



Journal of Nursing

Revista de Enfermagem

UFPE On Line

ISSN: 1981-8963

ARTICLE INFORMATIONAL

MENTAL HEALTH PUBLIC POLICIES AND SOLIDARY ECONOMICS: CONSTRUCTION OF A NEW CONCEPTION

POLÍTICAS PÚBLICAS DE SAÚDE MENTAL E ECONOMIA SOLIDÁRIA: CONSTRUÇÃO DE UMA NOVA CONCEPÇÃO

POLÍTICAS PÚBLICAS DE SALUD MENTAL Y ECONOMÍA SOLIDARIA: CONSTRUCCIÓN DE UNA NUEVA CONCEPCIÓN

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ABSTRACT

Objective: to discuss the importance of developing mental health public policies and the effective, efficient, solidary economics, for an alternative proposal of labor organization directed towards the psychosocial rehabilitation of patients with mental disorder. **Methodology:** this is a descriptive study on the mental health public policies and the solidary economics over time to the present day. **Results:** with the Psychiatric Reform movement, one sees the addition of dialogues on the ways how the patients with mental disorder were treated and observed, both in psychiatric institutions and in the community where they lived. In this panorama, resuming the submerged citizenship of these subjects presents itself as a great challenge to be thought through. **Conclusion:** one observed that the solidary economics provides the patients with mental disorder with the possibility of becoming solidary workers and allows their participation in decision-making and in the management of their own lives. **Descriptors:** Public Policies; Solidary Economics; Mental Health; Psychosocial Rehabilitation; Citizenship.

RESUMO

Objetivo: discutir a importância do desenvolvimento de políticas públicas de saúde mental e da economia solidária eficaz, eficiente, para uma proposta alternativa de organização de trabalho orientada à reabilitação psicossocial dos portadores de transtorno mental. **Metodologia:** trata-se de estudo descritivo sobre as políticas públicas de saúde mental e economia solidária ao longo do tempo até os dias atuais. **Resultados:** com o movimento de Reforma Psiquiátrica, percebe-se o acréscimo dos diálogos sobre as formas como os portadores de transtorno mental eram observados e tratados, tanto nas instituições psiquiátricas como na comunidade onde viviam. Nesse panorama, o resgate da cidadania submergida desses sujeitos coloca-se como um grande desafio a ser pensado. **Conclusão:** observou-se que a economia solidária possibilita e proporciona aos portadores de transtorno mental tornar-se trabalhadores solidários e viabilizar sua participação nas tomadas de decisões e na gestão de sua própria vida. **Descritores:** Políticas Públicas; Economia Solidária; Saúde Mental; Reabilitação Psicossocial; Cidadania.

RESUMEN

Objetivo: discutir la importancia del desarrollo de políticas públicas de salud mental y de la economía solidaria eficaz, eficiente, para una propuesta alternativa de organización de trabajo orientada a la rehabilitación psicossocial de los pacientes con trastornos mentales. **Metodología:** esto es un estudio descriptivo acerca de las políticas públicas de salud mental y de economía solidaria a través del tiempo hasta los días actuales. **Resultados:** con el movimiento de Reforma Psiquiátrica, se percibe el incremento de los diálogos acerca de las formas como los pacientes con trastorno mental eran observados y tratados, tanto en las instituciones psiquiátricas como en la comunidad donde vivían. En ese panorama, el rescate de la ciudadanía sumergida de estos sujetos se presenta como un gran desafío a ser pensado. **Conclusión:** se observó que la economía solidaria posibilita y proporciona a los pacientes con trastorno mental convertirse en trabajadores solidarios y hace viable su participación en la toma de decisiones y en la gestión de su propia vida. **Descriptor:** Políticas Públicas; Economía Solidaria; Salud Mental; Rehabilitación Psicossocial; Ciudadanía.

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INTRODUCTION

In contemporaneity, mental illness or psychic suffering has taken a new position with regard to the social praxis, through the possibility to resume the citizenship lost by the individuals with these disorders. From a perspective of constructing a change in the way how the person with mental disorder is thought through with regard to her/his life, her/his suffering, instead of just thinking in accordance with a diagnosis.

