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ORIGINAL ARTICLE

CONCEPTS AND INTERVENTIONS ON MENTAL HEALTH IN THE PERSPECTIVE OF FAMILY HEALTH STRATEGY PROFESSIONALS

CONCEPÇÕES E INTERVENÇÕES EM SAÚDE MENTAL NA ÓTICA DE PROFISSIONAIS DA ESTRATÉGIA SAÚDE DA FAMÍLIA

CONCEPCIONES E INTERVENCIONES EN SALUD MENTAL EN LA OPTICA DE PROFESIONALES DE LA ESTRATÉGIA SALUD DE LA FAMILIA

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ABSTRACT

Objective: to understand the perceptions of health professionals linked to the Family Health Strategy on mental illness and about care for people in psychological distress. **Method:** descriptive study with a qualitative approach, in which participants were nine health professionals linked to two Family Health Strategy teams of a municipality in the North of Rio Grande do Sul state. For data collection, a semistructured interview was used. Data were analyzed according to the content analysis technique, in the thematic analysis modality. **Results:** respondents related mental illness with violation of rules, escape from the normal pattern, dependence of care, inability to perform daily activities. The care for people with mental illness involves home visits, medical and nursing appointments, prescription of medications and referrals to specialized services. **Conclusion:** the care provided is weakened by the lack of qualification of the Family Health Strategy workers. **Descriptors:** Mental Health; Family Health; Psychic Suffering; Workers; Mental Disorders.

RESUMO

Objetivo: compreender as percepções de profissionais da saúde vinculados às Estratégias de Saúde da Família sobre doença mental e acerca do atendimento a pessoas em sofrimento psíquico. **Método:** estudo descritivo, com abordagem qualitativa, no qual participaram nove profissionais de saúde vinculados a duas equipes com Estratégia de Saúde da Família de um município do Norte do Rio Grande do Sul. Para a coleta de dados, utilizou-se a entrevista semiestruturada. Os dados foram analisados de acordo com a Técnica de Análise de Conteúdo, na modalidade análise temática. **Resultados:** os entrevistados relacionam a doença mental com infração de regras, fuga dos padrões de normalidade, dependência para cuidados, incapacidade para a realização de atividades diárias. A assistência às pessoas com doença mental envolve visita domiciliária, consulta médica e de enfermagem, prescrição de medicamentos e encaminhamentos a serviços especializados. **Conclusão:** a assistência prestada mostra-se fragilizada pela falta de qualificação dos trabalhadores da Saúde da Família. **Descritores:** Saúde Mental; Saúde da Família; Sofrimento Psíquico; Trabalhadores; Transtornos Mentais.

RESUMEN

Objetivo: comprender las percepciones de profesionales de la salud vinculados a las Estrategias de Salud de la Familia sobre enfermedades mentales y acerca del atendimento a personas en sufrimiento psíquico. **Método:** estudio descriptivo, con enfoque cualitativo, en el cual participaron nueve profesionales de salud vinculados a dos equipos con Estrategia de Salud de la Familia de un municipio del Norte de Rio Grande do Sul. Para la recolección de datos, utilizándose la entrevista semi-estructurada. Los datos fueron analizados de acuerdo con la Técnica de Análisis de Contenido, en la modalidad análisis temática. **Resultados:** los entrevistados relacionan la enfermedad mental con infracción de reglas, fuga de los padrones de normalidad, dependencia para cuidados, incapacidad para la realización de actividades diarias. La asistencia a las personas con enfermedad mental envuelve visita domiciliaria, consulta médica y de enfermería, prescripción de medicamentos y encaminhamientos a servicios especializados. **Conclusión:** la asistencia prestada se muestra fragilizada por la falta de calificación de los trabajadores de la Salud de la Familia. **Descriptor:** Salud Mental; Salud de la Familia; Estrés Psicológico; Trabajadores; Trastornos Mentales.

