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ORIGINAL ARTICLE

In-service training with professionals from a Psychosocial Care Center: analysis of mobilized reflections

Formação em serviço com profissionais de um Centro de Atenção Psicossocial: análise de reflexões mobilizadas

Formación en servicio con profesionales de un Centro de Atención Psicosocial: análisis de reflexiones movilizadas

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ABSTRACT

Objective: to analyze the reflections mobilized with professionals through in-service training in a Psychosocial Care Center. **Methods:** interventional study based on the Institutional Analysis framework involving 12 professionals from a Psychosocial Care Center in a capital in the Central-West region of Brazil. Five in-service training meetings based on Continuing Health Education were held. Thematic content analysis was used to analyze the contents of the transcription of meetings and the researcher's diary. **Results:** two categories emerged: "Resistance and difficulties that impact in-service training and interprofessional work"; "The instituting resonances in daily work and the importance of the Singular Therapeutic Project based on training". Resistance movements, hierarchical relationships, and the centralization of care on medical knowledge/power and medicine as the main therapy are established practices. On the other hand, there are instituting forces towards collaborative, integrated and interprofessional work, which aim to change and transform the mental health institution into a psychosocial care institution. **Conclusions:** collective training spaces make it possible to look at the world of work as a field for learning and raising awareness about occupational conditions and the movements instituting changes in practices mobilized in the work scenario.

Descriptors: Mental Health; Education, Continuing; Mental Health Services.

RESUMO

Objetivo: analisar as reflexões mobilizadas com os profissionais, por meio da formação em serviço em Centro de Atenção Psicossocial. **Métodos:** pesquisa-intervenção pautada no referencial da Análise Institucional, que envolveu 12 profissionais de um Centro de Atenção Psicossocial em uma capital da região Centro-Oeste do Brasil. Realizaram-se cinco encontros de formação em serviço, pautados na Educação Permanente em Saúde. O conteúdo da transcrição dos encontros e do diário do pesquisador passou por análise de conteúdo temático. **Resultados:** Emergiram duas categorias: "Resistências e dificuldades que impactam na formação em serviço e no trabalho interprofissional"; "As ressonâncias instituintes no cotidiano de trabalho e a importância do Projeto Terapêutico Singular a partir da formação". Os movimentos de resistência, as relações hierárquicas, a centralização do cuidado no saber/poder médico e no medicamento, como principal terapêutica, são práticas instituídas. Em contrapartida, há forças instituintes em direção ao trabalho colaborativo, integrado e interprofissional, que tencionam para mudança e transformação da instituição de saúde mental em instituição de atenção psicossocial. **Conclusões:** Espaços coletivos de formação possibilitam o olhar para o mundo do trabalho,

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como campo de aprendizado e conscientização acerca das condições ocupacionais e dos movimentos instituintes de mudança de práticas mobilizados no cenário de trabalho.

Descritores: *Saúde Mental; Educação Continuada; Serviços de Saúde Mental.*

RESUMEN

Objetivo: *analizar las reflexiones movilizadas con profesionales a través de la formación en servicio en un Centro de Atención Psicosocial.* ***Métodos:*** *estudio de intervención basado en el marco de Análisis Institucional que involucró a 12 profesionales de un Centro de Atención Psicosocial de una capital de la región Centro-Oeste de Brasil. Se realizaron cinco reuniones de capacitación en servicio, basadas en la Educación Continua en Salud. Se utilizó el análisis de contenido temático para analizar el contenido de la transcripción de las reuniones y del diario del investigador.* ***Resultados:*** *Emergieron dos categorías: "Resistencias y dificultades que impactan la formación continua y el trabajo interprofesional"; "Las resonancias instituyentes en el trabajo diario y la importancia del Proyecto Terapéutico Singular basado en la formación". Los movimientos de resistencia, las relaciones jerárquicas, la centralización de la atención en el saber/poder médico y la medicina como terapia principal son prácticas establecidas. Por otro lado, existen fuerzas instituyentes hacia el trabajo colaborativo, integrado e interprofesional, que apuntan a cambiar y transformar la institución de salud mental en una institución de atención psicosocial.* ***Conclusiones:*** *Los espacios de formación colectiva permiten mirar el mundo del trabajo como un campo de aprendizaje y sensibilización sobre las condiciones ocupacionales y los movimientos que instituyen cambios en las prácticas movilizadas en el escenario laboral.*

