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Formação e trabalho coletivo na Saúde Mental: Intersetorialidade e Sinergia

Training collective and work in Mental Health: Intersetoriality and Synergy

Formación y trabajo colectivo en la Salud Mental: Intersectorialidad y Sinergia

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RESUMO: O artigo apoia-se em bibliografia sobre o tema, na experiência docente no Ensino Superior e na produção discente de Trabalhos de Conclusão de Curso de Serviço Social da UFPI sobre o campo da Saúde Mental nos anos 1991-2016. O estudo analisa a questão da formação nesse campo de saber e de intervenção, considerando os aspectos inerentes ao trabalho na Saúde Mental, o arcabouço legal do Sistema Único de Saúde (SUS) relativo à produção do cuidado à pessoa com transtorno mental, as interfaces com as diversas políticas sociais indispensáveis à defesa da vida num espaço de trabalho, necessariamente coletivo, que precisa ser sinérgico. A experiência de vida dessa população tende a ser profundamente marcada pela desigualdade no acesso aos bens materiais, culturais e ao cuidado com a vida. A discussão é apresentada em três partes, no primeiro momento, discutimos os marcos conceituais e legais presentes na história recente desta Política no Brasil e em Teresina. Em seguida, confrontam-se as análises da produção dos formandos sobre esse campo de saber. Por último, destacam-se as narrativas na sua relação com os dispositivos de cuidado e as políticas sociais existentes no decorrer do tempo, visando discutir como o processo de compreensão do território, das políticas sociais e dos horizontes do cuidado destes dispositivos comunitários substitutivos ao hospital psiquiátrico, pode impactar e retroalimentar o processo de formação, abrindo espaço para uma compreensão ampliada do valor do trabalho coletivo em consonância com as necessidades de saúde e com as necessidades sociais desta população.
Palavras-chave: Saúde Mental, Formação e práticas de saúde, Rede de atenção, Serviço Social. Saúde Pública.

ABSTRACT: This paper analyses the production of undergraduate theses on the field of Mental Health from the Social Service Course of the Federal University of Piauí (UFPI) during the years 1991-2016, having as background the historical timeline of the evolution of Care in Mental Health in Brazil and the State of Piauí. We investigate the training and intervention, considering the inherent aspects of work in Mental Health, the legal framework of the Unified System of Health

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(SUS) related to the production of care for the person with mental disorder, the interfaces with the various social policies indispensable for the defense of life in a collective work space, which must be synergistic. The life experience of this population tends to be marked by inequality in access to the material, cultural goods and care of life. The present discussion is organized into three main sections: at the first moment, it is discussed the conceptual and legal landmarks present in the recent history of this policy in Brazil and Teresina city. Then, we analyzed the bibliography production of the undergraduates in this field of knowledge. And, finally, we discuss the relationship of the narratives with the care devices and social policies existing over time. In this last part we aim to discuss how the process of understanding the territory, social policies and, horizons of care of the community devices that replace the psychiatric hospitals, can impact and feedback the training process, opening space for an expanded understanding of the value of collective work in line with the health and social needs of population with mental health disorder.
Keywords: Mental Health, Health training and practices, Social Service, Public Health.

RESUMEN: El artículo se apoya en bibliografía sobre el tema, en la experiencia docente de enseñanza superior y en la producción discente de trabajos de conclusión del curso en servicio social de la UFPI sobre el campo de la salud mental entre los años 1991-2016. El estudio analiza la cuestión de la formación en ese campo del saber y de intervención, considerando los aspectos inherentes al trabajo en la salud mental, el marco legal del Sistema Único de Salud (SUS) relativo a la producción del cuidado de la persona con trastorno mental, las interfaces con las diversas políticas sociales indispensables a la defensa de la vida en un espacio de trabajo, necesariamente colectivo que precisa ser sinérgico. La experiencia de vida de esa población tiende a ser profundamente marcada por la desigualdad en el acceso a los bienes materiales, culturales y al cuidado con la vida. La discusión es presentada en tres partes. En la primera parte discutimos los marcos conceptuales y legales presentes en la historia reciente de esta política en Brasil y en Teresina. En segundo lugar, se contrastaron los análisis producidos por los estudiantes en ese campo del saber. Por último, se destacaron las narrativas en su relación con los dispositivos de cuidado y las políticas sociales existentes con el transcurso delt tiempo, buscando discutir cómo el proceso de comprensión del territorio, de las políticas sociales y de los horizontes del cuidado de estos dispositivos comunitarios substitutivos al hospital psiquiátrico, pueden impactar y retroalimentar el proceso de formación abriendo espacio para una comprensión amplia del valor del trabajo colectivo en consonancia con las necesidades de salud y con las necesidades sociales de esta población.
Palabras-clave: Salud Mental, Formación y prácticas de salud, Red de atención, Servicio Social, Salud Pública.

