented and, during the conversation, other questions emerged, enabling to explore new questions based on the participant's viewpoints. The interviews were recorded and transcribed in full for further analysis. The study had the participation of thirteen health professionals from different categories (upper, middle and basic education) who work in these units. Volunteers collaborated with the study and were explained about the study objectives and risks, with informed consent form reading and signature.

Four problem situations were presented to the study participants in written format; they represented fictitious cases related to clinical situations that would require articulation among different professionals and services to produce

Table 1 – Problem situations used in the study

PROBLEM SITUATION	DESCRIPTION
1	*Maria, a 59-year-old female patient, has four children (two were murdered and one was released from prison for drug trafficking in 2013), and four grandchildren of her only daughter, each from a different father. Also, in 2013, she became a widow and lost her mother. He does not work. Her home has been locked by the civil defense after a hill collapse. She receives a rent allowance.* *She comes to the medical center complaining of sadness, anxiety and insomnia. She cries during the appointment and says: "it's a lot to worry about, I can't sleep and I think I have a memory problem, I don't want to think about anything, I don't want to worry." She talks about the fact that she is irritated with her daughter because she is not rigorous with her children, so she is afraid they will quit studying and get involved with 'wrong things;' she speaks of the death of her mother and her husband – ""he was my support"" – and that she cannot sleep, she is worried about the intense shootings near her house. She also complains of severe abdominal pain, tenesmus (desire to evacuate, but without success) and rectal bleeding. Previous diagnosis of renal lithiasis Suspected diagnosis of anorectal cancer.* *She asks for a medicine to relax her mind.* ✓ How would you receive that request? What referral would you provide?

continues...

Table 1 – Continuation

PROBLEM SITUATION	DESCRIPTION
2	*João, a 19-year-old male patient, a student, comes to the appointment scheduled by his parents, who have noticed changes in his behavior. Lately, João has become more isolated at home, he does not want to meet his friends, he misses his university classes and feels restless. He has no prior history of mental disorder, he denies drug use and has no clinical complaints.* *He started a law school program some months ago after much dedication.* *The patient does not recognize this change in his behavior. He just says that the classes 'confuses his mind, but it is because of the high amount of information.'* *The health professional who received João, after providing care, says that he will refer him to a treatment with a specialized mental health service to help him overcome the problem, but the patient reacts and says that he is not crazy and does not need a treatment.* ✓ What would you do if you were the health professional who received João?
3	*Rafael, a 40-year-old male patient, without family or work bonds, lives alone in a rented room from a boarding house. His income is from the government benefit that corresponds to a minimum wage.* *He receives regular monitoring from a mental health network and regular clinical follow-up. He has been diagnosed with psychosis and systemic arterial hypertension. He follows the medication treatment prescribed by his physicians and a weekly follow-up with a psychologist.* *He is a patient who, when he is in a more acute psychotic crisis, feels threatened when people look at him on the street, and then he wants to react and protect himself or goes to the psychiatric emergency service and want to be hospitalized, claiming that the cannot live in the society, because they want to harm him.* *In these moments of crisis, he often visits different health services in his municipality asking for 'further care' to be 'more protected.'* ✓ Suppose Rafael has arrived at the medical center where your work and he asks for health care to feel more protected. What would you do? What would say to him?
4	*Ivete, a 37-year-old female patient, lives with her mother. She uses drugs and she is psychotic. She has three children who are always on the street, receiving care from neighbors and relatives.* *She arrives at the health center asking for advice because her child has diarrhea and she does not know what to do. The professional who receives her feels the situation is more complex than diarrhea and identifies Ivete's symptomatology.* *At the service, Ivete reported drug use, for her it was for fun, although she recognized that it brought negative consequences for her life and her children, including financial problems, as she had left her job as a supermarket cashier, and since then, she had no income and no free pass. After established a bond with the health professional, she reported that it was the first time she was able to talk about her problem without fear of being judged. The professional provides guidance regarding her child's care, requests that she returns with the boy for evaluation the next day and sends her to Caps AD. She says she had already been referred to this place, but she had never showed up. The professional explains the need for referral and insists that she should go. Ivete does not return with the child and does not follow the guidance of the professional.* ✓ Would you do anything different? Talk about this situation and the actions the professional suggested for Ivete's care.

