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The maze and the minotaur: mental health in primary health care

Alice Hirdes [1]
Helena Beatriz Kochenborger Scarparo [2]

Abstract *The article aims to discuss the issue of integration of mental health in primary care by matrix support in mental health. We point out the main barriers in the use of this work method, as well as the facilitating factors of the matrix support of mental health in primary care. The first are within the scope of epistemological specificities, professional issues and management in the political and ideological dimensions. Among the second, we highlight: the care for people with mental disorders in the territory; the reduction of stigma and discrimination; the development of new skills for professionals in primary care; reduction of costs; simultaneous treatment of physical and mental illness, which often overlap; the possibility of incorporating mental health care in a perspective of extended clinical service using an inter/transdisciplinary approach.*

Key words *Mental Health, Primary health care, Matrix support, Organizational innovation, Management*

[1] Programa de Pós-Graduação em Saúde Coletiva, Universidade Luterana do Brasil. Av. Farroupilha 8001, São José. 92425-900 Canoas RS Brasil. 92425-900 alicehirdes@gmail.com
[2] Departamento de Psicologia Escolar, Faculdade de Psicologia, Pontifícia Universidade Católica do Rio Grande do Sul.

Introduction

The Labyrinth and the Minotaur is one of the best known Greek myths. The minotaur, represented in classical art as a being with a man's body and the head of a bull, lived in the Labyrinth. In the Labyrinth tributes were offered, including young people intended for sacrifice. An agreement between king Aegeus of Athens and king Minos of Crete stated every seven years king Aegeus should send 14 young people to Crete, in return Athens would not be invaded by king Minos. Theseus, a young hero of Athens was among a group of young people offered for sacrifice facing the monster. The adventure takes place in a maze. Success depended on a thread young Ariadne had given Theseus fastened at the entrance of the maze leading him out of the labyrinth[1].

The main character Theseus can be used as a metaphor for the practices in Primary Health Care (PHC). The comprehensive principle of the Brazilian Unified Health System (SUS) in daily life can be seen as the image of the Minotaur: the head represents the experts in the field of mental health and the body represents general practitioners. It is not difficult to imagine mental health patients and their families wandering in the maze of treatment services, according to the guidelines of the SUS is not possible without integral care. In the field of Brazilian mental health over the last two decades, this care has been articulated to the ideas of deinstitutionalization[2], with the proposal of psychiatric reform being the target of heated debates in different social segments. Today we are witnessing processes of expansion of the network of extra-hospital care: Psychosocial Care Centres (PCC), ambulatory, therapeutic residential, beds of integral care to mental health (in general hospitals and PCC III), Return Home Program, cooperatives for income generation and work, community and culture centres and mental health in Primary Health Care (PHC).

In the global context, the World Health Organization (WHO) together with the World Organisation of Family Doctors (WONCA)[3] and the World Federation for Mental Health[4] advocate the inclusion of mental health into general health care, particularly in the PHC. In England, Thornicroft and Tansella[5] postulate that treatment for mental health should be an integral part of Primary Health Care. Resource-poor countries especially should implement mental health in PHC, with the rearguard of experts for advice, assessment and treatment. In the Argentine Patagonia, in the province of Neuquén, doctors in Primary Care coordinate the diagnosis, treatment and rehabilitation of people with severe mental disorders. The implemented model is premised on four elements: coordination by doctors of the Primary Care, community care, holistic care and expert support. The latter provide, in addition to reviewing and answering complex cases, the training of doctors and nurses from PHC. Chile, on the other hand implemented in 2001, the National Program for Depression in PHC. In this country, 90% of people with depression receive treatment in the territory. This inclusion has as key points the support of political and administrative leadership for the allocation of financial and human resources and the supervision and support of professionals in a community centre of mental health[3].

In Brazil, the pioneering experience of Campinas, São Paulo State, as well as others that followed, such as Sobral, Ceará State, Belo Horizonte and Gravataí, State of Rio Grande do Sul, have been developed with matrix teams of mental health. Matrix support provides integration and support of specialists and general practitioners in Primary Health Care, considering the specificities of each territory[6]. We believe this work methodology is relevant to the inclusion of the actions of mental health in Primary Care. It meets the integral care recommended by the SUS and the principles and assumptions of the Brazilian Psychiatric Reform.

