Cogitare Enfermagem

ORIGINAL ARTICLE

PROTOCOLS FOR MENTAL HEALTH CARE IN PRIMARY-LEVEL SERVICES: SUBSIDIES FOR TRANSFORMING THE ASSISTANCE PROVIDED

Gisele Fernandes Tarma Cordeiro[1]
Tatiana Marques dos Santos[1]
Rosa Gomes dos Santos Ferreira[1]
Ana Paula Freitas Guljor[1]
Angela Aparecida Peters[2]
Maria Angélica de Almeida Peres[1]

ABSTRACT
Objective: to analyze the repercussions on mental health care due to the implementation of Care Conduct Protocols in a Basic Health Unit from Juiz de Fora (Minas Gerais – Brazil). Method: a historical-social study carried out in 2018, having as direct sources written documents and oral testimonies analyzed according to the assumptions of the Psychiatric Reform. Results: the following categories are presented: a) Reorganization of mental health care through the implementation of Conduct Protocols; b) Referral and counter-referral process between Basic Health Units and specialized mental health care services; and c) Transformation of mental health care. Conclusion: the protocols organized the mental health care network, supporting multiprofessional training, introducing Primary Health Care as a gateway to welcoming, treatment and monitoring in territorial mental health.

DESCRIPTORS: Community Mental Health Services; Primary Health Care; Health Centers; Mental Health Care; Patient Care Team.

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[1]Universidade Federal do Rio de Janeiro, Escola de Enfermagem Anna Nery, Rio de Janeiro, RJ, Brasil.
[2]Escola Nacional de Saúde Pública, Fundação Oswaldo Cruz, Rio de Janeiro, RJ, Brasil.

INTRODUCTION

Until the 1980s, the mental health care model in the municipality of Juiz de Fora (Minas Gerais) was exclusively based on hospitalization in private hospitals, resulting in an industry of power, profit production, ill-treatment and invisibility of people in psychological distress. Consequently, the mental health care reality in Juiz de Fora became known worldwide for integrating the "corridor of madness" together with the cities of Barbacena and Belo Horizonte[1-2].

As a result of the strong asylum tradition, the process to implement the Psychiatric Reform (PR) in Juiz de Fora was initiated with the important social movement of health workers. The reformist initiatives in search of mental health care at the community level gained strength after repeated complaints to the Ministry of Health (*Ministério da Saúde*, MS), which reflected in the gradual closure of psychiatric hospitals. In this context, the year 1997 marks an important advance in the assistance field through an initiative to reformulate mental health care, with the objective of welcoming de-hospitalized people in the community[2].

Care reformulation in the city was carried out by the Mental Health Institute directors and coordinators with the support of the Minas Gerais State Health Department, the Ministry of Health, health professionals from the City Hall and professors from the Federal University of Juiz de Fora (*Universidade Federal de Juiz de Fora*, UFJF), together with the Psychiatry and Medical Psychology Service of the University Hospital, which proposed creating and implementing Conduct Protocols of the Juiz de Fora Municipal Mental Health System (*Sistema Municipal de Saúde Mental de Juiz de Fora*, SMSM/JF) with the intention to promote articulation between the primary, secondary and tertiary health care levels[2].

The social movement, as well as the authors, workers and managers of the city, were active participants through meetings, conferences, forums and other encounters that made possible to de-hospitalize users institutionalized on a long-term basis.

The merit was in investing in care in accordance with the principles of universal care, equality in access and comprehensiveness of actions subsidized by the SUS. The categorical objective was to turn Basic Health Units (BHUs) into the gateway, the first mental health care instance, in order to welcome, treat and monitor people in psychological distress and their family members in the area of residence. The protocols consisted of a manual that became known as the "Green Book" due to the color of its pages and served to equip the multiprofessional team, in primary care and at other levels, to meet in the context of de-hospitalization and reduction in the number of psychiatric beds[3].

Its content included a quick consultation guide to the main comorbidities found in the de-hospitalization process, at the different care levels and devices. A general flowchart of mental health care in the BHUs was defined, which directed identification of the risk groups and schematically guided the courses of action: caring, referring or supervising. Finally, there were specific chapters that dealt with the Psychiatric Emergency Service; Motivational Interview; Psychotropic Drugs in Primary Care and the Psychology of Illness[3].

