DOI: 10.1590/1809-4503201400060011

ORIGINAL ARTICLE / *ARTIGO ORIGINAL*

Social determinants for health (mental): evaluating a non-governmental experience from the perspective of actors involved

Determinantes sociais em saúde (mental): analisando uma experiência não governamental sob a ótica de atores implicados

Maria Lucia Magalhães Bosi[I], Anna Karynne da Silva Melo[II], Liliane Brandão Carvalho[II], Veronica Morais Ximenes[I], Maria Gabriela Curubeto Godoy[III]

ABSTRACT: ***Introduction:*** The Brazilian Psychiatric Reform, an ongoing process, and its developments involve the construction of new ways of seeing the subject in illness, establishing the mental health field in a new way of understanding the social determinants that reflect in the deinstitutionalization and social inclusion. ***Objective:*** This study, multidimensional analysis of the relationship between social determinants and deinstitutionalization in mental health focusing on a community movement in Northeast Brazil, whose proposed work is subjective and psychosocial dimensions, aims to explore and analyze how the experiences in course of the Movement highlights the importance of social determinants, the perspective of professionals. ***Methods:*** The methodological approach outlined in the qualitative approach in the form of case studies, employing techniques such as interviews and focus groups. The categorization of analytical information was built from the relationship established between a model based on the constituent dimensions of the psychiatric reform, covering different planes, namely epistemological, healthcare, legal and socio-political, and social determinants of health — living conditions, and work environment, community networks and support, economic, cultural and environmental behaviors and lifestyles. ***Results:*** The results show emphasis on the social subject, making the processing and knowledge of professionals, adding new ways to produce health; dialogue with multiple stakeholders, building autonomy, participative management, concern for professionalization; reorganizing the work process; appreciation of the everyday activities that weave and; invention of a new social site, among other elements in close interface with the determinants of health. ***Conclusion:*** These elements indicate that care practices woven into the daily life of the Movement involve the disassembling the traditional model of mental health care, stimulating new forms of citizenship, thus contributing to the institutionalization and promoting equality of income, social cohesion and participation policy for the promotion and protection of health.

Keywords: Social determinants of health. Health. Desintitutionalization. Care. Health professionals. Qualitative research.

[I]*Universidade Federal do Ceará* – Fortaleza (CE), Brazil.

[II]*Universidade de Fortaleza* – Fortaleza (CE), Brazil.

[III]*Universidade Federal do Rio Grande do Sul* – Porto Alegre (RS), Brazil.

Corresponding author: Anna Karynne da Silva Melo. Universidade de Fortaleza, Diretoria do Centro de Ciências Humanas, Psicologia. Avenida Washington Soares, 132, Edson Queiroz, CEP 60811-341, Fortaleza, CE, Brasil. E-mail: karynnemelo@unifor.br

Conflict of interests: nothing to declare – **Financing source:** National Counsel of Technological and Scientific Development (CNPq), under public notice MCT/CNPq/CT-Saúde/MS/SCTIE/DECIT 033/2008, and Foundation for Scientific and Technological Development of the State of Ceará (FUNCAP),under public notice PPSUS-2009.

