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ORIGINAL ARTICLE

Mental health in Primary Health Care from the perspectives of users and professionals: qualitative study

HIGHLIGHTS

1. Access barriers and lack of specialists weaken care.
2. Users highlight welcoming, but recognize limitations in services.
3. Professionals report advances, but with insufficient clinical management.
4. Ongoing education and matrix support strengthen mental health.

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ABSTRACT

Objective: To discuss the perceptions, challenges, and suggestions of participants regarding access and quality of mental health care in Primary Health Care. **Method:** Qualitative study conducted between June and November 2024, with semi-structured interviews analyzed using Bardin's thematic content technique. **Results:** 47 individuals participated, including 30 users with confirmed or under investigation mental disorder and 17 Family Health Strategy professionals. The analysis revealed four themes involving care challenges, user perceptions, professional perceptions, and strengthening suggestions. **Final considerations:** The findings reinforce the centrality of Primary Health Care in mental health care and indicate the need for continuous training of teams, inclusion of mental health specialists in Basic Health Units, expansion of the service network, and strengthening of Primary Care through matrix support and multiprofessional action, to consolidate problem-solving, integrated, and humanized practices.

DESCRIPTORS: Mental Disorders; Mental Health Services; National Health Strategies; Barriers to Access of Health Services; Quality Assurance, Health Care.

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INTRODUCTION

Mental health (MH) is a fundamental human right, essential to the comprehensiveness of health and social well-being. Its access must be universal and is directly linked to the social determinants of health, aligning with the Sustainable Development Goals (SDGs), promoting equity and social justice[1].

Mental disorders are one of the leading causes of the global disease burden. In 2019, approximately 970 million people lived with some mental disorder. In 2021, over 444 million new cases were recorded, with depression and anxiety disorders representing the majority of this impact[2].

In Brazil, the Psychiatric Reform, initiated in the 1990s, replaced the hospital-centered model with territorial and community care. The creation of the Psychosocial Care Network (RAPS) and the Psychosocial Care Centers (CAPS) was an important advancement, but there are still regional inequalities, especially in the North and Northeast, and challenges related to the insufficiency of CAPS, funding issues, and failures in service coordination[3-4].

In this scenario, Primary Health Care (PHC) plays a strategic role in the Unified Health System (SUS), serving as the main entry point for care and the privileged space for early detection, prevention, and monitoring of mental disorders. Due to its reach and the bond established with the community, PHC has the potential to offer longitudinal, comprehensive, and humanized care[5-6].

Despite its centrality, mental health care in PHC remains weakened by organizational and sociocultural obstacles[7-8]. In this context, understanding the perspectives and experiences of users and professionals of the Family Health Strategy (ESF) becomes essential to identify weaknesses, point out solutions, and improve psychosocial care practices in PHC. Listening to these subjects reveals needs that are not reflected in quantitative indicators, in addition to supporting the construction of more effective, humanized, and culturally sensitive services.

In light of this, this study aims to discuss participants' perceptions, challenges, and suggestions regarding access and quality of mental health care in Primary Health Care.

METHOD

This is a descriptive and exploratory study, with a qualitative approach, conducted according to the *Consolidated Criteria for Reporting Qualitative Research* (COREQ)[9] criteria to report the methodology.

The interviews were conducted by a nurse specialized in mental health and family health, a second-year resident of the Multiprofessional Residency in Family Health at a state university in northeastern Brazil. The interviewer received remote guidance from three faculty members: one PhD, one master's degree holder, and one master's student. She had no prior connection with the participants and presented the study's objectives before starting each interview, which facilitated the establishment of *rapport*. It is recognized that her training in mental health and family health could influence the conduct of data collection; however, the continuous supervision of the faculty team aimed to minimize interpretative biases.

The study was conducted in the municipality of Caxias, located in the eastern region of Maranhão, with an area of 5,201.93 km². The setting was a planned Basic Health Unit (UBS) in the urban area, which, during the data collection period, had a single ESF team responsible for 2,502 people, distributed among 937 registered families, according to data from the Electronic Citizen Record (PEC).

