*Trajetória de uma Fonoaudióloga em serviços substitutivos de saúde mental*

**A speech therapist's path in substitutive mental health services**

*Trayectoria de una Fonoaudióloga en servicios sustitutivos de salud mental*

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**RESUMO:** Este artigo surgiu a partir da produção teórico-clínica realizada nos dois anos de residência multiprofissional em saúde mental na cidade de Campinas, que teve como campo de atuação um CAPS III, um Centro de Convivência, uma oficina de trabalho e geração de renda, e uma rádio comunitária na cidade de Montevidéu (Uruguai) visitada durante o estágio eletivo. Tem-se por objetivo geral integrar as diversas experiências vivenciadas, a partir do campo da comunicação humana e de suas alterações, e, consequentemente, fomentar a discussão sobre a inclusão de outros núcleos de saber nas equipes de saúde mental (tanto infantil quanto adulto). Além disso, como objetivo específico, registrar as possibilidades de inserção da fonoaudiologia na saúde mental e ampliar a visão dos diversos profissionais para com o núcleo da fonoaudiologia. Como resultado, foi possível fomentar a discussão de uma construção em complementaridade dos núcleos de saber que os próprios usuários fizessem parte.

Palavras-chave: Fonoaudiologia; Saúde Mental; Redes Comunitárias; Autonomia Pessoal; Comunicação.

**ABSTRACT:** This article emerged from the theoretical-clinical production made in a multiprofessional residency in mental health, during two years in Campinas, which had as field of activity a CAPS III, a community center, an income generation workshop and a community radio in Montevideo (Uruguay) visited during the Internship. The general objective is to integrate the different experiences, from the human communication and its disorders, and then foster the discussion about the inclusion of other specialties in the mental health teams (both children and adults). In addition, as a specific objective, to record the possibilities of insertion of the speech therapist in mental health and to broaden the vision of mental health professionals to the core of the speech-therapist. As a result, it was possible to stimulate a complementary discussion of professional knowledge that includes the patients as part of it.

Keywords: Speech, Language and Hearing Sciences; Mental Health; Community Networks; Personal Autonomy; Communication.

**RESUMEN:** Este artículo surgió de la producción teórica y clínica llevada a cabo en la residencia multidisciplinaria en salud mental, por un período de hasta dos años en la ciudad de Campinas. El campo de actuación fue en un CAPS III, un centro de convivencia, un taller de trabajo y generación de ingresos, y una radio comunitaria en Montevideo (Uruguay) que se visitó en el trascurso de la pasantía. Se tiene como objetivo general integrar las diversas experiencias vivenciadas, a partir del campo de la comunicación humana y sus modificaciones, y, consecuentemente, fomentar la discusión sobre la inclusión de otros núcleos de saber en los equipos de salud mental (tanto infantil como de adultos). Además, como objetivo específico, registrar las posibilidades de inserción de la fonoaudiología en la salud mental y ampliar la visión de los profesionales de la salud mental hacia el núcleo de la fonoaudiología. Como resultado, fue posible fomentar la discusión de una construcción en complementariedad de los núcleos de saber que los propios usuarios forman parte.

Palabras clave: Fonoaudiología; Salud Mental; Redes Comunitarias; Autonomía Personal; Comunicación.

**INTRODUCTION**

This article arouse from the theoretical-clinical production carried out during the two years of multiprofessional residency in mental health in the city of Campinas, on the free initiative of the author, who had already started her clinical practice in this specialty when she was part of a CAPSij team in the city ​​of Rio de Janeiro for a period of about two years after graduating in speech therapy. The residency broached in this article has a 60-hour week workload, as stipulated by the Law 11.129 of 20051, being 45 hours of clinical-institutional work, and 15 hours of theoretical and compulsory disciplines, as I will present later.

Campinas is considered the third largest city in São Paulo state with approximately 1,080,113 inhabitants per square meter and a mental healthcare network established from health districts (North, South, East, Northwest, and Southwest). These are consisted of CAPS Ad III, CAPS Ad II, CAPSIJ, CAPS III, Street offices, RTCs (Residential Therapeutic Care) bounded to the CAPS III, TCU (Transitional Care Unit), CECOS (Community Centers), Work and Income Creation Services, hospital stay in general hospitals and bed in psychiatric hospitals, mental healthcare staff in health centers, and an online radio to be used as a communication channel among the users. This last one is a project of the institution that manages the mental healthcare services in Campinas, where users have the central role, and do not need any requirements to be part of it.

