interface
comunicação, saúde, educação
https://www.interface.org.br
eISSN 1807-5762

Articles

Mental Health' emancipatory practices

Práticas emancipatórias em Saúde Mental (resumo: p. 15)

Prácticas Emancipadoras en Salud Mental (resumen: p. 15)

Isabela Aparecida de Oliveira Lussi[a]
<bellussi@ufscar.br>

Adriana Leão[b]
<adriana.leao@ufes.br>

Tatiana Dimov[c]
<tatiana.dimov@ufsm.br>

[a] Departamento de Terapia Ocupacional, Programa de Pós-Graduação em Terapia Ocupacional, Centro de Ciências Biológicas e da Saúde, Universidade Federal de São Carlos. Rodovia Washington Luis, km 235, Monjolinho. São Carlos, SP, Brasil. 13565-905.
[b] Departamento de Terapia Ocupacional, Centro de Ciências da Saúde, Universidade Federal do Espírito Santo. Vitória, ES, Brasil.
[c] Departamento de Terapia Ocupacional, Centro de Ciências da Saúde, Universidade Federal de Santa Maria. Santa Maria, RS, Brasil.

This article aims to reflect on the power of actions and services in the field of mental health within the Brazilian public health system, aiming to promote emancipatory practices, especially in the context of setbacks experienced with the current New National Policy on Mental Health, which opposes to the precepts of the Psychiatric Reform. Anchored in theoretical elements about emancipation, the sociology of absences and the sociology of emergencies, we discuss mutual help and support groups, voice ombudsmen groups, social centers and solidarity economy initiatives, which aim to overcome the logic of the monoculture of knowledge, valuing the knowledge of users and adopting horizontalized and self-managed practices. Such experiences need to be systematized, experienced and multiplied so that the development of care networks with emancipatory potential is possible.

Keywords: Mental health. Social emancipation. Psychiatric reform. Psychosocial care network.

Lussi IAO, Leão A, Dimov T. Mental Health' emancipatory practices. Interface (Botucatu). 2022; 26: e220350
https://doi.org/10.1590/interface.220350

Introduction

This essay aims to develop a debate about the potency of actions and services in the context of mental health in the Brazilian public health system, in order to broaden the debate for the creation and development of more and more emancipatory practices, especially in the context of setbacks experienced with the current New National Mental Health Policy, an opposite of the precepts of the Brazilian Psychiatric Reform. For this, we will present theoretical elements about emancipation, the sociology of absences and the sociology of emergences, developed by Boaventura de Sousa Santos. Based on these theoretical elements, we will present, from the experience of the authors, four practices that we consider to have emancipatory potential, namely: groups of mutual help and support; groups of voices ombudsmen; coexistence centers, and solidarity economy.

The choice of such practices was also due to our understanding that they are developed with the people in mental distress and not for them, being a fundamental element in the emancipatory processes, according to Santos' considerations[1]. These are care strategies that contest the biomedical paradigm. And, obviously, they are not the only examples of practices with emancipatory potential developed in the field of mental health. However, we will focus on them, due to their historical importance in the field, such as the coexistence centers and the solidarity economy, and due to the power demonstrated in confronting the situation of suffering that we experience due to the Covid-19 pandemic, such as the help and mutual support groups and the voice-hearing groups, developed in a virtual environment.

In order to understand the challenges facing Brazilian mental health care, it is necessary to start from the understanding that this is a country of extreme inequalities, located in the global South. These inequalities also mark the power relations that are established in mental health care. According to Santos[1]:

> The poverty of experience is not the expression of lacking, but rather the expression of arrogance, the arrogance of not wanting to see, much less value, the experience that surrounds us, only because it is outside the reason with which we can identify and value it[1]. (p. 101)

Based on these conceptions, we argue that the biomedical paradigm, which strongly underpinned some practices in the context of psychiatry before the Psychiatric Reform period, contains, to some extent, what Santos[1] treats it as arrogance, since it disregards the experience of the very people who manifest psychic suffering as subjects of knowledge, silencing them. Traditionally, listening within this paradigm has played the role of identifying and classifying symptoms, disregarding the experience of those who have knowledge about what they are talking about. In fact, it was (or is) assumed that the knowledge or perception of those who are suffering psychically doesn't count because they are people devoid of reason.

Obviously, with the development of the mental health field, based on the psychosocial paradigm[2], this silencing has been minimized, but it is still present due to the insistence of the manicomial ideology based on the biomedical power that, in Brazil, is expressed in the incentive to increase the number of beds in psychiatric hospitals; in the separation

of the alcohol and other drugs policy from the Ministry of Health to the Ministry of Social Development and in the expansion of Therapeutic Communities, with the moral guidance towards abstinence; in the proposition of internment of children and adolescents as a form of assistance for this public; and, in the prescription of Electroconvulsive Therapy (ECT). The direct consequences of a acute dismantling process between 2016 until May 2019, with the construction of the "New Mental Health Policy," represented by the Technical Note 11/2019[3], go against the principles of the Psychiatric Reform and have been vehemently contested by different professional entities, user associations, and mental health researchers[4].