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INTRODUCTION

People who experience a mental illness often face difficulties because when seeking care in health services, they experience problems on reception, treatment and maintenance of links between professionals and users. Mental illness can be characterized as inappropriate responses to stress factors related to the external environment and the elements related to the subjects themselves, and evidenced by thoughts, feelings and behaviors that can interfere with personal, family, social and occupational functioning of the person.¹

In the field of mental health and psychosocial care, the idea of psychic suffering makes us think of a subject who suffers for their lived experience, carrier of a mental disorder. It gives us the idea of someone who carries an inseparable and indistinguishable burden, besides being a disturbed person.² Complementing this line of thought, user organizations have opposed to the use of terms such as mentally ill due to their medical field.³ Due to this fact, in this study the terms "mentally ill" and "carrier of mental disorder" will be replaced by the phrase "people/individuals/subjects in mental distress".

For a long time, the care to people in mental distress was centered in hospices. In the period of World War II, scholars started to criticize the hospital-centered, segregating and excluding model advocated by hospices.⁴ Thus, according to the Ministry of Health,⁵ at the end of the 70's, the Movement of the Psychiatric Reform began in Brazil, motivated by the crisis in the psychiatric hospital care model and by the efforts of social movements for the rights of patients. The result of this process was the enactment of the Federal Law for Psychiatric Reform on April 6, 2001, Law No. 10,216, which redirects the mental health care, focusing on offering treatment in community-based services by building a mental health care network to replace the hospital-centered model, and by the monitoring and reduction of psychiatric beds in hospices.⁶

The care to the subject in psychological distress extends to the different services, including the Family Health Strategy (FHS), established in 1994 by the Ministry of Health,⁷ which is characterized as one of the services that replaced the hospital-centered model, as it has, among various functions, the role of monitoring the subject who is experiencing a psychic disorder and their family. This form of service organization is important in mental

health as it seeks to break with the hegemonic medical model, has the challenge of taking the family on their socio-cultural dimension as the object of attention, plans and executes actions in a given territory and promotes citizenship and quality of life for people.⁸

It is known that the teams linked to FHS have some resistance to assist people experiencing psychological distress, in addition to having little theoretical support to fulfill this demand. A survey of health professionals working in FHS shows that they had difficulties to meet users in psychological distress, and the main reasons for this were lack of professional qualification and prejudices due to connection that still exists between the mental patient and asylums, aggression and fear.⁹

Therefore, studies that seek to understand the perception of health professionals regarding the attention to the subject in psychological distress in the Family Health Strategies are significant because these spaces are reference for treatment of this population group. Listening to the professionals involved in these scenarios can assist in building strategies that qualify care to these users and minimize the wear of the team.

Thus, understanding the perceptions of health professionals working in FHS regarding the care of people in psychological distress can assist in the qualification of this service. So, the guiding question of this study was defined as: "What is the perception of health professionals working in the FHS of a municipality located in the Northwest of Rio Grande do Sul state in relation to mental illness and to care of users in psychological suffering?". *So the study objective is: to understand the conceptions of health professionals linked to the FHS of a municipality located in the Northwest of Rio Grande do Sul state about mental health and about the care of people in psychological distress in these spaces.*

METHOD

This is a qualitative and descriptive study, carried out in a municipality of northern Rio Grande do Sul with two Family Health Strategies that are consolidated in this city. For this research, authors used the semi-structured interview, with questions relating to the characterization of the subjects and two open questions: what is mental illness for you? How is it for you to care for a person in mental suffering?

To collect the data, health professionals were contacted in person or by telephone in

order to previously schedule time and place that offered privacy and confidentiality of information collected. The respondent was asked to read and sign the Informed Consent Form (ICF) and answered the questions of the guiding script of the research, which did not allow identifying the respondent. The interviews were recorded on audio tape and after, transcribed in full.

The first Family Health Strategy visited to conduct the research covers a territory composed of three districts, whose total population is about 4,800 people. The health professional staff was composed of a nurse, a general practitioner, a dentist, two nursing technicians/assistants and three community health workers, who were acting effectively in the service. Regarding mental health, interventions consisted of home visits, medical and nursing appointments, as well as referral to a specialist when the physician deemed necessary.