Considering the residency a modality of *lato sensu* postgraduate education of cross-sectorial cooperation featuring a teaching-healthcare supervision, it is possible for the intern to have a clinical-institutional education that does not lose sight of the theoretical content training, which is important for the development of practical competences, enabling a qualified inclusion of young professionals into the job market.1

The choice of services focused on adult individuals occurred in a prospective way, through a process of professional construction fostered by the difficulty experienced in the contact with other professionals in accepting the speech therapy when still in a CAPSij, as well as the difficulty in finding scientific literature that addresses this professional's work in mental health in a broader way (not only with the child-youth audience or with individuals in the autism spectrum).

Therefore, there was a selection of locations for my practice: a CAPS III, a Coexistence Center, a work and income generation workshop and a community radio in the city of Montevideo (Uruguay), which I visited during the period of elective internship, as well as the Health Council, meeting of axis and mixed network. There was also interest in participating in a local Council and Collegiate Manager of CAPSIII, but the first was not possible due to the composition of the schedule and the second was not authorized by the service team.

Thus, the general objective of this study is to integrate the different experiences, from the field of human communication and its alterations and, consequently, to foment the discussion about the inclusion of other nuclei of knowledge in mental health teams (both children and adults). In addition, the specific objective is to register the possibilities of insertion of the speech therapy in mental health and to broaden the vision of different professionals in relation to the core of speech therapy.

**RESIDENCY IN MENTAL AND COLLECTIVE HEALTH**

The residency program that this work deals with was created in 2013, and it has in its composition a multiprofessional team, such as psychologists, nurses, speech therapists and occupational therapists. There are a total of 15 positions, but only one of them is for speech therapists, the other seven are for psychologists, five are for occupational therapists, and two are for nurses.

At the beginning of the activities, the program provides its participants with previously scheduled visits to Campinas health services, which serve as a field of action for young professionals. From this, the work occurs in a single service in the first year of residency, and two services in the second year, with a reduced time in the service experienced in the previous year and one month of experience in the service related to the elective internship.

From this, the field of action is chosen by free demand of the resident, which in the case of this work, occurred through a subjective logic of professional construction - experiencing something different from what she had already done in an infant and juvenile clinic. This insertion should prioritize a single district, so that it would be possible to build a network with a broader vision among the services, besides participation in other socio-political spaces, which was not possible due to the institutional organizations between the residency and the services.

During the first year of residency, the theoretical disciplines of 'introduction to health services and paradigms of mental health', and public policies, management and planning in health' were discussed, which occurred weekly in the afternoon in the auditorium of the training institution. In addition, there was a study group open monthly at night to network professionals, where clinical cases presented by the residents were discussed.

In the second year we had the discipline 'institution, groups and teamwork', construction of the course completion paper, plus an extension class in a period that could be morning or afternoon, depending on the subject chosen. As well as the period of the elective internship, on which we should also deliver a report telling the trajectory covered and contributions made in the visited network, which I will address later.

In addition to this theoretical input, there were part-time weekly supervision sessions, also at the training institution, in which all the residents participated together, and where selected subjects were approached in accordance with the discussions that arose during the supervision. These were provided by professionals in psychology (first year) and occupational therapy (second year), and in cases where issues were not addressed, there were times for individual supervision provided by the coordinator, moments when the residents could also access her in this function.

These supervisory spaces and theoretical disciplines, for many times, made it difficult for me to look at the process of insertion in the services due to the psychoanalytic view of supervisors and coordination. This was because some terms and the dense literature were difficult to understand from my perception as a Speech Therapist, which demanded more study time than expected from the schedule. At the same time that the collective health literature used was easy for me to understand and helped me understand certain institutional functioning.

