Original Article

WORK PROCESS AND MENTAL HEALTH CARE FLOW IN PRIMARY HEALTH CARE

Luana Cristina Bellini Cardoso[1]
Guilherme Oliveira de Arruda[1]
Bianca Cristina Ciccone Giacon-Arruda[2]
Marcelle Paiano[1]
Leandro Barbosa de Pinho[3]
Sonia Silva Marcon[1]

[1]Universidade Estadual de Maringá, Programa de Pós-Graduação em Enfermagem. Maringá, Paraná, Brasil.
[2]Universidade Federal de Mato Grosso do Sul, Instituto Integrado de Saúde. Campo Grande, Mato Grosso do Sul, Brasil.
[3]Universidade Federal do Rio Grande do Sul, Programa de Pós-Graduação em Enfermagem. Porto Alegre, Rio Grande do Sul, Brasil.

ABSTRACT

Objective: to know the work process and mental health care flow in Primary Health Care from the perspective of Family Health Strategy professionals.
Method: a descriptive and qualitative study developed in six of the 34 Basic Health Units in a city in northwestern Paraná. Twenty-nine Family Health Strategy professionals participated in the study. Data were collected from February to June 2018 through an open, single, individual and recorded interview. The statements were transcribed in full, and the resulting material was organized in the IRaMuTeQ® software and subjected to thematic content analysis.
Results: from participants' reports, it was possible to create a service flowchart, and after the data processing steps in the software, together with content analysis, three categories emerged. The importance of community health workers' work, family presence, referring patients to therapeutic groups and a specialized network, assistance provided to individuals in times of acute disorder and patient referral to the unit stood out.
Conclusion: it can be understood that the mental health care network in Primary Health Care is complex and there is a need for communicability between services, as disarticulation generates ambiguities in continuity of care.

DESCRIPTORS: Mental health. Workflow. Primary health care. Family health strategy. Mental health assistance.

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PROCESSO DE TRABALHO E FLUXO DE ATENDIMENTO EM SAÚDE MENTAL NA ATENÇÃO PRIMÁRIA À SAÚDE

RESUMO

Objetivo: conhecer o processo de trabalho e o fluxo de atendimento em saúde mental na Atenção Primária à Saúde sob a ótica dos profissionais da Estratégia Saúde da Família.
Método: estudo descritivo, qualitativo, desenvolvido em seis das 34 Unidades Básicas de Saúde de um município do Noroeste do Paraná. Participaram do estudo 29 profissionais da Estratégia Saúde da Família. Os dados foram coletados no período de fevereiro a junho de 2018 por meio de entrevista aberta, única, individual e gravada. As falas foram transcritas na íntegra e o material resultante foi organizado no *software* IRaMuTeQ® e submetido ao processo de análise de conteúdo modalidade temática.
Resultados: a partir dos relatos dos participantes pôde-se criar um fluxograma do atendimento, e após as etapas de processamento dos dados no *software,* juntamente com a análise de conteúdo, emergiram três categorias. Destacou-se a importância do trabalho do agente comunitário de saúde, a presença da família, o direcionamento dos pacientes para os grupos terapêuticos e para a rede especializada, a assistência dispensada aos indivíduos em momentos de agudização do transtorno e o retorno do mesmo para a unidade.
Conclusão: pode-se compreender que a rede de atendimento em saúde mental, na Atenção Primária à Saúde, é complexa e há necessidade da comunicabilidade entre os serviços, pois a desarticulação gera ambiguidades na continuidade do cuidado.

DESCRITORES: Saúde mental. Fluxo de trabalho. Atenção primária à saúde. Estratégia saúde da família. Assistência à saúde mental.

