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Mental health care, risk and territory: crosscutting issues in the context of safety society

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The aim of this study is to discuss the crosscutting discursive issues among the notions of mental health care, risk and territory in the National Conferences of Mental Health (NCMH) reports, placing them in the context of safety society. It is a descriptive, exploratory study of qualitative, documentary and retrospective analysis, under the framework relevance, emphasizing the centrality of these concepts for the consolidation of a new mental health care model in Brazil. As the asylum model went into decline, in the process of the archaeology of knowledge, by Michel Foucault. From the 2nd to 4th NCMH, it is observed that the glossary on the risk as probability, care and territory, presented progressive of building up a mental health care network territorialized and community-based, the discourses about the risks emerged, being core elements of the safety device.

Keywords: Care. Mental health. Territory. Safety Society.

Introduction

The Brazilian psychiatric reform movement has challenged us to revise the paradigms that, up to that moment, had been supporting care practices in the field of Psychiatry. It has introduced the psychosocial care mode, which presupposes a new form of conceptualizing its object of intervention and new configurations concerning institutional organization, composition of multiprofessional teams and relationship with the users of mental health services[1].

The need to propose different forms of tackling issues related to psychological suffering has resulted in the construction of new knowledge and new possibilities of technical and political action, connected with the construction of values and meanings about existing and suffering. Thus, each scientific field of the health and social sciences has had to invest efforts in order to incorporate the conceptions introduced by the mental health policy[2].

The constitution of a network of mental health care services and the search for theoretical-conceptual and technical-assistance ruptures concerning the presuppositions of the asylum model have enabled the construction of new theoretical and technical instruments to promote changes in the mental health field[3].

Yasui[3] highlights five concepts-tools that have allowed to re-situate the mental health field in its epistemological, technical-assistance, juridico-political and sociocultural dimensions, namely: territory, accountability, sheltering, network, care, and diversity of strategies.

An amplified view of the technical-assistance dimension of the psychiatric reform process reveals that the transformation of the supply of mental health care services has implied the establishment of care strategies that involve the reconnaissance of the territory and its resources, as well as accountability for this territory's demand. This transformation has implied establishing forms to shelter suffering through the creation of diversified care projects and strategies, articulated in network to this territory[3,4].

This structuring principle of the psychosocial care network is described in directive nº 336/2002 of the Ministry of Health[5], when it establishes that the *Centros de Atenção*

Psicossocial (CAPS – Psychosocial Care Centers), in all their modalities, must "be responsible, under the coordination of the local manager, for organizing the demand and the mental health care network in the scope of their territory" (p. 1).

The issue of the choice of the territory as the locus of mental health care, highlighted, mainly, in the report of the 3rd National Mental Health Conference (NMHC), needs to be analyzed, considering that the eminently relational attribute of care presupposes the existence of a place in which it is materialized[3].

Thus, this study aims to discuss crosscutting discursive issues among the notions of mental health care, risk and territory in the NMHC text and their repercussions on the current Brazilian mental health policy, situating them in the context of the society of security.

First, we will delimit the methodological course of the study. Then, we will present a theoretical framework that enables us to ground our analyses about mental health care, risk and territory on Michel Foucault's studies about the disciplinary society and the society of security. Finally, we will present our analyses of the NMHC and the related historical documents.

Methodological course

This descriptive and exploratory study employed qualitative analysis and was developed through a retrospective documentary analysis of NMHC reports in the perspective of Michel Foucault's archeology of knowledge[6]. The documentary field encompassed the final reports of the 1st, 2nd, 3rd and 4th NMHC, as these conferences were, during the Brazilian psychiatric reform process, the most important forums for the systematization of the technical and political advances achieved in the mental health field in Brazil, aggregating diverse actors committed to the anti-asylum struggle. The following documents were also included: the informative notebook of the 3rd NMHC (2001) and the world health report published by the World Health Organization (WHO, 2001), destined for mental health, entitled "Mental Health: new understanding, new hope"[7,8].

