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Analysis of interprofessional in-service education in a Psychosocial Care Center

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This article aims to analyze the interprofessional in-service education from the point of view of workers from a Psychosocial Care Center. It is part of the research study "Qualitative Evaluation of the Mental Health Services Network for Crack Users (ViaREDE)," whose methodological approach was the Fourth Generation Evaluation. The evaluation process provided reflections on interprofessional education based on the Integrated Multiprofessional Health Residency from the point of view of the Psychosocial Care Center's workers. The study showed residencies are important strategies for the development of interprofessional work in healthcare, contributing to permanent education actions and the creation of change processes in care practices. However, they still experience challenges in the micropolitical dimension between workers and residents.

Keywords: Interdisciplinary practices. Permanent education. Internship and residency. Mental health.

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Introduction

In Brazil, mental healthcare has a long history of discussions, proposals, and successful experiences in transforming a specialized psychiatric hospital-centered care into a broad decentralized network for psychosocial treatment, follow-up, and rehab, fostering citizenship to people in psychological distress.

A new range of alternative services to asylums were put into practice, which have been drastically changing the way insanity is dealt with and according to which treating means caring without exclusion and stigmatization. The Brazilian psychiatric reform resulted in great advances in the last few years, with a strong growth in the number of new services. Although this fact should be celebrated by workers in the area and by the state, there are still significant gaps[1].

One of these gaps is evident in professional mental health education. A great number of students still undergo the same technical or university-level education with knowledge based in the old model: psychopathology based on the questionable "presentation of sick people," a self-proclaimed self-sufficient psychopharmacology, a clinic based on medical practices and appointments.

On the other hand, education and discussion of public health and mental health policies are practically omitted when, instead of catering to all their fellow citizens, learning institutions cater to a specific social class. It is as if this perspective is the only possible and existing one, suppressing all the other existing ones in Brazil and worldwide[2].

This scenario is currently one of the greatest challenges to the psychiatric reform. Continued paradigmatic and care transformations resulted in worker education needs. Besides understanding traditional clinic, new workers need to keep in mind that the multifaceted care field spans the incorporation of concepts of network, teamwork, and social and community participation.

Silva et al.[3], for instance, mention that investing in mental health requires a teaching model grounded on, among other factors, human rights professionals who develop multidisciplinary work, relate to other sectors of the society, and are able to conduct cultural, sport, artistical, and income-generating activities. According to Peduzzi et al.[4], health professionals tend to act in a fragmented way, unrelated to the comprehensive approach that contemplates multiple health needs dimensions of users and the population.

Although these skills are still under construction among mental health professionals (since they are considered subjective and thus specific characteristics), studies[3,5,6] have been presenting proposals with vocational education as a pedagogical guideline. Experience and the relationship with work and life realities enable the emergence of critical and reflective processes that can result in changes.

Interprofessional education is inserted in this context and consists of joint education opportunities for the development of shared learning, i.e. two or more professional areas learn and work together based on knowledge exchange and sharing. Discussions on interprofessional education are recent in developed countries, and aim at improving healthcare through teamwork. The principles that guide interprofessional education apply both to different health university courses and to permanent education of a workforce's workers[7,8].

In Brazil, one of the strategies to implement interprofessional in-service education can be seen in *Residências Integradas Multiprofissionais em Saúde* (Rims)[(f)]. RIMS was implemented in 2004 by the Permanent Education Policy in

[(f)] Although the current legislation uses the term Multiprofessional Health Residency, we use the term Integrated Multiprofessional Health Residency in order to stress that, besides being multiprofessional, this education modality should be focused on principles and guidelines from SUS, the Brazilian psychiatric reform, and interprofessional work.

order to train health professionals to overcome health education, knowledge, and care fragmentations. One of its strategies was the creation of new concepts of educational process based on the population's health needs and on teamwork[9].

