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Global mental health: insights from an experience of cooperation between Brazil and Italy

Isabela Paschoalotto Marques (https://orcid.org/0000-0001-5952-0551) [1]
Massimiliano Minelli (https://orcid.org/0000-0002-8511-6090) [2]
Sabrina Helena Ferigato (https://orcid.org/0000-0001-7567-7225) [1]
Taís Quevedo Marcolino (https://orcid.org/0000-0002-9694-5118) [1]

Abstract *Recognizing the central role of mental health in global health and affirming the complexity of the universalization of care policy, this paper discusses aspects of global mental health in Brazil and Italy - two countries that are a potential reference for exchange between the global North and South. Using ethnographic and action research methodologies, we conducted a study of a virtual community of practice composed of Brazilians and Italians interested in community mental health care. The results are presented in scenes that provide insights for the international debate in three categories: the doctor-centered approach to care; the institutionalization of care and medicalization of suffering; and the contribution of community practices and non-specialized local knowledge. The locally situated scenes cast light on globally shared critical knots, elucidating a plural set of relationships that run through work processes and mental health care. The sharing of knowledge and experiences highlight what should be universalized: opportunities for horizontal exchange, rather than the production of national identities that radiate universalizing practices and policies.*

Key words *Mental health, Mental health care, Global health, International cooperation, Anthropology*

[1] Programa de Pós-Graduação em Terapia Ocupacional, Universidade Federal de São Carlos. Rodovia Washington Luis km 235, 13565-905. São Carlos SP Brasil. isapaschoalotto@hotmail.com
[2] Dipartimento di Filosofia, Scienze Sociali, Umane e della Formazione, Università degli Studi di Perugia. Perugia, Italy.

Introduction

Since the 2000s, the concept of international health has broadened to encompass global health, reaffirming health as a public good that cuts across boundaries. This concept goes against the global trend toward neoliberalism[1,2]. One of the key challenges is to find the right balance between the universality of health care and the social, historical and cultural specificity of nation states, overcoming the risks of the neocolonization or westernization of health-disease-intervention models[3].

In 2007, The Lancet[4] highlighted a global rise in mental health problems, low coverage of specialist services and an increase in epidemiologic indicators of mental disorder morbidity, resulting in significant social and economic impacts for different peoples around the world. This marker gave rise to international partnerships targeting middle and low-income countries, culminating in the Movement for Global Mental Health (MGMH), which continues to be loaded with old controversies over universality or the cultural specificity of mental disorders[3]. Mills[5], one of the main critics of the MGMH, discusses the psychiatrization of life as a form of coloniality swallowed like medicine. According to the author, this process masks collective socioeconomic crises produced by hegemonic modes of production, reconfiguring them as individual crises or mental illnesses.

Thus, acknowledging the centrality of mental health in global health[6], the issues in debate urge us to produce knowledge bound to action in order to drive the transformation of mental health care[7]. Stengers[7] proposes that to unveil the shape of this change, where possible and desirable, it is necessary to promote the creative engagement of the people to whom this question matters in pursuit of the construction of common sense. Mills[5] calls the effort to make singularities, contradictions and impasses visible, promoting the ethical and solidary construction of new metaphors, concepts and relations, the third space. Usually invisible, when it resonates, this experiential knowledge is not only bound up with situated experience, but also makes that which is affecting this experience widely visible.

Bearing in mind the complexity of the globalization of the mental health processes stemming from the relations between individual and collective subjects situated within a particular time and space, and affirming that local/traditional specificities should not deflect us from global right to mental health, this article takes up the challenge of discussing aspects of global mental health (GMH) using collaborative action research embodied in community mental health care in Brazil and Italy. The study explores an international cooperation project called "CoPBrit", developed by two countries that, building on a history of mutual collaboration, have activated a decolonial sensibility for global South-North collaboration[8].

