How to cite this article: Santos, W. (2019). The complexity of Psychosocial Attention in Primary Health Care: formative experiences. *Journal of Psychology, Diversity and Health, 8*(1), 28-40. doi: 10.17267/2317-3394rpds.v8i1.2074

Experience report

Journals BAHIANA
SCHOOL OF MEDICINE AND PUBLIC HEALTH

The complexity of Psychosocial Attention in Primary Health Care: formative experiences

A complexidade da Atenção Psicossocial na Atenção Primária à Saúde: experiências formativas

Willian Santos

Federal University of Reconcavo. Santo Antônio de Jesus, Bahia, Brazil. ORCID: 0000-0003-3224-3800. williantito@yahoo.com.br

RESUMO | INTRODUÇÃO: Este artigo relata uma experiência de estágio supervisionado desenvolvido no âmbito da graduação em Psicologia em uma universidade pública do interior da Bahia. **OBJETIVOS:** Esta experiência objetivou que os estagiários vivenciassem a complexidade da Atenção Psicossocial a partir de uma imersão real e efetiva na Atenção Primária à Saúde. **MÉTODO:** Os estagiários viviam durante um semestre a lógica de uma atuação interprofissional, compondo projetos de intervenção para atuar em Unidades de Saúde da Família, mas também fazendo interface com outros níveis de densidade tecnológica do Sistema Único de Saúde e com outras políticas setoriais, tais como a Assistência Social e a Educação. **RESULTADOS E DISCUSSÃO:** Este estágio, vivido principalmente através de atividades em grupo, atividades de sala de espera, atendimentos individuais, visitas domiciliares e interconsultas, convocou os discentes a lidarem com situações bastante desafiadoras para a Psicologia: compreender os determinantes sociais envolvidos nos processos de saúde-doença; a necessidade do trabalho multi/interprofissional efetivo, a articulação com a Rede de Atenção à Saúde/Psicossocial, entre outros aspectos. **CONSIDERAÇÕES FINAIS:** A inserção da Psicologia na Atenção Primária à Saúde deve se pautar na capacidade de ler o contexto das necessidades sociais e de saúde da população para pensar o tipo de cuidado que esta necessita. Faz-se necessário que a Psicologia e seus profissionais ultrapassem as barreiras de uma identidade profissional arraigada no saber biomédico e encontre uma prática e um comprometimento ético-político que cuide do usuário de forma integral e humanizada.

PALAVRAS-CHAVE: Atenção primária à saúde. Saúde mental. Serviços de saúde mental. Assistência ao paciente.

ABSTRACT | INTRODUCTION: This article reports a supervised internship experience developed within the scope of Psychology in a public university in the interior of Bahia. **OBJECTIVE:** This internship aimed giving to the trainees experiencing the complexity of Psychosocial Care from a real and effective immersion in Primary Health Care. **METHOD:** The trainees lived during a semester the logic of an interprofessional work, composing intervention projects to act in Family Health Centers, but also interfacing with other levels of technological density of the Public Health System and other sectorial policies, such as Social Assistance and Education. **RESULTS AND DISCUSSION:** This stage, lived mainly through group activities, waiting room activities, individual visits, home visits and interconsultations, invited the students to deal with very challenging situations for Psychology: to understand the social determinants involved in the processes of health-disease; the need for effective multi/interprofessional work, articulation with the Network of Health Care/Psychosocial, among other aspects. **FINAL CONSIDERATIONS:** The insertion of Psychology in Primary Health Care should be based on the ability to read the context of the social and health needs of the population to think about the type of care it needs. It is necessary that Psychology and its professionals overcome the barriers of a professional identity rooted in biomedical knowledge and find a practice and an ethical-political commitment that takes care of the person in an integral and humanized way.

KEYWORDS: Primary health care. Mental health. Mental health services. Health assistance.

Submitted 08/20/2018, Accepted 12/14/2018, Published 12/11/2018
J. Psycho. Divers. Health, Salvador, 2019 March;8(1):28-40
Doi: 10.17267/2317-3394rpds.v8i1.2074 | ISSN: 2317-3394

Introduction

The Psychology professional's entering in the field of heatlh policies is closely related to the paths of the sanitary reform, mainly to the Brazilian Psychiatric Reform since the middle of the 70's, during the decade of 1980 (Spink, 2007; Dimestein, 2013). As a direct result of the conceptions and the struggle of these two Reforms in the field of Health, the Unified Health System (SUS, from its initials in Portuguese; Sistema Único de Saúde) from 1990 onwards is consolidating itself as a structured State policy, gradually becoming an important space for practice, training and professional reference for psychologists in Brazil (Spink, 2007).

The Brazilian Psychiatric Reform (BPR) specifically, was a movement articulated by users, families, workers and health researchers, gradually reclaiming and considering the improvement of the assistance provided in the expanded field of Mental Health. The BPR offered treatment for people with psychic suffering within community-based services, working on the protection and rights of these users and vindicating the gradual phasing out of psychiatric hospitals.

The persistent fight of the BPR contributed to a proper administration for practicing the system's basis tenets. It implied the development of new services and devices in experiences regarding Mental Health in some Brazilian towns, still in 1980 and 1990. From 2001, public Mental Health policies are structured through the progressive implantation and development of Psychosocial Attention Centers (PSAC). At the beginning, it was focused on the specialized mental health assistance, introducing the Psychology entrance in the most vigorous way through the public services (Dimenstein, 2013).

