DOI: https//doi.org/10.13037/ ras.vol18n66.7320

Original Article

Received on: 31/08/2020 | Accepted on: 19/11/2020

Mental health care actions in primary health care: contributions from matrix support

Ações de cuidado em saúde mental na atenção primária à saúde: contribuições do apoio matricial

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Abstract
Introduction: matrix support is considered something new in the context of mental health and primary health care, requiring further study and innovations in practices and actions that adequately respond to the complexity of this challenging work tool. **Objective**: to evaluate mental health care in the territory provided by reference teams from a small city in Rio Grande do Sul. **Materials and Methods**: a qualitative study in the perspective of the fourth generation evaluation. Conducted between December 2018 and February 2019 through participant observation, totaling 84 hours; semi-structured interviews through the hermeneutic-dialectic circle, with a focus on the matrix support work in mental health, with eight professionals from the different reference teams in the city; and validation and negotiation group with professionals. **Results**: the main results highlighted by the professionals of the reference teams are that mental health care is carried out in individual care of people, home visits, mental health groups and monthly activities that stand out as important moments of self-care of the population and training of professionals. **Conclusions**: in the assessed context, there is an important diversity of mental health actions in the territory, which takes place in an integrated manner between reference teams and matrix support. In addition, it proved challenging, but satisfactory when viewed collectively, dialogically and horizontally between the different social actors.
Keywords: Mental health. Primary health care. Family health strategy. Comprehensive health care.

Resumo
Introdução: o apoio matricial é considerado algo novo no contexto da saúde mental e da atenção primária à saúde, necessitando de aprofundamentos, inovações de práticas e ações, que respondam adequadamente a complexidade desta ferramenta de trabalho desafiadora. **Objetivo**: avaliar as ações de cuidado em saúde mental no território, realizados por equipes de referência de um município de pequeno porte do Rio Grande do Sul. **Materiais e Métodos**: estudo de abordagem qualitativa na perspectiva da avaliação de quarta geração. Realizada entre dezembro de 2018 e fevereiro 2019, por meio de observação participante, totalizando 84 horas; entrevistas semiestruturadas por meio do círculo hermenêutico-dialético, como foco no trabalho do apoio matricial em saúde mental, com oito profissionais das diferentes equipes de referência do município; e grupo de validação e negociação com os profissionais. **Resultados**: os principais resultados destacados pelos profissionais das equipes de referência são de que o cuidado em saúde mental é realizado em atendimentos individuais das pessoas, de acompanhamentos domiciliares, de grupos de saúde mental e das atividades mensais que se destacam como importantes momentos de autocuidado da população e de formação dos profissionais. **Conclusões**: no contexto avaliado há uma diversidade importante

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de ações de cuidado em saúde mental no território, o qual se dá de forma integrada entre equipes de referência e apoio matricial. Além disso, demonstrou-se desafiador, porém satisfatório quando encarado de forma coletiva, dialógica e horizontal entre os diferentes atores sociais.
Palavras-chave: Saúde mental. Atenção primária à saúde. Estratégia saúde da família. Assistência integral à saúde.

Introduction

Matrix support is a health care tool, encompassing the logic of interdisciplinary and collaborative work, with the purpose of providing comprehensive and resolute care[1,2]. Its conformation can take place in different ways, adding different services and places of the health care network (*Rede de Atenção à Saúde*, RAS), which may occur between the teams of the family health strategy (*Estratégia Saúde da Família*, ESF) and the extended family health center (*Núcleo Ampliado de Saúde da Família*, NASF), the NASF and the psychosocial care center (*Centro de Atenção Psicossocial*, CAPS), ESF and CAPS teams; in short, different ways of working in health and different compositions across the network units.

These teams, in the field of matrix support, are called 'reference team' and 'matrix support team'. The reference teams are those responsible for direct assistance to individuals, have an assigned territory, and receive assistance from the support teams. While matrix support teams are responsible for technical-assistance and didactic-pedagogical support together with the reference teams[2]. Matrix support is a tool that has a considerable scope of use, especially in the field of mental health[3].

