Abstract

Objective: To understand how the professionals of the Family Health Strategy develop their actions with people who need mental health care.

Methods and Results: This is an observational and descriptive research, which predominantly had a qualitative approach. The participants of this research were the professionals of the Reference Teams of the Family Health Strategy of a municipality in the interior of Ceará, in this case, doctors, nurses and dental surgeons. The sample was of twenty participants, which was given by theoretical saturation about the object of study. For the data collection, two techniques were used: semi-structured interview and simple observation. This project was submitted and approved by the Research Ethics Committee of the State University of Ceará (CAAE: 44321015.4.0000.55.34 - Opinion No.: 1,082,101/2015). The data were organized through the technique of the Discourse of the Collective Subject. The results showed that health professionals are not yet ready to promote mental health care in primary care, since they still conceive mental health care from the asylum paradigm and, therefore, act based on the prevalence of diagnosis Psychiatric care, individual care, prescription drugs and renewal of prescriptions.

Conclusion: In this regard, we emphasize the need to invest in continuing education for professionals in order to train them for the mental health act.

Keywords
Mental Health; Primary Health Care; Family Health Strategy.
Introduction

Psychic suffering is part of life, human relations and the different forms of subjectivity. In this sense, people deal daily with losses, frustrations, family conflicts, social vulnerabilities, violence, illness and death, situations that generate the need for integral and continuous care in mental health in the Unified Health System, which should be performed by all health professionals and in all health services offered.

Until the 1970s, it was believed that people with mental health care needs should be kept locked in asylums and excluded from society, and subjected to inhumane treatment. However, this model of treatment of madness was questioned and opposed by health workers, social movements, users and their families, which gave rise to psychiatric reforms, which occurred in several countries, including Brazil. From these, the psychiatric hospital is no longer the center of attention and care in mental health is carried out by a network of community services [1, 2].

In view of this new reality, Primary Health Care emerges as a strategic space for mental health care and for the disruption of the asylum paradigm, since it promotes continuous, integral, longitudinal and territorial care, close to people and their families, by means of a differentiated model of health, that takes into account the determinants and social determinants and prioritises the prevention of diseases and the promotion of health and citizenship. However, such care is not always carried out in a qualified manner, due to the lack of preparation of health professionals and workers, the disorganization of work processes and the lack of structuring of services.

The Caracas Declaration places Primary Health Care as a field of actions and services responsible for the restructuring of mental health care, as it allows the promotion of alternative models, based on community, family and social networks [3]. In this same perspective, another study points out that the insertion of mental health practices in Primary Health Care promotes integral, continuous and humanized care to the subjects for services already inserted and known in the territories [4].

The Family Health Strategy, a model started in 1994, is how Primary Health Care is effective in Brazil, which became possible with the advent of the Unified Health System, based on the fundamental right of the citizen to health. The Family Health Strategy reoriented the model of health care in Brazil, since it guaranteed a health system based on Primary Health Care, making the first level of care the structuring center and computer of the health care services of the Unified Health System [5].

Because of its proximity to families and communities, the Family Health Strategy becomes a privileged space for mental health interventions, and it is quite common for professionals and workers of reference teams to be at all times with users suffering from psychological distress. In this context, because it aims to be the priority contact of users with the health service, it is in the Family Health Strategy that the first consultations will be with those users who need care and actions in Mental Health [6].

In summary, it is perceived that the practices of mental health in Primary Health Care are strategic for the promotion of humanized care, extended and integral to people with psychic suffering. Thus, for the implementation of mental health care in the Family Health Strategy, in addition to changes in the management and structuring of the network of mental health services, there must be a transformation of the work processes of the professionals who care for people in situations of psychological distress, that they develop practices that are based on interdisciplinarity, comprehensiveness and equity of care.

Mental health work must be predominantly alive [7], carried out creatively, innovative, non-mechani-
zed, non-bureaucratized, that goes beyond the mere notion of just withdrawing users from psychiatric hospitals and reinserting them into the family and community, but that provides comprehensive health care through an extended and subject-centered clinic. Therefore, there must be a true transformation of the paradigm of action in mental health, which requires that the relationships between professionals and users happen based on respect, welcoming, integral attention and the establishment of bonds [8], because it is no use implement an innovative policy if professionals continue to act through a mental asylum based on the outdated and limiting view of madness.

