Matrix support in primary care: challenges in mental health care

Apoio matricial na atenção básica: desafios para integralidade do cuidado em saúde mental

Apoyo matricial en la atención básica: retos para integralidad de la atención en salud mental

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ABSTRACT

Objective: To investigate the development of matrix support activities between the Expanded Family Health Center (Núcleo Ampliado de Saúde da Família), the Psychosocial Care Center (Centro de Atenção Psicossocial) and Family Health Strategy Teams (Equipes de Estratégia de Saúde da Família). **Method:** This is a qualitative research, developed through the perspective of Institutional Analysis in the city of Currais Novos, Rio Grande do Norte countryside from June to September 2017. Semi-structured interviews were carried out with 22 professionals from the aforementioned services of health. **Result:** From the Content Analysis carried out from the narratives produced by the interviews, three categories were identified: Weaknesses and difficulties in the practice of mental health care; Matrix support and the paths taken; Fragmentation of care and lack of responsibility for care. **Conclusion:** It was possible to identify that matrix support still has a long way to go, in order to lead and articulate that demands and equipment could be recommended.

Descriptors: Basic care; Integrality in health; Mental health.

RESUMO

Objetivo: *investigar o desenvolvimento das atividades do matriciamento entre Núcleo Ampliado de Saúde da Família, Centro de Atenção Psicossocial e Equipes da Estratégia de Saúde da Família.* ***Método:*** *Trata-se de uma pesquisa de natureza qualitativa, desenvolvida por meio da perspectiva da Análise Institucional no município de Currais Novos interior do Rio Grande do Norte no período de junho a setembro de 2017. Foram realizadas entrevistas semiestruturadas com 22 profissionais dos referidos serviços de saúde.* ***Resultado:*** *Da Análise de Conteúdo realizada a partir das narrativas produzidas pelas entrevistas, foram identificadas três categorias: Fragilidades e dificuldades na prática do acolhimento em saúde mental; Apoio Matricial e os caminhos trilhados; Fragmentação da atenção e desresponsabilização do cuidado.* ***Conclusão:*** *Foi possível identificar que o apoio matricial ainda necessita que um longo caminho seja trilhado para que o seu modo de conduzir e articular as demandas e equipamentos seja de fato como preconizado.*

Descritores: *Atenção Básica; Integralidade em saúde; Saúde Mental.*

RESUMEN

Objetivo: *Investigar el desarrollo de las actividades del matriciamiento entre Núcleo Ampliado de Salud de la Familia, Centro de Atención Psicosocial y Equipos de Estrategia de Salud de la Familia.* ***Método:*** *Se trata de una investigación de naturaleza cualitativa, desarrollada por medio de la perspectiva del Análisis Institucional en el municipio de Currais Novos, interior del Rio Grande do Norte, en el período de junio a septiembre de 2017. Fueron realizadas entrevistas semiestructuradas con 22 profesionales de los referidos servicios de salud.* ***Resultado:*** *Del Análisis del Contenido realizado a partir de las narrativas producidas por las entrevistas, fueron identificadas tres categorías: Fragilidades y dificultades en la práctica de la acogida en salud mental; Apoyo Matricial y los caminos recorridos; Fragmentación de la atención y "desresponsabilización" de la atención.* ***Conclusión:*** *Fue posible identificar que el apoyo matricial aún necesita que un largo camino sea recorrido para que su modo de conducir y articular las demandas y equipos sea, de hecho, como preconizado.*

Descriptores: *Atención básica; Integralidad en salud; Salud Mental..*

INTRODUCTION

Throughout history, it can be identified that mental health assistance and care practices have undergone many significant transformations. What was once seen as an evil that should be extirpated and separated from social life, became the object of intervention of a biologicistic psychiatry and articulated to the asylum apparatus as the only and primary locus of treatment[1].

Since the 1970s, Brazil has witnessed the emergence of a series of movements challenging the asylum paradigm and proposing new models and practices of mental health care. Based on the Brazilian Health Reform, the National Movement of the Antimanicomial Struggle was present, composing and consolidating the Psychiatric Reform (*Reforma Psiquiátrica* – RP) movement. Among other struggles, mental health has become recognized as part of comprehensive care, with a territorial-based care model that must be assisted in an interprofessional and intersectoral manner[1,2].

