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INTERPROFESSIONAL WORK IN MENTAL HEALTH: UNDERSTANDING OF PROFESSIONALS AND DAILY WORK

TRABALHO INTERPROFISSIONAL EM SAÚDE MENTAL: COMPREENSÃO DOS PROFISSIONAIS E COTIDIANO DE TRABALHO

TRABAJO INTERPROFESIONAL EN SALUD MENTAL: LA COMPRENSIÓN DE LOS PROFESIONALES Y EL TRABAJO DIARIO

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Objective: identifying the understanding of professionals of the Psychosocial Care Center about interprofessional work for the care of people under mental distress. Method: a qualitative, exploratory and descriptive study conducted between July and September 2020, guided by the principles of institutional analysis and thematic content. Results: there is a distancing between professionals and the concepts related to interprofessionality, which materializes and evidences a fragmented practice, without discussion and articulation of actions. The professionals point to the case study as a powerful space for the introduction of interprofessional work because it opportunizes collaborative work. Final considerations: although the approximation with the concepts of interprofessionality by some professionals of the Psychosocial Care Center of the researched institution is capable of provoking reflections, it is still not enough for interprofessional work to become something instituted, since most have a distant understanding of the concepts, favoring fragmented action in the care of the person under mental suffering.

Descriptors: Interprofessional Relations. Interprofessional Education. Mental Health. Health Communication. Comprehension.

Objetivo: identificar a compreensão dos profissionais do Centro de Atenção Psicossocial sobre o trabalho interprofissional para o cuidado a pessoa em sofrimento mental. Método: estudo qualitativo, exploratório e descritivo,

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realizado entre julho e setembro de 2020, balizado pelos princípios da Análise institucional e de conteúdo temático. Resultados: existe distanciamento entre os profissionais e os conceitos referentes à interprofissionalidade, que se materializa e evidencia uma prática fragmentada, sem discussão e articulação das ações. Os profissionais apontam o estudo de caso como espaço potente para a introdução do trabalho interprofissional, por oportunizar o trabalho colaborativo. Considerações finais: embora a aproximação com os conceitos da interprofissionalidade por parte de alguns profissionais do Centro de Atenção Psicossocial da instituição pesquisada seja capaz de provocar reflexões, ainda não é suficiente para que o trabalho interprofissional torne-se algo instituído, pois a maioria possui compreensão distante dos conceitos, favorecendo atuação fragmentada no cuidado a pessoa em sofrimento mental.

Descritores: Relações Interprofissionais. Educação Interprofissional. Saúde Mental. Comunicação em Saúde. Compreensão.

Objetivo: identificar la comprensión de los profesionales del Centro de Atención Psicosocial acerca del trabajo interprofesional para la atención de personas bajo situación de angustia mental. Método: es un estudio cualitativo, exploratorio y descriptivo realizado entre julio y septiembre de 2020, guiado por los principios de análisis institucional y contenido temático. Resultados: existe un distanciamiento entre los profesionales y los conceptos relacionados con la interprofesionalidad, lo que materializa y evidencia una práctica fragmentada, sin discusión y articulación de acciones. Los profesionales señalan el caso de estudio como un espacio poderoso para la introducción del trabajo interprofesional, porque oportunista el trabajo colaborativo. Consideraciones finales: aunque la aproximación con los conceptos de interprofesionalidad por parte de algunos profesionales del Centro de Atención Psicosocial de la institución investigada es capaz de provocar reflexiones, todavía no basta con que el trabajo interprofesional se convierta en algo instituido, ya que la mayoría tiene una comprensión distante de los conceptos, favoreciendo la acción fragmentada en el cuidado de la persona en sufrimiento mental.

Descriptores: Relaciones Interprofesionales. Educación Interprofesional. Salud Mental. Comunicación en Salud. Comprensión.

Introduction

Interprofessional practice is based on integrated action, with sharing of objectives and centrality of care in users, in order to favor dialogue and articulation of information and actions. In addition, Interprofessional Education (IPE) aims to strengthen the collaboration of different professional groups working in the same space, in order to enhance teamwork, co-responsibility and the implementation of the care network at its various levels, through the guarantee of the quality of the services offered, positively impacting the user[1-2].