Also called "matrixing", matrix support gives priority to comprehensive care for people, standing out as a tool for the management and organization of health work. The reference team is assisted by a specialized support team and they collectively perform care actions in the territory, which need to be systematically monitored and evaluated.

This evaluative stance is current and necessary for advancing in the field of health, management, work processes and assistance. The evaluation can occur through different objectives, which vary according to the subject who asks the question: when the manager asks, the evaluation probably serves to define whether any program or policy is really working or needs adjustments; the researcher, on the other hand, acts from the perspective of producing knowledge based on reality, knowledge with the potential to be incorporated into policies in the medium and long term, foreseeing transformations; and, last but not least, the user, when carrying out the evaluation, provides feedbacks of the services that are offered, analyzing their effectiveness and quality, among other aspects[4].

The Ministry of Health seeks to understand the evaluation as a fundamental stage for updating and reorienting the paths taken with regard to the health actions and services[5]. For this reason, it is essential to carry out evaluations in the field of mental health care, as they are relevant and contribute to the social actors (researchers, workers, managers, people with mental disorders and family members), together with the agencies and public institutions, so that they develop actions that ensure the care of individuals in psychological distress[6]. This assistance needs to be based on humanized, effective actions, aiming at psychosocial care and rehabilitation, based on the principles and guidelines of the Unified Health System (*Sistema Único de Saúde*, SUS).

Thus, this study proposes a participatory and responsive evaluation strategy created based on the constructivist paradigm, in which claims, concerns and questions of the interest groups serve as the organizational focus of the evaluation process, constituting a fourth generation evaluation[7]. Thus, matrix support has been

used on a large scale in the field of mental health and there is lack of evaluations that highlight the effects of the practical use of the support tool for the health professionals[3].

Matrix support is considered new in the context of mental health and primary health care (PHC), requiring further study, innovations in practices and actions, with an interdisciplinary composition and with the involvement of actors who seek to answer the complexity of this work tool that is young and, at the same time, challenging. Based on these premises, this paper aims to evaluate actions in mental health care in the territory taken by reference teams in a small city in Rio Grande do Sul.

Materials and Methods

Study sample and type

This is a qualitative study using the fourth generation evaluation[7]. It derives from the thesis entitled "Evaluation of matrix support experiences in mental health in a health region of Rio Grande do Sul"[8]. It was composed of two research stages, the first was the characterization of the support centers for primary care – mental health in Region 2 – Entre Rios, in the state of Rio Grande do Sul, and took place in three cities that maintained the Support Center for Primary Care (*Núcleo de Apoio à Atenção Básica*, NAAB – mental health) via the Google Forms electronic form. The second was the fourth-generation qualitative assessment of matrix support, which was carried out in a city in the region that stood out in the first stage with respect to the attributions listed by Resolution No. 403/11 – CIB/RS, which creates the NAAB in the State Mental Health Policy[9].

Eight professionals from the reference teams participated; the choice was made based on the hermeneutic dialectic circle, previously highlighted. The participants were three nurses, two nursing technicians, two community health workers and one physician. The professionals were identified with the letter "E", followed by the interview number (1, 2, 3, 4, ...).

Data analysis was based on the Constant Comparative Method, which is divided into two stages: the first consists in the identification of the information units; and the second concerns the construction of thematic groups or categorization. Only after the validation and negotiation group is formed is that the definite thematic categories or nuclei are constituted[7].

The ethical aspects were considered at all times in this study, and the participants signed the Free and Informed Consent Form. The research was submitted to the Committee of Ethics in Research (*Comitê de Ética em Pesquisa*, CEP) with human beings of the Nursing School of the Federal University of Pelotas, approved under opinion No. 3,038,987 of November 26th, 2018, an obtaining a Certificate of Presentation for Ethical Appreciation (*Certificado de Apresentação para Apreciação Ética*, CAAE) under number: 02237118.2.0000.5316.