Brazil and Italy share common features that favor dialogue between local experiences and GMH, including the development and implementation of universal redistributive health systems, the *Sistema Único de Health* (SUS) and *Servizio Sanitario Nazionale* (SSN), and pioneering mental health reforms. Despite significant political, historical and socioeconomic differences between the two countries, the Italian democratic psychiatry movement has deeply influenced Brazil's mental health policy and today is influenced by Brazilian policy[8].

Mental health care in Brazil is organized around the Psychosocial Care Network (RAPS, acronym in Portuguese), which has been gradually developed since the end of the 1970s, targeting people with mental suffering and problems related to psychoactive substance abuse. The RAPS consists of primary and specialist care services (psychosocial care centers/CAPS, for severe mental disorders; and centers for specific groups, including CAPS AD, for addicts and alcoholics, and CAPSij, for children and youth) and hospital services. With regard to primary care, specialists provide matrix support and there is an emphasis on community health workers (CHWs). The latter live in the catchment area and are the main bridge between the community and health teams. The RAPS develop actions aimed at promoting deinstitutionalization and psychosocial rehabilitation, and activities involving multiple support organizations and services[9].

In Italy, community mental health care is coordinated by Departments of Mental Health (DMHs), with the aim of promoting the mental health of citizens, the continuity of care, collaboration with patients and families, integration between medical services and local community participation, emphasizing social, education and work inclusion. Each DMH coordinates a network of mental health facilities within a defined catchment area, consisting of Community Mental Health Centers, Residential Facilities and General Hospital Psychiatric Units. Health teams are made up of psychiatrists, nurses, social workers, psychologists and social operators (profes-

sionals with varying academic backgrounds who are members of social cooperatives hired by the DMH to develop various social activities). Although Italy's alcohol and substance abuse policy is operated separately from mental health policy, integrated actions are developed in health territories[10].

In both countries, community mental health care policies have been gradually dismantled across different levels, driven by neoliberal political and economic forces and the moralization of everyday life and care[11,12]. It is within this context that Brazilians and Italians involved in community mental health care and interested in promoting change to improve practices got involved in the CoPBrit project. The aim of this article is to provide insights into GMH by examining this experience of open knowledge sharing and mutual learning and supersession of colonizing thinking.

Methodology

The study was conducted between 2017 and 2020 using ethnographic and action research methodologies, drawing mainly on Marques *et al.*[13]. The work is part of a broader project aimed at promoting international cooperation between Brazil and Italy on community mental health care beginning in 2011. Tripp[14] stresses that collaborative action research has two main aims: improvement of practice and generation of knowledge bound to practice, which in turn requires methodological flexibility. The community of practice (CoP)[15] framework is in line with this perspective, insofar as it proposes a flexible and dynamic methodological structure focused on practice. A CoP requires the engagement of people in a project of mutual interest to collectively reflect upon actions, values and knowledge inherent in practices, facilitating new forms of acting and participating[15].

Since the practice of concern – mental health care in Brazil and Italy – is complex and demands contextualization at various levels, we used ethnography to generate insight from textual and audiovisual materials produced by the project, highlighting cross-cutting issues between the two countries. This enabled us to identify new forms of subjectivity and potential resources for bringing together groups and transforming practice and the knowledge of mental health workers and service users[16].

Study design

The study was operationalized through a virtual community of practice (CoPBrit), created as a university extension course in community mental health care between September and December 2019. Besides enabling greater participation, virtual spaces allow researchers to go beyond geographical boundaries, which is essential for the development of international studies[13]. Data collection took place during the development of activities in three thematic blocks of interaction: synchronous face-to-face group meetings in each country (recorded, transcribed and condensed into narratives that were collectively validated by the participants); field activities (textual and audiovisual products developed by participants in each country to present the reality of care to the participants in the other country); and asynchronous virtual interaction activities using a social media app, whose final product consisted of collectively prepared questions and answers designed to provide a deeper understanding of the reality of participants in the other country (Chart 1).

Ethical aspects

The research protocol was approved by the Federal University of São Carlos' Human Research Ethics Committee (approval number 2.538.858). All participants signed an informed consent form.

