

# Community Health Agents' perceptions and practice in mental health

PERCEPÇÕES E ATUAÇÃO DO AGENTE COMUNITÁRIO DE SAÚDE EM SAÚDE MENTAL

PERCEPCIONES Y ACTUACIÓN DEL AGENTE COMUNITARIO DE SALUD EN SALUD MENTAL

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## ABSTRACT

The objectives of this study are to identify the perceptions of community health agents regarding health and mental disorders, and to verify the preparation these agents receive to work in this field. This qualitative study was performed using semi-structured interviews for data collection and utilizing content analysis to interpret the data. Interviews were performed with 45 community health agents working in the Family Health Strategy, who reported to 21 basic health units in the city of Maringá, PR. Results show the prejudice that these workers have regarding mental disorders. They recognize the importance of working with the patient and the family but do not feel prepared to provide adequate care. Because they share the same social context and have a close experience with the community dynamics, we see them as important facilitators of mental healthcare.

## DESCRIPTORS

Mental disorders  
Community Health Workers  
Family Health Program  
Psychiatric nursing  
Mental health

## RESUMO

Este estudo teve como objetivo identificar as percepções de Agentes Comunitários de Saúde acerca de saúde e transtorno mental, bem como verificar o preparo desses agentes para atuar na área. Trata-se de uma pesquisa qualitativa que utilizou como técnica de coleta de dados a entrevista semiestruturada e, para interpretação dos dados, a técnica de análise de conteúdo. Foram entrevistados 45 Agentes Comunitários de Saúde da Estratégia Saúde da Família, pertencentes às 21 unidades básicas de saúde do município de Maringá, PR. Os resultados obtidos demonstram os preconceitos, em relação ao transtorno mental, desses profissionais, que reconhecem a importância de se trabalhar tanto com o portador quanto com a família, mas não se sentem capacitados para prestar uma assistência adequada. Por compartilharem do mesmo contexto social e por conhecerem de perto a dinâmica da comunidade, vislumbramos os agentes como importantes facilitadores no cuidado à saúde mental.

## DESCRITORES

Transtornos mentais  
Agentes Comunitários de Saúde  
Programa Saúde da Família  
Enfermagem psiquiátrica  
Saúde mental

## RESUMEN

Estudio que objetivó identificar las percepciones de Agentes Comunitarios de Salud acerca de salud y transtorno mental, así como verificar la preparación de tales agentes para actuar en el área. Investigación cualitativa con datos recolectados mediante entrevista semiestructurada, analizados según análisis de contenido. Fueron entrevistados 45 Agentes Comunitarios de Salud de la Estrategia Salud de la Familia, pertenecientes a las 21 unidades primarias de salud del municipio (Maringá, PR). Los resultados obtenidos demuestran los preconceptos de estos profesionales, en relación al transtorno mental. Los Agentes reconocen la importancia de trabajar tanto con el afectado como con su familia, pero no se sienten capacitados para brindar una atención adecuada. Por formar parte del mismo contexto social y conocer de cerca la dinámica comunitaria, vislumbramos a los agentes como importantes facilitadores en el cuidado de la salud mental.

## DESCRIPTORES

Trastornos mentales  
Agentes Comunitarios de Salud  
Programa de Salud Familiar  
Enfermería psiquiátrica  
Salud mental

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## INTRODUCTION

In recent decades, the Brazilian Unified Health System (*SUS*, in Portuguese), established by the Federal Constitution in 1988 and regulated by supplementary laws, has gradually been built up on the pillars of universalization, integrality, decentralization and popular participation<sup>(1)</sup>. With the implementation of the Community Health Agents Program (CHAP) in 1991 and the Family Health Program (FHP) in 1994, it was sought to optimize health care and the organization of primary care, so as better to uphold the principles of the Unified Health System. The FHP proposes a broadening of the locus of health intervention, incorporating the home, and other spaces, into its practice. This characteristic has contributed to the strengthening of links between the health care professionals in the teams and the local communities<sup>(2)</sup>.

