Saúde e Sociedade
ISSN: 0104-1290
ISSN: 1984-0470
Faculdade de Saúde Pública, Universidade de São Paulo.
Associação Paulista de Saúde Pública.

Vargas, Everson Rach; Passos, Eduardo; Almeida, Beatriz Prata; Guerini, Lorena
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Saúde e Sociedade, vol. 28, núm. 4, 2019, Outubro-Dezembro, pp. 25-36
Faculdade de Saúde Pública, Universidade de São Paulo. Associação Paulista de Saúde Pública.

DOI: 10.1590/S0104-12902019190719

Institutional support for the Forum of São Pedro da Aldeia Mental Health Network as a dimension of the Gaining Autonomy & Medication Management research

O apoio institucional ao Fórum da Rede de Saúde Mental de São Pedro da Aldeia como dimensão da pesquisa de Gestão Autônoma da Medicação

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Abstract

This article shares an experience of institutional support for a group of workers of a municipality of Região dos Lagos, Rio de Janeiro, Brazil, in the period 2011-2014. This experience is the result of the intervention research that implemented and validated the Gaining Autonomy & Medication Management device at the Casarão da Saúde Psychosocial Care Center, in the municipality of São Pedro da Aldeia. The research stimulated the creation of a forum of workers of the Psychosocial Care Network (Raps) which works as a permanent space for negotiations and collective care of the experience of caring in the Raps. We are interested in this text to present and discuss the process of institutional support for the creation of this forum as an important stage of the research. From this experience, the relationship between research process and institutional support will be discussed, as well as its consequent methodological modulations, and the effects of this research-support process for the municipality's Raps, which has the prerogative of installing a device capable of taking care of the experience of caring in the field of mental health.

Keywords: Gaining Autonomy & Medication Management; Institutional Support; Mental Health; Participatory Research.

DOI 10.1590/S0104-12902019190719

Resumo

Este artigo compartilha uma experiência de apoio institucional a um coletivo de trabalhadores de um município da Região dos Lagos, Rio de Janeiro, no período de 2011-2014. Essa experiência é efeito da pesquisa-intervenção que implantou e validou o dispositivo de Gestão Autônoma da Medicação no Centro de Atenção Psicossocial Casarão da Saúde, no município de São Pedro da Aldeia. A pesquisa estimulou a criação de um fórum de trabalhadores da Rede de Atenção Psicossocial (Raps) que funciona como espaço permanente para negociações e cuidado coletivo da experiência do cuidar na Raps. Interessa-nos, neste texto, apresentar e discutir o processo de apoio institucional à criação desse fórum como etapa importante da pesquisa realizada. A partir dessa experiência será discutida a relação entre processo de pesquisa e apoio institucional, além de suas consequentes modulações metodológicas, bem como efeitos desse processo de pesquisa-apoio para a Raps do município, que tem como prerrogativa a instalação de um dispositivo que seja capaz de cuidar da experiência de cuidar, no campo da saúde mental.

Palavras-chave: Gestão Autônoma da Medicação; Apoio Institucional; Saúde Mental; Pesquisa Participativa.

Introduction

This article is aimed at presenting the creation of the Forum of Workers of the Psychosocial Care Network in the municipality of São Pedro da Aldeia – RJ, a space conceived from an intervention research carried out for the implementation and validation of the Gaining Autonomy & Medication Management (GAM) device and the Guide for Gaining Autonomy & Medication Management (GGAM).

For this experience of intervention and support – which generated the forum as a result of research – to be possible in that context, it was necessary for both researchers and workers (research field) to bet on a space for collectively dealing with issues related to mental health network. This bet is based on the indications of Kastrup and Passos (2014), who state that all research involving subjectivity production brings to the researcher the challenge of drawing a common plan with the research field.