INTRODUCTION

Mental Health work has the challenge of becoming a space of collective care, sensitive and decisive. The professionals are challenged to construct a way of working which is based on their respective occupations, marked by their ways of acting and intervening in social reality driven by the own corpus of knowing, but, at the same time, they need to build a relationships of belonging taking into account the multiple interfaces that unite and separate the various professions in Mental Health care. The professionals who work with mental health have it as a privileged locus of attention to the health and life of the other, focusing on the social determinants of the health-disease process understood by the Unified Health System of the Country and the "existence-suffering" by mental health.

Ceccim and Feurwerker[1] affirm the inseparable character present in the dimension of teaching, management, attention and social control in their analysis of what the authors denominate as the quadrilateral of formation for the health area. The authors extend the educational project to the technical-scientific domain of the profession and the structuring aspects of relationships and practices in all components of social interest or relevance, contributing to: i) raising the quality of the population's health with regard to the epidemiological aspects of the health-disease process; ii) the organization of sectoral management; iii) the structuring of health care, based on the challenge of the public management of the health sector, of ordering training policies, as foreseen by the Brazilian National Constitution; iv) and, include actions that strengthen the dimension of social control in health1.

According to Ceccim, Feuerwerker and, Sena[1-2], the training of professionals of health and the Institutions have been kept oblivious to the needs of the organization of sectoral management, structuring of care systems and social control required by the Brazilian health model. In the perspective of a shift in the paradigm from institutionalization to deinstitutionalization[3-7], which took place in several countries beginning in the 1960s, and in Brazil in the 1990s, the Mental Health care should be [re]thought in the various scenarios where it takes place, including the universities. Strengthening the process of deinstitutionalization presupposes, among other aspects[6]: 1) the reformulation of the user-professional and user-institution therapeutic relationship, 2) understanding that the mental disorder has an interdisciplinary character and should not be reduced to the treatment with a single professional, 3) reconstitute the complexity of life (or of existence) marked by the diagnosis of mental disorder and taking into account the stigma that historically surrounded this segment. Therefore, care is considered a central element to transform the way of living and feel the suffering of a mentally disordered person and his family in their daily lives. The change of paradigm requires and implies that the practices of mental health in field should construct the citizenship of the person with mental disorder, "proposing the collective construction of the subject of the madness, no longer as an alienated subject, but as a protagonist, that is, a new social relation with the madness"[6].

This paper has the proposal to know the historical production of undergraduate theses of the bachelor's degree in Social Service of the Federal University of Piauí, Brazil, in the Field of Social Security during the period of 1981-2017. We made a special time cut, from the years 1991-2016, that emphasize the field of Mental Health. We aim to understand the nature of this production over time and its articulation with the process of training professionals of Social Service given the changes in the Mental Health care. This work is a result of the conceptual deepening of the research Project "Social Service, dynamics of training and memory of the production of undergraduate thesis Social Service Course of the UFPI in the period 1981-2016: Emphasis on Social Security"[4] .

MENTAL HEALTH IN BRAZIL: SOME CONSIDERATIONS

The Psychiatric Reform, following the approach of Amarante, constitutes a "historical process of critical and practical formulation, whose objective and strategies are the questioning and elaboration of proposals for the transformation of the classical model and the paradigm of Psychiatry"[5]. The Psychiatric Reform arises at the heart of the Sanitary Reform but focus on civil rights and the caring for freedom.

The process of deinstitutionalization is not only the closure of hospices but transforming the set of scientific apparatuses, legislation, culture and power relations. In the opinion of Amarante[5], the sanitary trajectory led to the perspective of deinstitutionalization. At the Second National Congress of Mental Health Workers, with the motto "For a Society without Mental Hospitals", a new Mental Health project for the country starts, needing innovative ways of dealing with madness, including involving people and the community.