In this process, Law 10.216, of April 6, 2001, better known as the Psychiatric Reform Law, was a great legislative milestone in Brazil by institutionalizing the need for respect and dignity for people suffering from mental illness[3]. Subsequently, Ordinance Nº. 3,088, of December 2011, was responsible for establishing the Psychosocial Care System (*Rede de Atenção Psicossocial* – RAPS) within the Unified Health System (*Sistema Único de Saúde* – SUS, which must be structured by various devices and equipment[4].

However, it is essential in the process of dehospitalization and psychiatric deinstitutionalization, that the creation and expansion of the substitutive system in mental health occurs and that the problem of psychological distress is recognized and strengthened in Primary Health Care (*Atenção Primária à Saúde* – APS), making it necessary for the advancement of RP itself[5,6].

A study points out[7] that Psychosocial Care Center (*Centro de Atenção Psicossocial* – CAPS) occupies a prominent place in mental health and in the regionalization process, however, on the other hand, mental health care in Psychosocial Care (*Atenção Psicossocial* – APS) settings has been taking place with less investment and concern.

In the context of this research, mental health is shown as one of the main demands of the teams, reflected by a high culture of medicalization[8], resulting in the search for drugs, difficulty of the teams to develop promotion actions, groups, and even case identification. These teams also suffer because of the limited supply of specialized services and professionals that provide support and matrix support (*Apoio Matricial* – AM), to expand their actions and resolution scope.

To accomplish this, it is necessary to strengthen the role of Psychosocial Care (*Atenção Psicossocial* – APS) as the gateway and organizer of health care, expanding the supply of care, reducing the number of unnecessary referrals, and the chronic conditions of psychological distress. And it is in this logic that AM is inserted. It allows health to be understood in an expanded and integrated way, understanding that there is a sharing of knowledge and practices. It also contributes as a flow regulator, allowing the identification and understanding of the need for each case[7,9].

Matrix support, as stated in the Matrix Support Practical Guide, is also characterized by being able to provide specialized rear support for care, as well as providing support for health education and support for the collective construction of instruments that are part of matrix support, such as: o Singular Therapeutic Project, interconsultation, group consultation in mental health, group home visit, distance contact, genogram, ecomap[10,11].

Faced with a context of setbacks in public health policies faced in recent years and, in particular, in the mental health area, with notorious dismantling, scrapping, and underfunding of health care and support devices, the

pertinence and relevance of this study are anchored. Thus, the objective was to investigate the development of matrix support activities between the Expanded Family Health Center (*Núcleo Ampliado de Saúde da Família* – NASF), the Psychosocial Care Center (*Centro de Atenção Psicossocial* – CAPS), and the Family Health Strategy (*Equipes da Estratégia de Saúde da Família* – ESF) teams.

METHODS

This qualitative research is based on the concepts of Institutional Analysis. Institutional analysis allows the researcher to seek to understand a specific social and organizational reality in the face of the subjects' discourses and practices, based on a dialectical relationship[12].

This perspective assumes that the institutions studied "are not just the objects or rules visible on the surface of social relations. They have a hidden face. This face, which institutional analysis sets out to identify, is revealed in the unspoken"[13-68]. The study was conducted in a city Rio Grande do Norte countryside, which has, within the scope of the Health Care System, 17 Family Health Units, divided into rural and urban areas; 1 Mobile Emergency Care Service (*Serviço de Atendimento Móvel de Urgência* – SAMU); 1 Regional Hospital; 1 Polyclinic, in addition to 2 Expanded Family Health Center (NASF) teams, Psychosocial Care Center II (CAPS II).