In the GAM research process, it was verified that institutional support is an effect of the participatory research-intervention experience (Kastrup; Passos, 2014; Passos; Barros, 2009). With formation of Gaining Autonomy & Medication Management groups (GAM Groups) at the Psychosocial Care Center II (Caps II) of the municipality of São Pedro da Aldeia (Casarão da Saúde) and monitoring of the line of care in the Psychosocial Care Network (Raps), the participatory research-intervention experience, which lasted from 2011 to 2014, gained support dimension due to the peculiarity of its object, namely: the process of health production in the mental health network of São Pedro da Aldeia involving the different actors participating in this process. The research intervenes on the reality investigated and follows the processes triggered taking care of the work developed, which configures its support dimension.

The GAM strategy has as its guideline the contraction of the group and the promotion of collective autonomy. Contraction of the group is understood as an oscillatory experience from which there is possibility that the previously established roles of worker, user, family member and university

researcher1[1] are gradually dissolved in the group process. This dissolution demonstrates the power of the group experience in constituting other relationships between the different actors, which is considered essential for a more autonomous management in relation to medication.

In turn, this contraction fosters collective autonomy according as the rules that lead to this heterogeneous relationship are formed in the specific context of the collective experience, in codependency mediation among the participants. Thus, one works with the idea of collective autonomy (Passos et al., 2013) that does not aim at personal independence or self-medication. The group's dynamics, as well as the way in which the participants relate, will not be absolutely standardized by values and established logics, which are elaborated outside this space.

The function of the GAM devices, always of a group nature, is in their power to trigger processes. In this case, the GAM strategy gains some concreteness, that is, the device exists to develop this strategy (Passos et al., 2013), as it encourages sharing the experience of using psychiatric medication and discussing about the issues involved in this experience. Its tool, the Brazilian GGAM, results from the adaptation of a Canadian material (*Gestion Autonome de la Médication de l'Âme:Mon Guide Personnel*). The Brazilian guide consists of a set of steps that presents to the users questions and information to problematize their relationship with the use of psychiatric drugs, aiming to increase autonomy (Kinoshita, 2001) with respect to treatment, and betting on the directive co-management with the team that attends them.

Based on the authors' experience, it was noticed that the contraction of the group goes beyond the limits of the GAM group, involving other dimensions of health work. Such unfolding demands from research its dimension of support for the work process in the services. In this sense, the GAM research implies the different points of the mental health network, expanding the autonomy initially experienced in the group with Caps' users and workers to the entire Raps.

The forum of workers resulted from the authors' experience with the GAM device at Caps, with users and workers. Thus, between the work in the GAM group at Caps and the work in the creation of the Raps Forum of Workers, it is possible to verify an analogy that involves contraction of the group and production of collective autonomy, processes present at the base of the different research actions.

The strategy of participatory research-intervention is to follow processes from their subjective dimension. The start point is the assumption that health work is done in the relationship between subjects, and studying this process requires the participation of these actors in the research process itself, creating this analogy between participation in the process of production of health and in the process of production of knowledge of health. This is the challenge that the Brazilian National Health System (SUS) poses to the universities, forcing them to develop research methodologies that match the democratizing and participatory proposal of the health system. These subjects, in their heterogeneity, can embody the experience of participatory research and bring about changes in the intervention design.

The creation of the common plan generated by research, which follows the participants' subjective repositioning towards the network, gives the participatory character of the intervention the condition for the creation of devices in which the different actors can gain expressiveness and protagonism. The common nature is not necessarily related to the homogeneity of the participants or even to the establishment of consensus in the groups researched. It is about affirming – producing and accepting – the heterogeneous common nature that contracts as an autonomous group. The article will present how in this phase of the GAM research, in the process of creating São Pedro da Aldeia Raps Forum, the intervention

1 The term "university researcher" is used to distinguish them from other participants in intervention research who are included as protagonists in the process of knowledge production in the investigation. In this sense, the research is based on the action of university researchers, worker researchers, user researchers, and family researchers.

provided for in the GAM project gained institutional support characteristic throughout the research development.

When does research become support?

