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Health Managers' Social Representations on Competences, Work, and Mental Health

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Abstract

This research aims to analyze the social representations of workers in management positions regarding the competencies to address Work-Related Mental Health (WRMH), and how these representations can contribute to or hinder the development of these professional competencies among primary healthcare workers in this field. This is a qualitative, analytic-descriptive research. Nine semi-structured interviews were carried out, with occupants of management, coordination, or technical responsibility positions. The interviews were analyzed using thematic content analysis. The results show to different representations about competencies and SMRT among the interviewees, the use of active methodologies for the development of competencies, and limitations to the development and mobilization of competencies in WRMH due to the representations of the managers and the absence of work process transformations. The absence of the WRMH theme in the ongoing devices and work processes potentiates the difficulties in this area. These results indicate the need for actions that favor the understanding of health processes broadly, the perception of WRMH as a collective responsibility, the delinking of the notion of competencies exclusively to individual attributes and the development of protocols and instruments for investigating the causal link between mental health and work.

Keywords: professional competence, mental health, occupational health, health education, health management

REPRESENTAÇÕES SOCIAIS DE GESTORES DA SAÚDE SOBRE COMPETÊNCIAS, SAÚDE MENTAL E TRABALHO

Resumo

O objetivo da pesquisa foi analisar as representações sociais dos trabalhadores em cargos de gestão acerca das competências para atuar sobre a Saúde Mental Relacionada ao Trabalho (SMRT), e como elas podem contribuir ou dificultar o desenvolvimento dessas competências profissionais de trabalhadores da atenção básica nesta temática. Trata-se de uma pesquisa qualitativa, analítico-descritiva. Foram realizadas nove entrevistas semiestruturadas, com ocupantes de cargos de gerência, de coordenação, ou de responsabilidade técnica. As entrevistas foram analisadas por meio de análise de conteúdo temática. Os resultados demonstram diferentes representações sobre competências e SMRT entre os entrevistados, a utilização de metodologias ativas para o desenvolvimento de competências e limitações para o desenvolvimento e a mobilização de competências em SMRT devido às representações dos gestores e ausência de transformações dos processos de trabalho. A ausência da temática SMRT nos dispositivos e processos de trabalho em curso potencializa as dificuldades dessa área. Tais resultados indicam a necessidade de ações que favoreçam a compreensão dos processos de saúde de modo ampliado, a percepção da SMRT como responsabilidade coletiva, a desvinculação da noção de competências exclusivamente a atributos individuais e a elaboração de protocolos e instrumentos para investigação do nexo causal entre saúde mental e trabalho.

Palavras-chave: competência profissional, saúde mental, saúde do trabalhador, educação em saúde, gestão em saúde

REPRESENTACIONES SOCIALES DE GERENTES DE SALUD SOBRE COMPETENCIAS, SALUD MENTAL Y TRABAJO

Resumen

El objetivo de esta investigación es analizar las representaciones sociales de los trabajadores en cargos de gestión con relación a las competencias para abordar la Salud Mental Relacionada al Trabajo (SMRT), y cómo estas representaciones pueden contribuir o dificultar el desarrollo de estas competencias profesionales entre los trabajadores de atención primaria en esta temática. Se realizaron nueve entrevistas semiestructuradas a ocupantes de puestos de dirección, coordinación o responsabilidad técnica. Las entrevistas se analizaron mediante un análisis de contenido temático. Los resultados muestran diferentes representaciones sobre las competencias y la SMRT, el uso de metodologías activas para el desarrollo de las competencias y las limitaciones para el desarrollo y la movilización de las competencias en la SMRT debido a las representaciones de los directivos y la falta de transformación de los procesos de trabajo. La ausencia del tema de la SMRT en los dispositivos y procesos de trabajo en curso potencia las dificultades

en este ámbito. Estos resultados indican la necesidad de acciones que favorezcan la comprensión de los procesos de salud de forma amplia, la percepción de la SMRT como una responsabilidad colectiva, la desvinculación de la noción de competencias exclusivamente a los atributos individuales y el desarrollo de protocolos e instrumentos para la investigación del vínculo causal entre salud mental y trabajo.

Palabras clave: competencia profesional, salud mental, salud laboral, educación en salud, gestión en salud

Work-Related Mental Health (WRMH), understood as the health-disease processes related to mental phenomena, whose constitution and development are linked to aspects of work life that promote health or may potentially cause illness (Seligmann-Silva, 2011), has been a growing concern among health professionals and academics. This is because new modes of production and work organization, characterized by exhausting working hours, informality, flexibilization, gig economy, and precariousness (Franco & Ferraz, 2019; Marinho & Vieira, 2019; Vaclavik, Oltramari, & Oliveira, 2021), intensify the deleterious effects of work on the mental health of workers. The repercussions of this scenario have increasingly impacted healthcare systems (Cardoso & Araújo, 2018; Costa, Lacaz, Jackson Filho, & Vilela, 2013). This process is manifested by an increase in complaints related to mental health issues from users and their work relationships – or lack of work – and WRMH complaints from healthcare professionals. The health conception that has gained ground in Brazil considers various determinants of health, including social factors such as work and employment conditions (Andrade et al., 2015; Borde, Hernández-Álvarez, & Porto, 2015). However, studies have identified difficulties in incorporating occupational health policies into the *Rede de Atenção à Saúde* (RAS, Health Care Network), especially in Primary Healthcare (Araújo, T, Palma, & Araújo, N., 2017; Mori & Naghettini, 2016), a challenge shared by mental health care (Klein & D'Oliveira, 2017; Santos & Bosi, 2021) and added to recent transformations in primary healthcare policies that tend to reduce community-based interventions (Martins & Carbonai, 2021). Thus, the incorporation of WRMH into Primary healthcare represents a double challenge: understanding mental healthcare as being exclusively a responsibility of specialized professionals (Santos & Bosi, 2021), as well as ignoring the role of work in determining health processes (Almeida et al., 2021).

