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Matrix support in Mental Health: narrative revision of the concepts horizontality and supervision and their practical implications

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Abstract *The Matrix Support (MS) is one of the cornerstones of the integration between Primary Health Care (PHC) professionals and Mental Health professionals (MH). A narrative review was conducted on the articles on MS in MH published in national databases from 1998 to 2017, considering a brief history of the PHC reorganization processes that led to the creation of the MS proposal. The aim was to understand the meanings attributed to the terms "horizontality" and "supervision" as well as the descriptions of the "matrix support" itself. We sought to identify factors contributing to the difficulties that have been described in the practices and literature, based on the assumption that these concepts are polysemous and it is possible to generate ambiguities that operate to the detriment of interprofessional practices. Based on the analysis of the selected articles, we were able to conclude that, in addition to polysemy, the obstacles' force lies in the hegemonic model of professional Health training, as it is traditional, hierarchical and uni-professional, and hinders the development of dialogic relations that favor the integration of the matrix support teams and PHC and consequent resolubility and quality of care.*

Key words *Matrix Support, Mental Health, Primary health care, Horizontality, Supervision*

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Introduction

The integration between mental health and primary health care is considered a priority by the World Health Organization due to the global burden of mental disorders and the gaps that exist in the care provided in this field.

In the international context, "Collaborative Care" or even "Shared Care"[1,2] are the names given to a practice that integrates Mental Health professionals and Primary Health Care (PHC) professionals with the goal of guaranteeing integral care that meets the population's health needs.

In Brazil, in order to understand how these denominations are integrated, we must first briefly recount how PHC was developed in the country, with special attention to the end of the 1980s and beginning of the 1990s, a time marked by the Constituent Assembly that established health as a right to which all citizens are entitled and an obligation for the State, as well as actualizing the demands made by the Brazilian health reform movement regarding the creation of a Unified Health System (SUS, in Portuguese). In 1994, based on the accumulated PHC experiences already underway in the country and in the SUS principles of integrality, universality and equity, the government created the Family Health Program (PSF, in Portuguese), which included a team made up of doctors, nurses and community health agents. Thus, new needs arose, especially those related to professional training, which was considered insufficient for the user-centered care practice required by PHC[3-6].

In the Mental Health field, in 1997, Adib Jatene and Davi Capistrano proposed creating the Qualis/PSF Project, which consisted of Mental Health teams with the goal of effecting change in the care and administrative structure of health services, offering technical support to Family Health Teams[7]. This project is considered an embryo of subsequent proposals in the field[8].

In 1999, Gastão Wagner de Sousa Campos, seeking to make the country's actual organizational health arrangement adequate, coined the term "specialized matrix support"[9], now known as "Matrix Support"[10] (MS), which was then included in the official recommendations[11,12] for the Family Health Support Groups (NASF, in Portuguese) in their work with the Family Health Teams (ESF, in Portuguese).

MS is a guideline for the inclusion of Mental Health actions within PHC in the text of the Health Ministry's "Mental Health and Primary Care – The necessary link and dialogue"[13], published in 2003. However it was only in 2008, with the creation of the Family Health Support Groups[14], that MS became an effective practice in the Family Health Units, which began to include professionals from several health fields, varying their composition according to regional characteristics, depending on municipal administration, with the exception of Mental Health professionals, who are mandatory NASF participants.

The NASF guidelines[11] highlight the importance of the integrated work between Mental Health and Family Health professionals, since this intensifies care within an integral health perspective. NASF is, therefore, the main mental health care device within primary health care[15], which shows the importance of MS-based work, since that is NASF's main tool.

MS's goal is co-responsibility in health care among the multi-professional PHC teams and specialist support professionals, so that relationships are horizontal and the exchange of knowledge is not hierarchical[16,17].

Among the actions established by Matrix Support within PHC are technical-pedagogical consulting, joint care and specific health care actions, which must be decided in dialogue with the reference team. Individual, temporally limited care is also possible[18], maintaining co-responsibility between PHC and MS. The conception of MS recognizes that no isolated professional can guarantee integral health care[19].

The concept of MS is composed of two dimensions that integrate actors (support) and service organization (matrix). The term "support" presupposes relationships between subjects, dialogue, interdisciplinarity and horizontal relationships, while "matrix" presupposes the organization of an integral care network, based on dialogue and with the goal of providing long-term care. MS is an organizational arrangement and a form of inter-professional work[9,20].

