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THE CONTRIBUTION OF THE MATRIX SUPPORTER IN OVERCOMING THE TRADITIONAL PSYCHIATRIC MODE

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ABSTRACT. This article aims to report the work process of matrix supporter for the mental health care in Basic HealthCare, under the perspective of overcoming the traditional psychiatric model. This is an experience report held at the Matrix Support – Family Health Support Center (known as NASF in Brazil) of the Sanitary District II in the city of João Pessoa-PB. Data were collected from records in the field diary of the matrix supporter. Among the actions that were carried out by the supporter are: cartography, matrix meetings on mental health, case discussions, home visits, shared care, network articulation, among others. The experience highlighted that the matrix activities potentiate the performance of the teams of Basic Health Care for the demands of mental health in the territory. Such activities were essential in the work process for the implementation of mental health care. In addition, possible co-responsibility by the users and their families for better resolution of existing cases in the territory was possible.

Keywords: Matrix support; Public Health System; mental health.

A CONTRIBUIÇÃO DO APOIADOR MATRICIAL NA SUPERAÇÃO DO MODELO PSIQUIÁTRICO TRADICIONAL

RESUMO. O presente artigo teve como objetivo relatar o processo de trabalho do apoiador matricial para o cuidado em saúde mental na atenção básica, na perspectiva da superação do modelo psiquiátrico tradicional. Trata-se de um relato de experiência realizada no Apoio Matricial – Núcleo de Apoio à Saúde da Família (NASF) do Distrito Sanitário II do município de João Pessoa – PB. Os dados foram coletados a partir de registros realizados no diário de campo do apoiador matricial. Entre as ações que foram realizadas pelo apoiador estão a cartografia, as reuniões de matriciamento em saúde mental, as discussões de casos, a visita domiciliar, o atendimento compartilhado, a articulação da rede, dentre outras. A experiência evidenciou que as atividades de matriciamento potencializaram a atuação das equipes da Atenção Básica para as demandas de saúde mental no território. Tais atividades apresentaram-se

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essenciais no processo de trabalho para a efetivação do cuidado em saúde mental. Além disso, possibilitou a corresponsabilização pelos usuários e suas famílias para maior resolutividade dos casos existentes no território.

Palavras-chave: Apoio matricial; Sistema Único de Saúde; saúde mental.

LA CONTRIBUCIÓN DEL APOYADOR MATRICIAL EM LA SUPERACIÓN DEL MODELO PSIQUIÁTRICO TRADICIONAL

RESUMEN. En el presente artículo se tuvo como objetivo relatar el proceso de trabajo del apoyador matricial para el cuidado en salud mental en la atención primaria de salud, bajo la perspectiva de la superación del modelo psiquiátrico tradicional. Se trata de un relato de experiencia realizada en el Apoyo Matricial - Núcleo de Apoyo a la Salud de la Familia (NASF) de Distrito Sanitario II del municipio de João Pessoa-PB. Los datos fueron recogidos a partir de registros realizados en el diario de campo del apoyador matricial. Entre las acciones que fueron realizadas por el apoyo están: cartografía, reuniones de matriciación en salud mental, discusiones de casos, visita domiciliar, atención compartida, articulación de la red, entre otras. La experiencia evidenció que la actividad de matriciación potencializa la actuación de los equipos de la Atención Básica para las demandas de salud mental en el territorio. Tales actividades se presentaron esenciales en el proceso de trabajo para la efectividad del cuidado en salud mental. Además, posibilitó la co-responsabilidad por los usuarios y sus familias para una mejor resolución de los casos existentes en el territorio.

Palabras clave: Matriz de soporte; Sistema Único de Salud; salud mental.

Introduction

From the seventies intense social movements occurred – such as the Anti-Asylum National Movement – which resulted in the incorporation of a new model of assistance and care management in mental health, proposed by the processes of the Psychiatric Reform (known as RP in Brazil) occurred in many countries of the world and the Brazilian Sanitation Reform, which are opposed to hospital-hegemonic model. This new model seeks to qualify the care processes, to integrate the services and to transform the place of madness in the social environment, besides promoting the citizenship and the emancipation of the subjects involved in the process (Amarante, 2007; Garcia & Reis, 2018; Silva, Gomes, Castro, & Silva, 2017).

