

The Institutionalization of psychosocial care: the Mühlmann effect in the professional practices of a Psychosocial Care Center

A institucionalização da atenção psicossocial: o efeito Mühlmann nas práticas profissionais de um Centro de Atenção Psicossocial (abstract: p. 17)

La institucionalización de la atención psicossocial: el efecto Mühlmann en las prácticas profesionales de un Centro de Atención Psicossocial (resumen: p. 17)

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Under the assumption that professional practices in mental health services can reflect the institutionalization of psychosocial care in the technical-assistance context, the objective was to analyze the institutionalization process through the professional practices of a Psychosocial Care Center. It is a descriptive and qualitative study, part of intervention research. The data were analyzed in light of the theoretical framework of Institutional Analysis and the psychosocial care model. Although the founding movement of the Brazilian Psychiatric Reform puts tension on the established asylum, professionals tend to reproduce it in practice. Despite the theoretical-practical fragility, some perceive the need to promote the subject's autonomy, but the Mühlmann Effect is observed in their practices, which, in this case, means falsification-distortion of the principles of the Brazilian Psychiatric Reform. It is necessary to create devices for reflection and transformation of mental health care to face this institutional effect.

Keywords: Mental health. Psychosocial care. Work. Multidisciplinary team. Institutional Analysis.

Introduction

The Brazilian Psychiatric Reform movement (RPb) has made possible to advance in mental health care, with the restructuring of services and work processes so that care is directed towards humanization, comprehensiveness and respect for people in psychological distress and, therefore, is directed by the psychosocial care mode/model, which prioritizes territorialized care in community health services^{1,2}. Its directives are respect for human rights, guaranteeing the patient's autonomy, freedom and citizenship, and equitable care, which takes into account the psychosocial context of the person in psychological distress^{1,2}.

By going against the abovementioned psychosocial care model, the manicomial mode considers the disease (the sick subject), in its organic aspect, as the object of work/care, and aims to suppress symptoms, using medication as the main means of work, without considering the subjectivity and the subject's capacity for decision and participation in this process. Working relationships are based on hierarchization and, therefore, even if there are other possibilities for means/tools of care, the division of labor model corresponding to the 'assembly line' prevails, equivalent to the common production of goods in mechanization, without shared discussion and often reducing communication between members only through the medical records³.

Even with the advances made by the RPb, it is clear that the psychosocial care model continues as an instituting movement, that is, a force for change that confronts what is set as the norm - the instituted - denying it, stressing it and seeking to transform it⁴. As a consequence of this instituting movement, strategies and points of care for mental health have been created which should be articulated through the Psychosocial Care Network (RAPS), with the aim of replacing mental institutions and the instituted asylum model^{1,2}, in other words, what is already known, the rule/order already in place⁴. This process is called institutionalization - a dialectical movement that promotes a union-tension capable of turning the instituting into the instituted; there is no necessarily a good or a bad side in this process⁴.

However, despite the fact that psychosocial care has become a concrete institution, in terms of the legal-political sphere, materialized through community mental health care establishments, such as the Psychosocial Care Centers (CAPS), and in the reorganization of the RAPS as a whole, it is necessary to understand that the RPb is a complex social movement, made up of four dimensions, in addition to the legal-political dimension: the socio-cultural dimension, the theoretical-conceptual dimension and the technical-assistance dimension; which are intertwined and codependent within a process of transformation⁵, encompassing aspects of basic and in-service training, everyday practices, as well as, the historical view directed at the person in psychological distress, which can be loaded with stigma.

With regard to CAPS, they were created to serve as replacement services for mental institutions, since they were supposed to provide care according to the prerogatives and guidelines of psychosocial care⁶. However, there is a tendency to perpetuate/maintain asylum care in establishments/services with asylum-replacement principles⁷. Furthermore, as they are one of the main services of the RAPS, the daily life of the CAPS can reveal to us, through professional practices and the work process,

details about this continuous dialectic between the instituting and the instituted. Despite this, there are only studies that problematize the weaknesses and difficulties of psychosocial care, but which do not directly discuss the process of institutionalization of psychosocial care, based on institutional analysis^{8,9}.