This meant the recognition of the psychology professional as a worker able to contribute in the health assistance and to promote the mental health. He would have as an advantage the access in the technical and theorist arsenal able to be used in order to help patients who were potentially developing mental illness (Dimenstein, 2013).

The creation of alternative therapist measures and services based on the asylum model opened the doors for the admission of more psychology professionals in the mental health programs in Brazil, in 2001. At this time, the mental health policies were being analyzed constantly. As a result, it was identified the necessity of a Psycho Social Attention Network (PSAN) in order to strengthen the Psychiatric reform, attempting to expand the action to other levels of technological services of the SUS, and pursuing the interconnection of professional knowledge, practices and categories between workers. To achieve those objectives, the Ministry of Health in Brazil and other researchers acknowledged the necessity of investing on the increase of the mental health actions, especially on the Primary Health Care (PHC). It considered a great capacity of branches in the Brazilian territory, the accessibility for users and their families, and the proposal of a complete longitudinal care system (Ministry of Health, 2014, Paulon & Neves, 2013).

Specificity of the Primary Health Care

In the last years, the interest in the PHC has grown in the Brazilian Health policies. This interest is largely originated from the fact that PHC has been considered (by governments and specialists) as the gateway and coordinator of public health systems, taking into account that this level of technological density is closer to the users and their families, having the potential to solve most of the health problems (Aquino, Medina, Nunes & Sousa, 2014).

Although the discussion about PHC as a coordinator of health care is not a new issue (Mello, Fontanella & Demarzo, 2009), it was only in the 1990s, mainly with the implementation of the Family Health Program since 1994 (later called the Family Health Strategy (FHS)), that PHC was gradually structured as a national policy.

Until 2016, the last two National Policies of Basic Care (Ministry of Health, 2006; 2011) had in the FHS their prior strategy for expansion and consolidation of PHC, supported by a proposal of the reality transformation, and based on territorial planning, on the increase of social participation mechanisms, and on the provision of actions and services meant to include and integrate vulnerable populations, or victims of social injustice. Its performance was understood by the various levels of government as a priority by means of the reorganization of the

SUS health care model. It would imply a wide and complex capillarity in the most diverse territories, once the institutional legitimacy with the Brazilian population had been acquired (Aquino, Medina, Nunes & Sousa , 2014).

At the end of 2017, when the universal coverage was relativized, a new National Primary Care Policy was implemented (Ministry of Health, 2017), contributing to setbacks in the Primary Care in Brazil. The FHS is no longer understood as an organizer of the health care model. The possibilities of traditional services with a worn out performance were admitted, segmenting the access and recomposing health teams and work processes. Therefore, we see a series of risks regarding the historical achievements of strengthening Primary Health Care in Brazil, at the moment of strong neo-liberal ideology, when the changes proposed in this "new" policy reinforced the subtraction of rights and the process of deconstruction of the Unified Health System in the country (Morosini, Fonseca & Lima, 2018).

Despite this strong regression, PHC, as conceived in the 2006 and 2011 versions, was understood (and its performance in recent years has moved to this direction, despite the many deficiencies and challenges) to be as close as possible to the lives of people. Because of this privileged insertion, the main access and communication center of Health Care Networks (HCN) was designed to act as the preferred contact of users, considering the user's singularity and their sociocultural insertion in order to produce integral care. In PHC, this principle was translated into health services aiming to contemplate the collective and specific needs of users and their families, dealing with biological, psychic, social and even spiritual demands.

The FHS has been configured over time as an important policy for reorganizing SUS care models in Brazil. Although it is a policy sponsored and financed largely by the federal government, since the progressive decentralization of SUS, daily management and micro politics are the responsibility of municipal management. This is how the FHS assumes characteristics according to the local and municipal contexts, advancing and innovating, but also with incipient levels of implementation and a series of structural difficulties as well as in the work processes (Aquino, Medina, Nunes & Sousa, 2014). The impact of the "new" National Policies of Basic Care on the Brazilian PHC can only really be shown from studies that will be carried out from now on.

The insertion of Psychology in PHC

In historical terms, Psychology professionals have been active in PHC since the first experiences of parenting, especially in the support to Family Health Teams (FHT) on cares for people suffering from psychic disorders and their families (Dimenstein, 1998). According to Jimenez, the course of psychology in the PHC of Brazilian public health services has its starting point in the 1980s, when a combination of proposals and demands pointed to the need for important changes in approach to health problems, emphasizing the contribution of psychology in multi-professional teams (2011).

According to Dimenstein (1998), since the 1980s, mainly, we can see some insertions of Psychology professionals in PHC, mostly in the Basic Health Units (BHU). These BHUs, created in the 1930s, gradually began to have as their objective the recovery, health promotion and prevention of diseases and diseases, achieved through the integral care of people. From an objective viewpoint about this integral care and the realization of a socio-ecological vision of the health-disease process that should be transmitted to the community, the experience of inserting Psychology in these BHU was a great challenge, considering the difficulties in adequacy, the proposed model for the stereotypes regarding clients served, and the need to think of an different action, not the usual one.

With the implementation of the Family Health Program (FHP) in 1993, Psychology was excluded from the minimum professional staff, working directly in the PHC, in some municipalities (Jimenez, 2011), or in the rear work through substitute services for the Family Health Teams.

However, even when working in BHU of some Brazilian towns after the implementation of the FHP, it would be only in 2008, with the creation of the Family Health Support Centers (FHSC), that Psychology would have a more significant presence in Primary Care. Jimenez emphasizes that, aiming at completeness as a first command, the FHSC proposal

provided a Mental Health professional in each center due to the great epidemiological magnitude of mental disorders in Brazil (2011).