The sample was selected for convenience and included users and professionals from the only ESF team linked to the studied UBS. Users aged 18 years or older, registered in the Family Health Strategy (ESF), with a confirmed diagnosis or under investigation for mental disorder and preserved cognitive capacity, assessed by the Mini Mental State Examination (MMSE)[10], were included.

Among the professionals, those linked to the team for at least one year and with direct care involvement were included, regardless of their category. Only professionals who were away from service during the data collection period (due to medical leave, vacation, or other reasons) were excluded.

The information was collected through individual and in-person interviews, conducted at the UBS during its operating hours and during home visits, from June to November 2024, until theoretical saturation of the data was reached, understood as the point at which new statements ceased to add relevant elements to the research objectives[11].

Two distinct instruments were used: one directed at users and another at health professionals, both structured in three parts. The first part included sociodemographic data; the second included aspects related to mental health, and in the case of professionals, information about training and professional practice; and the third gathered open-ended questions about the challenges faced and perspectives on mental health care in primary health care (PHC).

Before the final application, a pre-test of both instruments was conducted with participants who were not part of the final sample, which allowed for the verification of the clarity, relevance, and appropriateness of the questions.

The sociodemographic, professional, and mental health-related data of the users were organized into spreadsheets and text documents. The interviews were fully transcribed and analyzed according to the technique of Thematic Content Analysis, proposed by Bardin, following the stages of pre-analysis, coding, grouping codes into subcategories, organizing into categories, and finally, inference, description, and detailed interpretation of the content[12].

After comprehensive and exhaustive reading, the categorization of statements and the preparation of an interpretative synthesis were carried out, presented in the form of analytical writing and charts, in order to establish a dialogue between the empirical material and the research objectives.

All participants signed the Informed Consent Form (ICF). To ensure anonymity, each interview received an alphanumeric code, without nominal identification. The interviews were recorded digitally, with prior authorization, and subsequently fully transcribed, resulting in a *corpus* for analysis[11].

The research was approved by the Research Ethics Committee (CEP) of a state university in Northeast Brazil, under Approval Opinion No. 6,748,320, in accordance with Resolution No. 466, of December 12, 2012, and Resolution No. 510, of April 7, 2016, both from the National Health Council.

RESULTS

A total of 47 people (63.8%) participated in the study, including 30 users of the ESF with diagnoses of mental disorders and 17 health professionals from the same team (36.2%).

Among the users, the majority were female (80%), aged between 18 and 75 years. The most prevalent diagnoses were anxiety disorders (50%) and anxiety associated with depression (26.7%), followed by combined cases of anxiety, depression, and panic syndrome (6.7%), isolated depression (6.7%), bipolar disorder associated with depression (3.3%), anxiety with panic syndrome (3.3%), and attention deficit hyperactivity disorder (3.3%).

Among the professionals, the majority were female (76.5%), aged between 27 and 62 years. Regarding education, 52.9% had completed higher education, 5.9% had incomplete higher education, and 41.2% had completed high school. The duration of practice varied from 5 to 43 years, with 35.3% having between 5 and 10 years of experience, 17.6% between 11 and 16 years, 41.2% between 17 and 22 years, and 5.9% having more than 40 years of practice. Everyone worked 40 hours a week and had participated in training in mental health in the two previous years.

The analysis of the interviews allowed for the identification of four thematic categories and 22 subcategories, reflecting the main challenges, perceptions, and suggestions of users and professionals regarding mental health care in primary health care.

Regarding the challenges faced by primary health care, the speeches highlighted access barriers, a shortage of specialized professionals, fragmentation of care, increased demand, and difficulties in managing users in psychological distress. These findings demonstrate structural and organizational limitations that compromise the comprehensiveness of care. Chart 1 presents the thematic categories and their respective subcategories.

Regarding user perspectives, satisfaction with the service and the perception of welcome stood out, although there were reported needs for improvements and expectations regarding the incorporation of specific instruments in mental health.

From the perspective of health professionals, perceptions of service limitations were observed, as well as reports of progress. The need for greater qualification, matrix support, and family support for the public in psychological distress also emerged.

