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Experience Report

The practice of the psychologist in the Health Family Support Nucleus: an experience in a multiprofessional residency program

Atuação do psicólogo no Núcleo de Apoio a Saúde da Família: uma experiência em um programa de residência multiprofissional

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ABSTRACT | INTRODUCTION: The residency is a post-graduate modality characterized by in-service training based on learning by daily practice. Multiprofessional residency programs aim to train professionals for qualified exercise in Primary Health Care, the main gateway to the Unified Health System (SUS), through active methodologies, teamwork, and humanized care. **OBJECTIVE:** To report the experience and the insertion of the psychologist, as a resident, in a multi-professional residency program in Family Health. **METHOD:** The experience report of a psychology professional was carried out as a resident of the Family Health Residency Program. The present experience took place between March 2018 and March 2020, and the following activities were described: (a) matrix support, (b) Psychological care attendance, (c) groups, (d) health education, (e) consultations, and (f) home visits. **RESULTS:** It can be said that the process of training public health professionals is a challenge for managers, educators, and workers involved in this process. Difficulties regarding the simultaneous stimulation of professional, interpersonal, and humanistic skills, as well as a critical sense of social responsibility, are common. Even so, the proposal for residency programs is a significant opportunity for learning and contact with other health areas. **CONCLUSION:** Several limitations could be identified during the daily activities of the residence, such as the lack of knowledge of professionals about the family health strategy and the role of the multi-professional residence in the health service.

KEYWORDS: Non-medical internship. Psychology. Primary Health Care. Multiprofessional team. In-Service Training.

RESUMO | INTRODUÇÃO: A residência é uma modalidade de pós-graduação que se caracteriza pelo treinamento em serviço, tendo como base a aprendizagem pela prática cotidiana. Programas de residência multiprofissional objetivam capacitar profissionais para o exercício qualificado na Atenção Básica de Saúde, a porta de entrada principal do Sistema Único de Saúde (SUS), por meio de metodologias ativas, trabalho em equipe e cuidado humanizado. **OBJETIVO:** Relatar a experiência e a inserção do psicólogo, enquanto residente, em um programa de residência multiprofissional em Saúde da Família. **MÉTODO:** Foi realizado o relato de experiência de uma profissional da psicologia enquanto residente do Programa de Residência em Saúde da Família. A presente experiência ocorreu entre março de 2018 e março de 2020 e as seguintes atividades foram descritas: (a) matriciamento, (b) acolhimentos e atendimento individuais, (c) realização de grupos, (d) educação em saúde, (e) consultas compartilhadas e (f) visitas domiciliares. **RESULTADOS:** Pode-se afirmar que o processo de formação de profissionais em saúde pública constitui um desafio a gestores, educadores e trabalhadores envolvidos neste processo. Dificuldades em relação ao estímulo simultâneo de habilidades profissionais, interpessoais e humanísticas, bem como senso crítico sobre responsabilidade social são comuns. Ainda assim, a proposta de programas residência é uma oportunidade significativa de aprendizado e contato com outras áreas de saúde. **CONCLUSÃO:** Diversas limitações puderam ser identificadas ao longo das atividades cotidianas da residência, tal como falta de conhecimento dos profissionais sobre a estratégia de saúde da família e o papel da residência multiprofissional no serviço de saúde.

PALAVRAS-CHAVE: Internato não Médico. Psicologia. Atenção Primária em Saúde. Equipe Multiprofissional. Capacitação em Serviço.

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The Health Family Program (PSF) emerged in December of 1993 as a proposal to restructure the public health system, organize primary health care, and replace the traditional health model, which had been applied in Brazil until that moment. According to Rosa and Labate (2005), the PSF is characterized as a proposal of reorientation of the healthcare model and the practice of workforce focusing on primary health care, aligned to the principles established by the Brazilian Unified Health System (SUS). From 2006 onwards, the PSF has become the permanent healthcare strategy in primary health care, and due to the need to continue the proposal, it has been denominated as Health Family Strategy (ESF; Dalpiaz & Stedile, 2011).

