

Influence of the São Paulo State innovative models on Brazil's mental health policy

Influência dos modelos inovadores paulistas na Política Brasileira de Saúde Mental
Influencia de los modelos innovadores paulistas en la Política Brasileña de Salud Mental

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ABSTRACT

Objective: to analyze the influence of two São Paulo State experiences in the choice of psychosocial care centers as guiding service providers for the national mental health policy. **Method:** qualitative, exploratory, and descriptive study using oral history as a methodology and theoretical reference. **Results:** eight professionals involved in the deployment of the mental health policy in the cities of Santos and São Paulo between the years 1989 and 1992 were interviewed. Data were analyzed after treating the narratives and grouping the most significant content. Two central themes emerged: development of the local-regional model, and the model's influence on the choice of the psychosocial care center. **Conclusion:** due to greater insertion of the Santos experience group in the spheres of the federal government, its influence on the choice of the substitute model was higher in ideological terms, whereas the São Paulo model had its influence restricted for political reasons.

Key words: Public Health Policies; Mental Health Services; History; Nursing; Mental Health.

RESUMO

Objetivo: analisar a influência de duas experiências paulistas na escolha do centro de atenção psicossocial como serviço norteador da política nacional de Saúde Mental. **Método:** pesquisa qualitativa, exploratório-descritiva que utilizou a história oral como metodologia e referencial teórico. **Resultados:** foram entrevistados oito profissionais envolvidos na implantação da política de Saúde Mental dos municípios de Santos e São Paulo (1989 a 1992). Os dados foram analisados após tratamento das narrativas e agrupamento dos conteúdos mais significativos. Emergiram dois eixos temáticos: desenvolvimento do modelo *loco* regional e influência do modelo na escolha do centro de atenção psicossocial. **Conclusão:** devido à maior inserção do grupo da experiência santista nas esferas do governo federal, sua influência na escolha do modelo substitutivo foi maior na dimensão ideológica, e o modelo paulistano teve influência restrita por razões político-partidárias.

Descritores: Políticas Públicas de Saúde; Serviços de Saúde Mental; História; Enfermagem; Saúde Mental.

RESUMEN

Objetivo: analizar influencias de dos experiencias paulistas en elección del centro de atención psicosocial como servicio orientador de la política nacional de Salud Mental. **Método:** investigación cualitativa, exploratorio-descriptiva, utilizando historia oral como metodología y referencial teórico. **Resultados:** fueron entrevistados ocho profesionales involucrados en implementación de política de Salud Mental en municipios de Santos y São Paulo (1989 a 1992). Datos analizados luego del tratamiento de testimonios y agrupado de contenidos más relevantes. Surgieron dos ejes temáticos: desarrollo del modelo *loco* regional e influencia del modelo en la elección del centro de atención psicosocial. **Conclusión:** debidos a la mayor inserción del grupo de la experiencia santista en las esferas del gobierno federal, su influencia en la elección del modelo substitutivo fue mayor en la dimensión ideológica, y el modelo paulista tuvo influencia limitada por razones político-partidarias.

Palabras clave: Políticas Públicas de Salud; Servicios de Salud Mental; Historia; Enfermería; Salud Mental.

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INTRODUCTION

According to the history of psychiatric reform in Brazil that can be found in the Brazilian literature and official discourse, the choice of the Centros de Atenção Psicossocial (Psychosocial Care Centers or CAPS, as per its acronym in Portuguese) as treatment centers occurred under the influence of innovative experiences in terms of mental health policies (MHP) that took place in some Brazilian cities.

Although there were previous decrees and reports by the Mental Health National Conferences (MHNC) that guided the MHP, it was only after the promulgation of Federal Law 10,216 in 2001⁽¹⁾ that mental health (from now on referred to as MH) actions became regulated through the resumption of national mental health coordination. Ministerial decrees enabled the implementation of changes proposed to the care model by means of specific legislation⁽²⁾.

