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Mental health in primary health care: health-disease according to health professionals

Saúde mental na atenção primária: processo saúde-doença, segundo profissionais de saúde

La salud mental en la atención primaria: el proceso salud-Enfermedad, según los profesionales de la salud

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ABSTRACT

Objective: to analyze perceptions of the Family Health Strategy (FHS) professional team about mental health-disorder and to identify health actions developed by the team for people with mental disorders. **Method:** a qualitative study of a Marxist theoretical framework and a dialectical method. 99 FHS middle and higher level professionals from São Paulo participated. Semi-structured interviews were conducted. Data were submitted to ALCESTE software and Thematic Content Analysis. **Results:** there were three empirical categories: *Training in Mental Health; Perception of the FHS professional about mental health-disorder; and Health actions developed by the FHS team with people with mental disorders*. Actions that converge and diverge from the psychosocial care model were identified. **Final considerations:** there is an effort from professionals to work according to the psychosocial care model, but it is necessary to invest in the Permanent Education in Health of these professionals to overcome barriers and foster successful territorial actions. **Descriptors:** Mental Health; Primary Health Care; Health Policy; Mental Health Assistance; Health Personnel.

RESUMO

Objetivo: analisar percepções da equipe de profissionais da Estratégia Saúde da Família (ESF) sobre o processo saúde-doença mental e identificar ações de saúde desenvolvidas pela equipe para pessoas com transtorno mental. **Método:** estudo qualitativo, de referencial teórico marxicista e método dialético. Participaram 99 profissionais de nível médio e superior da ESF, município de São Paulo. Realizaram-se entrevistas semiestruturadas, cujos dados foram submetidos ao *software* ALCESTE e Análise de Conteúdo Temática. **Resultados:** obtiveram-se três categorias empíricas: *Treinamento em Saúde Mental*; *Percepção do profissional da ESF sobre o processo saúde-doença mental*; e *Ações de saúde desenvolvidas pela equipe de ESF junto às pessoas com transtorno mental*. Identificaram-se ações que convergem e divergem do modelo de atenção psicossocial. **Considerações finais**: há esforço dos profissionais para trabalhar de acordo com o modelo de atenção psicossocial, mas é necessário investir na Educação Permanente em Saúde desses profissionais para superar barreiras e fomentar ações territoriais exitosas. **Descritores:** Saúde Mental; Atenção Primária à Saúde; Política de Saúde; Assistência à Saúde Mental; Profissionais da Saúde.

RESUMEN

Objetivo: analizar las percepciones del equipo de profesionales de la Estrategia Salud de la Familia (ESF) acerca del proceso salud-enfermedad mental e identificar las acciones de salud desarrolladas por el equipo para las personas con trastorno mental. **Método:** estudio cualitativo, con referencial teórico marxista y método dialéctico. Participaron 99 profesionales de nivel medio y superior de la ESF, de la ciudad de São Paulo. Fueron realizadas entrevistas semiestructuradas, cuyos fueron sometidos al software ALCESTE y al Análisis de Contenido Temático. **Resultados:** se obtuvieron tres categorías empíricas: *Entrenamiento en Salud Mental; Percepción del profesional de la ESF acerca del proceso de salud-enfermedad mental; y Acciones de salud desarrolladas por el equipo de ESF junto a las personas con trastorno mental*. Se identificaron acciones que convergen y divergen del modelo de atención psicosocial. **Consideraciones finales:** hay un esfuerzo de los profesionales para trabajar de acuerdo con el modelo de atención psicosocial, pero hace necesario invertir en la educación permanente en salud de esos profesionales para superar barreras y fomentar acciones territoriales exitosas. **Descriptores:** Salud Mental; Atención Primaria de Salud; Política de Salud; Atención a la Salud Mental; Personal de Salud.

INTRODUCTION

The adequate attention to Mental Health is a subject that has been growing in the Brazilian context since the initial efforts of the Psychiatric Reform. Prioritization of health care in the community, not only to the individual with mental disorder, but also to his family, implied an increase in the demand of these people in the Basic Health Units (BHU) and in Psychosocial Care Centers (CAPS - *Centros de Atenção Psicossocial*). BHU with Family Health Strategy (FHS) have historically occupied an important place in the SUS, aiming to reorganize them to create a link with the community according to their real needs, identifying risk factors and intervening when necessary[1-2].