To understand WRMH and the role of work in the health-disease process, it is necessary to consider historical, ideological, and cultural processes that influence public policies, still permeated by biologistic practices focused on bodily care at the expense of the social and psychological determinants of health (Jodelet, 2001). Many authors (Benevides & Passos, 2005; Paim, 2008; Pasche, 2009) consider that although the implementation of the Brazilian *Sistema Único de Saúde* (SUS, Unified Health System) is based on an expanded concept of health, including its social determinants, there still exists a biomedical health culture contradiction. This culture, resulting from conflicting interests, is reflected in the practices and work processes of services, despite the transformations proposed by policies and legal frameworks. Specifically concerning the field of occupational health – including WRMH – its constitution as a practice in public policies is linked to specialized services (Minayo-Gomez, Vasconcellos, & Machado, 2018), pre-dating the establishment of the SUS – *Centro de Referência em Saúde do Trabalhador* (Cerest, Workers' Health Reference Centers and Programs). In the 2000s, the *Rede Nacional de Atenção Integral à Saúde do Trabalhador* (Renast, National Network for Comprehensive Health Care of Workers) was created, again following the logic of Cerest. This arrangement has influenced how other SUS devices conceive occupational health as a specialized area, as it has historically been present and, as Lacaz et al. (2013) point out, has faced difficulties in intersectoral articulation.

With the *Política Nacional de Saúde do Trabalhador e da Trabalhadora* (PNSTT, National Workers' Health Policy) (Ministry of Health, 2012), there was a change in strategy, establishing the cross-cutting insertion of occupational health actions at all points of the RAS network, aiming for greater reach. In addition to this, the organization of the health network is still characterized by Taylorist precepts, especially in the hierarchical separation and distribution of planning and execution tasks among different points of the network, as well as valuing and encouraging professional specialization, despite more recent contributions from the health management field (Almeida et al., 2023). Amidst this context, the high prevalence of mental disorders among the working population is not sufficient to draw attention to work as a possible cause of illness, with many cases of WRMH going unnoticed (Araújo et al., 2017; Cardoso & Araújo, 2016).

To improve WRMH care in the SUS, implementing of training policies for health professionals is essential. Considering the responsibility of municipalities in executing public health policies, the developing of competencies to deal with WRMH among professionals in Primary Healthcare is, or should be, an important issue for municipal health managers. However, given the perception that the field of occupational health faces difficulties in programmatic insertion, it becomes necessary to understand the processes that either enable or hinder such development and, how health managers apprehend and mobilize these issues. This involves understanding the limitations for developing workers' fomative processes concerning this issue, particularly regarding the managerial processes involved. It is premised that managerial practices are related not only to historical, contextual, and/or programmatic factors but also to shared social representations concerning specific objects, understood as knowledge produced and shared by this social group, considering that these representations are related to the practices undertaken by the group (Jodelet, 2001; Moscovici, 2015). Therefore, depending on the representations about the addressed objects, the actions of these managers can either contribute to or hinder the process of developing competencies among professionals in WRMH. Based on this, the objective of the research was to analyze the social representations of workers in management positions regarding the competencies to address WRMH and how these representations can interfere with the development of these professional competences among Primary Healthcare workers in this area. Although formative processes cannot be limited to the managerial sphere, the strategic role of management in the development of competencies and the implementation of Permanent Health Education (PHE) policies is undeniable (Ceccim, 2005; Silva & Scherer, 2020), which justifies its investigation.

The concern for the development of health professionals' competences has been gaining prominence in recent years, including with the institutionalization of the *Política Nacional de Educação Permanente em Saúde* (PNEPS, National Policy for Permanent Health Education) (Ministry of Health, 2017). It advocates for the transformation of health professionals' practices through critical reflection on the work process, privileging methodologies that recognize the importance of the work context, the knowledge derived from experience, and the sharing of knowledge within interdisciplinary teams (Ministry of Health, 2017; Cardoso, 2012; Ogata et al., 2021).

These ideas are supported by different authors who discuss the development of professional competences in organizations, notably those aligned with the so-called French school of thought (Morais, Melo, & Bianco, 2015; Salles & Villardi, 2017), sharing the understanding that competence goes beyond the prescriptions of a position or job and is not limited to a set of knowledge, skills, and attitudes of a specific individual (Durrive, 2016, 2019; Le Boterf, 2003; Zarifian, 2012). This differentiates them, for example, from the American and British schools of thought (Morais et al., 2015; Salles & Villardi, 2017). Additionally, the issue of competence involves a complex combination of ingredients (Bianco & Holz, 2015; Schwartz, 1998) in a dynamic between knowledge and action mediated by values (Durrive, 2016, 2019). In this perspective, the development of competences is directly linked to the work context, the situations that workers face in their daily work, the ongoing debates on norms, and the values that permeate the work environment.