To enable use of the Conduct Protocols as a guide for mental health care, it was necessary to articulate the new mental health care system, the Regional Mental Health Reference Centers (*Centros Regionais de Referência em Saúde Mental*, CRRESAMs) and the Special Mental Health Programs (*Programas Especiais de Saúde Mental*, PROESAMs). The CREESAMs were intended for secondary level mental health care and operated as fundamental instances in the supervision and follow-up process in this specialty. They had operational objectives related to referral and counter-referral actions, organizing the flow of users, as well as supervising the BHU teams. On the other hand, the PROESAMs were responsible for offering specific treatments for each group of mental disorders, according to the pathologies classified by the International Code of Diseases (ICD-10), in

order to develop a therapeutic project and define prioritization parameters related to the peculiarities of each case. Although they were very similar to psychiatric outpatient clinics, seen as a starting point for the biomedical model, they made it possible to reorganize the network[3]. It is noted that the creation of matrix support only took place a few years later, in 2014[4-5].

The de-institutionalizing strategies undertaken in the municipality have contributed aids to understanding the history of mental health in Brazil and describe interfaces proposed by Primary Health Care (PHC), relevant to the process of disseminating anti-asylum ideas by managers and mental health workers in society, evidencing such a movement as prior to the national laws, which standardized and encouraged de-institutionalization in the country.

When commemorating 20 years of the enactment of Law No. 10,216/2001, it is fundamental to analyze the construction of the psychosocial field in Brazil. This is a political moment that enables a psychiatric counter-reform process, presented in Ministry of Health Resolution No. 32/2017(6), which included specialized psychiatric hospitals in the Psychosocial Care Network (*Rede de Atenção Psicossocial*, RAPS), among other guidelines for their support, which makes productions and actions urgent to foster discussions about the human rights of people in psychological distress. It is necessary to scientifically reassert the power of the substitute services to the asylum, among them, the inclusion of mental health care in the BHUs, consolidated as an indispensable device in the RAPS. This study aims at analyzing the repercussions on mental health care due to the implementation of Care Conduct Protocols in a Basic Health Unit from Juiz de Fora (Minas Gerais – Brazil).

METHOD

A historical-social study developed from the perspective of the History of the Present Time, which does not renounce written documents and considers oral history as a way of producing data for recovering history, considering the memory of those who lived and participated in the facts[7]. The documentary corpus consisted of direct, written and oral historical sources and indirect sources, which supported discussion of the results.

The time frame begins in 1997, when the Conduct Protocols were implemented at the BHU in the West region of Juiz de Fora, and ends in 2001, the year in which Law No. 10,216 that instructed substitution of the asylum-based care model by the psychosocial one was enacted.

The research setting was a BHU located in the West region of the municipality of Juiz de Fora, where the pilot project to use the Conduct Protocols was implemented, which was expanded to the other BHUs in the city. At the time of this implementation, the care provided to people in psychological distress at the BHU was in charge of the health team, consisting of nurses, nursing assistants, social workers, general practitioners, psychiatrists, psychologists and pharmacists, in addition to the administrative team.

The written documents consisted of those of SMSM/JF, including the Conduct Protocols and those related to the reformulation of mental health care in PHC. In order to evidence the historical phenomenon, documents were produced with oral sources from interviews with six participants, professionals involved with the implementation of the protocols at the BHU. The participants were identified through the documents and indicated by professionals from the municipality, adopting the following inclusion criteria: having worked in management of the SMSM/JF Conduct Protocols or as a health professional at the BHU in the West region of Juiz de Fora in the period when these protocols were implemented. The professionals who joined the BHU at the end of the study (2001) were excluded from the research. The indirect sources consisted of articles on the theme.

All the documents went through a scanning process and were organized into folders

named according to the theme. For the analysis of the written sources, an instrument created by the researcher was used to examine them, so as to assist in data treatment. The following rules and criteria were considered: pertinence, sufficiency, exhaustiveness, representativeness, homogeneity, and organization of the documentary *corpus* by sectors[8].

Thematic oral history was the technique for oral data collection[9]. Interviews guided by a semi-structured script were carried out from May to July 2018, with a mean duration of 50 minutes. Subsequently, they were transcribed and validated by the participants after reading the textualized material, by signing the Free and Informed Consent Term. The place for the interviews was defined by the participants. To identify the interviews, the initial letter of their profession was used, followed by the number corresponding to the sequential order of the interviews: nurse (N3), Physician (P4; P5; P6), Social Worker (SW1); and Nursing Assistant (NA2).

The analysis was carried out using the procedures considered as internal and external criticism to eliminate possible divergences as to the origin and content of the sources and to establish the study reliability criteria[9]. In this stage, triangulation of all the sources was carried out in order to establish a dialectical movement, enabling a better understanding of the results obtained. The data collected were organized chronologically, so that interpretation of the story could be carried out, according to the objectives to be achieved by the research.