The notions of institutional support and matrix support express ways of analyzing and co-managing organized groups for health production, but start from different points of view. While institutional support is a co-managerial function used in relationships between services, managers and workers, matrix support is a way of doing networking in relationships between team professionals, closely related to clinical practice and to user direct care. Thus, matrix support is a

> work process production logic in which a professional offers support in his specialty to other professionals, teams and sectors. The traditional and fragmented scheme of knowledge and doing is reversed, since, at the same time the professional belongs to his team/sector, he also works as support, as reference for other teams. (Brasil, 2010, p. 52)

It is known that management and clinic do not operate in isolation, as there is full connection and coordination between them, which allows stating that all matrix support is a form of institutional support The reciprocal, however, is not true because of the specificities of matrix support. What differentiates the two support modalities is the relationship they will establish with a specialized knowledge.

The methodologies of institutional support for the co-management of institutions and matrix support for the co-management of health care began to be tried in the public network of the municipality of Campinas, São Paulo, during the 1990s, in mental health, primary care and hospital area services. Inspired by this first experience, several other cities began to incorporate ways of providing institutional and matrix support, such as Rio de Janeiro, Belo Horizonte in Minas Gerais, Quixadá and Sobral in Ceará, Recife in Pernambuco, Aracaju in Sergipe and Viamão in Rio Grande do Sul (Campos et al., 2014).

Subsequently, institutional support and matrix support were incorporated by the Ministry of Health (MS) and became integral SUS' technologies throughout the country. In the Ministry of Health's document "Reference Book for the Formation of Supporters," it is possible to find that in 1998 the expression "institutional supporter" began to be used in the vocabulary of SUS federal administration. The same document states that the first official support experiences took place in the country in 2003. From these first official experiences, the MS began a process of formulation and implementation of institutional support in federation's states and municipalities, with two approaches: support for decentralized SUS management, coordinated by the Decentralization Support Department of the Executive Secretariat; and support for changing management and care models of health systems and services, coordinated by the National Humanization Policy (PNH). The PNH has incorporated the ways of providing institutional support and matrix support in order to rekindle the public dimension of health policy in SUS, intensifying the articulation between care and management, clinic and politics (Pasche; Passos, 2010; Pasche; Passos; Hennington, 2011).

The PNH then started having regional teams of supporters that articulated with state and municipal health secretariats throughout Brazil. In 2008, strengthening this process of dissemination of support technologies, the MS implemented a new policy: the Family Health Support Centers (NASF), which are mainly guided by the matrix support strategy, working with the Family Health Strategy teams with the objective of qualifying care, expanding the scope and resoluteness of the offers in primary care.

Spreading institutional and matrix support through all these MS initiatives brings a number of advances and, at the same time, faces a number of challenges. In any case, institutional support technology aims to be very attentive to workers' experience with their own work. In the case of the authors, it is about researching and supporting health professionals whose work base is mental health care. On the other hand, it is understood that the constitution of the care relationship between worker and user produces an experience

in the workers themselves, and the care of this care experience is the focus of support and research, as addressed in this study.

The intervention character of the GAM research is the effect of a double inclusion. On the one hand, there was inclusion of research participants – in the case of the GAM research, workers and users of health services that are the empirical field of research – who move from the passive position of research objects to that of participants in different stages of research: data collection, organization and analysis. Research intervenes when it adopts participatory methodology, which, in the field of mental health, gains a special sense of clinical intervention since users of these services are traditionally considered people without senses. On the other hand, intervention research includes the demands that occur along its path, the changes and provocations that the performance of the research generates in the field, constantly transforming its design.

In the study conducted in the municipality of São Pedro da Aldeia, the authors remained for three years in the Raps implementing the GAM and validating the GGAM adapted to the Brazilian reality with workers, users and family members. In the research, demands that were not foreseen in the initial project emerged, among them the network workers' request for a space of experience exchange and discussion of issues involving the municipality's mental health. The inclusion of this demand in the scope of the research gave intervention character in the Raps, which was attested in the process of creating the Raps Forum of Workers of São Pedro da Aldeia.

