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INTEGRATION BETWEEN THE FAMILY HEALTH STRATEGY AND THE PSYCHOSOCIAL CARE CENTER

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ABSTRACT

Promote a critical and updated reflection on the articulation between the Family Health Strategy and the Psychosocial Care Center, demonstrating its importance and the problems faced by analyzing articles on the articulation between these two specialized services, providing a better understanding of the subject and emphasizing the need for research in this area of activity. We opted for a qualitative approach, because of a literature review of contemporary scientific articles relevant to the theme, taken from the bases of Lilacs and Scielo to compose the theoretical framework. There are several obstacles to the articulation work between the two service networks. It makes necessary to build a structured and adequate knowledge to meet the complexity of the demands of those who seek help from both devices for comprehensive health monitoring mental, being necessary to resort to the matrix. It was concluded that in the organization of the mental health network, the relationship between CAPS activities and the FHS appears more as theoretical principles and not as they should occur in daily life, demonstrating that there is still a gap between the guidelines proposed by the health policy, mental and concrete practices.

Key words: Mental Health–Health Strategy–Psychosocial Care.

1 INTRODUCTION

In Brazil, about 15 to 20% of the population has some kind of psychosocial suffering, requiring care in the field of mental health [1]. Therefore, it is necessary to expand the lines of care and to establish an appropriate and accessible health care system that brings together all the key elements to promote a cooperative approach to welfare for all. Thus, an articulation between the Psychosocial Care Center (PCC) and the Family Health Strategy (FHS) devices aims to increase resolvability and produce greater accountability for mental health situations [2]. In an attempt to find theoretical support, this work aimed to better understand how we can achieve the articulation between the FHS and the PCC, aiming at comprehensive care and demonstrating the benefits of this form of association.

The development of works with this focus assumes importance as they aim at improving the mental health care offered by current public services through the production of knowledge, providing theoretical support, as well as contributing to reflection and debate on the subject. In this sense, it is essential to deconstruct the traditional care model in the field of mental health, which places certain services that are responsible for certain demands. Without changes in the assumptions and paradigms that guide the traditional care model, a satisfactory response to the modes of care cannot be expected.

For a chance to take place, it is necessary to look again at the subject as a whole and not only consider the disease itself. For this, it is also important to consider that this work aims to promote a new vision of ”care” based on principles and guidelines that envision the construction of more humane and more welcoming ways of thinking and promot-

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ing mental health, implying the elaboration of new ways to contemplate this perspective more broadly and in solidarity. Through the theoretical foundations, strategies have developed that allow the expansion of the frontiers of action beyond the territories demarcated with limits of responsibilities. These are proposals that seek to transform the relationships that society, subjects, and institutions establish with people who suffer from a mental disorder, leading these relationships to overcome the stigma of being called "the madman", aiming to ensure dignified attention, welcoming, singular and responsible to all people who are in psychological distress.

2 METHODS

The methodology used for the development of this work was the qualitative analysis. At first, a literature review was performed, searching for materials in relevant articles that deal with the topic of interest as a form of a strong theoretical basis. This narrative review did not use explicit and systematic criteria for searching and critically analyzing the literature. As only experience reports have used, the selection of studies and interpretation of information may be subject to the subjectivity of the authors.

In this systematic search for data independently, the Descriptors in Health Sciences (DeHS) used Mental Health, FHS, Articulation, Matriciation, and Integrality. These descriptors have initially researched in isolation. Later, they have combined in groups of two or three to produce a broader search on the topic in the Latin American and Caribbean Health Sciences Literature (LILACS) database, Scientific Electronic Library Online (SciELO), and Electronic Psychological Journals (EPJ). It has not delimited the time of publications of the researched works by observing that the theme in question is not a current problem.

This article has as its research source 37 scientific articles and a book that deals with the articulation between the specialized services in mental health (SMH) and primary health care (FHS). In the first instance, a target theme has raised to guide data collection, generating analysis and interpretation of the results and conclusions that each article presented. As for the articles discussed here, they include Matrix Support and the articulation of the FHS and PCC from 2006 to 2016. The authors under discussion are: Souza, 2006 [3]; Dimenstein & Bezerra, 2008 [4]; Arona, 2009 [5]; Delfini & Reis, 2012 [6]; Chiavagatti et al., 2012 [7]; Pinto et al., 2012 [8] ; Pegoraro et al., 2014 [9]; Hirdes & Scarparo, 2015 [10]; and, Camatta et al., 2016 [11].