Based on this, would it be possible to identify what is indispensable when conceiving a good MS practice? Its essence? Based on Campos[9,21] and Campos and Domitti[22] and on the Primary Health Care Reports[11,12,23], matrix support can promote the redistribution of power through a horizontal and collegial administration.

This matrix system, which combines reference (more polyvalent work) with horizontal offer (more specific, specialized work), enables the valuing of all health professions, both conserving the identities of each and pushing them to overcome a very bureaucratic posture, typical of traditional service organization[9](p.398).

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In this manner, inter-professional relationships would tend toward dialogue, the basis of a democratic practice. Thus, reference and matrix support teams, in partnership with patients, could attain a comprehensive clinical approach[24], centered on subjects and their needs. Through practices based on this approach, the development of efficacious and effective communication enables the enhancement of permanent education, with benefits for co-responsibility, prevention and integrality of care over time.

MS teams have their *raison d'être* in the relationship with PHC professionals and their tasks and, thus, can reinforce the role of horizontality in relationships as a crucial element.

Despite the cited bibliography, difficulties in MS practices have been described, as mentioned by Costa et al.[19]:

The analysis of how knowledge circulates between specialists and reference teams in the testimonies allowed us to conclude that there is a distance between intention and action in the different forms of conducting matrix support. In the examples of matrix support reported here, it was possible to notice a strong presence of liberal or traditional principles, as knowledge transmission was seen as the way in which people acquire knowledge. To some professionals, the recognition of the need to work in a dialogic way emerged as tension and desire, which revealed the lack of pedagogical tools so that they can act differently from the practice that was shown[19](p.498).

Given these difficulties, the Practical Matrix Guide[2] states that MS is not:

• specialist referrals

•individual care provided by a mental health professional

•collective psychosocial interventions carried out only by the mental health professional

The Guide[2] states that:

The matrix must supply the specialized rearguard of care, as well as technical-pedagogical support, an interpersonal bond and institutional support to the process of collectively constructing therapeutic projects alongside the population. Thus, it is also different from supervision, since the matrix provider can also participate actively in the therapeutic project[2](p.14-15).

It is therefore relevant to reflect on possible elements that contribute to practices failing to meet these proposals. Included in this category are polysemic concepts that may not be understood within practicing professionals' biases.

Thus, this article seeks to analyze the concept of horizontality presented in the literature on Matrix Support in Mental Health, understood as the field of care provided to individuals with psychic suffering, whether or not they have a mental disorder[2]. As secondary objectives, we propose an analysis of the uses of the term Supervision in light of the different meanings used in the field's main articles[9,10,20-22] and how the concept of Matrix Support is cited.

Methods

This is a narrative or traditional review, understood as a qualitative methodology that provides a basis for validating premises and understanding studies, stimulating reflection and controversies[25]. Rother[26] clarifies that these reviews are "appropriate for describing the development or "state of the art" of a given subject, form the theoretical or contextual point of view". This type of review criticizes and summarizes conclusions about the topic at hand, using relevant studies and knowledge of the subject. The narrative review does not necessarily require that the criteria used in the material selection process be made explicit, which does not mean that researchers have not established any rules. It is useful for summarizing and synthesizing a specific area, and it also has a role in continuous education. It is essentially qualitative[5,27]. The search was carried out in the Virtual Health Library (BVS, in Portuguese) databases for articles published between 1998 and 2017. We carried out a two-stage selection process: first, we used the search terms "matrix support" or "*matriciamento*" ("matricing") and "mental health", in Portuguese. We searched exclusively for Brazilian articles, since Matrix Support, as proposed by Gastão Wagner de Sousa Campos, was created within the Brazilian context. The second stage consisted of a search using the terms "horizontality" and/or "supervision", again in Portuguese, in order to filter the already-selected articles. Those that did not include either term were excluded. We only included full texts. Duplicate articles were considered as a unit. All articles were investigated in search of definitions for the concepts of Horizontality, Supervision and Matrix Support.

Results and Discussion

We found 106 articles about Mental Health published between 1998 and 2017 that included the term Matrix Support and/or "*matriciamento*".

After excluding the articles that did not mention the terms Horizontality and/or Supervision, we were left with 83, listed in Chart 1.

