THE NEW ALIENISTS OF THE POOR:
DEVELOPING COMMUNITY MENTAL HEALTH SERVICES
IN BRAZIL - 1978/1989

Thesis submitted by EDUARDO MOURÃO VASCONCELOS
as requirement for the degree of
Doctor of Philosophy for the
London School of Economics and Political Science,
University of London, 1992

ProQuest LLC
789 East Eisenhower Parkway
P.O. Box 1346
Ann Arbor, MI 48106-1346

To the people of the periphery of Belo Horizonte, Brazil,

from whom I have tried to learn
how to see the world through the eyes of those at the most devalued places of the oppressing systems,
as well as how to keep hope and commitment even in times of uncertainties.

To Bernadete,

for sharing life and friendship at this time of hard research work.

ABSTRACT

This thesis constitutes an investigation of the development of community mental health services in Belo Horizonte, Brazil - although information on two other cities, Rio de Janeiro and São Paulo, is used for contextual comparison. The study addresses two main issues:

a) the possibility of successful psychiatric de-institutionalization in a Third World country, where most of the historical conditions which allowed such processes in First World countries are, in general, not yet developed;

b) an evaluation of the hegemonic service models being implemented and their appropriateness to the clinical needs, class and cultural background of clients of these new services.

The research strategy uses 'multiple and embedded case study design', involving historical, ethnographic and survey methods.

First, the historical account traces the development of the mental health movement and of implementation of services between 1978 and 1989 and its political, economic and social basis. Second, the hegemonic service model being implemented is analyzed through original data obtained by fieldwork to assess its determinants and implications for the clientele.

The results suggest that services in Belo Horizonte are marked by economic and political constraints and a professional culture strongly influenced by the private clinic liberal practices. The main implication of these is a very low level of care for the very clients who are given formal priority in the programme: the continuing care client, their informal carers, and the poorest, uneducated client groups. This effect is also found in São Paulo and Rio de Janeiro using secondary analysis of existing data. However, the effect is lessened by the availability of a more complex service network.

The findings suggest also the inappropriateness of services to the cultural background of the target clientele, and alternative service models inspired by the popular representations of mental life and community practices are examined.

Finally, the prospects for the de-institutionalization process in Brazil are discussed, with some suggestions for political action and policy making.

TABLE OF CONTENTS

APPENDICES

ACKNOWLEDGEMENTS

The author expresses his deepest gratitude to **Dr. Shulamit Ramon** for her continuous personal support, stimulating feed-back and guidance throughout the period of study, investigation and writing up of the present thesis.

CAPES is thanked for the grant and sponsorship which guaranteed the financial support throughout the time spent in England and the payment of fees at the London School of Economics. CNPq is also acknowledged for financing the fieldwork activities in Brazil. Thanks also go to the Escola de Saude de Minas Gerais, which provided the room for a research office, including wide support in stationery, photocopying and library facilities. The author is specially grateful to the Grupo de Pesquisa em Saude Mental in Belo Horizonte, for opening their archives and providing all the support given during the collection of data.

Special thanks is owed to all mental health programme coordination bodies in Belo Horizonte (at state, metropolitan and municipality levels), São Paulo (state and municipality levels) and Rio de Janeiro (state level). They not only opened their archives for investigation, but also provided direct information on every aspect of their work. The author is also indebted to all other contacted agencies for their help, such as the INAMPS and DINSAM in Brasilia; Coordenação Regional da Perícia Médica, Escritório Regional and PAM-Carlos Prates (INAMPS-MG), FHEMIG, Conselho Regional de Psicologia - 4.a Região, in Belo Horizonte; and CIS-SES, CAPS and Ambulatório Centro in São Paulo.

Very special gratitude goes particularly to all professionals and auxiliary staff at the Lindea, São Paulo, Cabana and Sagrada Família district mental health teams, who provided full information and support for the local investigation.

In the same way, the author is grateful to all the

popular community organizations working in these areas and their leaders and activists, for the valuable and indispensable information and back up in all stages of the fieldwork.

In addition to those, several other informants who are listed in Appendix 1 are also thanked for their contribution during the interviewing period.

The author cannot forget the indispensable work of all research assistants and collaborators: Dilma, Elder, Lucia, Corina, and Zenaide in Belo Horizonte, Maria Poppe in Rio de Janeiro and Marina and Fernando in São Paulo. A very special thank is owed to Robson Lucas de Paulo, the direct assistant for all research activities in Belo Horizonte.

Thanks also goes for all who offered their individual support to this work. In Brazil, among several not named here, the following could not be forgotten: Eymard M Vasconcelos, William C Pereira, Solange Simões, Juarez Dayrell, Jurandir Freire Costa, Luis Fernando Duarte, Sônia Fleury Teixeira, Rafaelle Infante, Jeremias Ferraz Lima, Marcos Vieira, Stela Goulart, Anayansi Brenes, Sergio Kodato, Maria Mercês Somarriba, Virgílio Bustamante Rennó, Francisco Tancredi, Paulo Rossi Menezes and Marcia Scazufca. In London, special thanks goes to Christiano Fernandes and Teresa Albanese for the indispensable statistics' advice, and Robert Hart for the support in computer and software matters. Marina Cardoso, Marco Akerman, Claudia Resende and Erik Heydelberg (Amsterdam) provided important help in theoretical and practical issues. Caroline Franks and Alicia Spellen also receive thanks for the everyday back up in the Department of Social Administration. Martin Bulmer, Derek Cornish and others responsible for supporting the Phd students and for the provision of the facilities at the research students' room at the Department are also thanked.

Gratitude is also expressed to all colleagues and users of mental health services in Trieste, Italy, especially at

San Giovanni and Barcola mental health centre, from whom the author had an impressive example of commitment to mental health care in the community, without asylums. In London, the staff and users of the Avenue Day Centre, Islington, should be also included, for providing during a whole year of voluntary work an experience in the English 'path' to community care.

Finally, the author is also grateful to all who participated in the grammatical and style corrections to the manuscripts: Michael Wickham, Claudia Resende, Martin Evans and Brenda Pratt. In any way, the author alone is responsible for all remaining errors and style inappropriateness.

LIST OF TABLES

LIST OF FIGURES

LIST OF DIAGRAMS

LIST OF ABBREVIATIONS

Note: In case of agencies which constituted archive sources, see Bibliography (Primary Sources, List of Government Agencies).

AIS - Ações Integradas de Saude (Integrated Health Actions), a stage in the implementation of the CONASP plan.

AMP - Associação Mineira de Psiquiatria (Minas Psychiatry Association).

AMSM - Associação Mineira de Saúde Mental (Minas Mental Health Association).

Cd - Cabana district, Belo Horizonte.

CEBES - Centro Brasileiro de Estudos de Saúde (Brazilian Centre for Studies in Health), Rio de Janeiro.

CONASP - Conselho Consultivo de Assessoria a Previdência Social (Consultive Council of the Social Insurance System), which issued the plan of same name, launching the reform in the health system in 1982.

DINSAM - Divisão Nacional de Saúde Mental (National Division of Mental Health), Brasilia.

FHEMIG - Fundação Hospitalar de Minas Gerais (Hospital Foundation of Minas Gerais.

FUNED - Main organization responsible for paying professionals and staff working in the statutory health services in the state of Minas Gerais.

INAMPS - Instituto Nacional de Assistência Médica e Previdência Social (National Institute for Medical Care and Social Insurance).

INPS - Instituto Nacional de Previdência Social (National Institute for Social Insurance).

IRS - Instituto Raul Soares (Raul Soares Hospital), Belo Horizonte.

LBA - Legião Brasileira de Assistência (Brazilian Legion of Social Care, an agency of the Social Insurance System).

Ld - Lindea district, Belo Horizonte.

MS - Ministério da Saúde (Ministry of Health), Brasilia

PAM - Posto de Assistência Médica (Health Care Centre, provided by the INAMPS).

PIM - Programa de Intensidade Máxima (Maximum Intensity Programme), a special programme for ex-in-patients and continuing care clients in Sao Paulo.

PISAM - Plano Integrado de Saúde Mental (Integrated Plan of Mental Health), launched by DINSAM in 1977/78.

REME - Movimento de Renovação Médica (Doctor's Renovation Movement), launched in 1977 in several states in Brazil.

RMBH - Região Metropolitana de Belo Horizonte (Metropolitan Area of Belo Horizonte).

SNDM - Serviço Nacional de Doenças Mentais (National Service for Mental Illness), created by the Ministry of Health in 1944.

SPd - São Paulo district, Belo Horizonte.

UFMG - Universidade Federal de Minas Gerais (Federal University of Minas Gerais).

INTRODUCTION

Since the late fifties, there has been an increasing convergence of mental health policies in Western developed countries towards what has been called 'the model of community psychiatry'. A diffusion of this modality of services has been taking place in some Third World countries since the late seventies. There is a relatively large literature evaluating the experiences in the former, but in the latter, most inquiries made are local and unsystematic.

The claims for psychiatric services alternative to the traditional hospital care also reached Brazil, particularly with the internal emergence of new democratic movements in 1978. Since then, there has been attempts to create a new network of out-patient services, associated with a modest de-hospitalization policy. This thesis is an attempt to provide perhaps the first systematic investigation of this process of implementing community mental health services in the country, during the period between 1978 and 1989. It chooses as the main focus the metropolitan area of Belo Horizonte, the third Brazilian city in population, although also looking comparatively at the country's biggest urban areas, Rio de Janeiro and Sao Paulo.

Two main concerns underline the investigation:

a) What are the actual possibilities for successful psychiatric de-institutionalization policies in Third World countries, where most of the historical conditions which backed the process in developed countries are not yet fully developed? Given the lack of favourable economic, political, welfare and demographic conditions, what are the historical possibilities of such policies stimulating re-privatization of the burden of the care and social negligence?

b) What are the features and implications of the predominant

service models being implemented? Are they appropriate for the clinical needs, class and cultural background of the clientele of the new services, when reproducing the traditional hospital and middle class private clinic practices and approaches? Are there alternative models available?

The thesis in divided into eight chapters. Chapter 1 describes the literature available on care and social regulation in the mental health field. Contributions from several approaches are integrated in a critical way in a proposal for a theoretical framework, taking into account the need for internal philosophical coherence and appropriateness to the specific historical context examined in this study.

Chapter 2 starts by providing relevant background information on the country, including the main features of the health system and psychiatric services until the late seventies. The specific features of the area under inquiry are also briefly presented. A description of the adopted methodology is then outlined. The research design follows the model called "embedded and multiple case study design", as a study comparing more than one case at different levels (metropolitan and local service levels). The approach used includes historical (chapter 3), survey (mainly chapters 4, 5 and 6) and ethnographic (mainly chapter 7) sources and methods.

The process of implementing community mental health services is described in chapter 3, following the 'periodization' type of historical analysis. The major developments in the psychiatric reform are clearly associated with the periods of mobilization and institutionalization of democratic popular forces, particularly of the mental health movement. The internal features of the reform are also historically linked to some of the main characteristics and limitations of the mental

health movement.

Chapter 4 identifies the main in-puts and features of the dominant models of community service being implemented. Issues such as financing, infra-structure, human resources, professional culture, organizational aspects and formal and informal priorities of the mental health programme are described. In addition, the first implications of such service profile in two local services are indicated: the hierarchization of the clientele along social, economic, cultural and clinical aspects. This clearly undermines the formal priority of the programme, of supporting the de-institutionalization strategy.

The following chapter (5) deepens the analysis of the implications of the service model in Belo Horizonte, concerning two main issues. First, a low level of care is provided to former in-patients and the continuing care clients. Second, their informal carers, mainly their family and relatives, are not offered any substantial support. The features of the relationship between direct clients and the latter are also highlighted. Finally, this chapter compares the service profile among the three main cities of the country.

Chapter 6 also investigates the implications of the dominant service model, but focusing on broader cultural and political issues. First, the present findings tend to confirm previous indications from the country's critical literature: services based on individualized/psychologized models clearly conflict with implicit representations of the Person, mental illness and health predominant in the Brazilian working class. Despite the 'positive' aspect of an acknowledgement of the care for minor distresses as a social right, such services tend to induce individualization and reductionism in complex features of mental health issues. Two examples are especially discussed: the case of working class children with schooling problems in the literacy

period and of women who experience breakdown in their family, marriage and cultural ties.

The possibility of alternative models of community mental health care is focused on chapter 7. The 'nervousness' model of representing mental health and illness and the recent social movements, both common to the Brazilian working class population, are investigated as possible sources of alternative forms of care. Two local community projects in Belo Horizonte are then examined, showing inclusive how that population is able to develop counter-hegemonic strategies to impose their own views on mental health services.

Next, chapter 8 is an attempt to provide a conclusion for the study, divided into two parts. The first one provides a summary of the findings from the previous chapters and comments on the historical perspectives for the de-institutionalization in the country, including a comparison with the Italian case. Finally, the second part is an outline of suggestions for political action for the main actors in the mental health field - particularly the mental health movement - and for policy making.

Chapter 1

CARE AND SOCIAL REGULATION IN THE MENTAL HEALTH FIELD: LITERATURE REVIEW AND THEORETICAL FRAMEWORK

1. INTRODUCTION

To propose a theoretical framework to investigate community mental health services in a Third World country and their caring and social regulatory mechanisms is a very complex task. A comprehensive view of the phenomenon required me to deal with subjects such as:

- historical and political processes of formulation and implementation of a hitherto new kind of social policy in a country different from Western developed countries;
- economic and organizational features of the services and their implications on the care provided;
- assessment of the clients' needs being met or neglected;
- main service models, their roots in the providers' professional culture, and their caring and social regulatory mechanisms;
- specific social and cultural representations of mental illness and care within the target clientele and possible alternative models of mental health care.

Approaching them involves complex theoretical issues in different fields of knowledge, such as social policy, sociology, anthropology, and mainly psychology and psychiatry. Some of the most polemical discussions on care and regulatory mechanisms also include some epistemological and ontologic issues.

For this reason, an internally coherent framework required a broader review of several theoretical approaches present in literature on care and social regulation in the mental health field. This constitutes the first section of this chapter. The theoretical framework for the present

inquiry is outlined then in the second section.

2. LITERATURE REVIEW

2.1. THE CONCEPTS OF CARE AND COMMUNITY CARE IN SOCIAL POLICIES

2.1.1. The Classical Modernization Theories

A large literature has grown around the analysis of the changes in personal dependence and care during the process of 'modernization' in Western countries: Toennies' transition from 'gemeinschaft' to 'gesellschaft' typologies; Durkheim's change from mechanical to organic solidarity, and the transition from traditional to rational-legal authority by Weber. Bulmer, evaluating their contribution to the field, concludes that their concepts of care and community care

> "embody assumptions and hidden meanings which require urgent elucidation (...) and have at times left undefined, or defined so broadly as to be drained of meaning" (Bulmer, 1987: 35).

The dualist and linear concept of historical progression limits their ability to deal theoretically with more complex contradictions, retrogressions and combinations of traditional and modern patterns of social organization and care even in European countries (Mishra, 1981). This limitation is then worse when applied to developing countries, where unequal and combined forms of historical social development are common (Oliveira, 1973).

Perhaps their most important contribution has been at the empirical level, with a large number of studies investigating traditional solidarity ties surviving within modern societies, particularly through micro-sociological inquiries on kinship, neighbourhood and friendship (Bulmer, op cit: xiii).

2.1.2. The Citizenship Theory

Care and community care as elements of broader social policies have also been framed within the notion of social rights by Marshall (1950). Despite the limitations of the original formulations, as indicated by Mishra (1981), the approach has been critically reframed recently (Mann, 1987; Turner, 1990). It can also be useful within a more rigorous Marxist theoretical framework, as suggested below.

2.1.3. The Marxist and Historicist Approaches

Despite the frequent problems with mechanistic and functionalist analysis among these works (Mishra, 1981), it is possible to indicate some interesting examples of flexible and dialectic approaches to general economic and political processes and social policies, as in the works of the Gramscian tradition, Gough (1979) and Urry (1981).

Gramsci and his followers' works constitute an important framework to account for issues such as the dynamism of the economic, political and ideological hegemony and leadership, consensus and dominance, the role of intellectuals, and political strategies for change in contemporary Western countries (Buci-Glucksmann, 1980).

From Gough's perspective, care is linked to the reproduction of the labour force and of non-working groups through goods and services purchased as commodities ('values') in the market or services produced directly within the family ('use-values' or 'domestic labour') (Gough, 1979: 45-47). His work attempts also to provide a dialectic framework with which to analyze the welfare provisions and its contradictions (op. cit: 11-15). In turn, Urry's account of the anatomy of the capitalist civil society is a suggestive description of the latter's segmentation, focusing on issues such as gender, spatial

organization of labour and residence, religion, ethnicity and race as relevant criteria to construct social identities and sources for political action.

In addition to them, Bowles and Gintis (1986) point out that under the welfare state an increasing part of the workers' living standards has taken the form of social wage, through access to goods and services "secured simply by dint of citizenship rather than the sale of the labour force" (op cit: 58). In other words, as stated by Gordon et al (1982), the Keynesian state partially displaced the labour-capital conflict into the logic of citizenship. In this field, contradictions are found especially in how provisions are organized to match specific individuals, social groups and social classes' interests, and their strategies to access or appropriate specific groups of welfare benefits and services.

Within this framework, ideological aspects have a very important role. Laclau states that ideology constitutes individuals as subjects through 'imaginary interpellations' (Laclau, 1979) of their concrete conditions of existence, be they political, religious or familiar, which coexist in a relative unity in the individual or social group. The power of any ideological discourse is not determined by its internal logical consistence, but by its symbolic ability to condense, in the Freudian sense of the term, one's chain of several significant interpellations. The direct implication is that citizenship interpellations (such as the 'right to health and mental health care'), despite their theoretical inconsistencies, are able to be appropriated by citizens in

their struggle for wider or better social provisions[1].

From a more recent perspective, the present crisis of the state and wave of privatization policies, stimulated by the crisis of the Keynesian and Fordist strategies of

---

[1] Therefore, if one adds this insight to the notion of displacement of the capital-labour conflict to the sphere of the social provision, the notion of citizenship rights can fit within a more rigorous framework, avoiding the theoretical problems of the original formulation. In addition, such an account of ideological struggle avoids not only the old metaphysical problem of considering ideology as false consciousness, but also its counterpart of claims for a scientific legitimation for the Marxist theory. A more developed version of this theory is formulated in previous works (Vasconcelos, 1988, 1989).

economic growth (Murray, 1988, 1991)[1], have promoted the following changes:

- the reinforcement of important active political actors:
  - . the civil servants and social service workers, demanding maintenance of their posts, and limits to the present low wage and job-rationalization policies;
  - . the citizens' pressure groups, demanding more welfare spending, maintenance, improvement or new pattern of services;
  - . and the tax payers, against the burden of taxation.

  Despite some different interests, the possibilities of alliances among these groups are high (Gough, 1979; O'Connor, 1973).

---

[1] This approach views the historical development of welfare structures mainly focusing its process of production and broader economic and political regulatory mechanisms. Therefore, in Western countries since the seventies, the expansion of welfare was based on a Keynesian economic growth within national boundaries and on the Fordist mass production of services, like in industry. Accordingly, two processes are among the main determinants of the recent crisis of the welfare state:
a) The increasing internationalization and higher competition levels of the economic flows has broken the national barriers which allowed in the past single nations higher levels of internal protectionism and social investment.
b) The introduction of automatization in the sphere of production allowed the dynamization and 'complexification' of products and services according to different needs of specific consumer groups. This not only increased the productivity and efficiency of the general economy, decreasing costs, but also make obsolete all mass production of goods and services based on Fordist principles. This is particularly visible in the statutory sector, where bureaucracy, large dimension, complex decision making process and social concern make more difficult the implementation of innovation and a consumer oriented approach.
Finally, these are some of the reasons why the present historical transition is especially dramatic for Latin American countries, with their political culture of centralization, statism, patrimonialism and waste of public resources. For this, see chapter 2.

- the state tends to try to get rid of expensive forms of institutionalized care, such as the psychiatric hospitals, and of its role in direct provision of services, by contracting out to the private market. In parallel, the state also presses the claim for traditional forms of care provision, reinforcing the image of family and kinship ties and unloading the burden of care on the voluntary sector, the community and the family.
- an increasing critique of the statutory mass production of social services, towards a language of choice, flexibility, producer's accountability on behalf of the consumers, and a new democracy in service provision, replacing the old corruption of producer interests, including corporatist interests (Murray, 1988, 1991).

Perhaps one the most interesting contributions of the Marxist and historicist literature specifically for the mental health field is the discussion of the historical conditions which led to the emergence of de-institutionalization processes and community care, despite their common trend for functionalist and mechanistic analysis (Busfield, 1986). The following historical processes are identified, with different stresses among the authors:

a) Economic contexts of shortage of labour and re-valuing of human labour stimulates the investment in effective rehabilitation of population sectors hitherto considered 'unproductive', including the mentally ill[1] (Warner, 1985).

---

[1] The reverse is also true: periods of economic stagnation and rising unemployment are historically associated with increasing prevalence of distressing symptoms, suicide, admission rates and provision of beds in hospitals. They also mean that the chances for worthwhile social activities are lessened, with less general tolerance of the mentally ill. Finally, such periods are associated with less resources to be invested in social welfare, particularly in recovering 'unproductive' people (Warner, 1985).

b) Historical contexts of war reinforces national solidarity and stimulates the rehabilitation of soldiers and civilians with war-time distresses, in a process similar to shortage of labour. The development of therapeutic community experiences and of what Warner described as the 'social psychiatry revolution' in the forties and fifties, particularly in England, are good examples (Warner, 1985; Busfield, 1986).

c) Political contexts of democratization, revolutionary waves and reaffirmation of civil and political rights, tend to stimulate the acknowledgement of the mentally ill, particularly those inside the asylums, as human beings and citizens. The development of the anti-psychiatry movement in the late sixties onwards and the Brazilian case in the late seventies are examples of such changes. In particular, the political mobilization of mental health workers, users and allied social movements and parties, has been also an important element in successful de-institutionalization policies. The explicit action by mental health movements creates the political and ideological basis for implementing the needed changes in services, in the professional culture and training, and in attitudes towards mental illness in the society. The Italian experience is the best example of this.

d) The development of welfare systems and emphasis on social rights (Scull, 1984; Warner, 1985; Busfield, 1986) is a quite consensual indication. Social insurance schemes for disabled people guarantees a minimum income which allows care schemes in the community, even in the absence of employment opportunities. The development of broader personal social services makes caring resources available also for the mentally ill. Finally, the implementation of health systems politically committed to universal and a high standard of care also provides a favourable environment for the provision of integrated out-patient mental health services.

e) Demographic changes, particularly the increase in the proportion of elderly in the general population and changes in the family structure, can induce the development of social services in order to substitute or support the informal care provided in the family (Warner, 1986).

f) Changes in the process of production and financing social services, particularly neo-liberal inspired cost-saving policies, also induces de-hospitalization programmes, not always providing better options of being cared in the community. This was particularly the case of the US in the sixties[1] and of England in the late eighties onwards.

g) The changes in therapeutic ideas and practices in the twentieth century, particularly the development of psychological theories, was also stimulating, as not stressing any more the need for the removal of the individual from the ordinary environment (Busfield, 1986).

h) Community care also corresponds to strategies of the medical corporation to make psychiatry more integrated with the rest of medicine and to provided more opportunities for work with patients of higher social standing (Busfield, 1986).

i) Finally, the development of psycho-active drugs in the late fifties onwards was an important element in controlling the more disruptive symptoms for both acute and chronic patients in the community (Scull, 1984; Warner, 1985; Busfield, 1986).

---

[1] The introduction of Medicaid and Medicare in 1965 produced the financial basis for the large transference of in-patients to private nursing homes. Despite the development of community mental health centre programme launched in 1963, it meant in most cases a real deterioration of the care provided (Warner, 1985; Castel et al, 1982)). However, this does not imply exactly to subscribed Scull's thesis of the fiscal crisis of the state as the main determinant of community care in the US (Scull, 1984).

2.1.4. The Anthropological Approaches

Social practices of informal and formal care involve implicit diffused social representations of what the Individual/Person is and should be and its relationship to society (as in notions such as citizenship). These vary according to different cultures, social classes and historical context. This constitutes a substantial and complex subject in anthropology, sociology and social psychology (Mauss, 1973; Dumont, 1970, 1983; Marsella, 1985; Littlewood, 1990; Moscovici and Farr, 1984). Such representations are strongly linked to the different conceptualizations of the spirit, body, hygiene and moral norms, normality, which inform and constitute the different strategies of caring, healing and support for those in need. In the mental health field, important contributions have been made by the Anglo-Saxon cross-cultural psychiatry and the French correlate ethnopsychiatry, to be discussed later on.

2.1.5. The Feminist Approaches

The central issue of the feminist literature on care is the discussion on women as main providers of informal care in the family or of formal care as unpaid or low-paid workers.

One of the trends is the adoption of a Marxist perspective to highlight economic and social aspects of the informal care (Barret, 1980; Finch and Groves, 1983). The debate suggest several strategies in social policy and gender relations, to cope with the burden of informal care in the family and community, such as cash benefits for carers, pensions, work-sharing, special socialized caring services, changes in the labour market (Walker, 1983), and support services for informal carers (Lewis and Meredith,

1987). This issue is particularly raised by relatives of mental health services' clients in de-hospitalization processes (Giannichedda, 1989).

However, caring cannot be reduced to a technical labour process (associated to the male notion of 'doing'), but has a historical and psychological affinity with femininity (and its notion of 'being' and sensitivity, for example). Therefore, beyond a strict Marxist perspective, the matter requires a softer symbolic approach (Graham, 1983). The psychological aspects of caring are discussed in more depth by several other points of view (for example, Dalley, 1987), including psychoanalysis. The latter links the subject to the debate on motherhood, its unconscious drives and the perpetuation of male dominance (Chodorow, 1978; Dinnerstein, 1976; Eichenbaum and Orbach, 1982; Mitchell, 1974).

Feminist theories also stress, particularly in the health and mental health fields, how the common sense and scientific views of the specific female diseases and distresses are, in general, biased and misunderstood by sexism. The current deeply rooted stereotypes, ideologies and imagery also shared even by female professionals and staff, affect the treatment strategies and concrete attitudes towards female clientele (Allen, 1986; Corob, 1987; Miles,1988).

2.1.6. The Need-Oriented Approach

Within the Anglo-Saxon literature of social administration, a well established tradition is the assessment of the different needs to be met in specific clientele groups and sub-groups in a particular social context.

From the theoretical point of view, the concept of human needs is openly controversial. Attempts to pursue a universal definition of it, even from a Marxist perspective

(Doyal and Gough, 1984), have been so abstract and raised so many theoretical and political problems that have ended up being useless in the normative level. In my view, however, it can be considered a provisional construct internal to a particular applied field of knowledge, of the same type of 'interpellation', without any claim for a special ontological status. It can be useful in research and policy making for comparative and planning purposes, and as a discursive tool to be appropriated by political actors in the arena of social policy conflicts.

This does not mean that deducing social and health needs is a completely arbitrary procedure. The parameters generally applied by administrators and researchers, indicated by Bradshaw (1972), seem to be useful:

- normative needs: standards established by experts as norms to be compared to the reality, changing according to time and society. They are always affected by the producers' views and ideologies.
- felt needs: they constitute what is expressed when someone is asked, particularly through surveys and ethnographic methods. They are limited by the individuals' perceptions, the present knowledge of the availability of the services and by the social intentions during the collection of data.
- expressed need or demand: a felt need turned into action individually or by some kind of socialization process gives it a higher degree of reliability in relation to the previous one.
- comparative needs: those found by studying the characteristics of those in receipt of a service, and compared to others. They are expressed frequently by the gap between services in two or more different areas, but provision may still not correspond to need, or may not be the most proper way of defining and meeting those needs.

It is still possible to add an additional parameter: historical needs, established by assessing how a specific

need has been expressed and defined through the history of a specific social group, and how they have been met by informal or formal provision of care.

This approach also includes important studies done in a reversed perspective, with a clear influence on the present inquiry. Instead of looking at needs and then to deducing the necessary care structures to meet them, this point of view emphasizes inductive empirical investigations on how already implemented services meet the needs of the several sub-groups of the clientele. They stress particularly the clinical, social, economic, ethnic, cultural, spatial, gender and age segmentation of the clientele and how services may reinforce or reduce such inequalities. In the mental health field, Hollingshead and Redlich's (1958) classical work demonstrated how prevalence rates, diagnosis and different psychiatric settings and treatments are correlated to the individual's position in the social class structure.

2.2. APPLICATION TO MENTAL HEALTH CARE

When compared to other areas of social and health care, the mental health field presents several specific theoretical and practical issues, such as:

a) More than in any other area, the identification of the need for care and the notion of 'undesirability' or 'discomfort' associated with certain mental states varies enormously across the different cultures, social groups and historical contexts, as indicated by the trans-cultural and historical accounts of the subject. When focusing on the contemporary Western context, this poses very complex epistemological, ontologic and political issues, resulting in a large range of theoretical alternative approaches, as to be discussed in the next section.

b) The different stages of development and types of distress

shows different levels of dependency and ability to cope with normal tasks of life. In contemporary Western societies, this has led to the provision of a large range of differentiated compatible forms of care, including medical, psychological, social, rehabilitation and educational services.

c) The more challenging distressed states imply deeper impairment of the individual's functioning, several levels of personal suffering, including sometimes withdrawal and destructiveness. Such situations demand special mechanisms of support and control, which by their turn can degenerate into oppressive forms of social control and regulation.

d) Mental distress and its symptoms tend not only to confront the institutional status quo, but also the values and personal psychological features of carers and professionals. Comprehensive forms of care and treatment tend to induce, in psychoanalytic terms, a high level of transference and counter-transference between users and mental health workers. Hence, the high investment needed in terms of proper recruitment, constant training and supervision.

e) For the same reason, the differentiation between professional and non-professional care is sharpened, not only in terms of technical knowledge, but also in terms of long personal development in the ambiguities of involvement and detachment. In sociological terms, this tends to reinforce the power given to the former.

2.3. THE DIFFERENT CONCEPTUALIZATIONS OF MENTAL HEALTH AND ILLNESS IN THE LITERATURE

2.3.1. Introduction

The conflicting theories in the mental health field can be fully understood only by taking into account their

implicit philosophical systems and their historical determinants, which lie to a large extent outside the specific scientific field. Ingleby's (1981) attempt to classify the different approaches according to their 'mentalities' or scientific paradigms, in the sense given to them by Kuhn (1962), is a way forward. He shows that the traditional classification of theories in the field (somatic, psychological and social ones) tends to hide important similarities between perspectives that have been previously viewed as opposites. His suggestion will be developed and reframed here by establishing three separate criteria for classifying a theory or approach:

Criteria 1: How are the mental health phenomena substantially conceived, according to its specific ontological views? Where is the theory epistemologically located, according to the differing scientific paradigms?

Criteria 2: What kind of discourse or scientific evidence is produced or manipulated[1]?

Criteria 3: What has been the theory's historical praxis, through an evaluation of the social and political determinants, interests and implications of its several potential uses[2]? This praxis can vary according to different and contradictory perspectives:

a) The broad range of different needs to be met, practices, and services to be included in a comprehensive community

---

[1] For example, some approaches might manipulate empirical evidence, but it does not mean necessarily to have a empiricist or positivist theory of mental phenomena.

[2] A discussion on the use of the praxis as an epistemological category in the Anglo-Saxon literature can be seen in Habermas, 1972; Kilminster, 1979; Kitching, 1988 and Rubinstein, 1981. Some good examples of such kind of analysis can be seen in Banton, 1985; Frosh, 1987; Ingleby, 1981, 1983; Sedgwick, 1982a; Busfield, 1986.

mental health care system (see sections 2.1.6 and 3.3)[1];
- the different disciplines and scientific fields;
- the different social actors (the several professionals, non-professional workers, informal carers and users);
- the diverse characteristics of the clientele (social classes, culture, age, gender, etc).

In general, the debate among different approaches in the mental health field is carried out with propositions for unitary theoretical frameworks. This is probably a consequence of the corporatist competition in the academic and professional market, which tends to stimulate an invalidation 'in totum' of other points of view. The perspective adopted here stresses the impossibility of unitary approaches[2] and the importance of contributions from different fields of knowledge. In accepting an interdisciplinary approach, the relative autonomy of the different disciplines is also accepted.

As a result, for example, while an approach might have clear theoretical limitations for a strict professional practice (e.g., psychotherapy), it still may inspire relevant practices and analysis by users and informal carers. In addition, methods and techniques produced in one paradigmatic context can be re-articulated within a new ontologic and epistemological framework and with distinct political and social purposes. Finally, this emphasis on the contradictory aspects of theory and practice is also an acknowledgement of the intrinsic complexity of the subject,

---

[1] For example, a specific theory might have problems when approaching a specific kind of distress, but might present good results in other ones.

[2] In the case of building a theoretical framework for an individual study, what is important is **a minimal internal coherence among the several contributions, in terms of their implicit ontologic, epistemological and praxis perspectives.** This is the main reason for the present brief but careful review of the approaches available.

which reflects the different philosophical, scientific, political and ideological viewpoints when dealing with the human psyche. Such complexity is particularly stressed in the present post-modernist critique of the classical paradigms in human sciences.

2.3.2. The Positivist Approaches To Mental Health and Illness

According to Ingleby, the main implicit assumptions of this type of approach are:
- no features distinguish human beings from the other beings in the natural world;
- human sciences may use the same model as the natural sciences;
- theories can be constructed and mental life can be seen through the same causal, deterministic basis used in the natural sciences (criteria 1 above);
- observations can be made objectively - measures can be defined operationally and applied in a precise, replicative fashion (criteria 2).

According to Ingleby, there are two kinds of positivist approaches in the mental health field: 'strong' and 'weak' forms. The first, 'strong' form, also called the 'faulty-machine' or 'disease' model, suggests that mental illnesses are caused by somatic disorders, be they genetic or physiological, with the implication that they should be treated by physical methods. The historical emergence and development of this model is described and criticized by Foucault (1967, 1986), Scull (1979, 1984), Busfield (1986), Billington (1984) and Ingleby (1983).

The second, 'weak' forms, identifies mental illness as caused by psychological and environmental factors. Ingleby cites the behaviourist tradition (which views mental illness as an inadequate behaviour response caused by modelling and

conditioning), in some vulgarizations of the psychoanalytic theory or in some sociological works in the Durkheimian tradition. For Ingleby, the problem with this second type is not only a matter of introducing an alternative set of aetiological factors, but mainly to keep the notion of 'cause' and the same paradigm of explanation as the medical model itself.

The social implications of such approaches (criteria 3 above) are probably more complex: the division between subject and object in any human science hides the moral and cultural origins of the psychiatric or psychological norms as if a matter of empirical fact. Thereby, it reinforces socially sanctioned values, legitimizing the mechanisms of cultural and social control exerted through the professional practice. The somatic and psychological types of positivist approaches focus on the undesirable aspects of mental illness within the object only (the 'patient'). Such a framework avoids the discussion and individualizes wider social and aspects of mental illness, the stigma and social imagery associated to the former. Defining epistemologically the mentally ill as an object also means to view the psychiatric symptom as something not intelligible and meaningful, or to deny any potential new meaning, different to those already accepted socially. In this sense, some form of **invalidation** of the client's experience, which is stronger in the somatic model, is still present in the 'weak' approaches. The dichotomy subject/object tends also to reinforce the role and the power of the professionals and fits well with corporatist based interests.

Despite these criticisms, it is important to acknowledge the contributions of these approaches to the knowledge of some aetiological aspects of mental illnesses (be it somatic, psychological or social) and to the development of several treatment strategies (particularly the psychoactive drugs). These constitute elements which can

clearly be used critically by other broader approaches, when developing a comprehensive mental health service[1].

In addition to Ingleby's classification, I draw a crucial distinction between the positivist and what can be referred to here as empiricist approaches. The former view mental health issues as ontologically similar to natural phenomena and place them with the natural sciences (criteria 1 and 2 above). The latter refer to approaches such as psychiatric epidemiology, psychological testing and some types of experimental psychology (such as the gestalt theory). Despite being developed through empirical research (criteria 2), they do not necessarily imply positivist theories of mental health or illness (criteria 1). They constitute important resources in research, assessment of individual clinical cases and of psychiatric features of specific social groups, and enable the establishment of priorities for policy making.

2.3.3. The Interpretative Approaches

For Ingleby, interpretation implies an assumption that human beings are able to engage in meaningful behaviour, praxis, and intentionality. These cannot be described objectively, but explained in terms of intentions, motives and reasons, through interpretation. Using Habermas' distinction of practical and emancipatory interests, he indicates two main types of approaches:

a) the 'normalizing' ones, by which common sense or some

---

[1] The best example of such critical reappropriation of the medication is the Italian Psichiatria Democratica. When controlled by the doctors and pharmaceutical companies, it can be a chemical straitjacket; when appropriated by the consumer, it can be therapeutic because it allows an increase in the clients' level of awareness of their situation (Scheper-Hughes and Lovell, 1987: 13).

elaborated version[1] of it is capable of understanding the mental states, in a attempt to 'normalize'[2] and 'de-stigmatize' mental distress;
b) the 'depth hermeneutic' approaches, which actively criticize and transcend people's own understanding of themselves and increases their degree of autonomy.

2.3.3.1. The 'Normalizing' Approaches

Ingleby states that, in general, the 'normalizing' approaches are mainly identified with a more 'humanistic' view, inviting all to share the task of understanding and reconciling with madness. In this sense, they present anti-individualistic and non-directive professional components, more akin to prevention, informal care and support, rehabilitation and the protection of rights (see section 3.3 on these concepts). As such, they constitute important resources mainly for users, their families, the community and non-professional people. Hence, they also provide an important source for criticizing the social processes associated to mental illness and the power and repressive aspects of the psychiatric institutions and professionalism. Alternatively, most of these approaches tend not to induce a deeper symbolization and challenge of the individual's symptoms and their unconscious meanings. They also are not able to provide substantive explanations on the nature of the more complex nosological and mental states.

---

[1] Ingleby includes in this category the phenomenology, ethnomethodology, and analytic philosophy, although not providing a further discussion on that.

[2] The present work will draw a distinction between normalization, in the sense it is used in this section, and 'normatization', a concept suggested by Foucault to indicate the spread of norms of behaviour through disciplinary powers, as a mechanism of social regulation exerted also by mental health professionals.

a) The 'Normalizing' Theories

Their most common implicit assumption is that in some specific contexts, the mental distress is in fact a perfectly intelligible behaviour. However, they do not claim any notion of cause, as in the positivist view. Frequently, associations between oppressive situations and particular forms of symptoms are drawn. Examples are some studies on family and mental illness (Laing and Esterson, 1964), depression in housewives (Brown and Harris 1982; Miles, 1988), schizophrenia in adolescent crisis, stress in working conditions and maladjustment in school children. Some critical observations to this approach can be raised:
- social roles and situations associated with specific forms of stress cannot be viewed as a-temporal and isolated from the wider changeable economic, social and cultural broader contexts;
- the impact of environmental factors depend on the **meaning** ascribed to them, which has also social and cultural aspects. In other terms, a theory of how certain social roles or crisis in social identities in specific social groups can induce a crisis in the psychological identity is still needed.

However, these approaches are particularly interesting in planning preventative forms of care, in corroborating the assessment of social aspects in diagnosis and treatment of target groups. They are particularly useful as a base for self-help groups and support in the community. Clients and supporters having similar problems or living conditions are specially suitable to help themselves and organize actions in order to change or control stressful aspects of the environment. This approach is also useful in balancing the evaluation of some strict individualized and 'psychologizing' forms of care, by its emphasis on environmental aspects.

Sometimes, this approach is also associated with folk

social representations of mental distress, as in the case of the 'nervousness' model of the working class population in Brazil, to be discussed in the last chapters of this study.

Another version focuses on the psychiatric environment, practices or widespread images as a context which stimulates mental distress. This is the case of the symbolic interactionism, 'labelling' and anti-psychiatry theories. In the last fifteen years, several authors have indicated some of the limits of such approaches (Sedgwick, 1982a, 1982b; Miller and Rose, 1986; Scull, 1977; Ingleby, 1981; Busfield, 1986). Their criticisms are mainly centred on:

- the inability to explain the intrinsic and subjective aspects of mental illness, which cannot be reduced to the internalization of social labels;
- an implicit voluntarist view of mental health care, disregarding the responsibility and burden associated with it.

This last component makes them particularly suitable to be used by neo-liberal policies in order to close psychiatric hospitals without an adequate level of care in the community (Castel et al, 1982).

However, despite their theoretical limitations, these approaches are particularly useful as an analytic and political tool for researchers, users and mental health movements. They help to identify and challenge distressing and controlling aspects of psychiatric institutions and professionalism, the stigmatizing attitudes held by the population and the media, and to support initiatives of advocacy and protection of rights for users of mental health services. They constitute also an important theoretical instrument to assess the change in social and personal identities of users after institutional care (Ramon, 1990) and the implications of diagnosis and stigma.

b) The Emancipatory Theories

Although influenced by the 'normalizing' theories, some approaches re-emphasize their emancipatory components. Hence, they focus on concrete praxis by clients, professionals and other social groups towards re-valuing and empowering distressed people, on consciousness raising, and on changes in attitudes, in services and legal/organizational structures in the society.

The most influential approach among them is probably that of 'Psichiatria Democratica' (Basaglia, 1986; Basaglia and Tranchina, 1979). This bring together elements from the Institutional Psychotherapy movement, phenomenology, labelling theory and marxism (particularly the Gramscian version)(Ramon, 1985). Changes in psychiatry are seen as a process of 'cultural revolution' (Scheper-Hughes and Lovell, 1987). By this, they mean a process in which professionals, clientele and society should be hegemonized by a proposal for a complete de-institutionalization of care and closure of hospitals, as the key component for promoting a more radical change in the whole society's views on mental health. The process includes the need to take full responsibility for the care in the community, to empower users, to meet their concrete socio-symbolic needs, to offer alternatives with which to rebuild their identities, and to change stigmatizing attitudes in the wider society. The Psichiatria Democratica movement has produced the hitherto most radical and advanced experience of Western contemporary psychiatric reform and legislation[1].

Within the Anglo-Saxon literature, some of the aspects of the Italian proposals are present in the so called 'normalization approach' to mental health care (Ramon, 1991; Wainwright et al, 1988; Wolfensberger, 1972). It emphasizes the need to provide users with as ordinary an environment as

---

[1] A more detailed outline of the Italian experience is provided in chapter 8.

possible, with stress on sharing decisions, autonomy and client empowerment. These are considered essential elements for improving the users' mental health, with important implications in terms of professional practice.

Institutional Analysis, particularly the 'schizoanalysis' version (Deleuze and Guattari, 1977; Guattari, 1984) (see section 2.4.5), can also be included under this heading. Some proposals for 'popular education' and praxis, such as developed by Paulo Freire (1972a, 1972b, 1976) as the main name in the Brazilian tradition, should also be included here.

c) 'Redefinition of Goals' Approaches

The third type of 'normalizing' approach uses the tactics of ascribing a hitherto unrecognized purpose (a form of protest or self-cure process) to the 'sick' behaviour. According to Ingleby, these are the most romantic and the weakest aspects of the anti-psychiatry platform.

d) The 'Cross-Code' Approaches

It is assumed within this theoretical perspective that the problem behaviour does not have the superficial meaning which is usually ascribed to it, but instead belongs within a symbolic code or framework which accords it quite a different meaning. This is particularly the case of the cross-cultural psychiatry[1]. For them,

> "The meaning of illness for an individual is grounded in -though not reducible to - the network of meanings an illness has in a particular culture: the metaphors associated with a disease, the ethnomedical theories, the basic values and conceptual forms, and the care patterns that shape the experience of the illness and the social reactions to the sufferer" (Good and Good,

---

[1] Kleinman, 1980; Littlewood and Lipsedge, 1982; Littlewood, 1990; Marsella and White, 1984; Mercer, 1986; Rack, 1982. The Brazilian literature in this area will be indicated and described in the last chapters of this study.

1982, cit in Littlewood, 1990: 312).

This suggests that all systems for describing and classifying illnesses and the different patterns of treatment are culturally built, involving implicit notions of the Individual or Person, different forms of **individuation**[1] processes and of relationship to the wider society. Its usual investigation methods are similar to those of the social anthropology: participant observation and qualitative data gathered in small-scale communities and social groups. The approach is particularly important in the analysis of population groups with cultural features different from the mainstream Western societies. Therefore, they are extremely relevant in the critique of the ethnocentrism and cultural dominance so common in traditional cross-cultural studies and in the professional practice which uses language, methods and techniques which are generally originated in a different social and cultural context.

2.3.3.2. The 'Depth' Hermeneutics Approaches

The implicit assumption of these approaches is the notion of human beings as fragmented, self-contradictory and alienated from their own experience, and determined by deep unconscious, ideological or linguistic structures. Ingleby's model here is the psychoanalytic theory, particularly the Lacanian version of it, but also includes some formulations of the 'Freudo-Marxism' movement (Reich, Fenichel, Fromm, Horkheimer, Adorno, Marcuse, Habermas, Schneider).

---

[1] The present inquiry will assume the distinction between **individuation**, which is intrinsic to the psychogenetic development in every culture and to any psychotherapeutic treatment, and **individualization**, which is a specific pattern of individuation in Western cultures and some psychotherapeutic processes.

The method used is the interpretation as in the structural linguistic, semantic, rhetoric and poetic. The analyst decodes the 'latent' meaning of dreams, verbal slips, symptoms and behaviours. Mental distress and symptoms are viewed as a kind of return of unconscious repressed contents (Laplanche and Pontalis, 1983: 398,446) that cannot be handled by the ego in a 'healthy' way, threatening the ego's defenses. Therefore, the criticism of the previous approaches is that symptoms have a meaning, whose elucidation is dependent on the careful examination of one's personal experiences. In terms of the treatment aims, the Lacanian version emphasizes a critique of the methods which reinforces the ego and the imaginary adaptation to reality, stressing the radical split between the unconscious and the ego, and the de-centredness of the human subject (Jacoby, 1978; Frosh, 1987; Poster, 1978). Moreover, it represents a reaffirmation of a post-modern concept of the human being, open to an endless search of him/herself.

Historically, the psychoanalytic theory represented important achievements, such as the discovery of the unconscious, have eased the boundaries between the normal and the pathological, and the importance of the minor distresses as deserving public attention (Busfield, 1986).

However, both psychoanalytic and Marxist approaches have weaknesses. In logical terms, ontologies or theories which emphasize human alienation and criticize consciousness (ideological or unconscious fallacies), end up reaffirming their own knowledge (which are themselves built by another human consciousness) and reinforcing socially the role of those producing this knowledge. This is one of the philosophical reasons of the problems with the category of vanguard in most of the traditional Marxist formulations and why the psychoanalytic approaches have not challenged the medical corporation. Despite some initial resistance from the medical profession, the psychoanalytic practice spread

historically reinforcing the same medical model of private clinic practice for the elites (Busfield, 1986). In the traditional psychoanalytic setting, the power relationship between professionals and users of mental health services emphasizes the former's position. The client's discourse tends to be devalued in substance, read always as symptomatic and in need of the analyst's interpretation.

Moreover, even the Lacanian approach, with its more sophisticated post-modern philosophical framework, still induces cultural adaptation, by implicitly reinforcing the contemporary Western notion of individualization and detachment (Foucault, 1984; Frosh, 1987; Figueira, 1988). From the epistemological point of view, given the structuralist framework of the original Lacanian approach, the literature also points out:

- its inability to approach concrete social, political and cultural issues (Frosh, 1987; Baremblitt, 1972);
- its inability to evaluate their own praxis (Castel, 1978);
- that it induces a process of ethnocentrism and serious difficulties in dealing with social, cultural and linguistic differences and specificities (Ortigues and Ortigues, 1984; Duarte and Ropa, 1985).

2.4. SOCIAL CONTROL AND REGULATION IN MENTAL HEALTH SERVICES

The current literature on social control and psychiatry shows several different approaches (Ralph, 1983; Mayer,1983; Sedgwick, 1982; Busfield, 1986; Ingleby, 1983; Baruch, 1984). The following will illustrate their relevance in general terms to the present study.

2.4.1. The Sociology of Knowledge and the 'Professionalism' Approaches

An interesting contribution comes from the sociology of

knowledge and professionals and focuses on the conflict between the clientele and professional's cultures and interests. Professional care, according to Parry and Parry (1976), means specific services to society, relying on a claim of a unique conceptual and practical knowledge, performance of specific duties, decisions about and control of the clientele. This position is hegemonically accepted within civil society and/or established by a social mandate given by the state. In brief, professionalism generally includes the following elements:

- knowledge: a claim of mastery over a specific field of knowledge, attributed the status of basic or applied science.
- corporative organization, which establishes boundaries in relation to other professionals and non-professionals, exercises control over training and practices, and defends member's economic and political interests.
- culture: a set of rooted value preferences, theoretical approaches, life styles and practices (Ramon, 1987), including informal standards for the relationship with other professionals and clientele.

The different social and cultural origins between professionals and clientele tend to produce different culturally rooted conceptualizations of mental distress, health and care. This gap is particularly important in statutory services, whose clientele tends to be associated with lowest income population groups. An influential example of this kind of approach is provided by the French author Boltanski (1979), in his classic study of the medical practice.

Moreover, the professional/clientele relationship is also mediated by strong structures of power, and economic and ideological corporative interests. Freidson (1970) and Johnson's(1986) classic works account for these processes and their implications in terms of social regulation,

particularly in the medical profession.

2.4.2. The Anti-Psychiatry, Social Interactionism, and Labelling Theories

These approaches (Szasz, 1961, 1963, 1970, 1971; Laing, 1960; Laing and Esterson, 1964; Goffman, 1968; Scheff, 1966) have been historically associated with the left wing politics of the 60's. They have contributed to popularizing a critical thinking about the psychiatry and constituting an useful tool for users' and mental health movements in the struggle towards changes in the psychiatric system. They are particularly important in the critique of the in-patient care (Goffman's 'Asylums', for example, is still a powerful and compelling study) and its stigmatising and controlling implications, and of the segregation of the mentally ill in the broader community.

Despite the considerable differences among them (Busfield, 1986; Sedgwick, 1982), these approaches tend to share a strict coercive view of psychiatric power, as external to the individual. This does not allow them to tackle appropriately 'softer' and self-regulatory mechanisms of social regulation in community based services, apart from medicalization and stigma[1].

2.4.3. The Post-Structuralist Approach

The post-structuralist approach will be associated here with the works of Michel Foucault (1967, 1976, 1977, 1984, 1986, 1987a to 1987d), Robert Castel (1978, 1981, 1982, 1986) and Donzelot (1980). Although very schematic,

---

[1] As will be seen, in the Brazilian working class population and in the out-patient services investigated here, the stigma attached to mental illness does not seem to constitute a major problem.

the frame proposed by Rabinow (1987), can be used to provide a quick description of Foucault's three main modes of objectification of human beings:

a) 'Dividing Practices':

They constitute a mode of manipulating human beings that combine the practice of exclusion - usually spatially, but also socially -, with the mediation of a science or pseudo-science[1]. These form a substantial part of the subject matter of Foucault's earlier books, 'Madness and Civilization', 'The Birth of the Clinic', as well as latter books such as 'Discipline and Punish'.

b) 'Scientific Classification':

This is mainly found in 'The Order of Things', but also spread along other works, stressing how the different modes of inquiry constitute themselves and are given the status of science, with their respective changes and discontinuities along their histories. The concept of 'archaeology' refers to the description of the 'epistemes' of a particular field of knowledge in different historical periods, or the ensemble of discursive practices that followed certain rules and constituted a condition of reality for statements in each period.

c) 'Subjectification':

This is one of Foucault's main contributions, showing how the coercive, external and negative forms of power are

---

[1] The most famous examples in Foucault's works are:
- the isolation of lepers during Middle Ages;
- the confinement of the poor, the insane and vagabonds at the Hopital General in Paris in 1656;
- the new classification of diseases and the associated practices of clinical medicine in early-nineteenth century France;
- the rise of modern psychiatry and its entry in the hospitals, prisons and clinics throughout the nineteenth and twentieth centuries;
- the medicalization, stigmatization and normatization of sexual deviance in modern Europe.

poor in resources and positive production, incapable of invention (as reduced to an effect of obedience), being essentially juridical, centred on prohibitions, statements of the law and taboos (1984: 87). Foucault looks here at those positive forms of power, which are able to seduce and produce realities and rituals of truth, as in the processes of self-domination in which the person is active and initiates a process of self-formation and understanding. This can be mediated by an external authority figure, be he confessor or psychotherapist (op cit).

He is also looking at power relations within the family, drawing a distinction between what he calls:
- the 'deployment of alliance' ("a system of marriage, of fixation and development of kinship ties, of name and possessions');
- and the 'deployment of sexuality', "concerned with the sensations of the body, the quality of pleasures, and the nature of impressions". It "operates according to mobile, polymorphous and contingent techniques of power" (op cit: 106).

According to Foucault, since the eighteenth century, the latter has gained increasing prominence on the former, although not supplanting it. This movement has provoked an increasing wave of conflicts within the family, which has demanded help of professionals and a psychologization of the changes. To Donzelot (1980), who produced an historical account of this process in France during this time, psychoanalysis has been used as such a mechanism, 'regulating images' within the families.

The emergence of the 'deployment of sexuality' requires new forms of social regulation. It leads to an increase incorporation of human science professional expertise apparatuses in the judicial system: "a normalizing society is the historical outcome of a technology of power centred on life" (op cit: 144). In this respect, psychoanalysis is

one of the main mechanisms of 'subjectification'.

Castel (1978) develops this critique even further, showing how psychoanalysis parenthesizes its social and political effects, producing what he calls 'psychoanalysm', an active process of invalidation and denial of the social realm. This will be considered here as one of the forms of the **psychologization** processes[1]. In another work (Castel et al, 1982), he and his colleagues provide an account of the North American process of establishing community mental health services. An interesting indication is that much of the new services implemented from the sixties onwards have been directed to population groups different from the traditional, more underprivileged, clientele of the old hospitals (..."what must be cured is normality" [op cit: 174]).

Despite the complexity of the debate, some of the main problems raised by the literature on the Foucaultian approach can be listed as:

- the dissension between reason and madness is not just an epiphenomenal privilege of the Cartesian cogito, but a Greek heritage of Western thought (Derrida, 1978).
- Foucault develops an interesting critique of the mechanistic traditional theories of economy, state and power (as in most traditional Marxist theories). He proposes a new conceptualization of the relationship between history, causality, time and space (Lemert and Gillan, 1982). However, he implies that at times discursive formations,

---

[1] **Psychologization** will be considered here in broad terms as the reductionism in the multiple political, ideological, cultural and social aspects associated to mental health and illnesses induced by some theoretical or clinical approaches. The second meaning of the word refers to its specific cultural form, like in the induction of a Western representation of mental life and of the Individual, in opposition to representations of the Person and mental life in holistic and traditional societies. The issue is particularly discussed in chapters 6 and 7.

knowledge and power do not adhere to historical or geographical locations, as suggested in History of Sexuality I. There, the clinic, the family and the confessional practices are the only visible social relations, as an example of a transgression of "the epistemological categories of contemporary historiography" (op cit: 96).

- Foucault's implicit Nietzschean and post-structuralist notion of 'death of the subject' eliminates subjectivity and consciousness as explanatory concepts, creating a theory of negativity and transgression (Foucault, 1987d: 45). In doing so, despite realizing the importance of the historical action by the concrete subject, he leaves no room to discuss such praxis, which would require a positive theory of political practice and critical rationality (Foucault, 1987b). Another consequence is that sometimes the theory of the subject is substituted by a theory of body, reducing desire to self-consciousness, which is further reduced to a correlative of power, a device of '**normatization**', leading ultimately to a form of biological essentialism (Adams and Minson, 1978). Limiting desire to the body, he does not explain how or why desire participates in political action.

- another implication of his approach is that any positive notion of care is possible, as any demand for personal help and self-understanding would be reduced to 'normatizing' practices. This may be the reason why Foucault's accounts, like most literature on social control, concentrate on the conceptualization of madness or on the professional and institutional machinery, and say little about what actually went on inside the families and asylums, leaving patients themselves absent from the scene (Ingleby, 1983: 144).

2.4.4. The Marxist Approach

Under this heading, works such as those developed by Scull (1979, 1984) and Ralph (1983) will be commented on.

Scull (1979) outlines the historical emergence of the psychiatric hospitals and professionals, relating them with the context of relations of production and social reproduction. The origins of confinement in England are associated with the rise of waged labour (when the family living on a wage could not any more provide for its dependent members) and the system of parochial relief, segregating the non-able-bodied poor in institutions as a deterrent to the able-bodied malingerer. The segregation of the insane in asylums followed the same determinants: the insane in particular produced chaos and demoralization in workhouse discipline, and the standards of care could not be raised above those of the majority of the free and/or segregated working class population.

Scull also discusses the main humanitarian and reformist movements that provided ideological justifications of incarceration and of coercive or psychological forms of controlling the insane. The reformer's moral and rehabilitative components of the treatment were subordinated to economic limits: for reasons of economy, asylums were built so large and poorly staffed, as to render any treatment impossible. In addition, he addresses the rise of psychiatry as a profession, as a movement towards a formal status involving effective monopoly control over the market for services and gradually embracing an increasing range of fields. It depends on close supervision of training and qualifications, and on the possession of knowledge and skills publicly regarded as unique and efficacious.

Despite illustrating the long-standing historical roots of institutionalization and its relationship to broader social problems, Scull's work does not add greatly to our understanding of its social regulation aspects. His view of professionalism does not indicate the particularities of controlling insanity. The same kind of professional power could be exerted over any other handicapped group. Moreover,

he mostly takes the category of madness as given, without discussing the historical changes in its definition (Ingleby, 1983).

Ralph's work (1983) stresses the need to control the workforce as the main historical determinant of the emergence of community mental health care, in a particular good example of mechanistic and functionalist Marxist analysis.

2.4.5. The Freudo-Marxist and the Institutional Analysis Approaches

The so-called Freudo-Marxist tradition has provided two broader perspectives in analyzing power relations which are particularly relevant to the field:

a) a wider discussion on culture, repression of sexuality and unconscious drives, and psychopathology[1].

b) a more specific approach of power relations mainly in micro-level social structures such as institutions, organizations, groups and local communities, identified by the French and Argentinian literature as Institutional Analysis[2].

---

[1] Freud itself started the debate, mainly in Civilized Sexual Morality and Modern Nervousness (1908); Totem and Taboo (1921); Group Psychology and the Analysis of the Ego (1921) and Civilization and Its Discontents (1930). His work was followed by Reich, Marcuse, Adorno, Habermas, Lasch, Deleuze and Guattari and others.

[2] The Institutional Analysis movement, in the broader sense of it, encompasses three main 'schools' or theoretical trends: the socio-analysis, linked to the work of Bourdieu and Passeron (Garnham and Willians, 1986), in a more sociological approach; the so called 'schizoanalysis', mainly represented by Deleuze and specially Guattari (Deleuze and Guattari, 1977); and the Institutional Analysis in the strict sense, associated to Lapassade (1967), Lourau (1975), Pages, Pichon-Riviere, Baremblitt, Langer, and several others particularly in France, Argentina and Brazil.

The latter addresses the symbolic aspects and the hidden dynamics of the human relationship with authority and leadership, group processes and conflicts, mass behaviour and ideology, and correlated phenomena. Most 'institutionalists' see the traditional theories of ideology and power relations as idealistic and mechanistic ones, when considering only the manifest and rational historical determinants of those phenomena. Underlying and associated with ideological, political or social processes, they point out latent structures determined by a specific pattern of organization of the unconscious drives and images (Guattari, 1984), which are sometimes called 'social imagery' (Castoriadis, 1975; Thompson, 1982). In very few words, the symbolic 'efficiency' of most power and authority structures depend on their ability to induce, connect, or appeal to the individual or group's desire and social imagery.

These collective forms of organizing unconscious drives, which have been investigated mainly in the field of group dynamics, can be described by some theoretical models, according to the different emphasis on topographic, economic, genetic and dynamic aspects, as present in Freud's own work (Anzieu, 1986). The approach is particularly relevant in order to analyze and intervene in micro-level experiences of community participation and leadership, therapeutic and self-help groups, and the relationship among professionals, therapeutic approaches and users.

3. THE THEORETICAL FRAMEWORK OF THE PRESENT INQUIRY

3.1. BASIC ASSUMPTIONS ON THE RELATIONSHIP BETWEEN CARE AND SOCIAL CONTROL/REGULATION WITHIN MENTAL HEALTH SERVICES

This study takes its main assumptions from the following theoretical and historical statements:

a) Power relations and social regulation mechanisms are not

'negative' or 'positive' 'per se'. As proposed in the Foucaultian 'positive' concept of power' (in the philosophical sense)[1], they encompass all the social tissue, are a necessary element in the positive production of social realities and truths, and always generate resistance. There is never a position of 'exteriority' in relation to them, or of total subjection or lack of them[2].

b) All historical forms of care provision imply some mechanism of social regulation and/or 'normatization'[3]. Even in left wing or reformist social movements, the demand for care or social provision means also an implicit demand for a different form of social regulation. From the opposite perspective, even stronger forms of social control generally provide some form of care. One example is the psychiatric hospital itself, with its custodial and retreat aspects.

c) Despite the intrinsic difficulty in providing precise definitions for these terms, it is possible to say in a broad sense that some forms of care and social regulation allow more space for individual or collective resistance and

---

[1] Particularly as developed in History of Sexuality I (1984).

[2] This position is also confluent with the dialectic tradition, for example as exposed by Hegel in the Phenomenology of the Spirit (1977).

[3] At this point, it is necessary to go beyond Foucault's conceptualization, as no positive theory of care or praxis is ontologically viable within his negative philosophical perspective.

autonomy[1]. The concept of social control is probably more appropriated for the 'strong' forms of social regulation, generating confusion and misunderstanding when used specially in relation to the 'positive' and 'softer' mechanisms of power (Rothman, 1983).

d) The emphasis on caring and/or controlling aspects in mental health care depend historically on:

- the collective forms of organization of the instinctual life in a specific social group or society, or how unconscious drives are allowed to be expressed and the symbolic functions are organized in the cultural, social and political life;
- the political economy of the society, in its social relations of production and social reproduction, also involving demographic features. In modern societies, this includes specially the social investment in informal care and formal social and health policies, particularly those related to dependent groups, such as the children, handicapped, old and mentally ill people.
- the hegemonic patterns of social regulatory mechanisms, specially those dealing with anomic or deviant behaviour.
- the cultural and ideological systems of representing the Person, mental illness and care, including the systematic or scientific ones (with their respective epistemological territorialization) and those diffused in the social tissue.

e) The developed capitalist societies of the West have

---

[1] Gramsci's distinction between dominance, jacobinism and hegemony stresses exactly the ability for a leading group to keep the power and/or promote changes through more consensual and legitimated mechanisms (Buci-Glucksman, 1980). Both the Italian Psichiatria Democratica and the Anglo-Saxon 'normalization' approaches constitute attempts to emphasize the provision of care with the parallel clientele's empowerment. Historical comparative examples in the mental health field are the total institutions (as described by Goffman) and a open-door mental health service in the community.

witnessed in the last two centuries a transition, not necessarily linear, in their internal mechanisms of social regulation. They have moved from the 'dividing practices' (Rabinow, 1987) and devices of the 'deployment of alliance', to devices of the 'deployment of sexuality' (Foucault, 1984). In other words, from negative and juridical forms of power to more positive ones, emphasizing 'subjectivization' practices and individualization processes.

f) Also in a historical perspective, Keynesianism, the welfare state and the Fordist economic cycle, particularly after the Second World War, have deepened this move towards positive forms of social regulation, through the increase in mass social provision. Therefore, while making more complex and softer the process of social regulation, the emphasis is given to the provision of social, educational and health care, reaching gradually wider groups in the bottom of the social pyramid and hitherto remote spheres of human existence.

g) The Third World countries under the capitalist influence have been witnessing the formation of very complex configurations of 'unequal and combined' economic, social and cultural relations, by which traditional and contemporary patterns of social regulation and care co-exist and complement each other (Oliveira, 1976; Velho, 1981). In the social and health field, the main trend in policy making is for the transplantation of models from the developed countries, most times without taking into account the local context, and for their implementation most times in a more rhetorical way (Vasconcelos, 1989; see also section 2.3, chapter 2).

g) In developed capitalist countries the move from negative forms of social regulation and several specific historical changes identified before (section 2.1.3) induced a confluence towards the model of community psychiatry. It generally includes:

- some kind of de-hospitalization policy;
- the regionalized provision of locally-based out-patient services;
- complementing the medical approach with alternative social and psychological models of care, through the employment of multi-disciplinary professional teams;
- proposals for legislation stressing users' rights (Mangen, 1985).

h) The crisis of the welfare state in the late seventies onwards reinforced the trend towards de-hospitalization policies (Scull, 1984), inducing the closure of psychiatric hospitals without the parallel implementation of community mental health services. Neo-liberal policies tend to frame such procedures within a discursive critique of the mass production and inefficiency of the statutory sector, stimulating a consumer-oriented view. In addition, they tend to reappropriate de-hospitalization claims by mental health movements and 'interpellations' for lay and self-help to withdraw resources from mental health services (Castel et al, 1982; Mangen, 1985). Indeed, resources into community services are much more easily diverted than those concentrated in large institutions. Therefore, in such a specific context, the claim against 'strong' forms of social regulation associated to institutionalized mental health care might be used to produce negligence and re-privatization of the burden of care, particularly on informal carers.

i) From the mid seventies onwards, the model of community psychiatry started to reach Third World countries under capitalist influence, either by the induction from development agencies (such as the WHO) and local government policies, or through claims by mental health movements. However, its implementation presents at least the following contradictory features:

- the lack of most of the historical conditions which

allowed the process in developed countries, such as the context of shortage of labour force (given the local large dimension of the surplus workforce), the minimum universal welfare state provision and demographic changes;

- particularly in South America, the political conditions for democratization and re-distributive social policies became possible at the end of the period of military dictatorships. However, the crisis of the Keynesian and Fordist economic cycles, coupled by the international imposition of hard adjustment policies have induced serious constraints on the process of democratization and on any increase in the social provision and the development of community mental health services.

j) The analysis of the dynamics between care and social regulation specifically within community mental health services constitutes a very complex task, even in developed countries, as:

- they manipulate very complex mechanisms of social regulation, which take mainly the form of positive provision of care.

- from the point of view of the available theories, as seen above, the literature shows not only a trend to focus on care and control in a separated way, but also very polemic and conflicting approaches, given the reasons indicated above (section 2.2.1).

k) In Third World countries such as Brazil, this task is even more complex, due to:

- the lack of historical pre-conditions for de-hospitalization policies and the present context of economic and social crisis, as described in topic (i);

- the traditional use of the psychiatric hospitalization by lower income groups of the population as a mean to achieve sickness and retirement benefits, in a context of lack of

any social emergence programme and real unemployment benefit[1];
- community services have been implemented very recently, not allowing a longer historical perspective;
- the generalized lack of service records and of systematic service evaluation and research;
- the lack of service models built specifically to serve the working class clientele. The common feature is the systematic transplantation of techniques hitherto used in the upper classes' private clinic practices to the newly established services.

In such a context, then, any study is essentially an exploratory one. In addition, the proposed framework should have a very provisional character and be limited to the particular context on focus. With these qualifications in mind, the next section will consider some parameters for analyzing the process of implementation of community mental health services in Belo Horizonte.

3.2. PARAMETERS FOR ANALYZING THE RELATIONSHIP BETWEEN CARE AND SOCIAL REGULATION IN COMMUNITY MENTAL HEALTH SERVICES IN BELO HORIZONTE.

a) **The historical process of demand formulation and of implementation of community-based services and its main political actors:** historical description of the main events and actors, their respective socio-economic interests, ideologies and professional culture; their mechanisms of organizing a collective will, accessing power and promoting changes and concrete results in the service implementation. For this purpose, the main theoretical approach to be used is Marxist, including Gramsci's concepts on political and ideological struggle and hegemony, Psichiatria Democratica

---

[1] On this, see section 3.3 in the next chapter.

and the 'professionalism' approaches. When events are focused in the micro-level and enough information is available, concepts from the Institutional Analysis may be incorporated too.

b) **General organizational and economic features of the services being implemented:** location of the programme among the several types of social provision and other health services; and internal features of programme, such as financing, infra-structure (facilities, provision of basic material, medicines and maintenance resources), human resources policies, and decision making processes. Here, the analysis will be mainly descriptive, although the account for social and political determinants and implications may also use concepts from the Marxist tradition.

c) **The hegemonic service models:**

c.a) **The official plans for services and needs being actually met or neglected:** definition of priority approaches and treatment strategies in the service plans and guidelines; comparison to assessed potential and actual needs and contradictions with what has been actually being offered in the services along the period in focus; neglected needs and client groups and their specific features. Contributions from the epidemiologic, feminist, Marxist and the 'need oriented' approaches will constitute the main sources for analysis. In addition, a comparative list of potential needs in the mental health field for contemporary developed countries will be provided in section 3.3 below.

c.b) **The service models' roots in the providers' professional cultures:** assessment of the hegemonic theoretical and technical approaches among the main training institutions and among professionals in general;

recruitment, training, supervision mechanisms and specificities of the professional work within the statutory mental health service network, and implications to the hegemonic forms of care being provided. The main analytical tool to be used here is the 'professionalism' approach.

c.c) **The service models' epistemological and cultural features and the caring and social regulatory implications:** epistemological territorialization and the implicit cultural definition of mental life and care of the main approaches in use, contradictions with the client's hegemonic social representations, and their implications in terms of caring and social regulatory effects. The main theoretical contributions here come from the post-structuralist and anthropological (particularly the cross-cultural psychiatry) approaches.

c.d) **Connections with other welfare agencies and their caring and regulatory implications:** explicit or implicit links with other social or health organizations and institutions, and their implications in terms of care, social regulation, stigmatization and psychologization. The main theoretical tools here will be the Marxist and anthropological approaches.

c.e) **The concrete relationship established with the clientele:** formal guidelines and actual patterns of relationship with the clientele and the community; mechanisms of participation and interference in treatment issues, service planning and evaluation, and general decision making process. Theoretical contributions will come mainly from Marxist and Institutional Analysis approaches.

3.3. A COMPARATIVE LIST OF POTENTIAL NEEDS IN THE MENTAL HEALTH FIELD

The following table 1 provides a list of what has been indicated in contemporary developed capitalist countries as

Table 1 - List of Basic Needs/Care Structures in the Mental Health Field Identified in Developed Countries

CATEGORY	BASIC NEEDS	EXAMPLES OF STRUCTURES TO MEET THEM
Prevention	legal/organizat structures for protecting special groups against violence and negligence	special services for children, handicapped, elder and women
	change social/environment cond. which increase vulnerab. to mental distress	occupational psychological and ergonomic practices
	special schemes for information, education and advice	issues like drug addiction, sexual educ., prev. suicide, profess. choice, female/feminist issues
	collective assessment of needs	epidemiological research; planning
	early recognition	early diagnosis and referral system
Specializ. treatment, care and support	primary care	walk-in and consultancy unit with medical, psychological and social care and support
	secondary care	emergency/crisis interv. units; specialized med., psychol., social, rehab. care; family support
	tertiary care	acute/non-acute in-pat service
Care, support and social rehabilit. in the community	temporary/perman. resettlement and rehabilitation schemes	
	specialized comm. care for chronic and elderly clients	domiciliary care, day centres and hospitals, rehabil. activities
	sheltered/ supervised accommodation services	nursing homes, rehab. homes, hostels, staffed or non-staffed group homes, independent housing schemes
	family care/support schemes	family advice/therapy; domiciliary support, tempor. relief schemes
	soc. rehabil., special education, work and employment schemes	occupat. therapy/workshops; work coops, special employment schemes
	alternative/informal comm. care	self-help groups, socializing groups
Advocacy, protection of rights and concern within wider society		legal action, consciousness raising, militancy, changing stigmatizing attitudes within society and media

Sources: DHSS, 1975; MIND, 1983.

basic potential needs and corresponding care structures in the mental health field, some of them not consensually. This will serve comparative purposes later on.

. . .

Having outlined in this chapter the theoretical framework of the inquiry, the next step will look primarily at the general features of the Brazilian social context, the main cultural and epidemiological features of the population and the main characteristics of the health and mental health policies up to the seventies. In doing so, it will be easier to explain and justify the main methodological decisions. These topics constitute the subject of the next chapter.

Chapter 2

THE CONTEXT AND THE METHODOLOGY

1. INTRODUCTION

This chapter is divided into two main parts. The first will look at the basic historical, social, political, demographic and epidemiological background information needed to understand the context of the mental health field in Brazil, to be provided in the two initial sections. This first part will also address the basic features of the area and of the historical period under inquiry, which will constitute a third section. This view on the context will allow the reader a clearer understanding of the research design and the methodological procedures adopted, which will be outlined in the second part.

2. THE BRAZILIAN SOCIAL CONTEXT

2.1. HISTORICAL BACKGROUND INFORMATION ON THE COUNTRY

Brazil is the largest country in Latin America and the fifth largest in the world, with 8,511,965 sq km, almost 35 times the area of the United Kingdom. Its formal political independence from Portugal was achieved in 1822. It remained a monarchy until 1891, just two years after the legal abolition of slavery. All of these transitions occurred without major violence, indicating a relatively high level of political stability and national unity when compared to other Third World countries. At the same time, the political culture in the country has been characterized by a strong authoritarianism, centralization of power and influence from the military sector, and a 'patrimonialist' pattern of

domination[1].

Until the 1930's, the economy had been based mainly on export-oriented activities (hardwood, sugar cane, rubber, cotton and coffee). Industrialization was first induced by a state policy of substituting previously imported finished goods. Later on, in the sixties, a new pattern of industrialization was produced by a deliberate internationalization of the economy and external borrowing, mainly during the period of the military dictatorship (1964/1984)[2]. Since then, despite the cyclical downturns and spatial differentiation, the country has built a modern industrial sector able to compete in the international market, and ranks as the tenth largest economy in the world.

The international crisis of the mid-seventies led to a lower economic performance and a controlled process of political 'aperture' in the military regime, which ended up in a non-directly elected transitional government in 1984. Since then, a new constitution has been drafted and a new government was elected in 1989[3]. Concerning the economy,

---

[1] This Weberian concept refers to a political organization based on personal links instead of rational-legal rules, on the inability to distinguish between public and private and to public accountability, and diffusion of bribery and of illegal appropriation of resources. In Brazil, the 'clientelism', the horizontal and vertical system of exchanging privileges and the privatization of the public resources are good examples of such political culture (O'Donnel, 1988; Da Matta, 1983).

[2] O'Donnel (1988), in his already classic comparative studies of the military dictatorships in Latin America, has classified the Brazilian case as presenting a relatively good economic outcome, a comparatively low level of repression and a negotiated transition.

[3] O'Donnel (1988) suggests an important distinction between the transitions to political, and to socio-economic and cultural democracies. In the Brazilian case, the former was completed in 1989, and he indicates that the latter will also be longer and difficult.

the eighties were characterized by tough adjustment policies. These entailed a substantial transference of resources to the exterior, a decrease in the internal general rate of investment, recession (with parallel decline in the employment and real wage levels), a substantial decrease in the public sector's revenue and investment, and high interest and inflation rates (Souza, PR, 1989). In more global terms, **the eighties witnessed the re-emergence of the democratic political pre-conditions for re-distributive development strategies in Latin America. However, this happened in a context of structural crisis of Keynesianism, of Fordist mass production of social/ health services and of the state** (see chapter 1, section 2.1.3.) (Vasconcelos, 1989).

2.2. THE POPULATION AND ITS MAIN SOCIO-ECONOMIC, CULTURAL AND DEMOGRAPHIC FEATURES

The Brazilian population was estimated in 1989 to be 147,404,300, composed 53% of whites, 33% mixed ('mulatos' and 'mesticos') and 11% black people (Encyclopaedia Britannica, 1990: 576), although this classification is viewed as highly inaccurate. The original Amerindians are reduced by now to only 0.1% of the population.

The majority declared themselves in 1980 as Catholic (89.96%), followed by Evangelical (6.63%), Spiritist (1,29%) and others (1.24%)(IBGE, 1988: 52), including the Afro-Brazilian cults[1]. However, the proportion of the two latter groups, involved in medium practices, may be actually higher than is formally reported.

Despite the economic growth of several decades, the

---

[1] Such as the 'candomble', 'macumba' and 'umbanda', the result of the syncretism among the Amerindian and African cults.

country is persistently marked by low average standards of living and mainly by huge regional and socio-economic inequalities. Although the average per capita income was US$1,967 in 1986, in the North-East (the nation's poorest region) about half of the population (20 million) survived on less than US$300 per person, a level comparable to that of China, South Asia or West Africa (World Bank, 1988). Some additional social indicators are available in Table 2.

This inequality has led in the last four decades to a huge migration towards the largest and richest urban areas in the South-East, particularly to cities such as Sao Paulo, Rio de Janeiro and Belo Horizonte. Inequality is also found in the large 'favelas' and poor districts in the peripheral areas of larger cities, without the basic urban infra-structure and presenting very low living standards.

Table 2: Brazil - Social Indicators

	Infant Mort. Rate (p/ 1000 live births)		Life Expectancy		Secondary School Enrolment (*)	
	1965	1985	1965	1985	1965	1984
Northeast Brazil	125 (1976)	116	46	49 (1978)	3	15
Rest of Brazil	75 (1976)	52	58	64 (1978)	11	25
BRAZIL	104	67	55	65	6	21
CHILE	107	22	57	67	34	66
MEXICO	82	50	58	64	16	35
COLOMBIA	96	48	54	63	17	49
KOREA	63	27	55	65	35	91

Source: World Bank, 1988: 1.

Note: (*) Percentage of children of secondary school age enrolled.

Other aspects of the social inequality are indicated by the income, land distribution and ethnicity. The 40% lowest income group earned in 1980 just 9.8% of the total income, while the richest 10% accounted for 47.9% of it (Wood and

Carvalho, 1988: 76). This gap has constituted a persistent deteriorating trend in the last three decades. The land concentration is among the highest in Latin America. 90.1% of all rural properties (less than 100 hectares) in 1975 corresponded to only 21.3% of the total area, compared to 0.9% of the establishments (more than 1,000 hectares) with 42.9% of the total area (op cit: 83), and the situation was worse in 1985 (IBGE, 1988: 307). Finally, Wood and Carvalho have shown a long-standing persistence of racial inequalities in life expectancy in the country between 1950 and 1980. This is even when controlling for the effects of social and economic determinants such as income, education and access to clean water (op. cit: 151).

This long standing racial and social hierarchical system has deep historical roots, surviving the abolition of slavery not in a formal system of legal differentiation (as in South Africa) or in an open racist ideology (like in the USA). Instead, it has been coded at the level of personal relations. Therefore, the upper classes had no need to fear the freed slave, because the social relations had already been strongly hierarchized, with a powerful aesthetic component, expressed in the house, skin colour, personal appearance and other visible aspects (Da Matta, 1983).

This ethnic and social inequality and differentiation is also permeated by contrasting cultural heritages and patterns, which are revealed mainly in regional, ethnic, religious, family structure, rural/urban and social class differences. Examples are the stronger Amerindian influence in the Amazon and North-East regions, the marked Afro-Brazilian presence in Bahia or the survival of Italian, German and Japanese immigrants' culture in the South and South-East parts of the country. Particularly the rural/urban and social class polarizations are incorporated in the debate on what has been called the 'popular culture', or the ensemble of cultural features specific to the working

class population groups. The upper classes, instead, are identified by a more urban, Westernized and individualized way of life. The description of this debate and its implications for the mental health field are outlined in chapters 6 and 7.

When focusing on the demographic changes, the following main trends have been indicated:

a) As suggested before, there has been in the last four decades a strong process of rural/urban migration, but its speed decreased from the late seventies onwards[1].

b) After a long period of quick growth, a significant decrease in the annual population growth rate has occurred since the mid-sixties[2], due to reduction in the birth rate. The process is regionally and socially uneven, being more recent in rural areas and amongst the poorest population groups.

c) Life expectancy has increased significantly[3], in a growth profile similar to Asian countries.

d) The age structure has gradually changed accordingly, but the available data still points to a younger population than the European standard[4].

---

[1] The urban population has grown from 31.2% in 1940 to 73.9% in 1990. For the year 2000, it was estimated that the rural population will reach the ratio of 20.8%, which will still be high for European standards (Baltar, 1988: 71).

[2] From 3.0% in 1960 to 2.0% in 1990 (op cit: 69).

[3] From 38.5 in 1940 to an estimation of 68.6 in the year 2000. The life expectancy gap between average Brazilian and North American individuals was 25 in 1959, is around 10 years at the moment and is estimated to be 4 at the year 2025 (Ramos et al, 1987: 214).

[4] The group aged 20 or less will be around 40% of the population, against an average of 20% for the European countries (Baltar, 1988: 73). Those aged 60 or more were 4.8% of the population in 1960, 6.2% in 1980 (against an European average of 17%), and are estimated to reach 13.8% by the year 2025 (Ramos et al, 1987: 214).

e) Summing up, when compared to European countries,

> **"the estimations of global growth, spatial location and age structure show that there still exists a large scope for transformation in the demographic transition taking place in Brazil, and that it still allows for deep social and economic effects, in an historical process which can go on for several decades "** (Baltar, 1988: 73).

f) The decline in the birth rate has a direct impact on the average size of the family[1]. There is also evidence of a trend towards the increase in the number of one person households[2] and of a large increase in the number of female single parent families[3], a high proportion of the latter being reported as living in extreme poverty.

g) The demographic features of the urban labour market, when compared to the developed countries, can be summarized as:

g.a) a higher proportion of participation in the labour market in the extremes of the age profile (Baltar, 1988: 77-9):

- the schooling period is shorter and the rate of young men in productive activities is higher;
- higher rates of people aged 70 or more still working, not covered by social insurance or needing to complement the benefit, which is considered very low.

g.b) a lower proportion of male participation aged 50 to 59,

---

[1] Which changed from 5.1 in 1960 to 4.1 in 1984), particularly by reducing the number of very big families (7 or more members) and increasing those having 3 or 4 members (Berquo and Casenaghi, 1988: 158).

[2] From 5% in 1970 to 7% in 1984 (while the average in England in 1985 was 25%). The rate of growth during the 1970/80 period is 5.43%, twice the global growth rate of the population. There is a uniform distribution in the age range profile for men; for women, the predominance is for those aged 45 or more (op cit).

[3] Neupert et al (1988: 249-50) estimated a ratio of 9% of all women with children in 1980, although acknowledging several exclusions in their definition and that the figure must be higher.

due to early joining the labour force, early aging process and right to retirement after 30/35 years of work (op cit: 77).

g.c) a lower participation of women in all age ranges, suggesting a high proportion of domestic activities and/or non formal jobs. However, the participation is increasing rapidly and it is estimated that it will reach in the year 2000 ratios similar to what the English and French ones were in the early eighties (around 50%) (op cit: 82; Paiva, 1984).

h) In relation to the social insurance system, the possibility of increasing its revenue through the incorporation of women or extension of the coverage to groups hitherto excluded is probably higher than in the European counterparts. This allows the system, at least when considering only demographic variables, a potentially longer process of self-sustenance (Paiva, 1985).

2.3. MAIN FEATURES OF THE BRAZILIAN SOCIAL POLICIES

The current critical literature on the country's social policies has pointed out as their main basic features:

a) **hierarchization and social discrimination:** social programmes have historically privileged since the beginning of the century the better-off social groups in strategic positions in the economic and political system, most times with a clear corporatist component (Santos WG, 1979; Oliveira and Teixeira, 1985; Coimbra, 1986). For example, 19% of the lowest income group in the country receives only 8% of social benefits (World Bank, 1988: iv). Recently, attempts to universalize basic social and health services have been made, several times in a more rhetorical, a-systematic or precarious way (Vasconcelos, 1985).

b) **fiscal regressiveness:** the heavy reliance on payroll taxes and payroll-based social contributions (which account

for 75% of revenues for federal social expenditure) is highly regressive (World Bank, 1988: v; Coimbra, 1986; Souza and Affonso, 1977).

c) **bureaucratization and inefficiency**, which can be identified in:

- the financial structure, with a large share of revenue inflexibly earmarked, a complex and opaque system of transfers, and a rigid, centralized and politically manipulated financial control in all levels of the administration;
- the organizational structure, showing over-centralization in some programmes;superimpositionof institutions having the same functions; huge waste in bureaucracy and administration; 'patrimonialism' and 'clientelism'; lack of incentives for cost-effective and accountable approaches; corruption, mismanagement and privatization of public resources; and inappropriate use of the private sector (World Bank, 1988; Coimbra, 1986; Vasconcelos, 1985).

d) **paternalism:** several programmes have adopted the form of paternalistic benefaction, reinforcing the clientelism and attitudes of dependence and subordination, and avoiding active, participating, and self-sustained alternatives[1].

e) **under-funding:** despite being contested by the neo-liberal literature (World Bank, 1988), social expenditure is generally considered by the country's critical specialists to be low in relation to other areas, particularly during the military period and the eighties' adjustment policies (Souza and Affonso, 1977; Coimbra, 1986).

Given the complexity of the Brazilian welfare system, it would be practically impossible to provide here a brief view of the main types of social coverage and benefits

---

[1] The classic example is the complementary nutrition programmes, which have distributed ready food for over 40 years, instead of stimulating cooperatives of production and consumption (Coimbra, 1983)

available to the various needy groups. For this purpose, some bibliographic references available in English are provided[1].

