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Work-related Mental Health Surveillance in Brazil: characteristics, difficulties, and challenges

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Abstract *This paper addresses the challenges and difficulties in Work-related Mental Health (WMH) Surveillance in Brazil, based on a review of the bibliographic literature. From the compilation of identified academic research, it seeks to foster reflections about the current landscape of surveillance actions, its main obstacles, and possibilities for improvement. A survey of national publications was carried out using Scielo, Lilacs and PUBMED databases from 2002 until 2017. Systematizing the results allows us to group the following themes: Epidemiology of WMH in Brazil; Policies for WMH and VISAT; Work Environment for Mental Health; and, Actions and Interventions in the VISAT and WMH. The surveillance actions are still in the early stages; however, there is an effort to strengthen the RENAST, materialized in the creation of protocols and the promotion of national meetings which reflect the construction of a new surveillance model for worker health. We noted a search for new conceptual models of mental illness, a redefinition of the focus of care, and of intervention approaches highlighting the active role of workers, who are essential players in facing the challenges in this area.*

Key words *Occupational health, Mental health, Health Surveillance, Worker's Surveillance*

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Introduction

In recent years, profound transformations have resulted from the adoption of a new model of capitalist accumulation. This model is based on flexible capitalism and the social instability of work[1]. This is a model anchored in the idea of flexibility, in which everything comes to be disposable, substitutable, and ephemeral, including both the merchandise produced and those who produce it.It operates in the disassociation between capital and the forms of material wealth (use values), supporting the financialization of the economy (which makes the abstract character of labor into an absolute), and promotes unprecedented globalization in the production processes[1].

The social instability of work produces complex and intricate processes that materialize in precarious conditions of work and employment, of permanent insecurity and vulnerability, above all in facing the possibility of unemployment. In this way, instability is engendered, among other things, by vulnerability in the forms of social insertion and inequality, intensification of work, third party contracting, insecurity, multiple occupational exposures, long working hours, absence of decision-making power in carrying out tasks, repetition, and monotony[2]. These new-old forms of domination and exploitation of labor inaugurates or deepens different types of impact on worker's life and health.

In the work process, dynamic networks of relations of men with nature, of men with other men, and of man with himself enter the scene. It is also through work that individuals carry out their concrete insertion in reality, carving out possibilities for nourishing themselves, living, growing, self-realization, growing ill and even dying. The illusionist character of labor stems from its double character: labor is, on one hand, concrete labor (use value), and, on the other, abstract value (exchange value). Thus, use value appears to conform to identity, as an act of creation of human meaning given to nature, personal and non-transferrable meaning. While exchange value appears as a human capacity to produce socially-recognized material value. In exchange value, the universalization of labor prevails, the equivalence among all types of work, expressed in units of time, and effort embedded in commodities[3].

The process of work encompasses objective and subjective elements. The subjective element includes the form of work and the productive cost of the vital energies for the creation of use values meant for the satisfaction of needs[3]. The objective elements of work are constituted by the objects (raw material) and the means of work. Work appears as a mediator between the individual and social order: it is worth is not only determined by what it represents in terms of guarantee of survival, but also for being capable of securing for the individual the specificities that identify and distinguish them from other individuals – of what the subject feels, interprets, and enunciates as self, in opposition to that which they experience as "not-self"[4]. Work, therefore, bears relations of identification, in that it inscribes marks on one's image of oneself and of the world, which are internalized as belonging to that subject.

Work, by way of its double character, also carries out a double movement in the social construction of the identity of the subject: it conforms to an objective field of conditions of production-reproduction of the subject, and also permits symbolic play, the inscription of human meaning to the world. Thus, at the same time that work structures, either via the construction of identity, satisfaction, and pleasure, under certain conditions it can also constitute a pathogenic element to mankind[5].

Thus, aspects related to the work environment, content of work, organizational conditions, and needs and skills of the worker associated with the cultural and social context of the individuals and their personal characteristics are factors that can interfere in worker health, negatively affecting their psychic equilibrium[6].

The monitoring of work characteristics is therefore fundamental for the structuring of conditions capable of strengthening the center of work as a pleasurable means of building identity, and becoming health risks. The actions of health surveillance, specifically in this case of worker health, constitute a cornerstone on which to build these possibilities.

