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Original Article

# Occupational therapy practices in the child and adolescent mental health network[1]

## *Práticas de terapia ocupacional na rede de saúde mental da criança e do adolescente*

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## Abstract

**Introduction:** The network of mental healthcare for children and adolescents has expanded in recent years, becoming a significant space for occupational therapists' actions. **Objective:** To characterize the practices of occupational therapists in the children's mental healthcare network in Belo Horizonte, identifying actions and approaches. **Method:** Qualitative, exploratory-descriptive study carried out with occupational therapists in the care network. The data collection took place trough semi-structured interviews and resource for their prossessing was thematic content analysis. **Results:** Occupational therapists are present in the three devices of assistance network: nine in Complementary Teams; five in the CAPSi; four in the Art of Health Program. In the Complementary Teams, we identified three perspectives: the psychotherapeutic approach, the developmental/enabler approach and the perspective one, based on the principles of psychosocial rehabilitation. In CAPSi, the similarity of the team members' actions stands out, without specifying practices based on the professional nuclei, with affects, with tensions, the professional identity. In the Art of Health Program, occupational therapists, coordinators of this service, exercise the management function. **Conclusion:** The occupational therapists participate and contribute to the consolidation of proposals and the municipality's assistance network. There are no homogeneous practices. Such actions depend on the characteristics and scope of the service and the specificities of the professional's insertion. On the other hand, we identified the convergence of practices and approaches, making it possible to outline the professional's actions in the field.

**Keywords:** Occupational Therapy, Mental Health, Children, Adolescents.

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***Resumo***

**Introdução:** A rede de atenção à saúde mental da criança e do adolescente se expandiu, nos últimos anos, tornando-se espaço de ação significativo do terapeuta ocupacional. **Objetivo:** Caracterizar as práticas dos terapeutas ocupacionais na rede de atenção à saúde mental infantojuvenil do município de Belo Horizonte, MG, identificando ações e abordagens. **Método:** Estudo qualitativo, exploratório-descritivo, realizado com os terapeutas ocupacionais da rede de atenção do município. A coleta de dados se deu por meio de entrevistas semiestruturadas e o recurso para seu tratamento foi a análise de conteúdo temática**. Resultados:** Os terapeutas ocupacionais estão presentes nos três dispositivos da rede de assistência: nove nas Equipes Complementares; cinco nos CAPSi e quatro no Programa Arte da Saúde. Nas Equipes Complementares, identificaram-se três perspectivas de abordagem: a desenvolvimentista/habilitadora; a de tipo psicoterápico; e a perspectiva fundada nos princípios da reabilitação psicossocial. Nos CAPSi, destaca-se a similaridade das ações dos membros da equipe**,** sem especificação de práticas baseadas nos núcleos profissionais, o que repercute, com tensões, sobre a identidade profissional. No Programa Arte da Saúde, os terapeutas ocupacionais, coordenadores deste serviço, exercem a função de gestão. **Conclusão:** Verificou-se que o terapeuta ocupacional tem participado e contribuído na consolidação da rede de assistência do município e de suas propostas. Identificou-se que não há práticas homogêneas e que estas se relacionam às características e objetivos dos dispositivos e às especificidades da inserção do profissional. Por outro lado, identificaram-se convergências de práticas e abordagens, possibilitando o delineamento de algumas ações do profissional no campo.

**Palavras-chave:** Terapia Ocupacional, Saúde Mental, Crianças, Adolescentes.

## Introduction

Epidemiological profile studies have estimated that 10 to 20% of children and adolescents report some type of mental disorder. Considering the Brazilian population that is included in this period of development, it means approximately 6 to 12 million subjects needing some kind of assistance (Cunha & Boarini, 2011). Such magnitude and the late inclusion in the agenda of public care policies lead us to recognize the huge gap between the needs of assistance and the offering of public services provided to this population (Couto et al., 2008).

The formal inclusion of mental health care for children and adolescents, supported by public policies, was given by Ordinance n. 336\2002 (Brasil, 2002), which instituted the Child and Youth Psychosocial Care Centers (CAPSi). However, a large gap in assistance still persists (Taño & Matsukura, 2015), requiring effective responses from the government.

Although the quantity of new services is still insufficient to serve this clientele, those that already exist have required the presence of the occupational therapist as one of the professionals in the care teams (Bueno, 2013). This insertion brings to the field of occupational therapy challenges related to its specific theoretical and methodological

qualification, which has to consider the particularities for mental health care for children and adolescents.

Another challenge is also revealed in the publishing arena, given that, in a period of ten years, between 1999 and 2009, of a total of 84 articles referring to occupational therapy assistance to children, only 5.9% addressed the field of mental health (Gomes & Oliver, 2010). In the same direction, Bonetti (2011) found a great lack of scientific production related to occupational therapy actions in the field of children's mental health.

Such questions prompted the realization of the research that underlies this article and which sought to highlight the participation and contributions of occupational therapy in this field, having as a reference locus the mental health care network for children and adolescents in the city of Belo Horizonte. The municipality in question was a pioneer at a national and regional level in recent decades, having many proposals in the field of mental health, both in terms of the implementation and systematization of public care policies and in the expansion of services. However, throughout this period, the same advances were not observed in child and adolescent care (Prefeitura de Belo Horizonte, 2004). This field, on the national scene, also took a long time to be recognized in the political space and that, to some extent, has compromised its expression through public policies (Passos et al., 2017).

Starting in 1991, with a specific seminar in the field of childhood and adolescence, discussions began at the municipal level that served as the basis for the organization of a care network. Also held in subsequent years, these seminars brought together new and varied interlocutors, problematizing the assistance then offered, care policies and carepathways. Thus, the service network and the guidelines for the implementation of a care program were gradually being designed (Dias & Passos, 2017).

