Mental health care practices in primary health care: an analysis based on experiences developed in Florianópolis, Brazil

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Abstract *This article analyzes mental health care practices in primary health care (PHC) in the city of Florianópolis, which were based on proposals by Abilio Costa-Rosa regarding the asylum-psychiatric and psychosocial modes of care. The methods involved the following: a) the contextualization of the empirical field with documental analysis and interviews with managers; b) mapping interventions through interviews with professionals from nine selected Family Health Teams (ESF); c) deepening the understanding about these actions through observations and interviews with professionals and 20 case studies, which were systematized in accordance with the flowchart proposed by Merhy through interviews with service users and analysis of records. It was identified that the actions aimed at access and monitoring of the cases involved the whole team, and that medical and pharmacological treatment was centrally administered. Interventions based on words, socio-communitarian interventions and interventions based on the body were also present, and they showed the potential to operate from a perspective of valuing autonomy and singularity, aspects which are often underused when psychosocial approaches are absent. The need to improve care models and to bring together psychosocial care and PHC is suggested.*

Key words *Primary health care, Mental health, Care practices, Care models, Expanded clinic*

Introduction

Authors who have discussed the rapprochement between mental health and primary health care (PHC) have pointed out the epistemological and political compatibility of Health and Psychiatric Reforms in Brazil; however, they also refer to the emerging challenges in this process, including the operation of care[1-4].

Previous studies about mental health care practices in PHC have identified the need to identify demand (in conjunction with Community Health Agents - ACS), reception and diagnosis[5-7]. There has been a tendency to view mental health as a specialized area of expertise, which is linked with the corresponding implementation of matrix support[5,6,8]; the prevalence of drug treatments or other biomedical interventions[6,8,9]; the use of listening and guidance, which are often not perceived as intervention even by professionals themselves,[7,8] or improvised actions[9]; attempts to develop therapeutic projects involving individual consultations and home visits with low levels of care cover[5]; and the referral of cases, which are often emergencies, due to crises[5,7,9]. These studies have confirmed the shortage or absence of actions that use community resources[5,6] but they have also emphasized that guidelines and concepts which are crucial to the operation of PHC, such as reception, humanization and quality of life, are gateways to the valuing and structuring of mental health care[8,9].

In the light of the aforementioned findings, the research summarized in this article aims to: a) describe the proposals, identified target group, and the operation of mental health care practices offered in the PHC network in the city of Florianópolis; b) to analyze how these care practices are articulated to comprise therapeutic projects as well as the care itineraries that are produced; c) to situate these practices in the theoretical-technical fields of mental health and PHC, as well as commenting on their inter-relationship.

Care practices are actions in which tools and methods are used in relation to an object and guided towards an objective[10]. This definition has been transposed in relation to notions about disease, cure and treatment through the characterization of biomedicine by Camargo Júnior[11], and the axes of differentiation between modes of psychosocial care and asylum-psychiatric care, which have been systematized by Costa-Rosa[12]. For the latter author, the asylum-psychiatric mode is characterized by an immutable definition of disease, centralized on its organic determination. Treatment methods tend to be based on the suppression of symptoms, and therapies are compatible with biomedicine, with the prioritization of pharmacological interventions. However, the psychosocial care mode is characterized by an appreciation of political and bio-psycho-cultural factors such as the determinants of the disease process and the notion of the singularity of each case. The "cure" is understood as a subjective repositioning, and the privileged therapies are psychotherapy, labor-based therapies and socio-cultural reintegration devices, although, depending on the situation, medicines may be used as major or minor auxiliaries.

Methodological approach

In an attempt to expand understanding about the phenomenon under discussion, we adopted a triangulation perspective in terms of data collection, with diversification of the empirical material. Consequently, in addition to the material prepared by the researchers specifically for this research, the contextualization and the consultation of documents produced on a daily basis in the studied field were also important[13]. The research began with a study of institutional documents, interviews with municipal managers related to mental health and PHC, and interviews with professionals from nine Family Health Teams (ESF) in various health centers, who were selected on a basis so as to proportionally represent the health districts of the city. An in-depth study of care practices was subsequently identified through the following: interviews with professionals involved in actions (including some professionals from Family Health Support Centers (NASF); the observation of those professionals; and the systematization of 20 case studies of participants in these actions, which was constructed through the synthesis flow chart proposed by Merhy[14] based on interviews with service users and the analysis of medical records. Saturation indicated the moment of the interruption of data collection at all stages. The second phase of the research included eight interviews with professionals from various fields and the observation of six activities, which amounted to the direct participation of 21 professionals in the study. The service users who participated in the study were either nominated by professionals because they were receiving particular care practices, randomly selected from lists of cases or selected by convenience, when receiving assistance at the Health Center (CS) on a day that the researcher was present.

