

Mental Health Internship for Medical students: which is the best training setting?

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The 2014 Curricular Guidelines of the medical undergraduate courses include Mental Health (MH) as one of the required areas of internship. The objective of this paper is to present the integrated internship for MH and Family and Community Medicine (FCM) of UFRJ, as well as the rationale for choosing Primary Health Care (PHC) as the setting for the internship training. It presents a report of the experience of the integrated internship for MH and FCM of UFRJ and the discussion of its theoretical frameworks. The high prevalence of psychological distress and mental disorders in PHC, the fact that PHC is the gateway to the unified national health system (SUS) and the fact that the medical school must train general practitioners, make PHC a privileged locus for the training of medical interns in mental health.

Keywords: Mental Health. Family Practice. Internship and Residency. Primary Health Care. Medical Education.



4th Week

This week begins with a case similar to many seen before. A woman, bearer of grade III obesity with systemic arterial hypertension and diabetes mellitus, both poorly controlled. So far, nothing much different from our day to day, or what we expect to meet in our office. A niece kept company until the granddaughters entered into the consulting room. They knocked, opened the door, not bothering to disturb, stepping in and talking as if they were at home, sitting wherever they wanted. Their grandmother seemed uncomfortable with the situation and even disbelieving to be attended by students as the doctor ran around trying to sort out the pending issues. We explained that her situation was a little worrying, since she could not maintain control of hypertension and blood glucose and at this point it was necessary to start insulin. [...] The grandmother said that she could not diet or reduce stress, because the granddaughters were giving her trouble. She wanted the girls to do the bacilloscopy, already requested by the doctor, because they coughed a month ago, but they refused to be tested. Also, she wanted a contraceptive method for the girls, who as per the comments of family members, spent weekends at funk dances, appearing with a different boy every day. In one of the several entrances of one of the granddaughters in the room, I tried to make some contact to ask about the cough. [...] This one didn't even deign to look at us. She contacted, or I rather say, she did not make contact with us. Her indifference to us was such that it made me feel extremely distressed and angry. How to demand respect? How to ask for respect from someone who doesn't even seem to respect herself? Someone who may not have even learned the meaning of that word? They were 14 and 15-year-old girls demanding treatment like women, but acting like brats. My discomfort was huge. (...) Well, if I was extremely worried, I can really imagine grandma's nervousness. [...] In the afternoon, the girls returned alone because they wanted the result of the requested rapid tests and the contraceptive method, needing to go through the consultation with the doctor. The fifteen-year-old didn't seem to care what we were talking about, but she told the fourteen-year-old to tell the whole truth, since her grandmother was no longer there so we could treat her. My discomfort continued. [...] The girl was coughing for a month and was losing weight. I didn't know if she had a fever, but she was always partying [...] she had gone back to school, but had already tried to beat the teacher [...]. Assault the teacher? [...] I was really shocked; this is not part of my reality. [...] I don't know how these teachers treat students, but nothing justifies such aggression. [...] The doctor made it clear that condoms protected from STD, but they didn't give a damn. What was worrying was that they were not protected from pregnancy in the first month of contraceptive injection. I told them that condoms were their right and that they could demand from the guy or refuse. Really? Can they? I don't know, that sounded fake even in my head. I don't think a funk party guy will say, "Okay, honey, I'll do what you're asking." And I don't think they wanted to either. [...] I really meant to say that no sex well done, no popular guy, no apparent status would be worth their youth or the sadness of an STD diagnosis. I wanted to speak their language, shock them as much as I was shocked. I think it was going to be ineffective, I was really quiet,



my chest oppressed, distressed by the kind of education that our country is offering, the same way that I often feel helpless facing a terminal stage. Tuesday came to relieve me. I wanted to thank the teachers for the enriching afternoon talk. I sincerely think that exposing the situations we experience in the clinic can give us some ease. A good three hours and a half of conversation, reflection, polite debate. It was being able to breathe in the middle of a busy semester. I think, in medical school we are not given many opportunities to share, and it is difficult to find people from other areas willing to listen or understand. We are very used to studying well-defined protocols, elaborate behaviors, diagnoses already made, but we are not very encouraged to productive leisure, to reflect, to share. These hours proved to be much more productive in my week than if they had been spent in the office. I do not want to downplay the demand, but I am feeling that the moments when the group meets, are also fundamental to the education of a quality professional. (Field diary - 10th Semester, Integrated Internship of MH and FCM of UFRJ)

Introduction

In 2014, the current National Undergraduate Curriculum Guidelines (NCG) for Medicine¹ were published, including Mental Health (MH) as one of the mandatory areas of internship to be implemented by 2018. It is emphasized that the area to be included is mental health and not psychiatry. Is it a mere play on words? A goal of the NCG¹ is that:

The medical graduate will have general, humanistic, critical, reflective and ethical training, with capacity to act in different levels of health care, with actions of health promotion, prevention, recovery and rehabilitation, in the individual and collective areas, with social responsibility and commitment to the defense of citizenship, the dignity and the comprehensive health of the human being; and having as a permanent cross-cutting characteristic in its practice the social determination of the health and disease process.

