Matrix support in mental health in Primary Health Care: Barriers and facilitating factors

Apoio matricial em saúde mental no contexto da Atenção Primaria à Saúde: barreiras e fatores facilitadores

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Resumo

The present study addresses the barriers and facilitators to the decentralization of mental health systems through matrix support. This qualitative research was carried out with matrix supporters – psychologists and psychiatrists from the metropolitan region of *Porto Alegre, Rio Grande do Sul*, Brazil. The results revealed the following barriers to matrix support: non-recognition and full validation of matrix support from the management; overrating political issues at the expense of technical issues; incongruence between institutional and professional values; and different network settings in traditional Health care Units and Family Health Units requiring different organizational arrangements. The facilitators include personalized relationships between the matrix supporters, and the team formed by reference health professionals, and the professionals' availability and commitment, effective communication, co-responsibility, and regularity and organization of meetings. It was concluded that, despite the various obstacles, matrix support arises mainly from the motivation of the supporters towards the decentralization of mental health systems.

Palavras-chave: Health care administration; Matrix support; Mental health; Primary health care.

Abstract

O artigo discute as barreiras e os fatores facilitadores à descentralização em saúde mental por meio do apoio matricial. Trata-se de uma pesquisa qualitativa, realizada com apoiadores matriciais – psicólogos e psiquiatras da região metropolitana de Porto Alegre, Rio Grande do Sul, Brasil. Os resultados evidenciam como obstáculos ao apoio matricial a não validação plena da gestão; a sobreposição das questões políticas em detrimento das técnicas; a incongruência entre os valores institucionais e os profissionais; as diferentes configurações da rede em Unidades de Saúde tradicionais e Unidades de Saúde da Família, que demandam arranjos organizacionais diferentes. Dentre os fatores facilitadores, evidenciam-se as relações personalizadas entre os apoiadores e os profissionais de referência, a disponibilidade, o comprometimento, a comunicação fluida, a corresponsabilização e a sistematicidade dos encontros. Conclui-se que, apesar dos diferentes obstáculos, a manutenção do apoio matricial decorre essencialmente da motivação dos apoiadores à descentralização em saúde mental.

Keywords: *Administração em saúde; Apoio matricial; Saúde mental; Atenção primária à saúde.*

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Mental disorders nowadays are related to global and local issues due to cultural, political, and economic differences between the countries and to the responses of health systems to cope with these disorders provided by local communities. The grand challenges in global mental health include: identifying the causes, risks, and protective factors; enhancing prevention and implementing early interventions; improving treatment and expanding access to care; raising awareness of the global burden of mental disorders; human resource empowerment; and transforming health systems and policy responses. Accordingly, the transformation of health systems and policies should promote a redesign of health care systems to include mental disorders aiming at achieving parity of esteem between physical and mental disorders (Collins et al., 2011).

In order to meet these challenges, particularly with respect to human resources, and to change the way the referral system works, which prioritize referrals to the secondary health care services, some municipalities in the Brazil have implemented the *Apoio matricial em saúde mental na Atenção Primária à Saúde* (Matrix support in mental health in Primary Health Care). It was developed to offer support to the care provided and technical and pedagogical support to the reference health professionals in a personalized and interactive way (Campos, 1999; Campos & Domitti, 2007; Cunha & Campos, 2011). The dimension technical and pedagogical support refers to providing support to the reference health professionals and their collective actions, such as clinical discussions or specific interventions (consultations, visits, groups) in order to increase the response capacity of the teams, empowering them for a more efficient care provision. The dimension care support refers to individual patient care actions undertaken by the supporters (Campos, Figueiredo, Pereira, & Castro, 2014).