> [...] the question of **madness** and **psychic suffering** ceases to be exclusive to doctors, administrators and technicians of Mental Health to **reach out the cities**, **institutions** and **citizens' lives**, especially those who experience them in their lives[5] (our highlights).

The first actions towards the Psychiatric Reform in Brazil arose by influences of the international context with the articulation to supersede the asylum violence. Italy, with the model called Democratic Psychiatry, exerted a great influence for the Psychiatric Reform Movement in Brazil. This model of criticism of traditional psychiatry had in Basaglia the main idealizer and supported the notion of deinstitutionalization as a "process that must be carried out not only in the psychiatric hospital [...] but also in the set of knowledge and practices operated under the title Psychiatry[4].

Motivated by this logic, the Brazilian Psychiatric Reform Movement gains support from social movements like the Movement of Workers in Mental Health (Movimento dos Trabalhadores em Saúde Menta - MTSM) in 1978. This movement was considered an actor and a fundamental political subject in the struggles of the Brazilian Psychiatric Reform.[7]

The Health Reform brought important changes in the Brazilian national scenario playing a significant role in the process of Psychiatric Reform, since it enabled to create legal devices to break paradigms with the existing Psychiatric Model. Bravo states that "the constitutional text, with respect to health, after various political agreements and popular pressure, largely meets the demands of the Sanitary Movement,"[8] and the Federal Law No 8,080[9] of September 19, 1990, basing the structuring of the Unified Health System (Sistema Único de Saúde – SUS).

In the 1990s, we have "a new dynamism of the Psychiatric Reform Movement, especially by the legislative debate for the Bill No. 3,657 / 89"[10]. The financing of community services

associated with a policy of caring for freedom and the reduction of asylum beds required from the State response to a significant number of people who were previously circumscribed to the space of psychiatric hospitals and now needed a quality, humane and citizen care.

From the new frameworks of care in Mental Health, the Administrative Rule GM 224/1992[11] established the guidelines for: i) the organization of services based on the principles of universality, hierarchy, regionalization and, integrality of actions; ii) diversity of therapeutic methods and techniques at the various levels of care complexity; iii) ensuring continuity of care at the various levels; iv) multiprofessionality of the provided services; v) emphasis on social participation from the formulation of mental health policies to the control of the execution; vi) definition of local management agencies responsible for complementing this normative ordinance and for the control and evaluation of services. The administrative rule also defines the standards for outpatient care (Sistema de Informações Ambulatoriais do SUS) and conceptualizes the Centers of Psychosocial Attention (NAPS, Núcleo de Atenção Psicossocial and CAPS, Centro de Atenção Psicossocial).

The NAPS/CAPS were defined as local/regionalized health units that have a population defined by the local level and offer intermediate care between the outpatient and inpatient regimens in one or two four-hour shifts by a multi-professional team. The NAPS/CAPS: i) may be a **gateway of services** for actions related to mental health; ii) **attend patients referenced from other health services**, psychiatric emergency services or patients who have left hospital admission; iii) should be integrated into a **decentralized and hierarchical network** of mental health care; iv) are **care units that can operate 24 hours a day**, during the seven days of the week or during the five working days, from 8 to 18 hours, according to local management definitions; v) must have beds for eventual rest.

Therefore, only in 2001, the Law Nº. 10,216/ 2001[12] provided the protection and rights of persons with mental disorders, consolidating the policy of redirecting the mental health care model weakening the role of Psychiatric Hospitals and expanding the creation of community and decentralized equipment, aiming to break with the stigma that surrounds the person with mental disorder, as well as to integrate it socially, recognizing the person as a subject of law.

The Ordinance Nº. 336/GM[13] of February 19, 2002, established that CAPS I, CAPS II, CAPS III, CAPS i II and CAPS Ad II should be capable of following up patients, with severe and persistent disorders, in an intensive, semi-intensive or non-intensive way, within monthly quantitative limits that will be fixed in a normative act of the Secretariat of Health Care of the Ministry of Health. This Ordinance establishes that intensive care is intended for patients who, due to their current clinical situation, need daily follow-up. Semi-intensive treatments are for patients who need frequent follow-up, fixed in their therapeutic design, but who do not need to be in the CAPS daily and non-intensive care is intended for patients that, depending on the clinical condition, may have a lower frequency.

