"Back to the city, Mr. citizen!" — psychiatric reform and social participation: from institutional isolation to the anti-asylum movement

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The asylum model produced the exclusion of madness from social life, adopting the principle of therapeutic isolation, which led to the institutionalization of the person with mental suffering and their removal from the city and the social participation, subtracting from them the right to the city and the condition of citizenship. Currently, psychiatric reform in Brazil is one of the most important processes of criticizing the psychiatrisation of madness, promoting a deconstruction of the forms of social exclusion and the debate in society about the citizenship of the subjects in mental suffering and social vulnerability. Several innovative fronts, including work, art, culture, political activism and occupation of the city, have set new possibilities for life and expression for the people, in a new conception of madness and difference, in which the diversity of individuals have the right to the city and social participation.

Keywords: psychiatric reform; social participation; mental illness; asylum model; mental health.

"De volta à cidade, sr. cidadão!" — reforma psiquiátrica e participação social: do isolamento institucional ao movimento antimanicomial

O modelo manicomial produziu a exclusão da loucura da vida social, fundado no princípio do isolamento terapêutico, que gerou a institucionalização do louco e sua retirada da cidade e do direito à participação social, com a perda do direito à cidade e da condição de cidadania. Atualmente, a reforma psiquiátrica no Brasil é um dos mais importantes processos de crítica à psiquiatrização da loucura, promovendo uma desconstrução das formas de exclusão social da loucura e o debate na sociedade acerca dos direitos e da cidadania dos sujeitos em sofrimento mental e vulnerabilidade social. Diversas frentes inovadoras, de inclusão pelo trabalho, pela arte-cultura, pela militância política e de ocupação da cidade, têm configurado novas possibilidades de vida e expressão para os sujeitos, numa nova concepção sobre a loucura e a diferença, na qual os sujeitos da diversidade têm direito à cidade e à participação social.

Palavras-chave: reforma psiquiátrica; participação social; loucura; modelo manicomial; saúde mental.

"De vuelta a la ciudad, el sr. ciudadano" — reforma psiquiátrica y participación social: del aislamiento institucional al movimiento antimanicomial

El modelo de asilo produjo la exclusión de la locura de la vida social, fundado en el principio de aislamiento terapéutico, lo que llevó a la institucionalización de los locos y su retirada de la ciudad y la participación social, la pérdida del derecho a la ciudad y la ciudadanía. Actualmente, la reforma psiquiátrica en Brasil es uno de los procesos críticos más importantes para psiquiatrización de la locura, la promoción de una deconstrucción de las formas de exclusión social de la locura y el debate en la sociedad sobre la ciudadanía de las personas en la angustia mental y la vulnerabilidad. Varios frentes innovadores, la integración a través del trabajo, el arte, la cultura, el activismo político y la ocupación de la ciudad, han creado nuevas posibilidades de vida y expresión al sujeto, una nueva concepción de la locura y la diferencia en el cual los sujetos de la diversidad tienen derecho a la ciudad y la participación social.

Palabras clave: reforma psiquiátrica; participación social; locura; modelo de asilo; salud mental.

1. INTRODUCTION: PUBLIC POLICIES IN MENTAL HEALTH, MADNESS AND THE CITY: FROM INSTITUTIONAL ISOLATION IN THE ASYLUM TO SOCIAL PARTICIPATION AND INTERVENTION IN CULTURE

In the past decades, the psychiatric reform process in Brazil has been one of the most important mental health and inclusion of difference policies worldwide. It may also be considered among the most important human rights defense movements in the country, with transformations in the ways of madness care and treatment and in the forms of social and political participation of subjects in mental suffering (Amarante, 2015a, 2015c, 2011; Lancetti, 2000; Lancetti and Amarante, 2012; Pinheiro et al., 2007; Fontes and Fonte, 2010; Campos and Henriques, 1997; Bezerra Junior and Amarante, 1992; Desviat, 2015; Amarante and Costa, 2012).

This process occurs by means of various strategies and mechanisms of dismantlement of the psychiatric asylum model, as well as by means of a variety of experiences and activism collectives that have produced new discourses and practices on madness and diversity, composing a new scenario regarding the historical mad person's exclusion from the city's life.

The asylum model, founded at the end of the 18th century, had isolation as one of its fundaments. This produced the effect of removing the mad from the city, from work, leisure, family, culture, and social life. Pinel's founding act when inaugurating the first asylum for mentally alienated persons in 1793 created a new branch of medicine: mental medicine or alienism. The "therapeutic isolation" was one of the principles of the Pinelian technology (Castel, 1978), which sought the cure for mental alienation. From it derives the idea that the privileged place for madness is the asylum, and that reclusion plays the role of protection to the mad individual and society. A double process of isolation arises with the development of the knowledges of mental medicine (which unfold in the psychiatric clinical practice) and asylum institutions: "isolate to know" and "isolate to treat".

The principle of isolation, through the definition of mental medicine or alienism, is constituted of two strength lines: first, the direct influence of the Botanical method (as proposed by Pinel), by means of the use of a classificatory and nosographic language of diagnostic typologies. This classificatory language, which is present both in medicine and psychiatry and "makes one see" illness and mental illness from the viewpoint of a certain interpretation of the experience of suffering and falling ill made by modern medical and psychiatric discourses, was constituted and developed from the notion of the "clinical practice" (Foucault, 1987). When arising in the modern age as scientific truth discourses, both medical and psychiatric clinical practice depended on the isolation of illness and its observation in the hospital setting. Secondly, the madness isolation principle was also constituted from the idea of the need to isolate the object of knowledge to carry out scientific experimentation and verification. Therefore, it is inherited from the model of scientific rationality of natural sciences — the model of the laboratory, experimental control, production of evidence through foreseeability and reproducibility (Santos, 2000).

On the other hand, more recently, the innovations of the psychiatric reform with the social inclusion of madness and difference in the fields of the right to work, the right to culture, and the right to the city have been remarkable and unique, interrupting the historical segregation of the mad carried out through institutions and the founding knowledges of psychiatry and asylum practices.