Thus, articulation between Mental Health and FHS should have as principles: the notion of territory, the organization of a mental health network, intersectoriality, multidisciplinarity and interdisciplinarity, as well as deinstitutionalization, promotion of citizenship of the users and construction of a possible autonomy for people with or without mental disorder and their relatives[3-4]. However, it is possible to notice the existence of difficulties to carry out actions that involve the field of Mental Health as a result of the lack of investment in human resources and infrastructure and the cause of social stigma[5] perpetrated by professionals and society, which implies a misunderstanding about mental health-disorder.

In view of this context, the research questions emerged: what are the perceptions of the Family Health Strategy professionals team regarding mental health-disorder?; and what health actions does this team develop with people with mental disorders? Thus, this study aimed to understand mental health-disorder, in order to contribute to the evaluation, qualification of Primary Care actions and training of professionals in the field of Mental Health.

OBJECTIVE

To analyze perceptions of the Family Health Strategy (FHS) professional team about mental health-disorder and to identify health actions developed by the team for people with mental disorders.

METHOD

Ethical aspects

The project was sent for evaluation to the Research Ethics Committees (REC) of the *Universidade de São Paulo*'s School of Nursing and the City Hall of São Paulo City, obtaining a favorable Opinion.

Theoretical-methodological framework

The Marxist perspective was adopted and characterized as the most adequate to base this study, since it understands that health practices and programs express the conflicts and differences that exist in the sector and the conditions of the population class. Health practices must constitute the possibility of transforming the conditions that generate and reproduce disease situations and conflicting and inadequate systems to meet the population's health.

Type of study

This is a qualitative, descriptive and exploratory study. The study was developed according to the precepts of the Consolidated Criteria for Reporting Qualitative Research (COREQ - *Consolidados para Relatos de Pesquisa Qualitativa*).

Methodological procedures

This was based on the dialectical method proposed by Marx, whose investigation starts from the principle that there are contradictions between reality and ideology what must be considered to the comprehension of the object of study as a whole.

Study setting

Four BHU from São Paulo City were used as the study setting, more precisely from the Lapa/Pinheiros (neighborhoods) Health Technical Supervision. This region has 515,269 inhabitants and has an average Human Development Index of 0.950, classified as very high[6]. Each of the four BHUs cited had four FHS teams composed of one nurse, one doctor, one or two nursing assistants and five CHA.

Data source

All FHS professionals team of the four BHUs, totaling 120 professionals of both genders. However, 99 professionals participated. The remaining 21 did not participate in the study because they were under medical leave (two), maternity leave (three), vacation (ten) or because they refused to participate in the study (six). The contact with these professionals was carried out in person during working hours at their corresponding services.

The criteria for inclusion of these professionals in the research were to work more than six months in the FHS of the Health Unit; be between the ages of 18 and 65 years and not be on vacation, on leave due to illness, gestation or strike during the period of data collection. The period corresponded was from March to July of 2012, with 30 days for each participating Health Unit. Exclusion criteria were to refuse to participate, to be absent from the collection period or to fail to meet one of the inclusion criteria mentioned above.

Collection and organization of data

In-depth interviews were conducted, guided by a semi-structured questionnaire containing the following questions: 1) Describe a care you have performed on a person with a mental disorder; 2) How do you identify a person/family with Mental Health care needs? 3) What interventions (actions) were possible and which professionals developed them? Comment on the difficulties and facilities. 4) Have you participated in any training or course on Mental Health? Describe a case discussed with the Family Health Support Center (NASF - *Núcleo de Atenção à Saúde da Família*). 5) How do you notice the inclusion in the territory of people with mental disorders? 6) How do you notice the "improvement" in the health-disease of the followed-up persons/families?

The interviews were conducted individually with each professional according to the availability of participants in private rooms at work, recorded in digital audio, with average duration of twenty five minutes and transcribed in full.