The second Family Health Strategy visited for data collection also covers three districts and the assisted population is approximately of 4,400 users. At that time, there were a nurse, a general practitioner, two nursing technician/assistants and three community health workers working in the unit. The activities performed by this unit are the same as the first FHS visited, both for the general population and for users in psychological distress, except for dental care. In addition, this unit provides care for patients with leprosy or tuberculosis and group activities for the population in psychological distress.

Regarding inclusion criteria, professionals should be working in the service for more than a year. The participants were two physicians, two nurses and one dentist, representing all professionals of these categories in these locations. In addition to these, a nursing assistant and three community health workers were also interviewed, totaling nine participants.

Four study participants were male and five female. The age of the subjects ranged from 24 to 64 years old. Regarding marital status, one was divorced, two, single and six, married. As for education, four had high school level and five, higher education. With respect to religious aspects, six declared themselves to be Catholic, two, evangelical and one, Kardecist. The time of experience in the profession ranged from four to 36 years, but the period in the Health Strategy Family Team ranged from one year and five months to five years.

For the interpretation and analysis of data, authors used the thematic analysis technique,

consisting of three phases, which are ordering and classification of data and detailed analysis.¹⁰

The research project was approved by the Research Ethics Committee of the Federal University of Santa Maria, process number 23081.007671/2011-13. In order not to identify the subjects and preserve anonymity, the respondents were identified by the letter "R" followed by a number referring to the order of transcription of the speech.

RESULTS AND DISCUSSION

From the reading of information obtained from the participants, it was possible to build two analysis themes. The first deals with the concepts of family health professionals about mental illness and the second deals with the interventions made by these workers together with the person in psychological distress.

♦ Theme 1: Conceptions of family health professionals in relation to mental illness

By analyzing the speeches of the Family Health Strategy professionals on the conception they have about mental illness, it is clear that they associate this illness with a state of suffering experienced by the user and that affects all family members.

Mental illness is a disorder that I think it affects the person with a very great suffering, because in addition to suffering with their disease, with this psychism that they are going through, the family also gets very involved and often does not know how to deal with that sick person. (R2)

I characterize mental illness as a situation that brings suffering to the human being. (R3)

Mental suffering changes the daily life of the individual and their family. Even though the process of the Brazilian Psychiatric Reform has been happening for some time, the daily life of individuals in psychological suffering has been, in many situations, still permeated with prejudice. Often they are stereotyped as crazy or vagabond, which, added to the limitations imposed by mental distress, exclusion and shame, makes it impossible for them to perform activities of daily living. These changes, along with the responsibility for the care of that individual, can cause wear and conflicts between members of the family.

For a long time, people in psychological distress have been excluded from society and from family; their attention was restricted to psychiatric hospitals. After the Psychiatric Reform, priority has been given to the care of this population in community care services

and the family came to be understood as a fundamental part of the care, who could contribute to the improvement of the patient and remission of symptoms. However, with this change, the families and the very people who experience mental distress have been some difficulties to cope with the disease.

In this sense, the main difficulties to deal with the person in psychological distress are linked to the relationship with them due to aggressiveness, lack of affection, unpredictability, social isolation and financial costs beyond the expected. Also, there is the difficulty in accepting the mental illness due to prejudice and stigma that persist in society.¹¹

The mental illness of an individual causes changes in the daily contact with the family, disorganizing it due to feelings of anxiety and worry.¹² A study confirms that mental illness of one of the family members derails family dynamics and causes tensions before failures in social life and treatment, as well as feelings of guilt, weakness and impotence.¹³

It is important that the Family Health Team knows the family dynamics and develops partnerships that assist in the understanding of mental illness and in the development of strategies to facilitate interaction with the carrier of psychological distress. The conceptions that health professionals have about the family will define the interventions, contributing or not to the quality of care. Families need support to deal with conflicts and difficulties that appear in daily life as a result of mental suffering, but professionals must, often, free themselves from prejudices and understand the family in their uniqueness, understanding it as a partner and target of mental health care.¹⁴

Some interviewees also related mental illness with the violation of social rules and escape from the normal patterns. Also, there was no mention of the analogy between mental illness and intelligence.

