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ORIGINAL ARTICLE

EVALUATION OF PROFESSIONAL PARTICIPATION IN THE TEAM MEETING OF THE PSYCHOSOCIAL CARE CENTER

AVALIAÇÃO DA PARTICIPAÇÃO DOS PROFISSIONAIS NA REUNIÃO DE EQUIPE DO CENTRO DE ATENÇÃO PSICOSSOCIAL

EVALUACIÓN DE LA PARTICIPACIÓN DE LOS PROFESIONALES EN LA REUNIÓN DE EQUIPO DEL CENTRO DE ATENCIÓN PSICOSOCIAL

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ABSTRACT

Objective: to evaluate the participation of professionals in the team meeting of a Psychosocial Care Center (PSCC). ***Method:*** qualitative, evaluative study, with the theoretical-methodological reference of the Fourth Generation Assessment. Data collection took place from participant observation and from a focal group with 17 PSCC workers. Data analysis was performed using the Content Analysis technique, in the Thematic Content Analysis modality. ***Results:*** the evaluation process evidenced the importance of the support team and the psychiatrist physician to be included in the team meeting, as well as the limits and difficulties of this participation. The psychiatrist's non-participation in the team meeting highlights the way in which the professional works in the PSCC, with individualized actions without integrating the team. ***Conclusion:*** the participation of the professionals in the team meeting increases the sharing of information and the quality of the therapeutic actions of the PSCC. ***Descriptors***: Mental Health Services; Health Care Reform; Comprehensive Health Care; Health Evaluation.

RESUMO

Objetivo*:** avaliar a participação dos profissionais na reunião de equipe de um Centro de Atenção Psicossocial (CAPS). ***Método*:** estudo qualitativo, avaliativo, com o referencial teórico-metodológico da Avaliação de Quarta Geração. A coleta de dados ocorreu a partir de observação participante e de um grupo focal com 17 trabalhadores do CAPS. A análise dos dados foi realizada pela técnica de Análise de Conteúdo, na modalidade Análise de Conteúdo Temática. ***Resultados*:** o processo avaliativo evidenciou a importância da equipe de apoio e do médico psiquiatra se inserir na reunião de equipe, bem como os limites e dificuldades dessa participação. A não participação do psiquiatra na reunião de equipe coloca em evidência o modo de trabalho ambulatorial que esse profissional desenvolve no CAPS, com ações individualizadas sem se integrar à equipe. ***Conclusão: a participação dos profissionais na reunião de equipe amplia o compartilhamento de informações e a qualidade das ações terapêuticas do CAPS. ***Descritores*:** Serviços de Saúde Mental; Reforma dos Serviços de Saúde; Assistência Integral à Saúde; Avaliação em Saúde.

RESUMEN

Objetivo: evaluar la participación de los profesionales en la reunión de equipo de un Centro de Atención Psicosocial (CAPS). ***Método:*** estudio cualitativo, evaluativo, con el referencial teórico-metodológico de la Evaluación de Cuarta Generación. La recolección de datos ocurrió a partir de observación participante y de un grupo focal con 17 trabajadores del CAPS. El análisis de los datos fue realizado por la técnica de Análisis de Contenido en la modalidad Análisis de Contenido Temático. ***Resultados:*** el proceso de evaluación evidenció la importancia del equipo de apoyo y del médico psiquiatra se inserir en la reunión de equipo, así como los límites y dificultades de esa participación. La no participación del psiquiatra en la reunión de equipo, pone en evidencia el modo de trabajo ambulatorio que ese profesional desarrolla en el CAPS con acciones individualizadas sin integrarse en el equipo. ***Conclusión:*** la participación de los profesionales en la reunión de equipo amplía el intercambio de informaciones y la calidad de las acciones terapéuticas del CAPS. ***Descriptores***: Sevicios de Salud Mental; Reforma de la Atención de Salud; Atención Integral de Salud; Evaluación en Salud.