The actions being implemented are measures that restrict the freedom and the physical and moral integrity of the people being treated[4], not considering their potentialities, desires, and capacity for restoration. We need measures that break off with this hierarchical paradigm of care, that can use soft technologies[5,6] for a individualized construction of therapeutic projects that are adequate to the singularities and potentials of each person. This practice demands that the knowledge of people who suffer psychically be considered and their rights be guaranteed.

The waste of the experience in psychiatry: analysis from the sociology of absences

Santos' arguments[1] regarding the sociology of absences gives us theoretical foundations to deepen our reflection on the invisibility, the silencing, and the waste of the experience of people with mental suffering.

For the author, absences are the production of non-existence, that is, it is the discrediting of what exists. The sociology of absences aims at the transformation of "impossible objects into possible ones and, based on them, transform absences into presences"[1] (p. 102).

To reflect on the waste of the experience of people who suffer psychically themselves and their invisibility we will rely on three modes of production of non-existence identified by Santos[1]: the one that derives from the logic of the monoculture of knowledge and the rigor of knowledge, the one related to the logic of social classification, and the one based on the productivist logic.

The mode of production of non-existence[(d)] the most powerful is the one anchored in the logic of the monoculture of knowledge and the rigor of knowledge, because it is based on the argument that the production of knowledge occurs exclusively through modern science[1].

[(d)] For details of the five modes of production of non-existence see Santos[1].

Thus, any knowledge beyond what is valid in modern science is not recognized as knowledge. Thus, the knowledge about the psychic suffering of the people who experience it was absolutely disregarded by the branch of psychiatry anchored in the biomedical paradigm. Therefore, in this context there is the social production of the non-existence of the ignorant.

The logic of social classification relies on the monoculture of the naturalization of differences and consists of categorizing populations as a way of naturalizing hierarchies, creating superior and inferior categories. Inferiority is the form of non-existence produced in this logic and becomes insuperable because it is natural, that is, inferior people cannot be a credible alternative to those superior because they are insuperably inferior.

The insane, the madman, the mentally ill - terms used throughout history to designate people with psychic suffering - was considered to be a person without reason, unable to express opinions because of altered mental functions. This logic is based on the biomedical paradigm that focuses on the disease and not the person; pathology itself is conceived as a condition of inferiority. This conception justifies the great oppression suffered by people with mental suffering. Thus, the inferiority of people with psychic suffering is affirmed in the reason/unreason dichotomy and is legitimized to the extent that the condition without reason is conceived as insurmountable. This logic affirms the non-existence, the historical invisibility of the person with psychic suffering.

The productivist logic allows us to denounce the invisibility of the person with psychological suffering. Within this logic, economic growth is seen as an unquestionable objective, as well as the productivity criteria that are most adequate to this objective. This criterion applies to both nature and human labor. Productive nature is conceived as that which is fertile to the extreme in a given cycle of production and productive labor is understood as that which generates profits to the extreme in a given cycle of production. Non-existence is therefore "produced on the form of the unproductive which, applied to nature, is sterility and, applied to labor, is laziness or professional disqualification"[1] (p. 104).

Although, paradoxically, the labor of the insane has been exploited inside psychiatric institutions through work coated with therapeutic justification, they have always been considered unproductive for not fitting the demands of the capitalist and industrial society. This logic has printed professional disqualification to the greatest degree in people with psychic suffering and affirms their non-existence.

According to Santos[1], absences cause the waste of experience. Thus, based on this understanding, we point out all the experience wasted by the biomedical paradigm, in the name of hegemonic science, by not taking into consideration the knowledge of those who suffer psychically because they are, namely, ignorant, inferior, and unproductive.

In order to modify this social imaginary around people, the sociology of absences presents as a proposal the liberation of experiences, produced as absent, from the relations that historically produced them. In this way, people's experiences produced as absences must be placed as an alternative to hegemonic experiences, so that the relationship between these experiences can be an object of discussion and political dispute[1].

Overcoming absences: counter-hegemonic movements and emancipatory practices

Santos[1] argues that the construction of knowledge must recognize the plurality of heterogeneous knowledge about a given social phenomenon, thus replacing the monoculture of knowledge with ecologies.

The author proposes the horizontalization of the power relations that are established in the delimitation of the so-called "scientific" knowledge through the monoculture of knowledge. For him, the recognition of diverse knowledge contributes to an expansion and democratization of the knowledge production space[7].

