

Theoretical references that guide nursing practice in mental health

Referenciais teóricos que norteiam a prática de enfermagem em saúde mental

Los referenciales teóricos que orientan la práctica de la enfermería en salud mental

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ABSTRACT

Objective: This study aimed to identify the theoretical references that guide clinical practice in mental health nursing. **Methods:** Descriptive study of qualitative approach, conducted through semi-structured interviews. The study subjects were nurses working in Psychosocial Care Centers of Fortaleza/CE. It was used the analysis of content of Bardin. **Results:** Five categories emerged that link the theoretical references that guide the clinical practice of nurses: nursing theories referential, biomedical referential; alternative practices referential; referential of harm-reduction policy, and psychoanalysis reference. **Conclusion:** It was identified that the professional practice of the most of the respondents was guided by more than one of these references, although some present contradictions between them, and this was not perceived by the subjects. These references, at times, were applied only formally, without the purpose of reception of the subject in psychological distress and their care demands.

Keywords: Nursing Care; Mental Health; Professional Practice.

RESUMO

Esta pesquisa teve como objetivo identificar os referenciais teóricos que norteiam a prática clínica de enfermagem em saúde mental. **Métodos:** Estudo descritivo de abordagem qualitativa, realizado por meio de entrevista semiestruturada. Os sujeitos do estudo foram enfermeiros que atuam nos Centros de Atenção Psicossocial de Fortaleza/CE. Utilizou-se a análise de conteúdo de Bardin. **Resultados:** Emergiram cinco categorias que apontam os referenciais teóricos que norteiam a prática clínica dos enfermeiros: referencial das teorias de enfermagem; referencial biomédico; referencial das práticas alternativas; referencial da política de redução de danos; e o referencial da psicanálise. **Conclusão:** Identificou-se que a prática profissional da maioria dos entrevistados era norteada por mais de um desses referenciais; embora alguns apresentassem contradições entre si, isso não era percebido pelos sujeitos. Esses referenciais, em alguns momentos, eram aplicados apenas formalmente, sem o propósito de acolhimento do sujeito em sofrimento psíquico e suas demandas de cuidado.

Palavras-chave: Cuidados de enfermagem; Saúde mental; Prática profissional.

RESUMEN

Objetivo: Identificar los marcos teóricos que guían la práctica clínica en Enfermería de Salud Mental. **Métodos:** Estudio descriptivo, cualitativo, realizado por medio de entrevistas semiestructuradas. Los sujetos del estudio fueron las enfermeras que trabajan en los Centros de Atención Psicossocial de Fortaleza/CE. Se utilizó el análisis de contenido de Bardin. **Resultados:** Emergieron cinco categorías: teorías referenciales de enfermería; referencial biomédico; referencial de prácticas alternativas; referencial de la política de reducción de daños; y el referencial de psicoanálisis teórico. **Conclusión:** Se identificó que la práctica de la mayoría de los entrevistados se basó en más de una de estas referencias; a pesar de algunas contradicciones presentes entre ellos, esto no fue percibido por los sujetos. Estas referencias, a veces, se aplicaban sólo formalmente, sin el propósito de amparar el sujeto en sufrimiento psíquico y sus demandas de atención.

Palabras-clave: Atención de Enfermería; Salud Mental; Práctica Profesional.

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INTRODUCTION

The attention to the mental health by nursing, despite advances provided by Psychiatric Reform, is still permeated by reductionist approaches of madness, health and mental illness, reflecting a clinical practice that grasps the disease itself and disregards the subject who gets sick. These approaches are perceived in the practice of nursing in hospitals and Psychosocial Care Centers (PCC).

Theoretically, according to the guidelines of the Psychiatric Reform, the PCCs should be constituted in space for differentiated attention, where the principle of de-institutionalization of assistance would be materialized from a clinical practice centered in the subject and their care needs. Another principle to be sought would be the deconstruction of the concept of mental illness from the biomedical referential, and the adoption of a new way of perceiving the psychic suffering while existence-suffering of the subject in its relation with the social body. The attention in mental health should be organized in the form of a care network integrating all health services. In this perspective, the subject in distress would be welcomed in any service, and properly referenced to the PCCs.