The matrix support was developed and conceptualized by Campos[7] and Cunha and Campos[8] as a management methodology that aims to ensure specialized rearguard to teams and health professionals in a personalized and interactive way. The methodology seeks to provide rearguard support and technical and pedagogical support to reference teams. This work methodology depends on the customization of the relationship between the teams, in the expansion of scenarios where the specialized attention is performed and the shared construction of clinical and health guidelines between the reference team and the specialists of matrix support. Inseparable from the concept of matrix support there is the team and the reference professionals - those who have responsibility for the conduct of each case. Both matrix support and reference teams enable the expansion of clinical and dialogical integration between different specialties and professions.

The effort to implement mental health in PHC through the matrix support is justified for different reasons ranging from the reduction of suffering of patients and their families to issues of socioeconomic order. An important argument for this integration concerns the burden of mental disorders that have significant social and economic difficulties for affected individuals and families. Furthermore, the integration of mental health in PHC promotes the practices of integral care as it contemplates the concurrence of physical and mental disorders, improved access to mental health services, promotes human rights and reduces the gap between the prevalence of mental disorders and the number of people assisted. Positive evaluations of this integration are evident, especially when work articulates communities and service networks of secondary level[3], which strengthens the argument for the practice of matrix support in mental health in the PHC. In this sense, the World Health Organization and the World Association of Family Doctors3formulated ten principles for the integration of mental health in primary care: incorporating mental health care in primary care in health policy; change attitudes and behaviour through advice; training of primary care workers, proposed operational tasks; appeal to specialized mental health professionals; have access to essential psychotropic medications; see integration as a process; have a mental health coordinator; collaboration of other government departments, non-governmental organizations; have the human and financial resources in place.

The integration of mental health in PHC is the best way to ensure that people with mental illnesses receive the care they need. It favours the creation of strategies to increase the services, the inclusion of mental health as a public health priority; the reorganization of mental health services and its integration into health services in general; the development of human resources and the strengthening of public leaderships of mental health[9]. Such considerations lead us to discuss the main barriers to the implementation of the Matrix Support (MS) in mental health, as well as factors that facilitate the integration of mental health in PHC. This work, regardless of the different forms of approach to adopt (supervision and support of specialists to generalists or group care service) can propitiate access to integrated care in the territory and hence the decrease in referrals to specialist services. At the same time, it promotes early recognition of mental disorders and the development of promotion and prevention actions.

Barriers to the implementation of Matrix Support

Resistance of generalists and specialists

One of the barriers to the deployment of Matrix Support is the resistance of Family Health Strategy (FHS) teams in the accession to this working method. Such resistance is evident despite the integral health care being recommended - which obviously includes mental health care. The arguments used are that problems of "mental" order should be referred to specialists; furthermore, charging by productivity is a constant by the management, which results in limited availability compared to the high demand for attendance. Added to this the cultural aspects of each profession and the personal availability to the task are attributes that can promote a change in people's perspective as well as the interaction between professionals. A new perspective promotes the consideration of alternatives, a task that requires constant preparation.

The care of mental disorders can be considered increasing in demand. Although physical and mental illnesses comprise inseparable parts of people's lives, the motto "there is no health without mental health" advocated by international organizations[3] shows global efforts for the inclusion of mental health in PHC. For this to occur, besides the effecting of politics, it is necessary to sensitize the people involved to the paradigmatic shift.

If on the one hand, we address the resistance of the generalists, on the other hand we can see it transforming the practices of the specialists. Despite the lack of expert knowledge and gaps in the assistance in this area, there seems to be concern about the effects of the changes caused by the socialization of knowledge. In urban areas where the number of specialists is higher, there are cases of non-access to these professionals. This reality is more evident in smaller centres and rural areas, which often lack specialists or they exist in a number far below the minimum recommended. This is reflected in patient's lives, as they wander the maze of services having as a guiding thread a piece of paper as reference or counter-reference, at best.

