

## Dilemmas and challenges for implementing global mental health policies in Brazil

Dilemas e desafios para a implementação de políticas de saúde mental global no Brasil

Dilemas y desafíos para la implementación de políticas de salud mental global en Brasil

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In 2007, the first series on mental health in *The Lancet* was published as part of a larger effort to highlight the global scale of mental health problems and to urge international partners to join this “broad new social movement” to strengthen mental health <sup>1</sup>. The authors argued that mental health has been largely neglected by the global health agendas and pointed to epidemiological estimates on the burden of mental disorders for families, communities, nations, and international economic systems <sup>2</sup>. The series identified a major treatment gap between the need for and availability of mental health services and emphasized the individual and social costs of undiagnosed and untreated mental illness, in addition to the demand for effective and accessible interventions, especially in low and middle-income countries <sup>3</sup>.

However, the rise of the Movement for Global Mental Health (MGMH; <http://www.globalmentalhealth.org>), currently with some 10,000 individual members and 200 affiliated institutions, has lent new meaning to old controversies on the cultural universality or specificity of mental disorders and their symptoms. The critics accuse the movement of exporting a Western model of illness and treatment, underrating the role of practitioners of traditional therapies, ignoring cultural variability in comprehending and re-

sponding to mental suffering, and medicalizing distress and ignoring its social and economic causes in low and middle-income countries <sup>4</sup>.

Leaders of the MGMH refute such criticisms <sup>5</sup> on grounds that the movement adheres to a concern for human rights and post-colonial openness to collaboration between the global South and the global North. The movement encourages programs that are sensitive to local cultural traditions and result in collaboration with traditional therapists. Such programs are supported by the literature on socioeconomic determinants of mental illness and highlight that this literature established a multidisciplinary empirical basis to back the interventions.

Meanwhile, MGMH and its critics agree on several points. Based on a version of “universalism”, some MGMH researchers contend that for pragmatic reasons, addressing a challenge of such magnitude requires adopting standardized intervention packages with a favorable cost-benefit ratio and that are universally replicable and appear feasible and fundable to donors and governments. However, other MGMH researchers counter-argue that effective interventions in diverse contexts cannot be developed in standardized fashion using a database largely derived from research in developed countries, but that such interventions should be adapted to local

cultural specificities, the characteristics of existing local health systems, and the particular needs of given population groups.

This international debate has underscored the need to assess how this research and intervention agenda has impacted Brazil, or inversely, how it may be influenced by Brazil's academic output and health policies. Brazil's classification as a middle-income country is insufficient justification to apply the underlying arguments and scale-up strategies for expanding access to mental health care as tested mainly in African and Asian countries that lack well-structured national health systems. On the other hand, the Brazilian agenda is partially impervious to this global movement, thereby avoiding some of its biases but also missing important advances potentially offered by critical participation in these discussions.

The organization of mental health services in Brazil is shaped by a diverse and complex set of influences and is far from being a recent or neglected field in Brazil's health debate and practices. The existence of a unified and universal public health care system (Brazilian Unified National Health System – SUS) for more than 25 years has required the proposal and enhancement of policies to guarantee the social right to health, including its physical, mental, and social dimensions. Following the changes on a global scale, the Brazilian psychiatric reform has promoted the abandonment of the institutional model and the option for community care, the principal strategy of which has been the expansion of Centers for Psychosocial Care (or CAPS, in the Portuguese-language acronym) <sup>6</sup>.

Meanwhile, the SUS also provides a setting for the prioritization and growth of primary care through the Family Health Strategy (ESF). In the last ten years, the demand for mental health care within the ESF has become increasingly evident and is the target of specific policies for the implementation of to Family Health Support Nuclei (NASF). In parallel, the recognition of substance abuse (especially involving crack) as a serious public health problem has revived the wager on long-term institutionalization models, featuring the dissemination of distorted versions of therapeutic communities <sup>7</sup>. Given the emergence of these various health interventions and the involvement of diverse health care professionals, the integration of mental health services has also been the object of official measures such as the creation of Psychosocial Care Networks.

Brazil has thus witnessed at least 25 years of “endogenous” accumulation of laws, large-scale policies, and local experiences that converse with relevant themes in the MGMH, although not al-

ways going by this name. This transformation of public mental health care in Brazil has also been the field for a large number of studies, resulting in extensive research production <sup>8</sup>. However, some priority issues for the MGMH could receive more attention in mental health policies and research in Brazil, and we intend to highlight some of these issues.

As stated previously, there are normative instruments that situate the ESF as the locus for the supply of mental health care. However, the strategy's role needs to be defined more precisely, in addition to increasing its autonomy vis-à-vis specialized components such as the CAPS and NASF. Although primary care is responsible for the system's portal of entry and coordination, such functions are usually assigned to the CAPS, even though the latter are a specialized service. This secondary position of the ESF can be explained by the historical construction of its work process, determined by characteristics such as the lack of university-trained health professionals (physicians and registered nurses) specialized in primary care and an emphasis on the supply of services in packages, such as for hypertension, diabetes, and prenatal care <sup>9</sup>. Such packages limit users' access and do not include mental disorders. The ESF's role is thus often limited to referring patients to the specialist.

