The Brazilian psychiatric reform: historical and technical-supportive aspects of experiences carried out in the cities of São Paulo, Santos and Campinas

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ABSTRACT

The Brazilian psychiatric reform: historical and technical-supportive aspects of experiences carried out in the cities of São Paulo (capital), Santos and Campinas, in order to understand their material, social and political impacts, the progress in the process of breaking away from the psychiatric ward model, and the establishment of creative and productive groups, required to build up the psychosocial treatment in regard to mental health, as well as to evaluate the contribution that the SUS (Brazilian Public Health System) had on the psychiatric reform in the mentioned cities. The research, which is the basis of this paper, is part of a thesis regarding mental health care, whereby the innovative projects implemented in those cities served as framework and basis for comparison to analyze mental health policy in small and medium-sized cities and towns in the state of São Paulo.

Key words: mental health services, mental health, public health, National Health System (BR), health care reform.

Introduction

Since the establishment of SUS (Brazilian Public Health System) and its legalization by the Federal Constitution of 1988, when many cities in Brazil looked for actions to all health care sectors in order to make the users' legal rights feasible, many great difficulties have been ascertained to put the general directives about the sanity and psychiatric reforms into effect.

Fortunately, it has been possible to realize that some innovative actions, which strengthen the SUS, have been developed throughout proposals which had to fight off the "neo-liberal project" strongly set up in the country, mainly with regard to the increase of the private health system as well as the conflicts caused by it. Such actions have promoted the configuration of a new shape to the health and mental health policy throughout several institutional mechanisms, mainly the one of the decentralization.

Some cities and towns have taken over the mental health care and have demanded the federal and state government not only take charge of their responsibility and participation in the process as well as build up technical and operational instruments to allow them to establish and implement their mental health care.

Thus, many innovative experiences have been carried out in some of the cities and towns in the State of São Paulo. One of the most well succeeded ones is the construction of the first CAPS (Center of Psychosocial Care), in 1987, in the city of São Paulo (capital), under the name of CAPS "Prof. Luiz da Rocha Cerqueira", which is really a mental health policy innovative model, having been built up later in other cities.

In addition, in 1989, important cities like São Paulo, Campinas and Santos first elected their Labor Mayors, who nominated for the local health department professionals committed to the sanity reform, a decisive factor for the political and institutional process for the SUS setting up. When they took over their assignment, they did it in the means of instituting new directives for the mental health area, highly considered relevant to the psychiatric reform looking forward to putting the SUS into effect.

The establishment of the NAPS (Psychosocial Care Nucleus) in the city of Santos as well as the CAPS in the city of São Paulo, showed an indubitable influence of these experiences on the mental health national policy. The promulgation of the *Portaria*[1] 224/92 (a government regulation) of the Health Department which has ruled since January of 1992 can be considered as a result of the influence above mentioned. It restated the principles of the SUS, established and regulated the structure for the new services in regard to mental health designed for the experiences developed in the CAPS and in the NAPS. The new services named by the *Portaria* 224/92 as CAPS/NAPS were defined as local and regional health units being classified according to the localization of the population assisted by them, and they should render an intermediate care between the hospital ward regime and the hospital internment.

The CAPS and NAPS could also constitute the entrance door to the service net for the actions related to mental health, considering its characteristics of local and regional health unit. Referenced patients coming from the other health services, psychiatric urgency services or coming from hospital internment could also be assisted at CAPS and NAPS. They should be integrated to an independent and hierarchically structured net of care in regard to mental health (Brazil, 1997).

Although the *Portaria* 224/92 had meant an important progress to the development of the psychosocial attention, it should be pointed out it has some limitations. According to Amarante & Torre (2001), one of these limitations is the fact of the *portaria* 224/92 evaluated as equal distinct

[1] Portaria is a regulation which is not a law yet. It only regulates an specific action for an specific period.

experiences (the establishment process of the CAPS and the NAPS), which theoretical-conceptual, and technical-welfare work inspiration were different. At last, it considered both process a simple modality of service which apparently had come up from the identical models, losing their plurality.

This situation was modified when the health department promulgated the *Portaria* 336/2002. In this new regulation, the NAPS denomination is not associated to the CAPS denomination anymore. It chooses the simple nomination of CAPS, defining three different modalities based on its size/complexity and population range so that they can first treat nearby patients who suffer with severe and persevering mental disorder and are undergoing intensive, semi-intensive e non-intensive care.

Thus, CAPS should offer hospital ward service of daily care, and they should work following the area determinations as well as be independent from any hospital structure.

Moreover, they should articulate all the instances of care in regard to mental health developed in the basic attention in regard to health, in the Family Health Program, in the hospital ward and hospital net as well as in the activities for social support such as: protected work, leisure, sheltered homes, attention for social welfare matters and other rights (Brazil, 2002).

