The complexity of precarious work in Territorial Psychosocial Care: critical reflection on the Brazilian context

A complexidade do trabalho precário na Atenção Psicossocial Territorial: reflexão crítica sobre o contexto brasileiro

Israel Coutinho Sampaio Lima[1], José Jackson Coelho Sampaio[1], Karlla Christine Araújo Souza[2]

DOI: 10.1590/0103-11042023136141

ABSTRACT This article proposes to understand, from the perspective of Complexity Theory, and through critical theoretical reflection, the precarization of work as a reality in the Brazilian public health work market, and its influence on the results of a public policy based on the theoretical/practical paradigm of Territorial Psychosocial Care. It outlines a possibility of problematizing the central theme, through the principles: systemic, hologrammatic, retroactive circle, recursive, autonomy/independence, dialogic, and the reintroduction of knowledge in all knowledge, proposed by Edgar Morin, in view of the discussions and studies carried out by the Life and Work Research Group on the precariousness of work and mental health in a concrete field. This reflection is intended to be a source of recognition for actors on the real causes of precariousness, which derive from the way in which health work is exploited, which is closely related to the application of neoliberal prescriptions in authoritarian bureaucratic states located on the periphery of dependent capitalism. The reflection allowed the understanding of the whole and the parts that constitute the problem, recognizing the real causes of precariousness, which blame mental health workers, in the face of unhealthy conditions, working hours, and insecurity about social rights and labor rights.

KEYWORDS Employment. Mental health services. Mental health.

RESUMO *Este artigo propõe compreender, na perspectiva da Teoria da Complexidade, e por meio da reflexão teórica crítica, a precarização do trabalho enquanto realidade no mercado brasileiro do trabalho público da saúde e sua influência nos resultados de uma política pública baseada no paradigma teórico/prático da Atenção Psicossocial Territorial. Traça uma possibilidade de problematização sobre o tema central, por meio dos princípios: sistêmico, hologramático, círculo retroativo, recursivo, autonomia/independência, dialógico e o da reintrodução do conhecimento em todo conhecimento, propostos por Edgar Morin, diante das discussões e dos estudos realizados pelo Grupo de Pesquisa Vida e Trabalho sobre a precarização do trabalho e a saúde mental em campo concreto. Essa reflexão propõe-se a ser fonte de reconhecimento para os atores, sobre as causas reais da precarização, que derivam do modo de exploração do trabalho em saúde em estreitamente próprio da aplicação do receituário neoliberal em estados burocráticos autoritários situados na periferia do capitalismo dependente. A reflexão permitiu a compreensão do todo e das partes que constituem o problema, reconhecendo as causas reais da precarização, ao contrário da culpabilização dos trabalhadores da saúde mental, diante das condições insalubres, da jornada de trabalho e da insegurança sobre os direitos sociais e direitos trabalhistas.*

PALAVRAS-CHAVE *Precarização do trabalho. Centros de Atenção Psicossocial. Saúde mental.*

[1] Universidade Estadual do Ceará (Uece) – Fortaleza (CE), Brasil.
isracoutinho@hotmail.com

[2] Universidade Estadual do Rio Grande do Norte (UERN) – Natal (RN), Brasil.

Introduction

The Epistemological Field of Territorial Psychosocial Care (APT) was built through the struggles of the Brazilian Psychiatric Reform Movement (MBRP), which is the political and social basis for the approval of Law No. 10,216, of April 6, 2001[1], which rules about the protection and rights of people living with some kind of mental suffering and/or disorder. This law promoted the redirection of the mental health care model for the production of humanized interdisciplinary work, the respect for the subjectivity and the valorization of the health worker[2].

The field emerges from the need for overcoming the classic psychiatric model of the time, hospital, which focused on the fight against the symptoms of mental illness, under the biological logic of the positivist cause-effect. In the trajectory of overcoming, this last model, in turn, sought to advance, in its time, the ways that care for mental illness was materialized between the late seventeenth and early nineteenth century, characterized by the asylum model, which It excluded from society those considered dangerous, incurable and contagious, through violence practiced by social isolation over those who did not fit the social models considered as ideals[3].

In this evolutionary, non-linear and non-homogeneous process, the APT has been promoting changes both in care and in the practice of work production, mainly due to the advances promoted in the progressive replacement of psychiatric hospitals by Psychosocial Care Centers (CAPS). Such services produce mental health care, through comprehensive and humanized care, considering the history and role of people living with mental disorders, in addition to recognizing their individuality and autonomy, as beings, in a living territory, in which the APT needs to be articulated with the other points of the social and health care network, in order to favor comprehensive and citizen care[4].

