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Interprofessionality in the care of alcoholics: the professionals' perspective

Interprofesionalidad en la atención a los alcohólicos: la perspectiva de los profesionales

Interprofissionalidade na atenção ao alcoolista: o olhar dos profissionais

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Abstract

The study aims to understand the perceptions of professionals about interprofessional collaboration and the advantages and disadvantages of implementing it in the care of alcoholics. This descriptive-exploratory, qualitative study was conducted through semi-structured interviews with 16 participants and analyzed through thematic analysis. Professionals perceive and confuse interprofessional collaboration with multiprofessionality. Care centered on the user and family strengthens collaboration. However, the centralization of power, the feeling of not belonging to the team, work overload, informality of interprofessional work processes, ineffective communication, and centralized management hinder collaboration and must be improved through processes that produce consensus. Thus, the minority presented an understanding that approaches interprofessional collaboration, thus resulting in multiprofessionality and not interprofessionality. Continuing education in the service and management that has these principles favors collaboration. This study contributes to improving care for alcoholic users and to future research on this topic.

Descriptors: Alcoholism; Health Professional; Intersectoral Collaboration; Interprofessional Education; Education, Continuing.

Resumén

El estudio tiene como objetivo comprender las percepciones de los profesionales sobre la colaboración interprofesional y la facilidad y dificultades de implementación en la atención a los alcohólicos. Estudio descriptivo-exploratorio, cualitativo, realizado a través de entrevistas semiestructuradas a 16 participantes, analizados mediante análisis temático. Los profesionales perciben y confunden la colaboración interprofesional con la multiprofesionalidad. La atención centrada en el usuario y la familia fortalece la colaboración. Sin embargo, la centralización del poder, el sentimiento de no pertenencia al equipo, la sobrecarga de trabajo, la informalidad de los procesos de trabajo interprofesionales, la comunicación ineficaz y la gestión centralizada dificultan la colaboración y deben mejorarse mediante procesos que produzcan consenso. Así, la minoría presentó un entendimiento cercano a la colaboración interprofesional, resultando en multiprofesionalidad y no interprofesionalidad. La educación continua en el servicio y una gestión que siga estos principios favorece la colaboración. Este estudio contribuye a mejorar la atención a los consumidores de alcohol y a futuras investigaciones sobre este tema.

Descriptores: Alcoholismo; Profesional de la Salud; Colaboración Intersectorial; Educación Interprofesional; Educación Continua.

Resumo

O estudo tem o objetivo de compreender as percepções dos profissionais sobre a colaboração interprofissional e as facilidades e dificuldades de implementação na atenção ao alcoolista. Estudo descritivo-exploratório, qualitativo, realizado através de entrevistas semiestruturadas com 16 participantes, analisadas através da análise temática. Os profissionais percebem e confundem a colaboração interprofissional com a multiprofissionalidade. A atenção centrada no usuário e família fortalece a colaboração. Entretanto, a centralização de poder, o sentimento de não pertencimento a equipe, a sobrecarga de trabalho, a informalidade de processos de trabalho interprofissional, a comunicação ineficaz e a gestão centralizada, dificultam a colaboração e necessitam ser melhorados através de processos que produzam consenso. Assim, a minoria apresentou uma compreensão que se aproxima da colaboração interprofissional, ocorrendo então a multiprofissionalidade e não a interprofissionalidade. A educação permanente no serviço e uma gestão que tenha estes princípios favorece a colaboração. Este estudo contribui para a melhoria da atenção aos usuários alcoolistas e para pesquisas futuras nesta temática.

Descritores: Alcoolismo; Profissional de Saúde; Colaboração Intersetorial; Educação Interprofissional; Educação Continuada.

Introduction

Chemical dependence on alcohol and other drugs is a health problem that affects different dimensions of human life and can take many years to be diagnosed as addiction[1].

According to data from the National Health Survey (PNS) carried out in 2019 in Brazil, 26.4% of the population aged 18 or overused to consume alcoholic beverages once or more per week, which represents an increase of 2.5 percentage points compared to 2013, when this percentage was 23.9%[2].

