INTERVIEW WITH ALEJANDRA BARCALA

ENTREVISTA COM ALEJANDRA BARCALA

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Context of the interview: Due to the health demands caused by the Covid 19 pandemic, the interview was carried out remotely, using the ZOOM platform.

Presentation of the interviewee

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Márcia Mazon: Could you tell us a little about your academic trajectory, as a researcher with a degree in Psychology and a Master's degree in Public Health. How do you arrive at this issue of mental health and human rights? Reflecting a little on the histories of Brazil and Argentina, the experience of a military dictatorship and how this option of thinking about mental health from the point of view of human rights arises, I believe that this implies a political choice. A way to face not only the biomedical model, but also this excess of medicalization that marks Latin America and society as a whole in the 21st century. Could you comment a little on Transitional Justice – right to memory, justice, reparation; a path that Argentina followed very well and Brazil did not. Do you think this marks the field of mental health differently in one country and another, and how, in your opinion, does this happen?

Alejandra Barcala: I started my studies during the dictatorship and when I was in the middle of my degree, democracy returned in Argentina, with which, at that time, since my formation, the logic of human rights was something that crossed my university trajectory. In Argentina it is very difficult to think about mental health without articulating it with human rights for several reasons. Clearly, the fact that our country went through a dictatorship and that during and after that dictatorship there was significant resistance from the mental health movements that accompanied the victims of state terrorism, made those people who were sensitized within the university clear, we were later crossed in our practices by the need for policies of memory, truth and justice. During the dictatorship, the important mental health movement that existed in our country was dismantled. Most professionals had to go into exile, many professionals disappeared; in fact, the president of the Argentine College of Psychologists is missing. During the dictatorship, all group activities in the field of mental health were closed and a series of community practices that had taken place in Argentina since the late 1960s were prevented. The first mental health policies in Argentina date back to that time, promoted by Mauricio Goldenberg, who started a very important movement in the field of mental health, which had to do with the first forms of work in the community and the opening of general hospitals for patients with mental suffering. During the Goldenberg dictatorship he had to go

into exile, and Valentín Barenblit, who was another important figure in Argentina, and many colleagues who were psychologists, doctors and mental health workers also went into exile. In 1983, with the advent of democracy, the field of mental health was reorganized again. At that time, the psychoanalyst Vicente Galli took over the National Directorate of Mental Health, and his management made an important link of cooperation with the Italian reform, implemented interdisciplinary residencies in our country and started to propose deinstitutionalization in the different provinces. He supported the experience of asylum isolation in the province of Río Negro, which was the first in Argentina and involved the closure of a psychiatric institution. Well, it was in this context that I started my practice, in a context of democratic openness where territorial work and interdisciplinary work regained value in the field of community mental health. And from there my journey began. I worked in the province of Misiones organizing a primary health care program for a health area with a high percentage of families living in poverty and with many rights violated. Later, when I returned to Buenos Aires, I got in touch with the chair of Public Health and Mental Health, directed by Alicia Stolkiner. This was the first course at our College that included the human rights dimension in the curriculum. There, my first steps were taken in conceptualizing, researching and intervening in the field of mental health from a rights-based approach. I would say that as a professional I'm kind of amphibious, because while I was working in the academy, I was working in the health services. At the time, I coordinated the first community service for children and adolescents with severe mental disorders, which later changed its name to children and adolescents with psychosocial suffering, which served the entire city of Buenos Aires. Important regulatory frameworks emerged in the 1990s, including the Inter-American Convention on the Rights of the Child, and then the fact that this perspective of rights was already present in the work of monitoring victims of State terrorism, along with these regulatory frameworks that expanded rights, allowed, even within the framework of a neoliberal government, to implement practices with a rights focus in the field of mental health.

In Argentina, during the 1990s, the mental health problem was largely silenced until in 1997 the report "*Vidas Arrasadas*" was published by the Center for Legal and Social Studies (CELS), which made the situation in our country visible. It reported that there were twenty-six thousand people hospitalized in psychiatric hospitals and showed the conditions of vulnerability and violation of rights suffered by these people. The presentation of this report generated a lot of indignation and put the mental health situation back on the State's agenda, which reappeared under the government of Néstor Kirchner.

When the CELS report appeared, when it became known what was happening in the

asylums, the whole of society became very sensitive about what the clandestine detention camps had been like, about the missing-detainees and the way the psychiatric institutions treated the people who were there. The treatment was so cruel, so inhuman and degrading that it almost turned into torture. For this reason, the field of mental health and human rights are and continue to be closely linked. Until today the violation of rights occurs in institutions, recently a user of one of the psychiatric hospitals was killed by a pack of dogs, others died by being tied to a chair.