Although interprofessionality has been standing out among health policies in Brazil and in the world, both in the public and private sectors, due to the need to reconfiguration criteria and parameters for regulating professional activity and curricular organization of training for teamwork, there is still a lack of clarity as to its definition. Therefore, terms such as "multiprofessionality", "multidisciplinarity" and "interdisciplinarity" have been used, which do not understand the breadth of their concept[3].

The disciplinary and professional words refer to the field of technical or scientific knowledge and professional practice, respectively. The prefix used will determine its definition, since "multi" refers to a certain knowledge or to professionals who walk towards the same objective, but with little or no articulation with each other[3-4]. The prefix "inter" expresses the point of intersection, suggesting a strong association and articulation between the areas, whether disciplinary or professional[3].

The absence of a consistent definition about teamwork and interprofessional collaboration causes a weak production and some confusion/ignorance on the part of professionals. This can hinder the implementation of interprofessional relationships in health practices, since understanding the conceptual nature of interprofessionality is fundamental so that it does not lose its potency and, thus, there is a rigorous production and evaluation, for its development in practice[3,5-6].

Mental health care based on psychosocial care should be interprofessional, since it aims to expand access, qualify care through welcoming, articulate the services available in the network and democratization and co-responsibility of care, making the subject protagonist of this process[7]. Among the specific mental health care services in Brazil, the Psychosocial Care Center (CAPS) is a powerful space for interprofessional work, since its minimum team includes physicians, nurses, psychologists, social workers and nursing technicians[8].

It is understood that the understanding of professionals about interprofessionality can directly affect the care directed to the person in mental suffering and in the way of work, strengthening or not the ideal of replacing psychiatric hospitals with CAPS and other points of care in the psychosocial care network. The purpose of CAPS is care that includes the family and the community, seeking the recovery and reintegration of the person in mental suffering into society[9].

In this sense, the question is: What is the understanding of caps health professionals about interprofessional work? How is daily work configured?

Therefore, the aim of this study is to identify the understanding of caps health professionals about interprofessional work for the care of people in mental distress.

Method

This is a descriptive exploratory study with a qualitative approach. This type of study seeks to describe processes, relationships and phenomena that surround the object of study, making it possible to know its characteristics[10]. The data obtained are part of the first stage of an Intervention Research, guided by the theoretical-methodological framework of Institutional Analysis. Intervention Research is a method of political and participatory character, in which the researcher questions the practices and actions crystallized in the institutions, destabilizing them and opening possibilities for transformation and production of knowledge[11].

The research was conducted from July to September 2020, in a Type I Psychosocial Care Center, in a capital of the Midwest region of Brazil. All 24 professionals who worked at the institution were invited to participate in the study. However, due to the COVID-19 pandemic, there were several absences, which resulted in the participation of 9 of the 11 professionals who remained active in the service during the period of data collection, being 2 psychologists, 3 social workers, 1 pharmacist, 2 nurses and the unit manager.

Data collection/production was performed in person by a master's master, through the use of participant observation, notes in a research diary and semi-structured interview, with guide questions related to daily work and the understanding of professionals regarding the mental suffering of patients. For data collection, resolutions and preventive standards for COVID-19 were followed, using Personal Protective Equipment (PPE) and distancing.

The transcriptions of the interviews and the researcher's diary were used as a source of data and worked through thematic content analysis, composed of the following stages: pre-analysis, which had the transcription of the interviews, composition of the textual corpus, floating reading and definition of provisional hypotheses about the content read; exploitation of the material in which the data were encoded; and treatment of results and interpretation, which consists in the classification of the elements, based on their similarities and differentiation, grouping later into two categories[12].

The theoretical framework used for data analysis followed the concepts of Institutional Analysis: instituted, instituting and institution. The instituted is all that is fundamented, stabilized and evidences the institution, defined as norms, rules and/or laws. The institute, on the other hand, is every movement of transformation or setback, which moves the instituted. Therefore, the articulation between the instituted and the instituting is what provokes the process of institutionalization[13].