PROCESO DE TRABAJO Y FLUJO DE LA ATENCIÓN MENTAL EN LA ATENCIÓN PRIMARIA DE SALUD

RESUMEN

Objetivo: conocer el proceso de trabajo y el flujo de atención en salud mental en Atención Primaria de Salud desde la perspectiva de los profesionales de la Estrategia de Salud Familiar.
Método: estudio descriptivo, cualitativo, desarrollado en seis de las 34 Unidades Básicas de Salud de un municipio del noroeste de Paraná. Participaron en el estudio 29 profesionales de la Estrategia de Salud Familiar. Los datos se recolectaron de febrero a junio de 2018 a través de una entrevista abierta, única, individual y grabada. Los discursos fueron transcritos íntegramente y el material resultante fue organizado en el software IRaMuTeQ® y sometido a la modalidad temática proceso de análisis de contenido.
Resultados: a partir de los informes de los participantes, fue posible crear un diagrama de flujo del servicio, y luego de los pasos de procesamiento de datos en el software, junto con el análisis de contenido, surgieron tres categorías. Se resaltó la importancia del trabajo del agente comunitario de salud, la presencia de la familia, la orientación de los pacientes a los grupos terapéuticos y a la red especializada, la asistencia brindada a los individuos en momentos de agravamiento del trastorno y el retorno de los mismos al unidad.
Conclusión: se puede entender que la red de atención en salud mental en Atención Primaria de Salud es compleja y existe la necesidad de comunicabilidad entre servicios, ya que la desarticulación genera ambigüedades en la continuidad de la atención.

DESCRIPTORES: Salud mental. Flujo de trabajo. Atención primaria de salud. Estrategia de salud familiar. Atención a la salud mental.

INTRODUCTION

The lack of access to adequate mental health services and care, or even the difficulties in reaching devices capable of recognizing or diagnosing the mental disorder is called mental heatlh gap.[1–2] Therapeutic gap represents an important problem when it comes to mental health care, because in low and middle income countries, up to three quarters of people with mental disorders do not receive the treatment they should receive.[1]

In this sense, according to a literature review study, one of the main strategies to be implemented to combat barriers to access and the considerable distance between living with the disorder and the possibility of guaranteeing the right to assistance is integrating health care mental health with Primary Health Care (PHC) services.[3] Most mental health problems can be solved at this level of care, without the need for referral to specialized levels. It is noteworthy that the Psychiatric Reform fostered the deinstitutionalization of subjects and consolidated territorial bases for mental health care.[4]

The literature points to a high prevalence of mental disorders among people who are followed up by Basic Health Units (BHU) in Brazil. A study carried out in southern Brazil found that 18% of the 1,593 people older than 60 years old, surveyed, had considerable depressive symptoms.[5] In soustern Brazil,1,466 people identified high prevalences of Common Mental Disorder (20.5%), Common Mental Disorder of severe intensity (32%), cases that indicated a diagnosis of anxiety (37%) and depressive disorder (25.1%).[6]

PHC has the ability to work with mental health conditions, so much so that a study based on secondary data showed an inverse and significant association between the provision of PHC services and rates of hospitalization for mental disorders, more specifically those related to using alcohol and other drugs among men in São Paulo and Rio de Janeiro, and humor, among women, in Rio de Janeiro.[7]

In this regard, Family Health Strategy (FHS) has a fundamental role in the population's mental health care, as its concept of health is broader as well as the understanding of the health-disease process determinants However, it is necessary to implement the change from the traditional biomedical model to a holistic model focused on subjects' comprehensiveness in their family and social relationships,[8] in addition to endorsing the perspective of embracement as a beacon of the assistance provided.[9]

Controversies are still present in the literature regarding the effectiveness of sBHUtitute services and PHC in relation to mental disorders. It is estimated that, in Brazil, one in five Brazilians needs mental health assistance, although sometimes this need goes unnoticed by PHC services.[10] In a survey carried out with 27 professionals working at FHS, it was understood that teams perceive the demands that arise, are able to recognize resources for care; however, they cite barriers to integrate these resources and develop effective care.[11]

The approach to mental health in PHC seems complex, although present and recurrent in the daily work of professionals in this sphere of care.[12] In the face of this ambiguous context, the following questions are raised: how does the work of PHC health teams work to assist people living with mental disorders? How is the flow of care designed at this level of care so that users can access adequate care, and what factors permeate this flow?

Thus, this study aims to understand the work process and mental health care flow in PHC from the perspective of FHS professionals.

METHOD

This is a qualitative and descriptive study developed in six of the 34 BHU considered to have the highest flow of care in mental health, with, on average, three FHS teams each, located in a city in northwestern Paraná.

Thirty-five health professionals have been invited, including physicians, nurses and psychologists; three were away and three refused to participate due to demand for work and lack of time; therefore, 29 professionals participated in the study. Professionals who had been in office for at least six months were included and those who had been away for any reason during the data collection period were excluded. These professionals have been selected because they are the most prepared for assessment and completion of risk stratification in mental health and for being in charge of assistance and referrals to specialized service.