I understand mental illness as something that takes you out of your normal sense, that prevents you from having a good relationship with family, with friends, in your work. (R1)

Mental illness is all human behavior that violates the rules of social convention. (R3)

Mental illness is when a person comes out of the ordinary, of what is considered within the society, the social balance, the normal, the common. (R9)

It is understood that normality is a little measurable criterion to define the presence or absence of mental health/illness, because we live in a society with vast cultural diversity

that interferes in the way people live and their customs. Thus, what is normal for one person may not be to another and it does not mean that one of them has a diagnosis of mental illness. Terms such as typical or acceptable in relation to normality were considered ambiguous because they involve value judgment and vary depending on the culture.¹⁵

Also, researchers suggest a link between mental illness and loss of capacities, even with the use of drugs.

They (the people) in the case, can also receive drug treatment. And they cannot answer for themselves. They are people who live a totally alienated life. (R4)

The speech above shows the stigmatized perception in relation to the person in mental suffering, as it is understood that the patient is a care-dependent individual and unable to perform everyday activities such as working, studying and having fun. Furthermore, the idea that one "cannot answer for oneself" may represent that they are in a state of irrationality. However, whereas some mental illnesses limit one's life due to the instability caused by periods of aggression, agitation and/or the presence of psychotic symptoms such as delusions and hallucinations, most often they can resume their daily activities and self-care.

Another important element that should be emphasized in relation to mental suffering is that the individual does not remain in outbreak permanently. They may have worsening of symptoms for some periods or be disoriented, however, in spite of mental illness affects some functions of life, the person retains awareness of their actions and reactions around them in other periods. The madness does not normally interfere in all aspects of one's life, allowing the mentally ill person to keep aware of themselves, the world and their actions, although disoriented at times. This awareness can lead the patient to develop and experience stressful situations by being aware of their actual condition, which can result in impotence and vulnerability before the disease. This perception can cause feelings of sadness, anger, confusion and emotional instability.¹⁶

When considering these aspects, the primary care teams often feel unprotected, unable to meet the daily demands on mental health, especially when it comes to more serious or chronic cases. Therefore, there is need of a support network that provides technical support to professionals, qualifying them to handle the situations experienced in daily life. Matrix support would satisfy this

need and establish a co-responsibility sense in users.¹⁷

Professionals interviewed also identified lack of affection in users in psychological distress.

I felt she had a need, a need of someone who listened to her. (R1)

They are always very needy people. (R2)

Sometimes we have this difficulty that they take our freedom away, they forget that we are health workers, we follow them, but we are not a partner, one of their house mates [...]they are people who want to our presence almost every day. Sometimes it is difficult because we have to take another way in the street because if they see us on the street, they will take all our time. (R6)

Sometimes, professionals face difficulties due to the excessive attention requested by some users and also due to the need to "take shortcuts" to avoid contact with them. This speech is relevant to show that, although professionals differentiate professional care from personal involvement, they are not fully prepared to meet this demand and face difficulties in setting limits when necessary.

The lack of affection felt by sick individuals and the need to talk, as mentioned by respondents, seems to reveal that users in psychological distress find little space to talk in society and in the family. The interaction between the family and the person in psychological distress becomes impaired due to wear caused by the cumulative experiences of the everyday and the family loses the hope of cure or disease control and of living healthily with this person. Thus, Family Health Strategy professionals, especially community health workers, become reference and do not always have theoretical knowledge to account for this demand. On the other hand, one of the interviewees had the notion that he is not a friend of the person in psychological distress and that his position is of a professional who helps in care. This view reinforces the importance of professional and humanistic care, without involvements beyond this sphere.

There is the need to invest in the training of professionals working in the Family Health Strategy. However, investments aimed at improving mental health care may not always represent a necessity for the current managers. But the health professionals themselves, feeling the need and existing weaknesses in this area of knowledge, can make use of discussion times with a view to strengthening the theoretical support and qualify the care the person who experiences psychological distress.