Against this backdrop, this study sought to analyze the process of institutionalizing psychosocial care through the professional practices of a CAPS, since, given the complexity of this process, it is pertinent to discuss its effects and repercussions on mental health care and on the materialization of the mental health policies proposed by the RPb.

Method

This is a descriptive and qualitative study, part of the exploratory stage of an intervention-research entitled "Interprofessionality and mental health care", which was divided into three stages: entry into the field, exploratory moment and intervention moment with data analysis. The matrix research aims to analyze interprofessional care in mental health care, which covers the CAPS, and also two family health units in the same municipality, and which began during the Covid-19 pandemic. Participants included professors and students from the postgraduate and undergraduate nursing programs at a public university, all linked to a mental health research group, as well as health professionals from the services, who freely chose to contribute to the research as study participants.

Intervention-research takes on the political character of seeking transformations by questioning the various meanings crystallized in institutions¹⁰. The qualitative method proposes a subjective analysis, where motivation, aspirations, beliefs and values must be understood as part of social reality, observing situations through different interpretations, considering the individuality of the subjects¹¹.

The setting for this study was a type I CAPS in a state capital of Brazil. All CAPS health professionals were included in the study, and inactive professionals due to illness, vacations or other types of leave were excluded. Of the 24 professionals at the service, only 11 were active, and only nine agreed to take part: two nurses, two psychologists, three social workers, a pharmacist and a journalist, who worked as the service manager.

Data collection took place between June and September 2020, based on participant observation, in which individual appointments, case discussions and everyday situations were observed, recorded in a researcher's diary, and individual semi-structured interviews, with questions about the work routine and mental health care, which were carried out in the service itself during working hours, lasting approximately 50 minutes and recorded with an electronic recorder. To guarantee the anonymity of the participants, they were identified by the letter P, referring to professional, followed by cardinal numbers, chosen at random.

The analysis was carried out according to Bardin's thematic content analysis¹², which consists of three chronological stages: pre-analysis - where the data collected was subject to free-floating reading and then read exhaustively; exploration of the material,

in which coding units, classification and categorization are defined; and treatment of the results, in which inferences and interpretations of the data are made in the light of the theoretical framework of Institutional Analysis and psychosocial care^{4,5}. Based on the thematic content analysis of the participants' statements and the researcher's diary, two categories were formed: 1) Established practices in the organization of work and mental health care at the CAPS; 2) Training, management and working conditions: aspects that put pressure on the institutionalization of psychosocial care.

This study began after it was registered on the Brazil Platform and cleared by the Research Ethics Committee under opinion No. 4.199.950/2020, and the interviews and observations were carried out after signing the Informed Consent Form (ICF).

Results

Practices established in the organization of work and mental health care at CAPS

When working/caring people in psychological distress, some professionals use terms linked to infantilization or reduce mental health care to the empirical task of motherhood, far removed from scientific knowledge. In addition, one of the participants mentioned the need to be close to the user, more in the sense of guardianship than strengthening the bond.

And I know that the patients miss it too, because they call and say 'Auntie, when are you coming back?' [...] others don't even say 'Auntie', it's 'Mom! I miss you so much! That's very gratifying, we miss it a lot, don't we? (P3)

The distance [caused by the pandemic] is detrimental, especially in mental health practice, because we need to be closer, due to the whole issue of behavior [referring to dangerousness]. (P9)

On the other hand, the majority of professionals show that they have a broader view of the subject, beyond the diagnosis presented, in which the objective of the work is also to prevent hospitalization, to welcome the patient and to guarantee the patient's autonomy and social reintegration, even though one of the professionals mentioned cure as the purpose of the work.

It should be noted that the conceptions and practices of asylum and psychosocial care in the institutionalized-instituting relationship encompass continuous/articulated and non-polarized movements.