However, only in 2004, and supported by the formal inclusion of mental health care for children and adolescents in federal public policies – ministerial decree n. 336\2002 –, a document was formalized and presented to municipal managers (Prefeitura de Belo Horizonte, 2004). It was collectively constructed by all the previous discussions, and it defined the care model and the network structure to be implemented, counting on devices that already existed and should be expanded, in addition to others that would be implemented (Dias & Passos, 2017).

It was defined, then, that the mental health care of children and adolescents in the capital of Minas Gerais would be composed of a set of services, guided by the perspective of network care and based on the Psychosocial Care model, as it also occurred in other Brazilian regions, in the practices disseminated by the Psychiatric Reform (Costa-Rosa, 2000).

The municipal care network was structured with four devices: Basic Mental Health Teams (EqBSM) and the Art of Health program – Citizen Workshop (AS) at the primary care level; the Complementary Teams (EqCs), responsible for the secondary level; and the CAPSi (CERSAMI[2]), at the tertiary level, which would respond to emergency care and crisis conditions (Prefeitura de Belo Horizonte, 2004). Over these

[2] In the city of Belo Horizonte, the device that is equivalent to CAPSi is called CERSAMI (Reference Center for Children and Youth Mental Health), but, in this article, we chose to use the nomenclature of legal reference of services used nationally – CAPSi – to facilitate the understanding of readers.

nearly two decades, services have been implemented, but not at the pace or the necessary and desirable population coverage (Passos et al., 2017).

Occupational therapists have been working in the area of mental health for children and adolescents in the municipal healthcare network for over 25 years, even before the organization of the network presented above, and followed up on all the changes implemented. This means a set of trajectories of struggles, achievements, propositions and actions based on clinical experiences and an effective engagement in the public network.

Knowing what has characterized and shaped the presence of occupational therapists in the different devices of the municipal network of children and adolescents' mental health care in Belo Horizonte, identifying their practices, approaches and intervention proposals, can contribute to the expansion of the debate on the actions of occupational therapy in this field.

## Methods

### Methodological procedures

This is a qualitative, exploratory-descriptive study, carried out with occupational therapists from the mental health care network for children and adolescents in the city of Belo Horizonte, which are working in the care devices intended for this public.

The inclusion criteria for the subjects were: to have a contractual relationship with the municipal health network of Belo Horizonte, to be working in the field of mental health care for children and adolescents in 2017 (when data collection began) and to have agreed to participate of the research, signing the terms of consent.

The total number of subjects was of 18 participants [3], corresponding to all occupational therapists working in the care network devices included in the research[4]. At the time of data collection, the professionals were distributed among the care devices as follows: nine in the Complementary Teams, five in the CAPSi and four in the regional coordination of the Art of Health Program.

This study was approved by the Research Ethics Committee of the Federal University of Minas Gerais – CAAE n. 59016916.60000.5149 – and by the Research Ethics Committee of the Municipal Health Secretariat of Belo Horizonte (SMSA-BH), co-participating institution in this research, with opinion n. 1.779,110. This research was supported by the Institutional Research Assistance Program for Newly-Hired Teachers (Notice 01/2017 – ADRC/PRPq/UFMG) and the Voluntary Scientific Initiation Program – PRPq/UFMG.

[3] All interviewees were female.

[4] The Basic Mental Teams, the gateway to the clientele in the field, are located in the Basic Health Units and are responsible for serving the population covered by the UBS, of all age groups. Its composition provides a psychiatrist, a psychologist and one more professional at the discretion of the classification. Initially, from other municipal care units that were extinct, several occupational therapists composed some EqBSM, but, over the years, their presence in this device was reduced. During the period of data collection, there was only one professional team that was interviewed, however, we chose not to include this data in the scope of the analysis, as it is not a specific assistance device in the field of childhood and adolescence and because of the ethical aspect of the possibility of identifying the subject.

### Data collection and analysis instruments

The resource used for data collection was a semi-structured interview, consisting of an initial part of characterization of subjects and their workplace; and then a set of questions related to their carried out activities, focusing on the effective intervention proposals, the evaluation methods and therapeutic resources used, the theoretical models of reference and the facilities and difficulties encountered in their professional action. The interviews lasted an average of 1 hour and 20 minutes.

Thematic content analysis was used for data analysis. It is characterized as a set of techniques and procedures for processing information and for encoding, classifying and categorizing data. Decoding is used based on procedures in which the text (or data) is cut into comparable units or indexes. The type called *thematic analysis* refers to the procedures to discover cores of meaning or units of meaning, whose presence and frequency mean something to the understanding of the research object (Minayo, 2010).

## Results and Discussion

### Occupational therapist practice

#### *Occupational therapy in Complementary Teams*

The Complementary Teams (EqCs), created in 2002, aim to support the work of the basic mental health teams and the PSF (Family Health Program)/NASF (Extended Family Health Center) teams. The city of Belo Horizonte is divided into nine health districts and each one of them now has an EqC, located in one of the regional UBS (Basic Health Unit). The teams are composed of a child psychiatrist, an occupational therapist and a speech therapist. They function as an outpatient device for continuous care and offer individual and group care assistance; shared assistance, bringing together two or three professionals from the team; and timely intervention, characterized as the joint care of caregiver and child up to three years old, when a risk in their psychic development is identified (Prefeitura de Belo Horizonte, 2004). It was only in 2018 that the expansion of one more team for each of the regions began.

