# Mental health nursing and the family health strategy: how the nurse is working?*

SAÚDE MENTAL E ENFERMAGEM NA ESTRATÉGIA SAÚDE DA FAMÍLIA: COMO ESTÃO ATUANDO OS ENFERMEIROS?

SALUD MENTAL Y ENFERMERÍA EN LA ESTRATEGIA DE SALUD DE LA FAMILIA: ¿CÓMO ESTÁN ACTUANDO LOS ENFERMEROS?

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**ABSTRACT**

The link between the mental health practices and the Family Health Strategy is based on attachment, co-responsibility, in involvement and knowledge of the family group. This is an analytical study with a qualitative approach, using the oral history technique. The study was conducted with ten nurses belonging to three family health units of the West Health District of the city of Natal / RN. The study objective was to describe the health are activities for patients with mental disorders in the Family Health Strategy and identify whether the health professionals are prepared to deal with this particular clientele. According to subjects' reports, there are no activities for mental disorder patients in the primary health care network and the lack of training for nurses is as a challenge to be overcome.

**KEY WORDS**

Health mental.
Family health.
Community health nursing.
Public health nursing.

**RESUMO**

O elo entre as práticas de saúde mental e a Estratégia Saúde da Família está alicerçado no vínculo, na corresponsabilidade, no envolvimento e conhecimento do grupo familiar. Estudo do tipo analítico, com abordagem qualitativa, utilizando a técnica de história oral temática. Foi realizado com dez enfermeiros pertencentes a três unidades de saúde da família do Distrito Sanitário Oeste da cidade de Natal/RN. Seu objetivo foi descrever as atividades voltadas para a atenção ao portador de transtorno mental na Estratégia Saúde da Família e identificar se os profissionais encontram-se preparados para atender a essa clientela específica. De acordo com as falas pôde-se constatar que não há atividades para o portador de transtorno mental na rede básica, e que a falta de capacitação das enfermeiras emerge como um desafio a ser superado.

**DESCRITORES**

Saúde mental.
Saúde da família.
Enfermagem em saúde pública.
Enfermagem em saúde comunitária.

**RESUMEN**

La relación entre las prácticas de salud mental y la Estrategia de Salud de la Familia tiene su base en los vínculos, la corresponsabilidad, participación y conocimiento del grupo familiar. Se trata de un estudio del tipo analítico, con un enfoque cualitativo, utilizándose la técnica de la historia oral temática. Se llevó a cabo con diez enfermeros pertenecientes a tres unidades de salud de la familia del distrito oeste de la ciudad de Natal / RN. El objetivo fue describir las actividades encaminadas a la atención del afectado por trastorno mental en la Estrategia de Salud de la Familia y determinar si los profesionales están capacitados para brindar atención a ese grupo específico. El discurso de los entrevistados permite constatar que no existen actividades para el afectado por trastorno mental en la red básica y que la falta de capacitación de los enfermeros emerge como un desafío a superar.

**DESCRIPTORES**

Salud mental.
Salud de la familia.
Enfermería en salud pública.
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## INTRODUCTION

The creation of the Unified Health System (SUS), ensured by the Constitutional Charter of 1988, was a milestone in the trajectory of the Brazilian health system. This system provides an enlarged concept of health and aims to overcome the dominant perspective of focusing on health through disease, especially in the biological and individual dimensions[1]. SUS is based on organizational guidelines and doctrinal principles included in the constitution and ordinary laws that guide them[1].

Among the principles guiding the SUS, the following are highlighted: free health care to all, individuals and the community to which they belong are integrally cared for, and respect and human dignity are guaranteed. The implementation of actions should be decentralized where responsibility is delegated to cities, states and the federal government according to the scope of the problem sphere[2].

In an attempt to put into practice a techno-care model based on the SUS principles, the Brazilian Ministry of Health proposed the Family Health Program (FHP) in 1994 as a strategy to reorganize health services with a view to re-orient health care delivery and focus on the family while taking into account its social context[3]. Linking primary health care to a network that provides mental health care has been established as one of the original guidelines to put Brazilian psychiatric reform into practice, which reaffirms the importance of creating community and territory-based devices essential to overcoming the iatrogenic effects of hospital-centered mental health care[4].

Mental health care should be considered a branch of the FHS. In the FHS, patients and professionals are close and know each other by name, which encourages bonding. Patients are not merely numbers in medical files, but begin to be treated as citizens with a singular biography, with a known existential and geographic territory and thus, the FHS is considered to be one of the devices essential for mental health care practices[5].