In other words, in recent decades the psychiatric reform process in Brazil has produced a deep criticism of the psychiatric paradigm and engendered various processes of asylum dismantlement (with

the substitution of the asylum for networks of mental health services, and mechanisms and strategies of psychosocial care); it has also been promoting citizenship and the creation of innovative ways of social inclusion of subjects in mental suffering. To be highlighted are the inclusion through work (e.g., solidarity economy and social cooperativism, income generation projects and entrepreneurship in the field of mental health); and the inclusion through art and culture (e.g., artistic and cultural projects and groups of the psychiatric reform, in various artistical languages, like music, theatre, cinema and video, painting, carnival groups, among others).

Finally, great importance should be given to the occupation of the city and the intervention in the social imaginary, by means of multiple events, public acts, demonstrations, mobilizations, and the debate in society on violence in psychiatric hospitals and on social rights and citizenship of persons in mental suffering. In a broader sense, the activism of the anti-asylum movement, during the past 30 years, represents a historical change in discourses and practices on madness, turning the psychiatric reform into one of the most important movements of politization and demand for rights and in defense of the right to the city.

2. THE ASYLUM MODEL AND THE PRINCIPLE OF THERAPEUTIC ISOLATION: ALIENISM, PSYCHIATRY AND THE INSTITUTIONALIZATION OF MADNESS — MADNESS IS REMOVED FROM THE CITY AND SOCIAL LIFE

The concepts of mental alienation and later mental illness where construed drawing on an individual and collective experience on madness, originating from the process of constitution of the asylum and mental medicine, in which madness is captured by the medical discourse. In the classical age, madness was polymorphic and, to a great extent, free in the social environment; it was only in the modern era that the systematic medical-hospital internment becomes a fundament to deal with the mad and the different (Foucault, 1978, 1975). As a consequence, there is the removal of madness from the city and the horizon of social conviviality. Madness is excluded from the possibility of participation in the social pact, in social relations, thus establishing a kind of social death for the subjects considered as alienated of mentally ill.

In other words, it is the asylum as the new institution for the mad, a sort of privileged laboratory for experimentation and a true "hothouse" for observation of the new object of knowledge ("mental alienation"), that enables the birth and the development of a science of madness, initially named mental medicine, and later psychiatric clinical practice.

The confinement of madness in the asylum and its submission as an object of intervention of alienism produces a new experience of madness, captured by the medical discourse, which in a strategic manner construes the notion of madness as an error and absence of sense, disorder of reason and loss of moral discernment, and absence of psychic health. Alienation is understood as a disorder of human passions, which incapacitates the subject to share the social pact. The alienated is the individual who is out of his/her wits, out of reality, whose possibility of discernment is altered; unable to discern, incapable of the truth, and therefore dangerous to him/herself and to others. Hence the understanding that every mentally ill person must be potentially "protected" through the destitution of rights and freedom, autonomy and right to choose, and decision about his/her own life — this entire process is intermediated by the concept of mental alienation, which is created drawing on the constitution of the binomial asylum-alienism, i.e., the asylum internment and the conceptual capture as fundaments of the exclusion of madness.

Pinel's Moral Treatment, in its turn, aims at a moral re-education that corrects the disorder of passions; the alienist becomes the "master of madness" capable of submitting the mad's delirium and irrational will to his straight will, to return to reason (Foucault, 1997). The asylum becomes the place of the pedagogical-disciplinary process that enables recovering reason and attaining cure, and consequently would allow the alienated to become again a subject of rights and a citizen, i.e., to be free to the extent that he/she is capable of choosing, desiring and deciding, which are impossible attributes for someone who is alienated. The exclusion of the alienated, in this logic, is not a violence against his/her rights, but rather a therapeutic measure; and it does not mean a loss of rights, but rather the right to treatment.

The institutionalization of madness becomes a general rule and a universal principle, and isolation becomes a pre-condition to seek cure from mental alienation. The concept of "therapeutic isolation" is constituted on the base of two fundamental points: first, the principle of the hospital as the place of exam, in the sense of "isolate to know" — isolation is a condition for investigation and explanation of the causes and types of mental alienation. It is about seeking classification as the fundament of the explanation of phenomena; the nosographic and classificatory language, both in botany and alienism, would be one of the method's fundaments. Second, it is necessary to "isolate to treat", in the sense that the institution keeps away the malefic, morbific influences that cause and aggravate alienation — therefore, the asylum institution is an instrument of cure.

In the immediate post-French Revolution context, when Pinel initiates the transformation of Bicêtre hospital, in 1793, he fundaments the imperative need of institutionalization in his speech of inauguration of the first asylum for mental alienates in modern history:

> In general, it is so pleasant for an ill person to be within the family and receive care and consolation from a tender and indulgent friendship, that I painfully enunciate a sad truth, but verified in repeated experience, which is that of the utter necessity to entrust the alienates to foreign hands and isolate them from their relatives. [Pinel apud Castel, 1978:86]

Isolation, as a theoretical principle and institutional act, provides for a method, similar to the *in vitro* condition, keeps away the malefic influences and contamination. This method enables "to see" in a different way the mad figure (produces a new visibility on madness, which is then seen as mental alienation), and produces ways of understanding madness according to the belief on the treatment as regulation of disorder, by means of discipline, and as a return to reason ("to bend the alienated to reason"), a kind of orthopedics of the soul drawing on the model of the correctional institution.

