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Mental health in Primary Care: challenges for the resoluteness of actions

Saúde mental na Atenção Primária: desafios para a resolutividade das ações

Salud mental en la Atención Básica: desafíos para la efectividad de las acciones

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Abstract

Objective: To identify the challenges faced by professionals to add resoluteness to actions in mental health developed in the context of Primary Care. **Method:** Qualitative study with 30 professionals, including 17 nurses, four doctors, five psychologists and four social workers. Data were collected in three municipalities of Rio Grande do Sul, Brazil, in April 2018, through a semi-structured interview, later submitted to thematic analysis. **Results:** Challenges pointed out by professionals to add resoluteness to actions in mental health are related to the lack of specific knowledge to support the actions professionals perform; with the organization of services and participation of managers; and with the ambivalence of people with mental disorders regarding acceptance and continuity of treatment. **Conclusion:** The construction of shared practices among professionals, people with mental disorders and their families is necessary. **Implications for practice:** The study allows theoretical-practical articulations capable of generating transformations in mental health care model.

Keywords: Mental Health; Primary Care; Health professionals.

Resumo

Objetivo: Identificar os desafios enfrentados pelos profissionais para agregar resolutividade às ações de saúde mental desenvolvidas no âmbito da Atenção Primária. **Método:** Estudo qualitativo realizado com 30 profissionais, sendo 17 enfermeiras, quatro médicos, cinco psicólogos e quatro assistentes sociais. Dados coletados em três municípios do Rio Grande do Sul, Brasil, em abril de 2018 através de entrevistas semiestruturadas, posteriormente submetidos à análise temática. **Resultados:** Os desafios apontados para agregar resolutividade às ações estão relacionados com a lacuna de conhecimentos específicos para sustentar o que os profissionais desenvolvem; com a organização dos serviços e a participação dos gestores; e com a ambivalência da pessoa com transtorno mental em relação à aceitação e continuidade do tratamento. **Conclusões:** Necessária a construção de práticas compartilhadas entre profissionais, pessoas com transtornos mentais e suas famílias. **Implicações para a prática:** O estudo permite articulações teórico-práticas capazes de gerar transformações no modelo de atenção em saúde mental.

Palavras-chave: Saúde Mental; Atenção Primária; Profissionais de Saúde.

Resumen

Objetivo: Identificar los desafíos enfrentados por profesionales para agregar solución a las acciones en el campo de la salud mental en la Atención Básica. **Método:** Estudio cualitativo realizado con 30 profesionales, siendo 17 enfermeros, cuatro médicos, cinco psicólogos y cuatro asistentes sociales. Datos colectados en tres ciudades de Rio Grande do Sul, Brasil, en abril de 2018. Entrevista semiestructurada, posteriormente sometida al análisis temático. **Resultados:** Los desafíos indicados por los profesionales están relacionados con la falta de conocimientos específicos para sostener dichas acciones; con la organización de servicios y participación de los gestores; y con la ambivalencia de las personas con trastorno mental con relación a la aceptación y continuidad del tratamiento. **Conclusiones:** Se necesita la construcción de prácticas compartidas entre profesionales, personas con trastornos mentales y sus familias. **Implicaciones para la práctica:** El estudio permite articulaciones teórico-prácticas capaces de generar transformaciones en el modelo de atención en salud mental.

Palabras clave: Salud Mental; Atención Básica; Profesionales de Salud.

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INTRODUCTION

The resoluteness, one of the principles of the Unified Health System, is defined as the requirement that, when an individual seeks care, or a problem of collective health impact arises, the corresponding service is able to face it and solve it, up to its level of competence[1]. This is a reference to evaluate health services based on the results obtained with the care provided to the users of the place, but it is not an absolute term, since it incorporates particular aspects of each place[2]. Resoluteness can therefore be understood as a satisfactory response from the service to the person seeking care for their health. This response is not limited exclusively to the cure of disease, but to relief or reduction of suffering, promotion and maintenance of health.

