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ORIGINAL ARTICLE

# THEMATIC PRIORITIES FOR CONTINUING EDUCATION IN MENTAL HEALTH FROM THE PERSPECTIVE OF HEALTH WORKERS

## HIGHLIGHTS

1. Weaknesses in working in networks and referral culture.
2. Unpreparedness in humanized care revealed a medical-centered practice.
3. Disregarding professional suffering results in devaluation.
4. Education based on the problems experienced by workers.

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## ABSTRACT

**Objective:** To find out the thematic priorities for continuing education in mental health from the perspective of workers in the Unified Health System. **Method**: an exploratory and qualitative study was carried out with 37 health workers from a municipality in Mato Grosso do Sul, in September 2022. Data was collected using a self-administered individual questionnaire and a focus group, guided by a semi-structured script of questions. The material was subjected to thematic content analysis. **Results**: The themes 'Humanization in mental health care', 'Mental health in the context of primary care', 'Management of crises', and 'Mental health of health workers and professional valorization' emerged as priorities for continuing education actions in mental health. **Conclusion**: Knowledge of these thematic priorities makes it possible to plan continuing education actions based on the daily problems experienced by health workers.

**KEYWORDS:** Education; Education Continuing; Health Personnel; Mental Health; Unified Health System.

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## INTRODUCTION

In 2004, the Ministry of Health instituted the National Policy for Permanent Education in Health to boost educational actions that promote reflection on work processes, care practices, and institutional changes[1]. Permanent Health Education (EPS, in Portuguese) actions promote care qualification and strengthen public humanization policies within the Brazilian Unified Health System (SUS)[2].

The PEH proposal is anchored in meaningful learning and is based on contextualizing the local and regional needs of health workers and the population. It involves dynamic and participatory training aimed at expanding meanings about the health-disease process and how it is dealt with through the work process[3].

In PEH, health workers are the protagonists of the educational process, which, in turn, consists of education at work, through work, and for work, expanded participation, problematization pedagogy, strategic approach, multidisciplinary, and interprofessional. In this process, it is possible to analyze the work context, identify emerging problems, reflect, and seek solutions to daily adversities[4-5].

PEH also makes it possible to deconstruct practices based on established models of care centered on individualized, fragmented, and mechanized work. It is also a strategy for producing comprehensive care since it is built on the reflections of health workers on their practices[6].

In the mental health field, traditional training processes do not meet the complexity of the daily challenges of clinical services. The Psychiatric Reform movement and psychosocial care are understood as innovative models focusing on care in freedom, community, territorial work, social reintegration, autonomy, and the exercise of rights. PEH emerges as a strategy that enables reflection and the production of mental health care based on these values[7-8].

The scientific literature is still lacking in productions that address priorities for PEH in the field of mental health, especially in small Brazilian municipalities. These territories face challenges such as a lack of qualified staff and little professional involvement in mental health actions in services, particularly in primary health care. In these scenarios, PEH actions would promote discussions about psychosocial care, resulting in the denaturalization of hegemonic concepts and practices in the field of mental health and favoring welcoming and qualified listening[3,9].

Based on the above, it is essential to look at the priorities of continuing education in mental health from the perspective of SUS workers working in small municipalities. The authors' experience as teachers and researchers, committed to strengthening the SUS and training health workers, motivated this study, which was based on the following question: which mental health issues emerge as priorities for PEH from the perspective of SUS workers?

This study aimed to find out the thematic priorities for continuing education in mental health from the perspective of SUS workers.

## METHOD

This is an exploratory, qualitative study based on the criteria for reporting qualitative studies in the COREQ checklist - Consolidated criteria for reporting qualitative research. It was carried out in a small municipality located in the center-west of Brazil, the hub of one of the 11 micro-regions of the state of Mato Grosso do Sul. Its Health Care Network (HCN) is organized into levels of care: primary care consists of seven Family Health Units (FHU) and a Prison Health Unit; secondary care consists of three specialized care services; and tertiary care consists of a hospital and a Mobile Emergency Care Service (SAMU, in Portuguese). The municipality did not have a Center or Sector responsible for PEH actions, and these actions occurred through occasional initiatives by managers.