In the meantime, because of they work 24 hours a day, only the largest and more complex (CAPSIII) can be a strategic instrument to the changes of the assistance model in regard to Mental Health, guided by the logic of net and territory and, therefore, in accordance with the NAPS' proposal.

In this meaning, this article seeks to discuss the experiences which have been carried out in these cities since the 80s in order to understand their material, social and political impacts required to the establishment of the psychosocial treatment as a process of changing in the psychiatric ward and psychiatric paradigm in the political and ideological range as well as the theoretical and technical range. As a complex social process, the psychosocial attention is developed in the heart of the modern science paradigm transition process and it is supposed to articulate the simultaneous and interrelated changes in many dimensions regarding to the following areas: epistemological, techno-assistance, jury-political and socio-cultural (Rotelli, 1990; Amarante, 1996, 2003). Thus, the psychosocial attention looks forward to a radical change of the knowledge and psychiatric practices and related subjects, becoming

> a field able to congregate and nominate all the practices to replace the
> Internment Mode, but still open to the new actions which have been
> developed in the terms of psychosocial rehabilitation and others which
> will certainly come.(Costa-Rosa et al., 2003, p.34)

The research which is the basis of this paper is part of a thesis which regards to mental health care (Luzio, 2003), in which the innovative projects implemented in the cities of São Paulo (capital), Santos e Campinas served as framework and basis for comparison to analyze mental health policy in small and medium-sized cities and towns in the state of São Paulo.

São Paulo: distinct experiences in different Public Administrations.

The proposal of the State Health Department (SES): the Center of Psychosocial Care CAPS "Prof. Luiz da Rocha Cerqueira"

In the estate of São Paulo, from 1982 to 1986, during the André Franco Montoro Administration (PMDB)[2], guided by the project of mental health established in 1973, by Luiz Cerqueira, the extra-hospital care net was extended due to the development of actions in mental health at the Health Basic Units (UBS) and the building up of new hospital wards. In this context, the city of São Paulo, during the Mário Covas Administration (PMDB) through the Sanitary and Health Department, in partnership with the State Health Department (SES) of São Paulo state, carried out the Metropolitan Health Plan which was financed by the World Bank. Such experience was very useful to organize the services in regard to mental health, inserted into the public health net.

According to Cesarino (1989), it was started a wide process of discussion and critical reflections with regard to the usual execution of these actions and the public policy of mental health. Supported by the workers organization this process was enforced and made possible the establishment of new rules to achieve the collectivity. Programs of Maximum Intensity (PIM) are developed in the hospital wards directed to patients with intense psychic suffering. This program was one of the starting-points to the building up of the Psychosocial Care Center/CAPS, settled down in 1987.

To Yasui (1989), the building up of CAPS "Prof. Luiz Rocha Cerqueira" was

> […] an ultimate gesture of a public Administration. It was the place which took in some professionals who had lived significant experiences in public institutions holding important positions but even having to leave their activities and projects unfinished, they had not lost the capacity of dreaming about utopias (a society free of real or symbolic psychiatric wards with institutionalized violence, but a fair society where everybody has equal rights, etc) and moreover, they still believed that it was possible to build up a way towards them. (Yasui, 1989, p.51)

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[2] PMDB is a Brazilian political party. Until then, it used to be the most important and largest political left party which had worked in opposition to the Military Government recently finished.

The CAPS, placed in Itapeva Street, one block far from Paulista Avenue, in the city of São Paulo, was enrolled in the hierarchically structured, regionalized and integrated system of action in regard to health which was already established, with an intermediate structure between hospital and community, aiming to attend patients who considered psychotic and neurotic in severe degree. Thus, the CAPS acted as a structure of passage, in which the patients stayed until their clinical conditions become steady to go on the definitive treatment in hospital wards.

In this way, the center board of directors built up an institutional organization which should be simple, flexible and permanently open to new changes to assure quickness and diversity in the several therapeutic modalities.

By the original project SES-SP was supposed to build up a net of CAPS. It had the mission to develop a clinical practice whereby the patient speech could be taken "not by the symptom examination, but as the production of a social subject inside the limits, certainly problematic ones, imposed by the insanity" (Goldberg, 1996, p.21).

Thus, it aimed to break away from the model centered in the conception of disease as a mistake or disorder and whose treatment would have as an aim only the simple remission of the symptoms presented by the patient, through out moral practices which mechanize, homogenize and bureaucratize them. In short, it was intended to have a therapeutic project to make possible to approach the "mental illness taking in account an extended therapeutic set which is constituted in the doctor-patient relation to provide the emergency of the illness confrontation and awareness process itself" (Goldberg, 1996, p.58-9).