The resoluteness can be evaluated from two aspects: the capacity to meet its demand and; in the referral of cases that require more specialized care, ranging from the initial consultation, examinations and treatment of the user in the Primary Care service, to the solution of the problem in other levels of care[3].

In the area of mental health, the evaluation of the resoluteness of a service is associated to the measurement of results referring to the set of actions that it offers. It involves the knowledge of professionals about variables such as social conditions, clinical conditions, severity of symptoms, as well as working and housing conditions[4]. It is the capacity to solve health problems of individuals in situation of social and biological vulnerability, guaranteeing access to services and attention of needs in an integral way[5].

Thus, resoluteness involves aspects such as: reception of demand; satisfaction of the person in relation to their needs and the technologies offered by the service to meet the complexity of the level of attention. It also assumes that the services must present specialized references, guarantee of accessibility and availability of qualified professionals to welcome users into the adherence and continuity of treatment. Cultural and socioeconomic aspects, in the same way, need to be taken into account in order to reach resoluteness when they accept or reject the pathology, including the financial conditions to subsidize treatment as needed[6].

Although this theme has the support of public health policies, the literature points out that the professionals of the Family Health Strategy still develop an essentially biomedical model, with a curative structure, centered on the disease and rooted in psychiatric treatment with strong medicalization, reinforcing a model of health care that limits resolute actions in mental health. These professionals justify this model of care based on feelings related to impotence, anguish and unpreparedness in the execution of mental health care. In this context, the autonomy of the team members is reduced, compromising the resoluteness in the Family Health Strategy[7].

The literature also reinforces some of the barriers mentioned by professionals in the Family Health Strategy to insert mental health in Primary Care. These obstacles are generated by factors directly related to the field of practice and the production of new modes of mental health care. Thus, the actions performed with the users are not so resolute, focused on the disease, when they could receive home visits, participate in mental health groups and the development of the singular therapeutic project, among other actions[8].

However, there is evidence of the articulation of mental health actions, identifying resolute actions when integrations occur between these services, with innovations of psychosocial approaches, accountability of the person with mental disorder, family and community together with the health teams. The resoluteness is demonstrated at the moment when those involved in the work and care process take responsibility for the improvement of living and health conditions in the individual context or in the community[9].

This premise is proven at the moment in which the professionals of the Family Health Strategy and the Family Health Support Center interact as a multidisciplinary team, emerging the need to solve individual and collective problems. In this way, resoluteness inspires the possibility of linking knowledge, a harmonious relationship between team members which values their participation in care, and consequently qualifies their actions[10].

In order to maximize the resoluteness in mental health, the actions of professionals need to be integrated into multiprofessional teams, with services organized in a health care network. Even with the change in mental health care model, which has the resoluteness as one of its principles, what actually exist are health services with difficulties in their organization in terms of qualification of professionals. It is important for the professional to understand that the resoluteness of actions is related to the ability to identify and intervene in the risks, needs and health demands of the population, focusing on solving users' health problems[11].

It is a fact that community-based devices, despite the paradigm shift that advocates comprehensive and resolute attention in the territory of people's lives, face difficulties that make the majority not able to follow the policies advocated by the Ministry of Health. This study aims to identify the barriers and challenges faced by professionals to add resoluteness to the mental health actions they develop in Primary Care.

METHOD

This is a qualitative study carried out with thirty professionals who work in the Family Health teams of three municipalities in the northwest region of the state of Rio Grande do Sul, Brazil, including seventeen nurses, four physicians, five psychologists and four social workers. Twenty-seven are female and three are male, aged between 28 and 64 years. Service time varied between one and 30 years, and the time of formation between three and 44 years. With regard to professional training, the thirty participants have specialization in the area of health; and six, in addition to their specialization, have Master degrees.

