Mental health in Brazil: strides, setbacks, and challenges

Saúde mental no Brasil: avanços, retrocessos e desafios

Salud mental en Brasil: avances, retrocesos y desafíos

Rosana Teresa Onocko-Campos [1]

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It seems impossible now to conceive of Brazil's Psychiatric Reform without contextualizing in recent history the creation of the Brazilian Unified National Health System (SUS) in the 1988 Constitution and the advent of the progressive governments in the early 2000s.

Despite the permanent financial crisis and budget constraints that have dragged on ever since the creation of the SUS and its regulation, it is undeniable that re-democratization and the Psychiatric Reform process allowed the creation of mental healthcare networks throughout the country and with major expansion of community-based services.

This process, based on humanitarian values and guaranteed rights, was marked constantly by a strong ideological dispute with a certain sector of Brazilian psychiatry. And although civil society's participation was widely touted and actually implemented in some large Brazilian cities, in general such participation was actually weak. Although the Reform's nouvelle familiar emphasizes patients' and workers' movements as founding and important movements, they were not successful in spreading across Brazil, so that the Reform was impelled as a public health policy and not as a demand by civil society. By this, we do not mean to deny that there was a link between these areas, but to contribute to understanding the current directions and possible defenses for the Reform.

After nearly 30 years of the Reform, Brazil's research production now allows us to highlight some consolidated results in the scientific literature, featuring the following.

There was actually a major shift in expenditures in mental health, with community-based services receiving more budget funds than hospitals since 2006. The virtual majority of community mental health services are Centers for Psychosocial Care (CAPS) in the modalities I, II, or III (with overnight beds). Beds were closed in psychiatric hospitals, now known to be ineffective according to the international literature (this process is still unfinished, and there are various places in Brazil that still have psychiatric hospitals, with dubiously effective practices and suspicions of mistreating patients).

The expansion of community-based services has come to a virtual standstill since 2011, and data are lacking since 2015, in an unfortunate loss of transparency and accountability by the Ministry of Health. Despite the important expansion of coverage with community services, there was a persistent lack of scale for some relevant resources to implement recovery in society, such as the Program "De Volta para Casa" (Return Home), community contact centers, income generation centers, etc.

Meanwhile, the community-based services have shown (like all the services in the SUS) a serious institutional weakness and budget constraints due to insufficient funding. Some studies have identi-

[1] *Faculdade de Ciências Médicas, Universidade Estadual de Campinas, Campinas, Brasil.*

Correspondence
R. T. Onocko-Campos
Departamento de Medicina Preventiva e Social, Faculdade de Ciências Médicas, Universidade Estadual de Campinas.
Rua Américo de Campos 93, Campinas, SP 13084-971, Brasil.
rosanaoc@mpc.com.br

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fied excessive red tape, excessive oversight, and lack of effective support for patients' families [1,2], while other studies have shown consistent support from a well-articulated network of services and a reduction in hospitalizations after enrollment in the community services [3,4].

In 2008, an important Brazilian report already described the country's situation as follows: "*country has opted for innovative services and programs, such as the expansion of Psychosocial Community Centers and the Return Home program to deinstitutionalize long-stay patients. However, services are unequally distributed across the regions of the country, and the growth of the elderly population, combined with an existing treatment gap is increasing the burden on mental health care. This gap may get even wider if funding does not increase and mental health services are not expanded in the country. There is not yet a good degree of integration between primary care and the mental health teams working at CAPS level, and it is necessary to train professionals to act as mental health planners and as managers. Research on service organization, policy and mental health systems evaluation are strongly recommended in the country. There are no firm data to show the impact of such policies in terms of community service cost-effectiveness and no tangible indicators to assess the results of these policies*" [5] (p. 2).

This analysis rationally and systematically oriented the Ministry of Health's actions until early 2011, during which there was stimulus for the development of research and training in mental health that were consistent with the diagnosis expressed above. The expansion of services dropped off beginning in 2011, and the only existing small growth was virtually concentrated in the creation of treatment services for the population with alcohol and other drug abuse problems. Since that year there was only a very meek expansion of the CAPS III clinics, which are strategic services for concluding the process of closing single-purpose psychiatric hospitals. The CAPS-AD III services, created in 2010, were strongly induced in late 2011. In four years, the implementation of CAPS-AD III clinics reached a total of 88, nearly the same number as the CAPS III services took more than ten years to reach (92 services), and not fairly distributed across Brazil's territory [6]. This shows the power that public policy has to induce changes when it ties funds to political will.

