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Review Article

Mental health care practices in Primary Health Care: identifying researches in the brazilian context

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Abstract: Introduction: National and international debates point to the importance and necessity of mental health care in primary health care and discuss the main challenges and propositions. Objective: The aim of the present study was to identify and analyze what has been produced in the national scientific literature on mental health care practices in primary health care from a systematic literature review. Method: The review was carried out in the Latin American and Caribbean Literature in Health Sciences database (LILACS), of which 19 articles were eligible to be included in the study, according to the inclusion criteria adopted. Results: Six themes that were most frequently addressed in studies were identified: professional training and qualification; Biomedical model, medicalizing and excluding; Specialty of care; User, family and support network; Powers in the territory; Possibilities and challenges. From the results presented, the difficulties that permeate the care practices in Mental Health in Primary Health Care offered to users in psychological distress are evident. Conclusion: These results, in addition to causing concern, reveal the need for investment in effective and comprehensive care practices, supported by Mental Health and Primary Health Care Public Policies.

Keywords: *Mental Health, Primary Health Care, Care Practices.*

Práticas de cuidado em saúde mental na Atenção Básica: identificando pesquisas no contexto brasileiro

Resumo: Introdução: Debates nacionais e internacionais apontam para a importância e necessidade de um cuidado em saúde mental na atenção básica e discutem os principais desafios e proposições. Objetivo: O presente estudo tem por objetivo identificar e analisar o que tem sido produzido na literatura científica nacional sobre as práticas de cuidado em saúde mental na atenção básica à saúde, de acordo com uma revisão integrativa de literatura. Método: A revisão foi realizada na base de dados Literatura Latino-Americana e do Caribe em Ciências da Saúde (LILACS), tendo 19 artigos sido elegíveis para integrar o estudo, conforme os critérios de inclusão adotados. Resultados: Identificaram-se seis temáticas abordadas com mais frequência nos estudos: formação e capacitação profissional; modelo biomédico, medicalizante e excludente; especialidade do cuidado; usuário, família e rede de apoio; potencias-práticas no território; possibilidades e desafios. Com base nos resultados apresentados, evidenciaram-se as dificuldades que permeiam as práticas de cuidado em Saúde Mental na Atenção Básica oferecidas ao usuário em sofrimento psíquico. Conclusão: Tais resultados, além de causarem preocupação, revelam a necessidade de investimento em práticas de cuidado efetivas e integrais, respaldadas pelas Políticas Públicas de Saúde Mental e de Atenção Básica.

Palavras-chave: *Saúde Mental, Atenção Básica à Saúde, Práticas de Cuidado.*

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1 Introduction

The discussions about Primary Health Care (PHC)[1] were intensified in the international scenario from the 1970s due to the questions surrounding the health organization. The specialized and interventionist hegemonic medical model and inequality in access to health services in developed countries were proposed (CASTRO; MACHADO, 2010).

In Brazil, although the establishment of health care with a focus on Public Health from 1916 and the implantation of the first Health Centers of 1925, there was a growth of the Brazilian basic network in the early 1980s with the country's re-democratization process. The network was endorsed by the Alma-Ata Conference in 1978, advocating essential care for individuals to ensure health for all (LAVRAS, 2011).

In the 1990s, important changes occurred in the Brazilian political scenario, arising from the 1988 Constitution and also from the creation of the Unified Health System (SUS). Both were responsible for consolidating the decentralization of social security and for the municipalization of the Brazilian health system (CAMPOS et al., 2008; CASTRO; MACHADO, 2010).

The consolidation of SUS was supported by the understanding of the organization of health services through the articulation of a care network, with regulation and knowledge of the flow, aiming to meet the needs of patients, managers, and society determined by economic, epidemiological and cultural criteria. Also, PHC becomes the manager of the health care system in Brazil (OLIVEIRA; PEREIRA, 2013).

With the decentralization of health resources, some programs were instituted and regulated as part of the SUS consolidation and reorganization strategy. The Community Health Agents Program (PACS) is among these programs that now is understood as a transition to the Family Health Program (FHP) (BRASIL, 2010).

Created by the Ministry of Health in 1994, the FHP - later called the Family Health Strategy (FHS) – aimed at being a specific model of Basic Care (BC) organization. The health promotion and prevention, teamwork based on territory, inclusion of the community health agent, the profile of a professional with general training, among others (CAMPOS et al., 2008) should be included as guidelines.