This study was approved by the Ethics Committee on Human Research of the Federal University of Santa Catarina. Informed consent forms were signed by all participants in order to ensure freedom of participation and to establish strategies for the preservation of secrecy and confidentiality of information; the names of the participants were changed to pseudonyms.

In order to be consistent with the principles of qualitative research, which require that researchers are open and flexible to capture reality[15], a description and analysis of care practices was also performed, in addition to the composition of data. This description and analysis was situated within the theoretical debates within the field of PHC and was focused on the differences and tensions that exist between the modes of psychosocial care and asylum-psychiatric care. The axes of autonomy, bonding and singularity were taken as starting points to demarcate the differences between the two modes of mental health care under discussion. The attributes of access, longitudinality and integrality emerged as the most relevant in relation to thinking about the relationship between mental health and PHC. The search for trends and high density points were prioritized in order to enhance the debate about ways in which to further integrate PHC and psychosocial care.

It should be noted that the research field was PHC in Florianópolis, a city that, according to the IBGE, had an estimated population of 433,158 in 2012. In August 2012 the Ministry of Health indicated 93% of ESF coverage in Florianópolis. Matrix support, which had been implemented since 2006, was performed during the period of the research by 12 NASF teams, composed of professionals from different areas. Based on the understanding that the reference teams play an important role in the process of bonding with service users, in terms of longitudinal care and coordination of the care network, and that they rely on the support of specialized teams to strengthen their intervention[16], this research focused on the actions developed by professionals working in the ESF and also the actions taken in coordination with NASF professionals. This analysis made it possible to understand the challenges and achievements within the field of care practices, when a network exists that focuses on the consolidation of PHC and matrix support.

Results

The ESF teams, with the support of the NASF teams, have constructed a set of actions in relation to mental health that will be discussed in this text. However, these actions are still defined by a division of labor that keeps nurses and PHC centrally focused on areas such as access and the monitoring of cases, while treatment itself is left to doctors.

In this article, the description of what has been offered in terms of care was systematized into the following four axes, which are related to each other: pharmacological interventions; interventions based on words; socio-communitarian interventions; and interventions based on the body. These descriptive axes form the basis of a further four axes, which relate to the conceptual reading that was previously referred to, as shown in Figure 1.

Pharmacological interventions

The use of medication ran throughout the medical history and treatment of almost all the service users that were interviewed, often disassociated from a process of consultation or other forms of care. This was exemplified by the fact that, although the service users who were interviewed experienced various types of care practices, 17 out of 20 of them were using psychotropic medication at the time that they were interviewed. It was also highlighted by the case of Eugênia, who at the time of this study was undergoing frequent medical supervision and was without medication. She made the following comment: *They never called me to talk and didn't even refer me to a psychiatrist or anything, right? The first doctor told me 'this is a drug' and gave me some medicine. Of course, during the first week it helped me, but by the second week it no longer suppressed the problem and the desire to drink.*

