Original article

Dreams and utopias for the Psychosocial Care Network: perspectives of workers*

Sonhos e utopias para a Rede de Atenção Psicossocial: perspectivas de trabalhadores

Sueños y utopías para la Red de Atención Psicosocial: perspectivas de trabajadores

Valquíria Toledo Souto[I] , Marlene Gomes Terra[I] , Cristiane Trivisiol Arnemann[I] ,
Amanda de Lemos Mello[II] , Daiana Foggiato de Siqueira[I] ,
Mariane da Silva Xavier[III]

[I] Universidade Federal de Santa Maria. Santa Maria, Rio Grande do Sul, Brasil
[II] Estácio de Sá – IDOMED Polo Jaraguá do Sul. Jaraguá do Sul, Santa Catarina, Brasil
[III] Universidade Federal do Rio Grande do Sul. Porto Alegre, Rio Grande do Sul, Brasil

Abstract

Objective: to identify the dreams of workers about how the future of work in the Psychosocial Care Network (RAPS - *Rede de Atenção Psicossocial*) could be. **Method:** appreciative, qualitative research, with a participatory approach, guided by the Discovery, Dream, Planning and Destination Cycle, articulated to the theoretical framework of Paulo Freire. Thirteen RAPS workers from Santa Maria, Rio Grande do Sul, Brazil participated. Data were produced from December 2019 to July 2020, with semi-structured interviews and recorded discussion groups. Data analysis was performed through coding, categorization and identification of themes. **Results:** workers dream of a network with sufficient human and structural resources; care flow defined collectively; approach to management; work in the territory; committed workers, appreciation and attention to their mental health. **Conclusion:** dreams converged with what is already advocated in public policies, but require an organized and committed collective that fights for change.
Descriptors: Mental Health Assistance; Mental Health Services; Intersectoral Collaboration; Interprofessional Relations; Patient Care Team

Resumo

Objetivo: identificar os sonhos dos trabalhadores sobre como poderia ser o futuro do trabalho na Rede de Atenção Psicossocial (RAPS). **Método:** pesquisa apreciativa, qualitativa, com abordagem participativa, orientada

pelo Ciclo Descoberta, Sonho, Planejamento e Destino, articulada ao referencial teórico de Paulo Freire. Participaram 13 trabalhadores da RAPS de Santa Maria, Rio Grande do Sul, Brasil. A produção dos dados ocorreu de dezembro de 2019 a julho de 2020, com entrevistas semiestruturadas e grupos de discussão gravados. A análise dos dados foi realizada por meio da codificação, categorização e identificação de temas. **Resultados:** os trabalhadores sonham com uma Rede com recursos humanos e estruturais suficientes; fluxo assistencial definido coletivamente; aproximação com a gestão; trabalho no território; trabalhadores comprometidos, valorização e atenção à sua saúde mental. **Conclusão:** os sonhos convergiram com o que já é preconizado nas políticas públicas, mas requerem um coletivo organizado e comprometido, que lute pelas mudanças.
Descritores: Assistência à Saúde Mental; Serviços de Saúde Mental; Colaboração Intersetorial; Relações Interprofissionais; Equipe de Assistência ao Paciente

Resumen

Objetivo: identificar los sueños de los trabajadores sobre cómo podría ser el futuro del trabajo en la Red de Atención Psicosocial (RAPS). **Método:** investigación apreciativa, cualitativa, con abordaje participativo, orientada por el Ciclo Descubrimiento, Sueño, Planificación y Destino, articulada al referencial teórico de Paulo Freire. Participaron 13 trabajadores de la RAPS de Santa Maria, Rio Grande do Sul, Brasil. La producción de los datos tuvo lugar de diciembre de 2019 a julio de 2020, con entrevistas semiestructuradas y grupos de discusión grabados. El análisis de los datos fue realizado por medio de la codificación, categorización e identificación de temas. **Resultados:** los trabajadores sueñan con una Red con recursos humanos y estructurales suficientes; flujo asistencial definido colectivamente; aproximación con la gestión; trabajo en el territorio; trabajadores comprometidos, valorización y atención a su salud mental. **Conclusión:** los sueños convergieron con lo que ya es preconizado en las políticas públicas, pero requieren un colectivo organizado y comprometido, que luche por los cambios.
Descriptores: Atención a la Salud Mental; Servicios de Salud Mental; Colaboración Intersectorial; Relaciones Interprofesionales; Grupo de Atención al Paciente

Introduction

The demands in health work transcend the individualized actions of each profession, so they increasingly require collaborative, interdisciplinary, and networked work.[1] Networks are flows of connection, or modes of operation, that operate in health by virtue of the action of workers. It is a concept that is based on the idea that all are protagonists in the care process, and thus, the movements are shared and articulated with each other.[2]

The perspective of networks for the production of care at work in mental health emerged with the movement of the Brazilian Psychiatric Reform, which had already been defending the extinction of psychiatric hospitals, and their replacement by mental health care networks. However, its regulation was instituted through Ordinance n. 3,088, of 23 December 2011, which provides for the Psychosocial Care Network (RAPS - *Rede de Atención Psicossocial*).[3]

Considered as a priority action of the National Mental Health Policy (PNSM - *Política Nacional de Saúde Mental*), RAPS follows the premise of assisting people with mental disorders and needs,

resulting from drug use. It aims to expand and promote their access to health services, offering territorial care, based on citizenship and respect for the different expressions of human existence.[3]

It is worth noting that, since 2015, there have been important setbacks in this scenario, culminating in the promulgation of Resolution n. 32, of 14 December 2017, by the Tripartite Inter-Managerial Commission (CIT - *Comissão Intergestores Tripartite*), and the subsequent Ordinance n. 3.588, of December 21, 2017.[4-5] These regulations have impacted on the precariousness of territorial care devices and the rescue of the asylum model, through the underfinancing of substitute services, expansion of hospitalizations in psychiatric hospitals and legitimization of therapeutic communities.[6]