More recently, the precepts in the public policies emphasize that BC is developed with the highest degree of decentralization and capillarity, occurring in the closest place to people´s lives. Also, it should be the preferential contact of patients as the main gateway and communication center with the entire Health Care Network. Therefore, it is fundamental to be guided by the principles of universality, accessibility, linkage, continuity of care, integrality of care, accountability, humanization, equity and social participation (BRASIL, 2012).

Regarding the mental health, in the last decades, an important political movement has been observed aiming at transforming the care model to patients in psychic suffering, which prioritizes actions aimed at social inclusion, citizenship, and autonomy of the people. However, there are many barriers that need to be overcome, such as the overcoming of the biomedical and hospital-centered model in the mental health area (CORREIA et al., 2011).

The current Mental Health Policy, based on the guidelines of the Psychiatric Reform and the Movement of Antimanicomial Struggle, provides for the care of the person with mental disorder and mental suffering in their territory based on different healthcare equipment. Therefore, it is pointed out that the BC is considered the gateway and access to the Health Care Networks, forming with the Psychosocial Care Centers (CAPS) - the main strategic services in the area - the articulation role of the Network of Psychosocial Care (RAPS) (PINTO et al., 2012).

Although the new psychosocial care policies are focused on the inclusion of BC in mental health care, their trajectory - Mental Health and BC - has had a rather different course.

Currently, some studies in the mental health area have been conducted with a focus on BC (CORREIA et al., 2011; VECCHIA; MARTINS, 2009; MARCOLINO et al., 2016; SILVA; CID; MATSUKURA, 2018) and they suggest greater visibility in policy and assistance for the mental health in BC.

In an integrative literature review that considered the period from 2005 to 2009 and focused the actions performed by the professionals of the family health team in mental health care, Correia et al. (2011) identified 17 studies that indicated that the mental health actions developed in the BC were not uniform in their execution and depended on the interest of each professional or the manager's political decision.

Silveira and Vieira (2009) with the objective of mapping the modalities of mental health care

developed in a mixed health care unit in the city of Rio de Janeiro, found that in the mental health actions in BC, the biomedical model of health organization in health care, the bureaucratization of the work process and the centralization of intramural actions were also predominant.

There is a trend towards the insertion of BC as organizer of care in health systems both in Brazil and in the international scenario. However, it is considered that the emphasis in Brazil is still recent, going through adjustments and changes. Thus, the Ministry of Health has sought to expand and restructure BC mainly through the Family Health Strategy (SOUZA, 2015).

Regarding the insertion of mental health, Souza (2015) points out that care for individuals in psychic suffering must be always included in BC since in 1978, the Alma-Ata Conference proposed that primary care would be the point of care responsible for solving the population´s main health problems. The author also points out that mental health problems are gaining more visibility in the world, being a topic frequently debated in the last decade, reinforcing the need to expand care to this population through devices in BC (SOUZA, 2015).

Thus, identifying what has been produced about mental health practices in BC in recent years is important, to contribute to this discussion, as well as providing elements for reflection and debate in the field of national public assistance and policies.

2 Objective

This study aims to identify and analyze what has been produced in the national scientific literature on mental health care practices in BC through an integrative literature review.

3 Method

This is an integrative review of the national scientific literature that enables to summarize the past of the empirical or theoretical literature, through a broad analysis. In this way, it aims to contribute to a more comprehensive understanding of a phenomenon and the accomplishment of future studies (MENDES et al., 2008; BROOME, 2000).

Based on the choice of the integrative review, the following steps were adopted: identification of the guiding question; definition of the specific objective; data collection within previously established inclusion and exclusion criteria; categorization; evaluation of included studies; analysis of results; knowledge synthesis (MENDES et al., 2008). Therefore, the following question was asked: what has literature been producing about mental health care practices in BC?

The search was carried out in the Latin American and Caribbean Literature in Health Sciences database (LILACS) from September to October 2015. Descriptors were selected from the Descriptors in Health Sciences (DECS), and they were used in the search - mental health and primary care; mental health and basic care.

Inclusion criteria included complete studies, available in electronic form, in Portuguese, published between 2010 and 2015, which addressed practices of care in the mental health area in BC in the title, abstract or body of the text.

Initially, 318 articles were identified, and 108 of them were repeated at both intersections and another 78 addressed subjects that were distant from the study theme, such as articles on physical, cognitive and specialized services. A total of 132 articles were selected. After reading the title and the abstract, 19 were selected, and a thorough and full reading was made to identify findings and discussions that dealt with the subject sought.