The documents were examined according to the discursive textual analysis proposed by Moraes et al.[9] The first stage encompasses the process of disassembly of texts or unitarization. It requires examining the texts in their details, fragmenting them in order to identify their constituent units and the respective enunciations referring to the studied phenomena. The second stage encompasses the process of categorization, which involves building relations among base units, combining them and classifying them, and then placing unitary elements into sets, which result in systems of categories. The two processes described here enabled the emergence of a new understanding of the whole, which we reviewed and validated, resulting in the construction of a meta-text that explains, argumentatively, the new understanding that was achieved[9].

The documents were analyzed through the utilization of the ATLAS.ti software, composed of a set of qualitative analysis tools that are appropriate for large sets of textual data, under license nº 72BB1-ECAA3-57A7F-ROEN1-0039Y.

In the coding process of the textual corpus, it was possible to develop 21 codes that express different discursivities about care. For example, 'acts of care', 'care in the territory', 'comprehensive care', 'mental health care', 'primary mental health care', 'right to care', 'care apparatuses', 'care model', 'new forms of care', 'care networks', 'treating x caring', 'family x care'. The significant frequency with which the discursivities about mental health care emerged in the discursive textual analysis enabled us to consider it an analytical category.

Other codes that composed the meaning network, establishing relevant discursive relations to mental health care were: 'social construction of the health-mental illness process', 'demedicalization', 'medicalization', 'preventive psychiatry', 'reformulation of the mental health assistance model', 'risk as danger', 'epidemiological risk (synonymous with risk as probability)', 'power relations'.

To construct the meta-text, we selected relevant textual citations, trying to highlight the identified discursive relations, enriching and amplifying the reach of the analyses.

The locus of care: the transition from institutional care to territorial care

The locus of psychiatric practices has always been invested with special importance, an aspect that deserves a more specific analysis[3].

Since the 14th century, there have been records concerning the sheltering of the mad in medieval hospitals[10]. In the 15th century, the practice of confining the unreasonable in ships was developed, and the ship of fools stood out[10,11]. In the 17th century, internment houses were responsible for the confinement of the deviant; among them, the alienated[10]. In the 18th century, the asylum became the locus for the therapeutic isolation of the mad. It was replaced, in the 19th century, by psychiatric hospitals[12].

The practices of confinement of the mad that were typical of each one of the periods described above are representative of the rationality that was developed, mainly from the 17th century onwards, and was called disciplinary society. The function of disciplinary institutions like the asylum and the hospitals, was to neutralize dangers by fixing useless or agitated populations; at the same time, they played the role of increasing their usefulness, of fabricating docile and useful individuals[13].

The multiplication of these establishments enabled the ramification of disciplinary mechanisms; thus, the role of external surveillance was added to their specific internal functions, creating a margin of lateral controls. Hospitals, for example, gradually became a support point for the medical surveillance of the external population, and disciplinary procedures were disseminated from focuses of control spread in the society[13].

'Discipline' cannot be identified with an institution nor with an apparatus; it is a type of power, a modality to exercise it, that bears a whole set of instruments, techniques, procedures, levels of application, targets. It is a physics or an anatomy of power, a technology[13].

In this perspective, Bentham's panopticism, represented by its architectural and optical system, was configured as a political technology that enabled to unlock disciplines and make them operate in a diffuse, multiple and polyvalent way in the entire social body, invading daily life[13].

From the 18th century onwards, the modern Western societies started to take into account the fundamental biological fact that the human being constitutes a species, and a

new form of governmentality was founded, connected with the concepts of biopower and biopolitics[14].

While the disciplinary technologies were essentially centered on individual bodies, from the middle of the 17th century onwards, biopolitics started to focus on the body-species, on the whole population affected by the phenomena of life. The disciplinary techniques were not extinguished; on the contrary, they started to compose the new life technologies. As biopolitics focused on phenomena related to natality and morbidity, endemics and epidemics, it became possible to format a Medicine whose function would be public hygiene and health[15].

The French Sector Psychiatry is a categorical example of this new system of 'government of men'[14]. At the end of the 1950s, it proposed the country's division into territorial units composed of approximately seventy thousand inhabitants, assuming its function as a biopolitical strategy. Each sector should be assisted by a psychiatric team connected with a mental health center, which would be an intermediate service in relation to hospital admission. About this sector policy, Castel[16] proposes the question: "Hasn't the very recommendation of a 'psychiatry of extension' made the social dimension itself be a large ill body in which all dysfunctions would depend on medical solutions?" (p. 41).

