Pontificia Universidad Católica de Chile
Facultad de Ciencias Sociales
Escuela de Psicología

Mental Health Providers' Experiences of the Challenges they face working in the Public Mental Health System in Chile

Alexandra Epstein Milberg

Thesis presented to the Faculty of Psychology of the Pontificia Universidad Católica de Chile in Partial Fulfillment for the Degree of Master of Clinical Psychology

Guide Professor: Candice Fischer

Committee: Paula Errázuriz – Stephanie Vaccarezza

January, 2022

Santiago, Chile

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Summary

With mental health disorders on a rise especially after the COVID-19 pandemic, mental health services have been constantly challenged. This has created more pressure on mental health systems, increasing significantly the weight carried by mental healthcare providers (MINSAL, 2011). In Chile alone, there has been a 40% increase of cases of depression and 37% increases of cases of anxiety since the COVID-19 pandemic (Ceils-Morales & Nazar, 2022). In addition to the above, less than 40% of people who have a mental health diagnosis receive care in mental health care services or primary health care (Vicente, Saldivia & Pihán, 2016). There is also a significant lack of resources for Mental Health in Chile, which generates an even greater burden for the system and for those who work in it. In this context, there are few studies that address how these challenges affect Mental Health professionals in Chile. While numerous studies in this area have used a quantitative methodology, very few have applied qualitative methodologies to gather subjective descriptions of the experiences of mental healthcare providers. Thus, this methodology can provide significant data to explore in depth the factors that influence healthcare workers experiences which would be otherwise overlooked in quantitative methodologies. To achieve this, 15 mental health professionals which included psychiatrists and psychologists, were interviewed through semi-structured interviews. The results point to various challenges faced by these professionals that tend to promote negative experiences. However, despite being less frequent, some aspects are also presented that would lead to more positive experiences and that these have the possibility of mitigating the effects that more negative experiences have on therapists. The conclusions point to the effects that negative experiences have on therapists and how they affect the quality of the treatment provided in mental health care. The role of positive experiences are also discussed.

1. Introduction and problem statement

It is estimated that 792 million people live with a mental disorder, which accounts for approximately 10% of the population (Ritchie & Roser, 2018), and it has risen since the COVID-19 pandemic. Mental health disorders and substance abuse has increased in 13% during the last decade (WHO, 2017). Furthermore, 20% of minors suffer some kind of mental burden and suicide was the second cause of death of people between the age of 15 to 29 worldwide (WHO, 2017). During the pandemic, the mental health burden became even more pronounced. In the United States in March 2020, roughly 32% of adults reported a negative impact on their mental health, feeling worried and stressed due to the pandemic, which had risen up to 53% by July 2020 (Kearney et al., 2021). One study by Lian et al., (2020) evaluated the mental health of 584 youths in China during the pandemic and over 40% of them had psychological problems. Kwong and colleagues (2020) found levels of anxiety almost doubled after the pandemic started in a sample of adults in Scotland.

In Chile, the prevalence of mental health disorders is one of the highest in the world (23,2%) (ACHS, 2021) and with the pandemic, there is evidence that 56% of the Chilean population has developed mental health issues (ACHS, 2021). Almost a third of the population over the age of 15 has experienced a mental disorder in their lifetime and 22,2% have had one in the last year. Another alarming statistic is that less than 40% of those who have been diagnosed receive help from mental health services. This gap between the amount of treatment that is needed versus what is actually provided has been identified by the World Health Organization as a major problem, where they highlight a concerning shortage of mental healthcare staff as a contributing factor (WHO, 2018). The situation has become even more complicated with mental health disorders on a rise, thus creating more pressure on mental health systems, increasing significantly the weight carried by mental healthcare providers (MINSAL, 2011).

Another important aspect regarding mental health systems is the substantial scale-up of financial resources needed worldwide (WHO, 2018). Throughout the world, mental health remains a neglected priority, low on the agenda of policy makers and funders at the national and international levels. While this is shifting somewhat, there is still a considerable need to address the under-prioritization of mental health and well-being, perhaps even more so in the wake of the COVID-19 pandemic (Mahomed, 2020). In Chile, the expenditure on mental health is only 2,4% of the total budget available for health, far lower than the 5,1% that upper-middle- and high-income countries invest on average and also below the 5% proposed by the 2017-2025 National Mental Health Plan (Errázuriz et al., 2015; MINSAL, 2017). Two of the main consequences of the low investment in mental health are the further decrease in coverage and significant increase in the overload of primary and specialized healthcare teams (MINSAL, 2017). Additionally, WHO has also defined that countries should monitor the quality of mental health services to reassure personalized and comprehensive care provided by professionals that are humane, technically highly qualified and effective in their solutions (MINSAL, 2018). In 2014, The World Health Organization recommended -specifically for Chile- different courses of action to be taken to improve mental health treatments. Within those recommendation are the increase in monitoring of mental health systems, paying attention to quality, increasing and improving professional training, and fostering more research.

In Chile, the third Mental Health National Plan is currently in place (MINSAL, 2017). Many of the goals to be accomplish by 2025 require making drastic improvements in mental health's human resources. Specifically, there are goals to enhance mental health professionals' skills and improve their working conditions. Working conditions in the Chilean public mental health system are known to be

challenging at least: large number of patients, contextual limitations, scarce funding, few continuing education opportunities, large amount of administrative work, and turnover (Bedregal, 2017; de la Parra et al., 2019; MINSAL, 2017; Scharager y Molina, 2007).

Given all the challenges in the Chilean Public Health System, the Ministry of Health stated that it is fundamental to incorporate substantial changes in policies, planning, and the administration of economic, technical, and human resources. In this scenario, the healthcare personnel are an essential piece to lead the transformations needed to advance towards the improvement of the population's health (MINSAL, 2019). Due to the former, it is necessary to develop more knowledge from the healthcare staff's perspective. Since there is little literature regarding the experience of mental health professionals in Chile, this study intends to describe the experience of the challenges faced by the mental health staff in the public mental health system. In addition, most of the existing research used quantitative methods, thus this study will use a qualitative methodology to further understand the experience of the mental health staff. Furthermore, the existing research only addresses the experience of mental health staff working in the primary level of the Chilean public mental health system, thus, this study will include mental health professionals from all three levels of the system. These three levels named primary, secondary and tertiary level will be further detailed in the next section.

2. Background Information

For this literature review the existing body of work about the experience of mental health professionals in public services will be depicted first. Next, the challenges that are faced in public mental health settings will be addressed and, later, how these challenges are related to experiences of burnout will be addressed. For this section, I will first state prior research conducted in other countries and later in Chile for each theme mentioned above.

2.1 Experience of mental health professionals in public services

2.1.1 Experience of mental health professionals in public services in other countries

There is a substantial body of research regarding the experience of healthcare staff working with patients with mental illness. However, a significant proportion of this literature focuses on the experience of nurses working with mental health patients (Currid, 2008; Hagen, et al., 2017; Sharrock & Happell, 2006; Zolnierek & Clingerman, 2012). Research about the experience of psychologists and psychiatrists using a qualitative methodology is, however, much scarcer and even more so when it comes to public health contexts. Most studies have found that the experience of working in public mental health settings has both negative and positive aspects (Looi & Maguire 2019; Pilay et al., 2012; Sciberras & Pilkington, 2018; Solomon, 2019). Most of the negative aspects arise from specific challenges within public mental health contexts. Some of these challenges will be mentioned in this section, but will be further developed in the next section.

A common finding is the heavy caseload perceived by the mental health staff (Dallender & Nolan, 2002; Morris, 2011; Pilay 2012; Solomon 2019). While a few studies mention the number of cases as a factor that contributes to negative experiences (Morris, 2011; Pilay 2012; Solomon, 2019), Sciberras and Pilkington (2018) add that the nature and quality of the caseload is also a determinant factor when it comes to negative experiences. Namely, therapeutic treatments where progress was

perceived as slow were discouraging, while complex and chronic cases were considered stressful and exhausting.

Lack of resources further increased negative experiences (Dallender & Nolan, 2002; Kumar et al, 2013; Looi & Maguire, 2019; Onyett, 2011). Kumar and colleagues (2013) found that public mental health professionals in Pakistan felt more dissatisfied with their jobs due to low salaries, improper financial incentives, and understaffing. Looi and Maguire (2019) also found that lacking resources resulted in negative experiences in Australian psychiatrists regarding inadequate facilities and staffing. Similar findings were described by Solomon (2019), who explored the work-related experiences of psychologists in public health facilities in Botswana. Using a qualitative methodology, Solomon (2019) found that psychologists had to face several work-related difficulties including resource limitations, heavy caseload, communication difficulties with co-workers, and limited opportunities for professional growth.

In spite of the numerous challenges aforementioned, mental health care workers generally identify several positive aspects of working in public health. Solomon (2019) found that many psychologists had high levels of satisfaction regarding their work because they deliberately decided to focus on delivering high quality service instead of the challenges they face. Other studies found that positive experiences usually were related to feeling that the job is worthwhile and rewarding (Dallender & Nolan, 2002; Kumar et al., 2013), especially when there are some positives outcomes with clients (Sciberras & Pilkington, 2018). Some elements that further contributed to constructive experiences are teamwork (Norris, 2011; Onyett, 2011) and a positive work environment (Kumar et al., 2013; Pillay et al., 2012).

2.1.2 Experience of mental health professionals in public services in Chile

When it comes to the experience of mental health staff in Chile, there are very few studies. One study by Scharager and Molina (2007) focused on the working conditions of psychologists in primary health care centers in Chile's public system. Similar to international findings, 93% of the surveyed subjects felt satisfied with their work. However, around half perceived that they had poor working conditions and that their job was unstable. In addition, only 25% felt satisfied with their salary. Zúñiga (2018, cited in de la Parra et al., 2019) found that when it came to working in Chile's primary mental health services, there were several limitations that created negative feelings, such as working conditions that did not allow psychologists to provide an effective treatment to foster improvement of their patients' conditions. This entailed that, in this context, psychologists must develop a capacity to tolerate frustration. On a similar note, Fischer et al. (2019) also found that many psychologists of Chile's public service perceived that the treatment they offered was inadequate. The subjects also perceived that they had an excessive work load and felt devaluated by other members of their team. These contextual factors contributed to the perception that some patients are very difficult to work with. Furthermore, the results suggested that it was likely that negative emotional and bodily experiences while working with difficult patients were a consequence of the difficult context in which they had to provide therapy (Fischer et al., 2019).

