Matrix Support in mental health: the perspective of the experts on the work process

Apoio Matricial em saúde mental: a perspectiva dos especialistas sobre o processo de trabalho

Alice Hirdes[1]

DOI: 10.1590/0103-1104201811809

ABSTRACT The article discusses decentralization in mental health through the Matrix Support in Primary Health Care (PHC). The research had as general objective to investigate the Matrix Support in mental health in PHC from the perspective of the experts, taking into account the guidelines of the Unified Health System (SUS) and the Psychiatric Reform. This is a qualitative research, conducted through semi-structured interviews and a focus group with matrix supporters in mental health. The results show the procedural aspect of joint construction of interventions sustained by co-responsibility and co-management; the organizational and operational arrangements based on supervisory actions, discussion of clinical cases and joint care. Personalized relationships with referral teams, the public health bias of the specialists and the investment in sensitizing general practitioners and experts were identified in the research. It is concluded that the Matrix Support is supported by relational technologies, in the systematicity of meetings and longitudinality, and such issues should be considered in interprofessional care.

KEYWORDS Mental health. Primary Health Care. Comprehensive health care. Local strategies. Health management.

RESUMO *O artigo aborda a descentralização em saúde mental por meio do Apoio Matricial na Atenção Primária à Saúde (APS). A pesquisa teve como objetivo geral investigar o Apoio Matricial em saúde mental na APS na perspectiva dos especialistas, levando em conta as diretrizes do Sistema Único de Saúde (SUS) e da Reforma Psiquiátrica. Trata-se de uma pesquisa qualitativa, realizada mediante entrevistas semiestruturadas e grupo focal com apoiadores matriciais em saúde mental. Os resultados evidenciam o aspecto processual da construção conjunta de intervenções sustentadas pela corresponsabilização e pela cogestão; os arranjos organizacionais e operacionais fundamentados em ações de supervisão, discussão de casos clínicos e atendimento conjunto. As relações personalizadas com as equipes de referência, o viés de saúde pública dos especialistas e o investimento em sensibilizar os profissionais generalistas e especialistas foram identificados na pesquisa. Conclui-se que o Apoio Matricial se sustenta por meio de tecnologias relacionais, na sistematicidade dos encontros e na longitudinalidade, devendo ser tais questões consideradas no cuidado interprofissional.*

PALAVRAS-CHAVE *Saúde mental. Atenção Primária à Saúde. Assistência integral à saúde. Estratégias locais. Gestão em saúde.*

[1] Universidade Luterana do Brasil (Ulbra) – Canoas (RS), Brasil.
Orcid : https://orcid.org/0000-0003-3318-0514
alicehirdes@gmail.com

Introduction

International bodies and agencies, professionals and researchers advocate the inclusion of mental health in health services in general. Among the reasons for the integration mentioned, it is highlighted the importance of mental disorders in the populations; the simultaneous occurrence of physical and mental disorders; the disparity between the prevalence of mental disorders and the number of people receiving treatment; improved access to treatment in Primary Health Care (PHC); the protection of human rights; the reduction of costs in PHC[1,2]. In addition to the reasons listed above, researchers and authorities of the area[3-7] situate the current historical context, translated into the global economic crisis, poverty and conflict in different parts of the world, as an additional reason for the inclusion of mental health care in PHC .

In Brazil, the mismatch between the magnitude of the demand and the supply of mental health services, as well as the low incorporation of specialists to deal with severe patients, constitute a threat to the sustainability of the model[8]. The authors argue that the articulation of mental health with PHC would broaden the universalization of these services. They point out the obstacles to this articulation, which implies political challenges – the limitations of the Unified Health System (SUS), in terms of funding, government capacity and specialized personnel. Onocko Campos et al.[9] defend the investment in the processes of transformation of health practices and professionals, so that the advances achieved are not reversed. Lobosque[10] points out as fundamental challenges of the Psychiatric Reform the guarantee of care for the crisis, the inclusion of Primary Care through the establishment of partnerships with the Family Health Strategy (FHS), through matrix support in mental health, and the rearguard of the Center of Psychosocial Attention (Caps) for intensive care.