If mental health care still reproduces the attention focused on the disease, the purposes of the Reform have not yet been achieved. In part, this is due to the references adopted, and its approach or detachment of the principles of Psychiatric Reform. Given this, which theoretical references guide the nursing of the Psychosocial Care Centers (PCCs), in Fortaleza-CE? On the search for this response, this study was developed aiming to identify the theoretical references that guide the practice of nurses who work in PCCs, in the municipality of Fortaleza-CE.

This study reports, particularly, to nursing, as its practice, justified by the clinical and research experience in the mental health field where nurses seek to support theoretically, without falling into the risk to get away from an ethical commitment with the subjectivity of the carers.

It is emphasized that this study is relevant to propose a reflection about that practice, in order to exceed the level of theoretical abstraction and deepen the knowledge of what is referred to or perceived as theoretical reference for nurses working in mental health.

METHOD

It is a descriptive, qualitative research, from the research entitled "Nursing care in mental health: the contribution of the subject's clinic", submitted to the Research Ethics Committee of the State University of Ceará, and approved with the opinion paragraph 08350163 0, September 26, 2008. The production of the data was developed between the months of November 2008 to August 2009, in the 14 Psychosocial Care Centers distributed in six Regional Executive Offices (REO) in the municipality of Fortaleza-CE, being two PCCs infant mode, six PCCs alcohol and other drugs mode, and six PCCs II. For the

selection of subjects of the research, it was established as a criterion for inclusion being a nurse of the PCCs of the municipal services of Fortaleza-CE and accepting to participate in the study. And while exclusion criterion was being institutionally away from their professional activities. The subjects of the research were nurses who acted in these services, which, after contacted, they had demonstrated an interest and availability to participate in the study, signing an Informed Consent Form, totaling 14 professionals.

Visits were performed to the PCCs where the researchers presented the purpose of the study and applied as an instrument of production of semi structured interview data from the following question: what are the theoretical influences that permeate its performance in mental health? The data were analyzed from the proposed analysis of content of Bardin¹.

Following the steps proposed by this technique, it was performed the pre analysis with floating reading of the interviews (construction of the corpus); in the exploration phase of the material (inventory) the corpus of the study has been deepened from the clipping of significant words and phrases that constituted the frames of references. Context units were defined, of record, subcategories and finally the categories. For greater organization of testimonials, the subjects were identified with the letter "N" as a nurse, and then an Arabic numeral.

Thus, five categories arose, each one corresponding to a theoretical reference: nursing theories; biomedical referential; alternative care practices; harm reduction, and psychoanalytic theory.

RESULT AND DISCUSSION

The profile of the subjects showed that 66.6% had completed graduation on average for 4 years; 88.8% of them have at least one specialization course, not being in mental health; 55.5% acted in the area of mental health for at least 2 years; as for working hours, 66.6% worked up to 40 hours per week. As regards the professional experience, 28.5% of respondents worked in the Family Health Strategy (FHS), 28.5% worked in teaching and 57.1% in the hospital area. The time of operation on the PCCs at the moment of the research was an average of two years and six months.

From the lines of respondents it was observed that, in principle, the nurses presented difficulty to define clearly which theoretical referential subsidized its operations. However, from the subcategories extracted from the corpus, it was possible to identify the often implicit references in their answers.

Category 1: Nursing theories reference

Some subject of this research, when questioned about which reference were guided their practice, they referred to some theoretical precepts that have been associated with some theoretical currents of nursing. Subcategories members of category were identified: Florence Nightingale environmental

theory; theory of Self-care of Dorethea Orem; basic human needs theory, Wanda Horta; and the system and reach goals, of Imogene King. It is known that nursing theories reflect their movements in pursuit of their scientific theories. They emerged with the advent of modern nursing in the 19th century, with Florence Nightingale.

The respondents cited the theories, ranging from the miasmatic-bacteriological theory referential that in the 19th century influenced Florence Nightingale, until the late 1970's theories. Some answers show, also, a superficiality to list several of them, without explaining how they could be applied in the care of mental health nursing; according to N5:

Nursing theories that influenced me, theories that I read, as the holistic theory of nursing, and Orem's theory, the theory of Wanda Horta, King's theory, and others. Also Florence Nightingale [...] All this (N5).

Other respondents refer to the concept of self-care, from the theory developed by Dorothea Orem, but articulating it only to activities directed toward the dimension of care with personal hygiene and the correct use of medication. When in fact this perspective of self-care could encompass other issues inherent to the insertion of these subjects in family life and in society in general, allowing an expansion of the possibilities of social conviviality.

