Revista da Escola de Enfermagem da USP
ISSN: 0080-6234
reeusp@usp.br
Universidade de São Paulo
Brasil

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Contribuições da Copa da Inclusão para a consolidação do campo psicossocial
Revista da Escola de Enfermagem da USP, vol. 43, núm. 2, junio, 2009, pp. 384-392
Universidade de São Paulo
São Paulo, Brasil

Contributions of the Inclusion Cup to the consolidation of the psychosocial field*

CONTRIBUIÇÕES DA COPA DA INCLUSÃO PARA A CONSOLIDAÇÃO DO CAMPO PSICOSSOCIAL

CONTRIBUCIONES DE LA COPA DE LA INCLUSIÓN PARA LA CONSOLIDACIÓN DEL CAMPO PSICOSOCIAL

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ABSTRACT

This is a descriptive, analytical qualitative study, which looks at workers' action in the Inclusion Cup (their *work processes*). It aims to understand if that action considers mental health service users' *real life* and, to do this, it adopted the following theoretical categories: *the elements constituting the work process, health technologies* and *the premises of the psychosocial field*. The empirical data were collected by means of semi-structured interviews and analyzed according to the discourse analysis technique. Results point at *changes in the users' lives, in services and in the society* coherent with the premises of the Brazilian Psychiatric Reform. The Inclusion Cup proves that *intersectorial activities* are *living work in their action*, use *intervention instruments* that are very strong in terms of rescuing and building the citizenship of people with mental disorders. The changes (*purposes of the work processes*) may be occurring because the intervention project is no longer centered on the disease.

KEY WORDS

Psychiatric nursing.
Mental health services.
Deinstitutionalization.
Patient care team.

RESUMO

Este é um estudo descritivo e analítico de caráter qualitativo, cujo *objeto* é a ação dos trabalhadores na Copa da Inclusão (seus *processos de trabalho*). Busca compreender se tal ação considera a *vida real* do usuário de serviços de saúde mental e, para tal, adotou como categorias teóricas *os elementos constitutivos do processo de trabalho*, *tecnologias em saúde* e os *pressupostos do campo psicossocial*. Os dados empíricos foram coletados por meio de entrevista semi-estruturada e analisados segundo a técnica de análise de enunciação. Os resultados apontam *transformações na vida dos usuários, dos serviços e da sociedade* coerentes com os pressupostos da Reforma Psiquiátrica brasileira. A Copa da Inclusão prova que *atividades intersetoriais* são *trabalhos vivos em ato*, utilizam *instrumentos de intervenção* potentíssimos no resgate e construção da cidadania das pessoas portadoras de transtornos mentais. As transformações (*finalidades dos processos de trabalho*) podem estar ocorrendo porque o projeto de intervenção não é mais centrado na doença.

DESCRITORES

Enfermagem psiquiátrica.
Serviços de saúde mental. Desinstitucionalização.
Equipe de assistência ao paciente.

RESUMEN

Este es un estudio descriptivo y analítico, de carácter cualitativo, cuyo *objeto* es la acción de los trabajadores en la Copa da Inclusión (sus *procesos de trabajo*). Busca comprender si tal acción considera la *vida real* del usuario de los servicios de salude mental y, para esto, adoptó como categorías teóricas *los elementos constitutivos del proceso de trabajo*, *tecnologías en salud* y los *conceptos del campo psicosocial*. Los datos empíricos fueron recolectados por medio de entrevistas semiestructuradas y analizados según la técnica de análisis de enunciado. Los resultados apuntan *transformaciones en la vida de los usuarios de los servicios y de la sociedad,* coherentes con los conceptos de la Reforma Psiquiátrica brasileña. La Copa de la Inclusión prueba que las *actividades intersectoriales* son *trabajos vivos en acto*, utiliza *instrumentos de intervención* muy potentes en el rescate y construcción de la ciudadanía de las personas portadoras de trastornos mentales. Las trasformaciones (*finalidades de los procesos de trabajo*) pueden estar ocurriendo porque el proyecto de intervención no está más centrado en la enfermedad.

