Experience Report

# The practice of matrix support and its effects on primary health care

**Meyrielle Belotti[a], Maria Cristina Campello Lavrador[b]**

[a]Department of Integral Education in Health, Universidade Federal do Espírito Santo – UFES,
Vitória, ES, Brazil.

[b]Department of Psychology, Universidade Federal do Espírito Santo – UFES, Vitória, ES, Brazil.

**Abstract:** Introduction: This work is part of the context of discussions on mental health in primary health care. It is an experience report of Matrix Support practice in a Family Health Unit located in a city of Grande Vitória, ES, Brazil. Objective: We sought to identify the effects that the matrix meetings had in the astringency territory of the Family Health Strategy teams followed up. Method: The matrix meetings were performed using the Circle approach. Results: The results show that the practice of the Matrix Support favored the expansion of care strategies for mental health in primary health care; co-responsibility in the care; qualified hearing; increased resolution in this level of attention; and a decrease of referrals without criteria. Conclusion: In this regard, the Support Matrix was a tool able to promote dialogue between mental health services and primary health care. Thus, the Singular Therapeutic Project became a great ally, providing the construction of decisions and shared tasks, allowing the involvement and accountability of all caring for the person with psychiatric suffering.

**Keywords:** *Mental Health, Family Health, Health Care.*

## A prática do apoio matricial e os seus efeitos na atenção primária à saúde

**Resumo:** Introdução: Este trabalho insere-se no contexto das discussões sobre a saúde mental na Atenção Primária à Saúde. Trata-se de um relato de experiência da prática do Apoio Matricial em uma Unidade Saúde da Família, situada em um município da Grande Vitória, ES, Brasil. Objetivo: Buscou-se identificar os efeitos que os encontros de matriciamento provocaram no território de adstringência das equipes da Estratégia Saúde da Família acompanhadas. Método: Para a realização dos encontros de matriciamento, foi utilizado o Método de Roda. Resultados: Os resultados apontam que a prática do Apoio Matricial favoreceu a ampliação das estratégias de cuidados em saúde mental na Atenção Primária à Saúde; a corresponsabilidade no cuidado; a escuta qualificada; o aumento da resolutividade neste nível de atenção; e a diminuição dos encaminhamentos sem critérios. Conclusão: Neste sentido, o Apoio Matricial foi uma ferramenta capaz de promover uma interlocução entre os serviços de saúde mental e a Atenção Primária à Saúde. Neste caminho, o Projeto Terapêutico Singular (PTS) configurou-se como um grande aliado, proporcionando a construção de decisões e tarefas definidas de modo compartilhado, favorecendo o envolvimento e a responsabilização de todos no cuidado do sujeito com sofrimento psíquico.

**Palavras-chave:** *Saúde Mental, Saúde da Família, Atenção à Saúde.*

**Corresponding author:** Meyrielle Belotti, Centro de Ciências da Saúde, Universidade Federal do Espírito Santo – UFES, Av. Marechal Campos, 1468, Maruípe, CEP 29043-260, Vitória, ES, Brazil, e-mail: meyri.belotti@gmail.com

# 1 Introduction

Currently, we are facing a broad process of transformation in the mental health field, which has struggled to deconstruct the "asylum logic" as well as the protection of relationships established with the crazy person. Therefore, we observed a recovery of the basis territorial practices with the involvement of many social actors articulated in a network of care. In this scenario, the Primary Health Care (APS) has been shown to be a privileged place for the construction of a new logic to welcome madness, by its principles are guided by the comprehensive care, the host, the commitment to the community, establishing a link and the network link (BRASIL, 2012).

According to Silva (2010), the inclusion of mental health in APS should be done by creating care strategies able to recognize the differences and limitations of a person with mental suffering, thus favoring the expanded clinic.

> On this basis, it is sought to offer unique strategies of attention and care, restoring ties, compromising the health teams, enhancing family care and constant monitoring (SILVA, 2010, p. 17).

To Merhy (2006, p. 199), the APS must be understood as a strategic intervention for the redefinition of practices aimed at a change in direction of a "hospital-centered" system to a "basic-centered-network" [...] "that may be open up, therefore, the more different constitution alternatives of new production formats of health actions".

Thus, the inclusion of mental health in APS is a key strategy

> [...] For the reorganization of health care that is urgently needed in our reality, that it breaks dichotomies such as health/mental health, requiring the production practices within the principle of comprehensiveness (DIMENSTEIN et al., 2005, p. 26).

In this scenario, the Support Matrix (SA) can be used as a tool to promote a dialogue between mental health services and the APS, since it constituted a "[...] organizational arrangement that enables technical support in specific areas for teams responsible for the basic health care development [...]" (BRASIL, 2005, p. 34). Its proposal is to expand the capacity of solving the APS teams and the deployment of an expanded clinical and responsibility of care.

In other words, the SM in mental health aims to support, to discuss, to act together and to empower APS professionals for mental health care. This is to ensure care support and technical and pedagogical support teams to pay attention to the health problems of the population (CAMPOS; DOMITT, 2007).