Data analysis

Two techniques were used, carried out in two stages, the first with the use of the *Analyse Lexicale par Contexte d'um Ensemble de Segments de Texte* (ALCESTE) software[7-8], version 2010 and, in the second step, by content analysis[9], which was deployed in the following stages: pre-analysis, material exploitation, inference and interpretation of results. The ALCESTE software was developed with the purpose of classifying simple statements by the Chi-Square Test (Khi^2) based on calculations of the laws of vocabulary distribution to the lexical analysis of text words, regardless of its production origin[7] because it is adaptable to several research fields[8]. When combined with content analysis, which searches for the sense nuclei to compose the empirical categories to be analyzed, it speeds up the reading time in the initial separation of the thematic phrases, but it does not replace the technique process itself. Subsequently, new and successive readings were made with the purpose of deepening the themes that emerged in the text in each sentence. The presence of certain classes/themes defined in a more comprehensive study, seven empirical categories for the qualitative analysis of the results. However, in this study, three empirical categories were discussed and analyzed, namely: Class 1 – Training in Mental Health; Class 2 - Perception of the FHS professional about mental health-disorder; and Class 3 - Health actions developed by the FHS team with people with mental disorders.

The analytical categories employed were "National Mental Health Policy" and "Psychosocial Rehabilitation". It is understood that the National Mental Health Policy, implemented in Brazil until December 2017, was based on the principles of the Psychiatric Reform and inserted the right of people with mental disorders as a human rights issue; proposed an inclusive ethics to the society in relation to the madness and constructed a network of services substitutive to the psychiatric hospitals[10] (a policy that had a setback with the reinsertion of the psychiatric hospital into the psychosocial care network, starting in 2017); and Psychosocial Rehabilitation, as the process that occurs from a set of strategies oriented to increase the opportunities of exchange of resources and affections. It is within this dynamic that an "enabling" effect is created. There are no skills or abilities in themselves. It is extremely important that there be places where interventions take place, service organizations, interactions with health and social structures of a territory and resources placed in the field[11].

RESULTS

Among the health professionals who participated in the present study, 20.8% are nurses, 15.3% are doctors, 25.1% are nursing assistants, and 38.8% are CHA. The majority of participants were female (78.9%) and the mean age of all participants was 43 years. Married persons (47.2%) prevailed. 43.1% of the interviewees were graduates more than 20 years ago; 26.7% between one and 10 years; 18.9% between 10 and 20 years and 11.3%, up to one year after graduation. Regarding the complementary training, 46.5% presented a specialization degree. They work at the Primary Care from one to 10 years (36.3%), from 10 to 20 years (20.4%) and for more than 20 years (33.6%). The interviewees' work time ranged from less than one year (23.6%), from 10 to 20 years (27.6%), for more than 20 years (6.5%). The most prevalent workload was 40 hours per week (43.4%). They exercised the care function (87.6%) against 12.4% supervision/management. All middle-level care professionals followed an average of 929 families and an average of 2,787 families.

From the total *corpus* of the transcribed interviews, during the Descending Hierarchical Classification, 1,648 Elementary Context Units (ECU) were considered for the analysis of the 7,030 ECU initially divided, equivalent to a 69% use of the content submitted for analysis, which is considered good[7]**.** The analysis resulted in three classes, and it is valid to point out that Classes 2 and 3 address aspects that are consistent. The three classes in question had more significant and interrelated contents. The cut-off point (Chi-Square) Khi=14 was used to obtain the best observation of the results obtained by the program, together with the Thematic Content Analysis. The *corpus'* name was defined as "Mental Health in the Basic Health Unit of the Lapa-Pinheiros Health Technical Supervision of the Municipality of São Paulo".

A simple analysis was performed through the ALCESTE program and complemented with the Thematic Content Analysis. The thematic phrases obtained were identified according to "subject" and their identification number (Sub_000).

Class 1 – Training in Mental Health

It was elaborated through the results obtained by the most frequent words (course, training, mental health, participation, discussed, topic, meetings, specifications, education, NASF team, referral, training, punctuation, lectures, clarifications, two, cases, choice, learning) and by the typical ECU. Through these data, it was possible to infer that the contents are grouped around the training in Mental Health. In this class, it is evident the absence of Permanent Education in Health in the service by the management as it is verified in the example of phrase in relation to the subject.