In this context of change and the enactment of the Federal Law no. 10,216 (April 6, 2001) – which provides for the protection and rights of people with mental disorders – the implementation of community-based services has started which came later to compose the Psychosocial Care Network (known as RAPS in Brazil) established by Ordinance no. 3.088 (December 23, 2011), with the objective of the creation, the coordination and the integration of the assistance places of the health network, in the Brazilian territory, for people with mental disorder and needs resulting from the use of crack, alcohol and other drugs, qualifying the mental health care by expanding access, from welcome and a continuous assistance.

This network encompasses strategic components to ensure users' health care at its three levels (primary, secondary, tertiary). They are: basic health care, specialized psychosocial attention, urgent and emergency attention, residential care of transitory character, de-institutionalization strategies and psychosocial rehabilitation. These components integrate diverse points of attention, among them: Psychosocial Attention Centers (known as CAPS in Brazil) in their various modalities, Residential Therapeutic Services (known as SRT in Brazil) setting de-institutionalization strategy with the Return home Program, psychiatric beds in General Hospitals, besides the strategic actions in the Basic Attention (known as AB in Brazil) component as the ones which are developed by the Health Basic Units (known as UBS in Brazil) and by the Family Health Support Center team-known as NASF in Brazil (Garcia & Reis, 2018).

To bring network actions into effect presupposes working with the uniqueness of each territory, by entering their sanitary and socio-educational components in the enlarged production of the care. Considering the territory as living space, overcoming the geographical understanding by pointing the biopsychosocial and symbolic identity of the subjects, the importance of implementing the mental health care in the AB highlighting the strategy of the Family Health Teams (known as ESF in Brazil) is recognized as they follow, in their daily work, people in psychological distress (Brasil, 2013).

The ESF is the primary health care network gateway established for the purpose of reorienting the care model and the reorganization of the AB. It consists of a multiprofessional team with sanitary and territorial responsibility and the working process oriented for promotion and coordination of integral and continuous care, as well as for the arrangement of other network points of attention. Thus, AB integrates the psychosocial network as a strategic component whose mission is to order mental health attention in the territory together with CAPS devices with the aim of promoting the co-responsibility of the cases, the facilitation of social reintegration and the breaking with the exclusionary and mental asylum-hospital practices evidenced in the madness history, preparing strategies to direct the process of humanization in health and encouraging relational, dialogical and interactive working processes with the users and their families (Brasil, 2012; Garcia & Reis, 2018).

In this approach, the Ministry of Health aimed at expanding the scope of the AB actions, especially regarding the management of mental health, established from the Ordinance No. 154/08 the NASFs. The cores are composed of multiprofessional teams in order to support the ESF teams guided by the theoretical framework of Support Matrix (known as AM in Brazil). This support is configured in a specialized support strategy and offers both assistance backward and technical-pedagogical support to the ESF teams. Thus, the AM aims to increase the resolute capacity of the teams, their clinical and their co-responsibility in the direction of mental health flows, operating in the linked territory of each team and its demands. This integrated action allows shared services among professionals in both UBS and in-home visits and allows the building of Singular Therapeutic Projects (known as PTS in Brazil) through periodic discussions of clinical cases with the ESF. These discussions are configured as a clinical and managerial resource of excellence, especially in situations of greater complexity (Brasil, 2010; Brasil, 2014; Garcia & Reis, 2018).

In this approach, the aim of this study is to report the working process of the matrix supporter / NASF in the city of João Pessoa-PB, with a view to overcoming the traditional psychiatric model, for better mental health care in the AB - ESF.