DESCRIPTORES

Enfermería psiquiátrica.
Servicios de salud mental.
Desinstitucionalización.
Grupo de atención ao paciente.

*Extracted from the thesis "Contribuições da Copa da Inclusão para a consolidação do campo psicossocial", School of Nursing, University of São Paulo, 2007.

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Portuguese / English: www.scielo.br/reeusp

Received: 08/23/2007
Approved: 12/22/2008

INTRODUCTION

Weaving the psychosocial healthcare network – a challenge for the Brazilian Psychiatric Reform

The Brazilian Psychiatric Reform is part of a broader struggle for national redemocratization, joining the health reform process with the creation process of the Single Health System - Sistema Único de Saúde, or SUS[1].

According to public policies, the National Mental Healthcare Coordination of the Ministry of Health published regulations #189 (MS) and #224 (MS) in 1991 and 1992, respectively, establishing new guidelines for the Psychiatric Reform: a) reorientation of the mental healthcare model; b) incorporation of new procedures into the list of procedures offered by the SUS; and c) stricter rules for operation and inspection of psychiatric hospitals[2].

In 2001, after years of debate, the National Congress approved Law #10.216, which: a) covers the rights of people with mental disorders; b) surmises the access to humanized, respectful treatment within a therapeutic environment; c) directs treatment towards the maintenance of reinsertion of patients with mental disorders into their family, community and occupational environments, and d) guarantees protection against abuse and exploration, predominantly with treatment in community services, prioritizing the creation of extra-hospital resources, with hospitalization being considered the last healthcare resource[2].

Due to the issuing of Law #10.216, it was necessary to update Ministry of Health regulation #224 in 2002. As a consequence, regulation #336 was published, which classifies the centers of psychosocial care (CAPS - *centros de atenção psicossocial*) into CAPS I, CAPS II, CAPS III, CAPSi (for children) and CAPS ad – alcohol and drugs, according to the territorial complexity, coverage and characteristics, defining such services as *outpatient services that provide daily care, working according to the territorial logic*[2].

Regulation #336 allowed for the growth of the substitutive network, especially the CAPS services, in addition to placing them in a strategic position to reformulate mental healthcare, in the reorganization of the healthcare network and the local coordination of mental healthcare policies and programs[3].

In Brazil, the current healthcare policy is guided by the SUS which, within a given healthcare model, offers a set of closely articulated programs , aiming at contemplating the principles of the Health Reform, which are as follows: regionalization, hierarchization, accessibility, equity, participation and integrality of actions.

The healthcare model proposed by the Psychiatric Reform is based on the principles of the SUS, whose concept of health is understood as a process instead of the absence of diseases. It also considers the perspective of producing quality of life, emphasizing comprehensive and promotional healthcare actions. This model yields an individual project of intervention and more intricate social healthcare, being *mindful so that actions of exclusion and violence do not become a part of this scenario, with the perpetuation of the asylum logic*[4].

The characteristics of the new healthcare model are: c) user-centered care, human-dependent, reinforcing the quality and humanization of care; b) the central axis is the subject-to-subject relationship, emphasizing an emancipatory practice; c) broadened concepts of health and disease, where health is understood as a social right; d) practice in defending both individual and collective life, from the user's perspective; e) centered on the use of light (relational) technologies, emphasizing a logic of autonomy, sharing and decentralization of knowledge and power, focusing on care that is integral and human; f) values the complexity of teamwork and is open to change, creativity and sensitivity, leading to the emergence of satisfaction, happiness, rewarding work and, consequently, expanding life[5-6].

In this context, psychosocial care workers face a big challenge: implanting and implementing the aforementioned healthcare model, taking responsibility for mental care within the defined territory, mediating the social changes that are needed in order to retrieve the rights of citizenship and inclusion of people with mental disorders. In this model, the healthcare worker is expected to have a multifaceted performance, and to master several fields of knowledge: technical, social, ethical, legal and political[3].

