MENTAL HEALTH AND PSYCHOSOCIAL CARE

Strategies and Trends in Psychology and Mental Health

Ryan James

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Presentation

This book is loaded with stories and stories (as they used to say ‘in the old days’). When I graduated in medicine, and chose psychiatry as a specialty, there weren’t many prospects for a job that could be considered health. The almost certain fate of a newly graduated psychiatrist was to work in public, decrepit and filthy asylums or in private, decrepit and filthy asylums, where, to make matters worse, we were exploited by the “madness industry”, as the late and dear friend and Professor Carlos Gentile de Mello.

The option, which many adopted, was to turn a blind eye to this situation and set up a psychoanalysis office, an option that had a very promising and socially valued future. This is because, at that time, even in private practice, the practice of psychiatry was considered a minor practice. The goal of most was to be a psychoanalyst, to do analysis, and, in this line, the top was to become a trained psychoanalyst. As another friend, Antonio Lancetti, said, there were times when being anti-asylum was not fashionable.

It was in one of those asylums that, with two other medical colleagues, we decided to say no to the violence of psychiatry, denouncing to society the cruel and perverse reality of psychiatric institutions. But, as these were times of dictatorship, we were immediately fired and with us all those who dared to support us. But, there were also times of “democratic opening”, and other cries occurred here and there. One of these cries gave rise to the creation of the Brazilian Center for Health Studies (Cebes), where we are anchored – until today – and started to fight more collectively. In this context, the beginning of the Brazilian psychiatric reform process was marked, which has been transforming, since then, the relationship between society and madness, questioning not only the current psychiatric institutions and practices,

The purpose of this book is to instigate the reader to reflect on this entire journey, which goes from the foundations of psychiatry and the asylum to current projects for the construction of a new ‘social place’ for people in mental

suffering. Therefore, I started by characterizing the process of appropriation of madness by medicine with the constitution of knowledge and the main psychiatric institution, the hospice, identifying and developing the main concepts and practices that founded the psychiatric paradigm. Next, I made a brief history and discussion of the main experiences that aimed to transform psychiatry, whether adapting or adjusting the asylum care model or modernizing it towards mental health in the community (the so-called psychiatric reforms),

After this historical review, and based on it, I seek to contribute to the expansion of the understanding of the dimensions and strategies of the field of mental health and psychosocial care, for which I develop the concept of a complex social process that, in a word, launches us into a where the transformations are not limited to merely assistance changes. And as a next step, nothing more fair and necessary than starting an analysis of the paths and trends of mental health and psychosocial care policies in Brazil where utopia, understood as an objective and a project of struggle, is the construction of a new social place for people in mental distress.

Finally, I suggest some readings and some movies. The most profound and rigorous scientific treatise cannot, for the most part, speak as directly to the soul as a work of art. This topic is also the subject of our book…

I want to register my thanks to my companion Leandra Brasil and to my friends Edvaldo Nabuco, Paulo de Tarso Peixoto and Bia Adura for reading and observations.

1:Mental health, territories and borders

What is known as mental health is a very extensive and complex area of knowledge. How many times do we hear some professional say that they "work in mental health"? What is he saying with that? Who works with issues related to people's mental health? From a positive answer to this question, we can extract a first great sense of the expression 'mental health' so that we can continue with our reflections. And what is he? It is that mental health is a field (or an area) of knowledge and technical action within the scope of public health policies.

It is important to point out that few fields of knowledge and action in health are so vigorously complex, plural, intersectoral and with so much transversality of knowledge. Unlike psychiatry, mental health is not based on just one type of knowledge, psychiatry, and much less is exercised by only, or fundamentally, one professional, the psychiatrist. When we refer to mental health, we expand the spectrum of knowledge involved, in such a rich and polysemic way that we find it difficult to delimit its borders, to know where its limits begin or end.

Mental health is not just psychopathology, semiology… In other words, it cannot be reduced to the study and treatment of mental illnesses… neurosciences, psychology, psychoanalysis (or psychoanalysis, for there are so many!), physiology, philosophy, anthropology, philology, sociology, history, geography (the latter provided us, for example, with the concept territory, of fundamental importance for public policies). But if we are talking about history, subjects, societies, cultures, wouldn't it be wrong to exclude the religious, ideological, ethical and moral manifestations of the communities and peoples we are dealing with?

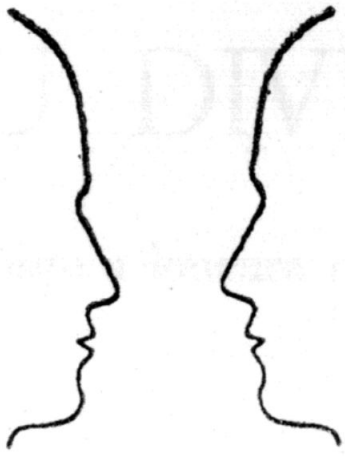
Anyway, what are the limits of this field? What are the types of knowledge that actually compose them? Can we have a definitive and exclusive answer to these questions? In The Divided Self, the first book by the psychiatrist and psychoanalyst Ronald Laing, one of the founders of the

current known as ‘antipsychiatry’ – and which I will discuss later –, a reflection on the notion of truth emerges from a very common image, which is generally used to ‘play an optical illusion’. To introduce the image, Laing (1963: 21) notes that

> man, in particular, can be seen as a person or a thing. Now the same object, viewed from different points of view, gives rise to two entirely different descriptions, and these give rise to two entirely different theories, which result in two entirely different groups of action. The initial way of seeing a thing determines all our subsequent relations with it.

At this point, he proposes that we examine the “equivocal or ambiguous figure” (Figure 1). Interestingly, thirty years later, the sociologist Boaventura de Souza Santos (1992) refers us to this same image, which is that of two profiles facing each other that, seen with another background and background perspective, makes us see, on the contrary, a greek pitcher on a black background. What is the true picture, he asks us? The two profiles or the jug?

Figure 1 – What is the true image? The profiles or the jug?



Source: Laing (1963).

Ambiguity? Error of perception or thought? Contradiction of reality?

But, finally, and this is the big question we have to face: is there a true image that cancels and makes the other or all the

others unfeasible? Why do we have to think in a dualistic, antinomic, simplified way? The nature of the field of mental health has contributed to us starting to think differently, no longer with this paradigm of the single and definitive truth, but in terms of complexity, simultaneity, transversality of knowledge, of "constructionism", of "reflexivity" (Spink, 2004), as we will see later.

Earlier, I argued that when a professional tells us that they "work on mental health," they are telling us that they work on issues related to people's mental health. But, in fact, in care practice, until very recently, working "in mental health" meant working with mental illnesses, with hospices, with asylums!

But, what is 'mental illness'? Is it the opposite of mental health? Is it mental imbalance? We are now faced with another meaning of the expression mental health, that is, with the idea that mental health is a healthy mental state, therefore, we could conclude, a normal state. Or, to put it another way, a state of mental well-being, or mental health, or yet, that there is no form of mental disorder.

The World Health Organization (WHO) considers health to be a "state of complete physical, mental and social well-being", and not merely the absence of disease. With this definition, we could admit that we have evolved a little, but that we continue with many difficulties and with the same previous problem, because it is very difficult to establish what this state of complete well-being is… Sometimes I question if there is anyone like that!

However, it seems obvious, but it is very difficult to define what 'disease' is. In many books we find health defined as the absence of disease; just as we find that disease is the absence of health! Leonidas Hegenberg, in Disease: a philosophical study (1998), observes that it is common to use the term disease to define health, and the term health to define disease.

We really are at an impasse. What is normal? What is normal? Up close, no one is normal? But if this is 'true', we can conclude, as Ernesto Venturini (2009) argues, that "up close, nobody is abnormal either"! There was a doctor who considered that normal was someone who was not properly

examined… More than a play on words, we are facing a very serious and serious scientific problem. For certain topics, for certain questions, it becomes much clearer that the dualist-rationalist scientific model (error vs. truth) is not enough to effectively deal with certain problems. And it's not just in the area of mental health! There are black holes, the enigmas of the origin of life and the universe, among many others, that science, especially alone, cannot clarify or understand.

It now seems that the relationship between the two great senses makes sense: mental health is a very polysemic and plural field insofar as it concerns the mental state of subjects and collectivities, which, in the same way, are highly complex conditions. Any kind of categorization is accompanied by the risk of a reductionism and a flattening of the possibilities of human and social existence.

As I noted a little earlier, until very recently, "working in mental health" was the same as working in hospices, asylums, outpatient clinics and psychiatric crisis emergencies. It was to work with aggressive madmen, in inhuman, inhumane, isolation and segregation environments. Note that I said "was" because it is no longer exclusively so. Many perspectives and scenarios are emerging around the world that are radically transforming the field of mental health.

2:An institution for the insane, the sick and the sane

Tomorrow morning, at the time of the visit, when, without any dictionary, you try to communicate with these men, please remember and recognize that, in front of them, you have only one superiority: strength.

Antonin Artaud and the authors of the manifesto of "La Révolution Surréaliste", in a letter to the directors of the hospices (apud Basaglia, 2005: 109)

To continue the discussion started in the previous chapter, it is necessary to go a little long, but very interesting and enlightening. For this we will start by revisiting the first steps of a science called 'alienism', a pioneer in the study of what is currently known as 'mental disorders'. From there, we will follow its most important transformations until we reach the present day, when we will analyze contemporary issues and national and international perspectives relevant to this field.

When we talk about alienism, we start by referring to Philippe Pinel, the doctor who became known as the father of psychiatry, the successor of alienism. Pinel actively participated in the events of the French Revolution, which was a process and a period that marked the history of humanity and, partly due to this reason, his ideas and deeds still have repercussions in our lives today.

The French Revolution was a unique historical moment; stage of several economic, social and political transformations that are of great importance for the field of medicine and the field of health and, in our particular interest, for the history of psychiatry and madness.

One of these transformations took place in the institution we know as a hospital. Currently, when we talk about a hospital, the image of a medical institution comes to mind: corridors with wards and patients lying on beds and assisted by doctors and nurses. It could not be otherwise, the hospital is the most important space for the practice of medicine.

But, it wasn't always like that. The hospital, strange as this may seem in modern times, was not a medical institution. It was initially created in the Middle Ages as a charity institution, whose objective was to offer shelter, food and religious assistance to the poor, miserable, beggars, homeless and sick. And it would not be surprising if a poor and miserable beggar were not also sick! Therefore, to name such religious institutions, the expression 'hospital' was used, which, in Latin, means lodging, inn, hospitality.

For George Rosen – one of the greatest scholars in the history of medicine and health policy – one of the basic values that motivated the emergence of hospitals were the teachings of Paul the Apostle, who preached "faith, hope and charity; but the greatest of these is charity" (Rosen, 1980: 336-337). Thus, from the 4th century onwards, from the pioneer hospital created by Saint Basil, in Caesarea, Cappadocia (369-372), many other institutions of this nature were created with the same purpose.

Finally, through a long process – which certainly did not happen overnight – the hospital was transformed into a medical institution. Until the moment of this transformation, madness and madness had multiple meanings – from demons to deities, from comedy and tragedy, from error and truth. Multiple and plural were also its places and spaces: streets and ghettos, asylums and prisons, churches and hospitals.

In the 17th century, a new modality of hospitals emerged, no longer exclusively philanthropic, but which began to fulfill a more explicit social and political function. I am referring to the General Hospital, created in 1656 by the King of France. For the philosopher Michel Foucault, the advent of the General Hospital was of fundamental importance for the definition of a new 'social place' for the insane and madness in western society.

When studying the origins of modern medicine and psychiatry, Foucault referred to the General Hospital as "The Great Internment" or "The Great Enclosure", even taking advantage of an expression used at the time that highlighted the fact that the institution carried out systematic and systematic practice.

widespread isolation and segregation of significant social segments. In fact, article XI of the founding decree of the General Hospital intended it for the poor "of all sexes, places and ages, of any quality of birth, and whatever their condition, valid or invalid, sick or convalescent, curable or incurable" (Foucault, 1978: 49).

In the words of the French thinker:

It is about collecting, housing, feeding those who present themselves of their own free will, or those who are sent there by the royal or judicial authority. It is also necessary to ensure the subsistence, good behavior and general order of those who could not find their place there, but who could or deserved to be there. This task is entrusted to directors appointed for life, who exercise their powers not only in the buildings of the Hospital but also throughout the city of Paris over all those who depend on their jurisdiction. (Foucault, 1978: 49)

As can be seen, with the advent of the General Hospital, hospitalization began to be determined by royal and judicial authorities. The director of the establishment was delegated absolute power that was exercised over the entire population, the institution's potential clientele, and not just over those who were already hospitalized. Considering such characteristics, Foucault concluded that the General Hospital would be, above all,

a semi-juridical structure, a kind of administrative entity that, alongside the powers already constituted, and in addition to the courts, decides, judges and executes. (…) Almost absolute sovereignty, jurisdiction without appeals, right of execution against which nothing can prevail – the General Hospital is a strange power that the king establishes between the police and justice, within the limits of the law: it is the third order of repression. (Foucault, 1978: 50)

Thus, as we can see, a great transition began, in which the charity hospital underwent a metamorphosis and began to assume more social and political functions. It was in these institutions that many doctors went to work in order to humanize them and adapt them to the new modern spirit, especially after the French Revolution, and ended up

transforming them into medical institutions. In a word, the hospital was medicalized; has been transformed into 'the' medical institution par excellence. In line with the motto Equality, Liberty and Fraternity, which guided the revolutionary ideal, all social spaces should be democratized. This is how hospitals became the object of profound changes. First, several inmates who were there as a result of the authoritarian power of the Ancien Régime were released. On the other hand, new assistance institutions were created by the republican state (orphanages, reformatories, correctional facilities, normal schools, rehabilitation centers). The hospital was losing more and more its functions of charity origin and later of social control; in the same proportion, it began to assume a new purpose: that of treating the sick.

Medical intervention in the hospital space, which was previously occasional and paroxysmal, would become regular and constant: knowledge about the hospital would allow the doctor to group diseases and, thus, observe them in a different way, on a daily basis, in its course and evolution. In this way, knowledge about diseases was produced that, informed by the epistemological model of the natural sciences, had not yet been possible to build.

But this process, which we call the medicalization of the hospital, had two sides: the hospital became the main medical institution, that is, it was appropriated by medicine, absorbed by its nature; on the other hand, medicine has become a predominantly hospital knowledge and practice. What this means? That, if, on the one hand, the hospital underwent fundamental transformations with the process of medicalization; on the other hand, the scientific model of medicine underwent transformations that would allow the birth of the anatomoclinic. For Foucault, this process of medicalization of the hospital took place at the end of the 18th century and was operated, essentially, from a political technology, which is the discipline.

In practice, what does discipline mean within the institution? Initially an art of spatial distribution of individuals; hence, the exercise of control over the development of an action (and not over its result); consequently, a perpetual and constant

surveillance of individuals (emblematized by the surveillance model made possible by Bentham's Panopticon, analyzed in Discipline and Punish (Foucault, 1977a); and, finally, a continuous record of everything that happens in the institution.

The hospital became, at the same time, a space for examination (as a research laboratory that allowed a new empirical contact with diseases and patients), a space for treatment (framing diseases and patients, discipline of the therapeutic body and the therapeutic technologies) and space for the reproduction of medical knowledge (school hospital, medical residency, privileged place for teaching and learning).

But if it is true that this new model produced original knowledge about diseases, on the other hand, it is true that this knowledge referred to an institutionalized disease, that is, a disease modified by the previous action of institutionalization. In other words, the isolated disease, in its pure state, as intended by natural history, ended up being a disease produced, transformed by the medical intervention itself.

The replacement of the absolutist society (monarchical, totalitarian, clerical) by the disciplinary society assigned a new role to institutions: the discipline of bodies, the introjection of the norms of the social pact built between peers, the normalization of citizens and the very notion of citizenship. This is how hospitals – before a place of mortification and 'de-historization' – became a place of truth, of knowledge, of positivity.