> *Here, I did not participate in any training or course on Mental Health. In the other BHU, I participated. About Mental Health, I've never discussed a case with the NASF team here. I also did not witness anyone arguing.* (Sub_008)

Faced with this, health professionals organize to seek education in and out of service.

> *I had training in my Residency. Here they had some occasional courses* [...] *but my major training was in the Residency.* (Sub_055)

> *The training or course on mental health that I participated in was this lecture* [...] *that the nurse did along with the doctors.* (Sub_081)

Some professionals reported that they never received Permanent Education in Health in the service or any other Mental Health training, making it difficult to implement the National

Mental Health Policy and psychosocial rehabilitation, as can be seen in the following speech:

> *I have never attended any course or training on mental health I cannot describe a case that was discussed with the NASF. I did not attend any. Nursing assistants rarely enter meetings. This is something that is being discussed.* (Sub_019)

Class 2 – Perception of the Family Health Strategy professional about mental health-disorder

Class 2 unveils the FHS professional's perception of mental health-disorder. With the most frequent words (take, bath, medicine, hour, walking, leaving, gone, man, responds, wants, turn) and the typical ECU, it was possible to obtain Class 2. Also, it was possible to infer that the contents are grouped around the understanding about mental health-disorder. In this class, it is evident that professionals identify mental disorder by signs and symptoms. They care about the treatment, stating that there is an ambiguity of models that guide practices. Here are examples of phrases regarding signs and symptoms of mental disorder as a limitation.

> *There are patients I see who have a mental disorder in terms of limitation. I'm remembering the case of a patient, 40 years. She has a disability, a delay, never worked, lives with parents, is also confused and repetitive.* (Sub_096)

They use the sign and symptom of the disease to assess whether it is well or not, and this is the indicator of need for intervention. Another way to identify the person with mental disorder is through self-aggression and observation about the conservation and care of the home by the service user.

> *Today apparently she has ceased to hear voices and whenever I have the opportunity, I ask her and she says that the voices have gone to the back of the yard and that they are no closer to her.* (Sub_021)

> *She would say hello to me, but she would talk to herself to shut up and beat up her face and self-aggrandizement. The house was all messed up, no cleaning.* (Sub_087)

Professionals identify the mental disorder as something that generates cognitive difficulties, unemployment and behavior change. Another way of identifying the person with mental disorder is related to the absence of listening on the part of the user, indicating a state of crisis.

> *I remembered something else; I have one more person with mental disorder. He is from the 72 family, according to his mother, he was normal until he was 36 years old. He married, had children, had a good job at a publishing house, then he was sent away, he went into a depression. He is schizophrenic. Yesterday I went there and he was very nervous.* (Sub_091)

> *We pass by and we have the freedom to enter the house. Today he can sit and talk to us more calmly. He did not listen, he used to talk all the time and he did not listen to you.* (Sub_067)

Professionals understand that when a person is isolated and does not want to contact other people, he or she is considered ill. Many refer to common-sense perceptions as if the mental disorder of a person were a problem of affective deprivation or a dependent person, that is, who does not have autonomy.

> *And it was something that I and the BHU doctor realized together and the nurse that was going to visit. We noticed that he was locked in the house; put a plate on the gate, did not want anyone in the house.* (Sub_039)

> *You see that he has lack of affection. No one in the family wants to interfere in the case, it would be this mentally ill person that I would go to, that they will do his registration and then he also has the issue that he does not let anyone enter the house.* (Sub_061)

Professionals notice as a consequence of illness that people with mental disorders are commonly abandoned by their relatives or that the family has difficulty living with their being, evidencing the need of the mentally disordered person to adjust to the daily life of the family, without taking into account their peculiarities.

> *"G" has taken action and is following this closely. He ended up leaving the hospital and we are very worried because he was no longer living with his brother, who married and went to another house, leaving him alone.* (Sub_015)

> *There was a time when we managed to get the grandmother to welcome the mother and the grandchildren who stayed with her for about a year or so, but the coexistence did not work and now she does not want to welcome them anymore.* (Sub_033)

Class 3 – Health actions developed by the Family Health Strategy team with people with mental disorders

It was generated by means of the most frequent words (mother, sister, mother, son, grandfather, hospitalization, aggression, pardon, drug, suicide, death) and ECU class 3. Through these data, it was possible to infer that the contents are grouped around the actions in Mental Health promoted by FHS professionals. In this class, it is evident the coexistence between two opposing care models: psychosocial care and traditional psychiatry. In this way, actions are often mixtures of models, indicating paradigm transition or, simply, highlight only the biologicist and medical model centered on traditional psychiatry.

