Revista Brasileira de Enfermagem
REBEn

THEMATIC ISSUE:
MENTAL HEALTH

RESEARCH

The multiprofessional work in the Psychosocial Care Centers of São Paulo State

O trabalho multiprofissional nos Centros de Atenção Psicossocial de São Paulo

El trabajo multiprofesional en los Centros de Atención Psicosocial de São Paulo

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How to cite this article:
Jafelice GT, Marcolan JF. The multiprofessional work in the Psychosocial Care Centers of São Paulo State. Rev Bras Enferm [Internet]. 2018;71(Suppl 5):2131-8. [Thematic issue: Mental health] DOI: http://dx.doi.org/10.1590/0034-7167-2017-0300

Submission: 05-06-2017 **Approval:** 09-19-2017

ABSTRACT

Objective: Analyze how professionals understood the multi, inter and transprofessionality and how these practices happened in the CAPS (Psychossocial Care Centers) of São Paulo/SP. **Method:** Qualitative, exploratory, descriptive study, and use of Content Analysis. We interviewed 27 professionals from nine CAPS. **Results:** Organized in two categories: definition of multiprofessional, interprofessional and transprofessional work in Mental Health; and specific aspects of professions and Conceptions about multi, inter and transprofessional teamwork in daily life. There were difficulties in conceptualizing modalities of disciplinary integration, little problematization in the reality of workers, and questions of specific practices of each area. The devices have been problematized, in which the distancing of Public Policies happen. **Final considerations:** There is coexistence of the biomedical, of insane asylum and Psychosocial Care paradigms in the discourses and actions of the teams, to compromise the effectiveness of the Psychiatric Reform. The practice was close to the ideas of integration and of auxiliary interdisciplinarity and not of the effective construction of shared therapeutic knowledge and projects.

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

RESUMO

Objetivo: Analisar como profissionais compreendiam a multi, inter e transprofissionalidade e como essas práticas aconteciam nos CAPS de São Paulo/SP. **Método:** Estudo qualitativo, exploratório, descritivo, e uso da Análise de Conteúdo. Foram entrevistados 27 profissionais de nove CAPS. **Resultados:** Organizados em duas categorias: definição de trabalho em equipe multiprofissional, interprofissional e transprofissional em Saúde Mental; e aspectos específicos das profissões e Concepções sobre o trabalho em equipe multi, inter e transprofissional no cotidiano. Dificuldades em conceituar modalidades de integração disciplinar, pouca problematização na realidade dos trabalhadores e questionamentos das práticas específicas de cada área. Foram problematizados os dispositivos em que se dão o distanciamento das Políticas Públicas. **Considerações finais:** Há coexistência dos paradigmas biomédico, manicomial e da Atenção Psicossocial nos discursos e ações das equipes, a comprometer a efetivação da Reforma Psiquiátrica. A prática se encontrava próxima das ideias de integração e de interdisciplinaridade auxiliar e não da construção efetiva de saberes e projetos terapêuticos compartilhados.

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

RESUMEN

Objetivo: Analizar cómo profesionales comprendían la multi, inter y transprofesionalidad y cómo estas prácticas ocurrían en los CAPS de São Paulo/SP. **Método:** Estudio cualitativo, exploratorio, descriptivo, uso del Análisis de Contenido. Entrevistados 27 profesionales de nueve CAPS. **Resultados:** Organizados en dos categorías: Definición del trabajo en equipo multiprofesional, interprofesional y transprofesional en Salud Mental y aspectos específicos de las profesiones y Concepciones acerca del trabajo en equipo multi, inter y transprofesional en el cotidiano. Dificultades en conceptualizar modalidades de integración disciplinar; poca problematización en la realidad de los trabajadores; cuestionamientos de las prácticas específicas de cada área. Problematizados dispositivos en que se dan y distanciamiento de las Políticas Públicas. **Consideraciones finales:** Hay coexistencia de los paradigmas biomédico, de manicomio y el de la Atención Psicosocial en los

discursos y acciones de los equipos, a comprometer la efectividad de la Reforma Psiquiátrica. La práctica se encontraba cerca de las ideas de integración y de interdisciplinaridad auxiliar y no de la construcción efectiva de saberes y proyectos terapéuticos compartidos.
Descriptores: Salud Mental; Políticas Públicas de Salud; Grupo de Atención al Paciente; Comunicación Interdisciplinaria; Servicios Comunitarios de Salud Mental.