World Health Organization reports[3] state that problematic alcohol consumption affects 43% of the global population, causing an impact on morbidity, mortality, and disabilities worldwide.

A dependent user is someone who cannot stop using alcohol alone, even though the harmful consequences of abusive use are evident, leading to the need to increase the amount of alcohol consumed to achieve the previous effects and symptoms. The physical, emotional, and social repercussions at this stage are more serious[1].

Living with an alcoholic deeply affects family members, leading to disagreements, lack of trust, difficulties at work, and unemployment consequently, thus creating an unstable life, in which emotional ties and material goods can be lost and, therefore, a change in the family's standard of living[4].

The consequences of alcohol use also burden society, as they increase the costs of the health system, judicial system, and social security system, among others[3].

The Ministry of Health recommends that professionals act in a comprehensive, interdisciplinary, and intersectoral manner, meeting each person's individual needs, according to the context in which they are inserted[5].

The interprofessional collaboration consists of the coexistence in the common space between different professions that develop the expanded clinic, involving communication and shared decision-making for the best production of health care[6]. This collaboration occurs when health professionals from different areas share responsibilities and exercise participatory practice in patient care[7].

The effects of interprofessional collaboration are essential for the quality and efficiency of health care. They improve the interaction of professionals through shared identity and interdependence. Communication between workers becomes more effective, as well as the optimization of team participation in decision-making and shared responsibility for care. Studies show that teams that perform collaboration are more capable and able to coordinate care, identify patient needs, and develop new care technologies, producing responses to the health demands of the individual and the community[6,8-11].

Thus, there was a need for research that aims to understand the perception of interprofessional collaboration in the care of alcoholic users in a specialized service of a university hospital, considering that this understanding is fundamental for planning strategies to implement comprehensive health care for alcoholic users.

Methodology

Descriptive-exploratory study, of a qualitative nature, developed at the Cassiano Antônio Moraes University Hospital (HUCAM), in Vitória, Espírito Santo, having as a setting the specialized service in health care for alcoholics, which since 1985 has been a reference for the entire state in the care of this patient and the medical clinic, gastroenterology sector, where patients are treated and monitored for comorbidities associated with alcoholism.

The participants were professionals from this service, with different backgrounds. Thus, the sample was constituted through saturation, which according to the author[12], after information is collected from a certain number of subjects, new interviews begin to present a repetition of content, causing broad homogeneity.

Semi-structured interviews were conducted between May and June 2022 and data analysis was performed using thematic analysis, which consists of breaking down the text into categories after transcribing the interviews[13]. The following categories emerged: Profile of professionals and activities performed, professionals' perception of interprofessionality and its relationship with care for alcoholics from the professionals' perspective, and Factors that facilitate and hinder interprofessionality: Dimensions of the D'Amour typology. Participants were identified by the letter E followed by a number.

The theoretical framework that guided the script for semi-structured interviews and data analysis was the theoretical production of D'Amour and collaborators, as well as authors in line with the theme.

The D'Amour typology presents four dimensions, from which aspects of collaboration can be analyzed and evaluated, such as[14]:

- Shared goals and vision: The goal most likely to bring stakeholders together is to promote patient-centered care.
- Internalization: one indicator is mutual coexistence (professionals must know each other personally, meaning knowing each other's values and level of competence), and professional knowledge (knowing each other's disciplinary references, to develop a sense of belonging to the group and establish common goals). Another indicator is trust. Trusting each other's skills and ability to assume responsibilities.
- Formalization: instruments to clarify the roles and responsibilities of professionals. And exchange of information, existence, and adequate use of an information infrastructure among professionals.
- Governance: concerns leadership at central and local levels, expertise, and the degree of connection between them[11], that is, the leadership functions that support collaboration and support innovation[14].

These dimensions and indicators are then categorized according to the level of interprofessional collaboration reported by the interviewees and an average is calculated, in which: Active collaboration (level 3), where common and consensual objectives are achieved, there is a

sense of belonging and mutual trust, and a consensus is reached on governance mechanisms and rules. Collaboration in development (level 2), is a collaboration that has not taken root in the cultures of the organizations. Potential collaboration (level 1) is the collaboration that does not yet exist or has been blocked by serious conflicts, negotiations do not occur. The typology is based on the concept of collective action in the organizational sociology of Crozier and Friedberg[14].