Furthermore, the formulation of the mental care policy,

> requires the development of integrated and intersectoral actions in the fields of Education, Culture, Housing, Social Services, Sports, Labor, Leisure, as well as the articulation of partnerships with the University, the Public Prosecution Service and Non-Governmental Organizations (NGOs), focused on improving the quality of life, social inclusion and citizenship of the people who receive care. In the development of projects within an intersectoral perspective, the need to contemplate the singularity of each territory should be noted[7].

According to this perspective, the concept of *territory* should be clarified, as it is not simply a given geographic area. Instead, it is

> a place, a particular space, where pain, grief, deep suffering and disease could receive attention, and treatment, if necessary. This is supposed to be a supporting space that delimits the work field of a team, a service or a program, fulfilling a mission of materializing a welcoming reception and bonding, which are indispensable conditions for any type of care[8].

By adopting *territory* as a guiding concept of a practice, new intervention strategies can be developed. Healthcare services should integrate the social network of the communities they are inserted in, taking responsibility for healthcare in this space and incorporating, in their practices, the knowledge of the people who are part of it. This happens because only a networked organization, instead of a single service, can provide care to the complexity of

the demands for inclusion of people with mental disorders who are stigmatized by society.

This is the task of the Centers for Psychosocial Care (*Centros de Atenção Psicossocial – CAPS*), which should assume their strategic role in the articulation and weaving of these networks, fulfilling their functions of direct care and regulation of the healthcare service network, working together with the Family Healthcare teams and Community Healthcare Agents in the promotion of community life and autonomy of the users by articulating the resources that exist in other networks: social-sanitary, legal, professional co-operatives, schools, companies and others[9].

It implies in including singular, intersubjective dimensions, considering hopes and ethical values for a culture of solidarity among users, relatives, professionals, SUS managers, interest groups , organized societies, NGOs, legislative and judicial entities committed to organizing a healthcare network that can face the complexity of the demand.

The network contains

> a resource-sharing model that contemplates the necessary continuity and complementarity. More than any other healthcare area, in order to concoct a resolutive healthcare strategy that has to respond to multiple necessities: affective (love, family, friendship, reciprocity, etc), material (income, housing, food, work, skills, culture, leisure, sports, etc), clinical (psychiatric, psychological, psychosocial, systemic, etc), which increasingly require more solidarity-based actions from governments, volunteers, common citizens and, especially, families[8].

Finally, the

> new orientation of the healthcare model has imposed the gradual and growing implantation of a healthcare network, whose organization demands a complex structure of community services articulated with territorial, cultural and social resources[10].

As such, the *intervention instruments* should adapt to the dynamics and flexibility of the *healthcare necessities* to respond to the complex therapeutic process.

In view of the above and the directives of the Psychiatric Reform, which prescribes a territory-based healthcare model and assumes the creation/articulation of the healthcare network, it can be inferred that new forms of comprehension and perception of madness are necessary, emphasizing respect to citizenship, singularity and diversity of people. Therefore, the coherent necessity to produce intricate and sophisticated *instruments* is noted. These instruments should respond to the increasingly sophisticated healthcare necessities of the population[11], as the

> production of healthcare projects and services in the context and in consonance with the guidelines of the Psychiatric Reform and the Single Health System - SUS - have presented a group of innovations and contradictions in different dimensions[2].

It is evident that there are not enough material, affective or intellectual resources.

This complex and ongoing scenario of the Psychiatric Reform permitted the creation of an innovative initiative - the Inclusion Cup, a sports even in the city of São Paulo - in the healthcare network, joining the Centers of Psychosocial Care.

The Inclusion Cup[a] attempts to induce events in the lives of people with mental disorders, exposing aspects that should be discussed and developed by the services, especially those focused on broadening the social networks of the users. Its main goal is to fight the inertia that was often caused by the complexity of the *object*, which is not the disease, but the life of people with a given mental problem.