Currently, the directive for mental health care is to strengthen the links between mental health and Primary Health Care (PHC). This is due in large part to the long history of struggle and demands that resulted in the approval of the current Law nº 10.216/01, or National Law for Psychiatric Reforms. In this context, the Family Health Strategy (FHS) functions as a strong ally of the family and the mental health services provided outside of hospitals for supporting people with mental disorders (PMD) at home. In addition to this, one of the principal tasks of the Community Health Worker (CHW) in the FHS is to collect information referent to the population's health needs, identify service users with problems, and refer them to the health center<sup>(3)</sup>.

Being as member of the community, the Community Health Worker becomes a mediator and facilitator in the relationship between the health service and its users, establishing effective interpersonal communication, because the residents, sharing the same local reality, can identify with the worker. Once established, this communication supports the proposals for psychiatric reform, giving the extramural services a major role in identifying and monitoring the cases, referring the patient and carrying out care resulting from the referral if necessary (counter-reference). Through their ability to establish links and contacts, the Community Health Workers have become important instruments in Mental Health care.

De-institutionalization, with the return of the subjects' personhood and a full role in society, along with the creation of services which aim for the psycho-social rehabilitation of persons with mental disorders, are basic premises of the movement for psychiatric reform<sup>(4)</sup>, which, among other actions, re-orientates the care of the person with mental disorders, seeking to replace the asylum model – segregating, excluding, reductionist and supervisory – which has, as the center of its care, the psychiatric hospital<sup>(5)</sup>.

Through their ability to establish links and contacts, the Community Health Workers have become important instruments in Mental Health care.

For the implantation of this model of care, one needs knowledge and technical skills which are capable of preventing the care becoming weakened and inefficient. Training which is not specific to the area, the absence of updating in the mental health area and difficulty in keeping up with the changes proposed by the reform can become complicating elements<sup>(6)</sup>.

In research carried out with health care professionals who were members of a family Health team, it was noted that Community Health Workers do not receive training or gain experience before their insertion into the FHS, apart from ad hoc moments in the training of university-level health care professionals, while the team's work was shown to deeply involve needs which require mental health care practices<sup>(7)</sup>.

Considering this issue in terms of Community Health Workers' training for working in the field of mental health, the problems seem to worsen, given the lack of knowledge specific to this area and the issues which involve the stigma of mental illness<sup>(8)</sup>.

It may therefore be understood that the position in which Community Health Workers find themselves may, according to their ideas and qualifications, facilitate the concretization of the integral health care called for by the Unified Health System and, as described by other authors<sup>(2,6)</sup>, achieve the re-insertion of people with mental disorders into society, besides affording them the dignity and respect which they are denied.

Mental health in primary care, especially in the Family Health Strategy, has been the target of various studies in the last few years; however, studies involving Community Health Workers are not so easily found, there being a lack of studies with such characteristics. As these health care professionals are the ones who, as a result of carrying out regular family visits, have the greatest contact with them, as the FHS requires, the authors proposed to undertake this study, believing that through learning about these professionals' reality it may be possible to prepare them to assist people with mental disorders and their families, in line with their needs.

Thus, the study aims to identify the perceptions about mental health and illness held by Community Health Workers working within the Family Health Strategy, and to verify their preparation to function in this area.

## METHOD

This is an exploratory-descriptive qualitative study, developed and carried out in the city of Maringá in the Brazilian state of Paraná. The city is the third-largest in Paraná, with 325,968 residents, and possesses 25 Primary Health-

care Centers (PHC), with 69 Family Health teams. For undertaking this study, the authors selected only FHS teams whose multiprofessional set-ups were in conformity with the Ministry of Health's requirements, believing that this is how care for people with mental health disorders and their families is of the best quality.

Based on this criterion, the study was carried out in 21 Primary Health Care Centers in the city, with the participation of 45 Community Health Workers who accepted to participate in the research. Information was collected in the period September 2008 – April 2009, through individual semi-structured interviews and annotation of observations in a field diary.