The selected articles were analyzed and categorized into Excel spreadsheets.

4 Result and Discussion

First, the data on the 19 articles found are presented in Table 1 and Table 2 below. Table 3 below shows the results and discussion of six thematic categories, identified after in-depth reading, regarding the mental health care practices in BC.

In the approach used in the studies of the total of the articles selected, there were 18 articles were characterized as qualitative studies and only one had a qualitative and quantitative approach.

Nine of the 16 studies that involved participants presented results exclusively from the perspective of professionals. Of the remainder, four covered only BC patients, two covered professionals and patients and only one had the participation of professionals, patients, and family members.

According to this result, it is necessary to emphasize the participation of patients in public health research. Presotto et al. (2013) advocate a paradigm change in psychiatric care to affirm the autonomy of the patient as an ethical north, territory and daily life as privileged places and times for the care and construction of autonomous ways of overcoming the limitations imposed by the mental suffering. The life experience

Table 1. Selected articles in this study.

Artigo	Title	Authors	Year
1	Mental Health: How can Family Health teams integrate this care into BC?	GRYSCHEK, G.; PINTO, A. A. M.	2015
2	Assistive practices in mental health in primary health care: analysis based on experiences developed in Florianópolis, Brazil	FROSI, R. V.; TESSER, C. D.	2015
3	Mental health practices in family health strategy: an exploratory study	MARTINS, V. K. L. et al.	2015
4	Strategies for care and support in mental health in settled women	COSTA, M. A.; DIMENSTEIN, M.; LEITE, J.	2015
5	Territorial support and multi-referential team: cartography of the meeting between institutional support and harm reduction in the streets and networks of Campinas, SP, Brazil	SOUZA, T. P.; CARVALHO, S. R.	2014
6	“I went there at the health center and the doctor sent me here”: process of medicamentalization and (dis) ways for mental health care in Primary Care	BEZERRA, I. C.	2014
7	The articulation of the child protection network and the intersectional application of the safety circle as alternatives to medicalization	BECKER, A. L. N. M. M. et al.	2014
8	Mental health in BC: possibilities for a practice focused on the expansion and integrality of mental health	MOLINER, J.; LOPES, S. M. B.	2013
9	The challenge of building comprehensive care in mental health in primary health care	LIMA, A. I. O. et al.	2013
10	Health-Mental Illness in primary care: a care practice under construction	COSTA, G. M. C.; CELINO, S. M.; COURA, A. S.	2012
11	Mental health groups in primary health care	MINOZZO, F. et al.	2012
12	Interfering factors in the actions of the Family Health Strategy team to the mentally ill person	PINI, J. S.; WAIDMAN, M. A. P.	2012
13	“Craft group”: conducive space to the promotion of mental health	SCARDOELLI, M. G. C.; WAIDMAN, M. A. P.	2011
14	A study on roaming as a care strategy in the context of public health policies in Brazil	LEMKE, R. A.; SILVA, R. A. N.	2011
15	The praxis of Mental Health within the scope of the Family Health Strategy: contributions to the construction of an integrated care	ARCE, V. A. R.; SOUSA, M. F.; LIMA, M. G.	2011
16	Mental health in BC: practice of the family health team	CORREIA, V. R.; BARROS, S.; COLVERO, L. A.	2011
17	Challenges of mental health care in family health strategy	CAVALCANTE, C. M. et al.	2011
18	Health work processes: mental health care practices in the family health strategy	CAMURI, D. D.; DIMENSTEIN, M.	2010
19	Construction of a mental health care project in BC	RAMOS, P. F.; PIO, D. A. M.	2010

of patients and their families and their autonomy are ethical and methodological directions, so the topic of participation in research becomes relevant, becoming an essential challenge in this field.

There is a current discussion in the literature about the participation of patients in research, being a recent experience. Although the patients′ participation is one of the important and valuable brands of the SUS constitution, as well as the academic environment of public health, the patient has been little incorporated as co-protagonist of the production of health knowledge (PRESOTTO et al., 2013).

It was found that only one study addressed juvenile mental health and only one study focused on alcohol and other drugs and adult patients.

