DOI: http://dx.doi.org/10.18569/tempus.v10i4.2000

Programa de Residência Multiprofissional em Saúde Mental: Narrativada implantação no processo de desinstitucionalização do Município de Sorocaba (SP) – Brasil

Multiprofessional Residency Program in Mental Health: narrative of the implantation in the process of deinstitutionalization of the Municipality of Sorocaba (SP) – Brazil

Programa de Residencia Multiprofesional en Salud Mental: narrativa de la implantación en el proceso de desinstitucionalización del Municipio de Sorocaba (SP) – Brasil

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ABSTRACT: This article describes the experience of implementing the Multiprofessional Residency Program in Mental Health in a medium-sized municipality in the interior of the state of São Paulo, during the period of development of the largest deinstitutionalization process in Brazil. The experience is shared in dialogue with the theoretical-practical reference of the Italian deinstitutionalization, presenting the difficulties and powers for the transformation of conceptions and practices in mental health.
Keywords: deinstitutionalisation; health human resource training; mental health.

RESUMO: O presente artigo narraa experiência de implantação do Programa de Residência Multiprofissional em Saúde Mental,em um município de médio porte, no interior do estado de São Paulo, durante o desenvolvimento do mais amplo e intenso processo de desinstitucionalização brasileiro. A experiência é compartilhadaem diálogo com o referencial teórico-prático da desinstitucionalização italiana, apresentando as dificuldades e potências para a transformação de

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concepções e práticas em saúde mental.
Palavras-chave: desinstitucionalização; capacitação de recursos humanos em saúde; saúde mental.

RESUMEN: Este artículo cuenta la experiencia de implementación del Programa de Residencia Multidisciplinaria en la salud mental en un municipio de tamaño medio en el estado de Sao Paulo, durante el período de desarrollo del proceso de desinstitucionalización más grande de Brasil. La experiencia es compartida en el diálogo con el marco teórico y práctico de la desinstitucionalización italiano, que presenta las dificultades y los poderes para la transformación de los conceptos y prácticas en salud mental.
Palabras clave: desinstitucionalización; capacitación de recursos humanos em salud; salud mental.

INTRODUCTION

The multiprofessional residency in health was established by Law nº–11.129, from 2005, regulated by the Interministerial Ordinance nº 45,from 2007, which envisioned the partnership between health managers and educational institutions, with the purpose of investing in the training of personnel for the Unified Health System (SUS). Somehow, it contributed to other initiatives by repairing the gap of a training policy, which should be simultaneous with the institutionalization of SUS itself.

While a system of universal, integral, equitable or equal character (dawsonian model)[4i], forged in municipal initiatives and resistance to dictatorship, defined in the chapter of social rights of the Federal Constitution of 1988, SUS was installed after the experience of the Decentralized Health System, "the National Institute of Medical Assistance of Social Security (INAMPS) for all", which maintained, by inertia, the technical-specialist paradigm (flexnerian model)[i], employer of specialists and subspecialists.

In discussing the theme "*The SUS we have and the SUS we want*", from the 12th National Health Conference, the fourth conference after the historic Eighth Conference, Sérgio Arouca emphasized that, despite having made the health reform that created SUS, a dehumanized, medicalized,erroneous nucleus was kept. He pointed out that the first ground for the still necessarychange would be to shift the focus to health promotion and not to the disease. As if the SUS had to ask what is happening in people's daily lives and how we can interfere to make it healthier.

Thereby, it was adopted, by the national autarchy for the social security medical care, the annual establishment of executive entrances. The first operational rule consigned the possibility of contracting services from state public establishments. The successive organizational changes were due to operational norms, such as those downloaded by social security institutes until the INAMPS from 1975, as an integral part of the National Social Welfare and Assistance System (SINPAS).

4 iThe Dawsonian model and the Flexnerian model, by Dawson and Flexner, which described and advocated the english health model (1920) and the american health model (1910).

So, not only have they remained, but instituted establishments have been strengthened for decades with state or social security subsidies, for the provision of servicesby means ofremunerated agreements by production. Thus, it also happened with the mental asylums, especially because they were exhausted by inefficiency in not curing, although they were efficient in excluding, the units instituted since the 1950s, inspired by the Psychiatric Hospital Plan of 1941[1].

In the place of the organization of services oriented towards the care of the suffering person, be it physical or psychic, or psychosocial, it was sought to fill the shortage of supply, as if attention to health were satisfactory for the access to the consumption of goods and services.

Each person, as subject of their existence, no matter how pauperized they may be, speak, and speak because they feel and suffer; they suffer because they desire and do not rescue the past, do not realize the future and do not enjoy the present either. This happens witheveryone and with each one, with each person, whoever they may be, whatever is the position in the relation of health care: professional or user, client or even manager[1].

It is important to emphasize that, during the implementation of the SUS a human resources policy that corresponded to its guidelines was not carried out, known as necessary and indispensable, having as consequence, in addition to the increasingly precarious working conditions, remaining work relationships as the original system, statutory of the specific services of the federal executive and state and municipal executives, inclusively, the Federal District. This resulted in the disrepute even of the workers themselves, in relation to the SUS project[2].

