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WORK AND MENTAL HEALTH: EXPERIENCES OF PRIMARY HEALTHCARE WORKERS IN FLORIANÓPOLIS[1]

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Abstract: In this study, we aimed to analyze how the relationship between work and mental health is presented in health care based on the experience of primary health care (PHC) professionals and in the debates of health conferences in Florianópolis. We take health work as an activity from the perspective of Clínica da Atividade. We used cartography as a methodological approach consisting of interviews with PHC professionals and our participation in municipal health conferences. The analysis elucidates the complexity of the relationships between work experiences and health situations, intensifying the experience of psychological suffering in relation to social issues of inequality and violence. Concerns persist about how to intervene in the face of the controversy that a large part of the Brazilian population needs to keep working for their subsistence, although work experiences present significant damage to mental health. The scenario of dismantling social policies constitutes another obstacle to work in PHC.
Keywords: Work, Mental health, Primary Health Care, Worker's Health.

INTRODUCTION

In this study, we aimed to analyze the relationship between work and mental health in public health policies, covering the scope of primary health care (PHC) as it constitutes the preferred gateway to the Unified Health System (SUS). In contemporary societies, work is established as an important mediator of social integration, it is a source of subsistence for individuals and the constitution of subjectivity. The work activity devoid of meaning, permeated by violence and without social support constitutes a source of threat to physical and/or psychological integrity, as well as the lack of work, as it puts livelihood and subjective value at risk. The way people experience and give meaning to work experiences is one of the social determinants of health and mental health.

The current capitalist system has intensified workloads with the primacy of profit and productivity, reduction of the workforce, pressure and competitiveness. Outsourcing and precarious working conditions have increased, in addition to growing threats of unemployment. This scenario contributes to aggravate work-related stress and psychological distress, which is intensified when considering the intersections of gender, race/ethnicity, social class, sexualities, among other markers of social differentiation. Furthermore, we are experiencing a context of dismantling of social policies in Brazil, among which the SUS (Unified Health System) is under threat.

The SUS (Unified Health System) is the main public health policy in Brazil, in which health becomes a right of all people and a duty of the State, guaranteed in the Federal Constitution of 1988 and in specific ordinances. In the articulation between health and work, the worker's health policy (STT) is configured as a normative that proposes guidelines to intervene in the relationship between the productive system and health at different levels of health care. We proposed as scope of the research the articulation between STT and mental health (MH) in PHC.

The problematic field privileges the perspective that health policy is made in the daily actions of SUS (Unified Health System) workers. We take health work as an activity, which means considering it in the micro-management of the distance between the *prescribed work* and *real work*,in the hiatus in which workers' initiatives establish relationships that modify norms, according to the perspective of Clínica da Atividade (CLOT, 2010). We used cartography as a methodological path with procedures consisting of interviews with professionals from the PHC of Florianópolis and our participation in health conferences in the city.

In the world of work, we face various forms of violence and violation of rights that reverberate in suffering with great challenges due to the invisibility, silencing and stigmatization of situations related to mental health, such as the experiences of moral and sexual harassment. Given the context of dismantling labor rights and social policies, how does the relationship between work and mental health permeate the daily work of PHC professionals? How do they reverberate in the production of health care? How do they affect the mental health of PHC professionals? These concerns drive the research that is woven from the work experiences narrated by professionals from the APS in Florianópolis.

This work is organized into four subsections. We begin by briefly situating some of the debates and data on the interface between work and mental health in the Brazilian context. Then, we present the methodological assumptions and procedures used in the cartographic journey, following with the reflections and questions raised from the initial analysis of the doctoral field research, and ending with some considerations.

WORK AND MENTAL HEALTH

The contribution of work experiences to changes in mental health ranges from occasional situations of exposure to a specific toxic agent, threats to physical and mental integrity, to the complex articulation of elements in the organization of work (VASCONCELOS; FARIA, 2008). Most psychosocial risk factors are related to the type of work, the organizational and management environment, the skills of workers and the support available to carry out their work (WHO, 2017).