But this historical link between the medicine that was being constituted along the lines of the new transformed institution and this, the hospital, which was being adapted to this hospital medicine, strongly marked the nature of the biomedical model of Western medicine, which came to be characterized as predominantly hospital. This medical model (because it is important to remember that there are other medicines, such as homeopathy, Ayurvedic medicine, theosophical medicine, acupuncture…) implies a relationship with the disease as an abstract and natural object, and not with the subject of the disease. illness experience. Thus, it is not just psychiatry that has this genetic relationship with the hospital (or hospital-

centric as they say), of being specialized (prioritizing isolated knowledge of organs, parts of the body),

But let's go back a little to observe in more detail the process of transforming the philanthropic hospital into a medical hospital in the case of psychiatry.

Upon arriving at hospital institutions, in the name of a new and promising knowledge about diseases, the doctor subtracted the administrative power of the hospital from philanthropy and the clergy. If previously the doctor was summoned to the hospital only to attend to some more serious cases; if he attended the hospital space occasionally and irregularly (in the same way that he was summoned in prisons, for example), he now became the fundamental character of the hospital. This is how, as the maximum holder of hospital power, the doctor Philippe Pinel began his great work of medicalization of the General Hospital in Paris. In 1793, Pinel began to direct the Hospital de Bicêtre (one of the units of the General Hospital), four years after the beginning of the Revolution, and later continued his work at La Salpêtrière. Pinel became known as the founder of psychiatry,

Pinel participated in the group known as the Ideologists, which was of enormous importance to French philosophical thought in the late 18th century. The ideologues sought a truly scientific basis for the knowledge of the phenomena of reality, taking as their main reference the model of Natural History. For them, "knowledge was a process whose basis was the empirical observation of the phenomena that constituted reality" (Bercherie, 1989: 31). In this philosophical tradition, the objective was the knowledge of man in the face of what is imprinted on him by his experiences, for himself and for what is external to him. This analytical-philosophical method is situated in the tradition of Locke and Condillac which, adopted by the Ideologists, was especially applied to medicine by Cabanis.

Locke's Theory of Knowledge emerged, in a way, as a counter-response to Descartes' doctrine of ideas. For Locke, ideas were constituted from empirical experience, since all human knowledge would have its origin in 'sensation', from

which ideas would be formed, from the simplest to the most abstract and complex. On the other hand, as far as political thought is concerned, Locke presupposed an absolutely free and independent nature of men, who should not be subjected either to divine absolutism or to that of political regimes. Pinel is inscribed in this same order, when proposing the freedom of the insane who, although released from chains, must be submitted to an asylum treatment, under a regime of complete 'isolation'. This, however, does not mean the loss of freedom, since, on the contrary, it is the treatment that can restore to man the freedom subtracted by alienation. The first and most fundamental therapeutic principle of 'moral treatment', the principle of 'isolation from the outside world', is a Pinelian construction that to date has not been fully overcome in contemporary psychiatric practice. If the causes of mental alienation are present in the social environment, it is isolation that allows them to be removed, transporting the sick individual to an environment where they can no longer harm him.

The clinic was born inspired by this nominalist philosophical tradition, in which the relationship between the perceptive act and the element of language would be fundamental. It is by the simple and pure observation of nature that science must find its order and truth. Foucault highlights that Pinel is inspired by Condillac to build his method of observation:

to analyze is nothing more than to observe in a successive order the qualities of an object, in order to give them in the mind the simultaneous order in which they exist… Now, what is this order? Nature indicates it by itself; is the one in which she presents the objects. (Condillac apud Foucault, 1977b: 108)

By writing the Medical-Philosophical Treatise on Mental Alienation or Mania, the first book in the discipline that would later come to be known as psychiatry, and by introducing several innovations in the practice of hospitals for the insane, Pinel laid the foundations for what became known as the 'alienist synthesis'. He elaborated a first nosography, that is, a first classification of mental illnesses, he consolidated the concept of mental alienation and the alienist's profession. With

the operation of transforming the hospitals in which he worked, Pinel also founded the first psychiatric hospitals, determined the principle of isolation for the insane and established the first model of therapy in this area by introducing moral treatment.

Let's take a closer look at some of these concepts and strategies. Let's start with the concept of mental alienation. First, it is curious and important to note that Pinel does not choose the term mental illness, but mental alienation. In discussions with Bichat, one of the fathers of pathological anatomy, he even questioned whether it was a disease or a process of a different nature, as he considered it a mistake to seek the seat of madness, insofar as nothing was "more obscure and impenetrable".

But what does alienation mean? Mental alienation was conceptualized as a disturbance in the scope of passions, capable of producing disharmony in the mind and in the objective possibility of the individual to perceive reality. For Hegel, who analyzed Pinel's book, alienation would not be the absolute loss of Reason, but simple disorder at its core. But, we might argue, could Reason be partial or by definition imply wholeness?

In the most common sense of the term, alienated is someone 'from outside', foreigner, alien (the etymological origin is the same). It could mean being out of touch with reality, out of control of your own wants and desires. Out of this world, out of this world (in the world of the moon!).

Alienated, from alienare and alienatio, also means becoming another. Another from Reason? Another of the human? An irrational stranger? To the extent that someone in this condition of alterity could represent a serious danger to society, by losing their judgment, or the ability to discern between error and reality, the concept of mental alienation is born associated with the idea of 'dangerousness'. In a certain sense, it can be considered that throughout all these years the concept of mental alienation has contributed to produce, as a consequence inherent to the very notion, a social attitude of fear and discrimination towards people identified as such.

Alienation, loss of Reason, irrationality, animality. Emil Kraepelin (1988: 22), considered the 'father of the modern psychiatric clinic', already in 1901 in his "First lesson" of the Introduction to the Psychiatric Clinic,

But, let's go ahead. The first, and most important, step in treatment, according to Pinel, would be isolation from the outside world. Isolation – which meant institutionalization/full hospitalization – would thus be a fundamental imperative so that the alienated could be treated properly. Therefore, the alienated person was removed from interferences that could harm both the accurate observation, for the consolidation of the most accurate and correct diagnosis, as well as the moral treatment itself, which, as one might suppose, would require order and discipline so that the unruly mind could again find your goals and true emotions and thoughts.

For Pinel, the isolation provided by hospitalization would make it possible to isolate "alienation in its pure state" in order to know it free from any interference. But it also became, and for the first time, a place of healing, and not just of death, because, ultimately, in the hostel-hospital, people went there to die. In other words, the principle of isolation would be associated with the production of knowledge in the field of alienism, as the Pinelian hospital, now transformed into a medical institution, became the very laboratory where people would be observed and studied, their behaviors described, compared, analyzed and classified. To the extent that mental alienation would be a disturbance in the balance of passions, and that the hospital for the insane could represent, as Pinel claimed, an establishment where it would be possible to subject the insane to "invariable rules of internal police", the hospital would itself be a therapeutic institution. Let's see how Pinel himself explains his ideas:

In general, it is so pleasant for a sick person to be in the bosom of the family, and there to receive the care and consolation of a tender and indulgent friendship, that I painfully state a sad truth, but confirmed by repeated experimentation, namely, the absolute necessity of entrusting the alienated into the hands of third parties and isolating them from their relatives. Confused and tumultuous ideas (…) demand a set of measures adapted

to the particular character of this illness, which can only be gathered in an establishment dedicated to them. (apud Castel, 1978: 86-87)

Finally, we reach one of the most important aspects of this text: the moral treatment. We saw initially that the hospital served as a laboratory, as an examination space for the study of mental alienations, and that later, as a disciplinary institution, which imposed rules, conducts, schedules, regiment, aspired in all of this to a therapeutic function for intending to establish a reorganization within the scope of the uncontrolled passions of the alienated. Moral treatment consisted of the sum of principles and measures that, imposed on the alienated, intended to re-educate the mind, ward off delusions and illusions and bring awareness to reality. The hospital, as a disciplinary institution, would itself be a therapeutic institution. Esquirol, Pinel's first and most outstanding disciple, argued that a home for the insane, in the hands of a skilled alienist, would be the most powerful agent for the cure of mental alienation. Pinel turns to Tenon for whom

a hospital is, in a way, an instrument that facilitates healing; but there is a great difference between a hospital for the febrile and a hospital for the curable; the first offers only a means of treating with greater or lesser advantages, depending on whether it is more or less well distributed, while the second has, in itself, the function of a remedy. (apud Castel, 1978: 61)

João Pinheiro Silva, a Brazilian alienist at the beginning of the 20th century, considered that asylums for the insane had many analogies with educational establishments because they re-educated unruly behavior and minds.

Among the most important strategies of moral treatment was what Pinel called 'therapeutic work'. Work assumed a very singular importance in society in the midst of transition of production mode, when capitalism was rehearsing its first steps, and work would therefore be a means of re-educating unruly minds and uncontrollable passions.

It is interesting to note that Pinel, in addition to being a doctor and philosopher, was an important politician of the

revolutionary period. Elected deputy of the National Constituent Assembly, which drafted the first republican democratic constitution, Pinel was one of the builders of the modern concept of citizenship. As we know, the French Revolution was a process of overcoming the Absolutist State, composed of the alliance between the monarchical aristocracy and the clergy. In the Ancien Régime, before the Revolution, the debate around human, social and political rights was considerably precarious. It was the French Revolution that came to bear the banner of these rights that, updating a concept from ancient Greece, were synthesized in the notion of citizenship. So, isn't it curious that around the same character, Philippe Pinel,

Now, citizen/citizenship comes from the city, from the polis, from the space of the city, the public space of social, political, economic exchanges between the members of a community. According to Hannah Arendt (1996), in Greece there were the realms of the house (relating to private space) and the polis (relating to the city, politics). The kingdom of the polis is shared with the others, because in the Athenian conception, man should participate in the life of the community, hence his civic virtue, his responsibility and commitment to society.

Now, at the same moment and historical context in which the concept of citizenship was built - as this responsibility and possibility of living and sharing with others in the same political and social structure - was also built, in part by the same social actors, the concept of mental alienation. If the alienated person was considered to be dispossessed of full Reason – and Reason would be the elementary condition to define human nature and differentiate it from other living species in nature – there would, at the beginning, be an impediment for the alienated person to be admitted as a citizen. For Leuret, a disciple of Pinel, mental alienation produced the loss of free will and, consequently, of freedom. To regain freedom (as free will) it is necessary to recover Reason!

The historic 'Gesture of Pinel' unchaining the mad could give us the illusion that the mad would have been freed from chains and saved from institutional violence. However, what existed

was a metamorphosis of the nature of the institution. As the hospital ceased to be a space for philanthropy and social assistance to become an institution for the medical treatment of the insane, unchained, but institutionalized, the insane remained cloistered, no longer out of charity or repression, but out of a therapeutic imperative. . But if, in these early years of alienism, the psychiatric hospital would be a therapeutic resource, the best remedy for mental alienation (perhaps the "universal remedy" sought by Simão Bacamarte, Machado de Assis' alienist), Shortly thereafter, Esquirol would list the five main functions of the hospice, starting with "ensuring the personal safety of the insane and their families" (the others are: freeing them from external influences; overcoming their personal resistances; submitting them to a medical regimen ; and to impose new intellectual and moral habits on them). In other words, the issue of safety/dangerousness already assumes a prominent role in relation to therapeutic functions.

Pinelian alienism won the world, mainly as a result of the context and issues linked to its emergence, that is, the French Revolution, the libertarian, republican, democratic and egalitarian principles that influenced countless countries, and not just western society, as observed. Eric Hobsbawm (1996).

Mainly after the enactment of the French law of June 30, 1838, the first law to assist the insane in all of history, several hospitals for the insane were created in the most different countries, reproducing the principles and strategies adopted and encouraged by Philippe Pinel. And, for his pioneering spirit and leadership, many of them bear his name and value his (undeniably) great work.

3:From reformed psychiatry to ruptures with psychiatry

From the first moments of its establishment, alienism was the object of much criticism. Many of his contemporaries noted that isolation and moral treatment represented paradoxes with the libertarian ideals of the French Revolution. What strange institution could this be that kidnapped and imprisoned those it intended to free? “How can so little knowledge generate so much power?” This is how Foucault (2006: 70) sums it up.

In Brazil, we have one of the most important and insightful critiques of alienism or even its contemporary version, psychiatry. In fact, it is a critique not only of alienism, but of the positivist model of science that authorized and legitimized it. But, curiously, this vigorous criticism does not come from a scientific work, but from a literary one. I am referring to Machado de Assis’ O Alienista, which is certainly a work that all professionals who deal with psychiatry, psychology, mental health and psychosocial care should know as a basis for serious and profound reflections and not only as literary satisfaction. The debate about normality/abnormality, about science as a producer of truth, about the myth of scientific neutrality; all these aspects are richly addressed by Machado de Assis.

The analogy established between O Alienista and the real story of the creation and transformation of the Hospício de Pedro II, the first Brazilian hospice that practically reproduces the French counterparts, is at least provocative. I suspect that Machado de Assis could have been inspired by João Carlos Teixeira Brandão, the first director of the Medico-Legal Assistance to the Alienated in Brazil and the first general director of the Hospício Nacional de Alienados, considered the “Brazilian Pinel”, since many situations in the story are similar to reality.

But returning to the criticisms of Pinel’s contemporaries, in fact, it happened that the first asylums were quickly overcrowded with inmates. The enormous difficulty in

establishing the limits between madness and sanity; the evident social functions (still) performed by hospices in the segregation of marginalized segments of the population; the constant denunciations of violence against hospitalized patients, made the credibility of the psychiatric hospital and, ultimately, of psychiatry itself, soon reach the lowest levels.

A first attempt to rescue the therapeutic potential of the psychiatric institution took place with the proposal of ‘colony of the insane’. The idea came from a convincing account by a French alienist about Geel, a strange Belgian village. The story began in the 6th century, in Ireland, in a mixture of legend and history. There is talk of a princess named Dymfna who, in the urge to escape the harassment of her widowed father who wanted to marry her, went to take refuge in the Belgian countryside. The hiding place would be perfect, if it weren’t for the Devil himself who, in addition to being responsible for the King’s tantrum, also took the opportunity to denounce the princess’s whereabouts. Found, as a result of her strong devotion and Christian conviction, she refuses to give herself to her father. Because of her irreducibility, she was beheaded in the public square by her own father.

The story would be reduced to one more case of filicide, among the many parricides, fratricides, etc., existing in the royal families, were it not for the fact that an insane person who had witnessed the scene had suddenly recovered his Reason. The princess was canonized by the Vatican, being considered the Holy Protector of the Insane. On the date of her death, pilgrimages began to be organized with her relatives and their insane, who came from all over Europe in search of a miraculous cure. As many were not cured in the first year, wealthier families began to pay villagers to take care of their relatives until the following year’s feast. Summing up the story, the community started to acquire a very special treatment with the alienated who, to the surprise of the alienists, started to work, with sickles and hoes, and to recover, no longer by miracle, but by work. Therapeutic work, they concluded.

And they started to organize institutions, called colonies of the insane, built in large agricultural areas, where the insane could

undergo therapeutic work. For the colonies, family members (called nutritious) were hired, who began to live in such shelters to take care of the inmates.

Brazilian alienists at the beginning of the 20th century, like Waldemar de Almeida, were ardent supporters of the alienated colonies, as they considered work to be ‘the most precious therapeutic means’, which stimulated the will and energy and consolidated brain resistance. tending to make ‘the traces of delirium disappear’.

The first Brazilian colonies were created shortly after the Proclamation of the Republic and were called Colônia de São Bento and Colônia Conde de Mesquita, both on Ilha do Galeão, currently Ilha de Governador, in Rio de Janeiro.

Under the management of Juliano Moreira, a psychiatrist from Bahia who directed the Medico-Legal Assistance for the Insane for almost three decades, dozens of colonies were created throughout the country, a trend that became even more radical in the administration of Adauto Botelho in the 40’s and 50’s. If you have a dimension of the immensity and scope of the project, the Colônia de Juquery, in São Paulo, reached 16 thousand inmates!

But the joy was short-lived: soon the colonies proved to be the same as traditional asylums. From a village of free people, with its own history and culture, asylum institutions for recovery through work were born. Could any explanation be found from this apparent contradiction?

