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Original Article

Potentialities and challenges of multiprofessional work in Psychosocial Care Centers*

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Objective: to verify the potential and challenges of multiprofessional work in Mental Health in the practice of services with the workers of the Psychosocial Care Centers of São Paulo, SP, Brazil. **Method:** a qualitative, exploratory and descriptive study. 27 workers from nine Adult Psychosocial Care Centers linked to the Municipality of São Paulo were interviewed. They answered four guiding questions elaborated by the authors that were evaluated by thematic content analysis. **Results:** in the Potentialities of multiprofessional team work in Psychosocial Care Centers category, enhanced care offered by the Psychosocial Care Centers proposal, training in the area and possible partnerships in teams, presence of interns/residents stood out; in the Challenges of multiprofessional team work category, precarious work and worker suffering, presence of "outpatient logic", lack of human resources and adequate training, appreciation of medication logic, prevalence of knowledge and medical power, lack of horizontality in relationship with users, fragility of interaction with other equipment in the care and intersectoral network. **Conclusion:** there is a gap between Public Mental Health Policies and the professionals' effective practice, the coexistence of the biomedical and Psychosocial Care paradigms in the services, compromising the fulfillment of the assumptions of the Psychiatric Reform and the place of the subject of the right to the users of the services.

Descriptors: Mental Health; Health Policy; Patient Care Team; Community Mental Health Services.

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Potencialidades e desafios do trabalho multiprofissional nos Centros de Atenção Psicossocial

Objetivos: verificar potencialidades e desafios do trabalho multiprofissional em Saúde Mental na prática dos serviços junto aos trabalhadores dos Centros de Atenção Psicossocial de São Paulo, SP, Brasil. **Método:** estudo qualitativo, exploratório, descritivo. Entrevistados 27 trabalhadores de nove Centros de Atenção Psicossocial Adulto vinculados a Prefeitura Municipal de São Paulo. Responderam quatro questões norteadoras elaboradas pelos autores, avaliadas por análise de conteúdo temático. **Resultados:** na categoria Potencialidades do trabalho em equipe multiprofissional nos Centros de Atenção Psicossocial, destacaram- se cuidado ampliado ofertado pela proposta dos Centros de Atenção Psicossocial, formação na área e parcerias possíveis nas equipes, presença de estagiários/ residentes; na categoria Desafios do trabalho em equipe multiprofissional, a precarização do trabalho e sofrimento do trabalhador, presença da "lógica ambulatorial", falta de recursos humanos e de formação adequada, valorização da lógica medicamentosa, prevalência do saber e poder médico, falta de horizontalidade na relação com usuários, fragilidade da interação com outros equipamentos da rede de cuidados e intersetorial. **Conclusão:** há distanciamento entre Políticas Públicas de Saúde Mental e prática efetiva dos profissionais, coexistência dos paradigmas biomédico e da Atenção Psicossocial nos serviços, comprometendo efetivação dos pressupostos da Reforma Psiquiátrica e o lugar de sujeito de direito aos usuários dos serviços.

Descritores: Saúde Mental; Políticas Públicas de Saúde; Equipe de Assistência ao Paciente; Serviços Comunitários de Saúde Mental.

Potencialidades y desafíos del trabajo multiprofesional en centros de atención psicosocial

Objetivo: verificar el potencial y los desafíos del trabajo multiprofesional en Salud Mental en la práctica de servicios respecto de trabajadores de los Centros de Atención Psicosocial de São Paulo, SP, Brasil. **Método:** estudio cualitativo, exploratorio y descriptivo. Se entrevistó a 27 trabajadores de nueve Centros de Atención Psicosocial de Adultos vinculados al Municipio de São Paulo. Respondieron a cuatro preguntas orientadoras elaboradas por los autores, evaluadas mediante análisis de contenido temático. **Resultados:** en la categoría Potencialidades del trabajo en equipo multiprofesional en los Centros de Atención Psicosocial, se destacó la atención ampliada que ofrece la propuesta de Centros de Atención Psicosocial, capacitación en el área y posibles alianzas en equipos, presencia de pasantes / residentes; en la categoría Desafíos del trabajo en equipo multiprofesional, trabajo precario y sufrimiento del trabajador, presencia de "lógica ambulatoria", falta de recursos humanos y formación adecuada, valorización de la lógica de la medicación, predominio del conocimiento y poder médico, falta de horizontalidad en la relación con los usuarios, fragilidad de interacción con otros equipos de la red asistencial e intersectorial. **Conclusión:** existe una brecha entre las políticas públicas de salud mental y la práctica efectiva de los profesionales, la coexistencia de los paradigmas de atención biomédica y psicosocial en los servicios, comprometiendo el cumplimiento de los presupuestos de la reforma psiquiátrica y el rol de sujeto del derecho de los usuarios de los servicios.