With the Psychiatric Reform weakened and a tendency to political, economic and ethical intensifications in the field of mental health work, the importance of articulation and the bet on the powerful, creative and living network among its workers, users and family members is reiterated, principles of the anti-asylum and antiproibicionist struggle, and in defense of the Unified Health System (UHS).[7]

With this, it is understood that, to move forward, it is necessary to reflect critically on these difficulties experienced, the situations that paralyze/ weaken the RAPS workers, but also on the dreams that move them. One considers the inspiration in Paulo Freire that it is possible, urgent and necessary to change the order of things, and one believes the dream and utopia as paths for change. Dreams are projects for which we must fight, are permeated by obstacles, which require advances, setbacks and struggle. Utopia is the dialectical relationship between the denunciation of limits in a given situation and the announcement of the possibility of overcoming them. One should not understand as synonymous with something impossible, but something that throws us to walk.[8]

Brazilian studies in the mental health field have sought to understand the conditions of access to RAPS services, the development and implementation of policies and strategies for the improvement of care in psychosocial care, stigmas and social vulnerabilities. They also seek to investigate the perception of workers, users and family members about care and its devices in different contexts and scenarios,[9] symbolizing, in most cases, the denunciation of dehumanizing conditions that permeate work in RAPS. Therefore, this research proposed to go a little further, by presenting, hopefully, also, the announcement of what is possible to live the ideal future that emerged in the dreams of these workers. Faced with this, the objective was to identify the dreams of workers about how the future of work in RAPS could be.

Method

This was a qualitative Appreciative Research (AR), with a participatory approach. AR is an innovative methodological path in the field of health research, still little explored, because, originally, it was designed for organizational studies. This type of methodology is usually used to answer research questions such as "how can we improve this situation?"[10] being operationalized by the realization with the participants of the four phases of the Discovery, Dream, Planning and Destination Cycle (DDPD).[10]

The first phase of the cycle, called Discovery, sought to identify the positive essence of care practices, the best practices, which were developed by workers in their daily lives. The second phase, called Dream, encouraged participants to unveil their dreams for the future of work in RAPS. The third phase, called Planning, validated the dreams emerged in the previous phase, and established priority for those who considered capable of planning and mobilization by the group. The last phase, called Destination, enabled the definition of strategies to reach the expected ideal, considering the possible dreams.

This type of study enabled an invitation to change, mediated by dialogue, reflection, planning and action directed to the goals collectively built in the research process. It was conducted and articulated to the theoretical framework of Paulo Freire. Freire's conceptual basis contributed to the interpretation of this study, as it advocates change driven by processes of democratic participation, dialogue, reflection and transformative action.

The scenario of this research was the RAPS of Santa Maria, a municipality in the central region of Rio Grande do Sul (RS), Brazil. From this RAPS, Primary Health Care (PHC) and specialized mental health care services (both in secondary and hospital care) were listed. These services were selected because they already had experience of articulation with the network, in the case of the Basic Health Units (BHU), because they received support from the Extended Nucleus of Family Health (NASF - *Núcleo Ampliado de Saúde da Família*), or because they are the totality of existing services in the municipality, as in the case of the NASF, Psychosocial Care Centers (CAPS - *Centros de Atenção Psicossocial*) and the hospitalization unit.

The participants were 13 workers linked to RAPS, being seven primary care workers (BHU and NASF), five from specialized care (CAPS) and one from hospital care. The criteria for inclusion in the research were: to be a worker of the municipality in which the study was carried out, of any level of training, being at least one year linked to the RAPS, because this time was considered the necessary, to have accumulation of experience in relation to the object of study. Workers with a

history of participation in collective spaces in the RAPS (working groups, matrix support, visit, among others) were also included. The exclusion criteria were: workers who were on sick leave or vacation during the data collection period.

It is noteworthy that the trajectory of academic and professional training of the researcher was built in the investigated RAPS, which facilitated the setting in the scenario, and also the approach with the participants. The fact of being known, among the possible participants and managers, facilitated the contact and receptivity to the research.

The proposed production of part of the data in group defined that the number of participants would consider the maximum of 20 workers, so that the active participation of all was viable. Thus, 30 workers were invited to participate in the research, of whom 13 accepted and had availability to participate in the groups and/ or interviews of the Dream phase of the research.

It is understood that AR seeks greater participation and possible engagement of people in research related to their area of expertise. For this reason, one opted for the workers of the services that integrate the RAPS in its different care levels, because it obtains the plurality of the context in which they are inserted.

The production of research data occurred from December 2019 to July 2020, being carried out through Discussion Groups (DG) and Semi-structured Interviews, which were methodologically guided by the DDPD Cycle. DG is an artificial group, convened according to the objectives of the research and controlled by the researcher who acts as moderator. It aims to evoke the active participation of the participants in the research, giving them freedom to express their opinion.[11] Semi-structured interviews are characterized as a research strategy that combines closed and open questions, in which the interviewee is free to position him/herself on the subject, with spontaneous conduction of the interviewer.[12]

Four DG were performed during the research process, two of which occurred in person and two remotely. The DG that occurred in person were related to the phases of discovery and dream. The DG that occurred remotely, with the help of the Google Meet tool, were related to the phases of Planning and Destination. The results presented in this study emerged from a DG in which six workers participated, as well as semi-structured interviews with seven other workers who had not participated in the DG.

The DG of the Dream phase lasted approximately 90 minutes, happened in person at a place reserved at the headquarters of the Center for Permanent Education (NEPeS - *Núcleo de Educação*

Permanente) of the city. On the other hand, the interviews took place in person, on a date and in a place defined by the workers who requested a reserved room, in order to ensure more privacy. The duration of these interviews was not delimited, as they were conducted according to the availability of participants, however, occurred around 40 minutes on average. All were recorded for further transcription, with prior authorization of the participants, through the Informed Consent Form. For the characterization of the participants, a form was used, with closed questions, applied at the beginning of the meeting, thus contemplating personal and professional information.