Gonçalves considers that care technologies comprise the material and non-material developments involved in health services practices[5]. Merhy states that health care technologies can comprise aspects of the relationship (soft technologies); structured knowledge (soft-hard technologies); or material resources (hard technologies)[6].

In the mental health field, it is of fundamental importance that users' experiences can be considered when it comes to the production of care technologies.

Based on these assumptions, we will discuss some counter-hegemonic movements in the field of mental health that have moved towards the recognition of the knowledge of people with mental suffering themselves.

We argue that the ideas and practices implemented in Trieste/Italy and internationally disseminated reveal the counter-hegemonic use of scientific knowledge about psychological suffering[8]. Strong inspiration for the Brazilian anti-manicomial struggle, as well as France, England, United States and Canada[9], The Italian democratic psychiatry movement stands out for putting the arrogance of the biomedical paradigm in check.

In Italy, the psychiatric reform movement was a historical process of deconstruction of the hospital-centric model, which questioned the rationalist paradigm of psychiatry. The first step of deinstitutionalization was the dismantling of the problem-solution relationship, with the renunciation of any form of causal explanation of the disease and the pursuit of the rational solution, that is, the fully restored normality. Instead, it has adopted a form of practical intervention that goes back to the chain of normative determinations, scientific definitions, and institutional structures, through which mental illness has assumed forms of existence and expression[10].

In the process towards deinstitutionalization, the institutional solution was deconstructed - the ways, the relationships surrounding the treatment of people were transformed - in order to deconstruct the problem - the suffering of people. Thus, the object of psychiatry becomes the existence-suffering of people and not the disease[10]. As Desviat points out[9], "Basaglia proposed, with his usual radicalism," that "it was necessary to put brackets to the disease" (p. 16).

Power relations, legitimized by psychiatry, marked the asylum institution. For Basaglia[8], only through the patients' and staff's awareness of such power relations and of the situation of total institutionalization to which these two categories were submitted inside the psychiatric hospital, could a real movement of rupture, negation, and destruction of the forces that generated such a situation emerge.

Thus, in the deinstitutionalization process that took place in Italy, of which the Trieste experience became an international reference and guided Italy's global institutional transformation, the change of model was also centered on the transformation of interpersonal relationships between staff and users so that instead of power relationships there would be a relationship of reciprocity, in addition to the focus on the understanding that the object of psychiatry is the existence-suffering of the person and not periculosity or disease[8,10].

We argue that by placing the focus on people's existence-suffering rather than on illness and confronting the relations of domination and power arising from scientific knowledge in traditional psychiatry, Basaglia and his followers used scientific knowledge in a counter-hegemonic way.

Taking as a basis the concept of abyssal thinking developed by Santos[11], which is characterized by the division of social reality into two distinct universes - the visible, that is, what is on this side of the line, and the invisible, what is on the other side of the line - and looking at the characteristics of the deinstitutionalization process promoted by Basaglia, described above, we can affirm that he faced the relation between dominant and dominated in the context of traditional psychiatry investing in the crossing of the abyssal line. In fact, people with psychological suffering ceased to be completely invisible after this process of deinstitutionalization.

We argue that there is, in this process, a passage from abyssal exclusion to non-abyssal exclusion. Non-abyssal exclusion is present in the processes of inclusion. In accordance with Santos[11], there are many forms of non-abyssal exclusion that have divided the modern world on this side of the line. One issue that underlies the argument for non-abyssal exclusion is the effective guarantee of citizenship rights for people with mental suffering.

We hold the view that this passage is more marked in the Brazilian case. The Brazilian Psychiatric Reform was a complex process that was strongly influenced by the Italian model, but was also influenced by the experiences in England, France and the USA[12]. It is possible to state that, in Brazil, people with mental health problems have gone from abyssal exclusion to non-abyssal exclusion. Such reflection is based mainly on two arguments: the participation of people with psychic suffering in the Reform movement and the reorientation of public policies until 2016, for a mental health care that met the real needs of people, that was territorial and community-based and guided by the affirmation of citizenship rights.

That is, when the needs and rights of people with psychic suffering become the focus of intervention and the orientation of care is no longer centered on the hospital/prison and begins to be directed to the territory/community, they cross the abyssal line. However, we point out that the passage happens from abyssal exclusion to non-abyssal exclusion, since the orientation of the intervention changes, the policies are redefined, but the access to rights remains insurmountable, in practice. Therefore, it is fundamental to promote practices that have as a premise the achievement of and access to rights.