The highlight of this program is the fact that the negotiations are conducted collectively between supervisors and residents, during supervision, through the training itineraries. It is not easy to reconcile so many desires, types of clinic and professions to the availabilities of services and territories of action, as well as it is not easy to reconcile the expectations of the supervisor with those of the group in which he/she is inserted.

However, as mentioned by Leo and Teixeira (2015), the formation of the identity of each individual is influenced by the education (formal or informal) and by the culture with which he/she came into contact and through the relationships built in the family, academic or work environment. That is why it is important to discuss collectively these itineraries, both the supervisor and the residents, so that everyone is responsible for their choices and their unfolding.3

For OURY (1991), an in-depth discussion is necessary, which takes into account the most varied experiences, since each detail can be of enormous importance, even if it is only for the organization of the profession. Not everything needs a strategy, statutes, roles and functions. For this reason, bureaucratic decisions and power relations do not fit into a construction in which all are in constant formation.4

In addition, the residents had their preceptory in the services in which they were inserted and, as a matter of priority, with core professionals, but it was common for Speech Therapy professionals to have two preceptors, one of nucleus and one of field, so that they were safeguarded in the services in which they acted and did not have the professional of the nucleus to aid them.

According to the Resolution CNRMS No. 2/2012, the preceptor should necessarily be of the same professional area of the resident under their supervision and be present in the practice scenario, as well as being responsible for the direct supervision of the practical activities performed by the resident in the health service where the program is developed. But this was another point of difficult organization due to the inexistence of Speech Therapy professionals in the adult services, as well as in the teaching body of the residency. Therefore, it was necessary to coordinate with another service, in this case the CAPSij of the same district, so that the Speech Therapist could become the preceptor of the nucleus.5

Another point of discussion in the formation was the non-dialogue between the preceptors (nucleus and field), which left the discussions very sectorized between what was of the speech therapy (core preceptor) and what was of the service (preceptory of field), making difficult a more integrated construction that contemplated the areas involved. Being also up to the resident to make this interlocution and filter the information for decision making.

Despite the absence of professionals in adult substitution services, the earliest reports of Speech Therapy in mental health date back to the 1980s, in São Paulo, where their participation occurred in outpatient clinics in the aforementioned integrated health teams, becoming more comprehensive in the following decade in day hospitals, coexistence centers and cooperatives.3 Becoming even more active since the implementation of the Ordinance No. 224/MS of January 29, 1992, which privileges the multiprofessional teams, and the creation of the CAPS through the Ordinance No. 336 of February 19, 2002, which constituted the minimum service team for children and youths (CAPSij).6,7

Another negative point that makes the profession not be inserted more broadly in mental health services is the fact that this specialty is not yet recognized by the Federal Council of Speech Therapy, which generates some resistance in the multiprofessional teams and even in relation to the professionals of the nucleus. These, in turn, feel insecure in their work due to the shortage of continuing education courses. In Campinas, for example, publications related to the performance of Speech Therapy are non-existent, and the history of the action is found only through reports of some network professionals.

In relation to the social control spaces, these were not directly related to the residency program, but they were spaces of articulation of several healthcare networks. Therefore, the participation was given primarily in the health council, through monthly meetings in the auditorium of the city hall.

As well as in the axis and mixed networkmeetings, which occurred monthly as a strategy to generate the interlocution between the services of the health area of the district, in order to plan the network of care in a collective and participative way, contemplating professionals of the services of mental health, basic care and services of reference.

There was also interest in participating in the local Council of CAPSIII and in the Collective Council of family members, friends and users of mental health in the city, but due to the composition of the schedule it was not possible. As there was also interest in participating in the Collegiate Manager of CAPSIII, which was not authorized because it is an institutional space in which there were discussions related to team situations, which the representatives considered inadequate to the presence of residents.

Also in accordance with the National Humanization Policy, the collegiate manager is a collective space for negotiation and definition of priorities, definition of investments, preparation of action projects and organization of operational procedures, preparation of proposals and strategies for involvement of all the members and teams of the service, of welcoming and referring complex demands, among others. This would be, therefore, a space for deliberation of the residency within the service through the amplification of mutual contributions and based on the SUS guiding principles.8

**METHODOLOGY**

The construction of this report did not require the approval of an Ethics Committee, since there was no manipulation of data or information inherent to individuals assisted by the services, and it served only as a monitoring of the specific services to this report with counterpart of knowledge production and possible improvements.