In this case, it wasn't possible to perceive clearly the contribution of this theory, in particular, to approach the dimension of psychic suffering, this approach inherent in intervention in mental health; as reports of N14:

We have a group of health education [...] we work both children as parents, this part of hygiene, of self-care, with the part of the daily needs of the child, adolescent (N7).

I participate and have a group with those who are in intensive care and in this group I guide them on medication, about self-care, trouble identification [...] (N14).

Another respondent tried to articulate the theory of Wanda Horta to be referred to mental health care, according to N5:

The person has psychic suffering exactly when she can't solve a mental problem, psychic that she is going through. [...] the professional nurse has this function, to help the person to satisfy human needs. It has even the theory of nursing. Is the theory... A holistic theory of nursing (N5).

Various approaches on human needs are present in nursing theories, having a great expression in propositions of Horta. The concept of basic human needs is broad, relative and generic, which determine interpretations, often confusing, geared to biological dimension, social, instrumental, subjective and motivational².

The concepts of mental health nursing care must be such as to enable the exercise of a practice which goes beyond a professional responsibility by the subject who is in care. In this way, to transcend a clinical practice that responds only to basic human needs, it is necessary that such a concept is articulated and the recognition of the uniqueness of the life story of each subject. Hildegard Peplau's theories and Joyce Travel bee contributions are examples of nursing theories that purport to achieve this approach. Support itself on the therapeutic relationship tool. This therapeutic relationship developed, then, allows the nurse recognizes the patient while subject participate in decision-making in their process of caring and coping of their suffering. However, the therapeutic relationship is a tool little prestigious, only understood as a friendly relationship with the patient³. Only one respondent made reference to the existence of this referential, even though to deny its use; According to him:

[...] This therapeutic relationship, I can't keep. It is as I say, I treat people as if they were my people, although having a limit, because I'm a professional, I'm not their mother, I'm a professional. So I deal with the heart (N7).

It is observed that the study subjects, despite making reference to the theories of nursing, cannot expose a coherent appropriation with the principles of these theories. It is understand that, in order to bring about their actions on attention to the suffering of psychic based on these theories, they must take ownership of the assumptions of such theories, reflecting critically on them so that they articulate to the reality of mental health care and health policy in Brazil.

Category 2: Biomedical Referential

Some speeches reflected a centered approach on a biomedical model, based on the traditional understanding of mental illness; in this reference, the intervention has the basis of the drug prescription (guided by advances in neuroscience), the normative of behaviors (in expectation of aggressive behaviors) and hospitalization as therapeutic horizon⁴, because:

[...] as here is part of a context, it doesn't escape the rule. I think the unit is still a bit... Not a little! It is a unit "centric medical" (N5).

With the team, the nursing consultation, for example is still a process, an achievement. It comes from the Doctor the nursing consultation, the orientation. But, it doesn't come as much of the others [professionals], it comes more from the doctor. Maybe because we're more on biomedical model [...] (N4).

Other lines showed appreciation of the use of psychoactive drugs as the main approach to the distress in the PCCs. It is

noticed the growing concern in appropriating this speech, which demarcates the psychic suffering only in terms of neurological order, whose healing process is obtained only based on the use of medicines. To N6:

[...] not only the health team is hit by this model, as well as users seek the service often only to receive medications. And patients here were accustomed to take the prescription, go to consultation and that's it. They went home and returned only in three, four months to get the recipe again. Anyway, there was no systematic follow-up before the reform, and we still don't have nowadays (N6).

This theoretical referential, in addition to reducing the complexity of psychic phenomenon, marks a space in which medical psychiatric knowledge imposes before the remaining knowledge. The assistive logic prevails in which the actions of other professionals in mental health care is neglected, and are brought into action, preferably mechanisms based on legitimacy of power/medical intervention⁵.

Other lines pointed to a critique of nurses against the biomedical referential. The nurse describes their conceptions about this model and its impact on their vocational training; according to N4:

During graduation was terrible because what I saw about Mental Health was totally "centric hospital". It was psychiatric hospitalization, people treated in an animalistic, and it shocked me too much. I would never think of working with Mental Health in those levels of suffering. I never would have guessed. In College, it wasn't a very humanized thing (N4).

The biomedical model has been criticized and combated by some public health sector policies. Such policies are aimed at replacing the hospitalizations for other warning devices, having as its main focus the subject and not the disease⁶.