So, the CAPS clinical proposal was the development of a practice based on the routine of both the institution and the patient due to permit the establishment of a sociability net capable of causing the therapeutic instance arises. Therefore, they worked to establish new collective rules to the circulation of the speaking, listening, experience, expression, the concrete making and the exchanging, the sense unveiling, the elaboration and decision making. The interventions should activate several therapeutic practices (medication, psychotherapy, groups, patients' meetings, expressive activities) in the patient global approach, based on the contemporary conceptions of psychiatry, other fields of the knowledge and, mainly, on the whole experience resulting from the practices (Goldberg, 1996).

At the beginning of its activities, the staff faced many difficulties. One of them was the moving-away between professionals and patients due to the lack of experience of the staff and also the prejudice against people with intense psychic suffering. There were still difficulties to break away from the medical model, as well as with the plan of actions hierarchically structured and the definition of professionals' competences in the therapeutic process. Slowly, the staff improved, and

started to realize the patient in his singularity, to value the collective projects, to admit the treatment as a continuous and long-term process of changes, as well as to conceive the institution as a reference to the patients (Goldberg, 1998).

In this context, another important instrument was instituted. It was settled down a civil entity, Franco Basaglia Association, with the participation of patients, family members and other interested people. The association, with the CAPS collaboration, started to build up especial projects to promote the autonomy, and a wider range of clients; to motivate the participation of family and other social segments, make possible the extra-clinical management of the patient's life (in the way to amplify the contractual power and also the possibilities of emotional and material exchanges) at last, to stimulate the entire citizenship and spread new values, notions, concepts and ways to realize the insanity and to put its care into effect.

Since the beginning of the project, the members of the team had often kept interpellation with other services which had also assisted people with intense psychic suffering. Among the interchanges, these ones stood out: 1) La Borde Clinic, in France (built by Jean Oury, in 1953, and also the place where Felix Guatari worked), about the formulation of perceptible interventions to the psychosis characteristics; 2) Mental Health Center of Setubal, opened in the decade of 1970, in Portugal, in charge of the public psychiatric care in several cities nearby, to operate with the sector conception used in the definition of the geodemography of the population to be assisted by the CAPS.

The SES-SP proposal to settle down a net of CAPS did not improve due to the retrocession caused by the Quércia and Fleury Administration (from 1987 to 1994), and also, to the implementation of the process in which the local Administration is totally in charge of the public health once the state Administration started to diminish its investment to create new health services. But the experience of CAPS "Prof Luiz da Rocha Cerqueira" remains as having been enough promising and the inspiration for the mental health national policy.

An experience of the local health department: the Convivial Gathering Centers and Cooperatives (CECCOs)

In 1989, the local Administration of the city of São Paulo, committed to the principles and directives of the psychiatric and sanity reforms, introduced a program of mental health based on two fundamental premises:

- the **first one** is that the psychic suffering was an integrating and inseparable part of the global suffering of people submitted to social differences;

- the **second one** is the relevance of a mental health policy that, in fact, breaks away from the hegemonic model centered on the psychiatric internment and in other psychiatric ward model.

According to the mental health project of the Health Local Department –SP (SMS-SP), this break would be carried out through:

- popular awareness, the fight against private interests and a net of assistance which could provided conditions to stop the hospital internment practice.

- giving priority to places for discussion with the local population as well as the unions and popular organizations, in order to explain the insanity and the mental disorder, as well as to promote the reflection of its social determiners.

- recognition and valorization of the knowledge, and the popular and cultural practices as a way of psychosocial balance; investment to extend the net of extra-hospital Mental Health services, according to the principles established by Health World Organization – HWO (Braga Campos, 2000).

According to this author, the mental health policy in the city of São Paulo resumed the psychiatric reforming model based on the primary attention to the health and guided following the principles of the SUS and the Statements of Caracas, in which new ways of primary attention are defined.

The SMS-SP also established new intensive attention services guided following the day-hospital model. It still developed actions to integrate groups of people excluded from social living and leisure possibilities: the Living Centers and Cooperatives (CECCOs) (Scarcelli, 1998).

The CECCOs were regulated according to two directives. At one side, they intended to fight off the psychiatric ward culture and withstand the arising of another psychiatric ward sign as well, besides the bureaucratic power of professional and institutional practices. At the other side, they proposed the inclusion of the patient; his family and the people who live on the fringes of society and are disperse through out it.

Eighteen CECCOs were established in parks, sports centers, squares and community centers of the city of São Paulo. They sought to turn the public property in collective space and, in this way, to make possible for people to live together as a process to rebuild the life history and future perspectives; the establishment of new bonds; and the relation of experience, representation an reality (Lopes, 1999).