In 2010, under the presidency of Cristina Fernández de Kirchner, the National Mental Health Law 26,657 was enacted, a law for the promotion and protection of human rights that establishes the definitive closure of psychiatric institutions by 2020. This was driven by what we call “the 26,000 laws”, which are the human rights laws that were enacted at the time. The governments of both Kirchners had a very strong policy that clearly established a public policy for the recovery of memories, with actions such as the annulment of the full stop and due obedience laws, and a series of gestures. Among them, removing the military personnel from the government house and taking over the building of the former ESMA (Marine Mechanics College), where one of the clandestine detention centers was located, and transforming it into a museum and memory,Truth and Justice Center. This reminds me of something that was also very exciting: last year, at the end of the year, at the National Council for Scientific and Technical Research (Conicet), where researchers and fellows work in our country, the files were opened for the first time workers of the agency who disappeared during the dictatorship and in an act in which the president and the minister of education were present, their files were returned to the families and the state apologized. In all these years these events were invisible and silenced, that is, we still continue with a proposal or a policy to recover certain memories.

Trabalho especialmente em pesquisas com crianças, adolescentes e jovens que se encontram em situação de vulnerabilidade social e com sofrimento psíquico grave, e o que mais nos preocupa são as crianças que estão institucionalizadas. Porque ainda hoje o nível de violação de direitos a que estão submetidos é imenso. Ainda há quartos de isolamento, ainda há contenção física (a contenção física é extremamente comum), há medicamentos (os chamados reforços todas as noites para que possam dormir), há distanciamento dos laços familiares ou afetivos e sociais. Há uma multiplicidade de violações de direitos. Nosso país é muito sensível às internações psiquiátricas e também às formas de campos de detentos desaparecidos. E isso levou ao movimento de resistência e é claramente uma opção ético-política. Nessa articulação entre direitos humanos e saúde mental, as Mães da Praça de Maio organizaram durante muitos anos os Congressos de Saúde Mental e Direitos Humanos, nos quais participaram milhares de

pessoas de todo o país todo mês de novembro. Muitos deles cumpriram as palavras de ordem da luta antimanicomial e tiveram forte impacto naqueles que foram os primeiros passos para a sanção e promulgação da Lei de Saúde Mental. Ou seja, todos os grupos que trabalharam pela sanção da Lei estavam ligados aos direitos humanos. Como nossa Lei de Saúde Mental é basicamente uma lei de direitos humanos, ela se enquadra nesse corpus normativo. I work especially in research with children, adolescents and young people who are in a situation of social vulnerability and with severe psychological suffering, and what concerns us most are children who are institutionalized. Because even today the level of violation of rights to which they are subjected is immense. There are still isolation rooms, there is still physical restraint (physical restraint is extremely common), there are medicines (the so-called reinforcements every night so that they can sleep), there is distancing from family or affective and social ties. There are a multitude of rights violations. Our country is very sensitive to psychiatric hospitalizations and also to the forms of camps for missing detainees. And that led to the resistance movement and it's clearly an ethical-political option. In this articulation between human rights and mental health, the Mothers of Plaza de Mayo organized for many years the Mental Health and Human Rights Congresses, in which thousands of people from all over the country participated every November. Many of them fulfilled the slogans of the anti-asylum struggle and had a strong impact on those who were the first steps towards the sanction and enactment of the Mental Health Law. In other words, all the groups that worked for the enactment of the Law were linked to human rights. As our Mental Health Act is basically a human rights law, it falls within this normative corpus.

Márcia Mazon: And now Alejandra, I would like to ask you to reflect on the tension between social inequalities and inequalities in health/mental health. We have, on the one hand, vulnerable children with little or no access to healthcare (your research shows this very well in relation to vulnerable hospitalized and medicated children - this construction of a pathologized subjectivity) and on the other hand a middle and upper class with excess of attention, medication, endless check-ups, hospitals that look like luxury resorts. However, when we talk about children's mental health, the design of this scenario shows that both high-performing schoolchildren and children in situations of vulnerability are excessively medicated and stigmatized, among others, with a diagnosis of ADHD and its corresponding medication. In Brazil, too, the diagnosis of ADHD follows the process of precariousness of public schools, with teachers who have Ritalin in the drawer and talk to the psychiatrist on WhatsApp to adjust the Ritalin medication, we have a student investigating this here in Santa Catarina in doctorate,

How do you see these processes?