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Results

Profile of professionals and activities performed

The PAA and the Medical Clinic (2nd floor) have a total of 30 health professionals who work directly in the care of alcoholic users. Of these, 16 participated in the research, 4 male and 12 female.

The study included nurses, nursing assistants, nursing technicians, social workers, nutritionists, physicians, and psychologists, as shown in Table 1. The average age was 41.5 years (between 29 and 64 years), and they had an average of 17 years of training (ranging from 8 to 40 years), with an average of 8 years of experience in these places.

Table 1. Participants, according to Professional Training. Vitória, ES, Brazil, 2022

Professional Training	(N)	(%)
Social worker	01	6,25
Nursing Assistant	02	12,5
Registered Nurse	05	31,25
Physician	02	12,5
Nutritionist	01	6,25
Psychologist	01	6,25
Nursing Technician	03	18,75
Physician (professor)	01	6,25
TOTAL	**16**	100,0

Regarding specializations and residencies, of the 11 professionals with higher education, 9 had completed one of these courses. When asked about courses about alcohol, drugs, and mental health, of the total number of participants, 7 said they had completed extension courses, specializations, doctorates, or residencies on these topics.

They were also asked about participation in research groups or projects that involved professionals from different categories during their professional training, and only two participants responded that they had participated, which demonstrated that 87.5% of professionals did not have this interaction during their professional training.

When analyzing the profile of the professionals, it can be stated that the participants have professional experience in their core knowledge, since the average training period was 17 years, with the one with the shortest time being 8 years. They also know their workplace and experience with that team, since they have been working in those places for an average of 8 years, thus favoring the bond, connectivity, and relationships with the other professionals.

Activities developed by professionals in the care of alcoholics

The professionals interviewed perform functions that are often common to other professionals, such as Health education for users before the pandemic; and continuing education: courses and training offered by the institution or carried out outside and reception of alcoholic users on demand and by appointment.

Regarding activities exclusive to some professions, the following responses were obtained: Referral after discharge to other services for continued care for the alcoholic or other activities; Clinical consultation of comorbidities related to alcohol and abstinence; Nursing consultation; Nursing procedures; Nursing supervision; Bedside visit to the hospitalized user; Services considered administrative; Socioeconomic assessment. And, finally, an activity that requires interaction between different professional categories: Discussion of cases, intending to evaluate the conduct concerning the user's treatment.

Professionals' perception of interprofessionality and its relationship with care for alcoholics from the professionals' perspective

Some professionals interviewed perceive interprofessional collaboration as an exchange of knowledge, cooperation, and interdependence between professionals.

> *"I think that this interprofessional collaboration is the exchange of knowledge, of know-how, for mainly complex issues"* (I2).

Others see it as having good interpersonal relationships with the team or being attentive to patients. These are issues that should be present in interprofessional work, but interprofessional collaboration goes beyond that.

> *"My way of collaborating is welcoming a patient differently, not letting them feel embarrassed outside, taking the patient's demand to the doctor as quickly as possible"* (I9).

> *"In our case, our team is very collaborative with each other. [...] I did this interview with you and my colleague volunteered to take care of my patient. We are like that; we are helpful to each other"* (I12).

A significant portion of those interviewed perceive interprofessional collaboration as multiprofessionalism.

> *"I believe that this is the way we work here, with the multi-team: social services, physiotherapy, medical team, nursing"* (I5).

> *"In medicine, it is about having some complication, you request it, and they are ready. In nutrition, it is a dietary correction, you request it, and they check it. For example, the patient does not want coffee with milk, he wants it separate"* (I12).

Most professionals perceive interprofessional collaboration as multidisciplinarity or having good interpersonal relationships with the team and being attentive to the patient. Of the professionals who perceive it as an exchange of knowledge, cooperation, and interdependence between knowledge, the vast majority have higher education. These perceptions about interprofessional collaboration are also related to how the professional says he/ she is appropriate in providing health care to alcoholic users.