The Psychosocial Care Centers in the various modalities are defined by increasing size/ complexity and population coverage. The three types of services fulfill the same function in public mental health care, distinguishing themselves by the characteristics, size of the team and the volume of activities required. According to the Ordinance Nº. 336/GM CAPS is an outpatient daily care service that works according to the logic of the territory.

In the following year, the Federal Law Nº 10,708/2003[14] established the "Back to home Program" (Programa De Volta para Casa), called "Bolsa-Auxílio", which is responsible for securing financial resources that encourage long-term inpatients to leave the hospices and stay with their families or community.

The Administrative Rule Nº. 106/2000[15] provides for therapeutic residences and the Ordinance Nº. 336/GM/2002[16] regulates the new services and the assistance model, which are responsible for introducing the modalities CAPS I, II and III, CAPS, I and CAPS Ad. This ordinance, when including the CAPS in the SUS, recognize the complexity of the provided services and the extension of actuation. Reconstituting the complexity of existing with mental disorder beyond an illness, in the new perspective, and by focusing on the multiple underlying needs of life in this condition, presupposes the existence of articulation with the Social assistance and Health networks **on the** and **in the** territory[17].

The Brazilian Law also includes services to people who use psychoactive substances. The Law Nº. 11,343[18], of August 23, 2006, provides to the crack users and other drugs user the universal access to the health services, attending "all levels of care, privileging extra-hospital devices such as Psychosocial Care Centers for Alcohol and Other Drugs (CAPS Ad) and Primary Care services"[19].

In 2010, the Administrative Rule Nº. 4,279/2010[20] creates five thematic networks that: Stork network (Rede Cegonha); Psychosocial Care Network (Rede de Atenção Psicossocial – RAPS); Network of Attention to People with Chronic Diseases (Rede de Atenção às Pessoas com Doenças Crônicas); Network of Care for the Disabled (Rede de Cuidado à Pessoa com Deficiência); and, Urgency and Emergency Network (Rede de Urgência e Emergência). The Decree 7,508/2011[21], which regulates Law 8,080/1990[22], reinforces the importance of the SUS to be guided by network action. This Decree defines the Health Care Network (Rede de Atenção à Saúde - RAS) as a "set of actions and health services articulated at levels of increasing complexity, with the purpose of guaranteeing the integrality of health care"[23]. In the perspective of the articulation of the actions for the care in Mental Health, the Ministry of Health through of Ordinance Nº 3,088/2011[24] established the Network of Psychosocial Attention (Rede de Atenção Psicossocial - RAPS).

Thus, the CAPS in its various modalities and as a strategic psychosocial care, act within the RAPS strengthening the care production in the field of Mental Health, aiming at "the creation, expansion and articulation of points of health care for people with mental illness or suffering and

needs arising from the use of crack, alcohol and other drugs within the Unified Health System"[24].

MENTAL HEALTH IN STATE OF PIAUÍ AND TERESINA CAPITAL, BRAZIL

The State of Piauí, located in the northeastern part of Brazil, is divided administratively into 11 development territories, has 224 municipalities, occupying an area of 251,529,186 km^2. The State has as its capital the city of Teresina, which concentrates most of the state's goods and services, including health equipment.

The development of psychiatric care in Piauí is similar to the history of Brazilian psychiatric care, having its emergency based on the hospital-centered model, whose main social and political actor is the medical professional. In this sense, Rosa emphasizes that "any historical development of psychiatric care in Piauí is intricately related to the trajectory of the Asylum of the Injured, the epicenter of therapeutic and assistential innovations and the political game in the psychiatric field"[10]. The Asylum of the Injured, created in 1907, is later called Areolino de Abreu Hospital (HAA). In 1954, a private psychiatric hospital was inaugurated in Teresina, which was contracted to the SUS, called Sanatoria Meduna. In this perspective, "the psychiatric attention widens but it is centralized in the capital of the State, concentrated in the two psychiatric hospitals"[10].