RIMSs are strategic actions aimed at transforming the organization of services, the education process, health actions, and pedagogical practices that, in turn, would imply in new work processes articulated with educational institutions and the health system. The political dimension of health professionals education through RIMS programs is specialization, and it currently covers the entire country.

Residency can be considered a tool able to improve professional education. Despite the difficulties faced by academic education, admission into residency provides the opportunity of working surrounded not only by decisive aspects in the health-disease process but especially in the wider concept of health[10].

These reflections were also made during the ViaREDE research. Its objective was to assess the psychosocial care network in order to cater to crack users of a Brazilian city. Professional education as a strategy to transform the mental healthcare model was discussed by workers in this evaluation process, where RIMS was one of the topics.

Considering the current scenario, we understand that teaching and education spaces can be catalysts and multipliers of new workers in psychosocial care and Brazilian National Health System (SUS). However, despite the great advances multiprofessional logic aggregates to public mental health policies, we notice a strong opposing movement to this consolidation. Therefore, this paper aims to analyze interprofessional in-service education based on the perspective of workers from a *Centro de Atenção Psicossocial Álcool e Drogas* (Caps-AD).

Methodology

This is a qualitative evaluation approach part of ViaREDE research funded by *Conselho Nacional de Desenvolvimento Científico e Tecnológico* (CNPq/Brazilian Ministry of Health) and developed in a city in the Brazilian state of Rio Grande do Sul.

The Fourth Generation Evaluation (FGE), developed by Guba and Lincoln[11], adapted by Wetzel[12], guided the research's theoretical and methodological process. FGE is an evaluation implemented through the constructivist paradigm's methodological assumptions, where claims, concerns, and issues of interest groups serve as organizational focus (the basis for determining which information is necessary) for the evaluation process through an interactive and participatory process[13].

The objective of involving interest groups in the evaluation process was both to search the most relevant issues in the evaluation context and to potentialize its analytical capability. FGE's educational dimension is considered important and aims to increase the contractual power of groups and their transformative action[14].

ViaREDE research included four interest groups: users, relatives, Caps-AD workers, and managers. Data collection was conducted from January to March 2013 through interviews.

Interviews with each selected group were conducted using the Hermeneutic Dialectic Circle[13]. In the first interview, the interviewee was asked to generally talk about care provided to crack users in the city. Data analysis was consecutively conducted, identifying information units that provided an initial formulation of topics related to the investigation object. In the second interview, the interviewee expressed their own issues about the matter, and the topics that arouse in the first interview were subsequently introduced.

This procedure was repeated with all group members, enabling each interviewee to take a stand and weigh in on the constructions that emerged throughout the analyses of other interviews in this study, in their respective interest group. The data analysis method is based on the Constant Comparative Method. Therefore, data collection and analysis needed to be parallel processes, one guiding the other[11].

At the end of the Circle, the negotiation step was conducted. According to FGE methodology, this step consisted on presenting provisional results analyzed by researchers for their respective interest groups[13]. This provided participants with access to all information obtained in the research, and opportunity to change or confirm its credibility. After negotiating with groups, the final data analysis step was conducted – information units were regrouped, enabling the creation of thematic categories. Each thematic category enabled the creation of evaluation texts. The word "text" here is used in the hermeneutic sense, i.e. a set of signs articulated by a given subject, either individually or collectively[15].

Each interest group raised a group of questions based on the place and relationship established with the evaluation object. Therefore, the aspects evaluated by a group were not always raised by the others. In this paper, we use data related to the interest group of Caps-AD workers from the studied city, comprised of eight participants. The main topics of this group were: health and intersectoral network, work process, and care model. Regarding care model, one of the evaluated issues was related to Rims-based psychosocial care education. Its trigger was the fact that the research location had held practices of a multiprofessional residency program in the mental health area. Based on this experience, the evaluation process enabled reflections on service as an education space. Additionally, inclusion of workers is based on their acknowledgement as a strategic interest group when discussing this topic.

