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Reports of Experience

ROUND-TABLE DISCUSSION IN THE PROCESS OF MENTAL HEALTH CONTINUING EDUCATION

ESTRATÉGIA DE RODA DE CONVERSA NO PROCESSO DE EDUCAÇÃO PERMANENTE EM SAÚDE MENTAL

ESTRATEGIA DE RUEDA DE CONVERSACIONES EN EL PROCESO DE EDUCACIÓN CONTINUA EN SALUD MENTAL

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This study aimed to describe an experience report on the use of round-table discussion strategy as driver of Healthcare continuing education in the context of Psychiatric Reform. This is a descriptive study that used participatory methodology with workers of four health regions of a municipality located in Rio Grande do Sul, Brazil. We identified the potential of the first movements of the strategy entitled Mental Health in Discussion in displacing the Primary Healthcare Workers, in the sense of reviewing their practices and their perspective on users in mental distress. It was concluded that the strategy used can enhance the process of Healthcare continuing education in the context of Psychiatric Reform, even as a new proposal, subject to modifications, and that is drawing its own course in each round.
Descriptors: Mental Health; Health Human Resource Training; Primary Health Care.

O objetivo deste estudo é descrever um relato de experiência sobre a utilização da estratégia de rodas de conversa como impulsionadoras do processo de educação permanente em saúde no contexto da reforma psiquiátrica. Estudo de natureza descritiva, em que foi utilizada a metodologia participante com trabalhadores da rede básica de saúde de quatro regiões sanitárias de um município localizado no Rio Grande do Sul/Brasil. Identificou-se a potência dos primeiros movimentos da estratégia aqui denominada Saúde Mental na Roda em desacomodar parte dos trabalhadores da Atenção Básica, no sentido de reverem suas práticas e seu olhar em relação aos usuários em sofrimento mental. Concluiu-se que a estratégia utilizada pode potencializar o processo de Educação Permanente em Saúde no contexto da Reforma Psiquiátrica, mesmo sendo uma nova proposta, sujeita a modificações e que vai desenhando seu próprio curso a cada rodada.
Descritores: Saúde Mental; Capacitação de Recursos Humanos em Saúde; Atenção Primária à Saúde.

El objetivo fue describir un relato de experiencia acerca de la utilización de la estrategia de ruedas conversaciones en el proceso de educación continua en salud en el contexto de la reforma psiquiátrica. Estudio de naturaleza descriptiva, tipo relato de experiencia, en que se empleó la metodología participante con trabajadores de servicios básicos de salud en cuatro regiones de salud del Rio Grande do Sul/Brasil. Se identificó el poder de los primeros movimientos de la estrategia aquí llamada Salud Mental en la Rueda en perturbar a los trabajadores de atención primaria, a revisar sus prácticas y su mirada a los usuarios con problemas mentales. La estrategia utilizada puede mejorar el proceso de Educación Permanente en Salud en el contexto de los ideales de la Reforma Psiquiátrica, aunque sea algo nuevo, sujeto a cambios y que diseña su propio curso en cada rueda.
Descriptores: Salud Mental; Capacitación de Recursos Humanos en Salud; Atención Primaria de Salud.

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INTRODUCTION

The Psychiatric Reform process in Brazil began in the 80s and was strengthened during the democratization process of the country along with the Health Care Reform Movement. This process was based on the principles of de-institutionalization and de-hospitalization, as a new proposal to rescue the citizenship rights of individuals with mental disorders[1].

The Psychiatric Reform is a complex political and social process, because it involves actors, institutions and forces of different origins and that focus on different areas, such as federal, state and local, universities, health services, professional councils, associations of persons with mental disorders and their families, social movements and the boundaries of the social imaginary, among others[2].

In this sense, we understand that the time to formulate a public policy in mental health corresponds to that of expressing a continuous process conducted by different actors. Thus, its value lies on the achievement of the collective desire and creation of concrete conditions for its performance.

These changes provoke a crisis in the daily activities of mental health workers, creating anxieties arising from the difficulty of operating with these new technologies. In addition, these professionals are faced with the lack of training to deal with certain situations that go beyond the diagnostic and therapeutic ability, such as the access difficulties for users with increasing repressed demand, the fragile articulation among mental health services and between these and primary care, among other aspects.

In this context of difficulties and challenges, the Health Department of a municipality located in the interior of the State of Rio Grande do Sul, Brazil, proposed the creation of a collective space for discussion among professionals working in mental health. This group of workers composed then the Mental Health Commission (MHC). This organization was created in 2005 and was comprised of representatives of regional and local management and of workers in mental health services, primary care network and educational institutions of health workers.