The matrix support arises from the *Paideia* theoretical concept and methodology developed by Campos (2000, 2003), which aims at the co-management of individuals and collectives with

ability to carry out analysis and interventions by the establishment of new subjectivation processes. The *Paideia* concept has three areas of application: institutional support; expanded and shared clinical care; and matrix support, which is the subject of this study. The support to the professionals aims at producing pedagogical, therapeutic, and institutional effects simultaneously. The educational effects result from knowledge improvement, which increases the technical capacity to intervene. The therapeutic effects arise from changes in the individuals, their values, and their worldviews. The institutional effects result from changes in relationships and in the context of work (Campos et al., 2014).

Therefore, the matrix support work is highly focused on "soft technologies" (Merhy, 2005), relational technologies, and invisible inputs (resources) (Thornicroft & Tansella, 1999). The first category of invisible inputs includes work relationships between specialists and general health services, as well as style of working. The second category of invisible inputs includes the legal and policy framework within which the service is authorized to operate. The third category concerns the organizational arrangements which shape how the process of care takes place (Thornicroft & Tansella, 1999). These invisible inputs, which often remain excluded from consideration in health care service evaluations, strongly influence work processes. Therefore, they affect the relationships established between professionals and those between them and the service users.

Since this is a relatively recent work methodology and given the peculiarities of the health system - such as the immense importance given to specialized care in secondary and tertiary health care services -, it is overridden by epistemological, structural, organizational, management, and policy challenges. Thus, considering that these factors can act as barriers or facilitators to the decentralization of mental health systems, the aim of this study is to investigate matrix support in mental health in primary health

care in order to identify the factors that promote or hinder interdisciplinary and intersectoral teamwork.

Method

This qualitative descriptive-analytical study was carried out in the metropolitan region of *Porto Alegre*, RS, Brazil. A total of six professionals (two psychologists and four psychiatrists) working in the matrix support in mental health in *Porto Alegre* participated in this study. The inclusion criteria of the matrix supporters were as follows: having being involved in the matrix support in mental health for at least two years, regardless of the type of intervention (case discussion, supervision, or collective work, and individual interventions performed by the supporter with subsequent care by the reference health professionals).

Data were collected through semi-structured interviews and focus group discussions (Barbour, 2009; Minayo, 2010) between April and September 2013. A guide containing questions about factors that facilitate or hinder the matrix support regarding organizational, epistemological, structural, and management aspects was used in both data collection methods. The semi-structured interviews were conducted in the first stage of the research; they were audio recorded and later transcribed. Subsequently, focus group discussions were conducted with all six supporters who worked at *Unidades Básicas de Saúde* (UBS, Primary health Care Units) and *Unidades de Saúde da Família* (USF, Family Health Units). The focus group discussions provided more detailed insight and information about the issues previously addressed in the interviews regarding the factors that act as barriers to the use of this methodology and the factors that facilitate its implementation. It is worth mentioning that the focus group discussions were videotaped and later entirely transcribed.

Initially, the data collected through the two methods were individually examined through a comprehensive reading of the texts, according to the theoretical/methodological proposal. Afterwards the two methods were combined focusing on an in-depth and thorough analysis that could problematize the topic under study. Data interpretation was performed using thematic content analysis, as proposed by Minayo (2010), which consists of sorting, classification, and final analysis of the data. It revealed internal organization of the internal organization of the symbolic forms and the structural characteristics, patterns, and relationships that are involved in this field. Empirical data were discussed based on national and international literature reports on this topic using the both the empirical data obtained and the theoretical framework.

The present study was approved by the Ethics Research Committee of the *Pontifícia Universidade Católica do Rio Grande do Sul* (Pontifical Catholic University of Rio Grande do Sul) Process n° 15813213.5.0000.5336. It should also be noted that this study was carried out in accordance with the principles of the Ethical Conduct for Research Involving Human Beings, Resolution n° 466/2012 (Ministério da Saúde, 2012). All participants signed the informed consent form. The results will be presented as two thematic areas: barriers and facilitators to matrix support.