It is worth mentioning that mental health care is one of the major problems of public health today, due to the high incidence and prevalence of mental disorders, which generate considerable impacts on individuals, their families and communities, as they can lead to a poor quality of life, the inability to perform work activities, the loss of autonomy and social discrimination. In addition to major economic impacts both for users and their families, and for the Public System [7-10-11].

In this context, the intention of this project arose from the process of territorialization carried out in the territories of the Family Health Units of a municipality in the interior of Ceará, where the author worked through the Multiprofessional Residency with emphasis on Family Health of the School of Public Health of Ceará. Also contributing to the preparation of this work were the mental health praxis developed in the Primary Health Care of Fortaleza-CE, through the role of the author as a monitor of the PET-Saúde (Health Education Program for the Work of the Family Health) of the Federal University of Ceará.

From these circumstances, the present research was carried out with the following objectives: to understand how the Family Health Strategy professionals develop their actions with those who need mental health care; Identify how they perceive mental health and what are the practices developed in Primary Health Care. These objectives were reached through this study.

### Methods

It is an observational and descriptive research, since it aimed to observe, register and correlate facts and phenomena related to mental health practices in Primary Health Care. The place chosen for the study was a Pole-Town of a Regional of Health of the State of Ceará, which is reference in secondary attention for the population of ten more municipalities. The same is located 219,344 miles from the capital Fortaleza and is characterized as a medium-sized city with an estimated population of 72,812,000 inhabitants, of the total 72% urban and 28% rural; 49% of the population is male and 51% female [12].

Participants in this research were the higher education professionals of the Family Health Strategy Reference Teams, in this case, doctors, nurses and dental surgeons, which together make up forty-nine (49) professionals (twenty nurses, twenty doctors and nine dentists). The sample for the research was twenty (20) participants, which was given by theoretical saturation about the object of study. Thus, the inclusion criteria of the sample were: to have a higher level (doctor, nurse and dentist) and belong to the reference teams of the municipality. The exclusion criteria were: not to accept to participate in the research.

For the data collection, two research techniques were used: semi-structured interview and simple observation. According to the determinate, the ethical precepts of research involving human beings were fulfilled according to the opinion of the Committee of Ethics in Research of the State University of Ceará (CAAE: 44321015.4.0000.55.34 - Opinion No. 1,082,101/2015).

The data of this research were analyzed using the Discourse of the Collective Subject (DCS) technique,
which promotes the organization of qualitative and quantitative data and is based on the theory of Social Representation. In Discourse of the Collective Subject, initially, the key expressions, most significant stretches, of each individual response are selected. After this, the synthesis, central ideas, of the discursive content of these key expressions is made. With the material of the central ideas are constructed the discourses of the collective subject, which are syntheses in the first person of the singular that represent the thought of a group or collectivity as if it were an individual discourse.

In the Discourse of the Collective Subject we work with four methodological dimensions called Key Expressions - reveal the essence of the testimony and describe the content of the argumentation; Central ideas - conform the synthesis of the participants’ speeches made by the researcher; Anchoring - is a statement that counts a value, a theory, a belief described by the researched and Discourse of the Collective Subject. Thus, the Discourse of the Collective Subject is a speech-synthesis, built on the basis of the key expressions of the similar or complementary individual discourses emitted by the subjects of the research answering on a certain theme [13].

Results
Field research involved twenty (20) professionals from Family Health Strategy Reference teams, in this case, ten (10) nurses, four (4) doctors and six (6) dentists. In relation to the interview, it was initiated by a triggering question, which sought to answer the main objective of the research. Then there was a script of open-ended questions, which were constructed according to the researched literature. During the interview, it was also possible to ask other questions as the dialogue between the researcher and the interviewee developed.

Initially, they separated the interviews of physicians, nurses and dental surgeons because each category has specific interventions, although there are general mental health care that are the responsibility of any health professional. In this way, the key expressions, the central ideas of the discourses of each profession and the anchorages were systematized by means of tables of answers and, through this process, the discourses of the collective subject were constructed.

According to the reference teams (doctors, nurses and dental surgeons), mental health problems are not addressed in the Family Health Strategy and that, in most cases, they only refer cases identified to the Psychosocial Care Center.