Schwartz (1998) argues that every professional activity can be partly anticipated through a protocol. However, it is also always an experience and an encounter that requires a form of competence suitable for infusing the historical aspect into the protocol, as what is done is never solely what is prescribed. This reinforces the contingency of the situation, as this aspect can never be standardized. According to Le Boterf (2003), it is important for professionals to be able to apply what they have learned in each situation to mobilize it in other situations of greater or lesser complexity, as this contributes to the development of their own competences and those of the collective of workers. Aligned with Schwartz's proposal (1998), Durrive (2019) argues that understanding competence as the mastery of knowledge, when acting in a situation, allows for the elaboration of reference systems and their social recognition. However, this mastery of knowledge is accompanied by a strong point of view that allows for the management of each situation in a singular way, mobilizing knowledge from a historical and collective perspective that involves the values of each professional.

The contributions of these authors align with the proposal of PHE, since health education and health work cannot be separated because they are mutually constructed, contributing simultaneously to the development of professional competences and the construction of the ethical-political subject and care provider identity (Ceccim, 2005, 2012; Silva & Scherer, 2020). It is from this theoretical perspective that the development of competences among professionals in WRMH will be analyzed in this article. This conception differs from traditional health competency practices, which are related to the accumulation of specialized technical knowledge and linked to an approach that defines competence as a set of knowledge, skills, and attitudes (Silveira & Villardi, 2022). In the adopted perspective, work is recognized as a human activity that cannot be dissociated from the historical and necessarily collective process in which it is embedded (Schwartz, 1998). To aid in the understanding of the investigated problem, the contributions of the Theory of Social Representations (TSR) were also used.

This theory seeks to understand Social Representations (SR), which are knowledge produced and shared by social groups in everyday life (Jovchelovitch, 2000; Moscovici, 2012,

2015). The purpose of SR is to make something unfamiliar familiar, overcoming the feeling of unfamiliarity. Through SR, the represented object is integrated into the mental and physical world, making abstract concepts more concrete. SR are created by individuals as a resource to stay informed, interpret events, and adapt to identified needs. They guide individuals in naming, defining, and interpreting aspects of everyday reality, enabling decision-making and defining positions (Jodelet, 2001; Moscovici, 2015). In constructing SR, individuals symbolize and interpret the object, being part of the construction and expression of the subject (Jodelet, 2001). SR should not be understood solely as a representational activity, as they are immersed in reality (Jovchelovitch, 2007). The social aspect plays an important role in forming representations, as they are related to communication and social practices, such as dialogues, rituals, discourses, work processes, modes of production, and culture in general. SR are social phenomena and not just an aggregation of individual representations (Jovchelovitch, 2007).

The formation of SR occurs through the processes of anchoring and objectification. Anchoring involves classifying the represented object based on the subject's network of meanings, seeking a fit for the unfamiliar. It refers to the process of integrating new knowledge into the existing network of meanings within the subjects' frame of reference (Jovchelovitch, 2000; Moscovici, 2012, 2015; Oliveira & Werba, 2013), in a way that fixes the object and representation in a network of significations (Jodelet, 2001). The anchoring process can be understood as linking something strange and disturbing to a paradigm that the subject already possesses (Moscovici, 2015). In this process, the object is readjusted to fit properly into a specific pre-existing category, acquiring characteristics of other objects in that category. Therefore, anchoring is not a neutral process and can reveal the theories that the subject holds about society or human nature (Moscovici, 2015).

The classification in the anchoring process can occur in two ways: through generalization, when subjects observe a characteristic of the represented object that is compatible with an object within the group's domain and, consequently, attribute all the characteristics of that domain's object to it (generalizing). On the other hand, particularization consists of identifying particular characteristics of that represented object in relation to the objects within the group's domain, keeping it under analysis as something specific. The anchoring process also involves the naming of represented objects, including them in a complex of words, in culture, and allowing their communication and connection to other images (Moscovici, 2015).

Objectification consists of identifying the iconic quality of an idea in an imprecise form; it is to reproduce a certain concept in an image format. For example, a comparison can be understood as a way of representing something. Comparing the concept of God with the figure of a father allows for visualizing God, a represented object, as a person with whom we can interact, the father (Moscovici, 2015).

The processes of objectification and anchoring occur concomitantly and interrelatedly, giving meaning to SR. These processes can be understood as a way of dealing with memory. The anchoring process is continually placing and removing classified and labeled objects, people, and

events from memory, focusing inwardly on individuals. The objectification process can be directed outwardly to varying degrees of intensity, seeking concepts and images to which the represented object can be linked to make them more familiar based on what is already known (Moscovici, 2015).

Social Representations are produced in various places such as bars, streets, offices, among others, where people analyze events and spontaneously develop ways of thinking that guide their behaviors through communication (Moscovici, 2015). Therefore, the work environment is a place that provides the necessary interaction for the construction of representations. It is worth noting that individuals and social groups are not passive in the process of forming SR, which has the everyday shared knowledge as its main element (Moscovici, 2015). This knowledge merges with scientific and technological knowledge, transforming them through their own rationality, which cannot be devalued in relation to scientific rationality (Jovchelovitch, 2007).

In the scope of this article, the identification of SR about competences and the development of WRMH competences, shared by the interviewees, helps to understand the knowledge, opinions, and values that guide practices directed at the process of developing competences in the WRMH domain.

This is a qualitative, analytical-descriptive research (Flick, 2007). The empirical locus was the Municipal Health Department (MHD) of a large municipality located in the Metropolitan Region of Vitória, Espírito Santo, Brazil.