Data were collected from February to June 2018, through an open, single, individual interview, recorded on digital media, with an average duration of 40 minutes. The first author - who had experience in qualitative research and had no previous contact with participants - was responsible for the interviews; they were previously scheduled and held in a private room at the institution, at the time of the participants' choice, without any or minimal interference in their activities.

During the interviews, the following triggering question was used: how is the assistance provided to individuals with mental disorders and their families at BHU? Other questions were included to deepen the data and clarify doubts that arose during the interviews. A structured questionnaire was used to access sociodemographic data and related to professional training and experience.

All speeches were transcribed in full, and the resulting material was organized in the IRaMuTeQ® and submitted to thematic analysis. Thematic analysis consists of discovering the nuclei of meaning that make up a communication, whose presence or frequency means something for the analytical objective sought.[13] The results were discussed based on the theoretical premises expressed by the Ministry of Health in the Primary Mental Health Care Booklet (*Caderno de Atenção Básica de Saúde Mental*),[14] Mental Health Guide Line of the State of Paraná (*Linha Guia de Saúde Mental do Estado do Paraná*),[15] and Mental Health Care Line in the City (*Linha Guia de Atenção à Saúde Mental do Município*).[16]

We have used IRaMuTeQ® 0.7 Alpha 2.3.3.1 (*Interface of the R pourles Analyzes Multidimensionnelles de Textes et de Questionnaires*) to support data analysis, which is freely available and open source. For this study, the correspondence factorial analysis made from the DHC (Descending Hierarchical Classification) (Post-Factor Analysis) was used, which represents, in a Cartesian plane, the different words and variables associated with each of the DHC classes. IRaMuTeQ makes it possible to recover, in the original corpus, all text segments associated with each class, at which point the context of the statistically significant words is obtained, enabling a more qualitative analysis of data,[17] always guided by a researcher's analytical and interpretation capacity.

To meet the ethical aspects, the study was approved by the Human Research Ethics Committee. All ethical precepts were respected according to Resolution 466/12 of the Brazilian National Health Council (*Conselho Nacional de Saúde*). All participants expressed their agreement to participate in the study by signing the Informed Consent Form (ICF) in two copies. To guarantee their anonymity, participants were identified with letter P, followed by a number indicating the order in which interviews were conducted.

RESULTS

Of the 29 study participants, 14 are nurses, eight are psychologists and seven are physicians, aged between 26 and 68 years old, and most are female (24 women). The average training time was 14 years and professional performance ranged from six months to 40 years. Only three professionals did not have neither a specialization, a master's nor a physicianal degree. Participants' reports allowed to identify the mental health care flowchart in the city under study (Figure 1).

