ORIGINAL ARTICLE

The constitution of competences in mental health nursing education and practice

A CONSTITUIÇÃO DE COMPETÊNCIAS NA FORMAÇÃO E NA PRÁTICA DO ENFERMEIRO EM SAÚDE MENTAL

LA CONSTITUCIÓN DE COMPETENCIAS EN LA FORMACIÓN Y EN LA PRÁCTICA DEL ENFERMERO QUE ACTÚA EN EL ÁREA DE LA SALUD MENTAL

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ABSTRACT

This qualitative study had the purpose to increase the discussions about the constitution of competences in the education of nurses so that they can work in the mental healthcare area. Goals: to analyze the representations of the research subjects about mental healthcare competences. Method: qualitative research. Setting: The nursing department in a public university in the state of São Paulo. Subjects: Professors and healthcare nurses working in the same area. The mobilization of testimonies happened in focus groups, followed by discourse analysis. The building of competences and promotion of complex situations in the students' learning process were discussed, and the discourse analysis yielded the following empirical categories: *The concept of competence*, *What is a complex situation*, *Which knowledge is necessary to manage complex situations in psychiatric nursing and mental healthcare*, *Competence: knowing how to manage a complex situation*.

KEY WORDS

Education, nursing.
Mental health.
Professional competence.

RESUMO

Esta é uma pesquisa qualitativa que teve como proposta ampliar as discussões sobre constituição de competência na formação do enfermeiro para atuar em saúde mental. Objetivo: analisar a representação dos sujeitos da pesquisa sobre competência em saúde mental. Metodologia: modalidade da pesquisa qualitativa. Cenário: uma Escola de Enfermagem de universidade pública do Estado de São Paulo. Sujeitos: docentes e enfermeiros assistenciais, que compartilhavam o mesmo campo de atuação. A mobilização dos discursos foi por meio de grupo focal, prosseguido de análise do discurso. Constituir competência promovendo situações complexas no processo de aprendizagem do aluno foi discutido no grupo, e da análise do discurso identificou-se as seguintes categorias empíricas que compuseram os temas: *O conceito competência*, *O que é uma situação complexa*, *Quais os saberes para administrar situações complexas em enfermagem psiquiátrica e saúde mental*, *Competência: saber administrar uma situação complexa*.

DESCRITORES

Educação em enfermagem.
Saúde mental.
Competência profissional.

RESUMEN

Se trata de una investigación cualitativa que tuvo como propuesta ampliar las discusiones sobre la constitución de competencia en la formación del enfermero para actuar en salud mental. Objetivo: analizar la representación de los sujetos de la investigación sobre competencia en salud mental. Metodología: modalidad de investigación cualitativa; Escenario: una Escuela de Enfermería de una universidad pública del Estado de San Pablo; Sujetos: docentes y enfermeros asistenciales, que compartían el mismo campo de actuación. La movilización de los discursos fue por medio de grupo focal, seguido del análisis del discurso. En el grupo se discutió la constitución de competencias promoviendo situaciones complejas en el proceso de aprendizaje del alumno. En el análisis del discurso se identificaron las siguientes categorías empíricas que compusieron los temas: *El concepto competencia*, *Qué es una situación compleja*, *Cuáles son los conocimientos para administrar situaciones complejas en enfermería psiquiátrica y salud mental*, *Competencia: es saber administrar una situación compleja*.

DESCRIPTORES

Educación en enfermería.
Salud mental.
Competencia profesional.

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INTRODUCTION

Discussions regarding competence are pertinent to all situations involved in the educational process. Although many educators may deny this necessity, there are several academic situations that expose us to this condition, such as the Curricular Directives of the undergraduate courses. We speak about competence in a dialogic conception, which addresses the development of abilities or attributes – either intellectual, psychomotor or affective – which, when articulated, result in distinct ways of successfully performing essential and characteristic actions of a given profession:

> different combinations can respond to the standards of excellence ruling that profession, allowing people to develop their own style, adequate and effective to face professional, familiar or unfamiliar situations[1].