**DCS1. In the Family Health Strategy does not meet mental health problems**

*If the case is simple, I give a medication or I renew the recipes that were made by a psychiatrist, since I am not a specialist." If the case is more Serious, I forward to the Primary Health Care.*

**Doctors.**

*Initially, I do a screening or screening to try to identify the complaint and classify which cases are on the Family Health Strategy or which should be referred to the Primary Health Care. I also pass the case on to the doctor to prescribe the medication or make a renewal of the prescription.*

**Nurses.**

*When I can get around the patient and he is not being aggressive or when the family or the user can identify the medication or the diagnosis, I will attend to the Family Health Strategy. If it is more serious, I will refer you to the Center of Dental Specialties.*

**Dental Surgeons.**

Regarding the second point in the research, On mental health actions in the Family Health Strategy, the following discourses of the collective subjects were constructed.
DCS2. What can be done in the Family Health Strategy

It is the treatment that can be done in the Family Health Strategy, such as referrals, prescribing medication, renewing recipes, conducting home visits and activities to relax.

Doctors.

I understand that the actions of mental health in primary care are all mental health care that can be carried out in the Family Health Strategy. These are possible actions, but very difficult to carry out due to the lack of time and the structure of the units. Sometimes these actions are not carried out, because when you do something is only renewal revenue or direct routes to the Primary Health Care. One should perform user listening and intervention with the family.

Nurses.

I think that these patients have the right to be treated in Primary Care, because they have common needs with other users. So I can do screenings, dental procedures, obturation, extraction, prophylaxis, scraping in cases of patients who do treatment and use medication, referral to the Center of Dental Specialties and family orientation.

Dental Surgeons.

In relation to the other questions treated in the interview, the same analyzes were constructed with Key Expressions, Central Ideas, Anchors and discourses of the collective subject. In this sense, there were still speeches related to professional training, difficulties in attendance, specific actions for mental health, organization of services, networking, skills to work with mental health.

The following are the DCS regarding the professional training of the Family Health Team reference team (doctor, nurse and dentist surgeon) to assist people with mental disorders.

DCS3. Deficit in vocational training

I’ve only had one discipline in psychiatry, but it’s been a long time. It’s geared more toward psychiatric disorders and the hospital, where we did internships.

Doctors.

I had a mental health discipline in undergraduate focused on psychiatric diagnosis and stage experience in the psychiatric hospital and the Psychosocial Care Center.

Nurses.

We had specific training for mental health. Only one facing discipline for people with special needs and psychology with techniques to circumvent these patients.

Dental Surgeons.

It was also considered to know the difficulties to deal with mental health cases and found the following speeches.

DCS4. Difficulties in dealing with mental health cases

Because I’m not an expert and did training in mental health. And not to mention that time is long gone to meet that kind of demand. And the delay for the user to be evaluated by a psychiatrist.

Doctors.

The difficulties that I perceive are: the training we have that is not directed at treating these patients in primary care, the case of people who arrive aggressive or in outbreaks, the health network that does not work, and also because I do not I have affinity.

Nurses.
I was not trained to work in mental health, and I also have the fear of a patient’s reaction, mainly because we deal with a lot of sharp instruments. The medication used.

Dental Surgeons.

It was also sought to identify in the participants’ discourses that specific actions are structured in the health unit for the cases of people with mental disorders.

DCS5. Specific mental health action offered by the team

As far as I know, there is no specific action offered by the team, but in my schedule I leave a specific shift for mental health care.

Doctors.

I do not think so ... but there is the anti-smoking group and there is also a shift that we leave only to attend these patients, when the doctor can not meet all the demand.

Nurses.

We do not offer.

Dental Surgeons.

Another point was regarding the organization of the work agenda. In the Family Health Strategy, due to being a multiprofessional team, it is expected that there is a common agenda for all the professionals involved in the care process as in the case of people with mental disorders.

DCS6. Organization of the work agenda

My schedule is divided in relation to the Ministry’s programs. Sometimes there is some urgent care and I get it too.

Nurses.

My agenda is divided between programs and urgencies.

Dental Surgeons.

In addition, the intersectorial articulations used were also identified in the discourses. The network support to the Family Health Team needs to be implemented considering the need for comprehensive care, ranging from actions of disease prevention and health promotion, treatment situations, hospitalization, drug distribution, among others.

DCS7. Network joints performed

The relationship that I realize is the referral to the Psychosocial Care Center.

Doctors.

The network articulation that I realize is only with the Psychosocial Care Center.

Nurses.

The relationship that I realize and the Center of Dental Specialties.

Dental Surgeons.

The skills and competences are foreseen in the process of training health professionals observing what is recommended in the National Curricular Guidelines of the students of the health area. Thus, students are expected to be at least up-to-date in conducting a supervised practice.
DCS8. Professional skills to deal with mental health

I think giving more time to these patients, promoting listening, having knowledge to have security to attend cases and have patience and love. 