Decree 336, of 2002, was an important landmark for the development of that model because it defined CAPS as the replacement service that would guide the Brazilian mental health national policy (MHNP). These services began to be classified in ascending order of size/complexity and population range into CAPS I, II, III adult care, alcohol and drugs (AD) and children's care⁽³⁾.

As a result of exclusive financing by the Ministry of Health (MH), CAPS were established in many municipalities and began to name various existing mental health services. According to more recent data (2012), there were 1,742 of these services in Brazil. Only 65 of them were CAPS III, which is significant because this is the only category of these services that offers observation beds for patients with acute, severe disorders 24 hours a day. There were also 32,284 beds in psychiatric hospitals and only 3,910 psychiatric beds in general hospitals. Together with the scarcity of replacement services, this fact portrays how far from our reach the longed for dehospitalization is⁽⁴⁾.

Considering the 13 years of the Federal Law from 2001⁽¹⁾, it is possible to observe that the changes proposed in the MH care model have enabled advances, but the replacement of the hospital model the core change in the asylum-based model encompassed mainly in the two first MHNC⁽⁵⁻⁶⁾ did not occur.

The adherence of Brazilian cities to the CAPS model is timid and slow, producing a lack of care due to the closing of psychiatric hospital beds without the corresponding creation of new care services⁽⁷⁾.

As a result of other problems seen in the current MHNP model, such as poor coverage for patients with mental disorders in primary care, CAPS patients being turned into chronic patients, and a CAPS-centered care model, we can see that the publicized psychiatric reform exists as a proposal, but it has not become a reality⁽⁸⁻⁹⁾, and asylum style practices persist. In 2012, the Psychosocial Care Network (*Rede de Atenção Psicossocial* or RAPS, as per its acronym in Portuguese) was created by the Ministry of Health⁽¹⁰⁾ in a clear attempt to resume some of the proposals contained in the first MHNC. However, adherence to it in Brazilian municipalities was not significant.

It is fundamental to remember the political factors that have led to the current mental health model to produce knowledge that will become the foundation for necessary changes.

OBJECTIVE

To analyze the influence exerted by experiences in mental health policies (MHP) conducted in the cities of Santos and São Paulo on the current Brazilian mental health national policy (MHNP) model, which is guided by the service provided at the CAPS.

METHOD

This is a qualitative study that addresses the thematic oral history⁽¹¹⁾ and whose core is found in narratives created in interviews. Our discussion is focused on a specific issue so that we can come to in-depth knowledge about it. This will enable us to better understand it through the collection, organization, and interpretation of facts. The departure point for this study is a specific, pre-established issue; its authors are committed to clarifying interviewees' opinions about some particular events beyond the official version.

The choice of the employees was based on the study's objective and guided by the affinities that brought them together. These led them to common destinations whose actions echoed in the community life of the places where they lived as they participated in the construction of their local MHP⁽¹¹⁾. They were leading players in the Movimento da Luta Antimanicomial (Fight Against Mental Hospitalization Movement) and deeply influenced the MHNP changes.

This study has also involved MH advisors and coordinators who participated in the Santos and São Paulo municipal administration between 1989 and 1992 and thus became the employees⁽¹¹⁾ in this study. The authors were particularly interested in learning how these employees perceived and experienced that period, clarifying controversial, conflicting, and contradictory situations expressed in their different accounts and opinions⁽¹¹⁾, in addition to their influence on the MHNP care models.

Data collection was conducted through recorded interviews and note-taking in the field. These were the guiding questions:

- Please tell us about the deployment process of the innovative mental health model in the city where you were during the city administration.
- How did the model developed in your city influence the consolidation of the Brazilian mental health national policy, as well as the CAPS model as the structuring, guiding service for this policy?

Interviews were conducted in the cities of São Paulo and Santos, both in the State of São Paulo, between April 2011 and July 2012. Eight employees were interviewed. Employees were told about the study goals and procedures, and the material produced (narrative scripts) was sent to all of them for confirmation. The study was approved by the São Paulo Federal University's Research Ethics Committee and an informed consent form was signed by the participants.