Barriers to matrix support

The difficulties are expressed in terms of structural, organizational, and management aspects. The analysis of the contents revealed many barriers to matrix support, showing the complexity of the process. These barriers were reported as problems of communication between different sectors, excess demand, overrating political issues at the expense of technical issues, and non-recognition and full validation from the matrix support management. Both in the interviews and in the focus group discussions there was a predominance and return to the issues that were directly or indirectly related to the matrix support management. Conflicts between professional and institutional values were identified.

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Cunha and Campos (2011) discussed the threefold purpose of healthcare organizations and their work. Their first purpose is the production of use values for others, i.e., health promotion. The second purpose concerns the welfare and livelihood of the worker, which can be improved through the development of other projects that create value to the people involved in health care business. And the third purpose refers to the comprehensive system of organizations fostering the generation of capital in the private sector and in the public sector as well, especially the *Sistema Único de Saúde* (SUS, Brazilian Unified Health System). Due to the interests involved, these three purposes can create conflicts if the goals overlap.

> *What makes it difficult is when the managers do not see it this way, and sometimes managers don't because they come from a policy that does not favor a more comprehensive and more democratic work, and it's not their fault; it is because sometimes they do not have a technical view, they have a political view that needs results, needs numbers* (MS1).

Despite the participatory discourse that underlies the SUS, the responses and comments of the respondents indicated a disconnection between the management and the reference health professionals. The overrating of political aspects at the expense of technical aspects shows that the long-standing clientelism still exists in health care practice and services in the country. Therefore, problems, denominated by Cunha and Campos (2011) as structural problems, hinder the adoption of the matrix support in the cities investigated. This results from little investment from the managers through contracts included in this activity. In the health care centers studied, the professionals involved were able to reduce their working hours in the outpatient clinic to work with matrix support activities instead.

The respondents' reports show the overrating of meeting demand, i.e., the number of people receiving care, at the expense of investment in preventive and health promotion actions, as well as in treatment and rehabilitation in the territory.

> *But since there is an overrating of the demand for health care services, which is a long-standing practice, this is what is prioritized instead of getting together to discuss and spend more time with more complicated processes that actually require more attention, so we end up doing the most superficial thing* (MS3).

This report refers to the persistence of the traditional fragmented health care system model, focusing on acute situations. The differences addressed by the supporters regarding the health care network and its vicissitudes and singularities refer to objective work-related aspects, such as working hours and salary levels. They recognize that there are discrepancies, for example, when a dedicated professional is paid less than one who does not meet the workload requirements and is still paid a higher salary. Although these situations may occur in any work setting, in the present study, the participants referred specifically to the traditional UBS, whose operation is primarily concerned with meeting demand.

> *Another limiting factor is that there are very large differences in salary between us, the professionals; sometimes the one who works more earns less, and someone who does very little work, besides being a hindrance, earns more. So when there is no recognition of work as something personal too, as a purpose in life, professionals who do not have such perception become involved in disputes and become jealous, pursuing things that are actually... material things* (MS1).

A study addressing the meanings of matrix support and medical interconsultation with

specialists and generalists, in *Porto Alegre*, RS, showed difficulties similar to those brought up by the participants of the present study, particularly with regard to difficulties encountered in the work linked to specialized services and participation in interconsultation and matrix support, focusing on medical doctors (Silveira, 2012). These findings are especially consistent with those of the present study about the work of traditional UBS. Factors that hinder integration in UBS include: meeting demand as the primary concern, focusing on productivity; staff turnover; and care centered on a clinician who is willing to provide mental health care. In traditional UBS, as an alternative to the absence of reference health professionals, there is a physician who provides "mental health" care. The matrix support supporters reported that this was a feasible solution for work integration in these health care units.

During the interviews and focus group discussions, the participants reported that there was resistance from primary care generalists and specialists of the *Centro de Atenção Psicossocial* (CAPS, Psychosocial Care Center) to participate in decentralization activities. The generalists' resistance results from the fact that they see matrix support as another job requirement. Specialist's resistance to decentralize mental health care can be attributed to changes in professional roles, mainly in interdisciplinary and intersectoral work. Studies have shown that professionals may be concerned about losing their professional identity, status, familiar work environments, and familiar ways of working (Silva & Oliveira Filho, 2013; World Health Organization, 2005).

