

UNDERSTANDING MENTAL HEALTH POLICIES: HOW DO STAKEHOLDERS
ADDRESS THE IMPLEMENTATION GAP?

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DEDICATION

For my advisor, Kristen Hill Maher, for your allegiance to human rights, guidance, and for your encouragement; for all the people with mental disorders, for their courage to face their inner challenges and social challenges; for my mother, Norma Souza Sahyoun, and my father, Kalil Sahyoun, for your unconditional love and everlasting support, for my sister Ida Leliana Sahyoun (*in memoriam*) for your support, optimism, light, and inspiration.

We know the images. They are familiar in all histories of psychiatry, where their function is to illustrate that happy age when madness was finally recognized and treated according to a truth to which we had too long remained blind.

-Foucault

Madness and Civilization: a History of Insanity in the Age of Reason

ABSTRACT OF THE THESIS

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by

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Brazil has enacted some mental health policies that are fairly progressive among Latin American countries. However, these policies are not always implemented as designed, particularly the ones addressing psychosocial care programs. This study investigates how Brazilian stakeholders in mental health address the implementation gap in psychosocial care programs targeting adults with severe mental disorders. The main questions are the following: What are the key elements that generate a gap between psychosocial care policy formulation and its implementation? How do institutional processes, fiscal processes, and stakeholders' interests interfere in mental health policy, especially in psychosocial care, and its success? What is the role stigma and health inequalities play in the policy implementation process? Do different stakeholders significantly differ in their perceptions about the process of implementation of mental health policies, particularly in psychosocial care and extant gaps? What are the prognoses for psychosocial care policy implementation in Brazil and what kinds of solutions can potentially help overcome anticipated gaps?

The methodology consists of semi-structured interviews with stakeholders at the national level in Brazil, supplemental participant observation in psychosocial care service providers, and documental research. The stakeholders included in the sample are legislators, policymakers and other representatives of government, consumer of services and family organizations, members of other mental health movements, representatives of professional associations, and academics. The interviews and field notes are analyzed qualitatively by theme. Documents include publications accessed in libraries and those given by stakeholders during data collection process.

The findings show that, although the current Brazilian mental health system has made advances in protecting human rights and including psychosocial interventions, participant stakeholders cited key elements that generate implementation gaps in psychosocial care policies: limitations of programs, services, and psychosocial care interventions, accentuated regional differences with emphasis on low priority for mental health at local levels along with limited accountability of municipalities, significant conflict of interests among stakeholders, and the influence of stigma and inequalities. In addition, stakeholders also indicated an implementation gap in the mental health national policy generated by insufficient investment in primary health care. Although this factor does not cause implementation gaps in psychosocial care policies, it reveals limitations of psychosocial care services, particularly, the insufficient interventions of the Centers for Psychosocial Care (CAPS) in the communities.

Findings also indicate that institutions, fiscal processes, and stakeholders interfere in psychosocial care policy success, resulting in: difficulty in defining common priorities, insufficient investments in psychosocial services, lack of intersectoral actions, deficient psychosocial services

delivery, lack of data from assessments of psychosocial interventions, and lack of legitimacy of the mental health reform at municipal levels.

Finally, the findings also reveal that stakeholders, in general, agree that stigma negatively impacts social and political support and therefore plays an important role in shaping implementation gaps in psychosocial policies, even if stigma does not prevail over other factors. In addition, most of the stakeholders agree that social inequalities, including poverty issues, make implementation gaps more evident, especially in which concerns to limited access to services and limitations of psychosocial interventions to reach ultimate goals such as increasing autonomy and promoting social and labor inclusion.

In summary, Brazilian mental health policy has various limits and implementation gaps, especially taking into consideration the ideals of the new paradigm. Because there are still significant limitations in achieving integration of people with mental disorders into social and community life and their labor inclusion, ultimate goals such as greater autonomy, full citizenship, and the improvement in quality of life for people with mental disorders are still far from becoming a reality.

In terms of policy formulation, I recommend amendments to current policies that incorporate specific goals of psychosocial care based on the evaluation of actual advances and limitations. In terms of policy implementation, I recommend: (a) a more collaborative position among stakeholders; (b) more investment to increase and improve the production of data based on assessment of services to advance planning and executing policies; (c) more investments in psychosocial interventions in general, and particular attention to labor inclusion, such as income generation and Solidarity Economy; (d) more investment in national campaigns of mental health, using resources in the mass media to reach people with different levels of education; and (d) more investments in policies to increase their participation and empowerment.

Although the implementation gap in mental health programs generates negative outcomes for individuals, families and the general society, studies of this gap are still scarce. This study augments the current literature and presents a reasoned analysis of the role of psychosocial care programs in the mental health reform in Brazil.

TABLE OF CONTENTS

	PAGE
ABSTRACT	vi
LIST OF TABLES	xi
ACKNOWLEDGEMENTS	xii
CHAPTER	
1 INTRODUCTION.....	1
2 LITERATURE REVIEW.....	8
New Paradigms in Mental Health and the Features of Brazilian National Policy	8
Mental Health: A Social Problem Challenging Policy Innovations	13
The Role Played by Stigma and Health Disparities in Psychosocial Care	19
3 BACKGROUND ON BRAZILIAN MENTAL HEALTH AND ITS STAKEHOLDERS: WHAT IS THE LANDSCAPE WE ARE TALKING ABOUT?.....	29
Brazilian Mental Health Policies and Legislation	32
Stakeholders and Issue Networks	34
4 METHODOLOGY.....	39
Semi-Structured Interviews.....	40
Stakeholders in the Sample.....	43
Participant Observation	44
Documental Research	50
The Role of My Professional Background in the Study.....	51
Data Analysis.....	53
5 HOW IS IMPLEMENTATION FALLING SHORT?.....	55
Previous Evidence of an Implementation Gap.....	57
Limitations of Programs and Services	58
Service Network.....	58
Access to Services.....	60
Quality of Services and Programs.....	63
Considering Advances	64

Conclusions	65
Limits of Psychosocial Interventions	67
Idealism vs. Pragmatism	67
Financial Resources.....	69
Psychosocial Care Resources	70
Lack of Data.....	75
Considering Advances	76
Conclusions	77
Primary Health Care	78
Considering Advances	81
Conclusions	81
Regional Differences and Municipalities	82
Regional Differences.....	83
Municipalities	84
Conclusions	86
Stakeholder and Conflicts of Interest.....	87
Conflict of Interests	87
Hegemonic Position of the Ministry of Health.....	91
Participation of the Civil Society.....	93
Considering Advances	94
Conclusions	95
Stigma, Prejudice, and Inequalities	96
Stigma and Prejudice as an Obstacle	97
Social and Political Support	98
Influences of Services and Programs on Stigma.....	100
Mental Health and its Association to Gender, Race, and SES.....	101
Considering Advances	105
Conclusions	106
Summarizing Themes.....	107
Patterns and General Summary	110
6 INSTITUTIONS AND PROCESSES OF IMPLEMENTATION AS IMPEDIMENTS TO POLICY SUCCESS.....	116

Stakeholder Conflicts.....	117
Institutions	124
Fiscal Processes and Priorities.....	136
7 OBSTACLES OF STIGMA, PREJUDICE, AND INEQUALITIES.....	143
8 CONCLUSIONS AND RECOMMENDATIONS	156
REFERENCES.....	162
APPENDIX	
A HIERARCHY OF GOVERNMENTAL OFFICES IN THE SECRETARIAT OF ATTENTION TO HEALTH/BRAZILIAN MINISTRY OF HEALTH	167
B INSTRUMENTS OF RECRUITMENT PROCESS.....	169
C INTERVIEWEES AND RESULTING ISSUE NETWORKS.....	175
D INTERVIEW GUIDE.....	177

LIST OF TABLES

	PAGE
Table 1. Brazilian Psychosocial Care Policies from 2001 to 2006.....	34
Table 2. Interviewees, Institutions They Represent in the Present Study, and the Role They Have in Mental Health Policy	56
Table 3. Interviewees, Their Types of Involvement, and Resulting Issue Networks.....	176

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CHAPTER 1

INTRODUCTION

Mental health systems of care have changed progressively worldwide. Comparing the current trends to former mental health systems of care, many countries have made countless improvements toward a more humane approach and more effective treatments, including psychosocial assistance. In the last half century, countries have formulated and implemented policies that transition mental health care according to their particular socioeconomic and cultural features. By “transitioning” care I refer to the process that moves from treatments offered almost exclusively by totalitarian institutions of custodial care for mental illnesses—the so-called asylums—to the promotion of community-based systems of care for mental health.

Although based on legitimate human rights motivations and an ever-growing number of studies showing the effectiveness of the new modes of treatment, mental health care reform has surely not been an easy or fast process. Overall, it has demanded intense activism from professionals and sympathetic sectors of civil society, who have continuously struggled for supportive legislation and socio-political support in regional or local levels.

In fact, the high burden of mental and behavioral disorders and associated disabilities has not been enough to significantly increase the overall low priority governments give to mental health. According to the World Health Organization (WHO) “The World Health Report 2001 - Mental Health: New Understanding, New Hope” (2001d), these disorders affect more than 25% of the world’s population at least once in their lifetime. The report also states that for the year 2000 unipolar depressive disorders were the fourth leading cause of disability-adjusted life years (DALYs) and the first leading cause of years of productive life lost due to disability (YLDs) among all diseases, all people, and all ages. This report also estimates that in 2020, if current trends continue, depression will become the second leading cause of DALYs lost.¹ For DALYs, unipolar depressive disorders are

¹ According to WHO’s health information systems and statistics at WHO’s website (2007) (<http://www.who.int/healthinfo/boddaly/en/print.html>), DALY is defined as “a health gap measure that extends the concept of potential years of life lost due to premature death (PYLL) to include equivalent years of ‘healthy’ life lost by virtue of being in states of poor health or disability.”

followed by schizophrenia as the eighth and bipolar affective disorders as the ninth leading causes. In the case of YLDs, these disorders follow similar trends, in which schizophrenia is the seventh and bipolar affective disorders the ninth leading causes. In addition, the Üstün et al. study (as cited in WHO, 2001d) points out that active psychosis was the third leading cause of disability (higher than paraplegia and blindness) among physical and mental conditions in that segment of the population included in a 14-country study.

It is also important to note that mental health involves far more than strictly a health issue, thus making the scenario even more complex. Mental health can also be considered a social problem, and like other social problems, the priority given to mental health in political agendas is also vulnerable to the influence of public opinion rather than to the accomplishment of its own demands and urgency for action. In addition, social problems are also susceptible to the influence of ideologies, cultural mores, and social representations which affect the desired socio-political support and policy implementation processes.

From this perspective, even today, mental health still suffers significant influence from a long history of discrimination and stigma associated with mental disorders. In a history of oppressive and ineffective long-term treatments carried out by the asylums, stigma, as a crystallized mind-set, generated negative attitudes toward people with mental disorders, attitudes that are deeply entrenched in the general public.

According to the Labeling Theory, stigma is defined as constructed psychiatric labels and negative stereotypes that lead to behavioral and cognitive consequences, producing social discrimination and negative clinical and socio-economic outcomes for people with mental disorders (Link, 1982; Markowitz, 1998; Rosenfield, 1997). There is a comprehensive literature about stigma, and scholars from different disciplines within at least the last four decades show the significant and negative role stigma plays on the social inclusion of people with mental disorders, mental health policies, treatments, and related outcomes (Goffman, 1963; Kelly, 2006; Link, Cullen, Frank, & Wozniak, 1987; Link, Struening, Cullen, Shrout, & Dohrenwend, 1989; Martin, Pescosolido, & Tuch, 2000; McSween, 2002; Mechanic, 1995; Morral, & Hazelton, 2004).

Therefore, more emphasis should be given to the production of scientific information and its access by the communities in general. It is fundamental to build an understanding which can be contrasted to misleading positions toward mental illness present in the general population, including among politicians, legislators, and policy makers. As Michels (1995) states:

The public . . . often believes that mental illness results from defects of “character”, “willpower”, or from intentional behavior or moral flaw. While most people acknowledge that “others” may develop mental disorders, they generally underestimate their own personal risk. They believe that mental illness is relatively unresponsive to treatment and often suspect that it is associated with violent, criminal, antisocial—or at least undesirable—behavior. In fact, every one of these beliefs is untrue . . . however, the political process is more responsive to public opinion than to scientific truth, and public opinion holds mental illness to be “different.” (pp. 193-194)

Greater access to information about mental health by the general public could play an important role in increasing the political and social interest in mental health and in diminishing the typical strangeness associated with issues of mental disorders. Together, these factors could generate a more favorable scenario to gain the needed support and priority in political agendas. In the view of some experts such as Levav, Restrepo, and de Macedo (1994) and Patel (2001) the generation and the subsequent access to aggregated systematic information might increase governments’ investments in national mental health policies and budget allocation to delivery of services. Thus, epidemiological studies, clinical trials, evidence-based practices, but also implementation research may offer a valuable rationale to increase governments’ priorities for mental health.

It is a vicious cycle. Governments—especially in developing countries—fail to recognize the prevalence of mental disorders and their associated disabilities, the seriousness of mental health, and how under-investment in effective care systems might negatively affect development. This failure inhibits the allocation of resources for research and policy implementation, thereby diminishing possibilities to generate and distribute better information. Subsequently, low access to information maintains the lack of awareness by the public, reinforcing the stigma and discrimination that keep governments from according mental health high priority.

This study therefore intends to contribute to the production of knowledge and information that could lead to improvements in mental health care reforms. It explores which elements of policy processes—from formulation to implementation—limit or advance mental health care reform in Brazil, particularly its related psychosocial care policies, in the view of a diverse group of stakeholders with exposure to the policies. According to Bolis (2002), author of a key Pan American Health Organization (PAHO) document, Brazil has been following the recommendations of the Caracas Declaration implementing “a fertile legislation reform” (p. 12).² If Brazil has been a “good example” of reform and

² The Caracas Declaration aimed to the creation of main guidelines to policies and care systems as well as the creation of means of cooperation among countries in the region of the Americas. Highlighting the new paradigm in mental

yet still has implementation problems, research on what is not working in Brazil may be an especially important case to help understand the landscape of mental health policies in Latin America and the Caribbean region more generally.

This study is grounded in the idea that the production of a systematic knowledge of implementation gaps and their causal factors will help improve mental health sector reforms in Brazil. Thus, early recognition of limitations, gaps, and obstacles opens the way to finding solutions which more fully implement psychosocial care policies, and more effectively deliver services.

Although the implementation gap in mental health policies generates negative outcomes for individuals, families, and society, studies of this gap in Brazil are scarce. The Brazilian scientific literature that most approximates “implementation studies in mental health” focuses on mental health workers’ issues, evaluation of services within mental health facilities, particularly the Centers for Psychosocial Care (CAPS), and evaluation of clinical or psychosocial intervention and their outcomes. Moreover, this literature was more focused on single regions or local experiences and not on national features. These trends not only reflect the independent research available in scientific journals but also the research funded by the Brazilian federal government as shown in the 2003-2006 mental health report from the Ministry of Health.³

This paper augments Brazilian literature in mental health by explicitly conducting implementation research based on the perception of diverse stakeholders regarding mental health care reform, psychosocial care implementation, and the influence of stigma and health inequalities in Brazil. This study also utilizes the Modified Labeling Theory to support explorations on stigma. There are still very few studies evaluating the implementation of mental health policies which involve the participation of the primary, active stakeholders at different levels of the implementation process, and particularly the stakeholders that are at the bottom level of mental health policies, or in other words, stakeholders who also access services delivered. The present study will help to fill this gap by including the voice of members of consumer of services and family organizations.⁴ Indeed, their participation in studies as

health, the declaration has a strong emphasis on the substitution of the central role occupied by traditional psychiatric hospitals for community based systems offering a network of services in mental health. According to the same PAHO document, the Caracas Declaration was signed in November 1990 by Latin American countries especially aiming at “promoting the respect for the human and civil rights of the mentally ill, and at the restructuring of psychiatric care on the basis of primary health care under the framework of local health systems” (Bolis, 2002, p. 1).

³ For further information on this report see http://portal.saude.gov.br/portal/arquivos/pdf/relatorio_gestao_saude_mental_2006.pdf

⁴ The term consumer(s) of services refers to people with mental disorders who access mental health services for their

members of active organizations for health care reform and human rights is essential to helping overcome the historical barriers of stigmatization and the socio-political exclusion of people with mental disorders.

Furthermore, considering that mental health is not just an issue for those with mental disorders but a socio-economic problem that affects the whole society, more effective and comprehensive policies are necessary. This study examines the fate and challenges of a progressive policy effort in Brazil to deinstitutionalize psychiatric care and implement a community-based mental health system which includes policies to assure full citizenship for people with mental disorders. Ultimately, the achievement of these policy goals will require involvement of various social and political actors such as advocacy groups, policy makers, legislators, mental health professionals, general private sector and entrepreneurs, academics, and organized civil society.

This study's main questions are therefore the following: What are the key elements that generate a gap between psychosocial care policy formulation and its implementation? How do institutional processes, fiscal processes, and stakeholders' interests interfere in mental health policy, especially in psychosocial care, and its success? What is the role stigma and health inequalities play in the policy implementation process? Do different stakeholders significantly differ in their perceptions about the process of implementation of mental health policies, particularly in psychosocial care and extant gaps? What are the prognoses for psychosocial care policy implementation in Brazil and what kind of solutions can potentially help overcome anticipated gaps?

Having these questions as a point of departure, I expect that there is a significant gap between mental health policy formulation, particularly regarding psychosocial care policies, and its practical implementation in Brazil. There is also an expectation that the implementation gap in psychosocial care policies is largely attributable to limits in the role of institutions at the various levels of policy implementation, limits of fiscal processes, and stakeholder's conflict of interests, including the influence of their political powers. In addition, I expect that the implementation gap is also shaped by inequalities in access to care that reflect more general types of inequality in Brazil, including socio-economic status, race, and gender. The overlap of stigma for mental disorders and social inequalities might negatively

treatment, including psychosocial rehabilitation resources. In Brazil, the term *usuários* (users) is used instead to refer to the same people. Although in Brazil this term was chosen to avoid other terms that already carried stigma, the term "users" is not used in this manuscript in order to avoid negative connotations which the term may have for English speakers.

affect the access to health, the socio-political support for psychosocial care programs, and subsequently the relative priority of mental health policies at the national level.

In order to examine the above questions, I used three main sources of data: (a) documental review of governmental and other documents representing current positions of stakeholder institutions regarding mental health care reform, (b) semi-structured interviews with 15 stakeholders in mental health policies in Brazil, and (c) participant observations of the actual implementation of psychosocial care programs in two facilities.

The semi-structured interviews represent the main methodological instrument in the study as the objective of their use is to gather as much information as possible about mental health policies in Brazil from the perspective of different stakeholders involved, especially in regard to the different positions they take about the implementation process. For the purposes of this study, the participant observation is a supplemental methodology. Even if the study primarily targets stakeholders' perception about policy implementation, I expect that observation at the street level of implementation will provide me personal contact with psychosocial care programs and their features, strengths and weaknesses, successes and limits. In addition, I expect that these observations will contribute to my understanding of the level in which psychosocial care policies are shaping the success and limitations of these programs. On the other hand, I also expect that the same observations will reveal how these interventions, in actual practice, challenge what is provided in the formulation of the same policies.

This study consists of eight chapters. The literature review is dedicated to exploring mental health care reform, mental health policy and implementation in Latin America, focusing on Brazil. It includes a description of Brazilian national policy, other correlated legislation, and policy implementation. This manuscript also presents a descriptive chapter about the Brazilian mental health landscape to give readers the necessary information to understand the broad picture of Brazilian mental health—in particular, how it is included in the Brazilian public health system, who the involved stakeholders are, and the what issue networks have resulted. The methodology is described in the forth chapter and is followed by three chapters that discuss the data collected. The fifth chapter, "How is implementation falling short?" presents findings on the key limitations and gaps in mental health care in Brazil, particularly in psychosocial assistance, demonstrating the nature of the implementation gap. The sixth chapter presents arguments and evidence about the institutional and fiscal processes of implementation and stakeholders' interests as impediments to policy success. The seventh chapter argues and presents evidence on how stigma, prejudice, social and health inequalities negatively affect

the implementation of policies. Finally, the last chapter concludes that even taking into account the advances in adopting a mental health system supported by community based services, Brazilian psychosocial care policies present gaps of implementation. Overall, these gaps point to: limitations of programs and services, limits of psychosocial care interventions, accentuated regional differences with emphasis on low priority for mental health at local levels along with limited accountability of municipalities, significant conflict of interests among stakeholders, and influence of stigma, prejudice, and inequalities. Yet according to findings, the nature of these gaps converges into four major themes: stakeholder conflicts, institutional processes, fiscal processes and priorities, and influences of stigma, prejudice, social and health inequalities. Overall, stakeholders differ more in their perceptions about the role played by their interests and institutions processes in the implementation process and less about the role fiscal processes and stigma, prejudice, social and health inequalities play in the same process.

CHAPTER 2

LITERATURE REVIEW

NEW PARADIGMS IN MENTAL HEALTH AND THE FEATURES OF BRAZILIAN NATIONAL POLICY

The beginning of the history of madness as a phenomenon for medical intervention and thus as a disease to be treated coincides with the increasing importance of rationality and the selectivity of the labor force within urban areas in western societies. The process of industrialization and the social demands intrinsic to urban conglomerates inaugurated new sanitation and labor dynamics. In the late eighteenth century, concerned about an appropriate model of recovery for the mentally ill, Phillipe Pinel in France and William Tuke in England unchained the alienated and implemented the so-called “moral treatment” in institutions specially developed for the mentally ill (Basaglia, 1997; Foucault, 1972/2006; Stein, & Santos, 1998).

For approximately two centuries, more prevalent than the moral treatment as a method, the asylum’s popularity spread, encompassing nearly all kinds of psychiatric treatments.⁵ Although various treatments emerged during this era, there is a general approach that characterizes the asylums which I would broadly define as an approach marked by hierarchic relationships between professionals and patients, isolation from social environments and bonds, and a central and quasi-exclusive position of the biomedical model and diagnostic. The strong presence of this approach produced a social logic in which the asylums were the only place able to undertake treatment for mental illness, giving birth to cycles of social exclusion of the mentally ill and reinforcing their stigmatized role in the social realm.

By the 1960s, psychiatric movements emerged, especially in Europe and in the United States, giving a new texture to treatments, incorporating human rights issues, and introducing community-based approaches to mental illness. In this new paradigm, mental health systems of care should include integration into community life and the guarantee of citizenship rights for people with mental disorders. According to Stein and Santos (1998), although the community mental health movement in the US attempted to solve the problem of hospitalization and the Medicaid federal

⁵ In the nineteenth century, for instance, Europe was at the forefront of the progressive emergence of humane treatments for mental illness, particularly in England and France.

program was enacted in 1965, there was an “inability to adequately care for severely mentally ill persons in the community” (p. 10). This also greatly increased the homeless population with mental disorders. Later, there were several social movements, particularly among professionals, that inaugurated models of recovery in the community which would respond to prior unsuccessful.

It seems that what has put the different efforts in different countries on common ground is the understanding that mental illnesses are a multi-faceted phenomenon based on the integration of biological, psychological, and socioeconomic factors. The new trends valued multi or interdisciplinary perspectives, extensive use of community resources, and a therapeutic and cooperative kind of relationship among professionals, patients, and families.

Franco Basaglia, who prompted psychiatric reform in Italy, inaugurated the notions of deinstitutionalization and territory as pillars of the new paradigm. These terms are largely used in the mental health literature and contextualize psychiatric reforms in a territorial network of service of reference, offering resources to enhance the sense of belonging and the promotion of “neighborhood beds” (Dell’Acqua, & Mezzina, 1998, p. 28). Basaglia was also intensely concerned about how available mental health systems were operating in the territory, especially in regard to psychosocial assistance. For him, actions following the new paradigm should go far beyond merely rehabilitation strategies and should additionally aim to achieve autonomy and citizenship for people with mental disorders. As Basaglia (1964) declared:

So all the measures that are now adopted (the Daily hospital and the nightly hospital) . . . may be one of the last steps towards the complete liberation of the rehabilitated patient. In this part-time hospital he can live on two levels: that of the treatment, and that of the re-conquest of a liberty of which he will feel himself master and for which he is responsible. For now, the patient continues to feel this liberty something coming from out side, not as a result of his conquest, so that for a long time, after the abolition of the gratings, within the limits that restrain him materially, he does not go beyond that which [t]he sane have imposed on him: for a long time the pattern of the courtyard remains in his mind, and the open door is to him, for a long time, a closed door. Without realizing it, he now, in his attitude of aggressiveness, completely vindicates his own personal right to personal freedom as a man and as a patient since, by accepting it as a gift from the doctor, he re-falls into a alien relationship of slave-lord. (p. 5)

Gradually, mental illness trends in various countries have shifted from the authoritarian and incarcerating treatment promoted by self-sufficient institutions to the recognition that mental disorders were just one of the elements of mental health. The scope of mental health goes beyond clinical treatment, including psychosocial care, health promotion, education, and human rights. For the

purpose of the present study, understanding of the last four resources is fundamental, highlighting a major focus on psychosocial assistance.

Overall, psychosocial care embraces various services aiming for social inclusion and the achievement of autonomy, and its interventions are expected to be taken into the community and integrated with other resources in the territory. Worldwide, a variety of evidence-based practices and studies (Caldas de Almeida, 2005; Cook et al, 2005; Wright, Gronfein, & Owens, 2000) demonstrate the effectiveness of psychosocial interventions and their potential to overcome the negative effects of institutionalization.

In most countries in Latin America, social movements for the human rights of people with mental disorders were the first political force to launch the discussion in the region, but most of them gained more voice only after periods of dictatorship. Therefore, these movements largely contributed to the emergence of local practices supporting the new paradigm, approximately two decades later than in other western countries.

In Brazil, these first experiences emerged in the late 80s, during the redemocratization period. Mental health professionals associated with social movements were the major political force to lead the advocacy for human rights for people with mental disorders in the country. They were particularly inspired by mental health experiences in the United States and Italy, making their claims for changes in the model of assistance, formulation and approval of new laws and policies toward effective treatments guided by human rights motivations (Medeiros, & Guimarães, 2002; Oliveira, & Alessi, 2005).

The Brazilian experiences were initially concentrated in the Southeast region, particularly in the cities of Santos and Campinas, where local governments greatly supported them. Both sites implemented community care centers, gave priority for psychosocial care, and emphasized consumers' rights and participation in decisions for their treatment as primary steps toward the achievement of citizenship. Unfortunately, these experiences neither impacted the priority given to mental health by the federal government nor the implementation of a greater number of local experiences in other regions.

It was only in 2001 that Brazil enacted the first federal law (law 10.216) establishing a national Brazilian mental health policy.⁶ This law was enacted after a process of intensive discussions among diverse stakeholders for 10 years after its initial presentation in the National Congress. It was primarily the contrary positions and interests between representatives of social movements and of the private

⁶ For the text of this law see <http://www6.senado.gov.br/legislacao/ListaTextoIntegral.action?id=219802>

sector, particularly owners of psychiatric hospitals, that fueled these discussions in a seemingly endless process.

The law 10.216 inaugurated provisions for the new model of assistance for mental health in Brazil, addressing general requirements for the progressive closure of traditional psychiatric hospitals and their replacement with community-based services. In addition, the law also presents substantial recommendations for the protection of human rights for people with mental disorders, being internationally recognized for its extraordinary impulsion given to human rights. With the advent of the law 10.216, Brazil has begun to implement policies for mental health reform, a theme that has gradually gained more ground in the political and social realms.

Before discussing more specific information about Brazilian mental health policy, it is necessary to mention the important role international agencies and global advocacy networks play in lending urgency to the call for action and improvements in mental health systems. Overall, they call for governments to give more priority to mental health, publicizing information, launching campaigns, and giving recommendations. They also call for the support of society in generating information to suit various groups, such as mental health professionals, consumers of services and their families, various social movements, and the population in general. For the purpose of this study, and in recognition of the well known role of the World Health Organization (WHO)/PAHO in aiding pro-mental health actions in the region of the Americas, I focus primarily on data reported by the WHO.

The WHO's definition of mental health, for instance, has contributed to orient discussions about how to adapt policies in the perspectives of the new paradigm: "It is a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community" (WHO, 2001b, para. 3). This definition calls for a non-fragmented approach toward mental health and an effort to bring mental health closer to a practical reality, enabling individuals to think about their mental health as a component of their general well-being and their role in the community. In accordance with the same definition, we can consider mental disorders as a lack of well-being which negatively affects individuals' abilities, their coping mechanisms to deal with stress, their productive work, and their contribution to their community. Therefore, the definition calls for a balanced integration among clinical and

psychosocial interventions based on intersectoral actions.⁷ Unfortunately, the reality of many mental health care systems worldwide is far from this ideal.

For instance, even though research shows that a system of care is more effective for the treatment of severe and persistent mental disorders than isolated treatments in institutional settings, a large number of countries are still investing more in traditional assistance and care. The WHO Project Atlas 2001 (WHO, 2001c) collected data on mental health resources among 185 member-associated countries, showing that about 65% of the beds for mental health care are in psychiatric hospitals, 37% of the countries in the study had no community-based care facilities, and 41% of the same sample of countries had no mental health facilities for severe mental disorders in primary health care. These percentages look even more dramatic if one takes into account the prevalence of mental disorders and the difficulties the population has in accessing effective care.

The WHO (2007) also estimates that 121 million people worldwide are affected by depression, and fewer than 25% have access to effective treatments, 24 million people worldwide are affected by schizophrenia, and more than 50% do not receive appropriate care. In addition, 90% of people with untreated schizophrenia are in developing countries. According to another report, the Mental Health Atlas 2005 (WHO, 2005b), among WHO low-income and lower-middle-income member states, only about 52% of these countries offer community care facilities in mental health, and approximately 74% and 83% (respectively, for low-income and lower-middle-income) of their psychiatric beds are in mental hospitals.

In Latin America, according to Caldas de Almeida (2005) and Funk, Saraceno, Drew, Lund, and Grigg (2004), even though improvements have been made, accessibility to treatment is still a considerable challenge to be overcome. Caldas de Almeida also points to other obstacles in the region such as the hegemony of psychiatric hospitals over community services, and the gap between policies' formulation and implementation.

The data shows the lack of priority in the political agenda for mental health. As I discussed earlier but would like to reinforce here, there is also an overall lack of awareness of associated negative outcomes, including high socioeconomic costs, generated by ineffective system of care in

⁷ In addition to a network of services for needs accessed by people with mental disorders and their families, mental health demands "intersectoral actions," or in other words, mutual collaboration among diverse sectors such as employment, social assistance, social security, art and culture, and sports. In the mental health field, the concept of intersectoral actions has become very popular and is commonly used in the literature, including in the reports of the World Health Organization.

mental health. These costs have a significant impact especially because the greater part of the population with mental disorders is young adults or adults who are part of the productive age population.

In accord with data published by the WHO (2001d)—as it is presented in the introductory chapter of this study—Marmot (2006) states that among adults between 15 and 59 years old, mental disorders are among the top 10 causes of disease burden measured by DALYs in the world. Unipolar depressive disorders are the second highest cause, followed by alcohol use disorders which are the sixth highest cause.

In conclusion, the literature indicates that despite a continuous increase in the credibility of the new paradigm worldwide, there is still a sizeable discrepancy between the ideal and practical achievements such as: (a) access to effective treatments, (b) reduction of the prevalence of mental disorders and associated disabilities, (c) promotion of deinstitutionalization of people with mental disorders, and (d) tackling stigma. Moreover, although there is a common agreement among mental health specialists and research institutions that mental health disorders are universal and that there are no significant differences in the magnitude of mental disorders among developed and developing countries, gaps in accessing mental health care, especially community-based programs, are greater in developing countries.

Consistent with the data available in the literature, this study suggests that research on policy implementation might significantly contribute to the understanding of the factors that are generating the discrepancy between the ideal models and their practical achievements.

MENTAL HEALTH: A SOCIAL PROBLEM CHALLENGING POLICY INNOVATIONS

In this section I will analyze mental health policy from the perspective of the policy-making process with an emphasis on policy implementation, and specifically on how the implementation framework serves as a reference to my study.

The implementation of a network of services is a primary piece in the large puzzle of the new paradigm of assistance and care. Today, a network of services in the community is considered the most effective model to intervene with the multi-faceted properties of mental disorders. Szasz (2003) comments on these properties as “the phenomenology of so-called mental illness, whose manifestations depend upon and vary with the educational, economic, religious, social, and political character of the individual and the society in which it occurs” (p. 48).

Taking into account what I call multi-faceted properties and what Szasz (2003) identifies as the phenomenology of mental illness, mental health systems of care—different from most other kinds of health care—call for intersectoral actions and demand ample sociopolitical support. Additionally, mental health requires a comprehensive range of policies and strategies of implementation.

In contrast to the ideal, the reality of mental health in the world points to the fact that there are few countries that incorporate such needs in their policies, and a large number of others that do not yet even have a mental health national policy. The WHO (2001a) “Mental health policy project: Policy and service guidance package” reveals that over 40% of countries studied have no mental health policy and over 30% have no mental health programs. In addition, the amount governments allocate to mental health illustrates the lack of priority they give to mental health resources. Another WHO (2001c) document “Project Atlas: Mapping mental health resources around the world” also claims that 28% of the countries in their sample of study have no budget dedicated to mental health, and among the ones that do have a budget for mental health, 36% allocate less than 1% of their health budgets. The lack of reported data and accessibility of information also indicates the lack of priority given to mental health. More than 27% of the countries in the same WHO study do not report mental health data in their annual health report. For countries that do report, there is lack of information useful for future planning and implementation.

It was even before all those data were presented that, in a strategy to open up vistas for the urgent need of policies and actions pro-mental health reform in Latin America, the WHO/PAHO and many other international, regional and national institutions co-sponsored the Regional Conference for the Restructuring of Psychiatric Care in 1990 in Caracas, Venezuela. This conference instituted the Caracas Declaration, which represents a benchmark to the actual steps toward mental health system reform in Latin America.⁸ Years later, Bolis (2002) concluded that there were three main impacts of the declaration on mental health legislation in Latin America: (1) the existence of a more organized mental health sector, with development of plans including multisectoral participation—but timid participation of consumers of services—and implementation of mental health programs, but the low priority in mental health is still present with few investments of resources; (2) growing movements to review legislation in mental health, in which the new laws include multidisciplinary cooperation, advocacy, and human and

⁸ For explanation about the Caracas Declaration, see footnote number 2.

civil rights for people with mental disorders; and (3) a remaining deep need of a legal framework that attracts political priority and becomes practically effective.

Indeed, while mental health is still not considered a priority in most of countries, formulated policies need a push from the civil society until continuous support from governments is given and becomes a feasible and sustainable reality. There is surely an increasing production of knowledge about mental health which could contribute to informing society in general and governments about the urgency for action. However, we may ask whether this information is being accessed, and if not, is it because of limitations of access or for lack of interest? If information is being accessed, why is it not producing major impacts on the priority given to mental health? Major organizations in civil society such as international agencies, professional associations, and global networks for human rights might play an important role in investigating information access and promoting effective ways to call attention to the urgency of mental health as a social and political concern.

As a matter of fact, in some places where mental health reforms are flourishing, their successes are, in large part, attributable to the active presence of progressive local sociopolitical forces and parallel support from the local governments. In general, the sociopolitical support gained such strength that local policies were enacted even before a national policy existed. In Brazil, for instance, this was the case in five states, starting with the state of Ceará which enacted its legislation for mental health in 1991—10 years ahead of the Brazilian National Policy—and which today is considered one of the most successful states in implementing mental health reform, including an extensive community-based system and successful interlocution with primary health care in many municipalities.

However, there is also a situation in different countries—which unfortunately has been even more common than the ones cited above—in which mental health national policies are enacted and yet there is insufficient or null investment by local governments, especially where there is little organization of social movements that are promoting mental health reform. The Alarcón and Aguillar-Gaxiola (2000) study of the development of mental health policy in Latin America suggests that the existence of an irregular pattern of community participation in Latin America is mostly due to a lack of information on mental health and economic hardship.

From both previous situations, we can conclude that, from formulation to the delivery of services, politics does affect the implementation process. Sociopolitical dynamics also exert undeniable influence on the availability of funds and budget allocation.

Literature in the policy field could contribute insights into what kinds of barriers play a role in keeping mental health a non-priority despite its high socioeconomic costs and even despite the advances that have been made already in legislation and policy formulation worldwide.

It is important, though, to make clear what kind of approach in policy implementation will be used to support the present study. First, to better frame this study's inquiries, it is essential to contextualize the implementation process within the sociopolitical and cultural realms in which they occur. As Palumbo and Calista (1990) note:

Implementation involves more than just the governmental agencies that are officially responsible for carrying out a program; they involve, in addition, private agencies and groups themselves . . . and, of course, the socioeconomic, cultural, and political conditions in the environment in which policies are supposed to operate. (p. 5)

It is expected that such a vast and federative country as Brazil, presents a national policy that presents variations in policy implementation within its diverse regions. This study recognizes the influence of socio-demographic patterns, economic factors, and political trends on policy implementation. It includes these factors as contextual elements only rather than comparative units of analysis. In other words, for this study, these factors represent the diversity of the environment in which policies operate.

In addition, I shall point out democratic participation and ethics as major bases to contribute to policy formulation and implementation in accordance with community development and also to what is needed in the perception of the target population. Without this consultation, policy may become just rhetoric and ineffective in the practical world. From this perspective, Barret (2004) states:

Increased attention to ethics and social responsibility in the policy process is overdue, and would bring into the implementation debate issues such as the value conflict between professional principles and codes of ethical practice versus the management performance imperatives. . . . Finally, a much neglected area within public services agencies has been the whole arena of social audit and democratic accountability with the consequent attention to the role of consultation, participation and advocacy in the implementation process. (p. 261)

Thus, even though governmental agencies have an essential role in promoting public policies, this study highlights the even more fundamental role of cooperation among different parties involved in the policy implementation process. Cooperation transforms the diversity of interests into productive actions. Even if obtaining consensus among diverse interests makes the pathway toward comprehensive policy and implementation more challenging, ultimately the fair representation of diverse interests contributes to greater social and political support during the policy implementation

stage. Based on these assumptions, this study considers the role played by stakeholders and the cooperation among them as vital elements of analysis.

As a third concern, it is important to consider policy implementation as a dynamic process that goes beyond being just the last step of a problem-solving process. To avoid fragmentation and gaps in policy-making, social and political actors should consider implementation in dynamic relationship with all other phases of policy cycle such as policy design, problem definition, policy formulation, and evaluation. Moreover, implementation is not an end in itself and should be constantly evaluated. From this perspective, the participation of diverse stakeholders throughout the entire policy process generates debates that fuel policy formulation as well as the regulation of policy implementation at the street level, such as delivery of services. Overall, social and political actors should also produce independent and collaborative data which contributes to evaluating and planning actions.

Finally, taking into consideration the dynamic nature of the implementation process, the influence of sociopolitical and cultural factors on this process, and the importance of ethics and democratic participation, implementation research should hold a comprehensive analysis of the different phases of policy implementation. Within these phases, I shall cite the following elements: (1) concepts and orientations present in policy formulation; (2) offices, human resources, and budget available for implementation; (3) methodologies, budget management, and available technologies—including human technology—in delivery of services; and (4) stakeholders' interests. The interaction among these elements can be productive or unproductive to problem solving, affecting goals and outcomes, and might produce implementation gaps.

The identification of gaps and successes in policy implementation is of great value to reorient or reinforce orientations present in policies, contributing to greater efficacy in the problem solving process. Lindblom and Woodhouse (1993) state that: "policy making often proceeds through trial and error. . . . Information generated in the process of implementing programs constantly pushes policy in new directions" (pp. 62-63).

Aiming to evaluate the policy implementation process scholars have developed a framework called implementation research. This framework is applied through different approaches: the top-down or forward mapping, the bottom-up or backward mapping, and the third generation. For the purposes of the present study I use the third generation approach.

According to Goggin, O'M Bowman, Lester, and O'Toole Jr. (1990) the third generation approach—or the communication model—combines both the analysis of negotiations made by

street-level implementers toward governmental representatives from federal, regional, and state levels (bottom-up approach) and the analysis of how federal agencies' personnel communicate with states or local governments (top-down approach). It takes a broader view of the whole range of actors and networks that shape how policy actually works in practice. The third generation approach offers the present study a model for understanding the actual trends of Brazilian mental health reform involving various stakeholders at different levels and associated institutional networks.

From the top-down perspective, this study includes analysis of how mental health national policy influenced changes in mental health care, especially the inclusion of psychosocial assistance. In addition, it is useful to investigate the role played by the Ministry of Health in the implementation process, its relationship with other stakeholders, and the existence or not of intersectoral actions among other ministries, such as Ministry of Labor and Employment, Ministry of Justice, and Ministry of Social Development and Combating Hunger.

From the bottom-up, it is valuable to investigate the effectiveness and limits in the delivery of services, in particular psychosocial care programs, including how they achieve goals and adapt or modify what was intended in original policy formulation. It could be of great value, to identify how human resources, budget allocation and management, access to services or programs, consumer's needs, and advocacy play roles in the implementation process and shape outcomes.

Moreover, implementation studies should include the role played by networks in the execution of policies, the so-called implementation networks. According to Meier and O'Toole (2006) these networks include all kinds of public—sometimes also intergovernmental organizations, as well as private for profit and nonprofit organizations, making policies' institutional settings even more complex and less controllable. As they affirm:

Networks, whether in the United States or elsewhere, can incorporate nonprofit organizations with deeply held values, private sector organizations that theoretically are almost immune to political influences, and other units of government elected by different populations. Lines of command are severed or, at minimum, seriously weakened and stretched, with no single actor given the authority to compel action on the part of others. (p. 127)

From this perspective, the understanding of how nonprofit organizations and the private sector participate in the implementation and delivery of services in mental health in Brazil also might contribute to frame policy patterns, successes, and failures.