At CAPS, our mission is not to let the patient reach hospitalization. [...] So, in reality, when we're in mental health, we try to see the patient in a global way, which we talk about holistically, [...] not just focused on mental disorders. (P1)



There is no magic way of curing someone with a disorder. So there are various possibilities for taking care of mental health. (P2)

At the end of the day, I think the goal is always to be able to offer the best treatment for the patient, right? This whole idea of mental health, [...] [care] being territorialized. For the person to increase their autonomy. (P8)

In mental health care, we have to see the patient as a whole, not just the issue of the disorder itself [...]. The patient is not just the disorder [...] you have to consider all areas, the private area, the social area [...]. (P5)

We need to build [care] together with users, right? Understand what they see and think is best for them. (P9)

Regarding the work instruments established in the service routine, home visits, matrix support, groups and individual care were the most repeated in the professionals' responses, even considering that most of these activities were suspended during data collection, which took place in the context of the Covid-19 pandemic. The inclusion of leisure activities was also mentioned by the participants as a working tool to be adopted by the service.

We do active search, nursing care, psychological care, social work too. (P3)

Here we have matrix support, the social referrals that come from CREAS and the Social Assistance Department. (P7)

Because before I used to do home visits, I used to do matrix consultations [...] with the pandemic, all these activities have diminished or ceased. (P8)

We had planned to add the issue of leisure to the activities planned for next year. (P9)

On the other hand, the Personalized Therapeutic Project (PTS) is scarcely used in everyday work and, when it is used, it is conducted in a fragmented way by the team. In addition, there was no reference in the data to user participation in the construction of the PTS.

I think we could change something or other in the sense of perhaps making a PTS, where patients were free to choose their groups. (P2)



There was evidence that the PTS was agreed with the user in a segmented way. Individual appointments are made with the psychology, social work and nursing 'services'. (Researcher's diary, 07/22/2020)

This fragmentation of work is not limited to the realization/construction of the PTS and is present, more intensely, in the work process and in the misuse of opportunities for interprofessional action, such as conducting case study meetings. It can be seen that the segmentation of work is sometimes recognized and criticized by the team professionals themselves.

What we do here is multi-professional work [...] the patient goes through reception, then if they have a clinical problem, they go to the nursing staff. Is he in a lot of pain and needs therapy? They go to the psychologist. [...] Sometimes one person says one thing, then another says something else and the patient doesn't know what to do next. (P4)

It would have to be done in this integrated way, but sometimes it's not done, everyone does their own thing, what they think suits them. (P5)

In situations of care for patients in crisis, the professionals don't work together to improve reception and the therapeutic procedures to be carried out. (Researcher's diary, 08/21/2020)

Another relevant aspect is the overlap between medicine and other professions. The professionals say that many users seek medication as a treatment, therefore the medical professional is their first choice, to the detriment of the work of other categories, which favors the centralization of care based on the biomedical model. However, this attitude is not unilateral, since the team also naturalizes the medical hierarchy within the service and works from this perspective.

In mental health, the issue of pathology is very strong, right? Diagnosis and medicalization. People are more used to it and look for it. They're less willing to come for nursing or social services. There are a number of issues of [the user] not understanding the importance or not knowing, or overvaluing medical care and medication. (P8)

We try to offer it at work, even if it's just the medication part. (P9)

[...] when there is medical care in the service, all the professionals work in function of this care, leaving aside their responsibilities, inherent to each profession. (Researcher's diary, 19/06/2020)



Despite the obvious fragmentation, there are some interprofessional practices instituted in the daily routine of the service, such as the discussion of conducts and some shared care, which lead to the institutionalization of interprofessionality, as well as demonstrating the recognition of the benefits of this type of work.

We always try to bring issues in a case to the team in this case study [...] when we want to solve it faster, we usually talk to the professionals who were there at the time, to see their opinion too. (P1)

The positive points [of interprofessional work] are that, as well as all the professionals knowing about each case [...], it's a way of communicating better internally, and it also helps patients better. (P7)

Today, two professionals from different categories attended to a user.
(Researcher's diary, 07/02/2020)

Training, management and working conditions: aspects that strain the institutionalization of psychosocial care

This study also identified that most professionals, despite the discourse of an expanded view of the subject, have weaknesses in some concepts and theoretical-practical knowledge closely linked to mental health care, as well as laws, ordinances and regulations that guide work in psychosocial care.