Management, leadership and health policies

In relation to managing, there is a need to convince managers of the need to value the matrix support as a proponent of alternative planning, management and evaluation of care for people in psychological distress. In the political context, it is noted the absence of leaders who defend such needs. At the same time, for the work to be effective it is necessary to have the institutional support of the local manager. It can happen, for example, by allocating a greater number of professionals attending Psychosocial Care Centres (PCC) and ambulatories, since, usually professionals need to reconcile the duties of care in specialist services and matrix support teams.

Another step in the decentralization of mental health is the creation of Family Health Support Centres (FHSC) in the municipalities. The work process of FHSC's should be performed by matrix support, through the creation of collective areas of discussion and planning with reference teams. The FHSC includes shared care; specific interventions with users and families; common actions in the territories of its responsibility developed in coordination with the professionals of FHS. The technological tools for the development of the process of this work are: matrix support, the expanded clinic, Singular Therapeutic Project (TSP) and the Health Project in the Territory (HPT)[10]. These nuclei could constitute themselves in important rearguard to FHS teams, however this articulation is incipient in the municipalities. Mainly, it should happen among PCC professionals, FHS and FHSC, with due care for the non fragmentation of work.

The integration of mental health in PHC proves a success when mental health is incorporated into a health and legislative policy that receives support from public leaderships, appropriate resources and governance underway[3]. The above aspects are weak points in Brazil. Although we set a minimum percentage to be applied in health, it proves far from the reality of Brazilian municipalities. The transformation of government policies in State policies proved to be a weakness in the health sector. Each change of government, depending on the interests and public leaders, highlights distant changes from dialogic processes necessary to implement integral health. We need to discuss the network, the type of care to be implemented, the principles and professional values that should permeate the practices, because these will reflect, ultimately, the quality of the service offered.

Epistemological specificities and human resources

Another barrier to matrix support in PHC relates to the need for conceptual and paradigmatic changes by the ongoing formation of FHS teams in the field of mental health contemplating treatment, psychosocial rehabilitation, extended clinic and individual therapeutic projects[11]. This implies the abandonment of the centralization of the biomedical model to incorporate knowledge and modes of intervention relating to an enlarged perspective of care. This is also an argument in favour of new ways of operating in the field, with a focus that includes belief in human potentialities and puts the disease in parentheses, as mentioned by Basaglia[12]. This is not to deny but to transform the clinic, and establish a relationship with the integration of experience[13], a key concept for paradigmatic split and for the construction of a mode of operating. These changes underlie the inclusion of mental health in an expanded perspective of the curriculum of courses in the field of health, especially in related disciplines to Public Health, Primary Health Care and Psychiatric / Mental Health disciplines. We can not expect professionals trained in a treatment paradigm, the centralization of symptoms and the therapeutic reductionism to have increased performance without having clinical training in the area. Some courses already include moves in this direction, but the realization is that they are not sufficient to effect full care practices. The comprehensive care beyond the constitutional concept should be considered as a value[10] and be reflected in the attitude of professionals. That implies recognizing demands and health needs, as well as prevention, promotional actions and rehabilitation actions. The opportunity for scholars from different fields to experience the matrix support in mental health reveals new possibilities for intervention in their work and professional practice in the future. Accordingly, the academy has an important role in the paradigm shift.

Certain skills and competencies are required for evaluation, diagnosis, treatment and support. Therefore, it is essential that mental health workers in the PHC have support in mental health work[3]. Furthermore, success in work implies a levelling of relationships and dialogical processes. All can learn by sharing their knowledge and consider the complexity and dynamics of the situations in focus. The practice of matrix support associated with notions of expanded clinic and

singular therapeutic projects favours the obvious inclusion of mental health in PHC.

We can not ignore the lack of human resources – professional experts for the realization of matrix support to teams of generalists in PHC. Usually, experts are linked to PCC, with the demands of the service itself. The allocation of these professionals in the matrix support implies not meeting the internal demands of the PCC and the displacement for the PHC teams. This requires the hiring of higher qualified and more effective experts. This mainly requires the recognition of the methodology by managers for the implementation of matrix teams in mental health. The institution of the FHSC teams could fill a gap using teams of matrix support, by defining the boundaries of the territory covered.