Inspired by principles of ethics and democratic participation, the present study aims to investigate the perception of different stakeholders at all levels regarding the implementation of mental

health policy in Brazil, policy process gaps, and potential solutions. It is appalling yet understandable the miserable situation in which people with mental disorders were immersed a hundred years ago. Resources were limited because knowledge was also limited, especially if compared to the aggregated knowledge we have available today. But today, with all of the information available and the demonstrated effective methods of intervention, the lack of access to humane care in mental health and the subsequent violations of human and civil rights for people with mental disorders is unacceptable. As Pressman and Wildavsky (1984) declare:

Implementation failures, in which actual policy results fall short of expected outcomes, are especially painful for target populations, who were supposed to have benefited. At the end of the implementation chain, they are often left with unrealized promises, promises that perhaps should never have been made if they could not have been kept. (p. 211)

THE ROLE PLAYED BY STIGMA AND HEALTH DISPARITIES IN PSYCHOSOCIAL CARE

This section analyzes the role played by stigma and health disparities on the citizenship of people with severe mental disorders and on desired outcomes of psychosocial care. I use “modified labeling theory” as a foundation for this analysis. Complementarily, I present the main international human rights laws addressing mental health and the important role of human rights movements in the struggle for humane and effective treatments in mental health.

Stigma is one of the most challenging obstacles to be overcome in mental health. Within the last two centuries, its social construction produced highly crystallized attitudes toward people with mental disorders. Scholars such as Foucault, Goffman, Castel, Szasz, and Franco Basaglia agree that the stigmatized “madness” is originally a construction of the selective modes produced by industrial society. As Castel states: “The insane is not subject to rights . . . is not able to work . . . does not participate in the regulated exchange circuit” (as cited in Oliveira, & Alessi, 2005, p. 192). Foucault’s analysis of the history of various kinds of confinements is famous worldwide and his concerns about the treatment offered for people with mental disorders also represent a great contribution: “Madness was individualized, strangely twinned with crime . . . between madness and confinement, a profound relation had been instituted, a link which was almost one of essence” (Foucault, 1965, p. 228).

As I mentioned in the first portion of this chapter, institutional treatment for mental disorders was inaugurated by Pinel. At that time, psychiatry claimed to be the only authority to treat mental disorders and thus sanitize society from associated moral risks. One of the major and calamitous consequences of that period—felt until today—was to take from society and families the

co-responsibility to face and to manage mental illness as well as their own coping mechanisms to deal with “irrational” behaviors and emotional sufferings.

Worldwide, the history of treatment for mental disorders has gradually changed, especially because of the existence of various forces, such as the establishing of psychoanalysis and other psychological theories and methods, the spread of human rights movements, and the emergence of therapies based on more communitarian approaches—particularly in England, France, and the United States. Despite all these changes, stigma toward people with mental disorders still persists.

The “modified labeling theory” introduced in the 1980s has greatly contributed to the understanding of how stigma produces the labels attached to people with mental disorders. According to Rosenfield (1997), this theory is a modification of “labeling theory” after critics had argued that stigma was nearly inconsequential. Created in the 60s, “labeling theory” claims that the diagnosis itself of a psychiatric disease would instantly produce the label of “patient”, obscuring all other social roles and producing social rejection. Subsequently, patients would just play this role and avoid social contact, creating a vicious cycle of exclusion and residual deviance. From this perspective, the diagnosis significantly contributes toward producing chronic and persistent mental disorders.

Rosenfield (1997) also asserts that critics of “labeling theory” argue that stigma is mostly transitory and thus cannot cause any illness. For them, social isolation and other negative outcomes are problems directly caused by symptoms intrinsic to mental disorders; these symptoms actually produce positive outcomes, as they are the reasons that people in need seek professional help and treatment.

According to Link et al. (1989), theorists of “modified labeling theory,” individuals, labeled or not, do internalize at different levels discriminatory social conceptions related to the label of being mentally ill. More importantly, patients and non-patients will expect that people with mental disorders will be socially rejected. Different from the first theory, they believe that there are various kinds of reactions from patients to their expected social rejection: secrecy, withdrawal, and education that may produce negative or positive outcomes. The authors state: “Thus, for some patients, labeling and stigma may induce a state of vulnerability that increases their likelihood of experiencing repeated episodes of disorder” (p. 404). Moreover, findings from these authors’ study reveal that the effects of stigma are consistent for both diagnostic groups in the study (schizophrenia and major depression), challenging the notion that stigma and labeling are inconsequential.

Modified labeling theory—especially the Devaluation-Discrimination instrument created by Link, which has a strong empirical base—has been applied in several studies. Most studies show consistency with the findings that stigma does matter and produces negative clinical and social outcomes. Markowitz (1998) studies the effects of stigma on psychological well-being and life satisfaction of people with mental disorders. His findings confirm that anticipated stigma and stigma experiences lead to coping mechanisms such as social withdrawal. In addition, the study's results suggest that a "substantial part of the effect of expected rejection may be due to stigma experiences" (p. 341). Wright et al. (2000) study the effects of stigma on the self-concept of patients with mental disorders during the first two years following the release from psychiatric hospitals in the state of Indiana, US. The results indicate that coping strategies such as social withdrawal are more a function of actual experiences of stigmatization and rejection than of anticipated stigma.

According to the UK700 Group's report (as cited in WHO, 2001d) the quality of life of people with mental disorders, even after recovery, continues to be poor because of the negative effects of social factors such as stigma. In addition, the same report refers to a recent study which demonstrates that among people with severe mental disorders, the unmet basic social and functioning needs were the largest predictors of poor quality of life.

Among the mental disorders, recent studies show substantial discrimination suffered by people with schizophrenia. It might be associated with symptoms such as hallucination and delirium mostly present in schizophrenia, which are also more commonly present in the social representation of madness. "Even though schizophrenia[s] . . . prevalence is relatively low, it is the main cause of disability among people between 15 and 44 years old and also reduces life expectancy about 10 years" (Caldas de Almeida, 2005).

Research conducted by Freitas (1998) in Brazil indicates that in practice most individuals, including mental health professionals, still reproduce exclusion and stigmatization. In this scenario, the role of traditional psychiatric hospitals is reinforced by the social need to have a service that by itself manages people who have the "disruption" of mental disorders. Freitas also found that the majority of admitted patients in a facility in Rio de Janeiro were between 18 and 44 years old, part of the productive age population, and just 4% of them voluntarily sought this service.⁹ Freitas concludes:

⁹ In Brazil, it was the law 10.216 of 2001 which mandated that both involuntary and compulsory admissions in psychiatric hospitals could negatively affect the rights of people with mental disorders, and thus they are conditional upon their communication to the State Public Ministry.

“being in the world as mentally ill is to be limited and subordinated [as] . . . someone who cannot be hired, constitute a family, sign a document, be responsible for their own acts” (p. 103).

The discussion about stigma also calls for continuing investigation of human rights. Overall, it is known that there has been a progressive trend in the world to adopt more humane treatments in mental health. Surprisingly and unfortunately, the WHO (2005a) document on human rights for people with mental disorders reports that there is still a substantial lack of legal protection in the world. It is alarming that in the year 2005, the WHO study found that some countries have poorly protected the human rights of people with mental disorders. WHO also denounces the wide range of human rights violations to which people with mental disorders are exposed:

In some communities, people with mental disorders are tied or chained to trees or logs. Others are incarcerated in prisons without having been accused of a crime. In many psychiatric institutions and hospitals, patients face gross violations of their rights. People are restrained with metal shackles, confined in caged beds, deprived of clothing, decent bedding, clean water or proper toilet facilities and are subject to abuse. (p. 1)

Since the 1990s, international laws or recommendations have been created targeting human rights issues associated with mental disorders. In 1990 the Caracas Declaration included human rights in its recommendations to the region of the Americas. The declaration states that treatments, national policies, and national legislations must include personal dignity, human and civil rights, and the organization of community-based services to guarantee the enforcement of these rights. Recently, the declaration has been used as an authority for reports on human rights and the freedom of people with mental disorders by the Inter-American Commission of Human Rights (IACHR).

In 1991 the Office of the High Commissioner for Human Rights of the United Nations adopted the “Principles for the protection of persons with mental illness and the improvement of mental health care.” Overall, the principles address the right to life in the community, humane standards for care, medication management, patients’ consent to treatment, resources available in mental health facilities, and patient’s right to access to information, such as personal records maintained by mental health facilities.

In Latin America, as cited in previous sections, the legislation for improvement of mental health care and for the guarantee of human rights has increased progressively. In Brazil, the national law 10.216 addresses the reorganization of mental health care, and includes strong human rights provisions.

Even though this law 10.216 and the significant participation of social movements represent great achievements to Brazilian mental health reform, Brazilian scholars point to significant barriers to

reaching policy goals. Maia and Fernandes (2002) studied the role of the Anti-asylum Movement in Brazil, including its important role of claiming the restoration of civil and political rights of people with mental disorders and the need of humane treatments, including vocational rehabilitation and inclusion in the labor market. The authors denounce the substantial socio-cultural barriers faced by this movement: “the integration of people with mental disorders in social environments (such as schools and work places) and the autonomy to decide about their own treatment are highly controversial themes” (p. 164).

Oliveira and Alessi (2005) also conclude that although the claims to citizenship rights in Brazil have been strongly incorporated in the mental health legislation, effective responses have been very shallow. For the authors, the guarantee of citizenship to people with mental disorders is only possible through treatments and psychosocial care processes that effectively aim at the amplification of social networks, work opportunities that are socially valuable, and an increased quality of life. Moreover, the authors critique the role of mental health professionals, who still hold on to positions that reinforce stigma and social constructions associated with the incapacity of people with mental disorders to participate in the social and political sphere. In fact, as mental health professionals are at the end of the implementation process, and are the ones actually offering services to people with mental disorders and their families, this finding also indicates a significant obstacle for policy implementation. Subsequently, it indicates the need for the Brazilian government to massively invest in training and qualification of mental health professionals or even professionals from partner sectors who are involved in mental health programs or actions.

Based on the literature, it can be concluded that stigma affects both the general population and people with mental disorders themselves, producing a vicious cycle between social and self-devaluation, and creating labels that, once attached to people with mental disorders, reinforce social rejection and social withdrawal. From this perspective, stigma might negatively also influence the quality of life and the access to full citizenship rights of people with mental disorders.

Furthermore, the discussion of stigma is also closely related to the discussion of poverty and inequality. Institutionalization and stigmatization are major obstacles for social and labor inclusion, increasing the number of people with mental disorders marginalized with overlapping sources of inequality. One of the major impacts from these processes is the significant participation of people with mental disorders in disability insurance programs. Not neglecting the fairness and importance of the disability insurance for people with mental disorders who are actually disabled, it is important to discuss

the countless cases in which the disability status was given because of stigma and negative outcomes produced by inappropriate and ineffective treatments. If governments had invested in comprehensive mental health care systems, including primary health care, and particularly labor inclusion, most of the disability insurance given to people with mental disorders would not be necessary. This whole situation can be especially aggravated in low-income families, neighborhoods or countries.

As Levav et al. (1994) concluded in their study on psychiatric care restructuring in Latin America:

The impact of [disability] on the largely precarious economies of the countries of the region may contribute to further deepening the hiatus between the goals for social development and the possibility the countries have of attaining these goals. Consider also that families living in adverse economic conditions may see their coping capacities overtaxed by the presence of a member affected by a mental disorder in the absence of immediately available services with which to share the burden. (pp. 73-74)

In the perspective of psychosocial care, the discussion about the negative effect stigma may produce on the unemployment of people with mental disorders and subsequent impoverishment of them and their families is also particularly valuable. Labels attached to mental disorders and associated disabilities might increase social modes of rejection and negatively affect the self-determination and behavior of people with mental disorders, significantly decreasing their chances of employment.

Studies show that independent of the level of development of countries, stigma has affected social opportunities for education, employment, and housing. The Martin et al. (2000) study uses data from the 1996 General Social Survey (GSS) administered by the National Opinion Research Center in the US to analyze public attitudes toward people with mental disorders. Their study shows that 48.4% of all respondents are unwilling to interact with people with schizophrenia, and that the majority of Americans reject the idea of having people with mental disorders as coworkers. Complementarily, in their study about vocational services in the US, Cook et al (2005) indicate that although recent surveys point to a willingness to work with people with mental disorders, their unemployment rate range is between three to five times more than the general population. In the nine years between the 1996 GSS and the Cook et al. study, the labor inclusion of people with mental disorders had not changed significantly in the US.

The literature also indicates that there is a positive relationship between mental health, poverty, and development, which in practice work as a pervasive vicious cycle (Funk et al., 2004; Levav, 1994; Patel, 2001). An epidemiological study by De Lima et al. (as cited in WHO, 2005b) conducted in Brazil demonstrated an inverse relationship among income, schooling, and the

prevalence of minor psychiatric disorders. Patel (2001) argues that societies with large income inequality, high unemployment, and lack of opportunities are most likely to generate mental disorders in their population, which in turn lead to associated disabilities, long-term treatments, and stigma, subsequently leading to impoverishment.

Recently, an increasing number of studies have developed a new approach toward the relation between health inequalities and health policy. There are data showing differences among low and high income countries, or low and high income neighborhoods. The anthropological study of Castro and Singer (2004) shows the importance of political and socioeconomic forces, and their intrinsic relations of power in shaping health, disease, and health care.

Leon and Walt (2001) study the relation between economic and structural adjustments in market economies and health access. The authors discuss that economic reforms, especially in developing countries, have affected the reorganization of the health sector, promoting considerable privatization of health services. In addition, their study points out that privatization tends to increase health inequality because it affects the equity access to services and effectiveness of treatments.

In accordance with the data presented by the former scholars, health inequality represents an important field to be pursued and might bring significant contributions for studies in mental health policy. Today, health inequality is one of the sharpest features present in the real environment faced by health policies.

In the case of mental health, I suggest that stigma and social representation also influence health inequality, especially in situations where other discriminations are overlapped with stigma, as is the case of gender, race, and socioeconomic status (SES). If health inequality has been considered an important limit to health policies in general, it may also contribute to gaps in the implementation of mental health policies.

Finally, it is important to discuss how stigma and social representation in mental health can create barriers to garnering influence, public support, and power in the political arena. The literature shows that compared to other minority groups, stigmatized groups have even less social support and political representation.

Schneider and Ingram (1993) develop a very thought-provoking discussion about how social constructions affect target populations. The authors demonstrate that the social construction of target

groups greatly influence policy designs, and the rationales that support these policies.¹⁰ Moreover, social construction may also influence citizen participation through the messages implied by policies targeting various groups, stimulating political participation among some and inhibiting it among others.

The authors formulate four different categories of target groups: the advantage, contenders, dependents, and deviants. According to these groups' characteristics, I suggest that today people with mental disorders would be characterized as dependents, with the exception of those with associated substance or alcohol use disorders, who are still socially categorized as deviants. For the authors, different kinds of policies are formulated for each of these categories. Thus, people with severe mental disorders—as a dependent group—can be expected to be the target of programs that will not promote representation or autonomy. These programs potentially involve labels, stigmatization, and the dependence of recipients on agencies. The dependent target groups are likely targets of symbolic policies. Schneider and Ingram (1993) conclude:

Symbolic and hortatory tools will commonly be used for dependent groups even when the pervasiveness of the problem would suggest more direct intervention is needed. Groups in dependent category will not usually be encouraged or given support to devise their own solutions to problems but will have to rely on agencies to help them. (p. 339)

The present study suggests that the number of policies and programs in mental health that promote this dependency is still large. Unfortunately, these policies are more symbolic than effective. From this perspective, policies reinforce negative social constructions of people with mental disorders and their self-understanding as people who do not deserve any better. These policies will also have two major negative impacts: they will negatively affect the effectiveness of mental health services and assistance that instead of dependency should essentially promote the autonomy of people with mental disorders; and they will reinforce the powerlessness of people with mental disorders, such as in their under representation in the political agenda and the limited resources allocated to mental health.

At this point, it is important to recall the fundamental role that information and education have for mental health policies. Unfortunately, the myths and misconceptions associated with mental disorders are also present among policy makers (Mechanic, 1995; Scallet, & Havel, 1995). "Most policy

¹⁰ The authors use the definition of social construction of Edelman: "The cultural characterizations of popular images of the persons or groups whose behavior and well-being are affected by public policy. These characterizations are normative and evaluative, portraying groups in positive or negative terms through symbolic language, metaphors, and stories" (Schneider & Ingram, 1993, p. 334).

makers know little about mental illness, share many of the stereotypes of the general public, and feel uncomfortable dealing with mental health concerns" (Mechanic, 1995, p. 77).

Information can greatly contribute to mental health policy-making. Facing stigmatization and the high burden of disease caused by mental disorders, it is necessary that scholars, policy analysts, interest groups, and international agencies inform politicians that people with mental disorders, beyond mere assistance, need dignity, autonomy, and citizenship rights, responsiveness from government, and effective policies.

As Oliveira and Alessi (2005) state:

[Citizenship in mental health] is something much deeper than administrative and legal reforms. . . . It is not just the exclusion of the mentally ill from the society, but also and more important, the acquaintance with a person that can be radically different from social patterns but who should have the right of citizenship. (p. 196)

As many countries still face significant obstacles to guaranteeing the rights of people with mental disorders, Kelly (2006) assertively defends the right to vote for people with mental disorders and the formation of effective interest groups as important mechanisms to enhance people with mental disorders' political participation. She also reasons that discrimination "is linked, at least in part, to the exclusion of individuals with mental illness from social and political decision-making processes, and a subsequent lack of emphasis on mental health at policy levels" (p. 2120).

The literature in stigma and health inequality calls for the participation of governments, organized society, and international networks to create and implement policies that include actions toward the reduction of stigma, social inclusion, and the guarantee of human and civil rights for people with mental disorders.

Dell'Acqua and Mezzina (1998) brilliantly identify the sociopolitical actors that participate in the stigmatization process: "The massive phenomenon of labeling which continues to endure in our society is fed and sustained by this circular process of reverberation between social institutions, the legal system, health institutions, the collective imagination, *clichés* and the mass media" (p. 15). Advocacy and access to information, especially scientific data, is fundamental to reduce stigma and discrimination, and to increase the social acceptability of community-based treatments and the support for psychosocial programs.

Overall, the literature presented in the present chapter converges to highlight the fact that social and political limits faced by people with mental disorders will begin to be overcome when effective policies are fully implemented. Policies should at least include the following: psychosocial

programs; access to services and medicine; production of research, evaluation, and information; human resources training; legislation and human rights; cooperation among different sectors both international and within countries; advocacy and support from the civil society; and consumers of services, families and community participation. Hence, mental health is a multi-faceted field, requiring policies that embrace comprehensive strategies, intersectoral actions, and full commitment of all of the parts involved.

CHAPTER 3

BACKGROUND ON BRAZILIAN MENTAL HEALTH AND ITS STAKEHOLDERS: WHAT IS THE LANDSCAPE WE ARE TALKING ABOUT?

This chapter describes the landscape of Brazilian mental health in terms of its policies, including the national elements which interfere in these policy processes: (1) First, the chapter profiles the general public health system in Brazil—presenting the major principles of the SUS¹¹ as a context for both health and mental health reform movements; (2) Second, the chapter presents major Brazilian mental health policies, particularly policies of psychosocial care; and (3) The chapter also introduces the main stakeholders with an interest in mental health policies and their policy issue networks. Moreover, this chapter focuses on describing policies as written, whereas later analysis will turn to how policies are actually implemented and how practices fall short of policy goals.

The 1988 Brazilian Federal Constitution, enacted six years after the period of military dictatorship, instituted the SUS emphasizing the right to health for citizens and the importance of primary health care. The SUS represents the first great achievement of the Brazilian health reform movement. Already provided for in the federal constitution, the SUS was defined and organized in the law 8080 of 1990. This law institutes the functioning of the SUS and guarantees public health for all citizens based on the principles of universality, equity and decentralization of actions at the three governmental spheres—Union, State, and Municipalities. The law also establishes the complementary participation of the private sector in providing health.¹² In addition, the SUS also entitles community participation through the so-called *mecanismos de controle social* (mechanisms of popular control),¹³

¹¹ The SUS—*Sistema Único de Saúde* (Unified Health System)—is the Brazilian public health system which functions under the principles of universality, decentralization of actions, and community participation, giving the State the responsibility to ensure that all its citizens have the right to access public health assistance. For further information see http://www.sespa.pa.gov.br/SUS/sus/sus_aspgerais.htm

¹² For further information about the law 8080 of 1990 see <http://www6.senado.gov.br/legislacao/ListaTextoIntegral.action?id=111667>

¹³ *Mecanismos de controle social* is an expression used in Brazil to refer to legitimate mechanisms of popular participation in the public sphere. Even if these mechanisms do not have decision powers, they can monitor public actions and suggest areas of priority. From this perspective, the term “mechanism of popular control” is used in this manuscript to

such as the Municipal, State, and National Conferences of Health, and the Local, Municipal, State, and National Councils of Health. At these conferences (held every four years) and councils, the participants indicate the main issues, priorities, and strategies to be pursued according to their major needs within the implementation of health policies. Thus, the different councils and the commissions of the National Council of Health do not execute policies; their participation is limited to only making recommendations.

At the national level, mental health is represented by the General Coordination of Mental Health in the Secretariat of Attention to Health (Secretaria de Atenção à Saúde - SAS) in the Ministry of Health. The main goal of this secretariat and its four departments is to contribute to the formulation and implementation of policies in primary health care and specialized health care. The General Coordination of Mental Health is a program of the Department of Programmatic and Strategic Actions (Departamento de Ações Programáticas Estratégicas - DAPE).¹⁴ Based on the diagram in Appendix A, we note that the General Coordination of Mental Health and its programs are situated within the Secretariat of Attention to Health, among other specific programs. Or, as the Ministry of Health calls them, programmatic and strategic actions toward specific groups of populations which are at risk of not attaining good health, such as women, workers, elders, prisoners, victims of trauma and violence, and so on. Based on the information available at the Ministry of Health website, it is not clear the why mental health is situated as shown, except for the fact that people with mental disorders are considered at risk. On the other hand, mental health seems to include all the other specific groups as well as the larger population, which may indicate that mental health is perceived as a specific program and thus overlooked or out of place within Brazilian official health programs.

Another representation of mental health at the national level is the mental health commission in the National Council of Health, which is not yet provided by law and thus is not a permanent commission. In fact, the commission only has an advisory power and acts when the national council needs advice to decide on mental health issues.

As the General Coordination of Mental Health is a program of the Secretariat of Attention to Health, which also includes primary health, it is worthwhile to discuss the relation between the mental health national policy and programs in primary health care. The Brazilian model for psychosocial care, greatly inspired by the Italian experience and the concept of territory they introduced in mental health,

avoid negative connotations or misinterpretation among English speakers.

¹⁴ For a descriptive diagram of the hierarchy of governmental offices in the Ministry of Health see Appendix C.

offers the Centers for Psychosocial Care (CAPS) as a reference service for mental health. Each center is responsible for a certain geographical area and designed in accordance to the size of the served population. In addition, there are CAPS designed for targeting specific populations such as the CAPS AD for people experiencing alcohol and drug abuse and the CAPS I to serve children and youth with mental disorders. The report from the Ministry of Health (MS, 2007) demonstrates how Brazil has gradually implemented the CAPS. Overall, the federal government gives financial incentives to states and municipalities, and the CAPS should be organized in multidisciplinary teams and receive clinical-institutional supervision to increase the quality of service delivery. The CAPS are also subject to evaluation of service management, effectiveness, and promotion of a good quality of life and citizenship to users. The report presents the following expansion of these services: Between 1980 and 1988, Brazil had its first six CAPS, increasing for a total of 208 CAPS in 2000, 605 CAPS in 2004, and reaching 1011 CAPS in 2006.

Beyond the CAPS implementation, the Brazilian mental health policy embraces several resources based on the ideal to offer a network of services integrated with the territory, such as: primary health care; outpatient services; social clubs; cultural programs; protective homes; and labor inclusion programs, such as vocational rehabilitation, protective employment, and solidarity economy.¹⁵ Therefore, this model proposes a mental health system largely structured on the resources of psychosocial care.

The report from the Ministry of Health (MS, 2007) also includes the expansion of mental health into primary health care as one of the major priorities for 2007-2010. Today, in the municipalities where the CAPS exist, they also implement actions in primary health care along with the so-called primary health teams. Among the municipalities that do not offer CAPS, outpatient services should organize these actions, an ideal which is still far from becoming a reality.¹⁶

¹⁵ According to Singer (2006), "The solidarity economy is a systematic response to the exclusion from the labor market, by those who do not want a society moved by competition in which necessarily emerge winners and losers. It is first of all an ethical, political, and ideological option and happens when excluded people build together entrepreneurs of production, exchange networks, financial institutions, schools, and so on. All these entrepreneurs are motivated to build a solidarity society in which no person is excluded against his own choices" (p. 11). Complementarily, Neamtan (2002) contextualizes: "After the second World Social Forum, which took place in Porto Alegre, [Brazil], in February 2002, where the social and solidarity economy were important themes, it is now clear that this movement is firmly inscribed in an international movement for an alternative globalization" (p. 2).

¹⁶ The outpatient services already existed before the reform and most of them still perpetuate the same culture of institutionalization as in the years before the reform. From this perspective, the report concludes that these services operate without substantial changes and that members of their teams are usually so accustomed to doing the typical outpatient kind of assistance that in general they are not committed to outreach beyond their institutional setting or "walls".

The Brazilian primary health care system is planned and implemented by the Department of Primary Care (Departamento de Atenção Básica - DAB) within the Secretariat of Attention to Health (SAS) and is organized primarily through the Family Health (SF) strategy. According to the Ministry of Health, this strategy has progressively generated positive impacts on the health indicators of attended populations. Beyond their similar hierarchic positions in the Ministry of Health, the mental health and the primary health care also share the inclusion of multidisciplinary teams and their interventions in the communities.¹⁷

BRAZILIAN MENTAL HEALTH POLICIES AND LEGISLATION

Since the law 10.216/2001, Brazil has enacted various administrative rules in an attempt to comprise a comprehensive mental health national policy. In this section I will not present all pieces of existing legislation on mental health, but only the major policies and laws regarding psychosocial care implementation. In addition, I will also cite other policies that, although targeting other ends, somehow affect psychosocial care in Brazil. The importance of accessing these policies and presenting them here is based on the fact that knowledge about policy provisions will enable a better understanding of how Brazilian mental health policy addresses psychosocial care issues. Subsequently, we will have a clearer concept of how the limits of psychosocial care implementation are also associated to limits of policy formulation. All of the following policies were identified through publications accessed through the documental review, especially the previously cited report of the Ministry of Health (MS, 2007).

The law 10.216/2001 mandates rights for people with mental disorders, such as: (1) access to high quality services of treatment, which includes humane assistance and social inclusion, preferably in community-based services; (2) protection against any kind of abuse or exploitation; (3) confidentiality and access to informed consent when involved in any kind of study or research; (4) access to information about his/her diagnosis, treatment, and involuntary admission in psychiatric hospital when it occurs. In addition, institutionalized patients must participate in special programs toward a planned release and concomitant psychosocial assistance. The law also prohibits admission in asylums and regulates the voluntary, involuntary, and compulsory admissions for psychiatric treatment.

¹⁷ The information of the Brazilian primary health care was retrieved from the official website of the Ministry of Health on April/2008. For exhaustive information in English see http://dtr2004.saude.gov.br/dab/docs/geral/developing_primary_health_care.pdf

In 2003, the law 10.708 created and defined the *De Volta para Casa* program with subsequent support of the rule 2.077 in the same year, which regulates this program and the criteria of inclusion of beneficiaries, and the transference of funds. The *De Volta para Casa* creates financial assistance to support the psychosocial care of institutionalized patients who have lived in psychiatric hospitals for at least two years and then returned home. The aid is equivalent to R\$240.00 (240 *reais*, the Brazilian currency) and given every month for a year through automatic deposit made by the federal government to the beneficiary. The aid can be renewed in the cases where full participation in society is still not possible. Moreover, the aid works as an incentive to families to accept members back in the home, alleviating the costs this return would produce.

In 2004, the administrative rule 52 was enacted instituting the Annual Program of the Restructuring of Psychiatric Hospitals Assistance within SUS hospitals. The program targets the gradual and systematic substitution of the care at psychiatric hospitals with the implementation of a community-based care system by the reduction of the supply of beds. Moreover, the budget no longer invested in hospitals must be transferred to mental health programs implemented in the communities and integrated to the territory, such as CAPS, protected homes, outpatient services, primary care, and others.

In 2005, the administrative rule 353 was approved with provisions for the Working Group for Mental Health and Solidarity Economy (Grupo de Trabalho de Saúde Mental e Economia Solidária). This group involves the discussion and planning of intersectoral actions involving the Ministry of Health and the Ministry of Labor and Employment aiming to promote social and labor inclusion. The group includes representatives of the federal and state governments, the solidarity economy, the experiences of labor and income generation in mental health, and consumers of services who participate in labor and income generation programs. Furthermore, these actions include the support for local experiences of income generation created by minority groups—particularly in this case by people with mental disorders—and based on solidarity actions, such as the so-called social cooperatives.

In 2006 the Ministry of Health and the Special Secretariat for Human Rights instituted the rule 3.347/06, creating the Brazilian Group for Human Rights and Mental Health. This group intends to create or improve mechanisms toward attaining human rights for people with mental disorders and producing systematic knowledge of mental health within the scope of human rights.

Information in Table 1 summarizes the policies referred to and their objectives.

Table 1. Brazilian Psychosocial Care Policies from 2001 to 2006

Policy	Objective
law 10.216/2001	Prohibits admission in psychiatric hospitals and mandates concomitant implementation of community-based care and emphasis on psychosocial care for institutionalized patients. Mandates several rights for people with mental disorders.
law 10.708/2003	Creates and defines the <i>De Volta para Casa</i> program based on financial aid for institutionalized patients in their return to home.
rule 52/2004	Institutes the Annual Program of the Restructuring of Psychiatric Hospitals Assistance based on gradual substitution of services and transference of budget from psychiatric hospitals to community-based care.
rule 353/2005	Provides the Working Group for Mental Health and Solidarity Economy which discusses and plans intersectoral actions involving the Ministry of Health and the Ministry of Labor and Employment.
rule 3.347/2006	Creates the Brazilian Group for Human Rights and Mental Health which intends mechanisms toward attaining human rights for people with mental disorders and the production of systematic knowledge in this field.

We may note that Brazil is gradually expanding mental health legislation in the direction of psychosocial and community-based care. More importantly, it is enacting a diverse range of laws and rules that can lead to intersectoral cooperation among social and political actors, such as the involvement of ministries other than the Ministry of Health. If policy implementation actually includes the participation of diverse sectors, Brazil is implementing policies that respect the multi-faceted characteristics of mental health and promoting a mental health system that truly leads to the social inclusion and citizenship of people with mental disorders.

STAKEHOLDERS AND ISSUE NETWORKS

This section aims to offer information about Brazilian stakeholders in mental health: who are they, how they are related to mental health policy implementation, and what are the policy issue networks among them? Information on stakeholders and their issue networks should enable a better understanding of the way mental health is represented in Brazil according to diverse interests and

perspectives. Moreover, it will enable the reader to more clearly understand the picture composed by the stakeholders represented in the sample of this study, which will be presented in Chapter 4.

The literature on policy issue networks investigates and theorizes the way different social and political actors respond to a specific policy issue and the subsequent interorganizational dynamics that are created. According to Skok (1995):

Many scholars in recent years have observed that, to an ever increasing extent, public policy is developed, implemented, and evaluated within specialized policy issue networks—communities loosely composed of specialists representing organized interests, many of which have a stake in the outcome of policy actions. (p. 329)

Forrest (2003) also creatively observes: “Policy decision-making often reflects a multiple actor bouillabaisse of decision-makers and stakeholders stirred in unpredictable and shifting patterns” (p. 594). Thus, it is also expected that networks organized around a specific issue affect the formulation of policies, incorporating the voice of interest groups in the various phases of the policy cycle. But, I suggest the way networks affect policy depends on other elements such as the size of networks, the influence and support they have in a broader social realm, the kind of relation between civil society and the State, and the way certain issues are present in major global trends.

In the case of Brazil, it is important to point out that the stakeholders of the mental health issue networks are responding to a seven-year-old policy that is being implemented in virgin soil. On the one hand, because it is so young, this policy may face more resistance or less support in the political and social realm, and so we can expect that it still has much to do. From this perspective, the Brazilian mental health policy demands hard work from all interested parties. On the other hand, also because it is young, the Brazilian mental health policy began implementation in an era when the global trends in policy-making pointed to the need for less bureaucracy and hierarchical relations and more applied knowledge. Stakeholders should take advantage of this. The knowledge from academic specialists, street-level implementers, and target populations could, if incorporated, greatly contribute to addressing problems in policy formulation, minimizing under representation of various interests, and subsequently, increasing cooperation and opportunities for satisfactory and full implementation.

Prior to discussing the current situation of stakeholders and their interests related to mental health issues, it is important to briefly describe their situation before the mental health national policy was instituted. The following description is based on my own understanding as a mental health professional attained over a number of years and also on the knowledge I gained through the interview

process, when various stakeholders related to me trends and facts from the history of the mental health reform in Brazil.

Overall, before the reform there was a state of acute inequity in which private interests prevailed over public ones and interests were broadly divided between those for and against reform. While human rights violations were widespread in numerous traditional psychiatric hospitals having an incredible number of beds, advocates from civil society worked to raise social and political awareness of mental health issues. These advocates generally included mental health professionals, public health professionals associated with the health reform movement, NGOs working in mental health and a modest number of consumers of services. The political support usually originated from legislators affiliated with more progressive political parties. These legislators helped enact state legislations and bring the debate into the states and national chambers or legislative assemblies at municipal levels. Activists tried to mobilize society by organizing public events, especially on the International Day for Mental Health (October 10th) and on the famous *18 de Maio* (May 18th) in Brazil, which celebrates the National Day of the Anti-Asylum Fight, strongly supported by the National Anti-Asylum Movement. On the other side, there were conservative forces associated with traditional psychiatry, especially the private sector, which owned psychiatric hospitals. Although their fight was silent, it was strongly organized in terms of economic power and their alliance with political forces in the three government spheres. Despite the fact that these forces were apparently in the minority, they were able to sustain the status quo for many years or until the reform had actually been implemented in the country. In some parts of the country, the private sector also gained strong support from family associations that believed the closure of hospitals would actually generate a lack of assistance for their relatives with mental disorders.

After the mental health national policy was enacted in 2001, the hegemony of the private economic interests progressively lost ground. Although still viable, their influence is considerably reduced. This sector is still strongly supported by traditional psychiatry and the owners of psychiatric hospitals. With the creation of a governmental office at the federal level to coordinate the mental health reform, there is also an increasing interest in mental health by political actors at various levels. Even though mental health has more political support today than decades ago, it still faces limits of priority in the political agenda of states and municipalities. Political interests are still closely allied with economic interests by either maintaining a pact with the private sector or launching the reform because of federal fiscal incentives to do so. But, the major interest of the federal government is to maintain resources to

guarantee the implementation of the mental health reform, especially through the implementation of CAPS and gradual incorporation of actions in primary health, which is a goal of all SUS areas of intervention.

In civil society, the Anti-Asylum Movement is still the major national movement that functions as a force to bring together other organizations, especially by promoting conferences, campaigns, and events all over the country. Most organizations are formed by mental health professionals and, as time goes on, may attract other social sectors. There are some professional associations that greatly support the reform such as the Federal Board of Psychology, which promotes actions that work to guarantee human rights for people with mental disorders; it also works to sustain critical debates about mental health reform. There is also a greater number of NGOs that are providing psychosocial care services and also act as advocates, contributing to bring the debate into the social realm.

There are also consumer of services organizations which receive strong support from professionals and college students, especially from psychology, social work, and occupational therapy. In general, there are a limited number of consumers of services that have a history of supporting the reform and advocating, but they stimulate greater consumer of services participation and contribute significantly to debates in mental health reform. However, because most people with mental disorders suffer institutionalization and social exclusion, most consumers of services are only recently engaged in this process. Moreover, in general their engagement seems to be still largely based on broad ideological support for the reform rather than on political awareness about specific mental health policies. Their interests are also more related to guaranteeing access to treatments rather than to their participation in decision-making processes.

In terms of family associations, as they perceive that the reform is offering services of assistance, they have progressively shifted from a more conservative position to one that is more engaged in the debate and actions that favor reform.

In regard to how the pro mental health reform movements are related to health reform parties, they share the goal to implement or improve health systems of assistance integrated into the primary health. Moreover, they support interventions in the community and a close partnership with public and collective health. Unfortunately, in actual practice, there is a diminished dialogue between actors of mental health and health in general, and mental health sector is more centered in its own realm.

There is also the involvement of academics and international agencies in mental health issue networks. It seems that academics interested in mental health reform are people that hold other

positions in this reform. They can be represented in more progressive or conservative positions as they advocate, work in mental health services, or are implementers or consultants for the reform working for one of the governmental spheres. International agencies in Brazil, such as PAHO, are primarily focused, as in other countries, on producing data, promoting regional conferences, and giving recommendations for successful implementation of mental health reform.

Today the Brazilian mental health issue networks involve more progressive than conservative positions toward mental health reform. Although these progressive positions are not uniform, the differences among them do not threaten the legitimacy of the reform anymore. However, depending on how the political power is distributed among those participants in the issue networks, they can change the routes already taken and affect either positively or negatively the kind of reform that has been implemented in Brazil.

CHAPTER 4

METHODOLOGY

This study investigates how Brazilian stakeholders in mental health address the implementation gap in psychosocial care programs targeting adults with severe mental disorders. Prior studies suggest that an implementation gap exists, which is not surprising for a complex and fairly new policy. However, they do not fully explicate the nature, causes, or implications of the gap between policy design and daily practice. The present study aims to do just that. To do so, it asks the following questions:

1. What are the key elements that generate a gap between psychosocial care policy formulation and policy implementation?
2. How do institutional processes, fiscal processes, and stakeholders' interests interfere in mental health policy, especially in psychosocial care, and its success?
3. What is the role stigma and health inequalities play in the policy implementation process?
4. Do different stakeholders significantly differ in their perceptions about the process of implementation of mental health policies, particularly in psychosocial care and extant gaps?
5. What are the prognoses for psychosocial care policy implementation in Brazil and what kind of solutions can potentially help overcome anticipated gaps?

Furthermore, the study seeks to understand how social stigmas of mental disorders and inequalities, including socioeconomic status, race, and gender, make more evident implementation gaps in psychosocial care policies. I expect that both stigma and inequalities negatively affect the social and political support for psychosocial care programs and subsequently the relative priority of mental health policies at the national level.

Therefore, my goal was to investigate the relationship between psychosocial care policies and the actual implemented actions, the effectiveness and weaknesses of these policies, and the influence of stigma and health inequality on their outcomes, according to various stakeholders. To satisfactorily support the investigation I chose to collect qualitative data utilizing the following methods: semi-structured interviews with stakeholders, supplemental participant observation of the actual implementation of policies at psychosocial care service providers, and documental research. As the study targets the understanding of mental health policy implementation at the national level, the

methodology was implemented in three of the five geographic regions in Brazil: southeast, middle-west, and northeast during a period of two and one-half months.

SEMI-STRUCTURED INTERVIEWS

The semi-structured interviews were conducted with 15 stakeholders selected on the basis of a purposive sampling technique, in which, according to Bernard (1994), the unit of analysis chosen provides the information you need. The interviews represent the main methodological instrument in the study as the objective of their use is to gather as much information as possible about mental health policies in Brazil from the perspective of different stakeholders involved, especially in regard to the different positions they take about the implementation process.

I chose semi-structured interviews because they permit a flowing “conversation” or a “free-wheeling quality” (Bernard, 1994, p. 209) with the establishment of an interview guide. The flowing rhythm of the interview allows informants to spontaneously raise their perceptions and beliefs, which are important elements in answering the main inquires of the study toward policy implementation. A guide for the questions enabled me to direct interviewees to talk about major themes of relevance to this study and to conduct a time-sensitive interview, which was appropriate for me since the data collection, occurring in another country, had a strict time frame. Furthermore, Bernard (1994) considers semi-structured interviews a well-suited method when targeting the kind of sample used in this study: “Semi-structured interviewing works very well in projects where you are dealing with managers, bureaucrats, and elite members of a community—people who are accustomed to efficient use of their time” (p. 210).

For the recruitment process, I first made an inventory of the types of institutions potentially involved in mental health policy implementation, including ministries, the Federal Chamber of Deputies, private sector institutions, consumer of services and family organizations and other mental health social movements, mental health professional associations, public universities, and the WHO/PAHO.

To recruit stakeholders I conducted internet searches, visiting governmental and nongovernmental institutions’ websites and identifying appropriate expert stakeholders, contacting them through email or telephone. A total of three stakeholders confirmed their willingness to participate in the study before my departure to Brazil. When I arrived in Brazil, out of all the people I contacted by phone, 12 agreed to participate. Among the different types of refusals to participate in this study, the majority were from people who did not return my email or telephone call. Among the ones who chose not to participate and did return my call or email, some excused themselves because of being out of

town at the time of the interview, others were unavailable due to a full agenda, others for not having the expertise in understanding mental health policies nation-wide, and only one for the nonexistence of any kind of payment for participation. Among those who refused, some gave me referrals for other potential participants. Unfortunately, I did not keep a record of a list of refusals and thus I was not able to determine a refusal rate, but I found that phone calls were more efficient than emails. In an effort to raise interest and trust in the study, along with the recruitment script, I also made available other documents such as my resume and a letter from the Center for Latin American Studies program in which I am a graduate student. Even when the first contact was made by phone, after I presented myself and the study, I asked stakeholders if they were interested in receiving the documents previously mentioned. All stakeholders demonstrated this interest and received an email with the recruitment letter and other documents attached. The recruitment process instruments are available in Appendix B.

Overall, the recruitment process encountered some barriers and took a considerable amount of time. Among the factors that highly contributed to this were (a) In general, stakeholders are busy people and do not have much time available, (b) Some institutions seemed to be just theoretically dealing with mental health policy issues and could not refer any professional who had expertise in these issues, and (c) Representatives from Brasília, the capital of Brazil, presented an even tighter schedule than other participants, especially if they were congressmen or from Brazilian ministries, usually working in the capital just three days a week and in other cities the remaining days.