Medical training has always been given priority to the field of biomedicine, and psychiatry is the discipline that institutes medical knowledge regarding madness, classifying it into different types of mental illness. Training in mental health is strategic for the expansion of knowledge and practice of the physician who must not only recognize mental disorders, above all realizing that human suffering can hardly be reduced to a diagnostic label.

How to provide this training to medical students?

There is an Institute of Psychiatry in UFRJ where specialists in this area are trained. However, for those doctors who will follow other fields of medicine, training in a specialized center, restricted to more severe patients, already diagnosed and medicated, could lead to distortions, such as the idea that patients with mental disorders (PMD) should necessarily be treated in specialized centers. Moreover, the alarming rates of early PMD mortality may also be related to the inability of doctors to deal with these



patients outside psychiatric settings²? Studies reveal that health professionals, including physicians, are among those with more prejudice towards PMD. We wonder if this fact is something that show that the training of these professionals should change^{3,4}? Primary Health Care (PHC) is internationally shown as the setting to be prioritized in the training of health professionals, in order to increase access and resolution of care and treatment for most mental disorders⁵⁻⁷. Thus, we conclude that PHC⁸, including Family Health Support Centers (NASF) plus community services from the mental health network - Psychosocial Care Centers (CAPS) and street-based clinical teams, articulated with the Family Health Strategy (FHS) teams should be the priority setting for the MH internship.

The UFRJ in 2006 started its internship in FCM training in the basic health units (UBS) of the Municipal Health Secretariat (SMS) of Rio de Janeiro. In 2015, it was implemented the MH internship integrated with the internship for FCM, increasing the training load at APS from 11 to 22 weeks, with 32 hours per week. The interns are part of the FHS teams and are accompanied at the UBS by a preceptor, family and community doctor from SMS. In a standard week they participate in 4 consultation rounds (1 dedicated to the prevention of cervical and uterine cancer, under nursing supervision); 1 home visit shift; 2 shifts of collective activities (Health Education, Continuing Education, Clinical Sessions; Unit Team meetings; MH matrix support); 1 shift of joint action of the teachers of MH and FCM of UFRJ, with the interns and the teams of the FHS. Interns are encouraged to perform the activities autonomously under supervision. We are presently in the seventh class of the 22-week internship. The difficulties have been and still are plenty. During the construction of the integrated model, the main questioning came from the interns due to their difficulty in understanding why the MH internship would not happen in the specialized institute, since the other internships - pediatrics, obstetrics and gynecology, happened in this way. Another important difficulty is the articulation of so many actors in so many settings - 38 teachers, 136 interns, more than 100 preceptors, 19 UBS, 5 CAPS, 2 street-based clinical teams. We have well-explained rules in the Internship handbook for this articulation; those rules are updated every semester, as well as web groups for real time communication. But the main challenge is that we are immersed in SMS's PHC network and therefore susceptible to the political changes of each municipal, state and federal administration, as well as to the ills of our city. This last aspect is both a difficulty and a trove, as the students need to leave the protected environment of the University Hospital and go out to live the reality of the SUS and the population they serve, making the integrated internship one of the pillars of UFRJ's medical education.

Mental health and/or psychiatry

A first point to be raised in this discussion regarding the future medical education in the field of MH is whether mental health is synonymous with psychiatry or if its concepts and practices are complementary. Why do we say MH, sometimes Psychiatry, and sometimes both - MH and Psychiatry? In the NCG, the term is clear - the internship will include the area of MH. In a text dedicated to the new NCG, professors from UNICAMP's Department of Medical Psychology and Psychiatry understand "Psychiatry/MH as one of the major areas of medicine and not just one



of their specialties” (p. 48), recalling a widely used slogan by the WHO that “there is no health without mental health”. However, in the text there is no separation between Psychiatry and MH:

[...] [their teaching and learning are part of] efforts to improve patient care.

