Collective mental health: a review of the concept in the academic literature of Brazil, Colombia, and Spain

Salud mental colectiva: una revisión del concepto en la literatura académica de Brasil, Colombia y España

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Abstract

INTRODUCTION: The notion of collective mental health refers to an alternative proposal to the biomedical and behavioral perspective that has been gaining centrality in academic publications in Brazil, Spain, and Colombia, especially in the last two decades. METHOD: In order to understand the meaning acquired by this notion, an analysis of the concept was carried out through a narrative review that used intentional criteria for the selection of the material. RESULTS: nuances were identified in each country and/or its associated problems, in close connection with the historical and socio-cultural particularities of each scenario. Violence related to asylum logic (Brazil, Spain), and those derived from armed conflict and political violence (Colombia) are the problems where collective mental health provides epistemological and practical guidelines for accompaniment in contexts of social suffering. CONCLUSION: the delimitation between the collective and the community is the main conceptual challenge that emerges from the intersection between mental health and collective health.

Keywords: Mental Health; Public Health; Violence; Community.

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DOI 10.1590/S0104-12902023210693en

Resumen

INTRODUCCIÓN La noción de salud mental colectiva hace referencia a una propuesta alternativa a la perspectiva biomédica y conductual que ha ido adquiriendo centralidad en las publicaciones académicas de Brasil, España y Colombia, especialmente en las dos últimas décadas. MÉTODO: Con el fin de comprender el sentido que adquiere dicha noción, se realizó un análisis del concepto desde una revisión narrativa que empleó criterios intencionados para la selección del material. RESULTADOS: Se identificaron matices particulares en cada país y/o sus problemáticas asociadas, en estrecha conexión con las particularidades históricas y socioculturales de cada escenario. Las violencias relacionadas con las lógicas manicomiales (Brasil, España) y aquellas derivadas del conflicto armado y la violencia política (Colombia) son las problemáticas en las que la salud mental colectiva aporta orientaciones epistemológicas y modelos de prácticas para el acompañamiento en contextos de sufrimiento social. CONCLUSIÓN: El deslinde entre lo colectivo y lo comunitario es el principal reto conceptual que emerge de la intersección entre la salud mental y la salud colectiva.

Palabras-clave: Salud Mental; Salud Colectiva; Violencia; Comunidad.

Introduction

The notion of collective mental health has been proposed as a response to the neglect of social care practices based on models such as the biomedical one. The purpose has been to overcome the traditional dichotomous definition articulated either by a logic of disease in the negative, in which case "health" is the absence of disease, by one in a positive sense, for which health is synonymous with "well-being", understood as a complete state of biopsychosocial balance (Coelho; Almeida Filho, 2002; Hernández-Holguín, 2020).

What becomes problematic in the biomedical and behavioral perspective is the centrality of pharmacological treatment, assumed almost as the only alternative legitimized by academia, the media, and the health sector without any interaction with other knowledge, which is in line with the hegemonic medical model or MMH (*Modelo Médico Hegemónico)*, defined by Menéndez (1988, p. 451) as:

> The set of practices, knowledge and theories ensuing from the development of what is known as scientific medicine that since the late eighteenth century has managed to establish as subaltern to the set of practices, knowledge and theoretical ideologies until then dominant in the social groups, until it was identified as the only way to treat the disease, legitimized both by scientific criteria and by the State.

For Mercedes Serrano-Miguel (2018), it is a model in which the establishment of a hierarchical order in the relationships between professionals and users has prevailed. Its strong tendency towards technification and medicalization in the responses to health problems has brought about a system of consumption that carries with it a certain depersonalization and mechanicity in therapeutic relationships, as well as a progressive exclusion of subjectivity in the processes of care.

On the one hand, the perspective centered on the pursuit of happiness, regardless of comfortable or precarious living conditions, promotes well-being and harmony of people with themselves and with others, and seems to neglect the socio-historical

and cultural conditions of those who do not meet the expected social standards. In fact, in this perspective, as well as in the biomedical and behavioral perspectives, when attempting to include the social aspects in approaches and practices, it was done in a subaltern, underhanded, functionalist, or mechanical way.