However, the worker, despite being considered one of the key elements for the implementation of the psychiatric reform, has been suffering from precarious working conditions in mental health. This situation makes the scenario, by itself, complex in view of the contradiction and duality of the development of the National Mental Health Policy, from the point of view of social and labor security[5] – in a crisis that deepens in the last five years, from the law No 13,467 of July 13, 2017[6], which incorporates the main trends of global flexible capitalism into public services, supported by a justifying theory called neoliberalism, which reduces the power of the State over the regulation and guarantee of labor rights[7].

These are actions that have a direct impact not only on the worker's health, but also on the individual and collective production of care provided to users by the entire Psychosocial Care Network (RAPS), especially among the services that grew the most numerically throughout the national territory, the CAPS, which stress the hospital-centered model in psychiatry[8].

It is in this complex configuration of the world, with oppositions, contradictions and non-linear shifts, that we intend to discuss a State policy, in the field of mental health, that values workers and that does not surrender to a productivist logic of capital over the production of the work, which, paradoxically, materializes the precariousness of work. At this juncture, the development of thinking and dialogue is a possibility, so that the theme is problematized and understood in relation to the real interests of the forces involved, aiming to face the alienation of beings in a disruptive real world[9-11].

The complexity of the world requires deep thought to understand it and that starts from the researcher's interpretation, on the systemic, hologramatic, retroactive circular, recursive circular, autonomic and dialogical principles[9-11] before the categories 'life', 'work', 'precariat', 'subjectivity', 'mental health', 'stress' and 'alienation'. These categories are problematized and studied by the Life and Work Research Group (GPVT), based at the

Humanization and Health Care Laboratory (LHUAS) at the State University of Ceará (UECE).

The research developed by the GPVT is guided by the problems arising from these themes, with the support of researchers from universities in Brazil, Argentina, Mexico and Spain. These social scientists bring to the group the dissemination of their productions, exchange of experiences and necessary discussions so that the understanding of psychosocial phenomena, which tend to affect life and work, is rethought from different angles.

This article proposes to understand, from the perspective of Complexity Theory, and through critical theoretical reflection, the precariousness of work as a reality in the Brazilian public health work market and its influence on the results of a public policy based on the theoretical/practical paradigm of APT.

Precarization of work, precarious work and the precariat

The understanding of the different ways of conceptualizing the precarization of work and/or precarious work, which will be problematized below, arises from the theorists debated at the GPVT. Moreover, the interpretation and understanding that we will make here are produced from the perspective of the construction of a complex thought, anchored in the systemic and hologramatic principles proposed by Morin[11], which makes such an interpretation unique.

Thinking initially according to the systemic principle, the individual crosses society and finds himself crossed, directly or indirectly, by it. There is, therefore, continuous interconnection, interdetermination and interdependence, in which forces that influence and are influenced by other systems coexist. In this logic, the systemic idea is opposed to the reductionist alternatives that seek to understand the whole as a simple sum of the parts, disregarding the inter and the trans.

By the hologramatic principle, the strength of evidence of each unit is perceived, since both biological organisms and societies can be represented by their constituent parts, whether by genetic information, languages, norms and rites[9,11]. As a theoretical perspective, the determination of a problem can be represented outside the place in which the problem is expressed.

From this perspective, the precariousness of work does not constitute a pre-established and homogeneous concept, which allows the representation of the constituent parts of the whole. What we have is a great diversification in the face of the heterogeneity of the parts that constitute it, in the concrete political, social and cultural fields, crossed by contradictions and overlaps, which influence the configurations on how societies organize themselves, in face of perspectives on democracy, social rights and labor rights, fundamental for identifying and understanding the problem.

In the western world, although in a peripheral position, therefore, more vulnerable, Brazil has shared, since the 1970s, an international capital, political, social and economic crisis, characterized in the specific world of work by part-time hiring, without social benefits, with low wages, in addition to informality, in which occupational risks are assumed by the worker, and not by the employer or the public authorities. Workers, atomized, depoliticized, find themselves on their own, facing oligopolistic capital, financialized and stateless[12,13].