3. THE MAIN FEATURES OF THE MENTAL HEALTH FIELD IN BRAZIL

3.1. Historical Background

The periodization of the history of medicine in the country's literature (Santos Filho, 1947; Montero, 1985) generally indicates three main broad periods:

a) the colonial period, with hegemony of the Amerindian, African and white[2] medicines;

b) the 'pre-scientific' period, which starts with the establishment of the first schools of medicine at the beginning of the nineteenth century;

c) the 'scientific' medicine, which gradually affirms itself mainly from the first decades of the twentieth century onwards.

In spite of the gradual increasing hegemony of the latter, remainders of the first still exists today among the working class population. This is despite the long process of transformation, mixing its internal elements and of being influenced by the official medicine (Montero, 1985).

---

[1] For a descriptive view of the risks' coverage and social benefits, see Leite (1990), despite his very a-critical approach. For a comparative analysis of the Brazilian system among other Latin American countries, see Mesa-Lago (1978, 1985, 1989). For a critical Brazilian perspective, Malloy (1979, 1982), Allen (1985), Shidlo (1990), Wood and Carvalho (1988), and Coimbra (1983). The World Bank report (1988) is also an interesting source for a critical neo-liberal view of the subject.

[2] Understood mainly as the healing practised first by the Jesuit priests and second by the colonizers, which main origin lies in the traditional popular Catholicism in the rural Portugal.

Until the nineteenth century, in a basically rural society in which all labour was performed by slaves, the poor and the mentally ill were included in a large group of undefined people without work[1], in the gap left between landlords and slaves. These included freed black slaves, poor whites, 'mestiços', vagabonds and offenders. They used to live then in the fields and streets, or, if acting aggressively, would be temporarily imprisoned, although there is no reference of places where they constituted a high number of inmates. In the case of rich families, it was common to have them hidden in special closed rooms (Medeiros, 1977; Resende, 1987).

This literature locates the beginning of the hospitalization of the mentally ill in the country in the first half of the nineteenth century, with similar features to those described by Foucault in his account of the Paris great confinement. They were initially heaped in the basements of the charity hospitals or in prisons, and therefore practically condemned to death by violence, malnutrition or infectious diseases. Later there were humanitarian calls for a special hospital for them. The first asylum ('Hospicio de Pedro II') was inaugurated in 1852 in the then capital of the Empire, Rio de Janeiro. It was built in a then very distant place from the city, and its 350 beds were completely engaged twenty one months later (Medeiros, 1977: 54). This constituted the main pattern of psychiatric care in the country until recently. New asylums were created far from the cities and overfilled very quickly, justifying claims for more resources and more hospitals. Medeiros (1977) numbers 55 other new hospitals built in the country up until 1950, basically following a similar path.

---

[1] The engagement in productive work by non-slaves was considered shameful and stigmatizing (Resende, 1987).

In the nineteenth century, hospitalization meant segregation and social control more than any curative or caring component. The hospital were mainly a result of demands to clear the streets of 'trouble-makers', in cities with quick population growth. Their clientele is also further evidence of this: practically no slaves were found, only free, poor, 'non productive' people, as indicated before. Mistreatment and violence was widespread and frequent[1]. Moreover, the specialized psychiatric knowledge penetrated the institutions only later on. The criteria for admission and classification[2] were basically non-professional; doctors were very few and had very little influence in administrative decisions (Resende, 1987; Medeiros, 1977).

Summing up, **this 'lay' psychiatry was essentially linked to the features of the neo-colonial slavery system. Its end and the transition to modern capitalist social relations not only aggravated the social deprivation and exclusion processes, but also led to the introduction of the 'scientific psychiatry and medicine' inside the asylums and**

---

[1] At the Hospicio da Visitacao de Santa Isabel, Olinda, for example, the mortality rate reached more than 50% of the inmates just a few years after its inauguration in 1864 (Resende, 1987: 39).

[2] As an example, almost 90% of all inmates at the Pedro II hospital in Rio were diagnosed using the category of 'atypical degenerated' (Resende, 1987: 43).

in the statutory control of the public health[1]. The new Republican discourse is strongly marked by the positivism, which also represented the main ideology of the historical affirmation of the medicine as a profession and its association with the state power. In the public health field, this was expressed in a new strong concern for sanitation and control of epidemics and infectious diseases, through direct intervention in the cities, medicalization of larger social problems and exclusion of the 'unhealthy'. In psychiatry, it meant a reaction against the 'decadent' and 'distrustful' French psychiatry and the development of a strong somatic and genetic model in the clinical and administrative practice inside the statutory asylums, charity hospitals and private 'resting-houses'[2]. Later on, it led to the first 'preventative' model of intervention in

---

[1] Chronologically, this process started after the establishment of the Republic in 1891. This period witnessed a gradual introduction of the manufacture in the larger cities, mainly through importing the skilled migrant labour force from Europe. Between 1905 and 1914, 31% of all in-patients of the Pedro II hospital were immigrants. Work constituted practically the only actual therapeutic activity available in the then newly built asylums, with the diffusion of the 'agricultural colony' model. Therefore, intentions of recovering and returning the able-bodied to the society was added to the almost exclusive controlling and segregative features hegemonic in the previous period (Resende, 1987: 46-7).

[2] Private in-patient houses for the rich ('casas de repouso') have been founded in Rio since 1860 and have diffused gradually within the country, according to Medeiros (1977: 38-42).

the social field, through the Hygienic movement[1].

The psychiatric care during the first half of the century was basically indoors, as very few out-patient units were established. The first two were inspired by the Hygienic movement in Rio de Janeiro, in the twenties. The first statutory out-patient clinic was established in Recife in 1931, framed by a broader conceptualization of care, also including proposals for open hospital and after care services. However, the project was not implemented. From 1944 onwards, with the creation of the National Service for Mental Illness (Serviço Nacional de Doenças Mentais - SNDM), other units were established within the country[2]. Moreover, the psychiatric practice was incorporated very recently (in the fifties, and even so only gradually) to other medical specialities in the health care provided by the several social insurance organizations[3].

This gradual and a-systematic establishment of out-patient care units from the fifties onwards is referred by Resende (1987: 56) as **the inauguration of a third period of the history of psychiatry in the country: the emergence of**

---

[1] The Brazilian League for Mental Hygiene was founded in Rio in 1923, with aims like the 'prevention, the eugenism and the people's education' (Costa, 1981b: 28). It reached the point of idealizing strong repressive measures, as repression of alcoholism, sexual sterilization of patients, segregation, eugenic tribunals and wage reforms, etc (op cit). However, in my view, the critique of the hygienic model in the country's literature seems to overemphasize its continuation in any later proposal for a social or broader approach in the mental health field (like in Costa and Birman, 1976; Giordano Junior, 1989).

[2] There is no consensus on the exact number of them in the available historical sources. Medeiros (1977: 43) indicates 22 'ambulatórios' created by the SNDM until 1958. Resende (1987: 54) points out 17 in all the country in 1961.

[3] Until the sixties, they were organized mainly in corporative organizations, called 'Institutos de Aposentadoria e Pensao'.

the 'mass psychiatry'[1]. In my view, it is important to note that the idea of a different historical period does not mean the substitution of the previous pattern of services, based on the asylum. They continued to exist practically unchanged until the late seventies, with the same features: overfilling, under-staffing, mistreatment, and very low living standards. As will be indicated later, the psychiatric system during the period has become much more complex and differentiated in organizational terms, linked to an ensemble of different and sometimes contradictory interests, intrinsically associated to the diverse social groups it has served. However, a better understanding of such a process will require a brief look at the broader changes in the health system during the military period.

3.2. The Health System During the Military Regime (1964-84)

During the late sixties and seventies, the health care providers in the country could be grouped in the following main structures:

a) The then recently unified Social Insurance system, providing individual curative medical services by one of its branches (today called INAMPS), to a population formally linked to the labour force[2].

b) The public health system including the Ministry of Health

---

[1] The expression is used by this author to refer to the psychiatric care incorporated to the social insurance system's medical practices, with a clear concern on the recovery of the labour force. It also marks a differentiation with the two previous periods, when psychiatric care had a more prominent exclusion role.

[2] The access to services is given by the presentation of the 'carteira de trabalho' (similar to the insurance number card in England), which practically constituted the symbol or the certificate of citizenship in the country (Santos, 1979).

(mainly responsible for collective measures[1]) and each state or municipality government. They have provided medical care through some hospital units, a hitherto a-systematic and rudimentary set of health centres and emergency units, generally also accessible to those not insured.

c) The private for profit health care system.

d) The informal sector, including an old and traditional charity sector[2]; healers, herbalists, family, etc.

The military government (1964/84) health policy emphasized the first one, namely the curative, individual and specialized medical care, almost absolutely provided by services contracted out to the private for profit sector. A huge industrial medical complex was created, with strong political influence on the Social Insurance system and government apparatus. This trend is shown in Table 3, indicating the evolution of the spending in curative and preventive health care previous to and during this period.

Such policies led to the emergence of a strong political movement in the late seventies mainly among the health professionals, towards a structural change in the health system.

The main criticisms raised at the time were:

- inequality and no universal accessibility to services;
- inadequacy and lack of efficacy in relation to the main basic health needs of the population;
- over-centralization of services in the large urban centres and in specialized units, particularly hospitals;
- very expensive and inefficient care, with uncontrollable increase in the costs and emergent financial crisis of the

---

[1] Communicative disease control, vaccination campaigns, and for some few hospitals in the former capital of the country, Rio de Janeiro.

[2] Particularly the religious hospitals, as the 'Santa Casas de Misericordia'.

Social Insurance system, with resources being drained to the private for profit sector;

- lack of organizational integration and duplication of services (World Bank, 1988; Oliveira and Teixeira, 1985; Mendes, 1980).

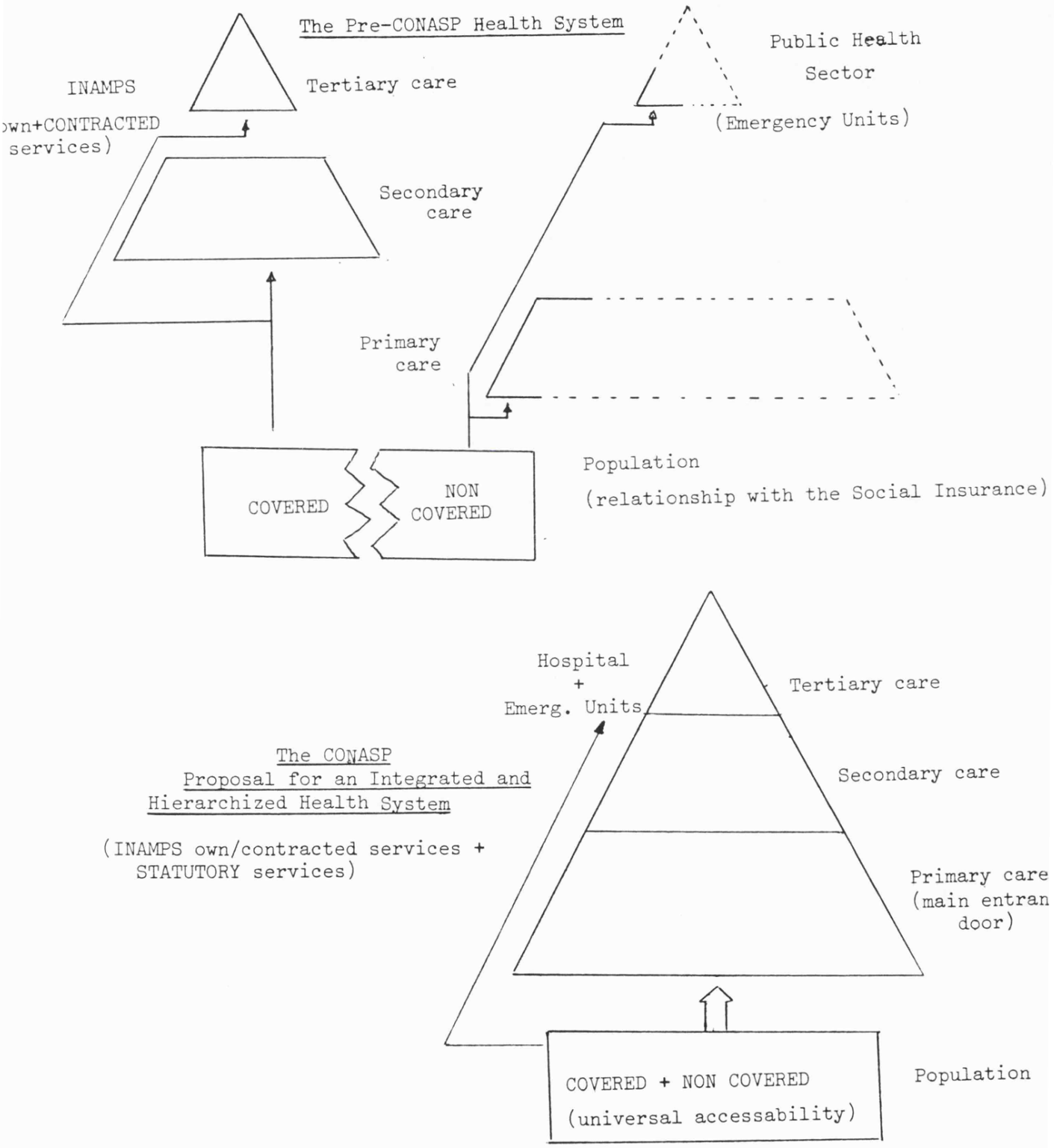
Table 3: Brazilian Public Health Care Spending, Curative and Preventive Shares, Selected Years, 1949-1982

Year	Curative	Preventive
1949	13	87
1965	36	64
1969	59	41
1975	70	30
1982	85	15

Source: World Bank, 1988: 44

In answer to the need for controlling costs and rationalization of the health system and to the political mobilization of the health professionals, the federal government launched in 1982 (called CONASP Plan) a policy of gradual shift to emphasis on the public health system. This model was inspired by the proposals of the World Health Organization (WHO/UNICEF, 1978), towards a unified, decentralized, regionalized and integrated health system, with emphasis on the provision of basic primary health care. Diagram 1 provides a quick view of the previous situation and of the new proposals from the CONASP onwards. The historical process of implementation and further description of their features will be outlined in more detail in the next chapter.

Diagram 1: The CONASP Proposal for an Integrated Health System in Brazil



3.3. Main Features of the Psychiatric System in the Late Seventies

In the psychiatric field, the policy implemented by the military regime followed lines similar to the general health sector, having as main implications:

- absolute emphasis on the expansion of hospital care through contracting out to the private for profit sector by the Social Insurance system, representing 95% of the INAMPS resources for psychiatric care until 1980. The treatment and living standards inside the hospitals have been generally very low. The few out-patient services were generally used as recruitment units by the private sector (Vaissman, 1983: 101-2).
- a very high rate of re-admissions (77% in the INAMPS funded services in 1977, when its official parameter was 30% [Moreira, 1980: 22]).
- low funding and a general deterioration of the care and living conditions inside the statutory asylums, as reported before, and complete lack of integration with the INAMPS structure.
- strong geographical concentration of the hospital and of the few out-patient units in the larger cities, mainly in the South-East region.
- absolute centralization of the professional practice in the hands of psychiatrists, indicating a strong medical curative and medicine centred care.
- a very high presence of mental illnesses among the disabling factors, constituting historically the first category in the provision of temporary sickness benefit and the second for retirement (Moreira, 1980: 25).

The last topic deserves a further comment. Recently, **there has been widespread recognition of psychiatric hospitalization as an active strategy used by deprived social groups to achieve social benefits or immediate relief**

in case of life or social hardship and crisis. This makes sense when the country's context of inequality and social deprivation, lack of basic personal social services and of an actual unemployment benefit programme is remembered. Moreover, hospitalization has became easier to get during the military regime due to the freedom allowed the private for profit hospital sector. A relatively large literature has provided substantive evidence on the subject[1].

At the end of the military period, the psychiatric system had achieved a high level of complexity and differentiation regarding its institutional links, clientele selection and the social interests involved. Souza (AL, 1987)[2], for example, pointed out four different lines of hospital care in Salvador, Bahia:

a) the statutory asylum, recruiting its clientele from the poorest, non directly productive and most devalued strata of the population. According to Souza, it legitimates

---

[1] Alves, 1982; Cardoso, 1986; Comissão Saude Mental/CEBES, 1980; Costa, 1979; Duarte, 1986b; Espinheira, 1982; Moreira, 1980; Sampaio, 1979; Soares, 1980; Souza AL, 1987; Tsu, 1986. The issue is also a common subject in the main official documents in the mental health field. The most common appointed secondary gains and uses of the hospitalization are:
- means to achieve temporary sickness benefit and retirement, and complement them with work in the large informal labour market;
- access to a temporary resting, holidays, energy restoration, or retreat place;
- access to a sheltered custody place for the elderly, abandoned children, disabled and people with learning difficulties, or as a last resource for other medical treatments;
- an strategy to avoid the criminal conviction in courts;
- in addition, hospitals are also traditionally used by the family and other institutions (police, justice) for disciplining and controlling deviant behaviour.

[2] Despite sometimes his analysis could be classified as a functionalist Marxist one, his contribution is important within the country's literature on the subject, and has influenced the approach adopted in the present research.

medically one of the last moments of the process of social exclusion originated in the structural inability of the dependent capitalist development to absorb all the labour force it produces;

b) the statutory university hospital, initially also attracting the poor, but after improving and modernizing their services, started to widen the access to a waged middle class clientele.

c) the private hospital contracted by the INAMPS: used by low and medium qualified workers, characterized by a very low standard of care. For Souza, it aims not at the recovery, but the fixation of the maladapted worker out of the productive circuit. As one of the 'perverse' aspects of the dependent capitalist development, this process has been used profitably by the capitalist hospital sector.

d) the private hospital: selling its services among the upper classes. According to the author, its aim is the recovery and the reintroduction of their clients in the productive and symbolic social market.

However, there is no example in the literature of a systematic evaluation of the recently implemented out-patient sector, which is one of the main purposes of the present research.

3.4. The Brazilian Psychiatric Legislation

Despite the large number of specific laws on norms and administration of psychiatric services in the country [A: DINSAM, ?: Souza: Legislação], the core of the legislation on mental illness is constituted by old legal instruments centred on the obstruction of the ill person's civil rights and exclusion through in-patient care, such as:

a) the Constitution (the previous one, dated from 1969 and the new one, from 1987) and the Civil Code (dated from 1916), all affirming the state of civil incapability and

dangerousness of the 'mad of all kind', which is the basis for obstructing all their civil and political rights;
b) the old federal 'Decreto' 24.559 (03/07/1934), on 'the care and protection of the individuals and properties of the psychopath', although is clearly more centred on protecting society against them[1].

3.5. A Very Brief Summary of the Main Epidemiological Findings in Psychiatry for the Brazilian Population

In Table 4, a summary of the findings on mental illness prevalence rates in Latin America is indicated, as following:

---

[1] Its main features are:
- a clear hygienist inspiration (Art 2 and 25, eg);
- the only concept used to refer to mentally ill people is 'psychopath';
- it reinforces the notion of civil incapability (Art 26, 27, 28), dangerousness, and emphasis on exclusion and protection of the society (Art 9, 10), with few and easy requirements for admission (Art 11 to 14).
- very few articles on the inmates' positive rights and basic requirements for services, and even so, all traditionally not guaranteed in the country, such as:
  . distinction among open, closed and mixed types of in-patient care (Art 7);
  . statement of voluntary admission in open ward, with the right to free self discharge (Art 11, paragr 1, and art 19);
  . right to a new independent examination (Art 30);
  . right to no violation of personal mail (Art 31);
  . establishment of a inspection body to reinforce the law.

Table 4 - Community Studies of Mental Illness Prevalence in Latin America between 1958 and 1977 (percent. of popul.)

PLACE	DATE	PREVALENCE						
		Neuros	Psychos	Alcoho	M Retard	Epileps	Dementi	Total
Santiago, Chile (1)	1958	10.0	0.7	5.1	1.2	2.0	0.7	19.7
Cali, Colombia (2)	1966		0.4		0.7	0.5		
Santiago, Chile (3)	67/68	15.3	0.3	3.0	1.2	1.1	1.5	22.4
Lima, Peru (4)	1970	8.8	0.4	3.4	1.9	1.6	0.6	17.0
Salvador, Brazil (5)	1976	22.6	1.3	22.6				46.5
B. Aires, Argentina (6)	1977	12.0	0.8	2.0	0.4	0.4	0.8	15.7
Salvador, Brazil (7)	1977	14.5	0.7	3.5	1.0	0.1	0.4	20.2

Source: Santana, 1982.

(1). Horwitz et al, 1958; (period of prevalence of 5 years)

(2). Leon, 1966

(3). Moya et al, (?): all groups above 5 years old

(4). Mariategui et al, 1968

(5). Coutinho, 1976; (Maciel district)

(6). Tarnopolski et al, 1977; (Lanus district)

(7). Santana, 1982; (O' district)

Note: The 1990 investigation, of which only the city of Sao Paulo results are available, was not included given the different nosological classification. However, the general rate of illnesses is **18.1%**, being 1.1% for schizophrenia and other psychosis, 6.4% for alcohol abuse and 2.5% for mental handicaps (Mari and Andreoti, 1990).

Some of the main studies considered the relationship between the prevalence of specific morbidities and social, demographic and economic variables. Summing up briefly their main results, it is possible to say that:

- there is a significant higher general prevalence rate for women, particularly for neurosis, in higher age ranges then men, and mainly for widows and the separated. However, a much lower rate is indicated for alcohol dependence (Santana et al, op. cit.: 292; Mari, 1990).
- the lower the living standards (in terms of social class, income, formal educational background and occupation), the higher the general prevalence rates, although the trend is sometimes not clear in relation to neurosis and inverted to organic brain problems (Santana, 1982; Almeida Filho, 1981;

Dunningham, 1986). The study carried out in São Paulo showed that this association is significant particularly for women (Mari, 1990).

- there are signs of association between migration and higher general prevalence rates (Santana, 1982; Almeida Filho, 1981; 1987), but the trend is specifically significant for women (Mari, 1990).
- there are also signs of higher prevalence rates among people practising Afro-Brazilian rituals, Spiritualism and some other cults, suggesting a trend of employing them as a strategy to deal with mental distresses (Santana, 1982).

A more detailed description of most above cited trends will be provided when discussing the present research findings.

4. THE AREA UNDER INQUIRY AND PERIODIZATION

4.1. DESCRIPTION OF THE AREAS

The present inquiry aims at contributing to the understanding and evaluation of the process of implementation of out-patient mental health services in the metropolitan area of Belo Horizonte, Brazil. For comparative purposes, information on similar processes in the metropolitan areas of the cities of São Paulo and Rio de Janeiro will be included. The three cities constitute the largest urban centres in the country, and are located in its richest region, South-East.

São Paulo is the main financial, industrial and cultural centre of the country, with an estimated population of 15,221,267 in 1985 in its metropolitan area (Enc. Britannica, 1990: 576). It is also the richest city in terms of ethnic composition, still showing clear signs of the European and Asian immigrants' influence. Northerners ('nordestinos', from the poor North-East region of the country) had also settled there in massive numbers,

enlarging its wide poor peripheral areas. Rio de Janeiro can be better characterized by its political, bureaucratic and tourist features, as the capital of the country until 1961, having 10,190,388 inhabitants in the metropolitan area in 1985 (op cit).

In turn, Belo Horizonte is the recently established capital (less than one hundred years old) of Minas Gerais, a state which has been historically known by its traditional mining and farming economy and an active participation in the national political scenario. During the last 30 years, the Belo Horizonte metropolitan area has witnessed the settlement of a large industrial complex, bringing up the population to 3,056,498 in 1985 (op cit) and forming an extended periphery of working class districts.

The choice of Belo Horizonte as the main locus for the inquiry was determined by two main reasons. First, due to the easy access to information[1]. Secondly, the city witnessed in the late seventies the strongest local political mobilization of the country demanding reforms in the psychiatric system, a process that will be described in the next chapter.

One of the main characteristics of the recently implemented mental health services under investigation is their peripheral location and accessibility to the poorest groups of the population. For this purpose, three working class districts were chosen. The first two have already established local statutory health centres with a mental health team, where the survey of users was carried out[2]. The third district has been implementing a self-organized

---

[1] The author lives there and has been engaged in the mental health activities since 1973, having easy access to most of the sources under investigation here.

[2] Which results will be provided in chapters 4, 5, and 6.

community project with activities in the mental health field[1], as follows:

a) The **São Paulo district** (SPd): located in a key position in the North-East region of the city, the district had a relatively older settlement in relation to the two others, initiated in the late forties and fifties[2]. The local social and health centre[3] covers a large population, including neighbouring districts[4]. Three main reasons determined its choice as one of the case studies:

- the fact that the health centre is located inside a larger social centre providing a wide range of other social services;
- in the beginning of 1989, a larger mental health team was added to some already established professionals with the explicit purpose of setting up a 'day-hospital' (equivalent to a English day centre), and of giving priority to continuing care clients.
- the team has been composed almost absolutely of professionals with a psychoanalytic background, being

---

[1] Which features will be investigated in chapter 7, also including the evaluation of a similar process in the Lindea district.

[2] Generally, the Brazilian urban peripheral areas have a common pattern of reproduction: the new dwellers can afford to buy a plot where no urban infra-structure is provided. When a minimum population density is achieved, the public investment in services becomes viable economically and politically. Then, as the price of the land and taxes increase, the poorest dwellers are expelled to a new further peripheral area, joining the new migrant incomers.

[3] The SPd Social Centre was created in 1954 and induced the creation of several local district associations, present until today in several ways in the administration of the local social and health services.

[4] At the time, the delimitation of catchment areas and population for each health centre in Belo Horizonte was not clear.

representative of a major trend among mental health professionals in the Belo Horizonte area.

b) The **Lindea district** (Ld): being located in the far west side of the city, in the periphery of the Belo Horizonte traditional industrial area, had a newer settlement than the SPd, during the sixties onwards. The main reasons for this choice were:

- the district is famous for its strong tradition of self-organized community projects and campaigns for achieving infra-structure and basic social and health services;
- the local mental health service was primarily organized autonomously by the community in 1977, and started to be staffed by the state from 1985/6 onwards.

c) the **Cabana district** (Cd): established in a process of squatting on private land in the early sixties, this district also has a long tradition of self-organization. An autonomous mental health project was initiated there in 1986, constituting the main reason for its choice.

The older settlement and the weaker rural background in the SPd (in relation to the Ld) is probably the best explanation for some statistically significant socio-cultural differences between the two clienteles[1]. Such

---

[1] The following variables in the questionnaire demonstrated statistically significant differences:
- the number of users not born in Belo Horizonte and of those migrated from country areas are higher in the Ld (question 2a)
- the formal educational background (number of users having completed the primary education)(q 4) is higher in the SPd;
- the number of users aged 12 or above not receiving any income (q 5a) is higher in the Ld;
- the number of housewives as clients (q 5e) is higher in the Ld;
- the number of single parent mothers as clients (q 6b) is higher in the Ld;
- the number of children per family (q 6c) is higher in the Ld;
- the number of users with family income below the poverty line (3 minimum salaries)(q 8b) is higher in the Ld.

differences will be controlled and referred to in the analysis of the survey when relevant in the specific comparisons of results from both centres.

4.2. PERIODIZATION

The historical starting-point for the present research was established in 1978, for the following reasons:

a) At the national level, this year is known specifically in the country's history for the re-emergence and open action of mass movements in the struggle for democratization of the military regime and for better conditions of life. Among them, the labour opposition unions, district associations, the 'cost of living' movement, the health professionals' movement, and also mental health movements.

b) In Belo Horizonte, as indicated before, the stronger process of political mobilization in the country against the conditions of life and treatment inside the psychiatric asylums also started this year.

c) The emergence of the mental health movements in 1978 represented the main determinant of the subsequent changes in the mental health policies in the country, as developed in the next chapter.

Finally, 1989 was established as the end of the inquiry period for practical reasons, as the fieldwork was completed by December of that year.

5. THE METHODOLOGY ADOPTED IN THE PRESENT RESEARCH

Having provided the basic information needed to the understanding of the historical, social and psychiatric context of the present inquiry, it is possible now to explain and justify the methodology adopted here.

5.1. THE RESEARCH DESIGN

The present study adopted the research strategy known as the '**embedded and multiple case study design**', as proposed by Yin (1984: 44-54), understood as a case study involving more than one unit or level of analysis and more than a single case. In this inquiry, a single public programme is investigated by looking at three cases in each level: São Paulo, Belo Horizonte and Rio de Janeiro in the metropolitan, and the SPd, Ld and Cabana at the district levels, for the Belo Horizonte case.

However, it is important to note that **at the district level**, the cross-case similarities and the need to increase the statistical significance of the results in the survey led to a strategy of **pooling the data across pairs of cases[1], as if each pair constituted one case study[2]**. Theoretically, in an embedded and multiple case study design, the results are analyzed primarily for each single case and only in a second stage compared with the others. This is not the case here, at least at the district level. However, the inquiry still maintains the original concept of the research design, when considering each pair of cases as one original case.

Taking into account the criticisms of the case study design, a careful consideration of the issue of validity was undertaken. In relation to the construct validity[3], two strategies were adopted:

a) the use of multiple sources of evidence, including quantitative and qualitative (Bulmer, 1982: 186), such as:

- a systematic survey of 194 clients of the Spd and Ld

---

[1] In the survey (chapters 4, 5 and 6), the findings on the SPd and Ld are pooled together; in chapter 7, the etnographic data on the Ld and Cd are also analysed together.

[2] This procedure is possible when each case's singularities are controlled, as specified before.

[3] In other terms, the establishment of correct operational measures for the concepts being studied.

mental health services, which will be described below;
- collection of written primary sources in the archives of the federal, state and municipality administrations of the mental health programme. All archive sources will be indicated here between square brackets followed by A: - [A: Archive noun, date, name of the author (when available) and of the document] - and will be listed in a section of the bibliographic sources;
- collection of articles related to the field in the main Belo Horizonte newspaper during the period, and of isolated relevant articles in other national newspapers and magazines. Press sources are referred between squares brackets followed by N: - [N: Name of the newspaper or magazine, date] - and will also be listed in a special section of the bibliography.
- collection of secondary bibliographic sources[1];
- ethnographic methods such as direct observation in the three district services, staff meetings at metropolitan levels, and informal and semi-structured interviews with community leaders, professionals and programme administrators[2] [3]. All interview sources will also be indicated between square brackets followed by I: - [I: Name of the interviewed person, date] - and a list with basic information on them will be available in Appendix 1.
b) the establishment of a chain of evidence by comparing and checking data from the micro to the macro level, from the different types of sources, and through the cross-case comparison analysis (Yin, 1984: 32).

The internal validity issue was taken into account mainly in the survey at the district level, by choosing a

---

[1] Nearly three hundred kilos of primary and secondary bibliographic material were collected and sent to England.

[2] For example, more than fifty hours of taped interviews were collected and transcribed.

3 Research assistants were used only to undertake interviewing for the survey and to collect archival and newspaper material. All other research activities were performed by the author himself.

rigorous sampling strategy (which included 58.3% of all the universe cases), by selecting specific statistical tests for the results, and comparing them with the data gathered through other sources. The conditions for generalizing the results (or the external validity issue) are viewed from a double perspective:

- first, case studies generally rely much more on **analytical** than on **statistical generalization** (Yin, 1984: 39), by building up explanatory and theoretical constructs which also identify the conditions by which the results can be generalized;
- second, when moving from the district to the metropolitan levels, the reader will be given a clear idea of the available amount and type of evidence produced from other sources at this level, showing the possibilities of generalizing the results from the district level.

However, it is important to note that, despite gathering all the data available, a series of constraints inherent to the field situation limited the amount of evidence to be provided here:

- the out-patient mental health programme in Brazil is a very recent phenomenon, and practically no systematic empirical research has been done in the field yet.
- in the country's statutory services, there is a rooted tradition of informality and lack of systematic assessment and accountability procedures, and the situation has deteriorated in the last few years due to the economic and political crisis.
- particularly in the district services under inquiry, no systematic individual or family records have been kept and no formal diagnosis has been completed. All the specific information on clients was provided directly by them or their companions during the survey interviews.

Such constraints have curtailed at times the ability to generate more conclusive statements from the findings,

suggesting a more exploratory character for some of them and indicating the need for further research.

5.2. METHODOLOGICAL STRATEGIES ADOPTED

5.2.1. Historical Methods

Chapter three will provide an historical account of the events during the period under inquiry. Here, historical methods refer specifically to:

- the use of traditional historical sources and types of evidence, such as from archive documents, newspaper coverage and interviews with key actors;
- the adoption of the 'narrative' as the methodological form.

The narrative has constituted an important and sometimes even indispensable method and/or style in historiography[1]. There, in chapter 3, the narrative will be structured in a periodization form, as described as the second type by Gehard[2]. Despite some controversy surrounding its use, it is considered necessary and unavoidable (Ritter, 1986: 315-17; Barzun and Graff, 1970: 177; Mandelbaum, 1967: 280).

5.2.2. Ethnographic Methods

---

[1] Ritter, 1986: 280; Toynbee, 1975: 299-300; Hexter, 1961: 21. In the British and North American tradition: Gallie, 1964; Danto, 1965; Whyte, 1965; Dray, 1969; Mandelbaum, 1967; Gruner, 1969; Ely, 1969.

[2] Gehard (1973: 476) identifies three general types of periodization: a) simple chronology; b) stage theories of social process, which draws phases of development as progress or decline; c) schemes that summarize the essence of an age.

The reference to this approach here means[1]:

- the use of traditional ethnographic sources (such as direct observation, and informal and semi-structured interviews with key actors) and respective types of evidence (accounts of events, quotations from informants) (Fetterman, 1989; Agar, 1980; Ellen, 1984).
- the use of the ethnographic report and anthropological analysis of the findings, with special emphasis on the dialogue with the relevant Brazilian literature on the subject.

This will be accomplished more specifically in chapters 6 and 7, although the use of such type of evidence will also be spread among other chapters.

5.2.2. The Survey

Most of the quantitative evidence provided here will come from a survey accomplished with users of mental health services at the Sao Paulo and Lindea districts. The main methodological guidelines were taken from Hoinville and Jowell, 1983; Vaus, 1986; Moser and Kalton, 1971; and Fink and Kosecoff, 1985.

The questionnaire[2] was formatted according to the model proposed by Hoinville and Jowell, in two versions

---

[1] Negatively, the present inquiry does not fit a more strict characterization of the ethnographic methods, as proposed by Agar (1980: 69-74) to differentiate it from hypothesis-testing ones:
- direct personal involvement with informants (research assistants were used here);
- the 'one-down' position, referring to the metaphorical 'child' or 'student' position the researcher initially assumes;
- a long-term and diffuse relationship with informants, in a variety of the latter's living contexts;
- intimacy and intensity of involvement with the community.

[2] It is available in the Appendix 2.

(client and companion), for basically two reasons:

- in some cases, the client is not able to answer him/herself the questionnaire;
- it was attempted to interview as many companions as possible, in order to assess informal carers' view on their relationship with the client and on the services provided.

Given the sensitivity of the subject, several parts of the questionnaire included open-ended questions[1]. Despite the difficulties in the coding and analysis processes, they were considered essential in order to pick up symbolic and semantic aspects of the users' discourse. In key issues where these aspects matter, examples will be listed.

The sampling strategy adopted as a first principle the policy to include cases as many as possible, because 'multi-purpose' surveys (Moser and Kalton, 1971: 149) need to increase the general statistical significance for all sub-samples, as results can not be predicted. Therefore, the strategy adopted depended primarily on the time available to do the interviews:

- for psychologists and social workers doing formal consultations, generally once a week for each client and with an average duration of 30 minutes, the strategy adopted was to interview all the clients. As a result, the sample size tends to correspond to the universe population.
- for psychiatrists providing medication control generally once a month and in shorter consultations, the strategy was the systematic sampling and interviewing of every second

---

[1] It is important to remember that they normally produce more than one answer per question, constituting multi-choice items. Therefore, the results can not be summed or regrouped straight-forwardly, making their interpretation more complex. There will be an indication every time such rates are shown.

client[1]. As a result, it should provide a sample size tending to 50% of the universe population.

Given the periodicity of the meetings between professionals and clients, a sampling period of 4 weeks for each professional was adopted. These strategies proved to be realistic in the pilot test accomplished previously in a third health centre, interviewing about 20 users. The test also allowed the adaptation of all questions and pre-coded answers. There were no major problems during the interviewing process, apart from disruptions such as days off and strikes (see chapter 4). Table 5 summarizes the universe and sample sizes, as well as the proportion of companion's questionnaire version achieved:

Table 5: Universe Population, Sample Sizes and Questionnaire Version Rate

	N	n	Compan' version rate
SPd	176	102	31.4%
Ld	157	92	29.3%
Total	333	194	30.4%

The frame for coding the open-ended answers emerged from the different patterns raised by the users themselves and the concern posed by the hypothesis. For each question, a sample of 30 or 40 questionnaires from different professionals were scrutinized, the similar patterns of answers grouped, indicating the definitive code.

The data was entered into a computerized spreadsheet through the Lotus 123R3 software, and then translated into SPSS/PC+ software for statistical analysis. During this step, cross-checking procedures were performed to avoid

---

[1] The starting point was alternated each day (the first and the second user alternatively), in order to avoid any bias associated with the order in which users arrive for consultation.

coding and typing mistakes. The following statistics tests were used in the analysis[1]:

a) **'t' test**, for checking the statistical significance between two individuals cells' scores in contingency tables. In these cases, the 5% standard normal deviation means z = + or -1.96, and values above or below this range are considered as significant.

b) **chi-square:** as most of the variables are nominal, this was the most common test to measure the association between two variables. Here, levels of significance lower than 0.05 will be considered an indication of association. Despite still being under discussion (Everitt, 1977: 40), an attempt to reduce the number of cells with small expected frequencies (not greater than five) to less than 30% was undertaken, through eliminating or regrouping secondary categories. When the ratio is over this level, it will be indicated. In some very small sub-samples (chapter 5, section 3.2.2), the number of cases was too low, making impossible the provision of the test.

c) **analysis of adjusted residuals:** this was used to identify the categories responsible for a significant chi-square. Values below and above - or + 1.96 will indicate statistical significance. They were checked for all the tables submitted to the chi-square test, but for economic reasons and because the graphics provide themselves a better view of the relevant figures which constitute the association, most times they are not shown. In a few cases, the chi-square is not quite significant for the whole table, but the difference between the observed and the expected values for a specific category within the table may suggest a non random allocation of cases. This may indicate the existence

---

[1] All of them are provided by the SPSS/PC+ software, except the 't' test, which was performed by entering its equations into MINITAB software.

of a certain relationship between two variables for that specific category.

d) **K-sample median test:** a non-parametric test for ordinal variables, providing a chi-square significance level.

e) **Kruskal-Wallis one-way analysis of variance:** also a non-parametric test for ordinal variables, providing a chi-square significance level.

. . .

After this view on the context and methodology, the next chapter will start the description of the findings, by outlining an historical account of the main events concerning the implementation of the programme under inquiry.

Chapter 3

THE PSYCHIATRIC REFORM AND THE POPULAR DEMOCRATIC STRUGGLE

1. INTRODUCTION

This chapter focuses on the psychiatric reform process between 1978 and 1989 in the Belo Horizonte metropolitan area, but also addresses in a comparative way the Rio de Janeiro and Sao Paulo cases. The following hypothesis will be discussed:

Hypothesis I

There is a strong historical direct correlation between the rhythm of implementation and qualitative features of the psychiatric reform[1], and the advances, setbacks and features of the popular democratic struggle[2].

Therefore, the chapter will constitute a longitudinal description, in a structured narrative style, of the changes in the two aspects or variables and their relationship during defined historical periods, each one corresponding to a more or less homogeneous pattern of changes.

2. THE BELO HORIZONTE CASE

---

[1] For psychiatric reform, one must understand here changes in the statutory psychiatric system, including hospital and out-patient care, and the administrative and training bodies directly linked to service provision. The hospital sector contracted out by the INAMPS will not be under investigation.

[2] The popular democratic struggle refers to the political action of an ensemble of social movements which emerged in the country in 1978 onwards, claiming for the democratization of the regime and better conditions of life, including the health and mental health movements.

2.1. THE BASELINE: THE STRUCTURE OF THE PSYCHIATRIC SYSTEM IN THE MID SEVENTIES

The general features of the psychiatric system in Belo Horizonte in the mid-seventies were basically similar to those described for the whole country (see section 3.3, chapter 2). Tables 6 and 7 summarize the information on the

existing service units at the time.

TABLE 6 - Statutory Psychiatric Hospitals (FHEMIG)(1) - Belo Horizonte, Late Seventies

Hospital	Barbacena (2)	Raul Soares	Galba Veloso (3)	N P Infantil
Found Date	1903	1922	1962	1946
Beds	1305	359	340	100
Clientele (4)	cov/non cov adult chronic	cov/non cov adult acute	cov adult acute	cov/non cov child acute

Source: Moreira, 1981: 4.

Table 7 - Statutory Psychiatric Out-Patient Services (5) - Belo Horizonte, Late Seventies

	Funding Agency	Clientele (4)
PAM - Carlos Prates (6)	INAMPS	adult/child cov
Raul Soares Hospital's clinic	FHEMIG	adult cov/non cov
Hosp. de Neuro-Psiquiatria Infantil	FHEMIG	child cov/non cov

Sources: Moreira, 1981; [A: DMS (1983) Plano de Assistencia].

Notes: (1) Besides the state owned hospitals administered by the Minas Gerais Hospital Foundation (FHEMIG), Belo Horizonte had at the time 8 private hospitals with a total of 1670 beds formally contracted out by INAMPS, although the average number of beds in use had been almost double (Moreira, 1981: 31). However, they will not be under investigation here.
(2): The Centro Hospitalar Psiquiatrico de Barbacena is located 180 km far from Belo Horizonte, but it will be included here given its political importance as the main target of the mental health movement.
(3) From 1974 onwards, all clients to be admitted in hospitals contracted out by the INAMPS should have passed first by the Galba Veloso Hospital, as an emergency service and referral centre. However, the private hospitals not only provoked unnecessary admissions directly from their own clinics, but also through setting hidden links with the regional INAMPS office and the Galba Veloso administration and psychiatrists (Moreira, 1981; 38,42)[I: Renno, 1987; Simone, 1987].
(4) The feature cov and non-cov refers to the admission of clients covered or non-covered by the INAMPS. In 1977, 47.62% of the country's population was not covered [A: DINSAM (1977) PISAM: 7]. However, the state of Minas Gerais presented one of the lowest provision of psychiatric out-patient care in the country for the covered population (18.81/1000 beneficiaries, while the national average was 43.68/1000) (data for 1979) [A: DMS (1983) Plano de Assistencia: 4-7]). The non-covered adult had no alternative for out-patient care out of the then badly equipped Raul Soares Hospital's clinic.
(5) For child care, some charities (mainly the APAEs) and few private clinics contracted out by the INAMPS have also provided some psycho-pedagogic care, but will not be under inquiry.
(6) The PAM - Carlos Prates had had 26 psychiatrists offering consultations in 1971, and just 17 in 1978. It was established in a wooden building, without any conditions for the attendance, and the quality of services was evaluated by INAMPS itself as

> "individual and only 'curative', considering the mass of consultations of each doctor, who tries, in the majority of the cases, to get rid of the patients, who bring in an overburden of high anxiety, given the amount of social problems the client expresses through the mental distress" [A: DMS (1983) Plano de Assistencia: 5].

2.2. THE FIRST PERIOD: 1978-1982: THE PUBLIC MOBILIZATION AGAINST THE OPPRESSIVE CONDITIONS AT THE PSYCHIATRIC HOSPITALS

2.2.1. The Main Events of the Period

2.2.1.1. The Process of Mobilization Against the Situation in the Hospitals

a) Antecedents:

The present mental health movement in Belo Horizonte has its roots in the mid 60s, when some of the contemporary leaders started at the Galba Veloso Hospital what was called the first 'Residencia' in psychiatry in the state (1968). This was a psychiatric specialization course placed directly in a hospital, linking academic and service provision activities [I: Barreto, 1989]. Later on, it was transferred to the Raul Soares Hospital. Among the leading names of the group, were Francisco Barreto, Virgilio Renno, Cesar Campos, Antonio Simone and A. Benetti. Theoretically, besides a 'solid formation in the classic authors and psycho-pharmacotherapy' (op cit), they were influenced by:

- the community therapeutic movement, participating in two actual experiences, at the Galba Veloso and Andre Luis Hospitals);
- the French experience of sectorization and social psychiatry, as in 1968 they participated in a new administration of all statutory psychiatry services in the state;
- the anti-psychiatry movement, particularly in the early 70's.
- Marxism[1], mainly during the 70's;
- psychoanalysis, which has been the main specific approach

---

[1] The sources did not specify what kind of Marxism approach.

related to psychic issues until the present time.
- the Italian experience, with the visits of Franco Basaglia in 1978 and 1979, which will be described below (op cit; I: Campos, 1989].
The group also had had contacts with experiences and other reformist groups within the country. The common practice had been the exchange of experience and discussions in official or academic congresses, through specific conferences and seminars or parallel activities, or even informal visits.

The emergence of broad social movements in 1978 induced the re-articulation of local health and mental health leaders at the national level. The Medical Renovation Movement (Movimento de Renovação Medica - REME) was the first of such organizations in the health sector, with nuclei in several states[1]. In the mental health field, the first meeting was held in October 1978, at the annual Brazilian Psychiatry Congress (Camboriú, state of Santa Catarina)[2], the main national academic event in the field. This first contact led to the organization of the First National Meeting of the Mental Health Workers in January 1979, Sao Paulo, with representatives of several states. In the same period, a Mental Health Working Group was formed in the Brazilian Centre for Health Studies (CEBES) in Rio. This

---

[1] In Minas Gerais, it was called Medical Studies Group (GEM) and was already perfectly organized in 1978 (Campos, 1988: 102).

[2] In this congress, a manifesto was launched, denouncing:
- the repressive and 'chronifying' character of the mental health system, particularly the privatization and commercialization of the psychiatric care contracted out by INAMPS and the negligence in relation to the public hospitals [I: Delgado, 1989].
- the precarious wages and working conditions of the mental health workers and the need for their organization, towards the participation in the policy making process in the field (Hegelberg and Lancman, 1987).

was considered the main 'intelligentsia group' of the health movement in the country. Therefore, in 1979, the national mental health movement was already established, through regional leadership/organizations and national meetings, despite the absence of a central body.

In Belo Horizonte, there were two main formal organizations in the beginning of 1978 which later on would have an important role in the mental health movement:

- the AMP (Minas Psychiatry Association), an organization of the psychiatric corporation including professionals of the state;
- the AMSM (Minas Association of Mental Health), multi-professional, founded in 1977, but hitherto without any important initiative and supported by a broad political spectrum[1].

b) The Impact of Basaglia's Visit and the Mobilization Process:

In the first week of July, 1979, Basaglia participated in a seminar on Institutional and Social Psychiatry organized by the group in charge of the Raul Soares Residence in Psychiatry, the president of which was Antonio Simone. In addition to the conferences, he visited the three statutory hospitals for adults in the region. After being granted permission by Simone, he made a series of

---

[1] For example, its first board of directors had as vice-president the owner of one of the biggest private hospitals in the city (Pinel) and also the then president of the FHMG (Minas Gerais Hospital Federation, the private hospital lobby's main organization)[I: Simone, 1987].

denouncements in the main newspapers of the country[1].

Basaglia provoked an actual mobilization of the public opinion in Minas Gerais towards psychiatric issues. A large group of professionals started to meet every week, and reorganized the AMSM under a new leadership, presided by Simone. They initiated the arrangements for a bigger congress in November, with the commitment by Basaglia to come back. In August, a prominent psychiatrist, Halley Bessa, challenged in the press the medical establishment to change the psychiatric system, re-stating similar denouncements, producing impressive repercussions [N: EM, 14-15/8/1979]. As he and another leader of the mental health movement, Francisco Barreto, received two months later a warning from the Regional Medical Association regarding the Ethics code, a wave of protest was raised and the warning suspended [N: EM, 18-19/10/1979].

In September, the journalist Hiram Firmino launched a series of reports in the main local newspaper ('O Estado de Minas') called 'At the Cellars of Madness', which later on won the important Exxon Prize of Journalism of the Year. He interviewed and photographed residents in the three hospitals, telling their lives and hopes, in a very sensitive and humanistic style, mobilizing the public opinion against the asylums. Actually, the 'O Estado de Minas' and some of their journalists had a very important role during this period. Between August and November, it presented almost daily news on the subject, participating

---

[1] The main topics were:
- the situation inside the state hospitals, mainly in Barbacena, which he compared to a concentration camp;
- the commercialization of madness, referring to the private hospitals network;
- the importance of the political struggle for the rights of the mentally ill people as one important element of the democratic struggle in the country, referring also to the changes in Italy (N: EM, July, 1979].

actively by covering or even 'producing' new events in the field. It also included denouncements in relation to the private hospitals, polemical treatments and restraint methods (mainly ECT and shackles).

Also in September, the INPS local administration reported the formation of three working groups to propose changes in the psychiatric system towards an emphasis on out-patient services [N: EM, 22/9/79]. At the same time, the state government announced the opening of all statutory hospitals to the media and, later on, a plan to reform their services, that could also include their [N: EM, 6/10 and 10/11/79]. The campaign was also assumed by the Brazilian Lawyers Association (OAB) at regional and national levels. Charities started to raise funds and other forms of support for those living in the hospitals [N: EM, 21/10/79]. Expectations were concentrated on the III Minas Congress of Psychiatry, to be held in the second week of November.

The Congress is referred to as the main stand-mark of the mental health movement in Belo Horizonte. As main visitors, it had Basaglia and Robert Castel, and it gathered most of the main specialists and leaders in the field at regional and national levels. There were also a large public - more than 600 people, mainly professionals[1] - , analyzing and discussing the situation in the psychiatric system, with a sound coverage by the press. It included a new photographic exhibition of scenes inside the hospitals, which were hitherto closed to the public, and the release of a film called 'In the Name of the Reason', a bombastic documentary on the Barbacena Hospital directed by Helvecio Ratton.

The main proposals from the congress can be summarized

---

[1] The available sources do not allow a conclusive evaluation of the actual representativeness of the participants.

as:

- total rejection of the existing statutory and private psychiatric services and legislation centred on hospital care;
- total rejection of the present psychiatrization of social problems and privatization and commercialization of the medicine in the country, calling for a Parliamentary Inquiry into the issue;
- creation of therapeutic alternatives, through the mobilization of unions and all representative organizations of the population;
- the empowerment of the national mental health workers movement, as the main partner of the government for working out new service plans;
- permanent humanization of the psychiatry, through the closure of the existing asylums (in the region, the Barbacena hospital), as formalized by Ronaldo Coelho (1979), **humanization** of the others and **emphasis on out-patient care**[1];
- for better working conditions and wages for the mental health workers, as well as the formation of multi-disciplinary teams [N: EM, 22/11/79].

c) The Response to the Mobilization:

The municipality and state authorities in the field avoided formal participation in the Congress [N: EM, 22/11/79]. In addition, the state government dismissed one of the movement leaders, Ronaldo Coelho, who had demanded the closure of the Barbacena hospital during the discussions [N: EM, 8/4/1980].

Interestingly, the strategy included the announcement

---

[1] The available data does not provide any specification of what was meant by these terms, and suggests that the movement itself had no clear idea of the particular changes to be made in this regard.

of 'radical' measures previous to the congress itself. A plan to close the hospitals and replace them for out-patient services was announced one month before. Nevertheless, the official initiatives were all centred on '**humanizing**' the hospitals, mainly through reforms in the physical structure and some improvement in the care provided. This is exactly what happened in the Barbacena Hospital, where the following measures were announced:

- the creation of a new experimental module within the old premises;
- a light de-hospitalization policy, placing residents with existing social contacts within their families;
- its transformation into a short and medium stay hospital, although keeping some of the old wards;
- and the transference of all the children to the Hospital de Neuro Psiquiatria Infantil in Belo Horizonte [N: EM, 22/4/1980].

A first plan to change the Galba Veloso Hospital, where at the time there was no active nucleus of the mental health movement, was proposed by INAMPS, but was openly influenced by the private hospitals' interests. It would decentralize the admissions, allowing the hospitals to admit directly through their own clinics, leading to the increase in the number of unnecessary admissions, as denounced by the AMSM [N: EM, 12/7/80]. In other words, the critique of the statutory sector made by the mental health movement was reappropriated by the private sector as a means to reinforce further their role in the system.

Still in 1980, a new director was called in by the FHEMIG in order to face the crisis and, although not directly linked to the movement, several changes were accomplished. The use of the hospital's emergency service as an entry door for the private hospitals had been denounced before. In 1981, the control of this service passed from the INAMPS to the hospital's own administration, with strict

guidelines to curb admissions [A: DMS: Gomes (1983) Minha]. In addition, a new acute ward was created.

In the Raul Soares Hospital, given the presence of an active group of militants, the process of change was more complex, based on the mobilization of and open discussion among the professionals and staff. In July 1979, before the congress, they had already organized an internal seminar suggesting changes. In 1980, another seminar was accomplished [N: EM, 17/4/80], and a plan was formalized by the state administration proposing:

- emphasis on the out-patient service and regionalization, connecting it to the already existing health centres with mental health teams in Belo Horizonte;
- formation of multi-disciplinary teams in each ward, which would be also regionalized and connected to specific out-patient services;
- special attention on the control and referral system for the discharged users [A: FHEMIG (1980) Proposta].

The administration plan left aside proposals for the implementation of an occupational therapy programme made by the staff. It also continued to ignore the claims for funding and integration of a very interesting project organized on a voluntary basis by students, called 'Projeto Guimarães Rosa'[1] [N: EM, 20/5/1983].

The mental health movement, mainly represented by the AMSM, supported explicitly the strategy adopted in the hospitals [N: EM, 22/4/80], sometimes participating directly in it, as in case of the Raul Soares Hospital. In addition,

---

[1] This project was inspired by the realization that the majority of the users had a countryside background. Therefore, a farm environment was settled in the hospital large yard, allowing them to work, cook and organize cultural activities by their own. It had very impressive results (Laia, 1984)[A: EM, 19/5/81], mainly compared to the situation inside the hospital, where patients used to lay in the cemented old ward yards, doing nothing all day long.

the movement also carried out additional actions until the end of the period[1].

2.2.1.2. The Integrated Mental Health Plan (PISAM):

In 1977, the Minister of Health, through its National Division for Mental Health (DINSAM), launched a special programme called PISAM - Programa Integrado de Saúde Mental, proposing and funding the majority of the states Secretaries for Health to implement initiatives in mental health care[2].

This programme was clearly a continuation of similar pilot initiatives in the general health field by the Ministry of Health[3]. In my view, they are all part of

---

[1] The main ones were:
- the denouncement of the dismissal of Mr. Ronaldo Coelho;
- the opposition to the INAMPS proposals for the Galba Veloso hospital;
- the denouncement of the living and treatment conditions in some of the private hospitals contracted out by INAMPS, like the Serra Verde clinic in January 1981 [N: EM,8-11/1/81].
- the promotion of a short course on alternative mental health care [N: EM, 23/5/1982].
- the successful campaign against the government plans to settle administrative buildings in the Raul Soares green yard [N: EM, 4/6/82].

[2] The main characteristics should then be:
a) integration to the primary health services network;
b) emphasis on out-patient 'secondary prevention' ("treatment and limitation of incapacitation");
c) participation of the family and the community;
d) priority to more serious psychiatric cases: psychosis, alcoholic addiction, epilepsy, serious neurosis and mental illnesses associated with Down's syndrome);
e) target population: those non-covered by the INAMPS;
f) services provided by non-specialists (mainly GPs), while specialists should provide supervision, training, assessment and only attendance of more complex cases;
g) emphasis on group techniques, in order to increase the attendance capacity [A: DINSAM (1977) PISAM: 2-12].

[3] Such as the PIASS, extending primary health care in priority poor areas in the country.

General Geisel[1]'s wave of social programmes included in the so called 'distension' political strategy launched in 1974. In the health field, it represented some openness to modern ideas such as those proposed by World Health Organization and to some initiatives of progressive specialists within the Ministry of Health staff (Vasconcelos, 1985). Therefore, the PISAM was not preceded by any specific mobilization by any civil society social forces. This context may explain some of its 'top-bottom' features, as a programme pushed down into each state administration (op cit: 230). However, in the majority of the states, it induced the establishment of the first pilot practices of out-patient services integrated to the primary health care network being created at that moment, mainly in the North and North-East areas of the country (Maris, 1982).

A similar move was accomplished in Minas Gerais, though on a different scale, where the programme had been formally active from February 1978 (when the specialist team was completed) to June 1979[2]. An evaluation of it made by Acúrcio and Akerman - two key staff members working at the metropolitan administration of the health and mental health programme (DMS) at the time - points out very few

---

[1] Non-elected military president of the country between 1974 and 1978.

[2] It performed concretely:
a) formation of a specialist team with 3 psychiatrists (with a week journey of 20 hours each) and 2 psychologists (40 hours each), with functions of supervision, training and direct provision of specialized services;
b) training 15 general practitioners and attaching 2 psychologists to 15 primary health care units, and the establishment of 4 units with specialists, to attend the more complex cases referred by the first level [A: DMS (1981) Acúrcio & Akerman: 1-4].

significant results[3] in Belo Horizonte, even considering its features as a pilot programme.

In 1979, the DINSAM stopped funding the PISAM in Minas Gerais, and any mental health activities within the primary health care network were transferred to the state administration. One of the specialists who worked at that time described the period following the PISAM as a "stagnation", given the lack of resources for further training and contracting new professionals [I: Souza, MDC, 1989]. Therefore, despite the few achievements, the programme at least performed a role of inducing pilot practices that were in a certain way assumed later by the local governments.

2.2.2. A Balance of the Period

---

[3] Their main topics are:
a) although the 4 quick training courses had fulfilled the requirements, the supervision met several constraints and did not work out properly, jeopardizing the results in terms of the care provided;
b) the structure of the primary care health clinics, with constant lack of medicines; an overburden in terms of large number of users and other programmes' duties, mainly on the practitioners; and lack of information to the clientele, which was used to the strategy of getting 'better results' at the hospitals; all this provoked serious setbacks, resulting in just "few isolated results" [op cit: 5];
c) the service provision statistics produced at the time are not reliable, not allowing any empirical inquiry;
d) there are indications of higher rates of psychoactive drug prescription by practitioners [A: DMS (1981) Acurcio & Akerman: 1-4].
In relation to the last item, a systematic study by Cardoso (1986) done in Itamarandiba, a small town in the Vale do Jequitinhonha, North-East of the state, supports the statement. It shows that under the influence of the PISAM, despite the irregular provision of drugs by the government, the amount of consumption of these drugs increased sharply, mainly in a context where practitioners do not have proper training to deal with mental distresses. She suggested, for example, that on average 50% of all consultations by the practitioners in the town were followed by psychoactive drug prescriptions (op cit: 72).

2.2.2.1. **Changes in Service Provision:**

a) The hospital sector:

Probably the main achievement during this period was the reform of the Barbacena Hospital. Being hitherto a traditional asylum[1], it was transformed from a chronic long stay into a prior short/medium hospital. The population decreased from 1360 in 1978/79 to 1060 in 1980 [N: EM, 22/4/1980], and to 800 in 1981, 30% of them being old asylum cases. The mortality rate dropped to practically zero [N: EM, 30/5/81]. The hospital was regionalized, as a reference for out and in-patient care for surrounding municipalities, and no transferences from others hospitals were allowed. A new module was settled providing a better environment.

However, it is important to highlight some of the limitations. The majority of the old wards still existed in the same situation as before, and a shortage of staff and professionals was denounced [A: DMS, op cit: 9].

In relation to the Belo Horizonte hospitals, the Raul Soares hospital will be considered first. Figure 1 indicates the evolution of the number of first admissions and readmissions and Figure 2 the number of out-patient consultations. Before the first effects of the reform in the 1981, the hospital had been submitted to a long process of under-funding, and all indicators show a sharp decline in all activities. It had basically the features of a traditional hospital: higher number of readmissions than first admissions and a relatively low number of consultations. With the reforms starting in 1981, the

---

[1] The institution has, from its inauguration in 1903 to 1979, induced the death of 60.000 residents. In 1969, 725 out of 2.734 residents died [A: DMS, 1983: Plano de Assistencia: 8]. In 1971, 17 schools of medicine had their practice anatomic courses done on corpses provided by the hospital. The contract still existed in 1977, at least for two schools, in Barbacena and Belo Horizonte (Moreira, 1980: 13).

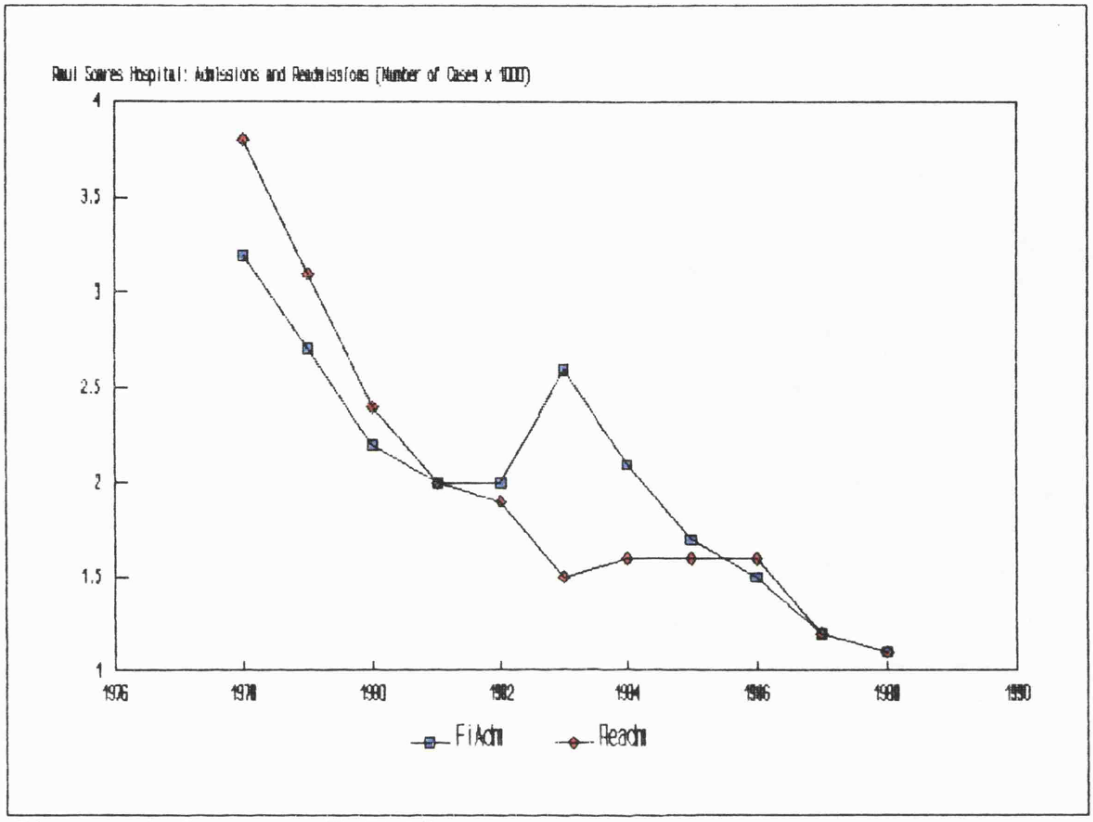


Figure 1 Source: FHEMIG

official number of beds was reduced from 359 to 300, and the emphasis on the out-patient services produced a sharp increase in the number of consultations, and an inversion in the admission sector is shown, as readmissions tend to decrease and first admissions assume the top position. It means clearly that the out-patient service tended to function more properly as an entry door for acute cases and as an obstacle to unnecessary readmissions of the chronic cases, which could be treated satisfactorily in the former. Similar conclusions were reported by Rati (1986: 43).

At the Galba Veloso hospital, the analysis is much more complex, given its different sectors and functions. Until 1981, the hospital also accounted for a declining output, as shown by all indicators in Figure 3. Changes demanded by the mental health movement started to be accomplished by the new

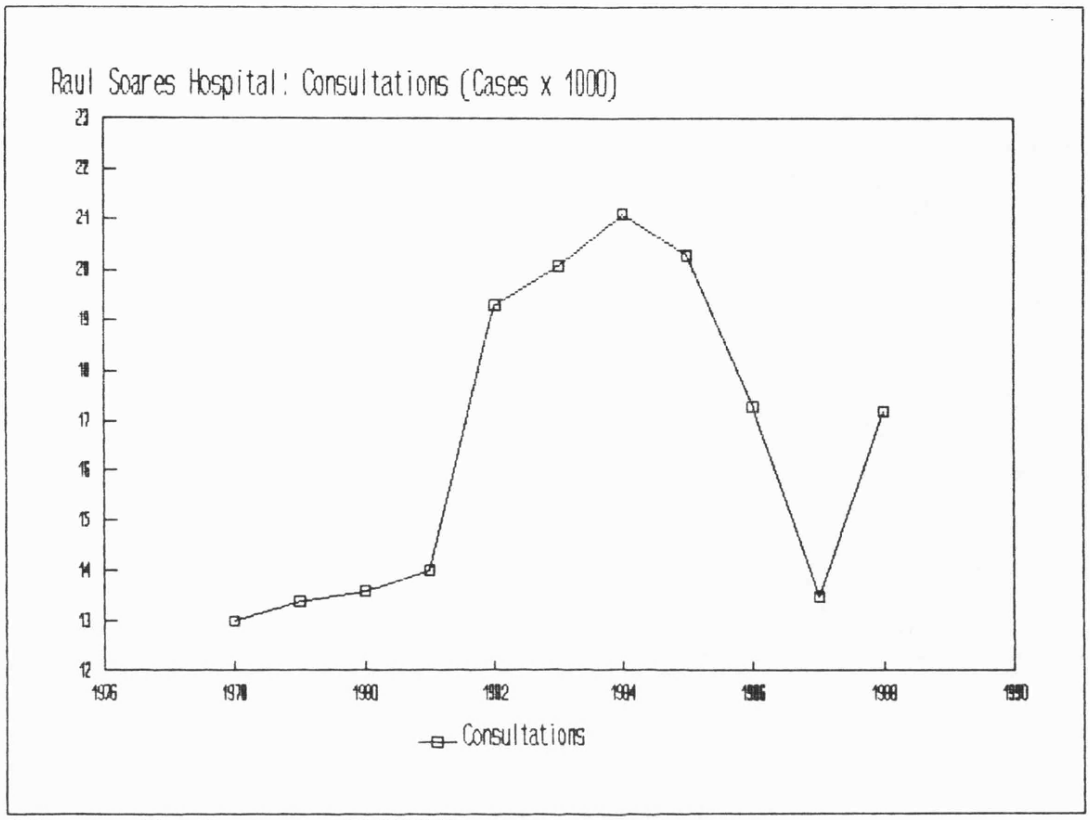


Figure 2 Source: FHEMIG

director in 1980/81, especially in the emergency service, leading to a sharp increase in the number of consultations. Consultations there, at the time, mean not exactly an out-patient service, but attendance in an emergency unit without an immediate admission or referral. This explains the associated further reduction in the number of admissions, readmissions and referrals to the contracted out hospitals.

Therefore, in the case of the statutory hospitals, there seems to be a clear association between the accomplished changes and the mobilization induced by the mental health movement in this period. This can be seen not only in the historical description of the events, but also empirically in the concrete out-put of the services. Furthermore, and after all, the mental health movement

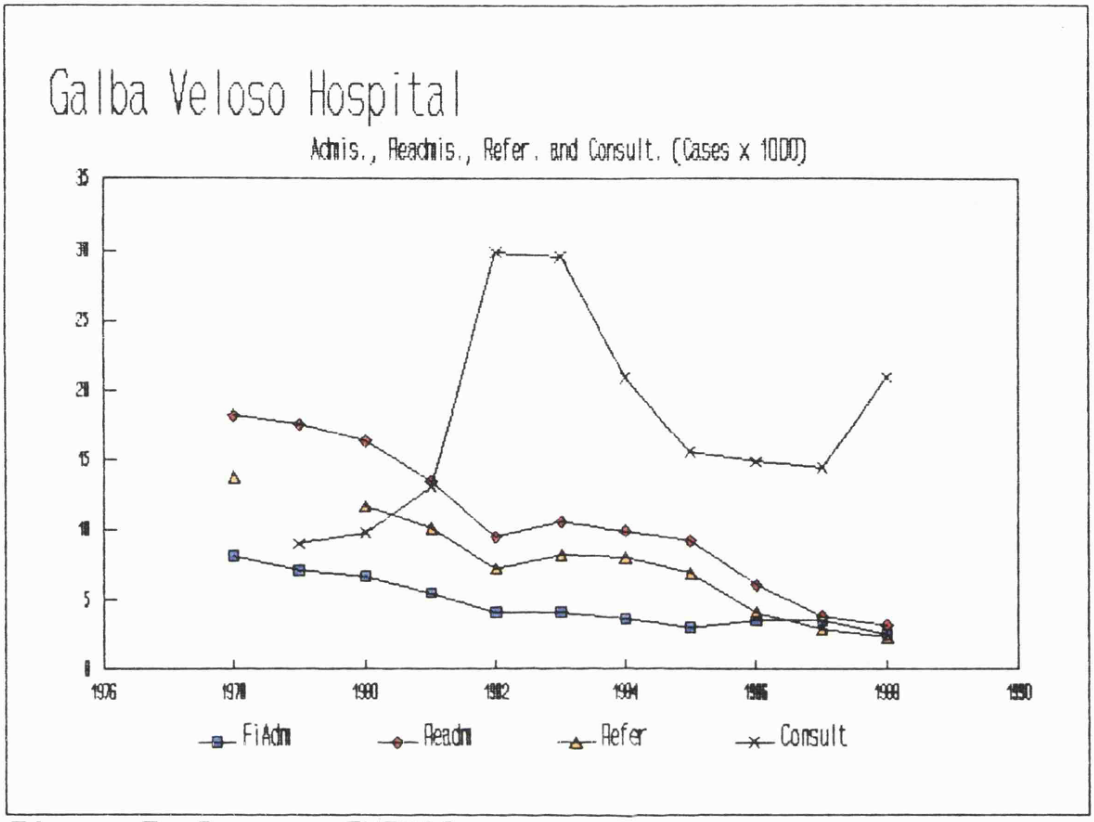


Figure 3 Source: FHEMIG

itself is also part of the process of emergence of the broader popular democratic forces in the country from 1978.

b) Out-patient Sector:

As pointed out before, some of the activities initiated by the PISAM programme were assumed by the state administration in 1979, mainly by keeping the already employed personnel, but there was no further investment during the period. The Table 8 summarizes the available data on out-patient services in 1982, showing the low performance during the period.

Table 8: Out-Patient Services Implemented In Minas Gerais and Belo Horizonte- 1978/1982	
Number of trained GPs in all the state	417
Number of health centres in Belo Horizonte with trained GPs	18
Number of mental health professionals performing clinical work in Belo Horizonte	14 (1)
Number of mental health professionals performing coordination work in the state	14
SOME COMPARATIVE INDICATORS OF ACTUAL NEED	
Number of municipalities in the state	723
Number of state funded health centres	585
Number of health centres contracted out by the INAMPS	851

Sources: [A: DMS (1983) Plano de Assistencia: 14];[A: DMS (1984) Relatorio do Programa].
Note: (1) Respectively 4 psychiatrists and 10 psychologists, and all the activities constituted an "isolated work without proper planning" [A: DMS (1986) Saude Mental: 2].

As pointed out before, in the case of these activities within the health centre network, the historical association with the mental health movement mobilization clearly does not exist. The PISAM was a central government initiative, and was taken before any open social mobilization in the country, following a different political logic. However, as can be seen, its results are minimal in Minas Gerais, apart from introducing a pattern of practices which will be further developed later on.

2.2.2.2. Qualitative Political Aspects of the Relationship Between the Mental Health Movement and the Changes in Services

The first main characteristic of the mental health movement in this period is clearly its main location **outside** the state administration. Some of its leaders had previous access to important posts in the state and in the INAMPS regional administration. Nevertheless, the main source of political power was undoubtedly the mobilization of public opinion and the organization of the militancy through the Minas Association of Mental Health (AMSM). In this process,

Basaglia's visit played a central role. He was well known as an international leader of the mental health movement, particularly after the then fresh victory of the change in the psychiatric law in Italy. Another important element was the role of the newspaper "O Estado de Minas", and particularly the journalist Hiram Firmino, author of the report series "At the Cellars of Madness".

This location of the movement is important as one of the reasons for the low level of actual changes in services. The conservative state administration tried to ignore or even repress the more radical claims (as in the case of the dismissal of Ronaldo Coelho). Economic constraints should also be considered, in a context of shortage of public resources, as indicated in chapter 2. However, the few achievements, mainly in the hospital sector, were undoubtedly a result of the public support gathered by and of the direct action of the movement.

In addition to this, some features of the movement itself should be considered. The main group within it was formed by psychiatrists with a mainstream professional background performed in psychiatric hospitals. This can be clearly shown in a previous event. In 1972, some of the leaders of the movement had assessed the regional INAMPS administration in a reform of the contracted out psychiatric services. The plan included an attempt to increase the dynamism of the hospitals, linking them to and giving priority to out-patient services, and placing all chronic residents in two of them. The result was the creation of two asylums in the INAMPS network, and no concrete measure in relation to the out-patient services was taken. Virgilio Renno, one of the participants of the process, realizes the mistake and makes the quoted remark, which can be clearly extended to the following events:

> "It happens that with our background (today we have a critical view of it), even thinking of the outpatient

> services as the solution, we had no actual acquaintanceship with it. Our formation was entirely in hospital environments.(...) And our familiarity in outpatient services was very precarious, therefore, they were overtaken (by the other measures)" [I: Rennó, 1987].

Moreover, the theoretical atmosphere in social psychiatry at the time also was pointing to a certain 'suspicion' of the community psychiatry model. This was clearly stated by influential specialists such as Costa and Birman (1976) in that context, who where under the influence of recent visits of Foucault in Rio.

This centredness on the hospitals was not only a feature of the psychiatrists, but of the whole movement: despite the formal priority given to out-patient services, very little concern was shown for the issue of alternative forms of care. For example, during the 5 days of the Congress, just 2 hours were formally left to discuss the issue. There was no explicit reference to practices being implemented at the time by the PISAM programme, nor concrete and detailed proposals for out-patient care. Despite the promotion of a 15 days course in 1982 on the subject through the Faculty of Medicine (UFMG), the conclusions and suggestions were still somewhat immature and voluntarist. Even so, a realization of the need for a different professional training was clearly emphasized [N: EM, 23/5/1982].

The reform centralization on the hospitals was also an answer to public opinion, which was mobilized directly by the denouncements of what was happening inside them. On the other hand, out-patient services may constitute by themselves a subject of very low public appeal, when links with the in-patient sector are not emphasized. Therefore, it could be expected that such a movement would suffer a demobilization process once changes in the hospitals had started.

In addition, the mobilization had as its main organizational basis the Raul Soares hospital staff, including its director. This also points to another qualitative aspect of the movement. In accordance with the national context of re-emergence of the trade-unionism at the time, the mental health movement has had a very strong **corporatist** component, as can be seen for example in the claims for better wages and working conditions as some of the conclusions of the Congress [N: EM, 22/11/79]. This aspect, associated with strategies to limit the internal reforms in the Raul Soares hospital on consensual proposals from among the staff, clearly reduced the space for more radical changes. Even the 'Guimarães Rosa' Project had some opposition from the staff, as it implicitly represented some disruption in the 'normal' routines in the wards and in the professional hierarchy of the institution. This may be one of the reasons why it was not funded during its existence and had to be stopped.

The militant organizations themselves had their own limitations. The AMSM particularly had previously been associated with the lobby of the private hospitals and had to be completely reorganized after Basaglia's first visit in July. The organizational structure of the militancy was very fragile. The higher expenses during the campaign had to be previously financed in advance personally by one of the leaders [I: Simone, 1987].

To sum up, these features may be important to understand the qualitative aspects of the mental health movement and its limitations in the process of inducing the changes. This was the case even for those called for in its main claims and key words, as the priority on the out-patient services.

It may be interesting now to see how history unfolds in the following period, where important changes happened in the country's political context, and particularly in the mental health movement and its relationship to the state.

2.3. THE SECOND PERIOD: 1983 - 1986 : THE LENT IMPLEMENTATION OF THE OUT-PATIENT SERVICES THROUGHOUT THE HEALTH CENTRE NETWORK - CHANGES FROM INSIDE THE STATE APPARATUSES

2.3.1. Reasons for Segmentation and Main Contextual Changes

Two main historical events will be considered here as determinants of deeper changes in the psychiatric services in most of the country and the reasons for the proposed time segmentation: - the free general elections of each state governor in November 1982;
- and a plan called CONASP issued by the Social Insurance Ministry in August of the same year, proposing changes in the concept and funding mechanisms of the health system.

The free elections were part of the democratization process induced by the increasing crisis of the military government and undoubtedly by the re-emergence of the popular democratic movement since 1978. Opposition governors were elected in Minas Gerais, Sao Paulo, Rio de Janeiro and other states, through political coalitions that embraced representatives of the main social movements at the time. The document with policy proposals of the opposition candidate in Minas Gerais, Tancredo Neves, included a substantive chapter on mental health policy written by some of the leaders of the mental health movement [A: DMS (1982) Equipe de Transicao]. Later on, three important secretariats of the social area (Health, Education, and Work and Social Care) were taken by leftist alliances. This opened some space for representatives of the medical and mental health movement inside the state policy making process at least until 1985, when political changes partially limited their action.

In turn, the CONASP plan was the most important of the hitherto several attempts to curb the deep crisis of the

social insurance system medical care branch (INAMPS) in the late seventies and early eighties (Oliveira, 1986: 269-300). The medical movement had had an important role in denouncing the situation and proposing more structural changes, mainly inspired by the suggestions of the World Health Organization as presented in the 1978 Alma Ata Declaration. The movement's proposals were incorporated in a first alternative plan by the Ministry of Health launched in 1978, called PREV-SAUDE. It was aborted mainly given the political pressure from the private sector lobby and their allies in government bodies (Oliveira, 1986: 275). The CONASP plan, in a more gradual political strategy and this time issued by the Social Insurance Ministry itself, reaffirmed similar principles, summed up as following:

- universalization of the medical care;
- creation of a integrated health system, including all private and statutory services, under the control of or giving priority to the latter. The new system would involve those owned or funded by the Social Insurance system, the Ministry of Health and each state and municipality governments;
- regionalization and hierarchization of all services, with the creation of entry doors at each catchment area through the primary care network. This would be then integrated to more complex secondary and tertiary services at more centralized levels;
- a funding system relocating resources from the richer Social Insurance system to statutory lower levels, and a different payment system to the private sector, in order to control the service overcharge and corruption [A: MPAS (1982) CONASP: Plano de Reorg].

The CONASP council also launched in 1983 a plan concerning specifically the psychiatric care. Sustaining the above cited general principles, the document proposed:

- priority to out-patient services, understood as:

. multiprofessional teams integrated to the health centre network;

. intermediary services as "day-hospitals, night-hospitals, pre-admission, sheltered hostels and work places";

- admissions as last resort;
- gradual implementation of psychiatric wards in general hospitals [A: MPAS (1983) CONASP: Programa de Reorient.].

There is no doubt that the CONASP plans are identified as having launched a new historical period in the historiography of the health policies in Brazil (DAP-ENSP, 1986). In conjunction with the political change in some of the states, such as Minas Gerais, the plans will be considered here a breaking point in the periodization of the history of the mental health services in Belo Horizonte.

Another contextual element is important to be cited during this period, the campaign for free direct elections for the country presidency in 1984 and the end of the military government. During the military rule, the choice of new presidents had been made inside the military bodies, and a new system would choose the next one from among civil candidates in an indirect election inside the controlled parliament. In that year, a campaign was launched by the opposition parties and the popular democratic movement claiming free direct elections. There were huge unprecedented demonstrations and gatherings in the main cities. Despite not achieving it, the process reinforced undoubtedly the popular movements and created the conditions for the opposition to present a compromise candidate (the then governor of Minas Gerais, Tancredo Neves) to the parliament, who was able to obtain the majority of the votes. Dramatically, he died just before assuming the presidency, but it meant the end of twenty years of military rule. Furthermore, he left a cabinet which opened some political space for the health movement in the gradual

implementation of the health system reform already indicated in the CONASP plan.

This process involved an actual 'positions war', in the Gramscian sense of it, with the formation of the so called 'Partido Sanitário' (Health Party) by the health movement (Oliveira, 1989; Gallo and Nascimento, 1989). It attempted the mobilization and politization of health issues within the civil society popular organizations. However, the main source of power has been the professionals and part of the statutory bureaucracy, occupying all possible political space within the government agencies (Teixeira and Mendonca, 1989: 209). The peak was constituted by the 1986 VIII National Health Conference, gathering a representative ensemble of delegates of civil society organizations and health statutory agencies, elected in a broad process of discussions. The conference outlined a detailed plan for the health system, basically developing further the principles already suggested in the CONASP plan.

2.3.2. Main Events of the Period

> "The official promises of reformulation of the mental health care in Minas Gerais disappeared into the void. The projects of humanization, started by the staff and professionals of these institutions are today paralysed by lack of support from the government" [N: EM, 25/5/83].

This is probably the best description of the state of affairs in the psychiatric scenario in the beginning of the period as outlined by the staff of the Raul Soares hospital, in the conclusions of an internal seminar in May 1983. However, the staff also realized that there was still "hope (...), after the political change", referring to the new state government [op cit]. The Conasp plan also induced similar expectations, with the approval of its proposals, "since it is not a mere declaration of intentions" [N: EM,

26/5/83].

The first answer from the new regional health authorities, which were present at the seminar, was to reopen the psychiatric hospitals to the press and community [N: Veja, 1/6/83], and call a "caravan" of journalists, politicians, intellectuals and students to visit them [N: EM, 26/5/83]. The government strategy was clearly to show an open sympathy to the problem, calling on "political action by all democratic forces" to change the reality. It also included some of the mental health leaders in the administration's key posts, but acknowledging explicitly the financial difficulties in promoting concretely the required reforms [N: EM, 21/5/83]. The financial crisis of the state treasury was such at the time that the resources were insufficient even to pay the civil servants wages [A: DMS, Mendes (1985) As Acoes Integradas: 2].

Linked to this new political context, this period witnessed a qualitative change in the mental health movement, in the direction of the demobilization of their organizations and actions in the open public sphere, and of a move inside the statutory institutions and bureaucracies. Probably its last open initiative was the organization of the II Latin American and VI International Meeting of the Network of Alternatives to the Psychiatry, in October/November 1983. It became actually an event of the national mental health movement, with previous meetings in other states (Hegelberg and Lacman, 1987). It also gathered the presence of some international leaders of the movement, with special attention to some of the Italian Psiquiatria Democratica members. Locally, it was marked by the expectations of practical measures and changes from the state government [N: EM, 30/10/1983].

After the congress, the Minas Mental Health Association was practically demobilized, and disappeared from the press. The role of advocacy of the public interest in the field was

performed by:

- some of the leaders alone;
- the press (particularly the 'O Estado de Minas');
- and by the more stable and formal organizations, as the Psychiatrists Association of Minas Gerais (AMP), and mental health workers unions, such as the doctors, psychologists and social workers, the latter two being organized during the previous few years.

On the other hand, the movement started to occupy the new institutional space available, organizing itself inside the statutory services, taking the shape of mental health workers' organizations. The contact among different states movements during the period continued to be done through informal meetings in congresses. However, since 1985, it became more institutionalized in regional meetings of mental health programme coordinators, including representatives of the federal agency in the field (DINSAM). The first one gathered representatives of the South East states (São Paulo, Rio de Janeiro, Espírito Santo and Minas Gerais) in 1985, in Vitória. A more informal meeting was held in Belo Horizonte one year later, to evaluate the implementation of the proposals and to prepare a following one for 1987.

The mental health branch of the CONASP plan took three years to have its implementation started in the Belo Horizonte area [A: DMS: Belisário (1986) Contribuições], owing to political reasons. The main problem had been the administration by covenants, integrating several agencies (INAMPS, the state and municipality Secretariats for Health), with different organization cultures and sedimented political interests. Each of the agencies would still keep their vertical organization structures in all levels during this stage of the new health system implementation. One example is how the still military central government (or their regional allies) would accept the transference of resources to state or municipalities administrations with

opposition parties in office [A: DMS, Mendes (1985) op cit: 3-11). The claim from the health movement was for the complete unification of the health system, but such a proposal would be legally achieved only later on.

During this time, several draft operational plans for the mental health programme in the Belo Horizonte area were issued by the responsible agencies[1]. Although a more specific evaluation of the proposals for care in the community will be provided in the following chapters, it is possible to say here that they basically repeated the CONASP plan principles and are very superficial as operational guidelines. The interviews and the analysis of the agencies' archives also shows that any systematic evaluation of the professional practice being held since the PISAM was accomplished and incorporated in the new proposals. In addition, the implementation of the programme was done by the simple incorporation of new professionals in the services network, with a very brief training. The basic team is defined in those plans as composed of one psychiatrist, one psychologist and one social worker.

