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Psychiatric reform and counter-reform: an analysis of a socio-political and sanitary crisis at national and regional level

Mônica de Oliveira Nunes (https://orcid.org/0000-0002-5905-4199) [1]
João Mendes de Lima Júnior (https://orcid.org/0000-0001-6436-8566) [2]
Clarice Moreira Portugal (https://orcid.org/0000-0003-0373-4141) [1]
Maurice de Torrenté (https://orcid.org/0000-0001-8804-4961) [1]

Abstract *This article addresses recent political, legal and welfare changes to mental health policies in Brazil, demonstrating their effects of Psychiatric Counter-Reform. Based on documentary analysis, we explain the tensions generated by this process, with its repercussions for the complex process of Brazilian Psychiatric Reform, particularly for the Psychosocial Healthcare Network. We discuss the paradoxical case of Counter-Counter-Reform, using the state of Bahia as an example because of its recent proposal to close psychiatric hospitals with the announced aim of deinstitutionalizing people who have been hospitalized, which does not coincide with this moment of change in Brazilian mental health policy. We conclude that the risk of the worsening of the sanitary, social and economic crisis in the country requires increased advocacy and mobilization measures, in order to prevent the loss of social protection mechanisms, which also include mental health. This crisis simultaneously poses a threat to human rights and to the inclusion of people in psychological distress, at the same time as it presents an opportunity to reinvigorate a reform that was at the peak of activity.*

Key words *Mental health policy, Psychiatric Reform, Anti-asylum movement, Psychosocial rehabilitation.*

[1] Instituto de Saúde Coletiva, Universidade Federal da Bahia. R. Basílio da Gama s/n, Canela. 40110-040 Salvador BA Brasil. monicatorrente11@gmail.com
[2] Centro de Ciências da Saúde, Universidade Federal do Recôncavo da Bahia. Santo Antônio de Jesus BA Brasil.

Introduction

A little-explored fact from the history of mental health was recently analysed by Desviat[1]: in current times, points of paradigmatic inflection addressing madness – usually known as "Psychiatric Reform" (PR) – are intimately connected to eras of crisis on the wider historical and social scene. He cites Amarante[2], asserting that:

It was thanks to the concept of crisis that preventative psychiatry assumed the features of a proposal for community mental health, in which teams at mental health centres began to take on the role of community consultants, identifying and intervening in individual, family and social crises (Desviat[1]).

Historical precedents, therefore, demonstrate that society's own view of madness often changes during periods of crisis. Desviat[1] uses the United States as an example: the country experienced a significant crisis due to the Vietnam War, with repercussions from the May 1968 events in France, as well as the terrible welfare conditions inside psychiatric hospitals. He concludes with a critique of the North American community psychiatry, resulting from the absence of a social protection and public health system capable of facing up to the challenges posed. At the same time, he highlights the important framework of the "emergence of deinstitutionalization"[1] even when reduced to de-hospitalization. In the same way, in France "(…) it is not by chance that the idea of the sector was developed on the day after the Second World War, by psychiatrists who, in huge numbers, had resisted or been deported"[3].

Together with the historical analysis in another seminal text by Desviat[4], these examples lead to some reflections: 1) PR is generally born out of moments of social, political and sanitary crisis, which produce and evidence vulnerabilities and tensions in the social fabric; 2) PR can not be reduced to a reorganization of the welfare model, since, in order to be more effective, the problems it reveals require structural changes to the framework and micro sanitary and intersectoral policies; 3) in order for PR to address, within the sphere of healthcare and welfare, the complex nature of the (psychic, social, political, economic and physical) crises that affect subjects, it needs to act according to a territorial, psychosocial, deinstitutionalizing and anti-asylum logic to avoid masking the conflicts and determinants of crises that may lead to the segregation of individuals or the medicalization of complex problems.