The fact that only one study has addressed the scenario of childhood and adolescence and also one study has addressed the issue of alcohol and drugs can be justified by the still difficult scenario that permeates the care to these groups, with a history of

non-attendance and negligence in the scope of care and public policies to these populations. Consequently, although recent advances are recognized, there is a scarcity of spaces in the agendas of important actors when the discussion is based on the investment in this area.

The results and discussion of the six thematic categories identified are presented below. As already mentioned, the categories were identified through the reading of the articles of this review, and other references were used to deepen the discussions and reflections.

Table 3 presents the thematic categories identified in the 19 review studies.

Table 2. Approach and nature of the study.

Study Approach	Number
Qualitative and quantitative approach	1
Qualitative approach	18
Nature of the study	
Original article	13
Theoretical article	1
Case study	1
Intervention/action research	2
Literature review/documentary research	2
Participants	
Professionals	9
BC patients	4
Professionals and patients	2
Professionals, patients, families	1

4.1 Thematic 1: professional training and qualification

Regarding the professional training and qualification of BC teams, it is revealed that Mental Health (MH) care practices are limited by the lack of knowledge and approximation of professionals with the MH area (GRYSCHEK; PINTO, 2015; BEZERRA et al., 2014). In this way, studies indicate strategies used in this situation and the importance of thinking about the training and qualification of the teams (PINI; WAIDMAN, 2012; MINOZZO et al., 2012).

The results of the literature review by Gryschek and Pinto (2015) indicate that most of the time, the teams do not know how to deal with mental health demands or do not recognize their daily practices as part of MH care due to professional training.

Pini and Waidman (2012), in a study carried out with teams from the Family Health Strategy of the municipality of Maringá aimed to know the factors that interfere in the actions to the mentally ill, discuss that the difficulty in developing care practices in MH is caused by the lack of updating after graduation and also by changes in mental health care. The authors also emphasize the need for more investments in the training of the teams, with the permanent education as one of the alternatives.

Minozzo et al. (2012) carried out an intervention research with two teams of Primary Health Care that aimed to analyze the care practices developed in mental health groups and their correspondence with the processes of deinstitutionalization of insanity, enrolled in the Brazilian psychiatric reform.

Table 3. Thematic categories present in the studies.

Thematic category	Articles
Thematic 1: Professional training and qualification	Gryschek and Pinto, 2015; Bezerra et al., 2014; Pini and Waidman, 2012; Minozzo et al., 2012; Cavalcante et al., 2011.
Thematic 2: biomedical, medical and exclusive model	Gryschek and Pinto, 2015; Frosi and Tesser, 2015; Bezerra et al., 2014; Arce et al., 2011; Moliner and Lopes, 2013; Costa et al., 2015.
Thematic 3: the specialty of care	Martins et al., 2015; Gryschek and Pinto, 2015; Lima et al., 2013; Camuri and Dimenstein, 2010.
Thematic 4: patient, family and support network	Pini and Waidman, 2012; Arce, Sousa and Lima, 2011.
Thematic 5: powers - Practices in the territory	Scardoelli and Waidman, 2011; Minozzo et al., 2012; Cavalcante et al., 2011; Souza and Carvalho, 2014.
Thematic 6: possibilities and challenges	Correia et al., 2011; Gryschek and Pinto, 2015; Bezerra et al., 2014; Pini and Waidman, 2012; Ramos and Pio, 2010; Lemke and Silva, 2011; Costa et al., 2012; Moliner and Lopes, 2013; Souza and Carvalho, 2014.

The authors discuss the need to create and strengthen permanent education spaces, such as training and exchange of experiences among professionals of BC teams to discuss clinical cases, construction of unique therapeutic projects and extended mental health care proposals besides medication and hospitalization.

It has been recognized that the training in the mental health area is decisive for overcoming exclusionary practices and centered on the biomedical model, being this one of the paths to be reached in BC (BEZERRA et al., 2014).

However, it must be considered that the possibilities of incorporating or improving mental health skills do not occur without concrete tools and investments. The results of this study reinforce the relevance of sensitization to the willingness to perform care, to identify needs and guidance to professionals precisely on the fact that the actions for subjects in psychological distress should be based on the same principles of health care in general, but adding tools for the exercise of psychosocial care. Thus, it is understood that the challenge is to enable professionals to face barriers related to professional and personal fears and to understand extended, qualified, comprehensive and interdisciplinary care.