In this phase, to mediate the discussion, a reflective task called "sowing dreams" was applied. At the beginning of the group meeting/interview, the mediator requested that the hopes and dreams for the work in the RAPS were listed in writing. Thus, participants were encouraged to raise aspirations about how the future of work in RAPS could be. At this stage, one sought to encourage them to think about what would be ideal in the future scenario, even if it seemed impossible to be achieved.[10]

Regarding the data analysis, this occurred through thematic analysis. The textual data generated by the transcription of the audio-recorded speeches of the participants were analyzed, during the DG and semi-structured interviews. For the analysis, four main steps were followed: data immersion, coding, categorization and theme generation.[13] The immersion stage was the first step of the analysis, with the moment of readings and re-readings of the text being transcribed to understand the general sense of the data.[13]

The coding step was performed with the help of the software MAXQDA, version 2020, from the organization and classification of information, contained in each speech, and in the group data set, and for each highlighted segment was assigned a code (concept that was apparent), and a definition (contextual interpretation of the code). In this way, each segment was analyzed, in terms of similarities and differences, starting from questions such as: what does this segment mean, to which it refers? As new data were reviewed, the previous ones were constantly compared, and the codes were being refined during the process.

The categorization step occurred throughout the coding process, and the data needed to be reviewed to analyze the ways in which the codes could be linked. This link of codes in macrocodes aimed to create categories.[13] At the end of this step, all relevant data were reduced to categories that contemplated them without losing their meaning.

The generation stage of the themes involved the evolution to an interpretation of the

question that was being investigated, considering that the themes are more representative than the categories, since they express the basis of the conclusions that were taken from the analysis.[13]

All stages of this study followed Resolution n. 466/2012, of the National Health Council, which establishes the Guidelines and Regulatory Standards for Research involving Human Beings.[14]

The research project was registered in *Plataforma Brasil*, aiming at the evaluation of the Human Research Ethics Committee (REC) of the Federal University of Santa Maria, being approved on 07/24/2019, with Certificate of Presentation of Ethical Assessment n. 3467894. Nevertheledd, given the context of the COVID-19 pandemic, and the need for social distancing, data production was suspended in March 2020, and an amendment to the REC was requested (approved on 06/30/2020, under Opinion n. 4.125.242) for remote continuation. To ensure confidentiality, anonymity and confidentiality, participants were identified by the letter W (of worker), followed by an Arabic number (W1, W2, W3, ...). The codes were also composed by the identification of the data collection strategy in which the speeches emerged (being: DG for Discussion Group, and I for Interview), for example, W1-DG or W9-I.

Results

The study participants in this phase were 13 workers, ten women and three men, aged 28 to 54 years. Regarding the professional nucleus, four were nurses, three psychologists, two social workers, two community health agents, a physiotherapist and a nursing technician. Concerning the academic degree: two had completed high school, one with incomplete higher education, eight with specialization and two with academic master's degree. As for the working time in RAPS, it was between 1 year and 6 months and 30 years. Among the participants, eleven already participated in more than one working group at RAPS.

The analysis of the data from this phase of the study originated a theme called: "utopias of RAPS workers", and two categories, with their respective macrocodes, according to the scheme (Figure 1):
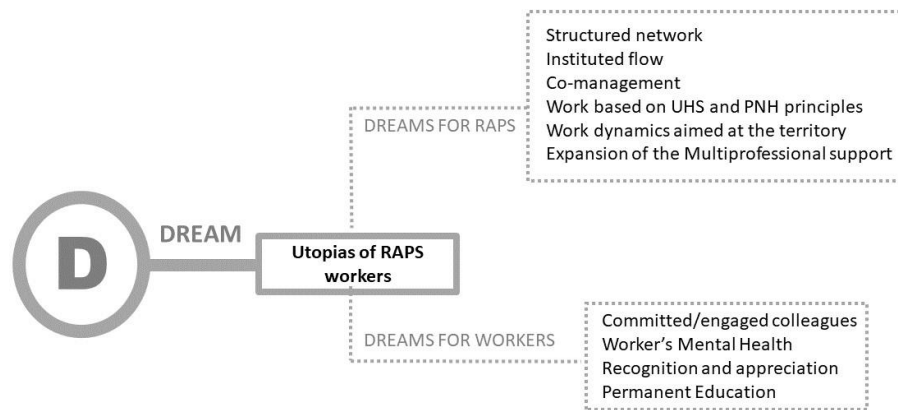
Figure 1 - Theme, categories and macrocodes emerged in the Dream phase. Santa Maria, RS, Brazil, 2022

Utopias of RAPS workers

The invitation to the participants to dream revealed the utopia that moved them in the face of existing conditions, and the search for others more appropriate to the needs of the RAPS and its workers. Therefore, there were dreams for RAPS, and dreams for RAPS workers.

Dreams for RAPS

The workers dreamed of a structured network (with adequate human and structural resources in sufficient numbers). They understood that this dream could already be a reality; they realized the possibility of qualifying the work, from some adjustments, such as the improvement in the logistic support of the network (for example, in relation to transport). Regarding the limitations of access to transportation, available in specific days/hours, they met users' needs, and affected the worker's "versatility".