However, it was also observed that this new order may bring distortions and, paradoxically, cause another form of institutionalization, characterized by the users' dependence on the institution, as well as the great limitations of their family and social networks, which are still reduced in relation to intra-institutional relationships. This happens because, when these people are not at the institution, the access to other activities is precarious, reducing their possibilities of exchange, their contractual power and autonomy.

Reflecting on the experiences related to the Inclusion Cup means reflecting on these contradictions, i.e. does the Inclusion Cup contribute to the production of new healthcare technologies, the construction of intersectoral actions and the healthcare network? Finally, does the Inclusion Cup contribute to the consolidation of the psychosocial field?

This study looks at the actions of mental healthcare professionals in the Inclusion Cup, the *meaning of their knowledge and their actions*, and attempts to comprehend whether these actions (*analyzing the elements that constitute the work processes*) consider the complexity of the *intervention object* (*the user's life*), aiming to contribute to the execution and consolidation of the Brazilian Psychiatric Reform and the psychosocial area.

OBJECTIVES

To reach the goal stated above, the study has the following objectives: characterizing the professional profile of the professional in charge of organizing the Inclusion Cup in the service where he works; comprehending the *work processes* of the organizer of the Inclusion Cup and analyzing whether these *work processes* result in transformations in the daily service routine.

The history of the Inclusion Cup Project started with the author of this article during the theoretical-practical teaching experience in the Psychiatric and Mental Care Nursing course at EEUSP, in the second semester of 2001, at *Centro de Atenção Psicossocial II of Perdizes*. It continued with the execution of a project funded by Coordenadoria de Assistência Social da USP – COSEAS. See study setting.

METHOD

This is a qualitative, descriptive and analytical study.

Study setting: the Inclusion Cup

The Inclusion Cup has been an annual event since 2002, consisting of an indoor soccer match followed by a friendly gathering at sports center of USP (*Centro de Práticas Esportivas da USP* - CEPE-USP) - against the Academic Athletic Association at School of Nursing at USP *(Associação Atlética Acadêmica da Escola de Enfermagem da Universidade de São Paulo* - AAAEE-USP) team. In this period, some of the undergraduate Psychology interns from Pontifical Catholic University (PUC-SP) also hold an indoor soccer match in the facilities of their University, motivated by user demand. These initiatives operated under the logic of handling relational technologies, providing the users with moments of exchange, affection, construction of subjectivity, socialization and relationships with the community. Some community members took part in the match and were invited to participate in the social gathering, contributing to change the stigma of madness and the acknowledgement of the territorial resources.

Difficulties were faced to put the project in practice. The most significant was the place to hold the sports event – a territorial resource –, which was solved through a partnership between PUC Psychology interns and PUC-SP itself, which made its indoor soccer court available on Fridays. It is located near CAPS Perdizes.

At that moment, a partnership was closed among CAPS Perdizes, EEUSP and PUC-SP, denominated the Inclusion Cup, a non-for-profit cultural and sports event, run by volunteers; a space for integration, knowledge exchange and socialization, which has gathered several services related to mental health and a few partners (both public and private). It has been organized by the Inclusion NGO since 2004[b]. The indoor soccer tournament is the central activity, but workshops and space are available for everyone who wants to take part.

The hosts of the event are psychiatrists, psychologists, nurses, social workers, occupational therapists, nursing assistants and technicians, physical educators, interns and high-school teachers. These social practices have been producing competences to deal with madness in the new mental care devices, intervention projects, strategies and services.

In 2006, the fifth year of the event attracted over 2000 people, with 400 players-users, in addition to supporter-users, relatives, technical and non-technical professionals from over 40 services, one association of users and relatives and people from the SESC Itaquera community. It is supported by the Regional Psychology Council – SP, the Indoor Soccer Federation of São Paulo and by SESC Itaquera.

[b] Logo of the non-governmental organization created as a result of the Inclusion Cup project, which currently organizes the event. It represents inclusion through an open door – a change of paradigms proposed by the Brazilian Psychiatric Reform – for the people with mental disorders in the world. It also represents society and the retrieval of citizenship.