The instrument used in collecting the data was a script made up of two parts, the first of which addressed socio-demographic characteristics and the second, questions referent to the study's objectives. The script contained the following questions: 1) *What do you understand by the phrase mental health?*; 2) *Of the activities which you carry out in your daily routine, which would you classify as involving mental health promotion?*; 3) *Do you develop/promote group activities in the PHC? In your opinion, what are the motivations of the people who participate in the group?*; 4) *In the area covered by your team, are leisure activities carried out? Which activities are carried out?*; 5) *Do you feel qualified to attend the families of persons with mental health issues? Why?*; 6) *When there is a family with a member with a mental disorder in the area covered by your team, irrespective of whether or not they seek help from the service, what sort of care is offered by the team?*; 7) *When you are contacted by a patient or their family from the area covered by your team due to experiencing a specific problem to do with mental health, what do you do?*; 8) *What is your main concern, when making a home visit to a family, if there is a patient there who has received treatment for mental illness for several years and who is currently being treated at home? Why?*; 9) *How is the communication between the mental health service and the Family Health Program, referent to the patients in the area you cover? Is there a process for referral and counter-reference?*; 10) *How do you evaluate your performance with people with mental disorders and their families?*

The interviews were scheduled ahead of time and carried out in a private room in the PHC itself and with the participant's consent; they were recorded and later transcribed in full. The data collected was subjected to the process of content analysis<sup>(9)</sup>. The technique works on the words and their meanings, that is, it seeks other realities through the message, using a mechanism for deduction based on the indicators constructed from a sample of private messages<sup>(9)</sup>.

The content analysis may cover three phases: 1) pre-analysis; 2) exploration of the material; and 3) treatment and interpretation of the results obtained. This last part is somewhat complex, as it is necessary to obtain from the data the subjectivity necessary for the interpretation

and inferences demanded by the analysis of this type of study<sup>(9)</sup>. The data from the field diary helped in the analysis and discussion of the results.

Once the *corpus* of the study had been outlined, the procedure of analysis was undertaken, in which four thematic categories were created: *The meaning of mental health and disorder for Community Health Workers*; *Assistance to the family: a reality under construction*; *The Community Health Worker and mental health actions*; *Obstacles to mental health care*. Participants in the research were identified by the use of pseudonyms, so as to ensure their anonymity. The study took into account all the ethical precepts demanded for this type of research and was approved by the Research Ethics Committee of the State University of Maringá (Verdict nº 110/2007). The participants were guided as to the objectives and procedures to be carried out and as to the voluntary nature of participation, and signed the terms of Free and Informed Consent.

## RESULTS

The 45 Community Health Workers who participated in the study are workers in the 21 Primary Healthcare Centers distributed across the city's territory and possessed the following characteristics: 84.4% were female; they were between the age ranges of 40 to 49 years (40%), 20 to 29 years (28.8%), 30 to 39 years (17.7%), 50 to 59 and 60 to 69 years (both 6.6%). The length of professional service was from one to five years (48.8%), from six to ten years (40%), less than one year (6.6%) and greater than ten years (4.4%); while the length of service in Primary Healthcare Centers was from one to five years (62.2%), from six to ten years (33.3%) and under one year (4.4%). In relation to level of schooling, 70% had finished secondary school, 22.1% had not finished secondary school, and 6.6% had completed university.

### ***The meaning of mental health and disorder for Community Health Workers***

The authors noticed how difficult it was to approach the theme of mental health/illness with the Community Health Workers. When the research was initiated, and the authors explained their objectives and the procedures to be carried out, some participants demonstrated difficulty in understanding the theme:

Is it all going to be mental? (Tulip).

Mental health? Oh, that's hard... (Sweetpea).

None of the community health workers could distinguish mental health from mental disturbance, treating them as synonyms. The authors observed that some participants had insufficient knowledge to differentiate mental disturbance from neurological problems. In the reports it is possible to make out the difficulty in distinguishing this difference:

(...) it's a person with some disability, something missing; who's born with some problem, so they end up with a mental problem (Begonia).

(...) it's a person who has some problems related to their neurons (Violet).

(...) They all have a disability, they can't read or write... I make a little table to keep track of the medication (Carnation).