 DOI 10.1590/S0104-12902017170298

integral care (Table 1). The purpose of using fictitious problem situations was to identify how the problem of networking is perceived by professionals and how the articulations happen. The study methodology captures the discourse underlying the action, imposing a limit of approximation of the practice. Then, the intention was not to evaluate the referrals of clinical issues, but to ensure network visibility.

Data obtained from the interviews were evaluated using Bardin's thematic analysis (2004). The thematic analysis of content consists in discovering the meaning cores that favor the capture of social representation of the **interviewees** on the studied object and the psychosocial contextualization surrounding this object (Minayo, 1992).

The study observed the guidelines of Resolution 466/2012 (Brazil, 2013b) and was approved by the Research Ethics Committee (REC) of Universidade Federal Fluminense in July 2016, protocol nº CAAE 56262116.5.0000.5243.

After analyzing the elements that emerged with the interviews, the first interpretation of the narratives was conducted through floating readings. The convergence of the answers towards three main categories was observed: (1) **meanings of a network of care**: concepts and characteristics; (2) **operating means** for the construction of a network of care: practice construction, challenges and enablers; (3) **proposals** to minimize challenges and implement a network of care. These categories can be expressed through guiding concepts and each of them was organized as subcategories: **networking**; **support networks**; **conflict**; **continuity of care**; **integral care**; **shared care**; **training process**; **broad discussion**; and **work organization** (Table 2).

The discussion continues when detailing the constructed categories and subcategories.

Table 2 – Categories defined from interviews with health professionals: construction of a care practice

Categories	Subcategories	Guiding concept
I: Meanings of a network of care: concept and characteristics	(I) **Networking**	The norm is an established standard, but it does not guarantee the means for the network to be created. It depends on the actors involved in the process.
	(II) **Support networks**	It shows the importance of a consistent, comprehensive and broad support network that goes beyond health issues, considering other trainings.
	(III) **Conflict**	It highlights the existence of conflicts that need to be mediated and managed in a network.
II: Operating means for the construction of a network of care – construction of practice – challenges and enablers	(IV) **Continuity of care**	It highlights the importance of accountability to enable continuous attention.
	(V) **Integral care**	It highlights the importance of integral care to patients, in the perspective of extended care.
	(VI) **Shared care**	It shows horizontalization, co-problematization, sharing of actions.
III. Proposals to minimize the challenges and consolidate a network of care	(VII) **Training process**	General principle: network as a guideline, which can be created with operators in this process using apparatuses managed by the professionals.
	(VIII) **Broad discussion**	It emphasizes the need for approach, conversation and meetings among professionals to create a network. Situations in which one can hear the other, without structural issues to take over clinical discussions.
	(IX) **Work organization**	It shows the risks of bureaucratizing care.

Regarding the transformation of concepts in practice operators

Category I: meanings of a network of care: concept and characteristics

The interviewees, when thinking about their answers to each problem situation presented in this study, used different articulation procedures, such as written referrals (in the referral and counter-referral form), telephone contact, institutional visits, or stopped articulating. It indicates a context in which different types of contact are produced between professionals from different services and professionals from the same team. It also shows that relationships happen in different ways, depending on the existing conditions, which produces a number of practical effects. This aspect was observed due to the different answers given by the professionals of different backgrounds, who work in the centers.

For example, the dynamics set by the PHC happens in a different way, with its own logic (Motta; Siqueira-Batista, 2015), when compared to the mental health services. In a PHC unit, the team, when addressing someone with a mental disorder, does not seem to establish a direct contact with another service, either for referral, to consider a joint intervention or clarify a requested evaluation. Most of the process flow, regardless of the situation complexity, is unique: requesting an evaluation from the mental health supervisor of the unit to operate a flow that is similar to the matrix support, as observed in the statements of the PHC professionals:

> *Schedule, as soon as possible an appointment with the supervisor, or refer to a physician.* (P4, nursing technician)