Surprisingly, it was especially difficult to contact stakeholders at the professional association of nurses and social workers, and at other Ministries such as the Ministry of Social Development and Combating Hunger and the Ministry of Justice. Unfortunately, even though I tried to contact them many times, I did not have the opportunity to include their voice in the sample.

To overcome these barriers I exhaustively followed up all contacts made with stakeholders' offices by telephone. No other person participated as a recruiter. In general, my first contact was made with assistants, secretaries, or whoever organized the agenda of the pre-selected stakeholders, and I spoke with them several times before the appointment was made. Anticipating that most of the stakeholders were busy people, I organized a file with the date and time I was asked to call back.

The final purposive sample included six members of NGOs, three representatives of professional associations, one representative of the Ministry of Health, one representative of the Ministry of Labor and Employment, one representative of the National Commission on Social

Determinants of Health (CDSS), two legislators—including a member of the Commission for Human Rights and Minorities of the Federal Chamber of Deputies, and one member of a state university.¹⁸ Unfortunately, this sample does not include two kinds of institutions: the private sector and the PAHO/WHO. Although I had contacted a temporary representative at WHO and met with her for an interview, she decided that her knowledge would not contribute to the specifics of this study. Among the six NGO members, two people had accessed mental health services for their own treatment and two were family members. They represent two different consumers of services organizations, which referred me to one consumer of services and one family member each. For this study, their inclusion in the sample is very important considering the different position that they occupy as stakeholders: they are the ones who access and use the services offered at the bottom level of mental health policies.

Of those who consented to participate, two informants worked in the southeast region in the city of São Paulo, seven in the middle-west region in the capital, and six in the northeast region in the cities of Salvador and Fortaleza. I drew a table which shows the mental health networks in which informants both past and current participate. It is a useful tool to understand how stakeholders are involved in this cause beyond the institutions they represent (see Table 3 in Appendix C). In addition, at the end of this section I present a sub-section “Stakeholders in the Sample” which shows that stakeholders do not represent simply one organization or agency, as much as a complex position amidst issue networks.

Respecting the San Diego State University Institutional Review Board (IRB) ethical propositions and subjects' rights, I asked all participants for their voluntary participation and presented to them the informed consent document. Each of the participants signed the consent form. They were also asked permission for their interviews to be recorded.

Preferably the interviews were held in a private place in the institutional setting in which the stakeholders were representatives, but I was flexible if there was a more convenient place for participants. The interview guide consists of four different themes and includes 19 questions. For the interview guide, see Appendix D. As happens in semi-structured interviews, I asked some probing

¹⁸ The CDSS is a proposal from the WHO to its country members which, once they are committed to establish the commission, they nominate various experts and well known citizens who represent the socioeconomic, cultural and scientific life of certain country. The commission also involves intersectoral groups, which in Brazil are nominated by the Ministry of Health. They are the presidency of the republic, ministries, national councils, secretaries, and WHO/PAHO. Among other objectives, the commission aims to evaluate policies and programs which may affect social determinants of health and that are implemented by governmental and nongovernmental institutions.

questions in response to informants' answers, insofar as they needed clarification or raised additional questions. No language barriers were encountered, as the interviews were held in Portuguese, the native language for the investigator and all informants. The interviews lasted approximately an hour, but this varied according to the interview flow and time frame. All interviews were digitally recorded and I also took some brief notes.

STAKEHOLDERS IN THE SAMPLE

Although I have already presented the position of diverse stakeholders in Brazil, I will also present the professional background and networks of stakeholders represented in the sample of this study. In this section I am highlighting their ideals and practices in mental health according to their professional background and their involvement in institutions or social movements other than the ones they represent in this study.

A considerable number of stakeholders are professionals in a mental health field, especially psychiatry and psychology, who had worked or are still working in clinical or psychosocial services, mostly offered in the public health system. A majority of the informants have been active with nonprofit organizations or movements in the civil society, including advocacy in human rights for people with mental disorders and a few informants have also been active with other minority groups such as the Brazilian indigenous population and juvenile delinquents. Among the 15 stakeholders, six are academics engaged in teaching and research activities in public universities. Moreover, almost half of the sample is involved in the federal sphere, holding governmental positions as consultants and/or producing knowledge through research. Based on these characteristics, it can be assumed that the majority of stakeholders in the sample holds considerable information about mental health issues and are well connected in both public sector and civil society. For complete details about interviewees' types of involvement in mental health and resulting issue networks see Table 3 in Appendix B.

Among the Brazilian social movements in mental health, the Anti-Asylum Movement was often cited by stakeholders as an active force for mental health reform. In fact, four of these stakeholders had a relationship, at different levels of intensity with this movement. Moreover, among the academics, half have consulted for the government at local, state, regional, or national levels. I suggest that the close relation among academic settings, mental health public services, and social movements is consonant with the fact that Brazilian mental health reform has strong roots in mental health professionals' advocacy and voice.

In contrast, the totality of consumers of services and families who participated in the study did not have a history of participation in social movements and only recently have begun to be more actively involved in mental health issues. The lack of participation of consumers of services and families from this sample reflects the overall minor role of consumers of services and families in the history of the mental health reform in Brazil, if not in the world. This minor role can be mostly justified by the long history of access to treatments that led to abandonment, institutionalization, and chronic mental disorders. But, it may have other associated causes, including the dynamics present in policy issue networks that can inhibit new entries. Moreover, it seems that the majority of consumers of services and families are following trends rather than contributing their own interests and voice. Hopefully, their participation is progressively shifting to more active positions, and they will also build a stronger sense of their own interests and gain more empowerment on mental health issue networks.

Finally, we can conclude that the background of stakeholders show that most of them, including government representatives, have actually participated in the process of mental health reform and share a strong desire to drive human rights—a trend that is remarkable in the Brazilian experience. Unfortunately the sample does not include stakeholders from the private-for-profit sector and from international agencies—such as PAHO—and thus, their interests and voices are not included in the discussion of issue networks, findings, and results in this study.

PARTICIPANT OBSERVATION

For the purposes of this study, I employed participant observation as a supplemental methodology. Because of a limited time frame, I chose a rapid assessment on a two week basis for each psychosocial care program to be observed.

Even if the study primarily targets stakeholders' perception about policy implementation, observation at the street level of implementation provided me with personal contact with psychosocial care programs and their features, strengths and weaknesses, successes and limits. Moreover, this contact would provide me with information based on actual policy implementation, increasing my "confidence about the meaning of data. . . . Whatever data collection methods you choose, participant observation maximizes your chances for making valid statements" (Bernard, 1994, pp.141-142). The main goal of these observations was to evaluate the success of these programs in actually meeting the goals of the psychosocial rehabilitation policy as designed. In particular, I observed the ways in which their activities enhanced social interactions and skills, improved vocational aptitudes, facilitated

insertion into community life and into the labor market or into programs for income generation such as Solidarity Economy.

Before I went to Brazil I had already contacted some institutions, and two had agreed to participate in the study. I was able to reach the directors of these institutions through my personal contacts. The fact that they already knew of my professional background and that they also are working to contribute to mental health reform probably helped in diminishing their resistance and increase their interest in the study proposals. Both institutions are located in the northeast region, but in different cities. In Brazil, I encountered countless difficulties in obtaining permission from at least one more institution, especially in the capital and surrounding areas, in which I stayed for almost three weeks. However, the short time frame definitely contributed to increasing these difficulties. Public services such as the CAPS are currently requiring investigators to submit research plans for their ethical commissions, a process that takes about three months and thus would be longer than the time I had available to collect data in Brazil. I also failed to reach any institution in the southeast region.

I conducted participant observation in two psychosocial care programs that had both been in place for more than a year by institutions that have provided a network of services in mental health. I spent two weeks with an average of six to eight hours a day holding participant observation in each program. In both cases, I first had a meeting with the directors, in which they described their institutions to me and I presented the study to them. However, they also invited me to visit all services provided by their institutions, which enabled to me to have a better understanding of their system and gave me valuable data. After the introductory steps, I conducted participant observation as a psychologist who was collecting data for her master's thesis and who had a professional background in mental health. All participants knew I was Brazilian but studying in the US. Moreover, they knew I would have a public defense of the thesis in the US and that the first publication of the thesis would be in English but that a copy in Portuguese would take more time. Usually, I arrived daily with my field notes and first participated in observing. As time passed, I was interacting more actively, usually talking to professionals and consumers of services. Most of time, this interaction would begin within 5 minutes of my arrival. In general, I felt that both myself and the participants of psychosocial activities were very open-minded and relaxed during our conversations. Sometimes I wrote my field notes, but at other times I did not. I wrote my notes in English to facilitate my later work and also to avoid confidentiality issues. Depending on the demands of the groups, there were times I took a more active role in helping with activities. This is described later in this chapter.

Both programs offer various psychosocial projects. The representativeness of these programs and the differences between them and other programs are difficult to estimate. On one hand, they follow the Brazilian pattern for the implementation process based on a localized context which in general varies according to organizational features, sociopolitical support, and available funds. On the other hand, they share some important Brazilian trends for psychosocial care implementation processes such as: (a) They are offered by NGOs—even if they have different levels of partnership with public institutions, (b) They offer a variety of therapeutic workshops to better fit their clients' needs, and (c) As projects for income generation or labor insertion, they utilize aspects of the Brazilian culture and ecological values to support the different kinds of goods they produce.

Taking the previous considerations into account, the program participants of the present study are considered representative for the design and objectives of this study but not for an evaluation of Brazilian implementation process for psychosocial care policies more broadly. While the findings of my observations are not representative, they do indicate limits and strengths that may be experienced by other programs for psychosocial care in mental health in Brazil and can generate recommendations which might be useful for future systematic comparative studies. Both programs are in their first years of implementation and are inspired by authentic goals of psychosocial interventions following the new paradigm, such as offering quality of work and quality of products made, and increasing the opportunities for their participants to achieve autonomy and citizenship. But, on a practical level, both programs are likely to be less successful as they face limited economic resources, affecting their sustainability and motivation among participants, and insufficient training of mental health professionals to work on the specificities of these kinds of programs.

The first program participant I observed was located in Fortaleza, in the state of Ceará. The institution in which the program is implemented was going through an important transition: after seven planned years and just ten days before my first visit, the previously private, traditional psychiatric hospital was transformed into a nonprofit organization intending to provide a network of mental health services within the community. The program incorporated two therapeutic residences, a protecting home, diverse therapeutic workshops, individual and group activities in the community, and a labor inclusion project for autonomy and income generation. All these psychosocial resources were organized in different locations and I was able to visit all of them. However, due to the distance between locations, I was forced to choose only one to conduct participant observation on a daily basis. I decided on a labor inclusion project called Ecological Broom Factory because, first, they met on a

daily basis, giving me more opportunities to be in contact with the project during the two weeks I was in Fortaleza, and second, among the various projects, they were the ones who had the most interaction with the community, either because of higher autonomy of participants in comparison to the ones in other projects, or because the project itself had been developed in less protective-based interventions than others.

Through the contacts I made in this program, I was also able to hold informal interviews with the coordinator of health for the State Health Secretariat and also with a member of the Mental Health Division in the Municipal Health Secretariat. Both interviews were very useful to my understanding about the actual mental health system and policy implementation in the state of Ceará.

The second program was located in Salvador, in the state of Bahia, and has been implemented by a public psychiatric hospital, which is also implementing a transitional process to provide a service network in mental health and diminish the number of psychiatric beds for long-term admissions. The psychosocial care program entailed a day-hospital, which included therapeutic workshops and group activities in the community, and a labor inclusion project also based on income generation. Different from the first program, the projects were organized in the same location, but in different buildings. Although I visited the day-hospital twice, I did not have a chance to hold systematic participant observation there. The coordinator of this project did not communicate to me the decision of the work-team to permit my presence during activities until the end of my second week at the institution. As a result, I was only able to collect information about the activities they offer, which were available on a board by the main entrance. Nevertheless, I conducted participant observation at the labor inclusion project, which offered four different kinds of activities: *cestaria*,¹⁹ artisanal made soaps and candles, recycled paper, and computer classes. The project had a kind of hybrid status, as it was supported by the institution for materials and professionals but had been already constituted as a nonprofit organization.

The process of data collection was fairly similar in both programs. After my first meeting with the directors, they showed me all the provided services and presented me to the psychosocial care projects' coordinators, with whom I set up the basis for my visits. In my first visit to each project they presented me to the participants: professionals and consumers of services.

¹⁹ *Cestaria* is a kind of art developed by native indigenous populations in Brazil which is made with natural fibers from palm trees and other similar plants. There is a great variety of objects that can be made with the use of this technique.

During the data collection, there was increasing interest in my study and most of the people asked me to send them the results or the thesis when completed. A high level of acceptance also opened up a kind of mutual support relationship between me and the participants. Several times, coordinators asked me to coordinate or be present in discussion meetings and to help in holding activities. In both programs coordinators showed great admiration for my work and my background. This attitude increased over time as we had conversations about mental health, our perceptions and ideals. In general, sharing values and ideals contributed to greater closeness and mutual trust. I see that my presence in these settings was, by the end, more recognized as a partner rather than strictly a researcher as in the beginning. It was common to exchange information in mental health, and the more they knew me, they felt comfortable asking for more participation in the programs, rather than only observing. I will give a couple of examples. Once, I was asked to coordinate a discussion about citizenship and voting because understanding these concepts was important to help the group manage their own system of choosing "the best worker of the month". At another program, I showed diverse products to a visiting group that included a nurse and her college students because when they arrived all consumers of services and professionals were busy and needed one more person to help.

Overall, my presence was assimilated progressively by the various projects' participants, especially by consumers of services, and did not substantially affect the course of activities and their goals. In both labor inclusion projects, during the first couple of visits, there was some expected distance between myself and a few participants who were mostly watching rather than interacting with me. This distance progressively decreased in a significant way during the period of participant observations and by the third or fourth visit our interaction mostly flowed very naturally when we had conversations similar to everyday conversations, based on sharing experiences, preferences, stories, or any other emerging topic. As Emerson, Fretz, and Shaw (1995) contend:

In learning about others through active participation in their lives and activities, the fieldworker cannot and should not attempt to be a fly on the wall. . . . The ethnographer cannot take in everything; rather, he will, in conjunction with those in the setting, develop certain perspectives by engaging in some activities and relationships rather than others. (p. 3)

In regard to how my presence seemed to affect the processes I observed, I emphasize three aspects: First, a few times, a handful of clients asked me for my professional opinion regarding their personal issues. I made it clear that I was answering based on my personal opinion and encouraged them to readdress their issues to a professional in the services they access. Second, my presence as a researcher also seemed to have positively affected the groups' esteem, as in general they were

interested in giving as much information as they could about their working process, the features of their produced goods, their perception about the projects, their own levels of commitment or enthusiasm, and their expectations for personal growth and quality of life. As a third issue, clients and professionals tended to expect that my research would bring them benefits such as gaining more visibility, even internationally, as they knew I was engaged in a master's program in the United States. I tended to have a more realistic approach, reinforcing that one of my expected benefits was to generate more interest from a larger public on psychosocial care and the recognition of its importance for increasing efficacy in mental health programs. I also reminded participants about the confidential aspect of the study and that no one, except for them, could identify which specific program I had observed, but that they could opt to use photographs taken by me to make their experience more visible. I fully explain the use of photographs in this study below.

I asked permission from all participants to take pictures of their production process (as both projects were based on vocational rehabilitation through artisanal processes) and show them in professional and academic settings. This request did not encounter any resistance. The pictures were taken with the intent of recording what I had the opportunity to witness, while at the same time preserving the participants' anonymity. The objective for taking pictures was to better illustrate the different types of psychosocial activities during any presentation of the present study to a larger public, such as at universities or scientific conferences. In addition, it also served as a high quality photographic record of the kinds of innovative techniques and activities conducted by the participant programs in order to promote their projects and gain visibility.

During my visits, I also conducted some informal interviews with the project's coordinator and other professionals. During participant observation, no interview of any kind was held with consumers of these services, as they are considered a vulnerable population, and it would have required a different IRB protocol. During informal interviews with professionals I sought information about their perceptions of the broader and local contexts in which their professional roles are implicated. I did not pursue any personal information but rather their opinions about the mental health policies in Brazil, how these policies affected the program and their jobs, and their opinions about the program itself or the institution in which it was implemented. In general, I wrote field notes after each visit, but a few times I also brought my notebook to the institutions and wrote down brief notes during observations. The notes recorded only program-specific or group information. Some participants showed curiosity and asked me questions about what field notes are. Although I explained to them how field notes were part of my

research methodology, confidential information was not disclosed. All notes were also written in English and I used codes instead of names. Back in San Diego, I prepared PowerPoint presentations with the pictures I took and sent them to the institutions.

Overall, the participant observation contributed to my knowledge about the successes and limits of the psychosocial interventions observed, the insertion of these interventions in communities, and the way they reflect or not what is endorsed in Brazilian national policies for mental health.

DOCUMENTAL RESEARCH

The documental research consisted in gathering as much data as possible from documents representing current positions of stakeholder institutions regarding mental health reform such as (a) mental health official documentation of Brazilian Ministry of Health, Ministry of Labor and Employment, and Federal Chamber of Deputies, including federal laws, administrative rulings, and reports; (b) official documents and recommendations for mental health from the WHO, PAHO, and United Nations (UN); and (c) any data offered by institutions when interviewing stakeholders or holding participant observations.

The documents comprised any data publicly available at governmental or nongovernmental institutions, their websites or libraries. Among the sources available on the internet were various publications and recommendations for mental health from the WHO/PAHO and official data for mental health at the Brazilian Ministry of Health, such as latest news, policies, and quantitative data from the DATASUS.²⁰ In addition, informants from the Ministry of Health, Ministry of Labor and Employment, and the Commission for Human Rights and Minorities of the Federal Chamber of Deputies gave me some publications that they evaluated as appropriate to this research and which were actually very useful. The directors, coordinators, and staff of the two psychosocial projects participant of the study made available for me to read their original constituent projects and a few annual reports.

This documental research contributed to the literature review and also offered valuable data to better frame mental health policy implementation in Brazil and its related policies. The variety of information collected through documental research greatly contributed to the analysis of (a) discourses present in policies, recommendations, and interviews, and (b) data from field notes, especially services delivered and their features.

²⁰ DATASUS is the data system from the SUS - *Sistema Único de Saúde* (Unified Health System). For explanation about the SUS, see footnote number 10.

THE ROLE OF MY PROFESSIONAL BACKGROUND IN THE STUDY

Since my bachelor's degree is in psychology from Federal University of Bahia, which is in Salvador, Brazil, I have developed a nascent interest and passion for mental health issues. I remember the two semesters in which I was enrolled in Psychopathology I and II when the students had to visit psychiatric, totalitarian hospitals and hold psychological interviews with patients who were attended through the SUS. First, I surely shared with my classmates the fear and discrimination toward the ones who were suffering from a mental illness in those contexts. Later, a great feeling of compassion for them and a significant criticism against those institutions compelled me to move on but in a different direction. Thus, during my undergraduate studies I took my first steps into a new approach when I decided to conduct a study with three other classmates about the relation between homeless people with mental disorders (in Brazil the so-called *loucos de rua*) and their home-community.²¹ This study was based on qualitative research for the Research Methodology II class based on participant observation and informal interviews with members of a community, including the *loucos de rua*. We were supervised by a professor who has been an advocate for humanistic mental health policies and human rights for people with mental disorders in Brazil. He also contributed to the present study, as he has played a very active role in the field on a national level.

By the time I received my B.A. in psychology and clinical competency in 1997, I was sure I would work in mental health in Brazil. But I was still not satisfied with the kind of institutions available in the territory of Salvador, and I was also sure that I would not contribute to them at any level—at least in the sense of perpetuating their status quo. In 1998 I moved temporarily to Italy for five months to obtain an internship at the Mental Health Department of Trieste. It was a remarkable experience in my life and very auspicious because of the fact that I was there when we organized the first Trieste International Congress for mental health celebrating 20 years of community-based mental health where critical thought and concerns were freely shared.

Back in my home country, I shortly started working as a psychosocial (re)habilitation coordinator at a mental health day hospital, which was based on interdisciplinary practices. I worked there until I came to San Diego to pursue my master's degree, and even from afar I still have a formal

²¹ In Brazil the *loucos de rua* are seen as traditional characters of the communities where they choose to live. Usually they live in these communities for a long time, if not for their entire lives as they mostly lose contact with their families. They usually have nicknames given by the community members which reflect the type relationship—either friendly or threatening—between these members and the *loucos de rua*. In Brazil, Salvador is a city especially filled by the *loucos de rua*, and many of them I have known since I was a child.

relationship with the institution, which testifies to the many changes implemented by our work-team, changes based on what our experience had shown us and on our professional growth. Among our interventions there, I will cite the ones which I believe most influenced my performance in the present study. From a day-hospital we became an institute for mental health dedicated to: clinical interventions and psychosocial care (both offering different intensity of health attention according to patients' need based on the belief that every person is an individual); partnership with universities offering internships for undergraduate students and implementing studies and research; participation in actions for the human and civil rights of people with mental disorders; and representation in mental health commissions in the Municipal Council of Health to contribute to addressing mental health policies. In 2001, I was also a witness to the end of a difficult process to enact the law 10.216, which became the first major step to embrace the reform of Brazilian mental health policy.

Finally and looking back to those roughly thirteen years of experience in mental health, I understand that the only reasonable role I can develop as a mental health professional must be toward a humanistic and ethical approach to mental health, an approach in which I may contribute to any human being's understanding that mental health is realistically possible and mental illness is just something to be overcome.

Reflecting on how my professional background and positions could affect the study, I consider the following issues: (a) Among stakeholders and directors of institutions who participated in the study, few knew ahead of time my professional experience and ideological positions. (b) It surely helped me to access the institutions to participate in participant observations, but did not, at least by itself, interfere in accessing interview subjects. Among the 15 subject participants, two knew me personally but both are recognized as important sociopolitical activists for mental health in Brazil as well. In addition, they often assume consultant positions for diverse kinds of institutions, which probably also contributes to their availability for interviews. Four interview subjects representing consumers of services and family associations were initially accessed through people I knew before. In these cases, their phone numbers were given to me, and I proceeded as with any other contacts and in accordance to the recruitment process previously described in this chapter. (c) Taking into account the previously mentioned characteristics of the two interview subjects who knew me before, I believe they did not try to fit their discourse into my own moral or political agenda. Furthermore, because I have also had the opportunity to access their speeches, scientific articles, books or other publications, it seems to me that their

discourse during the interviews are consonant with what they have declared in those other sources of information.

DATA ANALYSIS

Following what Babbie (2005) states on qualitative research methods, the present data analysis aims to identify patterns among data which lead to a theoretical understanding of the sociopolitical phenomenon in question: how stakeholders address the implementation gap of mental health policies in Brazil, particularly in terms of their psychosocial care portions. According to what Weiss (1994) calls issue-focused analysis, this study presents findings based on the description of what was learned from participants about specific issues within the main topic, which I coded thematically.

I audio taped all interviews on an electronic device and transcribed them as a Microsoft Word document in their original language. Only the quotations used in the analysis were translated to English. Both interviews and field notes were coded by theme using the three different but complementary methods of thematic analysis described below.²²

For interviews only, I created different sheets in an Excel program from Microsoft Office. Each sheet corresponded to the different themes included in the interview guide (see Appendix B), having 15 rows—related to the 15 interviews in the sample—and a variable number of columns related to emergent themes. It was very useful to have these specific issues from different interviews displayed in the same sheet. This facilitated a broader visualization of the main issues, and their frequency, approached by different stakeholders about the same topic. I also created a similar sheet with the contents of my field notes.

I also created codes in accordance with ideas and themes brought up by interview participants and from my own notes recorded in my field notes. First, I organized an outline with these codes, including their hierarchical sub-codes. The major codes were based on those themes which the questions in the interview guide were addressing. The sub-codes were determined according to the main themes of answers given by each participant. I gave each code a separate folder intending to

²² I used an analytic technique based on my advisor's expertise, which oriented me with models of analysis designed by her. In addition, I also used these models of analysis in accordance with my own expertise in conducting qualitative research both as an undergraduate student during my bachelor's program in psychology and as a qualitative research consultant for a market research institute in Brazil. Moreover, I was advised that using technological software would not be recommended or necessary as the sample of this study includes only 15 interviews.

aggregate all information related to them together. This was very functional as it allowed me to create a clear picture of the kind of information that was collected and its meaning.

Also based on the created codes, I produced a specific outline for quotations from interviews. It offered me convenient information especially for presentation of results and discussion.

Even if no statistical approach was implemented, I considered how frequently diverse codes occurred in the information which originated through various methodological instruments (interviews, field notes, and documents collected). While I especially focused on the themes that were most prevalent, in some cases, I also analyzed the themes that were relatively ignored insofar as they reflected either a lack of information from subjects, actual gaps in mental health policies implementation, or gaps in the present study.

CHAPTER 5

HOW IS IMPLEMENTATION FALLING SHORT?

Considering what has been implemented and what is projected in policies, my findings, generated by data collected from the semi-structured interviews, point to key factors that obstruct full implementation.

In this chapter, I undertake to answer a central inquiry of this study: What are the key elements that generate a gap between psychosocial care policy formulation and its implementation? Moreover, the main goal in this chapter is to present the findings of this study, as identified by the participant stakeholders as factors that contribute to the implementation gap. While this chapter presents what these factors are, most of the analysis of their relevance is presented in Chapters 6 and 7. These chapters provide the structure that supports the analysis and also attempt to show how the different positions of stakeholders affect their opinions about policy implementation gaps.

Although psychosocial care policies are the main focus of this chapter, I also touch upon broader elements of the reform. These elements were indicated by the same interviewees and contribute to the understanding of the context of the reform in which psychosocial rehabilitation policies are implemented.

As other studies in the literature and reports already point to the same shortcomings in the implementation of Brazilian mental health policies, I first present these existing studies in a preliminary section and then I flesh out the implementation gap based on my field materials.

My field materials suggest that the nature of the implementation gap is related to the following factors:

1. Limitations of programs and services.
2. Limits of psychosocial interventions.
3. Insufficient investment in primary health care.
4. Accentuated differences among regions or states and low priority and limited accountability at the municipal level.
5. Significant conflict of interests among stakeholders.
6. Influence of stigma and inequalities.

Each of these factors is presented separately in this chapter. To better illustrate these factors and give a vivid voice to interviewees, I offer examples of the actual comments of those I interviewed in ways that illustrate the patterns among them.²³ Table 2 describes the interviewees (using their pseudonyms), the institutions they represent in the study, and the respective role these institutions play in the actual mental health landscape in Brazil.

Table 2. Interviewees, Institutions They Represent in the Present Study, and the Role They Have in Mental Health Policy

Pseudonym	Institution	Role in Mental Health Policy
Alfredo	NGO located in the city of São Paulo	Interventions for income generation and advocacy for human rights
Mario	Brazilian Psychiatric Association	Mental health professional association
Fernando	Federal Chamber of Deputies	Legislation
Matheus	Federal Board of Physical Therapy and Occupational Therapy	Mental health professional association
Luciano	Federal Board of Psychology	Mental health professional association
Rafael	Ministry of Work and Employment	Solidarity Economy and mental health
Leonardo	Ministry of Health	Guidance, budgeting and policy monitoring
Norma	Federal Chamber of Deputies Commission for Human Rights and Minorities	Legislation and mediation between civil society and the chamber
Vanessa	NGO located in the city of Fortaleza	Social cooperative ^a
Marcelo	Ceará State University	Professional training, research, and Consultancy
Daniela	NGO located in the city of Fortaleza	Social cooperative ^a
Elias	"Umbrella" NGO	Advocacy in mental health and human rights
Claudio	Ministry of Health Commission for Social Determinants in Health	Production of knowledge and information to mobilize society
Bruna	NGO located in the city of Salvador	Consumer and family association and advocacy in mental health
Marina	NGO located in the city of Salvador	Consumer and family association and advocacy in mental health

^aIn Brazil, "social cooperatives" may coordinate informal economic production and sales like economic cooperatives in the US. Members are unsalaried, and profits are shared among the members. They have as their mission the social inclusion of minorities.

²³ In this manuscript, all of the communications by interviewees are translated from the original Portuguese into English by me. Moreover, to assure confidentiality, I gave the interviewees pseudonyms, but I also do identify the position they represent for the present study as stakeholders.

In addition, each major theme includes a sub-section of conclusions. I also present a "Considering Advances" sub-section at the end of each major theme in which advances of the mental health reform in Brazil and the progressive aspects of its policies, commented by the interviewees, are also presented. The chapter concludes with a section named "Summarizing themes" which summarizes findings from all major themes.

PREVIOUS EVIDENCE OF AN IMPLEMENTATION GAP

There is not an extensive literature on the implementation gap in mental health policies in Brazil, and the existing studies do not ask the same questions I am asking here. However, there have been a few studies that offer some preliminary insight into this issue; they are briefly reviewed here before I add the findings from my own fieldwork.

Mapping mental health resources in various countries, data from the WHO (2005b) indicates that although the Brazilian community-based care system includes mental health promotion and psychosocial care, they are all available for less than 25% of the treated population. Although the document recognizes that Brazil has progressively increased the number of CAPS, it also points out that they are greatly concentrated in the most developed regions or in capital cities.

In the same year the Brazilian Ministry of Health reported large differences still existing between the proportion of SUS admissions in psychiatric hospitals (2.26%) and Day-hospitals (0.19%) (Ministério da Saúde/SE/Datasus, 2005). Even though these data do not indicate the reasons that explain this difference, they point to the existence of a gap between the access to available community-based care system and the traditional medical model of treatment.

The literature is also controversial in regard to budget allocation for priority areas in mental health. While Morral and Hazelton (2004) point to a persistently high concentration of funds in the sphere of psychiatric hospitals, "currently representing 90% of expenditures on psychiatric care" (p. 120), data from the Brazilian Ministry of Health (MS, 2007) shows that in 2004 the costs for psychiatric hospitals represented 63.14% of total expenditure for mental health (p. 54). In either case, the data point to a superior budget allocation for psychiatric hospitals in 2004 than for community-based care. The same report from the Ministry of Health indicates progressive efforts to invert this trend and estimated the allocation of 51.33% of the total budget for mental health in extra-hospital services by the end of the year 2006.

In addition, discussing the Brazilian efforts to include mental health in the primary health care system, the Brêda, Rosa, Pereira, and Scatena (2005) study emphasizes limits faced by professionals

that work for the Family Health strategy. The authors point to six main limitations for the full and effective implementation of the new program: (1) existence of conflicted relations between discourse and practice; (2) hierarchical model developed by the Ministry of Health, limiting mechanisms of popular control; (3) deficient professional training to facilitate practices based on the new approach; (4) lack of information to families and community to better adhere to the program; (5) central role of psychotropic drugs in comparison with other resources; and (6) absence or inefficacy of reference services.

From the data reported by the Brazilian Ministry of Health, the WHO, and independent scholars, it can be concluded that although Brazil has shown efforts to overcome barriers against a more humane and effective mental health system, much of the program evaluation to date indicates a gap between the policy ideals and actual practice.

The literature that exists so far points to the potential contribution implementation research could have to develop a comprehensive understanding of the implementation process and the reasons for the apparent implementation gap.

LIMITATIONS OF PROGRAMS AND SERVICES

The first theme that arose from my fieldwork was about the limitations of programs and services at the bottom-level of policy implementation. The stakeholders I interviewed represented three main kinds of limitations of programs and services that get in the way of implementing the policies as designed. These limitations include:

1. Type of service network available
2. Access to services
3. Quality of substitutive services and programs of psychosocial care

At least one of these limitations was introduced by 10 among the 15 stakeholders, making this a strong theme in my interviews. It is interesting to note that based on interviewees' arguments, these limitations are likely to mutually interfere within each other.

Service Network

Regarding the existing service network, five stakeholders critiqued the transitional process from the old to the new model for mental health from different angles.

Elias, who is part of a non-profit organization which advocates for mental health reform and human rights for people with mental disorders, discussed that the desired substitutive services are

more often implemented merely as an alternative network of services instead of a systemic replacement: "There are forces that invest in increasing the number of soft services such as CAPS, but as an alternative service network: they manage stable patients in this network, but send the ones with persistent mental disorders to psychiatric hospitals." Beyond criticizing the coexistence of the implementation of the service network and the maintenance of the psychiatric hospitals, Elias also pointed out that this situation is slowing down the closure of psychiatric hospitals: "I believe that this kind of management favors a moment of stabilization instead of a moment of transition and subsequently we have a slower rhythm in the reduction of the supply of beds. The impetus is not the same anymore."

On the other hand, Mario, from the Brazilian Psychiatric Association, pointed out that it is the focus on the reduction of beds and the lack of substitutive services to deal with acute crisis intervention or cases of persistent and severe mental disorders that cause drastic gaps. Without beds and without services to deal with crisis intervention, the reform leaves a large number of people unassisted. First, Mario discussed the major trend of the mental health reform: "The Ministry of Health is focused on the restructuring of the hospital assistance only. For them, restructuring is equal to reduction of beds and increasing the number of CAPS. This is what they are doing." After some conjecturing he concluded:

Today we have an enormous lack of beds for the acute cases. . . . The alternative they claim is beds in general hospitals, which, actually, do not exist. . . . It generates a situation of non-assistance. What they propose does not include the ones who need interventions on acute crisis.

From Elias' and Mario's comments we can conclude that although they agree on the inefficiency of acute crisis interventions or the treatment of people with more persistent and severe mental disorders, they feel differently about the rhythm of the closure of psychiatric beds. While for Elias it is slow, for Mario it is too fast, particularly if compared with the availability of new services. Fernando, who is a federal deputy, did not consider the process of bed reduction or closure of psychiatric hospitals as slow or fast; however, he was concerned about the actual insufficiency of the number of substitutive services in general: "I am not aware of the latest statistics but I believe we reduced the supply of beds approximately 50%, and this is positive. What is negative is the lack of the concurrent offer of new services."

Norma, a member of the Commission of Human Rights and Minorities at the National Congress, also saw the reduction of the supply of beds as an advance: "I think that the reduction of hospitals is satisfactory. There were hospitals under serious denouncements for torture and

mistreatments that were closed.” But Norma also criticized the lack of a service network in the public sphere and said that there are various local experiences “that cannot be considered as policies; they emerge from the civil society and may have support of the public sector . . . but they are not assumed by the State and they are not universal.” What Norma argued is that in terms of psychosocial care numerous interventions are offered by NGOs or other organizations from the civil society, but are still few and unevenly distributed among regions.

Even though interviewees criticized the transitional phase of models of care in mental health from different perspectives, arguments exposing the insufficiency of the actual service network were frequent. In the end, these stakeholders called attention to the need for mental health policies to accomplish the SUS universal principle, which is to offer public access to health in recognition that health is a right of every citizen.

Access to Services

Seven interviewees addressed problems related to the access to psychosocial programs and services based on the ideals of the mental health reform in Brazil, particularly the goal of implementing psychosocial care resources in the community as called for in the law 10.216. The interviewees agreed that access to services was an important theme; however, they focused on varying kinds of problems related to access.

Some interviewees were concerned that the access to services has been limited to the access to CAPS. It is interesting to note that although these interviewees represented different institutions, all of them are closely associated to the civil society. Alfredo, a representative of a non-profit organization that works for the income generation of people with mental disorders, criticized the CAPS: “There is a trend that gives priority to and forces the increase of services, such as CAPS: the number of CAPS must increase—as if the number itself could solve the issues of the psychiatric reform in Brazil.” Similarly, even recognizing the existence of other services, Norma pointed out that the CAPS are the services mostly offered to the population: “It is a risk [to the success of the reform] that only CAPS are implemented among all the substitutive services. CAPS are what people know; there are protective homes, but CAPS are what people know.” Claudio, from the Commission for Social Determinants in Health, also perceived the insufficiency of a service network and subsequent intersectoral actions as a risk to the success of the reform: “I see a great risk that the psychiatric reform—something much bigger than the access to CAPS and protected homes—becomes a special program of the Ministry of Health such as TB, HIV-AIDS, elders’ health, and so on.”

In regard to limited access, Mario was more concerned about the access of services, such as protected homes and beds at general hospitals, for people with more persistent and severe mental disorders. In addition, Mario pointed to limits of the De Volta para Casa program in terms of the reduced number of people who actually access it. As Mario said, “The number of protected homes is insufficient to assist the needy population; the De Volta para Casa program is limited because a large number of patients in hospitals missed contact with their families. Going back home: but what home?” Mario disputed data from the Ministry of Health which concerns the supply of beds in general hospitals:

The Ministry of Health works with data reported from institutions. But this data does not reflect the reality. They said there were 2,500 beds, but frankly, they do not exist, and even if they did exist there would not be enough to meet the demand of the whole country. . . . The emergency service of the federal government, the SAMU, which makes available ambulances for people in need, has great difficulty in finding in the city of São Paulo, for instance, beds available to admit the patients.

Leonardo, as a representative of the Ministry of Health, seemed to be also aware of the limits of accessing beds in general hospitals and laments:

We have had great difficulty in having general hospitals attending appropriately and sufficiently the cases of mental disorders. We plan a configuration in which we have a service with a territorial base—the CAPS—and when necessary a service available to short in-patient admissions, preferably in general hospitals. But, there are difficulties in increasing the supply of these last services.

It is interesting to note that the Ministry of Health, aware of limits of access, agrees with other stakeholders that the assistance for people with severe and persistent mental disorders is still a point of concern and represents one of the major limitations of the Brazilian mental health policy.

An interesting topic in access of services but only discussed by two interviewees is the increasing number of homeless people with mental disorders. Marina, a family participant of an association of consumers of services and families, commented on the total abandonment which these people are facing: “I think there are still lots of things to be changed. You still see lots of mentally ill in the street. There is no place to take care of them; there are lots of them in need of services.” Mario shared how the topic is an actual concern among academics:

There are an increasing number of homeless people with mental disorders. We suspect this is related to the difficult access to beds in psychiatric hospitals, which is the topic of a study that is being conducted by the University of São Paulo. If people do not have a place to go, they may become homeless.

The situation of homeless people with mental disorders was also noticed by an assistant nurse I met during my fieldwork in the city of Salvador. In an informal conversation, this nurse showed deep

concern about the increasing number of homeless people with mental disorders and related this fact to limitations of access to substitutive services after the closure of a larger number of psychiatric hospitals. Although the reasons for this increase were based on conjectures only, we cannot overlook the fact that it was noticed among people from two different capital cities in the sample, and thus it is already felt at the street-level of policies.

In regard to access of services in general, Leonardo saw advances made, but admitted there are also still limits to be overcome. But, he acknowledged that up to this point of the reform in Brazil, the challenge is to work to sustain achievements made rather than work to increase access:

Now that we have achieved a network of assistance of almost 3,000 public services among CAPS, protected homes, out-patient clinics, and social clubs, the challenge is sustainability, the maintenance of this system. We definitely have increased access to treatments. It is smaller than desirable, or necessary, but it is much more than several years ago.

Leonardo's concerns introduce other stakeholders' concerns about the actual economy of the mental health system in Brazil, particularly the real priorities of the mental health national policy toward the implementation of services. In total, four interviewees questioned the budget that is still allocated to psychiatric hospitals, and the insufficient funds for maintaining the service network. It is interesting to note that they all have a strong connection with the advocacy for mental health and may be representing more general trends of the organized civil society.

Elias pointed to the still high investment in psychiatric hospitals:

There are still roughly 480 million [of *reais*] invested in 40,000 psychiatric beds. Today we have approximately 1 billion of *reais* per year for mental health, and 52% or 520 million should be invested in substitutive services. But, it is still too much to spend half of the budget on beds. Under our interpretation this trend is situated in the strategy to implement only an alternative network. If in four years of Lula's administration there was a reduction of 10,000 beds, we can project that we will need 16 years to reduce the remaining 40,000 beds.

Alfredo and Mario were also concerned about the guarantee of the transference of those funds from the budget which have not been invested anymore in psychiatric beds to the service network:

There should be a more efficient way to guarantee the investment of the budget previously allocated to beds in the reform. One of the criticisms is that the reform is a way to save money: without the guarantee of transference, the budget can be allocated to any other public policy out of the mental health sphere. (Alfredo)

When you have a budget that is not being allocated anymore, as is the case with the budget for psychiatric beds, and a field which is not a priority, as is the case with mental health, the local administration can allocate it for other needs in health other than CAPS. The money is not stamped. (Mario)

Here, Alfredo e Mario claimed that the funding for mental health in Brazil should include fiscal mechanisms to regulate transference of funds exclusively to the implementation of the service network. Similarly, Norma noted that the system should cost less (after implementation of infrastructure and counting only on the public cost per person assisted), but it is still lacking in access:

The public sector has allocated a small budget for psychosocial programs. Roughly, a patient with a severe mental disorder costs to the State around 800 and 900 *reais*. The same patient if attended to at a CAPS, will cost the equivalent of the minimum wage, 380 *reais*; the cost now is much lower. . . . Nevertheless, the services are not universal.

Based on these findings, it can be deduced that sectors associated with the civil society represented in this sample, when evaluating the reform were deeply concerned about the insufficient investment available to the implementation of the new services and the access to them.

Quality of Services and Programs

The findings also indicate that four stakeholders in the sample questioned the quality of services and programs of the Brazilian mental health reform, particularly concerning the deficient training of the human resources. These interviewees brought up this topic highlighting different but complementary aspects related to human capital,²⁴ and especially the professional formation and training of the mental health workforce. In sum, the findings point to an implementation gap based on what exactly the population is accessing rather than on the kind of institutions that constitute or do not constitute the service network.

Regarding the professional training in mental health, Leonardo, Mario, and Marcelo (a professor at a state university) pointed to a formation that is dissonant with the new trends in mental health. These informants perceived the professional training as also unsupportive or even a great obstacle to the new projects of the Brazilian mental health reform. It is interesting to note that even though they represented different institutions in this study, they are all psychiatrists and maintain a formal relation with universities in three different cities in Brazil, which heightens their concerns.

Leonardo was very concerned about professional formation and considers it one of the greatest challenges of the reform:

We need to broaden the production of knowledge about the new methods of intervention in mental health. We need to improve the mechanisms of professional formation, and this is

²⁴ The term human capital is used here as defined by Marshall (1998): "The education and training undertaken by individuals or groups or workers" (p. 286).

decisive. I consider the professional formation as it is today an obstacle; a managerial and strategic obstacle for the reform.