Although the findings of the previously mentioned studies are relevant, none of them include psychiatrists in their sample. Furthermore, only Fischer et al. (2019) had participants from the three different levels of service in Chile's public mental health system. The Chilean mental health public system is organized in three different levels: primary, secondary and tertiary services. The primary service providers are located in different neighborhoods and communities. All primary service

establishments must provide mental health prevention and promotion programs as well as diagnosis, treatment, rehabilitation, and referrals to other professionals or programs. These services are meant to manage low complexity cases, therefore there are mainly technicians, nurses and general doctors. The psychologists that work in these establishments are the only type of professionals that are specialized in mental health. Other specialized teams and psychiatrists are usually concentrated in secondary and tertiary services. The professionals at the primary level are able to refer higher complexity patients to secondary service establishments when deemed necessary.

Secondary level establishments are located in neighborhoods and provinces. They are meant to deal with middle to high complexity cases that don't require inpatient treatment. Within this level are specialized family mental health centers named COSAMs (due to its initials in Spanish for Centros de Salud Mental Familiar), Ambulatory Mental Health and Psychiatry Teams, Infant and Adolescent Psychiatry teams, ambulatory hospitals and "Short-Term" Psychiatry Services. The latter is meant to treat patients with acute episodes that can be managed in a relatively short period of time. There are also Protection Homes and Therapeutic Communities that focus on providing mental health services for specific issues such as drug abuse, alcohol dependency, domestic violence, among others. Patients attending secondary level establishments usually have to be referred by a professional from the primary level or by a professional from tertiary level in order to continue treatment after being discharged from inpatient treatment. Patients may also come from the justice system with a court order for treatment.

Tertiary level establishments are located in Provinces or Regions. While it is necessary to resolve the vast majority of cases in the primary and secondary levels due to the high prevalence of mental health disorders in Chile, tertiary services are meant to address the most complex cases. These cases usually are characterized by being resistant to the treatment provided. One of the main goals of this level of service is to "*return*" patients to ambulatory treatments as soon as possible (MINSAL, 2017). Some establishments within this level are Infant and Adolescent Day Hospitals, "Middle-Term" Psychiatry services, Ambulatory and Inpatients Addiction Units, Forensic Psychiatry Units, and Psychiatric Hospitals.

2.2 Public Mental Health challenges

2.2.1 Public Mental Health challenges in other countries

Given what has been reviewed so far, there seems to be an interconnectedness between negative experiences and specific challenges faced in public mental health settings. As previously mentioned, this section will address in a more detailed manner the findings about the main challenges that mental health workers face. At an international level, the World Health Organization (2015) has identified resource shortages, skill-mix imbalances, poor distribution of human resources, difficulties for inter-professional teamwork, inefficient use of resources, and poor working conditions as some of the main challenges that healthcare workers face.

Probably the most recurrent challenge in public mental health services is the lack of resources. As it was mentioned before, underinvestment in mental health is one of the greatest concerns in public health. One of the consequences of this issue is that healthcare workers are asked to work full time in public services for less money than what private services could pay them. A study in Australia found that many psychiatrists left public services because they were asked to work more hours than their contract (Newton et al., 2019). Other literature indicates that healthcare workers in public health

perceive their salary as low and that the existing work incentives are inadequate (Kumar et al., 2013; Pillay, 2012). Deficiency in resources also relates to understaffing (Kumar et al., 2013; Looi & Maguire, 2018; Morris, 2011). Understaffing has several consequences, including increased administrative work, which is related to a decrease in job satisfaction (Kumar et al., 2013; Onyett, 2011).

Related to the lack of resources, a heavy caseload is a common challenge (Dallender & Nolan, 2002; Morris, 2011; Lasalvia et al., 2009; Pilay 2012; Rupert & Morgan, 2005; Solomon 2019). A high number of cases paired with administrative work often leads to time management issues (Pillay et al., 2012). Moreover, there is evidence that many mental healthcare workers have received insufficient training to deal with the severe and complex cases, which tend to be higher in public contexts than the private sector (Sciberras & Pilkington, 2018). In one study in Malta, 86% of the participants expressed that they had insufficient training to manage these types of cases which is consistent with the idea that public mental health staff need continuous training (Kumar et al., 2013).

2.2.2 Public Mental Health challenges in Chile

In Chile, public mental health funding is also a major problem (Errázuriz et al., 2015; MINSAL, 2017; Valdés & Errázuriz, 2012). Scare resources led to understaffing, improper facilities and low salaries. Additionally, many jobs in public mental healthcare are full time and time-demanding, meaning that workers cannot have other sources of income to make up for their low salaries nor time to practice self-care activities (Scharager & Molina, 2007). Fischer et al., (2019) also reported problems that derive from funding issues including insufficient personnel, lack of medications, and inadequate infrastructure for treatment.

Scharager and Molina (2007), also found that psychologists felt unsatisfied with their working conditions and that their job was unstable due to their contract's characteristics. Work overload characterized by a heavy caseload and an exceedingly high number of patients per day also contributed to challenges in providing treatment (Fischer et al., 2019). Further, psychologists felt that there were several barriers to providing adequate treatment including low frequency of sessions (seeing patients once a month) and inappropriate amount of time per session. Another study also confirmed that the session's durations were up to 20 minutes below the 45 minutes that are recommended for an effective treatment (de la Parra et al., 2019). In the same line as the evidence mentioned above, research suggests that mental health personnel lacks knowledge and training to work with the specific difficulties of primary care settings (de la Parra et al., 2019; Fischer et al., 2019; Scharager & Molina, 2007).

Furthermore, these healthcare workers dedicated most of their time to individual consultations and not community centered interventions, which is contradictory with the Chilean Mental Health Plan (Scharager & Molina, 2007). The same issue is addressed in a later study by de la Parra et al. (2019), where the authors identified several inconsistencies between 2017-2025 National Mental Health Plan's (NMHP) goals and how the public system actually functions. Namely, the NMHP indicates that the provided treatment must be efficient and of quality. However, a great deal of funding comes from the number of patients that receive treatment, consequently favoring quantity over quality. In this sense, it is often unclear what the roles of mental health providers are in the Chilean system (Scharager & Molina, 2007) which has been related to feeling dissatisfied with their work (Onyett, 2011; Sciberras & Pilkington, 2018). Evidence also shows that providing treatment continuity is difficult because of high levels of turnover of the mental healthcare providers and the low number of sessions patients usually attend (three to five on average) (de la Parra et al., 2019).

Although there is literature regarding challenges faced by mental health workers in Chile's public service, the studies cited above focus mainly on the challenges of the primary level establishments. Further research is needed to address the challenges across the different levels of the public mental health system since countries that have addressed their health workforce challenges have developed significant results, such as improved health outcomes (WHO, 2016).

2.3 Burnout in mental healthcare workers

2.3.1 Burnout in mental healthcare workers in other countries

Many of the challenges listed in the previous section are related to the appearance of burnout, such as heavy workload, role unclarity, lack of sense of control, excessive work hours, and poor rewards (Lasalvia et al., 2009; Lee at al., 2020). Currently, the International Classification of Diseases (ICD-11), considers burnout to be a syndrome that is related to chronic work stressors that have not been successfully handled (Astroszko et al., 2020). The symptoms of burnout include exhaustion or a lack of energy, reduced professional efficiency, and negative or cynical feelings about work (Martínez et al., 2020). Maslach (2009) proposes that the focus of the burnout phenomenon is in the process of psychological erosion and the psychological and social results of a chronic exposure to stress. In other words, burnout is the result of an extended interaction with chronic interpersonal stressors in the workplace which tends to be stable throughout time. Furthermore, it is considered that burnout develops from a personal experience facilitated in the work context, where organizational factors have a greater impact than individual factors (Bambula & Gómez, 2016; Lasalvia et al., 2009).

Burnout is a relevant matter to consider since it contributes to absenteeism, higher job turnover, and increase in medical leaves, which in turn impacts significantly the quality of the services provided (Bearse et al., 2013; Morse et. al, 2012). Consistent with what has been noted before, there has also been an increased demand for service providers along with high demands for efficiency, thus increasing the risk for developing burnout (Green, et al., 2014). A study of over 2,000 public mental health workers in Italy found that one fifth of the participants showed severe levels of burnout (Lasalvia et al., 2009), while Lent & Schwartz (2012) found that professional counselors in the United States that worked in independent practice setting had less burnout than those in public settings. However, protective factors against burnout have been found. These include support from supervisors, support from co-workers, and organizational resources and support (such as having adequate information about how to work with patients) (Singh et al., 2020).

2.3.2 Burnout in mental healthcare workers in Chile

There is scarce literature regarding burnout in public health settings in Chile. One study measured burnout levels in health professionals working in a public hospital in Chile and the results indicated that 69% of those who were surveyed had burnout or were at risk of developing it (Ordenes, 2004). However, none of the professionals were specialized in mental health. Only two studies in Chile were found that address burnout in mental health professionals (Avedaño et al., 2009; Ipinza, 2010). Avedaño (2009) looked at burnout in a Psychiatry Unit in a public hospital and his findings show that 49% of the personnel had a tendency to have burnout symptoms and 20% were effectively burnout. This study also indicated that social support from peers and, especially, superiors, had a significant

effect on diminished levels of burnout. In the study done by Ipinza (2010) eight infant and youth psychologists of secondary level establishments were interviewed about their perception of burnout and self-care. Her findings show that administrative work, low salary, and a heavy caseload were risk factors for developing burnout. A conflictive work environment and frequent changes due to turnover were also risk factors for burnout. On a more personal level, deficient training was also associated to burnout. On another note, having specific time assigned to self-care practices, positive climate, clinical meetings, and supervision were protective factors against burnout. Furthermore, self-care and other personal activities during the psychologist's free time also contributed to prevent burnout.

It is deemed necessary to take different courses of action in order to reduce burnout, since it is an important factor to improve job satisfaction, improve the work and life balance, and reduce turnover. This would allow to retain clinicians and teams in public settings in order to deliver proper mental healthcare for those who need it (Green at al., 2014).

3. Objectives

General Objective:

Describe and analyze the experience of mental healthcare providers that work in public mental health services in Chile

Specific Objectives:

1. Identify and describe the challenges and/or negative experiences faced by mental healthcare providers in public mental health services in Chile.

2. Identify and describe positive experiences of mental healthcare providers working in public mental health services in Chile.

4. Guiding questions

Regarding the first objective:

1. What are the challenges and/or negative factors experienced by mental healthcare workers in public mental health services?
2. What dimensions of their work are impacted by the negative experiences described by this group of providers?

Regarding the second objective:

3. What are the positive factors experienced by mental healthcare workers in public mental health services?
4. What dimensions of their work, and in what ways, are they impacted by the positive experiences described by this group of providers?