Considering the specific field of Mental Health, the insertion of professionals of Psychology and other health workers in the NASF was conceived as a way of advancing and deepening not only the Sanitary Reform, but also the Brazilian Psychiatric Reform (BPR), given the extensive capillarity of the FHT in the territories, their greater proximity to the families and users and the longitudinal care. In this way, the FHSC has been (and still is) one of the great programs of the Ministry of Health as it has contributed to both quality and quantity increase of the actions in Mental Health in the SUS. The FHSC inserted in the PHC, in the FHS specifically, is designed for a multi-professional and interdisciplinary action, in an environment where there are joint actions, and where knowledge and specialties are crossed. This process produces new ways of interacting with users, repositioning the technical knowledge used by health professionals and developing new forms of care (Paulon & Neves, 2013).

Psychology, thus, will continue becoming more and more embedded in the BPR devices as long as it endures intense questions and paradigmatic ruptures in its performance. Research made in recent years show that the actions of Psychology professionals in PHC and more specifically in FHSC involve both the reproduction of the biomedical and clinical model, as well as the use of innovative experiences developed in the field of Collective Health (Cambuy & Amatuzzi, 2012; Azevedo & Kind, 2013).

Impacts on the developmental process and practice of Psychology professionals

The changes in the paradigms of health policies from the establishment of SUS convened the psychology professionals to rethink their practices. The science and the psychological practice in Brazil, historically uncommitted to the Brazilian social question, begins gradually to try to develop new languages, techniques and strategies to be able to deal with the innumerable social demands brought about by an insertion and whose objective is to promote the health of the community and a better quality of life for the population.

In the initial moments of insertion of Psychology into health policies, psychologists acted largely on the phenomenon of intrapsychic life of the users, without understanding them from their multi-determinations and complexities, disregarding the social, cultural, economic and political context in which patients were immersed (Dimenstein, 1998). Some of the main consequences of this intrapsychic approach were: the development of a traditional and elitist clinic as the main work strategy; the difficulty in delimiting the specific role of the psychologist in health policies; disregard of social issues; the incongruity between the interventionist and adaptive tradition of the profession versus the demands of the SUS for preventive multi-professional and interprofessional health and community actions, among others.

More recently researches have shown that the actions of Psychology professionals in PHC and FHSC are very diverse in relation to the themes, methodologies and public cared. They also show the development of innovative practices developed by professionals who work from the perspective and in the field of Collective Health. The results are new “airs” for the professional performance of Psychology. Among them, we can mention: matrix support, extended clinical practice, unique therapeutic project (UTP), articulation activities of the Health Care Network, the use of innovative theories and techniques, dialogues and partnerships with universities, work with specific populations, actions with families, partnership with groups, implementation of programs and public policies, among many other possibilities.

The psychologist has become, over time, an essential worker in PHC (Dimenstein, 2011). He has become a professional who has tried to promote community participation in his or her self-care and to become the point of intersection between the community and the Family Health team. However, the extension of the entrance of professionals from Psychology in PHC has brought the profession closer to reality than it is discussed and experienced in most of the undergraduate courses in Psychology in Brazil (Guareschi, Scileski, Reis, Dhein & Azambuja, 2010). Working mostly with a low-income population and dealing with a range of vulnerabilities (social, political, economic, emotional, familiar, etc.), psychology professionals feel confused in this space.

Inserted in the FHSC or in health units (BHU, for example) and working with a low-income population, psychology professionals often have to deal with languages, cultures and sociability that are unknown or strange to them. Thus, the Psychology professional working in the PHC is at a crossroad (Dimenstein, 2011). He often acts from the biomedical model (which does not take into account the human, its subjectivity and history, and only focuses on pathology or, in the case of Psychology, on psychopathology). In one hand, there is, therefore, a non-reflexive attempt of framing the users in a hegemonic identity, according to a "mental health", and a reproduction of the inequalities. On the other hand, it acts in a perspective of citizens' emancipation, configuring actions that imply possibilities of struggle and protagonist participation of individuals. This apparent contradiction may indicate a moment of transition in the formation processes. It happens when there are elements of a decontextualized formation and then another model is formed through dealing with the principles of the SUS and Collective Health.

According to Dimenstein (2011), Psychology professionals feel that they do not belong to APS: they are afraid, frustrated and resentful for not being able to act in a space in which the theories and techniques of Psychology are insufficient to meet the demands of the population, where there is no sense of stability and security. The population and other health workers do not know what to expect from psychology besides clinical and individual performance.

For many of these psychologists, security would come about as a consequence of the liberal professional model. There is a perspective of a traditional clinic heavily taught in undergraduate courses in Psychology. Each health unit has a clinic set up according to a series of technical specifications (with air conditioning, comfortable chairs and tables, acoustic insulation of the best quality, among other aspects) and a list of people previously scheduled.

In addition, many Psychology professionals feel uncomfortable not only with the (im) possibilities of acting, but also with the social reality they deal with every day. And this reality is sometimes so impacting that these professionals perceive themselves as mere spectators facing the immense suffering of people, families, the community as a whole. The most diverse situations caused by the most different forms of exclusion (poverty, unemployment, crime, violence, trafficking and drug abuse, among others) give this professional an extreme sense of impotence due to the size of the problem experienced. As a consequence, some have questioned their role in this policy, considering whether they are actually contributing to this population or not (Dimenstein, 2011).