The project was approved by the Research Ethics Committee of *Universidade Federal do Rio Grande do Sul* (protocol no. 20157/2011) and *Comitê Nacional de Ética em Pesquisa* (Conep/Brazilian Ministry of Health - Opinion no. 337/2012). The ethical principles were also guaranteed upon signing the consent document by the participants, in two copies. The subjects' anonymity was guaranteed by identifying them with letter "T," of "team," followed by the interview number (1-8).

Results and discussion

Issues raised in the empirical fact related to in-service education were: teaching-service articulation, clinical dimension and care policy, interprofessional work challenges, everyday conflicts, and the importance of residency to psychosocial care.

Regarding teaching-service articulation, Caps-AD workers indicated a gap between what is taught in academia and what is experienced in the health services reality. In this sense, when faced with this other reality, residents, who are mostly newly-graduates, discover a rather different territory than the one they learn in university. This results in conflicts and difficulties in field work, as the following report shows:

> In the market, they face a different reality from the one presented in university. [...] Some teachers [...] prepare students for private institutions, but 80% of health services are public. (E6)

> I think academia has a huge gap when compared with SUS. (E7)

They also highlight universities are not able to prepare professionals for being committed and responsible, which are required qualities to work in SUS and in mental health. This reflects in the residents' behavior, which is often observed by professionals: "I go, but not that much" (E8).

According to Costa[16], the physical structure of universities – organized in a segregated and fragmented way – is among the challenges and obstacles to accomplishing interprofessional education for health workers. The author also mentions education logic, which is still rather specific and content-based, contributing to actions that hamper the creation of strategies capable of preparing workers with collaboration-based skills, attitudes, and values.

Professionals acknowledge the importance of interprofessional education tools, such as Rims, and mental health specializations to worker psychosocial care education, since those who go through this experience have another view about the issues faced by practice: "Here in Caps, all higher learning

professionals have gone through residency or specialized in mental health. Therefore, I think those who go through residency and mental health places have another way of looking at things" (E4).

This different way of looking at things can be understood under the scope of experiences related to the needs of people who need the service, their life reality, their social, economic and class conditions, as well as the care service reality.

This is when a relationship capable of being therapeutic and building a new knowledge is established[17]. In this sense, residencies were established as a foundation to qualified education of health professionals by providing experience based on integrality and interdisciplinarity, reinforcing them as daily practices in building knowledge[18].

Regarding challenges faced by interprofessional work, professionals identified difficulties related to their role when dealing with the micropolitical dimension's complexity of the in-service educational process of residents, when taking into consideration RIMS specificities. Besides these challenges, this educational process requires workers to change and adapt, which is not always suitable to the service routine: "Incoming workers are poorly educated, and have vices and an academic mind, in the sense of a protected and privileged place where they are the know-it-all" (E7).

This report refers to interprofessional work concepts that, similarly to multiprofessional ones, are recurring subjects in several discussions in the Brazilian scenario, considered a challenge to be overcome in practice. Multiprofessional work is understood as a composition of different disciplines where specific knowledge is the basis for professional practice. Interprofessional work, on the other hand, incorporates the idea of teamwork, which optimizes healthcare aiming at the user's comprehensive health through interactional work. In this sense, residencies are seen as an alternative for the development of skills, attitudes, values, and decisions, which foster collaborative practice in health work[19,20].

On the other hand, workers indicate that the strategies to overcome these challenges in the workers-residents encounter and to fill the educational gap can occur throughout the process of "working in residency and being a resident." This means that work gains a new meaning through its own experience while a worker is trained in service, i.e. related to collectivity, who needs to incorporate integration premises in their practice in order to understand and process changes in mental health in a safer way: "In-service education spans dialogue spaces: conducting team meetings, thinking collectively, being together, resuming our activities every single day, asking, looking at each other, analyzing new vulnerabilities as a worker" (E7).

Therefore, professionals identified what is known as the Paideia effect of teamwork. According to Campos[21], it is an education for life, where life itself is the school, creating co-management modalities that enable subjects to be part of work, education, and intervention processes.