RESUMO: ***Introdução:*** A Reforma Psiquiátrica brasileira, um processo ainda em curso, bem como seus desdobramentos, envolvem a construção de novos modos de estar diante do sujeito em adoecimento, estabelecendo, no campo da saúde mental, uma nova forma de compreender os seus determinantes sociais que se refletem na desinstitucionalização e na inclusão social. ***Objetivo:*** Este estudo multidimensional, no âmbito da desinstitucionalização em saúde mental, objetiva explorar e analisar como nas experiências de um movimento comunitário no Nordeste do Brasil, na perspectiva dos profissionais, evidenciam-se determinantes sociais do processo com o qual interagem. ***Método:*** O estudo se fundamenta no enfoque qualitativo, adotando como desenho o estudo de caso e como técnicas entrevistas e grupos focais. Na categorização das informações, partiu-se da relação entre as dimensões constituintes da Reforma Psiquiátrica — epistemológica, assistencial, jurídico-política e sociocultural; e distintos determinantes sociais em saúde — condições de vida, ambiente e trabalho, redes comunitárias e apoio, condições econômicas, culturais e ambientais, comportamentos e estilos de vida. ***Resultados:*** Os achados revelam ênfase no sujeito social; inserção de novos modos de produzir saúde; diálogos com múltiplos atores; construção da autonomia; gestão participativa; formação e profissionalização; reorganização do processo de trabalho; valorização das atividades tecidas no cotidiano, dentre outros elementos em estreita interface com os determinantes de saúde. ***Conclusão:*** As práticas de cuidado do Movimento implicam desconstrução do modelo tradicional de atenção à saúde mental, potencializando novas formas de cidadania, contribuindo para desinstitucionalização e favorecendo equidade de renda, coesão social e participação política para a promoção e proteção da saúde.

Palavras-chave: Determinantes sociais da saúde. Saúde. Desinstitucionalização. Cuidado. Profissionais de saúde. Pesquisa qualitativa.

INTRODUCTION

This study originated from another study, "Práticas inovadoras e desinstitucionalização: analisando um movimento comunitário em saúde mental no Nordeste do Brasil", which covers a multidimensional analysis of aspects related to the social determinants of mental health focusing on a community movement - the Movement for Community Mental Health of Bom Jardim (MSMCBJ or Movement).

The MSMCBJ conducts its activities predominantly in the Greater Bom Jardim Region, outskirts of Fortaleza, an area characterized by marginalization, poverty and precarious living and working conditions[1]. Its purpose is to face the challenge of working with subjective and psychosocial dimensions, valuing people who come to experience hardship by offering different modalities of care, aiming to deinstitutionalization. Its activities are organized into five categories: therapeutic; education; art (music, culture and entertainment); professionalization; and training. In this study, we focus on the segment responsible for the activities of the therapeutic axis: community therapy, massage therapy, self-esteem and biodance.

We understand that the ongoing process of the Brazilian Psychiatric Reform and its advances involve the construction of new ways of coexisting with individuals undergoing the disease process,

instituting, in the mental health field, a new understanding of the social determinants that are reflected in deinstitutionalization and of the social inclusion that materializes in a territory-centric care network[2,3]. This progress demands conducting studies that address experiences considered effective in building psychosocial networks and building this new relationship in mental health.

This proposal is within the investigative scope and justified based on national and international visibility of the focused Movement, considering, among other evidence, that it has operationalized a differentiated model, with important outcomes in various walks of the life of those who participate in it, to promote improvements in the existence of these people, fostering their strengthening, aiming to promote changes in their personal and social aspects[1].

Until recently, this experience was neither systematic, nor evaluated based on assumptions and procedures guided by scientific rigor, which was a gap in the literature. Evaluation studies that we have been developing in recent years thematize the Movement in its theoretical framework, as well as from the perspective of the different actors involved[1]. This study is included in this scope, seeking to identify interfaces between practices and concepts, notably the framework of social determinants.

As a conceptual framework, we make the assumption that the social determinants correspond to situations of life and work of individuals and of groups that are related to their health condition, considering the social, economic, cultural, ethnic/racial, psychological and behavioral aspects that influence the occurrence of health issues and their risk factors in the population[4]. At the present stage of studies on social determinants, there is significant discussion of the relationship between the form of organization and development of a society and their health condition from themes such as health inequities or the systematic and relevant inequalities in this field[4], aspects which, as we shall see, make this a cross-sectional study.

The justification for this analysis of the experience of the Movement in a multidimensional perspective, focusing here on the views of professionals, although it is understood as part of the broader study, aims to contribute new insights to the field of mental health in a sense of new models that can support the ongoing reform in order to promote social justice, citizenship and, more specifically, the guarantee of the right to health.