Although in a study conducted only with nurses, Neves et al. (2012) found a weakness in professional training related to the shortage in the supply of mental health subjects during graduation that when existing, they focus on actions centered on the hospital model. The authors also verified that the actions of continuing education promoted by the Ministry of Health focus on certain areas, such as women´s health, immunization, hypertension, and diabetes, which neglects mental health, hindering to elaborate meaningful knowledge on psychosocial care.

It is also important to highlight that the knowledge of the public policies of MH by the Health Units team is extremely important, since they help in the dialogue and understanding about MH care, in the execution of practices that can go beyond those carried out inside the strategic care and also materialize in the daily life of the actions carried out in the territory in which the individual is inserted.

4.2 Thematic 2: biomedical, medical and exclusive model

Part of this study considered in this review (GRYSCHEK; PINTO, 2015; FROSI; TESSER, 2015; BEZERRA et al., 2014; ARCE et al., 2011) shows that the care practices developed in BC continue focusing on the biomedical model, the medical treatment and extremely exclusive, so few advances have been identified since the study carried out by Correia et al. (2011).

In the study by Moliner and Lopes (2013), the conception of mental health of the team professionals permeates the understanding of health as opposed to the disease, being strongly present a biologist concept, denying the subjective issues, as well as the social dimension that involves the patients.

In a study with the participation of professionals from the Family Health Strategy (FHS), Arce et al. (2011) revealed that there is a repressed demand related to mental health, with cases of patients who expect to wait more than a year for a medical consultation, evidencing a prioritization of outpatient medical care, with a fragile support network, especially by the family health staff.

Based on the discourses of professionals in the study by Bezerra et al. (2014), the resolubility of care was only associated with the availability of medicines by the health services, that is, according to professionals, the availability of a wide variety of medications free of charge would be an indicator of resolubility and continuity of care. It is observed that mental health care in the health unit was restricted to medical consultation and prescription of medications.

It is evidenced that the results of the studies do not establish similarities with the political proposals, the principles nor the guidelines of care to the patients in psychological suffering in the BC area.

Once again, it is necessary to return to the issue of professional training aimed at this type of care. Pereira et al. (2015) present a discussion about the dilemma of the health professions in their training and affirm that this situation is presented by a change in the logic of treatment and mental health care resulting from the Psychiatric Reform. The authors state that, in the academy, this process is under construction and that the actors in this scenario have not yet reached a plausible balance between the biological and psychosocial issues of mental disorders, which makes the middle term quite complex, influencing the training of professionals in the field of mental health.

There is relevance in the justifications for such difficulties because Brazil at the time was living a moment of expanding access to health services and implementation of the FHS, which would require human and professional resources that were not prepared for this kind of work and modality of care. Also, as Tanaka and Ribeiro (2009), point out, the closeness of the team to the community led

to the emergence of mental health demands when professionals, without support, ended up anchored in biomedical models and focused on the biological aspects of health problems. It is important to alert and question whether the continuity of medical-centered practices is not expanding and steadfast, characterizing, in a broader way, the practices developed in BC, as opposed to the assumptions in the policies.

It should be emphasized that in the current BC model, the FHS proposes an approach that differs from the traditional biologist paradigm, that is, an approach centered on the subject, his family and his community, according to the understanding of the whole context, understanding that care actions must go beyond curative practices (CAMPOS et al., 2008; OLIVEIRA; PEREIRA, 2013).

The results of this study indicate that, in spite of the period of experimentation and demands implied in the expansion of BC services, this reality has not changed over time. Thus, it is verified that the expansion of mental health care in extra-hospital, community, and territorial devices has not been effective or when approached, is still impregnated with purely biomedical and retrograde precepts.

Thus, it is important to problematize the fact that we are in a moment after the BC expansion and there are still gaps and/or practices that do not respond to the assumptions of public policies when focusing on mental health. Also, it is necessary to reflect on how we will advance in possibilities of care aimed at the population in general, and specifically in the mental health area.

4.3 Thematic 3: the specialty of care

Some studies identify that the referral to specialized services has been one of the practices adopted when the patient arrives in psychological distress at the Health Unit (MARTINS et al., 2015; GRYSCHEK; PINTO, 2015; LIMA et al., 2013). In other cases, when it remains in BC, patient care is performed by some professionals according to the specialty logic (GRYSCHEK; PINTO, 2015).