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INTRODUCTION

With the implementation of the *Sistema Único de Saúde* (Brazilian Unified Health System) in the 1990s, based on Health Reform, the concept of health was expanded in the paradigm of Social Production of Health, requiring interdisciplinarity[1]. In the field of Mental Health, the Psychiatric Reform introduced the Psychosocial Attention Paradigm, which seeks to overcome the logic of institutionalization and also evokes disciplinary integration[1]. Over the years, the *Centros de Atenção Psicossocial* (Psychosocial Care Centers-CAPS) have been configured as strategic equipment in the *Rede de Atenção Psicossocial* (Psychosocial Care Network- RAPS) and in the support of the logic of substitution to insane asylums because they are devices of intensive care, community and life-support providers[2].

Discipline is a homogeneous area of study, with well-defined boundaries, responding to power relations and forms of control of discourses[3]. Multidisciplinarity proposes the juxtaposition of several disciplines, without involving joint work and coordination[3]. Interdisciplinarity requires a common problem, with joint work and mutual learning, and recombination of the elements of each discipline[4]. Transdisciplinarity seeks to go beyond, proposing openness to what goes through and goes beyond all disciplines[5].

In fact, the CAPS shows difficulties in the development of multiprofessional practices with the teams, often transformed into a group of workers with parceled practices, still under the influence of the medical authority[2]. It is also observed the auxiliary interdisciplinarity as a challenge to the practices in a multiprofessional team, seen in Mental Health especially when Psychiatry assumes the role of coordinator of the other areas[4].

In addition to the challenges directly linked to disciplinary integration, there is the articulation with the territory and the structural lack as other fragilities of the CAPS. Even though the discourses show Psychosocial Care as the predominant conception, there are internal conflicts in the work processes of the teams and questions about the real viability of the execution of the Mental Health Policies, which seem to depend exhaustively on the creativity of the professionals to be executed[6].

OBJECTIVE

To analyze the conceptions of the workers of the CAPS on the different forms of disciplinary integration and as they happened in the reality of the services of the city of São Paulo/SP.

METHOD

Ethical aspects

The research project received a favorable opinion from the Ethics Committee of the *Universidade Federal de São Paulo* (UNIFESP) on April 23, 2015 and the Research Ethics Committee of the *Secretaria Municipal de Saúde* (Municipal Health Secretariat) of São Paulo/SP, on May 15, CAPS managers signed letters of authorization and all participants signed the Informed Consent Form.

Type of study

This is an exploratory, descriptive, qualitative approach study.

Methodological procedures

Methodological procedures were according to Content Analysis[7].

Study setting

It was carried out in nine adult CAPS in the city of São Paulo/SP, one in the Center-West region and two in each of the other administrative regions: South, North, Southeast and East. Data were collected from July to September 2015.

Study participants

The study was composed of professionals of higher level, and members of the multiprofessional team of the CAPS. The study participants were chosen for convenience, and a member of the coordination and two professional care providers were interviewed in each service, belonging to different professional areas. The inclusion criteria were: to be a minimum of one year in the CAPS and to be a public servant without connection with any Social Health Organization (OSS). In two units there were no coordinators who fulfilled this last criterion, due to the shortage of adult CAPS of direct administration of the City Hall of São Paulo/SP in some regions. It was decided to keep these participants to ensure representativeness and considering that they fit the other exclusion criteria.

Collection and data organization

The interviews were conducted from guiding questions, with audio recording and verbatim transcription for processing and data analysis. The data collection instrument was developed by the researchers, with data from the participant and the guiding questions: "Describe what you understand by working in a multiprofessional, interdisciplinary and transdisciplinary teamwork in Mental Health."; "How does multiprofessional teamwork in the service in which it operates?"; "What factors influence the presence/absence of multiprofessional work?"; "Do you consider that multiprofessional teamwork interferes with the service provided to the user? How?" The excerpts from interview responses are identified by the letter P (acronym for participant) followed by the number corresponding to the order of interview.