The Workers Health Surveillance program (or VISAT, from *VigilânciaemSaúde do Trabalhador*) is one of the components of the National System of Health Surveillance, responsible for a cohesive set of actions in health promotion and reduction of morbidity and mortality in the worker population. In 2002, as the main strategy of the Unified Health System (SUS, *Sistema* **Único** *de Saúde*) to guarantee the completeness of worker healthcare and health promotion, the National Network of Comprehensive Worker Healthcare (*Rede Nacional de Atenção Integral à Saúde do Trabalhador,* or RENAST) was created. RENAST integrates the

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network of SUS services by way of Centers for Reference on Worker Health (*Centros de ReferênciaemSaúde do Trabalhador*, or CEREST)[7].

In 2004, Work-related Mental Disorders (*TranstornosMentaisRelacionadosaoTrabalho*, or TMRT), combined with ten further grievances linked to work (ART), were defined as grievances requiring compulsory notification, coming to be registered in the National System of Grievances and Notifications (*Sistema Nacional de Agravo e Notificações*, SINAN)[8]. This constitutes an important regulatory milestone in the policies of Worker Health Surveillance, even while it is limited only to health units that are part of the Sentinel Network. The decree, however, was implemented only in 2006, with the first notifications of the ARTs at the national level.

The healthcare network has a major role in the identification, referral, and notification of mental disorders related to work, as well as determining or contributing factors in their occurrence. In the specific case of mental health, there are important lacunas regarding both the scale of the problem (under-reporting is a major characteristic of its monitoring), as well as identifying and taking action regarding the factors that produce these events (exposure factors).

The data on TMRT, even while it does not allow for the most reliable portrait of its magnitude, proves its relevance in the framework of worker illness. According to the World Health Organization, one in every four persons that visit health services have at least one type of mental disorder, but the majority are not diagnosed nor treated[9].

In Brazil, TMRT are among the main causes of lost work days, in recent years representing the third largest cause of concession of disability benefits for work incapacity. In a study of benefits concessions in the period from 2008 to 2011, an average annual increase of 2.9% in concessions was observed[10]. From 2008 to 2009, the number of work leaves resulting from mental and behavioral disorders reported to Social Security climbed from 12,818 to 13,478, and by 2012 had arrived at 16,978 cases[11].

In the current Brazilian political climate, there are proposals for the reformulation of workers' rights that move toward a greater weakening of labor relations with direct and indirect impact on the psychological health of workers. The House of Representatives approved outsourcing for all activities, which can have negative repercussion on work conditions. In addition, there is a proposal for pension reforms that entails an increase in the period of contribution and work before retirement. These reforms are being proposed in a context of economic crisis and social fragility, it which we can observe a dilution of the line of separation between included and excluded workers, with a clear lowering of standards in the general quality of life. According to the IBGE[12], unemployment reached a record high, with 13.5 million person without formal jobs. This situation, as mentioned earlier, accompanies the labor model of flexibility and social instability, which has an immediate impact on the growth of unstable work conditions to which people agree to submit, pressured by the possibility of unemployment. Such conditions substantially increase the health risks of workers, especially in mental health, this is a function of the undermining of workers, carried out by administrative and organizational labor models and the deregulation of work relations[2].

Therefore, the role of health surveillance in these contexts, centered on the monitoring of factors harmful to health, gains enormous relevance. This article has the aim of discussing aspects related to the surveillance of mental health and work in Brazil, with a basis in literature review of research produced between the years of 2002 and 2017. The objective is to foster reflections about mental health and work in Brazil, contributing to a better understanding of the current panorama in which the VISAT in Mental Health is found, in such a way as to strengthen surveillance programs and actions, both in regard to actions of monitoring of grievances, as well as initiatives of identification and effective intervention concerning the factors that produce such grievances.

Methodology

A literature review of national publications was carried out, with the proposed objective of reviewing Brazilian research and fostering reflections on the theme of Worker Health Surveillance – Mental Health, with a basis in a current assessment of the produced material. The following virtual databases were consulted: Google Scholar, Scielo, Lilacs, and PUBMED. The following descriptors were utilized: worker health, mental health, workers, mental health and work, and health surveillance, referenced in the database Descriptors in Health Science (*DescritoresemCiências da Saúde*, or DeCS). The search was done in April and May of 2017.

Since the RENAST was instituted in September of 2002 (Ministry of Health, decree No. 1,679), this year was defined as the starting point for the bibliographic search, and became the first search criteria. The retention of articles emphasized the inclusion of those that treated the following themes: Worker Health Surveillance and Mental Health. For this stage, a reading of the title and abstract of each work was carried out. Finally, considering the established criteria, the review identified sixnteen documents: ten articles, two dissertations, two theses, and two protocols of mental healthcare and work.