The study subjects

The guiding criteria for the choice of the study subjects were: regular participation in the Inclusion Cup services, as reported by the management of the Inclusion NGO and higher quantities of CAPS services, due to their higher representation in the Inclusion Cup. Six professionals were elected, responsible for organizing the Inclusion Cup in the following services: CAPS II in Pirituba, Largo 13, Itaquera and Perdizes, which belong to the northern, southern, eastern and central-western regions of the City of São Paulo; the CAPSad in Ermelino Matarazzo and the CECCO in Freguesia do Ó.

The instruments, empirical data collection and analysis methods

The study followed the ethical aspects of Resolution #196/1996 by the National Health Council – Conselho Nacional de Saúde (CNS), being approved by Ethics Committee (files #546/2006 and #174/06)

The authors chose the semi-structured interview for data collection, since it is considered that this type of interview does not induce the respondents to predefined answers, granting the necessary freedom and spontaneity to enhance the investigation and to maintain the focus on the material under investigation[12]. Several techniques have been developed to reach both manifested and the latent meanings in the qualitative material. Among them, discourse analysis better conforms to the qualitative investigation of healthcare material[12], which is one of the main reasons why this procedure was chosen in the present study.

The conceptual bases

To reach the study goals, the theoretical categories that guided the analysis of the *meaning of healthcare actions* (the components of the work processes), of the research subjects' knowledge and actions were:

a) The professional processes and the healthcare technologies

Work is the activity through which human beings control the natural forces, humanizing nature. One creates oneself through this activity. A transformation process occurs because human beings have *needs* that must be satisfied. Work is performed through the *workforce* and the mediation of the *instruments* inserted by the *agent* between himself and the *object*, to guide his activity towards a particular *goal*[13].

In the case of health, the work process occurs because either someone or a social group – *the intervention object to be transformed through intentional human work* – seeks out a service with a particular *need* to be satisfied. Therefore, the *goal of the work process* is the development of strategies that will respond to this *need*[11].

The *work instruments* in healthcare, especially in the mental area, acquire a superior quality, because the *pro-*

fessional object (a human being constitutively weakened by a mental ailment, as well as his life) is also more complex[11]. Besides the technical instruments and knowledge, proper of better-structured technologies, there is another aspect - the relational, fundamental for the production of care.

It is assumed that healthcare work is always relational, since it depends on *live work on the spot*, i.e. work performed at the moment in which it is produced[14].

The references for this study are the concepts of *technologies* present in healthcare work, which are classified into: a) hard technologies: equipment, machines and devices that yield *dead work*, a product of other moments of production. They comprise structured, materialized knowledge and actions, which are finished and available for use; b) soft-hard technologies: knowledge that guides work. These are the rules, protocols, knowledge produced in specific areas, such as clinics, epidemiology, management knowledge and others. They are characterized because they contain captured work, but can express *live work*; and c) light technologies: these are produced during *live work on the spot*, covering the relationships of interaction and subjectivity, allowing for welcoming, bonding, responsibilization and autonomy[14].

> In this perspective, changes in the healthcare model assume that the healthcare core will be affected, producing a hegemony of *live work* over *dead work*, featuring a technological transition that will result in the production of health, based on light, relational technologies and the integralized production of care, operating in healthcare divisions throughout the healthcare services, focused on the users' *needs*[15].

The complex technologies employed in the psychosocial field are the

> relationships among the subjects with unique histories, non-reproducible and non-transferrable, i.e. the mental healthcare area is a fertile area to produce and develop *light technologies*[10].

b) The assumptions of the psychosocial field

The assumptions of the psychosocial field are

> the planning of the collective healthcare model, produced in the multiprofessional space with an interdisciplinary quality; overcoming the rigidity of the professional specificities, and flexibility to produce mental care that is compatible with the *necessities* of the consumers of the mental care product[10].