Almost all CSs had some protocol for *prescription renewal*, which were generally managed by nursing staff. This practice, which has also been identified in other studies[2,17] was recorded in almost all the medical records that were examined. It also tended to be more present when there was a turnover of or a lack of doctors. There was also evidence of extended periods between monitoring and wider intervals between reassessments. Given the dissatisfaction of professionals who were interviewed, there were some changes in this procedure, but not always towards an improvement in care quality – in fact, changes often
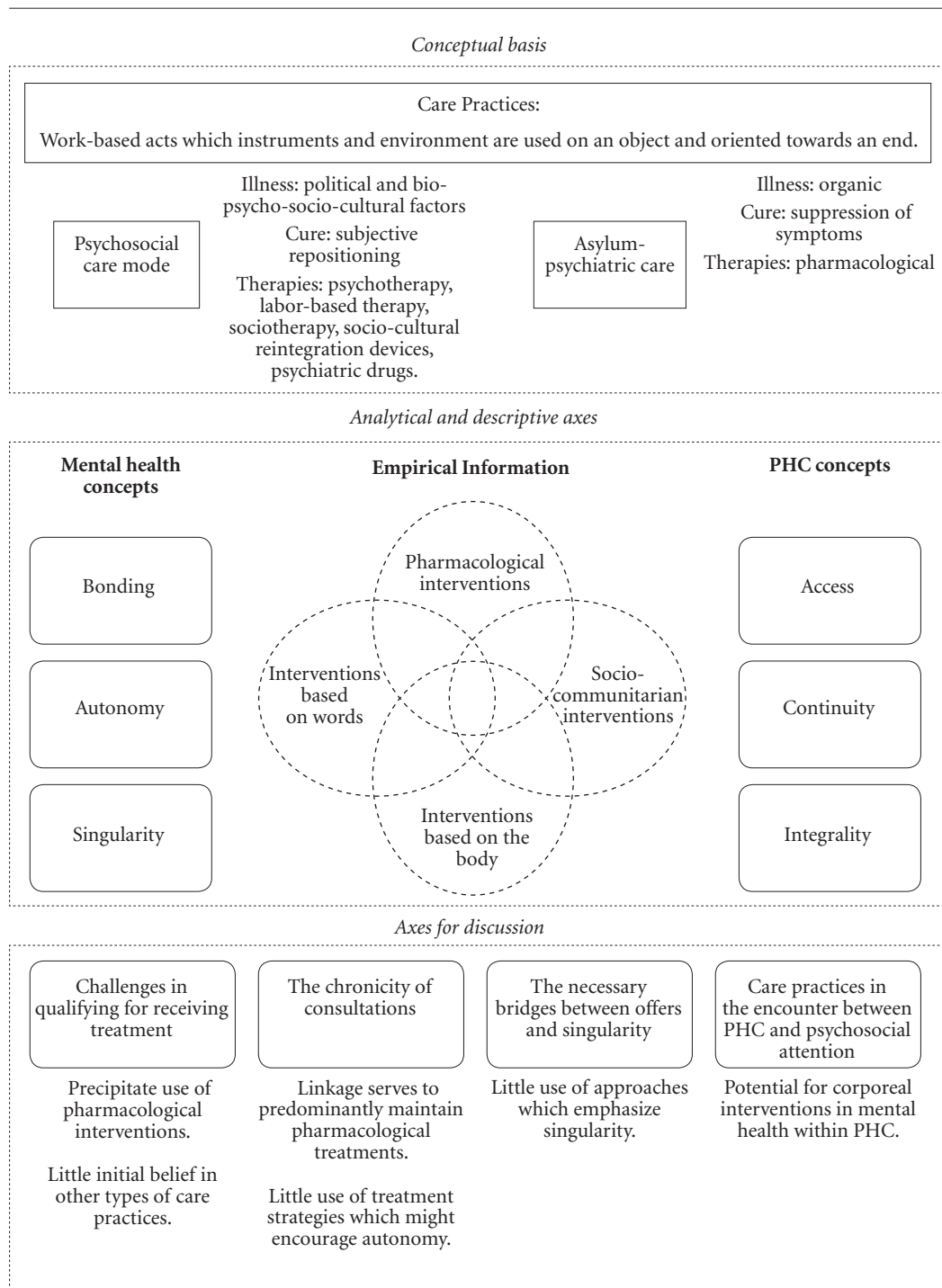
Conceptual basis

Care Practices:

Work-based acts which instruments and environment are used on an object and oriented towards an end.

| Psychosocial care mode | Illness: political and bio-psycho-socio-cultural factors
 Cure: subjective repositioning
 Therapies: psychotherapy, labor-based therapy, sociotherapy, socio-cultural reintegration devices, psychiatric drugs. | Asylum-psychiatric care | Illness: organic
 Cure: suppression of symptoms
 Therapies: pharmacological |

Analytical and descriptive axes

Mental health concepts

Bonding

Autonomy

Singularity

Empirical Information

Pharmacological interventions

Interventions based on words

Socio-communitarian interventions

Interventions based on the body

PHC concepts

Access

Continuity

Integrality

Axes for discussion

Challenges in qualifying for receiving treatment	The chronicity of consultations	The necessary bridges between offers and singularity	Care practices in the encounter between PHC and psychosocial attention
Precipitate use of pharmacological interventions. Little initial belief in other types of care practices.	Linkage serves to predominantly maintain pharmacological treatments. Little use of treatment strategies which might encourage autonomy.	Little use of approaches which emphasize singularity.	Potential for corporeal interventions in mental health within PHC.

Figure 1. Analytical Framework.

Source: the authors.

led to an emphasis on administration, such as when renewals started being handled directly by the pharmacy, suppressing the nursing consulta-tion in which service users progress was checked. One CS structured a group that was based on re-newals, coordinated by a psychiatrist. It should

be noted that the psychiatry matrix support was mainly associated with pharmacological approaches.

These case histories identified prompt medication, as well as a failure to end pharmacological treatments, hence the fact that there were many chronic users of psychotropic drugs. Some professionals referred to attempts to end drug treatments or to replace medication, including with the use of herbal medicines, but they mentioned difficulties. The case of Verena is illustrative of these difficulties and the need for the singularity of this proposal. From the analysis of Verena's medical records and her interview it was concluded that there had been little emphasis upon her participation in an exercise group, which could have been of her interest as she was perceived as a woman concerned with her appearance.. There was also a failure to identify her strong bond with the nurses when she was referred to a psychological support group, as her referral was directed by another professional. There was greater success in avoiding new prescriptions for anxiolytics, which was favored by the existence of clinical protocols that support this measured conduct.

There has been little emphasis in the literature regarding PHC in relation to the difficulties concerning the chronic use of psychotropic medication. There is a tendency to support increasingly long treatments, even though there is evidence regarding problems related to the use of such medication[18]. There is the potential to use the concept of *de-prescription* in this field, which has particularly been used in the case of polymedicated elderly people to foster a conduct that reassesses and accompanies the suspension of some medication[19].