5. Methodology

Design of the Study

The purpose of this study is to describe the perception of the experience of mental health staff working in public services in Chile regarding the challenges they face. Since the focus of this study is the experience of the subjects, a qualitative methodology deemed to be the most appropriate. Qualitative research allows to access insights that are profound and meaningful into *"the real worlds, experiences, and perspectives of patients and health care professionals in ways that are completely different to, but also sometimes complimentary to, the knowledge we can obtain through quantitative methods."* (Braun & Clarke, 2014, pp 26152). Thus, it is well suited for producing and refining theory by discovering links between concepts and behaviors (Bradley et al., 2007).

Sample

The participants were 15 mental health workers, including six men and nine women. Ten were psychologists and five psychiatrists. Since the objective was to describe the experience of working in public healthcare services, participants from all three levels of the Chilean public healthcare system were included.

The sampling strategy used was convenience sampling, a non-probability strategy. The participants were selected from a group of students that enrolled for two different post-graduate certificates from the Pontificia Universidad Católica de Chile; "Diplomado en Trastornos de Personalidad: Teoría, diagnóstico y tratamiento" and "Diplomado en Mindfulness y Psicoterapia". For the selection of the participants, different criteria were developed to determine whether the subjects should be included, or excluded, from the sample. Regarding the inclusion criteria, these were a) Being a professional psychologist or psychiatrist, b) having at least 2 years of professional experience in a public healthcare service, and c) having at least a 20-hour workload in a public healthcare service. Participants were selected from the students of the certificates because it was convenient, and because many of the students met the aforementioned criteria. Thus, at the beginning of the certificates, students were asked to volunteer to be part of a research project named "La experiencia de psicoterapeutas en su trabajo con pacientes difíciles en el servicio público".

Table 1 - Participant characteristics

n	Profession	Participant Pseudonym	Sex	Workplace
1	Psychiatrist	A	M	Hospital (3)
2	Psychologist	B	F	COSAM (2)
3	Psychiatrist	C	M	COSAM (2)
4	Psychologist	D	M	SENDA (2)
5	Psychologist	E	M	Job intermediation

6	Psychologist	F	F	SERNAM (2)
7	Psychologist	G	F	COSAM (2)
8	Psychologist	H	F	CESFAM (1)
9	Psychiatrist	I	F	Hospital and COSAM (3/2)
10	Psychologist	J	F	Hospital and COSAM (3/2)
11	Psychologist	K	F	CESFAM (1)
12	Psychiatrist	L	M	COSAM (2)
13	Psychiatrist	M	F	COSAM (2)
14	Psychologist	N	M	COSAM (2)
15	Psychologist	O	F	SENDA (2)

Note. 1: primary level institution; 2: secondary level institution; 3: tertiary level institution

Procedure for data collection

Once the participants agreed to participate, they responded a demographic questionnaire. The participants were initially contacted personally during the breaks they had during the certificate's classes. If they accepted to participate, they were then contacted in two different ways to schedule an interview. If the subject did not answer the emails in a timely fashion, they were contacted by a telephone call. Participants signed a consent form to participate in the research project. Initially, the interviews were held at a convenient location for the participants. Later, with COVID-19, interviews were held by a telephone call or a videoconference. All the interviews were only audio recorded and later transcribed. Any information that could allow the participants to be identified was changed in order to ensure confidentiality.

The instrument used to collect data was an hour long semi-structured and targeted interview that were approximately an hour long. This type of interview was chosen because, although it has a common theme throughout the questions, it allows a fair amount of flexibility, allowing interviewers and interviewees to add information, clarify ambiguities, and expand to related topics that the researchers might not have thought of. Interviews were performed by a total of four different trained psychologists. All four have experience in psychotherapy and research. The interviewer's audio-recorded the interviews and were later transcribed by

Ethics

This study was approved by the Scientific Ethics Committee of Social Sciences, Arts and Humanities of Pontificia Universidad Católica de Chile. The project was approved on the 2nd of May of 2019 under the title "Estudio del impacto de distintos programas de formación clínica en la experiencia subjetiva del terapeuta" (Protocol ID 170413008). The participants received a consent form after an explanation of the details of the interview that would be conducted.

Data Analysis

The data collected was analyzed according to Grounded Theory (Glaser and Strauss, 1967). Grounded theory allows the development of a theory based on abstractions that are grounded in the collected data (Vollstedt & Rezat, 2019). Open and axial coding was used during the analyses. Analyses were conducted using triangulation since it is a strategy to promote validity through the convergence of the information from different standpoints (Carter et al., 2014). The information was analyzed by the author of this thesis (a psychologist with four years of experience), a psychology doctoral student and the guide professor (who is an expert researcher).

Once the higher order codes were merged and placed into groups, the team advanced to the final stage which was selective coding. This stage entailed combining and selectively cutting axial codes in order to develop a theoretical model. This phase was repeated several times until there wasn't any new data emerging. During this process the team continuously worked towards the development of a consistent theory that emerged from the data.

6. Results

Given that the main objective of this study was to describe and analyze the experience of a group of mental healthcare providers that work in public mental health services in Chile, the results were organized into negative and positive experiences of working in public mental health settings. Within the negative experiences, six main themes were found: i) Negative working conditions, ii) Lack of resources, iii) Negative patient characteristics, iv) Negative impact on mental healthcare providers, and v) Perceived iatrogenic effect on patients. In terms of the positive experiences, the following two themes were found: i) Positive working characteristics and, ii) Positive impact on mental healthcare providers.

Table 2 – Negative and Positive Experiences of working in Public Mental Health Settings

Categories
Negative experiences of working in public mental health settings
Negative working conditions
Lack of resources
Negative patient characteristics
Negative impact on mental healthcare providers
Perceived iatrogenic effect on patients
Positive experiences of working in public mental health settings
Positive working characteristics
Positive impact on mental healthcare providers

6.1 Negative Experiences of working in public mental health settings

6.1.1 Negative working conditions

When asked about their experience working in public mental health settings, the participants described a vast set of difficulties they faced regarding the work setting itself. These difficulties were organized into three different dimensions: a) negative institutional characteristics, b) challenges regarding clinical treatments and, c) difficulties within work teams.

Table 3 – Negative Experiences of working in Public Mental Health Settings – Negative working conditions

Categories	Participants
Negative working conditions	
Negative institutional characteristics	
Institutional parameters that follow public policies but negatively affect quality treatment	5 (S)
Funding and administrative gap between institutions	4 (V)
Little recognition towards psychologists' work	5 (S)
Work overload - Excessive administrative work	3 (V)
Work overload - Heavy caseload	8 (S)
Scarce clinical supervision	2 (V)
High turnover rate of healthcare providers	6 (S)
Mental Health Stigma	4 (V)
Challenges regarding the clinical treatment	
Low frequency of sessions	10 (M)
Limited session duration	4 (V)
Limited number of sessions or treatment duration	1(V)
Difficulty to apply treatments, techniques, and knowledge	10 (M)
Challenges within the public service network	9 (S)
Long waiting lists	1(V)
Challenges within the clinical teams	
Difficulties within the relationships	2 (V)
Divergent perspectives on how to manage cases	3 (V)
Lack of policies that provide care for the teams	2 (V)
Lack of time to work as a team	1 (V)

Note. N = 15. M: most (10 – 15 participants); S: several (5 – 9 participants); V: some (1 – 4 participants).

6.1.1.1 Negative institutional characteristics

Table 4 – Negative working conditions – Negative institutional characteristics

Negative institutional characteristics	
Institutional parameters that follow public policies but negatively affect quality treatment	5 (S)
Funding and administrative gap between institutions	4 (V)
Little recognition towards psychologists' work	5 (S)
Work overload - Excessive administrative work	3 (V)
Work overload - Heavy caseload	8 (S)
Scarce clinical supervision	2 (V)
High turnover rate	6 (S)
Stigma on mental health	4 (S)

In the interviews, participants expressed certain characteristics of the institutions they worked for that prompted several difficulties. Being overloaded with work was the most common characteristic. This issue was described by some participants as an excessive amount of administrative work (3) and by several others (8) as a heavy caseload that was disproportionate to the number of hours they were hired for. Consequently, healthcare providers have very limited appointments per patient. Some of the participants that had full-time contracts had over 140 cases they had to provide therapy for. The former can be illustrated by this quote by Psychologist K:

"*One can't do much with 22 hours (part-time contract). And that is the truth. My 22 hours are completely filled with work, I can't even breath in normal times without the social uprising, without the pandemic… the caseload is very heavy, very, very, very heavy, and sometimes I don't see them (patients) in over a month, sometimes it's a month and a half, two months, so the bond... the bond. I don't feel like the treatment has continuity.*"

Regarding the excessive amount of administrative work, healthcare providers specially mention having to fill out a lot of paperwork, particularly their patients' medical file. Psychologist J explains that *"in 45 minutes I had to see the patient, enter my notes of the session and then fill in the medical file. In the end, filling out the paperwork was more important than the therapy you were providing."*

Psychologist N stated that he ended up working far more than the 22 hours he was hired for, having to take home work and paperwork to fill out because he didn't have enough time to do it at work. Regarding this, Psychologist N describes the following:

"I work much more than 22 hours, but I try to block my weekends, not do work stuff, but that has led me to accumulate a ton of work. I wake up in the middle of the night and say "oh crap, the paperwork" and then I fall back asleep, but it's like I'm constantly thinking about it."

Another issue mentioned by several (5) participants was that the institutions they worked at expected them to meet certain requirements rather than providing quality mental healthcare to patients. According to the participants, this mainly occurs because institutions receive funding based on the number of patients they give care to and not the quality of the interventions they provide. Funding priorities are also based on certain pathologies so, institutions receive funds for providing therapy to patients with a diagnosis of depression, but not those with personality disorders. This means that in many occasions, institutions prioritize treating certain patients more than others. Regarding this issue, Psychologist J states the following:

"I'm sorry, I'm not really positive about how the public mental health service works. In my experience, there is a design issue, where you have to provide an effective treatment, in short sessions, for a time restricted period, with certain

indicators, and these indicators aren't necessarily focused on improving the services provided (…) I remember being very frustrated in the COSAM because the only important thing was that the patient came to the sessions."