Descriptores: *Salud Mental; Educación Continua; Servicios de Salud Mental*

INTRODUCTION

The Brazilian Psychiatric Reform is a complex social process involving theoretical-conceptual, sociocultural, legal-political and technical-assistance aspects that initiated by questioning the then current psychiatric model characterized by the centralization of practices in medical knowledge-power[1]. This reform aims to provide care in freedom using the structure of the Psychosocial Care Network (Portuguese acronym: RAPS) with articulation and dialogue within its services[2,3].

As a movement for constant transformation of reality, from the perspective of the Institutional Analysis framework, the Brazilian Psychiatric Reform is one of the instituting forces that seeks to transform mental health practice/care. In this sense, mental health as an institution presents itself in its immaterial dimension with implicit and explicit regulations and rules; and in the material dimension, it is implemented through organizations and/or establishments[4].

The Psychosocial Care Centers (Portuguese acronym: CAPS) are specialized reference equipment/services and act as articulators within the RAPS. They may encompass different types of services defined in increasing order of size/complexity and population coverage, and constitute CAPS I, CAPS II and CAPS III. They are made up of different professional categories that act under an interprofessional logic, aiming to enable the social reintegration and psychosocial rehabilitation of people in mental distress[5,6].

However, CAPS, as strategic equipment to guarantee transformations within the complex social process, have been impacted by the scarcity of investments in material and human resources, with disarticulation of the network and setbacks in the legal-political sphere[7-9], which represent instituting forces based on the psychiatric counter-reform. Furthermore, weaknesses in the technical-assistance and theoretical-conceptual spheres are evident in these spaces, as the training of professionals is mostly direc00ted to uniprofessional logic and pedagogical approaches anchored in the biomedical model, which does not contribute to build collaborative practices[10,11].

Another problem is the institutionalization of subjects in services created to replace the biomedical and asylum model. These practices may be established in services/equipment that have the initial prophecy of being a substitute for the psychiatric hospital. In this context, it is necessary to mobilize instituting processes to promote self-analysis and collective reflection on daily work for the institutionalization of mental healthcare that overcomes the stigmas of madness and exclusionary and isolating practices[7] for care in freedom and based on human rights.

In view of this, in-service training with professionals based on principles of Continuing Health Education enables transformation and quality of mental healthcare. In addition, the professional is recognized as an autonomous subject in this process, since Continuing Health Education has potential to be a path to overcome the established hierarchization, hegemony and fragmentation of care actions and decision-making processes in institutions[12,13]. Continuing Health Education enables

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co-participation and co-management of the learning process, in which subjects can rethink established ways of organizing and planning both in-service training, and activities and routine of the practice.

In this sense, the objective of the study was to analyze the reflections mobilized with professionals through in-service training in a Psychosocial Care Center.

METHODS

This is an interventional study based on the theoretical framework of Institutional Analysis. Interventional studies have a political character of transformation of the various established meanings[14]. In turn, Institutional Analysis is one of the bases that supports the proposal of Continuing Health Education, as it seeks to understand a certain social and organizational reality[15].

Institutional Analysis understands the institution from the dynamic and dialectical relationship between three moments - instituted, instituting and institutionalization - and the institution is not configured as something static, but rather a system of norms that structure and regulate the functioning of certain social groups, such as family, health/mental health and education. The instituting forces provide changes and also result in a product called instituted. Thus, for Institutional Analysis, the instituted is the static force resulting from an instituting dynamic movement[4,15]. In this way, using Institutional Analysis as a theoretical reference to guide in-service training through Continuing Health Education can enhance learning by provoking reflections about the work process and expand the researcher's analytical process[16].

The study was carried out in a CAPS I in a capital in the Central-West region of Brazil.