In 1968, the Hospital-Dia was inaugurated, consisting in a new alternative to hospitalizations in the issue of Mental Health. Between 1980 and 1990, outpatient services were opened, with the presence of psychiatrists and, in Teresina, also with psychologists. However,

> [...] the lack of real progress led the Ministry of Health to press for a reduction of hospital beds, without any counterpart of the State and municipalities in the opening of psychosocial services. The first answers were given in 1997, when the hospitals of Picos and Parnaíba are created, consisting in second moment of decentralization of services, although completely timid, given the extent and heterogeneous reality of Piauí territory.[25]

Despite the advances, psychiatric care in Piauí remained precarious due to the resistance to the decentralization of psychiatric hospital care. In this context, despite the fact that federal public resources ensure the opening of community services, there was a reduction in the number of beds in psychiatric hospitals, due to negative evaluations of asylum services, and difficulties in attuning the local reality to that desired by the Federal Government. With risks of mental health mismanagement, a new political actor enters the scenario, the State Public Prosecutor's Office,

> [...] it was only in 2004, when the State Public Prosecutor's Office came to the scene as an inducing device of the Psychiatric Reform in Piauí, that the first signs of structuring the extra-hospital network of the State appeared, in line with the principles of the Brazilian Psychiatric Reform.[25]

In this sense, both the expansion of the CAPS and other alternative services to the psychiatric hospital happened from 2004, revealing a mismatch in relation to other Brazilian states. During the last years, the State of Piauí reduced the hospital beds and having as a milestone the "closure of the Meduna Sanatorium in May 2010, leaving only the Areolino de Abreu Hospital as State Psychiatric Hospital"[26]. The Areolino de Abreu Hospital, nowadays account with 160 hospital beds, and still is as a reference to the needs of Mental Health in the State.

Currently, the Network of Psychosocial Care (RAPS) of the city of Teresina is composed of "four CAPS type II, one CAPS type III, one CAPS AD, 251 Family Health Strategy teams, in addition to Emergency and Urgency Attention Care, Transitional Attention housing, hospital care and deinstitutionalization strategies"[27].

Rosa and Joazeiro[28] affirm that, "paradoxically, in 2015, due to the financial crisis of the Federal Government, there is a tendency of the municipal managers of Piauí to disinvest in Mental Health, observing an intense tendency of precarization and deterioration of the equipment verified through the denunciations received by the State Management of Mental Health"[28].

However, under the logic of the federal government, the local Psychosocial Attention Network of Piauí is situated positively in the national ranking of States in the scenarios of implementation of Psychosocial Attention Centers (CAPS). The Caps are regarded as the main mechanism of the Brazilian Psychiatric Reform, whose mission is to redirect the entire hospitalizations, acting predominantly in the attention to the crisis and reorienting the care model towards care in freedom, citizen, territorial and, community[28].

Still, due to the continuous presence of deep social inequalities on the State "the norms are not enough, it is necessary to activate the social forces for the SUS and that the principles of Psychiatric Reform happen in daily care"[28]. The intra and intersectoral dialogue need be increased, especially between the SUS and the Unified Social Assistance System (Sistema Único da Assistência Social - SUAS), which operate in the same territory of users' lives, with multiple forms of vulnerability.

RESEARCH METHODOLOGY

We used a quantitative-qualitative methodology [29,30] as a direct result of the nature of the object. The analysis was based on the use of a secondary source of information, that is, the production in the historical series materialized in the undergraduate theses of the bachelor's degree in Social Service of the UFPI in the period 1991-2016. The time cut analyzed the time of creation of the course until the graduates of the year 2016, having been found fifty-four undergraduate theses about Mental Health.

The systematization of data was undertaken through the triangulation of sources, articulated

and correlated with the institutional documentation, literature review on the subject and student production in the undergraduate theses of the Social Service degree course. The analysis was done after an exhaustive reading and categorization of the material in line with the objectives of the study, using an Excel® spreadsheet to record the information for subsequent analysis and comparison of the results.

MENTAL HEALTH CARE: FROM HEALTH TO SOCIAL NEEDS

From the historical perspective presented before, we analyzed the formative process on Social Service in work with Mental Health. We seek to analyze the choice of themes, the conceptual framework that anchors the analysis of the students who finished the bachelor's program in Social Service, aiming to discuss how the process of changing paradigm of care in the field of Mental Health (the paradigm of deinstitutionalization) was understood by the students during the process of construction of the thesis.