Thus, the system and the health services are constantly criticized by a large part of their workers, also reflecting the dissatisfaction of users, patients, families and communities, as well as being criticized by the media and undergraduate students, residents, masters and doctoral students; by their teachers and counselors, in educational establishments, among others.

It is imperative to consider that “health work has a specificity regarding subjectivity and the protagonist role of the worker” (Rosa, 2014. p. 27)[4] and, in this sense, it becomes evident the deficiency of strategies to respond to the historical urgency of to resist the logic of the mercantilization of health and to “turn into reality a very generous and rational policy” (Campos, 2007. p. 302)[5].

However, since the micropolitical exercise of overcoming the dichotomy of health models does not depend exclusively on the implementation of innovative proposals for professional qualification, the implementation of the political project of multiprofessional residences does not guarantee, in itself, the resolution of the devastating wounds of health in relation to the teams of workers. It is necessary to analyze how the political, economic and institutional powers influence the answers to the problems of human resources management. Therefore, it is worth questioning the interests that are at stake: for what and for whom do we want to qualify health workers?

The programs implemented in the several municipalities of the Country may be tied to a

precarious health network, with the simplification of municipal resources, such as: "offer assistance to a restrained demand [...] by taking advantage of the resident's work to disclose an illusory image of the expansion of the specialized professional offer" (Rosa; Lopes, 2016. p. 645)[6], rather than expanding the number of employees. In these cases, it is advantageous to have a residency program to guarantee the expansion of the service offer through additional workers, adding residents, servants/ preceptors, tutors/teaching staffin activity in health units, providing services to the population.

Another important point to be highlighted is professional training: what training? What kind of professional does the SUS need?

Thus, the attempt to legitimize a policy of people management, approaching the academy to the service and making the public health network a field of teaching-learning, facesmanyconstraints. Among them, can be highlighted the excessive fragmentation of knowledge and the difficulty in understanding reality, which can sustain a non-decisive/inefficient practical intervention.

However, the academy must be able to attend to its social commitment[7] to transformnot reduced professionals into technicians, but collective subjects, conscious and active, with sensitivity to provoke and produce health practices in the dimension of care. But, mainly, it must guarantee fields of force to facilitate multiple transgressions among students, teachers, users, patients, communities and territories. That is, the university must have the knowledge and power to create/invent forms of resistance to the truths instituted, allowing the exercise of the reflection on the strategies of domination of knowledge and the processes of annulment of the identity.

This way, it is understood the importance of discussing the challenges and potentialities of implementing the Health Multidisciplinary Residence Program, especially about the priority objective of deinstitutionalization, which is to transform power relations between the institution and the subjects[8].

DEVELOPMENT

1. Deinstitutionalization as ethical north, route and component of the psychosocial care network

The concept of deinstitutionalization was taken at different historical moments of the psychiatric reform movements in the world, aggregating a set of perspectives not always convergent, which produced, consequently, a diverse range of expectations and practices. The italian deinstitutionalization can be understood as "*a complex social process, that tends to mobilize as actors the social subjects involved, [...] to transform the power relations between patients and institutions [...] to produce structures of mental health that fully replace the hospitalization in psychiatric hospitals and that are born of the disassembly and reconversion of the material and human resources that were deposited*

there" (Rotelli; Leonardis; Mauri, 2001, p.18, free translation)[18].

In Brazil, the theoretical-practical perspective of the italian deinstitutionalization parameterized the criticisms to the logic and the insane institutions, feeding the vanguard practices of the Psychiatric Reform, marking, consequently, the directives of the National Policy of Mental Health.

Supported by Law nº. 10.216, of april 6, 2001[210], which covered eleven years of debate in the Federal Chamber, providing, finally, for the protection and guarantee of the rights of people with mental disorders and redirecting the mental health care model in the Country, the brazilian National Mental Health Policy is internationally recognized for its consolidation as a state policy, going throughseveral and distinct governments.

Essentially, the referred legislation places at the center of mental health care the defense and promotion of human rights, expressing the victory of the social movements of workers, family members and users, who denounced numerous violations and mistreatment suffered in asylum-type institutions, predominantly private, in Brazil.

It is in the midst of the redemocratization movements of the Country that the transformation of the care model begins, aiming at changes in the social places of people in psychic suffering. On a community-based basis, the built model proposes the availability of resources in territories and real life situations, having as a directionality the deinstitutionalization of the paradigm of psychiatry, embracing the dismantling of the mental asylum as a condition for the construction of territorial practices of care in freedom.

For Nicácio and Campos[311], the centrality of the affirmation of freedom to overcoming the asylum-type model places the need to find ways to approach *people with the experience of psychic suffering*, starting from the understanding of a diversity of modalities of existence, rescuing the Basaglia's proposition of *placing the disease in parentheses*, to effectively meet the experience lived by the other.