On Matrix Support

We observed no differences in the use of Matrix Support or *Matriciamento*. The terms are used indistinctly and even explicitly as synonyms[28].

We are not interested in discussing the concepts based on the assumption of a universal truth, but rather of taking the dialogic MS/ESF proposal as the defining parameter for what constitutes its success. When the term *matriciamento* is used, does that simplify the original proposal? Based on the texts we have analyzed, the terms "support" and "matrix" are complementary operators of the proposal[22].

It is clear that the concepts' openness to different interpretations, given the polysemy that characterizes them, is one of the obstacles cited by Campos[22]. Still based on the materials we selected, we can identify that the concepts translate a "modus operandi" and, between the lines, give rise to diverse interpretations, no less determining of practices.

The care not to fetishize[29] words is crucial, as if it were possible to separate the senses and meanings from the subjects who think them.

The crucial concepts for practice constitute a network that supports the work dynamic. An ill-defined or misunderstood concept may amplify the network's fragility, which may be prevented through dialogue, since it is through dialogue that change is possible, broadening views concerning new senses and meanings.

Despite the fact that the concept of Matrix Support is commonly used and that it is part of proposals that seek to integrate mental health care into PHC, there are open questions that contribute to reflecting on the success, or lack thereof, of the process of providing quality care and permanent education.

The first question concerns subjects' very comprehension of the proposal. As Fittipaldi et al.[15] state, MS became public policy without there being professionals who were qualified for the innovative character of this work methodology. Castro and Campos[16] reinforce this perception, observing that resistances to the project are a result of most professionals' lack of knowledge regarding MS and, when they are aware of its existence, their difficulties in understanding and applying the method. We can assume that if there is little clarity in the MS proposal, professionals will tend to work within the model with which they are familiarized, which, in the case of Mental Health, is supervision. Thus, a conceptual confusion is reinforced, since Matrix Support refers to an organizational arrangement in which two teams mutually and horizontally support one another in order to bring to PHC the expected, resolutive quality.

The understandings of MS we found are heterogeneous, which results in a generic use of the expression, which may be attributed to any practice carried out by the professionals responsible for it. Some studies even suggest that workers do not clearly understand what MS means[8,30].

On horizontality

It is noteworthy that, of the 106 articles we found, 51 do not mention horizontality, despite its structuring role in MS proposals.

By reading the selected articles that address horizontality, we may classify it, based on the meaning attributed to it, into 6 categories, as shown in Chart 2.

Chart 1. Selected articles.

Subject	Number of selected articles	References of selected articles
Contains Horizontality	39	1, 3, 6, 9, 16, 19, 21, 22, 28, 30, 36, 37, 40, 42, 47, 48, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73
Contains Supervision	28	1, 6, 9, 17, 21, 30, 38, 40, 41, 42, 44, 47, 51, 61, 62, 65, 67, 69, 70, 71, 74, 75, 76, 77, 78, 79, 80, 81
Contains Horizontality and Supervision	16	1, 6, 9, 21, 30, 40, 44, 47, 51, 61, 62, 65, 67, 69, 70, 71

Source: data collected by the authors.

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Reflections regarding the meaning of the term are crucial to its applicability. Some contributions made in the context of the 1st National Mental Health Conference discuss the importance of horizontality in professionals' work relationships, as something crucial to the construction of a non-verticalized bond between health system professionals and users[31].

Horizontality may be defined as a relationship between subjects, in which knowledge, in and of itself, does not define hierarchies and is, therefore, a condition for dialogue. Therefore, dialogue can be understood as an existential need that brings together reflection and action, overcomes simple exchanges or the deposit of ideas into the other[32]. Thus, MS's inter- and transdisciplinary proposal is supported by horizontality, dialogue and the understanding that different forms knowledge do not establish hierarchies, but rather complementarities.

In the service power play, verticality and horizontality compete. Verticality is constructed within the power of one's knowledge over another's, while horizontality acts upon the distribution of power that has its peak in co-participation, modifying and constructing realities[33].