After the selection of the material, the data was collected which took into account: title of the work, descriptors, sources consulted, scientific journal where it was disseminated, methods employed, objectives, and results. The results were categorized according to previous knowledge about the subject and its lacunas, and by repetition in the content. Through this process the following themes emerged as guideposts for the presentation of results and discussion: Epidemiology of Mental Health Related to Work in Brazil (SMRT); Policies for SMRT and VISAT; Work Organization and Mental Health; and Actions and Interventions in VISAT and SMRT.

Results and discussion

Characterization of the study's material

The material encountered, with a focus on Surveillance in Worker Health and Mental Health; included research with frameworks in Collective Health, Social Sciences, and Political Science. We emphasized publications (articles) in journals in specific areas: Public/Collective Health (n = 5), Occupational Health (n = 2), Psychology (n = 1), Epidemiology (n = 2); two dissertations and two theses that analyzed the profile of mental health disorders related to TMRT, the VISAT actions and aspects related to subsidies for action/intervention in surveillance of worker/mental health. Furthermore, in the identified material, two protocols of guidelines for VISAT actions in Bahia and São Paulo.

The research output was concentrated in the period between 2011 and 2017 (n = 12), reaching greatest visibility in the year 2014 (n = 6). The journal Science and Collective Health was the one with the greatest number of publications (n = 3). In relation to the methodological perspective, the majority of research was elaborated using literature reviews / theoreticalessays (n = 10), among these, four also included research with qualitative approaches, using different sources of data capture (analysis of documents, fieldwork with workshops and semi-structured interviews); another four articles were of an epidemiological character (Chart 1).

One of the protocols identified in this study was developedby the Board of Directorates in Worker Health of the Health Secretary of the State of Bahia, published in 2014, aiming to identify, settle and follow up its cases, notification and the SUS health surveillance actions[9]. In São Paulo, at the same period, a manual was formulated containing technicals guidelines to notify at SINAN about Work-related Mental Health Disturbances[13].

Based in the found data, the following analytical categories were organized: (a) the prospect of Work-related Mental Health (SMRT), contextualizing the current epidemiological scenario, policies and present rules, related to work organization and mental healthrepercussions; (b) main limitations (insufficiency or lack of fulfillment actions, the articulation between theSurveillance sectors, causal nexus difficulties and under-reporting) which promote the low visibility of the problem; (c) issues related to the few actions of intervention, insufficient and characterized by reductionist logic that does not combat the origin of the problems related to worker illness. The categories/themes that problematize these aspects are presented below.

Epidemiology of mental health related to work (*Saúde Mental Relacionada ao Trabalho*, or SMRT) in Brazil

In spite of the little attention given to mental and behavioral disorders concerning work-related illnesses, official statistics from Social Security and the results of epidemiological studies strengthen the relevance of these events as a cause of illness benefits concession due to incapacity, or indicate higher prevalence of mental illness in groups of workers in Brazil[10].

Brito[14] investigated reported TMRT cases in Brazil since the beginning of the SINAN registry in 2006 until the year 2012. In in this period, 2,444 cases were reported, with a marked increase (average annual increase of 142%) up to the year 2011. The CEREST, responsible for 74.1% of the reports, followed by the Basic Health Units (*Unidades Básicas de Saúd*e, UBS), with 8.4% and the CAPS (6.2%). The participation of the Family

Chart 1. Distribution of documents by type, methodological approach, authors, period, and journal.