In Brazil, primary health care is known as the gateway of patients to the SUS. It is characterized by decentralization, which is the preferable patient's contact, the main gateway to, and communication hub to all healthcare networks. According to Cezar et al. (2015), primary healthcare is characterized by individual and collective actions, encompassing actions focusing on promotion, protection, prevention, rehabilitation, diagnosis, treatment, and health maintenance. The primary healthcare origin goes back to the management public health models, which aimed to replace the hegemonic model until that moment, focused on both hospital and disease perspectives. Moreover, the current model is corroborated by the Alma-Ata Declaration guidelines, an essential and priority strategy to intervene, justified by appropriated and cost-effective technologies (CNRMS, 2012, 16 of April).

Primary healthcare predicts universality, accessibility, link, continuity of the healthcare, integrality, responsibility, humanization, equity, and social participation, which are important axis in the healthcare system (Ministério da Saúde, 2007). Thus, primary healthcare could be understood as a way to beat all limitations associated with a fragmented self-view and the construction of a new non-reductionist model to healthcare. From this perspective, it is important to take into consideration what is necessary to put this into practice in an effective way. The National Policies of Primary Healthcare (PNAB) choose family health as a priority strategy to organize the healthcare, which goes back to 1991 the implementation of Health Community. According to the PNAB (Ministério da Saúde, 1991), the ESF aims to reorganize the primary healthcare countrywide, expanding, qualifying, and consolidating the primary healthcare. It also supports a reorientation in the healthcare process, improving the principles, fundamentals, and main guidelines of primary healthcare. Moreover, the ESF objectives to enlarge the resoluteness and the main impact of healthcare in both individual and collective perspectives, as well as provide an important cost-effectiveness relation.

The fundamentals and guidelines of the primary healthcare point the necessity of an attached territory, to allow the planning, decentralization and development of sectoral and intersectoral actions, (b) allow universal and continuous access to the healthcare services, receiving patients to the system and promoting connection and co-responsibility in the healthcare needs, (c) identify all patients and establish connection and responsibility relations between healthcare teams and the population, ensuring the continuity of healthcare actions and the longitudinality of the healthcare, (d) coordinate the health integrality in its aspects, and (e) stimulate the patients' participation as a way to improve their autonomy and capacity in their own health care as well as their families and community, in the cope of health determinants and its relations, in the organization and orientation of healthcare services focusing on patients and their role in the social control (Dalpiaz & Stedile, 2011; Ministério da Saúde, 2017).

Within primary healthcare, there is a structure called Health Family and Primary Health Care Support Nucleus (Nasf-AB), a strategic apparatus to improve the overall quality of the primary healthcare system, expanding actions conducted through a better way to enlarge the capacity to solve problems related to healthcare within healthcare teams. According to the PNAB (Ministério da Saúde, 2017), the Nasf-AB is characterized as a multi-professional team composed of healthcare professionals from different fields of knowledge and complementary to those teams who work in primary healthcare and needs to working in an integrative way and supporting the family healthcare teams. Moreover, those teams must share and support their healthcare practices in the territory under their responsibilities, seeking to contribute to the resolution of clinical and public health problems, adding strategies to enlarge healthcare options, and ensuring healthcare longitudinality within the territory. The family healthcare team is guided by the theoretical-methodological base of matrix support (Chiaverini, 2011; Iglesias & Avellar, 2019), which seeks

to enlarge the range of healthcare actions as well as help to others connect with other healthcare services in the healthcare network, ensuring the continuity of the patient's healthcare. The ESF and the Nasf-AB use different strategies and techniques in their daily practice, such as singular therapeutic project (PTS), Health in School Program (PSE), home visits, group interventions (Dalpiaz & Stedile, 2011; Ministério da Saúde, 2017).

The multi-professional residency as a new proposal of paradigm for the education of healthcare professionals

Non-medical residency programs are a modality of graduate courses (also called lato-sensu specialization course in Brazil) with service training in which residents can improve their abilities and skills and get a specialization degree in their professional field of qualification. They are directed to healthcare professionals, except medical professionals, such as those professionals who graduated in biomedicine, biological sciences, physical education, nursing, pharmacy, speech therapy, veterinary medicine, nutrition, odontology, psychology, social work, and occupational therapy (Brasil, 2012). Those multi-professional residency programs aim to contribute to the qualification of healthcare professionals in an integral and interdisciplinary way, regarding to community health needs, as well as to break up with traditional paradigms associated with the education of the SUS (CNRMS, 2012, 16 of April).