Methodological path

This is an experience report that happened in Matrix Support / NASF of the Sanitary District II (known as DS II in Brazil) in the city of João Pessoa-PB, where one of the authors followed four (04) Family Health Teams (ESFs) over a period of four months. The AM / NASF of this district was formed in total by 21 supporters distributed in various professional categorical (physiotherapists, psychologists, social workers, nutritionists, etc.) for supporting all the ESFs located in this district and at the time also to the Health Integral Care Center (known as CAIS in Brazil), currently it is known as Polyclinic. These supporters were organized in pairs or trios, respecting the multiprofessional character demanded by the needs of each territory, to support up to five ESFs. However, this article reports the matrix support of only four ESFs developed in collaboration with two other support professionals who worked in the same UBS.

The DS II is a geographical area of health technical coverage with 32 ESFs distributed in nine neighborhoods, having among its social facilities a CAPS AD III, a Child-Juvenile Embrace Unit (known as UAI in Brazil), 'To believe to be' network, squares, public and private schools, among others. From this perspective, this proposal seeks to answer the demands of the ESFs based in a neighborhood in extreme need of mental health interventions, where the population besides presenting individual cases of moderate and severe disorders, still had psychosomatic complaints, alcohol and other drugs abuse, dependence on anxiolytic, among others.

The data that support the production of this experience report were collected from records held in private documents of the matrix supporter called field diary and discussed from the theoretical and practical relevance. The supporter's field diary is a requirement of municipal management to record all observations, concerns, perceptions and interventions along with the ESFs. According to Lorena (2018), the objective of a field diary is to subsidize the supervision activity of the realized working process and to facilitate the planning of strategic actions based on the potential of each supporter and the needs of each territory.

The report was systematized from the sequential order of actions developed by the Matrix supporter along with the ESF teams, as strategic and conceptual resources, which were used in everyday practice. In this context, the strategic basis for directing the activities was, primarily, the health needs perceived in that territory and the limitations of the teams to answer the existing demands on mental health care.

Among the actions taken by the supporter are: a cartography carried out in areas covered by the four ESFs in the first week of the inserting of the supporter in the teams; two meetings related to matrix support mental health for the four ESFs teams; clinical case discussions and construction of PTS during technical weekly meetings in each ESF, an in-home visit and shared care between CAPS and ESF teams, articulation of the health network of attention points, fortnightly meetings of the Mental Health Working Group (known as GT in Brazil) at the district of DS II. Among the themes discussed with the teams are the concepts of care lines, interdisciplinarity and co-responsibility in health.

Importantly, even when dealing with an experience report and not a human research, the ethical commitment with the participants regarding the confidentiality, the autonomy (the guarantee of free waiver at any time), the beneficence (proposes of bringing greater benefits to the user and to the work of teams), the non-maleficence (no activity was carried out to cause any intentional harm) and the justice were observed. These aspects were present during its production, thus performed according to the principles of bioethics that guided the resolution 466/12 of the National Health Council.

Experience reporting and discussion

Brief background of the matrix support in the city of João Pessoa - PB

The support matrix has been in place since 2006, as the main strategy to consolidate the national health model in defense of life, adopted in the municipality, which provides for the organization of strategic health actions based on the whole needs of the population and sanitary commitments seen as priorities. As such, the matrix support was configured as a collective space for discussion, planning, organization and structuring of shared care spaces aiming at the exchange of knowledge among different professionals and the overcoming of the fragmentation of the working process resulting from specialties.

Thus, before the emergence of NASF/MS teams in 2008, the city of João Pessoa has already guaranteed protected spaces for sharing of knowledge and collective construction of health actions with a view to co-management and co-responsibility for the care process. In this way, the teams were inserted into the AM logic based on the lines of care (women's health, child's health, elderly's health, etc.) recommended in Ordinance No. 399/GM of February 22, 2006, for the purpose of determine care through the encounter among the needs of each territory that makes up the DSs and the intervention technically oriented for health production.