[...] [It is important] to provide students with a psychiatry/mental health background capable of providing them with cognitive and affective communication skills, mental state assessment as well as the assessment, recognition and therapeutic planning of the most prevalent mental disorders⁹. (p. 49)

One option would be to always put the two terms together - Psychiatry/MH, pointing to a differentiation - one term is not the same as or substitute for the other - but at the same time they belong to a common field of knowledge and practice. Another option would be simply to separate the two terms - referring to psychiatry as the core of knowledge that recognizes and deals with mental disorders, while MH refer to the absence of these disorders, the possibility of balance, of coping with new situations, more focused on the field of prevention and health promotion.

A third possibility would be to use the notion of Field and Core proposed by Campos¹⁰.

MH would be the field - “space of imprecise boundaries where each discipline and profession would seek mutual support to fulfill their theoretical and practical tasks” - and Psychiatry a specialized core of knowledge - “identity of an area of knowledge and professional practice”. (p. 220)

In a 1999 text, “The Concept of Mental Health”, Naomar Almeida Filho argues that “in contrast to the great amount invested in the development of theoretical models of mental illness, little progress has been made towards constructing conceptually the object “mental health”¹¹ (p. 101). His reflection may be useful in many ways, but here I will highlight one issue that we experience daily in the construction of the MH-FCM integrated internship:

On the one hand, the concept of mental disorder, based on biomedical psychopathology, presents a high degree of stability as an explanatory model and a restricted applicability to collective contexts. On the other hand, the radical subjectivity implicit in the notion of illness, [...] refers to the impasse [...] of the irreducibility of the experience of mental illness, both to the communicative processes characteristic of social action and to explanatory systematical models that enable clinical technology. [...] We cannot disagree that reducing the “burden of mental illness” by reducing the volume of morbidity through the treatment and rehabilitation of cases will result in better mental health indices in the sense of health¹¹. (p. 123)



So this is undoubtedly a fundamental part of the work to be developed with the interns, the ability to recognize and treat mental disorders as they are described by psychiatry. But would they appear in the field of PHC in the same way that they appear in the field of specialty? For now, it is important to agree with Naomar when he points out that:

[...] In multicultural societies that practically define what has been called postmodernity, ethnic pluralism, social exclusion, the generational gap, gender inequality, and so many other heteronomy processes, indicate the need for culturally sensitive psychiatric care devices in order to at least increase the resolute capacity of its action. In this sense [...] it will not be desirable to design and plan mental health care programs based on models based on the restricted concept of mental disorder or on references of illness as an idiosyncratic dimension of the subject. [...] On the other hand, an expanded concept of mental health as an expression of social health necessarily becomes the object of a trans-disciplinary and totalizing approach, outside the scope of care programs. As a model-object constructed through cross-sectoral practices, mental health means a healthy *socius*; It implies employment, job satisfaction, meaningful daily life, social participation, leisure, quality of social networks, equity, in short, quality of life. In spite of the mandated end of utopias and the crisis of values, it is inescapable: the concept of mental health is linked to an emancipatory agenda of the subject, of an inappealable political nature¹¹. (p. 123)

This is a frequent question among interns - what can I do as a doctor to face so many problems that overcome me?

So many tragedies in succession affect the life of this family that it's hard to find the culprit, the cause, the etiology. If I was confused to find out the etiology of congestive heart failure, cancer, then I declare in this case an indeterminate, cryptogenic cause. It is so multifactorial that one single factor is diluted in the midst of so many others that affect life. From a distance, it is clear that poverty and social inequality are at the foundation of many of these problems. Seen from close, poverty scares more than through television. It smells, it sounds, it has tears. What doesn't seem to have, at least not in the near future, is solution. (Intern, 12th semester)

Therefore MH is something that goes beyond psychiatry, encompasses it, but is not restricted to it. In the conceptualization of Campos¹⁰, MH would be the field and Psychiatry the specialized core of knowledge. Psychiatry's core knowledge and its diagnoses may and should be reviewed in the PHC setting.

MH ratings in PHC

In the article "Classifications in Mental Health in Primary Care: Diseases change or Sick People change?"¹², Fortes et al point out that:



[...] MH in PHC has inherent particularities in its practice, including a distinct clientele profile from that of specialized services. It is very comprehensive, ranging from the construction of a biopsychosocial model of health and disease to the care of patients with serious mental disorders. It covers addressing users' emotional distress and developing community interdisciplinary therapeutic interventions, among others. (p. 191)

The authors' main argument is that, as PHC is the gateway to the health system, patients who show up are different from those found in specialized services, with a predominance of somatic complaints as well as the much more evident social determinants of health. One of the risks is that health professionals end up underestimating these complaints, considering that they are "normal" responses to the extremely difficult conditions of the population served or, on the contrary, without knowing what to do, they "medicalize" the malaise, lacking knowledge and training in other therapies than medicalization, not mentioning the scarce or inexistent integration with the intersectoral network and "informal" care.

