

ORIGINAL ARTICLE

Satisfaction and burden of mental health personnel: data from healthcare services for substance users and their families

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Objective: To evaluate satisfaction and burden of mental health personnel providing mental health services for substance users and their families.

Method: Five hundred twenty-seven mental health workers who provide treatment for substance users in five Brazilian states were interviewed. Data on sociodemographic characteristics and measures of satisfaction (SATIS-BR) and burden of mental health personnel (IMPACTO-BR) were collected.

Results: Type of mental health service and educational attainment were associated with degree of satisfaction and burden. Therapeutic community workers and those with a primary education level reported being more satisfied with the treatment offered to patients, their engagement in service activities, and working conditions. Workers from psychosocial care centers, psychosocial care centers focused on alcohol and other drugs, and social care referral centers (both general and specialized), as well as workers with a higher education, reported feeling overburdened.

Conclusion: This study offers important information regarding the relationship of mental health personnel with their work. Care providers within this sample reported an overall high level of job satisfaction, while perceived burden differed by type of service and educational attainment. To our knowledge, this is the first study with a sample of mental health professionals working with substance users across five Brazilian states.

Keywords: Substance-related disorders; occupational health; mental health services; mental health personnel

Introduction

An increase in the number of people who seek mental health services due to substance use-related problems has brought new challenges both to service managers and to mental health providers. Contemporary principles of mental health promotion and prevention of mental disorders demand a deep sense of participation from those involved with the patient, including friends, family, and significant others.¹⁻⁴

According to the World Health Organization (WHO), the quality of mental health services is associated with the job satisfaction and burden of mental health personnel.^{5,6} The literature states that the well-being and mental health of these workers affect the quality and efficiency of the services they provide.^{5,7} For example, studies point out that factors such as high levels of stress, lower job satisfaction,

increased staff turnover, increased absenteeism, lower productivity, and burnout (affecting staff physical health, mental health, job performance, and increasing intentions to quit) affect the care of patients and their families, as reflected by lower patient satisfaction and lower treatment engagement.^{8,9} Thus, assessing mental-health workflow and its repercussions is both a potential strategy for ensuring the provision of comprehensive care to substance users and their families and a useful means of increasing the effectiveness of the interventions offered to these patients.¹⁰

In a global scenario, previous studies have shown that job satisfaction in mental health care providers depends on the type of service, occupation, or specialization; sense of self-fulfillment; work environment; length of employment; gender; and age.¹¹⁻¹³ Moreover, job satisfaction correlates with stress levels at work, and providers are frequently exposed to feelings of overburden.¹⁴⁻¹⁶ Bandeira et al.⁵ showed that, in a Brazilian sample of mental health workers, the higher the level of burden, the lower the job satisfaction. The daily task of providing care for someone with a mental disorder carries a range of major psychiatric repercussions, which places workers at risk of developing occupational stress and psychological

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disorders.^{10,17} The treatments offered in mental health settings are generally long, and patient progress is not clearly visible. This can lead to recurring feelings of frustration in providers, which stem from the gap between expectations and the actual outcome of interventions.¹⁸ In the specific case of psychoactive substance use disorder (PSUD), complex demands are common, due to the high prevalence of psychiatric comorbidities, the use of multiple substances, and a great variety of possible problems affecting the user's life.^{19,20}

The current approach to recovery in mental health requires community-oriented care and support,²¹ but this extends mental health workers' duties. In Brazil, the many types of mental health service available through the Unified Health System (Sistema Único de Saúde [SUS]) are organized according to size and complexity; each has unique characteristics that demand specific training and experience with the treatment process.^{22,23} Mental health teams are multidisciplinary and personnel have different levels of education and areas of expertise, with each team member bearing responsibility for specific actions with service users and their families. Even though PSUD is an important problem in the Brazilian context,²⁴⁻²⁶ no studies focusing specifically on workers who provide care for this specific disorder were found. It is also important to note that preventing PSUD is of global interest^{4,18,27} and that negative impacts on the work environment may lead to absenteeism and workforce shortages.^{7,11,28}

Within this context, the aim of this study was to assess feelings of satisfaction and burden in a sample of mental health workers who provide care for people living with PSUD and their families.