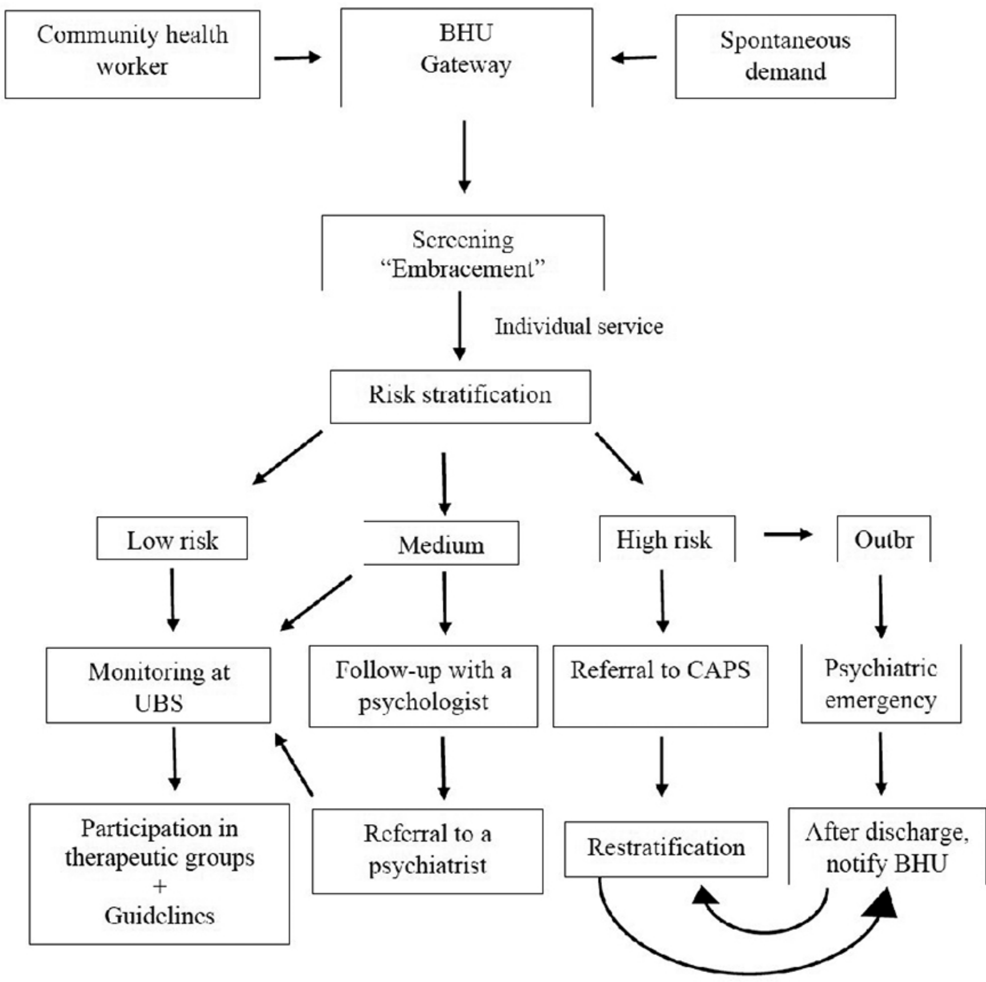

Figure 1 – Mental health care flowchart in the city. Maringá, PR, Brazil, 2019.

Data processing in the software gave rise to three classes; they were named according to the main subject addressed, identified from the words presented and interpretation of their thematic convergence with the conceptual bases adopted (Figure 2). Therefore, Class 1 was named network flow and work organization; Class 2, professionals' attributions/skills in service; Class 3, difficulties and facilities in mental health care. Classes 1, 2 and 3 are described below.

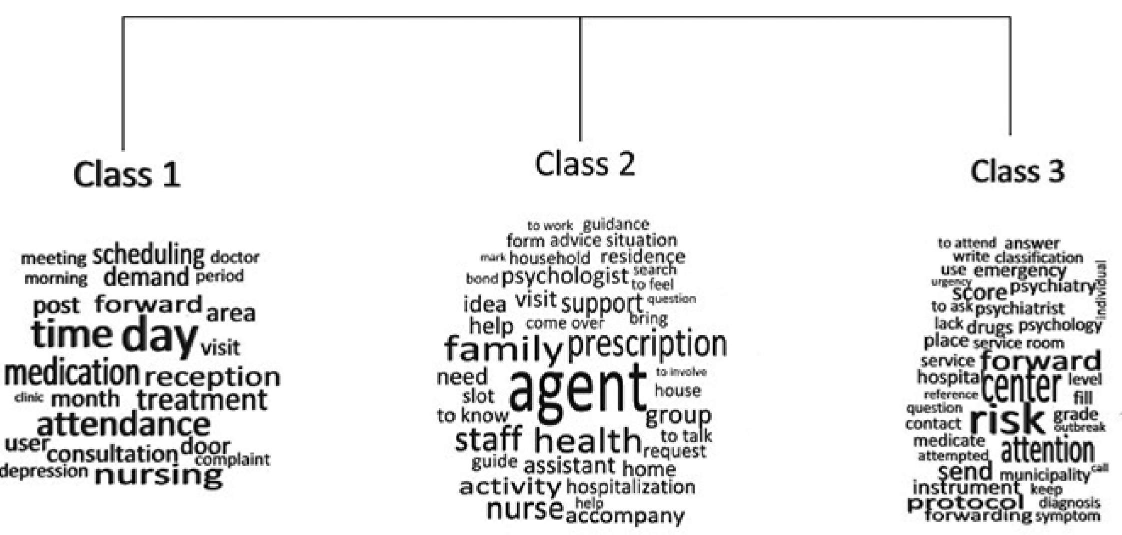

Figure 2 – Dendogram of words organized based on IRaMuTeQ®
and from participants' reports. Maringá, PR, Brazil, 2019.