> *In addition to the medical care itself, where she was requested to go, I think that here, in our PMF experience, I would also include mental health supervision analyze these issues of anxiety, sadness, even from that condition of empty mind that she reports.* (P2, nurse)

Considering this flow, a reflection is made here: in view of the different complexities of the situations in the health centers, what are the possibilities of articulation in the perspective of shared care? The network built internally among the professionals of a PHC unit is extremely important to support daily care, and the relationship established between the different levels of care seems to enable an effective construction of network: *This meeting with mental health professionals, whenever we can have this meeting, we have positive things. The problem is that this meeting is rare* (P1, physician, PHC). However, some situations are described in which this established logic was more flexible, which can be observed in the PHC physician's speech:

> *What I usually do with this type of patient is monitor. I have gone to Jurujuba Psychiatric Hospital a few times with a patient, and I have been to Caps Alcohol and Drugs.* [...] *The fact that you are there makes the patient feel secure.* (P1, physician, PHC)

This attitude was described by the professional with the perception that the support offered by the mental health supervision of the unit "*ends there, I'll refer the case, the existing structure is this one. It ends here. I have no interface*" (P1). The answers provided by the professionals of the mental health services show a greater availability of articulation in a network based on the needs of the situation.

> *I would contact the family physician to see if she is registered, if she is monitored, if they can help her at this moment; otherwise, I would see if the polyclinic could offer anything.* (P5, psychologist from the mental health outpatient clinic)

> *We can articulate the rest of the care networks* [...]. *From a certain network we have to build, then everyone together would be providing care.* (P10, coordinator of a Caps)

 DOI 10.1590/S0104-12902017170298

In the two excerpts, the professionals included care shared among the outpatient clinic/Caps and the PHC unit, in the perspective of integral care for the demand imposed by the situation. Networks are the result of efforts from workers who, driven by their desire to care, connect with each other, whether individually or collectively (Deleuze; Guattari, 1995).

> *I think the network is the link. The network does not exist without the professionals, the network alone does not support itself. I think it's one to one. Making direct contact with someone from the network, from a site, and every time it changes, it needs to be updated.* (P12, psychologist, coordinator of the psychiatric emergency)

In the speech of this professional, it is clear that the networks are made of people, connections between them, and not merely between institutions in an administrative and bureaucratic manner. The people connected with one another, because they comprise the institutions. This perspective shows the idea of a network for the health sector is not something new, but it was first considered as an internal element of the concept of system, with the system design as a great homogenizer (Rovere, 1999). More recent health networks use other logic.

Health work is essentially relational, involving subjectivities, demands, conflicts and territories, rather than an inert network of fixed constructions of existing health services and their relationships based on levels of attention (Ayres, 2011). This assumption is seen in the way the professionals interviewed in this study understand the meaning of network; in fact, a dynamic emerges in the process of relationships and their developments. Then, the networks and the ways to provide care are based on the interactions among the subjects.

The possible articulations involve the need to establish a support network, a structure that is able to provide some support. The idea usually refers to a group of organizations or entities that work in synchronization to collaborate to a certain question, in the case of this study, integral health care. A network is also produced with the territory that integrates it and with the social connections that are created. Then, a network of care should consider the patient as a subject in the society and recognize the importance of their relationships, their social support networks: *Strengthening the connections she has in the neighborhood where she lives, in the church, or the connections that can support her and try to support her in this sense* (P1, physician, PHC).

The field of health care, as seen above, should not be restricted to professionals from the area. An important part of the actors is in the interface with the social aspects, in the connections established by the patient with mental disorder, connections that should often be reestablished (Lobosque, 2007). However, the narratives of the professionals show the recognition of some aspects as challenges for the creation of a network in the moment of performing the care actions, which will referred to as conflicts:

> *One thing that significantly affected the patients I saw were the program changes, so we had to see more patients. When we assume more patients, an increase of 150% in relation to what I used to have in the beginning, we become overloaded. They don't want to see results, they want to see production, procedures. If they want procedures, they will have procedures and won't produce results. I think the question of quality management of family health services, mental health services, it's related to quality, asking for results. But they want care provision, then we provide more and worse care.* (P1, physician of a PHC unit)

These conflicts should be mediated so that effective networking can happen. Conflict is a 'network attack' (Rovere, 1999), and for such mediation, it is important to have network management. In this perspective, the existing conflicts appear in different ways. In the statements of the interviewees, it appears when a difference between services becomes an obstacle and when a professional does not have knowledge of a role from a certain service. This aspect raises a question: if someone does not know the role and

possibilities of a service, how can this person include it as a care alternative for the patient?