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INTRODUCTION

Mental health, in the last 30 years, underwent major transformations and advanced clinical, political and social debate regarding the care process. If before the attention of people in psychic suffering was directed to a single structure of exclusionary character, the psychiatric hospital, currently, care turns to a network of services, having, as the organizing point of the network, the Center for Psychosocial Attention (PSCC).[1]

The PSCC is one of the main instruments for implementing the national mental health policy, acting as a trigger for the construction of care networks. Thus, more than one service, it represents the possibility of a wide network of alliances in the territory that aims at the construction of shared strategies, helping in the resolubility of attention.[2]

The PSCC are divided into three types I, II and III, according to the population of the municipality, and there are also the specific ones for the care of children and adolescents (PSCCi) and for people in psychic suffering by use and abuse alcohol and other drugs (PSCCad). These services are a reference in the clinical follow-up and psychosocial rehabilitation of people in intense psychic suffering, are inserted in the territory and are organizers of the mental health care network.[3]

Since 2001, PSCC has become a major investment focus of the federal government, with the expansion of these services, from 295, in 2001 to 2328, in 2014, that is, low coverage, nowadays has very good coverage, operating significant transformations in the issues of access and maintenance of care in the community.[4] Along with the creation of these assistance devices, a new direction of work, was instituted with the introduction of elements that could support a more humanized and integral care in the perspective of psychosocial care, among them, team work and interdisciplinarity, considered as fundamental work strategies in the paradigm change of mental health care.

Psychosocial care, shows teamwork, centered on the individual, its socio-cultural aspects and subjectivity, and, in front of this, it is recommended a greater horizontality in the relations between the professionals and the construction of spaces that can subsidize a more collective work, process capable of contemplating the complexities of the individual and their dimensions, different from the asylum model, in which the practices are fragmented with vertical relations centered on the knowledge/power of the physician.[5]

Ordinance 3,088, of 2011, when establishing the Psychosocial Care Network, establishes that work in the PSCC should be carried out primarily in collective spaces, such as the team meeting.[3] This space has been stimulated by guidelines and principles of various health policies and programs the sharing of knowledge, the dialogue between professionals and the optimization of teamwork.[6]

Conducting team meetings, in a systematic way, allows, the services, to consolidate an interdisciplinary work process, with potential for discussion of the Unique Therapeutic Projects (UTP), considering the needs of the person and the possible articulations with the territory.[7] Therefore, it can be a valuable technology for managing mental health care.

Team meetings are common in the context of health work, but, in the context of the transformations of Psychiatric Reform and mental health, the need to understand and evaluate how professionals have used this collective space to build a care based on psychosocial care. Such reflection is based on the idea that the Psychiatric Reform is not given from the opening of substitutive services. It operates the possibilities of its implementation are the ways of producing care in the micropolitics of work. Therefore, the modes of care that are provided to people in psychological distress and how they have contributed to the consolidation of integral care must be analyzed. [8] Thus, how team meetings are conducted by interdisciplinary teams innovation, creation and other possibilities of building.

OBJECTIVE

- To evaluate the participation of professionals in the team meeting of a Psychosocial Care Center.

METHOD

Qualitative, evaluative study, with the theoretical-methodological reference of Fourth Generation Assessment, characterized as constructivist/responsive evaluation, alternative to the traditional forms used to evaluate health services, since the focus of the evaluation are the demands, concerns, and needs interest groups.[9]

This study was based on two previous studies: the Evaluation of PSCC in the Southern Region of Brazil (PSCCUL I), in 2006, and PSCCUL II, in the year 2011. The objective of these two surveys was to evaluate the

mental health services in the State of Rio Grande do Sul, Santa Catarina and Paraná, totaling 308 quantitatively evaluated services and three qualitatively, evaluated services based on the Fourth Generation Evaluation.