Interventions based on words

A group of strategies was identified which value the dimension of subjectivity, including, *the reception provided by nurses.* Although this is closely linked to the issue of access, with a predominance of referrals, it can also be constructed as a space for listening based on existing links with the community through other actions. This approach has been recognized by service users, as was expressed by Dalila: *So she called Dora, who led me to another room and had already talked to me* [...] *I think it's because of that that I see her as a reference.*

Although the *medical follow-ups* were generally focused on medication, some professionals provided a space for reflection on the situation of suffering, placing intervention based on medicines in a subordinate position to a subjective interpretation and encouraging care to be provided without medication. For example, in the medical records of the service user Guiomar, the health professional Gil noted that even if there were increasing complaints of aggression associated with a prescribed psychotropic drug, he would not change because there was an important role to be played through the expression of that aggression.

It was observed that, in addition to the dimension of reflection, interventions structured by words played cathartic and supporting roles, the latter being predominant. Continuity in the listening process seems essential to ensure that there are different types of care for these service users; however, this approach has often been restricted to the initial stages possibly because, at that time, there was the need to contextualize diagnoses to define treatments.

Interventions based on words, as a systematic measure, were based in *psychological support groups*, which were valued by management and considered by many professionals to be the first line of intervention in cases of psychological distress, especially because of their accessibility, as explained by Zoé: *Usually I try to resolve what I can with the help of the psychological support group at the unit.* These groups were based in the units in which there were psychologists in the NASF, i.e. in seven of the nine teams that formed part of the research. The *individual psychological care* service was identified as being extremely prompt, which may be appropriate for some, although not all, cases. Referrals for psychotherapy in NGOs or training centers were mentioned not only in the units without a psychologist, but also because they lacked this type of assistance when required.

Socio-communitarian interventions

Although *family approaches* are understood as a potential resource within the ESF, as well as family and community medicine (a significant proportion of physicians in this basic network were experts, unlike in the rest of Brazil), these were very promptly administered in this study, being primarily associated with crisis or more serious situations when a deeper understanding of family dynamics was required. The fact that other family members were users of PHC and sometimes had links with the ESF was a potential that could be further explored. The use of *home*

visits was also associated with the management of severe cases and family interventions.

Referrals to community groups as part of actions regarding mental health were common, as well as the use of different groups in the unit such as women's, walking and craft groups. These referrals were aimed at giving the opportunity for self-care, the use of leisure time and socialization. There was some under-utilization of these practices, as in Pilar's team, who were able to number many situations in which the network of reference services was used, but had difficulty remembering a case when referrals to their own unit's resources were made. Besides the need for coordination with other forms of care, we identified the need for singularity in the construction of these offers, a situation that was sometimes solved by the service users themselves, as noted by Guilhermina: *I do an embroidery course twice a week and I was getting nervous, and I said 'I don't want anything to make me angry, I want something to give me pleasure'. [...] Gus told me, 'do something with your time' because I'm not the sort of person who can do nothing. I tried to get a boyfriend. I'll find an old man who still wants to take advantage of me; I have a roof to offer. I even went dancing, they invited me and my daughter to go dancing, it's distracting and is also good exercise.*

One team encouraged patients who were severe cases to participate in a walking group and another offered *therapeutic workshops*, both of which involved partnerships between the NASF and the ESF. Thinking about this group of service users is a major challenge since many of them are unable to access the Psychosocial Care Unit (CAPS) and therefore only have a very limited access to therapy. That was the case of Teodósio, who unsuccessfully tried to gain access to CAPS before benefitting from a workshop. The expansion of these resources for severe cases is not always recognized as possible, as shown in the following comments by the health professional Ema: *It is different trying this with an elderly woman who is more or less depressed, compared with trying to make a similar type of intervention with a schizophrenic and severe bipolar case. It doesn't have the same effect, it is more difficult.*

Interventions based on the body

There was a greater authorship of the ESF teams in healthcare practices regarding the corporeal dimension, for example, in corporeal practices, in integrative and complementary practices (PICs), and in clinical care.

Among *corporeal practices*, the encouragement of *physical activity* was very common and it co-existed with the socializing or pleasurable activities offered to service users. However, in general, physical activity was not explored within the mental health care plan in an articulated manner. For example, Armênia struggled with symptoms of anxiety which made her eat a lot and she was advised to walk because of high cholesterol levels. However, there was no correlation between this activity and a strategy for coping with anxiety.

As well as being the initial point for the arrival of demands on the mental health service, the provision for *clinical care* showed important interfaces regarding appropriate attention, since it favored links with PHC professionals as well as the legitimacy of being associated with PHC, both by service users and by the specialized mental health services. When this kind of organic dimension is present there seems to be more resourcefulness to perform mental health interventions. For example, the health professional Nívea referred to an ongoing case that had been solely treated in terms of a psychiatric problem; after hypertension was diagnosed the dynamics of care changed, in a positive way.