There is considerable evidence linking psychosocial risks as one of the main causes of lost time from work due to its influence on mental health and impact on people's well-being, presenting significant costs for organizations, health systems, pensions and other programs of social protection. However, the recognition of the relationship between mental health and work is still the object of uncertainties and conflicts that lead to low identification of situations and little visibility of work-related mental disorders, aspects that make it difficult to understand and dimension the problem to promote appropriate actions (BRASIL, 2019). In addition to these challenges, Lima (2013) highlights the prevailing idea that mental health problems at work originate from strictly personal issues and that individual treatment must address them, disregarding working conditions and psychosocial aspects of the environment. of work.

In Brazil, a recent study carried out by Social Security analyzed the granting of benefits for temporary and permanent incapacity to work in the period from 2012 to 2016, in which mental disorders occupied the third place, corresponding to 9% of the situations (BRASIL, 2017). In the SUS (Unified Health System), work-related mental disorders are subject to compulsory notification in the Notifiable Diseases Information System (SINAN), but underreporting is evident. In the SINAN data analysis bulletin from 2006 to 2017, 8,474 cases of work-related mental disorders in Brazil were registered, with an increase in the number of notifications each year (BRASIL, 2019). Reactions to severe stress and adaptation disorders were the most common diagnoses, followed by depressive episodes and other anxiety disorders that was higher among men (BRASIL, 2019). Women's disadvantage is a result of gender inequities at work, such as moral and sexual harassment and other forms of violence.

In Santa Catarina (SC), an extensive survey carried out by UFSC, UNIVALI, FETIESC and FECESC (2013) presents an analysis of

the prevalence of health problems from the social security benefit granted among the fifteen main economic activities in the state from 2005 to 2011. The upheavals Mental and behavioral disorders occupy the third position among the most prevalent diagnoses in the granting of benefits for work-related illness with 10%, in which the majority refers to depressive episodes. In Florianópolis, 40 cases of work-related mental disorders were reported in 2014, of which 17 situations were accompanied by bullying; the most recurrent complaints were anxiety, nervousness and stress at work related to conflicting situations at work (FLORIANÓPOLIS, 2016).

In the Brazilian context, the SUS (Unified Health System) has made important advances with the establishment of a National Policy on Occupational Health (PNSTT) with an effort to strengthen the STT network that covers the different levels of care and health surveillance, with the mandatory requirement notification of work-related injuries in SINAN. Araújo, Palma and Araújo (2017) cite several challenges to be faced with regard to mental health at work in the SUS (Unified Health System): "underreporting; little or no articulation between the actors involved; lack of follow-up of cases, adoption of action models still centered on the disease with medical intervention; reductionist and punctual actions; difficulties in establishing a causal link" (p. 3244). Conciani and Pignatti (2015) also identify that actions in mental health at work are punctual and unsystematic in the SUS (Unified Health System), in addition to being insufficient to intervene in the sources of production of mental illness, as they are still based on reductionist logics that do not fight the genesis of problems related to illness at work (ARAÚJO; PALMA; ARAÚJO, 2017). Leão (2014) emphasizes that STT actions need to be systematic, focusing on work processes, aiming to provide transformations in the work context to reduce or eliminate factors associated with illness processes present in the organization of work, anchored in the active role of/ the worker, in spaces of dialogue with workers, valuing their perspectives on the work activity. Daldon and Lancman (2013) reinforce the importance of the role of primary health care (PHC) in strengthening STT actions.

CARTOGRAPHY AS A METHODOLOGICAL PATH

The study aimed to analyze how the relationship between work and mental health is presented in health care from the experience of primary health care (PHC) professionals and in the debates of health conferences in Florianópolis. We proposed a double perspective of analysis: from how work appears and permeates health care to how it reverberates in the mental health of PHC workers.

We use cartography as a methodological path because it makes it possible to follow a process in constant movement. The cartographic perspective was inaugurated by Deleuze and Guattari (1995), being developed as a research method and strategy to produce knowledge by authors in Brazil (FONSECA, 2003; PASSOS; KASTRUP; ESCÓSSIA, 2009; ROLNIK, 2011). It is based on the institutionalist movement that postulates the inseparability between knowing and doing, researching and intervening.

The cartographic route consisted of two main procedures: conducting interviews with professionals from the APS Florianópolis and participating in health conferences in the city in 2019. Interviews and spaces for debate operate as a device to compose the experience in speech, as it in narrative makes it possible to trigger meanings together with the people with whom one is dialoguing. Tedesco, Sade and Caliman (2013) propose the cartographic

trail of *saying experience*, through which we seek to activate the experiences of the interlocutors regarding the daily work in health.