For the development of this study, which deals with the team meeting, the data collection involved two steps: in the first stage, the qualitative database of the PSCCUL I and PSCCUL II surveys of the city of Joinville, in Santa Catarina, was taken up by field diaries and interviews with workers. Thus, 35 interviews and six field journals were read in full, totaling 535 hours of observation. The systematized analysis of these data aimed to identify issues of interest to workers, related to the work process in the PSCC, that contributed to the construction of care based on the perspective of Psychosocial Care.

The analyzed material was organized in a matrix, constituting information units, and, from its analysis and interpretation, were created the provisional categories, being these: team meeting, organization in miniequipe of reference and articulation of the PSCC with the territory.

The second stage of data collection occurred in April 2014 and was characterized by the return to the service studied for the participant observation and a focus group. Participant observation was carried out with the team in the following activities: team meetings, case discussions, therapeutic workshops and parenting meetings. All observations were recorded in field diaries, totaling 168 hours.

The focus group was attended by 17 workers. The analysis that emerged from the provisional categories was presented so that it could generate discussion. The objective of the focus group was to understand the changes, claims, the perception and the evaluation of the current moment of the work process concerning the provisional categories. In this article, the category related to team meeting will be considered, evaluated by the workers as one of the main working tools of the PSCC. The exclusion criteria of the workers in the survey were: being away for health leave and/or vacation during the period of data collection.

The thematic analysis was used to analyze data from the field observation and the focus group, which is presented in three stages: reading and ordering the information collected in the interviews and field diary; grouping the meanings nuclei, through of an exhaustive reading of the speeches, and interpretation of the material from the theoretical reference of the work process.[10]

The analysis of the material collected in the second stage allowed the grouping of the statements in two thematic categories: evaluation of the participation of the support team in the meeting of team and evaluation of the participation of the psychiatrist in the team meeting.

The ethical aspects of the study were assured to the participants according to Resolution no. 466/2012 of the National Health Council of the Ministry of Health. The research was approved by the Research Ethics Committee (REC) under opinion no. 750,144/2014. Respecting the anonymity, the workers' speech was identified with the letter "T" and the number corresponding to the interviewee and "DC" for the records of the field journals.

RESULTS AND DISCUSSION

♦ Evaluation of the support team in the team meeting

At the PSCC, the team meeting is one of the collective spaces of great importance for professionals to organize the work process. In this space, the team often meets to reflect and talk about work, about the cases followed, share ideas, knowledge, and experiences and doubts. The participation of the professionals in this space contributes to the organization in the division of tasks, besides promoting a better knowledge regarding the referrals of the cases and conduits to be followed.[11]

According to the mental health policy, the professionals who work in the PSCC must have different backgrounds and integrate a multiprofessional team, being characterized in two different groups: the technicians of higher level and the technicians of average level.

In the service studied, professionals are characterized by technical staff and support staff. The technical team is composed of professionals with technical and superior training and is responsible for organizing the users' reception, for the development of therapeutic projects and work in the activities of psychosocial rehabilitation, sharing of spaces for coexistence of the service and problem solving. The support team is formed by professionals of general services, vigilantes, drivers, and administrative assistants, who do not participate in the discussion spaces of the activities.

In the three years observed in the study, the team meetings were composed only by the technical team, however, in 2006, there was an understanding, on the part of the

professionals, that the support team should attend the service meetings, as they directly assisted the activities of the day day and were frequently in contact with users, assuming responsibilities and developing health interventions.

> *Vigilantes have already passed things to important people. The attendant is someone who has contact, because they speculate more than we do, they stop to listen, and why they can not be supported in this? they should have a place on the team, in the meetings [...], this has already been requested [...]. They are a fundamental part because they are circulating around. [...] and we see that they are giving hints, guidance, ... so dealing with them [users]. (T15)*

> *There are hours that are not up to us, which is the clinical part, but have active meetings that is part of everyday life that would be good, I think it would be worth participating, we would grow with them, acquire more knowledge, and I would know how to deal with this question, how to act. Now we become neutral, then complicate, sometimes do not even know how to handle that situation. (T8)*

> *There was one time that we needed one of them ... the guard almost freaked out, said that he did not do it, he got scared and that moved a lot with him. But this I think is for lack of guidance [...] that is a team failure. (T7)*

Support staff members are an important part of mental health care, and their participation in meetings could qualify the actions they already carry out in the service such as listening, dialogue with users and guidance. In addition, they could contribute to the meetings with important information about the users, which would help in the elaboration of strategies of care of the team.