The two great World Wars made society begin to reflect on human nature, both on cruelty and on the solidarity existing between men and thus created conditions of historical possibility for another period of psychiatric transformations. After the Second World War, society turned its eyes to hospices and discovered that the living conditions offered to psychiatric patients interned there were no different from those of the concentration camps: what could be seen was the absolute absence of human dignity! Thus, the first experiences of ‘psychiatric reforms’ were born.

There were many experiences of reforms that took place in various countries. Some, however, were more remarkable for their innovation and impact, to the point that they are still recognized today and continue to influence contemporary experiences. These are the ones that we will present and analyze here, which, simply for didactic purposes, will be divided into ‘two groups plus one’. The first group, composed of the Therapeutic Community and Institutional Psychotherapy, highlights two experiences that invested in the principle that the failure was in the management of the hospital itself and that the solution, therefore, would be to introduce changes in the institution. The second group is formed by Sector Psychiatry and Preventive Psychiatry, experiences that believed that the hospital model was exhausted, and that it should be dismantled “by the edges” as it is said in popular language, that is, it should be made obsolete from the construction of assistance services that would qualify the therapeutic care (day hospitals, therapeutic workshops, mental health centers etc.), while decreasing the importance and need for the psychiatric hospital. In the ‘other’ group, which includes Antipsychiatry and Democratic Psychiatry, the term reform seems inappropriate. Both consider that the issue itself would be in the psychiatric scientific model, which is all in question, as well as their care institutions. mental health centers, etc.), at the same time that the importance and need for the psychiatric hospital would decrease. In the ‘other’ group, which includes Antipsychiatry and Democratic Psychiatry, the term reform seems inappropriate. Both consider that the issue itself would be in the psychiatric scientific model, which is all in question, as well as their care institutions. mental health centers, etc.), at the same time that the importance and need for the psychiatric hospital would decrease. In the ‘other’ group, which includes Antipsychiatry and Democratic Psychiatry, the term reform seems inappropriate. Both consider that the issue itself would be in the psychiatric scientific model, which is all in question, as well as their care institutions.

The Therapeutic Community and Institutional Psychotherapy had in common the conviction that it would be possible to qualify psychiatry from the introduction of changes in the

psychiatric hospital, in such a way that it would become the effectively therapeutic institution sought by Esquirol. Let's take a look at these attempts to transform the hospital into a therapeutic institution.

In the post-war period, the psychological, social and physical damage suffered by young English soldiers was quite moving. Many of these were admitted to hospitals for treatment of their emotional problems. This situation caused two problems: an excessive number of people who needed care and, on the other hand, a very scarce supply of professionals to attend to them; excess of patients and precariousness of resources in a context of great need to recover the workforce for the national reconstruction project. At the end of the war, young people should change from soldiers to workers, and for that they should be treated for their illnesses.

In the midst of this impasse, Main and Bion Reichman, from Monthfield Hospital (Birmingham, England), found a very original and creative way out: they began to use the potential of the patients themselves in the treatment. They organized meetings in which they discussed the difficulties, the projects, the plans of each one; they held assemblies with two hundred or more patients; they elaborated work proposals in which everyone (patients and employees) could be involved, etc. According to George Rosen, the expression psychosocial emerged in this historical context, from a book by James L. Halliday entitled Psychosocial Medicine, published in London in 1948, which establishes the first relationships between social transformations and the psyche.

The experience became even better known with Maxwell Jones, from 1959, when it received greater systematization and greater dynamics. Jones went on to organize 'discussion groups' and 'operating groups', further involving inmates in their treatments, calling on them to actively participate in all available activities. He understood that the therapeutic function was a task that should be assumed by everyone, whether technicians, family members, or patients. To this end, he introduced daily meetings and assemblies, occasions in which all aspects related to the institution were debated. All possibilities were analyzed, with emphasis on the team's

performance, with the objective of avoiding situations of abandonment, carelessness and, mainly, violence.

By Therapeutic Community we came to understand a process of institutional reforms that contained in themselves a struggle against the hierarchy or verticality of social roles, or, finally, a process of horizontality and 'democratization' of relationships, in the words of Maxwell Jones himself. , which imprinted a therapeutic verve on all social actors.

It should also be noted that this original and innovative proposal has nothing to do with the current 'farms' and 'little farms' for the treatment of alcohol and drug addiction, generally of a religious nature, which are called – opportunistically and fraudulently – "therapeutic communities". " to gain social and scientific legitimacy. Let's end with a speech by Maxwell Jones (1978: 89): The emphasis on free communication between staff and groups of patients and on permissive attitudes that encourage the expression of feelings implies a democratic, egalitarian social organization, and not a social organization of the traditional hierarchical type.

The other experience of transformation of the psychiatric hospital in the post-war period took place in France, in a context and with characteristics very similar to the Therapeutic Community. The main character of this story was François Tosquelles, a Catalan who, taking refuge from the dictatorship of General Franco in Spain, ended up starring in the rich experience that became internationally known as Institutional Psychotherapy, although its founder preferred the name Coletivo Terapêutico.

Tosquelles understood that with the precarious social and economic situation experienced by France, a situation aggravated by the occupation and destruction by the Nazi armies, the hospitals had been deeply damaged. He believed, therefore, that the psychiatric institution had lost its ideals and possibilities of exercising its true therapeutic function. Among the most interesting proposals are the primacy of polyphonic listening, that is, the search for an expansion of theoretical references, so as not to reduce listening to this or that

conceptual current, and the notion of welcoming, emphasizing the importance of the team and of the institution in the construction of support and reference for the hospital interns.

And it is to this reconstruction of the therapeutic potential that Tosquelles dedicated his work. It was at the Hospital de Saint-Alban, in the south of France, that the work began, becoming one of the most successful experiences of psychiatric reform. The notion of 'therapeutic work' was rescued as an important activity that would offer possibilities for inmates to participate and assume responsibilities. One of Saint-Alban's most original innovations was the Therapeutic Club, an autonomous organization managed by patients and technicians that promoted meetings, parties, outings, fairs for inmates' products, etc. There were also the workshops or workshops of work and art that, based on the psychoanalytic reading, very expressive in those early years, aimed at an internal reorganization of the psychic dynamics. As in the Therapeutic Community, this experience of a therapeutic collective was based on the premise that in the hospital everyone would have a therapeutic role and should be part of the same community and, finally, should question and fight against institutional violence and verticality. in intra-institutional relations. But, unlike its English counterpart, Institutional Psychotherapy has moved towards proposing 'transversality', which I understand as the encounter and at the same time the confrontation of professional and institutional roles in order to problematize hierarchies and hegemonies. they should question and fight against institutional violence and verticality in intra-institutional relations. But, unlike its English counterpart, Institutional Psychotherapy has moved towards proposing 'transversality', which I understand as the encounter and at the same time the confrontation of professional and institutional roles in order to problematize hierarchies and hegemonies. they should question and fight against institutional violence and verticality in intra-institutional relations. But, unlike its English counterpart, Institutional Psychotherapy has moved towards proposing 'transversality', which I understand as the encounter and at the same time the confrontation of professional and institutional roles in order to problematize hierarchies and hegemonies.

Let's see what François Tosquelles says (1993: 93):

this is the difference between Basaglia and me: I was concerned that the psychiatric hospital would be a school of freedom, first of all. He did not say: "close the shed", because then there is no school of freedom in current social life, but only a school of administrative alienation.

Let's move on to the second group, represented mainly by Sector Psychiatry and Preventive Psychiatry, also known as Community Mental Health.

In the case of Sector Psychiatry, the limitations arising from the experience of institutional psychotherapy, which became more evident in the late 1950s and early 1960s, pointed to the need for work outside the asylum. It was necessary to adopt measures of therapeutic continuity after hospital discharge, in order to avoid readmission or even the hospitalization of new cases. In this sense, mental health centers (MHC) distributed in the different administrative 'sectors' of the French regions began to be created. Unlike the outpatient clinics, which eventually existed, and which until then should have been responsible for out-of-hospital follow-up, the proposed MHCs were established according to the population distribution of the regions.

In the understanding of the French, the sector is an administrative division or region, as we Brazilians usually call it. The idea of Lucien Bonnafé, the main character in the sector, was to subdivide the internal space of the hospital, allocating a corresponding ward for each sector. This time, all patients coming from a certain region, that is, from a certain sector, would be hospitalized in the same ward of the hospital. When they were discharged, they would be referred to the existing MHC in the same sector. According to Bonnafé the advantages were manifold. On the one hand, there would be countless possibilities for contacts between the inmates themselves, to get to know places, people, events, etc., which they could share. There were also possibilities of contacting relatives who visited the inmates, bringing news, letters, or objects and food sent by relatives of inmates in the same

sector. In short, there would be multiple situations created by this principle of sectorization.

But the most important of these possibilities was in another innovation: the therapeutic follow-up of patients could be carried out by the same multidisciplinary team, both inside the hospital and at the place of residence. First of all, the idea of teamwork should be highlighted, which represented a milestone of progress until the present day. The treatment came to be considered no longer exclusive to the psychiatrist, but to a team with several professionals.

Nurses, psychologists and social workers would, from then on, have a new role in the context of mental health policies. The team that accompanied the hospitalized patient would start to accompany him when he was discharged, continuing the treatment and exploring the positive factor of the bond already established in the hospital space. This was particularly important when the path was the other way around, that is, when the patient, who was being treated at the CSM, needed to be hospitalized. Contrary to the situation of certainly negative impact of being received by 'strange' professionals, sometimes tied up and restrained in a sudden way, the situation received a sensitive and innovative treatment.

A thought by Lucien Bonnafé (1969: 20) to conclude Sector Psychiatry:

the inhuman and antisocial state of institutions related to 'madness' contributes more seriously to maintaining and aggravating individual maladaptive reactions to mental health issues than the 'prejudices' anchored in the spirit of individuals who are not responsible for the maladaptation of institutions.

Preventive Psychiatry was developed in the United States and is also known as Community Mental Health. Its theoretical bases and intervention proposals were very well explained in the book Principles of Preventive Psychiatry by Gerald Caplan, considered the founder and main author of this current.

An important milestone for the emergence of Preventive Psychiatry was a census carried out in 1955 that surveyed the conditions of care in psychiatric hospitals across the country, the results of which fell like a bomb on the Department of Mental Health, giving visibility to the precarious conditions of care, to the violence and mistreatment to which hospitalized patients across the country were subjected.

The impact was so great that it triggered a historic speech and decree by President Kennedy, in February 1963, urging the country to change in the area of mental health. The decree redirected the US psychiatric care policy towards reducing mental illness in communities and, more than that, promoting their mental health status.

The historical context in which this experience began was very specific and unique in the country's history. The Vietnam War, the growing involvement of youth with drugs, gangs, the beatnik movement, the black power movement, were some of the important social issues faced by the State in that period. The Preventive Psychiatry proposal, endorsed by President Kennedy himself, produced an almost miraculous prospect of salvation for a country with major social and political problems.

Caplan adopted an etiological theory inspired by the model of the Natural History of Diseases, by Leavell and Clark, which presupposes a linearity in the health-disease process, and an (paradoxically) 'a-historical' evolution of diseases. Consequently, in his understanding, all mental illnesses could be prevented, as long as they are detected early. To the extent that mental illnesses were understood as synonymous with disorders, it was believed that they could prevent and eradicate the ills of society. The "search for suspects", an expression used by Caplan himself, was a very important strategy in the sense of detecting people who could develop a mental pathology in order to treat them early. Caplan understood that a person suspected of having a mental disorder should be referred to a psychiatrist for diagnostic investigation, whether on the initiative of the person himself, his family and friends, a community assistance professional, a judge or an

administrative superior at work. A real hunt was created for all types of suspects of mental disorders.

The notion of prevention adopted by Caplan was transposed from preventive medicine to psychiatry and it was considered that it could be carried out at three levels, according to the analysis carried out by Joel Birman and Jurandir Freire Costa (1998: 54):

1) Primary Prevention: intervention in the possible conditions of mental illness formation, etiological conditions, which can be of individual origin and (or) of the environment;

2) Secondary Prevention: intervention that seeks to carry out early diagnosis and treatment of mental illness;

3) Tertiary Prevention: which is defined by the search for the patient's readaptation to social life, after his improvement.

For preventive intervention, a concept became strategic: the concept of 'crisis', built fundamentally from the notions of 'social adaptation and maladjustment', derived from sociology, and which allowed the expansion of psychiatry's action beyond the notion more restricted from mental illness.

According to the same authors, seizures were classified into:

1) evolutionary – when related to normal processes of physical, emotional or social development. In such processes, in the passage from one phase of life to another, the behavior would not be characterized by an established pattern. It would be a transitional period, when the individual would lose his previous characterization without, however, acquiring a new organization. In the event that the generated conflicts are not well absorbed, they could lead to maladaptation that, if not elaborated by the person, could lead to mental illness;

2) accidental – when precipitated by some loss or risk (unemployment, marital separation, death of a loved one, etc.). The emotional disturbance caused by the crisis would eventually cause the emergence of some mental illness, thus, it becomes a strategic moment of preventive intervention, insofar as, on the other hand, the crisis can be seen as a possibility of growth for the individual.

Facing new obstacles, new conflicts, can be fruitful, if the person receives support in such situations: the crisis can become a means of growth; can promote health.

In large part, it was as a result of the concept of crisis that Preventive Psychiatry took on the characteristic of a proposal for community mental health, since from there came the strategies of community-based work, in which mental health teams began to play a role of community consultants, identifying and intervening in individual, family and social crises.

Another fundamental concept was that of ‘deviation’, also migrated from the social sciences, and which refers to a behavior that is unadapted to the socially established norm, which, in the understanding of Preventive Psychiatry, meant to say that it would be abnormal or pre-pathological.

It was also within the scope of Preventive Psychiatry that the concept of ‘deinstitutionalization’ emerged, which became one of the main guidelines of mental health policies in the USA. Deinstitutionalization was understood to be a set of ‘de-hospitalization’ measures, that is, to reduce the number of patients entering psychiatric hospitals, or to reduce the average length of hospital stay, or even to promote hospital discharges.

As strategies to implement de-hospitalization policies, several mental health centers, sheltered workshops, sheltered homes, day hospitals, night hospitals, wards and beds in general hospitals, etc., were implemented. The objective was to make the hospital an obsolete resource, which would fall into disuse as the incidence of mental illness was reduced as a result of preventive actions, and that community mental health services would acquire greater competence and effectiveness in treating diseases. in an out-of-hospital setting.

However, despite the fact that so many services and de-hospitalization strategies have been installed, there has been a significant increase in psychiatric demand in the US, not only for new out-of-hospital services, but also for psychiatric hospitals: the community services themselves turned into great recruiters and forwarders of new clients to psychiatric hospitals.

For some authors, Preventive Psychiatry represented a new project of medicalization of the social order, that is, a greater expansion of medical-psychiatric precepts to the set of social norms and principles. But for his followers, it was a psychiatric revolution. We close with Robert H. Felix, who presented Caplan's book (1980: 9): "Principles of Preventive Psychiatry is not just a manual for those working in community mental health: it is a Bible".

We will move on to the 'other' group for which I have preferred not to call it 'psychiatric reforms', as it would not be correct to do so, as I noted earlier. In fact, they would not be 'reform' experiences in the strict sense of the term, since they initiated processes of rupture with the traditional psychiatric paradigm. Let's start with one of Ronald Laing's (as always very provocative) reflections (apud Duarte Jr., 1987: 25): "what is essential is what exists between people. And psychiatric practice is, more or less, the complete denial of that."

Antipsychiatry began in England in the late 1950s, but its greatest repercussion was in the 'troubled' decade of the 60's. Some psychiatrists, among which Ronald Laing and David Cooper stood out, began to implement Therapeutic Community and Institutional Psychotherapy experiences. in the hospitals where they worked. But in a short period of time they realized that such transformations did not have a great future. Laing and Cooper came to consider that the so-called crazy people were oppressed and violated, not only in psychiatric institutions, where they should be to receive treatment, but also in the family and in society. They developed the hypothesis that the discourse of the mad denounced the plots, the conflicts, in short, the contradictions existing in the family and in society.