The mental asylumconsidered to be the *zero place of exchange*, which organizes itself through institutionalizing schemes of authoritarianism and coercion, promotes the annulment of individuality, with total objectification of man, precluding the projection of the future and the emergence of own subjectivities, and must be completely overcome[411]. As in Saraceno[512], the National Mental Health Policy affirms that there is no territorial policy without pursuing,simultaneously, the policy of overcoming the mental asylum.

In order to correspond to such directionality, there were several efforts and respective norms of reversion of the resource formerly destined mainly to the psychiatric hospitals, for the conformation of territorial and community networks; stimulus to the reduction of the size of the hospitals tied to the daily increase[613]; implementation of a National Program for the Evaluation of Hospital Attention in psychiatry and possible accreditation of SUS[714]; and the expansion of resources for territorial

services.

Such actions triggered closure and service substitution processes in some more organized experiences, such as in Santos (SP), Campinas (SP) and São Paulo (SP)[815], and in others, due to specific interventions regarding denunciations or simple withdrawal of owners, in the face of the reduction of profits obtained in previous times. The latter made de-hospitalizations, which generated, as in other countries, abandonment and transinstitutionalization for other mental health hospitals, or long stay institutions of another character, or, as Rotelli, Leonardis and Mauri[98] point out, *more obscure forms of hospitalization*.

The most recentnormative that regulates the then Psychosocial Care Network (RAPS)[16] explicitly excludes psychiatric hospitals as treatment spaces, considering them only from the deinstitutionalization actions, and presents a variety of services for the network care of the people with mental disorders, including those with needs arising from drug use.

The RAPS explains the principles and components to be organized to meet the dynamic and diversified needs of the process of care in freedom, among which, are the strategies of deinstitutionalization, consisting of initiatives aimed at the progressive social inclusion of people in hospitalization of long stay[1016].

However, for Nicácio and Campos[1111], the discovery of the freedom of the crazy, because obvious, is the most difficult task in the new relations to be established by the teams, maintaining the challenge of deconstruction and reconstruction of the medical-legal apparatus that restricts citizenship, facing and living the contradictions that can, conversely, objectify the very concept of freedom, sustaining the identification of the *sufferer* with the institution illness and mental asylum.

Forming *in* and *for* deinstitutionalization must involve, necessarily, accumulation for the confrontation of the structure of responses that have self-legitimized as rational solutions to the matter of insanity and relocate the emphasis from the professional action to '*invention projects of health and social reproduction of the patient*' (Rotelli; Leonardis; Mauri, 2001, p.31, free translation)[128].

To share the experience and also to critically analyze the articulated implantation of multiprofessional residency programs in mental and medical health in psychiatry, in the midst of the greater brazilian deinstitutionalization process, in the interior of the state of São Paulo, it is necessary to turn to the process-concept in its paradigmaticchange strand, more specifically, in dialogue with the route presented by Rotelli, Leonardis and Mauri[138].

2. METHOD

Understanding interpretation as a two-movement process – analysis and construction –, Onocko-Campos[1418] suggests that the former would be necessary for an improved comprehension

of the current phenomena, and the second, in the manner of a narrative, fundamental for formulating proposals and the elaboration of new senses. It is recognized, here, the hermeneutic dual task proposed by Ayres[1519]: 'to understand the operative discourses and to build knowledge that can respond to the new demands'.

For Ricoeur[1620], narratives are privileged forms of time representation; stories not yet narrated, symbolically mediated, articulated in signs, rules and norms, inscribed in social praxis. The agencying of the facts would occur not necessarily in a chronological or sequential way, but through a logical ordering, providing the fusion of horizons between narrator and reader, presenting as a powerful way to reveal a habitual mode, in a certain sociocultural context[1721]. In the hermeneutic perspective, the authors of this article will find themselves with the text already produced and will trace their analysis, narrating and guaranteeing textuality to the lived experience, which will gain autonomy to promote future debates.

3. Sorocaba (SP): creation of the Mental Asylum Pole

The defense of the destruction of the mental health apparatus assumed by the Movement of Mental Health Workers, since the 1970s, has not found anchorage in several territories of the Country, since there are many municipalities that still place health care in the mental asylum logic.

The territory in question was constituted as asylum-type, from an agricultural colony occupied by patients transferred from the "Hospital of Alienated", in 1895, coordinated by the doctor Franco da Rocha. This group of patients was transferred in the year 1898, at the end of the construction of the Juquery Hospital, and the colony gave way to another mental asylum, also serving as a police station and prison.

In the year 1950, the newly created Faculty of Medicine would confirm the separation of people diagnosed with mental illness, justifying the need for study and research, but, above all, aiming to preserve the health of the community. That way, the conduct of isolation was certified as a therapeutic principle, as well as the hospital with a remedy function and work as an instrument for healing.

From the 1960s, with the vertiginous rise of private beds throughout the Country, there has been a proliferation of beds and psychiatric hospitals, in its great majority, financed by the National Social Security Institute (INPS)[1822]. In the 1970s, there were already ten psychiatric hospitals in the region, created in partnership between physicians, located in the three municipalities 60 km away from each other, constituting the main resource for the treatment of mentally ill people, until the 1990s.