The CECCOs were a service with cultural purposes and not only techno-professional. Essentially, they used resources from Arts segment performing an inter-sector action with other culture instruments, with education, housing and sports. The practices were related to music, handcraft, painting, dancing, acting and sports. Moreover, the Living Centers promoted activities to give a new meaning to the work process, aiming the social inclusion. For this reason, some nuclei of work were created and they were in charge of goods and services production. These nuclei, besides being responsible for the goods sales and the profit share, they observed, questioned and analyzed the

whole productive process, including not only the product to be sold, but also the subject production that produces it.

In short, the experience developed by the local ruler at the beginning of the decade of 1990 reproduced, in a general way, the logic of the hierarchically structured model introduced in the 80s. However, it should be observed that the introduction of the CECCOs represented a significant contribution to the development of new ways of mental health care, although it has not been incorporated in the mental health national policy. It is an instrument which composes an articulated net of attention in mental health, and its purpose is to create the right to life, to the citizenship and spread out new values, notions, concepts, and ways to realize the insanity and put its care into effect.

During the Maluf and Pita Administration (1992-2000), this project was taken apart. In its place it was established the Plan of Health Care (PAS), in which the whole health and mental health care and other services were given to the cooperatives of professionals to execute them under a contract between the Public Administration and these institutions. So, they became responsibility of these cooperatives. The health municipal professionals, specially the mental health, did not join the PAS and the cooperatives hired new and inexperienced professionals. Thus, the actions, once more, became restrict to consultation and medical examination, based on the traditional model, doctor-curative. In truth, the PAS only produced lack of care and chaos to the public health system.

From 2000 on, the Marta Suplicy Administration has sought to reorganize the local health system and to establish the current mental health policy.

Santos: "cracking" the model of Brazilian psychiatric reform

Since 1989, the city of Santos has joined the fight for the development of the SUS. As the main city in the metropolitan area of Baixada Santista, in the southern coastline in the state of São Paulo, at that moment, this city presented a disorganization of its urban area, clearly perceived by the lack of projects dedicated to the border areas, multiplicity of collective houses and the increase of the buildings in dangerous areas as well as shantytowns. In short, it was clear the huge social debt of the local Administration with the lower class citizens.

The new local Administration, committed to social tissue, proposed to develop "an integrated and harmonic urban policy able to provide the population a better quality of life and decrease the differences concerning to the appropriation of space and the urban life advantages" (Caspritano Filho, 1997, p.17).

In the health range, according to Campos (1997c), until 1989, the sanity reform had not produced any "echo" in Santos. The organization of the health services was deficient and ineffective because it still reproduced the same logic and range of that one in the decade of the 1940.

The Sanitary and Health department of the city of Santos (SEHIG), also conducted by important agents of the sanity reform movement, took over the establishment of the SUS and then could demonstrate its viability and its commitment to the "Defense of Life". For this reason, it sought the combination of clinical practices and the ones of health promotion, as well as the decentralization and inter-sector exchange of actions. Then, it was in the mental health area that a higher radicalization degree of the "in defense of the citizens' life" model (Campos. 1997c) occurred.

This process was started by the beginning of the intervention decreed by Mayor Telma de Souza in the rest home Anchieta, in Santos, after an all to gether inspection performed by

the local Administration and many other sectors of the civil society (Nicácio, 1994).

After the intervention, the first actions were made in order to create basic conditions of convivial gathering in the hospital.

For this reason, they:

- stopped all and any situation or act of violence, forbidding physical and oral aggressions, the safety cells and the electroshock devices were taken apart.

- opened all the internal places in the hospital in order to make easier to people come and go even the visitor's access to inpatients.

- got back the sanitary and diet conditions to inpatients as well as their health conditions.

- reconstructed the inpatients' identity by the continuous act of calling them by their own names and by the definition of places (bedroom and bed) where they would sleep.

- recovered the inpatients' life history, as well as reviewed the diagnoses and medications.

This group of actions had an important meaning, because they represented the beginning of a new institutional order: non-violence; non-humiliation; more treatment; more dignity; more liberty; at last, the possibility of living with dignity.

Kinoshita (1997), one of the main agents of that process, defined the moment as the deconstruction of the "old order" and the construction of another one committed to a "new ethic".

This new ethic, which mainly got inspiration on Italian democratic psychiatry, began to guide the introduction of a new mental health policy in Santos. A policy which came from the radicalization on the confrontation and the facing up to powers (public power x hospital owners) as well as from the daring to put "the psychiatric ward up-side-down"; introduce and institute a process of "denying the institution itself"; and break away from the exclusion logic. In short, a policy which intervention made possible to put the illness enclosed in brackets, and to establish the contact with a person

considered insane, it means, with his existence-suffering, inserted into the social tissue. Interning does not mean to treat. At last, this intervention made possible to fight for a society free of psychiatric wards. (Nicácio, 1994).