We lack information since 2015, since the Ministry of Health interrupted the regular publication of data, in a demonstration of blatant disregard for Brazil's Information Transparency Law.

In 2015, a literature review revealed some progress in the integration between services and the network's linkage. This included the fact that mental health presents mechanisms of integration at the macro (system), meso (institutional), and micro (clinical practice) levels. The review also highlighted the expansion of the network of care and new forms of organization and training. However, the system continued to be underfinanced, requiring improvements in primary care and in the mechanisms of evaluation. Integrated practices related to the emergency care teams and inter-consultation support were considered improvements, as were the experiences with supervision and the multidisciplinary teams [7].

In 2017, another study – on governance and mechanisms of evaluation – identified mental health as an underfinanced area of the SUS, already chronically underfinanced. The governance model was held accountable for limiting the progress in essential services, creating the need for a regionalization process. The study claimed that the mechanisms for evaluation were not incorporated into health policy in the administrative field and that the policy's focus seemed archaic in relation to the psychosocial model's principles, concluding that the evaluation mechanisms needed to be expanded [8].

In a recent systematic review of the assessment of mental health services in Brazil, still in press, the principal conclusions were that the evaluation of Brazil's mental health network lagged behind the services' expansion. There was a lack of large-scale studies, since most of the studies focused on small numbers of services or single regions of the country. The evaluative studies pointed to challenges for the Brazilian mental healthcare network, where the lack of participation by patients and families was a worrisome issue. There were also few studies addressing patients' rights as citizens. Since Brazil lacks a strong culture of evaluation, the review warned of the need to develop an evaluation policy on the implementations of services expansion, without which, effort and money could be wasted.

Still, the major chapter of setbacks took an important step with *Ruling n. 3,588* [9] of December 21, 2017. Very briefly, this ruling, issued as the lights went out on the illegitimate Temer Administration, reintroduced into the Network of Psychosocial Care (RAPS) the figure of the Day Hospital, which had been superseded by the installation of the CAPS and which reclaims and values biomedical interventions over psychosocial and recovery practices.

The ruling further instituted the CAPS AD IV, which are nothing less than the legitimation of slipping into fat federal funding for the "therapeutic communities", a Brazilian euphemism for reestablishing practices of isolation and violation of individual freedoms that characterized the country's insane asylums throughout the 20th century.

Proceeding with the historical backstepping, the ruling further determines the readjustment of the fees for Authorizations of Hospital Admissions (AIH, in Portuguese) in psychiatric hospitals, "according to their size", running counter to all the international guidelines and the success of the Brazilian process itself in reducing the size of psychiatric hospitals (a process that began in the early 21st century), sweeping Brazil backwards into the 19th century with one stroke of the pen.

Consistently with its historical backstepping, the ill-advised ruling reestablished in the RAPS a secondary level of care through specialized mental health teams, opening the way for reinstalling hierarchical and stand-alone psychiatric outpatient clinics. This again shows the field's active inclination towards the hegemony of biomedical practices, since the adequate implementation of Centers to Support Family Health (NASF) would solve the linkage between levels of care, as shown by some recent studies [10].

Summarizing this brief history – and in light of evidence from recent evaluations – what would the RAPS need according to the available evidence and in keeping with the international guidelines (e.g., World Health Organization – WHO)?

It is important to encourage better regional distribution of community services and resources in general, aimed at stability of existing services and expansion to the country's less favored regions.

It is also necessary to improve the mechanisms for coordination of care between primary healthcare and the specialized community-based mental health services (CAPS), i.e., adequate implementation of the NASF in amounts and training, combined with continuing education.

It is essential to expand the coverage of services aimed at recovery, such as community contact centers, income-generation services, etc., as well as the implementation of active strategies to fight stigma. Other countries such as England have successful cases of official awareness-raising for this purpose. Fighting stigma is an also important factor for reducing the mortality gap in the population with mental disorders, when health services themselves tend to deny adequate and timely care because of the stigma. The retention of young people with mental disorders in schools and universities also requires active and specific strategies.