The intervention proposals of the EqCs professionals were the most widely described by the therapists and this is possibly due to the fact that this device brings together the largest number of research subjects and some specificities of their actions in these services. First, there is the characteristic of patients being referred, with demands for specific actions, related to the professional core of each team member. Another aspect may be related to the fact that devices with an outpatient care profile – such as EqCs – are organized by specialized clinical care, in which more traditional intervention practices and proposals are present (Mângia & Maramoto, 2006).

Even though proposals for shared care with other professionals and common projects, such as "Intervenção a Tempo" (Intervention on Time), have been described, the professional specialty is reinforced and demanded, making their actions stand out, favoring their recognition and description. Based on the report of the occupational therapists, three general principles or perspectives of approach that guide their actions were identified.

We call the first perspective of approach developmental/enabling approach, and its focus is on the development and acquisition of skills, considering both the promotion of these acquisitions and the damage that illness conditions bring to these processes. This approach was the most described by the occupational therapists of the EqCs and is associated with another singularity in the field of childhood mental health – attention to the development and acquisition of skills –, which more directly reveals the need and demands for intervention by the Occupational Therapist. Bueno (2013), in her research, also found references from the occupational therapists interviewed about the focus on skills development and about the attention given to the commitments and restrictions of daily activities.

> I characterize the sense of stimulus to development, it is the broadest! (I1).

> Look, I evaluated this child. Playing is compromised, there is a need to promote it, develop skills. To think about the skills, the act of playing, the performance, the actions of the child, who is at loss (I10).

All the occupational therapists of the EqCs referred to playing as the main axis of their interventions and highlighted its relevance for the child, their daily lives and their development. Rezende (2005) highlights that playing is one of the intervention focuses of Occupational Therapy and that researchers in the area have been dedicating themselves to its study.

More specifically, the therapists referred to the approach to resources and the child's exploratory capacity in relation to games and toys, the mastery of objects and playful interactions. The professionals also highlighted the encouragement and favoring of playfulness, the expansion of the playful repertoire, the achievement of symbolic play and the restrictions that may be present.

> ...I want, for example, that autistic children have an expansion of their playing repertoire… (I5).

> ...And the development of playing, in the sense of reaching the symbolic, see? (I1).

This focus on playful activity is close to The Playful Model developed by Ferlan (2006), which takes playing as its own treatment objective, due to its relevance in children's daily life, the potential for learning that it entails, as it is the main means of the children expressing themselves and appropriating the world.

On the other hand, the therapists also emphasized that, through playful activities, they can address what they called “behavior changes”, citing aggressiveness, reactions to frustration, non-acceptance of rules, organizational difficulties and persistence. They distinguished the use of recreational activities and their management as resources in the face of these difficulties.

> ...matters of limits of rules, of... these matters of behaviors too! […] issues with tantrums, dealing with frustration (I15).

In this case, the use of playing is taken as a tool, a means to achieve treatment goals. The offer, planning and management of recreational activities are resources that make it possible to improve the bond, develop specific skills, favor and/or modify behavior.

What we found in our research is in line with what was described by Fonsêca & Silva (2015) as the two main conceptions present in the clinical practice of occupational therapists when they refer to playing: using it as a means or resource to achieve certain goals or as an end in itself.

Still within the developmental/enabling perspective, the interviewees mentioned the aspects of interaction and their commitments and, for these cases, the prioritization of group care. They highlighted the importance of the bond, attention to the ways and resources of interaction of each child and the strategies that occupational therapy has to "unravel" the difficulties presented. These aspects raised are in line with what was presented by Brunello et al. (2006), which refer to the group and joint participation in activities, as favoring experiences of socialization and interaction, expanding the possibilities of exchanges, experiences and experiments. Some occupational therapists also referred to favoring language as a basis for group care proposals shared with speech therapy.

> The child did not look, did not speak… what is the resource that will get them to interact? I think that, in my training as an occupational therapist, it was easier for me to untangle, as I am an occupational therapist (I10).

Another aspect highlighted by the professionals was the attention to Activities of Daily Living (ADLs). Its approach happens preferably through the guidance of those responsible for the children, as, according to the interviewees, the available physical infrastructure and the spacing of the frequency of care[5], due to excess demand, hinder direct intervention. In these guidelines, with the objective of gaining independence and autonomy, they referred to the approach of the daily family and child's routine, their circulation through home and social spaces and the activities of dressing and undressing, feeding and hygiene, from which stand out the sphincter control and the unfurling.

> The issue with the child's autonomy, much of which comes from diaper removal. They do not know how to undress, get dressed! (I6).

> The mother sometimes complains a lot about the way of being at home, the objects that can be left nearby, how the house is organized, what we could improve a little; the issue of functionality for families. I guide a lot in what he can do by himself (I14).

It is also noteworthy that all occupational therapists referred to the use of the principles of Sensory Integration Therapy in assisting autistic children and in providing guidance to family members. According to the professionals, there has been, in recent years, a significant increase in the demand for assistance to this clientele and, due to the referrals received, the expectation for them to offer this approach. However, they

[5] There were reports of up to 100 cases linked to the assistance of the team's occupational therapist, in a workload of 20 hours per week.

highlighted the existence of important limitations for its implementation, such as: physical space restrictions, lack of materials and equipment of the technique and, for some, the lack of specific training.

In view of what was presented, it is identified that, in the complementary teams, the developmental/enabling perspective proved to be a significant axis of action in the practice of occupational therapists.

Often, when attending children, some activities, utensils, tools, games, toys and their modes of use, can be presented, initiated, facilitated and expanded based on our interventions (Bueno, 2007). The domain and acquisition of some skills, as Bueno (2003) points out, affect the development of these subjects, their conditions of participation, inclusion, construction of autonomy and their self-confidence. It is also important to point out that the acquisition of a skill enables the opening of new possibilities for action, the appropriation and sharing of ways of doing that are culturally constructed (Bueno, 2007). Helping them to develop resources to exercise their possibilities is one of our approaches in the field, in the sense that Ceccim & Palombini (2009, p. 308) warns us "to detect potentials of life and give them existence".