However, it is realized that they are still insufficient modifications that have occurred in the context of the services so far. Despite the many achievements with the Psychiatric Reform, the biomedical model still crosses the actions developed in the services. The form of financing mental health system through Authorization for Outpatient Procedures of High Complexity/Cost (AOPHCs) is perceived as a condition of maintenance of this model, towards payment for performed procedures, supported by International Classification of Diseases - ICD. For N4:

there is the desire to [...] going out, make some proposals for community work, but we got stuck to AOPHC, because we have to produce. AOPHC are 12 law procedures that intensive patients have to do, semi intensive. So, we're kind of stuck and I couldn't get out doing these works (N4).

This funding logic still strengthens an organized attention to performance of procedures in a logical asylum; the same reiterates the attention focused on the disease, diagnosis and treatment. Soon, there is no possibility to put the disease in parentheses, since the remuneration system, insofar as it privileges the treatment of the disease, is located as conditioning for the remuneration of the services.

With the Psychiatric Reform, means that it is not enough to carry the assistance of asylum for the PCCs; is necessary to transform the relationships of nurses with experience of madness and the psychic suffering. The de-institutionalization of attention to patient in distress necessarily implies that changing the focus of attention of the disease to the subject in its context of life⁷.

Category 3: References that subsidize alternative practices

Some nurses reported that their interest in working in mental health was due to experiences in the process of training where they could experience the care from alternative health practices. As examples the communitarian therapy was cited as care technology and art therapy as mental health intervention. In this frame, the care technologies used by nursing enable the emergence of the subject through the expression of subjectivity; the canals for this emergency are the listening of life history and the artistic productions. The communitarian therapy constitutes a set of relationships involving multiple situations, which always go beyond the individual and family level. It has as own characteristic the focus on the subject. This, when reporting their feelings, it profiles its uniqueness in the group and its identity markings, and strengthening self-esteem. It permits the recognition of their way of being in the world, subject to changes in personal life, in family relationships and in their integration in the community, on demand of the services, and in the exercise of their rights⁸.

In the context of art therapy, non-verbal expressions take on great importance in the relationship professional-client, since the behavior reveals some signs of non-verbal communication expressed by the body such as: posture, look, orientation of gestures and body movements, emotional expression, facial expression, approaching or distancing of personal space and tactile conduct⁹.

The art therapy has been considered a therapeutic intervention with its own characteristics, differentiating itself through two lines of business: art as therapy and art as psychotherapy. In the first one, the main focus of the therapy is in the artistic process, considering its potential of care. In the second line of action, making art occurs within a specific psychotherapeutic frame, aiming fundamentally, the emotional development of the individual, resulting in the expansion of creative potential⁹.

However, despite the model of attention of PCCs target reintegration into society and the construction of social ties, the subjects interviewed still find barriers to develop the careful in this respect. It is noted also that the reintegration of the social context from the perspective of the capitalist model seeks to

de construct the figure from being sick to be productive, which produces something to be consumed. In alternative practices referential, care is produced through the strategy of operating groups where the subjects involved are encouraged to produce something from its singular existence, apart from a marketing perspective of those same products. According to N9:

[...] we worked with the picture frame towards to be recycling, for example, CD covers (N6).

The jewelry is made, the work, the crochets, embroideries. We put there, we mount the stall and the community staff goes there. (N9).

Other strategies used from this referential are the theatre and films therefore enable interaction modes between the patients and the community. It is important to note that art therapy is not regarded as a mere entertainment, but rather, a form of language that allows the person to communicate with others⁹. Here are the stories of the subjects interviewed:

I am a nurse who consider myself mixed up in art. I love Theatre, I adore Theatre, I love to act. We work DSTs, here we did a theater (N4).

And, over the theater part that in Group Enfermarte we've developed the history of mental health and how much it is neglected and as the carrier of mental disorder are stereotyped [...] I always bring movies to address issues in the absence of conversation (N8).

We pass films that they can discuss in group along with the professional. I have a preference for films. I locate some things that direct (N3).

It is realized that nursing resorts to such practices as tools in their actions, allowing the involved the acquisition of autonomy and capacity for social transformation⁸. However, also are identified from the interviews that these same nurses in their everyday work have difficulties to conduct extramural activities in light of the bureaucratic activities inherent to the service.