In addition, this research represented an empirical investigation using the field journal for its construction, aiming to systematize in a reflexive way the experiences had in the services in relation to the social reality, to the subjects and to the process of professional intervention, allowing a better qualification of the actions in these services.

For Souza (2006), this scientific resource makes it possible to establish contact between memories and the teaching trajectory, relating the experiences to the different dimensions of the professional learning, making possible the self-knowledge and the knowledge of the relations that are established in the formative process. The biographical approach allows the subject to produce knowledge about himself, about the others and about the daily life. This knowledge is revealed with the narration through the subjectivity, singularity, knowledge and experiences.9

Zabalba (2004) complements saying that this resource offers important elements for the deepening of the analysis and data collected, which also has its therapeutic and educational effects, contributing to the reconstruction of the activities of the day, providing other meanings.10

**ADULT PSYCHOSOCIAL CARE CENTER (CAPS III)**

Aiming at a professional construction process possible only from the residency, since there are only professionals of speech therapy in substitutive services for children, the first year of education in service occurred in a CAPS III, in full time. This service is located in the southwest health district, with a coverage, in that period, of more than 100 thousand inhabitants, organized in three mini teams of which I chose one to start my activities.

Despite the difficulties of internal relationship, the handling of the cases in this mini-team seemed to be collective and, from the first day, I was included in these, even by the look of the Speech Therapy, although some members were not so open to my participation. The team consisted of an occupational therapist, two psychologists, a nurse, a psychiatrist (that was not a reference pair), three nursing technicians and a nurse; in addition, they were distributed in reference pairs with a teaching professional and a nursing technician.

The mini team in question offered matrix support to two Health Centers that were also organized in mini teams, these meetings were held monthly between a CAPS higher education professional and the SO staff. In one of the meetings I attended, the SO doctor had so many cases to discuss with the service team, which in my view turned out to be an internal, hierarchical team meeting, thus contradicting the precepts of matrix support. As well explained by Chiaverini (2011), the matrix support is a way of producing health, in which the teams create proposals of intervention in a process of shared construction, in which they must consider the therapeutic bond, integrating a collaborative care between the services and expanding the possibilities. Therefore, this should not be organized vertically with the production of schedules and tasks with transfer of responsibilities.11

In the work process of the institution there were several groups, I participated in some after receiving the invitation of the professionals who referred them. These were the reference group of the mini team with a nursing technician, a gardening group with an occupational therapist, a music group with another resident and an occupational therapist, and a group of guided going out (called a walking group) with a monitors and a psychology resident.

For Cardoso and Seminotti (2006) the group is a place for debate on the need for help from all and therefore a potent space of exchanges and sharing of experiences, reliever of anxieties and recognition of anxieties that are common to all members, enabling the consolidation of affective bonds and the construction of strategies.12,13,14,15

In some services the use of the group activities to suppress the demand was observed, due to the large number of people assisted in the area of coverage and lack of manpower, often becoming operational and bureaucratic spaces for control and delivery of medication or composition of schedules with weekly tasks. Unfortunately, this is something that deserves more attention from the various actors in this network, being an important indicator of work processes.

Regarding the reference group in which I participated, there was something that surprised me, because it was not part of my previous experience and, therefore, I consider something of extreme importance for my formation. Together, we went through several group processes, including in relation to the entry of a new professional in its composition. In addition, having to manage the anxieties common to all members, or those that were not common but which became a propelling factor for the group, was not easy, yet it generated an exchange of experiences between the members, soothing their anguish.

It is very common to use music as an exponent to bring people together, to release emotions, to unburden the anguish, to free other forms of expression. After the request from a user of this service, I started to be part of this group to assist them in promoting healthy environments in relation to the vocal health of their members, enabling a greater self-knowledge for their insertion/reinsertion and support in their social environment. Unfortunately, at that time, this group was permeated by political issues that were happening in the city and, therefore, which directly interfered in the functioning of mental health services throughout the city.