To a greater or lesser extent, PR movements provide evidence of a process that operates within the various dimensions of a country's social and political context, but which may also have an effect on people's lives, triggering a movement for liberation from situations of oppression and confinement, providing empowerment and social re-inclusion experiences and stimulating cultural transformations towards the acceptance of difference and the construction of a new social location for madness. From an economic perspective, such movements may confront market and private interests linked to the madness industry, which profit from the confinement of individuals, but are also connected to the pharmaceutical industry, which in turn profits from the excessive pathologization and medicalization of mental distress.

Since they have generated a whole gamut of tensions, no PR movement has been seen as a definitive historical victory. Such movements have suffered constant rejections and attacks, whose capacity to destabilize and disrupt their action rely on innumerable social, historical, cultural and political variables.

In a review of a number of PR movements in European countries and the Americas in the decades following the Second World War, Torrenté[5] identifies the recurrence of elements that pattern seven critical and converging nodes in Psychiatric Counter-Reform processes: 1) mere de-hospitalization; 2) bureaucratic drift; 3) fragmentation of reform; 4) neo-liberal instrumentalization; 5) ideological discontinuity; 6) one-track thinking and the homogenization of practices; and 7) the return to total institutionalization (even outside the institution's walls).

In the case of Brazil, Counter-Reform of the sanitary system was defined by Monteiro[6] as the actions of actors opposed to the constitutive decisions of the Unified Health Service (*Sistema Único de Saúde*: SUS) which "reflected different types of undercover institutional changes, the result of an active and constant political mobilization of those actors opposed to the wide-scale reform of the health system".

Counter-Reforms are paradoxical effects, that is, effects not expected by the social forces that conceived of, attained and implemented the PR in question. In other contexts, however, these have resulted in more or less prolonged and sometimes radical paradigm struggles. In the most extreme cases, they have relied on the reappearance of asylums or the function of the asylum, effecting transformations to the core of

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the healthcare model, through the hegemony of the biomedical model, with an emphasis on a biological explanation of illness and its therapeutic correlates. Counter-Reform may therefore be defined as a complex socio-political and cultural process which provides evidence of a correlation of forces and interests that strain or even reverse the transformations produced by PR, in terms of the four dimensions proposed by Amarante[7]: epistemological, care-technical, political-legal and socio-cultural.

In Brazil, the greatest wave of opposition to PR has taken place from 2017, with Decree GM/MS 3.588[8]. However, since its inception in the 1970s and 80s, Brazilian Psychiatric Reform (BPR) has opposed the interests of groups and agents who, for their part, have acted and manifested according to historically engendered forces. The social, political and economic crisis of recent years has followed a wave of austerity and minimum state policies of neoliberal, rentier and globalized capitalism and is managed nationally by political groups in line with this ideology. In the field of mental health, the response to the current crisis is manifest in changes to political and legal proposals, whose repercussions are the dismantling of the Psychosocial Healthcare Network (*Rede de Atenção Psicossocial*: *RAPS*).

In this article, we will explore data related to the political, legal and welfare changes within mental health, demonstrating the Counter-Reform's processual effects. We will briefly discuss Bahia as a paradoxical case of "Counter-Counter-Reform", because of a recent proposal from state health managers to close all psychiatric hospitals as part of their stated intention of the deinstitutionalization of hospitalized individuals, which does not coincide with the current political moment in Brazilian mental health.

Methodological considerations

Our research is based on documentary analysis. At the national level, we examined the following official documents, which redefine the Psychosocial Healthcare Network from 2017 onwards, marking a break from BPR's purposes: Decree GM/MS 3.588[8], Technical Note 11/2019[9] and Federal Law 13.840/2019[10]. At local level, we used documents that established the Inter-institutional Commission for Deinstitutionalization Planning in the State of Bahia (*Comissão Interinstitucional de Planejamento das Ações de Desinstitucionalização no Estado da Bahia*: CIPAD)[11,12], minutes from the commission's seven working meetings – which took place between April and August 2017 –, the State Mental Health Plan, and minutes from the State Health Council which discussed and approved this plan[13]. We also analysed the legal framework (Decree 543/2018[14] and Decree 352/2019[15]) promulgated in the State of Bahia's Official Gazette as a result of work initiated by the CIPAD and developed by the Bahia State Health Department's (*Secretaria da Saúde do Estado da Bahia*: SESAB) mental health technical team, which presents the position of a number of social actors as regards the three related themes: Reform, Counter-Reform and Counter-Counter-Reform. All the documents we consulted are of public and unrestricted access.