The process of implementation of the GAM device – the User Intervention Group (GIU), and the Family Intervention Group (GIF), both also composed of Caps' workers and researchers from the Universidade Federal Fluminense (UFF) – in São Pedro da Aldeia's Caps begins the GAM research in the municipality, when the GGAM is validated[2] for Brazilian reality. In the research unfolding, the effects of the research intervention are monitored, both in the support for the GAM continuity, now managed by service workers, user-monitors and family-monitors, and in the Raps Forum and the user and family association that began to reorganize.

The support dimension of the GAM research had been present since the implementation of GIU and GIF at São Pedro da Aldeia's Caps. Including the experience of using psychotropic medications reflected in the study, placing at the same level the several care practices developed at Caps, the ways of organizing this team's work process, and the functioning of the Raps in the municipality. However, although it was necessary for the research-validation to address work processes since the beginning of the GAM group, specific support arrangements have been built throughout the process.

Including the demands produced through this process was a methodological requirement that modulated the conduct of the research itself. Support work indissociable from the research process. In this sense, there is not a temporal linearity regarding these two movements, research and support. Implementing the groups meant to understand how the network works, the Caps' work process and the organization of the service so that it would be possible to think with the workers about the best way to organize their work, including setting up the GAM groups.

In this sense, the option was an implication sequence rather than a linear temporal sequence, which would involve a research stage defined as the GAM group at Caps and the subsequent institutional support stage. In other words, the support comes from the research process, made possible by the exercise of the analysis of the researchers' implications (Lourau, 1993), allowing being aware of the effects produced by the first movement of the investigation. This movement characterizes the intervention and participatory character of the research.

This analysis leads to certain unpublished developments that went beyond the stages predicted by the research and that had been agreed with

2 Traditionally, validation consists of a research procedure that aims to test the accuracy of a particular instrument under development. This experience allowed revisiting the notion and proposing a validation that occurs through the effects of the intervention. This allowed considering validation an assessment that includes the procedural dimension of the device, not just its effectiveness in itself (Passos; Kastrup, 2014).

the workers. Implication thus acquires its logical meaning: if there is an intervention in the field of research in which the authors are involved, then certain demands are produced and will in turn be included in the research unfolding and in its supportive dimension. It is, therefore, a sequence between the two phases of research that could be called logic-implication temporality.

With research that was also supportive, the aim was not the immediate improvement of the actions and services of the network, as if the objective was to reach a goal disregarding the comings and goings in the research process and what it triggers. Researching health work from the perspective of support is necessarily not to centralize work on pre-established goals, but favor and monitor group contraction or, ultimately, network contraction processes (Pozzana; Kastrup, 2009). Such processes modulate and reorient the scientific rationality involved in the knowledge production activity.

Lourau (1993) criticizes the assumption of the scientific rationality of "non-implication" of the one who knows in the face of the reality given. It is not without motivation that scientific research often neglects monitoring of reality transformation process. Its prerogative is to understand the phenomenon – what it considers an object of interest – as a form already constituted, exclusively. Through scientific procedures, the object studied needs to be stabilized, having as a consequence the residual nature of its production regime.

Assuming that science is responsible for describing states of affairs of a world that is external because it is detached from the subject, his/her experience and activity – either from the one who investigates or from the one who is investigated –, reality researched is not considered closely dependent on the very act of researching. The neutrality sought by the scientific method makes reality an object of study by excluding the production plan of this reality. This ideal of scientific intelligibility operates the classic distinction between researcher (subject) and what is researched (object) and, consequently, the hierarchical superiority of the subject who knows over the object known.

It is not necessary to go far to cite achievements of this scientific rationality. In the field of psychiatry, as Foucault (1975) has shown, knowledge was produced linked to the objectification of the experience of madness, placed in laboratory conditions at a madhouse. The scientific procedure that created the conditions for the emergence of knowledge of madness as a disease produced this reality in the act of investigation. Undoing this montage of knowledge production in the field of mental health gains shades and ethical-political implications.

The notion of support, when related to research, helps problematize these rigid boundaries between subject and object of knowledge, which are considered independent in the hegemonic epistemological legislation in modernity. In this sense, the difference between the position of university researchers and that of network workers is valued for establishing a relationship with the object of study that is not defined through a hierarchy between the one who thinks and the one who performs, the one who knows and the one who doesn't know. The relationship of knowledge production in intervention research is co-production between those who research and what is researched.