Social Service is a profession inserted in the social and technical division of labor, which has in the social question the basis of its foundation[31,32], having as an object of intervention the multiple expressions of the "social question". We use here the concept of the "social question" approached by Iamamoto, that is, the set of expressions of the inequalities of capitalist society, "which has a common root: social production is increasingly collective, work becomes largely social, while the appropriation of the fruits remains private, monopolized by a part of the society"[31]. The Curricular Guidelines for the Social Service course in Brazil define that the bachelor's in social service is the professional

> [...] that acts in the expressions of the social question, formulating and implementing proposals for its confrontation, with the capacity to promote the full exercise of citizenship and the purposeful insertion of Social Service users in the social relations and job market.[33] (our highlights)

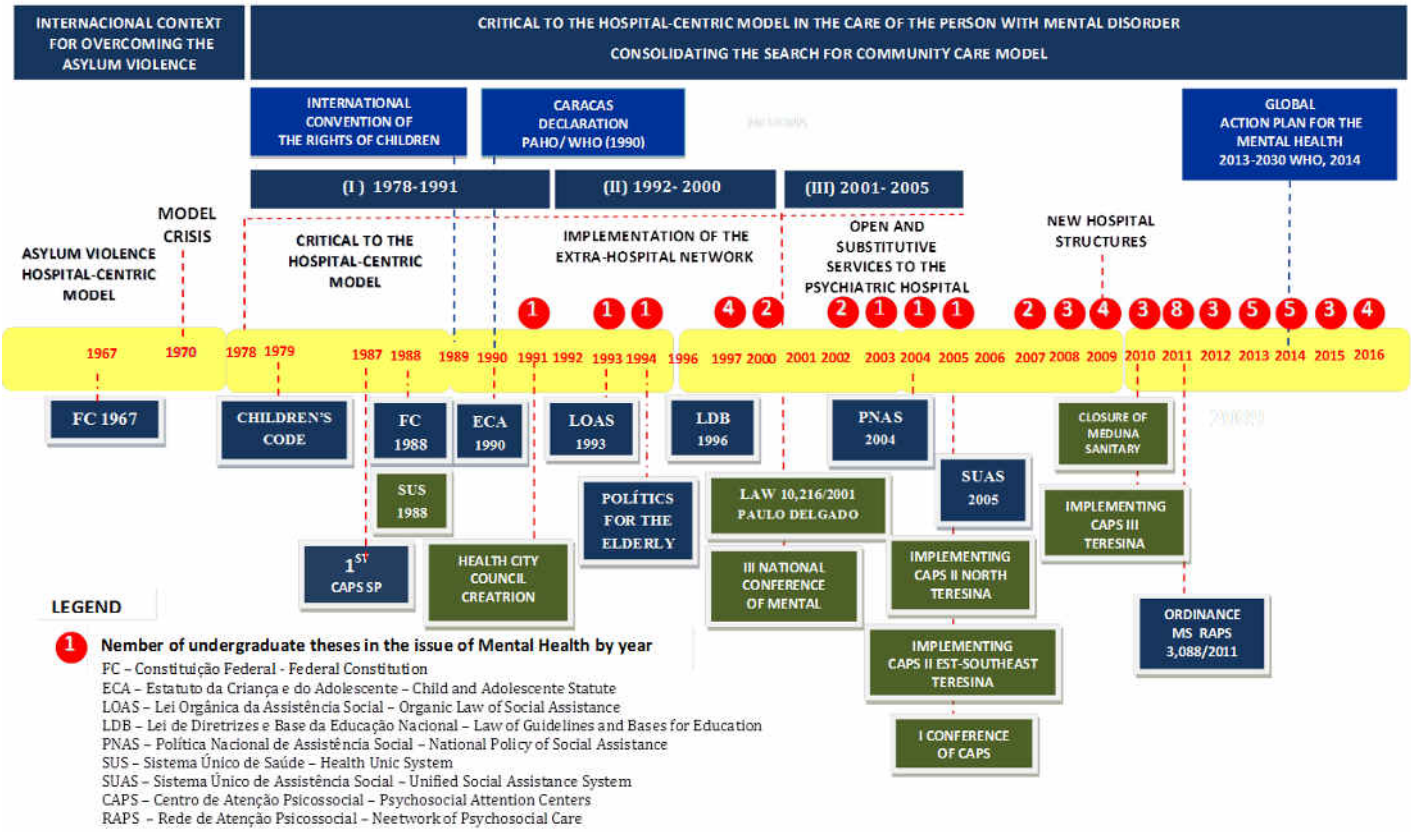
The Social Service Curriculum Guidelines assume a "permanent construction of content (theoretical-ethical-political-cultural) for professional intervention in social processes that are dynamically organized, flexible, ensuring high standards of quality in the formation of the social worker"[34].