Developing professional competencies requires instrumentalization of knowledge and abilities. However, it is not limited to this instrumentalization – there are resources that may be internalized such as knowledge and skills, which must then be mobilized by a professional in a given context. This is *knowing how to act in a situation*[2]. The competent professional knows how to manage a complex situation, or a problem situation, real and organized around concrete situations, such as obstacles to be overcome with the formulation of hypotheses and conjectures. It is not restricted to specific studies, or even to illustrative examples of classical educational situations[3].

This situation would work as an *enigma to be solved*. Faced with this situation, the student is encouraged to collectively collaborate and acquire intellectual instruments to build a solution. This solution must be resistant, so that the student's previous knowledge and representations can be invested in it, and it will lead to questioning and elaborating new ideas. These activities should be monitored by evaluation methods that will allow for the collective reexamination of the chosen pathway, resulting in a metacognitive reflection. The purpose is to aid students to become aware, heuristically, of the strategies that they execute and to fixate them in the available procedures for new problem-situations[3].

Discussing education through competence leads us to a transforming educational process, with a significant dimension which is still not wholly explored in academic practices. Therefore, it is pertinent to promote the debate and to publicize competence-based education, especially in the case of healthcare professionals, seeking the development of the critical sense in the social-political context of healthcare, as well as the guidelines of the SUS – Single Health System, Sistema Único de Saúde[4]. This knowledge is essential for the education of the nurse, who, in turn, is a member of healthcare teams in almost every setting of the SUS.

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Transposing this discussion to the scope of mental healthcare education in nursing means including the preparation of *human resources that are capable of overcoming the paradigm of tutelage for mad patients and madness*[5]. This condition demands changes in the healthcare model, the conception of madness, mental suffering and therapeutic technologies. In other words, educating competent nurses to work in the psychosocial healthcare field means contributing to the process of Psychiatric Reform, being aware that this is a complex social process, woven with the theoretical-conceptual, legal-political, technical-assistential and sociocultural dimensions[6].

Therefore, we represent the *problem situation* (or complex situation) in mental healthcare nursing education: preparing professionals with critical-reflective knowledge, versed in the SUS guidelines and with theoretical-practical preparation, autonomy and creativity regarding psychosocial healthcare. This situation is inseparable from the contradictions of reality, where the current mental healthcare policies prioritize a new, progressive focus on care for people experiencing psychic suffering – however, nursing practice still occurs mostly in hospital settings, reproducing the separation between school-taught knowledge and the care provided in mental healthcare services[6]. Many nursing students do not apply the knowledge they acquired in the teaching-learning process to the healthcare practice, and many others, when possible, avoid the area as their professional choice[7-8].

Considering the complexity of educating the nurse for psychosocial care, the traditional educational references will certainly not engender the necessary transformations, since they favor the reproduction of the dominant knowledge, sustained by the biomedical/psychiatric model. One possibility for change is to discuss educational practices incorporating coping strategies, adopting a differentiated pedagogic approach: the competence-based approach[4]. Therefore, this study is presented with the goal of advancing the constitution of this type of knowledge, broadening dialogue and reflecting on the education of nurses to prepare for work in the mental healthcare area.

OBJECTIVES

To analyze the representations of the study subjects (professors and healthcare nurses) regarding competencies in mental healthcare, by contrasting their educational references with the pedagogy of competencies.

METHOD

This study used the qualitative approach, and was approved by the Ethics Committee of School of Nursing at de

São Paulo University (CEP/EEUSP), file #327/2003/CEP-EEUSP. The subjects read and signed a consent form.

The setting was a nursing school in a public university in the capital of the state of São Paulo. A meeting room was used as the physical space for data collection. This institution was chosen due to its national renown of commitment to the preparation of critical and reflective nurses, showing interest and availability for new educational strategies, the development of research and graduate courses and, overall, because of its undergraduate nursing healthcare course, which is developed with services that substitute psychiatric hospitalization.

The subjects of the investigation were: four teachers of the school with different titles (Master, Doctor, Free Lecturer), working in mental healthcare education for at least two years; and four registered nurses, with a university or specialization degree in psychiatric/mental healthcare, working in the field for at least one year and in the practical areas used by the aforementioned teachers in the teaching-learning process.