In view of this context, the need of cultivating concrete possibilities of social inclusion through labor along with these populations becomes apparent, ensuring that those people who have specific problems (physical, sensory, psychological, and/or mental) are included and participate in social life from a perspective of equity, ensuring the opportunity and possibility to use their creative, artistic, and intellectual capacity and have access to sociocultural events.

It was from the 1980s that other understandings concerning people with mental disorders emerged; these people start being regarded and appreciated as human beings who articulate the individual to the community (social representation), allowing the emergence of significant and de-alienating productions, that involve an individual included in a given time and space. Taking into account the relation of man to labor and recording one of the biggest challenges for inclusion, one seeks to adopt a new model for its organization, having a system of cooperatives as a basis, advocated by the proposal of solidary economics.¹

It's within this possibility that solidary economics, by having as its major principles equity, collective participation, self-management, democracy, and cooperation, presents itself as being able to develop and implement the proposals resulting from the movement and the initiatives which rethink and re-signify the health care models and, especially, the management of mental health.

DIMENSIONS OF MENTAL HEALTH

• A brief history of Psychiatry

For many years, patients with mental disorders were regarded as alienated, "lacking good sense", abnormal. They were perceived as people who didn't understand their physical and mental capabilities, or, also, who were unable to exercise their rights in society.

In current times, this context has changed. There's a daily struggle for providing these people with a mental disorder with a dignified

mental health service, so that they can have a differentiated treatment and that society can respect them as common human beings, but with some limitations and restrictions.

History records that in ancient Greece it was believed that the mad ones (people with a mental disorder) had divine powers, supernatural powers. In turn, in the Middle Ages, these phenomena were associated with the devil and regarded as possessed entities and, thus, spent their days chained and exposed to cold and hunger and, in extreme cases, they were burned in bonfires as unbelievers. This kind of treatment has unfolded until the 18th century. At that time, nobody spoke of mental illness and neglect of people afflicted with mental disorders persisted. Everyone who had a different behavior, especially when agitated and aggressive, were regarded as mad. The society only cared about its safety and it had an inadequate conduct towards these people, it threw the mad ones in prisons and there they stood alongside with other excluded individuals waiting for death.²

In the face of this situation, there was a need for rethinking the public and social policies from the perspective of mental health. The political and social reforms, in the transition from the 18th to the 19th century, led the Frenchman Philippe Pinel, physician regarded by many as the father of Psychiatry, to take the first step to change the lives of these people. Madness has become a medical issue and it started being seen as a disease which could and should be treated. So, according to this conception, the clinics were born, as a place of hospitalization, as well as the studies on Psychiatry. With this new composition, nurses were in charge of caring for patients with mental disorders. In an attempt to quell madness and defend themselves from everything represented by the unknown, the psychiatric institutions worldwide have become places of repression, where the patient was isolated from society and family, which was unaware or ignored the suffering experienced by her/him.²

It was from these changes on that the physician who specialized in the treatment of patients with mental disorders was called alienist and, after these changes, big names stood out in Medicine due to their researches and innovations within this area. One may highlight the work of Esquirol, student and follower of Pinel, precursor of Psychiatry, who joined, along with Morel (1809-1873) and Edouard Séguin (1812-1880), the French school initiated by Pinel. In the 19th century, Emil Kraepelin, a member of the German

organicist stream, which, after a careful description of clinical symptoms, evolution, and anatomopathological analysis, formulated a new doctrine which provided the future generations of specialists with a reference. In the 20th century, Freud developed Psychoanalysis, which became popular worldwide and imposes itself as a landmark in the field of mental health. One also highlights the contribution of C. G. Jung with his works on mandala.²

With the great progress of studies on the mind, between 1940 and 1960, some therapies were included in the treatment of patients with mental disorders. One may highlight the electroconvulsive therapy (the technique consists of an electrical stimulation in the brain, in order to induce a seizure lasting about 30 seconds, still used, in the present day, in severe cases, such as catatonic schizophrenia, depression with psychotic symptoms, manias, according to a report from the medical board), the malariotherapy (patient's contamination with the protozoan malaria parasite, in an attempt to create disturbances), insulin therapy (inducing the diabetic patient through an insulin injection), and the use of cardiazol (drug used to induce seizures).²