Issues related to investment of time and energy and being open to different ways of working were also reported from a different perspective that includes professionals changing and stepping out of their comfort zone by becoming active and willing to work together with teams in health care units.

> ... . *For me to see patients in my office I have to be willing to do it, but I can just stay here (at the CAPS) and close the door and no one will see me. But if I have to work in*

> *the matrix support, and if I don't, people will notice. So, the person has to want to do it, and for this to work you have to want it, you have to be willing to do it , and the others who will welcome you there also have to be willing to do it because, if not, it will be like just working coordinated with the unit appointments ... (MS5).*

Machado and Camatta (2013) conducted an integrative review and identified the following aspects that hinder the matrix support: lack of professional training, lack of professionals trained to deal with the subjective aspects of mental health care, such as crisis management, interpersonal relationship, and therapeutic instruments; difficulty in understanding the matrix support; and the common practice of primary care professionals transferring responsibility through referrals to providers of specialized health care. On the other hand, when the specialist team fails to deliver the specialist care by not accepting a patient that was referred or by counter-referring the patient to the team, as well as the lack of communication between the teams, and the keeping the knowledge restricted to one's field of work instead of broadening it to include related fields can hinder the network actions. Empirical data show that an effective communication is a facilitator to matrix support and an important invisible resource.

In the present study, it was observed that the matrix supporters can, based on the specific realities of health care units (UBS and USF – intra-team and inter-team differences), develop strategies that enable implementing the work process. The interviews and focus group discussions also evidenced that the culture of matrix support already exists at the USF, whereas at the UBS, this process requires constant dedication and incentive by the supporters. Campos and Domitti (2007) showed that information sharing, interprofessional relationships, and the concern about understanding the various dimensions of the person with health problems are very restricted aspects in the traditional structure model of health organizations. Therefore,

it is important to acknowledge that changes in the structure of UBS are needed in order to enable the adoption of matrix support.

The lack of more comprehensive discussion forums at the Health Department with professionals from different areas was recurrently demonstrated in this study, and it was identified as a factor that hinders intersectoral work. Such challenge is called by Oliveira (2008) as project co-production, which requires the integration of planning practices while stimulating the active participation of those involved. The author recognizes that planning practices are more focused on pragmatic problem solving than on the creation of new scenarios. The study proposes a health care planning process that enables a shared understanding of the problem towards common and collective goals as an essential step in action planning.

Cunha and Campos (2011) discussed the need to resolve the uncertainty surrounding teamwork, which often occurs in an artificial way, by focusing on aspects related to the users' lives and neglecting the variables. In order for an organization to undergo changes, visibility is required so that conflicts can be solved. Oliveira (2008) argued that professionals need to have contextualized and processual self-criticism of the way they think and act toward the users. Accordingly, transferential issues, the focus on certain aspects of the users' lives, and the strategies adopted in the relationship with the users should be considered. This difficulty was reported by a psychoanalyst.

> ... . A difficulty of a case is a difficulty faced by the whole team; it is often a difficulty in treating or providing care for that person, and so it can be a subjective difficulty faced by those involved in the case ... then, you need to ask the rest of the team for help ... (MS3).

The participants rep orted several factors that hinder the matrix support regarding management. Their reports refer to not properly understanding the job role, the lack of institutional support, the non-participation of the management team in planning meetings, change of local government, the susceptibility of the professionals arising from new proposals by the managers, and the need to sensitize the management team to the matrix support. Therefore, it can be seen that there are several barriers to the successful implementation of the proposal. These barriers can be related to a passive management style or non-recognition from the management and to the hindering of the matrix support due to objective barriers. However, despite those obstacles, the matrix support was evidenced as an ideal that permeates the job of the reference health professionals, overcoming structural, operational, and management barriers.