The Mental AsylumPole, thus constituted, maintained 2.219 residents, still found in 7 psychiatric

hospitals, in the year 2008. This number of residents would characterize the function of tutelage and social control of the psychiatry and the mental asylum, corresponding to more than ⅓ of the hospitalized population in the state of São Paulo, contributing to the institutional fouling components of the "largest mental institution pole in the Country, with more than 2.700 patients"[1923].

In August 2012, this scenario became public, due to the denunciation, by the mainstream media, of human rights violations[5ii], which culminated in the execution of a Term of Adjustment of Conduct (TAC)[2023], which foresaw the extinction of seven psychiatric hospitalsof the region and the implementation of the RAPS, as recommended by the National Mental Health Policy. To the municipality of Sorocaba (SP), it would be necessary, besides the assumption of the management of the largest mental asylum in the region, to reformulate the assistance logic that revolved around the great institutions (the first one, implanted in the 1920s) and leverage a movement that should involve so many other instances and locations.

Among the main challenges, the following questions emerged: how to replace the hospices in a city that lived together, trivialized and ignored the atrocities that occurred with the more than 1,5 thousand inmates, behind the walls? How to promote the transformation of the services already implanted according to the logic of living and maintaining the psychiatric hospital? How to qualify professionals in a network in which technicians cannot criticize the system, by the naturalization of the current logic, and do not recognize themselves as part of the violence? How to overcome the idea of psychiatric hospitalization as an answer to the growing construction of this ideology, in relation to the problem with drugs? How to convince the judiciary, from the management, with so many technicians sustaining by reports the isolation as a principle of care?

It is used, here, the callsign of Rotelli, Leonardis and Mauri[218], of the dual task of *mental health operators*, which are the one of the performance of the therapeutic function while the institutional power of psychiatry is used as power of transformation. It was understood, therefore, for the establishment of this clinic-policy, the need for an intense formation process, that should be promoted in the meeting and the necessary estrangement between new professionals and those who were already there, in the most different practices scenarios.

This encounter involved the incorporation of new workers, with or without experience, in previous processes of deinstitutionalization, maintaining, in the management of services, those who added it. It should be noted that the professional staff was absolutely inferior to the one prevailing in the current laws, as well as the boldness to implement residence programs for the formation of new generations that could sustain a project of such breadth.

This way, it is understood the need to amalgamate the multidisciplinary program with the medical residency program, with the de-territorialization and production of the possibility of interventions in the historical participation of this category in the accumulation of technical and business power,

5 iiMore information at: https://www.youtube.com/watch?v=yN77n7gUKLk

of the great market of madness that was established. That is, to form holders of the *irreplaceable power of psychiatry*, through multidisciplinary processes, and aware of the conflicts of interests that involved the performance of the owners of these institutions as assisting physicians of the patients hospitalized there.

The intervention of the municipality in the largest hospice in the region was fundamental for the establishment of the institution as a Pole of Deinstitutionalization, stage of the exercise of structuring the new relations of power; main practice scenario, for which all residents should pass; and starting point of the new professionals for the conformation of the new services to be implanted.

4. The experience itself: scenes, events and actions

> *"In summary, the process of deinstitutionalization is characterized by three aspects, that are taking shape in the dismantling of the hospice:*
>
> *- The construction of a new mental health policy;*
>
> *- The centralization of therapeutic work, to enrich the global, complex and concrete existence of the patients – from the mental asylum, zero place of social exchanges, to the extreme multiplicity of social relations;*
>
> *- The construction of external structures, which are fully substitutive of the hospitalization in the mental asylum, exactly because they are born from the interior of their decomposition, and from the transformation of the resources that were there".*(Rotelli; Leonardis; Mauri, 2001. p.36, free translation)[228]

In quantitative terms, Sorocaba (SP) was not one of the cities where there was a shortage of mental health services. There were, on the contrary, diverse existing services, but they were fragile in terms of technical qualification and articulation among them, since all were private and linked to psychiatric hospitals, except for children and juveniles and a municipal ambulatory[2324].

The local RAPS was composed of, at that moment: Ambulatory of Mental Health – being 1 municipal; 10 Centers for Psychosocial Attention (CAPS) – being 6 CAPSII, 1 CAPSad (reference for problems with alcohol and other drugs) and 3 CAPSij (infantile-juvenile); 13 Therapeutic Residential Services (TRS); and 4 psychiatric hospitals (PH) with 512, 240, 250 and 110 beds.

In the field of the care with people with problems related to drug use, there were contracts with therapeutic communities (TC) for the fulfillment of compulsory hospitalizations, for which formal and continuous administrative flows were structured, without any monitoring of the people hospitalized there. Such hospitalizations were performed in an arbitrary manner, having, in the Mobile Emergency Care Service (SAMU), the executor of such judicial injunctions. In addition

to the CAPSad, which attended, mostly, people with chronic problems and not serious cases, and TC contracts for compulsory hospitalizations, there was also a Street Office (SO), under the management of the Social Development Secretariat[2424].