That is, the understanding that substitute services, especially Caps, will not account for the magnitude of the demand for care is another reason for the defense of mentioned articulation. In this case, the sustainability of the Psychiatric Reform depends on the integration to the PHC network. Thus, human resources are a central issue for mental health care in PHC, both for specialist professionals, who can provide supervision and support through matrix support, and for generalists who integrate family health teams. The latter deal day-to-day with mental health problems of the population, often without theoretical-practical subsidies for more complex situations. In this sense, 'living work' in health, operationalized through 'light technologies'[11], extended clinic[12] and invisible (resources) inputs[13] play a central role in the operationalization of mental health care in primary care.

Light technologies[11], relational, are fundamental for interprofessional work. The same occurs with the notion of expanded clinic, which allows an "extended redefinition of the object, objective and working methods of individual, family or group care"[12(157)]. This notion presupposes overcoming the disease-centered model, based on interventions that may be biological, subjective or social. The intervention on one will have an impact on the others. Invisible inputs[13] such as labor relations, usually forgotten, ignored or undervalued, can inhibit or potentiate visible resources (inputs). Invisible inputs can qualify the work relationships between professionals and the collaborative attendance, as well as the relationships between professionals and users, materialized in the care to the user.

The matrix support is an organizational arrangement that aims to grant technical support to the PHC teams, through shared

responsibility of cases. This can be done through case discussions, joint care or collaborative interventions to the family and the community[14]. However, it should be emphasized that mental health in PHC involves a complex process, permeated by different opposing forces – professional, political, ideological, epistemological and management. In the last resort, these factors refer to the human resources of the services, which can be a source of power and care.

In view of these considerations, this research had as general objective to investigate the matrix support in mental health in the PHC from the perspective of the experts, taking into account the guidelines of the SUS and the Psychiatric Reform. The discussion of the configuration of this work process may provide contributions to the advancement of knowledge in the area, regarding the structural, operational and technical issues in traditional Basic Health Units (BHU) and in the FHS, and, above all, in what concerns the invisible resources and the light technologies used by supporters.

Methodology

This is a descriptive-analytical research with a qualitative approach. Participants in the study were six professionals specialized in mental health (two psychologists and four psychiatrists) who act as matrix supporters in PHC. The following were listed as criteria for inclusion of the participants (matrix supporters): to act in the matrix support in mental health for at least two years, regardless of the modality of intervention (case discussion, supervision or joint care or specific interventions of the supporter, with later care by the reference team).

The field of study was the Municipality of Gravataí (RS), Brazil. The option for this place stems from the pioneering work with decentralization in mental health and Matrix Support in the state of Rio Grande do Sul. It has the sixth largest Gross Domestic Product and the sixth largest population in the state, with about 255.660 thousand inhabitants, in addition to an estimate of life that exceeds 70 years. It consists of urban and rural areas, presenting characteristics and problems typical of these two realities. Since 2004, the Districting/Regionalization of Health process, through the FHS, has been implemented. The primary health care network consists of 18 Family Health Units (FHU), in addition to 10 traditional BHU.

The research techniques used were semi-structured interviews and Focus Groups (FG). The data collection occurred in 2013. The semi-structured interview follows a script previously prepared by the researcher, ensuring that the questions related to the research problem will be covered in the conversation[15]. Focus groups provide insights of the processes, attitudes, and mechanisms involved, as well as questioning and the change of views. They are also useful to know what participants think, but, above all, why participants think as they think[16]. In this sense, focus groups can bring different perspectives, concerns and assumptions of the professionals involved in the matrix support and, thus, denote creative processes, singularities, inconsistencies and contradictions of the process. In the research, the databases were first analyzed individually, by means of the detailed reading of the texts, according to the analytical proposal. After this first movement, the data of the two techniques were triangulated.

For the analysis of data from semi-structured and focus groups interviews, content analysis was used, in thematic modality[15], which includes: ordering, classification and final analysis of the data. The data ordering stage consists of the

transcription of the interviews; rereading the material; organization of the reports in a certain order, according to the analytical proposal. The next step, of data classification, was operationalized by the horizontal and repeated reading of the texts. Through this "initial exercise, called by some authors as floating reading, the 'structures of relevance' of the social actors were grasped"[15(357)]. In them, the central ideas of the interviewees on the subject are contained, from which emerged the empirical categories. The triangulation of the two techniques (interviews and FG) provided additional insights and analytical data, which were used as a resource to produce parallel databases in the research[16]. In the second moment, the transverse reading of the data of each subset (semi-structured interviews and focus group) and of the set in its entirety took place, which gave rise to the thematic areas.