The first concrete step towards their implementation was in 1984, with the admission of 5 multiprofessional mental health teams for the PAM Carlos Chagas [A: DMS: CRIS SM (1986) Proposta: 4], the only out-patient service already existing in the 70s, but only with a team of psychiatrists. As the service belongs directly to the INAMPS, the above described political resistance was fragile. In September 1985, a first group of 30 new professionals was contracted

---

[1] Actually, the drafts are very similar, but reflect the different moments in the struggle for resources and planning the services by the mental health agencies in the state and metropolitan levels: [A: DMS (1983) Plano de Assistencia]; [A: DMS: Grupo de Trabalho INAMPS/SES MG (1984) Plano Operativo]; [A: DMS (1985) Proposta]; [A: DMS: CRIS SES MG (1985) Programa de Acoes] [A: DMS: CRIS SM INAMPS SRMG (1986) Proposta de Estruturacao).

out to work in the state health services network in the Belo Horizonte metropolitan area [A: DMS (1986) Saude Mental: 4][N: EM, 29/8/85]. Despite the opposition of the specific unions and other left parties, the professionals were chosen by the traditional 'clientelist' channels (indicated by politicians and notorious figures in power), without any evaluation of technical competence. In June 1986, on the contrary, a public examination took place and a new wave of 58 professionals was admitted. By this time, the Belo Horizonte local authority started to employ a few professionals for the same purpose.

The public examination was basically an achievement of the mental health workers movement [I: Campos, 1989], in a process which started in 1983. As they had already had an important nucleus in the Raul Soares hospital, the group supporting the new governor decided to take the direction of the Galba Veloso hospital, choosing in 1983 one of its psychiatrist leaders, Cesar Campos, as director. He started a process of democratization of the hospital, making all main decisions in general assemblies. As the hospital had still been used by the private hospitals as an entry door for recruiting patients, changes in the emergency service were accomplished.

The first one was to allow more time for the local detoxification of alcoholics, even against the agreement with the INAMPS, avoiding their referral to contracted out hospitals. New group techniques were adopted for first consultations at the emergency unit. A multiprofessional team used to gather direct users, relatives, policemen and all those bringing in the potential in-patient, in sessions which could even be followed by an informal visit inside the hospital. The purpose was to induce a more sensitive and immediate process of analysis of the demands for admission, showing the specific purposes of the psychiatric care and avoiding unnecessary hospitalizations just for social

reasons. Two short term admission wards were opened, with the same purpose. The next step was to set the pre-conditions for the creation of an out-patient clinic in 1986, able to attend on a more permanent basis those who would require only external consultations, as the mental health service network at the time was still very rudimentary. It would be only inaugurated in March 1987, before the transference of power to the new governor.

By this time, given the withdrawal of the governor Neves, the political space for the democratic forces within the health administration was reduced. Campos transferred himself to the general coordination of the state administration of hospitals (FHEMIG), in order to broaden his influence and resist the then strong opposition from the private hospitals lobby [N: EM, 20/8/85]. The first step of resistance was a direct election for the posts of director in all service units. Campaigns of support were launched by professionals and staff within statutory services on several occasions, also gathering support from known leaders of psychiatric movements mainly in Europe. One of his last achievements in office was the accomplishment of the cited public examination for recruiting the professionals for the mental health teams throughout the health centre network.

At the Barbacena hospital, a working group including representatives of the Pan-American Health Organization, Ministry of Health, FHEMIG (which psychiatric branch was then coordinated by Ronaldo Coelho, a movement leader dismissed by the latter administration) was set up at September 1984 [N: EM, 30/9/1984]. Almost one year latter, the project was finished and a new hospital started to be built in February 1986 in another location.

In turn, at the Raul Soares hospital the experimental module was only partially implemented. Despite the existence of the staff and professionals organization and the accomplishment of two internal seminars during this period,

the lack of resources and staff were the main constraints to the full establishment of the proposed changes. An attempt to introduce the 'Guimarães Rosa' project was made in one of the wards, but given the lack of support, was practically extinguished [N: EM, 23/8/85]. In addition, three of the six existing wards still had had no reforms at all, and were not linked to external out-patient services, creating a sharp division in the hospital (Rati, 1986). However, a new pilot 'day-hospital' for 12 users inside the hospital walls was created in April 1985, in an initiative of a group of staff supported by the movement there. The multiprofessional team was composed of seven staff, providing a range of activities in a model similar to the therapeutic community one, in a relatively successful way (Motta, 1989; Gazolla, 1986).

Another new out-patient service was implemented in 1986, the 'Centro Mineiro de Toxicomania' (Minas Centre of Drug Addiction), directed by one of the mental health movement psychiatrist leaders, Benetti. The project was manned by a multiprofessional team of 7 members added to some more administrative staff, providing individual and family consultations, in an approach marked by a strong influence of psychoanalysis.

2.3.3. A Balance of the Period

2.3.3.1. Changes in Service Provision

a) Hospital Sector:

As described before, the reform in the hospitals have been implemented in a gradual and slow way. The deeper changes in infra-structure were started in the Barbacena hospital with the establishment of entirely new facilities. They included small houses for recovered residents without contacts in the outside world, a new acute ward and an out-patient service linked to the regional health services network. This reform can undoubtedly be considered a result

of the open mobilization in the previous period and the political action of the health and mental health movement leaders within and supported by the new state administration. The same can be said of the described changes in the Galba Veloso and Raul Soares hospitals.

From another perspective, there was no increase in the number of beds in psychiatric hospitals not only in Minas Gerais, but also in the South-East states. This is acknowledged as an achievement of the movement interregional articulation [A: DMS: II Encontro (1987) Relatorio].

The concrete service output at the Raul Soares and Galba Veloso hospitals can be assessed by returning to Figures 1, 2 and 3. At the Raul Soares hospital, the trends already announced in 1982 continued through the staff's enthusiasm to keep the changes, producing a sharp increase in the number of out-patient consultations and a higher number of first admissions than readmissions. There was a decrease in the number of first admissions from 1983 which is partially compensated by a further increase in consultations. From 1985 onwards, however, the lack of support led to a general decline in all activities.

At the Galba Veloso hospital, the internal changes proposed under the Campos administration produced interesting results. Despite the creation of the new wards and new procedures for alcoholic detoxification, there is no significant increase in the total number of admissions. Actually, a light and gradual dehospitalization process was accomplished, with a decline in the number of readmissions and referrals. The introduction of the new procedures for emergency services in 1984 seemed to have produced a general decline in the number of consultations. The reasons are difficult to trace with the available information, but my hypothesis is that the new procedures generated some awareness within the most frequent clientele that the aim of easy admission would not be achieved so easily any more via

that hospital, causing a restraint in the demand. The proposal for an attached out-patient service would then compensate the decline in the overall activities and drive the specific psychiatric demand for the external treatment.

In conclusion, the general hospital output is again clearly associated to the changes induced or accomplished by the mental health movement.

b) Out-patient Sector:

At the end of 1986, the multidisciplinary mental health teams in the Belo Horizonte metropolitan area were distributed through the following network:

- under the administration of Belo Horizonte local authority: 12 professionals, constituting 4 teams working in two health centres (one of them in the Sao Paulo district).
- under the state administration: 93 professionals, constituting 31 teams, 19 of them being located in 12 health centres in Belo Horizonte and additional 12 in neighbouring municipalities [A: DMS (1986) Saude Mental]. Those recruited in the 1986 public examination actually started to work in January 1987, but will be counted here.
- under the INAMPS administration: 21 professionals throughout 5 multiprofessional teams, added to 27 psychiatrists and 4 nurses providing traditional clinical psychiatric attendance, all working at the PAM-Carlos Prates (Barros and Rotheia, 1985: 5).

The professionals' work is supported by a variable group of student probationers in Psychology and Social Work.

It may be interesting to compare this provision with some kind of estimation of the needs. A possible parameter is that offered by the National Division of Mental Health (DINSAM), proposing one complete multiprofessional mental health team for each 50.000 inhabitants [A: DINSAM (1987) Manual: 9]. In this case, the deficit for the whole area at

the end of 1986 would be 26 teams[1]. Magro Filho (1986), using epidemiological parameters, also reached a conclusion of deficit. However, such parameters themselves should be seen with caution, because they overestimate the actual capability of the teams, as to be shown in the following chapters.

2.3.3.2. Qualitative Political Aspects of the Relationship between the Mental Health Movement and the Changes in Services

a) The Movement and the Extension of the Service Network

The historical association between this significant increase in the provision of professionals throughout the health centre network and the advance of the democratic popular struggle is clearly more complex. Originally, the proposal was made at the federal level, with the CONASP plan, partially due to the crisis of the then hegemonic model of medical care funded by the INAMPS. However, the CONASP plan is also an answer to the strong claims by the health movement, consolidated in the first plan (PREV-SAUDE) and repeated in a more gradualist strategy in the former. Even the formulation of the CONASP psychiatric version was done with the participation of important leaders of the mental health movement [I: Delgado, 1989].

The implementation of the plan also has depended entirely on the political 'position war' between the 'Partido Sanitario' and the coalition of the private sector and conservative groups within the several government agencies, with its greatest moment in the VIII National

---

[1] This figure was obtained considering the estimated population of 3.375.796 in 1986 [A: DMS: CRIS SM (1986) Proposta]. Summing up the three service networks and ignoring the over-provision of psychiatrists and some nurses due to the hegemony of the traditional medical model in the INAMPS owned services, Belo Horizonte presented 40 complete professional teams in 1966.

Health Conference. According to Paim (1986) and Teixeira (1989), **if left on its own, the reform would be reduced to a mere rationalization and cost reduction process, keeping the main features of the model.** In addition, the general democratic advances in society, with the victory of opposition governors in 1982, the campaign for direct elections and the victory of the opposition transitional president in 1984 opened the space for further changes in the health system. Finally, the role of the regional health and mental health movement in Minas Gerais was crucial in negotiating the agreement with the INAMPS, which allowed to contract out new professionals, expanding the service network.

b) The Limitations of the Changes in the Hospital Sector

Again, the changes and achievements in the services are also influenced by the features and limitations of the movement. The reform in the hospitals are a good example. In my view, the new facilities in Barbacena reproduce clearly the concept of a traditional psychiatric hospital, perhaps in a more 'humanized' way[1]. In addition to this, most of the old wards were still there by that time, with the remainder of the old chronic residents, particularly the famous 'Crispim Jacques' ward, in the same terrible way as found by Basaglia in 1978. The new project was strongly

---

[1] The new place is even further and segregated away from the city of Barbacena than the previous location and surrounded by wire nettings. In a personal visit in 1988, the residents living in the houses still had nothing to do, not only by the lack of facilities and staff, but mainly because the independent access to the city is practically impossible. Sheltered residential accommodation within the city, probably a cheaper and more normalizing alternative, was not even projected. Out of the new houses and the integrated male/female ward, the present architectural structure can easily unfold towards an old asylum if the administration allows it.

influenced by Ronaldo Coelho, one of the leaders of the 70's movement, during this period in the coordination of the FHEMIG's psychiatric branch. Besides, no criticism from other movement leaders or groups was explicitly expressed. This reinforces the analysis suggested before, on the conceptual weakness and the hospital centredness mentality of the movement.

More widespread, however, is the professional culture orientated to specialization and private practice, and completely distanced from the public care provision. Rati (1986: 34) identifies these features as some of the main constraints to the professionals' full engagement in the changes in the Raul Soares hospital mainly during this period. Therefore, in a movement with a strong corporatist component, as reported earlier, these aspects are naturally amplified mainly given the context of crisis of the public sector and consequent impairment of wages and working conditions.

c) The Implications of the Exclusive Action inside the State

The most controversial issue referent to this period within the mental health movement is perhaps the way by which the full engagement in the state machinery was undertaken. The leadership has addressed the point explicitly, indicating some of the implications:

> "The entry of the people - with which the movement had been identified - in the state institutions ended up in decreasing the sphere of action and even the intervention autonomy of the movement, which in a certain way disappeared" [I: Delgado, 1989].

> "(...) We acknowledged the need for the articulation, but it was impossible. The whole process consumed us in such a way that we ended up in disarticulating even with the Raul Soares group" (Campos, leader of the reform process in the Galba Veloso hospital and FHEMIG) [I: Campos, 1989].

In Minas Gerais, this process had deeper implications, given the state economic crisis and the fact that the funding bodies were appropriated by conservative forces. Then,

> "The right got the strongbox, locked the door and left the bomb to explode in the left's hands, which were there with the health movement, with the education movement and the social area. Therefore, we had to confront ourselves the strikes, which was inevitable, while the strongbox keys were in the right's hands [I: Barreto, 1989].

The result was an increasing distrust in the leadership, and as the political arena was already marked by party divisions, these were sharpened in such a context[1].

d) The Mental Health Movement's Political Agenda

This period witnessed a relative advance in the evaluation of the local changes in the hospital sector. This happened particularly in the debate on the political and administrative challenges in the implementation of the reform, which generated a short term agenda for the movement. This is evident in the report of the South-East Region Mental Health Coordinators Meeting (see Appendix 3).

To sum up, it reaffirmed the basic principles of the national health system, and proposed no further creation of new psychiatric beds in specialized hospitals, both in the statutory and in the contracted sector, with gradual reductions in the number of already established beds where possible. New beds would be allowed only in psychiatric wards in general hospitals, and the emphasis is formally put on out-patient services, with special stress on intermediary ones. The tactics adopted in relation to the private sector were of a more realistic compromise, differing to that stated in the VIII National Health Conference (which

---

[1] This process was particularly strong in the Sao Paulo city (Hegelberg, 1987: 19-21], but also happened in Belo Horizonte.

proposed an entirely statutory and private non-profit system and was defeated later in the 1988 Constituent Assembly). The need to overcome the hegemonic medical model is explicitly acknowledged, but there is yet no indications of alternative ones.

It is interesting to note the kind of discourse in which the document is written. As a social movement entirely inserted in the state apparatus, its only form of expression had been the rational normative or administrative discourse, in the Habermas sense of it. The problem was, in my view, the ability of the movement to create alternative ways of communication and action in which it could generate the political debate, its own organization and mobilization of the public opinion. This was particularly acute vis à vis the then already predictable increasing restriction in the political room within the state agencies.

Moreover, and probably more important, the available data shows no further discussion on a medium and long term political strategy for the movement, particularly on alternatives to the hospital sector. The already identified conceptual weakness of the movement remains unchallenged at least during this period.

2.4. THE THIRD PERIOD: 1987 ONWARDS: THE RESTRICTION OF THE DEMOCRATIC SPACE AND THE REGRESSION IN THE MENTAL HEALTH POLICIES

2.4.1. Reasons for the Segmentation and Main Contextual Changes

Two main interrelated political processes will have direct implications in the mental health field and would determine the configuration of a different period in its regional history. First, at the federal level, there had been an increasing closure of the democratic space in the

federal administration[1], associated to a deepening economic crisis. Despite this, the health movement still got to insert the proposition for a unified health system in the new 1988 Constitution draft, mainly as a result of the previous mobilization which resulted in the VII National Health Conference. However, it had to compromise on the acceptance of the private sector as a complementary service provider and other minor issues [N: Proposta n. 13, Oct 1988]. Until 1989, it had been very difficult to approve the translation of the Constitution general principles into an ordinary legislation in order to set definitively the new health system. The same was happening to the implementation of the actual unification of all organizations and the transference of funds from the Social Insurance system to the local levels [N: Proposta n.s 17 and 18, respectively Aug and Sept 1989]. Finally, the victory of Collor de Melo (supported by conservative forces) in the presidential election in December 1989 and his first initiatives in the post in 1990 have indicated that the closure of the federal administration for more advanced policies will continue at least during the early 90's.

On the other hand, in the present international context of structural adjustments, external debt pressure and economic isolation of the Latin American countries, the general economic crisis has deepened sharply in the country during the last few years. In addition to the high inflation rates and recession, the state at national, state and municipality levels has displayed a permanent crisis in all

---

[1] The then president Sarney, the former vice-president who assumed the post after Tancredo Neves' death, was a traditional politician and supporter of the military government and gradually abandoned the democratic political forces who raised the coalition to power, gathering support among his old colleagues and military organizations. The National Constituent Assembly elected in 1986 was set and worked in a very constrained political atmosphere.

the existing statutory services. This practically immobilized the social policies in their role to reduce the effects of the economic crisis on the majority of the population. This crisis has been particularly acute in the newly established health and mental health service network. The usual result has been then a very rudimentary infra-structure, lack of basic material and sharp decline in wages and working conditions for all civil servants, who have confronted the situation with constant strikes.

Particularly for the state of Minas Gerais, the second important event in this period was the election of a very conservative, authoritarian and populist governor, Newton Cardoso, who assumed the post in March 1987. He not only launched a radical privatization policy by scrapping all statutory services through sharp decline in wages and under-funding, but also articulated a direct political persecution, dismissing all civil servants identified with democratic social movements. In the mental health field, he directed representatives of the private hospital lobby to run the hospitals administrative body (FHEMIG), practically reversing most of the previous achievements in the sector.

2.4.2. The Main Events of the Period

For most of the social and health policies in Minas Gerais, 1987 can be described as the "witch hunt" period. The main leaders of the mental health movement hitherto active in the state administration lost their posts: Barreto, Coelho, Campos and Benetti [N: EM, 28/8, 8/11, 10/11 and 11/11/87]. In addition, all directly elected directors of service units were dismissed. Also, the democratic decision making mechanisms implemented in the past were blocked [N: EM, 3/9/87]. Authoritarian practices such as compulsory admissions induced by politicians, independent of any medical assessment and decision, and

employment of staff without public examination by political indication, became common practice again in the psychiatric hospitals [op cit]. A quick policy of devaluation of the civil servants wages and of staff dismissals in all units was also launched [N: EM, 4/10/88][1]. Although the municipality in Belo Horizonte had been run by a coalition supported by some of the democratic opposition parties, financial hardship and political mismanagement also led to similar low wage policy, although less severe.

The main reactions by the health and mental health workers movement to this general reversion in the sector were the public denouncement and the strike. A wave of them was launched in all state run services, disrupting the service provision, with consequences particularly serious in the mental health out-patient services, as to be reported in the following chapters. The press, especially the 'O Estado de Minas', have been a very important instrument in denouncing the declining situation in the health sector [eg, EM, 24/8/89] and the mental health leaders dismissals, publishing a series of reports interviewing each one [ref. above].

The strategy adopted by the governor especially in relation to the Galba Veloso and Raul Soares hospitals was to use the strikes and the service disruptions to bring about their closure. This led to an acute crisis in 1988, especially in the latter[2] [N: EM, 2/10/88]. The event was followed by a large series of denouncements by the health and mental health movement of what was called a revival of

---

[1] In three years (Jan/86 to Dec/88) wages of the state health sector lost 54% of their value (DIEESE-MG, 1988), and an average of 250 to 300 staff asked to be dismissed every day in the state administration (SINDI-SAUDE, 1989: 22).

[2] During one of the strikes, he ordered the arbitrary transference of 84 residents to private clinics in Barbacena and discharged 66 of the remaining 77 [N: EM, 25-27/9/1988].

the "ship of fools" [N: EM, reports between 25/9 and 16/10/88]. Some days later, the government announced the closure of the two hospitals, transferring the remaining residents to private clinics and issuing an order to dismiss all staff [N: EM, 13/10/88]. The movement's immediate reaction was a collective circling of the Raul Soares hospital and other demonstrations, which led to government turn around in the dismissals and hospitals closure [N: EM, 14/10/1988]. However, no measures to improve the situation in the hospitals were taken until the end of 1989, and the denouncements of the precarious conditions in each one continued during the year [N: EM, 23-26/3; 14/4; 20/10/89].

The figure worsened when one of the biggest private psychiatric hospitals contracted out by the INAMPS, Santa Clara, with 400 beds, announced its closure[1] [N: EM, 10/10/89]. The mental health movement claimed that the loss of those beds could be compensated by the reactivation of old wards in the statutory hospitals and by investing in the out-patient services. Nevertheless, the only concrete measure until the end of the year was the creation and contracting out of a new private clinic, going against the previous position of all regional mental health administrative bodies of not contracting out more beds.

In relation to the out-patient services within the health centre network, there was little direct interference in its administration. However, a psychiatrist committed to the private hospital lobby was elevated to the post of the state mental health coordinator in the Health Secretariat. However, he stayed for just a few months and resigned, the vacant post occupied by Abilio Passos, a psychiatrist linked to the mental health movement. Despite this, the context of

---

[1] The initiative was part of a 'barring out' by all the private hospitals, blocking the access to insured users, as a protest against the low payment by the INAMPS [N: EM, 20/10/89].

crisis has had a huge impact on services, provoking a series of disruptions, to be outlined in the next chapter.

The mobilization against the political and economic constraints was accomplished by the health and mental health corporative organizations (the professionals trade unions, the Minas Psychiatry Association [AMP]) and a newly established group called Forum of the Mental Health Workers. Besides the local initiatives, the interregional and national organization through the institutional channels continued, with the participation of some of the Belo Horizonte representatives. The main initiative in this regard was the organization of the First National Mental Health Conference in June 1987, with similar purposes as of the VIII National Health Conference, which were to propose suggestions to the National Constituent Assembly in the field. Despite being preceded by regional meetings and producing a final report (Ministério da Saude, 1988), the impact of the conference was relatively small. It only confirmed the already hegemonic principles established in the preceding National Conference and in the 1985 First South East Meeting of Mental Health Coordinators, and proposed some legislative suggestions.

Probably the main reasons for this was its already highly institutionalized organizational basis, under the coordination of the National Mental Health Division (DINSAM) and linked to each state mental health coordination. After all, the restrictions in the space for dialogue inside the state apparatus could be already clearly identified. Not by coincidence, this was one of the main conclusions of a meeting of the mental health workers movement held in parallel to the formal events in that First National Mental Health Conference (Plenário de Trab. de SM do Est. de SP, 1987). As pointed out by one of the leaders,

> "All these people had kept a dialogue space supported and organized inside the state apparatus (..), which

> had constituted an institutional and official scenario. At the moment of the attacks (referring to the political closure), this scenario revealed itself absolutely insufficient and incompetent, which was also a characteristic of the conference that was happening there, of which there was a great distrust. We didn't trust in the DINSAM, in Mr X, who was the president, in the possibility of that space to generate any change: a new space was needed to be created" [I: Silva, 1989].

The discussion also acknowledged the necessity to overcome the existing corporatist component and party divisions in the movement, and to reinforce the links with the popular democratic social movements:

> "We haven't organized the basis (of the movement), we haven't created an organization outside the state which could keep the ability to make criticism, we haven't allowed a feed-back. I'm citing the words used at the time by the several leaders who were there" [ibidem].

Finally, the meeting called for the organization of a representative II Mental Health Workers National Meeting, preceded by regional meetings (Plenario de Trab de SM do Est de SP, 1987). This is known within the movement as the Bauru Congress, held in December 1987, which provoked an important change in the strategy of part of the movement, emphasizing two main proposals:

- to re-link the mental health workers movement in all the country with all popular struggles for democracy, social justice and against all discrimination, acknowledging the limits of the rationalization of the statutory services from the state;
- to redefine the political aims, adopting as key words the phrase "Towards a society without asylums ('manicomios')" [N: Jornal do Psicólogo-SP, Dec 87].

This last decision generated some polemics and resistance in part of the larger movement. It was proposed one year before in the III Latin American Alternatives to the Psychiatry Network Congress in Buenos Aires, and adopted by followers of the Italian movement within the Brazilian

leadership:

> "(..) while we have the hospital, it pulls and closes the scheme and the circuit, not allowing room for thinking alternatives. The hospital culture is very strong and all we've tried is just reform mending which all the world has already made in the last one hundred years, without finding the way out (...)" [I: Campos, 1989].

> "To discus the society without asylums is to take this question out of the limits of our institutions, it is to understand that madness has important social determinants, and if they are strong, it is essential that these problems to be discussed by the society as a whole, towards changing those relations and the epidemiological context of the mental suffering" (Mov. por uma Soc. sem Manicômios, 1988).

The main concrete form of action proposed was the establishment of the 18th of May as the National Day for the Anti-Asylum Struggle, when the regional Mental Health Permanent Forum nuclei would try to mobilize the public opinion. The first one, in 1988, had good media coverage, but few members of the public participating directly in the events [I: Silva, 1989]. In Belo Horizonte, as in most of the places, it stimulated divisions in the wider movement. The Minas Psychiatry Association released a public letter saying that they were not in favour of the ending the asylums, but of their humanization [ibidem]. In December of the same year, a national meeting of this more active group of the movement was held in Belo Horizonte. In 1989, the Belo Horizonte regional nucleus organized a week of events, with debates, films, and a photography exhibition [N: EM, 16/5/89].

At the national level, the last initiative of this sector of the movement was the attempt to approve a new law[1] proposing:

- the prohibition of the settlement of new specialized

---

[1] The new proposal has had good possibilities to be approved by the legislative during the period of 91/92.

psychiatric hospitals, indicating small psychiatric wards in general hospitals as the alternative;
- new mechanisms for making more difficult the involuntary admissions.

In turn, the group that remained withinthe state's institutional framework has experienced a process of resistance and demobilization, and did not organize any additional important inter-regional or national meetings during the rest of the period.

2.4.3. A Balance of the Period

2.4.3.1. Changes in Service Provision

a) Hospital Sector

This period was particularly disruptive for the hospitals, as described before. At the Barbacena hospital, even if the number of staff has been considered reasonable, the lack of financial resources practically paralysed the last stages of the infra-structure reforms and has provoked the shortage of almost all basic maintenance materials and food [N: EM, 26/3/89].

At the Raul Soares and Galba Veloso hospitals, the acute political and economic crisis described generated a sharp decline in all activities, as seen in Figures 1,2 and 3, but particularly in the admission sector. The establishment of the Galba Veloso out-patient service precariously in 1987 (still a result of the previous administration) and in a more definitive way in 1988, produced a significant increase in the number of consultations, despite the constraints at the economic and political level.

Again, all the changes in the hospital output are clearly associated with the political and economic constraints mainly brought about by the new state administration, and particularly by the closure of the democratic space for the mental health movement.

b) Out-Patient Sector

Despite all the disruptions, the number of professionals integrated into the health centres network increased during the period, as following:

- in the state services, there was an increase of 44 new professionals, totaling 137 (36 psychiatrists, 62 psychologists and 39 social workers), working in 39 health centres (22 in Belo Horizonte, and another 17 in neighbouring municipalities)[A: DMS (1989) Quadro];
- among the Belo Horizonte local authority's services, 31 new professionals were contracted out or transferred, totaling 43 professionals[1] working in 19 health centres [I: Carneiro, 1989];
- no increase in the number of professionals of the INAMPS run services was reported. However, there was in 1987 the inauguration of new installations, substituting the old wooden buildings, improving sharply the comfort offered to users and staff [N: EM, 30/5/1987].

Therefore, the whole network could provide in 1989 the total of 232 professionals, for a population of 3 631 681 [2]. In a rough estimation, considering the proposed criteria for one complete mental health team for 50.000 inhabitants, this provision means a small deficit of 8 professional teams[3]. However, if other criteria are considered, such as

---

[1] Unfortunately, the specific number of each professionals was not provided.

[2] This is an estimate based on the urban population growth rate between 1986 and 1989 indicated by the IBGE (1988: 55) for Minas Gerais, considering as baseline the 1986 population indicated above.

[3] Although the actual proportion of each kind of professional was not available, some broad estimate is possible. Taking off the PAM Carlos Prates excess of psychiatrists, the whole area would show a rough average of 65 mental health teams, which is almost the parameter's

epidemiological data, actual attendance hours by each professional, geographical distribution, absence of information and adequate referral systems, efficiency and adequacy of the services, as to be discussed in the next chapters, this parameter is revealed highly unrealistic.

Even the increase in the number of professionals must be understood not as a deliberate decision by upper levels policy makers, but primarily as an indirect result of the crisis, mainly in the state network. Most of them arrived by transferring themselves from administrative posts in other statutory agencies, with lower wages, or from the health network in the interior of the state[1]. The only probable exception was the local municipality public examination that took place in 1986, still in the previous period, by which at least 10 new professionals were admitted in 1987 [I: Carneiro, 1989].

Summing up, in this period, the setbacks in the democratic popular struggle and the economic crisis produced great disruptions in the newly established outpatient sector. Even the increase in the number of professionals, which can be identified as an advance in the period, is much more an indirect and unplanned effect of the crisis and a voluntary political strategy by representatives of the mental health movement than the result of political decisions by the conservative forces in power.

---

ideal provision of 72.6 teams for this population.

[1] The move had been a personal option to upgrade their posts, wages or to improve their work location in a context of crisis. This was a strategy stimulated (at least for the former cases) by the municipality and the state mental health coordinations, still in the hands of the mental health movement members.

2.4.3.2. Qualitative Political Aspects of the Relationship between the Mental Health Movement and the Changes in Services

The relationship between the identified constraints to services and the political setbacks of the movement is historically obvious and convincing. However, at least one aspect of the process in this period deserves further analytic consideration: the mental health movement's 'new' group and its political proposals. Despite the absence of historical distance, it is already possible to identify at least some issues for further debate.

In my view, the group was able to make a fairly perspicacious analysis of the political context, to identify some of the main long term problems of the movement, and to propose quick changes. First, the group was able to realize the strategic issue in relation to hospital care, as stated by one of the main movement leaders in Rio de Janeiro:

> "Now, we've got not only a political crisis, but we're living also a theoretical crisis: what should be the Centro Psiquiátrico Pedro II as a care unit, what should the Colônia Juliano Moreira be? (..) Despite the existence of proposals, there is a crisis, we need to submit our proposals to a more rigorous critique, and we must do it ourselves" [I: Delgado, 1989].

Second, the group was able to recognize the limits of the political action restricted to the state apparatus and represented a clear attempt to gather support in the civil society.

Nevertheless, it is important to acknowledge some doubts when considering the newly adopted strategy. Even for sympathizers of the Italian Psichiatria Democratica proposals, it is possible to ask if the adoption of such a key word **alone** - the abolition of the asylum - is in accordance with the original Italian strategy[1] and

---

[1] A comparison with the Italian psychiatric reform will be provided in chapter 8.

appropriate in the present Brazilian context. The latter deserves further discussion here.

First, because it does not consider the particularities of the psychiatric hospital in a country with a large surplus workforce and where no basic social services and unemployment benefits are provided and probably will not be so for a reasonable period of time. With such structural features, the possibility of a systematic provision of alternative forms of out-patient care are very low. In addition, beyond its social control use, as indicated in chapter 2, the asylum is also appropriated by the most impoverished population as a refuge from social crisis and as a means to achieve social benefits.

Second, as demonstrated by Castel et al (1982) for the United States, in a context of radical privatization policies and attempts to accomplish hospital closures in a violent way, a discourse centred on the abolition of the asylum is easily reappropriated by such negligent political forces. This was actually the case of the Raul Soares and Galba Veloso hospitals: some of the participants of the mobilization against the closure of the former, reported having not understood why a movement against the asylums could mobilize them to defend the hospitals. The event shows that there has been a probable confusion between the formulation of strategic (final) and tactical (for a specific context) political agenda[1], which generally tends to isolate political movements to those in accordance with the final aims.

This point also recalls a third issue. Despite

---

[1] It is interesting to note that when suggesting the legal change in 1989, the proposal presented by the same group was inspired in the previous I South East Region Coordinators Meeting's platform, limiting their positions to the claim for no further settlement of new psychiatric beds in specialized hospitals.

attempting to provoke a rupture in the corporatist component of the movement and relinking it to the broader social movements and democratic campaigns, the discourse is only **negative**, not offering any **positive** alternative for the users and their families. Therefore, not addressing the caring aspect, such tactics do not consider them as valid interlocutors in the service planning, execution and evaluation, and dispenses with their political support. It might even invoke their opposition[1], isolating the movement and reinforcing its corporatist aspects.

Furthermore, from the point of view of the Institutional Analysis, this kind of negative discourse is frequently associated with specific stages of radical liberatory social imageries and group processes. They may initially have an attractive appeal and may perform an important role with their creativity in transgressing the status quo, but on the other hand have a strong component of unproductiveness[2].

After these notes, a step forward could be taken in order to gain a general overview of all the periods, checking in a broader way the main trends of the relationship between the changes in the democratic struggle

---

[1] The Italian experience shows, for example, how users and family groups can perform a very important political role in de-hospitalization policies (Giannichedda, 1989).

[2] As acknowledged by one of the leaders highly sympathetic to the new approach, who asked not to be identified at this point of the interview:

> "(...) the key words (towards a society without asylums) bring up a lot of passion; it was a passionate congress (...) it was anarchic and liberationist and had a strong collectivization of thoughts, and had no formal structure. (...) It got to produce good debates, but I don't know if one could say that it is quite a narcissistic group, it hasn't got to transmit this discussion to the movement (...) or (when getting to do it), to go beyond just transmitting it, with a lot of organizational problems".

and in service provision.

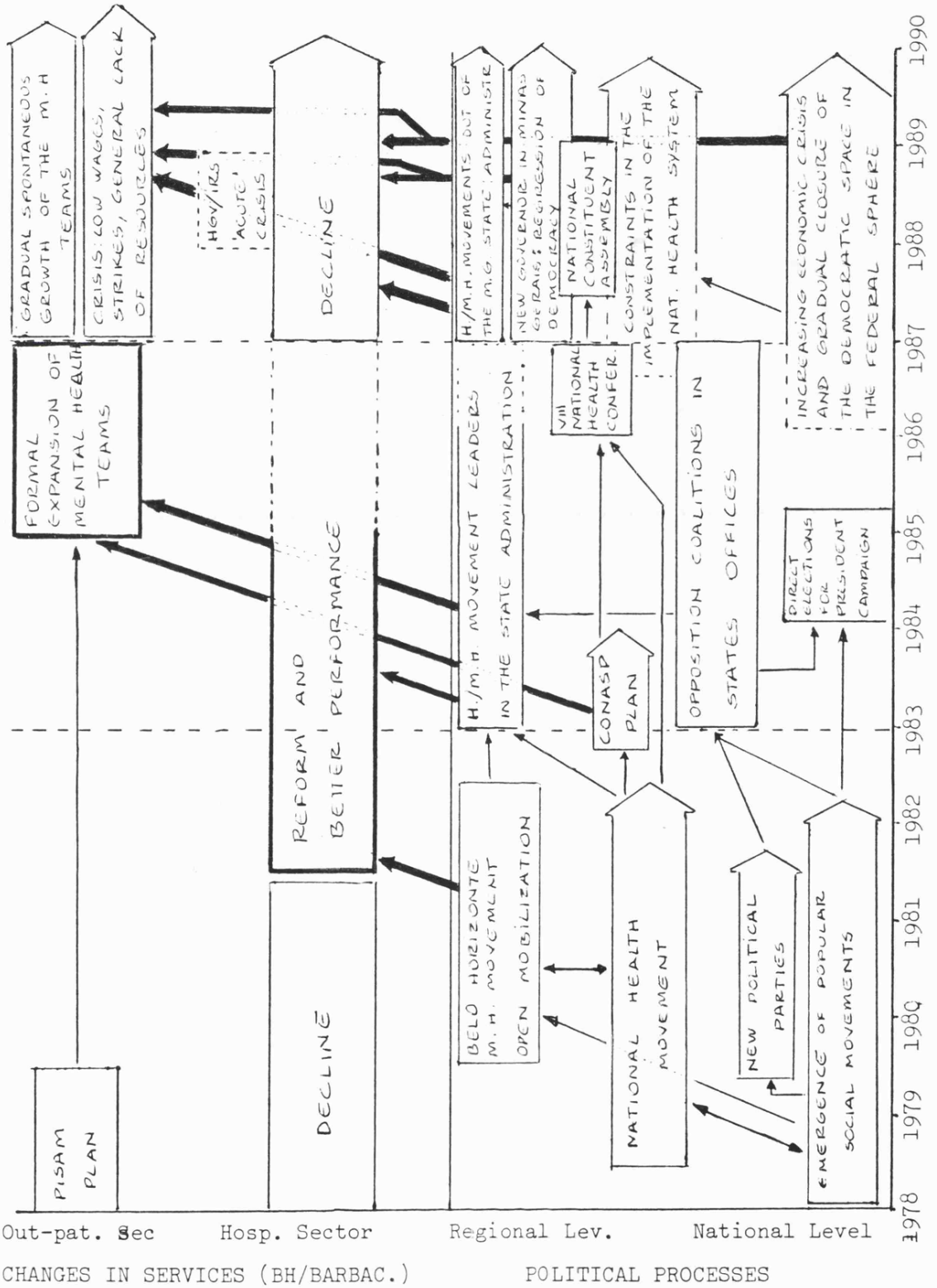
2.5. AN OVERVIEW ON THE HISTORICAL ASSOCIATION BETWEEN CHANGES IN SERVICE PROVISION AND THE DEMOCRATIC POPULAR STRUGGLE PROCESS IN BELO HORIZONTE

Diagram 2 is an attempt to provide an overview of the main processes during the period and, despite the inevitable oversimplifications, may be interesting for didactic purposes. The large arrows indicate the main proposed associations between the main immediate political processes and the changes in services. The bold boxes in the service sector account for the main events pushing forward the implementation of the reforms.

The time gaps between the events in the former and in the latter mean exactly the time needed for the movement of the changes from the political to the service spheres, suggesting an actual process of historical determination. However, this statement does not mean that these are the only determinants of the service events. I only means that the popular democratic forces, including particularly the health and mental health movements, constitute the main political actors responsible for the implementation of the psychiatric reform. Similarly, some of the qualitative limitations and weaknesses identified in the reform are also associated with specific features of the mental health movement.

An interesting suggestion now is to come back to the graphics provided in Figure 1, 2 and 3 above, and look at the general profile in the hospital sector output. They show exactly three different patterns of service provision, with two main cutting points: 1981 and 1985, being the period of greater change and reform implementation between the two dates. Comparatively, the main cycle of expansion of the out-patient service network comes a little bit later than in

Diagram 2: Historical Evolution of the Mental Health Services in Belo Horizonte - 1978/1989



the hospital sector, as the latter constituted the main target of the mobilization in the first period. In any way, the hospital sector also shows a similar movement and cycles of stagnation, development and crisis. Changes in both sectors correspond to a period of popular democratic mobilization or institutionalization in the region and country, and particularly of open mobilization or organization within the state agencies of the health and mental health movements.

After this detailed account of the Belo Horizonte case, it may be interesting to look briefly at the cases of Rio de Janeiro and Sao Paulo, in order to compare their main trends. This is the subject of the next section.

3. A CROSS-REGIONAL COMPARISON: THE CASES OF THE METROPOLITAN AREAS OF RIO DE JANEIRO AND SAO PAULO

3.1. RIO DE JANEIRO

3.1.1. An Overview of the Psychiatric Services in the Late 70s

As capital of the country until 1960, the city of Rio de Janeiro has concentrated a long established and complex network of health services, mainly provided by federal agencies (Geraldes, 1984), such as:

- those directly provided by the Ministry of Health, which owns three large traditional psychiatric hospitals: Centro Psiquiátrico Pedro II, Colônia Juliano Moreira and Hospital Pinel.
- those directly provided by the Ministry of the Social Insurance System (INAMPS), constituting 23 out-patient clinics (PAMs) with 269 psychiatrists and 6 psychologists in 1980.
- a large number of 10.000 beds contracted out by INAMPS in

50 private hospitals in 1980 (Duarte, 1982: 103-105).
- small services provided by the universities.
The services offered by the state and municipal authorities were not significant at the time.

If considering the metropolitan area, we would have to include three hospitals owned by the state in the neighbour city of Niterói (Carmo, Vargem Alegre and Jurujuba) would have to be included.

The overall picture in Rio was probably the best example of the basic features of the psychiatric system in the country already described in the previous chapter.

3.1.2. Periodization of the History or the Psychiatric Services in Rio de Janeiro

Mainly due to the heavy presence of the federal administration in the city, the history of the psychiatric services in Rio presents a dynamic and periodization different from those of Belo Horizonte and Sao Paulo, depending much more on the decisions taken in the central government than at the regional level.

In a very broad overview, the history of the psychiatric reform in Rio between 1978 and 1989 can be divided into the following periods[1]:

a) **1978/80: The Mobilization Period**

Given the strong emphasis on the services provided by the contracted out private sector and the oppressing conditions offered to their users, the mental health workers movement started its mobilization in 1978 by visiting with the press each one of those hospitals, in order to denounce

---

[1] This periodization was suggested initially by Delgado [I: 1989], one of the main leaders of the movement in Rio and at national level. Afterwards, it also seemed to fit well the analysis of the historical data from the city.

them [I: Delgado, 1989). Other aims of the denouncers were also the bad working conditions for mental health workers in all psychiatric hospitals (Delgado, 1982). The impact of the local mental health movement at the time was not comparable to the 1979 mobilization in Belo Horizonte. However, the national health movement certainly has had in Rio the country's strongest and most influential nucleus since the beginning, probably due to the concentration of federal public health organizations. It has had a very important role in the radicalization of the proposals for reforming the national health and mental health system from inside the Ministry of Health in this period, and later on also from the Ministry of Social Insurance System.

b) 1981/84: The 'Co-Management' Period - The Action Inside the Statutory Hospitals and Introduction of a Multiprofessional Approach

In 1980, the Health and Social Insurance System Ministries decided to administer the former's hospitals together, resulting in larger investments and in launching reform processes in each one. This step actually is considered to be a 'pilot' project which ended up in the national 1982 CONASP plan. Similarly to what happened in Minas Gerais and Sao Paulo after the 1982 governor elections, the event meant the opening of an important political space for members of the mental health movement to start the process of reaching the state service and administrative posts to promote changes from inside. This period witnessed a series of important changes in the system:

- a very rich process of reforms inside the hospitals, including: humanization of the infra-structure, administrative rationalization, introduction of multiprofessional teams and of out-patient services (external consultations, emergency, day-hospital) integrated

with other regionalized services in the city; democratization of the internal relations; rehabilitation, re-socialization and gradual de-hospitalization programmes for chronic residents; and creation of research, training and information units[1].

- the establishment of formal projects regionalizing all services in Rio and Niterói (Geraldes, 1984)[A: CCSM-Rio: Grupo de Trabalho (1983) Proposta], but working under several constraints, such as: the lack of a central coordination (Cerqueira, 1984), the strong role given to the hospitals in the system, even for out-patient services, and the lack of basic services in several regions [A: CCSM-Rio: Gonzalez (1984) Os Servicos: 4].
- the introduction of multiprofessional approaches in the hospital out-patient services and mainly at the INAMPS PAMs network, with special attention to group psychotherapy [A: CCSM-Rio: INAMPS-Rio (1981?) Anteprojeto] (Costa et al, 1984).

c) **1985/87: Bureaucratization of the Hospital Reforms and Organization of the Mental Health Service Network**

This period is identified as having a double face, according to the administrative links of the services, as following:

- under the Ministry of Health sphere, the reforms in the hospitals were confronted by the increasing closure of the democratic space and economic crisis in the central government, resulting in a strong process of bureaucratization and reversion of democratic achievements (Alves et al, 1984; Campos, 1986; Costa, 1989) [I: Delgado, 1989].

---

[1] For an overview on this process, see: Amarante, 1982; Brito, 1984; Camarinha, 1982, 1983, 1984; Cavalcante, 1983; Delgado, 1984; DINSAM/Colonia Juliano Moreira, 1982; Geraldes, 1982 and Massadar, 1982.

- under the state and INAMPS sphere, an agreement was signed in 1986, transferring partially the PAMs (INAMPS out-patient clinics) administration to the state, through the establishment of a mental health coordination [A: CCSM-Rio (1988) Relatório] [I: Amarante, 1989]. This clearly allowed a more integrated and coordinated network of services. There was also an extension of the services with the creation of several new out-patient units and the employment of new multiprofessional teams, including an attempt to decentralize them within the interior of the state [I: Ibidem].

d) **1988 onwards: Political Crisis in the Hospital Sector and in the Implementation of New Unified Health System**

This period is marked by the complete closure of the democratic space in the federal sphere, with very strong implications for the mental health field. First, an open intervention from the Ministry of Health changed the administration of the three hospitals in Rio. In the case of the Colônia Juliano Moreira, as residents and staff offered resistance, a military occupation was needed, with strong repercussions in the press (Leal, 1988). Within the state and INAMPS services network, a change in policy blocked the implementation of the new health system and the previously integrated administration, provoking serious setbacks in services [N: Proposta n.18, set/1989], despite the resistance from the mental health coordination. Additionally, the economic crisis has led to a sharp decrease in the wages of the personnel employed mainly by the state, generating strikes and other disruptions in services.

3.2. SÃO PAULO

3.2.1. An Overview of the Psychiatric Services in the Late 70s

The 'Big' Sao Paulo, as the metropolitan area is called, presented at the end of the seventies a very complex network of services in psychiatry, as following:

- unlike Rio, all statutory hospitals were provided by the state, constituting 4 units and 4155 beds (Vila Mariana, Agua Funda, Pinel, and Juqueri - the biggest, with 3500 beds) [A: CMS-ESP (1983) Sistema: 3];
- the state, despite under-funding their own hospitals, also contracted out private hospitals, providing 1780 beds in the Big Sao Paulo, and another 4960 in the interior of the state [Ibidem];
- some universities has their own general hospitals, including psychiatric wards inside them.
- additionally, the INAMPS also offered 5264 beds in contracted out private hospitals [A: CSM-ESP: MS/MPAS/SESSP/SHSMSP (1983) Programa: 3].
- in relation to out-patient services, INAMPS had 1 PAM specialized in psychiatry, and also contracted out few private clinics;
- in addition, there were at the time very few health centres provided by the state or local authority offering some kind of mental health service.

There were no systematic plans for out-patient services, despite a previous attempt in 1972, which was unsuccessful due to the opposition from the private hospital sector [A: CMS-ESP: Ferraz and Morais (1985) Política: 12]. The Mental Health Coordination was primarily, until 1982, an "actual cash till for paying psychiatric hospitals" (op cit: 13). The general picture of the system was basically as described in the previous chapter for the whole country.

3.2.2. Periodization of the History of the Psychiatric Services in São Paulo

Given the fact that most services are provided by the local state, its political evolution is very similar to that of Minas Gerais, and the history of the mental health field in São Paulo shows basically the same periodization marks as the latter, as below:

a) **1978/82: The Mobilization Period**

Probably due to the significant concentration of mental health workers and to the fact of being the political centre of the new emergent unionism in the country, the movement in the state was organized since the beginning as a very strong mental health workers movement, with a clear unionist and corporatist character. The main event was the First Mental Health Workers Meeting, held in 1979, with the participation of groups from other states (Rio and Bahia). A Front for the Defense of the Human Rights of the Mentally Ill People was also organized, but with a short life (Hegenberg and Lancman, 1987: 6-16). There was at least one initiative from the official side that is worth citing, the employment and training of 14 mental health teams (psychiatrists, psychologists and social workers) to work in health centres in the city, in 1979/1980 [A: CSM-ESP (1981) Relatorio].
At the end of 1982, there were 11 specialized mental health clinics ('ambulatorios') and 19 health centres had professionals of the field [A: CSM-ESP: Ferraz and Morais, op cit: 15).

b) **1983/86: Action Inside the State and Implementation of the Mental Health Programme**

Similarly to the Minas Gerais process, the new opposition governor who assumed office in 1983, supported by a large spectrum of democratic forces, gathered in his administration team leaders of the mental health workers movement and influential specialists, proposing a broad programme in the field. The changes implemented were:

- a comprehensive regionalization and integration programme for all services in the metropolitan area, according to the guidelines of the CONASP plan [A: CSM-ESP: MS/MPAS/SESSP/SHSMSP (1983) Programa].
- despite just a small increase in the proportion of financial resources allocated to this sector (from 5 to 7%)[A: CSM-SP: Ferraz and Morais, op cit: 14], there was a significant expansion of the out-patient service network[1]. Special programmes were established for target groups (alcoholism, epilepsy, neurosis, children and youngsters, and a special one on psychosis and discharged people, called Maximum Intensity Programme ('PIM') [I: Souza EN, 1989].
- a reform project for the Juqueri hospital was set, improving the infra-structure and expanding the human resources, with emphasis on social and occupational therapies and sheltered accommodation [A: CSM-ESP: Ferraz and Morais, op cit: 17-18]. There was a reduction in the number of beds in the statutory hospitals (less 427 beds) [A: CIS-SP] and no expansion in the number of contracted out private beds (Hegelberg and Lancman, 1987: 21).
- a programme of training and supervision was launched, by contracting out several university organizations.

During the period, the mental health workers movement had a relative demobilization, reappearing in 1986 in the self organized II State of São Paulo Mental Health Workers Congress (II Congr. de Trab. de SM do ESP, 1986). By this

---

[1] The number of health centres with activities in mental health was raised from 19 to 47, and of mental health clinics from 11 to 22. The latter had their professional scope broadened and the average team generally includes 5 psychiatrists, 3 psychologists, 3 social workers, 1 nurse, 1 occupational therapist, 1 language therapist and auxiliary staff. 6 new 24-hour emergence services were also settled in this period [A: CSM-ESP(1986) Relatório] and a very interesting and careful pilot experience of day-hospital was open in the heart of the city (Centre for Psycho-Social Care - CAPS).

time, another interesting event happening in the field was the emergence of popular health movements. Based mainly on district associations, they have claimed participation in the local services, including mental health. Probably the most important has been the East Zone of São Paulo Health Movement.

c) **1987 onwards: Crisis and Hope**

The new governor who assumed power in 1987 introduced a process of political reversal in the mental health programme and in the democratization of the services. No new clinics were created, and at the existing ones, there was a process of de-stabilization and of political persecution of the main leaders of the mental health movement. Furthermore, new private hospitals were contracted out and the reforms inside the statutory hospitals were blocked[1]. However, some hope could be seen already in 1989 with the then newly elected city mayor from the Workers Party (PT), the main popular democratic party in the country. The programme's new coordination was formed mainly with leaders and participants of the mental health workers movement. In addition to the support to the already established general principles being set since 1983, new proposals started to be implemented, such as:

- emergency services and admissions should be undertaken primarily in psychiatric wards in general hospitals;
- establishment of day-hospitals and of interesting "socializing and cooperative centres" ('centros de convivencia e cooperativa'), to be set up in parks and sports areas, with ecological, cultural, occupational, sports and working schemes, with participation of the user's

---

[1] For a more detailed view on this process, see: Cesarino, 1989; Yasui, 1989; [A: CSM-SP: I Enc. Est. Ambul. SP (1988) Texto]; [I: Souza EN, 1989]; [N: FSP, 25/10 and 10/11/87; ESP, 27/4/88; Jornal do CRM-SP, Jun 88].

families and the population in general;
- a proposal for gradual de-hospitalization of chronic cases, with the creation of sheltered residential units within the city area;
- to promote changes in the municipal legislation on mental health, which has been achieved in 1990;
- popular education in mental health, in order to "demystify madness and mental illness, and discuss their social determinants", with emphasis on the stigma and implications of the working environments [A: APSM-SMSSP (1989) Diretrizes: 1-2][1].

3.3. BRIEF COMPARATIVE ANALYSIS OF THE THREE CASES

From what can be seen in the historical narratives, all the cases present similar patterns of change:
- a first cycle of stagnation in the services and open mobilization of the health and mental health movement;
- a second cycle of changes and reform produced mainly from inside the state agencies with a strong role performed by those movements, coinciding with the main period of democratic institutionalization changes in the country;
- a third cycle of reversion in the achievements, overlapping with a major period of economic and political crisis and closure of the space to the democratic forces in the national level.

Even though there are also some important regional differences, they do not obscure the general trend for association between the main historical changes and the internal reform dependence on the mobilization and organization of the popular democratic forces, particularly

---

[1] For further reading on the whole set of proposals: [A: APSM-SMSSP (1989) Esboco; (1989) Educacao; (1989) Para Compreender; (1989)Programa].

the health and mental health movement. **Therefore, the chapter's hypothesis, which was confirmed for the Belo Horizonte case, can clearly be generalized to the other two cases.**

After all, in an authoritarian Third World country with a strong tradition of hospital centred psychiatric care and with a strongly organized lobby of private hospitals extremely dependent on the state resources like Brazil, the **reform's sensitivity and direct dependence on the political context is quite understandable.** Perhaps given the closure of the political life during the military period, the country has witnessed since the mid 60s a clear polarization in the political actors spectrum in this field: the private hospital lobby and their traditionally allied administrators, and alternatively, the health and mental health movements and their 'tentacles' in the state administrations, mainly after 1978. A broader differentiation in the political options would require a longer period of democratic life[1].

On the other hand, a political polarization like this implies serious difficulties when the issue of alternative policies in a context of state crisis is addressed. The debate on statutory versus private provisions is also too polarized, and the only alternative to statutory services is generally seen in terms of returning to the old order of unchallenged emphasis on private hospital care. Furthermore, in the absence of other political actors, like the users and other potential perspectives, the limitations of the mental health movement are not confronted. The debate on issues like corporatist and bureaucratic interests, the inadequacy and inefficiency of the statutory services do not find other

---

[1] An example of such a process of political diversification going on under a democratic rule was the 1987 first important split in the movement, generating a critique of the previous period's performance.

political interlocutors. These constitute questions to be discussed further in the next chapters.

The reform is also sensitive to economic problems in all cases, such as those generated by the economic depression, financial hardship of the state, lack of basic material and training, professionals' low wages and consequent strikes. Even so, the political component seems to be probably stronger than the economic one. A good example is the São Paulo case, where during the expansion period just a change of 2% in the mental health budget produced a significant improvement in the out-patient sector. Perhaps the economic crisis has more dramatic implications in poorer cases like Belo Horizonte, where the expansion of the out-patient network had to wait for at least 3 years until resources from the INAMPS started to be driven in, in 1985, in a political context still in favour of the proposed changes.

After all these common aspects, it may also be interesting to look at the differences among the three cases. First, in the case of Rio, probably given the strong federal presence, the bureaucratic tradition of the city, and the kind of political orientation hegemonic in the health movement[1], the initial mobilization of the latter targeted predominantly the occupation of the space inside the state, particularly the Ministry of Health, which was at the time already receptive to this presence. These probably may explain why the changes in Rio preceded at least two years those in São Paulo and Belo Horizonte, which depended much more on the political changes in each state government.

---

[1] There is a widespread recognition of the hegemonic presence of the Brazilian Communist Party in the health movement in Rio, with its tradition of emphasis on action inside the state apparatus. However, the local mental health movement had a different hegemonic political orientation, more sympathetic to the Worker's Party, what generated some conflicts between the two movements [I: Delgado, 1989].

This also highlights how the federal level could induce changes from the top, as in the case of the CONASP plan. In turn, Belo Horizonte started the process with a more genuine public opinion mobilization, based on a broader coalition of political actors, with more immediate repercussions in the national scenario. In the case of São Paulo, the character was clearly more unionist.

In the second place, it is interesting to see that in two cases (Rio and Belo Horizonte), the changes started by reforming the psychiatric hospitals, and the out-patient network was focused some years later. On the contrary, in Sao Paulo the two processes were simultaneous, and the emphasis on alternative out-patient services was clear since the beginning. This is probably due to a specific orientation by the regional administration and to the lack of large statutory hospitals within the city area.

Perhaps for these reasons and for the wealthier status of the city, São Paulo also accounts for a more advanced stage in the implementation of intermediary out-patient services, like day-hospitals, emergency units, specialized clinics, special programmes for target groups, particularly the Maximum Intensity Programme. The new proposals by the then new local authority there are extremely innovative and clearly based on a clearer conceptualization of popular participation, inspired both in the regional experience of social movements and in the Italian Psichiatria Democratica tradition. Finally, São Paulo also presents an older and more structured administrative body in the field, with a much more developed information service.

4. CONCLUSIONS

Summing up, it is possible to reaffirm for the psychiatric field the hypothesis posed by Paim (1986) for the general health system: if the former was left in the

hands of the traditional state bureaucracies hitherto in power, their allied contracted out private sector and the available political actors until 1978, such reform would constitute at most a rationalization or cost saving one, keeping the same hospital centred model. Therefore, in the Belo Horizonte case, and the provided evidence on the Rio and São Paulo cases also points in the same direction, **the hypothesis proposed in the beginning of this chapter is confirmed. There is a historical association between the rhythm and features of psychiatric reform implementation and the advances, setbacks and characteristics of the popular democratic forces.**

Furthermore, it is also possible to conclude for the Brazilian case:

- the correctness of Basaglia's insight, when suggesting that actual advances in the struggle against the oppressive features of psychiatry are necessarily and intimately linked up with the advance in the general democratic struggle.
- that in the Third World context of political authoritarianism, structural poverty, lack of basic social services and of crisis of statutory welfare provision like in Brazil, the democratic struggle for alternatives to the psychiatric hospital is comparatively more complex and difficult.
- that, similar to other fields in the Brazilian context, the popular democratic coalition, particularly the health and mental health movements, have been the main political force to push forward the changes in the psychiatric field.
- that in addition to other economic and political factors, the social and historical limitations of the mental health workers[1] - as the main political actor of the mental health

---

[1] Such as their conceptual weakness, the strong corporatist interests and the hospital centred hegemonic culture.

movement - have also cast the extension and qualitative features of the achievements of the psychiatric reform.

. . .

Now, after this overview on the general historical process of changes, the focus will be narrowed to highlight the specific features of the new community mental health service network. This is the subject of the following chapters.

Chapter 4

THE HEGEMONIC SERVICE MODELS AND THE HIERARCHIZATION OF THE CLIENTELE

1. INTRODUCTION

This chapter will discuss the following hypothesis:

Hypothesis II

The hegemonic model of mental health services being planned and provided throughout the health centre network in Belo Horizonte has induced a process of selection and hierarchization of the clientele amongst the types of services being implemented, in terms of:

a) geographical origin and cultural background,

b) formal education,

c) income and working status,

d) clinical status and previous treatment history.

The analysis will be divided into three main parts. In the first, it will deal with the in-put element of the hypothesis, attempting to describe the hegemonic model of mental health services being implemented throughout the health centre network in Belo Horizonte. Funding, local infra-structure, medicine provision and human resources policies will constitute the subject of the first sub-section. The next step will be a description of the main professional models being implemented. This will include an analysis of the hegemonic trends of the professional cultures in Belo Horizonte, of the programme organization features and its political and technical orientation. The second section will then address the above hypothesized topic evaluating the service out-put in terms of care

provided in the two case studies at the Lindea and Sao Paulo districts. Finally, a third part will attempt to address the conditions for generalizing the results from the two cases to the whole network.

2. GENERAL RESOURCES AND HEGEMONIC MODEL OF MENTAL HEALTH SERVICES IN BELO HORIZONTE

2.1. RESOURCES BEING PROVIDED

2.1.1. Financial Aspects

The mental health programme in Minas Gerais does not have an administrative and financial autonomy. The existing specific coordinating bodies in the state and municipality are not even formally acknowledged in the organizational structure, nor have any resources to be invested directly. Besides, they are placed among other technical advisory bodies, without formal executive powers [I: Passos, 1989][I: Carneiro, 1989]. Moreover, there are no specifications of financial resources for each of the included programmes, and therefore it is not possible to assess the amount directed specifically to the mental health one. Even so, the whole budget for the health sector in the state was not publicly available at the time of the fieldwork, and there seems to be political problems surrounding the issue[1].

Thus, the only way of making a rough assessment of the

---

[1] After the CONASP plan (1982), resources from the INAMPS started to be transferred to the state run health services. As denounced by the health sector civil servants' trade union, the Minas Gerais government has taken advantage of the federal flow by decreasing its participation in the sector, even being illegal. As an example, from 3.5% of the state general budget directed to the health sector in 1986, just 0.79% was offered in the 1989 budget proposal (I Congresso dos Trab. de Saúde - MG, 1989: 20).

evolution of the resources invested in the programme is to trace the evolution of the number of professionals included, as in the previous chapter. However, this does not mean a clear budget decision on the provision for the programme, as this number is much more a result of informal negotiations during wider recruitment processes for the whole health service network.

In the same way, all applications for special expenses (apart from wages) have to be negotiated to be included in the general network budget, competing with other programmes' priorities. After this, they are taken to the central financial bodies for approval and finally have the resources freed. This process generally takes a minimum of 6 months [I: Carneiro, 1989].

The implications of such a structure in a context of high inflation rates and fiscal crisis at all state levels, especially in Minas Gerais and Belo Horizonte, is disastrous. Besides all the bureaucratic difficulties to achieve approval and the waste of time, in most cases the values are not updated. Therefore, when the resources are freed they do not cover the planned cost.

The final result of this is a programme that practically relies only on the payment of the professionals wages and on a very unreliable and insufficient provision of psychoactive drugs. All other items, such as basic material and transport, must be obtained within the general resources already available for all the administration. Special resources for specific reforms in the infra-structure, training, research, supervision, contacts with other

experiences, etc, are practically impossible to obtain[1]. At times, they may be funded by other sources, such as the professionals or the community's own money; or must be produced with the available human resources. As a consequence of such conditions, the efficiency of the resources already invested in wages is very low. Moreover, this system blocks innovation, which would require quick management of resources, particularly in mental health care, as strongly dependent on human resources, training and supervision. The consequences of this situation and the specific features of the human resources and training policies, as well as the programme organizational structure will be evaluated separately in the next sections.

2.1.2. Local Infra-Structure

Very few health centre facilities were built directly for this purpose, and most of them are not even state owned buildings. A significant number of them are normal let houses, poorly adapted to function as such. The direct observation of several of them indicates that the average

---

[1] There are numerous examples. The supervisors at the metropolitan area coordination (DMS-MG) complained that the programme has had no materials such as paper, basic furniture like table and chairs, and toys (for child therapy). In December 1989, they were still waiting for a list of basic material sent to the financial bodies 11 months before [I: Souza, 1989]. Even light expenses like stamps or aerograms to re-contact clients are impossible to be funded [I: Siqueira, 1989]. The administrator of the Sao Paulo district health centre indicated the strategy adopted to keep the centre functioning as follows:

> "In relation to money, there is none. The mayor, in order to rationalize costs, cut everything. There is no money to buy anything. If you want to get something, you have to be at the municipality central storehouse everyday, in the morning and in the afternoon. The day there is any surplus, you are there and order it first. If you don't order, you lose it" [I: Melo, 1989].

facilities are badly equipped and not appropriate. The lack of enough rooms for all the activities to take place is the rule.

With the introduction of the mental health programme, the majority of the professional teams were placed within this service network in the second stage, without a compatible investment to expand or adapt the facilities. This meant their having to negotiate their space and to compete with the other normal activities of a general health centre. The most common result is the lack of rooms. Professionals are very often found providing consultations in the health centre storehouses, among the equipment in the gynaecologist's, dentist's or minor injury rooms [I: Souza MDC, 1989]. This is particularly disruptive for mental health activities, not only by offering an environment that can induce anxiety to already distressed users, but also as most of the rooms do not offer the minimum of sound isolation. Professionals working in several health centres have complained that it is distressing for users to report clearly their problems when they know that relatives or other known people might be listening behind the door.

The comfort offered to the users is also generally poor. It is usual to find centres where clients waiting for a consultation have to stand, maybe even for hours, due to the lack of sufficient chairs in the waiting places. Sometimes the complaints also address the cleaning of common areas and of the toilets.

In addition, most of the centres would have very few facilities to act in case of psychiatric emergency. Despite the common existence of minor injury rooms which could shelter temporarily a case of crisis, several constraints can be shown:

- the lack of medicines is frequent, as will be shown in the next sub-section;
- the psychiatrists tend to remain much less than the

proposed working day of four hours;

- there is no transport system when hospitalization is needed;
- there is no specific training for emergency procedures.

The São Paulo and Lindea district health centres are good examples of what has been said for the whole network. The former is situated in facilities built as a social centre and constitutes one of the largest health centres in the municipality network. There is only one room specifically reserved for a mental health team with 8 professionals providing consultations in three shifts during the daytime. They have to actually compete with other health professionals to find a room, using alternatively the latter's rooms and sometimes even an auditorium. The situation is described by the administrator:

> "Sometimes three practitioners arrive at the same time (...) the problem is all related to space, as the room available is small and everybody concentrates at the same attendance hours, and this is terrible. We had a better shift system before, but now they (the professionals) earn badly, have several employments and how can I ask then to attend at a different time?" [I: Melo, 1989].

The rooms are not prepared for the mental health programme, and professionals complain that the clients' speech can be clearly heard by the people waiting at the internal corridor [I: Cansado, 1989]. There are only two large benches available to the clients there. The corridor is vulnerable to the hot sun during all of the year and to the wind and constant rain for at least three months of the year. Even pregnant women were seen standing while waiting for a consultation. The general cleaning in all common areas was frequently bad during the fieldwork time, mainly in the toilets, and rats were seen around.

The Lindea case has some special features. The mental health team is situated at a normal house owned by the local

Psychology Community Association (the history of which will be outlined in chapter 6). Enough rooms are available, but the lack of proper waiting facilities and of administrative staff, the sound problem, and cleaning are the main visible problems.

The users opinions on these issues were sought in the questionnaire. Comparatively, the SPd facilities were given a better general infra-structure evaluation, and the users' views on specific problems tended to coincide with the above provided description based on direct observation.

2.1.3. Medicine Provision

The distribution of psychoactive drugs to the health centre network has been a constant problem, and has deteriorated further since 1987, mainly in the state run services [A: DMS (1989) Programa]:

> "The main problems we have been facing in the last years in relation to medicines are linked to central provision and distribution: the non-periodical quota provision by the (state) Secretariat of Health to the Metropolitan Directorate of Health was extremely accentuated in 1987. Furthermore, due to several problems in the our storehouse, the distribution to the health centres has been very irregular" [A: DMS (1988) Atividades: 2].

One of the supervisors of the state run metropolitan network described the situation as:

> "Angelica and I have been assuming the medicine provision for a while. It is a mess. There isn't enough (for all services), and we are trying to do a more consistent job, setting quotas for the health centres, (...) but we have no autonomy in the field (...). Besides, the amount is very small, not enough for the quota period of three months" [I: Souza MDC, 1989].

Another supervisor suggested that the distribution has not taken into account the local needs, citing some cases of health centres without mental health teams, where psychoactive drugs were found in surplus and exceeding the

expiry dates. He also described some problems in the health centres themselves, as underground selling or direct use by the staff [I: Akerman, 1989]. In addition, the data on medicine provision to the network has been also in such a mess that no assessment of periodicity and amount sent is possible. As an illustration of the state network situation, no medicines were provided to the mental health team at the Lindea district centre during several months of regular visits for the fieldwork.

In the municipality run services, the situation is a little better. At least the minimum quota is maintained [I: Carneiro, 1989]. Even so, at the São Paulo district health centre the local administrator indicates that, without the strategies of going everyday to the central storehouse or exchanging surplus packs within the other centres, there is no way of keeping the local provision [I: Melo, 1989].

2.1.4. Human Resources Policies

An initial idea of the main problems in relation to human resources is provided by the Health Sector Civil Servants' Trade Union, indicating its view of the main problems concerning the situation of their workers during the last few years:

- lack of wage parity. As several statutory agencies have been integrated into the new health service, big differences in the salary levels and employment schemes persist, up to a point that the state wages could have been six times lower than those for a similar post in federal agencies;
- a big concentration of workers in the bureaucratic posts, and a lack of them in the direct service provision, and no stimulus for those working in peripheral areas;
- admissions without public examination, by political means, and political persecution of those identified with the popular concern;

- lack of training policy;
- sharp devaluation of the wages (I Congr. Trab. Saude - MG, 1989: 22).

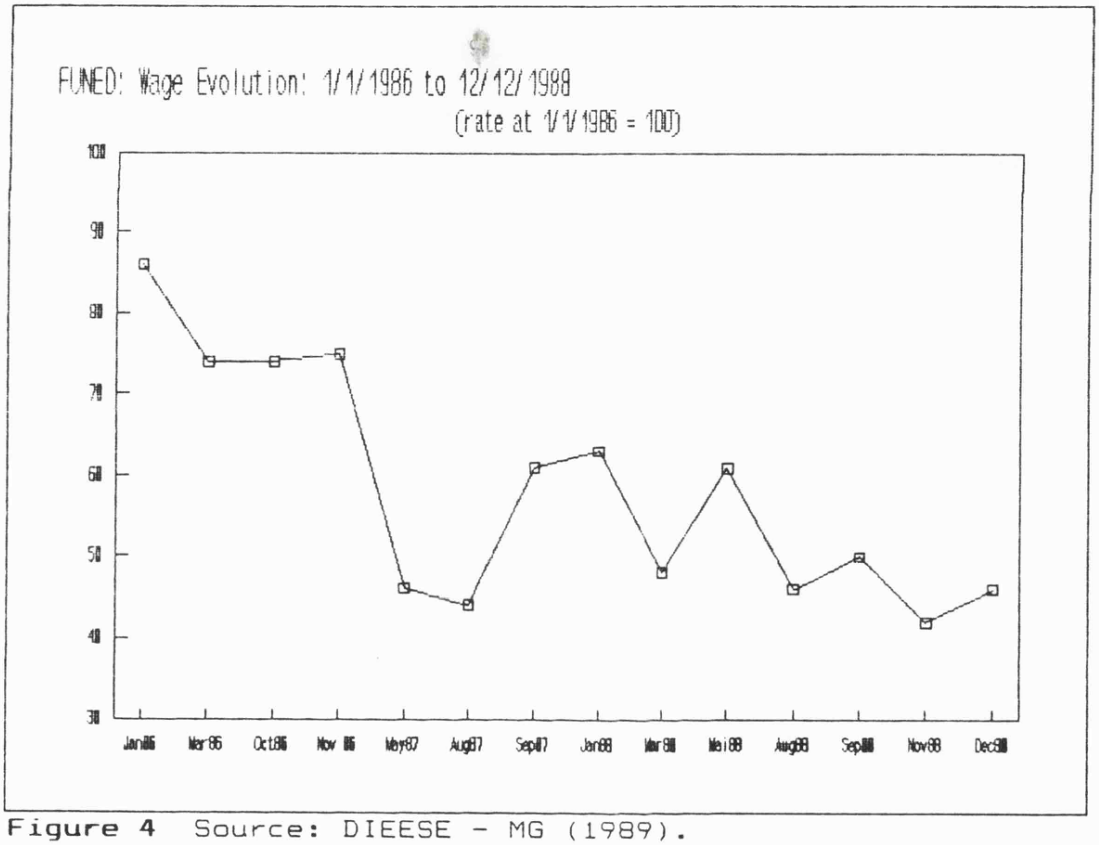


Figure 4 Source: DIEESE - MG (1989).

Figure 4 shows the recent evolution of the wages in the main state organization in the health sector (FUNED). The wages fell sharply after 1986 through updating rates below the inflation rate, producing losses of almost 60% in just

17 months (Jan/86 to May/87, for example)[1].

The implications of such a situation for the services are wide, from losses of the best professionals, over-employment[2], dissatisfaction and lack of motivation of all staff, to open disruptions like constant strikes and less work performed[3]. Most of the interviewed professionals also stated that there is apparently no impairment in the commitment to the clients directly during the consultations, but low wages affect all remaining activities[4].

---

[1] For comparative purposes, one of the professionals at the São Paulo district produced the following estimation: with his monthly wage there in November 1989, he could buy three good paperback books. When comparing the earnings from the private practice during the initial stages of their career, a psychologist charging a low price for each consultation would receive the same amount of money after 20 consultations. In other words, the payment made by five clients having just one session per week would be equivalent to the monthly wage a psychologist would get from the state for working journey of 20 hours per week.

[2] This process has been happening since the 70s. In 1970, 36.8% of all doctors in the country had worked for more than 50 hours per week, while in 1980 the figure increased to 46.2%. In consequence, 78,1% of all medical posts in 1980 were not full time (Medici, 1986: 411).

[3] For example, after July 1989, workers of the state network were working for only 4 days a week, due to an agreement between the administration and workers in the last wage updating negotiation, as an informal compensation for salary losses [I: Silveira, 1989]. Professionals estimated that between 1987 and 1989, one third of all potential working hours were wasted in the constant strikes.

[4] As suggested by one of the state coordinators and also a psychiatrist at the São Paulo district health centre until November 1989:

> "Out of the strike, what happens is a lower level of commitment to the organization. When consulting a client, we do it in the same way, independently of wage or whatsoever. (...) However, your availability in terms of the number of clients, or of the commitment to the organization of your work, or to the team work, are lowered down all together" [I: Passos, 1989].

In conclusion, some coordinators commented that the situation has produced a kind of organizational anarchy, by which it is difficult to impose basic working rules, supervision and/or production requirements [I: Souza MDC, 1989; Melo, 1989; Lauar, 1989]. From the professionals point of view, as there is no reciprocity from the administration in relation to their commitment and work performed, it is very common to hear statements like:

> "They know they pay us very badly indeed, so they can't claim or order anything".

2.2. HEGEMONIC PROFESSIONAL MODELS IN THE SERVICE NETWORK

The features of the professional models being implemented within the mental health program in Belo Horizonte are determined by several components, including:
- the current professional cultures in the training bodies, professional market and corporative organizations in the region;
- the organizational features of the programme, some of the main ones described above;
- the deliberate orientation assumed by the regional programme coordinations, through the major plan proposals, and the recruitment, training, and supervision mechanisms.
Each of these components will be looked at below, and a view of the two case studies offered as examples.

2.2.1. The Regional Professional Cultures[1]

2.2.1.1. The Psychiatrists

The main sources of professional training in Belo Horizonte are constituted by two schools of Medicine (one of them in the Federal University of Minas Gerais) and the Raul Soares Hospital Residence in Psychiatry. All of them locate their teaching units at psychiatric hospitals, where the out-patient services have a secondary role. Francisco Barreto, one of the mental health movement leaders and having a long experience in psychiatric training, describes the features of the two universities courses:

> "The feature of this psychiatry is exactly the lack of profile. (...) I wouldn't say it is a traditional psychiatry, because it is not even a consistent traditional one; on the contrary, it is shapeless ('amorfa'). (...) People there have a very diversified and heterogeneous formation, and do not constitute any trend. There were people following the American psychiatry of Meyer, others followed the classical German psychiatry, some others followed the psychoanalysis of the IPA, and others the American social psychiatry. There are people of all kinds, not constituting any expressive trend. They may be characterized by the lack and negligence" [I: Barreto, 1989].

The only statutory post-graduate training unit in

---

[1] The standard mental health team for a basic health centre is formed by one psychiatrist, one psychologist and one social worker. In the Brazilian health sector, the literature has pointed out a long standing trend since its expansion in the 60s for a polarization of the labour market: the doctors and poorly qualified auxiliary staff ('atendentes', 'auxiliares de enfermagem') constitute the two biggest categories. In the 80's, there was an effort to train the latter, achieving intermediary educational levels, and for contracting new multiprofessional teams. However, given the still over-supply of cheap auxiliary staff, graduated nurses are rare in the health sector and concentrated in the hospital sector. The most common situation is to have one or two graduated nurses per ward, training and coordinating a large team of auxiliary personnel (Girardi, 1986; Campos, 1986; Medici, 1986).

psychiatry in the state was located initially at the Galba Veloso Hospital Residence, and later on transferred to the Raul Soares Hospital. It is possible to describe the mainstream features of formation in psychiatry there following the comments by Simone, one of the movement leaders and former director of the latter in the late 70s:

> "There we had witnessed a constant dichotomy between being psychoanalyst in the private clinic, and to be organicist in the psychiatric hospitals. And in all hospitals we saw mainly the phenomenological psychiatry of Karl Jaspers, or with some influence from Spanish psychiatrists like Alonso Fernandes" [I: Simone, 1987].

During the 80s, the influence from psychoanalysis, mainly the Lacanian, has grown considerably. Belo Horizonte has been identified recently among professionals in other big cities in the country as the 'strongest nucleus of the Lacanian orthodoxy'. The process reached the main organizations in psychiatry, and the analytic discourse became without any doubt the fashion in the professional culture. However, when focusing on the practice being performed inside the hospitals and out-patient services, the dichotomy suggested by Simone is clearly the main pattern [I: Campos, 1989].

The information provided in 1989 by the program supervisors on the psychiatrists working in the state run service network confirms the statement. 50.0% of the known cases (n=22 and N=36)[1] had had training in psychoanalysis. Regarding the kind of practice being accomplished, 45.1% of the known cases provide traditional clinical psychiatric care, 36,4% are offering the latter but also mixing it with some kind of psychoanalytic approach, and no known cases were reported for exclusive psychoanalytic practice. In total, **despite the increasing diffusion of psychoanalysis within their professional culture, there seems to be a strong pressure from the clients' demands and from the division of labour within the mental health team for**

---

1 Throughout this chapter, the number of professionals for whom information was available is denoted by **n=**; the total number of professionals working within any given professional group is denoted by **N=**.

psychiatrists to perform the traditional clinical and drug therapy approaches.

2.2.1.2. The Psychologists

Psychology is a very young profession in Brazil, as it was legally acknowledged at the national level in 1962, which also marked the starting-point of the recognition of the first university courses in the field. Before that, it existed only as isolated disciplines in Philosophy, Social Sciences and Pedagogy courses, or specialized non-university courses in Organizational Management Psychology (Pessoti, 1988).

The private clinic and individual treatment model is the most attractive and hegemonic among the professionals, the university and non-academic courses, and among the students in the whole country[1]. The hegemony of psychoanalysis as main theoretical approach is undoubted[2], more emphatically in the late 70s, with the same features already indicated for the psychiatric field. The state of

---

[1] In a national inquiry conducted by the Federal Council of Psychologists published in 1988, the results show that 60.7% of all registered professionals work as clinicians and 55.3% have the clinic as the main job. The area is considered the most attractive, despite open signs of market saturation (Bastos, 1988: 174-191). The same research inquired on the models of clinical practice, and concluded that there has been a "hegemonic trend among the psychologists for a private, clinical and individualizing professional practice" (Sass, 1988: 215).

[2] By the same inquiry, the psychoanalysis is the main approach for the professionals in the country, with 37.1% of all indications, in all areas of work: 55.7% among the clinicians, 30.9% among the educational psychologists and 22.0% among those working in the organizational area. Among the clinicians, the psychoanalysis is followed respectively by the phenomenology, gestalt, and finally, the psychodrama and the humanistic approaches alternate themselves according to the different regions, at the 4th and 5th positions (Bastos and Gomide, 1989: 10-11).

Minas Gerais witnesses a similar profile.

In an isolated process, there has been an attempt since the mid 70s to introduce the discipline and practice of Community Psychology in all four Psychology degree courses in the city. In the main one, at the Federal University of Minas Gerais, there has been a probation programme for some of the students, held at the statutory out-patient services within the health centre network.

Again, the information gathered from the mental health programme supervisors supports this general outline. Among the psychologists working in the state network, 50.0% of the known cases (n=40; N=62) had had training in psychoanalysis, and 50.0% in other approaches; 45.0% are actually using psychoanalytic techniques, 47.5% other psychotherapeutic methods and 7.5% community approaches.

2.2.1.3. Social Workers

Compared to psychology, social work has a more complex history in Brazil. The first schools were founded in the 30s and 40s (Alayon, 1982: 22), under the influence of the Catholic Church. Ander-Egg identifies three periods in the social work professional culture history in Latin America:

- 1925/1940: a pre-professional period, dominated by a philanthropic ('benefico-assistencial') and paramedical and/or para-juridical characters.
- 1940/1965: an already professional period, dominated by two main views: first, an 'aseptic-technocratic' ('aseptico-tecnocratica') one, inspired in European and North American models; second, a developmental ('desarrollista') conceptualization, under the influence of the CEPAL studies, aiming at the integration and participation of the poor ('marginados') in development projects.
- 1965 onwards: This is called the 'reconceptualization' period, dominated by consciousness raising and revolutionary approaches, mainly inspired by Marxist theories, with major

emphasis on community work (Ander-Egg, 1984: 249-280).

The 'reconceptualization' process had one of its main locus the social work course at the Catholic University of Minas Gerais, in Belo Horizonte, the only source for professional training in the region. There, as already indicated, the main theoretical approach has been inspired by the Marxist theories. There is no specific training whatsoever in psychiatric social work, although some opportunities to have probationary periods in psychiatric services are available to the students, without proper supervision[1]. However, an optional discipline and a private course on systemic approach to family care is available.

Recently, there has been a process of revision and criticism of the reconceptualization concepts, still under the hegemony of Marxist approaches. Among those professionals working in the psychiatric field, the influence of psychoanalysis has been strong, and some of them have already identified themselves as doing psychoanalytic work. Within the state owned network, supervisors indicate that among the social workers, 22.2% of the known cases (n=18, N=39) have their practice at least influenced by psychoanalysis; 33.3% are using systemic techniques and 44.4% use other approaches.

2.2.2. The Organizational Features of the Programme

The previously described financial features of the programme have some effect on the service model being offered. The first refers to the kind of professional being attracted to it. Given the over supply and concentration of professionals in the big cities in a context of decreasing demand mainly due to the economic crisis, the statutory

---

[1] The author has been actually a lecturer on Social Policies in this course since 1982.

services can still recruit professionals. In 1986, when the only public examination was held to select the professionals to the Belo Horizonte metropolitan area, the wages were still attractive and thousands submitted to the test. However, with the salary devaluation, a selection process has been going on. It is possible to say that the average profile of the professionals is: young, with some idealism, at the initial stages of the career, with at least one additional activity (mainly a private clinic), and investing in the professional formation modelled by the private clinic practice.

The data provided by supervisors in the state network coordination for 1989 confirms this statement. 100% of the known cases (n=20; N=36) of psychiatrists and 58.6% (n= 29; N=62) of the psychologists have their own private clinic as at least one of their additional forms of income.

Secondly, with the existing resources - lack of research, information system and systematic assessment of the services - and the present improvised training and supervision, the room to propose innovations and alternatives professionals models is narrow. The direct supervision of each team is performed by the metropolitan team coordination, composed in August 1989 of six professionals, each of the members being responsible for an average of six service units. However, given the accumulation of central duties and lack of support (like transport), the supervision is precarious, or even non-existent for some of the units. In most of the cases, it has been more frequently administrative rather than clinical or

institutional[1] [I: Souza MDC, 1989]. In addition to it, there is a monthly meeting of all network professionals, also with the presence of the municipal and general state coordinators, exchanging the local experiences and discussing mainly organizational issues. However, the professionals' participation at these general meetings was low during the fieldwork time (Jul/Dec 1989), limited to an average of less than half of them. The municipality network also has a periodic meeting, with the same problems during the last few years.

In such an organizational context, then, the major trend has been the reproduction of the traditional models established by the university courses and the market forces. This means exactly the models being used in the upper classes private clinic market. There has been no systematic effort in the last three years to propose alternative methods more suitable to the specific features of the programme clientele.

2.2.3. The Deliberate Orientation of the Programme Coordinators

However, the service model is not only determined by the major economic and cultural processes, but also by a

---

[1] From the point of view of the Institutional Analysis, it is possible to have at least three types of formal supervision in mental health services:
a) administrative, looking at the accomplishment of the proposed organization tasks;
b) clinical, helping professionals to deal with technical and treatment issues;
c) institutional, generally accomplished by a professional from outside the organization, looking at political and power relations, personal aspects of the commitment to and performance of the services, and clientele empowerment and participation. The Institutional Analysis itself is a good example of a technical and political approach to this type of supervision.

deliberate political and technical orientation assumed by the programme coordination boards. This, despite the poor resources, might potentially reinforce or confront in some way the hegemonic professional culture models and propose more appropriate ones.

The regional and local coordinators have a large autonomy in adapting and detailing the general proposals from the federal (like those proposed by the PISAM and CONASP plans) to the regional level. In Appendix 4, a summary of the two last versions of the plan for community mental health services in the Belo Horizonte metropolitan area is provided.

However, it is interesting to see how these formal plans were appropriated by the programme coordinations and professionals throughout the period under inquiry. According to the specific documentation and interviews, it is possible to indicate three main historical trends:

a) During the PISAM plan (1978/79), the emphasis was on training GPs to provide diagnosis, basic advice and medication in case of mentally ill users;

b) After the admission of the first specialized professionals (basically in 1979-80) until about 1987, when the two main processes of expansion of the network took place, the interviews and available activity reports[1] show a predominant emphasis on the following:

- **individual treatment** (psychotherapy and pharmacotherapy);
- **operative groups,** not specifically with psychotherapeutic purposes, with pregnant women, newborn baby's mothers, hypertensive users, women, parents, old people, and

---

[1] The following reports were consulted: [A: SMS-PBH (1985) Relatorio]; [A: DMS (1985) Relatorio]; [A: DMS (1986) Relatorios]; [A: DMS (1985) Sintese].

sometimes with users discharged from psychiatric hospitals[1].

- **psychotherapeutic groups;**
- some isolated **community interventions** mainly at schools (on psycho-pedagogic problems), nurseries (training and assessment in child care) and health centres (training and supporting GPs).

Some coordinators identified the operative groups techniques, mainly based on the Argentinian Pichon-Riviere's approach (Saidon, 1982), as a fashion among coordinators and professionals during the period [I: Lauar, 1989], despite a general lack of deep knowledge of the techniques [I: Olga, 1989]. Some influences from the innovative Rio de Janeiro experiences at the Centro Psiquiatrico Pedro II with group attendance (Costa, 1983; 1984; 1989b)[I: Bezerra, 1987] within working class clientele were also cited [I: Passos, 1989]. Individual psychotherapy has meant an emphasis on psychoanalytic methods[2].

c) From 1987 onwards, the emphasis has been on **individual treatment**, despite the residuals of non specifically therapeutic operative groups. In the case of psychotherapy, an even stronger influence from psychoanalysis, mainly the Lacanian, has happened. The move is identified as a result of:

- the lack of proper training in group techniques:

---

[1] Most of these groups are mainly preventive, in the sense given to it by Kaplan (1964), and follow formal guidelines established in the plans. Their importance will be discussed in chapter 6.

