# DEVELOPMENT OF HUMAN RESOURCES FOR WORK IN MENTAL HEALTH SERVICES[1]

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**ABSTRACT:** The aim of this study was to understand aspects related to training and capacity-building of professionals working in mental health services within the State of Goiás, Brazil, from the point of view of the coordinators of these services. This is qualitative research, with the participation of 19 coordinators. The data was subjected to thematic content analysis with the help of Atlas-ti software. The themes that emerged from the content analysis were: characteristics of professionals to work in mental health; teamwork and interdisciplinarity as a care management model; academic training of professionals; professional practice and continuing education; and insertion into the work market. The study considers the emerging need to develop people, according to the psychosocial model, to work in mental health services and ensure work contracts that favor qualification and assistance.

**DESCRIPTORS:** Mental health services. Health management. Human resources. Continuing education. Mental health.

# DESENVOLVIMENTO DE RECURSOS HUMANOS PARA ATUAR NOS SERVIÇOS DE SAÚDE MENTAL

**RESUMO:** O objetivo deste estudo foi compreender os aspectos relacionados à formação e capacitação dos profissionais que atuam nos serviços de saúde mental no interior do Estado de Goiás, Brasil, sob o ponto de vista dos coordenadores destes serviços. Trata-se de pesquisa qualitativa, com a participação de 19 coordenadores. Os dados foram submetidos à análise temática de conteúdo com o auxílio do *software* ATLAS-ti. As categorias temáticas que emergiram da análise de conteúdo foram: características dos profissionais para atuar em saúde mental; o trabalho em equipe e interdisciplinaridade como modelo de gestão em serviço; a formação acadêmica dos profissionais; a prática profissional e a educação permanente; e a inserção no mercado de trabalho. Consideramos emergente a necessidade de desenvolver pessoas, segundo o modelo psicossocial, para atuar nos serviços de saúde mental e garantir vínculos de trabalhos favoreçam a qualificação e a assistência.

**DESCRITORES:** Serviços de saúde mental. Gestão em saúde. Recursos humanos. Educação continuada. Saúde mental.

# DESARROLLO DE RECURSOS HUMANOS PARA ACTUAR EN LOS SERVICIOS DE SALUD MENTAL

**RESUMEN:** El objetivo de este estudio fue comprender los aspectos relacionados con la formación y capacitación de los profesionales que trabajan en los servicios de salud mental en el Estado de Goiás, Brasil, desde el punto de vista de los coordinadores de estos servicios. Esta es una investigación cualitativa, con la participación de 19 coordinadores. Los datos fueron sometidos al análisis de contenido temático, con la ayuda del *software* Atlas-ti. Los temas que surgieron del análisis de contenido fueron: características de los profesionales que trabajan en salud mental; trabajo en equipo e interdisciplinario como un modelo de gestión en el servicio; los profesionales académicos; la práctica profesional y la educación continua, y la inserción en el mercado laboral. Consideramos reciente la necesidad de capacitar personas, de acuerdo con el modelo psicosocial, para trabajar en los servicios de salud mental y garantizar la vinculación trabajos que promuevan la calificación y asistencia.

**DESCRIPTORES:** Servicios de salud mental. Gestión en salud. Recursos humanos. Educación continua. Salud mental.

## INTRODUCTION

Over the last three decades, mental health care in Brazil has undergone a paradigm shift that began with the Psychiatric Reform. Deinstitutionalization, one of its main pillars of this movement, is understood beyond the measures related to dehospitalization, and includes social reintegration and the breaking of stigmas.[1]

After more than 20 years of demands initiated by the Movement of Mental Health Workers, which were boosted by the Health Reform Movement in the 1980s,[1] Brazil won significant change in mental health legislation with the enactment of Law 10.216/2001, which provides for the protection and rights of people with mental disorders.[2]