Further, the high turnover rate was mentioned by many participants (6) as a negative aspect of working in public mental health institutions. Psychologist H reflects on her first days on the job:

"*When I started my patients would ask me how long I was going to stay. That's how damaged patients were when it came to turnover in the mental health area, also having to tell their story again. They would say "before you, there was another therapist that stayed 2 months and then left." These patients had to open their conflicts, emotional world with someone who is going to leave (…)".*

An underlying theme mentioned in the interviews by some participants (4) was that mental health was stigmatized by healthcare providers, patients' families and even patients themselves. Psychologist G said that many of patients confided him with issues that no one else knew because they thought if they told other people they would be judgmental and find them crazy. Stigma was also observed between different types of professionals, where doctors were always prioritized. Meanwhile, other mental healthcare professionals were not valued as much. Psychologist K addresses this issue also:

"Everyone know that mental health is the last priority. They know that we, the psychologists, have an excessive number patients and that we could work more hours to lessen our workload, but they won't increase our hours because they will always give them to a doctor. That's one of the most frustrating things about the public service, they don't recognize psychologist or social workers."

Moreover, the participants observed that even mental health staff had a stigmatized view about their patients' diagnosis and treatment, especially those with personality disorders. Patients were often labeled as "burdens" and there were misconceptions about their prognosis. Subsequently, some professionals avoided treating these patients or simply refused to. Psychologist H elaborates on this topic:

"Doctors frequently have a resistance to treat mental health patients. "No, I don't want to see them, I don't want to see children, I don't want to see adults, I don't want to see depressions, I don't want this". This position, in my opinion, is also violent and discriminatory towards a person's mental health condition. So, I think there are several elements there, that in general… doctors or professionals don't have the disposition to see patients with mental health conditions. I actually prefer that they don't see these doctors."

Regarding this point, Psychologist E describes the following:

"When you have a patient that has been diagnosed by twenty people, all giving him a different diagnosis. Or he's been given a cocktail of medication that has several effects, they take away his appetite, that make him impotent, angry, they give him a dry mouth, (…) etc. That patient comes in feeling hopeless."

Psychiatrist I also elaborates on the stigmatized view of patients on behalf of the mental health staff:

"*I hear psychologists and psychiatrist say many times things like: "well, this person has a Personality Disorder, there is nothing that can be done, they will always be this way." And I swear that this is a stigma and that if the same people that work in mental health foster that stigma… what's left for the rest of the people?"*

6.1.1.2 Challenges regarding the clinical treatment

Table 5 – Negative working conditions – Challenges regarding the clinical treatment

Challenges regarding the clinical treatment	
Low frequency of sessions	10 (M)
Limited session duration	4 (V)
Difficulty to apply treatments, techniques and knowledge	10 (M)
Challenges within the public service network	9 (S)
Limited number of sessions or treatment duration	1(V)
Long waiting lists	1(V)

This theme addresses the challenges that come from specific conditions of the clinical treatments regarding practical aspects of the therapy provided in public mental health settings. In other words, these challenges are a group of concrete factors that conditioned what therapists were able to do within their treatments. First of all, most participants (10) reported that they weren't able to see their patients once a week, like a standard psychotherapy process. Psychiatrist I reported the following regarding this subject:

"I see patients once a month, once every 6 months and that's the psychotherapy that patients get. So, that's when you say "too bad", because maybe if these patients had more money and could go twice a week, once a week or even once every two weeks things could be different."

Furthermore, some respondents (4) said that therapy was hard to provide because their sessions were shorter than the standard 45 minutes for psychotherapy. Psychiatrist M explained that he had to see patients 30 minutes, which is something that he and his colleagues were intending to change:

"Well, and the other problem of the clinical treatment is that those 30 minutes are too short, and that's one of the issues we're going to fight for now; that they give us 45 minutes (per patient) (…)".

A second challenge mentioned by the majority of participants (10) was the difficulty to apply specific treatments, techniques and knowledge to the Chilean public mental health service. Participants said that even though they might have specific knowledge regarding how to treat certain patients or pathologies, it was nearly impossible to apply them because of the low frequency of sessions, the patients' attitude towards therapy and their cognitive limitations, lack of proper infrastructure and a shortage of financial resources. Psychiatrist A elaborates on this in the following quote:

"Now, what's frustrating is that there are so many techniques that could be implemented, but the resources become so scarce. The time you have is scarce. If you wanted to, for example, do TFP (transference focused therapy), it's difficult to do in the public health. Things similar to DBT (dialectical behavioral therapy) have been done (…). But there is always this ambivalence, there are some really good techniques, but there is algo a lot of: "unfortunately, we can't do that."

Psychiatrist L also elaborates on this issue:

"(…) You may have the knowledge, but you don't have the appropriate space, infrastructure nor financial resources. Let's just think about the financial resources, they're nonexistent. So, if you don't have resources, you can't treat them (…)"

Most respondents (9) experienced another challenge regarding clinical treatments; they found it difficult to work within the public health network. In other words, clinicians had trouble communicating and coordinating with other public health institutions. Subsequently, therapist faced several complications when trying to refer their patients, for example, to a specialized program or inpatient treatment. This was especially common with patients that had problems with drug and alcohol abuse or that were suicidal.

Difficulties with referrals were due to long waiting lists, lack of openings for clinical treatments and institutions that were unwilling to treat certain patients. This resulted in patients *"bouncing"* back to the original institution without being able to receive the specialized treatment they required. This problem was particularly frequent in primary care institutions because they are supposed to manage most of the patients with mental health issues, while secondary and tertiary level institutions are meant to treat only severe cases that require specialized care. However, the participants noted that when primary level institutions tried to refer more severe cases to secondary level ones, they were often rejected because they weren't considered *"severe enough."* This meant that these cases had to be managed by primary level institutions that don't even have a psychiatrist on staff. Regarding these issues, Psychiatrist I states the following:

"For example, one of my patients has a schizoaffective disorder and an alcohol addiction, a long-standing alcohol addiction. And the alcohol addiction triggers a psychotic episode that makes him more aggressive, he makes a wreck out of everything and his family doesn't care, they don't want to be in charge (…) This type of patient doesn't have a place in the public system's network, he doesn't exist, because you go to a therapeutic community (rehab) and they reject him. You go to another one and they say "no" because he needs to be treated for his psychosis first. Then you go to the legal system and they say "no, he didn't commit any crime that warrants incarceration, so he can't be withheld against his will. So, the patient is bounced around and, in the end, which is his destiny? Being re-hospitalized."

Psychiatrist L had a similar experience with patients being "returned" from the institution he referred his patients to and the personal consequences that this entailed:

"If the patient is a severe case, many times I will go over the session's time, I'm late with my next patient, I get stressed. And, on the other hand, it's a severe case so, you want to hospitalize him but you can't. It's typical, you say "I want to hospitalize this patient tomorrow", I refer him to the ER, there are no hospital beds, so they return him to my institution and I spend two months working with someone who should have been hospitalized. Many times, the patient recovers in the meantime, but at a personal cost because you had to see him at least once a week which meant working overtime with no extra pay. You're worried about something happening to him, you have to contact the family (…)"

6.1.1.3 Challenges within the clinical teams

Table 6 – Negative working conditions – Challenges within clinical teams

Challenges within the clinical teams	
Difficulties within the relationships	2 (V)
Divergent perspectives on how to manage cases	3 (V)
Lack of policies that provide care for the teams	2 (V)
Lack of time to work as a team	1 (V)

When the respondents described their work in public mental health settings, most participants mentioned that they had to work within a team. Although many described positive aspects of working with others (which is addressed later on), others mentioned difficulties with their teams and their members. First of all, a couple of participants (2) experienced tension with their colleagues due to personal factors. Psychologist M, for example, states that working within a team had made his job more stressful than when he worked alone:

"Sometimes I've asked some of my teammates for help with things and they don't do them. Sometimes I've asked a social assistant to call a patient weekly to check-up on them and then I realize that the patient was called once and nobody has followed up on him. In that sense, it's been frustrating, it's been more of a frustration than a protective factor."

Some participants (3) stated they had challenges within their teams because of divergent opinions on how to manage their cases. In other words, it was very complicated to reach a consensus about the patients' treatments among team members. Psychologist D explains that it was very difficult to have his opinion taken into account and reaching an agreement on how to treat certain patients. In his case, this was mainly caused by other clinicians that would refuse to take his opinion into account because their theoretical approach differed from his.

Other participants (2) referred that their institutions tried to prevent burnout and improve relationships between co-workers by having self and team care workshops or activities for the staff. Nevertheless, these workshops and activities were considered to be ineffective. Psychologist J explains that the institution where she worked at organized barbeques to care for their employees, however, it didn't fulfill the purpose of actually helping him, instead he felt obliged to socialize with people he didn't get along with. Psychologist H also had a similar experience:

"We do have "self-care" events, but ¿real self-care? No. They're more like occasions to hang out, to do something different, talk about anything else, but not self-care that would actually make a difference for the team's mental health, something like "lets supervise our cases, take care of our mental health, for our patients". No, that actually doesn't happen."

6.1.2 Lack of resources

Table 7 – Negative Experiences of working in Public Mental Health Settings – Lack of resources

Lack of resources	
Low salary and/or delayed payment	3 (V)
Lack of mental health professionals	7 (S)
Lack of professionals with proper clinical training	8 (S)
Lack of adequate infrastructure	4 (V)
Lack of materials for psychotherapy	2 (S)
Lack of psychiatric medication	3 (V)
Lack of specialized treatments	4 (S)

Note. N = 15. M: most (10 – 15 participants); S: several (5 – 9 participants); V: some (1 – 4 participants).

In the interviews, participants mentioned that there was a significant lack of resources within their institutions that affected several different aspects including low salaries, lack of mental health professionals, lack of professionals with proper clinical training, lack of specialized treatments, among others.

Several participants (7) pointed out that their institutions were lacking mental health professionals in general. Psychologist G pointed out that it was very difficult for him to refer his patients to see a psychiatrist because *"medical appointments here are scarce. Very, very scarce. Psychiatry appointments are even more scarce."* Psychologist B also perceives a lack of professionals due to insufficient investment in this area:

"(…) No funds are invested in public health, it's not a priority. There is never a replacement when someone is on medical leave, it's really hard. (…) There is always a scarcity of resources."

Beside the shortage of mental health professionals, some participants (8) further perceived that many professionals did not have the proper clinical training to treat patients. Psychologist D illustrates this by the following statement:

"The public service network is poorly articulated, clinical teams don't have proper training nor specialization. I've realized that. When clinical teams don't have the ability to work with a complex patient that is diagnosed with a personality disorder, we can't do anything. For example, last week the team from an inpatient care center called me telling me they're going to discharge a patient because they don't know what else to with him, that he's very narcissistic and perverse."