Participants

Given the diversity of practices and processes in healthcare, the study aimed to investigate the conceptions of competence held by managers, whose main responsibilities were directly related to the topics of interest, namely: managers involved in organizing competence development processes and professional training, as well as those who manage policies related to occupational health, mental health, and Primary Healthcare in the municipality. With the support of professionals indicated by the MHD, ten managerial positions in healthcare from these areas of interest were identified. This included both administrative management roles, such as managers and coordinators, and technical management roles in healthcare policies, such as Technical References. The sampling method was convenience sampling, and the choice of these research subjects was justified by their leadership positions and their importance in implementing competence development practices (Macêdo, Albuquerque, & Medeiros, 2014; Silva & Scherer, 2020). Moreover, they share opinions, beliefs, and values that shape Social Representations (Jodelet, 2001; Moscovici, 2015) and facilitate the emergence of understanding about competence and competence development (Durrive, 2016, 2019; Le Boterf, 2003; Schwartz, 1998; Zarifian, 2012). The study involved two participants holding managerial positions in the area of Healthcare Assistance (HA), actively involved in managing mental health and Primary Healthcare policies in the municipality, three participants who work in the field of Health Surveillance (HS), which encompasses epidemiological surveillance and surveillance of

occupational health, and four who were involved in Health Education (HE), working in the areas of training and competence development of healthcare professionals. Among the participants, five had a background in nursing, two in psychology, one in dentistry, and one in pedagogy. The length of their activity in the MHD varied between five and twenty-four years, with a mean age of 15 years. To maintain the anonymity of the participants, specific characteristics of the municipality are not described, and fictitious names were used when quoting them.

Instruments and materials

The data were collected through individual in-depth semi-structured interviews (Flick, 2007; Kvale, 2007). Qualitative interviews serve as a key tool for researchers to explore the subjects' experiences and understand their world through the description of their activities, experiences, and opinions in their own words (Kvale, 2007). The interviews were conducted in person, between November 2019 and March 2020, involving at least two researchers. A semi-structured interview guide was used, and the mean duration of interviews was one hour. All interviews were audio-recorded. The interview appointments were scheduled by directly contacting each participant via phone.

The interview guide was developed based on the research focus, aiming to identify the managers' representations of competences and how the development of competences in Primary Healthcare professionals occurs, both in general and specifically regarding WRMH. A test interview was conducted with a staff member from the health surveillance area of the MHD, leading to minor adjustments in the interview guide after the test and for each subsequent interview. The interview guide was structured in three parts: the first part addressed the interviewee's activities and responsibilities, the second part included questions about occupational health and Work-Related Mental Health, and the third part focused on the theme of competences and their development in relation to WRMH.

Procedures

The interviews were audio-recorded, transcribed, and analyzed using thematic content analysis (Flick, 2007; Gibbs, 2009). This approach was chosen due to its emphasis on the meanings and senses conveyed in the messages. The transcripts were subjected to an exploratory reading, and a coding matrix was developed (Gibbs, 2009). Codes were organized into themes, categories, and topics using the software Atlas TI (Muhr, 2020). All participants signed an informed consent form and were told about the research's objectives and potential risks. The research received approval from the Ethics Committee of the *Universidade Federal do Espírito Santo* (UFES, Federal University of Espírito Santo) under Protocol No. 3.378.498.

Results and Discussion

The analyzed discursive contents encompass the general theme of competence and its specificities related to WRMH, as explicitly mentioned in the text. The contents were organized

into four categories: *attributes of competence, knowledge required to operationalize the causal link between mental health and work, social representations of competence, and development of competences*. The "development of competences" category accounts for over 80% of the coded excerpts, as shown in Table 1.

Table 1

Frequency of occurrence of each category by area

	HE	HA	HS	Total
Attributes of competence	1	0	3	**4**
Knowledge required to operationalize the causal link between mental health and work	1	2	2	**5**
Social representations of competences	7	4	9	**20**
Development of competences	75	30	45	**150**
Total	**84**	**36**	**59**	**179**

In the category of "Attributes of Competence," the managers identified factors that contribute to a professional being considered competent in the work context: being self-taught, proactive, seeking knowledge, and working in a team. These attributes align with the PHE guidelines (Ministry of Health, 2017; Ogata et al., 2021), emphasizing that the practice of learning and teaching should be incorporated into the work and daily life of health organizations. They also corroborate the need for initiative and responsibility on the part of the worker (Zarifian, 2012).

However, the attributes listed are strongly related to the personal characteristics of the workers and, to some extent, moralistic (Durrive, 2016), as a worker who does not possess these attributes may be seen as a burden to the team, as suggested by Luana's (HS) statement: "*For me, the health professional must be self-taught, one of their main competences. They don't need to wait for me to arrive with a directive saying they have to study. No, they must seek knowledge by themselves... I can't just sit here waiting to be told what to do; I have to be proactive.*" This leads to the individualization and accountability of these workers for their own development (Amaro, 2008). Even teamwork is seen as an individual attribute that the professional needs to have, as mentioned by Iracema (HS): "*I think these are competences and skills that the professional needs to have; knowing how to work in a team is one of them*," in accordance with a conception of competency linked to individual characteristics, still prevalent in public health systems (Almeida et al., 2023). The context of developing these attributes at work and the responsibilities of managers in the process are not explicitly addressed and consequently downplayed.

To enable workers to take responsibility for situations, it is necessary to provide them with the means, including training and support, to exercise these responsibilities (Zarifian, 2012). Durrive (2016) warns that by disregarding the collective root of work and team belongingness, organizers reinforce a notion of competency as a permanently transferable individual quality, a relational or communicational knowledge. It is essential that workers can take advantage of

synergies of competences, relying on a support network to deal with specific situations (Schwartz & Durrive, 2010).