[2] For example, a large number of the network professionals were recruited at the 1986 public examination, and the required content of the test included mainly notions of public health, epidemiology, of group processes (mainly operative methods) and especially a great deal of psychoanalytic theory.

professionals reported interesting experiences with group therapeutic methods in the previous period, but having no technical background to cope with the emergent conflicts during the sessions [I: Olga, 1989] [I: Lauar, 1989].

- the constant strikes by professionals: the group is considered the technique most sensitive to the disruptions in services, as the users tend not to come back after strikes [I: Passos, 1989].

- group techniques, as a more complex technique and usually supervised by more than one professional, require a working environment more favourable to team supervision and exchange of experiences among professionals. This had not been the case of the service network during the period. It is not accidental that the new emphasis on individual psychotherapy overlaps exactly with the third period of economic and political decline in the programme, as indicated in the previous chapter.

- the stronger influence of the Lacanian theory in Belo Horizonte and within the coordination and professionals, given its criticism of group therapies and other psychotherapeutic techniques as inducers of ego-reinforcement effects (Frosh, 1987)[I: Lauar, 1989].

Another example of the psychoanalytic influence on the programme is the metropolitan supervision team itself. The most theoretically active ones are two Lacanian psychoanalysts, who had been offering the only two courses provided by the metropolitan coordination for the network professionals, both from a psychoanalytic perspective.

A more systematic course, with a 15 month 600 hour duration, and at a specialization level, has been provided by the Health School of Minas Gerais, with priority for professionals working in the mental health network. The analysis of the last years course programme and the approach adopted also shows a clear privilege to the psychoanalytic

theory, mainly its Lacanian version[1].

2.2.4. The Cases of the São Paulo and Lindea Districts as Examples

It is interesting to illustrate the afore mentioned recent evolution in the professional models by presenting a brief report on the Sao Paulo and the Lindea districts cases.

The SPd health centre is a municipality run service and, before the placement of a larger professional team in 1989, had few professionals working since 1984/85. It was a typical case of the activities described above for this period. The predominant approach was already individual treatment, but the first consultation was collective, and some clinic or operative groups for specific kinds of user were reported: psychotic clients and old people [I: Olga, 1989]. The direct reasons for ending the experiences were, according to one of the professionals developing such activities at the time:

> "I think that the group does not tolerate so many holidays as the individual alone does (...). Moreover, I think that the structure of psychosis itself, with the strike break, followed by the departure of X (another professional who also used to supervise the groups), and another strike, then we had three cuts in such a short time. Then, everything became individual (...). It is also interesting that in the past the coordination had required the professionals to form

---

[1] The last years content has been:
- Social Aspects of the Health/Illness Process: 80 hs
- Epidemiology: 80 hs
- Planning and Administration of Mental Health Services: 80 hs
- Clinic in Mental Health: 240 hs
- Supervision of clinic cases: 120 hs [A: ESMIG (1986) Curso].

The two last topics, which encompasses most of the available time, are viewed from the psychoanalytic approach, mainly the Lacanian one.

groups, and nowadays it doesn't do it any more." [I: Olga, 1989].

In the beginning of 1989, more professionals were added, in order to set up a day centre. However, mainly due to the lack of physical space and political determination, followed by a period of strikes and uncertainties at all statutory administrations, the proposal was practically shelved. In October 1989, the mental health team included the following:

- three psychiatrists, one doing exclusively individual drug therapy, and the other two doing individual mixed therapies (drug therapy associated to psychotherapeutic techniques), or just psychotherapy, both using psychoanalytic approaches;
- three psychologists doing individual psychotherapy, all using psychoanalytic approaches, with emphasis on child attendance;
- two social workers, providing individual consultation, with approaches heavily influenced by psychoanalysis.

The Ld is an example of a long experience of a mental health project implemented together with well organized district based community associations, which will be fully described in chapter 7. After the departure of key professionals in 1987 and 1988, the team and activities were reduced in 1989 to:

- one psychiatrist, doing exclusive drug and mixed therapies, the latter including the use of group attendance;
- one psychologist offering individual psychotherapy, mainly influenced by the systemic approach, with emphasis on child attendance;
- one social worker, providing individual consultation with emphasis on counselling and psychotherapeutic techniques from several approaches.

After this brief description of the hegemonic professional models adopted in the whole Belo Horizonte area and in these two cases, now the evaluation of the care

provided - as proposed in the chapter's hypothesis - will be considered.

3. THE OUTPUT: SELECTION AND HIERARCHIZATION OF THE CLIENTELE AMONG THE DIFFERENT TYPES OF SERVICES

3.1. METHODOLOGICAL INTRODUCTION

This section will consider initially the results of the survey carried out at the two local services described above, by comparing the type of treatment being provided and the indicators of cultural background, formal education, income and clinical status. Secondly, those results will be compared to the information available on the subject in other services in Belo Horizonte, and the conditions for generalizing the results will be addressed.

The type of treatment will be investigated by grouping the data on the professional responsible for each client (in the questionnaire heading), according to the different types of treatment being provided[1], as in the following classification:

- drug therapy, both in the SPd and Ld;
- mixed therapy (drug therapy associated with some psychotherapeutic or counselling techniques), also in both places;
- psychoanalytic therapy (SPd);
- other psychotherapeutic techniques (Ld).

The results were constantly checked with the answers to the question 13d, where users were asked to describe their treatments, generally producing similar figures.

Finally, all the following graphics will show the

---

[1] The aggregation strategy took into account the cases of different approaches used by the same professional, as some psychiatrists provide more than one type of treatment.

number of cases translated into percentages, in order to make the data comparable among the different types of treatment. When there is a very low number of cases which could have distorted the results expressed in percentages, this will be indicated.

3.2. RESULTS CONCERNING AGE ISSUES

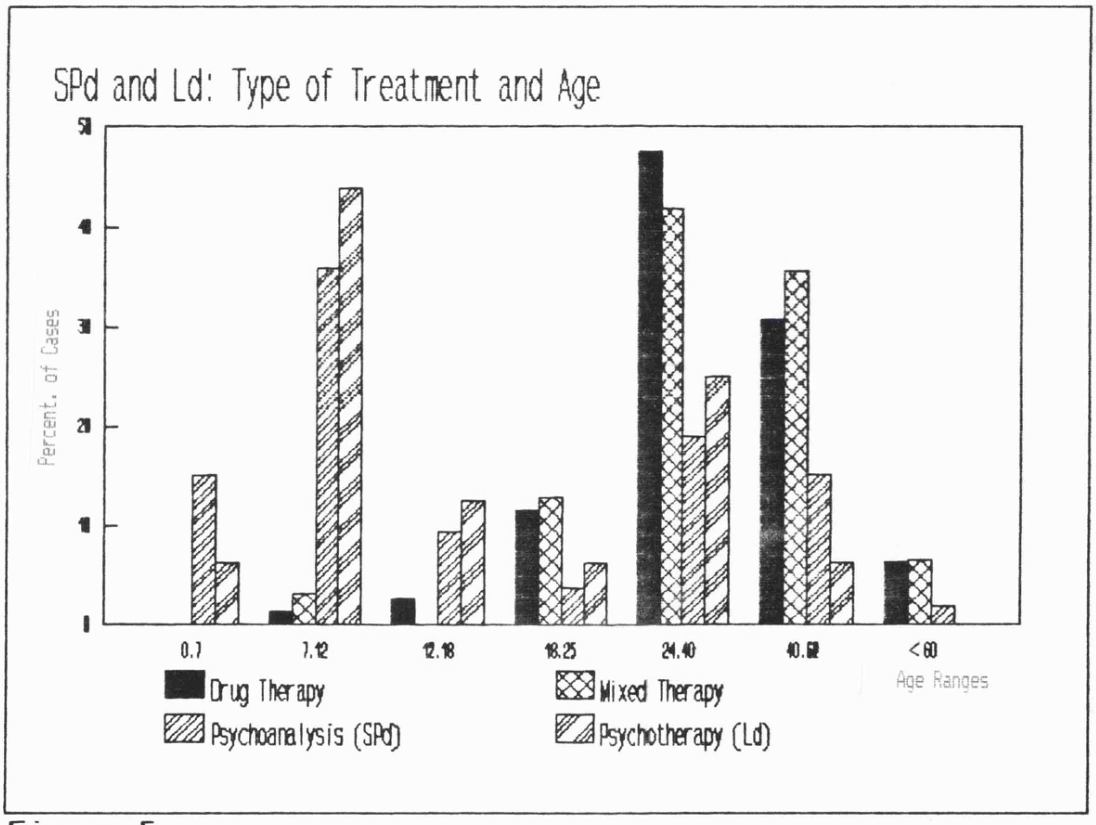


Figure 5.

Figure 5 presents the users' age profile for each type of treatment[1]. Both drug and mixed therapies shows similar profile, with treatments starting mainly from 18 years old, and peaking at the ages between 25 and 60 years old. Both

---

[1] Although this is a descriptive table, not requiring necessarily an association statistic test, chi>0.0000. However, the number of cells with less than 5 units was 53%.

types of psychotherapy start much earlier, reaching the children range, with a first peak between 7 and 12 years old (schooling period), and a lower peak at the ages of 25 and 40 years old. A similar table is obtainable through the same cross-tabulation with the description of treatment by users.

These figures can be considered quite normal from the psychiatric point of view, as drug therapy should be more associated with adulthood. However, this profile is also a matter of administrative decision. It is determined mainly by the kind of professional being recruited and by the decision on service priorities, establishing how many professionals and how much time would be dedicated to each age group. However, the lack of teenagers within the service clientele deserves further inquiry.

3.3. RESULTS IN RELATION TO GEOGRAPHIC ORIGIN, CULTURAL AND EDUCATIONAL BACKGROUNDS

When crossing the type of treatment and the place of birth (q. 2a), as shown in Figure 6, there is strong evidence of association between the two variables (chi=0.0021). As psychotherapy is more associated with children who, by their turn, are more likely to be born in Belo Horizonte, all cases of those aged below 12 years old were eliminated. **Users receiving drug therapy are much more likely to be born in rural areas than those in psychoanalytic treatment, who are clearly more closely identified with the urban background[1].** Mixed therapies and psychotherapy at the Ld do not show any special pattern.

---

[1] Although part of the result may be influenced by the difference in the two centres clienteles, as the SPd shows a more originally urban population, the differences would not justify the huge gap shown. The fact that the majority of the SPd clients born in country areas have been treated by drug therapy (58.3%) also reinforces the statement.

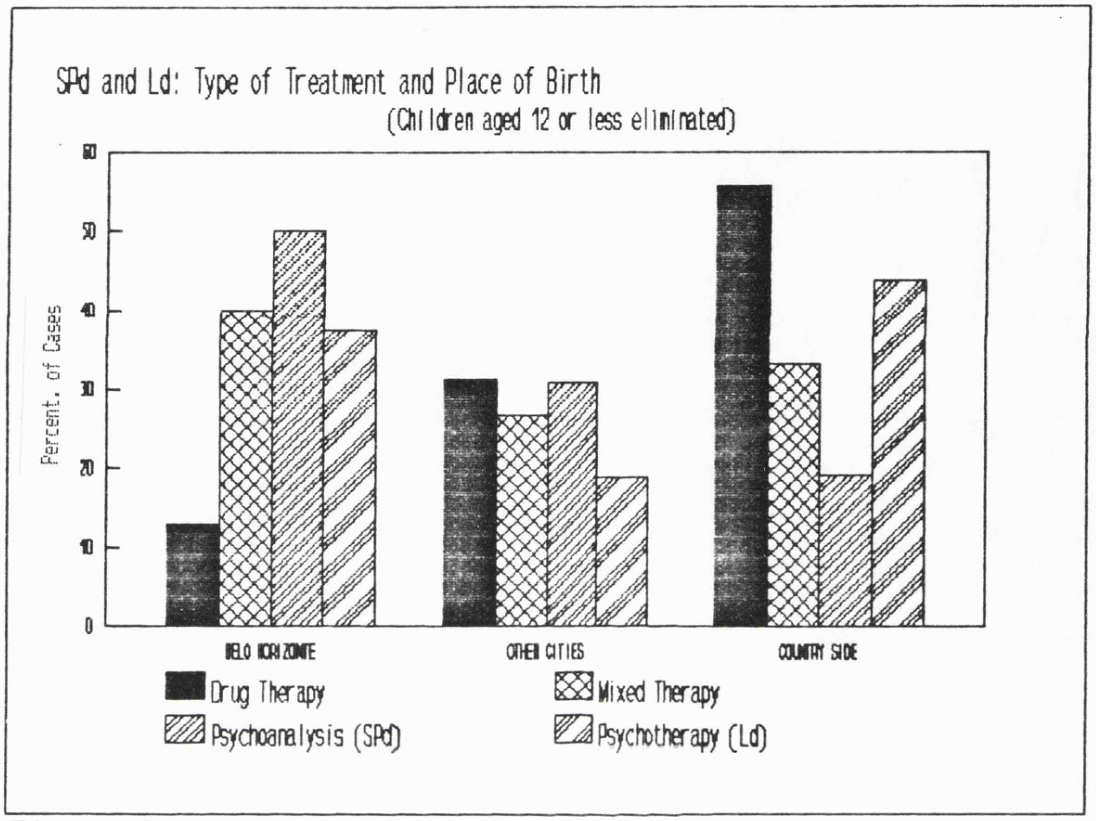


Figure 6.

The educational background shows a pattern similar to cultural background. The cross-tabulation between type of treatment and formal education (q. 4) is provided in Figure 7 [1]. This time, a clear division is shown between drug therapy and **all** other types of treatment, as the majority of the users (61.1%) in the former case are in the first two

[1] Chi=0.0147. The age effect is already eliminated by taking off all users aged 12 and below. In order to avoid many cells with less then five units, all cases with incomplete secondary school or higher educational levels were regrouped together (cells with EF<5 = 31.1%).

levels - no formal education[1] and incomplete primary school[2], while in the other types the rate is always lower than 30.0%. For them, the peak is on the incomplete 'ginasio' school range, without a significant difference among them. The trend is even sharper if the users criteria for types of treatment is adopted.

From the results being shown, **it is possible to state that in the investigated context, the type of treatment provided tends to select the kind of users being treated, concerning their geographical origin, cultural and educational background. Drug therapy is clearly more associated with migrants, to country and traditional cultural backgrounds, and less formally educated people. Psychotherapy and mixed techniques tend to require from users a more urban origin and cultural background, as well as a minimum of formal education. Specifically in relation to cultural background, psychoanalysis tends to be more selective than the techniques used in the Lindea district, and the mixed therapies do not show a special trend.**

These results are quite consistent with what has been discussed by an already classical literature in other countries (for example, Hollingshead and Redlich, 1958). Despite no systematic empirical evidence have been provided yet in Brazil, some studies particularly in anthropology

---

[1] 79.3% of all young and adult clients with no formal education at all are receiving drug therapy, achieving a standardized residual of 3.3 (although the residuals for all drug therapy cells are also significant). It means that the likelihood of this specific population group being treated with drug therapy is significantly very high.

[2] The primary school in Brazil has changed from four to eight years, including what was previously called the "ginasio" school (5th to 8th year). As the change is recent and almost formal - the majority of the working class children is expelled in the first years - and most people use the old classification, the author decided to keep the previous classification in the questionnaire.

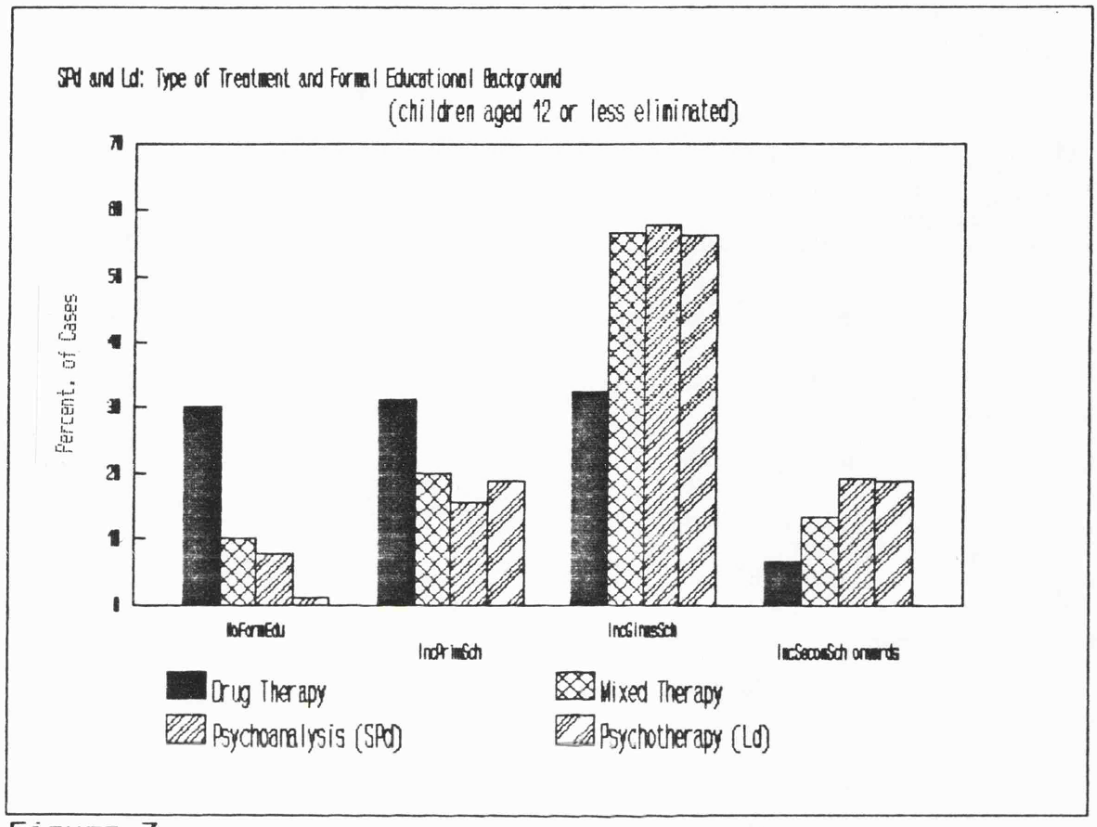


Figure 7.

have suggested this selective effect of the use of the psychoanalysis with working class clientele. This will be the subject of a substantive inquiry in chapters 6 and 7.

3.4. RESULTS CONCERNING WORK STATUS AND INCOME

There are some indications of a similar association between type of treatment and work status. Initially, no association is found between the former and the fact of having income or not (q. 5a). However, when crossed with the type of income (q. 5b), as shown in the Figure 8 [1], the

---

[1] Including only those with a positive answer to the previous question and those aged more than 12 years old. The table is significant (chi=0.0391), although cells with EF<5 = 62,5%.

results show that **psychoanalytic methods in the Sao Paulo district are significantly more associated with people actually working and less with retired people**[1], while others types of treatment do not reveal any significant trend. The figure is coherent with the results on cultural and educational background, as the working status is logically associated with more dynamic and modern cultural background.

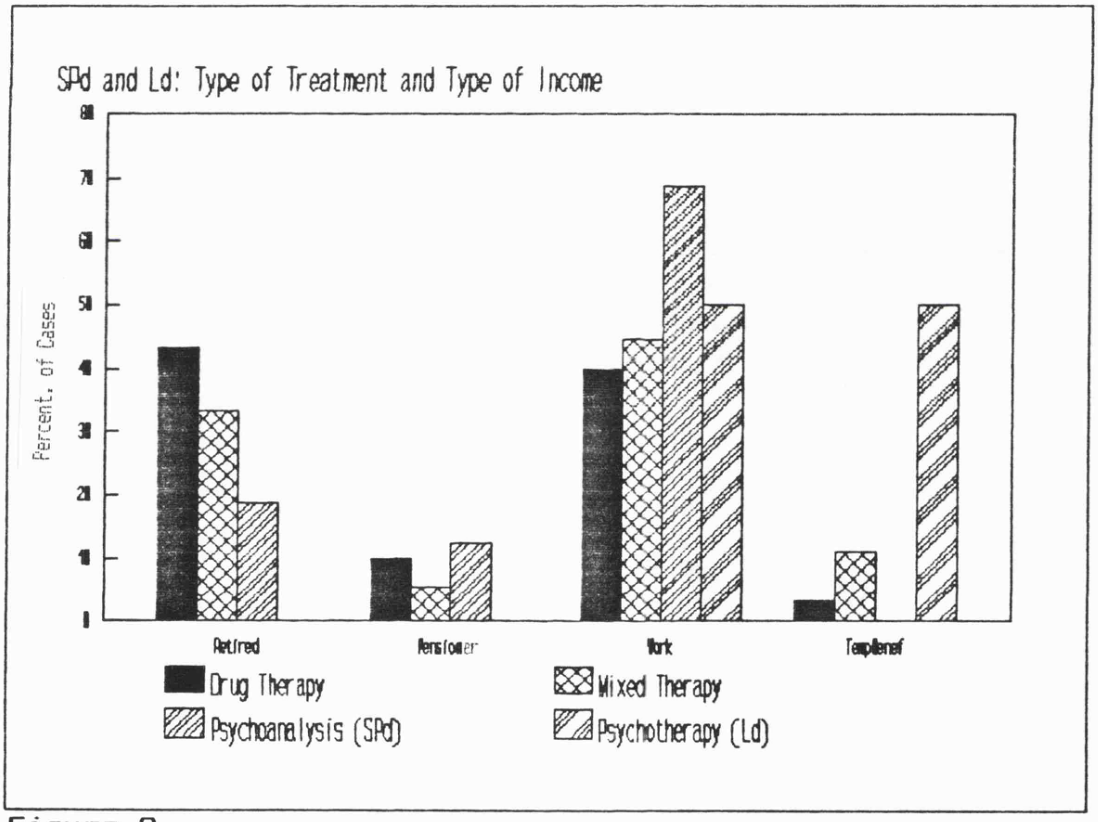


Figure 8.

The type of treatment also presents some kind of association with family income. In Figure 9 the type of treatment was crossed with the income range for the users'

---

[1] The difference between the two clienteles in regard of type of income was checked and would be insufficient to explain this result.

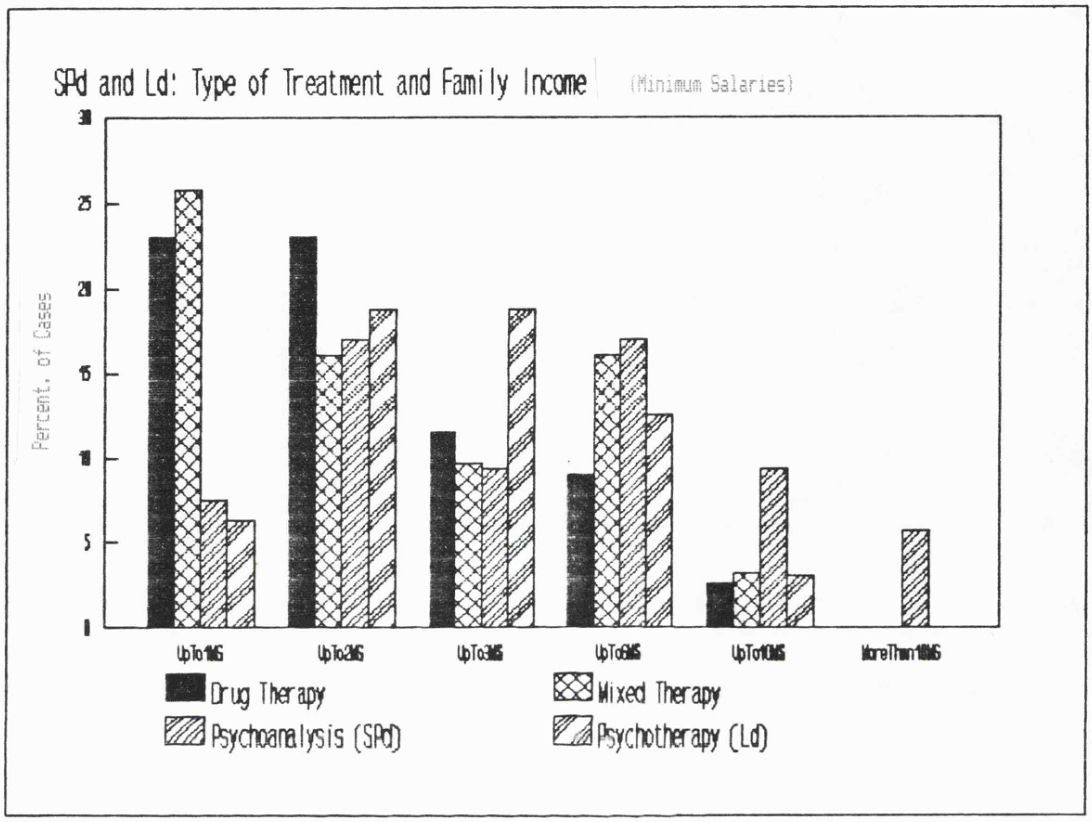


Figure 9.

families (q. 8b)[1]. It is possible to see that **drug therapy is significantly more associated with the poorest strata,** specifically those with up to 2 minimum salaries as family income, which is generally considered to be above the country's poverty line (around 3 minimum salaries per family). From this point onwards, the number of users declines vigorously. The mixed therapies present a peak in the first range (1 minimum salary), but the decline is slower, with reasonable number of cases still in the range of 3 to 6 minimum salaries. The psychotherapy in the Ld has a similar profile, but the peak is on the ranges between 2

---

[1] As ordinal variables, the statistic tests used were:
- k-Sample Median Test: chi=0.0321;
- Kruskal-Wallis One-Way Anal. of Var.: chi=0.0041 (after corr. for Ties, 0.0029).

and 3 minimum salaries. **Psychoanalysis shows an association with the richer strata among all options,** peaking between 2 and 6 minimum salaries and having the slowest decline up to more than 10 minimum salaries range. The table with the users criteria for types of treatment presented similar figures in the comparison between drug therapy and all psychotherapeutic approaches.

3.5. RESULTS IN RELATION TO CLINICAL STATUS AND PREVIOUS HISTORY OF TREATMENT

Despite the lack of systematic records of users' data in the services (as reported in chapter 2, section 5.1), some indirect indicators are available in the questionnaire mainly through their history of treatment, reasons for treatment and daily life.

When crossing the types of treatment (by both criteria) and reasons for treatment (questions 10b and 13b), the data provided was dispersed among several categories, and the only consistent and statistically significant (through the 't' test) differences identified are:

- **the reasons coded as 'specific body symptoms'[1] and 'serious behaviour symptoms'[2] are more associated with drug therapy.**

---

[1] This category was differentiated from unspecific symptoms (like those associated with 'nervousness' states), and the most frequent indications were heart burn, headaches, stomach ulcer, faints, impotence and hypertension.

[2] Categories which could be clearly associated to psychotic states or very serious acute neurotic crisis, such as 'psychosis', 'delirium', states of strong agitation and smashing things ('quebradeira'), loss of consciousness, strong feelings of persecution or 'selfgrandness', amnesia, suicide attempt, etc.

- the reason 'situational crisis and dramatic life events'[1] is more associated with the psychoanalytic therapy.

The data on inactivity behaviour[2] (q. 19a) indicates more clearly that **the most impaired cases have been treated with no psychotherapeutic methods.** The majority of the 'exclusive inactivity behaviour' cases (10 cases or 62.5%) were treated with exclusive drug therapy, and the remaining 6 cases were only treated by mixed therapies. For the 'non-exclusive inactivity' cases, 11 cases (64.7%) were treated with drug therapy, 3 cases (17.6%) with mixed methods, and just additional 3 cases were treated with psychotherapy.

Moreover, the type of treatment presents a particular relationship with the past history of admissions. In Figure 10 all users aged less than 18 years old were naturally eliminated, as admissions start to occur at this age range for the present clientele, and hence no age effect is present. It can seen that **all types of treatment include a reasonably higher proportion of users with past admissions, excepting the psychoanalytic techniques,** which presented a

---

[1] Such as conjugal crisis or separation; death, serious disease or alcohol addiction in close relative; pregnancy of single daughter; abortion (which is illegal in the country); difficult childbirth, etc.

[2] 'Inactivity behaviour' was a classification used to describe the non engagement in activities most people do, like household, work, educative actions, although may include ability to maintain social contacts. Generally, it induces a sense of unproductiveness in the domestic economy, as the individual is partially or completely not able to assume responsibilities on duties normally shared by all family members. These individuals normally spend part ('non-exclusive') or the whole day ('exclusive') sleeping, watching TV, looking at the window or, when able to have social contacts, talking to relatives, friends, neighbours, etc. The classification is easier for the male adult cases, who in general do not engage themselves in domestic duties, and is more fluid for women and children, although very few, if any, cases of the latter were included in this category.

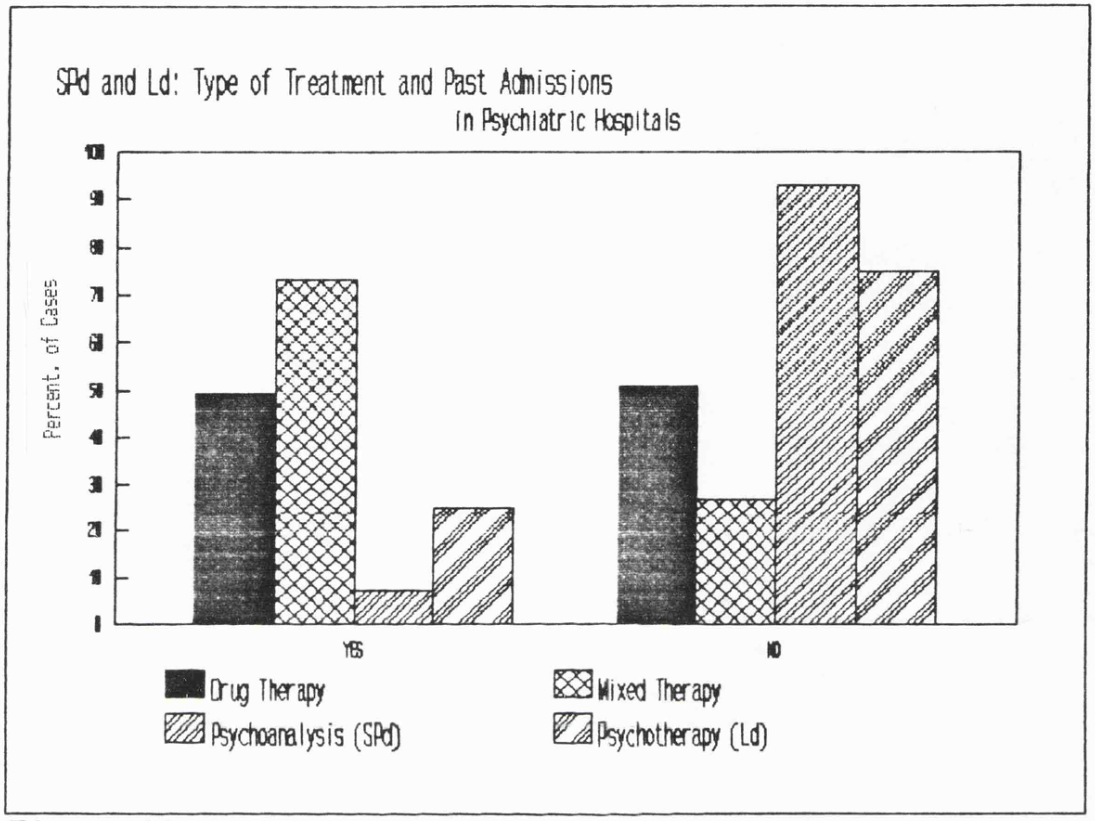


Figure 10.

rate of 92.6% of users without previous admissions[1]. This result is undoubtedly linked to the intrinsic features of the technique. However, service priorities at each centre, which depend on a different administrative and political will, could encourage professionals and staff to make efforts to reduce this "filtering process". The clientele itself seems to have no effect on the results, as the global rate of previous admissions is higher in the SPd than in the Ld, which should led to higher rates for non-admitted people for the psychotherapists in the latter, which did not happen.

The data on chronicity has also revealed some visible

---

[1] The standard residuals for both cells reached 4.1, which means a very high statistical significance. The chi-square here is also highly significant, less than 0.0000.

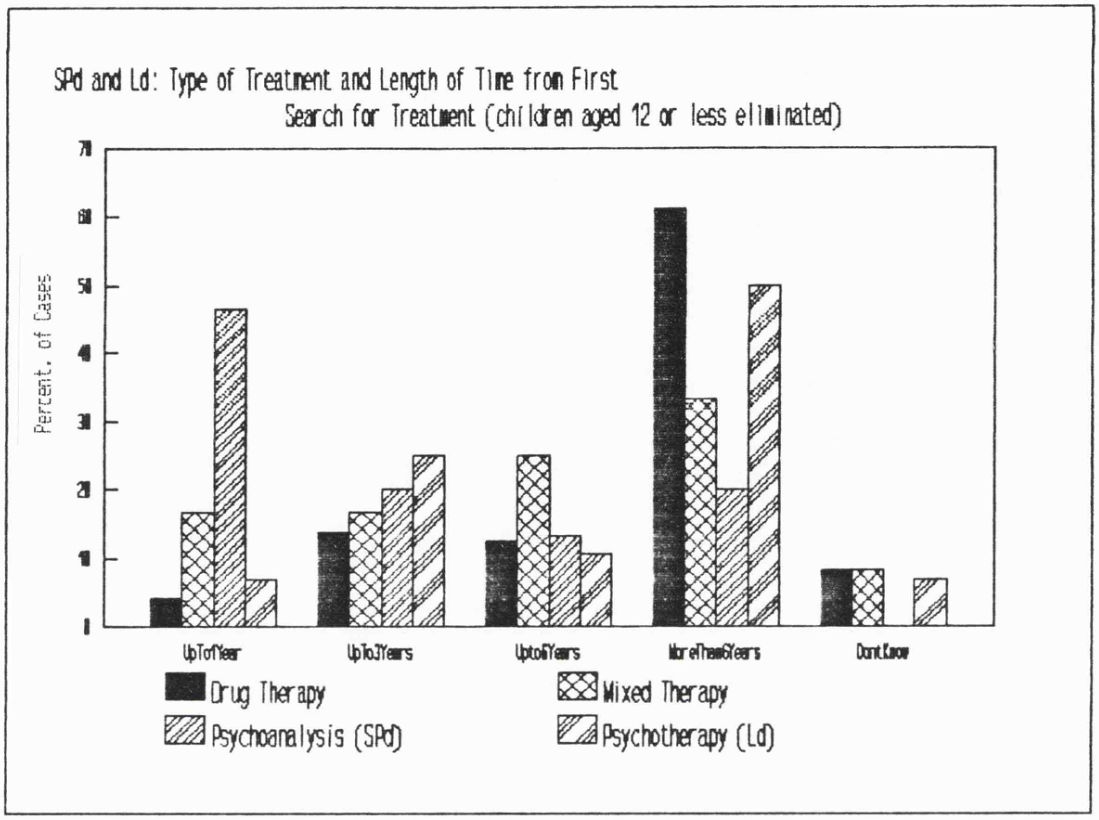


Figure 11.

patterns. The results of the question 10a, on the length of time from the first search for treatment are presented in Figure 11, where all children less than 7 years old were taken off, in order to eliminate the age effect. As can be seen, **drug therapy tends to absorb the most chronic cases; followed by mixed and then psychotherapeutic methods[1]. This indicates that chronicity shows a clear inverse association with psychotherapeutic methods.** A similar trend is found when repeating the table with the users criteria for types

---

[1] Chi=0.0007; however, cells with EF<5 = 55.3%. In the analysis of the standard residuals, drug therapy presented significant frequencies exactly in the extremes of the time ranges axis. Psychotherapy in the Ld also presented significant figures in the extremes, probably influenced by the district's trend for having less impaired cases and by the sampling time just after a strike.

of treatment.

A similar pattern seems to emerge among those with previous admissions, when crossing the types of treatment with the length of time from the first admission[1] (q. 11b). **Exclusive drug therapy tends to include more cases with older first admissions than the mixed therapies and even more than psychotherapeutic methods,** which actually presented very few absolute numbers of cases. There are indications that an analogous association could be found with the number of previous admissions (q 11c), but it did not achieve a satisfactory level of statistical significance (chi= 0.1772).

Summing up, within the two mental health services, **drug therapies tend to filter more impaired and chronic cases, and more users with previous and far earlier admissions in psychiatric hospitals than psychotherapeutic methods. Among the latter, psychoanalysis showed a particular accentuated trend to avoid users with past admissions.**

3.6. RESULTS CONCERNING THE PRESENT TREATMENT

The first aspect that could raise some interest is the length of the present treatment, for which the cross-tabulation with types of treatment is shown in Figure 12. The results present a quite interesting profile. The exclusive drug therapy percentages show a stable line across most of the first time ranges, peaking at the last two, indicating a trend to more stable links with the service. The mixed therapies peak on the range 6 to 12 months, followed by the psychoanalysis on 1 to 3 months, and the psychotherapy in the Ld on less than 1 month. There is no

---

[1] However, even when eliminating the only two cases of psychoanalysis, the rate of cells with EF<5 is still 66,7%. The chi-square found was 0.0426.

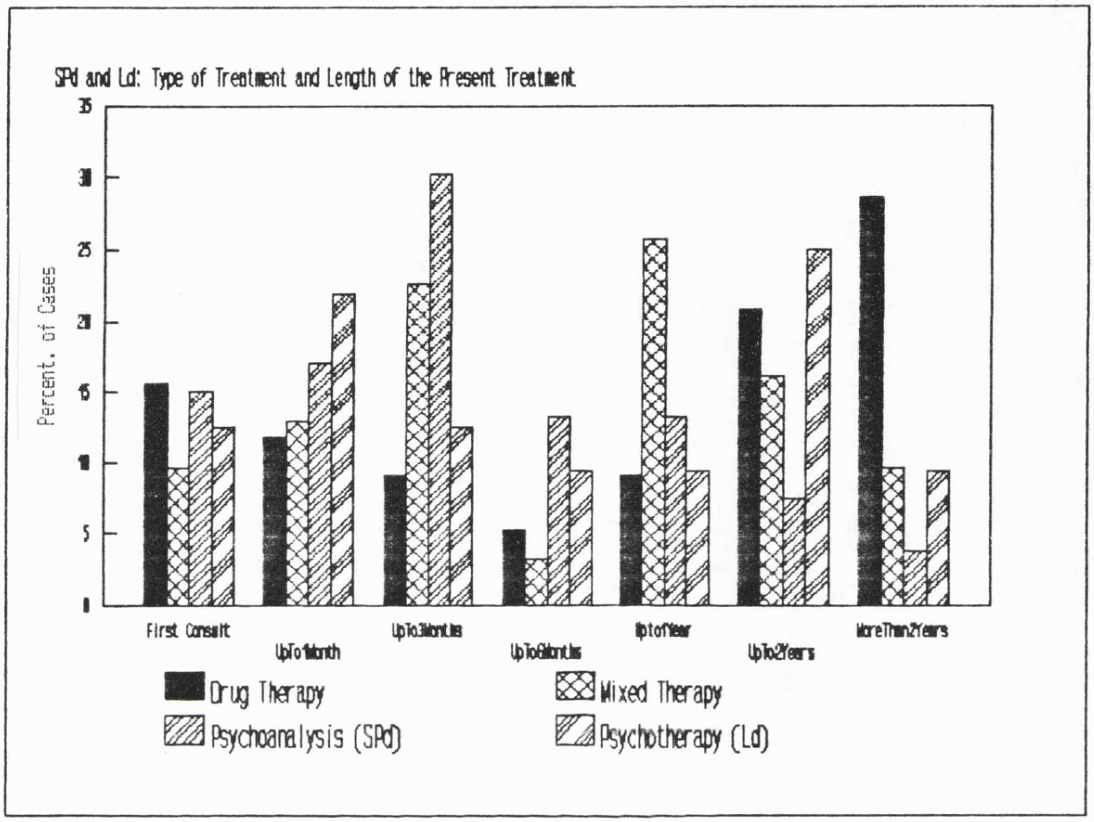


Figure 12.

doubt that the strikes and other service disruptions interfere in these results. The interviewing process was accomplished in the SPd exactly 3 months after the last strike, and most of the users in the Ld were interviewed just after the following strike. This can help us to understand the differences in the psychotherapeutic methods between the two places. In this respect, it is logical to believe that the **drug therapies resist much more the disruptions in the services provision and creates stronger links with the treatment** than psychotherapy. However, the differences in the length of treatment seems also to be associated with other aspects, such as the specific features and effects produced by each type of treatment and their perception by users.

From the users' perspective, there is no significant

difference in the number of positive answers to the question 14a, on important changes or improvement due to the treatment, as all the types of treatment presents figures around 75% of the total cases. However, the qualitative aspects of each treatment are seen as different, as shown in Table 9.

Table 9: SPd and Ld: Types of Treatment and User Description of the Changes Due to the Treatment

Description of the Changes	Type of Treatment (Number of cases/percent.)				
	Drug	Mixed	PsAna	Psych	TOTAL
Symptom Control	37 51.4	12 16.7	17 23.6	6 8.3	72 100.0
Improv. of Pers. Inter-relations	2 9.5	5 23.8	9 42.9	5 23.8	21 100.0
Better Perform. at School	0	0	8 50.0	8 50.0	16 100.0
Better Perform. at Work	6 66.7	2 22.2	1 11.1	0	9 100.0
Intra-subjective Changes (1)	0	2 14.3	9 64.3	3 21.4	14 100.0
Avoiding Admissions	2 100.0	0	0	0	2 100.0
No Change	2 22.2	2 22.2	5 55.6	0	9 100.0
TOTAL	57 39.9	23 16.1	42 29.4	21 14.7	143 100.0

Note: (1) Such as in the expressions: "I am a very dependent and authoritarian person; I discovered I can't be like that and then I'm feeling much better"; "my posture in relation to life and the others, the way I've reacted before, and the way I react now (have changed); he obliges me to think a lot, and driving me to realize that I've been leaving life to pass by..."; "in practice, not, but in the feelings, a lot of things have changed; I mean, my way of viewing things is very different now".

As a multi-choice question (more than one answer per case), it is not possible to verify the statistic significance of the results. However, the figures are

convincing enough to indicate the following:

- the drug therapy presents:
  . the highest rates for answers reporting a positive effect by symptom control;
  . low rates for improvement of personal relationships and of the performance at school and work;
  . no cases reporting subjective changes;
  . the only two cases reporting avoidance of new admissions;
  . a low rate of negative answers (no changes at all).
- the mixed therapies indicate:
  . a relatively small lower proportion of positive answers for symptom control than exclusive drug therapy;
  . a relatively high level of improvement in the personal relationships, but lower rates at the work and school;
  . only two cases reporting subjective changes;
  . a small higher rate of negative answers;
- the psychoanalytic therapies shows:
  . relatively lower levels for symptom control, but still a reasonable level (40.5%);
  . relatively good results for improvement of personal relationships, low rates for improvement at work and 8 cases of improvement at school;
  . the highest rate for intra-subjective changes (21,4%);
  . the highest rate of negative answers, but still very low (11.9%).
- the psychotherapy in the Ld presents:
  . the lowest level of symptom control answers;
  . the highest rates for improvement of personal relationships and at school, but no cases for work;
  . rates for subjective changes similar to the mixed therapies;

. no negative answers.

It is interesting to note that the two categories for psychotherapy are the only treatments associated with a specific kind of answer pointing to an alternative understanding to the question 20a, on the description of family problems related to 'nerve' problems. In such cases, mainly companions suggested that mental illness results from family or life problems, as an attempt to give a historical or psychological explanation for mental distress.

Finally, if trying to summarize these results, it is possible to say that, from the users perspective:

- the central feature of the drug therapy is symptom control, and therefore, the ability to avoid admissions, despite the low number of cases in the latter;

- the introduction of discursive techniques is associated with two main new elements: the improvement of personal interrelationships and performance, and intra-subjective changes, but the latter is mainly produced by psychoanalytic methods. However, the proportion of such kind of answer is still low for this specific clientele[1].

- the children's attendance and their improvement at school have been provided basically by psychotherapeutic methods.

When looking at this qualitative perception of the changes through time, it is possible to say that the users' recognition of symptom control effect for drugs therapies tends to increase with the time of treatment. The same effect for psychotherapies tends to decline after one year of treatment. Still for psychotherapies, the improvement in the interrelationship in general and at school has a more permanent effect, but it is intriguing that the intra-subjective changes were reported basically in

---

[1] This may be also due to the interviewing process itself, as subjective answers require some level of rapport and intimacy to be given.

psychotherapies with 1 to 3 months of duration. This may be an interesting issue for further inquiry.

3.7. TOWARDS GENERALIZING THE FINDINGS TO THE WHOLE SERVICE NETWORK IN THE BELO HORIZONTE METROPOLITAN AREA

As indicated in chapter 2, the case study may also have a different generalization logic than of the statistical one, as proposed by Yin (1984: 39) as 'analytical inference'. Through this, a particular set of results from a case study may also produce analytical associations between variables persuasive enough to suggest that if similar conditions are found elsewhere, corresponding effects can also be expected. A fully analytical explanation for the present results will be proposed in chapters 6 and 7, after a investigation of further implications of the present hegemonic professional model. For the moment, it is possible to provide additional evidence in relation to the whole service network.

Summing up some of the quantitative and qualitative evidence already provided in sections 2.2.1, 2.2.2., and 2.2.3., it is possible to say that the following, particularly for the state owned services:

- psychoanalysis is undoubtedly the most hegemonic and largely used approach in the newly implemented services;
- the absolute majority of the professionals, particularly psychiatrists and psychologists, had their training oriented to and actually work in private clinics for an upper class clientele;
- the programme could not develop alternative approaches more appropriate to the specific features of the clientele given its poor material and organizational conditions, but also because the existent resources were deliberately appropriated to reinforce the mainstream 'psychoanalytic culture'.

However, additional qualitative evidence on that can still be shown.

Although not providing numerical figures, the coordinator of the municipality network also indicated a clear predominance of the Lacanian psychoanalytic approach within the professionals under her supervision [I: Carneiro, 1989]. For both state and municipality service networks, the monthly professional meetings are marked by a clear predominance of the psychoanalytic jargon, mainly the Lacanian one, and by a trend to invalidate other intervention forms. In the written reports, bibliographic material and administrative documents, psychoanalysis is the hegemonic type of specific clinical and theoretical discourse in the field, together with the public health administrative and normative ones. In formal interviews with some professionals not using the psychoanalytic approach, it is possible to sense a kind of 'guilt' or lack of comfort when disclosing it clearly. Probably the best description of this phenomenon in Belo Horizonte was given by Mr. Campos, one of the most prominent leaders of the mental health movement:

> "This (psychoanalytic) seduction happens in all forms. It is intellectually attractive if you are doing a Lacanian formation, as this generates an important intellectual status, as something in fashion nowadays, in the top position, and you have a reading that is ready, which you have necessarily to come across, and then this is tranquillizing. You even have the excuse of doing an absolutely serious training, as something very difficult and which demands a lot of time, and that you are not omnipotent and can't do everything at the same time. Hence, you justify yourself by not focusing on anything social, of not discussing political issues, all that. In this regard, the Lacanian institution in Minas Gerais is a blockage to the advance of other models; it has a 'church' logic, as if everything outside it is bad, isn't it?" [I: Campos, 1989].

The recognition of this hegemony's implications in terms of the hierarchization of the clientele is still

rudimentary. First, because no information or assessment system has been set and the context of devaluation of the work in statutory services does not stimulate it. However, professional corporatist interests in keeping the present service model are contrary to such concern in questioning and producing evidence on such issues. Nevertheless, the teams' activities reports[1], available for the 1985/6 period, have already indicated some related issues, such as:

- a large number of referrals and strong demand for individual consultation, making it difficult to create alternatives for more collective forms of care;
- a very common disorientation of the teams when establishing themselves at the health centres, referring to the lack of clear service guidelines and to new and very complex and challenging situations which they were not trained to confront;
- resistance from GPs and other health centre staff to accept forms of intervention other than individual consultation;
- users' lack of knowledge of the new mental health services;
- a clear recognition of the contradiction between the programme's formal priority to former in-patients and the immediate demands of the population and health services. One of the reports states clearly that the former usually do not come to the health centres or, when they come, do not return or do not adapt to the treatment [A: DMS (1989) Sintese]. This issue will be fully discussed in the next chapter.

Finally, some members of the state supervision team not attached to the psychoanalytic approach had already verified signs of the phenomenon:

"I think that we could use psychoanalysis, but with a

---

[1] The sources were cited in the first footnote of the section 2.2.3. above.

> very specific and very well assessed clientele.(...) In the first moment it should be people who adapt themselves well, who are used to participate, because otherwise I think that they come and go, they stay very briefly. They start a psychoanalysis, but just after they go away, not tolerating the psychoanalytic scheme for a more adequate period. It is not a long period: after the fourth session, they leave, and I think this is a very short period " [I: Mancio, 1989].

Further evidence specifically on the effects of the psychoanalytic approaches will be provided in the following chapters.

4. SUMMARY AND CONCLUSIONS

The dominant types of service provided among the statutory mental health services within the health centre network in the Belo Horizonte metropolitan can be briefly summarized as:

a) period 1979/80 - 1986: (in order of frequency) individual treatments (pharmacotherapy and psychotherapy), operative groups, psychotherapeutic groups, and some isolated community interventions.

b) 1987 onwards: greater emphasis on individual treatments, with a stronger influence from the psychoanalytic approaches, mainly the Lacanian one.

The historical reasons for that may be summed up as:

a) the hegemonic regional professional models, established by the university training and the market forces, leading to an upper class private clinic practice and to wide use of psychoanalytic approaches;

b) the administrative and organizational features of the programme, with very low wages and bad working conditions, and with strong constraints on the establishment of a specific programme orientation, in terms of training, supervision, information system and evaluation of the services;

c) a deliberate orientation by the programme coordination.

When addressing the features of the care provided, the results of the survey in the two case studies confirmed the proposed hypothesis topics, leading to the conclusion that **the type of service models hegemonic mainly in the last period produces a process of clientele selection and hierarchization.**

Initially, when concerning age issues, exclusive drug and mixed therapies (drugs and counselling or psychotherapy) are associated with the adult clientele, while psychotherapy is prescribed to both adults and children. Hence, children have been treated basically by psychotherapeutic techniques.

Drug therapy is more associated with the migrant population and their more traditional cultural background, and to less formally educated people. Psychotherapy (and here, mainly psychoanalysis) and mixed therapies tend to require from users a more urban origin and cultural background, as well as a higher educational level.

Drug therapy is also associated with the poorest groups of the clientele, and psychoanalysis clearly selects fewer retired and more working people, and those showing higher incomes.

From the clinical point of view, the few available indicators suggest that the most impaired cases have been treated with no psychotherapeutic methods. Psychoanalysis in the Sao Paulo district is particularly selective in this respect, as few cases have had previous admissions in psychiatric hospitals, which may be linked not only to the technique features themselves, but also to implicit and/or informal local services priorities. Moreover, drug therapies tend to absorb the more chronic cases, rather than psychotherapeutic methods. For example, the former selects those users with older first admissions than mixed therapies (and naturally than psychotherapeutic methods).

In relation to the present treatment, drug therapies

create stronger links with the treatment and resist much more the disruptions in the service provision (like the civil servants' strikes, frequent at the two centres) than psychotherapeutic methods. From the users' point of view, the central feature of drug therapy is symptom control. Psychotherapy also indicates such results, but in a lower level and mainly concentrated in the first year of treatment. However, the main feature of discursive techniques is the induction of answers reporting improvement of the personal inter-relationships and performance, and intra-subjective changes. The latter is particularly produced by psychoanalysis, but in a low proportion in relation to its whole clientele and concentrated in the first three months of the treatment.

Despite the lack of systematic evaluations of the services, the evidence available suggests that similar processes have been happening throughout the whole mental health services network. Similar findings on social selection and hierarchization processes in mental health services were also discovered in hospital care in Brazil (Souza, 1987) and among treatment approaches in the USA (Hollingshead and Redlich, 1958).

Further details and implications of the dominant service models will be the subject of the following two chapters.

Chapter 5

THE HEGEMONIC SERVICE MODELS, THE CONTINUING CARE CLIENTS AND THEIR INFORMAL CARERS

1. INTRODUCTION

This chapter is going to address additional implications of the service models, through the discussion of the following hypothesis:

Hypothesis III
The hegemonic model of mental health services within the statutory health centre network in Belo Horizonte has:
a) offered a very low level of care to users discharged from hospital and/or presenting more chronic and serious problems[1];
b) failed to offer adequate support to informal carers.

As the characterization of the hegemonic service model was outlined in the previous chapter, this chapter will address directly the two hypothesis topics, in two sections. A third one will try then to compare the Belo Horizonte case, described in both chapters, with the situation in Rio de Janeiro and Sao Paulo.

3. THE LOW LEVEL OF CARE FOR FORMER IN-PATIENTS AND THE CONTINUING CARE CLIENTS

---

[1] It is important to describe what is meant here by 'more chronic and serious psychiatric problems'. From the clinical point of view, and employing the usual terminology of epidemiological inquiries, this expression indicates the cases of psychotic states, alcohol dependence, m. retardat. and organic brain problems. From a more user friendly terminology, such cases may be called as the continuing care clients.

3.1. ASSESSING THE POTENTIAL PRIORITY DEMAND

The category 'more chronic and serious problems' can be undoubtedly referred to the majority of the clientele of the psychiatric hospitals in most countries, including Brazil. Table 10 sums the findings by Souza, AL (1987), showing the diagnosis

Table 10 - Diagnosis Rate Profile of In-Patients in Four Psychiatric Institutions in Salvador, Bahia, 1981

DIAGNOSIS	INSTITUTIONS				
	Public Asyl	Univ Ward	Contr Hosp	Private Cl	TOTAL
Schizophrenia	39.8	34.1	30.1	24.8	33.3
Mani c-Depressive Psychosis	4.0	25.4	6.7	38.2	14.1
Other psychosis	13.0	4.8	10.0	8.9	10.2
Personality Disorders	0.6	1.6	1.5	3.2	1.5
Epilepsy	4.0	0.8	4.8	0.6	3.2
Mental Retardation	29.5	4.0	8.9	1.3	14.4
Neurosis	1.9	19.0	13.8	10.8	9.6
Alcohol and Other Drug Addictions	2.2	6.3	21.2	10.2	10.1
Others	0.6	2.4	1.5	0.6	1.1
Without Diagnosis	4.3	1.6	1.5	1.3	2.5
TOTAL AND NUMBER OF CASES	100.0 (322)	100.0 (126)	100.0(269)	100.0(157)	100.0(874)

Source: Souza AL, 1988: 75.

profile of in-patients in four different types of psychiatric institutions in Salvador, Bahia. Despite the known trend towards psychiatrization and misdiagnosing at the hospitals, mainly in social cases, it is possible to see that on average less than 10% of the hospitals' users were identified as neurotics, and more than 85% of the whole clientele would be included in the 'serious problems' classification.

An inquiry into 50 cases at one of the Raul Soares Hospital wards in Belo Horizonte in 1982 produced the following figures[1] [A: CPSM MG: Fajardo (1982) Um Breve: 10]:

schizophrenia: 76%	epilepsy: 6%
mani c-depress. psych.: 8%	alcohol addiction[2]: 2%
other psychosis: 2%	neurosis: 2%
m. retardat.: 4%	

This in-population, when discharged, would constitute the potential clientele for out-patient services in the area.

Another strategy used to assess the quantitative and qualitative features of the 'serious problems' cases in need is to make an estimate from population epidemiological studies, the main figures of which were presented in chapter 2, section 3.5. The prevalence rates found in the O' district in Salvador, which has socio-economic features similar to our two district cases in Belo Horizonte, could be used as reference[3]. Hence, for a standard catchment population of 50.000 per one complete mental health team, the following number of cases would be shown:

Psychosis: 350 (0.7%)	Alcohol Addict.: 1 750 (3.5%)
M. Retardat.: 500 (1.0%)	Epilepsy: 50 (0.1%)
Dementia: 200 (0.4%)	Neurosis: 7 250 (14.5%).

3.2. COMPARING THE POTENTIAL DEMAND AND THE ACTUAL CAPABILITY OF THE PRESENT OUT-PATIENT SERVICE NETWORK

---

[1] This study was accomplished in a period of mobilization and internal changes inside this hospital, with emphasis on controlling unnecessary admissions; therefore, the rate of minor problems is minimal.

[2] Several cases of alcohol dependence were associated with other nosologies and then classified primarily there.

[3] If the figures found for poor working class districts in Sao Paulo were used, higher prevalence rates should be considered.

In my view, there is reasonable cause to believe that the present psychiatric system in Belo Horizonte is not providing adequate out-patient care for the above described demand. The following reasons can be raised:

a) the relatively recent implementation of the services, when compared to the long historical tradition in the country of psychiatric care centred on the hospitals;

b) the political resistance from the hospital sector, already outlined in the chapter 3, and the lack of administrative integration between the hospitals and the out-patient services, including the absence of a reliable information system which would allow local teams access to the local potential target users.

c) the contradictions of placing out-patient mental health services at general health centres. Despite the advantages of using already available infra-structure and not inducing stigmatization processes towards specialized mental health services, the demand formation tends to be shaped particularly by GPs' referrals and by the sophistication of the general health care demand. This happens mainly in a context of lack or weakness of the programme political and administrative guidelines. This issue will be focused on in the next chapter.

d) the present standard working conditions for the professionals within the health centre network units. The basic team (one psychiatrist, one psychologist and one social worker) is contracted for a working week of twenty hours, or four hours per working day (Monday to Friday). As reported before, part-time jobs and over-employment are the most common features of the professional labour market in health services in the whole country. In such conditions, it is practically impossible to create a service qualitatively able to look after the continuing care client. Moreover,

when the potential demand numerically described above is looked at, it becomes clear that the official guidelines for catchment population for a standard mental health team clearly over-estimates its capability.

e) the present context of crisis in all statutory services. As described in the previous chapter, the present crisis of the social and health services in Brazil leads to a further impairment in their attendance capability, in terms of low wages and infra-structure, instable medicine provision, constant service disruptions and poor human resources.

f) the hegemonic service model. As also stressed in the last chapter, the emphasis on clinical models practised in the private clinics market tends to disregard the continuous care client. In addition, popular education activities are nor valued, in spite of their potential importance for the population in the discussion of their current views on mental health care and alternatives to hospitalization.

The SPd and Ld districts' services can provide substantive evidence of this. Despite the lack of systematic information on catchment population and on clinical status of their clientele, some comparative analysis is possible. First, the average number of clients per type of professional are: Psychiatrist[1]: 77; Psychologist: 19; Social Workers: 13; making a total of 109 clients. This figure is clearly much lower than the above described potential priority demand, according to the official guidelines, as described in the previous section.

In addition to this, despite the continuing care client's stronger links with the services when compared with

---

[1] Including only professionals doing exclusively drug therapy and counting for one month period sampling. Therefore, the actual number may be a little bit higher, but impossible to be estimated.

clients with minor distresses, the constant disruptions[1] and lack of medicine[2] in the two services are still very severe for them. With such a situation, it is expected that the poorest users and those more dependent on drugs would leave the local service, referring themselves to the existing better provided units - the psychiatric hospitals. There, at least medicine and professional care are certainly provided, and, in case of need, the only form of more complex service is available, i.e, admission.

The empirical findings describing the clientele of the two districts reinforces this hypothesis, suggesting that

---

[1] For several times during the fieldwork, such disruptions had occurred and no previous notice had been given to the users, mainly in the Sao Paulo district, showing a strong disregard or lack of concern with them. The situation is even worse when considering that most of the users are illiterate, and several times notices were given in written form without the presence of staff to explain what was going on. In the survey results, there is a comparatively higher rate of complaints by users about attendance problems (q 17a) at the SPd.

A good example of this process was the transference of one of the psychiatrists from the SPd to another service unit in the centre of the city in November 1989, without any previous preparation of his clients for it. Several incidents occurred in consequence, including agitation crisis by one of his distressed users when communicated that she would be transferred and had to wait hours to be consulted by another doctor.

[2] Some of the survey results seem to confirm this. Among those who take drugs, 56.7% stated having difficult to get them (q. 13f), and the Ld shows the highest figure, as expectable. If the pattern of answers to the question 13g - on what happens when they do not get them - are examined, 57,6% of the cases report the necessity to buy and 38.0% indicate strategies to cope without them or the symptoms' coming back.

the absolute majority of the users present minor distresses[1].

The available information for the whole Belo Horizonte service network, provided by professionals and programme supervisors and coordinators, also reinforce the statement. Despite not pointing out any exact figures, the municipality network coordinator indicated that an attempt to assess the number of former in-patients being treated in November 1989 in the local network was about to be finished, showing until then very low numbers [I:Carneiro, 1989]. The problem is clearly acknowledged in the network professional meetings, and explicitly pointed out by several professionals [I: Akerman; Olga; Silva; Marinho; Ferreira; Cilene] and supervisors [I: Barreto; Souza MDC; Jose Roberto; Passos].

Furthermore, the results from local epidemiological evaluation of the clientele by two mental health teams working in other health centres also confirm the phenomenon. The first was performed in the Alcides Diniz Health Centre, in Belo Horizonte, where only 23,9% of the users had had previous admissions in psychiatric hospitals and 16.7% were diagnosed as psychotic. The author concludes:

> "The major part of the clientele attending the programme is **not** formed by patients who seek hospital care. They are those who, as 'clients' of the health centre, receive now more resources, allowing them the sophistication of their demands -they can now be heard by specialized professionals. The patients who normally seek the hospitals as the only reference continue to do so.
> How to deal with this dissociation between the

---

[1] See chapter 4 and also section 3.1 in chapter 6. Some additional indications also reinforce the statement: in question 10b, on the reasons for seeking treatment, only 10.4% indicated any answer which could be classified as "serious behaviour problems". The rate of users presenting what was coded as "exclusive and/or non exclusive inactivity behaviour" in daily life (q. 19a) is 18.2%. Only 30.4% of all users had had at least one admission in psychiatric hospitals in the past (q. 11a).

> community demand and the programme demand? The patients who constitute the main subject of the programme's attention appear in a very low significant number in our statistics. It is interesting to note that only 12.8% of the people who seek us were referred by psychiatric hospitals" [A: DMS: Oliveira (1987) Diagnostico: 10-11].

The second health centre is in Varginha city, in the interior of the state, where the programme was also implemented, with only 12% of the users presenting psychosis, pre-psychosis or drug addiction. Conclusions identical to the previous case were drawn from this second study [A: DMS: Sales (1988) Estudo: 2].

To sum up, it is possible to say the following for the Belo Horizonte case:

- the real capability of a team working with the service model hegemonic in the present moment is actually much lower than the potential priority demand of users with 'more chronic and serious problems', when considering the official guidelines for a standard catchment population of 50.000 inhabitants.

- there is a former in-patient population which is either not being referred to or is not coming to or maintaining the treatment at the health centre network services.

- the present service model is clearly mobilizing and 'filtering' the clientele with minor distresses and problems.

3.3. COMPLEMENTARY NOTES ON THE HEGEMONIC PROFESSIONAL SERVICE MODEL AND THE CONTINUING CARE CLIENT

The present hegemonic professional culture in the region, with emphasis on the psychoanalytic approach and an upper class private clinic model, induces a clear practical resistance against an emphasis on the continuing care client. Some of the metropolitan supervisors seem to acknowledge clearly such implications of the psychoanalytic

diffusion among the professionals:

> "When the psychotic comes, he/she is generally seen by the psychiatrist. This consultation is guaranteed. But for the psychologists and social workers, this is very difficult to achieve. We see it and we have no answer. They come to me and say: 'I won't consult psychotics'. I can't just dismiss them (the professionals). (I reply) 'Do you want to do any course?', but I don't have means to impose, and there is no training for this person in order to make them consult the psychotics. Therefore, we have no answer, and only the psychiatrist does the job" [I: Souza MDC,1989].

> "Now we are facing a proposal to do what other programmes do, that is to come after the ex-in-patients. For example, sending letters to the family saying that it is important to the individual to come back and so on. Some psychoanalysts turn up their noses just to hear that ..." [I: José Roberto, 1989][1].

Ironically, even supervisors with a psychoanalytic background suggest some form of realization of the limits of their instrument to deal with this kind of clientele:

> "I think that, in relation to the psychosis, there is some theoretical deficiency to base the work even with the neurosis, and with the psychosis it is much more complicated. The psychoanalytic approach in this field is just initiating and does not sustain by itself in terms of theoretical production, and I think this is indeed a hole in the system. In the end, the person is only medicated ..." [I: Lauar, 1989][2].

Also among the professionals, there is a relative spread awareness of the issue [I: Silva, Ferreira, Silveira, Cilene, Olga, Siqueira].

How can such an awareness of the problem without substantive will for changes be interpreted? In my view, **the combination of a context of crisis in the statutory sector**

---

[1] Other supervisors also acknowledged the problem when asked like Carneiro, Mancio, Passos.

[2] The problem is also indicated by other supervisors with psychoanalytic background, like Barreto and Akerman.

(part time jobs, poor working conditions and training, and low wages) and of crisis of the middle class clinic market, induces a clear strategy of corporatist appropriation of the former by the professionals. The statutory services are then viewed as a temporary step while breaking through the huge competition in the private market. As a result, there is no material basis for a concrete interest in developing alternative service models more adequate to the specific features of the clientele of the former. The problem is more acute for the poorer continuing care clients, who require a much broader concept of care than that provided in the private clinic. The result is an over-psychologization of all complex and multiform aspects of mental illness, which leads to a clear negligence in relation to the continuing care clients. These have been just treated with medication, undermining the strategy of de-hospitalization. These findings practically confirm empirically some impressionistic predictions made by Giordano Jr (1988).

A very persuasive example of this was noticed in the Sao Paulo district: a case of m. retardat. and epilepsy in a male adult without any family support, for whom the health centre might be one of his main sources of support. He had been treated only with drugs by one of the psychiatrists, who made the following description of the case:

> "He is a person with a great potential, if we had a social and rehabilitation programme. I mean, he is a person who could be easily working packing goods in a supermarket without any problem, and perhaps be

inserted in several other activities easily..." [I: Passos, 1989].

The irony is that, despite the general lack of basic community care in the country, this specific health centre is inserted in a social centre with an exceptionally good provision of other social resources[1] which could easily be used in an informal and even immediate rehabilitation plan. However, the programme has no occupational therapists, and the two social workers included in the local mental health team offer only individual consultation heavily influenced by the psychoanalytic approach and have no contacts whatsoever with their colleagues settled less than 50 metres from their work place, inside the same social centre.

In my opinion, then, **it would be possible to expect from the mental health professionals some mechanisms to escape from the impotence in coping with the general lack of welfare structures to deal with all destitute people in the country, including the mentally ill. However, in the case of the Belo Horizonte mental health plan, this abandonment of the social approach is still reinforced and amplified by the corporatist strategy[2].** The São Paulo district service provides a persuasive example of this process, when even immediately available social resources have not been considered at all.

---

[1] The resources include: nursery school, complementary nutrition support for children, pregnancy orientation, a large range of basic professional courses (including for example office-boy, general clerical work, sewing, hairdressers, cooking, manual work and carpentry, easy repair of domestic electric sets, general cleaning, building electricity, plumber), several sports, gymnastics and martial struggles programmes and courses, and leisure activities. These are run by a community council and supported by social workers.

[2] The metropolitan programme coordinator described this process in just one phrase: "The social discourse is not as seductive as the psychoanalytic one, inclusive because it does not make money [I: José Roberto, 1989].

The irony goes even further. As indicated before, the recent concentration of three professional teams at this health centre had originally the purpose to set up a 'day-hospital' (actually a day centre, in English terms), with emphasis on the provision of care for former in-patients and the continuing care client. The local team visited other pilot projects throughout the country to discuss the proposal. Given the structural lack of space at the centre, added to the atmosphere of pessimism associated with the low wages and unsuccessful strikes, they gave up the idea at least until the end of 1989, when the fieldwork was accomplished. Therefore, the professional culture is so rooted and the corporatist answer to the constraints so strong, that even formally established to provide a care to the more needy client groups, the team ended up in offering the mainstream care model.

In any way, at least formally, the programme coordinators have launched some initiatives to deal with the issue. A proposal was launched in 1989 for setting up an information system which could allow a new emphasis on ex-in-patients, with active searching for recently discharged ones by each local mental health team in their respective catchment area [A: CPSM MG (1989) Encontro] [I: Passos, 1989]. In addition, a proposal for a 'Psycho-Social Care Centre'[1], also a facility model similar to the English day-centre, was issued in November 1989, to be implemented in the central area of the city with the participation of the state university.

Another measure is an attempt to deal with the staff biased distribution of clients to the different professionals for the first consultation. There is an

---

[1] The facility model is clearly influenced by the experience of the same name already established in the city of Sao Paulo, to be described later on in this chapter.

acknowledged informal mechanism within staff sections in bigger health centres, as the São Paulo district one, to refer the continuing care client to the psychiatrist instead of to other professionals, mainly in case of clear need of medication. Some effort has been put in to avoiding such selective processes, asking staff to refer to the first available professional regardless of the type of user problem.

However, **the impact of these initiatives' may be very low and superficial if not followed by a substantive debate and measures in relation to the range of factors identified above. Special attention should be drawn to a re-evaluation of the hegemonic professional culture in the statutory network and of the division of labour and specific tasks of each type of professional within the teams, especially regarding the continuing care client.** For this purpose, a substantive investment must be concentrated on research and training in alternative approaches for this kind of clientele.

The Belo Horizonte area itself can provide some modest but suggestive experiences in this respect, as counter-examples in relation to the São Paulo district case. The first one is the already described 'Guimarães Rosa Project', implemented voluntarily at the Raul Soares Hospital between 1979 and 1983 (see section 2.2.1.1.c. chapter 3), which could be easily expanded to out-patient units given its informal and simple technical approach. The second is located in Caete, a small town still belonging to the Belo Horizonte metropolitan area, where not only a careful medication is accomplished, but also a family group was implemented supporting and orienting the relatives. Moreover, some of the users have also been referred to an old people and pensioner's group, where they have access to some leisure and manual work activities. Despite the absence of figures, the number of admissions has dropped

considerably [I: Mancio, 1989]. Vila Marília health centre, in Belo Horizonte, has a similar experience of informal rehabilitation activities, by which users may perform a more active role, also reporting a decrease in the number of admissions [I: Ibid]. Additional experiences in the Belo Horizonte area, with popular participation, will be considered in chapter 7.

Therefore, occupational and social rehabilitation should constitute one of the first issues to be re-addressed, probably including the presence of trained occupational therapists and the consideration of more advanced models like work cooperatives, as in the Italian model. In addition, this would lead to the issue of intermediary services, which constitutes a real 'gap' in the Belo Horizonte service network. Further discussion on alternative service models will take place in the following chapters.

Finally, a last topic also deserves attention: alcohol dependence. Despite the acknowledgement of it as a major problem of public and occupational health in the country and its common association with other nosological states, mainly psychosis (Cardim et al, 1983; Santana and Almeida Filho, 1987), little attention has been concentrated on alternative forms of treatment. In the two cases focused on here (SPd and Ld), just two users among the sample of 194 showed some indications of alcohol abuse related problems in the past in all questionnaire answers. The absence of these cases in the service network is not only related to the service model, but with the complex intrinsic characteristics of the problem. In the whole metropolitan area, only the recent Minas Centre of Drug Addiction, created in 1986, is providing specific attention to it, also from a psychoanalytic perspective. In all service network, the trend is to transfer the problem to the local AA (Alcoholics Anonymous) groups, which is considered the most efficacious

strategy, and, in a great many part of the teams, contacts with them were not even made. To sum up, the whole issue would undoubtedly deserve more of the programme attention in terms of research and training.

3. THE FAILURE TO OFFER SUPPORT TO INFORMAL CARERS

3.1. THE LACK OF ACTIVITIES FOR SUPPORTING INFORMAL CARERS AND USERS' FAMILIES IN THE SERVICE NETWORK

With the already described service model hegemonic in the present context at the two health centres, **there is practically no room for supporting the user families and/or other informal carers.** In general, there are only two main occasions when relatives are at present contacted at the two district services.

The first one is in child attendance, when a usual contact with the mother is necessary to assess the case during the first encounter and at key periods of the treatment. Even so, the psychoanalytic approach used in the SPD tends to encourage professionals to cut the contacts with the relatives after this first period of assessment, in order to avoid the identification of the former with the family interests and the blocking of an autonomous transference relationship between client and therapist. The approach used by the psychologist and social worker at the Ld proved to be more flexible in this respect. For example, they tend to manage more dynamically first demands for child treatment which was basically hiding implicit demands for help by the mother, ending up in the latter being the main client. The social worker there use to make a systematic life history of their clients, having a broader view of their whole social network [I: Ferreira, 1989; Silveira, 1989].

The second occasion refers to the psychiatrists'

approach to drug therapy of the few more impaired users. In these occasion, first assessment, prescription changes or renewals also depend on the information provided by the user companion, or when specific instructions or brief advice is offered to them by the professional.

Of these occasions, contact with relatives is the exception. Following the characterization of the hegemonic service model in the Belo Horizonte metropolitan area in the last chapter, this seems to be the general situation in the absolute majority of the service units.

3.2. THE RESULTS OF THE SURVEY IN RELATION TO THE ISSUE

3.2.1. Methodological Introduction

It is important to acknowledge that the adopted survey design was not the most appropriate for the present topic. The interviews were accomplished at the health centres, after or before the consultation, and despite the guideline to reach as many companions as possible, the ratio achieved was only 30.4% of the cases. In addition, it is probable that some of the interviewed companions might not have been the best informants about the informal care provided to the direct clients. A better strategy in relation to informal carers and family issues would have been to interview and observe users, their relatives and friends at their homes, but for budget and time reasons, such an approach was impossible. Moreover, given the very low figures, most of the graphics here will represent the number of cases (the exceptions will be indicated) and no statistic tests were possible, as the proportion of cells with expected frequency less than five is very high (around 75%). Therefore, the analysis will be roughly made in terms of the absolute numbers and visible trends.

Despite all these limitations, the present results

still provide some useful exploratory insights into the subject, as following.

3.2.2. The Family as the Main Source of Informal Care

The results show that in a context of general lack of more complex services for the mentally ill people, **the family is undoubtedly the main structure for their care.** 96,9% of all users live with their immediate family or relatives. When trying to trace the living conditions of the most impaired clients, using the indirect criteria of inactivity behaviour (q. 19a) and of those requiring special care (q. 21a), it can be can seen that most of them live with their parents, and some with their spouses and children, or with other relatives, as shown in Figure 13.

The cross-tabulations between indicators of clinic and civil status shows that the higher the disability, the higher the probability of being single[1]. If crossing the number of previous admissions (q. 11c) and civil status, as shown in Figure 14, the rate of single people increases with the number of admissions, but there is no trend to increase the number of separated people. **This suggests that, within the clientele of the two centres, the disabling effects of mental illness decreases the likelihood of a mentally ill person getting married, but do not increase the chances of splitting already established marriages. Therefore, at least for this population sample with few cases of more serious problems, the family structure and marriage ties are strong enough to resist the disabling and conflicting effects of mental**

---

[1] Among the 18 cases requiring special care, 17 are single and 1 is married. Among those with exclusive inactivity behaviour, 14 are single, 1 is married and 1 is separated.

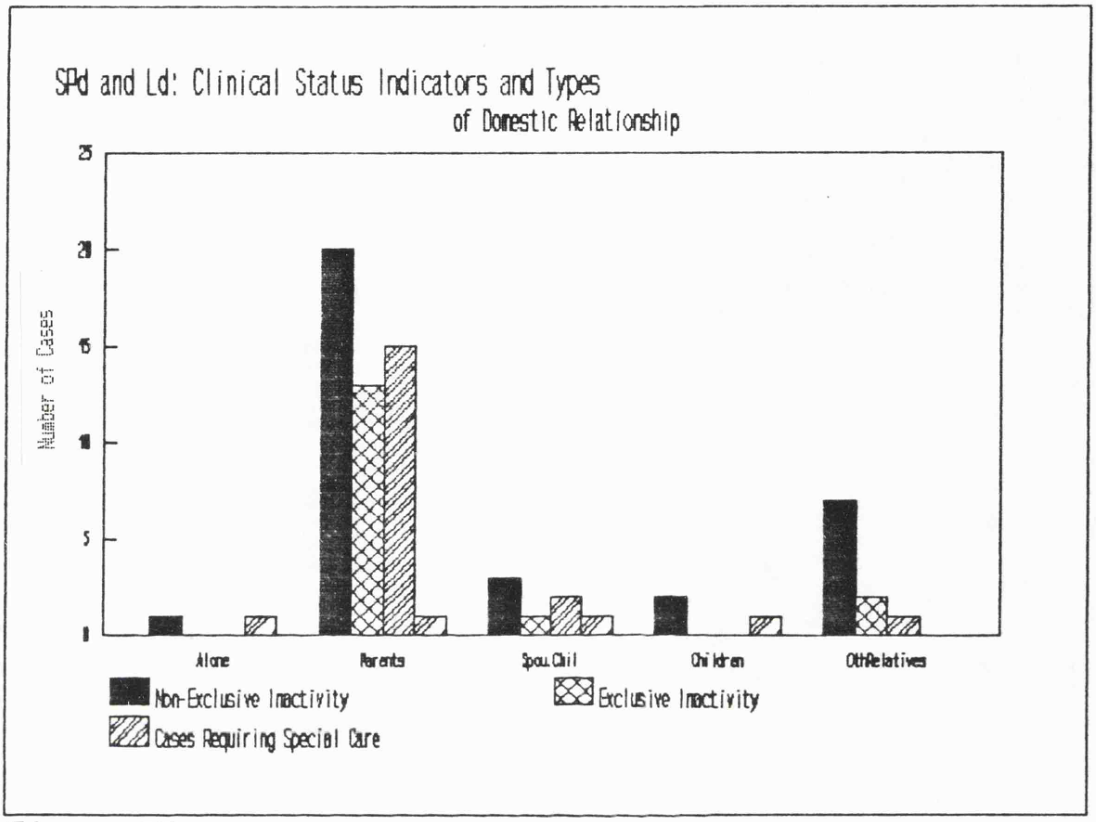


Figure 13.

illness. Similar findings were reported by Souza, AL (1987: 63) in Salvador, Bahia.

Moreover, **the kinship ties seems to function as an alternative structure of care in the case of those without the possibility of living with their closer relatives.** The cross-tabulation between the number of admissions (q. 11c) and the description of the household arrangement (q. 6b), shown in Figure 15, provides a useful indication. The only association is among those living with other relatives, for whom the higher the number of admissions, more cases are presented. Although it is impossible to assess carefully the

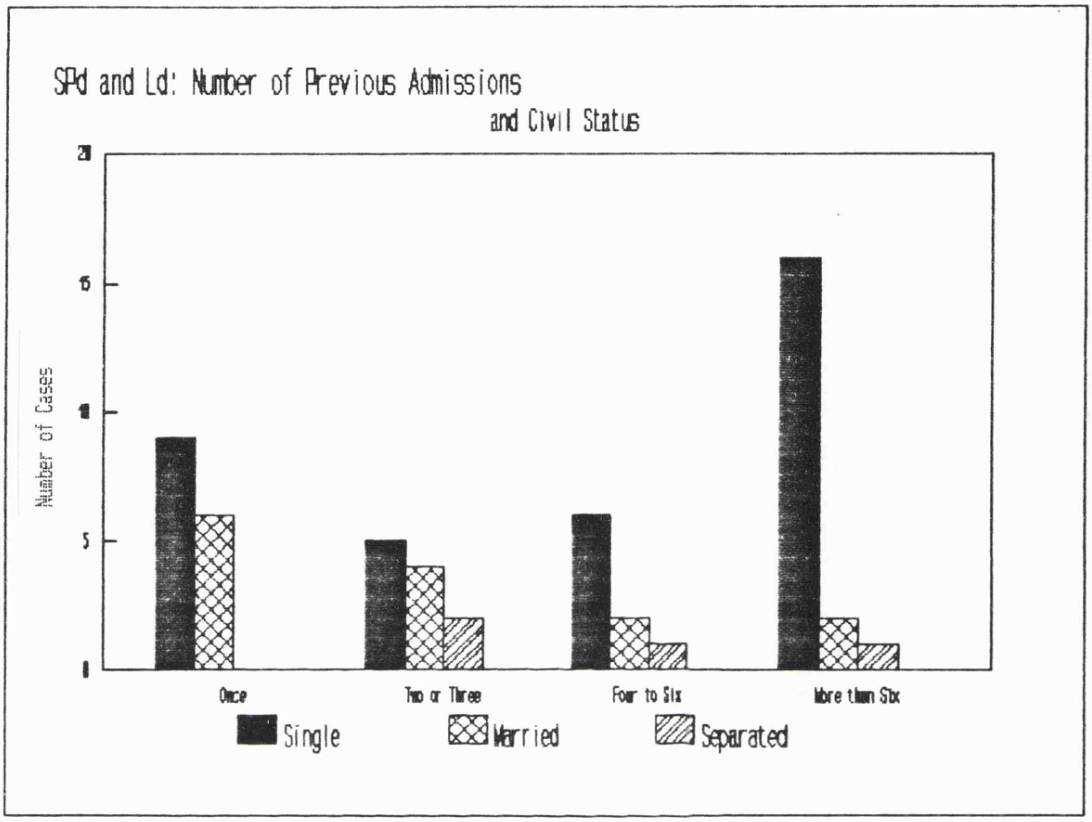


Figure 14.

reasons for this breakdown in the original family ties[1], it is clear that other relatives substitute the parents or spouses in the duty of providing accommodation and shelter. As a last observation on this topic, all family situations (q. 6b) seem to present similar rates of reported problems related to mental illness (q. 20a).

Among the eighteen cases who were taken to the two health centres and who were reported needing special care by their companions, the mother (72.2%) and the user' sisters (22.2%) are the main informal carers, **confirming the known trend for the female relatives to constitute the main source**

---

[1] They might be cases of rupture with or loss of the closer relatives, recent migration to Belo Horizonte or even rupture provoked by the effects of mental illness itself associated to the previous reasons.

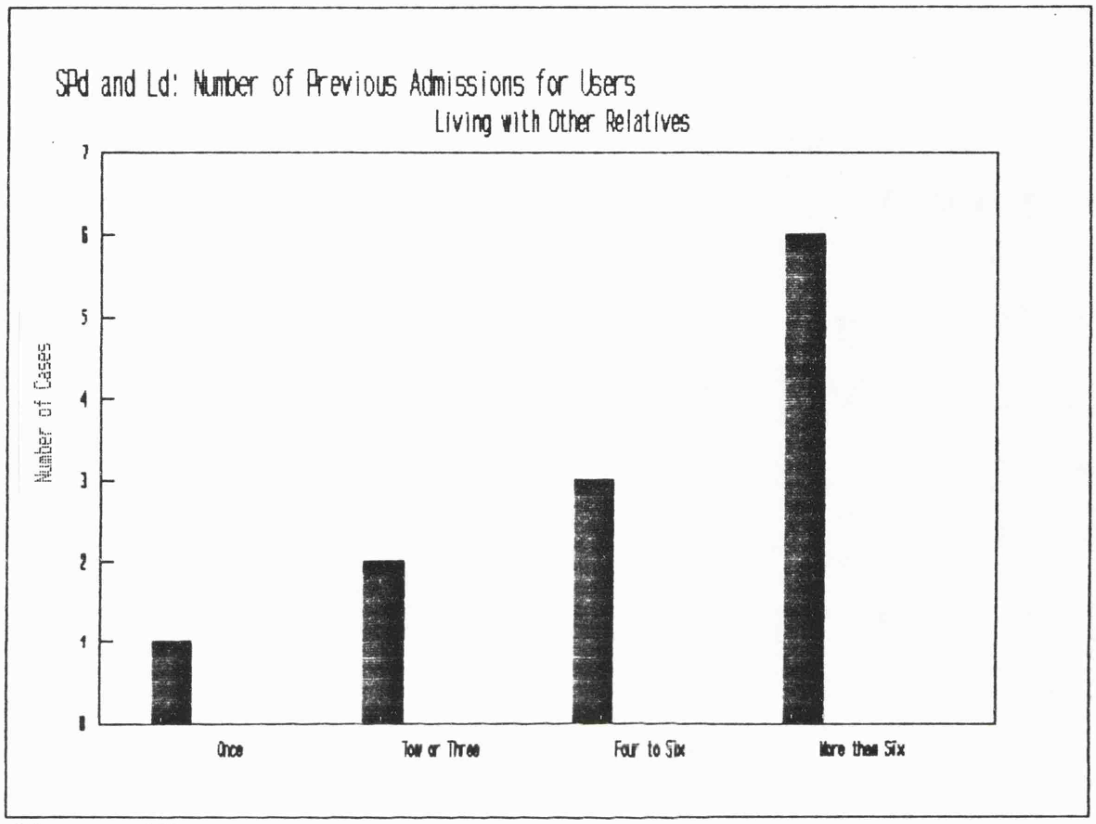


Figure 15.

of family care.