Alejandra Barcala: The Covid-19 pandemic, as we have all seen, clearly deepened social inequalities and allowed those who work with children and adolescents in vulnerable situations to understand a little more how these social inequalities impacted their mental health. Because? First, there is something that is happening in Argentina, which is increasing and continues: the psychiatric institutionalization of boys and girls. That is, in recent years the levels of institutionalization of boys and girls have increased significantly. And, in general, what we saw is that this higher level corresponded to girls and boys from very poor homes or who were living on the streets or institutionalized in convivial homes.

We were surprised by the number of institutionalized children who were hospitalized by special measures (often because their rights were violated within the family) and who followed what we call a "medicalization circuit". Boys and girls attended the health services referred by the school because they had intense affectations or emotions, usually the product of social determinants. These were quickly understood in psychopathological terms and accompanied by various diagnoses. This is what we call the "pathologization of social situations". These diagnoses ended up stigmatizing childhoods and were accompanied by the prescription "they are not for here". In other words, these girls and boys with serious illnesses were quickly expelled from the health services and referred to other health services, thus producing what we know as a long "institutional drift". Parents, families went through different services. All made diagnoses, all ended up putting a label, which could be the same or different, reducing complex problems to psychopathological categories and promoting this strategy of transit without an anchor, with no place where they were received, denying them the right to adequate care. When no health service received them and the situation continued to get worse or they presented what they called "crises of excitement", after medicating them, they ended up in psychiatric institutions. Especially the boys and girls institutionalized under the protection system in Argentina, with intense psychological distress, were quickly admitted to psychiatric institutions during a crisis.

We think that the so-called "psychomotor arousal crises" are ways that girls and boys have to express their suffering when they don't have symbolic mediations to process it psychically, so the only way they have is to express themselves is with behavior. In general, boys and girls who have suffered a lot of frustrations are less likely to endure frustrations, less tolerance because the feeling they have, or the image they have, is that there will be no different tomorrow or after, a different time. These crises are often ways of expressing enormous

suffering that cannot be mediated by words, as they have not found an adult who, in their socialization process, has helped them to symbolically mediate this through words.

This pathologization was not only accompanied by the phrase “they are not for here”, but in many cases “they are for Tobar García”, referring to the neuropsychiatric hospital for children and adolescents in Argentina. In other words, they are boys and girls who have defined themselves and assumed a denigrated identity, a subordinated identity, a shared stigma that almost led to the loss of existence. It means to say that there is nothing more to do with these boys and these girls. Saying “they are for Tobar García” is like saying that they are not for the places of childhood, they are not for school, they are not for living as a family, they are for being hospitalized in that place where they lose all possibility of citizenship. Because they live in a total institution where they have no choice who to live with, they have rigid and uniform routines for everyone, few daily activities, they do not have access to an interdisciplinary service as proposed by the Law, to a team that can work in their territory, that can build bonds with families, with the affective referents of the community, who can understand the complexity of a social problem and act accordingly. They were not biomedical problems, but their suffering was the product of social traumas suffered, which, instead of being understood as situated in a social context, were understood as if they were individual psychopathological problems, outside the family context, outside the relational context, because outside the context community. And this quickly led to a spatial segregation that can be summarized as: "let's put these children and adolescents in Tobar García or in therapeutic communities for drug users".

In Argentina, these therapeutic communities and children's psychiatric hospitals are subsidized by the State, they are outsourced with State resources, but they are in private hands.

There are clearly two issues: on the one hand, those boys and girls with a greater degree of psychological and social vulnerability, where the performative value of the diagnoses leaves them outside of all conditions of existence. They are childhoods subjected to a medical power structure and autism spectrum, pervasive developmental disorders, schizophrenia and bipolar disorder are some of the diagnoses that are taken as a reference in manuals such as the DSM. And so their stocks are pathologized although, in general, they are problems that should have been addressed with community responses, answers that can be given within a more comprehensive approach, as determined by the current regulation, that is, the National Mental Health Law, provincial laws, the International Children's Convention, the integral protection laws for children and adolescents of almost every jurisdiction in our country.

On the other hand, in relation to what was consulted about girls and boys with high school performance, we carried out with Dr. Silvia Faraone, an investigation that made visible,

from 2000 onwards, the boom in the diagnosis of attention deficit disorder had begun in Argentina with the rise of the diagnosis of attention deficit hyperactivity disorder (ADHD). We noticed from the professionals' reports that the medication had increased, but specifically we could verify when we saw that the importation of methylphenidate had increased strongly and that this was linked to a greater diagnosis in girls and boys. We analyzed what was happening in schools in the richest part of the city and noticed that there were more boys and girls diagnosed with ADHD and medicated with methylphenidate. And this had to do with the need for them to respond to the demands of dual-shift schools, to the demands of a society that forced them to be successful, to compete in the market, that is, to respond to the expectations that fathers and mothers had about how they should be. On the other hand, when we went to the area where the poorest schools were located, in the public schools, the behaviors for which boys and girls were medicated with methylphenidate and diagnosed with ADHD were defined as typical problems of those who lived in poor families in which there was family violence. And we noticed that in those areas they were much less medicated.