It sought the organization of the activities inside the hospital, guided by the reactivation of the subjectivity of all agents in the process, inpatients and their families, workers, managers and the local population. There was not a model to be followed and the starting point was the patients' needs. Places were designated to convivial gathering, they opted for group activities and even their needs, conflicts, desires and demands were discussed in groups.

> […] the moment of the meeting represented the denudation of the codified roles what made possible to professionals and inpatients talk, think and came up with alternatives and possibilities. (Nicácio, 1994, p.72)

At the same time the actions were directed to the spaces inside the hospital, it sought to involve the local society aiming to get closer the hospital/city relation, in order to facilitate the interchange of inpatients and community. In this way, they stimulate the local population to visit the hospital by promoting parties, visitings and other meetings. At the other side, they took the inpatients out around the city; they visited expositions, went to the movies, theaters and parties.

In addition to this interchange, it was introduced another strategy to stimulate the relation between hospital and community. They reorganized the hospital space in a way to accommodate the inpatients in wings and hospital wards corresponding to areas of the city. Thus, the several inpatient groups had their own reference team. These teams, at the other hand, also had the attribution of learning the inpatients' social-economical-cultural contexts, as well as to look for resources and develop projects in the territory in which the inpatient had been included. (Kinoshita, 1997).

From that moment on the development of new services and a new model for Mental Health Care was started. From 1989 to 1996, it created: five Nuclei of Psychosocial Support (NAPS), Unit of Psychosocial Rehabilitation, Tam-Tam Convivial Gathering Center, Sheltered Home, Nucleus of Drug Addicted Care, and Urgency Service in the Local Emergency Rooms.

The NAPS were able to attend all the mental health demand in each region, mainly the most severe cases. They began to work non-stop, executing full time hospitality actions during the day or night time; hospital ward care, home care; group care; community interventions; psychosocial rehabilitation actions and to deal with crises occurrence. The Psychosocial Rehabilitation Unit was in charge of coordination and following up the patient's working projects aiming his autonomy and social participation, projects such as: clean garbage; apian product sales team; water deposit

cleaning; adopt a tree; and building. In 1994, The Mixed Cooperative Paratodos[3] was set up based on this unit project. The convivial Gathering Center Tam-Tam promoted cultural and artistic actions and managed the radio station Tam-Tam. The Republic took in the severe users, former residents from the rest home Anchieta who had no family ties. The Nucleus of Drug Addict was in charge of drug addict attention through full time hospitality, hospital ward care, individual or group attention. Finally, the urgency service in the Emergency Rooms gave support to the whole system.

That substitute service net, developed in Santos, proposed to: 1) respect the guarantee of the user's rights to hospitality, as well as his protection or continence, according to his needs; 2) have available a quick and plastic institutional routine, able to response to the user's claims or the ones of his family's members. 3) insert assistance actions in the territory where the user came from; 4) priory the projects of life in the assistance services; 5) promote a continuous process of user valuing and his consequent social reinsertion (Kinoshita, 1997).

In short, according to Braga Campos (2000), when the experience developed in the city of Santos starts its mental health project from the inside of a hospital which was under the intervention of the local Administration, it breaks away from the logic of this model; makes possible the experiences extend; and other new models are created which innovations have guided the net remolding of the mental health care, the break away from the psychiatric ward logic predominant in the service organizations and work process, as well as overcome actions hierarchically structured, developing actions having the street as a therapeutic place, the articulation with the PSF and with other territory resources.

From 1997 on, the local Administrations which have come to power have not formally taken apart the mental health attention net which had been developed until then. The services have been working, but the mental health project has been stopped after having had its implementation until 1996.

Campinas: the development of a new model of health care and management in two periods.

In Campinas, since the years of 1970, the Health Popular movement had acted in a very well organized way. It was the fundamental actor for the development of the health basic unit local net, started, in 1976, by Sebastião de Moraes, local health Secretary, in charge of the local health department, and doctor for one of the main hospitals in the city (L'Abbate, 1990).

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[3] Translator note: the cooperative name not translated to English, "Paratodos", in Portuguese, is the joint of two words "para" and "todos", and in English it means "for everybody". In the context, these two words were joined just to compound the name given to the Cooperative, but they are always used separately.

But, in the decade of 1980, the local health authorities, and PUCCAMP[4] and UNICAMP[5], not only went on developing of a Health Integrated System, but sought its improvement. According to L'Abbate (1990), they improved the directives of the Pro-Attention Municipal Project (a version of the CONASP developed in Campinas) and the city started to organize and manage the services and the actions under their responsibility.

However, in Campinas, as in the other cities in the state of São Paulo where the current mental health policy was introduced, such proposals did not significantly change in the dominant psychiatric ward logic.