Supported by this law, in Brazil the National Mental Health Policy (NMHP) follows the global trend of organizing community care practices to replace institutionalized procedures for treatment. The NMHP proposes various devices for mental health care that should be articulated in a network, appointments for which must be made in the psychosocial care centers (*Centros de Atenção Psicossocial* - referred to as CAPSs, as per its acronym in Portuguese), therapeutic residences, outpatient clinics, general hospitals, social centers and psychosocial care units (*Núcleos de Atenção Psicossocial* - referred to as NAPSs, as per its acronym in Portuguese).[2]

The purpose of the NMHP is to guarantee the free movement of persons with mental disorders through the services, community and city, in addition to providing care based on the resources the community has, in accordance with the psychosocial model.[2]

It is important to recognize the complexity of the psychosocial care model, and how the actions of mental health services professionals are guided by establishing emotional and professional bonds between people, with a view to promoting citizenship, as well as emphasizing the importance of including the family in treatment and rehabilitation. These assumptions take the emphasis from intervention practices on the disease, fragmentation of care and the hegemony of psychiatric knowledge, to consider the subject in psychological distress in their cultural, family and social context.[2-3]

By questioning practices of social exclusion and chronification of the illness, the Psychiatric Reform reorients care to the community and directs actions to promote social reintegration and the exercise of citizenship.[4]

Thus, the organization of services was changed, making possible the inclusion of other actors and professional categories in mental health care, with the need emerging for the health care team to work from an interdisciplinary perspective,[4-6] guided by the responsibility and therapeutic association to comprehensively care for the subject and promote psychosocial rehabilitation.[7] Despite these changes, one cannot say that mental health practices followed this paradigm shift, as it is still possible to find, in services, practices focused on the organic dimension, of individual and physician-centered delimitation.[8]

Often the work by professionals in CAPS is still focused on the disease as an object of study, although this service is essentially a device guided by the psychosocial paradigm.[9]

The shift of paradigm and practice in mental health creates among professionals feelings of distress related to the new. The psychosocial care model breaks with the traditionally established practice that, as a rule, is reproduced in training courses, putting into question the identity of the professional him/herself.[10]

In the sphere of mental health care in Brazil, such transformations aroused the need to discuss the course of training of professionals in the field, considered a great challenge to professionals in practice and academia, as it depends on collective effort to implement public policies that encourage significant advances in the field.[11]

Although several segments in Brazil have mobilized and built new experiences of mental health care, it did not occur uniquely in time and space. There was an expansion of specialized public services that was not accompanied by the provision of compatible training for professionals, creating a shortage of qualified professionals in the field.[12]

Based on the above, the aim of this study was to understand the issues related to the education and training of professionals working in mental health services in the Brazilian state of Goiás, from the point of view of the coordinators of these services.

## METHODOLOGY

This was a descriptive study with a qualitative approach, developed in all CAPSs

in the state of Goiás that were accredited by December 2010.

To facilitate entry into the field, all municipal Secretaries of Health were notified about this research by the Department of Mental Health of the State Secretary of Health of Goiás. Subsequently, the researchers contacted the coordinators of the respective services, formalizing their invitation to participate, in order to later schedule the dates for data collection.

Data were collected from February to May 2011, together with the technical coordinators of the CAPSs, totaling 19 municipalities and 22 services. One of the CAPS lacked a technical coordinator and two coordinators were not present in the services at the time of data collection. Thus, 19 coordinators participated in the research.

After participants signed the Free and Informed Consent Form, individual interviews proceeded, which were guided by a semi-structured script with questions that sought to identify, among other aspects, the coordinators' understanding of mental health policies in Brazil and their impacts on services and professional groups working in these services. All interviews were entirely recorded and transcribed, and were subjected to thematic content analysis,[13] with the aid of the ATLAS-ti software, version 6.2.

This procedure focused on finding clusters of meaning in the communication presented by the material studied, by checking their frequency in relation to the purpose of the study. Thus, organization of the analysis centered on three points in time: 1) the preanalysis phase, in which the organization and reading of the transcripts occurred, which corresponds to the analysis plan; 2) exploration of the material, the phase in which it was sought to identify and codify all quotes relevant to the purpose of the research and group them by similarity of meaning, using the ATLAS-ti; and 3) treatment of the results obtained and interpretation, in which the raw results were categorized and treated to be significantly validated.[13]

The thematic categories that emerged from the analysis process were discussed based on official documents and literature on the subject.