Regarding the "*knowledge required to operationalize the causal link between mental health and work*," the managers mentioned the need to have a "broader view of health": "*For me, the main (competence) is to have a broader view of what health is, what the determinants of this health-disease process are*" (Iracema, HS). This broader view of health can be understood as recognizing the effects of social dimensions, including the labor market, modes of production, and working conditions, on health processes, going beyond strictly biological aspects (Borde et al., 2015). The scarcity of statements (see Table 1) and the mention of a single theme demonstrate that the interviewees have difficulty identifying what knowledge is required to operationalize the causal link in WRMH.

The process of anchoring SR helps understand the mention of the broad view of health. In an effort to think about the knowledge needed to handle WRMH issues, about which they do not have much expertise, the interviewees seek references in already established knowledge among them, such as the expanded concept of health (Borde et al., 2015). However, it is worth mentioning again that the model of care based on the expanded concept of health has not fully consolidated yet, being in dispute with the biomedical model, which remains an important anchor for representations and practices in health. This dispute poses difficulties for the development of competences in WRMH, which necessarily depend on a model that considers the social determinants of health.

This result corroborates the difficulty in establishing the link between mental health and work perceived by professionals (Araújo et al., 2017; Bernardo & Garbin, 2011; Cardoso & Araújo, 2018) and in identifying what is needed to deal with this issue in terms of technical and practical knowledge and work situations. Efforts have been made to provide tools for health professionals to address WRMH through the development of protocols in some Brazilian states (Department of Health of the State of Bahia, 2014; Department of Health of the State of Goiás, 2018). These protocols focus on what is legally recognized as mental disorders related to work and require information about the life and work history, as well as psychosocial environment and working conditions from the worker's perspective, involving a multidisciplinary team (Department of Health of the State of Bahia, 2014; Department of Health of the State of Goiás, 2018).

In the state of Espírito Santo (Brazil), the Clinical Guidelines in Mental Health provide, albeit in a superficial manner, guidance for the identification and management of cases of SMRT (Department of Health of Espírito Santo State, 2018). In the investigated municipality, documents of this nature were not identified. However, the existence and mastery of such protocols by professionals do not guarantee competent action (Durrive, 2016, 2019; Schwartz, 1998). Considering the importance of values in the dynamics of competence (Durrive, 2016, 2019; Schwartz, 1998; Schwartz & Durrive, 2010), it is necessary to discuss, in training processes, the impacts of work on mental health from a broad perspective. Such a conception will help expand the range of values around health production processes.

On the other hand, the belief that merely developing a broad view of health and all the values it entails is sufficient for the realization of the link between mental health and work can be relativized. This is because, even considering the high incidence of mental illness among the working population, it may not be enough to raise awareness of work as a possible cause of mental illness (Araújo et al., 2017). Having a broad view of health may also not be sufficient, as professionals lack investigation tools, case management tools, and specific knowledge. The absence of these factors hinders the mobilization of competences in WRMH, as this mobilization depends on means that allow workers to take initiative and assume responsibility (Zarifian, 2012).

Moscovici (Jodelet, 2001; Moscovici, 2012) proposes that the emergence of social representations is influenced by three factors in the communication process: 1) the dispersion and distortion of information about the object, with uneven access to information between groups and fields of interest; 2) the focus, with greater attention to certain aspects of the environment by the group, to the detriment of others, leading to inevitable variation in the relationship with the object from one group to another; and 3) pressure for inference, referring to the need for readiness to act and position oneself in everyday situations. Considering the responses given by the managers regarding the knowledge required in WRMH, it is necessary to reflect on how policies and productions on the subject reach the various management sectors and materialize in guidelines and work prescriptions. In other words, to what extent this topic is present and which aspects are focused on in training, meetings, and management instruments. Based on the responses given by the managers, it is reasonable to assume that the identified social representations are based on a communication process in which the dispersion of information about competences in WRMH and pressure for inference are uneven among the sectors, concentrating in the specialized area – occupational health surveillance. For this reason, when asked to take a position on the subject, the managers focus their response, in a very generic way, on that notion that would be closer to an attempt to analyze an element that includes the "work" element, which is the notion of expanded health.

In the category of "*social representations of competences*," the prevailing representations understand competences as a set of responsibilities and attributions: "(competency is) *what the professional has in terms of assignments in the exercise of their work activities*" (Iracema, HS); as specific activities of the professional category: "*I think, competency for diagnosing mental health issues, I don't know whether it's occupational medicine or occupational nursing. I don't know if... really, I don't know if I, a nurse, can make a diagnosis related to the worker's health, I don't know. I believe not*" (Joana, HA); and as skills and tools that the worker possesses: "*In general, I think it is the role of* (health education) *to develop some skills of professionals so that they feel increasingly capable, more competent to deal with health demands*" (Ivonete, HE). These representations are more frequent among managers in the HS field and are aligned with the American and English currents on competences (Morais et al., 2015; Salles & Villardi, 2017). This is due to the wide dissemination of this theoretical current in the field of management, including health management in Brazil (Silveira & Villardi, 2022). As pointed out by Moscovici (2012), social representations are

influenced by theoretical models that are closer to everyday experience. Thus, closer contact of these managers with this perspective contributes to the formation of these representations.