Many theoretical reflections (Paulon & Neves, 2013; Azevedo & Kind, 2013) have been carried out regarding the insertion of Psychology in PHC. However, we find few reports of a Psychosocial Care inserted not only in PHC, but also in the possibilities of articulating it with other areas and services of both PSAN and Health Care Networks. Thus, this is the purpose of this article: to describe and analyze a series of experiences developed in a proposal of a supervised internship in the Psychology area carried out in APS, and based on the complexity derived from the need to expand the contributions to the field of mental health and its network. We hope to contribute in this way to a development and improvement in the use of knowledge regarding the possibilities of Psychology professionals working in Primary Care, as well as to contribute to their network articulation, presenting ways in which this articulation can be raised and motivated in the training process of Psychology professionals.

Methods

Participants

In this experience of Basic Supervised Internship participated classes' groups of a maximum of 8 students of the undergraduate psychology course of the Federal University of Recôncavo da Bahia (UFRB) students in the seventh or eighth semesters of the course. These students were divided into groups of two or three people during the internship.

Place and context

The experience described here began in 2011 within the municipality of Santo Antônio de Jesus

(SAJ). The original idea was to engage the Family Health Strategy (FHS) with Family Health teams (FHT) and FHSC teams during one semester, the time of the Basic Supervised Internship. At that moment, the main objective of the proposal was to increase the theoretical-practical knowledge about the performance of psychology, and the possibilities of action in SUS and PHC especially. The proposal intended that the students develop actions with the teams and the users from the analysis of the socio-epidemiological demands of the reality of the population, and from an analysis of the territories in which the FHU's were inserted. During the semester-long periods, the objective of the original proposal was improved and came to predict the development of actions that facilitated and motivated the communication between users and health workers from the PHC as an articulating point and organizer of the Network of Psychosocial Attention (PSAN). This gradual change in the goal of the internship has led to an increase in the scope of the initial proposal and its possibilities for articulation with the health services and SANs. This internship experience lasted until 2017.

The intention of the internship proposal was to provide the student with a solid training based on the discussion based on the literature and legislation of the subject. Moreover, this proposal aimed to offer them a real and effective immersion in Santo Antônio de Jesus PHC, considering also the possible interfaces with the other levels of technological density of the SUS and other sectoral policies (such as Social Assistance and Education).

Its main focus was based on the student's performance from a Psychosocial Care applied in the context of PHC. It was also based on an intervention from the principles of the field of Collective Health, Human Rights and Social-Community Psychology, considering the logic of an interprofessional action that can and should be based on the principles of matrix support given in Mental Health (Campos, 1999, 2003). This perspective of the proposed action involved, therefore, that the performance of the professional of Psychology in the PHC should be based on a critical reading, dialectic and socially committed to the reality of the population.

Production of data procedures

Each semester, the internship began with an articulation with the Municipal Health Department (SMS) of Santo Antônio de Jesus (SAJ) in order to define in which Family Health Units (FHU) the students would develop their activities. Initially, this insertion was based on an observational ethnographic experience, usually developed for 3 or 4 weeks sufficient for the students to know the FHU; its physical structure, its workers, users and also the territory in which it was inserted. Along with this ethnographic insertion, the student was systematically composing a field diary in which his impressions on all possible aspects that would interface with the development of the stage were described objectively and subjectively: the actions performed difficulties and challenges in the individual activities (FH and FHSC), interpersonal relations, and health conditions of the population, among others.

The objective of this initial ethnography was to be able to make a descriptive diagnosis of the FHU that subsidized the elaboration of an intervention project that each group of students should carry out during the internship. It is important to consider that there was not a prioritized list of activities to be developed by students. The internship proposal took into account the student's freedom and analysis ability to understand and propose appropriate actions to the reality of each FHU. The proposals of the pairs were well received and discussed collectively at the supervisory meetings that were held weekly. Based on observations in the ethnography and analysis of the reality of each FHU, we conjointly constructed an intervention project that would serve as a reference for the team during the internship. This project often (almost always) was modified from the dynamics of acting in the service.

Data analysis procedures

From the analysis of the reality and the construction of the intervention project, the students began to act as psychology professionals in the process of formation. They experienced the joys and difficulties that a professional feels when entering for the first time under the SUS, due to all the idiosyncrasies and problems registered. Based on the analysis of data accumulated in the field journals and in

the work supervisions, the accumulated information was organized and systematized in the central description axes that composed the reports made at the end of each internship.

It is important to take into account that, although this article considers and describes the observation and exchange of experiences between trainees, health professionals and users, this experience did not need to be evaluated by an ethics committee in relation to research with human beings, because it was an internship experience.

Results and discussion

For the trainees, this first experience was an entrance into the professional practice of Psychology and the first insertion in the SUS. As a first professional practice, many students came to the internship very anxious about what they would actually do, what role and posture the field psychology professional had. Many reported that they had not participated in any research or extension project prior to entering the basic internship, and this would be the first time they actually acted on "people" in practice. For this reason, anxiety was quite present in the first weeks of the internship.

It is clear that the SUS and its entire complex multifaceted policy creates an enormous fascination in the student of Psychology, considering the number of professionals of Psychology inserted there. Especially with the implementation of the FHSC in 2008, the SUS became the public policy of today, giving the largest number of psychologists working in the field (Ferreira Neto, 2011), therefore it also allows the real possibility of insertion of future graduates of the course in Psychology at UFRB.