In oral history methodology, the product of the interviews becomes a document with further clarifications on the studied subject and equals the use of other written sources. Thus, it can establish exchanges with other documents. For the elaboration

of this oral document, sequence procedures must be adopted, going from the project establishment, employee selection, and data collection by means of recorded interviews to transcription, textualization, and trans-creation phases⁽¹¹⁾.

After these procedures, the text produced by the narratives was submitted to repeated readings in order to identify the most significant points, both convergent and divergent, regarding the guiding questions. Through this procedure, some main themes emerged based on the frequency with which they appeared in the text and on how strong and expressive the events and opinions contained in them were.

The emerging themes in the interviews were grouped and created the "central axes" of this study. These were analyzed separately but the interconnections were retained over the course of the entire content discussion process. They guided the discussion and analysis through dialogue established with the authors who make up the theoretical reference for this study and with official documents.

Although this study privileged narratives, documentary research on existing official documents that refer to the period studied (laws, decrees, conference reports, the Ministry of Health website, etc.) was also conducted, supporting the analyses of the document produced by the narratives.

RESULTS

The São Paulo and Santos networks were composed of four employees each and two central axes guided the analysis of this study: the development of the local-regional models and the influence of these models on the preference for CAPS. The authors could observe that, although the two MH models emerged in the same historical period, the way they developed was different according to each city's economic and political context. Such differences were made clear in the narratives of each city's employees and were also connected with the most influential reasons for each of the experiences on the option for the CAPS model.

As suggested by the oral history methodology, the text produced from the narratives became a historical document and the employees' opinions contained different versions from those existing in texts, books, articles, and theses on the preference for the CAPS model. Their narratives unveiled another truth that was found behind the scenes and was known only to those who directly participated in the process studied. The exchange established with the literature produced on the psychiatric reform history, the MHNP elaboration, and official documents was the primary instrument for our analysis and discussion.

Development of local-regional models

The São Paulo and Santos employees' narratives in this regard told us about how the models were created, their guiding principles, functioning, difficulties found, and the setbacks in both models at the end of the city administrations.

According to the Santos network employees, a radicalization of the anti-asylum structure fight occurred upon the deployment of that model with the closing of one hospital, the Casa de Saúde Anchieta. They argued that it was impossible to work and guarantee the rights of people with mental disorders at asylums. They

believed that only from the extra-hospital spaces could a new citizenship be created for people with mental disorders.

It was a very intense process; its energy was very powerful and there was profound dialogue between professionals and patients because there was a strong movement of changing relations. An internal transformation of the hospital was going on in terms of relations, organization, and dynamics given this possibility patients had to make the process their own and become co-responsible for it, together with professionals. (A1)

[...] the city was divided into regions inside the hospital, and the NAPS I team had already been caring for the inhabitants of the northwest zone. When the time came to establish the NAPS, the infirmary was closed and the entire team went to NAPS, which worked 24 hours a day, reducing the Anchieta occupation rate. The hospital was pretty empty when NAPS V, the last one, left and came to being shortly after URP [...] Anchieta was completely emptied in 1995, I figure. (A2)

The São Paulo network employees emphasized the fact that the MHP project for the city was drafted before the election and was accepted by the city manager, additional to the use of strategic planning for its writing. They believed in the need to work on the asylum culture in society and that people's participation enabled the decentralization of power.

In Luiza Erundina's campaign for mayor, we already had the mental health nucleus at PT [her political party] and some work had been carried out in East São Paulo for a long time [...]. We drafted a municipal mental health policy and delivered it to her staff. That ended up being one of her administration platforms [...] when she won the election we joined the city hall as mental health advisors and there was a managing collegiate composed by a psychologist, a social worker, a psychiatrist, and an occupational therapist [...] What is interesting is that we were thinking of this more general model and something that could counter psychiatric hospitals, even though the city was not municipalized. (B1)

We believed that having primary care as a front door to us would solve most health issues because it was a space in the community, a territorialized space, where people would perform health monitoring [...] It would determine the risk micro-areas within the concept of strategic planning and would intervene on them, carrying out an integration work, in addition to providing all types of care: medical; nursing; psychiatric; psychological; rehabilitation; social, etc. Everybody went to primary care, to mental health infirmaries, psychiatric emergencies, CECCOs, and also to the Intensive Therapeutic Community Living Units. (B2)