The PHC users seek care for a variety of reasons - [(from) prenatal to influenza]. In this context, due to the fact that the FHS team, doctor included, know and follow the whole family, both vulnerability and emotional distress can be perceived early and receive attention even before they crystallize into a psychiatric diagnosis. For this reason the classification in PHC should include not only the diseases themselves, but the problems that lead the person to seek the FHS team. There are in fact PHC-specific classifications, such as ICPC II (International Classification for Primary Care) and a MH-specific ICD in PHC.

These classifications are more dimensional than categorical because the differentiation between the various pathologies is much more subtle, there is a high prevalence of mixed symptoms with symptoms of more than one pathology. [...] Who or what can be considered normal? This dilemma is valid for both metabolic problems [...] as for mental disorders¹². (p.193)

How the suffering of someone who saw his son and mother being run over by a train, can be reduced to a diagnosis of depression, but at the same time to treat the depressive symptoms that it actually has? How to offer other therapeutic possibilities? In addition to broadening our classificatory framework we have to broaden our repertoire of possibilities for intervention in the community, and in this sense, the insertion in PHC and its integration with MH will be beneficial.

Biopsychosocial care and PHC

Has biopsychosocial care something to say to PHC and vice versa? One of the activities of this internship is the two-week immersion in a CAPS, preferably in the UBS service where the intern is linked. The field diary of interns who went through CAPS Magal in Mangunhos / RJ illustrate the experience of living in care spaces. Those care spaces show that working within the logic of biopsychosocial care can be important and transformative in medical education, and this same logic can illuminate PHC.



Though this be madness, yet there is method in it.

On Wednesday a difficult different, but above all especially exciting week would start: the immersion in CAPS Magal. The first thing I noticed when entering CAPS was that there were 2 quotes from Nise da Silveira on the walls. I even laughed by myself standing in front of the hallway walls colored by those words that were never dared to expose us to in the undergraduate psychiatry course at any time. [...] That entrance lit a little light of joy that didn't go out all week long: CAPS dares to let us experience. We were soon saying good morning and introducing ourselves to the patients who were sitting watching television. I first met Mr. Edimar, a retired gentleman in his late sixties who loves writing poems, lyrics and composing melodies as well. He was sitting with a yellow folder full of his creations. Bald, with a thin gray beard, wrinkles of age, a velvety voice tempered by a difficulty in the mechanical articulation of the words and a kind and calm look. It was K who made a point of introducing us because he knows I like to play guitar and I also try my skills at composing. We hit it off immediately, when I found myself listening to one of his poems and then one of his songs. I was really impressed with his ability to produce beauty. He woke me up to the fact that there might be many artists there. This is a full plate for a soiree! That's what I imagined at the time. (Intern, 11th semester)

Deinstitutionalization is a policy provided for by law, as well as due respect and protection to the MH user, but I can tell from this short experience in certain health care institutions how stigma survives at the expense of unpreparedness, ignorance, intolerance and hatred. Not infrequently the "psychiatric" patch is glued close to the user's bedside in a hospital as a kind of warning, precautionary instigation, and sometimes as a result of deep ignorance about MH and psychiatry. In a shift at an intensive care unit of a municipal hospital, I followed up a number of people with this amazing seal stamped on their beds. I remember well seeing a lady reproducing a series of delusions of persecutory content and some visual hallucinations. In her transfer to a ward, she began to cry for help, extremely frightened and disturbed. As she said shouting, she was sure they were planning her murder. Two staff members in the sector were carrying her to the stretcher and in an extremely joking tone confirmed her fears, yes, we will kill you. They laughed. The astonished look of the lady is frighteningly alive in me.

There is no reason to promote integration and socialization if we do not see the MH user as being worthy of respect. The struggle against institutionalization carries a struggle for respect and recognition of the user as a citizen worthy of belonging to society. CAPSs break aspects of stigma as soon as we enter the institution. It is not a very large space, but it is alive, covered by light and color. Users of the institution, staff and health professionals enjoy the same spaces. (Intern, 11th semester)

Unlike all forms of therapy I have known so far, the workshops come to surprise me and provide what is most valuable of what I have had at CAPS so far:



living with patients with mental disorders. I have said in other opportunities that medical practice actually makes sense to me whenever doctor and patient can recognize each other even subtly. Sometimes we cannot even recognize the humanity of those who seek us, even though that recognition alone should be enough for decent care.