Brazilian psychiatric reform: progress, stagnation and retreat

BPR represented a memorable social achievement and a civilizing advance. Over three decades, the different sectors of the anti-asylum movements managed to construct a counter-hegemonic proposal for National Mental Health Policy, previously focused on hospital care. The first 15 years of the 21st century were very high-spirited for the BPR movement – the result of both a historical struggle and a favourable political climate, translated into highly progressive and internationally recognized mental health policies[16].

Gradually, official Ministry of Health (MH) documents began to incorporate terms such as "deinstitutionalization" and "psychosocial care"[17,18]. It is well-known that the MH never openly advocated for the absolute extinction of psychiatric hospital beds. However, the direction in which action was taken over this period suggested the construction of a strong model able to turn the psychiatric hospital (PH) into an obsolete part of health policy gearing.

Public oversight, as represented by the final documents from the four National Mental Health Conferences (*Conferências Nacional de Saúde Mental*: CNSM), was always favourable to the extinction of psychiatric hospitals. The Report of CNSM-III, in 2001, suggests that one should "dispense with the psychiatric hospital" and that, by 2004, all beds in psychiatric hospitals should be extinct[19]. For its part, the Report of Intersectoral CNSM-IV, in 2010, reasserts:

the effectively public nature of Mental Health Policy, rejecting all forms of outsourcing of service network management. In this sense, it makes man-

agers, at the three government levels, responsible for the development and sustainability of Mental Health Policy… (SUS, CNS[20]).

This report advocates funding for psychiatric beds in general hospitals, in parallel with the prohibition of an "increase in financial resources for psychiatric hospitals"[20]. If, on the one hand, the MH was never explicit about the extinction of PHs, on the other, public oversight recommendations made within institutional arenas (health conferences and councils) underpinned political decisions. This institutes a minimally democratic process in the construction of mental health policy, one of the strongest features of that period.

With Law 10.216[21], we see a real change in the welfare aspect of mental health, translated into an important network of services outside the hospital, inserted within the community and programmed to expand care practices and projects with a strong intra- and inter-sectoral relationship. This reversed the service funding curve, most specifically in 2006, in such a way that expenditure on services outside the hospital began to surpass hospital expenditure (Table 1).

With this change in the funding profile came a rise in the number of Psychosocial Care Centres (*Centros de Atenção Psicossocial*: CAPS) to the order of 1,722%, rising from 148 in 1998 to 2,539 units in 2017[22]. The Returning Home Program, which regulated rehabilitation benefits, currently in the region of BRL 412.00 per month for those leaving long-term hospitalizations, also expanded significantly: in 2003, there were 206 beneficiaries, in 2014, this number was 4.349[18], a rise of 2,111%. The number of Residential Therapeutic Services grew by 200% over three years, rising from 289 licensed units[18] in 2014 to 578 in 2017[23]. Added to this are new therapeutic practices, psychosocial technology, social participation strategies, rehabilitation and social inclusion, all of which have had concrete impacts on the lives of a significant number of people who experience psychic suffering, as attested by a substantial number of studies[24-27].

However, this series of processual advances, incomplete and unequally distributed across the nation, with varying levels of implementation, has been contentious, both because of the challenge represented by the transformations demanded by the reform movement itself, and from interests opposed to the solidification of anti-asylum and democratic psychiatric reform. The 2010 CNSM-IV Report provides a snapshot of these disputes, paying particular attention to "corporatist demands and, particularly in psychiatry, a new emphasis on the biomedical model and a weighty and explicit campaign against psychiatric reform"[20].