Highlighting that mental health is a multidisciplinary field, Mario considers the practical trainings in multidisciplinary institutions or programs as a fundamental resource during professional formation. But he knows these kinds of training barely exist in practice: "Work in multidisciplinary teams is a very hard task for many professionals, especially because the formation offered by universities in general is practically based on theoretical contents but not on multi-professional perspective trainings."

Marcelo believed that the idea of services like CAPS is very successful, but not their human resources:

The idea of CAPS in cities of 45,000 or more habitants is triumphant: what is not is the lack of a qualified workforce. Every reform in mental health is made basically of people: people with competency and sensibility. The professional in mental health must have four great abilities: technical, relational, communicational, and political to deal with the differentness, with the rights, with the negotiation of rights. Thus, we need trained people and we don't have them.

Matheus, a representative of the Federal Board for Physical Therapy and Occupational Therapy, questioned if there is a competent workforce and also conjectures whether the subsequent quality of services accessed by the population is leading to actual advances of the reform as a public policy:

Is the implementation of the national policy really advancing in offering integral assistance, as mandated by the SUS, to the population? Are patients being attended by qualified and competent professionals? We, from the federal board, are very concerned about the quality of offered services.

It seems that the concerns about the quality of services offered by professionals working in the diverse interventions of the service network are not universal among interviewees but are very intense among the ones who perceive their limitations, given their professionals positions.

Considering Advances

In general, stakeholders participating in my interviews also agreed that the new system represented an improvement and supported its general goals. Overall, interviewees recognized the importance of and supported a policy to reduce the supply of beds in psychiatric hospitals. Some interviewees considered that this policy announces to society that there is a history of mistreatment that is coming to an end, giving way to new methods and services. "It is positive that the society, especially families of people with mental disorders, gain awareness that the hospital is not the only place for treatment . . . but just a short passage when services are efficient" (Fernando). All interviewees

recognized the improvement in the protection of the human rights of people with mental disorders. Some of them, as Mario, knew about the assessment of psychiatric hospitals conducted by the Ministry of Health and recognized that “based on it, we can see that the existing hospitals increased in quality of services provided.” Although recognizing limits of access, interviewees considered the existence of new services a tremendous step to facilitate social inclusion of people with mental disorders instead of their seclusion from social bonds. From the perspective of a top official in the Ministry of Health, Leonardo, “increasing the access . . . is the major objective of the reform because it assures the rights of patients. Their primary right is to be assisted by methods that respect human rights and aim toward their social inclusion.”

In general, interviewees believed that the gradual transference of SUS funds from hospitals’ beds to a community-based service network was, for the most part, possible because of the priority given to mental health in President Lula’s administration. As Claudio concluded:

President Lula’s administration greatly supported the expansion: provisions in policy formulation have gained resources, launching the policy for reduction of the supply of beds—more than 1,000 beds in less than two years—and the implementation of protected homes and CAPS.

According to stakeholders, the reduction of the supply of beds in psychiatric hospitals is a fundamental economic strategy to launch mental health reform. Matheus argued: “The Ministry of Health reported that 50% of the budget that used to be invested in hospitalization was already reallocated for the mental health national policy. I think this is the right pathway.”

Conclusions

Overall, interviewees indicated some limitations of programs and services as impediments for full implementation of psychosocial care policies. These limitations pointed to the existing kind of service network, to insufficient access to services, and to the quality of services and programs.

Regarding the service network, a third of the interviewees in the sample were dissatisfied with the kind of service net that has been implemented in the project of the mental health national policy. These interviewees (several from NGOs and the legislature, and one from a professional association) represent institutions that work toward the rights of people with mental disorders.

Although all these interviewees pointed to the insufficiency of substitutive services, it is also interesting to note how their positions highlight different aspects of the same issue. The NGO representative focused on characterizing the service network as an alternative network because of the concomitant existence of psychiatric beds, while the representative of psychiatrists pointed out the lack

of assistance for acute crisis intervention and more specifically for a lack of beds in general hospitals. In addition, representatives of the legislature focused on the lack of substitutive services.

Concerning access to services, seven interviewees were concerned with this topic, in very different but complementary ways. Some of them—all representing the civil society or closely related to social movements—pointed out that the efforts to build a service network are still too focused on the CAPS. Both the representative of the Ministry of Health and the representative of the Brazilian Association of Psychiatry saw a lack of beds in general hospitals as a major limiting factor to consolidating the reform in territorial bases. But only for the latter interviewee, does the lack of other programs or interventions, created to attend the population with persistent and severe mental disorders such as the *De Volta para Casa* program and the protected homes, limit the consolidation of the reform. Two other interviewees, a user and a psychiatrist who has access to an academic study, also reported that there is an increase in the unassisted homeless population with mental disorders. In sum, although interviewees pointed out the lack of access in services or programs in which they have a focus of interest, their concerns suggest an insufficient service network that fails in the implementation of various kinds of assistance.

Also related to the issue of access to services, some of the interviewees who indicated access as an implementation gap were concerned about the management of the budget for mental health. Advocates were concerned that there is still a high investment in psychiatric hospitals and small budget invested in psychosocial rehabilitation. Among these advocates, one in particular reached the same conclusion as the representative of the Brazilian Psychiatric Association who focused on the need for a guarantee of transference of funds from psychiatric beds to new services.

Finally, four of the interviewees, three psychiatrists who also have a formal relationship with universities, and the representative of a professional board, expressed their concerns about the quality of services offered by professionals in general, pointing to their formation and training as dissonant to the new project for mental health implemented in the country. These concerns particularly addressed the mental health professionals' political understanding of this project and the quality of assistance they give to people that access services. Moreover, interviewees were specifically concerned about the lack of training for multidisciplinary interventions and in subsequent and potential lack of integrality of interventions. Meanwhile, psychosocial assistance under the new paradigm perspective is only possible when mental health professionals incorporate political understanding, a multidisciplinary approach, and integrality of actions into their routine interventions.

Although interviewees pointed to these various limitations, they agreed that the new policy had finally become a priority at the federal level and had definitely advanced in protecting human rights due to: its strategy to reduce beds in psychiatric hospitals, the monitoring of existing hospitals, and the implementation of services that, even if insufficient, operate under new motivations of treatment.

LIMITS OF PSYCHOSOCIAL INTERVENTIONS

The second theme from my interviews concerned the limits of psychosocial interventions. This theme ranges between concerns for formulation and concerns for the implementation process, but all converge in questioning how far these policies are actually inclusive, and, when implemented, if they address access limits, guarantee integral assistance and quality of services provided. Findings reveal four major factors that specifically inhibit a full implementation of psychosocial rehabilitation policies. In this section these factors were identified at least once by the majority of the stakeholders in the sample of 11 out of 15 interviewees:

1. Availability of psychosocial care resources
2. Availability of financial resources
3. The distance between idealism and actual practices of the reform
4. Lack of data

Among those interviewees, six also supported their arguments confronting what they consider ideals for the reform versus what the reform pragmatically accomplishes or offers. This section first presents this last topic as it is more general than the specific issues on services, programs, budget, and data matters.

Idealism vs. Pragmatism

Among all interviewees, the three representatives of professional associations, the two representatives of the legislature, and the representative of the umbrella NGO, pointed to a situation in which there is a gap between the idealism for psychosocial care and its practical actions. Two of the interviewees considered that psychosocial programs and interventions are still characterized as actions of specific private groups, and not necessarily in the public sector, showing a limit in the universal principle of the SUS. In addition, five interviewees indicated that there is a lack of intersectoral actions, isolating psychosocial interventions from other sectors such as culture, education, sports, and welfare.

Norma lamented that the ideals of the new paradigm have not yet universally spread out throughout the different regions and cities:

The services are correct, but they are not universal yet. The implementation of services by the local sphere is also correct, but unfortunately there are low investments and resources and therefore services are not universal. We don't have a broad network of services yet; we have local and specific interventions and not a public policy that is universally implemented.

In general, among the interviewees who criticized the lack of investment in intersectoral actions, there was a concern that without a mutual collaboration among sectors, policies might fail in effectiveness and become superficial and symbolic gestures. More practically, interviewees perceived that the lack of integration between psychosocial programs and various community resources limit strategies for social inclusion. As Mario said:

To handle psychosocial rehabilitation you have to deal with social work. . . . [In general] patients do not know about their rights . . . and we need to seek, for example, professional qualification courses and referral institutions for them. This is a function of social work, for example.

Luciano, representing the Regional Board of Psychology in Brasília, commented on the lack of mental health actions among ministries: "I don't know about any intersectoral actions among ministries. All political actions are limited in the Ministry of Health including the entire available budget for mental health. The same is true for states and at municipal levels."

Matheus lamented that Brazil has implemented "very fragmented policies. . . . Departments, ministries, and secretaries do isolated work. Programs waste human and financial resources. . . . [Meanwhile] we want the physical, mental, and social health. We need to have more intersectoral policies."

Elias saw the lack of intersectoral actions as an obstacle for the reform to accomplish the ideal of the psychosocial rehabilitation. For Elias, the reform is still only beginning to work on some actions of social inclusion, a concept that is more limiting than psychosocial rehabilitation. He explained:

I don't think the concept of rehabilitation is significant in the episteme of the Brazilian psychiatric reform. I don't think this concept leads, governs, or orients. We still have a limited discussion about intersectoral and interinstitutional actions, and these are discussions that should have been previously made in order to enhance the way the government establishes a relationship between its various secretariats to work together.

Finally, Fernando includes both issues, lack of universal and intersectoral actions in only one thought:

What we see are specific and local programs that implement intersectoral actions. But they are important: the culture, the arts, the sports. But, what exists is far behind what we need. . . . And we must work on intersectoral actions. Today, it is not pragmatic anymore to have single actions from single sectors.

As we can see, interviewees comprehended that the minimal existence of intersectoral actions showed that, in practice, psychosocial care policies are fragmented or in other words, do not incorporate the full spirit of their scope in accordance with the new paradigm in mental health.

Financial Resources

To reinforce the findings of programs' and services' limitations, another three interviewees pointed to the limited financial resources to be invested specifically in psychosocial interventions. This may indicate that although interviewees associate limiting budget allocation to different ends, there is great concern about budget issues as a contributing factor of the implementation gap.

For all three interviewees, their concerns were specially related to what they do or represent in mental health.

Matheus, an occupational therapist, pointed out how the insufficient budget for the implementation of psychosocial care, particularly the CAPS, is forcing services to assist the population with limited human resources:

In the actual mental health policy and in terms of psychosocial care, municipalities may contract what this policy calls a "minimum team," which is a doctor, a nurse, a nurse assistant, and a social worker, or a psychologist, or an occupational therapist. This is a major concern for me because the last three are distinct professions; one cannot substitute for another and each has a specific function in the team. I am sure that if we don't have the three professionals working and forming a complete multidisciplinary team, consumers of services will not access an integral assistance. Who will promote the social inclusion in the families and in the social realm? Who will promote labor inclusion interventions?

A different perspective was presented by Marcelo, who is also a consultant at regional and local spheres for the implementation of the service network in mental health. Marcelo criticized the way funding is planned and allocated, limiting more effective implementation of service networks. According to him, the SUS still funds the various kinds of mental health interventions based on admissions and clinical procedures. This kind of funding does not work, especially in the case of primary health and psychosocial interventions, which call for another system of allocating funding. In addition, the centralization of the budget at the federal level limits its allocation according to local needs. Marcelo argued:

The reform is based on the notion of territory and the great problem is that funding is still allocated per procedure or in other words admissions, appointments, and others. We need to find another way to fund the system. . . . If we fund based on procedures, the CAPS cannot improve and the interventions in primary care cannot advance. . . . Another limitation is, for instance, the funding for the *De Volta para Casa* program: in places where the reform was already advanced there was no need for this program. However, the

federal government is investing national budget to finance this program. For instance, we—that are one of the poorest states in the country and don't have the need for this program [because we have an effective deinstitutionalization process already]—are somehow financing the program in states that did not do their homework. Very few people in our state were thus actually benefited from this program.

Vanessa, a consumer of services participant of a social cooperative which does not receive support from the federal government or, more specifically, from the Solidarity Economy program, regretted that the cooperative does not yet have the opportunity to gain start-up capital. She explained:

We have some help from the UNISOL that teaches us how to implement and self-manage a cooperative and from the municipal administration that gives tokens for transportation. We also make an effort by contributing materials. There are professionals that know the cooperative and order products, such as bags for conferences and aprons for culinary courses. But it is still hard. In the market we are a little fish competing with a shark, thus it is difficult to generate income. Today we are selling around 20 *reais* a month; what is 20 *reais* when you divide by 30 people? We are constantly seeking solutions, but there are people that want to give up. We work but we don't have financial return. We really need financial support because it is good to work, but it is sad to work and not have money.

Here, Vanessa is clearly talking for the group of consumers of services who work with her in a social cooperative. She showed general frustration in the continuing failure of the practices of this kind of organization to produce motivational elements for consumers of services to believe they can increase their financial autonomy and life satisfaction. Therefore, it seems that for consumers of services, the government has not been giving the financial support they expected to have. Based on Vanessa's thoughts, there are also limits of psychosocial interventions that are related to poverty issues, which seems to be an intriguing topic to be analyzed more deeply in further chapters.

Psychosocial Care Resources

Based on the fundamental role played by psychosocial care, interviewees also pointed to a series of gaps in the implementation of psychosocial care in Brazil. Findings show that despite interviewees' recognition that Brazilian national policy is substantially progressive and inclusive of the various kinds of psychosocial resources, they questioned the quality of psychosocial services, particularly the CAPS, the De Volta para Casa program, the protected homes, and the available labor inclusion resources. As they questioned the quality of these services or programs, interviewees were also concerned about how beneficial these resources are for the target population.

Among the 11 interviewees who cited limits of psychosocial interventions as a kind of implementation gap, a total of 10 identified some current issues among the psychosocial care resources. Among these 10, four interviewees pointed to the limitations of the CAPS.

Two interviewees, Alfredo and Elias, both members of NGOs who also advocate for mental health, commented about how CAPS are isolated from health sectors in general and from other community resources. Moreover, both interviewees perceived this trend as a threat for the new paradigm. For them, CAPS functioning without the notion of territoriality is a mere repetition of the asylums but in an “open” structure. Alfredo said: “We have more than 1,000 CAPS in Brazil, in various regions . . . but I think these CAPS need to be more interconnected to a broader network, otherwise they will not have ‘walls’ but will function under an old paradigm.” Elias argued:

Somehow the psychosocial rehabilitation resources are seen as resources that should be ‘in’ the CAPS. The CAPS don’t seek in the social realm the workshops that could be interesting for patients to join. The CAPS prefers to offer training workshops in the CAPS with the patients of the CAPS. This indicates a fragile comprehension about being a territorial-based service. This generates something that I call the engradamento [imaginary bars] around the CAPS. In other words, the CAPS start having bars, not the real ones; the doors and windows are opened, but now they have the bars of activities and the patients are circumscribed by these bars—permanent, regular, and endless activities.

Matheus questioned if the CAPS are actually offering an effective assistance in which consumers of services are progressively attaining social bonds and roles or if they are unassisted. Matheus said:

Is the assistance sufficient to keep the person included in his or her family and in social life, or is he/she abandoned on the streets? Last month, very recently, there was a situation in which a patient assisted at a CAPS in the state of Maranhão was sleeping in the street because his family does not accept him at home anymore. . . . Is this patient being assisted or unassisted? During the day he is assisted at CAPS but at night, sleeping in the street, involved with prostitution, alcoholism, violence, whatever he is involved in the street but susceptible to everything that happens there.

Although the theme of professional training was already presented in previous section, here Mario suggested that there is an insufficient direction of how CAPS specifically should implement their actions and what roles and actions are expected from the teams. Consequently, Mario perceived that various CAPS repeat functions from other services. He said:

I think there is a certain lack of direction as to what to do. In my opinion, many CAPS’ professionals are reproducing what they used to do before. Those who worked at a day hospital and are now working in CAPS still work as if they were working at the day hospital; the ones who worked at out-patient clinics work as if they were still working at an out-patient clinic.

Expressing concerns about the *De Volta para Casa* program, five interviewees from various networks criticized the access to this program and two of these interviewees also disapproved of the value of the financial aid. For Elias and Daniela—who represent a consumer of services and family

association—one of the problems is how the program's provisions work as a limiting factor to the access to benefits. Daniela, concerned about how inclusive the *De Volta para Casa* program is, said it does not address the new cases of long term admissions as it provides financial assistance only for people living in hospitals for more than two years. Daniela said: "The *De Volta para Casa* guarantees the right to go back home only for patients who have lived at least two years in a hospital" and argued: "Does it mean that if a patient be admitted now [and stay for a long-term period] he will not have this right?"

Elias argued that the *De Volta para Casa* program is the major policy for deinstitutionalization available to guarantee the rights of people with mental disorders to have a home, but unfortunately fails in effectiveness:

The *De Volta para Casa* is seen as a very special program of the psychiatric reform of Lula's administration, but it is actually a very limited program. It de-hospitalized 2,800 patients in 4 years in a population of approximately 11,500. I don't have it too precise but they are in this magnitude. A program that is stagnant, in which the value is frozen, cannot be readjusted. It was created in a decree that established a date and from that date until now there are already a number of people that were admitted. This program is much more for effect than is effectively promoting de-hospitalization.

In sum, Daniela and Elias were concerned about the case of people institutionalized or that have lost contact with their families in less than two years and how mental health policies are addressing this problem.

Norma considered that the responsiveness of the *De Volta para Casa* program is low. But she presented a different number of people accessing the program: "*The De Volta para Casa* assists roughly 1,800 people today. In terms of benefits this is too low, yet especially if we compare with the prevalence. There is a low investment in this program and its responsiveness is very low." Norma also commented about the value of its financial aid: "The idea of the *De Volta para Casa* is innovative. It is interesting that the families have a financial incentive to take back their relatives, but the incentive is not much: 240 reais is too low."

Leonardo presented similar numbers of people benefited by the *De Volta para Casa* program as Elias, but gave the official numbers from the government. Although he saw the program as limited in its first years, he believed this is only the beginning:

Today, we have around 3,000 patients in this program. In our estimates we still have around 9,000 to 10,000 patients living in psychiatric hospitals that also can be benefited. Thus, we have benefited a third of patients of the long-term admissions' patients. But the process is installed and is under way.

But, interviewees such as Fernando and Mario (please see Access to Services on page 59), were more concerned about the population that lives in psychiatric hospitals and had lost contact with their families. According to Fernando:

The *De Volta para Casa* surely has positive effects, but it is still very limited because there are people who do not have a home anymore. The situation is so dramatic that they do not have any place to return anymore. I had the opportunity to talk to few people about it, and we see the results, but very limited results.

As the service network includes resources such as the protected homes, these resources should be an answer for these concerns. But, in general, not too much was said about the protected homes during the interviews. Regarding their limits, Mario pointed out that there are no clear definitions about their function. Mario said: “Protected homes are for patients who cannot live with autonomy, but it is also true that the definition is not clear in terms of their function, goals, or mission.” Having other kinds of concerns, Norma regretted the lack of availability of this service in different regions and suggested that greater use of this resource is a solution for the long-term patients who have lost contact with their families. “I would invest more in protected homes as many people have lost their family bonds, and I would create them all over the country. The increase of this service is an alternative for people in this situation.”

On the other hand, six interviewees raised a series of issues related to the labor inclusion resources that range from legislation to quality of promoted actions.

Rafael, who works at the Ministry of Labor and Employment and specifically for the Solidarity Economy—social and productive entrepreneurships based on solidarity exchanges funded by groups of socially and economically excluded people—explained that the whole legislation of cooperatives in Brazil must be reviewed and adapted to new Brazilian socio-economic features, and surely this affects the more specific legislation such as for the social cooperatives. Here are his comments:

There are bills to update the legislation of cooperatives running in the congress for 15 years that are not voted because there are various interests in play. Until last year there were two bills in transit but neither one covered the diversity of the Brazilian cooperatives. We are trying to have a consensus in the federal government to update the general law of cooperatives and this is fundamental to allow advances in other specific laws. For the social cooperatives, we already have legislation but it is totally inadequate, and it has been used to inadequate ends. But first we need to have a consensus in the government, dialogue with the society, and build political power and alliances in the National Congress to finally put the bill in transit.

In sum, Rafael considered legislation for social cooperatives a limitation for its actions in mental health but assumed that the issue is much far beyond for what is the scope of the Solidarity Economy and Mental Health program.

From the perspective of one of the representatives of the legislature, Fernando, there should be more investment in solidarity economy and mental health:

I think the State should invest more in solidarity economy which talks about equity: equity among the ones who share being socially excluded. It is how we can give opportunity to them to build the sense of collectiveness and being socially included. Their self-esteem is also increased because it is not only a job, or an income. It is a kind of reeducation as they work to an association and should not be individualist. It is a great resource but it has been little oriented and stimulated.

For other interviewees, the lack of communication of mental health with other sectors is a central point of discussion because it limits a labor inclusion program that includes different strategies for work and employment. Elias criticized:

In terms of income generation and solidarity economy there are very local and specific interventions. I think there is a governmental initiative because they promoted a seminar. But, the big issue is that the sanitary services do not traditionally work with intersectoral actions, or to work with other actors. Thus, they don't have a sociological understanding or understanding about the dynamics of the economy. Moreover, they are not willing to realize and stop doing things that are so primitive in terms of what will promote income generation.

Mario and Vanessa pointed out the lack of partnership between mental health and the commerce and services sectors. Mario analyzed the situation in the following perspective:

For income generation the government has what they call a work team, but they don't promote any action: they are only studying how it could be. I think they should invest, for instance, in work quotas for people with mental disorders in various companies in the market. But the problem is not only in this work team because it is necessary to have general orientations, but the problem is at the municipal level, and their management to deal with these kinds of policies.

Vanessa only knew about governmental actions for labor inclusion promoted by the CAPS: "Only the CAPS have these kinds of actions. At the CAPS we can start a cooperative and show our products at street fairs. This is the way we can work."

Daniela's perspective illustrates how the legislation is operating under limits at the street-level of policies and believes there is an adjustment missing between the new laws and the legislation for benefits at the social security. Daniela said:

I think the law has a gap because if people with mental disorders start working again, they lose their disability pension from the social security. When they work in a cooperative, it is

not an economic advantage to be an official member because it means they will lose their pension. What is happening is that many people choose to work as volunteers and consequently will not have the same benefits as the official members of the cooperatives do. Although I have heard that there are cooperatives that produce well and members earn good money, there are others, as in our case that do not. In our case, the money is not sufficient to the point that they can give up their social security benefit.

Similar to Vanessa's concern (regarding limits of financial resources), Daniela's concern not only points to limits of legislation but intrinsically also indicates limits of sustainability of programs and the subsequent financial hardship of members of social cooperatives. It suggests that consumers of services and family members are apprehensive about how the Brazilian government is addressing the issues of financial limits of social cooperatives.

Lack of Data

A total of four stakeholders pointed to limitations of policy implementation caused by the lack of data in planning programs and actions in psychosocial care. Mario, for instance, stated:

In Brazil we probably have multiple realities, and we cannot have a single recipe that fits them all. I suggest a documenting of these realities. This is why it is important to think in terms of local planning—state and municipalities. The first step the Ministry should have taken was to implement studies or grant epidemiologic research; as far as I know this resource does not exist. The extant studies are academic and much too specific. . . . other studies are from international agencies.

Moreover, interviewees said that as data is scarce, it is difficult to understand about the national trends of psychosocial care policy and the successes or failures of implementation in various states or municipalities. "There are numbers: 910 CAPS, 475 protected homes, 2840 benefited people, R\$240 for the De Volta para Casa, but there is no data from the Ministry of Health on psychosocial programs, social inclusion, actions on citizenship, or labor inclusion" (Norma).

Matheus was very concerned about the existence or lack of a monitoring system for psychosocial care and questions:

We not only worry about knowing the number of people assisted, but if there is a monitoring system. We want to know if municipalities are taking care of monitoring patients assisted in programs. . . .Is the patient who is only being assisted at the CAPS and having a home, having a job, and participating in the community today, also being monitored?

Mario and Leonardo commented specifically about the lack of data produced by the CAPS. "There is no specific assessment of what CAPSs are doing; [only] the quantity of CAPS is well tracked. This is a gap. Reports exist about some [experiences] but they portray very specific situations, limiting our understanding about larger regions" (Mario). Talking about the assessment of the extra-hospital

system, Leonardo only reports one kind of assessment specifically designed for CAPS. Being certain that this assessment is not enough, he also is not entirely satisfied with the actual evaluation resources available and admitted:

In regard to the assessment of the extra-hospital system we have a very initial kind of screening, called "Avaliar CAPS" [Evaluating CAPS]. It is conducted annually but we need to have more frequent evaluations. It also needs to be deepened. Basically, it is a quantitative questionnaire to be responded to by the CAPS coordinator or the person in charge of the service. It has just one informant. We need, therefore, to aggregate qualitative assessments.

In sum, although stakeholders emphasized the lack of different kind of data, they all agreed about the need of more investments in research, assessments, and monitoring in order to advance in planning and executing policies in mental health.

Considering Advances

All of the interviewees support psychosocial care and agree that an effective psychosocial care system guarantees the civil and human rights of people with mental disorders, because "the person, feeling he/she is respected, will rehabilitate as someone who is considered as an individual, having a history, having a life" (Fernando). Besides, stakeholders in the sample understand psychosocial care as the component in mental health that guarantees integral care, a principle of the SUS:

Mental health cannot be understood in a strictly sanitary context, offering resources typically organized as . . . medical technologies, technologies of treatment to recover health damage; this is where the idea of rehabilitation helps: it calls for the promotion of the rights of health and welfare. (Marcelo)

Based on these priorities, although stakeholders pointed to various limits of policy implementation, although they also recognized advances in the Brazilian mental health system. Daniela, as a family representative from Fortaleza in the state of Ceará, recognizes the advances already taken within the CAPS initiatives:

At least in my city the CAPS already started to work in the communities. We can tell that after this last government administration there is a big change: the patients are not only being transferred from hospitals to CAPS, at least here, they are calling for the families' participation. They even conduct domiciliary visitation. The ideal is this: families and teams working together.

Moreover and in terms of labor inclusion, almost every interviewee gave a high value for collective experiences, such as social cooperatives, which facilitate the feeling of belonging. Based on his expertise, Rafael was glad Brazil could include social cooperatives in its labor inclusion program and explained:

In social cooperatives, it is fundamental that participants decide collectively what they will do, why, with what goals, and for what public. It is gathering and deciding together for a common good. . . . It was a forward step when the Ministry of Health launched an edict in which part of SUS resources could be invested by the governments in mental health activities. This means we do not need to use resources from the same funding that goes to mental health in general and that states and municipalities which implemented actions in income generation would have more resources aggregated.

Therefore, Rafael saw as positive the efforts of the government to create a strategy in which it could ensure investments in this area.

Conclusions

As illustrated by interviewees, the concerns for psychosocial care policies in Brazil are mostly due to how inclusive the policies are when they are formulated and how inclusive they are when implemented, particularly in regard to the access to various psychosocial interventions from services or programs. Moreover, interviewees pointed out the limits of the quality of services provided and questioned if the assistance has been integral, or in other words including various disciplines and partnerships among different sectors. A total of 11 interviewees indicated limits of psychosocial interventions. Findings show the following trends of opinion among participant stakeholders:

Six interviewees, who represented institutions which defend the rights of society to have quality of access and assistance in health, were very concerned about how distance is still the ideal of the reform from pragmatic issues. All three stakeholders in the sample representing professional associations, which in Brazil also have as main function the monitoring of the quality of services provided by professionals, were among the ones who pointed to lack of intersectoral actions. In addition, the representative of the “umbrella” NGO indicated the same limitation. Beyond the fact that one representative of the legislature confirmed limits of intersectoral actions, both representatives of the legislature also considered the majority of psychosocial interventions as originally from the civil society, and thus from local and specific groups. Representatives of the legislature, concerned about the guarantee of the rights provided in legislation, saw the minimal existence of psychosocial interventions in the public sector as a threat to the universal principal of SUS for access to health.

A small number of interviewees indicated issues related to financial resources allocated to psychosocial care, and here it is clear how their positions highlight this issue in different ways. A representative of a professional association was concerned about the low budget allocated to contract human resources; a consumer of service representative of a social cooperative was concerned about the low budget invested in labor inclusion and more specifically income generation initiatives; and an

academic, who is also a consultant for regional and local implementation of the service network in mental health, pointed to limits on how funding is planned to be allocated, limiting regions or locals in which the reform had already advanced.

Regarding the psychosocial care resources more specifically, 10 interviewees pointed out the limits of CAPS, the *De Volta para Casa* program, the protected homes, and the labor inclusion initiatives. Overall, members of NGOs were concerned about the limited access of psychosocial services or programs, sometimes related to provisions in legislation, and their isolation from other community resources, as well as the limited financial aid of the *De Volta para Casa* program. Members of professional associations also pointed to the lack of communication of services and programs with other sectors or community resources. But they were also concerned about professional training and the kind of assistance offered by professionals working for CAPS and the still unclear definition of the scope of the protected homes. Representatives of the legislature indicated various limits of access, especially among the long-term admissions population still remaining in psychiatric hospitals and their housing issues. They also pointed to the low investment in solidarity economy. For the representative of the Ministry of Health and the Ministry of Labor and Employment, their concerns were about the necessary steps to enable programs that have excellent perspectives to gain practical sustainability and effectiveness. The Ministry of Health indicated the necessity to increase access to the *De Volta para Casa* program, and the Ministry of Labor and Employment pointed to the need of adequate legislation for cooperatives in Brazil, particularly for social cooperatives as is the case for mental health.

Moreover, four interviewees presented concerns about the current lack of data produced by the Ministry of Health in reporting the mental health reform's trends, failures, and successes. Representatives of professional associations and legislature pointed out the lack of program evaluation and monitoring systems for the various psychosocial resources, particularly the CAPS. In the case of CAPS this issue was also confirmed by the representative of the Ministry of Health. In sum, interviewees were especially concerned about how the Brazilian reform will achieve full implementation if there is a lack of data to support planning and evaluations.

PRIMARY HEALTH CARE

The third theme from my interviews regarded the way that mental health intersects with primary health care programs. As mental health is part of the SUS, Brazilian mental health strongly inclines toward the gradual implementation of more and more programs in primary health. This trend is closely associated with the SUS features inaugurated and carried out primarily by the health reform,

and which, since the 70s, has had a mutually influential relationship with mental health reform. In addition, the model of psychosocial care adopted in the country reinforces this trend when it is inspired by the concept of territory. Thus, both factors significantly contribute to push Brazilian mental health policy to implement services based on the resources and people in the community. In this context, it is expected that psychosocial care programs and education in mental health establish a close partnership with primary health programs, particularly the Family Health strategy.

On the other hand, this section presents findings on how the implementation of psychosocial policies is negatively affected by insufficient investment of the Brazilian reform in primary health care. Five interviewees contrasted ideals with limits of implementation and of legislation, and raised their concerns about various issues such as:

1. Limits faced by professionals from the Family Health Strategy
2. Shallow interventions of the CAPS toward the community
3. Limitations of legislation

Considering that this theme is proportionately less prevalent than others, and that the three sub-themes overlap, the findings in this section are presented together in a text without sub-headings.

Two interviewees criticized services offered and training of professionals to implement mental health in primary care. For one of these interviewees (Mario) the insufficient availability of substitutive services limits programs that already exist in partnership with the Family Health Strategy. According to Mario, professionals in this strategy program work in the communities but “don’t have the necessary support” and subsequently do not know how to address problems: “Where to refer the patient? How do we deal with situations in which we identify a case of mental disorder?” Norma presented similar criticism:

The Family Health strategy and the Community Health Workers are fantastic programs in the SUS; they are the closest programs to the population, but you don’t see in their teams professionals with qualifications to handle cases of mental disorders. This is what I call the lack of a universal policy. If the policy was universal, it would also transverse these other programs in the community.

Mario agreed with Norma that the partnership with the Family Health Strategy is one of the greatest instruments to facilitate mental health in the communities, but regretted that the insufficient number of services is limiting the effectiveness of this partnership:

We have an insufficient number of beds, but the demand exists and it is even greater after the interventions of the Family Health Strategy in the community. The visits of the community outreach workers naturally increase the demand for services, especially among individuals who have not yet reached an out-patient clinic or an emergency service. Many

times, they are people in miserable conditions; sometimes suffering human rights violations such as being tied up or locked in a small room in the backyard. All these are horrible situations. These cases don't reach the system without community interventions.

Similar to criticisms presented in the previous sections toward psychosocial care implementation, two stakeholders, Claudio and Matheus, criticized mental health in primary care citing the limitations of actions of the CAPS' programs. Claudio, for instance, criticizes the isolation of these services as if they were self-sufficient and said that if health professionals in Brazil "used to criticize the specific centers for diseases [for acting autonomously], now this is also happening in psychiatric reform." Claudio, who also has been an activist for health reform and has supported mental health reform since the 70s, affirms the ideal of mental health being integrated with health care in general and regrets mental health's actual trends: [First the Ministry of Health implemented] the CAPS' service network without integration with the health service network, and only now [this ministry] is trying to see how [the CAPS] can be a partner with the Family Health strategy." In other words, Claudio perceived the lack of planning of actions toward the partnership between mental health programs and the primary health, particularly between the CAPS and the Family Health strategy, as a threat to the ideal of the project of the reform. Without planning, involving both sectors, actions in the communities cannot be effectively implemented.

Taking into account that the CAPS "are the front door to assistance in mental health," Matheus highlights the important role of these centers to offer care for the needy population in accordance with the SUS principle of integrality. This principle defines individuals as bio-psycho-social beings and therefore guarantees health assistance that respects this intrinsic characteristic. "Today, the CAPS are assisting the demand coming from the hospitals. In fact, they should be working with the community and with prevention. [This happens] when we implement decentralization in a context that [does not offer any other services]."

While Mario, Norma, and Claudio pointed to limits of implementation based on limitations of interventions, Alfredo indicated limits of policy formulation and laments that the law 10.216 does not mandate about interventions in primary health, limiting the scope of actions integrated to the community.

I think that it is a problem, the fact that the law 10.216 does not include any specificity regulating the cooperation between mental health and other areas of health in general, such as the Family Health Strategy and the basic health units [or health centers]. These services are subordinate to primary health which has its own management and the Mental Health General Coordination is limited, without legislation for it, to implement actions in primary health.

All of these interviewees are concerned about the shallow cooperation between the mental health and the primary health care sectors and tend to see this as a harmful element for mental health's full implementation and achievement of goals, particularly the accomplishment of an effective community-based service network.

Considering Advances

Although it was not cited by other participants of the interviews, Leonardo from the Ministry of Health revealed a great advance in mental health and primary health: a training course in mental health for 5,000 community outreach workers. According to Leonardo this course inaugurates new trends and one of the main goals for mental health in the year 2007: promotion and improvement of interventions in primary health. He explained:

Last year we promoted a monitored online training course for 5,000 community outreach workers! We are also working on a project that is still in negotiation among the Ministry of Health, the municipalities, and the states. We are discussing with the primary health a proposal to expand the funding for the municipalities to implement mental health interventions in the primary health. This means that the funding will allow municipalities to contract mental health professionals responsible for supervising cases, assisting with primary health teams, and training primary health professionals to be able to assist the population, thus avoiding referral to secondary systems or hospitals, which is possible when needed.

No other interviewees brought up advances in the cooperation between mental health and primary health, but hopefully the goals for the year 2007 were accomplished and, in the near future, other studies will be able to record even more advances.

Conclusions

According to interviewees, there is little interaction between mental health and primary health, a kind of gap that might harm the full project for the new system of assistance in mental health.

Mario, representing a professional association, and Norma, representing the Commission of Human Rights at the legislature, believed that there are limits faced by the Family Health Strategy generated by an insufficient service network in the community and by a lack of trained professionals to conduct interventions. These insufficiencies make it difficult for referrals and services to follow up the identified cases. In addition, Matheus, also representing a professional association, and Claudio from the National Commission for Social Determinants in Health, pointed out a trend in which the CAPS are isolated from the health sector in general, focusing their interventions on absorbing those demands which were first assisted by the hospitals. This trend limits CAPS' interventions to more clinical

approaches, inhibiting other interventions based on CAPS' primary functions: the responsibility for certain geographical areas through territorial actions.

In sum, for mental health professionals and members of national commissions in health and human rights, both the lack of training of human resources in mental health in the primary health and the shallow intervention of the CAPS in the communities represent how the implementation of the new system has fallen into a very limited comprehension of the scope of mental health.

Finally, only a NGO representative, Alfredo, raised a concern based on the extant legislation, in which neither the mental health sector, nor the primary health sector has clear definitions to regulate mental health interventions in primary health.

In terms of advances, only the top official of the Ministry of Health pointed to positive perspectives in actions integrating mental health and primary health, particularly the training of primary health workers in mental health issues. As these perspectives are in contrast to one of the major concerns presented by other stakeholders—the lack of training in human resources—they require a more analytical approach based on a broader picture of the implementation process, which is presented in the following chapter.

REGIONAL DIFFERENCES AND MUNICIPALITIES

The fourth theme from my interviews concerns the differences in implementation between regions or municipalities. As we have seen, decentralization is another important feature of the SUS and means that municipalities have the major responsibility for implementation of policies. Overall, the intention is to avoid long bureaucratic processes of implementation between the federal government, states, and municipalities, and to promote the implementation of policies that are closely related to the specific needs of a population. As Matheus says: "the national policy aims to achieve social inclusion through a decentralized process that calls for the responsibility of municipalities."

Concurrently, eight interviewees pointed out various limitations of implementation already existent, such as:

1. Accentuated differences among regions, states, and municipalities
2. Issues of municipalities

Accentuated regional differences are associated to limits of management at local levels. In terms of municipalities' issues, these findings also include the low priority and the limited accountability at the municipal level as among the major factors causing these differences.

A total of eight interviewees in the sample pointed out how difficult it is to characterize Brazilian policy implementation because of these accentuated regional differences and/or how the central role and autonomy of municipalities has tended to further minimize the priorities for mental health, particularly psychosocial care.

Regional Differences

Four interviewees presented their concerns based on the unevenness of access and care in the actual process of implementation at the local spheres. They presented these regional differences in a variety of ways and with their own interpretations of the causal factors.

Marcelo said he has traveled frequently for consultancy in different cities. Therefore he provided a big picture of the implementation process according to regional differences:

The reform didn't advance equally in the different regions, for it was not possible in some regions. We have states where the reform—and the health reform—never happened. The capital cities and their counties are the places where this process has been the last to arrive, but we achieved the reform in medium-sized and inland cities. Today, among the capitals, these three are the most advanced cities: Belo Horizonte, Fortaleza, and Salvador. I consider their progress more for their efforts to initiate the reform rather than for the results because they have only three or four years of implementation.

Fernando showed that the dependency of Brazilian public health on public administration of municipalities has resulted in discrepancies for the assistance of citizens in all areas, including mental health:

Many municipalities do not offer anything; it is a total abandonment. . . . In the past we had the city of Campinas with good capability in mental health. In my state [of origin], today I do not know any municipality that is treating the situation as it should.

In agreement with Fernando, Luciano reaffirmed the regional differences in implementation and considered social and political support as determinant factors:

We observe that there are excellent interventions in certain places. Many times, they achieve a high quality of actions because of social issues rather than for the implementation process itself. I also perceive that primarily, everything depends on political support and motivations.

Besides political and social support, regional differences were thought to be a result of gaps of implementation of CAPS. Elias evaluated the accelerated rhythm of the process of implementation of CAPS a major causal factor of these differences:

For me, many things in many places happen in many different ways. I have difficulty characterizing Brazilian implementation. There was a very intense and rapid process in the

implementation of CAPS. Thus, a large part of these CAPS is still learning how to proceed or is thinking how to implement psychosocial interventions.

Although I do not identify any patterns of opinions in accordance with various stakeholders' interests in this topic, it is clear that these stakeholders share the opinion that reaching more evenness in access to care is a major challenge in implementation.

Municipalities

Six stakeholders in the sample pointed to implementation gaps caused by low priority given to mental health, lack of information, and budget management issues at the level of municipalities. In fact, these interviewees call our attention to limitations at the bottom-level of the implementation process. These limitations are also considered as causal factors in heightening regional differences.

The two interviewees representing the Ministry of Health indicated a still low priority given to mental health at municipal levels. Claudio discussed the different impacts or motivations of the reform among various municipalities:

The law [10.216] legitimized and convinced the State that the old model was not appropriate, but did not have an impact at local levels. Since 2001, only after President Lula's administration in 2003, we started to have a broader impact. In terms of policies for mental reform, we have already discussed at least the main issues, we included in the political agenda, we formulated and enacted legislation, and now we are implementing. Where implementation follows motivations of the reform, we have satisfactory processes; but where the mayors only used the reform as a way to gain resources, randomly contracting professionals but not considering their competence, the implementation will not be satisfactory.

Leonardo associated the lack of priority at local levels to the lack of awareness about the seriousness of mental health and stated:

In general, the municipal managers believe that mental health doesn't deserve the same priority as an emergency, neonatal intensive care, special surgeries, and so on. One of the tasks we have is to increase awareness about mental health problems and show managers that because mental disorders are highly prevalent—even if not so visible—they need to implement an effective service network.

Another interviewee, Fernando, also considered the lack of awareness or information a central issue in the limitations faced by mental health at local levels. Fernando said that "governments in general, and particularly mayors and governors, do not have the least notion of what an ethical treatment in mental health means and what assures dignity for the man or the woman in treatment."

In addition, the autonomy of municipalities also negatively accentuates regional differences of policy implementation in the country, a problem associated with budget management. Matheus, who

once worked for the government sphere, affirmed there is no limitation of funding at the federal level and emphasized the role played at the local level in managing budget for programs:

The SUS is financed based on the three parties: municipalities, states, and federal government investing together. . . . There is a rigorous transference of funds every month to all municipalities and states. The ones who want to work and work honestly, receive their resources, but also the ones who do not work honestly. We have resources, but they are not being invested correctly. Besides, we see in the news: in all governmental sectors—executive, judiciary, legislative—there are scandals with misappropriation of money that should be invested in the population.