Regarding this same topic, Psychologist O thought that *"(…) the public service needs to invest more, invest in providing quality training for the professionals that work there, because with the salary they pay it's impossible for professionals to pay for their own masters or Ph.D."*

Psychologist J had worked in an institution in an isolated location, where professionals had even less training. She explains that "*(…) it was like living in the 80s, in terms of the interventions, intervention models, ideologies. The knowledge was very outdated. Not much was up to date. Therefore, the interventions were ones that nobody did anymore. That made things even more complicated."*

Some participants (4) indicated that the lack of resources was also reflected in inappropriate infrastructure to provide treatment. Psychiatrist M says that:

"The infrastructure is not good because it's a very narrow house, so the offices are on different floors. Then we don't have an elevator and that has always been a problem for us (they are not accessible to everyone). And one of the major issues we have is the infrastructure because, additionally, we don't have enough offices."

Psychiatrist L also comments on this issue, explaining that *"there is an immense precariousness, I don't even have a heater in winter."* Psychologist O also addressed significant issues regarding the infrastructure which led her to take matters into her own hands:

"Look, I don't know if there was an uglier, darker, and more humid room, and that's where we saw kids. Well, and honestly, I'm a motivated person so I painted it, I brought a new computer monitor (…) I painted the room whiter because it was tiny, I put in a little rug (…) to make it a little cozier."

6.1.3 Negative Patient characteristics

This category refers to common characteristics that patients have in public mental health settings. These characteristics tended to increase the complexity of the treatment and the negative experiences of healthcare providers in public mental health settings.

Table 8 – Negative Experiences of working in Public Mental Health Settings – Patient characteristics

Negative Patient characteristics	
High proportion of difficult patients	4 (V)
Acute psychosocial vulnerabilities that interfere with progress in therapy	2 (V)
Patients that do not adhere to therapy	1 (V)

Note. N = 15. M: most (10 – 15 participants); S: several (5 – 9 participants); V: some (1 – 4 participants).

According to the participants of this study, therapeutic work in the public mental health was especially challenging due to three main characteristics of the patients. Specifically, some therapists (4) mentioned a large proportion of the patients were very complex cases, others (2) reported that the patients didn't adhere to therapy and one stated that they had psychosocial vulnerabilities that interfered with the progress of their treatments. Psychologist G estimates that around 70% of his patients are very difficult cases, 20% have chronic symptoms, and only 10% are rather stable patients. Psychiatrist C reported having around 150 to 180 patients and also states that most of them are difficult patients where there isn't "*enough mental space to remember them all (…), how many borderline patients can one sustain without having their treatments being interfered?"*

Psychologist N specially had difficulties with those patients that didn't adhere to therapy:

"In the end I had the same patient assigned to me eight times. I read his medical file and saw that there were records from years ago, with therapists that don't work here anymore. You look at their problems and they're the same, so these patients are eternally coming here."

Psychologist G gave special emphasis to how vulnerable public service patients were. He explains that patients sometimes would arrive without having had a meal during the entire day. Therefore, it was difficult to make progress in therapy when even their basic needs weren't met.

6.1.4 Negative impact on mental healthcare providers

Table 9 – Negative Experiences of working in Public Mental Health Settings – Negative impact on mental healthcare providers

Negative impact on mental healthcare providers

High levels of frustration and burnout	9 (S)
Lack of empathy towards patients suffering	4 (V)
Dehumanize their patients	5 (S)
Overinvolvement in cases	1 (V)

Note. N = 15. M: most (10 – 15 participants); S: several (5 – 9 participants); V: some (1 – 4 participants).

When asked about their experience working in public mental health settings, most participants addressed that it had a negative impact on their mental health. The most recurrent theme (9) mentioned by the therapists was the participants' feelings of frustration and burn out while working in public mental health services. Healthcare providers explained that they felt frustrated due to several different causes that included many of the aforementioned factors: negative working conditions, the difficulty of the patients, the lack of resources, difficulties with the work team, among others. These issues led healthcare providers to perceive that there were many obstacles that they had no control over. Thus, they believed that the care their patients received was low quality and that they couldn't do much to improve it. Psychologist J comments the following regarding this topic:

"Frustration associated with what I've already said, sometimes there are things that you just can't manage because they're related to the context, the environment, the education, the public health service, with public policies."

Psychiatrist I also addressed this issue:

"(…) it's so hard to deal with certain issues, what's difficult here is that there isn't a proper structure to support the patient. There isn't a family structure, nor institutional, nor health, nothing. So, these patients become difficult because you get really frustrated. For example, I saw a patient come in four different times. I wondered what happened, we would give him medication and two weeks later he would be fine. But it's like Groundhog Day, it's like same things happen again and again. And that's when I say: "if this person had appropriate outpatient support, he wouldn't have to be hospitalized.""

Psychologist D illustrates how the public mental health service's setting frustrates their employees and, subsequently, patients don't get the help they truly need:

"Mental health becomes the underprivileged relative we ask for money to cover other issues we have, administrative issues. And the teams are burnt out, overwhelmed. So, what happens? A patient comes in with a complex diagnosis of personality disorder, they can't refer him to a specialized service or rehab, so they call him back for another session in another month because there are no earlier openings. This makes the patient not want to return and it's a relapse, after relapse, suicide attempt after attempt, cut after cut. The team does a pseudo cognitive behavioral intervention and that's it. Patients aren't emotionally regulated at all."

Psychologist N explains how having to work with other institutions within the public health network is particularly difficult:

"*I feel trapped (…) that's the feeling I get by working here, it's almost like learned helplessness. I have a severe patient, I have to work with certain institutions, but those institutions aren't working how they're supposed to. So, it wears you down. This made me super stressed."*

This same therapist later explains that he ultimately ended up quitting his job in the public mental health service because he felt that he was burnt out and it was affecting his health:

"*I thought I was going to work for years in the public service and that idea fell to pieces because I don't want to live in these conditions. (…) I felt that this job was harmful (…) I'm never going to work in these conditions again, a place where I can't regulate the number of patients I see, how many times I see them, the setting, the length. I won't work in a place where I can set those boundaries for myself. In the end that's what happens, you end up burnt out."*

Several participants (5) observed that healthcare providers started to dehumanize their patients, losing sight that they are working with another human being and that their role is to try to help them. Psychologist D addresses this issue in depth:

"*(…) patients worsen, they get worse in these dynamics, in these teams that play with ethical and legal issues because of the lack of supervision from the health department. The health department is only interested in data. ¿How many depressed patients do we have? 100. Perfect, that reaches the minimum we need to get financed. Done. That leads the patient to be in "no man's land". When I worked in public mental healthcare, the administration required me to report certain number of patients for the depression program. If you want to have a specific medication available, if you want to earn this much, you have to report depressed patients. It was like: "who is sad? Welcome to the depression program". But the system is perverse and it abuses and re-traumatizes the patients. Patients that have been violated and that are more vulnerable in terms of their personality. So, it's complicated, it's a super complicated scenario. It's also complicated to deal with that."*

The following quote by Psychologist N also reported a similar experience:

"It's something that I have to constantly fight with. I am providing treatment and everything, but how effective is it for the patient? How is it meeting the objective of the patient actually changing, or becoming less aggressive? To actually contribute and not just let time pass. I'm always conflicted because that's what happens in the COSAM, it's like ok, we met the minimum requirement and patients are treated like they're just a number."

On a similar note, some healthcare providers (4) noted that they had a lack of empathy towards their patients' story and suffering. According to Psychologist N,

"These dynamics end up exhausting you. I understand that you can be sick of the job, and I get that you're fed up with it, but make a move when you see that your patient is at risk, in the end that's what happens, you start becoming desensitized, you no longer perceive the risks (of your patients)."

6.1.5 Perceived iatrogenic effect on patients

Table 10 – Negative Experiences of working in Public Mental Health Settings – Perceived iatrogenic effect on patients

Perceived iatrogenic effects on patients	
Patients become chronic	7 (S)
Public health system reinforces the pathology	2 (V)
Ineffective treatment	6 (S)

Note. N = 15. M: most (10 – 15 participants); S: several (5 – 9 participants); V: some (1 – 4 participants).

One factor that contributed significantly to participants' negative experiences was the perception that the clinical treatments that were provided in public mental health had an iatrogenic effect on their patients. Many participants (7) noted that the treatment either worsened the patients' condition or made it chronic. In other words, their patients' symptoms became persistent in time and had long-lasting effects on their mental health. Psychologist G shares his experience regarding this:

"It's complicated because in a psychiatric hospital it's easy to regulate a patient, it's super easy. However, the patients can also become chronic, I have a colleague that works in a public hospital in a Personality Disorder Unit. He tells us to not refer patients there because it's a bad institution, they only make their disorders more chronic."

Psychologist J also addressed this topic in the interview. From her point of view, patients' symptoms became chronic because public health institutions measure how many appointments they provide and not the efficacy of the treatment. She stated that "*in the COSAM they measure the number of appointments, so it's great if a patient comes every week for 10 years. (…) It's terrible to say it, but that's what it was like. As a professional, it ended up being very frustrating."*

Several participants (6) also perceived that the treatment they provided was ineffective. Participants pointed out that they felt that the work they did with their patients did not foster improvement. Psychologist K commented that *"I'm sure that if we saw many of the patients we see here in a private mental health setting or somewhere that they could get quality care, have sessions once a week at least, I'm sure they would improve tremendously, one could do many things."*

Some participants (2) even considered that the public system actually reinforced the patients' symptoms or pathology. The therapists perceived that this mainly occurred due to the staff's deficient training on how to deal with the public system's patients and their difficulties. They also observed that in some occasions the administrative staff also contributed to this issue because they didn't know how to manage patients. Psychologist J gives the following example:

"They had a symptom that was associated to a personality issue that they always had and they always did the same things. And in the COSAM they gave him tea and had him sit the entire day on the couch. And everybody was comforting him, because that's what my colleagues did. This patient was always going to come back and do the same thing. And that's what happened, every certain amount of time he would come in and everything. So, the system reinforces it a lot, it reinforces their pathology."

6.2 Positive Experiences of working in public mental health settings

6.2.1 Positive working conditions

Table 11 – Positive Experiences of working in Public Mental Health Settings

Categories	Participants

Positive working conditions	
Positive institutional characteristics	
Work and clinical protocols	3 (V)
Effective self and team care workshops	1 (V)
Opportunities to work with the community	1 (V)
Positive aspects of clinical teamwork	
Opportunity to work in an interdisciplinary team	9 (S)
Team meetings and formal supervision	5 (V)
Informal instances to discuss cases	4 (V)
Informal referrals among co-workers	2 (S)

Note. N = 15. M: most (10 – 15 participants); S: several (5 – 9 participants); V: some (1 – 4 participants).