If there is no hierarchy, neither was it sought to homogenize the parts in this relationship. This bet seemed a condition for the research-support: in addition to including in the analysis the different subjects involved in the research process and the demands it produced, it was necessary to sustain the otherness, the common plan that the research outlined.

This mode of relationship with the other's work, which is one of the bases of this research, could be developed through different institutional arrangements, aiming at the continuity of the devices and not of the research, which has an expected end. One of the possible arrangements to support this discussion of the municipality's mental health work process could be the Caps team meeting; however, the demand produced in the GAM research process in the municipality required the establishment of another arrangement: the Raps Forum of Workers. The increased communication openness at Caps indicated the direction of unfolding for the contraction of a group of workers that involved different spaces of the line of care in mental health, the municipal network.

When the research-support pointed to the creation of a municipal Raps forum, what was the demand for support? Which was the problem being delimited by the research-support when the meaning is the creation of a Network Forum?

There was a demand from workers for a better articulation between services, so as to enable user continuous care when operating different health services in the municipality. In addition, it pointed to the need for a space directed to welcoming and facing the relationship difficulties between the different spaces of the psychosocial care network. Due to these demands, a new horizon research was defined as supporting the creation of a forum with participation of workers from the different services that make up the network. The focus of the research-support was to foster Raps' co-management capacity, that is, a space to co-analyze the functioning of the network in the health actions and services network itself, and not outside it.

Co-management is the ethos of the GAM research, which has been present since the management of the GAM groups with users and family members. This mode of work organization in health seeks to include, in the field of management, the different subjects involved, other ways of doing, as well as new tasks and mandates. The multiple inclusions broaden the scope of management that is concerned with the protagonism of workers, institutional analysis, training of workers, changing the standard of responsibility (distributing it), valuing the subjective and collective dimension of work and communicational openness.

Co-management implies expansion of the role of individuals in decision-making processes in relation to their work. Nevertheless, quantitatively increasing subjects' participation in planning and decision-making is not exactly enough to make co-management practices concrete. As argued by Gastão Campos and Gustavo Cunha, "the task of co-management would be to make contracts and commitments, always provisional and subject to review, between these actors, enabling some acceptable viability from the point of view of each of them" (Campos; Cunha, 2010, p. 33). Creating the conditions for effective participation involves transforming the ways of working and the management model. With regard to the inclusion of new tasks, co-management broadens the scope of management, which is traditionally based on the search for work results, when considering the task of analyzing the institution and formulating projects that include the dispute of political groups, constituting itself as collective decision-making space and training space (Brasil, 2009).

Thus, it was verified, throughout the research, that other demands were produced. Demands related to the Raps contraction to transform health care and management practices. This process unfolded from the GAM approach implementation phase at Caps to the Raps support phase. This practice of group contraction of this implementation, with an increased degree of autonomy – increased intragroup (GIU and GIF) and intergroup (GAM groups and Caps team) communicational openness (Guattari, 2004) – generated the demand for expansion of communication networks, either by the continuity of the GAM approach in the service after the end of the research, by the creation of the association of municipality's mental health users and family members, or by the creation of the municipal mental health forum. This research supported the processes generated by the research itself.

The emergency plan of the Psychosocial Care Network Forum

Since 2009, when the Gaining Autonomy & Medication Management was imported through the multicenter research project, until 2014, the date of the end of the *Alliance Internationale de Recherche Universités-Communautés – Santé Mentale et Citoyenne*té, which made it possible to adapt the Canadian GAM guide to the Brazilian reality, a methodological path that can be divided into different phases was designed: first, GGAM was translated and adapted to Brazilian reality; subsequently, the GGAM was validated, and finally, institutional support for São Pedro da Aldeia's Raps was offered.