Norma shared similar experiences:

In certain places the reduction of psychiatric beds are more related to the subsequent reduction of costs than to a differentiated conception of mental health public policy. . . . Unfortunately, the municipal administrations have used public resources in a very inappropriate way. The majority of them don't have transparency in accountability, and in general the federal resources aren't invested in the population.

Two interviewees, Leonardo and Elias, pointed out that even if they consider the decentralization process an advance in implementation of the SUS, they also fear that this process, which transfers managerial autonomy to local spheres, may produce negative effects on mental health policy implementation. Leonardo clearly described the differences between the ideal of the SUS proposal for decentralization and its viability at the bottom level of policies, and like many other interviewees, feared the risk of disinvestment in mental health, "because in the municipalities mental health faces the challenge of its own legitimacy. Officials comprehend that mental health is not a major priority and think that mental health does not have too many problems." Today the priority given to mental health is more centered in the federal government than in the majority of states or municipalities, and decentralization may put at risk advances already achieved and future perspectives.

Elias shared similar concerns:

In terms of funding, there was an increase of investment in mental health actions during President Lula's administration. Now, we are in a situation of the SUS in which there is a process of decentralization and therefore, inducing mechanisms of the federal sphere will disappear. Thus, we will become more dependent on the initiatives of the municipal administrations to both reduce the number of psychiatric beds and to promote the implementation and necessary improvements of the service network.

Based on Leonardo's and Elias' concerns, we can note that some stakeholders in the sample were not only criticizing the implementation of psychosocial policies at local levels, but were also hesitant toward the future guarantees of implementation when the decentralization process will be accomplished.

Because interviewees did not indicate overall advances made by local spheres in the implementation of mental health policies, this section does not present a “Considering Advances” portion. In general, a positive element on which the stakeholders in the sample agree is that, when priority for mental health will be given at local levels, the implementation process will be highly successful. High priority, political and social support, and autonomy to invest in local problematic or unsatisfactory areas, seem to be a fundamental resource to successful implementation.

Conclusions

Overall, findings on regional differences and municipalities indicate that the implementation of mental health policies, particularly in psychosocial rehabilitation, presents limitations of access and other limitations related to the role played by municipalities. In addition, some interviewees agreed that decentralization may cause negative effects on the implementation process because mental health, in general, does not have legitimacy at regional and local levels.

Various stakeholders in the sample indicated that there are accentuated regional differences in the implementation of mental health policies, particularly in psychosocial rehabilitation. This may indicate that the patterns for regional differences are more related to factual differences at the bottom level of implementation rather than to the interests of stakeholders. In sum, an academic (who is also a consultant for mental health implementation at regional and local levels), a legislator, a professional association representative, and a NGO member pointed out that political support and the lack of technical and methodological knowledge at local spheres impede the full implementation of policies and affect access and quality of care. In addition, the academic (Marcelo) also noted that size and geographical location of cities may affect implementation and observed that medium-sized and inland cities are more advanced.

Regarding municipalities' issues, various interviewees (four representatives of the government sphere, including the ones from national commissions, and a mental health professional who previously worked for the government sphere) pointed to the low priority given to mental health at regional and local levels, to the lack of awareness or information by local officials, and to inappropriate budget management. Moreover, Leonardo, from the Ministry of Health, and Elias, representing a NGO, raised issues about the lack of legitimacy of mental health at local levels; therefore, the potential negative effects of the decentralization process on policy implementation.

STAKEHOLDER AND CONFLICTS OF INTEREST

The fifth theme that arose from my interviews centered on the conflicts of interest between the various stakeholders in this policy area. Stakeholders also discussed their roles in mental health reform and their influences in policy implementation, but in general the trend was to point out limitations caused by other stakeholders and not by their own groups of interests. In this theme, patterns of opinions divided by the various interests become even clearer.

A total of eight interviewees pointed to one or more of the three major negative influences of their roles in policies:

1. Conflict of interests
2. Hegemonic position of the Ministry of Health
3. Diminished participation of the civil society

Conflict of Interests

In general, conflict of interest was present in seven interviewees' discourse. I say discourse because there was no question in the interview guide treating this theme and thus it was brought up spontaneously throughout the process of interviewing. Most of time, they pointed to the role of the institutional psychiatry, social movements, and the Ministry of Health. As in any context in which different forces exist, their arguments were determined by their own interests, trying to make their point of view to prevail over the others. At this point I will present divergent positions that well represent the general trends of conflict of interest, but the way these conflicts affect policy implementation will be discussed in the next chapter.

Two interviewees, Claudio and Elias, recalled the origins and history of the conflict of interests among stakeholders in mental health, which is worth noting here. Claudio illustrated this conflict using the broader context of health in Brazil:

The psychiatric reform and the health reform were born together. During the 70s, groups that questioned the situation of mistreatment of people with mental disorders were the same ones who also questioned the health conditions and assistance in general. Another issue was the health policies in which misappropriation of public funds from public hospitals was common and guaranteed the privatization of the health system. This happened in a very dramatic way in psychiatric hospitals and asylums. In this context, the groups who fought the authoritarianism, who fought for the democracy and against the dictatorship, who fought for a change in the health conditions of the population and for better assistance, were together.

Claudio, who has been an advocate of the health reform and largely supports the mental health reform, divided the conflict into two major blocks of interests: on one side, conservative forces that were associated to private economic interests and on the other side, progressive forces in the health sector that also fought for democracy. Elias, illustrating a more recent history, also pointed out:

The law [10.216] took roughly ten years in the National Congress to be approved. It happened based on a dispute of space at the legislative, a dispute represented by different conceptions and representatives of the industry of madness, particularly the private sector, which was profitable and associated with psychiatric assistance. It was a dispute for hegemony in which the political power of the private sector in congress and in society was greater than any other, causing limited growth of the new model.

Both Claudio and Elias considered the private economic interest and its political power as a major barrier for the process of mental health reform in Brazil. In addition, they contextualized historically the conflict of interests involving only two trends: a block of conservative forces and a block of progressive forces. After such insightful recollections, it is worthwhile to analyze the current landscape of mental health, particularly the one vividly represented among the stakeholders in the sample.

A total of six interviewees pointed out, from various perspectives, a conflict of opinions between institutional psychiatry and the progressive sectors in the mental health reform. Luciano shared his thoughts as a person who participates in the progressive sectors and discussed the concept of the reform:

We have avoided using the term psychiatric reform . . . this is something for the psychiatrists: if they want to reform, they reform, if not, they don't reform. We talk about mental health care as part of health in general and we even include the anti-asylum movement discourse, but we do not reduce the reform to this. [Mental health can go even further] than the proposal of alternatives related to the new policies of substitutive services and practices that do not include the asylums or psychiatric hospitals.

Luciano argued that the mental health reform goes much beyond psychiatric issues. Based on the interviews, it seems that most of the stakeholders agree with this position, which contributes to our understanding of the current context of the mental health reform. Alfredo, for instance, believes that the conflict is, at least in major part, based on the centrality of the medical power:

Traditional psychiatry, including the Brazilian Psychiatric Association, says it is in favor of the reform, but I think this is a political strategy because it goes against the reform every time an opportunity arises. The trends are something like this: we support the reform . . . we work at the CAPS, but the CAPS must be coordinated by a doctor and, as a last resort, the interventions must be based on medical interventions.

Also illustrating the different perspectives between the institutional psychiatry and the progressive forces, Leonardo showed how the comprehension of primary health by institutional psychiatry differs from the comprehension of the Ministry of Health:

Institutional psychiatry understands that our project in primary health is mistaken because primary health should identify the cases and refer them to the hospital; . . . we understand that it is necessary to train professionals from primary health to be better qualified to assist the cases of psychosis; otherwise we will be continuing down the same pathway of referring to the hospital.

Alfredo and Leonardo pointed out that the corporate interests of the institutional psychiatry have resisted a project of reform in which the role of beds in psychiatric hospitals is progressively disappearing, and the role of the psychiatry is not central anymore but reduced in prominence among other disciplines and interventions.

Moreover, Elias said that there are other ways in which traditional sectors resist the reform. As a NGO member, Elias affirmed that these traditional sectors take advantage of the current disagreement or conflict within the progressive sectors:

The Brazilian Association of Hospitals and the Brazilian Psychiatric Association took advantage of the criticisms the Anti-asylum Movement was making toward the implementation of the new policies and reactivated forces and initiatives of counter-reform. But, at that point, it seemed that they had already given up: numerous psychiatric beds were closed during the President Lula's first administration because owners of hospitals decided that the business was not sufficiently profitable anymore.

Similarly, Norma pointed out that not only the conflict between progressive forces, but the insufficient service network also provides opportunity to the institutional psychiatry and the private economic interest to take these advantages. Norma explained that even though there had been great advances by the closure of asylums, there are still some situations in which hospitals are still profiting from assistance to SUS patients and exerting political powers:

I cannot say that the services of hospitals were more technical or competent than services of CAPS. But, the medical sector is still evaluating beds at hospitals as necessary because the CAPS don't support a more technical approach. At the same time, there is still a strong lobby from the private sector to keep some hospitals. I guess it is more for economic interest than for the treatment of people with mental disorders.

Mario, representing the Brazilian Psychiatry Association, perceived the position of the psychiatry from a different perspective. He acknowledged that psychiatry is in a difficult position in the mental health reform in Brazil. On one hand, the new services that include psychiatrists are not yet properly structured yet in the network; on the other hand, the demand for medical interventions still exists but the psychiatric hospitals are already ignored among social and political forces:

The Ministry [of Health] proposes that psychiatry should assist along with other disciplines. But, for instance, psychiatry is not included in the primary health; thus, there would be psychiatric beds in general hospitals. . . . In my point of view, at least in the transitional period, the psychiatric hospital could be improved to assist the population and, progressively, we would expand the other services. . . . Sometimes the CAPS referral patients to this hospital, and when I tell this to the people in the ministry they say that they shouldn't do it. But, in most of the CAPS, they don't have a doctor there. In the end, the discussion of the reform is still filled up by corporate interests and the society is still associating the psychiatric hospital with the dictatorship, with the repression, and now the hospital is too stigmatized.

From previous discourses, we can note corporate interests represent an important issue in the conflict among stakeholders. Two other interviewees, Luciano and Claudio, indicated this same issue. Luciano also believes that when professionals assume corporate positions, there is also a bureaucratization of their roles and subsequently of the services in which they work. But, he focuses on the corporate interests among professional boards: "I don't see communication or interdisciplinary discussions among professional boards. In practice, we observe they have their own issues and repetitive complaints which will cause a stratification and bureaucratization of services." Leonardo goes even further and explains that corporate conflicts produce the current crisis in the process of building a mental health reform in the country:

There is a current crisis in building the reform based on the conflict opposition between mental health and psychiatry, as if this opposition naturally existed. But this opposition is produced by corporate manifestations on both sides. There was a strong corporate position from psychologists and nurses, presenting their demands as demands against the medical corporation. . . . But what is predominant is the strong discourse from the traditional psychiatry to recover an idealized past. . . . This is in the sense that there is a dispute about the entire process of implementation of the new model of assistance in the name of the 'true' psychiatry and of the 'true' method to organize mental health services.

Claudio analyzes the corporate interests among professionals as a threat to the progress of the reform:

The corporate battles of doctors and surely of other professionals in the mental health field took them away from broader and generous ends. This also happened in other fields, but I was always enthusiastic with the fellows from mental health in our times of battles, and now, this strategic or even reactionary position of certain professional categories is limiting the progress in mental health. It is too difficult to define universal policies when each one is looking at his own situation. Therefore, a discussion of power is necessary.

As Claudio said, it is necessary to understand the relation of power among the diverse stakeholders to better comprehend the existing conflict of interests. Chapter 6 includes a subsection to exclusively treat and analyze this issue. But, as we saw in the beginning of this section, findings still

point to two other components of the influence of stakeholders in the implementation process. The next subsections present them.

Hegemonic Position of the Ministry of Health

Almost all of the six interviewees who brought up conflicts arising from the position of the Ministry of Health, particularly the General Coordination of Mental Health, critiqued its hegemonic role in mental health policy, especially in the second term of office of President Lula's administration.

Elias pointed out the isolation of the General Coordination of Mental Health of Lula's administration from social movements. For him, this position was unfortunately the strategy this Coordination created to keep the relation between them and local officials safe:

[They] stopped the dialogue with social movements since these movements have a local action which most of the time will confront local officials, and the Ministry wants to keep a good relation with them. The interest of this Ministry is to persuade in numbers, like 'the more, the better.' I am not saying that this policy does not have logic. It has: you consolidate a substitutive service network, and then you implement in a short time a great quantity of services to make volume.

Mario contributed to the discussion of the hegemonic position of the Ministry of Health, pointing out the negative effects of this position on the creation of a rationale to facilitate the necessary support to mental health reform:

I think it is missing a rationale. The Coordination is not working with universities and many other social actors. Theoretically, sometimes they come, they talk, but when they do something, they do according to their own way. It is too hegemonic. The lack of dialogue, of interface, of interchange is huge at this time.

Mario also specifically talked about the dialogue between the Coordination and the Brazilian Psychiatry Association:

They intended to do their job in a too self-sufficient way. We are trying to having a dialogue, but the way they perceive our movement is as if we were confronting them. In truth, we don't want to confront. We are willing to participate. At least we may contribute with subsidies, but we are also conducting several studies in various perspectives.

In parallel, four interviewees, criticizing the powerful position of the Ministry of Health, framed it as a typical situation intrinsic to politics: that of an unequal game among forces and powers. Alfredo recognized that the coordinator of the General Coordination of Mental Health himself "has also participated in the Anti-Asylum Movement" and concluded, "But it is obvious that when you are an official you cannot hold the same position as an activist because there are politics involved and all the political pressures." Fernando lamented: "There was an incorporation of some representatives of social

movements in the institution for execution of mental health policy. When it happens, they are not representing social movements anymore. They don't mobilize actions anymore." Luciano characterized the hegemonic position of the General Coordination of Mental Health as in other offices of the Brazilian public sector:

For me the major problem of public policy in Brazil is the implementation without consulting the forces at the bottom-level. It is a political issue. 'I impose, I determine, I don't suggest, I don't propose, I don't discuss.' It comes from the top down.

Mario was a little bit more sarcastic: "I do not know what happens in Brasília; I really think something happens there, maybe it is the water. Everybody after arriving there seems to become kind of autistic."

On the other hand, Leonardo, from the General Coordination of Mental Health at the Ministry of Health, indicated diverse movements of dialogue between this Coordination and other mental health actors. In terms of the relationship between this Coordination and the psychiatric sector, Leonardo perceived attempts of the Ministry of Health toward a dialogue with this sector:

After the intensification of positions of certain institutional psychiatry sectors, this process has not yet improved, and it is because the Ministry of Health did not make efforts to promote a dialogue. There were different ministries in recent periods but they all, according to this Coordination's suggestion, received various leaders of the psychiatry association to discuss issues, create work groups, and so on.

Leonardo also talked optimistically about the new dialogue between the Coordination and public universities:

We are [also] supporting public universities to create discussion groups toward the production of knowledge on psychiatric reform. In accordance with the principle of democracy from the SUS, we are having annual scientific conferences to draw up a proposal to the Ministry of Health to have a regular scientific publication on mental health in the public health sector. The intention is to better qualify the debates and discussions.

Up to this point, it is clear that the perception of the General Coordination of Mental Health and other interviewees differ in terms of whether there is a hegemonic role played by this Coordination and its repercussion in the reform. But, among the ones who believed there is an isolated and hegemonic position of the Coordination, two interviewees that represent NGOs in the sample and that have an active involvement with the Anti-Asylum Movement also admit that criticisms are part of the game. As activists, they stated that, independent of the Coordination being currently coordinated by more or less progressive actors, the role of the activist is to question and always ask for more progress:

The mental health social movements, since their origin in Brazil, defend the need of an organized society with alliances among professionals, consumers of services, families,

progressive organizations, but always independent of the government and the State. This is our goal, this is our place. The position of who is in the Coordination is transitory; we cannot count on the position. The positions in the government change but we are always in our place, the place of making counter-points (Elias).

"We cannot say that the Brazilian mental health policy is conservative. On the contrary, compared to many other countries it is very progressive. But, our role as militants is to constantly push and question for more advances or progress" (Alfredo).

In sum, it is important to note that although most interviewees agreed on the hegemonic position of the Ministry of Health, there are other factors that shape the relationships among stakeholders. Among these factors, the interests of various positions and the dynamics of forces and powers intrinsic to politics also play an important role in the Brazilian mental health reform.

Participation of the Civil Society

The diminished participation of civil society as a force to push the priority for mental health was felt after the approval of the law 10.216. According to Claudio and the two representatives of the legislature in the sample (Fernando and Norma), all the activity and mobilization that made this law possible waned once it passed.

Claudio evaluated the overall participation of the civil society as insufficient and more specifically, much less active if compared to the 90s. Moreover, Claudio called attention to the fact that the SUS structure incorporated the participation of the organized civil society as a fundamental component. Unfortunately, mental health social movements are not taking advantage of this as much as they could:

In the SUS whoever mobilizes and organizes also wins. At the health conferences, whoever organizes a group and participates can suggest topics for discussions in the agenda. Moreover, a more democratic government [as the current one] will be more available to listen to certain claims. . . . The mobilization must be progressively enlarged, but instead, mental health movements are diminishing since the 90s. The Anti-Asylum Movement itself is losing strength.

Fernando said that even if the reform is not entirely accomplished in the country, "steps that were already taken . . . suppressed the fight against the asylums and the fight for the human rights. Today, there is too little coming from society to the parliament and the participation of movements is reduced." Norma, in a similar way, addressed this issue:

It is lacking more organization from the civil society . . . because it has fought tirelessly for twelve years for the approval of the law [10.216], but from 2001 until now they have only sponsored the third national conference of mental health and nothing else. Thus, the civil

society needs to be more active, fight more, call for a new conference and evaluate the law. I see little mobilization in mental health, little pressure on the public sector. All of the advances achieved in this country have happened because our society has fought for them; if you don't fight, you don't see actions.

It is interesting to note that none of the three interviewees that brought up the diminished participation of the civil society are active members of the organized civil society in mental health, but all of them are supportive of mental health movements and in the past contributed to their actions.

Considering Advances

In general, interviewees recognized the important role of mental health professionals, who are also activists, for launching mental health reform and sustaining its human rights inclinations. The role of the organized civil society, particularly the Anti-Asylum Movement, was also cited as fundamental for the implementation of community-based services independent of the public sector and of the approval of the law 10.216.

In terms of how the Ministry of Health is advancing in its dialogue with the society and its different sectors, Leonardo brought up a couple of advances. He previously had cited the new partnership with public universities; another advance he identified is that this Ministry has been able to attract more social support to the mental health reform, particularly from the *Ministérios Públicos* (Public Ministries).²⁵ Leonardo is very optimistic about the support the *Ministérios Públicos* have given to the reform, having more interest and knowledge about the mental health national policy and contributing with the monitoring of the implementation of it at local levels, particularly in cases of from society. Leonardo states: "The *Ministério Público* has given great support to the reform. It acknowledges the legislation, issues solicitations to municipalities in order to follow what is mandated in the legislation, and so on."

In regard to the relationship among stakeholders, Marcelo perceived a productive consensus among social sectors at the bottom-level and considered this consensus essential to the reform continuity, particularly in times of crisis or political instability: "There is a consensus among the workers, researchers, university leaders, certain social and community leaders, and more progressive parties which guarantees the continuity of the reform."

²⁵ The *Ministérios Públicos* are defined by the Brazilian juridical power as "a permanent institution, essential for the function of the juridical power of the states. Among its functions it should: defend the juridical terms, the democratic regime, and the social and individual interests." For more details please see <http://www.mp.rs.gov.br/conheca>

Finally, for both Mario and Leonardo the emerging discussions about mental health and the process of its reform in Brazil is very fruitful, provoking professional discourse and stimulating an increasing research in the field. Leonardo admits studies are still scarce but is optimistic about future trends that are having their origins in the current process of the reform:

We need to increase the production of knowledge about new methods in mental health. Certainly these new methods are not throwing out Freud, Kreplin, biological psychiatry, phenomenology theory from Jaspers, tradition of the psychopathology, psychoanalysis, psychology, and so on. On the contrary, it will incorporate all these.

Mario also optimistically views the production of knowledge among mental health actors, particularly psychiatrists:

It is important that actors are willing to increase their knowledge, particularly the hospitals and the Brazilian Psychiatric Association. It is important to have the impetus to know what exactly has been discussed. In the psychiatric field, we are starting to have a greater interest in epidemiological studies, the impact of various procedures, the impact of public policies, and so on. Before our studies were too centered on medication, treatments, or more ideological issues, but little attention was given to the system and methods of mental health care.

Both Leonardo and Mario believed the increase in production of knowledge will contribute to productive debates about the reform and may minimize conflicts based only on habitual ways of thinking among different interests.

Conclusions

The theme “Stakeholders and Conflicts of Interest” is represented by three major themes discussed by a total of eight stakeholders in the sample:

The findings show that the first theme, “Conflict of Interest,” was brought up by seven interviewees. These interviewees highlight: the historical conflict between the interests of the private sector and the progressive sectors of the reform, the role played by psychiatrists in the process of the reform, and the strong presence of corporate interests among professionals in discussions and positions taken for the reform. Moreover, it is interesting to note that the conflict characterized between two blocks—the ones in favor and the ones against the reform—took other configurations after the Brazilian national policy was enacted. Although there are still forces that resist the rapid progress of the reform, conflicts are also felt among the ones in favor of the reform as their interests are diverse.

Regarding the theme “Hegemonic Position of the Ministry of Health,” six interviewees among NGO members, representatives of professional associations, and members of the legislature, pointed out the limits of this position from different perspectives. They talked about: (a) The isolation of the

General Coordination of Mental Health from social movements, especially for its interest in maintaining a balanced dialogue with local administrators; (b) the isolation of the same coordination from universities and its resistance to dialogue with psychiatrists; and (c) the typical position taken by more progressive sectors when in power, especially because of dynamics of politics. Concurrently, a contrasting perspective is given by the representative of this Coordination, in which discourse has revealed the possibility for establishing dialogue with other sectors, such as universities and even the psychiatric sector. However, whether or not the hegemonic position of the Ministry of Health is a major issue of implementation, interviewees' discourses clearly show how their interests might shape their interpretations about this phenomenon. Findings from the militants' discourses also reveal that the most important aspect in their criticisms about the position of the General Coordination of Mental Health is their role in the reform of keeping an acute and constant criticism of the process, and subsequently pushing officials toward advances in implementation.

Three interviewees included the theme "Participation of the Civil Society" as one of their major concerns. Findings indicate that the civil society's participation in political institutions has progressively diminished, and consequently is losing political power and opportunities to be represented in the various mechanisms of popular control. For interviewees this current position of the civil society can greatly harm the level of priority given to mental health.

On the other hand, there are also optimistic views among stakeholders, in particular brought up by academics, psychiatrists, and top officials. They envisioned a better perspective in the future for the debates among stakeholders about the reform. They saw an increasing and productive consensus at the bottom-level, and the emergence of new trends in research on mental health which might contribute to maximize productive dialogues among actors, even if they have different interests. They also perceived the emergence of social support from institutions not in the mental health sector, which may help to weaken the particular interests of groups, thus enhancing the spirit of common goals directed toward the success of the reform. Further analysis is given in Chapter 6.

STIGMA, PREJUDICE, AND INEQUALITIES

Finally, my stakeholder interviews showed how stigma, prejudice, and inequalities can be related to the implementation gap of mental health policies, mainly in psychosocial care. In regard to stigma and prejudice, findings also show the interrelationship between stigma or prejudice and implementation, which suggests a vicious cycle. There are situations in which stigma or prejudice negatively affects the implementation of policies, and others in which gaps of implementation reinforces stigma. All

interviewees at least once indicated a relationship between stigma or inequality and mental health policies, making this one of the strongest patterns among the explanations for the implementation gap.

Findings show the presence of the following factors as limits of implementation:

1. Stigma and prejudice as an obstacle to implementation success.
2. Lack of social and political support.
3. Influence of services and programs on stigma.
4. Prejudice against people with mental disorders deepened by association with other discriminated groups, such as low socioeconomic status (SES), race, and gender.

Stigma and Prejudice as an Obstacle

Five of the stakeholders in the sample agreed about how the persistence of stigma and the presence of prejudice can serve as obstacles against mental health policy implementation, constituting a service network in the territory, and more specifically, the implementation of psychosocial services and programs.²⁶ For Alfredo, the major limitation to full implementation is the “prejudice existent in the culture. There is still a great prejudice against people with mental disorders.” Luciano and Marcelo agreed, but also in terms of stigma: “One of the great barriers to be overcome in the implementation of psychosocial rehabilitation is the social image or the social stigma present in the general society” (Luciano). “In psychosocial rehabilitation it is important to overcome barriers of stigma and prejudice, which are not only a problem in Brazil but in the western societies.” Rafael saw that, in terms of policies, the great barrier is among politicians and professionals: “The mentality of governmental officials and of health professionals is a strong barrier. This reflects what the society in general think about people with mental disorders.” Bruna, a consumer of service representative of an NGO, perceives that prejudice against people with mental disorders is a long-lasting type of social attitude: “The prejudice will never end. For example, when employers know that a person has depression and takes medicine, they are not willing to have this person as an employee anymore, because now they think this person is mad.”

²⁶ As many interviewees used both terms, stigma and prejudice, I present the findings using both as well. Stigma, a concept developed by Goffman (please see Chapter 2), corresponds to the devaluation attributed to people with mental disorders. Prejudice is used as stereotyped beliefs and negative attitudes toward people with mental disorders.

Social and Political Support

Eight interviewees indicated that social and political support for the reform and for psychosocial actions is negatively affected by stigma or lack of information, which can lead to barriers in implementation. Moreover, they also conjectured about the role dissemination of information may have in diminishing stigma and prejudice and increasing social and political support.

In terms of political support, Alfredo admitted that although the current Brazilian government has made advances in proposing “more equitable policies in health and distributing resources among various sectors, mental health issues have several myths and representations that make mental health the last to be thought of in terms of public investments.” He also conjectured that the different levels of government do not give the priority to mental health because of the low “political participation of people with mental disorders.” Even though other interviewees did not bring up how the political participation of consumers of services affects the political support for mental health, it is a topic also discussed in the literature. Therefore, even if in the sample it does not represent a major pattern, I include a brief analytical discussion about it in Chapter 6.

Similarly, Rafael perceived low political priority and admitted the old mentality is still dominant in society and subsequently within different governmental spheres:

Sometimes it seems that the society still believes that the old solution is the first attempt to deal with the problem: the asylums and the methods of treatment to make people quiet and avoid social disturbances. This is the easiest way. I think this mentality is also present within some officials at the three governmental spheres. This is one of the reasons that make the reform an even longer process. Yet, there is low political priority given for mental health.

Some stakeholders in the sample also agree that stigma and prejudice may not be an obstacle for implementation when the society in general is informed about mental disorders and mental health trends. In addition, interviewees also mentioned that parties, especially the government, should invest in public dissemination of information about mental health. Daniela affirms: “As stigma and prejudice come from the culture, information is important. I perceive that prejudice is different where there is more knowledge about mental disorders.” Luciano defended the point that it is necessary to make public all mental health matters, so people can become familiarized with this issue. For him, depression is progressively overcoming stigma and prejudice because it is thought about and talked about by the public. Unfortunately, he said, this is not the case of schizophrenia and other severe mental disorders:

[Stigma and prejudice] is a cultural problem and is present in the political and in the social realms. Unfortunately Foucault’s idea of madness as something to be marginalized is still present. But, for some mental disorders the situation is much improved: nobody today

needs to talk about depression by whispering, as it was 20 years ago. While depression is already well known, most of the severe mental disorders still constitute a more complex situation. Schizophrenia is still a stigma as it is explained in Goffman. Cultural resources have an invaluable role in changing these old trends: plays, movies, TV, and so on. And culture should be a great partner for mental health.

The role of the media was also contemplated by some interviewees such as professionals, representatives of the legislature and of NGOs. Similar to the idea of publicizing mental disorders, brought up by Luciano, Fernando also supported the idea of the use of the media as a great partnership:

We need to promote educational processes through the media. We should inform about both sides: including or excluding behaviors, prejudice and non-prejudice. While in a meeting I can reach 15 or 20 people, through the TV I reach millions of people. We don't do it yet.

And Alfredo highlights the kind of information that should be emphasized in educational campaigns and media in general:

A huge educational campaign in mental health at the national level would open to discussion the concept of mental health today in Brazil. What the media presents today is still strongly related to the understanding of mental health from biological psychiatry. Even among the middle class few people know what CAPS is, what psychiatric reform involves and has introduced; so this information is too limited to mental health professionals and users who participate in movements, but other than that, the asylums continue, the asylum mentality continues to prevail and predominate in the culture.

Elias did not focus on increasing or decreasing social stigma but on how mental health actors should deal with the presence of stigma in society:

I believe it is a myth that there is a great stigma. The issue is not the stigma; the issue is how to deal with it. For example, the way neighbors will look at a person with mental disorders, as if he or she is a kind of weird person, this will not change. But, if you ask these neighbors whether they support treatment in the asylums or at a nice place with humane treatment, they will support the latter. Today the humanistic concept is greater than the fear. But, it is greater in terms of ideology and not in terms of individual behavior.

Elias contributed to a realistic approach about fighting of the stigma toward people with mental disorders. From his perspective, mental health actors should not focus on attempting to diminish the differentness. Differentness is a fact. Instead, they should focus on mobilizing the society to think ethically and humanely about mental disorders and their treatment, which is already in progress. Therefore, it is possible that enhancing moral values contributes to new social responses in terms of acceptability and tolerance and subsequently their social support of the project of the reform.

Influences of Services and Programs on Stigma

Interestingly, six stakeholders pointed out how mental health services, even if they are designed and implemented according to the new policies and new perspectives, reinforce stigma and discrimination, putting policies' social goals at risk. As example of services that somehow reinforce stigma, interviewees cited: inadequate resources for crisis intervention, the organization of CAPS in sub-categories dividing up the target population, and how some protected homes are organized. In addition, three other interviewees discussed the theme from a different perspective. Considering that psychosocial services and programs also have a fundamental role in fighting stigma, a low investment in the implementation of these services or in their appropriate functioning may minimize this role.

In terms of the findings that support the first perspective, Mario's statement illustrates how inadequate resources for crisis intervention reinforce stigma:

It seems incredible but there are some initiatives of the ministry [of health] that, while targeting stigma reduction, stigmatize much more. . . . If a person with mental disorders arrives at an outpatient service having behavioral-related symptoms, this will stigmatize him. It is not at this moment that we have to fight stigma, but when he is stable.

Claudio criticizes the several specializations created to organize the CAPS in the territory, such as the general CAPS, the CAPS AD for alcohol and drug abuse, and the CAPS I for youth and kids. For him, despite the efforts to end discrimination, these specializations, especially the CAPS AD, reinforce existing labels.

If a person lives close to a CAPS AD, he/she already knows that in that place they have only drug users; the cab driver that brings the patient will think 'I see, he [uses drugs]'; the bus driver, the ticket taker, when stopping to pick up a passenger, will already know! Maybe with the best intentions, unwittingly, we are stigmatizing people in another way. (Claudio)

Luciano calls attention to the invisible persistence of stigma even in programs that are put into place to support a service network in mental health and talks about what he saw when visiting a protected home: "Maybe for insufficient budget or creativity, a protected home—that is supposed to deinstitutionalize people with mental disorders—has classic hospital beds and uses hospital sheets. I thought: 'this is the maintenance of the status quo itself.'"

Findings also show how interviewees support the idea that low investments in psychosocial interventions contribute to the maintenance of stigma and prejudice. Vanessa lamented the low investments in experiences of income generation as a way to fight discrimination:

If the government gives us, people with mental disorders who are working, greater support, we may be more highly regarded seen by society. They should help us to show our work, our products, especially in the solidarity market here or in other countries, such as in Italy.

Similarly, Norma focused on the issue of the lack of information on positive outcomes generated by psychosocial resources:

We don't find data from the Ministry of Health on the results of psychosocial rehabilitation programs, such as actions in citizenship and in income generation. You can find some descriptive information on these interventions but not reports on their results. This is a serious problem because the lack of information is associated with the persistent idea that people with mental disorders will never be able to be a citizen and be socially included and that they don't have any social function or ability to work.

Rafael, based on his knowledge about the positive results generated by solidarity economy experiences with people with mental disorders, stated:

We have a DVD about solidarity economy and mental health in which there are insightful testimonies from the people of the communities in which these experiences exist. We note that the society has begun to see mental health differently. They don't look at people with mental disorders with pity, but they recognize these people as able to produce, to generate income, and this is fundamental. But, unfortunately, this needs to be more publicized. We live in a country of 180 million people, and if we don't have good publicity of these experiences, the society will not know about them.

Here, Vanessa, Norma, and Rafael, representing various institutions, indicated that the visibility or publicity of actual interventions and their positive outcomes greatly contrast with prejudices and discrimination, showing society that the project of the reform is effective.

Mental Health and its Association to Gender, Race, and SES

Findings indicate that ten stakeholders in the sample believed there is an association between stigma for mental disorders and other social discriminations such as gender, race, or socioeconomic status (SES), especially the last two. Some of the interviewees identified this association as an overlapping of stigma for mental disorders and other social discriminations, which may deepen their negative effects. For other interviewees, this association is related to health inequality issues, particularly in the access of services. There was one interviewee who didn't believe this association exists, except in public opinion but not based on scientific logic. Overall, interviewees admit that there is a limited knowledge about this association and some suggest more research is needed on this topic. Because of the large proportion of interviewees who affirm this association, this section presents only the most representative comments.

One of the most comprehensive statements of the associations among stigma for mental disorders and social discriminations came from Alfredo:

A person with mental disorders who is also of African descent will be more discriminated against because of the racial discrimination that already exists, and this cannot be ignored. If the person is a woman, the discrimination against the female gender will also play a role. . . . But I think the impoverished socioeconomic status is the one which is most associated with madness in peoples' minds. Poverty in Brazil is strongly related to madness, thus, it is common, for example, for people in general to ask: 'but he is a cultured person, from the middle class, how can he be mad?' As if madness has a direct relation with class status; as if being rich impeded a person from madness. Nevertheless, we know, through research, that mental disorders equally affect all social classes.

In addition, Norma indicated the interaction of various kinds of discrimination is a trend that repeats in other minorities.

There is an interaction that deepens even more the different discriminations: a person with mental disorders who is also African descent, poor, and female, will have an even deeper suffering. The prejudice will be greater. We see this happening in other minorities, other discriminations, other problems of inequality, and the association surely deepens inequality. There is also a very high inequality in Brazil. More than poverty, we have a very high inequality.

Norma's statement also includes issues of inequality—a theme that was also brought up by various interviewees, serving in different positions in the reform.

Those interviewees that indicated an interaction of discriminations affecting health inequality showed that their responses were more conjecture about the topic than expressing an opinion based on systematic information. This fact seems reasonable since the discussion of health inequality is quite new in the health field. Among the few who had a more solid opinion, the 'double doors' situation was more often cited. In Brazil, the term "double doors" means the existence of different entrances and facilities in the same institution. These double doors are divided to serve citizens who have private health insurance and for those who use public health services. The 'double doors' were very common in Brazil but seem to be diminished progressively in accordance with advances of health reform. In the case of mental health, this trend is associated with the gradual reduction of the number of beds in psychiatric hospitals and the increase of substitutive services.

Matheus considered that health inequality affects the access to health by the population in general and it is one of the major issues to be treated by public policies:

The public policies should investigate more carefully the health inequality issue and pursue to strive to defeat its causes. Health inequality is very common and does not only affect mental health; it is also an issue among the different classes when accessing services. People from upper classes have health insurance and access health centers offering much

better and sophisticated technologies. Those who do not have health insurance must wait to be attended in the SUS lines. . . . I can imagine how this situation is even worse in the case of people with mental disorders. For them, the access to health in general is probably much harder.

Claudio approached health inequality in a similar way, but includes a discussion of power in the relationship between professionals and patients:

The great difference in accesses to health between the private and the public sector is the kind of contract you have. In other words, the person who pays and pays well has a different kind of power. Even if the professional does not like homosexuality, he will have to tolerate who is paying for the service. Professionals at the public services don't feel they should have this kind of horizontal contract; instead, other values are in play when they treat their patients skillfully and appropriately: doctrines, political consciousness, the kind of formation they have, and so on. Unfortunately these values are not present in most part of the public sectors and professionals are more susceptible to reproducing what is hegemonic in the society.

Claudio, who works in the public health field, highlighted the difference in approaches between professionals in private and in public sectors. He expressed his awareness of the minimal or nonexistent power of the population when accessing public services in Brazil. Even though the population pays taxes which sustain these services, in actual practice professionals behave as if this contract did not exist. By contrast, for Claudio the clear existence of financial power exerted by clients in the private sector contribute to increased tolerance and guarantee the access to services.

Alfredo addressed the 'double doors' issue, including private and public hospitals, as a very polemic issue in Brazil today. "Independent of being public or private, to offer two different kinds of assistance in the same space is too schizophrenic, right? This factor itself influences the process of health-disease in hospitals because you are distinguishing and creating discrimination already." He also affirms that "the defense for the 'double doors' is not hegemonic in Brazil, on the contrary, in the majority are the ones who are against this differential assistance; and this position is not just in mental health but in the collective health field."

Vanessa talks about how the upper classes do not access mental health public services such as the CAPS: "The upper class do not access the CAPS, [people from this social class] prefer the private institutions, pay health insurance, and will not leave their wealthy houses to come to treatment in the same place as the poor." Vanessa, as a consumer of services, reinforces what other interviewees previously suggested about an overlapping of discriminations in Brazil. First, there is the fact that upper classes do not access public services in this country, and second, there is a difference

between classes in how they are treated for mental disorders. Therefore, the interaction of these elements leaves SUS community-based services in the realm of the poor and the “mad.”

Luciano believed that health inequality in accessing services is more a result of the high social stratification in Brazil, than because of an extant interaction between mental disorders and other discriminations. But he admitted there should be more studies to investigate this interaction, which may reveal its existence as a factor generating health inequality: “I believe that people in general believe in this interaction, but I cannot identify the rational logic for this interaction. But it exists in the public opinion, and we should better acknowledge this interaction, especially in a stratified society like ours.”

In addition to the discussion of how discriminations, and particularly differences of socioeconomic status, and mental disorders interact, deepening health inequalities, some interviewees discussed the profound link between mental disorders and poverty in terms of the economic needs of the mentally ill in Brazil. From the perspectives of a consumer of service and a doctor, findings show that the ways in which the traditional psychiatric system has mixed mental disorders and poverty continues to affect services today, especially psychosocial assistance which needs to deal with both needs.

For instance, Marcelo frames the issue between mental disorders and poverty comparing Brazil and the US, which is very useful for the understanding of what kind of poverty stakeholders in general were discussing:

We have to deal with the issue of managing poverty. In the United States it is very different; I suppose that people are homeless, somehow, either by choice or by psychological destiny. But here, there is a socioeconomic hardship that does not allow people to have options: to choose to live in the street, or at home; or to choose to be a bank owner or a beggar on Wall Street. Thus, we must always be dealing with issues related to the confrontation of poverty, and here is the question: How can I separate my technical actions toward mental disorders from the actions that protect the person or the citizen from the conditions that lead to misery?

Bruna shared how many people with mental disorders who are from the lower classes are still dependent on services:

There are many people who do not work and do not have a wealthy family. What should they do? How will they survive? So, many times they come to the CAPS only to have lunch. They receive treatment here but sometimes, as they don't have any where else to go, they arrive only at lunch time to eat.

From Marcelo's and Brunas perspective, it can be noted that stakeholders at the street-level perceive that a large part of the population with mental disorders who access the public service network “bring” their economic needs to their treatment. Especially in the case of psychosocial

rehabilitation issues, this fact cannot be overlooked and must be addressed by interventions for social and labor inclusion.

All the different themes considered in this section seem to be part of the major patterns of how implementation is falling short and are more fully analyzed in Chapter 7.

Considering Advances

Basically, two interviewees pointed to progresses achieved regarding some of the themes treated in this section. Elias, as a NGO member and mental health reform active militant, considered that the society has been giving increasing support to mental health, even if stigma is always present. In addition, Elias perceived that professionals are progressively opening their minds to the idea of the reform and its new structure. Elias stated:

In general the professionals consider the idea of the reform ethical and have progressively supported the reform. They feel enthusiastic and seek to be updated about how the reform is advancing. . . . In terms of the society, we are largely 'the winners'—at least while people are not directly affected by the issue—and I believe the society supports the cause because the idea is ethical and democratic.

Leonardo, having access to the new projects of the mental health reform, felt very optimistic about the gains of the reform. According to him there are new ideas and new modes of intervention that facilitate the bringing together of the society and its different cultures to mental health:

Madness was always perceived as something strange, mysterious that demanded external interventions of total institutions which could isolate madness from the social realm. It is great progress to have public resources that are offering interventions of treatment that call for participation of families and that respect different cultures in different regions of the country. Our efforts are to make the strangeness something familiar and include the families in the network. When we make that which was strange into something familiar, we combat the stigma.

For Leonardo, because the Brazilian mental health policy is built on the idea of a service network in the communities, the population will become familiar with diverse mental health issues and this familiarity is a major gain in fighting stigma. Moreover, he recognized the importance of cultural competency in programs and, during the interview, he cited examples of new interventions, which will bring this new perspective which respects different cultures. Among others, he cited a mental health project to be developed with the indigenous population in the Amazon region.

Conclusions

Findings indicate that all interviewees mentioned some kind of association between mental health, stigma and prejudice, and health inequalities.

Findings show that various stakeholders—advocates, professionals, academics, top officials, and consumers of services—recognize stigma and prejudice as a significant barrier to full implementation of mental health policies, particularly in psychosocial rehabilitation.

Regarding how these factors affect the social and political support for mental health reform, some interviewees agreed that stigma, prejudice, and lack of information might negatively affect the social and political support for psychosocial care policy implementation. Although there are interviewees that agreed the federal government gives priority to mental health (as we have seen in previous sections), when talking about stigma and prejudice, those interviewees pointed to a low priority given to mental health at diverse public spheres.