It was identified, similarly to Rotelli, Leonardis and Mauri[258], that what was established in Sorocaba (SP) did not come to be configured as a network, but occurred as a *psychiatric circuit*, distributing impoverished and reductionist responses, in different services, that served to psychiatry social problems as great institutions of *point of discharge* to everything that escaped control. The inconsequent supply of psychoactive drugs, the inefficiency of offers, passivity and lack of criticism, between users and workers, to the *reciprocal feeding game*among services, that should be territorial, and hospitalization in mental asylums were evident. The circuit reproduced the logic of abandonment to people in distress and seemed to distance itself from the responsibility of the more explicit violence behind the walls.

In fact, the current range of the diagnoses and the training of professionals limited to specialized and compartmentalized knowledge make it even more difficult to perform a critical action in relation to the business way in which health systems are organized,and in relation to the bankruptcy of psychiatry itself in the supporting of the rationalist paradigm of identification and optimal solution about a disease.

> *"Its object is unknowable, and often incurable. Chronicity continues to be the object par excellence, the problem and most evident sign of the impotence of psychiatry in reaching the solution-healing (and mental asylums are the concrete evidence of all this").* (Rotelli; Leonardis; Mauri, 2001, p.26, free translation)[268].

The residency programs were approved with 30 positions for the multiprofessional program, including psychologists, nurses, social workers, occupational therapists and pharmacists, in an articulated way, with 6 positions for the residency program in psychiatry, with planning of specific pedagogical activities and common axes. The insertion of residents took place in services under the most direct responsibility of public management: the mental asylum under intervention; the CAPS and general hospital, implanted by the current administration, which counted on professionals specially hired and/or relocated to the process of deinstitutionalization; and the Basic Health Units (BHU), which also lived a profound reformulation of their mission and form of organization and functioning.

To put in question, therefore, the entire circuit, including its apparent organization and its theoretical-technical discourse, it was necessary the implantation of services that were effectively born from different perspectives, placing in doubt and confronting the pre-established "harmony", as well as corresponding paradoxically to the demands produced in this scenario, so that they could be legitimately transformed, aggregating users, new workers and the community, for such process.

It was predicted, thus, in a daring way, a collective and shared construction of knowledge, while a real army of resident professionals who would compose this movement was presented to the workers of the desired network. It would be challenging, however, to accompany this large group, to support the proposal, without affecting the automatic reproduction of current practices, which, sometimes presented itself as the expectation of many of those involved, and thirsty for new professionals that corresponded to what was legitimized as a demand specialized care.

The preceptors were organized from their professional centers[2725], guaranteeing some safe territory for the radicalism that would come, but received and composed the accompaniment of residents with different backgrounds.

Rotelli, Leonardis and Mauri[288]state that deinstitutionalization involves the practical work of transformation, which dismantles,from the deconstruction of the mental asylum, the existing institutional solution, and needs to overcome the problem. By abandoning the illusory search for healing, also therapy must be reconfigured as a set of daily strategies for transforming the ways in which people are treated *or not treated*, to transform, by consequence, their own suffering. To renounce the *rational solution* that supports the *problem-solution rationality*, as the first step in deinstitutionalization. The goal becomes *therapeutic emancipation*.

On this aspect, it is worth emphasizing a confrontational action, regarding the specialized structure that maintains the logic that was intended to overcome: the transformation of the dismantling of an ambulatory of psychiatry, thatsustains the open sky psychiatric control, and the veiled abandonment to the suffering of the population. As reported, many services were linked directly to the mental asylum of the city – some existing; others, not even that – in service agreements. The majority presented irregular forms of payment, by means of daily relocation, maintaining, for example, billings of Authorization of Hospital Admission (AIH) of patients already in residential therapeutic services.

One of the services to be implemented was a CAPSIII, which would be the second with 24 hoursof continuous operation in the city, after the opening –also by the current management – of a CAPSadIII, this, the first CAPS of the own management of the municipality, which also generated estrangement to the companies that have always managed services of this nature in the city. The team had been fully hired and was located inside the Pole of Deinstitutionalization, learning and collaborating with the dismantling of the relations structures established between professionals and users. In addition, it began an approach with the residents who would be accompanied by them, during and after leaving the hospice. Participation was supported, desires were projected, possibilities of life were opened outside the walls.

In a pressure movement to increase hospital rates, one of the companies announced that, if such an increase did not take place, it would no longer, within one week, assist “ambulatory patients”, which would account for about one thousand residents, in chronic use of medicines, no longer

counting on the renewal of revenues, which basically was offered to them in the service in question. Considering, also, the legal limitations of transfer of public resources, in the absence of contractual validity, the refusal to extend the contract would also affect the interruption of assistance offered by two other CAPS, under the management of the same company.

Certainly, the attention to the users inserted in the CAPS would behave, given the existence of other services of this modality, although in a frank process of reorganization, through definition of the contours of territorial responsibility, qualification of attention to the most acute population and processes of expansion of democratic relations, and more effective actions. But, the psychiatric ambulatory could be a great trump to be used in the attempt to consolidate the discourse that the ongoing process of logic change would result in neglect.