The participants' interviews were encoded in the ATLAS-ti software and the citation reference is formed by the subject number, followed by the serial number of the core theme in the transcribed document.

All ethical procedures were complied with in accordance with CONEP Resolution 196/96, which regulates research involving human beings, and the study was approved by the Research Ethics Committee of the Federal University of Goiás, with Protocol 303/10.

## RESULTS AND DISCUSSION

### Professional characteristics for work in mental health

The coordinators of the CAPS highlight the importance of theoretical knowledge about mental health, although this is not sufficient to guide the practices of establishment of ties and accountability in the territory, as the psychosocial care model advocates. The themes mentioned by respondents relate to the Psychiatric Reform, the NMHP, care and/or psychopathology technologies, with the development of skills and attitudes to work in mental health being fundamental, such as ability to develop bonds, affinity with the field, knowing how to work on a team, and having collective consciousness and social participation.

[...] *not everyone who enters has skills or emotional preparation for working with mental illness. Having knowledge isn't enough; you have to have vision,* [...] *have to like it, you have to become attached to stay in this field* (3:6) .

*The professional that works thinking only of doing his work, that which he learned in college, if it's just that, he is not making a contribution to future generations as well. We, as social actors, have to think of collective constructions* [...]. *One thing is you don't have a clue, don't have a direction, and it's one thing you live with and gain experience, but for this to happen, the professional has to want to* [...]. *Working in CAPS, in mental health, is an exercise of struggle* (8:6:36).

[...] *one of the things that hinders the service is this policy of recommendation. I think it shouldn't happen, it must be banned. The person from mental health has to have a profile. Most people who work have no training, but they have a talent, they have a profile* (5:21).

According to the psychosocial model, responsibility in work requires of the professional an attitude critical of the asylum model, since it is also subject to the process of paradigm change, and therefore demands greater involvement and commitment to alternative practices.[3]

Users and family members are also protagonists of the changes in the field of mental health, although health professionals are responsible for driving this process. In this sense, the relevance of the collective consciousness and citizenship[6] was mentioned by one of the coordinators.

Linked to vocational training, the coordinators emphasized that to work in mental health, it is essential to have an affinity with the field. From the point of view of the coordinators, it would be interesting to have a professional profile to work in mental health, considering its specificity.

[...] *I don't know if we from mental health are very happy or very unhappy. Happy because those of use in mental health are rare fixtures in the market and we are unhappy because nobody looks at us, at our work, at our service* [...] (5:15).

[...] *now it will depend a lot on him...so the person's involvement with the service, you know, so I think it is not the category* [professional] *of the person. So if we could have a curricular selection or a profile of the professional to work in these services, we would gain a lot* (10:27).

The profile referred to by most of the coordinators relates to the use of relational tools and skills development and therapeutic attitudes, geared to acts of listening, openness, availability and commitment to the other.[14]

The work in CAPS requires the willingness of professionals to listen, talk and share knowledge and practices with users, relatives and multiprofessional staff.[3]

## Teamwork and interdisciplinarity as a service management model

Work in mental health must necessarily take place on a team, although this is not always an easy task. The coordinators understand the professionals' work as multiprofessional, but there is no definition of roles, and they highlight the importance of interdisciplinarity.

In principle, the team ceases to be a set of specific categories, forming a new, interdisciplinary collective responsible for meeting the different demands and dimensions of the subjects suffering from mental illness.[15] Interdisciplinarity does not propose the abolishment of specificities; rather, it seeks interaction between occupational categories without losing specificity.[3]

*Although each one has inherent powers, the proposals that they have some interface are decided in staff meetings, in a very democratic manner* (4:17).

[...] *It is very complicated to define responsibilities in regard to the PCC team. Because it has to have a complicity with interdisciplinarity. We've had some professionals who didn't identify with this idea and failed to perform any work. The responsibility of each one here is with all the services, otherwise the team doesn't work* (14:19).