When the authors[5] affirm that the FHS can be considered a Mental Health Program, they are considering a continuous treatment that allow patients to re-signify their experienced symptoms and suffering, to count on being welcomed into treatment, which is a usual practice in the mental health field, and also to participate in collective activities in general such as walking, lectures, group activities, among others.

The link between mental health practices and the FHS is based on health professionals and patients bonding, taking co-responsibility, involvement and knowledge of the family. It is essential that the FHS also practices asylum deconstruction methodology because it is imperative to move from a hospital-centered model, in which patients are contained and abused, to a community and territory-based model, in which patients are no longer contained but are welcomed, listened to and cared for.

A study carried out in Salvador, BA, Brazil concerning how health professionals interpret mental suffering and how they plan and develop their interventions in the FHS, found that some professionals invest a lot of work *creating bonds* between the community and the health unit and also increase its participation in the resolution of problems at the family health level[6].

Bonds can ground a committed relationship between the team, patients and families, enabling a connection that has to be sincere and responsible. Hence, bonds facilitate partnership because through a close relationship we have a more human and unique connection in which a care delivery that best meets the needs of individuals and families is the goal, with a team more sensitive to listening, understanding vulnerable aspects and constructing individual therapeutic interventions[7].

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It is important that professionals are sensitized to understanding the family model organization in order to coordinate work between the FHS and the mental health field, respecting its values, beliefs and desires, not judging family behavior but rather offering support so the family itself makes the final decision.

This study covers some basic questions, such as: Are FHS professionals prepared to care for these individuals according to the principles established by the SUS? Is mental health care delivered in a continuous and planned way with the appropriate follow-up?

## OBJECTIVE

To describe the activities focused on the care delivered to patients with mental disorders in the FHS and identify whether professionals are prepared to care for this specific clientele.

## METHOD

We opted to use a qualitative methodology since the objective is the depth and breadth of the understanding of a social group[8]. This study was carried out in three neighborhoods in the peripheral area of Natal, RN, Brazil in 2007. A high level of drug consumption, both legal and illegal, is observed in these neighborhoods.

Before initiating data collection, the researchers visited the Family Health Units and informed the professionals there of the study's objectives and that it complied with Resolution 196/96. Afterwards, the study project was sub-

mitted to the Ethics Research Committee at the Federal University of Rio Grande do Norte, which approved it on June 2, 2006 (Protocol 031\06)[9].

Ten nurses participating in the study met the following inclusion criteria: being a nursing worker for at least one year; voluntarily agreeing to participate in the study and signing a free and informed consent form. The criterion of repetition and saturation of answers was used and indicated when interviews should cease. To ensure the participants' confidentiality, we opted for using code names of flowers such as: *Lily, Gerbera, Calla Lily, Carnation, Heliconia, Tulip, Lisianthus, Sunflower, Celosia and Estrelicia*.

To improve understanding, thematic oral history technique was used to collect data. This technique is based on collecting and recording information based on individuals' oral reports. This is a modern resource to be used in studies addressing the social experience of people or groups[10]. *It is history of present time and is also acknowledged as live history.* The thematic oral history is the one that most approximates solutions presented by scientific studies in several fields of academic knowledge. It is almost always used because it interacts with other documents[10].

Based on the theoretical framework, a pre-analysis was carried out: interviews were skimmed through with a view to grasp the reports' central ideas through an exhaustive contact with the material. Then, the Corpus was composed and interviews were grouped according to their common characteristics. The Corpus was cutout in units formed by phrases, words, excerpt or theme, which was defined as *Convergent Corpus* and *Divergent Corpus* as a way to separate central ideas from the transcribed material[8].

The instrument used to collect data was an individual, semi-structured interview, which was tape-recorded with the participants' consent.

Afterwards, information was aggregated and three categories were defined: medical consultation and transcription of prescriptions; lack of follow-up; and professional qualification.

## RESULTS AND DISCUSSION

### *Medical consultation and transcription of prescriptions*

There is a therapeutic tendency in psychiatric institutions that privileges medicating patients and the disease so as to alleviate symptoms, despite continuous efforts to socially integrate individuals with mental disorders[11].