Positive working conditions were mentioned less frequently, unfortunately. However, there were some positive aspects of working in the public mental health service which included positive institutional characteristics and positive aspects of clinical teamwork

6.2.1.1 Positive institutional characteristics

Table 12 – Positive Experiences of working in Public Mental Health Settings – Positive institutional characteristics

Positive institutional characteristics	
Work and clinical protocols	3 (V)
Effective self and team care workshops	1 (V)
Opportunities to work with the community	1 (V)

Note. N = 15. M: most (10 – 15 participants); S: several (5 – 9 participants); V: some (1 – 4 participants).

Participants mentioned that even though working in public health settings was, in general, frustrating, there were some benefits. First of all, some therapist (3) mentioned that their institutions had clear protocols of how to work with patients; when and where to refer them and how to plan treatments. Psychiatrist A describes his positive experience in the following quote:

"So, my experience, I mean, comparing myself with other colleagues that work at different institutions, I can tell that I have a lot more tools because I know what my limits are, who to work with, what to do and how to organize treatments. It follows certain protocols. So, in that sense, it's been very positive."

Contrary to what some of other participants mentioned previously, Psychiatrist A mentioned that in his institution they had effective self and team care workshops that had positive effects on his clinical team's mental health. In his case, each team member had to prepare a workshop that involved a group interaction and include activities regarding their cases.

Another positive experience mentioned by one participant was that her institution truly had the intention to work with the community and provided opportunities to do so. Regarding this positive experience, Psychiatrist M says this:

"Our institution does try and makes the effort to work with the community with the tools they have, which are always scarce. In fact, every year we have an activity with the community where we meet with different neighborhood representatives and groups."

6.2.1.2 Positive aspects of clinical teamwork

Table 13 – Positive Experiences of working in Public Mental Health Settings – Positive aspects of clinical teamwork

Positive aspects of clinical teamwork	
Opportunity to work in an interdisciplinary team	9 (S)
Team meetings and formal supervision	5 (V)
Informal instances to discuss cases	4 (V)
Informal referrals among co-workers	2 (S)

Note. N = 15. M: most (10 – 15 participants); S: several (5 – 9 participants); V: some (1 – 4 participants).

In the interviews, a recurring theme among the positive experiences was working with a team. One of the most significant benefits mentioned by several of the participants (9) was the opportunity to work in an interdisciplinary team. Participants felt that they could learn from their co-workers and also rely on them to make clinical decisions about their patients. Regarding this topic, Psychologist K says the following:

"Besides the frustration, I really like working in the public service, I really like working with my colleagues, with the social workers, with the doctors, I enjoy it. You learn from all these different professionals, from midwives, physical therapists, dentists. But it's super important to know that you're working in Chile's public service and we all know it has its wounds."

Another benefit of working with a clinical team was that it was a lot less lonely than working in a private practice. Several (5) participants described having frequent team meetings where they were able to talk about their work and supervise their cases and plan treatments. Psychologist B described that in her workplace they had weekly meetings. However, she recognized that it was a privileged and that is rather uncommon in the public health service.

As reported by some participants (4), working with a team also allowed the healthcare providers to be able to have informal instances to discuss and ask their colleagues questions about their cases. Psychologist O illustrates this with the following statement:

"Working in private practice is very solitary, so here it's possible to have instances to supervise (…) and with patients this difficult it's much better to have an interdisciplinary treatment. It's better that different professionals see the patient and not having to deal with him on your own."

According to some of the therapists interviewed (2) working with a team also had the advantage to be able to make informal referrals among co-workers. For example, in a situation where a certain healthcare provider had little experience in a particular area or type of pathology, they had the opportunity to refer their patient to a co-worker with more expertise.

6.2.2 Positive impact on public mental healthcare providers

Table 14 – Positive Experiences of working in Public Mental Health Settings – Positive impact on public mental healthcare providers

Positive impact on public mental healthcare providers	
Opportunity to acquire unique clinical knowledge	3 (V)
Feeling gratification with their work	7 (S)

Note. N = 15. M: most (10 – 15 participants); S: several (5 – 9 participants); V: some (1 – 4 participants).

The respondents described two positive outcomes of working in a public mental health setting. First, some (3) considered that the clinical knowledge they acquire from working in the public service was unique. Psychologist O expressed the following regarding this subject:

"The public service has been very useful. It has its disadvantages, personally, I'm completely burnt out with everything I have to do, but I feel it has given me a different perspective on my patients and my clinical work. I truly appreciate that. So, it does have a positive side to it."

The second positive outcome according several respondents (7) was that they felt gratified with their work. There were different reasons why participants felt this gratification. Some felt like they were making a contribution to the public service. Others felt highly satisfied because, in spite of all the challenges due to the working conditions, they were able to help their patients. Some participants also felt pleased because they saw breakthroughs in their patients even though they had complex pathologies or had severe psychosocial vulnerabilities.

It is noteworthy to mention that some of these positive experiences seem to contradict the aforementioned negative experiences. This seems to be more noticeable when it came to the institutional characteristics. This difference can be explained, in part, by a significant funding and administrative gap between institutions. Psychiatrist L works simultaneously in two different institutions; therefore, he can exemplify this gap from his own experience:

"The funding of these institutions depends on the Municipality they belong to. In Institution A there are very few resources and it is poorly administrated. Institution B has a fair number of resources and it is well administrated, so we have all the medication we need, for example. It really doesn't function any different from a private service institution."

Psychologist B also compared her experience with those that worked in another facility nearby:

"I feel like we're really fortunate here and I hope it doesn't change because it really allows you to make progress and work more. I see the difference with Institution C, they have a completely different reality. We're practically neighbors but our reality is different regarding the human resources and turnover. There is no investment in public health, it's not a priority. There is always scarce funding, that why I'm telling you that we feel privileged."

7. Discussion

The results portray the experience of 15 different healthcare providers working in public mental health settings in Chile. Most participants identified both negative and positive aspects of their experiences, which is consistent with the existent body of literature regarding experiences of working in public mental health settings in other countries (Looi & Maguire 2019; Pilay et al., 2012; Sciberras & Pilkington, 2018; Solomon, 2019). However, the negative experiences were much more prevalent than positive ones. Similar to other research, therapists reported several difficulties related to the characteristics of the institutions they worked for, such as a heavy caseload and excessive amount of work (Dallender & Nolan, 2002; Fischer et al., 2019; Morris, 2011; Lasalvia et al., 2009; Pilay 2012; Rupert & Morgan, 2005; Scharager & Molina, 2007; Solomon 2019). Participants mentioned feeling that these issues contributed to feeling overwhelmed and ultimately burnt-out. The effects of a heavy caseload and/or excessive amount of work has been previously related to the development of burn out (Lasalvia et al., 2009; Lee at al., 2020).

Another common negative experience was that therapists had many challenges regarding the clinical treatment and setting. Specifically, having shorter sessions (less than 45 minutes), having them being spread apart for up to over a month. Similar difficulties were also reported by other studies done in Chile (de la Parra et al., 2019; Fischer et al., 2019; Scharager & Molina, 2007). Due to the challenges and limitations that stem from the characteristics of the treatments in public mental health settings, participants found it very difficult to apply treatments, techniques, and knowledge to this specific context. This may be explained by what other studies in Chile have discovered about the lack of specific education about the characteristics of working in public mental healthcare (de la Parra et al., 2019; Fischer et al., 2019; Scharager & Molina, 2007), making it hard for mental health professionals to replicate their skills and knowledge in such a difficult context.

Contrary to what has been described by prior literature, working in a clinical team generated complications for some participants. They felt that it was difficult to agree on how to manage cases and that personal issues between each other interfered with the work. There isn't any evident explanation for why only some of the participants had this experience. However, research should be conducted to clarify this issue because feeling support from a clinical team is a protective factor for burnout (Avedaño, 2009; Norris, 2011; Onyett, 2011; Singh et al., 2020), as it is mentioned below.

One of the most significant findings within negative experiences was that there was a significant lack of resources. This lack of resources mainly led to consequences such as understaffing, lack of properly trained professionals and lack of adequate infrastructure. Funding issues and their consequences had already been described by prior research both in foreign countries (Kumar et al., 2013; Looi & Maguire, 2019; Morris, 2011) and in Chile (Errázuriz et al., 2015; MINSAL, 2017; Valdés & Errázuriz, 2012). Some of the findings of prior research were also found in this study. For example, that understaffing led the participants to have to pick up extra work that ended up increasing negative feelings towards their job (Kumar et al., 013; Onyett, 2011). The lack of properly trained staffed has already been addressed by former Chilean research (de la Parra et al., 2019; Fischer et al., 2019; Scharager & Molina, 2007). Participants in this study highlighted the fact that they felt unprepared to work in public mental health settings when they began. They also observed that many mental health professionals do not have adequate training to treat more complex cases like those in public services. Similar to the results of Looi and Maguire (2019), therapists also found that lacking resources also contributed to having inadequate facilities to work in, and this ultimately contributed to feeling unsatisfied with their job.