In accordance with Ordinance No. 336 of February 19, 2002[17], the CAPS I has operational capacity to serve municipalities with a population between 20,000 and 70,000 inhabitants. Under coordination of the local manager, it is responsible for organizing the demand and the mental healthcare network within its territory; has technical capacity to act as a regulator of the gateway to the care network; may coordinate the supervision activities of psychiatric hospital units within its territory by delegation from the local manager; supervises and trains primary care teams, mental health services and programs within its territory and/or care module; carries out and keeps updated the registration of patients who use essential medicines for the mental health area regulated by Ordinance/Minister's Office (Portuguese acronym: GM)/Ministry of Health (Portuguese acronym: MS) number 1077 of 24 August, 1999 and exceptional medicines regulated by Ordinance/Secretariat of Health Care (Portuguese acronym: SAS)/ Ministry of Health (Portugues acronym: MS) number 341 of 22 August 2001 within its care area.

In accordance with the aforementioned Ordinance, at CAPS I, the care provided to patients includes activities such as: individual care (medication, psychotherapy, guidance, among others); group care (psychotherapy, operational group, social support activities, among others); care in therapeutic workshops run by a professional with higher or secondary education; home visits; family care; community activities focusing on the patient's integration into the community and his/her social and family insertion.

In CAPS I, the minimum technical team to care for 20 patients per shift must be composed of a physician with training in mental health; a nurse; three higher education professionals (psychologist or social worker or occupational therapist or pedagogue or other professional necessary for the therapeutic project); four mid-level professionals: nursing technician and/or assistant, administrative technician, educational technician, and artisan.

The CAPS of this investigation was selected for convenience since it is the place where one of the researchers performs her teaching activities and in-service practical activities with undergraduate students.

At this location, all 24 workers in the service - from the administrative sector, reception, general and care services - were personally invited to participate. Workers on leave were excluded. Of these, 12 refused to participate; three were unavailable at the time and day of the week chosen by the majority for the in-service training and nine were not interested thus, 12 professionals participated in total.

The five in person in-service training meetings were coordinated by a ph.D experienced in interventional research and two undergraduate students, and the biosafety protocols established to protect against Covid-19 were followed. The topics covered were about the Singular Therapeutic Project, from the elements and concepts that make up this tool, its collective construction, and the critical look at the instrument previously used by the team that was mistakenly called Singular Therapeutic Project.

The meetings took place on Mondays at fortnightly intervals between July and November 2022, lasted approximately two hours each, and were audio recorded for later transcription and analysis. The researcher's diary, which is the researcher's narrative within the historical-social context, reflecting the daily research activi-

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ty, was used[18,19]. The recording units were linked to the in-service training meetings and the researcher's diary.

Data were analyzed based on principles of the Institutional Analysis[16] and the Continuing Health Education[20]. The latter is an education strategy that seeks to transform practices and the training process itself under guidance of the subjects playing a protagonist role in their learning, considering the circumstances in which they are inserted, in order to enable workers to take contextualized actions based on critical reflections[20]. Thematic content analysis was used in data analysis[21]. The Microsoft Word® (2016, Microsoft Corporation, United States) resource was used in the organization of data by following three steps for the analysis: 1) skim reading of the researcher's diary and transcripts of the meetings; 2) separation/decoding of themes through phrases/statements that stood out the most, initially emerging seven coders of data; 3) grouping of themes by similarity and construction of thematic categories.

The research was approved by the Human Research Ethics Committee (Certificate of Presentation of Ethical Review – Portuguese acronym CAAE - number 29310620.1.0000.8124). The names of the professionals were identified by the letter P, followed by Arabic numbers in ascending order for the preservation of participants' anonymity. The researcher's diary was identified as RD.

RESULTS

Twelve professionals participated in the study: four nurses, three psychologists, a pharmacist, a physical educator, two social workers and a unit manager with a degree in Journalism. All professionals were working under a temporary two-year contract with the possibility of a 12-month extension. The average working time at the CAPS was one year. Only one psychologist and one nurse participated in all meetings, the unit manager was only present in the first and the others participated in at least three meetings each.

The discussions were permeated with reflection on the activities developed in the services and interprofessional/collaborative practice, covering aspects related to knowledge and training based on interprofessional education, collaborative teamwork, so that limitations and possible interventions based on psychosocial care could be identified in the collective sphere.

The themes derived from the two data sources (transcript of meetings and researcher's diary) were grouped into two thematic categories: "Resistance and difficulties that impact in-service training and interprofessional work"; "The instituting resonances in daily work and the importance of the singular therapeutic project based on training".