This movement was created in order to reflect on the course of the Psychiatric Reform in the city, from the reality of mental health services and the need to redesign the local health care network. Therefore, it was focused on structuring a mental health care network, in which all services in Mental Health Care and Primary Health Care were included, so that it was possible to have a broad discussion on mental health, in accordance with the Psychiatric Reform principles.

To implement the MHC proposal, many actions were needed, for example, identify the professionals with profile and training in mental health, trigger the process of continuing education in these workers, understood as the starter of the process, present to the local health care network the role of Psychosocial Care Centers (CAPS) and design the flows of these services.

In this line, the Mental Health Commission, seeking articulation of the Mental Health Care Network, chose as strategy the Mental Health in Discussion, understood as a space for dialogue and discussion in which everyone has a voice and whose main purpose is the exchange and articulation between mental health services and the basic health care network. This commission is based on performing interaction and integration activities with the teams of Basic Health Units (BHU) and Family Health Strategy (FHS), putting everyone involved in the discussion.

From this, we outlined the objective of this study of describing an experience report on how the Mental Health in Discussion, implemented by the MHC, can be characterized as triggering and driving the process of continuing health education of workers in the context of

the Psychiatric Reform principles. Justified by the need to socialize the experiences and encourage healthcare professionals to report their work process in order to advance the debate on mental health.

METHOD

The strategy of Mental Health in Discussion is inspired on round-table discussions, a method of collective interest that consists of creating spaces for dialogue, where people express themselves, and listen to others and themselves. This strategy encourages the construction of personal autonomy through questioning, information exchange and reflection for action[3]. In this perspective, the discussion serves to foster exchange circuits, mediate reciprocal learning and/or associate skills, and that everyone who enters the discussion has equal powers on the subject they speak of[4:57-9].

Thus, considering that workers need to be better prepared to assist the demand of users in psychological distress, this study had as guiding question: How Mental Health in Discussion can encourage the continuing health education?

RESULTS

Unfolding mental health in discussion

To drive the process of continuing health education, we used the participatory method with workers. This method allows the effective involvement of the participants in the educational process without considering them mere receptors, which are deposited in knowledge and information. In the participatory approach, we value the participants' knowledge and experience, involving them in the discussion, identification and search for strategies to solve the problem-situations that arise. This method also facilitates the process of personal, interpersonal and teaching-learning reflection, integrating people and establishing bonds of affection and mutual respect[5].

This experience report is described from the access and analysis of records of Mental Health in Discussion meetings, the name given to the strategy of round-table conversation, in every region of the municipality where this dynamic was implemented, as well as the Report of the Local Mental Health Policy in 2008.

The municipality in which the Mental Health in Discussion took place is located geographically in the center of the State of Rio Grande do Sul, Brazil, with a population of approximately 270,000 inhabitants and, thus, is the main healthcare center of the Macro-region Center-west of the State. This municipality, given the high demand from users who seek health services, has faced difficulties in health management for effective attention to local and regional demand, especially regarding mental health care.

This municipality is divided into four healthcare regions (north, west, south and east) and in each one of them Mental Health in Discussion was structured as follows: the coordinator and workers in each health unit (FHS or BHU) were initially invited to attend the meeting of the Mental Health Commission to present the proposal of the Mental Health in Discussion. At this time, we asked these professionals to report their main difficulties regarding the assistance to users in mental distress, in order to provide the members of this committee with necessary instruments to organize the discussion so that, later in the meeting with the entire team in Basic Health Units or in the Family Health Strategies, these issues were primarily addressed and triggered discussion.

The mental health workers and other members of the Commission were Discussion starters and were distributed according with the proposed theme for each round. The themes, in turn, also varied from one region to another, and group participants determined and chose the agenda based on the weaknesses of the team, their main doubts, worries and concerns.

In general, as regards to the difficulties reported

by workers of Basic Health Units, we highlight the often non-assistance to users suffering from psychological distress. We identified the needs from workers to confront their anxieties and the community's; the need to assuage the fear in contact with the user in distress, as well as the user of alcohol and other drugs and the violent situations in the community. This referred to the need, stated by them, for a permanent staff and a mental health professional with the staff.

We also highlight that in each of the local health regions, the meetings occurred with different timing and frequency, according to the demand of the region and those professionals. The activity occurred in each region over a year and started in 2005, in the North region, followed by West, East and South, respectively.

The first region where the discussion took place, in other words, where the issues began to be discussed, was the North region of the city, in which there were five fortnightly meetings with two groups of workers. Among those who participated, we highlight the doctors, nurses, nursing technicians and community health workers. These meetings were conducted in a BHU located in the region and were coordinated by two mental health workers, triggers of the process and members of the Mental Health Commission.

