

## From “mentally ill” to “citizens”: historical analysis of the construction of political categories in mental health in Brazil

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**Abstract** *Public policies are based on categories that have a double effect: build eligibility for rights and generate symbolic effects, reproducing or fighting social stigmas. This article aims to analyze the historical setup of categories targeted in mental health policies in Brazil. Based in a study of the legislation from 1841 to 2017, we observed how was the processes of constructing the political categories of mental health – passing from users to citizens or mentally ill. The processes of control of public policies were selected for the respect of users of mental health policy, the social framework of data and the criteria for access to policies and the construction of social stigmas. The analysis shows important changes in these categories over time that tried to remove stigmas based on new conceptions proposed by social movements of mental health, international policies and social changes, such as Brazilian re-democratization. However, we also highlight the difficulty of effectively coping with stigmas due to the lack of consensus in the field itself, resistance to changes in social categories, family members and health professionals.*

**Key words** *Political categories, Mentally ill, Citizen*

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## Introduction

State action is built by rules that make up the categories concerning the public served<sup>1</sup>. The rules divide the population by identity, behavior, or situations, constructing or reproducing categories that should receive differentiated treatment based on their characteristics. Public policies can be seen as a deliberate arrangement of the world from distinct treatments proposed for different categories, supported by rules<sup>2</sup>. If, on the one hand, this categorization process and the actions implemented it generates can be seen as a rational state action to facilitate policies, it becomes a potential problem given the need to reconcile equality and universalism – democratic ideals – with the differentiation required by policy operation<sup>2</sup>.

This is a more critical process if we think that categorization, besides generating different treatments, can also revert to (re)producing inequalities. This is because the state has a vital role in the construction, alteration, and legitimation of social categories from the public policies that it builds. Policies are the first tool by which government acts to institutionalize, perpetuate or change social constructs, and are how government can support or curb widespread social segregation and support practices, or punish disadvantaged groups<sup>1</sup>. Also, through policies, the state creates new categories that would not exist without the force of the law and end up becoming a social stigma.

Thus, policies can serve to both reinforce social constructs and to change them, affecting the social inclusion and exclusion of certain groups<sup>1</sup>. In this sense, Harrits and Moller<sup>6</sup> use a differentiation between the concepts of social categories and political categories. The former ones are the result of social regulation and reproduce in the broader social relationships of society. On the other hand, political categories are clusters produced by public policies that materialize state action. At times, social categories are reproduced by political categories. In others, political categories are used to confront social categories.

Political categories, therefore, play a fundamental role in understanding state action and its effects on inclusion and exclusion, both in material and symbolic terms<sup>7</sup>. On the one hand, they build eligibility for public rights and services by determining who can access what. On the other hand, they produce symbolic effects, considering the stigmatization that can be (de)constructed by eligibility<sup>1,4</sup>. This is what can happen, for ex-

ample, with the classification in the category of “poor beneficiaries”<sup>10</sup>, “pregnant teenagers”<sup>11</sup> or the “mentally ill”. Thus, eligibility can become access, but it can also become stigmatization of social groups categorized by policies.

Considering, therefore, this dual effect of categorization processes in material and symbolic terms, this paper aims to analyze how the classifications around those eligible for mental health policies in Brazil have been constructed historically. Therefore, we start from the analysis of two categories: citizen and mentally ill. The category of citizen is understood as a political social identity, a subject recognized by a nation-state as an integral part of their society and whose civil, political and social rights are guaranteed<sup>12</sup>. The mentally ill is understood as an individual who is sick, irrational, who must be protected and regulated. Both categories are historically antagonistic. It is hypothesized that, initially, through the mental health policy, the state built the category of users of these services linked to the concept of mentally ill considered as “crazy, degenerate, dangerous and incapable” – individuals who had to be excluded not to disturb the social order. This category was modified in light of the idea of citizenship and inclusion over the years.

Although the history of mental health is a hotly debated topic in the literature, the innovation of this paper lies in setting the analysis within the broader scope of public policy and categorization processes. Thus, instead of looking at the policy contents, we analyzed how the eligible audiences were built from a contrast between political and social categories. Therefore, we analyzed the Brazilian legislation between 1841 and 2017, observing how the processes of construction and change of the political categories of the users of the mental health policy occurred. It is assumed that the type of social and political framework affects access to public policies and whether or not rights are guaranteed. From the historical analysis of changing political categories, we sought to understand to what extent they approached or faced social categories over time, proposing who could be classified as mentally ill or citizen. Approaching these concepts reinforces or fights against the stigmas suffered by this population, facilitating or hindering its social inclusion. As Schneider and Ingram<sup>1</sup> point out, “the history of disability exclusion thus illustrates the relationship between public policy and the social construction of certain groups as deserving and entitled”.