The Research Ethics Committee (CEP) approved the research under Opinion

nº 4,199,950 and Certificate of Presentation of Ethical Appreciation (CAAE) 29310620. 1.0000.8124. It commend all the current national resolutions, especially Resolution nº 510/2016 of the National Health Council, which deals with the development of research involving the human and social sciences. The anonymity of the participants was guaranteed, and the confidentiality of the information was preserved. The research was only initiated after the signing of the Free and Informed Consent Form (TCLE) by the participants. The speeches were identified by the letter P, when they referred to the workers, followed by the randomly chosen Arabic numbering; the records of the research journal were pointed out by the initials RJ, plus the reference month. It is noteworthy that this study followed the 32 recommendations of the Consolidated Criteria for Reporting Qualitative Research (COREQ) checklist.

Results

After the interpretation of the data, the classification of the elements resulted in two categories for discussion: The understanding of professionals about interprofessional work and the multiprofessional work instituted in the daily practices and instituting movements of change.

The understanding of professionals about interprofessional work

Most professionals reported doubts regarding the term interprofessionality or presented weak and confused understanding, often associating the definition of the term with multiprofessional work, as if they were synonymous, or to the concept of intersectoriality.

> [Have you ever heard of interprofessional work?] *If it's a synonym for multiprofessional work.* (P2).

> *Is interprofessional work the same thing as multiprofessional work?* (P5).

> *It is similar to intersectoriality* [...] *The difficulty is that we can maintain intersectoriality. The intersectoriality does not, the interprofessionality that you are using right?* (P7).

In addition to distancing themselves from the concept and foundations of interprofessional work, some participants still understood the ideal work as the exercise of specific functions performed by team members, in which each one could contribute to mental health care, based on his or her look, not specifying collaborative and integrated work.

> *We have several professionals, each doing its own specific function, and, in this way, we will be contributing to get you to work, manage to give all the necessary attention to this patient, in general, right?* (P1).

> *Interprofessional is when all teams are interconnected, right?* [...] *where all the teams are inserted, where each one is a part.* (P3).

> *Professionals adopt different practices, in which some understand that care should be conducted only by the reference professional, while others understand that care should be based on co-responsibility between users and staff* [...] *In daily practice, reference professionals compose therapy alone, with no exchanges between the various professionals and little co-responsibility* (RJ - Jun-Jul. 2020).

Some professionals, even though they were a minority in the team, presented an understanding that is close to what interprofessional work would be, when they mention the importance and need for teamwork based on joint, integrated actions and knowledge sharing.

> *The social worker collaborates with the psychologist, with the nurse, with the physiotherapist, with HR* [human resources] *and here, in mental health, I see as complementary. You absorb the knowledge, the perception of other professionals, the way they attend and see what differs from my performance, right?! So, I am always evaluating myself, my performance with professionals from other areas.* (P2).

> *There are several knowledges that have to complement* [...] *and then the issue of the interprofessional is from the moment we join, it is not only the professional "x" knowing such part, or professional "y" of the part such. There must be a moment of joining the knowledge. I cannot, for example, refer a person to a certain question and then the professional neither want to know or else not want to go after or just get "is not my part" or "my part is just the physical issue", and it is not, it is a set. Even if I have forwarded to the specific care of that professional, I interact, I do not let loose.* (P5).

For the study participants, the discussion of cases by the team allowed the sharing of knowledge, besides being an opportunity for collaborative work and articulated practices, which points to an instituting movement to transform work and care relationships.

> *Everything you do, any questions you have or something you're looking for, or want to talk about the patient, you always go on the team, right? The whole team gathered, and then you discuss the case, about what's going on* [...]

> *When you are in any doubt, a colleague brings a solution; the other brings another solution and soon we solve.* (P3).

> *We end up sharing the knowledge within the case studies, seeking the help of another about what we do not understand* [...] *trying to know what the nurse thinks, what the psychologist thinks.* (P5).

The multiprofessional work instituted in the daily practices and instituting movements of change

It was possible to identify that the daily practice of CAPS professionals is based on multiprofessional work, demonstrating an individual performance, in which several professionals address the same person, but there are no exchanges or joint action between them.