Through the interviews with the health professionals, and subsequently in the case studies, it was discovered that acupuncture had been used for cases of anxiety, as well as the use auriculotherapy (in conjunction with the psychological support group) and the use of herbal medicines. Interventions with PICs were part of the attempt to de-medicalize the practices of the health teams and they denote a sense of integration of the physical and psychological dimensions. They also indicate the opportunity for integrated interventions, as in the case of service user Virgílio, who had cardiovascular disorders related to anxiety, for which he was prescribed acupuncture, psychological and physical therapy. Regarding this treatment Virgílio commented: *I had a lot of pain in the legs, I couldn't sleep, and then it improved. I had a pain in the chest, I thought it was my heart, they stuck those needles in and everything improved a lot [...] Then I saw a psychologist and I began to improve [...] I take fluoxetine in the morning and I take 2mg of clonazepam at night. But it helped because I don't ... I like to go fishing and I had stopped because I was afraid. I was even afraid to talk to people, you know. All this was holding me back [...] then Vik referred me and that really helped me because I was getting kind of tired in the legs and things.* Some teams had been using these offers of alternative therapies even for new cases, pro-

viding a new type of care, shared by professionals from the medical and nursing fields.

In general terms, it was observed that the expansion of forms of care has been proposed rapidly in the most recent cases, either in an articulated way, which was more effective, or in a punctual and tangential manner. However, less common were approaches that effectively inverted the offer by carrying out the non-pharmacological interventions prior to the prescription of psychotropic drugs.

Discussion

As can be seen in Figure 1, the following four axes for discussion emerged from this study: the qualification to access; the tendency to become chronic; the importance of singularity as a reference for therapeutic offers; and the body as a framework for the psychosocial clinic of PHC.

Challenges in qualifying for receiving treatment

Whilst acknowledging the initial role of the ESF teams in dealing with various types of illness and suffering[18], it seems that there is need for less emphasis on psychological distress as an illness and the recourse to a prompt administration of medicines. This occurs even though there is an approach – which should be strongly publicized in the field of PHC - which is known as "watchful waiting"[20]. In the field of psychological distress, this would not serve as an assessment of a spontaneous remission, or to provide a clearer delineation of symptoms, as is common in the biomedical clinic of the "body", but mainly to assess the effect of non-pharmacological measures.

The difficulty with this process is not only linked with the fact that the teams did not offer other forms of care, but above all with the possibility of taking chances on their effects, as an alternative prior to pharmacological interventions. One change would involve embracing in a more systematic and integrated way, and from the outset of care, a number of other interventions, singularizing them and analyzing their effects continuously.

It should be noted that there exists a range of situations in which physical and mental suffering are presented in an articulated manner. The integrated approach to dealing with problems like pain, insomnia and weight gain is through the use of weight loss groups, physical activity,

PICs etc. It is also important to increase the solving-potential of teams, in addition to pharmacological solutions.

The chronicity of consultations

It was observed that there was an under-utilization of the longitudinal follow-up of service users and of links designed to sustain non-pharmacological treatments. Paradoxically, psychopharmacological interventions eventually extend over time, resulting in a situation where treatments that should have a defined time period continue without interruption [21,22]. Consequently, PHC has to deal with illnesses and treatments that become chronic in nature. This phenomenon has possibly been naturalized as if it were an extension of consolidated approaches towards chronic diseases or conditions such as hypertension and diabetes, in which care is based on a permanent pharmacological behavior, i.e. "continued use" medication.

It should be mentioned that, although these are sometimes prolonged periods of care, compared to other health conditions, and even the possibility of new episodes in life, it is expected that mental health service users need to undergo care interventions that help them to overcoming their difficulties, which in principle does not justify the maintenance of permanent treatments. An exception to this is severe and persistent disorders, which should also be addressed by increasing offers of assistance which encourage the development of autonomy.

One of the analogies that seem to be appropriate when considering mental health care in PHC, as an abstraction and in a limited way given the big difference in the field of materialities and explanatory models, is musculoskeletal disorders. Although the latter require diverse and systematic interventions, such as physiotherapy or guided physical activity, they show significant changes, especially for those service users who are involved in this care space and who can receive support to change some situations that tend to reproduce suffering.

Therefore, it is important that PHC receives sufficient resources to be able to reorganize care, such as the singularization of care plans and the construction of interventions shared by teams. This includes the ongoing evaluation of care, which is generally referred to in the field of Brazilian public health as "singular therapeutic projects", which was not identified as a strategy that was used effectively in the teams covered by this

study. Such a tool can be very relevant as a way to rearranging case records, which is essential to deal with the effects generated by the rotation of personnel in the continuity of care.