## Methods

This is an exploratory and qualitative study. The processes of change of the political categories concerning mental health policy users, the social framework assigned to them, and their effects on access to policies and construction of social stigmas were analyzed.

The 24 central legal norms (identified in Chart 1) that supported the construction of the Brazilian mental health policy were selected for analysis. The selection considered its centrality in the normative construction of the policy. The timeframe ranges from the opening of the first Brazilian psychiatric hospital to the last resolution published in December 2017. Given the importance and influence of the National Mental Health Conferences for the field, we decided to include the Final Reports of the four conferences, and employed the content analysis method in our review<sup>14</sup>.

Firstly, the political category was mapped in the legal category by identifying the beneficiary and the concept/term to which it is referred. In the second stage, summarized in Chart 1, the

frameworks were analyzed based on the categories of citizens and mentally ill. A citizen is understood here as a political social identity of a subject recognized by the State as part of society, with assured civil, political and social rights<sup>7</sup>. The mentally ill is the individual considered ill and irrational and in need of guardianship. In the third stage, the history of the use of political categories of mental health policy users was reconstructed to analyze its impacts on the framework assigned to these individuals, that is, the construction, the restatement, or deconstruction of stigmas. In the fourth and last stage, through secondary data from research carried out by third parties, we analyzed the maintenance of stereotypes perpetuated by mental health professionals and other citizens after changing the political categories.

## Results and discussion

### Categorizations and public policies

Categorization can be defined as a cluster of objects sharing common, particular characteris-

Chart 1. Analysis of categories.

Name of legislation	Political categories of beneficiaries	Actions implemented/proposed to policy beneficiary	Is there any path in the law to cope with social categories of politics?
Decree nº 82 of 1841	Persons of unsound mind. Category: mentally ill.	Specific care for individuals considered persons of unsound mind	No.
Decree nº 1.132 of 1903	Persons of unsound mind. Distinction: common mentally ill and those who have committed a crime. Category: mentally ill.	Regulates internment: required by public order or some private individual. Hospitalization as a way of upholding public order, the security of the population.	Ratifies the stigma of dangerous by justifying that internment aims at upholding public order or the safety of the population.
Decree nº 8.834 of 1911	Persons of unsound mind and mental diseases, congenital or acquired.	Insertion in public colony facilities for "destitute persons of unsound mind". Brings the conception of productivity/work.	Ratifies the stigma of dangerous and unproductive.
Decree nº 14.831 of 1921	Convicts with symptoms of madness. Category: mentally ill.	Regulates the internment of convicted criminals who are diagnosed with a mental disorder.	Links crime to madness. Reinforces the stigma.
Decree nº 24.559 of 1934	Psychopaths, abnormal minors and drug addicts. Category: mentally ill.	Regulates mental health services. Regulates the modalities of detention and civil interdiction. Mentions for the first time the hospitalization of minors.	It ratifies the stigma of dangerous, disturbing social order and morals. Introduces the concept of disability.

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**Chart 1.** Analysis of categories.