Another example can be found between the 1920s and 1930s in Brazil, a moment in which the eugenic ideals of the Brazilian League of Mental Hygiene enabled the frontiers of Psychiatry to expand, including the social field[17]. Likewise, in the 1960s, in the United States of America, the American Preventive Psychiatry introduces the notion of risk and proposes strategies for the prevention and early detection of the mental disorders that affect the entire society[3,18].

Therefore, it is possible to notice that the place of care in Psychiatry has moved: it has left the place of isolation, exclusion and disciplinarization, represented by the asylum institutions and by the modern hospital, and has assumed a new place, represented by the social tissue[3,17].

However, this is not merely a change of place. Castel[16] argues that the medical-psychological knowledge has become an instrument of a differentiated population

management, supported by the sophistication of computer technologies and systematic risk prevention.

Risk profiles are attributed "to the presence of one or of an association of criteria"[16] (p. 114), either of medical or of social nature. Epidemiological risk calculations presuppose the identification of population-based groups exposed to certain risks that are supposedly susceptible to prevention, and individual variations are reduced to averages. In this perspective, risk means the probability of danger, generally with a physical threat to the human being and/or the environment[19].

This rationality connected with systematic risk control is typical of what Foucault[14] decided to call apparatus of security, when he defined some fundamental propositions to the understanding of his studies about power.

To the author, since classical antiquity, three modalities of 'government of men' have developed: first, the legal mechanism, which consisted of the creation of laws that established a binary division between what is permitted and what is prohibited, and whose violation implies punishment; second, the disciplinary mechanism, which was added to the legal mechanism, in such a way that, "outside the legislative act that establishes the law and the judicial act that punishes the culprit, a series of adjacent, detective, medical, and psychological techniques appear which fall within the domain of surveillance, diagnosis"[14d] (p. 20), of individuals' subjection; third, the apparatus of security, which considers phenomena in a series of probable events, so that these phenomena will be interesting to power as long as they imply a calculation of cost, and an average that is considered optimal will be fixed and will become the reference for normal/abnormal, acceptable/unacceptable[14,20].

The society of security is grounded on the superposition of disciplinary and biopolitical strategies, so that the three mechanisms described above occur neither in isolation nor successively[14].

There is not a series in which the juridico-legal, disciplinary and security mechanisms will succeed one another, so that one emerges and makes its predecessor disappear. "There

[d] The citations in English were extracted from Foucault M. Security, Territory, Population. Lectures at the Collège de France, 1977-1978. English series editor: Arnold I. Davidson. Translated by Graham Burchell. Palgrave MacMillan, 2009.

is not the legal age, the disciplinary age, and then the age of security"[14] (p. 22). On the contrary, there is a correlation system among the three mechanisms, in such a way that the disciplinary corpus is broadly activated and propagated by the establishment of mechanisms of security, and in turn, there is a real inflation of the juridico-legal code to make the system of security work[14].

For example, if, in the disciplinary mechanism, we attempt to correct a mentally ill individual by means of reclusion and disciplining in the asylum apparatus, due to risk of relapse and recidivism, represented in the notion of dangerousness, we can say that the mechanisms of security are equally very old, just like the juridico-legal and the disciplinary mechanisms. In this example, the notion of risk was already implicit. To Foucault, what changes is the 'dominant characteristic', that is, "the system of correlation between juridico-legal mechanisms, disciplinary mechanisms, and mechanisms of security"[14] (p. 22). In short, if, in a society, a technology of security is set up, it will make juridical, disciplinary and security elements function through its own tactic[14].

Therefore, based on the socio-historical and political principles presented above, we can return to the question asked by Yasui[3] about the extent to which "we must pay attention to the relations between care production and the territory" (p. 125), so that we do not commit the imprecision of reproducing, in this relation, other logics of subjection and domination.

In this perspective, we are interested in understanding what crosscuttings issues are configured among the notion of mental health care and the concepts of risk and territory, in the context of the society of security, in order to instrumentalize the mechanisms of "differential population management"[16] (p. 101), in a similar fashion to what occurred with the medical-psychological knowledge in the process of advance of liberalism[16].