3.2.3. Some Features of the Problems in the Relationship between the Family and its Mentally Distressed Member

a) The Hospitalization and the Domestic Economy

Probably as a consequence of the low number of very impaired users in the two centres, there is no association between having one or more previous admissions and the performance of household duties. No correlation was found between the results of questions 5g (do you perform household duties?) and 5h (length of time spent in those tasks) and of the questions 11a (have you had previous admissions?) and the number of admissions. In other words, for this population sample, the fact of having previous

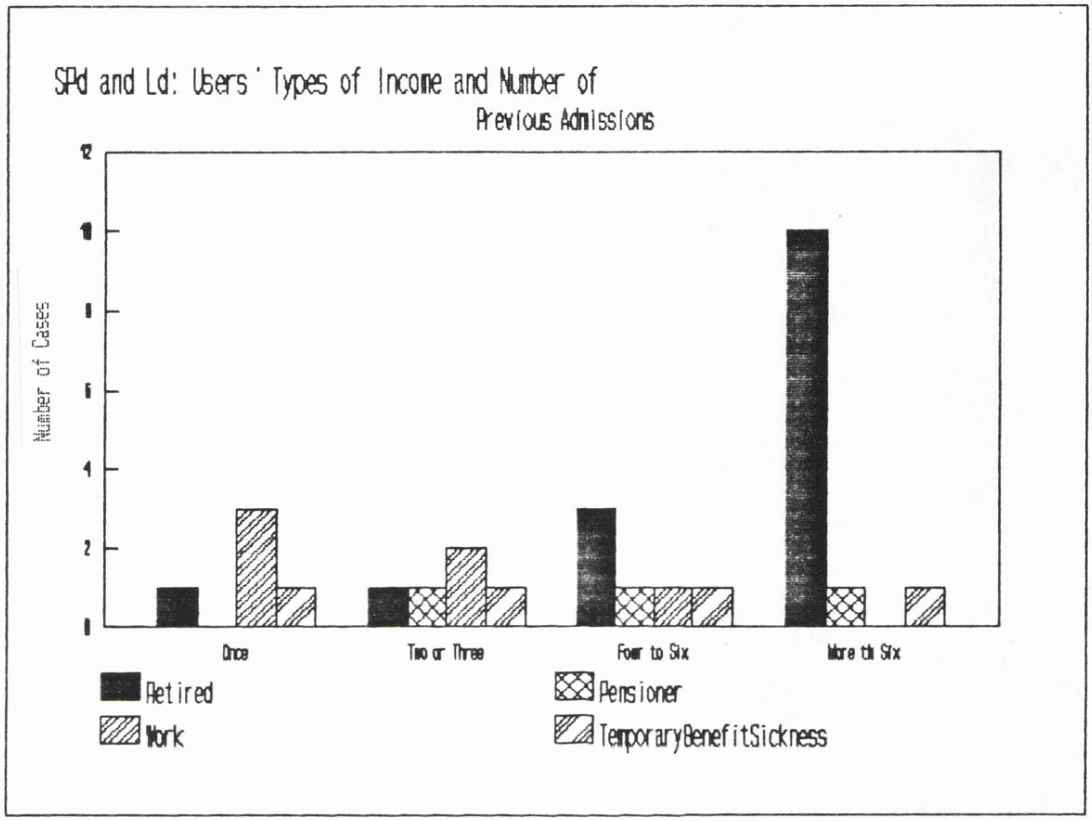


Figure 16.

admissions alone has not affected the ability to perform housework, and does not provoke any important change in the domestic production of services. This probably also means that admission is not a good indicator to evaluate the impairment of the mentally ill member from the point of view of the family.

Further evidence of this can be found from the financial perspective, as shown in Figure 16. While successive hospitalizations tend to increase the inability to earn money from formal work, this trend is compensated by the fact that admissions increase the likelihood of achieving retirement benefit. The figures comply with the literature in the country indicating the strategy to seek admissions as a means to achieve social benefits (see section 3.3, chapter 2). Only those with disabilities since

younger age, which does not enable them to have previous experience of work and to achieve a formal link with the social insurance system, could be considered a special burden to the family from the financial point of view.

b) Gender Aspects

The issue of burden on the family can not be discussed without taking into account gender. In a population with a high proportion of individuals performing informal work at home, which is more associated with the female role, it can expected that the disabling effects of mental illness in the domestic sphere will be felt more by men than women, as staying at home and performing some homework is a more acceptable situation for and by women. The survey's results support this view. The number of cases with exclusive inactivity behaviour (q 19a) and of those requiring special care (q 21 a), and the general rates of inactivity behaviour (19a again) are significantly higher for men[1].

Women also seem to be more sensitive and aware of the consequences of their distress which may be unpleasant to the significant other than men are for theirs. In the description of family problems associated with mental illnesses (q. 20b), the answers grouped in the category described as 'self-acknowledgement of unpleasant symptoms in

---

[1] The exclusive inactivity behaviour shows a higher number of cases for men (13, against 3 for women), and the non-exclusive inactivity for women (11, compared to 6 men). The total number of cases classified in both cases is higher for men (19 cases or 27.9%, n=68) than for women (19 cases or 11.2%, n=125; z=3.21). The rate of users requiring special care is also significantly higher for men (chi=0.0296 - before Yates correlation).

the daily relationships'[1] showed a higher rate for women (21 cases or 22.3%, n=94) than for men (4 cases or just 8.3%, n=48; z=-2.81).

c) Age Aspects of the Relationship between Mental Distresses and the Family

Despite the signs that the questionnaire was not sharp enough to measure the issue and that figures had not achieved the desirable level of statistical significance[2], **there seems to be indications of a trend for a higher number of family problems (reported by both users and companions) related to mental illness (q. 20a) particularly in the two periods of life in which individuals are more dependent:**

---

[1] Like in the following expressions: "I have mania of everything very clean. They (the relatives) arrive late and I don't allow that they change my life rhythm. When I'm watching TV, I don't allow anybody to change the channel, these things..."; "we maltreat the persons without noticing it, and when we come back to normal, then, we remember what happened"; "I tried to kill my mother and my sisters, and everybody ran jumping through the window"; "sometimes we have nerve problems, many times we become nervous without reason and the people loose their patience. Just this is already a problem.."; "the nerve, we try to throw it out, we say so many things, breathe out, and then we hurt the people, and they don't understand..."; "in my case I feel an almost obsessive drive to change certain things which run out of my control, to require people to be perfect...".

[2] For the whole table, chi=0.1708. However, if taking only the age ranges of 0/7, 18/25 and more than 60 years old, the result was significant. There are clear signs that the questionnaire and the research setting were not adequate for such a sensitive issue (q. 20.a): just three cases reported no problems at all, and the table was set comparing the positive with the 'don't know' answers. The question was asked in an abstract form, as proposed by Vaus (1983: 73) for sensitive matters, in order to allow users and companions to distance from their immediate problem, but the effect of projection (in the Freudian meaning of this notion) would suggest that part of their own reality might have been inserted in the answer. The issue clearly deserves further investigation and more appropriate research instruments.

infancy and old age. Figure 17 suggests that the percentage

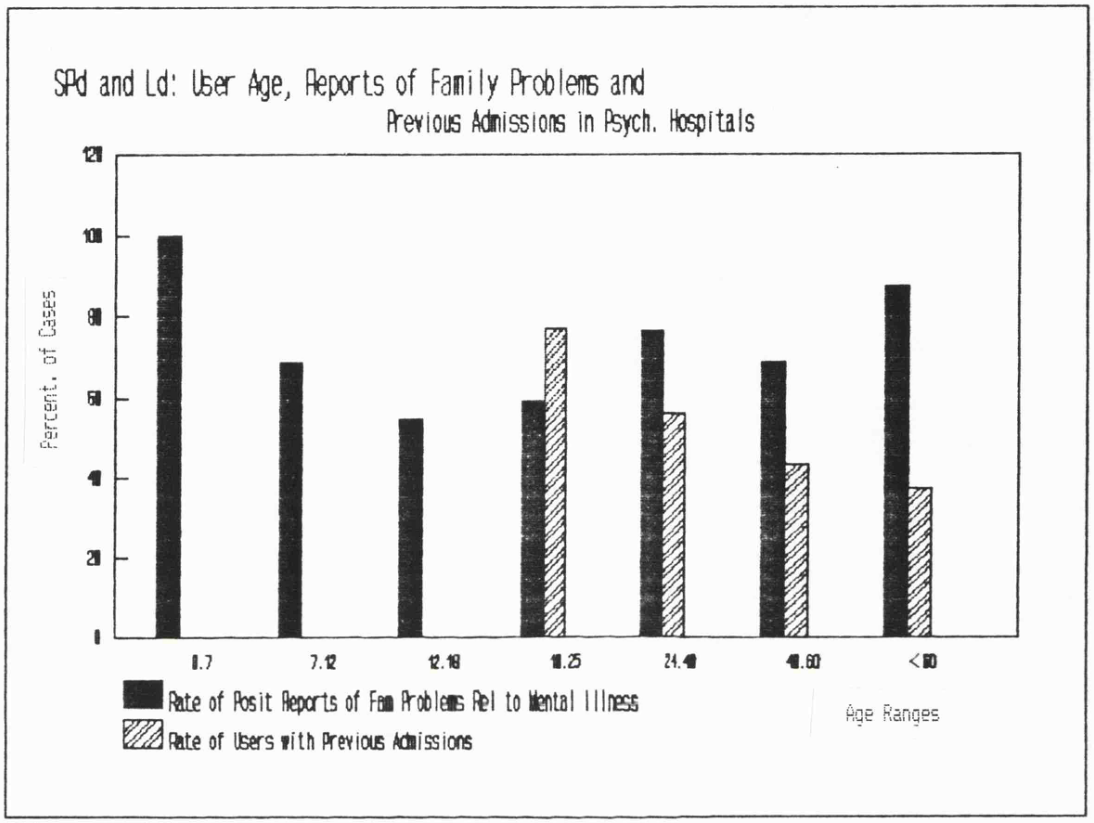


Figure 17.

rate peaks on the borders of the age distribution, having the lowest figures during the two periods between 12 and 18, and 18 and 25 years old.

What is striking in relation to age is that **an inverse trend** is shown when crossing age and the question on existence of previous admission in psychiatric hospitals (11a), as also indicated in Figure 17. As it is clearly possible to see in a highly statistically significant way[1], children and old people have the lowest likelihood of admission. In turn, hospitalizations actually start and peak for individuals aged between 18 and 25 years old. A further cross-tabulation of variable sex shows that the same trend

---

[1] Chi=0.0001 for the specific cross-tabulation age and number of admissions, although cells with EF<5=42.9%.

is maintained for both sexes separately, and also in a statistically significant way.

How could such an apparent contradiction between the number of reported family problems due to mental illness and the number of admissions be interpreted? If the indications reported here are correct, it could be hypothesized that **the family tends to protect their naturally dependent members, to whom an admission would be inconceivable and generate too much guilt, although feeling (probably in an unconscious way) that they represent the heaviest burden for the family. From the opposite perspective, the hospital performs the complementary function of releasing the family burden of their more independent distressed adult members, who the family might feel not so guilty about sending to the hospital.** Following the same reasoning, it is also possible to expect that a potentially similar role could be performed by out-patient services, when provided systematically and aimed at releasing the burden and supporting directly the family in its specific needs in relation to the care of its ill member(s).

Despite the lack of studies focusing on the issue in such a disaggregated way, the few findings reported by the Brazilian literature on this subject are quite coherent with the results outlined here[1].

3.2.4. Users and Companions' Different Points of View on Family Problems Related to Mental Illness

---

[1] It emphasizes:
- that working class families tend to hospitalize their members only as a last resort, when they can not bear any more the problems and crisis by their distressed member (Alves, 1982: 96).
- that the first admissions tend to occur earlier for men than for women, being one of the reasons the family protection towards them (Tsu, 1986: 131).

A richer and more complex description of the family problems, however, is to be found in the open-ended question asking individuals to describe these problems[1] (q. 20b). Here, substantial differences emerge when differentiating who reports these family problems, between users and companions.

Table 11 sums up the main significant trends among the answers. As it is possible to see, there is a strong internal logical coherence within the results. The complaints with significant higher rates for users point to a general lack of understanding from other members of the family[2] and stigmatizing attitudes[3], although the latter's rate is relatively low.

---

[1] As reported before, this question was asked in an abstract form.

[2] It is worth showing some examples of their own discourse: "the people do not understand well my problems"; "the people at times do not tolerate our problems"; "the people should be more communicative with him/her (the ill person) to allow him/her to feel more confident ('seguro')"; "there are people who respect the others' problems, but other people don't. When it is time to avoid trouble, some people don't, provoking more the ("nervous") person ..."; "the family don't understand, and provoke"; "I've already suffered from nerve, and the people at home think that we're ignorant, that (when we do like that) is just to cause problems"; "lack of understanding, of dialogue, all these things are part of the life of the nervous people".

[3] Some of the main expressions are: "the people who see themselves as normal sometimes are more nervous than us. Sometimes the nervous person's leg is shaking and the other shouts at him/her to stop, as it is driving him/her nervous"; "a lot of people have (problems); there are some people in the family who don't accept that that is normal, and end locking up in hospitals the persons who is mad"; "the people start to reject, 'cause you are crazy. We know that the person is nervous, impatient. When we are in depression, when a fly passes by us, people see a camel. If you go out to look for a job and say that you have a problem of depression, you get nothing".

Table 11 - SPd and Ld: Description of Family Problems by Users and Companions (number cases / respect. perc.)					
FROM THE USERS PERSPECTIVE	USERS		COMPANIONS		Z
a) lack of understanding within the family	25	25.8	6	13.3	2.18
b) stigmatizing attitude associated to mental illness	7	7.2	0		3.23
c) lack of knowledge/training on how to deal with mentally ill people	4	4.1	1	2.2	0.75
FROM THE COMPANIONS PERSPECTIVE					
d) complaints about the users 'nerve symptoms' (sum‡)(‡‡)	9	9.3	24	53.3	-6.45
d.a) to be nervous, 'nerve' symptoms	3	3.1	12	26.7	-4.05
d.b) disquietness, agitation, lack of patience, irritation	0		4	8.9	-2.45
e) complaints about the special care needed by the mental ill person	1	1.0	5	11.1	-2.47
f) complaints about tension assoc to the fear of violence/aggression	2	2.1	4	8.9	-1.77
TOTAL NUMBER OF CASES	97	100.0	45	100.0	

(‡) This refers to a sum of all sub-categories of a specific type of answer, in a multi-choice question, for illustrative purposes; the number of cases indicated are higher than the actual ones, as one case can give more than one sub-answer. Two of the most significant sub-categories and their score are shown (d.a and d.b).

(‡‡) The coding process here made a differentiation between complaints of "nerve" states identified in the individual considered mentally ill, and similar states in other family members as a sign of the distress associated with having a mentally ill person at home. The indicated score refers to the first option.

From the companions perspective, the first topics are related to the ill person's unpleasant symptoms. The category of 'nervous' behaviour, which will be fully discussed in the next chapter, seems to accrue the highest rate of complaints. It seems to be associated with some kind of disrupting effect within the family, suggesting a sense of "irritation" that is difficult for the relatives to

handle[1].

Complaints about the special care needed[2] and about the tension associated with the fear of the user's violence and aggression[3] were reported by a very small group of companions, partially due to the low number of them in the whole sample, but also given the low number of impaired users among the clientele of the two centres. Some special tabulations were accomplished in order to identify the main

---

[1] Let some of the expressions speak for themselves: "when we say something to her, giving some advice, she cries a lot, she turns up very nervous"; "I am nervous and she is also nervous, when he is nervous I have to control, (...) and there is also the girl, who is a little nervous (as well)"; "it is difficult to understand, the minor problem the person becomes nervous, with a lot of preoccupation". However, mainly in the case of users, it also may refer to intra-subjective states and distresses, like in the following case: "I have seen a lot (of problems). There are a lot of arguments between the husbands and the sisters-in-law. I myself am not like that, my nerve is just for myself, in silence".

[2] Here are some common expressions used: "It is not everybody who likes to help to care for, and then arguments start, 'cause one complains that the other does not help, or that the treatment is not good, and therefore, the quarrel begins..."; "we need to have a lot of patience to look after him, mainly as he thinks that the world turns round him. People does what he wants"; "it is necessary to stay the whole day looking after her, it is hard difficult".

[3] Like in the following expressions: "due to the tension, everybody becomes tense, as we have to think of him and of the others, and when he starts to be more schizophrenic, we hide the keys, 'cause he has already killed a dog"; "the other children become preoccupied. He may be aggressive, and he is strong. The last time, he struck me in the face. Then, we have to call the police ('os home') and take him to the Galba (local psychiatric hospital)"; "I and my children have difficulties in living with my husband due to his drinking. I'm afraid to go out, as he can beat the children when drunk".

features of the first group[1]. When compared to those also taken to two health centres by companions, but who do not require special care, the description of their weekdays and sundays presented the following features: more inactivity, less housework, less schooling activities, less playing and games (in the case of children), and less sociability (in terms of visits and talk to friends, relatives, neighbours and religious activities).

The additional questions in the companions' questionnaire version provides some important information on the burden of caring[2]. Despite being a small group, given the features of the clientele, the results points to a significant burden on the female members of their families. This is only in terms of time consumed, but also of personal stress and even of special financial expenses. In line with the results on the low number of very impaired users, and with the fact that the previous admissions do not

---

[1] A total of 18 cases reported the need for special care (q. 21a). As one can see in the Appendix 2, the question gives the following examples of care: "to bath, to dedicate attention, to take for outings, to care for, to feed, etc". The positive answers refers mainly to male cases (13 cases), 6 children (4 of them between 0 and 7 years old) and 9 adults between 25 and 60 years old. Half of them had been admitted to psychiatric hospitals before. Among them, 5 presented exclusive inactivity behaviour and just one additional case, non-exclusive inactivity (q 19a). 4 cases of the group indicated as reason for treatment, problems with neurologic or hormonal origin.

[2] More than half of those requiring special care need up to 3 hours of daily care (q. 21b), and just 4 cases (23.5% of the group) require more than 6 hours. Half of the group (9 cases) reported problems related to daily living and caring for their ill family member (q. 21 d), describing problems such as irritation, tension and fear of aggression and violence. The people identified with these problems (q. 21f) are mainly the housewives and/or mothers (4 cases). Among this case group, 10 reported having special expenses with the user (q. 21g), including mainly (q. 21h) medicines (9 cases), and one case each for education, special wishes (mainly snacks), special food and transport.

constitute a criteria for impairment from the perspective of two centre users' families, the complaints by companions do not present any consistent trend when cross-tabulated with the question on previous admissions (11a, 11b and 11c). Sometimes the data seems to indicate less of the reported family problems for those admitted, which could suggest that hospitalization would confirm the role of being ill and encourage the family to exempt its admitted family member from criticism. However, the trend is not consistent along all indicators and tabulations, reinforcing the above indicated findings about the no association between the admissions and the families evaluation of their mentally ill members' impairment. The issue, therefore, requires further research with a more direct approach to family members and environment as the main source of information.

To summarize, **the results show few cases of very disruptive conduct and of very impaired clinical status. Among those who require special care, the general situation is more passive behaviour and lack of social contacts. The provision of informal care is basically a female role, and does mean a significant burden in terms of the time consumed, personal stress and special expenses, even with the special mild features of the two centres clientele' problems. If the epidemiological profile of those admitted in the psychiatric hospitals above outlined are considered, such figures might be just a sign of the huge hidden problems of the informal carers' burden within the whole country's population.**

3.2.5. Other Sources of Informal Support for the Mentally Ill

Questions 18a to 18h asked about the sources of support users have sought in order to deal with problems and difficulties related to the 'nerve' problems. The questions

make an implicit but clear **distinction between support and care**, as the former introduces a sense of **voluntariness** from the users perspective. It means that the care provided by the family, in a context of systematic lack of alternative out-patient care, constitutes a kind of compulsory kinship obligation which, added to the family 'normatization' roles and the structural family aspects of mental illnesses, generates constant feelings of ambivalence, guilt and conflicts. Therefore, immediate relatives might not constitute a good source of informal support from the point of view of the mentally ill member, mainly when personal subjective issues are concerned.

However, **the family still constitutes one important source of support for an important fraction of the users**, with the option 'several times' indicated by 32.0%. **Neighbours and friends, and the church and related people are the main additional sources**, with special attention to the latter in the Ld, showing a rate of 39.6% for the 'several times' option[1]. Out of those, very few other sources were indicated, as following: the school and related people (pointed out by seven children), Spiritualist (sixteen cases) and Afro-Brazilian (six cases) cults, although the actual rate for the latter two may be higher[2].

The answers to these questions were also cross-tabulated with the available indicators of clinical status, in order to investigate the main sources of support for the most impaired users. Given the problems in relation to

---

[1] Not only by the its more traditional cultural background, but also by the strong community organization induced by and linked with the Catholic Church in the area.

[2] As suggested before, it is difficult for traditional Catholic people to report explicitly the participation in such medium rituals.

questions 18d to 18g during the interviewing process[1], the cross-tabulations were accomplished only for the first three options (family, friends and neighbours, and church and related people).

No consistent trends have emerged when crossing these answers with the criteria of previous admissions (q. 11a) and the category of 'serious behaviour symptoms' in the question on reasons for treatment (10b and 13b). In other words, family, friends and neighbours, and the church seem to alternate as most frequent sources of support for those with more serious problems. However, two other important indicators of clinical impairment present some interesting patterns.

The first one is related to the group of users needing special care (q. 21a). When crossing this question which was only present in the companions version of the questionnaire, and the question 18a, on relatives as source of support, Figure 18 shows a statistically significant association between the two variables (chi=0.0303). It can be seen clearly that **the higher the number of people needing special care, the less the family has been a source of support,** and the trend is more accentuated in the SPd. It may mean that **the ambiguities and conflicts implicit in the compulsory care imposed on the family may be undermining its ability to provide informal support, given the reasons indicated above.** A similar table may be obtained with the church activities and personnel (chi=0.0466).

The cases reporting '**exclusive inactivity behaviour**' **in the description of the daily activities (q. 19a) points to a**

---

[1] The above described difficulties in relation to medium practices induced anxiety for some users, and the questions were avoided. As most users did not know anything about Alcoholics Anonymous and Samaritans and required information about them, in a context of time pressure for not loosing other users waiting to be interviewed, these questions were also avoided.

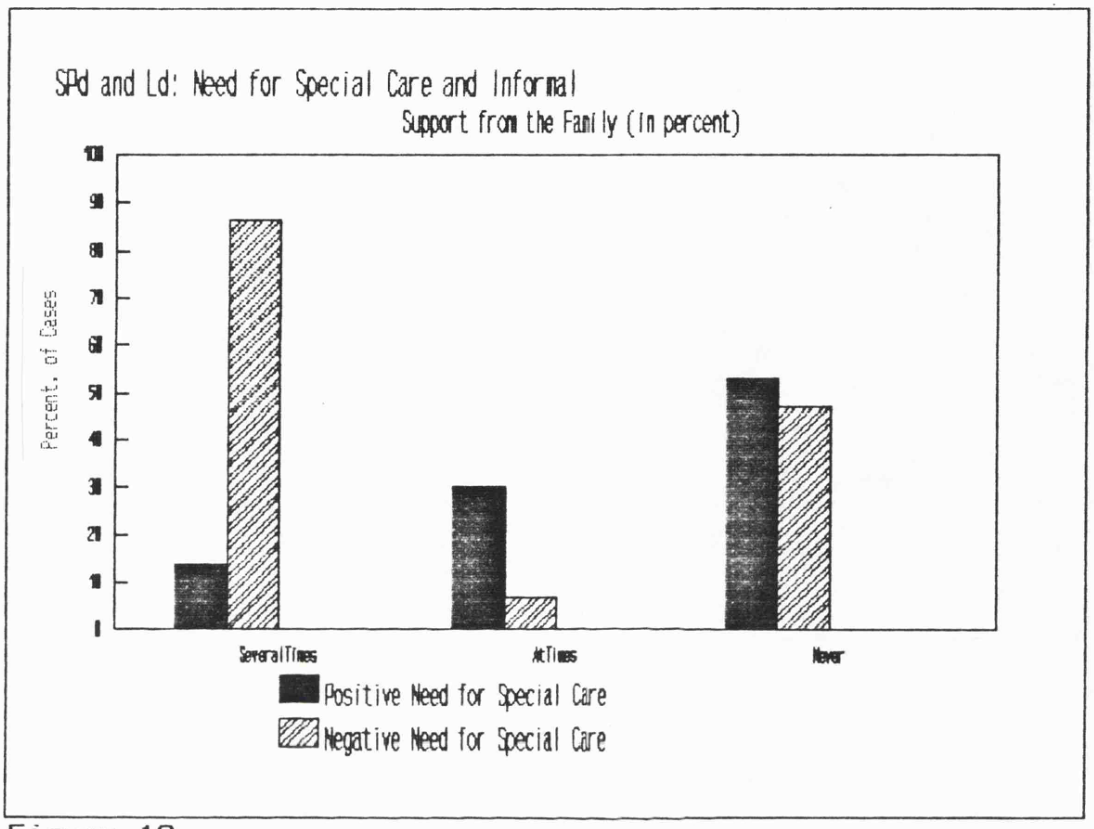


Figure 18,

similar pattern, as shown in Figure 19. All three sources of support had a level of positive answers, for both sexes and both users and companions perspectives, with the exception of family support, as it is only visible in the companions version and for the male users, who are the majority of the cases[1]. This might be related to the gender aspects of the relationship between the family and its identified ill member, as indicated before.

The answers on additional sources of informal support (q. 18h) for those with exclusive inactivity behaviour

---

[1] No statistical test was possible here through the SPSS\PC+ software, because the question is a multi-response one, which needs to be regrouped by special procedures (MRGROUP) that do not allow the normal statistical tests.

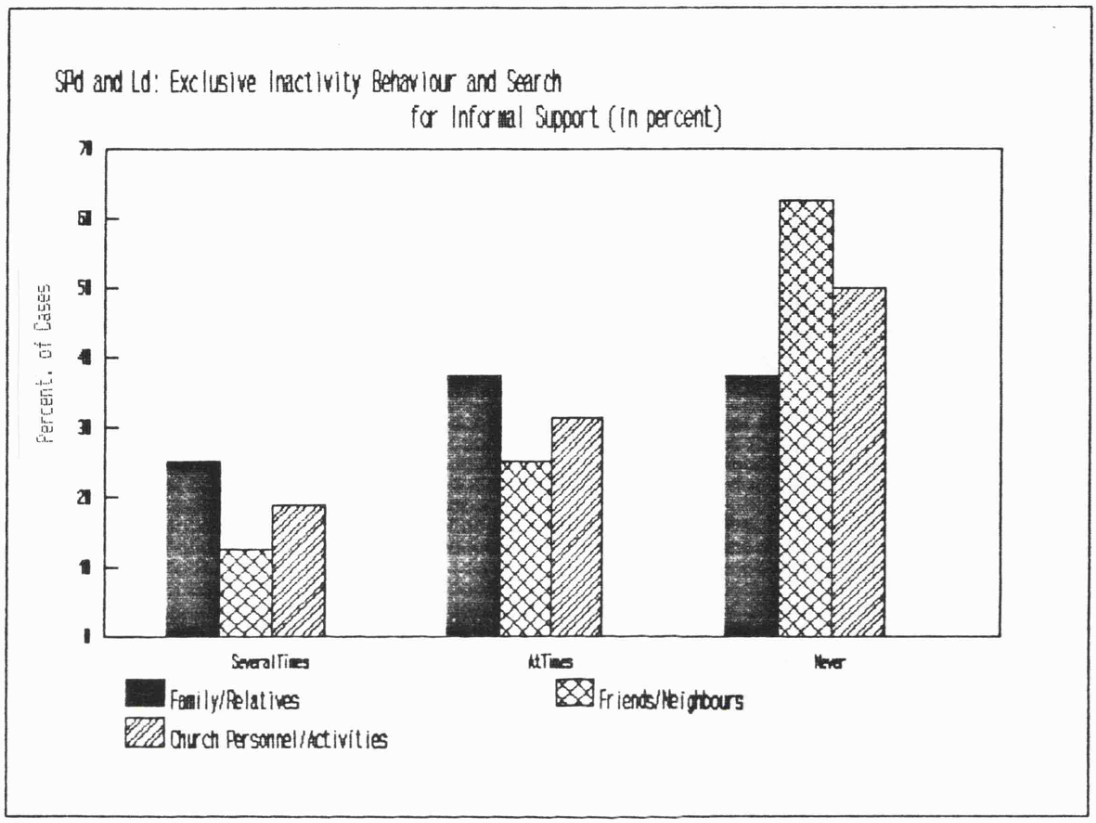


Figure 19.

showed relatively low rates[1]. It is easy to see that for this user group the sources of informal support are scarce, which is quite congruent with the description of their social lives provided above. It suggests that on occasions of personal crisis few alternatives for getting support are available, leading to impairment in their clinical conditions.

. . .

After this analysis of the implications of the hegemonic service model in Belo Horizonte, it may be

---

[1] The majority of the group with 'exclusive inactivity behaviour' (11 out of 15 valid cases) indicated none, one pointed to the family, two to the church activities and personnel and one to mystic and body practices.

interesting to compare it with the available data on what has been happening in Rio de Janeiro and Sao Paulo.

4. CROSS-METROPOLITAN COMPARISON OF THE FINDINGS ON SERVICE MODELS

4.1. THE MAIN TRENDS IN SERVICE MODELS IN RIO DE JANEIRO AND PROBABLE IMPLICATIONS

The influence of psychoanalysis and of the private clinic model in Rio is even stronger than in Belo Horizonte. Among the psychologists of the state, for example, 66,8% indicated it as the main approach regardless of the field of work, the second highest rate in the country. The state also showed the lowest rate of psychologists working in the community (1.9%, while the national average is 5.6%)(Bastos and Gomide, 1989: 9-11). The diffusion of psychoanalysis not only reached the professional cultures in the mental health field, but also created a real 'psychoanalytic culture' encompassing the upper classes culture and even the media (Figueira, 1984; 1988).

In the statutory hospital sector, from the 'Co-Management Period' onwards, the service model evolution took two main directions:

a) Introduction of occupational and social rehabilitation programmes, at the Jurandir Manfredini and Colônia Juliano Moreira hospitals. Mainly in the latter, they include a small part of the large in-population and have huge difficulties in discharging long-stay patients, mainly given the lack of more substantive out-patient care [A: CCSM: Gonzalez (1984) Serviços: 13] (Keusen et al, 1988: 33-37). The long established and internationally known Unconscious Images Museum, at the Centro Psiquiátrico Pedro II constitutes a very important research centre and pilot project in arts therapy and rehabilitation with

schizophrenics (Silveira, 1981; 1987). However, from the point of view of the whole service network, the number of patients included is very low and the project has not been diffused into other units.

b) The establishment of attached out-patient clinics, offering drug therapy and psychotherapy for the surrounding population, with strong influence from psychoanalysis, particularly group therapy. The main and most influential experience took place at the Centro Psiquiátrico Pedro II, between 1982 and 1988, in a attempt to adapt the traditional psychoanalytic techniques to cultural and linguistic features of the working class population (Costa et al, 1984; Bezerra Jr, 1987)[I: Bezerra Jr, 1987], which will be further discussed in the next chapter.

In the out-patient sector, mainly represented by the out-patient clinics in general hospitals and by the INAMPS' PAMs, the mainstream has been the traditional clinical psychiatric treatment by teams with an absolute majority of psychiatrists. The first new move was to set up emergency services in each of health regions of the city, through which all admissions should be directed. The introduction of psychotherapy in the PAMs took mainly the form of group therapy, probably given the influence of the experience at the Centro Psiquiátrico Pedro II and the pressure to attend a higher number of users[1]. However, individual and family

---

[1] The main conflict in the introduction of psychotherapy in a network centralized in larger services like the PAMs, is the negotiation by the professionals of the possibility to book their follow-up appointments freely, by decreasing the number of compulsory first consultations. However, it generates a quick filling up of the professionals' agenda, blocking the huge demand by new users. A further problem is the transport, as users living and/or working in places distant from the PAMs (which are concentrated in the South and richest area of the city) can not afford the transport costs and the time spent for regular sessions, abandoning the treatments [I: Fortes, 1989].

therapy has also been provided by a few professionals. Nevertheless, there is no specific programme or specialized services for families, nor is there any specialized training for them (Alonso, 1987). It is interesting to note the existence in Rio of an important users' voluntary organization, SOSINTRA[1], denouncing the lack of rehabilitation and family support services (SOSINTRA, 1985; 1987).

Furthermore, the problem of keeping professionals in peripheral areas of the city and in the interior of the state is more acute in Rio than in Belo Horizonte[2]. There is no doubt that low wages and a deficient public transport are some of the reasons, but the phenomenon is also a result of a professionals' corporatist strategy of reappropriation of the statutory services, which undermines the programme aims to decentralize the services. In addition, it is also acknowledged in Rio that the statutory services constitute a step on the way to a place in the private clinic sector (Lo Bianco, 1988).

Summing up, **despite the even stronger influence of a 'psychoanalytic culture', the hegemonic service model in Rio is still heavily marked by the traditional psychiatric clinic practice, and the use of psychotherapy has been influenced by an interesting attempt to adapt it to the**

---

[1] 'Sociedade de Servicos Gerais para a Integracao Social pelo Trabalho' (Society of General Services for the Social Integration through Labour), founded in 1979, gathering mental health services users, their relatives and friends, with the purposes of advocating their basic rights and the importance of occupational rehabilitation and sheltered accommodation programmes.

[2] Programme coordinators complained that even doing public examination specifically for a peripheral area, professionals use political means to be transferred to central services. Therefore, the latter end up having professionals in excess, while in peripheral services they are lacking.

cultural and linguistic features of the working class population. Despite the lack of research on that, it may mean that services have been less selective than the Belo Horizonte case in the last few years. However, they are much more geographically centralized and the weight of medicalization and hospital centred practices seems to be stronger than in the latter. Finally, in a service network with these features, the level of out-patient care for the continuing care client and informal carers seems to be very low, like in Belo Horizonte.

4.2. A BRIEF VIEW Of THE SERVICE MODELS IN SÃO PAULO AND THEIR IMPLICATIONS

As already indicated in chapter 3, São Paulo presents a larger and much more complex service network, which is naturally difficult to be described so briefly. From the point of view of professional culture, psychoanalysis is still the dominant approach, but, when compared to Rio and Minas Gerais, it shows a stronger participation of other theoretical perspectives, particularly behaviourism for the psychologists (Bastos, 1989).

The state mental health coordination provides a large range of courses and supervisory activities for the professionals, particularly those contracted from the Instituto Sedes Sapientiae. This allow them to create and support service models not necessarily among those hegemonic in the private

market[1]. One example is the great emphasis on group techniques in all services.

The out-patient service network also shows a more complex structure and variety of professionals, as following:

a) health centres with GPs being trained and supervised in mental health care;

b) health centres with a basic mental health team: a psychiatrist, psychologist and social worker;

c) specialized mental health clinics ('ambulatorios'), with a standard team of five psychiatrists, three social workers, three psychologists, one nurse, one language therapist and one occupational therapist, plus auxiliary staff;

d) emergency mental health teams settled in general health emergency units, with observation beds for a maximum of three days.

Out of these, there is a very interesting pilot project called 'Centro de Atenção Psicossocial' (Psycho-Social Care Centre), a broader day-centre, teaching and research unit caring for 60 adult cases - generally psychosis or severe neurosis, excluded from their families and for whom the hospital would be the 'natural' option. It offers a large range of daytime therapeutic and social activities[2], and

---

[1] These initiatives include: specific training for administrators of mental health services, GPs, social workers and occupational therapists; courses on group techniques; psychopharmacology; psychodynamics diagnosis and psychotherapy; psychotherapy for adults, children and women, or specialized for psychotic users; clinical and institutional supervision; and study groups on several subjects [A: CSM-ESP: Inst. Sedes Sap.(1984-1988), annual activity reports].

[2] Personal counselling, body expression, outings, gardening, cooking, several handcrafts, artistic, leisure and sports activities, and daily meetings. In 1989, some new projects were started: work cooperative, accommodation alternatives and family group therapy.

the results in terms of avoidance of admissions have been encouraging (Goldberg, 1989)(Yasui, 1989)[I: Goldberg, 1989].

Another specific initiative related to the continuing care clients is the Maximum Intensity Programme (PIM) assumed by the majority of the 'ambulatórios', very similar to what in England would be called a day centre programme. It constitutes a clear strategy to break the hegemonic trend for these kinds of users to be treated exclusively with medication. Care includes social, occupational and therapeutic activities from three to five days a week, including family support (Santos and Busnello, 1986) (I Encontro Est. de Ambulatórios de SP, 1988) [A: CSM-ESP: Equipe (1988) Ambulatório]. Special attention has also been focused on the integration of all level services at regional level, as in the North Zone of the São Paulo County Project [A: APSM-SMSSP: Secretaria (1985) Projeto] (Cesarino, 1985; 1989).

There is no systematic information in the literature on the hierarchization of the clientele within the services. However, a-systematic evaluations reported the following segmentation of the clientele:

- division according to programmes inside the 'ambulatorios': cases of psychosis are basically absorbed by the PIM programme [I: Souza EN, 1989];
- division according to professionals: cases of psychosis and other serious problems are more likely to be treated by psychiatrists and occupational therapists [I: Ibid];
- division according to service level: more acute and/or serious cases, particularly of alcohol addiction, tend to seek care directly at the hospitals, emergence units and, in

the last instance, the 'ambulatorios'[1] [A: ASMC-SP: Costa (1986) Programa] [I: Gallo, 1989].

- geographical distribution: it is difficult to keep those living far from the unit coming several times a week to attend the PIM programme activities [I: Gallo, 1989]. Another geographical problem is to keep professionals in the more peripheral areas, as they tend to move themselves to more central services [A: CSM-ESP: I Encontro (1988) Texto], as in Rio and partially in Belo Horizonte.

Despite the absence of a systematic evaluation and the presence of several constraints (I Encontro Est. de Ambulatorios de SP, 1988)[I: Souza EN, 1989], it is possible to state that **the mental health programme launched in 1982 in São Paulo has made an explicit attempt to provide specific attention to the continuing care client and support a de-hospitalization policy.** This can be witnessed both in the existing literature and in actual training and service activities. Some inquiries accomplished at unit level have demonstrated a capacity for the 'ambulatorios', when fully backed, to support continuing care clients enough to avoid readmissions even with a decrease in the average level of medication (Cesarino, 1989: 24; 1985: 135) [A: CSM-ESP: Equipe (1988) Ambulatório: 2].

In addition, it is also possible to state that **there is a clear attempt to provide some support to the family at least through the PIM programme. This is undertaken not only in the form of some kind of direct counselling, but also offering regular activities for the main users, alleviating the burden of informal carers.**

The recent proposals from the municipality mental

---

[1] Therefore, the São Paulo experience reinforces this chapter's findings for the Belo Horizonte area that the continuing care client tend to not adhere to services provided by basic mental health teams, requiring more complex structures of care.

health coordination outlined in the chapter 3, also point to a deepening of this commitment to the continuing care client and their informal carers. Along with the already established CAPS experience, they represent the only initial proposals to deal with needs such as sheltered accommodation and social rehabilitation through labour.

5. SUMMARY AND CONCLUSIONS

In the end, the results outlined above for Belo Horizonte seem to confirm the proposed hypothesis for the present chapter. In relation to the care provided to ex-in-patients and continuing care clients, it is possible to state the following for the Belo Horizonte case:

- the guidelines for catchment population overlook the present capacity of a standard mental health team to deal with the number of estimated continuing care clients in need in their respective areas;
- the absolute majority of the former in-patient population and of continuing care clients which has not been referred to or, if it has actually been so, has not come to or kept up their treatment at the health centre network services, mainly given the low level of adequate care for them;
- the de-hospitalization and decentralization strategies have been undermined. The most impaired cases probably have been seeking treatment at the hospitals, where a more reliable service is provided from the point of view of the user. Moreover, the present situation represents a real problem for those living in the interior of the state, where no accessible complex services are available.
- in all, the pattern of expansion of community mental health services in Belo Horizonte seems to be similar to what has been happening in the USA, as described by Castel et al (1982): the new services are forming a new clientele with minor distresses, instead of caring for the traditional

ex-in-patient population.

The main probable reasons identified here for that are:
- the long tradition of hospital centred services;
- the political resistance from the hospital sector and the lack of integration and information between the latter and the out-patient service units;
- the setting up of services in general health services, shaping the demand for mental health care through a sophistication of the health care demand;
- the present standard scheme of part-time services, bad working conditions and low wages, the constant disruptions in the services, and the poor infra-structure and medicine provision;
- finally, and mainly, the present hegemonic service model, with a systematic lack of intermediary services, lack of popular education activities and dominance of the private clinic model and of the psychoanalytic approach. It is interesting to note that even for the Belo Horizonte metropolitan area there are few isolated counter-examples of alternative service models which seem to offer better and more efficient care for this type of clientele.

In such a context, most of the administrative initiatives being hitherto proposed by the present programme coordination tend to be formal and superficial, and hence, to have their impact lowered.

When addressing the issue of informal care, the service model hegemonic in the two surveyed districts and in the whole service network seems to offer practically no support to informal carers. Relatives are mainly considered as case assessment informants or as recipients of basic instructions how to collaborate with the user's treatment. The survey at the two service units, despite its methodological limitations, made an attempt to investigate the features of the informal care being actually offered to the present clientele.

The family is undoubtedly the main source of informal care for the users in that context. However, users also find some support among neighbours and friends, religious organizations and related people, and at schools, but in most case in a non-systematic way. There is also some indications that the most impaired cases have had difficulties in getting informal support from the latter sources, which can lead to personal impairment in occasions of crises.

The disabling effects of mental illness may decrease the likelihood of a user getting married, but in the sampled group, the family and marriage ties are strong enough to resist the conflicting effects of mental illness.

However, these figures are associated specifically to this clientele, in which there is a low number of very impaired users. Therefore, the fact of having previous hospitalizations does not interfere in the domestic economy, and, by this way, does not seem to constitute a criterion of impairment from the point of view of the family. The amount of reported family problems related to mental illness does not show any consistent differences between those having previous admissions and those not having them.

The burden for the family depends primarily on the sex of the client. The disabling effects of mental illness are more prominent in the male group, and women seem to be more aware of the unpleasant symptoms in relationships with others. Furthermore, women are the main producers of home care for their families' distressed members and are the most affected by the stressing and disrupting aspects of mental problems within the family. Despite the low number of impaired cases within this clientele and the consequent low number of relatives indicating the problem, the burden of care for such cases seems to be substantial.

The burden also depends on age. Despite the indications that the amount of reported family problems are more

identified in infancy and old age, the children and the elderly are less likely to be admitted in hospitals. This suggests that the family tends to protect their naturally dependent members, despite the higher rate of problems reported. In addition, hospitalization seems to perform the complementary function of releasing the family burden generated by the adult distressed members, resulting in lower rates of complaints associated to mental distresses. It was hypothesized that out-patient services could also probably perform a similar role.

From the specific point of view of the users, the complaints about family problems are concentrated on the lack of understanding and on stigmatizing attitudes from family members. From the perspective of the companions, the problems are more related to some of the users' symptoms (particularly those described by the "nerve" representation), the special care required and the fear of violence and aggression.

From a cross-regional comparative perspective, Belo Horizonte indicates the narrower service profile. In Rio de Janeiro, despite a stronger psychoanalytic diffusion, there is a clear effort to adapt psychotherapeutic techniques to the working class clientele. For the continuing care client, the services show a stronger presence of the traditional clinical psychiatric practice and a marked centralization in terms of geographical distribution and placement in hospital units. In addition, no systematic concern with the family and informal carers has been indicated.

In São Paulo, there is a more diversified professional culture and a broader range of intermediary out-patient services. Besides, despite the several constraints indicated, there is an explicit attempt to provide care to the continuing care clients and informal carers, linked to clear purposes in support of a de-institutionalization policy. Such experiences seem to show a reasonable capacity

to be provided more systematically in the future, either in the region and in other places of the country.

Summing up, it is possible to say that the present situation in the South-East region of the country still shows a significant gap regarding the needs of the continuing care clientele and their informal carers in the community, particularly for the Belo Horizonte and secondarily to the Rio de Janeiro cases. If comparing the provided service profile and the ideal list of needs to be met by a mental health policy, as described in chapter 1, it is possible to state that mainly in Belo Horizonte, most sub-topics on prevention, collective assessment of needs, social support in the community, and structures for advocacy and concern within the wider community have not been met.

In the Brazilian context, it is reasonable to expect professional cultures to develop escape strategies from the impotence of coping with the structural lack of basic welfare services for all the destitute people. However, particularly for the Belo Horizonte case, the general lack of concern with most of the above indicated needs is even reinforced by the corporatist interests of the professionals, as outlined in this chapter. Some additional implicit political and cultural issues which also constitute important components of such reality will be addressed in the next chapter.

Chapter 6

THE HEGEMONIC SERVICE MODEL AND ITS CULTURAL AND POLITICAL IMPLICATIONS IN RELATION TO THE WORKING CLASS POPULATION

1. INTRODUCTION

The present chapter will address the following hypothesis:

Hypothesis IV
The hegemonic model of mental health services being offered within the statutory health centre network in Belo Horizonte has:
a) conflicted with the implicit popular social representations of the Person and of mental distress;
b) encouraged less serious and short term psychological problems to emerge as potentially deserving public attention and treatment, as widening the scope of social citizenship rights over hitherto hidden needs;
c) reinforced a process of individualization and psychologization of broader social, cultural and gender conflicts associated with mental distresses, particularly in the case of children referred by the educational system and in the case of mature women who have experienced breakdown in their cultural, family and marriage ties.

The analysis will address directly each of these topics in order. In most of the sections, a brief description of the country's literature and debate on the subject will be provided, followed by the specific findings and contributions from the present inquiry. Given the broad range and complexity of the subject, as well as the undeveloped state of research on most of the above topics in Brazil, the strategy adopted was to gather as many sources

as possible. The evidence provided is probably still indicative, giving this chapter a more exploratory character. In addition, the ethnographic data collected at the Cabana district will be introduced here.

2. THE CONFLICT WITH THE POPULAR REPRESENTATIONS OF THE PERSON AND MENTAL DISTRESS

2.1. THE WORKING CLASS 'NERVOUSNESS' MODEL AND ITS OPPOSITION TO UPPER CLASSES MODELS IN THE BRAZILIAN LITERATURE

There has been now a relatively consensual literature in the country detailing what has been called the 'nervousness' representation model of mental life within the Brazilian working class population[1]. In Appendix 5, a more detailed description of the model is provided, based on the anthropological work of the country's leading researcher in the area (Duarte, 1986b). Its reading is essential to an understanding of this and subsequent chapters.

The discussion of the model is generally framed by the literature within a wider discussion of the contradictions between the working class representation of the Person and what is called the "individualistic" and/or "psychological" model of representing the Individual and mental life. That is common to the upper classes in contemporary Western and Brazilian societies. The debate is clearly similar to the issues raised in the Anglo-Saxon and European literature on ethnicity, transcultural aspects of mental distress, ethnopsychiatry and socio-linguistics. It is possible to briefly summarize the literature as follows:

---

[1] The main studies referred to are: Alves, 1982; Cardoso, 1986; Duarte, 1986a and 1986b; Santos, 1984; Souza, MCG, 1983.

a) The culture of Brazilian working class population is predominantly marked by a specific notion of the Person rooted in a holistic and hierarchical world-view, in opposition to the notion of the Individual and privacy dominant in Western societies[1]. The analysis is mainly based on theoretical contributions by Mauss, Dumont, Simmel, Berger and Foucault. Taking into account the need to avoid an oversimplified dualism, this literature builds a more dialectic approach (Velho, 1981; Bezerra Jr, 1982; Machado, 1982). It also points out the induction of individualization processes implicit to the diffusion of the psychoanalytic culture to working class population, which may be articulated with strategies of cultural and ideological hegemony (Duarte, 1986b; Figueira, 1988; Ropa and Duarte, 1985).

b) The individualistic approach implies an epistemological tendency to divide the 'old' human totality in successive layers of reality, which becomes the specific focus of each of the new human sciences (Duarte, 1986b). However, this psychological model, deeply marked by the psychoanalytic culture in Brazil, tends to invade all aspects of human life - as a kind of monistic empire - and to occupy the place left by the crisis of religion (Duarte, 1986b; Figueira, 1988). This process further reinforces the individualization and cultural dominance mechanisms.

c) The holistic and psychological models provide different representations of the healthy and pathological states, implying different ways for people from upper and working classes to recognise the need for, to demand and to follow treatments (Bezerra Jr, 1987).

d) The psychological model and treatment, mainly based on

---

[1] As examples: Bezerra Jr, 1982, 1987; Cardoso, 1986; Costa, 1983; Da Matta, 1983, 1987; Duarte, 1981, 1985, 1986a, 1986b; Durham, 1986; Figueira (org), 1985, 1988; Lopes (org) 1987; Machado, 1982; Velho, 1980.

psychoanalysis, requires at least three elements which are seen as contradictory to the cultural features of the working class population:

d.a) an 'eidos' (thinking logic) characterized by notions of causality and temporality[1] developed through formal education and cultural life in Western societies.

d.b) an 'ethos' (emotion code), marked by a high "level of 'reflectiveness' of the psychic culture" or the ability to observe and discriminate among emotions and sensations through a specific verbal discourse, with an emphasis on introspection and 'interiorization' (Ropa and Duarte, 1985: 187).

d.c) a 'dialect' or specific discourse. Based on Bernstein (1964), psychotherapy requires an 'elaborated' linguistic code which is contradictory to the working class 'restricted' code (Nicolai-da-Costa, 1988; Ropa and Duarte, 1985).

e) The psychologization process associated with the diffusion of the upper classes model tends to provoke an individualization and a reduction of the complex and broader determinants and symbolic meanings of mental distresses present in the 'nervousness' model (Montero, 1985; Cardoso, 1986; Costa, 1983, 1989b; Ropa and Duarte, 1985).

f) According to Bernstein's (1964) analysis, the psychological model operates an authority system (originated primarily in the family) described as 'oriented to the person', while the working class system is predominantly

---

[1] Causality here means the ability to understand that all human events are determined by specific reasons, even when hidden, and are capable of a logical explanation. Temporality means a specific linear and continuing notion of time, and the individual's ability to remember and link the past to a changeable future, by a personal investment in changes in the present (Ropa and Duarte, 1985: 189; Bezerra Jr, 1982: 115-17).

'oriented to status'. This can generate tension for members of the latter group when submitted to the former (Nicolai-da Costa, 1988; Lo Bianco, 1981; Bezerra Jr, 1982). Similar explanations show the recent deep changes in family structure and socialization process in Brazil as important reasons for the diffusion of the psychoanalytic culture and therapy within the upper classes: as means to deal with the personal identity crisis in such a context[1] (Nicolai-da-Costa, 1985; Figueira, 1985b; Costa, 1984a; Bezerra Jr, 1982; Santos, 1982).

g) The hegemony of the psychological model in mental health services generates power relations between professionals and clientele which reinforce attitudes of dependence and immobility, blocking user participation, creativity, collectivization and militancy (Baremblitt, 1990).

2.2. THE PRESENT INQUIRY'S FINDINGS ON THE SUBJECT

a) From the survey:

The survey is not the best methodological instrument with which to investigate the subject, which would be better perceived through ethnographic and qualitative methods. However, an effort was made in the question formulation and answer coding processes to select the specific categories used by the clientele. In addition, some of the findings included in previous chapters also highlight the subject in an indirect way. To sum up, **it is possible to say that the general findings of the survey are fairly accordant with the literature outlined in the previous section,** in the following ways:

Firstly, the social, economic, educational and cultural segmentation of the clientele throughout the types of

---

[1] This issue will be further discussed in the next chapter.

treatment described in the chapters 4 and 5 can be considered as one of the main direct consequences of the conflict between the hegemonic service models and the clientele's cultural representations and cognitive features. In other words, **it is expected that in a service model emphasizing psychologized representations, the clients who identify culturally with the latter will accept and adapt to it much better than those who identified themselves with another cultural world-view. Therefore, it is not accidental that the poorest and migrant working class clientele, which constitute undoubtedly the neediest user group, are those who are receiving less in the present hegemonic service model.** The same could be said about the continuing care client, as indicated in chapter 5, who generally requires a broader concept of care than the one emphasizing only psychological aspects.

Secondly, **the 'nervousness' categories were directly and frequently used by the clients on several occasions, and represented the most consistent category used to refer to mental distress.**

In answers to question 10b, on reasons for the previous treatments, 27.8% of all users described their experiences using categories such as 'nerve problem', 'nervousness', 'nerve crisis' or 'nerve state'. No other single category for reasons for treatment reached rates above 8%[1]. The same 'nerve' category, at similar rates, was indicated when:

- reporting the reasons for admissions (q 11d), which would naturally refer to more serious problems;
- describing both the direct client's unpleasant symptoms

---

[1] One could fairly argue that this result was elicited by the use of the expression in the questionnaire itself. However, if so, one could expect a decrease in the rate as the distance from the stimulus increases, which did not happen. For example, in the question 11d, on reasons for previous admissions in psychiatric hospitals, the rate is 28,8%.

within the family and the relatives' own behavioral implications of living together with him/her.
In my view, **these results suggest a clear use of the 'nerve' category as a 'switching device' for different meanings and levels of distress,** in accordance with Duarte's analysis of the nervousness model (see Appendix 4).

Interestingly, there is a consistent significant difference between rates found in the Sao Paulo and Lindea districts[1]. **This may indicate a probable association between a more widespread representation of 'nervousness' and the socio-economic and cultural differences between the two districts** (see section 4.1, chapter 2).

The description of the treatment (q 13d) and of the changes due to the treatment (q 14b) also reveals the contradictions between the 'nervousness' and the psychologized representations. In the question 13d, **the rate of answers which could suggest a sense of individualization and understanding of the subjective aspects of the treatment is low[2]**. In question 14b, **the changes are described in the majority of the cases in terms of symptom control and self performance in social relations, at school or at work,** as already described in a previous chapter. These figures may be in part associated with the interviewing process itself,

---

[1] The rates found are:
- q 10b: Ld: 37.1%; SPd: 18.9%; z=-3.28.
- q 11d: Ld: 30.8%; SPd: 21.2%; not significant given the small sample.
- q 13b: Ld: 24.4%; SPd: 14.9%; z=-2.52.

[2] Answers with explicit reference to or some awareness of the mechanisms of psychotherapy reached the rate of 4.2%; and the answers referring to subjective experiences in relation to the treatment, just 2.4%. The latter are particularly representative of the individualized representation, as in the expressions: "just to chat with her helps me, helps me to take decisions, and I've always lived for others and forgotten myself"; "I come here to talk about problems that I had never told to anyone else".

when the subject is a sensitive one. However, in my view, they are also linked to the more collective representation of the Person. Besides, **they might be linked to the highly exploitative economic and social context as well, which would stimulate a specific popular perception of being healthy and sick/ill strongly determined by one's physical and mental ability to perform work** (which is an important element in the nervousness model ['força' and 'fraqueza'])[1]. In addition, the rate of intra-subjective responses for this question is also low (9.8%).

b) From the ethnographic sources:

The direct observation, informal talks and unstructured interviews with community leaders and users also revealed a convincing and interesting material showing that these groups have broad and complex representation of mental illness. Given the space limitations, a very brief set of statements was gathered in Appendix 6, and its reading is also considered essential to the understanding of this and the following chapters. It is striking to see how some of the social and economic vulnerability factors identified by the working class groups as leading to mental distress have been confirmed by epidemiological studies in the country. The available literature summarized in section 3.5, chapter 2, shows a clear association between the higher prevalence rates of mental distresses and socio-economic and educational statuses[2].

---

[1] A similar analytic suggestion is made by Costa (1989b).

[2] In São Paulo, for example, the estimated rate found for the poor working class Brasilandia district is 29.9%, while for the Aclimacao district, an upper class one, the rate is 15.4%. There are also indications of association between higher prevalence and educational background and income, particularly for women (Mari and Andreoli, 1990: 7).

Therefore, in my opinion, it is possible to say that the results of the present inquiry are consistent with and confirm the description of the nervousness model as hegemonic within the working class population in the studied districts, following the model already described in the country's literature. In addition, they also indicate how the present hegemonic service models conflict with this population's diffused representations. However, what has not yet been explored by the Brazilian literature is the ability of these popular social representations constituting a source of alternative models for service provision, more in line with their views on what mental health and distress are, and how mental health care should be organized. This matter will be addressed in the following chapter, after further anthropological and political discussion on the contradictions of the present service model.

3. THE EMPHASIS ON MINOR DISTRESSES AND SOCIAL CITIZENSHIP

3.1. THE EMPHASIS ON PSYCHOTHERAPEUTIC METHODS AND MINOR DISTRESSES IN THE HEGEMONIC SERVICE MODEL

As indicated in the chapter 2, there had been only very sporadic non-private provision of care for minor distresses in Belo Horizonte and in most of the country until the late 70s. As a consequence, the most common treatment strategies hitherto referred by the population and identified by the Brazilian literature[1] have been:

- in instances of very disruptive, odd or violent behaviour, as a last resort families might hospitalize their members;
- the use of religious interventions;

---

[1] Although the issue will be discussed in the next chapter, the main references may be found in Alves, SRP, 1982; Montero, 1985; Santos, 1984; Cardoso, 1986; Duarte, 1986; Costa, 1984; and Scasufca, 1990.

- the use of traditional herbal and healing treatments;
- the use of medical treatment (mainly perceived by users as being somatic and involving prescription of medicines), at times in conjunction with 'dialogues' with the doctor.

Thus, for the majority of the population, regardless of all the constraints already described, the present services constitute the first opportunity of access to a new kind of treatment: psychotherapy. This is clearly shown in the confusion, ambiguities and fantasies associated with the figure of the psychologist demonstrated in studies on the social representation of the psychologist in the country (Leme, 1989); by reports of first contacts of these professionals with the population in Belo Horizonte [A: DMS: Coura Filho (1985) Levantamento: 14]; and by the description of the phenomenon by network supervisors [I: Akerman, 1989].

As indicated in the previous chapter, the programme hegemonic service model emphasizes individual treatment, focusing especially on psychotherapeutic methods. In the two case studies, the latter is the only form of treatment for 43,8% of the users (excluding those doing mixed therapy). However, the figure is more significant if looked at the proportion of professional time which is spent in these methods, as regular psychotherapy means fewer clients per professional[1]. Thus, the actual investment of the mental health programme in individual types of treatment can only be assessed properly in terms of the proportion of the total professionals' time being spent in each one. In this respect, considering that each professional has formally the

---

[1] At the Lindea district, for example, the average number of clients per professional using psychotherapeutic methods, in 4 weeks sampling, is 16.5, while the psychiatrist doing mainly medication control showed 60 patients. The figure at the Sao Paulo district is biased given the disruptions in the work of the only psychiatrist doing exclusive drug therapy, who was leaving the unit, but the projection would indicate an even higher difference.

same work hours, the SPd shows a figure of 75.0% of professional time being spent in psychotherapy, 12.5% in mixed methods, and only 12.5% of the professionals time in medication control. The Ld rates are currently 66,6% of the time for the former, and 33.3% for the latter. It should be noted that in both places there are very few users being treated by two professionals at the same time. Summing up, **a very high proportion of professional time, and consequently, of the mental health programme resources, is invested exclusively in psychotherapeutic methods. These tend to treat less serious mental distresses and to form a new clientele, different from that which has traditionally sought hospital care,** as seen in chapter 4.

3.2. THE PROCESS OF DEMAND FORMATION FOR MENTAL HEALTH SERVICES

If services primarily offer a treatment that is unknown to the population, it could be fairly asked how the demand for the treatment is formed. The answers for question 13d of the questionnaire, asking clients who had informed them of the services, provides an interesting profile, as shown in Table 10. If options (a), (b) and (f) are grouped, 56.0% of all referrals were mediated institutionally, by health and education services. Based on the reasons outlined above, it is also realistic to assume that a significant part of the non-institutional referrals might have been originally a direct demand for medical or, in extreme cases, for traditional psychiatric care, and not for psychotherapy. The rate of self-referral is very low, and the options (c) and (d) indicate clearly a pattern of gradual diffusion in the community mainly through contacts with people with previous knowledge of the services, but not necessarily meaning psychotherapy. In my view, then, it is possible to conclude that **the demand for mental health care, and mainly for**

psychotherapy, is formed basically by direct institutional initiative, primarily by a process of sophistication

Table 10: SPd and Ld: Main Referrers for Mental Health Services		
a) medical services	42.5	82
b) school	10.4	20
c) relatives	18.1	35
d) friends	13.5	26
e) no indication; just knew about services	7.8	15
f) profess. treating a relative asked to come	3.1	6
g) others	4.7	9
TOTAL	100.0%	193 cases

of the general medical demand, and secondarily by the educational mediation, the effects of which are then gradually diffused within the community.

3.3. THE IMPLICATIONS IN TERMS OF SOCIAL REGULATION AND CITIZENSHIP

What could this mean from the critical perspective described in chapter 1, in terms of the dynamics between social regulation and care? From a strict anti-psychiatric or Foucaultian points of view, these could be seen as the expansion of disciplinary and 'normatization' powers within the society, that produces specific kinds of subjectivity and individualization processes among the general population. This perspective would stress, for example, the emergence of the mental health programme in the country as a demand of the professionals rather than a demand of users themselves, as a sign of this expansion of disciplinary powers.

However, from the wider theoretical approach adopted

here, while such processes may be real, they need to be assessed carefully in their precise historical and social circumstances[1]. For this reason, the following sections will approach this discussion more specifically for two clientele groups. In broader terms, however, it is possible to say here that the phenomenon is much more complex than the Foucaultian perspective would allow. First, **the problems and conflicts implicit to the demand for care actually exist - even if not formulated or showing a clear conscious representation by the individual - and are expressed through suffering and distress, as clearly reported by users in the form of specific symptoms or general feeling of discomfort.** Secondly, despite the described incompatibilities with the working class features, the present services constitute, even if in a contradictory way, <u>an historical public acknowledgement of the minor mental distresses as a problem of public health, and a first attempt to offer attention and care to meet such needs for the wider Brazilian population[2].</u> In other words, the present analysis reaffirms the hypothesis topic, suggesting that **the present services encourage less serious and short term psychological problems as potentially deserving of public attention and treatment, as widening the scope of social citizenship rights over hitherto hidden needs.**

However, these statements must be carefully considered,

---

[1] See theoretical discussion in section 2.4.3, chapter 1.

[2] Actually, this has been one of the important historical social contributions of the Freudian thought in the Western societies in the first decades of the twentieth century, that is, to induce the recognition of minor distresses as deserving the public attention, as indicated by Busfield (1986). The historical emergence or acknowledgement of specific psychiatric states in particular contexts can also be viewed in Foucault (1967) and Ramon (1986).

because the concept of citizenship is also culturally structured[1]. Therefore, while taking into account the several problems within the hegemonic service model, it is important to realize that, contradictorily, **it induces a 'positive' effect (from the point of view of the working class population interests). This happens when services acknowledge such needs and offer more systematically a caring space to work out the personal and social conflicts in the mental health field[2]. Such dialectic space constitutes a field of struggle for hegemony, in which the working class population and their allies can also have the initiative and propose alternative service models.**

Part of the clientele seems to present some political perception of the phenomenon, in different levels of explicitness. This is shown in a pattern of answers which emerged in all questions related to opinion on the infra-structure and the general quality of the care provided (15b, 15h, and 17a). They were coded as an 'implicit acknowledgement of the constraints' to which the services are submitted, and, given the context of a hitherto complete lack of services, the conditions provided are viewed as

---

[1] As suggested by Durham, 1984; Duarte, 1981 and Vasconcelos, 1989. The use of the concept here, according to the framework proposed in chapter 1, does not mean necessarily to reaffirm the linear individualistic or evolutionist world-view as originally formulated. The concept means here to realize that particularly the last three centuries have witnessed the historical acknowledgement of needs hitherto left entirely to the private sphere, or the emergence of new needs in the field of social reproduction, and dislocated partially such conflicts from the former to the public spheres.

[2] As reported in chapter 2, this has been the historical pattern of the expansion of social rights in a hierarchized citizenship system like the Brazilian, in which patterns of social services are appropriated by upper classes and then gradually and selectively expanded to larger population groups.

reasonable[1]. However, among the community leadership of the Ld and Cd, the phenomenon is widely acknowledged, and political strategies to deal with it were set during the implementation of the services, which will constitute the subject of the next chapter.

Finally, it is important to add that the proposal for alternative models must be associated with a careful assessment of the specific needs of particular client groups. Therefore, it may be interesting to focus on examples of client groups in which the present hegemonic service model brings about a clear reduction in the

---

[1] Despite low rates (around 10% of the clients), it constitutes a constant pattern, presenting the following connotations:
a) good evaluations, despite the visible bad quality, such as: "here there is no comfort, what we've got is simple, but is good"; "in the way life is now, this is good enough"; it is good 'cause they attend us, (and in this condition) the treatment may even be under a tree"; "we, having this here, is already good enough"; the medicines are lacking, but at least the doctors are here".
b) a clear consciousness of belonging to a social group that has had nothing until now, and despite the constraints, services are viewed as reasonable: "for those who can't afford to treat themselves in specialized clinics, (the situation) leads us to be treated in health centres ('posto medico')"; "for people who had nothing it is good, but it is far from being what one might wish for"; "'cause we haven't got conditions to pay, we, having this here, it is already good".
c) a clear distinction between the efforts made by staff and professionals, and the conditions offered by superior structures: "it could be far better, it should have 'more' conditions, equipments, and then they would attend us much better"; "what they give is the maximum from their part: the doctors, sometimes, even work beyond the time"; "sometimes it is impossible to do what the doctor or psychologist want to (given the 'lack of conditions')".
d) a reference that, despite the constraints, services are free: "at least, it is free".
e) a consciousness that, despite the provided constraints, the services are already an achievement of the community struggle (in the case of the Ld): "I think that it was already a great victory having gotten this here, we can't even complain about the comfort, just having it...".

determination and meaning of their needs. This is the subject of the following section of this chapter.

4. THE CHILDREN AND WOMEN: REDUCTIONISM IN TWO COMPLEX CONSTELLATIONS OF PROBLEMS

4.1. WORKING CLASS CHILDREN AND THE EXCLUSION PROCESS IN THE LITERACY PERIOD

4.1.1. The Description of the Issue in the Country's Literature

The Brazilian literature on the issue has pointed out the following main points:

a) The exclusion of working class children from the school in the literacy period is generally seen by the lay people and by the majority of school and other health professionals much more of a student's individual or family problem. Therefore, categories such as educational or school 'non-adaptation', 'evasion', 'failure' ('fracasso'), and 'cultural deprivation' are most commonly used (Brandao et al, 1984; Valla, 1989; Nicolai-da-Costa, 1981, 1987).

b) However, the issue is almost consensually considered by the critical literature as a wider social and collective issue. Thus, a more appropriate category would be that of 'exclusion' process (Fukui and Sampaio, 1982), with the main following determinants:

b.a) malnutrition: there is no definitive consensus on its effects on the schooling performance (Brozek, 1979; Collares, 1985; Moyses, 1986; Valla, 1989).

b.b) major socio-economic inequalities: the phenomenon is clearly linked to the major economic and social inequalities in the country, as expressed in the dichotomies such as rural/urban, rich/poor regions, and income (IBGE, 1988b; Valla, 1989). Figure 18, for example, shows how the

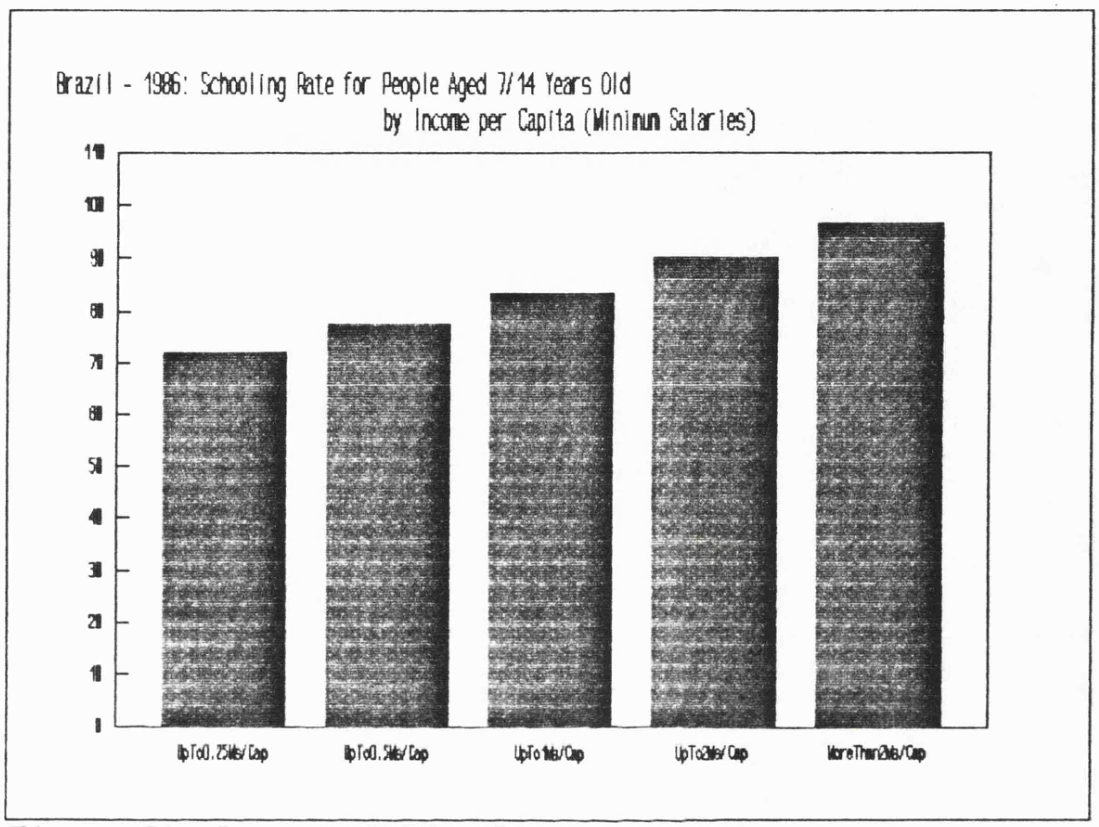


Figure 20. Source: IBGE, 1988b.

'schooling' rates among the children aged seven to fourteen years old in the country are clearly associated with income.

c.c) major education policy issues: low wages; excessive numbers of pupils per class; poor funding, infra-structure and training; general lack of nurseries and pre-school units. (IBGE, 1988b; Valla, 1989; Fukui, 1982; Cordeiro et al, 1978).

c.d) differences in cultural and linguistic background: the school tends to use the upper class codes. This is discussed in a similar way to that described in the previous section on cultural models (Nicolai-da-Costa, 1981, 1987; Calsing et al, 1986; Fukui and Sampaio, 1982; Valla, 1989).

d) The scale of the problem is enormous: the country's average rate of 'failure to pass' plus 'evasion' in the first year of primary school is 50%, but reaches 70% in

poorer areas like the North-East (Valla, 1989: 105). Figure 21 shows the country's average rate of five to seventeen year olds attending school in the appropriate year, according to age and urban/rural environment, suggesting a huge 'failure' rate in the first year.

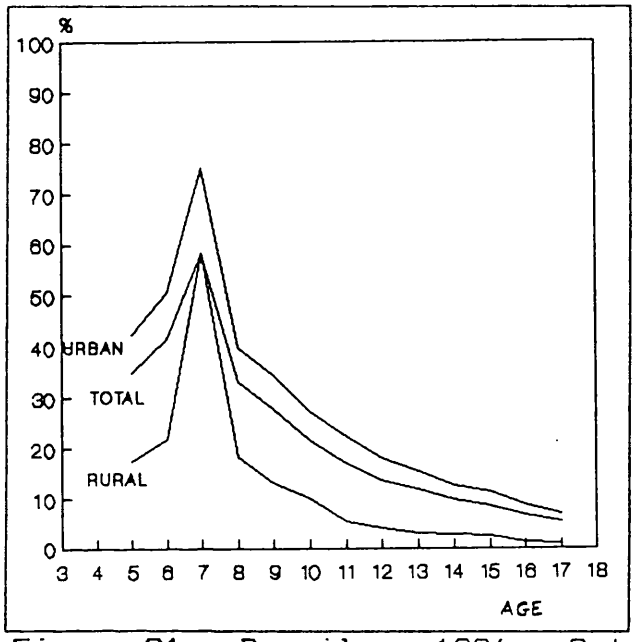


Figure 21. Brazil - 1986: Rate of 5 to 17 Years Olds Attending School in the Appropriate Year, per Age and Type of Area.
(Source: IBGE, 1988b)

e) The epidemiological studies of prevalence of mental illness in infancy are scarce. A classic study accomplished by Almeida Filho (1985) at the Amaralina district in Salvador found a global annual prevalence rate of 23% for all cases, and 10% for moderate and severe ones (with predominance of male cases). They were divided into 1.6% for development problems, 15.3% for neurotic and psycho-somatic ones, 2.5% for organic or brain disorders, 2.6% for mental retardation and 1.2% for other diagnosis. Despite the low comparability of these figures, they suggest that more than half of the national average of schooling 'failure' rates could not be attributed to individual psychological features.

f) When mental health services are available, a significant contingent of school exclusion cases tend to be referred to them, and the risk of medicalization and individualization

of broader problems is real (Collares and Moyses, 1985)[1]. The description of such cases in a study conducted in the city of Sao Paulo (Cordeiro et al, 1978) showed their main prevalent characteristics to be:

- male;
- children in the first or second year of the primary school, with several 'failures' to pass the school year;
- referred due to complaints of behaviour problems (49.7%) and learning difficulties (31,6%), and of diagnosed cases of transitional[2] (25.6%) and learning (15.8%) problems;
- finally, the rate of diagnosed serious problems (epilepsy, mental retardation and psychosis) was relatively low (18.9%).

4.1.2. The Present Inquiry's Findings

Just after the mental health teams were set up within the Belo Horizonte health centre network, those teams who started to offer child services were practically invaded by a huge demand from local state primary schools to treat their 'difficult' cases. An inquiry carried out in 1987 indicated that practically all those units reported the problem, with several cases suggesting an explicit lack of criteria by the schools for referring the children [A: DMS (1987) Atendimento] [I: Silveira, Ferreira, Mancio, Marinho]. Some professionals reported having received huge lists from the local school [I: Mancio, Marinho] [A: DMS:

---

[1] This seems to be also a common phenomenon in other countries, as suggested by Conrad, referring to the category of hyperactivity for school children (1981).

[2] Defined according to an international classification not specified, as "disturbances more or less transitional of every seriousness which may occur in individuals without any apparent basic mental disturbances, and who present acute reaction to environmental tension" (Cordeiro et al, 1978: 58).

Sales (1988) Estudo], sometimes of entire classes [I: Viana].

From the perspective of the services, most professionals indicated that the majority of their infantile clientele were referred by schools, in rates varying from 50 to 80% [I: Cansado, Siqueira, Viana, Silveira]. The results of the survey at the Lindea and Sao Paulo districts reinforce this view. In question 13b, on reasons for treatment in the local service, 52.9% (n=34) of the children aged between seven and twelve years old or their companions reported explicitly being backward or having disciplinary problems at school, or being referred by school personnel. However, there are indications that the real figure is even higher[1]. All other available sources in Belo Horizonte point out that the category of 'behaviour problems' is the most frequent complaint leading to the demand for treatment, followed by 'learning difficulties'[2]. There is a predominance of male cases (mostly associated with aggressiveness) and of literacy period ages [A: DMS: Sales, op cit] (Savassi, 1984).

Viana, a child psychologist working at the Centro Psico-pedagogico and a militant in the mental health workers movement in Belo Horizonte, presented the following view of the problem:

> "This is not a peculiarity of the state schools. The private schools also do not get to deal with the minor

---

[1] Exactly one third of these questionnaires were answered by the children themselves and, therefore, there are fair reasons to suspect that they might have not known or not wanted to declare the referral process.

[2] As reported by professionals [I: Viana, Olga, Siqueira, Silveira, Ferreira] or by a more systematic study accomplished at the 'special school' attached to the Centro Psico-Pedagogico, the only state tertiary child service: behaviour problems 44.5%; behaviour problems plus learning difficulties 26%; learning difficulties 16%. (Savassi, 1984: 27).

> difficulties, and this is seen in the private clinic. Most children presenting learning problems associated with lack of discipline are taken out. However, at the state schools this happens mainly between seven and ten years old, while at the private ones it starts mainly from ten years old. The possible explanations for this are: first, because the clientele of the private primary school is more stimulated and controlled by the family, and the school is also more stimulating and liberal, and thus, more capable of dealing with disciplinary problems. In addition, the school manipulates a middle class culture, and the clientele of the state school identify themselves less with the content (of what is taught) [I: Viana, 1989].

A similar opinion was reported by Silveira, a child psychologist working at the Lindea district and also owner of a small clinic contracted out by LBA for child attendance:

> "The school does not know how to deal with the pedagogic and behaviour problems. What happened then? The kids repeat the year, (...) and you have a 'vicious circle': they failed to pass, go to the backwards class, and the teacher there is the worse at the school. Thus, this is a circle, with no way out. I think the school has a very important role in all that. But they haven't got the minimum structure. (...) We're trying to discuss it together, in order to force the Education Secretariat to assume their part, because these are problems which could be solved inside the schools themselves, but ended up coming here ..." [I: Silveira, 1987].

The situation pictured by those providing child care within the health centre network points out the most common service problems. These are, in order: the huge demand from the schools, for mainly diagnosis and psychotherapy[1]; the

---

[1] Professionals generally have their agenda filled very quickly after starting work. Some set a waiting list and others just do not accept additional cases.

lack of alternatives for referring more complex cases[1]; and the general problems of infra-structure and lack of training [A: DMS (1987) Atendimento]. Other sources suggest a further problem as being the stigmatization of the children referred to treatment outside the school [I: Silveira, 1989] and to 'special schools', when coming back to the 'normal' ones (Cirino, 1985). Finally, some child psychologists indicated that internal difficulties for the good development of the psychotherapeutic process are linked to the fact that the demand for treatment never comes from the children themselves, but from the school and the family [I: Siqueira, Silveira].

There have been some attempts made by the programme coordination to tackle the problem. An inter-organization working group was formed and a first conference of professionals in the field was held in 1986. Their diagnosis of the situation indicated that the main problems were:

- the lack of an explicit policy, of integration and definition of specific roles of each type of service, as well as lack of criteria and disorganization in the referral system;
- low efficiency of all services;
- the "transformation of learning problems into mental health problems" [A: DMS (1986) I Encontro].

The proposals included primarily an integration and hierarchization of the services, and lobbying the education

---

[1] More complex cases are generally considered as neurologic, psycho-motor, language, sight, and pedagogic problems. This means that the health centre network services are reduced practically to case assessment, psychotherapy and family attendance, with few exceptions. In addition, the main alternative for referring the cases are the few clinics contracted out by LBA, which are very well known by the huge waiting lists, the continuous handling of the users as 'hot potatoes' among them [A: DMS (1986) I Encontro], and the well known precarious attendance they provide [N: Jornal do Psicólogo, 4.a R, Jan/Feb 1988].

authorities to create a psycho-pedagogic support service within the state run school network. This would have the purpose of discussing and dealing with the broader technical and political aspects of educational problems and to make clear the specific role of mental health services within it [A: op cit].

However, after these initiatives, the problem has deteriorated even more, given the following:

- the retrogression in the state run primary school system and mental health services since the change of state governors in 1987, as outlined in chapter 3;
- the stronger emphasis on individual treatment in the professional model, as indicated in chapter 3 and 4.

Therefore, despite the non-systematic state of the empirical evidence available and the need for further research, **the findings seem to indicate that, for Belo Horizonte, out-patient mental health services have been used as a device to "transform pedagogic into mental health problems". The process constitutes an attempt to hide the broader and complex social and collective aspects of the exclusion mechanisms in operation in the educational system, expelling particularly the working class children who do not adapt themselves to the present mainstream primary school structure. In addition, despite the limitations of the present inquiry and the need for further research, there are indications that the recent increasing emphasis on individual treatment and psychoanalytic methods tends to accept even less critically this demand. This leads to further reinforcement of the process of individualization and psychologization of the problem and of the stigmatization of the children referred to them.**

The service network itself provides some isolated examples of alternative and more collective approaches, mainly during the previous period. At the Venda Nova district unit, the team joined the local community

initiatives in the field, grouped in what was called the 'Underage ('Menor') Integration Group', with several activities like crafts, education, nurseries, etc, and also emphasizing family care [A: DMS (?) Contribuicoes]. The Pompeia local team, in turn, invested in supporting the local community nurseries, not only in terms of individual assessment, but also trying to establish a dialogue with their own collective representations and perceptions of child care [A: DMS (1986) Relatorios]. Finally, the Sagrada Familia team produced direct interventions at the schools, promoting activities such as psycho-motor stimulation training; teacher group dynamics; meetings gathering teachers, children and their parents; sexual education and assessment of the teacher-students relationship [A: DMS: Mendonca Filho (1984) Relatorio]. Further examples will be given in the discussion on alternative service models in the next chapter. Before that, however, another example of individualization and psychologization processes will be given briefly, concerning women and their family and cultural ties.

4.2. THE MATURE WOMEN WHO EXPERIENCE BREAKDOWN IN THEIR CULTURAL, MARRIAGE AND FAMILY TIES

4.2.1. The Relative Lack of Attention to the Issue in the Brazilian Literature

There is a relative lack of more qualitative discussion on this issue in the country's literature. Despite the author's limitations in terms of accessing the bibliographic material, it is possible to describe the main trends of the literature as:

a) The subject is investigated as a problem of mental health practically only by epidemiological studies. Almeida Filho and Bastos (1982) found that migrant women with lower

educational background and without partners are significantly more liable to develop depressive symptoms. Mari (1986) indicated significantly higher rates of minor psychiatric morbidity among women than men within the clientele of three health centres in Sao Paulo, particularly among women with lower incomes and irregular housing conditions. Santana (1982) also found a higher rate of neurosis among women at the 'O' district in Salvador. Tancredi (1979) reported significant higher levels of psychoactive drug (mainly tranquillizer, hypnotic and sedative ones) consumption in the following female groups in the city of Sao Paulo: widows and the separated aged between thirty and fifty years old, with lower educational background. No association was found though with housing conditions. Souza AL (1987: 61) pointed out that women tend to be the majority of those admitted to all types of psychiatric hospitals in Salvador, from the age of thirty five onwards. Finally, Mari and Andreoli (1990) presented findings showing higher rates of psychiatric morbidity for women in São Paulo (24.6% against 11.7% for men). This also was associated with migration, being widowed or separated, low schooling levels, low incomes and occupational situation. However, none of these studies provide a convincing theoretical explanations for their findings.

b) The problem is clearly acknowledged by professionals in general, in clinical studies and reports of health and mental health services. However, such cases are most often identified pejoratively by the lack of precise diagnosis, by 'multiple complaint' ('poliqueixosas') or typical 'nervousness' cases. Besides, no systematic attention is paid to producing a full assessment of such cases and to checking the adequacy of the care provided. Only a few brief essays (Arilza and Bezerra, 1986) [A: ASMC-SP (1986) Mulher] (Borges and Atie, 1989) were found that attempted to address the issue, but still only superficially.

c) The feminist literature, including studies from an anthropological point of view, acknowledges the existential stress associated with separation and being a single parent for working class women. However, in my view, they present some theoretical limitations in terms of approaching the issue in a satisfactory way[1]. The literature on the 'nervousness' model, despite offering some indications on the specific symbolic meanings associated with the female role and their distresses, has still not approached the specificities of the subject more systematically.

4.2.2. Findings from the Present Inquiry

4.2.2.1. The Identification of the Problem

The proportion of women within the clientele of the Sao Paulo and Lindea district health centres is higher than for men (64,9% against 35.1%). The possible reasons for this could be:

- the attendance hours, overlapping with the normal work journey, increasing the possibility of housewives and other non-active individuals attending consultations;

---

[1] Despite the limitations in access to the literature, the available cases suggest, in my opinion, that the full meaning of the cultural and family breakdown for working class women is sometimes misunderstood by specialists from an individualized and politicized cultural background. The family is at times viewed as an economic unit for social reproduction (Fausto Neto, 1982; Bilac, 1978; Salem, 1981) and the fragility of the lonely women is generally associated with the double workload and difficulties of the labour market, or with the submission to the patriarchal ideology (Salem, 1981: 93). Some of the symbolic aspects of the family and loneliness for this specific group in the country could be better approached, in my view, by the literature on the notion of Individual and Person, and on the 'nervousness' model, as described in the first section. A good example of it applied to the analysis of media, feminist and psychoanalytic issues was developed by Santos (1982, 1988).

- cultural gender features, as women are more associated with the caring role, with greater sensitivity to subjective issues and with greater acceptance of the need for searching for help and support.

However, **following the epidemiological findings described above, there are also indications that this higher proportion of women being treated in the two services are also a result of the higher prevalence of distresses among the female population.**

The first step taken was to test a possible influence of the female double workload and domestic duties as a vulnerability factor to mental distresses. **No association between the burden of domestic duties and the demand for mental health care and drug consumption was found[1].**

Despite the suggestion of the literature that civil status may be a relevant variable, **the results of question 6b (who do you live with) produced sharper associations with indicators of mental distress, particularly for 3 groups: those living only with their children, alone or with other relatives.** The comparison between the two variables indicates that, at least for the Brazilian context and for women who experience breakdown in marriage, family and cultural ties, the category of civil status is too formal and static to reveal the very dynamic and complex life situations in which women can be found[2].

---

[1] There was a lower number of women actually working within the clientele of the two service units (just 21 cases reported receiving some income from work, in a sample of 100 adult women aged 18 or over).

