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The Mental Health Team: Evaluation From a Professional Viewpoint. A Qualitative Study

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ABSTRACT

Background: Health care institutions include workers who must operate in accordance with the requirements of the position, even though there are psychosocial influences that can affect the stability of the worker.
Aims: To analyze the organizational culture of the team of professionals who work in the mental health network.
Method: A qualitative methodology was used to assess a sample of 55 mental health professionals who have been practicing for at least 5 years.
Results: "Team" was the overall topic. The subtopics within "Team" were: getting along in the unit, getting along with the patient, personal resources for dealing with patients, adaptive resources of team members and, resources that the team uses in their group activities.
Conclusion: It was observed that the team does not work with a common objective and needs an accepted leader to manage the group. The definition and acceptance of roles can result in conflict. By increasing the skill level of each worker, the multidisciplinary team would be more collaborative.

Introduction

Social structure can be understood as a permanent network of relationships and links manipulated by the social process itself. Although this social structure is institutionalized and determined by rules, laws, or models (Herrero, 1974; Lucas & García, 2002), it is not static. Rather, social structure is continuous over time (Herrero, 1974) but can also change, and it renews the structure of society itself (Kreps, 1990).

People conduct their lives in complex environments. There are many variables that influence their work, and as a result, their behavior is determined in part by their social environment. Individuals are not isolated but belong to a social system with interdependent segments and functions. Each variable influences all the others, and every action has an impact on the entire organization, because all human and non-human units are connected (Bertalanffy, 1993).

The health care system has experienced historic progress in terms of human capital and organizational dynamics (Arce & Temes, 1997). Many health care institutions have management models to optimize specialized services and guarantee satisfaction for both health care users and professionals. When such models are effective, health care professionals achieve harmony between the work performed and the demands of their jobs, and can also deal with these demands themselves (Fuentes Rodríguez, 2002).

Professionals must become aware of themselves as a member of a group who are aware of the patterns of interaction that lead to the establishment of what is usually called a group structure (Vendrell & Ayer, 1997, chap. 3).

The World Health Organization (2010) emphasizes the importance of the development of practice and inter-professional collaboration. In their document, importance is given to the adoption of policies that develop programs of integration of tools to develop a clarification and acceptance of one's role, as well as to resolve conflicts and team leadership, together with functional collaboration between the members of a team (Dunlap & Dunlap, 2017). Interprofessional collaboration between different specialists offers, in the long run, a higher quality of care and provision of care to the individual (Gaugeon, Johnson, & Morse, 2017), According to the strategic mental health plan of the Madrid Community (Abella, 2011), the network of mental health care resources includes a set of "specialized care centers," which are a part of an integrated network, to facilitate coordination and patient flows between different units and programs, both at the community level and at the level of partial and total hospitalization. In these centers, interprofessional collaboration among professionals is of vital importance, as the exchange of ideas it generates allows exclusive, comprehensive and holistic care of people with mental problems.

In general, mental health care resources are structured on two levels:

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1. Units of care: this includes the unit of short hospitalization (or short stays indicated for intake in acute situations), psychiatric emergency room (ER) units, and district-level mental health centers (axis of assistance and coordination of all resources), providing care for community-dwelling patients.
2. Institutions with multiple care units, including *treatment and rehabilitation hospital units* and *specific long-term inpatient hospital units* (with the aim of overcoming their symptoms and disabilities and achieving the highest possible level of personal autonomy and social participation), *addiction treatment units*, *units for the treatment of personality disorders*, *units for the treatment of eating disorders*, *child and adolescent units*, and so on.

Nurses, doctors, nursing aides, psychologists, occupational therapists, and social workers are overlapping professionals who work in the same operational space, and are particularly impacted by stressors arising from a combination of variables that may be physical, psychological, or social (Poggenpoel & Myburgh, 2011). Being on permanent alert, withstanding intense work rhythms, and encountering verbal aggression, as well as fatigue, discouragement, fear and anxiety (Ludmilla Rosi Rocha, Leonardo de Oliveira Gaioli, Henriques Camelo, Mininel, & Vegro, 2016), make professionals believe in the use of conflict-resolution skills at stressful points to adapt to the environment.

In this study, we combine the organizational procedures of companies with regard to community demands, together with the acceptance that our society has for the mental health patient. We also immerse ourselves in the reality and experience of the professional, which we consider as the experience of a human being, the form of how he perceives and enacts his feelings, ideas, and motivations, learning how individuals know, think, and act, according to their cultural paradigms (Martínez, 2004; Morín, 2001).