It should be highlighted, also, that the ethical aspects related to research with human beings were respected, as determined in Resolution nº 466/2012[17]. The research was submitted and approved by the Research Ethics Committee accredited, under nº 304 227, in the year 2013. All participants signed the Term of Free and Informed Consent (TFIC). In order to ensure anonymity, they will be identified by letters and numbers (AM1, AM2, AM3...).

Results and discussion

Work process in Family Health Units and Basic Health Units

In this thematic area, the conditions that trigger the process of decentralization in mental health and its subsequent configuration in what is currently called matrix support in mental health, as well as the structural, operational and technical arrangements will be discussed. Decentralization in mental health in the municipality under investigation derives from, in a first moment, structural and operational issues, as a response to the resolution of the demand for assistance to a large contingent of people, as well as to the pressure of the media.

The first movement occurred in the decentralization of mental health care in the FHU, later extended to the traditional BHU.

> *So, this matrix support began, at first, with the group work, in the decentralization of physical space, but already being perceived as a seed that we would be going a little closer to the community, leaving the space designated then only for mental health.* (AM1).

Two distinct situations are evidenced: the assistance in group in the health units and the concomitant work of decentralizing the users of the Caps, by establishing a day for the discussion of the people who would be counter-referenced by the unit. This process was initially called 'decentralization' in mental health. Subsequently, the expression 'matrix support' in mental health was adopted, as proposed by the Ministry of Health[14].

A similar situation occurred in the experience of Campinas (SP), which triggered the decentralization of two mental health services that started to function in the matrix logic. In Gravataí, these organizational arrangements made possible the constitution of two different forms of work in mental health – the therapeutic groups in the community and, later, the Matrix Support (MS) as such. Although this process of decentralization in mental health has been going on for 16 years in the municipality and the MS was implemented in 2007, there is no published research on the experience in progress. The two pioneering brazilian experiences

documented – Campinas and Sobral; in addition to the Qualis Project, in São Paulo, prior to the theoretical construction of MS – proved to be a powerful space for the construction of projects and interventions in mental health.

In the guidelines of the Ministry of Health[14], matrix teams should, in addition to supervision and joint care, of specific assistence and training, prioritize collective and group approaches as strategies for mental health care, which may occur in health facilities, as well as in the community. As well as, among other actions, mobilize community resources and develop networks of support and integration. These are called 'shared responsibilities'. In the study, it can be deduced that the initial movement occurs in the opposite direction. The actions of decentralization through groups sustained the fields of interaction that led to the institution of the MS.

> *This was the first aspect of the matrix support, the thinking and the action of group work, the Violet Group as the first that decentralized. And, at the same time, we thought that those patients who had been in the unit for a long time and who are chronic, or who could be cared for in the units, we would have a specific day that, at the time, was on Thursday mornings, so we would take the references and counter-references to their units.* (AM1).

The instituted way of personalizing the relationship of decentralization, by going together to explain and discuss with the professionals of the health units, in replacement of the previous system via reference and counter-reference 'interoffice mail', following the decentralization of some midfield professionals (psychologists, neurologists, psychiatrists), is embryonic in the MS process.

> *So, some colleagues, and so do I, we started every Thursday morning: first, the nursing, social work, and psychology staff taking these promptuaries and talking to the nurses there, with doctors from there, giving an explanation of how was the monitoring of these users in the Caps and how it could be done in the unit.* (AM1).

The speech evidences that, since the beginning of decentralization, the personalization of relations, co-responsibility and co-management of the process takes place. Thus, a central aspect of the work stems from the interprofessional networks that have been constituted through the work carried out in the community spaces.

The implantation of the MS in some pioneer Brazilian municipalities differs in the process between them[18]. While in Campinas, considered the cradle of the concept, it is carried out by psychologists based in health units in Sobral, as well as in Gravataí, it is carried out by mobile teams that work in specialized services, which allows a broad view of the system. In the case of Gravataí, MS is performed by psychologists and psychiatrists who are based at Caps, and one of the psychiatrists in the emergency. Supporters reported that such insertion into different services enables an expanded view of the health care network. This arrangement allows the supporters to invest in articulated work processes, however, without being part of the 'permanent framework' of that BHU. This configuration provides a look from another position and place, desirable and necessary.