Signs of stagnation were already being felt. It is well-known that a significant barrier to mental health policy in Brazil is public funding. WHO considers that, in developed countries, average mental health spending are over 5% of the general health budget[28]. In Brazil, between 2001 and 2012, this average remained between 2.3% and 2.5%[29]. According to Gonçalves, Vieira and Delgado[30], in 2001, Brazil's mental health budget was BRL 1,003 billion; by 2009, this had reached BRL 1,517.9 billion, representing a jump of 51.2% over the period.

However, in presenting its "New Mental Health Policy", the MH stated that, in 2017, the budget for mental health was approximately 1.6 billion, varying by less than 3% over a 7-year interval[31]. In 2013, the proportion of mental health spending in the general MH budget fell to 2.1%, decreasing again to scantly 1.6% in 2016[31]. Chronic underfunding has begun to have an impact, both in hindering network expansion and in the deterioration of existing services; this has compromised the effectiveness of the reform itself, which began to receive criticisms from opposing sectors.

With changes to the correlation of political forces in the Federal Government, such interests have gained voice, power and emphasis within the official Ministry of Health political agenda. In 2015 already, the first change in course was an-

Table 1. General policy expenditure (in percentage).

Type of Expenditure	1997	2001	2006	2010	2013
Out-of-hospital	6.86	20.46	55.9	70.57	79.39
In-hospital	93.14	79.54	44.1	29.43	20.61
Total	100%	100%	100%	100%	100%

Sources: Brasil[17] e Brasil[22].

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nounced, symbolized by the nomination of a historical defender of the asylum model as National Mental Health Coordinator. Less than three years after these first signs, patent setbacks to Brazil's mental health policy have occurred, including through legal instruments, initially expressed in Decree GM 3.588 of December 2017[8], which aims to reverse the psychosocial model guidelines. Since then, these changes have culminated in the presentation of new legal frameworks for mental health policy, which official Federal Government agencies and the Chamber of Deputies have called the "New Mental Health Policy", coupled with the 2018 constitution of a "Parliamentary Front in Defence of the New Mental Health Policy".

In terms of the asylum interests at play on the current Brazilian scene, it is important to understand that, although the current national mental health policy does not necessary re-establish the same asylum model that envisages the long-term isolation of people with mental disorders, it does not prevent their return. In relation to this, Decree GM/MS 3.588/17[8], assertively includes a place for PHs in RAPS, in contradiction to all decisions previously made for the planning and management of Brazilian mental health policy.

The new configuration brings together supposedly more advanced neurobiological treatments and the more archaic moral treatment, segregating and long-lasting, currently most forcefully aimed at illegal drug users, as laid down in Law 13.840 **of 2019**[10], which radically changes the national drug policy matrix and includes abstinence as its target and hospitalization, even when involuntary, as its method. This satisfies, on the one hand, the pharmaceutical industry, by strengthening outpatient clinics specialized in pathologies (with no criticism of the nosological inflation of the last decades, which reflects a cultural construction affected by economic interests and a de-contextualized reading of human suffering) and, on the other hand, Neo-Pentecostal religious communities, significant beneficiaries of public funding for therapeutic communities.

Psychiatric hospitals, now revamped as "modern and humanized" – as described in the MH Technical Note 11/2019[9] – strengthen the medical class, since the hospital-centric model is organized around psychiatry and the use of hard technology, either psychiatric drugs or ancient and recent surgical interventions. It is no exaggeration to state that, in all corners of Brazil or in remote and marginalized zones of cities, even this idea of "modern and humanized" care is just another brick in the wall of spaces insulated from the outside and therefore immune to public oversight, this being the major characteristic of those asylums that still exist in the country.