The NASFs were intended to modify this situation but were faced again with health care professionals in the ESF that mostly lacked specialization in primary care and thus had insufficient skills to manage the most prevalent mental disorders. Meanwhile, mental health specialists have little training to offer integrated treatment within primary care and lack more objective lines of care for mental disorders in keeping with this level in the system and for orienting the dialogue and treatment approaches by these professionals.

One argument used by the MGMH to defend the adoption of protocols to address these disorders on a large scale is to gather scientific evidence demonstrating that mental disorders have effective and easily accessible specific treatments. The applicability of these protocols in Brazil merits analysis and research, especially considering the possibility of mixed quantitative-qualitative pragmatic trials that evaluate interventions in representative scenarios for their expected conditions of application. Thus far, for the SUS and at the nationwide level, there are few available references for addressing and managing mental disorders; the existing references focus largely on broad principles <sup>10</sup>, with little guidance for the rational use of psychoactive drugs or more specific and standardized psychosocial interventions.

Members of the MGMH have increasingly

assumed as a central issue the study of cultural aspects of large-scale mental health interventions. To deny access to diagnosis and treatment of mental disorders violates the human rights of persons with mental suffering, but to reduce the intervention to the replication of protocols and especially to the supply of medicines also reproduces an approach that is negligent, harmful, and lacking in evidence on mental disorders. Hence the interest in studies that objectively, subjectively, and qualitatively assess these interventions, for example involving community-based leaders, groups, and health workers and adaptation of protocols to specific local characteristics. Although Brazil boasts an important production of qualitative studies in mental health <sup>11</sup>, since there have been few standardized, large-scale therapeutic interventions, the field is still not open to studies on the cultural interfaces of such measures.

We believe that the recognition that *“every culture has its own popular idioms of distress - culturally sanctioned modes for expressing suffering that are intelligible to others within a community”* <sup>12</sup> (p. 47) is not opposed to the observation that mental disorders (especially the most severe ones) share elements across different cultures and affect individuals in all societies. This assumption allows considering the social and structural determinants of mental illness, highlighting the usefulness of diagnostic tools and protocols that are both locally derived and internationally standardized <sup>13</sup>, thus permitting the development of therapeutic strategies especially for interventions in areas lacking resources in mental health. These questions have the potential to permeate and enrich the reflections and proposals on the expansion of public mental health services in Brazil, meanwhile helping to open the international debate to unique contributions from the Brazilian experience.

## Contributors

The two authors contributed equally to all stages of the article.

1. Horton R. Launching a new movement for mental health. *Lancet* 2007; 370:806.
2. Prince M, Patel V, Saxena S, Maj M, Maselko J, Phillips MR, et al. No health without mental health. *Lancet* 2007; 370:859-77.
3. Patel V, Prince M. Global mental health: a new global health field comes of age. *JAMA* 2010; 303:1976-7.
4. Summerfield D. Afterword: against “global mental health”. *Transcult Psychiatry* 2012; 49:519-30.
5. Patel V. Why mental health matters to global health. *Transcult Psychiatry* 2014; 51:777-89.
6. Mari JJ. Um balanço da reforma psiquiátrica brasileira. *Ciênc Saúde Coletiva* 2015; 16:4593-6.
7. Perrone PAK. A comunidade terapêutica para recuperação da dependência do álcool e outras drogas no Brasil: mão ou contramão da reforma psiquiátrica? *Ciênc Saúde Coletiva* 2014; 19:569-80.
8. Gregório G, Tomlinson M, Gerolin J, Kieling C, Moreira HC, Razzouk D, et al. Setting priorities for mental health research in Brazil. *Rev Bras Psiquiatr* 2012; 34:434-9.
9. Tesser CD, Norman AH. Rethinking the access to healthcare in the Family Health Strategy. *Saúde Soc* 2014; 23:869-83.
10. Departamento de Atenção Básica, Secretaria de Atenção à Saúde, Ministério da Saúde. *Saúde mental*. Brasília: Ministério da Saúde; 2013. (Cadernos de Atenção Básica, 34).
11. Souza LGS, Menandro MCS, Couto LLM, Schimith PB, Lima RP. Saúde mental na estratégia saúde da família: revisão da literatura brasileira. *Saúde Soc* 2012; 21:1022-34.
12. Kirmayer L, Swartz L. Culture and global mental health. In: Patel V, Minas H, Cohen A, Prince MJ, editors. *Global mental health: principles and practice*. New York: Oxford University Press; 2014. p. 41-62.
13. Kohrt BA, Mendenhall E, Brown PJ. Historical background: medical anthropology and global mental health. In: Kohrt BA, Mendenhall E, editors. *Global mental health: anthropological perspectives*. Walnut Creek: Left Coast Press; 2015. p. 19-35.

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