In the psychosocial paradigm of care, listening, dialogue, the building of bonds, trust, acceptance and commitment to the other, that is, relational tools of encounters and subjectivities, as well as equipment and technological knowledges, are prioritized.[12] Faced with this , the work of all professionals who are in contact with users and families, even those who are not specialists, become important and necessary for the construction of mental health care, lacking support and supervision.[13]

It is observed that the meeting between the professional of the support team and the user happens frequently and, therefore, this moment can be used as a therapeutic possibility, with respect to the experience and the knowledge of the professional and valorization of its possibilities for the use of relational technologies. In this sense, the participation of the technical team and the support team in the meeting would contribute both to the qualification of the actions of these professionals in the service, and to the construction of the unique therapeutic plan.

The encounter between the different knowledge in circulation is able to draw, from the learning experience, and technological innovations. In producing the technological innovations, acts of care are produced because they support innovative and creative practices, expanding the look and the technologies for the production of mental health care.[1]

The participation of the support team in the meetings would also enable the latter to become better acquainted with the proposal for the substitutive mental health service, its mode of organization, purposes and objectives, information considered important for those working in the PSCC.[14] This would reduce the professional's suffering of the support team that, is often, faced with complex situations without knowing how to act.

The nature of work in mental health, often associated with working conditions, and the configuration of the teams are stressful conditions.[15] These issues have become more emergent from the changes of care provoked by the Psychiatric Reform, being necessary preparation for the new possibilities of health care, including, attention to the crisis and all of its complexity of approach in the open services.[16]

In the context of the service researched, some attempts are made to insert the support team in the meetings. However, they were not effective, since there is a flaw both of the technical team that, although it tried to include them, presents resistance, as well as the team of support, that always justifies other tasks at the time of the meeting and, moreover, mention the outsourced link as a justification for not being included in the meetings:

> *I see that it is important [participation of guard and servants in the meeting]. Now, there are two things: the team has a certain resistance, but they have to choose to be out. There was a time that was called, that was tried to include, but it is that thing, "ah I have this to do, that, today does not give, tomorrow", is the non inclusion of themselves. (T14)*

> *[...] I think it is our fault, we do not put them together with us [...] we have often spoken of "ah will have to attend the meeting" [...] but there is always something*

> *that they can not [...], they say they are outsourced professionals, [...] they do not want to attend our meetings or some of the activities that the team requested. (T7)*

Of course, there are some limitations to the participation of these professionals in the meeting, as the culture of service organization, that does not include these professionals in the team's collective activities, the demand for work and also because they are outsourced professionals, being more susceptible to turnover, a factor that also discourages their insertion in organizational activities.[14]

In 2011, the participation of the support team in the team meetings was not a necessity mentioned by the professionals and, in 2014, the support team showed no interest in participating, referring to this moment as a generator of nuisance and stress.

> *The general services official said she even knows a little about users' lives, but would rather not get involved because it gives a lot of annoyance, stress, nervousness. He says that he would not like to attend the meeting [...], that the professionals disagree with things, are different opinions and see the stress it gives. (DC1)*

> *At the end of the staff meeting I went into the kitchen and there was the General Service employee [...]. She did not participate in the meeting because she, the driver and the other cleaning employees do not participate, nor the discussions, they seem to function as a separate team, [...] there is no interest on the part of them to participate [...]] has been working at PSCC for many years, and even so, reports being afraid of some users. He says that he always works with the kitchen door closed, because he is afraid that some user will come in surprise and hurt him [...] thinks the service is a mess, that the door is open and there is no time for anything. (DC3)*

Failure to participate in the team meeting makes it difficult to understand the work process of service professionals, since the diversity of opinions and discussions generated in team meetings can be understood as fights or misunderstandings, when, in fact, they may be related to the implication of the team in the referral of the cases and situations of the service.