<b>I National Mental Health Conference of 1987</b>	Mentally ill, individuals considered mentally ill and users. Category: citizenship.	Integrated health actions; Expanded financial and technical resources; Prioritization of extra-hospital activities; Installation of psychiatric units in general hospitals; Organization of rehabilitation and resocialization programs; Avoid bedding; Training of technicians in the primary network.	Expanded mental health vision beyond the hospital focus; Discussion about users' citizenship rights.
<b>Ministerial Ordinance n° 189 of 1991</b>	Mental health service users. Category: citizenship.	Diversifies services beyond hospitalization: allows hospitalization in general hospitals, CAPS, and treatment in therapeutic workshops.	Possibility of out-of-hospital treatments and help to overcome the stigma of the need for exclusion.
<b>Ordinance/ SNAS n° 224 of 1992</b>	Mental health service users. Category: citizenship.	Regulates outpatient services (UBS, CAPS, and NAPS), Day Hospital, Emergency Care in General Hospital, Specialized Hospital. Prohibits the use of strong prison cells and restrictive spaces; inviolability of correspondence and treatment records.	Provides for the humanization of care and the preservation of citizenship rights. Reinforces the citizen category.
<b>II National Mental Health Conference of 1992</b>	Mental Health Policy Users. Category: citizenship.	The applicable Brazilian mental health legislation clashes with the new practices of care and citizenship of users. Recommendations: a) revoke Decree 24.559/1934; b) regulate the Municipal Organic Laws concerning mental health care.	Comprehensive mental health care, treatment vision beyond the psychiatric/ biological sphere; reinforces the need for user participation and citizenship rights.
<b>Law n° 8.742, dated December 7, 1993</b>	Disabled person. Category: citizenship.	Establishes BPC for people with disabilities and older adults	Promotes financial aid for social inclusion.
<b>Ordinance n° 106 of 2000</b>	Person with mental disorders. Category: citizenship.	Creation of Therapeutic Residences for former psychiatric hospital patients.	Promotes housing alternative during the social reintegration process.
<b>Law 10.216 of 2001</b>	People with mental disorders. Category: citizenship.	Provides for rights; regulates modalities of hospitalization and states that the treatment aims social reintegration. Establishes the progressive replacement of beds with a community psychosocial care network.	Ratifies rights and that the purpose of "treatment" is social reintegration and not exclusion.
<b>III National Mental Health Conference of 2002</b>	People with mental disorders. Category: citizenship.	Strengthening the Psychiatric Reform Proposal. Health services integration and comprehensive user care	Replacement of the asylum model; social participation and control; guarantee of users' rights; comprehensive care.
<b>Ordinance/ GM n° 336/2002</b>	Mental health service users. Category: citizenship.	Extends the modalities of out-of-hospital services.	Strengthens out-of-hospital and comprehensive care. Fights against the asylum model.

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Chart 1. Analysis of categories.

<b>Federal Law nº 10.708 of 2003</b>	Former patients of interaction in psychiatric hospitals and asylums. Category: citizenship.	Installs financial aid for psychiatric hospital former patients.	Reverse internment policy and financially assist former patients during social reintegration.
<b>Ordinance Nº 2.077 of 2003</b>	People with mental disorders. Category: citizenship.	Regulates the registration of the assisted and the responsibility of the municipalities on the implementation of the program.	Reverse internment policy and financially assist former patients during social reintegration.
<b>Ordinance nº 52 of 2004</b>	Patients. Category: citizenship.	Bed closures and strengthening of the outpatient model.	Helps to combat the asylum model
<b>Ordinance nº 1.190 of 2009</b>	Psychoactive substance users. Category: hybrid	Regulates services and the construction of the Emergency Plan to Expand Access to Treatment and Prevention in Alcohol and other Drugs in the SUS	Emphasizes the treatment of psychoactive substance users in the mental health policy.
<b>IV National Mental Health Conference of 2010</b>	People with mental disorders. Category: citizenship.	Reaffirms the field of mental health as multidimensional, interdisciplinary, interprofessional, and intersectoral, comprehensive social care and health. Reinforces interfaces with the fields of human rights, social assistance, education, justice, labor and solidarity economy, housing, culture, leisure, and sports, and the like.	Broadens the understanding of health beyond the biological perspective, seeking an interdisciplinary and community-based and inclusive treatment approach.
<b>Ordinance nº 3.088, of 2011</b>	People with suffering or mental disorders and needs arising from the use of crack, alcohol, and other drugs. Category: citizenship.	Structuring a network of mental health services.	Building a community, comprehensive service network. Deinstitutionalization strategy. Removes the psychiatric hospital and exclusion from the mental health treatment center.
<b>Ordinance nº 3.090 of 2011</b>	Graduates of interaction in psychiatric hospitals. Category: citizenship.	Regulates on-lending for funding and implementation of Therapeutic Residence Services.	Encourages deinstitutionalization, social reintegration of former patients and care in outpatient services.
<b>Ordinance nº 131 of 2012</b>	People with needs arising from the use of crack, alcohol, and other drugs. Category: hybrid	Regulates the establishment of institutions for the hospitalization and treatment of psychoactive substance users.	Confirms the need for inpatient treatment for psychoactive substance users.
<b>Resolution nº 32 of 2017</b>	Mental health service users. Category: hybrid	Readjust the value of beds in psychiatric hospitals.	Reintroduces the hospitalization regime for RAPS and leaves gaps for the paralysis of the deinstitutionalization strategy.

Source: Authors' elaboration.

tics and differing from other clusters. The categorization process builds belonging and boundaries between the included and the excluded in specific categories<sup>5</sup>. The daily action of the state is intrinsically based on categorizations, which can be found in policy and service operating rules<sup>5</sup>. These categories organize the social world based on identities, belonging, and social, economic, or material characteristics.