According to Galvão (2012, p.145), "overcoming a management centered on programs and detached from the reality of services, requires the creation and support of collective spaces for co-production of care, which can be created based on strategies such as matrix support". Some important qualities of managers for the integration of mental health into UBS include: actively engage in the work of the professionals, listen to their needs, and identify new ways of working based on evidence. An essential aspect of human resource management is the capacity to attract and retain skilled professional staff (World Health Organization, 2005).

Effective management and support to skilled professionals are vital for overseeing the implementation of strategic actions. Policy makers are responsible for the allocation of human resources and for monitoring targets and outcomes. Managers and support staff are responsible for the planning and implementation of human resources, management of the work environment and conditions, information systems for human resource, performance, and retention of professionals. Investments in health management capacity are an important component for increasing human resources for mental health (Kakuma et al., 2011).

Some national studies have addressed the difficulties in the management of public health

(Cunha & Campos, 2011; Delfini & Reis, 2012; Dimenstein et al., 2009; Onocko Campos et al., 2011; Prates, Garcia, & Moreno, 2013), such as structural barriers to matrix support. These barriers include the lack of human resources and services, staff turnover; lack of matrix support in mental health policy; lack of qualified workforce, hiring methods; turnover of management personnel; rigid schedules; and productivity pressure, which hinder or even prevent the effective matrix support operation. These are structural problems that depend on management skills. *"… . We had to fight to be able to form the group; we didn't have a lot of support from the administration or even from the Health Department…"* (MS5). It can be said that since its beginning, the matrix support has been supported by the specialists despite the various structural barriers to effective teamwork.

Failure to understand the work process and the lack of recognition from the management team was expressed by the respondents. *"Another thing that also limits the matrix support work is that sometimes managers do not understand that the work done outside of an office, outside of four walls, is as important as in the work done within four walls"* (MS1). Thus, the quantitative aspect of meeting demand overrides the work done in the territory. *"And matrix support is something much more … it goes beyond numbers and linking, healing, care provided, and wellness processes"* (MS1). Therefore, structural, political, and management factors can act as barriers to the implementation or continuance of matrix support across the municipalities studied.

It was observed that there are human resources; however, the structural issues related to resource allocation need attention and consideration.

> *… . Financially speaking, I think it's important that there is no "single" contribution of work from the professionals; finally, it comes to a moment that if there is no support, the person has no energy left (MS3).*

> *Another limiting factor is the physical structure, the lack of cars …; we usually use our own car, and so we need to find other ways to make up for these problems* (MS1).

Investments in human resources for mental health care are needed to reduce dissatisfaction among professionals by: paying fair wages and establishing career development and promotion structures; improving working conditions; investing in personnel training; developing supervision and support structures, developing a supportive leadership; and allocating part of the resources for all members involved for the achievement of the goals (World Health Organization, 2009).

The present study revealed different situations, the lack of objective work-related issues and the presence of subjective aspects that permeate the process. The latter refers to the non-recognition and appreciation of professional work along with the barriers to effective process operation. Thus, the matrix support administration needs to make an effort to solve conflicts, reveal the outcomes, recruit new staff - specialists and generalists -, and motivate the different professionals involved. This work is based on everyday situations due to the different factors that hinder the implementation of the matrix support and that involve the management team.

Integration is successful when mental health is incorporated into health policy and legislative frameworks and is supported by senior leadership, adequate resources, and ongoing governance (World Health Organization & World Organization of Family Doctors, 2008). In other words, providing stability to prevent professionals from being susceptible to change of government. This is a concern expressed by the participants. Other studies carried out worldwide on the integration of mental health into UBS indicated the lack of leadership at various levels, hindering its assimilation and integration (Kakuma et al., 2011; Saraceno et al., 2007).