Category 4: Subsidized public policy Referential of Harm Reduction

The use and abuse of drugs has controversial and reductionist conceptual boundaries who disregard the many interface between biological, pharmacological, psychological, social and cultural variables. These are closely related to drug addiction however, the understanding of isolated form does not enable the integral care and subjective coping of the subject and its health needs¹⁰. From the nurses' lines, it is understood that the way to understand the genesis of the drug use and the type of approach to that question guide the actions of the nurses who work in this field¹¹.

The subject is singular, and so, is also its relationship with drugs, materialized in licit drugs (alcohol) or not (drugs whose use is prohibited by law in the country). The nurses who work in mental health are key people in the approach regarding the use of drugs; since its practice is guided by knowledge beyond the biomedical clinical paradigm¹².

From this aggregation attempt of new paradigms is that the Alcohol and Drugs Psychosocial Care Center (PCC) was created in order to focus the service users/dependent on alcohol and other drugs in the logic of Harm Reduction Policy. This policy was formalized in the 1990 proposing a social mobilization and developing activities for the reduction of harms associated with drug use.

Initially, the focus was on prevention of Sexually Transmitted Diseases (STDs), Acquired Immunodeficiency Syndrome (AIDS) and Hepatitis among Intravenous Drug Users (IDU's), in virtue of the parenteral transmission of diseases. Today, the focus is the prevention of STDs to reduce social harm, aiming at a completeness of health actions¹³. Here are the subjects' reports with regard to referential Harm Reduction Policy:

When I came to the mental health and I went to see the issue of the psychiatric reform, which is exactly taking these people out of the psychiatric hospital, it was then that I believed in the mental health and all I am going to do, first I think of the psychiatric reform and then I can run the rest of my issues on mental health. [...] Nursing is essential in this AD PCCs: not curative, but rather preventative. Is the issue that we work: harm reduction. [...] We have a group of harm reduction that works all this issues of how to prevent diseases.

It should be noted that the speech of harm reduction puts the subject as a citizen; however, it is considered that citizenship is not always a necessity of the subject, but rather an ideal pursued by the society. This Ideal is founded in a philosophical-political conception which defines in a universal form these subject's rights, known as citizens. Even opposed to the dominant discourse, it can be seen that in this speech that is unique to each subject is still little regarded. It can be noted in the subsequent speeches of the nurses who work in AD PCCs, the Harm Reduction program as a guiding approach of his practice; saying by N13:

[...] in that AD PCCs, there is the issue of harm reduction. The nurse is here not to medicate. They have to educate users that they can use at the time that they are trying to use [...], because there's a moment when they will stop using and will use the drug with caution, use it with respect to his body in order to prevent (N13).

However, some of these nurses, even stating work with the referential reform and so, with the program of harm reduction, are unaware of or do not have as objective the reduction of

damage itself. For this program, abstinence is not the focus, because the goal is the change in the pattern of drug use from replacement therapies. The nurse knowing the effects, dosages, and damage forms of drug use, act in preventing acute poisoning or overdose^{14,15}. For N1 and N5:

[...] we have to work on these two perspectives: abstinence and harm reduction. Because not always the person can leave what it would work, in my opinion, more here, it would be to harm reduction strategy. It would be more efficient. But we would also work with the issue of abstinence. It is important too. But, here the main focus is abstinence, is not reduction. It is still the abstinence (N5).

With respect to treatment, we work not only with abstinence, but also with the harm reduction. Today, it has been much discussed the harm reduction. We are still in the process of discussion, but the treatment will be very much: about abstinence (N1).

The speeches of the nurses interviewed here, and who work in the AD PCCs, confirmed the results of other research on the subject of drugs: the lack of preparation of nurses during graduation, by their own curriculum that is deficient for the theme; the myths, stereotypes and prejudice of nurses, which complicates the therapeutic link; and assistance focused on the planning strategy for the promotion of health, based on prevention and social reintegration¹⁵. It is considered that the reflection on the possible contributions of this approach with the patient in drug use will make great contributions to the construction of clinical nursing care to the chemical dependent.