The mentioned representations contribute to the operationalization of the concept by the interviewed managers. However, there is a limitation in considering the notion of competency as a characteristic that is entirely predictable from some requirements of the work activity that can be anticipated (Durrive, 2016; Le Boterf, 2003; Schwartz & Durrive, 2010). This can lead managers to overlook the contextual aspects of work and the importance of support networks for competent action, making it difficult to mobilize competences in daily life. Training processes based on these representations may contradict the logic of PHE, which emphasizes the importance of the work context for the development of competences (Ministry of Health, 2017). Regarding WRMH, linking the notion of competences to the specific activity of the professional category, a rationality linked to the long trajectory of professional training and corporate disputes seeking to segment health practice and assign specialties and powers to specific areas of work, hinders the implementation of comprehensive health care for SUS users (Ceccim, 2012; Santos & Bosi, 2021), contrary to the guidelines of public policies that highlight the need for all RAS professionals to be able to establish relationships between living conditions, health-disease, and current or past work of users (Ministry of Health, 2018).

On the other hand, in smaller numbers and specifically in the area of health education, there is recognition of competence related to the possibilities of the context and how the ability to deal with situations: "*...sometimes the public servant comes, takes the course, but when they get there, they can't, sometimes they can't do it even on their own, because it doesn't depend only on them, it depends on the director, it depends on colleagues to help organize that action they learned here. Sometimes they can't implement it*" (Mariana, HE). This demonstrates openness to a contextual notion of competence (Durrive, 2019; Le Boterf, 2003; Zarifian, 2012) in the field of health education, provided by the influence of the logic of PNEPS (Ministry of Health, 2017). It is thus evident that there are internal debates between forces that seek an expanded view of health, which is, in fact, the anchoring object for WRMH, and those related to the usual practices of segmenting knowledge and practices of professionals in the face of existing demands. This specificity of representations in the HE field demonstrates how social insertion and belonging, as well as lived experiences, are important conditions for the production of representations (Jodelet, 2006). As this is an area specifically dedicated to training processes, it can be assumed that they have more regular contact with experiences and information about more plural approaches to the process of developing health competences (Ceccim, 2012).

In the category of "*competence development*," five themes were identified: strategies, evaluation of learning, conditions for competence development, upward planning, and guiding documents for competence development. The higher occurrence of this category in health education reflects the sector's specific characteristics, which deal directly with the subject.

The interviewees pointed to guiding documents for competence development, such as the Municipal Health Plan (MHP), Network of Care Guidelines, Ministry of Health Guidelines on

PNEPS, and Curricular Guidelines for courses offered in the health education area: "*We have the Municipal Health Plan, the Annual Health Plan, health indicators that we follow, Network of Care Guidelines, Ministry of Health Guidelines focused on Permanent Education Policy*..." (Bruna, HE). In health surveillance, the *Caderno de Atenção Básica à Saúde do Trabalhador e da Trabalhadora* (CABSTT, Basic Care Guide for Worker's Health) is also mentioned: "*So, it's not by chance that the Ministry itself has the basic guide for worker's health, because work is an important determinant of this health-disease process*" (Iracema, HS).

These documents are important for competence development because it is from the prescriptions that the worker places themselves in the situation, interpreting the singular through the prism of values (Durrive, 2016, 2019; Schwartz, 1998). PNEPS, *Plano de Desenvolvimento Institucional* (PDI, Institutional Development Plan), and CABSTT recognize the importance of context for mobilizing competences (Ministry of Health, 2017, 2018), in line with the French current (Durrive, 2016; Le Boterf, 2003; Schwartz & Durrive, 2010). However, in the MHP, it is possible to observe representations of the notion of competence more linked to the Anglo-Saxon currents. These documents present generic guidelines that recognize the social determinants of health and the need for continuous development of professional competences to meet the demands of services. The more direct guidelines for Primary Healthcare professionals on WRMH are found in the CABSTT guideline (Ministry of Health, 2018). In the absence of locally developed protocols to deal with WRMH, the documents that guide professional action have a more general and non-protocol content. However, when combined with other contextual elements, they act as work prescriptions. Thus, the reproduction of more consolidated professional practices is expected. In this case, the segmentation of knowledge, biologistic care, and fragmentation of assistance, as previously indicated.

"*Upward planning*" is highlighted as the way in which the MHD schedules activities that contribute to the development of professional competences, based on the needs of the work context: "*We do the upward planning, visit the units, try to identify what demand is being pointed out there, talk to the management, try to organize it with material, with indicators, with data from the previous year to think...*" (Ivonete, HE). However, in some statements, it is possible to observe that the responsibility for pointing out the necessary actions is concentrated in sectors and management: "*So, what they* (HE) *even call upward planning for educational actions. Each sector, each management points out what is necessary, what they understand as necessary for some actions, processes to occur*" (Iracema, HS). The exclusion of the professionals who actually perform the activities in the daily process of defining the trainings to be carried out can lead to the inadequacy of the training for the specific work context (Durrive, 2016). This information indicates that in the management of policies in this municipality, and possibly in a significant part of Brazilian municipalities, there is still the need to overcome this Taylorist bias that is still prominent in the public sector of the country: there are those who execute, and there are those who plan. Even recognizing the efforts of disruptive policies regarding more traditional practices, such as PHE, the discourse of centralization in decision-making about training and execution at central levels

is still relevant. SR and practices are inseparable and mutually engender in a dialectical process where representations guide practices, which, in turn, act in the creation and transformation of representations. The latter are rooted in a collective history, in which practices and experience in relation to social interactions play an essential role (Abric, 2011). Thus, the concrete practice of centralization in management regarding decisions on planning formations ultimately reinforces representations of competence that are more traditional and less aligned with the more recent discourses of policies.