Research design

The study was conducted in a health region of the state of Rio Grande do Sul, with data collection between December 2018 and February 2019. For data collection, a previous ethnography was performed through participant observation, totaling 84 (eighty-four) hours. The observation occurred in the daily routine of the health services, following the daily routine of the professionals, in home visits, individual and group appointments, meetings and activities; the records were made in the format of field diary notes. In addition, the interviews were conducted using the hermeneutic-dialectic circle, totaling eight interviews, with a mean duration of 27.85 (twenty-seven point eighty-five)

minutes per interview. The interviews took place in private rooms with each professional and were audio-recorded and transcribed in full. And the meeting was held in a validation and negotiation group, lasting 1 (one) hour and 53 (fifty-three) minutes, which took place in the meeting room of the health secretariat, with recording and full transcription of the content, in addition to the observations recorded in field diary notes.

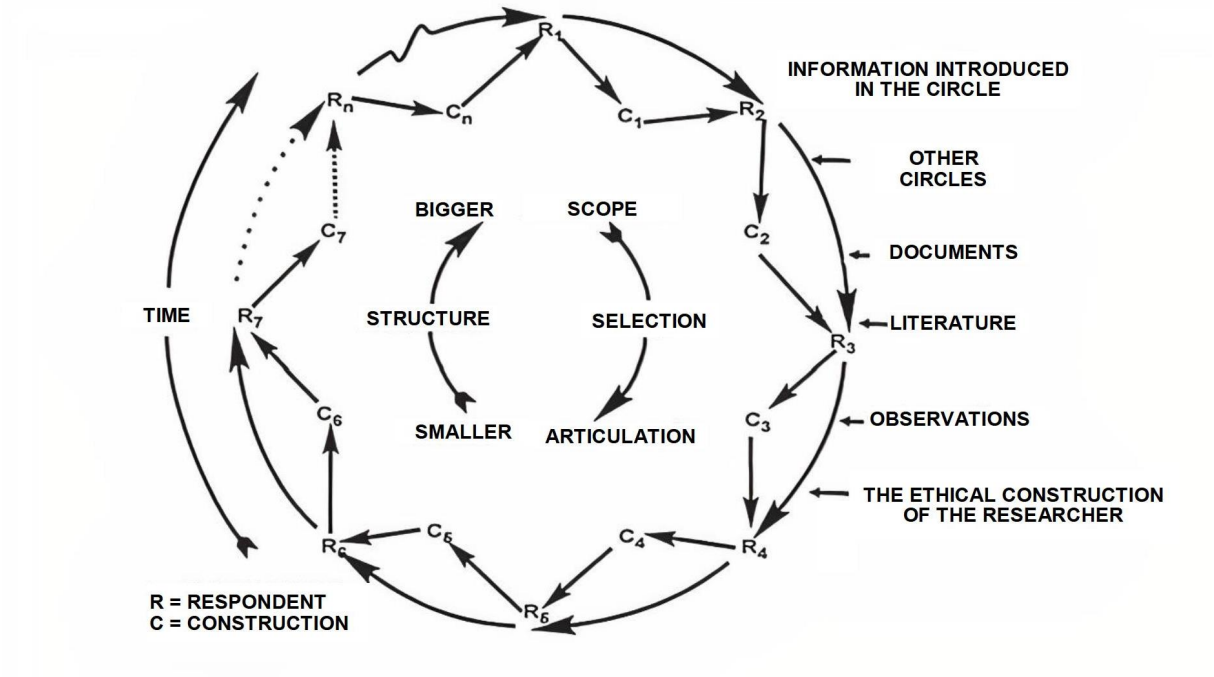
Inclusion and Exclusion Criteria

The following selection criteria were used: being a professional working in a reference team (ESF) of the city, being over eighteen years old, having been indicated in the hermeneutic dialectical circle, accepting to participate in the research, and signing the free and informed consent.