Type	Methodological Approach	Authors	Year	Periodical
Article	Literature review on the influence of the social sciences on overcoming reductionist concepts in the work-health relationship.	Minayo-Gomez and Thedim-Costa	2003	Science & Collective Health (Ciência & Saúde Coletiva)
	Literature review; analysis of interviews conducted in the Centers for Reference on Worker Health (*Centro de Referência em Saúde do Trabalhador*, or CRST) in Campinas, São Paulo.	Sato and Bernardo	2005	
	Theoretical essay that systematizes and discusses theoretical approaches and practical experiences in mental health and work; outlines strategies for the integration of mental health into VISAT actions.	Leão and Minayo-Gomez	2014	
	Theoretical essay that presents reflections on the incorporation of aspects related to mental health into the scope of Worker Health surveillance actions in SUS. Critically discusses concepts in SMRT.	Leão and Brant	2015	PHYSIS: Journal of Collective Health (Physis Revista de Saúde Coletiva)
	Archival research (analysis of states' health plans) and qualitative research with participant observation and interviews.	Conciani and Pignatti	2015	Health Area Journal (Revista Espaço para a Saúde)
	Literature review with a focus on the relationship Health / Mental Health / Work and its repercussions.	Borsoi	2007	Psychology and Society (Psicologia & Sociedade)
	Literature review deepening understanding of the aspects involved in the field of VISAT, and of the policies and guidelines that orient them.	Daldon and Lancman	2013	Brazilian Journal of Occupational Health (RevistaBrasileira de SaúdeOcupacional)
	Descriptive epidemiological study involving 161 CEREST, with the goal of describing the main mental health actions related to work at the RENAST.	Cardoso and Araújo	2016	
	Theoretical essay that systematizes the experience of the field of Worker Health, considering the themes of health promotion and inter-sectoriality.	Machado and Porto	2003	Epidemiology and Health Services (Epidemiologia e Serviços de Saúde)
	Descriptive epidemiological study that analyzes the TMRT cases reported to SINAN in the state of Bahia during the period of 2007 to 2012.	Cordeiro et al.	2016	
Dissertation	Exploratory study with a time-series design. Analyzed cases of TMRT recorded in the SINAN database for Brazil in the period of 2006 to 2012.	Brito	2014	Graduate Program in Collective Health of UEFS/ BA (Programa em Pós-Graduação Em Saúde Coletiva da UEFS/ BA)
	Literature review; document analysis; conducting of Workshops, conceptually based on the contributions of the Italian Workers Movement (MOI) in Social Medicine and the Psycho-dynamics of Work.	Freire	2014	The Sérgio Arouca National School of Public Health, Fiocruz / RJ (Escola Nacional de Saúde Pública Sérgio Arouca, Fiocruz/ RJ)
Thesis	Literature review with systematization of theoretical frameworks and existing practices in workers' mental health, with investigation of the reports from different collective forums in worker health.	Leão	2014	ARCA – Institutional Repository of Fiocruz (ARCA – Repositório Institucional da Fiocruz)
	Qualitative research, with document analysis and interviews with SUS workers who deal with worker health in the field of mental health.	Souza	2017	Digital Library of PUC - Campinas (Biblioteca Digital da PUC – Campinas)

Health Units was very low (only 1.4%), although it had shown a gradual growth in notification across the years. The most frequent diagnoses were neurotic and mood disorders, with 56.4% and 30.4% respectively.

Cordeiro et al.[15] analyzed data from SINAN pertaining to the state of Bahia. The men were 51.2% of cases. The study emphasized the greater frequency of cases among workers with high school and college educations, in the formal job market, belonging to the sales and service sectors. The grievances with the most notification were post-traumatic stress, followed by depressive episodes. Temporary incapacity was the most prevalent outcome, representing 74.4% of the diagnosed cases, followed by partially permanent incapacity (13.3%) and non-confirmed cure (2.4%).

According to the Annual Statistics Report of Social Security[16], there havebeen recorded drops in retirements for disability related to Mental and Behavioral Disorders concessions. In 2013, 12,068 cases were reported, and in 2015 there were 8,417 cases, contrasting with data from the period of 2008 to 2011 in which an increase was verified in the number of benefits from this cause[10]. The number of rural retirements due to disability in this same period also fell, from 876 to 640. The same logic prevails for the quantities of sick leaves granted in the period, which fell from 209,218 to 156,895.

Studies showed that sick-leave benefits due to accidents had an increase in the number of concessions beginning in 2007, as described above, suggesting the hypothesis that this increase could be associated with the implementation of a pension epidemiological technical nexus (*nexo técnico epidemiológico previdencârio*, or NTEP), that allows for the recognition of cases with an epidemiological basis. In an analogous way, it is probable that the reduction in the number of observed cases beginning in 2012 reveals barriers to the recognition of cases, as a reflex of governmental efforts encouraging the refusal of benefits to sick workers, by way of restrictions and guidelines adopted by the INSS. These examples, for their part, reveal how much this event is bound up with the context of the correlation of the relationships between capital and labor, and the degree to which we are still far from a more precise understanding of the scale of the problem

It must be taken into consideration that these data are dependent on the notification and establishment of the causal nexus, which certainly does not correspond to the magnitude of the reach of the country's cases – the predominance of formally employed clerical workers in the TMRT records of SINAN is an example of this. Therefore, the effort of the CEREST to improve such a system and increase visibility for TMRT must be noted.

Various studies[15,17-19] demonstrate the chronically invisible character of Work Related Mental Disorders tied to the phenomenon of under-reporting. Because of these skewed statistics, mental health at work still lacks prioritization in the planning of actions and public policies. The role of the health professional - in the investigation and establishment of the nexus between the mental grievance and the work condition, in the notification, in the follow-up on cases, monitoring of the conditions, and organization of work - is emphasized. This highlights that the professionals still confront troubling difficulties in their education, which includes lack of training, and a traditional view of illness centered on the medical model with a focus on the disease, which obstructs, impedes, or weakens the actions of VISAT in the RENAST[19].