The denomination Antipsychiatry only appeared much later, suggested by Ronald Cooper, and it seems not to have been a good choice insofar as it became too identified with an attitude of mere contestation and rebellion. However, the term chosen sought to point to the idea of an antithesis to psychiatric theory, proposing to understand that the so-called pathological experience occurs not in the individual in the condition of a

sick body or mind, but in the relationships established between him and society. The most profound criticism of psychiatry refers to its theoretical-conceptual framework, which, by adopting the same model of knowledge of the natural sciences, would produce a huge methodological mistake. Cooper considered that some principles of the natural sciences would have been imported into the human sciences, which would have an absolutely different nature. Already Laing (1988:

In this theoretical and political tradition, the psychiatric hospital would not only reproduce, but, on the contrary, would radicalize the same oppressive and pathogenic structures of social organization, strongly manifested in the family. As a result of these criticisms of social and family structures, Antipsychiatry very quickly – and unfairly – became associated – and restricted – to the protesting and anti-institutional movements that shook Western Europe in the 1960s and culminated in the May 68 Movement. .

Antipsychiatry was strongly influenced by the Theory of Logic of Communications from the Palo Alto School, from which it extracted the concept of ‘double bond’, which would be at the heart of the schizophrenic experience. This concept, which can be roughly understood as ‘double meaning’, concerns a communicational form in which the message expressed verbally would contradict or oppose the message expressed gesturally or emotionally. As an example, we could imagine the mother who, upon receiving the news of her son’s marriage, would speak of her joy at learning of such an important event that, at last, would free her to remain alone in the solitude of an empty house…

In the context of Antipsychiatry, there would be no mental illness as a natural object, as psychiatry considers, but a certain experience of the subject in his/her relationship with the social environment. Insofar as the concept of mental illness was then rejected, there would not exactly be a proposal for the treatment of ‘mental illness’, in the classic sense that we give to the idea of therapy. The principle would be to allow the person to live their experience; this would be, in itself, therapeutic, insofar as the symptom would express a possibility of inner reorganization. The ‘therapist’ would be

responsible for helping the person to experience and overcome this process, accompanying him, protecting him, even from the violence of psychiatry itself.

One author, who was certainly not an antipsychiatrist in the strict sense of his conception and belonging to the group of authors/social actors who participated in it, became very identified with this experience: Erving Goffman. A sociologist dedicated to the study of institutions, Goffman became one of the most forceful and well-known critical analysts of the institution and the theoretical model of psychiatry. In Asylums (published in Brazil as Manicômios, Prisões e Conventos), he carried out a micro-sociological analysis of the psychiatric asylum, equated with other institutions of control and violence he called "total institutions". For Goffman, what psychiatry calls the "natural course of illness" is actually the "moral career of the mentally ill".

By scrutinizing the mechanisms and systems of this modality of institutionalization, in which the moral career, stigmatization or mortification of the self stand out, the notion of deinstitutionalization becomes more complex and starts to distance itself from the North American notion, synonymous with de-institutionalization.

To begin Democratic Psychiatry, there is nothing more opportune than to start by listening to its most expressive protagonist, Franco Basaglia (1985: 315-6):

once the process of institutional transformation is triggered, we realize how contradictory is the existence of an institution that denies its own institutionality within our social system, and whose dynamics tend to absorb any movement that could alter the general balance. (…) our situation has no other way out than to continue being contradictory: the institution is simultaneously denied and managed; the disease is simultaneously bracketed and cured; the therapeutic action is both refuted and carried out.

The Italian experience began in the early 1960s in Gorizia, a small town in northern Italy. And it began when Franco Basaglia, accompanied by Antonio Slavich and other young

psychiatrists, set out to renovate the existing psychiatric hospital.

Giuseppe Dell'Acqua, coordinator of Mental Health for Trieste, reports that when Basaglia first entered the hospital it was as if he had received a shock. His impression was that of entering a prison, or rather, a concentration camp. He would have come to mind, says Dell'Acqua, a fable he heard when he was imprisoned in the dictatorship of Benito Mussolini. The fable tells of a serpent that entered a man's mouth while he was sleeping and lodged in his stomach. And from there he began to command his life, his desires, his destiny. For Basaglia, the snake would be the psychiatric institution itself, its processes of mortification and dehistoricization.

In the early years of the experience, initially also inspired by the Therapeutic Community and Institutional Psychotherapy, Franco Basaglia – who personally knew these experiences and their leaders – used them with the aim of making the Gorizia hospital a place for effective treatment and rehabilitation of inmates. . But, as the years passed, he began to feel that the 'snake' could not be fought through administrative or humanizing measures.

Fundamentally from the contact with the works of Michel Foucault and Erving Goffman, Basaglia realized that the fight should be of another order: the period of denial of psychiatry as an ideology began. Franco Basaglia began to formulate an absolutely original thought and institutional practice, focused on the idea of overcoming the asylum apparatus, understood not only as the physical structure of the hospice, but as the set of scientific, social, legislative and legal knowledge and practices. , which underlie the existence of a place of isolation and segregation and pathologization of human experience.

Gorizia's experience gave rise to the book The Negated Institution, coordinated by Basaglia, with the participation of many actors in the process, which contains all the debate, principles and strategies of the new stage of psychiatric reforms, whose basis will be the deconstruction of the asylum . In the early 1970s, Basaglia, with a large part of the team that worked in Gorizia, started work at the psychiatric hospital in

Trieste, a medium-sized city, also located in northern Italy. There, the richest and most original experience of radical transformation in contemporary psychiatry began, which inspires many experiences throughout the world. And, as we will see later, it will be the fundamental reference of the process that will be implemented in the city of Santos (SP), at the turn of the 80's to the 90's,

In Trieste, simultaneously with the closing of the pavilions or psychiatric wards, several other services and devices were created to replace the asylum model. The expression substitutive services started to be adopted in the sense of characterizing the set of strategies that envisaged, effectively, taking the place of classic psychiatric institutions, and not being just parallel, simultaneous or alternative to them.

As for the process of closing the hospital, as happened in Gorizia, the influences of the Therapeutic Community and Institutional Psychotherapy were very important. But Franco Basaglia does not take them as an end in itself, as the ultimate goal to be achieved, but as provisional and intermediate strategies for dismantling the asylum structure. The assemblies, the intern clubs, the mobilization of social actors, including patients, family members, technicians, etc. , would serve no other purpose than to build the bases, the possibilities, the understanding that it would be possible to overcome the institution of the cloister.

The first substitutive services were the mental health centers (MHC), all regionalized, that is, carefully distributed throughout the various regions of the city. With regard to the implementation of the MSM, it would be possible to verify the influence of the French sector, or of the American community mental health. But, unlike these, the Trieste centers did not work in two directions. In other words, they were not services that continued treatment after hospital discharge and that readmitted patients to the asylum when the situations were considered serious, and the impossibility of treatment in an external regime was justified. Based on the concept of 'taking responsibility', the MHC began to assume the integrality of issues related to care in the field of mental health in each territory. Thus, more than regionalized centers, were

territorially based centers. In other words, centers that, acting in the territory and reconstructing the ways in which societies deal with people with mental suffering, would start to reestablish the social place of madness that, traditionally, since Pinel, was related to error, dangerousness, foolishness , to disability.

Other strategies concerned the real possibilities of social inclusion, either through the creation of work cooperatives or the construction of residences so that the former inmates of the hospital could live in the city itself, or through the invention of innumerable forms of participation and production. (musical and theater groups, video production, workshops, among many others).

Franco Basaglia, in one of his last writings, confessed that if the history of this experience were ever to be reported, he would prefer it not to be through dates, numbers of legislative acts or service ordinances, but through the history of lives that were reinvented, reconstructed, rediscovered from this transformation process.

Franco Rotelli, who replaced Basaglia after his death in 1980, observes that the Italian proposal broke with previous experiences, mainly with regard to the understanding of deinstitutionalization, adopted as a synonym for mere dehospitalization in Preventive Psychiatry and in others that were inspired by it, and as a deconstruction of the problem-solution rationalist paradigm in the Italian process. In other words, Rotelli (1990) considers that the obscure evil of psychiatry lies in having separated a fictitious object, ‘the disease’, from the global, complex and concrete existence of subjects and the social body. And it is on this artificial separation that the set of scientific, legislative and administrative apparatuses (precisely the ‘institution’) were built, all referring to the ‘disease’. The operation called deconstruction would then be the dismantling of this set of devices in order to reestablish a relationship with the suffering subjects. Rotelli proposes ‘another way’, considering that this is a complex social process, which seeks to activate the social actors directly involved; which understands that the

transformation must transcend the simple reorganization of the care model and reach social practices and conceptions.

4:Strategies and dimensions of the field of mental health and psychosocial care

We have seen that the psychiatric model, born out of the biomedical model, had as one of its main characteristics a 'therapeutic' system based on hospitalization. As this model presupposes a patient with a disorder that robs him of Reason, an insane, foolish, incapable, irresponsible person (the legislation even considers the insane person to be civilly irresponsible), the psychiatric hospital system is very close to prison, correctional, and penitentiary institutions. Therefore, a system founded on surveillance, control, discipline. And of course, a system with punishment and repression devices. In this regard, we can see in article 32 of the statutes of the Hospício de Pedro II (decree 1077, of December 4, 1852) the means "of repression permitted to force the alienated into obedience":

1st - The deprivation of visits, tours and any other recreation;

2nd - The reduction of food, within the limits prescribed by the respective Optional;

3rd - Solitary confinement, with the bed and food that the respective Clinician prescribes, not exceeding two days, each time it is applied;

4th - The straitjacket, with or without confinement;

5 - The capsizing baths, which can only be used for the first time in the presence of the respective Clinician, and in the subsequent ones in the person's presence and for the time he designates.

I never forget the story of a woman who was imprisoned in a strong cell in an asylum and was forgotten there, to the point that she died, from hunger and cold! Such was the neglect that, only many years later, her body was found, already petrified. The mummified silhouette indicated the amount of suffering in that woman in the fetal position, in complete abandonment. Her crime was being crazy! Interestingly, the silhouette brand

did not come out with any cleaning products, not even with acids. It remained there as a denunciation and a cry of pain. When the management heard that the news was running out of the asylum, they had the floor ripped out. But, before that happened, we managed to take the photograph and published it in the magazine Saúde em Debate, n. 13 (1981).

Finally, it becomes evident that a model of this nature concentrates a good part of the efforts of professionals committed to the ideals of change in the sense of implementing a process that is effectively different from the previous one. Perhaps it is because of this imperative need to overcome the psychiatric model that innovation initiatives have often been reduced to the simple restructuring of care services, in a movement that goes from the biomedical asylum model towards the mental health and psychosocial care system.

The great experiences of psychiatric reforms, as we could see, incurred this limitation, that is, they were reduced to simple proposals for reformulating services. In some of them, we witness attempts to humanize the hospital, to introduce new techniques and treatments to transform it into a therapeutic institution. In others, we saw the effort to create external services that minimize the harmful effects of the hospital or that avoid hospitalizations, trying to make the hospital a resource used only as a last resort. In both cases, changes were restricted to services that dominated the attention and agenda of professionals and managers.

Therefore, a first major challenge is to be able to overcome this vision that reduces the process to the mere restructuring of services, even though it becomes evident that they have to be radically transformed and the asylums overcome. But this transformation should not be the objective itself, but a consequence of principles and strategies that precede it.

How then to overcome this limitation? Let’s do it by steps!

The starting point is to start thinking about the field of mental health and psychosocial care not as a model or closed system, but as a process; a process that is social; and a social process that is complex. This is the proposal of Franco Rotelli,

Basaglia's successor and one of the most important expressions of the Italian reform (Rotelli et al., 1990).

When we talk about process, we think of movement, of something that walks and changes permanently. In this walk, new elements emerge, new situations to be faced. New elements, new situations, presuppose that there are new social actors, with new – and certainly conflicting – interests, ideologies, worldviews, theoretical, religious, ethical, ethnic conceptions of belonging to a social class… In short, a social process complex is constituted as an intertwining of simultaneous dimensions, which sometimes feed each other, sometimes conflict; that produce pulsations, paradoxes, contradictions, consensus, tensions.

Only with the aim of enabling a more systematic reflection on this process, with an exclusively didactic objective, one can think about some of these dimensions (Figure 2).

Figure 2 - Dimensions of the complex social process

Initially, let's look at something about the theoretical-conceptual (or epistemic) dimension. As we mentioned earlier, the natural sciences that founded the constitution of psychiatric knowledge about madness are in an important transition phase. The assumption that science was a neutral, unsuspected knowledge, which, if provided with a good method (experimentation), would produce only the truth, nothing more than the truth, is no longer universally accepted. There are several world-renowned scientists debating these issues such as Ilya Prigogine, Edgar Morin, Isabelle Stengers, Fritjof Capra, Henry Atlan, Umberto Maturana, Francisco Varella, Boaventura de Sousa Santos, and many others.

For the definition of a political or social initiative, it was believed that only the knowledge produced by science would be fully sufficient. It even aspired to a society planned and managed in a completely scientific way; this was the project of Auguste Comte that was identified as the most important of the positivists. The following scheme perhaps conveys this

attitude in which the action/intervention would be determined exclusively by scientific principles and assumptions.

SCIENCE

↓

ACTION/INTERVENTION

It is now known that things are no longer like that. When designing an intervention, a health program for a community, any social or political action, the actors responsible for the implementation of these actions and/or programs know that they must consider a set of aspects that, although unrelated to science, interfere in the formulation of their strategies. These are aspects of an ideological, political, ethical order… These aspects are interspersed with religious, cultural, moral issues… Anyway!

Let's see what the scheme would look like now (which is always insufficient and always provisional).

SCIENCE

↓

IDEOLOGY → ACTION/INTERVENTION ← POLICY

↑

ETHIC

In short, this dimension leads us to reflect on the most fundamental concepts of psychiatry which, as we have seen, was founded in an epistemological context in which reality was considered a natural datum, capable of being apprehended and revealed in its fullness. It was born in a context in which science meant the production of positive, neutral and autonomous knowledge: a univocal expression of truth! This is how psychiatric concepts must be evaluated, contextualized in a certain model of science that is in full transformation. Based on this conception, we can consider that the psychiatric reform process is not an invention of dissatisfied or insurgent psychiatrists (as advocates of psychiatry claim), but a natural consequence of a transformation of science itself.

Franco Basaglia considered that psychiatry had an "obscure evil" for having separated a fictitious object, 'disease', from the global and complex existence of subjects and the social body. By considering the disease a natural object, external to man, psychiatry started to deal with it and not with the subject who experiences it. Psychiatry treatises classify mental illnesses as objects of nature. They analyze the types, their similarities and distinctions: "schizophrenias are divided into …."; "there are so many types of neuroses…"

They took care of the diseases and forgot about the subjects who were only as a background for them. Depending on age, sex, or social class, the disease could take on this or that characteristic, course or prognosis. Finally, if psychiatry had placed the subject in parentheses to deal with the disease, Basaglia's proposal was to place "the disease in parentheses" so that it would be possible to deal with the subject in his experience. Franco Basaglia was inspired by Edmund Husserl, considered the father of phenomenology and author of the

concept of “analog reduction” or of putting the concept in parentheses.

The idea of illness in parentheses can be understood as an epistemic attitude, that is, an attitude of knowledge production, which means the suspension of a certain concept and implies the possibility of new empirical contacts with the phenomenon in question, which, in this case, , is the experience lived by the subjects. Thus, the illness in parentheses does not mean the denial of the existence of the ‘disease’, in other words, it does not mean the refusal to accept that there is an experience that can produce pain, suffering, difference or discomfort; it is not the denial of experience that psychiatry has come to call mental illness. The strategy of putting the disease in parentheses is, at the same time,

And to the same extent that the disease is put in parentheses, the subjects appear who were neutralized, invisible, opaque, reduced to mere symptoms of an abstract disease. In this way, it becomes possible to verify what Basaglia (inspired by the poet and playwright Antonin Artaud) called the “double of mental illness”, that is, the set of preconceptions, prejudices (stigmata, values, judgments) related to mental illness. As soon as he started his work in Trieste, Basaglia met an intern who was always asking for a comb. I am disheveled, she said, “I want to comb my hair; but I don’t have a comb, I need a comb, I’m entitled to a comb!”.