The CAPSIII team to be inaugurated was called to action – together, residents and preceptors, in addition to the managers and workers of the BHU and the entire Health Department, which included an improvised medical office in the period of such intervention. The circuit would be in crisis. This aroused the interest of the authors of this article, but it would not be possible for anyone to stay on the path. Then, the team of authors prepared for what would be accomplished: the arrival of users at the door of the service. They were greeted by a printed statement, that there would be no more service.

The exhaustive experience that was stablished included the direction of all users to the CAPSIII, which functioned provisionally in a space provided to receive an TRS, in which the teams involved carried out group hosting and shared the situation of the time. Users have been invited to revisit and to be jointly responsible for their demand. After this first moment, in which the situations of risk and seriousness were also evaluated, the users were directed to follow in CAPS or in the BHU, always according to a certain territory of reference.

This action, surprising to all involved, generated great strangeness and opened a series of new questions. Many users, mostly women, structured their lives from the use of psychotropicsubstances and amphetamines, but were unable to recognize what they were suffering from: depression? Anxiety?Side effects of medications?Benzodiazepines dependency?Loneliness? The medical office prepared at the Health Department allowed those who had moved there to have their assistance guaranteed, as well as their treatment, redirected or not.

Others were surprised to be assisted. They did not know the experience of spaces of listening and sharing of their suffering. And others, so serious, had not attended the service for years, through automatic renewals of recipes as exclusive responses to suffering, including their relatives. The teams were exhausted and called for an end to the action, but the confrontation could not end because that was just the beginning...

It is worth mentioning that, in the italian deinstitutionalization, each mental health center was

responsible for all the demand in territories of about 40 thousand inhabitants, not working the mental health operators with patient selection, in a perspective of indivisibility of the demand, considering that the common differentiation between chronic and acute has as a parameter the disease, making the services ineffective[298].

The National Mental Health Policy foresees the existence of CAPS with 24 hours of operation, from 150 thousand inhabitants, considerably increasing the territorial responsibility of the teams for situations of psychological distress. It is also possible to understand, due to the expansion of the scope of psychiatry on the said common sufferings, that the situations of lesser gravity are initiatives foreseen in the scope of the Primary Health Care, with greater capillarity in the community, always with matrix support[3025] of health professionals inserted into Family Health Support Centers (NASF) and CAPS.

Residents regularly participated in the formal social control space of SUS, the Municipal Health Council. In the city of Sorocaba (SP), however, this space, peculiarly, had strong presence of service providers, including the owners of some psychiatric institutions and curators of the residents of the hospitals, one of them being forged representativeness through an association, that one could never know if it existed effectively.

Faced with the confrontation and the threat of the lack of assistance in order to obtain bigger hospital stays, the owner of the company took with him numerous patients from his ambulatories and CAPS, absolutely convinced that the management had taken the initiative for the contract termination, inflating, under this perspective, the space of the Council, for also entering into crisis, which translated into a series of accusations, clarifications, threats and lack of control on the part of many of those present. After that moment, the entire network of services was mobilized to restructure offers corresponding to the needs presented.

This was how the proposal for matrix support[3125] began, starting with professionals and residents of the CAPS and the NASF, initially welcoming groups of hundreds of people referred to specialized care, abandoned in the queues for psychiatric consultation or psychotherapy, without any criterion of gravity or priority. Group hosting helped the qualification and the redefinition of the demand for specialized treatment, in addition to requiring some directions, in an attempt not to interrupt what was meant by treatment – this referring to the contradictory maintenance of the medicines in use, with professional reassessment, even though punctual, and revision of this indication, whenever necessary, making the expert knowledge of the psychiatrist to physically move to basic care services, composing a responsible territorial care, reducing the wandering of the users through an infinite low-response circuit.

Rotelli, Leonardis, and Mauri[328] point out the important role of technicians within asyluminstitutions, that exercise their therapeutic roles, activating and stimulating the powers of the institutional action system. This is because, from these relations, it is also possible theactual

practice of changes and the mobilization of other institutional actors.

> *"[...] the deconstruction work of the mental asylum is produced through elementary gestures: to eliminate the means of containment; to reestablish the relation of the individual to the body; to reconstruct the right and the ability to speak; to eliminate ergotherapy; to open doors; to produce relationships, spaces and objects of interlocution; to release feelings; to restore civil rights by eliminating coercion, legal guardianship and dangerousness status; to reactivate a base of income to be able to have access to social exchanges – simple changes, which help to understand how the deinstitutionalization is, mainly, therapeutic work, aimed at the reconstitution of the people, as suffering people, as subjects".* (Rotelli; Leonardis; Mauri, 2001, p. 32, free translation)[338].