A study addressing matrix support from the perspective of management highlighted similar

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difficulties: need to consider matrix support as a policy; need for continuous training of managers and professionals in order to ensure broad concepts or domains of knowledge; seeing the matrix support as a strategy for the development of integrative practices; interdisciplinary and intersectoral approach; and the commitment to acknowledge the matrix support as a management tool (Galvão, 2012). *"So, it's not because the government changed that we have to change everything; let's reiterate or reinforce the technical-scientific reason to continue. So, this is sometimes a limiting factor to our work"* (MS1). This political issue has also been addressed in another study (Prates et al., 2013), which showed the interruption of the matrix support work due to change of management.

Fragmented work processes, in which each professional has sufficient knowledge of his/her field but overlooks the value of networking have also been reported. According to the World Health Organization and World Organization of Family Doctors (2008), in order to be effective and efficient, primary care for mental health must be coordinated with a network of services at different levels. However, this does not mean to terminate the referral system but rather to increase UBS capacity to meet mental health demand through professional training.

The respondent's reports indicated that conflicting values (Gabel, 2011; Leiter, Frank, & Matheson, 2009) permeate the relationships with the management team. This occurs when there is no alignment between the professionals' values and the health organization values. This phenomenon can result in occupational burnout, request for job transfer, or resignation. The interviews and focus group discussions showed that there has been an effort to maintain the work of the supporters, even in the absence of an active institutional support. In other words, the supporters have made an investment of time and energy (subjective) as well as a monetary/logistics investment - going from one location to another and organizing the appointment schedules of the UBS doctors (goal). The supporters require

recognition and a formal institutional endorsement in objective and subjective terms.

The lack of support from the Psychosocial Care Center management was also reported in the focus group discussions.

> *In fact, the participation of the administration, as well as the recognition of how things have been done, in my opinion, only happens if people participate. There is no point in having a meeting there at the Psychosocial Care Center with everybody; it has happened before, it can be a way, a way to achieve recognition ... maybe to manage resources (Focus Group MS2).*

A study on matrix support from the perspective of management has showed that the matrix support is a strategic tool to rethink the health care model (Galvão, 2012). Therefore, the matrix support is an important tool for the consolidation of the psychiatric reform.

According to the World Health Organization (2005), several factors can be associated with improved staff motivation, such as: recognition, good relations with colleagues, identification with the group or sense of belonging, opportunities for growth, opportunities for solving problems, autonomy, reduction of unnecessary hierarchy and bureaucracy, transparency, participation in decision-making, job security, professional development, and emotional and psychological support. The first factor, recognition from the management team, was referred to as non-existent. However, all other factors were mentioned by the participants, which may explain the continuance of the matrix support even in the face of the adverse conditions reported by the professionals.

Facilitators to matrix support

The factors discussed below were indicated as facilitators to matrix support. Among them are effective communication, the possibility of

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moving back and forth around different locations, the close relationship between different teams in Primary Health Care and in other health care services, formal and informal discussions held at UBS and USF, and the possibility to move around in the geographic and persons' existential territory. Other factors include work motivation, freedom to plan interventions; co-responsibility, commitment; clarification of the role of those involved in the process, flexible work boundaries (participation of people from outside the work), and the recognition of everyone's work.

The organization and regularity of meetings and communication (face-to face or over the telephone conversations in emergency situations) were reported by the participants and indicate an opening for co-responsibility and process co-management. Campos and Domitti (2007) argued that the matrix support depends on collective spaces, co-management, co-responsibility, interpersonal relationships, information flow, and interprofessional contacts, i.e., a dialogic and interactive work.

… . Information and discussion among those involved, when we talk and one team knows about the work of the other team, we know how we can count on the support of that other team, and this can work either for a small team or at a UBS, where the doctor will approach the nurse, who will approach the nursing technician, who will approach the community health worker (MS3).

In order for this to happen, there is a need to create collective spaces, spaces for critical reflection, production of subjectivity and subject constitution. Collective spaces are concrete spaces (place and time) for communication (listening and information sharing about aspirations, interests, and aspects of reality), for preparation (analysis of the reports and information) and decision making (priorities, projects, and contracts) (Campos, 2000).

