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THE CHALLENGES OF PROVIDING MENTAL HEALTH CARE: FROM THE DIALOGUE TO THE MULTIPROFESSIONAL RELATIONSHIPS

Os desafios da produção do cuidado em saúde mental: do diálogo às relações multiprofissionais

Los desafíos de la producción del cuidado en salud mental: del dialogo las relaciones multiprofesionales

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ABSTRACT

Objective: The study's purpose has been to analyze the conformation of the multiprofessional and interdisciplinary working process with emphasis on the decision-making process and the construction of interpersonal relationships for the development of mental health care. **Methods:** It is a qualitative study that was performed over the period from July to August 2017 at a *Centro de Atenção Psicossocial* (CAPS) [Psychosocial Care Center], which is located the in municipality of *Crateús, Ceará* State, Brazil. This research counted with ten participants. The interviews were guided by a semi-structured script and processed through the content analysis. **Results:** The data points to a predominant conformation of the alignment of professional groups, due to the fragmentation of language, objectives, technical differences and professional autonomy. **Conclusion:** Bearing in mind the existence of overlapping actions among the professional groups, it is important to include the conflict mediator, which can enable a common assistance project.

Descriptors: Patient care team, Communication, Mental health services.

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RESUMO

Objetivo: Analisar a conformação do processo de trabalho multiprofissional e interdisciplinar com ênfase na tomada de decisão e na construção de relações interpessoais para o desenvolvimento da atenção à saúde mental. **Método:** Trata-se de um estudo qualitativo, realizado no Centro de Atenção Psicossocial, de Crateús, Ceará, Brasil, entre os meses de julho a agosto de 2017, com dez participantes. As entrevistas foram guiadas por roteiro semiestruturado e tratadas através da análise de conteúdo. **Resultados:** Os dados apontam para uma conformação predominante do agrupamento dos núcleos profissionais, diante da fragmentação da linguagem, dos objetivos, das diferenças técnicas e autonomia profissional. **Conclusão:** Tendo em vista e existência da sobreposição de ações entre os núcleos profissionais, torna-se importante incluir neste processo o mediador de conflitos, o qual possa viabilizar um projeto assistencial comum.

Descritores: Equipe de Assistência ao Paciente, Comunicação, Serviços de Saúde Mental.

RESUMEN

Objetivo: Analizar la conformación del proceso de trabajo multiprofesional e interdisciplinario con énfasis en la toma de decisión y en la construcción de relaciones interpersonales para el desarrollo de la atención a la salud mental. **Método:** Se trata de un estudio cualitativo, realizado en el Centro de Atención Psicosocial I, de Crateús, Ceará, Brasil, entre los meses de julio a agosto de 2017, con diez participantes. Las entrevistas fueron guiadas por guión semiestructurado y tratadas a través del análisis de contenido. **Resultados:** Los datos apuntan a una conformación predominante del agrupamiento de los núcleos profesionales, ante la fragmentación del lenguaje, de los objetivos, de las diferencias técnicas y autonomía profesional. **Conclusión:** Teniendo en vista y existencia de la superposición de acciones entre los núcleos profesionales, es importante incluir en este proceso el mediador de conflictos, el cual pueda viabilizar un proyecto asistencial común.

Descriptores: Equipo de Asistencia al Paciente, Comunicación, Servicios de Salud Mental.

INTRODUCTION

The interfaces established in daily mental health work are closely linked to the asylum deinstitutionalization paradigm and the split with its biomedical practices. These changes had great significance for the Brazilian Psychiatric Reform, but the reformist path goes beyond the reorientation in regard to forms of caring. It redirects the concept of mental illness in the sociocultural and legal-legal fields, as it seeks to reinvent the meaning of life, social life and health.[1]

Therefore, the focus of attention to mental health care falls on the multidisciplinary team, requiring a certain interdisciplinary, objective and subjective disposition for the development of actions planned in a shared way.[2]