Methods

Design and sample

This cross-sectional study stems from a large scale epidemiological survey on use of alcohol and other substances in Brazil. The survey, in turn, is part of the government program Integrated Actions (Ações Integradas),

and was designed to identify health and resocialization activities intended for substance users and carried out by both governmental and non-governmental entities. Data collection took place between November 2011 and March 2012, under the responsibility of a private research company with trained research supervisors.

The facilities included in the survey had been identified in a previous study,²⁹ which mapped all care providers for substance abuse in areas involved in the National Program of Public Safety with Citizenship (Programa Nacional de Segurança Pública com Cidadania, PRONASCI). This program was deployed in the states of Bahia (BA), Espírito Santo (ES), Goiás (GO), Rio de Janeiro (RJ), and Rio Grande do Sul (RS), as well as the Brazilian Federal District (DF). All institutions registered with the National Secretariat on Drugs Policies (SENAD) in the PRONASCI territories were included in our convenience sample. Services were then sampled by snowballing in order to include care providers and facilities not listed by SENAD.

Measures

The facilities were classified as follows: 1) outpatient – institutions that offer outpatient care; 2) inpatient – institutions that have the capacity to provide inpatient care; 3) social care referral centers (Centros de Referência da Assistência Social, CRAS) and specialized social care referral centers (Centros de Referência Especializados de Assistência Social, CREAS) – public institutions that offer social care, not necessarily or specifically in relation to mental health or substance use; 4) psychosocial care centers (Centro de Atenção Psicossocial, CAPS) – public institutions that offer day care to persons with mental health disorders; 5) psychosocial care centers focused on alcohol and other drugs (Centro de Atenção Psicossocial Álcool e Drogas, CAPS AD) – public institutions which offer specialized care to patients with problems related to the use of alcohol or other drugs; 6) therapeutic communities – private, nonprofit institutions with open and exclusively

Table 1 Sample of mental health personnel stratified by state – Brazil, 2012

	RS	ES	RJ	GO	BA	DF
Type of institution						
Outpatient	13 (6.9)	24 (49.0)	43 (38.1)	0 (0.0)	25 (39.7)	16 (19.5)
Social care referral centers*	58 (30.7)	0 (0.0)	17 (15.0)	7 (23.3)	4 (6.3)	0 (0.0)
Psychosocial care centers (alcohol/drugs) [†]	31 (16.4)	3 (6.1)	4 (3.5)	1 (3.3)	8 (12.7)	14 (17.1)
Psychosocial care centers [‡]	31 (16.4)	13 (26.5)	30 (26.5)	9 (30.0)	8 (12.7)	5 (6.1)
Inpatient	19 (10.1)	3 (6.1)	1 (0.9)	2 (6.7)	5 (7.9)	16 (19.5)
Therapeutic community	29 (15.3)	2 (4.1)	10 (8.8)	11 (36.7)	4 (6.3)	25 (30.5)
Other	8 (4.2)	4 (8.2)	8 (7.1)	0 (0.0)	9 (14.3)	6 (7.3)
Educational attainment						
Primary	8 (4.3)	3 (6.2)	0 (0.0)	5 (17.2)	1 (1.6)	9 (11.1)
Secondary	45 (24.1)	9 (18.8)	27 (24.1)	6 (20.7)	19 (30.2)	27 (33.3)
Higher	134 (71.7)	36 (75.0)	85 (75.9)	18 (62.1)	43 (68.3)	45 (55.6)

Data presented as n (%).

Brazilian states represented in the sample: Bahia (BA), Espírito Santo (ES), Federal District (DF), Goiás (GO), Rio de Janeiro (RJ), Rio Grande do Sul (RS).

* Centros de Referência da Assistência Social/Centros de Referência Especializados de Assistência Social (CRAS/CREAS).

[†] Centro de Atenção Psicossocial Álcool e Drogas (CAPS AD).

[‡] Centro de Atenção Psicossocial (CAPS).

voluntary enrollment that provide care free of charge to patients with problems related to the use of alcohol or other drugs; and 7) other – institutions that did not fit any of the above categories.

Personnel were interviewed by trained data collectors, who followed a standardized questionnaire which contained items about sociodemographic status, a scale for assessment of satisfaction for mental health care teams (SATIS-BR Profissionais), and a scale for assessment of work burden in mental health services (IMPACTO-BR). Educational attainment was categorized as primary, secondary, or higher.