Doctors.

I think it has to develop knowledge, goodwill, interest on the part of the professional, because not all professionals know how to handle, thus, do not like to deal with this type of patient.

Nurses.

Patience, understanding the case, interest, knowledge, to be secure in what you are doing.

Dental Surgeons.

Faced with what was presented, eight discourses of the collective subject were generated, which represent the visions and understandings regarding mental health in the Family Health Strategy that the professionals have and the practices they carry out.

Discussion
Regarding the discourses presented by the professionals, it was identified that the mental health actions developed by the professionals researched in the Primary Health Care were still shown Fragile, based on the asylum paradigm of care for people with mental disorders.

In the case of DCS1, doctors’ discourses demonstrated that they focus their actions only on individual care, in which the prescription of medications, prescription transcription and referral to the Psychosocial Care Center are performed. There is no effective care based on qualified listening and care, although they have mentioned the need for these actions, in addition, there is the problem of renewal of recipes and the indiscriminate use of psychotropic drugs, mainly benzodiazepines.

Psychotropic drugs constitute one of the forms of treatment of psychiatric diseases and mental health disorders. However, health professionals and users generally identify the use of medication as the only effective form of therapy, due to the immediate reduction of symptoms and sedative effects, the latter associated mainly with benzodiazepines. Many people become dependent on benzodiazepines, mainly because they use them for stress relief and sleep disorders, which have been reported by doctors, even when they no longer need to use the medication.

In this context, a study has found that in recent years, in developing countries, there has been a significant increase in the occurrence of the phenomenon associated with indiscriminate use and insufficient control of psychotropic drugs. Prolonged use of these drugs, particularly benzodiazepines, can lead to tolerance, withdrawal, and physical, chemical and psychological dependence [14].

Regarding the physicians’ understanding of mental health actions in Primary Health Care, in this case, DCS2, these professionals mentioned the issue of referrals, medication prescription, renewal of income, home visits and activities for to relax. Although they mentioned home visits and activities to relax, doctors do not carry out these actions, as they consider that it is the responsibility of other professionals and the Community Health Agents.

When it comes to academic training, DCS3, the medical professionals interviewed are already graduates for more than ten years and had only one mental health discipline, which was focused on the psychiatric diagnosis and hospital. On the other hand, the difficulties for mental health work, DCS4, cited by the doctors, were the fragility of the training, the lack of continuous education, the delay in the evaluation of the users by psychiatrists and the high demand for care.

This last reality, of the high demand, both harms the attendance, because it decreases the time and quality of the same, as it disregards the doctor in
relation to the other actions of the service, such as
the conduction of groups or the performance in the
context of the schools. The issue of high demand
is the justification of doctors for not performing
care in mental health, since these require more
time for listening and care. In addition, the agenda
of this professional, in the municipality researched, is
focused only on the Ministry of Health and free-
demand programs, a model that often harms the
mental health user’s access. This context of physi-
cians’ performance in Family Health Strategy and
mental health in Primary Health Care can also be
verified in other studies [15,16].

On the other hand, nurses also presented as the
focus of their mental health actions, DCS1, indivi-
dual care, which is based on screening with the pur-
pose of passing the case to the doctor or referring
the patient to the Primary Health Care. The nurses
reported that they had few intervention tools in the
context of mental health. In this way, they unders-
tand that care should be taken in relation to mental
health, but they do not or consider that possible
actions are restricted. This same context regarding
care in mental health in the Primary Health Care by
nursing is reported in another study [17].

The academic training of nurses in mental health
is guaranteed by a discipline that, although based
on psychiatric diagnosis and psychotropic medica-
tions, is more comprehensive than that of physi-
cians because it has a focus on Psychosocial Care
Center (DCS3). The major difficulties reported by
nurses in relation to mental health are the fragility
in academic training and the absence of continuing
education, as well as the fear regarding the aggres-
siveness of the users, the insecurity to intervene in
the situations of the outbreak and the low frequen-
cy of users in family health units. In this last point,
it is necessary to reflect on the organization of the
work processes of the nurses surveyed, who have
the agenda predominantly based on the assistance
of the Ministry of Health Programs. This way of
organizing does not allow a space for the mental
health user, who, for many times, they only receive
some care when they report situations of psychic
suffering within the prenatal, hyperdia and consul-
tation Gynecological.