The workshop spaces allowed me to recognize myself in these people, to note similarities and to share difficulties. The stigma of patients with psychiatric disorder dehumanize them and misleads us in thinking that we are better or superior. (Intern, 11th semester)

Upon returning to UBS after CAPS immersion, the interns were different. They began to question the group spaces of the unit, inside and outside the clinic, collective interventions, art, and income generation.

These are all possible and desirable therapeutic devices in the FHS. And they may be as therapeutic or even more than an antihypertensive or benzodiazepine. This is what I called “the logic of biopsychosocial attention, is renewing the work developed at the UBS”. It reminds to UBS itself of the potentiality of PHC, since many of these principles come close to PHC principles. For example, the logic of biopsychosocial care advocates teamwork in a trans-disciplinary way, in which the various disciplines interact, rather than succeeding in a logic of complementarity or successiveness, and through their interaction, they build, with the direct participation of the subject a therapeutic project or simply, a life project.

The issue of access is central, both for PHC and Biopsychosocial Care, as both have as a pillar the responsibility for the clientele of a given territory. Not matter if it is the patient or family coming to the service, the important thing is that comprehensive care may reach them. The same can be said regarding longitudinality, accompanying the patient throughout life. In the case of CAPS, this monitoring will be for patients with mental disorders requiring intensive care. In PHC longitudinality is for everyone to accompany all families throughout life. Comprehensiveness refers to the recognition of the care needs of that individual and, even if the necessary care cannot be offered at that level of health care, this care must be enabled through PHC. The coordination of care is like the conductor, who conducts the orchestra, even not playing all the instruments; it requires a strong partnership between PHC and other levels of health care and others, including CAPS. The derivative aspects of PHC principles (family-centered; cultural competence; community-oriented)¹³ are also shared by Biopsychosocial Care, showing that the interrelationship between them is very large, as is large the capacity for reciprocal empowerment.

It is noteworthy that not by chance, the principles governing PHC and MH are approaching each other. The normative guidelines of SUS - universalization, equity, comprehensiveness, as well as its organizational principles - regionalization and hierarchy, decentralization and popular participation are effects of the reorientation of Brazilian health system in the 1990s.



MH integration in PHC

Among many other elements, one of the crucial reasons for the integration of MH in PHC is the huge gap in the treatment of mental disorders. It is estimated that 32.2% of schizophrenic patients, 56% of depressed and 77% of those who do harmful use of alcohol does not receive treatment⁵. WHO points to seven good reasons for integrating MH into PHC (WHO, 2008¹⁴):

- 1- The burden of mental disorders is large.
- 2- The problems of MH and physical health are interconnected.
- 3- The treatment deficit for mental disorders is huge.
- 4- Primary care for MH improves access.
- 5- Primary care for MH promotes respect for human rights.
- 6- Primary care for MH is affordable and has a good value for money.
- 7- Primary care for MH generates good health results.

The presence of patients with mental disorders in PHC is quite high in many parts of the world as well as in Brazil. A multicenter study conducted in Rio de Janeiro, Sao Paulo, Porto Alegre and Fortaleza with PHC users, found a rate of mental disorders from 51.9% to 64.3%¹⁵. There is no doubt that the training of MH interns in APS has its *raison d'être*.

The remaining complex question is to train the interns in order to recognize and treat mental disorders from the perspective of care and/or biopsychosocial care, taking advantage of the potential that PHC offers due to its insertion in the life context of patients and their families.

Challenges

The first macro challenge is the mobilization and resistance against the de-characterization of SUS, Primary Care and MH Policy.

The second is related to the teams, as several studies have shown a high rate of burnout and depression among PHC professional^{16,17}.

However, the biggest challenge of our integrated MH medical training program for FCM is posed to us when some interns ask us if the internship has MH. "Where are the 11 weeks of MH scheduled at the Internship program? Why don't we do the 11 weeks of MH at the Institute of Psychiatry?" This is a question still open and it needs to be worked out. The elements presented here make clear that the best setting for training future general practitioners in MH is PHC. The fact that this question is asked to us may mean that it is not evident for everyone. It needs to be tested and built.

Authors' contributions

Maria Tavares Cavalcanti participated in the conception and design of the work, writing of the manuscript, critical review of the content and approval of the final version of the work. Maria Kátia Gomes participated in the critical review of the content and approval of the final version of the manuscript. Lucia Maria Soares de Azevedo participated in the writing of the manuscript, critical review and approval of the final version of the paper.

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