ABSTRACT
Objective: to verify how Mental Health professionals understood multi, inter and transprofessionality, occurrence in practice and influences for residents. Method: exploratory, descriptive study, with qualitative approach. The sample consisted of the coordinator and at least two professionals with different graduations at each service. The collection instrument consisted of four guiding questions. Data were analyzed using the Content Analysis technique. Results: the participants did not know how to define multiprofessional, interprofessional and transprofessional work in Mental Health; there was no work in a multiprofessional, interprofessional and transprofessional team at the units and the Program did not offer conditions for insertion in the health system nor training for such. Conclusion: there were difficulties in the conceptualization of disciplinary integration modalities. Facilitating and hindering elements of those actions were listed. The importance of Multiprofessional Residences in health training and the effective approximation of Public Health Policies were discussed. Descriptors: Mental Health; Interdisciplinary Treatment Approach; Public Policies.

RESUMO

PERCEPTION OF MENTAL HEALTH PROFESSIONALS ABOUT THE MULTIPROFESSIONAL WORK WITH RESIDENTS
PERCEPÇÃO DOS PROFISSIONAIS DE SAÚDE MENTAL SOBRE O TRABALHO MULTIPROFISSIONAL COM RESIDENTES
PERCEPCIÓN DE LOS PROFESIONALES DE LA SALUD MENTAL EN EL TRABAJO MULTIDISCIPLINARIO CON LOS RESIDENTES

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INTRODUCTION

The Health Social Production Paradigm highlights the interdisciplinary work in health, carried out by multiprofessional teams, which is a requirement of the current model of health promotion in SUS, since its definition is interdisciplinary.¹

The Psychiatric Reform introduced a new paradigm of Psychosocial Care, which proposes different ways of dealing with insanity and the broader approach to health care. Interdisciplinarity started to be evoked, since the work object of Mental Health involves, concomitantly, social relations, emotional, affective and biological expressions, requiring complex thinking.¹

The concept of interdisciplinarity can be discussed in relation to other terms, such as multidisciplinarity and transdisciplinarity. Despite the differences in the understanding of those possible interactions, the disciplinarity is conceptualized as a homogeneous study area, with well-defined boundaries, which cannot be thought without considering the relations of power that are placed as a form of controlling the discourse production.²

Multidisciplinarity proposes the juxtaposition of several disciplines, without necessarily implying joint work and coordination.² Interdisciplinarity is linked to the notions of integral care and to joint production of a modified discipline. It is more than the taking elements from other disciplines; it is incorporating them into a new way of thinking, the combining disciplines, provoking reciprocal transformations in each one.³ Transdisciplinarity goes further; it is not restricted to interaction and reciprocity, but proposes the absence of frontiers⁴, openness to what crosses and surpasses the disciplines, regardless the domination of one over the other.⁵

There are obstacles to interdisciplinarity in Mental Health teams due to a strong positivist and biocentric tradition in treatment, the power spaces of disciplinarization and the structure of educational institutions.¹

The traditional health care model, structured from medical knowledge and corporate interests, still influences the organization of the teams and contributes to weaken relationships and integrated multiprofessional work.¹ The multiprofessional conception has a different basis, when requiring that professionals use singular knowledge, constructed from different logics, in a shared way⁶.

The training of professionals in service is important and necessary, since the new modalities of Mental Health Care include different ways of relating to insanity under the ethics of inclusion, and considering that education institutions did not assimilate the Psychiatric Reform and have little contribution to its evaluation and development.⁷

One of the Union duties is the participation in the policy of training and development of human resources for Health.⁸ In that context, Multiprofessional Residency programs have been developed with the following guidelines: the expanded health concept; pedagogical strategies that promote integral and interdisciplinary learning; integration of knowledge and practices to build shared competences; articulation of the Multiprofessional and Medical Residence and integrality.⁹

One seek to connect the knowledge acquired in undergraduate courses to the complexity of the determinants that interrelate in the services practice and are alternatives to promote changes in health care practice, to favor teamwork, deep exchanges of knowledge and actions and a new reality of health for the users.¹⁰ They aim at transforming the health services that trains, which can be encouraged to reflect on the practices they develop and their possibilities and limitations to reconfigure them.¹⁰

The Multiprofessional Residency Program in Mental Health of the Federal University of São Paulo has existed since 2011. As part of the hours of practical activities, residents are divided into multiprofessional teams that take turns in different services, working with the equipment teams.