Resistance and difficulties that impact in-service training and interprofessional work

Initially, some professionals were resistant to participate in the interventional study and advance in the self-analysis process, and expressed uncertainty and insecurity, even after clarification. They questioned the motivation of the study, its relevance for the team and researchers, and highlighted a possible overload brought by the training in relation to the activities that should be developed.

But how will this continuing education fit into our work dynamics? Because you know, the reality at the unit is that we are "drowning" in work. [...] What is the general proposal for us professionals to gain something too? Because the idea of continuing education is very interesting, it's cool, and we need it. However, what is the focus, what is the interaction? (P6)

[...] P6, was often harsh questioning the authenticity of the study. P4 invalidated the issues raised by trying to show the changes in the team/unit. It seemed that the study caused discomfort and some professionals were on the "defensive", not wanting to move on to the self-analysis process. (RD)

When asked about this first analysis and the resistance movements, they mentioned fear regarding the risk of dismissal, given the fragile employment relationship and that continuing education could be interrupted because of the high turnover of workers.

[...] they were afraid, often in a hidden way, of verbalizing anything and being fired. (RD)

It's a normal fear, I guess, because in our role, in a situation that can change, we might leave... you know what I mean? It's a fear you understand, don't you? (P5)

Participants mentioned a high turnover in the service, which was a restrictive factor for greater involvement with the study.

Another point is also the time of this professional in the unit, because some professionals are civil servants and will stay here for a long time, us, under a temporary contract, we'll stay here for two years and then only God knows [...] Why improve if I'll leave in a few months? (P6)

Other reflections mobilized among professionals concerned the way of working and the medical-centered knowledge. One of the professionals mentioned the possibility of improving discussions in the study with the presence of a physician.

Here, if there is no physician, it all goes off the rails, because patients themselves are still very attached to the medication, [...] the physician indeed makes a lot of difference, even for the flow of work. (P1)

[...] two professionals paralyzed their facial expression (non-verbal communication) as if they had never reflected on it until that moment which presented itself as an opportunity to rethink. (RD)

This statement was problematized, and several reflections were promoted.

It will have to get better, because now we are receiving another colleague in our team, who is the psychiatry resident and he will probably participate in the case studies, so the case study will have to get better than what is being done, as it will have the presence of a physician, it has to have much more resolution than just opening and closing cases. (P8)

We say, "I don't know what, it wasn't seen by the physician, for an evaluation by the physician, and we can't do such a thing". It's not quite like that, physicians are not a totalizing knowledge, a supreme knowledge, above all other knowledge and they don't bang the gavel. (P6)

[...] The speech of a participant, provoking a reflection in the group, made it possible to look at the organization of work. (RD)

The professionals reflected on the uniprofessional way of acting, comparing it with the objectives of the service, in addition to the lack of communication, especially with medical professionals, identified as one of the problems that make interprofessional work more difficult.

When you get here, most professionals arrive addicted to doing everything alone. When we begin to understand that the logic of CAPS is to work together, and it is exchanging, building collective knowledge, we become involved in several things because you already have your construction of a profession, society has a construction about your profession. (P6)

It's not that there's resistance, but it's just that there's no habit of talking to the physician about things here. (P1)

Let's say, slightly shyly, the relationship with the physician colleague. Isn't it P8? It's kind of shy. (P9)

Another aspect that mobilized the professionals' reflection was the gap between the theoretical model of psychosocial care and the practice carried out in daily work, as well as the non-use and/or lack of knowledge of essential care instruments to offer autonomy for people in mental distress.

What is user embracement, CAPS, why the person is there, all that, sometimes the person arrives here raw, without knowing these things, and when they get in the room, you don't know what you are doing here, you don't know how conduct, so, we need to know what CAPS does and what it doesn't do, there must be a theoretical basis. (P5)

When proposing to start the training based on a Singular Therapeutic Project that already existed in the service, professionals reported that they did not perform the Singular Therapeutic Project, had never performed it, or were unaware of any more information about this strategy.

We don't do a singular therapeutic or individual project, at least since I got here, we haven't done it. (P9)

One of the participants mentioned that the Singular Therapeutic Project

…was limited to a checklist of signs and symptoms and which group activities/workshops the user would participate in. (RD)

They recognized the lack of clarity about the nature of the Singular Therapeutic Project.

