Original Article

Attitudes of Primary Health Care nurses towards mental illness: Brazil-Portugal comparison

Atitudes de enfermeiros de cuidados primários frente à doença mental: comparação Brasil-Portugal

Actitudes de enfermeros de atención primaria de salud con relación a personas con enfermedad mental: comparación Brasil-Portugal

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Abstract

Objective: To analyze comparatively the attitudes and experiences of Primary Health Care nurses from Brazil and Portugal towards people with mental illness.

Methods: This cross-sectional and quantitative study was conducted with 500 Primary Health Care nurses. Data were collected through a socio-demographic questionnaire and the Opinions about Mental Illness scale. Descriptive and correlational statistics were applied using Mann-Whitney and Spearman correlation tests ($p<0.05$).

Results: Brazilian and Portuguese nurses showed positive attitudes by presenting, in the total dimensions of the scale, a score below the mean, 43% and 74%, respectively, except in the Authoritarianism (M=44.6), Social Restriction (M=42.0) and Interpersonal Etiology (M=30.6) dimensions. Compared to people with mental illness, Brazilian nurses had a higher mean.

Conclusion: Overall, attitudes in both countries towards people with mental illness are positive, except in the Authoritarianism dimension. Care experiences interfere with the attitudes of nurses in both countries. Negative attitudes should be recognized and deconstructed for the inclusion of mental health in Primary Health Care.

Resumo

Objetivo: Analisar comparativamente as atitudes e as experiências de enfermeiros de cuidados primários de Brasil e Portugal frente à pessoa com doença mental.

Métodos: Estudo transversal, quantitativo realizado com 500 enfermeiros de cuidados primários. A coleta dos dados ocorreu por meio de questionário sócio demográfico e da escala "Opiniões sobre a Doença Mental". Aplicou-se estatística descritiva e correlacional, com os testes de Mann-Whitney e correlação de Spearman ($p<0,05$).

Resultados: Os enfermeiros brasileiros e portugueses demonstraram atitudes positivas ao apresentar, no total das dimensões da escala, pontuação abaixo da média (43%) e (74%), respectivamente, exceto nas dimensões Autoritarismo (M=44,6), Restrição Social (M= 42,0) e de Etiologia Interpessoal (M=30,6) frente à pessoa com doença mental, os enfermeiros brasileiros apresentaram média mais elevada.

Conclusão: No geral, as atitudes em ambos os países em relação às pessoas com doença mental são positivas, exceto na dimensão Autoritarismo. As experiências de cuidados interferem nas atitudes dos enfermeiros nos dois países. Atitudes negativas devem ser reconhecidas e desconstruídas para inclusão da saúde mental nos cuidados primários.

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Resumen

Objetivo: Analizar comparativamente las actitudes y experiencias de enfermeros de atención primaria de Brasil y Portugal con relación a personas con enfermedad mental.

Métodos: Estudio transversal, cuantitativo realizado con 500 enfermeros de atención primaria. La recolección de datos ocurrió mediante un cuestionario sociodemográfico y con la escala "Opiniones sobre enfermedades mentales". Se aplicó estadística descriptiva y correlacional, con las pruebas de Mann-Whitney y correlación de Spearman ($p<0,05$).

Resultados: Los enfermeros brasileños y portugueses demostraron actitudes positivas al presentar una puntuación por debajo del promedio en el total de las dimensiones de la escala (43 % y 74 %, respectivamente), excepto en las dimensiones Autoritarismo (M=44,6), Restricción social (M=42,0) y Etiología interpersonal (M=30,6) con relación a personas con enfermedad mental, que los enfermeros brasileños presentaron un promedio más elevado.

Conclusión: En general, las actitudes de ambos países con relación a las personas con enfermedad mental son positivas, excepto en la dimensión Autoritarismo. Las experiencias de la atención interfieren en las actitudes de los enfermeros en los dos países. Las actitudes negativas deben reconocerse y deconstruirse para que haya una inclusión de la salud mental en la atención primaria.