The issue of under-reporting of the TMRT is only one of the difficulties encountered, which also extend to the offering of health services with a focus on mental illness. In a survey to evaluate actions in mental health (MH) in the RENAST conducted by Cardoso and Araújo[20] in the year 2014, it was observed that 47.8% of the CEREST units carried out informative actions and ongoing education of theCenters for Psych-social Care (*Centros de AtençãoPsicossocial*, CAPS), and only 26.0% referred to such activity with mental health outpatients; 40.9% carried out recommended support actions in MH for the SUS services; and 35.5% developed frequent informative actions about MH for workers in general.The inspection of the work environment (58.8%) and the systematic records of the TMRT cases in SINAN (53.2%), were the most mentioned actions. Therefore, there is much progress to be made in the structuring of mental health and work services at the SUS, including their expansion at RENAST itself, since the actions carried out were still incipient.It is further noted that 67.7% of the CEREST reported having professionals trained for Mental Health service.

These data, as a group, demonstrate much fragility in the incorporation of mental health in the VISAT actions. As Leão and Minayo-Gomez[21] observe, even while the practices in mental health and work are characterized by the predominance of actions geared towards assistance and for the

diagnosis and notification of the TMRT, these still occur in a tentative fashion, with a very limited reach (they are still not developed in half of the existing CEREST units, for example).

Policies in Work Related Mental Health (*Saúde Mental Relacionado ao Trabalho*, or SMRT) and the VISAT

The National Network of Comprehensive Worker Healthcare (RENAST, for Rede Nacional de Atenção Integral à Saúde do Trabalhador) was created in 2002[22], and brought up to date with decree 2.728/09[7].The Centers for Reference on Worker Health (CEREST) constitute the RENAST, which can have coverage at the state, regional, or municipal level[7].

In spite of the robustness of the whole Network, there is enormous difficulty in the coordination among the different organs and sectors that act on the issues related to SMRT. The surveillance actions are local, and many times reduce the problem to curative care, without focusing on the determining factors for the observed illness. The understanding on the part of the workers themselves of the functions and applications of the Network's components reveals the incipient state in which we find the VISAT in the field of actions for Mental Health.

Therefore, a crucial aspect in the consolidation and strengthening of the VISAT refers to the role of the worker as an active subject and articulating agent of change at their work. The exercise of this active role, decisive in the effectiveness of Surveillance action, depends on the awareness of the worker in recognizing him or herself as a protagonist in these actions. This links back, for its part, with the process of valuing oneself and the appropriation of knowledge pertaining to the work context. This process, however, has its own challenges. Daldon and Lancman[23] confront the development of the VISAT, incorporating the acting, conscious worker with the current panorama of limitation of material and human resources, and of little investment in technical training, showing that the strategy of adding this actor to the Surveillance process is still a work in progress. However, it is worth stressing that the active participation of the workers as a crucial point for the development of the VISAT is an aspect highlighted by practically all the authors that produce research on this subject[17,21,24,25].

In addition to these, other outstanding lacunas in the VISAT actions can be perceived, like the distinctions among such actions in different regions. In fact, to regionalize such actions could be considered positive in the sense of understanding the specific demands of each locale, and to act sensitively regarding them. In practice, however, this has meant a great heterogeneity in RENAST actions, with very different theoretical and methodological foci and presuppositions. Thus, instead of strengthening actions in this field, it has produced fragmentation, absence of planning and the minimum consensus that, concretely, act as a buffer to the desired growth of these actions. The needed advances thus remain inviable or difficult.

Among the necessary advances, Leão and Minayo-Gomez[21] emphasize it is fundamental that there is an insertion of the context of workers' mental health into the legislation and technical standards of health surveillance with a basis in specific guidelines. Cardoso and Araújo[20] point out the necessity of new research for the construction of instruments that guide and assist the process of establishing the nexus of mental health grievances at work, and the actions of monitoring the factors associated with the production of these grievances, facilitating a base of greater support for VISAT actions, as a function of the preventable character of mental illness.

The definition and implementation of public policies of mental health protection and promotion is a central aspect of this context. Freire[18], in accord with the questions treated here, highlights the absence of a specific guideline protocol for mental and behavioral disorders, which is especially due to the difficulty in constructing a minimum consensus among the unions, experts in Social Security, companies, and SUS technicians.