Finally, regarding suggestions for strengthening mental health in primary health care, participants emphasized the importance of having specialized professionals in each health unit, offering training, adequate infrastructure, intersectoral partnerships, and management support. They also highlighted the relevance of popular education, operational groups, and continuity of care. Chart 2 illustrates these perceptions through representative statements.

Chart 1. Thematic categories and subcategories identified from the thematic content analysis. Maranhão, Brazil, 2025

Thematic Category	Subcategory	n*
Challenges of Primary Health Care in mental health demands	Difficulty in access	105
	Shortage of specialized and qualified professionals	9
	Fragmentation of care	17
	Increased demand	34
	Difficulty in managing users in mental distress	6
User perspectives on mental health services	Satisfaction with the service	14
	Perception of welcome	32
	Need for improvement in the service	10
	Positive expectations about the use of instruments in mental health	58
Health professionals' perspectives on mental health services	Perception of service limitation	3
	Feeling of progress	5
	Need for professional qualification and matrix support	18
	Lack of family support for those in psychological distress	22
Suggestions for strengthening mental health in primary care	Mental health professional in each UBS	233
	Professional qualification and commitment	12
	Adequate infrastructure	6
	Use of clinical instruments in mental health	58
	Intersectoral partnerships	4
	Support from management	6
	Operational groups	5
	Popular Education in Health	5
	Continuity of care	41

Legend: *The frequencies presented (n) correspond to the approximate number of statements in which expressions or terms related to each subcategory emerged, according to the thematic content analysis[12]. The count was based on the recurrence of keywords present in the interviews (professionals and users). These values should not be interpreted as absolute statistics, but as indicators of the intensity and relevance of the identified themes, highlighting which subcategories appeared most frequently in the analyzed *corpus*.
Source: The authors (2025).

Chart 2. Thematic categories and illustrative statements according to the analysis of the discourses. Maranhão, Brazil, 2025

(continue)

Thematic category	Illustrative discourse
Challenges of primary health care in mental health demands	**Users:**
	"It took too long... almost a year passed."
	"They referred me from one place to another... then I didn't go anymore."
	Professionals:
	"There are few psychologists in the network, psychiatrists."
	"It's difficult to deal with a mental health patient."
	"There is a high demand, especially after COVID-19."
	"Lack of qualified professionals to work in this area."
	"Planning."

Chart 2. Thematic categories and illustrative statements according to the analysis of the discourses. Maranhão, Brazil, 2025

(conclusion)

Thematic category	Illustrative discourse
User perspectives on mental health services	**Users:**
	"I am very well received."
	"Weak, because we needed professionals at the UBS in our neighborhood and we didn't have any."
	"It would be good to have a manual with step-by-step instructions."
	"It was great, in my case it was, they attended to me very well."
Health professionals' perspectives on mental health services	**Professionals:**
	"We do our best... it's not enough."
	"It's still broken... the patient is still very loose."
	"I think it has improved a bit."
	"Today, I no longer see that challenge after the training we had."
	"Welcoming is what we have best here at the clinic."
Suggestions for strengthening mental health in primary care	**Users:**
	"Each clinic should have its own specialist."
	"The executive, along with the health department, should provide complete technical support."
	"We need to raise awareness among the population."
	Professionals:
	"Training, the use of instruments, and a fixed professional within the UBS are fundamental."
	"There needs to be commitment from professionals and management [...]."
	"Operational groups and therapeutic follow-up are important."
	"It was if there really was, if there was really a psychiatrist, a psychologist here at the UBS."

Source: The authors (2025).

DISCUSSION

The results of this study indicate that psychosocial care in PHC faces structural and organizational barriers, such as the shortage of specialized professionals and the difficulty of coordination between ESF teams and other RAPS services. These weaknesses compromise the continuity of care and the effectiveness of psychosocial care in PHC units[13].

In low- and middle-income countries, the literature on mental health points to similar scenarios, with a shortage of specialized professionals, low training of primary care teams, and the persistence of social stigma. This situation reflects the difficulties encountered in Brazilian basic units, highlighting broader dilemmas common to universal systems that seek to consolidate mental health as a priority[14].