The SATIS-BR Profissionais scale was used in its abbreviated form, which comprises 32 items divided into four subscales that assess four factors of the job satisfaction construct: the first refers to satisfaction with the quality of the services offered to patients; the second, to the team's satisfaction with its level of involvement in the service; the third, to satisfaction with working conditions; and the fourth, to satisfaction with social relations within the work team. The global scale measures the overall level of team satisfaction with the mental health service. All scales range from 1 to 5, with 5 representing the highest level of satisfaction and 1 representing the lowest.²⁷

The IMPACTO-BR scale was also used in its 18-item abbreviated form. Items are divided into three subscales, each assessing a factor that constitutes a general effect of daily work as a carer for patients with mental health disorders: the first refers to effects on the team's physical and mental health; the second, to the impact of work on team functioning; and the third, to the psychological effects of work and feelings of overburden. The global scale measures the extent to which the carers are burdened, with scores ranging from 1 (no burden) to 5 (extreme burden).

Both scales and their respective subscales were shown to have good validity,³ consistency, and construct validity in previous studies.^{5,7}

Statistical analysis

Scores were summarized as means and standard deviations (SD). The difference between means for type of facility and educational attainment was tested by ANOVA. Within-group differences were assessed with the Tukey honest significant difference (HSD) test. Statistical significance was set at $p < 0.05$ for both procedures. Analyses were carried out in R version 3.2.4.

Results

A total of 527 mental health workers were interviewed (36.1% in RS, 9.3% in ES, 21.4% in RJ, 5.7% in GO, 11.9% in BA, and 15.6% in DF), distributed across 407 facilities (23% in outpatient care facilities, 16.3% in CRAS/CREAS, 11.8% in CAPS AD, 18.2% in CAPS, 8.7% in inpatient care institutions, 15.4% in therapeutic communities, and 6.6% in other institutions). Only 5% of respondents had completed primary education alone; 25.7% had a secondary education, and 69.3% had a higher degree. A breakdown of the sample by state is presented in Table 1.

Table 2 Satisfaction of mental health personnel, stratified by type of institution – Brazil, 2012

	Outpatient	Social care referral centers*	Psychosocial care centers (alcohol/drugs) [†]	Psychosocial care centers [‡]	Inpatient	Therapeutic community	Other
Global satisfaction	3.63 (0.66)	3.64 (0.50)	3.59 (0.54)	3.56 (0.42)	3.82 (0.59)	4.07 [§] (0.44)	3.87 (0.48)
Patient treatment	3.76 (0.73)	3.77 (0.57)	3.74 (0.67)	3.73 (0.52)	3.95 (0.63)	4.13 [§] (0.45)	3.98 (0.48)
Engagement in service	3.62 (0.78)	3.59 (0.65)	3.64 (0.55)	3.54 (0.52)	3.86 (0.70)	4.00 [§] (0.64)	3.94 (0.58)
Working conditions	3.45 (0.78)	3.32 (0.69)	3.31 (0.64)	3.22 (0.57)	3.72 (0.74)	3.94 [§] (0.53)	3.77 (0.58)
Social relations	4.05 (0.88)	4.03 (0.66)	4.17 (0.56)	3.94 (0.65)	4.28 (0.56)	4.22 (0.79)	4.11 (0.62)

Data presented as mean (standard deviation). Comparisons deemed significant at $p < 0.05$ (Tukey's HSD).

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[‡] Centro de Atenção Psicossocial (CAPS).

[§] Significant vs. outpatient, social care referral centers, psychosocial care centers, and psychosocial care centers (alcohol/drugs).

^{||} Significant vs. psychosocial care centers and psychosocial care centers (alcohol/drugs).

Satisfaction with mental health services

The mean (SD) SATIS-Global score was 3.71 (0.55). The subscale scores were 3.84 (0.61) for the first subscale (quality of services), 3.70 (0.67) for the second (team participation), 3.48 (0.70) for the third (working conditions), and 4.09 (0.72) for the fourth (work relationships).

The ANOVA model was statistically significant for both the global scale and all subscales. Mean scores for those who worked in therapeutic communities were significantly higher than those of personnel working CAPS, CAPS AD, and CRAS/CREAS in the global, first, second, and third scales. For the third scale, those working in "other" institutions also had higher scores than those working in CAPS and CAPS AD. Mean scores for the SATIS scales and subscales stratified by type of institution and educational attainment are shown in Tables 2 and 3, respectively.