The new mental health policy and Counter-Reform

Through the government's post-impeachment political transition arrangements, since 2016 the National Department of Mental Health, Alcohol and Drugs has manifested behaviour contrary to part of the principles of the movement that inspired BPR. Here, we would like to highlight three aspects that provide evidence of what could be called Psychiatric Counter-Reform: 1) the current changes imposed to the guidelines of national mental health policy do not respect the historical flux constructed by public oversight, through either national mental health conferences or health councils. On the contrary, the CNSM III report stipulated the extinction of psychiatric hospitals in Brazil, a target that was never met. The "New Mental Health Policy" thus ignores one of the pillars of psychiatric reform, which is precisely democratization and social participation in decisions. The National Health Council itself approved "Recommendation No. 001, of January 2018", which demands the decrees structuring the "new policy" to be repealed[32]; 2) from 2017 onwards, the supposedly new mental health policy introduces the psychiatric hospital, not mentioned as part of RAPS in Decree 3.088/2011[33], as a recognized service, in contradiction to the historical advances of sanitary and psychiatric reform. On the Ministry of Health website's presentation of the "New Mental Health Policy"[31], we read that "deinstitutionalization will not be synonymous with the closure of psychiatric beds and hospitals any more"; 3) the MH, in intersectoral coordination with other ministries (Justice, Social Development) has created funding streams to pay for private services, such as those known as "therapeutic communities" (TCs), which in Brazil are aimed at people who use drugs. The privatization of scarce public funds is thus added to investment in the return of the asylum model, centred on moral treatment and isolation, taking us back to Esquirol's 19th century psychiatric doctrines.

The following events relating to the gradual formalization of the Counter-Reform took place in 2017 and 2018. In December 2017, Decree 3.588[8] introduced PHs and TCs as healthcare points in RAPS, while in August 2018, Decree

2.434[34] provided a generous readjustment of up to 62% in the pricing table for psychiatric hospitalizations, in order to redress psychiatric hospital budgets, in parallel with the freezing, since 2011, of monthly transfers for CAPS.

In March 2018, Resolution 001/2018 of the National Council for Drug Policy[32] realigned the National Alcohol and Other Drugs Policy and formalized support to civil society organizations who work with drug users, opening up a pathway for the public funding of TCs. In the following month, the same council published Public Notice 001/2018[35] in the Federal Official Gazette, calling for the accreditation of TCs and providing BRL 87 million to contract 7,000 beds, at values equal to or above those for psychiatric hospital beds.

In November 2018, Decree GM 3.659[36] suspended the transfer of financial resources that foster the monthly funding of some RAPS services, alleging that these were not providing information about productivity, leading to a shortfall in yearly funding of more than BRL 77 million; while Decree GM 3.718[37] demanded, for the first time, the repayment of funds that had been transferred and supposedly not carried out, reducing the RAPS budget by an additional BRL 43 million.

Promising opportunities of commercializing mental healthcare emerge from these changes, almost replicating the madness industry that was denounced in the 1970s. To some extent, this is already substantiated in some repetitions of the modalities that profit from madness, such as maintaining a large number of beds in medium-sized establishments and private services, while increasing the amount paid per bed.

The readjustment to the value of the Authorization for Psychiatric Hospitalization contributes to discourage de-hospitalization and deinstitutionalization processes in certain states and municipalities, where economic calculations prevail in administrative or political decision-making processes. The past commercialization of mental health is also repeated when massive investments are made in institutions, such as therapeutic communities, which continue to practice human rights violations, including forced labour[38].

Added to this are new forms of financialization[39], often related to closer links between the public and private sectors, including the government purchase of private sector services, such as the above-mentioned high-cost procedures, e.g. electroconvulsive therapy and transcranial magnetic stimulation[9]. Business groups and private interests have begun to compete with greater force and activity in this market. The multiplication of specialized outpatient clinics may also serve to increase the purchase of psycho-pharmaceuticals, as well as the promotion of focused and reductionist research, much of which bears the risk of molecularizing solutions to highly multi-factorial and complex human problems.