Descriptores: Salud Mental; Políticas Públicas de Salud; Grupo de Atención al Paciente; Servicios Comunitarios de Salud Mental.

Introduction

The Psychosocial Care Centers (*Centros de Atenção Psicossocial*, CAPS) are strategic in the reorientation of the assistance model in Mental Health, devices of intensive care, community and life promoters[1]. They were implemented as main equipment and structuring axis of mental health care in the context of the assumptions of the so-called Brazilian psychiatric reform, being questioned whether this option was appropriate in view of the different needs and panoramas in a country with such locorregional diversity, considering the choice of political-ideological profile over innovative experiences of network assistance in the municipality of São Paulo/SP, as we can verify in studies on this subject matter[2-4].

As challenges in the daily life of the CAPS, the following stand out: hybridity of the paradigms for madhouse care and Psychosocial Care; user chronification; deficiencies in intersectoriality; insufficiency in care and high demand; plurality in the theoretical references for the performance of the teams; unpreparedness of human resources; limitation of interventions; deficit of units and professionals; inadequacy in the care of acute cases; and lack of effective response to the need for hospitalization[5].

Due to the peculiar trajectories of implementation and extension of the city of São Paulo/SP, the CAPS have different profiles, heterogeneous regarding the forms of organization and functioning[6]. The multiprofessional work of the Mental Health teams is an important strategy for implementing the deinstitutionalization process and elaborating new psychosocial care practices in the CAPS. There is no literature that can account for the national evaluation of this equipment and no content regarding multiprofessional work in the city of São Paulo/SP, a gap that needs to be filled by studies and this brings to light data to uncover how multiprofessional work was done in this equipment.

This research aimed to verify the potentialities and challenges of multiprofessional work in Mental Health in the practice of services with workers of psychosocial care centers in São Paulo, SP, Brazil.

Method

An exploratory, descriptive and qualitative study, using Thematic Content Analysis. It was performed in nine Adult CAPS from São Paulo/SP, one in the Midwest region and two in each of the four administrative regions (North, South, Southeast and East). The participants were higher-level professionals from the multidisciplinary team. The inclusion criteria were as follows: being at least one year in operation in the CAPS as a public servant without any link with the Social Health Organization (*Organização Social de Saúde*, OSS), except in two units where there were no coordinators with this criterion, due to the scarcity of direct administration Adult CAPS. Exclusion criteria: being absent at the time of data collection.

The participants were defined by convenience, consisting in one member of the coordination and two professional assistance providers in each service.

The data collection instrument was elaborated by the researchers, containing information describing the participants and four other questions that addressed the theme of the study: Please, describe what you mean by multiprofessional, interdisciplinary and transdisciplinary teamwork in Mental Health; How is multiprofessional teamwork done in the service in which you operate?; What factors influence the presence/absence of multiprofessional work?; Do you consider that multiprofessional teamwork interferes with the service provided to the user? How?

The interviews were conducted by a researcher, with a view to the question of reflexivity on the data, between July and September 2015 with audio recording. The interview excerpts are identified by the letter "P" for participant, followed by a number representing the order of the interviews.

Data analysis was performed through the thematic content analysis framework[7] and resulted in two thematic categories. In the pre-analysis, the interviews were organized; several readings of the contents were necessary in order to apprehend the central ideas and their meanings. The interviews were fully transcribed and, to exhaust communication with the interviewees, criteria of representativeness of the universe surveyed, homogeneity to obtain the data, pertinence of the data obtained in line with the objectives of the study and exclusivity were used, so that the data would not be used in more than one category[7].

After fully analyzing the transcripts, the factic elements of communication ("linguistic sticks"), which are specific to oral language, were subtracted from the interviews. Personal and service names were changed to preserve the participants' identity.