Burden in mental health services

The mean (SD) IMPACTO-Global scale score was 1.65 (0.54). Mean scores for the first (effects on mental and physical health), second (effects on team functioning), and third (psychological effects) subscales were 1.45 (0.64), 1.71 (0.65), and 1.94 (0.69), respectively. Mean scores stratified by type of institution are shown in Table 4, and by educational attainment in Table 5. The ANOVA model was statistically significant for the global scale and all subscales. After stratification, the model was only significant for the third subscale.

Discussion

The main findings of this study were the differences in level of satisfaction and burden between professionals who worked in different types of facilities and with different levels of education. Mental health care providers who worked in therapeutic communities and those who had only completed primary education reported higher satisfaction in working with substance users.

It is important to examine these results considering WHO's current definition on the treatment of disorders related to psychological stress, which state that interventions should be community-based, offer social support, and look towards recovery and reintegration.²¹ In Brazil, therapeutic communities offer mental health services where the cornerstone of therapy is encouraging social interaction among peers,³⁰ which would likely help explain

the distribution of findings in this study. Moreover, higher levels of personnel satisfaction in this type of service may be associated with its unique characteristics, specific guidelines, and infrastructure, which differ from those of other services such as CAPS and inpatient care facilities.³¹ Similar differences were found in a Brazilian study that compared different types of mental health services.³² An Italian study also found that care providers working in outpatient facilities or clinics report higher levels of satisfaction when compared to hospital workers.¹²

In general, care providers in this sample showed a somewhat high level of satisfaction with their relationship with coworkers and supervisors; however, their satisfaction with working conditions, such as the physical state of facilities and wages, was lower. This situation seems similar to that of Brazilian health workers in other settings. For instance, Rebouças et al.³³ reported that lack of a sense of accomplishment through work, problems in team cohesion, and lack of financial resources directly influence the care that is provided by these workers to service users. Other studies have shown that issues related to work environment, particularly internal problems within teams and a lack of human and financial resources, are associated with job dissatisfaction.^{7,13}

Teams in our sample reported high satisfaction with the quality of services offered to patients and with their engagement in these services. This refers mainly to decision making, implementation of new treatments, and the ability to have their opinions about the general running of the service heard. These are positive results, especially in light of previous studies^{5,12,32} which stressed the mutual relation between quality of care and job satisfaction in mental health personnel. Our findings seem to support the most recent PAHO/WHO report showing an improvement in health services in Brazil.³⁴ They also support the notion that not only the availability of services but also their quality should be considered as an indicator of a nation's social development, and, as such, should be assessed regularly.^{5,32}

In this study, personnel with higher degrees and those working in CAPS and CAPS AD reported higher burden. These scores may illustrate a difference in intensity of demand due to the hierarchical organization of the Brazilian SUS. CAPS and CAPS AD were established as part of a strategy that aimed to enhance the quality and expand the network of outpatient care services in all areas of the SUS. Thus, these services offer treatment to patients with severe and persistent mental disorders, while also serving as gatekeepers of access to the mental health network within the system.³⁵ In addition, changes

Table 3 Satisfaction of mental health personnel, stratified by educational attainment – Brazil, 2012

	Primary education	Secondary education	Higher education
Global satisfaction	4.06 (0.61)	3.78 (0.57)	3.67* (0.53)
Patient treatment	4.11 (0.55)	3.89 (0.60)	3.80* (0.61)
Engagement in service	4.02 (0.72)	3.73 (0.67)	3.68* (0.66)
Working conditions	3.97 (0.73)	3.63 (0.71)	3.40 [†] (0.69)
Social relations	4.24 (0.76)	4.11 (0.63)	4.07 (0.75)

Data presented as mean (standard deviation). Comparisons deemed significant at $p < 0.05$ (Tukey's HSD).

* Significant vs. primary education.

[†] Significant vs. primary and secondary education.