The professional practice of trainees in the PHC revealed new and old problems in the SUS: the influence of party politics on the insertion of health professionals and on health care; a series of structural problems (health units without adequate structure, lack of space required for care, lack of materials, etc.); precariousness of the labor bond between workers; lack of commitment on the part of health workers; lack of permanent health education, among other aspects (Paim & Almeida-Filho, 2014). These subjects were observed by the students, and their recurrent discourse pointed to a huge gap between the theory / legislation and the daily practice of health workers in SUS.

In addition, focusing specifically on the case of Psychology, the insertion in the PHC called the students to deal with challenging situations Psychology did not have answers: difficulties in understanding the social determinants involved in health-disease processes; the need for effective multidisciplinary and interdisciplinary work; the articulation with the Network of Attention to Health; the use of "technologies" for care used in other areas and professional categories; difficulties with the "language" of health; performance with other categories that act from a classic outpatient logic, among others (Dimenstein, Lima & Macedo, 2013). These aspects were continually observed in FHUs and strategies were proposed to address and overcome them.

At the beginning of the internship proposal, a partnership was established with the Psychology professionals working in the FHSC so that the work was carried out through an orientation and direction by specialists in the field. However, from some joint actions during two semesters, an evaluation revealed that the partnership was not continued. The logic of this discontinuity was due to the realization that the performance of psychology professionals working in the NASF was very far from the way it was conceived by researchers and theorists in the field of Collective Health. To this we also add the explicit distance between the work to be developed and what was recommended by the Brazilian Ministry of Health (Leite, Andrade & Bosi, 2013, Paulon & Neves, 2013). In fact, the work of Psychology in the FHSC did not work, at that specific moment, as a plan to act in an interdisciplinary way, nor as an agglutinating and acting element considering the Matrix Support paradigm. It was based mostly on a biomedical, clinical, individual and disjointed perspective of the social and epidemiological reality of the territory and the population

It is important to highlight that we based our field activities mainly on the theoretical-methodological framework of matrix support. This framework,

formulated by Campos (1999, 2003, 2007), proposes a series of arrangements and devices to stimulate the democratization of management, interdisciplinarity, and the expansion of the clinic. The notion of support indicates a multi and interprofessional action allowing each professional to seek support in other specialties in order to develop their actions. Here lies the basis of matrix support: professionals in specialized areas, who are not involved in their daily lives with the demands of the reference team, offer specialized technical support to them. The specialized nucleus supports the interdisciplinary field of reference teams. The notion of a Matrix Support includes two types of specialized rearguard. Those are clinical-assistance and technical-pedagogical. The clinical-assistance dimension is one that will produce direct clinical action with the users, while the technical-pedagogical dimension will produce actions of educational support with and for the health team.

We planned our internship activities starting from the two dimensions contained in the matrix support framework: clinical-assistance and technical-pedagogical. Without prioritization, the actions developed considered the epidemiological, cultural and socioeconomic reality of each population, in an attempt to carry out actions that focused on the most pressing demands of the population and the territory.

Regarding the clinical-assistance dimension, the main actions developed were: group activities, waiting room activities, individual visits, home visits and medical interconsultation visits.

The group activities were the most developed by the groups in the field. The scope of Psychology actions in the SUS through the realization of groups as a way to reach and increase the impact on the community of users has been a very popular concept for discussion (Paulon & Neves, 2013). Some official guidelines (Ministry of Health, 2014) emphasize group practices as an important resource in the care of PHC users, understanding that these practices cannot be defined as a way of solving a quantitative demand only, but as actions that promote socialization, integration, psychic support, exchanges of experiences and knowledge and construction of collective projects. The main role of many of these groups should be in health education, resulting in the empowerment and development of autonomy, as well as the participation and co-responsibility of users, as some of their objectives.

It was from these premises that the groups developed their actions in the teams. However, among the various possibilities of configuration under the label of "group" (polysemic concept), we had two main configurations: health education groups and group waiting room. These activities were directed to several publics: children, adolescents, women, elderly, parents, hypertensives, diabetics, pregnant women and caregivers, especially the elderly.

What is called health education refers to the set of actions developed by health professionals whose goal is the reconfiguration of knowledge, attitudes and behaviors, in order to find an improvement in the quality of life and health of the user. The trainees developed as a group an approach that led new knowledge about a certain theme, always adapting the language to the audience for whom it was intended. In addition, the trainees were encouraged to use the format and posture of the work of the educational workshops in this space, where the pair of students placed the users in the role of facilitator of the activities, always empowering users in proposing themes, activities and motivating them to have their own driving.

The public, theme and periodicity of each group were discussed between trainees and Family Health teams. Once the composition and dynamics of a given group were defined, the necessary collaboration of the Community Health Agents and the nurses of the FHU were generally needed because they are the main disseminators and articulators of the activities carried out in the health units.

Often, once the group was defined and composed, it began to function as expected for some time. However, for a number of reasons, some of them ended up having no more participants. So they ceased to exist. Some of the reasons observed in practice were: lack of support and dissemination of the activity (mainly by the CHA), lack of snacks (sometimes the only motivation to attend the group) and the non-interest of the users, having already participated in a series of group activities at FHU.

One negative point we had was the duration of the groups that were conducted by the trainees: usually between 6 and 8 meetings. This often reflected the lack of interest of some users in participating in the groups, because of the short time of their existence.

It is important to consider that this particular activity brought to the students the greatest joys and the greatest frustrations in their stages. They experienced joy because they succeeded in developing groups in which they perceived a series of changes in the users (receiving even several significant returns from these); and experienced frustration when they could not reach the expected group when only a few users attended, and when the trainees realized that they had not achieved the group's goal. In any case, gathering groups for a considerable amount of time is always a challenge within SUS, and these students have been able to face this challenge in practice.