The testimonies were collected in a focus group session. This is a technique to collect qualitative data, used to encourage the discussion of a given topic. It involves feelings, emotions, opinions and the relations of the actors involved in the process. The group discussion was encouraged by research in a pre-group moment, for 20 minutes, when the participants discussed concepts related to competence (the triggering theme), its definition and knowledge to be developed during the educational process. Following, the researcher started the group activities, by posing the following guiding question: *Could you describing a situation that, according to your perspective, mobilized your own (or the students') knowledge and skills in order to develop competencies?* The meeting was held with the eight subjects and lasted 65 minutes, being recorded through researcher's notes and audio recording. The recording allowed for the creation of a chronic, which reported the group movements (the group event) and the full transcription of the subjects' speeches, which were analyzed later.

A technique based on the theory of Generation of Meaning was used to analyze the testimonies, allowing us to capture the thematic phrases[9] and executed as follows: 1st phase: organization of the material, with a thorough and repetitive reading of the transcribed material, capturing the underlying themes, where the themes and figures were highlighted in the text itself (figures: words or expressions referring to something that exists in the natural world). 2nd phase: linking and articulating themes and figures, seeking points of agreement or ambiguities in the subjects' speeches. 3rd phase: wholly rebuilding the thematic phrases that synthesize the themes and subthemes of the discourses (codified in the resulting texts with the letter T – theme phrase), followed by a number indicating the order in which it emerged in the discourse and, in parentheses, the letter/number G1 – Focus group #1. Finally, the discourses were decoded, grouped according to their theme phrases, with the categorization (identification) of the empirical category.

Therefore, the following themes were identified: *The competence concept*, *What is a complex situation*, *Which knowledge is necessary to manage complex situations in psychiatric nursing and mental healthcare*, and *Competence: knowing how to manage a complex situation*.

RESULTS

Competence: knowing how to manage a complex situation

The competence concept.

Some of the theme phrases unveiled two distinct concepts about competence. Here is the first:

> A competence can be treated as a bureaucratic instrument, with distinct characteristics, discriminating the functions and routines of a professional or group T. 50 (FG1).

> The functions, norms and routines of a mental healthcare service must be jointly built with the nursing auxiliaries and the whole multidisciplinary team T. 44 (FG1).

The subjects spoke of a competence identified as bureaucratic; they brought their own conception of functions, routines, and pre-established norms in a given service. This conception can be described as a model inherited from Taylorism and Fordism, where the subject is an operator with limited competence, knowing how to execute procedures according to prescriptions. In this model, competence is limited to standardized, expected and observable knowledge, an important controlling management tool[2].

This need for controlling the professional setting, through prescriptive knowledge, caused opposing responses in the group, which showed the insufficient resolution regarding situations at work. They concluded that, when describing specific norms and routines of each professional, they do not build knowledge, nor do they mobilize skills and knowledge to cope with real situations in mental healthcare.

> A bureaucratic, administrative competence will solve relational problems in a multiprofessional team T. 46 (G1).

> A bureaucratic competence does not mobilize skills and knowledge to solve problem situations. It is not compatible with the concept of pedagogic competences, or built knowledge T. 51 (G1).

Following that line of thought, the subjects described another competence concept:

> The definition of competence is broad. It includes knowledge, information, attitude, values, and leads us to question whether it is an academic or practical attribution. T. 53 (G1).

This is a conception of competence that is compatible with the perspective of the knowledge economy. Accord-

ing to this perspective, the subject is considered an actor, the one who goes beyond prescription; the professional knows how to act, has initiative, and is capable of triggering and handling resources (knowing, knowing/doing, others) and actions. Therefore, there is no unique way of being competent in a universe of actions[2]. Management is characterized by leading, yielding the emergence of the competence in the professional context.

What is a complex situation?

In an effort to report a real situation involving mobilization of knowledge and skills, they elected the practical field as a promising setting for the verification and validation of competence building:

> Thinking about building competences reminds us of practical events that we experienced T. 1 (G1).

Events describing real situations, experienced during practice.

Complex situations are:

> Being faced with the patients' aggressiveness; Being faced with users that have undergone several types of treatment, unsuccessfully; Being faced with the grief and anxiety of those who suffer from a mental disease; Being faced with the tears, the pain and the abandonment of the person T. 5 (G1).