The research performance in the municipality occurred by suggestion of the then State Secretariat of Health and Civil Defense – currently State Secretariat of Health -, in a meeting held in 2010,

when the team of researchers from UFF presented the GAM to the supporters of the Secretariat, as well as and the results of the first phase of the multicenter research (involving UFF, State University of Campinas, Federal University of Rio de Janeiro and Federal University of Rio Grande do Sul) in the states of Rio de Janeiro, São Paulo and Rio Grande do Sul. At that time, the Secretariat of Health's suggestion allowed making a more assertive choice regarding the municipality in which the work would be developed in the second phase of the research through the Autonomy and Human Rights project: Validation of the Guide for Gaining Autonomy & Medication Management (GGAM), supported by the Foundation for Support of Research in the State of Rio de Janeiro (Faperj) from 2011.

GIU, the first GAM group held in São Pedro da Aldeia at Caps, was composed of three university researchers, a psychiatrist, an occupational therapist and an average of 12 users. GIU met weekly for two hours, making a total of 27 meetings that took place from March to October 2011. At these meetings, GGAM-BR was read, discussed and validated collectively, and showed important therapeutic effects on Caps' users.

GIF, performed at the same space, had the participation of different service workers throughout the process, including a social worker, a Caps psychologist/coordinator, two nursing technicians and a psychologist, three university researchers and an average of seven family members. The group started in May 2011 and ended in March 2013.

Driven by the experience of publicizing collective problems and the various questions about São Pedro da Aldeia's Mental Health network that initially emerged in GIU and GIF groups, an immersion work in the main services of the network was proposed in order to map the dynamics between them, mainly evaluating the care and attention to the mental health user in the Raps. In 2011, there was monitoring of the line of care for a week through immersion in the network, when pairs of researchers monitored the workers of different spaces of the Raps, in a dialogical observation of these professionals' work, seeking to understand how the services articulated in the network.

In this process, university researchers took turns in the mornings and afternoons in each of the service places, monitoring the professionals' work with a semi-structured script of questions about service practices. A methodology for monitoring the line of care in the municipality was established and, through this immersion (Alvarez; Passos, 2009), it was possible to map the care practices that occurred between Casarão da Saúde, the expanded Casa Azul outpatient clinic, the Therapeutic Residential Service (SRT) and the emergency room, in order to understand how this network articulated. These practices were enabled by institutionally formalized relationships, such as the attributions of services and the services provided, and also by other elements, such as the good relationship between some teams that cooperated more with each other to solve some issues, or even the political alliances that favored certain investments in the network. By following the work closely and talking with workers, users and family members about topics such as access, care and medication management, relationship between network services and among the different actors that circulate through them, care and management practices in the area were identified.

Some restitution meetings for network workers were organized when they recognized situations that analyzed (Guattari, 2004; Lourau, 1993) work in the Raps. Analyzers are events that produce disruptions and catalyze flows in processes of change in institutions. They perform analysis, removing the centrality of the role of the analyst, as they point to possibilities present in the research, denaturalizing the instituted forms, and pointing to the instituting forces and institutionalization processes (Passos; Barros, 2000).

From sharing with the workers the impressions gathered by the research by means of the interventions both in the groups with users and family members and in the monitoring of the line of care, the proposal of creating a forum of workers to broaden and deepen the discussions about the work in the Raps arose, as well as creating a space in which workers would meet to discuss their problems, share their difficulties, and think collectively about strategies for qualifying mental

health care in the municipality. From a desire to expand the collective spaces for work and mental health worker care, it was noticed a demand for the establishment of a device able to take care of the care experience (Macerata; Dias, 2014) of the workers of that network.