Introduction

Worldwide, approximately 650 million people meet diagnostic criteria for mental illness,[1] which represents an important public health problem due to its chronicity and treatment difficulties.[2.3] Mental illnesses are characterized by apparent behavioral changes that can generate negative attitudes and associated beliefs.[4]

The belief that people with mental illnesses are dangerous and responsible for their own disease triggers stereotypes about this clinical condition.[3] By agreeing with a certain stereotype and emotionally considering this idea, due to some behaviors, such as fear of people with mental illness, prejudice is established.[5]

Stigma linked to mental illness compromises the biopsychosocial and emotional well-being of people, family members and caregivers, as well as their behavior in seeking health care.[4] In the mental health field, the stigma of both the general population and health professionals is observed, and they externalize more negative attitudes towards the progress of treatment,[6.7] hindering its evolution.[8]

Stigmatizing behavior is based on a sociocultural component in the face of something, involving affective, cognitive and behavioral domains in the face of a social situation. It is considered a response to a stimulus that can negatively influence the social integration of the individual, or positively, when it provides support to the person with mental illness.[9] Whereas primary health work nurses are at the forefront of care and that their attitudes may interfere with the quality of care they promote,[7] it is essential that they are prepared and supported to constitute positive attitudes, reflected in therapeutic relationships that are an indicator of results for the improvement of treatment/rehabilitation.[4]

Studies that investigate and contribute to promote change in attitudes related to stigmatized health problems are necessary to boost practices that strengthen care, guided by continuing education and targeted training,[10] thus corroborating the relevance of understanding how the phenomenon attitudes process.[6] In a literature review, studies on attitudes of Primary Health Care professionals were found, however, some do not contemplate the opinion of nurses. In China, a study with primary health care providers points out pessimistic and negative attitudes towards people with mental illness.[6] In Finland[10] and South Africa ,[11] Primary Health Care nurses have positive attitudes towards this clientele. It should be noted that none of these studies used the Opinions about Mental Illness (OMI) scale proposed here.

A comparative study between European countries,[12] including Portugal, makes an approximation with the theme attitude, but does not specifically evidence the reality of attitudes of Primary Health Care nurses. In Brazil, there are no studies with Primary Health Care nurses in the face of mental illness, and those who approach were conducted with nurses from psychiatric units and general urgency/emergency,[13.14] using the OMI scale. Thus, little is known in both countries about the attitudes that Primary Health Care nurses have towards people with mental ill-

nesses and their experiences of care, constituting a research gap that determines the essence of the attitudes of this group.

In the context of mental health policy reforms, Brazil and Portugal approach the agenda of mental health insertion in Primary Health Care,[15] but to sustain it must bring Primary Health Care nurses closer to the needs of people with mental illnesses and invest in knowledge/skills that help them identify, care for and refer people with mental diseases to specialized works in a qualified manner. Therefore, this study aimed to analyze comparatively the attitudes and experiences of Primary Health Care nurses in Brazil and Portugal towards people with mental illness.

Methods

This is a cross-sectional, descriptive, quantitative, multicenter study, developed in six Family Health Units of the Northern Regional Health Administration, Porto/Portugal and 69 Basic Health Units of the six Regional Health Coordinators of São Paulo, São Paulo/Brazil.

The study participants were nurses recruited through a non-probabilistic sample. The inclusion criteria were being a nurse, regardless of the time passed after graduation and operating at the current work, working in management and/or care. A total of 500 nurses presented eligibility criteria in both countries, 250 of each.

Data collection was performed from April to August 2018, in both countries simultaneously, through a Googledocs form, containing socio-demographic data such as sex, age, marital status, academic qualifications, time passed after graduation, operation at the current work, weekly workload, experience/frequency with which it is faced with people with mental illnesses. Initially, telephone contact was made with the health works coordinators to talk about the research, to disclose to nurses and request voluntary participation, with positive feedback. To ensure confidentiality in the collection, the coordinators of the works were sent the link to Googledocs (research forms, guidance for completion, and Informed Consent Term) to pass on to the nurses' e-mails.

Attitudes towards mental illness were raised by the OMI scale.[16] The OMI was developed by Struening and Cohen in 1963, being widely used in national and international literature. The OMI was translated and validated into Portuguese by Rodrigues (1983) to be used in Brazil,[17] under the title "*Escala de Opiniões sobre a Doença Mental* (ODM)". Since this research is in the public domain in Brazil and Portugal, there was no need to request authorization from the authors.