In this health practice scenario, the research field occurred in the NASF, CAPS, and ESF, which must perform and be involved in matrix support. In these health services, semi-structured interviews were conducted with 22 professionals, 11 of whom were ESF professionals (6 nurses and 5 doctors); 3 from CAPS (psychologist, coordinator - psychologist, and psychiatrist) and 8 from NASF (2 psychologists, 1 social worker, 1 physiotherapist, 1 physical activity professional, 1 pharmacist, 1 psychiatrist, 1 coordinator – social worker), from 06/2017 to 09/2017.

The professionals were chosen based on convenience and because they met the research interest, encompassing health units that received students from the Multiprofessional Residency Program in Primary Care of Multicampi School of Medical Sciences (Escola Multicampi de Ciências Médicas – EMCM/ Universidade Federal do Rio Grande do Norte – UFRN), which the researcher was associated with at the time of the study. To this purpose, the priority was given to listening to the professional categories that worked more directly with the practice of preceptorship and matrix support – doctors and nurses, as well as all higher education professionals who worked in the main matrix support devices in the city, such as CAPS and NASF.

The interviews were conducted on an individual basis, and recorded with the authorization of the subjects who deliberately accepted participation in the research by signing the Free and Informed Consent Form (*Termo de Consentimento Livre e Esclarecido* – TCLE). They took place in reserved rooms on the premises of the health services at a previously agreed time with the participants. The interviews were transcribed and subsequently discarded after the different stages of content analysis. It is also emphasized that the whole process was accompanied by the field diary, in a way to compose a wider range of information about the phenomenon under study.

The interviews were conducted based on the following questions: 1. personal identification; 2. welcoming in mental health; 3. perception and conduction of Matrix Support and all its tools (Singular Therapeutic Project [*Projeto Terapêutico Singular* – PTS], genogram, ecomap, group consultation, interconsultation, group home visit, and distance contact); integration and articulation between mental health equipment; and perceptions of how mental health care can be improved.

The discursive identification of the interviewees was given by the acronyms ESF, NASF, and CAPS, indicating the workplaces of the participating professionals, and by the numbering from 1 to 22, representing the total number of participating subjects. In addition, it is important to emphasize that this numbering was given randomly, seeking to preserve the identity of the professional, as assumed by the TCLE.

From the information obtained, the process of identifying themes was carried out through Content Analysis, following the three main stages of content analysis: the pre-exploration phase of the material or floating readings of the corpus of the interviews; the selection of the units of analysis and the process of categorization and subcategorization[14]. It is also important to emphasize that the material produced was based on field diary writing and service observation.

From this identification process, three thematic categories were elucidated: 1) Weaknesses and difficulties in the practice of welcoming in mental health; 2) Matrix Support and the paths that have been taken; 3) Fragmentation of care and failure in ensuring accountability.

It should be emphasized that the present work went through all the ethical precepts established by Resolution 466/12 of the National Health Council, having been analyzed and accepted by the Ethics Committee of the Faculty of Health Sciences of Trairi of College of Health Sciences (*Faculdade de Ciências da Saúde* – FACISA/UFRN) with

the number of Certificate of Submission for Ethical Appraisal (*Certificado de Apresentação de Apreciação Ética* – CAAE) 67839717.0.0000.5568.

RESULTS AND DISCUSSION

The thematic categories mentioned in the methodology will be presented and discussed in the sequence bellow.

Weaknesses and difficulties in the practice of welcoming in mental health

In this category are organized the elements that correspond to the first contacts with the demands and cases in mental health area, as well as the paths and routes derived from this.

In general, mental health patients arrive at the ESF, mainly through the Community Health Agent or a family member, being referred for medical consultation, in which they are most often medicated. If it is considered a serious case, it is referred to the NASF psychiatrist, who goes to the Basic Health Units (*Unidades Básicas de Saúde* – UBS) every three months, revealing fragmented care, insufficient and rooted in the traditional biomedical paradigm. Thus, only one ESF nurse claimed to make the referral to CAPS, according to the gravity of the case.