In the exploration of the material, coding, categorization, decomposition or enumeration operations were carried out[7]. For the researchers' convenience, enumeration was not performed, that is, the frequency of appearance for certain elements of the message.

There was clipping of the speeches with the purpose of constructing registration units, the units of meaning, which were through themes in consideration of the study objective. Decomposition occurred by the choice of the registration units and the content considered as the base unit in the search for categorization. Categorization was performed for the classification of constitutive set elements by differentiation and then by regrouping according to the analogy, with criteria guided by the study objectives. The categories were organized by group of elements (registration units), with the grouping from the

common characteristics of the elements. As categorization criteria, semantic, syntactic, lexical and expressive were used[7]. The categorized data were related to the research theoretical framework and objectives, with triangulation being performed in order to control possible biases.

Research project approved in the Ethics Committees of the Federal University of São Paulo (*Universidade Federal de São Paulo*, UNIFESP), under CAAE No. 43383515.6.0000.5505 and the Municipal Health Secretariat (*Secretaria Municipal de Saúde*, SMS) of São Paulo/SP, under CAAE No. 43383515.6.3001.0086, according to Resolution 466/12 of the National Health Council.

Results and Discussion

Twenty-seven professionals working in nine Adult CAPS from the five regions of the city of São Paulo/SP were interviewed, being eight CAPS II and one CAPS III. Two occupational therapists, nine psychologists, seven nurses, six social workers, two psychiatrists and a pharmacist participated.

Regarding the sociodemographic aspects, 24 participants were female and three male, aged between 28 and 64 years old, with a mean of 45 years old. The time of graduation was from 4 to 35 years, with a mean of 18 years since graduation, while the working time in the unit was from one to 19 years, with a mean of 10 years.

Potentialities of multiprofessional teamwork in the CAPS

In this study, the professionals highlighted as a potentiality of teamwork the expanded care offered by the CAPS proposal; possible partnerships between team members with the service network; the entry of professionals with training in the area; and the presence of interns/students.

Multidisciplinary work proposes professionals open and permeable to different positions, available to partnerships and with professional competence, which guarantees safety in the exercise of autonomy and shared practice[8]: *The facilitator would be this horizontality and openness to dialog and to the new (...). That people may hear, may talk. (...) Through a dialog, a dialogical relationship (...) listening to the other genuinely and also being able to transmit, being heard* (P21).

The dialog spaces were related as elements favoring teamwork in Mental Health because, by requiring the participation of all knowledge areas, they constitute democratic spaces, for decision-making and of shared responsibilities.

The installation of democracy environments and institutional and intra-team mechanisms allowing for the growth of the practices among knowledge areas is paramount, especially because collaboration between service members amplifies exchanges in decision-making and enhances team autonomy in the face of the challenges it experiences[9]: *The Mental Health and CAPS institutional project lays the basis for multiprofessional work and this is an advantage, because there is no possibility of not having coexistence between these professionals. (...) What facilitates are the public policies, training and spaces for dialog within the institution. (...) In our project it is implied that, for example, in the team meetings it is a democratic space. The responsibility is always of all the categories, this promotes multi work* (P17).

There is an emphasis on the importance of establishing the expanded team, capable of involving actors from other services to enrich the STP of the users, considering matrix support as a tool. Matrix Support aims to provide specialized back-up to the teams and professionals who take care of mental health, providing co-responsibility between teams and diversity of therapeutic possibilities, allowing for an approximation of the demand in mental health that reaches primary care, users, family and territories[10]: *Enrichment when working as a team. (...) An extended regional team, it is a "matrixing" thing that we do with the other CAPS, with the BHUs (Basic Health Units), with everyone together. This also enriches the Therapeutic Project of the subject, it is you knowing your neighbors and working together with them* (P7).

The presence of interns/residents favoring important debates and discussions among the team must be considered, as they often assume the role of questioners and spokespersons of certain discomforts that allow reflections to the team. Residents and interns present themselves from a privileged "no place", which can generate changes in what is instituted and creation of instituents, strengthening bonds between workers, users and community[11]:

It is an internship field (...) the team (...) you find yourself faced with the need to debate and discuss, even because students in training end up being much more questioning, because they are living a training moment (P19).