In the 1960s, Kaplan emerged with his preventive psychiatry, with his experiences with the therapeutic communities in England, which created other paradigms; afterwards, Franco Basaglia emerged, and he became, in 1961, the director of the Gorizia Psychiatric Hospital. His ideas were spread in Italy, in 1968, and they're still influential today in the psychiatric care for patients. Currently, Brazil is experiencing a strong challenge for implementing the de-hospitalization process in the treatment of people undergoing psychological suffering, i.e. the creation of therapeutic homes, a higher effectiveness in the treatment of the Psychosocial Support Centers (CAPS), social inclusion, etc. The goal of people in favor of the Psychiatric Reform is turning the mental health framework into a new reality, which has as its motto "Caring, yes, excluding, no".²

• Mental health in Brazil – Psychiatric Reform

During the redemocratization political context in Brazil, the various social movements were potentiated in this initial struggle for democracy. The Brazilian Psychiatric Reform (BPR) is a movement which began nearly thirty years ago, which wishes to be understood as a complex political and social process and whose originality is due to the fact that the criticism to the model driven

by large hospitals (hospitalization) ceases having as its goal improving it or humanizing it, directly criticizing the psychiatric assumptions and condemning their effects of regulation and control. BPR brings as one of its major features the requirement for recognizing the users' rights and citizenship.

One of the initial milestones of BPR was the creation, in 1978, of the Mental Health Workers' Movement, which combined labor claims with denunciation of the abuse and neglect to which the patients admitted to the clinics participating in the program (private clinics receiving public funds transfer) were subject. In 1979, the I National Mental Health Workers' Meeting was held, in which emphasis was given to expanding access to health, prioritizing the planning and administration of health services. In the 1980s, more precisely in 1987, two key events occurred: the I National Conference on Mental Health and the II National Mental Health Workers' Meeting. The latter had as its theme "For a society without asylums" and it's no longer a movement limited to the sectors of health, incorporating community representatives, users, and relatives. In this event, the political and conceptual meaning of anti-asylum was expanded.

[...] Anyway, the new stage [...] consolidated in the Congress of Bauru, reverberated in many domains: in the clinical model, in cultural action, in the legal-political action. In the clinical model domain, this route is marked by the emergence of new ways of attention, which started representing a real alternative to the traditional psychiatric model [...].^{3:82}

Then, the Anti-Asylum Struggle Movement was created, leading to the discussion on the society's relationship with the mad one and with madness.⁴

In 1989, Paulo Delgado (PT-MG), then a federal representative, presented a bill which reshaped the whole psychiatric care in the country. After twelve years, in 2001, it was enacted. Law 10,216, from April 6, 2001, also known as the Paulo Delgado Law and the Psychiatric Reform Law, established a new model of treatment of mental disorders in Brazil. The main goal of this law was the gradual replacement of the asylum clinical model by an extra-hospital network, supported by public funds. The law fostered an impulse to this process throughout the country. However, in many states, this process had already begun long before the enactment of the law. There's no doubt that it represented a great victory and also an important engineering, which further strengthened the reformation movement.⁵

Given the above, some experiences occurring over the years in Brazil stood out:

- In Santos, Sao Paulo, Brazil, in the early 1980s, there's, undoubtedly, one of them, especially due to its pioneering. It starts from the municipal intervention in the Anchieta Health House, a large private clinics participating in the program and unique in the region. The clinics was closed due to denunciations of abuse, violence, and neglect of its patients, with the parallel implementation of a network of daily care services, which were named Psychosocial Care Centers (NAPS).
- In 1987, in the city of Sao Paulo, the CAPS Professor Luiz da Rocha Cerqueira was created, the first in Brazil. The CAPS in Sao Paulo established itself through the initiative of workers from an outpatient unit in the city. Thus, its origin is primarily reflected on a clinical proposal change, which ended up becoming a reference and model for all subsequent proposals throughout the country.
- In Angra dos Reis, Rio de Janeiro, in the early 1990s, there was also a very significant experience. Within the period of three municipal administrations, the Public Power was able to prevent the occurrence of prolonged psychiatric hospitalizations, organizing care around a daily care service, which then was already called Integrated Activities on Mental Health Center (CAIS). In addition, the "Back Home" program, which proposes the social reintegration of people affected by mental disorders and discharged from long hospitalizations, according to criteria defined by Law 10,708, from July 31, 2003, which also provides for the funding of a psychosocial rehabilitation aid. This program brought back to their homes about 500 inhabitants, who were hospitalized, some for more than 20 years, in private clinics from other towns.⁶