When the nurses were asked about what services were offered to patients with mental disorders, they mainly reported *transcription of medication*, that is, medical prescriptions were repeated without appropriate clinical evaluation as observed in the following:

> We have a serious problem here: there's a psychiatrist here who distributes psychotropic prescriptions as he wants. There're people who go crazy if you don't give them a psychotropic prescription […] They get crazy here, why? Chemical dependency. They have chemical dependency […] So, this is a very serious problem that happens in the neighborhoods of Natal (Tulip).

> The services offered here are basically [...] psychiatric transcriptions of prescriptions. The physician consults these patients, transcribes the medication when the patients are already used to the psychotropic dose; it's only a transcription really. By the way, the physicians, some physicians, have a weekly notebook where all those who come to get the prescription medication are scheduled (Heliconia).

> The neighborhood of Felipe Camarão has 60,000 inhabitants. Only in my area, I have […] 53 patients who use psychotropic drugs. And none of them […] He gets back to the psychiatrist, he decides on that prescription and the physician only repeats it […] If the patient has something [orients] […]the most difficult thing is the psychiatric specialty, it takes months, you know? So, that's it, transcription of prescriptions. That's it. The treatment here is medication. There is no prevention (Gerbera).

> [...]It's practically a transcription of medication. It's like […]. There's a difficulty, as the physician puts it, the issue of counter-reference. Because the patient is consulted by the psychiatrist and doesn't know what to say, like: how the medication will be used, for how long, what is necessary for the patient to check (Celosia).

> [...] If you check how many people here are taking diazepam [...] Diazepam is like water with sugar, because it is a lot, really […] (Gerbera).

A study was carried out in two cities in the state of São Paulo analyzing the prescription and distribution of psychotropic drugs through analysis of prescriptions confirmed the irrational use of these medications. A total of 108,215 prescriptions were processed and 76,954 were of benzodiazepine drugs. Another relevant fact is the destination of these prescriptions: women received more prescriptions than men[12]. Another study addressing the use of psychotropic drugs and carried out in a Family Health unit in the northern region of Natal found that 50 out of 59 participants used psychotropic drugs, of which 31 were women and 19 were men. Only nine participants did not use this type of medication[13].

Another study carried out in Natal, which investigated the meaning and function attributed to the use of anxiolytics by women in the primary health care service and by general clinicians, indicated that there is an excessive use of anxiolytic psychotropic drugs and abusive prescription of these medications by professionals[14].

> [...] There were women who lived alone or lived with their families with many problems and when they found a partner, they didn't need the diazepam anymore, didn't need the medication anymore. And when the relationship didn't work out and the woman thought the problem could be corrected with medication, she started to take the medication

again. We proved to her she didn't need to take the medication but she was addicted to it and they aren't able to stop taking the medication (Lily).

There are many people in my area who take controlled drugs, like on a daily basis. And when we try to educate them and say that the medication is for an extreme need, with the follow-up of a psychiatrist and evaluation of a psychologist, they're so addicted that they don't want to know about that, they only want the prescription. And if we don't give them a prescription to buy the medication, they get upset […] Because they think that if we take the medication from them, their lives are over (Lily).

It is important to highlight that the onset of benzodiazepine use can be marked by a life event though it might lose its meaning due to the medication's prolonged use[15].

There is no efficient control of the consumption of psychotropic drugs in the primary care service. Some patients use artifice to enable inappropriate use of these medications. Some of the reasons are the sale of prescriptions and the maintenance of retirement via social security.

Because we know they also sell prescriptions, you know? And since here there are many drug users, it is also to control this. And people use that, you know? Diazepam here is like […] too much, too much! (Gerbera).

[...]And there're those patients who we know are not working and receive a pension from social security and who need these prescriptions to maintain their retirement (Gerbera).

Medicalization culturally transforms populations, diminishing their ability to autonomously cope with the majority of illnesses and daily pains, which leads to an abusive and counterproductive consumption of biomedical services, generating excessive dependency and alienation[16]. The use of benzodiazepines can become a threat to patients when they realize they are dependent and cannot control its use. Autonomy is lost because the medication is now to cope with the pressures of everyday life, to get immediate sleeping effects, to forget the issues that trouble the lives of these patients[15].

Despite the ongoing transcription of prescriptions, we highlight the fact that nurses are concerned and want to develop actions geared toward patients with mental disorders.