Regarding the publicizing of their experiences:

The Santos experience had great, nationwide repercussions. There was a parade of people going there to see what was going on. We sometimes spent a lot of time showing everything around. We had to be alert because we would always go to other places to speak, and everybody came. (A2)

And what did Santos do? It was smaller, you can cause a “frenzy” because you boom it out and put all that under the spotlight—a psychiatric hospital and “an action”—and that becomes marketing [...] when you have all the press, everybody looking at it and saying “Oh, how wonderful!” [...] then it doesn’t depend only on who’s in the administration [...]. Everything shed light on that, all the external references, even international ones. (B2)

Influence of the model on the choice for the Psychosocial Attention Center

Some diverging opinions can be found in the narratives about the São Paulo State models’ influence on the MHNP. Some aspects of the particular nature of each one of them were emphasized, because they were in line with local scenarios. The São Paulo network employees argued that their model’s influence on the MHNP was small and that the service chosen to be the foundation and guide of the replacement model, that is, the CAPS, was strongly influenced by the Santos model.

I think that in the current policy the São Paulo model’s influence is almost null [...]. Because this policy is similar to the Santos concept, CAPS-centered, where the CAPS is the foundational service [...] I think it’s a shame and I think this vision is asylum-based. [...] a service that should be temporary, which is the day hospital, the night hospital, but ends up being a service that offers everything: care; work; living; workshop [...] this CAPS-centered idea is a mistake and the source for this guideline was the Santos model. I have no doubt! (B2)

What we did in São Paulo was a horizontal model with no services above the others. I believe horizontality is key and it enables another regulation mechanism, and we were clear about that. And what was our regulation mechanism? The primary care center was questioned by the intensive therapeutic community living units, by the Labor Health Reference Center, and they were questioned by the general hospital’s mental health department, and the Living and Cooperative Center questioned everybody, and everybody gathered at the collegiate to collectively discuss the solution for obstacles, the wrong choices, etc. [...] the construction of a model within this intersectoral vision included this horizontal nature and this is what we did in the city of São Paulo. (B1)

For the São Paulo employees, the experience developed in the city was put aside because of misunderstandings within the Anti-Asylum Movement and within the political party PT.

[...] it seems to me that there was a rejection of what happened in São Paulo. I think that this deletion, this rejection, might have to do with the very history of the anti-asylum fight and with political issues connected to the PT. The party seemed not to support what was happening in São Paulo. As for the Anti-Asylum Movement, there were discussions since the beginning about the movement’s relationship with the state and about the insertion of its members in the governmental realm. If you read the first Anti-Asylum Movement Meeting Report, you’ll find questions concerning this relationship between the

movement and the state. We shouldn’t forget that there are power games, political relations, and consequently, who was occupying certain positions! (B3)

Thinking about the people who have been ahead of the Ministry of Health, the space we had [the São Paulo people] was always very small and there were many clashes. We conquered a space in the National Reform Committee and I presided over the State Reform Committee here in São Paulo for over one year. The São Paulo city space was very difficult in view of the conditions they gave us. I think other cities got closer such as Campinas, Santos, and Belo Horizonte. (B2)

For the São Paulo employees, this experience was erased from the official discourse and fell into oblivion.

This is violence because you may not agree with the purpose of what was done in a city; however, removing important stuff from the symbolic universe just because you don’t agree with it [...] This tells me where things are going! (B3)

The Santos employees spoke in their narratives about the strategy of occupying power spaces.