The necessary bridges between offers of care and singularity

The appreciation of individuals, in their singularized dimension, is central to the psychosocial mode, which does not target the total suppression of symptoms[12] (even less so permanently, as when medicines are used preventively) and rather encourages that individuals with these symptoms work towards their own singular transformation[12,23]. It is precisely this approach, which was seen to be quite deficient in the practice of the teams, which would allow a concerted approach between offers of care and listening, including the issue of medication, which would still be an option when symptoms prevent the transformation process.

The lack of contact with the theoretical and technical framework of psychosocial care, especially with its clinical basis, seems to have had the effect of failing to provide some forms of care that were available. The contributions of this perspective could strengthen the re-appropriation of care through the concept of bonding, which, as can be seen from this research, is fairly present in PHC but is not always incorporated in an operative manner to provide transformative mental health care.

The presence of a person-centered approach, with an appreciation of the inseparability of the physical and psychic dimensions and an understanding of social and family dynamics, as well as the notion of reception, would allow PHC to provide care that was articulated by listening in a move towards a psychosocial approach. It is precisely from these situations that a more cautious introduction of medication emerges or, depending on the singularity of the case and the use of more diversified interventions, which include systematic care, delivered through strong bonds between service users and professionals. These actions have the potential to be alternatives, or at least to be complementary, providing a necessary

balance to the predominant practice of suppressing symptoms by the chemical route, which tends to increase chronification.

Care practices in the encounter between PHC and psychosocial attention

Psychiatric reform has diversified therapeutic practices, incorporating art and culture as ways of providing subjective expression and reconstruction, including through the use of social bonds. The body is present in terms of dance and theater and sometimes through sport[24]. Mental health interventions in PHC seem to rely more on corporal aspects for their expansion, possibly due to the composition of its field of knowledge and the expectations about its performance. This study identified that interventions to address other medical conditions, such as corporealy practices including physical activity and also PICs, were shown to be possibilities to complexify mental health care, even for more serious cases.

Considering the massive supply of psychotropic drugs that are available, the PICs, which are still far from mental health, have been posited as an alternative because, in general, the clinical approach that supports these practices values corporeality as an expression of the subjective dimension. There is a concern to meet the demand to suppress symptoms from measures which are also linked, and also referring individuals to the implications of their health condition, justifying in this sense, a certain de-medicalized status that supports them[25].

Attention should be paid to the distinction between the concept of physical health, which is appreciated here as a potency. Due to its restricted view, the concept of physical health de-legitimizes the field of listening and subjectivity. Lucchese et al.[9] point out that the fact that physical health, which emerged as a biomedical category, not only focuses on the body and disease, but it also subordinates and orders mental health. Thus, although the *expertise* of health professionals is powerful in the structuring of more diverse actions, it is essential to also appreciate therapeutic offers that are free of this recognized function, such as those supported by expression,

ludic socialization etc, reaffirming its ability to put non-prescriptive care on the agenda.

Final Considerations

This study identified the important role of ESF teams in terms of access and the monitoring of cases, with an emphasis on long-term drug treatment, accompanied by difficulties in performing care actions that value singularity and the development of autonomy, which are references that structure differences between the modes of psychosocial care and asylum-psychiatric care[12]. Thus, care practices end up being akin to a notion of care similar to community psychiatry or preventive care, which was important in the (pre) history of Brazilian psychiatric reform by becoming the first space to offer non-asylum attention, incorporating systematic and early care as a way to avoid psychiatric hospitalization. This model was subsequently considered to be limited because it did not question the way in which psychiatric knowledge objectified suffering/madness and due to its medicalization effects[26,27]. It is important to consider the comments of Mondoni and Costa-Rosa[28] in a study conducted in the state of São Paulo, who found that the mode of psychosocial care coexisted with the influences of traditional and preventive psychiatry. They concluded that the latter, due to its similarity with and proximity to psychiatric reform, impedes improvements in psychosocial care.

It should be noted that mental health care, guided by the principles of PHC, in the emphasis on Brazilian policies[16,29], remains concerned about the issue of access and the longitudinal follow-up of cases, but its attributes also support and value actions that have the strengthening of autonomy and a focus on subjectivity as central areas, such as encouraging participation in community activities, the PIC and support groups. Although they already exist, these interventions are still under-utilized, precisely because they are not central to care processes or even explored sufficiently, including the issue of singularity, which also depends on greater psychosocial foundations for the activities to be undertaken.

Consequently, it is recommended to those who are involved in the transformation of mental health care in PHC to further diffuse the use of singular therapeutic projects[30,31], while attempting to prioritize the use of non-pharmacological treatment strategies from the outset of cases. The actions of all the ESF teams should also be understood more broadly, especially the roles of nursing and ACS professionals, with specialized care being guaranteed in cases where it is necessary. It is also proposed the qualification of actions which interfere with the chronification of pharmacological treatments, monitoring periods of the use of medication and empowering service users in relation to their treatment, taking as an example the Autonomous Medication Management Groups[32].