When asked what is the greatest demand of the service, the answers were the same: mental health! Even so, the welcoming and assistance in mental health are still flawed and with limited clarification on how it works. This problem is exemplified in the following speech:

> "Things are like this... The dots are loose, there is no definition of who is who, I can't visualize." (ESF2)

Likewise, the professionals recognize the fragility of this welcoming and difficulties in developing mental health care actions:

> "This welcoming is made in a precarious way." (ESF2)
> "It is very... this welcoming is very limited." (ESF5)
> "Ouch... it's so difficult to take them in..." (ESF7)

As illustrated in these statements, there are many flaws and difficulties in welcoming patients, ranging from the user's entry to the proper paths that can be followed inside the system. Such issues were also observed in a study[15] that shows that professionals must be aware of complaints and needs from welcoming to the entire health care of this subject.

Similarly, one of the NASF professionals supports these aspects by illustrating that:

> "They arrive at the basic units, and automatically the nurses send them to the anxiety group, that's basically what is done." (NASF16)

The aforementioned problem shows that mental health care is perpetuated in a disjointed manner and with little interlocution between APS reference teams, teams, and specialized services, as the following statement illustrates:

> "There is a huge demand for controlled drugs here, but we always try to improve the service, making a referral to the specialist". (NASF1)

This finding reveals the lack of criteria in loose referrals, without first developing welcoming and listening actions as recommended at this level of care, which shows the fragility of work processes and the need for self-organization[16].

Although some professionals question and identify the need to change this context, when the ESF itself attends to the patient in mental distress, the care is limited to prescription renewals, focusing exclusively on medical and pharmacological care, as one ESF professional revealed:

> "Here, patients with suffering from mental illness who take psychotropic drugs, are almost always sent by family members to pick up the prescriptions." (ESF5)

Regarding the situation mentioned above, authors[17] state that this method of action hinders the possibility of a multidirectional approach to mental health, making care even more centered on the use of medication.

When we talk about matrix support, mental health, and welcoming, we consequently think of an organizational process of attention to care, in which there is a path to be followed, by the patient and professionals, in the various

facilities according to their demands[18]. Matrix support in mental health in APS can change the entire system, clarifying the role of each professional and service. This way, patients won't just be "hostages" to care at the CAPS[19].

From this category, ESF professionals showed themselves to be knowledgeable about the responsibility of welcoming mental health patients. However, it is understandable that this knowledge is still held back by practices based on the biological model, not knowing which paths should be taken by these patients and what should actually be done[20,21].

In this way, patients are often left to their own devices, wandering from service to service, searching for some kind of help that will bring them relief. Thus, this happens without the commitment and responsibility of health professionals and services in shared cases.

Matrix support and the paths taken

This category illustrates the trajectory of Matrix Support, the conceptions, and the action process of the professionals involved.

To make matrix support in mental health effective, teams need to be informed, aware and able to understand with a deinstitutionalization approach[20]. Therefore, this requires a lot of intellectual, emotional, and practical investment, aimed at intersectoral, comprehensive, multiprofessional, and interprofessional work.

From this perspective, it was possible to verify that a large number of professionals still have difficulties understanding the concept and importance of matrix support. Thus, as pointed out in a previous study[21], this ends up creating even more difficulties in its implementation, as the following quote reveals:

> "The matrix support, at first, was very nice when we started, because we managed to bring together... it's... in the first matrix support all the units were present, the whole unit, doctor, nurse, Community Health Agents (Agente Comunitário de Saúde – ACS), everyone was present, but now it's basically just the nurse and us." (NASF16)

When teams don't have a clear idea of the concept of Matrix Support, they end up creating obstacles that shouldn't exist in the first place, making it difficult to provide comprehensive and continuous care[22]. Professionals working in the mental health field need to understand the need to update themselves in a new field of knowledge in an attempt to (re)build new health practices. In this way, it will be possible for mental health to be put into practice within substitute services as spaces for care aimed at the health-mental illness process of the user and their family[17].

Considering that Matrix Support is a care and work tool, as well as a way of managing health care, helping to reduce the fragmentation of work, and aiming for a process of transdisciplinary action[21], it is clear that these failures end up damaging this path, as well as the possibility of new achievements.