3 DISCUSSION

The FHS needs to be guided by some guidelines that support its activities. The central strategy was based on the idea of the restricted territory where this form of Primary Care proposes to reorganize the health work process in the face of inter-sectoral operations and actions that promote health promotion, prevention, and care [12]. It has enabled HUS managers, professionals and users to understand the dynamics of territories and their subjects, allowing the denudation of social inequalities and health inequities [13]. In this sense, the territory that delimits the users' education has defined, providing relationships of the bond, affection, and trust between families and professionals, where they become a reference for care, promoting the continuation and resolution of actions related to health and longitudinally of care [14].

The FHS has specific work characteristics, such as keeping the register of families and members updated, using this data to analyze the condition of the health of these individuals. It takes into consideration the social, economic, cultural, demographic and epidemiological factors of the territory, it is possible to define the worked territory, mapping and recognizing the defined area, always keeping this definition updated according to the health risk criteria. The priority is to solve the most recurrent health problems, carry out extended family care through knowledge about the structure and functioning of families, aiming to promote interventions that collaborate to the health-disease processes of the subjects, families and of the community as a whole.

The PCC are institutions that are willing to welcome patients with mental disorders, stimulating their social and family integration and supporting them in their initiatives to build their autonomy, thus offering them medical and psychological care. Thus, integrating them into a precise social and cultural environment, in this case, their "territory", is their main characteristic. For this reason, these centers are the main strategy of the Psychiatric Reform process [15], as they assume a strategic role in the organization of the community care network. Thus, the main objective is to provide care for the population of its territory through clinical monitoring and social reintegration of civil rights, as well as strengthening family and community ties.

There are several types of PCC. These are arranged in PCC I, in which psychosocial care service has the operational capacity to serve in municipalities with a population between 20,000 and 70,000 inhabitants. The PCC II addresses municipalities with a population between 70,000 and 200,000 inhabitants and the PCC III provides services to municipalities with a population of over 200 thousand inhabitants. We still have the PCC I II, the psychosocial care service for children and adolescents, as reference for a population of about 200 thousand inhabitants or another population parameter to be defined by the local manager, according to epidemiological criteria. The PCC ad II provides the psychosocial care service to care for patients with disorders resulting from the use and the dependence of psychoactive substances with the operational capacity to care in municipalities with a population of over 70,000 [16].

The care provided to patients in PCC I and II include activities as individual care (medication, psychotherapy, and orientation, among others), group care (psychotherapy, operative group, social support activities, among others). The attendance in therapeutic workshops, performed by a professional of superior or medium level, the family visits, the

attendance to the family, the community activities, focusing the integration of the patient in the community and their family and social insertion. The patients are assisted in one shift (four hours), entitled to one daily meal, while those assisted in two shifts (eight hours) receive two meals daily [16].

In PCC III, the assistance provided is the same as in I and II, but it adds the night reception, on holidays and weekends, with a maximum of five beds for eventual rest and/or observation. The stay of the same patient in the night care is limited to seven calendar days or 10 days in 30 days [16]. In PCC I II, what adds is community activities focusing on the integration of children and adolescents in the family, school, community or any other form of social inclusion. In PCC ad II, community activities have added, focusing on the integration of drug addicts into the community and their social family insertion and detoxification care [16].

According to Campos & Domitti [17], Matrix Support is a form of work that has characterized by being the back of a specialized team, offering both technical and pedagogical support. This support depends on the shared construction of clinical and health guidelines between the support team and the reference team [18]. The referral team is responsible for conducting an individual, family or community case. This aims to increase the possibilities of a bond building between professionals and users. Where the responsibility for driving is to take care of care over time, similar to what occurs in family health teams. Therefore, the concept of referral staff is analogous to professionals working in polyclinics or hospitals, such as occupational therapists, psychiatrists, and psychologists working in psychosocial support centers [17].

The Matrix Support and Referral teams are organizational arrangements and a methodology that aims to increase the possibilities of the expanded clinic and dialogic integration between different specialties and professions for the management of health workers. Thus, both the referral team and the creation of matrix support specialties seek to create ways to work with increased clinical and health care workers, as a specialist alone cannot guarantee a comprehensive approach. Therefore, such methodology aims to ensure greater effectiveness and efficiency to health workers, but also make an investment in building user autonomy [17].