Also, it is clear that the interviewed professionals have some wrong or outdated conceptions in relation to mental illness, which results from the limited scientific knowledge they hold about it. The main consequence of this is the care provided empirically and without the quality that this service requires. The training of these workers would provide theoretical support and thus greater confidence to decide the best way to perform the care.

♦ Theme 2: Mental health interventions conducted by Family Health Strategy professionals

Respondents' speeches showed that the group activity is one of the intervention strategies used with users in psychological distress, although one of the interviewees demonstrated the idea that there is need of help of specialized professionals to carry out group activities in mental health area. They also claimed to have difficulties to implement these activities due to the physical and functional structure of the health unit.

We have tried to make groups, but we did not receive support from the psychiatrist, from the psychologist. Also, the physical structure is small here. So we could not deal with mental health so far. (R2)

It is comprehensible that health professionals have difficulty to conduct interventions in mental health without the support of workers in this area. On the other hand, professionals linked to the Family Health Strategy, during their training courses, studied content that addressed issues relating to the care of the person in psychological distress. Moreover, the lack of physical structure is used as an obstacle to the development of mental health activities. However, other groups are developed despite the weakness in the physical structure. In addition, it is possible to perform other actions aimed at meeting the needs of users in psychological distress, such as individual assistance, health education and home visit.

Study shows as factors of inefficiency of care to people in psychological distress the deficiency in academic education, which causes little knowledge, the lack of update and training, the lack of affinity by professionals with mental health and the excess of responsibilities, among others.¹⁸

In the scenario of mental health, family health is considered an important strategy for the construction of other ways to relate with madness, giving to people in psychological distress the opportunity to transit in a different space, which is not segregating nor excluding.¹⁹ Through non- specialized care, it

is possible to demystify madness in everyday life, allowing that this population strata share the same space as other people in the health unit. In this concept, on the role of nurses in mental health in the Family Health Strategies, a study reveals that nurses do not feel qualified to care for individuals in psychological distress, a fact that is due to the lack of initiative of the professionals themselves to seek knowledge that enable care that meets the demands of those individuals.⁹ The attitude of the professionals depends on the recognition of psychological distress manifestations of the clientele of the Family Health Unit as the object of their work, identifying them quantitatively and qualitatively. Thus, through actions implemented in the FHS they will be able to accommodate, assist and provide a better quality of life for these people.²⁰

In the speech of R2, there is an indication that home visits are only held to users in psychological distress when the symptoms are dramatically aggravated or when, for some reason, the patient needs care of the FHS professionals and is unable to reach the unit.

We provide individualized care. We even have a patient that was burned and he has a severe burn on his leg and "B" (nursing technician) goes every day to his house to do the dressing. Tomorrow we have a scheduled visit to his house, the nurse and the doctor; so, we give this home support for these mental patients. When they asked us to go to the house, when the patient is very unsettled. So we have repeatedly gone to see some unsettled patients. (R2)

As for the interventions for the person in psychological distress, the home visits are an important resource in the mental health area, as they enable assessing the family dynamics and the living conditions of individuals in psychological distress. However, it seems to be more used by the Community Health Worker. Nevertheless, the home visit in mental health is a facilitator to approach users and their families. Through this resource, one can understand the family dynamics and verify the possibility of family involvement in the user treatment.²¹ Similarly, home care provides a more humanized care, health promotion and reduction of hospitalizations, which is opposed to the service of psychiatric hospitals.²² Thus, home visits to users in mental distress could be used by the FHS team as a powerful tool for the identification of situations with the potential to trigger in the user the psychological distress, the worsening of the symptoms of their disease with the possibility to intervene and consequently

avoid the worsening of clinical symptoms. Moreover, it can constitute an instrument that contributes to the social reintegration of the subject in psychological distress.