However, it's worth emphasizing that even though the professionals don't have a clear idea of how Matrix Support works, there is already an attempt at a different way of acting that is more in line with the tool. This aspect can be better clarified by looking at the speeches:

> "Matrix support happens once a month with the whole NASF team and the primary care team" (ESF6)
>
> "Matrix support is scheduled monthly with the NASF according to demand" (ESF9);
>
> "We instituted it every last week of the month, we do it every last week of the month" (NASF17)

It is worth considering that this way of working is in agreement with a proposal that puts forward two basic ways of establishing contact between the reference team and supporters[22]. One is by combining meetings between the ESF and the NASF on a regular and periodic basis (weekly, fortnightly, or over a longer period of time)[21].

This indicates that the teams are undergoing, even if superficially, a process of self-analysis, which allows the members to evaluate the conditions they are in, and from there they will search together for solutions to the identified problem, allowing simultaneously self-organization[16].

Another point that became clear is that matrix support is clearly understood as discussing cases and planning actions. As the professionals mentioned:

> "I see matrix support very much as this issue of organizing actions, of discussing cases with the teams." (NASF18)
>
> "I really see it as a detailed conversation for certain cases and in addition to appointments for certain things." (NASF19)
>
> "Matrix support goes from case discussion to planning." (NASF20)

The meetings (matrix support meetings), as mentioned above, can be used to discuss cases and draw up

a Singular Therapeutic Project *(Projeto Terapeutico Singular – PTS)*. The thing to watch out for is how it's being conducted, in which case it often appears to be something just for discussion, with no initiative for action/practice. This way of working can also compromise a greater organization of knowledge and practices, making it more distant from a transversal relationship between the teams[21,23].

The teams in question were unfamiliar with most of the instruments used to assist in matrix support (PTS, genogram, ecomap, joint home visit, distance contact, interconsultation, and combined consultation). This situation, therefore, strengthens their actions in clinical and individual care, with little room for instrumentalization and empowerment of the teams[9,10].

Thus, it is possible to say that even though there is already a space for doing things differently, there are still many obstacles to promoting initiatives that make the instituting possible. When we consider that these moments are centered on planning and discussing cases, they result in a more closed practice, with no openness to new potentialities and making it impossible to break away from segregating and excluding practices, leading to the established[13]. There are still many paths to follow, especially when it comes to the construction and implementation PTS.

The interview script contained a specific topic about the use of the instruments (PTS, genogram, ecomap, interconsultation, combined consultation, combined home visit, and distance contact) indicated by the Practical Guide to Mental Health Matrix Support, which enhance and contribute to the realization of matrix support[9,10].

The professionals were already familiar with the PTS or had already done it in some way, but its implementation did not go beyond the case discussion format. Cases are discussed and possible solutions are thought up individually, leaving the systematic process that guides the PTS vulnerable:

> *"From what I understand, it's a case study, like the history of each patient and who to contact, the professionals to contact, then there's the planning and the whole process of studying a patient's case." (PEE5)*

The interviewees from the ESF said they didn't know exactly what PTS was, but said that it had already been done at the ESF by the NASF team. This situation is contradictory if we consider PTS as a device that requires intersectoral, interdisciplinary, multiprofessional actions and a reference professional, usually from the ESF[9,10].

The following speech is a good illustration of this problem:

> *"Now! With a patient, through the NASF. The NASF developed it, there was a patient of ours who was bedridden and had cancer and the NASF team developed the PTS, we didn't." (ESF10)*

This statement provokes the need for more horizontal relationships within Primary Health Care (ABS) itself. This horizontal perspective provides the basis for building a system of care networks, as it emphasizes the need for all facilities to be articulated for the same purpose: comprehensive care[24,25].

ABS represents a privileged and comprehensive setting for the process of reorienting ways of acting in health, where the valorization of soft technologies and the commitment to the expanded and shared clinic can facilitate the quality of the health work process, and consequently the mobilization for comprehensive care[23].