Countless situations challenged the transformations of relationships, within the hospice under intervention. Spaces for participation and free expression of the people interned were opened; the questioning of disseminated practices of civil interdiction was opened, with the owners of the companies as curators of the inmates; team meetings were implemented; the units, old wings or pavilions, were reorganized, no longer by pathologies, but by naturalness/origin, affinity, future plans of dwelling. Each unit had, then, a small team, which proposed the establishment of representatives in spaces of fomentation to shared management. None of this without conflicts, divergences, tensions. The democratic spaces were lived by some workers as disrespect to the institutional hierarchy, producing a certain scenario of cheering for the wreckage of some of the strategies. The assemblies were constant; the visits, open for the relatives; and the relatives, invited to enter the spaces, so cunningly hidden before. The horror of the naked hospice, although contradictorily still real, for some time…

It may be strange and may be interrupted: the prescription of multivitamins, which obscured the poor quality and the lack of food; the glass of water for collective use, taken out of a bucket, to administer the medication; sexual abuse; purchases with curators, who had a certain destination… or even the absolute absence of them, and no access of some users to their own financial resources, although they did not present pending issues with the surveillance authorities. People began to be surprised by violence, as the scene of a user contained at the gate of his unit, and the excuse of the technician: with a professional for a hundred users, that was what was possible to do. Some transformations were witnessed, and it was possible, collectively,to dream about some new possibilities.

This intense reinvention of the relations, understandings and directionality of practices was,at times, experienced with much suffering. The realization of the abandonment was experienced by some, accompanied by much rancor, that sometimes was transferred to the care team: "*– Would you have the courage to leave your child here? I was abandoned!"; "You told me I was discharged! I want to leave!"; "– Why are they leaving before me?".*

It was also evident the ambivalence towards freedom, especially in situations of greater autonomy of users, who delayed theirremoval. It seemed that a certain power built from privileges granted in institutional dynamics, and the identity built inside the mental asylum, were threatened. The real faces of suffering arose… Those that are not easily resolved, healed. But of which professionals must be concerned '*to transform concrete and everyday life, and thus to transform the ways of living and feeling, with the possibility of a richer resource existence'* (Rotelli; Leonardis; Mauri, 2001. p. 33, free translation)[348].

Many actions beyond the walls allowed it to, gradually, inform the community about who, in fact, had been segregated under the risk level and social protection. A remarkable event happened at the Week of Anti-manicomial Fight, which was deepening in the city from the concreteness of the ongoing actions. Partners of the same fight of cities in the region supported the accomplishment of a picnic in the square of a noble neighborhood of the city, full of music, snacks and good meetings. In the presence of many of the residents and former residents of the local mental asylums, managers and workers, it was possible to announce to the community that there were people who had been imprisoned for years in the local hospices. The emotion took everyone, and some residents sought the team of authors of this article, making themselves available to compose the efforts.

An also fundamental aspect was to question the recurrent mechanism of civil interdiction of the internees, as indicated by Rotelli, Leonardis and Mauri[358], in an *obsession to the progressive objectification of new statutes*, restoring their civil rights. The challenge was enormous, and it could not be concluded. But, it is worth registering what was witnessed here, to serve as an intervention for new professionals in the field of health and law.

It was a practice in the mental asylums of the city, the interdiction of the residents and the assumption of curatorship by the owners of the institutions, which could coincide in some cases, with the direction of the establishment. The justification for the interdiction was to obtain a social security benefit, which did not even have this action as a criterion for access.

In one of the hospitals, the residents had not been civilly restrained, but the financial benefit from the social security benefit remained under the administration, also in a nominal bank account, of the institution. In that case, the appeal was visible, it was available.

However, to most the residents in a situation of prohibition and with this benefit granted, was evident the lack of material resources, although there was no knowledge of any pending in terms of accountability. The understanding was that this resource was used to meet basic needs, perhaps some of those provided by the responsibility of the institution itself. The greatest strangeness occurred when the team of authors of this article encountered a judicial authorization that predicted the allocation of the appeal of a group of interned women to the purchase of a transport, in the name of the legal entity of the institution, that would be destined to accomplish, with them, some walks. The objectification of the people found there overcame any movement of criticism of what

had been established.

> *"We watched several scenes inside the mental asylum, like the promotion of some lunches, always following the same menu and the choice of the healer; walks in the same places, also chosen by him; equal and infantilized gifts for all the protected ones, like toys and objects that had no value in use for the group. However, they were the figure expected by the resident patients, who called him father".* (Godinho; Lazarini; Rosa, 2016. p. 112, free translation)[3626]

In this uncritical scenario, in which internees could only be represented by those who could accumulate conflicts of interest, and with the lack of success in attempting judicial reversal of interdiction processes, even with the technical team subsidizing this possibility/necessity, a working group was created with the purpose of building strategies, involving local public defender and public ministry, with participation of the local social movement. At that moment, what was to be expressed in the Brazilian Law of Inclusion was still not available: the mechanism of decision-making supported (BRAZIL, 2015).

> *"The expertise, a sovereign act more than any other, can continue to decide by the total absence of intellect and will of a subject, by 'zeroing out', and to persist in written codes and in those that structure judicial and sanitary apparatuses".* (Rotelli, 2001, p.62, free translation)[3727].

Thus, the little that one's could glimpse was the attempt to add family members, the few with whom it was possible to recover contact, workers, militants and/or students, who accepted the task of living the contradiction of the possibility of assuming the place of curator, to, then, build a more solid process of proving the need to extinguish the civil death status of the people there interned. As there was no consensus on this proposal, and with the disruption of the deinstitutionalization process, as it was being conducted, no forwarding is known that has overcome such issue in Sorocaba (SP).