There are two types of categorization: social and political<sup>5</sup>. The first is marked in broader social relationships and reflected in the way social groups interpret and relate in particular economic, symbolic, and moral contexts. They are created in the interaction between processes of self-identification and identification of the “other”, as well as in the relationship with primary sociability, family, medicine and market relationships<sup>3</sup>.

Political categories appear in the operation of the state, whether similar or different to social categories. Political categories create legitimacy as to which individuals may (or may not) access policies and thus construct meanings about how each expects to be treated in the face of state action<sup>5</sup>. Therefore, on the one hand, while political categories determine access to goods and services, on the other, they shape users’ identities and expectations of themselves and policies<sup>4</sup>. They are, therefore, constitutive elements of public policies because they influence the distribution of sanctions and benefits and the construction of citizens’ identities, that is, they have material and symbolic effects<sup>4 5</sup>.

On the other hand, although with some degree of independence, it is not possible to unlink the production of political categories from social categories. Both are contextualized in a complex network of mutually influencing discursive and moral processes. Political categories can be constructed by reproducing social categories or by contesting and seeking to alter them. Thus, social categories are often a constitutive element of political categories, but public policies can be proposed precisely to change social categories<sup>1</sup>.

The analysis of the construction of political categories allows us to understand how, over time, the classification of more or less deserving users, with or without rights. In an analysis of the construction of the idea of “citizens” in American democracy, Schneider and Ingram<sup>1</sup>, for example, show how the construction of the idea of “disabled people allows understanding the relationship between public policy and the social construction of certain groups as rights’ holders”. As the authors point out, there is a double causality

between public policies and the social construction of deserving ones.

The authors also analyze how the political categories of the mentally ill and citizens were established in the mental health policy. Historically, the construction of these categories occurred in the institutionalization of psychiatry amid the Enlightenment, where the presumed irrationality manifested by the madmen was seen as disturbing the order and should be restrained and corrected<sup>1</sup>. The new institutional legal order in force determined new functions for the state. The Declaration of the Rights of Man and the Citizen emerges in this context, in 1789. Citizenship was an attribute of equal, rational, and normal, which excluded the mentally ill, dispossessed of reason, to participate in social decisions. This is when the first paradox emerges between madness and citizen condition when a specific conception of what normality would be like is built. Historically, this paradox was established with the advent of the French Revolution, since the recognition of the condition of full citizenship and social right (freedom, equality, and fraternity) did not encompass the mentally ill, as they were not equipped with rationality and should be assisted by the state<sup>27</sup>. Thus the madman is inscribed in the new political order as a being without reason.

It can be said that the categorization of the individual considered mentally ill in Brazil as irrational and incapable and, therefore, not a citizen, was within the framework of modernity<sup>10 7</sup> and of a broader construction of the social category of normality<sup>3</sup>.

### **Overview of the Brazilian mental health policy**

Currently, public mental health care is structured through a network of services called Psychosocial Care Network (RAPS) that, normatively, should prioritize community and territory-based care. This scenario is the result of a historical process that shaped advances and achievements in public policies not restricted to the mental health policy, but linked to the democratization of the country, struggles for rights and influence of innovations in mental health internationally. The main influencing movements were the Health and Anti-Sanatorium Struggle and Psychiatric Reform movements in the 1970s and 1980s that culminated in the establishment of the Unified Health System (SUS). This was followed by a gradual process to structurally reform the design of the mental health care model,

with the onset of psychiatric bed closures and the creation of an out-of-hospital replacement network<sup>30,31</sup>. Since then, reinforced by the new institutional devices, many advances have been witnessed in the mental health policy in breaking with asylum paradigms to overcome stigma and recognition of citizenship rights. According to Costa-Rosa<sup>32</sup>, such devices were based on a new mental health paradigm called psychosocial mode, which, among other aspects, does not consider madness an exclusively individual phenomenon, but also a social one. The extensive literature on the history of Brazilian mental health shows that this field has many contentions and contradictions<sup>11,12</sup>.