Iamamoto[31,32], Yazbek[35], Raichelis[36], Martinelli[37] assume the centrality of expressions of the social question as a matter of Social Service with emphasis on the fundamental mediation of social policies in the professional practice. According to Yazbek[35],

> [...] the work of the professional of social service is profoundly conditioned by the existing relations in society, and undoubtedly the present scenario of capitalist development imposes new demands and competences on the contemporary social service, both in terms of knowledge and in concrete terms of intervention and political negotiation in the scope of Social Policies.[35] (our highlights)

It is important to point out that "intervening in the processes and mechanisms linked to the confrontation of the social question in its most acute manifestations" is one of the peculiarities of Social Service as a profession and that interventions are "**renewed** and **updated** in the face of different sociopolitical conjunctures"[36 (our highlights)]. It is the characteristic of confrontation of adverse conditions in the space of work that is explained by the students who entered the field of Mental Health in the years 1991-2016.

FIGURE 1 – Timeline of the history of the Psychiatric Reform in Brazil, legal frameworks and production of the undergraduate theses in Social Service on Mental Health in the UFPI - 1991-2016



SOURCE – Authors production

The Social Service course was created in 1976, but we observed, through the analysis of the timeline in Figure 1, that only in 1991 the first student chose the subject of Mental Health as the object of his/her undergraduate thesis. Thus, in the period from 1976 to 2016, the increase in the incidence of the choice to write about the field of Mental Health shows a gradual increase in interest in the subject. (see Figure 1)

An analysis of the distribution of graduates interested in this field of knowledge throughout time reveals a triple concern regarding the insertion and the work in the Mental Health: i) the heterodetermined relation of power present, with the predominance of medical knowledge; ii) the absence of a social policy capable of providing conditions for confronting the interfaces between

health and social needs resulting from the social inequality experienced by the user population; iii) the daily struggle to place itself in this scenario given the fragile relationship of the profession to the aforementioned dimensions. The perception of the authoritarian relationship in the process of care to the person with mental disorder consists of a constantly cited aspect.

The late implantation of substitutive devices to the Psychiatric Hospital in Piauí and Teresina (2005) seems to have influenced the low incidence of choice in the field of Mental Health in the initial years of study. However, after the implantation of CAPS II and CAPS III (2005-2016) there is an increase in the demand for students interested in this subject, with 41 undergraduate theses produced.