We present the psychiatric patient care team with the intention of evaluating the relationships between the psychiatric patient care team, the communication mental health workers establish with the mental health patient, in the perception mental health workers have of the organizational and social management, and in the emotional management of conflicts that arise in the mental health field. As an objective, we will analyze the personal experience and organizational culture of the team of professionals who work in the care facilities of the Mental Health network of the Community of Madrid from their own perspective, beliefs and customs.

Method

A qualitative ethnographic study has been performed, wherein the researcher is integrated into the target group, with the intention of collecting and capturing the activities, descriptions and affirmations that the participants have about the reality (Guber, 2011; Pérez Gómez, 2012). This is a descriptive and inductive study. The design is structured with the concept of flexibility: during the research process, new and unexpected situations related to the subject of study may have implied changes in the research questions as well as in the purposes of the study (Maxwell, 2005). The unit of study was taken as the unit of analysis, mental healthcare workers (Psychiatrists, Nurses, Nursing Aides and Orderlies) from psychiatric care hospital centers in the Community of Madrid were the units for analysis. The research was conducted between the months of January 2011 and December 2013.

The study invitation was extended to four centers from the Community of Madrid. The choice of designated hospitals was made considering two criteria: 1) a hospital-only setting and 2) it covered psychiatric patient care resources, both in Short-Stay Hospitalization Units and in Treatment and Rehabilitation Units. Of the hospitals selected, two actively participated. At a third, there were difficulties and time restrictions preventing participation. At a fourth, only in-depth interviews could be conducted with its mental healthcare professionals due to issues with scheduling and shifts. The inclusion and exclusion requirements (Table 1) were taken into account.

Table 1
Inclusion and exclusion criteria.

Inclusion criteria	Exclusion criteria
Professionals of both sexes	Professionals who do not perform their professional duties at a psychiatric unit
Professionals with more than 5 years of experience working in Mental Health Units, in morning and afternoon shifts	Professionals with less than 5 years of experience.
Psychiatrists, nurses, nursing aides and orderlies	

The inclusion criteria were being mental health professionals who have been working for at least 5 years on a continuing basis in mental health services and professional members of a multidisciplinary team. Furthermore, the team must be composed of members of both genders. Professionals who, even if they had 5 years of experience, were not working in mental health units at the time of the study, were excluded, as were those who did not have sufficient experience in the treatment units. Initially, sampling was theoretical or intentional based on the needs identified from the first results; subsequently, it became a sampling avalanche or snowball where previous informants recommended new informants.

Data collection

Data collection was carried out using participant observation and interview techniques. With regard to the **interview**, we believed it appropriate to perform two interview techniques simultaneously: in-depth interview (Báez & de Tudela, 2007) and focused interview (Valles, 2009). We planned first, to conduct an interview in depth and then a semi-structured interview. From a total of 55 study participants, 13 agreed to conduct an in-depth/focused interview (table 2). The interviews were conducted between the months of January 2011 and December 2012.

An in-depth interview was carried out with participants to capture their speech, in free response, taking part in events and activities that could not be directly observed by the researcher. The interview began with the opening question: “Tell me from your perspective, what's it like working in a mental health unit?”.

Subsequently and in the background, the interviewer, using a semi-structured interview (Table 3), collected information from those participants who did not provide information on their own initiative. The interviews were conducted in Spanish. The informants' authorization was requested through an informed consent form ensuring agreement, confidentiality and safeguarding of his or her identity. The interviews lasted for 60 to 90 min. They were recorded with a non-intrusive built-in microphone and transcribed verbatim. The overall recording time was 15 h 42 min per interview. Before starting the recording, the following was explained to each informant: the importance of signing the informed consent form, the objectives of the study, confidentiality and anonymity, the possibility of abstaining from a question if he/she deems it appropriate, and the participants' access to the information collected in the interview.

We conducted interviews at places and times that the informant chose. Most interviews occurred in the unit in which the worker was employed, during their work shift, in offices or quiet areas, such as the library or therapy rooms.

Participant observation

From December 2011 to August 2012, The sites included, a 20-bed brief hospitalization unit (BHU) in a general hospital, a 42-bed rehabilitation/medium-term care unit in a psychiatric specialty hospital, and a third hospital, a paired BHU and medium-term unit, with 20

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