With regard to dental surgeons, they understand
that their role in caring for people suffering from
mental suffering, DCS1, is only to perform dental fo-
llow-up, individual-interventional care, and referral
to the Center of Dental Specialties, which has the
professional specialized in the care of people with
special needs. In this sense, dental surgeons concei-
ve the mental health user only as having the diag-
nosis of severe and persistent disorder, not including
people with mild depression and/or anxiety or only
those who need listening and guidance, although
The most frequent cases in the dental office are
anxiety disorders [18]. From this context, it is also
inferred that these professionals do not assume the
role of general mental health care that should be
performed by any health professional.

In the municipality surveyed, there is the pro-
blem associated with the fact that when people
with mental disorders need dental care, they are
usually referred directly to the Center of Dental Spe-
cialties. This situation is not appropriate because,
according to the guidelines of the Ministry of Health
[19], users should only be referred to the specialist
when all possibilities for performing the basic den-
tal procedures in the Family Health Strategy are ex-
hausted, even those with a diagnosis Of severe and
persistent disorder. Thus, professionals resistance to
these patients, which, often do not have the rights
guaranteed in relation to dental care at the Family
Health Unit.

Dental surgeons, in relation to academic trai-
ning, DCS3, do not have mental health discipline
in their graduation, only in some courses, there is
a chair on caring for patients with special needs,
including hypertensive, diabetic, pregnant women,
People with disabilities and with mental disorder,
or psychology, which deals with some behavioral
techniques to deal with such users. In this way,
you have a fragility regarding the understanding of mental health care, which causes the problem, observed in the research, to confuse mental disorders and neurological diseases. Dental surgeons also stated that they organize their schedules, DCS5, from the Ministry of Health Programs, which was not confirmed by simple observation of their work processes, since most of them work based on spontaneous demand.

The major difficulties in dealing with mental health cases, DCS4, in relation to dental surgeons were: fragility of the training, fear and the fact that, most of the times, users and their families do not know how to report on the diagnosis and the Used. When they reported the issue of fear, the professionals explained about the fear of receiving some aggression that could be facilitated by the existence of piercing materials from the dentistry. When the users and their families do not know how to report the diagnosis and medications used, dental surgeons said they feel insecure because of the possibility of drug interaction between psychotropic drugs and local anesthetics.

This reality of the performance of dental surgeons in mental health was also verified in a study carried out in the city of Fortaleza-CE. According to the authors, dental surgeons receive little academic training to act on the users' mental health needs and, because of this, present difficulties in identifying psychic suffering. Consequently, they do not promote the resolution of the demands found, which weakens integral health care, since they can only look at the individual from oral diseases [18].

Regarding work schedules, DC56, it is noticed that the professionals do not have a common agenda and that they work with focus on the Programs of the Ministry of Health or in the free demand. Thus, the professional suggestions that there was a guarantee of mental health care in primary care were the training and sensitization of professionals and the organization of a specific shift in the agenda for the care of patients with mental disorders. In the latter case, the Ministry of Health states that mental health care should be promoted across the programs and not by a specific, precisely so that mental health is not seen as a specialty or related only to the issue of disorder mental [20].

In reference to social representations of mental health and the mental health patient of the discourse, it is clear that professionals still have the mental hospital and limiting view of the approach to madness, which was produced by psychiatric institutions and the cultural exclusion context in this sense, cultural asylums still pervade your thoughts and influence their ways of acting in health. One of the questions regarding this fact is that these professionals still conceive Mental Health as synonymous with mental disorder, when considering only the illness situation, and realize the mental health needs as disassociated health status in general, from the logic of a mind-body dualism.

Mental suffering you can not be proven in tests, it does not go away with medication and requires listening and compassionate care, a reality that generates insecurity and fear in the pros. In this sense, many of the limitations in mental health care stem from the academic formation, which still does not enable professionals to work in the Family Health Strategy and the current model of mental health. If health professionals dominate with ease issues with pain and other physiological changes, they fail to deal with the suffering of people, which involve not only biological, but social, economic and life context [21].

And how cultural asylums are still present in health professionals, another fact observed was the representation of mental health users as aggressive, violent or permanent crisis. The question of aggressiveness is historically associated with the person with mental disorder, which was heavily criticized by Franco Basaglia, because it realized that the manifestations of violence of users in psychiatric hospitals were more applicants due to the institutionalization of situation than the symp-
The representations that professionals have in relation to mental health and users with mental disorders produced the design that they have in relation to which care must be made. In this sense, the actions mentioned in the interviews revolved around the medicalization practices, prescription medications, transcription revenue and the exclusive use of psychiatric diagnosis, as well as the indiscriminate referrals to the Psychosocial Care Center.