Participants identified differences in MS in relation to the BHU and in those units where the FHS is implemented. While in the former the logic of meeting the demand prevails, to solve specific problems, in the units of the FHS, by the very characteristics of the program proposal, there is a look at the wider context for the family. In this sense, both the FHS and the Brazilian Psychiatric Reform advocate in defense of integral care in the

territory. There is the recognition that in FHS the MS form is also modified by supervising the cases, whereas in the BHU joint care usually occurs. Supervision (discussion of clinical cases), also seen as a qualification in service, is directed not only to a professional, but extended to the FHS team. In this way, similar situations can be solved by the reference team itself, increasing, therefore, the resolutive capacity of professionals.

> *In units that have the characteristic of being family medicine (FHS), there is the involvement of the whole unit with the family group that belongs to that area or sector. It's a bit different... Actually, we look at the integrality of that family [...] it's a character of supervision, conduct and procedures that can be almost like training in service and in the sense that future people with characteristics of the illness of that patient can be assisted by the group without the need of the specialist, however, with the support.* (AM6).

The supporter recognizes that support will continue to be necessary. In this sense, the successful experiences of decentralization in mental health, both nationally and internationally, have as common element the systematicity of encounters and longitudinality[19-23].

The notion of team and reference professionals produced points to those who have the responsibility for coordinating a case, be it individual, family or community[24]. In the study, when they are traditional BHU, the professional of reference is centralized in the figure of the clinical doctor, who will be responsible for coordinating and conduction of the case. According to the interviewees, because of the configuration of these units, the MS, in this characterization, consists of solving a specific question: meeting the demand of people with mental disorders. Theoretical construction predicts that the reference team always has an interdisciplinary composition, with a view to the dialogical integration between different specialties and professions[25,24].

In the case of professionals of the BHU, in the reality studied, there is a single professional in each BHU who is the reference for the MS. In the absence of this professional (for dismissal, vacations, health leave), there is a mobilization of the supporters to identify another professional who accepts to attend mental health cases.

> *In the FHS, we can work with the entire team, while in the BHU today it is a professional that is the reference for matrix support. Tomorrow or later, he is no longer there, there is another one [...] then, we have to mobilize another professional who wants to accept these users and serve them as reference, while there in the FHS, no, they are all reference, and in BHU, no.* (AM1).

The availability of the professionals of the FHS teams facilitates the process of interprofessional work, while in the BHU the process is more complex. In this case, the complexity is not due to the interventions, but because of the need for an earlier arrangement: the meeting of supporters and generalists. The complexity, in this case, is structural, organizational, and refers to the logic of operation of these units.

The results of a study based on collaborative team models show that clinical doctors with wide experience are the ones who least prefer in-depth discussions about patients. The research warns that the individualized approaches of the support team with the clinical doctors can generate deviations in the treatment, due to multiple ways of communication[26]. Other authors[25] identified that professionals are accustomed to professional autonomy, deliberating on cases in an isolated manner. Among the reasons for this conduct are the attachment to the identity of its specialty nucleus and the security

that comes from known practices. In addition to these, there is, still, a dominant culture, which establishes that professional nuclear knowledge is 'private property'. Thus, the stiffening of the frontiers of knowledge may be due to a reserve of professional market, such as the Law of the Medical Act[24].

The solitary work in the BHU reported in the speeches finds resonance in another study[9]. The feeling of loneliness, impotence and unpreparedness to deal with mental health situations arise from the lack of professional profile of the MS, the difficulties of understanding the proposal and the organization of the meetings by the management. In the screen survey, the loneliness mentioned by the interviewee refers to the collaborative care exclusively with the clinical doctor, without the presence of other people in the team, and not the profile of the MS.

> *[...] in the BHU, the work is much more solitary. It's curious... the doctor assists the patient, then he makes a reference, a reference document for himself, because he makes the reference for the day we go there. He will read that reference, and we will assist the patient with him or we will discuss that case [...].* (AM5).

Among the barriers to integrating mental health into PHC are fragmented work processes, still focused on the figure of a single professional (the doctor), as well as factors related to prejudice with the field and stigma related to people with mental disorders. However, the MS has the power to build new models of health care, articulated to the SUS. The technologies of relations, based on the reception, the bond, the co-responsibility and the resolubility of the care must permeate the organization of the work processes[27]. Other authors argue that, in order to overcome barriers, the mobilization, sensitization and training of basic care must be constantly increased[22]. This need for systematic investment was also reported by supporters as essential to maintaining the proposal.