Most of those interviewed believe that alcoholism should be understood as a disease and that comprehensive health care should be provided, characterized by multidisciplinary care, continuing after discharge.

> *"I think it should involve the entire multidisciplinary team, the patient's family, social services. I think it is part of the entire context to be able to approach this patient"* (I5).

> *"Alcoholism is a disease like any other, with the same advantages and disadvantages. So, this is our role: to treat the individual, to look at the family, to look at previous contexts"* (I16*).*

However, professionals did not relate that including the user and family members in this treatment and recovery process is practicing interprofessional collaboration. But they know that users and family members must be heard and considered. This reflects the attempt to practice comprehensive care within the SUS and the lack of knowledge about what interprofessional collaboration is.

> *"He thinks he will be "undertreated" because he is an alcoholic. [...] and the whole team welcomes him, we show that we believe in him. And then I feel that all these patients that we managed to welcome, they gain the strength to want to, they always leave here saying that they don't want to drink anymore"* (I7).

> *"We have always worked on understanding alcoholism as a disease, its causes and consequences in people's lives. If they want to undergo treatment, then that makes all the difference"* (I14).

Care for alcoholic users involves the responsibility of the entire team and the co-responsibility/participation of the user in this process. It involves establishing a bond between professionals and users, and between professionals, which will bring better health conditions, and social and family relationships and restore dignity as a human being, in addition to benefits to collective health.

Factors that facilitate and hinder interprofessionality: dimensions of the D'Amour typology

Objectives and shared vision: In this dimension, it is observed that the main facilitating element is care centered on the patient and their family, which is also present among the participants.

> *"We discuss as a team, but we also listen and work with him (the user). We must investigate his history"* (I4).

> *"The treatment of the family member, together with the patient, is essential for the good development of the situation. It is important for the family member to be involved and to learn about the true disease of alcoholism"* (I16)".

As hindering elements, we have the need to adjust interests (centralization of power), doing only what is appropriate for that professional category and waiting to be requested by another profession.

> *"I think this is ridiculous, I think we have to interact! Everything is "only if the doctor prescribes it" or if we are calling. I realize that this routine is missing [...]. We try to ask, but some say something like: 'if it is prescribed, I will attend' or 'if there is an opinion'"* (I11).

> *"It's something we deal with quite often. You gave your position, passed it on to the team, but you see that it stopped where you said it, there was no follow-up. And this often demotivates our work"* (I5).

These facilities and difficulties presented by the research participants show that interprofessional collaboration is not rooted or strengthened in this dimension, but already presents some positive attitudes, which need to be better worked on to achieve the active development of collaboration.

Internalization: mutual coexistence and trust

> *"I feel very included. I think they respect me, they ask my opinion, and they respect my opinion. We are always included. 'Look, I'm going to have to be discharged now, and the discharge will be like this, what do you think?'. Then I answer"* (I10).

> *"The good thing is the respect we have, the history of the service, of working with alcoholics since the 1980s. The interpersonal relationship is great"* (I15).

However, the overload of some professions imposed informally by colleagues from other categories, the lack of accountability for care, the absence of formalized moments of meetings, gatherings and the feeling of not belonging to a multidisciplinary team, whether by oneself or by exclusion imposed by the hierarchical system, are factors that hinder interprofessional collaboration.

> *"We are overwhelmed by other service demands. So, this ends up making it difficult to share care. And then some specific interventions end up being defined for certain professions"* (I2).

> *"Since I am the person who participates the least (nursing technician), there is none. Because I do not fully participate in their care. They do not introduce me to their program as a person who participates"* (I9).

There were reports in which a lack of trust in the other person's opinion and work also interfered with collaboration and demonstrated that professional appreciation only occurs after knowing and trusting the other person's competence.

> *"Over the years, the appreciation has been increasing. It is a job of gaining space and, often, of confrontation, so that you can gain space. Professionals begin to see results in their work and become more confident"* (I2).

The internalization of this research in the field proved, according to reports, to be very difficult to implement.

Formalization

Not having a daily moment and place to exchange information is considered a problem, however, we highlight here the resilience in often using their means of communication for information and discussion of cases and not realizing that they need these formalized moments of exchange and with means of communication from the organization, which facilitate the work of these professionals, which in the final analysis of the dimension causes an impact.