The last methodological stage consisted in discussing the data interpreted in the light of authors who advocate the concepts supporting the PR movement and mental health actions in primary care. The following categories emerged: a) Reorganization of mental health care through the implementation of Conduct Protocols; b) Referral and counter-referral process between Basic Health Units and specialized mental health care services; and c) Transformation of mental health care.

The study was approved by the Research Ethics Committee of the proposing institution under Opinion No. 4,845,403, dated July 14th, 2021.

RESULTS

Reorganization of mental health care through the implementation of Conduct Protocols

The context in which the protocols were implemented at the BHU was the effervescence of people in psychological distress leaving psychiatric hospitals, pioneered by the PR in Juiz de Fora in the 1980s[4]. The municipality was *avant-garde* in concentrating efforts to achieve this paradigmatic transformation only possible through the action-reflection-action process of its social actors.

The protocols were fundamental because they emerged from the de-hospitalization context. It was necessary, as it encouraged the development of an efficient outpatient care structure. (SW1)

The protocols came in a context: the Psychiatric Reform and de-hospitalization. The service should then happen to meet this demand, especially in the specific mental health care included in Primary Health Care. (N3)

The demand for mental health has always been intense and, prior to the implementation of the Conduct Protocols, the system was disorganized (...) this care model is part of the larger issue, which is de-hospitalization in mental health. (P4)

The Conduct Protocols served to simplify diagnosis in basic, general areas. They allowed

BHU professionals to identify those patients who eventually brought some psychological distress and deserved attention. Thus, they were referred with basic guidance and a diagnosis. (P5)

The professionals at the BHU located in the West region recognized that interventions were necessary to facilitate the process to welcome people in psychological distress who were de-hospitalized because, before arriving at the BHU, they were in a space surrounded by coercive practices. In this sense, interdisciplinarity aimed at reorganizing the assistance provided and management of the Conduct Protocols to include mental health care in primary care duties.

The protocols were created by a multidisciplinary team (...) we discussed and presented suggestions regarding what could be done, reformulating the system. (N3)

There were Nursing professionals, social workers and physicians. We discussed and developed the outline of the tools that would be used to create diagnostic hypotheses to be employed by medical and non-medical professionals in primary care. (P4)

The organizational decision to implement the protocols took place through a meeting, still in the system formulation phase (...) professionals from the multidisciplinary team from almost all units participated so that we could present suggestions. (P5)

The importance of dialogue between health devices is identified, especially when referring to the situational diagnosis of a population, its interests and its care demands. Before creation of the protocols there was concern among managers and teams to get to know the clientele, their problems and needs, which, in the context analyzed, stands out as a problem situation: psychological distress.

Referral and counter-referral process between Basic Health Units and specialized mental health care services

The participants recognized that the CRRESAMs, together with the PROESAMs, responsible for specialized mental health care in the secondary level, operated as fundamental instances of the mental health care network.

We thought about the referral modality for the secondary care teams, the counter-referral processes, how they would take place and, from there, we put it into practice (...) and it expanded to the municipality. (P4)

When the PR was conceived, the idea was not only to remove patients from the hospitals, but to establish an adequate flow, which meant having a defined entry point and having an efficient referral and counter-referral mechanism. (P5)

The CRRESAMs received these patients from the BHUs (...) their role was to try to define the status of the referred patients, whether they needed to be seen by a specialist: if so, they were referred to the PROESAM; if not, they would be counter-referred with supervision by the CRERESAM. The following month, the team took the case and offered its feedback, explaining what should be done to the primary care team. (P6)

Referral and counter-referral are frequently presented by the participants, with the need to note these professionals' maturity in an attempt to reorganize the care flow in the health system, adopting the BHU as the preferred gateway to mental health care in the territory, according to regionalization.

Transformation of mental health care

A connection is assumed between mental health clinics and the primary health care level from the implementation and development of the Conduct Protocols.

(...) it is there that lies the importance of integrating mental health actions with health in a comprehensive way (...) mental health is part of health care, it is a specialty like any other. (P6)

The protocols humanized the service, it was possible to refer and have contact, to know what happened to each person. (N3)

Comparing the psychiatric hospital and the BHU, welcoming was better in the first than in the second. There was no service at the BHU before 1990. The patients arrived at the emergency room with complaints and were referred to the psychiatric hospital. With care at the BHU, people did not even go to the hospital. (NA2)

In this system there was referral where the control was scheduled if the patient was assisted or not, we had feedback (...). (P4)

It was very effective for the patients. The protocols allowed for basic approaches. If the patients had a more severe profile, they were referred (to the secondary level); if the profile was a demand for assistance at the primary level, they (also) received assistance. (P5)

The data portray the expansion of health care in the sense of the whole, the interlocution between specialties and the individuals' demands. It is only by reaching this level and critical sense that settings are transformed and adapted to the population before any political interests, paradigms and laws. In this way, according to the struggle of the reformist social movement, interests that are in line with the SUS guidelines and principles such as equality, regionality, access to human subjectivity, integrality and social participation are integrated into these concepts and its actors.