There were 494 workers working in the HCN. Participants were selected for convenience, seeking to ensure that at least one professional per health service was represented, respecting the inclusion criteria: being a professional working in the HCN regardless of level of training, position, and length of professional experience; and exclusion criteria: being on leave for any reason.

Data was collected in September 2022 using a focus group and an individual self-administered questionnaire, both designed by the researchers. In the focus group, a semi-structured script was used which contained the following questions: 'What topics do you consider to be priorities to be addressed in PEH actions?', 'What are your main doubts regarding the priority topics mentioned above?', 'How do situations related to the priority topics mentioned permeate your professional practice and how are these situations handled?

The focus groups took place over three days, each for a different level of care, and the questionnaire was administered at the start of each focus group. Thirty-seven health workers took part, 15 of whom worked in primary care, 11 in secondary care, and 11 in tertiary care. In addition, two researchers mediated the focus group, accompanied by three other researchers responsible for observations. The meetings took place in a meeting room provided by the municipality's Health Department. The average time taken to administer the questionnaire was five minutes and the time taken to hold the focus groups was one hundred and fifty minutes.

The participants' narratives in the focus group were recorded on digital recorders, allowing the findings to be transcribed later. The transcriptions were made using an electronic document validated by a second researcher and kept in the researchers' possession, to guarantee the confidentiality and anonymity of the participants. The material was subjected to thematic content analysis to identify units of meaning and group them into thematic categories[10]. In this sense, the analysis took place in three phases according to the framework: pre-analysis; exploration of the material, and categorization of the data. The theoretical constructs of 'public health policies' and 'psychosocial care' were used as a conceptual basis, as well as scientific texts that address the subject under study.

The study was approved by the Research Ethics Committee of the Federal University of Mato Grosso do Sul, under opinion no. 5.472.063/2022. To guarantee the anonymity of the participants, the quotes used were identified with the description of the level of health care at which the worker worked in the HCN.

## RESULTS

The participants in the study had a mean age of 39.3 years; their ages ranged from 19 to 64, and 30 were female and seven were male. Of the participants, 15 worked in primary care ( FHU, Prison Health Unit, Dental Specialties Centre, Health Academy, Vector Control Centre), 11 in secondary care (Specialized Outpatient Service, Polyclinic and Psychosocial Care Centre - CAPS) and 11 in tertiary care (Hospital and SAMU).

Seven participants worked in health service management (direction, coordination, and administrative management); 24 worked in user health care (community health agent, oral health assistant, social worker, physical educator, nurse, pharmacist, doctor, nutritionist, psychologist, receptionist, occupational therapist, and nursing technician); and six worked in support functions (reception, kitchen, hygiene, and administrative help). The shortest time working at the HCN was two months and the longest was twenty-two years.

According to Chart 1, 13 units of meaning were recorded, from which emerged four thematic categories relating to the thematic priorities of PEH in the field of mental health:

**Chart 1 -** Units of meaning and thematic categories emerging from the content analysis. Campo Grande, MS, Brazil, 2023

| | Sense units | Thematic categories |
|---|---|---|
| Thematic priorities for continuing education in mental health | Recognition of the legitimacy and uniqueness of the health needs of people in psychological distress | Humanization in mental health care |
| | Professional preparation to offer humanized care | |
| | Sensitization of health workers to care for people in psychological distress | |
| | Articulation between health services in the psychosocial care network | |
| | Co-responsibility of health workers in networking | |
| | Possibilities for mental health care actions in the territory | Mental health in the context of primary care |
| | Articulation between primary care and other levels of care in mental health care | |
| | Matrix support as a strategy to promote interprofessional coordination and integration | |
| | Involvement of primary health care workers in mental health care | |
| | Health workers' stigmas about people in crises | Crisis management |
| | Common interventions in crisis management and responsibility for care | |
| Thematic priorities for continuing education in mental health | Suffering and psychological illness of health workers | The mental health of workers and professional development |
| | Relevance and scarcity of professional development and continuing health education actions | |

Source: The authors (2023).