While recognizing the contradictions of this process, we believe it is essential to highlight here the historical changes and disputes surrounding the social and political categories that governed this process. The emergence of mental health policy in Brazil from the nineteenth century arose from the conception of madness as a social issue that required institutions and practices to control it<sup>35-16</sup>. Its history was related to the urban and economic development of the country. The idea of madness was linked to individuals considered disorderly and vagrants, becoming a concern of the authorities seeking urban space order<sup>13</sup> through the control of deviant behaviors that became a hindrance to modernization. Keeping in mind this historical overview of the emergence of mental health policy is critical to stress that this policy built on stereotypes and created new stigmas, resulting in the exclusion of citizenship status of these individuals.

### Political category and social category

The historical analysis of the legislation that permeated the construction of the Brazilian mental health policy allows us to observe how the political categories were constituted, how they underpinned or sought to transform the broader social categories, and how the process of building the citizenship of these individuals occurred. The following table summarizes these changes in the legislation and conferences, which will be discussed below.

Considering the legal framework of the Brazilian mental health policy between 1841 and the 1980s, references to individuals with some diagnosis of mental disorder are closer to the mentally ill category. The most commonly used terms were “alienated” and “psychopaths” to address this political category.

Two laws are worth mentioning: Decree No. 1.132, of 1903, and No. 24.559, of 1934. The former indicates the establishment of the Judicial Asylums and regulates that internment may be required by public order or some subject, and this action is justified by the need to keep public order, the security of the population and individuals. This reinforces the view that the target public of the mental health policy would be dangerous and disorderly, reinforcing the social stigma that these individuals must be detained in asylums and socially excluded. Thus, a new political category associated with mental illness was created, linking the identity of these individuals to irrationality and abnormality.

On the other hand, Decree No. 24.559, of 1934, was the first to address guardianship/tutelage, as well as the hospitalization of minors and individuals using psychoactive substances. It introduces the notion of civil incapacity, which further distances such individuals from the category of autonomous and rational citizens. Also, it replaces the denomination “alienated” with “psychopaths”, besides linking the use of psychoactive substances to the mental health policy. These changes generated a new kind of context in the policy category that associated a previously existing category (of mental illness) with new types of behavior (psychoactive substance use) also subject to social stigma. That is, subjects falling into the “crazy” category are broadened and diversified.

The analysis of the legislation until the 1970s allows us to verify that the political categorization of mental health acted in line with the precepts of science through the psychiatric discourse on rationality and, through the construction of the mental health policy and its legislation, legitimized the discourse of reason and reinforced the political target audience in the mentally ill category. An alignment between the political category and the social category, supported by a scientific basis for the construction of (ab)normality thus occurred. This process can be seen in virtually every legislation from 1841 to the 1970s. Besides the use of terms such as “alienated”, “mental illness”, “psychopaths” and “abnormal”, the type of action implemented was based on the scientific conception about the treatment given to this abnormality: isolation and hospitalization.

As explained by Schneider and Ingram<sup>1</sup>, public policy-elected categories can shape identities and influence social categories by constructing stigmas based on the differences between categories of people. Thus, the mental health policy

of the time reinforces the idea of treating what is considered “abnormal” from a physical separation from the “normal” ones. It also served to link the identity of the subject considered crazy to the stigma of dangerous and irrational, as well as linking the ideas of crime and madness. Such actions influence the social category by generating a discourse that legitimizes the state’s action against what is considered abnormal behavior.

The confrontation with these categorizations begins simultaneously with the re-democratization process when workers, users, and family members begin to debate politics in the fight against stigma, through the creation of new social categories. The analysis of this period allows us to identify a significant change in the categories previously attributed to these individuals. The most commonly used reference is that of users – an individual who makes use of a specific public policy – a term that becomes a common denomination to the public of post-1988 Constitution policies, referring not to a simple service consumer, but a citizen accessing certain rights. Thus, the then users of mental health services were considered as rights-holding citizens.

Also, during this period, a theoretical and political renewal occurs in social movements that seek more independent organization forms, distancing themselves from the state and encouraging the participation and organization of entities formed by users and their families. A democratic action was sought, giving voice to these actors who had not previously participated in decisions about treatment.

The Conference reports evidenced how the notion of citizenship amid re-democratization influences the search for policy changes. The First National Conference on Mental Health (1987) was one of the first steps to overcome the mental health policy vision beyond the asylum focus, the search for alternatives, and the discussion on citizenship rights of users. It was the onset to overcome the stigmas of “incapable” and the need to exclude the social environment, that is, the creation of a new inclusive social category and a social movement that sought to surpass the political categories that imprinted exclusion and the violation of human rights.