Procedures

The fourth generation evaluation is an evaluation model in which the demands, concerns and questions of the interest groups serve as the focus to organize the evaluation, respecting the methodological principles and the constructivist paradigm[7]. In this stage, participant observations were made in the daily routine of the services, named previous ethnography, which followed the daily lives of the teams, totaling 84 hours of observation, recorded in a field diary. Furthermore, the process of the hermeneutic-dialectic circle took place through semi-structured interviews, with eight professionals from the reference teams of the city.

Figure 1 – Hermeneutic-dialectic circle[7].



The hermeneutic-dialectic circle consists of a methodology for collecting empirical data, as illustrated in Figure 1, in which the researcher intentionally chooses an initial respondent (R1), who is an individual that occupies a strategic position in relation to the object of the assessment (in this case, a professional who stood out in mental health actions in the territory). Next, an open interview is conducted to determine an initial construction regarding what will be

investigated. The respondent is asked to comment on the claims, concerns and questions, and on positive and negative aspects of the service[7].

At the end of the interview, the respondent is asked to indicate another respondent (R2), whom they consider to have constructions different from their own. The central themes, concepts, ideas, values, problems and questions proposed by R1 are analyzed by the researcher, in an initial formulation of its construction, called C1[7].

Later, R2 is interviewed and after, asking their own questions, the themes of R1's analysis are introduced, and R2 is invited to comment on them. As a result, the interview with R2 produces information not only about R2, but also critical to R1's demands and constructions. The researcher requests the indication of an R3 and completes the second analysis (C2), with more informed and sophisticated constructions based on two sources. The process continues at this pace, adding new subjects, until the information becomes redundant or until two or more constructions remain in conflict in some way[7].

From this process, negotiation took place through the validation and negotiation group with professionals from the reference teams who participated in the hermeneutic-dialectic circle. At this meeting, the main results of the field work were presented and the consensus and dissensus were systematized together with the participants; there was also a discussion and search for possible solutions to the difficulties, thus marking the day for exiting the field research.

Describe in detail which procedures are performed in the interventions. If the procedures used already have solid references in the literature, quote the source of the procedure and describe it. If it is a new or little used procedure, describe its origin, in addition to quoting the reference.

Results

In their speeches, the reference teams indicate the mental health care actions that are taken in the city, which, in most cases, are supported by the matrix support centers, in particular by the NAAB, which is the center responsible for mental health care. The team members understand that care for this population occurs: during home visits; in individual appointments; in mental health groups; and in monthly activities.

Home Visits

It is possible to notice the articulation of the professionals from the reference teams in carrying out the visits in a shared manner with the matrix support, seeking to focus on the issues of greatest need in the territory, as evidenced in the following interview excerpt:

We make visits; these shared visits are focused on this public, really focused on them. (E2)

Another professional highlights how they plan and how they use this tool:

I think that the visits [...]. Whenever necessary, we expose at the meeting, then if they think it is necessary and there is a possibility, we do it [...]. They never refused, when we call for something; if someone can't, then the other comes, they are very participative. (E4)

Individual Appointments

Another care action that the professionals in the reference teams indicate is the individual appointments, which are seen as an opportunity for mental health care, as shown in the following statement:

Individual appointment and I have actually called the user a lot to talk, to get to know [...]. (E3)

In addition to the clinical care provided by the professionals in the ESF teams, there is also the satisfaction of demands by professionals of the centers

and the specialized assistance professionals, who work with the municipal polyclinic, as monitored in the observation. It is worth noting that the professionals recognize the individual appointments conducted by the medical professionals, but they also highlight the rest of the team, such as nurses, psychologists and other professionals.