The gardening group was a group open to users at all times during the day, but it was crossed by several modifications in the work process of the service, with a sudden output from the professionals who referred it and had a great bond with their routine participants. With this, the objective was to enable these users to maintain the routine of an activity that interested them and to manage to connect with other professionals.

The going out group was also an open group, where we used to hold a conversation circle at the end of each activity to collectively decide the places to be visited, and all the financial and personnel organization that it demanded. But this was another group permeated by political issues and the leaving of service professionals; and the reduction of personnel made it difficult to maintain the internal work routine. With this, the walks were more spaced and closer to the service, because that way it would not require so many professionals.

**COEXISTENCE CENTER**

This service, which had been operating for more than 10 years in a region of social vulnerability in the southern district of the city, had a small team: a coordinator, two psychologists, a monitor and a general service assistant. Its smaller composition than usual for mental health devices is consistent with the way in which the CECOS teams in the city of Campinas were organized. Despite the need for a traditional break in the health work and an approach beyond the core of knowledge, these services were organized with re-assigned professionals and volunteers.16

After visiting the space, that would not be the choice for construction that I had in mind, but due to the desire for the dynamics of a community center as a service more connected to the community, a device for building social and affective ties, this was the service that I had to choose. Unfortunately, the number of positions for CECO in the territory where I was previously included was lower than the number of residents in that district.

The dynamics of this service without the presence of professionals from other areas was something that made me raise many questions, since in mental health we value the multidisciplinarity, in order to break with the fragmented patterns of the professional knowledge. What is the place of integrated care in a space managed and referenced only by psychologists? This was one of the most difficult discussions to make within the service, given the difficulty of the coordination in breaking with its convictions and power-centered clinic - according to it, a clinic of psychoanalysis.

The routine of this CECO had a range of activities ranging from the youngest interested in freedom to play, to the mental health users of the CAPSIII in the region, to the ladies who went to sew and weave patchworks, but actually went to find space for talking and exchanging life experiences. But this presence only occurred at the times established for the activities; at other times, the space had the emptiness of the presence of individuals and comforting feelings.

Aleixo (2013) says that a CECO should be an open service, a space that people can use to produce experiences, develop their potentialities, inter-subjectivities, exchanges, experimentation, encounter production, learning, emerging in a meeting of possibilities and social inclusion.16

For this service, I intended to build a professional approach in which the traditional standards of the core of professional knowledge were not the only determinants of the conduct to be adopted among the users who accessed the service. Despite being targeted at all the age groups, the visitors were mostly school children.

Therefore, I joined in the attempt to participate in activities in which I could be with the different age groups, I chose a group of children's cooking and a handicraft group that were to the users of the CAPSIII of the region, accompanied by two professionals of reference. To better explain this choice, I will discuss about the outcomes in the results.

With this in mind, I tried to think about what the children's agitation and aggressiveness communicated to the CECO professionals and how important that device was to them, since in some way it enabled them to express their anguish. This group arose from a specific demand of children and adolescents during an assembly, already in a constitution of autonomy, and had the form of a spontaneous demand or by referrals.

The general objective of this activity was to validate the desire of a population with few resources to carry out a workshop that focuses on the group interaction of these individuals, but it also serves as a listening and welcoming space for conflict resolution within the group itself, often, of social situations that only arise from the bond.17

The commitment of the speech therapy to the children was through listening and not simply to the symptoms that emerge in the dialogical situation, considering playing as an imaginative space that produces changes in the language and that makes it possible to attribute other meanings to life and other roles as a speaker. Thus, it was proposed that the children could do their activities in an individualized way, dealing with themselves and their own anxieties, even within a group.18, 19, 20, 21

**WORKSHOP AND INCOME GENERATION**

The workshop visited for over a year was composed of approximately 20 users of the mental health network in Campinas, as well as two health professionals. It had as a work object the production of handmade paper from the recycling of paper, cardboard and the reuse of foods such as onion peel and banana fiber. In addition to the direct production for sale in the store, there was a partnership with other workshops, through the supply of raw material for the production of other decoration and stationery products.