The "*conditions for competence development*" are seen positively, especially regarding the openness and participation of different professionals in the discussion spaces: "*Yes, I understand that (professionals have an active voice, they usually participate actively), I see this moment more as a very powerful tool for work management, case handling, and there is indeed no degree, no hierarchical character in knowledge. It's really an exchange*" (Iracema, HS). This active participation in discussion spaces is essential for sharing knowledge and reflecting on work processes, allowing for their transformation (Le Boterf, 2003; Schwartz & Durrive, 2010).

On the other hand, the need for professionals to be absent from work to participate in training courses or events and the underutilization of team meetings are identified as challenges for competence development: "*We have a problem when you involve these workers in the discussion... I would need to release the workers for a certain process, sometimes the health unit's process does not allow everyone to have access to all the opportunities that the department offers*" (Jaqueline, HE). "*In practice, team meetings still happen, but they are not utilized enough for this purpose (competence development), even though it could be the space for it since it is guaranteed*" (Iracema, HS). These factors demonstrate the difficulties in ensuring the necessary means for professionals to take initiative and assume responsibility for certain work situations (Zarifian, 2012) since the update promoted by training processes is essential for professionals to adequately meet the demands of SUS users, and team meetings need to be conducted to promote the constant reorientation of work processes (Ministry of Health, 2017).

At this point, it is important to once again point out that social practices in a particular context are also determining factors for social representations. Specifically considering professional practices, it must be considered that work organizations impose constraints and force the adoption of certain behaviors. When representations and practices are divergent in a context of strong constraints, the tendency is for representations to transform according to practice when workers do not have much autonomy (Abric, 2011; Rouquette, 2000). In this sense, the social representations present among managers regarding the notion of competence as a set of personal attributes and worker's health as an assignment of specific professional categories do not contribute to identifying WRMH as an issue of interest.

Among the different competence development strategies mentioned by the interviewees, active methodologies stand out, which are mentioned in PNEPS as teaching–learning methodologies that use work as the structuring axis of training processes, promoting learning based on real work practices and problems (Ministry of Health, 2017). The use of active methodologies in all training

processes is seen as an important advancement for PHE in the municipality. According to the interviewees, all training processes use this type of methodology, which requires openness to discussing issues specific to the work context. "*All our courses here are based on active methodologies. (...) As I use active methodologies, I necessarily need to give some room (for the worker to bring work-related issues)*" (Ivonete, HE).

The displacement of professionals from management to the territory, for example, is mentioned as one of the ways to apply active methodologies, which is essential for addressing WRMH, planned by the department: "*This movement we are making with the occupational health team, raising awareness in these professionals who are in our service with these visits to their service, raising awareness for them to recognize these patient's conditions. So, this has really been planned, being part of our planning*" (Luana, HS).

Matrixing understood as a PHE strategy that aims to expand the offer of health actions through articulation and shared responsibilities among different actors involved in health care (Souza & Bernardo, 2019), is pointed out as a more direct possibility of addressing WRMH based on the demands of the territory *per se*. Through this strategy, according to the interviewees, there could be a sharing of knowledge, and operational strategies, among others, with the pedagogical team that would assist primary healthcare teams in identifying the causal link between mental illness and work. This debate was initiated among managers for subsequent implementation in the units, as suggested by Luana (HS): "*We often do what is called matrixing in the pedagogical support of our team with the health unit when a professional comes there with this demand. So, it is up to us to work on the link here together with those who are on the frontline*." This strategy is seen as a possible and necessary path for the inclusion of WRMH policies in Primary Healthcare (Souza & Bernardo, 2019).

Holding roundtable discussions based on real cases from the different regions helps identify areas that need improvement in patient care. This strategy is indicated by one of the interviewees as the best strategy for professional competence development: "*For me, this is what works best, roundtable discussions are what work best*" (Luana, HS). These roundtable discussions occur either at the initiative of health units or managers, when they identify issues that require intervention: "*So, it's always by demand. Sometimes a situation happens, and then you need to go there and have a roundtable discussion to listen to qualified people, to think about what strategies need to be taken to solve that problem or even to prevent it from happening again. So, there are both by demand and by provocation*" (Mariana, HS). It is observed that competence development strategies are used for different purposes, including addressing the demands identified through upward planning and the needs of managers. The indication of this strategy as the most effective for competence development may be related to its use to address demands perceived by managers.

The different strategies of competence development pointed out by the interviewees take into consideration the professionals' work reality as an important factor for competence development, in line with the PNEPS policy (Ministry of Health, 2017; Ogata et al., 2021) and the literature that indicates that competence is always related to specific work situations (Le Boterf,

2003; Zarifian, 2012). In this aspect, the approach to work allows for the identification and sharing of knowledge specific to that reality, incorporating elements of competence that cannot be identified without this approach (Durrive, 2016, 2019; Schwartz, 1998). However, this approach to professionals' reality also did not prioritize the need for competence development in WRMH, i.e., it was not sufficient to break the vicious cycle resulting from the lack of connection between work and mental health.

The adopted strategies seem to directly contribute to the development of professionals' knowledge regarding topics relevant to WRMH. However, they do not necessarily lead to prescriptions for returning to work after the discussions. Therefore, the potential impact of these strategies on transforming work and work organization to incorporate WRMH into Primary Healthcare, as indicated by the interviewees, is not achieved. Among the possible reasons for this limitation, it can be mentioned the lack of priority and visibility of WRMH, the absence of protocols and care guidelines that pragmatically guide practice, the lack of data, indicators, and specific training on the subject, as well as the managers' social representations regarding competences and worker's health. PHE assumes a dialectical relationship between professionals' training and health care practices that enable the transformation of work processes (Ogata et al., 2021). Therefore, the transformation of prescribed work (Durrive, 2016, 2019; Schwartz, 1998) from training processes is an important step for PHE. To what extent the real constraints imposed by precarious working conditions in health are limiting factors contributing to this difficulty in revising prescriptions requires further research. Nonetheless, it is evident that the traditional Taylorist separation between planning and execution contributes to hinder the return of discussions held in collective contexts to prescriptions.