> The asylum, through therapeutic isolation, enables both the possibility of cure and the knowledge of madness. Isolation is an act at the same time therapeutic (moral treatment and cure), epistemological (act of knowledge) and social (dangerously mad, irrational subject). [...] The concept of "mental alienation" produces a social place for the mad, excluded from the social pact, the place of the subject of unreason or the absence of subject — absence of the rational subject, civically and legally responsible — a delirious subject without citizenship, who stops being a social actor to become an object of alienism. [Torre and Amarante, 2001:75]

The alienated subject is lost in thoughts, a stranger to him/herself, and the asylum is the instrument of re-education of the alienated, by means of the Moral Treatment and practices that constitute what Robert Castel (1978:85) named "Pinelian Technology", in which isolation was one of the central strategies for the elaboration of the concept of mental alienation, that produces the mad person as the subject of error. This historical process renders possible the construe of the concept of an alienated, unruled subjectivity, at the same time that the institution becomes the place of treatment, and institutionalization becomes a necessity.

Isolation as a scientific principle relates to removing the investigation objects from their chaotic settings and removing the interferences of the natural environment, transporting them to the aseptic environment of the laboratory, which places a fundamental epistemic problem: the conception of studying the mental disease by isolating the mad, by investigating inside the hospital. This principle is founded on the idea that to treat it is necessary to know, and to know it is crucial to remove whatever external influences. The observation *in vitro* removes the bad influences, enables the division into types for the constitution of a space of knowledge.

Regarding the field of psychiatry and mental health, the reflection made is that the observation *in vitro* transforms the "nature" of the disease and that the experience of institutionalization alters the experience of "alienation" or mental suffering. The processes of de-subjectivation, de-historicization, and loss of networks of relationships, which result from the institutionalization of subjects who suffer, constitute an actual machine of de-figuration of the subjectivity and possibilities of expression and sensibility, in a way that behaviors and symptoms that derive from the "mental disease" or from the psychiatric crisis that leads to internment no longer originate; rather, there are the effects of institutionalization, through the "mortification of the self" (Goffman, 1978) and the destruction of subjectivity, engendering what Franco Basaglia named the "double in mental disease" (Basaglia, 2005). This puts into question medical observation's naturalism and leads one to a deep criticism about what psychiatry understands as effects of the "chronicity" of mental disease's nature, in the sense that these effects are largely produced by institutionalization. For psychiatric knowledge, though, the subject's degeneration or deterioration is caused by the mental disease, with no connection with the institutional relationship established between madness and the mad person!

> Mental disease conceived from the naturalist perspective is the notion that provides the fundamental support for psychiatric practice, power and knowledge. The History of madness demonstrates the history of madness in the asylum and its medicalization and pathologizing, and its transformation into mental disease: Our society does not wish to recognize itself in the ill person whom it persecutes or confines (Foucault, 1975). It is through this operation that a psychiatry of madness is made possible. [Torre and Amarante, 2001:78]

In its turn, *medicalization* transforms the social place of the mad. It is not restricted to being captured by medical observation and practice on the mad.

> The 'medicalization' does not mean, in fact, only the confiscation of madness by medical observation. It implies the definition, through the medical institution, of a new juridical, social and civil status of the mad: the *alienated*, fixed by law in the year 1838, for over a century, in a state of social minority. [Castel, 1978:55]

3. PSYCHIATRIC REFORM AS DE-CONSTRUCTION OF THE ASYLUM MODEL: THE CITY AS AN INFINITE PLACE OF SOCIAL EXCHANGE — RETURNING MADNESS TO THE CITY

If the removal of madness from city life and the horizon of social conviviality, and the separation of subjects considered mad by placing them in secluded treatment institutions, originates from the Pinelian version of the "therapeutic isolation" principle, which is incorporated in the perspective of the traditional psychiatric clinic, then the dismantlement of this fundament lies at the center of the de-institutionalization work in the field of mental health and the psychiatric reform processes. Hence the importance of forging a new concept of mental suffering drawing on the questioning of the concept of mental disease or derangement that does not reduce it to the medical, psychiatric, psychological or sanitary "therapeutics".

In synthesis, the dismantlement of the asylum begins with the closure of asylum structures, follows with the construction of new concepts, practices, spaces of care and new ways of dealing with madness, and reaches its broader range with the struggle for a new culture and a new way of seeing and caring for madness and difference in the city. The cure becomes the action of producing subjectivity, sociability — changing the subjects' stories, which then begins to change the history of the disease: "The process of de-institutionalization becomes the re-construction of the object's complexity. The emphasis is no longer on the process of 'cure', but rather on the project of 'invention of health' and 'the patient's social reproduction' […]" (Rotelli et al., 1990:30).

The place of "cure" and "rehabilitation" is no longer the treatment institution or the healthcare service, although public assistance at open services is crucial for the change in the ways of caring and strengthening of mechanisms and strategies of psychosocial care. The city is the place of emancipation and autonomy, understood as dynamic realities to be constructed; the possible social relations take place in the city, in spaces of collective conviviality, spaces of social participation, in different social groups, and in the search of integral care and access to public policies. In other words, to promote the right to leisure and work, the right to culture, the spaces of militancy, the right to health, education, housing, nutrition, social mobility, and to a sustainable city with broader equity for the subjects in their diversity.

The traditional concept of cure gives place to a complex conception of the subjects in which the psychopathological diagnosis is insufficient for the construction of concrete possibilities of life. The "cure" is then understood in the sense of emancipation, autonomy and active citizenship, transforming and broadening the very notion of the "therapeutic act", previously tied to the reductionism of the medical-psychiatric perspective, now centered on the de-construction of the tutelage relationship and the place of object that captures the possibility of being a subject. The therapeutic emancipation becomes the substitute objective of the "cure" (Rotelli et al., 1990:31).