So that this individual is socially reinserted, they need to rescue their autonomy and citizenship, feeling able to play their role in the community. Therefore, it is important that the Family Health team includes psychosocial rehabilitation activities in its everyday routine, which will allow users to develop new skills. Psychosocial rehabilitation is a set of actions that aim to increase the person's skills, minimizing deficiencies and damage caused by the disease process. When a person considers oneself unable or powerless before the events of life, this reduces their coping capacity in face of difficulties.²³ A study refers to rehabilitative recreation as a form of intervention, in which painting activities, fine arts, music, dance, role plays, games and rides in squares and parks are carried out, while respecting the desire of the person to participate in a particular activity and evaluating their practice and attitudes. The said study also showed that the main feelings experienced by the participants were pleasure, excitement, tranquility and union with the team.²⁴ It is likely that the feeling of welfare experienced by users assist in the control of the psychic pathology, reducing the possibilities of worsening of symptoms and, consequently, hospitalizations.

The lack of qualification and training of professionals working in the Family Health Strategy (FHS) to meet users in psychological distress is identified in the following statements:

I do not feel prepared to work with mental health. (R2)

I will not talk in details about the crack and things like that, which do not make part of my generation or my study time and we hear more about it on television than, in reality, knowledge about the side effects in the medium and long term. (R9)

In this context, we emphasize the importance of the work developed by the community health worker, because as they live in the region where they work, they know the reality of local residents, and share this reality, which can facilitate the approach with families. Despite being a professional of the FHS team, they are seen by the community as part of it, which promotes the connection between the parties involved.

However, due to the Family Health Strategy is in development, mental health has been poorly covered in the training programs,

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which interferes with care to the user.²⁵ In order to increase the response capacity of primary care teams, the Mental Health Coordination/MHC established as one of the guidelines the Matrix Support for Family Health Teams.²⁶

The most severe mental illnesses require specialized intervention, although often the assessment by the FHS team is fragile and they end up choosing by forwarding the patient. On the one hand, this can be positive, because, that way, the care to users in psychological distress will be made by professionals who theoretically would be better able to meet this population. However, for the care to be effective there must be a shared responsibility with the FHS team and this cannot have the idea that, after forwarding the user to the specialized service, the team loses the responsibility to accompany the patient. The FHS professionals need to understand the specialized service as a support service provided by primary care and not as a substitute.

Despite the difficulties to develop activities that meet people in psychological distress, the Family Health Strategy seeks to exercise the function of gateway, referring to specialized services only users with more severe mental disorders.

The work in Family Health Strategies here, in mental health, is very little, because now we have a reference. The patients that we cannot account for the treatment are all sent to the reference, when patients have schizophrenia or another disorder, they are forwarded straight to reference, for the psychiatrist. (R2)

Professionals recognize the importance of reception in the care, which is done through listening and conversation. However, there is a difference in how the reception is held by some respondents, who refer to the conversation beyond listening, which allows the establishment of links between professional and user. Nevertheless, for other participants, listening is apparently passive, with no quality, no exchange with the user. The moment is not used to establish links, negotiations related to treatment or behavior, and to better understand the user's life and their family dynamics. In addition, the speech of one of the interviewees identifies the difference between the approach of a user in psychological distress in the Basic Unit with the Family Health Strategy and without this type of care.

Always performing a good reception, talk to these people, calmly. (R2)

I hear and I do not speak. (R3)

And you have to have the patience to listen.

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And talk very little. When you speak something, say something they will like to hear, never critical or something like this. (R6)

I have worked a little more than 14 years in a service that it was not the FHS, and then I came to work here. It is totally different. And there is no way out, we have to sit down, we have to talk, we have to give attention. (R7)

The health service has the function to welcome, listen and respond positively, being able to solve the problems of the population. In that way, they re-establish relationships of trust and support to the user. The host also allows the reorganization of the labor process as it changes the central axis from the doctor to the multidisciplinary team, which is responsible for listening and problem-resolution of the user. Finally, the welcome qualifies the relationship worker-user, which must happen with humanization, solidarity and citizenship, aiming to provide a quality health service.