> *"We have a WhatsApp group for gastroenterologists, in which all professionals are included. Any problems with a gastroenterologist patient are reported there"* (I13).

The following factors hinder interprofessional collaboration in this dimension: lack of clarity in their role and that of the other professional, lack of routines that establish activities, interprofessional meetings with the inclusion of all categories or representatives of these, lack of a unified system for scheduling and developing shared care, and professionals remaining in the sector only during the morning period.

> *"To this day, working here, I don't know what the nurse's role is in this program, where he works. [...] I don't know what his role is in this process. I don't know why they never told me"* (I9).

> *"There is a difficulty in this collaboration. Both culturally and in the system itself, [...] if it could generate a field where you could place a service from several professionals, the patient would leave here with a single appointment, you know? Then in the field within the system, it would be a unique evolution of the team"* (I2).

Interprofessional collaboration relationships are very fragile due to reports of a lack of formalization of activities, protocols, and routines within the team. Thus, this dimension is surrounded by conflicts that hinder negotiations and communication between professionals.

Governance

It concerns leadership at central and local levels. In this service, governance attributes are rigid concerning the hospital's central management.

> *"Normally we have close contact with the head of the unit. However, not all decisions are made by the head of the unit. And so, we often see that something is not going to be good in practice, but we end up having to do it, because it has already been established and that's it"* (I2).

Another factor that makes collaboration difficult is having a large demand from alcoholic users, with issues that are often complex and require a team, and having a number considered small by human resources interviewees.

> *"I have a lot of patients to see and sometimes I can't triage them all. Sometimes I go by what they call me. Today, I have 40 (patients), I may not be able to handle them. But that's also up to the institution, due to the number of people we have"* (I10).

At the local and sector level, management is more open to sharing decisions and responsibilities for providing care with team members.

> *"As for our sector management, unit manager, yes, we are heard, we sit down and talk, we ask questions, we try to seek improvements"* (I6).

Professionals have incentives for continuing education, but they do not report access to training and courses that encourage interprofessionalism.

> *"What makes it difficult: the system, professional training, incentives from the institution to maintain this teamwork, and time dedicated to exchanging knowledge between teams. Nowadays, one person thinks one thing, and the other thinks something else. Sometimes they agree and sometimes they disagree"* (I2).

The governance dimension brings connectivity between professionals, which must be encouraged and supported by management throughout the work process and not only when there are problems or issues to resolve.

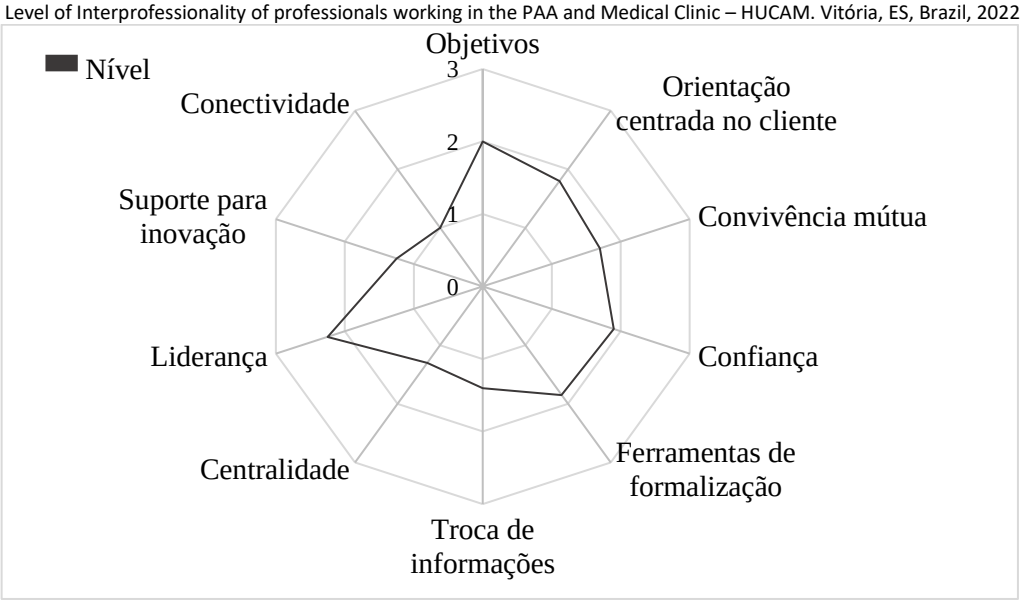
> *"Whenever there is a problem, we get together to solve it. But there is no way to formulate ideas or protocols. It is more about putting out fires"* (I11).