There is also the need for an improved articulation of clinical and political dimensions of care. Professionals bring this issue up as a challenge in practice when trying to overcome this fragmented relationship. In routine work, these dimensions come up as dichotomous and often end up separating the team of residents from its own workers, instead of aggregating them around their differences:

> I think it is important to discuss health policies, but I think residency comes down to that. This is my opinion and a demand from residents themselves. The Physical Education teacher and a residency graduate were talking, 'Because they (RIMS residents) only want to discuss mental, collective, and public health, and doctors only want to discuss cases.' It ends up disaggregating and not working. (E8)

Under the Brazilian psychiatric reform's scope, separation between clinic and policies indicates a concentration in places filled with knowledge/power and specialisms. It is possible to perceive a territory where the production of practices and individuals through binary opposition is still predominant, i.e. which connects them to identities determined by technical and scientific specialties typical of a capitalist society, as well as oppositions, such as theory versus practice, subject versus object.

Questioning this fixation enabled to understand it under the research context not as something individual or personal to workers but as a result of a care model that, despite psychosocial transformations, still strongly imposes its truths to subjects that integrate this scenario. It is understood that questioning and tightening up these dichotomies based on the discussion of Caps-AD as a multiprofessional education scenario enabled to rethink established practices in a transformative way to beyond its mere analysis (even if partially).

In the Caps-AD in question, there was a conflict between residents and the team that resulted in separation without the creation of a mediation space. This evidenced not differences that are essential to healthcare practice but mostly a fragmentary dichotomy of several dimensions: between residents and the team, interprofessional and uniprofessional, education and service, theory and practice. In their reflections, they show fragmentation between clinical and political dimensions. This separation (even due to the cartesian model's hegemony) tends to draw differences apart, making it more difficult to procedurally analyze possibilities of integration.

The answer to these difficulties, tensions, and conflicts was to end Caps-AD as a practice scenario to Rims. However, in the evaluation process, professionals understood that it was time to review this behavior: "Something that I think is important to highlight about residency teams that worked here while I was here: there were relationship issues with the team, and this is a two-way street. Something that I did not agree with but I was outvoted on was ending residencies. I think we can build these things" (E8).

It is possible to notice here that, in the research scenario, Rims produced ruptures that resulted in reflection movements. Multiprofessional education favors constructive criticism on the reorganization of work, emphasizing collaborative practices and their implications to care for the solution of some problems faced, thus understanding the process of working in groups[22,23].

In this sense, acknowledgement of the importance of residencies to psychosocial care based on work of residents in community spaces and social participation of the city becomes evident, as well as the influence the exit of residents from this scenario had on the Users Association space dissolution: "I think it (the Association) stopped a little, because it changed. It was like residencies. With their (residents) exit, they stopped... Since these periods were broken and residents left, maybe this bond was broken [...]" (E6).

Based on these aspects, it is observed that the role residencies and residents play is contradictory and strong, and should be constantly re-analyzed in context with local health policies. The contradiction is revealed in the inclusion of residents as part of the team, in an attempt to consolidate them into health services. Since they are graduated workers, they replace residents/graduate students, with a temporary employment relationship.

Therefore, we understand residents play an important role in practice scenarios while replacing foreigners, acting and producing in this scenario, but in a transition place where they might not continue. This is an interesting contradiction that both strengthens, since it changes reality, and weakens the process. In these cases, Rims still need to be discussed from the pedagogical guidelines point of view, which are able to articulate the multiprofessional role of residencies according to the local practice needs and the health needs of the population from the regions where they are implemented.

Residencies are intercessor spaces of permanent health education actions, since they provide a relationship environment that results from the encounter among workers, enabling changes in healthcare practices. Within the interdisciplinary teamwork movement, a teaching and learning process focused on comprehensive care of people's health and improvement in quality of the community's life are constituted, as well as approaching the population's health needs to beyond the individual-biological scope[24]. In this sense, we were able to visualize, along with workers who took part in the research, through FGE's methodological framework, that RIMS presence in the studied Caps-AD produced an intercessor space of permanent education for workers and service residents based on questioning the mental health work process.