In Brazil, since the 1950s, the implantation of Fordism, in a heterogeneous and truncated way, despite protecting some more advanced sectors, created a chain of precarious working conditions, represented by salary insecurity, occupational insecurity, lack of professional qualification and housing insecurity. The new work logics were restricted to large urban centers, in the midst of the absence of labor rights, in face of a rural society that migrated

to the metropolis in search of better living conditions – with the precarization of work, effectively precarious work, experienced by large fraction of the working class, despite the great conquests of rights that took place under the sign of Fordism[14].

In the 21st century, the precarization of work in Brazil began to be related to the outsourcing of work promoted by Law No 13,467/2017[6], which expands the possibility of the existence of outsourced work with precarious and provisional contracts, with low salary standards, formerly restricted to private companies, now heavily incorporated into public institutions. This starts to affect higher and technical level workers, mainly in health services, such as doctors, nurses, dentists, psychologists, occupational therapists, nutritionists and nursing technicians[15].

In this same context, Casulo[16] expands the concept of precarization of work, adding the term flexible or flexibility to the form of hiring, involving vulnerable contracts, remuneration and convertible working hours, from the point of view of management idealized as the Toyota Production System; based on the neoliberal production of capital for the entire working class, regardless of the level of education and qualification, now in a just-in-time and work office way of life.

It is about this new way of working life that the precarization of work – the one which became like this – and the precarious work – the one which already is like this – will involve and affect the professional identity psychosocially, due to the absence of a career and the constitution of a social memory, belonging to an occupational class, wrapped in stable practices, under ethical aspects of behavior, reciprocity and fraternity[17].

Despite the precarization of work involving heterogeneous characteristics, within a class or social group, the precariat, a set of people under precarious conditions, is still being formed, without a constructed identity. It is understood that these professionals share yearnings, which could be the defining league of this new class, or subclass, as precarization affects all professionals, regardless of qualification, type of work performed and type of employment relationship[8].

Beyond the chronological period, the precariousness of work has become a standard on the mode of labor production, in which each characteristic is interconnected, producing a new evolutionary and retrograde form on the alienated conditions of work, characteristic of a concrete productive logic. It does not seem possible to separate past characteristics, from the present and from a possible future, due to the indeterminacy of the phenomenon discussed. Labor policies tend to create interconnected systems around the world or part of it, in a course of alienation production that involves self-destruction and the recreation of production and reproduction of work, with old precepts, however, in a heterogeneous and non-linear way, reducing the power of mass organizations.

Therefore, the precarization of work is projected as a general condition, in its inequality, and constant, in its non-linearity, forming a constituent part of the working social classes, regardless of the educational level, which are under painful working conditions, with bonds of flexible and/or temporary work, regulated or not by law.

Construction and reconstruction of Territorial Psychosocial Care

The reflection proposed by this topic is based on Morin's[11] inferences about the principles of the recursive circle and autonomy/independence. They require the necessary clarity so that the construction and reconstruction of past and present facts can be contextualized from a dynamic and broad point of view, considering the scenarios, situations and actors involved in the process.

At this stage of the discussion, we propose to return to the facts through the continuous and productive process about the intrinsic product-producer relationship, in which the actions and effects of an event feed back into the production of phenomena, in a chain of historical links by the State that is an actor of public policies and the society to which these policies are intended, for example, in Brazil, the construction of the Unified Health System (SUS) and the Psychiatric Reform, a consequence of three key movements: redemocratization after military dictatorship, and health reform and anti-asylum struggle.

The principle of the recursive circle breaks with the notion of regulation of self-production and self-regulation, as both the action and the process and product, whether single or multiple, are necessary for their own determination and production[10,11].

Autonomy and independence express the capacity that organizations, structures and society have to organize themselves, depending, therefore, on their needs in relation to the geographic, cultural and political-economic environment in which they are inserted. Hence, autonomy, or the degree of autonomy, is constructed in relation to the characteristics of each culture and physical environment; therefore, each society or each individual is self-organizing, continually producing itself, depending on many other systems, such as, for example, the environment[11].

Thus, the new places proposed by the APT, built over the last three decades, due to the MBRP, in a political proposal that has been developed since the 1970s, were only possible due to the support, fortification and impetus given by the remodeling of the public health policies, promoted from the struggle of the Brazilian Movement for Sanitary Reform (MBRS) and the country's redemocratization process, triggers of a new social conscience that involves democracy, humanization, social inclusion, collective, collaborative, multidisciplinary and interdisciplinary work , with intersectoral participatory planning[18].