What is observed in the practice of care is that the professionals are not always able to work in the perspective of interdisciplinarity, where teamwork means complementing, and not overlapping or hierarchy of disciplines. Despite the coordinators visualizing the joint activities in the field of mental health, they do not identify the specific activities of each professional category.

[...] *I said that everyone does everyone's work, but in the specific field each one has their area* [...] *we don't have a line like 'this here is the role of the psychologist, this is the role of the social worker'* (7:11:15).

Health care practices should be guided by comprehensive care. The multiprofessional team that seeks to work in an interdisciplinary manner at different treatment sites should not be more focused on the disease, but on the existential suffering of the subject and his or her relationship with society. The social vision of the individual and the family should be considered in psychosocial rehabilitation and sociocultural reintegration of subjects in psychic suffering.[15]

In regard to the multidisciplinary team, the coordinators cite the difficulty of inserting physicians into the staff meetings. The observation arising from professional experience verifies that this is a reality in many health services, in which the physician carries out his/her work without sharing their experiences with the staff, and therefore fails to take notice and monitor the therapeutic practices which he or she has employed.

Especially at the undergraduate level, professional training should commend teamwork between these categories, including the importance of comprehensive care in mental health. However, training still occurs in isolation, without preparing professionals for interdisciplinary and interdepartmental work.[8, 12]

*We know that we should interact mor*e [...], *but unfortunately we can't put the doctor in front of all of the functions that the team has* (3:11).

Furthermore, the coordinators highlight some differences in terms of employment and wage conditions between doctors and other categories, which hamper teamwork.

There is dissatisfaction among professionals with their salaries, specifically those engaged in the field of mental health, compared with other core activities, particularly medicine, in which the professionals are better compensated.[5]

## Academic training of professionals

There are several obstacles to the realization of the NMHP in the state of Goiás, including the training of professionals aligned with the proposals of this policy. In general, health workers receive fragmented training that does not allow the comprehensive view of the individual, and most of the time is disjointed with the professional practice developed in the health services.

[…] one *thing that I think is essential in this improvement is the actual training of these professionals, of how to work in mental health. Today there is a very large deficiency of therapeutic arsenal, of the establishment of a model that would be individual, but is collective. That can meet the individual needs to do together* (4:23).

One reason for the lack of knowledge of new practices established in the field of mental health is the fact that undergraduate courses are focused on the biological and drug model, and do not update the forms of health care.[12] In this respect, despite having arisen due to psychiatric reform, practices such as fragmentation of care, the centrality of the physician in decision-making, and the hegemony of psychiatric knowledge over practices of promoting citizenship, health and reintegration, are often present in services.[8]

Academia has striven to include the discussion of mental health issues, whether in undergraduate courses, postgraduate courses and research. However, historically, they have not realized the great demand for specific training to work from the perspective of the Psychiatric Reform.[12]

The joint dialogue between the different categories could be reflected during undergraduate studies. Professional training is also occurring in isolation without preparing professionals for interdisciplinary work.[8] True interdisciplinarity would occur more naturally if its concept and importance were experienced beginning in undergraduate studies, integrating students from different areas of health care in clinical practice, encouraging group clinical reasoning and discussion of knowledge for the benefit of the care.

The coordinators highlight the need for adaptation of curricula and courses offered in undergraduate healthcare education to guide the actions of future professionals, highlighting the urgency of this care for the mental health field as well.

[...] *a course to train professionals for mental health. This would be needed in the universities, in the undergraduate courses. The professionals need to leave school already having a bit of theory on this area* [...] *because otherwise they get really insecure – 'what can I see? What can't I see? How far can I go? How far can't I go?' - Get it?* [...] (6:10:11).

[...] *in the service, I am learning more about mental health service in the day-to-day. In college it was very superficial, I was at the hospital* [psychiatric] for *just one week of internship, so it was very fast. I also visited the PCC...for one day! So the internship was very quick* (2:2).

The coordinators point to the superficiality with which mental health is addressed during undergraduate studies, and the limited exposure to alternative services during internships and/or practical classes. Exposure to curriculum content relevant to this field makes it more likely that students develop positive attitudes toward people with mental illness.