It is worth emphasizing the importance of care actions being inserted in the social context, in the reference territory, because, as Saraceno (2001, p. 112) points out, "it is only within such dynamics of exchanges that the enabling effect is created". Thus, the previous perspective cannot be isolated from the second perspective of the identified approach, which is the one based on the *principles of psychosocial rehabilitation.*

This approach, mainly in this device and considering the audience of children and adolescents, can also be thought of, beyond the rehabilitative perspective, as psychosocial empowerment (Bueno, 2003). The actions and conditions of participation will need to be built and developed together with the subjects, unlike the emphasis given to adults, in which the focus is the perspective of reconstruction, rescue, reappropriation of lost community functions, regaining participation (Juns & Lancman, 2011).

From the perspective of psychosocial care, the center of actions refers to social inclusion, highlighting the spaces of sociability and citizenship (Costa et al., 2015). It is considered that the possibilities of social exchanges, participation, the exercise of roles and positive social places, coexistence and the experimentation of relationships in collective spaces affect the prognoses. The aim is also to promote and facilitate possibilities for opening and exiting from a domestic isolation, so often present, in the reality of assisted children and adolescents and their families (Lykouropoulos & Péchy, 2016).

The consideration of the territory imposes itself as the basis of this perspective, and the actions extend beyond the clinical approach. In the field of childhood and adolescence, and specifically with the clientele assisted by the EqCs, the care scenarios also include and resize other settings, such as the spaces for living, studying and living together (Mângia & Maramoto, 2006).

> Issues related to this insertion. I always try to see how it is in school, in friendships, at home, in the routine (I10).

> I try to focus on autonomy, on her circulation through spaces, in the space of the house and the street. […] she started going out with me, I went to the neighborhood to shop with her (I14).

However, it is important to highlight that this approach perspective has not been fully implemented. The reduced number of teams and professionals[6] and the huge demand end up absorbing them in clinical care. The EqCs' own care model, which favors the outpatient and specialized perspective, also contributes to this reality, persisting traditional settings and the dissociation between the treatment context and the real life contexts (Mângia & Maramoto, 2006).

Although occupational therapists express the desire and recognition of the importance of actions in the territory, with contextualized practices, in addition to guidelines, which focus on achieving autonomy and social insertion, these have not been fully implemented. Home care, family approach, proposals for social participation, therapeutic follow-up, partnerships with the school and actions aimed at school inclusion have happened in a very sporadic and isolated way and under very specific conditions.

This difficulty identified in the report of the EqCs professionals is in accordance with what was presented by Fernandes et al. (2020), despite referring to actions in CAPSi. The authors' reflection on psychosocial care in the field of children and adolescents highlights that structural, training and human resources aspects can contribute to the difficulties of overcoming the clinical model and to carrying out actions that go beyond the institution's space and reach other social contexts.

Given these conditions and difficulties and, as Bueno (2013) questions, without effective action in the territory, can we actually affirm the foundation in the perspective of psychosocial rehabilitation? It is important for managers to consider that the response to demands should not be thought of only by the number of cases received, but also by the effective and comprehensive care of the needs presented. It is worth remembering that the number of teams and professionals has remained the same since its implementation until 2018. This reality implies the need for arrangements, prioritization and wide spacing in the frequency of care[7]. The anguish shown by the professionals, given the volume of patients and the need to offer care, was expressed through terms such as: "drama, emotional exhaustion, fatigue, suffering!". Such conditions may indicate the precariousness of care, which, due to the reduced number of professionals and the pressure of demand, lead to answers that fall short of the complexity of the cases and the possibilities of intervention and guidance from a territorialized and psychosocial perspective.

Finally, the third approach is called *psychotherapeutic approach.* This approach is associated with the clinical care model and its central aspect is the expression/expressiveness, the analysis of the contents expressed by the subject through their activity and the possibilities of approaching and elaborating these contents.

[6] It is important to highlight that, at the time of the research, there was a complementary team for each health district, which could include populations of up to 300,000 inhabitants, becoming a reference for 19 Basic Health Units. It is also noteworthy that the EqCs were composed by only one professional from each category - occupational therapist, speech therapist and child psychiatrist, with a workload of 20 hours per week.

[7] There were reports of up to 100 cases linked to the assistance of the team's occupational therapist, in a workload of 20 hours per week.

> [...] while playing, the child brings their internal contents, we even elaborate the processes (I1).
>
> I work a lot in the line of Chamone, which is to make people talk about what they do! […] They will talk about what they did, they will talk about their feelings, they will tell about what was done (I16).

What stands out in this approach is close to what Lykouropoulos & Péchy (2016, p. 94) describe as a treatment logic through the "problematization of symptoms". They affirm the importance of contextualizing them and understanding them as the subjects' responses to the issues that cross them. They refer to "the expectations, affections, conflicts that exist in the situations in which they are immersed, the family and social place they occupy and how it can or cannot respond to it..." (Lykouropoulos & Péchy, 2016, p. 95). It is about the consideration of the symbolic and subjective conditions that present themselves to be unveiled.

This perspective is a traditional approach to occupational therapy within the field of mental health and, as Castro et al. (2016) say, the emphasis is on the expressive and subjective character of plastic language. The subject's relationship with the activity and their meaningful doing as a means of expression are considered, as well as experimentation and elaboration of suffering, through the interpretative possibilities (Costa et al., 2015).