This course of change, arising from popular aspirations and community-based social movements, had strong support from trade unions, higher education institutions and a portion of the progressive political class; resulted in the inclusion of its own section in the Brazilian Constitution of 1988, the approval of the Organic Health Law (LOS), No 8,080 and 8,142, both from 1990, and the creation of the SUS[19], effectively implemented in 1992, after due inclusion in the Budgetary Law of the Union (LOU) approved in 1991. By holding municipal, state and national conferences, it was possible to hold the National Mental Health Conferences (CNSM), the first of which took place in 1987, as a result of indication of the VIII National Health Conference (CNS), held in 1986 – in addition to the discussion of collegiate spaces for the promotion of mental health care, which broke with the asylum model and the classic hospital psychiatric model: the first, centered on the exclusion and full protection of the 'crazy'; the second, centered on the disease, on assistance, on combating symptoms, based on the biological positivist view[3].

In constant opposition, the APT model, built from the MBRP and implemented nationally until the present day, has been expanding the concepts of health, mental health and integral health, facing the nosological and fragmented view of the parts that constitute the whole, in this case, the individual and the individual/environment/individual relationship, in addition to the utopia about understanding health as the absence of disease and complete biopsychosocial well-being. This paradigm is built from a political, historical, socioeconomic and cultural perspective, which cannot be reduced, given the possible isolated understandings of the mental illness phenomenon, given the complexity of health-disease processes in the midst of the territory of production of care in a network[3,20].

It was in the clashes promoted in collegiate spaces, between conservative and progressive forces, that Law No. 10,216/2001[1] emerged as a new milestone for the MBRP, being, therefore,

an achievement for the collectivities. It incorporates, in its precepts, the recognition of the characteristics and social needs in the face of the particularities of the subjects and the territory in which they live, resulting in the redirection of the assistance model of that time, to the APT model, intercentered in the subject, in the family, in the caregiver, in the community, in the production of collective and creative work, in a given territory, where these relationships and experiences originate, reinvent themselves and adapt, in a new proposition of health services, now focused on psychosocial care, in a living territory.

In this new political and social context, the first CAPS were created and disseminated throughout Brazil, managing to bring mental health care to municipalities with small populations, with up to 20,000 inhabitants, through Ordinance No. 336, of February 19, 2002[21]. Such services began to gain prominence in the process of rebuilding mental health care, ahead of the progressive replacement of psychiatric hospitals throughout the national territory. Services are now organized by population size, characteristics of users and territory, being classified into CAPS I, CAPS II, CAPS III, CAPSi (children and teenagers) and CAPS ad (alcohol and other drugs). It was due to its success and its approximation with the territories that Ordinance No. 3088, of December 23, 2011, began to understand them as points of articulation of a network, the RAPS[22].

In this way, a set of mental health actions is carried out in the SUS, whose central objectives seek to expand access to the APT, through the articulation of primary, secondary and tertiary health services, in addition to intersectionality with the other devices existing in the territory. Furthermore, new spaces are opened for the production of mental health, with reflections on management, work and care, among other thematic groups[3,18,23].

The success of CAPS implementation can be scaled by expansion in numerical terms. The Ministry of Health (MS) reports that the number of CAPS was 148 in 1998, rising to 2,209 in 2014[24], and 2,661 in 2019[25]. Coverage was 0.21 services per 100,000 inhabitants in 2002, rising to 0.86 in 2014[25]. However, in 2017, the directions of the National Mental Health Policy (PNSM) changed in the face of an agenda implemented by the federal government, which published Resolution No. 32, favoring and expanding financing – through SUS – of private psychiatric hospitals, in opposition to the republican reformist precepts of the APT, paralyzing the creation of new CAPS.

Currently, despite the advances achieved by the MBRP, which sensitized several federal governments during redemocratization to discuss the social place of mental disorders and work in the collective field of mental health, these themes have gradually been left out of the governmental agenda: the classic psychiatric hospital model was resumed in practice and norms; the individual pharmaco-biological treatments were increased; and funding for private services was revalued.

It is demonstrated, therefore, that the process of change suffered negative inflections that challenge the full implementation of the epistemological field of the APT, precisely because of the way in which CAPS users, family members and caregivers, workers and mental health managers 'adapted or conformed' to with the improvements achieved in a process of self-organization of divergent groups of interests, starting to live with the political-budget limitations of CAPS's lack of funding imposed by the federal government since at least 2016.