In the field of mental health, these elements become especially sensitive, because despite the search for interdisciplinary work and the struggles to define its objects, methods, and practices, it is undeniable that the more conventional psychiatric logic continues to be the logic of choice over other disciplines that also participate in the processes of accompanying people and communities in mental health (Serrano-Miguel, 2018). This logic, moreover, hinders the potential of social determinations of mental health that are at stake and the active participation that people with psychological suffering could have in their own care and attention. Martínez-Hernáez and Correa-Urquiza (2017) take up Kleinman (1988) to affirm that under these conditions a "bureaucratic construction of knowledge" is produced, which advocates for a professional hierarchy of legitimacies between psychiatrist, psychologist, social worker, among others.

These concerns have even appeared in the so-called "hard" sciences, which in some cases have joined a sort of epistemological revolution to give a more prominent place to the subject in the production of knowledge. An example of this in the clinical field is the Narrative-Based Medicine (Greenhalgh, 1999) or models such as decision-making shared or supported by professionals (Simmons; Gooding, 2017).

Mental health is a complex field, offering competing orientations. In Brazil, the notion of collective mental health was already present in training courses for mental health professionals in the late 1980s. In this context, Fagundes (2006, p. 95) describes the concept not so much in relation to the study of the populations' health or the preventive model, but as a project of a "public policy of expression and affirmation of life in its diversity, multiplicity and plurality." It is a concept that makes sense in the debate of social movements in collective health in Brazil, Argentina (Spinelli, 2004), among other Latin American countries (Breilh, 2013), in addition to the influence of the Italian psychiatry and the reflection on the psychiatric reform processes that were beginning to be implemented.

In the Colombian case (Hernández-Holguín, 2020), the scarcity of perspectives of a cultural type and from the social determination of mental health in the academic production has been evidenced, with some studies that have addressed the perception of mental health from the approaches of Latin American social medicine/collective health. In Spain, the more psychosocially oriented journals such as *Psiquiatría Pública* and the publications that flourished in the 1980s around psychiatric reform have not maintained their relevance, with the exception of the *Revista de la Asociación Española de Neuropsiquiatría* (Journal of the Spanish Association of Neuropsychiatry). Now, in both countries, the lower production is in contrast with the forcefulness of the debates they install, where issues such as the pathologization of life and identities, the medicalization of suffering and the social uses of medical categories are addressed (Arias-López, 2013; Correa-Urquiza, 2018), that is, a whole ethical debate on the subject, their suffering and experience, in the key of a located historical process.

The provocative nature of these proposals led us to clarify the emergence of the notion of collective mental health, which was especially enunciated by the voice of Brazilian (Fagundes, 2006), Argentine, and Spanish scholars, and is incipient in the Colombian production. Thus, the objective of this article is to present a narrative review aimed at problematizing the meaning of what is called, in the academic production, as collective mental health, as well as the two intersecting fields, namely mental health, and collective health, in terms of their budgets, fields of action, inquiry, and reflection. It aims to find the paths of confluence or divergence in the academic production from Brazil, Spain, and Colombia, and then expand the comprehensive horizon of how the collective perspective of mental health has been emerging in these three countries.

Methodology

A conceptual analysis review (Guirao, 2015) was conducted with the intend to trace and achieve a better understanding of the notion of "collective mental health," especially its background, the context of emergence, derivations, attributes, and emphases, in addition to the associated empirical referents in Brazil, Colombia, and Spain. The databases Redalyc, SciELO, Dialnet, Virtual Health Library (VHL), and Google Scholar were searched using the descriptors "collective mental health" and "mental health and collective health" in Spanish, Portuguese, and English and a temporal delimitation from 1998 to 2020. The bibliographic sources of the articles found and other texts recommended by the authors were reviewed. Initially 88 references were found, of which three were discarded, corresponding to book reviews, leaving 85 including original and review articles, research reports and books. These were prioritized according to thematic and methodological relevance. Of the 58 texts identified as highly relevant, 38 were selected for complete reading and categorical analysis and 20 for triangulation, validation of findings and contributions in writing. The categorical analysis was done intra- and intertextually. The categories "psychiatric reform," "violence and mental health," and "collective mental health/the community" are of an emergent nature, guided by the objective of the analysis, and were reviewed according to the emphases for each country, as well as the points in common in the approaches to "collective mental health" and "the community." The documentary analysis disclosed the need and the search for a flexible, open, and located concept of mental health that, from a collective health perspective, has led to dissimilar constructions, coherent in this case with the socio-historical conditions of Brazil, Colombia, and Spain.