What I think is this, it's a person who (...) is scared of going out of the house, who's scared of walking in the street, there are some who are scared of being alone; I think this is what a disturbance is (Begonia).

In the accounts it is possible to detect the feeling of fear of some of the interviewees in relation to people with mental disturbance, due to considering them aggressive or their behaving in an agitated way.

(...) sometimes, when you meet a patient and you know he's taking medication, he has problems, you know, sometimes he'll start changing, and whether you want to or not, you feel afraid (Violet).

(...) there are some patients who arrive already shouting, and you can't do anything, in case you say something and you might even get hit. But there are patients who are more... who you can talk with (Tulip).

(...) they're changed. You only find out if he's okay or not when you get there...! (Jasmine).

### **Assistance to the family: a reality under construction**

Some Community Health Workers are afraid of entering the family dynamics, but recognize the psychological suffering which the family members go through and know that involving them in the care as active subjects will help to get people with mental disturbances involved in society.

(...) Ah, I try to get close to the family and get chatting... you know... building links with the family to see if I can solve their problems (Orchid).

(...) it's not just medication, you have to see it in general terms. Not just specifically that problem which you go to see, thinking that that's all there is; you've got to see what's going on in the family (Violet).

Nevertheless, the authors identified that some participants believed that assisting the family is not necessary and that they try not to interfere in the members' dynamics.

I try, you know, as a health worker, not to get involved with the family members (Rose).

Ah, I think we have to try not to enter much into getting close to the family. I don't go giving opinions... and if there's a conflict while I'm there, I try, you know, not to get involved in it. It's...I prefer keep my distance (Tulip).

### **The Community Health Worker and mental health actions**

The authors noticed that the interviewees were aware of their importance to the community attended by their team, and recognized their role in facilitating the relationship between the community and their health center.

(...) generally the first person they're going to speak to is us. We're the entrance door (...) I'm a connecting link (Daisy).

We go in the house and talk to him, we take everything... everything is the CHW (Jasmine).

When the participants were questioned about the relationship to the target-public of the health actions in which there is the opportunity to work with mental health, the authors noted that these actions are restricted to the denominated *risk groups*, encompassing adolescents, pregnant women, the elderly, hypertensives and diabetics, as can be observed in the description of the actions carried out in the PHC:

Group of hypertensives, group of pregnant women, the walking group, the adolescent group (...) elderly, that's older, but there's also the adolescent group, that's younger, right? Between the ages of 14 and 16 (Tulip).

The authors noticed that the role of care in mental health in the Community Health Workers' work is still not clear, as the Community Health Workers' main worry is still the groups considered at risk in health terms, as the Ministry of Health stipulates.

There's the walking group, it's more adults, for the elderly... a lot of them live alone...It's a way of socializing, of having a stronger link of friendship, not staying alone at home, thinking rubbish,, and in this group they have this possibility (Violet).

Another activity described by the Community Health Workers as capable of establishing a therapeutic relationship was the home visit (HV), which is a facilitating instrument in approaching service users and their families.

It's through the length of knowing somebody, the link you have with their home. Every month, once a month, I pop in; so you can notice when somebody's not well, or when they are. So, it's through the link that the FHP has with the home visit (Sunflower).

The visits which we make, we advise, chat, monitor the medication; when we refer somebody to a psychologist, the treatment is up to the psychologist (Orchid).

In the visit, normally the CHW goes first... we go to the house and talk with him (Jasmine).

The interviewees understood the importance of multidisciplinary work in health care in which everybody has the common objective of achieving the well-being of the family and its member with mental disturbances, through work formulated which affords comprehensive care.

So we have to be there, advising the family with the doctor or the nurse who is going to be watching; if it's necessary, refer them to the...psychiatrist. We have a psychologist who sometimes gives us support (Dahlia).

### **Obstacles in mental health care**

The health care professionals say that, as a result of the high demands on the service, there's no time for them to dedicate themselves to mental health activities.

Well, it could be better, but we can't be in two places at once, you know? You can't do everything at the same time (Jasmine).