Multiprofessional residency programs in health (RMS) are seen in Brazil as a new strategy to implement innovative public policies. They have as their main aim the proposition of health actions focused on humanized health assistance, and effective implementation of the health system according to their principles and guidelines. Beyond that, they also aim to break up with traditional paradigms associated with education for the health system and contribute to qualifying the health assistance through integrality in the actions and interdisciplinary activity. Although the residency programs present differences in their methodological designs, they also have in common the focus on active and participative teaching and learning methodologies as well as the continuing education of both residents and healthcare professionals throughout the whole professional qualification process (Rosa, & Lopes, 2009; Silva, 2018).

Regarding the professional qualification process for the SUS, the RMS creates an innovative action according to the logic from medical residency programs, which are historically linked to medical specialization or uniprofessional residency programs without a collective or multi-professional discussion (Silva, 2018). An interdisciplinary qualification is a way of professional qualification, which shares knowledge but keeps the particularity of each professional field of knowledge as well as the socialization of knowledge and speeches throughout the qualification process and health work (Monteiro et al., 2019; Silva, 2018).

In 2005, the RMS had been legally established as a modality of qualification for the SUS in which was also established by the Brazilian National Commission of Multiprofessional Residency Programs in Health (CNRMS). In that year, there were about 22 RMS, and in 2016, according to the CNRMS office, about 1,500 uniprofessisonal and multi-professional residency programs were registered to be assessed. In 2010, the Ministry of Education started to contribute to the maintenance of multi-professional residency scholarships. According to its reports, in that year, there were paid 414 scholarships, whereas in 2019 there were 3,326 scholarships (Monteiro, 2019).

Guido et al. (2012) describe the residency program as a professional qualification process in health with innovative actions, in comparison with traditional learning and teaching process and service training in both graduate and undergraduate courses. However, they also highlighted that some points need to be evaluated as stressors in the whole process, in particular, because they do not apply to the current teaching model. Among those stressors, the most common are teamwork and activity, activities with the active participation of the resident such as forums and discussion groups, interpersonal relationships with professionals from other fields of study, the responsibility to apply integral and humanized care, excessive administrative work, excessive assistance and work throughout the professional qualification process, problems associated to the quality of both teach process and educational settings. The outcomes of their study showed that multi-professional residents present feelings of low efficiency and productivity at work, i.e., the questioning of professionals about their professional choice, doubting about their ability to work, and felling both professional and personal unqualified for the position.

Psychology as a field of action in public health

Initially, psychology was been included in the minimum team in the ESF. Although psychology had been included in primary health care since the 1980s, effective change has been observed only from 2000 onwards. According to Cordeiro et al. (2017), the insertion of psychologists in the SUS occurred in 2004 by interministerial ordinances which encourage matrix support in primary healthcare. Even with those legal statements, there were only a few changes and effective inclusion of psychologists in primary healthcare teams only started in 2008 (Jimenez, 2011, Lima, 2005). Those inclusions occurred due to the expressive increase of demand for mental health services in primary health care (Campos & Domitti, 2007). According to Dimenstein and Macedo (2012), and Cezar et al. (2015), practices from psychology demonstrated a series of fragilities in the work of the psychologist in the primary health care setting. Among those fragilities, the most prominent the maintenance of a model focused on individual psychotherapy, difficulties to execute contextualized activities, and teamwork. In those settings, the work of the psychologist is more important. However, there is a lack of discussion about the insertion of the psychologists in either the ESF or in multi-professional residency programs. Considering the prevalence of mental illness in the general population, the principles of primary healthcare, the primary healthcare as the gateway to access the whole healthcare network, as well as the importance of psychologists and their role in the ESF, the current article aims to report the experience and the insertion of the psychologist, as a resident, in a family health multi-professional residency program.

Methodology

The present report is about the experience of one of the psychologist residents in the Family Health Multi-professional Residency Program, managed by the Federal University of Latin America Integration (UNILA) in partnership with the Municipal Secretary of Health of the Municipality of Foz do Iguaçu. Because it is an experience report, it is characterized by the description of a professional experience considered successful (or not) inside a particular context, contributing to either the professional performance of future professionals in similar situations or the improvement of the healthcare service provided by the healthcare team and the residency program. Moreover, it is important to highlight that, due to the nature of the work, it is not possible to replicate the study because it describes facts and reflects situations from a determined period. The present experience occurred from March 2018 to March 2020 and described the following activities: (a) matrix support, (b) welcoming and individual care, (c) holding groups, (d) health education, (e) consultations, and (f) home visits. Because it is an experience report, the present study was not submitted to the Human Ethics Committee. However, all ethical procedures, such as secrecy and confidentiality were followed during the writing process. Finally, it is important to point that due to the innovative aspect of the present article, the present experience report will be able to contribute to future psychology residents in non-medical residency programs as well as in the formulation of new strategies in the ESF.