The professionals were recruited in the Basic Health Units, considering as inclusion criteria to be developing their work activities, at least six months ago in the Family Health Strategy. Those who were on vacation or on leave during the data collection period were excluded from the study. To preserve anonymity,

participants were identified by the letters that correspond to their professions, followed by a number that identifies the order of the interviews ("N_1", "P_2", "D_3", "SW_4").

The three municipalities included in this study - identified as municipality 1, 2, 3 -, are covered by the 19(th) Regional Health Coordination of the State of Rio Grande do Sul (19(th) RGC / RS). The three cities have a Psychosocial Support Center (PSSC), a Psychiatric Unit in General Hospital and Basic Health Units with assistance in Family Health Strategy.

The health service network of Municipality 1 has six Family Health Strategy teams, covers 80% of the population, a Psychosocial Support Center that serves adults with mental disorders, problems with alcohol and other drugs, and a general hospital that has 14 psychiatric beds in agreement with the Unified Health System.

The health service of Municipality 2 has eight Family Health Strategy teams with 100% population coverage, a Psychosocial Support Center that meets all the demand of the municipality, a general hospital that has a Psychiatric Unit in General Hospital with ten psychiatric beds in agreement with the Unified Health System and a Reference Center for Social Assistance.

Municipality 3 has the Primary Care service structured with four Family Health Strategies teams, 100% population coverage, a Psychosocial Support Center that serves adults with mental disorders, problems with alcohol and other drugs, a general hospital which has a Mental Health Unit with 14 psychiatric beds in agreement with the Unified Health System.

Data collection was done through a semistructured interview, held in April 2018 at the place where the professionals worked, with schedules previously arranged. The main topics addressed in the interviews, through direct questions, were the strategies used and their resoluteness according to the guidelines of Mental Health in Primary Care. Then the professional was asked to reflect on how he performed the care of the person with mental disorder.

The data were organized and analyzed according to the thematic analysis[12], from the following steps: pre-analysis, with reading and classification of the answers; grouping of similar responses; identification of the analysis product. Next, larger nuclei were created, understood as the main themes, which enabled the analysis and the interpretative synthesis to elaborate three thematic nuclei, named: (1) The specificity of mental health as a challenge for the resoluteness of actions; (2) The challenge posed by intersectoral communication and participatory management in health services; (3) Non-adherence to the treatment of people with mental disorders as challenges to resoluteness.

This study was submitted to the Ethics Committee of the institution to which it is linked, receiving the certification No. 81977318.2.0000.5324. In its development, the determinations of Resolution 466/2012 of the National Health Council, which deals with research with human beings, were respected[13].

RESULTS

The specificity of mental health as a challenge for the resoluteness of actions

In this study, the professionals mentioned that they do not have enough theoretical basis to support the specific actions that people with mental disorders require in the Basic Health Units. They refer, for example, to the fact that they do not know how to act in the face of a psychiatric emergency, or even to identify adverse reactions of specific medications that people with mental disorders use.

> *I see that when a person with a mental disorder arrives, they think only the psychologist needs to see if it is an emergency. We do not know what to do. I also miss knowing more about medications, we do not know much* (P_2).

They also reported the need to know what is the responsibility of multiprofessional teams in mental health work in Primary Care. Also stated that they do not know their specific mental health competencies in a Basic Health Unit, which weakens the organization of their practices in the daily life of health services.

> *We do not have all that mental health knowledge. You need to know how the team can work to develop a good job. So I think, the professionals need to have this support, to be preparing themselves, with a good knowledge to be able to attend the patients* (N_1).

> *Teamwork is difficult. I see the issue of teamwork very complicated, because when we talk about mental health, it is very difficult to work, the answer is always the same, we still do not know how to do it, and we do not have a work plan here* (N_2).

In general, professionals consider that the demands in terms of mental health are complex and do not feel instrumental in carrying them out, pointing out that Permanent Learning can provide knowledge with approaches that allow adequate behavior towards people with mental disorders and their families, as evidenced in the following statements:

> *We need specialization or improvement for all levels of professionals. The team must be qualified so that we have the knowledge to make the approach, follow up and, in fact, ease and solve his problem* (N_1).