DISCUSSION

Hospital discharge of an increasing number of people in psychological distress stimulated a discussion that started a process consisting in articulating networks and offering support so that the BHUs were better able to offer mental health care.

In Juiz de Fora, mental health care feasibility became possible during this period due to the engagement of professionals in the planning and organization of an outpatient structure. The changes discussed in the legal-political and technical-assistance fields provided an opportunity to reflect on the transformation of the mental health care paradigm in which the fundamental aspect was not only to close the asylums, but to open the doors of the community to welcome these people in their territory of belonging, in view of the territorialization of BHUs[5,10].

Creation of the protocols was strengthened by the emphasis on primary care in mental health, discussed by the IV State Health Conference in the 2000s, in which the objective was to build a regionalized and hierarchical care network. The proposal was conceived based on the BHUs and referred to the CRRESAMs under monitoring of the PROESAMs, which, linked to the other care levels in the health system, aimed at care promotion and continuity[3].

The articulation between the primary, secondary and tertiary care levels was one of the advances brought about by the Conduct Protocols, considering the SUS prerogatives.

At the national level and based on the concerns raised by the PR, in order to deal with the transformations pointed out, the health teams and society needed to understand that, by remaining linked to the asylum model, they suppressed the citizenship of people in psychological distress[11]. The Health Reform and the PR were not independent movements and, even today, their theoretical-conceptual bases feed back in the sense of providing

egalitarian and adequate care based on the interlocution of a network of services[12].

In the context of the implementation of the Conduct Protocols in 1997, the intention to conduct health services in support of the de-hospitalization process was perceived, which was not simple in a municipality where the number of private psychiatric clinics sustained the economic power of an influential medical group[13].

In the proposal for conducting mental health care implemented by SMSM/JF, the service should be planned and organized based on the consideration of multifactorial variables that encompass the subjectivity of each person. For this, good quality integration between the members of the health team was essential, as well as with the other network services[5].

It is pointed out in the literature that the specificities and ranges of mental health care, through the interface with the PHC, complement each other and enhance their role in offering comprehensive care; however, it is still common to conduct care through medicalization. When looking at the process herein studied, it is relevant to note the importance of establishing the mental health care network together with the support network for primary care professionals[12].

The municipality invested in offering mental health care so that the professionals had support for the care to be provided, although without being able, at that moment, to prepare the teams for de-institutionalizing actions, a more complex process that would be the object of investment later in time. The BHU teams' acceptance to follow the protocols and the way they recognize them as instruments to qualify mental health care, eliminating behaviors consisting in reproduction of prescriptions and referrals, represent a transformative step in care.

The object under study reflects a paradigmatic change in the field of the PR by showing that, in the perception of the professionals involved with the implementation of the Conduct Protocols, medical knowledge is no longer unique in care organization, and the other team members have gained space to contribute to management of these protocols.

Juiz de Fora took a step forward in the field of mental health care, as the possibility of discussion among professionals made it possible to exchange knowledge through the theoretical foundation that encompasses the various specialties, which qualifies the services due to horizontality in the relationships among health professionals, bringing them closer to the concept of an interdisciplinary team[12].

From the moment that a paradigmatic transformation of mental health care takes place, paths are opened to substitute the hospital-centered, isolated and coercive model with a multidisciplinary, territorial and community one, giving rise to nuances that stand out and are seen as inseparable from life, health and human rights.

Teamwork is one of the challenges for quality care and must be increased by integration and knowledge of the possibilities and limits of actions, characterizing interdisciplinary dialogue, which favors alternatives that contemplate human rights in the territory, through exchanges of experiences in the collective construction movement, which generates comprehensive care without hierarchy[13].

The possibility of including institutionalizing behaviors, stigma and prejudice of "mental disease", in parentheses is considered as a scientific option, with the objective of listening to these people's voices beyond stereotyped interpretations and pre-judgments, shedding light on the subjects loaded with subjectivities, their family members and non-Psychiatry specialists. This conception allows a therapeutic relationship for the elaboration of a freedom plan[14-15].

To guarantee access to health care, as one of the SUS guiding principles, it is necessary to think about health in its expanded concept and to make use of prevention

and promotion strategies as allies to guarantee this. The proposal of the protocols was to decentralize care, introducing the BHU as a gateway, becoming an important device for network care, which was based on the promotion of territory-based care[2,10].