… . We have to be willing to go and we have to go; it's through talking, calling, or going to a place and joining people too; calling someone from there to come here, calling someone from there to go there and to another place, where we will also go to meet each other within the network (MS5).

The matrix support conception as the creation of relational moments with exchange of knowledge and affection between different professionals (Bertussi, 2010) permeates the supporters' job. Thus, cooperative relationships are established and the supporters and the reference health professionals assume co-responsibility for their actions.

… . Because in all the units that I go, they also feel that there is a commitment on our part, a responsibility (MS6).

… . Go and check what is going on, ask questions, give our contribution to the process as whole in which I'm the "fractal", but I have it all; but I also need to see the entire process so that I can "upgrade" myself. (MS1).

Seen as a strategy or a tool, the matrix support is a complex social process since it leads to the need to develop and grasp concepts and to rethink and reinvent practices and values (Galvão, 2012).

And it also depends a lot not only on the professional training, but also on the person, the person has to want to do this; whatever it may be, you have to want to do it. But this is something that means a shift of attention, and then people have to be willing to do things differently from the way they have been done (MS5).

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This finding corroborates that of Campos et al. (2014, p.993), who pointed out that, ultimately, the assumption within the *Paideia* methodology does not intend to change something "for" the other but "with" the other.

The matrix support pedagogical role of on-site training has been reported in other studies as an essential aspect to help the reference health professionals to learn how to intervene in the field of subjectivity (Figueiredo & Onocko Campos, 2009; Galvão, 2012; Hirdes & Scarparo, 2015).

The knowledge for recognition of situations ... then, there is an organization that is more learning related; it is focused on training and not only on demand (MS2).

... . Talking about what I believe will promote the interdisciplinary work is like this; it means to bring the teams closer and closer, and those who are already in tune can broaden their experience and show others who have not yet participated the importance of joining and "multiplying" (MS3).

The contact between different groups promotes interdisciplinarity, and training also results from the contact with professionals from other teams by sharing experiences.

Therefore, regular contacts with the teams, longitudinality, and the characteristics of USF were mentioned as factors that increase job performance.

There is an advantage in the process by being a USF, where a team stays longer in the unit, and so the team works for a longer period of time and can have the chance to meet the users, the families (MS3).

... At the USF, we have more freedom and more availability to plan our work; we have

set up a team meeting day, so we direct the activities to those moments (MS2).

Communication, described by Morin (2010) as a transdisciplinary element, permeates the job of these professionals. The processual aspect of the work done is demonstrated by the constant contact of the supporters with the professionals across different parts of the territory. Thus, a formal and informal network is woven in people's physical and existential space. This network is not exclusive to people with mild or severe mental disorders, but it is also open to people who need psychosocial support.

The first factor that is a facilitator to an "inter" work is communication... the possibility of meetings for this to happen; I set up the meeting in the community and I participate in it... I contribute by going, doing, walking not by sitting and waiting (MS1).

This report corroborates the matrix support fundamental assumption that the supporter adopts a dialogic and interactive approach in the process (Campos et al., 2014).

"The interdisciplinary work also depends on subjective predisposition to deal with uncertainty and receive and express criticism and toward shared decision-making" (Campos & Domitti, 2007, p.404).

... The personal matter is also involved; everyone needs to realize how important it is to express yourself and communicate with others so they can understand and help with the process. So there is no point in developing and implementing the matrix support individually without sharing what is being done with other colleagues so that they can also have the support, help, and get help. Thus, communication is the first step (MS1).

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This respondent demands co-management mediated by communication, which promotes the interdisciplinary and collaborative approach.

Among the principles and values that guide the work process are the relational technologies (Merhy, 2005) that support the practices in people's existential territory, affecting the matrix support members, generalists, and users. The relations established between the supporters and the reference health professionals are strongly based on personalized relationship, face-to-face communication, affection, and the desire to work in the UBS. Therefore, it can be said that these resources described by Thornicroft and Tansella (1999) as invisible inputs, give support to the decentralization of mental health services.