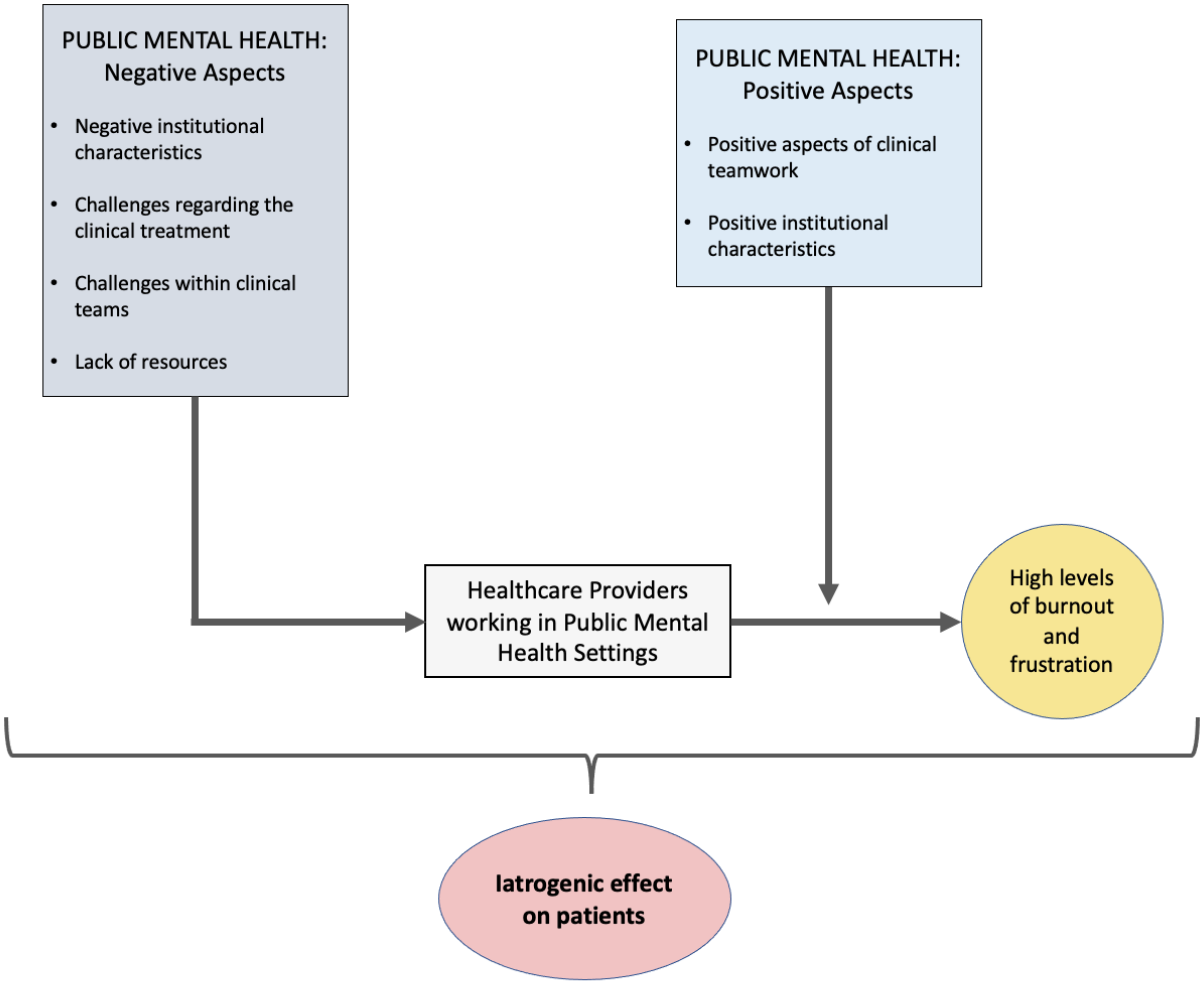

Figure 1 – Interaction of negative and positive aspects of public mental health services and its effects on healthcare workers and their patients

As Figure 1 illustrates, when taken together, the challenges posed by the Chilean public mental health setting has a direct effect on the mental healthcare providers. Most participants emphasized that their experiences had a negative impact on their mental health. As it was mentioned above, the negative aspects of working in public mental healthcare fostered feelings of frustration and burnout. Thus, several participants felt that there were many problems which they had no control over. If we look at prior research, lack of sense of control has been widely related to developing burnout (Lasalvia et al., 2009; Lee at al., 2020). Some participants identified that high levels of burnout and frustration led to other negative effects such as lacking empathy towards their patients, forgetting the fact that their patient is a human being, and getting overinvolved with their patients' cases. All these finding support the general idea that burnout develops from a personal experience facilitated in a specific work context where organizational factors are most determinant (Bambula & Gómez, 2016; Maslach, 2009; Lasalvia et al., 2009).

Furthermore, healthcare providers not only felt burnt-out due to the job's characteristics, they also became overwhelmed and frustrated about the poor quality of the therapy provided. Consistent with

what Fischer et al. (2019) describes, many participants felt that the treatment they offered was inadequate and/or ineffective. This eventually fostered the perception that public mental health treatments ultimately have an iatrogenic effect on their patients. In other words, the treatment provided in many cases actually had negative effects on their patients. This finding is certainly disconcerting since it emphasizes the idea that therapists feel that they harm their patients in some cases. Several participants noted that their patients' disorders were either exacerbated or became persistent over time. Moreover, some participants considered that the public system itself intensified the patients' condition. Some participants attributed these issues to the fact that they were obliged to prioritize certain protocols and requirements rather than focusing on providing an appropriate treatment. The therapists explained that this happens because institutions receive funding based on certain statistics and number of patients that receive treatment. Hence, institutions are evaluated and later funded depending on the number of treatments they provide and not the quality of them. De la Parra et al., (2019) had already described the complexity of this issue and the dire consequences that come from it.

Despite all of the negative experiences depicted by most participants, not all participants reported feeling burnt-out nor frustrated. Similar to prior research, some participants felt that working with a team provided support in many different ways (Norris, 2011; Onyett, 2011). Having regular supervision and feeling support from co-workers was reported as a positive aspect of their jobs. Some even felt that this was an advantage when comparing it to their work in private practices. In some specific institutions, there were also clear protocols of how to plan treatments and refer their patients, which participants found very useful. Consistent with previous research, feeling support from supervisors and co-workers, and having organizational resources to work with (such as treatment protocols) were associated with lower levels of burnout (Avedaño, 2009; Singh et al., 2020). In addition, further research should be conducted to comprehend the underlying factors that may explain the differences among participants regarding the experience of working within a team. It would be interesting and useful to understand why some participants experience working with a team as a positive aspect of their jobs and why others consider it a burden.

Although most of the therapists felt either frustrated or burnt-out, it appears that the positive aspects of the public mental health system in Chile described by the participants fostered a positive impact on mental healthcare providers that, in turn, was a protective factor against burnout. Some felt very gratified with their work and that it was worthwhile because they perceived that they were making a contribution by helping their patients as much as they could. Others felt that they benefitted from the experience because they acquired unique clinical knowledge that they couldn't have obtained elsewhere. These positive experiences moderated the effects that the challenging context had over the providers wellbeing.

Despite the fact that the stigma towards mental health mentioned by the subjects is not included in this model, it's noteworthy to mention that it is an underlying factor throughout the interviews. As the results show, patients were often stigmatized by their mental health struggles and diagnosis, even by their own mental healthcare providers. It seems that one underlying factor may be the lack of proper trained and informed professionals. Nevertheless, forthcoming research should focus on fully understanding the phenomenon and how to address it since it has a profound impact on patients' care.

Although we collected data from different levels of care, it was beyond the scope of this paper to address whether this affected the experience of mental healthcare providers.

Strengths and Limitations

The strength of this study is that it included participants that work in all three different levels of the Chilean public mental health service, that is, primary, secondary and tertiary levels. Thus, the participants also had different professions and roles within their institutions, providing a wider range of perspectives. This study also contributes to the scarce amount of literature that take into account the experience of healthcare workers and their wellbeing when working in public mental health services in Chile. The findings of this study may be valuable to highlight the importance of taking into account the experience of both clients and employees of mental healthcare services when creating and modifying public policies in Mental Health.

However, some limitations should also be mentioned. First, participants were selected through convenience sampling, which affects how representative the results are of the population. Further research should broaden the participants, taking into account participants other than those that are studying a post-graduate certificate. Another limitation is that only one participant of this study had worked in an institution outside of the Metropolitan region. Future research should try to expand to the experience of mental healthcare providers in other regions or remote locations.

8. Conclusion

It must be emphasized that feelings of frustration and burnout are attributed by most participants in this study to the characteristics of their jobs in public mental health services. It is interesting that not only burnt-out professionals are at risk of providing ineffective treatments for their patients, but some of the characteristics of the job itself could be interpreted as risk factors for providing inadequate treatment. Furthermore, participants perceived that in many occasions the treatment that was provided actually had an iatrogenic effect on patients. This finding has true relevance since it leads us to question: In this context, would the patient have been better off not receiving any treatment at all?

In spite of all the negative experiences, some participants had positive experiences such as feeling gratified for their work and acquiring unique clinical knowledge. This implies that different strategies may be adopted in order to promote more positive experiences. One option supported by the existing literature (de la Parra et al., 2019; Fischer et al., 2019; Scharager & Molina, 2007) is that training programs should include contents that are tailored to the challenges and conditions that arise when working in public mental health settings. This may better prepare professionals for this difficult context and prevent burnout and turnover.

REFERENCES

Alkhamees, A. A., Assiri, H., Alharbi, H. Y., Nasser, A., & Alkhamees, M. A. (2021). Burnout and depression among psychiatry residents during COVID-19 pandemic. *Human resources for health*, *19*(1), 1-9.

Atroszko, P. A., Demetrovics, Z., & Griffiths, M. D. (2020). Work addiction, obsessive-compulsive personality disorder, burn-out, and global burden of disease: Implications from the ICD-11. *International journal of environmental research and public health*, *17*(2), 660.

Avendaño, C., Bustos, P., Espinoza, P., García, F., & Pierart, T. (2009). Burnout y apoyo social en personal del servicio de psiquiatría de un hospital público. *Ciencia y enfermería*, *15*(2), 55-68.

Bambula, F. D., & Gómez, I. C. (2016). La investigación sobre el síndrome de burnout en latinoamérica entre 2000 y el 2010. *Psicología desde el Caribe*.

Bastidas Ruiz, M. M. (2017). Experiencia de psicólogos clínicos que trabajan en centros de salud mental al utilizar las estrategias de autocuidado como método para tratar el Síndrome de Desgaste Laboral (Bachelor's thesis, Quito: USFQ, 2017).

Bearse, J. L., McMinn, M. R., Seegobin, W., & Free, K. (2013). Barriers to psychologists seeking mental health care. *Professional Psychology: Research and Practice*, *44*(3), 150.

Bentley, M. C. (2014). How clinical psychologists experience working in an acute mental health inpatient setting.

Bradley, E. H., Curry, L. A., & Devers, K. J. (2007). Qualitative data analysis for health services research: developing taxonomy, themes, and theory. *Health services research*, *42*(4), 1758-1772.

Braun, V., & Clarke, V. (2014). What can "thematic analysis" offer health and wellbeing researchers? *International journal of qualitative studies on health and well-being*, *9* (1), -. https://doi.org/10.3402/qhw.v9.26152

Busch, I. M., Moretti, F., Mazzi, M., Wu, A. W., & Rimondini, M. (2021). What we have learned from two decades of epidemics and pandemics: a systematic review and meta-analysis of the psychological burden of frontline healthcare workers. *Psychotherapy and psychosomatics*, 1-13.

Carter N, Bryant-Lukosius D, DiCenso A, Blythe J, Neville AJ. (2014) The use of triangulation in qualitative research. *Oncol Nurs Forum.* (5):545-7. doi: 10.1188/14.ONF.545-547.

Celis-Morales, C., & Nazar, G. (2022). Cambios en la prevalencia de depresión en Chile y el mundo debido a la pandemia por COVID-19. *Revista médica de Chile*, *150*(5), 691-692.