In these meetings, workers suggested mental health-related issues to be discussed in subsequent meetings. The main themes were related to knowledge on mental health in its broad aspect (concept of mental health, types of mental illness, treatment options, and psychiatric reform), as well as the need to know the local mental health services and referral methods.

The recognition of mental health care network occurred in situ, given that all workers have chosen to conduct a visit to mental health services, since most workers did not know them. Based on this, a minibus from the Local Health Department was available and we went to recognize the facilities and the operation of each mental health care service. In the last meeting, everyone received an instrument to assess the dynamics proposed, in order to contribute to this process.

It is worth mentioning that, two workers of the mental health services maintained a permanent agenda with this Region, conducting monthly meetings and providing support to units professionals in case discussion, embracement and referrals.

In assessing this movement, workers expressed that the discussion strategy used to address mental health enabled a better articulation between professionals of mental health services and primary care network. With this, the issue of mental health has gained prominence in everyday activities of the teams, and therefore in comprehensive health care for the population.

The discussion strategy in the Western Region occurred in 2006, through five meetings. In this region was discussed the issue of violence. And in the assessment, some workers expressed initially believing that the discussions occur through lectures rather than integrated and participatory as the meetings took place.

DISCUSSION

Reflections on mental health in discussion

This brings us the questions of the fragility of workers, placing them as a group vulnerable to processes designed by a directive instance, inserted on the idea of continuing education, where the continuity of "knowledge transfer" is required to meet a supposed deficit training for health services[6].

It was verified that the discussions in each region have been driving the discussions in that area as they enabled to reaffirm the movements derived from this process.

In this sense, the implementation of continuing educational activities directed at multidisciplinary teams of primary care enabled the incorporation of more appropriate intervention technologies such as embracement and qualified listening. This can help

increase the ability to detect situations of violence, as well as identify alternatives in the context of community partnerships, which allow the construction of social support networks and coping with violence situations[7]. During the meetings, the workers reported that the proposal of Mental Health in Discussion made the team feel valued and encouraged.

In 2007, the Discussion was conducted in nine meetings with workers of BHUs of Eastern Region. It is worth mentioning that in addition to experience exchanges and case discussions, we used the support material Integrated Protocol for Mental Health of Curitiba[8] and primers of the National Humanization Policy[9] in order to broaden the discussions.

In this region, drug addiction was one of the first topics proposed by the group, and that raised questions such as: What drives persons to do drugs? When is the moment to refer the user to specialized services, considering the bonds? What health workers consider as a successful intervention?

The importance of listening and care for users and their families, and the feeling of helplessness experienced in the search for solving the cases were also discussed. Another topic discussed was the mental health in childhood and adolescence, starting from the survey of what was understood as a problem at this stage of development, which enabled to bring up the discussion of common manifestations during this process, as well as factors of health and risk promotion, besides the important role of the family.

Interestingly, the group went from discussions about childhood to those about the elderly, whose specificity is not addressed in the FHS training. The last two meetings have focused on the relationship of health professionals and the user, which led to study the concept of extended clinical care. Extended clinical care suggests that health professionals develop the ability to help people not only to fight diseases, rather to change themselves, so that the disease, even though boundary, does not prevent them from experiencing other things in life[10].

From this proposal, it was possible to identify the importance of Mental Health in Discussion as triggering the process of continuing health education at the local level and driving the discussions focused on comprehensive health care, a situation endorsed in the assessment process of this region.

We verified that the methodological proposal used in this process by mapping the needs of workers to organize the discussion, provided an opportunity for a movement that connected other health policies, therefore, being effective.

In the second half of 2008, the Mental Health Commission held the 4th Edition of Mental Health in Discussion, directed to health workers of Southern Region of the municipality. In these meetings were addressed topics such as mental health in primary care, embracement, extended clinical practice and networking, permeating the specific needs identified by all workers in this region.

In this perspective, workers highlighted that some important changes derived from the Mental Health in Discussion strategy, such as enabling the referrals of users from one network service to another, in a more appropriate and organized way.

This fact can be partially justified when, at the end of each round, workers were asked to rate the Discussion meetings, which was recognized by them as an important space for sharing experiences, fears and insecurities, helping to reduce conflicts and anxieties inherent in working in this area.

This reminds a definition of mental health work based on a metaphor: "Eye of the Hurricane", relating it to the place that mental health workers occupy in the context of Public Health, for considering that this analogy summarizes the level of complexity involved in the construction and, therefore, the analysis of mental health practice[11].