> *The professional needs to know the managing of mental illness, care with medication, because whoever has a*

mental problem, the family needs to know about the disease. There is lack of professional knowledge (D_1).

Everyone needs Permanent Education. With knowledge, you can meet the situations, this is important to develop the work. Learn to do according to the needs of the patient. Resoluteness is better, achieves results (N_{17}).

Although it is still a matter of conception about the place where people with mental disorders can be treated, the professionals mentioned that they are being referred to the Psychosocial Support Center (PSSC) or to the hospital. They consider that this type of referral is a transfer of attribution, since the professionals do not recognize as their competence the attention to these people in the Basic Health Unit. They make the referral to what they consider as a specialized mental health service, as the following speeches show:

We have as reference of mental health, referrals to the PSSC, directly thinking of centralizing care with psychiatry follow-up, the municipality's norm is to refer to the PSSC (N_1).

There is a need to have more professionals of the psychiatry specialty, here we do not know how to do, referral is to the PSSC that is our reference (N_{13}).

It should be noted that referrals from Primary Care to the Center for Psychosocial Support are the cases of anxiety, depression, schizophrenia, among other disorders. In acute cases of seizures, patients are referred directly to hospitals and subsequently evaluated by psychiatrists. Practitioners have reported that they do not know what to do and understand that referral to specialist services can meet the needs of the mentally disordered person.

In severe cases, patients are sent to the hospital. If they are in crisis, depressives, in the cases where they arrive at the unit with the disease, they are already of the PSSC, we do not know how to do because we do not follow the case, so we send to the PSSC which is our reference (N_4).

If I see that a case is not for me, but for a specialist, I refer the patient to the PSSC and to the hospital (D_4).

The professionals considered referrals as a decisive action that they perform, since they are offering what the municipality has of more specialized in mental health. Such conduct reveals the lack of knowledge about the change in the model of care that advocates actions in mental health, with care in the Basic Health Unit, including clinical evaluation of the professional. Not getting the means to solve the situation in Primary Care, they carry out the referral.

The challenge posed by intersectoral communication and participatory management in health services

This thematic nucleus is constituted by the organizational structures of the health services that compromise the resolution of the actions of the professionals, it groups the professionals' barriers to the organization of the health services with regard to intersectoral communication and requires the participation of the municipal managers in the organization of the health services.

The participants of this study pointed out difficulties in communication between the services that attend people with mental disorders, resulting in the mismatch of information between sectors, which interferes in the reference and counter reference of the conduction of the treatment. They identify that the communication of these services is flawed in relation to the referrals related to the organization of documents of sick pay, investigation of violence or neglect and abandonment of treatment. The professionals report that the lack of communication compromises the follow up of the treatment of these users, compromising the resolution of actions in mental health, as can be evidenced in the following statements:

Public management is speaking the same language, but needs to have a policy that works together with education. The Mental Health user is not static, he/she circulates in places, has other needs, requests complementary services, wants access to other services. Thus, stays without resoluteness (P_1).

Communication failure is on discharge from patients. Patients end up taking antidepressants for the rest of their lives, it's a lot of medicine, and they become drug addicts. We need to know the person (N_{16}).

For professionals, the participation of managers in health services is considered relevant to promote municipal health policies in the comprehensive attention and resoluteness of actions. They acknowledge that the management of health services in Primary Care serves wide fields of specialization, but does not identify that work in mental health takes place in the priorities of the managers.

We feel the need of the support of the managers, without this help the team cannot work with the mental illness, we need support (N_2).

Need to have more professionals with respect to the psychiatric specialty (N_{13}).