> My dream is very simple, in fact there was no need to be a dream, it should be a reality, which is simply a structured network, with workers and services that work and exist in adequate numbers. That alone would certainly solve a lot of problems. (W1-DG)
> We work well, but sometimes we don't work in the best way [...] there are some adjustments that need to be done, because we need all the support that we don't have: our car on a fixed day, when we have we know the day, and we know that there is no time, that there is no day for people to become unbalanced and need something. So, it turns out that we don't have all that versatility that we wanted to have. We are not as versatile as we would like. (W2-DG)

We have determination in the CAPS for the car to stay there, I never saw a car there, it is not effective. And mental health has already bought car fleets with surplus money, as we know. (W8-DG)

They also dreamed of an instituted care flow, starting from the collective discussion between services, which could be built and maintained by their workers, in which it was possible to reduce the bureaucracy of user's access to services.

I also included the dream of less bureaucratic work. This thing of the user needing to go somewhere to get a piece of paper to go somewhere else. This all ends up being an obstacle, you need more access and have a flow that flows. (W4-DG)
A flow discussed by all services and implemented, that is, it is the basics. (W5-DG)
I also put the construction and maintenance of an effective flow, so that the user is indeed assisted or has no need to go through countless places that don't meet their demand. (W9-DG)
In some cases, ok, let a flow come, in a little while from top to bottom, but let the conversation also come: "we thought about this flow, what do you think, what is going on, what it's not working, what do the teams have to improve? (W11-I)

The workers dreamed of approaching management and attention, with participatory and democratic management, with co-management, with the UHS that works, the ideal UHS, which needs to be continuously revitalized. They understood their role to make it work, which is not only the responsibility of management. Finally, they dreamed of working in the RAPS, based on the principles and guidelines of the UHS and the National Humanization Policy (PNH - *Política Nacional de Humanização*), with more equitable care, with appreciation of the protagonism and autonomy of the user.

Also, the dream of working based on equity, on the user's role. I also brought this thing from the PNH, the approximation between management and care, we managed to have an effective dialogue with management [...]. *This issue of integrated planning, of us being able to be together with the management building, not only the management thinking and us executing, but that we can together, workers, managers and users build these care proposals. All of this is a UHS that we believe in, that we know that works, but that at times we need to be getting stronger. Also understand that we have a fundamental role in all of this, that it isn't just management, we are also co-responsible for this.* (W4-DG)
My dream is also not far from that, participatory management and coordination [...]. (W5-DG)

The work dynamics was a dream, which was closer to the reality/territory of the users, allowing the planning of contextualized care actions, in partnership with families, which was less fixed in the service and demands. They dreamed of investing in territorial care, with an expanded look at families, but this required the expansion of the Primary Care teams (FHS and NASF).

What if we could act more proactively with the mental health teams? Thinking about what the girls said, about the power of work in the territory, so that we can better understand the situations and better think about the developments for the cases [...]

> *what I see in everyday life is that we are very fixed. An example is that we can listen to a patient in crisis for a few weeks, and their crisis was triggered by several situations, lack of pharmaceutical assistance, lack of a lot of things, and every week they go to the CAPS, and ask to talk, and I talk to them, but I can't read the situation, it takes me several weeks to read what was really going on, because I don't know the reality [...] our steady job is a dumb job.* (W2-DG)
>
> *I put effective care in the territory. And about that, I put strengthening Primary Care with more Family Health teams, more NASF teams working an Expanded Clinic logic. I raised the care issue, looking at the context of the families, which we see that this works very well, we manage to provide care in the territory, this is very effective.* (W4-DG)

Workers also dreamed of more partnerships with educational institutions, with the expansion of multiprofessional support. They understood that the demands of the territory would be better received, if there were the inclusion of other professional centers, such as physical educator, pharmacist, nutritionist and physiotherapist.

> *I've already opened* [place] *for physiotherapy, for physical education, it is open, but the hard thing is to get someone who wants to come, to expand, there is a lot of need here. Where there were more of these partnerships, adding more areas that could work together would be very good. We have struggled a lot to add more participation from other areas. It's been two years since we got mental health* [residency]. *We didn't have, for example, residency, there was none, we also got the obstetrics that came here, and here we wanted a physical educator. People would like to have, for example, a walking group, an exercise group, and they don't have the conditions, we don't have the skills for that.* (W12-I)
>
> *My dream is to have a residency here, this dream is very feasible, but the dream has taken so long, that I don't know if one day it will come true, but, if we had a pharmacy resident, a nutrition resident, it would already help a lot with our patients.* (W15-I)

Observing this worker's statement, the dream was to dream communion, part of the recognition not given to things, and, thus, the meetings would enable invention, creation. Creating possibilities for change exhausts, but these are possible meetings for those workers who dream.

> *The possible dream is of the order of meeting things. It depends a lot on the movement that each person is building in their life. I believe that two people who meet each other in the process of life can do a lot. And a lot of people also believe that many people are willing to invent, because things aren't given. We also have the challenge of making things possible, this demands a complex amount of time, which is available beyond work. It is often exhausting beyond the emotional. Many resources are hard to achieve, with many setbacks, but the possibility always exists for those who dream* [...]. (W10-I)

Dreams for workers

In the dream scenario emerged those who were focused on the worker, their expectations, needs and attitudes that could be different in the ideal world.

The workers dreamed of more committed (work) colleagues, who showed greater

commitment in their functions, with the look and do expanded beyond what is put, and with an empathic posture. At the same time, they reflected whether the lack of engagement would not be linked to the unawareness of their role, the possibilities in the exercise of the function in the service and in the network work.

> *I think workers committed to doing their jobs. At times, it isn't demanding more from people, but sometimes we need to do something more, sometimes with a colleague, sometimes with a patient, with a user, things that are very much linked to a matter of empathy, because, if you have an adequate number of services and workers, and the services don't work, the workers don't work the way they should, it's no use, you can hire infinitely and the business won't work. So this is a dream that shouldn't be a dream.* (W1-DG)
>
> *I think that we had to awaken in people this commitment to work, but that is up to each one of us. We can say that they don't engage, but then I kept thinking that maybe nobody said how to do it, and then I'm going to do it as I think is best.* (W8-DG)

Regarding the spaces to deal with the issue of the worker's mental health, the interviewees mentioned that there is offer of listening, embracement of demands.