Horizontality enables us to reduce the hierarchical teacher-student model and to stimulate collaborative work in which one "knowledge" is not worth more than another, especially if isolated in itself. A simple example is that of the relationship between health professionals and patients, in which two types of "knowledge" are opposed, that of the professional (technical, formal knowledge) and that of the patient (knowledge of one's self and one's circumstances), which must interact in order to create bonds and trust. Both must assume that neither type of knowledge is enough in itself and only through a mutual, integrative recognition is it possible to move towards an outcome in the direction of health. As Barreto[34] tells us: "there is no type of knowledge that is superior to another, but a knowledge to be shared. We are all apprentices".

We may, therefore, understand that horizontality contributes to the constitution of good work relations that generate dialogic models, and that this experience reverberates in the ESF/Patient/Family relationship.

This trilateral horizontality[9], consisting of Family Health and MS professionals and users, is especially important, because the success of the MS proposal is located not only in the realm of professional relationships, but also in users' relationship with the service, of which a – also trilateral – co-responsibility is expected .

Partnership, collaboration and reciprocity are fluid where horizontality is present. There is no expectation of uniformity, but rather of differences, which are both respected and valued, among persons, degrees and types of knowledge, with no submission to a pre-established hierarchy[35].

The view of specialists as people who already know and who have the answers to the anguishes found in clinical practice reinforces the mythification of knowledge, vertical relationships and a focus on a pathology that "exists" independently of the subject. In this context, it becomes difficult to carry out joint consultations, a cornerstone of MS, since without horizontality, this is reduced to a mere consultation with the specialist[15,16,18,36-38] and, thus, one loses the sharing of competencies, the production of knowledge and the efficacy of communication between participants[6].

Chart 2. Article distribution according to analytical categories.

Categories	Number of selected articles	References of selected articles
Service organization/democracy/distribution of power	19	1, 9, 21, 22, 28, 30, 42, 44, 47, 50, 53, 54, 59, 61, 62, 66, 67, 69, 70
Teams' work mode	11	9, 21, 22, 28, 47, 48, 51, 59, 67, 71, 72
Long-term care	06	6, 9, 16, 22, 40, 70
Essential requirement for interdisciplinarity/ knowledge exchange/dialogic relationships	24	1, 3, 6, 9, 16, 19, 21, 22, 30, 44, 47, 48, 52, 54, 55, 56, 57, 60, 63, 64, 65, 66, 72, 73
Opposition to verticality in services and relationships	05	16, 37, 44, 64, 66
Subject singularity	05	3, 57, 58, 59, 68

Source: data collected by the authors.

The texts therefore highlight that horizontal relationships have an affinity for equity, while vertical relationships have an affinity for hierarchy, confirming the belief that the traditional model "tends to perpetuate a power relationship through the disposition of instituted places of knowing and not knowing"[39].

Vertical relational structures are reinforced by the hegemonic culture, which makes the nuclear professional knowledge private, resulting in exclusions of responsibility among professionals, stiffening knowledge borders and stimulating market reserve[7].

Another issue that merits reflection is the distance between what is defended as MS and what that actually produces in practice. In some settings, professionals do believe in the proposed model, however, in the everyday reality of services, they do not apply it, reinforcing the idea that theory is necessary, but not sufficient, for praxis[17].

Additionally, there are issues regarding professionals' academic training, which, generally speaking, is not articulated with SUS principles and is insufficient for working as matrix supporters[16].

On supervision

The 29 selected articles that discuss the concept of supervision offer different understandings, of which we highlight:

1) As a common MS practice, mostly within a vertical relationship[17,31,40,41]. Thus, we may infer that when Mental Health professionals set out to supervise PHC professionals without a proposal of horizontal relationships, there is a tendency to "guide" the PHC professionals, which does not corroborate the MS proposal.

In this conception, the Latin etymology of the word is present, in which "super" means "over" and vision comes from "visio", vision, that is, vision over something or someone.

The practice of supervision is traditional in Mental Health, however, in this specific case, what is at stake is not a more experienced professional with less experienced Mental Health professionals but, rather, Mental Health professionals providing matrix support alongside PHC professionals. Mental Health "expertise" should not repeat the supervision model, since the goal in the matrix supporter/PHC professional relationship is not to transform the latter into a Mental Health specialist, but rather to collaborate so that they are able to deal with the vicissitudes of this field within their own "expertise".

2) As clinical-institutional supervision of the MS team itself, frequently associated with a Psychosocial Care Center (CAPS, in Portuguese).

3) As technical matrix supervision, a term that presupposes an implied horizontality in mental health practices.