The author of this study was part of the incoming residents in 2013 and was intern at six services. From the experiences, we observed that the multiprofessional work occurred in an incipient way in many of the training services. If we consider that many were, and still are, managed by medical professionals, from the separation between Medical and Multiprofessional Residency, we saw that the practice was closer to the ideas of auxiliary interdisciplinarity¹,³ and grouping team¹¹ than to the joint construction of knowledge and therapeutic plans.

OBJECTIVE

- Verify how Mental Health professionals understood multi, inter and transprofessionality, occurrence in practice and influences for residents.
Exploratory, descriptive study, with a qualitative approach\textsuperscript{12}, carried out in three practice fields of the Multiprofessional Residency in Mental Health of UNIFESP in 2013: Coexistence and Cooperative Center (CECCO), of the Municipal Health Secretariat of São Paulo (SP), Brazil. Center for Psychosocial Care (CAPS) and outpatient clinic for children and adolescents, both from the Psychiatry Department of UNIFESP.

Graduated professionals were interviewed, members of the fixed service team. The sample was defined by convenience and consisted of one person from the coordination and at least two professionals with different graduations, service providers at each service. Inclusion criteria: being at least one year at the equipment and having participated in activities with the residents.

The interviews were conducted using guiding questions, with audio recording and transcription for data processing and analysis. The researchers developed the data collection instrument, which had data from the participant and the guiding questions: What do you mean by multiprofessional teamwork in Mental Health? Do you consider that there is multiprofessional teamwork at the service where you work? What is the biggest challenge of multiprofessional teamwork at your unit? How do you perceive the participation of Residents of the Multiprofessional Residency Program in Mental Health in this field? What is your perception of the multiprofessional work of the unit professionals with residents?

The data processing and analysis based on the assumptions of Content Analysis. There were three phases: pre-analysis; material exploration and treatment of results; inference and interpretation. For the convenience of the researchers, there was no quantitative analysis.\textsuperscript{12}

The interviews were transcribed without omission of data and the transcriptions had no language mannerisms of the researcher and the interviewees. After categorizing the data, they were related to the theoretical framework, so that such symbiosis could give meaning to the interpretation.\textsuperscript{12}

The research project received a favorable opinion from the Research Ethics Committee of UNIFESP under no CAAE 647.539/2014.

Eleven professionals were interviewed during the months of June and July 2014, four of them from the CECCO, four from the CAPS and three from the outpatient clinic. There was participation of one nurse, three physicians, two occupational therapists, two social workers, two psychologists and one social scientist. In order to preserve identity, there was no description of the equipment of each professional.

The ages of the interviewees ranged from 31 to 63 years, with an average of 45 years. The working time at the Health unit ranged from one to 16 years, with an average of seven years. As for graduation time, it ranged from seven to 39 years, with an average of 21 years.

Three categories were developed, which will be described below.

\textsuperscript{1} Category 1 - Definition of multiprofessional, interprofessional and transprofessional teamwork in Mental Health

Some interviewees approached the concepts of multi, inter and transprofessional teamwork; others did not know about it and tried to answer and a third group admitted not knowing and did not answer.