In practice, the SM happens from meetings with the presence of APS staff and supporters professionals, with discussions of the mental health cases identified in the territory. In some specific instances may occur interventions together (home visits, assistance, etc.) to better "resoluteness" of the case. Thus, it is intended to qualify the APS teams for a larger attention as well as to the distinction of cases that can be accepted at this level of attention from the real situations that require specialized mental health care.

Campos and Domitt (2007) points out that the practice of SM is in the construction of Singular Therapeutic Projects (PTS). PTSs are configured as a tool for building innovative practices that single out the processes of the subjects and their health needs, presenting new perspectives on the production of autonomy, leadership and social inclusion (BARROS, 2010). Thus, the PTS is an instrument that incorporates a uniqueness to look, necessarily involving and with the responsibility of the health team and the user in the management of common interests.

According to the Ministry of Health (BRASIL, 2006), the PTS is nothing more than a new way to carry out the discussion of "clinical case" capable of providing an integrated team performance, incorporating other aspects in addition to the psychiatric diagnosis and medication for the treatment of individuals. Therefore, its development occurs in discussion spaces, where all knowledge is important and contribute to help understand the subject with some health care demand.

This article is the result of an experience report on the implementation of the SM in a Family Health Unit (USF), located in a city of Vitória-ES. His proposal is to present and discuss the effects that matrix meetings resulted in the astringency of the territory of the accompanied UBS.

# 2 Method

For the conduction of matrix meetings, it was opted for the circle method, aiming to make possible the construction of collective spaces, conducive to critical reflection on the daily lives of service and work process. It attempted to enhance the analysis capabilities of these individuals about their health

practices and the implementation of co-management (CAMPOS; DOMITT, 2007).

It is worth noting that the matrix meetings were to favor the proposed dialogue between the APS and mental health; generate knowledge for the ESF teams in the mental health field; broaden the scope of mental health actions in the APS, and therefore encourage greater degree of resoluteness of cases of mental health at this level of attention. Thus, it sought to enable professionals to the reflective analysis of work processes aimed at questioning crystallized processes; that is, the intention was not to carry out major structural changes, but the creation of new care strategies to break the asylum logic.

The setting of this experience was one USF located in a city of Vitória-ES which was located in a poor and rural characteristics territory. Regarding careful network mental health of this municipality, it is a very complex because it has services that are local administration and others that are state management in its territory. Under municipal management, there are three clinics of Mental Health operating in Basic Health Units. Under state management, there are two centers of Psychosocial Care II (CAPS), seven Therapeutic Residences (RT) and State Hospital, which is a reference to all Grande Vitória in Emergency and Psychiatry Emergency.

At first, before the operation of the conversation circles, a meeting with USF professionals for the presentation of the SM proposal and its working methods was performed. All USF professionals were invited to participate. In total, there were 24 health professionals participated in the following categories: nurses, social workers, community health workers and nursing technicians. The meetings took place at USF, with a biweekly frequency, except in emergency situations which were demanded by the ESF teams.

The conversation circles were held from February to September 2012. In total, there were 18 meetings held, lasting approximately two hours each. The meeting had the presence of professionals from three ESF teams and two mental health professionals, the technical reference in mental health in astringency territories of USF, and developed the role of mental health supporters.

## 3 Results and Discussion

Initially, it was found that mental health actions by the ESF teams before the matrix were restricted in referrals to mental health services without any involvement and acceptance of the subject with psychological distress. In this scenario, it was identified an excessive number of referrals without criteria to mental health services, that is, for the most part, these referrals did not have a specific demand to justify the need for specialized care. This reality was present due to the difficulty of professionals to carry out a qualified hearing and the sense of helplessness experienced by those facing a mental health demand. Also, there was a lack of preparation and training in mental health and the presence of stigmata of madness.

The feeling of helplessness that pervades the mental health care may be linked to a role within a perspective of the biomedical model, which is founded on the disease in remission of symptoms to cure. In the field of mental health, this care model becomes unfeasible. For this reason, among others, many of the expectations created by the users with psychological distress are not reached, causing suffering to the worker.

The feeling of impotence can also be justified by the lack of knowledge in the mental health field. Several studies (SILVEIRA; VIEIRA, 2009; JUCA; NUNES; BARRETO, 2009; BRÊDA et al., 2005) show the existence of a lack of preparation in the APS teams to work with individuals in psychological distress. Queiroz (2010) points out that the current challenge of the Psychiatric Reform Movement is to ensure the care of production at APS. Therefore, it is necessary that: a) the teams are trained and qualified for the demands on mental health; b) professionals are prepared to perform a qualified hearing; c) all members of the APS team know how to organize the mental health network to ensure comprehensive care.

About the stigma surrounding the madness, the existence of the concept a correlation of dangerousness with madness was identified, in which some professionals reported that they were afraid of being attacked by individuals with mental suffering and therefore did not perform any care strategy on mental health in the astringency of territory.