Today, what worries us the most, since in Argentina more than 50% of boys and girls are below the poverty line, are the social determinants and their impact on child suffering. We currently find diagnoses more frequently, such as pervasive developmental disorders, such as the autism spectrum. Because the problem is that, just as the school has the great capacity to accompany and transform and open up a possible world for a boy, it also has the possibility of subjectively marking him with a diagnosis throughout his life. And that's what we see.

Institutions are producers of subjectivity and the way in which a school, a health institution looks at a boy, a girl, constitutes it subjectively. When she looks at it and names it in terms of pathology, in terms of diagnosis, in terms of devaluation and not in terms of its potencies, it generates an indelible mark on its subjectivity. We work a lot in schools and legal protection or rights services, asking them: When you report a child, do you highlight their strengths, their abilities? Or just mention the list of difficulties. What effects would be produced if, instead of saying that they behave badly, that they are restless, that they do not pay attention, that they fight with their friends, they mentioned some positive characteristics, their strengths, their abilities; for example, that he likes music, or that he responds softly when spoken to, that he has a good relationship with someone in particular etc. Why not make that bet? It's as if discipline has crossed us and we can't make generative bets. We seem formatted to make diagnoses, not to think of boys and girls in terms of their possibilities, their desires, their opportunities.

Marcia Mazon: Alejandra, we would now like you to address this intersection of legislation, politics and mental health. Although Brazil and Argentina have ratified the international convention on the Rights of the Child and have national laws for the protection of children (in Brazil, the ECA is more than three decades old), these rights are threatened in different areas, including child mental health. As her research shows very well, the discursive practices of professionals in the sector not only silence children, but these same practices produce suffering and silencing of vulnerable children. You show very well how "psi" knowledge limits the application of human rights. What are the possible strategies to unravel these processes and submit them to public debate? If you could explore a little bit this tension between human rights normative frameworks and mental health policies.

Alejandra Barcala: In Argentina, since the 1990s, we have had important regulatory frameworks for our region, since the Declaration of Caracas, with the International Convention on the Rights of the Child and the National Law on Mental Health. But nevertheless, there is a gap, a very important tension between regulatory frameworks and mental health policies and practices. There is a very important gap in this regard. The perspective is very interesting because Brazil and Argentina have a different history. We hypothesize that Brazil has advanced much more in mental health, in the fight against asylum and in the creation of Psychosocial Care Centers (CAPS), because they have a single health system, an integrated health system, something that Argentina has never may have.

In a recent investigation that we carried out on health services together with different provinces of our country on child health services, we observed that there was a better response, a greater range of responses in these provinces, such as Santa Fe, where the Mental health system is very integrated into the overall health system. There we have an important difference, because Brazil had an important anti-asylum movement, but it has a single integrated health system and Argentina does not. This, although we have sanctioned, from 2010, a very progressive National Law on Mental Health, which proposes the closing of psychiatric institutions by 2020, which builds the institutionality to protect the rights of hospitalized people. The Mental Health Law marked a transformation in the ways in which the State related to people with mental health problems. It installed a turning point and allowed the transformation of a biomedical, technocratic model, based on exclusion and the pathologization of the problems of poverty, to a model based on the perspective of rights, community integration, listening to users and proposing a strong participation and listening to people with psychological distress. And, above all, it installed a community model of mental health.

However, what is very good as a regulatory framework, contradicts what many investigations show is that there continues to be a high level of violation of the rights of girls and boys.

So, one might ask, what happens in Argentina that this regulatory framework has not been consolidated and implemented? First, to differentiate it from Brazil, we do not have an integrated health system. One of Argentina's central indicators is the fragmentation of systems between social projects, the public system and the private system, with which this also brings a whole series of complications. Surprisingly when it comes to mental health, middle-class boys and girls do not receive a better level of mental health benefits than others when they are in severe distress. This happens because they often also fit into the same logic of medicalization and pathologization of suffering and there are also no psychosocial strategies that accompany families or these children with interdisciplinary approaches in order to advance.