To systematize what was identified at the end of the cartography of the line of care, a committee was formed with representatives from the different services of the Raps, which was responsible for the municipal coordination for the organization of the meeting called pre-forum. In this meeting, from the discussions between university researchers and workers, 10 problematic points were listed:

1. Co-management of medication in the relationship between workers, users and family members.
2. Partnership between workers, families and support network in mental health care: social control and conferences, association of users and family, and the family group in the services.
3. Co-responsibility of the mental health network in the construction of Singular Therapeutic Projects: the partnership between services.
4. Care in mental health and religion.
5. Income generation and social reintegration devices through work.
6. Mental health and sexuality.
7. Importance of intersectoral approach in mental health care (Social Assistance Reference Center (Crass), education, transportation, garden school, etc.).
8. User's profile in the relationship with the spaces: what distinguishes "Caps profile" and "Outpatient profile." User's profile and referrals in the network with referral change.
9. Mental health and autonomy development: what is autonomy in mental health?
10. User aggressiveness: the limit as clinical direction and the limitation of clinical services.

It is understood that the insertion of research in the network had produced a demand for institutional support, expressed through workers' request to participate in the collective discussion spaces they wanted to build and also through Caps workers' request to help them continue GIU and GIF.

The provision of institutional support for the municipality's mental health network was made possible through the construction of the Autonomy and Human Rights project: Validation of the Guide for Gaining Autonomy & Medication Management (GGAM) – Continuity, with support from Faperj, which provided for the provision of both types of support during 2013-2014.

The implementation of the GAM device in São Pedro's Caps has raised the question of the relationship between Caps, SRT, extended outpatient clinic, emergency room (which also offers psychiatric beds), and other network services. The objective was to know how the network worked, and, even more, how the Caps operated care in that municipality in their articulations and what was its capacity for ordering this network. More than providing a diagnosis about daily life, there was elaboration, with the cartography of the line of care, of restitution in the form of conversation with the workers about what was experienced with them in this work follow-up week, seeking to discuss the issues that were raised from the daily routine of services. This meeting between different actors was a fact that already changes the daily functioning of services.

The conversation at Caps warmed up the group and generated the demand for further discussion beyond the service team. The research had found the emptying of collective spaces in the work of the mental health network in the municipality, and proposed a Raps stimulus arrangement. On the occasion of this feedback meeting, what had been observed was shared with the mental health coordinator and the Caps' team. Sharing with them the experience in monitoring the work made this collective evaluation experience create other meeting devices between those actors.

The conversation with the workers was prepared in the same way as the line of care follow-up script was built, thinking about how the articulations of that mental health network operated. The collective will was created by experiencing, in that feedback meeting, a group interested and mobilized for

discussion. Thus, the absence of meetings between the spaces, the poor communication between the services, besides all issues gained their dimension as a shared problem. A common plan experience was created (Kastrup; Passos, 2014), which connected workers around collective issues. Outlining a common research plan involved the challenge of ensuring the participatory character of the research. By evading the logic of feedback to the investigated as information of what the researcher collects, organizes and analyzes on the data, a desire to transform the way of working and relating to the network was operated in this group. Then, the project to create the Forum of Mental Health Workers arises.

Other effects of research-support in mental health

The creation of a forum of workers gains importance because it is a space for sharing both the collectively analyzed working conditions and the network crises that appear in users' daily care.

By betting on the desire to expand the collective spaces for work and mental health worker care, the meetings started being operationalized with them by defining the location. The forum would be held bimonthly, with workers from Caps, emergency room, extended outpatient clinic and Nasf. Locations varied between services.

Three questions have become fundamental: (1) the precariousness levels of relationships – precariousness of labor relations, expressed through fragile employment relationships, low salaries, reduced number of team professionals, lack of basic inputs and adequate physical structure; precarious relationships between the professionals who compose a team and between the teams of the different services, expressed through little dialogue, isolation and a great sense of work overload; precariousness of the relationship between workers, users and family members expressed through fragile bonds, poor promotion of autonomy and great sense of helplessness; (2) the definition of the users' profiles, categorized as "Caps profile" and "outpatient profile"; (3) medication management.

At first, a lot of discomfort that did not gain expression was experienced together with the workers. It was possible to feel discomfort, but it was not expressed. It was clear that the precariousness of working relationships was expressed in the way each worker positioned himself/herself in the meeting. It was also clear that the relationship between workers and management was marked by strong verticality, and that the centralization exercised was related to the silence of the vast majority of workers.