The psychiatric mechanism operates in disseminated spaces, but its practice is *par excellence* in the asylum. In the asylum, sociability is reduced to zero. This is one of the central issues in the process of criticism of the asylum institution and the de-construction of the psychiatric paradigm:

> Governability had psychiatry among its management instruments of disorder and misery. *The asylum is: the place of zero exchange.* Tutelage, internment has this one only purpose: subtraction of exchanges, establishment of relationships of mere personal dependence (Rotelli, 1990:61). […] the problem is not the cure (productive life) but the production of life, sense, sociability, use of forms (of collective spaces) of disperse conviviality. [Rotelli et al., 1990:30]

The concept of autonomy becomes a key concept to rethink the objectives and the very concept of psychiatric reform; the construction of autonomy transcends the access to sanitary services and healthcare policies, developing into the production of life in coordination with formal and informal social support networks, spaces of conviviality, work, culture and art, as well as the access to public policies and citizenship rights. Secondly, State delivery of social protection or assistance policies is not sufficient for the promotion of citizenship and autonomy to subjects who are excluded or in social disadvantage — it is also crucial that social movements take part in negotiation spaces and in the construction of social agendas. Autonomy is not produced only by means of official normative or institutional channels; it is promoted when social actors and activism movements become protagonists capable of ensuring an appropriation of mechanisms and strategies in the construction of rights and political and social participation.

Thus, one can understand that the innovations under way in Brazil in psychiatric reform are utterly important to rethink the institutionalization of the Unified Health System (SUS) regarding the criticisms to its bureaucratization or reduction to a government model. The fundament of social and community participation, as one of the democratic fundaments of the country's healthcare system, is central to any universalistic and inclusive healthcare policy that seeks struggling against the technification and the verticalization of power. In other words, this means that the discussions about the occupation of the city and social participation in mental health policies, and the innovative experiences under development in recent years in the processes of psychiatric reform and social inclusion of persons in mental suffering, have a huge potential to contribute to the strengthening of the dialogue between health policies and social movements. This contribution is also in direction that the field of healthcare seeks intersectoral coordination, which is crucial for the inclusion of subjects of diversity and the production of equity and citizenship in a broader perspective of healthcare. These are significant contributions from the anti-asylum movement for a more extensive action in collective health policies, thus overcoming the mere assistentialism and the individual and medicalizing biomedical view.

If the asylum is the place of zero social exchanges, the city is the place of infinite social exchanges, and this is one of the crucial issues at stake in the various innovations in the psychiatric reform in Brazil, especially in the innovative forms of social and cultural inclusion that are under construction in the processes of transformation in the field of mental health in the recent decades.

4. PSYCHIATRIC REFORM AND OCCUPYING THE CITY: PRODUCTION OF LIFE, AUTONOMY AND SOCIAL PARTICIPATION

In the field of mental health, the Psychiatric Reform has been using references that come close to this new approach on health and public policies, expressed in the criticism of the curative hospital-centered model and in the idea of social production of health and coordination with the territory and culture (Biehl, 2011; Yasui, 2010; Amarante et al., 2012; Melo and Ferreira, 2011; Pinho et al., 2014; Santiago and Yasui, 2015; Lima et al., 2013). This is expressed in the political character of the Psychiatric Reform and the need to substitute the cure of mental disease for the production of health in individuals with a different psychic experience, which is then identified with the "invention of health" (Rotelli et al., 1990) and the production of life, beyond the symptom remission or harm repair, and beyond the focus on the disease (Amarante and Torre, 2017; Whitaker, 2017; Venturini, 2016).

The production of health is not centered on the sanitary or psychiatric institution, nor only on the multidisciplinary teams; it depends on getting to know the living forces in a region, organizations and institutions in the neighborhood, beyond the city's administrative division; overcoming the logic of assistentialism towards an action on the territory, mobilization of communitarian forces and its living resources: "Re-center psychiatry in the city does not mean the (more or less) artificial implementation of extra-hospital equipment and teams, but rather re-invent it while developing other social practices with the direct help of the concerned populations" (Guattari, 1992:195).

The production of health and the construction of life projects are centered on the re-inscription of madness in the city, i.e., the insertion of the "user" of mental health services in the city's life and his/her social reproduction. Overcoming the asylum is the process of constructing structures and policies that make feasible the "invention of health"; in this sense it becomes clear that it is not something ready nor static, that there is an uncertainty implied in "leaving the asylum", because there opens a field of uncertain and contradictory possibilities, difficult and new.

A central issue becomes the differentiation between the concepts of "de-hospitalization" and "de-institutionalization", related to the processes of asylum opening and psychiatric reform (Amarante, 1996; Basaglia, 2005a; Rotelli, 1994; Venturini, 2010; Rotelli et al., 2001; Goulart and Durães, 2010; Guljor, 2013; Alverga and Dimenstein, 2006; Amorim and Dimenstein, 2009a, 2009b; Bandeira, 1990; Barros, 1990; Liberato and Dimenstein, 2013). "De-hospitalization", in a broad sense, may even refer to the removal of patients from dwelling in a hospital environment and the re-insertion in a residence and in community spaces. However, with the concept of "de-institutionalization" it is possible to imply the de-construction of the founding concepts and knowledge of the psychiatric paradigm, seeking the transformation of the *social place* of madness and difference. This conceptual key issue enables a critical view on the experiences of psychiatric reform in the post-war period, in the sense that some were limited to the introduction of sanitary and assistance technologies but had no effects on the fundaments of psychiatry. In this aspect, these experiences were different from, e.g., on the one hand, those in the French Psychiatry Sector and especially in the North-American Preventive Psychiatry; on the other hand, those of the Italian Democratic Psychiatry and of Anti-psychiatry. In the same way, in the field of Collective Health, the criticism of the traditional biomedical paradigm is crucial for the politization of interventions on SUS and the creation of actually inclusive health policies. Hence, the necessary differentiation also between popular participation and social control in SUS, on the one hand, and the mere introduction of re-ordinations of the assistance model in a bureaucratic and technifying sense, without promoting power horizontality and community strengthening, on the other hand.

In so far as de-institutionalization is not taken as de-construction of the psychiatric mechanism and paradigm, there is a strong possibility of producing the management of madness in sanitary services that do not develop the cultural work, i.e., one ends the "institutions of violence" to create "institutions of tolerance". It is the up-dating or metamorphosis of asylum practices, having the appearance of new, "cutting-edge" technologies, which then take place no longer in the asylums and traditional asylum-like macro-institutions, but in the "open" and "territorial" services.