\textsuperscript{1} Multiprofessional teamwork in Mental Health

Ten professionals approached the concept of multiprofessional teamwork in Mental Health. Most highlighted the contribution of the various looks and professional backgrounds in this modality:

Team of various professions. Work with a common goal, keeping the specificity and the particular look of each profession. The multi […] is more compartmentalized […] each professional carries out his or her practice […] practice that is still very specific. […] There is still no such […] sharing, this intertwining of knowledge. (E6)

\textsuperscript{1} Interprofessional teamwork in Mental Health

Six professionals approached the concept of interprofessional teamwork. They emphasized the exchange between the different professionals and the decisions that take place in a more integrated way than in the multiprofessional one:

The interdisciplinary […] that there is a greater horizontaliy, in fact discussing, deciding things together. Conduct, treatment directions and I think Mental Health needs to be at least this way […] The interdisciplinary proposal seems, for me, closer to the possible […] because people will be able to maintain their Specificity. (E1)
Transprofessional teamwork in Mental Health

Six professionals approached the concept of trans-professional work, of them, three worked at CECCO. They emphasized the dissolution of the frontiers between the specialties and the challenges of operating that modality in the quotidian:

[...] It is something that goes beyond inter, a proposal that I still have many doubts about where the specific really goes in there. [...] It is something [...] abstract, I think it is not palpable [...]” (E1).

[...] there is a greater malleability in this composition [...] In our professional work, we perceive the limits, but these limits are not well defined, well determined. (E6)

Category 2 - Perceptions regarding multiprofessional, interprofessional and trans-professional teamwork at the units where they worked

Interviewees answered whether teamwork was done in a multi, inter or transprofessional way at the services and the factors considered harmful to the disciplinary integration: centrality of the actions in the doctor’s figure; absence of professionals and adequate training; lack of institutional conditions and physical infrastructure and difficulty to integrate different knowledge in team practice. They talked about factors that favor such practices and their potency in the care of users, as well as on the concept of Unique Therapeutic Project (PTS). This category will discuss only the most relevant aspects.

Perception of the interviewees regarding the work at the services in the multi, inter or transprofessional functions

At CAPS, two professionals considered work as multiprofessional. They said they did not know exactly the concepts of inter and transprofessionality. Two other interviewees reported that work was interdisciplinary. At CECCO, one professional considered the work as multiprofessional, while other three considered it transdisciplinary. In the outpatient clinic, one professional considered the work multiprofessional, while two others said that, currently, there is no multi, inter or transprofessional work, which happened only with the insertion of the Residence in that field.

Three interviewees considered that the work was carried out in a multiprofessional way at the Mental Health services where they worked:

The team make most decisions, people complement each other, work around the

same case, we have several spaces for discussion [...] There is certain homogenization [...] The service needs it [...] When there are these questions of people who for some reason do not make up, we try to mitigate, try to take care of it. (E10)

Three interviewees considered interprofessional work at their equipment:

The work here is multiprofessional, but, in this line, it is interdisciplinary [...] In moments of supervision, when it is recommended that there is a pair of professionals from different areas; in the group interventions when, in the possible, it is recommended that there is a co-therapy of different areas. The families end up being the greatest reference of the interprofessional care here of the CAPS. [...] The space of supervision is the space that does this exercise [...] all professionals have their space to be discussed, when they are with little space, they are called to occupy this space, that we make it the most possible egalitarian. (E5)

Three interviewees perceived the work as transdisciplinary, all of them being CECCO:

The transdisciplinary is much closer, I think it is the way we work here at CECCO, which is this evolution of coming and going in the case with our knowledge, with our techniques [...] being transiting and sharing the specific knowledge, but, at the same time, maintaining the global vision of the user [...] It is not that transdisciplinarity is exclusive to CECCO, it is that, from the places where I worked, the place where I found it the strongest [...] was here [...] (E6)

Two interviewees pointed to the non-existence of multi, inter or transprofessional work in the outpatient clinic, which happened only during the insertion of the Multiprofessional Residency students in that field:

We do not have this, because today the assistance [...] with the loss of the Residency, the trainees of Medicine and Occupational Therapy and the Multi Residence, I think there is a flaw there, an absence of multi assistance, today, we have basically only assistance from psychiatry. Because of this lack of professionals. (E11)

Factors that negatively interfere in the multi, inter and transprofessional practice at the units where the interviewees worked