This research reaffirms the understanding that it is necessary to explore the characteristics of PHC in relation to its approach to the model of psychosocial care. It also identifies the need to strengthen contact with the accumulated production of psychosocial care in this field, which was sometimes restricted to specialized services, and which was not converted, so far, despite the implementation of matrix support. This gap between psychosocial care and the field of PHC has already been indicated in other studies[1,4] and it can also be seen in important bibliographical references for PHC or matrix support professionals[33,34]. It is therefore suggested that this care model should the subject of interventions in the fields of training and the continuing training of this group of professionals. It is worth noting here that there are several points to be explored and developed in the relationship between psychosocial care and PHC. For example, in relation to the criticism of medicalized interventions in mental health and their interfaces with the debate within the PHC, from the standpoint of the concept of quaternary prevention[35], or regarding the approximation between the body and subjectivity, which emerged in this study as a powerful encounter between these fields.

Collaborations

RV Frosi and CD Tesser participated jointly in the design and final version of this article.

References

1. Nunes M, Jucá, VJ, Valentim CPB. Ações de saúde mental no Programa Saúde da Família: confluências e dissonâncias das práticas com os princípios das reformas psiquiátrica e sanitária. *Cad Saude Publica* 2007; 23(10):2375-2384.

2. Dimenstein M, Severo AK, Brito M, Pimenta AL, Medeiros V, Bezerra E. O apoio matricial em Unidades de Saúde da Família: experimentando inovações em saúde mental. *Saude soc.* 2009; 18(1):63-74.

3. Vecchia MD, Martins STF. Desinstitucionalização dos cuidados a pessoas com transtornos mentais na atenção básica: aportes para a implementação de ações. *Interface (Botucatu)* 2009; 13(28):51-64.

4. Tesser CD, Teixeira BC. Saúde mental na atenção básica: estratégias de implantação a partir de uma experiência. *Saúde em Debate* 2011; 35(88):83-95.

5. Caçapava JR, Colvero LA. Estratégias de atendimento em saúde mental nas Unidades Básicas de Saúde. *Rev Gaúcha Enferm* 2008; 29(4):573-580.

6. Baroni DPM, Fontana LM. Ações em saúde mental na atenção primária no município de Florianópolis, Santa Catarina. *Mental* 2009; 7(12):15-37.

7. Arce VAR, Sousa MF, Lima MG. A práxis da Saúde Mental no âmbito da Estratégia Saúde da Família: contribuições para a construção de um cuidado integrado. *Physis* 2011; 21(2):541-560.

8. Buchele F, Laurindo D, Borges V, Coelho E. A interface da saúde coletiva na atenção básica. *Cogitare Enfermagem* 2006; 11(3):226-233.

9. Lucchese R, Oliveira AGB, Conciani ME, Marcon SR. Saúde mental no Programa Saúde da Família: caminhos e impasses de uma trajetória necessária. *Cad Saude Publica* 2009; 25(9):2033-2042

10. Mendes-Gonçalves RB. Práticas de Saúde: Processos de Trabalho e Necessidades. *Cadernos Cefor PMSP/SMS -SP* 1992; 1.

11. Camargo Junior KR. *Biomedicina, saber & ciência: uma abordagem crítica*. São Paulo: Hucitec; 2003.

12. Costa-Rosa A. O modo psicossocial: um paradigma das práticas substitutivas ao modo asilar. In: Amarante P, organizador. *Ensaios, subjetividade, saúde mental e sociedade*. Rio de Janeiro: Fiocruz; 2000. p. 141-168.

13. Triviños ANS. *Introdução à pesquisa em ciências sociais: a pesquisa qualitativa em educação*. São Paulo: Atlas; 1992.

14. Merhy EE. Em busca do tempo perdido: a micropolítica do trabalho vivo em saúde. In: Merhy EE, Onocko R, organizadores. *Agir em saúde: um desafio para o público*. São Paulo: Hucitec; 2007. p. 71-112.

15. Minayo MCS. *O desafio do conhecimento: pesquisa qualitativa em saúde*. 9ª ed. São Paulo: Hucitec; 2006.

16. Brasil. Ministério da Saúde. Portaria nº 2488/GM, de 21 de outubro de 2011. Aprova a Política Nacional de Atenção Básica, estabelecendo a revisão de diretrizes e normas para a organização da Atenção Básica, para a Estratégia Saúde da Família (ESF) e o Programa de Agentes Comunitários de Saúde (PACS). *Diário Oficial da União* 2011; 24 out.

17. Campos RO, Gama CA, Ferrer AL, Santos DVD, Stefanello S, Trapé TL, Porto K. Saúde mental na atenção primária à saúde: estudo avaliativo em uma grande cidade brasileira. *Cien Saude Colet* 2011; 16(12):4643-4652.