There is a constant risk of reducing the psychiatric reform to a re-organization of sanitary services and, therefore, get out of the asylum and continue to reproduce the mechanisms of the psychiatric

device, an operation that Castel (1978) named *aggiornamento*, the re-edition of old models made-up as "new", maintaining the same places of knowledge and power and bureaucratic operational rules and with little or no participation of the subjects: "[…] Agile psychiatric equipment may be created in the urban fabric without, nonetheless, working on the social field. Old segregational structures are simply miniaturized and, nevertheless, they are interiorized" (Guattari, 1992:195).

The mere opening of the psychiatric hospital is not sufficient to "abate the sickness of the walls"; it is necessary to invent new strategies, re-encountering the city as a space of social habilitation or re-habilitation, which ceases to be a more advanced service or technique. For Basaglia, the best places or forms for re-habilitation are the city's spaces (Amarante, 1996:102). The purpose of de-institutionalization becomes, thus, to control the psychiatric internment circuit and to weave the relationships of individuals, previously institutionalized, with the city's life and activities. The history of this process may then be reported not so much from juridical, institutional, and technical acts, but from the story of many lives that are transformed, "sick" who are transformed into persons. Re-center the place of health within the city is the path that leads from the asylum "zero place" of social exchanges to the external multiplicity of social relationships. Instead of asylum structures, there should be the emergence of spaces for productive cultural and economic activities, taking part in the city's active life. The example of the Italian city of Trieste is representative of this process, with the opening of the asylum complex to the city's life, being transformed into a public park comprising also cooperatives, workshops, bar and restaurant, volunteers and students accomodation, and a mental health research center (Dias Barros, 1994; Rotelli, 2000; Rotelli and Amarante, 1992; Amarante, 1996; Dell'Acqua, 2014).

5. "BACK TO THE CITY, MR. CITIZEN!": THE CULTURAL ANTI-ASYLUM MOVEMENT AS TRANSFORMATION PROCESS OF THE SOCIAL PLACE OF MADNESS — MADNESS OCCUPIES THE CITY

The de-construction of social exclusion of madness and "desires of asylum" (Pelbart, 1986) is a complex social problem of dismantlement of the psychiatric mechanism, which does not intend to be an ideal model. Therefore, it is endless and should be continuously reinvented in search of the production of life and forms of social reproduction for the subjects who have been deprived of the right to the city and to freedom, which leads to the reconstruction of life and recovery of the condition of being citizens and subjects of rights. Thus, it also leads to redefining the place of the subject of difference in society, beyond the psychiatric diagnosis, with enormous potential in the redefinition of what the city is and in rethinking the relation of the city with public policies.

The collective construction of protagonism requires leaving the condition of "user-object" and creating actual forms to produce an "actor-object", a political subject. This has been happening by means of initiatives to reinvent citizenship, such as: associations of users and relatives; social cooperatives and groups of solidary economy; art and culture projects; meetings and events of the anti-asylum movement; participation in forums to formulate healthcare policies and councils; and many other ways of promoting human rights and cultural diversity in the process of transforming the social place of madness, which goes beyond the de-construction of institutionalization practices of the mad.

A new vision of the city arising from the cultural movement of psychiatric reform is being shaped through public acts and demonstrations, cultural interventions and dissemination of debates and polemics in society. In the words of the poet Paulo Mendes Campos, "Back to the city, Mr. citizen!".

One first aspect of the issue of the relationship between citizenship and culture is that in social and human sciences some critical authors, who discuss the problem of cultural rights and contribute to a reflection on *cultural citizenship* (Souza, 2012; Yúdice, 2004; Chauí, 1995; Santos and Chauí, 2013), point that the feeling of belonging to a culture or a community is a crucial condition for the existence of active subjects, capable of participating in the expression channels and sharing mechanisms of social reproduction (Souza, 2012:185).

Another issue regards cultural colonization, through the imposition of hegemonic cultural models on different cultures and social groups having cultural diversity and being considered minorities. In this sense, culture becomes an instrument of resistance when the subjects and social groups question the large information channels of the mass media and strive to express their own thoughts and world views, besides struggling for the preservation of their cultural heritage, memory and values, as in traditional communities and ethnical groups.

Hence the understanding that it is crucial to disseminate instruments and resources aiming at the defense of cultural diversity and the recognition of differences. Without the right to cultural diversity there is no concrete possibility to exercise cultural citizenship; it is then captured by mechanisms of the "cultural industry" market or by mechanisms of cultural imposition and operating modes of colonization paradigms. One example of legitimation of the right to cultural diversity in Brazil was the country's ratification of the "Convention on the Protection and Promotion of the Diversity of Cultural Expressions" (Unesco, 2006).

One of the most significant cultural policies in recent years was achieved by means of the Programs "Cultura Viva" [Living Culture] e "Pontos de Cultura" [Spots of Culture], of the Ministry of Culture. These programs enhanced the production and traditions of subjects of diversity, in a vision of culture as collective public heritage beyond the entertainment market or the large official channels of cultural expression (of 'celebrities' and 'mainstream' media). Hence the subjects of diversity could have their culture recognized and valorized, and hundreds of groups and cultural expressions became Spots of Culture within the immense cultural diversity present in the country. One of the groups of the diversity that became recognized by cultural policies was that of people in mental suffering.

In 2007, by means of the Project "Loucos pela Diversidade" [Crazy for Diversity] (Amarante et al., 2008), created from a covenant between the Ministry of Health and the Ministry of Culture (MinC), through Fiocruz (Oswaldo Cruz Foundation), took place the event named "*Oficina Nacional de Indicação de Políticas Públicas Culturais para pessoas em sofrimento mental e risco psicossocial*" [National Workshop for the Indication of Public Cultural Policies for people in mental suffering and psychosocial risk]. The aim was the construction of a participative agenda, with artists, researchers and activists of the anti-asylum movement throughout the country; it represented a huge innovation for the mental health field. For the first time, the actors of the psychiatric reform, researchers, and founders and protagonists of artistic-cultural projects and experiences of inclusion through culture, took part in a process of formulation of proposals and a guidance agenda to elaborate cultural policies for people in mental suffering. In 2009, there was a cultural contest — "Concurso Prêmio Cultural Loucos pela Diversidade — edição Austregésilo Carrano" [Cultural Prize Contest Crazy for Diversity], with over 400 applications from all over Brazil; different categories of prizes went out to important cultural groups and artists.