From the process of the Brazilian Psychiatric Reform, which provided important achievements, with the approval of the Law number 10.216/2001[13], which provides guidance on the rights of people with mental disorders and the redirection of the mental health care model, or the implementation of new services and actions, which were systematized and organized from the Administrative Rule 3088/2011[14], which established the Psychosocial Care Network (RAPS), counter-hegemonic practices to the traditional medical psychiatric knowledge/power have materialized. Based on the above, in the context of Psychosocial Care in Brazilian National Health Care (SUS), we affirm the importance of some emancipatory practices, among others: the mutual help and support groups; the voice-hearing groups; the coexistence centers; and the solidarity economy, for we understand that these strategies call on people's knowledge, their experiences, and thus, move in the direction of the ecology of knowledges, proposed by Santos. We also understand that these practices are characterized as emergencies[1], since they are posed as concrete possibilities (potentiality) and capacities (potency).

For Santos[1], the sociology of emergences is related to the investigation of alternatives of a future with plural and concrete possibilities and acts "[...] on both possibilities (potentiality) and capacities (potency)" (p. 118).

A care strategy that has been developed in Brazil puts its wagers on community-based peer support, with potential for development in the territory, the mutual help and mutual support groups[15]. Mutual help groups, aimed at the welcoming, the exchange of experiences and emotional support among people who share the same problems[15].

> [...] mutual help group meetings are characterized by face-to-face meetings in spaces in which participants regularly exchange life experiences, and strategies for dealing with their common problems, or to discuss some topic previously agreed upon by the group[16]. (p. 25)

Mutual support, on the other hand, would be a modality in which the group performs together social, artistic, cultural, sports, community, leisure, recognition activities, and the use of social resources in the local community and society[17]. The initiatives for mutual help and support create possibilities for peer support and citizen insertion for people who have traditionally been marginalized, creating strategies for overcoming inequalities. More mature mutual support groups can even develop more complex projects, aiming at work, income, housing, or associative organizations that fight for rights or develop social work.

The work methodology of the mutual help and support groups is counter-hegemonic in that it promotes forms of exchange in which the knowledge that comes from experience is valued, breaking with the monoculture of knowledge. Mutual support groups are also configured as a strategy to confront social *apartheid* by qualifying the social insertion of these people, creating strategies that stimulate the citizenship insertion of its participants.

An example of mutual help groups that occur in several Brazilian locations are the groups of people who hear voices, commonly held from mental health services, such as the Psychosocial Care Centers.

The movement for hearing voices originated in the Netherlands in the 1980s with the creation of the organization The International Network for Training, Education and Research into Hearing Voices, known as Intervoice, with the aim of providing people who hear voices with administrative support and the coordination of initiatives based on new approaches to care, with the understanding that the problem is not hearing voices, but the relationship of coexistence established with them.

It is estimated that more than 80 countries are part of the international community of voice-listeners[18]. In Brazil, the first experience of groups with the theme of hearing voices was an initiative of the psychiatrist Octávio Serpa Junior, from the late 1990s. In 2015, the First Forum on New Approaches in Mental Health, held at the IPUB, reheated the discussion on the theme and the International Movement of Voice Listeners became widely known[19]. Since then, in different regions of the country, some experiences of voice-listening groups are already known in the context of psychosocial care.

It is still hegemonic the discourse of psychopathology that restricts the symptoms, to the detriment of the experience of people who experience the situation of psychic suffering, in relation to hearing voices, a fact placed as a manifestation of "auditory hallucination", without considering the relationship and the meaning that the voices play in the history of people's lives.

In this sense this practice manifests itself as counter-hegemonic to traditional psychiatry, because it contributes to the rupture of the problem-solution paradigm pointed out by Basaglia, once the phenomenon of hearing voices begins to have another meaning.

The fact that people who hear voices are considered "experts by experience," while mental health professionals, academics, and activists are "experts by profession"[18], makes clear the place of people's knowledge from this experience of hearing voices.

Thus, mutual aid and voice-hearing groups aim to break with the monoculture of knowledge as they value the knowledge that comes from people's own experience. While mutual support groups break with the logic of social classification, creating possibilities and spaces for the social insertion of traditionally marginalized groups and the recognition of equal differences, as Santos points out[1], on the ecology of recognition, which is the way to confront the absences generated by the logic of social classification. Another device that also aims at breaking with the logic of social classification are the Coexistence Centers.

One of the attention points of the Psychosocial Care Network (Raps), with the task of offering the general population spaces for sociability, production and cultural intervention in the city[14]. The Coexistence Centers are inter-sectoral, community, and

territorial facilities that aim to promote the social participation of all people, and were created especially for the social inclusion of those who, for some reason, experience situations of exclusion from social spaces. Through actions in the fields of culture, arts, sports, work, and education, among others, the possibilities for coexistence and social inclusion are offered.