There was emphasis on the entry of people with training on Mental Health in the service as an element that enhances the multiprofessional practice, due to the numerical increase of professionals and strength in sustaining forms of work aligned with the Psychiatric Reform – to favor dialog, an expanded look at the demands of users and greater disciplinary integration.

Challenges of multiprofessional teamwork in the CAPS

Among the factors listed as challenges, the following stood out: lack of human resources; the persistent "logic of outpatient care"; recent adaptation of some CAPS to the Public Mental Health Policies; working conditions of the teams; difficulties in the articulation with other services in the network; professional training distant from

the proposals of disciplinary integration; management of the services by the OSS; lack of clinical-institutional supervision; and presence of hierarchy among different professions, with medical knowledge prevailing.

Lack of Human Resources (HR) was the most commented element by the participants: *The biggest challenge is HR and this interferes with work, because you don't have room to discuss, to see everyone. (...) The one who is here will have an appointment, the one (...) that we have to visit, that is in crisis, we have no way. (...) When you are unable to work on the activities, to do the STP (Singular Therapeutic Plan) of the person, you go to the outpatient clinic: consultation, doctor, drug* (P5).

The following were considered as obstacles: low capacity of the HR-training device in health; the high formalization of the professional practice established by corporations; management difficulties of the SUS itself (diversified forms of contracts and workload); the distancing of the policies of business administration principles (professional appreciation, regulatory practices of autonomy and corporatism), especially the need for the definitive inclusion of the HR problem in the agenda of proposals for funding, care models, flexibilization and regulation with participation of the health professionals in the political, administrative, technical and social aspects[12].

A recent study showed that the psychosocial network of the city of São Paulo had failures that compromised the provision of care and hindered the development of the precepts of the psychiatric reform, with emphasis on the unpreparedness of the professionals and the lack of knowledge and practice to work in substitute services[13].

The absence of specific training of the professionals can lead to practices that harm or go against the proposals of the psychiatric reform and promote a feeling of insecurity in them due to the lack of scientific knowledge to carry out the actions[14].

The participants observed that the relationship between the size of the team and the number of users assisted directly interfered in the possibilities of multi/interprofessional teamwork, since professionals overloaded by high demand promote the outpatient practice of the CAPS, decreased spaces for discussion, with only users who "draw more attention" being seen with care. They asserted that there is a large number of "outpatient" users in the CAPS, without any STP or care proposals beyond medical attention. Logic is also perceived in the territory and other health services, favoring the biomedical paradigm, as in working with the intersectoral network, which still makes requests from the disciplinary perspective: *Mental Health is counter-hegemonic (...) and will encounter a lot of resistance (...). Some difficulties with other agencies that are together with us, Ombudsman, Public Prosecutor's Office, they make requests from the medical specificity and they make requests to us like this: "This guy is capable or not capable for the acts in civil life?", "What is the diagnosis?" and we do not answer, we answer who this user is* (P11).

There is a need for a change of thought about the team and users, bringing them closer to the notion that the CAPS is a fundamental service at the crisis moment: *The work process is not changed only by theory, (...) turning this equipment into a CAPS in fact, because it still has many users who come just to see the doctor. (...) Qualifying the CAPS project, implementing. (...) Realizing that the crisis is in here. (...) The users in crisis are either at their homes or they are hospitalized, they are in hospitals* (P22).

An effect of the overwork of the teams, it is perceived that the professionals were overloaded, tired, with little commitment, to interfere in the team practices. The poor conditions and precariousness of the work of the Mental Health teams are also obstacles to multiprofessional work: *There was a time that (...) I was the only one who made groups. (...) Each professional handles the work alone. (...) You can't do a verbal group with 30 people, but it is done (...) I don't know how interesting this is for the user* (P4).

An aggravating factor due to the lack of institutional supervision, a fundamental space for the elaboration of the health practice and strengthening the care of users and workers: *We no longer have supervision. How do we take care of the team and how does the team take care of each other and how do we take care of each other... I have seen people here getting sick* (P9).

The Psychiatric Reform managed to make some progress, but challenges persist that affect its sustainability, among them the training of the professionals[15] and the functioning of the substitute services, mainly the CAPS[16].