> The psychiatric patient notices the fear and insecurity of the nursing students T. 19 (G1).

There are challenging situations for students and professionals, such as aggressiveness, dealing with the chronic user that is disregarded by the healthcare services, and instrumentalizing oneself in order to cope with overwhelming emotions in those who suffer with a mental disorder and with social indifference. They report that the contact with the field and the person experiencing psychic suffering had a significant emotional dimension for the students' learning process, which the patients notice. At first, fear and anxiety in these educational situations caused a potentially negative effect[11].

The aspects that respondents described as complex situations were closer to moments of impediment than the promotion of education. Circumstances resulting in overwhelming feelings for the students, or difficult to resolve, like a real *shock therapy*, were far from what could be considered an educational moment, with good results for learning and its evaluation.

A problem situation is an educational situation that proposes a task, demanding the subject to mobilize resources, activate routines (habits, organizations of life that direct our actions) and make decisions – different from a machine, which solves the problem in an acritical, uniform and preprogrammed way[12]. Therefore, the human being is placed in front of a situation that challenges him to reach a goal, by making judgments, committing to the response and deciding. In doing so, values are mobilized, dilemmas are coped with, the best and fairest choices are judged and, in view of success or failure, the goal is achieved.

Seeking to comprehend the complexity of the nursing student's experience in the mental healthcare educational process, a study confirmed the feeling of fear in the students who have to take the course. This happens due to the misconceptions they have about the mental patient, since they believe that the patient is the individual who, according to common sense, is aggressive, violent, and incapable of identifying what is right and wrong. However, throughout the process, these feelings are slowly transformed, with a change in thoughts and attitudes emerging as they acquire the necessary skills and techniques to provide care for the patient[11].

The mental healthcare courses are generally focused on the responsibility in addressing and discussing the intra- and interpersonal dimensions, since its own dynamics favor personal contact, self-reflection, self-knowledge, and overall, the expression of feelings[13]. As such, the emotional dimension of learning is expected to make its way into these moments. The teacher should be sensitive enough to lead students towards overcoming the obstacles[11], developing an empathic and humanized attitude[13].

Which is the necessary knowledge to manage complex situations in mental healthcare and psychiatric nursing?

The professional must be able to go beyond what was prescribed, not only executing what is prescribed[2]. It is also necessary to act in view of unpredictability and contingences. The professional will make decisions, have initiative, negotiate, make choices, provide resources, assume risks and prevent incidents. In this perspective, the study subjects reported a distressing reality: it is not clear to the nursing students what they have to do and how to advance in view of everyday situations. They limit themselves to a prescriptive practice or seek a pre-established form.

> Faced with real situations, the student does not know what to do and requests a formula describing how he or she should act T. 3 (G1).

> The nursing student seeks pre-prepared knowledge, described in a textbook that follows medical prescriptions. This necessity is also reflected in their professional life T. 29 (G1).

When faced with the aforementioned situation, the requirements of creativity and initiative, necessary to know how to act professionally, seem not to exist, as professionals are not educated to develop these areas of knowledge. Therefore, the students did not take on responsibilities for mental healthcare patients and considered nursing as an occupation that has been losing ground by not assuming responsibilities through their actions.

> It is difficult for the nursing students to be reliable when dealing with the mental patient, because they are afraid of becoming a reference for the patient T. 27 (G1).

> Nursing has been losing its functions within the team, especially because it is self-limiting and does not assume responsibilities: [...] *if we are not careful, we will end up carrying the patient aids* [...] T. 39 (G1).

In the subjects' opinions, knowing how to act is not being applied in the education of nurses. They are educated to have bureaucratic competences.

> The education of the nurse is fractured, tutelary, and jeopardizes the student's autonomy, *because they are* only taught how to follow medical orders T. 31 (G1).

> The education of the nurse does not support the brave attitudes of making oneself capable and responsible in the relations T. 30 (G1).

> Nursing education reproduces elementary and high school education, since it prioritizes a huge amount of content T. 35 (G1).

The subjects' discourses showed a close connection with the educational theories that supported (and still support) the education of nurses in Brazil – especially the traditional, technicist pedagogy.