## Humanization in mental health care

The participants' narratives revealed humanization in mental health care as a relevant theme for EPS actions. There was a need for health workers to be more involved in mental health care and in welcoming people in psychological distress:

*This welcoming from coworkers is sorely lacking. The coordination team is very supportive, but something must be done about the co-workers, to make them more welcoming, and to get more involved.* (Secondary health care worker)

Excerpts from the reports show that the complaints and anxieties of people in psychological distress are not valued as sufficient grounds for receiving humanized care, in other words, the difficulty in recognizing the legitimacy of the health needs brought by these users:

*Most people who don't have this problem [psychological distress] don't know how to deal with it, they don't have the patience. There's a lack of acceptance from the people around them, both professionally and in the family. They think it's a joke, that you're trying to get a certificate, or that there's nothing wrong. I see this a lot.* (Secondary health care worker)

Some narratives suggested that there were difficulties in providing a welcoming atmosphere, qualified listening, and therapeutic communication, which contributed to resorting to drug prescriptions and physical restraint as mental health care practices:

*There are no professionals with this* [humanized] *outlook. Even when it comes to restraint and medication. Doctors who prescribe medication are also a bit lost. They are not prepared for this psychiatric part of caring for these patients* [in a humanized way]. (Tertiary health care worker)

Mentions of the lack of coordination between health services at different levels of care, an important element for humanization and comprehensiveness in the care of people in psychological distress, also emerged in the participants' reports, revealing weaknesses in the work of workers from the perspectives of networking and co-responsibility:

*The demand arrives and I don't even understand that it's also my responsibility. I already think it's the other person's responsibility. I don't even welcome it, I don't listen to it, I don't know the flow of the network. Can I treat a patient like that in primary care? Yes! But what do I have to know to welcome and listen to this person?* (Primary health care worker)

Some narratives showed that health workers' insecurity and lack of involvement in providing mental health care promoted a culture of referring people, sometimes unnecessarily:

*If you can be resolutive there, you can avoid taking people unnecessarily to a secondary sector, to a hospital. It's common, due to a lack of understanding of how to handle this, to simply act on the basis that the child is yours. Our FHU is next to the CAPS, and we routinely refer* [people in psychological distress] *to the CAPS.* (Primary health care worker)

## Mental health in the context of primary care

The reports revealed the need to develop EPS actions on mental health care in primary care and with articulation between the other levels of health care. Matrix support emerged as

an EPS strategy that promotes integration between professionals from different categories and specialties, the collective production of knowledge and possibilities for mental health care:

*We must be resolutive in matrix support, which is sorely lacking. I miss routine meetings with psychiatrists and psychologists to address this flow issue, to discuss a more complex case and we try to have the training to solve it.* (Primary health care worker)

Despite recognizing the importance of matrix support for the articulation between mental health and primary health care and the training of health workers in general, the participants highlighted the discontinuity in the development of this EPS action:

*A matrix support business was started. CAPS started doing this work in the USF, but it ended up not being followed up. All the professionals at the FHU must know how to handle a situation like this, to know whether they can intervene or not. This issue of matrix support is extremely important.* (Primary health care worker)

The narratives mentioned the need for primary health care workers to be more involved in mental health care in their territory, especially community health workers, considering their proximity and knowledge of the territory in which the person suffering from mental illness lives:

*I can [in primary health care] detect a depressive disorder, with the help of community health workers who are in the patient's home, resolve that and not just go to secondary care for it. I miss the matrix support that I've seen in other places, and I haven't seen here.* (Secondary health care worker)

**Managing crisis situations**

The managing of crises emerged as a topic shrouded in doubt and ignorance, leading us to consider it another priority in EPS actions:

*When it comes to managing psychotic outbreaks, I practically have no way of giving an example because I've never had a situation like that. There are no such cases, that is, there are and there aren't. When cases arise, doubts arise.* (Secondary health care worker)

There was a need to develop EPS actions that promoted knowledge and reflection on the practices developed in crises and the expression of feelings experienced on these occasions. The stigma of the dangerousness of people in crises also seemed to interfere with workers' attitudes, making it difficult or impossible to welcome and listen to users:

*The hospital is a passage. Patients spend days trying to contain their rage, and then they become nice. These days, there was a* [person in a crisis] *at reception whose husband couldn't hold it in. I think I should have taken her in and tried to calm her down. The staff were at a loss, they didn't know what to do. I talked to her. I think there was a lack of conversation with her, she wanted to talk, but we didn't even listen to her. She just took it. I think there was a lack of welcome."* (Tertiary healthcare worker)

In the participants' narratives, the management of crises emerged as the responsibility of the medical and nursing teams, with physical restraint and drug prescription being the most recurrent interventions on these occasions. These behaviors were experienced in everyday life naturally, with little reflection and without dialogue with professionals from other backgrounds and specialties:

*He* [the person in crisis] *will break everyone and the hospital. He* [the person in a crisis] *will break everyone and the hospital. When cases arise, how do you proceed with this patient? How to contain it? We call CAPS, the doctor sends the patient in an outbreak. Sometimes she prescribes the medication for the doctor here* [at the hospital] *to follow, or he takes the medication that he thinks will calm the patient down in the emergency room. But we don't have that situation of treating that patient.* (Tertiary healthcare worker)

Some of the reports mentioned the importance of welcoming, listening, and dialoguing with the person in a crisis, although the way to carry them out was permeated by doubts and challenges:

*First, try to calm the patient down, find out what's going on, see if they can have a dialog with you, and plan a way to welcome them by talking. That's the main thing, to know how to proceed. It's harder for us to act, we must think a lot, we have to be very strong. If you can't find a solution, you call support, and you call SAMU to try.* (Primary health care worker)

**The mental health of health workers and professional valorization**

The participants' narratives also contained references to working conditions, the psychological suffering experienced by health workers, and the strategies used to care for their mental health. There was also mention of disregard for the anguish and psychological suffering produced by the work itself:

*Mental health is lacking. The employees are out of their minds* [laughs]*. Everyone takes sertraline to cope. We hear jokes: 'Are you complaining about your work? Make room for someone else! The civil servant who has dedicated his whole life there is disposable by his colleagues. They should think that one day it could be them. I see this a lot in my sector.* (Secondary health care worker)

Excerpts from the reports suggested possible causes of suffering and mental illness among health workers, related to work, social and family contexts. These aspects involving the mental health of health workers could be addressed in EPS actions:

*Daily, I notice this psychological aspect, this problem that we* [health workers] *are having with mental health. Especially with the* [Covid-19] *pandemic. It's increased so much. A lot of sick people in our work environment."* (Primary health care worker)

The lack of actions to value health workers was another aspect present in the narratives, both at the initiative of the management sphere and on the part of the workers themselves. Participants also mentioned the possibility of compromised work performance in the face of this gap:

*We're in such a tense routine and nobody recognizes what we do. Management has a tendency not to recognize the professional. If a good professional isn't recognized, they feel undervalued and start to decline. What is being done here is a way of recognizing how important we are, and how we work.* (Primary health care worker)

Finally, the participants emphasized the importance and need for democratic and participatory EPS actions, which give visibility to the experiences of health workers, enable

dialogue and collective strengthening, and promote reflection and knowledge for action in health services:

*In these meetings, there is an exchange of experiences. We are so ingrained in our sector that we think the world is just that and don't realize the nuances of other places. These are situations that bring an understanding of things that we haven't experienced, but that we can experience and now know how to deal with. We pass on what information we have and so does our colleague. Understand each other's point of view. Each reality differs. Doctor, nurse, reception staff. Each one brings a point of view to try to work out common points. It's productive.* (Secondary health care worker)

## DISCUSSION

The results of the study corroborate research that indicates the need for PEH actions on humanization in mental health care. Health workers still need training to take responsibility for mental health care, as well as integrated and articulated practices that distance themselves from the asylum model and traditional psychiatry, enabling welcoming, therapeutic relationships and the subjective expression of people in psychological distress[11-12].