But no one attended to him: was the obsession with the comb a mere psychotic symptom? What would a madwoman need a comb for? Would she turn him into a weapon? Would she throw it away and ask for another, and another, and yet another? With the mastery of the notion of mental illness, a simple basic need, including self-care and autonomy, can be understood as a mere symptom. Nothing else belongs to the subject: everything refers to the disease!

The authors of psychiatry do not assume, but Antipsychiatry and Democratic Psychiatry forced psychiatry to abandon the concept of mental illness insofar as they proved that it contributed practically nothing to understanding and dealing

with the subjects thus classified: the response of psychiatry was create psychiatric asylums.

Therefore, psychiatry began to experiment with new definitions and more recently chose to adopt the terms ‘mental disorder’ (in Portuguese and Spanish) and ‘mental disorder’ (in English). Brazilian legislation uses the expression ‘those with mental disorders’. Doesn’t it give us the idea of someone carrying a burden, an enormous and eternal weight, inseparable and indistinguishable from the subject? If we were to take the idea of a carrier to the limit, we could consider that we all carry the burden of our personality and character. On the other hand, a person with a mental disorder is a disturbed person, which is the same as possessed! In English, the term mental disorder leads us to think about non-order, breaking of order, without order, and then we return to the beginning of the question: what is the mental order? What is mental normality? For these reasons, in the field of mental health and psychosocial care, it has been used to speak of subjects ‘in’ psychic or mental suffering, since the idea of suffering leads us to think of a subject who suffers, in a lived experience of a subject.

Finally, if, with the disease in parentheses, we are faced with the subject, with his vicissitudes, his concrete problems of daily life, his work, his family, his relatives and neighbors, his projects and anxieties, this allows an expansion of the notion of integrality in the field of mental health and psychosocial care. Services will no longer be places of repression, exclusion, discipline, control and panoptic surveillance (Foucault, 1977a). They must be understood as strategic devices, as places of reception, care and social exchanges. As services that deal with people, and not with diseases, they must be places of sociability and the production of subjectivities. And here we are already in the ‘technical-assistance dimension’, and we can already perceive some of its interrelationships with the dimension that we have just analyzed.

On the other hand, if madness/alienation is not synonymous with dangerousness, irrationality, civil incapacity, the exercise of citizenship, in the ‘legal-political dimension’ there is a set

of challenges and strategies. The review of all legislation is a first aspect, as both the criminal and civil codes or other laws and social norms are full of harmful references to subjects in psychological distress and represent significant obstacles to the exercise of citizenship. The granting of the Continued Benefit (BPC) provided for in the Organic Law of Social Assistance (Loas) is a good example, insofar as it is restricted to people diagnosed with mental disabilities and the beneficiary cannot have any professional activity (nor even in cooperatives and income generation or solidarity economy projects),

The issue of human rights takes on a unique expression here. It is a struggle for the inclusion of new subjects of law and new rights for subjects in mental suffering. Right to work, to study, to leisure, to sport, to culture, in short, to the resources that society offers. “Back to the city, sir”, says the poet Paulo Mendes Campos.

A decisive step in this direction was taken with the enactment of law n. 10,216 on April 6, 2001. Although the original project was rejected, after twelve years of processing, a substitute was approved that provides for “the protection and rights of people with mental disorders and redirects the mental health care model” . The text of the approved law did not guarantee some of the most fundamental aspirations of the original project, such as the progressive extinction of asylums. Even so, it revoked the archaic legislation of 1934, which was still in force, and meant a considerable advance in the assistance model. It became known as the Brazilian Psychiatric Reform Law.

A very important aspect with regard to the social process of psychiatric reform in relation to law n. 10.216/2001 is the inclusion of the State Public Ministry, which must be notified, within 72 hours, of all involuntary admissions, as can be seen in article 8.

On the other hand, while the national law was being debated, eight state laws and many municipal laws were passed and led to the advance of the psychiatric reform process in Brazil. The following are state psychiatric reform laws:

• Rio Grande do Sul – Law no. 9,716 of August 7, 1992;

• Ceara – Law no. 12,151 of July 29, 1993;

• Pernambuco – Law no. 11,065 of May 16, 1994;

• Rio Grande do Norte – Law no. 6,758 of January 4, 1995;

• Minas Gerais – Law no. 11,802 of January 18, 1995;

• Parana – Law no. 11,189 of November 9, 1995;

• Federal District – Law no. 975 of December 12, 1995;

• Holy Spirit – Law n. 5,267 of September 10, 1996.

But we know that talking about citizenship and rights is not enough, just as it is not enough to just pass laws, because it is not determined that people are citizens and subjects of law by decree. The construction of citizenship concerns a social process and, as we refer to in the field of mental health and psychosocial care, a complex social process. It is necessary to change mentalities, change attitudes, change social relationships.

Throughout its history, all societies create certain interpretations about facts, people and things. All seek to make sense of the things and sensations they see, experience or fear. These interpretations and meanings become collective representations, as they are, by a natural process, shared in a similar way by the components of the social group. Psychiatry has contributed a lot for society to understand that 'the insane are dangerous', that 'the insane place is in the asylum', that 'the mentally ill are irrational', that 'the mentally ill'… Have you ever stopped to think in how many prejudices are there about people with mental problems? How many anecdotes are there about madmen? How many cases of angry madmen, murderers, perverts… Kraepelin himself, in that same initial class of the psychiatric clinic course,

At least a third of the total number of suicides is caused by different mental disorders, as to a lesser extent they are also the inducers of crimes against indecency, arson, theft, fraud and others. Crowds of families mourn their ruin because of these unfortunate sick people, who squandered their fortunes or means of existence in foolish initiatives or because of the

effort to alleviate social and bodily sufferings born of laziness, incapacity for work, which almost always accompany the all mentally disturbed. (Kraepelin, 1988: 22-23)

Isn't it scary? There are those who say, on the contrary, that they are not afraid of people who are not right, but of those who think they are too right! It is to this extent that the notion of complex social process is strategic, as it is necessary to introduce a series of transformations that permeate the various dimensions mentioned here. , and so on, we will build institutions of discipline, moral correction, surveillance, custody, punishment. We are going to build, in the same way, restrictive, authoritarian, impeditive laws. Let's, finally, build social representations and social meanings of fear, risk, exclusion: stigma, discrimination, prejudice. At most we will perceive some attitudes of tolerance. But, Franco Basaglia insisted that the issue should not be directed towards the idea of tolerance. The "ideology of tolerance", as he referred to it, is arrogant and pretentious, as it implies supporting (tolerating) the other.

On the other hand, if we refuse those archaic concepts and try to feel and relate to the suffering subjects, if we address people and not their illnesses, we can envision therapeutic spaces in which it is possible to listen and welcome their anxieties and lived experiences; spaces for care and reception, for the production of subjectivities and sociability. In this way, we contribute to the practical questioning of exclusionary laws and norms, building effective strategies for citizenship and social participation, which are, at the same time, foundations and material evidence of the new assumptions. Ultimately, the entire set of previous transformations and innovations contribute to the construction of a new social imaginary in relation to madness and suffering subjects, which is not one of rejection or tolerance, but of reciprocity and solidarity. Franco Basaglia observed that it was important to question not only "the asylum nor psychiatry as a science, but everything that, starting from the 'territory', repelled the disease and entrusted it to psychiatry and the asylum" (Basaglia, 2005: 243).

The sociocultural dimension is, therefore, a strategic dimension, and one of the most creative and recognized, both

nationally and internationally, in the Brazilian psychiatric reform process. One of the fundamental principles adopted in this dimension is the involvement of society in the discussion of psychiatric reform with the objective of provoking the social imaginary to reflect on the theme of madness, mental illness, psychiatric hospitals, based on the cultural and artistic production of the social actors involved (users, family members, technicians, volunteers). To this end, a National Anti-Asylum Struggle Day was instituted, on May 18, in which (and even in the days close to the date), cultural, political, academic, sports activities, among others, take place throughout the country.

A remarkable experience for me was the invitation received from Franco Rotelli to organize a samba school with users, technicians, family members and volunteers at the Trieste carnival in 1992. Based on the theme Meninos de Rua, I composed the samba-enredo “Tutti i bambini della strada” and we had a beautiful party that marked the Triestino carnival.

Now, let’s look at examples of activities in Brazil. In 1992, on the occasion of Carnival, it was decided not to make a ‘sick block’ to play at the dance in the hospice’s courtyard, but to organize a wing in one of the most famous blocks in Rio de Janeiro, “Simpatia is almost love”. The wing came out with the name “Ala do maluco Beleza” (in allusion to the music by Raul Seixas), and was very successful in the block and in the media. In later years, several similar initiatives were organized and even samba schools in Rio de Janeiro paraded with wings and themes approaching madness, difference, diversity. There are, in the country, many carnival blocks and collectives that allude to the theme. In Rio de Janeiro, the highlights are “Ta Pirando, Pirado, Pirou!”, “Loucura Suburbana” and “Tremendo nos Nervos”. In Paracambi (RJ), there is the “Maluco Sonhador” block; in Sao Paulo, the “Bibi Tantã” cord; in Natal, the “Lokomotiva”; in Ouro Preto the “Conspirados”; and many others across the country.

At the Gaucho Mental Health Forum, some participants wore T-shirts with phrases related to the anti-asylum struggle and psychiatric reform. The one that stood out the most was “Nobody is normal up close” taken from the song “Vaca

profana" by Caetano Veloso, to which I referred at the beginning of this book. From then on, there was a proliferation of T-shirts with drawings, paintings and phrases with the aim of bringing the debate to public opinion, of instilling people's curiosity about the topic. Songs, images and poetry served as the bait for this strategy: "Gente é pra glitter…", based on music also by Caetano Veloso; "Maluco Beleza" and "Alternative Society", both by Raul Seixas; "there is so much life out there…", "Like a wave", by Lulu Santos; "They say I'm crazy for thinking like that. If I'm crazy, because I'm happy. But crazy is the one who tells me he's not happy, he's not happy", "Balada do Crazy", by Arnaldo Baptista and Rita Lee; are some of these songs that help to provoke and instigate people to ask what this or that phrase meant, and the reason for being in that shirt and thus produce dialogues and encounters (in the sense of meeting people/between people) on the theme of madness, segregation, prejudice.

Community televisions also represented an important initiative. Among those that stood out the most are, in first place, TV Tam Tam, created in Santos right at the beginning of the process of dismantling the asylum structure in the city. A few years later, in the same vein, TV Pinel appeared in Rio de Janeiro, which in 2006 completed ten years, with very creative and highly awarded programs. More recently, TV Parabolinoica was born, in Belo Horizonte. All of them have scripts, footage and performance by users, family members, professionals and volunteers. Another proposal is that of radio programs, among which Radio Tam Tam, also from Santos, was the pioneer. But there are many across the country, always with creative names and alluding to the countryside, such as Radio Antena Virada (Paracambi), Radio Cala a Boca Ja Morreu…

In 2005 the Centro Cultural Banco do Brasil, one of the noblest spaces of national culture, opened its doors for the event Madness and Culture and that same year the Festival da Madness was started in Barbacena.

From the Associação Loucos pela Vida, in which users, family members, technicians and volunteers participate, a musical group was born that recorded a CD with several songs, among

them “Nas terras do Juquery” and “Coucos pela vida”, by Luizinho Gonzaga, which prophesies that “one day the walls of Juquery will fall”. In Rio, the musical group Harmonia Enlouquece was created, which recorded “Sufoco da vida” with the voice of Hamilton Assunção: “I am living in the world of the hospital, taking mental psychiatry medicine. Haldol, diazepam, rohypnol, promethazine, my doctor doesn’t know how to make me a normal guy.” Or Paulo de Tarso with “we sowed the sun… we made the sun shine… we made the sun rise so we wouldn’t drink haldol”. And many other initiatives in the field of music, such as Magicos do Som (Volta Redonda/RJ), Lokonaboa (Assis/SP), Viajar (Santo André/SP), Tan Tan Train (Belo Horizonte/MG), Zé do Poço (Ribeirão das Neves/MG), Altered Nervous System (RJ), Cancioneiros do Ipub (UFRJ), Impatientes (Juiz de Fora/MG), or the historical shows of the Project Sings Madness at the Barcas da Cantareira Station (Niterói/RJ). At the last World Social Forum in Porto Alegre, an exciting event brought together mental health activists with hip-hop.

Making a link between music and theater, the Scenic Choir was created in São Paulo, a beautiful proposal to sing, dance, represent, signify. In Rio, from the Teatro do Oprimido, by Augusto Boal, the Grupo de Teatro Pirei na Cenna was created, but there are numerous initiatives like these throughout the country. The Theater of the Oppressed is a good example of how it is possible to produce works guided by principles such as emancipation, autonomy, critical awareness, among others, that are not reduced to a therapeutic character. It’s just theater! (And isn’t it enough?)

In Rio de Janeiro, there is also the theater group ‘Os nomads’ and ‘Camisa de force’, which accompanied the Grupo de Ações Poéticas Sistema Nervoso Alterado, a cultural intervention conceived by the plastic artist and physician Lula Wanderley.

With the objective of creating a public culture policy in the field of Mental Health, the National Secretariat for Identity and Cultural Diversity, of the Ministry of Culture, and the Sergio Arouca National School of Public Health, of the Oswaldo Cruz Foundation (Ensp/Fiocruz) , launched, in

August 2007, with the presence of Minister Gilberto Gil, the Crazy for Diversity project. The originality of this project lies in the fact that it is the first regular cultural policy initiative for people in psychological distress. No other country has a similar initiative! In 2009, the public notice for the Crazy for Diversity project, which paid tribute to Austregésilo Carrano (author of the book that inspired the movie Bicho de 7 Cabeças), received almost 400 project entries. The award ceremony, presided over by the Minister of Culture Juca Ferreira, took place at Caixa Cultural's headquarters,

But there is a fundamental aspect in this sociocultural dimension that demonstrates its interrelation and interactivity with the other dimensions: the social and political participation of all the social actors involved in the psychiatric reform process. Since the early years of the process, in the scenario of national redemocratization, social participation has been the object of deserved prominence. Let's look at some aspects of this participation.

In 1978, the Movement of Workers in Mental Health (MTSM) was created in Rio de Janeiro, which in the same year became a national movement and, in January 1979, organized the I National Congress at Instituto Sedes Sapiæntia, in São Paulo. In 1979, the first family association in the country was created, called Sosintra, which is still active today and an important protagonist in defense of Brazilian psychiatric reform. The arrival of Franco Basaglia contributed decisively to the constitution of the transformation movement in the country, whether in 1978, when he came together with Felix Guattari, Robert Castel, Erving Goffman, Thomaz Szasz to the I Brazilian Congress of Psychoanalysis, Groups and Institutions in Rio de Janeiro , or in 1979, when he came to the III Minas Gerais Congress of Psychiatry, in Belo Horizonte,

The initiative of Sergio Arouca, then president of Fiocruz and Coordinator of the 8th National Health Conference, to effectively involve Brazilian society in the discussion and formulation of health policies opened a new field of possibilities for what we currently know as the Unified Health System (SUS). With the organization of the 'Oitava' (as it became known), not only health professionals, but also users

of the system, family members, activists from associations, non-governmental organizations, unions, churches, political parties, in short, from various segments of Brazilian society. At the I National Conference on Mental Health, held as an offshoot of the Eighth, the various participants of the MTSM decided to hold the II Congress, which took place in December 1987, in Bauru. In this congress, the MTSM underwent a profound transformation, becoming a movement no longer (predominantly) of mental health professionals, but with the effective participation of users and family members. On the other hand, it was decided to assume a clearer character in relation to the role of the psychiatric hospital and, for that, it adopted the motto: For a Society Without Asylums, which had emerged at the III Meeting of the Network of Alternatives to Psychiatry, held in the year in Buenos Aires, from December 17 to 21. Many associations and cooperatives were created since then, among which I highlight some, just as a form of historical record: Crazy for life (initially in Juquery and later in Ribeirão Preto/SP), SOS Saúde Mental (São Paulo/SP), Franco Basaglia (São Paulo/SP), Franco Rotelli (Santos/SP), Cabeça Feita (São Gonçalo/RJ),

Social participation, not only in mental health, but in health policies in general, had a decisive boost with the introduction of the health chapter in the 1988 Constitution and, later, with the institution of SUS, regulated by law n. 8080 of September 19, 1990. Soon after, on December 28 of the same year, law n. 8,142 established community participation in the management of the system, which became known as “social control”. The holding of the four National Conferences on Mental Health, in 1987 (Rio de Janeiro, from 25 to 28 June), 1992 (Brasília, 30 November to 2 December), 2001 (Brasília, 11 to 15 December) and 2010 (Brasilia, June 27th to July 1st) offered unparalleled possibilities for social actors to participate in the discussion and construction of mental health and psychosocial care policies. Ideally, there should be regularity in the convening of these conferences. The involvement of social actors in state and municipal Health Councils and in the Mental Health Commissions linked to these Councils and to the National Health Council is still very important.