There is also the professional error of not including actions of psychiatric care in one's practice, due to considering other forms of care to be of greater relevancy:

So, we could do more, even...; sometimes it's because there isn't enough time, for going there more times. Sometimes, it's because of a lack of priority (...) that sometimes we give priority to the child, to the pregnant women, to the elderly, you know, and leave other problems which are just as serious and sometimes, even, important too. (Violet).

Other items mentioned by the interviewees were the delay in referral and counter-reference and the lack of health care professionals:

The counter-reference is a bit slow and the queue for the psychiatrist is slow as well (Begonia).

Our performance is good. It would be better if we had more doctors. Because sometimes you need to help a patient and they stay waiting in line... Because you see the problem, you know the family is going through difficulties, but at the same time, your hands are tied; you can't do anything, because it's not in your hands. All we are is a little seed.... (Sunflower).

Another relevant piece of data is that many health care professional do not feel qualified to attend people with mental disturbances due to lack of courses or training:

Last year we had a four-hour course on mental health. We didn't get much benefit from it, because it was only theories, theories and more theories... it's difficult to put it into practice (Sunflower).

Ah, it's like this, we don't get much specific training for this; so, to deal with this type of problem (...) we're not qualified in mental health like we are in other areas. (Violet).

One of the interviewees, on being questioned about her preparation for dealing with issues related to mental health explained that she had only been contracted one month previously and was still in her training period, which explained her lack of preparation for working in the area:

Not yet, but I'm still being prepared. Every day we're being prepared to be attending (Orchid).

## **DISCUSSION**

Historically, people with mental disturbances who did not fit into the standards of normality present in each historical context were the victims of prejudice and stigmatization on the part of individuals considered *normal*. In the last few decades, movements and struggles for the de-institutionalization of psychiatry have sought to re-insert these people into the midst of family and social life; but, as no work was undertaken to demystify the pre-existing concepts, while the hospital walls were torn down, the concepts continued firmly rooted in the popular imagination<sup>(6)</sup>, which ends up generating the stereotypes identified in the survey.

It was possible to perceive during the study a distorted vision of reality and confusion about mental disability and mental disturbance. The themes that emerged described the person with mental disturbances as a person who is dependent, incapable, aggressive, dangerous and lacking the autonomy necessary to manage his or her own life and take decisions. It is known that, with appropriately medicated and continuous treatment, depending on the gravity of the illness and the support offered by appropriately-structured services provided outside hospital premises, these patients can live in society and fully exercise their citizenship.

It is noticeable that the stigmatization that fell on people with mental disturbances depended on the connivance and even the support of health care professionals. This fact may be observed firstly in the dichotomization of the human being, whose care, which should be the work of all the healthcare professionals, irrespective of the area they work in, is carried out in a fragmented way in different areas of knowledge, and secondly in the pragmatic division of hospital care services<sup>(10-11)</sup>.

This perception of the person with mental disturbance as an aggressive person creates fear in approaching them, which directly interferes with the care to be given. The authors believe that this concept of dangerousness may be based on two elements: 1 – the previous paradigm, which called for isolation and considered the person violent and unable to live in society; 2 – the fact that the Community Health workers, through belonging to a professional category which lacks technical training for working with this issue, end up using imagery from folk knowledge, that is, that anybody with mental disturbances is dangerous.

In relation to assisting the family, it is known that living with a person with mental disturbance imposes on their family members feelings and emotions that are difficult to articulate and understand. This is evidence for the great need for interventions which take into account the suffering of the families<sup>(6)</sup>. The struggle for de-institutionalization implies the widening of the care focus, as these families present doubts and difficulties in living with the person with mental disturbances, which renders fragile their

relationships and links, making it more difficult to re-insert the person into the community and maintain them there.

Another important data from the study reveals that the interviewees do not understand the need for intervention in family relationships. Their members may be in conflict due to the lack of health care professionals to teach them to manage the person with mental disturbance, as others too in the family need care, due to the excessive burden which caring for a family member may generate. Studies report<sup>(12-13)</sup> that dealing with the disturbance brings with it changes in the routine of the patient and family alike, implying certain limitations on habitual activities; nevertheless, this individual must be valued and stimulated to exercise their potential and their autonomy.