However, training should be associated with supervised clinical practice in public services of the replacement network and in transdisciplinary logic, seeking to avoid psychiatric hospitals as the practical scenario.[7,12] It is also worth mentioning that the student's exposure to the services sensitizes the future professional to the scope of the social network into which the subject is inserted.

These results also deserve reflection on the Brazilian educational panorama, which in recent years has greatly expanded various undergraduate courses. It is known, however, that not all of them offer the minimum content engaged to the scenario of health care, and more worrying, stop providing *in situ* experiences in the learning process. These courses restrict students' contact to technical visits and should prioritize moments of important practical experience so that the future professional incorporates them into their learning repertoire.

Another aspect not to be overlooked is the training and preparation of the educators. Many of them have little experience with the current model of care, failing to stay abreast and limiting themselves to the transfer of stigmatized ideas without stimulating the search for new knowledge by the students, urging them to leave the commonplace in the context of care in the height of transition.

## Professional practice and continuing education

The issue of continuing education for professionals working in the CAPS was cited by all respondents in this study, and is related to the quality of the activities offered in these services. Insofar as opportunities for continuing education no longer exist, it was considered that the effectiveness of the NMHP is impaired, since these provide opportunities for discussions and measures inherent to professional practice.

The adaptation of curricula in undergraduate health care was mentioned by the coordinators faced with the need for training and updating of professionals.

Continuing education is to promote significant learning in the ability to transform the practice of mental health workers and what happens in the services, based on everyday problems.[16]

The great need for continuing education in mental health stems, first, from the specific nature of this field of knowledge in the health care sector; as well, because many health care professionals working in these services received their academic training before the Psychiatric Reform process; and finally, because academia failed, over time, to work in conjunction with the NMHP.

The Ministry of Health stipulates that the training of health care professionals should encourage education according to the psychosocial logic. Thus, psychiatry residencies and the creation of multidisciplinary residencies in mental health should be designed within a community care model.[12]

The coordinators emphasized that it is very common in the services to receive professionals without specialized training to work in mental health; moreover, opportunities for training in order to minimize their difficulties are not provided.

*We really need training. I'm also speaking for myself; I came to work in mental health* [...]*, and training was not promoted by the mental health policy* [...] (9:8).

Change to the model of mental health care generated insecurity in the professionals, even unconsciously, because there were changes of meanings and senses of mental illness and care in the field. It is important, therefore, to have contact with the patient, to work in an interdisciplinary manner, and to "reframe their own knowledge."[10: 1456]

One study conducted in Goiânia indicated demand for training by newly-arrived workers in the services, related to the lack of preparation during their formal education.[17] Similarly, the coordinators emphasize that it is essential to train primary care professionals, as it is they who, for the most part, first enter into contact with people and need specialized care, in addition to being part of the network of mental health care.

*Each one begins working with his clinical knowledge, but it ends up that what is fundamental of the Psychiatric Reform, of the policy, sometimes many professionals don't have this. So I think first we have to train professionals who will work in every area, whether CAPS, whether ESF, NASF... I think that for all* (12:5).

A major limitation of the actions of mental health in the Family Health Strategy is the unpreparedness of professionals to handle issues related to psychological distress and subjective needs in everyday care. The activities undertaken by family health teams do not allow the identification and description of demand and involvement in the area of mental health. Thus, assistance is improvised and everything is done informally by establishing contact with the person in psychological distress who appears in the service.[18]

Unsurprisingly, the Community Health Workers are the ones that most identify cases of people that can be inserted into the network, which is why they deserve highlight in continuing education initiatives.

The need for specialization courses as an important strategy of permanent education processes in mental health was also emphasized by the study respondents, who highlight the difficulty of finding specialization courses.

*Training isn't everything, but it is very important, because you have a specialization, you are seeking*

*more knowledge and bringing other practices to the municipality through theoretical knowledge* [...] (8:14).