An analysis of changes made to the mental health policy in the last three years reveals a trap. There is no suppression of the use of relevant BPR signifiers; the words are the same as those used in the previous legal frameworks. New documents continue to pay lip service to a "psychosocial healthcare model", leading to the belief that there is a "new psychiatric reform". This requires analysts to be vigilant and remember the aphorism that "the devil is in the detail", in order to untangle what actually lies behind these terms. The "new reform" sells recycled antiquities from the period prior to BPR.

Following the BPR's trajectory, we can see that it has also had transmission effects on the restructuring of healthcare services in the private sector, particularly in the high-end market, demonstrating that changes have occurred to the way madness is treated by biological psychiatry, although some of these effects are more cosmetic than profound. However, when the current figures and priorities are unveiled, one rapidly recognizes the extent to which it is the very psychosocial, anti-asylum and territorialized healthcare model that is under threat.

In 2017, a draft of the Federal Government's "new policy" proposed an investment of BRL 240 million to expand services for alcohol and other drugs, with more than BRL 120 million for TCs, as opposed to BRL 31,752,720.92/year for network expansion and the creation of new territorial services[40]. In 2019, this rose to BRL 153.7 million for TCs alone. The government extended this to 496 accredited institutions, with an offer of 10,883 beds exclusively for psychoactive substance users[41]. On the other hand, in 2017, there were only 406 CAPS-ADs (for alcohol and other drugs dependency care)[42]. Through this change, TCs now exceed CAPS-ADs, resulting in an inverted curve compared to that observed in 2011, when the historical cycle of the hospital-centric model was overturned, in both number of services and funding priorities[22].

Taking into account the power of attraction of capital and of a communication approach that includes powerful bio-psychiatric lobbying in the mass media, it is not hard to envision the conquest of new followers and the inducement

of that sector of society that has never stopped associating madness with danger and chronic illness or maintaining a relationship marked by prejudice and stigma with this segment of the population. Neither should one discard the magnetism of the bio-medicalizing and sophisticated discourse of biological psychiatric. As we have asserted, these tensions persisted throughout the period of change brought about by BPR, over an extremely shorter time frame than the *longue durée* of the asylum model.

Signs of a Counter-Counter-Reform in Bahia?

In February 2017, the Bahia State Health Department (*Secretaria da Saúde do Estado da Bahia*: SESAB) announced a proposal to close the last state public psychiatric hospitals, in the form of an official correspondence (DGC No. 09/17) to various institutions and groups. The main reason, it stated, was that these hospitals had attained a lower score than that required for accreditation by the Annual Programme for the Restructuring of Psychiatric Hospital Care in SUS, which is 61%; the hospitals in question obtained less than 40%. Furthermore, the state administration would, it was suggested, "adopt the necessary measures to implement the process for deinstitutionalization and replacement of the healthcare model, based on the guidelines and items of the Psychosocial Healthcare Network"[11].

The announcement mobilized groups both in favour of and counter to the proposed changes. On one side, we find the Psychiatry Association of Bahia (*Associação de Psiquiatria da Bahia:* APB) and the Association to Support Families, Friends and Patients with Mental Disorders in Bahia (*Associação de Apoio a Familiares, Amigos e Pacientes com Transtornos Mentais da Bahia*: AFATOM), while, on the other, are the FrenteRAPS (a coalition bringing together a number of professionals, academics and users who defend the anti-asylum struggle) and the Association Walking Metamorphosis (*Associação Metamorfose Ambulante*: AMEA), a long-standing association of family members and users of mental health services. While the former position themselves against the closure of the hospitals, upholding the risk of lack of care and the defence of the role of the psychiatric hospital within the mental healthcare network, the latter are in favour of closure, if performed in a responsible manner, and use the opportunity to defend the expansion and strengthening of RAPS in Bahia.