> *I think we're in different work times, you know. One thinks that the other has to ensure the care. I think it shows the lack of partnership here. Even at work, we end up performing based on the "grab what you can and let the devil take the hindmost".* (P5, psychologist from an outpatient center for mental health patients)

> *I don't know where Caps II is. I don't have patients there. What's it for?* (P1, physician, PHC unit)

One of the possibilities of dealing with conflict when seeking to establish a network of support among people or a cooperative attitude would be knowledge. Recognizing the other as an important interlocutor will allow an articulation; then, divergences in the evaluation for the definition of a therapy, for example, can be genuinely mediated and treated among those involved to ensure care is provided (Rovere, 1999). This action produces connection and cooperation. When it does not happen, that is, when the partner is unknown, or whose care is considered unnecessary, or when disagreement becomes an obstacle to dialogue, the possibility of network articulation to operate integral care becomes difficult, or sometimes prevented.

In this perspective, care is an essential dimension in the professionals' attitude with patients, which should expand beyond technologies or procedures (Merhy, 1997) and include integrality in health care. If the work developed by the other is unknown, the chances of partnership and sharing are compromised.

Category II: Operating means for the construction of a network of care – practice construction – challenges and enablers

Mental health care is provided in different situations, for example, in psychosocial care, and one of its goals is to provide mental disorder subjects with the best level of autonomy for life in society (Amarante, 2007). Psychosocial care proposes an expansion and a change in the way to understand the problem, assigning importance to the subject as the main actor of the treatment and providing social reinsertion apparatuses. In this perspective of a network of care, complementarity stands out as an important notion, expressed by the ability of services to enable continuity of follow-up through access to different interventions at different times, roughly speaking, in different treatment sites.

Based on the aspects observed in the speeches of the interviewees, they highlight the importance of accountability to enable continuous attention (Ayres, 2011). This perspective can be articulated with Ministerial directive nº 4.279, of December 30, 2010, which provides the guidelines for the organization of RAS in the scope of SUS and, in the objectives, indicates a systemic integration of health actions and services with integral, quality, accountable and humanized **continuous attention** to enhance the system performance in terms of access, equity, clinical and sanitary efficacy, as well as economic efficiency (Brazil, 2010).

The organization by lines of care aims to establish articulations among teams and flows of patient referral, considering their demands and needs, in a network of progressive care, in which each point of articulated attention seeks to ensure support, accountability, problem solving and continuity of service (Silva Júnior; Mascarenhas, 2004). In this sense, some statements explain this dimension of integral care to patients with mental disorders. The excerpts highlight the importance of integral care based on expanded care. Integrality is understood here

> in the extended sense of its legal definition, that is, as a social action that results from a democratic interaction of the actors in the daily life of their practices in the provision of health care at the different levels of attention of the health system. (Pinheiro; Luz, 2007, p. 19)

In mental health, concepts such as **care**, **connection**, **network** and **integrality** are essential operators to produce work in line with the

 DOI 10.1590/S0104-12902017170298

guidelines and the construction of a network of care. However, the way each professional understands and uses these concepts can support or obstruct integral care to the patient, as it interferes in the construction of a network with partners from other services. This way, taking care of a patient's health does not mean a technical interference in an object. In order to produce care – in the approach used in this study – the health professional should consider and construct projects including the patient's perspective: "Then, it is necessary to know what happiness project lies there in the mediate or immediate action of care. The attitude of caring cannot be only a small subordinate task of health practices" (Ayres, 2011, p. 37).