[2] The majority of those living with their children are married, but a reasonable proportion are also single, widows or separated. Most women living with other relatives are single, but there are also some cases of married, widows and separated ones. Among those living alone, two are single and one is separated.

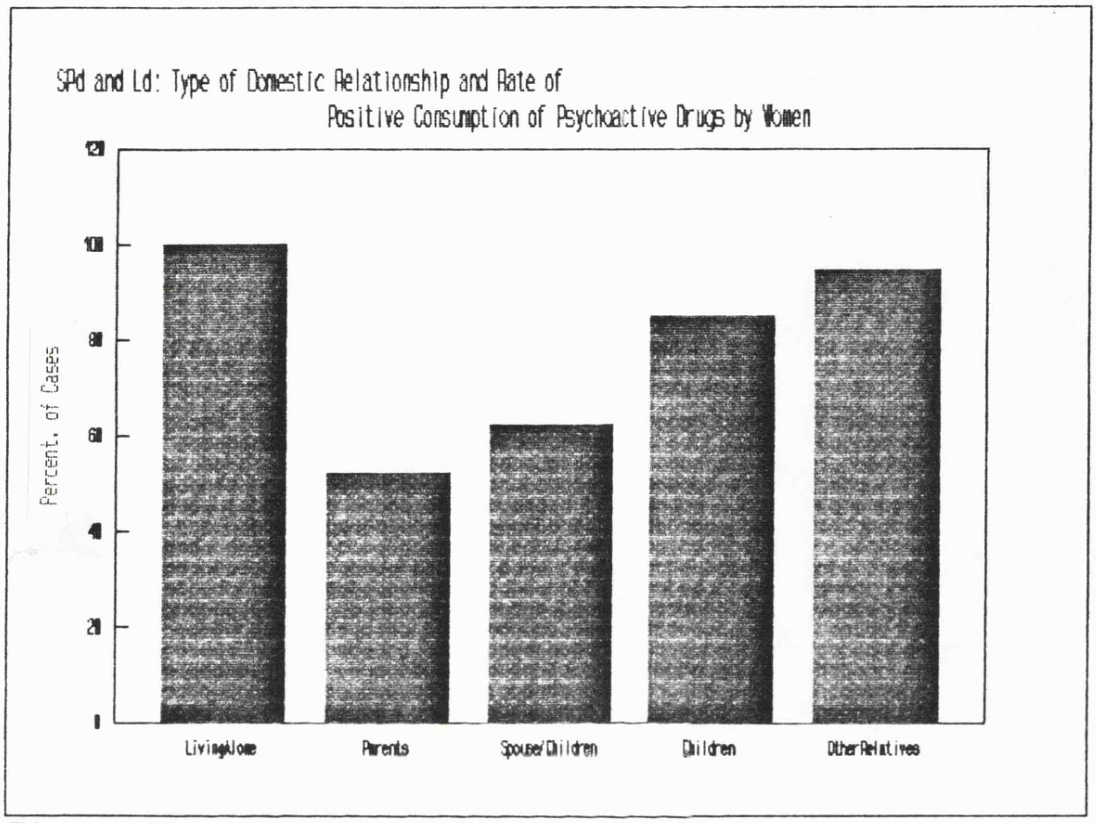


Figure 22.

4.2.2.3. Clinical Features of the Women Who Experience Breakdown in their Family, Marriage and Cultural Ties

The number of female users reporting the use of psychoactive drugs is clearly associated with the kind of family context one lives in, as shown in Figure 22. **The consumption rate increases in accordance with the following order of types of domestic relationship: living with parents, spouses and children, only children, others relatives and alone**[1]. The cross-tabulation of these results

---

[1] Chi=0.0041, cells with EF<5 = 33.3%. The category of those living alone presents just 3 cases and, therefore, graphics using percentages should be read carefully. If the age effect is taken off, by eliminating all children aged 12 or below, the only change is that those living with their parents go to the second place, with 74.1% of the cases taking drugs.

with age are also significant[1], showing particularly significant standard residuals for those living with other relatives and aged between 18 and 40 years old.

Those living with other relatives not only presented the highest rate of drug consumption, but also the highest rate of positive evaluation in the question on their opinions on psychoactive drugs (q. 13h)[2]. Nevertheless, when asked about the reason for this opinion on drugs (q 13i), the three risk groups indicated (living alone with their children, living alone or with other relatives) showed the highest rates for the answers grouped as "negative evaluation, but associated to actual obligation, mainly in order to control the symptoms". The rate for this type of answer was higher for the group of single parents, probably not only for clinical reasons, but also for the higher pressure from children and household duties, and in some cases, from the role of breadwinners.

Despite not achieving the standard level of significance[3], **there are also indications that the three categories, particularly those living with other relatives, might also be associated with the higher rates of cases with previous admissions in psychiatric hospitals in the past[4]**

---

[1] Chi=0.0083, although cells with EF<5 = 77.1%.

[2] 52.9% of all cases with a positive opinion, against an average of 29.0% for any other category.

[3] If the category of living alone is eliminated, giving the low numbers, chi=0.1664. The standard residuals are significant for those living other relatives.

[4] As indicated in the previous chapter, there is no reason to believe that admissions may induce separations, as the breakdown of marriage ties seems to occur before the first admissions. In addition, the higher the number of previous admissions, the higher the number of cases of those living with other relatives, which is more associated to migration than anything else, as shown later in this chapter.

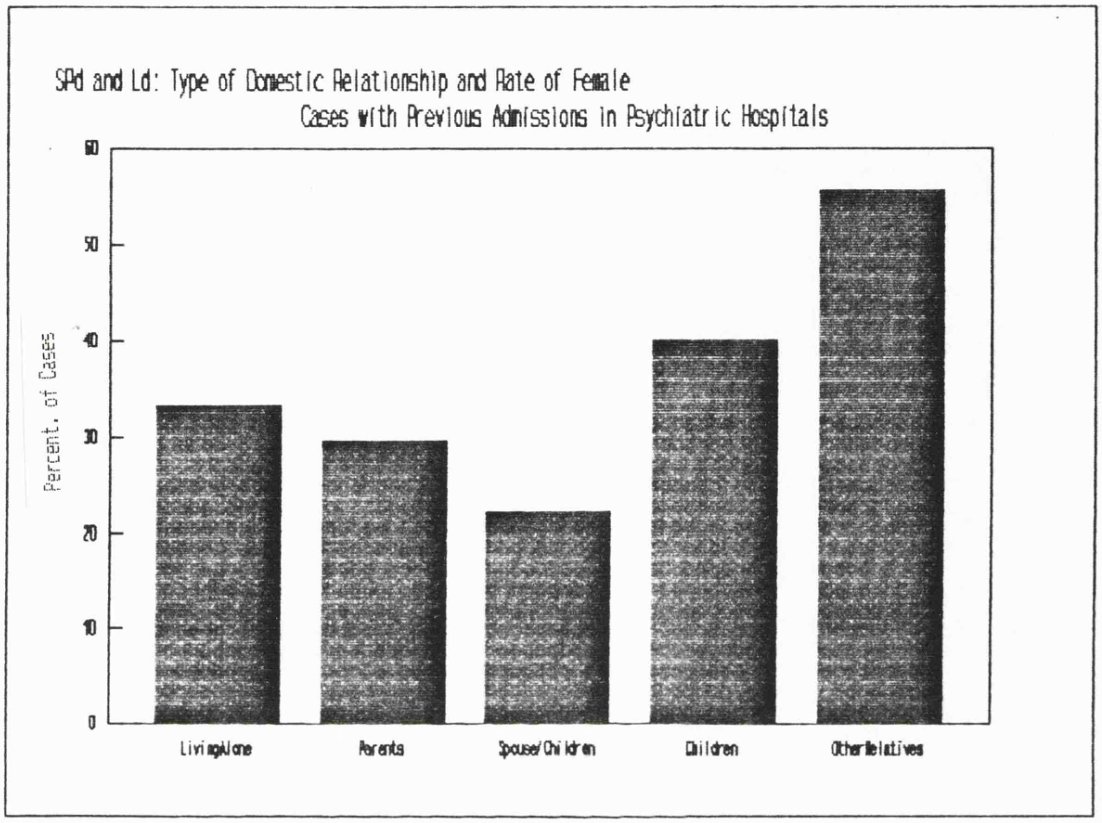


Figure 23.

(q 11a), as shown in Figure 23.

The answers to question 10b, on reasons for the first search for treatment, show a specific profile for those living with their children and with other relatives[1]. The results are provided in Figure 24, and refer to the proportion of members in each group who reported the indicated reasons for the treatment. No statistical tests were possible given the multi-choice character of the question. **The women living only with their children and with other relatives present the highest rates for the following:**

- **crisis and dramatic events in family life and socio-**

[1] For those living alone, no trend is shown given the low number of cases (3) and the dispersion within a large range of possible answers.

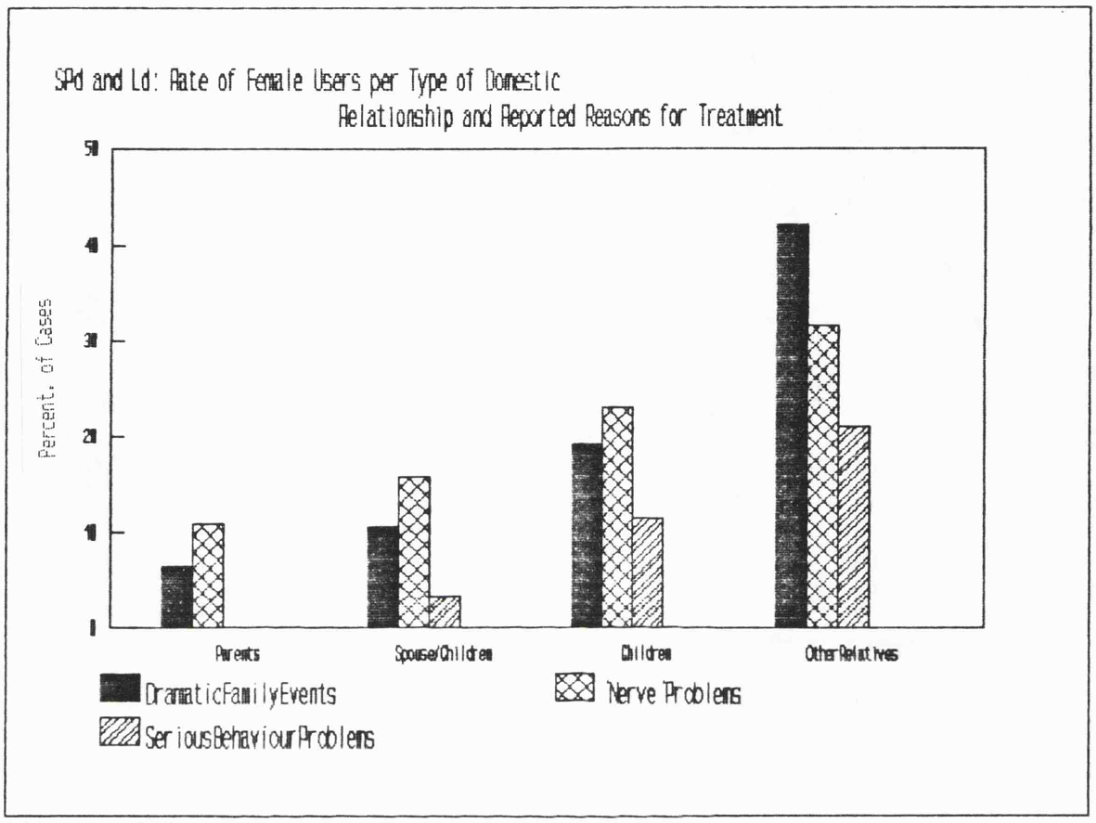


Figure 24.

economic hardship, confirming the trend for family breakdown;

- the category of "nerve" problems;
- answers grouped as "serious behaviour symptoms", more associated to psychotic or serious neurotic states.

Also according to these indicators, those living with other relatives seem to have the most impaired clinical profile.

When cross-tabulating the domestic relationship with the description of the typical weekday activities (q. 19a), it is possible to see that the rate of "inactivity behaviour" is not high, and it is again more concentrated on those living with other relatives[1]. As pointed out before,

---

[1] The two groups present 1 in a total of 3 cases of exclusive inactivity, and 7 in a total of 11 cases of non-exclusive inactivity.

women in general showed a very low level of complete inactivity, in line with the domestic activity female role, and mainly with the responsibility of looking after their children, in the case of single parenthood. This group, in particular, accounts for the highest number of hours spent in household duties (q. 5h) among the three groups, but their profile is very similar to that shown by the women living with their spouses and children. The need for performing domestic duties is relatively lower for those living with other relatives, which presents a profile similar to those of single people living with their parents.

4.2.2.2. Tracing the Social and Demographic Meanings of the 'Domestic Relationship' Categories and Vulnerability Factors

The great majority of the women included in the three risk categories have migrated from country areas (average of 60%) and other cities (average of 30%), but the rate is not different for married women. The only difference is that **most women living with other relatives had migrated to Belo Horizonte more recently, while there are indications that the first admission did not take place immediately after the migration[1].**

The group living only with their children shows a higher number of children than the average married ones, as half of them have 4 or 5 children. The age profile suggests that those living alone and with their children tend to be

---

[1] 58.3% of them being more than 20 years old at the time of migration [q. 2b], while those living with spouse and children and those only with children peak between 10 and 20 years old. Further cross-tabulations with those living with relatives, including the date of migration (q. 2b), date of first admission (q. 11b) and age (q. 3), demonstrated that the likelihood that admissions had occurred just after migration (which could suggest that migration would be associated or caused by a mental distress or crisis) is very low.

older than those grouped in other categories.

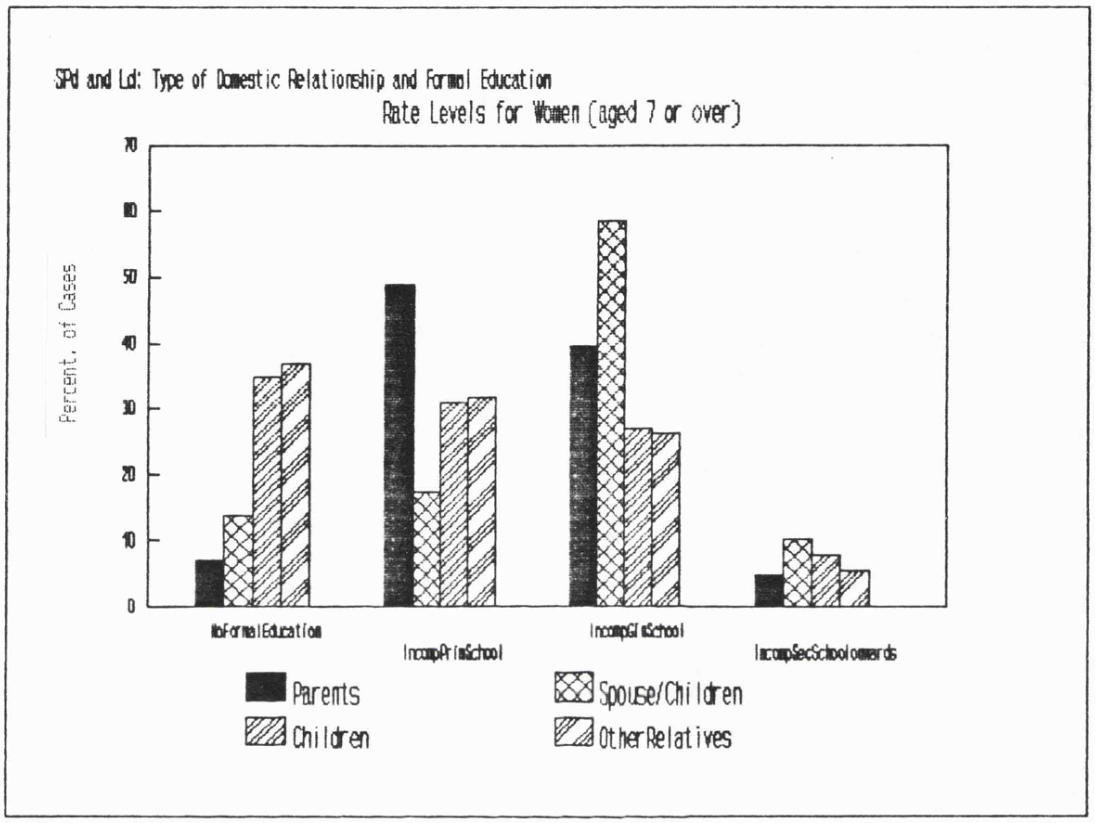


Figure 25.

The formal educational background is shown in Figure 25 [1], indicating **a clear trend for those living only with their children and with other relatives to be the formally less educated groups.** As there are just 3 cases of women living alone, it was not possible to identify any trend given the dispersion of the data and the need to keep a reasonable rate of cells with EF<5.

Findings related to income type are provided in Figures 26 [2] and 27. In general, the three **groups tend to be the**

---

[1] Chi=0.0145, cells with EF<5 = 31.3%. Children aged 7 or less were eliminated.

[2] Chi=0.0581, although cells with EF<5 = 70.0%, giving the low numbers of them receiving income. No children aged 12 or less were included here.

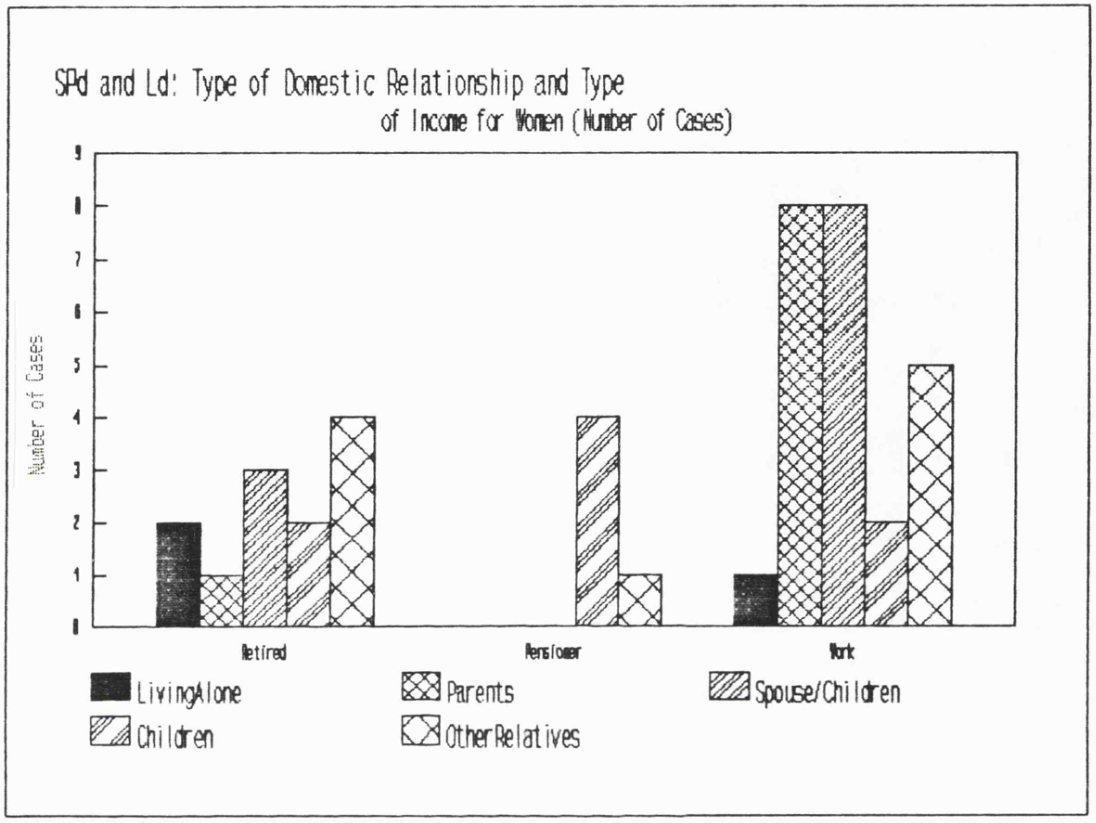


Figure 26.

less active (the majority are housewives) and dependent on retirement benefits and pensions. Those living with other relatives have a higher rate of cases in work, but not as high as those living with their parents or spouses. The cross-tabulation with income profile shown in Figure 25 [1] indicates that the three groups are the poorest among all other categories, particularly those living alone (three cases).

Finally, it may be important to frame these findings into the context of the major demographic trends already outlined in section 2.2, chapter 2. The average rate of growth for individuals living alone between 1970 and 1980 is 5.43%, two times higher than the average growth of the total

[1] Chi=0.0326, although cells with EF<5 = 55.0%.

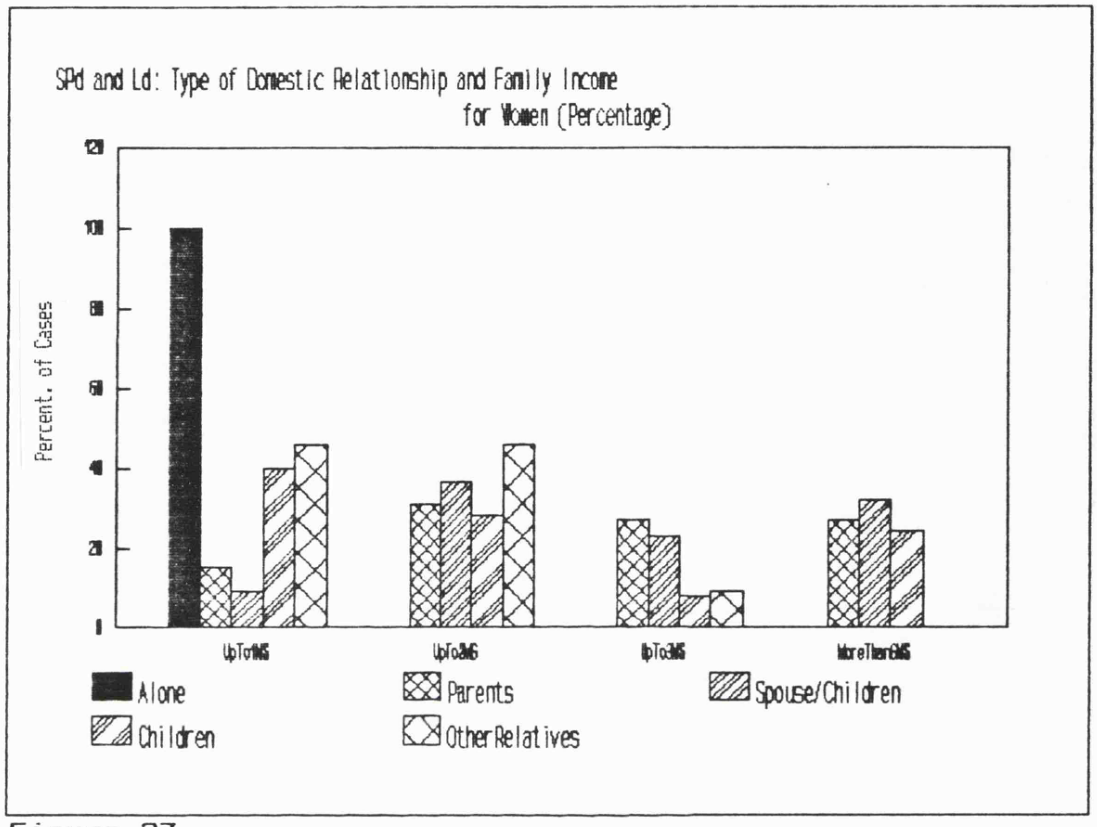


Figure 27.

population aged 15 and over (Berquó and Cazenagui, 1988: 157). In turn, the female single parent families constitute the type of domestic unit presenting the highest rate of growth in the country in the eighties, from 9.6% in 1981 to 11.4% in 1986 (IBGE, 1988: XXIV). However, this rate can achieve striking levels among the poorest population groups[1]. Data on migrant women living with other relatives were not available.

These figures and the epidemiological data outlined in this section suggest that **those female groups with features associated with highest prevalence rates of mental illness**

---

[1] 14.9% among those families with income up to 1/4 of the minimum salary per capita and reaching 59.8% of the families without any income, both figures for 1986 (IBGE, 1988b: 65).

present one of the highest growth rates among other female population groups. It may mean that, in the future, the issues identified here will tend to be even more acute, constituting a major epidemiological issue requiring urgent initiatives in the field of mental health policies.

4.2.2.4. Critical Comments on Female Risk Groups and Service Model

It is surprising as these groups constitute a significant part of the clientele of out-patient services in the country and have been recognized as a major problem by epidemiological studies, and yet there is no specific investigation or discussion of it. The bibliographical references and the direct observation in the Belo Horizonte area indicate that this clientele group is known by the professionals in their day to day practice[1]. However, there has been no attempt to deal more systematically with the issue, taking into account the specificities of the working class and female clientele and not reducing it to the traditional psychiatric or psychoanalytic approaches based on institutionalized or private clinic practices.

In addition to this, from the services' perspective, there is no specific approach for these groups, and the treatment provided has been the same as that given to all female and male users. It is centred mainly on drug prescription and some psychotherapy, which is provided in

---

[1] For example, when asked about the issue, mental health workers, and especially GPs, are generally able to describe several cases seen recently, identifying them as a client group with particular features.

the great majority of cases on an individual basis[1].

This situation suggests that services might be performing a **reductionism in the complex determination and symbolic meanings of mental distress in relation to these groups**, at least in two ways:

a) By **ignoring the specific social and cultural determinants of mental illness and the respective specificities of the therapeutic strategies** needed when approaching such client groups. Nowadays, there is a relatively large literature focused on the subject, concerning mainly depression, which seems to be the most common nosology of these female groups[2]. For example, Brown and Harris (1982) and Brown et al (1975) provide an extensive outline of social and cultural, provoking and vulnerability factors for depression, suggesting that working class women were five times more likely to become depressed than middle class women. In relation to community therapeutic strategies, Corob (1987) suggests the importance of working out individual and collective concrete alternatives for life, such as employment, overcoming isolation and loneliness, developing socialization and new meaningful activities.

b) By **ignoring the gender aspects attached to the determinants and therapeutic approaches to these kinds of distresses**, as particularly developed by the feminist and feminist therapy literature. Despite the theoretical

---

[1] When crossing the domestic relationship categories with the type of treatment, the two main groups (women living with their children and with other relatives) showed a profile similar to the other categories: averages of 60% of cases being treated by exclusive drug therapy, 20% with mixed therapies and the remainders by psychotherapeutic methods. All three cases of women living alone are treated by mixed therapies.

[2] In addition to the works cited in the text, see Weissman and Klerman, 1977; Miles, 1988; Pearlin and Johnson, 1977. The Brazilian literature is already described in the section 4.2.1 of the present chapter.

diversity within it (Ernst and Maguire, 1987; Frosh 1987), its common denominator has been the importance of viewing the specificities of the female psychological stresses as a result of a complex combination of psychic and external structures of patriarchical oppression[1]. Moreover, widely spread and deeply rooted sexist stereotypes, views and attitudes from professionals, even female ones, may bring additional stress to female clients[2] (Corob, 1987; Brown and Hellinger, 1975; Allen, 1986).

In relation to drug therapy, the adult female users and/or their companions seem to realize implicitly some of these processes. The majority of them (63.3% of all female drug takers aged 18 or over) evaluated negatively the psychoactive medicines (q 13i) with expressions such as:

> "I have to take them, otherwise what could I do? I think that this must be more or less like a drug addiction, isn' it?"; "if I don't take it, I don't get to do anything"; "it (the pill) does not cure, does not heal, just makes us sleep in peace and rest".

Some among the Cabana district leaders (this experience will be fully described in the next chapter) express it in a more explicit way, when evaluating the experience of hearing a group of women dependent on tranquillizers:

> "This kind of "nervous" patient, he/she cries out to the doctor the impotence to deal with his/her state. The doctor feels that the only thing he could do is to give him/her the famous "shut up your mouth", that is the diazepam and other drugs, isn't it? That is what he could do at that moment, then it is what he does. He prescribes the medicine and thinks that he has got rid

---

[1] Chodorow, 1978; Dinnerstein, 1976; Eichenbaum and Orbach, 1982; Mitchell, 1974; Allen, 1986; Miles, 1988.

[2] In my opinion, the implicit pejorative connotation attributed to female users with unspecified symptoms ('poliqueixosas') by GPs and even mental health professionals, and the lack of scientific attention to the above described groups, are undoubted signs of such biased views.

> of the problem. And the person, from his/her side, continues to delude him/herself, swallowing the pills and feeling anaesthetized, and so things go on. (...) In our research, some women said that they could not live without the diazepam, that the diazepam is everything for them. Then, it is a total dependence. (...) And we also see the unconsciousness of the professional who prescribes the drugs in this way, as if this would mean nothing..." [I: Luci, 1989].

In relation to mainstream psychotherapeutic techniques, it may be illuminating to follow the evaluation accomplished by the research team at the Cabana district. The team, through a consultant specialist in Institutional Analysis, indicated the presence of specific individual and collective configurations in the local group of women dependent on psychoactive drugs, such as:

- depressive configurations, as in the series of complaints about everything and the lack of self-esteem, including guilty and masochist imageries;
- persecutory, mainly in relation to the male figure;
- manic and messianic, as in the expectancies of solution.

However, one of the most interesting conclusions of the report was that, **despite the fact that these configurations constituted part of the group's own reality, they were also induced by the research instruments themselves** (in the case, psychoanalytic hearing):

> "The objective situation of absolute misery (exploitation, domination, devaluation and alienation) in which this collective lives leads to realistic and widely justified complaints. However, the deliberate and unconscious implementation of a clinical set (the provision of which had already reached this social group), even getting to avoid the medicalization, psychiatrization, pedagogization, 'assistencialismo', philanthropy, proselytism, etc, etc..., does not avoid the generation of a peculiar dependence relationship which induces the inquired group to produce itself as an 'identity' of 'lack', 'deprivation', 'insecurity' and 'incompleteness'. (...) (Baremblitt, 1990: 170-175)
>
> The analysis explicitly points to the alternative

development of broader community practices, which led to the reorientation of the action-research strategy at the Cabana district, to be outlined in the next chapter. Implicitly, it suggests the direction of practices already available in that community and in the Belo Horizonte area, such as those developed by the female and feminist movements. As reported by Miranda et al in relation to groups in Belo Horizonte (1987: 197),

> "the beginning of the practices of several groups unfolded by focusing first more on concrete subjects, or on which could be approached publicly without causing embarrassment. (...) As other sectors of the society as a whole and of the women in particular started to dedicate themselves to the issues of the women in the work and to politics - their exploitation and their militancy -, the discourse of the feminist groups could advance to other themes like subjectivity, pleasure, violence, naturalization of roles, the family, sexuality and the cultural elements of subordination."

There is no doubt that the Brazilian specificities of the phenomenon and the particularities in which the mental health services approach it need further investigation. However, from the present findings, **there are indications from the three focused districts that the hegemonic service model may be stimulating a process of medicalization, psychologization, individualization and reproduction of sexist views in the attendance of this specific clientele groups.**

5. SUMMARY AND CONCLUSIONS

The working class population in Brazil is hegemonically marked by a cultural structure based on a holistic and hierarchical view of the world and the Person, in opposition to notions of Individual and privacy dominant in Western societies. In the mental health field, this implies a specific representation of mental health and distress named

in the literature as the 'nervousness' model, which presents mental phenomena intrinsically integrated to the environmental conditions of life. Such a view is clearly opposed to the individualistic and psychological model present in the upper classes groups. Hence, the diffusion of the psychoanalytic culture and of mental health services using this latter model for working class clientele is identified by the country's literature as inducing individualization and psychologization processes.

The findings from the present inquiry tend to confirm these statements. The categories used by users and community leaders to describe mental health issues are quite consistent with the 'nervousness' model. The results from the previous chapters point in the same direction, as the imposition of upper classes service models leads to the expelling of and/or reduction in the care provided to those clients who are better identified with to the nervousness model.

Even so, the present mental health programme's emphasis, in terms of overall professional proportion of time, has been on the provision of psychotherapy, which tends to treat less serious cases of distress. The analysis of the process of demand formation reveals that it is produced in the majority of cases by institutional initiative, mainly through health and educational services. However, the present service model still presents a 'positive' aspect, from the perspective of working class interests, as a historical first acknowledgement of the minor mental distresses as deserving of public attention, which widens the scope of social citizenship rights over hitherto hidden needs. Despite the hegemonic service model contradictions and the cultural relativeness of the concept of citizenship, the programme represents the creation of a new systematic and dialectic space for mental health care, constituting a field of hegemony struggle, where the working

class can also propose alternative models. Signs of the phenomenon are in some extent realized by a small proportion of the clientele in the two surveyed districts, but is fully acknowledged by the community leadership in the Lindea and Cabana districts.

Contributing to the debate on alternative service models, this chapter also focused on the contradictions of this new access to care for two important clientele groups. For both cases, the data available provided indications in the direction of confirming the proposed hypothesis topics. First, the present hegemonic pattern of services centred on individual treatment and psychoanalytic methods tends to accept more a-critically the demand to treat children excluded from the primary school system. This mechanism tends to select particularly children from working class and lower income population groups, in a process of individualization and psychologization of the contradictions of the educational structure.

The second group is constituted by mature women who experience breakdown in their cultural, marriage and family ties. They have already been identified by epidemiological studies as showing higher prevalence rates of mental distresses, but the issue lacks detailed qualitative research and discussion. The results of the survey showed that the best indicator for identifying this clientele group is the type of domestic relationship, indicating single parents, those living with other relatives or alone as the main risk groups. They showed the lowest levels of formal education, of income, of productive work, the highest dependence on retirement benefits and pensions and the highest rate of crisis and dramatic events in the family life. Those living with other relatives had most recently migrated to the city. These groups showed the worse clinical features among all women, as follows:

- higher rates of positive use of psycho-active drugs;

- indications of higher rates of cases with previous admissions in psychiatric hospitals;
- higher rates of answers using the 'nerve' problems categories and answers coded as 'serious behaviour problems', as reason for seeking treatment.

Despite the clear social and cultural vulnerability factors identified by the literature and the need for considering specific therapeutic strategies for such cases, the present hegemonic service model has approached them with the same strategy adopted for all men and women. Therefore, in spite of the need for further research, the few quantitative and qualitative sources seem to suggest that the social and gender aspects of their distresses has been ignored. Summing up, the available indications suggest that these client groups have been submitted to a process of medicalization, psychologization, individualization, and reproduction of sexist bias.

In conclusion, these two examples point out to the need for alternative models adequate not only to the cultural and social features of the whole clientele of this type of service, but also to the particularities of age, gender and situational variables within it.

Focus on the existing attempts for building alternative models is the subject matter of the following chapter.

Chapter 7

THE 'NERVOUSNESS' MODEL, RECENT SOCIAL MOVEMENTS AND THE POSSIBILITY OF ALTERNATIVE POPULAR MODELS OF COMMUNITY MENTAL HEALTH CARE

1. INTRODUCTION

In this chapter, I will look at the possibility of alternative approaches and models for community mental health care, more appropriate to the Brazilian working class population. If a social group presents specific social and cultural characteristics, it is to be expected that its own practices in the field would constitute a important source for generating alternative forms of care that are closer to their own reality. Here, two sources of experience for the Brazilian working class will be focused on: the 'nervousness' model, and the popular social movements, which have been identified as one of the most genuine expressions of the working class social interests in the country since their emergence in 1978. Therefore, **this chapter will explore the possibility of the 'nervousness' model and the popular social movements constituting actual sources for the building up of alternative models of community mental health care, more appropriate to the working class social, cultural and linguistic features.**

This chapter is structured in the form of an ethnographic report and analysis. The argument will be developed by firstly describing very briefly the main features of such social movements, according to the Brazilian literature . Secondly, two local community mental health projects in Belo Horizonte will be described - in the Lindea and the Cabana districts - including comments on their participatory and self-management mechanisms, which guaranteed local control of the experiences. Finally, an

analysis of the common features of both experiences will be provided, indicating how the present community practices and the 'nervousness' model can actually generate interesting insights on alternative views on community mental health care. This last section will also include a more substantial theoretical discussion, outlining the contributions to the debate made by the Brazilian literature as well as some of my own analytical suggestions which have emerged during the present inquiry.

2. A BRIEF DESCRIPTION OF THE LITERATURE ON THE COUNTRY'S RECENT SOCIAL MOVEMENTS

a) Historically, the social movements emerged in the late seventies, after a period of political repression and absence of active political life within the working class population. Antecedents can be found in some of the populist social movements in the fifties and sixties, and particularly the experiences of popular education in the early sixties, particularly those based on the contributions of Paulo Freire (Costa, NR, 1989: 52).

b) The present movements have taken several forms: religious base communities ('Comunidades Eclesiais de Base' or CEBs), union opposition groups, district associations, women, black people, environmental, human rights and popular health movements and groups (Singer and Brandt, 1980; Pompermayer, 1987; Viola and Mainwaring, 1987; Almeida, 1989).

c) The most common internal characteristics are[1]:

- tackling mainly day to day and basic needs and problems;
- having a local dimension, although some can be quite massive, by a horizontal multiplication of nuclei and

---

[1] See Scherer-Warren and Krischke, 1987; Pompermayer, 1987; Singer and Brandt, 1987; Costa NR, 1989; Cardoso, 1983; Boschi, 1983; Durham, 1984.

groups, like the church base groups and district associations;
- based on principles of independence, autonomy, auto-organization, and attempts to be as far removed from the institutionalized and vertical political structures as possible;
- innovative and strongly participant practices;
- strong emphasis on personal relations, equality, cooperation,
direct democratic and consensual decision making (but accepting some forms of more fluid representation and leadership), in opposition to hierarchical and instrumentalist practices;
- an heterogeneous social base and composition;
- an 'intelligentsia' support from popular education agencies.
d) From the political and cultural perspective, the following roles and meanings have been attributed to them[1]:
- a form of resistance and defense of the popular culture and interests;
- a rupture with the classic forms of political representation, such as parties and unions;
- a relative rupture with the Latin American political tradition of authoritarianism (both from the right and left of the political spectrum), elitism, corporatism, and populism;
- the emergence of a new concept and culture of citizenship, by the affirmation of basic needs and claims as universal rights;
- the development of new patterns of relationship between men and women;

---

[1] See Scherer-Warren and Krischke, 1987; Pompermayer, 1987; Viola and Mainwaring, 1987; Jacobi and Nunes, 1982; Durham, 1984.

- the stimulation of a discussion on new patterns of local power and management.

e) Despite initial over-optimism from some studies (Castells, 1974, 1980; Jordi, 1975), the literature has pointed to some limitations of the movements[1], such as:

- local, fragmented and volatile character, difficulties in making public their claims and new practices, and lack of more global political efficacy;
- 'basism', fragility in relation to the institutionalized political spheres, and difficulties in dealing with internal political and ideological differences;
- a continued vulnerability to populist manipulations at times.

f) Given the inadequate implementation of the primary care health centre network in the country, some district based movements started to struggle for the improvement of the services, resulting in some innovative experiences such as: participation in local health councils, co-management of services (Almeida, 1989; Valla and Siqueira, 1989; Somarriba, 1988), emergence of a National Popular Health Movement gathering self-organized local health groups, and even some more sophisticated proposals in popular health education, including the use of the media (Ramos, 1989; Vasconcelos, EyM, 1987, 1989).

g) Finally, in the mental health field, some sporadic and isolated experiences and proposals have been suggested and developed (Vasconcelos, 1983; Pereira, 1990) [A: APSM-SMSSP (1989) Educação]. This is the subject of the next section, focusing on two projects in Belo Horizonte.

3. TWO CASES OF POPULAR COMMUNITY MENTAL HEALTH PROJECTS IN

---

[1] See Schere-Warren and Krischke, 1987; Singer and Brandt, 1980; Viola and Mainwaring, 1987; Costa, NR, 1989; Cardoso, 1983; Boschi, 1983; Durham, 1984.

BELO HORIZONTE

3.1. THE HISTORY OF THE LINDEA DISTRICT PSYCHOLOGY COMMUNITY ASSOCIATION

The Lindea district has had a strong community organization introduced mainly by combative members of the Catholic church who settled themselves there in the early seventies, despite the systematic political repression in the period. In 1976, the local district association launched a research-action among the population, in order to assess the health situation in the area and mobilize the community around the issue. This resulted in the elaboration of careful plans for the setting up of a local health centre, and in a massive process of making claims upon the state and municipality agencies. Services should be implemented under their own guidelines, including the employment of pre-selected professionals already committed to the local community work.

In 1978, a group of Catholic students of psychology and pedagogy (supported by a psychologist priest and with some funds from a Spanish aid agency) proposed the local community groups the establishment of a pilot service for children with severe learning problems and mental handicap. The first initiatives followed the traditional methodology in the field: recruitment of potential cases within the area and individual diagnosis using tests (not adapted for that kind of clientele). In their own words, the results were

> 'useless, as the outcome was practically the same (for all children), as we couldn't use any of the tests' scales for that type of children ... [I: Marinho, 1989].

In any event, twenty children were selected by broader and

more informal means[1] and premises were rented to house several activities: pottery, drawing, writing, sports, cooking and gardening workshops, outings and play-therapy. Children were encouraged to take on some easy household and garden tasks, and other community duties. Gradually, parents were called in to participate in fortnightly meetings. In response to a demand from the local popular organizations, open meetings for adults were held at the main community centre, discussing issues chosen by the residents, such as marital relationships, children's education, sexual problems, alcohol and drug addiction, and unemployment. The meetings were followed by the formation of voluntary operative groups[2] coordinated by a pair of students or professionals, with an average duration of up to three months[3]. There, participants would both express their feelings and problems that were related to the subject and also develop strategies of caring for those in need in the

---

[1] Most students had had a previous practice of Catholic and student militancy, and their insertion in the area was achieved under the supervision of the local Catholic church and district association. Moreover, their previous professional practice had been reduced to a short period of probation. In my view, these are the main factors which made them more flexible and able to adapt their technical background in psychology to the specific reality found there.

[2] According to the technique developed by the Argentinian Pichon-Riviere and followers (Saidon, 1982). The hegemonic technical discourse within the team was inspired by psychoanalytic theory, but the concrete techniques were wider and adapted to the local needs, including body work based on bio-energy, bio-dance, collective child stimulation according to La Pierre, etc [I: Marinho, 1989].

[3] "We worked a lot with this model of group work with a pre-fixed time, with a contracted time. For example, for one month this group would meet to do that, and in the end of the month it had to present results. This required everybody to be objective, as we had a concern on avoiding the endless treatment" [I: Marinho, 1989].

community. The practices also included interventions at the local schools - in order to discuss the increasing demand to treat children with learning and discipline problems - and a closer relationship to other community groups, supporting them in their specific needs and vice-versa[1]. The operative groups lasted for five years, between 1981 and 1986, with up to twenty autonomous groups meeting every week and a general meeting every fortnight [I: Marinho, 1989].

Every activity had their own user meetings and groups, electing a user and sometimes also a professional as representatives to a monthly open general assembly where the main decisions were taken[2]. An advisory body was formed by professionals and students, to discuss their own issues and make suggestions which were taken to the general meeting. From 1981 onwards, the 'clinic' had already acquired its own premises, in a house situated near the main community centres, in the heart of the district, which was also used for other different popular activities.

At this point, there was a great concern with the heavy reliance on voluntary work undertaken by students and professionals - which caused a constant turn over in the team - and with the need to develop permanent forms of organizing the work. The first initiative was to create a formal community association to be responsible for the whole project. This process took a year of general discussions,

---

[1] For example, the professional team used to help in the assessment of candidates for the local community mechanics professional school, and the local community nursery in the assessment of child care. From the reversed perspective, the local community craft workshops were contacted in order to discuss the possibility of integrating some of the local mental health project clients.

[2] Apart from general statements from professionals and local community leaders affirming a general high representativeness of such meetings and assemblies, no further evidence is available, given the historical gap between the events and the fieldwork.

and ended with the establishment of a charity organization called 'Lindea Psychology Community Association', whose main decisions were taken in the periodic general assemblies. In addition, all statutory authorities were contacted, in order to claim the funding for a detailed project worked out by users and professionals. In 1984/5, with the first attempts to implement the CONASP-AIS plan in Belo Horizonte by the employment of mental health professionals, the community organized rallies[1] to insist that the district should be placed on the priority list for settlement of mental health teams and to ensure the employment of those professionals already committed to their work there.

The shift from being an autonomous community organization to being a statutory service generated a series of constraints that will be outlined later on. Even so, according to the community leaders, a relatively reasonable level of functioning was maintained until 1987/88, mainly due to the continued presence of a reasonable number of professionals committed to the community work, including a new psychiatrist. Special attention was focused then on ex-in-patients' cases, with low medication dosage group discussions, participation in informal activities such as art-therapy, crafts, gardening, participation in community groups, domiciliary visits and family counselling and support, with very good results:

> "The people being treated stopped being re-admitted, and they were people with on-going and frequent hospitalizations, some were even very serious and chronic cases" [I: Marinho, 1989].

However, with the crisis induced by the new

---

[1] The state and municipal authorities were afraid of the well known massive rallies promoted by Lindea district popular organizations. They used to mobilize the community, hire and load several buses with people and 'invade' the authorities offices. This strategy was adopted to achieve practically all the basic infra-structure and public services in the district.

governorship in 1987, the services suffered a set back. First, due to the substitution or departure of key professionals committed to a community based strategy of work. Secondly, with all the political and economic constraints already identified in chapter 3, and the changes brought about by the shift in the project management. The services were thus reduced to the model already described in chapter 4.

3.2. THE HISTORY OF THE INTEGRATED CENTRE OF COMMUNITY HEALTH (CISC) AT THE CABANA DISTRICT[1]

In 1981, the Catholic church in Brazil promoted its traditional Easter social campaign focusing on the theme 'Health for All'. In the Cabana district, the campaign resulted in several meetings and popular courses within community groups. In one specific area called Antena, the residents opted out, after a community plebiscite, to set up a 'different' health centre, based on people's participation and built by the residents themselves. Acquiring additional support from European aid agencies and regional funding bodies, including campaigning and massive rallies aimed at the authorities, they finished the building and implemented the infra-structure of the centre. After a long process of discussion, a detailed plan of how the centre would function was outlined, including a strategy for recruitment and the training of professionals by the community itself. Some of their key claims were not accepted by the state authorities, and together with constant bureaucratic and political constraints, the initial project was eventually left aside. Even so, a precarious medical service has been maintained on

---

[1] This brief summary is based on direct observation of meetings, interviews and particularly by the action-research report of the experience organized and published by Pereira, WCC (1990).

the premises by the state government funding.

In 1986/87, Willian Pereira, a psychologist supporting the local community work for a long time, started an action-research project involving the community. His main purpose was to investigate the demands for mental health care that were emerging at the health centre, and to devise alternative ways of meeting these demands. A group of twenty mothers were chosen, among the most socially needy, all receiving complementary nutrition for their children and most of them dependent on tranquillizers.

This stage of the action-research was not yet participatory, using domiciliary visits and group techniques only as means to collect information from a psychoanalytic perspective. As reported in the previous chapter, the team's own evaluation of this stage acknowledged the problem:

> "(...) the 'psychoanalyzing' setting mentioned by the collective and more or less explicitly assumed by the team (with the purpose of raising data for creating agencies articulated with the mental health ones) can only create in advance a strong modulation of the results. (...) (The 'psychoanalytic hearing'), as one knows, far from being neutral or abstemious, reinforces automatically the trend for collectives to define specific life events and wider and complex life effects as family and intimate events or, in a more modern way, as signifiers... and to expect technical solutions. (...) (Alternatively, it is possible to think the) Desire as a force which seeks an active synthesis of 'creation', of struggle, militancy, invention, collectivization and fraternal initiatives..." (Baremblitt, 1990: 171-175).

After this realization, the team changed its approach and in 1989 began a wider process of returning the findings to the community, mobilizing some of the local popular groups. A first meeting with nine of them was held, and they not only demonstrated a surprising concern as to the reality indicated by the research report, but also decided to join the project and call all the additional community groups to take part in it. After a three months process of weekly meetings, workshops and discussions, this collective of

community groups produced a proposal for what they called CISC, an integrated community centre for the provision of health and mental health care. It would include activities to be developed by professionals and community groups, involving all the Cabana area. A building was offered by the Catholic church, a process of mobilization was launched, and claims were made for funding from the state and municipal authorities, and from the universities[1].

The CISC would therefore constitute a coordination, assessment and support body, but also a direct service provider, integrating but also respecting the autonomy of the following 'collective apparatuses' ('dispositivos')[2]:

a) Natural health group: a consciousness raising group formed one year before, with the purpose of spreading integral body-mind notions of health, including good nutrition and self-knowledge.

b) 'Capoeira'[3] group: through this martial art, an educative programme for children and youngsters aged seven to fourteen years old has been performed, including the following aspects: basic hygiene and health care, gymnastics, stimulation of psycho-motor development, music

---

[1] I was present in several of these meetings and assemblies, and was impressed by the representativeness and mobilization produced at the Cabana district. As an example, in the popular assembly to launch the CISC on 10/10/89, in the presence of the authorities, the local Catholic church where it was held was completely crowded, with almost 300 people, which is a high figure for the area.

[2] In the end of the present fieldwork, in December 1989, most of these claims were already accepted, and a detailed outline of the centre regulations and activities was about to be finished.

[3] 'Capoeira' is a popular martial art created by the Brazilian black slaves to fight the landlords. It is performed mixed with dance, as an exotic body ritual, in such a way that the training did not need to be underground or hidden.

teaching, and also a socialization and aggressiveness expression and self-discipline programme.

c) 'Barracão' Cultural Group: initially, this was a group of students establishing a collective place where they could study more quietly, given the small houses at the Cabana area. It developed into a group concerned with ecological and cultural interests, trying to recover and support the black culture, the popular music, theatre, folk parties and to set a local library.

d) Health 'Pastoral' Group: being a religious oriented group, it has raised funds by promoting parties and community events, in order to visit, support and orient sick and ill people and their families on how to have access to health services and basic care at home, and to provide some financial help for medicines and emergency transport. Besides, it promotes meeting and discussions on health issues, such as mental illness, alcohol and drug addiction, AIDS, etc, with the participation of specialists in the field.

e) The Cabana District Association: this is the oldest and best organized community organization in the district, supporting all the other community groups.

f) The health centre: the process of mobilization included claims to re-settle the local health centre under the municipality authority and integrate its activities with the CISC.

g) Women's Popular Movement Group: formed in 1984, the group has promoted several activities on women's body consciousness, work, violence against women, racial discrimination, family planning, child education and marital relationships.

h) Pro-nurseries and schooling support group: started in 1981, the group has tried to mobilize resources and the family's participation in the nurseries, improving the quality of the services, and supporting children aged 7 to

12 in their schooling activities.

i) Alcoholics Anonymous Group

j) Dentistry Clinic Group: a group setting a community dentistry clinic with the support of aid agencies.

k) Teaching, Research and Statistics CISC unit: in agreement with and subsidized by universities, this unit would assess and support theoretically and methodologically all of the work integrated into the CISC.

l) Debate, Forum and Publications CISC Unit, in order to promote popular self-education activities on health and mental health issues.

m) Specific Health Services CISC Sector, offering specialized care provided by professionals and probationers, with specific programmes for children, men, women and adolescents, also proposing a detailed programme based mainly on group activities and integration with community initiatives.

n) Institutional Analysis CISC Unit: as all the work is based mainly on groups, this unit would assess the community movement to deal with group processes, like leadership, participation, unproductiveness and self-management, performed by a specialized professional team.

. . .

After this brief outline of the experiences, it may be interesting to investigate how this popular community practice tradition and the 'nervousness' model may be instrumental in developing new ideas on community mental health services.

4. COMMON FEATURES OF THE TWO EXPERIENCES, OF THE 'NERVOUSNESS' MODEL AND OF THE COMMUNITY PRACTICE TRADITION AND THEIR CONTRIBUTIONS TO ALTERNATIVE FORMS OF COMMUNITY MENTAL HEALTH CARE

4.1. THE CONCEPTUALIZATION OF MENTAL HEALTH ISSUES AND SERVICES AS INTEGRATED TO THE COMMUNITY PRACTICE AS A WHOLE

As indicated before[1], the 'nervousness' model's concept of mental health is viewed as intrinsically integrated to the whole context of social deprivation and to the struggle for a better life, in a complex network of concrete and symbolic relationships. Consequently, mental health services must have the same feature. As expressed by the Cabana community leaders:

> "I made an assessment of a person who arrived here and went to have a consultation with the doctor, and after went to the psychologist, and almost like in madness went to the psychiatrist, and ended up with the social worker, and came back to the district association and is now in the group to struggle for housing. I see the mental health service leading to this circle and being able to refer the man to where he needs to be, which is to claim politically for a solution to his pain, that brought him here today, which is one of the major problems, that is the housing problem in the region. (...) And we have other cases, who are actually problems of anguish, isn't it? As the person who is not having someone to talk, given the amount of financial problems, low wages, and then the person reaches the crisis, as he is feeling a great pain..." [I: Almeida, 1989].

> "I would like to reaffirm exactly the experience we're living here, that I believe that is the most complete and efficient in the treatment, that is exactly to try to work the situation in which the person lives and in the environment she lives, and then to develop this work in a more 'communitarian' way. This means in the periphery not only to shelter the ill people, but all the work of infra-structure and support that the public sector should provide. Therefore, I think that they should invest less in hospitalizations, in chemical treatments and other types of treatments in relation to health, and to invest more resources in the community support for this kind of work [I: Scaramussa, 1989].

> "I know several cases here who have nerve problems, and

---

[1] See section 2.1, chapter 6, and the Appendices 5 and 6.

> they walk around in the streets, come to the community. (...) And in the streets they are stigmatized, provoked, exactly to (the provoker) see the reaction. It looks like a spirit of provocation just to see how the person actually reacts. There is no social sense of support, of help, of shelter. Then, this is a problem which needs to be worked out in the community" [I: Scaramussa, 1989].

Mental health is also associated with the right to have access to the positive aspects that makes life happier, like cultural activities, leisure and parties:

> "Health would be then the right that each dweller, each person or human being have for caring for his mental part. Health for the Cabana dweller would be to have room for leisure, as we have very little, and we struggle for it" [I: Luci, 1989].

The list of activities developed in both projects also constitutes a good illustration of this association. The idea of going to local primary schools to discuss the huge demand for child attendance at the Lindea district is another good example of this holistic approach of mental health issues.

This view of health and mental health care as part of a broader structure of social services and rights was also expressed in some of the survey results, particularly in question 17b, on services needed for mentally ill people and their families, apart from those already provided in the health centre. The figures are shown in Table 13. At first glance, this table reveals very low figures for the vast majority of the facilities referred to, suggesting a very low and diffuse awareness of those alternative services. Despite this, it is striking that **virtually ALL the facilities were indicated by at least one or two persons in both places.** In addition, **in the end, the collective range of selected alternatives are exactly what would be found in a comprehensive list of mental health needs and services for contemporary European countries** (MIND, 1983). Willian Pereira, the psychologist who initiated the action-research

in the Cabana district, described the phenomenon as follows:

> "Now, what I found interesting is that each one starts to speak and unfolds a network of free associations, which one picks up from the other's discourse, and links here, links there, and in the end of the meeting you note clearly that they have a full picture of the reality and of their situation. It is like if one speaks on nutrition, other on medicines, another one makes an analysis of his own work, of the objective conditions of the individual, the issue of space... and how life is. And afterwards, they have to participate in it and the several alternative forms that they have, like the discovery of the 'capoeira', the healing of the women, the AA itself... They constitute practices that they carry out, which in practice is what they can count for in the day to day life..." [I: Pereira, 1989].

Table 13 - SPd and Ld: Ideal Mental Health Services as Reported by Users and Companions (in perc.)

DESCRIPTION	SPd	Ld	Average
a) general satisfaction with what is offered by the present services	6.1	3.3	4.7
b) generic reference to more personal support and care from the community	13.1	13.0	13.1
c) local in-patient services	5.1	4.3	4.7
d) local mental health emergence services	1.0	2.2	1.6
e) refer. to non discrimination, less dependency and more autonomy	3.0	0.0	1.6
f) facilities to increase sociability and leisure‡	9.1‡	13.1‡	11.0‡
g) more professionals and specialized health and mental health services	12.1	9.8	11.0
h) financial support or allowance	5.1	3.3	4.2
i) accommodation services	2.0	1.1	1.6
j) free public transport tickets	2.0	3.3	2.6
k) free provision of medicines and exams	3.0	2.2	2.6
l) work opportunities	4.0	4.3	4.2
m) general and special education schemes	7.1	4.3	5.8
n) community activities	1.0	2.2	1.6
o) other answers	16.1	8.7	13.6
p) don't know	26.3	45.7	35.6
NUMBER OF CASES	92	102	

Note: (‡) It refers to sum of sub-codes aggregated on this heading in a multiple answer question; therefore, the actual general rate might be a little less than what is shown.

This phenomenon has also been reported in the Brazilian ethnographic literature as 'fragmented consciousness', in a concept similar to that of Levi-Strauss' 'bricolage' (Ortiz, 1980). **Therefore, the community organization represents the concrete possibility of overtaking the fragmentation of each individual or group views, of building a more comprehensive and integrated world-view. Moreover, and what is also very important, it constitutes a necessary condition for political efficacy,** as reported by one of the community leaders of the Lindea district:

"In 1979, when I settled myself here, I had already found these people struggling, but struggling indeed, a brave people, with a great will power ('garra'), and we've had to go to the state agencies to claim everything, the improvements at the district. In 1981 I started to participate in the association, and from then on I've followed and seen how the work has developed from the time the people started to unite themselves to struggle, because what we see is the following: when the people struggle individually, it is very, very difficult to get any thing. But when the people unite and organize themselves, and launches a claim, the achievement comes much more easily than when individually done. Therefore, the history of the district is more or less like that..." [I: Oliveira, 1989].

To sum up, in my opinion, **the popular concept of mental health is actually more associated with an interdisciplinary approach than the psychologized and corporatist mainstream view of mental health services in Belo Horizonte[1]. It is also much closer to the European concept of a welfare system and personal social services, and to the idea hitherto hegemonic in England and in the Italian Psichiatria Democratica, of community mental health care as an integral part of a wider range of social and mental health services.**

4.2. AN ALTERNATIVE VIEW OF THE 'PSYCHOLOGICAL' DIMENSION AND OF TREATMENT STRATEGIES

4.2.1. The 'Nervousness' Model, the 'Psychological' Dimension and the Brazilian Context

Could the above described popular conceptualization of mental health issues and services be identified as a 'socially oriented' one, in which the 'psychological' dimension (in the Western sense of it) is lacking and where

---

[1] This author is aware that in a peripheral country like Brazil, the reductionism in the concept of care by the professional elites is also a direct consequence of the lack of basic welfare services for the working class population.

thus there would be practically no room for psychotherapeutic treatments?

In my view, this would be the common ethnocentric way of formulating the problem. Duarte, in his studies on the 'nervousness' model, has already warned us about the difference between the Western 'psychologized' representation and the complex popular way of viewing the phenomenon (1986a: 163, 277; see also Costa, 1989b). He has indicated the difficulties in systematizing the therapeutic strategies in the latter, although pointing to the common phenomenon of resort to 'multiple strategies', linked to different 'signification sub-systems' (op cit: 272). By this, he means the trend to seek help from different and sometimes concomitant concrete and symbolic resources, be it religious, medical or from traditional healing methods. In addition, he indicates the presence of the representation of 'talk' as a resource acknowledged by the Brazilian working class groups[1], although distinguishing it from the idea of 'talks' in formal appointments and in a clinic environment (op cit: 163, 277).

From a perspective more centred on the Western representation of the concept, Costa (1983, 1989b) proposes that the nervousness model includes an implicit 'psychological' component as a basis for the use of psychotherapeutic methods with this clientele.

The present inquiry produced some evidence on this. Part of them have already been discussed in chapter 6, sections 3.1, 3.2 and 3.3. In addition, in the survey, categories like 'talk', 'dialogue', 'tell the life' ('contar

---

[1] Also indicated by other studies (eg, Alves, 1982: 109).

a vida'), 'conferência'[1], 'papo' (chat) were the most used to describe the treatment in the case of psychotherapy (q 13d). When evaluating the treatment provided (q 15d), the majority of the users tended to do it making explicit reference to the personal qualities of the professional. The sum of all cases in both places referring explicitly to the positive personal features of the professional is 64,5%, disregarding the form of treatment, although one client could use more than one sub-category. In any event, this is undoubtedly the hegemonic way of evaluating the treatment provided. Sometimes, the process is explicit, as in the expression:

> "This is not only due to his profession, but I think that depends a lot on the temperament as well".

The most valued qualities were:

- to be attentive, concerned or demonstrating will to help (18.6%);
- to be tranquil, calm and patient (14.2%)
- to be polite and to receive clients well (11.5%).

Similarly, as already described, the positive changes due to the treatment were in the majority of cases described in terms of symptom control and positive development of personal performance, and very few users reported answers that could be described as 'insights' or access to 'psychological' or intra-subjective changes (q 14b).

These results could again be easily and ethnocentrically misinterpreted as reinforcing the idea of deprivation of the 'psychological' dimension. In my view, however, it is necessary to stress the diversity of situations and the complexity of the debate on the psychological dimension in different cultures, as suggested

---

[1] Which has a more conversational meaning than its direct translation 'conference', probably given the proximity with the verb 'conferir' (to check).

by cross-cultural psychiatry. According to this approach, in non-Western cultural contexts the self is differentiated according to quite different criteria, more often 'moral' than psychological (Harre, 1986)[1].

The Brazilian 'nervousness' model clearly requires further research. However, an attempt to produce an alternative interpretation of the present findings could be done by linking some of the suggestions already pointed out in the literature. Initially, it may be interesting to consider the analysis undertaken by Costa (1983, 1989b) of the clinical material gathered in the project for adapting psychotherapeutic methods for working class clientele at the Hospital Pedro II, in Rio[2]. One of his main conclusions is that **among those sharing the 'nervousness' model, the 'psychological identity' is highly dependent on the social identity, a process that is not only determined economically, but also symbolically.** Other social groups can deal with life stresses without these conflicts necessarily reaching the level of the psychological identity. However, the peculiarity of the population group identified with the nervousness model is that some life stresses (unemployment and work problems for men[3], as the given examples) can actually induce distresses in the 'psychological' sphere, identified by them as 'nerve' problems.

In my view, though, the most interesting analytical

---

[1] China during the process of Cultural Revolution is a good example of this: in a political context which emphasizes a tight moral consensus, the experience of somatic distress might well be more appropriate than psychological distress (Kleinman, 1986; Littlewood, 1990).

[2] See section 4.1, chapter 5.

[3] A work by Jovchelovitch (1990) suggests some clues, from a psychoanalytic perspective, on how working conditions have intrinsic implications in the psychological identity within the Brazilian 'nervousness' model.

insights on this have been offered by Da Matta (1983). For him, in a society such as Brazil, with a strong hierarchization and domination system based on personal relations, the process of individualization for the working class is 'dramatic', in the anthropological sense. This process means the actual loss of all substantive rights provided by kinship ties, marriage, friendship and 'compadrio'[1] relationships and its implications in terms of social acknowledgement, respect and concrete social protection, particularly in a society without basic welfare rights and in which the legal system is inoperative for the underprivileged. In sum, individualization and psychologization means for the working class personal powerlessness, complete lack of protection and risk of violence, both concretely and symbolically:

> "This is the deepest experience of exploitation in semi-traditional societies, like the Brazilian case: to be an individual in a society which has its framework in a hierarchy, to be treated like a number or a global data in a mass, in a world highly personalized, where all are persons ('gente') and seen with the respect and consideration due ('devido respeito e consideracao')" (Da Matta, 1985: 188).

It is not a coincidence that one typical example of the effects of this individualization process for the working class is found in the mental distress of the women who have experienced breakdown in their family, marriage and cultural ties, as described in the previous chapter. Da Matta's anthropological description of the migrant fits quite well with this case:

> "This is an individualized mass, dislocated from their origin place, where their members were treated with respect and consideration. Actually, the majority of them constitutes dislocated migrants, important step

---

[1] 'Compadrio' means the relationship between the parents of a child and the latter's god-father/mother, which for the Brazilian working class can sometimes establish ties that are as strong as kinship ones.

> for their transformation in individuals without any representation, entirely submitted to the market and state laws" (Da Matta, 1985: 188).

Why exactly then should women be more vulnerable to such dramatic loss of personalized ties? In the nervousness model, according to Duarte (1986a), the opposition female/male superposes other dichotomies such as house/street, family/work, sensibility/strength, interiority/exteriority, morality/physics, nerve/blood and private/public spheres. The individualization process is even more dramatic for the woman because she is confronted exactly with her antithesis, losing her basic world of reference, being 'thrown away in the street', in the public sphere, in the anonymity of the market 'jungle' laws, in the 'male' world.

In such a context, it is possible now to understand a basic feature of the **community model: the treatment strategies clearly target towards some kind of reintegration in community groups where the individual not only can reconstruct a personalized network of ties and social support, but also reframe his personal/social/political identity in terms of more reciprocal and egalitarian relationships and in terms of a new concept of citizenship[1].** This is quite coherent with the Basaglian and the normalization approaches, in their stress on the importance of empowering and increasing the contractual power of clients as an integral part of the therapeutic strategy.

In my view, however, group activities can perform not only these sheltering and empowering functions, but also can induce individuation processes which are connected to the

---

[1] These specific features of the present Brazilian social movements are particularly described by Duhram (1984). These relational and extra-relational aspects and their links with the nervousness model are also analysed by Duarte (1986a).

'psychological identity', using the term proposed by Costa. In this respect, the notion of the 'contrasting' principle in the process of social identity formation[1], as suggested by Oliveira (1976) and Duarte (1981), can be useful. Hence, the process of individuation - intrinsic to psychogenetic development and to any psychotherapeutic treatment - may be performed by the individual also by contrasting voluntarily his/her own social and psychological identities with other existing and potential ones, in order to differentiate him/herself or re-signify his/her own experience[2]. In anthropological terms, then, **for social groups hegemonically characterized by a holistic cultural system and inserted into a hierarchical system of social domination like the Brazilian one, individuation may occur without necessarily**

---

[1] By this, briefly, one can understand that an important strategy of individual or group social identity formation is the process of differentiation in relation to other individuals or social groups.

[2] From this perspective, we could re-interpret a suggestive indication from Costa (1989b: 37-8), based on the experience of alternative psychotherapeutic techniques in Rio: the frequent imperative reactions (advice, straight opinions or disagreements) to one's experience or the constant superposition of similar personal events by other participants, during the group sessions with working class clientele. From an ethnographic point of view, these settings would perform functions which might be described by a continuum varying between:
- the concept of 'retreat' ('refugio'), already used to refer to mental health facilities, as a sheltered environment for re-signifying and re-building in crisis or stigmatized identities;
- the concept of 'trip' ('viagem'), both in the concrete (short journey) or psychedelic senses, as an opportunity to contact new views of the world, people, work and personal life.
The Institutional Analysis' concepts of 'productive desire' and 'collective analyser' may be also relevant to elucidate the process.

leading to an individualization process[1].

This hypothesis is also in line with an important tradition of anthropological studies in Brazil, particularly represented by Velho. According to him,

> "the furtherer an individual expose him/herself to diversified experiences, deal with contrasting 'ethos' (thinking logic) and world-views, and open his/her network of relationships in the level of the day-to-day life, the deeper will be the self-perception of singular individuality" (Velho, 1981: 32).

For him, hierarchy/holism and individualism sometimes oppose, but sometimes complement each other, and it is necessary to map the room for individualization in each social group or context, focusing its specificities. Individualization in complex societies like Brazil means the development of a personal 'project', within a 'field of possibilities', circumscribed historically and culturally, in terms of the existing notions of Person, themes, priorities and cultural paradigms. According to him, psychotherapists tend to have a linear, non-relativist and reductionist view on the complex links between the individual personality and this 'field of possibilities'. In the Brazilian case,

> "this (reductionism) is expressed acutely in the relationship with other social classes, especially with the lower income groups, whose possession religions and other 'exotic' belief systems, linked to different world-views, constitute several times unsurmountable

---

[1] A very good example of such a possibility is outlined by Ortigues and Ortigues (1984), from a rigorous psychoanalytic perspective, for ethnic groups like the Wolof, Lebou and Serer in Senegal. For these individuals, the solution of the Oedipean stage is accomplished by the identification with the 'brothers' and with the collective tradition, in a strategy opposite to the individualization process implicit to the traditional psychoanalytic treatment in Western cultures.

barriers" (Velho, 1981: 30)[1].

In conclusion, then, for a population steeped within a strong personalized and hierachized domination system and in which the 'psychological identity' is so intrinsically fused with their social identities, the integration of treatment strategies with community groups may have therapeutic functions, such as:

- the reconstruction of a network of personalised ties and social support;
- empowerment and reconstruction of personal/social/political identities in more egalitarian and reciprocal terms;
- singularization and individuation processes[2].

Furthermore, the community groups constitute a concrete form of claiming for and providing support and care when a wider

---

[1] A good example given is that of a man attending an Afro-Brazilian ritual and receiving a 'blessing' ('passe'). Bezerra Junior comments that in this case, "what for somebody is an irreversible act of self-abandonment, is for another a safe step towards a reinforcement of individual qualities, as the ritual is a result of an option, of his own will, and is a strategy for the individual to differentiate from the others by his personal qualities" (Bezerra Jr., 1982: 158-159). A similar interpretation is proposed by Montero (1985: 256-7): instead of keeping the feeling of failure or 'weakness' ('fraqueza'), as the distress is perceived in the 'nervousness' model, it can be re-signified and re-ordered in a positive way by the ritual symbolic system, even by inducing a new arrangement in the interpersonal relations by the regular participation in the 'terreiro'.

[2] The definition of pre-conditions for this specific function will undoubtedly depend on further research. However, it is possible to say that one of them is the voluntariness and the existence of a minimum 'market' of options. This is important in order to differentiate, for example and in the extreme, from tribe rituals in closed social groups, which tend to reinforce the tradition and the already established social identities. At the opposite pole, the social and cultural diversification in larger urban areas is particularly stimulating for such purposes.

intervention is needed, mainly in the case of the continuing care client and family carers.

4.2.2. The Reappropriation of Psychotherapeutic Practices by the Community Oriented Model

From a more cautious perspective, it is also important to be aware of the limitations of these community methods, mainly in terms of 'normatization' and ego reinforcing effects[1]. From the Institutional Analysis perspective as well, the phallic mechanisms of the groups can generate dependence and passivity. In addition, it is possible to expect among the clientele of health centres some cases with actual demands for a deeper individuation process and individualized approach.

In such cases, the two experiences indicate some routes to follow. The first is **the need for specialized support in group assessment, in order to help the community groups deal with their internal processes,** as in the creation of the CISC's Institutional Analysis Unit. Another example is the

---

[1] These criticisms have been raised mainly by the Lacanian and Foucaultian approaches and must be considered seriously. However, they can not be taken in an orthodox way: as wisely indicated by Figueira (1988: 144-5), **even an explicit demand for singularity through a psychoanalytic therapy is always and inevitably adaptive, mainly to a culture in which the hegemonic values are the psychologized individualism.** Ethnographically speaking, this may be found within the Brazilian urban middle class, whose influence by the psychoanalytic culture can be seen in the use of expressions such as 'analysed person' as synonymous of 'liberated person'. It also explains why among such social groups to do a psychoanalytic therapy constitutes a symbol of status and of being up to date.

use of techniques such as supervised operative groups[1], which also include an approach to those mechanisms implicit to group practices.

The second is **the implicit and practical acknowledgement by both community projects of the importance of and of some autonomy of the professional work with individual or group psychotherapy.** However, this realization is accomplished by re-framing psychotherapy in at least six main ways:

a) The first one is the need for **a more flexible notion of the therapeutic contract**, given the different demand formation processes and different perceptions of time and of what constitutes the problem to be treated, as shown in section 2.1, chapter 6. This element is present, for example, in the Lindea case, in the attempt to set a deadline for the operative groups, based on an explicit critique of long treatments by traditional techniques [I: Marinho, 1989]. It is also present in the way users refer to the professionals, when answering the survey's question on their opinion on the treatment provided (q 15d)[2]. Specialists assessing the Pedro II experience in Rio also reported the same fact:

> "The idea in a general way, as we perceived afterwards, but without noticing in the beginning, is that (the clients) like to have the professionals available at the clinic, and once solved that immediate problem, they would go, but with the possibility of coming back" [I: Bezerra, 1987].

---

[1] The group operative technique itself proposes deadlines for the therapeutic or operative task proposed and stresses a constant awareness of the group's symbolic death, as a mean to induce a permanent confrontation with the unconscious conflicts of the group life (Saidon, 1982).

[2] Like in the expressions: "when we need him, he is always there"; "she (the professional) is so concerned with my case that she gave me her phone number and said that if I had any problem I could call"; "the Dr. X always keeps time ('é pontual'), we're those who used to be late".

b) The second aspect is a **more 'courageous' and flexible attitude towards the use and research of a wider range of therapeutic methods, with a clear emphasis on those based not directly on discursive communication forms.** Among the two experiences, it is possible to list the used or proposed methods as follows:

- collective psycho-motor stimulation for children based on the techniques proposed by the French author La Pierre (Ld) and play-therapy (Cd);
- bioenergetic techniques (Ld);
- bio-dance, a technique developed initially in Chile during the seventies (Ld);
- operative groups (Ld), diversified group dynamics and Institutional Analysis techniques (Cd);
- art and praxis-therapy (Ld);
- family counselling, including domiciliary visits (Ld);
- capoeira (Cd);
- psycho-drama and other dramatic techniques like those proposed by the Brazilian Augusto Boal (known as 'Teatro do Oprimido') (Cd)

Drug therapy was also included in the treatment options, though emphasizing lower levels of doses and collectivization of the decisions:

> "We worked there with medication at very low levels, just as an auxiliary to control symptoms. (...) Mr. X (the psychiatrist) had a medication group. It was very interesting, I mean, all the people used to participate to discuss if they thought they should take it or not, or if it should be a higher or lower dose, and it was very, very interesting, wasn't it?" [I: Marinho, 1989].

c) The **priority for group psychotherapy** constitutes the third aspect, and is explicitly reaffirmed not only in the two Belo Horizonte experiences, but also in the Rio adaptation of psychotherapeutic techniques for working class clients. The reasons reported also include a concern on accessibility to a larger clientele. However, the main ones

are centred on the realization that group techniques are more appropriate to the different cultural and linguistic features of the users, with arguments such as those described in section 2.1, chapter 6.

d) The fourth aspect is that **psychotherapy must be integrated with other community or rehabilitation activities in order to provide the opportunity for users to be active, productive and to feel him/herself useful for the community.** This guideline is very similar to those suggested and practised by the normalization and Basaglian approaches. The previous discussion on integration of mental health practices to the general community work has already provided some evidence on that, particularly in the Cabana case. At the Lindea district, this was a constant guideline, as described above through listing some of the concrete activities, or as explicitly pointed out by Francisco Marinho:

> "If you think about the practice of endless treatment, (...) you do not become a health agent. It is not the case that we had no such clients, but it is always articulated to something else. (...) There, the individual, besides being attending consultations, becomes already an agent. For example, when representing the clinic in a community meeting. And there goes someone who could be viewed as a 'loony', representing and defending the work.(...) In the therapeutic setting you play a dependence relationship, but we introduced also another relationship, by which he/she decides what to do and work actively" [I: Marinho, 1989].

e) The fifth suggestion refers to **the importance of complementing therapeutic by educative practices, such as the provision of full information to users, and even popular education programmes for some specific issues.** This theme is in general strongly challenged in the Brazilian literature, given the traditional hygienist, 'assistantialist' ('assistencialista') and 'proselytist' practices of several social agencies in the country and the constant risk of

'normatization' processes[1]. Within the two projects, several examples can be provided. The first is the practice of reception or medication groups, in which the demand for treatment and drugs is analyzed, including the provision of information on technical procedures and side-effects. Also in the Lindea district, it was a constant guideline to provide direct information on services and leaflets on general health and mental health issues, including sex education. The general assemblies to discuss specific themes and operative groups were other examples of such practices. In the Cabana case, the CISC Debate Forum and Popular Publications Unit and the list of community groups and activities included in the former gives a clear example of this kind of integration.

f) Finally, **the general guidelines for and the practical effects of professional work must be clearly accountable to the collective co-management and control of the community.** This will be fully described in the following section.

4.3. DEMOCRATIZATION, KNOWLEDGE SHARING, PARTICIPATION AND CONTROL OF THE PROFESSIONAL PRACTICE BY COMMUNITY GROUPS

As implied in the historical outline above, there is a clear political and practical awareness by the community leaders of the distance between the mainstream interests of

---

[1] The best example of this is an essay by Costa (1981), where he argues that mental health is by any means a result of education. The argument may be valid if based on very restricted concepts of education and mental health, as implied in the text. Besides, this work is particularly historically influenced by the context of criticism of the past hygienist practices in the country and by Foulcault's presence in Rio during the seventies. In my view, if the meaning of such concepts are widened to include the country's tradition of critical popular education and of a productive approach to Desire, as proposed by the Institutional Analysis, the issue deserves a reappraisal.

professionals and of the population, and of the ideal relationship between them:

> "The experience from the health centre here, the information that I have from the participation in this working group is that not all the professionals have the disposition to develop a work with the community. Indeed, some professionals, mainly from the medical field, have a very strong resistance, and feel disturbed when having to discuss things with the people, mainly when having to listen to some suggestion or having some participation from the people in this field. In general, they try to develop a completely independent work. Now, there is the experience of this last team who arrived in the centre, it seems to be different. The professionals have a different working mentality, disposition to work with the community, to sit and discuss together, and to assess and listen to the community. Therefore, we perceive that from the professionals, there are two types of them and two types of behaviour" [I: Scaramussa, 1989].

> "(the professional's account to the community) is a right of the community, because that health centre was built up by the community, if it is there, it is because the community settled it down there, it was achieved by the community and it was a struggle of the community" [I: Oliveira AC, 1989].

It is important to look at the strategies adopted by the community movement to achieve this goal. From the two experiences, it is possible to list:

a) **Recruitment schemes by the community:** as indicated in the two historical accounts, both communities lobbied the statutory agencies to ensure the employment of already chosen professionals, according to their previous concrete experience of the professionals' practice and political commitment to the local work. Sometimes, the candidates put forward by the authorities would be submitted to a special selection process, as in the case of the Cabana district:

> "The leadership of the Association, faced with the new project, started to claim autonomy to indicate professionals to the Health Secretariat, believing that it was of great importance to establish an alignment of concepts between staff and the Association. (...) Besides, a general scheme was programmed for the selection test of candidates to health auxiliary posts,

which included:
- application form;
- 'recycling' course with the duration of 4 weeks;
- selection test consisting of an essay about the health centre, an interview about the community participation of the candidate and, finally, a technical evaluation with the professionals of the Metropolitan Health Centre" (Pereira, 1990: 30-1).

b) **Special training schemes, particularly for professionals not chosen by them:** using their own pedagogic methods, the community groups in both projects provided informal or formal training according to their interests:

"The probationers, for example, who from this time onwards started to come, among them concerned people, because the work was prospering a lot. Then we had a kind of 'course' of introduction for probationers. We gathered the group, then X (the local Catholic priest) used to tell the history of the district for them, and to take them for a walk in the district, for them to start making the contact with everything which existed, etc, to avoid the individual 'to jump in as by parachute'. They had to read all the reports and to discuss everything that we had made, for the person to achieve a minimum notion of where he was, with what type of population and with what kind of data he/she would deal with" (Ld) [I: Marinho, 1989].

"(The Cabana district association) presented a project of course for the future professionals which included the following programme:
- health policy;
- analysis of the Cabana social reality;
- participation of the community in the control of the health quality;
- community campaigns, courses for the population, etc." (Pereira, 1990: 30).

c) **Formation of community councils, meetings and assemblies as the main decision making bodies:** as described above, the community strategy includes a constant assessment of practices of all of the main agents involved and refers the main decisions to the collective bodies, including the main guidelines for and evaluation of professional work. The Lindea district, given its longer experience, can provide very interesting examples of the local leaders awareness of

professionals' corporatist interests and political limitations; of the need to evaluate and control them; of the strategies adopted to do it; and of the ethical and political problems involved in the process[1]. In the event of ethical problems, the local psychology association had a specific group to deal with them, or could create a special commission for a particular case, always formed by professionals and people from the community.

The relationship between professionals and the

---

[1] "(Imagine) if you were a bad professional. (Imagine) I'm also a professional here, we all work in the same area, don't we? We will make a meeting, and would I tell that you are a bad professional in the presence of the community? I mean, 'dirty clothes are washed up at home' ('roupa suja se lava em casa'), I agree, I'm not against the professionals. There should be a special meeting within us, to tell the bad professional off, for the good functioning of the centre. (...) It's all right, because if you are a bad professional, and if we tell this to the community, I mean, you'd lose your credibility, and no one would like it. (...) However, there should be another meeting with the community. Some professionals would not say anything, but X (a previous professional committed to the community work and dismissed by the governor for political reasons) would do it. She would tell you off, in a light warning ('puxãozinho na orelha'): 'it is wrong, this should be done that way', etc. In any case, there should be indeed this meeting with the community. However, that professional who is (at present) there does not accept this, she thinks the community should not intervene in anything there; who decides is only them there. (...) Besides, the present governor (...) does not want the community to organize itself, he wants to demobilize the communities. (...) Why did he dismiss X? Because she was supporting the community. The governor didn't like it and replaced her for another one, who is hard (to the community). That is the reason why she doesn't accept the community intervention." [I: Oliveira, president of the Ld Psychology Community Association].

"Y (a psychologist) is someone with a fantastic ethical concern, he belonged to the association own group of ethics. Any problem which might have happened, both inside or outside the association, Y was responsible for constituting a special commission which was formed by professionals and people from the community, to tackle any problem." [I: Marinho, 1989].

community constitutes an actual area of conflict, especially due to the difficulties of the social movements in dealing with the political divisions within their own community movement. In the Lindea case, for example, there were periods of mismanagement and interference from political parties even through the elected district association's board of directors, with potential repercussions in the Psychology Association. At such conjunctures, the professionals developed mechanisms of protection in the Association[1].

d) **Implicit and explicit mechanisms of knowledge sharing and democratization of the relationship between different professionals, and among professionals, staff, users and community members:** the above described mechanisms, valuing collective decisions and shared responsibility under the control of the community, implicitly promotes the democratization of the relationship between different professionals in the team. Besides, as outlined below in the section of popular pedagogic methods, professionals are constantly invited to assess community groups and to give participatory seminars and workshops. This also functions as a strategy by the community to evaluate their practices.

e) **By easing the boundaries among professional and voluntary**

---

[1] "The board of directors in the Psychology Association worked in a collegiate way. There had been an initial clause that was reformulated later on: (...) the board of directors posts could only be occupied by mental health professionals who were providing services in the association, because at that moment we were very worried with the issue of political appropriation that had been happening in the Lindea district. It was not anymore the same organization form, and there was already some partisanship and political dispute, and not only objective practices towards the community interest. (...) (Even so), this collegiate used to take decisions only in regard to technical issues, and all ideological and practical issues for intervention in the community, all programmes, priorities, were all decided in the monthly meetings, which gathered representatives of the parents groups and of the community" [I: Marinho, 1989].

work, and community militancy: as most of the social movement practices developed in the country, the majority of the community projects involving professionals had to be initiated on a voluntary basis. Even after some institutionalization and regular financial or staffing statutory support, which is frequently given at very low levels, professionals are required to accomplish tasks much more based on political than on paid compensation. Besides, community meetings are generally held in the evenings and week-ends, outside the normal work time, in order to allow a broader participation.

This also constitutes an area of contradictions and constant conflicts. From the community side, this voluntary work constitutes a constant way of evaluating the professionals' commitment to the community. However, from the workers' perspective, this means lack of acknowledgement and of the possibility of longer dedication and professionalism, generating dissatisfaction, turn over in the team, and instability and shorter duration for the projects. The Lindea case is the best example of such problems, which reduced the participation of professionals to those employed by the state. An important element to tackle the problem is a flexible work time, by which professionals could attend community meetings and compensate them by reducing the total amount of formal working hours.

4.4. THE ADAPTATION OF THE 'POPULAR PEDAGOGY' TO HEALTH AND MENTAL HEALTH ISSUES

Since their inception the social movements have developed what is called in the literature a 'popular

pedagogy'[1]. This means the informal and/or formal methodologies for relating themselves to scientific and practical knowledge, to the intellectuals and for promoting education and consciousness raising. **The concrete experiences in health and mental health projects have stimulated the systematization of practices and adaptation of such 'pedagogy' to the specific issues of these fields.** The description of the two experiences by community leaders and professionals are punctuated with references such as:

> "It is significant to realize that part of the community, through the association, had already a clear consciousness of the health model that they then wished. According to the historical formation of the health centre, the community had been formulating their claims through:
> - research and analysis of the demands;
> - religious rituals, meetings and discussions in the 'Bible circles' ('circulos biblicos', a very popular technique of reading the Bible and discussing life events related to it);
> - courses on the association between health and work, statutory health policies, control and quality of medicines, mental illnesses, etc;
> - discussion and writing up of the project to be sent to foreign aid agencies;
> - courses provided by the PUC-MG (the local Catholic university) together with the association, for dentistry auxiliary staff;
> - conferences and debates between professionals and the community;
> - community campaigns to statutory agencies;
> - 'mutirões' (voluntary collective building work by local residents) for building the Community Health Centre" (Pereira, 1990: 29-30).