One factor mentioned by participants that directly affects teamwork is the infrastructure of the location. Having an environment that encourages dialogue, facilitates the movement of workers, facilitates the exchange of information, and speeds up tasks would favor the provision of care to alcoholic users in an interprofessional manner.

> *"More suitable physical space, [...] to use the computer, you must go up and down; to use the phone, you must go up and down. This logistics prevents a better fluidity of work and even a better quality of life for the worker"* (I14).

When asked about leadership and management, the interviewees were, in most cases, superficial. It was noted that they had difficulty expressing opinions about governance. The governance dimension shows that interprofessional collaboration in the management of the service for the care of alcoholics is fragile and needs to be discussed involving professionals, central management, and leaders so that protocols, routines, and activities can be initiated that encourage collaboration and consequently assistance to these users and the work routine of this team.

Graph 1. Level of Interprofessionality of professionals working in the PAA and Medical Clinic – HUCAM. Vitória, ES, Brazil, 2022



Note: 1 – Potential/latent level of collaboration; 2 – Level of collaboration in development; 3 – Level of active collaboration. Portuguese to English Translation: Nível = Level; Objetivos = Objectives; Orientação centrada no cliente = Customer-centered orientation; Convivência mútua = Mutual coexistence; Confiança = Trust; Ferramentas e formalização = Tools and formalization; Troca de informações = Exchange of information; Centralidade = Centrality; Liderança = Leadership; Suporte para inovação = Support for innovation; Conectividade = Connectivity.

Discussion

The study shows that 87.5% of professionals did not interact with professionals from other categories during their training. In Brazil, this fragmented education into disciplines, with a focus on biological determinants, makes it difficult to look at the real needs of the user, who is a complex being, each with a life story[15].

These professionals have experience in their core knowledge and are familiar with their workplace. It is important to note, however, that since this is a service that provides care to alcoholic users, a small number of professionals had completed some course/training focused on this topic, which contrasts with the years they have worked in the same service, demonstrating the lack of training and ongoing education offered to these professionals. Providing this learning consists of maintaining the individual's qualifications and adding care practices[16]. Since the professionals who have some training in this subject are all at a higher education level.

Study[17] distinguished common skills as those activities that are common to all professions; complementary skills as those activities that distinguish one profession from another, that is, that demarcate the identity of a profession; collaborative skills, are attitudes necessary to work effectively with other professions, which aim to inform users, family members and team members through active communication and understanding for all[9,17].

Thus, the activities developed by professionals in the care of alcoholics require common, complementary, and collaborative skills and are essential for the proper functioning of the work environment and health care for users. Collaboration implies the idea of sharing and collective action, guided by common objectives, in the spirit of trust and harmony among the members of a work team[6].

For health professionals to effectively exercise collaboration and interprofessionality, they must want to learn from the knowledge of others who are different from the user/ person[8].

We saw that a small portion of the interviewees understood interprofessional collaboration as an exchange of knowledge. A significant portion perceive interprofessional collaboration as multiprofessionality, which reflects the multiplicity of professions and each professional will act according to their specialized knowledge, formal exercise of an occupation[18].

Mid-level professionals often do not share the same team experiences as higher-level professionals. Most professionals who perceive collaboration as an exchange of knowledge, cooperation, and interdependence between knowledge have higher education.

The lack of improvement leads to confusion/lack of knowledge among professionals about interprofessional collaboration. This can hinder the implementation of interprofessional relationships in health practices[19].

This way of understanding collaboration has repercussions on the care provided to alcoholics. The interviewees report that alcoholism should be understood as a disease and should receive comprehensive care, which for them is synonymous with multidisciplinarity.