> *One thing I always use to say to people who arrive: "Guys, if for some reason you don't have the conditions, ask for help! Because if not, in a little while, you're becoming sick". "Ah, but I have a problem at home, I can't hear the patient". It won't flow, go out, get some water, call a colleague for support, tune in and come back. This is caring for the caregiver. Then, people start to lock themselves up, they don't even want to work. We also have to be loving with this no, because this no is an impossibility.* (W8-DG)
>
> *I also mentioned support for the worker, the issue of the worker's mental health, in the sense of listening.* (W9-DG)

They also dreamed of greater recognition and appreciation among peers. The dynamicity of work, beyond the limits of the CAPS itself, is not recognized, and makes the worker need to justify him/herself. In relation to appreciation, the included dream is a better salary appreciation.

> *Sometimes, I leave home and say: "Please, don't call me, because I'll dive into my work" because I'll try to do the best I can, exchanging ideas. And then what happens: "oh* [mentions own name] *walk around a lot, doesn't stop here, I don't know what you have to do with these issues". I can't just stay here, but when I'm here, I'm here! You can open the door, call me, not that I know much. But sometimes, all you have to do is change it, have a mate or whatever, it goes away like that [...]. I know that I earn little, my ideal is to fight for more!* (W8-DG)

Finally, the dream is of more Permanent Health Education (PHE) activities.

> *[...] more spaces of permanent education, more spaces to meet different services.* (W4-DG)
>
> *[...] services with permanent education and qualifications.* (W5-DG)

Discussion

It was identified that the participants dreamed possible dreams, with what is already

foreseen in the policies and regulations of the area, but that, in this scenario, is still as limit-situations that require effectiveness.

Limit-situations are the boundary between being and being more. They can be understood as barriers and obstacles that need to be overcome.[15] As they seek to overcome obstacles, instead of accepting them, passively, subjects perform limit-acts. Thus, overcoming the limit-situations occurs through limit-acts, which are understood as necessary responses that address the overcoming and denial of the limiting context with a decided attitude towards the world.[16]

One of the limit-situations mentioned by the participants was the precarious infrastructure of this RAPS, which did not have, for example, sufficient/efficient logistics system services (emphasis on transportation).

The transport system is one of the fundamental elements that make up the logistic support in the operational structure of RAPS.[17] It is expected that workers produce care, based on the territory, that they perform home visits, that they make active search for users, that go to other services, such as in PHC, to perform matrix support, among other strategies that are consistent with the psychosocial care model, but how to ensure that this occurs without giving them the conditions to do so?

By organizing the transportation system without the dynamicity that mental health requires, obstacles are created for access, for bonding, for humanization and autonomy of users, family members and RAPS workers. As they seek to overcome the obstacles, instead of accepting them passively, the subjects perform limit-acts, and can create unpublished viable (possibilities), which are in the limit-situation, but are not perceived by them when they do not use criticism.[16] The reflective-critical and collective movement triggered by this research sought to encourage the construction of viable unpublished in the RAPS, which were related to the hopes and dreams of these workers.

The term unpublished viable translates the power of collectives to transform reality, from dreams, hopes and, mainly, through praxis. As something new, not yet known and lived, is unveiled as a valuable possibility of the future, it becomes a dream that, through action-reflection-action, can become reality.[16]

The dream of the UHS that works, nourished by knowledge and hope of effectiveness of its idealizing principles was also raised in this research. One of the PNH guidelines highlighted was co-management, which refers to a way of organizing health work, and includes collective thinking and

doing.

Co-management or shared management aims at the inclusion of new subjects in management processes. It was conceived as an ethical and political guideline, which aims to motivate and educate workers, a management model, which is proposed to be centered on teamwork, collective construction.[18] Incorporating dialogue with workers who can manage work processes, considering their individual desires and acts that characterize their autonomy, without this meaning disregarding the dialogue with users and needs that emerge in society.[18] This form of collective management, arising from pacts between subjects, and not requirements on them, brings to health production the implication and co-responsibility for care. It differs from how, apparently, it has been happening in this RAPS, even in relation to the care flows, which workers dream of qualifying, through collective, dialogical agreement, in a permanent and dynamic movement of conformation.

The organization of care flows in this scenario is a demand charged at the management level, but the history is of agreement of temporary flows, which end up not being sustained over time and turnover of workers in services. As a consequence, there is fragmentation, pilgrimage and lack of assistance of users on the Network.

Overcoming the challenges of care fragmentation demands reorganization of work processes. Greater or lesser completeness of the care received, according to the way workers' practices are articulated, with health care being "a complex web of acts, procedures, flows, routines, knowledge, in a dialectical process of complementation, but also of dispute".[19:2]

The flows can also be understood as lines of care, standardizations that explain information related to the organization of the provision of health actions in the health system, describe routines of the patient's itinerary, activities, to be developed by a multidisciplinary team in each health service. Its implementation provides an opportunity to improve communication between teams, services and users, organizing a *continuum* of care.[20]

It should be considered that the institutionalization of flows serves to clarify the role and possibilities of each service/worker in the network, but do not guarantee fluidity and continuity of care alone. Also, one cannot forget that the space (territory), where the user circulates, is a space bounded by power relations, in which the predominant logic, which guides care practices, is strongly rooted in the user's social submission and exclusion.

Flows must be dynamic, welcoming of subjectivities. They cannot be constructed by

collective work. In the moments that precede the implementation of such flows, one must listen to the users, workers and everyone involved in this process.