Participants

The CoPBrit involved researchers, managers, health professionals, service users, family members and volunteers from the field of mental health in two medium-sized cities in the state of São Paulo and one medium-sized city and one small city in Umbria. The Brazilian group was made up of two researchers, six managers, 22 professionals and one family member. The Italian group consisted of two researchers, one family member, one community member, four psychology students, four members of the Hearing Voices Groups, 16 professionals and five managers.

Data collection and analysis

The textual and audiovisual materials produced by the participants were analyzed using NVivo. Initially, we performed a thematic analysis of each passage of the textual material,

Chart 1. Study design.

Phase	Face-to-face, field and virtual activities
Who are we?	Participants had contact with both countries' social/epidemiologic data and health/mental health policies, discussed expectations, and defined the field activity (to present their reality using textual or audiovisual materials posted in a closed social media group)
What do we learn from the other reality?	Participants looked at the other country's textual or audiovisual materials and devised questions to delve deeper into themes of interest. For the field activity, the participants organized themselves into small virtual and/or face-to-face groups to answer the questions sent by the other country
What do we learn from knowledge sharing?	The answers were read and discussed. The course was evaluated

Source: Marques *et al.*[11], p. 4.

comparing them to the audiovisual materials and identifying core themes. We then looked for points of convergence and divergence within the thematic categories, performing procedural analyses of complex cases presented in the form of scenes, thus integrating contributions from multiple actors. The points of intersection involving common mental health care dilemmas were analyzed bearing in mind that each scene constructs a hybrid biopsychosocial, cultural and political network[16], enabling it to be compared to the global agenda. Multiple points of intersection were found. For the purposes of this article, we focus on the findings that can help broaden the GMH debate. In an attempt to unravel the critical and/or potential knots in this debate, these scenes seek to reveal tensions over the doctor-centered and institutionalized approach to care, the hero/villain binary in the psychiatrist figure, the institutionalization of care, the medicalization of suffering, and minor knowledge as network activators.

Results and discussion

The results are presented in the form of scenes that articulate the interactions in a collective dialogue, overcoming the spatiality and temporal linearity in which they occurred. We sought to articulate the discourses surrounding the tensions brought to the surface in the CoPBrit, without polarizing them with national identities. The statements reveal the protagonists of the ethnography: Brazilian and Italian people involved in mental health care, their personal characteristics, professional positions and national affiliations – while favoring new relationship processes and exchanged cultural production.

Scene 1: The psychiatrist – hero or villain?

Rúbia, a young and communicative psychiatrist, began her participation in the Brazilian group saying: *I'll be sincere, being the only psychiatrist in the group, I thought you wouldn't have accepted me!* Some of the other participants promptly responded that they beg for the presence of psychiatrists in multiprofessional spaces and a Brazilian manager mentioned the difficulty maintaining psychiatrists in public services due to competition from the private sector, which offers better salaries: "*psychiatrists are difficult to find*". Rúbia's participation prompted us to reflect on the doctor-centered approach to care beyond the Manichean view of the culprit/victim and hero/villain, exemplifying situations that reveal dynamics, which everyone is involved in and responsible for, that perpetuate this logic. Rúbia refers to the fact that health teams criticize medicalization, but often ask doctors to make this type of intervention: *Nobody on my team likes me, but they like my stamp!*

After watching the materials produced by the Italian group, Rúbia is the first to speak, mentioning the transition process a young service user went through when he left a residential treatment program to live alone in an apartment in the city center. She mentions that the transition was supported by the social operators and other service users in the residential facility. She highlights that, in her experience of care as a psychiatrist, she tends to medicate more when the user has weak social support networks*: I assume*

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[responsibility] for the side effects so as not to assume [responsibility] for certain risks. In contrast, when the patient has social support, she tends to make other freer and less drug-based contributions, highlighting that the absence of networks is an indicator of asylum practices*: a CAPS without a network is an asylum!* Finally, she mentions the amount of activities developed without a psychiatrist at the head, highlighting that a strong multidisciplinary team significantly reduces the burden on doctors. Without strong multidisciplinary teams, doctors are called on more often, reinforcing their centrality and a care approach focused on disease, diagnosis and medication.