> *What we do here is this multiprofessional work, which are several professionals attending the same patient* [...] *If he has any clinical problems, he goes to the nursing staff; then, if he's in a demand for great suffering, he must go to therapy. You pass them on to the psychologist.* (P4).

> *So, he needs the look of the doctor, he needs the look of the technician, the nurse, the look of the psychologist. So, I think that each professional ends up doing his part, helping the same patient* [...] *sometimes he needs a benefit, which enters the part of social work; and sometimes it also has the nursing part. I think the team, each with their own gaze, ends up helping the patient a little.* (P6).

Even with notes that moments of interprofessional work have already been experienced in their daily lives, the service operates in an established way, under a disjointed logic and without discussion of interventions, understanding this as respect for the work of the other professional.

> *I've lived this interprofessionality more within the CAPS, right? We're going to sit longer and talk more about it; of us exchanging more ideas. Today I consider that here is more multi than inter.* (P8).

> *Not always the conduct that we believe it is, will be in the end, will be outright right. So, in this interprofessional work, we must respect the work of the colleague and welcome what is forwarded to that situation, which I often do not know if it would be there what I intended. But, as it is a collective situation, of teamwork, we respect those referrals that were made.* (P9).

The fragmentation of care and work practices extends to case studies, which function as a transfer of the information and conducts adopted and, in most cases, with the absence of some professionals, such as the physician, for example.

> *Everyone does his part, which he thinks suits him and is often not done the way it should be* [...] *Nowadays, we no longer have this participation of the doctor in case studies, for example. So often, this collaboration of all for a given case and such is lacking.* (P5).

> *Each professional present at the meeting took a bag of medical records. I was reading the case. I decided the conduct and took the stamp from the other professionals. By reading only the patient's medical records, it gives the impression that the case was discussed collectively and that the adopted conducts were thought together, which is not consistent with the practice in reality.* (RJ - Aug. 2020).

Although the multiprofessional practice is instituted in daily work, the participants expressed instituting movements of reflection and understanding of the need for communication between the team, as well as initiatives of greater interaction and discussion among professionals, even if the majority is summarized only in the most serious cases, in which the responsible professional finds difficulties to meet the necessary demands of the case.

> *We always try, in case studies, to be bringing everyone. If there is any difficulty that we have in solving a case, a case of a particular patient, we try to take to the team, during the case study, which is the moment that we will pass what is happening to the other professionals.* (P1).

> *A nurse, a social worker, will have other ideas, other visions, another focus of what is important in the situation, and you did not take care.* (P8).

> *We can't manage all the situations in case studies, which would be the right one. But what we propose to do is to take the most urgent cases, the most serious cases, and move to the team in this case study, aiming at this care [based] on the exchanges of knowledge.* (P9).

Despite the difficulties evidenced, both in relation to the understanding of interprofessional work and the daily mental health care based on collaborative work, when presented and discussed with the participants the fundamentals and concepts articulated to the interprofessional work, during the interview, the professionals highlighted the importance of this way of work, reinforcing their contribution to a complete/integral care, with centrality in the individual and in practices based on the collective.

> *It's about bringing well-being to the user, isn't it? Serve the user in order to give good health. Offer safe care, so he can have good health.* (P3).

> *I think it's important even for the user himself to achieve this autonomy, this improvement. I think he would be met*

> *more in his entirety even, not only the specific issue, that specific problem, and is often treated only that specific problem* [...] *When there is interprofessional work, we see more positive responses in the same patient.* (P5).

After the discussion of the concepts, an instituting process of recognition of interprofessional work occurred, but it was not enough to point out ways to achieve and establish this practice in the service. The view of understanding interprofessionality remained as a complementarity to the established way of working, which considers individual knowledge as central in the process.

> *Sometimes I see that just my professional performance would not be enough to meet the needs of the patient. So, it's like a complement; it stands as something that incorporates and adds. Without the other specialties and professions, the profession would be incomplete too, because it is done together and in its entirety. When she needs others, she can combine that performance.* (P2).