Interprofessional work? If it's a synonym for multi-professional work... (P2)

The psychosocial care network? it's the CAPS, right? (P5)

[Psychic suffering] is the deception of the mind. (P7)

It's noticeable that one of the professionals doesn't know the laws, ordinances and regulations that are basic guidelines for mental health care in the psychosocial care model. (Researcher's diary, 08/14/2020)

Several precarious working conditions were also identified, such as a lack of materials and structure, temporary contracts and disparity in salaries. In addition, there is dissatisfaction with local management, specifically the municipal mental health coordination, due to the distance and little support for the development of actions that go beyond individual care.



We don't have an adequate structure. There's no material, there aren't enough rooms for appointments, rooms for group appointments. We have no support from the manager. They don't provide a car once a week for visits and matrix support. (P1)

The CAPS is required to provide care for patients in crisis, as it is supposed to, but it doesn't have the necessary support and structure to do so. In addition, the professionals complain about the disparity in salary between the forms of hiring and the employment contracts by appointment, instead of selection by technical capacity. (Researcher's diary, 08/17/2020)

[...] one point that weakens the institutionalization of psychosocial care is the disarticulation between local management and professionals. I've noticed that the manager of the service only has organizational responsibilities, and the local management has been distant from the service. (Researcher's diary, 07/03/2020)

Even though care is centered on the physician, the professionals also denounce the precariousness of human resources, high turnover of workers, little or no space for permanent health education/in-service training and lack of supervision and/or clinical and institutional support.

Because there's only one doctor, and with the reduced number of patients, this waiting list is growing [...] then you have to see the most serious ones among the serious ones, to schedule them with the doctor. [...] We don't have continuing education, and the turnover of professionals is very high. We don't have the support to go to the PSF every month, guiding the teams. (P1)

[...] I fell into this CAPS like a parachute, I'd never heard of a CAPS. (P4)

I think CAPS needs clinical supervision because things become very automatic and we need the eye of another experienced professional. (P6)

Despite the established practices that strain the process of institutionalizing psychosocial care, it is worth noting that there are professionals with knowledge and commitment to the anti-asylum struggle and that they recognize the weaknesses and problems of the service and local management, such as the fragmentation of work, the centralization of care based on medical knowledge, insufficient theoretical training and, in this way, shed light on the practices that establish psychosocial care within the CAPS.

I don't know about RAPS in a complete way, I should know more. (P2)



Ideally, we should always work as a team, because often my knowledge goes as far as "x", but then another professional has more knowledge. (P5)

Care in the territory is this whole idea of mental health being territorialized. For the person to increase their autonomy, and not have just one place of reference. Territoriality has to do with that. (P8)

Discussion

The Brazilian Psychiatric Reform was an enabler of movements in the theoretical and practical fields, stressing the paradigm shift in mental health care, through practices and services that replace the medical-psychiatric/manic model¹³. However, this study reveals that professionals are also crossed by the "asylum" institution as they reproduce asylum/medical-psychiatric practices, by having care based on infantilization, reducing it to the empirical task of motherhood and the tutelage of users. In other words, they reproduce attitudes that seek to preserve what has already been established and, therefore, hinder not only the institutionalization of psychosocial care but also the process of analysis and self-reflection¹⁴.

The infantilization of the subject in psychological distress is extremely closely linked to the process of institutionalizing the patient within asylum services. In these environments, it is a method of removing civil autonomy, freedom and the ability to make decisions about oneself; guardianship, arising from this infantilization, is seen as inevitable and seen as a form of protection¹⁵. In this sense, linking the guardianship of users with motherhood can be a way of minimizing the bad effects of this attitude, reinforcing it as an act of affection, which makes it difficult for professionals and society itself to perceive the harm¹⁶ and violence of this castrating guardianship¹⁶ of desires and movements, producing investment paths in the world in order to take it over and make it their own, as well as curtailing the rights and autonomy of the person in psychological distress¹⁶. In contrast to the paradoxical autonomizing guardianship, which provokes a movement to produce autonomy and the possibility of life, where from dependence, liberation and accountability are sought through the use of instruments that increase the degree of governability and enable the subject to manage their decisions, where the living action of one triggers the production of life in the other¹⁶.