In addition, professionals, family members, representatives of the legislature, advocates, and top officials agreed that access to information might contrast social representations and misinformation existent in the general population. Although they perceive there is low social support to the mental health project, Elias considered the social support today much higher than some years ago. Actually, Elias perceived that the social support is higher even though stigma is still present and because of this fact, Elias pointed out that it is not stigma which serves as a barrier to social support but the way stigma is managed in society. From his perspective, the project of the reform is successful in bringing together the population regarding mental health issues. However, it seems that the main point for most of the interviewees is the need of policies to increase the publicity and visibility of mental health issues. This is also confirmed when these interviewees observed that the low investments in psychosocial interventions, and/or in their appropriate functioning, minimize the visibility of actions and outcomes and subsequently the role they play in fighting stigma and prejudice. For them, the publicity of these outcomes together with national campaigns are major contributors in increasing social support.

Up to this point, it seems that there is no visibility of outcomes but there is already the visibility of services. The representative of the Ministry of Health considered, for instance, the existence of public services for mental health in the communities as a great advance. On the other hand, especially because these services are today more visible to the population, some interviewees raised a concern about if services and programs are aware of how they reproduce stigma in their own settings. These interviewees (two members of professional associations and the representative of the National

Commission of Social Determinants in Health) pointed out that services and programs, such as CAPS and protected homes, and the inappropriate management of the crisis interventions in the service network are reinforcing stigma.

Finally, the majority of stakeholders in the sample identify the existence of an interaction between mental health and other social discriminations. It is also interesting to note that these stakeholders are representatives of the legislature, consumers of services, and professionals that work in public services. Therefore, most of them are constantly dealing with street-level matters and may acknowledge this interaction based more on their everyday life rather than on research data. In fact, they admit the interaction they see is based on conjectures, and in general, they pointed to a higher degree of interaction among SES and mental health than with the other factors and health inequality issues. Interviewees believed that differences among classes divide the access to health, and therefore cause different access to technologies, different quality of assistance by professionals, and vulnerability to access due to stigma or discrimination. In addition, two interviewees spoke about the economic needs of people with mental disorders, which bring mental health and poverty closer to each other in Brazil. This discussion calls attention to the role played by psychosocial interventions to address the problem, requiring more effective actions toward social and labor inclusion.

SUMMARIZING THEMES

Before we go to the next chapters, I will summarize the findings in this chapter with the sole function of recapping the main factors affecting the implementation of psychosocial policies, according to the interviewees' point of view. This recap is useful for those readers who are primarily interested in the main issues indicated by participant stakeholders in the sample. Afterwards, I will recap the major and minor patterns derived from the various opinions and interests of stakeholders, as well as their agreements and disagreements.

Within the first theme -- *limitations of programs and services* -- stakeholders indicated three kinds of implementation gaps coming from the dynamics of policies at the street-level:

1. Type of service network available: The service network presents a lack of substitutive services. For some stakeholders, it seems to be more an alternative network in which there are both substitutive services and psychiatric hospitals.
2. Access to services: Services are limited on CAPS, and there is insufficient access to protected homes and to the *De Volta para Casa* program. There is also a lack of psychiatric beds at general hospitals. Issues on access to services were also highly associated with budget management, which points to high investments in psychiatric hospitals, the lack of

mechanisms to guarantee the gradual transference of budget from beds to services, and, small budget for psychosocial care.

3. Quality of substitutive services and programs of psychosocial care: The quality of substitutive services and programs was indicated by deficiencies of human resources. The professional formation and training are still dissonant with the new paradigm. Professionals are not well trained to work in multidisciplinary teams, affecting integrality of interventions, and also have a scarce political understanding of the project of the reform.

Within the second theme, interviewees pointed to *limited psychosocial interventions* as a kind of implementation gap generated in four specific ways:

1. Availability of psychosocial care resources: The isolation of CAPS, their effectiveness and the scarce training and orientation for professionals are major limits of implementation. As well as it is: the low access to the *De Volta para Casa* program, the insufficient number of protected homes, and limits of labor inclusion interventions. The latter still present limits on legislation, are scarce in number of interventions, are lacking intersectoral actions, and in general receive low investment for solidarity economy.
2. Availability of financial resources: There is low budget invested in human resources and labor inclusion and funding is not efficiently planned and allocated in which concerns to its adaptation to the different realities of the mental health at the local levels.
3. The distance between idealism and actual practices of the reform: There is a large number of specific and local interventions, which cannot be consider actions in the public sphere. There is also a lack of intersectoral actions.
4. Lack of data: There is lack of data from assessments and monitoring systems, making difficult the evaluation of failures and success and, subsequently limiting planning for future actions and priorities.

The discussion of the third theme showed how interviewees raised concerns about the insufficient investment of the Brazilian reform in *primary health care and its effects on mental health policy implementation*:

1. Limits faced by professionals from the Family Health Strategy: There is an insufficient support from the mental health service network, especially because access to them is still limited. There is also lack of trained professional to work in the perspective of the mental health in the primary health.
2. Shallow interventions of the CAPS toward the community: CAPS are considered as isolated in their interventions, what question if they are actually being responsible for a certain geographical area, in which the notion of territory is applied.
3. Limitations of legislation: Legislation in mental health does not include provisions in primary health.

Fourth, interviewees pointed out accentuated regional and municipal differences and limitations at local levels based on the following key issues:

1. Accentuated differences among regions, states, and municipalities: Usually these differences are associated with the kind of political support existent. The lack of information in the political realm may be also affecting the insufficient political support at local levels.
2. Municipalities issues: There is a low priority given to mental health at local levels. In addition, when there is implementation of mental health interventions according to the new system of assistance, there is also limitation of budget allocation because of inappropriate budget management.

Fifth, stakeholders discussed their own roles in mental health reform and their influences in policy implementation and pointed to one or more of the three major negative influences of their roles in policies:

1. Conflict of interests: It is also based on historical trends which, mainly, presented a dispute of interests between the private sector and more progressive groups. There is an important role played by the psychiatry, criticized for being resistant against the processes of changing for a new system of assistance. There are conflicts based on professional corporatism.
2. Hegemonic position of the Ministry of Health: There is isolation from the Ministry of Health from the social movements, universities, and psychiatrists. Some interviewees considered also that this isolation is many times associated to intrinsic dynamics of politics.
3. Diminished participation of the civil society: There is low participation of the civil society at political institutions, reducing its political power. Interviewees also indicate the need of mental health been more represented at mechanisms of popular control such as conferences and councils. All factors are being harmful to include mental health as a priority by the various political levels and spheres.

Finally, all interviewees at least once indicated a relationship between stigma or inequality and mental health policies and identified the presence of the following factors as limits of implementation:

1. Stigma and prejudice as an obstacle to implementation success.
2. Lack of social and political support: Interviewees indicate stigma, prejudice, and information negatively affect social and political support. But, it is interesting to think about how to manage stigma and prejudice to increase these supports. Information is one of the major resources to be used.
3. Influence of services and programs on stigma: Some services are also reinforcing stigma, such as CAPS, protected homes, and the inappropriate management of acute crisis interventions. There is low investment on psychosocial programs. This low investment and the low effectiveness of these programs minimize their potential to also help fighting stigma.
4. Prejudice against people with mental disorders deepened by association with other discriminated groups, such as low socioeconomic status (SES), race, and gender: There is an association among these social discriminations. In terms of health inequality, interviewees point to a difference of access among social classes. Mental health and poverty are also highly associated in Brazil.

PATTERNS AND GENERAL SUMMARY

In this chapter we acknowledged the key issues in the way of full implementation of mental health policies, particularly in psychosocial rehabilitation, through the perspective of various stakeholders in the sample. All of the information we have just recapped are facts answering the broadest question of this study: What are the key elements that generate a gap between psychosocial care policy formulation and its implementation? In this section, my objective is not to simply recap the key issues anymore but instead to begin to elucidate the patterns of stakeholders' discourse and position in the mental health issue network and what these patterns reveal about the implementation gap. Both the key issues and these patterns are addressed in a deeper and more analytical discussion in the following chapters.

As we have seen before, other studies in the literature and reports on the implementation gap of mental health policies in Brazil (Brêda et al., 2005; Ministério da Saúde/SE/Datasus, 2005; WHO, 2005b) have already shown that there are: (a) Limited access to psychosocial care and programs of mental health in primary care or health promotion; (b) uneven access to CAPS among different regions which are greatly concentrated in the most developed regions or in capital cities; (c) a larger number of SUS admissions in psychiatric hospitals than in Day-hospitals; and (d) limitations in the implementation of mental health actions in the primary health care because of distance between discourse and practice, limited power of mechanisms of popular control, deficient professional training, lack of information to families and community, and absence or inefficacy of reference services.

Data from my field materials is consonant with the major themes presented in the literature and adds troubling issues. First, my data shows that the factors that were indicated as limitations for the implementation of mental health in primary health in the literature are factors that currently also reflect limitations of implementation of psychosocial interventions as a whole. Particularly for primary health, the opinion of professionals, members of the legislature, and the representative of the National Commission of Social Determinants in Health in the Ministry of Health, confirm the lack of training for human resources and limited reference services as major barriers.

Although the literature and stakeholders in the sample indicate major barriers in primary health, the top official representing the Ministry of Health brought up new perspectives. Although he admitted that investments in primary health are still insufficient, he affirmed that this Ministry's major goal now is to invest in mental health through primary health programs, having started with a course to train community outreach workers in various regions of the country.

A topic of agreement among various stakeholders, except for consumers of services who did not talk about this topic, is to consider the accentuated differences of implementation among regions and the low priority and low accountability of municipalities as major obstacles for implementation. It is a troubling issue especially because mental health in the SUS is designed to be implemented with the local levels having progressive autonomy. This prompts us to ask: will decentralization threaten the continuity of the reform as some stakeholders already believe? Although supporting decentralization as an important process within the SUS system of health care, stakeholders from the Ministry of Health and NGOs fear decentralization at this moment of the reform considering it a very delicate transition.

In terms of the implementation of psychosocial programs and services and their interventions, criticisms were strongly brought up by street level stakeholders such as the organized civil society, mental health professionals, and consumers of services. Representatives of the legislature, who are not at the street level but represent the needs and the rights of citizens in the governmental sphere, also pointed to limits of psychosocial care. Even taking into account the Brazilian advances for the mental health system in fighting against human rights violations and offering a community-based model of services, stakeholders pointed out that the low investment in psychosocial care, lack of intersectoral actions, and lack of universal access to psychosocial services indicate that in actual practice this system is still far from reaching its ideal. Moreover, all these stakeholders, except for consumers of services, considered that there should be regulatory means to guarantee the transference of funds from psychiatric beds to substitutive services.

The organized civil society, which has always fought for the implementation of a community-based system for mental health, tends to see the Brazilian service network as an alternative network. From the militants' perspective, the low investment in building a service network—especially if compared to the budget still allocated to psychiatric hospitals—results in the coexistence of insufficient access to substitutive services and a significant use of psychiatric hospitals to deal with people with more persistent and severe mental disorders and acute crisis intervention. Consonant with their ideal in having psychosocial rehabilitation as a priority in the mental health system of care, NGO representatives called attention to a service network that is largely limited to CAPS; a service that still has little interaction in the communities and thus is not fully implementing its function. Moreover, they criticized the lack of intersectoral actions between mental health and other sectors, resulting in minimal existence of public initiatives in labor inclusion.

Mental health professionals focused on the quality of services offered, particularly in terms of human resources training (a focus with which other actors such as the Ministry of Health and academics agreed). In general, professionals' practices are still dissonant to the major goals of the reform, such as the implementation of a system of care based on multi or interdisciplinary approaches. We can expect the professionals in the sample to focus on human resources' issues, especially because in the sample they represent professional associations or boards, which have a social responsibility in contributing to the quality of services provided by their respective professional categories. But, for professionals, the quality of services is also affected by lack of data. They regretted the lack of monitoring systems and assessments of psychosocial interventions, which negatively affects planning and definition of actions at all levels of implementation, including the delivery of services.

In addition, the representative of the Brazilian Psychiatric Association stressed limitations in the access of services for the population with more persistent and severe mental disorders, such as the lack of acute crisis intervention services other than hospitals, the limited scope of the *De Volta para Casa* program and insufficiently protected homes. In the psychiatrists' point of view, this insufficiency of the system to deal with more persistent and severe mental disorders is what greatly reinforces the need of psychiatric hospitals services.

Presenting a different point of view, the representative of the General Coordination of Mental Health in the Ministry of Health admits the assistance for people with persistent and severe mental disorders and who are highly institutionalized is still very insufficient. However, this Coordination indicated an overall improvement of access and was more concerned about managerial issues on how to promote the sustainability of services and programs already implemented.

Regarding the general insufficiency of access of the service network, academics and consumers of services brought up an intriguing concern about the increase of the homeless population with mental disorders. This situation also occurred in other countries in the moment of transition to a new system of care, and it may be currently happening in Brazil. But, surely, each country has its own specificities, and the causal factors for this increase in Brazil was still unknown by the time of the data collection of this study.

In accordance with the findings, it seems that insufficient access and the inefficacy of the system in offering adequate treatment for acute and/or institutionalized cases are critical points of agreement among stakeholders, including the top official of the Ministry of Health. What differs is the nuance each of them gives to these issues according to the kind of interests they represent.

But, except for the issue of the increase in homeless population with mental disorders, consumers of services do not seem to be concerned about access to services, especially CAPS which are the most well known services. The major issue raised by consumers of services (that was also raised by other NGO members and academics) was the lack of financial support for projects of income generation, mostly founded as an NGO or a social cooperative. The fragile economic situation of these projects threatens their sustainability and the motivation to work of many participants.

Members of the legislature were strongly motivated to think about the right to access services and the guarantee of the protection of human rights, which are in accord with the strengths of Brazilian policy formulation. In general, they recognized limits of access to various programs and services, particularly the *De Volta para Casa* and the protected homes; and along with other actors, the limits of low investment in labor inclusion. They also agree with professionals in regard to the lack of data produced by the Ministry of Health and by services in general, limiting the understanding about actual trends, successes, and failures of policies.

In terms of labor inclusion, the information from the top official representing the Ministry of Labor and Employment is in contrast to the information from members of the legislature. For him, at least for solidarity economy, the investments are already larger than few years ago, and it is progress that the Ministry of Health could approve an independent funding for social cooperatives. Therefore, for him, investments are not the problem, but it is the legislation for cooperatives in Brazil that is inappropriate and it has been in debate and waiting for consensus in the Congress for years.

A rich topic for further discussion in the following chapter is how the conflict of interests among stakeholders generates limits of implementation. Based on what was brought up by various interviewees, we can note there are different configurations of conflict before and after the Brazilian national policy. Before, conflict existed between those in favor and those against the reform; a "battle" that was marked by the barriers of private economic interests. Today, although these interests still exist they are not hegemonic and do not seem to threaten the reform. The conflict of interests exists among actors who actively participate in the implementation of the reform. This conflict of interests is based on two major issues: the diverse corporate interests among professionals and the resistance of the institutional psychiatry against the model of the new system of care. In parallel, NGOs' members and professionals pointed out the hegemonic position of the Ministry of Health which, especially during the second term of President Lula's administration, is controlling the decision process and significantly limiting the dialogue among forces. This is not confirmed by the top official representative of this

Ministry, who indicated this Ministry is looking forward to having an open dialogue with psychiatrists and a partnership with various universities to stimulate the production of data. Of course, discourses reflect different sides of conflicts and tend to express what the different parties are willing to reveal. But the important fact to be discussed is how this conflict affects the implementation gap. Also contributing to conflict, along with the diminished dialogue among forces and the participative decision-making process, is the under mobilization and participation of the organized civil society, which was a great concern especially among members of the parliament. The conflict of interests among stakeholders was one of several obstacles to implementation that are "institutional." Chapter 6 evaluates these institutional obstacles in greater depth.

Finally, we saw a key theme among stakeholders who all talked about stigma, prejudice, and social inequalities in complex ways that deserve greater analytic attention in a later chapter. For NGOs' members, professionals, academics, consumers of services and families, and the top officials at ministries, stigma and prejudice constitute another great barrier for implementation, mostly because they negatively affect social and political support for the reform. Increasing the publicity and visibility of mental health issues and increasing the participation and political power of consumers of services and their families were frequently considered among stakeholders as a means to gain more social and political support. Concurrently, some NGO members admit that today the reform could increase social support to the project of the reform even if there is yet social stigma. Therefore, what is exactly the role played by stigma on social and political support?

Another very surprising issue suggested by some of the stakeholders was the way services and programs can reinforce stigma and prejudice brought by some of the stakeholders. When professionals and the representative of the National Commission of Social Determinants in Health had offered different examples of different services, they essentially talked about the careful choice of methods which should be used to produce the desired visibility to fight prejudice and stigma and increase social and political support. This is also a strong pattern in this topic.

Regarding how stigma and prejudice for mental disorders interact with social inequalities in gender, race, and SES, various stakeholders considered an interaction to exist which deepens segregation; but the stakeholders only conjectured about this topic. Most of them, independent of what they represented in the sample, are professionals working in the public health system (or in the case of consumers of services and families who access the public health system), indicated class as an essential variable in determining access to health services in general and particularly in mental health.

Different from the way class affects access to health, but very intriguing, is the role poverty may play in the treatment. Two stakeholders, a consumer of services and a professional, indicated that a significant number of people with mental disorders “bring” their economic needs to their treatment, and the reform needs to have effective ways to deal with it. Here is a place to think about the important role psychosocial care interventions might play in addressing poverty as economic need. How effective should interventions of psychosocial care be in order to be able to increase autonomy, integration into the community life, quality of life, and more specifically, the opportunities of employment and better earnings? The diverse discussions on stigma, prejudice, and health inequality will be discussed in-depth in Chapter 7.

While all of the above elements inform the discussion in the following chapters, I will be focusing primarily upon the final two – institutional obstacles and the impediments of stigma and inequalities.

CHAPTER 6

INSTITUTIONS AND PROCESSES OF IMPLEMENTATION AS IMPEDIMENTS TO POLICY SUCCESS

Throughout this chapter, I invite the reader to reflect on a simple statement of Pressman and Wildavsky (1984): “Implementation should not be divorced from policy. There is no point in having good ideas if they cannot be carried out” (p. 143). It is not that good ideas are not welcome; in fact, the social and political mobilization inspired by the new paradigm in mental health has produced various policies worldwide. With no universal recipe, these policies usually are formulated in accordance with cultural and sociopolitical peculiarities of countries, and largely deal with *old sleeping giants*, requiring the inspiration and mobilization of activists.²⁷ But, the main point here is to reconsider creative ideals within the frame of what is practicable.

The arguments presented in this chapter represent this desired level of practicability and indicate why the key elements presented in Chapter 5 impede the practical achievement of ideas and ideals in mental health problem solving in Brazil. Explorations on stigma, prejudice, and social inequalities and their interaction with mental health issues are analyzed in Chapter 7. Based on these key elements, the main goal in this chapter and in Chapter 7 is to analyze of their relevance and deepen the discussion about how the different positions of stakeholders affect their opinions about the implementation gap. In these chapters I am moved to answer the following question: Do different stakeholders significantly differ in their perceptions about the process of implementation of mental health policies, particularly in psychosocial care and extant gaps?

In addition, the data analysis process revealed that the key elements presented in Chapter 5 converged into four themes: stakeholder conflicts, institutional processes, fiscal processes, and stigma and prejudice. The first three themes are discussed here: How do stakeholders, institutional processes, and fiscal processes interfere in mental health policy, especially in psychosocial care, and its successes?

²⁷ By *old sleeping giants* I mean the old social and political structures that kept untouched the asylums and their supportive forces, perpetuating social isolation and human rights violations as intrinsic elements of the treatments for mental disorders.

Moreover, and differently from Chapter 5, the arguments in this chapter and in Chapter 7 are based not just on the findings from interviews but also incorporate data from participant observation. In the present chapter, I discuss these elements in different sections: Stakeholder conflicts, Institutions, and Fiscal Processes and Priorities.

STAKEHOLDER CONFLICTS

In this section, I address limitations of mental health policy implementation, particularly in psychosocial care, caused by problems specifically related to stakeholders' roles, interests, and intercommunication. In the policy field, especially in areas that demands high levels of intersectoral programs such as mental health, a collaborative and productive interaction among stakeholders is required. The ideal is that "those in implementation networks can affect the outcome of the implementation 'game' by moving in a number of ways, and at a number of levels, to reduce uncertainty and institutionalize cooperative arrangements in the interests of policy success" (O'Toole, 1996, p. 252).

Based on the findings of this study, it is clear that a majority support the mental reform based on a community-based system of services. However, it seems that communication, mutual tolerance, and productive exchanges among stakeholders are fairly low, negatively affecting cooperation among them. Overall, interviewees point more easily and frequently to limitations or barriers of other stakeholders, but there were very few criticisms about their own role or limitations. Different levels of government were common targets for critique, but especially municipalities and the General Coordination of Mental Health, which, in general, are seen as playing a hegemonic role and limiting dialogue among parties. As expected, stakeholders tend to highlight priorities according to their own interests; but unfortunately these trends seem to be creating a significant mutual distance among general stakeholders and the State. This distance is accentuated particularly among the corners of the historical "triangle": State-Civil Society-Private Sector.

As was demonstrated previously, this triangle corresponds to what stakeholders perceive as: a hegemonic and authoritarian position of the Ministry of Health, a significant decrease of the participation of the civil society, and a quasi-exclusive economic interest of the private sector. Although private economic interests still play a role in the reform, the new trends of conflict among stakeholders suggest a transition in which the institutional psychiatry is taking its place in the "triangle." Especially from the perspective of the organized civil society, this transition is strategic. Even though in the history of the reform in Brazil (since the initial attempts to do the reform at street-level and in the legislature)

the private sector and the institutional psychiatry have walked together, the strength of private economic interests has been progressively diluted but not the role of psychiatrists. Subsequently, not only the organized civil society but also parties at the federal sphere of the government perceive strong corporate interests of the institutional psychiatry as taking place in this "triangle." This analysis of the dynamic of relationships among stakeholders calls attention to a second type of configuration characterizing their relationships. Therefore, in this new configuration, the dynamic among stakeholders does not point to a central position of the Ministry of Health anymore. But, in sum, the scarce communication among these three sectors can be extremely harmful for overcoming limitations that already challenge the reform.

For stakeholders who are not from the General Coordination of Mental Health, or from the organized civil society, or from the private sector, there are different kinds of solutions. Norma, as a member of the Commission of Human Rights at the Federal Chamber of Deputies, said: "The national policy presents several problems. Until these problems are discussed in an open exchange with the civil society, we will not significantly advance."

Luciano, representing the Regional Board of Psychology in Brasilia, considered his position as more neutral because although sometimes he contributes to mental health, this is not his field of intervention. He said, therefore, it was easier for him to have a less intense emotional criticism and summarized:

First, there is an issue of political will which carries an economic based incomprehension: They do not understand that prevention is cheaper than solutions. But there is the economic interest: solutions are what make profit. There is a strong capitalist determinant. Moreover, our politicians are qualified but lacking in rationality. They don't admit that they don't know about certain issues and that they should consult someone who has the expertise. Usually these are the deputies, senators, and politicians who create the laws and we see terrible things. This is a big problem and usually, instead, things work in a patronage system: 'I like you and you are my friend, so I will believe in what you are saying.' This is a serious political barrier. This is why we have only one national policy that is implemented in so many distinct ways in diverse regions of the country.

Thus, Luciano points out that major barriers for policy implementation are related to a convergence of political and economic interests. These interests do not incorporate expert analyses and recommendations, negatively affecting the practicability of policy implementation in the field. Furthermore, from this perspective, Luciano indicates a conflict of interest that puts stakeholders from the private sector and regional or local officials on one side and stakeholders with expertise in mental health on the other side. Stakeholders from the legislature agree that there are negative impacts of the

private sector's economic interests and problems in the definition of priorities at the municipal levels. Norma explained that it is the close relationship between private economic interests and the public sector that strengthens the influence of these interests in impeding advances:

The private sector, or specifically the big groups interested in maintaining psychiatric hospitals, negatively interferes in the advance of the reform. It is unavoidable the influence of the economic interests of the private sector and these interests maintain things that are not in the interest of human rights. They are strong economic groups in close relation with the public sector and politicians. This is one impediment to certain advances.

Considering what was said from these actors out of the "triangle," there is evidence that, for them, the "triangle" still has the same historical configuration in which the private economic interest, instead of the corporate interests of the institutional psychiatry, plays an important role.

Analyzing the process of policy implementation based on the managerial powers of the executive power at various levels, Fernando contributes to our analysis on the important place knowledge has in this process. Fernando reaffirmed criticisms made by other stakeholders, such as Luciano, on local officials and managers:

The Union in Brazil or the federal executive power does not execute programs; it gives directions or general guidance. In this context, the national law represents a national parameter for what should be done. Within these parameters there is space for creativity since it respects these parameters. The municipalities do not do it for economic poverty, cultural poverty, or technical poverty, that may be aggregated. Sometimes the reason is not the money; I know municipalities that have the budget, but the mayor and the public administration is poor in creativity, in knowledge, and thus, do not plan anything as it should be.

Regarding the role played by the local government executive power, it is also important to note that mental health is not alone. The way these stakeholders characterize the issue shows limitations caused by Brazilian political trends and specifically, the way top officials and managers conduct policy implementation.

However, some stakeholders perceived there is also a role played by relationship between the federal and local executive powers. Mario, representing the Brazilian Psychiatry Association, understood the limits of implementation in the municipalities within the kind of extant relation between them and the Ministry of Health. For him, the authoritarian position of this ministry is what creates such barriers:

In the past they have a hospital that served for multiple counties. Today, when this situation does not exist anymore, the municipal officials and administrators have to plan what to do and need time for it. I think that in any situation the Ministry of Health should first consult the state and municipal managers; they know their municipalities. This ministry

should also do that in order to open discussions and make clear the directions and the fiscal incentives for policy implementation.

Therefore, Mario (as well as Fernando in his previous comment) put the role of informing the municipal levels in the hands of the federal executive sector. In a situation where there is a lack of knowledge among local implementers the role of guidance and orientation from the federal level is fundamental. It may not guarantee the execution of policies, but it certainly contributes to overcoming at least the barriers to acknowledging of what should be done. We can note that among stakeholders it is a firmly held perception that a strong presence exercised by the Ministry of Health in fully exerting its role of guidance is fundamental for the continuity of the reform; however, they also agree that the hegemonic position of the Ministry of Health is not helpful. But since it is a discussion of power, in the field it can be difficult to balance strong guidance and hegemony. Some scholars in the political science literature discuss political and managerial skills that approximate what stakeholders would rather like to see in the implementation process. Discussing the conditions of effective implementation, Sabatier and Mazmanian (1979) consider the support of top officials as fundamental:

Policy support is essentially useless if not accompanied by political and managerial skill in utilizing available resources. Political skill involves the ability to develop good working relationships with sovereigns in the agency's subsystem, to convince opponents and target groups that they are being treated fairly, to mobilize support among latent supportive constituencies, to present the agency's case adroitly through the mass media, and so forth. Managerial skills involves developing adequate controls so that the program is not subject to charges of fiscal mismanagement, maintaining high morale among agency personnel, and managing internal dissent in such a way that dissidents are convinced they have received a fair hearing.

Nevertheless, there are stakeholders who prefer to analyze limits of implementation caused by stakeholders' conflicts and positions through a bigger picture. Elias, who is an active stakeholder fighting for mental health reform within the last decades and represents the organized civil society, describes differences among stakeholders by mapping the diverse positions they have in the mental health reform:

There are different loci of opinion about the mental health reform: one locus is formed by managers and professionals in the public sector and the ones who are in the private sector and survive from it. Among them, they dispute opinion, but fortunately the defense for the reform has a good representation. The conservative forces that are intent on the maintenance of the status quo have less space today. The medical corporatism is still active, but in a very quiet way, so they maintain stability in their positions. We have a kind of academic and bureaucratic psychiatry that also reacts and tries to protect the role of the psychiatric hospitals. These are the actors who argue against reform. There is another locus of opinion formed by users and families, or more specifically, by the ones who

directly access mental health care and assistance and depend directly on the policy. Here, they have some dissatisfaction but their confidence is increasing in the system after the implementation of these 1,000 CAPS. In my point of view, the population learns to consume what is offered and if the assistance is good, supportive, and increases quality of life, everything is fine for them; there are no ideological issues for this population.

From Elias' perspective, in general, stakeholders support the reform and even if they have different interests they will not cause negative impacts on the reform. The exception is in the position of the private sector and its economic interests—as also pointed out by Luciano—and also in medical corporate interests, particularly represented by psychiatrists.

Mario, as a psychiatrist, also reflected on the criticism of corporate interests and dogmas also present in the dispute of opinion among stakeholders, but from a different perspective:

The discussions generate positive results but, obviously, there are also corporate interests. . . . The debate is still too much based on habitual ways of thinking in the reform because the psychiatric hospitals become overly associated to the dictatorship, the military, and the repression. The image is still the same within the whole society. I think the debates should have more objective fundamentals.

In general, among interviewees that brought up the theme of corporate interests, they all agree in how much it impedes an ongoing process of changes intrinsic to the reform. The constant conflicts it brings into the discussions among professionals make it harder to build a common path in which the final goal is the guarantee of human rights, community integration, and quality of life of people with mental disorders. It is interesting to note that when vested in corporate interests, mental health professionals are discussing inclusive policies but mutually excluding each other, which is rather contradictory. In other words, they discuss how to promote social inclusion which is a debate about how to constructively deal with differentness, but they are very inflexible in that which concerns their own perspectives. From the perspective of various stakeholders, many of them are bringing into the discussion of the reform their habitual ways of thinking instead of openness to build a common rationale.

But, going back to Elias' previous comment, even though he showed the overall context of positions of the different forces in mental health, he does not mention the diminished participation of the organized civil society as other actors did. What Elias does mention is a very intriguing issue when describing the position of consumers of services and families, who care more for what kind of services the policies are actually providing rather than for policy processes. The consumers of services and families who participated as interviewees aptly fit this representation. In general, they had very little knowledge about mental health policies and therefore limited opinions about them. But they presented

numerous issues of what is provided or lacking in services. During interviews, most of them described the fight for reform as spectators rather than activists:

Sincerely, comparing to what we had before, there are lots of advances. From what I see, from what I hear, the fight of professionals for us promoted these changes. Before was very hard, today there are the CAPS and the asylums are closed. I see the fight of the professionals to close them. (Marina)

As consumers of services and families, especially consumers of services, do not have a long history of militancy, it is interesting when other actors collaborate with them, stimulating participation in areas of debate. Based on interviews conducted with consumers of services and families, and on participant observation, this is a trend that has been put into practice in some instances. In both settings, it was common to hear them mentioning some participation or invitation to participate in forums, conferences, or public events at universities. During interviews, other participants also mentioned examples of events they promoted or participated in, and in which the participation of consumers of services and families were stimulated.

Claudio, from the Commission of Social Determinants in Health, defended a strengthening of the general organized civil society as a way to better promote the idea of the reform and as contributing to the reform's gaining more social and political support:

I personally advocate and value [the reform] but I know there are limitations intrinsic to our society. It is necessary that movements among professionals and NGOs create facts incessantly and gain power to implement what they perceive as ethical and effective. If they leave it in the hands of the economic mind set or of the interests of the State, the reform will not be real.

Therefore, Claudio argues for strengthening the third weakest segment of the "triangle," which is another common topic among stakeholders, especially commented on by the ones who are not from the civil society. But for all them, the advocacy and the defense of collective interests that fuel the civil society are great contributors to progressively gaining social and political support, especially at local levels and in the legislature. Overall, interviewees defended the need of mental health representatives in increasing their participation in mechanisms of popular control and lament the under use of these mechanisms by the organized civil society in mental health.

For all consumers of services and families participating in the study, the role of professionals has been and still is fundamental for the advances in the reform. Some of them also include their participation and they seem to view it as a movement that they must follow, but they don't create. Marina says:

I see lots of commitment among [professionals]. They do their best to fight for the reform and the rights of people with mental disorders. I see the manifestations: the involvement of social workers and coordinators [of CAPS], our fight in the Federal Chamber of Deputies. But, these fights are long. In Brazil we have too much bureaucracy, everything is too slow. But, one day we will win.

In general, all these positions seem to be built on legitimate claims, mainly because it reflects how various stakeholders perceive the issue network for mental health as an active participant. But concurrently, up to this moment of the reform, these positions are often based on conjectures or their habitual ways of thinking rather than practical actions. This may diminish the potential of the impacts of these conjectures when dealing with issues of implementation process in actual practice. Increasing production of data might help to balance the implicit differentness of their perceptions and positions and the need of practical actions based on cooperative dialogues.

WHO (2004) considers both the dissemination of policies involving all stakeholders and the advocacy conducted to increase political support and funding as key issues to build a “basic support for policy” (p. 63). In addition, throughout this document WHO points out the important role played by research and evaluation either as a mode of cooperation among diverse stakeholders or as a tool to increase more social and political support, involving even more stakeholders.

According to Innes and Booher (2003) effective policymaking is possible through the collaboration of diverse stakeholders and, as they call it, an “authentic dialogue” among them. The authors frame this dialogue with Habermas’ arguments on communicative rationality which includes that participants, in our case stakeholders, must speak based on legitimate interests with sincerity and accuracy. Overall, the authentic dialogue results in reciprocity, relationships, learning, and creativity, contributing to effectiveness in collaborative policymaking. Innes and Booher argue that the combination of authentic dialogue and the diversity and interdependency among stakeholders is fundamental to building agreements and productive approaches. The authors declare:

Stakeholders in a policy dialogue must be diverse in order to take full advantage of the creativity that can come from trying to find actions that can respond to a wide set of competing interests. They must also be interdependent in order to achieve the kinds of results that will allow them collectively to create an adaptive learning system that can be robust and effective. The stakeholders must be aware that they cannot meet their interests working alone and that they share with others a common problem, so they will continue to work together in response to change. Most voluntary collaborative processes are, in our observation, instigated and driven by a shared perception of interdependence around a problem, although this may be only vaguely articulated. (p. 40)

I believe that in the nascent reform, the roots of the conflict of interests among Brazilian stakeholders in mental health, especially in the “triangle” State-Civil Society-Private Sector, are based on long-established relationships, already embedded with labels and resistances. Thus, time is a factor that must be taken into account. It may be possible that along the course of implementation, these conflicts will evolve into another configuration, hopefully, a more inter-collaborative one. But maybe the conflict is already too crystallized to be overcome so that the reform will have to be implemented under the limitations produced by this conflict. In this case, even if theoretically the theory of Innes and Booher (2003) contributes to a more optimistic approach, practically Brazilian stakeholders may not be able to perceive that they have a common problem and will continue working in isolation.

From this perspective, policy studies might contribute to inform stakeholders about their own limits and the barriers they create for policy implementation and they may well be open to comprehend that policy and policy implementation are formed by diversity intrinsic to sociopolitical and cultural dynamics and, inescapably, enclose a wide range of different ideals, interests, and claims. Thus, they can never expect an unwavering atmosphere surrounding policy implementation issues. But, they may be also open to admit that cooperation and not competition is the best tool to accommodate claims and plan better perspectives and that differences but not divergences are the best fuel to challenge, motivate, and enhance creativity.

INSTITUTIONS

The institutions directly involved with processes of implementation are responsible for some of the gaps between ideals and practice. In this section, these institutions include: (1) the Brazilian governmental sphere at the three levels of government (ministries, states secretariats, and municipal offices); (2) the mechanisms of popular control established by the SUS (local, municipal, state, and national councils of health; and municipal, state, and national conferences of health); (3) the network of mental health services, particularly psychosocial care services; and (4) social institutions such as universities, private sector, and non-profit organizations. My analysis approaches these institutions based on the idea of democratic governance and networks that mutually influence one another. Taking into account the role played by these institutions, this sub-section addresses limitations of: policy formulation, means of participation of various stakeholders, the organization of the service network, services and programs of psychosocial interventions and their human resources.

The Brazilian mental health policy has followed democratic inspirations such as the intense participation of the civil society to formulate and to enact the law 10.216 and the utilization of SUS

propositions to organize mechanisms of popular control. But, as we have seen in the previous section, there are practical limitations of cooperation among actors in the implementation of policies. Hence, as stakeholders constitute and run institutions, the consequences of this limited cooperation also affect the function of running institutions.

In the sample, there is a strong belief among various stakeholders that civil society has been the main sector pushing for mental health interventions at the street-level. For instance, Rafael (from the Ministry of Labor and Employment) and Mario (from the Brazilian Psychiatric Association) who are not affiliated with NGOs, pointed out the important role played by NGOs in increasing the priority given for mental health at local spheres. Rafael cited a good example in the state of Minas Gerais “where there is a stronger movement in the society, including the State Forum for Mental Health. Thus, in states like Minas the initiatives are effectively more advanced than in others.” Similarly, Mario also recognized the important role of the organized civil society and believed that it should take advantage of the democratic political spaces available to increase their political power: “The participation of militant NGOs in the fight for mental health reform in the Municipal Councils of Health empowers them to make demands for their interests and force municipal officials to have a more positive attitude toward mental health.”

However, as we saw in Chapter 5, there has been a significant reduction of the mobilization of civil society, especially after the year 2001 in the parliament and in mechanisms of popular control. Subsequently, today the organized civil society has less voice in the establishment of priorities than it had a few years ago. If we recall the history of the Brazilian mental health national policy, 2001 was the year in which the law 10.216 was enacted. According to Fernando, a federal deputy, “the fight for mental health in the Federal Chamber of Deputies barely exists today as a result of the approval of the national policy and the definition of various administrative rules by the Ministry of Health.” We may ask why, after this first and essential victory in the Congress, there was a decrease of the mobilization of the civil society. Why did it happen right at the moment of implementation?

Probably, there is more than one answer for these questions. In an attempt to answer these questions I use stakeholders’ comments and some resources available in the literature. Moreover, I also analyze the potential effects of this shift in the participation of the civil society in mental health issues.

Regarding the participation of the civil society in the broader political arena, stakeholders point to some factors that are intrinsic to the Brazilian political realm and contribute to the civil society having

a weaker voice. For instance, Norma from the Commission of Human Rights of the Chamber of Deputies commented that there is a dependency of mental health commissions at the state and municipal levels on the will of officials who are representatives of secretariats of health. The secretariats of health have the autonomy to establish their commissions which, in practice, usually depend on the presence of a representative of a certain health field as an official of the state health secretariat. For instance, if a mental health professional or activist or sympathetic person works in a state secretariat of health, he/she can suggest the creation of a mental health commission and from this point, there may not be any major obstacles to actually instituting it. But if there is no one to represent mental health, the opportunities for instituting a mental health commission are few. Thus, interests strongly influence this situation in which mental health representation in commissions depends on the will of officials and on the importance and priority they give to mental health. In addition, at the national level, there is a commission of mental health but it has only a consultant role when it is needed. Norma was the only interviewee who, beyond talking about the importance of the civil society in the mechanisms of popular control, explained how the mental health commissions are organized in the councils of health in Brazil:

The National Commission of Mental Health in the National Council of Health should have a stronger power of decision, as well as the other mental health commissions at the various levels. The states decide if they will be instituted and usually they exist in the states where the health council is more active and only if there are representatives of mental health in the councils. But it is far from being a provision or determination.

Norma's comments reflect a criticism that even though the SUS provides norms in which the essential role of community participation in health issues is clear, it does not include mechanisms that could guarantee the democratic use of its instruments of participation such as the commissions and the councils. It seems that this situation reinforces a vicious cycle between the lack of representation and the lack of priority in mental health that are difficult to overcome without such mechanisms.

Both the lack of civil society's presence in the parliament and the sparse mental health representation in commissions impede a greater contribution from the civil society in enhancing the practicability of policy formulation and implementation when addressing psychosocial gaps. As Fernando said: "Without awareness, without mobilization, without organization, the trends are that actions represent those of the current government administration and not of the national policies." Fernando pointed out that the lack of participation of the civil society makes it easier for politicians to implement policies that are more in accordance with their interests than in accordance to what is actually mandated in national policies.

The lack of the presence of the civil society in the parliament limits improvements in the legislation for mental health, both in enacting new, necessary policies and in reviewing what is not satisfactory in the existing legislation based on actual practice. Furthermore, this lack of presence also means that there is no force to push the political priority for mental health in the parliament, especially because mental health is not yet considered a major issue among most of the Brazilian legislators.

In sum, the low representativeness of mental health in mechanisms of popular control, particularly the councils of health at the three levels of government, and the uneven participation of civil society in parliament, show that the democratic participation is still fragile. Scholars such as Encarnación (2000) question exactly how much the civil society can contribute to consolidation of democracy.

Encarnación (2000) includes in his analysis a section about Brazilian democracy and the participation of civil society. The author contrasts the extensive resurgence of Brazilian civil society and concomitantly large network of NGOs with the fact that Brazilian democracy is not yet consolidated. For him, "The growth of civil society in Brazil at the expense of the political organization has atomized society and dispersed political power. In turn these developments have greatly complicated the process of democratic consolidation" (p. 14).

The Encarnación (2000) analysis contributes to a better understanding about the way the Brazilian political context and institutionalization shapes mental health problem solving, including the dynamics in civil society. First, why should political forces give mental health greater representation in health councils if, among such a large network of interests, mental health interest groups are the minority representing a minority (people with mental disorders) among minority groups? Second, considering that mental health is such a minority issue, after enacting a national policy and instituting a specific Coordination in the Ministry of Health to deal with its implementation through states and municipalities, why aren't these achievements enough? Third, isn't it politically correct enough to have representatives of the active civil society in this Coordination?

As we saw in Chapter 5, some stakeholders recognized that when working in the state bureaucracy a small number of activists are not enough for such a long-lasting fight, especially because they are also affected by power relationships and will find their actions limited. Concurrently, the majority of the stakeholders not representing the executive power also agree that the Ministry of Health has adopted a hegemonic position in deciding areas of priorities in mental health, in designing programs and services, and in organizing the service network. The predominance of this ministry's

perspective is obscuring not only the demands of the organized civil society, but the needs of various actors at the bottom level of policy implementation.