The educational theories most often manifested in the history of nursing education were the Traditional, the Technicist and the Critical schools, with the former two being the strongest. It is difficult to determine the beginning of any of those in a timeline, but these theories can coexist and cohabitate in the same educational system, with long-lasting characteristics[14].

Traditional pedagogy prioritizes the transmission of content through normative courses, with teacher-centered activities. The student takes the role of receiver of class topics, and is expected to memorize knowledge and reproduce it. The teacher-student relationship is based on the hierarchy of the educator's sovereign knowledge, which is always on a higher level, with his authority being highlighted[15]. This educational model prioritizes the technical procedures through fragmentary learning, being opposed to an integral educational process for the nurse[13], which is essential for psychosocial healthcare.

The influences of the technicist pedagogy in nursing education occurred in response to the demands of the historical-political period on the Brazilian society after 1964, when the militaristic regimen forced the educational institutions to conform to the guidelines of the State. The nursing schools were accused of preparing workers with low qualifications and submitted to a curricular reform that favored a biologicist, mechanicist perspective of the health-disease process, focusing on the hospitalized individual[14].

> Teaching one to follow medical prescriptions is not a part of the discourse of the nursing schools and courses, but, actually, that is observed in practice T. 65 (G1).

The traditional and technicist pedagogic approaches are still present in nursing education, sometimes in disguise, which causes dissociation between the discourses[14].

> The nursing students are taught to follow medical prescriptions, and when they take the mental healthcare nursing courses, they suffer an impact because they do not find the same educational approach T. 64 (G1).

We trust in education that aids in the process of social and nursing transformations, opposed to prescriptive education. This is the moment when the nursing educator must seek new teaching strategies to provide an atmosphere of learning, using transforming actions. It is necessary to develop critical and inquiring thinking, encourage leadership, and explore the potentials of *being human* in each student by employing problematizing strategies, disregarding traditional education methods[16].

Until now, with the information we analyzed, and with the subjects' conception of constitution of competencies, we can conclude that nursing education has many obstacles to overcome.

> Thinking about building competencies means thinking about broadened types of healthcare education and practice, focused on people who often have difficulties in being heard, of relating with others or establishing actions T. 49 (G1).

> It is necessary to teach less content and focus education on whatever is necessary to mobilize responsibility, as in being responsible for deciding instead of just following therapeutic directions T. 36 (G1).

However, we found two curricular views that provoked and still provoke dilemmas around the discussion about *prepared minds* or *full minds*[17]. Knowledge and competence are complementary; the cause for conflict was the priority of one over the other, especially in the division of time and activities in the classroom.

One curricular view consisted of following the whole range of knowledge, unconcerned about students' mobilization, placing the guarantees of constituting competencies under the professional education or life. This form is historically dominant and is part of the educational system. The other curricular view drastically limited the amount of information taught and required, so that the students could focus on their mobilization in complex situations[18].

The resources developed by the respondents supported the professionals' knowledge about how to act, attributed them autonomy, and were incorporated in the daily routine of the service.

> We started with an amount of knowledge, from our senses, so that we could intervene without having to ask for permission to do so T. 61 (G1).

> Applying the techniques and theories of therapeutic communication and relating in practice is possible only by being available to learn while you're doing it T. 6 (G1).

This means knowing how to extract knowledge from experience[2]. The professionals transform their actions in experience, self-learning and self-achievement by turning their

practices into opportunities to create knowledge. There is no doubt that this process will only be possible when followed by reflection about action, leading to a new professional attitude[19].

> In mental healthcare/psychiatric nursing practice there is no concrete *intermediate object*, such as a tray, bandages or materials to apply a concrete substance. The *intermediate object* is the person itself, in the professional-patient relationship T. 32 (G1).

> The therapeutic relationships applied in practice are often attributed to personal characteristics, when they are actually technologies to be learned and developed T. 33 (G1).

> The school cannot provide all the elements necessary to develop the healthcare technology for people with mental disorders. It is necessary to seek for continuous improvements in life, everyday T. 34 (G1).

In the practice of relating, they learned that the resources to be used are much more personal than material. These resources had an educational character that can be invested in as a type of technology, which is updated and developed continuously, to understand oneself and one's own relations, both personally and professionally.