Working with the family in the paradigm of de-institutionalization means breaking both prejudices and concepts, as well as formulating thoughts characterized by partnership and care for the family<sup>(13)</sup>; however, the health care professionals of the FHS have not been familiarized with the mental health universe or with its logic or language, which stops them taking into consideration the idiosyncrasy of the problems historically experienced by people with mental disturbance<sup>(10)</sup>.

The lack of care mentioned above shows that it is not interest that is lacking, but rather *comprehension* about the importance of the family participating and becoming integrated in the care, which denotes these professionals' need for continuous education, as care in mental health involves the reformulation of concepts and thoughts which generally segregated and excluded the person with mental disturbances and their family<sup>(13)</sup>.

Even with the advances obtained through this new model, the integration of the family into the service users' therapeutic project remains a challenge, as, in practice, as it has not been accompanied by the infrastructure necessary for either its success or for the achievement of the psychiatric reform's rehabilitative objectives<sup>(14)</sup>.

In relation to the care offered to people with mental disturbance in primary care, a study has observed<sup>(15)</sup> that Community Health Workers have a more cordial, affective and understanding attitude, which facilitates the relationship, the building of a link, and the establishment of effective interpersonal communication with these patients. The knowledge and practices of Community Health Workers act as areas of synthesis between scientific knowledge and popular knowledge, making it possible to build important strategies for mental health care<sup>(16)</sup>.

Regarding the mental health activities carried out, the authors found few specific actions in the framework of prevention of mental health problems or the promotion of mental health for support groups for people with mental disturbance or their family members or workplaces. These actions should transpose the centralization of actions in the biomedical model of illness, which is possible

through an approach which combines treatment, psychosocial rehabilitation, expanded practice and individualized therapeutic projects<sup>(12)</sup>.

Another activity cited was the home visit, which appears as an important resource, as it makes it possible to understand the family dynamics and to check the possibility of involving the family in the treatment offered to the service user<sup>(17)</sup>. Through the home visits, the Community Health Workers interact with the service user in their family environment and advise the family, which contributes to both being able to achieve conditions in which they can live, work and be productive, co-existing with the mental disturbance in a more positive way<sup>(5)</sup>.

That the Community Health Workers share the same social, cultural and linguistic context as the community attended by the PHC was seen as something which facilitates the identification of factors which are responsible or which intervene in the process of falling ill among people who live in the neighborhood<sup>(17)</sup>. Furthermore, through their search for knowledge and through the implementation of daring and innovative experiments to care for families, the health care professionals have gradually advanced in the process of de-institutionalizing people with mental disturbance.

Nevertheless, for there to be real change in the way families are attended, a union of interests is necessary, that is, integrated work between people with mental disturbance and their families, the community, and health care professionals in the area<sup>(18)</sup>.

During the study, it was possible to perceive some obstacles in the care of people with mental disturbances, with the high demand for the service being mentioned, along with the consequent lack of time for dedicating to mental health activities. The organization of the workers' work – they spend a lot of time on the bureaucratic side of their activities, filling out documents and sometimes even carrying out tasks outside their field of responsibility – makes it difficult for them to provide holistic care for the families, including mental health care.

One factor visible is the undervaluing of mental health, when Community Health Workers mention in their accounts that *the problem might even be important too* – that is, problems which are not visible, or which are not part of institutionalized programs – do not have priority. In this discourse, the Community Health Worker made it clear that she thought that mental illness, for not being *visible, observable* in laboratory exams, might *sometimes* not be considered an illness, and for this reason, not be on the *serious/priority* list.

Another obstacle mentioned is the organization of services which can replace the role of the psychiatric hospital, as the organization of these health services has shown itself to be inefficient. The fragility of the health network's referral system constitutes one of the critical nodes in the

configuration of the apparatuses for daily care, such as care strategies designed to substitute hospital care<sup>(19)</sup>.

It may be seen that the wait for care is a result of the low availability of human resources, which is revealed as an obstacle for care. In spite of the Mental Health Policy stimulating practices grounded in the area and combined with a wide network of health services, there is still a wide gap between what the Guidelines propose and what may be observed in reality<sup>(10)</sup>.