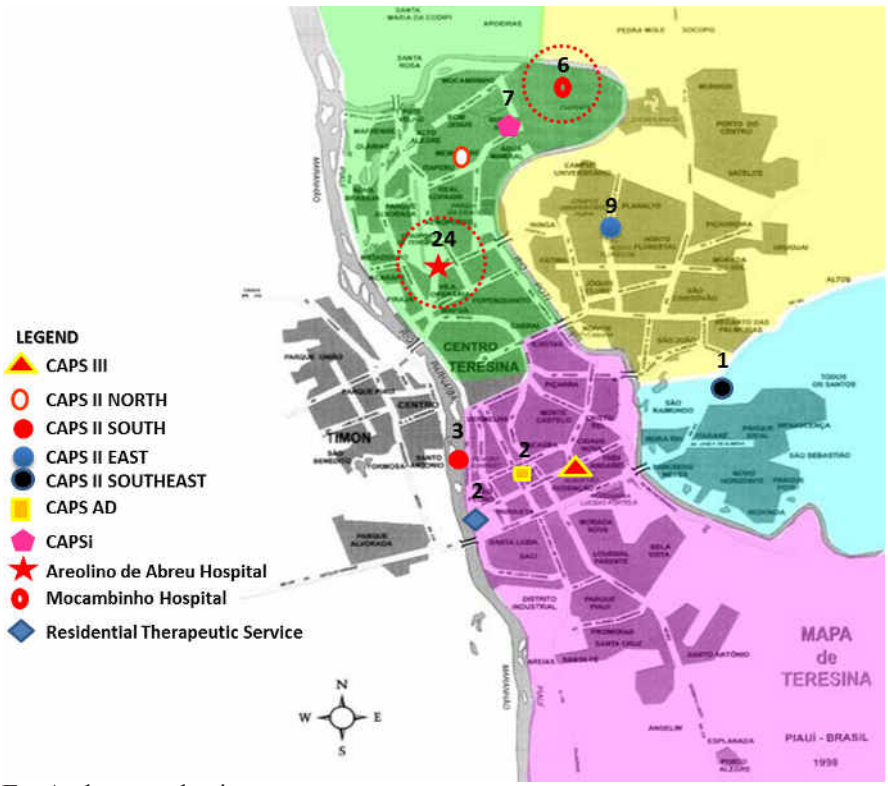
TERRITORY AND NETWORK OF PSYCHOSOCIAL CARE OF MENTAL HEALTH IN TERESINA

According to Carvalho, "everyday life, this everyday life of all men, is perceived and presented differently in its multiple colors and faces"[38] and for the most part, it is a space for professional intervention. As a praxis for carrying out the work of the social worker, there is an articulation in a context of complex social relations where the mediations between "[…] the particular and the global, between the singular and the collective"[38] occur.

The social practice according to Carvalho[38] is determined by a set of aspects as the different interests and forces, the vision of worlds that guides the individuals, the context in which this practice will be exercised and the needs of the different actors in the reality in which they are inserted. The social praxis does not correspond to an individual and singular act, but is moved by collective subjects, that is, the work by the social worker is done in articulation with a collective, either with groups composed by users of the services or professional groups or interdisciplinary teams of various institutions of the local and regional network,

> [...] an intersectoriality has been considered as: a new management logic that transcends a single sector of social policy; and/ or a political strategy of articulation between "sectors". In addition, related to its condition of strategy, an intersectoriality is also understood as: an instrument of optimization of knowledge; Skills and synergic relations for a common goal; and social sharing practice, which requires research, planning, and evaluation to carry out joint actions.[39] (author highlights)

Figure 2 – Distribution of the production of undergraduate theses of Social Service Course of the UFPI in Mental Health equipment in Teresina, Piauí - 1991-2016



SOURCE – Authors production

What kind of scenario did these professionals enter in the field of Mental Health during the historical series? A look at the territory of Teresina (Figure 2) reveals that 30 undergraduate theses were related to Hospital field (Areolino and Mocambinho) and 24 anchored in substitutive services to the Psychiatric Hospitals inserted in the local Psychosocial Care Network of Mental Health (CAPS).

Throughout the historical series, we could identify that the authors continually contextualize their work into the ideas of the Sanitary and Psychiatric Reform, by inserting it into the framework of concepts and values inherent to the process of construction of the history of Mental Health. In this perspective, there has been a constant appreciation of the intersectoral and intersectoral issues as a challenge to be consolidated and strengthened through the establishment of a link between the fields of Health, Social Assistance and, other social policies.

Thus,

> [...] The intersectionality is the articulation between the public policies by means of the development of joint actions destined to Social Protection, the inclusion and confrontation of the identified social inequalities. It supposes the implementation of integrated actions and the overcoming of the fragmentation of attention to the social needs of the population.[40]

According to the narratives of the professionals, the knowledge present in the space of

multidisciplinary and interdisciplinary work still must overcome, in some moments, the difficulty in communication which require an "organizational composition capable of handling the problems that arise from the womb of this plurality, difficulties, the demarcation of professional frontiers and the asymmetries between disciplines"[42]. Therefore, there is the need to encourage the dialogue to make the collective spaces favorable in the production of care.

The proximity and density of student production inform us the challenges of training and professional intervention, especially that of the social worker. The social worker is challenged to intervene in the multiple expressions of the social question and needs to understand and know how to decipher the needs of the user, the institution and, above all, need to know how to dialogue with the other constituent nuclei in the field of Health and Mental Health, as well as with other public policies in order to value the power of the present in the search for a future marked by the right to life, and to a positive, citizen identity.

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