In Florianópolis, health care is organized into four health districts (DS), of which we proposed to approach four family health teams (eSF), one from each DS (centre, continent, north and south) and with professionals from the centers family health support (NASF). The territories were chosen with the proposal to cover different realities of the city in the ways of living and working, in the determinants of health, in the organization of health work, and we used data on notification of work-related health problems. The project was approved by the ethics committee for research with human beings (CEPSH-UFSC) and follows the norms of the National Health Council (CNS).

We conducted individual interviews with 20 PHC workers covering different professional categories: nurses, doctors, nursing technicians, community health agents, social workers and psychologists. Among the interlocutors, 18 women and 2 men participated, with experience in PHC between 3 and 20 years. As selection criteria, we prioritize when professionals from the same eSF are interested in participating. We invited the NASF professionals who provide matrix support to the participating eSFs for an interview. We proposed individual interviews due to the possibility of deepening the dialogue, in addition to facilitating the approximation with the health teams through the organization of the work process.

Health conferences correspond to the collegiate instance of social control in the SUS (Unified Health System) designed to assess the health situation and propose guidelines for the formulation of health policy. They are organized by health councils every four years and take place in three spheres: municipal, state and national. Participation in this instance focused on paying attention to how the interactions between work and mental health appear in this space of social participation.

We followed the developments of the problematic field, placing ideas in a provisional way in what emerges from the potential and unique of the experiences. We seek to provide movements that drive thinking, questioning and denaturalizing. How does work appear and permeate the daily life of public health policies? How to (re)affirm a health policy that guarantees human rights in the context of dismantling social policies in Brazil? How does precariousness in the world of work impact people's lives and (mental) health?

RESULTS

By analyzing the relationship between work and (mental) health based on the experiences narrated by PHC professionals, it was possible to problematize the way in which health practices can constitute a cog in the capitalist system, as happens in situations of medicalization to support the pain and the issues of life and work that cannot be changed. Doctor Claudia's narrative [2] exemplifies this question: "*There's kind of this situation where you have to work and you have to be fine and not have this view that maybe you have to change something at work so that the person is fine (...) It's as if we were part of the The system itself... the patients are parts, gears that we just go there and lubricate so that it can return to a sickening process. So it's not a transformative process. We are kind of part of the system to keep working. So you give medicine to the person to be able to bear it and keep working. Kind of doesn't have much to do, the person has to keep working, earn money, support themselves. It is*

2. We use fictitious names to preserve the confidentiality of research participants, in accordance with the ethical standards of the National Health Council for research with human beings. For the same reason, we do not identify other information related to workplaces.

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distressing in this sense that we are part of the system's cogs"

Concerns about the controversy persist: a large part of the population followed by the PHC (Primary Health Care)/SUS (Unified Health System) teams need to keep working for their livelihood, although the work activity presents significant harm to (mental) health, as in meaningless works, as the physician Júlia puts it: *"Most of the people I see aren't doing things they necessarily like or want to do with their lives, or aren't feeling so good about doing it. So, this in itself is sickening".*

The experiences narrated reflect the efforts made by PHC professionals to identify the working conditions with the health status of the population being monitored, although this relationship is invisible or dissociated in work environments. The interlocutors situate the circuit of pain that encourages wear and suffering – physical, psychological and social – and even a loss of the ability to work for the part of the body destroyed by the work activity. narrate that "*the most common is the path of pain*" reverberating like "*snowball*" in the process of suffering and illness. Thus, they see health situations in a contextual and integrated way with the ways of living.

Interlocutions were predominant with and about women as protagonists of care, depending on the multiple journeys, invisibility of domestic work and discrimination based on gender, which is reflected in lower wages and/or greater demand for professional requirements. In addition to these situations, most of the narratives reflect the tension experienced by women in the gestational period and in the postpartum period due to the persecution and harassment suffered at work, as we situate the speech of nurse Bianca: *"In our population, we assist women who work in cleaning matters a lot, and when they are pregnant, there are bosses who put a lot of pressure on them to get a certificate. We had several pregnant women in this situation that we asked for help from the social worker. Some of them even had to be sent to the Ministry of Labor for harassment, pressure for her to resign. And in the end, we ended up leaving because the work was doing bad for the woman and even interfering with the pregnancy."*