Given the above, the purpose of this study was to explore and analyze how, in the current experiments of the Movement, the importance of social determinants is stressed, from the perspective of professionals working on this instrument.

SOCIAL DETERMINANTS AND PSYCHIATRIC REFORM: AN UNDERSTANDING OF ITS DEVELOPMENTS IN A PERSPECTIVE OF DEINSTITUTIONALIZATION

The ongoing movement of the psychiatric reform has contributed to the implementation of a new public policy for mental health care, guided by the idea of deinstitutionalization, which can be understood as dehospitalization - prevention of admissions to psychiatric hospitals; lack of attendance, lack of care; and deconstruction, break with the paradigm of madness and with the medical knowledge that reduces the subject to a disease[5].

We defined the prospect of deinstitutionalization as deconstruction, as proposed by Amarante[2,3], requiring not only a new place for madness and the disassembling of "scientific, regulatory and administrative apparatus"[6] that are typical of the traditional psychiatric paradigm, but also a new relationship with otherness.

Given these propositions, we chose to operationalize an analytical model structured in the dimensions of the Psychiatric Reform, marked by Amarante[7] considering such a model both appropriate to the field of psychiatric reform and, more importantly, to understanding other perspectives of mental health care. Given the focus of this study, we define each of the following spheres: epistemological or theoretical-conceptual; technical/assistance; legal-political and sociocultural; aiming to, in this exercise, show their relations to the social determinants of health

The epistemological dimension, or theoretical-conceptual, concerns the revision of the concepts underlying the knowledge/action behind each perspective, as well as the production of other forms of knowledge. The assistance dimension refers to the question of the model of attention and care, addressing instruments, equipment and technical tools proposed to meet the demands in the field of mental health. The legal-political dimension brings up discussions on citizenship and civil, social and human rights, as well as on the creation of laws specific to that field. Finally, the sociocultural dimension is linked to the place reserved for people in psychological distress, which includes considering stigmas and prejudices the same way as strategies and interventions that enable a new way of relating to madness, that is, new places[7].

In turn, the social determinants are defined as the social, economic, cultural, ethnic/racial, psychological and behavioral factors related to health problems and risk factors to which a population is exposed. The debate about the determinants is not new: it's been under discussion since the 1970s, in the Alma-Ata Conference, and, in the activities relating to 'Health For All by the Year 2000', the theme was again in evidence, bringing back a previous debate. With the intensification of the debate on social determinants, the National Commission on Social Determinants of Health (CNDSS) is created in 2005, based on the recommendation of the World Health Organization, thus becoming a path for bringing this debate back, making it current. The CNDSS is guided mainly by the Federal Constitution of 1986, in which health is recognized as a right for all and a duty of the State, guaranteed by social and economic policies that seek to reduce the risk of diseases and other ailments[4,8].

In the indicated route, we consider the existence of three generations of discussion on social determinants, namely: the one that describes the relationship between poverty and health; the one that describes the health gradients from socioeconomic stratification criteria and the one termed as the current generation, which investigates the mechanisms that produce inequalities. This last perspective focuses on countries with less investment in human capital and social support networks, such as those marked by larger social inequities[9].

METHOD

Given the nature of the object, the methodological path turned to the subjective production of the subjects involved, which led to the adoption of a qualitative approach that, in recent years,

has been widespread in public health, considering its contributions to the to understanding of phenomena. The debate between qualitative and quantitative approaches has moved towards an understanding of complementarity, without thereby losing the ontological design of each tradition (and its variations) and the adequacy of the method-object ratio[10].

Faced with the diversity of methodological designs of qualitative social research, we opted for a case study, which favors the construction of comprehensive knowledge and insights from the uniqueness of a case[11].

Thus, through a comprehensive and descriptive design, we intend, as alluded to before, taking the speech of professionals involved in a community movement committed with deinstitutionalization as the study material, to highlight and understand how social determinants are expressed, constituting case study, that is, a singular experience that interfaces the Mental Health Network in Fortaleza, but it is not formally included in it.