Data analysis

Two categories of analysis were elaborated with two thematic units in each: 1. Definition of multiprofessional, interprofessional and transprofessional teamwork in Mental Health and specific aspects of the professions (Thematic Units 1.1 Definitions of multi, inter and transprofessional work in Mental Health, and 1.2 Professional specificity and multi, inter and transprofessional work); and 2. Conceptions about multi, inter and transprofessional teamwork in the daily life (Thematic Units) 2.1 Perceptions about multi, inter and transprofessional teamwork in the daily life of CAPS, and 2.2 Interventions and devices that support multi, inter and transprofessional teamwork in CAPS.

RESULTS

Twenty-seven professionals from nine CAPS Adult were interviewed from the five regions of the city of São Paulo/SP. Of the total of services participating, eight equipment were CAPS II and one, CAPS III. Seven nurses, two psychiatrists, one pharmacist, two occupational therapists, six social workers and nine psychologists participated. There were three male and twenty-four female respondents. The participants' ages ranged from 28 to 64 years, with an average of 45 years and a standard deviation of 10.78 years. Working time in the unit ranged from 1 to 19 years, with an average of 10 years and a standard deviation of 7.03 years. Regarding the graduation time of the professionals, there was variation from 4 to 35 years, mean of 18 years and standard deviation of 8.8 years.

The categories and respective thematic units are presented below.

Category 1 – Definition of multiprofessional, interprofessional and transprofessional teamwork in Mental Health and specific aspects of the professions

When answering about how they understood the modalities of disciplinary integration, sixteen participants approached the concepts of multiprofessional teamwork and eighteen of the interprofessional work; only six knew the transdisciplinary proposal; and twenty-six interviewees believed they knew what the three modalities were about without approaching the concepts in the answers, when the three thematic units were observed. Professional specificities of each area and contradictions experienced in practice between these and the integration proposals were also commented on.

1.1 Definitions of multi, inter and transprofessional work in Mental Health

Among the participants whose answers approached the ideas of multiprofessional work in Mental Health, the main points were the maintenance of disciplinary aspects and the absence of common exchanges and objectives between the areas, focusing on problem solving:

> *The Health equipment is composed of several professional categories. It does not mean that they look at the same work object or* [...] *with the same objective for that subject.* (P7)

Interviewees who addressed the concept of interprofessional work in Mental Health highlighted the occurrence of "exchange" and "integration", as well as the perspective of widening the gaze, and the clinic, observing affinity with the notion of integrality of care:

> *It changes this organization from the institutional hierarchy, from the management, in the relation of the worker, in the worker-user relation; proposes this integration, extended understanding of the subject.* [...] *A real integration of these specificities, of projecting together.* (P22)

Only six participants addressed definitions of trans-occupational work in Mental Health, which still presents challenges:

> *I'm not only talking about my part, nor my part integrated with hers, but a part that has to do with this whole, but that is mine.* (P18)

> *Thinking singularly* [...] *in the user and constructing new knowledge* [...], *which don't belong exactly to any of these sciences, but that the three communicating with each other awaken a new thinking.* (P20)

> *The trans would like to know some service that can do it with excellence. I haven't known it before. In my whole career* [...], *I have never seen service for trans.* (P22)

1.2 Professional specificity and multi, inter and transprofessional work

The disciplinarity was considered necessary in some moments of the practice, especially as possibility of technical improvement and expansion of knowledge:

> *Disciplinarity plays its role when it is needed, but integrated into that whole and has to think that it is not only what it is doing.* [...] *Disciplinarity is never going to die* [...] *is a wealth* [...]. *But you cannot just focus on it.* (P18).

Category 2 – Conceptions about multi, inter and transprofessional teamwork in the daily life of Psychosocial Care Centers

2.1 Perceptions about multi, inter and transprofessional teamwork in the daily life of Psychosocial Care Centers

When questioned about the practices of disciplinary integration in the daily life of their services, the participants listened to some multi, inter and transprofessional moments in the CAPS, which were also approximated to ambulatory practices in some situations. The shared groups, the team meetings, the elaboration of the *Projeto Terapêutico Singular* (freely translated as Unique Therapeutic Project) and the host were listed as examples of disciplinary integration in the CAPS, being verified that they cannot by themselves be considered multi, inter or transprofessional practices, ranging between each service or even in the different situations of the same equipment. In general, teamwork was considered a condition for the approximation of care advocated in Public Policies and the broadening of the user-oriented approach:

> *Sometimes it is inter, most of the times, trans.* [...] *I attended on my own,* [...] *I didn't take it for discussion. This case is seen only by me, it has seen something restricted.* [...] *If I ask*

her to do it to me, she will interfere, she will have another idea, she will be taken to the meeting and she will be seen in a much more transprofessional way than if she had done it that way at the beginning. (P7)

No matter how hard you try not to respond, it is ambulatory scheme. [...] *In these moments we still work as a multiprofessional team.* [...] *Although our team is more multi, from time to time it is inter, and sometimes happens to be transdisciplinary...* (P21)

From the clerk to the receptionist, everyone is of paramount importance, because the treatment at CAPS happens from there at the clerk. [...] *Everything that happens in the service out of the eyes of university professionals, they are talking ... and it is of paramount importance and there is no difference between them either.* (P3)

The patient undergoes screening [...]. *Scheduled* [...] *assistance with the technician, assistance with the doctor for an assessment* [...]. *If the team feels that the patient still has no conditions, they continue to monitor him in other groups* [...]. *As the patient doesn't respond, doesn't adhere, the person in charge of the workshop assesses that the patient is not well, brings to the discussion* [...]. (P13)

2.2 Interventions and devices that support multi, inter and transprofessional teamwork in Psychosocial Care Centers

In commenting on the reception devices, ambience, *Projeto Terapêutico Singular* (freely translated as Unique Therapeutic Project) and Technical Reference (TR), therapeutic groups and workshops, clinical-institutional supervision and networking and their articulations with the multi, inter and transprofessional proposals in the reality of the services, draws attention to the distance between the theory and documents of the Ministry of Health and the practice in the CAPS. It can be verified, in the speech of the participants, the impoverishment of these resources in front of scattered and overburdened teams and the difficulty of approaching Psychosocial Attention. As main examples of this subunit, one can consider the reality of PTS and TR devices, therapeutic groups and workshops and ambience:

Very focused on workshop [the PTS] *and sometimes a person's life project does not contemplate any of that. Project of life. The demand of the person is not that of the service.* (P24)

It had a range of activities, it seemed more like entertainment than a follow-up (therapeutic groups). [...] *The most theoretical thing, we realized that we didn't have as much.* (P20)

If there are no workshops taking place, [...] *turn on the TV and they stay in the ambience.* (P14)

Everyone [...] *have the Unique Therapeutic Project, although many patients only consider it important to consult a doctor.* (P13)

They divided the patients [...]*, about 110 for each one, and we are beginning to call them* [...]*, re-adapting the Project.* [...] *You can't think of inter, you were attending ... Now that we have the most structured team.* [...] *Almost 50% of the patients or even more only come to a medical appointment* [...] *and in this, many patients were kind of left behind.... It's no use for you 20 or 30 patients doing activity with the clerk and you cannot go there to see if someone is in crisis, whether it is improving or not...* (P6)

The professionals integrate more, they know what they are doing in one group and in the other, they discuss more about it, they plan an activity that has to do with the others [...]. *Integrate the therapeutic offer itself* [...] *Moving closer to something more interdisciplinary, more integral.* (P18)

It's hard to handle. Before, we had institutional supervision and the City Hall took it. [...] *I think it's very important.* [...] *Possibility of being able to work our difficulties as a team, in the question with the user, in the way we relate to the team, is also the form that will appear there with the users* [...]. (P9)

DISCUSSION

Category 1 – Definition of multiprofessional, interprofessional and transprofessional teamwork in Mental Health and specific aspects of the professions

11 Definições de trabalho em equipe multi, inter e transprofissional em Saúde Mental

In the proposal of interprofessional work, the team meetings were valued, especially when the porosity between the professional boundaries and the specific aspects of each area was problematized, the importance of work organization and the reduction of the hierarchies between management and worker and these and the users.

As a result of the trans-professional work, the interviewees considered it as a possibility to go "beyond" the other modalities, from the production of something "new", not belonging to any of the fields per se, with the user's needs as the main goal of the actions. It was possible to verify, both in the answers that went away and in those that approached this proposal, that the notion of transdisciplinarity referred the interviewees to a distance between literature and practice, being considered unreachable and sometimes non-existent in the current reality of CAPS.