[...] *priority in mental health is to encourage health care professionals to specialize in mental health service, because we also have no incentive to be able to do this. Not everyone likes the service* [...]. *It is not easy for you to find one that has a specialization in mental health. Nor is it easy for you to find this service of specialization* [...] (5:6).

The coordinators also cited lack of incentives, mainly by municipal managers, to attend specialization courses. These incentives are related to the cost of courses, travel of professionals to locations where the courses are offered, flexibility of hours at work and consent of the managers.

Another strategy of continuing education frequently cited by the coordinators was the need for clinical-institutional supervision, which is a strategic tool proposed by the Ministry of Health[19] and legislated by the National Council of Health.[12]

Clinical-institutional supervisions are understood as an activity that qualifies and integrates mental health services teams, considering clinical cases and the institutional context, that is, the resources of the territory where the service is embedded, public policy and management. Further, the supervisor provides the team with a space for reflection and construction of a treatment plan that articulates the subject, network and territory.[19]

In this logic, the notes or diagnoses made by supervisors with the team are key to decision-making and directing practices.

[...] *I think the main movement made here in the PCC was the request for this supervision. It really made a very big difference, because we began to have information that would actually work in the* PCC [...]. *Extremely enriching in the sense of giving us a guide of how to work* (17:11).

Clinical supervision is seen as a support to guide the work processes in the CAPS, in addition to qualifying interpersonal relationships among the staff. However, it is recommended that the supervisor be external to the team and needs to be committed and qualified according to the principles of the NMHP,[12] have knowledge about the workings of CAPS, the organization of work, and a welcoming attitude towards the team.[17]

The coordinators also cited the supervisions performed by professionals from the State Secretary of Health of Goiás (SSH/GO) as a scheduled supervision. In this perspective, SSH/GO has a fundamental part of the responsibility for training of professionals who are working in the services. To organize the network, the state also has the responsibility to act as a modulator agency in mental health care, and to train professionals working in the services. It was evident from the coordinators' reports that the professionals support the supervisions conducted by SSH/GO. However, they understand that the initiatives must go beyond the bureaucratic and supervisory character.

*It is necessary to improve the clinical supervisions, as there is still a lot of bureaucracy,* [...] *know the staff size and the workload. They don't want to know what are the needs of the clientele, don't not want to know what that territory needs* [...] *it is very bureaucratic!* (4:24:25).

[...] *if there was more of these visits, not auditing, but visits, guidance. It would be a condition of the supervision. We don't have as much access because you have to enter a project and the budget is very small and in our state, unfortunately, the financial difficulties are very great, and they are absent in mental health* [...] (10:4).

Municipalities should take responsibility for the implementation of health care actions, and the State Secretary should work so that the blind spots located in the municipalities are resolved. Thus, more than simply implementing service units, the State must establish and develop the system as a whole.[20] Such logic follows decentralization, one of the principles of the *Sistema Único de Saúde* [Unified Health System] (SUS), in which each level of government assumes specific responsibilities. The coordinators of the CAPS question the incipient way in which SSH/GO is configured in many services, resulting in the lack of visibility of their actions.

Another issue emphasized was the need to include municipal health managers in the process of professional training. Although they are health care professionals, many of them do not understand the NMHP.

[...] *It is a difficulty* [...]. *We can't get a discount, a ride, gas, something...something that facilitates your life for what you're doing* [...]. *But there is also another part, I will seek innovations, arrive here in my town I can't apply. I'll get frustrated* (13:13).

It is worth noting that the continuing education of managers should also include training in developing projects to raise funds and to seek to expand interinstitutional partnerships with research institutions, in addition to funds.[12]

It is undeniable that well-prepared managers facilitate and enable the performance of health care programs in territories under their responsibility.

## Insertion in the labor market

Employment contracts are understood as a structural part that professionals have to work in the services in a qualified manner. This condition is related to the quest for qualification for the professionals and the bonds that they establish with service users.