Working process and contributions of the matrix supporter in João Pessoa city

The work of the matrix supporter next to Health Family Teams sought to reflect and to respond to the real health needs of the population of the reference territories, for this the AM makes use of executed cartography activity, preferably with the Community Health Agents (known as ACS in Brazil) of each ESF by recognizing their knowledge of the life context of the enrolled families. Hence, this activity was carried out in the first week of AM's performance with the ESFs held in order to transit significantly by its geographical boundaries in order to find the subjects and to contextualize their demands towards the live and natural movement of the territory.

Mapping the territory of operation is above all else to distinguish it as living space produced by the people who inhabit it and for its social, economic and cultural history, exactly as Merhy (2002) stated that the cartographic method follows in locus the health actions and expands the vision and the way of actioning in health. According to the same author, the territory is where occurs the subjective experiences – the protesting unconscious – and the subject's illness, the segregation and the lack of assistance, as well as the family and the social ties that make up the basic scenario of manifestation of people's everyday lives.

So, the mapping is to identify the conditions and people's livelihoods, their potentialities and their risk factors; as well as to map the equipments and the available public services, the community organizations, and other resources in order to expand the ability to operate in the territory towards the improvement of the health status and quality of people's lives (Godim & Monken, 2008). Thus, we understand that the disorders in mental health emerge from a multicausal process and hence the importance of knowing the territory and the population's life stories so that the promotion and prevention actions in mental health are meaning ful and produce care, guided by the bond and the welcome.

The conduct of this activity alongside the ESFs enabled the recognition of mental disorder and addiction cases who were not assisted by multiprofessional in mental health

care, as well as false imprisonment situations that existed in the territory. These situations were mistakenly understood by family members and professionals of AB as a necessary resource for the protection of the user, their family and community. It was also possible to identify the appropriate devices for clinical management and social reintegration of these users, for an offer of integral and humanized monitoring.

After the cartography performed by the supporter and as each ESF team had weekly technical meetings, a process of reflection and discussion about the reality found was instigated. Through these discussions, it was found, from the local actors speech, the difficulties to meet the demands and to solve situations where the psychic framework was aligned with inadequate family and social care as well specialized health; the critical nodes that make this weakened attention in AB were jointly scored, including the stigma and prejudice still present in this context, little knowledge about mental disorders, psychiatric reform and the new services in the municipal mental health net, resulting in weakness or even no articulation with the reference CAPSS.

This process understands that the technical meeting is beyond a moment of encounter, in fact, it is like an educational process that aims to support and to ground, through the sharing of knowledge, the praxis of the various professionals who make up the ESF (Continuing Education in Health - known as EPS in Brazil). In João Pessoa, at that time, the EPS seemed to dialogue very strongly with the developing of Popular Education of Paulo Freire whose motto is that the making and the learning is mutual and complementary.

Soon, it was possible to plan and to organize two meetings on matrix support with the four ESF teams together in order to produce innovations in mental health care in AB. The initial logic of the matrix practice was to attempt to break with the paradigms that tend to reduce people with Mental Disorder to objects, reflecting on the history of madness and RP processes, offering elements for joint monitoring based on the subjective needs of each subject in psychological distress. This practice of AM is configured as technical-pedagogical support for the production of permanent education in health, with and for the team, expanding the possibilities of analysis of the various aspects that permeate the mental health care and the improvement of staff skills (Brasil, 2014).

At the first meeting, supporters held a systematic presentation on the new Policy on Mental Health in Brazil with the objective of adding knowledge to practice and encouraging the team discussion. Then, to raise awareness and to illustrate the entire changing process from chronic confinement to a developed psychosocial care in the territory a video, *Um outro olhar*, by the Ministry of Health was used. This video portrays the context of RP and the attention in mental health performed by the CAPS modalities, awakening society to the need to demystify in the madness the false beliefs of danger, disability and giving way to new forms of interaction between society and madness.

At the second meeting of the AM, there was a presentation of the mental health network of the city describing: the type, the demand, the main activities that were carried out, the recommended professional, the location, the territorial reference, and its flow. This presentation aimed at facilitating the networking joints and the route in the construction of the future PTSs. For this time, a representative of the municipal coordination of mental health was invited in order to explain and to illustrate the current configuration of the mental health network in the city of Joao Pessoa.