This has been a concern, because there is a very large number of people who have mental disorders and they come very frequently to the unit in emergencies looking for prescriptions. So […] we intend to at least gather these people, make monthly meetings with them. Since they turn to the service looking for prescriptions, we have to take advantage of it and develop other activities (Tulip).

I've already thought about what we could do and we have to visit these patients at home. But the physician himself says that he's going to prescribe medications and what is it that we're going to do in these houses? So… those more violent patients… they are put in a room, stay there in that corner. Now, when they have a crisis they stay there locked in, they are hospitalized when they are very violent, and when they are not in crisis, they stay in the streets. Then they go home to sleep. We have about four patients in this condition (Gerbera).

Given the fact that primary health care is a privileged service to welcome the needs of mental health care, with interventions that break with the asylum model, the FHS nurses should be prepared to provide primary health care to patients with mental disorders, reducing the harm involved and avoiding potential hospitalization. Nurses should be qualified to guide the community and the family with a view to include patients with mental disorders in several community organizations, enabling new opportunities of psychosocial rehabilitation[13].

***Lack of follow-up...***

The daily care of patients with mental disorders that relies on the family is seen as a burden[4],as the reports show:

The way the family tries to get rid of, to throw them away… It is historical, put the person in the asylum, put him out of (the house). Because that is a family destructuring that […] I guess that it is a thing here in Brazil commonly suffered, re-insertion is not respected, nobody values the re-insertion of these people into society, into the community. So […] He goes there, gets out of the crisis and goes back to the same situation and has no follow-up, there is no institution that support a social re-insertion so that the person has some activity, starts to work or study, whatever (Tulip).

I have patients, both those using psychotropic drugs and those in more severe conditions. Those who spend more time inside the house, locked in the backyard. The family frequently sedates the patient, to calm him. They want the medication so the patient becomes calm. I have a patient here who is currently on the streets because the parents died and his siblings wouldn't take him in, so he lives on the streets with the help of families (Gerbera).

It is observed in professional practice that families have difficulties in dealing with mental patients. Another aspect observed is related to the burden family members experience in relation to poor living conditions, unemployment and difficulties in finding activities for the mental patient in the community. *Gerbera* portrays this burden in her use of the word *encumbrance*:

I have Ana Maria and she lives on the streets, there's no dialog with her. I guess she doesn't talk with her family, even. And the family sees her as an encumbrance, you know? I feel that there must be something. Nobody cares for these patients (Gerbera).

The burden experienced by the family and its negligence with the mental patient is also perceived in *Gerbera's* report:

I see it like this [...] They are discriminated against by the community, by the population. They are totally alienated from where we are. An example, I have a girl […] her disease […]

she has epilepsy and also mental retardation. So we see the lack of hygiene. She studies […] the coincidence is that she is from my area and my sister is the teacher who teaches her. And she says that she goes to school with lice, dirty clothes, you know? And we go to her house […] like […] what can we do to help that mother care for her? So, we feel that mental patients are neglected by the family itself (Gerbera).

The commitment of the family to care for a patient with a mental disorder requires the family to re-organize itself. However, this responsibility is positive for the family, because in addition to intensifying its relationships, family members become partners of the health team in the care delivered to the patient[7].

The treatment of these patients requires an individualized project so one does not lose the perspective of the whole. The pace and time of each patient has to be respected with a view to enable them to increase their level of autonomy, their ability to make choices. We observe the lack of care for patients in the reports of *Lisianthus* and *Heliconia* because these nurses state they have no contact with these patients.

As a nurse I don't have contact with [...] Actually, no contact with these patients. They come only in the afternoon to see the psychiatrist, get the medication […] The nursing team does not act directly (Lisianthus).

Look, I don't even see them, you know? Because like [...] the patients in my area who have mental disorders are cared for by the physician. In one or another situation that there's a crisis, the physician […] he is referred to psychiatric emergency care and then needs medication. So, it is when we see them. There were about three situations in which I visited their households […] but all were cases in mental health care in which the nurse acts are related to crises, when the situation is critical. In case the patient injured himself or assaulted someone or came referred by a psychiatrist and has prescribed medication (Heliconia).

A community-based composition of mental health services permeates the discussion of the decentralization process since ascribing the clientele to the territory where the FHS teams intervene strengthens the creation of bonds and the continuity of care delivered to the population, important elements in Brazilian psychiatric reform[17].