Mental Health Groups

Another action indicated is the mental health and coexistence groups, which are highlighted as a mental health care strategy in the territory For this, matrix support is integrated with the ESF teams through the organization of groups, which can be shared between the support and the supported teams, or specific, carried out by the support, as shown below:

We create groups, well-being group, one group per month. We take the waiting room and they love the group, they leave thrilled but they do not return; they are delighted with the activity. In these groups, we seek to search and integrate professionals from the NAAB and the NASF. So that everyone can offer a little bit of experience, knowledge of each one, or together or separately, everyone, and always happens with one. A team member is responsible for the group with a member of the NAAB and the NASF. (E2)

It is important to highlight that each unit has autonomy in the way of organizing groups in PHC. Thus, there is diversity in the composition of the groups and in the internal organization of each one. There is integration of the professionals from the reference teams with the matrix support centers in the groups, with the collaboration of each professional.

Some difficulties that the teams experience with the mental health groups are highlighted in the following excerpt:

It is a difficult area to work on. It is precisely the group that we find it most difficult to invite the participant, and it seems like they often come, they like it a lot, but they are more relapsed and end up not coming back, you know? It seems like this is the group that we most enjoy doing and is the group that the fewest people end up participating. (E1)

From the observation, it was possible to notice that there is diversity in facing these difficulties in the city. There are units that, despite facing difficulties and resistance, carry out the health groups in the waiting room or through specific groups. On the other hand, there are units that have similar difficulties, but that do not carry out any collective intervention with people with mental disorders.

In order to overcome issues like these, some professionals create alternatives, thinking that the groups could be experiencing difficulties due to the way the teams were calling the space. From that, they built solutions and new possibilities, according to the following statement:

The population always shows a little resistance to participate in this group. We changed the name to see if they show more adherence, but no. The population is still not careful with prevention. They think that, if they go to the doctor, they will give them some medicine and the treatment is done [...] I don't know if it's fear, if it's shame, I don't know what it is. And bring them, to participate in this group, although we don't even mention that name [...] but the name is well-being and it is for everyone, but it is difficult, very complicated to invoke the population to participate in this group. (E2)

It is necessary to reflect that, at some moments, the professionals recognize and attempt to review what happens with the group, not focusing exclusively on the people, but trying to understand what the team may be doing wrong. Thus, some strategies are listed below:

We've already reconsider the strategy to bring them [...] and the public here in our community prefers the mornings; it is in the morning that things

happen here; the other groups that gather together in the morning, we have greater participation. But in the afternoon it seems like a hindrance for them to come to the unit. (E2)

The discussion about the shift is essential as the professional notices that there is a shift in which the population attends the service and this is fundamental, since the activities need to be conducted at that time. During data collection, it was possible to notice that the reference teams show goodwill, some with more initiatives than others but, as far as possible, they strive for the actions to be carried out.

The reflection on the groups is something that the professionals have been active at, and they list situations that need to be guided and discussed with the entire group:

The population is used to coming to the unit with the doctor, and recently that is changing. The group of hypertensive and diabetic people, they like and they come, because the focus is to check the HGT (hemoglucotest) and to measure their pressure. And now in this mental health group, what do they think they're going to do? Take care of what? What are they going to check here? And what will we say we will take care of? Of themselves? But I'm not sick, I'm already taking my medicine. It's very complicated and our point is to find a strategy to bring more people into the unit, and we certainly have been trying. Wow! We have already made visits, we have made posters, fliers, invitations on the networks, everything, and we have found difficulties [...]. It's very focused on disease and medication. I think maybe if I said that they were going to check something, to do some exam, maybe they wanted to, because they still haven't realized the importance of having moments like these. (E2)

If we create a group of diabetics and hypertensive patients, it is crowded. But the part of mental health is very difficult. I don't know why this happens. Or if it happens because it's in the central area and they think they are not going to come because someone will know, that kind of thing. (E7)

It can be verified that different units have similar problems, and the professionals propose issues that need to be addressed. One aspect concerns the understanding of the biomedical model of health care, linked to the groups, while the other refers to the question of the stigma that people with mental disorders suffer in society.