It consists of a mental health device of the municipal health network of Campinas that emerged in 1991 and acts on the logic of the psychosocial rehabilitation through work inclusion, aiming to meet the work demand of people with mental disorders. It is a space in which the disease is put on hold and is not reduced to the treatment of diseases and a therapeutic space, it is a source of sociability and contractuality.22,23

Something to think about as a substitutive device for the social inclusion that seems to me as urgent is the authorization for screening only through referrals from other health devices. Based on Amarantes & Beloni (2014), it is necessary to transcend the care model that reduces the therapeutic scope and the treatment of diseases, since at work people know each other, recognize each other and cooperate to overcome obstacles, in a process that connects what is common to all. It is a source of sociability and contractuality that puts the disease between parentheses to deal with the experience of concrete subjects, the expression of citizenship.24,25

Therefore, in this service, my interventions were based on the health aspects of the worker due to the use of machinery with high intensity noise over a long period of time.26 As I also prioritized intra and intrapersonal communication strategies among the workers, important communicative aspects to work relations, building strategies to recognize their own communicative skills and awareness as a subject of choices and senses.27

In addition to these proposals, there was direct interference with one of theworkers aiming at the construction of strategies to recognize their communicative skills and work, acceptance of themselves as subjects of choices and senses. In order to increase their interest in new ways of positioning themselves as a "person" and no longer cancel themselves out from the speech of others.

Therefore, daily life situations were used both inside and outside the workshop to enable the workers to understand the aggravations of the occupational noises to which they were subjected, elaborating (together with workers and staff) strategies that eliminate or reduce their exposure to the noise, as well as the sound competition between the noise of working utensils, radio and ambient sound. Situations that have been worked through weekly conversation circles, as well as during the work routine of these workers.

**COMMUNITY RADIO (ELECTIVE INTERNSHIP)**

Residents are allowed a one-to-three-month internship in other services, in health networks of different cities within and outside the country. Therefore, this device, which is considered a space for social inclusion and mental health in the city of Montevideo in Uruguay, comprised of volunteer professionals and users of hospitalization, and mental health outpatient clinics in the city, was selected for the exploration of new forms of mental health.

It is a space coordinated in a participative way between volunteer professionals and mental health users, composed of specific workshops to organize the program live and open to an audience, which takes place on Saturdays. The workshops have specific topics and are organized by the days of the week, aiming at writing information, making decisions, organizing the live program, and space for socio-political empowerment.

My estrangement was due to the delay of the Uruguayan psychiatric reform, since the last government reformulated the entire health network, but the mental health was kept mostly with hospitalizations in psychiatric hospitals and treatments with electroshocks. At the time the construction of a law to create substitutive services was contemplated, which intended to have people in their territories and not in isolated and vertical treatments.

In this space, I was able to contribute with my Speech Therapist's perspective, in order to consider that the communicative processes were favorable and how to potentiate them according to individual and group abilities. Thus, strategies for valuing and stimulating the communication, the dialogical circulation and the exercise of expressing themselves were devised.

It was an observation internship, but there was room for intervention due to the participants' view of the Speech Therapy professional in Uruguay. According to the reports, it would be a profession closed to other eyes and directed only to the rehabilitation of grievances.

As a speech therapist and mental health professional, I was able to contribute with these participants, taking into account their personal characteristics through the improvement of the articulation of speech, diction, speed of lexical access, working memory, voice, vocal projection, fluency, prosody, speech rhythm, and other communicative skills that were needed.

**RESULTS**

As well as children, adults with mental disorders may also have language alterations that change their communicative abilities, auditory alterations, changes in chewing and swallowing, dysphagia, and vocal changes as observed in the services I have been through. In addition, the social isolation of these people is recurrent when they cannot communicate with their network, remembering that it is through the interaction that the language is developed and that the subjectivity is constructed.

I believe that one of the most observed limiting points in this experience process was the difficulty of other health professionals to perceive how situations of delay or loss of speech-language skills affect both human life and their ability to communicate. In situations that they were able to observe this, they did not direct the appropriate referral for a more appropriate sharing of the case.