Godoy and Bosi (2007, p. 294) point out that the exclusion imposed on the subject with psychological distress favored the social construction Madness stigma.

> About the crazy person, an action of violence is exerted, multiple segregations: from reclusion to abandonment naked and filthy in the asylum courtyard, building up the crazy concept as being dangerous, nefarious, unable a "not to be" giving him the condition of "non-citizen", "not individual".

For Goffman (1988, p. 15), the reduction of the subject to his stigmatized trait legitimate "[...] various

kinds of discrimination through which effectively and often unthinkingly reduce his chances of life". The stigmas around the madness, present in the social imaginary, are designed as obstacles in advancing the concept of another social place to madness.

> "The social place of madness, despite a certainly produced displacement, remains, in general, the one place in the margins of society [...]" (NUNES; TORRENTE, 2009, p. 104.).

In this scenario and to promote an approach to mental health theme with teams accompanied ESF, as well as their training in this field of activity, the first matrix meetings took a pedagogical character. Thus, readings were taken and text discussions on mental health policy in Brazil and presented the care network in the mental health of the municipality. Through these meetings, it was proposed to build a form to be used while receiving mental health. The form was prepared with questions dealing with in addition to the biological aspects, such as the family constitution and their relationships, the social context of the user, their daily lives, desires, and life prospects.

Together with the construction of the host form, a mapping of equipment/community services was carried out to integrate them as another therapeutic option of PTS, not to restrict its actions to clinical questions. Also, the proposed mapping of existing social resources in the community aimed to seek spaces in which subjects with psychological distress could move along with others, to demystify the madness and the asylum and exclusionary character of practices. In this mapping process, the following territorial resources were identified: an open school with several professional courses and cultural and leisure activities; a social project that manufactures crafts with recycled material; and another that developing sports practices. It is noteworthy that in addition to these identified territory resources, the actions of the PTS were also articulated with the said county health network, which is operated from the user-submitted demand. Thus, both the health services at different levels of complexity (APS, Medium Complexity, and high complexity) and mental health services were included in PTS according to the need and complexity of the discussed case.

After the conclusion of this stage, the case discussions were initiated and implementation of PTS, in situations that were more complex, or in severe and persistent cases, elected by the staff.

The structure of the PTS was developed from the following steps: 1) preparing the situational diagnosis, considering the organic aspects, psychological and singular subject context; 2) negotiation and planning of actions with the user and his caregiver (s), each project had action-term achievement and responsible for implementation; 3) Revaluation for adjustment of the actions. It is worth noting that the user and his caregiver (s) also had responsibilities in implementing the PTS.

All PTS actions were accompanied by a professional who assumed the role of the articulator and potentiating the process, establishing a relationship of partnership with support networks. This professional became a reference for the team and the user and caregiver(s) involved, keeping always informed the group about the case and demanding further discussions if needed since the actions of the projects were flexible and open to change. The choice of the reference professional was performed considering the quality of the link to the user.

Some difficulties have arisen during the preparation and implementation of PTSs such as the search for immediate and prompt responses aimed to cure and which referred to the biomedical model; create bonds with users and carers involved; respect the choices and users' time; committed, qualified listening; respect for singularity. However, in the course of discussions on the construction of PTS, it was noticed an improvement in the look of the mental health care and these difficulties began to be eased.

Along the way, we found that the practice of SM, promoted a change in the way of dealing with the "madness," causing some effects on the accompanied territory, such as the supply of qualified listening to the subject with psychological distress; reducing referrals without criteria to mental health services; creation care strategies in mental health; and responsibility for care.

## 4 Final considerations

This article reports the SM deployment experience in mental health in primary health care. Its proposal is on analyzing the effects on the health of territory by the matrix meetings. Throughout the conversation circles, there is an empowerment of the ESF teams in relation to activities in the field of mental health, which favored: the expansion of care strategies for mental health; the responsibility in care; increasing the degree of problem solving

cases of mental health in the level of attention; qualified listening; and fewer referrals without criteria. This fact reiterates the proposal Iof the V Mental Health Conference, requesting in its final report, the strengthening and expansion of the ESF actions, reaffirming the matrix strategy as one of the important tools for the integration of user-level of APS (BRASIL, 2010).

It is important to highlight the importance of PTS during the matrix meetings. The PTS proved useful to mediate relationships and establish a dialogue among health staff, users, and caregivers, providing building decisions and a set of shared mode tasks, allowing the involvement and accountability of all the subject of caring for psychic suffering.

This experience also indicates the importance of investment in both the SM actions to strengthen mental health in APS, and for the effective incorporation of mental health at this level of attention, through the production of knowledge based on the premises of the psychosocial care model, in contrast to the asylum logic.

It is important to note that one of the limitations of this experience is because the study was conducted only in one USF, and the results can not characterize the effects of SM throughout the municipality. It is worth noting the difficulty of participation of doctors in the matrix meetings, as the insertion of this professional could enrich the discussions and elaborations of PTS.

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## Author's Contributions