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*** Researches in Progress**

The use of audiovisual media in the construction of shared knowledge in health care: an experience in psychiatric emergency

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Abstract
This paper is the result of an extension of the research "Addressing the epidemiology of suicide risk at AP1&3 by means of a psychiatric emergency service" developed at ICICT/Fiocruz. It is an action research with exhibition of videos on health in the waiting room of one of the psychiatric emergency poles in Rio de Janeiro. The videos gave visibility to issues that are relevant to the construction of shared knowledge, i.e., to the combination of technical information with the social daily experience. It could be seen that this space allowed for discussions about other ways to produce and organize information on health, not only by the research team but also by entire organization. It was noted, however, that there is little investment in the production of good quality videos on health as well as the use of technological and audiovisual resources for actions on mental health. The use of audiovisuals as a tool to promote the production of new kinds of knowledge capable of democratizing information on health care deserves further investigation.

Keywords: Health Education; Mental Health; Psychiatric Emergency; Video on Health, Information.

This research investigates the Psychiatric Emergency device, equipment created to deal with psychological distress requiring immediate attention with minimal wait. This paper derives from the research "Addressing the epidemiology of suicide risk at AP1&3 by means of a psychiatric emergency service" developed by ICICT/Fiocruz, with funding from FAPERJ and support from VideoSaúde/FIOCRUZ. This service is located near the business center of the Rio de Janeiro city and is a "gateway" in mental health care, together with other three municipal units.

Three sets of problems directly associated with the ineffectiveness of this service can be pointed out: deficient training in general emergency, particularly in psychiatric emergency, during graduation in

Brazil (doctors, psychologists and nurses); lack of psychopathological crisis models oriented to the incidence of cases to the detriment of the emphasis on the prevalence of chronic/chronicized disorders; and the need to implement an urgency intervention network in the Psychiatric Reform that transcends the mere anti-asylum proposition, partially accomplished. Literature is limited, lacking observational epidemiological studies (either transversal or longitudinal) or even ecological studies. Qualitative researches have revealed the systematic practice of "ambulatory service", replacing and obliterating the qualified emergency care. New ways of approaching emergency have been proposed, with emphasis on prevention care as far as violence is concerned, with emphasis on mobile, home care and partial support.

The resources from the Public Health Service have been limited to the supply of substitute equipment to the asylum model, with bad use of the emergency device, which would avoid the expensive, painful and strenuous course of mental disorders, often treated inappropriately, dehumanized and careless regarding the epidemiological evidences available. False or naive dichotomies, of corporate nature, are still often encountered in the field, such as: psychotherapy versus psycho-pharmacotherapy; home treatment versus part-time institution; rehabilitation versus shelter/protection; concealing a fragmented, biased college education, with inadequate curriculum and lack of properly monitored training.

Situations of care to people in crisis, with acute degree of psychological pain, by health professionals available at any time, are unusual. The director of a unit estimated in 3/30 the daily care ratio of the cases really eligible, according to his opinion. What has been usually seen in a psychiatrist emergency room is mostly a contingent of patients and relatives waiting for "emergency care", which consists of ambulatory care, with long wait time and very short consultation time. It is worth noting that the level of understanding and the ability to use the emergency intervention in mental health by patients that seek assistance in public health care is very variable, either as a function of insufficient mental health literacy or due to a mental problem causing cognitive impairment.

The larger research consisted of conducting focus groups and semi-structured interviews addressing the suicide experience as well as observation work and field reports. The atmosphere in the waiting room has shown to be more important after the methodological triangulation, which required a deeper observation of the setting and the relationships that have taken shape there. This project of showing educational videos on mental health in the psychiatric emergency room has connection with the research on suicide prevention (CAAE - 0011.0.408.000-09), whereby the construction of a front-desk micro-ethnography and a study of the attending scripts began.

The reception lounge for patients who arrive seeking assistance – also paradoxically known as the emergency waiting room – is a wide space where you can see free demand for emergency care seven days a week, 24 hours a day. The degree of complexity of care is the most varied, from simple expectations such as the prescription of medications or adjustment of the drugs dosage to unquestionably emergency situations involving psychotic, schizophrenic, maniac or depressed patients with or without the risk of suicide. The patients come alone or accompanied by relatives and/or friends (many of them neighbors); sometimes they come by ambulance, in crisis, or to be transported to another institution. Therefore, in this space you can see people waiting for care, seeking information, keeping a variety of indirect links with the demanding subject or the care unit.

In general, you can describe it as an unstable setting with respect to a qualitative-quantitative analysis of attendance. The room may suddenly be overcrowded and also be a lull in the most varied times of the day. Necessarily there is not a particular time or week day more or less stable, except after 5 p.m., when the flow slows down considerably. Just as the presence of a patient in great psychomotor agitation – consolidating a stress atmosphere, as might be expected in situations of crisis – the reception at a given time may become extremely quiet, with patients waiting for prescriptions or medication adjustments or even people with no demand for care.

