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Francisco Ortega & Manuela Rodrigues Müller

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# Rethinking structural competency: Continuing education in mental health and practices of territorialisation in Brazil

Francisco Ortega <sup>a,b</sup> and Manuela Rodrigues Müller <sup>c</sup>

<sup>a</sup>Catalan institution for Research and Advanced Studies (ICREA), Barcelona, Spain; <sup>b</sup>Medical Anthropology Research Center, Universitat Rovira i Virgili, Tarragona, Spain; <sup>c</sup>Faculdade de Ciências Médicas, Universidade do Estado do Rio, de Janeiro (FCM-UERJ), Rio de Janeiro, Brazil

## ABSTRACT

Brazilian mental health focuses on the social determination model within mental health policies and interventions to address mental and social suffering as resulting from social exclusion and structural violence. Structural concerns focused on class stratification and socioeconomic inequalities overweight cultural ones in Brazilian mental health. In this article we examine, first the role of culture and interculturality in mental health practices and mental health guidelines for health professionals continuing training in Brazil. Second, we explore interviews with health professionals around Continuing Education in Health provided by mental health collaborative care initiatives within primary health care as illustration of a local practice of structural competency in mental health. Finally, we examine the central role played by the practices of territorialisation in shaping health care training and care interventions. The focus on the territory can promote critical apprehensions of the intercultural and structural factors that shape health practices, enrich health professional education oriented towards the basic tenets of social medicine and provide global discussions around structural competency with innovative ways of thinking about health education, health care and spatiality. We believe that our results may be useful for comparing structural competency training initiatives in global health.

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Structural competency; territorialisation; mental health; Brazil; health education

## Introduction: Social determination of health in Latin American Social Medicine and Brazilian Collective Health

Brazilian Collective Health, informed by Latin American Social Medicine (LASM) is committed to the transformation of social conditions, the recognition of the relationships between social structure and health problems and the alliance between academic groups and social movements struggling for the right to health as civil right and social justice (Béhague & Ortega, 2021; Krieger, 2003; Waitzkin et al., 2001; Fonseca, 2020). LASM focuses on social transformation and the tackling of social and structural determinants of health (Porter, 2006).

Major conceptual and practical innovations of LASM are captured in the critique of the ‘social determinants’ of health and its replacement by ‘social determination’ of health. For LASM scholars, the social determinants of health (SDH) approach, first, reduces social processes to individual

**CONTACT** Francisco Ortega  francisco.ortega@icrea.cat  Catalan institution for Research and Advanced Studies (ICREA), Barcelona, Spain, Medical Anthropology Research Center, Campus Catalunya, Universitat Rovira i Virgili, Av. Catalunya 35, 43005 Tarragona, Spain

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intragroup dynamics. Socioeconomic status understands social determinants as individual interactions. As a result, power dynamics, structural injustices or oppression underlying socioeconomic hierarchies are rendered invisible. Second, education, income, occupation and other personal attributes are removed from the socio-historical context of the individual, offering a distorted and naturalised view of life conditions as static, which eclipse the emancipatory efforts of social movements to radically transform society (Fonseca, 2020; Harvey et al., 2022; Morales et al., 2013). Finally, by disregarding the complexity of health phenomena, the structural processes linked to diseases and the dynamics of situated processes that determine the distribution of population health, SDH approach favours top-down and fragmented programmes and interventions isolated from the political actors of social change. Besides, it does not question ‘the structural basis of health inequities’, associated with ‘capitalist accumulation’ (Fonseca, 2020, p. 148).

Unlike the SDH approach which ignores the role of social structures, economic and political forces in the health-disease process and fragment contexts into factors imposing a linear ordering of determinants, the ‘social determination’ approach shifts the focus from the individual to the socio-political context and to social stratification (Harvey et al., 2022). There are limits of a perspective solely based on the correlation of fragmented macro-social factors, such as economic and social policies to change social stratification or that interfere in the vulnerability of specific social groups. Social determination involves public policies aimed at reducing social stratification, and ensuring equity, universality and comprehensiveness, and transversal programmes of community strengthening that value social bonds and popular participation (Borghi et al., 2018; Dimenstein et al., 2017).

Brazilian collective health emerged in the 1970s, as part of LASM, and promoted the development of studies aimed at understanding the social determination of diseases and the social organisation of health care services (Vieira-da-Silva, 2021). There were also at that time vibrant interactions between experiences of health care municipalisation, academic production and health care reform institutions that led to the creation of the Health Reform Movement.

The constitution of 1988 granted the right to health; the health care law was approved in 1990 and the Unified Health System (*Sistema Único de Saúde* or SUS) was created in the same year (Lima et al., 2005). The basic principles of SUS are universality, comprehensiveness (integral health from prevention to curative care), equity, decentralisation and social participation. Health services are financed and provided by the state at the federal, state and municipal levels. The Family Health Strategy (FHS, *Estratégia da Saúde da Família*) is the primary health care model of SUS, providing universal access and comprehensive health care. The development and expansion of SUS constitute a unique illustration of scaling up universal health coverage in a highly unequal country with relatively low resources allocated to health care (Paim et al., 2011).