Financial resources and ethical aspects

Another barrier to matrix support in PHC is the lack of financial transfers by the Ministry of Health, through the inclusion of mental health indicators in the Primary Care Information System (PCIS). The allocation of resources could constitute an incentive for adopting the methodology of matrix support in the cities, especially for managers. As of 2006, the actions of mental health in primary care were included in the Guidelines of the Agreed and Integrated Programming of Health Care (PPI), published in the Official Decree nº 1. 097, of May 22nd, 2006. This decree is still not in force in relation to the transfer of funds, which is conditional on the inclusion of mental health indicators in the Ambulatory Information System (AIS) of the SUS[14,15].

The allocation of financial resources for mental health historically was included in the specialized services commonly psychiatric hospital funding was at the expense of the extra-hospital care network. In recent years this scenario has been undergoing considerable changes. Nevertheless, it is necessary that these resources are invested mainly to municipalities with fewer than twenty thousand people who do not have specialized services such as PCC.

Among the ethical obstacles, the issue of confidentiality should be brought up, and a basic assumption of teamwork relates to socialization, discussion and planning of a unique therapeutic project. This is desirable, but needs attuned talk and consistent practices. The socialization of personal information to a diverse group of people (health workers, technicians, professionals and academics) implies constantly consideration of the ethics that justifies such a practice. Serious situations such as domestic violence, of gender or child, populations in vulnerable situations or excluded, mobilize feelings in the teams in the sectors involved.

Facilitating factors for Matrix Support in Mental Health

Integral care and stigma reduction

One of the powerful arguments in favour of Matrix Support relates to the care of people with mental disorders in the territory. Matrix support will ensure access to care for people at the margins of the health system, unassisted, with no possibility of specialized care. Millions of people worldwide do not have care potential in specialized services. Specialized services are usually concentrated in larger urban centres. Thus, use of the health centre as an entry point to the system can provide a qualified care, avoiding reference to the specialized service (in mental health) as the first option. The advantages of a territorially based care include: Professional knowledge of the situation of that person's life (and not just the disease), the issue of the bond, the possibility of activating resources of the community, connecting with other sectors - education, social assistance, government programs, among others.

Another argument for the inclusion of mental health activities in the PHC through the Matrix Support concerns the reduction in stigma associated with the person with a mental disorder, in care on the territory. Besides the suffering of having a mental illness, the stigma follows people with mental disorders as an indelible mark, especially for people who underwent traditional hospitalizations in psychiatric institutions. The concept of stigma is necessary to understand the experiences of social exclusion of people with a mental disorder. According to Thornicroft et al.[16] Stigma is conceptualized as a combination of three problems: of knowledge (ignorance), attitudes (harmful) and behaviour (discrimination). The authors argue that the strongest evidence for the reduction of stigma result from direct contact with people with a mental disorder.

The document *Human Resources and Training in Mental Health*[17] says that the care in general health services help stigma reduction compared to the demand for specialized mental health services. The document points out that stigma are a major problem for generalists, due to these being the first contact for people with mental disor-

ders. Stigmatizing attitudes that come from those professionals can become a barrier that prevents people from getting the care they need. Thus, within a territory there may be viewable different ways of interacting with patients with mental disorders: from coexistence to exclusion, one is not recognizing the other. Through these different forms of interaction, the matrix support professionals can implement strategies to increase the relational exchanges between the professionals of PHC and those with a mental disorder and the community. The care in the territory provides the demystification of mental illness, as well as the ideas related to the mentally ill as dangerous people, that need to be isolated and institutionalized.

Support, training and extended reformulation of work in health

The establishment of support from specialists in mental health to professional generalists, as previously reported on the experiences of countries that have managed to include mental health in PHC, is essential to the process. Matrix support, as organized collective around a common goal of work[18], propitiates co-responsibility, co-management and a bond. The longitudinal care, joint accountability for cases, co-management of an individual treatment plan, the link established between the different professional categories, as well as the professionals with the people treated, presuppose the understanding that the generalists will have support from the specialists for the care of situations of greater complexity. Investment in meetings aiming to explain and achieve adherence to the project becomes a purpose. Otherwise misunderstanding and rejection will occur because the generalist professionals of teams will have to meet more demand, which is usually forwarded to specialist services.