The castrating guardianship is linked to the asylum model, annulling any existence of desiring subjectivity, which results in the subject not being mobilized as a participant in their treatment, with the body/ organism being the object for which actions are directed and, thus, the individual continues to be seen as sick, with few possibilities for active participation, playing the role of merchandise, in which not only the tasks are fragmented, but also the subject, in which even in a job made up of several professionals, the castrating tutelage is intensified, by the determination based on problems as a biological order and, therefore, the efficacy is expected to come from chemistry, with medication being the main means/instrument of care^{3,16,17}.

The reproduction of asylum practices in substitute services such as CAPS, for example, reveals the inevitable contradiction for institutional analysis, in which the practices instituted by professionals falsify the initial principles of the founding spirit of the "psychosocial care" institution, in which workers often forget why they work¹⁸. In this case, the instituted is represented by practices linked to tutelage, infantilization, hyper medicalization, among others, which are reproduced in the daily work of the CAPS, covering up and denying the initial objectives in the foundation of that service, that is, (re)building the autonomy of people in pain, social reinsertion, co-management and co-participation, which enable psychosocial rehabilitation. In this way, we can see what we call the principle of falsification¹⁸, since the service is implemented to put the principles of psychosocial care into practice, but its actions are asylum-like.

In this sense, we can see the infantilized view of the person in psychological distress and the hierarchization of biomedical-psychiatric practice over others as a manifestation of this principle in the daily work of these substitutive services. The political and biopsychosocial factors as determinants, as well as the investment in mobilizing the subject as the main participant in treatment, with emphasis on the individual and the social and family group in the process of care and understanding of mental suffering, according to the psychosocial mode/model³, materialized in substitutive equipment, such as the CAPS, for example, created and planned to replace the asylum, sometimes works from the perspective of the established asylum model, with regard to the professionals' perception of the object and instruments of work².

The sovereignty of the psychiatrists and their practices over the knowledge and autonomy of other professionals, such as nurses and psychologists, is also historically sustained by the culture. This culture in terms of mental health, is closely related to the strengthening of the asylum logic, where the insane individuals need to have their behavior controlled by physical and chemical methods, rather than being understood as subjects with basic human needs, or seeking to promote care that provides more safety, less organic risk and guarantees these needs in a comprehensive and humanized way².

These instituted practices in the CAPS demonstrate an effect of the institutionalizing process, which we call the Mühlmann Effect, in which the institution tends to be formed from the negation of the initial prophecy¹⁸. Prophecy, in this sense of institutional analysis, distances itself from the religious concept and is understood from the initial objectives of the instituting movement. In this study, it is characterized by the Psychiatric Reform/anti-asylum struggle, which has as its principle the reorientation of the mental health care model, as well as the construction of a new social place for madness, aiming at comprehensive care for the subject, in order to promote their autonomy and social reintegration^{2, 18}.

This contradiction is inevitable and results from the action of the principle of equivalence, in which the instituted only "accepts" the instituting movement to the extent that it becomes equivalent to the norm already established¹⁸. In other words, the mental health/psychosocial care institution can use working tools that were initially created with the aim of replacing asylum practices, but which are used for the benefit of the instituted.



In this sense, the manifestation of the principle of falsification, linked to the Mühlmann Effect, is also identified in this study, when other practices instituted in the CAPS relate to the dialectical aspects of the institution and the effects of the institutionalizing process. The use of instruments that are specific to the psychosocial care model, such as groups, home visits and the PTS, in a territorial and free care service, are only possible thanks to the strength of the institutionalizing movement of the RPb. However, the data shows that professionals often apply the tools of the psychosocial model, but distort their purposes and use them to maintain the established^{2,18}, with care being reduced to the purpose of control, tutelage and even cure.

In this way, the initial prophecy is denied by the established through the practices of professionals¹⁸. This happens, for example, when the PTS, which is fundamentally an interprofessional work tool, based on collective construction, with the active participation of users and the promotion of their autonomy over their health-disease process, is used by professionals without actually including users/people in psychological distress in therapeutic planning and without encouraging their autonomy over their health decisions¹⁹.