Débora, a worker at the CAPS, added that the absence of a doctor can also prompt the team to engage more with the health network, as happened in the service where she worked. However, Maicon, a Brazilian psychologist working in an outpatient service, argues that: *This might be a capacity to be developed, but it seems like a bit of a façade; because although our doctors are not managers (like in Italy), we are still very doctor-centered*. Stefania, an Italian psychiatrist and manager, argues that although doctors played a very important role in the Italian health reform, the biologic and prescriptive approach is more prominent than ever before. She highlights the following contradiction: *despite the small proportion of psychiatrists both in Italy and in Brazil, these professionals play a pivotal role in mental health services*.

Both groups discussed how much psychiatry has taken on a normative and controlling role, advancing across common life spaces. As a result, high social expectations that psychiatrists can resolve all kinds of problems hang over these professionals, leading to the banalization of psychiatric practices and revealing a social tendency to seek "heroes" who provide an immediate solution to social and health problems. In the words of Stefania: *We find ourselves with a stigmatizing referral mechanism that views psychiatry as a subject who can find solutions for everything. [...] Psychiatry is called on once again to manage marginality.*

However, power is not limited to psychiatrists, just as the asylum logic extends beyond the locked doors of institutions. Paternalism in professional-patient/family member relationships demarcates the health professional's position of power, reinforcing relationships of protection as opposed to emancipation. As Solange, a Brazilian psychologist and manager says: *There's the question of power, of that special position of who can listen, give answers. [...] As much as we know it's bad, it's seductive...*

Mills[5] warns that the discourse of protection is one of the colonial markers of mental health. Adopting the politically correct but little practiced discourse of empowerment, paternalistic actions continue to be propagated without questioning the maintenance of the status quo[17]. Power asymmetry can be seen in interpersonal relationships (between doctors, other health professionals and service users) and in international relations (between middle/low-income and high-income countries). Rúbia highlights that technologies like interdisciplinary working and strengthening social support networks are strategies for confronting psychiatric hegemony, because "scientific-care" packages alone, without ethically considering interpersonal networks and local dynamics, do not ensure the quality of intervention[18,19]. Talking about her role as a health professional she concludes: *I say we are Batman; we're not the superhero they want*.

Scene 2: Minor knowledge as a network activator

Running counter or contributing to discussions surrounding psychiatry, two actors who play an important role in health care were also the focus of admiration and curiosity – the CHW in Brazil and social operator in Italy – both of whom do not possess specialist technical training. Tullio, an Italian social operator working in a facility for drug addicts is amazed by the video produced by Márcia, a Brazilian CHW. The video shows her work in resocializing a service user from a poor neighborhood in partnership with occupational therapy students from a public university: *The figure of the community health worker is very inspiring: the territorial service doesn't wait for service inside its spaces; quite the contrary, it moves around, transfers itself, it's attentive to [...] the community it belongs to.*

The Brazilian participants underline the important role CHWs play in promoting engagement between the community and health team and between specialist mental health services and primary care. However, Márcia raises the following question: *A lot of people say that we are important, but few attach importance [to us]*. She says that many of her fellow CHWs do not fill in the report on patient records because they do not feel appreciated. She also mentions the following problems: excessive workload due to administrative tasks; the fact that CHWs live in the

community means they end up working outside their normal working hours; and lack of involvement in care by professionals with a degree. She also says that only professionals with a degree are paid to receive university students despite the time CHWs spend with them. A psychologist working in a CAPS criticizes the defense of the horizontality of knowledge when staff with a certain knowledge receive greater financial rewards than others.