Faced with the lack of guidelines, principally for the establishment of the causal nexus, as a great challenge for the VISAT, the Division of Worker Healthcare and Surveillance (DIVAST, for *Divisão de Vigilância e Atenção à Saúde do Trabalhador*), State Center for Reference in Worker Health (CESAT, for *Centro Estadual de ReferênciaemSaúde do Trabalhador*), and the Health Secretary of the State of Bahia (SESAB, or *SecretariaEstadual de Saúde da Bahia*) developed the Protocol for Mental Healthcare and Work. In this document, normative instruments for the guidance and theoretical and methodological support for activity in mental health and work were brought together. These included the following: configuration of the causal nexus for mental disorders, observation and referral of cases, of monitoring of work conditions and organization, so as to follow the principle of integrated

care, envisioned in the SUS principles. This instrument reinforces the Surveillance actions from the perspective of strengthening the institutional relations and interconnection among the different types of health surveillance[9]. In the same way, the Division of Labor Health Surveillance of the CEREST of São Paulo created a manual with the purpose of facilitating the notification process of TMRT cases to SINAN[19].

Some initiatives, even while still tentative, were carried out with the intention of standardizing the processes for establishment of the technical epidemiological nexus, such as were instituted in Law 11.430/2006 of the TRT in São Paulo, which provides an increase in Social Security benefits, strengthening worker compensation[27]. Such a model, eminently oriented in a medicalized-welfare, psychiatric, and reductionist manner in treating the problem, in spite of not confronting the origins of the illness itself, recognizes the need for establishing policies attending to Work Related Mental Health, which already represents a disposition for paying attention to such questions.

Leão[26] still emphasizes the need to mobilize the social actors of the Brazilian state for the development of tools to control the forms of work organization that induce suffering and disorders. Souza[19] highlights the necessity of interdisciplinary approaches for understanding the constitution of the subjectivity of the individual with the aim of promoting mental health. To this end, coordinated group actions undertaken by different actors, at different levels of complexity, are imperative. Another relevant aspect in this direction is the Worker Health's approach to Primary Care, as a structure of first contact with the individual, reinforcing its character of comprehensive and universal care and underscoring psychosocial care, instead of maintaining a model of individualized and institutionally-based model of care. Once again, the social role of workers assumes relevance in the discussion, becoming central to the labor movement for Surveillance actions, owing to its role in the collective representation of workers' interests.

In fact, articulations between different VISAT actors is necessary for effective change that forms a foundation for the adoption of new intervention models and the structuring of specific laws that put the organization of labor itself at the center of the debate, along with need to regulate its internal relations in a way that promotes and protects worker health. Machado and Porto[27], at the beginning of the 2000s, already discussed the possibilities of inter-sectorial actions as VISAT strategies, establishing them as insufficient from the perspective of a healthcare approach to establish the relations of illness at work.

For confronting the many challenges found by the VISAT, coordinated group actions become necessary at the national level, which involve consensus about mental health actions, and training via meetings for the dissemination, discussion, and reflection on experiences, as a first step in this process. However, it is worth noting the warning pointed out by Leão and Minayo-Gomez[21], that although there has been specificity in the issues related to mental health, it is not enough to operate exclusively in the field commonly labeled as "mental," "psychic," or "subjective." The actions on which we should be shining a light encompass more general concerns, involving the process and organization of labor; therefore they are not limited to actions in the clinical area. Leão and Brant[25] argue that the central issue to supplant this approach is in the "desacralization" of the clinical and epidemiological perspective for the unleashing of Surveillance actions, urging that we must concentrate on efforts for understanding the complexity of the inherent phenomenon of suffering at work for the production of information and practices that are not solely based on the diagnosis and quantification of these phenomenon.

Organization of Labor and Mental Health: a debate that remains necessary

It is necessary to understand the existing relationships in the world of work and their repercussions in order to trace strategies in the direction of a healthy environment for the worker, in that work can be an equilibrating factor as well as a fatiguing one, depending on how the desires of the individual are either manifested or repressed[28]. To identify the aspects related to suffering or pleasure, taking into consideration the experience of the worker, it is fundamental to know / understand the relations between the organization of work and illness[6-21]. The elements of work interact dynamically among themselves and with the worker, forcing him into a process of adaptation to the processes and workloads faced which become wearing and, consequently, have repercussions in their physical and psychic capacity[23].