Based on the narratives of the interviewees, the way they receive the demand, that is, the subjective dimension, and not exclusively the technique, implies the operationalization and functioning of a network of care. Interfaces between different services, the definition of referral criteria, for example, can often be attributed to the network participants, who may support or obstruct the process.

Also regarding the operating means for the construction of a network of care, the narratives emphasize the dimension of shared care and/or sharing of actions, in terms of importance and what is involved to operate using this logic:

> *Networking is difficult. I think it partially depends on the willingness of the professionals to establish this articulation which I think it's not insignificant, it's important. Knowing its importance and the effects it can produce. I think it happens somehow, but it could be better.* (P9, psychologist at Caps)

> *I think it's about trying to share, share that responsibility for care. It's about trying to articulate with the territory, with the apparatuses, there's so much we don't even know, actually.* (P13, psychologist, psychiatric emergency service)

When analyzing the fragments, a misalignment is observed between the direction of an articulated work and the validation of this idea in the daily life of the services. In this context, there is the challenge of thinking about care to overcome the tensions between directions and work processes, as it will be discussed later.

We recognize that there are many possible relationships and articulations among the health services addressed in this study, pointing out differences as to how they happen. Referrals, telephone contacts, institutional visits, referral counter-referral forms are some of these possibilities, but they involve different procedures and/or instruments and different levels of availability of the professional involved in care.

The speeches of professionals show the need for network expansion and articulation. To make it happen, it is important for the professional to follow and approach the health demand of the patient and his/her family, which should be understood as a structuring concept (Pinheiro; Luz, 2007), with the ability to extend the definition of integrality in health care.

When a patient is heard and participates in the definition of a therapeutic project, there is an opportunity to construct a network, starting from the points of attention, or rather, the interaction and the articulation among several services that are mobilized to offer care. The statements of interviewees recognize the partnership, the articulation, sharing of tasks among the points of attention for care integrality. However, one of the interviewees points out a huge gap between the recognition of a guideline as important and its transformation into **living work** (Merhy, 1997) for the construction of care practice. It is a problem to be properly addressed. The contact is often performed with another service to think of a referral, and not for shared care:

> *Sharing is very rare. It rarely happens and when it happens, it's a direct referral.* (P6, coordinator of the mental health outpatient center)

Sometimes, we share one case or another, but it's not a rule. (P10, coordinator, Caps)

Assuming that a single health service is not able to address all demands and that the articulation starts from the recognition of a need that cannot be fulfilled by one service, but that can be properly addressed by another one – for being part of a specific scope of responsibility; requiring complementary interventions or cross-sector articulations; or involving more intensive attention in moments of crisis – considering these demands, the professional should assume the responsibility for the engagement of another service. Then, a work object is created, which goes beyond individual responsibility to become a network object.

This subcategory may include the question of how referrals are conducted and conceived. They are usually in writing, not always with a telephone contact, and hardly result from discussion meetings in which situations are shared and collectively planned among services. In the written notes, the situation is not always clearly presented. Sometimes these referrals are described by one of the interviewees as "bureaucratic":

That's it, sometimes it has an explanation, sometimes we don't understand very much the reason for the referral [...] *the contact helps a lot, because the person can explain better what happened.* (P8, physician, Caps)

These aspects show the importance of perceiving the behaviors, of reflecting and assuming new positions with the patients, establishing new dialogues. A behavior to assume responsibility for the care and the professional-service-patient connection. A behavior to consider the patient's point of view, not the professional's perspective of unilateral knowledge, considering the presence and influence of established or to-be-established networks of support, such as families, friends, work, other professionals.

Category III: *Proposals to minimize challenges and consolidate a network of care*

Training can support and change articulation. The statements of interviewees highlight the important role of this process in the relationship of professionals with their work as a vector in the production of care:

I think this question of an interface is often a matter of permanent education process. (P1, physician, PHC)

It's good to stop and think about these things because the daily routine doesn't allow us to stop and think about our own work. (P8, psychologist, Caps)

RAS shows the need for permanent promotion of education strategies, which can be conceptualized as a process that analyzes the daily work and health education, permeable to concrete relationships that operate realities and enable the construction of collective opportunities for reflection and evaluation of the meanings of daily produced actions (Ceccim, 2005).