As for informants, we sought professionals of core therapeutic practices at several therapeutic axes, considering them as actors and enablers in the unveiling of the phenomenon investigated, in a dialogical perspective. The choice of these professionals, therefore, was made given their relevance to the issue under study, that is, the subjective previous knowledge about the object and its relation to the theoretical framework underlying the research[12]. The sample size was outlined by the principle of theoretical saturation, according to which, "the new information provided by the survey participants would add little to the material already obtained, not contributing significantly to the improvement of theoretical reflection based on the data being collected"[13].

The sample consisted of 24 mental health workers (considering them as 'professionals', with or without college education, with or without a formal contract), since, in the exploratory phase of the research, we found that a team that is very different from that which composes the institutionalized instruments participates in the Movement.

Regarding the research techniques, individual interviews and focus groups conducted by researchers from the staff at the headquarters of the Movement were used, from a starter question, unfolded according to the principle of non-directivity, depending on the categories and themes that showed to be significant through the process.

According on the ethical principles adopted, following the procedures of Resolution 196/CNS, in the terms and conditions approved by the Research Ethics Committee of *Universidade Federal do Ceará*, the criteria for inclusion of the participating professionals were: minimum of six months participating in the Movement, in order to favor the familiarity of participants with the object and to ensure a previous knowledge that allows them to approach the object at hand; minimum age of 18 years, to ensure their liability for depositions; being in sound mental and physical conditions to provide information; and agreement to participate after learning about the free and informed consent term and other information about the study.

Regarding analytical categorization of information, we used the following procedures: after transcription by the research team, all discursive material was subjected to successive and extensive reading, during which the categories were appointed in a free and carefree manner, according to unique themes cited by each informant. Subsequently, we performed horizontal readings of the narratives, in order to account for the recurrences and repetitions and thus outline common axes

that led to the identification of the information from the relationship established between a model based on the constituent dimensions of the Psychiatric Reform, covering different levels, namely: epistemological, assistance, legal-political and sociocultural[2,3,7]; and social determinants of health[4,8,9].

RESULTS

SOCIAL DETERMINANTS AND DEINSTITUTIONALIZATION: THE MOVEMENT FROM THE PERSPECTIVE OF THE PROFESSIONALS

Based on the foregoing, we present the categorization of information obtained from the professionals of the analyzed Movement by specifying them according to each of the four constituent dimensions of the Reform[7], as detailed above, in its relation to social determinants.

EPISTEMOLOGICAL DIMENSION AND LIVING, WORKING AND ENVIRONMENTAL CONDITIONS

In this first dimension, we observed a major reconfiguration of the object of intervention in the Reform's Movement, whose purpose is not the mere remission of symptoms, but the social subject and their needs, encompassing changes in their living, working and environmental conditions. Thus, there is a need for a different approach to health, one that empowers a new understanding as to the availability and access to essential goods and services for health promotion and healthcare - understood as a right.

In the speech of the professionals, an emphasis is revealed both on the need to build a potentiating environment and on the ability of the subjects to experience diversity. The Movement is a space for acceptance and growth (R1). The differential aspect of the Movement in relation to other mental health services is that, there, the person is seen as a whole, in their biological, psychological, social and spiritual dimensions (R2). The major difference that occurs in the Movement is that it was not deployed. It was born from a reality, from a clamor, from an answer to something that was needed and to the history of a population. What happens in the Movement is made to suit a population (R3).

Some issues were revealed, such as opportunities and professional training for the people in the community, which favors the inclusion in the labor market and income equity, and the organizational challenges of the Movement were pointed out from the increased activities. The Movement enables each person to experience various roles, creating opportunities for volunteering and the most diverse backgrounds (Focus Group). The MSMCBJ cannot be defined as a job but as a mission, as something that has a lot to do with its own identity, with its existence, with what gives meaning to its existence (R3).