> *From the concept you read, the ideal would be the interprofessional, because it is a collective work, aiming at a common situation, where everyone has the same weight during the service, during the follow-up. But they both happen; a little bit of both modalities.* (P9).

Discussion

The introduction of aspects inherent to the perspectives of interprofessional relationships, such as interprofessional competence and integration teamwork, is necessary within the service[3,6]. However, the lack of knowledge of the meaning of interprofessional work may be related to the fact that this is not a practice instituted in the service, since the understanding of its foundations is fundamental for the development of collaborative and interprofessional work. That is, there is no integrated practice with articulation of actions, if the theoretical-conceptual aspects are not clear to the team or there is a fragility in understanding. This also occurs if these are not related to daily life and care directed to interprofessional work[3,6].

It is understood that IPE and interprofessional work should be instituted in work management and health education, as well as in the daily practices[3]. However, the manuals and ordinances that deal with the organization of CAPS still refer to this type of work with multiprofessional composition and acting under an interdisciplinary logic. Moreover, the educational system currently established does not form a professional able to develop collaborative skills in an articulated way. However, it is expected that it works collaboratively and integrated with the team, so that there are significant repercussions on the quality of care, such as commitment to safety and comprehensive care to the user[14].

In this sense, the relationship between the scopes of the complex social process, in which care is related not only to training, but to sociocultural and legal-political aspects, the vague or absent discussion of IPE and interprofessional work in training and policies and ordinances, as an instituting movement, results in the conservation of established uniprofessional practices. Thus, the principles of the Unified Health System (SUS) do not take effect, nor do they contribute to the institutionalization of integration teamwork, which prioritizes shared learning, user centrality, the singular needs of subjects in mental suffering, in the construction of their autonomy, social reintegration and psychosocial rehabilitation[6,15-16].

The multiprofessional work currently instituted, as well as the misunderstanding about the concepts, with consequent distancing from understanding and training based on IPE, can result in a practice far from the realization of these fundamentals in the daily mental health care. This was observed in the discourses of the professionals, especially by the use of the term "part", which represents a fragmented and disjointed work, and evidences the materialization of conceptual doubts. Thus, the understanding of professionals is realized in a multiprofessional practice, in which they not only act individually, but also think and write in specific fields related to each profession, with well-delimited borders[17-18].

In this scenario, the work is hierarchical, evidencing the relations of knowledge/power, which are, in most cases, centered on the medical figure within the CAPS, which restricts the work instruments used for medicalizing care, with an established practice of care centered on the

disease and not on the subject. Moreover, the hierarchical relationships established in health compromise interprofessional relationships, hinder health communication between those involved in care, providing that certain professional categories, and even the user himself, refrain from expressing contributions to care, limiting care[2]. In parallel and/or as a function, the physician may not be involved in team meetings and other spaces, as presented in this study, in which the relationships established in this service are guided by superficial and punctual contact, with little or no sharing and discussion among team members.

The institutionalization of interprofessionality is realized, as meetings and case discussions are incorporated into the daily work, given the potential of these spaces to provide not only reflection, problem solving and knowledge exchanges, but also to expand the capacity to transform practice and strengthen care and bonds among workers, contributing to the valorization of professionals and to the instituting movement of collaborative work construction. Therefore, one of the possibilities for the realization of interprofessional relationships is team meetings with the participation of the various professional categories[19-20].

However, the statements showed a setback, because, while identifying the transformative potential of this space for a collaborative and articulated practice, it is evident that this is not effective in practice, since the use of team meetings is based on the transfer of information and decisions taken. Therefore, it is noticeable the need to present the concepts about interprofessional work and the existence of a space whose objective, in principle, is to promote health communication among team professionals. In addition, instruments and strategies of education and teamwork based on IPE are necessary, so that interprofessionality is instituted in the daily life of the CAPS, as an instituting movement for articulated practice[16].