Results

Of the texts reviewed, 41.3% are publications from Brazil, 32.8% from Spain and 25.9% from Colombia. The literature review suggests that the socio-historical framework in which *collective mental health* emerges, either in its foundations or in the direct way of naming it, is linked to the process of psychiatric reform in Brazil, post-reform in Spain, and the context of the armed conflict in Colombia. In all cases, violence appears as a phenomenon and form of relationship driven by the confluence of disciplinary and *profane* knowledge, which confronts the naturalized notions and relationships that ignore the experience of suffering and promote the standardization and commercialization of the social response in a context of violence.

Another common issue is the incorporation and claim of the communal, an area that has been used in a functionalist manner by preventive mental health and is a privileged space in which mental health is expressed in an integrated and complex manner.

Contexts of enunciation of collective mental health: psychiatric reforms and violence

Both Spain and Brazil experienced difficult moments of military dictatorship in the mid-twentieth century, whose moment of resolution and beginning of democratization occurred at the same time as an important movement for the defense of the rights of "psychiatrized persons." The abuses and ill-treatment experienced by these people in asylums had been denounced throughout the century.

In Spain, democratization implied less social participation than in Brazil, and psychiatric reform was oriented by governmental agencies towards deinstitutionalization and the offering of multidisciplinary mental health services in the community. Only later, *first-person* movements (Correa-Urquiza, 2018) of users of mental health services and their families added their voices to summon, in the last decade, the reflection of alternative experiences to traditional services, and advocate for the rights of people diagnosed with mental disorder, criticize coercive measures and claim more horizontal participatory models of care. They have come to remind us of something that was central to the Brazilian and Italian reforms, but not so much in the Spanish one: that reform should be permanent so as not to recreate processes of manicomialization in community-based mental health care spaces, and that it should be open to the needs of the users. The role of these movements was added to the sensitivity of a group of professionals

who had already played a leading role in the Spanish psychiatric reform (Desviat, 2012) or who later tried to channel this sensitivity through training projects, such as the Postgraduate Course in Collective Mental Health at the Universitat Rovira i Virgili (incipient edition in 2004 with the Porto Alegre Collective Mental Health group), and the creation of spaces for the defense of users' rights (Correa-Urquiza, 2018) and research (Pié-Balaguer; Correa-Urquiza; Martínez-Hernáez, 2021). In the case of Catalonia, the emergence of the notion of "collective mental health" is linked to the close relationship of these researchers with the Brazilian and Argentine mental health professionals, managers, and researchers.

The Brazilian psychiatric reform occurred with greater affinity with the democratic psychiatry of Italy, a movement that demands a historical-critical analysis with respect to society and the way it relates to suffering and difference, in whose context the overcoming of the asylum apparatus is understood "not only as the physical structure of the hospice, but as the set of scientific, social, legislative and legal knowledge and practices that underlie the existence of a place of isolation, segregation and pathologization of human experience" (Amarante, 2016, p. 30, our translation). Another antecedent in the Brazilian experience is consolidated in 1980 with the collective health proposal, which emerged as an epistemological, ethical, and political movement committed to social transformation, against welfare interventions. It was alternative to traditional public health and preventive medicine (Paim; Almeida Filho, 1998), and found greater complexity in the "promotion-health-disease-care" relationship as part of complex and contradictory societies, in specific historical contexts.

For Onocko-Campos and Furtado (2006) the conflict, tensions, and transformations in the field of mental health, associated with the reform of the Brazilian National Health System, should be analyzed in terms of epistemological ruptures whose scope is not only conceptual, but should be evident in practices. For example, in relation to "madness," the authors propose to challenge the principles that consolidate the psychiatric logic, centered on natural sciences; the concept of mental illness, as error, unreason or dangerousness; isolation and the asylum institution as therapeutic resources, and the moral treatment present in normalizing therapies. These reflections challenge mental health in relation to the asylum logic as a central practice both in face of psychiatric diagnoses and other problems associated with life in society.

The case of Colombia is different. On the one hand, it did not experience periods of prolonged dictatorship like Spain and Brazil, but a short period that gave way to an agreement between the traditional political parties for the monopolization of power, undermining social participation and contributing to the origin of armed guerrillas, giving rise to a process of social delegitimization of democracy, with a complex history of violence and armed conflict that was sustained for decades. Added to a historical structural violence, it marks a context that causes suffering for many Colombians. On the other hand, in the health sector a reform to the social security system was carried out in 1993, with an evident mercantile cut, which not only disregarded the strategies of community work, but also relegated to the background the mental care services and care, which only started being resumed around 2005-2007 (Hernández; Sanmartín Rueda, 2018).