The host and the bonding are decisive in the relationship between professionals working in mental health and the user because they facilitate the construction of the autonomy of the subject through shared and agreed accountability. Moreover, the host enables re-structuring the comprehensive care in mental health by overcoming the concepts of pathology and diagnosis with emphasis on subjectivity and singularity of each subject that is in psychological distress.²⁷

Some professionals also demonstrate in their speeches a concern about the indiscriminate prescription of psychoactive drugs. On the other hand, there are those who say that drug therapy is used with caution, temporarily, associated with psychotherapy and in order to reduce the dosage when the user is clinically stabilized.

I use the drug therapy a lot. But with caution. (R3)

I have been noticing the excessive use of drugs. We have made an effort, especially within the FHS, to reduce dosage, replacing the medication until making a full weaning. We must always do something like this: I am thinking of giving a drug to improve temporarily and we will see what happens, as the patient does psychotherapy. (R9)

Although there have been efforts by some professionals to reduce prescriptions and over-consumption of psychotropic drugs, the care of patients in mental distress by the doctor and the prescription of medications have been the main forms of treatment and approach to this demand.

Some patients we see they have depression,

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they are showing some mental problem and the doctor here, for example, comes here and sees the patient is depressed, sometimes the doctor himself prescribes a medicine for depression. (R2)

The use of psychoactive drugs is of fundamental importance in the treatment of people in psychological distress, because it helps in the reduction and control of the symptoms of diseases, thus avoiding worsening of symptoms and subsequent readmissions. However, the use of medications for mental health should not be considered as the only possible intervention to be carried out, but should be combined with other care modalities, such as psychotherapy and group activities, in order to enable the user to talk about their suffering, and their reintegration in the community. In addition, by listening to the complaints it is possible to carry out an effective assessment of the real need for the use of psychotropic drugs as the prescription of medication is not indicated in all cases of psychological distress.

Regarding the use of psychotropic drugs, the Family Health Teams usually find the prescription of medication as the only possible approach. In addition, the teams working in FHS should not prioritize traditional treatments of psychiatry, such as psychiatric or psychological counseling and medication.⁸ However, it is necessary to consider the risk of psychiatrization of mental health care, which gives priority to medication as the sole strategy of care for people in psychological distress.

It is known that, often, drug prescription ends up being the chosen conduct when a patient in psychological distress seeks the FHS. Thus, this raises the question on whether what happens in the FHS is the social medicalization, characterized as a complex socio-cultural process that transforms experiences and suffering in medical needs because the medicalization often causes damage to users.²⁸

But we can also see concern about the conduction of activities that go beyond consultation and medication:

If you come here to do a physical activity, make a manual activity or simply talk to someone else, it will already help you, it is already part of treatment. (R5)

In addition, the care given to the user in psychological distress in psychiatric emergency or in case of worsening of symptoms is basically restricted to the mechanical containment and drug administration.

We try to handle it as a normal thing, as

long as the person is not in the outbreak, which allows providing care. I remember a time we called the doctor, they had to help holding her, and they had to call the ambulance. (R1)

Normal ... For me it is normal, I have no difficulty in serving them. I even think it is a good thing when they come to ask for help. The greatest difficulty is when a patient is in outbreak. (R5)

Because then the psychiatrist was attending in X or in Y. So when something like this (outbreak) happened, they would forward directly to these units. (R7)

The care in cases of worsening of symptoms is a difficult for respondents due to the lack of training to deal with such situations; the only procedure adopted is to direct the user to medical care. The immediate intervention of a multidisciplinary team in front of a psychiatric emergency is essential because it prevents further damage to the individual's health, and eliminate possible risks to their life and others people's lives.²⁹ There are some forms of intervention with patients in psychological distress in psychiatric emergencies, including the planned and structured intervention by the professional, making use of the therapeutic communication, listening reflectively, providing support, comfort, information and awakening in the user confidence and self-esteem. Communication must happen in a direct, honest, calm and non-threatening manner, and the practitioner should be attentive to verbal and nonverbal communication of the sick individual. The approach should also include assessment of stress-generator factors, of physical and mental state, of potentially suicidal or homicidal risk and drug use. There is also the physical restraint, which is an intervention option when patients have exacerbated behavioral manifestations which endanger their physical integrity and of others.