It is perceived the need to strengthen social control in the RAPS, and ensuring that popular participation actually happens is a fundamental requirement for the construction of a mental health policy aligned with the ideals of the Psychiatric Reform and the Anti-asylum Struggle. One study, which investigated the panorama of social participation in Brazilian mental health policy, indicated the need to institute evaluation processes that would strengthen and qualify the formal and informal experiences of participation of users, family members and workers, for greater power in decision-making in mental health policy, as a whole, and in the daily life of health services.[21]

In relation to the dream of care, based on the territory, it is emphasized that the normative and technical guidelines of the Ministry of Health emphasize the importance of the territory in the technological assistance organization of Mental Health initiatives in the UHS. When adopting this perspective, it is necessary to consider the social and cultural diversity of the different places, as an essential aspect to articulate the actions of health and mental health, "in the space where life happens as it is", in its fullness. It also implies overcoming the logic of exclusion and annihilation of the differences that affect the so-called "crazy", and also on all those who explain different ways of existing. [22:173]

The forces that can offer resistance to social reintegration/territorial care to people with mental disorders or who use drugs, coming from the economic, clinical and moral field need to be considered. These authors reinforce this idea and question: "how to produce transformations in relations in territories and places in which life happens increasingly governed, from economic interests that determine the uses and, therefore, the ways of inhabiting or not inhabiting the city?"[22:186]

Forces of resistance or negligence permeate policies within the scope of RAPS, which regress in investments in services aimed at the family and the territory, as occurred by changes in the Primary Care Policy, published in Technical Note n. 3/2020, which extinguished the NASF, being in charge of the municipal manager the organization of the teams in Primary Care. This Technical Note was complementary to the institution of the *Previne Brasil* Program, which also changes the financing of PHC for payment, by performance, and does not include any mental health action.[23]

Another dream for the RAPS raised by the workers was the expansion of multiprofessional

support, through partnerships with educational institutions, especially the desire to be a field for the Multiprofessional Health Residency (MHR) experience that proved positive in other services.

The activities developed by residents in the services have a positive impact on the organization of the work process, including the consolidation of workers' interpersonal relationships, and new paths for decision-making, from a new angle and experience that this resident brings with him/her.[24] MHR enables the creation of spaces for discussion, collective involvement in the construction of knowledge and approximation with practice, through teaching-service integration.

The teaching-service integration can be constituted, from the collective work agreed, articulated and integrated by residents and professors of the health area, with workers and preceptors who make up the teams of health services. The purpose of such integration is to promote the quality of individual and collective health care of the population, the excellence of professional training and the development/satisfaction of service workers.[25] However, It is considered pertinent to point out that there are challenges to be overcome in the understanding of health services workers regarding the role of residents, which, in some realities, is still seen as "labor" to cover the lack of network resources.

Concerning dreams for workers, they dreamed of more committed colleagues in RAPS. Also, they believed in micropolitics, in professional commitment, as a possibility of change, and without which macropolitics is insufficient, but who can compromise? For Freire, assuming a committed act requires action, that is, the necessary politicity to the worker, who, in recognizing that "history is a time of possibility and not of determinism, that the future is problematic and not inexorable",[26:20] is committing to another possible world, leading more and more articulated actions towards a powerful RAPS. For assuming such posture, the participants of the research felt themselves bothering the accommodated. They wished to have their practice more valued among colleagues, since there was indignation and suffering in speech.

The concern with the health of those who work with health is another point that needs to be highlighted. How to think concretely about developing a collective, multiprofessional, intersectoral work, with horizontal relations, multiple activities, qualification of knowledge, without meeting the basic needs of workers, as a decent wage, stable employment relationships and a working environment in appropriate conditions?[26]

Moreover, the current context of public policies has led to the disruption of the work

collectives of the teams, the lack of solidarity and trust between groups, and a weakening of professional social ties harming the ways of organizing work. This is a context that is still evident in scenarios in which there are partnerships or outsourcing of services, which reflect the fragmentation of the system, regulatory problems, lack of transparency, monitoring failures, problems in establishing fixed goals, limits to innovation and creativity, high professional turnover and impact on employment.[27]

Therefore, the weakening of the ties, which were established in relationships with people and organizations (commitment), was also affected by the pandemic context. The thin border between work and life, a condition raised by remote work, has impacted on the levels and forms of manifestation of ties, affecting the mental health of individuals.[28]

When collectively dreaming possible dreams, the participants also emphasized the importance of PHE as a mediator for the desired changes. The problematizing and dialogical perspective of PHE instigates to open up other visibilities for the work and bring the complexity of lives to the scene. It opens space for reflections and exchanges, for learning through experience, which is done collectively, and expands to potency, but it takes work, challenges and generates uncertainties.[29]

Human existence is marked by dynamicity, one always lives in conflict between the ideal and the real, the already conquered and the future possibilities; the needs, the goals not achieved, the projects not realized. Therefore, regardless of the historical moment in which society is, whether that of the viable or the impracticable historical, the role of the social worker, who has chosen change, can be none other than to act and reflect with the individuals with whom he/she works for the realization of his/her utopias.[30]

It is emphasized the interpretation that utopia has no end, is not limited, since what is achieved is already transitory in the ethical path to the realization of the ontological vocation of human beings to be more. In this sense, when an unpublished viable one is reached for which one dreams and fights, so many others arise as fit in the feelings and reasons dictated by human needs.[8] Thus, it is believed that dreaming requires daily reflection on practice, so that it is possible to discover the limits of one's own practice.[8]

The methodological path of AR, in this research, led to a valuable direction in relation to workers in the visualization of dreams in the context of work in RAPS. There was the possibility of raising appreciative questions about the dreams that allowed the "beauty of the findings". In this

sense, it was perceived the need for the pertinence of more research committed to knowing, not only the whys that build the logic that disarticulates and weakens workers, reinforcing the determinisms in the health network, but also the dreams that mobilize, motivate and still give life to work in RAPS.

It is believed that significant contributions in these themes can result from research with participatory approaches, enabling dialogue, with the use of methodologies that allow mobilize and rekindle the hope of the subjects of interpellation in history.