The OMI consists of 7 dimensions: Authoritarianism, with 11 questions about the opinion about the subject with mental illness belonging to a "class of people with lower value"; Benevolence, with 14 questions about paternalism in relation to individuals with mental illness; Mental Hygiene Ideology, with 9 questions about the perception of the mental patient as being a "normal person"; Social Restriction, with 7 questions about mental patient x dangerousness for society; Interpersonal Etiology, with 10 questions in the face of the belief that mental illness is the result of poor interpersonal experiences lived in childhood. In total, there are 51 questions. It has amplitude from 51 to 306, with midpoint 178.5. The higher the mean (midpoint) obtained, the more negative the attitudes are, except for the Benevolence and Mental Hygiene Ideology dimensions.

The data were encoded, cleaned and analyzed by using the software Statistical Package for the Social Sciences (SPSS), version 25. Descriptive and correlational statistics were applied to verify the correlation between the socio-demographic/labor variables and the OMI dimensions in the samples. Mann-Whitney and Spearman correlation tests were applied. The 95% Confidence Interval was adopted, which presented significance among the results with a p value of <0.05.

The study followed all ethical principles in research. The Ethics Committee on Research with Human Beings of the *Universidade Fernando Pessoa* of Porto/Portugal (Opinion 155-2017), and the *Escola de Enfermagem da Universidade de São Paulo* (Opinion 2,384,303) approved the study, in accor-

dance with the Declaration of Helsinki. All participants signed a consent term for participation.

Results

Based on the findings, there are important differences between Brazil and Portugal, especially regarding the fact that Portuguese nurses are older, have more time passed after graduation, have job stability, and many have a Master's degree. The socio-demographic variables in common between the two realities are: female, married, age ranging from 36 to 42 years, and who have had experience with people with mental illness.

In relation to the time passed after graduation and operating at the current work, Portuguese nurses presented higher frequency, 10-20 years= 34.8% and 10-20 years= 36.4%, than Brazilians, 5-10 years= 39.2% and 1-5 years= 42.8%. Concerning weekly workload, Brazilian nurses had a higher mean (40 hours= 62.8%) than the Portuguese (35 hours= 54.4%), as well as the frequency with which they come across people with mental illnesses (daily= 63.3%) and Portugal (weekly= 34.3%). In relation to academic qualifications, Portuguese nurses have a higher number of Master's degrees (18.0%) (Table 1).

Portuguese nurses have more experience with people with mental illnesses (94.8%), are faced weekly with people with this condition (34.8%), consider adequate their knowledge about health care needs with this clientele (53.2%), consider inadequate the assessment of health needs and the care provided in their works (63.6%) and (54.8%), respectively.

Brazilian nurses believe that their knowledge about health care needs is very adequate (42.0%), consider that primary health care provided in mental health is very adequate (50.4%), data higher than the universe Portuguese. They also believe that the assessment of the health needs of people with mental illnesses is adequately conducted (33.6%), the care provided by their works is adequate (40.4%) and very adequate (31.6%), demonstrating relevant contrasts (Table 2).

Table 1. Sociodemographic characterization of the sample, study on PHC Attitudes, Porto-Portugal and São Paulo-Brazil, (n = 500) nurses

Variables	Portugal (n=250) n (%)	Mean (+/-SD)	Brazil (n=250) n (%)	Mean (+/-SD)
Sex				
Male	43(17.2)		36(14.4)	
Female	207(82.)		214(85.6)	
Age (years)		42.0(7.7)		36.3(7.7)
Marital status				
Single	23(9.2)		88(35.2)	
Married	178(71.2)		143(57.2)	
Common-law marriage	23(9.2)		-	
Separated	3(1.2)		2(0.8)	
Divorced	20(8.0)		-	
Widow	3(1.3)		17(6.8)	
Academic qualifications				
Bachelor's degree/Teaching degree*	202(80.)		238(95.2)	
Master's degree	45(18.0)		10(4.0)	
Doctoral degree	3(1.2)		2(0.8)	
Time passed after graduation				
< 1 year	5(2.0)		2(0.8)	
1 to 5 years	50(20.0)		76(30.4)	
5 to 10 years	33(13.2)		98(39.2)	
10 to 20	87(34.8)		63(25.2)	
> to 20 years	75(30.0)		11(4.4)	
Time of operation at the current work				
< 1 year	7(2.8)		38(15.2)	
1 to 5 years	50(20.0)		107(42.8)	
5 to 10 years	65(26.0)		66(26.4)	
10 to 20	91(36.4)		33(13.2)	
> to 20 years	37(14.8)		6(2.4)	
Weekly workload				
20 hours	6(2.4)		-	
30 hours	-		39(15.6)	
35 hours	136(54.)		-	
36 hours	67(26.8)		31(12.4)	
40 hours	40(16.0)		157(62.8)	
44 hours	1(0.4)		23(9.2)	