> "I wrote to X (a psychologist who worked in the community), asking him what could I do to keep a group equal to that in which I had participated, without being a psychologist. He said that there would be no problem (...), but he indicated Y (another local psychologist), who said: 'I do the work with you', and then we started. There were people with strong

---

[1] Wanderley, 1980; Souza, 1982; Costa, 1981; Costa, 1989; Cury, 1986. In the health field, see especially Vasconcelos, EyM, 1987 and 1989.

> depression, people without any self-confidence, people with self-confidence but not trusting anybody else, people with infantile traumas, very frightened, and other things. Then we started to work on that. But it was like that: Y could not be always with us, then she used to pass something for me, and I would apply in the meeting with the people, taking notes, and on Saturdays I used to meet her. Then, I would tell her what happened in the meeting, she would analyze, we would then talk, and from that talk that we had had, she would suggest guidelines for the next meeting.(...) After some time, Y left the district and I stayed 'holding the hot potato' ('segurando o pepino') alone. I went on alone for one year with this people" [I: A resident participant of the activities at the Lindea District Psychology Community Association].

4.5. THE RELATIONSHIP TO THE STATE AS THE MAIN SERVICE PROVIDER

The long experience of dealing with statutory agencies to claim for basic infra-structure and social services has induced a process of increasing political consciousness among the community leadership and participants in general. **In this confrontation, strategies have been developed to enhance their power, to affirm their views on how these services should be provided, organized and controlled, in an actual counter-hegemonic struggle.** The table 14 tries to sum up those used in the two projects in the health and mental health field, including the ones already described for the relationship with the professionals. Specifically in relation to

Table 14: Ld and Cd: Counter-Hegemony Strategies Used in Relation to State Agencies and Professionals/Staff

STAGE	ACTIONS & STRATEGIES	PURPOSES
Claiming For a Service	Action Research	.assessment of actual needs; .mobilize the community; .produce evidence to convince state and press.
	Careful Plan for Services	.set ideal service accord. to comm. interests; .mobilize community; .negotiate with the authorities.
	Campaigning	.maximum political pressure.
After Service Settlement	Structures of Accountability and Involvement of Professionals/Staff: a) recruitment schemes; b) training schemes; c) comm. bodies as decision instances; d) knowledge sharing; e) stimulate militancy.	.attract, shape and control profess./staff practice accord. to community interests; .democratization of relationship among profess., staff, users and residents.
	Comm. Bodies as Mediators Among Clientele, Profess./Staff and Authorities	.comm. groups as legitimate political interlocutors.
	- Attempt to Keep Autonomy from State - Diversify Funding Sources	.reduce economic/political dependence from superior instances.

the state agencies, the following strategies can be listed:

a) Making the claim for the settlement of local health centres is generally preceded by a process of assessing the dimension of the problems in the district, mainly through action-research techniques. It initially has the purpose of assessing their reality and of being able to convince state agencies and the press of the real need for the service. In addition, the research is generally designed to contact almost every household, towards mobilizing the population from the research stage onwards, in order to produce, for example, the already described 'massive visits' to statutory agencies and politicians' offices, when necessary.

b) Before and during the process of claiming the settlement of a local health centre, both communities initiated a discussion on what kind of service should be provided, how the centre should function, priority programmes, management

and participation of the community, the type of professionals and staff, recruitment and training strategies, etc. **The process of claiming, then, would also constitute a negotiation on this previously detailed plan for the ideal health centre outlined by the community, trying to keep as many of the planned conditions as possible, in order to ensure that their interests** are safeguarded.

c) After the settlement of the local service, some strategies are developed to maintain a certain level of control over the centre's activities. **Internal to the health centre, the mechanisms are mainly centred on the already described structures of accountability and involvement of the professionals and staff.** Moreover, the two community movements have tried to cover the **external links of the health centre, by reaffirming themselves as legitimate political mediators in the relationship among clientele, professionals and authorities.** This is achieved by bringing the claims and demands of the population, professionals and staff to their meetings, systematising them and posing themselves as legitimate mediators or representatives in the relationship between them, but mainly in relation to the authorities. In their own words,

> "After the health centre started to work down there[1], it seems that it was like that, going away from the communication with the community and with the association. Then, the service started to deteriorate, because before we had worked together. What had been lacking in the centre, they used to bring the problem to the association, and the association would elaborate those problems to claim to the authorities and have them solved. In that way, the service could then go on. Now, not only the communication between the centre and the association has deteriorated, but also all the health services in the 'big' Belo Horizonte became

---

[1] In the Lindea case, the health centre was settled initially inside the Catholic church building and only later moved to its own statutory facilities.

terrible" [I: Oliveira JM, first coordinator of the Lindea District Association, 1989].

d) The last strategy is constituted by the attempt **to keep the services autonomous from the state for as long as possible, and to diversify the funding sources.** This is the subject of the next section.

4.6. THE PROSPECTS FOR AUTONOMOUS NOT-FOR-PROFIT POPULAR ORGANIZATIONS IN THE FIELD

Both communities started their projects autonomously, and were obliged to consider the external funding after realizing that they were unable to continue on a self-financing basis. **The discussions on that reveal how autonomy and self-funding (as an inducer of the community mobilization) have been important values to those communities, side by side with the recognition of their right to health care.** This is exemplified in the initial stages of building up the health centre at the Cabana district:

> "The community could not any more afford alone the high costs of the building. This reality would require more participation of the population and, fundamentally, more financial resources, which in that situation would not be that easy. This consciousness of their own impotence was well expressed in the discouragement, in the absence at the meetings and in the over load of tasks on few people. Facing this, external financial help started to be considered: state and foreign aid agencies. On the other hand, some people pointed out the possible risk of receiving external aid, leading to the demobilization of the community with the donations. In parallel, the government responsibility to the people's health was also remembered. That was another dilemma posed to the residents. The initiative to work out projects to the exterior and government agencies ended up being hegemonic" (Pereira, 1990: 29).

At the Lindea District Psychology Association, the project was kept autonomous for practically nine years (1978/85), having received only some initial foreign aid and

contributions from a Catholic priest and psychologist, without any interference in its development. The remainder had been based on self-raised funds[1] and voluntary work by students and professionals. As reported before, the crisis of the project emerged particularly in response to the impossibility of retaining volunteers [I: Marinho, 1989], leading to the claim that some professionals be employed by the state.

The change from an autonomous to a statutory service had very serious and important implications for the project, as reported by Francisco Marinho and the then board of directors of the Psychology Community Association in 1989, and summed up as follows:

a) As now a free statutory service, the process of mobilizing clients to become associates, to pay the monthly fee or to be invited to perform support activities to the association in a voluntary way could not be accomplished any more. This had serious symbolic implications in terms of the financial responsibility to keep services going on and of political commitment and participation in the project.

b) The state assumed some of the professionals wages, but not the remainder of the maintenance, clerical staff costs and medicine provision, practically suffocating financially the association, because their normal fund raising mechanisms were affected by the change, as indicated above.

c) The professionals and staff's wages started to be compressed particularly after 1987, generating dissatisfaction, lack of commitment to the work, constant

---

[1] Users were asked to become associates and pay a symbolic monthly fee, around the price of two cigarettes packs, which could be reduced to one tenth of it, in case of no ability at all to pay. Besides, the association had also some external associates among middle class intellectuals, who used to pay a more relevant contribution. Finally, a private educational body provided students as probationers to supervise operative groups [I: Marinho, 1989].

and long strikes, and all sorts of service disruptions, as reported in chapters 3 and 4.

d) In 1987, the administration replaced the local psychiatrist by another one who did not fit the previous service model, inducing a strong regression in the hitherto alternative methods. At the local health centre, other staff were employed by political means. In sum, all the dynamics of the professional life tended to be absorbed by the state management and negligence, decreasing the efficiency and the possibility of community control of the services.

e) Given the strong community organization, the district suffered a strong process of political discrimination and blockage of resources and professionals.

From this experience, how did the Psychology Community Association project its future? This is an issue intrinsically associated with the strong feeling for the personal and collective need of such services, as in the then President's own words:

> "This is a peripheral district, a poor one, deprived, and the people here do not have financial resources, very deprived indeed. It has to be a free clinic. Here we have several people (needing these services), inclusive my own daughter. I had got a specialized school for her at the Barro Preto district, in the centre of the city, it was a great difficulty to take and bring her every day. Then, I stopped here, and the 'ship was sinking', and now it is only floating. Then, why (did I assume it)? Because I felt that it would be good for me and for all the community (...) not to leave the ship to sink, because I have already the experience and have seen already the results, as my daughter is attending now the second year of the school. Then, I have to thank psychology. We though, and I want it to work without being linked to anybody: municipality, state, with anything. (...) **We are electing a new board of directors tomorrow, and we'll pass to them this thought, that the association has to pull the ship alone, I mean, not linked to any politician, nor to the municipality nor to the state. The association would then contract the psychologists and all staff by itself. This is our plan**" [I: Oliveira AC, 1989].

Despite not reporting the means for achieving it, this kind of discourse, as one can easily see by the historical and analytic outline above, is clearly based on their previous experience of having services organized autonomously by the community, only to be passed on to the state and then almost 'sunk'[1].

From a critical analytic perspective, can such a discourse be considered relevant in terms of a realistic proposal for community mental health services in the country's present context? In my view, **the answer may be positive. The present crisis of the statutory social and health services opens space for privatization policies which do not have to rely necessarily on private-for-profit alternatives**[2]. The country and the Belo Horizonte area have already witnessed several experiences of social services provided by the voluntary sector and even by community

---

[1] In my view, this position does not seem to constitute any 'a priori' anti-state policy, but a pragmatic one learnt from the long experience of dealing with Brazilian governmental agencies, which main features were described in section 2.3, chapter 2. This position has been reinforced more recently with the deep crisis of all statutory social and health services.

[2] The distinction between public and private in social policies does not have to be dichotomised (which would mean to equalize the concepts of public and statutory), as seen in developed countries where the voluntary sector has a very important share of the non-profit public services. Holland, for example, has good historical examples of successful popular organizations and consumer cooperatives in the health sector, in a model very different from the American professional ones, covering inclusively a wide range of curative and preventative activities (Heydelberg, 1991).

organizations, with sponsorship from statutory bodies[1]. Besides, as seen in this chapter, the community movement in the two cases has reached a stage of organizational development, practical experience and accountability that is sufficient to adequately manage their own cooperatives or community associations in the mental health field. The two districts are only two examples among several others which also would be able to accomplish the task, if constant and adequate financial and political support is guaranteed. If the present statutory bodies have been contracting out mental health services in the private-for-profit sector, as in the case of the LBA programme for the care of children, there is no reason why services could not be contracted out in the community based voluntary sector. Therefore, the sponsorship of community based projects may constitute a very interesting alternative in terms of policy making for statutory agencies working in the mental health field in Brazil.

This acknowledgement should not be confused by any means with a romantic proposal to substitute voluntary sector projects for the statutory provision, that is currently being implemented according to the concept of a public national health system. The voluntary sector, especially the self-organized associative forms, depends mainly on the population's own initiative and is very well

---

[1] Two examples in Belo Horizonte can be remembered here: first, the Minas Gerais state PRODECOM (Community Development Programme) programme developed in the late 70s and early 80s, funding basic infra-structure, social and health services managed by district based popular organizations. Second, the community nurseries have been struggling now for almost ten years to increase their sponsorship from the state, but keeping their complete autonomy from it. Despite the low level of financial support and some attempts by the state to use them politically, these examples point to a very important alternative way of combining statutory sponsorship and popular autonomy, with higher levels of efficiency.

known for its inability to provide an even coverage (Mangen, 1985), particularly in the most deprived and non-literate areas of Third World countries. However, within an integrated, regionalized and 'hierachized' network of health and mental health services, as has been implemented in Brazil since the eighties, the role and coverage of such units could be very well established[1]. They would constitute a real laboratory of alternative practices, with an undoubted influence on the statutory sector, especially on the professional culture of those responsible for the direct provision of services within it. A more systematic outline of the implications of the present discussion for the statutory service network will be undertaken in the following chapter.

5. SUMMARY AND CONCLUSIONS

In my view, the two studied cases, Lindea and Cabana districts, offer significant insights into the formulation of an alternative model of community mental health care more adequate to the specific social and cultural features of the working class clientele. In a broader sense, both cases exemplified some interesting features of the emergent social movements in the country, particularly the ability to:

- accomplish a local process of resistance and defense of

---

[1] Projects like the Lindea and Cabana districts ones can be easily integrated into the present health centre network as primary and/or secondary out-patient units, as actually happened in the two cases. However, the two experiences do not provide any clue on possible alternatives to in-patient or emergency care. This would require much more complex structures, much above the actual present capability of the community movements, including accommodation facilities and round the clock staff availability. Such a statement does not mean, though, that community projects could not achieve this stage in the future.

the popular culture and interests, in a clear counter-hegemony struggle;
- affirm a new concept of citizenship and social rights;
- develop long-standing, innovative, participant and autonomous self-organization practices.

This experience was extended to the health and mental health fields by implementing two creative projects of which the main feature has been the community participation and control of the main decisions and activities.

In the analysis I have indicated some common elements of the two experiences and of the 'nervousness' model which could lead to an implicit formulation of an alternative model for community oriented mental health care, as follows:

a) Mental health issues are viewed as intrinsically integrated into the context of social deprivation and the struggle for a better life, in which the community organization is the main instrument, overcoming the fragmentation of the individual perception and offering more efficacious means for such a struggle. This view seems to be more implicitly interdisciplinary and closer to the European notion of community mental health services as an integration of wider welfare services than the individualized concept hegemonic among professionals in Belo Horizonte.

b) Beyond the first appearance of deprivation in what the Western culture calls as the 'psychological' dimension, the popular representation of the 'psyche' showed specific features and structure. The 'psychological' identity seems to be intrinsically connected to the social identities. This makes the working class particularly sensitive and 'nervous' in instances of, for example, stressful work and financial problems (mainly for men) and breakdown of marriage, family and cultural ties (mainly for women). The individualization induced by such breakdowns is identified as especially dramatic for the underprivileged in a society marked by a hierarchical and personalized system of social domination.

Therefore, in the two studied projects, treatment strategies are directed towards the participation in community groups, as a means to reconstruct personalised ties and networks of social and caring support, reconstruction of identities in more egalitarian and reciprocal terms, and even of singularization processes. However, the latter does not mean individualization as implied in the Western psychologized view.

c) The problems intrinsic to group processes (such as leadership, authority, participation, social imageries) are acknowledged and specialized support is valued.

d) Despite the different view on the 'psychological' sphere, psychotherapy is also accepted, although re-framed in several ways, as following:

- a more flexible and informal notion of therapeutic contract;
- a more daring and flexible attitude towards the use of and research into a wider range of techniques, with emphasis on non-verbal communication forms;
- a priority for group psychotherapy;
- the integration to other community and rehabilitation activities, offering the opportunity for users to be active, productive and useful to the community;
- the integration of psychotherapy to informative and educative practices in some specific issues.

e) The professional practice must be under strict control and co-managed by the community organizations, constituting an important field of hegemony struggle, through:

- special recruitment schemes by the community;
- training schemes, particularly for professionals and staff not recruited by them;
- formation of community councils, meetings and assemblies as the main forum for decision making, including special commissions on ethical issues. This was revealed to be a very conflicting area, given the political problems within

the community movement itself;
- mechanisms of knowledge sharing and democratization, with regard to the relationship between different professionals, and between professionals and auxiliary staff, users and community members;
- easing the boundaries among professional practice, voluntary work and community militancy;
f) The adaptation of what has been called a 'popular pedagogy' approach to the health and mental health issues;
g) The relationship to the state revealed to be probably the main field of counter-hegemony strategies, through:
- a previous assessment of the problems in the community mainly through action-research techniques, not only as a matter of convincing the state and the press of their needs, but also of mobilizing the community around the issue;
- setting out a detailed plan for the community project whereby negotiations with the state agencies could be entered into;
- constituting the community associations as legitimate political representatives and mediators among clientele, professionals and authorities;
- keeping the projects autonomous from the state as long as possible and diversifying the funding sources.

The community oriented projects manifested a great desire to be autonomous from the state's direct management, which was considered to be potentially feasible in the present context of crisis in the statutory welfare provision. **The community projects showed sufficient organizational maturity to deserve state sponsorship, which could constitute an alternative to the present strict policy of contracting out services in the private for profit sector.** Such a suggestion does not imply any systematic substitution of the present policy whose goal is to implement a National Health Service in the country, as the voluntary sector depends on local initiatives and is unable

to offer an even coverage of services. However, they can constitute a real laboratory of alternative practices, influencing the statutory service network and the professional culture. In this direction, the present chapter might already constitute a useful contribution for those concerned about the changes that are necessary in the present statutory services in the mental health field in Brazil. However, a more comprehensive list of suggestions based on the analysis offered so far will be outlined in the next chapter. Finally, at the political level, such community based experiences are important as an attempt to balance the interests within the mental health movement, enhancing the voice of users, their informal carers and of the community in general in a movement hegemonically centred on the professionals and corporatist side.

In sum, the proposal for autonomous community projects with state sponsorship seems to be one of the main direct consequences of the present inquiry and must be taken seriously by the present mental health programme agencies in the country.

Chapter 8 - Conclusions

PART A:

SUMMARY OF THE FINDINGS AND HISTORICAL PERSPECTIVES FOR THE DE-INSTITUTIONALIZATION PROCESS IN BRAZIL

1. INTRODUCTION

After the analysis of the recent specific changes in the mental health field in Belo Horizonte and, in a brief comparative way, in Sao Paulo and Rio de Janeiro, it is now relevant to broaden the focus to the whole country. Therefore, after a brief summary of the main findings in the first section, an examination of the historical and political prospects for mental health policies in Brazil will be outlined. This second section will include a comparison to the Italian case and two additional sub-sections on the specific features of the Brazilian experience.

2. SUMMARY OF THE FINDINGS

As demonstrated in chapter 3 [1], the process of implementation of mental health out-patient services in Belo Horizonte, Sao Paulo and Rio de Janeiro during the period under inquiry has been extremely sensitive to the political and economic context. The major developments were historically associated with the waves of democratization and political mobilization of democratic popular forces. The mental health movement was undoubtedly the main single

---

[1] Chapter 3 addressed the following hypothesis:
"There is a strong historical direct correlation between the rhythm of implementation and qualitative features of the psychiatric reform, and the advances, setbacks and features of the popular democratic struggle".

political actor in pushing ahead the reform, with its mobilization within civil society (mainly between 1978 and 1982) and its deliberate insertion within state administrations (mainly in the period 1982/86).

Given this dependence on the political sphere, the achievements of the reform and the features of the new services have also been marked by the weaknesses and limitations imposed on the mental health movement. This is illustrated in the strong corporatist components, conceptual and practical weakness[1], and a professional culture strongly influenced by private clinic and traditional in-patient practices.

However, the main constraints on the development of the psychiatric reform particularly after 1986 have been the conservative political administrations at central and each state levels, the crisis of the economy in general, and the deep crisis of all statutory services in the country. This is mainly reflected in:

- closure of more creative projects and dismissal of committed administrators and professionals;
- reinforcement of the private hospital sector and a stagnation of the process of reform or even violent attempts to close statutory hospital units;
- in the new out-patient services, bureaucracy, poor infra-structure and medicine provision, part time jobs, few training opportunities, low staffing and wages, and bad working conditions;
- consequent constant strikes, disruptions in services, low commitment to work and reinforcement of corporatist strategies by mental health workers.

When focusing specifically the Belo Horizonte case, the hegemonic service model has been characterized by:

---

[1] Particularly in relation to the substitution and alternatives to hospital care, as indicated in chapter 3.

- setting basic mental health teams - one psychiatrist, one psychologist and one social worker - along the health centre network, with practically no intermediary services;
- an absolute emphasis on individual treatments - pharmacotherapy and psychotherapy - with a great emphasis on the latter, heavily influenced by a professional culture centred on private clinic methods and on a strong diffusion of a psychoanalytic culture.

The findings on the implications of such a hegemonic

service model[1] suggest the following:

a) There is a process of clientele selection and hierarchization among the different types of treatment.

b) Drug therapy is more associated with migrants (with their more traditional cultural background), the poorest, less educated and the most impaired and chronic user groups.

c) Psychotherapy is more associated with an urban background, higher incomes, the more educated user groups,

---

[1] In this respect, the following hypotheses were proposed:

Chapter 4:

"The hegemonic model of mental health services being set up and provided throughout the health centre network in Belo Horizonte has induced a process of selection and hierarchization of the clientele amongst the types of services being implemented, in terms of:
a) geographical origin and cultural background;
b) formal education;
c) income and working status;
d) clinical status and previous treatment history".

Chapter 5:

"The hegemonic model of mental health services within the statutory health centre in Belo Horizonte has:
a) offered a very low level of care to users discharged from hospital and/or presenting more chronic and serious problems;
b) failed to offer adequate support to informal carers".

Chapter 6:

"The hegemonic model of mental health services being offered within the statutory health centre network in Belo Horizonte has:
a) conflicted with the implicit hegemonic popular social representations of the Person and of mental distress;
b) encouraged the less serious and short term psychological problems to emerge as potentially deserving public attention and treatment, as widening the scope of social citizenship rights over hitherto hidden needs;
c) reinforced a process of individualization and psychologization of broader social, cultural and gender conflicts associated with mental distresses, particularly expressed in the attendance of children referred by the educational system and of mature women who experience breakdown in their cultural, family and marriage ties".

and with minor distresses and less chronic mental distresses.

d) Psychoanalytic techniques demonstrate to be even more selective in social, cultural and clinical terms than other psychotherapeutic techniques.

d) The vast majority of the former in-patient population and continuing care clients have not come or continued their treatment in the new services, mainly given the low level of care offered. This clearly undermines the de-institutionalization strategy.

e) The emphasis on psychotherapy and minor distresses tends to generate a new clientele of the mental health services, different from that of the psychiatric hospitals, in a process that is similar to what happened in the US from the sixties onwards.

f) One 'positive' effect of this phenomenon was found: that minor distresses have been acknowledged as deserving of public attention, thus widening the scope of social citizenship over hitherto hidden needs.

g) No service or support is provided to informal carers of the few continuing care clients using the services.

h) The family is the main provider of care for clients with mental illness. Within the family, the heaviest burden of caring is put on women's shoulders.

h) The present service profile conflicts with the hegemonic popular social representations of the Person and of mental distress, described as the 'nervousness' model by the Brazilian literature. The findings suggest that these representations are strong within the population of the three districts under investigation. This conflict seems to constitute one of the main reasons for the present social, cultural and clinical hierarchization of the clientele. According to the country's literature, it also means the induction of individualization and psychologization processes by the services.

i) The hegemonic model tends to accept more a-critically the demand from the educational system that pedagogic problems be translated into mental health problems, as merely individual problems of the children. This seems to be another topic in which services might be performing processes of individualization, privatization and psychologization.

j) When approaching women who experienced breakdown in their family, marriage and cultural ties, the present services have ignored their specific social and gender features, also indicating a process of individualization and psychologization of broader conflicts.

Two experiences of community mental health care in two working class districts in Belo Horizonte were also examined[1]. Current district based social movements and the 'nervousness' model in the two areas have constituted important sources for the development of alternative forms of mental health care, more adapted to the social, cultural, and linguistic features and needs of the local population. The common elements of these alternative strategies were outlined. Moreover, the community projects were able to implement very interesting participant and counter hegemony mechanisms, mainly in relation to the state and the mainstream professional culture, in order to affirm their views on services. Therefore, a recommendation for the state to stimulate and fund such autonomous projects was made.

From the cross-regional comparative perspective, some

---

[1] Although not formulated in a hypothesis form, given the chapter's ethnographic approach, the proposed subject was:

"(to) **explore the possibility of the 'nervousness' model and the popular social movements constituting actual sources of building up alternative experiences of services and models of community mental health care, more appropriate to the working class social, cultural and linguistic features**".

of these trends were also identified in Rio de Janeiro and São Paulo, although services there seem to be more developed and/or to present specific features. In the former, despite a stronger psychoanalytic diffusion, there have been some attempts to adapt psychotherapeutic techniques to the working class clientele. In relation to the continuing care client, the emphasis is on traditional clinical psychiatric practices. Services are relatively more centralized, both geographically (central parts of the city) and in terms of placement in psychiatric hospitals. No systematic service to the family and informal carers is available.

In turn, São Paulo presents a more diversified professional culture and a broader range of intermediary services. A-systematic sources revealed similar processes of hierarchization of the clientele across different programmes, professionals, types of services and distance from the users' homes. However, attempts to provide more specialized care for the continuing care client have been tried, explicitly aimed at supporting a de-institutionalization policy. Some of these programmes and isolated projects are expected to offer an important sedimentation of experiences for a more systematic and even provision of services in the future.

3. THE PROSPECTS FOR THE BRAZILIAN PROCESS OF DE-INSTITUTIONALIZATION

In order to frame this discussion, it may be useful to take up the issue referred to in section 3.1.j, chapter 1: what could be the characteristics of a diffusion of psychiatric de-institutionalization policies in a Third World country like Brazil, where some of the basic historical pre-conditions which allowed the emergence of this kind of policy in developed countries are lacking?

3.1. THE BRAZILIAN AND ITALIAN HEALTH AND PSYCHIATRIC REFORM IN A COMPARATIVE PERSPECTIVE

As Italy and Brazil constitute the only two recent cases of broad political mobilizations for reforming both the health and mental health systems (Berlinguer, 1988; Teixeira e Mendonca, 1989), a comparison between the two countries may be useful. Despite the inherent risks of oversimplification, table 15 offers a summary of the characteristics of the general health system reform in both cases.

Despite some similar historical features, like the late capitalist modernization and building up of the welfare system, and sound inter-regional differences, the Brazilian reform of the health system is specifically marked by:
- stronger constraints at the political level (tradition of centralization, 'patrimonialism', authoritarianism and repression during the military dictatorship), inducing a relatively younger and less experienced health movement, at the practical and conceptual levels, less able to meet the challenges of process of implementing the new system;

Table 15 - Italy and Brazil: Comparative Features of the Health System Reform

ITALY	BRAZIL
a) previous tradition of decentralization	strong tradition of political centralization
b) previous health policy: liberal	strong privatization of state funded health services
c) longer maturation process (since early 60's) within a left wing alliance formed in the anti-fascist struggle, and after a defeat in the war	isolated/individual resistance until quick emergence (context of political repression: 1977) and starting change implementation (1982)
d) political context during implementation: parliamentary democracy, with room for left/popular interventions, mainly after 1976 elections	fragile, long and conservative leaded transition to democratic regime, with strong authoritarian and 'patrimonialist' components
e) despite some crisis of the welfare system and temporary recession, general context of economic growth	context of deep crisis of the economy, of the statutory sector and of the already restricted welfare system
f) main basis of the movement: left wing professionals, supported by unions and left parties	intellectuals, professionals and civil servants, sporadic extension to union and popular movements
g) changes in health serv. provision, but also achieving productive system (occupational health)	scope limited to the provision of health care; state apparatuses as main arena of political struggle
h) corporatist element: stress on worker's health	stress on universal health care; corporatist aspects, as strongly influenced by interests of service producers
i) decentralized administration, concentrated mainly at municipal level	attempt to decentralize, but restrictions and constraints to financial and administrative autonomy
j) GP clinics as private units paid on a capitation basis (English model)	GP clinics as state administered and staffed units (Cuban model)

- a more directly statutory based model, more vulnerable to the present fiscal crisis of the state and of the Fordist statutory mass production of social and health services;
- a health movement with shorter historical experience and less influenced by a broader range of interests of the civil society as in the Italian case. Consequently, this leads to a health system more vulnerable to corporatist appropriation by service producers;
- stronger economic constraints, given the present long-standing crisis of the economy in the Latin American context.

It is interesting to take the comparison further, and consider the intrinsic features of the psychiatric reform

and of the hegemonic service models being developed in both countries. Again, in spite of the risks of over-simplification and surmounting the regional specificities, it is still worth trying to summarize the main differences, as in table 16.

How can this comparison be included within the broader discussion proposed in this section, in terms of the historical pre-conditions which have allowed successful de-institutionalization processes (section 2.1.3, chapter 1)? In my opinion, **the Italian case shows the most contemporary radical psychiatric reform among all other countries, even being a country where these historical pre-conditions have being achieved mainly simultaneously with it. An immediate important factor has been the propitious economic context, but the main key steps were achieved through political means**[1]. This happened particularly after the 1976 elections, when left wing parties reached a larger share in power and were able to propose significant advances in the welfare and general health system. **Moreover, conditions have been gradually achieved specifically for the mentally ill through political struggle by the Psichiatria Democratica professionals and their**

[1] It is important to avoid the use of the notion of historical pre-conditions in a mechanistic way, withdrawing from concrete social actors the ability for identifying their reality and inducing changes through political action.

Table 16 - Italy and Brazil: Comparative Features of the Psychiatric Reform and Service Model

ITALY	BRAZIL
a) process of maturation of the mental health movement since early 60's, under parliamentary democracy	quick emergence (1978) & maturation, under dictatorsh., before changes (1982); conceptual and practical weakness
b) uneven develop. in the country (mainly North/Centre)	ibidem, mainly big cities in South-East and South
c) polit. actors: minority but active professional group; broad support from political parties and trade unions	except. isolated areas, movement restricted to MH workers and struggle limited to state apparatuses; corporatism
d) theoretical sources: existentialism, deviance school, therapeutic community and Marxism	strong psychoanalytic diffusion & anti-psychiatry, Foucault, Psich. Democratica, Freudo-Marxism and Marxism
e) at national level, final stage of the reform induced by changing psychiatric law	until 1990, reform induced at national level by political/administrative changes in service provision
f) strategy: to stop entrance to public hospitals; emergency care in psych. ward in general hospitals; after some time, definitive closure of hospitals	light de-hospit., improv. of in-pat. facilities and control of admission policies; no further beds in specialized hosp., only in psych. ward of general hosp.
g) out-pat serv.: absol. priority for supporting de-institut. policy (ex-in-pat. and contin. care clients)	prior. to ex-in-pat isolated to specif. areas; formation of new clientele with minor distresses (like US)
h) broader concept of MH care: advocacy, assuming social needs, empowering clients, medication, counselling, domicil. care, accommod., social rehabil, productive work; psychotherapy not much valued	restrict concept of care: absolute emphasis on medication & psychotherapy; very few social rehabil. and day care serv.; no accommodation and productive work facilities; no integration to other few support/social agencies
i) break with tradit. psychiatric methods: diagnosis, prescrip. and counselling as complements; interv. on whole person funct.: social networks/living conditions	apart introd. of psychol. approach and less importance given to diagnosis, traditional clinical psychiatric method and individualizing practices maintained
j) strong politicization (also causing decision delay); concern with changes in public opinion and in attit. in the community, desegregation and normalization	politicization more limited to service administration; none or isolated initiatives in changing attitudes and normalization
l) two basic service levels: quick emergency and CMHC, including beds and 24 hours staff availability; high integration between these levels	three levels: hospital, emerg. and specialized units, and MH teams in health centres; emphasis on restrict part-time services; weak integration among these levels
m) CMHC: walk-in centre; informality and flexibility of therap. roles; relat. failure to evaluate carefully such methods and neglect to train formally new staff	appointment basis; formality and reinforcement of professional prerogatives; very isolated evaluation and training initiatives
n) explicit concern on the poorest clientele groups	concern limited to formal accessability to services, not on adapting therapeutic methods; 'filtering' process
o) children: closure of special schools; stress on re-integration and support at ordinary schools	special schools, classrooms and MH services (very few); transf. of educat. problems into MH issues
p) no systematic approach to specific female issues	ibidem
q) formal acknowledgement of need for supporting families of adult clients, but low level actually provided	low acknowledgement and practically no services for families and informal carers

allies. This has been accomplished by stressing the politicization of the field and by giving priority to the de-institutionalization of care, to the most socially devalued and impaired client group, to the role of empowerment and advocacy on their behalf and assuming responsibility for their social needs.

Indeed, the strategy adopted of a legal change at the national level has increased the risks of social negligence and voluntarism, mainly where the historical conditions are less developed (like in the South of the country) and where the movement nuclei are weak or simply non-existent. However, political action can create innovative and creative changes where these given conditions are more developed, as can be seen in the undoubted achievements of the reform in central and northern parts of the country.

3.2. THE PARTICULARITIES OF THE BRAZILIAN CASE AND THE CHANCES FOR A SUCCESSFUL DE-INSTITUTIONALIZATION PROGRAMME

A comparison between the historical context of the Brazilian experience and that of the European, and of the Italian case in particular, can be drawn by re-addressing the discussion provided in section 2.1.3, chapter 1. Some of the political conditions, such as the emergence of a process of democratization, the mobilization of a health and mental health movement and attempts of building up a universal welfare and health systems were also given, at least initially. This was demonstrated in chapter 3, when the main achievements in the reform were historically associated with the political advance of popular democratic forces. However, **the dilemma of the Brazilian case lies mainly in:**

a) Potential political conditions for democratization and re-distributive social policies emerged at the end of the military cycle. However, this coincides with an already open

crisis of the Keynesian and Fordist cycles[1] and the present structural adjustment policies imposed to Third World countries, that have induced a long period of economic stagnation and crisis of the welfare system. Therefore, during the eighties, this has enlarged the already substantial gap between rich and the poor, and worsened the living standards of the majority of the country's population.

b) Specifically in the Brazilian case, the political transition negotiated from above and hegemonically controlled by conservative forces has imposed serious limitations on the process of democratization in the country, particularly from 1987 onwards[2].

Moreover, another feature of the Brazilian society also suggests a low level of development of the historical conditions for a successful de-institutionalization policy. From the demographic point of view, the country's population is still comparatively young and the family structure in most of it is still very strong, not generating a large demand for a wider development of social services for the elderly and other dependent groups.

In addition to these broad economic, political and demographic conditions, the mental health movement itself has demonstrated several limitations in carrying out the reform, as outlined in chapter 3 and summarized above. Only

---

[1] As referred before, these structural crisis are probably more dramatic in Latin American countries, with their political culture of centralization, statism and patrimonialism. Such features are important constraints to a quicker modernization of their economies, as they oppose the new patterns of internationalization, stress on market dynamism and competitiveness hegemonic in the present wave of capitalist growth.

[2] The implications of this to the psychiatric reform were described in chapter 3.

more recent local initiatives such as that of Santos[1], a medium size city in the state of Sao Paulo, have created more opportunities for the mental health movement to experience more radical local projects of de-institutionalization and de-hospitalization.

I am aware that any major statement on the prospects for a psychiatric de-institutionalization policy in Brazil should also be based on a careful assessment of the hospital sector in the whole country, which was not included in the present inquiry. However, a provisional approach from the point of view of its historical pre-conditions and of the availability of adequate out-patient service, as discussed here, is already possible.

Therefore, in my view, **the general socio-economic and political conditions that would enable the implementation of a successful de-institutionalization process on a national scale are not developed.** This means that in Brazil, **the likelihood of a national policy including de-hospitalization procedures inducing social negligence and the re-privatization of care for the mentally ill is very high.** Moreover, the burden would fall particularly on the shoulders of families and women. To corroborate this, one demographic trend should be remembered: that women are increasingly being driven to the formal labour market and less available for home care, as indicated in section 2.2, chapter 2.

For similar reasons, the claim for a 'society without asylums' as a catchword for the Brazilian national mental health movement - as raised by its most active group in 1987 - seems to me politically inopportune in the present

---

[1] The municipal administration, recently taken over by the Worker's Party, assumed the responsibility for the only local psychiatric hospital, opened its doors and is developing an experience inspired by the Italian model, particularly by the Trieste case.

context. That moment represented undoubtedly an important insight by the group in relation to hospital care in the country and the hitherto hegemonic political strategy for changes in the psychiatric field. However, the visible side of the new strategy has coincided with and could be easily appropriated by neo-liberal and pro-privatization policies, in order to withdraw resources and induce social negligence. Probably, a **positive** catchword stressing the need for care in the community, as an alternative to in-patient care, would be more politically advantageous and better able to gather support among professionals, users, their families and the population in general.

Despite all these structural and contextual constraints to a national de-institutionalization policy, the concept of historical pre-conditions should not be understood in a mechanistic way, as indicated above. At least two issues are relevant in this regard. **First, Brazil is such a complex and heterogeneous country that it is also necessary to address the internal regional differences.** I tried to demonstrate with the cross-regional comparison how these historical conditions can vary even among different metropolitan areas in the South-East. For example, in Sao Paulo, the richest region in the country, a light change in the budget priorities allowed the highest standards of out-patient care for the continuing care client among the three areas. Belo Horizonte, on the other hand, the poorest region, provides the worse service profile. In poorer regions of the country, such as the North-East, the historical pre-conditions necessary for a programme of de-institutionalization succeed are probably even less developed.

Second, within the existing resources and the wider political context, there is always scope for political action and change. The historical narrative of the 12 year period under investigation (as outlined in chapter 3) shows a clear correlation between the most significant

achievements of the reform and the political struggle performed by the popular democratic forces and the mental health movement, even under severe financial constraints.

Combining the two topics, then, it is possible to say that there is a relative autonomy at regional and local levels for political action that allows a space for change in the provision of welfare, health and mental health policies[1]. **Therefore, where the political context is favourable and the structural regional or local conditions are sufficiently advanced (or could be made so simultaneously), there must be scope for more radical de-institutionalization pilot projects.** This was the strategy adopted by Psichiatria Democratica before the mid-seventies, which subsequently provided the core experience from which to propose the more wide reaching changes in 1978, when the national conditions were more favourable.

On the other hand, this relative autonomy of the political sphere can also be viewed in the way **a specific regional programme, organized by the local administration and professionals, can reproduce or even accentuate the constraints associated with the underlying historical context.** As seen in chapters 4, 5 and 6, the hegemonic service model for out-patient services mainly in the Belo Horizonte case pointed to a strong influence from private clinical practices and the psychoanalytic culture. The described results suggest how limited existing resources, in terms of personnel, training[2] and professional time, have

---

[1] The current process of municipalization of the health and mental health care in the country, including more financial autonomy, is an important aspect in this regard.

[2] The best example of this is how the majority of training resources available in Belo Horizonte have been appropriated by sophisticated approaches which are mainly used in the professionals own private clinics, as shown in chapter 4.

been diverted from the formal programme priorities. In this instance, the political strategy adopted has reproduced traditional patterns of social programme delivery in Brazil (see section 2.3, chapter 2): they have been appropriated by interests of producers and well-off users.

Therefore, **in the Brazilian context, an urgent requirement for a successful de-institutionalization policy is to re-state the mental health programme's actual political priorities. Diverting the limited resources in the creation of a new clientele shaped by the upper classes' pattern of consumption of mental health services might have few 'positive' side effects in terms of social citizenship, but the priority for the ex-in-patient and the continuing care client needs to be reaffirmed.**

However, this is not simply a matter of administrative decision making: it is important to understand the political and cultural roots of the present situation. This is the subject of the following section.

3.3. HEGEMONIC SERVICE MODELS AND CULTURAL ISSUES: THE PROSPECTS FOR CHANGE

It is necessary to ask about the cultural reasons why, in the Brazilian context, such a change in service profile is not an easy political achievement. In my view, one of the main cultural determinants of the present hegemonic model is probably the widespread and strong diffusion of the psychoanalytic culture in Brazil within the upper classes and the media, on a scale only comparable to countries like

France and the United States[1]. What is the main historical basis for this?

In an already classic work, Martins (1979) suggests that the phenomenon is one of the results of the political authoritarianism in Brazil since the sixties, inducing subjectivism and privatization of social issues within social elites. Without denying such aspects, others[2] have insisted on the need to also consider the specific cultural features of the process, converging towards an analysis similar to Foucault's transition from the deployment of alliance to that of sexuality (section 2.4.3, chapter 1). In other words, up until the sixties, the upper classes in Brazil were structured by a predominantly traditional Catholic culture and family structure. In the following period, there occurred a very rapid cultural change and individualization process which was produced by a strong process of urbanization, modernization and the growth of the economy, following the path of more advanced capitalist societies.

Following this kind of analysis, it is possible to say that the family change and the process of individualization have also had dramatic effects on the upper classes, but these are particularly centred on the symbolic level. The psychoanalytic practice and culture has been appropriated

---

[1] Britain, for example, is a very special case of psychoanalytic diffusion. Despite the importance that British institutions have had internationally, psychoanalysis has not influenced academia nor the mainstream culture and life style. A good example of this is that to be a patient in this country may be stigmatizing or associated with 'self-indulgence' for the majority of social groups. For further reading on that, see Figueira (1984; 1988).

[2] Such as Costa (1984a), Figueira (1985b), Nicolaci-da-Costa (1985) and Ropa & Duarte (1985).

then a cultural mechanism to work out such conflicts[1] and to provide an alternative to the previous 'weltanschauung' in crisis. Moreover, it fits well with the political ideologies hegemonic in the country at this time and among these social elites.

Hence, in my view, it is not accidental that Belo Horizonte has witnessed in the eighties one of the most orthodox Lacanian movements in Brazil. The region is known to have a very strong Catholic background and traditional family structure, a heritage of the mining cycle particularly during the eighteenth century. The area practically constituted the centre of the colony's economic and political life, under the influence of the Portuguese Counter-Reform and baroque culture dominant at that time. After the decline of the mining activity in the nineteenth century, the economy reverted to farming and the cultural exchange practically stagnated until the late nineteen sixties. Then, a wave of industrialization brought about rapid cultural changes and a shake-up in the family structure and the representation of the Person. This also coincided with the introduction of feminism and its implications in terms of gender identity crisis, all within an one-generation time span. The Lacanian approach has been undoubtedly used by the local elite as a mechanism to

---

[1] The phenomenon of changes in the social imagery being also induced by explicit cultural action accessing unconscious structures is frequent in human history, as in all mythologies. More specifically, for some hellenists, the tragedy in Ancient Greece was not only a literary work, but also a social organization and a political experience. 'Oedipus Rex' itself, which constituted one of Freud's main inspirations, is a good example. It was written by Sophocles and lived by the citizens as a public play, and its symbolic structure matched the imagery changes needed during the period of cultural transition from the old monarchic tradition to the new democratic political life. For this, see Chaui, 1984.

elaborate these transitions[1]. As indicated in the previous chapter (section 4.2.2), the demand for psychoanalytic therapy also constitutes a demand for adapting to new cultural patterns, including the social status of a 'liberated' person.

Therefore, the psychoanalytic culture in the present context in Brazil is not simply a diffusion of a technical or theoretical approach among professionals. It is a much deeper cultural process with wide pervasiveness within the social elite and media.

The criticism raised here on its implications for the newly implemented statutory out-patient services does not mean a critique of the approach 'in totum'. Historically, the psychoanalytic theory has undoubtedly constituted an important and irreplaceable contribution to our understanding of human beings. However, it is necessary to acknowledge its limits as a body of knowledge and as a

---

[1] This appropriation is quite understandable given the Lacanian approach's implicit post-modern theory, stressing the need for detaching from all notions of fixed social identity, the endless search for individualization and singularity, and the 'illusion' of the 'real' and of the social world, in favour of the symbolic realm.

therapeutic method[1], in order to appropriate its best contributions[2]. In the Brazilian context, however, the psychoanalytic culture has meant more than this, as transformed itself in a 'weltanschauung', with imaginary functions. It is then associated with corporatist strategies from professional groups, and tends to be reproduced ethnocentrically, following the long established historical trend for cultural colonization of the underprivileged by the elites.

As a consequence, a change in the present hegemonic service model is not easy to accomplish: not only given the already identified poor historical conditions, but also because it requires a strong political will to confront

---

[1] See section 2.3.3.2, chapter 1. However, for the purpose of the present discussion, it is possible to sum up the following main limitations:
- despite its contributions to those fields, the psychoanalytic theory has an epistemologically based inability to deal with its '**exterior**' (political, cultural and social issues), which is however essential for an understanding of its structure and practice;
- therefore, while criticizing the social illusions and religion, it tends to occupy culturally the same space left by them;
- its difficulties in treating psychotic states, despite its important contributions on a theoretical level;
- its difficulties in dealing with clients with social, cultural and linguistic features different from Western elites, as indicated in chapter 6, section 2.1. Therefore, while pursuing singularizing functions, it may perform 'homogenization' ones when confronted with such client groups;
- its historical association with the private liberal medical practices and its strong corporatist implications.

[2] From the point of view of the Institutional Analysis, this dialectic acknowledgement of limits is the analogue of the symbolic castration necessary for a non exclusive imaginary relationship with any authority, institution or theory. The Institutional Analysis itself, one of the theoretical contributions adopted here, is an example of a critical use of psychoanalytic theory integrated into broader progressist social theories.

these deeply rooted aspects of the mainstream professional and social elite's culture. However, the main step forward in this direction still constitutes a task for the mental health movement, and within it, for most of the committed leaders and professionals. Political action then would have two main targets:

a) changes in strategy and political orientation in the statutory mental health programmes, and among professionals and mental health workers in general;

b) broadening the participation in and the support of the mental health movement, attracting and including new political actors, ideological perspectives and interests.

This was one of the main reasons for the investigation provided in chapters 6 an 7. The purpose was to stress the possibility of having alternative service models based on the 'nervousness' representation of mental life and on the community practices developed by recent working class social movements in Brazil. As indicated previously, in the mental health movement and other services heavily influenced by professional interests, the strategies employed by community organizations can provide an important source of alternative theoretical and ideological perspectives that can more adequately address the needs of the wider population. They may also constitute at the local level a concrete counter-hegemonic political force trying to balance interests in the services' day to day life. Moreover, in the present context of crisis of the statutory welfare provision, alternative private-not-for-profit forms of care have better historical chances of success. Indeed, this should be actively pursued by the mental health movement and their allies.

Another important role in this scenario can be played by specific mental health service users' movements, self-help and pressure groups. Within the Brazilian working class population, given the high level of social deprivation and illiteracy, probably the best environment for their

emergence would be the district based community movements, by a process of differentiation of their specific interests. The experiences at the Lindea and Cabana districts are good examples of such a possibility. However, among the upper classes, the few existing groups[1] show a more independent profile, able to take alone advocacy actions in a more autonomous way and in more elevated political spheres. In either context, the role of stimulating the development of users groups should be seriously considered by the mental health movement.

The last component in this political scenario is the public in general and the media. Indeed, gathering support among them depends on the ability to denounce the negative and oppressive features of traditional institutionalized care. Nevertheless, public back up also depends on the positive acknowledgement of the care needed by the mentally ill; of the support required by the family and other informal carers; and on the ability of the mental health movement to show restraint in their corporatist interests.

Moreover, **stressing the importance of political actors like the community based projects, and self-help and pressure groups, should not mean over-estimating unrealistically their role as direct providers of mental health care.** Such a perspective would both ignore the specific and pilot character of this kind of project and also increase the risks of romanticism, voluntarism, re-privatization and social negligence. The process of 'des-territorialization' produced by the capitalist economic flows is inevitable, bringing with it increasing fragmentation of traditional social networks and a

---

[1] SOSINTRA in Rio de Janeiro and an organization of relatives of autistic children in Belo Horizonte are examples.

differentiation of interests[1]. Even for the Brazilian working class, for whom the kinship and locally based ties still constitute the main source of social support and insurance, resistance will not be able to break this inevitable historical tide.

Therefore, **it is imperative that a permanent, even and universal basic coverage be provided by the state[2], as expressed in the struggle for a unified and decentralized health system and in an integrated network of out-patient mental health services.** This is going to constitute a medium to long term process in Latin America, given the present unfavourable historical context. However, the establishment of universal health care and social insurance schemes of reasonable quality is an essential condition not only for a successful de-institutionalization programme, but also for 'des-dramatizing' this advancing individualization process in its material components, for the majority of the Brazilian population.

In such a context in the future, the development of a systematic provision of mental health services will raise

---

[1] It is important to recognise that, despite this fragmentation of interests, new differentiated and dynamic forms of solidarity are generated, as seen in contemporary advanced capitalist societies in the environmental, feminist, gay & lesbian, and other movements. They constitute the concrete basis for creative collective practices, in the local and sometimes even at the international level, as in the ecological struggle.

[2] I am not considering here the radical neo-liberal alternatives, which could be disastrous for the poor population of Third World countries like Brazil, with its already strong tradition of privatization of public policies. In the same way, my position does not mean supporting a proposal for the comprehensive and direct statutory provision of services at all levels, particularly given the country's strong tradition of statism, bureaucracy, waste of resources, patrimonialism and clientelism. However, there is no scope here to develop further such a complex discussion.

new challenges regarding how the population handles insanity and its political links with the mental health movement. Nowadays, most families tend to keep their mentally ill members at home as long as possible, as the only alternative available is the temporary hospitalization. However, **normalization is not a natural and spontaneous approach and process.** The future wider individualization and the availability of new facilities may reinforce the exclusion of the ill member from the family environment, unless proper measures are developed. To create imaginative structures of formal and informal support to families[1] is probably the main answer. These can provide then the material basis for a deliberate campaign for normalization principles among families and professionals, convincing them not to take away the mentally ill and to provide him/her with an as ordinary as possible environment.

Before this, however, it is important to consider the political means and goals for re-orientating the present network of services in the line with the priorities discussed above and with the cultural and social features of the most needy clientele. This is the subject of the next section, which will consider some suggestions for political action by the mental health movement and general policy making.

---

[1] In terms of domiciliary care, day centre activities, sheltered productive work, therapeutic companions, etc. See suggestions below.

PART B:

SUGGESTIONS FOR POLITICAL ACTION AND POLICY MAKING

1. INTRODUCTION

This last part of the thesis will outline suggestions for action by mental health movement nuclei, policy makers, mental health workers, user and community movements, which I hope can constitute a coherent policy according to the political strategy discussed above. Some of the suggestions can be adopted immediately, others may be seen as unrealistic at the present time and will depend on developments in the medium to long term and on a more favourable historical context. Even so, they do suggest how complex and long is the path of the struggle for community mental health care in the country.

2. GENERAL STRATEGY AND RELATIONSHIP WITH THE IN-PATIENT SECTOR

a) To avoid any global, full-scale or top-to-bottom de-hospitalization process on a national scale, and to develop further the general strategy set in 1985 by the mental health movement[1]. However, there is some scope for launching more radical local and regional experimental initiatives where the conditions for providing support in the community are developed or could be achieved simultaneously.

As discussed above, the present general historical conditions concerning caring for the mentally ill in the community are not yet developed in the country, and the present context of crisis of the welfare provision will not allow short term systematic improvements. Yet, the mental

---

[1] See appendix 3.

health movement is still reduced to small nuclei in the biggest cities, and a process of sedimentation and maturation of experiences at both the theoretical and practical levels is urgently needed. In such a situation, any global process could result in voluntarism and social negligence.

Therefore, in my opinion, the basics of the national strategy launched by the movement in 1985 is still valid, in terms of:

- not contracting or establishing more beds in specialized hospitals;
- situating any new beds only in psychiatric wards of general hospitals;
- a strict policy for controlling admissions.

However, the strategy should be developed further on. The proposal for a 'gradual reduction of statutory or contracted beds according to careful assessment of the local needs' is too vague and should specify some differentiations

and guidelines[1].

However, more radical projects on a local or regional scale could be launched where the conditions for supporting clients in the community could be achieved. In this regard, the present experience in Santos is very instructive. Any of these projects should emphasize the political responsibility of the local authorities, mental health workers and the community in offering alternative out-patient care for the clients.

For this purpose, it is essential to achieve key posts in the direction of local hospitals, in mental health

---

[1] For example:
a) specific strategies and priorities should be drawn according to: acute/chronic units; statutory/contracted units; big cities/countryside and interior of the states; and according to the different regions of the country. For example, it is important to centre the struggle for the reduction of beds first in the private sector. In the statutory sector, the emphasis should be on out-patient and rehabilitation care. Geographic decentralization of the beds is also a very important issue, and may be an important element in negotiations with the private sector.
b) The reduction in the number of beds should be negotiated carefully, in order to replace such resources for beds in psychiatric wards in general hospitals or out-patient service units, be it private, statutory or INAMPS owned.
c) How to consider the need for investment in infra-structure during this period? Again, the strategy has to be differentiated according to the above indicated features. However, the experience of Barbacena during the eighties (see chapter 3) should inspire us one lesson: why not to consider more radical proposals, such as selling big properties, such as those more stigmatized or isolated from cities, and to replace them for small decentralized urban units? It is certainly a cheaper alternative than investing in redeveloping or building new asylum structures. The smaller units could more easily:
- be converted to in future and/or also offer out-patient services;
- provide a more 'normalized' environment and better prospects for social rehabilitation and re-integration to the society;
- offer more social visibility;
- contemplate different levels of dependency and autonomy.

programme coordinations at local or regional levels, and to propose legal changes in individual municipalities or states. These can be pursued through broad alliances with social movements and popular democratic parties. Again, in this regard, the history of the Psichiatria Democratica can be an interesting source of inspiration.

b) To change the present political emphasis of the campaign by the most active group of the mental health movement.

As discussed in chapter 3 and above, the slogan 'for a society without asylums' is quite inopportune for the present context. A more careful political strategy and pedagogy should be adopted[1], in line with the tactical aims of the moment and to the purpose of gathering a broader support among the ensemble of professionals, social movements, users, their families and the community in general.

c) To reinforce the public campaign by the mental health movement, besieging the existing private and statutory hospitals, in order to restrict their more prominent controlling, segregative and alienating practices, and enhance their caring components.

If it is inevitable to live with the psychiatric hospital in Brazil for some time, it is important to extend the struggle to its internal practices and external links. The present context of discussion and the probable launching of a charter for the rights of the mentally ill by the United Nations may induce a favourable atmosphere for raising such issues. In a previous work (Vasconcelos, 1991),

---

[1] In my view, it should be essentially positive, emphasizing social responsibility for caring for the mentally ill; that the best care is provided in the community, and the need to implement services able to assume in full such a responsibility.

I discussed at greater length some of these issues, including the legal procedures and specific campaigns the mental health movement could propose at municipal, each state or national level[1]. The project of national law launched in 1989 by Mr. Delgado, a MP from the Workers' Party, is a good example of such initiatives[2].

d) In relation to out-patient services, absolute priority should be given to supporting the de-institutionalization policy, with full stress on ex-in-patients and the continuing care clients and a service model in line with these purposes.

As discussed earlier, this is one of the most challenging political tasks to be accomplished, involving several battle-fields and stages. The specific suggestions for this will be outlined in the next section.

---

[1] The list of suggestions could include the following:
- the general quality of accommodation, therapeutic and rehabilitation services;
- admission control policies and increasing emphasis on attached out-patient care;
- restricting or making involuntary admissions more difficult, guaranteeing users' rights and requiring special legal and administrative procedures;
- stimulating and guaranteeing the status of voluntary admission and its attached rights;
- restricting the use or guaranteeing users' rights in the case of polemic treatments, including expressed consent or right to independent professional assessment;
- guaranteeing the main basic civil, political and social rights in all in-patient facilities;
- full regionalization and integration with the out-patient services, including an efficient communication and referral system. A special programme should be implemented, taking all users in discharging process on formal visits to the out-patient service unit closer to their homes.

[2] It proposes the prohibition of the establishment of new psychiatric beds in specialized units and some restrictions to involuntary admissions.

3. SPECIFIC SUGGESTIONS FOR THE OUT-PATIENT SERVICE NETWORK

3.1. INFRA-STRUCTURE AND ORGANIZATIONAL MEASURES

a) To give absolute priority to more complex secondary services (community mental health centres, day centres, day hospitals, emergency and crisis intervention units), instead of expanding the service network by just adding more basic mental health teams working in health centres.

As seen in chapter 6 and above, the Brazilian model distinguishes between primary and secondary services, with the majority of the teams working in the former. In Belo Horizonte, the vast majority of the teams are settled in primary units, and those supposed to function as secondary ones tend to work following the same model, as seen in the Sao Paulo district. This tends to produce a demand for mental health services through the sophistication of the demand for health care and to produce a new clientele different from that of the hospitals. This discussion is already present in São Paulo, where it is clearly realized that the priority clientele do not come to the primary care units. Therefore, the alternative should be the establishment of services open more hours per day, with bigger teams, better infra-structure and a different service model.

When confronted with such a proposal, administrators will present some resistance, probably pointing to:

- the structural lack of resources;
- it means less political 'dividends', because less services will be open;
- it is more difficult to keep a large number of professionals in peripheral and rural areas, given the concentration of social and cultural resources in the big cities, the lack of good quality public transport and more time spent in travelling.

The last argument deserves some attention, and it is possible to propose some alternatives, such as:

- setting up compulsory probation schemes for undergraduates in the final stages of their training in these areas;
- adopting stricter rules attaching job posts to specific areas;
- controlling the turn over and applications for job reallocations; - offering a system of incentives for those working in peripheral and remote areas.

As in the Italian model, the idea of providing a short number of beds and twenty-four hour staff availability in community mental health centres may be interesting, and has been tested in the present experience in Santos.

b) To re-state and reinforce formally the priority target groups in terms of eligibility for service: the continuing care client and those discharged from psychiatric hospitals.

After the political formalization of the priority, attention should be paid to its operationalization measures, such as:

- full priority in the professionals' agenda for the referral from the hospitals;
- a minimal number of new first consultations per week per professional;
- attempt to insure the target clientele access to collective and informal walk-in activities;
- strategies for tracing local ex-in-patients who have not contacted the local unit.

c) To offer full time jobs, compatible wages and flexible work time for professionals and staff.

It is important to create a professional culture specific to the needs of the statutory mental health services and to the features of their clientele. The low wages and over employment phenomenon induces lack of

commitment and allows the corporative strategy of using the public services as a temporary step until establishing a better position in the private clinic market, which is then considered the ultimate model for training. On the other hand, despite the structural constraints, a struggle for reasonable wages is essential. Such an achievement would lower the level of disruption, such as strikes and absenteeism, and increase the commitment to the work and to the collective activities.

Finally, a flexible work time allows the absorption of creative professionals and enables their attendance at community meetings.

d) To provide regular and sufficient medical provision.

As seen in chapter 4, the availability of psycho-active drugs in the decentralized units is essential to keep continuing care clients attached to the services. As a consequence, it avoids their referral to more centralized and better equipped units such as the hospitals' out-patient clinics. This not only adds to the personal costs of transport and time wasting, for both users and companions, but also implies a low level and a non-comprehensive type of care, generally reduced to medication control.

e) To change the guidelines for the catchment population per service unit.

As shown in chapter 5, the present guidelines over-estimate the real capability of the local professional teams, as it does not consider their real work time and conditions, the epidemiological profile of the population and its differentiation according to social class, culture, gender and migration features. Politically, the effects are to offer a wrong criteria to policy makers and to society for the estimation of the needed service provision, and an overload of work on the mental health workers' shoulders.

Therefore, new realistic and differentiated criteria should be estimated and issued.

f) To keep whenever possible a range of social and rehabilitation resources under the responsibility of the regionalized administration of the mental health programme. Where such allocation is impossible, to implement a real integration with the responsible agencies.

The lack of integration between mental health and social & rehabilitation services produces the known phenomenon of the revolving door, with any one service actually assuming the responsibility for the clients, who tend then to lose their connections with care providers. The Italian experience shows that a unified administration is a very important factor in planning and implementing a successful de-institutionalization programme, allowing services to assume full responsibility for the client.

g) To set up a well equipped monitoring system, with priority to evaluate the implementation of the de-institutionalization support policy within the out-patient service network.

h) To start a specific programme to stimulate and fund autonomous community based projects, emphasizing creative forms of mental health care more adequate to the cultural and social features of the working class population and the participant control of the services, as discussed in chapter 7.

3.2. MEASURES FOR IMPLEMENTING A SERVICE MODEL COMPATIBLE WITH THE PRIORITY FOR THE DE-INSTITUTIONALIZATION POLICY AND TO THE FEATURES OF THE CLIENTELE

a) To stimulate professional practice to become more

informal and flexible, the use of an interdisciplinary approach and of mechanisms for democratizating knowledge and decision-making, mainly at each service unit.

The maintenance of formal prerogatives and the present appointment scheme is a deeply rooted aspect of the professional culture in Brazil. It is also an obstacle for an interdisciplinary and broader approach to mental health care and to practices more suited to the continuing care client. Some basic measures could be proposed here, such as:

- the adoption of more collective forms of first consultation, as previously experienced in Belo Horizonte and Rio de Janeiro.
- the implementation of walk-in schemes for priority clients, including traditional day-centre activities, like rehabilitation and leisure. The Italian model and even successful Brazilian experiences like the 'Guimaraes Rosa Project' at the Raul Soares Hospital in Belo Horizonte (see section 2.2.1.1.c, chapter 3) and the CAPS (Centro de Atencao Psico-Social) in Sao Paulo may constitute good sources of inspiration.
- the adoption of therapeutic community procedures and operative groups techniques for decision making, sharing responsibilities and accomplishment of specific day-to-day duties, with the inclusion of professionals, staff, users and informal carers.
- shift schemes for all professionals and staff to participate in such collective activities.
- the stimulation of practices of collective supervision of all types, of informal training schemes involving all professionals, and of the involvement of consultants from multiple fields.

b) To adapt and implement therapeutic methods appropriate to the priority clientele and the cultural, social and linguistic features of the working class population.

This suggestion means a great effort in mobilizing existing, and creating new resources for research, evaluation, training and supervision of professional practice. This is an essential pre-requisite for political and practical changes in the service network, in order to overcome the mainstream trend to reproduce the models inspired by private clinical and traditional hospital practices. Two main criteria should be remembered here for the selection of practices: those more adequate to the continuing care clients, and to the nervousness model of representing mental life. Some of the indications made in chapter 7 may be interesting here: more flexible therapeutic contracts, priority to group and less discursive techniques, and the necessary integration into rehabilitation, community and popular education schemes.

c) To give a strong emphasis to rehabilitation practices, including a revision of the mainstream view, which has mainly centred on formal professional supervision, and on artificial, culturally alienating activities not socially useful or productive.

The Italian and the normalization approaches emphasize the need to create activities as close to normal life and to the client's own culture as possible, with an emphasis on those which could generate earnings and acknowledgement as useful from the local community. Users should be stimulated gradually to assume basic life functions, as well as financial, civic and political responsibilities and duties, in order to promote self-esteem, personal autonomy and de-stigmatized social identities. Proposals like cooperatives, arts workshops, sheltered work schemes in the normal labour market, special grant schemes within the health and mental health service network itself and community activities could be adopted. Again, Latin America has already provided some inspiring relatively informal experiences, such as that

described by Moffatt (1980) and the 'Guimarães Rosa Project'.

d) To stimulate professionals, particularly social workers, to perform an active role in advocacy and in setting up strategies to find creative and alternative forms of social rehabilitation and financial support and benefits, in a joint effort with the client and the community.

As indicated above, the historical conditions for the provision of the social support needed in mental health care have to be achieved as yet. As a great part of services of infra-structure, social, educational and health care in peripheral urban areas in Brazil has been achieved via community mobilization and struggle, the same must happen to mental health services and social benefits to their clients.

e) To implement pilot projects of sheltered, supervised and independent accommodation.

Given the structural shortage of resources to be invested in welfare, this may be one of the most difficult items to achieve in Third World countries. However, where possible, attempts to implement creative pilot experiences which could inspire more systematic provision in the future should be tried, in order to shelter those without family support or when the contact with the latter has clearly deteriorated. It is necessary to contemplate differentiated dependence levels, expressed in a range of options, such as:

- statutory sheltered units with full time availability of specialized support;
- statutory units with part-time supervision;
- special supervised and financially supported foster families;
- voluntary sector organizations' units;
- self-financed group accommodation;
- community projects.

f) Set pilot projects of formal and informal 'therapeutic companions'.

Some continuing care clients certainly need support in performing normal daily routines, work, or in gaining access to social and leisure activities. Auxiliary staff, probationers, students and volunteers from the community could be trained quickly to constitute 'therapeutic companions' for specific clients, during key periods of the rehabilitation process. Users with public, charity or private financial support could also pay small amounts for such a scheme.

g) To stimulate the emergence of service users groups and the development of local active popular education initiatives or programmes within the community. These would focus on the population's own strategies of care, the alternatives for hospitalization, advocacy and the rights of the mentally ill, de-stigmatization and normalization principles, participation in the local service and new informal and voluntary forms of care and support.

h) To stimulate and create mechanisms which would make mental health services more permeable to the influence, participation and evaluation of their local communities, users pressure groups and the civil society in general.

As discussed in chapter 7, the participation of the local communities in the planning, settlement, and day to day evaluation of the services have a strong potential for making them closer to the features and interests of the local population. In the same way, this participation can also be accomplished at higher levels, by reinforcing the already planned municipal, regional and state inter-organizational consultative councils for health and mental health policies.

i) In relation to child care, to lobby the education system to set up psycho-pedagogic support services in public and private schools. Until then, it is important to establish guidelines for mental health professionals to offer child care inside the schools and nurseries, in a process of becoming more sensitive to the broader aspects of the demand for care and to consultancy work.

3.3. SPECIAL PROGRAMMES

a) **Focus on women:** as indicated in the present inquiry[1], women who experienced breakdown in their family, marriage and cultural ties tend to present a general higher prevalence of mental illness, with specific features given the social and gender aspects attached to the phenomenon. A special programme should be drawn, including therapy and support groups, initiatives for reinforcing social networks, sociability and exchange of intimacy, contacts with feminist and community groups, etc.

b) **Focus on the family and other informal carers:** as discussed in chapter 5, family members are the main source of informal care and support for the mentally ill, and supporting them directly is an essential condition to lower intra-familial tension, improve the quality of care and decrease the likelihood of new admissions. This can be accomplished by:
- establishing special local activities and support groups for relatives and informal carers;
- providing domiciliary visits, care and support by appropriate staff;
- using neighbours and informal carers as paid support

---

[1] For epidemiological data, see section 3.5, chapter 2; for the findings at the SPd and Ld, section 4.2, chapter 6.

workers, with training and supervision opportunities;
- offering special opportunities for the family to share the burden of caring through direct work with their mentally ill member, such as day centre and leisure activities, outings, and 'therapeutic companions'.

c) **Stimulating the development of self-help, users and advocacy groups:** experiences such as the Alcoholics Anonymous, Neurotics Anonymous, Samaritans and the several types of self-help and user militant groups, as seen in England, are good examples of how users and their sympathizers can be a good source of support themselves. They can also stimulate improvements in the quality, appropriateness of services and advocacy work in the wider society.

3.2.4. Suggestions for Further Research

During the present study, a significant number of issues showed a special low level of attention and investigation in the Brazilian context, despite their importance in the mental health field. The list provided below is an attempt to suggest some of the main topics which would deserve further investment in terms of theoretical and practical research:

a) Short, medium and long term alternative strategies for substituting in-patient care and hospital closure in the Brazilian context;

b) Epidemiological features of the Brazilian population and their association with socio-economic, migration, gender and cultural issues;

c) Women who have experienced breakdown in their family, marriage and cultural ties and mental illness in Brazil;

d) Alternative therapeutic methods more appropriate to continuing care clients and to the cultural and linguistic

features of the working class population;

e) Family and informal support for continuing care clients in the Brazilian context;

f) Child care, schooling problems and alternative forms of mental health care;

g) The implications of the nervousness model for therapeutic methods;

h) Community based projects in the mental health field: evaluation of experiences, organizational alternatives, popular pedagogic methods, therapeutic approaches and prospects for the future;

i) Present crisis of Fordist[1] statutory mass production of social and health services, cross-national recent alternatives for reform and specificities for the Brazilian context.

---

[1] See section 2.1.3, chapter 1.

Appendix 1

LIST OF INFORMANTS

Akerman, Jaques: Psychologist, one of the members of the Mental Health Programme Coordination in the state of Minas Gerais (CPSM-SES-MG), and member of the mental health movement from mid-eighties onwards.

Almeida, Vicente Fernandes: community activist, coordinator of the Community Association of the Alto da Vista Alegre in 1989, the main community organization at the Cabana district, Belo Horizonte.

Amarante, Paulo: Main coordinator of the Mental Health Programme in state of Rio de Janeiro (CCSM-RIO) in 1989, and also activist of the mental health movement there.

Araujo, Maria Martha ('Dudu'): community activist, president of the Community Association of the Sao Paulo district, president of the Community Council of the North East Region, and first treasurer of the Federation of Associations of Districts, Villages and Slums in 1989, Belo Horizonte.

Barreto, Francisco Paes: Psychiatrist, psychoanalyst, one of the main leaders of the mental health movement in Belo Horizonte since the sixties, and one of the members of the Mental Health Programme Coordination in the Belo Horizonte Metropolitan Area (DMS SES MG) in 1989.

Bezerra Junior, Benilton: Psychiatrist, lecturer at the Institute of Social Medicine in Rio de Janeiro, and one of the consultants to the project of research and adaptation of psychotherapeutic methods to working class clientele at the Pedro II Hospital during the mid eighties, also in Rio.

Campos, Cesar Rodrigues: Psychiatrist, one of the main leaders of the mental health movement in Belo Horizonte since the late sixties. Main public leader of the movement after 1982, as director in charge of the Galba Veloso Hospital and director/president of the FHEMIG (Hospital Foundation of the State of Minas Gerais) in 1986 and 1987.

Cansado, Suzana: Psychologist, specialist on child psychotherapy, working at the Sao Paulo district health centre, Belo Horizonte, in 1989.

Carneiro, Bianca: Psychologist, coordinator of the Mental Health Programme in the Belo Horizonte municipal area (CSM-PMBH) in 1989, and active member of the mental health movement during the eighties.

Cilene: Social worker, working at the Sao Paulo district health centre, Belo Horizonte, in 1989.

Delgado, Pedro Gabriel Godinho: Psychiatrist at the Juliano Moreira Colony in Rio de Janeiro, one of the main active members of the mental health movement in the state and in the national level, having also an important role in the idealization of the CONASP plan for the implementation of out-patient mental health services with funds from the INAMPS.

Ferreira, Virgínia: Social worker, working at the Lindea district mental health service, Belo Horizonte, in 1989.

Fortes, Sandra Lucia Correa Lima: Psychiatrist, working at the Psychiatric University Hospital of the Institute of Psychiatry of the UFRJ, and member of the Mental Health Programme Coordination of the state of Rio de Janeiro (CCSM-RIO), in 1989.

Gallo, Maria Áurea: Psychiatrist, coordinator of the Mental Health Programme in the SUDS II Area, Sao Paulo city, in 1989.

Jose Roberto Ayres: Psychiatrist, main coordinator of the Mental Health Programme in the Belo Horizonte metropolitan area (DMS-SES-MG) in 1989.

Lauar, Helio: Psychiatrist, psychoanalyst, member of the Mental Health Programme Coordination in the Belo Horizonte metropolitan area (DMS-SES-MG) in 1989, and a previous participant in the mental health team working at the Lindea district.

Luci: community activist and secretary of the CISC (Integrated Centre of Community Health), Cabana district, Belo Horizonte, in 1989.

Mancio, Heloisa: Social worker, lecturer at the Department of Social Work in the Catholic University of Minas Gerais, and member of the Mental Health Programme Coordination in the Belo Horizonte metropolitan area (DMS-SES-MG) in 1989.

Marinho, Francisco: Psychologist, one of the starters of the community mental health project at the Lindea district, Belo Horizonte, in 1977, and the first professional employed by the state to work there, as a result of a massive campaign by the local community movement. He left the district in 1988.

Melo, Nilo Eustáquio Batista: Laboratory technician, general coordinator of the Sao Paulo district health centre, Belo Horizonte, in 1989.

Melo MO (Murilo): Psychologist, member of the coordination of the LBA's (Legiao Brasileira de Assistencia, an agency of the Social Insurance Ministry) programme in the state of Minas Gerais for funding private clinics in the provision of specialized mental health child care, in 1989.

Olga: Psychologist, one of the first mental health professionals to start working at the Sao Paulo district health centre, Belo Horizonte, in the mid eighties. She was still working there in 1989.

Oliveira AC (Antonio Celestino): Community activist, president of the Psychology Community Association of the Lindea district, Belo Horizonte, in 1989.

Oliveira JM (Jose Marinho): Community activist, president of the Community Association of the Lindea District, Belo Horizonte, in 1989.

Passos, Abílio Jose Oliveira de: Psychiatrist, main coordinator of the Mental Health Programme Coordination of the state of Minas Gerais (CPSM-SES-MG), member of the mental health team working at the Sao Paulo district health centre until November 1989, Belo Horizonte, and activist of the regional mental health movement.

Pereira, Willian Cesar Castilho: Psychologist, author of several books on Community Psychology; community activist, particularly at the Cabana district, Belo Horizonte. Main starter of the local mental health project which developed later on in the creation of the CISC (Integrated Centre of Community Health), in the same area.

Scaramussa, Tarcísio: Catholic priest at the Cabana district, Belo Horizonte, and active participant in the local community organizations.

Silva, Marcus Vinicius: Psychologist, member of the National Council of Psychologists in the mid eighties, important activist of the mental health movement in Belo Horizonte and in the national level.

Silveira, Ines: Psychologist, working in the Lindea district mental health service, Belo Horizonte, in 1989.

Siqueira, Fábio Antunes: Psychologist, specialist in child psychotherapy, working at the Sao Paulo district health centre, Belo Horizonte, in 1989.

Souza, MDC (Maria Dolores Coelho): Psychologist, member of the Mental Health Programme Coordination in the Belo Horizonte metropolitan area (DMS-SES-MG) since the implementation of the PISAM plan, in 1978.

Souza, EN (Emmanuel Nunes de): Psychiatrist, coordinator of the Mental Health Programme in the Sao Miguel region, Sao Paulo city, director of a specialized mental health service at the same area, and one of the main coordinators of the 'Encontros dos Ambulatorios' (Meetings gathering professionals of specialized mental health services) in the city in the late eighties.

Viana, Francisco: Psychologist, specialist in child mental health care, psychologist and consultant at the Child Neuro-Psychiatry Hospital in Belo Horizonte in 1989, activist of the mental health movement in Belo Horizonte.

Appendix 2

QUESTIONNAIRE

Interviewer: Version: user 1
Date: companion 2
Service Unit:
Responsible Professional: number:

(Explanation of the Purposes of the Research and Rapport) (READ)

When answering the following questions you will be supporting a research being done by some professionals from the Catholic University of Minas Gerais, with the purpose of evaluating the services provided by the government for those with 'nerve' problems. We are concerned with what has happened to those people and their families, like you, your needs, and your opinion on services like those provided in this health centre. We believe that the result of this research can induce improvements in those services throughout the country.

Your name will not appear in this paper where your answers will be recorded, and even the professionals who work here will not know what you will say here. Therefore, you can be sure that all data, opinions and personal comments you make will not be known by anyone else.

For this reason, we would like you to trust us and be as sincere as possible. This is the best thing you can do to help us in the improvement of the services for all who are cared for in health centres like this one.

Notes:
a) The user version will be provided here, added to the additional questions for the companions one. In the original latter version, the reference to the user is changed from the second to the third person and, in some questions, interviewers were also instructed to use the client's Christian name.
b) All instructions to the interviewer are provided in capital letters.

		/OPTIONS/	/JUMP TO/
1. Sex (MARK WITHOUT ASKING)	male	1	
	female	2	
2.a) Where have you been born? (IN CASE OF NOT BEING BORN IN BELO HORIZONTE, ASK: Have you been born in a city or in the countryside?)	Belo Horizonte	1	2c
	other urban area	2	2c
	countryside	3	2b
2.b) How old were you when you or your family came to live in the city?	up to 10 y. old	1	
	bet. 10 and 20	2	
	more than 20	3	
2.c) Where do you live at the moment?	Belo Horizonte	1	2d
	other urban area	2	3
	rural area	3	3
2.d) What district do you live in?	surroundings	1	
	another B.Horiz. area	2	

3. How old are you now?	0 - 7	1	6a
	7 - 12	2	
	12 - 18	3	
	18 - 25	4	
	25 - 40	5	
	40 - 60	6	
	over 60	7	
4. Have you studied?	no formal education	1	
Until which school year?	incomplete primary school	2	
	complete primary school	3	
	incomplete 'gymnasium' sch.	4	
	complete secondary school	5	
	any univers. level	6	

(IN CASE OF CHILD AGED 12 OR LESS, JUMP TO 6a)

5.a) Do you have any source of income at the moment?	Yes	1	5b
	No	2	5c
	unemployed for less than 1 year	3	5d
5.b) How do you get this income?	retirement	1	5d
	pension	2	5g
	work	3	5e
	temporary sickness benefit	4	5d
	other (WRITE)	5	CHECK
5.c) Have you worked in the past?	Yes	1	5d
	No	2	5g

5.d) What have you done? (WRITE)

5.e) What do you do at the moment? (WRITE)

5.f) How many hours you work per day?	Up to 5 hours	1	
	5 to 8	2	
	8	3	
	8 to 12	4	
	over 12	5	
5.g) Do you do household duties at home?	Yes	1	
	No	2	6a
5.h) How much time do you spend a day doing this housework?	Up to 3 hours	1	
	3 to 6	2	
	6 to 10	3	
	over 10	4	
	don't know	5	
6.a) Which is your marital status?	single	1	
	married(\$)	2	

[(*) Or any informal partnership alike]	widow(er)	3	
	separated	4	
	other (WRITE)	5	
6.b) Whom do you live with?	alone	1	8b
	parents/brothers/sisters	2	7a
	partner with/without children	3	6c
	children	4	6c
	other relatives	5	6c
	friends	6	7a
	other (WRITE)	7	7a
6.c) How many children do you have?	up to 2	1	
	3 or 4	2	
	more than 4	3	

(7a to 7e: ONLY IN CASE OF THOSE LIVING WITH THEIR PARENTS)

7.a) Which is the job/profession of your father? (WRITE)

7.b) Does he live with the family?	Yes	1	
	No	2	
7.c) Has your mother worked now or in the past?	Yes	1	7d
	No	2	7e

7.d) Which kind of work has she done? (WRITE)

7.e) How many children are you?	1	1	
	2 or 3	2	
	4 or 5	3	
	more than 5	4	
8.a) How many people help to pay the expenses at home?	1	1	
	2	2	
(IN CASE OF UNEMPLOYED FOR LESS THAN A YEAR, CONSIDER AS ONE BREADWINNER)	3	3	
	4	4	
	more than 4	5	
8.b) How much is your family's (or your) income?	up to 1 minimum salary	1	
	up to 2 minimum salaries	2	
(TRY TO ESTIMATE WITH THE USER; IN LAST CASE, MARK ALTERNATIVE 7)	up to 3 minimum salaries	3	
	bet 3 and 6 min salaries	4	
	bet 6 and 10 min salaries	5	
	over 10 minimum salaries	6	
	don't know	7	
8.c) The house where you live is ...	rented	1	
	yours	2	
	owned by friends/relatives who allow you in ('morar de favor')	3	
8.d) How many rooms does it have?	up to 2	1	
	up to 4	2	
	up to 5	3	

		up to 7	4	
		more than 7	5	
8.e) Does your house have:	plumbed water?	yes	1	
		no	2	
	drainage?	yes	1	
		no	2	
	electricity?	yes	1	
		no	2	
	telephone?	yes	1	
		no	2	
9.a) Which is your religion?		Catholic	1	
		Protestant	2	
(IN CASE OF CHILDREN, ASK: Your family religion is...)		Evangelic ('Crente')	3	
		Afro-Brazilian ('Candomble', etc)	4	
		without religion	5	10a
		other (WRITE)		
9.b) Do you practice the religion frequently?		Yes	1	
		No	2	

Now we want to know about your 'nerve' problems and how you have treated them

(IN CASE OF FIRST TREATMENT, JUMP TO 13a)			
10.a) When have you searched for 'nerve' treatment for the first time?	up to 1 year	1	
	up to 3 years	2	
	up to 6 years	3	
	more than 6 years	4	
	don't remember/know	5	

10.b) What made you search for treatment? (WRITE)

10.c) What kind of treatment have you done? (WRITE)

11.a) Have you been admitted to a psychiatric hospital?	Yes	1	11b
	No	2	12a
11.b) When was it?	up to 2 years	1	
	up to 5 years	2	
	up to 10 years	3	
	more than 10 years	4	
11.c) How many times have you been in a psychiatric hospital?	once	1	
	2 or 3 times	2	
	4 to 6 times	3	
	more than 6 times	4	

11.d) What made you be taken to the hospital? (WRITE)

11.e) How have you be taken to the hospital? (Who have taken you and how?) Was it in a voluntary way or have you been taken against your will? (WRITE)

11.f) Have you had any problems in your family related to your nerve problem before your admission?	Yes	1	11g
	No	2	12a
	don't remember	3	12a

11.g) What kind of problem? (WRITE)

11.h) How was(were) the experience(s) of returning home? (WRITE)

12.a) Have you done any other kind of treatment before coming to this health centre?	Yes	1	12b
	No	2	13a

12.b) For how long?	some months	1
	up to 1 year	2
	up to 2 years	3
	more than 2 years	4

12.c) How as this treatment? (WRITE)

Now we want to know about the treatment you have been attending here

13.a) Who referred you?	doctor/any other health service	1
	school	2
	relatives	3
	friends	4
	nobody, just knew about the presence of the professionals and came	5
	a relative is attending	
	(had attended) a treatment and the professional asked for coming	6
	(ASK WHO AND WRITE) other	7

13.b) Which kind of problems have made you come? (WRITE)

13.c) Is this your first consultation, or how long have you been attending treatment here?	first consultation	1	13e
	up to 1 month	2	
	up to 3 months	3	
	up to 6 months	4	
	up to 1 year	5	
	up to 2 years	6	
	more than 2 years	7	

13.d) How is the treatment you have been attending here? (WRITE)

13.e) Do you take medicines?	Yes	1	13f
	No	2	14a

13.f) Have you had any difficult in getting the medicines?	Yes	1	13g
	No	2	13h

13.g) What happens when you don't find or get the medicines? (WRITE)

13.h) Do you like to take medicines?	Yes	1	
	No	2	

13.i) What are the reasons for your answer (yes or no)? (WRITE)

(IN CASE OF FIRST CONSULTATION, JUMP TO 15A)

14.a) Have you felt any significative change or improvement in your life due to the treatment you have attended here?	Yes	1	14b
	No	2	15a
	don't know	3	15a

14.b) Which changes? (WRITE)

Now, we want to know what do you think about the services provided here in this health centre. Remember that nobody will know what you are going to say here, even the professionals and staff.

15.a) How would you evaluate the building, the attending rooms, the comfort provided to the people who come here? (READ THE OPTIONS)	very good	1	
	good	2	
	more or less	3	
	bad	4	
	don't know	5	15c

15.b) Which are the reasons for your answer? (WRITE)

You attend treatment with Dr. a) ..... (WRITE)
b) .....

15.c) What is your opinion on the treatment you receive here? a) Dr. ..... (READ THE OPTIONS)	very good	1	
	good	2	
	more or less	3	
	bad	4	
	don't know	5	15e/15g

15.d) What are the reasons for this answer? (WRITE)

15.e) b) Dr. ..... (READ THE OPTIONS)	very good	1	
	good	2	
	more or less	3	
	bad	4	
	don't know	5	15g

15.f) What are the reasons for this answer? (WRITE)

15.g) What do you think about the provision of medicines and laboratory exams? (READ THE OPTIONS)	very good	1	
	good	2	
	more or less	3	
	bad	4	
	don't know	5	16a

15.h) What are the reasons for this answer? (WRITE)

16.a) Can you remember any event in which people lacked the respect or consideration as they knew you had have nerve problems? — Yes 1 → 16b; No 2 → 17a

16.b) How was(were) that(those)? (WRITE)

16.c) Have you felt similar situations here in this health centre, within the staff, or in the surrounding area? — Yes 1 → 16d; No 2 → 17a

16.d) How was(were) that(those)? (WRITE)

17.a) Imagine now you were the boss of all the health services and that you could change everything you would like. What changes in this health centre would you order? (WRITE)

17.b) Besides these services provided here at this health centre, what else would the people with nerve problems and their families need (other kind of services and help)? (WRITE)

18. Within the items we will list to you, which kind of help have you searched for recently, to cope with life troubles and nerve problems? (READ THE OPTIONS FOR EACH ITEM)

a) to talk to relatives	several times	1
	sometimes	2
	never	3
b) to talk to friends and neighbours	several times	1
	sometimes	2
	never	3
c) to look for people or to participate in activities linked to the church	several times	1
	sometimes	2
	never	3
d) to go to Spiritualist centres	several times	1
	sometimes	2
	never	3
e) to go to macumba, umbanda, candomble centres (Note: Afro-Brazilian rituals)	several times	1
	sometimes	2
	never	3
f) to go to Alcoholics Anonymous	several times	1
	sometimes	2
	never	3
g) to go or to call up the Samaritans	several times	1
	sometimes	2
	never	3

h) besides those, are there other ways to seek

help for your life troubles and nerve problems?
(WRITE)

We want now to know about your social life within and out of your family

19.a) Imagine a normal week day in your life: what do you do, how do you feel and the main problems. (WRITE)

19.b) Tell us now how are your Sundays. (WRITE)

20.a) In your opinion, do the people who suffer from nerve have problems with those people they live with?	Yes	1	20b
	No	2	21a
	don't know	3	21a

20.b) What are the most common kind of problems? (WRITE)

(IN CASE OF COMPANIONS, GO STRAIGHT TO 21a)

22) We reached now the end of the questionnaire. From our point of view, we are quite happy with what you have told us. Would you like to say something else we haven't talked about?
(WRITE)
Note: Any answer to this question was transferred to the relevant open-ended questions inside the questionnaire.