1.2 Definitions of multi, inter and transprofessional work in Mental Health

In this unit, the interviewees observed the importance of maintaining the disciplinary knowledge, and the contradictions between the specific aspects of each area and the proposals of disciplinary integration; the lack of clarity of the teams and users of the CAPS (cited by professionals interviewed) on the different professional roles; the disputes between knowledge and power; and the importance of dialogue among workers. One can think of the confrontations between the proposals of disciplinary integration and the formal and bureaucratic aspects, like the Professional Councils, marked by the disciplinary logic and control of the speeches, and the *Registro das Ações Ambulatoriais de Saúde* (Registry of Ambulatory Health Care Actions- RAAS) (fundamental for indication of service productivity), which does not allow placing two professionals coordinating the same group, for example.

The notion of discipline is related to the Cartesian Method, which defends the fragmentation of the object and the specialization of the researcher, proposing strict boundaries between knowledge[4]. Although fundamental to the development of several existing technologies, this paradigm has as its difficulty the apprehension of objects that are not subordinated to only explanatory approximations, but which cannot but be part of the field of science[4]. Concerned with the multiplicity of the real, Morin[8] presents the concept of complex objects, which seeks to account for the articulations between different disciplines and the different dimensions of the events that present themselves. In this context, health can also be understood in an expanded way, from Public Health to Collective Health, a field marked by epistemological innovation, with the inclusion of new dimensions and understood as transdisciplinary in health-disease-care integrals[4].

Based on the definitions of multi, inter and transdisciplinarity, Almeida Filho[4] observes that these modes of understanding disciplinary integration do not consider the practical difficulty of different fields, which start from different assumptions, to be able to communicate effectively and propose some redefinitions in the idea of transdisciplinarity. It suggests that disciplinary fields are understood as praxis rather than structures, composed of intraparadigmatic elements (symbolic, ethical, political, pragmatic) and knowledge is an institutional network operated by concrete and pragmatic historical agents, which are linked to the socio-political context[4].

Therefore, transdisciplinarity would occur from the communication between the agents of each disciplinary field and not between the fields[4]. It would be the "transit of the subjects of the speeches" that would guarantee the different accesses to particular facets of the complex object[4]. In each field there would be "agents of scientific practice", moving between at least two disciplinary fields and "experts", who remain in their own fields and the syntheses could take place in the paradigmatic bias in each disciplinary field, with the enrichment of each and transdisciplinar, from the practice of the agents, with the reach of provisional totalizations of the complex objects[4].

In the various conceptions of disciplinary integration, it is worth emphasizing that the forms of disciplinary, multi, inter and transprofessional work do not cancel out, which would retreat to the idea that there would be a unique form of response to the multiplicity of life, but can be thought of as four arrows of the same bow[9]. It is observed the importance, rather than the attachment to the different forms of work, that care is centered on the demand of the user and that knowledge can be produced from the idea of democracy[4,10].

Category 2 – Conceptions about multi, inter and transprofessional teamwork in the daily life of Psychosocial Care Centers

2.1 Perceptions about multi, inter and transprofessional teamwork in the daily life of Psychosocial Care Centers

In this thematic unit, we highlight the perceived differences between the definitions of the disciplinary integration modalities of each interviewee and the practices of the different equipment, such as services in which there is a glimpse of transprofessional actions and others still mostly ambulatory.

The problematization between the ideal discourse in contrast to the possible practice was also highlighted, especially when considering the overload to which the professionals are submitted, often approaching ambulatory practices. Ramminger and Brito[6] will relate this to the "anticipated unforeseen events", daily events that have no forecast in the team's schedule and the attendance of users who could be in other levels of attention of the network in the CAPS.

Some respondents note the way in which "non-conventional" professionals (not directly related to the health area or even without a higher education level) appear in the care of the users: although one wishes to speak of a valuation of different forms of knowledge, present in the ideal of disciplinary integration[9], in practice it is verified that, in addition to legal difficulties, such as deviation of function, secrecy, etc., they still occupy the role of informants of the technical team. Ramminger and Brito[6] point out, in contrast to the answers to the guiding questions, that the work in the CAPS ends up maintaining social divisions and other characteristics of the practice in psychiatric hospitals, so that the professionals seem to have recourse to the model they intend to overcome.