Overall, Minayo [19] points out the advances and weaknesses of the Unified Health System (SUS), noting that, in practice, the guidelines of completeness and equity have advanced little. This occurs because the HUS, despite advocating universal access to health, works mainly for the low-income population, serving about 80% of this public, while for the remaining 20%, users of private medical services, the SUS acts as a complementary service. As private plans do not offer coverage in cases of high complexity, completeness has become compromised due to the fragmentation of actions and the poor complementarity in health care.

The Human Resources and Training in Mental Health (2005) document reveals that stigmatized attitudes by health professionals can become a barrier that prevents people from receiving the care they need. In the territory in which they find themselves, different forms of interaction with the mentally ill person may be visualized from living together to exclusion and from not recognizing the other. Care in the territory provides the demystification of mental illness, as well as ideas related to mentally ill as dangerous people, who need to be isolated, institutionalized [9].

The PCC can provide theoretical support, taking into account that it is a parallel training, where the Mental Health Team has much to learn from the FHS, considering that it knows very well the territory in which the user lives. The Mental Health Team needs to learn, above all, about the community, its habits, leadership, lifestyle, local culture. Therefore, PCC and primary network teams must work in an integrated manner so that both share responsibility for cases and ensure greater resolution in handling situations involving psychological distress. This way, they can prevent PCC from having the role of serving the user just in a moment of crisis and then return it to the territory to reinsert it socially. It brings us to the asylum model that operates care within a specific location and return it to society. The FHS reproduces a model of initial care that is exempt after referral [20].

The need to insert mental health issues into the dynamics of the FHS becomes daily visible in health practices since the arrival of users with psychological distress in health units is quite frequent and complaints are the most varied. For this reason, staff should be prepared to provide a greater solution to the problems of these users. However, it is observed that mental health care is not effectively addressed by ABS, since at this level of attention still prevails a fragmented conception of the subject - in body and psyche -, which consequently reflects in a fragmented supply of care. Therefore, ABS, instead of assisting the subject in its entirety, delegates psychosocial care exclusively to specialized services in the mental health field.

Each family health team is responsible for an area that corresponds to 600 to 1000 families in a total ranging from 2400 to 4500 people divided into micro areas where each health agent is responsible for an average of 400 to 750 people [21]. It is also expected that in cases already installed of mental illness/disease, primary care seeks to reintegrate the affected people in the community to they no longer suffer from exclusion and social violence [22] . The development of new professional skills, from both experts and generalists, requires openness, flexibility, a learning posture, as well as the ability to put consensus into practice [10]. Working with mental health requires much more than just doing service, requires commitment, understanding, involvement, and knowledge only become valuable when used to turn services into actions. Devices must look for means, not just passively hoping that this articulation will be an obligation rather than a necessity.

The dynamics of the daily problems of the ESF end up giving priority to the immediate and procrastinating other necessary actions. As pointed out by Dimenstein et al. [23], FHS teams are closer to families and communities, so they are of fundamental importance for users to have coverage

Table 1. Technical Team to Act in each CAPS

Psychosocial Care Service	Minimum Technical Team for CAPS
CAPS I - 20 (twenty) patients per shift, with a maximum limit of 30 (thirty) patients/day, in intensive care	- 01 (one) doctor with training in mental health; - 01 (one) nurse; - 03 (three) upper-level professionals among the following professional categories: psychologist, social worker, occupational therapist, pedagogue or other professional required for the therapeutic project. - 04 (four) mid-level professionals: technician and/or nursing assistant, administrative technician, educational technician, and artisan.
CAPS II - 30 (thirty) patients per shift, with a maximum limit of 45 (forty-five) patients/day, in intensive regime	- 01 (one) psychiatrist; - 01 (one) nurse with training in mental health; - 04 (four) h level professionals among the following professional categories: psychologist, social worker, nurse, occupational therapist, pedagogue or other professionals needed for the therapeutic project. - 06 (six) mid-level professionals: technician and/or nursing assistant, administrative technician, educational technician, and artisan.
CAPS III - 40 (forty) patients per shift, with a maximum limit of 60 (sixty) intensive care patients/day	- 02 (two) psychiatrists; - 01 (one) nurse with training in mental health. - 05 (five) higher-level professionals in the following categories: psychologist, social worker, nurse, occupational therapist, pedagogue or other professionals needed for the therapeutic project; - 08 (eight) mid-level professionals: technician and/or nursing assistant, administrative technician, educational technician, and artisan. For the night reception period, in 12-hour running shifts. - 03 (three) nursing technicians/assistants, under the supervision of the service nurse; - 01 (one) mid-level professional in the support area. For noon hours on Saturdays, Sundays and holidays. - 01 (one) higher-level professional from the following categories: doctor, nurse, psychologist, social worker, occupational therapist, or other higher-level professional justified by the therapeutic project; - 03 (three) technicians/auxiliary nursing technicians, under the supervision of the service nurse - 01 (one) mid-level professional in the support area.
CAPS i II - 15 (fifteen) children and/or adolescents per shift, with a maximum limit of 25 (twenty-five) patients/day	- 01 (one) psychiatrist, neurologist or pediatrician with training in mental health; - 01 (one) nurse. - 04 (four) upper-level professionals among the following professional categories: psychologist, social worker, nurse, occupational therapist, speech therapist, pedagogue or other professionals needed for the therapeutic project; - 05 (five) mid-level professionals: technician and/or nursing assistant, administrative technician, educational technician, and artisan.
PCC ad II - 25 (twenty-five) patients per shift, with a maximum limit of 45 (forty-five) patients/day	- 01 (one) psychiatrist; - 01 (one) nurse with training in mental health; - 01 (one) clinical physician, responsible for the screening, evaluation, and monitoring of clinical complications; - 04 (four) upper-level professionals among the following professional categories: psychologist, social worker, nurse, occupational therapist, pedagogue or other professional required for the therapeutic project; - 06 (six) mid-level professionals: technician and/or nursing assistant, administrative technician, educational technician, and artisan.