Monthly Activities

Other spaces understood as for mental health care are the monthly activities that take place in the city. Each month includes an activity on a specific topic. In these activities, there are interventions with the professionals, following the logic of permanent education in health, and interventions with the community.

These activities are annually promoted by the Ministry of Health based on the organization of social movements and associations or institutions in the health area, which prioritize certain months and establish colors to emphasize care with certain diseases, with a media and marketing approach in disease prevention actions.

Based on this, it is necessary to understand the diversity of issues that are addressed during the year by the professionals from the municipal network. Regarding the month of mental health, a professional reports what was accomplished:

In January, there was "white January", which refers to mental health. So we threw a little get-together at the unit, we invited users to discuss and debate. We had a conversation circle, a little get-together, with music; in short, it was a very constructive space for discussing mental health with the users, the team and with the participation of the NAAB. (E3)

Discussion

The professionals state that the visits are conducted in a shared manner with the matrix support, highlighting the participation of the centers in this process. In addition, they understand the rational use of the support device because, by highlighting that the visits are made as needed, they demonstrate such concern, since it is impossible to make shared visits to all people in the territory. In addition, there is organization at the time of the meeting, in which the professionals expose the situations; this space is for discussing case measures and defining actions based on what was discussed.

Home visits are one of the tools that constitute the therapeutic arsenal of the territorial-based health care devices. Thus, the CAPS and the ESF are services that maintain intrinsic competence in conducting home visits, being used for different reasons in the daily routine of these teams. The ESFs keep regular visits in their territories due to the vast demand for appointments. First older adults, home or bedridden patients are prioritized, followed by the issues of vulnerability and psychosocial complexity. The latter, in particular, has matrix support as a support and aid in longitudinal monitoring[10].

However, during the process of previous ethnography, it was possible to notice that difficulties such as social vulnerability are a complicating factor in mental health care. Thus, the city under study presents important data regarding the population's income, with approximately 36% being in extreme poverty or poverty. This number is provided by the management and visualization system of the several programs, actions and services of the Ministry of Citizenship[11].

The percentage of people in vulnerable situations, according to their income, can be considered high for the reality of the city under study. Furthermore, it is highlighted that the data from the *Bolsa Família* Welfare Program corroborate the fact that the individuals who are beneficiaries of the program transit through social assistance, health and the education network. Thus, they are monitored by the public services existing in the city territory. However, the professionals from the reference teams recognize the importance of social vulnerability in the field of mental health.

Care must be taken when making the association between psychological distress and social vulnerability issues so that there is no simplification of logic, associating madness with poverty. This association tends to reinforce stigma and prejudice towards people with mental health needs. Additionally, Gama, Campos and Ferrer[12] seek perspectives that allow for an approximation with mental suffering, without the need to categorize it, thus enabling greater flexibility in its comprehension, in addition to the production of various understandings and countless intervention possibilities in this field.

In this sense, a study carried out in a large city in the Southeast region sought to evaluate the articulation between PHC and the mental health network in regions of high social vulnerability. The professionals revealed a feeling of impotence in the face of social vulnerability and said that they perform palliative treatment, which consequently causes extreme medicalization of the symptoms in the field of mental health. Furthermore, they verify that matrix support is an important tool for defining flows, qualifying teams and promoting shared assistance[13].

Thus, there is a need to transform the health practices by overcoming the view of the disease as the centrality of care, of curative and medicalizing assistance. Thus, interventions are proposed to give meaning to mental suffering, to value the social relationships of people with mental disorders, and to seek the real social insertion of the individuals, promoting autonomy and freedom[12].

The use of the individual assistance

tool is then an alternative for interventions with people in mental distress. Thus, individual appointments facilitate some processes, such as: focus on people's specific needs; attentive and qualified listening to demands; and ease of creating and strengthening bonds (due to the proximity that is established in this type of service).