***Professional qualification***

Mental health care, as an integral part of public health, is included in the plan of a decentralized, regionalized and hierarchical system. It is a type of special action that must be developed in the city, enlarging an integrated proposal of health service with an interdisciplinary, scientific, social, cultural and humanized character[11].

However the nurses do not feel able to care for patients with mental disorders in this context.

Oh my Gosh! [...] We were just talking about it with the agents. Because we have some appalling cases and I honestly don't feel capable of handling them. There's no psychologist here to give support, you know? And like […] I don't know how we can work with this demand. We […] The only thing that I manage to do is to facilitate their access to the service (Carnation).

Because I really don't have preparation [...] nurses lack preparation to work with the issue of mental health. Since our time in college we have had this difficulty, of the technical preparedness and also working in the units because we don't have support. Because here we have a population of about 50 thousand inhabitants and one psychologist in the unit. She can barely do anything, almost nothing (Sunflower).

Among the participants, *Tulip* is the only one who reports participation in a training program during the discussion of the psychiatric reform:

I attended a training program when [...] I guess it was in the beginning of the 1990s because it was when psychiatric reform was implemented and all that issue of closing the asylums, of creating alternatives for people such as the CAPS, the current CAPS, Psychosocial Care Center […] From then on, that I remember… I don't recall any other training, especially after the family health team. There were training for hypertension, diabetes, children health, a lot of things. But… like […] addressing mental health, no (Tulip).

The low investment of psychiatric reform in the primary care network has repercussions for the professionals' subjective experiences because they were kept apart from the social movement for mental health and did not engage in the creation of a more inclusive care that promotes social life. Even today, the whole movement is driven by the creation of clinical-political responses to mental suffering and the need to construct a territorial and integral care and rarely gains traction in the primary care network[18].

First, the qualification of FHS professionals in mental health is hindered due to the lack of initiative of the professionals themselves in seeking out knowledge and practices that enable care delivery. Additionally, many professionals stayed on the sidelines of the Psychiatric Reform Movement and did not follow the practical changes that the movement promoted[18].

The work with patients with mental disorders requires one to break with one's own preconceptions because the image of mental patients is linked to that of asylums, aggression, fear and this image is difficult to erase because it has educational roots. However, health professionals have to detach themselves from this image in order to perform their functions and to exercise commitment to the other, which is inherent to the profession, so as to work in favor of these patients and their families.

## FINAL CONSIDERATIONS

Nurses are aware that transcribing prescriptions should not be the only practice developed with mental patients

and that an evaluation should be carried out to control psychotropic drugs and users.

Actions focused on patients with mental disorders were not observed in the participants' reports. There is an awareness that the development of actions is essential but the nurses report that a lack of qualification related to mental health and the absence of a multiprofessional team to support the Family Health Unit hinder the development of such actions. The reports evidenced that additional challenges are related to the lack of training programs addressing mental disorders, which maximize the barriers against nurses implementing actions focused on this population.

Professionals at all care levels interacting with this population should be professionally qualified, not failing to promote coordinated actions at the level of public policy and prevention in partnership between the Family Health Units, schools and entities in the neighborhoods. Professionals should also promote *roundtables* among qualified people in the unit with a view to seek support for the implementation of activities focused on patients with mental disorders and forward this planning to management, i.e., the Secretary of Health. It is worth highlighting the need to involve local leaders and representatives of patients so as to socially control these processes. Likewise, educational institutions should also be involved in the process.

However, in practical terms, the re-insertion of patients with mental disorders into the community is a big challenge for health professionals working in the FHS. Professional education during undergraduate programs and the lack of training programs during the exercise of the profession emerge as challenges faced by professionals in the care delivered to these patients.

## REFERENCES


1. Vasconcelos CM, Pasche DF. O Sistema Único de Saúde. In: Campos GWS, Minayo MCS, Akerman M, Drumond Júnior M, Carvalho YM, organizadores. Tratado de saúde coletiva. São Paulo: Hucitec; 2006. p. 531-62.

2. Scóz TMX, Fenili RM. Como desenvolver Projetos de Atenção à Saúde Mental no Programa de Saúde da Família. Rev Eletrônica Enferm [periódico na Internet]. 2003 [citado 2008 jul. 15];5(2):[cerca de 7 p.]. Disponível em: http://www.fen.ufg.br/revista/revista5_2/mental.pdf

3. Brasil. Ministério da Saúde. Saúde da família: uma estratégia para a reorientação do modelo assistencial. Brasília; 1997.