and treatment for mental illness. In this regard, professionals understand that many users of Primary Care need specialized care in mental health because they understand their territory and their main demands.

Research from the WHO - World Health Organization [24], shows that one in four people develop a mental illness at some point in their lives, and in developing countries such as Brazil, 90% of these people do not receive adequate treatment. There is a high prevalence of mental distress that reach primary care. Campos & Nascimento [25] warn that patients who come to specialized mental health care do not have their needs met by the technologies used by the specialties, but by creative efforts and joint professionals that mobilize and articulate institutional, community, individual, material and subjective resources with a user and social network.

Since 2003, the Ministry of Health, through the document Mental Health and Primary Care: the necessary bond and dialogue prioritizes matrix support as the form of organization of mental health actions with primary care [22] . The actions aimed at articulating the devices should also start from an action plan of the managers where they would put the matrix as a goal to be achieved, but what we see in reality are teams of the two devices with their agendas full of activities for developing their responsibilities to users within the devices in question.

The role of the family health team in the early identification of behavioral changes and other chronic signs of worsening psychiatric disorder has fundamental importance. Besides it, it's needed the monitoring, including medication of

people with mental distress to promote discussion with family and community about the insertion of this user, breaking or minimizing the existing stigma regarding such disorders [26]. These practices should be guided by activities with the proper theoretical safeguards to work in a way that works. Another important issue in the dynamics of mental health care in the FHS is the involvement of the family in the care of users with psychological distress.

PCC is a daily mental health service that is a substitute for psychiatric hospitals. They have a responsibility to assist people with severe and persistent mental disorders, working under the logic of territoriality. These services have regulated by Ministerial Ordinance GM 336, of February 19, 2002 [26]. PCC works with a multidisciplinary team and the activities developed in this space are very diverse, offering care in groups and individuals, therapeutic and creative workshops, physical activities, recreational activities, art therapy, besides medication, which was considered the main form of treatment. In this service, the family is considered as a fundamental part of the treatment, having specific care (group or individual) and free access to the service, whenever necessary [27].

According to Brazil [15] , PCC also has a responsibility to organize the mental health services network in its territory: to support and supervise mental health care in the basic network. The practices performed in the CAPS have characterized by occurring in an open, welcoming and inserted in the city, in the neighborhood. The projects of these services often go beyond their physical structure in search of the social support network that enhances their actions, worrying about the subject and its uniqueness, its history, its culture, and its daily life. Through support, PCC should provide matrix support to primary care teams, that is, provide them with guidance and supervision, jointly address situations more complex, conduct home visits accompanied by primary care teams, address complex cases upon request for care basic.

The articulation with the FHS can provide the formulation of new attention technologies, theories, and practices, and characterize it as an innovative device because the idea of innovation brings with it a character of rupture that has been established. If there is no broad mobilization and ethical-political commitment of planners, managers, and workers about this inversion of the care model, there is a risk that promising experiences, such as mental health in primary care, reproduce the logic of health care, of examinations and diagnostic patterns and poorly resolved referrals [3].