In addition, in the area of mental health, prejudice is an issue that must be worked on by the team itself. The user, is often seen, as a violent and aggressive person. This perception perpetuates the maintenance of mental health practices in open mental health services.[17]

Care in the territory means that substitute services can constantly rediscuss their role in the construction of care, in order to combat prejudice and stigma within the service and in society. However, this is only possible when teams are integrated and perfecting humanized approaches with sensitivity to welcome without judging and problematizing the weaknesses of their own practices.

It is known that, in the health services, it is common for professionals to refer to the meeting as a stress-inducing activity, tiresome and without objectivity. However, its benefits are unique to joint planning, the socialization of knowledge, and the discussions that can support better decision making.[18]

Given this, what is highlighted, in this study, are the need and the possibility of insertion of the support team in the meeting, perhaps, not with the weekly frequency, but in a strategic way, that can contribute to the mental health care of the team and also promote a better understanding of the proposal of psychosocial care, reducing anxieties, fears, prejudices and even turnover of these professionals in the service.

The importance of employee participation in meetings is evidenced when they recognize this space as a source of discussion, exchange of information, experiences and knowledge, ensuring greater safety of professionals in the work process. Thus, mental health professionals should reflect on how best to insert and value the support team in collective activities, in order to better understand the role of the PSCC, as well as to enhance their care practices.

♦ Evaluation of the participation of the psychiatrist in the team meeting

In the three years studied, the professionals mentioned the importance of the participation of the psychiatrist in the team meetings, because the proposal of work of the PSCC is of an interdisciplinary work and the physician plays a relevant role in the care of the person in psychological suffering. However, the psychiatrist's work in the PSCC occurs in an outpatient setting, focused on the disease, with the use of medical means. Their participation in the service does not happen in collective exchange spaces, but in an isolated way, in the office.

> *[...] he has more privileges, his attendance is more outpatient than PSCC, he passes the medication, the prescription, see how he is and he leaves. It does not get involved, it does not participate in the meetings, it does not participate in any group, rarely in one event and another [...] it is a category that does not participate. I think in a PSCC should have the presence of the psychiatrist*

> *with the team, the meetings, the groups, workshops, like another professional. (T10)*
>
> *It is we do not have what we would like to have the PSCC psychiatrist [...] the one as soon as he would get involved with actions, participate in the workshops, some groups, circulate [...], the psychiatrist's participation in the team PSCC is very little. He does not take part in the daily meetings, [...] he only consults himself [...]. (T7)*
>
> *[...] it is only in the office, I think the doctor also has to come here, because he enters, goes to the office, sits, consult, leaves and leaves. And I think PSCC doctor had to live with PSCC. You should participate, know which group, which workshop, even group, would be ideal [...]. They do not know! only know when you sit in front and talk, do not participate in the conviviality. (T11)*

The psychiatrist's interaction with the team is made in a timely manner, when another professional seeks him or her to talk about some need. However, the doctor should participate in the programmed therapeutic activities and service meetings, so that he/she would better understand the teamwork process, the way of organization and the therapeutic activities offered.

The way in which the psychiatric medical professional is inserted in the services of psychosocial care substitutes reinforces the difficulty of these professionals in adapting to a new model of mental health care that advocates interdisciplinarity, engagement and collective commitment.[19]

The Psychosocial Attention model requires a constant contraposition of the centered medical practices and, therefore, an adaptation of all the professionals of the team to substitutive practices of care whose strengthening is given by the involvement of the professionals in collective spaces of reflections and analysis of the different opinions.

Collective spaces, such as the team meeting, brings the power of the confrontation of contradictions, and it is important that, at such moments, interdisciplinary discussions be done not to ignore the limits of the service, be it defined by the walls of the service or reductionist scientific knowledge of each category professional. Thus, it is understood that these services do not have ready and defined models, but, on the contrary, a constant confrontation of the limits of the culture, of the medical professional, of the team.