Results and discussion

Psychology as a field of action in public health

A general vision of the family health multi-professional residency program at UNILA and the professional performance of the psychology in this setting

The family health multi-professional residency program at UNILA is relatively new and started its activities in March 2017, with the following undergraduate professional: nursery, physiotherapy, nutrition, odontology, public health, and psychology. In general, the residency program aims to qualify professionals with knowledge, abilities, and attitudes to work in the ESF and Nasf-AB, providing healthcare throughout the life cycle and considering the local strategic plan, the work process organization in teams, and interprofessional and interpersonal approaches in health. Moreover, there is a special interest in the border situation and its peculiarities because the municipality of Foz do Iguacu is located in a triple border area with Argentina and Paraguay (UNILA, 2016).

The Political-Pedagogic Project (PPC) of the family health multi-professional residency program of UNILA proposes as an egress profile a professional with an expanded conception of his role in primary healthcare, with active capacity, co-responsibility as well as the critical-reflexive view. This profile predicts that egresses professionals demonstrate commitment with practices directed totally to SUS principles, following social, epidemiological, and public health needs of the border area population. The residency program also proposes a critical and transforming professional qualification to work in the ESF, according to each area's needs. Finally, the residency program proposes that the residents would be able to motivate by the permanent education, capacity of teamwork spontaneously and rationally, with quality and resoluteness according to each professional background (UNILA, 2016).

There is also a section in the PPC in which the egress profile is described according to its professional background. In the specific situation of the psychology, it is required that the professional would be able to develop all actions included in the Nasf-AB competency, as well as provide matrix support to healthcare teams and act accordingly to community needs, following the whole practices and current guidelines. Similar descriptions were highlighted by Queiroz (2019), who researched the insertion of egress psychologists from Brazilian multi-professional residency programs. However, according to Cezar et al. (2015), thus there is a small insertion of those professionals and in most of the cases, they were restricted to an individual and clinical model without any contextualization to social determinants of health, as well as the ability to develop activities in groups and teams.

One of the activities described as part of the psychology egress profile is matrix support. According to the Ministry of Health (MS; Chiaverini, 2011; Ministério da Saúde, 2014), the matrix support could be understood as an organizational arrangement to concede pedagogical and technical support in some fields of knowledge to those healthcare teams who are working with primary health care in the territory. According to the Guidelines number 39 of the Primary Health Care, from the Ministry of Health, actions from the Nasf-AB need to be oriented by the matrix support. The same guidelines also provide several resources to allow the implementation of this support, such as periodical matrix support team meetings, case studies, home assistance, group, and collective activities, and specific individual assistance (Ministério da Saúde, 2014). From a psychological perspective, the matrix support could be understood as an excellent resource to help the insertion of the psychologist, in particular in those actions of mental health. On the other hand, the matrix support could be seen as a resource to develop actions in mental health patients in communities, throughout the territory where they live. Those activities could be conducted through productive, systematic, and interactive meetings between primary healthcare teams and mental health teams of the health network (Campos, 1999; Chiaverini, 2011; Iglesias & Avellar, 2019).

Although it is also expected among attributions and responsibility of psychologists within Nasf-AB, according to recommendations and guidelines, it is one of the underdeveloped actions among the psychologist's activities in this setting. Only a few support matrix activities had been developed in the primary healthcare in Foz do Iguacu as a whole during the period of the residency and, in particular, including both psychology and mental health fields. It could be concluded because there were no regular meetings among professionals of the healthcare network of Foz do Iguacu, regardless of the field of action. On the other hand, both team and workers' health meetings were used as a setting to discuss topics associated with mental health, such as workflow of possible activities which could be developed, if necessary. Frequently there were discussions and disagreements among different professionals of the healthcare team about matrix support and how it could be applied, which showed the need for a greater exploration of this field of study, not only from a psychology perspective but also from different professionals' view.