> *He went to do the home visit and I went with him, and he came in with the intervention. He also saw the medication, because the relatives were there and changed, I do not know if it was one or two, it improved well, I will not say that he is cured, but he has improved a lot.* (Sub_087)

> *Now if the person has an outbreak, go to the emergency room, first because they give the medication, then they can even be hospitalized 24 hours.* (Sub_069)

The actions carried out by the FHS professionals cover the individual care that occurs within the service itself or through home visits. They lead to the construction of a bond with the

person with mental disorder and their relatives, evidencing the presence of the psychosocial care model, although not clearly identifying the model.

> *She did not get up to eat, take the medications. I figured it out and I took her to the team. The BHU doctor and a nurse came to her house. We talked to her a lot; we gave her all psychological counseling. If you saw it, you would not believe it. It was a good intervention.* (Sub_073)

In addition to health care provided by FHS professionals, there are actions that need specialist orientation because they do not have sufficient knowledge to intervene. Thus, they carry out joint actions with the NASF team in order to obtain better results.

> *Conclusion, the burden that this patient was carrying, she was not enduring. She reached a stage of depression and talked about trying to kill herself. With that came the NASF, with the psychologist, and we followed it.* (Sub_085)

Diverging from the paradigm adopted by the SUS regarding psychosocial care, there are individual actions based on the centered/biologistic medical paradigm, aiming only at medication. There are also actions that are contrary to SUS guidelines, since they refer people from their territory that must be assisted by the Health Care Network (RAS - *Rede de Atenção à Saúde*) and not simply referred by Primary Care to Tertiary Care. On the contrary, in RAS, Primary Care must be aware of the entire course of each user within the network.

> *Despite this, she was a normal person: she came out, came to the BHU to measure pressure and everything. I brought the case up to the team, we worked with the psychiatrist, and the Miss. "T" was medicated.* (Sub_021)

> *When he visits specialists or performs exams, he talks where he was what he did. He is well-rounded, very fond of reading. The interventions that we made, in relation to this case, we tried to make him more out of the house, to have a more specialized care in the tertiary sector because we are Primary Care.* (Sub_089)

In this way, it is noted that there is difficulty in providing qualified assistance to people with mental disorders due to lack of knowledge of the field of Mental Health. This makes them perform referrals to other services and maintain the logic of the treatment compartmentalized, diverging from what is proposed by the National Mental Health Policy.

> *But, with every episode of the user, "J" completely disassociates. The mother has even received a death threat, and she says she will no longer try to save her son. Recently, he was hospitalized and fled the clinic and got himself into a homicide case. The doctor and the psychiatrist are forwarding the "J" to CAPS and PROSAM.* (SuB_071)

In this sense, professionals complain that the network is fragile because it does not provide sufficient support for crises, nor does it provide knowledge. Also, they do not understand the operation of the network, because once forwarded to another service this should not return the case.

> *When the patients stabilize, the CAPS return them to us, so this guy is now in the CAPS with the psychiatrist and the psychotherapist. It is a very recent case and it was very difficult for us to deal. He was discharged on a Thursday so we did not know where to turn him and he just went through an evaluation the following week.* (Sub_002)

Nonetheless, professionals describe articulation actions with the points of care of the Psychosocial Care Network (RAPS - *Rede de Atenção Psicossocial*), which is a subdivision of the Health Care Network (RAS - *Rede de Atenção à Saúde*), aiming at the networking of the person with mental disorder. These actions are more joint to NASF, CAPS and the Social Care Reference Center (CRAS - *Centro de Referência de Assistência Social*).