In this study, users highlighted the delay in scheduling specialized consultations and the discontinuity of follow-up. Professionals reported insecurity in clinical management and overload in the face of increasing demand. National literature corroborates these findings by evidencing levels of dissatisfaction and overload among mental health

workers, associated with structural and organizational weaknesses of the RAPS, which compromise the quality of care provided[15].

These results align with the reality of other universal health systems, where, despite the presence of psychologists and multiprofessional teams in primary care, structural challenges persist, such as the high volume of demands and the need to reorganize care flows. The analyzed literature indicates that such barriers, by impacting the satisfaction and overload of workers, reveal a pattern that transcends local contexts and reflects common dilemmas in consolidating mental health as a priority in public systems[16].

Another relevant aspect was the predominance of a biomedical care model, which results in early referrals to specialized services and reduces the problem-solving autonomy of primary care. International studies describe the over-medicalization of mental health symptoms in primary care as a barrier to comprehensiveness. Patients reported quick prescriptions, with no space for psychosocial practices, fear of losing control over treatment, and reinforcement of the stigma associated with medications. These findings reinforce that the low incorporation of psychosocial approaches compromises the quality of care and highlights the need for integrated strategies in primary care[17].

In contrast, international recommendations from the World Health Organization (WHO) and the Pan American Health Organization (PAHO) guide the progressive replacement of hospital- or medication-centered models with community, territorial, and multiprofessional strategies. In this context, the *Mental Health Gap Action Programme* (mhGAP), updated in 2023 by WHO, has established itself as a reference in low- and middle-income countries, training non-specialized teams in the management of common mental disorders and expanding access through psychological interventions, including digital ones, which contributes to reducing inequalities[18]. The comparison highlights that the reality of this study, although localized, reflects the gap between international guidelines and everyday practice in Brazilian primary care.

Despite structural limitations, users highlighted the welcoming and qualified listening as positive aspects of care. This recognition reinforces the value of so-called light technologies, which favor the creation of therapeutic bonds and strengthen trust in the service. Both nationally and internationally, literature has highlighted welcoming and other humanization practices as central to strengthening primary care in mental health. These devices allow for closer relationships between professionals and users, favor trust bonds, and ensure qualified listening, which humanizes care, even in contexts of resource scarcity[19].

Evidence shows that relational and community practices contribute to treatment adherence, reduce social stigma, and enhance the effectiveness of psychosocial care, especially in vulnerable populations[20]. Brazilian legislation reaffirms this principle by introducing the concept of humanized care in the SUS, according to Law No. 15,126, of April 28, 2025, which amends Law No. 8,080, of September 19, 1990, making the humanization of care a central principle in health policies[21].

The professionals reported perceptions of progress after participating in local training, mentioning greater confidence in the clinical management of cases. This finding highlights that ongoing education plays a central role in qualifying primary health care, by increasing workers' confidence and reducing exclusive dependence on referrals to specialized services.

In this context, the implementation of continuous professional development programs, such as ongoing education, has shown positive impacts on the performance

of health professionals and patient outcomes. Multicomponent programs and the use of educational technologies are identified as effective in improving clinical performance and the quality of care[22]. Moreover, ongoing education has been considered essential for transforming care practices, favoring continuous learning and meeting local needs, especially in primary health care[23].

Another point highlighted by professionals was the need for greater matrix support to qualify care in mental health. This finding underscores the importance of matrix support to enhance the problem-solving capacity of primary health care, as well as to promote collaborative and multiprofessional practices, fostering shared responsibility for care.

The implementation of matrix support contributes to this logic of shared care, facilitating the articulation between primary health care services and CAPS, being fundamental to integrate health services and promote continuity of psychosocial care. This intervention model reinforces the need for matrix support to be incorporated as a structuring public policy, with stable funding and well-defined protocols, avoiding that its execution depends exclusively on local initiatives or specific projects[24]. Additionally, the articulation between mental health services and primary health care, promoted by matrix support, can strengthen the integration between services and favor collaborative practices, such as active listening and sharing of care[25].

Users and professionals highlighted the need to have specialists in mental health, such as psychologists, psychiatrists, and occupational therapists, who work directly in primary health care units. This demand highlights the importance of Multiprofessional Teams (E-Multi) in overcoming the traditional model centered on the doctor and nurse.