At the end of 1989, I came back to Santos. In 2001 I became a mental health articulator in the Sapopemba region, during the Marta Suplicy administration, in São Paulo. I guess for four years I was in the Marta administration coordinating the mental health area in Sapopemba because they were creating a CAPS [...]. But soon I received an invitation from the Ministry of Health because there had been a federal intervention in a hospital in the State of Paraíba and they needed to appoint an intervener. Then I went there to occupy this position. (A1)

I left the administration in Santos in 1997 and went on to work at the ER here. I also worked a little as a consultant. For 10 years I attended a doctoral program at Unicamp and finished it in 2000. Then I went to São Paulo for the Marta administration, in 2003-2004. (A4)

I also took part in two experiences that happened simultaneously to the one in Campinas: one of them in the city of Campina Grande, where I intervened in another mental asylum that the Ministry of Health wanted to close, a horrible thing. [...] In the city of São Vicente, I became the mental health coordinator [...]. When I came back, I worked at the same time in Campinas and here in the city of Diadema, then in the city of São Bernardo do Campo. (A2)

As far as the proposed model goes, the São Paulo employees understood that it could not go national.

[...] they were able to keep the intervention and were given the management of the Anchieta Hospital—which was private—in court. Later, they began to spread the idea of regional NAPS, structures that ran 24 hours a day with hospitalization beds. And we understood that the closing of that hospital was the Santos model. In that sense, we totally respected it, but it could not be the model for the entire country. We didn’t even advocate for our own model. We

argued that each territory should build its own model and what concerned us the most was the future of the Brazilian psychiatric reform process. (B1)

The influence that the global mental health network in São Paulo had on the MHNP was the inclusion of a Community Center (CECCO) in the RAPS, albeit lacking ministerial sponsorship up to that moment.

The second MHNC was basically the São Paulo model. There was no CAPS, NAPS, none of that, because we understood things differently. Today there is very strong political interference; therefore, my history becomes a personal discourse, quite different from the official one. (B1)

The Santos employees downplayed the influence of their experience.

I think the Santos experience was actually very influential but it was not the only one: the São Paulo experience was very influential; the beginning of the Porto Alegre experience was influential; CAPS Itapeva in São Paulo itself, a state-level experience, influenced the constitution of the policy [...] there was a synchronicity and in the social movement some people who became managers in some cities developed some practices, and a legal field was created. Little by little, the national policy was established and the decrees, the financing mechanisms, and the regulation of new services were also established. (A1)

We already had the São Paulo CAPS, the CAPS Itapeva, of 1987. These services had different perspectives, but the Santos NAPS was the first 24-hour service in the country, what we know today as CAPS III. I think they have different theoretical perspectives that come closer at times, with a different way of thinking at other times. However, I consider them to be two experiences in terms of building foundational services for the later psychiatric reform and MHNP. (A3)

The avant-garde radicalism that overflowed in the Santos experience led to the spreading of that model and consequently influenced the political decisions on the national plan.

I think that this mental health movement in Santos had a very powerful energy that ended up being contagious among the people; therefore, I guess it was very influential. (A2)

At that moment it was the first time this was done in the national scenario. When they were communitarian and territorial, we called them NAPS; today, with the national policy, they became known as CAPS III. I think this is a major contribution not only in the mental health field but also in the general health field, considering that continuous care 24 hours a day had always been seen as a type of care provided by hospitals. (A3)

The principal members and leaders of the Santos MHP had been to Trieste and experienced the city's 1980s experiment very intensively. Additionally, the Santos experience was supported by intellectuals and mentors of the deinstitutionalization experience that occurred in Trieste.

The experience here was very inspiring and this was very important—not for the policy, but for the reform movement, for the social movement, and for the militants [...]. As a model for functioning, organization, and discourse, I don't think the current MHP was that much influenced by our model considering what we understood as mental health. My experience and learning took place in Trieste; thus, the way to understand the mental health issue is that of Trieste and this has never been hegemonic in the national policy. (A4)

DISCUSSION

The construction of innovative models in terms of the mental health policy in the cities of Santos and São Paulo at the end of the 1980s was directly connected to two significant factors: the avant-gardism of the state government in the 1983-1986 administration, which enabled political restatements in mental health, and the election of mayors who belonged to the Partido dos Trabalhadores (Workers' Party - PT) in various municipalities in the State of São Paulo, especially the cities of São Paulo and Santos⁽¹²⁾.