Subsequently, SESAB set up an Inter-institutional Commission for Deinstitutionalization Planning in the State of Bahia (*Comissão Interinstitucional de Planejamento das Ações de Desinstitucionalização no Estado da Bahia*: CIPAD), as published in the Official Gazette of 31 March 2017[12], including a significant number of representatives from institutions with varying positions on mental health policy. CIPAD was also made responsible for drafting a State Mental Health Plan, an unprecedented move in Bahia, later officially approved by the State Health Council in December 2017[13] and published in the Official Gazette of 29 May 2018.

At the time of the promulgation of Federal Decree 3.588[8], a clear alliance could be observed between the National Mental Health Department and the Brazilian Psychiatry Association *(Associação Brasileira de Psiquiatria:* ABP), including its representatives in Bahia (APB), in support of the new policy changes. This had strong repercussions across the country, and greatly hindered the process that had been initiated in the state of Bahia.

Finally, moving in the opposite direction, Bahia publishes two instruments that indicate its inclination to follow in the steps of Psychiatric Reform: Decree No. 543/2018[14], which establishes monthly state financial incentives to fund CAPS III and CAPSad III, and Decree No. 33/2019[43], which institutes provisional and monthly state financial incentives to foster the creation and regular defrayal of Therapeutic Residential Mental Health Services.

Although it is true that psychiatric hospitals in Bahia have until now been maintained, and even strengthened through the new mental health policy, we have also seen progress arising from the process that has occurred. We note that the existence of a Mental Health Plan functions as an instrument for the defence of Psychiatric Reform, both through its legal nature and in the mobilization process it has triggered. Currently, the State Public Defender office has come in as a new partner pressing for RAPS progress, and CIPAD is once again called into action, now to monitor and evaluate the plan's implementation.

Final considerations

In this article we set out to exemplify the tensions generated by the Psychiatric Counter-Reform, at national level but also based on a concrete case, with its particular repercussions for the Psycho-

social Healthcare Network, although we agree that Psychiatric Reform goes beyond the reorientation of the healthcare model and its network of services.

PR is a process subject to advance and retreat, underlining its dynamic nature, as noted in international experiences. The threat, however, is not all-encompassing, since several achievements have taken root. In other words, if the reforms do not crystallize, their repercussions are still distinctly palpable, even in such a controversial political context. The processual constitution of epistemic subjects and innovative practices traverses the various (and, sometimes, intractable) historical and socio-political contexts imposed upon it. On a prospective basis, therefore, it is possible for the correlation of forces to be modified, as has been seen in the process of Counter-Counter-Reform witnessed in the state of Bahia.

Given that PR operates as a social inclusion policy, it is palpable that the current risk of a worsening in the sanitary, social and economic crisis around the country requires increased advocacy and mobilization measures in order to avoid the loss of guaranteed protection and social inclusion mechanisms, including within the open services network itself, ensuring more humanized and qualified care and a greater degree of autonomy. In other words, as well as generating powerful and legitimate concerns, the current crisis Brazil's mental health field is experiencing simultaneously provides an opportunity, as demonstrated by historical precedents, to reinvigorate a reform that had been in full flight.

Although historical time is slower and far exceeds that of the individual, it is nonetheless to be feared that the resumption of the BPR, with its political and ethical stand for the protection of life and against the violation of rights of those who experience mental disorders, will arise from a worsening of the socio-sanitary crisis in the country, as Desviat[4] warned when discussing the genesis of reforms. The repetition of history, in this case as farce, may involve serious harm for this social group, as observed and denounced by Basaglia in the 1970s, and take the form of a new Brazilian holocaust.

Collaborations

MO Nunes: data analysis, drafting and review of the article; JM Lima Júnior: data collection and analysis, drafting and review of the article; CM Portugal: initial design, drafting and review of the article; M Torrenté: drafting and review of the article.

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