The dynamic and interactive way of the meetings allowed many exchanges of knowledge and experience among the professionals, as they constituted open, horizontal and dialogical spaces. It is important to highlight that these spaces of EPS, organized by

AM, may also favor the professionals regarding the presentation of their difficulties and/or fears related to the attempts of getting closer to users in psychological distress in their territory.

As the EPS is based on the needs and the daily work questions, it provides an important strategy for the qualification and training of health workers and aims to ensure an integral, resolute, humanized and participative assistance (França, Silva Matos, & Pereira, 2017). Thus, it allows the matrix supporter to reflect on the need of including the users in the daily monitoring process carried out by AB offering them the opportunity to be welcomed into their peculiar and delirious elaborations common to the subjects of psychotic structure, by listening offer aiming new productions of meaning to these strange phenomena to the subject.

The organized offer of these matrix activities resulted in an interventional action along one of the Family Health teams on a false imprisonment situation brought by a professional where it was possible to discuss and propose solutions. Here, we will not discuss the clinical case, but we will evidence as the matrix supporter performance in AB may propose new ways of dealing with the lack of assistance to the user and of promoting the teams' responsibilities in the line of care in mental health.

The situation described by the ACS allowed discussing, during the technical meeting, on the carelessness with users in these circumstances and the need for co-responsibility by mental health care, in a permanent articulation process between specialized care (CAPS) and AB. It was also addressed to the staff about the need to establish dialogue, to establish links and to assign 'voice' to the other who, for many years, was excluded from his condition of citizen.

In that space it was reflected more intensely on the 'crime of false imprisonment', as years of stay in psychiatric hospitals generate the chronicity of any subject in psychological distress, depriving him of the natural habits of a human being (Amarante, 2007). In addition to the importance of working the dimension of the reconstruction (clinical approach) and social reintegration of these individuals, through continuous link establishment, the welcome, the listening to the subject and to the family in order to produce relations and the articulation with other necessary network devices which are necessary to the psychosocial rehabilitation process.

On the dimension of the reconstruction, the training for professionals who provide care in the SM line is essential, because it is necessary to be able to:

[...] set up an explanation for the voices and delirious, even if this explanation is itself delirious; to restore a relationship with the family that seemed lost, or to realize that, in the impossibility of a family life, there are other legitimate living and affection spaces; making art, looking for work, setting policy, participating in movements [...] in short, to create new productions of meaning (Lobosque, 2001, p. 21).

For care in relation to this addressed situation, a PTS was conducted, since it was a case that demanded greater severity and complexity. PTS is an intervention device, a care management tool that aims at organizing the team working process and favoring integral care through qualified welcome, link establishment, division of tasks and shared accountability. The use of PTS as care praxis in mental health in basic health care is justified by the importance of structuring the psychosocial care network, as well as enhancing the lives of individuals and families in psychological distress (Laurito, Nascimento, & Lemes, 2018).

In this sense, one of the organized tasks for better management of the case was the articulation with the CAPS III team reference, a central device in overcoming the traditional

psychiatric model process. The articulation was interventive and resulted in a home visit by CAPS and ESF teams with a shared assessment of the case and referral to treatment in a substitutive mental health network in a care sharing process between AB and specialized service. When you take as a focus the micropolitical of the working process, in the production of care, it is clear that the network operates on the work of health teams, so, workers become operators of this network, being of great importance this joint as it facilitates the action planning (Quinderé, Jorge, & Franco, 2014).

As a resource to enhance the work of the matrix support is provided by the municipal administration the participation of supporters in GT meetings which are specific to each type of care for a multidisciplinary construction and shared actions. In this approach, the Mental Health GT, constituted commonly by psychologists and social workers professionals, aims to think, to discuss and to strengthen humanized practices of integral care in mental health in AB, sharing the debate on collective and supporting the discussions for the remaining supporters of the DS who do not make up the Mental Health GT. The fortnightly GT meetings took place at the DS II headquarters.