Such propositions go back to the influences of the psychodynamic approaches of the 1960s, influenced, in turn, by psychoanalytic theory, internationally highlighting theorists such as Azima and Azima, Fidler and Fidler (Lima, 2016). In Brazil, Luiz Cerqueira and Nise da Silveira stand out and, from the 1970s onwards, focusing on the therapist-patient-activity relationship and on the therapeutic process, Jô Benetton and Rui Chamone (Mângia & Nicácio, 2001; Faria, 2007) stand out. It should be noted that psychoanalysis and these last two authors were the most cited in this research, in response to the question about the theoretical references used. The prevalence of psychoanalytic theoretical orientation in the mental health network in the city of Belo Horizonte is also highlighted.

The theoretical-clinical proposal of Associative Trails developed by Benetton (1991) underlies the method called *Dynamic Occupational Therapy*, characterized by "the observation, elaboration and intervention on the dynamics established between external reality and internal reality", based on the triadic relationship therapist-patient-activity (Ferrari, 2005, p. 13).

Rui Chamone's studies, on the other hand, point to the understanding that free and creative activities are an "opportunity for identification, establishment of ties and self-recognition" (Faria, 2007, p. 174). The objects produced become symbolic axes. They are plastic languages that will be understood and interpreted in the occupational therapeutic relationship that is established and based on five elements: materials, tools, objects produced, the subject and the therapist (Chamone, 1990).

However, although these are already traditional approaches in the broader field of mental health, occupational therapists are challenged by the specificities of the childhood clinic, which brings other components.

The first aspect of specificity of the psychotherapeutic approach which can be highlighted in the field of childhood and adolescence, is the reference to the use of playful activity in its expressive dimension, subject, therefore, to management and interpretation. Another point that deserves to be highlighted, as Vicentin (2006) points out, is the need for those who care for children to become "bilingual", in the sense of mastering childhood codes, considering the uniqueness of their language, expression and understanding. Added to this is another specificity of the children's clinic, which is the need for symbolic/metaphorical supports so that we can reach and contribute to the expansion of resources and children's understanding of what causes their suffering.

Thus, some of the contributions of occupational therapy stand out, because the activities in which the child engages, the events revealed and the interactions, in the time and space of care, are sources of evidence, symbolic/metaphorical supports, possibilities of identification, production of meanings, resources for understanding and coping with their suffering conditions, to be promoted and addressed by the occupational therapist.

Finally, it is important to point out that, as presented by Fernandes et al. (2020), an essential condition in the care of children and adolescents is the guarantee of their rights to speech, action and the subjectivities they involve.

### *Occupational therapy in CAPSi*

Although the first CAPSi in the municipality had its implementation approved and foreseen in the aforementioned document of 2004, it was only effectively instituted in 2008 and, only at the end of 2016, the second CAPSi was implemented[8].

CAPSi can be characterized as devices that offer intensive care actions for those with intense psychological distress and/or in crisis. In addition to providing assistance under these conditions, it also aims to carry out the articulation of the strategies and actions necessary for each case, in the territories covered by it. It is an open service that welcomes subjects based on spontaneous demands or referenced by other health devices and all will be admitted via reception. According to the definition of the singular therapeutic project, the permanence in the service can be partial (one shift), full (two shifts) and with nightly hospitality, if the case so requires.

The concept of care in CAPSi, the dynamics and organization of its functioning, similarly to what occurs in other CAPS modalities, are characterized by teamwork, collective practices and strategies for coping with everyday situations.

In a way, this implies the loss of a professional background, as most of the activities carried out are common to all. This condition directly affects the definitions of specificity (Juns & Lancman, 2011), calls into question the rigidity of professional specialties and demands greater flexibility in performance.

As reported by occupational therapists, they do not perform any specific activity and the actions of team members are similar. These are recognized as reference technicians in mental health – "psi professionals" (I4) – and argue that there are no exclusive attributions, except for those protected by the Professional Councils. They emphasized that the proposal built in this care device does not expect an action based on professional

[8] Currently, the coverage of the nine health districts of Belo Horizonte is divided between the two municipal CAPSi and an assistance service from the state health network.

nuclei and that the functions and activities to be performed are the same for everyone, such as the conduct of the shift, its complications and outpatient care.

> I have been acting much more as a mental health reference technician than within a specific occupational therapy practice. [...] I think it is the field of mental health in Belo Horizonte, it pulls professionals to work in the field rather than in their professional specialties (I2).

> Everybody does everything related to serving this clientele, so there is nothing that is exclusive to other professionals! (I7).

Thus, considering the logic of non-differentiation of attributions and actions, the professionals justified the permanence of the multidisciplinary composition of the team, which is why they characterize it as "diversity of views" and knowledge, not actions. This reference is in line with other studies (Juns & Lancman, 2011; Almeida & Trevisan, 2011; Constantinidis & Cunha, 2016), which pointed out the shift from specificity to "looking", not being found, therefore, in actions or in intervention proposals, but in the way it is understood, in what the professional is able to extract from what they see.

> I think it is the looks that are different. I think that, in the end, we dilute it so much… because we do not have that much distinction anymore, right? (I4).

The specificity of the "gaze" was associated, by the interviewees, with the gain of autonomy, social circulation, self-expression, expansion of the repertoire of activities, occupational history, as well as family and social relationships and engagement activities, such as school and work.

> ...we have this look at how the individuals relate to their own activities (I9).

These observations have repercussions on occupational therapy, as traditional actions, such as the offer of workshops and purposes of occupational therapy work, such as attention to significant activities, the context of daily life, the focus on the subject's autonomy and social participation, have passed to coincide with paradigms of Psychosocial Rehabilitation (Almeida & Trevisan, 2011; Constantinidis & Cunha, 2016), and became common objects for the entire team.