As a member of the organized civil society, Elias summarizes the trends of the Ministry of Health and briefly explains how the hegemonic position affects implementation:

When the Ministry of Health oppresses, competes, or is close to a dialogue with the social movement, it produces a kind of emptiness of, for example, the consumer of services and family organizations . . . In Lula's second administration the position of the Coordination of Mental Health was: "I am the representative of the anti-asylum movement in the government; I am the government and I am the movement." This position stripped off the political and ideological aspects [of the reform], and the desired effects of psychosocial rehabilitation do not go beyond its attempts. These effects are still held and centralized by the Coordination.

Members of professional associations such as Luciano concurred with Elias and other NGO members and lamented the position of the Ministry of Health: "Mental health is completely filled up in a secretariat in the Ministry of Health. . . . For me, we don't have communication and, instead, we became slaves of a certain sector that does not comprehend its own locus."

On the other hand, in Chapter 5 we also noted that Leonardo, representing the General Coordination of Mental Health at the Ministry of Health, cited some attempts or actual opportunities to open a dialogue with other sectors. Due to different versions about the availability of the Ministry of Health to other actors, the analysis does not attempt to identify the true side. It may be that each version has some truth due to the inclination of stakeholders in each side to raise the issue according to their own interests. However, it is clear that a conflict exists when questioning if mental health interests have been actually represented in the public sphere. It seems that the response from actors at the bottom-level has been based on doing as much as they can independent of this dialogue. But, a few stakeholders call attention to the fact that available data that reports successful experiences are mainly based on specific local contexts but could not be generalized as a successful implementation of the national policy. For example, Mario and Norma observed:

This ministry doesn't listen to other actors: service providers, patients, [and others]. They have a plan which they impose. . . . Some reports indicate positive results, but they are not results from the implementation of the national policy; everybody is trying to do what is possible and the positive results are from local situations (Mario).

We see experiences from civil society, creating social clubs, workshops, cooperatives, and all excellent. But, we cannot say that they are public policies. They are local experiences and may have some partnership with public sectors. . . . But, [the public sector] does not have models [of interventions] giving directions (Norma).

Recalling the central elements of previous discussions—the diminished participation of the civil society and the low collaboration among stakeholders and particularly the hegemonic position of the Ministry of Health—we can note that all these elements and the lack of data on limitations and successes of implementation, accentuate the impediments to establish mental health policy implementation as a national priority.

Another important topic in the reasons that institutions affect the implementation of psychosocial policies is the way public institutions that provide mental health services are organized within the service network. We shall recall that stakeholders pointed to a great variety of limitations, ranging from policy formulation to delivery of services. These criticisms were raised mainly by stakeholders at the street-level, such as representatives of NGOs, professional associations, and consumer of services and family associations.

As it was mentioned in Chapter 3, it is valuable to know if limits of psychosocial care implementation are at least in part associated to limits of policy formulation. From this perspective, Alfredo, representing a NGO, criticized the coexistence of asylums and the new services, and understands that limits of the transitional period are related to gaps of formulation in the law 10.216: “The Paulo Delgado law was already enacted with a major problem: inversely to what was initially discussed, it does not define a deadline for the total closure of the asylums . . . now we have to coexist with them.” Moreover, he criticized the significant reduction of efforts for deinstitutionalization, which was originally proposed only as a general statement of this law (a common criticism among the organized civil society in general):

The law says: gradual reduction in the number of beds and concurrent implementation of community-based services to advance the mental health reform, etc., etc. . . . The advances occurred in the first five years, but then it is practically paralyzed. There are no more advances in the deinstitutionalization.

For stakeholders there are two phases of the deinstitutionalization process that affect negatively the goals for psychosocial rehabilitation. In the first phase, there was a strategy of the Ministry of Health to concentrate efforts on the reduction of the number of beds in psychiatric hospitals and on the increase of the number of CAPS. In the second and current phase, the process of reduction of beds has slowed down, reinforcing the idea of the implementation of an alternative service network.

The first phase seemed to fail in what stakeholders called “*capscentrismo*” (or *capscentrism*) and in the quality of services implemented by the CAPS. Norma thoroughly summarizes the *capscentrism* perspective:

Only CAPS were effectively implemented among the substitutive services. CAPSs are what people know. There are some protected homes, but the population knows the CAPS; even if they are not so universal. In summary, there is a trend that everything is centralized in the CAPSs; as before, it was centralized in the psychiatric hospital. It seems to me to be a trend of the substitution of one kind of institution for another.

Unfortunately, the trends of the *capscentrism* indicate that the reform is more concerned with installing CAPS than with the quality of their functioning. On one hand, it is understandable the need to increase the number of units of assistance in the transitional process. This, at least in part, guarantees the access to new services. On the other hand, it is not worthwhile that this trend, which was supposed to occur only in the very initial phases of the reform as needed, becomes the actual mental health reform in Brazil.

Contributing to this discussion, Mario said he knew professionals who work at the CAPS, and among them, many are frustrated because the expectation from the top level of policies is that they respond to all demands in mental health, as if the CAPS was the only solution for them: "Professionals from CAPS are very anguished because they have to respond to all demands but they are not able to do it alone; they are not self-sufficient." If the frustration of these professionals is represented also in the larger CAPS mental health workforce in Brazil, we may speculate it would have a negative impact on the quality of delivery of services at the CAPS. This discussion prompts some intriguing questions: If mental health demands intersectoral actions, how would professionals from only one kind of service attend to all these demands? If they are attending to all these demands, do they have sufficient training to deliver such diverse actions? Is this training effective in practical terms? And finally, if the training is effective to enable professionals to attend all these demands in only one kind of service, where is the importance of the service network?

The discussion points to the fact that stakeholders seem to be arguing for the new paradigm and the original motivations of the mental health reform, in which the focus on psychiatric beds is shifted for the focus on clinical and psychosocial interventions in the communities. They are arguing for the original inspirations on the mental health reform in other countries, especially in Italy, and the goals of the Caracas Declaration as we saw in Chapter 2.

In terms of the second phase, in which various stakeholders pointed to a reduction of efforts to reduce the psychiatric beds, especially those representing non-profit organizations agreed that there is still a role played by private interest, and that there is an unbalanced budget invested in psychiatric hospitals and substitutive services. Here, we shall recall that numerous psychiatric hospitals in Brazil are private and are paid by the SUS when admitting SUS patients. These factors indicate practical

limits to what is formulated in the administrative rule 52 which provides that investments must enable a progressive and satisfactory transition between systems of care, and substantially guarantee the assistance of substitutive services in the community.

In addition, Elias was the only interviewee who indicated a third way in which the implementation of psychosocial care could be negatively affected in the current phase of the reform in Brazil:

The existence of small asylums or modern psychiatric hospitals threaten the implementation of a network of services because it does not force services to produce their maximum efforts in terms of interventions and in their attempt to maintain individuals out of admissions [in psychiatric hospitals].

What Elias, as an activist, meant to say is that the ideal of the reform is to maximally avoid any kind of institutionalization; either in the classic form, centered around large traditional psychiatric hospitals, or the “modern” form which is represented by small hospitals but still utilizes the same traditional concepts. For him, and for many other activists, a reform that includes psychiatric hospitals subsequently includes some of these traditional concepts and does not push its services to respond effectively. Within this view, services should be effective in terms of increasing health and minimizing the chances of admissions. Or, alternatively, services can also be effective in terms of managing crisis intervention by themselves, counting on the support of the CAPS III—the most specialized type of CAPS in the model of the Brazilian reform—or of the general hospitals.

Consonant with this idea but under a reverse logic, Mario, as a psychiatrist who supports the important role hospitals play in crisis intervention, concludes that if the service network is effective in its assistance for mental health, there will be a very low demand for admissions in psychiatric hospitals. Thus, these hospitals will not represent a concern anymore: “With out-patient services and investment in primary health, the need for acute cases to be admitted in hospitals diminishes by itself; it would not be necessary for the Ministry of Health to focus on regulating and controlling these hospitals.”

On the other hand, although the Ministry of Health recognizes that the reform faces limits of implementation of psychosocial assistance, such as difficulties in reducing the number of institutionalized patients who live in hospitals, it tends to see implementation as satisfactory for offering a comprehensive network of programs. Leonardo from the General Coordination of Mental Health in the Ministry of Health summarized:

So today, the most typical configuration [of assistance] is: the patient that had lived for 20 years in psychiatric hospitals today lives in a protected home, receives financial

assistance from the *De Volta para Casa*, and participates in a social cooperative in which he/she earns some more money and improves social skills.

Leonardo's position is somewhat controversial, particularly when he stressed that this is the "most typical configuration" of assistance created for people with mental disorders in the country. As noted in Chapter 5, although this configuration is present among the major goals of Brazilian mental health national policy, other stakeholders in the sample agreed that psychosocial programs are still presenting insufficient access.

The insufficient number of psychosocial interventions, for whatever causes, not only threatens the universal principle of the SUS but negatively affects the integral assistance provided by the SUS and the mental health policies. In consonance, WHO (2004) recommends the organization of mental health services in three complementary strategies: reduction of large psychiatric hospitals, development of community services, and integration of mental health care into general health. And WHO (2004) affirms that the experience of "several developed countries have demonstrated that deinstitutionalization is possible through the development of comprehensive community services" (p. 32).

Beyond the limits of assistance of CAPS, as shown in Chapter 5, psychosocial interventions also are limited in terms of access to the *De Volta para Casa* program, interventions of protected homes, and initiatives in labor inclusion. Considering that these four psychosocial resources are the main structure of the psychosocial intervention of the reform today, we can ask: what is the effectiveness of the psychosocial care program?

In terms of the organization of substitutive services in the territory, overall, stakeholders point to a typical configuration today in which the CAPS need to be better articulated with community services in the territory, protected homes should be better defined, the *De Volta para Casa* program needs to increase access, and interventions in labor inclusion must have greater financial support.

Furthermore, it is not only the organization of the service network that worries stakeholders, but also the implementation of actions and their practical results. From this perspective, the discussion about intersectoral actions and the quality of services offered by the human resources indicates more gaps and limitations in psychosocial interventions.

Regarding the lack of intersectoral programs in mental health, the origin of the problem seems to emerge from both a lack of collaboration among ministries and a weak partnership between the Ministry of Health and the general organized civil society. In my field work, as I cited in Chapter 4, I also perceived these limitations. Sometimes, when I was trying to recruit stakeholders from different

ministries or secretariats for interviews, I found that there were none. And that in most of these departments there was no division for mental health, and in other departments the people answering the phone could hardly think of anyone in the institution who could talk about mental health, or refer to someone who had some kind of intervention in this field. This situation includes the Ministry of Social Development and Combating Hunger, which, for me, is a dramatic example of scarce representation. At other times, I witnessed instances of social entrepreneurship filled with great ideas and amazing talents struggle to survive, as in the case of the two labor inclusion projects in which I conducted participant observation. Their financial hardship risked the continuity of these projects, which should have had more access to at least initial financial assistance from programs investing in labor inclusion, income generation, or Solidarity Economy. In both cases, consumers of services were from the lower classes, having barely enough money for their own survival; they would not have the possibility to launch their projects out of their own pocket. At this point I would say that the lack of intersectoral programs may represent more barriers than limitations to policy implementation. O'Toole (1996), in a study of interorganizational networks in policy implementation, states:

The importance of intergovernmental grant programs and regulatory mechanisms, the prominence of public-private partnerships, and the emergence of salient policy problems cutting across administrative jurisdictions on issues ranging from health care to homelessness to economic growth all testify to the centrality of interorganizational arrangements for dealing with today's implementation challenges.

In the last decade, the idea that successful implementation does not depend exclusively on technical expertise has gained favor. Instead, with satisfactory managerial skills, managers or officials could make policy implementation even more successful if they foster cooperative linkages among diverse actors and organizations.

It seems that in Brazil, mental health policies are going in a different direction. Mario, for instance, shared the view with most stakeholders that psychosocial interventions become effective when they are perceived as an "interface" of mental health with other areas. Mario also shared how the limits of intersectoral actions are felt in practice:

We have been discussing with the Municipal Health Secretariat the case of homelessness with mental disorders which has increased over the years. . . . Unfortunately, we don't see sectors willing to contribute to this issue; in fact, they tell us it is the responsibility of other political actors. In other countries, by contrast, discussions in mental health often start in social work and then link with health at a certain point. Thus, there is this division between what relates to health and to social work, when interventions should be developed in cooperative actions. When you talk about psychosocial rehabilitation you need a partnership within different sectors, which we don't see in terms of public management.

Even the partnership between the Ministry of Health and the Ministry of Labor and Employment for the implementation of experiences in Solidarity Economy is greatly dependent on the budget allocated for mental health in the former ministry. This intergovernmental program is potentially successful, but still encounters some limits. In the description of Rafael about the program we can identify some of these limits:

We have a partnership between the two ministries but the implementation is for the Ministry of Health. There are some projects that we, as the National Secretariat of Solidarity Economy, support. They were presented for the Ministry of Labor and Employment; we analyzed and evaluated that they deserved to be supported. But this is not our role as a secretariat. We expect that the support should come extensively from the SUS budget. If possible, our idea is to only monitor and link these social entrepreneurs in contact with the Solidarity Economy Movement, so they can be trained. Moreover, we publicize and make campaigns on the importance of these experiences.

Some stakeholders in the sample and the majority of people I met during participant observations had no knowledge about the collaboration between these ministries. Other than this partnership there is no other mutual collaboration with other ministries.

In regard to intergovernmental practices with primary health, although the representative of the Ministry of Health reported the development of courses in mental health for professionals in primary health, the majority of stakeholders did not acknowledge them. Beyond the influence of visibility and publicity of interventions that will be discussed in the last chapter, these courses are probably a very incipient intervention if compared to Brazil's vast size and great number of primary health teams. On the other hand, previous literature points to serious limitations of mental health in primary health and stakeholders who brought up this issue were also somehow in close relation with primary health teams or professionals and know that in the field, these professionals encounter countless barriers to address mental health situations.

Finally, yet at the bottom-level of implementation, and more specifically at the delivery of mental health services, stakeholders—and more often representatives of professional associations—frequently cite either the limits of mental health professionals' qualifications or the reduced number of psychiatrists in Brazil. In fact, according to Alarcón and Aguilar-Gaxiola (2000), this deficit of human resources is also a trend of Latin America as a region. They attest that "training programmes in psychiatry produce less than 600 new graduates a year, some with only limited technical skills and inadequate training. Less than 10% of psychiatrists in Latin America devote time to educational activities" (p. 4).

The issue represents a major problem, as human resources are the ones that directly deliver services to the needy population. They are the ones who introduce new cases into the system and help existing consumers of services and families in the transitions intrinsic to the new methodologies and available service network. An un-trained or un-qualified professional cannot appropriately address the demands of consumers of services and families and may be, even unwittingly, reproducing old discourses, methods, and stigma. According to WHO (2000), "human resources are the most important assets of the mental health system. The performance of the health care system depends ultimately on the knowledge, skills and motivation of the people responsible for delivering services" (as cited in WHO, 2004, p. 33).

Today, a massive number of professionals support the ideals of the new paradigm in Brazil. But, what is missing is professional training which would enable professionals to build necessary skills for comprehensive psychosocial assistance. Interestingly, the unsatisfactory professional qualification is also a result of the lack of policies addressing professional formation and other human technology issues. According to stakeholders who discussed this topic, overall, the professional education and training in academic institutions repeats over and over the same classical methods and techniques as decades ago. In other words, most classes and internships are in the psychiatric field, not in mental health, and are developed in traditional psychiatric hospitals.

Leonardo also considers professional training one of the major components of the mental reform but confesses to minimal advances and says: "We haven't yet achieved positive results in terms of the kind of reform that leads to significant changes in academic institutions, especially of doctors and psychiatrists." Mario affirms: "In fact, professional training has been the great void of the reform."

I also noticed this human resources issue during my participant observations. In general, I could see that technical limits were more related to poor professional training than to professionals' willingness to develop new kinds of interventions in favor of human rights, citizenship, and autonomy for people with mental disorders. In one of the participant institutions, throughout the transition from services centered in the hospitals to a service network in the community, professional training was considered by the director one of the hardest tasks. During the seven years of transition, there was great investment in preparing professionals for the new tasks and development of new skills. Despite all these efforts, there are still some situations in which behaviors tend to be influenced by the old and traditional approach. Once, when participants of the broom factory went for a walk in the community to collect materials to make the products, the coordinator was a little apprehensive for their safety in

crossing streets or walking on the sidewalk. And yet, all of them come from and go home every day by themselves without the need of help. As time went on, the coordinator was less and less apprehensive and let them go wherever they chose, in groups or alone, or in other words, based on their own choices. For me, this situation illustrates a natural reaction from someone that in the old system was trained to assume the responsibilities of patients instead of giving them tools to gain their own autonomy.

In addition, beyond the lack of qualified professionals, there is also a limited number of professionals available, particularly psychiatrists. Marcelo, an academic who also has supervised CAPS, considered:

There is a reasonable supply of professionals from social work, nurses, occupational therapy, and psychology. My problem with them is the way they were trained at academic institutions. It is a big gap between their training and what we offer as services today. . . . The psychiatrists are in scarce number.

Going back to a broader picture, we can observe that in Brazil up to this phase of the reform, gaps in psychosocial interventions are generated by the low representation of various interests in the definition of priorities, by the organization of the service network, by the lack of intersectoral actions and by the quality of interventions due to limitations in human resources. Although diverse stakeholders have identified these themes from different angles, they tend to agree on the limitations of these themes. However, contrasting views were more often presented by the top implementers, such as the Ministry of Health.

In terms of how these gaps affect the ultimate goals of the new mental health system, they represent obstacles for the increase or improvement of autonomy, self-esteem, and life satisfaction of people with mental disorders and, particularly in the case of the limits of labor inclusion, gaps are also obstacles for a better economic situation of people with mental disorders and their families.

FISCAL PROCESSES AND PRIORITIES

Obviously, funding and budget allocation are one of the major resources to launch policy implementation processes. Even the best ideas, tremendous creativity, willingness to work hard, and commitment with ethical principles together are not enough to sustain implementation of policies. This is true of contemporary societies in any place in the world. Along these lines, WHO (2004) defines financing:

[as] the mechanism whereby resources are allocated for infrastructure, technology, the delivery of services and the development of a trained workforce. As such it is a powerful

tool allowing the ministry of health to translate policy into reality and to develop and shape mental health services and their outcomes. (p. 30)

Brazilian mental health policy aims to finance the implementation of a effective system in which progressively less investment will be given to beds in psychiatric hospitals and pensions for disability, and more investment will be given for the deinstitutionalization of people with severe and persistent mental disorders, for psychosocial care, and for mental health promotion. These goals, if achieved in Brazil, will contribute to increase access to psychosocial care and the effectiveness of its interventions, and subsequently, increase the participation of people with mental disorders in the social realm and increase their opportunities of labor inclusion. These accomplishments would break a Latin American tradition summarized by WHO (2004) as a significant lack of financial resources from governments and intensive participation of social security systems.

Even though the national policy provides for a gradual transference of funds from old priorities to new ones, in practice, there are limits of implementation. As mentioned in Chapter 5, my data indicates various budget issues, but most significantly the role played by municipalities in managing financial resources and addressing mental health priorities. These issues indicate that fiscal processes represent an important component in causing policies to fall short today. Very intriguing is the fact that interviewees raised a great variety of issues related to fiscal concerns, which I do not see as contradictory but as different. The variety itself reveals how broad this subject is.

Among representatives of the legislature, funding is a major concern in mental health, especially regarding the budget available for psychosocial interventions. Fernando, for instance, considered that "the lack of budget allocation is a great barrier: it impedes the implementation of services and appropriate personnel. The legislation is okay, but the lack of financial resources is, in my opinion, the greatest limit today." Fernando's idea that with resources, policy ideals have much more potential to be realized is consonant with what Meier and O'Toole (2006) call factors that enhance or weaken commitment of organizations and their personnel: "Any bureaucratic task is easier to achieve if the administrative organization has ample resources. Resources allow an organization to invest in more skilled human capital, add technology, or simply attempt to overwhelm problems with personnel" (p. 102).

But, beyond the great contribution that different resources might bring to the practicability of policy implementation, budget management seems to be a fundamental element to consolidate practices, their continuity, and sustainability. As noted in Chapter 5, the sustainability of actions already implemented is the major concern of the Ministry of Health for mental health. This concern was raised

when the representative of this Ministry—and a NGO member—discussed the potential problems that can be caused by decentralization as it enables autonomy at local levels to invest in different issues adapted to their priorities. It is commonly agreed upon among stakeholders in the sample—but the sample did not include the voice of any local manager or official—that the federal government supports mental health, but obstacles exist at local levels, including the priority given to mental health.

More specifically, it is known in Brazil, and stakeholders also agreed, that President Lula's administration was the first in Brazil to give priority for mental health and to allocate the diverse kind of resources to launch and sustain the national mental health reform. Claudio, who recently conducted a study analyzing the website of the Ministry of Health to identify the priority areas of this administration, reveals: "I perceived that in discourse—in the number of administrative rules, in resources allocated, and in reported outcomes—mental health was one of the priorities." Elias, recalling historical facts of the mental health reform, confirmed: "Based on the propositions of the 1993 Conference, President Lula's government assumes and adopts a policy of implementation of substitutive services network—a policy of induction in which the federal government finances the municipalities to enlarge this network." If the perception of these stakeholders reflects a true trend, we can assume that the role played by municipalities, and maybe by the states, in transforming fiscal processes into barriers for implementation is extremely large.

Based on my data, we can note that the role played by municipalities involve general policies in Brazil and not only mental health issues. Stakeholders from professional associations, NGOs, the executive and legislative powers in the government lacked trust in municipalities and agreed that there is a lack of accountability and management transparency at local levels. For instance, Matheus, who represented a professional association, commented on this situation:

The barrier is in the conscience of municipal managers, in their capacity to manage the public sector with care, ethics, and to benefit the community. I don't perceive the problem as lack of resources, investment, or fiscal planning, but lack of planning for execution of programs. It depends on the conscience of managers to invest resources where they should be invested.

Therefore, there are two conditions to be explored: how the mental health sector can deal with the general problematic budget management at local levels and how the mental health sector can contribute to a high priority given to mental health at these same levels.

As the first problem refers to a more general political issue among Brazilian officials, actions from the mental health sector itself are very limited. It may be that a larger representation of mental health in the mechanisms of popular control would be helpful. But this topic was addressed by some

stakeholders, such as Norma, when analyzing the theme of regional differences in policy implementation. (Please see the section “Regional Differences” and the sub-section “Municipalities” for more details.) Mechanisms of popular control could also contribute in monitoring the quality of interventions. This is because sometimes, even when a budget is used for mental health ends, it can be allocated without the appropriate knowledge and thus negatively interfere with the quality of services provided at the bottom level of implementation, sometimes even producing distortions in services’ goals and limiting a service network. Mario gave an example:

As there was the incentive from the Ministry of Health to municipalities and they should invest the money, in some cases they simply distorted pre-existing services. For example, you see CAPS with 3,000 patients but if you check the diagnostics you will see that these CAPS are working more as out-patient clinics. It is everything in just one place.

With this example Mario asserted that more attention should be given to not only to funding but to directing how a budget should be allocated to produce cost-effectiveness; this is a problem that is very common in policy implementation in diverse areas.

To deal with the lack of legitimacy at local levels, stakeholders in general propose the use of information to increase the awareness and the level of priority given to mental health. Data on mental health is necessary to show local managers that prevalence and social and economic costs of mental disorders are still high even if they are invisible. As Leonardo suggested “A task we have is to increase awareness, showing to municipal managers that there is a high burden of mental disorders, a high prevalence, which is not so visible. This will convince them to implement an effective service network.”

Although the role played by municipalities is evident and President Lula’s administration has given priority to mental health, my data points to the low budget allocated to mental health.

A primary consideration to understand is that the transitional phase of any mental health reform is extremely expensive. For sure, investments only based on the transference of the budget from psychiatric hospitals to substitutive services are not enough, for instance, to afford human resources training and an infrastructure that makes available several facilities spread throughout the territory. Among stakeholders, few remarked on the expenses of the transitional phase. Mario was aware of this issue and concluded:

The costs increased in every place where there was the implementation of a community-based system of care in mental health. They increase especially in the first phase because there are costs with professional training and with the implementation of a system of interconnection among different units of assistance.

Particularly in the case of human resources, some interviewees not only question the quality of services and programs associated to an unqualified workforce as it was shown in previous sections, but believe this is also a consequence of the under funding of government spheres in human resources.

Facing such a situation, some stakeholders criticized the executive powers at the different levels but inverting their criticism toward the federal government: they identified as insufficient the amount of financial resources that have been invested by the federal government for state and municipal mental health needs. This is a second budget issue to be considered. Alfredo considered this a common position among all stakeholders, including the General Coordination of Mental Health:

Budget is what unifies all different positions in the mental health reform. This includes the coordinator of mental health in the Ministry of Health who recently said: "one of the issues we can have a consensus on is the need of increasing resources for mental health." Reforms are not possible without resources, right?

Unfortunately, even with the consensus that increasing the budget is fundamental, in actual practice, budget is still limited. Mario, for instance, pointed out that there is actually a reduction of funding. He recalled a study conducted by the UNIFESP (Federal University of São Paulo) in the years between 1995 and 2005 aiming to evaluate the investments of the federal government in mental health. The study demonstrates that "while in 1995 the total investment in mental health was approximately 5% of the total health budget, in 2005 it dropped to 2.3%."

The same data can be found in a study by Andreoli, Almeida-Filho, Martin, Mateus, and Mari (2006), which shows that there was a reduction in the expenditure in mental health in Brazil:

In 2005, federal resources to SUS were around \$15 billion US (\$82.7 US per capita), of which \$358 million US (\$1.95 US per capita) were directed for mental health care. The expenses in mental health were \$2.66 US per capita in 1995 and \$1.95 US per capita in 2005, a decrease of 26.7%. The percentage of mental health expenditure in relation to health expenses was reduced from 5.8% to 2.3%. (p. 45)

Besides the general budget issues brought up by stakeholders in the sample and by the literature, a third issue narrows the subject to the understanding of the limits of psychosocial care assistance, particularly for CAPS and labor inclusion interventions, when resources are limited and inhibit opportunities of partnership with services in the territory.

As we have seen in Chapter 5, Marcelo was the only interviewee who had brought up how the allocation of federal funds in Brazil has been a limiting factor for the expansion of the psychosocial care in regions where the reform is more advanced. However, Marcelo challenges the executive power at the federal level to solve the problem of how national funds can be allocated to respect local

peculiarities. Otherwise, in places where the reform has already advanced, funding limits improvement of interventions already in process or the implementation of new areas of priorities in accordance to local advances and limitations. Therefore, decentralization is not the only problem to address regarding mental health priorities in different regions.

In terms of partnership with resources in the territory, a few stakeholders among NGO members and the legislature pointed out that budget issues also limit the access to funds for non-profit organizations, decreasing the chances of implementation of interventions based on the partnership between the State and the civil society. Alfredo shared his frustration when trying to apply for funds that support non-profit projects in psychosocial rehabilitation, particularly in income generation:

First, it must be a project approved by the municipal administration. . . . Second, the administrative rule provides 15 thousand reais for each county for these projects. When I read the rule I thought it would be 15 thousand for each project. But it is not. Imagine in a city like São Paulo, having numerous NGOs, various CAPSs, to have only 15 thousand to implement income generation projects. It may be effective in small counties that have only one CAPS and one non-profit, but not in big cities.

Norma agreed: "It is necessary to have a more criteria-based evaluation of the municipalities. Funding should not be allocated only for them. It should be available for interventions created by civil society that many times, even with tight resources, produce positive cost-effectiveness."

Finally, a last intriguing issue points to labor inclusion interventions. As noted in Chapter 5, consumers of services and representatives of the legislature indicated a low investment in labor inclusion programs, which should have to be one of the priority areas of investment in psychosocial care. But in the same chapter, the representative of the Ministry of Labor and Employment pointed to available investments that would have been much better allocated if the Brazilian legislation for cooperatives had been reviewed. It seems to be an opposition of ideas, but for me it is more a reflection of the limited dialogue among parties that readdresses the problem for the relationship among various stakeholders: on one hand, implementers at the different levels should have more presence in the parliament and remind legislators what the priorities are of certain mental health issues that face barriers of policy formulation; on the other hand, more legislators should be aware of the importance of mental health to the rights of citizenship and to the quality of life of the population which they represent at the federal sphere.

According to the findings of this study and available data, I suggest that we shall consider the following overall fiscal processes issues in Brazil: The federal government includes mental health in its priorities and has a specific budget for it. Unfortunately, the budget available seems to be insufficient if

we consider the expenditures necessary in a moment of transition between such different mental health care systems, especially the initial investments in new facilities, professional training, and as Mario said, “a system of interconnection among different units of assistance.” But, up to now budget allocation has been transferred from the federal level to municipalities, where there are different levels of priority to mental health and different managerial features. Among priorities at different levels, data also suggest the priority given for psychosocial care is still very low, affecting the kind of reform that was initially intended for the country.

Luciano connects these different issues in a very creative way. His insight is also linked to Schneider and Ingram (1993) who argue that unfunded policies are largely symbolic actions that are most common for “dependent” targets, who have a sympathetic position but no political power:

Nobody argues that the idea is exceptional, but there is an enormous distance between the idea and the impetus to implement. I have no doubt that our great problem is political: public health, and especially mental health, does not deliver votes, does not elect anybody; thus the budget is never sufficient, either for inappropriate management or for inappropriate allocation.

As we saw in Chapter 2, today, people with mental disorders are probably among these “dependent” targets. Representatives at various government spheres and the society in general, if asked, potentially support a mental health system that respects human rights and improves the life of people with mental disorders. But, of what importance is their issue among so many others? Why should their situation have priority? What is the visibility of these people? What should be done to overcome these limits? The arguments presented in the present chapter contributed to the understanding of the pertinence of these questions in terms of the place of mental health within institutions and the diverse interests of stakeholders. The next chapter contributes to this understanding by highlighting the place of mental health in the social realm.

CHAPTER 7

OBSTACLES OF STIGMA, PREJUDICE, AND INEQUALITIES

Intriguingly, all interviewees often talked about stigma or prejudice throughout the interviews, even when there was no question directly touching these subjects. It is also thought provoking that just as often they talked about the importance of the dissemination of information. This suggests that even if Brazil has successfully overcome traditional and institutionalizing methods of treatment and human rights violations, stigma and prejudice in communities are still key themes for discussion. Moreover, it also suggests that for most of the stakeholders, various kinds of information are considered to be a key tool to fight stigma and prejudice. Overall, this chapter is motivated to answer the following inquiries: What is the role stigma and health inequalities play in the policy implementation process? Do different stakeholders significantly differ in their perceptions about the role stigma and health inequalities play in the policy implementation process?

The high incidence of stigma and prejudice as a topic of discussion during interviews might also be influenced by the fact that among 11 interviewees, nine either presently have or have had a close relationship with someone with mental disorders. This number may have increased if the timeframe had allowed me to ask the same question for four more participants.²⁸ One interviewee said he has a close relationship with someone who suffers discrimination or stigma, but it is a case of mental deficiency and not of major psychiatric disorders. Among the nine interviewees who have this experience, there are two who are consumers of mental health services and two who are relatives of consumers of services. Even if we do not count these four people in the sample—because their closeness with someone who has mental disorders is part of their representation in the sample—there are still five or one third of the sample who have friends or relatives with mental disorders. The study does not have data to investigate if they had first a relationship with someone with mental disorders or

²⁸ Stigma and health inequalities were part of the last theme in the interview guide and when the interviewee and I had a time constraining issue, I gave preference to questions that raised more analytical issues and so would contribute to more qualitative data. Honestly, I only realized now that the question number 3 in theme 04 (see Appendix B) could contribute as much as others with such stimulating thoughts, even if, most of time, it gave me very objective answers.

a professional position that deals with mental health, but what really matters here is the fact that they have a close relationship to mental health and are well informed. One might presume that such people would not themselves perpetuate stigmas associated with mental disorders.

However, from the discourse presented by just the two interviewees with mental disorders we can also conjecture that close personal connection is not enough to fight stigma and prejudice. This became clear when these interviewees presented a discriminatory discourse toward people with schizophrenia, but not with depression. Similar to the general population, they talk about schizophrenia or people with schizophrenia as lunatics or in other words, people who lose their bond with reality, sometimes violent, and with limited recovery. Vanessa, commenting about what the government should do to fight stigma, agreed: "I would like the government to disseminate in TV the laws that combat the discrimination against people with mental disorders. They should differentiate depression and the disorders that impede closeness to other people, to humanity." Bruna said: "I think there should be a program to give economic support for people that have a mental problem and take medicine. The person must have the help from the government." In the context of the interview Bruna talked about this help from the government not as a right provided in the legislation but as a consequential need when someone takes psychiatric medicine because ultimately the medicine indicates an ongoing disability.

But, the discrimination present in the discourses of consumers of services and families does not mean that they support old-fashioned treatments. Indeed, they support the fight against stigma and they support humane treatments and social inclusion interventions for people with any kind of mental disorders. But, it seems that even these interviewees perceive others with "more severe" disorders as "dependents" as defined in Schneider and Ingram (1993) and tend to believe that they would be better in treatments which include psychosocial assistance, even if their achievement of autonomy is hardly possible. I would say the stigma present in their discourse is often very subliminal. For instance, discussing stigma Vanessa seemed to be raising the issue from a different perspective than previously, when she naturally shifted from depression to general mental disorders: "There are people that think that depressed people are crazy, but they are not. . . . They think a person with mental disorders is not able to interact with others. There is still this discrimination." However, when I asked her to define "crazy" she, once more, presented evidence of stigma in her discourse:

Q: And how do you define crazy?

Vanessa: Crazy is the person who is not rational, who has nothing in their mind, who lives in his or her own world, that needs someone to take care of him or her so he or she will not do crazy things.

Q: Even if they have access to treatments like you have, will they not be able to interact with others?

Vanessa: No because here we work with scissors. Here, the only ones that work with scissors are people who we determine have control and ability. The ones that we determine could have an accident, we give another kind of work.

Q: So, even the ones you are defining as crazy, who do not have only depression, have abilities to work with others?

Vanessa: They have. Many who were considered crazy in the asylums but had the capacity to interact in home, where the family takes care of them, and that are in treatment at CAPS, are enjoying our cooperative. Although they are not official members, it works as a therapy for them.

In the first part of Vanessa's discourse we may note that she perceives people with more persistent and severe mental disorders as being devalued: they are closed to social interaction, they depend on others, and they lack control and abilities. Although these characteristics could be the case for some highly institutionalized people, her perception is built on the fact that any people with persistent and severe mental disorders can be described in this way. Vanessa considers these characteristics as intrinsic to these individuals and not as a result of an authoritarian and secular system of treatment that also results in disabilities. But, ultimately, Vanessa believed that somehow they can positively respond to the new kinds of treatments. Still, however, her way of thinking suggests that they respond in quite a limited way and that a cooperative experience would only work as a therapy for them—which even if it is not a rule, may be a more reasonable way of thinking toward the case of those highly institutionalized people. But, the discussion on Vanessa's discourse continually brings up other concerns such as, in this case, the adequacy of activities according to people's psychological and social conditions at a certain moment. It also raises an important question: what is therapeutic? Or, what does therapeutic mean? Being in the same place where others do beautiful things? Unfortunately, this is not the main subject of this study or section, and we have to go back to our main point of inquiries, but it might be a very intriguing topic for future studies.

Here I will return to my earlier conjecture that close personal connection with mental disorders is not enough to fight stigma and prejudice against people with mental disorders. It was a consensus among stakeholders, independent of their interests and issue networks, that the access to various kinds of information would be a fundamental tool to fight stigma: production of scientific data and publicity in society, promotion of education in mental health at various levels of education, promotion of cultural events, publicity for actual programs, their projects and positive outcomes.

My point of view about what was brought up by these interviewees is that as mental disorders are, in general, still marked by social representations, prejudice, and stigmas in the public opinion, interviewees perceived these various kinds of dissemination of information as tools to increase social and political support. Recall that within the public opinion it is also included the opinion of politicians, future mental health professionals, and consumers of services and their families.

When interviewees were asked about the social support of people and communities for psychosocial actions and programs, they concur that stigma, prejudice, and lack of information affect general support. But we also should recall the contrary opinion of Elias that the major problem for mental health is not the stigma but the management of the stigma. Although on one hand his comment seems to be pessimistic in terms of how changeable stigma and the behavior or opinions based on stigma are, it also seems very realistic. For me, what he meant is that the main point is not to fight against the differentness but to build a social sense of closeness with differentness. Nobody needs to lose differentness, but people should believe it is possible to work, to love, to play, to cook, to drive with differentness.

In terms of political support, Alfredo, as a NGO member as Elias, considered that stigma and prejudice are not the only factors in game. Recalling his comment in Chapter 5, Alfredo considered that the lack of political representativeness of people with mental disorders in the political arena and their weak political power influence political support as well.

Social representation was also identified by interviewees as another important factor in the generation of stigma. Discussing social representation and stigma, they particularly considered historical and cultural influences in building the concept of mental disorders. In addition they cited social feelings such as fear, and images that, in their point of view, are still associated with people with mental disorders such the image of the mentally ill as dangerous, anti-social, and beyond hope of recovery. Bruna, for instance, stated: "I think that people in general fear that a person with a mental disorder will be aggressive and violent." When social representation was the issue, information had a major role in fighting stigma and prejudice against people with mental disorders. Fernando pointed to the importance of working to diminish the social association between the treatment for mental disorders and the asylums: "We have the law but we don't work for awareness. If the need of admission in asylums is still present in the culture, the stigma that people with mental disorders should be excluded also persists."

Besides, interviewees pointed to primary health care and the dissemination of successful experiences of psychosocial care as the main tools to fight stigma and discrimination. Mario considered dissemination of information a priority: "We are in the beginning and so we should first inform. Inform the population and inform professionals in primary health. Today, information is a central issue." In agreement, interviewees perceived this as a long process, with some modest seeds planted already. Luciano, for instance, creatively discussed this:

First, people keep distance, then slowly they get closer like a scared little puppy. This is natural, normal, human. We have to deal with it. What we cannot do is to try to determine ideals as absolute truths. Otherwise, we will create conflict of ideas. . . . This demands time, and time is one of the problems of public policies: they demand time, planning, education, and all these cannot be achieved from night to day.

Overall, interviewees tended to support the idea that stigma and prejudice might be fought with real examples to what people with mental disorders can do. This is in contrast to what was shown in Chapter 5 which was that interviewees regretted that the low investment in psychosocial programs also minimizes the opportunities in which their results could be used to fight stigma. The idea is basically related to the fact that one may combat stigma and prejudice using the same logic of those who discriminate. As stigma and prejudice for mental disorders are highly associated to behaviors and inabilities, they may be also fought by the familiarity with other behaviors and their positive results. Here, strategies of integration into community life and labor inclusion can have a special function.

Only two interviewees in the sample are very pessimistic. They think there is no social support and because of discrimination there never will be. Coincidentally or not, both interviewees were consumers of mental health services who, because of their own experience, may truly feel the stigmatization processes more present in their lives. Vanessa explains her point of view: "[Support] people without mental disorders? No, they don't [support] because they perceive people with mental disorders as people who do not have the ability to feel closeness. This discrimination still presents."

From a different and intriguing perspective there are stakeholders' arguments that fuel a discussion in implementation about how substitutive services reinforce stigma. It is also a discussion scarce in the literature. As it was shown in Chapter 5, these concerns involved CAPS, protected homes, and inappropriate management of crisis intervention when interviewees questioned the quality of services and the effectiveness of resources offered to the population with mental disorders. Claudio questioned how CAPS are organized to attend different categories of mental disorders. Discussing the other two services, professionals (Mario and Luciano) showed how this issue affects the population with more persistent and severe mental disorders, which are already the most institutionalized and

discriminated and need greater efforts and resources in psychosocial rehabilitation. In essence, these stakeholders open a discussion in which labels are still present in the new system, even if in a very slight way. As services are closer to the community, what they show seem to be fundamental to change or reinforce social representations, stigma, and prejudice. Surely, this discussion also requires deeper technical discussions that are not approached here as the main issue is limited to understanding how aspects of stigma and prejudice are present in policy implementation.

In my point of view, in the case of CAPS and acute crisis intervention services, the arguments of stakeholders approach the kind of visibility that has been shown to the population. Even counting on the fact that the population can easily label people who are accessing the so called CAPS AD, it is recognized by mental health professionals that their treatment includes different approaches and techniques and this is what the Ministry of Health is trying to do. On the other hand, CAPS AD are accessed at a stage of the treatment in which people search for appointments and psychosocial activities and here, it seems fine that these interventions could be offered at the regular CAPS, counting on professionals who specialized in alcohol and drug addiction. The core of the discussion for CAPS AD brought up by Claudio seems to be questioning if it is possible to offer specialized services without labeling. In terms of crisis interventions, Mario shows an opposite need. As crisis situations show in a very explicit way the behaviors associated to social representations that carry negative connotations, this should not be the moment to make mental disorders visible to the population, in this case, at general emergency services. Even if his claims are legitimate, the question here is if there is any place that, intervening in crisis interventions, would not be reinforcing labels. How would services work on this visibility in a way in which prejudice and stigma would not be reinforced? Is it possible? Would crisis situations always be a property of psychiatric hospitals? How could policies work on the images created by crisis situations and psychiatric hospitals? Would it be possible to make them visible from different angles or perspectives?

In the case of the protected homes, Luciano pointed to a discussion that is more related to the invisible maintenance of the status-quo. As shown in Chapter 5, the image that he brought up about the beds made with hospital sheets is, in truth, questioning if the assistance and environment offered at these services are really differential, or in actual practice reproducing the old paradigm in smaller open structures.

Another major pattern to which stakeholders pointed is the role of the dissemination of scientific information in the educational sector. Although some stakeholders, particularly from NGOs

and legislature, included interventions in all levels of education, in general, stakeholders focused on the professional training of future professionals at academic institutions. Alfredo concludes: “[For the society in general,] discussions of social representation, meanings and images associated with mental disorders, will change discrimination. But, if the professionals still have traditional training, how will discrimination change?” It is important to note that this concern was also confirmed by stakeholders at the participant ministries, and was considered a major challenge today in Brazil to be overcome.