Some justifications are pointed out, by the professionals, for the doctor's lack of participation in the service, such as: reduced working hours compared to other professionals; fear that the doctor may ask to leave the service because he does not understand that his participation in the meetings is part of his activities and demand for clinical care by the physician. Such justifications make some workers support that the doctor work the way he or she wishes.

> *[...] that circular question is not just in the room, behind a desk, consulting and passing medication. Even because there the other question right, the time. They make a different schedule. We work six hours for a salary, they work three times for the same, it already decreases the time that it stays here ... it diminishes the actions [...]. (T7)*
>
> *There is one thing that I have been striking a lot at this key, even at a meeting, which is the dexterity that professionals do toward psychiatrists, the fear of them asking for the account makes them do everything they want. (T9)*
>
> *Depends on his availability! The miniequipe always pulls, always wants, always brings to itself, to appropriate the cases, to ask for an aid, but not always there is this possibility, we see that the demand of it is great [...]. (T12)*

These limitations also demonstrate the difficulties that medical professionals face to compose teamwork in psychosocial care services. The action of these professionals, as well as others in the health area, is multidetermined, and is related to factors related to academic training, professional qualification, and stigma and social prejudice itself.[19,21]

The differentiation of the doctor's workload in the PSCC, in relation to the other professionals of the technical team, can be one of the factors that contributes to the maintenance of medico-focused practices, reinforcing the idea of a hypervaluation of the medical category, to the detriment of other professions. In addition, differences in salary conditions reinforce this idea and hamper teamwork.[19]

Differences in the work regime lead to an organization among professionals, in which the physician develops an individualized work, focused on the demand for clinical consultations, not on the broader needs of users who, because they are complex, require the collective construction of care. Thus, due to the doctor's restriction on the work in the office, there is a devaluation of his participation in fundamental activities such as groups, assemblies and team meetings, which should be a priority in PSCC.[3]

The lack of psychiatrists to work in mental health services also causes the staff not to

problematize the work of these professionals in the PSCC, for the fear of not wanting to work in this service. The low demand of professionals to work in the area of mental health may be related to stigmas and prejudices not overcome during undergraduate courses, the little approach with extrahospital services and the challenges of the psychosocial way of care. It is also, necessary to consider the devaluation of relational skills of care and the hypervaluation of technical equipment and procedures.[22]

With this, the changes in the training courses in the health area are relevant. It is in this sense that the new National Curricular Guidelines and some university movements for the reformulation of the curricula are already under way, seeking to integrate the contents in a way that minimizes the fragmentation of the care provided by the professionals.[23] However, it is necessary to invest more in the curricular changes and the instrumentalization and qualification of professionals.[7,23] It is understood that the teaching of health professionals, including those of psychiatrists, must adapt the proposals of the mental health policy, inserting internships and practical classes in the Psychosocial Care Network (PSCN).

The innovations and changes promoted in the formation of a professional committed to the transformations defended by the ideology of the Psychiatric Reform should not be restricted to technological resources of qualification of the therapeutic relations, but, especially, to include the new forms of organization of the teams, such as the interdisciplinary work and the role of technicians, the articulation between clinical and political aspects of psychosocial care, that is, resources that can go beyond the understanding and execution of policies and models, but that stimulate self-reflection and constant reassessment of the impact of the work on the worker's own subjectivity. Thus, it is a complex task, since it is a process that must reconcile a solid theoretical and technical formation, with a critical and creative vocation, that meets the challenges of a continuous process of transformation, such as the Psychiatric Reform.[23, 24]

Although academic training is important, the professional's participation in the day-to-day service also contributes to the training process as a mental health worker. The very space of the team meeting can be considered formative, because it enables constructive discussions among the workers.[25]

According to professionals, the fact that the psychiatrist does not participate in the discussions of the cases interferes with the care being offered, hindering the therapeutic process of the user in the service, because, when working in isolation, such a professional makes decisions that, are often, not discussed with the team and/or are not in line with those agreed upon at the meeting. This situation makes it difficult for the professionals to understand the doctor's behavior and causes, the team, to feel that they do not have autonomy in the work process.