*Undergraduate degree in Portugal is equivalent to Bachelor's degree in Brazil

Opinions about Mental Illness

Brazilian nurses have a minimum OMI point of 124 and maximum 260, with a mean of 197, above the mean value of the scale of 178.5 and standard deviation of 17.2, which allows establishing that overall, about 43% of Brazilian nurses have positive means, that is, they have positive attitudes towards mental illness. Portuguese nurses had a minimum OMI point of 106 and a maximum point of 220, with a mean of 117.0, below the mean value of the scale of 178.5 and standard deviation of 13.8, which allows establishing that about 74% of Portuguese nurses also have positive means, i.e., positive attitudes in general towards mental illness (Table 3). In relation to the OMI scale dimension, Portuguese nurses have slightly more Benevolent (M=64.41) and Mental Hygiene Ideology (M=39.35) attitudes than Brazilians. Brazilian nurses have more Authoritarianism (M=44.55), Social

Table 2. Characterization of the experiences of Primary Health Care nurses towards people with mental illness, study on PHC Attitudes, Porto-Portugal and São Paulo-Brazil, (n= 500) nurses

Variables	Portugal (n=250) n (%)	Brazil (n=250) n (%)
Experience with people with mental illnesses		
No	13(5.2)	91(36.4)
Yes	237(94.8)	159(63.6)
Frequency of people with mental illnesses		
Daily	65(27.2)	159(63.6)
Weekly	82(34.3)	76(30.4)
Monthly	67(28.0)	15(6.0)
Occasionally	25(10.5)	-
Knowledge about health care needs for people with mental illness		
Very inadequate	10(4.0)	33(13.2)
Inadequate	104(41.6)	14(5.6)
Adequate	133(53.2)	98(39.2)
Very adequate	3(1.2)	105(42.0)
Knowledge about the role of primary health care in mental health care		
Very inadequate	10(4.0)	22(8.8)
Inadequate	113(45.2)	15(6.0)
Adequate	119(47.6)	87(34.8)
Very adequate	8(3.2)	126(50.4)
Assessment of the health needs of people with mental illnesses		
Very inadequate	23(9.2)	60(24.0)
Inadequate	159(63.6)	37(14.8)
Adequate	8(3.2)	84(33.6)
Very adequate	60(24.0)	69(27.6)
Assessment of care for people with mental illnesses provided by their works		
Very inadequate	28(11.2)	33(13.2)
Inadequate	137(54.8)	37(14.8)
Adequate	5(2.0)	101(40.4)
Very adequate	80(32.0)	79(31.6)

Restriction (M= 42.04), and Interpersonal Etiology (M=30.62) attitudes towards people with mental illness, compared to the Portuguese.

Opinions about Mental Illness x specific variables

In the comparison between the two countries, weekly workload is associated with negative attitudes towards Brazilian nurses, being (p=0.324) 40 hours/week (62.8%) in relation to the Portuguese. The time passed after graduation (p=0.198), from 5 to 10 years (39.2%), is positively related, expressing itself in more negative attitudes. The frequency with which Brazilian nurses are faced with people with mental illnesses (p=0.227) correlates positively with the shorter time of operation at the current work (42.8%), expressing itself in more negative attitudes.