This falsification may also happen in the use of case study meetings, when they are limited to referrals or discharges, with little or no discussion between the team, without shared decision-making, or even when therapeutic activities are restricted to the internal environment of the CAPS. Instead, they don't value the integration of these users with society and the territory in which they live, and don't promote the reinsertion and social autonomy of people suffering from mental illness, objectives initially professed by the movement that established the RPb.

It's worth pointing out that practices linked to the psychosocial care model are only an effective substitute for the medical-psychiatric model if they are carried out with the aim of (re)building autonomy, social reintegration and care in freedom, where the user is the center of care. Otherwise, there are just new costumes and names for practices that have already been instituted and are permeated by the asylum model²⁰.

Despite the instituted practices mentioned above, there are instituting movements that put pressure on the institutionalization of psychosocial care, as many professionals mention humanized care, which promotes the protagonism of the suffering person, considers the subject as a whole, and takes a critical stance in relation to the centralization of care in doctors and medication, as well as vertical and hierarchical relationships. When the professionals point out the importance and need for interprofessional work, recognizing that they still reproduce a fragmented way of working that hinders the institutionalization of psychosocial care, there is a tension in relation to what has been established and, therefore, a possibility for change.

The theoretical-conceptual framework of the complex social process, which encompasses university and in-service training, plays a fundamental role in the paradigm shift and, therefore, in the teamwork approach, which leads to interprofessionality (technical and care sphere). Interprofessional work can foster the institutionalization of psychosocial care and promote efficient and respectful professional practices among health categories²¹. Therefore, university training,

residencies and the Permanent Education in Health (EPS) are ways to overcome uni-professionalism and possibilities to promote discussion on the subject and better prepare professionals who work in caring for people suffering from mental illness.

Professionals' distance from the National Permanent Education in Health Policy (PNEPS) and the lack of in-service training spaces can strengthen established practices and put a strain on the process of institutionalizing psychosocial care. EPS spaces generate reflection on established professional practices, enabling collective mobilization for change and overcoming obstacles to psychosocial care²².

It is important to note that the reproduction of the asylum model by professionals and the distancing from EPS are also the result of political setbacks, such as the strengthening of asylum instruments and establishments, through recommendations and funding from the federal government and the 2017 National Mental Health Policy, which provides for an increase in beds in psychiatric hospitals, including them as components of the RAPS, as well as the Technical Note 87 CGMAD/DAPES/SAS/MS no. 11/2019, which redirects beds in psychiatric hospitals. No. 11/2019, which redirected resources to the purchase of electroconvulsive therapy equipment and advocated psychiatric hospitalization and therapeutic communities for alcohol and drug users^{23,24}.

This political setback is accompanied by precarious working conditions, which blocks or hampers the provision of care based on the psychosocial care model and, consequently, strains and weakens the movement to transform practices^{2,25}.

To the extent that professionals use work tools created from the RPb/psychosocial care model, but used for psychiatric purposes, a contradiction and tension is identified between the instituted and the instituting, strengthening the instituted *modus operandi*, i.e. the Mühlmann Effect and the principle of falsification¹⁸. But if the transformation of the practices instituted in the daily life of mental health services is the goal of the social movement of the RPb, it is natural that, in the face of these principles, the question arises: is it possible to resist the falsification of prophecy and the principle of equivalence?

According to Hess, it is possible to form micro-nuclei of resistance to the falsification of prophecy, in order to transform established practices¹⁸. Still on this subject, it is logical to conclude that, if we consider RPb to be a complex and multifaceted movement, so too must these actions of resistance⁵.

Therefore, beyond the legal-political area, it is important to strengthen and encourage research, especially intervention research, because for professionals who are immersed in the established logic of the service, this type of study challenges them to look at the context and produce new knowledge and working tools while transforming everyday practices by getting to know them. The principle of institutional analysis - transforming in order to know - directs the subject to participate in the institutional dynamics⁴ and, therefore, with the possibility of taking a critical look at the instituted processes, favoring the strengthening of the institutionalization of psychosocial care. In addition, extension projects, in-service training based on EPS, co-management and co-participation spaces for users and professionals, the implementation of interprofessional residencies and internships at universities, are also some of the

options for changing social, care and educational practices and attitudes towards mental health care in Brazil^{2,26,27}.