Class 1 - Network flow and work organization

After users with mental disorders enter the health service, either through Community Health Workers (CHWs) or due to spontaneous demand, health professionals embrace and schedule appointments to institute treatment and offer the necessary support to families. *If necessary, we refer the family to a psychologist to learn how to deal with the initial problem, but then they get used to it; but in the beginning, for them, we try to provide support for the whole family, but it is basically the consultation* (P04). *When they arrive at the unit where treatment is instituted, they already explain to the family what is happening, how it will be going forward; at that time home visits of community workers occur* (P25).

Thus, with the reorganization of mental health care in the city, primary care services started to adopt the Risk Stratification protocol. Referrals to other levels of care occur only through the low, medium and high risk classification. Patients classified as low risk are followed up at the health unit; those of medium risk are referred for psychological and/or psychiatric care; and those at high risk go to Psychosocial Care Centers (CAPS - *Centros de Atenção Psicossocial*). *In a normal consultation, we do risk stratification. Low-risk patients are treated within the unit, where we, physicians, can medicate, and medium-risk patients are referred to network psychiatrists and those at high risk to CAPS* (P23). *For patients to be referred, they need to be classified within a score; if they do not show those symptoms, I cannot send them to the psychiatrist or to CAPS* (P05).

Some words in this class complement referrals of patients in acute/crisis condition who arrive at the health unit or who enter a crisis at home, for which professionals reported that assistance is done with an open door. These are referred to the Psychiatric Emergency at the Municipal Hospital; however, some professionals mentioned that it is not always immediate or simple, as they had to contact the psychiatric emergency service team. *For psychiatric emergencies it is a little more difficult to refer when you think it is necessary or send to the emergency department or have to call. It has already happened that I had to call the emergency room and talk to someone from the nursing staff and explain what was happening* (P18). *We open the door in crisis situations, we embrace and, if*

necessary, make the referral. If there is a risk to persons or to third parties, we refer to the psychiatric emergency (P11).

Finally, patients referred to other points of the Psychosocial Care Network (RAPS – *Rede de Atenção à Saúde*) end up returning to primary care in order to continue the assistance and the therapeutic process, either to stabilize the previous crisis or to reassess and generate a new risk stratification by specialized service. *All the patients who go there do not stay on treatment forever, only a few, others after carrying out monitoring, to be stabilized, go back to the clinic physician to be monitored* (P29). *There are some nurses who make the referral, so in a little while a patient comes back to us because he or she is from our field. Every week we receive by the system, in the unit's e-mail, graduates from the psychiatric hospital and graduates from hospitalizations* (P09).

Class 2 - Professionals' attributions/skills in service

In this class, the initial elements in caring for patients with mental disorders and their families were addressed. There are several ways for the sick individual to enter the health system. In professionals' reports, it is noted that CHWs have a fundamental role in mental health care; they are the mediators between the family and the health service, and the embracement referred by professionals constitutes a procedure operationalized by the team. *The worker brings the case to the team, we mobilize the team and this family is guided. If necessary, we bring the whole family to the unit depending on the need as appropriate* (P02). *Health workers are the ones who bring a situation to us, they identify it at the residence or that users can come for a complaint whatever nurses attend or even if that person goes through embracement with nursing assistants* (P14).

Analyzing the words highlighted in the dendogram, it is clear that, in this class, the reports are aimed at monitoring patients with mental disorders at BHU. Individual consultations were the most pointed out by professionals as one of the main forms of monitoring. However, some participants reported that, in addition to individual calls, there are group calls, however these do not always work as they should. *Here at the unit we do individual care and according to the needs of patients, we do not do group assistance. Medication is usually already prescribed by a psychiatrist; then patients come, we examine them and try to guide them in the best way* (P28). *Here we are doing individual clinical and group care. It is a general practice for people of all ages, elderly, children, adults, adolescents; all users in our field are potential psychology patients* (P11).

Another aspect highlighted was the scheduling of consultations and replication of prescriptions for controlled medications. Some professionals reported that patients who arrive with a mental health demand do not need to make an appointment. Others are attended according to the date of the medication to be dispensed. *My team always provides special care, so patients with mental disorders are preferred. They do not need to schedule appointments* (P22). *As the group comes every fifteen days and as the medications have a certain date for them to come and get them, we end up scheduling them according to the date of the medication they have to take* (P13).