Parallel to these developments the Brazilian psychiatric reform also emerged in that period. It was inspired by the Italian reform and the Italian democratic-psychiatry movement led by Franco Basaglia in Trieste and the Lacanian-inspired institutional psychotherapy programme of La Borde in France (Foot, 2015; Robcis, 2021). Mental health care in the country was reoriented in the 1990s from a hospital-centred model to community mental health care and primary health care models according to the Pan American Health Organisation (PAHO) guidelines. The Psychiatric Reform Law from 2001 promotes reduction of long-term admissions in psychiatric wards, and its replacement by beds in general hospitals, the deinstitutionalisation of psychiatric inmates and their psychosocial insertion through work, culture and leisure policies (Ministério da Saúde, 2004).

Major arguments advanced by LASM and Brazilian collective health echo with main claims of Brazilian scholars around the psychiatric reform, even if they do not explicitly draw on the critique of the SDH approach and the interventions it promoted. Still their arguments converge with the critique of the structural basis of health inequalities and its relationship with capitalist accumulation (Amarante, 2000; Desviat, 2016; Vasconcelos, 2008).

In this article we examine, first the role of culture and interculturality in mental health practices and mental health guidelines for health professionals continuing training in Brazil; second, we analyse interviews with health professionals around a practice of structural competency in mental

health: Continuing Education in Health (CEH, *Educação Permanente em Saúde*) provided by mental health collaborative care (MHCC) initiatives within primary health care. Finally, we explore the key role played by the territory and the practices of territorialisation that shape professionals' health training (CEH) and care interventions. In deepening the examination of continuing education in mental health collaborative care with a focus on the territory and the practices of territorialisation, we argue that this strategy can encourage the development of a critical apprehension of the inter-cultural and structural factors that shape health practices. We believe our discussion of continuing health education and the practices of territorialisation would enrich health professional education oriented towards the main tenets of social medicine and provide global discussions around structural competency with innovative ways of thinking about health education, health care and spatiality.

### Silencing of culture and interculturality in Brazilian mental health practices

Brazilian collective health has developed care strategies that promote interculturality (Harvey et al., 2022), i.e. 'the integration of several cultures in the midst of a shared cultural vision, for the construction of a common project of democratisation and equity, that is, where different cultures can reproduce and mutually sustain themselves under equal rights, responsibilities and opportunities' (Breilh, apud Harvey et al., 2022, pp. 5–6). Popular participation is key to intercultural health practices in Brazil. However, the strong focus on class, social justice and inequality as markers of difference within Brazilian psychiatric reform and the organisation of post reform mental health services and policies in the country hinders a nuanced understanding of interculturality and its introduction in the definition and planning of mental health policies and interventions and the organisation of health services (Menéndez, 2016).

Culture is a 'fluid, situated and negotiable intersubjective system of meaning and practice relevant to specific social contexts' (Kirmayer, 2012, p. 252). Its inclusion in mental health practices and policies provides tools to assess the social contexts of knowledge and power in which the illness experience is embodied. The local 'silencing of culture' which downplays the role of cultural differences within mental health practices (Ortega & Wenceslau, 2020) historically relates to the imaginary national understanding of Brazil as an ethnic homogeneous nation which integrates cultural, racial and ethnic differences. The imaginary of 'cultural uniformity' is defended even by Marxists' social scientists and it is embedded in a deeply stratified society marked by harsh class differences and structural injustices (Ribeiro, 2000). The 'silencing of culture' in Brazil coexists with the 'hollowing out' or emptying of the notion of culture. This leads to the paradoxical situation in which spiritual and religious beliefs and practices are deemed relevant for the therapeutic process but left outside health professionals' understanding of culture. Moreover, racialisation is rarely considered significant for such processes.

Brazilian Psychiatric reform was imbued with such national understanding which converges with its own focus on class differences and inequalities influenced by the Italian Psychiatric reform and the resistance to the dictatorship. Italian *Psichiatria Democratica* had a definite progressive and leftist spirit, which favours class relations over cultural aspects. This leftist Marxian spirit was transferred to the Brazilian reform (Amarante, 2000; Foot, 2015). In this context, the stratifications that gather policy attention are not those of culture, but those of class. Such an understanding has influenced both the Psychiatric Reform as well as mental health policies and service organisation in the country, favouring class stratification and socioeconomic inequalities. This emphasis on class stratification has been criticised by indigenous, black and LGBT movements, and, although there has also been specific health care policies for those populations, they occupy a marginal role with insufficient financing and legal support (Ortega & Wenceslau, 2020, 2021).

The erasure and internal contestation of culture leads to the ignorance or misrecognition of the cultural dimension of mental distress within mental health practices and services, resulting in some cases to its rejection, reification or caricature (Ortega & Wenceslau, 2020). Brazilian mental health

privileges 'structural concerns' focused on class stratification and socioeconomic inequalities over 'cultural' ones. It is important to capitalise on the emphasis on social determination of mental health within mental health policies and interventions which addresses mental and social suffering as resulting from social exclusion, violence, marginalisation, stigma, discrimination/racism, poverty, unemployment, housing conditions, lack of access to social protection programmes (Dimenstein et al., 2017). If mental health professionals in the country may not be imbued of sufficient 'intercultural competency' (Fleckman et al., 2015) to address the challenges of cultural diversity and their impact on users' mental health, they however deploy diverse forms of 'structural competency' even if the notion is not widespread in the country.