The sociocultural dimension receives a lot of visibility through the regular holding of large meetings fully organized and carried out by the social actors of the psychiatric reform: users, family members, professionals and other activists of social movements for citizenship and defense of life. There are as many meetings of the National Movement for the Anti-Asylum Struggle as there are exclusive meetings with users and family members After several manifestations of society, in particular the anti-asylum movements, which culminated with the March of Users on September 30, in Brasília, the IV National Conference on Mental Health was held, which took place in Brasília from June 27 to December 1, 2019. July 2010. The innovative character of this conference was the fact that it was intersectoral, with the participation of the areas of culture, human rights, labor, among others. Although intersectoriality has been restricted to the participation of government representatives, and has not been extended to social movements, the remarkable opening conference by Minister Paulo Vannuchi, of Human Rights and the conference by Professor Paul Singer on solidarity economy, entered the history of the Brazilian psychiatric reform.

In 2007, on the occasion of the Brazilian Congress of Collective Health promoted by the Brazilian Association of Collective Health (Abrasco), in Salvador, professionals, users and family members realized the need to create a new form of entity in the field of mental health and psychiatric reform that could bring together the various segments of the field, as well as the political struggle and the production of knowledge. Thus, the Brazilian Association of Mental Health (Abrasme) was born, which has since held three national congresses (Florianópolis in 2008, Rio de Janeiro in 2010 and Fortaleza in 2012) with significant participation of people from all states of the federation, as well as from other countries. . More than seven thousand people participated in the last congress. Furthermore,

5:Paths and trends of mental health and psychosocial care policies in Brazil

We will see some current proposals that are outlining new possibilities in the field of mental health and psychosocial care. Through the analysis of these experiences, I believe it is possible to observe the complexity of the actions and the richness of the interrelationships between the dimensions analyzed above.

Crisis care and psychosocial care services

Crisis attention represents one of the most difficult and strategic aspects. In the classical model of psychiatry, a crisis is understood as a situation of serious dysfunction that occurs exclusively as a result of the disease. As a consequence of this conception, the answer may be to grab the person in crisis at any cost; tie her up, inject her with strong intravenous drugs that act on the central nervous system in order to dope her, give her electroconvulsive therapy (ECT) or electroshock, as it is better known in the popular domain. On the contrary, in the context of mental health and psychosocial care, the crisis is understood as the result of a series of factors that involve third parties, be they family members, neighbors, friends or even strangers. A moment that can be the result of a lowering of the threshold of solidarity with each other, from a situation of precariousness of resources to treat the person at home, in short, a situation that is more social than purely biological or psychological. For this reason, too, it is a social process.

Therefore, it is necessary that there are psychosocial care services that make it possible to welcome people in crisis, and that all the people involved can be heard, expressing their difficulties, fears and expectations. It is important that affective and professional bonds are established with these people, that they feel really heard and cared for, that they feel that the professionals who are listening to them are effectively focused on their problems, willing and committed to helping them. In psychosocial care, the expression ‘taking responsibility’ for the people being cared for is used.

Psychiatry refers to the doctor-patient relationship, but what it actually establishes is a doctor-disease relationship. In mental health and psychosocial care, what is intended is a network of relationships between subjects,

PROFESSIONALS	↔	*USERS*
↕		↕
SOCIETY	↔	*RELATIVES*

The term ‘user’ was introduced by SUS legislation (laws 8080/90 and 8142/90), to which I have already referred, in the sense of highlighting the protagonism of what was previously just a ‘patient’. The expression ended up being adopted with a very unique meaning in the field of mental health and psychosocial care, insofar as it meant a displacement in the sense of the social place of people in psychological distress. Currently, the term has been criticized for the fact that it still maintains a relationship between the subject and the health system. For this reason I will always use it in parentheses. This is an important indication of the permanent movement of reflection and construction in the field of psychiatric reform.

Properly heard, people need to be oriented and, as far as possible, they should be involved in solutions, referrals and treatments built by common agreement, always trying to avoid that the person taken to the service is excluded from the process.

Psychosocial care services must have a very flexible structure so that they do not become bureaucratized, repetitive spaces, as such attitudes represent that they are no longer dealing with people, but with diseases. As they must be places where the crisis can be welcomed, they may have to offer support beds in which people can be hospitalized for a short period. In Brazil, ministerial ordinances n. 189/91 and 224/92 established several modalities, including day hospitals, therapeutic workshops and Psychosocial Care Centers (CAPS), which were restructured by ordinances n. 336/2 and 189/2 establishing various modalities of CAPS.

CAPS work, at least, during the five working days of the week (from Monday to Friday). Opening hours and opening hours on weekends depend on the type of Center:

• CAPS I – municipalities with a population between 20,000 and 70,000 inhabitants – are open from 8 am to 6 pm, from Monday to Friday.

• CAPS II – municipalities with a population between 70,000 and 200,000 inhabitants – are open from 8 am to 6 pm, from Monday to Friday. It can have a third period, running up to 21 hours.

• CAPS III – municipalities with a population of over 200,000 inhabitants – are open 24 hours a day, also on holidays and weekends.

• CAPSi – Services for children and adolescents – municipalities with a population of over 200,000 inhabitants – are open from 8:00 am to 6:00 pm, Monday through Friday. It can have a third period, running up to 21 hours.

• CAPSad – Assistance for chemical dependency (alcohol and drugs) – municipalities with a population of over 100,000 inhabitants – open from 8 am to 6 pm, from Monday to Friday. It can have a third period, running up to 21 hours.

Users who spend a four-hour shift at CAPS must receive a daily meal (Brasil, 2004).

As you can see, CAPS III are open 24 hours a day and offer beds for crisis care. Unlike psychiatric hospitals, they are beds in open rooms, with ample possibility of monitoring people throughout the period they are hospitalized.

Psychosocial care services seek to have operators from different professional categories, many considered ‘external’ to the health area, such as: musicians, visual artists, artisans, among others, depending on the possibility of each service, each city or the creativity of each.

Psychosocial care services must seek to develop their skills to the maximum in working in a territory that, as we discussed earlier, is not limited to geographic space. The service can be considered all the more territorially based, the more it is able

to develop relationships with the various resources existing within its community. In American and French mental health centers, workshops were created within the services. They had the character of a therapeutic craft (reminiscent of the notion of moral therapy) and a normative function, of producing subjectivities suited to the social norm. Currently, the tendency is to build 'studios' throughout the social space, throughout the city… The challenge lies in the possibility of finding civil associations, football teams, commercial entities, in short,

We are talking about the principle of intersectoriality, that is, strategies that permeate various social sectors, both in the field of mental health and health in general, as well as public policies and society as a whole. In other words, psychosocial care services must leave the service's headquarters and seek links in society that complement and expand existing resources. They must be articulated with all existing resources in the field of mental health, that is, with the Mental Health Care Network (other psychosocial care services, cooperatives, residences for graduates or other people in a situation of social precariousness, outpatient clinics, hospitals, -day, psychiatric units in general hospitals), and in the field of health in general (Family Health Strategy, health centers, basic network, outpatient clinics, general and specialized hospitals, etc.) or within the scope of public policies in general (public ministry, social security, police stations, institutions for children, the elderly, the underserved in general, churches, educational policies, sports, leisure, culture and art, tourism, transport, action and social welfare, etc.), and, finally, within the scope of the resources created by civil society to organize, defend, and show solidarity. Mental health and psychosocial care policies must be organized in a 'network', that is, forming a series of meeting points, cooperation paths, simultaneity of initiatives and social actors involved. of sport, leisure, culture and art, tourism, transport, action and social welfare, etc.), and, finally, within the scope of the resources created by civil society to organize, defend and show solidarity. Mental health and psychosocial care policies must be organized in a 'network', that is, forming a series of meeting points, cooperation paths, simultaneity of initiatives and social actors involved. of sport, leisure, culture and art, tourism, transport,

action and social welfare, etc.), and, finally, within the scope of the resources created by civil society to organize, defend and show solidarity. Mental health and psychosocial care policies must be organized in a 'network', that is, forming a series of meeting points, cooperation paths, simultaneity of initiatives and social actors involved.

THEFigure 3presents an idea of a Mental Health Care Network as understood by the Ministry of Health, but which can be much broader and more complex, according to the local possibilities and creativity of each service or team.

Source: Brazil, 2004.

The strategies of residentiality and emancipation of subjects

The more than three hundred years of psychiatric hospital-centered psychiatry have produced many sequels and disasters in the lives of many thousands of people. When we started a work of deinstitutionalization and constitution of a work of mental health and psychosocial care, we came across many people who have lived for decades cloistered in these institutions. The psychiatric and asylum model that oppressed them reduced their expectations, obstructed their life projects, flattened their expressions and feelings. In this way, the vast majority of them are not able to live again without the help of third parties and, therefore, it is very important that programs and strategies of psychosocial support are organized for these people, among which the strategies of residential housing and subsidies. financial. After many years of institutionalized living, many do not want to leave the cloister, many do not have families or their families no longer want them at home. Families, even as a defense mechanism, so that they do not suffer so much from the hospitalization of one of their members, they reorganize themselves and even rearrange the spaces of the house. After some time, there is no more room for the one who has departed.

But, as I said earlier, many internees also do not want to return to their homes, and if we look closely at some of the contributions of Antipsychiatry, we will understand why. Thus, public policies must provide conditions for the process of deinstitutionalization of these people. An initial step is

taken with the organization of multi-professional teams, whose objective is to accompany people, helping them to build autonomy and independence: getting ready, preparing food, reading newspapers, listening to the radio and watching television, singing, dancing, walking around the city, talking to people on the street, going to church, playing soccer…

Teams can continue to accompany people in different degrees of autonomy and independence. There are dependent people who cannot carry out the activities of daily living, but they should not be kept in closed institutions. It is incredible how the experiences of deinstitutionalization have shown that many of the people hospitalized, in whose medical records there are notes of alienation, social disinterest, stereotypes, lack of initiative, etc., are protagonists of a radical transformation. To know how far they can go, there is only one option: to enable them to participate in the deinstitutionalization process!

In many situations, it is necessary for the residences to be assisted or supervised in degrees of complexity that vary with the autonomy and independence of the residents. But in several countries (for example, Italy, Spain, Canada, Norway, England, among others), there are experiences of absolutely autonomous residences. In homes with less autonomous people, professional care (medical, psychological, physical therapy, etc.) can be offered, while, in homes with more autonomous people, all so-called therapeutic activities are carried out in the health resources existing in the territory. In any case, it is important to have as a principle that the Family Health teams comply with the supervision and 'matrix support' of psychosocial care services (as we will see later),

In the case of Brazil, through ordinance n. 106 of February 11, 2000, "therapeutic residential services" were instituted, intended for inmates in psychiatric institutions for a period of at least two years. Despite the fact that the residences are called services and, more seriously, therapeutic, the initiative has contributed to overcoming the still hegemonic predominantly asylum psychiatric model.

The observation related to the denomination does not refer to a simple conceptual rigor, but to the risk of inducing undesirable

aspects of homes that should be less institutionalized and of institutions that intend to be therapeutic in themselves (let us remember Esquirol and Tenon with the hospice as the best medicine!). Therapy must be a function of technicians and treatments in the places intended for this purpose (which are not therapeutic per se). In this way, it is never too much to warn about the risk of institutionalization of residences. In order to avoid this fate, it is necessary to keep in mind, at all times, that it is a question of houses, and to refuse daily the tendencies towards trivialization, repetition, standardization of attitudes or 'serialization' (as Sartre points out). We must remember that everyday life must be from a house!

The Brazilian policy of residential strategies is still restricted to subjects who have graduated from institutions in which they have been hospitalized for more than two years. It is our expectation that the proposal will be extended to all those who also have difficulties in housing or family life. The measure would certainly contribute as an alternative for these people, especially for those who have never been to a psychiatric hospital, which would restrict the process of institutional chronification or the "moral career of the mentally ill", an expression used by Goffman (1992) to name the process of institutionalization produced by the psychiatric institution.

Since many people who have lived long years institutionalized do not find it easy to get a job, or a job with enough income to support themselves, or another form of financial resource, several countries guarantee a minimum monthly income as a subsidy. In Brazil, as part of a program called "Back home", Law n. 10,708, of 7/31/2003, instituted the psychosocial rehabilitation aid for people with mental disorders released from psychiatric hospitalizations.

Cooperatives, social centers and social enterprises

An initiative considered very daring, even insane for the time, was the creation of work cooperatives for patients admitted to the psychiatric hospital. Franco Basaglia found that, back in 1973, at the Ospedale San Giovanni, which he ran in Trieste, a good part of the 'employees' were 'inpatients'. Well, if they could work, they could get paid for their work, nothing could be more fair! But the public administration did not allow it because it considered them crazy. In addition, he understood that the work they performed was either 'voluntary' (certainly included in the modalities that total institutions create for the control of inmates, through the system of privileges, awards and punishments) or even 'therapeutic' (adapted to the archaic views of labor therapy and ergotherapy, legitimate daughters of the therapeutic work in the alienated colonies). This is how history recorded the 'first strike of madmen' in all of humanity!

The solution was to discharge everyone involved, which ended up forming a cooperative – called Lavoratori Uniti (United Workers) – which was hired to perform various tasks at the hospital (cleaning, cooking, laundry, general services). Years later, the initiative was considered so innovative and effective (even 'therapeutically', if this were a therapy), that the WHO started to support the project, to publicize and stimulate similar initiatives in other countries. Furthermore, a national law was passed creating social cooperatives, designed to provide work to people considered 'socially disadvantaged'. This ended up inspiring legislation by the European Economic Community, which began to politically and financially support the projects now called Social Enterprise.

In summary, mental health and psychosocial care policies began to adopt more specific and concrete strategies for creating income-generating projects for people being monitored in the network. With cooperatives or social enterprises or even with income-generating projects that incorporate the same principles as the previous ones, the issue of work underwent a turning point. Work ceases to be a therapeutic activity (prescribed, guided, protected), or it ceases

to be a form of simple occupation of idle time, or even a form of submission and institutional control to become a strategy of citizenship, of autonomy. and social emancipation. Currently, there are many inclusion initiatives through work and income generation, among which the Solidarity Economy network (Ecosol) deserves to be highlighted.

It is in this sense that, also in Brazil, law n. 9,867, of November 11, 1999, which instituted social cooperatives "constituted with the purpose of inserting disadvantaged people into the economic market, through work" and that "are based on the general interest of the community in promoting the human person and the social integration of citizens" and, although it was born within the scope of the social movement of mental health and psychiatric reform, it expanded the range of beneficiaries of the law.

In São Paulo, there is an experience, begun in the early 90's, which still has a great expression for its originality. These are the Coexistence and Cooperative Centers (Cecco), which provide spaces for sociability, social networks of solidarity and encounters between subjects of different origins and social and cultural conditions. The Ceccos taught us that the city is full of resources and that all it takes is a project and the will to find them.