Some of the studies demonstrate the power of the Coexistence Center as an emancipatory practice due to the possibilities of autonomy production[20]; of cultural production[17,21]; coping with stigmatization[22]; of health promotion, care from the perspective of expanded clinical practice, coexistence, and social participation[23-26].

The Coexistence Centers, which are still few in number in Brazil, were created prior to the publication of the Administrative Rule 3088/2011[14], as pioneering experiences in the cities of São Paulo, Campinas, Belo Horizonte, among others, with the perspective of the Psychiatric Reform and are also called *Centro de Convivência e Cultura* and *Centro de Convivência e Cooperativa* (Ceccos).

Specifically in relation to the Ceccos, they have existed in the city of São Paulo for over thirty years, with the initially outlined proposition of, in addition to coexistence, the reinsertion of people in the world of work and, for this, had the incentive to create work cooperatives, with the initial support of the service, as a form of organization and viability of the proposal. Due to the unfeasibility of legal regulation regarding social cooperatives in Brazil, but still pursuing work as a device for social inclusion, many of the Ceccos contemplate activities of income generation and Solidarity Economy.

It was precisely because of the non-materialization of social cooperatives in the national context during the first years of the Psychiatric Reform process that, in 2004, there was an approximation of this movement with the Solidarity Economy movement aiming at fomenting initiatives of social inclusion through work[27].

The solidarity economy is antagonistic to the capitalist one, in which the person and human labor are valued, and not profit and capital, as is the case in the capitalist model. There is no hierarchy among the workers, decisions are collective, and everyone owns the enterprise.

The solidarity economy is a counter-hegemonic mode of production, commercialization, consumption or credit, which must effectively practice self-management[28].

Because of these characteristics, it is another way of life for people, which stimulates solidarity, democracy, and respect for the other, for nature, and for differences, opening the way for social inclusion through work for people who, for various reasons, are socially excluded and cut off from the world of work.

The partnership between mental health and solidarity economy has greatly increased the number of initiatives of social inclusion through work. In 2006, there were 230 initiatives mapped by the Registry of Initiatives of Social Inclusion through Work (CIST) throughout the country[29]. In 2013, this number reached 1,008 initiatives[30].

Besides this advance, many others have been achieved, such as, for example, the National Program of Support to Associativism and Social Cooperativism - Pronacoop Social, which had the objective of planning, coordinating, executing and monitoring the actions destined to the development of social cooperatives and solidary economic enterprises that count on socially disadvantaged people, among them, mental health users[27]. However, like other public policies in the field of mental health and the solidarity economy, since 2016 it has suffered dismantling.

What we have observed is that the solidarity economy is an effective way for people with mental health problems to be inserted in productive initiatives that are fairer and more supportive. In some cases, the work has been configured more as a production of life than an alternative of income generation. These conditions allow a way out of the condition of non-existence of the unproductive.

The power of the practice of self-management opens the way for processes of social emancipation. In the daily life of the enterprises, autonomy, freedom, and engagement in production processes and in the enterprise itself become visible through the opinions shared spontaneously by people during work and in assemblies.

Through participation in solidarity economy fairs and the conquest of previously unattainable spaces such as, for example, representation and participation in Councils and Forums of Solidarity Economy, the processes of participation and social emancipation evolve and progress.

Emancipatory practices: challenges and resistances

Boaventura de Sousa Santos works with the concept of emancipatory practices, relating them to the potential for the achievement of rights and equality[31]. The practices presented in this text have emancipatory potential as they aim to overcome the logic of the monoculture of knowledge and the rigor of knowledge, recognizing and valuing the knowledge of users and adopting horizontalized and self-managed forms of operation. They focus on overcoming the logic of social classification by proposing strategies that aim at qualifying people's social insertion. And they aim to overcome the productivist logic by creating space for self-managed and counter-hegemonic forms of production.

The production of mental health care under the banner of deinstitutionalization, represented by the practices discussed, currently faces two important challenges, either by the pandemic of Covid-19 and the consequences of its impact, but, above all, by the setbacks faced with respect to the consolidation of the RAPS, despite the historical challenges of the Brazilian Psychiatric Reform process in the constitution of the field of psychosocial care.

Faced with the serious social and health context experienced from 2020, due to the pandemic of Covid-19, with the need for physical distance, it was necessary to reinvent the care actions from the mental health services, even though the production of these practices is not systematized and widely known, among the others carried out, they somehow had continuity in a remote way, despite the losses, with the use of information and communication technology.

On the other hand, it is worth remembering that digital exclusion on the part of service users, in situations of greater social vulnerability, calls the attention to a problem that expresses the context of inequities and social inequalities, and it is essential to affirm the digital inclusion of people as part of citizenship rights and as a banner to fight for the anti-mental institution and Psychiatric Reform movements[16].