Cultural competence, i.e. the capacity of health professionals, practitioners and services to effectively engage with patients' cultural backgrounds, values and beliefs (Kirmayer, 2012) has become popular among clinicians and researchers in the last decades. Yet the practice has been criticised for promoting a naïve understanding of culture as synonymous with ethnicity, nationality and language and for reducing individual symptoms to patients' cultural affiliations (Kleinman & Benson, 2006; Lekas et al., 2020). In addition, health professionals do not recognise biomedicine as part of a specific culture (Taylor, 2003), thus reaffirming hegemonic forms of culture (e.g. Western, Eurocentric scientific culture). As a consequence, notions such as intercultural competency, cultural humility or structural competency have been advanced. Structural competency was also developed in US medical education and trains health professionals attentive to the structural nature of stigma and health inequalities. Unlike cultural competence that focuses on identifying clinical bias and improving communication in clinical encounters, structural competency enables clinicians to assess social, economic and political conditions producing health inequalities (Metzl & Hansen, 2014).

In contrast, Brazilian collective health and psychiatric reform and the organisation of post reform services have somehow followed an inverted path, placing from the beginning the emphasis on the structural determinants of health practices and downplaying the role of cultural differences in health practices. Despite this emphasis on structural determinants the issue of racialisation and racial discrimination, which is central to the US approach to structural competency has been for a long time marginal in Brazilian mental health policies and service organisation and is only recently being recentred. Moreover, the terms 'structure' and 'structural' have a more restricted meaning in Brazilian mental health than in US discussions around structural competency and structural violence. In the former, structure and structural mainly refer to class, class stratification and socioeconomic inequalities, whereas in the US literature those terms indicate hierarchies of not just class but also racialised groups, gendered groups, etc. Many authors use 'structural violence' to include the harm done by these hierarchies that are based not just in class but also race, sex, gender, sexuality, ability, among others (Bourgois et al., 2017; Farmer, 2004; Metzl & Hansen, 2014; Metzl & Roberts, 2014; Stonington et al., 2018).

In the next sections, we examine one practice of structural competency in mental health, which significantly impacts the structural sensibility of professionals, the case of Continuing Education in Health (CEH) developed in primary health care and provided by mental health collaborative care (MHCC) initiatives. Specific to this practice is the reflection on the (notion) of territory and the practices of territorialisation. With this focus, we want to examine a practice of structural competency that precedes historically and also diverges from the way this notion has been theorised in the US.

## **Continuing professional training in mental health care in Brazil**

Latin American Social Medicine and the Health Reform Movement in Brazil have shaped fundamental values of the Unified Health System (SUS), orienting theory and practices of health care towards the sociocultural, economics and structural determinants of the health-disease phenomenon – captured in the notion of social determination of health – challenging the biomedical paradigm and promoting an expanded concept of health (Fonseca, 2020; Paim et al., 2011). In this context, health professionals trained to recognise health as a social and complex phenomenon

are crucial to develop comprehensive health care practices. Therefore, health professional training has been considered a key element since the emergence of SUS (França et al., 2016; Silveira et al., 2020).

Training carried out within health services, in an interdisciplinary and dialogic way, attentive to the local features of the communities involved, enables contextualised learning, attentive to SUS values (França et al., 2016; Gigante & Campos, 2016; Silva et al., 2019). With these values in mind, health education proposals advanced towards establishing several mechanisms to improve health training such as reviewing curricular guidelines for health education, adapting them to local and regional realities, technological advances, epidemiological needs. These initiatives aimed to address the reductionist character of professional health training and thus reaffirm the principles of SUS and the focus on the territory and the practices of territorialisation (Gigante & Campos, 2016; Silveira et al., 2020).

Continuing Education in Health (CEH) was officially introduced in the early 2000s (Silva et al., 2019) as a strategy for health professionals' training within health services. CEH should be implemented by the continuing education centres, an inter-institutional and local-regional instance responsible for identifying health professionals' training needs, in addition to building strategies and education processes that qualify care and management and strengthen social participation (Brasil, 2007).

CEH establishes organic relationships between teaching and services. Thus, it is intended for multi-professional audiences, that is, health teams within different services in the health network. CEH takes the problems identified in the work process as a starting point for educational actions, making use of active teaching-learning methodologies, emphasising problem solving. It is based on Paulo Freire's view on adult education, nurtured by problems resolution and new knowledge emerging from the individuals' previous learning and experiences (Gigante & Campos, 2016).

The process of professional training is recognised as one of the main obstacles to implementing psychosocial care in Brazil (Kinker et al., 2018; Scafuto et al., 2017). Psychosocial care stands for comprehensive care practices and mental health services within the healthcare network of a catchment area. It has been promoted by the Brazilian psychiatric reform movement as a form of care and social inclusion that deals with the sociocultural, epistemological and legal-political dimensions of mental suffering (Yasui et al., 2016).