In the interior of Goiás, almost all professionals working in public mental health services have employment contracts through annual and temporary contracts, and/or linked to the mandate of the mayor, with no labor guarantees. Thus, in the beginning of each year or municipal government, the professionals are uncertain about the renewal of their contracts and/or the changing of the professional staff in the health care units. In the statements by the coordinators, it is perceived that this type of contract has prevented or hindered the formation of bonds with users of the services,[7] teamwork and even the possibility of qualifying professionals.[15] A very similar situation was reported in the state of Mato Grosso, where few managers invest in effective hiring.[7]

*The majority of professionals that work in the PCC work under an annual service contract. So with that there is a very high turnover of professionals* [...]. *So I think that this makes it very difficult. If it were possible for a public tender to stabilize this team, I think it would help a lot, because then there could be more investment in the professional, more training and, for sure, there would be more solutions* (12:16:17).

Studies show that there is dissatisfaction with mental health work due to deregulation and easing of the way professionals are hired. Consequences may include tension, fear and insecurity of the worker.[4-5] Therefore, precarious employment contracts, decreased working hours and worker turnover are situations that hinder the formation of bonds and the search for professional qualification.[7]

Thus, the need for changes related to the management of human resources in the SUS is emphasized, beginning with the form of employment into services, so that professionals feel responsible for the functioning of services, and capable of making decisions about the organization and execution of care.[4] Furthermore, according to the coordinators, it is important to consider the professional profile to contract professionals who will work in the field, regardless of the form of contract. Even if the professionals take public service exams, it is essential to have pre-established criteria published, and that the possibility of those approved being allocated to mental health services is clear.

[...] *I see that the public service exam is not just to gain knowledge. There has to be the profile as well, of the professionals who pass these exams, and are called up, not everyone can handle working in the public sector, not everyone has the profile to work in mental health. Or they end up a bad professional, or suddenly accommodate and don't really develop what they should develop* [...] (3:5:6).

However, it is possible to notice that the affinity between the public exam and the profile to work in mental health has an intrinsic relationship with the stigmatized conception that the PCC professionals possess about mental illness. Professionals often refuse to work in this field due to fear, dread and even revulsion for mental health services users.[21]

This relationship also occurs due to lack of knowledge by professionals, or their experiences in psychiatric asylums that violate human rights, discouraging the interest of the worker to dedicate him or herself to the area. Against this background, the V Conference of Mental Health in Brazil proposes the implementation of a policy of specialization and ongoing training for professionals, with guaranteed immediate hiring, via public service exam, of people with the profile to work in mental health.[12]

## FINAL CONSIDERATIONS

The coordinators of the CAPS in the interior of the state of Goiás highlighted many aspects related to the preparation of professionals to work in mental health. Universities need to adapt the curricula of undergraduate courses in order to prioritize the precepts of the NMHP, and fields of practice and internships should occur in services with anti-asylum ideals so that future professionals have contact with the territory, with the coordination of services and with the community, according to the psychosocial model.

Academic training also needs to promote teamwork, even during studies, so that interpersonal relationships and the importance of interdis-

ciplinarity make sense in the profession and in the process of mental health work.

Thus, for professionals who have not had training according to this logic, the importance of ongoing education is highlighted, in order to facilitate understanding of concepts and actions based on the psychosocial model, capable of overcoming the paradigm of guardianship of the insane and mad. Permanent education processes must occur in services, considering the territory in which they are inserted, the population served and service network. In this regard, clinical-institutional supervision would be the best strategy because it considers these aspects and working processes of the entire team. However, we notice that opportunities lack for professionals to qualify and there is still little incentive on the part of municipal managers.

All coordinators stressed the importance of hiring professionals who have the profile for work in mental health. This profile is related to the affinity of the professional with the field, and the expertise that he has of relational tools such as bonding, acceptance, listening and accountability.

It was possible to identify the precariousness of employment contracts of PCC professionals in the interior of the state of Goiás, which has also been demonstrated in other studies. In this regard, it is essential to review the conditions of the employment contracts of the workers, because stability is essential to encourage professional qualification, teamwork and relationships with users.

Considering the results, the idea is reinforced that investments in human resources may represent the possibility of the leap of quality that psychiatric care in mental health needs to actually implement the National Mental Health Policy.

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