> Professionalism is a product of the professionals' history, as well as their biographical pathway, either professionally, personally or socially. This is one of the most important sources of the trust placed in them. The client relies more on the professionals' experience than on their diplomas[2].

In cases where nurses are found to be working in innovative ways in the psychosocial or clinical healthcare realm for the patient, we can observe that these differentiated actions were acquired in practice rather than in the academy[7]. Another pathway taken by the professional resulted from the capacity to articulate their attitude with their creativity, in going beyond the prescription received, doing more than what had been established.

> In mental healthcare, taking responsibilities is linked to the personal capacity of taking a stand, because there is no textbook that describes the steps to be taken in the relations T. 48 (G1).

> Fighting against the limitations of the nurse within a team is to seek knowledge, to be willing to learn continuously, to specialize, to invest time and financial resources T. 58 (G1).

There is a concept for the use of competence, and the research subjects outlined some of these settings: the setting that poses the reality in which one is inserted demands that the nurse mobilize the capacity of adaptation, since knowing how to act, in a professional context, includes its assessment and the required adequacy. *Plasticity is in the heart of competence*[2]. Competence has a variable aspect, and is not characterized as a constant.

Being competent in mental healthcare/psychiatric nursing is:

> Adapting actions to the local reality; Being together with the person that has a mental disorder, and monitoring him; Knowing how to listen attentively; using silence therapeutically; Involving oneself, becoming responsible for the therapeutic relationship; Discussing the feelings of fear T. 4 (G1).

These are relational networks among subjects, *subjects that listen and care*, fundamental for mental and psychosocial healthcare. This is translated in the expression *becoming responsible* for people who are receiving care, with the practices of welcoming, structuring affective bonds and commitment to the process of caring for the person experiencing psychic suffering and the family[6].

> Effective nursing actions include non-verbal communication in looks and attitude, verbal communication in dialogues and listening, and in touching, such as taking one's hand and doing massages T. 17 (G1).

> To solve a complex problem, we depend on some cultural capitals that allow us to do so. We count on our own history, our knowledge, skills and culture T. 63 (G1).

They also outlined the spaces where they learned how to act in mental healthcare:

> The group discussions are precious moments for teachers and students, nurses and team to learn and interact T. 11 (G1).

> Building knowledge and actions in psychiatric nursing collectively is a possible way to develop professional autonomy T. 12 (G1).

> In mental healthcare we are often faced with not knowing what to do when confronted with real situations. Not knowing what to do puts us in contact with the situation and invites us to collectively build new possibilities T. 14 (G1).

Acquiring knowledge and knowing what to do through collective experiences – the knowledge of *learning to live together by living together* – represented an assumption to overcome individualism. The discovery of the other resonates in a real educational practice containing empathy, recognition, openness to alterity and questioning[18]. Learning to live together is promoted by early participation in projects of cooperation in several areas, as well as in community actions, aiding those in need, and movements of solidarity, among others. This is the field of mental healthcare, comprised of a complex knowledge network, woven together in rich, polysemic ways, which could even make it difficult to establish its boundaries[6].

Another dilemma that interferes in interpersonal relations within a team was noted by the group:

> When a service does not have an institutional project that supports the actions of the professionals, it causes grief in the nurses in the field T. 66 (G1).

> Thinking about an institutional project is thinking about the common good, it is addressing the collectivity T. 69 (G1).

There is need for institutional projects elaborated collectively, because it supports the knowledge and the actions of the team and promotes changes, in a manner which is consistent with the one described by regulation #147, passed in August 25, 1994.

> [...] defined as the group of objects and actions established and executed by the multiprofessional team, focused on patient recovery, from admission to discharge. It includes the development of specific and interdisciplinary programs that are adequate to the characteristics of the clientele, making the treatment proposal compatible with the necessities of each user and their families. It represents the existence of a philosophy that guides and permeates the whole institutional action, granting quality to the healthcare provided[20].

An up-to-date reflection about mental healthcare nursing:

> Nowadays, mental healthcare nursing is undergoing a period of transition, a renovation; it faces changes in knowledge and techniques T. 56 (G1).

The professionals take the current situation of change faced by the mental healthcare services upon themselves. The Psychiatric Reform project has been a part of the national context for over two decades, having both advanced and fallen behind. It is a complex social process, in a permanent state of transformation, marked by simultaneous dimensions that support each other as much as they clash[6].