Brazilian mental health collaborative care (*matriciamento em saúde mental* - MHCC) is both a health care strategy to ensure access to and continuity of care and a framework for teaching health professionals. MHCC was instituted by the Brazilian Ministry of Health in 2003 as a strategy for the inclusion of mental health interventions in primary health care (Chazan et al., 2020). MHCC's main objective would be co-responsibility in health care between Family Health Strategy (FHS) teams and mental health specialists. MHCC is carried out on a regular and continuing basis and furthers interdisciplinary and intersectoral care planning and practice (Santos et al., 2021; Chazan et al., 2020); it promotes contextualised learning in health settings, consistent with SUS values and aware of the local features of each community or catchment area. Dialogic relationships among professionals from different backgrounds enable shared therapeutic planning and technical-pedagogical support to the FHS teams within services. The technical-pedagogical support is a differential of mental health collaborative care in the country (Chazan et al., 2020; Santos et al., 2021; Saraiva et al., 2020).

## Methods

Brazilian health professionals are attentive to sociocultural and structural determinants influencing clinical cases. It is important to examine how such sensitivity has been developed and is enacted in health care practices. In this sense, we developed guiding topics for conducting interviews around PHC and MHCC professionals' understanding of interculturality and structural competency in mental health.

The research was carried out in the city of Rio de Janeiro, at health units located in a highly socially vulnerable part of the city, formed by 17 neighbourhoods, some very violent due to drug trafficking and police raids. This region comprises 25 health units, responsible for 444,961 users (CAP 3.2, n/d). These units are part of the FHS and are identified as Family Clinics. Two units were selected for our fieldwork due to their accessibility by public transport and less violent surroundings, so we were able to access them and interview the health professionals safely.

We interviewed 11 professionals, 7 family physicians and 4 mental health professionals – two psychologists, one social worker and one physical educator. MHCC and specific mental health services are potential workplaces for professionals trained by these programmes. Interviewees' names were hidden for ethical reasons, and they signed an informed consent form. Interviews were recorded on audio and transcribed. They were conducted using the episodic narrative model. Data collection received clearance by the Ethics Committees of our institution and the Municipal Health Secretariat of Rio de Janeiro.

Episodic narrative interviews allow the interviewees to display their experiences contextually, making the episodes the object of narratives and thus a way of accessing relevant experiences of the subjects. Everyday events and routines are expressed without constraining the interviewees by the theoretical domain of the theme (Flick, 2000). A field diary helped the interpretation process. The diary was used to contextualise the fieldwork and enrich the interviewees' narratives. The interviews were analysed through discourse analysis. Discursive formations and conceptual axes were established from the reading of the material, followed by the identification of the significant nuclei and slippages of meaning.

### **Mental health collaborative care as a framework for teaching health professionals and strategy of promoting structural competency in the territory**

We conducted open interviews with professionals in which the interviewees discussed the intercultural and structural elements of their practices focusing on mental health cases followed in family health strategy. Professionals highlighted the relevance of interculturality and structural determinants for recognising health problems, priorities and modes of intervention. As a consequence, they stressed patients' local contexts and the need to show an empathetic attitude toward them. In the following excerpts, two recently graduated physicians working in primary health care express their concern to apprehend interculturality and structural determinants influencing patients' health conditions:

*Trying to understand all the baggage that a person brings along. Each person in each community has a previous story. You should always try to particularise people. (...) When you are inserted in a society, that society has aspects that are important to it. (Bernardo, general practitioner)*

*[It is important] to be aware of the cultural diversity of where we live, different beliefs, ways of seeing the world and trying to insert that into the way you work. Trying to demystify the issue of diagnosis. People sometimes have wrong beliefs about what certain diseases are. (Bento, general practitioner)*

Professionals are aware of the differences between medical and lay perspectives and the need to negotiate these differences to define a therapeutic plan. Bento observes that patients do not know the 'right' diagnosis and establishes a comparison between their perceptions and values, called 'beliefs', as opposed to (scientifically) proven medical knowledge. As Greene (2008) argues, these opposing notions expose health professionals' orientation towards biomedical knowledge. They denote a tendency to disqualify the diverse lay perspectives of health services' users. Our interviewees observed that differences between biomedical and patients' views are easily perceived when there is a confrontation (refusal or questioning of diagnosis and treatment), or when dealing with patients from different populations ('exotic', such as the indigenous, or of lower socio-economic status, such as users living in favelas). Neff et al. (2020) argue that health education attentive to the structural determinants of the health-disease process helps to recognise the phenomena of

structural violence and naturalisation of inequities. We notice that the professionals interviewed naturalise some situations, for example by disqualifying lay knowledge, or by showing prejudice in relation to low-income and low-schooling patients or migrants from poorer regions of the country. This behaviour illustrates the effect of naturalisation of inequalities, which confirms the crucial role of professionals' previous training and the model of health education to address these difficulties.