> *After that, the sister gave up on everything because she was trying to help and the son took all the money. In this case, I will have a meeting on April 5 with the NASF and the CAPS staff to look at what we can do to help this lady.* (Sub_004)

> *If you do not do this, it will be dumped.. The shelter was inaccessible and we did not know anything that happened to this old man because he would not let anyone in. Finally, with the help of CRAS, we had access to the patient and we discovered that the house was divided with a man of about 40 years.* (Sub_031)

In addition, the lack of Permanent Education in Health of professionals makes understand that the act of inviting to participate in an activity will cause the person with mental disorder to join a treatment, forgetting that for there to be compliance there must be bond.

> *I ask him every day, he says he went and did not go. He's stuck in the house because he's afraid of being caught. The biggest difficulty, I think we are not able to approach to have a greater join of them in therapy, because they live running away when it seems that is going, they fail to come.* (Sub_071)

There are also actions that professionals believe to be social inclusion of the person with mental disorder. However, these actions are entertainment, aiming only to keep the user within the service. This demonstrates that the asylum model prevails in the actions of FHS professionals, diverging from the proposal of psychosocial rehabilitation.

> *At great cost, I began to bring him to the BHU and he could come back alone, until he came and went without anyone. The nurse from USP also went out with him a lot. We went to several places. And one day we took him to the orchard near here and he was delighted with the colorful fruits, vegetables and greens.* (Sub_025)

There are professionals who discriminate the person with mental disorder, giving priority to other cases that they consider to be more important.

> *I could not always go to that master's house. I only serve the community agent responsible for that area every 45 days because I have to do a home visit for other people.* (Sub_031)

The ECU reveal the stigma that is perpetrated by society and is in the imaginary of professionals, such as psychomotor agitation,

preventing them from performing actions that deconstruct the stigma in their territory of action. They believe that people with mental disorders should have "adequate" behavior for social interaction, referring to the issue of the norm/normality.

> *I mean, did not even let her live, it already changed, because she left the person under pain. She was medicated, but she bore by pressure. So that's it, sometimes they have patients that I know they walk, when they get medicated they stay correctly in society.* (Sub_087)

Professionals notice fear present in people without the disorder and reveal that there are actions that seek to increase the social network of the person with mental disorder, converging with one of the axes of psychosocial rehabilitation.

> *Some people in the community are afraid. I think it's delicate to give a job. But we make many groups with depressive people to get them out of it. So, we have groups of viola* [Viola is a musical instrument of the violin family]*, samba* [Brazilian dance]*, we have a fraternization tea that we go in the house of the person, if she is resistant to come.* (Sub_071)

DISCUSSION

Issues that interfere negatively with the FHS work process and which have emerged in the workers' discourses are in agreement with what is already stated in the literature. Issues related to the limitation in training in the health care service and the non-integration between the team for the planning of Mental Health care, mainly among professionals at the secondary and higher level, including the NASF, are highlighted. It is noteworthy that mid-level and CHA professionals, who most identify demand, do not participate in team meetings in the units studied, as well as in decision-making. As a consequence, there may be damage in the exchange of information and in the way communication is established in the units, reflecting the quality of work[12-14] and the difficulty of join what is established by the psychosocial care model.

Moreover, it was noted that the majority of health workers do not receive Permanent Education in Health in the service, in order to upgrade them to work in the field of Mental Health. This is a limitation, since the Permanent Education in Health of FHS professionals and Mental Health is the starting point for the reinvention of practice in Health and professional practice[15], with a view to social inclusion and the promotion of the autonomy of the person with mental disorder, going against the psychosocial rehabilitation and, consequently, of the National Mental Health Policy of community base which has been threatened with new policy of 2017.

Permanent Education in Health is a strategy of the Brazilian Unified Health System (*Sistema Único de Saúde*) to the training and development of workers for the Health that aims to encourage, follow up and to strengthen the professional qualification of workers to transform health practices towards the fulfillment of SUS principles from the local reality and from the collective analysis of work processes[16]. The investment to promote this type of educational process is essential for the transformation of the work process, towards the realization of mental health practices within the scope of the FHS and for the deconstruction of stigma related to the person with mental disorder, health care worker.