In the psychosocial field, the *intervention instruments* should conform to the dynamicity and flexibility of the population's healthcare needs; the organization of work should be the main instrument of healthcare actions; the *agents* can *experiment with new technologies, test them and produce them, discard them or retrieve them*[11]. The service should be the place where the praxis can be exercised, where knowledge stems from concrete reality and transforms it. By transforming reality itself, it will need to transform itself again, in a constant dialetic relationship with reality.

RESULTS AND DISCUSSION OF THE EMPIRICAL DATA

The professional processes related to the Inclusion Cup

a) The workforce in the Inclusion Cup

Regarding professional education, a wide array of academic areas could be observed: one nurse, two psychologists, one social worker, a physical therapist and a physical education intern. Regarding their graduation, two of them have a specialization degree in mental care and one in public health. The others do not hold specialization or other graduate degrees.

The professionals are involved with activities focused on professional qualification, directly or indirectly related with mental health: psychoanalysis, institutionalized groups, adolescents, chemical addictions, school inclusion, leisure and recreation. This shows a diversified latent theoretical arsenal to work in a multiprofessional team with interdisciplinary characteristics. Five professionals (83%) are involved with social groups, taking part in seminars, meetings and congresses directly related to the psychosocial field. One of the professionals did not take part in any event of the sort in the past three years.

a) The goals of the work processes *in the Inclusion Cup*

The *goal* perceived in the empirical data regards the enlargement of the social network, emphasizing users' active participation in the process of restoring their autonomy, which could result in citizenship.

The *goals* of the *work process* are coherent with the assumptions of the psychosocial field and the Brazilian Psychiatric Reform. When they are related to the internal services, they tend to focus on the users' *necessities* and their *subjectivity*; when they are related to the *territory*, they produce *intersectoral actions* for the development of activities that will enlarge the social network and the contractual power of the participants, based on their empowerment.

c) The work objects in the Inclusion Cup

The outlining of the work object occurs only when the agent of the professional project intends to transform the object or a goal to be reached through a previous project. In order to execute the project that will transform the object, the agent needs to identify certain characteristics of the object that could undergo a transformation[13].

The *organizers* of the Inclusion Cup define the user and the community as their work object, and consider the user as an active participant in the construction of his project for life, as stated by the psychosocial paradigm. In this setting, the technical (professional) knowledge is well regarded, as well as the knowledge of lay users, considered as people with opinions, desires, etc.

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This type of relationship between professionals and users shares responsibilities and successes, being one of the assumptions of psychosocial work. It could be strongly reproduced in the services in order to evaluate the quality of the care offered, according to the user's perspective.

The Inclusion Cup works mostly with the concept of *enlarged object* (the user and his life in relationships), overcoming the traditional psychiatric conceptual model that elects the mental disease as the object of intervention. Data about the concept of the *work object* impregnated with concepts of the psychiatric area were found to be sparse.

d) The intervention instruments *in the Inclusion Cup*

The change in concept of an *object of intervention* invites new *instruments* – intervention strategies, therapeutic projects and other therapeutic goals and *purposes*. While this new object requires other instruments, it is also redesigned/conformed by the new instruments, in a concrete dialectic that is presented in the daily professional routine of psychosocial care professionals. The empirical data revealed three categories of *intervention instruments* that influence the *objects*:

• Personal work instruments: specific knowledge

The *instruments* are the mediators that the *professionals* place between themselves and the professional *objects*. Knowledge is the indissociable part of the transformations that occur in the healthcare model[16].

The data show that one of the *work instruments* is the *specific knowledge* of Psychology, Physical Therapy and Physical Education. In addition to structured technical knowledge, there is another type of knowledge – the relational availability. It is not that simple. It transforms an unspecified action into a differentiated action. Two professionals denied using any type of structured knowledge in their practices related to the Inclusion Cup.