Such perspectives are also revealed when one realizes the change in care and service delivery that occur in the Movement, and when one has both the perception of the difference and of the impact on the lives of the subjects who receive care by the service. The dimension of the

reception appears in the speeches behind the propositional basis of the actions of the Movement as a service that supports differences. The Movement does not treat anyone, it welcomes, and there is a big difference between treating and welcoming someone (R3). The major reception strategy enables the care of residents marked by an internalized poverty, where venting, talking about it, sharing, generated processes of transformation of pain into wisdom (R4).

The professionals also reported that they wanted to do a professional job and, at the same time, maintain the characteristic of the Movement, which is to educate people, either externally or people who work in it. Therefore, due to, for example, work relations, and not only due to financial, economic trades, it is possible to provide care to the caregiver, and to make room for the growth of people within the Movement (Focus group). Caring for the Caregiver as a structuring activity of the work processes in the Movement [...] (R1).

TECHNICAL/ASSISTANCE DIMENSION AND COMMUNITY AND SUPPORT NETWORKS

In the testimonies, this second dimension is presented by respondents as a dialogue-production with multiple actors in the Movement. The community actively participates in the Movement, whether in some activity or simply visiting the site (E2). The relationship with the community is one of openness and dialogue, which is expressed in participatory ways and in the various activities offered, in which the community has a voice (R1).

Professionals describe the issue of the importance of the reorganization of the work process and of building a working condition that is not stressful and that does not expose them to a situation of vulnerability, which we can understand as another characteristic of this dimension. When hiring someone to work in the Movement, one thing that is always said to the newcomer professional is the basic need of knowing how to take care of oneself. For example, anyone can take one hour off and get a massage with a massage therapist from the Movement, who is there daily to serve its users, workers and also people in the community (R3).

Respondents indicate the existence of a level of social cohesion marked by the collective. It is the collective that makes the Movement (R1). The community is important in building mental health; there is a concern with the education of the people in the neighborhood, with the opening of new spaces of professionalization, beyond the therapeutic dimension of mental health care. All activities created in the Movement took place from listening to the needs of the community (Focus Group).

LEGAL-POLITICAL DIMENSION AND ECONOMIC, CULTURAL AND ENVIRONMENTAL CONDITIONS

The professionals describe in this third dimension their personal and social transformation. Currently, after my direct involvement in the Movement, I graduated in pedagogy and did a specialization in family therapy. I feel greatly strengthened in my life journey, overcoming shyness and feeling more valued and empowered (R1). The differential aspect in health is to

transform, lead people to the understanding that they are co-responsible for their own health (R3). Today, I am no longer in the Movement as a professional, I am going to do other work in Maranhão; I do my best for the Movement, I'm sharing, experiencing and conveying what I've learned here (Focus Group).

SOCIOCULTURAL DIMENSION, BEHAVIORS AND LIFESTYLES

The last dimension, sociocultural, is reported by professionals as the relationship between the individual and the social, between the lifestyle of each individual and what is indicated to be social determinants of health.

In this regard, there are several reports such as the following: The Movement enables everyone to try various roles, opening opportunities for volunteering and for the most diverse backgrounds (Focus Group). [...] In qualifying the people in the community to work, this professional will have better conditions to change their everyday life with some differences, such as the knowledge they have of their own community, the possibility of bonding that comes from the sense of belonging and a language closer to the people (Focus Group).

DISCUSSION

The Movement analyzed is characterized as a non-governmental organization committed to the process of personal and collective transformation, aiming at the stimulation of autonomy and empowerment of the people and the community, seeking the transformation of the local reality[1]. In this sense, and from the perspective of the professionals who were the informants of this research, we can say that the mental health practices woven into the everyday life of this experience, far from intending or being restricted to make an apology to the case investigated, imply deconstruction or breaks with the traditional model of mental health care, contributing to an improvement in income equality, social cohesion and political participation with the aim of promoting and protecting health.