Working in Mental Health is complex, multiple, interdisciplinary, intersectoral and interprofessional, which, ultimately, only happens if it's linked to a cultural change in the social imaginary, in the various social subjects and actors, in other words, it also generates new anti-hegemonic possibilities to understand the human multiplicity and suffering within a social field of inclusion and citizenship[9].

Based on these, we were able to identify the Mental Health in Discussion as a process of continuous education, training, triggering movements of "strangeness, discomfort, questioning and implication," potential for a collective differ from oneself and unfold new practices[12:453].

The continuing dialogue process with all workers of the Health Regions, where the Mental Health in Discussion has already taken place, remains through a monthly and permanent agenda in each of the Regions. On these occasions, two mental health workers act as facilitators of the process.

Through the reports of the workers involved in assisting the groups, of contacts with mental health services, and of assessment instruments at the end of each round, we verified the contribution of Mental Health in Discussion in the process of team work and especially in support of Community Health Agents.

Authors state that mental health practices within the primary health care are important means of enabling the Psychiatric Reform principles, since they maximize the integration of social networks and promote practices aimed at mental health promotion and disease prevention[11].

In this sense, we highlight the importance of continuing assistance provided by mental health workers, such as support to primary care teams, especially to Community Health Agents. This is justified, given these people are daily faced with complex situations in the lives of users, and for being mentioned by other health workers as those who have more difficulties facing the mental health problems of their communities and should be assisted in a special way.

It is observed that, despite the positive assessment of advisors as support for primary care, insecurity and anxiety were identified among mental health workers for failing to meet the great demand of the daily activities of these teams, and especially for the difficulty of the network flows related to users in psychological distress.

Thus, every time a situation triggers anxiety in the team, it is referred for another one, until the fear or feeling of helplessness is minimized. More than that, the macro-political solution, i.e. the referral policy for specialized services, by itself will always be insufficient, as its supply generates increasingly demand if we do not change the healthcare production[13].

In this context, to achieve an effective mental health care in primary care services, the problems must be addressed in order to enable a qualified listening and relevant interventions, being a powerful marker that points to the incorporation in everyday practice of the broader concept of the health-disease process. Thus, it will be able to maximize the ability of teams to leave the complains-conduct action type, building competence to articulate community and intersectoral resources[7].

It is argued that, only in this way it is possible to consider the citizens as a whole, in their individual and collective needs, contributing to resolute health actions. Therefore, intersectionality seeks to overcome the fragmentation of policies to consider the human being in its uniqueness and complexity, which is possible only through the construction of truly strategic alliances between different government, non-governmental, private and civil society sectors built on everyday services[14]. Still, we cannot deny the importance of sectoriality, since it is fundamental to achieve intersectionality[15].

In this construct, it is understood that intersectionality is a complex political strategy, which

helps the local management to overcome the fragmentation of policies in the various areas where they are implemented, assuming the dialogue between their performers and their managers. Therefore, the main challenge is to articulate different sectors in solving problems in everyday management, creating a mechanism to guarantee the right to healthcare access, since this production is derived from multiple social policies to promote quality of life, especially in mental health[16].

FINAL CONSIDERATIONS

This experience report described how the dynamics of mental health work was organized, placing the subject in debate, and literally under discussion. Effectively, everyday situations emerged, in which the group raised problems and sought some possibilities for intervention or referral. Thus, the production of knowledge in the collective space took place, making this a singular moment in the lives of workers.

In the meetings of Mental Health in Discussion, important issues to articulate the Mental Health Network in the city were also addressed, among which the urgent need to increase the population's access to mental health care; discussion among workers about welcoming users with psychological distress and their families, as well as the social integration of users who are being treated at the local CAPS in their communities.

With the Discussions, we realized its power in triggering a process of collective production of knowledge between Primary Health Care and Mental Health, and it proposed new health practices, where the services are also responsible for the users. At each meeting we began a new challenge, respecting the characteristics of each region, which provided not only a technical-scientific improvement, but also a new perception of mental health work.

The Mental Health in Discussion offers potential for all health workers, since it uses the context as a starting point for discussions, as well as it seeks to bring the Local Mental Health Policy closer to the Psychiatric Reform principles, triggering the process of continuing education for mental health services to workers in Primary Care. This movement can cause effective changes in everyday practices of workers, especially in the care for users in psychological distress.

Thus, we believe in Mental Health in Discussion as a strategy, a way for continuing education, something new that is subject to changes, which unfolds, expands and deepens, supported by ideas and the use of theoretical-methodological frameworks, and effective participation of workers in the network.

Therefore, the Mental Health in Discussion strategy stands out as powerful mechanism for Continuing Education in Health in the context of the Psychiatric Reform principles, enabling the interaction and integration of services in the achievement of the health care network, establishing its own course on every round.

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