Working with mental health exposes workers to numerous tensions in their daily routines. Creating permanent training and educational activities for teams is thus essential to avoid excessive bureaucracy and ineffective clinical practices.

Finally, a policy to constantly upgrade and assess the RAPS would be a minimum standard of accountability in a rational context. Quality improvement and permanent assessment is how the system functions in countries with successful experiences.

In Brazil's current political content, it appears unlikely that any of these recommendations will be implemented. The current public administration in Brazil does not adhere to scientific evidence. We live dangerously on the brink of infamy and disrespect for civil, political, and social rights. Persons with mental disorders generally experience weaknesses in their socialization and social and work market insertion. They are less successful than average in the typically fierce competition of Brazil's late and peripheral capitalism and tend to swell the ranks of the unemployed and the outcasts on society's fringes. They will need our advocacy more than ever, our engagement in their defense and in the struggle to support their demands.

What is to be done in this new *Entranced Earth* [11]?

I believe that we should endeavor to work actively to build strategic alliances. Ernesto Laclau, in his book *On Populist Reason* [12], states that the creation of a people involves the equivalence of an empty signifier. Grounded in the reading of group psychology and analysis of the Ego in Freud [13], Laclau contends that it would be through mechanisms of identification that it would become possible for different demands to become "equivalent". For example, where would the common ground be in the defense of quality public education, the defense of social security, and the defense of public funding for scientific research? Strictly speaking, each of them constitutes a field full of specificities and is represented by different interest groups. Still, according to Laclau, it would be in the equivalence of

some empty signifier (i.e., democratic rule of law or any other name capable of harboring these various demands) that it would be possible to organize a people and their effective political mobilization.

Following his line of thinking, I think that the narcissism of small differences, a mechanism identified by Freud in *Civilization and its Discontents* [14], would be the worst enemy of people's power in the times in which we are living. The narcissism of small differences exploits the mechanism of identification in the reverse sense, seeking to produce a buttress through any and all minor differences between very similar groups, any minor disagreement as grounds for separating each other and becoming enemies.

Along this line of reasoning, I believe we should overcome the fight between the Psychiatric Reform Movement and "the" psychiatry and that we should approach critical psychiatry, ethnopsychiatry, and countless psychiatrists with good intentions who want to work in the public system, bringing scientific reasoning to the field through research and the communication of WHO guidelines, among other contributions.

Ricoeur [15] says that ideology is always necessary at the founding moment of movements, and that it also plays a motivating role for the continuity of struggles, yet it is also a source of misunderstanding and distortion of meaning. Ricoeur contends that ideology "is operative and not thematic", so it is more likely that we will think "through" ideology than "about" it. I believe that for some time now the Reform's excessive ideologization, once its original foundational power had passed, has become an obstacle to critical reflection on new resources and for the incorporation of good practices. I consider this exercise indispensable, even to be able to confront the problematic field of medicalization of human suffering and to qualify the rational use of psychoactive medication based on the principles of quaternary prevention [16,17].

I believe it is also essential for us to emphasize the strategies to include patients: to support and encourage patients' associations, the creation of income generation cooperatives, to develop active strategies to fight stigma and encourage orientation of existing services for recovery. We are facing a huge challenge for the field of social participation which results from Brazil's ignoble socioeconomic inequality and the enormous educational gap separating our patients from the staff and health professionals.

In the academic field, I believe it is crucial for us to rethink and restructure our professional training strategies. It is not true that only psychiatry has to review its training processes. Many other professions exhibit outdated training, drawing on ideological arguments and displaying severe technical deficiencies, which disqualifies their practices and contributes to the perpetuation of moralistic treatment.

I also believe it is essential to redesign our research to make the studies increasingly participatory and inclusive. The struggle with research agencies for specific calls for research and development projects in Mental Health must not be interrupted. Likewise, we should step up the struggle with the administrative and policy-making agencies to establish mechanisms for monitoring and independent assessment of the RAPS and access to information.

In these paradoxical twists of history, at moments in which we would otherwise have much to celebrate and rational and scientific ways of tackling the challenges, we find ourselves grappling with the need to resume the struggle and to mobilize with unprecedented impetus. What is at stake is not only Psychiatric Reform, but democracy itself.

May the orishas help us!

Additional information

ORCID: Rosana Teresa Onocko-Campos (0000-0003-0469-5447).

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