4. Vecchia MD, Martins STF. Concepções dos cuidados em saúde mental por uma equipe de saúde da família, em perspectiva histórico-cultural. Ciênc Saúde Coletiva [periódico na Internet]. 2009 [citado 2009 fev. 5]; 14(1):[cerca de 10 p.]. Disponível em: http://www.scielo.br/pdf/csc/v14n1/a24v14n1.pdf

5. Lancetti A, Amarante P. Saúde mental e saúde coletiva. In: Campos GWS, Minayo MCS, Akerman M, Drumond Júnior M, Carvalho YM, organizadores. Tratado de saúde coletiva. São Paulo: Hucitec; 2006. p. 615-34.

6. Jucá VJS, Nunes MO, Barreto SG. Programa de Saúde da Família e Saúde Mental: impasses e desafios na construção da rede. Ciênc Saúde Coletiva [periódico na Internet]. 2009 [citado 2009 fev. 5];14(1):[cerca de 10 p.]. Disponível em: http://www.scielo.br/pdf/csc/v14n1/a23v14n1.pdf

7. Schrank G, Olschowhsky A. O Centro de Atenção Psicossocial e as estratégias para inserção da família. Rev Esc Enferm USP. 2008;42(1):127-34.

8. Minayo MCS. O desafio do conhecimento: pesquisa qualitativa em saúde. 8ª ed. São Paulo: Hucitec; 2004.

9. Conselho Nacional de Saúde. Resolução n. 196, de 10 de outubro de 1996. Dispõe sobre diretrizes e normas regulamentadoras de pesquisas envolvendo seres humanos. Bioética. 1996;4 (2 Supl):15-25

10. Meihy JCSB. Manual de história oral. 4ª ed. São Paulo: Loyola; 2002.

11. Buchele F, Laurindo DLP, Borges VF, Coelho EBS. A interface da saúde mental na atenção básica. Cogitare Enferm. 2006;3 (11):226-33.

12. Noto AR, Carlini EA, Mastroianni PC, Alves VC, Galduróz JCF, Kuroiwa W, et al. Analysis of prescription and dispensation of psychotropic medications in two cities in the State of São Paulo, Brazil. Rev Bras Psiquiatr [periódico na Internet]. 2002 [citado 2007 set. 8];24(2):[cerca de 6 p.]. Disponível em: http://www.scielo.br/pdf/rbp/v24n2/a06v24n2.pdf

13. Dimenstein M, Santos YF, Brito M, Severo AK, Morais C. Demanda em saúde mental em Unidades de Saúde da Família. Mental [periódico na Internet]. 2005 [citado 2007 jul. 6]; 3(5):[cerca de 20 p.]. Disponível em: http://pepsic.bvs-psi.org.br/pdf/mental/v3n5/v3n5a03.pdf

14. Carvalho L, Dimenstein M. A mulher, seu médico e o psicotrópico: redes de interfaces e a produção de subjetividade nos serviços de saúde. Interações [periódico na Internet]. 2003 [citado 2007 jul. 6];8(15):[cerca de 28 p.]. Disponível em: http://pepsic.bvs-psi.org.br/pdf/inter/v8n15/v8n15a03.pdf

15. Mendonça RT, Carvalho ACD. O consumo de benzodiazepínicos por mulheres idosas. SMAD Rev Eletrônica Saúde Mental Álcool Drogas [periódico na Internet]. 2005 [citado 2007 ago. 27];1(2). Disponível em: http://pepsic.bvs-psi.org.br/pdf/smad/v1n2/v1n2a09.pdf

16. Tesser CD. Medicalização social (I): o excessivo sucesso do epistemicídio moderno na saúde. Interface Comum Saúde Educ [periódico na Internet]. 2006 [citado 2007 ago. 27]; 10(19):[cerca de 16 p.]. Disponível em: http://www.scielo.br/pdf/icse/v10n19/a05v1019.pdf

17. Vecchia MD. A saúde mental no Programa de Saúde da Família: estudo sobre as práticas e significações de uma equipe [dissertação]. São Paulo: Universidade Estadual Paulista "Júlio de Mesquita Filho"; 2006.

18. Figueiredo MD. A saúde mental na atenção básica: um estudo hermenêutico-narrativo sobre o apoio matricial na rede SUS [dissertação]. Campinas: Universidade Estadual de Campinas, São Paulo; 2006.

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