The fragility of Psychosocial Care Network, DCS7, is clearly seen in the speeches that show poor communication between the Psychosocial Care Center and the Family Health Strategy and the absence of this contact with the General Hospital. In this perspective, it appears that there is no case sharing between Psychosocial Care Center and Family Health Strategy and that the mental health services in primary care are restricted. It is noticed also an absence in the discourse of professionals conducting joint actions between the Support Center for Health and Reference Team for increasing resoluteness of mental health cases.

For the three categories surveyed, the necessary skills, DCS8 for mental health activities are summarized, knowledge, patience and gift/will. From these, it is inferred three directions, the training for learning of psychiatric diagnosis and some forms of specific intervention, the need to be patient, because the mental health patient is difficult and aggressive, and a feature innate, which could not be developed even with continuing education. Thus, there are contexts linked to the psychiatric ward vision treatment of madness and what most concerns, the notion that the trader would have to be born with the ability to handle users with mental disorders.

The simple observation of the professional work processes, it found that many users when they come with demands of mental health are directly forwarded to the Psychosocial Care Center without any attempt to follow the Family Health Strategy team. It is in this context that professionals claim that does not meet mental health problems in the Family Health Strategy, because there is no comprehensive care cases, which in many cases are forwarded to the Psychosocial Care Center with trying to generate irresponsibility in relation to the Family Health Strategy. Importantly, even referring to the Psychosocial Care Center, the health team of the family should continue following the case, because it is the ordering of care. Another fact is that does not require formal referrals to the Psychosocial Care Center, since this device is also gateway to the Psychosocial Care Network, and the Family Health Strategy is the priority gateway.

This reality was also found in a study with professionals of Health teams Brazilândia Family - Federal District, which sought to identify how were the performances of those in mental health care. The results were mainly related to low-solving capacity in the health of the family, for mental health users were immediately sent to the specialized services, since there was no strategies in the unit to deal with such cases, and the unpreparedness family health teams to receive and monitor cases of mental health [4].

In this context, it is perceived that professionals surveyed work from processes of stiff work and decontextualized the mental health needs of the population, through a dead work, especially yeast technologies. In a few moments, they cited lightweight technologies, which should be the most used in mental health care, as qualified listening and establishing therapeutic relationship. An interesting fact was that even when their teams had different actions as conducting therapeutic groups or health promotion, anti-smoking, pregnant women and the elderly, professionals did not identify those interventions such as mental health care generators. Also they did not report the use of other clinical tools of
work in mental health in the Family Health Strategy, as matricial in mental health care, construction Singular Therapeutic Project or training therapeutic groups.

Compared to what was presented, it is emphasized that the conclusions made in this study will serve to promote reflections in relation to the actions of the Family Health Strategy professionals in mental health, contributing to the strengthening of the theoretical and practical knowledge of this field. It should be noted that in addition to professionals, managers should also be aware of the mental health needs of the territories, as they are responsible for promoting the strengthening of Psychosocial Care Network, through the articulation between mental health and Family Health Strategy.

Another point to be considered is the strengthening of social participation, through ensuring participatory planning and spaces for discussion and joint evaluation of mental health policies. Users and their families should be the main subjects involved in these processes, you have to give time and voice to people in psychological distress, which often has its disrespected and disregarded opinions. We must fight the veiled prejudice that still exists in relation to people with mental disorders through respect for different forms of expression of subjectivity.

### Conclusion

On what has been presented, it is clear that mental health care in the Family Health Strategy continues to happen fragile and deficient, as much of the professionals still work from mechanical and stiff work processes, limiting their actions to individual calls, prescription medications, prescription refills and referrals to specialized services. Moreover, family health teams, in general, are unprepared to promote the comprehensive and humane care of people with mental disorders, because their professionals still look for mental health and health coupled in general and from the paradigm asylum hegemonic when designing madness as something dangerous that should be contained with medications and hospitalizations.

In this sense, it is necessary that there are more investments in continuing education for professionals in the Family Health Strategy, in order to promote the training of technical and political leaders who are able to perform the comprehensive care and territorialized in mental health and to strengthen the fight for execution Psychiatric Reform. It is worth also noting that such training must have in order to generate the transformation of limiting cultural practices on the madness that still pervade the practices of health professionals.

### Abbreviations

DCS: Discourse of the Collective Subject.

### Conflict of interests

Do not.

### References