Regarding the *evaluation of learning*, different views were observed among the interviewees. Some point out the evaluation of students' satisfaction with the courses offered by the Health Education area and the evaluation of the faculty as the main evaluation forms: "*Our evaluation process is listening to the workers who went through the training process... evaluating the instructor who provided the training, evaluating the infrastructure, evaluating the contents*" (Jaqueline, HE). Other interviewees mention the improvement of services and health indicators as a result of training actions: "*When I carry out these actions and see that these indicators improve, I think that it is not a fundamental part, but it is a part that contributed to the improvement of this indicator along with other issues*" (Mariana, HS). However, it is also possible to observe the lack of systematic monitoring of the impact of training actions on services: "*We have been doing this (competence development actions) frequently, but I can't see, today, a way to verify its impact. A way that I say systematically as an instrument to verify the impact of these activities on work. Anyway, I don't know of anything that has been done like that*" (Elton, HA).

The absence of a systematic evaluation process, as mentioned by one of the interviewees, in addition to complicating the identification of the impacts of competence development actions on health services, may discourage the implementation of PHE policies and participation of the professionals in the actions offered. In this perspective, training management is disconnected

from work management, and the evaluation process focuses on the workers' interest and perception of the training conducted since there is a responsibility of professionals for developing their competences, understood as personal attributes. Evaluation is a key point because, in addition to identifying the effectiveness of implemented competence development strategies, it can support the transformation of work prescriptions, reducing the (always present) distance between prescribed work and real work. This transformation is possible when competence is recognized as a complex mix of ingredients with different degrees of adherence to specific work activities (Schwartz, 1998), and when the subject that engages in the situation is recognized through mobilized values (Durrive, 2016, 2019). However, as discussed, this transformation of representations is closely related to social practices. From this perspective, the implementation of evaluation practices that incorporate collective reflection on the outcomes of training in daily service actions can gradually transform representations of competence development.

Although the actions described by the interviewees may contribute to the development of necessary competences to deal with WRMH by these professionals, the strategies used, and the evaluation methods described are not sufficient, on their own, to improve services since they do not promote the necessary transformations in prescriptions. Professionals who participate in roundtable discussions, matrixing, or other competence development strategies, based on a situation involving WRMH, may broaden their repertoire of knowledge to deal with this issue. However, they still have to start from the same prescriptions about work that are disconnected from reality. Thus, without transforming work processes and given the absence of specific guidelines on the subject, as well as the representation of WRMH as an assignment of specific professional categories, WRMH remains neglected (Souza & Bernardo, 2019).

Final considerations

The research analyzed the social representations of workers in management positions regarding competences to address WRMH and how they can contribute to or hinder the development of these professional competences in primary healthcare workers. It was identified that the prevalence of social representations regarding competences as job assignments and positions can influence competence development and mobilization. The discourse showed a limited dissemination of information about occupational health and WRMH among non-specialized sectors, which may hinder the transformation of social representations about WRMH from a specialized area to a cross-cutting theme in the healthcare network. Different strategies for competence development that can contribute to improving WRMH assistance, with a particular focus on the use of active methodologies, have been implemented. However, the lack of resources, including time and personnel, is identified as a challenge for competence development, and the absence of discussions related to WRMH exacerbates this specific area's issues. The evaluation of training processes, focused on the participants' judgments without tracking transformations in prescriptions and work processes, limits the potential for work transformation based on reflections by these workers.

Based on these findings, it is understood that the processes of developing professional competences, in the analyzed context, can be enhanced by disseminating a notion of competence that is not linked to job assignments, as adopted by the PNEPS, among healthcare professionals. Additionally, implementing monitoring or evaluation of transformations promoted in work processes or protocols based on training processes and disseminating an expanded view of health that considers the modes of production and work processes as determinants are necessary for competence development in WRMH. Furthermore, the inclusion of the topic into training processes, the development of protocols that guide professionals' actions, the provision of other means to favor case identification and management, and the adoption of strategies to demystify WRMH as an area restricted to specific professional categories are also essential.

One limitation of this research was the exclusive interview with MHD managers. Future research is planned to include frontline professionals in primary healthcare. Another limitation was the inability to use initially planned research techniques, such as focus groups and observation, due to the Covid-19 pandemic context. Nonetheless, the research allowed for significant reflections of academic and practical interest.

This study contributes to WRMH research, indicating possible paths for developing competences regarding mental health and work relationships for SUS primary healthcare professionals to address the effects of new modes of production and work organization on health. It also contributes to PHE discussions by problematizing the need for transforming work processes and social representations through PHE actions as a competence development strategy. The articulation between PHE principles and the French approach, as well as the recent dynamic approach to competence, based in Ergology, represents theoretical contributions of this work. The main theoretical contribution is the relationship between managers' social representations and the competence development process, as the representation of competence as personal attributes and WRMH as the responsibility of specific professional categories tends to limit the actions taken by managers in contributing to the development of frontline professionals' competences to address this issue. From a practical standpoint, this study provides municipal health departments with an analysis of the development of competences among primary healthcare professionals based on SR shared by health managers in the municipality. It also suggests pathways to effectively achieve the desired changes.

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