Spaces for discussion, such as mental health collaborative care, can unveil the structural determinants underlying health interventions and promote more effective coping strategies by health teams. Differences observed in the interviews between physicians without family medicine specialisation, physicians with family medicine training and MHCC professionals reinforce this observation. While the former tend to be less sensitive and flexible in dealing with users' and families' structural and sociocultural diversity, physicians with specific training and longer experience and MHCC professionals tend to be more aware of interculturality and the structural determinants of health practices (Müller, 2019). In addition, MHCC professionals prove to be more attentive because they work in different services and always in partnership with other health professionals. They usually follow different teams, sometimes in more than one health service, so they are able to compare the ways in which users relate to health services and the effects of this interaction, not only on patients, but also on health professionals. Such situations confirm the belief that sensitivity to context is developed in the spaces of exchange of experiences between professionals, in response to the challenges of care practices on a daily basis (Faria et al., 2021), as the following observation illustrates:

*We assess the context of each person, of each family we serve. I try to work on the family history, on the importance of understanding that such a symptom is not just a symptom of such a person, but a family's symptom. (...) We forget that, behind all these issues, there is a situation that belongs to that context, that we need to understand what causes it. (André, mental health professional)*

André is a MHCC professional and his observation highlights the role of the family in the expression of suffering and confirms Menéndez (2016) conditions for intercultural observations and interventions of social groups, or micro groups. Families are favoured in these interventions, and their inclusion will enable an effective intercultural negotiation process. We also noticed a confusion in the apprehension of socioeconomic aspects (e.g. income, education), reflected in the limited integration of interculturality and structural determinants in the assessment of patients. This is probably related to insufficient inclusion of those issues in health professional education (especially in medicine and other health degrees) as well as theoretical and methodological gaps in Brazilian mental health research (Targa & Oliveira, 2012; Menezes et al., 2018). The following excerpt illustrates the limited incorporation of interculturality and structural determinants:

*We are present in two units and they have very different cultural issues. In this unit we usually attend to people from Rio de Janeiro, middle class, elders and people with a different situation. They're able to discuss everything you tell them. If you are talking about a group, there is group consciousness, if you talk about a certain disease, they know a lot about it (...) Whereas in the other unit, we see people from much lower income. These are people mostly from the Northeast; we see the struggle of the Northeasterners migrating here, so understanding health, understanding space-territory is different. (...) Then, professionals arrive to a certain area and you must respect that to implement the health service in a way not to adapt it, while taking into consideration the particularities of those populations. (Elisa, mental health professional)*

Elisa identifies different social determinants (income, education) that influence health care in populations from different territories, but the professional is not aware of her own prejudice about the Northeasterners (*nordestinos*), who coming from one of the poorest regions in the country, are frequently mistreated and stigmatised in many southern Brazilian cities (Serrão, 2020). This prejudice hinders her from approaching users in a more nuanced way and rescuing their values and health habits in a negotiated manner. Moreover, healthcare professionals are also subjected to the cultural biases and modes of expression prevalent in the rest of the population.

The interviewed physicians identified consultation, search for absent patients and home visit as strategies to improve the knowledge of the social context in which users live. Context assessment takes place through joint consultations and home visits with mental health professionals. However, interviewees did not mention a space for discussion or reflection on those initiatives. The continuing education in health framework promotes the recognition and discussion of health problems in the territory as a way of advancing knowledge and practices among health professionals. But if this activity is neglected as some authors identify, then the learning effects of MHCC will be limited (Faria et al., 2021).

The initiatives proposed by the interviewees may be grasped as ways of approaching the socio-cultural context in which users live. Still, they fail to consider that social reality is constituted through the coexistence of different (medical) systems and the negotiation of perspectives between politically active subjects (Greene, 2008; Langdon, 2014). The following excerpts seem closer to a dynamic understanding of the conformation of sociocultural diversity and its apprehension.

*What we believe to be the best is not always the best. Therefore, it is important for us to outline a singular therapeutic plan. When we talk about a singular therapeutic plan, it means individualising the cultural and social context in which that person is inserted. (...) I believe the main thing here is active listening. What you set as goals has to be adapted for each patient, her reality and needs.* (Bernardo, general practitioner)

*Active listening is the first step. Listening to what the patient has to say, what she brings from her perception of the world and her own condition. Dealing with this, I imagine ... as long as it doesn't compromise the treatment, in the sense that she may refuse treatment, which may happen, but adopting certain practices that go against the treatment she is undergoing. My role would be to guide her in this regard.* (Bento, general practitioner)

Although identifying groups' particularities and negotiating therapeutic plans are listed by the interviewees, there seems to be an assumption that the technical language scares patients and compromises the therapeutic plan. This configuration raises the question of power relations among health professionals and users (subordination) and the limits of true exchanges and negotiation, as it would be expected within a context of interculturality (Menéndez, 2016).

The issue of inequality in clinical encounters is central in structural competency literature and is seen as one of the main aspects to be taught and addressed by health professionals (Metzl & Hansen, 2014; Gajaria et al., 2019). Interpersonal communication in clinical interactions is crucial, especially when racial, ethnic, linguistic, economic and other differences are evident. However, biomedicine traditionally focuses on the clinical encounter as the main space of care practices, neglecting the structural factors that shape the health-disease process. Finding ways to address this inequality is fundamental in the structural competency approach (Metzl & Hansen, 2014; Neff et al., 2020) and is also key in CEH initiatives such as mental health collaborative care.