At this meeting, in several responses of this study it was possible to verify the coexistence in the CAPS of the Psychosocial Care Paradigm and the insane asylum mentality, seized for example in language (users still as patients without voice) and few allusions to participation and to the social control of users, an important way for the effective place of citizens, as well as the prevalence of auxiliary interdisciplinarity[4]. Despite the advances made by the Psychiatric Reform, CAPS are still understood as a place for "patient treatment"[6] and many discourses still seem empty, repeaters of ideals with no resonance in everyday life. In this respect, Mattos[11] points to the loss of political power due to the "banalization of use"[11], especially regarding the use of terms with empty sense, which draws even more attention when considering that the Psychiatric Reform is process that demands constant construction.

2.2 Interventions and devices that support multi, inter and transprofessional teamwork in Psychosocial Care Centers

When approaching the reality of TRs in the CAPS, it is verified that, faced with the daily overload of care and tasks, these end up distancing themselves from effectively therapeutic proposals and the production of contractuality. They are able, at most, to manage the care of the user, knowing, for example, the facts of their daily lives and their follow-up in the health service or in other spheres of the network. The same happens with PTS, which ends up being reduced to "what activities the user is inserted" or even "on what days it comes to the CAPS". In the worst case scenarios, the participants emphasized the presence of users only in medical consultations, valuing medication care to the detriment of others.

The PTS faces as limitations to its practice the difficulties of teamwork, centered on the biomedical model and with reduced knowledge sharing; the removal of the theoretical bases in the daily life; the overload due to the high demand of the services; the lack of discussion of the PTS with the user and the family; the fragmentation of the PTS implementation in the different levels of attention and the restricted understanding of the PTS only as an administrative tool[12].

In this sense, the presence of "expected contingencies"[6] in the daily life of the CAPS teams and the attendance of users of other levels of care are also observed in these services, either because of the difficulty of articulation with Primary Care or even by the presence of the "chronic-beauty"[6], users who no longer need CAPS, but there they attend because they are not inserted in other spaces. Dedicated to the figure of TR, Miranda and Onocko-Campos[13] observe that this device supports a permanent paradox, involving the delicate relationship between giving support to the user and taking care that it does not become "pathological identification", not producing autonomy.

Regarding therapeutic groups and workshops, it is worth mentioning the disconnection of these with the theory, which become "recreational" and are little problematized, as if the simple occurrence guaranteed an approximation with the presuppositions of Psychosocial Care. It was possible to verify, in the participants' speech, the occurrence of shared groups, being able to alternate between multi, inter or transprofessional proposals, depending both on the interviewee's understanding of these modalities and on the reality of the service. The professionals highlighted the need for integration between the CAPS workshops, observing greater power when these spaces talk, and recycling aligned with the users' PTS and equipment mission. In some responses, there was a devaluation of the "doing" of groups to the detriment of those who use speech, in a simplified view of these actions, which can be equally therapeutic if appropriate.

Cedraz and Dimenstein[14] have critically devoted themselves to understanding whether the groups and workshops in the CAPS actually deal with deinstitutionalizing modalities and could point out how they can be used in favor of insane asylum logic, of "morality treatment" or even simple occupation. They pointed to the presence of consumer bias in these spaces, with users as "consumers" of the products that the team proposes, with little participation in the construction and production of their meaning[14].

Also from a critical perspective, Thomé[15] opposes the idea of a "schedule of activities", widely disseminated in the CAPS, observing that this organization seems to respond to the need for productivity of services and not to care in Mental Health and ends up avoiding the direct contact of the team with the users, when promoting mediated and stiff attention. As a proposal, considers the urgency of approaching the team with psychosis, through "disagreeing care" and the willingness to take care of the user as and when they can present themselves, thus enhancing the ambience. Such management would bring the service closer to a "psychotic" and not "neurotic" functioning, favoring the care of the crisis in the CAPS[15].

Although this perspective has a great theoretical power, it is questioned, from the interviewees' statements, how this happens in the practice of services, considering the routine of the teams and the difficulty of significant ownership of the CAPS devices. Thomé[15] points out that the unmediated contact with madness can affect the worker, which seems even more worrying in teams without clinical-institutional supervision, something brought by some participants of this study.