The assessment of health needs conducted at work (p= -0.157) is negatively related to the view that this assessment is conducted adequately (33.6%), expressing itself in more negative attitudes towards people with mental illness, contrary to the high levels in the Authoritarianism and Social Restriction dimensions. As for sex, in Portugal, men score a mean of 2.68 more than women in the total OMI scale. In Brazil, men score less (0.246). The longer the time passed after graduation for Portuguese nurses, the total OMI decreases by 0.03 points. The longer the time passed after graduation for Brazilian nurses the total OMI increases by 2.3 points, suggesting that nurses with longer time passed after graduation are less conducive to negative attitudes in both countries (Table 4).

Table 3. OMI Total and Dimensions, study on PHC Attitudes, Porto-Portugal and São Paulo-Brazil (n= 500) nurses

Dimension	Portugal (n=250)								Brazil (n=250)							
	X	SD	Min	Q1	Mean	Q3	Max	(95%) CI	X	SD	Min	Q1	Mean	Q3	Max	(95%) CI
Total Scale	177.04	13.83	138	168.2	177	185	222	175-178.5	197.02	17.25	121	188	198	208	260	195.5-200
Authoritarianism	31.04 64.41	6.56	17	26	31	36	50	30.22-31.86	44.55	6.23	23	41	45	49	63	43.78-45.3
Benevolence		6.97	26	61	65	69	78	64-65.5	51.68	5.37	31	48	52	55	68	51-52.5
Mental Hygiene Ideology	39.35	4.71	23	37	39	43	51	38.76-39.93	28.12	3.97	18	25	28	31	42	27.63-28.6
Social Restriction	24.90	6.05	10	21	25	29	44	24.14-25.65	42.04	5.08	24	39	42	45	55	41.4-42.67
Interpersonal Etiology	17.34	5.57	7	14	17	21	38	16.65-18.04	30.62	4.76	15	28	31	34	42	30.03-31.21

X = mean; Total scale: 51-306 (Midpoint 178); Authoritarianism: 11-66 (Midpoint 38); Benevolence: 14-84 (Midpoint 7); Mental Hygiene Ideology: 9-54 (Midpoint 31); Social Restriction: 10-60 (Midpoint 35); Interpersonal Etiology: 7-42 (Midpoint 24).

Table 4. Correlation of OMI data with socio-demographic and professional variables, PHC Attitudes, Porto-Portugal and São Paulo - Brazil (n= 500) nurses

Variables	Portugal (n=250)			Brazil (n=250)		
	P value	io.CI	hi.CI	P value	io.CI	hi.CI
Female sex	-0.085	-3.201	8.563	0.055	-6.58	6.077
Marital status	-0.034	-5.569	5.608	0.023	-7.070	1.897
Religion	0.068	-4.241	8.259	-0.067	-10.374	4.694
Academic qualifications	0.003	-5.335	4.955	0.006	-6.096	10.833
Time passed after graduation	0.040	-1.955	1.887	0.198**	-0.207	4.85
Time operating at the current work	0.106	-0.531	3.677	0.030	-3.642	0.875
Workload	0.052	-0.977	0.435	0.324**	0.638	1.716
Knowledge needs care in MH	-0.103	-5.871	1.583	0.005	-1.348	3.99
Knowledge role of Primary Health Care in MH care	-0.102	-4.701	2.376	-0.056	-2.536	2.298
Participation in training activity in MH	-0.0333	-3.556	6.505	0.076	-1.924	7.87
Clinical experience with people with MI	-0.078	-10.988	8.955	0.66	-1.433	17.212
Frequency of people with MI	0.034	-3.519	1.112	0.277**	2.795	10.004
Health needs assessment conducted at work	0.054	-4.304	2.571	-0.157**	-3.401	0.399
Assessment assistance available on the work	0.010	-6.646	2.117	-0.075	-7.146	-0.748

*Correlation at level 0.001 (bilateral); **Correlation at level 0.05 (bilateral); ***Significant correlation for p < 0.05; io.CI= Initial Confidence Interval; hi.CI= Final Confidence Interval; MH – mental health.

Discussion

The research was conducted with nurses working in heterogeneous works regarding geographic, demographic, epidemiological, financial reality, number of care practices, human resources, work team, work process, productivity, and type of unit, which ensure home, individual, and family health care.

The work context of nurses in both countries shows relevant differences regarding weekly workload, time passed after graduation, time operating at the current work and academic qualifications that impact the care process of people with mental illness. Similarities do not escape the scope of the reality of the nursing profession in the global context, presenting an eminently female profile.