There seemed to be little dialogue between professionals of the same service, and even less between professionals of different services. The feeling of loneliness and overload among the workers was very strong, reflected in the distance between the network services, which seemed to work in an inarticulate manner. Even issues regarding clinical care and worker-user relationships were poorly shared within teams.

Identifying the precariousness of the relationships that were established in the network, it was important to strengthen the co-management of work processes, so that management was exercised by all involved and not only by the figure who occupies the position of manager. This is the direction of SUS' democratizing bet, a public policy and not a government policy, that is, a policy sustained by the citizens. Discussions in the phase of support for the mental health forum in São Pedro da Aldeia rekindled the public dimension of mental health policy by building co-responsibility for the functioning of the network.

However, it was difficult to include in the forum meetings the caregivers of therapeutic residency (RT), generally people without higher education. On one occasion, a case that was difficult to handle was discussed: RT had to bring back an inpatient that often had issues of coexistence with other residents. The RT coordinator was concerned and felt unable to resolve the situation without the presence of the RT caregivers and the fellow residents who could contribute to the possible internment release.

The forum then decides to hold the next RT meeting to include caregivers as well as residents/users in the collective decision about caring for

that user. The problematic point number "10. User Aggressiveness: the limit as clinical direction and the limitation of clinical services" was emphasized at meetings by workers as one of the most delicate. Many felt vulnerable and without clinical resources when attending users in crisis, as was the case of the RT resident who needed to be released from internment.

There was an in-circle meeting in the backyard of RT, reinforcing the invitation to residents to discuss what decision to make. Some spoke of their difficulty in dealing with the sometimes aggressive crises when the user in question was at home. The technicians spoke openly about the situation of internment and the precariousness of treatment. Residents said it was the user's right to be able to return to the place. The forum provided a collective space for clinical direction in the care of this user – internment release and return to RT – and, moreover, allowed the team and users to take such difficult clinical decisions, such as aggressiveness, more co-responsibly.

Rancière (2005) helps think about this situation in its clinical-political aspect. Sharing the sensitive nature is, for the author, a political practice of the common plan: who can speak, who can take part in the common from a certain function, and the ways in which the visible is shared and the invisible occurs in this common.

In this forum meeting at RT it was possible to promote other possibilities for managing the common and mental health care, in which other forms of participation for that group were possible, such as the consideration of users' opinions in a clinical decision. We understand that a clinical-political intervention, as developed from the forum, involves changing the regime of sensitivity in mental health care practices for this group. What gains visibility and what emerges from invisibility change when the common is share from different positions, activities and parts. The partition between visible and invisible is redrawn so that the subjects change the way they take part in situations.

The research ended its participation in the forum with a very positive evaluation. The workers said: "It is very important to continue taking care of those who care"; "This was very good because you stimulated us, gave us fresh air!"; "It was different because you took our hand and were not demanding"; "It was a very rich exchange"; "It was a fight, and we had many achievements"; "Things we never imagined doing today are much easier"; "Today, the network is more connected, although there are still many issues."

Outlining a common plan in the research field included different interests and produced engagement between different subjects who were involved in the research process. This was made participative by the collectivization of the research experience, passing by the support for the movements of these groups that were monitored. Collective care in a crisis situation is to share an aspect of care that is both visible and invisible: responsibility.

Researching mental health workers involves placing different positions in a same circle: management at the central level, equipment coordination, temporary contract workers and civil servants, those with higher education and those acting as caregivers and do not necessarily have university education. Differences that are political and singular at the same time, composing, as other vectors, concrete practices of working in the network with users and their families.

The promotion of autonomy in mental health involves dealing with this heterogeneous common nature that characterizes staff and users. Sharing the responsibility of clinical decision between different actors promotes another form of management of the common, so marked, until today, by the poor decision-making autonomy of users in their therapeutic projects. Accompanying this process of collective autonomy contraction characterized the research in its intervention, participation and support dimensions.

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Authors' contribution

Passos, Almeida and Guerini conceived the study. All the authors designed and wrote the article. Vargas performed the technical review.

Received: 09/01/2019
Approved: 09/26/2019