18. Poli-Neto P. *Encontros no centro de saúde: a medicina de família e comunidade (MFC) e o sofrimento social* [tese]. Florianópolis: Universidade Federal de Santa Catarina; 2011.

19. Gavilán-Moral E, Barroso AV, Gracia LJ. Como desprescrever medicamentos. In: Gusso G, Lopes JM, organizadores. *Tratado de medicina de família e comunidade*: *princípios, formação e prática*. Porto Alegre: Artmed; 2012. p. 828-835.

20. Kloetzel K. O Diagnóstico Clínico: Estratégia e Táticas. In: Duncan B, Schmidt MI, Giugliani ERJ, organizadores. *Medicina Ambulatorial: condutas de atenção primária baseadas em evidências*. Porto Alegre: Artmed; 2006. p. 131-142.

21. Fleck MPA. Depressão. In: Duncan B, Schmidt MI, Giugliani ERJ, organizadores. *Medicina Ambulatorial: condutas de atenção primária baseadas em evidências*. Porto Alegre: Artmed; 2006. p. 874-884.

22. Osório CMS, Abreu PB, Gama CS, Lobato MI. Psicoses. In: Duncan B, Schmidt MI, Giugliani ERJ, organizadores. *Medicina Ambulatorial: condutas de atenção primária baseadas em evidências*. Porto Alegre: Artmed; 2006. p. 885-896.

23. Costa-Rosa A. *Operadores fundamentais da atenção psicossocial: Contribuições a uma crítica dos processos de subjetivação na saúde coletiva*. 2011 [tese]. Assis: Universidade Estadual Paulista; 2011.

24. Luzio CA, L'Abbate S. A reforma psiquiátrica brasileira: aspectos históricos e técnico-assistenciais das experiências de São Paulo, Santos e Campinas. *Interface (Botucatu)* 2006; 10(20):281-298.

25. Tesser CD, Barros NF. Medicalização social e medicina alternativa e complementar: pluralização terapêutica do Sistema Único de Saúde. *Rev Saúde Pública* 2008; 42(5):914-920.

26. Amarante P. *Loucos pela Vida*: *a trajetória da reforma psiquiátrica no Brasil*. Rio de Janeiro: Fiocruz; 1995.

27. Devera D, Costa-Rosa A. Marcos históricos da Reforma Psiquiátrica Brasileira: Transformações na legislação, na ideologia e na práxis. *Rev Psicologia da UNESP* 2007; 6(1):60-79.

28. Mondoni D, Costa-Rosa A. Reforma psiquiátrica e transição paradigmática no interior do estado de São Paulo. *Psic.: Teor.e Pesq* 2010; 26(1):39-47.

29. Brasil. Ministério da Saúde. Portaria nº 648/GM, de 28 de março de 2006. Aprova a Política Nacional de Atenção Básica, estabelecendo a revisão de diretrizes e normas para a organização da Atenção Básica, para a Estratégia Saúde da Família (ESF) e o Programa de Agentes Comunitários de Saúde (PACS). *Diário Oficial da União* 2006; 29 março.

30. Franco TB. Fluxograma descritor e projetos terapêuticos para análise de serviços de saúde, em apoio ao planejamento: o caso de Luz (MG). In: Merhy EE, Miranda Junior H, Rimoli J, Franco TB, Bueno WS, organizadores. *O Trabalho em Saúde: olhando e experienciando o SUS no cotidiano*. São Paulo: Hucitec; 2003. p. 161-198.

31. Brasil. Ministério da Saúde (MS). Secretaria-Executiva. Núcleo Técnico da Política Nacional de Humanização. *HumanizaSUS: prontuário transdisciplinar e projeto terapêutico*. Brasília: MS; 2004.

32. Del Barrio LR, CYR C, Benisty L, Richard P. Autonomous Medication Management (GAM): new perspectives on well-being, quality of life and psychiatric medication. *Cien Saude Colet* 2013; 18(10):2879-2887.

33. Chiaverini DH, Gonçalves DA, Ballester D, Tófoli LF, Chazan LF, Almeida N, Fortes S. *Guia prático de matriciamento em saúde mental*. Brasília: Ministério da Saúde; 2011.

34. Albuquerque MAC, Dias LC. Abordagem em saúde mental pelo médico de família. In: Gusso G, Lopes JM, organizadores. *Tratado de medicina de família e comunidade*: *princípios, formação e prática*. Porto Alegre: Artmed; 2012. p. 233-240.

35. Jamoulle M, Gusso G. Prevenção quaternária: primeiro não causar dano. In: Gusso G, Lopes JM, organizadores. *Tratado de medicina de família e comunidade*: *princípios, formação e prática*. Porto Alegre: Artmed; 2012. p. 205-211.