As for the mutual help and support groups, with the pandemic and the need for physical distance, groups that used to take place face-to-face began to take place in a remote format[16], moreover, with the worsening of depression, stress and anxiety during the pandemic, new mutual help and support groups started to be offered remotely to people all over the country[32,33].

In the case of voice ombudsman groups, since 2007, with Intervoice and its proposal to create an interactive online community through social media, it was possible to observe by the study conducted by Barros[18], that cyberspace provides the offer of participation, support, comfort, minimization and deconstruction of stigmas and prejudices, and enables the construction of a process of mutual help and emotional support and empowerment through shared information.

In the same way, the actions of the Coexistence Centers have gained the virtual environment and the possibility of meetings, networking and anti-mental asylum affective production is observed, elements that mean "vital breaths in suffocating times"[20] (p. 104).

At the time of the pandemic, the solidarity economy initiatives and enterprises were also forced to paralyze, especially the fairs, and reinvented themselves with virtual commercialization and the holding of fairs and virtual events. Although the strategies cited aim at mitigating the psychic effects of the pandemic, it is undeniable that the challenges imposed, which have affected everyone, have made even more fragile the living conditions of people living on the streets, people who work in precarious or informal jobs, residents of the suburbs or slums, in short, people who are in social groups that are "south of the quarantine"[34]. Thus, the pandemic has made the contradictions of the neoliberal mode of production explicit, and has greatly deepened social inequalities in the Brazilian context.

Initially we refer to the Technical Note 11/2019[3], which is one of the expressions of the disaster of political and social character that occurred in 2016, when the country experienced a political coup, and in 2018, through elections based on fake news[35,36], with the rise of a government notably guided by fascist, sexist, racist and antidemocratic values, which results in measures contrary to the rights of citizenship, to the environment, to the material and immaterial heritage, as a function of conservative and privatization logics[37], In short, against life in its different possibilities of existence.

This context, intensified by the pandemic, further weakens the Raps as a whole, which characterizes the greatest challenge of the Psychiatric Reform in its counter-hegemonic process. It is a crossroads where mental health workers, people in situations of psychic suffering and their families try to resist and create emancipatory forms of care in freedom while they are disrespected in their human rights and face the difficulty of access to public policies.

On the other hand, these and other emancipatory practices are possible paths to the social transformation that is so fundamental in the current context. It is necessary that social actors become aware of the structures that oppress them so that they can create resistance strategies and create new possible worlds. Practices of care in freedom, territorial and led by people, create a weaving of soft and soft-hard technologies of care[38], in that they constitute care devices that include relational aspects that value the experience of the subjects, besides encompassing a set of theories that subsidize the practices presented here. Such experiences must be understood as a reference for the creation of public policies. They need to be experienced, multiplied and systematized so that it is possible to develop care networks with emancipatory potential.

Authors' contribution

All authors actively participated in all stages of preparing the manuscript.

Funding

Part of the article comes from research developed by the first author during her Postdoctoral studies held at the Center for Social Studies, University of Coimbra, with a Capes grant.

Conflict of interest

The authors have no conflict of interest to declare.

Copyright

This article is distributed under the terms of the Creative Commons Attribution 4.0 International License, BY type (https://creativecommons.org/licenses/by/4.0/deed.en).