All the interviewees pointed out the actions focus on the doctor’s figure at the services where they worked. They emphasized the importance of the horizontality of relationships to think of multi, inter or transprofessional work.
The job is in a horizontal team. [...] Everyone working together, it is not hierarchical ... One area that stands out [...] is the medical field. It would be a lie to say no, demagogic, because [...] you do not have supervision without a doctor [...] the CAPS cannot work without a doctor. I think that it is a health service that ends up having certain difference in relation to the role of the doctor, but I think that this is extremely attenuated, especially thinking that we are in a medical school [...] It is not ideological issues, it is need issues [...]. (E10)

Everyone get the same thing by functions. As far as doctors are concerned, this is more complicated [...] Overcoming this barrier, I think it is utopian what I am going to talk about, if it is a medical school, I think this is a deep-rooted premise, but I think this medical-centered model of medical supremacy, that knowledge [...] Treatment can be something broader, things do not have to be exclusive, they can be complementary. I think this is a big obstacle [...] it is a challenge and we get a lot here, it is not something focused, but that is what I told you, I think it is something that comes from graduation, from college [...] (E11)

Eight professionals highlighted the daily difficulties to integrate different knowledge and making them reflect on joint action with the user:

Here and everywhere, it is that the multi is not a lot of different things, that the multi is the dialogue and the integration, so that we can converge the knowledge of each one and the formation and the specificity in therapeutic projects, in workshop projects [...] (E3)

Potentialities perceived in multi, inter and transprofessional practice

Seven professionals highlighted the relevance of multi, inter and transprofessional practices in the care of the services users.

According to the current policy of Mental Health, there is recognition of the need for several looks for this issue [...] In addition to helping us to make a wider diagnosis, to be able to think about various behaviors, I think that working in a team is a way of not only dividing up the work, but also building something that is as [...] complete as possible. (E1)

I think it is the only way to deal with such a complex object that is Mental Health care, both in promotion and prevention [...] Understanding the human subject [...] Relationships, I think no area alone can very much [...]. All can a little, all together can a little more. (E3)

Nine interviewees talked about characteristics of the equipment where they worked that could favor multi, inter or transprofessional work. They emphasized the openness to the dialogue and the joint action of the people in the teams, guarantee of discussion and study spaces, common theoretical references and the experience and commitment of the professionals to their practice.

Category 3 - Perceptions on the work developed by residents of the Multiprofessional Residency in Mental Health of UNIFESP

The respondents answered about the potential of the Program, its challenges and the pedagogical-assistance project for the students’ performance. Among the potentialities, they mentioned the exchange of knowledge that the insertion of the residents allowed and the motivation and good formation of the students. They also highlighted as challenges the short time in each internship camp and the difficulties of interaction with the fixed team.

All the interviewees observed the importance of the Residence work at their work units, valuing the possibility of mutual exchange installed with the arrival of the residents.

Seven professionals considered small the residency time of residents in Mental Health services, especially those of the CECCO and the CAPS. All interviewees considered the interaction of residents with fixed health service teams as a challenge. They emphasized students more available than others and the little time added to the routine of the service as difficulties of that process.

According to some interviewees, the residents brought the demand for production of care in a network to the equipment, not always existing at the university services of UNIFESP and central to the proposals of Sanitary and Psychiatric Reform.

DISCUSSION

Disciplinary integration actions stemmed from the need to incorporate different practices in health care, through the new conception of the health-disease process (WHO), which incorporated socio-cultural and collective dimensions.13

When defining the different modalities of disciplinary integration, the majority realized that in multidisciplinarity, despite the existence of a joint sense, there is still fragmentation of the attention offered to the users of the services, since there were not necessarily changes between professionals. Even with joint interventions, they based on the logic that each professional maintains
his/her specific way of thinking and acting, which compartmentalizes the service.

The definitions of multiprofessional work approach to the notion of grouping team11, characterized by fragmentation of attention and juxtaposition of Health actions and greater clarity between the frontiers of each professional specificity. They also approach to actions in which there is help among professionals, without joint construction of therapeutic plans.