The change in the Mental Health care model proposed by the psychiatric reform with a view to undoing the hegemony of the psychiatric institutions through open services for the treatment of individuals with mental disorders sought with the CAPS to provide this answer, but supporting the assistance proposals has been increasingly difficult, due to the lack of investments to make the work of the professionals feasible, and to the difficulties in developing knowledge and efficient care technologies to meet the complexity of demands, allowing for the total exclusion of madhouse practices[16].

As for the workers of the Mental Health services, there is insufficient number, lack of satisfactory training, with low remuneration, devaluation and a prejudiced view on the part of some of them, making it impossible to advance the proposals of the psychiatric reform. Due to the professionals' performance, it is verified that the lack of adequate training influences family care. A number of studies pointed to the absence of family assistance groups in the substitute services and to the inadequate performance of some professionals due to the

lack of scientific basis to guide the actions and that the development of the work was empirical[14,17-18].

There is fragility in the functioning of the Mental Health care network, a fact associated with factors such as the relationship between the high number of users and the insufficient psychosocial care network to assist them; the deficiency in the articulation between the network services, mainly with primary care; the insufficient number of specialized Mental Health services; and with the CAPS as the guiding axis of assistance due to the difficulty in sharing actions and establishing connections with other services in the network and other sectors[14,18-20].

Multiprofessional work in health is an important advance; however, it also produces tensions linked to power and conflicting interests; it generates wear out, alienation and relationship problems, to which the service users may end up as depositaries. Frequently, the users assisted carry a great symbolic load of violence suffered throughout their history, transferring part of it to the relationship with the professionals, with public health equipment reflecting, reproducing or even institutionalizing this structural violence, reinforced by the inequalities and ideologies of the dominant classes[21].

Labor legislation needs to be preserved, such as social rights and the recovery of the dignity of work and its social function. It is also necessary to expand employment, with effective inclusion and social belongings, reduced workload, changes in mentality and political culture, and a new meaning for work to build sociability[22].

As for the precariousness of work in Mental Health, few respondents discussed administration by the OSS, a current striking aspect of the SUS in São Paulo/SP, with only P24 criticizing: *Their working mode (professionals hired by the OSS) is very focused on the symptoms, medication and the goals, too (...). The City Hall itself demands goals and I find this way of working strange. (...) You have to reach that goal without questioning. (...) The contract is for five years (with the OSS), and it can be renewable or not. I mean, so is this rotation going to stay? How is Mental Health care? There is the issue of the contract that you take longer to establish, the issue of trust* (P24).

The managerial ideology affects work processes and health management, implying greater social and personal pressure on the workers, work overload, lower degree of autonomy, reduced social recognition and support from co-workers, managers and users[23].

In this study, one of the participants highlighted the importance of training focused on the practice of a multidisciplinary team: *The greatest difficulty (...) it's up to you to integrate the professionals (...). This issue comes from the training of the professional. (...) The comfort of the professionals speaks against teamwork (...), but this impoverishes the person and the patient, mainly because he has poor vision* (P7).

The very constitution of the professions brings interests in guaranteeing the labor market (retention of knowledge, so that it is increasingly specific and accessible to few people), and is related to the professional identity, highly valued in the capitalist society, so professional collaboration and professionalism end up in constant opposition, with codependent existences. The increase in professional collaboration reduces individual autonomy, which can be difficult for some people, as therapeutic plans go through negotiations between the team, expanding the group's autonomy in the face of problems[9].

The horizontality between different types of knowledge can be threatened, configuring itself as a power struggle and the prevalence of certain "psy" knowledge as coordinators, especially in the medical field: *The hierarchical issues, different powers, also (...) get in the way. (...) In relation to the medical field, it is more evident, in a certain discourse and in the medication issue, that what guarantees the patient's improvement is medication and what I do as a psychologist is recreation or secretarial. There is no recognition (...) the effectiveness of the therapies, the reference work, the follow-up, as if it had less weight* (P17)*; Also the shielding of the doctor, because the idea of madness and health is very much linked to a mental illness and needs a remedy and we know that this is not the case. (...) Breaking the positivist paradigm that is still very strong, even in Mental Health. (...) This shielding, he does not do it himself, it is the team and the users, the population, it is the discourse* (P21).

Medical education expects these professionals to be in control in different contexts, turning to results, not relationships, with authoritarian physician-patient relationships, unlike other Health areas that respected the users' self-determination, did not perceive as an obstacle the feeling of the leadership division with the interprofessional team. Other team members, trained in the biologizing logic, expect physicians to assume the role of leaders[24].