Concurrently, stakeholders also included the access to information for the general public and that it should be one of the major strategies of mental health reform. According to Leonardo, the Ministry of Health needs to have the media as a partner and is already working for it: “We need mass media campaigns at the national level. We are working toward it, but it is very expensive. It is necessary that this campaign should focus on the autonomy of people with mental disorders”. Rafael concurs: “The State should invest in campaigns in the mass media to contribute to fight discrimination in the population. In general there is an authoritarian and violent perception about mental disorders.”

The dissemination of various kinds of information to the general public is related to what Acuña and Bolis (2005) said about the influence of stigma on the access to health care for people with mental disorders. They also recommend the involvement of citizens through dissemination of information: “Information . . . focusing attention on advocacy for the rights of these persons and incorporation of the topic into the public agenda. In this context, activities to disseminate information should include social dialogue as a means of involving citizens in the debate.”

I perceive the general discussion, brought up by stakeholders in the sample and in the literature, about the role of the dissemination of information among various societal groups as a strong belief that the publicity of general data and actions is a great contributor to lift mental health out of the mysterious places in which it has been for the last centuries. I also see that this general trend in the sample is reinforced by the fact that the publicity of mental deficiencies, HIV, and cancer was very favorable to significantly change societal conceptions about these disorders or diseases and subsequently about the people with these diseases. Also having these other examples, I agree with the important role played by strategic visibility and publicity to diminish general strangeness in the public opinion regarding mental disorders. But, I also agree with Elias that stigma is something that may never be completely overcome, but prejudice can be fought, tolerance can be increased, and visibility and publicity can play an important role in the work of building a social sense of closeness with differentness.

In regard to the association between other discriminations such as race, gender, or socioeconomic status and stigma for mental disorders, as was noted in Chapter 5, the major part of stakeholders who indicated a positive association work at the street-level of policies, but all either work at or access public health services. Among stakeholders in general, socioeconomic status was the major factor associated, followed by differences of race. It is interesting to note that this theme was largely approached through discussions on access and health inequalities.

Norma considered social class a most influential factor in the way families deal with mental disorders and in the kind of treatment they seek for their relatives:

If a family is from the middle and upper classes, they will opt for a private and specialized service; in general the person with mental disorder in these families is not even visible as the family hides him/her and treats the person in a private way. They will not use the public service. When the person with mental disorder is poor and of African descent the treatments have a very low quality. This is because the more differences you carry and they are associated to discriminations, the more you will have difficulties in accessing rights and the inequality deepens.

Similarly, Elias' point of view also highlighted class status:

The great problem of our consumers is that they are poor, with limits of access to education, and they carry on their bodies the mark of subordination which is an effect of discrimination by society. This condition, leads to a diminished value as a person independent of what else he/she is. Then, he/she will have layers of madness, layers of ethnicity, layers of his/her gender; these layers have a mutual association. But, I believe class is a major issue.

The fact that stakeholders approaching this issue work at or access public services make them close to the actual dynamics intrinsic to health inequalities that affect not only mental health but health in general in Brazil. But they also believed health inequality may be accentuated when those who access services are people with mental disorders.

We may observe from Norma's comment that there is also an important discussion on how health inequalities are marked by differences among the private and public sectors. Among stakeholders, there was a clear distinction between lower classes accessing public services and upper classes accessing private providers. Here, I suggest that the contrast between public and private can be also linked to the previous theme of visibility. But, not the visibility of services, outcomes and other kinds of information, but to what extent these different classes deal with the visibility of mental disorders. It seems that upper classes not only access private providers but keep mental health issues within their own private realm. They do not want their private problems to become public, and they can afford this privacy. On the other hand, the lower classes not only access public services but without

resources—such as having a private car, paid days off from a formal job, private caregiver to take care of the one who is ill and so on—they need to solve their problems in ways that result in their private lives becoming more publicly visible. They take the bus; they ask for help from a neighbor; they wait for appointments in lines—sometimes on the sidewalks, and so on. They do not want their private problems to become public, and they cannot afford this privacy.

Another intriguing issue, but more based on conjectures about the future of mental health in Brazil, is when mental reform will be already consolidated and effective. I believe, and a few stakeholders, too, that people accessing public services will be accessing more effective services in the near future as they usually offer a larger range of psychosocial resources. Surely there will also be other variables interfering, such as individuals' diagnoses, but here and in consonance with the objectives of this study, I am discussing the cases of major mental disorders and therefore, people who will be more often accessing psychosocial care resources. Surprisingly, this shift seems to contradict the extant situation of health inequality in mental health in Brazil where private services seem to offer treatments with better access and technology. But, this is what seems to be starting to happen. As the lower classes access public health, and this is where the reform is happening, they are accessing services that, currently, are at least aiming to offer a comprehensive treatment. Alfredo explained:

The access of services in the mental health system in Brazil is much greater by the lower classes. The middle and upper classes, in contrary, face a great problem: that is the nonexistence of services working in the new paradigm. The majority of the private clinics have a vision based on the perspective of the asylums. They are extremely expensive and based on the perspective of the asylums. This is a large problem today.

As it was shown in Chapter 5, professionals and consumers believed there is also a high association of mental disorders with poverty in Brazil. Facing also poverty in most of their assisted cases, public providers such as CAPS and out-patient clinics have to deal with poverty issues: "When a bank owner arrives at a service, you treat his/her mental disorder. You don't treat his/her condition of being rich. When a poor person comes, you also want to treat poverty. It is necessary to make this distinction" (Marcelo). But the theme was also raised by Fernando, from the legislature, who raised the issue of social exclusion and its expressions in lower and lower-middle income countries:

Today, the exclusion in countries such as Brazil is not peculiar to a segment of the society. Social exclusion happens for diverse reasons: because of lack of technical skills, because of illiteracy, because of insufficient education, because of mental disorders, because of being too old, because of lack of experience, and so on. Thus, the exclusion of the access to employment or other societal provisions is not exclusively for mental disorders; but, obviously, when there is a mental disorder the problem is aggravated, and the person will surely be excluded. But it is not the exclusivity of the exclusion.

Many stakeholders agree that in treating mental health in the public sector, poverty becomes also a key issue because of negative effects of institutionalization, associated disabilities, less opportunity of employment, and/or demands intrinsic to poverty, conditions common to most of the consumers who access public services or even to those who do not access public services. In these circumstances, the need of intersectoral programs is even greater. Here I include the people who do not access public services; indeed, they do not access any kind of services because of a specific issue pointed to by only two interviewees: the homeless and unassisted population. But, it is necessary to recall in this chapter, that this same issue was brought up by an assistant nurse whom I met during my participant observations, and who informally spoke with me. These three people represent consumers, academics, and professionals from two different capital cities from different regions in Brazil (Salvador and São Paulo), who are calling attention to an increasingly complex problem. As we have seen in Chapter 2, this problem is expected because other countries that implemented new systems of treatment in mental health have also faced this situation. Therefore, countries should anticipate this problem and plan ahead to find more effective ways to address it.

Facing the complexity of the theme of mental health and poverty, we turn to Amartya Sen (1999) who discusses how the understanding of poverty is unsatisfactory when it is measured only in terms of income and suggests the incorporation of social features as fundamental components: "Poverty must be seen as the deprivation of basic capabilities rather than merely as the lowest level of income, which is the standard criterion of the identification of poverty" (p. 87). The author also identifies the specific problem of poverty when addressed by public policies: "Policy debates have indeed been distorted by overemphasis on income poverty and income inequality, to the neglect of deprivations that relate to other variables, such as unemployment, ill health, lack of education, and social exclusion" (p. 108).

To be effective, mental health policies should address stigma, social inequalities, and poverty issues. Mental health, as social exclusion, is an area that we cannot treat alone, because if we do we will be neglecting the right for quality of life. A great number of collaborative services must be incorporated as partners for actions in education, poverty alleviation, and physical health, facilitating the implementation of programs in various levels of mental health care. However, when asked if the society was ready to support diverse actions in psychosocial care, Matheus said:

Our society is not ready for that. We still have to work a lot to change concepts, break some paradigms that the society still has. We need integrated policies in education, health,

social services, working collectively in the community. Moreover, we need to have a common goal: offer services and promote well being for communities.

The majority of stakeholders perceived experiences in Solidarity Economy as excellent instruments to the accomplishment of various goals: to increase sociability and feelings of social belonging, to enhance skills and increase income, to reduce stigma and discrimination as it works on social representation and shows what is possible to be accomplished in a very concrete way. Rafael optimistically declared:

The Solidarity Economy embraces various economic activities of: production, commercialization, credit or others, implemented by workers who also collectively manage these social entrepreneurship. If a group of people with mental disorders is collectively developing abilities and skills, improving these skills through training, and working for the production of goods and services, particularly the art-crafts of Brazilian culture, they are participating in Solidarity Economy. This is the way the Solidarity Economy is a partner of the mental health policy: generating these alternatives.

Vanessa, as every other stakeholder, supports the idea that the government should give more visibility to mental health issues, disseminating to the general public successful experiences:

I also work at the store of the cooperative. I always inform consumers about ours and others experiences, showing that, even if we have certain problems, we have ability to work. All consumers were amazed and used to ask me "and you, where do you work?" I always answer that I have a mental disorder and I am in treatment at the CAPS, "Interesting, if you hadn't said that I would not have known, and I wouldn't have known you were also a member of the cooperative."

Contrasting these comments with the actual investment in labor inclusion, as shown in previous discussions in Chapters 5, 6, and in this chapter, and with the concern from the Ministry of Health in increasing sustainability of actions, we shall ask what kind of sustainability the government is referring to. It seems that in the current stage of the reform, this Ministry pointed out the need to guarantee managerial processes that lead to the accountability of the system in what it is currently offering. However, other stakeholders pointed to a sustainability that, besides accomplishing to what the Ministry pointed out, reaches investments in psychosocial rehabilitation, particularly labor inclusion projects that, producing positive outcomes might lead to diminishing the dependency of the target population on services and increase cost-effectiveness of programs.

Finally, during the interviews, participants were asked to imagine a psychosocial care program in the community (Appendix B); this turned out to be a very constructive way to identify limits of implementation in the real field. As we talked about a perfect model to accommodate interviewees' dreams for mental health, participants suggested several components. On this subject, there were no

majority or minority patterns of ideas or opinions, but a variety of suggestions (as it should be in the real world). Making it fair for all participants I organized all features together, but I included all their dreams, even if cited only once. The following description will represent the dreams of this group for Brazilian mental health policy: a mental health service network providing specialized services, labor inclusion, community interventions such as education at all levels and access to primary care, all based on a multidisciplinary functioning and intersectoral perspective. This perspective includes increasing access to general health providers, the use of social spaces, participation in community projects, and dissemination of information in social and political realms, including fairs and cultural events where there are collective actions from Solidarity Economy or other income generation groups. Funding should have ways to guarantee the transference of budget for mental health. Special funds would be created to stimulate groups of people with mental disorders to implement their own initiatives and entrepreneurships. Furthermore, participants of the system would be producing data and disseminating it through the media, contributing to the planning, monitoring, and assessing of policies and the increase of social and political support. Special attention would be given to train competent professionals who would also have an approach that would reduce the suspicion of the population toward mental health services. The ideal would also include the use of the mass media for national campaigns and publicity of general information in mental health, including successful initiatives, to fight stigma. In this way, stakeholders say, the community would progressively accept the idea as being in accord with their opinion about the actual social support for mental health policies.

Surprisingly and in contrast to the data from interviewees, my participant observation of psychosocial interventions of income generation showed that, in comparison to other limitations such as economic hardship and sustainability, stigma by itself does not seem to be a major barrier for implementation. However, participant observation confirmed information from those interviewees who showed how psychosocial interventions can help in fighting strangeness, prejudice, and stigma. Overall, the contact of the community with these programs was made in the commercialization of goods they produce, which have been very welcomed by the community. Surely the quality and the creativity invested in the products are initially large contributors towards people's interest. Among them, and according to participants, they increase interest and feel amazed in knowing that products were made by people with mental disorders.

Both projects have gradually increased integration into the community, which contributes to the cause. At the broom factory, members of the community donate plastic bottles for the production of

brooms, and the products are sold especially by people that work or are treated in the same institution. But they all say the interest is increasing and better still, that the brooms work really well. At the *cestaria*²⁹, the project is also supported by an art institute, and they often participate in cultural fairs, where the products are more easily sold. They also have a few consumers already who call and order products, which also shows the excellent quality of these products. Both projects also present an increasing participation of its participants in decisions and evaluations, and that a satisfactory level of solidarity, cooperation and mutual respect exist among participants. All these facts point to the discussion of what kind of visibility is desired in Brazilian mental health reform. In this chapter, this visibility is definitely not restricted to the discussion of the access to community-based services, but it is supported wherever quality of services and programs and their interventions exist.

On the other hand, these projects encounter great financial barriers and are very far from achieving sustainability, which also confirms previous discussion. Many participants feel frustrated and some demotivated for having produced goods of great quality but still having low economic returns, which greatly affects their personal autonomy. Projects also are economically dependent on the institutions from which they emerged, such as salary for technical professionals when needed, the use of their facilities, and the purchase of materials needed.

These projects greatly contribute to reinforce the fact that if the Brazilian government invests more in: having a more distributive funding, giving priority to intersectoral programs to work on the effects of inequalities and more effective psychosocial interventions, and increasing visibility, major barriers will progressively be reduced and there will be positive impacts on the quality of life for people with mental disorders and for their families. Moreover, stakeholders believed that “the reform is also made by society. . . [that] the society needs to change” (Daniela); and “[that] the society also needs to contribute” (Marina), calling for more social and political support.

²⁹ For the definition of *cestaria* see footnote number 11.

CHAPTER 8

CONCLUSIONS AND RECOMMENDATIONS

Brazilian mental health policy has gradually incorporated fundamental components that support a mental health reform, and worldwide it is recognized as very progressive in terms of formulation. Mainly, it embraces the protection of human rights for people with mental disorders as the reference principle of the reform. In terms of psychosocial care interventions, this policy includes: the implementation of centers of psychosocial care in the community; specific resources to address the deinstitutionalization of people with severe and persistent mental disorders, such as the *De Volta para Casa* program and protected homes; and intersectoral action to support collective experiences in Solidarity Economy.

However, even taking into account the advances in adopting a mental health system that protects the human rights of people with mental disorders largely via psychosocial interventions, Brazilian policy suffers from gaps of implementation in psychosocial care policies.

Throughout this study, the main questions drove the kind of explorations I expected to do, and the attempt to answer those questions revealed major and minor patterns of implementation gaps in psychosocial policies. We recall that these questions are following: What are the key elements that generate a gap between psychosocial care policy formulation and its implementation? How do institutional processes, fiscal processes, and stakeholders' interests interfere in mental health policy, especially in psychosocial care, and its success? What is the role stigma, prejudice, social and health inequalities play in the policy implementation process? Do different stakeholders significantly differ in their perceptions about the process of implementation of mental health policies, particularly in psychosocial care and extant gaps?

In this chapter I present the major extant patterns, and I am also moved to answer the questions: What are the prognoses for psychosocial care policy implementation in Brazil, and what can potentially contribute to overcome anticipated gaps.

In terms of the key elements related to stakeholders' interests, institutional processes, and fiscal processes that generate implementation gaps in psychosocial care, major patterns point to a landscape that is shaped by the following trends.

Stakeholders play an important role in limiting psychosocial implementation. Conflict of interests among stakeholders—and the lack of dialogue and more cooperative attitudes—and the diminishing role of the civil society, especially in the parliament, all contribute to create an ineffective issue network. The lack of cooperative dialogues and attitudes were evidenced specifically by diverse corporate interests among professionals, resistance of the institutional psychiatry against the model of the new system of care, and once more by the hegemonic position adopted by the Ministry of Health. Instead of enhancing the quality of policies including the multiple ranges of issues intrinsic to interests, stakeholders are holding their own positions and dealing with differences as though they are divergent and rigid barriers.

National features also impact psychosocial care implementation, such as the SUS decentralization. Although there is an overall support for the ideals of decentralization, the lack of information or priority for mental health at regional and local levels still represents a major problem to make implementation effective. In addition, stakeholders agree that municipalities, with few exceptions, lack in accountability and budget management transparency, which puts at risk the allocation of resources for mental health.

In regard to the implementation of the Centers for Psychosocial Care (CAPS), general criticisms point to the focus on the increase of numbers of CAPS in diverse regions but not in the quality of services offered. It seems that CAPS needs more direction and monitoring from the federal government, which should implement better methods of assessments, produce more data, and create normative rules to increase the power of mechanisms of popular control. In addition, scarce human resources and the lack of professional training to implement mental health according to the new paradigm negatively affect the quality of services provided, causing major impacts on the bottom level of psychosocial policies. There is insufficient investment in intersectoral actions involving the CAPS and other sectors such as primary health, culture, education, and social and professional training services in the community. The focus of the Ministry of Health in implementing CAPS and the still-typical isolation of these services is causing what stakeholders have called *capscentrism* which threatens the logic of the service network in mental health and may result in only substituting one kind of institution—namely, the asylums—for another kind.

Considering the number of people with mental disorders that are highly institutionalized in the country, the *De Volta para Casa* program and the protected homes have presented limited access.

Some stakeholders also point out limitations of interventions of the latter, especially concerning the need to enhance autonomy and integration into community life.

Moreover, taking into account that psychosocial interventions are those which in mental health mainly represent the loci for intersectoral programs, the hegemonic position of the Ministry of Health limits the range of actions these interventions could reach. This position results in the lack of dialogue with other actors and the lack of coordination with other ministries—except for the still-shallow interventions in partnership with the Ministry of Labor and Employment. These trends exert a harmful influence in connecting mental health with communities and subsequently on the potential to promote mental health and reduce the negative social representation associated with mental health and people with mental disorders.

Finally, in terms of the role stigma and prejudice play in the policy implementation process, the findings also reveal that stigma and prejudice are major patterns in stakeholders' discourse. They perceived that stigma and prejudice negatively impact social and political support and therefore play an important role in shaping how societal responses contribute to implementation gaps in psychosocial policies. However, the data from the participant observation of the two projects in labor inclusion and some participants of NGOs revealed that stigma and prejudice are not the only factors that generate implementation gaps. Stakeholders in general pointed to the use of diverse kind of information to enhance publicity and the visibility of mental health issues in the social realm, and therefore educate the various social groups, diminishing strangeness and contributing to the social closeness to the differentness. Other forms of discrimination, such as differences of gender, race, and socioeconomic status, seem to overlap with stigma for mental disorders, producing even more intense social exclusion. However, there is scarce literature on the topic and my conclusions on this point are only suggestive. In the case of mental health, stakeholders attribute a major role played by socioeconomic status, including access of public services of mental health.

In regard to the role social and health inequalities play in implementation, most of the stakeholders agree that social inequalities, including poverty issues, make implementation gaps more evident, especially in which concerns to limited access to services and limitations of psychosocial interventions to reach ultimate goals such as increasing autonomy and promoting social and labor inclusion. The access of these services quasi-exclusively by the lower classes is also a repetition of national, and sometimes international, trends in health in general. As the Brazilian government is investing in restructuring mental health (if the system becomes really effective), these trends will

enhance the quality of treatment in mental health for the lower classes while the other classes will still be accessing treatments that repeat the asylum mode. But, poverty continues to be strongly associated with mental disorders in Brazil. As mental health represents the association of various layers of social exclusion, poverty still shapes demands of consumers and families addressed to services, and psychosocial interventions cannot be blind to these demands. It is necessary to incorporate interventions that not only alleviate poverty and its intrinsic conditions but that increase social opportunities.

In summary, the differences in how stakeholders perceive the process of implementation of mental health policies, particularly in psychosocial care and extant gaps, vary according to the different themes. It is interesting to note that these differences are more evident and strongly debated when stakeholders discuss the role played by their interests and institutional processes in the implementation process. On the other hand, they tend to agree more on national patterns that influence fiscal processes and the role played by stigma, prejudice, social and health inequalities in the implementation process.

Considering advances, overall stakeholders support the new ideals of the Brazilian mental health system and consider that it is fair to say that this system is much better than decades ago. Brazilian mental health care policy during the past seven years has shifted from the old traditional scenario of human rights violations, to a mental health system intended to care instead of mistreat. In terms of legislation, since the law 10.216 Brazilian policies have progressively broadened to include a great variety of actions involving different social and political sectors. From this perspective, policy formulation for mental health in Brazil has been very progressive and satisfactory.

However, in terms of the prognoses for psychosocial care policy implementation in Brazil, we can note that stakeholders point to various problems of implementation on the ground. This does not mean that Brazilian national policy is not working at all, but that the implementation of policies is not perfect and should be continually readdressed.

In terms of mental health policy implementation, there is no doubt that there was an actual investment in the implementation of new services and new actions. In the last 10 years, mental health services have extraordinarily improved. However, despite the great merit of adopting the new paradigm in mental health and preparing the soil to plant the seeds of a new system, there are various limits and implementation gaps to be addressed. The Brazilian mental health context indicates that there is no major factor in producing gaps in psychosocial implementation, but a combination of factors that taken

together, make policies fall short. This is especially true taking into consideration the ideals of the new paradigm. Beyond protecting human rights for people with mental disorders and offering a service network, the new paradigm points to the adoption of practices that lead to greater autonomy, full citizenship, integration of people with mental disorders into social life, and the improvement in quality of life for people with mental disorders.

Obviously, those are long-term outcomes, and time matters, especially when a mental health policy is still very young, as is the case in Brazil. But, independent of the time it will take, these ultimate goals need to be incorporated as a standard in every step of the implementation process in order to have them be reached.

Finally, I present factors that can potentially contribute to overcome anticipated gaps.

In terms of policy formulation, I recommend the discussion and revision of the law 10.216 and the creation of legislation to incorporate more specific provisions of psychosocial care and its diverse interventions including the participation of various stakeholders. After almost a decade of implementation of the national policy, it is essential to revise the current legislation based on the evaluation of actual advances and limitations.

I also recommend that stakeholders adopt more collaborative positions which will diminish disputes of interest, enrich debates, and enhance their creativity. This way, stakeholders will be contributing to more comprehensive and effective policies.

The production of data based on assessment of services is fundamental to advance in planning and executing policies. Now that most of the structure is implemented, the Brazilian government needs to have valid information that will support decisions in regard to: the identification of the needs of various regions and municipalities, the increase of access to psychosocial programs and services, the priority areas for budget allocation, the adoption of intersectoral programs and interventions, and the implementation of professional training. The inclusion of qualitative research could also contribute to these goals and may increase the dialogue and exchange among different local experiences, increasing the chances of mutual collaboration to overcome obstacles and to enhance quality.

It is also necessary that Brazil invests more in psychosocial interventions in labor inclusion, such as income generation and Solidarity Economy. Facing remaining prejudice, stigma, and the structural socioeconomic problems of this country, these experiences could represent an effective

solution to increase recognition of skills and ability, social and economic autonomy, and subsequent quality of life for people with mental disorders and their families.

I also recommend more investment in national campaigns of mental health, using resources in the mass media to reach people with different levels of education. The participation and mobilization of social and political actors in mental health issues is missing, which keeps mental health hidden from the public view. Brazil has good examples of creative and effective campaigns in health such as for HIV/AIDS and mental deficiencies showing that with a budget and willingness, campaigns might be an effective step toward successful social and political support.

Finally, it seems that consumers of services and families members in the sample do not have knowledge about the mental health policies, with the exception of scant information about the law 10.216. Considering that they represent a very important position as stakeholders because they are the ones who are in need, suffering from mental disorders, and who, subsequently access programs and services, it urges policies that increase their participation and empowerment.

In sum, worldwide, it is agreed that psychosocial resources are an essential component in mental health care and governments should give more priority to it. Producing positive clinical and social outcomes, supporting treatments which do not isolate from social life, working for the autonomy and citizenship of people with mental disorders, these psychosocial resources have demonstrated the advantages and effectiveness of this new way to look at the mental disorders, or better, to mental health. Psychosocial care fuels the hope for inclusion of differentness. It fills up the hearts and calms the minds of those who feel themselves different, but who now know they do not need to give up on life. It contributes to a more promising society, when it transforms social discrimination into compassion and solidarity.

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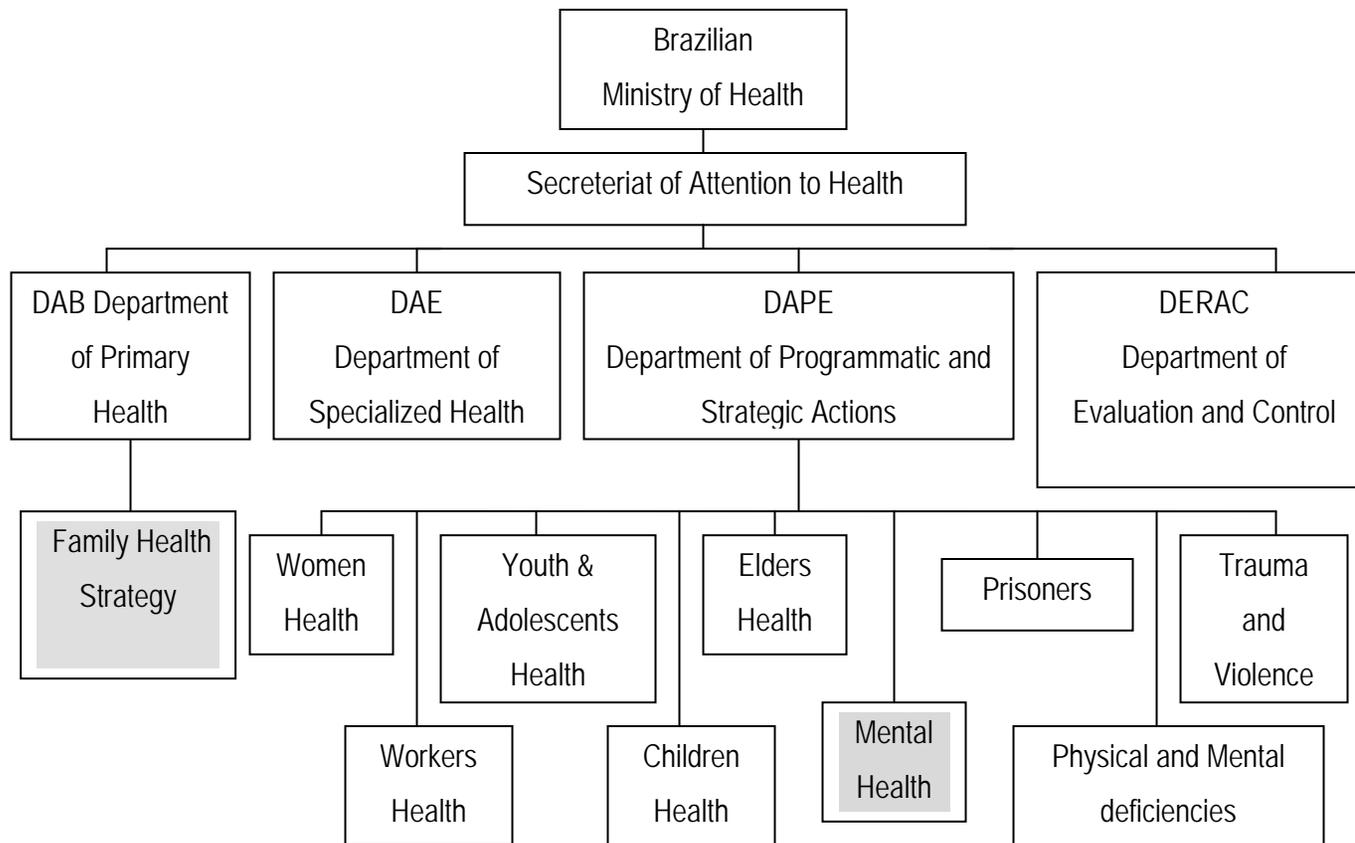
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APPENDIX A

**HIERARCHY OF GOVERNMENTAL OFFICES IN THE
SECRETARIAT OF ATTENTION TO HEALTH/BRAZILIAN
MINISTRY OF HEALTH**



APPENDIX B
INSTRUMENTS OF RECRUITMENT PROCESS

RECRUITMENT SCRIPT FOR INTERVIEWS

(DATE)

TO: (Name)

FROM: Nadjla Sahyoun - Psychologist, graduate student at the Center for Latin American Studies (CLAS) at San Diego State University (SDSU), California, USA.

RE: Interview with Thesis Project "Understanding mental health policies: How do stakeholders address the implementation gap?"

I am writing to invite you to participate in my thesis research project as a stakeholder for mental health policies in Brazil, particularly psychosocial rehabilitation ones. Below, I will give you more information about what is the project and what your participation would entail.

This research project addresses how Brazilian stakeholders for mental health policies perceive and evaluate the implementation of the same policies, especially psychosocial rehabilitation ones. Starting by January of 2008, I will be holding interviews with stakeholders in select institutions/organizations in Brazil, particularly in the southeast, middle west, and northeast regions.

The interviews will ask about stakeholders' perceptions of Brazilian psychiatric reform process, Brazilian mental health policies, Brazilian psychosocial rehabilitation policies implementation in mental health, and Stigmatization due to mental disorders. The interview process will take place in stakeholders' offices or institutions' conference rooms. As a semi structured interview, each interview should take roughly one hour, depending on how much you have to contribute.

All interview materials will be kept completely confidential, and I will maintain participants' anonymity in reporting the results.

Although I cannot pay anyone for their participation, the interviews may help you to critically think about the implementation process of mental health policies in Brazil and also may help you to think the role of the institution/organization you represent in the same process.

The findings of this study will most likely be published in San Diego State University and be accessed by its library. It also may be published in Brazil in a book format or as a chapter of a book for those interested in mental health policies.

Please contact me if you would like further information about the project, or if you or someone you know would be willing to participate.

For your participation, you will also be asked to send to me a letter of authorization to develop the interview signed by you and in reference to the institution/organization you will be representing for the ends of the present research. Please, send the letter of authorization for the email address below. When I receive this letter, I will contact you to set up a date and hour to develop the interview. In attachment I am sending you a document with my resume and another document with a letter of presentation from CLAS/SDSU.

If you have any questions in the meantime, please feel free to contact me at the following email address or number: sahyoun@rohan.sdsu.edu or 1-619-792-5259.

RECRUITMENT SCRIPT FOR PARTICIPANT OBSERVATION

(DATE)

TO: (Name/Institution)

FROM: Nadjla Sahyoun - Psychologist, graduate student at the Center for Latin American Studies (CLAS) at San Diego State University (SDSU), California, USA.

RE: Program observation with Thesis Project "Understanding mental health policies: How do stakeholders address the implementation gap?"

I am writing to invite your institution's psychosocial rehabilitation program to participate in my thesis research project regarding mental health policies in Brazil, and particularly policies about psychosocial rehabilitation. Below, I will give you more information about what is the project and what your participation would entail.

This research project addresses how Brazilian stakeholders for mental health policies perceive and evaluate the implementation of the same policies, especially psychosocial rehabilitation ones. Starting by April of 2008, I will be conducting program observation of psychosocial rehabilitation programs and their activities in select institutions/organizations in Brazil, particularly in the southeast, middle west, and northeast regions. As I observe these programs, I will be taking notes about the processes of the activities and registering my own impressions about them.

The program observation will be held at institutions which implement a psychosocial rehabilitation program in accordance with Brazilian mental health policies. The observation of psychosocial rehabilitation activities involving people with mental disorders will contribute to a better understanding on how psychosocial rehabilitation policies have been implemented in Brazil. The program observation will be conducted just by me for a period of fifteen (15) days on a daily basis for at least 4 hours/day. I will not hold program observations in any other program sponsored by your institution and no clinical services will be contacted. I will not be interviewing any participant, professional, user, or their family members. The program observations aim to understand not individuals' abilities, but the more general labor insertion or socialization activities of such programs in order to evaluate their achievements and limits according to what is expected in Brazilian psychosocial rehabilitation policies.

All materials will be kept completely confidential, and I will maintain all participants' anonymity both in my notes and in reporting the results.

Although I cannot pay anyone for their participation, the findings of the present study may help your institution to critically think about the implementation of psychosocial rehabilitation activities according to Brazilian mental health policies. Moreover, it may contribute to your institution's capacity to reflect on strengths and weakness of national policies and the role of your institution in their future success.

The findings of this study will most likely be published in San Diego State University and be accessed by its library. It also may be published in Brazil in a book format or as a chapter of a book for those interested in mental health policies.

Please contact me if you would like further information about the project, or if you are interested in having your institution participate in this study.

Each participating Institution will be asked to send to me a letter of authorization to conduct participant observations at their facility. This letter should be signed by you and clearly include your position and the name of the institution. Please send the letter of authorization to the email address below. When I receive this letter, I will contact you to set up a date and hour to have a first meeting in which we can establish all necessary details to hold the participant observation. In an attachment I am sending you a document with my resume and another document with a letter of presentation from CLAS/SDSU.

If you have any questions in the meantime, please feel free to contact me at the following email address or number: sahyoun@rohan.sdsu.edu or 1-619-792-5259.

RECRUITMENT SCRIPT BY PHONE CALLS FOR INTERVIEWEES

1. General salutation when in the first contact with institutions.

Hello, good morning/afternoon,

My name is Nadjla Sahyoun, I am a graduate student at San Diego State University in California, United States, and I am calling regarding my master thesis project. As my project is in mental health public policy I would like to know if there is someone in this institution/organization who I can talk about it and also invite to participate in the same project.

Thank you very much and have a great day!

2. Contact to stakeholder/prospective subject

Hello, good morning/afternoon,

My name is Nadjla Sahyoun, I am a graduate student at San Diego State University in California, United States, and I am calling regarding my master thesis project. How are you?

My project addresses how Brazilian stakeholders perceive the implementation of psychosocial rehabilitation policies in Brazil. In the next months I will be holding interviews with stakeholders in the southeast, middle-west, and northeast regions in Brazil. I would like to invite you to participate and if it is your interest I will tell you more details about the interview process.

2a. If the person does not have interest, just say:

Thank you very much for your attention and have a great day! Bye.

2b. If the person does have interest:

The semi-structured interviews will ask about your perception about the mental health reform process, Brazilian mental health policies, Brazilian psychosocial rehabilitation policies implementation, and Stigmatization due to mental disorders. The interview process will take place in your office or any private place available at the institution you are representing. The interview should take roughly one hour, depending on how much you have to contribute. All interview materials will be kept completely confidential, and I will maintain participants' anonymity in reporting the results. Although I cannot pay anyone for their participation, the interviews may help you to critically think about the implementation process of mental health policies in Brazil and also may help you to think the role of the institution/organization you represent in the same process. The findings of this study will most likely be published in San Diego State University and be accessed by its library. It also may be published in Brazil in a book format or as a chapter of a book for those interested in mental health policies for future purposes.

Do you have any questions?

Would you be willing to participate?

2b.1. If the stakeholder does not have interest I will just thank him/her for his/her attention and wish a good day.

2b.2. If the stakeholder does have interest:

May we please set the date and time for the interview?

Thank you very much for your interest and please contact me if you would like further information about the project, or if someone you know would be willing to participate. Would you like my telephone number?

Would you please also send to me a letter of authorization to develop the interview signed by you and in reference to the institution/organization you will be representing for the ends of the present research?

Thank you. Please, send the letter of authorization for my email address: sahyoun@rohan.sdsu.edu . As a last question, would you like to receive my resume and a letter of presentation from the Center for Latin American Studies in which I am a graduate student at SDSU?

Thank you very much, have a nice day.

APPENDIX C

INTERVIEWEES AND RESULTING ISSUE NETWORKS

Table 3. Interviewees, Their Types of Involvement, and Resulting Issue Networks

Types of Involvement	Interviewees by pseudonym														
	Alfredo	Mario	Fernando	Matheus	Luciano	Rafael	Leonardo	Norma	Vanessa	Marcelo	Daniela	Elias	Claudio	Bruna	Marina
NGOs	X		X			X	X	X	X		X	X			
Users of services and families members									X		X			X	X
Grassroots movements ^a								X							
Psychiatry	X	X					X			X					
Universities		X			X		X			X		X	X		
Health reform										X			X		
Local government				X						X		X	X		
Psychology					X							X			
Federal sphere			X			X	X	X		X		X	X		
Philanthropic organization		X													
Occupational Therapy				X											

Note. X = main stakeholders positions represented in this study; x = past or current additional involvement of any kind such as voluntarism, consultancy, partnership, or any other kind of collaboration.

^aGrassroots movements are spontaneous organization among members of a community and usually do not have a formal structure or organization.

APPENDIX D
INTERVIEW GUIDE

Semi-structured interview to stakeholders in mental health policies / Country: Brazil

I. General information

Date

Name

Representative of

II. Theme 01: current position

1. Could you describe your current position for me, and what kind of involvement you have had with mental health issues?

1a. How long he/she has worked in the current position?

1b. What did you do before you were in this job/position?

1c. Did you work/participate in other institutions, including NGOs and agencies, involved in mental health issues?

II. Theme 02: psychiatric reform in Brazil

1. Would you please describe the current trends of the psychiatric reform in Brazil?

2. What do you see as positive effects of these trends? And what do you see as negative ones?

3. Do you think Brazilian mental health national policy is satisfactory? What would you change in this policy?

III. Theme 03: psychosocial rehabilitation policies in Brazil

1. In your opinion, does psychosocial rehabilitation have an important role/place in psychiatric reform?

1a. Do you think they are working well?

1b. Do you think they really address the main issues?

1c. Do you think they are more than symbolic gestures?

2. In terms of psychosocial rehabilitation, what do you see as the great barriers to be overcome? Are there any budget allocation issues interfering on implementation?

IV, Theme 04: stigma and health inequalities

1. Do you think people/communities are ready to support actions for psychosocial rehabilitation in mental health?

2. How do you think discrimination against people with mental disorders happens?

3. Do you have any personal experiences or are you close to someone who was affected by discrimination for mental disorders?

4. How do you imagine a program of psychosocial rehabilitation in the community you live in?
 - 4a. How people would respond to it?
 - 4b. Do you think gender, racial, and economic status affect psychosocial rehabilitation in Brazil?
5. What kind of things would you like to see happen to reduce stigma or discrimination, and inequalities in mental health?

Thank you.

ABSTRACT OF THE THESIS

Understanding Mental Health Policies: How Do Stakeholders Address the Implementation Gap?

by

Nadjla Sahyoun

Master of Arts in Latin American Studies

San Diego State University, 2008

Brazil has enacted some mental health policies that are fairly progressive among Latin American countries. However, these policies are not always implemented as designed, particularly the ones addressing psychosocial care programs. This study investigates how Brazilian stakeholders in mental health address the implementation gap in psychosocial care programs targeting adults with severe mental disorders. The main questions are the following: What are the key elements that generate a gap between psychosocial care policy formulation and its implementation? How do institutional processes, fiscal processes, and stakeholders' interests interfere in mental health policy, especially in psychosocial care, and its success? What is the role stigma and health inequalities play in the policy implementation process? Do different stakeholders significantly differ in their perceptions about the process of implementation of mental health policies, particularly in psychosocial care and extant gaps? What are the prognoses for psychosocial care policy implementation in Brazil and what kinds of solutions can potentially help overcome anticipated gaps?

The methodology consists of semi-structured interviews with stakeholders at the national level in Brazil, supplemental participant observation in psychosocial care service providers, and documental research. The stakeholders included in the sample are legislators, policymakers and other representatives of government, consumer of services and family organizations, members of other mental health movements, representatives of professional associations, and academics. The interviews and field notes are analyzed qualitatively by theme. Documents include publications accessed in libraries and those given by stakeholders during data collection process.

The findings show that, although the current Brazilian mental health system has made advances in protecting human rights and including psychosocial interventions, participant stakeholders cited key elements that generate implementation gaps in psychosocial care policies: limitations of programs, services, and psychosocial care interventions, accentuated regional differences with emphasis on low priority for mental health at local levels along with limited accountability of municipalities, significant conflict of interests among stakeholders, and the influence of stigma and inequalities. In addition, stakeholders also indicated an implementation gap in the mental health national policy generated by insufficient investment in primary health care. Although this factor does not cause implementation gaps in psychosocial care policies, it reveals limitations of psychosocial care services, particularly, the insufficient interventions of the Centers for Psychosocial Care (CAPS) in the communities.

Findings also indicate that institutions, fiscal processes, and stakeholders interfere in psychosocial care policy success, resulting in: difficulty in defining common priorities, insufficient investments in psychosocial services, lack of intersectoral actions, deficient psychosocial services delivery, lack of data from assessments of psychosocial interventions, and lack of legitimacy of the mental health reform at municipal levels.

Finally, the findings also reveal that stakeholders, in general, agree that stigma negatively impacts social and political support and therefore plays an important role in shaping implementation gaps in

psychosocial policies, even if stigma does not prevail over other factors. In addition, most of the stakeholders agree that social inequalities, including poverty issues, make implementation gaps more evident, especially in which concerns to limited access to services and limitations of psychosocial interventions to reach ultimate goals such as increasing autonomy and promoting social and labor inclusion.

In summary, Brazilian mental health policy has various limits and implementation gaps, especially taking into consideration the ideals of the new paradigm. Because there are still significant limitations in achieving integration of people with mental disorders into social and community life and their labor inclusion, ultimate goals such as greater autonomy, full citizenship, and the improvement in quality of life for people with mental disorders are still far from becoming a reality.

In terms of policy formulation, I recommend amendments to current policies that incorporate specific goals of psychosocial care based on the evaluation of actual advances and limitations. In terms of policy implementation, I recommend: (a) a more collaborative position among stakeholders; (b) more investment to increase and improve the production of data based on assessment of services to advance planning and executing policies; (c) more investments in psychosocial interventions in general, and particular attention to labor inclusion, such as income generation and Solidarity Economy; (d) more investment in national campaigns of mental health, using resources in the mass media to reach people with different levels of education; and (d) more investments in policies to increase their participation and empowerment.

Although the implementation gap in mental health programs generates negative outcomes for individuals, families and the general society, studies of this gap are still scarce. This study augments the current literature and presents a reasoned analysis of the role of psychosocial care programs in the mental health reform in Brazil.