The dimensions of the D'Amour et al. typology help in the process of analyzing the factors that facilitate and hinder interprofessional collaboration.

The “objectives and shared vision” dimension shows that including family members and users in this process means practicing comprehensiveness and collaboration. Through dialogue and reflection between professionals, users, and family members, understanding should be sought for the pertinent and contextualized application of technical-scientific knowledge relevant to the individual’s health needs[20].

The internalization dimension revealed that work overload, lack of accountability for care, and the absence of

moments that provide knowledge about each team member and thus a sense of belonging to that team make collaboration difficult in the daily life of this team. Likewise, the difficulty in valuing the work of others, which only happens after employment relationships.

Professional hierarchies created in the past by various factors create dysfunctional communication patterns. Therefore, it is expected that communication regarding hierarchy takes place respectfully and equitably, so that contributions that could be important for the evolution and interaction of work are not lost[19].

Regarding formalization, one of the detrimental factors is the lack of appropriate and formalized moments for exchanging information, while the fact that they use their technologies, such as groups on social networks, facilitates this work. However, professionals do not understand that this should be overcome by service technologies.

At the management level, the governance dimension requires greater connectivity with professionals and an infrastructure that favors the development and strengthening of interprofessional collaboration. This was evidenced in superficial statements about management.

Collaboration cannot be established without a complementary learning process and without the organization involved taking advantage of internal or external experience to support this learning process[14].

One way to improve these collaborative attitudes is through ongoing education at work, through the constant qualification of the individual. These moments are democratic and participatory spaces for socialization and dissemination of information, production of knowledge, and planning of actions[17]. EPS and EIP can be complementary to promote practices that provide the expected change for the implementation of comprehensive care, universal access, and quality of health care[21].

Thus, the analysis of the dimensions of interprofessional collaboration carried out through the interviewees' reports allows us to infer that it occurs similarly in the dimensions of objectives and shared vision, internalization, and formalization, developing some collaborative attitudes, but which still need to be improved through negotiation processes that produce consensus. The governance dimension, on the other hand, was the one that demonstrated the most difficulty in being collaborative, with several conflicts and difficulties reported that still need to be overcome.

Conclusion

The professionals who work in the care of alcoholic users at HUCAM have years of professional experience, training and experience in that service, which did not represent a relevant factor in interprofessional collaboration. Because they did not have this opportunity during their training courses, having a fragmented education in disciplines and, during their professional career, there is this difficulty in understanding the subject, causing fragile and confusing understanding, associating the term with multiprofessionality.

The minority of professionals presented an understanding that is close to interprofessional collaboration, when they express that this involves an exchange or sharing of knowledge and expertise.

They also report the importance of care centered on the user and family, with the sharing of responsibilities, but do not relate these factors to interprofessionality.

To improve this understanding, there is a need for ongoing education in the service and management that has these principles as its governance priorities, helping to develop these collaborative skills at work. This is a gap that has existed since the training of these professionals. Another factor that needs to be addressed in this team is the provision of training on the topic of alcohol and drugs.

Better communication is necessary for greater collaboration. Professionals see the exchange of information as essential, but they need spaces, agendas, protocols and means of communication. These institutionalized organizational devices were found to be insufficient to stimulate and support interprofessional collaboration. When these spaces for knowledge exchange and learning do not occur, professionals appear to have more difficulty in feeling like they belong to a team. It is also necessary to provide students with interprofessional education. Since this is a university hospital, there is great capacity for a collaborative service between the various professions that share learning and comprehensive care.

The limitations of this study include the fact that it was a qualitative study and that some participants superficially mentioned aspects that often-caused discomfort, even when encouraged to speak, as was the case when management/leadership was discussed. The fact that there was no time to observe reality, and the participation of users also caused a limitation, as it did not allow a comparison of the participants' statements with what would have been observed in practice and the users' perception. Finally, this study opens avenues for future research, raises questions that can be better clarified, especially by directly addressing the dimensions of interprofessional collaboration in healthcare settings, and contributes to improving healthcare services for alcoholic users.

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