The relationship between multiprofessional work is due to different health backgrounds. Such logic, when associated with interdisciplinary work, seeks to make different actors share specific knowledge of their backgrounds, articulating them in collaborative practice at the expense of care.[3]

The work process in this study is characterized by two types of teams, described as integration and grouping. The first seeks to articulate actions, through participatory and shared decision making, with the articulation of actions through the integration of agents, with the joint elaboration of language, inherent to the effectiveness of communicative acting. The actions of the care project are common to all participants, which seeks to reduce technical inequalities between specialties, thus corroborating for greater flexibility in the division of labor, through the interdependent autonomy of agents.[4]

Concerning the grouping team, there is a juxtaposition of the actions, where each actor gets together, but they do not interrelate cooperatively, then generating fragmentation of care practices. In this conformation, there is no act-communicative, as communication has a personal and technological characteristic. The agents are not aware of the dominant health care model, so they are unable to re-elaborate a common care project among the team. Thus, strengthening the differences between specialties, the exclusive competences of the training areas, where autonomy is related to the type of professional category.[4]

Hence, when considering the interrelation in the work environment of health services, the literature5 states that the mental health work process consists of objective and subjective elements, whose transformation of biomedical practices, can only occur during the development of work, through the participation of actors in the act of caring and in reflecting on how such actions are affecting users of health services.[5]

Commonly, the team's lack of perception about the daily practices of care activities of a biomedical nature, tend to make working relationships in mental health fragmented, even though these professionals are linked to community mental health services.[6]

Given this framework, the study aimed to analyze the conformation of the multidisciplinary and interdisciplinary work process with an emphasis on decision making and the construction of interpersonal relationships for the development of mental health care, taking as a parameter the integration and alignment of actions.

METHODS

It is a descriptive-exploratory study with a qualitative approach, which was derived from a research performed within the scope of a master's degree in Family Health by the *Universidade Estácio de Sá* (UNESA), Brazil. The qualitative method seeks to answer questions of extreme particularity, the closest to the reality experienced, distancing itself from the measures of value in its interpretation.[7]

The study was carried out in the municipality of *Crateús* located in the *Ceará* State, Brazil. The city has a population of 72,812 citizens, according to the last census surveyed by the Brazilian Institute of Geography and Statistics.[8] Having as a setting the *Centro de Atenção Psicossocial* (CAPS) [Psychosocial Care Center], as it is the only psychosocial care device in the present municipality. The data became

saturated after interviews with 10 participants who were part of the multi-professional team at the higher level of a *CAPS* in the municipality of *Crateús, Ceará* State, Brazil.

Data collection took place from July to August 2017, through an interview recorded with the aid of MP3 and guided by a semi-structured script. In the first stage, data were collected on the characterization of the study participants; in the second stage, open questions were asked aiming to meet the following guiding question: How does work the multidisciplinary and interdisciplinary working relationship in mental health focused on both communication and common assistance project?

Content analysis was used as a technique for data processing.9 In the first moment, pre-analysis was carried out through floating reading and choice of the speeches of the systematized content. Subsequently, the material was explored through the analytical description of the content corpus, being guided by the guiding question and theoretical foundation. Conclusively, the results were treated by inference and interpretation, coded and categorized, which enabled the discussion and analysis of the following empirical categories: challenges of communication in mental health; challenges of the specificities and autonomy of specialized work; and, common assistance project.

The study obtained a favorable opinion from the Research Ethics Committee of the *Universidade Estácio de Sá* (UNESA), under the *Certificado de Apresentação para Apreciação Ética* (CAAE) [Certificate of Presentation for Ethical Appreciation] No. 61273316.0.0000.5284, which guarantees the ethical precepts of studies involving human beings, according to the Resolution No. 466/2012 from the National Health Council.[10] In order to guarantee anonymity to the participants, they were identified by a random letter, followed by an Arabic number following an interview, such as the following example: F2.