I understand that Basaglia's ideas, Basaglia thought, did not have as much impact in Argentina as in Brazil. He had it in the province of Río Negro, but not in the rest of the country, where there are only sectors that understand it as such. I think we also have a problem in the training of human resources, because most professionals are trained in institutions that do not think about mental health problems from the perspective of rights, but respond to technocratic, professionalizing and disciplinary models. In turn, any problem is referred to a health service as if a psychologist in individual treatment or a psychiatrist prescribed a mediation could solve it We think about the individual and not about the common, there is no context of the common to think about the field of mental health. This makes the tutelary, paternalistic, patriarchal models intensify. And in childhood this is worse, because a very strong adult-centered look is added.

There is also a budget issue, we often do not have the necessary or adequate amount of services to respond to or favor access, especially for those boys or girls with more serious problems. How to make? How is this changed? We have long researched and worked with institutions to understand the obstacles and contribute to the transformation of health policies and services.

Recently, the president of Argentina spoke of the need for a national mental health strategy. On 14 of June of this year, the I Forum of Research in Mental Health was held, in which researchers and public policy managers participated, with the objective of passing on the research results to them. In addition, they are considering implementing a national formation of a community mental health model to transform services and support this process of psychiatric deinstitutionalization and creation of territorial services. We have high expectations, the Minister of Health is committed to this and would have a budget to implement it.

In the province of Buenos Aires, a very interesting reform is beginning. The four existing psychiatric institutions are working on a process of deinstitutionalization and have already, even in the context of the pandemic, managed to ensure that a percentage of hospitalized people started living in convivial homes, with their families or in their community. The motto is "Buenos Aires free of asylums". They have a project to build a neighborhood of community housing within which there are some for users, and also to build cultural centers and memory spaces in psychiatric hospitals. In turn, interdisciplinary teams are being strengthened in General Hospitals and Primary Care Centers. And even in this difficult context of few resources and post-pandemic, a reform in the health system is being developed that we hope will be consolidated.

For example, in relation to children and young people, a program was created that we are advising and which, from an ethical-political stance, aims to “build the future in the present”. Its strategy is to listen and monitor children and adolescents. And precisely what we have been highlighting in the investigations is that they claim that they are not heard, that they want to speak and are not heard at school, in the family, or in the health services, and that, for example, when they are heard in the territories quickly, they assemble creative strategies to face the problems. For example, after the suicide of a young man in a school, his colleagues, alone, assemble a group that meets on Saturdays in the square to listen to others. They started making Tiktok and making music, and they went to ask the local health service to accompany them if they had any questions or faced a very complex situation. Based on this proposal, more and more young people participate in activities supported by health teams. So, what happens when these spaces for listening and participation are made possible and promoted in institutions? Young people have their own appropriation capacities and their own agencies to invent their own care devices. We propose that in order to approach mental health care, it is necessary to listen to the child and adolescent, their desires, their needs, their proposals.

Another challenge is to do work that involves the reflexivity of workers in the field of mental health, justice and education, that avoids adult-centric views, that is, that avoids giving meaning, saturating with meaning what happens to children and adolescents. Because that ends up objectifying them and doesn't open up the possibility of enabling their own voices. We say that boys and girls should not be empowered, but that they should accompany the power they already have, that is, not crush this power and have the capacity to be able to hear them in terms of subjects of rights, in terms of epistemic subjects that generate their own knowledge, their own narratives, and which can transform reality. For example, during the pandemic they complained that they thought of many strategies to go back to school or to help their colleagues,

and no one asked or consulted about how they thought they should take care of themselves, apply the protocols in their classroom, how they could follow a colleague with problems, how they could create bonds between them beyond the mandatory distance. What happens to adults that we cannot include boys and girls in the strategies, favor their participation, is it as if they really have no voice, as if we are really generating more and more protective practices?

Another issue is to recognize diversities, because if there is something that diagnoses do, it is, in some way, to unify, homogenize boys and girls as if they were a single group, and thus, territorial, ethnic, gender and cultural diversities are nullified. A service located in one territory is not the same as in another. That is why we propose that it is central to think about situated subjectivities, socially, culturally, geographically and historically. And also talk about gender diversity, because much of the violence we see in services is symbolic violence, gender disqualifications, various forms of discrimination. For example, in hospitalizations, gender identity is not respected and someone who was born biologically female, but who identifies with the male gender, is admitted to a female ward because “it is their biology”. And they call you with the name of your document and not with what you feel represented. That is, in hospitalizations there is subjective violence, violence on bodies, denial of their desires and the existence of these subjectivities.

Of course, we have to think about how we deal with social trauma, because in the face of the pandemic we have to be able to understand that it will take many years to recover. This is why many of the situations we need to symbolize today have to do with contextual effects and the elaboration of a social duel. These are not individual duels. We continue to think in terms of individual problems: "this boy doesn't want to go to school", "this boy doesn't want to leave the house", "this boy has difficulties". We must think about the manifestations and affects of childhood in a post-pandemic context, in a context in which the State, through its institutions, has to be present to accompany those situations that are more difficult to navigate.