The MHP developed in São Paulo was guided by the principles of deinstitutionalization and psychosocial rehabilitation. It counted on a wide range of care spaces at specific centers for citizens suffering from psychiatric conditions: day hospitals; emergency rooms at general hospitals; mental health departments at general hospitals (psychiatric hospitalization); mental health outpatient clinics; primary care centers with mental health teams; cooperative and community living centers (*Centro de Convivência e Cooperativa* or CECCO, as per its acronym in Portuguese); and residential services. These were supposed to work as an integrated network to pose an effective alternative to hospitalization in psychiatric hospitals⁽¹³⁾.

The MHP developed in the city of Santos was based on the intervention of the Anchieta Hospital (*Casa de Saúde Anchieta* or CSA, as per its acronym in Portuguese), a private psychiatric hospital that underwent deep reformulation and internal transformation, both in its facility structure and in the relationship between professionals and patients. Simultaneously, some replacement services were established: psychosocial care centers (NAPS, as per its acronym in Portuguese), which began to care comprehensively for each region's mental health cases mainly the severe ones uninterruptedly; and psychosocial rehabilitation centers (URP, as per its acronym in Portuguese), in charge of the coordination and development of job inclusion projects, in addition to a community center and a residential shelter. Psychiatric emergency cases started to be seen in the central emergency room. Within six years, the Anchieta Hospital was completely empty⁽¹⁴⁾.

It is possible to observe that different visions of how to conduct changes in the local-regional MHP enabled the construction of different models; the Santos one was based on asylum deconstruction and the creation of specialized services (NAPS).

The São Paulo model was based on the construction of a comprehensive mental health network consisting of various services targeted at doing without psychiatric hospitals and working on the asylum culture. Both took the Basaglia thought as a reference, but each model was built according to its local context, in a particular way, with its own complexities and histories.

It is important to mention that the setback of these models occurred in both experiences after the end of the city administrations because of the change in the political party in the municipal administration. The mental health services' functioning was affected, suffered from a setback, and was even dismantled in some cases⁽¹⁵⁻¹⁶⁾.

In the psychiatric reform history, it is often said that the Santos and São Paulo experiences were innovative and inspired the MHNP elaboration models^(14,16); nevertheless, employees stated that there was a distinction as to the advertising and publicity given to these models.

Although these experiences began in the same period, in 1989 the group in charge of its implementation in the city of São Paulo remained only for a single administration (up to 1992), whereas in Santos the group involved remained for two administrations (up to 1996). This favored the advancement of the initial proposal. This fact also proved significant for the model's visibility, as previously mentioned.

We observed that in Santos the publicity given to the model was expressive and became a significant hallmark of this experience. The same thing did not happen in the São Paulo experience because of the shorter time it lasted, and also because its dismantling occurred because of the administration change. In fact, the social players involved had given very little publicity to what was done in that period.

The impact the Santos experience caused was leveraged by the above-mentioned advertising and publicity, which were initiated by the intervention in and later closing of the only psychiatric hospital in the city. The space given by the leading group to professionals, journalists, students, and whoever else wanted to learn about the Santos experience produced an increased visibility, as in Trieste⁽¹⁷⁾.

The narratives confirm the differences in the model developed in São Paulo and its limited influence on the existing MHNP model, which was criticized for being too centralized and choosing a single specialized service instead of a comprehensive service network. The Santos model's greater influence can be perceived when comparing the current CAPS and the Santos NAPS, whose purpose is to be a service that meets all mental health demands through the five existing NAPS.

In this proposal there could be no room for intermediate services or places where patients could be referred to, once their mentors, in keeping with the Trieste proposal, were against hierarchy in services, service reference, and counter-reference. Therefore, the NAPS was to encompass all of the patients' needs in a single service. And this is the way the current CAPS have been structured.

Another characteristic that is worth highlighting is the existence of a managing collegiate in the São Paulo experience, based on the requirement that decisions be made and discussions on the model's progress take place onsite, strengthening the gap between that proposal and what we have today. It is possible to observe that the democratic and collective character in the elaboration of public policies in Brazil was actually lost as part of a social global phenomenon.