PEH actions are also essential to sensitize these workers to the legitimacy and uniqueness of the health needs of people in psychological distress. Acting as an agent of care for others is complex and requires health workers to embrace otherness, while at the same time dealing with their desires and the discomfort caused by relationships with others[13].

For PEH actions to transform mental health care, discussions and reflections need to raise awareness and make sense to health workers. This process includes problematizing the reality experienced; the use of concepts, terms, and nomenclatures adopted by these individuals; and the opportunity to share fears and insecurities to collectively build knowledge and ways of coping with situations[3].

Another theme that emerged as a priority for PEH actions was mental health in the context of primary care, coinciding with a study in which health workers considered primary care to be a privileged setting for care that replaces the biomedical, hospital-centered, and reductionist model. The principles and characteristics of primary care place its workers as key players for change in mental health care, requiring sensitivity, discussion of stigmas and prejudices, and intersectoral and interdisciplinary action[14].

The inclusion of mental health care in primary care is still a challenge and faces barriers at local and national levels. At the local level, there are difficulties related to teamwork, resistance to discussing and managing cases, feelings of inability to deal with mental health demands, weaknesses in reception qualifications, using biologic methods, recurrent and excessive use of referrals to other services, and a lack of PEH actions on comprehensive health care. In the national context, there have been recent attempts to dismantle public health and mental health policies in terms of underfunding and a return to the asylum perspective[3,9,12].

The link between primary health care and the Psychosocial Care Network (PSCN-RAPS, in Portuguese) is fragmented and lacks intersectoral actions, which can contribute to stigma, institutionalization, and the functioning of the asylum logic. PEH actions can generate reflective processes on mental health care in the community that produce greater engagement, bonding, and co-responsibility of primary health care workers, including

community health agents in the comprehensive care of people suffering from mental illness and their families; and in the articulation between services of the PSCN and PCN[4,15].

PEH actions aimed at problematizing the health practices developed in primary care services could be the starting point for health workers to approach and appropriate the knowledge and technologies developed and made available by the SUS for everyday practice. The establishment of lines of care that integrate different points of care, as well as the definition of soft technologies and ways of organizing the practices of multi-professional health teams, can be the object of PEH actions[16].

Although the participants in the study recognized the importance of matrix support in mental health, health workers still have difficulties and resistance in conceiving primary care as the gateway and organizer of the PSCN, understanding that responsibility for mental health care does not fall solely on psychologists and psychiatrists, and making matrix support a regular daily practice[9,14].

Matrix support in mental health as an PEH strategy consists of a way of producing health in which teams propose pedagogical-therapeutic interventions for chosen cases, in a dialogical and shared construction. This model can increase co-responsibility for care and provide greater security for health workers when handling cases involving elements of mental health[17].

Health care in primary care requires therapeutic and interdisciplinary relationships between professionals, aiming for a holistic approach and collaborative practice, considering the person in psychological distress and their family as members of the health team. To this end, changes are needed in health work and training, broadening the epistemological and political scope of the field of professional knowledge and practice. Interdisciplinary training in health fosters coexistence and sharing between different areas, as well as producing a sense of belonging, enabling dialog between areas of knowledge[18].

Within the scope of EPS, Interprofessional Health Education (IHE, EIP, in Portuguese) stands out as a priority approach to be formally incorporated to strengthen the SUS. IPE consists of an intervention in which workers from more than one health profession learn together interactively, to improve interprofessional collaboration. This strategy is in line with the constituent elements of the SUS, especially in the model of care centered on primary health care, which incorporates shared action between different professionals in teams[19].