In Colombia, one could not strictly speaking speak of a psychiatric reform, since the anti-mental health discourse has not had an institutional or social context that gives it full meaning. What can be found throughout these decades is the positioning of mental health as a field of interest for the victims of armed conflict, a matter that is substantiated in the inclusion of the psychosocial perspective into the Victims Law of 2011. Simultaneously, an approach to mental health begins to be positioned based on social medicine/collective health, in the framework of community experiences, which based on its need to address the suffering associated with social and political violence has developed social practices aimed at the search for peace (Rettberg; Quishpe 2017), many of which constitute mental health care practices. This particularity has allowed an approach from a non-pathological and non-medicalized view of suffering caused by war, and the possibility of health production in relation to peace-building and other social resistance practices.

This brief overview allows us to affirm that, in Brazil and Spain, the term collective mental health

appears closely linked to the debates of their explicit psychiatric reforms, while in Colombia it is related to the achievement of greater understanding of the situations derived from political violence and armed conflict in that country.

Violence in the collective mental health debate

The relationship between mental health and violence can be found in several moments and situations: in the debates after the two World Wars in the 20th century; in the struggle against dictatorships and the claim for freedom and democracy; in the movements against institutions of oppression, including psychiatric hospitals, which would lead Basaglia to name (Basaglia; Ongaro, 1977) the work of intellectuals and technicians in favor of the asylum as *crimes of peace*; and also the forms of relationships that produce systems of inequity and social injustice. All this becomes a struggle against all forms of violence, rooted in the struggles for the defense of human rights.

Cooper (1980 cited in Correa-Urquiza, 2010, p. 171) already stated that: "Violence is at the heart of our problem," i.e., collective mental health resonates with relations of domination, exclusion, expropriation and annulment of people; it is a field that allows itself to be challenged by dynamics of subordination, of imposition of power, which includes both manifestations of physical force as more subtle and symbolic forms of imposing it. Collective mental health then expresses inclusive and libertarian pretensions, which recognize the potential that people have to understand their socio-historical place and act accordingly, as well as to be managers of solidarity support and care.

Derivations and emphasis

In Brazil, as noted above, collective mental health accompanies criticisms of community mental health models that reproduce the psychiatric logics. In Spain, it encourages practices of working with the community to integrate people with psychiatric diagnoses, especially through creative experiences, as is the case of *Radio Nikosia* (Correa-Urquiza, 2010) and other experiences based on dialogicity and narratives or art, which have increasingly opened up to society in general without a declared clinical interest, despite their therapeutic effects. In Colombia, the richness of community initiatives in populations affected by the armed conflict contributes to this alternative by relying on its culture, art, historical memory, and communal link to the land toward the care of life.

These particularities also express a differential place of State participation. In Brazil, these actions are largely led by governmental entities, which means that collective mental health takes on institutionalized forms of deployment and operation. In Spain, there is a mixed collaborative partnership between public institutions and social organizations, although there is a diversity in the different autonomous communities that have competencies in health care, social services, and education. In the case of Catalonia, for example, there is a highly outsourced public network where organizations and foundations operate in the provision of services with very diverse models of care ranging from the most hegemonic biomedical orientations to alternative models, such as the Finnish open dialogue (Seikkula et al., 2006). In Colombia, on the other hand, actions seem to be limited mainly to the interests of social and academic organizations, and to a lesser extent to state proposals.

Brazil, as mentioned above, managed to bring the collective health proposal to its health system, in a post-dictatorship and democratization period, together with a new Constitution, in which mental health took a relevant place. There, collective health and mental health perspectives were combined, finding confluences on the conception of subjectivity and the position in face of human suffering, as well as strategic elements related to a new conception of the expanded clinic and the territorialization of services. The first one refers to a clinic centered on the subject rather than on the disease and on the socioeconomic circumstances of the groups in which health emerges (Silva et al., 2007). The territorialization of services, on the other hand, takes shape in the Psychosocial Care Centers, in which mental health is proposed to produce care beyond psychic suffering, i.e., oriented to the production of life (Ferreira et al., 2016).