The results found express, in general, positive opinions towards the person with mental illness, similar to a study developed with Italian, Irish, Finns, Portuguese and African[11.12], except in the Authoritarianism dimension, similar to the reality of Lithuanian and Chinese nurses,[6.12] conducted with another scale of assessment, reality also found in Brazil, using the OMI scale.[14.18] However, although the attitude of Brazilian nurses is negative in the Authoritarianism dimension, this is not enough to indicate the view that people with mental illness are inferior and require an imposing approach on the part of these professionals.

Brazilian nurses have shorter time of operation after graduation, so they are slightly more authoritarian than Portuguese nurses. Studies have pointed out that training evolution over twelve years allows less negative attitudes in the Authoritarianism dimension.[19] More educated nurses are more aware of the stigmas that involve people with mental illnesses in relation to those with less education, which results in less discriminating attitudes.[4] Moreover, the higher are the levels of education that the professional has, the greater the positive impact on the reduction of stigmas and labels.[20] Therefore, designing curricula designed to restrict negative beliefs and attitudes towards mental illness in nursing education can minimize factors that influence these phenomena.[2]

Holding an attitude of authoritarianism, Brazilian nurses believe that people with mental illness are unable to make decisions about their own lives,[21.22] which represents adversity in the health/mental health field that leads to stigmatization, discrimination, obstacles in recovery, social insertion,[8] reproducing the asylum logic, widely confronted by the process of reform of the mental health care model in the two countries.[23,24]

Comparing the two realities, Brazilian nurses also present more negative attitudes in the Social Restriction and Interpersonal Etiology dimensions, which designate that the person with mental illness should be restricted from the social context,[25] and that mental illness occurs due to individual choices conducted throughout life, against the background of problematic interpersonal relationships,[26] data that find answers due to shorter professional train-

ing time.[19] It is emphasized that, when users receive negative attitudes, the future possibilities for nurses to revert them to a positive attitude decrease and impact on their treatment.

The frequency that nurses face people with mental illness is high in the Brazilian reality, but it did not allow more positive attitudes, predominantly authoritarian, restrictive and discriminatory positions. Possibly, these findings are also due to their shorter training time, compared to the Portuguese. However, Brazilians are critical in recognizing the importance of their professional role in primary mental health care, like the Portuguese. By studying the effects of direct and indirect strategies of stigmatizing attitudes in the constitution of a mental health program without stigmas, the authors[25] detected that the time of professional training extends the deconstruction of discriminatory beliefs, the understanding of individualities and comprehensive attention to the needs of the person with mental illness.

A Portuguese research states that the increase in the contribution of clinical experience in mental health is likely to produce more positive attitudes towards people with mental illness.[27] In the case of clinical experience with people with mental illnesses, there was no correlation in relation to the two countries, yet Brazilian nurses affirm that their knowledge is very adequate regarding the health care needs of these people, and the assessment of the care provided by their works, much higher than that which Portuguese nurses consider.

The Benevolence dimension was above average for both nationalities, although slightly higher in the Portuguese reality, and is directly related to the recognition that nurses have of the care needs of people with mental illnesses within their work circumstances, a data corroborated in a Brazilian study.[19]

Having benevolent attitudes means exercising a paternalistic and protectionist view towards the person with mental illness, however, it is questioned whether or not this attitude enhances a more qualified care and confers contractual power to the person with mental illness. It is noteworthy, however, that in nurses this profile predominates a reflection of the paternalistic and gentle singularity in relation to mental illness, whose origins derive from religion and humanism, and not from science.[28]

The work process of Brazilian nurses implies a weekly workload higher than that of the Portuguese and is associated with more negative attitudes. The exposure of the nursing team to long working hours compromises the quality of care,[29] exposes the professional to more exhaustive routines, leading the nurse to prioritize goals and results. The wear and tear in this route can interfere in the relationship it has with the work user, in the narrowing of bonds, in the clinical reasoning and about health needs, reducing its benevolent attitude.