This contradictory, dual and ambiguous relationship makes the socio-political context of the APT confusing and conflicting in the face of the principles of the SUS and the very proposal of this model of care. They are intertwined currents that remain in constant tension in the face of what is desired as a social and labor policy, in the face of the neoliberal management model that is being implemented with greater force in public administration every day, disguised as an opportunity or new possibilities for work in this area. Moreover,

there is a necessary relationship for its condition of existence, causation and production, as the models coexist in crisis, advances and resistance, the one from APT and the one of the setback, through the precariousness of the RAPS and the SUS.

Precarization of work in Territorial Psychosocial Care: where are we?

In a retroactive, dialogic process, reintroducing each piece of knowledge into all knowledge, in which the effects of an event are continuously reverberated, it can be said that the current conditions of the precarization of work in the APT have been taking shape since the implementation of the SUS. It was affected by reactionary forces, exponentially reinforced from 2016, including in parallel the principles of neoliberalism, on supply and public-private partnerships for the constitution of the health network, as the health reform did not completely bend in face of the strong imposition of businessmen to make the health network completely private, which would express the full realization of capitalism in health.

Theoretical elements of life and work in mental health, which we discuss from Morin[10,11], put as the principle of the retroactive circle – which seeks to break with linear causality – that there will always be a cause-effect, unidirectional, allowing knowledge of the opposite and non-linear relationship, in which it is possible to reflect on the various retroactive processes of individuals/organizations/organizations/individuals.

As the process of changing paradigms in mental health is complex by itself, due to stigmas, in historical, social and political moments – moments that are always heterogeneous – the dialogical principle seeks to highlight the antagonism of ideas, situations, environments and/or characteristics that are, at the same time, interdependent, excluding and/or complementary. The dialogic seeks to highlight the difficulties and antagonism between phenomena, as they are fundamental parts for the whole to be understood, through the inseparability of what is complementary, thus distancing itself from what is dual, dubious or that can make thinking confusing[11].

Therefore, the reintroduction of knowledge in all knowledge is necessary through the construction and reconstruction of facts, contexts, phenomena, from the different forms, means, situations or subjects involved in the process. Thus, the observer must remain aware of his place in the historical development and of the anthroposocial particularities that constitute it, so that he can recognize other ways of seeing and understanding the phenomena, in a process of restoration of the being that is unaware of the particularities and interactions of that place.

Based on the aforementioned perspectives, the privatist logic in health has been subverting and gaining strength over public rationality, despite the former recognizing the need for the existence of the SUS for its own existence, considering the socioeconomic conditions of the Brazilian population. In this parasitic relationship, the entry of private entities in the management of the health network gains space and strength, which introduce new forms of work management in view of the way workers are hired and controlled. This relationship has made work precarious in several SUS services, including the CAPS[5].

This interface is built and solidified from the privatist point of view of the slowness of hiring via public tenders and the poor management of the SUS, which directly impacts human resource costs according to the limits established by the Fiscal Responsibility Law No. 101, of May 4, 2020, thus making it necessary to incorporate outsourcing and flexibility of employment contracts throughout the SUS5 network.

The expansion of outsourcing and temporary contracts by state services shows a new form of precarization of work, in which

private companies, Social Organizations (OS) and the State seek to reduce labor costs, by lowering wages, increasing working hours and the intensity of work. Thus, workers become totally hostages of the capital due to the fragile employment bond, with the use value of work totally dominated by the exchange value[16,17,26,27].

The path of precarious work has been legitimized since 2017, from the reform of the Brazilian State apparatus, which occurred through Law nº 13.467/2017[6], which incorporates in public services the main trends of global flexible capitalism, which reduces the power of the State on the regulation and guarantee of workers' rights. Thus, the labor reform, implemented by President Michel Temer, sharply affected the Consolidation of Labor Laws (CLT), deepening the logic of exploitation of flexible work[7].

Neoliberal policies have turned against the stable form of employment relationships due to the strength that this group has in relation to the organization of their peers, in a possible confrontation with their employers, in the search for guarantees and improvement of the aspects that value work; in the same way that the guarantee of the bond accompanies the right of representation of the whole by a leadership, which has the right to voice in favor of the valorization of its category or professional community[7,16,17].

This fact acts directly on the work of the public service, generally unknown by the population, affecting the performance of the servants due to the neglect of the work infrastructure, segmentation of activities, ambiguous management models, conflicts of interest, lack of plans for positions, careers and wages that equalize income, promotions, appointments or dismissals – in addition to disagreements between the extension of labor ties and the demands of individual and collective therapeutic projects[26,27].