Campos[7] values the coproduction of the singular in the health-disease process. To this end, making use of the concepts of clinic and collective health shared, to propose the extended reformulation of the work that translates in the theory and Paideia Method. In these concepts, changes are inevitable. It is a resource to increase the potential of intentionality of the individuals, considering that just as people are influenced they also react and interact with the subjects/situations. Meaning, there is co-responsibility in the formation of natural contexts. The singular is the situational context, the product of the encounter between subjects in a given organizational context, cultural, political and social. The coproduction of the singular arises from the interaction between universal and particular factors, resulting in specific summaries. Different factors (biological, psychological, socio-economical) influence the constitution of the ways of life of individuals and their states of health and disease. The difference is in the degree to which each factor acts on a given specific situation. The challenge is to capture this variability and propose unique projects appropriate to each situation. Accordingly, the theory and the Paideia method aim to support the creation of reflective subjects, which, in addition to understand themselves and the world, have the ability to act on it. Subject to reflection and action, that understands and interferes with the expansion in the co-responsibility by the constitution of natural contexts.

The logic of the matrix support is a possibility that reference professionals and specialists maintain a horizontal relationship in which the supporter and the reference team can work in the form of planning, building a multi-and Tran disciplinary vision for teamwork, sharing the knowledge of its knowledge core, of its experience and world view, incorporating the demands brought by other professionals and the patient itself, creating collective spaces that allow the interaction of these differences for the construction of new concepts and practices of mental health[6-8]. This way, by adopting a style of work consistent with the assumptions and principles of Brazilian psychiatric reform and of the SUS, can consolidate practices of matrix support in the country.

Failure to detect and untreated mental disorders in primary health care occur for various reasons and can be divided into: patient factors, factors related to health workers, factors related to the health system, as well as factors of society and development. Many patients do not recognize that they have symptoms of a mental disorder but focus on the physical health problems as symptoms of fatigue, headaches, insomnia and gastrointestinal symptoms. Others underestimate the severity of the problems and erroneously believe they can handle the situation without the help of formal health services. Factors related to employees concern the non receiving of adequate training in mental health problems[3].

Factors related to the health system include the inadequate financial and human resources, especially the difference between the number of people who need care and those who receive care in PHC. Other factors include inadequate

reimbursement for mental health treatments by governmental authorities, fragmented and poorly structured health systems, lack of treatment resources and facilities for vulnerable populations. Factors related to society and development includes discrimination and stigma. We emphasize the stigmatized understanding in the general population, which tends to associate mental disorders with violent and irrational behavior3.

Through Matrix Support, professionals in Primary Care can recognize mental disorders, psychosocial situations of vulnerability and violence, use / abuse of psychoactive substances for the establishment of early interventions. In this sense, the logic of Matrix Support propitiates both in-service training through the discussion of clinical cases, as support to general practitioners by the joint care in more complex cases. Thornicroft and Tansella[5] defend that high priority should be given to support mental health professionals of the PHC, so that abilities to recognize and treat mental disorders are part of the core competencies of caregivers.

Procedural aspects, co-responsibility and leadership

The methodology of matrix support is a process that requires the collective construction. This perspective can reduce the risk of institutionalization routes and conduits of iatrogenic. This way, there is the possibility of incorporating mental health care from the perspective of magnified clinic by an interdisciplinary and / or Tran disciplinary approach. Matrix support in mental health implies the collective construction of work as a process. So, the matrix support creates opportunities for "higher coefficients of transversality in relations between professionals of reference teams, between teams of several services and between these and the professionals of specialized fields"[19].

The interaction of the matrix supporter with the professional of reference, one affecting and being affected by the other, sharing knowledge, experiences, worldviews, consonances and dissonances including, emergence of new perspectives, productive possibilities and interpersonal relationships. The richness of this process concerns the interventions occurring not only in the life of users but also in the existential universe of operators. The process involves the construction of the work in action, listening and sharing information, planning a singular therapeutic project, and the co-responsibility of the professionals involved. Some features are necessary or desirable: professionals with leadership skills but without monopolizing or centralizing the process, ability to listen to different opinions and understandings, ability to value the acquisition of control of another field, ability to collude and achieve consensus.