• Psychosocial rehabilitation processes

In the early 20th century, the discussions about the cruel conditions of custody and treatment to patients in psychiatric institutions emerged. It took a few more decades so that the criticism to the asylum model referred not only to its inhuman character, but, especially, to its ineffective therapeutics.

In the face of the connection of the social exclusion related to madness, one thought of a de-alienating asylum process for these patients and their integration into society. As a result from this, there was an exchange of the traditional asylums by CAPS, which should show more agility and ability to prevent hospitalization. The CAPS should encourage the creation of projects concerning art, culture, and income, besides the organization of users and families' associations. The individual therapeutic projects should investigate and explore the users' abilities, the professional training, the digital inclusion, the self-care, and the increased user's autonomy. This new expectation brings along a new look on prevention, treatment, and social integration.

In this search for new mental health practices, the rehabilitation proposal emerges with principles able of grasping a new meaning for itself. It discusses not only new care models, but it also brings a dispute regarding the citizenship of people undergoing psychic suffering.

[...] Then, the rehabilitation process would be a reconstruction process, an exercise of full citizenship and, also, of full contractuality in three major scenarios: habitat, social network, and labor [...], we don't need schizophrenic painters, we need schizophrenic citizens, we don't need that they produce ashtrays, we need that they exercise citizenship. Something which doesn't mean to say that a step towards reconstructing contractuality pass through theater, visual arts, producing ashtrays, pass through, doesn't end in [...].^{7:16}

In the 1990s, national public policies were outlined in the health sector, establishing a care network which presented alternatives to hospitalization in psychiatric hospitals, with support from national and state legislations for ensuring a new care model for treating the population's mental health problems, besides providing the patients with mental disorders with the right to citizenship.

According to the aspects surveyed⁷ on the process of social reintegration and preparation of contractuality in the three large panoramas of life, habitat, social networks, and labor with a social significance, one thinks that:

[...] In concrete societies, especially the Brazilian one, the lack of social investments in the social area will determine that some people receive care and others are rejected by the care system. Those revealing a complete unfitness for work will be the most rejected ones, since, in the horizon of expectations, the inclusion in the formal or informal job market enters as a positive indicator in almost all care projects [...].^{8:24}

The contemporary man chases ways of social inclusion through labor, disregarding the fact that this labor isn't that available or flexible to tolerate the various individual and collective demands that the contemporary society establishes.

Inherent and indispensable to the capitalist model in which we live, exclusion is the pathway outlined by capitalism for some workers, the excluded share and that regarded as incapable (patients with mental disorder).

The de-hospitalization processes have coincided with the affirmation of the extra-hospital care models, they have rearticulated new spaces in the rehabilitation culture through labor, with a differentiated emphasis on the occupational therapy aspect, professional training, re-integration into the job market.

The proposed therapeutic activities generate new possibilities and purposes in the intervention process; they provide a knowledge and an experience which assist in the transformation of routines and established orders, offering people tools for their own use, extending communication and enabling personal growth, autonomy, social interaction, and cultural inclusion.

The work with psychiatric patients shouldn't be restricted to performing tasks, which end up keeping them restricted to the subjective and existential field. From this perspective, labor, the education process will start and have its intention completely directed towards the human being, in view of forming autonomous citizens able to establish their own health-illness-care processes. In this process, there's a quest to incorporate the praxis of values such as solidarity, democracy, citizenship, development, and equity, along with strategies involving some actors: individual, family, State.⁹

Thinking through the issue of right to work, there's, in Brazil, awe-inspiring structural unemployment rates, and it becomes even more complex when one thinks of the classes doubly excluded from this right, as it's the case of patients with mental disorders, who are excluded by the disease and the labor world.