Intangible resources and systematic and longitudinal work process

There is recognition on the procedural aspect of MS, built in the daily practice by the people involved in the work. This process is eminently sustained through immaterial, symbolic resources that cross practices, mediated by the relationships established between the supporters and the professionals of the reference teams.

> *Matrix support is not something given by anticipation, that is, they are characteristics that you see in practice, in the development of work; are characteristics where you need to deal with a group, with several people, interact with several professionals, many teams. You have to make yourself available to work with several people, different people, different visions, visions similar to yours, visions conflicting with yours, with several teams, so this brings you to an effort to interact, to listen, to be able to propose, to have this flexibility.* (AM2).

The complexity of the process stems, in a first moment, from the relationships and interactions that are being constructed in daily life. These are permeated by values, principles, meanings and representations of the subjects involved. Thus, the understanding of the MS as a relational, systematic and longitudinal process is fundamental to decentralization and will determine the sustainability of the proposal.

In the previous speech, some characteristics for the work are evidenced, such as the possibility of composing with people with different perspectives, with different teams, with different professionals, through an exercise of listening and flexibility availability. These characteristics refer to the possibility of self-government

of the workers to print changes from intersubjectivities in the work process. Light technology is produced in living work, in act, in a process of relations[11].

> *[...] it depends on people... maybe this is the biggest difficulty, but it's also what gives hope, because then we can touch people, we can talk and sensitize, and a team is not only one person, so in each team the thing can work differently, and we take advantage of what each team has to offer for working with mental health.* (AM5).

Light technologies[11] establish themselves par excellence in interprofessional work developed in matrix support in mental health. These technologies can be produced between professionals and users, as well as between professionals (generalists and specialists). Invisible resources[13], through the exercise of availability, openness, acceptance, bonding, new ways of operating, possibilities of creating new scenarios, can make changes in the lives of users and professionals, generalists and specialists.

> *[...] the support is closer because the team is united, it is not distant, it is not communicating only by paper [...] the repetition of these experiences will make the next cases that arise are already more familiar with the team and the team already know exactly how to proceed.* (AM3).

As an unfoldment, the MS provides the permanent education of the teams.

The supporters report two different situations, the first one being an obstacle: in the BHU occurs the meeting of the demand, in the form of interconsultation (doctor and specialist), without a space for discussion of cases, while in units with FHS teams there is discussion with the team, with availability for the planning of a therapeutic proposal, with longitudinal follow-up. A characteristic of MS in BHU is that, in these, through negotiation with professionals, a professional was identified who had availability, desire and motivation for mental health care. In this way, this professional became a reference for all cases of mental health. This situation is pointed out as a possible arrangement in the current configuration of traditional BHU without FHS teams.

> *At BHU, it is usually more inter-consultation, that is, the patients are together, they are assisted and, then, together with the clinician, we discuss the cases.* (AM2).

At the BHU, the service logic, which comes from a system implanted before the SUS, works in a different way from the FHS and with another rationality. In this sense, the MS in the BHU is characterized in some units according to the performance of the professional in a perspective of care and demand resolution. It should be noted that there are differences in the way of conducting MS among the specialists, which could be verified in the speeches and also in the FG. The experts said they could discuss the cases with the FHS teams; while at the BHU the centrality was the result of the joint service permeated by some discussion, mainly to solve the BHU demand.

> *In the units that do not have the proximity to the patient, with the group, it is a purely assistance thing, with quality, but, assistantial in attendance.* (AM6).

Another configuration of the work process refers to the joint realization of home visits. Besides the psychosocial paradigm, another one is identified, that of promotion of life. People at risk of suicide, in addition to the systematic follow-up in consultations, are also inserted in a network, which provides the support and the connection to life. This result finds resonance in the Lima and Dimenstein[28] research, which emphasize that MS is an important tool for crisis prevention and intervention in the territory.

> *[...] putting a professional performing matrix support will increase the ability of Primary Care to be attentive to issues that would have been challenging for a specialist, and would be disconnected from what is happening at home, in the family, in the community, on a daily basis of staff [...].* (AM5).