Although the National Primary Care Policy (PNAB), established by Ordinance No. 2,436, of September 21, 2017, advocates a model based on multiprofessional teams, focusing on training primary health care teams to provide comprehensive care, without the need for permanent specialists in primary health care units, the presence of these specialists could represent an important advance in the qualification of psychosocial care[26]. Law No. 10,216, of April 6, 2001 (Psychiatric Reform Law), and Ordinance No. 3,088, of December 23, 2011, which regulates RAPS, advocate for the decentralization of care in mental health, with primary health care functioning as the entry point and matrix support for the qualification of teams. The presence of specialists occurs through technical support and training, and not necessarily through direct action in primary health care units[27-28].

Thus, although the current model is based on the PNAB and RAPS and on strengthening family health teams through matrix support, it would be valuable for the presence of specialists to be more integrated into primary health care, expanding service capacity and qualifying psychosocial care.

Consequently, although the primary health care unit is planned, the deficiency in the full implementation of planning still results in limitations in care. Planning involves the integrated organization of health services, focusing on the coordination of flows, allocation of resources, and continuous training of teams[29]. However, even with the planning of the primary health care unit, professionals attributed difficulties in managing mental health to other factors, such as the lack of adequate resources and the scarcity of specialization. This highlights that ongoing education is vital for improving the quality of the service provided, allowing primary health care professionals to effectively perform comprehensive and continuous care.

In this way, the inclusion of specialists, as previously argued, could strengthen care, but continuous training and the strengthening of multiprofessional teams are essential to ensure that all professionals can act resolutely, regardless of the constant presence of specialists.

The findings of this study reveal that the limits observed in primary health care are not restricted to the local scenario, but reflect structural gaps in the Brazilian health system. The absence of specialists in primary health units, the fragility of matrix support, and the lack of systematic continuing education programs demonstrate that mental health still does not occupy a priority position on management agendas.

Recent reports from the WHO and PAHO emphasize that investing in the integration of mental health into primary health care is a strategic and cost-effective measure, capable of increasing access, reducing inequalities, and avoiding unnecessary hospitalizations[30]. To this end, it is essential to adopt public policies that ensure: (i) the mandatory inclusion of mental health professionals in primary health care teams; (ii) stable funding for matrix support; (iii) the creation of national continuing education programs; and (iv) the strengthening of multiprofessional teams as the central core of the psychosocial care network.

The limitations of this study are inherent to its qualitative nature, marked by being conducted in a single primary health unit and by convenience sampling, which limits the extrapolation of the findings. Nevertheless, the methodological rigor adopted, with systematic application of content analysis and supervision of the investigative process, provided consistency to the interpretations and contributed to the robustness of the conclusions.

FINAL CONSIDERATIONS

The results demonstrated that psychosocial care in primary health care is compromised by structural and care-related barriers, expressed in access difficulties, the scarcity of specialized professionals, fragmentation of care, and limitations in the clinical management of cases. However, positive aspects emerged, such as the welcoming and the perception of progress, which reaffirm the strategic potential of primary health care in mental health care.

In light of these findings, it becomes essential to invest in the continuing training of teams, ensure the inclusion of mental health specialists in primary health units, expand and articulate the network of services, and strengthen primary health care through matrix support and multiprofessional action. Thus, pathways can be consolidated for the construction of more resolutive, integrated, and humanized practices, aligned with the needs of users and the guidelines of the Unified Health System.

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Substantial contributions to the conception or design of the work; or the acquisition, analysis, or interpretation of data for the work - **Costa FSVM, Oliveira ANA, de Sousa Neto AR, Lima GTB, da Silva GRB, de Almeida LM, Almeida RN.** Drafting the work or revising it critically for important intellectual content - **Costa FSVM, Oliveira ANA, de Sousa Neto AR, da Silva GRB, Almeida RN.** Agreement to be accountable for all aspects of the work in ensuring that questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved - **Costa FSVM, Oliveira ANA, de Sousa Neto AR, da Silva GRB, Almeida RN.** All authors approved the final version of the text.

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