During this study of comprehensive nature, the Movement presented experimentation as its hallmark, in the sense of creating, building passages and producing new modes of care for people in hardship, focusing on understanding and building the social subject. It reveals itself as a locus in which these new modes of care production materialize in less exclusionary practices and in recognition of the biological, psychological, social and cultural determinants of illness, in which health is now considered a biosocial process leading to greater investment in human capital and social support networks[9].

We can find these questions well demarcated in the relationship established between the dimensions that constitute the Reform[7] and the social determinants of health[4,8]. Thus, we understand that in the first dimension discussed — the epistemological dimension, and living, working and environmental conditions — there is a recognition of the need to transform the

knowledge and the practice of professionals, which means the existence of the construction of new theoretical bases and new practices for the conduction of assistance projects, as well as the invention of new ways of health[14], and knowledge production, transforming and diversification of answers[15], which leads us to understand that there is a practice in the Movement leading to the invention of new methods to produce health and to the diversification of responses, considering the context of poverty and abandonment[16]. The context of poverty considered here is not only unidimensional, in the monetary aspect, but multidimensional, encompassing health, education, living standards[17] and the subjective production caused.

As for the other relationship established - the technical/assistance dimension and community and support networks, we have seen that this is presented as the production of dialogues with multiple actors, namely: professionals, users and the network of relationships — family, neighbors and people of the territory[15]. As an outcome of this change in the technical/assistance production of the Movement, it was necessary to reorganize the work process and to focus the service more on the needs of professionals and users[18], as well as a participatory and responsibility action from various actors[19], for the appreciation of activities that weave the everyday life and the action in the territory foster the strengthening of support networks and comprehensive care[5]. This makes us understand that these factors highlighted by professionals indicate a level of social cohesion[8]. In the legal-political dimension and economic, cultural and environmental conditions, we perceive a transformation regarding taking responsibility; greater citizenship; personal worth and personal power[20]; strengthening[21]; autonomy and bargaining power[14]; as well as the production of rights[15] and the overcoming of the dependency and fatalism by professionals[22].

In the relationship between the sociocultural dimension and the behaviors and lifestyles determinant, we corresponded it to the production of local and intersectoral public policies, as well as substitute and territorial networks and services aimed at overcoming the asylum model. The invention of a new social place for the experience of the disease process is constitutive of this dimension. Therefore, we emphasize how important it is that the mental health service be permanently aware of the risk of not reproducing an asylum practice in their daily lives and that the discourse does not happen only in the discursive level, but especially in projects of a more humane manner of care that values volunteering and flexibility of roles. These aspects have a close relationship with the behaviors and lifestyles determinant, which lies between the individual level and the social determinants of health, because the behaviors, as we know, are not the result of free will, but even if there is choice, they also depend on access to information, advertising, peer pressure, (im)possibility of access to healthy foods and recreational spaces[8].

To problematize the social determinants and dimensions of the Psychiatric Reform, in a perspective of deinstitutionalization as deconstruction[2,3,7], is considering the possibility of inclusion of marginalized populations and improvement of their health. For this, it is essential that more comprehensive and effective policies are developed, including the production of local intersectoral policies.

There are several aspects that should be considered: governance for action at all levels, in a holistic perspective; political participation of the community, enhancing the quality and responsiveness in the sector; and the monitoring of inequities, powered by data from other sectors.

The development of political and technical capacities is another important point in enabling the implementation of actions of the various sectors of society that may facilitate health prevention and promotion[4,8,9].

The emphasis is therefore on a new ethos, a new attitude toward the experience of the person suffering, guided by responsibility, inventiveness, respect, listening, affectation, dialogue and ethical-political commitment[3]. These dimensions enable the construction of bridges to autonomy, whose importance is increasingly evident facing the understanding of the determination process of health disorders, which challenges us to join forces in all action plans, from local to global, understanding the interfaces between the social determinants of health, based on an integrated and systemic perspective[3,4,7,9].