Considering that the knowledge of the critically-built psychosocial field is also considered structured knowledge, with a *purpose* (the construction of the mental healthcare users' citizenship), there is a risk of performing alienated work by denying the importance of structured knowledge in the relationship with the new *work object*, which would not be in agreement with the assumptions of the Brazilian Psychiatric Reform.

Other *work instruments* were made evident by the empirical data: a) *being capable of working as a multiprofessional team* with interdisciplinary characteristics (the practices are related, there is reciprocity, interaction, with a common identification of the *object*); b) *the tendency towards horizontalization of the power relationships of* between mutual knowledge and gains (17); *appropriation and responsibility for the work process* (the professional identifies with the process of intervention and recognizes himself as an actor who catalyzes transformations); d) *knowledge of mental healthcare policies* (indispensable in the psychosocial field, as the appropriation of work occurs accordingly – object, purpose and instruments –, not in an alienated way); and e) *circulation through the territorial resources* (in the social context of the users, which makes it possible for them to broaden their social network).

Considering the collected data, the *personal instruments* are coherent with the psychosocial healthcare model. Mostly, in its work process, the *workforce* uses hard-light technologies, *ruled over* by the *light technologies*, i.e. *live work* that is produced *on the spot*, when the user encounters the professional, which makes it possible to create new knowledge and new mental healthcare practices, contributing to the consolidation of the psychosocial field.

• The *institutional work instruments*

The data show the predominant use of groups and meetings, characterized as spaces for reflection and listening, which are indispensable for the construction of responses to the users' *necessities*. In this studied universe, it is possible to state that the Inclusion Cup causes the construction/invention of collective spaces, *instruments* and *purposes* of the work purposes that are coherent with the assumptions of the psychosocial field.

This type of relationship between professionals and users shares responsibilities and successes, being one of the assumptions of psychosocial work.

• The intersectoral work instruments

Regulation #336/GM rules on the execution of community activities, i.e. joint activities developed with community associations and other institutions with the following goals: social exchanges, integration of the service and the users with the families, the communities and society in general[2].

The soccer workshops are held in the Convenience and Cooperative Centers – *Centros de Convivência e Cooperativas – CECCO*, the city clubs, the Tietê Ecological Park, Chácara Matarazzo, PUC-SP and in a private indoor court. Places used as *intersectoral intervention instruments* are clearly inserted in the *territory*, promoting the insertion of the users in public spaces.

Other *intersectoral instruments* were identified in the empirical data: a) *preparatory meetings for the Inclusion Cup held at CRP-SP* (a decision forum where users, relatives, professionals and the board of directors of the Inclusion NGO have an active voice in the construction of the collective intervention project); b) *participation of the relatives in the organization of the Inclusion Cup* (as the protagonist of the territorial occupation strategies, the relatives break away from the place they used to hold in the theories of the psychiatric model professionals – producing the disease of their relatives or helpless victims of pun-

ishment) and c) *activities that are indirectly related to the Inclusion Cup* (acknowledgement and appropriation of the *territory*, enlargement of the social network and increased contractual power of the users).

The Inclusion Cup is an innovative, ambitious project, which mobilizes and questions the internal organization of the services, the knowledge, the relationships of power between professionals/professionals, professionals/users and users/users. In order to take part in it, they need to search for resources in the *territory*, which is not restricted to the places where the workshops are held, but it also includes public and private partnerships.

It is necessary to reunite theory and practice in the work process, i.e. the praxis, allowing for the production of transforming healthcare actions. In the studied universe, it was observed that there is coherence between the election of the *work object*, the types of knowledge used by the professionals and the *intersectoral and institutional instruments* that are employed.

e) Difficult and facilitating aspects to execute the work process in the Inclusion Cup

The difficulties found to execute the work process in the Inclusion Cup are mostly related to the lack of material and financial resources, the lack of transportation, the distance from the place where the event was held, the lack of governmental support, the context of social exclusion of the users and the precariousness of investments in the field of the public healthcare policies in the city of São Paulo.