> *For the network to function, investments are needed, it is necessary to have a policy that works together with education and other management sectors (P1).*

Professionals understand that municipal managers - including mayors, city councilors and health secretaries - need to know health services in all specificities and offer conditions in terms of professional qualification, human resources and materials that are important to potentiate resolute actions in daily life of primary health services. The professionals understand that the managers, when they exercise the attribution of legislating the municipality, have the power to provide working conditions according to the demand of the health services, including public health policies.

Non-adherence to the treatment of people with mental disorders as challenges to resoluteness

This nucleus is constituted by the feelings and behaviors of people with mental disorders that, in the perception of the professionals, constitute challenges to add resoluteness in the actions. The feelings of denial about being bearer of mental disorder have been identified as barriers to actions. When there is no acceptance of the individual to carry out his/her treatment, the caring action is limited to the follow-up of the professionals. These people fight an internal struggle between the need for treatment and their acceptance, however, in the understanding of the professionals, it is necessary that they recognize the need to carry it out, as can be identified in the segments that follow.

> *First thing: to bring the patient the awareness of his/her illness, because it is not correct to give medicine if the person does not know about his/her illness. Without awareness of his/her illness the patient has no continuity in treatment* (D_3).

> *Interference is the biweekly care, and also when the patient does not accept the disease and skips the consultation and then takes time to make contact again. So we end up being expropriated of the story and the bond is not effective* (P_1).

> *When the patient does not accept, everything is an excuse, from being away, having no transportation, having no way to go, when the family does not participate together, it makes it difficult!* (P_1).

The professionals identified that the acceptance and the knowledge about the mental disorder, by the users of the service, potentiate the resoluteness in the attention in mental health. However, when the disorder is identified, the patient tends to hide it from the people close to them, especially the relatives, out of shame and fear of rejection. The professionals consider that they need to inform about the conduct of the treatment and that, in most cases, the doubts are regarding the use of medications and the symptoms of the disorder.

Discontinuation of treatment was also identified as a barrier to the resoluteness of the treatment, which compromises the patient follow-up, resulting in recurrence of symptoms and his/her return to the health service, as shown below:

> *I perceive the discontinuity of the treatment, patients who use a continuous medication, patients who work during the day and cannot have a direct follow-up. Then, time passes and he/she returns in an even worse situation* (N_8).

> *When the patient considers that they are better, they no longer do the treatment, after a time they recognizes that they have to continue and then they return to us* (N_{16}).

In this context, discontinuation of treatment involves different factors. Among them, the economic ones, which culminate in the difficulty of maintaining the treatment, since the medicines have a high financial cost and are not available in the public system. Another factor that is related to the diagnosis of mental disorder is the patient's refusal to adhere to the treatment, since they fear that they may be away from work or even lose it because of the stigma of having a mental illness.

> *People are ashamed to say that they have mental problems, they hide, they are ashamed, they do not tell their friends, they leave the treatment because of the prejudice and then they come back to us* (N_{10}).

> *They abandon treatment because of the cost. There is also the issue of the sick pay, those who prefer to leave the sick family member to continue gaining. So they are always stopping and taking medicine* (P_5).

Another factor noted is neglect and abandonment of the family in relation to treatment. In this context, family relationships are fragile and do not accept the member with mental disorder for being different. Thus, this stigma has repercussions on the neglect and abandonment of the family in relation to the sick person, resulting in a lack of follow-up of drug treatment, which can lead to aggravation of symptoms, with hospitalization.

> *We get sad because the family often interferes and not always in favor, it interferes against, understand? And we sometimes feel like we have not done anything, they fight at home and don't accompany the sick family member (N_{14}).*

> *We must be calm, because they have already lost respect for each other and dignity. The family needs to understand*

> *that the person is sick, but that he/she can do many things, but that it is difficult to continue the work when this happens* (P_5).

The professionals also mentioned that they do not have the time to perform specific actions, such as home visits or mental health groups, through which they would obtain information about the daily life of the person with mental disorder.