It was considered, as limitations of the research, its focus restricted to a specific scenario – the RAPS of Santa Maria, RS, which has problems already perceived in other RAPS, but that cannot be generalized. The context of a pandemic, due to the COVID-19, was also one of the limiting situations for the execution of the research, since it diverged the participants during the process, weakening the tie and, in a way, the initial collective engagement.

As contributions to the research area, one added the value of the dream approach in the methodological path of AR, still incipient in studies with application in the health and nursing area in Brazil, possibilities of use in different care and management contexts.

It is recognized that the qualification of the work in the RAPS and, consequently, of the assistance to the user, which gives meaning to the action, is a challenge. It involves multiple subjects in a process that needs to be of communion and solidarity among the existing ones. It is not possible to move forward without public policies that guarantee decent and quality assistance. It is also not possible to conquer them without an organized collective, aware of its historical, ethical, political, moral and affective commitment, which fights for change.

Conclusion

The future of work in RAPS is related to the dream of a structured network (with sufficient human and structural resources), a better defined care flow (collectively), closer to the management and effectiveness of co-management, commitment to principles and guidelines of the UHS and the PNH, a work dynamics that, in fact, is closer to the reality/territory of users. In addition, it is expected that workers are committed, and this is related to the need for their less turnover, and that there is investment in actions of mental health care of the worker, who is vulnerable and requires recognition, support and appreciation.

The dreams for the RAPS were presented, as it is already advocated in terms of public

policies, but that require an organized and committed collective that fights for change. They are possible dreams, many already lived previously, which have limit-situations to be overcome for its effectiveness. In view of this, the importance of articulation between workers, users and family members is emphasized for the guarantee of the principles of the Psychiatric Reform and in the defense of the UHS.

References

1. Casanova IA, Batista NA, Moreno LR. A educação interprofissional e a prática compartilhada em programas de residência multiprofissional em saúde. Interface. 2018;22 (Supl 1):1325-37. doi: 10.1590/1807-57622017.0186

2. Quinderé PHD, Jorge MSB, Franco TB. Rede de Atenção Psicossocial: qual o lugar da saúde mental? Physis Rev Saúde Colet. 2014;24(1):253-71. doi: 10.1590/S0103-73312014000100014

3. BRASIL. Portaria/GM nº 3.088, de 23 de dezembro de 2011. Institui a Rede de Atenção Psicossocial para pessoas com sofrimento ou transtorno mental e com necessidades decorrentes do uso de crack, álcool e outras drogas, no âmbito do Sistema Único de Saúde (UHS). Brasília, DF: Ministério da Saúde, 2011. Disponível em: https://bvsms.saude.gov.br/bvs/saudelegis/gm/2011/prt3088_23_12_2011_rep.html. Acesso em: 13 jun. 2023.

4. BRASIL. Portaria nº 3.588, de 21 de dezembro de 2017. Altera as Portarias de Consolidação, nº. 3 e nº. 6, de 28 de setembro de 2017, para dispor sobre a Rede de Atenção Psicossocial, e dá outras providências. Brasília, DF: Ministério da Saúde, 2017. Disponível em: https://bvsms.saude.gov.br/bvs/saudelegis/gm/2017/prt3588_22_12_2017.html. Acesso em: 13 jun. 2023.

5. BRASIL. Portaria nº 3.659, de 14 de novembro de 2018. Suspende o repasse do recurso financeiro destinado ao incentivo de custeio mensal de Centros de Atenção Psicossocial (CAPS), Serviços Residenciais Terapêuticos (SRT), Unidades de Acolhimento (UA) e de leitos de saúde mental em hospital geral, integrantes da Rede de Atenção Psicossocial (RAPS), por ausência de registros de procedimentos nos sistemas de informação do UHS. Brasília, DF: Ministério da Saúde, 2018. Disponível em: https://www.in.gov.br/web/dou/-/portaria-n-3-659-de-14-de-novembro-de-2018-50486192. Acesso em: 13 jun. 2023.

6. Amarante P, Nunes MO. A reforma psiquiátrica no UHS e a luta por uma sociedade sem manicômios. Ciênc Saúde Colet. 2018; 23(6):2067-74. doi: 10.1590/1413-81232018236.07082018

7. Duarte MJO. Política de saúde mental e drogas: desafios ao trabalho profissional em tempos de resistência. Rev Lib. 2018;18(2):227-43. doi: 10.34019/1980-8518.2018.v18.18604

8. Paro CA, Ventura M, Silva NEK. Paulo Freire e o inédito viável: esperança, utopia e transformação na saúde. Trab Educ Saúde. 2020;18(1):e0022757. doi: 10.1590/1981-7746-sol00227

9. Menezes ALA, Muller MR, Soares TRA, Figueiredo AP, Correia CRM, Corrêa LM, et al. Paralelos entre a produção científica sobre saúde mental no Brasil e no campo da saúde mental global: uma revisão integrativa. Cad Saúde Pública. 2018;34(11):e00158017. doi: 10.1590/0102-311X00158017

10. Arnemann CT, Kruse MHL, Mello AL, Souto VT, Terra MG. Pesquisa apreciativa. In: Lacerda MR, Ribeiro RP, Costenaro RSG, organizadores. Metodologias da pesquisa para a enfermagem e saúde: da teoria à prática. Porto Alegre: Moriá; 2018. p. 295-314.