From the patients' and escorts' statements in the focus groups and interviews, we realized that the waiting room could be used for more systematic disclosure of information on health. The qualitative survey suggests that the users of that unit are interested in the exhibition of videos as a means of communication and dissemination of information about mental health. Bastos (2010) points out to the underutilization of the waiting rooms where users circulate and remain for some time lacking quality information about mental health, the network organization and the most prevailing disorders.

The initiative to implement a regular session of videos and evaluate its impacts as an alternative strategy for health promotion, instead of the traditional leaflets and folders, has shown to be timely and significant, seeking to transform the patients' wait into a moment of education and health. Ferry (2008) discusses the importance of the use of audiovisuals to support actions of social intervention in health, claiming that videos produced to interfere socially, when they integrate illness prevention

actions and health promotion, they enable access to information and the synthesis of new ways of thinking and acting. There was a bet on this "nothing to do/wait" space as one potentially capable of receiving a specific kind of intervention, such as a video workshop.

From a list of videos offered by VídeoSaúde Distribuidora, partially from the "Projeto Viva Legal" (Living Well Project) of the Ministry of Health, supposedly designed to be displayed to the users, and videos of varied contents, duration and language, a selection was made by an independent staff who passed from the thematic themes to the examination of the videos themselves, totalizing twenty initial titles. The titles ranged from general matters, such as "healthy food", "dengue" and "aging", to more specific ones, like "depression" and "licit and illicit drugs abuse". The insufficiency of titles and approaches on mental health, clinical psychiatry, psychology and critical patients care soon became apparent.

Meetings with the hospital directors were necessary to discuss the project objectives. Some questions were raised as potential difficulties, for example: technical aspects, such as the great distance between the TV set and the patients and the sound inadequacy; the pertinence of addressing themes like Mental Health among emergency patients; and aspects relating to the patients' educational and understanding level, taking into account their socio-cultural diversity. We decided to start showing the videos despite the difficulties, once a week, by way of experimentation. We offered to the hospital a copy of the videos so that a future video library could be implemented, and asked them to watch the videos and give a score to each one, so that we could jointly evaluate the best videos profile to be displayed.

We used the TV set already existing in the waiting room, installed on a high rack, trying not to change the setting already offered to the patients. The possibility of installing another TV set, closer, at a stand, was put away at first, because its location could somehow, due to its proximity, impose the programming on patients waiting for care. It was also important to consider that many patients in crisis might put the equipment at risk, as well as that they might not be stable enough to concentrate on the video or listen and absorb its content appropriately, i.e., they might develop adverse reactions or feel uncomfortable.

Though the sound did not appear to be appropriate, we installed the DVD player successfully and showed the movies. As the TV was too high (over three meters high), we needed a ladder to connect the DVD to the electrical outlet. So, we routinely took the DVD player from the Administration – where they kindly keep it for us – and then with the help of the maintenance staff we installed the equipment, adjusted the sound and displayed the videos. Whenever possible, the intervention was conducted by two members of the project so as to improve observation and the recording of the situations presented.

The initiative took place two or three times a week, during approximately 60 minutes. There was no criterion for the choice of the titles of the movies, being it open to the suggestions from users, relatives and even professionals from the hospital. Attention to the discourses and actions by all people present – as well as openness to the approach – enabled and even encouraged more in-depth conversations among those who were interested.

The researchers developed maps of attendance, the users' movement and attention to the videos, and the configuration of these maps was essentially based on the format of tables that crossed two fundamental variables: composition of the audience and attention of those present. We also used photos and filming as recording tools. After the interventions – at most 48 hours later – the field diary was completed, which contained individual detailed descriptions of events, observations, hypotheses and interpretations. This material passed to comprise data that were shared with the other members of the research team using Google Docs. Every two weeks there were meetings for field discussions and assessment of the data collected.

We conducted a total of 26 sessions, 11 of them in pairs and the remaining 15 individually. Throughout the period of nine months of the work (September 2009 to June 2010), four researchers participated.

Taking into account the individual differences and depending on the day that the videos were exhibited, the users showed greater or lesser interest in the themes. At times, everyone kept the eyes on the video; at other times, no one was interested; they talked, cried, stared at the floor, watched the TV momentarily, or moved restlessly. Often the users came to the researchers to talk about the quality of the presentation (sound, format, etc) and the contents of the videos, or even seeking attention and guidance. We observed more interest in the videos that dealt with issues related to their experiences (depression, drugs use, self-medication, etc); a notion that generated a feeling of enthusiasm, expressed in the reports and in the progress meetings.

In one of the exhibitions, in the very first times, we observed all patients and escorts interested in the video about depressive disorders (catalog number). Even the front desk employees and the doctors that crossed the room stopped to watch the movie for a while. On this particular day, there was silence in the room, the patients did not appear to be in emergency and the sound was clear and appropriate.