In this way, art-culture has been a potent instrument to rethink the social place of madness and difference, and its insertion in the city and in democracy. Hence the importance of artistic-cultural experiences and public acts and cultural interventions as ways of occupying the city and returning to

the city those subjects considered as "different", who were excluded for not fitting the socially accepted normality pattern. The return to the city has been made possible thanks to innumerous events and productions, which have provided people in mental suffering spaces for expression, conviviality and social circulation; ultimately, those spaces have enabled this new process of madness occupying the city with significant protagonism and creativity.

An equally instigating and rich universe of cultural production has been gaining visibility in different artistic expressions, such as music, theatre, painting, literature, radio, TV and audiovisual languages, handicraft and fashion, carnival groups, among others. Several artistic-cultural experiences can be highlighted in the Brazilian psychiatric reform to illustrate the multiplicity of the socio-cultural production of the anti-asylum cultural movement as a significant and innovative field of practices and knowledge for changes in the social relationship of madness with society. Most groups have humorous names referring to the mental condition and the artistic-cultural expression, with difficult translation. In music, projects as "Harmonia Enlouquece" (Harmony Goes Crazy), "Grupo de Ações Poéticas Sistema Nervoso Alterado" (Group of Poetic Actions Altered Nervous System), "Devotos de São Doidão" (Devotees of Big Mad Saint), "Trem Tan Tan" (Tan Tan Train) with the artist Babilak Bah, "Coral Cênico Cidadãos Cantantes" (Scenic Choir Singing Citizens), "Mágicos do Som" (Sound Magicians), "Cancioneiros do IPUB" (Troubadours of the Psychiatric Institute), "Grupo de Hip Hop Black Confusion" (Black Confusion Hip Hop Group), "Zé do Poço and Sarieiro" (musical duo), "Heterogênese Urbana" (Urban Heterogenesis), among many others. In theatre, the groups "Companhia Teatral Ueinzz" (Ueinzz Theater Company), "Trupe Maluko Beleza" (Beauty Wacky Troupe), "Grupo de Teatro do Oprimido - Pirei na Cenna" (Theater of the Opressed - Crazy in the Scene), "Companhia de Teatro Os Nômades" (Theater Company The Nomads), "Companhia Teatral Nau da Liberdade" (Theater Company Freedom Ship), among others. In the field of radio and TV, "Rádio Tam Tam" and "TV Tam Tam" (Tam Tam Radio and Tam Tam TV), "TV Pinel" (Nutty TV), "TV Sã" (Lucid TV or Healthy TV), "Rede Parabolinóica" (Parabolinoiac Net, a neologism with parabolic plus paranoiac), "Rádio Cala a Boca Já Morreu" (Radio Shut Up Already Died), "Rádio Antena Virada" (Radio Disturbed Antenna), "Rádio Web Delírio Coletivo" (Collective Delirium Web Radio), "Rádio Maluco Beleza" (Beauty Wacky Radio), and many others. Finally, the creative Carnival groups: "Bloco Carnavalesco Loucura Suburbana" (Carnival Block Suburban Madness); "Bloco Tá Pirando, Pirado, Pirou" (Block Going Crazy, Mad, Got Mad); "Bloco Maluco Sonhador" (Dreamy Crazy Block); "Bloco Tremendo nos Nervos" (Block Shaking in the Nerves); "Bloco Conspirados" (Crazy Conspiracy Block); "Cordão BiBiTanTã" (BiBiTanTã Cord); "Ala Loucos pela X" (Sector Crazy by the X); and "Loko Motiva" ("LocoMotivate", locomotive + motivate).

These are experiences with great potency for social inclusion and also critical reflection for civil society; they enable the emergence of a new scenario for reconquering the right to the city and to social participation (Siqueira-Silva et al., 2012; Amarante et al., 2012; Amarante and Costa, 2012; Amarante and Nocam, 2012; Melo and Ferreira, 2011; Thomazoni and Fonseca, 2011; Pelbart, 1998; Lima, 2009; Lima and Pelbart, 2007; Amarante, 2015b).

Besides all the artistic experiences and cultural groups, there is another dimension in this process that might be especially transforming, with enormous extent, and social and political representativity, which comprehends public demonstrations, scientific and cultural events, meetings of activists, other spaces of intervention in the city, forums of debates, and social movements organization.

One of the marks of this dimension of activism and cultural intervention was the 2nd International Forum of Collective Health, Mental Health and Human Rights, held in Rio de Janeiro in 2008. The event took place at the University of the State of Rio de Janeiro (Uerj). There were many debates and conferences, with important names from scientific, academic and technical fields, but also with the participation of users, relatives and artists, besides cultural performances. The highlight occurred on Sunday morning at the closure of the event, with a public parade at Copacabana beach, with the presence of hundreds of professionals, relatives, users of mental health services, people from the communities and artists. It was a large demonstration on a sunny day on one of the most famous shores in Brazil, when many people were strolling and enjoying the beach. There was music playing compositions of the anti-asylum movement (and others), with the presence of the percussion and other sectors of a famous Samba School (Escola de Samba Caprichosos de Pilares). Anti-asylum participants were using carnival costumes, T-shirts with sayings referring to the movement and also singing, with a multitude of people gaining the streets and being visible in the urban space. It was a significant intervention named "Theatre-Procession", proposed by Centro do Teatro do Oprimido [Center for the Theatre of the Oppressed], in Rio de Janeiro. It emblematically synthesized the public demonstrations that have been taking place throughout the country for many years, with social visibility and political significance. One example is the celebration of the Dia Nacional da Luta Antimanicomial [National Day of Anti-asylum Struggle], held every 18th May for the past three decades; there are large open parades in the streets of cities throughout the country and other events with large participation, public debates and the publicizing of the anti-asylum movement.