In the study by Arce et al. (2011), there are actions of the service team that seek to alleviate in some way, the suffering of the subjects who present some mental disorder, such as conversations and orientations for patients and family, enable by the established link and through home visits. However, such actions are limited from the moment they are usually followed by referral to specialized professionals, such as marking a psychiatric consultation.

In this sense, Correia et al. (2011) discuss in their study that FHP professionals send the patients in psychological distress to different locations, from clinical physicians (physical complaints and psychotropic prescription acquisition) to specialized consultations in outpatient clinics. not holding BC responsible for these patients.

In a study carried out in CAPS and BC, the authors found that it was difficult for the patients to obtain care in the health unit, for two main reasons: not receiving the demand brought to the service and difficulty in obtaining care. These results show the difficulty of networking and the disarticulation of the flows between BC and specialized care, pointing to a failure in the responsibility of the professionals involved in the process of integral care (BEZERRA et al., 2014).

The results obtained in the selected studies are far from the public policies of the sector since the Ministry of Health recommends that mental health care practices should be performed in the BC, as well as by all health professionals and not according to the specialties. There are actions that can be performed by all BC professionals, such as receiving the user in suffering, offering support, listening and building the link (BRASIL, 2013).

Wetzel et al. (2014) argue that BC services remain supportive of the idea that specialty is the best way to guide and resolve mental health cases that come to the service. This conception with the lack of a service network is today characterized as one of the great challenges of the Psychiatric Reform, which leads to a decentralized and territorial care.

It should be emphasized that this logic of care by specialty and consequently fragmented as previously stated, has conceptions established by the paradigm of the medical-centered model, as already discussed in another theme.

Therefore, investing in possible care actions to be developed in the BC and in the territory is also extremely important so the logic of referral and specialty as the only option can be overcome.

4.4 Thematic 4: patient, family and support network

The studies also identify some difficulties in performing care practices, relating the support network of the patient, such as the family, with his involvement in issues related to his care. It should be noted that the main difficulties are related to the low therapeutic adherence due to the lack of patient support network and, consequently, the low

resolution of the cases attended (PINI; WAIDMAN, 2012; ARCE et al., 2011).

The study by Pini and Waidman (2012) emphasizes that the professionals´ discourses reveal the non-obligation of the family member to attend some services, which hinders to understand the case assisted, as well as the responsibility of the family for caring for the suffering psychic patient. Also, professionals report difficulty in adhering to the care proposals, due to the chronicity of the situation and the non-acceptance of the guidelines given by the professionals.

It should be pointed out that health professionals often expect the family to accept and care for the person in intense psychic suffering without at least having taken any kind of guidance. It is observed that to hold the family responsibilities and place it as the protagonist of this care is a difficult task and must be done with great care and guidance (BRASIL, 2013).

The family´s hosting, involvement and participation in mental health care have been pointed out as some of the great challenges for advancement in the area and appear to be present at all levels of care (TAÑO, 2014; GALHARDI, 2016). Although considering family participation as fundamental in health actions in general, it is important to emphasize that when considering mental health, this perspective becomes even more complex.

It is important to emphasize the importance of thinking and implementing care practices that are distanced from the guilt-individualization binomial and expand to the involvement of family members as demanders and care protagonists for actions of empowerment and social control.

4.5 Thematic 5: powers - Practices in the territory

In contrast to the difficulties, positive aspects were identified in the mental health care practices in BC.

Two articles specifically address groups and therapeutic workshops (SCARDOELLI; WAIDMAN, 2011; MINOZZO et al., 2012), where the authors point out the power of these spaces as a deinstitutionalization device, promoters of mental health and improvement of the quality of life, favoring the psychosocial development of these patients.

Besides the articles mentioned previously, other articles highlight the importance of the therapeutic group for patients with psychic suffering. The study by Moliner and Lopes (2013) points out that the groups is an alternative to a new way of doing in mental health within the BC, and, for that, a comprehensive and expanded view on psychic suffering is needed.

Both the National Policy of Basic Care (BRASIL, 2012) and the Ministry of Health (BRASIL, 2013) reaffirm the importance of collective spaces of care, aiming to observe the disease and cure for the re-meaning of suffering and the empowerment of new individual ways and grouping of being in the world, through new models of group, that is, to stimulate the participation of the people in the decisions of a group and in the production of collective benefits.

According to Minozzo et al. (2012), the group is characterized as a deinstitutionalization device, through the provision of psychosocial care in the territory, articulating the care network, aiming to broaden social ties and allowing participants to be seen as protagonists of their own lives.