Table 4 Level of burden experienced by mental health personnel, stratified by type of institution – Brazil, 2012

	Social care referral centers*		Psychosocial care centers (alcohol/drugs)†		Psychosocial care centers‡		Inpatient	Therapeutic community	Other
	Outpatient								
Global burden	1.54 (0.53)	1.67 (0.47)	1.86§ (0.63)	1.76 (0.52)	1.46 (0.44)	1.6 (0.55)	1.53 (0.44)		
Effects on physical and mental health	1.37 (0.62)	1.43 (0.51)	1.69* (0.85)	1.60 (0.69)	1.22 (0.35)	1.39 (0.60)	1.32 (0.54)		
Functioning	1.6 (0.62)	1.73 (0.61)	1.94* (0.75)	1.84 (0.63)	1.59 (0.64)	1.62 (0.65)	1.51 (0.51)		
Feeling of overburden	1.77 (0.67)	2.10** (0.69)	2.19** (0.73)	2.07 (0.66)	1.61 (0.51)	1.82 (0.69)	1.86 (0.62)		

Data presented as mean (standard deviation). Comparisons deemed significant at $p < 0.05$ (Tukey's HSD).

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§ Significant vs. outpatient and inpatient care.

|| Significant vs. inpatient care.

* Significant vs. outpatient care and therapeutic community.

** Significant vs. outpatient care, inpatient care, and therapeutic community.

such as implementation of the National Policy on Humanization of Care (HumanizaSUS – Política Nacional de Humanização [PNH]), which took place in 2003, could also be affecting workers' perception of their workload, since the policy aims to increase their level of commitment with patients.³⁶ Similar findings of higher burden in mental health personnel working in SUS have been reported previously, albeit in long-term mental health care teams.³³ Another study compared different types of mental health services and did not find differences between inpatient services and CAPS.³² However, this result can be deemed positive when analyzed in the context of another study, which showed that workers with no stress symptoms reported levels of burden similar to those found in our sample and lower than those of professionals who experienced symptoms of stress.⁵

Regarding the feeling of burden brought by working with mental disorders, the highest levels of burden were reported by care providers with a college degree and those who worked in CRAS/CREAS, CAPS, and CAPS AD. In comparison to another Brazilian sample of subjects with indicators of stress, the IMPACTO-Global scale scores in this sample were lower.^{5,32,33} These findings are relevant, since overall burden not only affects providers' physical and mental health, but is also associated with poor provision of care if it progresses to burnout syndrome.³⁷

To the best of our knowledge, this was the first study to assess a sample of mental health professionals that work with substance users across five Brazilian states. It is worth noting that these professionals worked in urban areas with high crime rates at the time of data collection. It may be understood that, despite working in violent settings, these care providers are reasonably satisfied and do not feel severely overburdened by their activities. This is a significant finding in personnel exposed to such a wide range of challenges and factors that could lead to stress and burden.

The limitations of this study are associated with its cross-sectional design, which restricts findings to the circumstances of the time in which data were collected. As such, in addition to individual aspects of each participant, the political and social environment in Brazil could have had an influence on the results. In addition, the sample is not representative of the country as a whole; therefore, our data cannot support any inferences about all mental health workers in Brazil. In fact, the predominance of mental care providers from RS and, to a lesser extent, RJ may skew our results towards the reality of these states. The results of this study should be analyzed in the context of the users of the assessed services,^{6,38} while also taking into account that, in the majority of facilities (77%), only one professional was available to be interviewed. Another limitation concerns the instruments used to measure burden and satisfaction in this sample: neither scale offers cutoff points for acceptable levels of burden or optimal levels of job satisfaction.

The assessment of satisfaction and burden in mental health personnel is an important aspect in the pursuit of high-quality mental health services both for users and for providers, who are themselves essential actors in the process of promoting health. It also reinforces the notion of a complex psychosocial context involving service users,

Table 5 Level of burden experienced by mental health care personnel, stratified by educational attainment - Brazil, 2012

	Primary education	Secondary education	Higher education
Global burden	1.57 (0.53)	1.62 (0.56)	1.65 (0.52)
Effects on physical and mental health	1.33 (0.60)	1.41 (0.62)	1.47 (0.62)
Functioning	1.67 (0.66)	1.73 (0.70)	1.69 (0.62)
Feeling of overburden	1.82 (0.73)	1.79 (0.64)	2.00* (0.70)

Data presented as mean (standard deviation).

* Significant vs. secondary education (Tukey's HSD, $p < 0.05$).

their families, and care providers, with great emotional commitment by all involved in finding the best treatment and ensuring its success. Further research may consider approaching the assessment of satisfaction and burden in a longitudinal design, to ensure that these findings are consistent across time and in different contexts.

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Disclosure

The authors report no conflict of interest.

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