The paradigm of "production of life" identified in the respondents' reports, shows potential to change the ways of living and feeling through building relationships and solidarity networks among people. The movement in different spaces of the territory is a resource to support the decentralization of mental health care, through the matrix support, the UBS and USF teams, or the activities carried out with people in the community. Among the work strategies adopted, there is some evidence of recognition of people's work and practices.

Final Considerations

Based on the different barriers to matrix support, it can be inferred that it has so far survived due to personal motivation of the professionals involved. These motivations stem from the alignment between principles and personal and professional values, the professional profile, the desire to work within the community, and the professionals' natural inclination toward working with public health. These results are in agreement with those reported in the study of Castro, Oliveira, and Campos (2016), carried out in *Campinas*, SP, in which it was found that the matrix support remains firm despite the political difficulties due to the efforts of the professionals. However, Prates et al. (2013) showed the interruption of the matrix support

due to change of management, which demonstrates political and management difficulties.

Among the factors that hinder the matrix support, management difficulties with regard to the lack of institutional support and changes of government were reported. Similar findings were found by previous studies (Castro et al. 2016; Prates et al., 2013), and they are related to structural factors. Another barrier is due to the fact that the management team does not acknowledge that the matrix support can reduce the need for referrals to specialized services. The epistemological factors are related to the difficulty of professionals, mainly those working at UBS, in handling mental disorders in the territory. This result, corroborated by other researchers (Hirdes & Scarparo, 2015; Machado & Camatta, 2013; Quinderé, Jorge, Nogueira, Costa, & Vasconcelos, 2013), highlights the importance of the matrix support technical and pedagogical support as an essential resource for the teams.

The fragmented work processes that hinder health service networks have been addressed in other studies (Campos et al., 2014; Cunha & Campos, 2011; Silveira, 2012; Quinderé et al., 2013). Therefore, despite the implementation of the *Rede de Atenção Psicossocial* (Psychosocial Care Network) as a public policy in Brazil, there are barriers to an effective health care network. The different organization of work processes in the UBS and the professional turnover were reported as factors that affect the successful implementation of the matrix support. The present study showed that a feasible approach adopted in these units was the identification of a professional with the desire to be a reference in mental health. This result was not found in other studies, and it shows the need for flexible arrangements in the UBS and indicates knowledge improvement.

Another finding is related to the therapeutic groups in the community, which were implemented before the matrix support and are not restricted to a particular geographical region. The members can participate in different groups, according to their need or desire, which allows a non-regulatory approach and the expansion of sociability networks and support in

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the territory. The professionals recognize that the matrix support and the therapeutic groups are different activities; however, they influence each other and are aimed at the same purpose, decentralization of mental health services.

Similarly, the professionals are not the only ones to move back and forth around USF and UBS to participate in matrix support meetings and clinical case discussions; the UBS practitioners also go to different health care units to establish face-to-face interprofessional contact and communication and to learn from clinical case discussions. This way of working strengthens interpersonal relationships, and it is an important invisible resource for the continuance of matrix support.

Despite the different barriers discussed, which demonstrate the complexity of the process, through relational, personal, and systematic work, the professionals can support a particular proposal. Therefore, considering that the through supervision and support, the professionals can promote the expansion of mental health care in UBS, identifying the supporters who have the desire for and are motivated to work is of extreme importance. Otherwise, the matrix support may not survive due to the obstacles and barriers. Accordingly, an increase in knowledge indicates the need to select and hire specialists with a "supporter profile". In other words, being a mental health specialist, although essential, does not necessarily qualify the professional to work within primary health care.

Contributors

A. HIRDES is responsible for the conception and design of this study, data collection and analysis, and manuscript writing. M.K.R. SILVA contributed to the transcription of the interviews and focus group discussions.

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