Whereas the psychiatric reform was closely related to social movements in the 1990s, in the new millennium it became

institutionalized, as also happened with the sanitary reform. Although it has enabled the consolidation of a health care project that opposed an hegemonic model, it wandered away from social movements and organizations, placing civil society's main struggle focus within the state apparatus⁽¹⁸⁾.

This functioning of the health care policy in Brazil led to a greater concentration of power by the state, while the social players who had been involved in the fight for changes gradually lost their social and participatory functions in the elaboration of public policies. Such context placed the current main players in ministerial cabinets to write norms and decrees, whereas institutions and services are no longer political protagonists⁽¹⁹⁾.

To associate such characteristics of the health care policy in Brazil with the differences between the São Paulo and Santos models is relevant because it brings to light important questions, historical and political contexts that have not yet been mentioned.

For São Paulo employees, the São Paulo experience was put aside because of the misunderstandings within the Anti-Asylum Movement and the PT. Additionally, the Santos group wove a network of power relations throughout the two PT city administrations, which enabled various members to occupy positions in the Ministry of Health and other spheres. This power relations network might have produced a greater influence of the Santos model on the MHNP's directions.

Analyzing the Santos employees' narratives, it is possible to infer that their journeys were diverse at the end of the 1996 administration. In fact, their relations with the PT became closer; they occupied positions and developed activities at the Ministry of Health and in municipalities where the party was the city administrator. The São Paulo employees faced a different situation; they stayed in the city and were alienated from the process of conducting and implementing the MHNP from that time on.

For a São Paulo employee, the Santos NAPS model was assimilated by the current CAPS model, which spread across the country from Decree 336/2002⁽³⁾. With the argument that it had been granted federal financing, it was approved by mayors in Brazilian cities.

The authors of this study believe that there were advances towards the implementation of a specific MH policy by the federal government; nevertheless, the means to this end are the subject of critical reflection in this study because much of what had been built more collectively in MHNC I and II was lost.

The functioning of public policies gradually changed, as this study has pointed out. Social participation lost heart throughout the years and decisions were made at ministries' cabinets involving specific groups of MH professionals in their implementations.

The official discourse, as well as a large portion of the Brazilian literature on the national psychiatric reform, states that the Santos experience and other experiences influenced the MHNP elaboration. In the case of São Paulo, the official discourse dismisses the experience of Luiza Erundina's city administration and highlights the creation of a state-level service, CAPS Itavepa (1987), as the single innovative and inspirational service and the choice for a replacement service for psychiatric hospitals, the current CAPS.

We can pinpoint recurring mentions of the NAPS and CAPS services as those that inspired the choice for the current model,

albeit always referring to CAPS Itapeva. Since its creation, over 20 years ago, this service has been sponsored by the São Paulo state government and is the only CAPS in the entire country that did not become municipalized after the creation of Brazil's Unified Health System. It did not integrate the city of São Paulo's comprehensive mental health care network and remains as part of the São Paulo State Secretariat of Health structure.

Currently, CAPS Itapeva serves a restricted and selected number of patients and its management was passed on to the private social health organizations⁽²⁰⁾.

The Santos network employees confirmed the influence of their model; however, they argue, it was not the only one, and several other experiences also contributed to the elaboration of the current model. They also advocate that the sum of existing experiences in the country influenced the creation of decrees and norms that guided this model.

According to these employees, there was no direct relation between the Santos experience and the adopted model; nevertheless, they confirmed that the Santos model influenced the choice for the CAPS model, particularly CAPS III, the 24-hour service inspired by the Santos NAPS.

For a Santos employee, had the Santos experience been the most influential one, only CAPS III would exist across the country and that has not happened yet. Instead, the Santos model served as a reference and a landmark.

We believe this position is no longer consistent considering that the recent changes brought about by Decree 3088⁽¹⁰⁾, which implemented the RAPS, created financing mechanisms for the construction of CAPS III, with a particular emphasis on CAPS AD, on the grounds that the alcohol and drugs policy has had great visibility. For some years now, the Ministry of Health has privileged this type of equipment.