It's because we had the wrong definition of it [the singular therapeutic project], right? (P1)

The instituting resonances in daily work and the importance of the singular therapeutic project based on training

Despite the weaknesses, an instituting movement towards collaborative, integrated and interprofessional work was identified and demonstrated by more debates among professionals, even outside the case discussion meeting.

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Several times I sat outside the case study to discuss the case with them, before the assistance […] I don't know if it's my personality, but when it comes to the case, I talk directly to them. (P5)

Sometimes, while offering user embracement, I heard "this, this and this" and then you end up overlooking it, but these are important details […], it's about paying attention to all the information that all professionals are giving. (P6)

Some reflections go in the opposite direction to what is established in the service, in order to think about care considering the bond and other therapeutic possibilities. We have workshops, individual care, we have a multidisciplinary team, and yes, the physician and medication come into play at these points, but it is not just focused on that. (P1)

When they start attending the groups, they understand this, when they start coming to the groups they start to realize [that medication is not the only "treatment"]. […] We also cannot forget that when patients enter here, they create a bond, they transfer something, they put something into this relationship, they have an affection here. (P6)

From the discussions, some professionals understand the potential of user embracement and listening for the assistance in psychosocial care, and recognize the importance of training. It was understood that training is performed based on daily work and is fundamental for the criticism and transformation of asylum practices.

Here at CAPS you have to know how to listen to patients, especially when they tell you they are doing very well, you see they are not doing well at all. You have to know how to listen, offer the right listening, since the better I guide them the fewer the chances of the patient backtracking on treatment. (P2)

Continuing education is a dream, I guess of every institution, having a continuing education program, but it is not a reality. It's the ideal, every professional should have this space, in fact, every Friday was supposed to be for this training environment, but it never happened, for me it's new. (P6)

Among the weaknesses identified collectively, the one discussed in more meetings was the construction of the Singular Therapeutic Project. Throughout the in--service training process, repercussions related to its ele-

ments, its implementation and relevance for improving interprofessional care in mental health were observed, which had a direct impact on teamwork.

I have improved my access to the team in general by asking for opinions when I have doubts. Putting the patient in charge of their care has already changed a lot. (P1)

The way I offer someone embracement, when I assist a person, I already think that it makes sense, when I want to put it into practice, I'm still learning, but I already think. (P5)

For example, at least the STP [Singular Therapeutic Project] is something I'm trying to do. (P6)

Through the reflections mobilized, an openness to transform the service offered to users at CAPS was perceived.

In the meeting before the last one, two nurses and a social worker requested support and clarification for the organization and structuring of a Singular Therapeutic Project *that they had started in the service with a user.* (RD)

DISCUSSION

In-service training based on continuing health education has the capacity to highlight practices established and crystallized in daily work, thus awakening reflections, discomfort and/or resistance. When participatory modes that promote self-analysis and collective reflection are proposed, professionals rethink their practice, thus, it is expected there will be reluctance[22].

Resistance can present itself in movements of complacency, retaliation, or the opposite, and be a means of sustaining good practices in a precarious scenario[23]. The participants were under a temporary contract, which makes working conditions precarious and exposes the professional to financial and emotional instability and insecurity. Among the various forms of precariousness, the most prominent is related to irregular forms of hiring, but not only that. Precariousness is a concept used to discuss the deregulation and increase in workload, the deterioration of working conditions, the extension of working hours, the growing lack of social protection, the increase and intensification of physical and/or mental suffering related to work and unemployment[24].

Precarious work is a national reality that extends beyond the CAPS[25,26], including outsourced adminis-

tration of services, lack of human resources, disproportionate relationship between the number of professionals and users served. This causes a tense flow - increased productivity with the minimum quantity of human resources, and results in the impossibility of interprofessional work[25] and the conservation of established asylum practices.

Through the resistance identified in the interventional study, movements of complacency or retaliation and precariousness clearly converge and coexist in the team. Centralized and little-shared decisions, as well as the initial stance of professionals who contest and judge in-service education and the proposal to think and reflect on daily practices as an "additional task", are examples of resistance that go hand in hand with the conservation of what is established. On the other side, attempts at collaborative work and the interest of some professionals in actively participating in meetings represent instituting movements that seek different ways of care.