Despite the manifestation of the feeling and sensation of abandonment, instrumentality of the practice and universalization of alienation, by the workers[17], what is observed is the existence of a collective anomie, paralyzing the MBRP, in the face of the precarious conditions of work, by the very naturalization and conformism of the phenomenon as necessary for the existence of employment and the minimum conditions of existence, probably associated with the privilege of not being excluded by the labor market, compared to another portion of workers, especially in a moment of political and economic crisis that Brazil currently is[28].

However, this is antagonistic to the principles of MBRP and APT, which seek to redirect care practices towards humanized, interdisciplinary care, from the point of view of collegiate management in collective spaces, which value workers, users and mental health managers. However, this conflict is perceived only on the effects of the cause, given the insufficient number of professionals[5], attention centered on individualistic and medicalizing therapies[18], work overload[29], absence of collegiate spaces[27], several employment relationships in the same team[26], unhealthy conditions and inadequacy of the physical space of the CAPS[30].

In this way, CAPS workers become subject and take upon themselves the effects of the neoliberal privatist cause incorporated in the management of such services, assuming a profile of re-signification of the blame for such problems in the face of an exclusive and particular responsibility associated with the team, using the understanding o the cause/effect and effect/cause relationships, through the process of alienation that involves blaming oneself and the team for failures and precarious working conditions arising from the shattered public policy.

Final considerations

As a point of understanding, it can be inferred that the recognition of how the phenomenon of precarious work has been constituted takes place in force fields that interinfluence each

other, in which their representation is diverse, especially in the concrete political, social and cultural fields. The contradiction about the guarantee or loss regulated by law of social rights and labor rights is an observed and real fact, inherent to the process of alienation promoted by the economic and political system. In this sense, it is fundamental to problematize the precariousness of work, through the consideration of the multifactorial nature of the representations of inequalities, in its different modes of production, alienation and affectation in the face of the existing complexity that the work in mental health is in a given historical range.

Despite the advances achieved by the MBRP, the political situation appears to be unfavorable to the reformist and progressive process, due to the forceful implementation of an extreme right-wing government agenda, which privileges the classic psychiatric model, with emphasis on individual pharmaco-biological treatments and the revaluation on financing private services as opposed to CAPS.

Reflection on the theme-problem can be carried out in a way that considers the principles: systemic, hologramatic, retroactive circle, recursive, autonomy/independence, dialogic and the reintroduction of knowledge in all knowledge, resulting from a complex and critical look, or in other ways that promote understanding of the whole and of the parts that constitute it in interdependence and interdetermination.

Such discursive possibility will allow the present facts in the timeline to be reflected and debated collectively, in attempts that promote the resumption of the social-labor struggles, proposed by the MBRS and by the MBRP, in the dynamics resulting from the SUS and the APT, so that the processes of alienation that blame mental health workers, given the unhealthy conditions, the extended/intensified workday and the insecurity about social rights and labor rights, in their various forms, can be broken. This can benefit key actors that are the source of recognition of the real causes of precarization, which derive from the mode of exploitation of health work that is closely related to the application of neoliberal prescriptions in authoritarian bureaucratic states located on the periphery of dependent capitalism.

Collaborators

Lima ICS (0000-0002-1929-6142)* contributed to the elaboration, conception and design of the work; and acquisition, analysis of information for it. Sampaio JJC (0000-0003-4364-524X)* contributed to the design of the work, critically reviewing it for important intellectual content and final approval of the version to be published. Souza KCA (0000-0002-3992-2163)* contributed to critically revise it for important intellectual content. ■

*Orcid (Open Researcher and Contributor ID).

References

1. Brasil. Lei nº 10.216, de 6 de abril de 2001. Dispõe sobre a proteção e os direitos das pessoas portadoras de transtornos mentais e redireciona o modelo assistencial em saúde mental. Diário Oficial da União. 6 Abr 2001. [acesso em 2020 out 10]. Disponível em: http://www.planalto.gov.br/ccivil_03/leis/leis_2001/l10216.htm.

2. Aboud-Yd M. Por uma clínica antimanicomial: a ousadia de um projeto. In: Campos FB, Lancetti A, organizadores. Saúde Loucura: experiências da Reforma Psiquiátrica. São Paulo: Editora Hucitec; 2010. p. 91-100.