Social practices in health are assumed as the scenario in which there is also the production of subjectivity, the resingularization of relationships and the conception of the "mad person" as a social player and political subject of rights, who discusses treatment, institutionalization and participates and interferes in the political field (Torre; Amarante, 2001). Interdisciplinary articulations are promoted (Bedin; Kochenborger Scamparo, 2012) by understanding the health-disease process in its social, cultural, biological, and economic character, among other factors that may affect one's ways of life. One of the achievements in this sense is the process of autonomization that the artistic-cultural field has been gaining in Brazil (Amarante; Torre, 2017), with which psychiatric paradigm is breaking up. Experiences involving art and culture expand the rooms for citizenship and social circulation of subjects with mental distress or psychosocial vulnerability, not based on instrumentalization, but on instances of promotion of their artistic, cultural, and political potential. In Spain, the mental health proposal was also marked by the speeches of demanicomialization, for which networks of mental health care services were created and coordinated with community initiatives. There, the conception of the subject, the relationships between knowledge, an ethical position in face of affliction and suffering were also rethought and, although no planning issue has been found, some productions highlighted the value of culture and art as facilitating elements in the process of creating new identities, beyond the label of psychiatric diagnoses.

Considering the subject with mental suffering, the texts reviewed in the collective mental health perspective propose to link the disease objectified by the disciplines with the subjective experience of affliction, as two fields of analysis that intersect with the material and structural conditions that determine and impact the subject and their disorder (Correa-Urquiza, 2018). Just as in the Brazilian productions, the Spanish production calls for a historical and political subject who actively participates in its recovery.

In the Spanish context, the concept of "laterality" is introduced and gives rise to the definition of collective mental health based on the permeability between diverse knowledges, as a hermeneutics of the relationships between the knowledges that operate in the construction of health and, therefore, is multiple, mutable, dynamic, and political (Martínez-Hernáez; Correa Urquiza, 2017). An example of this permeability of knowledge has been given in projects of the *Guía GAM* (Serrano-Miguel, 2018) for the Autonomous Medication Management, an experience that has been carried out in Canada, Brazil, and Spain, and that starts from the legitimization of the subjective experience of users of mental health services, and the increase of their capacity to negotiate with health personnel concerning the use of medications and other decisions around their treatment.

In Colombia, the articles reviewed show that advances and approaches to collective mental health have been made externally to the institutional and formalized health care systems. Paradoxically, in the framework of a new political Constitution the health system reform represented a setback for mental health in the country (Hernández-Holguín; Sanmartín, 2018), so that communities affected by the armed conflict, political violence, and structural violence have been forced by their social practices to take care of their mental health, often in articulation with their social struggles. Collective mental health appears as a frame of reference that accommodates diverse knowledge and enables creative forms of mental health social production, shaped by the social, historical, economic, and cultural conditions of the communities. In this approach, health-illness overcomes its dichotomous connotation to become "constituent elements of a process that always occurs in society and culture and are, therefore, historical [...] a complex, multidimensional and dialectically determined object" (Ruiz-Eslava, 2009, p. 133, 136).

From these perspectives, primacy is given to the subject and their daily events, their relationships and connections, transcending labels and diagnoses; promoting the voices of the collectives that sustain and incorporate them. Hence, proposals for resistance, claim, and care arise, tied to what gives meaning to life, for example, peasant life: food production and the relationship with the territories in whose experiences, alien to passivity, it is possible

to locate salutogenic processes (Arias, 2016) or the tranquility and stability that represents good living and harmony for indigenous communities (Ruiz-Eslava, 2015). In these approaches, the category "suffering," as opposed to the category "disorder," allows politicizing and historicizing the process of constitution of the subjects (Arias-López, 2013), in accordance with the singularity of the lived experience and the events of everyday life.

Delimitations and clarifications

The notion of *collective mental health* in the three scenarios chosen seems to have epistemological orientations and methodological routes either insinuated or stated, but not clarity in its conceptual elements. For example, the community is a concept that appears in the three cases in an indiscriminate and ambiguous manner giving rise to a problematic node, insofar as it confuses what is named as *collective mental health* and what is named as *community-based mental health.* It should be recalled that, strictly speaking, the latter is a formalized term that names a model of care proposed by the World Health Organization as an alternative to the psychiatric model of care for people with a diagnosis, whose connotation seems to obey more to the legacy of the preventive model and of the North American community health, oriented to the transfer of hospital medical services to the community sphere and not so much to the purpose of democratizing care practices.