Then, continuing education strategies in the context of permanent health education should be proposed for care qualification, so as to change the autonomous and isolated work into multiprofessional and interdisciplinary work, from an individualized perspective of the patient to an approach of a subject, a citizen inserted in a family and social context (Dittz et al., 2010). In this sense, training requires the inclusion of aspects from the production of subjectivities, technical skills and thinking, as well as proper knowledge of SUS that can "revert biologic theories of health education to a theory of integrality in the education of health professionals" (Ceccim; Feuerwerker, 2004).

To change this reality, it is necessary to think of and treat training as **forms** of action, that is, consider the training process not separately from the way of conducting it; using the daily work and including interference in actions and processes. In addition, subjects and objects are produced from this encounter, so dialogues with networks of knowledge and experiences are present, and sharing of experiences should exist (Heckert, 2007).

 DOI 10.1590/S0104-12902017170298

It is important to consider work as an object of reflection, and share the responsibility and have professionals experience the discussion about the practice to place them closer to each other and make them use the concepts, guidelines and operating means for the development of their care actions in health.

It should be noted that, with all complexity and interfaces involved in health work, especially in mental health care, weekly supervision meetings are extremely important, not only to discuss care cases, but also to evaluate the challenges to each team member. It implies a particular perspective of different contexts. A continuous program is proposed to professionals who address mental health situations in their practice, that is, an opportunity for each professional to talk about the challenges and feelings experienced in their daily life, leaving a position of isolation. These professionals often realize the knowledge learned in upper education training and books is not enough to deal with the problems faced while conducting their activities.

These excerpts emphasize the need for working closer, regular conversations and meetings with the professionals, associating a facilitator function with the contact, so that a network of care can be weaved and operated:

> *I'm thinking now about the meetings that we have, I think the network often promotes isolated meetings, without larger meetings with the participation of all services, with things agreed by everyone.* (P13, psychologist, psychiatric emergency service)

> *This meeting with mental health professionals, whenever we can have this meeting, we have positive things. The problem is that this meeting is rare.* (P1, physician, PHC)

The professionals should have opportunities to discuss their own practice, in the perspective of each professional, prioritizing the real situations they experience. In addition, public forums should be promoted for the construction of political proposals, especially in the current context where technology, individualism and immediacy prevail (Siqueira-Batista et al., 2013). The contemporary society is creating **absence of communication** and loneliness, involving the risk of generating indifference, poor reflection and search for quick resolution to problems, which may force to think of life and events in a limited and fractioned manner (Paro et al., 2017). In the practice of health professionals, with strong indifference, the effects are disastrous. The answers, often assuming such immediacy, are too fast and disregard the complexity involved in health care – the body, illnesses, subjectivities, ways and conditions of life, ways to affect each other and relate to the other, either patients or co-workers.

This category built from the discursive elements also highlights the organization of the work conducted by the professionals, which shows the risk of care bureaucratization. The narratives, besides addressing the organizational aspect of the practice, point to the challenges in dealing with mental health issues in primary care. This theme should be emphasized in times of increasingly incisive proposals for the implementation of mental health actions in primary care. This precariousness destroys the network. This theme is important because it shows not only how management participates in terms of macro policies, but also how it involves responsibility when joining the points.

> *I think what obstructs* [shared care] *... from our part, of the family physician team, is a lack of involvement as a team to deal with these problems. But our team is not structured to receive or even conduct an active search at the sites. We would need more time and faster mechanisms to do that* [...] *we don't have conditions to do it today, so... it's no good to cry here and say 'Only the service there is not structured and here we do what we can'.* (P1, physician, PHC)

Another point to be highlighted in the speech of professionals is about the effects on care when the health work organization is at the mercy of

bureaucratic charges. With busy agendas, institutional sites are not valued and included for discussions and reflections of the professionals, especially when considering the current structures of the society, inscribed in the logic of late capitalism (Siqueira-Batista et al., 2013), which changes at great speed, at the expense of the pre-eminence of technology and the fluidity of relations among people, for example, in health work (Rossoni, 2015). The proposed areas for discussion would represent opportunities to **speak/listen** without structural challenges in clinical discussions. It is important for professionals to have moments to discuss their practice.