It was only from 1989 on, when a local Administration committed to popular movements and with the establishment of the SUS came to power, this scenario could be changed. The SMS[6], from that time on, took over the planning and improvement of the process in which the local health policy was totally taken over by the local Administration having the Municipal Secretary of Health who was in charge of the local health policy as the chief of the Local Health Council (L'Abbate, 1990).

The SMS sought to give the population the assurance of the access to health services, improving and professionalizing the health centers, turning them into "entrance door", following the rules of SILOS. It replaced the Immediate Attention by hospital wards and made possible the Municipal Hospital becomes an effective emergency service in the city (L'Abbate, 1990). At the same time, it developed some actions in order to integrate the mental health care to the general health system, in its several levels of complexity and in a progressive way (Braga Campos, 2000).

In the mental health care policy, the SMS sought ways to promote actions to break away from

> the guided models of the welfare system, which mechanically produced in mental health what was proposed in the general health by means of a hierarchically structured system in the primary, secondary and tertiary attentions. (Paulin, 1998, p.146)

Medeiros (1994) states that, at that moment, it was held the I seminar on Mental Health counting on health professionals and local Administration manager, and also, it was set up administrative reforms in regarding to the services, and the co-administration in "Cândido Ferreira" psychiatric hospital. In the I Mental Health Seminar, held in 1989, according to this author, the conclusions restated the directives of the model previously set up, but its deliberations had different

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[4] PUCCAMP stands for Catholic University Pontifical of Campinas - SP, one of the most important private universities in Brazil.
[5] UNICAMP stands for University of Campinas. It is a state University of São Paulo State and one of the most important public universities in Brazil.
[6] SMS stands for Local Health Department

comprehensions among the social agents involved with them. This provided territorial delimitations which caused conflicts and contradictions in their practices.

Seeking for breakaways from the welfare system-communitarian model

The set up of mental health care project which elected the health center as the "entrance door" caused to the users the increase of the access possibilities, as well as the capacity of health problem resolutions. It started an administrative reform which shut down the mental health hospital ward, decentralized the services, and reorganized the roles and attributions of the professionals who worked in mental health attention. Finally, it sought to develop a model of attention guided by new patterns of planning and administration, resource policy, clinical practices more lined with the "in defense of life" model, and not only directed to the mere reproduction of work force (Campos, 1994).

The promoted changes caused several reactions by the older professionals who resisted to them. In general way, the resistance arose centered on the perspective of changes in the structure of health centers. According to Campos(1997b), the basic net had to take in the former hospital inpatients in its area. The action should be planned according to the population needs and the work-in-group conditions. It left behind the idea of minimum team, composed by: a psychiatry, a psychologist and a social assistant, as the national and state policy recommended at that time. The type and size of the groups in the basic net began to be determined by therapeutic project of the unit.

The co-administration of Cândido Ferreira hospital

In 1990, it was established a co-administration agreement between the local health department and "Dr. Cândido Ferreira" hospital. The fact represented the challenge of producing, in fact, the outdoing of the psychiatric ward and its segregated practices "inside" the system itself. For this reason, it started there the diagnostic reviewing process, recovering life histories and the location of the inpatients' family. Finally, the user became the center of the therapeutic actions. Besides the functional and physical alteration of the hospital building, there was the organization of four production units: day-hospital, internment unit, nucleus of working activities and the unit of inpatients' rehabilitation. This arrangement was done "starting by the definition of the goals to be achieved in each phase of the mental illness development process the patient is in" (Onoko, 1997, p.360).

This was a moment of much effervescence and for many challenges. According to Braga Campos (2000), then, two models of mental health care were configured in the city: the basic net model and the co-administration one set up in "Cândido Ferreira" hospital. In Campinas, these two models gave the mental health care a certain "hybridism". From one side, it was the challenge of the development of substitutive practices to the psychiatric ward model, through the changes in the

basic net, centered on the local planning and on the team autonomy under the coverage area. At the other side, it was the challenge of deconstructing, and not only improving a psychiatric ward.

They established interchanges with other experiences in development, mainly in Santos. Seminars, courses and meetings were intensified in order to make possible to set up the model of assistance directed to "Life Defense".

The reformulation introduced in "D. Cândido Ferreira hospital" had the support of the Planning Laboratory and Health Service Administration (LAPA) of the Social and Preventive Medicine Department of the Medical Sciences College of UNICAMP. In the process of the services' organization, it was applied a participating system of planning and management starting from the attention, technical support, and management teams of the production units. In this context, it sought to carry out the process of changes based on the planning theories, mainly the ones by Carlos Matus and Mário Testa, in order to make possible the definition of the institution mission, the system of planning committed to the psychiatric ward deconstruction as well as its segregating practices inside it, finally, a historical practice committed to a social change (Onoko, 1997).