For this reason, the relationship between the FHS team and the CAPS mental health team is a new organizational and methodological arrangement that allows a broader look at the clinic, as well as a more enriching dialogue between professionals from the most diverse specialties. According to the literature, the actions of matrix support in mental health should start from CAPS, equipment that occupies a prominent place in the promotion of mental health from the Psychiatric Reform [23].

The comprehensiveness of care beyond the constitutional concept should be considered as a value to be reflected in the professional's attitude, regardless of which HUS device he works, implying in recognizing health demands and needs, as well as prevention and prevention actions, promotion and rehabilitation actions. The insufficient integration between the CAPS and the FHS reveals a need to strengthen the relationship between Psychosocial Care Networks so that quality care can be developed for the user, respecting important HUS guidelines, described by article 198 of the Federal Constitution of 1988, as the Integrality of care [28] . In the health field, the word matrix indicates the possibility of "suggesting that reference professionals and specialists maintain a horizontal rather than vertical relationship, as recommended by the tradition of health systems" [17]. In turn, the term support indicates a horizontal relationship without authority based on dialogical procedures.

4 RESULTS

To better analyze the results, nine articles referring to Matrix Support, or the articulation of the FHS, or the articulation of the PCC were been selected from 2006 to 2016. Table II presents the authors and their authors and the year of publication, as well as the objectives of each selected article (study basis for current scientific material):

It can be seen that among the articles discussed, one is from 2006, one from 2008, two from 2009, two from 2012, one from 2014, one from 2015 and one from 2016. It can be observed that the theme Support Matrix in mental health, as well as the possible implementation of mental health in primary care, is a subject that requires discussions that lead to solutions for service improvement. Thus, it is clear that this is a theme of recurring concern since it has been a research subject to the present day.

Table III shows the types of studies, that is, how the methodology used to carry out each research carried out by its respective author.

Two articles have performed as literature/literature review, obtaining a qualitative character; an article has given descriptively and analytically also with qualitative character. Another article was conducted in a critical and reflective perspective, still with qualitative character and five articles with an emphasis on field research. Evaluating these aspects, according to MINAYO (2010), this may be a result of the need to be closer to the object of study. Its reality besides the use of different data collection techniques includes semi-structured interviews, participant observation, use of photographs and ethnographic strategies.

It is possible to note that the existence of new care strategies is necessary within the mental health care policy. It is also verified that few territories are working with Matrix Support and those who are already using this tool are still crawling at this point. In addition to being a basic structure for family care, the FHS becomes a necessity for these, in addition to being the citizens' right and the Government's duty, to provide quality health services and provide this basic support. It is not enough just to build an ESF or

Table 2. Correlation author (year)/Objectives

Authors (year)	Objectives
SOUZA, A; C. (2006)	Discuss the implementation of mental health policy within primary health care.
DIMENSTEIN, M. & BEZERRA, E. (2008)	Discuss the implementation of the proposal of matrix support in mental health according to PCC workers from the city of Natal, Rio Grande do Norte, Brazil.
ARONA, E; da C. (2009)	Implement in Primary Care a project of intervention in local management under the eyes of the municipal manager. It seeks to ensure the teams of the UBS greater support regarding the accountability of the care process, ensuring comprehensive care throughout the health system, seeking to implement program changes and actions that decentralized access to the specialty, as well as providing resources and equipment to enable the response.
DELFINI, P. S. de S. & REIS, A. O. A. (2012)	Report a partnership experience between PCC and three Family Health Program teams in the central region of Sao Paulo
CHIAVA-GATTI, F; G. et al. (2012)	To analyze the forms of articulation that the Psychosocial Care Centers (PCC) establish with the Primary Health Care Services.
PINTO, A; G; A. et al (2012)	To analyze the articulation of mental health actions between the FHS and CAPS teams through the matriculation process with emphasis on the care matrix and care resolution.
PEGORARO, R; F. et al. (2014)	Understand the meaning of matrix support in mental health offered by a PCC team according to professionals who worked in three FHS units in Goiania, Goiás, Brazil.
HIRDES, A. & SCARPARO, H; B; K. (2015)	Discuss the issue of integrating mental health in Primary Care through matrix support in mental health.
CAMATTA, M; W. et al. (2016)	Understand the expectations of family members of users with a mental disorder of the FHS, regarding mental health actions.