In the presence of a space for reflection, exchanges and discussions, the construction of comprehensive and critical mental health care is institutionalized, in view of the reality of the service, the singularities of the user and their active participation in the management of their own care[20]. The benefit of the institutionalization of interprofessional work and IPE results in the improvement and qualification of care, makes professionals open to collaborative practice and to the recognition of interdependence and the common among professions, which favors overcoming competition between professional categories and fragmentation of care. Therefore, it extends to the safety of the user because it provides effective practices directed to the needs of the subjects and the humanization of care, since they are planned and executed aiming at the integration and articulation of knowledge and agents[3,21-22].

The CAPS is one of the spaces with the greatest potentiality of the construction of instituting movements, as a place of questioning of the established practices, which are reproduced according to the manicomial model. Such questions aim at change, proposing not only the break with the manicomial logic[23], which is also present in services that should be substituted to the psychiatric hospital, but also provides the creation of the new, the different, that places the user as the center of care. It should be emphasized that, for AI, mental health, as an institution, is a product that results from a permanent confrontation between the instituted (which is already put and seeks to remain) and the instituting (forces of change). Thus, this institution (mental health) can fail its initial prophecy, by covering up an established practice, whose effect is to deny the initial objectives, in to follow its own objectives, unrelated to the founding moment[24].

In this sense, mental health, as an institution, with prophecy and initial objectives based on social reintegration, psychosocial rehabilitation, construction of autonomy of the person in mental suffering and care centered on singularities, which requires change in basic assumptions, can fail. This occurs when reproducing a manicomial practice within spaces/services that were born to be replaceable, being covered by medicalization,

for example, which is characterized as an established routine that denies and maintains no relation with the initial objectives of the anti-manicomial struggle.

Therefore, the logic of interprofessional work shows that the size of the demand of a CAPS, from the perspective of integrality and singularity of the subject, cannot be overcome from the perspective of uniprofessionality or multiprofessionality. This view is marked by the performance corresponding to specific campuses, becoming a great challenge to be overcome for the realization of interprofessionality[9].

As limitations of the study, it is noteworthy that the research was conducted in the local context in the midst of the pandemic scenario, with absences and absenteeism of professionals, which may have impacted the results.

The present study contributes to the discussion of interprofessional work in mental health/ health services, as a support for mental health care to be performed in a manner articulated by the various professionals of the network, perpetuating collaborative, co-responsible and integral care.

Final Considerations

The two categories demonstrated that, even though some professionals presented an understanding that was close to the definition of interprofessional work, most had a deficient understanding, with a daily work based on fragmented practices. However, even in this reality, it was also possible to identify moments in which this articulated work had already happened, as well as the presence of instituting movements in the direction of interprofessionality.

The impact of distancing concepts from practice in service is noticeable and favors fragmented action, with no discussion of actions. The minimum approximation with the fundamentals of interprofessionality is capable of provoking reflections on the way of work and the potentialities of its adoption, from the perspective of the transformation of mental health practices. However, only the explanation of the term is not enough, so that interprofessional work becomes something instituted in the CAPS and in all health services encompassed in the psychosocial care network.

It is necessary that interprofessionality be instituted in health graduations and practices in service, to provide reflection on mental health care as an institution. The aim is to favor an instituting movement built by the anti-manicomial struggle, which overcomes the manicomial practices still instituted in the services and fulfills the objectives and prophecies that must be based on social reintegration, singularity of the subject and effective articulation of care.

Collaborations:

1 – conception, design, analysis and interpretation of data: Mirelly Thaina de Oliveira Cebalho, Larissa de Almeida Rézio, Ana Karolina Lobo da Silva, Flávio Adriano Borges, Marina Nolli Bittencourt, Felipe Aureliano Martins and Samira Reschetti Marcon;

2 – writing of the article and relevant critical review of the intellectual content: Mirelly Thaina de Oliveira Cebalho, Larissa de Almeida Rézio, Ana Karolina Lobo da Silva, Flávio Adriano Borges, Marina Nolli Bittencourt, Felipe Aureliano Martins and Samira Reschetti Marcon;

3 – final approval of the version to be published: Mirelly Thaina de Oliveira Cebalho, Larissa de Almeida Rézio, Ana Karolina Lobo da Silva, Flávio Adriano Borges, Marina Nolli Bittencourt, Felipe Aureliano Martins and Samira Reschetti Marcon.

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