Thus, based on Campos' distinctions[9] (2000, as cited in Mângia & Barros, 2009), some actions, previously identified as the core competence of occupational therapy, became part of the team's field of competence. This coincidence of assumptions was also recognized by the occupational therapists of this service.

> What comes to mind are the references and concepts of psychosocial rehabilitation, when we think about the contractuality that takes place in the

[8]Campos (2000, as mentioned in Mângia & Barros, 2009) defines the Professional Nucleus as one that outlines the professional identity, demarcating an area of knowledge and practices used predominantly by a certain discipline; and "field" as the space for performance with imprecise limits, in which each discipline supports the other.

> field of work, family, social relations... I think the occupational therapist sees this and puts together a proposal that sees occupation as a path (I2).

It was identified that the report made by occupational therapists of the non-differentiation of their actions often includes a sense of achievement through professional recognition and more symmetrical and egalitarian relationships and functions within the team. However, as Saupe et al. (2005) alert, even without the focus on specialties, the hierarchical relationship, of prestige of practices and status between professions and professionals is not always dissolved.

> When people thought of the occupational therapist, they thought in a pejorative way: "have you organized the party?" [...] Not anymore, that doesn't happen anymore (I7).

> There is an understanding here that the function is not… it is the same as the others! (I9).

> Then I fight, I say: "I have full capacity to handle any case that comes here in this service" (I4).

As the authors Constantinidis & Cunha (2016, p. 45) ask, with the dilution of professional specialties and the enhancement of interdisciplinary practices, "what would the occupational therapist's identity look like in the field of mental health?". The loss of professional background affects the occupational therapists in this research, as an element of tension, expressed when talking about their practices.

> ...It bothered me not to have it defined… it bothers me a lot (I7)

> ...I ask myself consistently about what more I can do as an occupational therapist (I2)

For the aforementioned authors, the main activity that reveals a tension over identity is the workshops, as they have become "mediators of the interdisciplinary work of the team", a common denominator for professionals working in the field of mental health and attribution of all (Constantinidis & Cunha, 2016, p. 45). This tension was also strongly present in the statements of occupational therapists, when referring to the offer or not of this care strategy.

At the two CAPSi in the municipality, there is a mid-level technician, called a workshopper, who is responsible for organizing and proposing workshops, which should take place daily, in both shifts. As reported by the occupational therapists, during these workshops, the team professionals (including the occupational therapist) can accompany the patients, observe, and perform some intervention, without being responsible for its proposal, coordination and conduct. This fact, according to the occupational therapists, influenced the decrease in the expectation that they would carry out workshops, differently from what they say has already happened in the past.

> Because some people felt that the therapeutic workshop was the exclusive responsibility of the occupational therapist (I7).

> As we have a workshopper here, the expectations on OTs doing the workshops at all times are a little lower. It's not an OT function to keep the patient busy (I9).

As already mentioned, none of the occupational therapists systematically developed any intervention proposal that they recognized as related to their professional core, but four of them spoke of their desire to be able to propose and implement them, especially referring to the workshops, always bearing in mind that this would be an action also expected of all professionals, not just occupational therapists.

> I had great expectations, when I arrived, of being able to think about, propose, and develop a workshop. I still can't (I2).

> Everyone has to carry out workshops. I try to help my colleagues to think about workshops, to understand the therapeutic sense. […] we manage to intervene in a different way than the workshop does! Professionals must do a workshop, not just the occupational therapist. […] there needs to have a reason, it is not just to pass the time (I9).

The tension identified in the occupational therapists' speech can mean the perception of the workshop as a place of risks: the risk of disvalue, of carrying out work that can be seen as underqualified, and of becoming an entertainment practice, which hides the institutional vacuum, as Costa et al. (2015).

Let us also remember, as indicated by Lima (2016), that the workshops were an important element of the asylum logic, but they were also called to participate, as a structuring action of the substitute services, in the deconstruction of this same logic. It is possible that this double condition affects occupational therapists, leaving them ambivalent about the workshops.

On the one hand, there is the recognition of therapeutic possibilities that may be present in the proposition of workshops and which has been addressed in many publications in the profession. It is a care practice that, when based on clinical reasoning, inseparably combines the production of materiality and subjectivity (Lima, 2004). With a posture of invitation to the meeting and for meaningful action, on the part of the therapist, it is possible to sustain in the workshops the space and time for exploration, experimentation and learning, to get it right or wrong, to do it again, to "discover themselves as a being of possibilities and limitations" (Gontijo & Morais, 2012, p. 203). They can be a place of exchange, interactions and unique events, and it is up to the occupational therapist to analyze the complex dynamic that is installed between the group interaction and the activities they carry out (Brunello, 2002). As Lima (2004) points out, what is produced becomes language, and it is the therapist's role to help the patient to give meaning to what is being perceived and expressed by the activity. Or, as Bueno (2002) tells us, the subject can see and recognize himself in what he produces.

On the other hand, there is the fear of taking the place of entertainment, of occupation-by-occupation, of devaluing this proposal, compared to other interventions.

Kinker (2014) warns us about the voracity of some institutions in the mental health field for entertainment proposals. Perhaps, because they know this voracity, the occupational therapists in our research try to dilute the relationship of their training, expertise and understanding in the proposition of workshops, conditioning their exercise to their sharing with other professionals, or leaving it as secondary to other activities demanded by the team.

Thus, as we have been describing, the discussed aspects of tension about professional identity affect the interviewees and their proposals and actions. However, the proximity and coincidence of psychosocial rehabilitation assumptions with the training, purposes and objectives of occupational therapy (Almeida & Trevisan, 2011; Costa et al., 2015), as already presented, would not be strengthening factors for the realization of actions and propositions by the professional?