Another fundamental dimension of the activism that is a mark of the psychiatric reform process and the anti-asylum movement in Brazil is the political participation, in which innumerous events take place with broad participation of the subjects in mental suffering and the actors of the psychiatric reform. The highlights among these events were the following: four Conferências Nacionais de Saúde Mental [National Conferences on Mental Health] (1987, 1992, 2001, 2010); and fourteen Encontros Nacionais da Luta Antimanicomial [National Encounters of the Anti-asylum Struggle] (between 1993 and 2014). During this period, many associations of users and relatives, and work cooperatives were created and currently exist, promoting spaces of work, conviviality, re-signification of life and social inclusion, and breaking prejudices and stigmas. Also, worthy of being stressed, there was the movement "Fora Valencius" [Away with Valencius], which in 2015-2016 repudiated the nomination as national coordinator of mental health of a known defender of the asylum model. This movement represented an enormous capacity of struggle and resistance, with the occupation of the head-office of the National Coordination of Mental Health of the Ministry of Health, in Brasília, for over one month, with caravans of coaches with anti-asylum activists from several parts of the country.

Equally essential are the many posters, T-shirts, banners, images and all types of iconographic material, produced and publicized during almost 40 years of activism, in forums, seminars, meetings, congresses, solidarity fairs, public demonstrations, parliament sessions, national conferences on health and mental health, and other spaces, in which the movement's actors have had an expressive activism. This relates to the unique characteristics of the Brazilian process in comparison with other processes of psychiatric reform worldwide, demonstrating a meaningful political participation and critical stand, with mottos such as [in free translation]: "From near no one is normal"; "Locking is not treating"; "Health is not to be sold, Madness is not to be held"; "People are meant to glitter"; "Freedom even if Tam Tam"; "Asylum never again"; among many others. One of the most important is the motto "For a Society without Asylums", that marks the beginning of a phase of broadening of the range of the

movement, which in 1987 changes the name from Movimento de Trabalhadores de Saúde Mental [Movement of Mental Health Workers] to become Movimento da Luta Antimanicomial [Movement of the Anti-Asylum Struggle]. All this iconography and activism production is certainly crucial to broaden the visibility of the psychiatric reform process in the past decades and it should be part of the documental collection of the history of the mental health field.

Also important are the art exhibits, launching of books, poetry, music and multiple events, such as the Madness Festival in Barbacena (one of the largest asylum towns in the history of psychiatry in Brazil); itinerant performances of the project "Crazy for Music" (with well-known Brazilian artists and opening shows by artists and groups of the anti-asylum movement); and historic shows like the project "Sing Madness" at Estação das Barcas da Cantareira, in Niterói/RJ. Other events to be highlighted were the Festival of Diversity of IPUB/RJ; the event "Loucura e Cultura" [Madness and Culture], with a seminar and an exhibition, held in 2005 in Rio de Janeiro, at Centro Cultural Banco do Brasil (CCBB), one of the most important cultural institutions in the country. Finally, in 2010, the "Festival da Independência da Cultura" [Festival of Culture Independence], on the National Independence Day, celebrated on September 7th, held at Arcos da Lapa, in downtown Rio de Janeiro, with cultural diversity groups from all over the country, as indigenous, *quilombolas*, traditional groups and artists of the anti-asylum movement, among others, with a large musical show and dance performances.

Other important events were the congresses and forums of Abrasme, the Brazilian Association of Mental Health (Abrasme), founded in 2007, with five Brazilian Congresses on Mental Health (2008, 2010, 2012, 2014, 2016). The 3rd Congress, held in Fortaleza in 2012, had over 7,000 participants; the 1st, 2nd and 3rd Forums on Human Rights and Mental Health, in 2013 in São Paulo; in 2015 in João Pessoa/PB (with over 3,000 participants); and in 2017 in Florianópolis/SC, on the 10th anniversary of the Association. All eight events represented moments of great political mobilization, with the organization of activism movements, meetings, debates, activities and cultural performances of all kinds.

One of the most remarkable characteristics of Abrasme events have been the cultural performances, with musical shows, theatre, photography exhibitions, and books launching. And especially the Solidary Economy Fair, with dozens of exposers, artisans, entrepreneurs and cultural producers, selling and publicizing a wide variety of products, from cooperatives and groups, with handicrafts, different kinds of food, clothes, embroidery, mosaics, paintings, accessories, recycled materials, souvenirs, books, etc.

The cultural movement of the psychiatric reform comprises artistic-cultural groups and projects in activity in different artistic expressions (which function as spaces of inclusion, work, conviviality and cultural production); but it also comprises cultural urban interventions in the public space, the occupation of the city, public demonstrations and parades, the celebrations of May 18th, every year and all over the country, and the social-cultural production (films, books, theatre, music pieces, shows, performances, solidarity fairs, etc.). This cultural movement of psychiatric reform demonstrates strength and sharpness in the criticism of the exclusion of madness that surpass the mere policy of assistentialism to the "disfavored", appearing as a vigorous movement of political transformation and as a clear experience of generation of social innovation technologies for public policies, in the sense of rethinking the right to the city.

For the psychiatric reform, in this broad and activist sense, it is necessary to occupy the city, occupy the cultural spaces, no longer inside the asylum, nor in sanitary or psycho-pedagogical spaces. It is necessary to return to the public space, allow a voice to madness, which was made silent by the asylum and psychiatric repression. And, in this way, madness occupies the city and breaks the hegemony of

the compulsory normality pattern and the political apathy of the post-modern individual, recovering the fundamental sense of the meaning of the city as a democratic space.