> *I think it's a matter of networking, that's the first question: networking has to work. We need to do more work with the families, the home visit, for example, help them in the information they need, they will be able to have a better coexistence with these patients* (SW_3).

> *I think everything we've done here is relevant, but the bond with the family needs to improve. Being closer to them, they are weak in the affective bond and we are being able to work in strengthening this bond* (SW_4).

Regarding the treatment of people with mental disorders, the result of this nucleus showed that, for actions to be resolutive, some factors must be involved, such as the confronting of people with mental disorders, acceptance of the disorder and involvement of the family. It was also identified that professionals recognize the need to perform actions closer to the families of people with mental disorders.

DISCUSSION

The results of this study allowed the identification of the confrontation of the professional challenges to add resoluteness of actions in mental health in Primary Care. As challenges to resoluteness, it was first identified that one should attend the person in the health service; then the organization of services and participation of health managers; and soon the non-adherence to the treatment of the people with mental disorders. It was also identified that these three elements, specifically in this study, compromise attention to the needs of people with mental disorders and their families in their daily life, implying in the resoluteness of the actions of the professionals that work in the services.

The challenges faced in the daily life of professionals to add resoluteness are related to the theoretical bases, which do not support their attributions in Primary Care, since they report feeling insecure to care for people with mental disorders from the reception in the Basic Health Unit, to the more specific actions on drug and psychotherapeutic treatment[14].

Specifically, family physicians, for the most part, identify gaps in university education for community-based mental health care, since the thematic approach addressed in the training was conducted with an eminently hospital focus, curative approach, out of tune with primary care. In addition, it reinforced prejudices and taboos, establishing barriers that hindered medical interest in relation to people with mental disorders[15].

These elements are similar to the results pointed out in the literature, which emphasizes that professionals find problems to recognize their roles in primary health care services, transferring care usually to the Psychosocial Support Center or to the hospital with psychiatric beds[14]. In a general manner, especially, the family medical practitioner perceives him/herself unprepared to use the non-medicated form of treatment, such as active listening or the preparation of a care plan.

In this context, medical care prioritizes medicalization, rather than the mobilization and use of community resources for mental health care, such as community therapy, self-help groups for family members and a group of refractories or somatizing patients[15]. The barriers in relation to the professional performance from the instrumentalization to the care to the person with mental disorder in the Primary Care, are not exclusively of the doctors; the community nurses share this premise, showing difficulties to carry out actions to promote mental health[16].

The findings in the literature corroborate with the results of this study, emphasizing that the professionals of these institutions do not have the proper theoretical basis for sustaining mental health actions. Primary Care workers feel powerless and distressed due to their own unpreparedness and their feelings of powerlessness in the face of this lack of knowledge to perform mental health care actions. The professionals pointed out that these aspects are barriers to effective bonding, co-participation and commitment[7]. The results suggest the need for Permanent Education in order to enhance knowledge about mental health in order to promote the autonomy of team members and to organize care in the context of the Family Health Strategy[15-17].

In spite of the change in the care model that advocates care in the territory of people's lives, this study shows the existence of a mismatch between what was legally instituted and what was done in Primary Care. On this, it is reinforced in the literature that referral to other levels of attention is a common practice of professionals, since they do not conceive mental health care in Primary Care. The psychosocial model, unlike biomedical, favors networking, although it is difficult to break with the logic of referrals, due to the absence of organized services to provide care in the institutions[6,11].