In the reality of Brazilian nurses, negative attitudes come from negative opinions, and are generated by the shorter time of working in the work. As the works, research fields used, are of indirect management, that is, administered by Social Health Organizations, it is high that turnover is high and there is no stability, because labor contracts are conducted according to the labor laws of the country.[30]

The redirection of the Brazilian Mental Health Policy recommends an integrated and expanded network of works, guided by the Psychosocial Care Network (*Rede de Atenção Psicossocial*), guidelines[31] that has in the components of primary works one of the axes for its implantation, and calls to nurses in this field of practice that, daily, they deal with people with mental diseases, a more qualified look. However, their positive attitudes have not yet advanced enough in the face of other realities, since they are more negative than Portuguese nurses. Nevertheless, Brazilian nurses consider that they conduct an assessment of the health needs of people with adequately mental illnesses, an understanding that may compromise their therapeutic behaviors.

The Primary Health Care field does not have nurses specialized in mental health, nor should, since the generalist nurse is committed to training assist the individual in its integrality. However, in many graduations, contents of this sphere are not

addressed, and when they are, the hospital-centered/biomedical logic[32] and little interest arouses in future professionals are weak and restricted. Given this situation, continuing education is a condition *sine qua non* for nurses to identify and intervene early with the person in psychological distress, and/or refer them to specialized works.[33,34]

A study points out that there is a connection between a less critical view of caring for the person with mental illness, the inexperience in the current work field, and/or the absence of additional training in mental health, during or after the training of younger nurses, which result in more stigmatizing attitudes and even fear in dealing with this clientele.[10]

Practical experiences produce more positive changes than theoretical ones in relation to people with mental illness.[33] On the other hand, contact with people with mental illness has a positive impact on beliefs and attitudes, specifically at the level of stigmatizing attitudes and discriminatory behaviors.[5] It is considered that nurses play a fundamental role in the fight against stigma and discrimination, for this, it is necessary more investment in the professional training of Primary Health Care nurses to strengthen their positive attitudes.[10]

Since mental health care needs permeate all levels of health care and should be respected, in both countries investigated, nurses have work experience with people with mental illnesses. It is higher in Portugal, possibly, because they have a much longer time operating at the current work (10 to 20 years) than Brazilians (1 to 5 years).

This reality is currently configured with a high demand in Primary Health Care, a care field that calls for possibilities of responsive and resolutive psychosocial care, consistent with the logic of comprehensiveness and longitudinality of health systems and public policies in force in the world. Mental health care integration to Primary Health Care improves users' access to health works as a whole, minimizes stigmas, discrimination, promotes respect for human rights and represents an important indicator of the quality of care.

Although the limitation of the study falls on the fact that data collection was conducted through electronic questionnaires, which makes it difficult to recognize the total population, it is important to highlight that this study is a pioneer in the investigation of attitudes of Primary Health Care nurses in Brazil and Portugal towards people with mental illness, and has the strength to direct mental health nursing care. Moreover, it subsidizes training programs that qualify teams, with a view to deconstructing the excluding paradigm and strengthening the psychosocial model of care.

Conclusion

This study revealed that in general, attitudes among Primary Health Care nurses in both countries in relation to people with mental illness are positive, except in the Authoritarianism dimension, higher in Brazil. In Portugal, the Benevolence and Mental Hygiene Ideology dimensions predominate. Care experiences showed important differences in attitudes between Portuguese and Brazilian nurses. Variables such as lower weekly workload, longer time passed after graduation, operation at current work and frequency of clinical experience in mental health positively influence attitudes. The opinion that nurses have about their role in the assessment of care and health care needs to people with mental illness also have a positive or negative impact on their work attitudes. The evidence found between the two realities is distinct, but similar in terms of the historical process, therefore, they allow reconfiguring knowledge and care practices, supporting a praxis free of stereotyped conceptions and advancing in the construction of a new paradigm in the Primary Health Care field.

Collaborations

Nóbrega MPSS and Fernandes CSNN participated in the design of the project, analysis and interpretation of the data, relevant critical review of the intellectual content and final approval of the version to be published. Duarte E, Chaves SCS participated in the analysis, interpretation of the data, writing of the article and final approval of the version to be

published. Moreira WC participated in the analysis, data interpretation, writing of the article, relevant critical review of the intellectual content and final approval of the version to be published.

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