Accordingly, we have identified two types of leaderships: one located in the macro context, which, normally is under the management – municipal, state or national level – and the micro leadership, which operates the work process itself. The leadership at the micro level refers to who leads the team of experts of mental health of the matrix teams, working in this process together with generalists. This last leadership must have the characteristics mentioned above, in addition to personal characteristics, such as ability to aggregate, empathy, flexibility, conflict resolution and synthesis, as well as having technical skills and work experience in the area. The specialists should also be careful not to present themselves as experts who know everything and treat generalists as not possessing specific knowledge, those who "know little or nothing". Rather, they must build alliances, disciplinary exchanges and promote the empowerment of the group of generalists and the group as a whole. Thereby, people marked by the above listed characteristics aggregate specialists and generalists in defence of care for mental patients in the territory.

The lack of public health leaderships that defend the inclusion of mental health in PHC has been identified by the WHO and other international organizations[3,4,9,17]. In this sense we understand the figure of the leader as the one person who can rally political, administrative, organizational strategies and resources that promote such inclusion. Above all, a person that can establish a dialogical relationship with the team, whether specialists or generalists. The above considerations are in agreement with the proposal of Cunha and Campos[20], interdisciplinary coordination. The authors point out that the heads of corporations tend to fragment the work of teams. As well as tending to be more concerned with a corporate activity than with the end result, in addition to strengthening the over all group between different categories (community health workers, doctors, nurses...) which can lead to devaluation or rivalry. The authors argue that the coordination of the reference team should "take care of building a positive interaction between professionals, building common goals and ob-

jects, despite the differences (and not against the differences)"[20].

Crises, emergencies and paradigmatic change

Family Healthcare constitutes a strategic resource by representing the input port of the health system for managing different types of disorders, from mild to severe mental disorders, use and abuse of alcohol and other drugs, including situations of risk (and suicide attempts) and family violence. In this sense, the "dialogued reception"[21] as a technique that can be operated by any professional of the health service at any attendance time, at any meetings enables early identification of different situations mentioned above. According to the author, "the dialogued reception" corresponds to that component of the conversations that take place in services where we identify, elaborate and negotiate the needs that can be met.

An important deconstruction that is needed is the idea of the urgency of mental / psychiatric health to an ethic of urgent care to the person in crisis. While attending psychiatric emergency symptoms are usually focused through the centralization and medicalization of these to the detriment of the history of life[22]. In this new paradigm, we must first change the mode of operation of the professionals, resulting in being able to intervene in the psychiatric emergency room, making use of, usually as a first option, the psychopharmacological resources. We recognize the importance of psychopharmacology and how much this feature has revolutionized the treatment of mental disorders. Meanwhile we must look for parsimonious use under the burden of a reductionism and simplification of human suffering. This simplification corresponds to the advent of "psychopharmacological societies"[23], expression coined by the author to the unprecedented use of psychiatric drugs in contemporaneity. Especially when conducting a "diagnosis of life", in a larger context, it creates numerous possibilities of intervention in the suffering that may have a place in the territory, extending the possibilities of acting on the social and economic factors.

An important argument in favour of Matrix Support in mental health on PHC refers to the development of new skills for primary care professionals and the staff of matrix support, as well as joint and participatory construction of knowledge-action. The most significant challenges are the integration of soft and soft-hard technologies[24,25] of different professional categories involved. Professionals, in addition to specific knowledge, carry personal and professional values, own ways of acting and personal characteristics that will influence the operating modes. The development of new professional skills, on both specialists and generalists, requires openness, flexibility, posture learning, as well as the ability to put into practice the consensus.

The change of the biomedical paradigm to the expansion of clinic permeates the experience of collective construction of a treatment plan for the team, and the longitudinal follow-responsibility. We emphasize an important distinction: not having an answer, not knowing what to do is different from not getting involved or mobilizing over the situation brought and together seeking alternatives. The procedural question involves the methodology of work and this is an important aspect that should be considered by managers and professionals. The last usually want to see palpable results measured in a short period of time. The finding that the inclusion of mental health is a process that takes time and requires the awareness of the team membership of the proposed investment and the mobilization of all stakeholders is essential.