The group practices in which the students perceived a greater participation and involvement of the users were those in which the trainees were able to successfully create an effective bridge of communication with them. It was noticed that there was a listening and a real interest in what the user brought (a story or knowledge); since the user was placed in an active role with a purpose in relation to the topics discussed, participating in the organization and conduction of the group.

Another action that was also quite present in internship practices was the waiting rooms. Under the name of waiting room were developed health education activities in the waiting rooms of the FHU. Students usually discussed subjects that were on the agenda according to the health subject especially during a certain period (such as diabetes, hypertension, healthy eating, among others). Also, after an analysis as a group, they presented relevant topics (such as mental health, depression, interpersonal relationships, child development, etc.).

It was common for trainees to schedule the waiting rooms. They already knew what and how the issues would be approached, often distributing materials with information, provided by SMS or organized by them. In a different period, the students opened the debate on a theme as a way to listen to the users' opinions, opening a free discussion about the theme. The length of the meetings in the waiting room was a rule. It could not last for more than 30 minutes. The big challenge was getting users' attention and engaging them in the debate. Often the students achieved this goal and had very interesting discussions with users. But there were times when attention and debate did not happen. As a consequence, there were moments of frustration and reflection about elaborating more engaging forms of participation.

Individual attention was also carried out by the trainees. In fact, under the label of "individual service", some forms of interaction with the users were developed individually. These involved some types of clinical management with them. One of these ways had to do with an initial reception or first user service that was forwarded by FH or that came about spontaneously at FHU. In this process the identification of the problem and the referral to HAN / PSAN could arise. Another method of individual care developed was to perform a psychological modification in a FHU. Due to a demand in the health unit, the trainees assigned a time of their work stages to the realization of a spontaneous listening to the users, resulting in a very interesting adhesion and return of the users.

Another modality also developed by the trainees was the realization of interconsultation. This action was developed in one of the USFs in which there was a Cuban doctor, working in the program More Doctors of the Ministry of Health. I would like to point out that where there were Cuban doctors in the USF, the work was easier and more cooperative. The Cuban doctors were willing to carry out a series of activities with the trainees, such as waiting rooms, interconsultation, group work, etc. These activities did not have the expected participation of the Brazilian doctors.

Trainees also developed home visits. These visits usually occurred with users who were bedridden or had difficulties that made it impossible for them to go to the USF. The visits were mediated by the articulation and presence of CHAs, sometimes with the follow-up of FHSC or eFH professionals. An unfolding of these visits was also the discussion between the professionals and the trainees, contributing to the establishment of some lines of intervention for the users. The home visits brought significant gains for the students, as presented in their own report.

Besides the clinical-assistance dimension, there was an incentive in each new semester for the trainees to carry out technical-pedagogical actions directed to the health teams. On this regard, the main activity developed were group activities directed to the CHA. There had been several attempts to carry out actions with other health professionals, but unfortunately we have not been able to fulfill them. But it was noticed that the main resistance on this regard was the denial of many professionals. They believed that the few experience of the psychology trainees made them incapable of developing any activity with trained and experienced health professionals.

During the initial diagnosis and in the search for the units' demands, some CHA members at some FHU indicated that they needed to know more about the issues surrounding Mental Health. They indicated mainly that they needed to have moments in which they could speak and express the innumerable difficulties experienced in their daily work. When these activities took place, there was a very interesting personal and professional growth between the trainees and the CHA through the exchange of experiences. The ability to express and re-signify their daily demands on the physical and also relational plane helped a lot because these professionals continually complained of the devaluation they suffered from other health professionals.

Another field of action experienced by students was the demand for articulation with and PSAN in the municipality. Many of the users served had demands that clearly extrapolated the services offered in the FHU's, as well as demands present in other points of the networks.

In the specific field of mental health, the institutional culture of the municipality's PHC was to direct the psychologists of the FHSC to act in any type of situation that was evaluated as having relation with mental health. These could range from a family conflict to severe and persistent mental disorder. Since the focus of Psychology services in the FHSC was not on individual psychotherapy, these psychologists usually hosted these patients and referred them to the mental health outpatient clinic and the CAPS II of the municipality, considered the central points of the PSAN. However, both the outpatient clinic and the CAPS did not receive demands for family conflicts, or cases of learning difficulties for children or adolescents, or even headaches (very frequent situations). At that time, the municipal PSAN had no level of technological development in any service that met these user profiles. This should have been addressed in theory by the FHSC psychologists, but this did not happen systematically. In this way, a gap was created in the possibilities of attending these users in the PHC.

This gap was one of the fronts of the trainees. Helping and following up some users forwarded from some FHUs to the CAPS was the focus. Some trainees accompanied these users in the first consultations with the CAPS team and in the developments that followed. One of the main problems was that the CAPS did not give continuity to the visits and the user "returned" to his FHU without a care perspective. A series of interventions were carried out with these users. The interventions involved a systematic evaluation carried out in the health unit itself, group activities with users with the same profile (pregnant women, elderly, adolescents, etc.), and articulations in PSAN / HAN on other demands that went beyond the field of "mental health ": Appointment for consultations, exams and even surgeries.