However, caution is needed so that the matrix support team does not become an outpatient care team and devotes only to individual appointments. And that the reference team does not devote only to individual appointments, failing to carry out other activities in the territory. Because, if this occurs, there is a risk of filling the schedules with this type of care and so no room is left for other powerful activities in mental health care.

The focus on individual appointments can be the result of how some professionals, with a traditional view, understand their work. Or it can even be a weakness of the network that has professionals who exclusively provide this type of service. And, in this context, matrix support sometimes absorbs this demand and provides individual appointments to the detriment of other types of assistance.

In this sense, a study with psychologists who work in matrix support indicates that the individual clinical action of these professionals is a reflection of the traditional model of praxis, often facilitated by the initial training of the professionals, with exposure of this practice in the education process or in the theoretical-methodological approach used by the professional[14].

Matrix support has a different care logic in PHC and it is not at all simple and, even so, it relies on the individual and private view of professionals, managers and people who use the services[15]. This view imposes a challenge in the daily routine of the services that seek to overcome the traditional models of health care and to advance in the provision of health in a collaborative, inter-professional and collective way.

With regard to the groups, studies in different realities of matrix support analyze the insertion in the groups. The experience in the city of Belo Horizonte shows, in the matrix support routine, little investment in group activities, with greater emphasis on individual appointments[16]. While in the city of Gravataí, in the state of Rio Grande do Sul, matrix support occurs in two different ways, with therapeutic groups in PHC and the support itself together with the reference teams[17].

An official Brazilian document states that the supported teams need to identify matrix support as a group of professionals who offer support to the teams, and that they have important singularities in the composition of the body of workers, with specificities. Thus, it presents an example of support, helping the ESF in the conduction of therapeutic or educational groups, taking advantage of the potential of the support professionals and of those from the reference teams[18].

In addition, the document provides the differences between the shared and specific collective activities. In the shared activities, the matrix support centers support planning and execution, which can be requested by the teams or by the management, and even by the support center itself, based on the identification of the need. In the specific activities, the collective activity is coordinated by the professional in the center based on their professional knowledge; the participation of ESF professionals is recommended as a tool for permanent education in health[18].

Regarding the difficulties faced, a study on the insertion of mental health actions in the ESF showed that the activities are centered on individual appointments and with a focus on the medicalization processes. In this sense, no reports were found on the conduction of therapeutic groups or other collective activities in the care for the population with mental health care needs[19].

The biomedical model is introduced

from the 1910 Flexner Report, when an American physician introduced questions regarding medical training that should be focused on biological research and on the diseases. It became a reference for the organization of the clinical models, since its basis was medical prescription, medicalization, hard technologies and specialized knowledge[20].

From this, the biomedical model can be seen influencing, in a certain way, the population's perspective. This is evidenced by verifying that, in groups of chronic diseases, such as hypertension and diabetes, people seek to 'measure' something. Thus, it is possible to note the resonance of this model centered on diseases, medication and exams.

In this sense, that model is hegemonic in today's society and, consequently, people with mental disorders are also captured by it. Therefore, it is necessary to build other alternatives in the consolidation of the groups, that is, to reflect that the collective space needs to promote health, welcoming all the individuals, regardless of their clinical conditions, being built in a dialogical and horizontal manner. Groups of chronic conditions are important for preventing diseases, but end up reinforcing the biomedical model. Thus, it becomes necessary to think about health promotion groups, seeking to include the largest number of people and promoting self-care in the territory, freeing itself from that model centered on the disease in favor of a model that valuespeople's health.

The evaluative and participatory research proposes that the professionals occupy the position of thinking and reflecting on their practices and daily activities. This tends to contribute so that some strategies are devised to solve problems and difficulties. The change of name, dates and times was a plan to try to solve the issue, but it was in vain. This is due to the stigma that madness faces in society as a whole; it can also be due to the way the service is seen by the population, the form of organization or the difficulties in training in the field ofmental health.