It is one of the most discussed issues with the teams and it is well explained by Japiassu (1976), the interdisciplinarity is a necessity to better meet the reality of the global formulation of the human existence, self-knowledge, which goes beyond the dissociation between theoretical domains. Therefore, this would allow a mental health clinic that encompasses the users' demands, more for its existence in the social environment in which it is inserted than for the pathology and mental health framework.28

It was important to observe in the space of CAPS III the role of language, of the image between the subject and the context of the social group in which it is found, and to provide fundamental conditions for the (re)signification of the symptoms through the change in relation with the language, thus, communicative processes favorable to the improvement of relations, the re-signification of the social relations on the difficulties and on the conditions of language and communication.

In this service, at the beginning of my activities, the limiting point was the resistance of some professionals of the service to accept the core of Speech Therapy in CAPSIII, which made me look for partnerships in which the dialogue was more possible and through which the discussion could progress. With the withdrawal of these professionals the service dynamics became more fluid and participatory.

Consequently, there was a greater interest of both practitioners and service users to learn more about the Speech Therapy skills and, as a result, they began to seek guidance on conduct related to hearing, speech, language, feeding, and more broadly about communication.

With the team, there was the identification of the demands for Speech Therapy and request of help to identify the possible flows with discussion of the cases of differential diagnosis in team meetings and also in matrix support in the health centers. With this, some guidelines were made regarding the communication of the users with the service and the service with the users, and redistribution of the demand with sharing of the cases that needed rehabilitation with the intention of enabling the users to reach the maximum of their potentialities.

It was important to welcome the users' demands, building a personalized therapeutic planning that would take into account their singularities and decisions. This made them realize the speech-language aspects that needed intervention and, from that, they sought my help, building agreements that were coherent to their needs.

In relation to the Coexistence Center, my reports are crossed by the difficulties in the institutional and work relationship that I have experienced, and I share therefore a statement by Foucault (2009), which says: “nor the relation of domination is more a 'relation', nor the place where it occurs is place... it imposes obligations and rights; it constitutes careful procedures. It establishes marks, records memories in things and even in bodies”. Therefore, it is the correlations of force, in their inequality, that continually induce ever-localized and unstable states of power.29

Thus becoming a space not consistent with the precepts of mental health, a space of asymmetrical relations of an authoritarian and institutionally sustained vision, a place where dialogue was not possible, always crossed by violent situations of non-valuation of the resident and constant complaint.

It was requested not to stay in this space, due to the complex institutional relationship between the residency program and the institution that manages the services, I was not allowed to leave this space. This created a defense in which I became less purposeful, channeling the violence in order to make my body sick and without desire for work, which influenced even in the writing of this article.

In this situation, I found myself as a result of what Benelli (2014) cites in relation to the tolerability of frustration when he says that the psychic organization of the individual begins to collapse, without perspectives, since the indicated paths are not feasible when the medium (in this case CECO management) sends constant messages of how much you are disqualified to be there.30

However, with the children and the users of CAPSIII who participated in activities in the space, I was a figure that represented affection and bond, which made possible the re-signification of the way they participated in the activities, becoming more active and agents of their own actions, deciding to modify the rules that did not make sense to them, organizing themselves and helping to reach a common goal for all.

In addition, a cookbook was produced, about which they decided collectively and collaboratively the week before, what kind of recipe they could make in the next activity. Which should fit the financial possibilities of the space, since it was fully financed by the service box. In addition, they organized themselves over who would read the recipe and explain it, who would copy it in the book and who would be responsible for each stage of it. In the end, everyone who participated tried the final result and signed the book their participation in that construction.

The effect of this coexistence was the key point of my stay in the service, producing a better link between myself and the users, as the senses were incorporated into the dynamics of the group, with consequent elaboration and acceptance of limits and rules by the children, as well as of the time of the events, which allowed for new skills, other cultures and food experimentations.

This is because playing, for Vygotsky, is a time when the child is not concerned about the outcome, but implies that there are rules and imaginative actions. Since its management is enabled by the clinical method in playing, which produces changes in the language (and subjectivity) of the child and it is how one can reflect on how the symptom presents itself in the speech of a particular subject, is an activity that allows to attribute other meanings to the everyday life.20,21

As for the work and income generation workshop, my construction was affected by the experiences in CECO, since every day my body became ill and I could not do it anymore, always forcing myself to the labor production to match the demands of the program: being in three services, organizing the elective internship, attending extension classes, supervision, program classes, meetings and other collective spaces.