Structural racism is a key component of structural competency as is understood and taught in the US (Metzl & Roberts, 2014; Neff et al., 2017; 2019; 2020). Diverging from discussions in the US, the issue of racism did not emerge in our interviews. This absence is symptomatic of the silencing of culture in Brazil which downplays racism and racialisation underlying class differences and inequalities. Moreover, as already mentioned, structural racism is not integrated in Brazilian mental health's understanding of structural competency which focuses on class stratification and socio-economic inequalities. It thus hampers a broader understanding of the term to address the harm done to racialised and gendered groups among others. Although the process of universalisation of the right to health in Brazil as a fundamental social right in democratic societies and the constitution of the SUS involve a discussion of issues of racialisation, initiatives to address racial inequalities have not been systematised and are underfunded. Likewise, Brazilian psychiatric reform explicitly condemns discrimination against Blacks, indigenous and LGBT populations. Still, there is very little discussion of mental health care policies to address gender, ethnic or race differences. The special health care policies for black, indigenous and LGBT populations (Souto et al., 2016) have a marginal place, resulting in poorer health outcomes for these groups (Coimbra et al., 2013; Popadiuk et al., 2017; Werneck, 2016). Conversely, there is a growing body of research that highlights the presence

of ethnic, racial, gender and religious differences and their embodiment in modes of exclusion and segregation within Brazilian society (Layton & Smith, 2017). Inflamed debates around affirmative action in Brazil have fuelled issues of racial differences, identity politics and multiculturalism that reverberate in Brazilian mental health care and policies (Bernardino-Costa & Blackman, 2017). The murder in 2018 of Marielle Franco, black woman, lesbian, favelada and left-wing politician and the election of far-right Jair Bolsonaro as President of the Republic in the same year have boosted the debates around structural racism and racialisation in the country (Perry, 2020; da Silva & Larkins, 2019). The direct impact of racialisation on health outcomes, as the COVID-19 pandemic has revealed (Martins-Filho et al., 2021), requires some iterative changes in structural competency practices within continuing health education to include more focus on intersectionality.

### Promoting structural competence in Brazilian mental health through practices of territorialisation

Our interviewees stressed the sociocultural context in which users live as an important dimension to understand and plan healthcare interventions. They highlight the central role played by the territory and the practices of territorialisation within mental health practices and initiatives as well as in continuing education in mental health.

Instead of community, the concept of territory was raised to an operational category in Brazilian mental health (Yasui et al., 2016). At the time of the design of the organisational guidelines of the health system, it was argued that the interventions and health services would integrate regionalised, hierarchical and decentralised networks (Müller, 2019). Besides this organisational character (territorial division in SUS) the territory is shaped by a set of sociocultural and economic determinants that configure the daily life and insertion in the world of those who inhabit it. Thus, care practices are built with the population served, considering that health services are part of a care network and operate in an established geographic region (Yasui et al., 2016; Dimenstein et al., 2017).

The focus on the territory guides the assessment of the population needs and the situational diagnosis of the community. Most of the information is obtained through secondary sources, such as censuses and epidemiological bulletins, but the recognition of the territory's resources and the health assessment of different population groups may be retrieved through individual consultations, meetings with the community and visits to the region. Territorialisation is the process of appropriation of pertinent information on the territory and is tantamount to exploring structural determinants (violence, poverty, marginalisation) that determine the health-disease phenomenon (Müller, 2019). MHCC as a health education strategy promotes the competency to recognise and incorporate those determinants in the health care interventions developed in a given territory. In the following clippings we see how the idea of territory is introduced:

*A lot depends on what we have available in the territory [she lists different types of institutions and activities available around the health unit] (Antônia, family health physician)*

*[It is really important] to understand the context in which that person lives, to find a support network, family or people with whom she lives and bringing these people to the consultation (Bento, general practitioner)*

Furtado et al. (2016) pointed out in their review of the notion of territory that its vague or instrumental use (for example, as a territorial division in SUS) has implications in patient care. Based on definitions spawning from critical geography and social sciences, the authors emphasise the territory's political character arguing that the concept of territory encompasses the awareness that power is always exercised in a given space and through such a space, be it a nation-state or less evident territories, such as drug trafficking or the luxury real estate industry (Furtado et al., 2016, p. 2). Consequently, the territory is seen as a tensioned conjunction, stage for disputes and resistance. 'Territorial stigmatisation' (Wacquant, 2007) is common to the communities where we conducted our fieldwork. People living in those territories are suffering from diverse forms of structural

violence. However, unlike other contexts of territorial stigmatisation across the world, there are public health policies specific for vulnerable populations in Brazil oriented toward social justice and the principles of SUS and primary health care professionals have to deal with those situations of stigmatisation and structural violence in the territories where they work. The implementation of health units and teams is planned considering the vulnerability of these stigmatised territories because health conditions are known to be worse in these communities. Thus, health planning concretely responds to the challenge of ensuring access to health care and facing these conditions. But, more than that, by promoting actions of prevention, health promotion and coordination with other sectors within the territory, health care assistance becomes a political strategy aimed at social justice that gives some visibility to the structural violence experienced in these communities. Addressing this violence could be more powerful with greater intersectoral coordination and social participation, considering the intercultural approach and the incorporation of more sensitive approaches guided by the social sciences which complement epidemiological assessments.