> *What can we offer to bipolar? do not know [...] we'll read in the literature? Let's talk to someone who knows? Then the psychiatrist hits the hammer and it's over. So one or two professionals is the one who has the courage to dare to face a psychiatrist, neither will. [...] I think these difficult ones are going to get these things. (T12)*

> *The miniequipe points out the need, the possibility [of discharge]. The dude is ready, so the mini-team understands that her job is over, if the doctor thinks not, then she stays [...] The mini-team had autonomy [...], today it has no more. There is no such thing as teamwork with the doctor [...]. (T1)*

The difficulty of inserting the doctor in the team meetings is a reality of several health services and, in this way, they end up not sharing their experiences, not even taking notice and following therapeutic practices developed by the team.[19]

It is understood that the power of teamwork and user therapeutics are compromised when a professional's decision prevails in isolation. Participation in decision-making areas could improve the psychiatrist's understanding of the perception and the conduct of other team members, facilitating links and working relationships, sharing information, experiences, feeling of autonomy and appreciation of other professionals in the technical team, in addition to more effective care strategies.

The professionals understand that, in a way, they are themselves acting to reinforce the psychic doctor's power logic in the PSCC, because, sometimes, they feel inferior to this professional, or, also, when the team focuses on the medical therapeutic centered resource, believing that the medication is the only form of treatment, or, when the professionals leave the doctor the final decision regarding care.

> *The professionals they diminish before the role of the psychiatrist, they give the power [to the psychiatrist], [...] he does not want the psychiatrist to have, he thinks that [the psychiatrist] should not have, but she ends up repeating this, this model. (T2)*

> *[...] Is the medication just medication? [...] And then I get caught, as a team, when the psychiatrist does not make us go and "look this guy could take", how many times have I already thought about [...] you end up reinforcing the role of psychiatry , you end up calling and giving them all the power, the guy [psychiatrist] is not here but you are using your therapeutic resources that you think you have [...]. (T12)*
>
> *As much as he sometimes defends and tries to believe that his service is very multidisciplinary [...] sometimes the team gives responsibility, the last word to him. So whether or not we have to train it, it's about how to work interdisciplinarily even with this medical psychiatrist figure, that he feels a participant in the team, that he comes to the meeting, that he argues, that he thinks, that he can listen the opinion of others. So I see it, when he comes we have to know how to use, how to make him feel part of the team. (T5)*
>
> *The doctor's speech is often brought to the team meeting. "Because the doctor said that, that." "But the doctor will not accept that." "It has to do with the doctor first." (DC1)*

It is noticed that the doctor, even though not participating in the meetings, has as their decisions and opinions are always brought to the team discussions by other professionals and/or the doctor is expected to make a final decision at another time. Thus, professionals, in the meeting, space also reinforce a model of medical-centered attention, which is the target of criticism from the workers themselves.

The professionals recognize that this medical centrality of decisions is the responsibility of all, at the moment that "non-medical" professional reinforces a medical hegemonic logic, and, also, does not develop strategies of inclusion of this professional in the team, with the goal of involving him and making him responsible, the process of collective work.

In this sense, there are no "guilty" or "victims", but one can perceive the perpetuation of a hegemonic medical knowledge-power that weakens the proposal of interdisciplinarity and the horizontality of the relationships among professionals, hindering the paths to new practices of mental health care whose different professional knowledge, is important for overcoming health needs.[8]

The shift from medical-psychiatric knowledge to interdisciplinarity is an important pillar of psychiatric reform whose challenge is to deinstitutionalize the hegemonic medical discourse of mental health care practices. De-institutionalizing such discourse means rethinking naturalized practices and creating new forms and possibilities for care. Thus, biomedical discourse is part of a network of relationships, not only located in the medical professional, but involving users, managers, different professionals and society in general. With this, the concept of deinstitutionalization proves to be potent, since it aims to trigger movements of rupture with the established and crystallized knowledge.[8]