The materials produced by the social operators also impressed participants from both countries because they show experiences of care oriented towards social participation, as shown by the following statement made by Marisa, an Italian psychology intern: *What emerged [...] demonstrated the importance of the experiences, of the structured or improvised expressive and/or entertainment activities that the operators made possible [...] and that, in my view, are at the center of the concept of care.* However, Valentina, who has been a social operator for 12 years, criticizes the lack of appreciation of the value of social operators and mentions that, despite belonging to important networks and living in the community, these professionals feel excluded from formal health networks: *Social operators [...] are outside the formal network. [...] The network work should be rebuilt around social operators, because we are outside. [...] I hope this context opens up real possibilities to create authentic networks.*

The Italian participants emphasized the richness of the experience of the integration of mental health and primary, an experience that has not been expanded in Italy. The experiences of CHWs and social operators show that, besides incorporating specialist knowledge into primary care (such as matrix support), we need to use the potency of the territorialization of care brokered by "minor knowledge". According to Deleuze and Guattari[20], minor knowledge is knowledge that is subalternized by hegemonic discourses. However, this type of knowledge can form alliances to confront forms of logic that can be superseded by the potential of fragile communities, precisely through their fragility, to open up possibilities to introduce the new.

Despite the potential of primary care in Brazil for promoting mental health, some Brazilian participants initiated a debate about the prevalence of biomedical logic and specific procedures, because they are more visible and countable than subjective work. According to Carol, a Brazilian psychologist: *It is difficult to do prevention work, because giving injections is a procedure that is already authorized*. Maicon, a psychologist, defends that the implementation of Brazil's family health program was the fruit of cost containment in the SUS, resulting in the dismantling of specialist services without making them effective or less drug-based: *Before, the outpatient clinic had six psychiatrists and was criticized for medicalizing too much; suddenly it can't keep psychiatrists, [...] the family health [program] begins, and now there are 29 psychotropic prescribers.*

Talking about his experience of working in the World Health Organization, Saraceno[17] suggests that the agency and the MGMH has encouraged the integration of mental health and primary care services. However, many middle and low-income countries have experienced problems, such as a rise in the prescription of psychotropic drugs, lack of funding and dismantling of specialist mental health services, often leading to an increase in coverage by primary care services without improving the quality of care. This situation also ends up increasing the workload of primary care workers, who have to meet both general and mental health demands. Cecilio, Carapinheiro and Andreazza[21] problematized these challenges, questioning the idealized formulations of primary care and valorizing the real understanding of the dynamics of its day-to-day functioning, emphasizing the role of service users as pathmakers.

Scene 3: The production of health or the institutionalization of care?

Pietro, an Italian nurse working in a MHC, questions whether care actions occur within the realm of *salute* or *sanità*, saying: *[...] If a person pees in the high street, call the MHC! [...] There is a fine line between normality and abnormality. [...] the question [...] is how invasive we're being with 'sanità' and not with 'salute'.*

In Italian, *Sanità* refers to health care, while *salute* refers to health or well-being, the common good. Pietro's remarks invite us to reflect upon how much the institutional field of health invades spaces of care and well-being, highlighting that, just as suffering is not purely a psychiatric condition, care is not purely *sanitary*, as Veronica, the Italian psychiatrist and manager adds: *People are people, not the ill and not-ill [...] this is the scenario we must confront.*

Contributing to this reflection, a Brazilian manager and an Italian researcher mention, respectively, that care is very focused on the professional, and we need to "*recognize the potential*

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every person has to help another person's recovery process", and understand that "*we, as people, are the network's resources*". These reflections gave rise to contradictory ideas among some of the Brazilian professionals working in an outpatient mental health clinic, who value the role of the professional so as not to lose identity at work, but also recognized the need to "stuff the protocols", because they hamper creative work, which is sensitive to professionals' skills and service users' needs.