Respondents also stated that serving people with worsen psychological distress symptoms is not a problem.

I like to deal with these people ... In these four years I think I had about eight cases of people in outbreak, which I also had no problem to deal with, I have no fear. (R6)

I have no difficulty in serving them. Of course we have to be more careful when taking care of them because there are some that are angry. I try to treat them the same way as I treat others. It is about patience, hearing what they have to say, because they have a disorder, and they come here, they want something, so if we stand against them, the situation will get worse. When we say no to a mentally healthy person, they

will not like, so imagine to a person like this. (R7)

For me there is no problem. I treat everyone the same. (R8)

The professional understands that the subject in psychological distress should not be opposed in their speech. Professionals' silence may be appropriate in cases where the user has disorganized speech, but only with verbal aggression, without putting at risk people who are close to them. However, in situations where there is a risk of physical aggression and invasion of others' spaces, it is necessary to set limits and contain this subject.

Although some respondents have mentioned they do not face difficulties in meeting subjects in psychiatric emergency, intervening in these situations is not easy and usually arouses different feelings in professionals.

By analyzing the above data, one can see that even though professionals do not show resistance to serve users in mental distress, the care provided to this population is hampered due to lack of knowledge and training of professionals working in the Family Health Teams. So that the principles of Psychiatric Reform are effectively achieved, it is important to broaden the discussions among workers in different areas of activity. Therefore, the strengthening of ties and the shared responsibility between professionals and the population is fundamental so that the purpose of the Family Health Strategy is reached with regard to mental health care.³⁰

FINAL REMARKS

By performing data analysis, researchers concluded that the professionals who work in the Family Health Strategy understand that the experience of psychological distress affects the sick person and also their family. Even though the speeches have not demonstrated actions that include care to the family of that user, this perception enables the implementation of activities that include the family in the care provided.

Some professionals have shown in their speeches the relationship between mental illness and violation of social rules, escape from normal pattern, and associate it with lack of intelligence. The lack of knowledge by workers in relation to psychological distress commonly results in little appropriate intervention, and full of prejudices. Moreover, the confusion between the concepts mental disability and mental disorder is due to the period in which the care of mentally handicapped and the mentally ill was held in the same space, the psychiatric hospital.

Another perception that emerges in the respondents' speeches is that the patient is an individual that is dependent of care and unable to perform their daily activities, in addition to having a life associated with the continued use of drugs. This notion contradicts the assumptions of the Psychiatric Reform, which points out that the person in mental distress does not remain in outbreak all the time. Even though, for periods, the sick person presents worsening of symptoms or finds themselves disoriented and the disease affects some functions of life, a person can remain aware of their actions and reactions in other periods.

Professionals also understand that mental health care should be carried out exclusively by specialized professionals. This perception interferes directly in the care provided to users in psychological distress, because it hinders the assessment and contextualization of symptoms with the experiences of those who falls ill and disclaims those working in FHS from mental health care.

With respect to the interventions of FHS workers to care for users in psychological distress, the main strategies mentioned were conducting group activities, home visits, listening and prescription of medications. However, it is noticed that there are some difficulties and shortcomings in the implementation of certain activities.

The lack of preparation to meet the growing demand in mental health is recognized by the very professionals who work in the Family Health Strategy. In fact, despite the considerable increase of users in psychological distress, professionals seem to have little initiative to seek technical expertise to carry out this work efficiently. This fact is probably due to social prejudice against mental illness that pervades the daily life of health teams. The support of specialized professionals to the Family Health Strategies workers, through the matrix support, could collaborate in the care of individuals in psychological distress and their families.

Given the presented data, it can be concluded that there are weaknesses in the care to the user in psychological distress in services with the Family Health Strategy surveyed. In this context, the importance of increased investment in professional training for mental health care is perceived, since the primary care is at the gateway of health services and the first care and monitoring of users who are mentally suffering must be made in this type of care and can be decisive for the continuation of treatment or their

withdrawal.

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