The Second Conference (1992) played a central role in the debate on the category of citizenship and the change of the political category by concluding that the then legislation applicable to mental health conflicted with the new care practices and the pursuit of citizenship. The conference report is based on the concept that citizen-

ship is exercised by encouraging participation so that users can exercise their rights. Also, a review of legal bases that reinforced exclusion was proposed.

Legislation enacted in the 1990s changed the political category by shifting from the category of “mentally ill” to the category of “citizenship”. The following laws contributed to the attempt to break the stigma of irrationality and dangerousness and sought to guarantee the social and civil rights of this portion of the population. Two legislations especially deserve attention: Law No. 8.742/1993, of Social Assistance, and Ordinance No. 106/2000, of the Ministry of Health. The first regulated, among other items, the Continuous Cash Benefit (BPC) to the disabled and the elderly. The second legislation established the Mental Health Therapeutic Residence Service (SRT) to assist former patients of Psychiatric Hospitals and residents of the Custody and Psychiatric Treatment Hospitals (HCTP). Linked to social and civil rights, this service aims to guarantee housing for these individuals and their return to social life.

Law No. 10.216/2001, which provided for the protection and rights of people with mental disorders, and redirected the mental health care model, was the first legal turning point of a policy that reinforced the exclusion of its target audience for action aimed at inclusion by encouraging outpatient treatment and user maintenance in the community environment. Based on the new legislation, Ordinance No. 336 established outpatient care modalities defined by size, location, and complexity of care and was published in 2002.

Two more legislations followed the breaking line of asylum paradigms: Law No. 10.708, of 2003, and Ordinance No. 52, of 2004. The first established assistance for the rehabilitation of patients suffering from mental disorders formerly hospitalized through the *Volta para Casa* (Going Home) Program, regulated by Ordinance No. 2.077/2004. This benefit qualified the de-institutionalization policy that began with the creation of SRTs and supported individuals in their social inclusion and combating the negative consequences of exclusion, chronification, and breaking of family and social ties. The second legislation established criteria for the gradual reduction of psychiatric beds, strengthening out-of-hospital care, and inclusive policy. Thus, both norms collaborated to combat the treatment model focused on hospitalization and social exclusion.

After several advances in mental health policy



that imprinted an inclusive policy and a categorization that reinforces the concept of citizenship, the ensuing legislations were more contradictory: some reinforced this process, and some did not. The legislation that had a hugely positive impact was Ordinance No. 3.088/2011, which established the Psychosocial Care Network (RAPS) for “people suffering from or with mental disorders” and with needs arising from the use of crack, alcohol and other drugs under the SUS. This network enables comprehensive and interdisciplinary care in mental health care. It integrates specific mental health services with other SUS services at all levels and complexities. It was established on the same day as Ordinance No. 3.090, which provided for the costing and implementation of SRT within the RAPS.

According to Costa<sup>38</sup>, in times of restricted rights, RAPS has been considered a breakthrough by the movement of mental health workers. However, it focuses on changing the care model and “the social struggles that are currently being fought in the field of social policies, and especially in mental health, cannot break the previous model [...] it is not possible to achieve an effective break with the asylum paradigm”<sup>10</sup>. Among the justifications are the maintenance of medical, biomedical logic, and the transfer of the asylum paradigm to the CAPS by professionals. This evidences the difficulty of the current legal norms to change the previous political categories and the resistance of a group of workers.

Concerning the legislation that has led to a return to political categorization linked to the concept of the mentally ill and promotes its exclusion, some are related to drug policies. Ordinance No. 1.190 of 2009 established the Emergency Plan for Increasing Access to Treatment and Prevention in Alcohol and other Drugs in the SUS. This policy advances the debate by proposing that the treatment of psychoactive substance use be incumbent upon the mental health policy. However, one of the objectives of the Intra and Intersectoral Articulation axis is the holding of the national workshop for articulation with Therapeutic Communities (TC) and NGOs, as well as the creation of criteria for regulating vacancies for hospitalization in TCs, which goes against the Reform’s precepts, reintroducing hospitalization as a treatment option. Along the same lines, Ordinance No. 131 was published in 2012, which again reinforced hospitalization for cases of treatment of alcohol and psychoactive substances.

Finally, sixteen years into the enactment of Law No. 10.216/2001, which regulated psychi-

atric hospitalizations and promoted changes in the care model for patients with mental distress, the Tripartite Interagency Committee (CIT) approved Resolution No. 32/2017, which reintroduced the psychiatric hospital into the Psychosocial Care Network and strengthened the Therapeutic Community. This legislation is a setback in the inclusive policy that was being consolidated by the Ministry of Health.