As perceived by most of the interviewees, in interprofessional work, there is an approximation of the idea of sharing, which is a step beyond joint work (pointed out in multiprofessional practices), towards the shared, with greater horizontality, discussion and joint decisions. Differently from the definitions of multiprofessional work, when speaking of inter, workers used terms such as “exchanges”, “compose with the other”, “joint and common actions”, “mix” and “sum”, in order to indicate that, in this modality, there is greater integration between different knowledge. It is also possible to say that there is a greater chance of working as an integration team11, since the articulation between its members takes place more effectively and the boundaries of each specialty become more flexible.

Interprofessional work, when establishing connections between different areas, seems to be the only way to approach the objectives of the Psychiatric Reform14, which proposes new ways of working as a team, aiming at transversality between subjects, respect and appreciation of how to do different training and the co-responsibility of each user.6

When considering that the work was in the perspective of disciplinary integration, most respondents justified from meetings, supervisions and case discussions in a multiprofessional team in the daily life of the equipment. Although they are central tools to organize multiprofessional teamwork, and its periodic devices, it is noteworthy that only the configuration of such spaces does not seem to account for the fact that the practices of the service are effectively multi, inter or transprofessional.

Regarding the answers that indicated that there was no multi, inter or transprofessional work at the outpatient clinic, the disciplinary integration was possible only during the year when the Residence was present at the service, because, after it, there was only psychiatric assistance. Such situation relates to the absence of non-medical professionals at the equipment, which raises the question of whether it is possible to train residents in a multiprofessional perspective where there is no team composed by different specialties. It seems certain perversion of the proposal of Multiprofessional Residences that the training service needs the residents to function in a multidisciplinary way. How can the education offered at a service whose assistance is in the bias of Psychiatry, and not of Psychosocial Care, approach the conceptions of Multiprofessional Residences in Mental Health? How is it possible to connect with the proposals of the Psychiatric Reform and SUS being at a service distanced from them? Those questions appear to other clinics that made up the residents’ curricular grade.

We emphasize that the proposals for disciplinary integration seek the equality of conditions of the different professions, which ideally have the same responsibility for the users of the Mental Health services, where the different knowledge has the same weight and the PTS are built together.14 Regarding the actions focused on the doctor’s figure, it does not seem possible to separate ideology from necessity, so that the idea that the Mental Health service cannot function without a doctor brings influences of the way of thinking the subject and the mental disorders, inheritance of asylum practices.

Most interviewees in our study considered disciplinary integration still a challenge, especially as different knowledge could mean effective joint action on behalf of the user. The professionals pointed, as barriers to the low resoluteness of the teams, the importance that multi does not mean many different proposals, but effective integration; the focus of treatment, in that same sense; and an agreement. From the literature15, we can relate such perceptions to the different values historically developed by specialty, formations with different emphases, in addition to communication difficulties. Each one may fulfill his/her function without thinking about the group insertion, which generates conflicts and disorganization, configuring the “work in assembly line”.15 That characterization becomes critical to the process of teamwork, which, despite being part of an integral perspective, ends up being fragmented. When differentiating the practice from idealization, many services are considered multi or interprofessional; however, they may just work different specialties.

The literature16,14 understands the multi and interprofessional practices as central for the proposals of the Psychiatric Reform to become reality, which, in our view, also speaks of the political character of that professional act. Political in the sense that
the theory and practice in Mental Health, thought in the context proposed by the Psychiatric Reform, propose the constant debate about the world and the desired life. That dimension did not appear in the answers of the interviewees, who focused on the clinical practice itself.

The notes from the interviewees' statements can also be expanded for multiprofessional residents, especially regarding the restricted discussions about the concepts of multi, inter and transdisciplinarity, little worked in the two years of training at the program, and the reduced direct articulation with the public policies and the political action of Mental Health workers and residents.

We question how much the residents' actions may end up focusing only on the clinical aspects of case management, which relates to the received training and the ideologies of those who teach. Teaching, ideally, is a contradictory, political action that transmits social values, a process that occurs with conflicts and difficulties, used to transform and construct Multiprofessional Residences.