The subsequent development of the institutional micro-process approach demanded other technologies, aiming the construction of autonomous collective, ethic, and critical subjects. In this meaning, it sought a work of intervention in the team working process to know the phenomena that operated in that field and, also, how they presented themselves in their several strengths. In this way, it sought inspiration from the institutional analyses, mainly from theoretical production of Lourau, Lapassade e Guattari (L'Abbate, 1997, 2003).

In short, Campinas experience guided itself not only by extending of the public net, but also, and mainly, by the need of reformulating practices and conceptions of public administration and the ways of organizing the health care.

According to Braga Campos (2000), it was also started the discussion process aiming the CAPS setting up. They were supposed to work non-stop, 24 hours a day, to attend the situations of crisis, night-hospitality, and also to develop psychosocial rehabilitee actions. Finally, they set up Children's Convivial Gathering Center and Reference Center to Alcoholism and Drug Addiction.

The development of a new model of health administration: mental health and Paidéia Program – Family health

The local Administration started in Campinas in 2001 evaluated that the local basic net presented different problems which indicated its incapability of take in the demand or even to attend the basic health needs (Local Health Department – SMS, 2001a). In this way, they resume the experiences developed in the health area during the time from 1989 to 1991.

When the former local health Secretary, the sanity doctor and UNICAMP professor, Gastão Wagner de Souza Campos, came to power again, he processed the reorganization and the extending of health care, guided by the principles and directives of the SUS, and in the changing perspective of the attention and administration model, as well as the redefinition of the working process in regarding to health and in the relation between the working teams and patients.

Thus, the SMS set up a health program known as Paidéia Program, which proposed to work together the concepts of health and citizenship and had as its fundamental axle not the health equipment, but the local team of reference to the families registered in a determined area.[7] Moreover, its priority was to become responsible for caring and clinical practice expanding in a way to range the subjective and social dimension of the health and illness process. It also sought to expand the basic net capability to solve health problems by amplifying the collective health actions, and the integration of promoting, preventing, cure and rehabilitation actions (Campos, 2003).

In this way, the health department set up the reference local teams – family health teams, and collective health nuclei – and the prime teams. These teams which were made up as production units, shared the same aims and also had their own administration capability, it means they could have a relative autonomy to think and organize their work process and the therapeutic projects. It was possible because the participative management recognized that it "was exercising the co-management that would be being possible to establish agreements and commitments among subjects involved in the system" (Campos, 2003, p.165).

This co-management system was composed by collective spaces, such as health local councils (coordination, team and patient); management colleges (interdisciplinary team), other resources (workshops, meetings with patients, meetings with category of professionals, etc) and routine management democratically carried out to study the themes and make decisions involving the interested people. These collective spaces operated the government rules, strengthen the subjects and produced an institutional democracy from the dominating relation changes, the establishment of new agreements, consent composing, alliances, and the introduction of projects. Finally, they could increase:

> the potential for analysis and intervention of the human grouping, to improve its capability for recognizing a sanity situation; identifying the involved determinants and, despite the context or people difficulties, amplifying the possibilities of intervention in the cases considered harmful. (Campos, 2000, p.1)

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[7] It seeks to develop a singular experience of the Family Health Program (PSF) also integrating the mental health attention, in example of what happened in 1990, in other cities, such as: Quixadá, CE, in 1994; Camaragibe, PE, in 1995; São Paulo, SP, in 1998; and others (Lancetti, 2000).

To achieve these results, the SMS – Campinas accepted to realize, with the support of the universities and the Family Health Capacitating Centers, a continued education process with local reference and support teams[8] with the purpose of modifying the working process in the Health Basic Units (UBS) and amplifying the clinical practices. In this way, all the health professionals were instructed and trained to act in a more heartwarming, humanized and committed way. The pedagogical model adopted was the knowledge constructive and intervention in the reality, with an articulation of information, text, analysis, and praxis.

According to Braga Campos (2001), the introduction of Paidéia Health Program was also a challenge for the mental health care net, once it had put the mental health team of the UBS, CAPS, Convivial Gathering Centers and other services in contact with a demand which did not fit the caring modalities available in the net.

The professionals in charge of the mental health in the basic net accepted to join the teams of prime support to the reference local teams of the Paidéia Health Program, with the purpose of: a) supporting and following up the reference local teams; b) interchanging of knowledge and contributing to the development of a generalist and multidiscipline reasoning, through out the mental health case study; c) providing specialized care according to the perspectives of an extended clinic, developed all over the geographical, historical, biographical and subjective field (SMS, 2001b).