We found two other expressions in different articles, "specialized matrix supervision"[9,21] and "technical matrix supervision"[42], both used with the same meaning, that is, seeking to broaden the process of critical reflection and permanent education and, therefore, compatible with horizontality. One study takes this issue further, defending a dialectic interaction between an external, ontological knowledge and an internal, praxis-related knowledge[43], that is, between types of knowledge that constitute personal and professional development and those that emerge from everyday service practices. In this sense, the authors understand that, by accumulating these competencies, one can work from the perspective of a "matrix supervision" which, in turn, can avoid the authoritarian, vertical character inherent to the traditional idea of supervision. On the other hand, we may point out the difficulty involved with this possibility, since it demands knowledge and reflection about subjects, their relationships and the environment in which their praxis is inserted. We may, therefore, assume, based on the bibliography we analyzed, that, within the MS perspective, the meanings attributed to the concept of supervision were broadened.

Another perception we found in the selected articles relates to psychologists' understanding of MS. These professionals viewed MS as case discussions and supervision, and saw themselves as having the job of "capacity-building" and "guiding" professionals who were not trained in Psychology[41]. This perspective reproduced the vertical model between those who have knowledge and those who need to acquire it[17].

The term Supervision therefore reinforces existing practices carried out by professionals who were trained in traditional pedagogical conceptions, in which the hierarchical teacher-student model reigns, translating the "banking" approach to the teaching-learning process, in which students are viewed as passive recipients of deposited knowledge[32].

The literature we analyzed shows an inconsistency in practices with disastrous experiences, which may be exemplified by an account[61] in which a Family Health team, when seeking to collaborate with an Alcohol and Drugs CAPS, obtained nothing more than a master class and

generic guidance regarding what they should or should not do. A fact that corroborates the premise, as Iglesias and Avellar[41] demonstrate, that MS professionals' lack of understanding regarding the proposal puts the MS work at risk. Thus, we may assume that the literature has not yet fully explored the theme of the lack of "clarity", since studies such as those review by Machado and Camatta[45] present the lack of understanding about "the real use of matrix support", and also Lima and Dimenstein[46] studies demonstrate serious obstacles to the work process: political vulnerability in PHC; heterogeneous praxis conceptions and models; managers at different levels who do not offer support; irregular processes; PHC network flows that are not activated; PHC network flows that are not significantly influenced; Family Health teams and MS teams with relational and schedule difficulties; lack of psychiatrists and persistence of the outpatient model of referrals and appointments.

The difficulties, such as lack of clarity, reported in the literature as associated with the consistence of the described experiences seem to stem from the verticalized and dissociated training health professionals receive, which demands more research into the relationships between teaching and verticality/horizontality. Thus, we may assume that the manner in which the way of thinking, feeling and acting is constructed in the training process directs subjects' understanding of concepts so as to confirm a previously-established perspective. In this setting, dialogue and horizontality proposals become fragile or unreachable. Among the major challenges are transforming undergraduate curricula and making graduate training viable for professionals already inserted into health care networks[17,41,47-49].

Although the themes addressed in this article do not encompass the totality of concepts that are important in MS, and the analyzed material is restricted to the Mental Health-PHC interface, this article's main strength is the intention of contributing to the reflection regarding MS practices, proposing a discussion of concepts and their polysemy and drawing attention to educational processes in the health field, in addition to indicating a path for future research.

Conclusions

The analysis of MS practices proposed by Gastão Wagner de Sousa Campos and of the literature that followed them demonstrates that the concept of horizontality is vital and reflects a democratic ideological posture, without which dialogue between different actors does not reach its potential to transform the reality of health care provision. Though issues of polysemy are present, the obstacles to practice are complemented in the still-hegemonic model of professional training in Health, which is traditional, hierarchical, uni-professional and non-dialogic, and which hinders integration and collaboration between matrix support and PHC teams and, consequently, service resolutiveness and quality.

Regarding Mental Health, we must highlight that a lack of understanding of MS, as well as a scarcity of professionals in PHC, may result in the practice of an outpatient logic, which hinders the provision of integral health care to the population, especially those experiencing psychic suffering.

Collaborations

LF Chazan worked on the design, method and research and on the final essay. SLCL Fortes and KR Camargo Junior contributed to the critical review and strategic discussion of the article.

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