Currid, T. J. (2008). The lived experience and meaning of stress in acute mental health nurses. *British Journal of Nursing*, *17*(14), 880-884.

Curry L, Nembhard IM, Bradley E. (2009) Qualitative and Mixed Methods Provide Unique Contributions to Outcomes. Research Circulation; 119: 1442-52.

Dallender, J. & Nolan, P. (2002), Mental health work observed: a comparison of the perceptions of psychiatrists and mental health nurses. Journal of Psychiatric and Mental Health Nursing, 9: 131-137. https://doi.org/10.1046/j.1365-2850.2002.00414.x

Errázuriz, P., Valdés, C., Vöhringer, P. A., & Calvo, E. (2015). Financiamiento de la salud mental en Chile: una deuda pendiente. *Revista médica de Chile*, *143*(9), 1179-1186.

González, C. (2021, April 15). La salud mental de los chilenos es la segunda que más ha empeorado en pandemia en el mundo. *El Mercurio*. Retrieved June 21, 2021, from https://portal.nexnews.cl/showN?valor=g5pss.

Glaser, B. G., & Strauss, A. (1967). The discovery of grounded theory: Strategies for qualitative research. *Chicago: Aldine*.

Goldenberg, J., & Molina, M. L. (2007) El trabajo de los psicólogos en los centros de atención primaria del sistema público de salud en Chile. *Revista Panamericana de Salud Pública. 22(3)*:149–59.

Green, A. E., Albanese, B. J., Shapiro, N. M., & Aarons, G. A. (2014). The roles of individual and organizational factors in burnout among community-based mental health service providers. *Psychological services*, *11*(1), 41.

Hagen, J., Knizek, B. L., & Hjelmeland, H. (2017). Mental health nurses' experiences of caring for suicidal patients in psychiatric wards: an emotional endeavor. *Archives of psychiatric nursing*, *31*(1), 31-37.

Hossain, M. M., Tasnim, S., Sultana, A., Faizah, F., Mazumder, H., Zou, L., ... & Ma, P. (2020). Epidemiology of mental health problems in COVID-19: a review. *F1000Research*, *9*.

Ipinza, W. (2010). Percepción del Burnout y Autocuidado en Psicólogos Clínicos Infantojuveniles que trabajan en Salud Pública en Santiago de Chile.

Johnson, J., Hall, L. H., Berzins, K., Baker, J., Melling, K., & Thompson, C. (2018). Mental healthcare staff well-being and burnout: A narrative review of trends, causes, implications, and recommendations for future interventions. *International journal of mental health nursing*, *27*(1), 20-32.

Kearney, A., Hamel, S., & Bordie, M. (2021) Mental Health Impact of the COVID-19 Pandemic: An Update. Kaiser Family Foundation. www.kff.org/coronavirus-covid-19/poll-finding/mental-health-impact-of-the-covid-19-pandemic. Retrieved July 13, 2021.

Kumar, R., Ahmed, J., Shaikh, B. T., Hafeez, R., & Hafeez, A. (2013). Job satisfaction among public health professionals working in public sector: a cross sectional study from Pakistan. *Human resources for health*, *11*(1), 1-5.

Kwong, A. S., Pearson, R. M., Adams, M. J., Northstone, K., Tilling, K., Smith, D., ... & Timpson, N. J. (2021). Mental health before and during the COVID-19 pandemic in two longitudinal UK population cohorts. *The British Journal of Psychiatry*, *218*(6), 334-343.

Lasalvia, A., Bonetto, C., Bertani, M., Bissoli, S., Cristofalo, D., Marrella, G., . . . Ruggeri, M. (2009). Influence of perceived organisational factors on job burnout: Survey of community mental health staff. *The British Journal of Psychiatry, 195,* 537–544. http://dx.doi.org/10.1192/bjp.bp .108.060871

Lee, M. K., Kim, E., Paik, I. S., Chung, J., & Lee, S. M. (2020). Relationship between environmental factors and burnout of psychotherapists: Meta-analytic approach. Counselling and Psychotherapy Research, 20(1), 164-172.

Lent, J., & Schwartz, R. C. (2012). The impact of work setting, demo- graphic characteristics, and personality factors related to burnout among professional counselors. *Journal of Mental Health Counseling, 34,* 355– 372. http://dx.doi.org/10.17744/mehc.34.4.e3k8u2k552515166

Liang, L., Ren, H., Cao, R., Hu, Y., Qin, Z., Li, C., & Mei, S. (2020). The effect of COVID-19 on youth mental health. *Psychiatric quarterly*, *91*(3), 841-852.

Looi, J. C., & Maguire, P. (2019). Surviving the heart of darkness: reflections on the experience of psychiatrists working in public mental health services in Australia. *Australasian Psychiatry*, *27*(6), 634-636.

Martínez, J. P., Méndez, I., Ruiz-Esteban, C., Fernández-Sogorb, A., & García-Fernández, J. M. (2020). Profiles of burnout, coping strategies and depressive symptomatology. *Frontiers in psychology*, *11*, 591.

Mahomed, F. (2020). Addressing the Problem of Severe Underinvestment in Mental Health and Well-Being from a Human Rights Perspective. *Health and Human Rights*, *22*(1), 35.

Ministerio de Salud de Chile (2017c). *Plan Nacional de Salud Mental 2017-2025*. Santiago: Minsal.

Ministerio de Salud de Chile (2018). *Red de Servicios de Salud Mental y Psiquiatría.* https://www.minsal.cl/portal/url/item/71e4f2dd2b638460e04001011f01239d.pdf. Retrieved 1July 15, 2021

Ministerio de Salud de Chile (2019). *Orientaciones para la Planificación y Programación en Red 2019*. Santiago: Minsal.

Morris, N. L. (2011). A grounded theory study of the experiences of clinical psychologists working in crisis resolution and home treatment teams (Doctoral dissertation, Cardiff University).

Muller, R. A. E., Stensland, R. S. Ø., & van de Velde, R. S. (2020). The mental health impact of the covid-19 pandemic on healthcare workers, and interventions to help them: A rapid systematic review. *Psychiatry research*, 113441.

Newton, R., Beasley, A., Bosanac, P., Castle, D., Copolov, D., Hopwood, M., ... & Tiller, J. (2019). The challenges facing the public mental health sector: implications of the Victorian Psychiatry workforce project. *Australasian Psychiatry*, *27*(6), 618-621.

Onyett, S. (2011). Revisiting job satisfaction and burnout in community mental health teams. *Journal of Mental Health (Abingdon, England), 20*(2), 198-209.

Ordenes D, Nadia. (2004). Prevalencia de Burnout en trabajadores del hospital Roberto del Río. *Revista chilena de pediatría*, *75*(5), 449-454. https://dx.doi.org/10.4067/S0370-41062004000500006

Organización Panamericana de la Salud (2009). Estrategia y Plan de Acción sobre Salud Mental. Washington DC: Organización Panamericana de la Salud.

Pillay, A. L., Kramers-Olen, A. L., Kritzinger, A. M., & Matshazi, V. (2012). Experiences of clinical psychologists working in public health service facilities. *Journal of Psychology in Africa*, *22*(4), 663-666.

Rupert, P. A., & Morgan, D. J. (2005). Work setting and burnout among professional psychologists. *Professional Psychology: Research and Practice, 36,* 544 –550. http://dx.doi.org/10.1037/0735-7028.36.5 .544

Sciberras, A., & Pilkington, L. (2018). The lived experience of psychologists working in mental health services: An exhausting and exasperating journey. *Professional Psychology: Research and Practice*, *49*(2), 151.

Sharrock J, Happell B (2006) Competence in providing mental health care: a grounded theory analysis of nurses' experiences. *Aust J Adv Nurs 24*:9–15

Singh, J., Karanika-Murray, M., Baguley, T., & Hudson, J. (2020). A Systematic Review of Job Demands and Resources Associated with Compassion Fatigue in Mental Health Professionals. *International Journal of Environmental Research and Public Health*, *17*(19), 6987. MDPI AG. Retrieved from http://dx.doi.org/10.3390/ijerph17196987

Solomon, W. (2019). *The work-related experiences of psychologists in public health facilities in Botswana* (Doctoral dissertation, University of Pretoria).

Streepy, J. (1981). Direct-service providers and burnout. *Social Casework*, *62*(6), 352-361.

Thompson, I. A., Amatea, E. S., & Thompson, E. S. (2014). Personal and contextual predictors of mental health counselors' compassion fatigue and burnout. *Journal of Mental Health Counseling, 36,* 58–77. http:// dx.doi.org/10.17744/mehc.36.1.p61m73373m4617r3

Thompson, M. N., Nitzarim, R. S., Cole, O. D., Frost, N. D., Ramirez Stege, A., & Vue, P. T. (2015). Clinical experiences with clients who are low-income: Mental health practitioners' perspectives. *Qualitative Health Research*, *25*(12), 1675-1688.

Valdés, C., & Errázuriz, P. (2012). Salud mental en Chile: el pariente pobre del sistema de salud. *Clave de Políticas Públicas*, *11*.

Veliz Burgos, A. L., Dörner Paris, A. P., Soto Salcedo, A. G., & Arriagada Arriagada, A. (2018). Bienestar psicológico y burnout en profesionales de atención primaria de salud en la región de Los Lagos, Chile. *Acta universitaria*, *28*(3), 56-64.

Vicente, B., Saldivia, S., & Pihán, R. (2016). Prevalencias y brechas hoy: salud mental mañana. *Acta bioethica*, *22*(1), 51-61.

Vollstedt, M., & Rezat, S. (2019). An introduction to grounded theory with a special focus on axial coding and the coding paradigm. *Compendium for early career researchers in mathematics education*, *13*, 81-100.

World Health Organization. (2013). Investing in mental health: evidence for action. World Health Organization. https://apps.who.int/iris/handle/10665/87232

World Health Organization. (2016). Global strategy on human resources for health: workforce 2030.

World Health Organization. (2018). Mental health: massive scale-up of resources needed if global targets are to be met.

World Health Organization. (2020). COVID 19 Public Health Emergency of International Concern (PHEIC). Global research and innovation forum: towards a research roadmap.

Yang, Y., & Hayes, J. A. (2020). Causes and consequences of burnout among mental health professionals: A practice-oriented review of recent empirical literature. *Psychotherapy*, *57*(3), 426.

Zolnierek CD, Clingerman EM (2012) A medical-surgical nurse's percep- tions of caring for a person with severe mental illness. *J Am Psychiatr Nurses Assoc 18*:226– 235