To keep its commitment with the responsibility of being in charge of the patient, it extended and consolidated the psychosocial care services and its multidisciplinary teams, in the way to assure the flexibility of availabilities necessary to a more effective treatment, and, therefore to break away from the hierarchically structured service system. In addition, it started and concluded the shutting-down process of Tibiriçá Psychiatric Hospital, with the relocation of its financial resources as well as the human ones, in the substitutive net in the city.

According to the Management Report from 2001 to 2004 of the SMS, the mental health substitutive net, existing in the five districts of the city, in 2004, was composed by: five CAPS III, with eight beds each; one CAPS II; five Cooperation and Convivial Gathering Centers; and twenty Income Producing Garages; 33 Therapeutic Home Care (SRT). Campinas can still count on emergency actions and primary attention in the mental health field realized by SAMU; Chemical Addiction Care, and Children and Teenager Attention (SMS, 2004).

This experience introduced in Campinas, from 2001 to 2004, during the Labor Party Administration, pointed out some important aspects which contributed to the development

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[8] See in Moura et al.,2003

of the psychosocial care model, which, in fact, replaced the traditional psychiatric model.

Final considerations

All the described experiences much contributed to the advances in Brazilian psychiatric reform. In their similarities and differences, these experiences are committed to the introduction and consolidation of the SUS, showing, in this way, the viability and importance of Brazilian health public system to promote health and treatment with good quality in the population. For this reason, they had as their action axle the defense and quality of the citizens' life, and not only the relation cost/financial benefit of services and actions.

Each experience, in its own way, contributed towards the new mental health legislation, elaborated from the decade of 1990 on to carry out the psychosocial care in the SUS in Brazilian cities. It was observed that the results, associated to the reflections and proposals operated by the movement for the psychiatric reform, made it visible and spread abroad among managers, workers, patients and the civil society, well as promoted tensions in the spheres of the federal and state Government, in the way that they not only fulfilled their responsibilities as partners in the process, but also developed techno-operational instruments in order to permit the cities to set up and implement their mental health services.

According to what was indicated in the text, such practices not only faced the "neo-liberal project" strongly implemented in the country, mainly with regard to the increase of the private health system as well as the conflicts caused by it, but they also made possible the shape configuration to a new model of health and mental health policy.

The experiences carried out in São Paulo, by the state and local administrators, and the experience in the city of Campinas, in its first moment, although they had resumed the psychiatric reform model centered in the primary care to health, under the guidance of the principles of the SUS and the Statements of Caracas, they reproduced the logic of the hierarchically structured model, but they were also innovative.

The administrators took over, with regard to mental health, the challenge of not only advance towards the humanization of the relations among subjects, society and psychiatric institutions, and in the development of new technologies for caring in the area, but they also sought to build another place for the insanity that was not the one of the abnormality, danger, irresponsibility, incompetence, foolishness, of the defect, and incapacity, because the aims were centered on the inclusion, solidarity and citizenship.

The project in Santos was more daring and radical. It produced facing and confronting conflicts between the public power and the owner of hospitals, through the interdiction process of "Casa

Anchieta" psychiatric hospital; it produced a more effective breaking away from the psychiatric ward logic; assured the decentralization and inter-sector actions in the perspective of a caring net with resources from the field. However, the lack of social movements and, consequently, of the organization of the civil society in defense of public policies dedicated to the needs and interests of the most part of the population, before the local administration of 1989, certainly caused problems to the defense and maintenance of the changes occurred in health and mental health care.

The discontinuity political-administrative also caused negative effects, but in São Paulo it was worse. The deconstruction of the health System and mental health care and the mental health care net, built during the Luiza Erundina Administration, carried out in the Maluf/Pita Administration, according to what was reported before, caused the chaos and lack of assistance which is very difficult to recover.

In Campinas, the situation was different. Since the decade of 1980, the city took over the responsibility of developing an integrated health system. In what is related to mental health, based on the work evaluation developed in the health basic net, it was integrated, in a progressive way and in the several levels of complexity, the mental health care to the general health system. Thus, this experience, associated to the universities partnership and the popular movement for health, permitted the development of an "in defense of life" care model, dedicated to the reorganization and amplifying the health care, guided by principles and directives of both the SUS and a co-administration system composed by collective spaces where the government directives are carried out; the subjects are strengthened (administrators, workers and patients), as well as the dominating relation are changed; new agreements are established, the consents and alliances are composed, and projects are introduced.

In short, it can be concluded that, with the political commitment of administrators, the participation of teams in the care and organization of the patients, it is possible to promote changes in the mental health care model. Because of being a change in the psychiatric model and in its theoretical-conceptual, techno-attendance, political-juridical and social-cultural dimension, it can be stated that the approached experiences were founding agents of the process of the paradigmatic transition currently in its course.

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