As Constantinidis & Cunha (2016, p. 49) question, "wouldn't it be possible to make a bridge between the gaze and the practice?". In other words, the contribution of professional specialties, in addition to the comprehensive and discursive scope, can also be revealed in the actions proposed and in the practices carried out.

In our understanding, becoming a professional in the field or "professional psi", as the interviewees said, does not nullify the professional centers and the contributions that result from them. This is at the base of the perspective of the multidisciplinary composition of the team, bringing together professionals who are expected to be competent in their professional field and for collective work (Juns & Lancman, 2011).

It can be noted, on the one hand, that the collective project, shared actions, common purposes and objectives, trans and interdisciplinary proposals do not imply the annulment of professional identity. On the other hand, identity and the lessening of tensions about it are not based on pretensions to stock exclusivity. It can be exercised, experienced, recognized, with the appropriation and exercise of propositions, actions, interventions, directing attention and focusing on what is proper to us, on aspects that are connected to our professional core, our training and our knowledge.

In the construction of the common care project, in exchanges, in relationships, in the formulation of the singular therapeutic project, in the realization of collective actions, in case and team discussions, hybrid, cooperative, shared, collective spaces, transdisciplinary fields that require openness and flexibility. This configuration does not undermine the importance of everyone being appropriated of their expertise and professional competence for which they were trained. As well as the importance of exercising, at the theoretical level, of understanding and reflection, and at the level of action and intervention proposals.

### *Occupational therapy in the Art of Health program*

The Art of Health program – Citizen Workshop (AS) – was implemented in one of the municipal districts in 1994, after the partnership with Cáritas/Regional MG, and expanded, at the end of the 2000s, to all health districts. It aims to offer spaces for socialization and coexistence, mediated by artistic and cultural workshops. The program works as a support for the mental health care network for children and adolescents and is guided by the territorialized perspective of health promotion, intersectoral articulation and listening, prior to or alternative to specialized treatment and medicalization. In each

regional, there is a general coordinator, who oversees the activities of at least five centers of workshops, offered in different districts of the region, given by monitors (Prefeitura de Belo Horizonte, 2004).

In AS, the coordination position is not defined by the professional category, and can be occupied by any of the professionals in the field of mental health, but the inclusion of occupational therapists in this role indicates a new space for participation and contribution of occupational therapy, which is the space of management. According to Furlan & Oliveira (2017), the expansion of the concept of health itself has enabled the incorporation of different professionals in the management of services and programs.

In exercising the management function, the occupational therapists highlighted the proximity of the program's assumptions with the foundations of training and action of occupational therapy. This sharing of assumptions is taken by the professionals of Art of Health as support for their professional identity and their capacity to exercise their function. This proximity to the domains of their professional competence is also felt as a strengthening of their role as coordinator and recognition in the field.

> AS has everything to do with OT (I8).

> I had the desire to come to Art of Health because I identified, as an occupational therapist, with this proposal. The proposal did not come from an occupational therapist, it did not have this connotation of specificity […] but I think it has the looks, the identity of occupational therapy (I13).

In this program, the role of the workshops and, mainly, their territorialized conception, are perceived, proposed and structured, as mechanisms of empowerment, protection and social participation and as an element of transformation and opening up possibilities for the subjects assisted. This proposal is close to what Castro et al. (2016, p.182) as "a space of life, coexistence, the enrichment of everyday life and existence itself".

> Art of Health intends to open up horizons for the boys. […] I still believe that this activity that boys do, they are, they transform their reality, they transform objectively and subjectively (I13).

Occupational therapists highlighted as their main contributions the concern with the construction, path and meaning and less with the final product, attention to other contexts of insertion, such as school, neighborhood and family - *"for the subject in their context" (I12)* – attention to what they can achieve and the potential of children and adolescents. All occupational therapists highlighted as a central aspect of their action, especially in the orientation of the monitors, the way the workshop itself is thought, its function of openness and social participation and its relationship with the territory,

> Occupational therapy does not pass activities for the sake of an activity, it does not put the boys to do the things just for the sake of it. What they do needs to have meaning, needs to be transforming of some reality (I13).

> It would be how the workshop is thought, it would be how the organization in the territory is thought. It's the look of my training! (I12).

It is thus evident that the engagement of occupational therapists in the coordination of this device has been based, preferably, on the care assumptions of the proposal, on the dynamism that they imprint due to the proximity they identify with their professional field and, as a result, the recognition of potential and the complexities inherent in the proposal. The exercise of this role of manager has been supported by their professional foundations and care assumptions, and they have been building their experience and developing their skills for the more administrative aspects of the function.

The professionals identified several activities that make up their role in addition to guiding the monitors, monitoring activities and the assistance offered, such as: planning expenses, financial management and accountability of funds available for materials and food[10], organization of activities and participation in cultural events associated with the workshops, purchase of materials, participation in the selection of monitors and control of their presence, monitoring the frequency of users, participation in various meetings with other managers, articulation with the mental health network, with other devices of the health district and with the entire child and adolescent protection network. All interviewees highlighted the perception that the coordinator's 20-hour workweek is insufficient for all the duties of the function and expressed the expectation of being able to extend the working day in the future.

> There is an issue with the workload. We work 20 hours in coordination, so it is very little! (I8).

As highlighted by De Carlo et al. (2009), the management function demands several skills and competences, which in turn require knowledge specific to this assignment. Santos & Menta (2017) highlight that the health management function implies administration principles that are related to the planning of services and actions, their organization, controllership, decision-making, coordination of people, monitoring and evaluation of activities and political negotiations.