When we think about the history of medical training at UNIFESP, we verify how the depoliticized training focused essentially on the strictu sensu clinic and the hegemony of medical practice were still present in the Multiprofessional Residence, also inherited from the model of formation of Health specializations, specifically in Mental Health, at that University.

The Multiprofessional Residency of UNIFESP is in line with the Public Health Policies propose. In spite of non-medical coordinators and professors, there is little questioning of the concepts of multi and interprofessionality, and the residents' practice turns out to be closer to auxiliary interdisciplinarity. Given the barriers placed on residents to question medical power, the latter continues to position as the coordinator of Mental Health care, away from the proposals of horizontalization of knowledge and integrality of care, central to the Psychiatric Reform.

Regarding the alignment of theoretical references, especially when referring to Psychoanalysis/Psychodynamics (line of choice of the CAPS and other services that compose the grid of the Multiprofessional Residency in Mental Health of UNIFESP), we ask if the psychoanalytic (or psychiatric, behavioral, etc.) service, can indeed relate to interprofessional practices, insofar as the interdisciplinary value for the integration of different knowledge, which is not present in the homogeneity of the same theoretical discourse.

Specifically in Mental Health, the training issue is still one of the great challenges for the effective implementation of the Psychiatric Reform, which is in line with the proposal as a politicization in service training, as the educational tendency for resident training, capable of establishing new ways of caring and organizing the work process.

Although not mentioned by the interviewees, the main power of the Multiprofessional Residency in Mental Health concerns the possibility of the formation engaged with the presuppositions of the Psychiatric Reform and the SUS, the formation of workers-citizens, with a profile to political action in their practice. They shall have an expanded and integral health vision, with humanist, democratic and critical actions of reality, in line with anti-asylum actions.

The main characteristics of Multiprofessional Residences are decentralization of knowledge and practices, so that the activities planned for residents do not only insert them in substitute services, but also encourage a global and critical view of the network as a whole.

It is important to value the role of residents, at the same time professionals and students, as occupants of a privileged "non-place", capable of producing changes in the instituted and of creating institutes in the Health field, as well as of relevance in the narrowing of links between workers, users of health services and the community.

Although most of the professionals consider their practices as multi or interprofessional, the medical hierarchy and the verticalization of the relations were still realities in the equipment connected to the Department of Psychiatry of UNIFESP, which compromised the effective disciplinary integration. The professionals associate multi and interdisciplinarity to meetings and team case discussions, which does not necessarily show the existence of shared objectives and actions, characteristics intrinsic to interprofessional actions.

In addition to the inheritance of the professional specializations offered prior to the Multiprofessional Residency Program, it still seems to occur in a similar way to the Medical Residency in Psychiatry of UNIFESP.

Despite the lack of integration, supported by the Ministry of Education when establishing two separate residences, when multiprofessional residents and physicians had
shared activities, they were structured around medical knowledge. Furthermore, the training of multiprofessional residents focuses on the care model of the training units, which do not always align with the Public Health Policies, as they do not articulate with the SUS network.

CONCLUSION

It is fundamental to re-approximate the Multiprofessional Residency in Mental Health of UNIFESP to the public policies in Health and to what the legislation of that specialization modality states, what could be done from the greater participation of the residents of the Program in services that compose the Psychosocial Care Network of the city of São Paulo/SP, to the detriment of those linked to the Department of Psychiatry of UNIFESP. Another possibility of approaching the SUS proposals seems to be the involvement with services focused on prevention and health promotion, such as Basic Health Units (BHUs) and Family Health Support Centers (NASFs), in order to recover the importance of integrality in the Health care models in our country.

It is also noteworthy the fact that the challenges pointed out in this study do not seem to be exclusive to the mentioned Multiprofessional Residency in Mental Health, but can dialogue with difficulties experienced throughout the country, regarding both Mental Health equipment as the modality of in-service training proposed by Multiprofessional Residencies. The criticisms and problematization here presented point to the need for more discussions and spaces to rethink practices, of both the professionals who have been dedicating to the field of Mental Health for a longer time, as those who have recently approached it.

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