In those days when we had crisis situations, we could note much instability among everyone, from employees to the patients in wait; many times the cries of the patient in the ambulance invaded all settings, including the waiting room, while the others remained half paralyzed, stunned, hoping the situation to be over soon and the routine take over again. At such moments, the atmosphere was inappropriate for the videos, being necessary to turn down the volume and wait. Sometimes, even the most regular audience of some escorts waned, showing concern, distraction or unable to sustain attention for more than a few minutes.

Often, the employees and the healthcare staff were helpful to the technical demands, asking about the themes addressed and watching parts of the videos. This situation, however, many times gave rise to episodes marked by distrust or discomfort in relation to our regular presence. There were even times when the young interns of the research were the target of jokes by the waiting room staff, which did not occur, at any time, with users and carers.

The most discussed issues in the meetings were any lack of interest and the patients' low level of understanding; comments on the users' depressive process; and the poor performance of the TV audio. The notion that the patients were less interested than the escorts became clear. We admitted the preliminary hypothesis of the patients' circumstantial cognitive impairment and the escorts' practical concern in seeking solutions. Regarding the audience's judgment, favorable comments were frequent, although silence or lack of interest prevailed. Many reported, always spontaneously, that the videos session was very good, that the issues discussed were interesting, and that they would like us to present the videos more often and bring other themes.

The video on health should not be an end in itself, i.e., a mere transmitter of information to an assumedly neutral receiver. Thus, it is not the case of using the video to send information vertically, which makes the exchange between the interlocutors difficult (Bastos, 2010). The use of audiovisuals for health education should be characterized by its horizontality, without actually admitting a previous hierarchy between the speakers. Shared understanding helps the achievement of truly common objectives (Oliveira, 2000).

Our observations also pointed out to the need of discussing other ways to produce and organize information on mental health, and to think the communicative mediation process not only by the research team, but especially by the mental care institutions, such as CAPS, ESF and the basic units. Coherence with the institutional propositions and the team's engagement in designing the educational intervention seem to be crucial to expand its potential. The regularity, reproduction ability and sustainability emerge as equally important aspects, derived from public health campaigns. This kind of initiative, aiming to expand the communication between the professionals and the population "should be used under permanent assessment, to represent *another option*, a space to improve the access to information and the possibilities of communication and understanding of individual and collective health problems and the possibilities to deal with them" (Reis, 2006). Information-communication through a single channel or media is not advisable, neither the implementation of actions detached from the local settings, nor admitting it without permanent criticism either.

Ferrari et al. (2009) claim that the educational materials on health should not only be clear and objective but its use should be associated with group discussions to provide visibility to the community's doubts and practices, including information that meet the needs of the individuals and groups that there are present. As a matter of fact, those in a waiting room do not know each other or have a stable relationship. However, the implementation of an educational activity can form "a unique, specific team work for that setting. The composition of the people in the team is kept at that time by the initiative of those who initiated the educational sharing process on health" (Teixeira and Veloso, 2006, p. 321).

The evaluation of the data collected during the research is still under way, but it is possible to mention some starting points for reflection on the results. The videos presentation on health gave visibility to issues related to the construction of shared knowledge, i.e., the combination of technical information with the everyday socially-shared experience. The notion of the illness experience and the problems of the illness narrative gain emphasis. It is important that its production and use be integrated to the healthcare actions and programs.

Another important issue is the low investment in the national production of good quality videos on

health, as well as the use of technological and audiovisual resources for actions on mental health, especially aiming to education, literacy and promotion of health (healthy behaviors regarding drugs). Audiovisual production on mental health, besides incipient, preliminary and challenged by the actors of the field is still too limited to the documentary format, which far from being a standard for the community requires actions to form the audiences. Development of material that addresses mental health intervention should be encouraged because its mobilizing potential (Ferry, 2008) can be outlined as a tool of great value to its audience, whose struggle for inclusion is still necessary.

Surely, we should also consider the aspects of ambience and humanized care of the patients arriving at the psychiatric emergency services. Education on health does not depend only on the physical space that hosts the patients, but on the attitudes taken, so that the users could feel empowered, informed and understood. As we noted throughout the research work, information on mental health and, of course, on health in general, is becoming an important demand.

A TV/video screen as a means of information in healthcare units proves to be a very practical resource, with optimum cost-benefit ratio and capable of reaching people with the most varied levels of education. It is a matter of making information available during the daily life of the healthcare users, seeking nexuses, contexts and opportunities. Informing integrates the concept of humanized care, aligned with the SUS (Public Health System) propositions, and health education is still a vital preventive attitude to solidify the foundations of the population's life quality. In this regard, the cultural differences, along with their importance, should be taken into account in the information and prevention materials. The use of audiovisuals as a tool to promote the production of new kinds of knowledge that can democratize information in the health field deserves further studies.

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