Relations among mental health care, risk and territory in the context of the society of security

The understanding of territory as a "geographical delimitation in which a certain service becomes responsible for assisting the people enrolled in that place"[3] (p. 127) evokes

an administrative and bureaucratic conception, imprecise, reductionist and incorrect, that needs to be overcome.

It is possible to utilize theoretical references that enlarge this perspective about the territory. For example, Yasui[3] defines this conceptual category, which is central to the Brazilian psychiatric reform process, as

> [...] the relation between natural and social, as the production of imprisoned subjectivities, but also as potentiality of disruption, of creation of new existential territories, of spaces for the affirmation of autonomous singularities. This means finding and activating the local singularization resources that exist. For example, establishing alliances with art groups and movements or with worker cooperatives to potentialize actions to affirm singularities and social inclusion [...] creating other resources, inventing and producing spaces, occupying the city's territory with madness.[3] (p. 128-9)

This enlarged understanding of the territory is essential to produce acts of care beyond the health services, constituting another assistance logic in mental health, which will produce new social places for madness[3]. Above all, we understand that, to develop comprehensive mental health care in the territory, it is necessary to invest in 'new forms of care', according to what we read in the NMHC reports.

Remarkably, after the 3rd NMHC, we observed an intensification of debates about the implementation of mental health substitutive networks in the logic of the territory, integrated into the other health services, strengthening and amplifying the actions of the Family Health Strategy, mental health teams in primary care and Family Health Support Nuclei[4].

The analysis of the text of the 1st NMHC, which was held in 1987, revealed the inexistence of a direct approach to mental health care or to territory; therefore, the debate about the reformulation of the assistance model was constructed without the presence of such concepts in any theorizations.

In fact, during more than two centuries, the rationality that sustained and legitimated the therapeutic practices of Psychiatry in specialized hospitals with asylum characteristics was

marked by acts that produced relations of domination and violence[3]. Thus, the concepts of care and territory did not compose the linguistic framework of the initial moment of the Brazilian psychiatric reform movement, which Amarante[18] called alternative trajectory.

On the other hand, the theme of epidemiological risk has been embedded in debates about mental health policies in Brazil since the 1st NMHC. This tradition of risk as probability is linked to the historical perspective of discourses about risk that are related to governmentality in Michel Foucault[21,22].

Attached to the report of the 1st NMHC, we find the proposal of 'The Mental Health Policy of the New Republic', published by the Ministry of Health through the National Department for Special Health Programs in July 1985, the year that preceded the organization of the 1st NMHC. In this document, there are arguments in favor of the inclusion of the presuppositions of Preventive Psychiatry in the new mental health care model that would be constructed in Brazil[23].

This proposal begins by presenting the general panorama of the deterioration of the Brazilian population's life and health situation due to the rural exodus, income concentration, high indexes of unemployment and, in contrast, to the significant impact of the number of psychiatric hospitalizations on the cost of hospital admissions in Brazil[23].

The proposal also presents the complex situation of mental health as a public health issue, based on data from epidemiological studies on mental illnesses in Brazilian population groups, mainly in poor and marginalized populations, which showed "prevalence rates around 20 percent"[23] (p. 36).

In addition, this proposal included a discussion about the need to delimit the field of action of mental health, indicating two dimensions of this action: one targeted at the 'totality of the population', and the agents of this field would be responsible for reporting knowledge about the environmental, social, familial, individual and genetic factors that might act to favor mental health or, inversely, to favor mental illness. Concerning this first dimension, the proposal states that the field of action "covers 100 percent of the population", and that action in mental health should essentially have pedagogical objectives. The other proposed dimension refers to the field restricted to "the population group that is ill or that has a high

risk of getting ill"[23] (p. 38). Once again, we notice the adoption of discursive elements related to Preventive Psychiatry and to the concept of epidemiological risk.

Although the concept of epidemiological risk was already consolidated in the field of collective health, it underwent re-contextualizations so that it could operate, in the field of mental health, connected with the concept of care.