Another research[22] shows that the MS produces a direct response in meeting the demand in mental health in Primary Care, by favoring the autonomy and decision making of professionals. The research reports that professionals acquire expertise in mental health practices, with decreased demand for specialized services.

> *So, what sustains work in the units, I think the main one that sustains is our will to make the MS. No one asked us. When I entered the city hall, the person who came to speak was the (Professional X), was not the manager, was not the coordinator, was not the coordinator of Mental Health.* (AM 5 FG).

The MS resulted from the protagonism of a group of professionals specialized in decentralizing mental health care. In this sense, it is recognized that, despite the different forces at play and management changes, the MS was maintained because of the desire and the protagonism of the supporters. This result finds resonance in Elery[29(214)], who argues:

> We consider that interprofessionality is possible, since organizational and collective conditions are available, mobilizing subjective aspects of professionals. The offer of conditions of possibility, at the organizational level, is indispensable, but not sufficient for the integration of knowledge and interprofessional collaboration. Without the mobilization of the affections, desires and micropowers of each subject, there is no possible interprofessionality.

Matrix support presupposes the expectation of an interprofessional work built by different actors. Professionals should be able to overcome the limits imposed by disease, stigma, adverse living conditions, to produce other ways of operating, through the specific situations that arise. One of the assumptions of matrix support is the shared responsibility of cases, which requires an interprofessional and interdisciplinary approach, which is built through the diagnosis, the formulation of therapeutic projects and the joint approach, mediated through communication and established relations between the professionals. Different perspectives can be raised, with the enrichment of therapeutic interventions.

> *[...] discussing cases, doing some actions together with them, doing home visit, doing joint care... working in a way to expand the work of Primary Care, not doing for them, doing with them to qualify their attention.* (AM5).

Speech brings with it an essential question: 'not doing for them, doing with them'. The 'do with' presupposes the logic of co-management and co-responsibility, guidelines of the MS. Without this logic, reference and counter-reference are established as the main means of communication among professionals.

In the BHU, the patients are assisted by the generalist and the expert. In the FHU teams, this joint care is aimed at the most serious situations, when the therapeutic proposals discussed above have been exhausted. However, it should be emphasized that these organizational arrangements are not tight, rigid. They depend, above all, on the work style of each supporter.

> *In the posts where the Family Health Strategy works it is more the discussion of clinical cases. The doctors bring them to be discussed in group and, also, eventually, with the presence of patients. In some more complicated cases, we do*

inter-consultation, we discuss watching the patient, talking to the patient. (AM2).

In this sense, there are consensuses established in the arrangements between the supporters and in the work developed between them and the professionals of the health units, whether BHU or FHU.

Research on the MS indicates that in this strategy there are no managers, supporters or ready workers. Even when they seem to have the tools to deal with diversity in the production of the encounter, it is necessary to open space for the construction of a collective in production. These spaces must have the appearance of difference, since this is necessary for the production of a collective. In this sense, support is a self-analytical process, through a reinvention perspective in the management and production of health care. From this process new modes of interpreting and relating are produced, through the communication flows between users, professionals and managers[30].

Matrix support has a lot to do with it, with the dynamics of the team, with how the team manages to work some cases and some cases are analytical for the team, cases that demonstrate something that is stuck in the team. The difficulties of the team appear, sometimes, when attending cases. (AM5).

The supporter brings the need for a contextualized and self-referential look to the work developed in the group, in an internal evaluation process.

Final considerations

In the research, we have observed that care is the central element of the interventions, which enables co-managements, support, and monitoring of limit situations in the community. The work is sustained primarily by the personalized relationships between supporters, professionals of reference teams and users, through complex work processes of territorial basis. It can be observed that decentralization in mental health occurs not only in the universe of users, but also of specialists (supporters). These can break with the instituted, outpatient care, and become protagonists of creative and innovative processes. The organizational and operational arrangements of the work process are based on actions of supervision, joint care and discussion of clinical cases. These arrangements are structured according to the particularities of the BHU, with or without FHS teams and the professionals involved.