Mental health and family health

One of the most promising areas is this of mental health in family health. The Family Health Strategy (ESF) emerged in 1994 under the name of the Family Health Program. The basic team of the FHS is composed of a general practitioner, a nurse, a nursing assistant and four to six health agents, who must be residents in the team's own territory. In some cases, a dentist is included. Each team is responsible for caring for around 800 families, which means around 3,500 people.

The ESF is considered one of the forms of primary health care, which focuses on the family and aims to reverse the predominantly biomedical care model, centered on disease and treatment. It is as a result of this objective that 'program' was replaced by 'strategy'. Let's see why.

As we saw earlier, the biomedical model ended up constituting a system highly centered on the hospital, and this not only within the scope of psychiatric care. Modern clinical medicine was born in the hospital and reproduced in the hospital. All of us, health professionals, are trained in the hospital, do 'residency' (ie, we live in the hospital) and develop our activities predominantly in the hospital. As a result of this model, we learn to deal only with the sick, or rather, with the illnesses of the sick. We don't learn to deal with people, with families, with communities. Anyway, we don't learn to deal with health. A question that has always intrigued me is that, when I started medical school, the first class I had was anatomy; my first contact was with 'parts' of organs from people who had died.

This disease-centered model brought about another characteristic: 'hyperspecialism'. Each specialist treats only one type of disease; in general, each deals with only one organ of the human body. In short, medicine has taken the idea that it is the art of curing diseases to an extreme, minimizing the idea that it is also the art of preventing diseases and dealing with health.

The ESF represents the beginning of the possibility of reversing this situation, investing in health promotion and defense of life, educating the community and developing practices of thinking about and dealing with health. It is considered that around 80% of health problems could and should be solved within the scope of the basic network, that is, with simpler (but not disqualified) care, without much technological sophistication of diagnosis and treatment.

This brings us to an important observation: primary health care is also a 'de-medicalization' strategy, and this can be understood in two ways. The first is in the sense of this high resolution capacity of the ESF, which dispenses most of the referrals to the most sophisticated and complex levels of care, such as outpatient clinics and other specialized services of diagnosis and treatment (secondary level) and hospitals and other treatment units. and hyper-specialized diagnosis (tertiary level), not valuing or excessively stimulating the 'patient career' in the person who experiences the disease.

The second refers to certain consequences resulting from some medical interventions (and here it should be noted that I am referring to medicine and its professional agents and therapeutic resources, and not just to medical professionals). There is a certain consensus in considering that medicine itself is capable of producing or aggravating diseases, which is called iatrogenics. “Do no harm”, proclaims one of Hippocrates’ fundamental principles. But the invasive attitude and the intermediation of interests from the so-called medical-industrial complex can cause many excesses and risks to users.

However, the term medicalization has two meanings and can be quite ambiguous. In the tradition inspired by Michel Foucault (1977a) and Ivan Illich (1975), medicalization refers to the appropriation, by medicine, of everything that is not exclusively medical, or predominantly medical. In other words, it concerns the possibility of making what is social, economic or political, ‘medical’, such as, for example, a situation of social violence in which people who are the object of violence are medicalized. In other words, the term is related to the possibility of making people feel that their problems are health problems and not inherent to human life. For example, great sadness after the loss of a family member who, when ‘medicated’, becomes ‘depression’; and the person,

The other meaning of the term, which is usually a consequence of the previous process, is the use of drugs to respond to the situation that is understood as pathological. The most correct, at least for didactic purposes, would be to call this second possibility ‘pharmacologization’ or ‘medicamentalization’, in order to differentiate it from medicalization, as we saw earlier.

But, returning to the discussion, one of the principles of mental health in family health is exactly the principle of demedicalization, in the sense of not appropriating all the problems of a community as medical-sanitary problems. In the conception of Lancetti (2006), it is within the scope of family health that we can reach the radical nature of deinstitutionalization. To this end, family health teams must be well trained in the more general conception of psychiatric reform and health reform, understanding both as complex social processes that aim both at improving medical care and

promoting health and building awareness. health in communities.

In addition to good training, it is important that teams receive 'matrix support' to better manage mental health cases. For Campos (1999), the matrix support aims to provide a rearguard to the teams that serve the families. Mental health professionals must offer matrix support to family health teams, helping them to achieve maximum success in their interventions, without the need to refer people to more complex levels of resources. With the objective of offering matrix support, the Family Health Support Centers (Nasf) were established, by decree GM n. 154, of January 24, 2008, who have performed this important role.

Lancetti (2006) also notes that, in the case of mental health in the context of family health, the idea of complexity is inverted. What this means? In the case of medicine in general, the complexity moves from the basic network (more simplified interventions) towards tertiary services (with more sophisticated and specialized resources). In the case of mental health, the complexity is inverted: at the tertiary (hospital) level the answers are standardized, massified, elementary: sedative medications, bed restraints, isolation, etc. At the primary level, of the basic network, actions must be more complex: dealing with the family, with people in crisis, with the neighborhood, with the social actors in the territory in which they live.

Innovations in psychosocial care: Raps

With the objective of expanding access to psychosocial care for the general population; promote the linking of people with mental disorders and with needs arising from the use of crack, alcohol and other drugs and their families to points of care; to guarantee the articulation and integration of the attention points of the health networks in the territory, qualifying care through reception, continuous monitoring and attention to emergencies; the Psychosocial Care Network (Raps) was established through ordinance n. 3,088 of December 23, 2011.

The Psychosocial Care Network consists of the following components:

Primary Health Care

• Basic health Unit

• Family Health Support Center

• Street Office

• Support for the services of the Residential Care component of a Transitory Nature

• Community and Culture Centers

Specialized Psychosocial Care

• Psychosocial Care Centers (CAPS I, CAPS II, CAPS II Childhood and Adolescence, CAPS II Alcohol and Drugs, and CAPS III including specialized in alcohol and drugs)

Urgent and Emergency Care

• Samu 192

• Stabilization Room

• 24-hour UPA and emergency/emergency care hospital doors, Basic Health Units

Residential Care of a Transient Character

• Reception Unit

• Residential Care Service

Hospital Care

• Specialized ward in General Hospital

• Reference Hospital Service for people with suffering or mental disorder and with needs arising from the use of crack, alcohol and other drugs

Deinstitutionalization Strategies

• Therapeutic Residential Services

• Homecoming Program

Psychosocial Rehabilitation

• Work and income generation initiatives

• Solidarity enterprises and social cooperatives

Final considerations: a new social place

For more than two hundred years, the relationship that Western society maintained with people in psychological distress was more or less the same: long and interminable hospitalizations in psychiatric hospitals, characterized by abandonment or acts of violence. The concept of mental alienation (as well as its later derivations, illness and mental disorder) implied negative social attitudes, of fear and rejection, due to the resulting conceptions, such as dangerousness, incapacity, irrationality, always stigmatizing and discriminatory.

Many thousands of people have died in psychiatric hospitals around the world. And, despite complaints, struggles and innovative practices, there are still many deaths in psychiatric hospitals and many other situations of violence. In August 2006, the Inter-American Court of Human Rights of the Organization of American States (OAS) condemned the Brazilian State for the death of Damião Ximenes, which occurred in a psychiatric clinic in the city of Sobral (Ceara) in 1999. Most of these deaths and the situations of violence against people in mental suffering does not, however, come to the attention of public opinion. Every now and then we learn about one or another dramatic situation.

As we saw earlier, the picture began to change at the end of the Second World War, when humanity realized the atrocities that men practiced against each other and, finally, realized that acts absolutely similar to those practiced during war were habitually carried out. against the ‘mentally ill’ in institutions that were in no way different from concentration camps. Basaglia (2005) summed up this condition decisively and revealingly when referring to “peace crimes” committed in the name of science, order and reason.

And it is precisely because of this radically critical stance towards the farce of such institutions that call themselves therapeutic, that the Italian experience is certainly the most vivid and current among all the international experiences we have visited. On May 13, 1978, the Italian Parliament passed law n. 180, which reorganized the care model for people with

mental suffering in the country. The Basaglia Law, as it is also known, determined the end of psychiatric hospitals and enabled the opening of legal conditions for the construction of a new assistance and political scenario. The date of approval of this law served as inspiration for the establishment of the National Anti-Asylum Struggle Day in Brazil, which, since 1988, has been celebrated on the 18th of the same month of May.

The foundations of the field of mental health and psychosocial care contain many principles arising from the way Basaglia built and operated his intervention project. One of the factors in favor of the greater success of the process lies in the fact that it took place in a later period than the others. In this way, the 'Basaglian tradition' was able to exercise some of the principles and learn from the mistakes and successes of previous experiences. As an example, the Therapeutic Community and Institutional Psychotherapy were valued and incorporated the need to involve social actors, all of them, from users to family members, as well as all those who work in the system (which from then on came to be called, indistinctly, , of operators). Principles such as democratization, social participation, involvement, co-responsibility, reception,

But, from Basaglia, it became clear that such experiences should not be an end in themselves, that is, the objective-image would not be the transformation of the hospital model into a modern, sanitized, humanized model, since the asylum characteristics always meant that advances were limited when they did not set them back. Assemblies, team meetings, patient clubs, among other resources born in the Therapeutic Community and Institutional Psychotherapy were adopted as strategies for the process of dismantling the asylum logic and not for its improvement. This is one of the fundamental principles of the mental health and psychosocial care proposal: overcoming the asylum model.

Sector Psychiatry contributed enormously by taking the first step out of the hospices, organizing the first strategies for the recovery of culture, society, and the family. When introducing the issue of the sector, there was a shift from psychiatry towards professional practices, which expanded to other

categories and other areas of knowledge. Patients are no longer exclusive to ‘the doctor’ to become ‘the team’. It was certainly a great innovation.

The principle of referral and counter-referral was also decisive for this new field, insofar as the graduates of an asylum institution were already discharged, knowing where to go and with whom to continue the treatment. The organization of the wards with people from the same region is widely used in the de-asylumization processes with the objective of stimulating social bonds and preparing definitive exits from the hospital space.

In this aspect, there is an original contribution from Basaglia: the sectoral services should be strengthened to the point that the way back to the hospital no longer needs to be carried out. This initiative increased the importance and the technical and political competence of the ‘multidisciplinary’ teams. On the other hand, in the Basaglian tradition, the sector will be re-signified as a territory, in the sense of revealing people’s living space as a space for real and symbolic exchanges, which must also be transformed. It is in the territory that the mechanisms of solidarity, fraternity, rejection and discrimination are built in the daily life of a particular social culture. Acting in the territory means transforming the social place of madness into a society.

As for Preventive Psychiatry, first of all, it is necessary to reject its claims to ‘combat social ills’ or ‘improve the mental health of the population’. Basaglia got to know her very closely when he was a visiting professor in the USA and about her he wrote the Letter from New York, in which he warns us about the risks of searching for suspects and the dangerous ideology of universal mental health. With these reservations in mind, Preventive Psychiatry introduced the principle of biopsychosocial unity, which points to a path to overcome Cartesian dualism (mind versus brain), consolidating the idea that was established as the mode of psychosocial care (note that the ‘bio’ was forgotten; for some because it was implied!).

As a result of this last aspect, the concept of crisis took on a new dimension, ceasing to be the expression of a process that

would occur exclusively in the subject. As we know, the crisis was previously considered an alteration in the psychic economy, for some, and an organic disturbance, for others.

Finally, Preventive Psychiatry contributes to two displacements in relation to psychiatry. A first shift that goes from psychiatry to mental health, also rescuing the notion of psychosocial mode, which undoubtedly represents an expansion of the conceptual field and an innovation in the ethical aspect of psychiatry. And another, which goes from the hospice to the community, which, together with Sector Psychiatry, was a first step towards restoring responsibility for madness to society.

The Brazilian process incorporated the questions arising from all these experiences, including learning from the Basaglian tradition to reflect and incorporate the mistakes and successes of previous processes. The set of strategies and principles in the field of mental health and psychosocial care in Brazil is responsible for a new political scenario in which there is an effective process of participation and social construction unparalleled in any country in the world, even in Italy.

There are many strategies and devices that have contributed to the configuration of the new framework: the state psychiatric reform laws and law n. 10,216/01; the important role of the Public Ministry; participation and social control in mental health and psychosocial care policies; the political participation of movements in favor of psychiatric reform; the permanent and consistent criticism of the violence and segregation produced by the psychiatric hospital and medicalization; the reduction of more than forty thousand hospital beds with the simultaneous construction of psychosocial care services, residential strategies, coexistence centers, cooperatives and social enterprises; the Back Home Program; inclusion projects through work; cultural initiatives; the Family Health Strategy.

Basaglia (2005: 246-247) insisted that:

although updated, humanized, ‘medicalized’, the psychiatric hospital, continuing to exist, also induces and sanctions, in relation to old and new care needs, a whole series of

concentric circles of contagion, corresponding to so many institutional apparatuses (. ..). In this sense, the psychiatric hospital, although modified and transformed, remains – as such – a cause of illness.

Or, in other words, even when 'made up', the psychiatric hospital remains a 'golden cage', where there is no citizenship, freedom and autonomy (Basaglia, 2005).

What is taking shape is, of course, the construction of a new way of dealing with mental suffering, welcoming and effectively caring for the subjects, and the consequent construction of a new social place for diversity, difference and mental suffering. . Franco Basaglia spoke of the "utopia of reality", Sergio Arouca spoke of the "civilization process". This is how we understand this great movement of life transformations from the field of mental health and psychosocial care. And I always remember the words of Eduardo Galeano at the III World Social Forum in Porto Alegre:

Utopia is there on the horizon. I approach two steps, she moves two steps away. I walk ten steps and the horizon runs ten steps. As far as I walk, I will never reach. What is utopia for? It works for this:

Suggested readings and movies

On the transformation of the hospital, from a charity institution into a medical institution, and on the transformation of medicine, from social knowledge and practice into hospital knowledge and practice, there is the chapter “The birth of the hospital” in Microphysics of Power (Rio de Janeiro: Graal, 1979) and the book O Nascimento da Clínica (Rio de Janeiro: Graal, 1977b), both by Michel Foucault. A History of Public Health (São Paulo: Unesp/Abrasco/Hucitec, 1994) and From the Medical Police to Social Medicine (Rio de Janeiro: Graal, 1980), both by George Rosen, are also fundamental.

The birth of psychiatry, the biomedical model and the psychiatric paradigm are addressed, in different ways, in Mental Illness and Psychology (Rio de Janeiro: Tempo Brasileiro, 1968) and History of Madness in the Classical Age (Rio de Janeiro: Perspectiva, 1978) , the two by Michel Foucault; in The Psychiatric Order: The Golden Age of Alienism, by Robert Castel (Rio de Janeiro: Graal, 1978), and in Psychiatry as a Discourse on Morality, by Joel Birman (Rio de Janeiro: Graal, 1978). A beautiful book by George Rosen, entitled Madness and Society: Sociologia Histórico de la Enfermedad Mental, was unfortunately not published in Brazil, but can be found in Spanish (Madrid: Alianza Universidad, 1974).

Regarding disciplinary institutions, also called ‘total’, it is essential to know Discipline and Punish : the history of violence in prisons, by Michel Foucault (Petrópolis: Vozes, 1977a), and Asylums, by Erving Goffman, published in Brazil under the title Manicômios , Prisons and Convents, which reduces the scope of the asylum institutions he studied (São Paulo: Perspectiva, 1992).

On the Therapeutic Community, the book of the same name, by Maxwell Jones, The Therapeutic Community (Petrópolis: Vozes, 1978), one of the greatest expressions of this current, is the best read. Regarding Institutional Psychotherapy, publications in Brazil are rare. Among them, we can mention the article by Giovanna Gallio and Costantino Maurizio,

entitled “François Tosquelles: the school of freedom”, in Saúdeloucura 4 (organized by Antonio Lancetti, São Paulo: Hucitec, 1993) and the one by Vertzman, Serpa and Cavalcanti, “Institutional Psychotherapy: a review”, published in Psiquiatria sem Hospício: contributions to the study of psychiatric reform (edited by Benilton Bezerra and Paulo Amarante, Rio de Janeiro: RelumeDumara, 1992).