We agree with the statement that one of the greatest challenges for the collective healthcare system is to educate professionals to work within mental care, being especially competent to work in services that substitute for psychiatric hospitalization. This challenge is added to epidemiological data from 2003, which enumerates a low number of psychiatrists, psychiatric nurses and psychiatric nursing assistants working in the healthcare system, with specialist nurses being noted. They represent 0.38/100 thousand inhabitants[21].

We also consider that, in addition to increasing the numbers of specialist nurses, there are a few aspects inherent to the Psychiatric Reform process that must guide professional education, and these regard accessibility and equity, with the following necessities: a dense, varied and effective healthcare network, to provide care for the person with severe and persistent disorders; the necessity of services directed towards people who need mental care, but do not suffer from serious disorders; rearrangement of resources due to the existence of services that concentrate resources and have low coverage rates (hospital and outpatient clinics); articulating and enlarging mental healthcare in the primary services; inter-sectorial articulation of healthcare for drug addicts, especially those in situations of co-morbidity; and qualification, supervision and professional education, especially for those who live far from educational and research institutions.

FINAL CONSIDERATIONS

The theme of constitution of competencies in the education of nurses is controversial, wide-ranging and dynamic. Therefore, it was not the author's intention to explore all the facets of this phenomenon, but to enlarge the discussions and visualize pathways. Actually, what we feel is that the practice and the education in mental healthcare nursing are out of synchrony; the apprentices' difficulty in articulating and mobilizing their own resources, learned during formal education, when they experience real situations – this is what really intrigues us.

It is necessary for the nursing educators to be aware of the historic and social moment in order to change this situation, as well as the contemporary paradigms that must adjust their educational practice, transforming the technical dimension of learning. Regarding the education of the nurse for psychosocial and mental care, there is a long way to go. At first, it is necessary to dismantle the bureaucratic, controlling and excluding spaces, with rigid structures, where the professional is expected to have fragmented and disarticulated actions, which only reinvigorate the psychiatric practices. It is not enough to change the setting, i.e., transferring the healthcare services for people experiencing psychic suffering and their families from the psychiatric hospitals to the community services, if we (healthcare professionals) keep reproducing knowledge and actions based in total control, with vertical, hierarchical and dominant relations.

One of the obstacles for such dismantling is focused on the traditional educational practices, which are still present in the education of the nurses. They prioritize *conveying medical/psychiatric knowledge*, preventing the apprentices from being creative, innovative, and of becoming responsible for their own learning process. If the students' autonomy is not exercised, how can we encourage autonomy in the relation to the other (the one we provide care for)?

The process of professional education is discontinuous, tutelary, focused on the content and provides little possibility of the students' taking part in real situations, especially in the practical field, which represent dynamic spaces for the development of competences. The practical mental healthcare classes mobilize several resources, especially emotional ones, in students and teachers, becoming complex situations, attributing the responsibility of managing this *privileged* moment to build knowledge about actions that can overcome the psychiatric model. How? By promoting reflection-on-action and the elaboration of healthcare (therapeutic) projects, with strategies, execution and evaluation, allowing the apprentice to be autonomous and creative.

The testimonies revealed the lack of opportunity available to discuss everyday events that are common to learning and healthcare, due to the absence of a common political-educational and therapeutic project, involving the fol-

lowing subjects: teacher, healthcare nurse, educational institution, healthcare institution, student and user of the healthcare service (each with their own project, addressing their own restricted reality); and the lack of harmony between the paradigms of the transforming pedagogy and the Psychiatric Reform. There is also a pathway to be beaten for the execution of the transforming praxis, and what little could be achieved in the construction of knowledge about actions in the psychosocial model was built empirically, in the everyday routine of the mental healthcare services.

Finally, we consider that education cannot deny practice, and vice versa, in the construction of psychosocial healthcare knowledge, which must advance in the constitution of knowledge and actions: becoming responsible for the person and the family receiving care; living together and strengthening the interactions between workers/managers/users; welcoming people who suffer from mental disorders in places that care for the subjects, and finally, in being autonomous and responsible for continuous education.

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