Despite its ambiguities, collective mental health has an impact on the project of producing, in a collaborative manner and with all the actors involved, a mental health scenario and life projects that go beyond the aspirations of the model defined as community-based. In this way, it attempts to fill the *gap* between a system of services focused on the cure/mitigation of the disorder, and a demand from users and their families that is very diverse as it includes basic needs, employment, non-discrimination on the basis of diagnosis and the recovery of citizenship rights, among other demands. Collective mental health can be understood as an alternative to the exhaustion of the notion of community mental health for not responding to needs and aspirations that were there; also because of the trivialization of the concept of community and its circumscription to the rhetorical dimension rather than to practices, since a device is not "community" merely for being located in a neighborhood, but for being a model of care that aspires to comprehensiveness and a dialogic relationship with the social groups it assists. The lack of training in social sciences in the sense of collective health on the part of mental health professionals has also been a cause of this exhaustion since they have not been provided with instruments to carry out an ethnographic and situational analysis of the communities where they operate or to incorporate dialogic and participatory models. Hence, the authors from Spain call for a review of the category of the *communitarian*:

> Thus, we observe approaches that are nothing more than a mimicry of the communitarian and that end up semantically suffocating individuals [...]. It is not so much a question of emphasizing the *where* of the communitarian -which is also the case-, but rather the *how* of the conception and articulation of practices and the transformation of relational habits between subjects, experiences and narratives. (Correa-Urquiza, 2018, p. 581, 583)

A core element in this problematization is to understand that in the community perspective the "social bond" is fundamental. It is in this social bond that lies the subject's capacity to establish links with others, allowing life in common (Ardila; Galende, 2011). The community as a bond is related to a project grounded on a set of beliefs, values, attitudes, and feelings shared on a daily basis, which enables *the construction of a "we"* as a political task in contexts of plurality and tensions (Torres Carrillo, 2013).

Final considerations

At this point we can affirm that the approach to *collective mental health* in the three countries has as its starting premise an explicit critique of the hegemonic medical model MMH. To this end, two fields that have occupied marginal epistemological places intersect, such as *mental health*—not psychiatric knowledge—and *collective*

health, in which the political and the ethical appear as axes that cut their theoretical-practical positions. The violence and suffering derived from inequitable, marginal, and precarious contexts are situations that have encouraged researchers from the three countries to seek alternative forms of understanding and care, anchored in the debates on demanicomialization, the defense of human rights and life in dignity.

In this adventure of intersecting the fields in question, the permeability and porosity between diverse knowledge, the recognition of the subject and his experiences, the importance of the context in determining health and the value of daily life and social practices as a scenario for the production of mental health, as a capacity for relationship and production of vital projects, are put as epistemological principles.

A point of conceptual confusion that this review shows is the way in which the notion of *community* and *communitarian* is incorporated. The allusion to community health, community mental health, community services, among others in many of the academic documents reviewed, imposes a challenge to outline their scope and connotations when they are inserted into collective mental health; that not to mention the difference between community and society, which would lead us down more complex paths that we cannot address in this article.

This implies overcoming the instrumental views that reduce the community to a geographical space, to advance the notion of social bond. In other words, the common alludes to the social bond that allows me to link myself with others, while the collective allows us to understand ourselves as part of shared cultural frameworks, and shaped by diverse social determinations that give meaning to the social bond. In short, the collective puts the social bond to work for the common good. The collective, thus, outlines a project and, therefore, a policy more *for* life than (the management) *of* life.

In summary, based on our review, we can affirm that *collective mental health* is a consolidated proposal in Brazil, defended in Spain and emerging/marginal in Colombia, which is presented as an alternative for the understanding, attention, and care of the problems associated with relational life that generates suffering. Although it is necessary to underline the danger in which it finds itself, given the hegemony of a world epistemology that has imposed a geopolitical model of truth and has denied the possibility that, from other knowledge and other (peripheral) territories, there is a discussion about what is already ordered by nosology and clinical protocols, as well as about the ordering (Martínez-Hernáez; Correa-Urquiza, 2017). This is the great challenge for those of us who are oriented towards collective mental health.

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Authors' contributions

Hernández-Holguín worked on the conception and design of the review, the analysis and interpretation of data, and writing the article. Arias López participated in the conception and design of the review, and in writing the article. Martínez Hernáez contributed to the critical review and writing of the final version of the article.

Acknowledgements

This work was developed with financial support from the *Comité para el Desarrollo de la Investigación* (Codi) of the Universidad de Antioquia, strategy for sustainability of research groups; and from Colciencias (Ministry of Science, Technology and Innovation) National Doctorates 647/2014.

Received: 08/17/2021
Approved: 02/28/2023