The analysis of the report of the 2nd NMHC revealed possibilities of formalization of the concepts of 'care' and 'territory' in the scope of the new discursive formations of the mental health field, from the 1990s onwards, in Brazil.

Unlike the 1st NMHC, in which the notion of care did not circulate, it can be noticed, in the report of the 2nd NMHC, a movement to attempt to differentiate it from the notion of treatment, as well as efforts to define, delimit and situate it in the foundation of the new mental health policy, and also of the new strategies and assistance resources that will start to compose the Brazilian psychosocial care network.

According to the documentary evidences discussed above, it is possible to observe the emergence of analyses about the territoriality of the new forms of care in the scope of the new mental health care model: therefore, we would have a network of services that would be preferably external, community-based, discriminated in the territory, and a small hospital backup, restricted to situations in which permanence in society can be considered counterproductive, either in moments of crisis (for short periods of time), or in situations of profound physical and/or mental dependence[24].

In the report of the 3rd NMHC, the notion of care is invested with diversified meanings, among which we highlight care as integrating a territorialized and decentralized psychosocial care network, so that there is continuity between public institutional care and private family care. It was admitted that planning the organization of the psychosocial care network would be one of the most important tasks of this conference, in order to guarantee the implementation of community-based mental health services, integrated into primary care programs and the general network of services, using the most adequate strategies to each region/territory, with the purpose of overcoming the traditional model[7].

In the same direction, the report of the 4th National Mental Health Conference – Intersectoral (4th NMHC-I) recommended that psychosocial care should be the organizer of the intersectoral network, with the establishment of planning and management centered on intersectoral territorial modules composed of a set of services and/or apparatuses with differentiated and complementary profiles, taking into account the local sociocultural, economic and political realities[4].

The 4th NMHC-I represents an advance because it displays a perspective of territory as "process, relation, breaking with the notion of scanning the society"[3] (p. 130) and with the delimitation of catchment areas solely based on the city's map. Thus, the number of territories to each CAPS will depend on the singularities of its users and of the social groups to which they belong[3].

In view of this, it is fundamental to perceive, in the scope of our study, that, in Brazil, as the asylum disciplinary practices started to decline, in the process of constitution of a territorialized, community-based mental health care network, discursivities about risks emerged, as risks are central elements of the apparatus of security.

The glossary related to risk as probability and to care gradually acquires relevance in the reports of the 2nd, 3rd and 4th NMHC, respectively. In fact, both concepts are central and recurrent in debates around the consolidation of a new mental health care model, revealing the process of autonomization of this field in Brazil.

In this new rationality, we will be interested in knowing, for example: How many people, in a given population, suffer from mental disorders? What risk do we run by maintaining these people in their territory if they abandon drug therapy, as they may become violent and dangerous? Which epidemiological indicators will be adopted to plan investments in interventions in the mental health field?

One of the essential characteristics of the apparatus of security, according to Foucault[14], is that populations are managed through the estimation of probabilities. Therefore, the encompassing presence of discursivities around the concept of epidemiological risk in the NMHC reports is justified, as well as its complementariness in

relation to the concepts of care and territory, due to the fact that the new model of care operates as an element of the apparatus of security.

What other evidences obtained through the analysis of the documentary corpus of this study lead us to establish this theorization?

In the 3rd NMHC, the constitution of 'substitutive care networks' or 'mental health care networks' started to be emphasized. Furthermore, the 4th NMHC proposes 'local mental health care networks'. The issue of networks is intimately related to the issue of territory in the apparatus of security.

Studies carried out by historians about cities of the 17th and 18th centuries indicate that the space was treated differently by the legal and disciplinary mechanisms and by the apparatus of security. However, in spite of these differences, which we will describe below, the issues of multiplicities and circulation remain common to the three mechanisms[14].

To the author, the central problem for sovereignty is the hierarchical disposition of the seat of government in the territory; to discipline, the city's space must be constructed so as to maintain a hierarchical and functional distribution of elements; security, in turn, will try to plan a milieu that maximizes the positive elements, so that people can circulate in the best possible way and, at the same time, risks such as thefts and diseases are minimized, bearing in mind that they cannot be simply suppressed. Therefore, it is necessary to inscribe, in the space, a series of possible and aleatory events[14].