Category 5: psychoanalytic theory Referential

The proposals for modification of the focus of intervention in mental health give emphasis in the treatment of disease to interventions aimed at subjects in their contexts of life, encouraged professionals to seek theoretical references more committed to this perspective. Psychoanalysis then arises as an alternative reference opposed to the medical and "hospital centralised" model. It is outlined of the opposition to the field of descriptive psychiatry is phenomenal and General psychopathology by the unconscious field and its formations (Freud) or the field of Another¹⁶. The following statement shows the search for this referential, as well as the uncertainty as to support him, respectively:

I read magazines. When there are things about mental health, I care about it. And I enjoy reading Lacan [...] triage is listening. Listening is very important here. Usually as a listener you can solve a lot of things (N6).

In this study, the reference to therapeutic listening is identified, in the contents of the speech of the nurses, from the referential of the psychoanalytic theory. Therapeutic listening is

not synonymous with the act of listening, or it is constituted in a space of confession to the individual, report their complaints and it should not be restrict as a selective data collection instrument to delimit the pathological history and symptoms of the disease¹⁷.

In the practice of mental health, there is a growing contribution of psychoanalytic concepts on assistance in construction and discussion of clinical cases; this contribution has been called clinical subject. Through the tool of listening, the clinic of subject searches the offset for the subject of the unconscious, from the signifiers that intertwined his speech¹⁶.

However, it should be considered that there is no psychoanalysis without the acceptance of its fundamental concept: the subject of the unconscious. Thus, it is not possible to reduce their clinical instruments to a trivialization of their use, or to an over valuation of their concepts. It is essential to point out the direction of diagnosis, including the subject of the unconscious¹⁸.

The unconscious is psychic representations so-called latent dynamic, by staying away from the conscious plan, but which become evident to bring about symptoms, dreams, failed acts, lapses, jokes - demonstrations of this unconscious that never stops¹⁸.

In this sense, the mental health nursing should be aware to, the manifestations of the unconscious, which can it used as therapeutic listening, a tool based on psychoanalysis. Nursing interventions must therefore extrapolate its character and be instrumental passed by an articulation with listening tools, where the word is the raw material³. For the guy to speak, the professional is willing to listen to him. However, this is not a passive listener understood only as a synonym for listening. Listening is a therapeutic tool; through it is possible to extract the signifiers that intertwined his life story. The greatest interest is not on the ready narrative, but in the recognition of what is between the needs and the demands of that subject; and that is not expressed by words like, for example, the symptoms. Listening allows a reformulation of what the other says, through questions free of pretension to troubleshoot, judgments or interpretations. When using this tool from the referential of psychoanalysis, it implies the recognition of the other as a subject of singular experiences; subject who transformed and it is transformed into the meeting between health professional and the user¹⁷.

In this context, nursing can understand the clinic as a way to listen and act on the basis of listening to the subject rebuilding himself from his speech. This is possible because the unconscious is structured as a language. The psyche is symbolically of signifiers, which differ from sense to each subject. Therefore, in the process of listening as the subject speaks, he reveals himself to traumatic facts and repressed in the unconscious, giving a meaning to them.

Although identifying the psychoanalysis as a guiding reference of listening therapy, it is realized that the subject of this study still appropriate superficially this referential. In practice, they listen - hear - what they want and make referrals for not dominating the tools of listening therapy. Some study subjects stated including referential of psychoanalysis with other references,

according to the dialogue established with the subjects addressed in the CAPS. It is necessary to emphasize that psychoanalysis is not in line with the other referential identified; when considering the subject as a subject of the unconscious, it is opposed to any reference that does not follow this way to apprehend him. Thinking of articulate this referential with other theoretical perspective presupposes knowledge of their fundamentals and the risk of developing strategies of care without considering the subject which demands care.

CONCLUSIONS

The theoretical references that guide the clinical practice of nurses in mental healthcare in the PCCs of Fortaleza, CE can be categorized under nursing theories referential; Biomedical referential; referential that subsidize alternative practices; referential subsidized by public policy of harm reduction; and referential of psychoanalytic theory.

It was identified that there was not always a consistent theoretical appropriation able to allow a coherent relationship between the aforementioned referential and production in mental health care. Although not perceived by the nurses, it was found in the interviews the mention of more than one theoretical referential, sometimes contradictory to each other.

Despite the process of de-institutionalization of mental illness, with the ongoing Psychiatric Reform, there is a predominance of biomedical reference in the speeches of nurses in relation to other identified referential. Some strategies and specific actions of certain policies, such as harm reduction and alternative practices in health care have been mentioned so punctual and disjointed from its principles and guidelines.

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