The aim is that the ESFs, through AM, are covered with the needed knowledge to enhance the de-institutionalization process and, at the same time, be important strategies to prevent arbitrary hospitalizations. Thus, the matrix support in mental health along the ESFs provides to substantiate the teams' actions for effective interventions and co-responsible during the process of social reintegration and psychosocial rehabilitation of people with mental disorders. By increasing the capacity of the ESF teams in dealing with psychological distress and integrating them with other health care points, the support matrix gradually strengthens the mental health care as a legitimate demand of AB (Amaral, Torrenté, Torrenté, & Moreira, 2017).

The participation of these supporters in Mental Health GT enabled the expansion of knowledge about the process of Psychiatric Reform and its new practices and the knowing of the substitutive network of mental health in the city through technical visits to the devices. This practice allows the supporter to own the Mental Health Municipal Policy organization, seen as substantial for the adequate support to the ESF teams regarding mental health care.

The work of the matrix supporter, also harmonized interdisciplinary practice, brings the challenge of building collectively practices that go beyond the individual walls for every profession and arise for a job that enables the sharing of knowledge with a view to caring based on the 'to do with'. However, deadlocks and embarrassments followed the whole process, given that work with professionals, who are unaware of the Anti-Asylum policy and the principles recommended by the Ministry of Health, affects the development of actions, as many professionals close themselves in a fragmented working logic, centered on traditional practices care.

Thus, there is a need to make the connection to the institutionalized and not institutionalized social places, with the health care network, with the community and, consequently, with all the geopolitical territories in which they experience life. As they also present the potentialities and the impasses of the matrix supportive role regarding the care line in Mental Health (Lancetti, 2002).

Expressing some considerations

The process of Psychiatric Reform invites all professionals and services to rethink on their actions in mental health, in a care logic that promotes the de-institutionalization, the

appreciation of the speech of the subject and the overcoming of the attention focused on medicalization, so it is possible to think of therapeutic processes that may or may not produce the social reintegration of these users. From this, the asylum paradigm has been deconstructed, generating new demands for the thinking and the doing of these professionals.

The inclusion of AM in the logic organized by the city of Joao Pessoa-PB for the support to the ESFs allowed a closer communication between basic health care and specialized services, promoting meetings of knowledge that provide more integral and less fragmented care. Although the activities of the matrix supporter were already planned in the field of basic care, the ESFs offered mental health care with even crystalized interventions and with little knowledge of the psychiatric reform process and substitutive network which harms the quality of care. It is important to highlight that in general the teams were receptive to the proposed actions by AM, even with initial resistance from some professionals, as they brought in their speech the logic reference of fear and risk to society, whose thought is linked to the social imaginary on madness.

Thus, we believe that the shared work between the AM and the ESFs through the technical-pedagogical support made it possible to aggregate knowledge and provide positive reflections in order to undo the 'knots' of de-institutionalization, to establish longitudinal ties and to strengthen the look of the ESF teams to the territory regarding the demands of mental health. Nevertheless, we believe that the AM could empower these teams to establish new processes to facilitate the dialogue and the ability to assume obligations with the mental health of the users.

This experience in the AM also allowed us to infer about the positive potential of his performance along side the ESF in caring for people in psychological distress in their territory. It can also contribute both for discussions/reflections on the organization of the supporter working process and for the decision-making process of the management teams in the three government spheres. It facilitated the actions and strategies planning to improve the quality of care with a view to overcoming the traditional psychiatric model as well as the sharing of significant interventions of a 'to do with' in Life Defense.

It is to the authors' conviction that these positive and transforming actions related to the working process of the ESFs as the logic of segregation and stigmatization of mental health was being deconstructed, thus qualifying the care and assistance for the mental health users. However, this is not an ending process. The deconstruction of institutionalizing care practices deserves and should be reverberated, reflected and questioned in all health fields so that there will really have a transformation of the madness place in the social environment.

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