(ONLY FOR COMPANIONS)

21.a) Does ..... need any kind of special care (e.g. help for baths, special attention, to take for outings, to feed, etc)?	Yes	1	21b
	No	2	22

21.b) Imagine now the last two weeks: how much time has been spent **per day** to provide this special care?	up to 1 hour	1
	up to 3 hours	2
	up to 6 hours	3
	more than 6 hours	4

21.c) Who does provide the major part of this care?	mother/wife	1
	sisters	2
	father/husband	3
	brothers	4
	other relatives	5
	(WRITE) other	6

21.d) Among those who are in contact with ..... every day, have anyone complained about any problem related with this acquaintanceship and the special care needed?	Yes	1	21e
	No	2	21g

21.e) What are the problems which they have complained about?
(WRITE; ONLY IN CASE OF NO UNDERSTANDING, GIVE EXAMPLES:
tiredness, irritation, lack of sleep, nerve, etc)

21.f) Who are the people most impaired with these problems?	mother/wife	1
	other women of the family	2
	husband/ other men of the family	3
	children	4

Appendix 3

Ist Meeting of the South-East Region Mental Health Coordinators (Vitoria, 1985) - Conclusions.

Main proposals:

I. To reverse the hospital-centred trend: the admissions must be transitional, never permanent events. The reference for care provision must be the out-patient system.

1. The following strategies for desospitalization are established:

a) the sector will not contract out nor set up new psychiatric beds in specialized units;

b) in regions where new psychiatric beds are necessary, they should be necessarily located in general hospitals;

c) gradual reduction of statutory and contracted out asylum beds according to careful assessment of the local needs;

d) stimulus to the establishment of resources alternative to integral admission, such as: day-hospital, night-hospital, pre-admission, sheltered hostels, self-managed nuclei, etc;

e) assessment of admissions from the statutory health centre, out-patience and emergency services;

f) the service network must be 'hierarchized', regionalized and integrated, and provided with referral and counter-referral mechanisms.

2. The out-patient services must be statutory, decentralized, widespread and better provided technically, towards a better efficiency;

2.1. The out-patient services must be reformulated, towards a divestment of the asylum ideology;

2.2. Reversion of the medical organicist model which leads to a 'normatizing' and biological care;

2.3. Incentive to the use of multidisciplinary alternative techniques leading to models more adequate to the demand needs;

Note: The statutory sector has the duty of organizing, managing and executing the mental health care programme, while the private sector should have a complementary and gradually reduced role.

3. Systematization of the discussion on mental health care in the health

centre network, in order to get a better definition of strategies to be adopted.

II. Development of a democratic personnel policy, adequate to the needs of inter-organizational programmes (followed by specific recommendations)

III. To ensure a funding policy compatible to the care and managerial model proposed in the AIS plan (an operationalization of the CONASP plan) and to an effective social control of the resources' use (followed by specific recommendations).

IV. To guarantee the insertion of the mental health programme in a managerial model by which all statutory organizations can participate in an egalitarian way, and in which users can participate mainly in the local level (followed by specific recommendations).

V. Creation of an unified, efficient, decentralized and democratic system for controlling, evaluation and information in mental health (also foll. by specific recomm.).

VI. To change the existing asylums, guaranteeing minimum living and treatment conditions to their residents (plus spec. recomm.) [A: DMS: I Encontro (1985) Documento Final].

Appendix 4

The Plan for the Belo Horizonte Metropolitan Area Mental Health Programme[1]

Summary of the Section on Service Model and Guidelines for Out-Patient Units

1. The description of the model stresses the replacement of the traditional centredness in the psychiatric hospital to the out-patient care, to be provided at two levels: primary and secondary. A referral and counter-referral system must be established according to a regionalization plan, in which a specialized team (secondary level), should have a catchment population of 200.000.

2. The Primary Care Level

This is understood as the entry door of the system, provided by GPs and auxiliary staff. Its functions are:

a) make public the mental health programme;

b) 'resolution' of the less complex problems;

c) referral of cases demanding specialized care.

This level's ability to 'solve' less complex problems and to avoid an excessive number of referrals will depend on the integration between the primary and secondary teams, including constant information, supervision and training by the latter.

The 1984 version also adds that the primary team should have a strategy of social and community practices aiming at changing the population's attitudes in relation to the mentally ill. It also proposes a resolution rate of 80% of cases and points to additional activities, such as:

d) diagnosis;

---

[1] This summary is based on the last known version [A: DMS (1985) Programa], but it will also be enriched with notes from the previous one [A: DMS (1984) Plano], when a indication will be shown.

e) emphasis on 'preventative' activities, such as prevention of nutritional oligophrenia and counselling on child psycho-pedagogic problems);

f) control and treatment of ex-in-patients;

g) domiciliary visits, aiming at family counselling;

h) alternative actions to stimulate a better re-integration of discharged users in the community;

i) planning and evaluation of services with community leaders and users.

3. The Secondary Level

This is constituted by specialized teams (one psychiatrist, one psychologist and one social worker), with the following features: an interdisciplinary approach to mental health, emphasis on group attendance, guidelines for increasing the resolution capability and for allowing admissions only as a last resource. The main service guidelines are:

a) emphasis on the most prevalent nosologies: neurosis, alcoholism, epilepsy and psychosis; guidelines also stress avoidance of stigmatization processes and consequent unnecessary admissions;

b) those discharged from psychiatric hospitals should receive special attention, with family follow-up and formation of support groups, in an attempt to break the admission cycle.

c) support to other health programmes, working together with GPs and other specialized doctors, aiming at approaching emotional aspects of the psycho-somatic diseases.

d) technical support to the primary level;

e) integration with community resources (schools, nurseries, district associations), supporting them in the promotion of mental health, linking them with the services and making public the mental health programme.

f) child attendance, through psycho-pedagogic activities in groups, in an integrated work with parents and schools.

g) evaluation of the programme through research, assessment of epidemiological aspects and of the population's perception of mental

illness.

The 1984 version also includes:

h) family attendance, through basic advice and psychotherapeutic support.

i) adolescent's groups.

j) pregnant women groups.

k) special groups for users with hypertension, leprosy and resistance to treatment.

l) residential visits (similar to the proposal made for the primary care level).

m) assessment of the infra-structure, social and cultural features of the region and their community and social services; support and supervision in the assessment of mental health issues in working environments and in the re-integration of the mental ill people;

n) supervision of probationers in psychology, social work and occupational therapy.

o) training of community leaders in mental health education activities.

Appendix 5

The 'Nervousness' Model of Representation of the Mental Life Hegemonic in the Brazilian Working Class Population[1]

From the historical point of view, the representation found in this segment of the population has been cast in a model whose origins lie in the intense efforts of the European eighteenth century natural sciences to replace the holistic/dualist humoral and Christian model by a physical and unitary one. In Brazil, some evidence of the latter has been found since the first decades of the last century through the French influence in the medical faculties, and was widely diffused by the Hygienist movement in the present century, with deep pervasiveness. Despite the lexical continuity, the present Brazilian 'nerve representation' has little in common with the European model:

> "Instead of the radical physicality of the original conceptualization, one finds here a nervous system that may be host to all kinds of spiritual entities and may carry moral qualities together with sensorial impressions. Instead of the universal support for equality, it serves here as the confirmation of difference; of the deep differences that oppose men and women, for instance. Instead of being the inner connective of individuality, it is the vehicle of relationship between all men and between men and the world" (op cit: 10).

However, some common elements are the concern with **substance, communication, irritation/sensibility and obstruction** that pervaded the tradition of human physiology since the beginning of the eighteenth century:

> "**Substance** is fundamentally a question of '**força**' (force, strength, power) and 'fraqueza' (its opposite). These are quite important and quite general qualities. There is a physical **força** and a moral **força**. Their commuting point are the **nerves**, which serve as a bridge between the realm of the **body**, whose **blood** is the substance of physical force, and the realm of the **head**, where the **brain** is the siege of mental and moral force. As the brain is, however, the very nucleus of the nervous system; the referred

---

[1] Based on the work of Duarte (1986b), undoubtedly the most synthetic and systematic description of the phenomenon in the Brazilian literature.

> commutation implies a hierarchical relationship between the two terms: moral life, through the brain and the nerves (which are considered to be white) encompasses physical life, as represented by the body and blood (which are red)" (op cit: 11).

The difference between man and woman depends heavily on the **nerves/blood** nexus. Man is hierarchically prominent by three forces: physical, mental (intellectual) and moral, standing logically at the side of **blood**. Woman is considered a moral entity, standing at the side of the **nerves**. Therefore, the female events concerning blood are considered dangerous, such as in menstruation, pregnancy and childbirth. As their moral qualities correspond to a basically **nervous** quality, they are also considered the most "natural" victims of the wide range of disturbances related to **nervousness**.

The communication issue is also important. **Nerves** receive and transmit moral and physical impressions to the **body**, to and from the **brain**. An irritation caused to the **nerves** by any accident spreads to the **nervous system**, and the way to express it is to say that the **nerves** were 'attacked', by moral damage, physical damage to the **head**, or by a series of processes regarding the **body** and mediated by the **blood** and the **liver** (as a 'filtering unit'). **Obstruction** may also constitute the origin of problems.

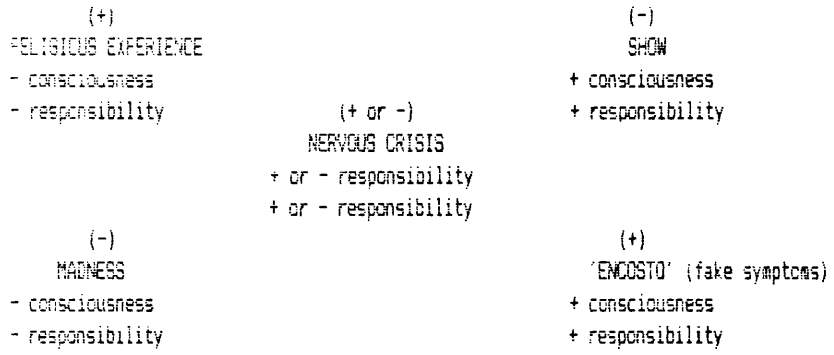
The logic of **nervousness** is also related to wider cultural issues. Family is probably the foremost source of identity in those social groups. The **home** is a very strong symbolical focus of life, and constitutes a complex hierarchical unit, based on the opposition between husband and wife. Man has the **forças** for the maintenance and protection of the home, and is also its public face. Woman represents the moral level and must keep intact the honour of the family and bring up the children according to the best moral standards. She is the inner face of the house.

Nervousness is also one of the main instruments people can handle for social appraisal:

> "The sequence of categories related to **nervousness** is a long one, from the lighter to the more serious situations. It is possible to say that someone is plainly **nervous**, that he is in a state of **nervousness**, that he is '**maluco**' (a lighter kind of madness) or that he is '**doido**' or '**maluco de verdade**' (really mad). (...) The

> logic that presides over these classifications is a fully "situational" one. (...) The wide range of categories offered by the **nervousness** model and its physical-moral quality account for its outstanding role in inter-personal appraisals".

The following diagram presents some of the principal meanings generally associated with the expression 'nervous crisis' and their moral nuances:



From it, it is possible to see that a nervous crisis may mean, for example:

- a strategy to receive the full retirement benefit ('encosto'), when most people stress that their **nervous** condition was simulated ('perhaps the case was just a bit of nervousness');
- religious experience, referring to the possession of spirits or trance, as in the Spiritualist and Afro-Brazilian (such as 'candomble' and 'umbanda') rituals;
- "real" madness;
- a show.

Two of the positions correspond to positive labels (signed with +) and two others to negative ones. The "show" is certainly the most negative, given the person's awareness, although the consequences of 'madness' are more radical. In the end, the representation constitutes a switching device for the process of significance and defence against stigma:

> "The "victim" of these disturbances may not feel himself able to classify them and to deal accordingly with their symptoms and causes. One of the most interesting aspects of **nervousness** is the way it serves to designate all kinds of inordinate states and pieces of behaviour, while still allowing the "victim" to "choose" a more specific meaning for them ("religious" or "psychiatric", for instance) without really moving out of the **nervousness** symbolic field" (op cit: 16).

When addressing the origin of the mental problems, the urban working-classes **nervousness** is seen by its "victims" as the result of multiple disruptions not only as physiological accidents, but also of the most basic rules of their cosmology.

It may occur at the "inter-personal" level, as in case of damage or danger to family values. Women are especially seen as prone to this kind of **nervousness**, as in the loss of a family member or failure of husbands to provide financially for their families. Problems related to work are foremost among the causes of **nervousness** for men, ranging from unemployment to inconvenient or dangerous working conditions.

The disruption of adequate order at the level of local life (the '**bairro**', '**favela**', '**pedaço**', etc) is also highly inductive to nervousness. Local identity, a strong sense of belonging to one's own place, is almost as important as family identity. It depends on the maintenance of adequate levels of moral behaviour, and categories like '**falta de respeito**' or '**consideração**' (lack of respect or of consideration) are very frequent, meaning a break of reciprocity links. This may be the case in the urban workers denunciation of evil present in the industrial, urban and political life, which subverts the appropriate rules of reciprocity that should preside over the relationship between persons and groups. They seem to become unbearable when personalized in the owner's, manager's or politician's unwillingness to be fair, i. e. to reciprocate at a certain level according to an unwritten code.

Urban life is another source of disturbance. Cities are seen as the realm of abundance and consciousness, against the image of the backward, hard-living rural conditions. Despite their continuous efforts, their lifelong dedication to urban magnificence has never allowed them to participate in it riches. This is another version of the reciprocity theme. Alongside this, they are confronted with the worst possible life conditions, as lack of water, energy, bad or inexistent transport systems, educational, medical and commercial facilities, which provide a composite of disturbing circumstances.

Finally, religion is also an important element in the **nervousness** model. It is considered the ultimate level of reciprocity, the highest

instance of a hierarchical world-view, and therefore, the place of personal reassurance of such values. Some of the sects also provide other instruments to deal with nervousness, such as the Pentecost, Spiritualist and Afro-Brazilian ones, within a framework of possession and trance. There are many levels of agreement and belief, and concomitance and alternation are very frequent.

Appendix 6

The Complex and Multifarious Representation of Mental Health and Illness by the Working Class Population in Belo Horizonte.

Statements by Community Leaders and Users of the Sao Paulo, Lindea, Cabana and Sagrada Familia districts.

1. The Child Development, the "Inter-Personal" and Local Levels

"The crisis encompasses everything. You see the malnutrition, the mother is underfed when she gives birth. Then, the child comes out malnourished, weak. Then this reaches the nerve, which attacks the head, all this. This is what I think that happens in mental illness" [I: Oliveira AC, President of the Psychology Community Association of the Lindea District].

"Mental health, the problems comes from the pregnancy, if one doesn't have a good pregnancy, it affects the foetus, and if one does not have good food, it affects the child. Sometimes, the child is born healthy, but the mother leaves the child on his own, because she has to do the washing up, the cleaning (referring to maids), and therefore, the infants and adolescents suffer..." [I: Araujo, President of the Community Association of the São Paulo District, and also working in the Program of Complementary Nutrition distributing food for mothers with newborn babies].

"Then what we perceive in those children is deprivation of affection ('carencia afetiva'), especially in the family situation, as several of them don't have the presence of the father, producing then this deprivation. Many don't have the presence of the mother, it is the grandmother or another relative who takes care of them, (generating) a lot of aggressiveness. It shows off then in a very aggressive form, which is the expression of this situation in mental illness. It is also due to malnutrition - and we realize that they have difficulties in their studies -, which provokes deficiency in the development of the brain; hence, the (existence of) cases and problems of mentally disabled people. And several cases then, I would say, more extreme: epileptic

people, and several, several cases of learning difficulties ('excepcionais') and behaviour inadaptation ('desajuste'). Here we haven't reached the point of serious delinquency, but of inadaptation indeed, of theft, aggressions, misdemeanours and things like that. However, among the kids, what shows off more is this aggressiveness. I think this is due to the fact that they live in very stuffy places, the street and the houses are very stuffy, this family environment, all that (does not provide them) without a way of expressing their energy, and stress becomes accumulated and ends up being discharged in the from of aggression to the others, or of depredation, or alike" [I: Scaramussa, a Catholic priest at the Cabana district, actively integrated in the local community mental health project].

"In relation to the women, it seems that the situation is more complicated yet, because the majority of them generally stay confined to the house, have to deal with all the household, have to work to earn and pay for the family and the children, and are also responsible for the situation of the children, and that situation of lack of dialogue with the husband. All this drives them to situations of neurasthenia indeed, of nerve problems which are reflected mainly in these types of nerve problems. Then, they naturally seek the medical service, presenting even physical symptoms, such as head ache, stomach ache, ulcer, liver problems, problems like these. Everything in practice has a more social and psychic origin, given that situation " [I: Scaramussa].

"The people here do not have the opportunity to play, the time for leisure, the time for partying. They don't know how to distinguish party and problems, they've got problems and carry them constantly with them. This is a great illness (doenca), very serious indeed" [I: Almeida, coordinator of the Alto da Vista Alegre District Community Association, Cabana area].

2. The Work 'World'

"Mental illness, I think it is the set of all problems of our people here, isn't it? Mental illness is for example to have to leave home so early in the morning, to carry the 'marmita' (the case where they carry the lunch, a symbol of the anger), to be trodden in the

buses, not to be respected in the job. (...) Then all this forms a complex of things which provokes mental illness. It is when people feel oppressed, pressured, and don't know from whom... " [I: Luci, secretary of the Integrated Centre of Community Health, Cabana district].

"I think that one of the main problems of mental health in our district comes from the times we're living, from the social crisis that people are facing. From the low wages that the workers, us, are earning, from the unemployment, which affects a lot the population. As I said, we live in a working class district, in a 'dormitory' district where everybody makes his/her living from work. Then, it is when work is lacking, as in the last few years, and with this pressure down in the wages, and the wages can't afford the basic needs of the family. Then, the man has to leave very early to one side, the woman to the other, leave the children alone, because it is not everybody who has the possibility to leave them in the nursery and work at ease. All that generates a physical stress in people and ends up affecting their mental health. (...) Besides, it is not only the repression in the wages which are reduced, but also the fact that at the job, the boss puts pressure on you, requiring the production and the work timetable. This affects the mental health, because I was in this situation, I faced the problem, and it is a serious problem, and thanks to God I got to overtake it. (...) The public transport is also another reason that contributes to the problem of mental health, 'cause in the morning, at the time to go to work, it is enough to stay and see how these people make the journey in the buses. A crowd of people goes, even hanging up out of the bus, running the risk of falling and even dying somewhere. Therefore, all that is accumulating, provoking a nerve state in the person, and ends up reaching their mental health" [I: Oliveira JM, First Coordinator of the Community Association of the Lindea District].

3. The Broader Political World

"The main cause of the mental problem is the under-development. Latin America is an immense hospital of drug addicts, alcohol addicts, problems caused by misery, socially mad people, who don't have food, medicines, structure to educate themselves, and I feel all that, see

that, and I become sick. I hate North-Americans who explore Latin American countries and these corrupt politicians who survive at the expense of people's ignorance, and I have no hope that this will be changed in the next elections" [an adult female user interviewed in the piloting period at the Sagrada Familia health centre, with several problems in her original family ("my father was super brute, treating us as bandits, it was a misery. But he also was a wretch man, he suffered a lot") whose one of the main reported symptoms is, symbolically, to eat paper of magazines, books and self-written stuff].

BIBLIOGRAPHY

1. PRIMARY SOURCES

1.1. ARCHIVES SOURCES

1.1.1. List of Government Agencies

Note: Both São Paulo and Belo Horizonte have different regional agencies coordinating the mental health programme, according to the geographical coverage and level of administration. Belo Horizonte has the most complex system: one coordination at state level (Minas Gerais - CPSM-SES-MG), one for the whole metropolitan area (Belo Horizonte plus neighbour municipalities - DMS), and one for the Belo Horizonte municipal area (SMS-PMBH). São Paulo has two: at state (CSM-ESP) and municipality (APSM-SMSSP) levels. Finally, Rio de Janeiro has just one, at state level (CCSM-RIO).

a) **APSM-SMSSP:** Assessoria ao Programa de Saúde Mental, Secretaria Municipal de Saude de São Paulo ('Mental Health Programme Coordination, Municipal Health Secretariat of São Paulo').

b) **ASMC-SP:** Ambulatório de Saúde Mental Centro, São Paulo ('Centre Specialized Mental Health Clinic, São Paulo).

c) **CCSM-RIO:** Comissão Coordenadora de Saúde Mental da Secretaria de Estado da Saúde do Rio de Janeiro ('Mental Health Programme Coordination of the Health Secretariat of the State of Rio de Janeiro').

d) **CIS-ESP:** Centro de Informações de Saúde, Secretaria de Estado da Saude de São Paulo ('Information Centre on Health, Health Secretariat of the State of Sao Paulo').

e) **CPSM-SES-MG:** Coordenação do Programa de Saúde Mental, Secretaria do Estado da Saúde de Minas Gerais ('Mental Health Programme Coordination, Health Secreatariat of the State of Minas Gerais').

f) **CSM-ESP:** Comissão de Saúde Mental, Secretaria de Saúde do Estado de São Paulo ('Mental Health Comission, Health Secretariat of the State of São Paulo', actually the mental health programme coordination at state level).

g) **DINSAM:** Divisão Nacional de Saúde Mental, Ministério da Saúde, Brasília ('National Division of Mental Health, Ministry of Health', the coordination of mental health issues at national level').

h) **DMS:** Divisão Metropolitana de Saúde, Assessoria Técnica de Saúde Mental, Secretaria do Esta do da Saúde de Minas Gerais ('Mental Health Technical Advisory Body, Metropolitan Division for Health, Health Secretariat of the State of Minas Gerais', the actual mental health programme coordination for the Belo Horizonte metropolitan area).

i) **ESMIG:** Escola de Saúde de Minas Gerais ('School of Health of the State of Minas Gerais',

responsible for training professionals to work in the state's health services and administration).

j) **FHEMIG:** Fundação Hospitalar de Minas Gerais ('Hospital Foundation of Minas Gerais', agency of the Secretariat for Health of the State of Minas Gerais responsible for administering all state owned hospitals, including the psychiatric ones).

l) **MPAS:** Ministério da Previdência e Assistência Social ('Ministry for Social Insurance and Care').

m) **SMS-PMBH:** Secretaria Municipal de Saúde, Prefeitura de Belo Horizonte (this refers actually to the mental health programme coordination in the Belo Horizonte municipal area, which has no formal existence within the 'Municipal Health Secretariat').

1.1.2. List of Archive Documents: [A: ...]

Note: The list will be presented in alphabetical order **according to the agency of origin;** individual authors or sub-sections of the main agency will be referred after the latter, as indicated along the body of the thesis.

APSM-SMSSP (1989) Diretrizes para a Política de Saúde Mental do Município de São Paulo.

APSM-SMSSP (1989) Esboço de Projeto de Saúde Mental - Projeto Centro de Convivência.

APSM-SMSSP (1989) Educação Popular em Saúde.

APSM-SMSSP (1989) Para Compreender a Atual Política Municipal de Saúde Mental do Governo Democrático e Popular da Cidade de São Paulo.

APSM-SMSSP (1989) Programa de Saúde Mental - Secretaria de Saúde da Prefeitura do Município de São Paulo.

APSM-SMSSP: Secretaria de Higiene e Saúde do Município de São Paulo (1985) Projeto de Ações Integradas de Saúde Mental na Zona Norte.

ASMC-SP (1986) Mulher e Saúde Mental: da produção da loucura a falência dos tratamentos.

ASMC-SP: Costa, AL et al (1986) Programa de Saúde Mental ERSA 7 - Documento 1.

CCSM-RIO (1988) Relatório de Atividades da Assessoria de Saúde Mental da SRRJ-INAMPS - 86/87.

CCSM-RIO: Gonzalez, R (1984) Os Serviços de Saúde Mental do Rio de Janeiro: Relatório de Avaliação (Abril 1984).

CCSM-RIO: Grupo de Trabalho de Saúde Mental do Projeto Niterói (1983) Proposta de Reorientação da Atenção a Saúde Mental no Município de Niterói.

CCSM-RIO: INAMPS-RIO (1981?) Anteprojeto para Implantação de 'Programa de Ações de Saúde Mental nas Unidades Hospitalares da Superintendência Regional do INAMPS no Rio de Janeiro.

CPSM-SES-MG (1989) Encontro de Coordenadores Regionais de Saúde Mental.

CPSM-SES-MG: Fajardo, YN (1982) Um Breve Estudo Psicológico e Sociológico da 6.a Enfermaria do Instituto Raul Soares.

CSM-ESP (1981) Relatório Geral de Atividades das Equipes de Saúde Mental da Grande São Paulo (março 1980 - março 1981).

CSM-ESP (1986) Relatório do Grupo de Saude Mental.

CSM-ESP (1983) Sistema Hospitalar de Assistência Psiquiátrica.

CSM-ESP: I Encontro de Ambulatórios de São Paulo (1988) Texto Preparatório.

CSM-ESP: Equipe de Saude Mental da Vila Brasilândia (1988) Ambulatório de Saúde Mental da Vila Brasilândia - práticas e estratégias de saúde na assistência aos psicóticos.

CSM-ESP: Ferraz, MPT e Morais, MFL (1985) Política de Saúde Mental - revisão dos dois últimos anos, in Arquivos da Coordenação de Saúde Mental, XLV, (11-22).

CSM-ESP: MS/MPAS/SESSP/SHSMSP (1983) Programa de Ações Integradas de Saúde na Região Metropolitana de São Paulo

CSM-ESP: Instituto Sedes Sapientiae (1984/1988) Relatórios de Atividades do Convênio do Sedes Sapientiae.

DINSAM (1987) Manual de Orientação para Funcionamento e Supervisão dos Serviços de Saúde Mental - versao preliminar.

DINSAM (1977) Projeto Integrado de Saúde Mental (PISAM).

DINSAM/Colônia Juliano Moreira (1982) Seminário para Discussão de Modelos Alternativos no Atendimento Psiquiátrico.

DINSAM: Souza, Zoraide (?) Legislação Psiquiátrica.

DMS (1987) Atendimento em Saúde Mental Infantil - Centros de Saúde: Estado/Prefeitura.

DMS (1988) Atividades Desenvolvidas em 1987 e Considerações.

DMS (?) Contribuições na Estruturação do Trabalho na Equipe de Saúde Mental de Venda Nova.

DMS (1983) Plano de Assistencia a Saúde Mental do Estado de Minas Gerais.

DMS (1984) Plano Operativo para o Programa Integrado de Saúde Ambulatorial na Região Metropolitana de Belo Horizonte.

DMS (1984) Programa de Ações em Saúde Mental - Região Metropolitana de Belo Horizonte.

DMS (1989) Programa de Ações em Saúde Mental: relatório de atividades - 1988.

DMS (1985) Proposta de um Sistema de Saude Mental dentro das Ações Integradas de Saúde.

DMS (1989) Quadro Geral dos Profissionais e Respectivos Centros de Saúde.

DMS (1989) Relatório de Atividades 1988 do Programa de Ações em Saúde Mental.

DMS (1985) Relatório do Encontro de Profissionais de Saúde Mental da Regiao Metropolitana.

DMS (1984) Relatório do Programa de Saúde Mental.

DMS (1986) Relatórios Trimestrais - Saúde Mental - 1.o Trimestre de 1986.

DMS (1986) Saúde Mental na Região Metropolitana de Belo Horizonte.

DMS (1985) Síntese dos Relatórios 1985 - Programa de Saúde Mental

DMS : Acúrcio, FA e Akerman, M (1981) PISAM - Implantação no Centro Metropolitano de Saúde (1977/79).

DMS: Coura Filho, P (1985) Levantamento de Aspectos da Organização da Comunidade do Barreiro de Cima - Belo Horizonte; das Queixas de Doenças da População e das Possibilidades de se Pensar uma Prática em Saúde Mental na Região.

DMS: CRIS-SES-MG (1985) Programa de Ações em Saúde Mental - Região Metropolitana de Belo Horizonte.

DMS: CRIS-SM-INAMPS-SRMG (1986) Proposta de Estrutura de Saúde Mental no Estado dentro das AIS Ambulatorial.

DMS: I Encontro de Coordenadores de Saúde Mental da Região Sudeste (1985) Relatório, Vitória, Espírito Santo.

DMS: II Encontro de Trabalhadores de Saúde Mental da Região Sudeste (1987) Relatório, Barbacena.

DMS: Equipe de Transição (1983) Documento de Transição - Governo Tancredo Neves - Setor Saúde Mental.

DMS: Gomes, SC (1983) Minha Passagem por um Hospital Psiquiátrico Público.

DMS: Grupo de Trabalho INAMPS/SES-MG (1984) Plano Operativo para o Programa Integrado de Saúde Mental a Nível Ambulatorial na Região Metropolitana de Belo Horizonte.

DMS: Lauar, HB et al (1989) Projeto de Implantação de um "Centro de Atencao Psicossocial".

DMS: Mendonça Filho, JB (1984) Relatório do Setor de Psicologia do Centro de Saúde da Sagrada Família.

DMS: Oliveira, EG e Greco, MG (1987) Diagnóstico, proposição de objetivos e sistema de avaliação do Programa de Saúde Mental do Centro de Saúde Alcides Diniz.

DMS: Sales, JR (1988) Estudo sobre a Clientela da Área de Saude Mental na Policlínica de Varginha.

ESMIG (1986) Curso de Saúde Mental.

FHEMIG (1980) Proposta de Reestruturação do Instituto Raul Soares.

MPAS: CONASP (1982) Plano de Reorganização da Assistência a Saúde no Âmbito da Previdência Social. Portaria n.o 3.062, de 23/08/82, Brasília.

MPAS: CONASP (1982) Programa de Reorientação da Assistência Psiquiátrica Previdenciária, Brasília.

SMS-PBH (1985) Relatório Saúde Mental - periodo agosto 1984/ junho 1985.

SMS-PBH (1986) Ante-Projeto para uma Unidade de Cuidados Intermediários em Saúde Mental.

1.2. NEWSPAPER SOURCES

1.2.1. List of Newspapers and Other Non Scientific Publications [N: ...]

EM (O Estado de Minas): main traditional daily newspaper in Minas Gerais and Belo Horizonte.

ESP (O Estado de São Paulo): one of the two main daily newspapers in the state of São Paulo, city of São Paulo

FSP (A Folha de São Paulo): one of the two main daily newspapers in the state of São Paulo, city of São Paulo.

Jornal do Campus: Publication of the Dep. of Journalism e Editing, University of São Paulo, São Paulo.

Jornal do CRM-SP: Publication of the Regional Council of Medicine, São Paulo.

Jornal do CRP-06: Periodical publication of the Regional Council of Psychology, São Paulo.

Jornal do Federal: Periodical newspaper of the National Council of Psychology, Brasília.

Jornal do Psicologo - CRP-04: Periodical newspaper of the Regional Council of Psychology, Belo Horizonte.

Proposta: Periodical publication of the Oswaldo Cruz Foundation, Rio de Janeiro.

Saude em Debate: periodical publication of the CEBES - Brazilian Centre of Studies on Health, Rio de Janeiro.

Tema: Periodical publication of the Oswaldo Cruz Foundation, Rio de Janeiro.

Veja: main weekly magazine of the country.

2. SECONDARY SOURCES

Adams, P and Minson, J (1978) The Subject of Feminism, M/F n.o 2, cit in C Lemert and G Gillan (1982)Michel Foucault: Social Theory as Transgression, N. York, Columbia University Press.

Agar, M (1980) The Professional Stranger - An Informal Introduction to Ethnography. London, Academic Press.

Alayon, N (1982) Las Escuelas del Trabajo Social en America Latina. Buenos Aires, Hvmanitas.

Allen, E (1985) Poverty and Social Welfare in Brazil: a challenge for civilian government. Glasgow, Institute of Latin American Studies.

Allen, H (1986) Psychiatry and the Construction of the Feminine, in P Miller (ed), The Power of Psychiatry. Cambridge, Polity.

Almeida, CM (1989) Os Atalhos da Mudança da Saúde no Brasil. Brasilia, OPAS/OMS.

Almeida Filho, N (ed) (1979) Assistência Psiquiátrica no Brasil (Seminário), in Rev. da Associação Psiquiátrica da Bahia, suplem. n.o 2, out., Salvador.

Almeida Filho, N (1980) Urbanização e Doença Mental, in Rev. da Associacao Psiquiatrica da Bahia, n.o 1, vol 1, Salvador.

Almeida Filho, N (1981) Força de Trabalho e Saúde Mental em um Setor Urbano da Salvador, Bahia. Jornal Brasileiro de Psiquiatria, 30: 463.

Almeida Filho, N (1985) Epidemiologia das Desordens Mentais na Infância no Brasil. Centro Editorial Didático da UFBA, Salvador.

Almeida Filho, N (1987) Epidemiologia Social das Desordens Mentais: revisão da literatura latino-americana, in SA Tundis e NR Costa (ed) Cidadania e Loucura - Políticas de Saúde Mental no Brasil. Petrópolis, Vozes/ABRASCO.

Almeida Filho, N e Bastos, GB (1982) Estudo de Caso-Controle da Associação entre Migração e Desordens Depressivas em Mulheres, in Jornal Bras. de Psiqu., vol 31, n 1, jan/fev, Rio de Janeiro.

Alonso, MIB et al (1987) A Família, seus Cuidados e os Serviços Assistencias na Cidade do Rio de Janeiro, in Jornal Bras. de Psiqu., 36 (3): 199-203.

Alves, SRP (1982) Do Outro Lado do Muro: Estudo sobre Representação da Doença Mental em uma População Favelada do Rio de Janeiro. Tese Mestrado, Inst. Psiqu. UFRJ, Rio.

Amarante, PDC (1982) Hospitais Psiquiátricos da DINSAM - Alternativas e Propostas. Mesa Redonda no Seminário "Perspectivas da Saúde Mental no Brasil", DINSAM/Centro Psiquiátrico Pedro II, Rio.

Ander-Egg, E (1984) História del Trabajo Social. Buenos Aires, Hvmanitas.

Angerami-Camon, VAA (ed) (1986) Crise, Trabalho e Saúde Mental no Brasil. São Paulo, Traço.

Anzieu, D (1986) El Grupo e el Inconsciente - lo imaginário grupal. Madrid, Biblioteca Nueva.

Arilza, MM e Bezerra, BC (1986) A Saúde Mental da Mulher como Possibilidade de Ação. Anais da Conferência Nacional de Saúde e Direitos da Mulher, Brasília.

Baltar, PEA (1988) Evolução Demográfica, Emprego e Demandas Sociais Urbanas no Brasil, in VI Encontro Nacional de Estudos Populacionais - Anais, vol 1. Assoc. Brasileira de Estudos Populacionais. Belo Horizonte.

Banton, R et al (1985) The Politics of Mental Health. Oxford, Macmillan.

Baremblitt, GF (1990) Investigação sobre 'Saúde Mental' na Cabana do Pai Tomas, in WCC Pereira, O Adoecer Psíquico do SubProletariado. Belo Horizonte, SEGRAC.

Barret, M (1980) Women's Oppression Today: Problems in Marxist Feminisa Analysis. London, Verso, NLB.

Barros, JJC e Rotheia, EF (1985) Equipe Saude Comunitária do Posto de Assistência Médica Carlos Prates - Relatório de Pesquisa. Mimeo, PAM Carlos Prates, Belo Horizonte.

Baruch, G (1984) Straightening the Bend: sociological contributions towards the development of community mental health care, in J Reed and G Lomas (1984) Psychiatric Services in the Community. London, Croom Helm.

Barzun, J and Graff, HF (1970) The Modern Researcher. New York, Harcourt, Brace and World.

Basaglia, F (ed) (1986) L'Istituzione Negata. Torino, Enaudi.

Basaglia, F e Tranchina, P (ed) (1979) Autobiografia di un Movimento - Dal Manicomio alla Riforma Sanitaria. Arezzo, Amministrazione Provinciale.

Bastos, AVB (1988) Areas de Atuação - em questão o nosso modelo de profissional, in Cons. Feral de Psicologia, Quem é o Psicólogo Brasileiro. São Paulo, EDICON/EDUC/Scientia et Labor.

Bastos, AVG e Gomide, PC (1989) O Psicólogo Brasileiro: sua atuação e formação profissional, in Psicologia, Ciência e Profissão, ano 9, n 1, 6-15, Brasília.

Bender, T (1978) Community and Social Change in America, News Brunswick, NJ, Rutgers Univ. Press.

Berlinguer, G (1988) Análise Comparativa das Reformas Sanitárias Itália/Brasil. Rio de Janeiro, NUPES, mimeo.

Bernstein, B (1964) Social Class, Speech Systems and Psychotherapy, British Journal of Sociology, 15 (1).

Berquo, ES e Cazenaghi, SM (1988) Oportunidades e Fatalidades - um estudo demográfico das pessoas que moram sozinhas, in VI Encontro Nacional de Estudos Populacionais - Anais, vol 1. Associação Brasileira de Estudos Populacionais. Belo Horizonte.

Bezerra Jr, BC (1982) A Nocao de Indivíduo - reflexão sobre um implícito pouco pensado. Tese Mestrado, Instit. de Medicina Social, UERJ, Rio.

Bezerra Jr, BC (1987) Considerações sobre Terapêuticas Ambulatoriais em Saúde Mental, in SA Tundis e

NR Costa (ed) Cidadania e Loucura - Políticas de Saúde Mental no Brasil. Vozes/ABRASCO, Petrópolis.

Bilac, ED (1978) Famílias de Trabalhadores: estratégias de sobrevivência. São Paulo, Símbolo.

Boltanski, L (1979) As Classes Sociais e o Corpo. Rio Graal.

Borges, SMN e Atie, E (1989) Vida de Mulher: estratégias de sobrevivência no cotidiano, in NR Costa et al (ed) Demandas Populares, Políticas Públicas e Saúde II, Petrópolis, Vozes.

Boschi, R (ed) (1983) Movimentos Coletivos do Brasil Urbano. Rio de Janeiro, Zahar.

Bowles, S and Gintis, H (1986) Democracy and Capitalism - Property, Community and the Contradictions of Modern Social Though. London, Routledge and Kegan Paul.

Bradshaw, J (1972) The Concept of Social Need, in New Society, 30/03, London.

Brandao, Z et al (1984) Evasão e Repetência no Brasil: a escola em questão. Achiamé, Rio.

Brito, ESR (1984) CJM: Importância das Relações Interpessoais no Programa de Ressocialização. in Cad. de Psiquiatria Social vol 3, n 12, CJ Moreira, Rio.

Brown, CR and Hellinger, MC (1975) 'Therapists' Attitudes Towards Women. Social Work, 24, 4: 266-70.

Brown, GW et al (1975) Social Class and Psychiatric Disturbance Among Women in an Urban Population, in Sociology, 9: 225-54.

Brown, GW and Harris, T (1982) Social Origins of Depression - a study of psychiatric disorder in women. London, Tavistock.

Brozek, J (1979) Nutrição, Desnutrição, Comportamento, in Cadernos de Pesquisa n 29, jun. Fundação Carlos Chagas, São Paulo.

Buci-Glucksmann, C (1980) Gramsci and the State. London, Lawrence and Wishart.

Bulmer, M (1982) Social Science and Social Policy. London, Allen and Unwin.

Bulmer, M (1987) The Social Basis of Community Care. London, Allen and Unwin.

Busfield, J (1986) Managing Madness - changing ideas and practices. London, Hutchinson.

Calsing, E et al (1986) O Menor e a Probreza. IPLAN/IPEA - UNICEF - SUDENE. Brasilia.

Camarinha, HS (1982) Hospitais Psiquiátricos da DINSAM -Alternativas e Propostas. Mesa Redonda no Seminário 'Perspectivas da Saúde Mental no Brasil'/ DINSAM/Centro Psiquiátrico Pedro II, Rio de Janeiro.

Camarinha, HS (1983) CJM: um asilo em transformação, in A Saúde no Brasil 1 (3), jul/set. Ministério da Saúde, Brasília.

Camarinha, HS (1984) CJM: O destino dos pacientes em um hospital psiquiátrico para crônicos, in Cadernos de Psiquiatria Social, vol 3, n 2, dez. Rio de Janeiro.

Campos, FE e Oliveira Jr, M (1986) Contribuição ao Debate de uma Política de Recursos Humanos para o Setor Saúde no Brasil - a situação da categoria médica, in Cadernos de Saúde Pública, 2 (4): 477-92, out/dez. Rio de Janeiro.

Campos, GWS (1988) Os Médicos e a Política de Saúde. São Paulo, Hucitec.

Campos, MB (1986) Nova Crise da Colônia Juliano Moreira. Carta a Redação, Psiquiatria Hoje, ano II, n 4-6, jul/dez, Rio de Janeiro.

Cardim, MS et al (1983) Epidemiologia Descritiva do Alcoolismo em Grupos Populacionais no Brasil. Trabalho de Conclusão do Curso de Metodologia de Pesquisa em Saúde Mental. ENSP/FIOCRUZ, Rio de Janeiro.

Cardoso, M (1986) Médicos e Clientela: sobre a assistência psiquiátrica a coletividade. Tese de Mestrado, Instit. de Filosofia e C. Humanas da Univ. Estadual de Campinas, Campinas, São Paulo.

Cardoso, R (1983) Movimentos Sociais Urbanos: Balanco Crítico, in SV Cruz et al, Sociedade e Política no Brasil Pos-64. Brasiliense, São Paulo.

Castells, M (1974) Movimentos Sociales Urbanos. Mexico, Siglo XXI.

Castells, M (1980) Cidade, Democracia e Socialismo. Rio, Paz e Terra.

Castel, R (1978) O Psicanalismo. Rio, Graal.

Castel, R et al (1982) The Psychiatric Society. New York, Columbia Univ. Press.

Castoriadis, C (1975) L'Institution Imaginaire de la Societe, Paris, Seuil.

Cavalcante, JM (1983) Novas Formas de Atuação no CPPII, in A Saúde no Brasil 1 (3), jul/set. Ministério da Saúde, Brasília.

Cerqueira, L (1984) Um Orgão Coordenador de Saúde Mental para o Rio de Janeiro, in Psiquiatria Hoje, ano 9, n 2, Rio de Janeiro.

Cesarino, AC (1989) Uma Experiência de Saúde Mental na Prefeitura de São Paulo (Projeto de Ações Integradas da Saúde Mental na Zona Norte do Município de São Paulo: uma gestão democrática de um projeto público de saúde mental), in Saude e Loucura 1, São Paulo, Hucitec.

Cesarino, AC et al (1985) Projeto de Ações Integrads de Saúde Mental na Zona Norte do Município de São Paulo - diretrizes gerais, conteúdo e configuração atual, in Rev. Associação Bras. de Psiquiatria, vol 7, n 27: 131-39.

Chaui, M (1984) Repressao Sexual - essa nossa (des)conhecida. São Paulo, Brasiliense.

Chesler, P (1974) Women and Madness. London, Allen Lane.

Chodorow, N (1978) The Reproduction of Mothering. London, CIS

Cirino, OAA (1985) 'O que foi feito de nós' - pesquisa sobre egressos do CPP-FHEMIG. CPP, Belo Horizonte, mimeo.

Coimbra, CMB (1989) A Supervisão Institucional como Intervenção Sócio-Analítica, in Psicologia, Ciência e Profissão. ano 9, n 1, Brasília.

Coimbra, MAES (1983) Welfare Policies and Peripheral Capitalism: the case of nutrition policy in Brazil. PhD Thesis, Univesity of Manchester.

Coimbra, MAES (1986) As Políticas Sociais no Brasil. Seminário de Serviço Social/AIS. CEDEPLAR, Belo Horizonte, mimeo.

Collares, C e Moyses, MPA (1985) Educação ou Saúde? Educação x Saúde? Educação e Saúde, in Fracasso Escolar: uma questão médica?, in Caderno CEDES, 15, CEDES/CORTEZ, São Paulo.

Comissao de Saúde Mental - CEBES/RIO (1980) A Psiquiatria no Âmbito da Previdência Social, in Saúde em Debate 10, abr/mai/jun, Rio de Janeiro.

II Congresso de Trabalhadores de Saúde Mental do Estado de São Paulo (1986) Série de boletins de divulgação.

I Congresso dos Trabalhadores de Saude de Minas Gerais (1989) Resolucoes (1/2 junho). Sindi-Saude, Belo Horizonte.

Conrad, P (1981) On the Medicalization of Deviance and Social Control, in D Ingleby (ed) Critical Psychiatry, Harmondsworth, Penguin.

Cordeiro, EG et al (1978) Caracterização de Alguns Problemas Psico-Mentais Verificados na Demanda Infantil de Saúde Mental, in Saúde em Debate, n 7/8, abr/mai/jun, CEBES, Rio de Janeiro.

Corob, A (1987) Working with Depressed Women - a feminist approach. Hants, Gower.

Costa, B (1981) Para Analisar uma Política de Educação Popular. Cadernos de Educação Popular. Petrópolis, Nova/Vozes.

Costa, JF (1979) Ordem Médica e Norma Familiar. Graal, Rio.

Costa, JF (1981) Saúde Mental, produto da educação?, in Saúde em Debate n 11, CEBES, Rio de Janeiro.

Costa, JF (1981b) História da Psiquiatria Brasileira. Rio de Janeiro, Campus.

Costa, JF (1983) A Consciência da Doença Eanquanto Consciência do Sintoma: a 'Doença de Nervos' e a Identidade Psicológica. Instit. de Medicina Social, UERJ, Rio de Janeiro, mimeo.

Costa, JF (1984) Violência e Psicanálise. Rio, Graal.

Costa, JF (1989) Psiquiatria Burocrática: duas ou tres coisas que sei dela. Instit. de Medicina Social, UERJ, Rio de Janeiro, mimeo.

Costa, JF (1989) Psicanálise e Contexto Cultural - Imaginário Psicanalítico, Grupos e Psicoterapias. Rio, Campus.

Costa, JF et al (1984) Algumas Reflexões sobre um Projeto Alternativo de Psicoterapia, in Cad. de Psiquiatria Social, vol 3, n 2, Colônia Juliano Moreira, Rio de Janeiro.

Costa, JF e Birman, J (1976) Organização de Instituições para uma Psiquiatria Comunitária, in Relatórios e Resumos do 2.o Congresso a APPIA - Associação de Psicologia e psicopatologia da Infância e Adolescência, Rio de Jnaeiro.

Costa, NR (1989) Transição e Movimentos Sociais: contribuição ao debate da Reforma Sanitária, in NR Costa et al (ed) Demandas Populares, Políticas Públicas e Saúde I. Petrópolis, Vozes.

Coutinho, DM (1976) Prevalência de Doenças Mentais em Comunidade Marginal: um estudo de Maciel. Tese de Mestrado, UFBa, Salvador.

Cury, CRJ (1986) Educação e Contradição. São Paulo Cortez.

Dalley, G (1987) Ideologies of Caring - Rethinking Community and Collectivism. London, Macmillan.

Da Matta, R (1983) Carnavais, Malandros e Herois - para uma sociologia do dilema brasileiro. Rio, Zahar.

Da Matta, R (1987) A Casa e a Rua - espaço, cidadania, mulher e morte no Brasil. Rio, Ed Guanabara.

Dantro, AC (1965) Analytical Philosophy of History. Cambridge, Cambridge Univ. Press.

DAP/ENSP (1986) Estudo das Políticas e Estratégias de Construção do Sistema de Saúde: perspectivas da reforma sanitária brasileira. Escola Nacional de Saúde Pública, Rio de Janeiro, mimeo.

Deleuze, G and Guattari, F (1977) Anti-Oedipus - Capitalism and Schizophrenia. New York, Viking Press.

Delgado, PG (1982) Alternativas Institucionais em Psiquiatria. Mesa Redonda no Seminário 'Perspectivas da Saúde Mental no Brasil. DINSAM/CPP II, Rio de Janeiro.

Delgado, PG (1984) Do Quarto Forte as Eleições: Breve Itinerário de uma Luta pela Reconquista dos Direitos Civis dos Loucos, in Psiquiatria Hoje, ano 9, n 1, jan/fev, Rio de Janeiro.

Derrida, J (1978) Cogito and the History of Madness, in Writing and Difference. Chigago, University of Chicago Press.

Devereux, G (1970) Essais d'Ethnopsychiatrie Generale. Paris, Gallimard.

Devereux, G (1978) Ethnopsychoanalysis - psychoanalysis and anthropology as complementary frames of reference. Berkeley, Univ. of California Press.

DHSS (1975) Better Services for the Mentally Ill. London, Her Majesty's Stationery Office.

DIEESE - MG (1988) Evolução Salarial dos Trabalhadores da FUNED. Belo Horizonte.

Dinnerstein, D (1976) The Rocking of the Cradle, and the Ruling of the World. London, Souvenir Press.

Donzelot, J (1980) The Policing of Families. London, Hutchinson.

Doyal, L and Gouch, I (1984) A Theory of Human Needs, in Critical Social Policy, vol 10, summer: 6-38.

Dray, WH (1969) Mandelbaum on Historical Narrative, in History and Theory, 8:287-94. Middletown, Wesleyan Univ. Press.

Duarte, CE (1982) A Assistência Psiquiátrica nos Estados - Rio de Janeiro. Mesa redonda no Seminário para Discussão de Modelos Alternativos no Atendimento Psiquiátrico, DINSAM/Colônia Juliano Moreira, Rio de Janeiro.

Duarte, LF (1981) Construção Social da Identidade e Hierarquia em um Grupo de Classe Trabalhadora. V Encontro da Assoc. Nac. de Pos-Grad. e Pesquisa em Ciências Sociais. Nova Friburgo.

Duarte, LF (1986a) Da Vida Nervosa nas Classes Trabalhadoras Urbanas. Rio, Jorge Zahar Editores e CNPq.

Duarte, LF (1986b) What means to be nervous (competing concepts of the Person in Brazilian urban culture). Paper to the XIII International Congress of LASA. Boston, 1986.

Duarte, LF and Ropa, D (1985) Considerações Teóricas sobre a Questão do 'Atendimento Psicológico' as Classes Trabalhadoras. in S Figueira, Cultura da Psicanálise, São Paulo, Brasiliense.

Dumont, R (1983) Essais sur L'Individualisme. Paris, Seuil.

Dunningham, WA (1986) Estudos Epidemiológicos das Relações entre Doenças Mentais e Classes Sociais em Dois Setores Urbanos da Região Metropolitana de Salvador. Tese de Mestrado em Saúde Comunitária, UFBa, Salvador.

Durham, E (1984) Movimentos Sociais e a Construção da Cidadania, in Novos Estudos CEBRAP, n 10, out. São Paulo.

Durham, E (1986) A Pesquisa Antropológica com Populações Urbanas, in E Durham (ed) A Aventura Antropológica - teoria e pesquisa. Rio, Paz e Terra.

Eichenbaum, L and Orbach, S (1982) Outside In ... Inside Out. Harmondsworth, Penguin.

Ellen, RF (ed) (1984) Ethnographic Research - a guide to general conduct. London, Academic Press.

Ely, RG (1969) Mandelbaum on Historical Narrative, in History and Theory 8: 275-83. Middletown, Wesleyan Univ. Press.

I Encontro Estadual de Ambulatórios de São Paulo (1988) Relatório de Pesquisa. São Paulo, mimeo.

Encyclopaedia Britannica (1990) Britanica Book of the Year. Chicago, Univ. of Chicago Press.

Ernst, S and Maguirre, M (ed) (1987) Living with the Sphinx - papers from the Women's Therapy Centre. London, Women Press.

Espinheira, CF (1982) Reorganização da Assistência Psiquiátrica no Âmbito da Previdência Social, in MS/DINSAM/CPP II, 'Perspectivas da Saúde Mental no Brasil', Rio de Janeiro.

Everitt, BS (1977) The Analysis of Contingency Tables. London, Chapman and Hall.

Fausto Neto, AMQ (1982) Família Operária e Reprodução da Força de Trabalho. Petrópolis, Vozes.

Fetterman, DM (1989) Ethnography - step by step. London, Sage.

Figueira, SA (1984) The Study of Psychoanalytic Diffusion. PhD Thesis, University College, London.

Figueira, SA (1985a) Introdução: psicologismo, psicanálise e ciências sociais na 'cultura psicanalítica'. in SA Figueira (ed) Cultura da Psicanálise. São Paulo, Brasiliense.

Figueira, SA (1985b) Modernização da Família e Desorientação: uma das raízes do psicologismo no Brasil, in SA Figueira (ed) Cultura da Psicanálise. São Paulo, Brasiliense.

Figueira, SA (1988) Psicanalistas e Pacientes na Cultura Psicanalítica. in SA Figueira (ed) Efeito Psi - a influência da psicanálise. Rio, Campus.

Figueira, SA (ed) (1985) Cultura da Psicanálise. São Paulo, Brasiliense.

Figueira, SA (ed) (1988) Efeito Psi - a influência da psicanálise. São Paulo, Brasiliense.

Finch, J and Groves, D (ed) (1983) A Labour of Love - Women, Work and Caring. London, RKP.

Fink, A and Kosecoff, J (1985) How to Conduct Surveys - a Step-by-Step Guide. London, Sage.

Foucault, M (1967) Madness and Civilization. London, Tavistock.

Foucault, M (1977) Discipline and Punish. London, Penguin.

Foucault, M (1979) My Body, This Paper, This Fire. in Oxford Literary Review, vol 4, n 1, autumn.

Foucault, M (1984) History of Sexuality I, Harmondsworth, Penguin.

Foucault, M (1986) The Birth of the Clinic - An Archaelogy of the Medical Perception. London, Tavistock.

Foucault, M (1987a) The Politics of Health in the Eighteenth Century, in P Rabinow (ed) The Foucault Reader. Middlesex, Penguin.

Foucault, M (1987b) Space, Knowledge and Power, in P Rabinow (ed) The Foucault Reader. Middlesex, Penguin.

Foucault, M (1987c) Truth and Power, in P Rabinow (ed) The Foucault Reader. Middlesex, Penguin.

Foucault, M (1987d) What is Enlightement?, in P Rabinow (ed) The Foucault Reader. Middlesex, Penguin.

Freidson, E (1970) Profession of Medicine - A Study of the Sociology of Applied Knowledge. New York, Harper and Row.

Freire, P (1972a) Cultural Action for Freedom. Harmondsworth, Penguin.

Freire, P (1972b) Pedagogy of the Opressed. London, Sheed and Ward.

Freire, P (1976) Education, The Practice of Freedom. London, Whiters and Readers Publ. Coop..

Frosh, S (1987) The Politics of Psychoanalysis - an introduction to Freudian and Post-Freudian Theory. London, Macmillan.

Fukui, L and Sampaio, E (1982) Escolarização e Sociedade: um estudo de excluídos da escola, in Educação e Sociedade, ano IV, n 11. São Paulo.

Gallic, WB (1964) Philosophy and the Historical Understanding. N York, Chato and Windus.

Gallo, E and Nascimento, PC (1989) Hegemonia, Bloco Histórico e Movimento Sanitário - em busca de uma teoria. Sao Paulo, Cortez/ABRASCO.

Garnham, N and Willians, R (1986) Pierre Bourdieu and the Sociology of Culture: an introduction. in R Collins et al, Media, Culture and Society - a critical reader. London Sage.

Gazolla, LRA (1986) Implantação de um Hospital Dia na Instituição Pública - relato de uma experiência. V Congresso Mineiro de Psiquiatria, Belo Horizonte, mimeo.

Geraldes, PC (1982) Hospitais Psiquiátricos da DINSAM: Alternativas e Propostas. Mesa Redonda no Seminário 'Perspectivas da Saúde Mental no Brasil, DINSAM/CPP II, Rio de Janeiro.

Geraldes, PC (1984) Avaliação Crítica dos Programas de Saúde Mental no Estado do Rio de Janeiro, in Jornal Bras. de Psiquiatria, 33 (6): 403-6, Rio de Janeiro.

Gerhard, D (1956) Periodization in European History, in The American Historic Review 61: 900-13. Washington.

Giannichedda, MG (1989) 'A normality for us without confinement for them': notes on the association of families of the mentally ill, in the International Journal of Social Psychiatry, 35 (1), Spring: 62-70.

Giordano Jr, S (1988) Algumas Indagações sobre a Saúde Mental na Atenção Primária, in Rev, ABP/APAL, vol 10, n 3: 91-94.

Giordano Jr, S (1989) A Persistência da Higiene e a Doença Mental: contribuição a história das políticas de saúde mental no Estado de São Paulo. Tese de Mestrado, Fac. Medic. USP, São Paulo.

Girardi, SN (1986) O Perfil do 'Emprego' em Saúde no Brasil, in Cad. Saúde Pública, RJ, 2(4): 423-39, out/dez.

Goffman, E (1968) Asylums: Essays on the Social Situation of Mental Patients and Other Inmates.

Harmondsworth, Penguin.

Goldberg, J (1989) Centro de Atenção Psicossocial - uma estratégia. CAPS, São Paulo, mimeo.

Gordon, D et al (1982) Segmented work, Divided Workers: the Historical Transformation of Labour in the United States. Cambridge, Cambridge Univ. Press.

Gough, I (1979) The Political Economy of the Welfare State. London, Macmillan.

Graham, H (1983) Caring: the labour of love, in J Finch and D Groves, The Labour of Love, London, RKP.

Gruner, R (1969) Mandebaum on Historical Narrative, in History and Theory 8: 283-87. Middletown, Weslevan Univ. Press

Guattari, F (1984) Molecular Revolution - Psychiatry and Politics. Harmondsworth, Penguin.

Habermas, J (1972) Knowledge and Human Interests. London, Heinemann.

Hegel, GWF (1977) Phenomenology of the Spirit. Oxford, Clarendon Press.

Hegelberg, M and Lancman, S (1987) História do Movimento dos Trabalhadores da Saúde Mental do Estado de São Paulo. São Paulo, mimeo.

Hexter, JH (1961) Reappraisals in History. Evanston, Ill.

Heydelberg, E et al (1991) Cross Societies, Cooperatives and Social Action - development in community health in Netherlands. Amsterdam, unpublished.

Hoinville, G and Jowell, R (1983) Survey Research Practice. London, Heinemann.

Horwitz, J (1958) Investigaciones Epidemiológicas acerca de Morbidad Mental en Chile, in Rev. Serv. Nac. Salud, 3: 277-91. Santiago.

IBGE (1988a) Perfil Estatístico de Crianças e Mães no Brasil. Rio de Janeiro.

IBGE (1988b) Anuário Estatístico do Brasil 1987/1988. Rio de Janeiro.

Ingleby, D (1983) Mental Health and Social Order, in A Scull and S Cohen, Social Control and the State, Oxford, Martin Robertson.

Ingleby, D (ed) (1981) Critical Psychiatry - The Politics of Mental Health. Harmondsworth, Penguin.

Jacobi, P and Nunes, E (1982) Movimentos Populares Urbanos, Poder Social e Conquista da Democracia, in P Jacobi, Cidade, Povo e Poder. Rio, CEDEC/Paz e Terra.

Jacoby, R (1975) Social Amnesia - a critique of conformist psychology from Adler to Laing. Boston, Beacon Press.

Johnson, TJ (1986) Profession and Power. London, Macmillan.

Jordi, B (1975) Movimientos Sociales Urbanos. Buenos Aires, Siap.

Jovchelovitch, S (1990) Trabalho e Sofrimento Psíquico. Tese de Mestrado. Instit. de Psicologia, PUC-RS, Porto Alegre.

Kaplan, G (1964) Principles of Preventive Psychiatry. London, Tavistock.

Keusen, AL et al (1988) Censo de Pacientes Crônicos, in Cadernos do NUPSO, ano 1, n 2, Colônia Juliano Moreira. Rio de Janeiro.

Kilminster, R (1979) Praxis and Method - a sociological dialogue with Luckacs, Gramsci and the early Franckfurt School. London, Routledge and Kegan Paul.

Kitching, G (1988) Karl Marx and the Philosophy of Praxis. London, Routledge.

Kleinman, A (1980) Patient and Healers in the Context of Culture. Berkeley, Univ. of California Press.

Kuhn, TS (1962) The Structure of Scientific Revolutions. Chicago, Univers. of Chicago Press.

Laclau, E (1979) Politics and Ideology in Marxist Theory. London, NLB.

Laia, SAC et al (1984) Da Liberdade Vigiada ao Projeto 'Guimarães Rosa'. Belo Horizonte, FAFICH, mimeo.

Laing, RD (1960) The Divided Self: an Existential Study in Sanity and Madness. London, Tavistock.

Laing, RD and Esterson, A (1984) Sanity, Madness and the Family - Families of Schizophenics. London, Tavistock.

Lapassade, G (1967) Groupes, Organizations et Institutions. Paris, Ganthier-Villards.

Laplanche, J and Pontalis, JB (1983) The Language of Psycho-Analysis. London, Hogarth.

Lasch, C (1984) Capitalism and Infancy. London, Free Association.

Leal, CP (ed) (1988) A Intervenção nos Hospitais Psiquiátricos do Rio de Janeiro, in Jornal Bras. de Psiquiatria, 37 (4): 217-219. Rio de Janeiro.

Leite, CB (1990) Brazil, in J Dixon and R Scheurell, Social Welfare in Latin America. London, Routledge.

Leme, MAVS et al (1989) A Representação Social da Psicologia e do Psicólogo, in Psicologia, Ciência e Profissão, ano 9, n 1, Brasilia.

Lemert, CC and Gillan, G (1982) Michel Foucault: Social Theory as Transgression. New York, Columbia University Press.

Leon, CA (1950) Prevalência de Transtornos Mentales en un Sector Urbano de Cali, Peru. Cali.

Lewis, J and Meredith, B (1988) Daughters Who Care - Daughters caring for motehrs at home. London, Routledge.

Littlewood, R (1990) From Categories to Contexts: a Decade of the 'New Cross-Cultural

Psychiatry', in British Journal of Psychiatry, 156, 308-327.

Littlewood, R and Lipsedge, M (1982) Aliens and Alienists: Ethnic Minorities and Psychiatry. Harmondsworth, Penguin.

Lo Bianco, AC (1988) Psicologismo e Importação de Teoria - a formação do profissional em psicologia, in Cadernos do NUPSO, ano 1, n 2, nov.. Colônia Juliano Moreira, Rio de Janeiro.

Lopes, JSL (ed) (1987) Cultura e Identidade Operária - aspectos da cultura da classe trabalhadora. Rio, Marco Zero/UFRJ Editoras.

Lourau, R (1975) A Análise Institucional. Petropolis, Vozes.

Machado, LZ (1982) Identidade e Individualismo. XII Reuniao da Assoc. Bras. de Antropologia, Sao Paulo, mimeo.

Magro Filho, JB (1986) Prioridades em Saúde Mental, in Anais da Faculdade de Medicina, UFMG, Belo Horizonte, 35 (1): 39-48, jan/abril.

Malloy, JM (1979) The Politics of Social Security in Brazil. Pittsburgh, Univ. of Pittsburgh Press.

Malloy, JM and Borentzky (1982) Politics, Social Welfare Policy and the Population Problem in Latin America. in International Journal of Health Services, 12, 1: 77-98.

Mangen, S (ed) (1985) Mental Health Care in the European Community. London, Croom Helm.

Mariategui et al (1968) Prevalência de Desordenes Mentales en un Distrito de Lima, in Congresso Boliviano, 2. Congresso Interamericano de Psiquiatria, 5, Bogota, Anais.

Mari, J (1986) Psychiatric Morbidity in Three Primary Medical Care Clinics in the City of Sao Paulo - issues on the mental health of the urban poor. Faculd. Ciencias Medicas da Santa Casa de Sao Paulo, Sao Paulo, mimeo.

Mari, J e Andreoli, SB (1990) Estudo Multicêntrico de Transtornos Mentais - Relatório Preliminar - Setor São Paulo. Escola Paulista de Medicina, São Paulo.

Maris, PJC et al (1982) Avaliação do Projeto Integrado de Saúde Mental nas Regiões Norte e Nordeste do Brasil - PISAM, in Inform. Psiq., 3 (1): 3-9.

Marsella, AJ et al (1985) Culture and Self: Asian and Western Perspectives. New York, Tavistock.

Marsella, AJ and White, GM (ed) (1984) Cultural Conceptions of Mental Health and Therapy. Dordrecht, R Reidel.

Marshall, TH (1950) Citizenhip and Social Class and Other Essays. Cambridge, Cambridge Univ. Press.

Martins, L (1979) A Geração AI-5, in Ensaios de Opinião vol II. Rio, Paz e Terra.

Massadar, CT (1982) Colônia Juliano Moreira: uma história de transformações e repetições. Monografia do Curso de Especialização em Psiquiatria Social, Col. Juliano Moreira/ENSP, Rio de Janeiro.

Mauss, M (1973) Une Categorie de L'Espirit Humain: la notion de personne, celle de moi, in M Mauss, Sociologie et Anthropologie, Paris, PUF.

Mayer, JA (1983) Note towards a Working Definition of Social Control in Historical Analysis, in A Scull and S Cohen, Social Control and the State, Oxford, Martin Robertson.

Medeiros, TA (1977) Formação de Modelo Assistencial Psiquiátrico no Brasil. Tese de mestrado Instit. de Psiquiatria da UFRJ, Rio de Jnaeiro.

Medici, AC (1986) Emprego em Saúde no Conjuntura Recente: Lições para a Reforma Sanitária, in Cad de Saúde Pública, 2 (4): 409-422, out/dez, Rio de Janeiro.

Melo, JAC (1976) As Práticas de Saúde e a Educação, in Saúde em Debate, São Paulo, CEBES, 1 (1).

Melo, JAC (1985) Educação Sanitária: uma visão crítica, in Cadernos CEDES, 4: 28-43, São Paulo.

Mendes, EV (1980) A Evolução Histórica da Prática Médica. PUC-MG, Belo Horizonte.

Mercer, K (1986) Racism and Transcultural Psychiatry, in P Miller, The Power of Psychiatry. Cambridge, Polity.

Mesa-Lago, C (1978) Pressure Groups, Stratification and Inequality. Pittsburgh, Univ. of Pittsburgh Press.

Mesa-Lago, C (1985) The Crisis of Social Security and Health Care. Pittsburgh, Center for Latin American Studies.

Mesa-Lago, C (1989) Ascent to Bankruptcy: financing social security in Latin America. Pittsburgh, Univ. of Pittsburgh Press.

Miles, A (1988) Women and Mental Illness - the social context of female neurosis. sussex, Wheatsheaf.

Miller, P and Rose, N (1986) The Power of Psychiatry. Cambridge, Polity.

MIND (1983) Common Concern - MIND's Manifesto for a Comprehensive Mental Health Service. London, MIND.

Ministério da Saude (1988) I Conferência Nacional de Saúde Mental - relatório final. Brasília.

Miranda, GV et al (1987) Movimento de Mulheres, in MJ Pompermayer (ed) Movimentos Sociais em Minas Gerais. Belo Horizonte, Ed UFMG.

Mishra, R (1981) Society and Social Policy: theories and practice of welfare. London, Macmillan.

Mitchell, J (1974) Psychoanalysis and Feminism. Harmondsworth, Penguin.

Moffatt, A (1980) Psicoterapia do Oprimido. Cortez, Sao Paulo.

Montero, P (1985) Da Doença a Desordem - a magia da umbanda. Rio, Graal.

Moreira, D (1980) Assistência Psiquiátrica em Minas Gerais. Fundação Joao Pinheiro, Belo Horizonte.

Moscovici, S and Farr, M (1984) Social Representations. Cambridge, Cambridge Univ. Press.

Moser, CA and Kalton, G (1971) Survey Methods in Social Investigation. Hants, Gower.

Motta, J (1989) O Hospital-Dia no Instituto Raul Soares - uma possibilidade. Monografia do Curso de Especialização em Enfermagem Psiquiátrica, UFMG, Belo Horizonte.

Movimento por Uma Sociedade sem Manicômios (1988) 'Retrocesso no Atacado'. Manifesto do Encontro Paralelo ao Congresso da Assoc. Brasileira de Psiquiatria, Vitória, Out.

Moyses, MPA et al (1986) Desnutrição, Rendimento Escolar, Merenda: uma querela artificial, in FLS Valente, Fome e Desnutrição - determinantes sociais. Cortez, São Paulo.

Murray, R (1988) Life After Henry (Ford), in Marxism Todau, Oct, London.

Murray, R (1991) The State After Henry, in Marxism Today, May, London.

Neupert, RF et al (1988) Os Arranjos Domicialiares das Famílias Matrifocais, in VI Encontro Nacional de Estudos Populacionais - Anais, vol 1. Assoc. Brasileira de Estudos Populacionais, Belo Horizonte.

Nicolaci-da-Costa, AM (1981) 'Privação Cultural', 'Privação Linguística' e Família, in SA Figueira e G Velho, Família, Psicologia e Sociedade. Rio, Campus.

Nicolaci-da-Costa AM (1985) Mal-Estar na Família: descontinuidade e conflito entre sistemas simbólicos, in SA Figueira, Cultura da Psicanalise. Sao Paulo, Brasiliense.

Nicolaci-da-Costa AM (1987) Sujeito e Cotidiano: um Estudo da Dimensão Psicológica do Social. Campus, Rio de Janeiro.

O'Connor, J (1973) The Fiscal Crisis of the State. New York, St. Martin Press.

O' Donnell, G (1988) Transições, Continuidades e Alguns Paradoxos, in FW Reis e G O'Donnel (ed) A Democracia no Brasil - dilemas e perspectivas. São Paulo, Vertice.

Oliveira, F (1976) Questionando a Economia Brasileira: A Crítica a Razão Dualista. Seleções CEBRAP 1, São Paulo.

Oliveira, JAA (1989) Reformas e Reformismos: para uma teoria política da Reforma Sanitária, in NR Costa et al (ed) Demandas Populares, Políticas e Públicas em Saúde, Petrópolis, Vozes/ABRASCO.

Oliveira, JAA e Teixeira, SF (1985) (Im) Previdência Social. Petrópolis, Vozes.

Ortigues, E e Ortigues, MC (1989) Édipo Africano. São Paulo, Escuta.

Ortiz, R (1980) A Consciência Fragmentada. Rio, Paz e Terra.

Paim, JS (1986) Ações Integradas de Saúde (AIS): por que não dois passos atrás, in Cadernos de Saúde Pública, 2 (2): 167-183, abr/jun, Rio de Janeiro.

Paiva, PTA (1984) Cinquenta Anos de Crescimento Populacional e Absorção de Mão de Obra no Brasil:

de 1950 a 2000. CEDEPLAR, Belo Horizonte, mimeo.

Paiva, PTA (1985) Crescimento Populacional e Previdência Social no Brasil. CEDEPLAR, Belo Horizonte, mimeo.

Parry, N and Parry, J (1976) The Rise of the Medical Profession: a study of social mobility. London, Croom Helm.

Pearlin, LI and Johnson, JS (1977) Marital Status, Life Strains and Depression, in American Sociological Review, 42 (5): 704-15.

Pereira, WCC (1990) O Adoecer Psiquíco do Subproletariado. Belo Horizonte, Segrac.

Pessoti, I (1988) Notas para uma História da Psicologia Brasileira, in Conselho Federal de Psicologia, Quem é o Psicólogo Brasileiro, São Paulo, EDICON/EDUC/Scientia et Labor.

Plenário de Trabalhadores de Saúde Mental do Estado de São Paulo (1987) Por Uma Sociedade Sem Manicômios (Relatório da 1.a Reunião para o Encontro Nacional de Trabalhadores de Saúde Mental) São Paulo, mimeo.

Pompermayer, M (ed) (1987) Movimentos Sociais em Minas Gerais - emergência e perspectivas. Belo Horizonte, UFMG.

Poster, M (1978) Critical Theory of the Family. New York, Pluto Press.

Rabinow, P (1987) Introduction, in P Rabinow (ed) The Foucault Reader, Harmondsworth, Penguin.

Rack, P (1982) Race, Culture and Mental Disorder. London, Tavistock.

Ralph, DS (1983) Work and Madness: the rise of community psychiatry. Montreal, Black Rose Books.

Ramon, S (1985) The Italian Psychiatric Reform, in SP Mangen (ed) Mental Health Care in the European Community. London, Croom Helm.

Ramon, S (1986) The Category of Psychopathy: its professional and social context in Britain, in P Miller and N Rose, The Power of Psychiatry. Cambridge, Polity Press.

Ramon, S (1987) The Making of a Professional Culture: Professionals in Psychiatry in Britain and Italy since 1945, in L Hantrais and S Mangen, Doing Cross-National Research n 3, Aston University, Birmingham.

Ramon, S (1990) The Relevance of Symbolic Interaction Perspectives to the Conceptual and Practical Construction of Leaving a Psychiatric Hospital. Social Work and Social Sciences Review, vol 1 (3), 1989/90, London.

Ramon, S (ed) (1991) Beyond Community Care: normalization and integration work. London, Macmillan.

Ramos, CL et al (1989) Quem Educa Quem? Repensando a relação médico-paciente, in NR Costa et al (ed) Demandas Populares, Políticas e Públicas e Saúde. Petrópolis, Vozes/ABRASCO.

Ramos, LR et al (1987) Envelhecimento Populacional: uma realidade brasileira, in Rev. Saúde Pública,

21 (3):211-24. Sao Paulo.

Rati, RMS (1986) Evolução Histórica das Políticas de Saúde Mental em Minas Gerais - o caso do Instituto Raul Soares. Monografia ao Curso de Especialização em Saúde Pública, Fac. de Farmacia e Bioquímica, UFMG, Belo Horizonte.

Resende, H (1987) Política de Saúde Mental no Brasil: uma visão histórica, in SA Tundis and NR Costa (1987) Cidadania e Loucura - Políticas de Saúde Mental no Brasil. Petrópolis, Vozes/ABRASCO.

Ritter, H (ed) (1986) Dictionary of Concepts in History. N York, Greenwood.

Ropa, D e Duarte, LF (1985) Considerações teóricas sobre a questão do 'atendimento psicológico' as classes trabalhadoras, in SA Figueira, Cultura da Psicanálise. São Paulo, Brasiliense.

Rothman, DJ (1983) Social Control: the uses and abuses of the concept in the history of incarceration, in A Scull and S Cohen, Social Control and the State, Oxford, Martin Robertson.

Rubinstein, D (1981) Marx and Wittgenstein: social praxis and social explanation. London, Routledge and Kegan Paul.

Saidon, O (1982) O Grupo Operativo de Pichón-Riviére - guia terminológico para construção de uma teoria crítica dos grupos operativos. in G Baremblitt, Grupos - teoria e técnica. Rio, Ibrapsi.

Salem, T (1981) Mulheres Faveladas: 'com a venda nos olhos'. Rio, Zahar.

Sales, JR (1989)Estudo sobre a Clientela de Saúde Mental em Varginha. In Psicologia, Ciência e Profissão, ano 9, n 2. Brasília.

Sampaio, JJC (1979) Reflexões em Torno de uma Psiquitria Alienada. Dep. Psiquiatria de Univ. Federal do Ceará. Fortaleza, mimeo.

Santana, VS (1982) Estudo Epidemiológico das Doenças Mentais em um Bairro de Salvador, Série de Estudos em Saúde, Secret. de Saúde do Est. da Bahia, Salvador.

Santana, VS e Almeida Filho, N (1987) Alcoolismo e Consumo de Álcool: resumo de achados epidemiológicos, in Rev. ABP-APAL, vol 9, n 1, 15-22.

Santana, VS, Almeida Filho, N e Mari, JJ (1988) Revisão de Estudos Epidemiológicos em Saúde Mental no Brasil I e II, in Jornal Brasileiro de Psiquiatria, 37 [(5): 227-31] [(6): 291-95].

Santos, D e Busnello, EA (1986?) Cuidados Primários em Saúde Mental. Programa de Educação Continuada da Sociedade Bras. de Psiquiatria, n 4, vol 6. São Paulo, Medisom.

Santos Filho, L (1947) História da Medicina no Brasil. Col. Brasiliana, São Paulo, Brasiliense.

Santos, NRO (1984) A Respresentação Social da Doença Mental na Camada Popular - em estudo exploratório de discurso popular sobre a doença mental. Tese Mestrado em Psicologia Social, USP, São Paulo.

Santos, TC (1982) A Difusão da Psicanálise na Família: um estudo de seus efeitos sobre a mulher. Tese Mestrado em Psicologia, PUC-Rio, Rio de Janeiro.

Santos, TC (1984) A 'Mulher Liberada' e a Difusão da Psicanálise, in SA Figueira (ed) Efeito Psi - a influência da psicanálise. Rio, Campus.

Santos, WG (1979) Cidadania e Justiça. Rio de Janeiro, Campus.

Sass, O (1988) O Campo Profissional do Psicólogo, esse confessor moderno, in Conselho Federal de Psicologia, Quem é o Psicólogo Brasileiro? EDICON/EDUC/Sciencia et Labor, São Paulo.

Savassi, M (1984) Caracterização dos Alunos Matriculados em uma Escola Especial. Centro psico-Pedagógico, Belo Horizonte, mimeo.

Scazufca, M (1990) O Usuário de Calmante: um estudo de representações mentais de pacientes atendidos em ambulatórios de saúde mental da Secr. de Est. da Saúde de São Paulo. Tese Mestrado Psicologia, USP, São Paulo.

Scheff, TJ (1966) Being Mentally Ill, London, Weidenfel and Nicholson.

Scheper-Hughes, N and Lovell, A (ed) (1987) Psychiatry Inside Out: Selected Writings of Franco Basaglia. N York, Columbia Univ. Press.

Scherer-Warren, I e Krischke, PJ (1987) Uma Revolucao no Cotidiano: os novos movimentos sociais na America do Sul. Sao Paulo, Brasiliense.

Scull, AT (1979) Museum of Madness: the Social Organization of Insanity in the Nineteenth Century England. London, Allen Lane.

Scull, AT (1984) Decarceration - Community Treatment and the Deviant - a radical view. Cambridge, Polite Press.

Sedwick, P (1982a) Psycho-Politics. London, Pluto Press.

Sedwick, P (1982b) Anti-Psychiatry from the Sixties to the Eighties, in WK Gove, Deviance and Mental Illness. London, Sage.

Shidlo, G (1990) Social Policy in a Non Democratic Regime - the case of public housing in Brazil. Oxford, Westview Press.

Silveira, N (1981) Imagens do Inconsciente. Rio, Alhambra.

Silveira, N (ed) (1987) Os Inumeráveis Estados do Ser. Museu do Inconsciente. Hosp. Pedro II, Rio de Janeiro.

SINDI-SAUDE - MG (1989) Resoluções do I Congresso dos Trabalhadores da Saúde. Belo Horizonte, mimeo.

Singer, P e Brandt, V (1980) São Paulo: O Povo em Movimento. Petropolis, Vozes/CEBRAP.

Soares, SSF (1986) Enlouquecer para Sobreviver: manipulação de uma identidade estigmatizada como estratégia de sobrevivência. Tese Mestrado Antropologia, UnB, Brasília.

Somarriba, MM (1988) Participação Popular e Distritos Sanitários. Serie Desenvolvimento de Serviços de Saúde n 3, Brasília, OPAS/OMS.

SOSINTRA (1985) A Readaptação Social do Doente Mental - Coletânea de Palestras . CBCISS, Rio de Janeiro.

SOSINTRA (1987) Coletânea de Palestras. Rio de Janeiro, mimeo.

Souza, AL (1987) Bahia de Todos os Loucos - um estudo de psiquiatria social. Salvador, Contemporânea Editora.

Souza, H e Affonso, CA (1977) Estado e o Desenvolvimento Capitalista no Brasil - a crise fiscal. Rio, Paz e Terra.

Souza, LAG (1982) Classes Populares e Igreja nos Caminhos da História. Petrópolis, Vozes.

Souza, MCG (1983) 'Doenca de Nervos' - uma estratégia de sobrevivência, in A Saúde no Brasil 1 (3) jul/set. Ministério da Saúde, Brasília.

Souza, PR (1989) Quem Paga a Conta? Dívida, deficit e inflacao nos anos 80. São Paulo, Brasiliense.

Szasz, T (1961) The Myth of Mental Illness: foundations for a theory of personal conduct. N York, Hoeber-Harper.

Szasz, T (1963) Law, Liberty and Psychiatry. N York, Macmillan.

Szasz, T (1970) Ideology and Insanity. N York, Doubleday.

Szasz, T (1971) The Manufacture of Madness: a Comparative Study of the Inquisition and the Mental Health Movement. London, Routledge and Kegan Paul.

Tancredi, FB (1979) Aspectos Epidemiológicos do Consumo de Medimentos Psicotrópicos pela População de Adultos do Distrito de São Paulo. Tese Mestrado. Faculd. Saúde Publica da USP, Sao Paulo.

Teixeira, SF (1989) Reflexões Teóricas sobre Democracia e Reforma Sanitária, in SF Teixeira (ed) Reforma Sanitária - em busca de uma teoria. Rio/São Paulo, Cortez/ABRASCO.

Teixeira, SF e Mendonca, MH (1989) Reformas Sanitárias na Itália e no Brasil: comparações, in SF Teixeira (ed) Reforma Sanitária - em busca de uma teoria. Rio/São Paulo, Cortez/ABRASCO.

Thompson, JB (1982) Ideology and the Social Imaginary - an appraisal of Castoriadis and Lefort, in Theory and Society, 11 (5): 659-81, University of Cambridge.

Toynbee, A (1975) Narrative History: the Narrator's Problems. Clio 4: 299-316.

Tsu, TMJA (1986) Busca de Internação em Hospital Psiquiátrico: análise do discurso dos acompanhantes. Tese Doutorado, Instituto Psicologia da USP, São Paulo.

Urry, J (1981) The Anatomy of Capitalist Societies - the economy, civil society and the state.

London, Macmillan.

Vaisman, M (1983) Assistência Psiquiátrica e Previdencia social: análise da política de saúde mental nos anos 70. Tese Mestrado, Instituto de Psquiatria UFRJ, Rio de Janeiro.

Valla, VV e Hollanda, E (1989) Fracasso Escolar, Saúde e Cidadania, in NR Costa et al (ed) Demandas Populares, Políticas Públicas e Saúde, Petropólis, Vozes.

Valla, VV e Siqueira, SAV (1989(O Centro Municipal de Saúde e a Participação Popular, in NR Costa et al (ed) Demandas Populares, Políticas Públicas e Saúde. Petrópolis, Vozes.

Vasconcelos, EM (1985a) O que e a Psicologia Comunitária. São Paulo, Brasiliense.

Vasconcelos, EM (1985b) O Contexto das Políticas sociais no Brasil: 1974-1984. Tese de Mestrado, Dep Ciência Politica, UFMG, Belo Horizonte.

Vasconcelos, EM (1988) Estado e Políticas Sociais no Capitalismo: uma abordagem marxista, in Serviço Social e Sociedade, 28, IX, dez, São Paulo.

Vasconcelos, EM (1989) Políticas Sociais no Capitalismo Periférico, in Serviço Social e Sociedade, 29, X, abril, São Paulo.

Vasconcelos, EM (1991) Avaliação dos Avanços Recentes em Legislação Psiquiátrica no Plano Internacional - uma contribuição ao debate sobre a reforma da lei psiquiátrica no Brasil. No prelo, Jornal Brasileiro de Psiquiatria, Rio de Janeiro.

Vasconcelos, EyM (1987) A Medicina e O Pobre. Sao Paulo, Paulinas.

Vasconcelos, EyM (1989) Educação Popular nos Serviços de Saúde. São Paulo, Hucitec.

Vaus, DA (1986) Surveys in Social Research. London, George Allen and Unwin.

Velho, G (1980) Projeto, Emoção e Orientação em Sociedades Complexas. in SA Figueira (ed) Psicanálise e Ciências Sociais, Rio, Francisco Alves.

Velho, G (1981) Individualismo e Cultura. Rio, Zahar.

Viola, E e Mainwaring, S (1987) Novos Movimentos Sociais: cultura política e democracia: Brasil e Argentina, in I Scherer-Warren e P Krischke (ed) Uma Revolução no Cotidiano? Os novos movimentos sociais na América do Sul. São Paulo, Brasiliense.

Yasui, S (1989) CAPS: aprendendo a perguntar, in Saúde e Loucura 1, São Paulo, Hucitec.

Wainwright, T et al (1988) Day Care in an Inner City, in A Lavender and F Holloway, Community Care in Practice - services for the continuing care client. Chichester, John Wiley and Sons.

Walker, A (1983) Care for Elderly People: a conflict between women and the state. in J Finch and D Groves (ed) A Labour of Love, London, RKP.

Wanderly, LEW (1980) Educação Popular e Processo de Democratização, in A Questão Política da Educação Popular, São Paulo, Brasiliense.

Warner, R (1985) Recovery from Schizophrenia -Psychiatry and Political Economy. London, Routledge and Kegan Paul.

Weissman, M and Klerman, G (1977) Sex Differences and the Epidemiology of Depression. Arch. Gen. Psychiatry 34: 98-111.

White, MG (1965) Foundations of Historical Knowledge, cit in H Ritter (ed) Dictionary of Concepts in History. N York, Greenwood, p 280.

WHO/UNICEF (1978) Conferência International sobre Atención Primária de Salud. Alma Ata.

Wolfensberger, W (1972) The Principle of Normalization in Human Sciences. National Institute on Mental Retardation. Toronto.

Wood, CH and Carvalho, JAM (1988) The Demography of Inequality in Brazil. Cambridge, Cambridge Univ. Press.

World Bank (1988) Brazil - Public Spending on Social Programs: issues and options.

Yin, R (1984) Case Study Research - design and methods. London, Sage.