Class 3 - Difficulties and facilities in mental health care

In this class, the difficulties and facilities found in the work process related to assisting people with mental disorders were found. Absence of a professional/staff prepared to carry out care aiming at the comprehensiveness of subjects and their families stand out, as well as the necessary insight to intervene in the situations that appear in the daily care in Primary Health Care. *Here is a large unit, not all professionals are trained, there is training for FHP teams, but sometimes the receptionist and other professionals who are not involved in the teams also needed training to be able to know*

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how to approach, how to receive and how to refer this patient (P08). *The difficulty is that not every professional knows how to deal with mental disorder* (P25).

It is noted, in the reports, that the figure of psychologist is still considered the most responsible for caring for users in mental distress, which affects the overload of these professionals and users' access due to the impossibility of offering a listen or due to accumulation suppressed demand on waiting lists. *I think one of the difficulties is the involvement of all health professionals to understand that mental health is everyone's issue and that everyone can, in some way, manage with a listening, an embracement* (P14). *Physicians and technical staff need to be prepared to listen and embrace patients, not just psychologists. This is a difficulty. Maybe that's why our waiting lists are always long* (P09).

A set of actions developed by professionals during the work process at BHU can be perceived. Despite the lack of trained professionals to deal with mental health, the successful implementation of these actions in PHC happens due to the efficiency of working with multidisciplinarity, taking the preparation and attention given by professionals as quality indicators. *The little amount of professionals we have here is very good; NASF is very good, our social worker is very good, our psychologist is very attentive; although there is the NASF psychologist, there is the unit psychologist, they are very attentive, our professionals are well trained, the occupational therapist is also very good and our physician is also* (P01).

In this category, the main aspects of risk stratification recently implemented in the city were addressed. It was noted that, although managers consider it a new network care tool, professionals reported flaws in the tool - incomprehensible items, terms not clinically used and being too large. Even so, some professionals pointed out benefits in its use as a better direction of flow and demand, and an approximation with the theme. *There are several issues within the risk stratification that you can understand, there are ambiguities. Sometimes some things are missing that the patient has that are not scored properly. There are some flaws in this regard; for instance, I make a stratification that gives a score, if a psychologist does it sometimes, it is different, if the secondary care physician does it too, then it would be interesting for you to have a standardized thing* (P24). *Stratification has greatly reduced the burden, because the one who can follow me, accompanies here. The one who only needs a psychiatrist can be referred to a psychiatrist, the more serious cases go to CAPS* (P29).

However, even with risk stratification, another limiting point reported was the counter-referral from the specialized service. Although this is of paramount importance for continuity of care, some reports showed that communication between services does not always happen. *Counter-referral is something that could improve a lot, because you send the patient to see a psychiatrist and you don't know anything, because they don't use the system and don't bring anything in writing. We are sometimes a little lost* (P04). *Counter-referral is a bit complicated; it always has been. From the moment I started working at the unit, it never worked, we never had a case when I sent a patient to CAPS and they sent a counter-referral to me* (P28).

Finally, it was identified that the physical space for the development of activities aimed at users is insufficient. There are no rooms for embracement or group therapy, a fact that compromises the confidentiality of information and even prevents quality care. *The physical structure of the unit is unable to adequately care for these patients; sometimes we do not have a room prepared to listen and in our unit the number of mental health patients is very large* (P17). *Here is not even the question of how to approach or where to refer, it is more physical space, our unit is small, and we do not have a room to properly assist patients* (P18).

DISCUSSION

Among the findings of the present study are the importance of CHWs' work as an initial link between users and BHU; family presence; directing patients to therapeutic groups (although periodized based on drug treatment) and to the specialized network, according to risk stratification in mental health; assistance provided to individuals in times of worsening of a disorder and their return to BHU. However, some gaps were identified in preparing professionals, service and in network flow, such as lack of training for professionals; the idea that assistance in the face of mental disorders should be essentially the responsibility of psychologists; limited physical space for customer service; fragility in communication between points of attention.