In the context studied, it was noticed that the team has a critical eye regarding its model of medical work centered, recognizing the limits and the challenges of this model. In addition, they make moves towards a more collective practice. This can be observed when professionals value the need for all workers to be involved in the decisions and planning, and also when they show the hope that the work process is still developed with the participation of all in the different collective activities:

> *We try to search, try to call. There is now the next meeting the name of our psychiatrist is there to be participating in the meeting, if it happens I do not know, but his name is there. So we try to involve them, but there is resistance. (T7)*
>
> *My dream, like some professionals, is for the PSCC doctor to be together with other professionals, in groups, in workshops, in discussions and in meetings, listening to the team, giving suggestions and building with family members and users. (T9)*
>
> *[...] we understand, I understand that our doctor is part of the team, so he can not be left out in an evaluation reports the social worker during the discussion of a case [...]. (DC1)*
>
> *This goes a lot of the doctor [...] but, it's the team too, we can not expect to sit in a meeting that the doctor comes on his own, sometimes he's not there because he feels a little out of context, because it is not called much. [...] I think if we see that the doctor is not wanting too much, we have to pull! Why are we going to work? If he has to be part of the team [...]. (T1)*

The team recognizes the importance of physician participation in meetings, assemblies, groups, workshops, and finally, in the collective spaces of the PSCC and not just in the office. This professional is a social agent that is part of the team and therefore must share and interact with the other members of the service, enabling a better dialogue in the work process and care based on psychosocial care.

It is evidenced a movement of the team against this traditional mode of medical-

centered organization, with professionals worried about better integrating the doctor with the team for a more resolute and integral assistance. However, it is an important challenge to promote a rupture with the biomedical care model and the construction of an articulated practice among professionals that can overcome the barriers of fragmentation to promote psychosocial care.[26]

In this way, teamwork requires the constant involvement of professionals, and team meeting can be a valuable strategy for meeting these agents. Therefore, it is up to the workers, to enhance the proposal of this collective space, developing strategies of inclusion, right to voice and opinion among all professionals.

CONCLUSION

In this study, the evaluative process evidenced the importance of the support team and the psychiatrist physician to be included in the team meeting, as well as the limits and difficulties of this participation. It should be noted that the support team, for their day-to-day approach to the users, could bring, important information to the team meeting, besides using this space to better understand the complexity of the care that happens in the universe of the service, reducing fears and anxieties of this worker.

In relation to the psychiatrist and his/her non-participation in the team meeting, it shows the way of ambulatory work that this professional develops in the PSCC, with individualized actions and without integration with the team. The interaction of the physician with the other team members is of paramount importance, as it directly interferes with mental health care, in the development of actions of the singular therapeutic plan such as the PSCC discharge proposal, that is, complex actions that require joint decisions and agreed in the team meeting.

Thus, the work of all the professionals that are inserted in the service, in contact with the users, are fundamental, for the construction of the mental health care. The participation of professionals in the team meeting can increase the possibilities of exchanges and information about the users, as well as the quality of therapeutic actions. With this, the team also feels more secure to develop the actions, sharing information, knowledge, doubts and yearnings about the work process in the PSCC.

Therefore, the Psychiatric Reform Movement calls for understanding and attention to the difficulties that historically interfere in the construction of collective practices and mark the complexity of psychosocial care, above all, to unify efforts to transform these practices within the services in the territory. Thus, mental health teams have an important responsibility to be involved in the changes in structures, practices and modes of work organization that still support the asylum model.

Finally, we pointed out the limits of this study, the non-participation of the support team and the psychiatric doctor in the focus group. It was decided to respect the choice and the availability of professionals to carry out the focus group at the time of the general meeting, in which, there is in fact no participation. However, it is important to note that these professionals participated in semi-structured interviews and in field observation.

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