• Social inclusion through work

Solidary economics may be understood as a movement which is established within the context of associated labor and which comes from multiple combinations and possibilities.¹⁰ It's also understood as an exercise of shared power, social relations, and cooperation between workers, favoring labor to the

detriment of capital, which experiences other forms of labor organization that can overcome the individualist and competitive capitalist economics.¹

It's a slow process presenting a disruption. It involves different rationales and principles of economic interaction, and it's, therefore, a set of practices constituting a wider dynamics. It was from the 1980s on that a significant number of workers excluded from the formal job market emerged and intensified the solidary economic experiences, based on the cooperation and self-management proposing the workers' influence on the productive process.

Given this reality, one clearly realizes the various movements and initiatives within the solidary economics context:

[...] It isn't a coincidence that several movements and initiatives, within the solidary economics context, repeatedly seek to invent new supporting elements, going beyond the immediate production and work process, highlighting the creation of social currencies, credit unions, new social technologies, mechanisms to achieve a kind of inter-organizational network or solidary network, among other initiatives [...].^{10:76}

Within this context, many workers have opted for solidary economics, from a perspective in which there may be a greater chance for patients with mental disorders, in terms of a practice encouraging self-management, social integrity, collective work, and solidary relationships, which may provide a social inclusion pathway for economically and socially disadvantaged populations.

The prospect of social inclusion through work is a strategy of the Federal Government for psychosocial rehabilitation of people undergoing mental disorders and also those who suffer from disorders resulting from excessive use of alcohol and other drugs. The laws 9,867, from November 10, 1999, and 10,216, from April 6, 2001, justify and ground this initiative from the Ministry.^{11,5} The first provides for the creation and operation of social cooperatives, aiming at the social integration of those who are disadvantaged in the economic market, according to article 3 from Law 9,867, defines as disadvantaged people: I – the physically and sensory disabled ones; II – the mentally ill, the people dependent on continued psychiatric monitoring, and people discharged from psychiatric hospitals; III – the drug addicts; IV – former prisoners; V – (VETOED); VI – people sentenced to alternative punishments to the detriment of detention; VII – adolescent people with an appropriate age for work and

difficult family situation from the economic, social, or affective viewpoint.¹⁰ And the latter provides for the protection and rights of people with mental disorders and redirects the mental health clinical model.⁵

The suggestion of the Social Inclusion through Mental Health Work is a partnership between the National Secretariat of Solidary Economics (SENAES), from the Ministry of Labor and Employment, with the National Coordination of Mental Health, from the Ministry of Health. It's presented and regulated by Portaria Interministerial 353, from March 7, 2005, establishing the working group of Mental Health and Solidary Economics, and providing for other issues.¹²

The solidary economics landmark as a movement to fight social and economic exclusion promoted by capital, emerges as a natural partner for discussing the exclusion of people with mental disorders from the job market. In fact, the movements of the Psychiatric Reform and the solidary economics share key principles by making the ethical, political, and ideological option for a society marked by solidarity. It's only in 2004, however, that these movements start meeting each other, to recognize and dialogue to each other, initiating a continued collaboration between these fields and among members of the corresponding social movements, having as a challenge the social reintegration of people discharged from asylums through the construction of solidary and self-managed enterprises.

The solidary economics, today an official policy of the Ministry of Labor and Employment, is an organized movement in response to exclusion by gender, race, age, lifestyle, and educational level, among other factors, of people from the labor field. It's clear in this reference frame the harsh criticism to the capitalist rationale of endless production of winners and losers. As the horizon of solidary economics one finds out the establishment of solidarity as a social norm and the construction of collective and self-managed enterprises in response to market exclusion. It's through a continued dialogue between the mental health and social economics fields that the Program for Social Inclusion through Labor of people with mental disorders and disorders due to use of alcohol and other drugs starts being outlined.¹³

● Mental health and solidary economics in Brazil

The solidary economics may be defined as:

[...] The set of associative economic initiatives in which: work, ownership of its

means of operation (production, consumption, credit, etc.), The economic results of the enterprise, knowledge about its functioning, and decision-making on issues related to it are shared by all people directly participating in it, seeking relationships of equality and solidarity among its participants [...].^{14:69}

It consolidates itself on self-managed and sustainable bases, and these have the difficult role of turning the solidary enterprises into democratic and egalitarian interaction centers, besides economically productive, contributing to the emergence in the society of a new development model, in which the human being receives the true appreciation.