RESULTS AND DISCUSSION

Participants' characterization

Most participants were female (six). Regarding the age group, there were a total of five professionals from 30 to 39 years old. Nursing has notoriety within the area of professional training due to the strong participation in the study with a total of five participants, including three psychologists, one social worker and one occupational therapist.

When considering the professional training degree, six have a specialist's degree in the following areas: Mental Health (three), Infantile Development (one), Psychodiagnosis/Psychopedagogy (one) and Family Health (one). With regard to the type of professional bond, six were part of the Multiprofessional Residency in Mental Health Program, three had long-term employment bond and one was hired.

Challenges of communication in mental health

This category refers to communication between professionals, technical differences, specificities, and autonomy of specialized work. Challenges these faced in the scenario of the present study, by two opposing forces, formed by the team of multiprofessional residents in mental health and permanent professionals of the service, who compete for dominance over the work process, through communication.

Although there is communication between the teams, it is affected by the different understandings of the development of the work process between the professional groups, as highlighted in the statements below.

> *There is communication between the professionals, but the service professionals have a certain difficulty in understanding the collective work process of residents in mental health, which generates certain resistance [...]. (F2)*

> *The relationship is conflicting, precisely because they do not understand the logic of collective work in mental health [...]. (D5)*

> *Communication is undermined, because the service professionals do not understand the work process of the residency program [...]. (A10)*

As noted in the statements, the integration of agents is affected by the resistance or difficulty of understanding by the *CAPS* permanent professionals, in the face of the collective work in mental health, proposed by the residents. Such a split experienced between the teams, makes the work process difficult, conflicting and fragile, as there is no mediating agent. This element would make such a privileged moment, given the possibility of problematizing the work processes of both groups, which could favor the integration between agents.

This conflicting relationship between the professional groups of this study, presents elements that constitute the grouping team, as it corresponds to a level of tension, which is manifested by the technical dialogue, overlapping of actions associated with the profile of practices with a sense of friendship or the exchange of favors, inherent to the hierarchical position of the team's professionals.[4,11] Situation observed in this context, portrayed by D5:

> *We have a coordinator and we have a person who takes on some functions as if he were an informal leader [...] sometimes the team understands not to do an activity and the management staff says: you are going to do so [...] then what happens is that this other person who is behind the coordination ends up doing the same thing, as if it were an exchange of favors. (D5)*

With this sense, the communication between the actors presents a sense of friendship or exchange of favors, operating in the personal and technological dimension, where the subject overlaps the technical agent and the work, there is a reduction in the interaction and the notion of teamwork, for example. stand out for the association and dependence on good relations due to the hierarchical subordination of the grouping model.[4,11,12]

Although there is no act-communicative, due to the opposition of ideas between the professional groups. The literature presents this event as a privileged moment of conflict, precisely because it provides a problematic tension in the practice of mental health workers.[13]

It is in view of the debate promoted by communication that the psychosocial model proposes to value the contradiction of biomedical care, reproduced unconsciously in psychosocial care, precisely because it problematizes traditional and innovative practice, between what was hegemonic truth and what can now be considered one more truth. Promoting a new form of interrelation between the clinic, the subject, the service and the community.[13]

This challenge of the multiprofessional communicative process will only be integrated through the inclusion of a professional who acts as a mediator of interests and conflicts, who is equally involved in the development of the work process among the professional groups. This interdisciplinary exercise has the potential to create mediation plans between the knowledge of the subjects or groups that make up the multiprofessional team, in view of the knowledge and the operative care action.[14]

Nonetheless, it is emphasized that the environment alone will not favor the interdisciplinary path. It is essential to have the figure of the mediator, as this has the role of favoring the re-elaboration and reformulation of possible solutions in the face of opposing interests.[15]

Challenges of the specificities and autonomy of specialized work

The different ways of understanding the construction of knowledge and the intervention techniques within specialized work refer to inequalities in values, ways of hierarchizing work and social norms, which tend to technically discipline professions. Therefore, corresponding to the different professional areas and the power relationship that each has over the other.[4]