As Mental Health incorporation into Primary Care has been promising, taking into account the convergence between the principles of Primary Care and Psychosocial Care, especially with regard to interdisciplinarity in care and the territorialization of actions[1-15]; that the policies have advanced in order to standardize and give subsidies for Mental Health care to be incorporated into the daily practices of Primary Care, such as NASF itself; and that the literature has been pointing out for a decade that there is an important limitation in the Mental Health training of FHS workers[17-19], it is questioned, in the face of the results found, why training is still the main impasse to make feasible the incorporation of Mental Health into the work process at the FHS.

Nevertheless, by the FHS's own configuration, some advances are noticed with respect to the instruments used as: the use of the territory, the link and the home visit. This was observed in the results when talking about home visits with different purposes, the participation of neighbours in the identification of Mental Health care needs of service users and groups performed with different community actors, as well as the concern of workers to know about the potentially attractive resources in the territory.

However, with the new National Mental Health Policy (CIT Resolution 32/2017 and Ordinance 3,588/2017), there is a potential threat of retreat from what has been achieved, since it Traditional Psychiatry in the middle of the RAPS added to the remnants of resistance in relation to the National Mental Health Policy of community base of some professionals working at the RAPS. It is also observed a retrogression with the new Primary Care National Policy (*Política Nacional de Atenção Básica*) of 2017, which distorts the principles of universality, equity and comprehensiveness. There is the possibility of disengagement of managers with the universal provision of Primary Care services at national, state and municipal level, and reinforcement of the privatization of public services and the purchase of private plans by wealthier people. It also favors the segmentation of access to care, the separation of the teams from the territories and the disqualification of the work of CHA, accentuates the biologicism of the activities and criticize people with social vulnerability.

Participants (health professionals) have identified the mental disorder through signs and symptoms, indicating knowledge about what a mental disorder is. However, it is verified that their knowledge is based on the model of traditional psychiatry, which still prevails in the training of health professionals. When there is no training they believe that the person with mental disorder is limited and incapable of being or doing something, which reveals the social stigma of mental disorder.

In this way, professionals eventually identify people with mental disorders with observations based on common sense. They do not understand that unemployment is the historical result of the stigma that leads to the social exclusion of these people[5]. In general, they do not bring themes based on psychosocial care, which is the regent model of Mental Health care in the SUS, but the biologicist discourse of traditional psychiatry, pointing out yet another contradiction. In addition to the Permanent Education in Health, invest in undergraduate courses in the field of Health that focus not only on the biological part of diseases, but also on psychosocial rehabilitation, aiming at the social inclusion of the person with mental disorder[20] is fundamental to be able to

revert the care based on the traditional psychiatric model and implement the psychosocial care model.

Another perception of the participants is related to the absence of listening on the part of the user with mental disorder, as well as their social isolation as a sign of illness, demonstrating ignorance about crisis and its consequences, that is, its unpreparedness. In relation to the lack of listening by the person with mental disorder, which is indicative of crisis, there is a need for more focused intervention for these cases. The professional should be prepared to intervene with techniques that seek qualified listening, as well as the understanding of when to request a specialized orientation or even the transfer to a specialized service to contain more serious crises, always aiming at the accountability and coordination of care with in order to avoid loss of bond. In this way, there is a need to take courses that qualify the FHS professionals, as well as Permanent Education in Health, in order to promote the overcoming of this fragility[21].

As for social isolation, this is a sign/symptom of high prevalence among people with mental disorders, who usually withdraw from social contact, losing contact with close friends and some relatives. However, professionals understand that this is something caused by the disease, there is the difficulty of providing actions that minimize social isolation. Professionals also understand that users with mental disorders are dependent people, that is to say, a person without autonomy who often presents affective deficiency, again showing the prevalence of traditional psychiatry and common sense, again showing stigma, common sense and his knowledge of traditional psychiatry[22], which opposes the proposal of the psychosocial care model adopted by SUS.

Workers understand that people with mental disorders are abandoned by their families, resulting in social isolation. In the literature, several authors understand that relatives, due to lack of knowledge of the consequences of mental disorder, have difficulties to provide care for the person with mental disorder. Still, they indicate that these relatives suffer with emotional and physical overload, related to the care. However, the family strategy should focus on the health of the family, and what is seen is that there is abandonment of people with mental disorders. Thus, it can be understood that the family is overloaded and is not being assisted or is not adequately supported, indicating that the FHS has difficulties in this regard.