This was one of the most challenging aspects faced by trainees really. Clearly, there was no network culture and management in the municipality. The basic principle of PHC, even with the presence of Psychology, was to identify users with demands in the field of Mental Health and refer them to the CAPS and the outpatient clinic of the municipality. This was the beginning of responsibility for care as specialized attention. Because there was no systematic care for mental health in the FHUs and it was evident that the teams did not have a sense of responsibility in relation to the subject, internship work also included providing information and practices for health professionals in the field of mental health from informal conversations, formative experiences and recapitulation of specialized literature.

Final considerations

I understand that the action of Psychology in PHC rather than developing new technologies in health

care should be based on the ability to read the context of the population's social and health needs in order to think about the type of appropriate care. More than to act from "new" caring technologies (which can even frame and restrict creative freedom), the Psychology professional needs to develop a differentiated view on health. The Collective Health field can demonstrate and reference this very well.

As the history of Psychology itself shows (Ferreira Neto, 2012), we do not yet have a framework of sufficient experience and theory in which the psychologists who are forming can refer to work in this field. This framework is being built today, not only by professionals who are in the field but also by researchers and psychologists who try to investigate this field of professional activity. In recent years, there has been a greater reflection on the need for change regarding the role of Psychology professionals in SUS as a whole, and in PHC in particular.

The new curricular guidelines for undergraduate courses in Psychology (Brazil, 2004, 2011) are aligned with SUS premises and contemplate a new kind of Psychology professional. They corroborate the formation of a professional that is not based only on the establishment of descriptive behavior patterns that attempt to establish what is normal or pathological. They also propose that the professional is not bounded by delimiting the conduct from what he establishes as "right" or "wrong", normal or pathological. He must be a psychologist who respects alterity, differences, and understands the conditions of production of subjectivities in social and historical contexts (Guareschi, Scileski, Reis, Dhein & Azambuja, 2010).

In this way, the formation of UFRB's Psychology undergraduate course provides a critical and reflective view, not only from this internship experience, but also from many other discussions and experiences provided to students during the course, on SUS and on the possibilities of a qualified and efficient insertion of these professionals in this field.

Even today, most of the new professionals of Psychology that are being college graduates in Brazil, are prepared to work from a hegemonic and traditional clinical model, without knowledge about SUS (Guareschi, Scileski, Reis, Dhein & Azambuja, 2010). Thus, these professionals complete their undergraduate course and begin to work in the SUS without a sensitive point of view, contrasting in the time to meet the various determinants in the health-disease process, without compromising with the social transformations and without the knowledge to act in this public policy.

In order to have a closeness between psychology and SUS or PHC, it is necessary to overcome the barriers in terms of a professional identity rooted in its history (Jimenez, 2011). It is from this transformation that the professional can be integrated with the health teams, having a position and an ethical-political commitment that allows him to take care of the individual in an integral way. This form goes beyond the differences of social class and culture between them and the users served.

The experience described here had the clear limit of circumscribing a performance during a semester, developed by an undergraduate course in Psychology. In this sense, its scope of intervention and analysis has been reduced and focused. However, even during a brief period of intervention, the trainees were able to show how the health services and teams were unprepared and uncompromised with the field of mental health in PHC. In addition, they realized the need for a link between PHC and PSAN / HAN, in order to truly consider integral and integrated network care.

This formative experience was presented with the purpose of making a contribution, or at least trying to do it, even with simple characteristics, so that the graduates of this Psychology course could have this differentiated and committed posture. It can also help the SUS to deepen as a fundamental public policy for the Brazilian people, even if it is constantly attacked by conceptions and foundations that make it a Brazilian state's executioner, instead of being understood as a fundamental right stated in our Federal Constitution, and needs to be defended constantly.

Conflicts of interest

No financial, legal or political conflict involving third parties (government, business and private foundations, etc.) was declared for any issue in the submitted work (including advisory council, study design, manuscript preparation, statistical analysis, etc.).

References

Aquino, R., Medina, M. G., Nunes, C. A., & Sousa, M. F. (2014). Estratégia Saúde da Família e reordenamento do Sistema de Serviços de Saúde. In: J. S. Paim & N. Almeida-Filho (Orgs.), *Saúde Coletiva: teoria e prática* (pp. 353-371). Rio de Janeiro: MedBook.

Azevedo, N. S., & Kind, L. (2013). Psicologia nos núcleos de apoio à saúde da família em Belo Horizonte. *Psicologia: Ciência e Profissão, 33*(3), 520-535. Recueprado de http://www.scielo.br/pdf/pcp/v33n3/v33n3a02.pdf . doi: 10.1590/S1414-98932013000300002

Resolução Nº 8, de 7 de maio de 2004. Institui as Diretrizes Curriculares Nacionais para os cursos de graduação em Psicologia. Recuperado de http://portal.mec.gov.br/cne/arquivos/pdf/rces08_04.pdf

Resolução Nº 5, de 15 de março de 2011. Institui as Diretrizes Curriculares Nacionais para os cursos de graduação em Psicologia, estabelecendo normas para o projeto pedagógico complementar para a Formação de Professores de Psicologia. Recuperado de http://portal.mec.gov.br/index.php?option=com_docman&view=download&alias=7692-rces005-11-pdf&Itemid=30192

Cambuy, K., & Amatuzzi, M. M. (2012). Experiências comunitárias: repensando a clínica psicológica no SUS. *Psicologia & Sociedade, 24*(3), 674-683. Recuperado de http://www.scielo.br/pdf/psoc/v24n3/20.pdf. doi: 10.1590/S0102-71822012000300020

Campos, G. W. S. (1999). Equipes de referência e apoio especializado matricial: um ensaio sobre a reorganização do trabalho em saúde. *Ciência & Saúde Coletiva, 4*(2), 393-403. Recuperado de http://www.scielo.br/pdf/csc/v4n2/7121.pdf. doi: 10.1590/S1413-81231999000200013

Campos, G. W. S. (2000). Saúde pública e saúde coletiva: campo e núcleo de saberes e práticas. *Ciência & Saúde Coletiva, 5*(2), 219-230. Recuperado de http://www.scielo.br/pdf/csc/v5n2/7093.pdf. doi: 10.1590/S1413-81232000000200002

Campos, G. W. S. (2003). *Saúde Paideia*. São Paulo: Hucitec.