The model of territory of the society of security has been appropriated by the modern neoliberal State, to which the notion of network is central. Pelbart[25] (p. 21) argues that neoliberal capitalism "depends on the circulation of [...] capital flows, information, images, goods, [...] and, mainly, of people", although not everybody will extract the same benefits from this circulation.

Networked capitalism is accustomed to connections, fluidity, to the capacity of moving around in the territory and feeding the productive flows of the consumer market. Therefore, it produces new forms of exploitation and exclusion. In this new context, being excluded means not having the right to be networked, not only in computer networks, but also, in a broader sense, in 'life networks'[25].

> If, before, belonging to networks of meaning and existence, to modes of life and subjective territories used to depend on intrinsic criteria – such as traditions, rights of passage, community and work relations, religion, sex –, this access has been increasingly mediated by commercial tolls, which the majority cannot pay.[25] (p. 21)

In this perspective, the recommendations of the 4th NMHC-I revisit the territory's dimensions of process and relation, and value its social, cultural, economic and political singularities, which may create 'circulation routes' to subjects in psychological suffering that are not mediated by market relations[3,25]. Nevertheless, in case this understanding is not achieved, new exclusion processes may be triggered, fed back by the impossibility of subjects' circulation in the territory.

In this new rationality of the society of security, risks related to the circulation of people in psychological suffering are minimized by a new disciplinary strategy: the docilization of bodies, no longer by physical confinement, but by chemical confinement[14]. The utilization of psychotropic drugs controls habits and behaviors, dominates thoughts and deliriums, minimizes the risk of violence, but at a very high psychological (and social) cost[26].

The issue of the circulation of the person in psychological suffering, after all, continues to have importance and centrality; therefore, guaranteeing that this individual will circulate without causing damage or trouble to society is one of the central themes in therapeutic programs. This guarantee is attributed both to the psychotropic drugs' possibility of controlling undesirable behaviors and to the role of control granted to the family.

In the society of security, the individual is permitted to have some degree of autonomy, and an active posture regarding his/her self-care is required. Even if the individual is considered ill and fragile, it is possible to hold him/her accountable for the management of his/her risks[20]. To Foucault[14], freedom is necessary so that the apparatus of security functions.

In France, what enabled mental health to reorganize itself and operate within the apparatus of security was the notion of 'routes of care'[20]; in Brazil, the analysis of the NMHC

reports revealed that this possibility is attributed to the related notion of 'care networks' or to the homonymous expression 'lines of care'.

Care is situated precisely in the crossroads between what makes us live and what lets us die. Thus, care no longer is a strategy through which people are framed in diverse regulations and norms that focus on the individual and his/her behaviors in a continuous way – a role that care used to play in the disciplinary society. It has started to operate as a component of the apparatus of security[12,20].

According to the NMHC recommendations, care must continue dealing with the subject's integrality and must reach all the dimensions of human life, capturing it in its totality. Furthermore, it must be organized in amplified networks, formed by institutional components, like the CAPS and primary care units, among others, and it must include other community-based spheres situated in the territory, such as the family, local networks, represented by neighborhood associations, by the church and, moreover, intersectoral components, like the school, social work services, etc.

In the society of security, through care, the agents of the mental health field will be able to reach the entire territory of circulation of the person in psychological suffering, in a new relationship of horizontality and transversality, to the detriment of the verticality that characterized it in the disciplinary society. Doron[20] tells us about 'an open territory' that enables subjects' free circulation, anticipating and reducing to a minimum level the risks implied in this circulation, in order to maximize the relation between freedom and security.

Thus, care will be able to contribute to the new functions of Psychiatry: managing population flows, alternating between stages of hospital care and community-based care, being committed to preventive and intersectoral practices, and negotiating the frontiers between "disciplinary isolated individuals"[20] (p. 10).

According to Castel[16] (p. 125), "modern prevention is, first of all, a risk tracker". Risks, in the context of the society of security, are not consequences of a real danger, but of the delimitation of risk factors that indicate the possibility of emergence of undesirable behaviors. In this perspective, "to prevent is [...] to surveil, [...] being able to anticipate the

emergence of undesirable events (diseases, anomalies, deviant behaviors, [...] etc.) in the midst of statistical populations, [...] bearers of risks"[16] (p. 125-6).