Editor
Simone Paulon
Associated editor
Moises Romanini

Translator
Félix Héctor Rigoli

Submitted on
05/19/22
Approved on
06/27/22

References

1. Santos BS. A gramática do tempo: para uma nova cultura política. 3a ed. São Paulo: Cortez; 2010.
2. Costa-Rosa A. O modo psicossocial: um paradigma das práticas substitutivas ao modo asilar. In: Amarante P, organizador. Ensaios: subjetividade, saúde mental, sociedade. Rio de Janeiro: Fiocruz; 2000. p. 141-68.
3. Brasil. Ministério da Saúde. Secretaria de Atenção à Saúde. Departamento de Ações Programáticas Estratégicas. Coordenação-Geral de Saúde Mental, Álcool e Outras Drogas. Nota técnica nº 11/2019-CGMAD/DAPES/SAS/MS. Brasília: Ministério da Saúde; 2019.
4. Cruz NFO, Gonçalves RW, Delgado PGG. Retrocesso da reforma psiquiátrica: o desmonte da política nacional de saúde mental brasileira de 2016 a 2019. Trab Educ Saude. 2020;18(3):e00285117.
5. Gonçalves RBM. Tecnologia e organização social das práticas de saúde: características tecnológicas do processo de trabalho na rede estadual de centros de saúde de São Paulo. São Paulo: Hucitec; 1994.
6. Merhy EE. Saúde: a cartografia do trabalho vivo. 2a ed. São Paulo: Hucitec; 2005.
7. Santos BS. Para uma sociologia das ausências e uma sociologia das emergências. Rev Crit Cienc Soc. 2002; (63):237-80. Doi: https://doi.org/10.4000/rccs.1285.
8. Basaglia F. A instituição negada: relato de um hospital psiquiátrico. Rio de Janeiro: Graal; 1985. As instituições da violência; p. 99-133.
9. Desviat M. Coabitar a diferença: da reforma psiquiátrica à saúde mental coletiva. São Paulo: Zagodoni; 2018.
10. Rotelli F, Leonardis O, Mauri D. Desinstitucionalização, uma outra via: a reforma psiquiátrica italiana no contexto da Europa Ocidental e dos países avançados. In: Nicacio F, organizador. Desinstitucionalização. São Paulo: Hucitec; 1990. p. 17-59.
11. Santos BS, Meneses MP. Epistemologias do Sul. Coimbra: Edições Almedina; 2009. Introdução; p. 9-19.
12. Amarante P. Saúde mental e atenção psicossocial. Rio de Janeiro: Fiocruz; 2007.
13. Brasil. Presidência da República. Casa Civil. Lei nº 10.216, de 6 de Abril de 2001. Dispõe sobre a proteção e os direitos das pessoas portadoras de transtornos mentais e redireciona o modelo assistencial em saúde mental. Brasília: Presidência da República; 2001.
14. Brasil. Ministério da Saúde. Portaria nº 3.088, de 23 de Dezembro de 2011. Institui a Rede de Atenção Psicossocial para pessoas com sofrimento ou transtorno mental e com necessidades decorrentes do uso de crack, álcool e outras drogas, no âmbito do Sistema Único de Saúde (SUS). Brasília: Ministério da Saúde; 2011.
15. Vasconcelos EM, Lotfi G, Braz R, Lorenzo R, Reis TR. Manual ajuda e suporte mútuos em saúde mental. Para facilitadores, trabalhadores e profissionais da saúde e saúde mental. Brasília: Ministério da Saúde; 2013.
16. Vasconcelos EM, Cerda MW. Desafios e recomendações para a realização de atividades de ajuda mútua *on-line* no campo da saúde mental. In: Vasconcelos EM, organizador. Novos horizontes em saúde mental: análise de conjuntura, direitos humanos e protagonismo de usuários(as) e familiares. São Paulo: Hucitec; 2021. p. 292-309.
17. Ferreira FL. Um dicionário da Ala Loucos pela X: compartilhando experiências com o grupo de trabalhadores numa pesquisa de inspiração etnográfica [dissertação]. São Paulo: Instituto de Psicologia, Universidade de São Paulo; 2017.

18. Barros OC, Serpa OD Jr. Ouvir vozes: um estudo netnográfico de ambientes virtuais para ajuda mútua. Physis. 2017; 27(4):867-88.

19. Coimbra VC, Bretanha AF, Rodrigues CGSS. Sobre os caminhos do primeiro grupo de ouvidores de vozes no Brasil. J Nurs Health. 2018; 8(esp):e188421.

20. Alvarez APE, Fernandes JB, Oliveira MIQ, Silva ICA, Castro RM. Convivência virtual: a arte de tecer redes com o trabalho afetivo antimanicomial. Rev GEMInIS. 2020; 11(3):87-107.

21. Maluf JCG, Lopes IC, Bichara TAC, Silva JA, Valent IU, Buelau RM, et al. O Coral Cênico Cidadãos Cantantes: um espaço de encontro entre a música e a saúde. Rev Ter Ocup Univ São Paulo. 2009; 20(3):199-204. Doi: https://doi.org/10.11606/issn.2238-6149.v20i3p199-204.

22. Leão A, Lussi IAO. Estigmatização: consequências e possibilidades de enfrentamento em Centros de Convivência e Cooperativas. Interface (Botucatu). 2021; 25:e200474. Doi: https://doi.org/10.1590/interface.200474.

23. Aleixo JMP, Lima EMFA. Invenção e produção de encontros no território da diversidade: cartografia de um Centro de Convivência. Cad Bras Ter Ocup. 2017; 25(3):649-59.

24. Cambuy K, Amatuzzi MM. Experiências comunitárias: repensando a clínica psicológica no SUS. Psicol Soc. 2012; 24(3):674-83.

25. Ferigato SH, Carvalho SR, Teixeira RR. Os Centros de Convivência: dispositivos híbridos para a produção de redes que extrapolam as fronteiras sanitárias. Cad Bras Saude Ment. 2016; 8(20):79-100.