11. Godoi CK. Grupo de discussão como prática de pesquisa em estudos organizacionais. RAE Rev Adm Empresas. 2015;55(6):632-44. doi: 10.1590/S0034-759020150603

12. Minayo MCS. O desafio do conhecimento. Pesquisa qualitativa em saúde. 14ª ed. São Paulo: HUCITEC; 2014.

13. Green J, Willis K, Hughes E, Small R, Welch N, Gibbs L, et al. Generating best evidence from qualitative research: the role of data analysis. Aust N Z J Public Health. 2007; 31(6):545-50. doi: 10.1111/j.1753-6405.2007.00141.x

14. BRASIL. Ministério da Saúde. Conselho Nacional de Saúde. Resolução nº 466, de 12 de dezembro de 2012. Diretrizes e normas regulamentadoras sobre pesquisa envolvendo seres humanos. Brasília, DF: Conselho Nacional de Saúde, 2012. Disponível em: https://conselho.saude.gov.br/resolucoes/2012/Reso466.pdf. Acesso em: 13 jun. 2023.

15. Freire P. Pedagogia do oprimido. 17ª ed. Rio de Janeiro: Paz e Terra; 1987.

16. Freire AMA. Inédito viável. In: Streck DR, Redin E, Zitkoski JJ, organizadores. Dicionário Paulo Freire. 3ª ed. Belo Horizonte: Autêntica; 2017. p. 223-6.

17. BRASIL. Portaria nº. 4.279, de 30 de dezembro de 2010. Estabelece diretrizes para a organização da Rede de Atenção à Saúde no âmbito do Sistema Único de Saúde (UHS). Brasília, DF: Ministério da Saúde, 2010. Disponível em: https://conselho.saude.gov.br/ultimas_noticias/2011/img/07_jan_portaria4279_301210.pdf. Acesso em: 13 jun. 2023.

18. Ministério da Saúde (BR). Política Nacional de Humanização - Humaniza UHS. Brasília (DF): Ministério da Saúde; 2021.

19. Cecílio LCO, Merhy EE. A integralidade do cuidado como eixo da gestão hospitalar. In: Pinheiro R, Mattos RA. Construção da integralidade: cotidiano, saberes e práticas em saúde. Rio de Janeiro: IMS ABRASCO; 2003. p. 197-210.

20. Secretaria de Atenção à Saúde (BR). Linhas de cuidado da Secretaria de Atenção Primária. Brasília (DF): Ministério da Saúde; 2023. Acesso em: 2023 jun 14. Disponível em: https://linhasdecuidado.saude.gov.br/portal/

21. Pires RR, Ferreira GSM, Alencar AB, Sampaio JJC. Participação social na política de saúde mental: questões pertinentes para sua avaliação. Dialog Interdiscip Psiq Saúde Mental. 2022 [acesso em 2023 abril 12];1(1):70-7. Disponível em: https://revistas.uece.br/index.php/dipsm/article/view/7276

22. Yasui S, Luzio CA, Amarante P. Atenção psicossocial e atenção básica: a vida como ela é no território. Rev Polis Psique. 2018;8(1):173-90. doi: 10.22456/2238-152X.80426

23. Secretaria de Atenção Primária à Saúde (BR). Departamento de Saúde da Família. Ministério da Saúde. Nota Técnica nº. 3/2020. Brasília, DF: Ministério da Saúde; 2020.

24. Silva CA, Dalbello-Araújo MD. Programa de Residência Multiprofissional em Saúde: o que mostram as publicações. Saúde Debate. 2019;43(123):1240-58. doi: 10.1590/0103-1104201912320

25. Mello AL, Arruda GT, Terra MG, Arnemann CT, Siqueira DF. Fatores que interferem no ensino e aprendizagem de residentes multiprofissionais em saúde: revisão integrativa. ABCS Health Sci. 2019;44(2):138-46. doi: 10.7322/abcshs.v44i2.1176

26. Aciole GG, Pedro MJ. Sobre a saúde de quem trabalha em saúde: revendo afinidades entre a psicodinâmica do trabalho e a saúde coletiva. Saúde Debate. 2019;43(120):194-206. doi: 10.1590/0103-1104201912015

27. Cegatti F, Carnut L, Mendes A. Terceirizações na área da saúde no Brasil: reflexos no UHS, nas políticas sociais e nos trabalhadores. J Manag Prim Health Care. 2020 out 23 [acesso em 2023 abr 13];12:1-41. doi: 10.14295/jmphc.v12.978

28. Oliveira GL, Ribeiro AP. Relações de trabalho e a saúde do trabalhador durante e após a pandemia de COVID-19. Cad Saúde Pública. 2021;37(3):e0001832. doi: 10.1590/0102-311X00018321

29. Merhy EE, Feuerwerker LCM, Santos MLM, Bertussi DC, Baduy RS. Rede Básica, campo de forças e micropolítica: implicações para a gestão e cuidado em saúde. Saúde Debate. 2020;43(N Esp 6):70-83. doi: 10.1590/0103-11042019S606

30. Freire P. Educação e mudança. 12ª ed. Rio de Janeiro: Paz e Terra; 2013.

Authorship contributions

1 – Valquiria Toledo Souto
Corresponding Author
Nurse, PhD in Nursing - valquiriatoledo@hotmail.com
Conception, development of the research, manuscript writing, review and approval of the final version.

2 – Marlene Gomes Terra
Nurse, PhD in Nursing - martesm@hotmail.com.br
Conception, development of the research, manuscript writing, review and approval of the final version.

3 – Cristiane Trivisiol Arnemann
Nurse, PhD in Nursing - cris.trivisiol@gmail.com
Conception, development of the research, manuscript writing, review and approval of the final version.

4 – Amanda de Lemos Mello
Nurse, PhD in Nursing - amandamello6@yahoo.com
Revisão e aprovação da versão final.

5 – Daiana Foggiato de Siqueira
Nurse, PhD in Nursing - daianasiqueira@yahoo.com.br
Review and approval of the final version.

6 – Mariane da Silva Xavier
Nurse, PhD in Nursing - marianexavierenfa@gmail.com
Manuscript writing, review and approval of the final version.

Scientific Editor in Chief: Cristiane Cardoso de Paula

Associate Editor: Márcia Aparecida Ferreira Oliveira

How to cite this article