Another relevant fact is that many health care professionals do not feel qualified to provide care for people with mental disturbances, which may be explained by the way in which health education is worked out in the training courses, which approach mental health in a purely theoretical way, not providing support for the health care professionals' practical work. The continuing education practices must emphasize, as well as conceptual questions, practical forms of intervention<sup>(20)</sup>.

One of the reasons that can explain the lack of training is the turnover of health care professionals in the Family Health Strategy (FHS). The authors noticed that the health care professionals start their practice without being prepared, which means a period of working in the area without instruction, until training is received. It is important for the Community Health Workers to receive guidance on dealing with people with mental disturbance before they start their activities, as the incidence of these disturbances has increased considerably over the last few decades. Furthermore, it is necessary to work on the promotion of mental health and prevention of mental illness, such that the Community Health Workers may have a minimum of knowledge about the area – including knowing that mental health is different from mental illness.

The data found here have been corroborated by another study<sup>(21)</sup> which reports the great lack of information and training for confronting the complex situations present in the Community Health Workers' daily routine. These data show that, despite working in this diversity the Community Health Workers still lack specific training, which needs to be dynamic and grounded in the reality experienced by each community, allowing the healthcare professionals to meet the conflicts present in their care.

In this context, the training and empowering constitute alternatives such that all the actors involved in the care process may benefit – both the persons with mental problems, who may thus receive appropriate care, and the health care professionals, who get to acquire the qualifications necessary to work with these patients from the very beginning of their practice in the community.

## CONCLUSION

The Community Health Workers interviewed have a perception of the dangerousness that can create fear

when practising and lead to prejudice and stigma. The authors infer that this may be the case because these health care professionals belong to a professional category that lacks general technical training- principally in the area of mental health – which leads them to base their conceptions on commonly-held beliefs.

This distorted understanding of mental disturbance and those who suffer from it interferes to a certain degree with the care offered, but, despite this, the results show the mental health care provided by the Community Health Workers to be an important instrument in the strategy of de-institutionalization, especially in home visits, as based on these, links are forged which make it possible to understand the reality into which each family is inserted. This means that the workers, along with the rest of the health team, can elaborate better quality care.

Primary care, principally through the Family Health Strategy, is shown to be a fundamental instrument for re-inserting people with mental disturbances into society; the challenge, however, is a support network which is qualified and trained to care for the person with mental disturbance and their family, as well as services which can serve as back-up for these professionals' work – elements which would permit, when necessary, good referral and appropriate care back in the original context following the referral.

One fact which called the authors' attention was that the majority of the participants did not understand that 'intervening' in family relationships was part of their job. It is known that conflicts can lead to alterations in mental health in 'healthy' families and that living with a person with a mental disturbance can create changes in family relationships; this is why the health care professionals who are closest to the family – in this case, the Community Health Workers – do indeed need to practice this intervention, although in doing so they must have the sensitivity necessary.

It is necessary for these health care professionals to have the appropriate preparation for addressing and meeting this demand, through training courses which lead them to let go of stigma and prejudice, so that they may contribute effectively to the social and family rehabilitation of people with mental disturbance, giving them back their dignity and their right to playing a full role in society, because it is these professionals who have the greatest contact with the families and serve as links between them and the team.

It's an important fact that these health care professionals are under the supervision of nurses, and due to this it is necessary to propose strategies which minimize the problems met in the provision of care and that thus it may be possible to prepare health care professionals to function in mental health, an emerging theme since de-institutionalization.

This study permitted the authors to understand that the Community Health Workers, due to the position they hold, can, in line with their competencies, facilitate the

implementation of holistic health care as called for by the Unified Health System and thus become an important assistant in mediating between the health service and its users. For this, strategies are needed which work on the imaginary meanings present in these health care profes-

sionals' understanding of mental health, so as to qualify them to provide care free from prejudice. Demystifying these segregating concepts would contribute, in practice, to improving care in mental health and to contributing to the struggle to value persons with mental disturbance.

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