3. Nunes JMS, Guimaraes JMX, Sampaio JJC. A produção do cuidado em saúde mental: avanços e desafios à implantação do modelo de atenção psicossocial territorial. Physis. 2016 [acesso em 2020 nov 2]; 26(4):1213-32. Disponível em: http://www.scielo.br/scielo.php?script=sci_arttext&pid=S010373312016000401213&lng=en&nrm=is.

4. Bleicher T, Sampaio JJC, Gomes VB. O auxiliar em saúde mental: da concepção à prática do serviço. Trab educ saúde. 2015 [acesso em 2022 jun 21]; 13(supl1):61-76. Disponível em: https://doi.org/10.1590/1981-7746-sip00043.

5. Barros ACF, Bernardo MH. A lógica neoliberal na saúde pública e suas repercussões para a saúde mental de trabalhadores de CAPS. Rev Psicol UNESP. 2017 [acesso em 2020 nov 2]; 16(1):60-74. Disponível em: https://seer.assis.unesp.br/index.php/psicologia/article/view/845/826.

6. Brasil. Lei nº 13.467, de 13 de julho de 2017. Altera a Consolidação das Leis do Trabalho (CLT), aprovada pelo Decreto-Lei nº 5.452, de 1º de maio de 1943, e as Leis n º 6.019, de 3 de janeiro de 1974, 8.036, de 11 de maio de 1990, e 8.212, de 24 de julho de 1991, a fim de adequar a legislação às novas relações de trabalho. Diário Oficial da União. 13 Jul 2017. [acesso em 2020 out 10]. Disponível em: http://www.planalto.gov.br/ccivil_03/_ato2015-2018/2017/lei/l13467.htm.

7. Alves G. A nova precariedade salarial e o sociometabolismo do trabalho no século XXI; Reforma trabalhista: a nova ofensiva neoliberal no Brasil. In: Casulo AC, Silveira C, Alves G, et al. organizadores. Precarização do trabalho e saúde mental: o Brasil da era neoliberal. Bauru: Canal 6; 2018. p. 14-62.

8. Araújo-dos-Santos T, Nunes DO, Pereira RB, et al. Associação entre variáveis relacionadas à precarização e afastamento do trabalho no campo da enfermagem. Ciênc. saúde coletiva. 2020 [acesso em 2020 nov 2]; 25(1):123-33. Disponível em: https://www.scielo.br/j/csc/a/S89Xqvmcdg3rP7gGz7BKqfD/?lang=pt.

9. Morin E. A cabeça bem-feita: repensar a reforma e reformar o pensamento. 20. ed. Rio de Janeiro: Bertrand Brasil; 2000.

10. Morin E. Ciência com consciência. 6. ed. Rio de Janeiro: Bertrand Brasil; 2002.

11. Morin E. Introdução ao pensamento complexo. 5. ed. Porto Alegre: Sulina; 2015.

12. Kalleberg AL. O crescimento do trabalho precário: um desafio global. Rev bras ciênc soc. 2009 [acesso em 2022 jun 21]; 24(69):21-30. Disponível em: https://doi.org/10.1590/S0102-69092009000100002.

13. Fink L. The First Precariat? Int Labor Work Class Hist. 2017 [acesso em 2022 jun 21]; 91:99-108. Disponível em: https://doi.org/10.1017/S014754791600034X.

14. Braga R. A política do precariado: do populismo à hegemonia lulista. São Paulo: Boi Tempo; 2012.

15. Druck G, Dutra R, Silva SC. A contrarreforma neoliberal e a terceirização: a precarização como regra. Cad CRH. 2019 [acesso em 2022 jun

21]; 32(86):289-306. Disponível em: https://doi.org/10.9771/ccrh.v32i86.30518.

16. Casulo AC. O Brasil e a nova ordem neoliberal: impactos na saúde mental da classe trabalhadora. In: Casulo AC, Silveira C, Alves G, et al. organizadores. Precarização do trabalho e saúde mental: o Brasil da era neoliberal. Bauru: Canal 6; 2018. p. 63-81.

17. Standing G. O precariado: a nova classe perigosa. 1. ed. Belo Horizonte: Autêntica Editora; 2019.

18. Amarante P, Nunes MO. A reforma psiquiátrica no SUS e a luta por uma sociedade sem manicômios. Ciênc. saúde coletiva. 2018 [acesso em 2022 jun 21]; 23(6):2067-74. Disponível em: https://doi.org/10.1590/1413-81232018236.07082018.