Gradually, work has come to be considered as a determinant factor in the health-illness process, consolidating conceptions about the role of work

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in the genesis of sickness[23]. However, when we deal with mental health and the etiological recognition of its specific grievances, the VISAT is found in an embryonic state, confronting many impasses in the establishment of the nexus between work and mental illness. In other words, we are faced in this case with greater challenges than those that are found, for example, in the analysis of a typical work accident, in which it is possible to observe the grievance in a palpable way, as well as its causal agent[26]. According to Sato and Bernardo[17], the CEREST is perceived by the worker as a center oriented only towards the physical problems caused by work, being seldom procured for demands related to mental health, in function of the subjective characteristics that are involved in this demand, that are not directly observable, perceptible to the inattentive eye, suffused by the traditional biological model of the clinical approach. Therefore, regarding the TMRT, there are difficulties in the path of professional activity, in which the criteria of identification of cases is not clearly defined, as well as the perception of the problems related to mental health by the workers themselves.

Such a situation obscures even further questions related to mental health at work. Or rather, the understanding of the workers themselves is limited to a comprehension of illness linked to the body, making recognition of mental illness difficult. The isolation of the worker facing suffering is constructed by the dominant conceptions of the maladaptation of the worker to the work, reinforcing an understanding that the psychic illness occurs because of a failing, weakness or personal inability. Therefore, this sustains a kind of erasure of the harmful situations in the work context. The worker, who should be protagonistic in Surveillance actions to better understand themselves and the work they execute, is captured by the discourse of scapegoating imposed by capital and succumbs to the notion of their "luck" to be working. This dimension is reinforced in the studies of Freire[18] that identified a habitual attempt at the invalidation of diagnoses of psychological grievances related to work in the discourse of the SUS technicians, INSS experts, technicians of the Health Services and of Work Medicine at the companies, and even at the unions. In other words, the contributions of work to the process of mental illness are erased or naturalized, in that their origins are found, above all, in relational and psychosocial aspects, yet there remains the idea that the worker is responsible for their situation or even that they simulate an illness for their own benefit. Thus, as much by the workers themselves as by the other actors involved, the concept is reinforced that since the characteristics of work are a result of their own nature, then they are inherent conditions in the exercise of work activity. Thus, they accept situations that could be unsustainable.

This relation of submission is materialized in the fear of being dismissed from work. According to Minayo-Gomez and Thedim-Costa[29], the degraded states of mental health can imply long periods of absence from work and the fear of unemployment, confirmed in the study by Souza[19] as crystalized from the situations that push the worker toward isolation, intensifying and aggravating the suffering. Frequently the mental illness turns visible when the situation becomes very aggravated, and it is no longer possible to hide it or underestimate it.

These aspects stem from the new model of flexible accumulation, anchored in the social instability of labor as a strategy of domination[1]. In this model, the condition of unemployment and permanent threat of loss of employment produce the isolation of workers, generating a loss of bonds, and of the collective perspective of challenging them. The feelings of insecurity provoked by the eminent disposability, devaluation, and exclusion shatter the sense of solidarity among workers, with competition among them coming to dominate. Isolated by the heterogeneity of their employment arrangements, division, and competition, the potential actions of workers are fragmented and weakened, especially the action of the unions. The low degree of social protection resulting from the process affects all forms of illness, but is particularly cruel in the case of mental illness in the sense that it lacks the materiality that a physical illness or a work accident possess. In this case, the experience of becoming ill as an individual shortcoming is more intensely felt by the worker[2].

As we can observe, the consolidation of the relations between characteristics of work and mental illness is something still being constructed, which can easily be shown by the complete absence of any regulation of the aspects related to the organization of work, although an abundant scientific literature attests to this relationship. Minayo-Gomez and Thedim-Costa[29] note the centrality of psychosocial determinants in this process: the sexual division of labor and unequal gender relations, sexual harassment, the lack of social recognition, the disqualification and absence of autonomy and control over one's own

work, are all considered as conditioning factors in suffering and occupational burnout. They emphasize the intense fragmentation of tasks, the absence of mastery over the stages of one's work, and the consequent intellectual obliteration and suppression of pleasure in working, setting up devastating health situations for the worker.

Faced with situations that produce suffering in the world of work, strategies of collective defense emerge[5]. The worker can construct and deconstruct the meaning of their work, making possible their development in adverse conditions. These strategies minimize the suffering, but do not represent the restoration of health to the worker, nor do they help the suppression of the determining factors of the illness. Thus, to direct the focus of Surveillance from actions of registries and notifications of illnesses toward actions that contemplate the clash with the generative sources of illness in work organization is fundamental.

Actions and Interventions in the VISAT and SMRT process

The conceptual limitations and practices of Worker Health Surveillance in Mental Health are evident in the degree in which they consider actions in very restricted spheres, such as the processing of notification forms and a few clinical protocols. Conciani and Pignatti[24] deal with the isolation of these actions, which are occasional and unsystematic, aside from being insufficient to intervene regarding the production of mental illness.