Contatore *et al.*[22] underline the need to recover the social/ontological dimension of care, based on the concept that care is intrinsic to human existence and manifests itself through solidarity pacts, reciprocity and social cohesion. Care is therefore a need, responsibility and possibility for all and the role of the carer is neither fixed nor outsourced to health professionals. In the audiovisual materials produced by the Brazilian participants, the work of the professionals was focused inside the institutions, revealing the risk of institutionalization of care, based on a logic centered on access to services instead of strengthening engagement with the community. As Solange points out: *Here in Brazil we bring service users to the service, in the videos we saw, the [Italian] professionals go to the community. That's a different logic, [...] it takes place in the community, [...] a network of relations that provide support is created.* Lia, a Brazilian occupational therapist adds: *We make a point of keeping people in the spaces; if the patient doesn't turn up, he/she needs to come back here.*

Marina, a Brazilian psychologist reflects on the possibility of overcoming this dilemma: *People work alone within their practice, within their anxieties […] we have to build spaces […] in which each person arrives the way they are, stripped of techniques, ready to try something […].* This illustrates that the access to treatment advocated by GMH should not be limited to access to services. Access to community resources, or rather the possibility to build and strengthen these resources, is embodied in a conception of health that is not encapsulated by protocols, institutions and health professionals, insofar as it is produced collectively in the scenarios of everyday life. To develop truly collective work for health care, we need to see ourselves beyond our professional roles, valuing knowledge and attitudes that go beyond that which is expected from a given position. Mehry[23] helps us to think of strategies to address these challenges, drawing on the concept of living work, defending that care is relational, played out with the freedom to build practices based on autonomy and relationships that respect desiring subjectivities. Based on this logic, workers can use their desires as power to experiment new work processes, and their creativity to distance themselves from the bureaucratic automatisms of health policy.

Scene 4: Common suffering or widespread illness?

Adelaide is a blond woman with a calm and amenable expression. Her husband and son are alcohol dependent, and her recently deceased sister was diagnosed with schizophrenia. During one of the meetings, the Brazilian group had a heated discussion about medicationalization as a quick solution to problems. Adelaide asks to speak and, in a confessional tone, says that due to the difficulties she is facing with her son's drinking problem, she began to take her sister's benzodiazepine: *I am scared of becoming addicted, but I need to sleep*. Her remarks give rise to mini-confessions from the Brazilian group and Solange says: *Whom of us professionals have never taken sleeping pills?*

Adelaide's insomnia is related to complex family and social problems that are not resolved by the time she goes to bed. Her remarks also reveal the negligible distance between the suffering experienced by patients and health professionals, suggesting a collective suffering, which should therefore be addressed collectively, as Cida, a Brazilian psychologist, says: *This thing of getting frustrated permeates all relationships. [...] Because you deal with the disease, with the difficulty, with the conflict... we're not prepared, we want to solve the problem in the right away. I think this anxiety is part of the collective.*

The experiences of suffering mentioned by the participants are characterized by the concept of illness, showing how psychopathology is evoked to describe what we and others feel. By understanding suffering as mental illness, we are using a visibly predominant concept from the global North that fails to encapsulate all existing conceptions. While this concept offers an avenue of self-understanding, it deploys a series of shortcuts that demarcate and shorten the path between life experiences and diagnosis and between diagnosis and medication. The common suffering experienced by health professionals and service users illustrates the unsustainability of certain forms of care that actually fail to care for people, regardless of the roles they occupy.

This prompts us to look at the mental health of people based on that which is common to us: human vulnerability to suffering and our capacity to cope. In this sense, departing from that which is common to us seems to be a propositional way of building a "communal" sense, supporting a care approach grounded in values of interdependence (as opposed to individualistic liberal values) that advances towards the promotion of mental health, understood as a dimension of everyone's life.