Thus, mental health is a broad area of knowledge and involves, among other aspects, the use of soft technologies in the care of people. Therefore, one of the explanations for the 'emptying' of the mental health groups can be in the concept of care centered on the people, which does not directly require the use of hard technologies[21].

Another aspect that makes the conduction of mental health groups more difficult is related to the stigma that people with mental disorders carry before society. This stigma is the result and consequence of misinformation about mental disorders. For these situations to be overcome, the professionals have co-responsibilities in combating the stigma of mental disorders. People need to be seen beyond their conditions or diseases and understood as subjects of their own history[22].

Regarding the monthly activities, it is verified that preventive actions have been taking place in different spaces, driven in particular by the campaigns of the "colored months", extending from simple blood pressure and capillary glucose checks to invasive tests, such as cervical preventive and rectal exams[23].

It is necessary to reflect on the positive mobilizations that these movements produce in society, awakening self-care. But they can offer risks and limitations, such as actions that are not always ethical, scientifically justified and indicated for a specific population, generating unnecessary investments and exposing people to procedures that are not indicated[23].

Based on this discussion, it is possible to conclude that the monthly activities carried out by the city are powerful in the sense of stimulating the population for self-care regarding specific topics. They also contribute to integration between the reference teams, the matrix support centers and the population of the city, who work collectively so that the

actions are made possible. On the other hand, it is understood that the use of the "colored months" can also be a trap, since it most often highlights the disease. And, as discussed so far, the ESF and matrix support work with a focus on health, aiming at the promotion and transformation of the practices.

If, on the one hand, there are campaigns that put the issues under discussion in the media, in the health services and in society as a whole, on the other hand it is understood that health care is something of everyday life that needs to occur every day and in a particular way for each person. Thus, the "colored months" do not take into account the therapeutic itinerary of each and every person. This itinerary is something individual and health professionals need to look at the person based on their trajectory. People seek different care strategies through spirituality, integrative and complementary practices, biomedical model and where they feel most comfortable. Because of this, it is necessary to think about the monthly activities with great caution and considering the cost-benefit of these actions in health care.

Conclusion

It is noteworthy that the mental health care actions carried out by the reference teams of the city under study receive specialized assistance from matrix support and have significant importance, as they seek to promote mental health in the territory in different ways and by integrating the actors. The ESF teams recognize that they provide this care through individual appointments, home monitoring (often shared with matrix support professionals), mental health groups and monthly activities, which stand out as important moments to encourage self-care among the population and the training of professionals.

From this, it is necessary to recognize that there is diversity in mental health care actions and, therefore, the offer becomes dynamic and heterogeneous in the territory. Thus, they contribute to the development of autonomy and insertion of people in psychological distress in society, since the actions are based on psychosocial care and rehabilitation, following the SUS principles and guidelines, occurring satisfactorily from an evaluative point of view.

Another aspect that deserves to be highlighted in this evaluation process is the fact that the reference teams recognize their limitations and difficulties in providing mental health care. It is worth highlighting the discussions about the groups, in which the teams have difficulties and seek alternatives to overcome, problematizing important discussions in the current context. In addition, the evaluation seeks to establish itself as a permanent process for the teams and to provoke reflections on the possible changes in reality, based on the professionals' understanding.

This research has limitations for being a single case study, which does not allow for confrontation and comparison with different realities. However, it seeks to use and present mental health care strategies in the territory, made possible by ESF teams with the assistance of matrix support, devices available in most Brazilian cities. Care needs to be prioritized in the context of the ESF; even though challenging, it needs to be seen collectively, dialogically and horizontally across the different actors, in addition to being technically based, with respect to freedom, human rights, seeking social insertion, valuing the autonomy of people and the humanization of relationships.

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Como citar este artigo:

Weiss Pinheiro GEW, Kantorski LP**.** Mental health care actions in primary health care: contributions from matrix support. Rev. Aten. Saúde. 2020; 18(66): 69-81.