There is a strong indication that the team formed by residents in mental health seeks to build relationships through communication, given the flexibility of actions, according to the psychosocial model of mental health care. These characteristics are related to the integration team, as noted in the following transcripts:

> *[...] there is a difficulty in acceptance concerning the development of work without a label, more flexible and collective among the multidisciplinary team [...]. (F2)*

> *[...] the service professionals are more focused on the medical model of caring, medication, individual nursing work, psychology, medicine, social assistance, each one with their own assignment [...] where everyone has to be working in the CAPS, right [...] who does not work in the CAPS, is not working [...]. (A10)*

The literature points out that the greater the acceptance of flexibility in the division of collective work in mental health, the greater the integration of agents and the greater the specificity of the work, the closer the professionals are to the grouping team. In this sense, the development of collective work favors less inequality between the different actors and their specialties, with greater integration in the team, as the professionals understand that the central objective of care is the subject.[4,14,16]

Thus, it is emphasized that both the integration team and the grouping are affected by the technical differences of specialized work, however, the lower the hierarchical inequalities between professionals, regardless of their professional background, the closer the integration is to the team.[3,4]

Adding to this framework, the biomedical model tends to generate wear and tear in interprofessional relationships, between both professional groups, as observed in the aforementioned statements of F2 and A10. It is evident that the team of mental health residents seeks to plan their actions with a focus on making work more flexible, where agents develop a common care plan inside and outside the *CAPS*, as they seek to approach the psychosocial model.

The team formed by the permanent professionals of the service, on the other hand, seek to agree on assistance plans centered on the disease, where each professional has a knowledge protected by their own skills, in an inflexible hierarchical structure. Such inflexibility will tend to generate split of the groups in face of the attempt of the full exercise of autonomy or the absence of it by the professionals, where each team works in a different way, as F2 addresses.

> *[...] it turns out that the permanent team of professionals at the unit works in one way and we in another one [...]. (F2)*

In this process of inflexibility of specialized work in mental health developed within psychosocial care, the most affected element is the user, since the grouping of work agents does not allow their health problems to be welcomed and resolved. The user in this context becomes an adjunct to the mental health care process, due to the dispute over the territory (service) by the professional groups.

This overlapping of interests between the professional groups of the study, is characteristic of the grouping model, precisely because they ignore the scope in which the development of the work proceeds. Thus, the

literature points to the overlapping of interests, related to instrumental knowledge and regarding the practice, which is associated with the positivism of biological sciences that tend to generalize all aspects, since the central objective is the cure of the disease. On the other hand, psychosocial rehabilitation seeks to recognize practical rationality, given the psychosocial health needs of users in a given socio-cultural, economic and political context.[17]

In regard to professional autonomy, there are three distinct concepts, with full autonomy and the absence of autonomy linked to the grouping team. In the first, the professional seeks a conformation where he has full autonomy, through the broadest spectrum of independence in his profession, the second ignores the autonomy of his own work. Interdependent autonomy, on the other hand, seeks to understand the technique and the set of agents, being common in integration teams.[4]

Full autonomy or its absence is seen as a barrier between professionals working in mental health, precisely because it promotes a breakdown of agents, in the face of a fragmented plan of care, where each professional group focuses on defending their professions. However, there is evidence that the insertion of multiprofessional residency programs can assist in changing the paradigm involving work in individual mental health, through the inclusion of actions and joint planning of goals in view of the needs of health service users.[18]

This change process promoted by the insertion of the multiprofessional residency program in mental health is observed by the participant W3:

> *[...] it has improved over time; it seems that the service professionals are beginning to understand the logic of collective and flexible work [...]. (W3)*

Evidencing the potential of this strategy as a mean of promoting the development of the work process, anchored in psychosocial care through interdisciplinary actions in collective mental health.