As can be seen from the analysis of the legislation, the policy against alcohol and drugs has been gaining more and more space for some ten years now in the field of mental health, and its care strategy has again brought a care model that replicates the asylum logic that was being fought. Its construction has been guided by a group ideologically opposed to the PR, with a discourse that psychiatric de-hospitalization promoted the lack of assistance to users<sup>10,41</sup>.

The historical analysis of the Brazilian legislation on mental health allows us to affirm that there were three moments of change in the political categories associated with different service models. The first occurred with the birth of the policy itself, in line with both the medical discourse (birth of social medicine and biomedical discourse on reason) and the political one (rationality as a prerequisite for the exercise of citizenship) then in force. At this time, the political category was approaching the concept of the mentally ill, that is, the irrational and dangerous that had to be removed from social life and admitted to the asylums.

The second moment occurred in the late 1970s and early 1980s, based on the idea of citizenship, central to the re-democratization process, with social movements that influenced the transformation of a policy that until then was based on the social exclusion of its target audience. This change was initiated bottom-up through the social movements that guided the transformations and managed to approve a set of new legislation and policies aimed at a new kind of political categorization that approached the concept of citizen and at the same time faced the broader social category and the ideas of abnormality and irrationality.

The third moment, the current one, is the most complex because it is still a new moment and hard to interpret. While services implemented with the Psychiatric Reform are ongoing, there is evidence of a return to the old model with the resurgence of hospitalization services, especially for users of psychoactive substances, and with a tendency to resume the political category linked

to mental illness. According to Amarante<sup>42</sup>, the resolution “practically revives the asylum model and initiates a dismantling of the entire process built over decades within the Brazilian Psychiatric Reform”.

An essential element identified in this analysis is that, from the second moment, the policy itself incorporates as part of its objective the coping with broader social categories based on stigma and exclusion. Thus, since the 1990s, the conception of citizenship appears in practically all the norms of the policy. This is associated with a set of strategies to address exclusion and stigma, such as the idea of social participation of users, reinforcement of the guarantee of rights, social reintegration, and a community and inclusive perspective. These elements resulted in putting on the agenda a new position of the State regarding the treatment of the mental health issue and the context setting of the normality of this population, which is now seen as a citizen and bearer of rights that demands specific care given its needs.

#### **Consequences of political categories in combating stigma**

Although the normative analysis shows that there were essential proposals for changing political categories to overcome social categories, this process is not linear and is full of contradictions. Thus, it is important to analyze to what extent the changes from the categories of “crazy” to “citizens” actually turned into real changes in policy implementation. In this section, we analyze, from secondary data from other research, to what extent changes in political categories have tackled social stigma.

As stated, the political category of the first phase cannot be unlinked from the social category that created and perpetuated the stigma of these individuals as dangerous and mentally ill. Although in normative terms the change of this political category is evident, and public policies have tried to change the stigmas of the social category, there are still a lot of resistance and barriers to the effective social inclusion of these individuals and the definitive breaking of their stigmas. It is important to emphasize that the bibliography of the field also points to challenges in this asylum culture change process, either in the social field or in the implementation of the policy itself. Research on the stigma and stereotypes of mental health users evidences their persistence in both society and professionals in the field.

Gomide *et al.*<sup>43</sup> noted stereotypical beliefs about alcoholics by the treating professionals: beliefs that they have no willpower and that they are morally weak people. In empirical research evaluating the representation of mental health users by family professionals, Maciel *et al.*<sup>44</sup> state that more than 80% of the health professionals surveyed considered mental health users aggressive and without judgment/without reason, which reinforces that his judgment on mental health is anchored in the notion of rationality. On the other hand, 64% of relatives considered them without judgment and 48% aggressive, which leads us to think that while they see the need to take care of these individuals under tutelage, a particular aversion by considering them aggressive (violent) is observed. Regarding hospitalization in psychiatric hospitals, Maciel *et al.*<sup>45</sup> observed that professionals and relatives have a favorable view of stating that hospitals take care of and protect their residents.

In a specific study on schizophrenia-related stereotypes, Loch<sup>46</sup> noted that most psychiatrists, as well as most of the general population, stigmatize individuals with schizophrenia, establishing a discriminative culture.

Cusinato<sup>47</sup> identified within a CAPS a portion of workers who eventually reproduced and naturalized the asylum logic in the service. Some had contradictory conceptions, sometimes advocating anti-asylum practices, sometimes dissonance, depending on the theme addressed.