Regarding the genogram and ecomap, only one professional from the ESF and two from the NASF had already heard about them. However, they didn't really know how they worked, and both had never put them into practice:

> *"I don't know what that is. No, that doesn't exist here." (ESF2) "I think it has, but I can't remember, I think it has already been done." (NASF19)*

This situation shows limited knowledge of the material that guides their work since only one professional has read it and even then hasn't practiced the tools under discussion:

> *"No. I saw how it was in the guidelines, I saw how it was done, but we never actually did it". (NASF18)*

Building and leading a space for active communication and sharing knowledge about care processes[24] is becoming increasingly necessary for support teams and reference teams. With interconsultation and group consultation, the reality was a little different. Although they didn't recognize it by name and didn't know how to talk about the concept itself, most of them told us how they carried out interconsultation and group consultation:

> *"Yes. Normally, it's... the times they've happened have been at the growth and development (Crescimento e Desenvolvimento – CeD), and then there's been a nutritionist, physiotherapist, psychologist, and social worker." (NASF17)*

Only the doctors reported that the above consultations were not common practice. They affimed little understanding of interprofessional health practices, with unprofessionalism as a central element of medical practice in the setting surveyed.

> *"How? No. I get in touch with the nurse. She picks up the phone and sends it to me, and I pick it up and send it to her". (ESF1)*

When it comes to group home visits, all of them confirmed that it was a daily activity in their way of working, but few said that it was done from an interdisciplinary perspective. The Health Agent accompanies all the visits, but the doctors, nurses, and NASF team have one day each.

> *"We have the demand for home visits, and that demand is met by the nurse and technician to assess that patient, and it happens frequently that the nurse and the health agent go. It's something more frequent. With the NASF too. (ESF6)*

For many, the distance contact was considered incipient. Others said it was always done as a reminder, or to clear up doubts. Only one professional said that she used distance contact as a care tool, and even had groups on her personal cell phone app (*WhatsApp®*) with specific members (pregnant and postpartum women).

It is clear that this acting process needs to be directed towards acting with more protagonism and awareness of their problems and demands. Self-analysis is necessary[12,13], subverting power relations in order to build bonds based on transversality[25].

Among other aspects observed here, we highlight the need for greater commitment from managers to encourage permanent education spaces and to equip professionals for daily care practice. More than a superficial knowledge of some concepts and/or altruistic and spontaneous execution, professionals need to be trained and qualified to carry out the matrix support actions as guided and recommended.

Fragmentation of care and lack of accountability

This category shows how care has been given, realizing that its development has been fragmented, with unsatisfactory management.

It was clear that each ESF and professional handle the management of people suffering from mental illness differently. This makes the entire process confusing and fragile, even for professionals from all the other facilities in the system, showing just how flawed integrated, interdisciplinary and intersectoral work still is. As he says:

> *"Isolated! The CAPS staff are isolated there, overloaded, right? When they arrive, there are 40, 50 to attend to and they can't attend to them, they have to select, and there's no way of connecting with them either. And the NASF also arrives and does its own thing there, and only makes referrals. I need a nutritionist and I make a referral, and then often I don't even hear back from them. When the patient comes back to me for something else, that's when I find out." (ESF3)*

A study conducted in the same region shows a significant number of ESF professionals is unable to perceive mentally ill patients as part of their demand. In many cases, care is structured around the logic of referral, leading to a lack of responsibility on the part of the ESF towards the user and their family member[26].

The professionals from the support equipment and services have also revealed difficulties in offering support to the PHC teams, making it clear that there are several challenges in the implementation of matrix support, especially when it is directed at the articulation of the equipment itself, as explained below by a professional:

> *"I don't think we've ever had contact with the CAPS for anything, so I can't even say what the difficulty is because we've never had contact. Normally, the patients we've seen at the UBS were either patients who went to the CAPS, but didn't like the place and didn't stay, so they went to the UBS and we saw them there. So we haven't had any contact like that... with a common patient who was needing help until now." (NASF17)*

This shows how the equipment's lack of coordination is not in line with the principles that should guide mental health actions in primary care: "the coordination of knowledge and practices, the welcoming of patients; accountability for the clients served in the territory; the establishment of relationships between the people involved; and comprehensive care"[27-1127].