Faced with various tools that strengthen the established and the denial of the initial prophecy of the institutionalization of psychosocial care, such as poor professional training, the permeation of the asylum model in the practices of CAPS professionals, precarious working conditions and, above all, the still recent setbacks in the Mental Health Policy, it is understood that the RPb is and should be a permanent movement of resistance and, therefore, can promote the transformation of practices.

Conclusions

The study allowed to analyze the process of institutionalization of psychosocial care through the professional practices of the CAPS, revealing the dialectical reality of tensions between the instituted asylum and the instituting movement of the RPb, which produces the Mühlmann Effect in the daily life of the service and, therefore, the falsification of the prophecy of the psychosocial care model and the CAPS itself, since strongly instituted asylum practices and the distortion of the purpose of work instruments initially designed to meet the purpose of psychosocial care were identified.

The research-intervention in which this study is inserted has also produced, from the restitution of the exploratory stage and the articulation with the current needs of the service, fortnightly meetings for in-service training, with the active participation of six professionals from the service, lasting approximately two hours, which makes it possible to strengthen instituting practices based on psychosocial care. In this sense, it is important to value the team's openness to looking at everyday work with the possibility of creation and resistance to the Mühlmann Effect.

Despite the limitations of the study caused by the pandemic and the reduction in the number of professionals at the time of collection, it was possible to reflect through the results on the practices of strengthening the asylum instituted within the CAPS, and on the strategies of precariousness and weakening of the institutionalization of psychosocial care, in the four areas of the complex social process of RPb, and the need to promote and strengthen devices for reflection and transformation of practices, whether through research that brings contributions to the services, through in-service training, or university extension projects, public hearings with popular participation, among other forms of continuous resistance to the falsification of prophecy.



Authors' contribution

All authors actively participated in all stages of preparing the manuscript.

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Conflict of interest

The authors have no conflict of interest to declare.

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Cientes de que as práticas profissionais nos serviços de saúde mental podem refletir a institucionalização da atenção psicossocial no âmbito técnico-assistencial, o objetivo da pesquisa foi analisar esse processo de institucionalização por meio das práticas profissionais de um Centro de Atenção Psicossocial. Trata-se de um estudo descritivo e qualitativo, parte de uma pesquisa-intervenção. Os dados foram analisados sob à luz do referencial teórico da Análise Institucional e do modelo de atenção psicossocial. Embora o movimento instituinte da Reforma Psiquiátrica brasileira (RPb) tensionasse o manicômio instituído, os profissionais tendem a reproduzi-lo na prática. Apesar da fragilidade teórico-prática, alguns percebem a necessidade de promover a autonomia do sujeito; porém, observa-se o efeito Mühlmann em suas práticas, que, nesse caso, significa uma falsificação/distorção dos princípios da RPb. Faz-se necessária a criação de dispositivos de reflexão e transformação do cuidado em saúde mental para enfrentar esse efeito institucional.

Keywords: Saúde mental. Atenção psicossocial. Trabalho. Equipe multiprofissional. Análise institucional.

Conscientes de que las prácticas profesionales en los servicios de salud mental pueden reflejar la institucionalización de la atención psicossocial en el ámbito técnico-asistencial, el objetivo fue analizar el proceso de institucionalización por medio de las prácticas profesionales de un Centro de Atención Psicossocial. Es un estudio descriptivo y cualitativo, parte de una investigación-intervención. Los datos se analizaron a la luz del referencial teórico del análisis institucional y del modelo de atención psicossocial. Aunque el movimiento instituyente de la Reforma Psiquiátrica brasileña (RPb) tensiona el manicomio instituido, los profesionales tienden a reproducirlo en la práctica. A pesar de la fragilidad teórico-práctica, algunos perciben la necesidad de promover la autonomía del sujeto, pero se observa el Efecto Mühlmann en sus prácticas que, en este caso, significa falsificación- distorsión de los principios de la RPb. Es necesaria la creación de dispositivos de reflexión y transformación del cuidado en salud mental para enfrentar ese efecto institucional.

Palabras clave: Salud mental. Atención psicossocial. Trabajo. Equipo multiprofesional. Análisis institucional.