Data analysis allows us to infer that work processes are anchored in light technologies, supported by personalized relationships between supporters and reference teams/professionals. It can be concluded that the systematicity of the meetings, the longitudinal relations, the public health bias of the specialists, the profile for the work in the community support the proposal. These, together with the characteristics of the group, such as respect for the ideas and positions of the other, respect for the different ways of realizing the MS, respect for the different theoretical lines of each professional, the feeling of personal growth derived from interprofessional relations, mediated by relations of affection, give support to the proposal. Other attributes of the supporters who cross the practices are flexibility, involvement, availability, co-responsibility, communication and care. These can be considered as desirable and necessary competencies for the supporter, which subsidize the work process. As well as the recognition of the notion of process implied in the work and the complexity resulting from the fields of interaction. The extended care strategies were also evidenced in the joint work, by not centralizing the disease model in the biomedical model. There is, on the part of the supporters, the logic of working the issues from an understanding of the context of

people's lives, which also involves sickness, but is not limited to that. It is worth noting that the training of supporters provides such an approach, such as, for example, psychologists and psychiatrists with training in community mental health.

The issues of organizational, structural, epistemological and political nature are indispensable to the operationalization of the MS. However, in addition to these, invisible resources, such as personalized relationships between supporters and reference teams/professionals, emerge as a central issue for maintaining the proposal. The process is sustained on relational work in the act, on the daily services, on the spaces of the territory and on the built symbolic network, which demands creative practices that allow the co-emergence of new scenarios, internal and external, in people's lives. Thus, through MS, the principles of decentralization, integrality and equity of the SUS, in addition to idealized, abstract principles, are built and reinvented in interprofessional practices.

One of the limitations of the research was the impossibility of carrying out a second FG together with the supporters, the professionals of the BHU and the FHU, being the last two segments object of another analysis. This occurred due to the impossibility of reconciling the agenda of all professionals. ■

References

1. Federación Mundial para la Salud Mental. Atención primaria y salud mental, salud mental em la atención primária: mejorando los tratamientos y promoviendo la salud mental. [internet]. 2009 [acesso em 2013 jun 20]. Disponível em: http://www.wfmh.org/WMHD%2009%20Languages/SPANISH%20WMHD09.pdf.

2. Patel V, Belkin, GS, Chockalingam A, et al. Grand Challenges: Integrating Mental Health Services into Priority Health Care Platforms. PLoS Medicine [internet]. 2013; [acesso em 2013 jan 10]; 10(5): e1001448. Disponível em: doi:10.1371/journal.pmed.1001448.

3. Collins PY, Patel V, Joestl SS, et al. Grand challenges in global mental health. Nature [internet]. 2011; [acesso em 2013 set 20]; 475:27-30. Disponível em: doi:10.1111/j.1365-3016.2007.00869.x.

4. Patel V. Global Mental Health: from science to action. Harvard Rev Psychiatry [internet]. 2012; [acesso em 2013 nov 12]; 20(1):6-12. Disponível em: doi:10.3109/10673229.2012.649108.

5. Whiteford HA, Degenhardt L, Rehm J, et al. Global burden of disease attributable to mental and substance use disorders: findings from the Global Burden of Disease Study 2010. The Lancet [internet].

2013; [acesso em 2013 set 28]; 382(9904):1575-1586. Disponível em: doi:10.1016/S0140-6736(13)61611-6.

6. Becker AE, Kleinman A. Mental Health and the Global Agenda. The New England Journal of Medicine [internet]. 2013; [acesso em 2013 set 10]; 369:66-73. Disponível em: doi:10.1056/NEJMra1110827.

7. Evans-Lacko S, Knapp M, McCrone P, et al. The Mental Health Consequences of the Recession: Economic Hardship and Employment of People with Mental Health Problems in 27 European Countries. PLoS ONE 2013; [acesso em 2013 dez 28]; 8(7):e69792. Disponível em: doi:10.1371/journal.pone.0069792.

8. Ribeiro JM, Inglez-Dias A. Políticas e inovação em atenção à saúde mental: limites ao descolamento do desempenho do SUS. Ciênc Saúde Colet. 2011; 16(12):4623-4633.

9. Onocko Campos R, Gama CA, Ferrer AL, et al. Saúde mental na atenção primária à saúde: um estudo avaliativo em uma grande cidade brasileira. Ciênc Saúde Colet. 2011; 16(2):4643-4652.

10. Lobosque AM. Debatendo alguns desafios da Reforma Psiquiátrica brasileira. Ciênc Saúde Colet. 2011; 16(12):4590-4592.