Also, in the studies of Minozzo et al. (2012) and Scardoelli and Waidman (2011), groups are understood as conducive and promoted spaces to talking, listening, sharing and also teaching and learning. Therefore, the authors emphasize how much these spaces are promoters of the mental health and of improvement of the quality of life, favoring the psychosocial development of these individuals.

As for the positive aspects, other studies address the importance of active search in the territory and home visits and how much they are still permeated by professionals´ fears. In the paper by Correia et al. (2011), the authors identify that the professionals of the FHS teams do not attend or are unaware of the existence of mentally ill patients in their area of coverage, which raises the discussion about the importance of home visits. Professionals report that although home visits are considered one of the most accomplished care practices, the difficulties pervade how best to work, address and care for patients suffering from psychological distress and their families.

4.6 Thematic 6: possibilities and challenges

The studies also discuss how MH care practices developed in BC should be performed and what principles should be supported. In this context, they reinforce the importance of linking, welcoming, intersectional and networked work and professional training (CORREIA et al., 2011; GRYSCHEK; PINTO, 2015; BEZERRA et al., 2014; PINI; WAIDMAN, 2012).

In the study by Correia et al. (2011), the bond and the host are considered fundamental for the assistance to the patient in psychological suffering and their relatives in the BC. The professionals of the FHS teams have the power to offer MH care, especially because of the bond they establish with the families (GRYSCHEK; PINTO, 2015).

Therefore, Souza and Rivera (2010) discuss common axes between BC and mental health, addressing the guiding principles of these two scopes, articulation, and responsibility.

Regarding the articulation, the authors affirm that in mental health care there is a need to articulate knowledge with other areas of knowledge and other practices, as the possibility of interlocution between the fields would enable social transformations in search of an effective Psychiatric Reform (SOUZA; RIVERA, 2010).

In the responsibility, the authors affirm that services, professionals and other social actors should be responsible for the patients and the population in the area of coverage, because, if there is such responsibility, they will certainly promote improvements in health and life conditions of people, developing an active role in the promotion of mental health (SOUZA; RIVERA, 2010).

As advocated, mental health interventions must be built in the daily meetings between professionals and patients, so together, they can build health care (BRASIL, 2013). For this, it is necessary to count on the real participation of the patients, in the day to day in the work, in the offered care, or in the investigations, being possible to make them protagonists of the own life. It is noteworthy that few studies were identified in this research in which the participants were the patients or even the relatives. Most of the time, the studies had the participation only of professionals.

Also, it is observed that in this study there were no results that refer to actions of prevention and promotion of mental health in BC, which indicates the need to expand actions and studies in this area.

5 Final Considerations

In Brazil, an increase of the care offered to patients in psychological distress, in different equipment of the psychosocial care network is important, aiming to guarantee an effective and integral care to this population.

The results of this study point to the need for qualification of BC professionals in the mental health area. Also, there is a logic of care based mainly on the biomedical, medical and exclusive model and many difficulties in teamwork, intersectional and in the territory.

However, reflections in an advance in the mode of care are also presented, such as the fact that workshops and therapeutic groups are developed in the context of BC, allowing a new way of thinking about care for individuals in their community. The territorial proximity enabled by BC practice and the home visits performed by the unit team are important strategies in the actions of prevention and promotion of mental health.

Thus, despite the many challenges to be overcome, it is expected that this study can give visibility to reality and contribute to advances in actions in the area, in the knowledge and in the construction of public policies, favoring the care to the patient in psychological suffering in BC.

However, other studies should seek to understand how the new forms of care proposed by Brazilian mental health policies are being implemented in different regions of the country. The Executive Branch at all levels - Federal, State, and Municipal - must be involved in issues related to mental health, as well as its involvement in all current health issues.

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Author's Contributions

Amanda Dourado Souza Akahosi Fernandes: contributed to the whole process of elaboration of the article. Thelma Simões Matsukura: contributed in writing, reviewing and discussing the article. Mariana Santos De Giorgio Lourenço: contributed to the writing and discussion of the article. All authors approved the final version of the text.

Notes

[1] In Brazil, Basic Care and Primary Health Care are considered synonyms (GIL, 2006). It is pointed out that in the international scenario the PHC nomenclature can vary: primary care, basic care. However, the literature has used the PHC nomenclature to refer to this level of health care, as observed in the research and also at the Alma-Ata International Conference (1978).