According to Daldon and Lancman[23], investments for the creation of effective routines in the actions of surveillance are indispensable. Leão[26] emphasizes that such actions need to have a systematic character, with a focus on the work processes, seeking to provide transformations in the work context, reducing or eliminating the factors associated with the process of illness present in the organization of work. These authors reinforce, once again, the relevance of the active role of the worker for surveillance actions, reinforcing the need for spaces for interlocution with the workers, valorizing their perspectives and understandings about their activity, with this being the point of departure for a more satisfactory, effective, and transformative surveillance.

Therefore, to understand the worker as the holder of knowledge about their activity is only one stage in the process of surveillance, which needs to involve other actors so that actions unfold in a more structured and consequential manner. Cardoso and Araújo[20] emphasize the importance of the participation of everyone at all levels of SUS care in these actions, suggesting the broadening of inter- and intra-sectorial relations throughout RENAST, highlighting the role of the CEREST and especially CAPS, in addition to its own articulation among the Surveillance units, considering that VISAT is only one segment of Health Surveillance.

Thus, it is worth reinforcing the need for VISAT articulation with the remaining services of the healthcare network, whether in the sense of integrating them with the other surveillance types (environmental, epidemiological, sanitary), or with the other healthcare networks, such as the Psychosocial or Primary Care Networks, which are important services of contact, prevention, promotion, and recuperation of mental health[26]. According to Conciani and Pignatti[24], the absence of Surveillance actions for Work Related Mental Health contributed to increasing the existing lacuna among the CEREST and the SUS Network,giving it an isolated character and, consequently, an invisibility that persists to the present day, materialized in the precariousness of a large part of the current actions.

There is a record of articulation initiatives of the reference centers with CAPS, in which they seek to overcome the enormous challenges encountered, but these actions are occasional and very distinct in the different regions of the country[20]. Furthermore, tied to this diffuse tangle of actions, the predominant models of care in the VISAT actions in Mental Health are based on medical, outpatient perspectives, of a curative character and therefore reductionist[19-25], clashing with the comprehensive conceptions of the psychosocial model defended in the Organic Health Law (*Lei Orgânica de Saúde*). Daldon and Lancman[23] stress the need for the decentralization of services as essential to the VISAT strategies, giving emphasis to the role of Primary Care and to the Community Health Agents as an alternative of first contact for the SUS service, in worker health as well as in mental health and work. This process of articulation and decentralization of responsibilities places the municipality as a central entity responsible for the VISAT actions. In this process, it is also evident that there is a need for redefinition of these health services on a basis that questions the dominant model centered on the illness[20].

In spite of the many challenges in the creation and execution of policies for worker health,

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it is worth emphasizing that there is also much that has advanced, especially with the establishment of a National Policy of Worker Health[30]. To guarantee and broaden these services, the ethical commitment of the health professionals is essential in defense of a public and comprehensive health system, and the strengthening of initiatives that incorporate workers and their representative institutions as protagonists in the definition and implementation of worker health actions.

Final Considerations

In spite of the conquests achieved, such as the mandatory notification of mental disorders resulting from work or the NTEP, there still exist many challenges to be faced. Important problems remain: under reporting; little or no articulation among the actors involves; absence of follow-up on cases; adoption of models for action that are still centered on the illness with medicalized intervention; reductionist and occasional actions; difficulties in the establishment of the causal nexus; and absence of a unified guiding protocol. On the other hand, there are significant efforts to strengthen the Network in terms of the VISAT and SMRT, apparent in the construction of instruments such as the Protocol of Mental Healthcare and Work, in Bahia, and the promotion of national meetings that aim at reflecting on these issues and the creation of a new model of Worker Health Surveillance, one that is more effective and coordinated to attend to the enormous challenges that still persist in the field of Work Related Mental Health. In these efforts, the actions to identify the determinant factors of suffering and mental illness present in the organization of work must be given prominence, giving the VISAT the transformative perspective that is expected from it.

Collaborations

TM Araújo was responsible for conceptualizing the article, guiding the compilation of data, carried out the critical revision and the final revision and rewriting of the manuscript. TF Palma was responsible for the conception of the study, development of instrument, collection and analysis of data, development of the article and for the final revision of the manuscript. NC Araújo was responsible for the conception of the study, development of the instrument, collection and analysis of data, development of the article and for the final revision of the manuscript.

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Erratum

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where it reads:
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reads up:
Tânia Maria de Araújo [1]
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