Another peculiarity of the italian deinstitutionalization is the replacement of the necessity of hospitalization, constructing entirely substitutive services. It is not possible, during the process, to revert all the expectation still deposited in the appeal of hospitalization – either by the insecurities of the technical teams, or by the complexity and the aggravation that the cases have been presenting, or by the innumerable interferences of the judiciary in understanding this procedure as a protection measure, when it presents great difficulties in sustaining the *risk of freedom*[388,11].

It was worked, in this way, with the prevision, in the RAPS, to count on back-up beds in mental health, in a general hospital, under 24-hour regulation, and hospitalizations may be indicated after exhaustion of community resources and, essentially, for organic situations and of multiplicity of diagnosis, in a space that also became a learning scenario, implemented along with medical and multiprofessional residency programs.

CONCLUSION

In the current context, of numerous confrontations, it is important to sustain health as a social right and of the transformative practices in mental health. Defining investment strategies in the formation of people can be an element that determines new ranges and actions to enable a resistance to the neoliberal political model. It is necessary to confront the strengthening of the market logic, which benefits the transformation of services into products, to the detriment of universality and integrality with equity, with social justice. It is necessary to foster reflection on the daily professional practices that are reproduced.

It is, also,indispensable the interface between education and health, strengthening the critical-practical perspective of the teams of the workers of SUS. In this direction, the new programs of formalized multiprofessional residency with the advent of the law and the respective regulations provided space of opportunities for interfederal cooperation in health care and education at the same time, in the same territory, bringing institutions to the ground of daily life, in spite of the possible reproduction of programs with multiprofessional arrangement by inertia, guided by specialized parameters of one profession, from the sexagenarian tradition of medical residency. It was not by chance that the pioneer category in residence was excluded from the possibility of inclusion in the new programs, but by fidelity to its original model submitted to the logic of a promising market, based on the generation of new necessities of goods and services made consumer product, even if universally inaccessible.

Training *for* and *in*the deinstitutionalization should promote enrichment of professional skills and resolution autonomy.

> *"The emphasis is placed on acquiring knowledge, theoretical and operational, about the way of functioning of the institutional network in which people are inserted operates. Knowledge is built through daily critical analysis and operational intervention, to contrast the effects of impoverishment, disability that that institutionalized way of functioning produces in people's lives".* (Rotelli; Leonardis, Mauri; 2001, free translation)[398].

Dealing with the multiplicity of resources and the innumerable cultural possibilities of community insertion shows that, instead of forming for a specialty, one must train for work *in* and *with* diversity. Transiting through common fields of responsibility, reviewing itineraries and starting from the assumption of *affirmation and promotion of freedom*[4011] amplifies the power of teamwork, making collaborative learning, even if through dynamics that predict moments of confrontation and conflict. Teams operating as *collective supervisors*.The increasing contractual power of users and family members being, at the same time, an objective and *element of crisis and criticism* in the self-assessment composition of the team[418].

Such radicalism seems fundamental when it is sought to sustain, in moments of serious threats,

the rights conquered throughout the young brazilian democracy. It is advisable to warn about the risks of implanting programs that include mental asylums as practices scenarios through which deinstitutionalization processes are not proposed, with the risk of continuing to train specialists who feed the psychiatric circuit in Brazil, which is so unequal.

Along the ups and downs of local management, there was,in Sorocaba (SP), a disruption in the conduct of the process, being disconnected, deliberately, the main supporting leaders of the transformative practices. Thus, many proposals were abandoned, and there was a confirmation of the return of the mental asylum policy:

> *"[...] we returned to the hospital and the sensation was no different from when we first entered, a year ago: it was easy to count the patients who walked, in freedom, the garden. They walked like zombies with no destination, barefoot, withdirty feet and mistreated, toothless, sunburned skin, naked or semi-covered bodies, sad eyes, apathetic and aged appearance. The wings were overcrowded [...]The professionals worked in small numbers and were apparently robotized [...]".* (Godinho; Lazarini; Rosa, 2016. p. 115, free translation)[4226]

The formation of two generations who could intensely learn *from* and *in* deinstitutionalisation produced effects throughout the health care network, touching and enchanting many other hundreds of practitioners who experienced the effectiveness of community and emancipatory practices. Certainly, it was not enough to overcome the place of the mental asylum in the local culture, that has been careful, currently,to quantitatively close of the dehospitalization process, without realizing that, in the circuit, a place of segregation will always be necessary.

It is hoped, however, that the counter-reformation experienced, in all its harshness, has produced, collaterally, effects of dissemination of the experience of those who lived there, as narrated by Nicácio and Campos (2007, p. 146, free translation)[11], in the *"[...] production of a diverse and complex therapeutic practice, based on the understanding of the person, in the transformation of his concrete possibilities of life, from the daily construction of the encounter and the uncompromising affirmation of freedom".*

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Artigo apresentado em: 10/01/2017
Artigo aprovado em: 05/02/2017
Artigo publicado no sistema em: 28/06/2017