11. Merhy EE. Saúde: a cartografia do trabalho vivo. São Paulo: Hucitec; 2005.

12. Campos GWS. Saúde Paidéia. 2. ed. São Paulo: Hucitec; 2003.

13. Thornicroft G, Tansella M. The mental health matrix. A manual to improve services. New York: Cambridge University Press; 1999.

14. Brasil. Ministério da Saúde. Secretaria de Atenção à Saúde. O vínculo e o diálogo necessários. Inclusão das ações de Saúde Mental na Atenção Básica. [acesso em 2018 ago 25]. Disponível em: http://portal.saude.gov.br/portal/arquivos/pdf/diretrizes.pdf.

15. Minayo MCS. O desafio do conhecimento: pesquisa qualitativa em saúde. 12. ed. São Paulo: Hucitec; 2010.

16. Barbour R. Grupos Focais. Porto Alegre: Artmed; 2009.

17. Brasil. Conselho Nacional de Saúde. Resolução nº 466, de 12 de dezembro de 2012. Diretrizes e normas regulamentadoras de pesquisa envolvendo seres humanos. Brasília, DF: CNS; 2012.

18. Tófoli LF, Fortes S. Apoio Matricial de Saúde Mental na atenção primária no Município de Sobral-CE: o relato de uma experiência. SANARE. 2007; 6(2):34-42.

19. Patel V, MajM, Flisher AJ, et al. Reducing the treatment gap for mental disorders: a WPA survey. World Psychiatry [internet]. 2010; [acesso em 2012 fev 10]; 9(3):169-76. Disponível em: http://www.ncbi.nlm.nih.gov/pubmed/20975864

20. Eaton J, McCay L, Semrau M, et al. Scale up of services for mental health in low-income and middle-income countries. The Lancet [internet]. 2011; [acesso em 2013 dez 14]; 378(9802):1592-603. Disponível em: doi: 10.1016/S0140-6736(11)60891-X.

21. Minoletti A, Rojas G, Horvitz-Lennon M. Salud mental em atención primaria en Chile: aprendizajes para Latinoamérica. Cad de Saúde Coletiva [internet]. 2012; [acesso em 2013 dez 18]; 20(4):440-447. Disponível em: doi:10.1590/S1414-462X2012000400006.

22. Morais APP, Tanaka OY. Apoio Matricial em Saúde Mental: alcances e limites na atenção básica. Saúde e Sociedade 2012; 21(1):161-170.

23. Prates MML, Garcia VG, Moreno DMFC. Equipe de apoio e a construção coletiva do trabalho em Saúde Mental junto à Estratégia de Saúde da Família: espaço de discussão e de cuidado. Saúde e Sociedade 2013; 22(2):642-652.

24. Cunha GT, Campos GWS. Apoio Matricial e Atenção Primária em Saúde. Saúde e Sociedade 2011; 20(4):961-970.

25. Campos GWS, Domitti AC. Apoio matricial e equipe de referência: uma metodologia para gestão do trabalho interdisciplinar em saúde. Cad de Saúde Pública 2007; 23(2):399-407.

26. Dobscha SK, Leibowitz RQ, Flores JA, et al. Primary care provider preferences for working with a collaborative support team. Implementation Science [internet]. 2007; [acesso em 2012 dez 5]; 2:1-6. Disponível em: doi:10.1186/1748-5908-2-16.

27. Vasconcelos MGF, Jorge MSB, Pinto AGA, et al. Práticas inovadoras de saúde mental na atenção básica: apoio matricial na redefinição do processo de trabalho em saúde. Cadernos Brasileiros de Saúde Mental 2012; 4(8):166-175.

28. Lima M, Dimenstein M. O apoio matricial em saúde mental: uma ferramenta apoiadora da atenção à crise. Interface (Botucatu) 2016; 20(58):625-35.

29. Elery AEL. Interprofissionalidade na Estratégia Saúde da Família: condições de possibilidade para a integração de saberes e a colaboração interprofissional. Interface (Botucatu) 2014; 8(48):213-5.

30. Bertussi DC. O apoio matricial rizomático e a produção de coletivos na gestão municipal de saúde [Tese]. Rio de Janeiro: Universidade Federal do Rio de Janeiro; 2010. 234 p.

Received on 06/07/2018
Approved on 07/31/2018
Conflict of interests: non-existent
Financial support: Foundation for Research of the State of Rio Grande do Sul (FAPERGS)/National Council for Scientific and Technological Development (CNPq)