In Antônia's and Bento's reports we noticed a functional understanding of the concept of territory, which assumes that neighbourhoods and existing facilities are potential therapeutic resources. It is an interesting, however limited perspective for even if there are few options in a territory, users and professionals tend to be restricted to those possibilities and fail to build other alternatives (or to reflect on such structuring). Moreover, such a perspective misses that health units are also resources in the territory and that the relationships established with the population are dynamic and part of a broader and ongoing social process (Menéndez, 2016).

In the following statements the understanding of the territory as a repository of potential therapeutic resources resurfaces:

*The family health strategy team needs a moment to build its own map of the territory. It is all about building what is alive, what is powerful in that territory. (Andre, mental health professional)*

*This thing about the relationship with the territory is really cool. The partnerships you make with the territory. At the beginning, when we first arrive ... we go round to get to know the territory and all the facilities we have in the territory. (...) When we attend patients, we pass this idea on to the teams, and we identify that those patients may find in that space a potential aid to improve their therapeutic projects. (Bianca, mental health professional)*

The territory is seen positively in all the excerpts. It is important to bear in mind that interactions in the territory are not always friendly or positive. Professionals also reported coming across difficulties, such as violence and social vulnerability, which they noticed to be more prevalent in some regions. Implementing meaningful and effective mental health interventions requires problematising limited apprehensions of the territory which largely focuses on the positive elements. In addition, territory assessment instruments and strategies should be expanded. In the following excerpt, André, a MHCC professional, reflects upon teamwork and its potential to develop cultural sensitivity among family health professionals:

*I work with professionals so they may evaluate and think about building an action plan. Professionals go on reproducing a certain logic, a practice of automatism, of protocols; they don't know what they are doing. (André, mental health professional)*

André's suggestion focuses on health teams' ability to critically observe their own actions as a condition to assess the social contexts and power relations that underlies users' suffering. It is also a good illustration of CEH's dialogical character. Teamwork may reveal professionals' automatic, non-conscious actions and provoke an estrangement that results in a reflective process around meaningful interventions. Interrupting automatisms occurs by facing patients' questions and their subversive self-care strategies emerging from users' interactions in the territory that challenge biomedical interventions. Beyond the interaction with the patient, the interruption is revealed when questioning and subversion are legitimised (Müller, 2019). Thus, it is important to be aware of power relations that delegitimise patients' demands (Metzl & Hansen, 2014; Gajaria et al., 2019). André's observation reinforces the observations of Neff et al. (2020) around differences in the

framings of problems by professionals from various disciplines and at different points in their training and the expectations they hold regarding a structurally competent practice.

*Mapping everything. That's a territorial diagnosis, territorial situational diagnosis. I think this should be mandatory. Because sometimes the doctor arrives and that team has been without a doctor for months and they keep seeing the same things.* (Elisa, mental health professional)

The professional alludes to another issue emerging from the insufficient discussion around territory. Mental health professionals disclosed having little time to prepare this mapping with the teams and that many managers favour quantitative data regarding the prevalence of health conditions in the region. Such difficulty reinforces the weakness we perceive in our fieldwork that limits MHCC's space for continuing learning, namely, the dependence on work processes and routines of health units defined by service and local managers. This dependence does not allow differences in professionals' backgrounds to be recognised and addressed in MHCC practices and brings forth power relations between managers and professionals. It also results in inequality in the training of professionals and compliance with care practices at the regional level (Gigante & Campos, 2016; Silva et al., 2019).

Mental health collaborative care success regarding both health assistance and continuing education practice rests on several factors. MHCC is promoted as a strategic policy to broaden mental health care in primary health care, but its performance differs across different Brazilian regions and even within municipalities and depends on the availability of resources and the interplay of professionals, health facilities and communities in each territory.

Some health managers and professionals favour more conservative care practices oriented to biomedical perspectives and reducing collaborative care to specialised care. There are also MHCC professionals with limited clinical experience, which distort collaborative care, especially when they have to provide mental health advice to FHC teams with extensive experience. Moreover, the psychoanalytic training of some MHCC professionals hampers communication with FHC teams with different theoretical backgrounds.<sup>1</sup> Several undergraduate and graduate health programmes are not aligned to SUS principles of health professional training oriented towards interdisciplinary, intersectoriality and comprehensive care, keeping teaching practices oriented toward early specialisation and the private market. Uneven distribution of continuing education centres among different regions of the country, mainly due to disagreement between training institutions, managers and services, also affects the detection of training needs as well as the development of specific regional teaching strategies (Gigante & Campos, 2016; França et al., 2016; Faria et al., 2021).