The ambience also seems to be an odd device as a scenario of the distance between theory and practice. When it is problematized as "watching television" (P14) or even "all spaces of the CAPS" (P20), it ends up moving away from the possibility of qualification of space and relations, fundamentally promoted by the team. According to Willrich, Bielemann, Chiavagatti, Kantorski and Borges[16], this device allows interactivity and integration between professionals and users, production of meaning and redemption of citizenship in daily demands. One can think of the possible autonomy of each subject in a place, from the appropriation of the spaces and the coexistence, therapeutic bond and individualized look[16].

This is also valued as a possibility to move in the face of the diversity of strategies used by CAPS based on the varied needs of users[16]. In practice, it turns out that this intervention ends up being mostly in charge of Nursing technicians, given the routine of TRs and the "doctor's armor" (P22), which also does not participate in this space. In this way, it turns out to be only space for coexistence and the accomplishment of daily tasks, entertainment or self-care.

Returning to the ideas of Thomé[15], the question is again whether the reduction in the supply of groups can actually be signified in the CAPS, nowadays, as a plastic possibility and of greater contact with the users or if it ends up becoming empty the services, and load the routine of the TRs of scheduled care of "ambulatory" users. It is felt that this change, by itself, would not be enough to guarantee the care of the crisis, which is more related to the possibilities of qualification of attention, effective work in network and increase of the investment in these services.

Finally, although certain CAPS devices support substitutive practices, the change of logic in Mental Health care does not occur automatically, as do the multi, inter and trans-professional proposals, which do not depend only on the coexistence of areas in these services. They can be leveraged by investing in the training of Mental Health professionals[17-18] and by enhancing the service/matrix support network[18-19] in order to ensure that changes in care are no longer linked to spaces, being able to reach changes in mentalities[20]. It is also observed the importance of political decisions in the direction of the Psychiatric Reform and the effective implementation of RAPS, since the CAPS equipment is not enough to overcome the psychiatric paradigm[21].

Study limitations

Participation of two managers linked to OSS in order to maintain the coverage of all the regions of the municipality. The use of the interview method, which allows respondent' "desirable" responses, and bias in qualitative research, possibly due to the researcher and participants being agents of the process. As a strategy to reduce these losses, the importance of trained researchers, who can reduce the impact of "familiarity/strangeness" of the participants, is considered. Multiprofessional teams should have knowledge about multi, inter and transdisciplinary work to try to develop them.

Contribution to the areas of Nursing, Health or Public Policy

Deepening of the discussion and listening of the professionals on the modalities of disciplinary integration, condition to implement the Psychiatric Reform. Approximation of the reality of the CAPS of São Paulo/SP, a municipality whose SUS implantation occurs in a peculiar way, due to the extension and political history not always aligned with the Ministry of Health,

and still lacking in publications. It criticizes the coexistence of the insane asylum model in substitutive services, and reinforcement of the need to change mentalities for the implementation of the Psychosocial Care and Psychiatric Reform Paradigm, also exemplary of the national reality.

FINAL CONSIDERATIONS

By listening, it was possible to perceive that the proposals of disciplinary integration are still little problematized in the reality of the services. Although they are valued in the interviewees' discourses and in the literature, they show concepts about which there is no clarity or there are simplified appropriations, usually in the bias of dialogue and integration between different knowledge, but little problematized as the production of democracy and horizontal relations . We also highlight the prevalence of auxiliary interdisciplinarity and the contradictions experienced by professionals between what they consider to be specific to their training, or even what is advocated by professional councils, and the proposals for disciplinary integration.

There were differences between the interviewees' perceptions about the CAPS in which they worked, and some services were considered primarily ambulatory, with incipient disciplinary integration, while in others there were references to transdisciplinary practices.

The challenges pointed out do not seem to be exclusive to the service surveyed, which justifies the importance of dialogue with the difficulties experienced throughout the country in the implementation of substitutive equipment. The expansion of research and the daily approach of the teams that work in the multi, inter and transdisciplinary perspectives are fundamental tools for the implementation of the SUS and the values of the Psychiatric Reform, as well as the political action and necessary investments in the area.

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