26. Ferreira PHR. Centro de Convivência e Cultura e suas repercussões na vida de usuários de um Centro de Atenção Psicossocial [dissertação]. Campinas (SP): Universidade Estadual de Campinas; 2014.

27. Singer P, Schiochet V. Economia solidária e saúde mental: a construção da política nacional de cooperativismo social. In: Pinho KLR, Pinho L, Lussi IAO, Machado MLT, organizadores. Relatos de experiências em inclusão social pelo trabalho na saúde. São Carlos: Compacta Gráfica e Editora; 2014. p. 4-7.

28. Singer P. A recente ressurreição da economia solidária no Brasil. In: Santos BS, organizador. Produzir para viver: os caminhos da produção não capitalista. Rio de Janeiro: Civilização Brasileira; 2002. p. 81-129.

29. Brasil. Ministério da Saúde. Saúde mental em dados. 2a ed. Brasília: Ministério da Saúde; 2006. v. 1.

30. Brasil. Ministério da Saúde. Cadenos HumanizaSUS. Saúde Mental. Brasília: Ministério da Saúde; 2015. v. 5.

31. Lussi IAO. Emancipação social e terapia ocupacional: aproximações a partir das Epistemologias do Sul e da Ecologia de Saberes. Cad Bras Ter Ocup. 2020; 28(4):1335-45.

32. Ricci EC, Dimov T, Cassais TS, Dellbrügger AP. University experiences of occupational therapy in Brazil during the Covid-19 pandemic: contributions and support in mental health for the population. WFOT Bull. 2020; 76(2):75-7.

33. Costa C, Fabiani I, Ferrari J, Fripp JC, Silva LD, Roque Filho A. Os desdobramentos dos grupos de ajuda e suporte mútuo on-line em tempos de crise sanitária mundial. Rev Saude Redes. 2020; 6(2):7-22.

34. Santos BS. A cruel pedagogia do vírus. São Paulo: Boitempo; 2020.

35. Jardelino F, Cavalcanti DB, Toniolo BP. A proliferação das fake news nas eleições brasileiras de 2018. Comun Publica. 2020; 15(28). Doi: https://doi.org/10.4000/cp.7438.

36. Dourado TMSG. Fake News na eleição presidencial de 2018 no Brasil [tese]. Salvador: Universidade Federal da Bahia; 2020.

37. Dimenstein M, Simoni ACR, Londero MFP. Encruzilhadas da democracia e da saúde mental em tempos de pandemia. Psicol Cienc Prof. 2020; 40:e242817.

38. Franco TB, Merhy EE. Cartografias do trabalho e cuidado em saúde. Tempus (Brasília). 2012; 6(2):151-63.

Este artigo visa refletir sobre a potência de ações e serviços no campo da Saúde Mental no sistema de saúde pública brasileira, com o intuito de fomentar práticas emancipatórias, sobretudo no contexto de retrocessos vivenciados com a atual Nova Política Nacional de Saúde Mental, que se contrapõe aos preceitos da Reforma Psiquiátrica. Ancoradas em elementos teóricos acerca da emancipação, da sociologia das ausências e da sociologia das emergências, discutimos os grupos de ajuda e suporte mútuos, os grupos de ouvidores de vozes, os centros de convivência e as iniciativas de Economia Solidária, os quais visam à superação da lógica da monocultura do saber, valorizando o conhecimento dos usuários e adotando práticas horizontalizadas e autogestionárias. Tais experiências precisam ser sistematizadas, vivenciadas e multiplicadas para que seja possível o desenvolvimento de redes de cuidado com potencial emancipatório.

Palavras-chave: Saúde Mental. Emancipação social. Reforma psiquiátrica. Rede de atenção psicossocial.

El objetivo de este artículo es reflexionar sobre la potencia de acciones y servicios en el campo de la salud mental en el sistema de salud pública brasileña, con la intención de fomentar prácticas emancipadoras, sobre todo en el contexto de retrocesos experimentados con la actual Nueva Política Nacional de Salud Mental, que se contrapone a los preceptos de la Reforma Psiquiátrica. Ancladas en elementos teóricos sobre la emancipación, la sociología de las ausencias y la sociología de las emergencias, discutimos los grupos de ayuda y soporte mutuos, los grupos de oidores de voces, los centros de convivencia y las iniciativas de economía solidaria, cuyo objetivo es la superación de la lógica de la monocultura del saber, valorizando el conocimiento de los usuarios y adoptando prácticas horizontalizadas y de autogestión. Tales experiencias precisan sistematizarse, experimentarse y multiplicarse para que sea posible el desarrollo de redes de cuidado con potencial emancipador.

Palabras clave: Salud mental. Emancipación social. Reforma psiquiátrica. Red de atención psicosocial.