We understood that, even with the separation of residencies, the workers-residents encounter was powerful to enunciate processes of change in the service's mental health work. It was constituted based on sharing and exchanging knowledge among workers, which are essential for mental healthcare, for the psychiatric reform advancement, and for the reorientation of education and the healthcare model.

The creation of emancipated-oriented joint and agreed strategies based on social science, health policy, epidemiology, health planning, clinic, and pedagogical process knowledge should favor the basis for the provision of elements by involved agents, not only for the biological health of individuals but also of citizenship as an essential part of existence[25].

Conclusion

The workers-residents encounter is often permeated with conflicts and tensions that unfold in the field of knowledge and practices in the work routine. The participatory evaluation process developed including Caps-AD workers showed evidence of some difficulties and challenges of this encounter based on the gap between what is taught in university and the reality of mental health services. The encounter between residents and the team is a constant and simultaneous process of constructions-deconstructions-constructions, which is typical of the complexity and dynamism involved in the articulation between education and service, and in the processes of permanent education and interprofessional education.

It was also possible to observe that while universities are still distant from the psychosocial care network's concrete needs and from the psychiatric reform's assumptions, Rims bring to this scenario possibilities to build other points of view and ethical behaviors to workers, which are consonant with SUS principles and guidelines. However, residencies still have a lot of challenges as to the micropolitical dimension of the educational process of residents who experience the health service reality, bringing the idea of academia as a privileged place that does not reflect reality. Meanwhile, it was also understood that these difficulties and the end of these practice scenarios as education spaces widen even more the gap between education and service.

Rims and residents occupy a place of non-places that enunciates space construction processes in practice scenarios while the team is also called upon to change and relocate in this process. In this sense, we believe the power of the unexpected and the dimension of possibilities arise in the resident's occupation of this non-place. However, these enunciations can be processed with conflicts, permeated by tensions and estrangement that thus need strategic spaces, tools, and resources to promote permanent dialogue, mediation, and negotiation among workers, residents, and residency programs. These articulations enable the creation of a common plan based on differences, since they can produce positive and constructive resonances, instead of dichotomous and fragmentary relationships, for interprofessional healthcare practices.

Therefore, we visualized that the Integrated Multiprofessional Mental Health Residency presence in the studied Caps-AD is constituted as spaces of change, growth, learning, permanent education, and mental health education from the psychiatric reform perspective. Even with the residents' distance from service, the relationship built in the workers-residents encounter fostered processes of change in established ways of thinking in the work process. It was also understood that FGE was an important tool used by workers to "make someone speak" and "make someone be heard" when they enunciate and express difficulties found when residents are present in services, discomforts and diseases they felt, potentialities they glimpsed, questionings made by them, and limits they recognized throughout this process.

We highlight one of the greatest challenges of health evaluations is being able to cause reality transformations towards reorientation of the care model. We found in FGE the possibility of contemplating the workers' issues, concerns, and claims through the evaluation process.

Interprofessional education and service as a space for its accomplishment thus appear as a relevant issue for this group, even having already been discussed in previous studies. This perspective follows qualitative researches whose main purpose is to build on certain topics that intersect practical and theoretical fields, situated in a specific context, understanding these truths are born in places, relationships, culture, and history.

Therefore, opening up for this topic provided the establishment of an interlocution with service, reediting its sense under the studied context. It enabled the participatory process' educational dimension to increase the analysis ability of the involved groups, allowing them to rethink previously-made decisions and rebuild intervention strategies in health practices.

Authors' contributions

Christine Wetzel, Eglê Rejane Kohlrausch and Leandro Barbosa de Pinho actively participated in the data collection and analysis, in writing the paper, and in the critical review and approval of the manuscript's final version. Fabiane Machado Pavani and Franciele Savian Batistella actively participated in the discussion of the work's results and in the critical review and approval of its final version.

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