We also have to reduce the gaps that exist, because there are clearly gaps in the possibilities of access to the necessary care and treatment. You saw recently that in Argentina there is a very strong attack on the National Mental Health Law and that this attack comes from the hand of many mothers of young people with problematic consumption problems who blame the Law for not being able to hospitalize their children. However, the problem is not the Law (which also allows involuntary hospitalization when there is a certain and imminent risk; as a last resort and for a determined period), but that there is no public policy that responds to its principles. It is not a problem of the Law, it is a question that there are no answers to the problem of problematic consumption other than hospitalization. The truth is that there are no territorial

services, interdisciplinary teams, that is, there is still a lot of work to be done. We don't have CAPS like you, we don't have psychosocial care, in many primary care centers or hospitals they don't work with children and young people who have problematic consumption, so clearly in crisis situations the only thing left is hospitalization. In addition, these families are also very unprotected and conflicts are generated that again call into question a very valuable instrument such as the Law, which, on the contrary, proposes a model of community mental health and starts to guarantee the rights of those who have forgotten, in and cannot leave.

The subject that Sandra works on, linked to psychiatric drugs and medication, is also a very serious problem. There are researchers who are working specifically on this topic in Argentina, but we have noticed that in homes where girls and boys deprived of parental care live together, the number of girls and boys who are medicated has increased in recent years, that is, when they enter the institution are quickly medicated or medicated. We visited homes where 80% of the boys and girls were medicated. They were admitted without psychological problems and, after a while, they were medicated with psychoactive drugs. This is a major concern given the level of vulnerability they are at.

Sandra - In the book "Mental Health and Childhood in the Autonomous City of Buenos Aires", you analyze the articulations and tensions between public policies and current legislation. This book, from 2015, shows the difficulties of implementing the mental health law, at least in the city of Buenos Aires, in relation to the classic model, based on the hegemony of biological psychiatry and psychiatric institutionalization. The questions I would like to raise have to do, on the one hand, with the formation of these doctors and the health professionals who work in these institutions. How does this process take place (somehow you already referred to it saying that they don't have a human rights perspective)? How does this formation centered on a biomedical hegemony particularly affect children? In recent days, a statement circulated to Congress, drawn up from the academic community, in defense of Law 26,657. I ask: why is it necessary today to create strategies to defend this framework of rights established by the Mental Health Law in 2010, when these rights already seemed to be consolidated? How to understand the resistance that today appears against this law?

Alejandra Barcala: Argentina is a federal country, therefore, according to our Constitution, the provinces and the City of Buenos Aires, a federal district, have autonomy in determining health and education policies. This means that they may not accept national government provisions, although in practice they usually make the same commitments or

adhere to national commitments. And the Mental Health Law, being a Human Rights Law, must be complied with throughout the national territory. However, for example, the city of Buenos Aires has been in charge of a right-wing government, the Macrista government, for many years. If we think about how the Mental Health Services are in relation to 2015, if there were changes, even in relation to Law 448 of the Municipality, which is also very progressive and is still not complied with, I would say that it is worse than what we described in that book, because at that time there were still programs that had a community perspective. Today the hegemonic medical model has intensified in the City and then the process of medicalization of childhood deepens. A thesis student I'm supervising is doing a study on young people and problematic consumption and can't find any territorial state service in the city of Buenos Aires that serves young people with problematic consumption to carry out her field study. It is very serious that these devices have been disarmed. The City is the stronghold where the more classical, more positivist hegemonic psychiatry prevails, which continues to think that the mental health problem is a biological problem, which has to do with individual characteristics and the answer must be hospitalization.

In 2012 I worked coordinating a community program of mental health care and the Macrista government disarmed it for considering that we had a very community vision and did not put young people in psychiatric institutions; and that this was some sort of danger to society. Just as they dismantled this program, they did so with many others who had this perspective. In other words, I would say that in the City of Buenos Aires, in addition to the current regulatory framework, there is resistance from the more traditional psychiatric associations and the union of psychiatrists known as "municipal doctors", a version of professionals with a perspective who occupy political positions in the and which opposes the implementation of the National Mental Health Law.

This does not happen across the country, for example in the province of Buenos Aires, which has a political line that responds to Kirchnerism, the opposite happens. Julieta Calmels, responsible for the Undersecretary of Mental Health, Problem Consumption and Gender Violence, implemented a plan fully articulated with a human rights approach. This program is really very interesting, it has a perspective that has been transforming mental health through cultural spaces, game libraries, with an intersectoral articulation with protection services, education, culture, sport, to broaden the perspective. There are many provinces that are doing very well in implementing reform actions.