There is an articulation between the BHU and the other care levels currently put into practice in Juiz de Fora, which are recognized as matrix support in health and focus on health production and on shared construction between the clinics. This care model enables a transformation of the work process through care co-responsibility among the teams that comprise the health care instances in the territory[16].

The professionals who created the 'protocols' understood mental health as a specialty that demanded care like any other clinical condition. This was possible given the strengthening of the referral and counter-referral system, nowadays called articulation in a network, which is characterized by the attempt to organize access to the secondary health system, evaluation, screening, referral and expansion of the care to be provided for health problems.

Juiz de Fora innovated in the field of mental health care by including psychological distress in the framework of care needs offered at the BHU, identified as a public policy in the 1990s. The above corroborates the reflection that mental health care is effective when it provides the opportunity for freedom of social coexistence and expands exchange through the full exercise of democracy in the territory, enabling the production of meanings[17].

The Conduct Protocols were relevant for the promotion of welcoming in the people's area of residence, enabling care humanization and the promotion of bonding as a fundamental factor for treatment continuity. De-institutionalization prevails in its assistance dimension, which opens space in the territory to provide assistance beyond mental illness, expanding actions that place, as a priority, each human being's subjectivity at the heart of the scene[5].

The notes ratify what has been discussed in the last 20 years, in which more than half of the mental health care services seek to act in a network, through articulation with PHC, resorting counseling strategies, some related to specific interventions (consultations) and others focused on pedagogical care actions in which the team has the possibility to discuss cases and ensure care continuity[18,19,20].

The process to regulate mental health care in Brazil has taken place since the 1990s. However, it was only in 2001 that its legal-political dimension was ratified through the legal framework established by Law No. 10,216, which transformed the National Mental Health Policy (*Política Nacional de Saúde Mental*, NMHP), territorially based and grounded on care in freedom, into a State policy. Through the concept of integrality, Psychosocial care establishes de-institutionalization as a guide to care for people in psychological distress and recognizes their rights as citizens[4].

The experience herein discussed reflects the challenge of outlining a continuous practice, not always linear, of a path for human rights and for the citizenship of people in psychological distress. Despite its limitations in the context of the complexity of multidimensional interventions, it presented strategies used in a historical framework for the continuous construction of an anti-asylum clinic whose territory is the space that generates possibilities[21,22].

The limitations of this study are restricted to new historical sources, which may be discovered or located over time and which may come to relate new facts and adjustments to this history of social struggle, given that social movements are alive and come from different interlocutors.

FINAL CONSIDERATIONS

This study is a record of how Brazil is moving towards reformed mental health care and the importance of managers, professionals and users in advancing conquest of the territory as a place of psychosocial care and assistance. The dialogue between mental health and primary care, expanded by the implementation of the Conduct Protocols, was able to meet the paradigm supported by the PR and the SUS care prerogatives.

The final reflection is that, even before the milestone of Law No. 10,216/01, which turned 20 years old in 2021, the PR was developed in the face of the wish of the anti-asylum movement, desirous of ending indiscriminate and permanent institutionalization of people in psychological distress in Juiz de Fora and, certainly, in other municipalities for conquering human rights in society. In order to effectively get to know the Brazilian PR, studies in all regions of the country must be encouraged to record and publicize so many struggles that were and are being fought in the field of mental health since the first steps of the Anti-Asylum Struggle and that are now threatened by the counter-reform movement.

The results make it possible to reflect on the challenges to contemplate equitable care, as the asylum culture does not present itself as exclusive to psychiatric hospitalization environments but it is also present in society, and the historical construction and its tensions should be understood so that coercive practices are not concealed in spaces that aim at psychosocial rehabilitation.

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Corresponding author:
Gisele Fernandes Tarma Cordeiro
Universidade Federal do Rio de Janeiro- Escola de Enfermagem Anna Nery
R. Afonso Cavalcanti, 275 - Cidade Nova, Rio de Janeiro - RJ, 20211-130
E-mail: gisele_fernandes123@hotmail.com

Role of Authors:
Substantial contributions to the conception or design of the work; or the acquisition, analysis, or interpretation of data for the work - Cordeiro GFT, Peres MA de A. Drafting the work or revising it critically for important intellectual content - Cordeiro GFT, Santos TM dos, Ferreira RG dos S, Guljor APF, Peters AA, Peres MA de A. Agreement to be accountable for all aspects of the work in ensuring that questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved - Cordeiro GFT, Peres MA de A. All authors approved the final version of the text.

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