Thus, a relevant aspect that the cited authors point out is the importance of training and qualification of professionals for the exercise of these functions. They identified in their research, however, that the contents related to management, in general, are little studied in occupational therapy undergraduate courses, as is the case in other courses in the health area. In the same direction, Cruz et al. (2014) highlight the scarcity of publications on the subject, indicating few subsidies in the area that help professionals to base their practices in the role of manager.

The occupational therapists in our research were building their knowledge and skills based on their engagement in the function and, therefore, in a non-systematized way. They also reported that they did not have, in their training, content that addressed the management of services.

[10] In all workshops, snacks are provided for children and teenagers.

> So, I think I was bulding my knowledge, right? Regarding my practice, my performance (I17).
>
> ...I have never studied this before, you understand? So... I think that in relation to more administrative issues, at least in my education, it was very limited (I12).

The expansion of possibilities for professional performance in the field of management, beyond clinical practice, found in our research, leads us, together with authors from the field, such as Furlan & Oliveira (2017), Cruz et al. (2014) and De Carlo et al. (2009), to highlight the importance and need to include, in a more systematic way, this type of knowledge in professional training.

## Conclusion

Our intention was to present how the actions of occupational therapy have been delineated in the field of mental health in childhood and adolescence, based on the municipal network of Belo Horizonte. Exposing the panorama of occupational therapists' contributions allows their recognition and the expansion of debate with teams, managers and with fellow occupational therapists.

The characterization of the occupational therapist's actions in the field of mental health in childhood and adolescence indicated that there is no single, homogeneous or uniform action that could be identified and analyzed. Each subject has singularities of formation, approach and understanding, which will interfere in their actions. In addition, each device has its own proposals, characteristics, functions, target audience, connection to different levels of care and specificities, which will condition the professionals' insertion. There is, therefore, a heterogeneity of actions that leads us to recognize specificities and focuses, but there are also convergences that could be analyzed.

In the EqCs, we were able to identify, based on the practices described by the professionals, that the clinical paradigm and the biomedical model are present and have been predominant, supported by organization systems similar to specialized clinics, focused on the subjects and their symptoms, structured in appointments and complete filling of the agendas, which end up limiting other proposals for action. Even though managers and professionals have been supporting collective proposals, such as Intervention on Time, shared attention and action among professionals in group care, this has not been enough to change the model.

There is also an important path to be followed and built so that the psychosocial model and the possibilities of action of occupational therapists in this perspective can, in fact, be effective in a specific way, but also dialoguing and relating to other perspectives of analyzed approach – developmental/enabling and psychotherapeutic approach.

Thus, the perspective of an expanded clinic, founded on the recognition of the complexity of cases, of the health-disease processes, which considers and integrates the contexts of life, daily conditions and the territory into the care proposals, and which is articulated with the precise intersectorality needs to be expanded. This expansion will

certainly imply changes in work processes and the expansion of teams and professionals and, therefore, it also directly involves managers.

In the CAPSi, what stood out was the collective care model, the sharing of functions not differentiated by the specialty, in which the occupational therapists of the device have been engaged, but which resonates, with tensions, on the aspect of identity and professional practice, especially with regard to the proposition of workshops. This sharing has left as secondary or present, in isolated and individualized actions, the exercise and appropriation of their professional expertise.

Such appropriation does not mean, in any way, exclusivity of attributions and actions, as the psychosocial care model is based on common and shared assumptions. It seemed to us that, involved in the shadow of the risks of simplification, hierarchization or not understanding their practices, discussed above and, like other professionals in the team, absorbed by the dynamics and structuring activities of the service, occupational therapists have not been able to carry out their proposals in a systematic way, acting below the potential of their knowledge and professional practice.

The propositions of Psychosocial Rehabilitation are a common good that have been built and achieved through collective actions, based on inter and transdisciplinary proposals, for which we have important contributions to be made and added to the wealth of collective propositions and the complexity of clinical demands.

In the Art of Health program, it was identified that the proximity between the program's presuppositions and professional training was described as a support element for the exercise of the managerial function and for the orientation that they imprint on the proposal. Another relevant aspect highlighted is the need for institutions responsible for the training of occupational therapists to include, in the training contents, in a more systematic way, knowledge related to the exercise of the managerial function, as this place presents itself as a promising and growing space for the professional field.

Finally, it was found that the occupational therapist has effectively participated and contributed to the consolidation of proposals and the healthcare network in the city of Belo Horizonte. However, we could also identify that the healthcare network is still reduced compared to the contingent population coverage and the complexity of their demands. Other devices need to be implemented and the number of professionals increased, questioning managers in their political commitment to the field of mental health in childhood and adolescence. This condition also indicates to the occupational therapist the perspective of a growing field, for which he needs to be prepared, from a theoretical/methodological point of view, and politically committed to its construction.

We recognize as a limitation of this research the number of interviewed subjects, when we consider the number of professionals working in each of the devices. Another limitation refers to the scope of the research to professionals from the municipal network of Belo Horizonte, which may have resulted in the bias of a single model of assistance guidance. In future research, the inclusion of professionals from healthcare networks from other municipalities and institutions from other management levels – such as the state level, for example – may increase the number of subjects and the complexity of the proposals to be analyzed.

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Kátia Maria Penido Bueno responsible for the conception and coordination of the research, data collection and analysis, conception and writing of the text. Simone Costa de Almeida responsible for the review and contributions to the writing of the text. Mariana Moreira Sales research initiation scholarship holder, responsible for carrying out the collection and transcription of research data, literature review and organization of sources. Mariana Ferreira Salgado volunteer research initiation scholarship holder, responsible for performing data collection and transcription, literature review and organization of sources. All authors approved the final version of the article.

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