It adopts new *purposes* in its work processes, using a wide array of *intervention instruments* to consolidate the psychosocial field, broadening the concept of the *object of intervention*. The creation of new devices is not enough – above all, there is a need for real public investments in the sector, following a public policy of mental healthcare aligned with the Single Health System, an extremely fragile scenario in the city of São Paulo.

In the context of having no public resources, the services, in response to user demands, articulate more intensely with the territory, aiming to consolidate (public and/or private) partnerships to fulfill these necessities.

The positive aspects of the lack of public policies for the sector and the consequent consolidation of the psychosocial healthcare model are the transformations in professional routine, forged by the articulation and resistance of the professionals, users and relatives, which corroborates the history of the struggle of the Brazilian Psychiatric Reform.

Conversely, the research data point to *facilitating aspects*. Among them, it is worth noting the passionate feelings of Brazilians for soccer, which causes: a) identification of those involved with the project; b) transformation of the workshop into a *technology* that is mostly *light – live work* built *on the spot*, when players meet non-players, users and non-users. Those involved are recognized as citizens because of soccer; there is also tolerance to differences and the reduction of the social stigma of madness, and c) the development of teamwork with interdisciplinary characteristics.

The acknowledgement and strengthening of teamwork to develop the activities related to the Inclusion Cup is possibly related to the culture of soccer in our country, propelling everybody (users, relatives, professionals and community) to overcome the difficulties found in the realization of this unique project in the psychosocial field, contributing for transformations in this field.

SYNTHESIS

The contributions of the Inclusion Cup for the consolidation of the psychosocial field

a) Transformations in the lives of the users

The results point to important transformations in the life of the *users*, which are coherent with the *purposes* of the work processes, previously defined by the professionals: a) the enlargement of the social network; b) the development of autonomy; c) improvements in the quality of life and d) retrieving the users' citizenship.

The *instruments* used (personal, institutional and intersectoral) are adequate to reach these *purposes*. The choice of the *work object* is coherent, considered an active person in the construction of his citizenship. The transformations are coherent with the new political, social, scientific and healthcare-related paradigm proposed by the Brazilian Psychiatric Reform, where citizenship is the central *instrument* of the therapeutic approach and, at the same time, the *goal* to be reached.

b) The transformations in the service routine

The transformations in the service routine confirm that both *professional means (instruments)* and *work objects* are transformed: On the one hand, the *object* has demands that are more complex; on the other hand, the service is invited to develop more sophisticated *intervention instruments*.

These transformations cover: the enlargement of the actions provided by the service in the *territory*; b) better rapport among the professionals who work for the services, resulting in teamwork with interdisciplinary characteristics; c) organization and planning of healthcare actions related to the Inclusion Cup; d) changes in the roles (power) of the professionals in the relationship with the other professionals and the users, and e) incorporation of new actors (relatives, collaborators, sponsors, partners and supporters) with their knowledge in the psychosocial field.

c) The transformations in the life in society

The *transformations in the life in society*, related to culture and the collective images about madness, point to a

better participation of the people in the community (relatives, collaborators, sponsors, partners and supporters) in the activities related to the Cup and the reduction of the social stigma of madness, a result of the preparatory activities and the Inclusion Cup.

The Inclusion Cup proves that the intersectoral activities, with community participation, are *live work on the spot*, because it uses very powerful *intervention instruments* to retrieve and build the citizenship of people with mental disorders.

The transformations (*purposes of the professional processes*), in this case, may occur because the *intervention project* is no longer centered on the paradigm of the disease, i.e. the *professional object* of these services was *enlarged and complexified*, regarding the real life of real people living in their real *territories*.

The *professionals* needed in the psychosocial field – a fertile area for the production of *light technologies* – should have *praxis-oriented* awareness of their actions. They produce and reproduce different types of knowledge with the clear *goal* of *transforming realities*. The collective operationalization of this great *instrument*, full of *relational technologies*, named Inclusion Cup, is completely coherent with the assumptions of the Brazilian Psychiatric Reform and the psychosocial field.

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