> *Then we start an urgency of something that we have to deal with, and then when we work in the emergency, and need to deal with it, and need to do it and need to respond, it's* [...] *a lot different from clinical responsibility of things.* (P6, coordinator, mental health outpatient center)

In fact, each service has a form of functioning, which translates into differences to be sustained, and not considered as evaluative qualitative aspects. In the current world, where forms of work organization engender competitive and isolated subjects (Deleuze, 1992; Siqueira-Batista et al., 2013), health services are also affected. It is known that health is also an effect of the living and working conditions of the population, who is very stressed today, and it can weaken social ties and prevent the construction of area that can drive a new logic to interpret and act on health (Palacios; Souza; Lacerda, 2008).

The narratives presented in this study refer to the point at which professionals are taken by naturalized procedures and practices, so that they cannot guarantee the fabric of a network in the daily life of their practices. Considering that, collective areas for discussion are important for the construction of articulated work in order to develop a network of care.

Final considerations

This study did not have the pretension to exhaust the analyzed subject, but to point out issues that should be included in the daily agenda of discussions in the field of collective health, given the great ethical-political challenges to be faced for the construction, consolidation and sustainability of an expanded and strengthened network of care to SUS patients with mental disorders.

The professionals interviewed in this study express different concepts of network, which implies a singular way to produce care, although they are under the same normative guideline. It showed that the work process of these professionals does not follow a rigid and inflexible pattern, since the practices of care are performed according to the singularity of each one. In fact, the recognition of a subjective production of health care is highlighted (Ayres, 2011). In addition, the process of constituting a network, as reported by the different professionals interviewed in this study, points to multiplicities, that is, an absence of unity to guide the relations among the subjects.

Based on this assumption, the trajectory of a network may be broken, resumed, restarted at any point, since, on the one hand, it maintains an organization (distribution among services), and on the other hand, it has holes and deviations. It involves taking care of the work process and creating and supporting collective areas for discussion and sharing. With the expression of different forms of action for the creation of articulated work in a network, each professional constructs a singular practice, that is, his/her own health care model.

This statement is expressed in different attitudes and distinct referrals based on problem situations, as well as in the answers to supplementary questions. Some situations were observed in which professionals perceive and describe network articulation and shared care and responsibility. However, in some situations, sharing and co-responsibility actually exist. In most contexts described, the contact between professionals - when it occurs directly - is based on the understanding that the service responsible for the referral prescribes the referral because it is not able to handle the demand, instead of

considering the patient visit to other places of attention as positive aspects of shared care.

The results also indicate that, despite the new ways to enable care – effects of the Sanitary Reform and the Psychiatric Reform, legitimized in the political and normative fields –, the daily health practice still reproduces fragmentation and barriers to access, obstructing the patient flow across the network of care (Gomes; Rego, 2013). Due to this gap between what was observed and the effects expected with the creation of RAS and Raps, the daily effort is essential to support care to mentally ill patients in an expanded, integral and articulated way.

The network potential as a care producer is emphasized in these final considerations. In fact, Guimarães Rosa in his book *Tutaméia* is quoted here: "a net is a lot of holes tied with ropes" (Rosa, 1985). There is no flow without holes; emptiness allows joining together. However, these holes are tied by us. "We", a group of subjects, including the speaker, and a noun, a knot[2] using ropes to attach them or join one to another. We are like ropes, professionals monitoring our patients' flow through the nets we all weave, transforming the vision of SUS from the cold letter of legislation into the power of creating care.

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2 In Portuguese, 'we' and 'knots' have the same spelling (*nós*).

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Author's contribution

Bermudez developed the cases presented in this study, designed the study that originated this article, based on his experience with the theme, and wrote the first version of the text. Siqueira-Batista guided the development of the study and performed a critical review of the manuscript. Both authors approved the final version submitted for publication.

Received: 04/22/2017
Resubmitted: 11/13/2017
Approved: 11/16/2017