In the literature, CHWs are identified as the main links between family and health service, whose performance is surrounded by difficulties, advances and setbacks, as they are health workers in whom the professionalization process is still recent.[18] In a study carried out with 17 CHWs working in five FHS teams in southeastern Brazil, it was evidenced that the CHWs had, in listening, their main care technology, as they were able to identify problems, not only of the illness process, but also the psychosocial demands of users and family, in addition to observing, in practice, the positive effects for users with mental disorders.[11]

It was observed, in the statements, that there is a distance from the embracement that is performed by professionals in relation to that proposed by the Ministry of Health (MoH). However, although maintaining the characteristics proposed in relation to that of screening, professionals refer to embracement as a procedure and not as an ethical posture that guides care. Embracement at BHU, according to MoH, is a practice based on respect, solidarity and recognition of populations' rights and demands in the territory.[14] A study carried out with nurses and CHWs from two BHU in the city of Rio de Janeiro showed similar results regarding care practices directed at this population.[19]

The interviewed professionals sometimes mentioned the family, especially when dealing with embracement and the need to guide family members about the condition and therapeutic follow-up. This finding is supported by the scientific literature, considering a cross-sectional study carried out with 328 nurses working in primary care in Porto/Portugal, which pointed out a high degree of agreement on the part of professionals in relation to the importance of families in nursing care for people with mental disorders.[20]

It was evidenced that the main care/monitoring resources are individual consultations with or without family member presence, therapeutic groups, individual psychotherapy and the psychiatric approach focused on medicalization, always performed within BHU. This finding corroborates the literature, emphasizing that even therapeutic groups seem to be centered on medication, as they are periodized according to the users' drug treatment progress.[4,21]

Concerning mental health care flow reorganization in the city, health professionals highlighted the risk stratification protocol in mental health as a guide for referrals to specialized care. The instrument was cited as being too large, difficult to understand, with ambiguities in its content. In this context, it is worth noting that the state of Paraná held the Mental Health Workshop to train and qualify PHC professionals, contributing to developing mental health actions in the municipalities and in the state, in order to cover what the Brazilian National Mental Health Policy (*Política Nacional de Saúde Mental*) does not include.[15,22]

Thus, defining the parameters adopted in the risk stratification was mainly based on the need to define the level at which health care will occur. Signs and symptoms were organized into six groups, according to the frequency in which they appear in the respective psychopathological syndromes, and were scored according to the level of severity, low, medium and high risk. After stratifying the

risk, a care plan is drawn up that includes the definition of a point of health care, in which users will be treated at first.[15]

Therefore, in situations stratified as low risk, among which those with mild to moderate symptoms of depression, anxiety and somatization, symptoms tend to overlap, in addition to sharing the same risk factors and evolution patterns. The recommended strategy is to start with low intensity care, going through support groups that explore issues such as self-esteem or resilience, evolving to use drug therapy with specialized supervision and group or individual psychotherapy, if necessary.[15–16,23]

In situations stratified as medium to high risk, PHC plays an important role in early diagnosis, in the early onset of treatment with rapid and effective interventions in crisis, in maintenance of pharmacological treatment and in psychosocial rehabilitation programs for stable chronic psychotic conditions. Teams must have training, supervision and matrix support from NASF and secondary care points, such as CAPS. However, users do not always remain linked to the reference PHC in their territory.[15–16,23]

Therefore, to continue caring for these people referred to secondary and tertiary levels, it is necessary that the referral and counter-referral system be effective and efficient, considering the local RAPS for care organization. These results corroborate those of other studies, in relation to the difficulties and lack of articulation and communication of PHC with other services. Furthermore, it is necessary to ensure and know the referral and counter-referral system, as this is one of the essential management tools for strengthening the Unified Health System (SUS - *Sistema Único de Saúde*).[24–25]

In practice, it appears that these limitation of articulation at RAPS produce disagreements and users and families end up being loose in the network, that is, they do not understand where their monitoring will come from and what will be constituted. The longing of the inquired professional for something standardized, referring to the risk stratification instrument, occurs due to the differences found in professionals' assessments of different health services, which generate comings and goings from users without resolution. Although the instrument is structured and there is a description of signs/symptoms to be assessed, completion is surrounded by subjectivity and momentary observation of professionals; it is sometimes required that the instrument be completed together.