Integral care in the territory, promotion and prevention

The argument of the simultaneous treatment of physical and mental illnesses, which make up a life process and that often overlap, should be among the strongest arguments in favour of matrix support in mental health. Family Healthcare provides comprehensive care to health, which includes mental health/illness. Meanwhile, despite the fact that comprehensive care is preconized from the perspective of FHS, in practice mental health care is still being understood to be, in many places, as an experts assignment. Several reasons contribute to this: the feeling that generalists are not qualified in caring for people with mental disorders; the workload, the pressure for productivity (number of people served). Productivity as is usually conceived and qualified mental health care usually does not go hand in hand. Listening, bonding; redemption of life history,

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the diagnosis is compromised by an attendance in series focused on medicalization of symptoms.

The use of areas in the territory, including the set of economic and sociocultural references that are part of their everyday life, of their project of life, of their insertion in the world[26] may extend the contractual power, exchanges. Rehabilitation was established as *a set of oriented strategies to increase the opportunities for exchanges of resources and affections: it is only within such a dynamic of exchanges that is possible to create an 'enabler effect'*[27]. The contractual power of the person with a mental disorder tends to be invalidated by the family, the environment and often by the professionals themselves. Stereotypes tend to crystallize, regardless of the person instituting modes of relationship behaviour. Hence the importance of matrix support as a device capable of finding areas of negotiation for all involved.

The expansion of the clinic will be possible only in the reorganization of knowledge through an extensive process of training of teams to deal with subjectivity and a reorganization of the ways on how you work, allowing the construction of bond[7]. The expansion of the clinic also meets the principles of psychiatric reform, defended by Rotelli et al.[28] as the centralization of the therapeutic work in order to enrich the global existence; care as a key element for transforming the ways of living and feeling the patient's suffering in its concreteness in everyday life. This expansion of clinic especially resonates in the principles of enriching the professional skills and spaces of autonomy and decision making and the demolition of the compartmentalization of therapies (medical, psychological, social, pharmacological, ...).

The arguments in favour of Matrix Support, discussed above, confirm that PHC is an essential resource for mental health promotion. National and international documents report the prevention and promotion, however, housed in an "overall package" and part of the list of duties of public health. Territory is the place par excellence for the development of promotion and prevention of mental disorders, use and substance abuse, violence prevention, social pathologies, as well as intervention in exacerbating conditions of physical and mental illnesses, such as unemployment, poverty, conditions of work stress and gender discrimination. The World Health Organization advocates that mental health promotion can be developed through effective public health and social interventions. Inter-sector collaboration should be enhanced and encouraged, because it is the key to effective programs of mental health promotion[28].

Final Considerations

The integration of mental health in PHC, although desirable, is facing different forces that oppose and which are at the professional level (generalists and specialists), political, ideological, epistemological and of management. It is a complex process due to different knowledge, powers and desires and different players at stake. Going back to the myth of the Minotaur, the spool of thread has knots that need to be untied, discussed previously in the main barriers to the matrix support. The white flag to be hoisted, forgotten by Theseus, is the flag of integration, generalists, specialists and managers. In this sense, human resources are a fundamental resource, the most valuable asset to the inclusion of mental health on PHC.

However, despite the resistance, this is an ongoing process in various parts of Brazil and the world, because of the understanding of the necessity of the inclusion of mental health in Primary Health Care. Some contrary arguments to the Matrix Support, e.g., the need for conceptual, epistemological and paradigmatic transformations are also arguments in favour of new ways of operating in the field of health and mental health, for both generalists and specialists. That is, depending on the perspective in question, the initial difficulty with a specific core of knowledge can be transformed into a creative power producer of new scenarios. Transformations occur not only in the lives of people with a mental disorder, but also in the lives and views of the world of professionals.

Matrix support in mental health requires the weaving of a network of people and services (just like Ariadne's thread) and involves the construction of a process of interdisciplinary/trans-disciplinary work. The allocation of financial resources by the management body is an important part of the process. Meanwhile, in addition to the regulation of administrative rules, the effectiveness of this method of work must be understood as a process, and so it implies the collective and joint construction of generalists and specialists,

through the support of managers. Thereby, mental health can be incorporated into health care in the primary care network, providing opportunities for interventions in psychological distress in the territory and producing new relationships.

Collaborations

A Hirdes worked in the study conception and design, acquisition of data, analysis and interpretation of data, drafting of manuscript and critical revision of the final version. HBK Scarparo was involved in the study conception and design and critical revision of the final version.

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