The CAPS, in turn, is a center whose practice is based on matrix support[25], although the CAPS research has not yet managed to develop movements that are consistent with matrix support, focusing its practice on the center itself,

even though the professionals know and are aware of the need for this movement to promote anti-asylum practices.

The need for greater integration with the teams was also revealed when asked about the relationship between CAPS, ESF and NASF:

> "At the moment it's quite precarious. Because we never call to find out... only when there's a problem, it's not a friendly relationship... and then they only call us if they have something wrong, something... and the NASF is the same, I think the NASF came here once and we never went there." (PC1)

This scenario demonstrates a traditional way of working, centered on the biomedical model of exercising health care, through a light-hard care technology[28], in which each device works in isolation, which tends towards fragmented and weakened work, without the necessary resolution.

The following statement reflects a CAPS professional's perception of how this coordination with other services has been going:

> "This dialog is far apart and it ends up that we don't even understand them and they don't understand us. So it's a question of building connections. We don't have any links! If we do, it's very fragile." (PC1)

This way of working ends up preventing new practices and the integration of care, allowing us to be led by the established, in other words, a conservative format, guided by something already established and with limited openness to change[16]. A study conducted in the same region indicates that a significant number of ESF professionals are unable to perceive mentally ill patients as part of their demand. In many cases, reception is based on the logic of referral, leading to a lack of responsibility on the part of the ESF for the patient and their family member[29].

It is worth emphasizing that most of the professionals interviewed are aware of the fragility of mental health care, as well as the viable alternatives for overcoming these problems: continuing health education, more integration and communication between professionals and equipment, and the creation of psychiatric beds in the general hospital. But nevertheless, these professionals don't seem to believe in a different system.

It should also be emphasized that mental health matrix support, in the context of all the management challenges, as well as the individual relationships between teams of each professional, requires more integrated ways of relating, which are not based on occasional meetings, without intentionality and centered on the patient/family[30].

FINAL CONSIDERATIONS

The last few decades have seen a series of changes in the field of mental health, which have been seen in the creation of public policies, the expansion of replacement mental health devices and equipment, as well as specialized matrix support teams. However, the teams still find it very difficult to identify and manage patients in this area, facing obstacles when it comes to referrals and coordination with more complex levels and within Primary Health Care itself.

It was possible to identify that matrix support still needs a long way to go before its way of conducting and articulating demands and equipment is actually as recommended in the Ministry of Health's guidelines, but specifically in the Practical Guide to Matrix Support and in the writings of Campos, the mentor of this tool.

This scenario shows how easy it is for professionals to reproduce the old, the "usual", the established, rather than trying to bring about changes and ruptures in what is in place. It became clear that professionals end up being reproducers of a model in which there is a lot of struggle for its non-existence. Even those who know a little more about how it can be done end up giving in to the same biomedical way of working.

Another notable issue is how precarious working conditions are, with a lack of Permanent Health Education, insufficient management support, excessive demands for a few professionals to cope with, and often without any resources, as well as a lack of professional stability. None of the NASF professionals are permanent employees. However, only five federal employees were interviewed from the ESF and CAPS. Thus, the fragility of the system also shows how weak the teams are.

In order to achieve the goal of Matrix Support, a practice with an intersectoral and comprehensive approach is necessary, focusing on an ideal of social transformation and a break with domination, exploitation, and mystification, so that it is possible to recontextualize care in the mental health field.

It is worth noting that this study was crucial in showing that Matrix Support is a topic of interest and mobilizes teams. On the other hand, the limitations of this study are noteworthy: it is a local study from the point of view of specific actors who do not give up on analyzing all the sides and aspects of this phenomenon.

CONFLICTS OF INTEREST

The authors declare no conflicts of interest.

CONTRIBUTIONS

Jackeline de Freitas Costa contributed to the preparation, execution, and design of the study. **Bruno Gonçalves de Medeiros** and **Jonas Rayfe Vasconcelos da Silva** contributed to data analysis and interpretation. **Tiago Rocha Pinto** and **Dulcian Medeiros de Azevedo** contributed to writing and revising the manuscript. All the authors have approved the version of the article to be published and are responsible for its content and integrity.

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