Common assistance project

The common mental health care project has been affected in the study scenario, precisely because there is no agreement between the professional groups, regarding the planning of mental health care.

The presence of the biomedical model and the non-recognition of its practices within psychosocial care, by the permanent professionals of the service, tend to hinder the development and implementation of a common action plan. Such non-observance causes fragmentation of mental health care in both teams, precisely because there is no communicative action, flexibility of specialized work and its specificities, which reduces the autonomy of the multiprofessional team within the work process. This conformation can be observed in the following statements:

> *We perceive resistance to work on some things that are recommended by the policy, some questions from the Public Health School itself that involves the work of the residency program; for instance, leaving that assistential and biomedical model, where each professional is separated in a room [...]. (R1)*

> *Like the medical prescription renewal [...] we see that it needs better quality, because renewing a medical prescription just to do it; you should not be with a patient just delivering a medical prescription. The residents did see the users again, but the service professionals did not do it [...]. (W3)*

The non-existence of a common care project is also seen in another study, which is characterized by the lack of a guiding philosophy for the actions and central objectives for the development of user embracement and treatment in the mental health network. The focus of teamwork in this context is on the technical disposition of each specialty and not on the joint elaboration of actions.[17]

Nonetheless, the unit's permanent team of professionals disregard the exercise of hegemonic practices linked to the biomedical and asylum model, unconsciously promoting the reduction of multiprofessional work, by segregating and limiting the new forms of mental health care, which considers the subject as a unique individual in a psychosocial framework.

This demonstrates that the services can be innovative, but the development of the practice within it may still be conditioned to the asylum and biomedical model of health care, which promotes institutional violence and exclusion. It is useless to promote the opening of new community-based mental health services, if their interior resembles an asylum.[13]

When taking on such responsibility, professionals will be working with the logic of team integration, precisely because there is the acting-communicative approach. Where everyone dialogues together, recognizing the hegemonic models of care, seeking to collectively transform the dominant models into new practices, which are part of the team's common ideas.[4,14]

This difficulty of understanding manifested by the residents on how to understand their own work, in the face of the behavior of the permanent professionals of the service, refers to the inability or to the unconscious process of reproduction of techniques, skills, and way of managing biomedical health care practices. mental, within the psychosocial model. The non-recognition of such actions is considered as peculiarities such as:

> *[...] there is a lot of residents [...] each one with his/her particularity [...]. (G9)*

The literature calls attention to the construction of a

psychosocial culture, in the field of professional training, which can understand the need for development and policies regarding mental health. Having as strategy the reorientation of undergraduate curricula, as well as the inclusion of multiprofessional residency programs in mental health, within the services, which can break the technical isolation that the biomedical model institutionalized in mental health services in Brazil.[18-21]

Bearing in mind the aforesaid, although we seek changes or the breaking of the asylum paradigm, if we are not aware of the overlapping of instrumental and biomedical actions on the ways in which mental health care practices take place, we run the risk of repeating old practices in new contexts asylums. Therefore, recreating new asylums without ways and locks, but which continues to segregate and exclude subjects from care practices.[21-3]

CONCLUSIONS

It is observed that the teamwork process in this context is affected by two types of professional groups described as the multiprofessional team of residents in mental health and the team of permanent professionals in the service.

Given the aforementioned analysis, it is possible to affirm that the work process of the groups may conform as an overlap of actions, in a gathering of powers and knowledge, which interrelate in a fragmented way, exactly because there is no common assistance project. Although there is a space for communication on issues related to the teams' work process, it is affected by the lack of a mediating agent, which favors the effectiveness of the communicative act through problematization, given the psychosocial needs of the users assisted by this service.

The importance of including multiprofessional residency programs in mental health in psychosocial care services is underlined, as well as professionals who can mediate interests and conflicts in scenarios that coexist in different multiprofessional groups. The mediating professional will seek to promote the integration of the mental health team, by valuing and making each experience more flexible through communicative acting.

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