It is possible to observe that the current MHNP proposal is actually to transform all MH territorial services into CAPS III, similarly to the Santos NAPS, under the allegation that this mechanism could replace psychiatric hospitals.

Although none of the two CAPS III types have been consistently deployed in Brazilian cities, either to replace psychiatric hospitals or to minimize the drug abuse problem, they have actually embedded the proposal of becoming 24-hour CAPS, something that was already envisaged since Decree 336, of 2002⁽³⁾.

To solve the problem of insufficiency in the number of CAPS III, investment was made in the expansion of CAPS I and II, which have currently been turned into CAPS III, following the trend in services such as MH outpatient clinics and day hospitals. We believe that these mechanisms confirm the MHNP's intention of implementing the Santos model, even though it was put into practice much later.

The Santos MHP model contemplated Basaglia's radical ideological principles, inasmuch as in Trieste the model that was developed laid its foundations on a mental health services network, with mental health centers and outpatient clinics; social cooperatives; psychiatric diagnosis and treatment services (emergency in general hospital); and training, rehabilitation, and social reintegration residential services⁽¹⁷⁾.

We believe the MHP of the São Paulo model could not have had much visibility because the PT partisan political context did

not allow its permanence; alternatively, the Santos group established alliances that were strong enough to make the characteristics of the MHP Santos model prevail, particularly the NAPS and its influence on the choice of the CAPS model.

To erase the São Paulo MHP experience from the history of Brazilian psychiatric reform was but one of the strategies to eliminate any chances of returning to the proposal initiated there. In addition to everything that experience involved from the political-ideological standpoint, its structuring would be considerably more expensive; there would be a much greater need for human resources and professional training.

In theoretical terms, that proposal was the closest one to the Basaglia tradition, as it involved changes in health care services as well as in society in general. A project like that of São Paulo would create the need for all health care services to manage mentally disturbed people, such as in the context of social inclusion through the CECCO.

It is worth highlighting that many nursing professionals were involved in and contributed to this process of change in psychiatric care through their engagement in the Anti-Asylum Movement, the Sanitary and Psychiatric Reform Movement, and the MHNCS, as well as in education and research on the subject. With their experience in the new models, nursing professionals have helped change the prejudicial lenses nurses and doctors used to be seen through in other words, that they were the villains of asylum practices and became agents of change and therapeutic assistance.

As a limitation of this study, the authors realized that some employees were cautious in their accounts on the subject that was being analyzed.

FINAL CONSIDERATIONS

Regarding the influence of the two MHP innovative models of Santos and São Paulo that were analyzed in this study, the authors have come to the conclusion that the choice for a CAPS-centered MHP model was guided by political and ideological interests that remain in place to this day, and also on the grounds of the availability of resources for financing that model.

Nonetheless, in its functioning and practical deployment, it ended up not eradicating asylum practices and it cannot meet the mental health demands in Brazilian cities. Such choice occurred for political and economic reasons, in keeping with Brazil's submission/adhesion to neoliberal ideas that divest the state from its responsibility toward public policies.

It is possible to observe that the Ministry of Health's preference for RAPS involves some characteristics of the MH comprehensive care network implemented by the Luiza Erundina administration in the city of São Paulo, which leads to a need to rethink the current model on the grounds that a criticized, officially disregarded experience has been recreated under a different name.

Such fact is evidence of what many professionals engaged in care for mentally distressed individuals suspected: the CAPS cannot be the answer to the care model because, without the care network, it is neither possible to articulate the care nor to adequately cater to the demands and specific and subjective features of individuals with psychiatric conditions.

To bring these facts to light proves extremely relevant for the continuity of the fight for the necessary changes in MH care in our country. It is worth emphasizing that this study brought to the surface the contexts and history of the MHNP establishment and Brazilian psychiatric reform that differ from the official history

and provoke the need for change in the current MHNP direction. These are data that should influence a shift in public health care policies in this area. Nursing is involved in the care provided according to the new model and also in the fight for the implementation of true and full psychiatric reform.

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