In-service training is still capable of provoking different reactions in the field of emotions, such as fear of the new/unknown. Every change that the subject generates or undergoes is susceptible to the tension proposed by the "new", which may result in anxiety, excitement, anguish and fear[24].

The fear of the new, as identified in this study, is not only related to the instituting forces through reflections/self-analysis and changes in daily work; a training space that questions established and automatically reproduced practices causes deterritorialization in the professional not only within the scope of care, but also in the awareness of few possibilities for coping with fragile employment relationships that are one of the materializations of the neoliberal policy[24]. It has imposed a mode of production that reconfigures the organization of work, including practices such as the flexibility of contracts, causing work overload, high turnover and deconstruction of professional identity[26]. The deregulation of employment, salary reduction, deterioration of working conditions and growing lack of social protection result in mental/physical suffering related to work, in search and permanence in different jobs and types of fragile work engagements[27-29]. These factors make it impossible to have an affective and effective involvement with a critical look at routine practices.

These repercussions lead to the loss of subjectivity and pleasure, restrict work to a means of survival, not integrated with life, resulting in alienation at work[27]. Therefore, individuals are less likely to get involved in the critical-reflective training process because of the feeling of devaluation and insecurity in the work setting, which results in fear of confrontations for change, loss

of individual and collective identity, and concern about preserving their employment relationship. This scenario of precarious work restricts the institutionalization of mental healthcare based on the psychosocial care model.

Neoliberal policy strengthens hierarchical ways of working established in the service, which limits the collective and creative participation of workers. In this sense, the apex-base power flow, which also imprints this vertical relationship on the user, compromises dialogical spaces, such as in-service training. As there is a limitation in the critical-reflective training process, there is a loss in looking at established practices and situations/phenomena with hidden or unspoken meaning.

Hierarchical relationships are also manifested by subalternity in relation to medical power/knowledge. The power/knowledge relations established at the CAPS, especially when they are centered on the medical figure, restrict the care instruments to medication only, hence, care is centered on the disease and not on the user-person[30]. This contributes to maintain the biomedical-psychiatric model established in daily work.

The centrality of care in medication includes two important aspects: reinforcement of the supreme importance of medical knowledge-power; and social understanding of the magical solution to suffering through the use of medication. This belief has a historical location in relation to the birth of mental health as knowledge (birth of psychiatry), which limits the person in mental suffering to madness and dangerousness and, therefore, in need of being cured, standardized and normalized.

This knowledge constituted and instituted as a historical care practice is intensified by a neoliberal policy that produces and institutes social beliefs related to medication as the only solution to suffering and, therefore, when it is not prescribed by medicine, it is required by CAPS users themselves or any other mental health service[31]. The institutionalization of mental health/psychosocial care model is the result of instituting forces of social and political struggle for the transformation of care, and it is also a fight for better working conditions.

The absence or little communication between the team, especially with the physician, may be linked to the uniprofessional way of acting, for according to participants, many new collaborators starting at CAPS do not understand the premise of collaborative work. This logic of action is related to the training process of these professionals, in which the established education model is verticalized, promoting fragmented care, where there are no exchanges, discussions or assistance based on co-responsibility[32].

The training of professionals is often directed towards the uniprofessional logic with pedagogical approaches

anchored in the biomedical model that do not contribute to construct collaborative practice skills[10,11]. This type of training maintains and intensifies asylum practices established in replaceable mental health services and weakens the technical-assistance and theoretical-conceptual scopes, and has repercussions on care and on work relationships.

Furthermore, if there is distance and little integration of actions and knowledge between professionals, both in training and in care, there will also be less possibility of learning in and through work. The fragility of knowledge based on psychosocial care is materialized in difficulty in embracement and care for people in psychological distress, including by the lack of understanding and/or lack of knowledge about the objective of CAPS and existing tools in the service, such as Singular Therapeutic Project, which provide not only integrated/interprofessional work, but also promote autonomy, co--participation and psychosocial rehabilitation.

In this sense, interventional research based on in-service education guided by the principles of Continuing Health Education allows professionals to take an analytical look at practice, identifying weaknesses, but also advancing in the recognition of strengths and investing individually and collectively in the learning at/through work that enables better mental healthcare, including the understanding about user embracement and qualified listening.