In relation to Sector Psychiatry, there are also few references. One of them is Robert Castel’s book, Risk Management: from antipsychiatry to post-psychoanalysis (Rio de Janeiro: Francisco Alves, 1987), which extends to the study of Preventive Psychiatry and Antipsychiatry. To get to know Preventive Psychiatry, there is nothing fairer than starting with Gerald Caplan’s Principles of Preventive Psychiatry (Rio de Janeiro: Zahar, 1980). The essay “Organization of institutions for a community psychiatry” by Joel Birman and Jurandir Freire Costa (in Social Psychiatry and Psychiatric Reform, edited by Paulo Amarante, Rio de Janeiro: Ed. Fiocruz, 1998) is essential for critical analysis of it.) and the “Letter from New York: the artificial patient”, by Franco Basaglia,

Antipsychiatry was one of the experiments that produced the most literature, and also on which a substantial amount of work was produced. I highlight Ronald Laing’s Divided Self (Rio de Janeiro: Zahar, 1963), considered the pioneer work of Antipsychiatry. By the same author, The Voice of Experience: experience, science and psychiatry (Petrópolis: Vozes, 1988) is one of the most vigorous critical incursions into the scientific model of psychiatry. Psychiatry and Antipsychiatry, by David Cooper (São Paulo: Perspectiva, 1973), the inventor of the term Antipsychiatry, offers an overview of the conceptual bases and the main practical experiences, such as the Tavistok Clinic or Vila 21, at the Shenley Hospital in London. Among us, João Duarte Francisco Jr. published A Política da Madness (Antipsychiatry),

Selected Writings, by Franco Basaglia, (which we referred to earlier) and Deinstitutionalization, a collection of texts by Franco Rotelli et al. (São Paulo: Hucitec, 1990), address the conceptual and historical principles and foundations of Italian democratic psychiatry and the notion of a complex social

process. For her master's thesis, Denise Dias Barros elaborated a detailed research work in Italy, which originated one of the most complete books on Italian psychiatry, from its constitution in the 19th century, through the 1904 law, to the situation of the Italian reform in 1990s. It is The Gardens of Abel: deconstruction of the asylum in Trieste (São Paulo: Lemos/Edusp, 1994). Allow me to include The Man and the Serpent: other stories for madness and psychiatry, by me (Rio de Janeiro: Ed. Fiocruz, 2003),

In A Reforma Psiquiatrica, the Spanish psychiatrist Manuel Desviat (Rio de Janeiro: Ed. Fiocruz, 1999) takes an interesting path from the birth of psychiatry, through the reforms that we study here, and reaches the most important national mental health experiences and policies. currently, including the Canadian, the Spanish and the Brazilian.

To deepen the study on the birth of psychiatric institutions in Brazil and the constitution of a national psychiatry, references are made to the books Danação da Norma: social medicine and constitution of psychiatry in Brazil by Roberto Machado et al. (Rio de Janeiro: Graal, 1978) and Arquivos da Loucura: Juliano Moreira and the historical discontinuity of Vera Portocarrero's psychiatry (Rio de Janeiro: Ed. Fiocruz, 2002). On the first decades of the 20th century Jurandir Freire Costa, based on the analysis of the Brazilian League of Mental Hygiene, discusses the issue of prevention in mental health, as well as the political, social and ideological role of psychiatry in the History of Psychiatry in Brazil: a ideological cut (Rio de Janeiro: Documentary, 1976). The relations between madness, justice and legislation are contemplated by Pedro Gabriel Delgado,

On the history and process of psychiatric reform in Brazil, I recommend a book based on research carried out by our team at Laps over a number of years at Fundação Oswaldo Cruz: Loucos pela Vida: a trajectory of psychiatric reform in Brazil (coordinated by Paulo Amarante, Rio de Janeiro: Ed. Fiocruz, 2005). In addition to a genealogical analysis of the Brazilian process, it contains a review of the conceptual bases of Brazilian reform, revisiting all international reform experiences. The contribution from Santos, not only to the

psychiatric reform, but also to the Brazilian health reform, is present, all of it, in Contra a Maré à Beira Mar : the SUS experience in Santos, organized by Florianita Braga and Claudio Maierovich (São Paulo: Hucitec, 2000). The first work cooperative of users of psychosocial care services and the bases of the Naps are presented and analyzed in the collection. The important experience of São Paulo, capital, can be better known in Tecendo a Rede: trajectories of mental health in São Paulo 1989-1996 (Taubaté: Cabral Ed. Universitaria, 1999), organized by Maria Claudia T. Vieiria, Maria Cristina G. Vicentin and Maria Inês A. Fernandes. As the title itself demonstrates, the book also develops an interesting discussion on the theme of the network in psychosocial care. Vieiria, Maria Cristina G. Vicentin and Maria Inês A. Fernandes. As the title itself demonstrates, the book also develops an interesting discussion on the theme of the network in psychosocial care. Vieiria, Maria Cristina G. Vicentin and Maria Inês A. Fernandes. As the title itself demonstrates, the book also develops an interesting discussion on the theme of the network in psychosocial care.

Ana Pitta, one of the pioneers of psychiatric reform and psychosocial care in Brazil, has a very prolific production in the field, but the organization of the collection Psychosocial Rehabilitation in Brazil (São Paulo: Hucitec, 1994), which brings together important national authors, deserves special mention. and international on the subject. Bernadete M. Dalmolin has recently published Esperança Equilibrista: Cartographies of Subjects in Psychic Suffering (Rio de Janeiro: Fiocruz, 2006), a work that is both poetic and research that encourages us to rethink even the mode of psychosocial care and the new care services and practices and points us towards the radical direction of the territory as a way of deconstructing madness.

The family theme is very important and must always be central to practices that are intended to be innovative, as there is no deinstitutionalization without the effective participation of family members. In this sense, some references are essential: Family and Mental Illness: rethinking the relationship between health professionals and family members

of Jonas Melman (São Paulo: Scriptures, 2001) and Mental Disorder and Care in the Family by Lúcia Cristina dos S. Rosa (São Paulo Paul: Cortez, 2003). Eduardo Mourão Vasconcelos is concerned to reflect not only on family members, but also on the users themselves. With Richard Weingarten, Carla Leme and Patrícia Novaes, he published Reiventando a Vida: narratives of recovery from living with mental disorders (which reminds me of one of Basaglia's last opportunities),

Regarding the principles, conceptual bases and strategies adopted by the new mental health and psychosocial care services, the text by Giuseppe Dell'Acqua and Roberto Mezzina, "Response to the crisis: strategy and intentionality of intervention in the territorial psychiatric service" is practically a must-read, as it is at the heart of the historical care modality of the so-called territorially based services – In: Amarante, P. (Org.). Archives of Mental Health and Psychosocial Care 2, Rio de Janeiro: Nau Editora, 2005. Still on psychosocial care services, there is the book A Clínica da Psicose, by Jairo Goldberg (Rio de Janeiro: Ed. Te Cora, 1992) and the aforementioned book by Jonas Melman. Both rescue the principles and constitution of the first Brazilian CAPS.

Antonio Lancetti (Org.) dedicated issue 7 of the Saúdeloucura Collection to the topic of Mental Health in the Family Health Strategy (São Paulo: Hucitec, 2002). It is a book full of ideas and reports of the most important experiences developed in Brazil in the aforementioned thematic interface. With Antonio Lancetti, I prepared the chapter "Mental Health and Family Health" for the Collective Health Treaty (collection organized by Gastão WS Campos et al. Rio de Janeiro/São Paulo: Ed. Fiocruz/Hucitec, 2006). Mental Health in Family Health: subsidies for care work is a very objective and relevant text to support professionals who work in care, authored by Alice Bottaro Oliveira, Marcos Antônio Vieira and Socorro Andrade (Cuiaba: NESM/Olho d'Agua , 2006). About community therapy, the most suitable book is Step by Step Community Therapy,

The question of new possibilities/transformations in the clinic is one of the most debated and tense topics in the area. As indications, there are Clínica em Movimento, by Ana Marta

Lobosque (Rio de Janeiro: Garamond, 2003), Saúde Paidéia, by Gastão Wagner Campos (São Paulo: Hucitec, 2003) and Clínica Peripatética, by Antonio Lancetti (São Paulo: Hucitec, 2006). A very general discussion of the psychosocial mode, its origins and impasses, is carried out by Benedetto Saraceno in Liberating Identities: from psychosocial rehabilitation to possible citizenship (Rio de Janeiro: Ed. Te cora, 1999).

Still in the field of mental health and psychosocial care, it is worth mentioning two collections that offer a series of important contributions to the area – Saúdeloucura and Archives of Mental Health and Psychosocial Care. And as for laws (especially Law No. 10,216/0, referring to psychiatric reform), ministerial ordinances and official Brazilian policy, it is worth consulting Legislation on Mental Health: 1990-2004 (Brazil. Ministry of Health/SAS, Brasília: 2004) and Mental Health in the SUS: Psychosocial Care Centers (Brazil. Ministry of Health/SAS, Brasília: 2004).

The professional who works in this field and who intends to incorporate the notion of complexity and complex social process, should not refrain from reading and seriously reflecting on the writings of people who experienced the institution ‘on the other side’, that is, as internal. For some professionals, such works are nothing more than curiosities or emotional and moving accounts, however, exaggerated and fanciful in many cases. I urge that we change this form of opinion. Affonso Henriques Lima Barreto, or simply Lima Barreto, as he became famous in Brazilian literature, recorded the harsh and cruel daily life of the National Hospice for the Insane in Rio de Janeiro in Diario do Hospício. He also produced some (to what extent?) fictions in which psychiatry and the asylum are objects of criticism. Cemetery of the Living makes us believe it’s part of his diary; How Man Came is a blow to psychiatric violence and arrogance; The Sad End of Policarpo Quaresma discusses sanity, madness, society. The latter gave rise to a beautiful film (Policarpo Quaresma: Herói do Brasil), in which director Paulo Thiago treated with special care the criticism of psychiatric science and its vision of social normality.

In the 1940s, journalist Maura Lopes Cançado wrote one of the most compelling accounts of a psychiatric hospitalization. Lived in the National Psychiatric Center, in the Engenho de Dentro neighborhood of Rio de Janeiro, O Hospício é Deus: Diario I (Rio de Janeiro: Record, 1979) speaks for itself about the truths of the psychiatric institution. Due to legal action by the family, Diario II was never published. It was in the same hospital, in Engenho de Dentro, that the journalist, composer and tropicalist poet Torquato Neto was hospitalized. As part of his mission to "define the choir of the happy", Torquato left us an enormous cultural legacy, among them some reflections written in the hospice published under the title "D'Engenho de Dentro", in the book Os Últimos Dias de Paupéria (The Last Days of Paupéria). Rio de Janeiro: Eldorado, 1973). More recently, another psychiatric hospitalization record book is worth mentioning. O Canto dos Malditos by Austregésilo Carrano Bueno (Curitiba: Scientia et Labor, 1990) gave rise to the feature film Bicho de Sete Cabeças, directed by Laís Bodansky, still today the most awarded Brazilian cinematographic production. The author was sued by the owners of the psychiatric hospital where he was almost killed as a result of the ill-treatment he suffered. Journalist Hiran Firmino published Nos Porões da Loucura (Rio de Janeiro: Codecri, 1982) and received, for the book, the Esso Journalism Award, one of the most incisive denunciations of the reality of Brazilian hospices or "a striking portrait of the concentration camps of Brazilian psychiatry" as announced in the book itself. Scientia et Labor, 1990) gave rise to the feature film Bicho de Sete Cabeças, directed by Laís Bodansky, which is still the most awarded Brazilian film production today. The author was sued by the owners of the psychiatric hospital where he was almost killed as a result of the ill-treatment he suffered. Journalist Hiran Firmino published Nos Porões da Loucura (Rio de Janeiro: Codecri, 1982) and received, for the book, the Esso Journalism Prize, one of the most incisive denunciations of the reality of Brazilian hospices or "a striking portrait of the concentration camps of Brazilian psychiatry" as announced in the book itself. Scientia et Labor, 1990) gave rise to the feature film Bicho de Sete Cabeças, directed by Laís Bodansky, which is still the most awarded Brazilian film

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Machado de Assis is an author who has dedicated many of his works to the theme of madness. Be it in Memórias Póstumas de Bras Cubas, be it in Quincas Borba or in many of his chronicles published in newspapers, such as the one published in A Semana, in 1896, about the escape of the ‘doudos’ from the National Asylum for the Insane. Was the chronicler one of the fugitives? But it is in O Alienista that Machado de Assis exceeds all expectations with reflections and criticisms of the scientific model of psychiatry that are still absolutely current and pertinent. Nelson Pereira dos Santos made Azyllo Muito Louco, a free film adaptation of O Alienista, with the participation of Leila Diniz, in which the alienist Simão Bacamarte is replaced by a priest!

It is important to highlight some other films that are fundamental for knowing and reflecting on issues related to

the field of mental health and psychosocial care. The first of them is the short film with which Helvécio Ratton made his debut as a filmmaker. It is Em Nome da Razão, one of the most realistic and moving documentaries about psychiatric institutions, all filmed in the wards, strong cells and courtyards of the Psychiatric Hospital of Barbacena. This film became emblematic of the anti-asylum struggle in Brazil.

Another work of enormous importance is the trilogy produced by Leon Hirszman about three intern painters at the Museum of Images of the Unconscious, at the Pedro II Psychiatric Center in Rio de Janeiro. The films are: Images of the Unconscious – 1. In Search of Everyday Space; Fernando Diniz; 2. In the Kingdom of Mothers: Adelina Gomes and 3. A Barca do Sol: Carlos Pertuis. About the museum's founder, Walter Melo produced the beautiful work Nise da Silveira (Rio de Janeiro: Imago, 2003).

The life of a crazy garbage collector was one of the most beautiful productions of Brazilian cinema and one of the most awarded as well. About a madwoman and her garbage, director Marcos Prado, perhaps because of his unscientific journalistic vision, made Estamira, a poem. Sem Controle, by Eduardo Moscovis, presents a prejudiced view, but it is still worth it for the scenes in which Hamilton Assunção sings Sufoco da Vida and the art workshops. There is also Verônica Decides to Die, a book by Paulo Coelho and a film by Emily Young. And there is also Lóki, by Paulo Henrique Fontenelle, about Arnaldo Baptista (Os Mutantes); the Prophet das Aguas, by Leopoldo Nunes about the story of Aparecido Galdino, imprisoned in the military dictatorship and later sent to the Juquery judiciary asylum; The Colors of Utopia by Julio Nascimento on the Bahian painter Reginaldo;

In the international filmography there are many productions that deserve to be highlighted, but I will focus on a few, given the nature of this work. The Follies of King George, (directed by Nicholas Hytner) about the 'royal' madness of George III of England, in the midst of the independence process of the American colonies, and Wicked: foolish sunset (directed by Carlo Lizzani) refer to the first years of life of alienism and psychiatry/psychoanalysis, respectively. One Flew Over the

Cuckoo's Nest, by Milos Forman, with Jack Nicholson, reminds us of both preventive psychiatry and antipsychiatry. About the latter, Vida em Família (directed by Kenneth Loach) became a classic and even had the collaboration of Ronald Laing. Laing's thought influenced many cultural works and interventions, but one that deserves to be highlighted is the thought-provoking film The Committee by Peter Sykes, with a soundtrack by Pink Floyd and The Crazy World of Arthur Brown. Filmed in 1968, it was missing for many years.

Regarding the Italian experience and the process of mental health and psychosocial care, Ivo, o genio, by Alessandro Benvenutti, about a young man leaving an asylum who returns to his village, and Uma Janela para a Lua, by Alberto Simone, about the encounter of an astronomer with a cooperative of madmen, and Da Pra Fazer, by Giulio Manfredonia, about a cooperative that actually existed in Pordenone. The Turning Point, by Bernt Capra, supervised by his brother Fritjof Capra, author of the homonymous book that originated the film, can be very interesting to complement reflections on science and truths, opening more windows and perspectives.