Professionals identify the impact of situations of discrimination experienced in work environments, intensified in the black population and/or residents of peripheral neighborhoods, as contextualized in the narrative of psychologist Raquel: *"That we have a divided city, right. And black people are in these places. Women, black, poor and squatters. It's a package that will go into work, in a position that is delegated by a slave, it will be stigmatized in some way. (...) And people are also stigmatized for being from a vulnerable community".*

Some meanings were produced by the participants when recognizing their commitment in the search for affirmative solutions at the relational level, such as the availability to monitor, dialogue and support users in a unique and contextualized way, despite the feeling of impotence or "*of not doing enough*" by "*not to be able to solve*" or "*not to keep up with the demand*". The complexity of health situations associated with social issues of inequality and violence intensifies the experience of psychological distress experienced by PHC professionals. These people find meaning in the recognition of the work activity they carry out, in the support among colleagues.

The scenario of growing social lack of protection and dismantling of social policies constitutes another obstacle to work in PHC. We are faced with movements against the expansion and consolidation of the SUS and other social policies with the approval of Constitutional Amendment 95/2016, also known as the PEC of the ceiling that limits

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public spending for 20 years for fiscal and social security budgets to from 2018. This is an economic austerity measure that freezes and makes it impossible to increase investment in social policies, weakening the entire social protection network, such as health, education, social assistance, housing, sanitation, among others. Social policies already suffered from underfunding and now face a reduction in public spending, regardless of population growth and complex health needs. In addition, they face the impacts arising from the labor reform approved in 2017 with Law 13,467, which increases the precariousness of working conditions. The current government policy presses for the approval of the social security reform, still pending in the Senate, with strong rejection by the population, as manifested in the meetings of the health conferences by rejecting the proposals for the funded system, the increase in the minimum age and the contribution time, reduction in the value of pensions, among other aspects.

The relationship between work and mental health appears in the debates of pre-health conferences when the overload of PHC professionals is identified due to incomplete teams due to the non-replacement of workers who reduced the workload, retired or left for illness. Conference participants showed interest and approved in the final plenary the proposal to expand PHC coverage by 100% in the municipality with full teams and mobile teams for vacation situations, by hiring professionals through public competition, a proposal that had been approved at the conference of 2015, but not effective. Another topic discussed in relation to working conditions was the defense of public management, with an approved proposal to revoke outsourced management models, as is the case with social organizations (OS) in the management of the UPA (Emergency Service Unit) Continente. The debate revolves around the importance of a public and quality SUS that guarantees decent working and bonding conditions for the qualification of professionals for the SUS. In the pre-conference of the northern health district and in the free conference on women's health, the family health residents pointed to the illness of SUS professionals, suggesting actions aimed at the mental health of these workers, but this proposal was not prioritized in the vote. The only approved proposal that addresses the T&SM relationship was raised at the free conference on mental health with regard to expanding the devices and teams of the psychosocial care network (RAPS) in the municipality and ensuring the qualification of professionals in "mental health, mental health and work, mental health in childhood and adolescence, in the care of users of alcohol and other drugs". Thus, the relationship between T&SM was discussed in a timely manner at health conferences and appears more in the context of training health professionals and in the recognition of work overload in PHC and in situations of precarious working conditions with the outsourcing of public management with the hiring of OS.

SOME CONSIDERATIONS

The relationship between work and (mental) health (M&W) is identified by health professionals in their daily work, raising reflections on the intervention possibilities, with the recognition of the importance of training in this area and actions aimed at (mental health) of health workers. On the one hand, the complexity of health situations associated with social issues intensifies the experience of psychological distress and wear and tear due to the burden experienced by PHC professionals. On the other hand, the interlocutors narrate the satisfaction of feeling their work recognized, especially in the encounter with users in situations

where the bond and dialogue enabled improvements in the person's life. They stress the importance of peer support and work with teaching residents. They recognize that health care is part of a complex social context of inequalities, in which they understand that their role as health professionals also involves guaranteeing rights, although in a scenario of dismantling of social policies. Some meanings were produced by the participants when recognizing their commitment in the search for affirmative solutions at the relational level, such as the availability to welcome, accompany, dialogue and support users in a unique way, despite the feeling of not being able to cope demand or not doing enough.

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