This characterization of preventive practices, in the context of the society of security, allows us to understand the reason why the NMHC recommend that strategies and practices inscribed in the care networks must be planned according to criteria and indicators obtained through epidemiological studies, enabling the rationalization of costs and investments in the mental health field.

First, the fact that community-based care strategies and practices are conceived as soft technologies and, therefore, imply lower costs and a better cost-benefit ratio compared to the costs of hospital assistance, makes the community-based mental health care be easily adjustable to economic objectives in the sphere of health management, in the context of neoliberal societies.

In fact, the NMHC reports recommend that the costs of investments in hospital-based psychiatric assistance be effectively reallocated to the implementation of substitutive services, and we highlight many Brazilian regions with real assistance gaps due to the great difficulty in implementing the psychosocial care network.

In this debate, another characteristic of the apparatus of security is revealed, discussed by Doron[20] (p. 11): "the maximization of the cost-efficacy ratio" by means of the "inclusion of interventions in an economic calculation". In the disciplinary normalization, a norm, developed from a certain knowledge, delimits, a priori, the criterion for what is normal/abnormal, for what is acceptable/non-acceptable. In the security normalization, a calculation of frequency needs to be established to determine if the phenomenon is significant and if it requires the State's intervention. The relation between abnormal and normal is of continuity and contiguity. This new logic implies the establishment of an efficacy criterion to the services offered by the State[14,20].

It is possible, in the society of security, to accept as normal a certain frequency of occurrences of phenomena at the population level. The subjects' singularities are reduced to averages, to a set of epidemiological data, which means that the individual will be considered

based on the population. Thus, epidemiology and statistics are fundamental types of knowledge[14,16,20].

In short, in the context of the society of security, the concept of care tends to operate as a fluid and flexible concept that assumes certain configurations depending on whether it needs to approach, distance itself from, or reconcile political and theoretical lines that, in principle, are opposed. Doron[20] believes that care is a dim concept that, if ill defined, may be misunderstood and be connected with lines of thought and practices of an ideological nature.

Final remarks

The period represented by the 1st NMHC had the necessary conditions for a criticism of the hospital-centered asylum model and opened space for the emergence of new epistemologies and new concepts in the mental health field. However, at the same time, we observed discursivities defending the presuppositions of Caplan's Preventive Psychiatry, a line in which the Brazilian Psychiatry has been investing since the 19th century.

From the 2nd until the 4th NMHC, we observed that the glossary related to risk as probability, and also to care and territory, gradually acquired relevance, pointing to the centrality of these concepts in debates about the consolidation of a new mental health care model in Brazil.

The notion of care plays the role of annunciating the renovation of technical-assistance practices in the direction pointed by the anti-asylum movement, which struggles to return to the person in psychological suffering his/her status of juridico-political subject. The mental health policy, in turn, has advanced in the structuring of a care network that substitutes psychiatric hospitals, moving care from asylums to community-based networks of territorial and intersectoral coverage, presupposing practices that do not favor the medicalization of daily sufferings.

However, based on our documentary research, it is possible to situate the concepts of epidemiological risk, care and territory as crosscutting issues in relation to the elements that

constitute the apparatus of security, revealing their functionality in the contemporary mental health field. This fact can be considered an aspect that limits the development of an amplified clinic that contributes to a new understanding of the health-suffering-psychological illness process, as well as to the invention of care practices in accordance with the propositions of the national mental health policy and with the singularities of each territory in the psychosocial care network.

In this perspective, it is necessary to invest in studies about the functionality of the concept of care and related concepts, such as territory, in order to clarify in what way they can reinforce the mechanisms of medicalization and depoliticization of life, being part of the disciplinary, biopolitical and risk management strategies that compose the apparatus of security. Or, on the contrary, how they can oppose the process of medicalization of mental health and of daily psychological sufferings, provided that they are constituted as a social practice that enables to revisit human subjectivity and the potency of life, which have been sequestered by the contemporary modalities of biopower.

Collaborators

The authors participated in all the stages of preparation of this article.

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