When speaking spontaneously about horizontality in the equipment, some interviewees considered that the teams functioned horizontally, with the prevalence of medical knowledge perceived only from the specific questioning of the interviewer. In other statements, the naturalization of this knowledge/power and the drug response is perceived as the main path in some services, in contradiction to the discourses aligned with the Psychiatric Reform: *There is a knowledge that here is not considered the most important, but that (...) is essential (...), it is the doctor's knowledge. Because, suddenly, he starts to get agitated, aggressive and no social worker, psychologist (...) can handle it. (...) But in terms of (...) that figure X is more valued, no. There isn't much here, but there are moments that only the doctor will be able to handle* (P14).

In a study on CAPS, there was dominance in the medical field recognized by all respondents. Although the team had good theoretical training in the assumptions of the Psychiatric Reform, in the analysis of the practical

intervention and definition of the mental disorder phenomenon, there was still a significant influence from the medicalizing perspective with an organic basis. The difficulty of intervening in the users' living conditions and insufficient means available to the CAPS were also perceived as reasons for a practice impregnated by the traditional model and professionals' insecurity in promoting alternative actions, placing these as complementary to the treatment recommended by the psychiatrist[25].

Some interviewees in this study observed the search of users and families for care exclusively or mostly with medication, valued for the quick and effective results, or even for hospitalization. Such data lead to questions about the effectiveness of the Psychiatric Reform and the features of multiprofessional work in the practice of services.

When thinking about the horizontality of the relationships in the CAPS, it is expected that it can occur both between members of the multiprofessional teams and between professionals and users: *We cannot develop any multi-task work (...) if you are not speaking horizontally. (...) This is very difficult (...). Thinking about this horizontal professional thing within the service, with the relationship between the professionals, and thinking together with the user and how much we are prepared to build with the user* (P22).

It is no longer possible to think about acting through intersectoriality and interdisciplinarity with the practice centered on the understanding of mental distress in a unicausal manner as in the biomedical model, based only on nosological diagnoses[26]. It is necessary to interact with all the equipment and services available, all the various and different professionals who provide assistance and seek comprehensive care to avoid fragmentation of the system and the gap in care continuity[27].

Multiprofessional teamwork in Mental Health is based on the notions of the therapeutic bond, interdisciplinarity and collegiate management, to overcome the fragmented logic of health care and the hegemonic medical model. In addition to potentiating the sharing of practices and knowledge, it favors the overcoming of specular relationships between team and users and the support of the professionals by the other team members in cases of difficult management[9].

The currently existing difficulties regarding access to and contact with strategic equipment and services for the provision of assistance in Psychosocial Care are important. This fact refers to the premise of enabling funding and qualification to the development of existing equipment and services and to the working professionals[28].

This study contributed to deepening the discussion and to listening to the professionals about the reality of the Mental Health practices in the CAPS from São Paulo/SP, a topic lacking research studies. Little progress is perceived in the conquest of a new social place for madness beyond considering it an illness, the functioning of multiprofessional teams distant from the notions of horizontality, and democracy in relationships. Changes are still taking place more in the physical spaces than in the mentalities.

As limitations, the participation of managers linked to the OSS and the use of the interview method are observed, allowing for "desirable" responses from the participants and possible bias due to the researcher and participants being agents of the process.

Conclusion

As potentialities of multiprofessional work in the CAPS from São Paulo/SP, the following stood out: the CAPS care model; possible partnerships between workers; presence of interns/residents; and training targeted at the area in question. Among the challenges, attention was drawn to the difficulties related to HR in the quantitative aspect and lack of adequate training, precarious work and suffering of the worker, functioning close to the outpatient clinic, due to the appreciation of the medication logic/prevalence of medical knowledge and power, lack of horizontality in the relationship with users, and fragility of interaction with other equipment in the care and intersectoral network. There is a gap between mental health Public Policies and the effective practice of the professionals, coexistence of the biomedical paradigms and Psychosocial Care in the services, which compromises the fulfillment of the Psychiatric Reform assumptions and the place of the subject of right to users of the services.

Thus, it becomes essential to hold debates, as well as to conduct studies and a municipal mental health conference to analyze the problems and plan interventions that are necessary in view of this scenario verified in our study.

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