Another regular activity from NASF psychologists was psychological care attendance, a modality of brief care requested in emerging and urgent conflictive situations, with a transient relief of symptoms and feelings, as well as individual psychotherapy (Furigo et al., 2008; Sonneborn & Weba, 2013). Those activities filled most of the psychologist and psychologist residents' scheduled activities since there was a waiting list for patients from the community who looked for psychological support. Additionally,

some patients were referred from physicians and other professionals from the primary healthcare center and healthcare reference teams. The clinical practice was characterized as the most common activity conducted by psychologists in the public health center, according to their daily experience and professionals report during meetings with healthcare professionals from the whole municipality of Foz do Iguaçu. Similar outcomes were identified in the literature, as described by Cezar et al. (2015).

The psychological care attendance method, implemented by the Nasf-AB team, in which the first author was resident, comprised scheduling individual appointments from the waiting list available at the primary healthcare center, medical referral, or spontaneous demand. According to general guidelines of those psychological care attendances, each patient may have up to five individual appointments, which aim to assess the major complaint and possible brief interventions and, if necessary, referral to other mental health services. Priority patients for those attendances were pregnant, elderly people, complaints related to grief and loss, and suicide risk. In practice, even with general guidelines, most of the patients were attended longer than five appointments and were incorporated into the routine of the regular individual psychotherapy. In some moments, psychological care attendance was conducted emergency, i.e., other professionals from the primary healthcare center and healthcare reference teams contacted one psychologist who were at the primary healthcare center to conduct the first approach for complaints reported during medical appointments. In those situations, either the psychologist or the resident conducted an immediate and brief attendance, even another activity was scheduled at the same time.

Still talking about individual psychotherapy and psychological care attendance, the most common patients' complaints were psychiatric issues, such as both depressive and anxious disorders, as well as a high frequency of suicide attempts and ideation. The major limitation of this therapeutic approach is the low coverage because there was a long waiting list for individual appointments, making it unfeasible to follow general guidelines for this sort of approach. Because of the large number of patients who looked for individual healthcare appointments, most of the patients reported that during the telephonic contact they either solver or looked for another option to deal with their complaints. Among those who did not find alternatives, the major complaint and symptoms got worse. Finally, the high demand complicated the inclusion of activities focused on prevention and promotion of health, which would be the principal focus of primary healthcare.

Another activity conducted during the period of the residency was operative groups with patients from the primary healthcare who were followed by the ESF in the territory. In general, operative groups are characterized by the possibility to elaborate the knowledge and integration, in which the learning process occurs through a continuous process of communication and interaction (Bastos, 2010). Those groups were punctual and led by professionals other than psychologists, with their participation. Among operative groups developed and conducted, one of them was the "Lighter life" idealized and led by the nutritionist in which all participants had complaints related to diet and weight loss. The main objective was to promote better and healthier diet habits and weight loss. The groups were planned to be conducted through eight weeks, with a specific topic for each encounter. In the encounter in which the psychologist participated, the following topics were discussed: anxiety, depression, emotions and feelings, and their relationship with eating behavior. In those encounters, there was low adherence from the participants, even with participants' interest in the topic and the content. In summary, due to the conditions, it was not possible to reach the knowledge. Some additional interventions were thought and planned, such as specific and focused interventions, but they were not developed because of operational difficulties and activities demands.

A second activity proposed activity was the planning and implementation of smoking cessation therapeutic groups, which were organized with specific topics and several sessions based on protocols and guidelines proposed by the National Program of Smoking Cessation of the Brazilian Ministry of Health. For those groups, there was the rotative participation of different professionals who worked at Nasf-AB, according to their role in the program. A third group focused on workers' health was conducted weekly with workers from the primary healthcare center where the resident worked. In general, all sessions were split into two moments: a first one focused on work activities and a second moment as a discussion group focused on topics of interest of the participants, led by the psychologist and the resident.

Health education activities frequently occurred in the community where the resident worked, which were characterized by interventions with the community population aiming to generate reflection and promote knowledge about disease prevention and health promotion. One intervention was the implementation of the Health in School Program, an intersectoral policy developed by both the Ministry of Health and the Ministry of Education in December 2007, which aimed to improve disease prevention and health promotion to provide healthy development in children and adolescents by the integration between health and education (Farias et al. 2016).