Therefore, the FHS should carry out mental health actions that support the user and their families, establishing a space for interaction and dialogue between user-family-professional. In this setting, there are other cases that professionals observed that the family has difficulty living with their being, evidencing the need for the person with mental disorder to adjust to the daily life of the family without taking into account their peculiarities. This differs from the principles of psychosocial rehabilitation, which is not the strategy of enabling the disabled, making the weak strong, being a process that aims at making changes, in order to create possibilities of life and to build full citizenship in the medium the society[11].

The actions carried out by the FHS professionals pervade the individual care that occurs within the service itself by groups or through home visits, which entail the construction of bond with the person with mental disorder and their relatives. There are actions that professionals believe to be social inclusion of the person with mental disorder. However, they are entertainment, aiming only at the maintenance of the user within the service. This demonstrates that the asylum model prevails in the actions of FHS professionals.

In addition to the health care provided by FHS professionals, there are actions that they need to be educated because they do not have sufficient knowledge to intervene. Thus, they carry out joint actions with the NASF team in order to obtain better results. In this sense, they act in accordance with what is advocated in the community-based National Mental Health Policy.

Nonetheless, professionals describe articulation actions with the points of care of the RAPS, which is a subdivision of the RAS, aiming at the networking of the person with mental disorder. These actions are more joint to NASF, CAPS and CRAS. Diverging from the paradigm adopted by SUS regarding psychosocial care, there are individual actions based on the medical/biologistic paradigm.

There are also actions that are contrary to SUS guidelines, since they refer people from their territory/service to another institution and do not follow the itinerary of that user, nor do they maintain contact with the other service to obtain information about their situation. This type of follow-up is contrary to the RAS paradigm, where Primary Care should be aware of the entire path of each user within the network. It is noticed that it is difficult to provide qualified assistance to people with mental disorders due to lack of knowledge of the field of Mental Health, causing them to make referrals to other services, maintaining the logic of the compartmentalized treatment.

In this sense, health professionals complain that the network is fragile, because it does not provide sufficient support for crises and, much less, provide knowledge. Also, they do not understand the operation of the network, because, for them, once the user has been sent to another service, the latter should no longer return the case. In addition, the lack of Permanent Education in Health of professionals makes it understood that the act of inviting to participate in an activity will cause the person with mental disorder to join the treatment, forgetting that for there to be compliance, there must have bond. These findings converge with current study results[19].

There are professionals who discriminate the person with mental disorder, giving priority to other cases that they consider to be more important. ECU reveals the stigma that is perpetrated by society, and is in the professionals' imagination, such as incapacity and dangerousness, preventing them from performing actions that detract from the stigma in their territory of action. They believe that people with mental disorders should have "adequate" behavior for social interaction in referring to the issue of normality.

Study limitations

There were data that could have been more contemplated in the discussions. However, the factor time of accomplishment of the study interfered in the research process and these limitations did not compromise the quality of the data obtained.

Considerations in the fields of Mental Health and Nursing

This study has significant potential, by offering elements to understand how this important public policy of Mental Health has been constituted. It offers a perspective of the implementation and dynamics of the understanding of mental health-disorder by Primary

Care professionals, in addition to understanding their potentialities, challenges that health managers need to value and overcome.

FINAL CONSIDERATIONS

Care for mental health-disorder has changed, as the strategies contained in mental health policies are established. In this way, the vision of professionals before the person with mental disorder has followed the model of Psychosocial Care. But, there are professionals who maintain the biologicist and medical vision due to lack of knowledge and/or Permanent Education in Health or social stigma.

There are actions that meet the new model, such as home visits, networking with other services, specialist orientation and socialization groups. However, it is observed that even with paradigm shift, there are still actions based on the traditional psychiatric model.

Thus, it is believed that managers should prioritize the Permanent Education in Health of those who are already acting in Primary Care in partnership with universities that should prioritize the psychosocial model in the training of new professionals. Thus, the effective implementation of mental health practices within the FHS would be obtained, as well as the construction of critical and reflexive practices based on the need of the subjects to deconstruct the stigma rooted in health professionals in relation to the person with mental disorder and overcoming the traditional psychiatric model.

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