REFERENCES

1. Bosi MLM, Carvalho LB, Ximenes VM, Melo AKS, Godoy MGC. Inovação em saúde mental sob a ótica dos usuários de um movimento comunitário no nordeste do Brasil. Rev Ciên Saúde Coletiva 2012; 17(3): 643-51.
2. Amarante P, organizador. O homem e a serpente: outras histórias para a loucura e a psiquiatria. Rio de Janeiro: Fiocruz; 1996.
3. Amarante P. Loucos pela vida: a trajetória da reforma psiquiátrica no Brasil. Rio de Janeiro: Fiocruz; 1998
4. Buss PM, Pellegrini Filho A. A saúde e seus determinantes sociais. Physis 2007; 17(1): 77-93.
5. Godoy MGC, Bosi MLM. A alteridade no discurso da Reforma Psiquiátrica Brasileira face à Ética Radical de Lévinas. Physis 2007; 17(2): 289-99. .
6. Rotelli F, Leonardis O, Mauri D. Desinstitucionalização. São Paulo: Hucitec; 1990.
7. Amarante P. A (clínica) e a Reforma Psiquiátrica. In: Amarante P, organizador. Archivos de Saúde Mental e Atenção Psicossocial. Rio de Janeiro: Nau editora; 2003. p. 45-65.
8. Comissão Nacional sobre Determinantes Sociais da Saúde. As causas sociais das iniquidades em saúde no Brasil. Rio de Janeiro; 2008. [Relatório final, 216].
9. Buss PM, Pellegrini Filho A. Iniquidades em saúde no Brasil, nossa mais grave doença: comentários sobre o documento de referência e os trabalhos da Comissão Nacional sobre Determinantes Sociais da Saúde [informe]. Cad Saúde Pública 2006: 22(9): 2005-8.
10. Bosi, MLM. Pesquisa qualitativa em saúde coletiva: panorama e desafios. Rev C S Col 2012; 17(3): 575-86.
11. Yin RK. Estudo de caso: planejamento e métodos. Porto Alegre: Bookman; 2001.
12. Schwandt TA. The Sage Dicitionary of Qualitative Inquiry. New York: Sage Publications; 2007.
13. Fontanella BJB, Ricas J, Turato ER. Amostragem por saturação em pesquisas qualitativas em saúde: contribuições teóricas. Cad Saúde Pública 2008; 24(1): 17-27.
14. Barros OMAF, Silva ALA. Práticas Inovadoras para o cuidado em saúde. Rev Esc Enferm 2007; 41(Esp): 815-9.
15. Nicácio F, Campos GWS. A complexidade da atenção. Rev Ter Ocup USP 2004; 15(2): 71-81.
16. Drew N, Funk M, Tang S, Lamichhane J, Chávez E, Katontoka S, et al. Human rights violations of people with mental and psychosocial disabilities: an unresolved global crisis. Lancet 2011; 378(9803): 1664-75.
17. Sen A. Desenvolvimento como liberdade. São Paulo: Companhia das Letras; 2000.
18. Franco TB. Produção do cuidado e produção pedagógica: integração de cenários do sistema de saúde no Brasil. Interface Comun Saúde Educ 2007; 11(23): 427-38.
19. Pinheiro R, Guizardi FL. Cuidado e integralidade: por uma genealogia de saberes e práticas no cotidiano. In: Pinheiro R, Mattos RA, organizadores. Cuidado: as fronteiras da integralidade. 2ª ed. Rio de Janeiro: Cepesc/UERJ/Abrasco; 2005. p. 21-36.
20. Góis CWL. Noções de Psicologia Comunitária. Fortaleza: Editora Viver; 1993.
21. Montero M. Teoria e Práctica de la Psicologia Comunitária. Buenos Aires: Editorial Paidós; 2003.
22. Martín-Baró I. Psicología de la liberación. Madrid: Trotta; 1998.

Received on: 04/30/2012
Final version presented on: 03/12/2013
Accepted on: 06/12/2013