These studies allow us to state that, while the political categories have changed over the years, and sought to combat and modify social stigmas attributed to mental health service users, the image of these individuals before professionals and societies is still associated with the stereotypes of dangerousness and incapacity. Notably, the maintenance of these stereotypes in the professionals' view is a critical factor for opening a space for the implementation of actions and treatments based on social exclusion, such as hospitalization, excessive medicalization, and an indication of civil interdiction. Such examples show how difficult it has been to overcome the social categories that strengthen stigmas even with a change in the political categories.

The justification for this maintenance lies in the lack of internal consensus in the field of mental health. That is, as it is a field of constant dispute, these changes – both in services and in the conception of the health and disease process – did not occur consensually among all actors involved. Spaces of resistance that still believe in

the hospital-centered model and the exclusively biological conception<sup>15</sup> are observed. Moreover, we cannot exclude from this analysis the market's force exerted on these disputes, either by expanding medicalization or by maintaining and creating new niches of state-funded internment institutions, such as the nearly 3,000 Therapeutic Communities existing currently<sup>11</sup>.

The analysis of legal norms and research suggests that the debate on whether or not to be a citizen in normative terms is no longer in question. This means that citizen status is already assigned to mental health policy users as a political category. However, controversial as it may be, stereotypes and stigmas remained in discourse and practice, influenced by broader social categories. The result of this new situation is the creation of citizens who are not indeed included in society.

### Final considerations

This article aimed to analyze how, historically, the public-related political categories of mental health policies in Brazil were constructed and changed. Besides a discussion about the content of the policy itself, already quite advanced in the literature, this paper sought to reconstruct the course of the policy from the changes of political and social categories linked thereof and point out the difficulty of overcoming the stereotypes and stigmas reinforced in the emergence of the mental health policy. To this end, we have analyzed legislation since 1841, noting its changes in the construction of specific audiences based on an understanding of the mental health event and its appropriate implemented actions. Thus, we sought to understand how the political categorization and its effects in the construction of identity, stigmas, and access to services were constructed and changed. We also looked at whether and how policies sought to address – or reinforce – broader social categories and the stigma attached to them.

What can be seen by analyzing the processes of transformation of political categories is that there is a normative change of these categories over the decades and, as a consequence, of the action implemented concerning this population. The central focus of this change is both the more general processes of the Brazilian State construction (re-democratization), and a modified scientific discourse on mental health itself influenced by the social movement. Since the 1990s, these two changes have brought about a rearrange-

ment of political categories and services, together with a confrontation with broader social categories and an attempt to reverse the social stigma associated with them.

Three processes were relevant to these changes. First, the role played by the social movements that influenced the psychiatric model supported by the scientific discourse, which played a fundamental role in this change, rearranging both the category and the service model offered. Secondly, more general and international movements to understand the event, which influenced the actions taken in Brazil. Thirdly, the process of re-democratization, which rearranged the subjects of the policy under the tone of rights. These changes together build both an essential modification to the way policy users are viewed and arranged and changes in the type of actions implemented to address them. These actions, in turn, were reflected in changes in the design and implementation of public policies for this audience that incorporated the changes in state action. Finally, the changes also built in state action a focus on the reversal of stigmas and broader social categories, so that public policies themselves incorporated the mission to address stigmatization that they reproduced from their political categories. However, as other research shows, this process is not linear and is fraught with contradictions. Due to the lack of consensus of the mental health field itself, among other factors, change in social categories has met resistance in the society itself, relatives, and professionals in the field. That is, while political categories have changed, they have not yet overcome stigmatizing social categories.

Thus, aiming at the analysis of mental health policies, we managed to understand how the process of political categorization has changed over time and how it is inherent and essential for understanding state action. This analysis allowed us to understand how the state is transformed in the light of the processes of construction and change of the political categories mobilized by it. In the specific case of mental health, it allowed us to understand how the state reacted to broader and stigmatizing social categories, either to reinforce them or to create policies to address them.

The historical analysis of political categories allows us to understand how the broader transformations of society and sciences take place and how these changes are reflected in changes in public policies.

Finally, despite having started in the seventies, we can state that changes in the mental health policy did not occur consensually and still

have a long way to go. This is due to the thematic complexity that involves economic, historical, political, and cultural processes that aim to transform the relationship between society and madness, a relationship still based on maintaining stereotypes, creating excluded citizens.

### **Collaborators**

MIS Costa and GS Lotta contributed to the research, methodology and final writing of the article.

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