Furthermore, it was noticed, in professionals' reports, the absence of mention of matrix support, which indicates that articulation between points of care may be impaired due to lack of a closer relationship between the teams. In a study carried out with six active professionals, as matrix supportive of PHC, in a city in the state of Rio Grande do Sul, it was found that matrix support in mental health goes beyond the reference and counter-reference practices, as it presupposes work in the living territory community among supporters, the reference team (FHS) and users.[26] It also requires professionals from specialized services to act beyond outpatient care, through organizational arrangements that allow supervision, joint care and discussion of clinical cases, according to the particularities of each coverage area.[26]

In the city where this study was carried out, in the last three years training courses were developed for different sectors (health, education, public safety, social assistance, justice...), including PHC professionals, with a focus on topics such as risk stratification in mental health, suicide prevention and post-prevention and care for people with mental disorders related to using psychoactive substances. However, lack of professional preparation has become an obstacle to an efficient and effective performance of care activities in mental health. Studies point to the lack of professional training and permanent education, not only for BHU teams, but also for specialized services.[27–28]

Despite the important local initiatives for professional training, they still do not meet professionals' needs with regard to developing mental health care in PHC. Thus, a major challenge is the redefinition of the work process, so that the influence of the biomedical model still persists today, both in professional

training and in practice, requiring transformation, especially in training these professionals to work at SUS.[29]

A finding that also draws attention is the centrality of mental health care in psychology professionals. It was observed that nurses and nursing technicians have an intermediate role in the flow of care in PHC, both at BHU itself and at RAPS in general; they receive demands identified by CHWs, they embrace (procedure) in specific situations and refer them through risk stratification or crisis situations assessment. The potential for listening and nursing relational skills is minimized. Physicians, especially psychiatrists, are delegated and psychologists the role of monitoring, support, qualified listening and the institution of therapy. Thus, the implementation of a care practice based on interdisciplinarity is impaired.

Professionals also pointed out the lack of structure as an obstacle to mental health care. Patient treatment is incomplete, as there is no space to provide quality care, a good embracement, effective listening and even group meetings (therapeutic or matriculation). Ambience has great influence on assistance, considering that the inadequate structure, with reduced size or lack of comfort, impairs working conditions, increases professional demotivation and makes it difficult for users to seek service.[12]

It is noteworthy that physician-centered and psychologist-centered service, lack of physical space, unpreparedness of professionals and disarticulation of the network can generate insecurity in professionals and negatively affect creating the Singular Therapeutic Project (PTS - *Projeto Terapêutico Singular*) and care production within the scope PHC; therefore, this will generate dependence on specialized services and an excess of referrals.[30]

Considering these findings, a possible limitation of the study was non-inclusion of CHWs and secondary level professionals, such as CAPS. The perspectives of these actors would enrich the understanding about mental health care configuration and would make it possible to cover their real demands, leading to improved assistance and greater effectiveness of actions. However, even so, this study sought to discuss results together with Public Mental Health Policies at both national and state and municipal levels. Thus, data can be used to support carrying out other studies in mental health, strengthening the theme and seeking new care strategies adapted to each reality found in Brazil.

It is essential to conduct new studies on the subject, covering all aspects of mental health integrated to Primary Care, not only from the perspective of workers, but also from users and family members who demand care in this field.

CONCLUSION

It can be understood that RAPS service, having PHC as a care provider, is complex and there is a need for communicability between services, as disarticulation generates ambiguities in continuity of care. Health workers highlighted the importance of CHWs, fundamental servants, being configured as the entrance doors to services. Among the difficulties and facilities highlighted are the lack of preparation of professionals to deal with mental health, demystification of the idea among other professionals that assistance is essentially that of psychologists, limited physical space and risk stratification in mental health recently implemented.

It is considered that in order to improve assistance, it is necessary to register between health teams and CAPS. Therefore, it will be possible for all health professionals to share the same knowledge, since Primary Care should not only be a gateway, but also act resolutely in most health problems, including mental health problems.

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NOTES

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Study design: Cardoso LCB, Marcon SS.
Data collect: Cardoso LCB.
Data analysis and interpretation: Cardoso LCB.
Discussion of results: Cardoso LCB, Marcon SS.
Critical writing and/or content review: Cardoso LCB, Marcon SS, Arruda GO, Paiano M, Giacon-Arruda BCC, Pinho LB.
Final review and approval of the final version: Cardoso LCB, Arruda GO, Marcon SS, Giacon-Arruda BCC, Paiano M, Pinho LB.

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CONFLICT OF INTEREST

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CORRESPONDING AUTHOR

Luana Cristina Bellini Cardoso
luana.bellini@hotmail.com