User embracement is an important strategy for building the user's and family's bond with the institution. It is an extremely powerful and necessary tool in CAPS and together with qualified listening, involves identifying the demands of the person in suffering considering their uniqueness and territory[33,34].

In-service training based on Continuing Health Education has the purpose of removing participants from the static and vertical place of knowledge, causing discomfort and leading them to become apprentices from the perspective of doing to knowing, questioning crystallized attitudes[35]. In this sense, the five meetings also provoked discomfort and questions about the power relations existing in CAPS, so that together they could rethink communication in the team and new articulations and modes of care, also considering the subject in psychological distress in this process.

Thinking about the Brazilian Psychiatric Reform as a complex social process requires a perspective and criticism beyond established processes restricted to public policies that implement and enable the creation of services, protection of the rights of people in mental suffering, theoretical-conceptual and technical-assistance transformation. It is necessary to strengthen collective

spaces so health professionals can guarantee working conditions that favor their physical and mental health, and the creation of collaborative, territorial, inclusive, dialogical practices, thereby promoting the institutionalization of the psychosocial care model, and transforming public policies into established practices as they are effectively implemented.

Without a context of adequate working conditions, such as fair wages, adequate human resource numbers, stability and labor benefits, it is not possible to advance discussions that transform established practices, as well as aspects of cultural and social understanding. What is the possibility of a critical stance regarding the institution of asylum "care" as a practice established in a scenario of fragile work ties? At risk of loss of financial stability? How can we broaden our view of subjects and their suffering, including the social determinants in this process, if the work is carried out based on a tense flow with work overload?

Thinking about mental health as an institution means understanding the instituting forces that enable the institutionalization of care based on psychosocial care, as well as paying attention to the tension established between instituting forces and the instituted, in which the instituting also challenges and questions achievements resulting from political and social struggles, producing labor setbacks, with loss of rights already guaranteed.

The setbacks that have occurred in recent years of the Mental Health Policy in Brazil, such as re-asylum and the aforementioned neoliberal trends, are instituting forces that deconstruct already established social and labor guarantees. The emphasis on policies that weaken comprehensive mental healthcare limits professionals' exposure to innovative and human rights-based approaches and, therefore, preserves what already exists/is established in the service.

Regarding the limitations of the study, the low adherence and the turnover of participation in the meetings stand out, as these have made it impossible to advance in the depth and scope of collective analyzes. Despite this bias, it was possible to produce important reflections.

In this sense, in-service training based on Continuing Health Education is reiterated as a powerful space for collective learning through a critical-reflexive look, not only for practices, with the inclusion of new care approaches based on human rights[8], but also for looking at the world of work, with the opportunity to strengthen movements that create collective struggles for better working conditions.

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CONCLUSIONS

The reflections mobilized with professionals through in-service training in mental health reveal instituting forces that seek to transform the mental health institution. They were produced in the work scenario itself, as this is a space for self-analysis and collective reflection that can advance in new perspectives of care based on psychosocial care.

Learning through the world of work, from the perspective of in-service training based on Singular Therapeutic Project causes deterritorialization in the professional and is configured as an instituting movement in the production of transformation of asylum practices established in a process of institutionalization of mental health-psychosocial care. On the other hand, the precariousness of work, which hinders these movements of change and acts in favor of what is established, was identified.

In this sense, this study produced resonances and movements to change practices mobilized in the work scenario itself, as it is a space for self-analysis and collective reflection, and there may advances to new perspectives of care based on psychosocial care.

The participation of professionals from different areas, even if not regularly, is essential for the promotion and depth of discussions, and contributes to the construction of collective knowledge, which are powerful strategies for breaking power relations and crystallized and centralized knowledge in the biomedical-psychiatric model. Furthermore, collective training spaces make it possible to look at the world of work as a field of learning and awareness about working conditions, which can favor the collective struggle.

Conflicts of interest
None.

Author's contributions - CRediT
LAR: conceptualization; data curation; formal analysis; investigation; methodology; project administration; supervision; validation; visualization; writing – original draft and writing - review & editing.

CGW: conceptualization; formal analysis; investigation; supervision; validation; visualization; writing – original draft and writing - review & editing.
RLVS: investigation and writing - review & editing.

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