In the specific situation of Foz do Iguacu, the municipal management has one staff member who handles the program coordination and articulates different professionals to take part in it. During the first year of the residency, there was greater involvement of the psychology residents in all steps of the program, from its planning process to the evaluation, including demand survey, topic, and intervention design and implementation. Following both PPC and ESF guidelines, those actions were developed interdisciplinary, evolving not only psychology residents but also other residents and healthcare professionals, such as physiotherapists, nutritionists, and nurses (UNILA, 2016). The actions approached topics related to sexuality with students from fourth and fifth grade from an elementary school from the same territory where the resident worked during the residency program, and other territories, according to their specific demands. There were from two to four encounters with each school class, in which participated approximately 30 students.

The expected outcomes for the Health in School Program could be considered in the medium and long term, in particular, because some topics included in the intervention are related to specific behaviors and attitudes. However, some outcomes were observed immediately after the intervention was conducted, through teachers' and education professionals' reports of behavior at school. Some topics discussed emerged during regular classes and other important moments at school. Moreover, it was clear that a greater comprehension and interest of students about topics discussed between encounters.

Regarding limitations, there was a shortage of time to implement a larger number of interventions, and the impossibility to start them precociously. Another important limitation was related to the comprehension and parents' adherence to the intervention and its topics, even with a clear explanation during a meeting before this intervention.

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Other important health education activities developed during the residency were conducted directly in the primary healthcare center with chronic disease patients, such as those with hypertension who participated in weekly therapeutic groups called 'Hiperdia', and insulin-dependent patients who participated in monthly therapeutic groups. There were also walk groups and spine groups which occurred twice a week with a heterogeneous group of participants, mostly over 50 years-old with chronic health conditions. The psychologist and psychology residents used to participate weekly in those groups, walking with them, aiming to create and establish interpersonal bond and to survey the territory. Those situations were auspicious settings for some thematic interventions, such as Yellow May, Blue August, Yellow September, Pink October, anti-asylum fight, drug use, and abuse prevention, topics related to the quality of life, mental health, diet, relaxing exercises, and relief of pain, blood pressure control, collection of anthropometric measures and any other topic of interest.

Following the previous monthly and weekly activities conducted focused on target topics, therapeutic interventions were also conducted in the waiting room or other community settings, as well as events scheduled by the reference team for "D-days" actions. One of those actions was entitled Health Cinema and comprised the exhibition of a movie to both the community and healthcare professionals in the primary healthcare center and, following it, there was a discussion about the topics displayed in the movie and their relationship with health. Other actions developed during a Saturday in which the primary healthcare center was opened to the community, the psychologist and the resident were available to assist and offer attendance to men, in particular psychological care attendance. There was also a gymkhana in the parking lot in one of the primary healthcare centers where the resident worked, including health promotion and quality of life as target topics.

Shared medical appointments were one activity which provided a better comprehension and bonding between healthcare professionals and the primary healthcare team, and between both of them and the community. Shared medical appointments could be characterized as a particular strategy that privileges transversal communication among members of the healthcare team, from distinct perspectives (Luz et al. 2016). With the current residency, those activities used to occur mostly with the nurse and the physician in childcare and prenatal care appointments.

The experience as a resident during shared medical appointments could be evaluated as enriching because they allowed the resident to be in contact with different healthcare professionals and their daily practice and the community. During the scheduled appointments by the reference, the patient was presented and informed about the role of each professional during the appointment and, if necessary, they were allowed to ask their doubts throughout the appointment (e.g., how they were feeling during the pregnancy or in that moment, how their partners and relatives were involved in the pregnancy which was her most problematic issues at that moment). Regarding the psychology practice, the resident was responsible to investigate and evaluate situations related to maternal bonding, baby blues signals, post-partum depression symptoms, or any other significant emotional symptom, in particular when other professionals were in doubt about a specific symptom or situation. If any of the patients showed emotionally fragile, an individual psychological care attendance could be conducted by the resident or the psychologist of the primary healthcare center.

Although home visits are a constant activity in the ESF as well as in the Nasf-AB, the psychologist was not totally involved in this situation at the primary healthcare center where the resident worked. Reports in the literature pointed the importance of this activity in the Nasf-AB and, according to Oliveira et al. (2017), most home visits are related to some degree to mental health issues and need to be conducted with patients who cannot leave their residencies. In the specific situation of the territory where the resident worked, even with its importance, there were only a few home visits to patients who cannot go to the primary healthcare center to receive healthcare assistance. This activity was conducted only once, during the diagnosis process at the beginning of the residency. According to the authors cited before, this activity needs to be rethought according to their aim and targets from a psychological perspective because of its importance, the frequency of mental health issues in the general population, and, in particular among those patients who cannot leave their homes to seek healthcare assistance (Oliveira et al. 2017).