As a speech therapist, my intention was to observe how my look at the speech-language aspects, improvement of the human communication patterns, could influence the dynamics of the service. Since communication is the channel responsible for transmitting and receiving information, it is a social practice of everyday life that occurs in an individual and collective way, fundamental to the interpersonal relationships as it is essentially a relation, not forgetting aspects such as autonomy and effective communicative attitudes.

With the workers, there was a sensitization due to the presence of a speech therapist next to them in the work process, although an inconsistent presence. This allowed for core interventions in the communicative aspects that are important to the work relations and to the individuals present in this.

This is because the group is a "place of creative constructions in the field of social relations", as pointed out by Panhoca & Leite (2003), be it a group of therapeutic activities or a working group, as in the case of this workshop of generation of income that is called a therapeutic work space. In the case in which I worked in a more individualized way, with the passing of the days, it was different from removing body and subjectivity from a series of pre-established attributes, there was a re-signification of the space and the worker began to propose new experiences.13,14,15

With the technical team (monitor and coordinator) it was possible to construct an article for presentation at a congress, which would tell about our experience as moderators of the conversation circles that took place weekly in the workshop. In addition, the coordinator was responsible for my field preceptory and someone who was close to embrace me in the conflicting situations that occurred in the other service.

In the case of the community radio, during one of its workshops, the participants themselves used the knowledge of the speech therapy in the work process of the users, as it is a service in which the means of communication uses the sending of messages, whether by verbal or written codes. Although they were not aware of the many possibilities of action of this nucleus, they considered that everyone should improve their abilities related to the verbal oral communication necessary for the live presentation, in which agility of reasoning, good diction and an expression without failures are required.31

With this, shortly after my entry, I was proposed by the participants a workshop where we could work on the communication skills related to the oral presentation on the radio, because they believed that among their members there was difficulty in speaking, which often caused a change in the understanding of the message passed both to those in the audience and to those who listened on the radio.

The limiting point of this space was not to find professional nucleus partners and to understand the place of the speech therapy in that city, as well as the mental institution logic of the society, having its crises treated in a psychiatric hospital and more chronic cases excluded from the society in therapeutic colonies in the suburbs.

This space is of great importance in my training, due to the social dynamics that I found, the culture of which I was part for little more than a month, the possibility of learning and new perceptions for the mental health clinic. With this, I was asked by the tutor responsible for the internship a conclusion work in which I could share my findings and experiences in a document that could remain as a project for them.

**CONCLUSION**

The speech therapy has a training aimed at treating disorders already in place, but also has a social function to fulfill in relation to language and communication, which should prioritize the increase of autonomy, social and family inclusion, communicative attitudes that stimulate the practice of dialogue and the exercise of expressing oneself in the face of singular experiences.

As a speech therapist with experience in mental health for children, during my residency I was provided another mental health speech therapy clinic, the clinic with adults. In this, it was possible to reframe the speech-language work and expand intervention proposals, allowing a new knowledge and recognition of the skills directed to human communication.

Even though the speech therapy activities cause great strangeness to mental health teams, it was possible to sensitize some professionals and services about the importance of observing the human communication and other more specific speech and language aspects such as hearing, language, voice, and swallowing. In these services I experienced a diversity of encounters and possibilities that helped me in the construction of the professional clinic that I believe to be multifaceted and in an eternal construction, made in contact with the other. Not without understanding that each individual is unique, with individual differences and lives.

I leave this process wishing that the looks for the mental health speech therapy are more generous and welcoming, and that the Federal Speech Therapy Council invest in the recognition of this specialty, empowering the professionals who for so many years have been trying to contribute to a new speech therapy clinic, which is less focused on curing pathologies.

I also hope that this construction contributes to multiple approaches that consider the several moments in which the subjectivities emerge as an ongoing process that is constituted through a multiplicity capable of apprehending the subject's movements in the sociocultural environment as something that implies effects of meaning in the construction of identities of the subject, and of the affections that enable them to belong to themselves and to the territories they occupy, reflecting the interchange between the internal and the external.

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