Table 3. Presentation of the type of research and methodological theoretical framework used in the articles by their authors

Authors /Year	Types of Study / Methodological Theoretical Reference
SOUZA, A; C. (2006)	Qualitative and bibliographic research.
DIMENSTEIN, M. & BEZERRA, E. (2008)	Field research, using the semi-structured and qualitative interview.
ARONA, E; da C. (2009)	Qualitative field research.
DELFINI, P. S. de S. & REIS, A. O. A. (2012)	Qualitative field research.
CHIAVAGATTI, F; G. et al. (2012)	Descriptive and analytical research with qualitative character.
PINTO, A; G; A. et al. (2012)	Qualitative research in a critical and reflexive perspective.
PEGORARO, R; F. et al. (2014)	Field research, using interview and qualitative character.
HIRDES, A. & SCARPARO, H; B; K. (2015)	Qualitative bibliographic research.
CAMATTA, M; W. et al. (2016)	Qualitative field research.

PCC headquarters, because it is necessary to promote this articulation with the community, and that is where the importance of Matrix Support comes from.

5 CONCLUSIONS

It has found that the actions of the FHS directed to mental health practices consist of powerful tools for changing the health care model, understood as collective spaces for reflection and transformation of realities. Regarding PS Support Centers, articulation with the territory and integration with other network services have considered fundamental for psychosocial care. The research also revealed the importance of a core network to meet mental health needs. She also notes that ways of producing health services and practices have also much focused on medical diagnostic and therapy procedures, with little attention to disease prevention and health promotion.

Although the plan of inclusion in public policies focused on mental health is underway, there is still a long way to go, obstacles and challenges will appear, it is up to all actors, users, professionals, researchers to persist in the journey so that we can build an increasingly comprehensive and respectful health system. Without structural changes in the assumptions and paradigms that guide the traditional care model, a satisfactory response of the modes of care cannot be expected. This requires deconstructing and reconstructing the model.

It is expected that this study contributes to the theme studied, promoting reflective actions that enable changes in positioning by professionals that include mental health. Through awareness-raising related to the evaluation of the social role of these agents regarding ethical responsibility in the execution of the work process built in the daily service of primary care, in coherence with the principles of HUS and the Brazilian Psychiatric Reform.

Table 4. Results Obtained in the Chosen Articles

Authors /Year	Main Results
SOUZA, A; C. (2006)	It was observed that the orientation of mental health care policies points to the consolidation of new care strategies as it proposes to redirect actions to territorially based services.
DIMENSTEIN, M. & BEZERRA, E. (2008)	It has found that AM is under construction in the local network. However, the importance given to breastfeeding is quite clear, despite some difficulties faced, especially regarding the lack of training in the mental health area, as the respondents well point out.
ARONA, E; da C. (2009)	The benefits obtained were frequent meetings with the ES/UBS team and the professionals involved. It includes the acquisition of two professional transportation cars, training meetings with the teams, meetings to discuss difficulties encountered, proposal to expand the UBS and ESF, as well as the construction of new units, one for reference to the health of the elderly and Establish risk rating pacts to organize referral flow.
DELFINI, P. S. de S. & REIS, A. O. A. (2012)	The matrix support team is small due to the great demand in the region, the services are scattered and isolated making it difficult to create an articulated network. Also, the PSF is very shy in downtown Sao Paulo, where a small portion of the population has served. There is a clear need for increased coverage and expansion.
CHIAVA-GATTI, F; G. et al. (2012)	It was observed that this articulation is structured in the supervision and training of teams and a referral and counter-referral system, often masking under the logic of referrals. However, these actions are more suggestive, referred to in the documents as objectives, than translated into actions as a logic of concrete operationalization of these, in the daily practice of services.
PINTO, A; G; A. et al. (2012)	Matrix support in mental health operates innovative practices and focuses on multidisciplinary attention. In the assistance flows, the improvement of the articulation between the services has promoted between the PCC and the Family Health Units. Constituting comprehensive health care, recognizing the psychosocial field as an indispensable focus in all care and promotion actions requires a managerial, clinical, ethical and political composition that prioritizes inter-subjectivity, participation, and inter-sectoral articulation.
PEGORARO, R; F. et al. (2014)	The interviewed professionals reported as benefits of matriculation a more efficient drug prescription since it has made by professionals with technical competence in the psychiatric area. Another benefit reported by professionals refers to the significant improvement of users' behavior from self-esteem, life perspectives, future planning, decrease aggression and manifested inappropriate behaviors.
HIRDES, A. & SCARPARO, H; B; K. (2015)	The integration of mental health in PHC, although desirable, faces different opposing forces that are located in the professional (generalist and specialist), political, ideological, epistemological and management levels. It is a complex process because of the different knowledge, powers, and desires of different actors are at stake. However, despite the resistance, this is an ongoing process in several

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