The work of these professionals is reduced in justifications for the lack of ability in face of mental health, ignoring the organization of actions with people with mental disorders and their families. Protocols for referrals to other levels of care are established, disrupting the capacity to contemplate resolution and integrality in primary care. The literature indicates to the professionals an action that considers the subjectivity, singularity and autonomy of the person with mental disorder, potentializing their abilities in order to face the difficulties and their daily experiences. All those involved in the work process in mental health can know their attributions and recognize the need for actions in the territory of people's lives, avoiding referrals and developing actions in accordance with legal guidelines.[17-18]

In this study, intersectoral communication is another barrier to promote the resoluteness of actions among all health

services that should assist people with mental disorders. In this context, there is disagreement with the resoluteness of actions, interfering with the flow of reference and counter reference of the treatment. In this way, intersectoral actions, if not performed in a manner consistent with the need, interfere in the service flow, affecting the achievement of desired results and interfering with the resoluteness of actions. Services need to be organized in a network, with proposals for actions in line with the Basic Health Units, Family Health Strategy, Psychosocial Care Centers, among others that involve the process of deinstitutionalization.[18]

In the perception of the multi-professional team, the public managers need to know the problems faced to plan, structure, organize and evaluate the actions performed in the services, in order to contribute in the process of management in mental health. In this sense, they need to know the needs to aggregate actions with the implementation of policies, programs and projects that are able to intervene on the health status of the population to be served. According to the literature, this possibility is pertinent, emphasizing the manager's role in the planning and organization of the health services network.[19-21]

Managers recognize the need to participate in the planning of health service actions, as well as structural problems, such as the lack of trained human resources which result in poor outcomes of the teamwork's health planning. In addition, international experiences and strategies show an organized, integrated and resolute work structure. They point out that professionals have their roles with specific definitions in health spaces, with actions aimed at the promotion of mental health. They are able to detect in spontaneous demand those who have mild mental disorders to attend in order to prevent aggravation.[22-26]

Another aspect that compromises the resoluteness of the mental health service in Primary Care is the discontinuation of treatment by the person with mental disorder. This greatly impacts on the effectiveness of care, implying challenges for professionals to assist the user in the service. The literature emphasizes that a person's refusal to accept treatment, rejecting of care and abandoning it, compromises their health, aggravates, most of the time, the symptoms of mental disorders.[27-28] Discontinuity is related to absence of communication between the person with mental disorder and health professionals, besides the lack of accountability of the service with its user.

In this scenario, access to the service is difficult for the user, and professionals are unable to act and intervene at the time of crisis and denial of treatment[29]. However, the workers are not prepared for the necessary interventions. It is also emphasized that the active search of the users, the home visit and the groups of people with mental disorders as an approach of the user of the Primary Attention service is insufficient. Obviously, there is a need for approaches with effective communication between users and professionals, dividing accountability among family members, as recommended in the Primary Care Policy in the pursuit for comprehensive care.[30-31]

FINAL CONSIDERATIONS AND IMPLICATIONS FOR PRACTICE

In the present study, it was identified the recognition, by the professionals, of having no theoretical base to support the care they perform on people with mental disorders, in the Basic Health Unit. They understand that the referral to the Psychosocial Support Center or the hospital is the appropriate conduct to promote mental health care in Primary Care. At the same time, professionals need to lead health teams to comply with the guidelines of the Family Health Strategy, whose purpose is to be implanted in an assigned territory to potentialize full and resolute actions. The search for the knowledge of the specificities in mental health needs to be worked on in the daily life of the health services, Permanent Education, improvements and specializations about mental health.

Ineffective communication between services that integrate mental health actions compromises the workflow of referral and counter referral of the treatment. As long as the logic of care does not happen, abandonment of treatment by the person may occur, which implies a failure in the integrality of the actions and insufficient resoluteness in the attention to the user. Communication between professionals who assist people with mental disorders needs to happen in the transversality of treatment, when all those involved are aware of it.

It is a fact that professionals, in order to aggregate resoluteness to their actions, need to broaden the discussion about the organization of services to attend the user, involving service managers and promoting investigations about the challenges faced by professionals to integrate mental health in Primary Care.

Finally, this study made it possible to glimpse gaps in terms of the organization of services and the training of professionals, and the disregard for health policies that are often disregarded.

The study allows theoretical-practical articulations with potential to support reflections and enable changes in the mental health care of the Primary Care network.

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