An important marker of the fragilities that permeate care in both countries were issues that have been a low priority over the years in mental health policy: child and youth care and the mental health of immigrants and refugees. Stefania highlights the rise in the number of underage heroin users in Italy. Professionals in Brazil reported the large number of child and teen drug users referred to CAPSij with the expectation that they will be medicated and have their marginality treated, as Amanda, a Brazilian social worker says: *The judge made an admission request, but he doesn't need to be admitted, he doesn't need medication, he needs a father, [...] mother, [...] to occupy his time. He's not ill, we need to promote health!* The dilemma of mental health problems during childhood and adolescence pose major challenges for health services, which have an immediate responsibility to articulate the network and develop new non-pathologizing perspectives and complex practices, as Stefania adds: *When talking about teenagers, we are talking about a broad set of issues, how they are in the world, how to be happy.*

Other actors that prompted debate about the "depsychiatrization" of care were immigrants. While the arrival of European immigrants on indigenous lands is legitimized in Brazil, Italy is currently witnessing a rise in immigration mainly from North Africa and the Middle-East, turning Italy into an ethnically plural society. This has given rise to cultural clashes and the emerging challenge of delivering care that meets the needs of this population[24]. In this sense, cultural pluralism has the power to build a community mental health approach that crosses international and interpersonal borders, as Stefania adds: *The immigration issue can be managed in a minimalist or anti-institutional way and through community mental health care. The immigration issue certainly brings service difficulties to light.*

The issue of immigration, be it European or African, encompasses the legitimacy of human mobility around the world, and how much the wandering and settling of immigrants can contribute to giving momentum to perspectives and watertight mental health practices. This issue demonstrates that, despite the popularization of the biopsychosocial model and the fact that social determinants of health are part of the discourse and literature on GMH, interventions remain focused on the diagnosis and pharmacological treatment of mental illness, excluding the cultural, social and political complexities bound to suffering[5,17]. As a decolonial strategy, it is urgent to question which voices are being heard in local and global debates, in order to dismantle colonized health care devices, such as the protection discourse, power asymmetry and the failure to recognize otherness.

The challenge is posed: listen to minor knowledge to map how it activates networks and resources (institutional and informal). This perspective does not entail "giving people a voice" or "promoting participation", but rather enabling becoming minorities to express themselves and point to pathways to ethical care built with plurivocality. Adelaide apologized a number of times in the meetings of the CoPBrit, saying that her comments always ended up making the issue personal. One day in particular, the group talked about a messy unison, which was exactly the contribution we wanted and expected from her in her role as a family member and SUS user. Through her need for care, she showed us the possible paths of flow – affection, bonding, willingness to share and non-judgment – and said: *I'm glad I can help you see who's on the other side.*

Final considerations

By revisiting scenes and their discussions in a transversal manner, we may ask what insights this experience provides into global mental health. While understanding that Brazil and Italy have tread intertwined paths in the implementation of mental health reform, the historical exchanges between the two countries show that the field of knowledge and practices in contemporary psychiatry is plural and contradictory. The locally situated scenes cast light on globally shared critical knots, such as ambivalence and contradictions concerning the role of psychiatrists and CHWs/social operators, elucidating a complex set of knowledge, powers and subjective productions that run through the hierarchization of work processes, having a palpable effect on health care. The Brazilian and Italian experiences have certainly brought concrete possibilities for

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mental health with social participation processes to the contemporary scenario of neoliberal policy.

Our experience with the CoPBrit frames "micro-stories" and "local knowledge" within the panorama of the international mental health system, showing the experiments of people who accepted the challenge of sharing how they are affected, based on problem situations. This challenge can provide important methodological and ethical insights into global mental health and, more specifically, the production of knowledge about/with globally distributed professionals and users of mental health care. So, we ask ourselves: what can be universalized?

This article dares to assert that the universalization that matters is not that involving national identities that irradiate universalizing practices and policies, but rather that centered on exchange for the construction of a "universal common" and sharing experiences that break with colonization, be it one country subjugating another, be it unconscious processes of colonization [25]. We advocate the construction of a collective planetary intelligence from situated and problematizing experiments fueled by that which is local, artisanal, to which all those to whom mental health matters are called to contribute, even running the risk of the improbable and being non-protocol-based. We advocate the construction of a global shaped by multiple singularities.

Collaborations

IP Marques, TQ Marcolino and M Minelli worked in the article's conception and design; in the discussion of the results; and in the writing of the manuscript. SH Ferigato contributed to the discussion of the results and to the critical review of the content. All authors approved the final version of the manuscript.

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