From that media issue in which mothers appeared expressing their concern about the suffering of their children, the right manifested itself, which is against this perspective of rights,

which claims that the perspective of rights is something ideological, that they have the scientific truth about the what is happening and that scientific truth is being ignored. Above all, they criticize article 20 of the National Mental Health Act, which states that involuntary hospitalizations can only be carried out if there is an imminent risk. They question that and that people should volunteer or consent, and argue that families should be able to put people in if they wish and ask a judge, as it was before. Based on the Mental Health Law, the judge can no longer intern in a psychiatric hospital, for this there must be an interdisciplinary team composed of a psychologist or psychiatrist and a professional from another discipline that proposes that, in case of a certain and imminent risk, that person must be unintentionally compromised. Anyone can be admitted voluntarily, no problem. What is being strongly questioned are involuntary hospitalizations and there are four projects that try to modify articles of the Law. There is a very strong bet between traditional psychiatry and the therapeutic communities that press for the maintenance of the old paradigm and many of the mental health workers and human rights organizations. The Law also creates two institutions: the Review Body and the Lawyers Unit, whose objective is to guarantee the rights of interned persons. In an interdisciplinary way, they intervene, carry out audits and ensure that their rights are not violated. And that, for psychiatric institutions used to managing themselves as they wish, implies a very strong level of control, which they resist.

The formation of human resources clearly affects this while professionals continue to be trained in universities and with current residency models, also attentive to the proper implementation of a community health model. The organization of residences is another reason why the situation in the city of Buenos Aires has worsened. Before they were interdisciplinary and now there are psychiatrists on one side and psychologists on the other. Little can be generated, instead of progressing we are going backwards.

They asked me why. Because the National Mental Health Act was passed at a time when there was a lot of consensus, but clearly it never had legitimacy on the part of medical associations. It was a bid that was won by a progressive sector, but it was not followed by psychiatry, which was clearly totally against it. These attacks occur in a pendular way, that is, from time to time there is an offensive against the Mental Health Law, which is an advance against guaranteeing the rights of people with mental suffering to live in the community, have a job, be treated form a health center, in order to have a life. In fact, the difficulty of this perspective in accepting diversity, and any manifestation of otherness, as Rita Segato says, is a problem and only ceases to be a problem when it is sifted through an equalizing grid, neutralizing particularities. And those who do not pass must be put aside, as left over beings.

This is the line that crosses the judges of the court, a kind of psychiatrist and a political elite that opposes another collective context. These are the two country models that are strongly confronting each other in Argentina at this post-pandemic moment. The pandemic put mental health on the agenda and different ways of understanding it began to appear. In the media it is said that we have a pandemic of mental disorders in childhood and psychiatric diagnoses are attributed to various emotional disorders, but there is another perspective in the field of mental health that understands that they respond to defensive and adaptive reactions expected in the child and that we have to collectively try to overcome the difficult time we are going through and generate mental health mechanisms where girls, boys and young people are heard and accompanied.

Sandra Caponi: The last question we had to ask you was precisely about the pandemic and this was clearly seen around the world, here in Brazil it was very clear, the amount of mental suffering that occurred in times of a pandemic, the new diagnoses that several people who talk and they say they have relatives with panic disorder, children who no longer want to go out on the street, increased cases of autism, etc. I wanted to talk a little about the book you published, which is called "Facing psychological suffering in the pandemic", the chapter "Social vulnerability in times of pandemic. For the construction of mental health policies in Argentina", by her and Silvia Faraone, discusses the impact of social vulnerabilities, poverty, exclusion, aggravated by the pandemic, with the increase in psychic suffering. In the field of childhood, this could have led to a reflection on the conditions that produce psychic suffering: scarcity, poverty, marginalization and what we observe is yet another continuity, even in these moments, of the processes of diagnosis and psychopharmacological therapy. I wanted to ask you: How do you think children's mental health has been affected by the covid-19 pandemic? And how to understand the need to think about these social vulnerabilities and their relationship with the pandemic? I do not want to say that middle-class children do not have suffering, but to emphasize that the suffering produced, both in the most socially precarious children, as well as in the boys and girls who live in other social realities, seems to have worsened strongly in the pandemic.