Dimenstein, M. D. B. (1998). O psicólogo em Unidades Básicas de Saúde: desafios para a formação e atuação profissionais. *Estudos de Psicologia, 3*(1), 53-81. Recuperado de http://www.scielo.br/pdf/epsic/v3n1/a04v03n1.pdf. doi: 10.1590/S1413-294X1998000100004

Dimenstein, M. (2011). Contribuições da Psicologia Social para a saúde como direito e construção da cidadania. In: B. Medrado, & W. C. M. Galindo (Orgs.), *Psicologia Social e seus movimentos: 30 anos de ABRAPSO* (pp. 161-182). Recife: ABRAPSO/Ed. Universitária da UFPE.

Dimenstein, M., Lima, A. I., & Macedo, J. P. (2013). Integralidade em saúde mental: coordenação e continuidade de cuidados na atenção primária. In: S. Paulon, & R. Neves (Orgs.), *Saúde mental na atenção básica: a territorialização do cuidado*. Porto Alegre: Sulina.

Ferreira Neto, J. L. (2011). *Psicologia, políticas públicas e o SUS*. São Paulo: Escuta; Belo Horizonte: Fapemig.

Guareschi, N. M. F, Scileski, A., Reis, C., Dhein, G., & Azambuja, M. A. (2010). *Psicologia, formação, políticas e produção em saúde*. Porto Alegre: EDPUCRS.

Jimenez, L. (2011). Psicologia na Atenção Básica à Saúde: demanda, território e integralidade. *Psicologia & Sociedade, 23*(n. espec.), 129-139. Recuperado de http://www.scielo.br/pdf/psoc/v23nspe/a16v23nspe.pdf. doi: 10.1590/S0102-71822011000400016

Leite, D. C., Andrade, A. B., Bosi, M. L. M. (2013). A inserção da psicologia nos núcleos de apoio à saúde da família. *Physis Revista de Saúde Coletiva, 23*(4), 1167-1187. Recuperado de http://www.scielo.br/pdf/physis/v23n4/08.pdf. doi: 10.1590/S0103-73312013000400008

Mello, G. A., Fontanella, B. J. B., & Demarzo, M. M. P. (2009). Atenção Básica e Atenção Primária à Saúde: origens e diferenças conceituais. *Revista de APS, 12*(2), 204-213. Recuperado de https://aps.ufjf.emnuvens.com.br/aps/article/view/307/203

Portaria nº 648/GM de 28 de março de 2006. Aprova a Política Nacional de Atenção Básica, estabelecendo a revisão de diretrizes e normas para a organização da Atenção Básica para o Programa Saúde da Família (PSF) e o Programa Agentes Comunitários de Saúde (PACS). Recuperado de http://bvsms.saude.gov.br/bvs/publicacoes/politica_nacional_atencao_basica_2006.pdf

Portaria No 2488, de 21 de outubro de 2011. Aprova a Política Nacional de Atenção Básica, estabelecendo a revisão de diretrizes e normas para a organização da Atenção Básica, para a Estratégia Saúde da Família (ESF) e o Programa de Agentes Comunitários de Saúde (PACS). Recuperado de http://bvsms.saude.gov.br/bvs/saudelegis/gm/2011/prt2488_21_10_2011.html

Ministério da Saúde (2014). *Núcleo de Apoio a Saúde da Família / Ministério da Saúde, Secretaria de Atenção à Saúde, Departamento de Atenção Básica*. Brasília: Autor. Recuperado de http://bvsms.saude.gov.br/bvs/publicacoes/nucleo_apoio_saude_familia_cab39.pdf

Portaria N. 2436, de 21 de setembro de 2017. Aprova a Política Nacional de Atenção Básica, estabelecendo a revisão de diretrizes para a organização da Atenção Básica, no âmbito do Sistema Único de Saúde (SUS). Recuperado de http://bvsms.saude.gov.br/bvs/saudelegis/gm/2017/prt2436_22_09_2017.html

Mendes, E. V. (2005). Entrevista: O SUS e a Atenção Primária à Saúde. *Revista de APS, 8*(2), 13-25. Recuperado de http://www.ufjf.br/nates/files/2009/12/entrevista1.pdf

Morosini, M. V. G. C., Fonseca, A. F., Lima, L. D. (2018). Política Nacional de Atenção Básica 2017: retrocessos e riscos para o Sistema Único de Saúde. *Saúde Debate, 42*(116), 11-24. doi: 10.1590/0103-1104201811601

Paim, J. S., Almeida-Filho, N. (2014). *Saúde Coletiva: teoria e prática*. Rio de Janeiro: MedBook.

Paulon, S. M., & Neves, R. (2013). *Saúde mental na atenção básica: a territorialização do cuidado*. Porto Alegre: Sulina.

Spink, M. J. P. (2007). *A Psicologia em diálogo com o SUS: prática profissional e produção acadêmica*. São Paulo: Casa do Psicólogo.