Care anchored in humanization, collaborative interprofessionality, and person-centeredness can also be incorporated into the work process of health services with the implementation of the Singular Therapeutic Project (STP – PTS, in Portuguese). This is one of the pillars of the expanded clinic, which seeks to develop practices that decentralize the disease and bring health professionals closer to each user/family. The STP consists of a set of articulated therapeutic conducts carried out through interdisciplinary work and matrix support[20]

These findings highlight the management of crises as another priority issue for PEH actions. The scientific literature shows that people in crises are often stigmatized and have other health needs neglected. Myths and prejudices that permeate the practices of health workers who work with these users can contribute to fragmented care that is not properly welcoming[21].

Feelings of fear and discomfort among health workers when faced with people in crises stem, for example, from stereotypes of dangerousness and violence that still nourish the social imagination associated with the figure of this user. Health workers who are not properly prepared to deal with crises can be influenced by this perception, which can hurt the care provided[22].

Educational strategies that address successful deinstitutionalization practices can help tackle the stigma of dangerousness. Among these practices, the opportunity to listen and talk to people in psychological distress in circumstances that do not reduce them to their diagnosis can foster solidarity, respect for differences, and reduce social distance and the belief in the need for restrictive care[23].

The study revealed that the management of crises was still the responsibility of the medical and nursing teams, with little team discussion in collective spaces. The focus on medicalization denotes the medical-hegemonic content of the decisions made by the professionals involved in these occasions and the need to overcome this fragmented care through broad interventions based on the knowledge of the various workers working in this context[12].

Stigma and prejudice, combined with weaknesses in professional training in the context of mental health, are responsible for reproducing the culture of referral and not listening to users' mental health demands. Health workers often place the subject in psychological distress as the object of the psychiatric clinic and its professionals, disregarding their singularity and comprehensive care. This scenario rekindles the discussion about the need to reformulate the political-pedagogical projects and curricula of health schools, including mental health in the training of health professionals[24].

There is also a need to institutionalize the integration of Integrative and Complementary Health Practices (ICHP-PICS, in Portuguese) in professional training, which could contribute to the implementation of curricula that value humanized health care, centered on the subject and autonomy, and promote integrality in health care as a principle and right. Content related to PICS could be included in the teaching plans of different subjects in undergraduate courses, to prepare health professionals capable of dealing with the specific demands and challenges of mental health[25].

The scientific literature shows the use of ICHP as a care strategy for people suffering from mental illness, aligned with the psychosocial care model, and could be a proposal for redirecting mental health care practices. Considering the need to understand the subject of psychological distress in its entirety, ICHP can be configured as a structuring axis of mental health care, especially in primary health care services[26].

PEH actions that give visibility to workers' experiences, including the anguish produced by the work itself, have also proved to be urgently needed. These individuals have historically been undervalued as SUS workers, and are continually held responsible for resolving service problems, while at the same time dealing with adversity. PEH actions could provide space for welcoming, emotional exchanges, listening, and care for these workers[3-4].

These PEH actions could also include community therapy circles, massage therapy, art therapy, games, walks in parks, picnics, and birthday celebrations. Moments like these, of self-care and emotional exchanges, can have a positive impact on the working practices of health workers[27].

Although limited to a specific reality of workers at the three levels of care, the method used in this study does not aim to generalize the findings, which represent a product of the context investigated, including its dynamics and interaction between the participants.

## CONCLUSION

Humanization in mental health care, mental health in the context of primary care, the management of crises the mental health of health workers, and professional valorization emerged as priority themes to be addressed in PEH actions. Knowledge of these thematic priorities represents a first and important step in planning and developing PEH actions aligned with the problems experienced by health workers, and in carrying out future scientific research.

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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 - **Lima H de P, Souza VS de**. Drafting the work or revising it critically for important intellectual content - **Lima H de P, Machado CFT, Britto ACS, Rozza SG, Costa MAR, Souza VS de.** 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 - **Lima H de P, Souza VS de.** All authors approved the final version of the text.

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