Also understood as an instituted reaction to the exclusion posed by the capitalist market rationale, on the part of those who don't want a society driven by competition, or those who simply have no other survival conditions, unless alienate themselves by selling their labor power to this market, from which they emerge as winners and losers. It's above all, an ethical, political, and ideological option which turns into a practice when people want to be choosers and find the excluded ones and get together to construct solidary enterprises, productive, exchange networks, financial institutions, schools, representative entities, etc., pointing out a society marked by solidarity, from which nobody is excluded against her/his own will.¹²

The psychiatric reform also consists of those opting for a society without asylums (psychiatric hospitals), which join to patients with mental disorders (more severe psychic sufferers) to construct with them the institutional bridges leading to social and economic reintegration. One understands that there're many excluded people due to the most varied reasons – gender, race, age, lifestyle, etc. The fight against exclusion is taken by many social movements which, politically, mobilize, protest, and pressure the established powers, vie for elections. Economically, they construct joint ventures.⁴

In the early 2000s, several other projects popped up all over Brazil, specific experiences, some very successful, but that, nevertheless, suffered from the lack of public policies allowing projects to have the desired sustainability. Since 2001, support for social inclusion projects through work became public policies, thus enabling the support and expansion of them. At this time, the Technological Incubator of Popular Cooperatives (ITCP), located at the state of Rio de Janeiro, started organizing events which allowed the interaction among the various projects already existing. The event

“Fall down on this Madness”, held on four occasions, led within universities issues involving the Psychiatric Reform and, especially, the discussions on how to promote an effective network of projects on social inclusion through work, as well as on the mechanisms allowing these projects to grow and achieve an actual autonomy.¹⁴ In 2004, the Technical Area of Mental Health and the National Secretariat of Solidary Economics launched a partnership to promote the experiences of Income Generation in the Mental Health area, thus forming an inter-ministerial work group for discussing the theme.¹²

In 2008, ITCP was called by the Ministry of Health to implement a project consisting in the analyses of the projects benefiting from resources provided for by the *portaria* and in the design and implementation of a training course on management of solidary enterprises.

In 2010, important contributions to the Mental Health Policy and the Solidary Economics, with emphasis on the three national conferences held, which allowed the debate on the theme of social inclusion through work in a democratic and participatory way: I Thematic Conference of Social Cooperativity, II National Conference on Solidary Economics, and IV National Conference on Mental Health – Intersectoral (corpus). Also in 2010, the year ends with 640 mental health enterprises enrolled in the Database of Initiatives of Social Inclusion through Work (CIST) from the Ministry of Health, training more than 350 representatives of mental health solidary enterprises.¹⁵

FINAL REMARKS

This study sought to present, in a certain way, the history and development of mental health in the world and in Brazil and the development of solidary economics in Brazil and its interrelation with the inclusion through work of patients with mental disorders. In this action, by dissolving a concept still assigned to the mentally ill people of being incapable and doomed to abandonment, neglect, and, especially, exclusion, and walking towards the achievement of an actual implementation of full citizenship.

Otherwise, we think of contributing to sharpen a little bit the memory of those who care about issues related to the Psychiatric Reform movement, the anti-asylum struggle, social inclusion, and the construction of a

society with effective and efficient public policies.

In this study, one could see that the solidary economics provides patients with mental disorders with opportunities to become solidary workers and achieve not only the support for inclusion into the community and social world, but also enable their participation in decision-making and management of their own lives.

In the movement for solidary economics there's a possibility of establishing social relations more solidary and cooperative among human beings. By linking these issues of inclusion through work with mental health, we realize the great challenge of defining ways how these workers do their jobs, what actions are able to modify the pathway of suffering and how it can be modified, transformed into creative actions, so that it might favor a possibility of improving mental health and, as a result, of improving social life.

Therefore, one suggests to deepen the researches focused on the theme concerned, understanding the importance of the mental health public policies and the solidary economics as an auxiliary tool in this interrelation process.

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Submission: 2012/09/02

Accepted: 2013/01/19

Published: 2013/03/2013

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