Conclusion

The residency program is a relatively new education strategy, and its implementation is still a pathway to be adjusted, even though it would be an ideal setting to qualify the healthcare professional to work in primary healthcare. The educational qualification process in public health is a challenge to managers, educators, healthcare workers and always has some sort of complexity regarding the encouragement to present interpersonal, humanistic, and professional skills as well as responsible critical sense. Even so, the multi-professional residency is a great opportunity for a significant learning process and to know how different professionals act in their practice. One of those challenges is the opportunity is interdisciplinary and multi-professional work related to the reference teams and to work with residents undergraduate in different fields of knowledge. However, when the residency is analyzed from the psychology point of view, in particular the insertion of the psychologist in both the public health and in the ESFs, there is some additional challenge. One of the biggest obstacles experienced was the inclusion of psychology and its practice into ESFs teams. It could be related to the difficulty of psychologists to work in teams and groups and contextualized, which could be associated with the educational process during the graduation focused on traditional and uniprofessional paradigms and well as individual practice (Cezar et al. 2015).

Although there was some progress in the healthcare models, it is still possible to observe traces of the past biological model, focused on disease. This model is still taught in undergraduate courses and applied by several practitioners, which makes it hard the insert discussions, reflections, and changes in the way of think about health in a broad way. The same could be said about the insertion of the psychologist in primary healthcare, which still focused on individual psychotherapy, a traditional paradigm in psychology. Even with a clear attempt to update the model, including new approaches in its practice, it is possible to observe traces of a traditional model in the psychology in primary healthcare, such as the psychological care attendance and individual psychotherapy to those patients who looked for this modality of attendance. To overcome this model within the psychology and the residency program, it is important to highlight that professionals need to be sensitive to local demands and personal experiences, applying new strategies against traditional approaches in healthcare. This overcoming needs to occur not only among healthcare professionals but within psychologists.

A highlight point and emphasized by Cezar et al. (2015) is the lack of public health components within psychology undergraduate courses. In most of the psychology courses, there were no specific subjects focused on public health, which reflects in their practice as a psychologist in the public health and primary healthcare services, and in their conception the role of the psychology and other professions within healthcare teams. Although a psychologist in the team is essential, the focus remains on psychotherapeutic models, reproducing a hospital-centric model. The maintenance of this traditional perspective could be directed related to the lack of specific components on their whole professional qualification process.

The multi-professional residency tries to generate reflections about the effectiveness and improvements in the SUS as a whole, implementing problematizing reality as one of its responsibilities. The difficulty to contextualize the psychology to different practice settings added that there is a lack of knowledge in the professional qualification process focused on public health complicates those reflections from a psychology point of view. Although other healthcare professions have similar challenges, because of their better theoretical background focused on public health, those challenges are less complicated to fulfill, as observed throughout the residency. Following this reflection, in particular, at the beginning of the residency, all psychology residents were observed as a separated group within the resident groups, even when there were some specific demands about their activities in the community. These facts needed to be overcome to create an adequate setting for teamwork and personal and professional bond with other healthcare professionals.

One of the biggest limitations which contributes to that reality was the lack of structure of the public health services in the primary healthcare setting, both human and physical. Moreover, the lack of knowledge about the role and the importance of the residency and how it works for professionals within the public health services. Specifically, in the mental health field, there were several difficulties coped by the resident

such as the lack of some healthcare professionals to provide specific assistance to patients. Finally, it is important to highlight the lack of preparation and skills of primary healthcare professionals to intervene with mental health issues, who frequently wrongly referred those patients, generating long-term consequences to them.

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Author contributions

Lupatini SC participated in the conception, description of the outcomes, design of the case report, interpretation of the results and writing the article, and Zazula R conception, description of the outcomes, design of the case report, interpretation of the results, and writing the article.

Competing interests

No financial, legal or political conflicts involving third parties (government, companies and private foundations, etc.) have been declared regarding any aspect of the submitted article (including, but not limited to grants and funding, participation in advisory councils, study design, preparation of manuscripts, statistical analyses, etc.).

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