6. FINAL CONSIDERATIONS: FROM ASYLUM TO TERRITORY: AUTONOMY AND FREEDOM IN SOCIAL INCLUSION OF DIFFERENCE AND DIVERSITY

With the emergence of psychiatry and the asylum in the modern age, with the principle of the "therapeutic isolation" and the model of asylum institutions, there was a process of institutionalization of the mad person and constitution of the notion of "mental disease" as the truth about madness. Consequently, there was the production of a conception and social view of madness as error, incapacity, inferiority, and perilousness, which removed madness from the city and the mad from the horizon of social conviviality, excluding people in mental suffering from the right to work, leisure, culture, and spaces of social and political representation, therefore, from participating in the social pact.

In the 20th century, with the rise of international psychiatric reform experiences in the post-war period, criticisms and innovations in the forms of dealing with madness inaugurate the possibility of overcoming the asylum psychiatric model. This movement developed by means of the defense of freedom, conviviality, the right of expression, aiming at leaving asylums to live in the cities, seeking to question hierarchies and relations of power and submission, the concept of mental disease, among other fundamental issues. The psychiatric reform in Brazil started later in the international picture; thus, it benefited from knowledge and from errors and successes accumulated elsewhere. Moreover, it was constructed by different actors in a singular trajectory, as an innovative social process that is broader than the re-orientation of public policies in the field of mental health; i.e., it was constituted as a transformation process of social relationship with madness and difference. Two aspects are highlighted here: the criticism from an epistemological perspective, i.e., criticisms of the notion of mental disease as incapacity and the concept of "mental derangement"; and criticisms of mental health policies and psychosocial care services, by means of refusing that mental health services be of control, vigilance, repression or sequester, which configurates the permanence of the asylum model.

Therefore, it can be stated that the psychiatric reform in Brazil, from its beginning, was constituted as a social movement of construction of a new discourse and new practice in dealing with madness and mental suffering, away from the psychopathological discourse, against the social exclusion of subjects in crisis or psychosocial vulnerability, and in defense of a society without psychiatric asylums. The historical marks and the vast iconographic, artistic, and activistic production of the anti-asylum movement in Brazil demonstrate that the psychiatric reform arises from the political bases of criticism against authoritarianism and in favor of freedom, and that it is consolidated as a social movement demanding the rights of citizenship, inclusion of "different" people, and under the sign of human rights.

In four decades of changes, the scenario has been deeply transformed, with the closure of over 70,000 asylum beds; from 100,000 beds in the beginning of the 1980s, currently 30,000 beds remain. This process of changes comprised the construction of a network of mechanisms and services of mental health and psychosocial care, strategies of residentiality, work and income generation, social participation and activism, spaces of conviviality, solidarity and freedom practice, and access to culture, leisure and social support networks. All these innovations can be understood as ways of producing a reflection on the guarantee of the right to the city for people in mental suffering, and on a broad conception of public policies that include the social movements and political participation as essential for the inclusion of

the difference and for the democratic process. The Psychosocial Care Network (Raps) had a notable expansion in the country, with the constitution of over 2,200 Centers of Psychosocial Care (Caps) in all regions, and also Therapeutic Residences, Cooperatives of Work and Solidarity Economy, Centers of Conviviality and Culture, matrix support in Basic Care, Reception Units, Street Consultation teams, among the main substitutive mechanisms (Brasil/Ministério da Saúde, 2015).

However, in the present scenario there are surely deep challenges for and paradoxes in the processes of psychiatric reform, which include the under-investment in the public sector, especially in a time of political and social "crisis" and a conservative administration, and a clear tendency to impose the interests of returning to the asylum regime and institutionalization, linked to the mercantilization of health. There are also limitations regarding the advancement in essential aspects such as capacity-building and working conditions for the coordination of the Psychosocial Care Network with Basic Care services, which continue to be pressed by a strong medicalizing bias and frequently show a strong rejection for the consideration of mental health cases. This points to the need of investment in Matrix Support in the coordination of Mental Health with Basic Care. This aspect stands out as a problematic boundary in the advancement of change processes; it is one of the main challenges for the re-orientation of the current assistance model, which has Basic Care as the health care ordinator.

Another important aspect is that innovative experiences in the psychiatric reform, in de-institutionalization and in the field of work, culture and social inclusion, may be considered as models for the reflection on the formulation of public policies that promote the strengthening of communitarian participation in the decisions concerning health policies. However, there has been a tendency of a current limitation, with a prevalence of the return to the biomedical model, which constitutes a risk of reducing health and mental health services users' interference in the decisions regarding health treatments.

Finally, there has been a recurrent permanence of subjects in mental suffering inside the so-called "open" institutions, producing a new institutionalization in the Centers for Psychosocial Care (Caps). There is the risk that these become "protected" spaces, with a strong tendency to becoming enclosed spaces and to prioritizing traditional protocols such as psychopharmacologic medication, psychiatric consultation, and restrictions to the institution's internal activities. Furthermore, there is the risk of relegating to the background the participation and reception of relatives, as well the communitarian interference to transform the stigma related to the psychiatrized madness.

In this context, the role of the Capss becomes that of constantly seeking the tendency to openness, the construction of possibilities in the territory, district, neighborhood, and the dialogue with social movements and cultural diversity groups; also seek intersectoral and transversal spaces in the city as an alternative to the repetition of technical-sanitary responses, and thus de-construct the obvious or easy way of traditional protocols. And, especially, receive and foment the activistic collectives, and politicize the transformation processes. In this direction it is possible to transmit the legacy of the anti-asylum movement to the field of collective health.

All these elements can be related to the difficulties of occupying the city and promoting policies to articulate with urban life and social and community fabrics. In this sense, the innovations of the psychiatric reform in Brazil provide significant contributions to re-think SUS and its democratic fundaments, from understanding the implications of social participation forms that have been discussed, for the strengthening of the directive and principle of community participation in the construction and consolidation of the Unified Health System, founded on the promotion of human rights and on the struggle for social inclusion and the right to cultural diversity.

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