Alejandra Barcala: At the beginning of the pandemic, we did work for Unicef that covered several locations in the country, investigating through references from children and adolescents and through games, what was happening to them. With a playful design, we realized that boys, girls and adolescents from all social classes, in addition to inequalities, had an

incredible playful and creative capacity that allowed them to elaborate on the uncertain and potentially traumatic nature of the pandemic. We, who thought there was a much greater level of suffering or difficulty, found ourselves with many boys and girls playing. In fact, we realized that the indicator to see if one or some of them were really bad was to see if they had stopped playing, if they had given up, if they couldn't connect. Contrary to the discourse of "how bad the boys are", that "they are suffering a lot", we note that in the first year of the pandemic the situation in general, that girls, boys and adolescents found enormous capacities to be able to elaborate and symbolize the situation in different ways. What, in the middle class, was processed through the use of digital technologies, in the popular classes happened in the game with the children of the neighborhood. They even showed a greater ability to play with the boys in the neighborhood than middle-class girls and boys who spent most of their time watching television. At this point, the adult-centric view of assigning meaning to childhood and adolescence was greatly affected, it was a misguided question.

I understand that the problems started to appear in the second part of the pandemic or post-pandemic with the return to daily routines. That time was and is a difficult time. That's when some indicators of psychic discomfort began to appear, for some it was difficult to return to socialization, to reintegrate, and I understand that in the face of this problem, the school and the teachers are the socializing agents responsible for intervening. We perceive, mainly in the boys from the lower classes, the value of the teacher, the girl, and the relevance of the school as a place for opening horizons, for cultural development. It caught our attention that when a teacher made a round trip with the boys and girls under her responsibility, when she was a close contact agent, these boys and girls had much more capacity to return and learn. And for those who have had or have difficulties, we have a critical view of pathologizing what happens to them, so we say that we have to rethink the issue of trauma, not pathologize these levels of suffering, but we had to accompany them in the current social context.

I think that for us who work with human rights, these lessons are very important to think about the pandemic today, that instead of saying "this boy has a phobia" or this "boy has ADHD disorder and we are going to medicate him so he can get out of his house" try to listen, understand and accompany. We can listen and generate social, collective processes, and this includes the media that operate all the time generating this representation, this narrative of childhoods that are totally objectified, instead of subjects of rights. When a boy receives a diagnosis and is medicated, you take away the possibility of his agency, take away his power, take away the possibility of thinking that he is capable of transforming his world, the possibility of building his citizenship, of building autonomy, of having a lot of to say and do, to transform

in relation to their lives. I believe that we put boys and girls in a place of subordination where there is no other option but to be the diagnosis we give them. It is important to note that when a boy or a girl is seen differently, he will react differently, and if he is labeled insane, medicalized and committed to a psychiatric institution, he will act according to the imposed etiquette. And I think we should reflect on the effects of diagnoses. If we say "this boy has a psychotic disorder" or "he has a bipolar disorder, a phobia", it's like saying "I'll stay calm about it". In this way, I put a label on them and exonerate myself from the social obligation we have to alleviate their suffering and transform their lives.

Sandra Caponi: This question you were talking about about the two models that are in conflict, a model that has to do with human rights and a model that says: "we are not scientists". I believe that the intensity of this degree of scientificity should be reduced a little, that is, to demonstrate the epistemological disputes that exist in this field, to show that it is not as scientific as it is said to be. To conclude, and now to conclude, I would like to hear from you what do you think that the social sciences in general, sociology, can contribute to this process?

Alejandra Barcala: I believe that we at the academy have an obligation to build knowledge that contributes to solving the problems that our people have, in our case the suffering that children and adolescents have. I believe in the construction of categories that allow us to think about problems and transform realities, that help those who are permanently working in the territory, to rethink and reflect on their practices, to have tools to be able to distance themselves from everyday work and be able to think and build strategies, alternatives, from a rights approach, this seems to me to be central.

And I believe that, as Boaventura de Souza Santos says, the academy has to think of itself in terms of extension, cooperation, collective construction of knowledge that can be useful to workers in the areas of health, education and justice, who allow thinking of better forms of intervention in the approach to alleviate human suffering. How can we reveal through our knowledge that this is not so scientific? How can we reveal that boys and girls are not objects? How to make institutional violence visible? How can we make rights violations visible? And also this, which seems central to me, how can we contribute, how can this be transformed? Because I think that sometimes the only thing left for the academy to do is to analyze the realities, which is not little, it is extremely valuable to show how certain issues occur, but also how to deconstruct them, how to transform them, into those questions that you asked me and that we've been working, how do we make sense? How do we construct a meaning of what is

happening? But, at the same time, how do we think about the challenge of building and being able to think in different formats? I think we owe a debt to be able to convey this in the media as well, to build narratives that compete with the hegemonic narratives, because clearly mental health is a field of dispute. I believe that we have a lot to contribute with arguments so that this discourse has more force in this dispute or can win it.

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