19. Brasil. Lei nº 8.080, de 19 de setembro de 1990. Dispõe sobre as condições para a promoção, proteção e recuperação da saúde, a organização e o funcionamento dos serviços correspondentes e dá outras providências. Diário Oficial da União. 19 Set 1990. [acesso em 2020 out 2]. Disponível em: http://www.planalto.gov.br/ccivil_03/leis/l8080.htm.

20. Sampaio JJC, Guimarães JMX, Abreu LM. Supervisão clínico-institucional e a organização da atenção psicossocial no Ceará. 2. ed. Fortaleza: EdUECE; 2019.

21. Brasil. Ministério da Saúde. Portaria/GM nº 336, de 19 de fevereiro de 2002. Dispõe sobre a proteção e os direitos das pessoas portadoras de transtornos mentais e redireciona o modelo assistencial em saúde mental. Diário Oficial da União. 19 Fev 2002. [acesso em 2020 out 10]. Disponível em: https://bvsms.saude.gov.br/bvs/saudelegis/gm/2002/prt0336_19_02_2002.html.

22. Brasil. Ministério da Saúde. Portaria 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 (SUS). Diário Oficial da União. 23 Dez 2011. [acesso em 2020 nov 10]. Disponível em: http://bvsms.saude.gov.br/bvs/saudelegis/gm/2011/prt3088_23_12_2011_rep.html.

23. Moreira MIB, Onocko-Campos RT. Ações de saúde mental na rede de atenção psicossocial pela perspectiva dos usuários. Saude soc. 2017 [acesso em 2020 nov 2]; 26(2):462-74. Disponível em: https://www.scielo.br/j/sausoc/a/PkZqTgktdvt6R4wJT6PqTqR/abstract/?lang=pt.

24. Brasil. Ministério da Saúde. Coordenação Geral de Saúde Mental, Álcool e Outras Drogas. Saúde Mental em Dados 12, Ano 10, nº 12. 2015 out. [acesso em 2020 nov 10]. Disponível em: https://www.mhinnovation.net/sites/default/files/downloads/innovation/reports/Report_12-edicao-do-Saude-Mental-em-Dados.pdf.

25. Oliveira T, Boldrini TV. Atenção psicossocial: Investimento em Saúde Mental cresceu quase 200%. Brasil. Ministério da Saúde. 2020 jan 9. [acesso em 2020 nov 10]. Disponível em: https://www.gov.br/pt-br/noticias/saude-e-vigilanciasanitaria/2020/01/investimento-em-saude-mental-cresceu-quase-200.

26. Campos GWS. O SUS entre a tradição dos Sistemas Nacionais e o modo liberal-privado para organizar o cuidado à saúde. Ciênc. saúde coletiva. 2007 [acesso 2022 abr 20]; 12(supl):1865-74. Disponível em: https://doi.org/10.1590/S1413-81232007000700009.

27. Campos AG. Efeitos da Terceirização sobre a saúde e segurança no trabalho: estimativas com base nos afastamentos. In: Campos AG, organizador. Terceirização do trabalho no Brasil: novas e distintas perspectivas para o debate. Brasília, DF: Ipea; 2018. p. 187-203.

28. Lee CK. Precarization or Empowerment: reflections on recent labor unrest in China. J. Asian

Studies. 2016 [acesso 2022 abr 20]; 75(2):317-33. Disponível em: https://repository.ust.hk/ir/Record/1783.1-99464.

29. Clementino FS, Miranda FAN, Martiniano CS, et al. Avaliação da satisfação e sobrecarga de trabalho dos trabalhadores dos Centros de Atenção Psicossocial. Rev Fund Care Online. 2018 [acesso 2022 abr 20]; 10(1):153-9. Disponível em: https://www.researchgate.net/publication/322364513_Avaliacao_da_satisfacao_e_sobrecarga_de_trabalho_dos_trabalhadores_dos_Centros_de_Atencao_Psicossocial.

30. Lima ICS, Nascimento CEM, Brandão CB, et al. Precarious work in health and mental suffering in Brazil within the context of COVID-19. Research, Soc. Develop. 2021 [acesso 2022 mar 30]; 10(4):e27510414141. Disponível em: https://rsd-journal.org/index.php/rsd/article/view/14141.

Received on 06/27/2022
Approved on 12/20/2022
Conflict of interests: non-existent
Financial support: non-existent