Professionals' academic background is crucial to understand the importance of MHCC and to deploy better care practices. Studies suggest that health professional training based on the principles of Latin American Social Medicine and SUS impacts on the quality of the health care provided to the population (França et al., 2016; Batista & Gonçalves, 2011). Our interviewees confirmed this perception. Mental health collaborative care as a framework for teaching health professionals constitutes a powerful strategy of promoting structural competencies among professionals, attentive to the local needs of the community and their vulnerabilities in each territory, with important benefits for the access to and organisation of health services (Santos et al., 2021; Faria et al., 2021).

Another relevant obstacle identified by our interviewees is the scarce (mental) health network available to users and their families in their region. Family health physicians are responsible for all patients in their catchment area but other professionals and assistance levels are needed to follow up some cases both considering symptomatic severity or social vulnerability (Chazan et al., 2020). The availability of resources and the interaction of professionals, institutions and communities in the territories need to be considered in order to enhance collaborative care in mental health.

## Conclusion

The development of primary health care and collaborative care in mental health as national policies of comprehensive health care attentive to local contexts illustrates SUS commitment to the key

tenets of Latin American Social Medicine. Brazilian collective health has become a strong field for reflection and construction of innovative health education frameworks and health care practices (Vieira-da-Silva, 2021). Continuing education in health is a public policy initiative that seeks to articulate learning and experience of health professionals, in an interdisciplinary way and attentive to local contexts. It is an original framework for teaching health professionals and a strategy of promoting structural competency. The reflection upon the territory and the practices of territorialisation are central to this form of structural competency.

The introduction of such a professional training strategy in mental health care with a focus on the territory reflects SUS values and also the social determination model. It is a major challenge to implement public policies that reduce social stratification, as well as promote equity, universality and comprehensiveness in health care. Mental health collaborative care is a powerful framework for the continuing training of health professionals with an emphasis on the territory and the practices of territorialisation. It places centre stage key conflicts in Brazilian society, such as structural violence, marginalisation and discrimination of different groups (black, indigenous, LGBT, among others), political arrangements at national and group levels, corporate interests of health care professionals and demands of social movements. The successful implementation and continuity of those training programmes are related to these conflicts and complexity.

In this article, we examined health professionals' sensitivity regarding interculturality and the structural determinants that shape the health-disease phenomenon in a territory and how this knowledge is introduced in health care practices. Professionals with background in primary health care and longer experience in teamwork practice this form of structural competency. We also noticed that prejudices prevail when interculturality and structural determinants are not considered in consultations and team discussions.

Structural racism is an important component of structural competency in the US (Metzl & Roberts, 2014; Neff et al., 2017, 2019, 2020). The issue, however, did not come out in our interviews. This absence illustrates the silencing of culture within mental health practices in the country which pays scarce attention to racism and racialisation underlying class differences. In addition, the operationalisation of structural competency in Brazilian mental health prioritises class stratification and socioeconomic inequalities and does not include a focus on structural racism. The direct impact of structural racism on health outcomes demands important changes in structural competency practices within continuing health education to include more emphasis on intersectionality. Class inequality, recognised by professionals as low education and income, was not nuanced by other intersectional dimensions that mark the health-disease-care-seeking phenomenon, such as race, ethnicity, gender, or age. The integration of social science approaches in continuing education in mental health will enable a nuanced and contextualised understanding of these vulnerability markers and the related practices of territorialisation. The interweaving of these elements has specific weight in health care planning and need to be included in case discussions and interventions. Moreover, interviewees' observations disclose that the impact of work organisation within health units and the availability of health services that make up the health care network in each region of the city - and in different cities - get not enough policy and managerial attention. The difficulties related to care management and the characteristics of the territory are not sufficiently considered by physicians, who spend more time in individual consultations. And MHCC professionals working in different units and different primary health care teams are more aware of local realities, related to the resources available in the communities or to the obstacles experienced in the territory. Still, they are also limited by the internal demands of the services and the characteristics of health care networks.

The Brazilian experience of continuing education within health services with a focus on the territory and the practices of territorialisation shows that reducing the interpretation of structure to one element, social class, without incorporating other social markers of difference such as race, ethnicity, gender, age and without problematising the specific relationships that take place in each territory can result in reduced use of the potential of contextual learning promoted in CEH/MHCC

and jeopardise the development of structural competencies among health professionals. The negotiation of (lay) care practices of different social groups observed in mental health collaborative care reveals the sociocultural and structural aspects that cut across communities and go beyond the individual perspective (Metzl & Hansen, 2014; Menéndez, 2016). Balancing the recognition of interculturality with awareness of inequality and other structural determinants of health strengthens the analysis of both dimensions, as structural vulnerabilities take on unique forms in specific cultural contexts (Martinez-Hernaez et al., 2021).

## Note

1. In Brazil, psychodynamic interventions (especially psychoanalysis) are largely used within community mental health services (Menezes et al., 2018). Although psychoanalysis defies biomedical understandings of mental suffering, its emphasis on subjectivity and intrapsychic conflict with limited problematization of the interactions that take place in the territory has provoked disagreements among primary health care professionals (Müller, 2019).

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## ORCID

Francisco Ortega  <http://orcid.org/0000-0002-5039-9449>

Manuela Rodrigues Müller  <http://orcid.org/0000-0002-7851-9000>

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