

The continuity of psychiatric hospitalization of children and adolescents within the Brazilian Psychiatric Reform scenario

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Within the Brazilian Psychiatric Reform scenario, a new policy for mental healthcare specifically for children and adolescents is under construction. However, studies have indicated that hospitalization in psychiatric institutions still occurs among this population. As a preliminary research result over a two-month period, we identified who are these children and adolescents in a hospital with psychiatric beds were and the reasons for their hospitalization. We analyzed the medical files of 28 subjects using a hermeneutic dialectic approach. The results indicated that hospitalization of cases with a profile similar to that of the time before the reform of psychiatric care was continuing and that the main reason for hospitalization related to aggressiveness and dangerousness. It was concluded that, despite the reform, psychiatric hospitalization in institutions of asylum nature is still occurring.

Keywords: Mental health. Hospitalization. Deinstitutionalization.

Mental health care in infancy and adolescence in the context of the Brazilian Psychiatric Reform

Brazilian National Mental Health Policy has been building and establishing a model of mental health care that is open and territory-based, designed to be inserted into the real-life contexts of the people who are undergoing psychic suffering¹. This process began at the end of the 1970s through the Brazilian Psychiatric Reform, described as a 'complex political and social'

movement, 'comprising actors, institutions and forces from different origins that act on various territories', including 'territories of the panorama of social imagination, and of public opinion'¹ (p. 6). The criticism of the asylum-based and hospital-centered model indicated a new paradigm in this area of health care, with implementation, progressively, of a network of services that substituted beds in psychiatric hospitals. A landmark in this process was Law 10216, of April 6, 2001, which makes provisions governing mental health care and the rights of people undergoing psychic suffering^{1, 2}.

Amarante³ (p. 45) considers that what the Psychiatric Reform involved was not 'simple restructuring of the healthcare model', but that there was a continuing movement of innovation of actors, concepts and principles. Various inter-related dimensions comprised this process – namely: theoretical-conceptual aspects, technical-healthcare aspects, legal-political aspects and the socio-cultural dimension. The theoretical-cultural dimension refers to the movement for a break with the psychiatric paradigm, and requires preparation, criticism and the production of new areas of knowledge. Articulated with this dimension is the technical and healthcare aspect, with construction of new services, new professional practices, and new modalities of care³. In the legal and political sphere, there is the need to 're-discuss and re-define social and civil relationships in terms of citizenship and human rights, and in social terms'. The social-cultural aspect refers to 'the group of actions that aims to transform the concept of 'madness' in the imagination of society at large'³ (p. 53).

In general terms, the Psychiatric Reform had the form of an 'ethical, and aesthetic, process, which recognized new situations that produced new subjects in law and new rights for those subjects'³ (p. 50).

Mental health care for children and adolescents has historically been based on 'a group of measures founded on the 'hygienist' logic and inspired by the concept of law and legal rules', giving rise to a scenario of institutionalization of care⁴ (p. 8). The changes in this scenario began with the Psychiatric Reform, the passage into law of the Children's and Adolescents' Law (*Estatuto da Criança e do Adolescente*, or ECA) – Law 8069 of July 13, 1990 – which was a milestone in the construction of new policies and modes of healthcare directed toward the population of children and young people⁵, and the consolidation of the National Mental Health Policy, which called for restructuring of care.

The construction of specific public policies is recent, beginning in 2003 with Ministerial Order 1946/GM⁴. Taking this initiative as a starting point, in 2004 the National Children's and Adolescents' Mental Health Forum was created, which has been building the bases and guidelines for this public policy and creating new services and strategies of care⁴. According to the document that orients this policy, national mental health care for children and young people should provide for support for any person in the community, nationwide, automatic referral, permanent construction of the network, and inter-sector activity in the care provided, so as to 'make emancipatory actions possible' and generate 'a network of care that takes into account the

singularities of each person and the constructions that each individual makes based on his or her condition¹⁴ (p. 14).

Overnight stay and admissions services – the current scenario

The consolidation of the Psychiatric Reform demands, simultaneously, de-construction of asylum-type institutions, with gradual and programmed reduction in the number of beds in Psychiatric Hospitals, and construction of substituting services, of which the central elements are the Psycho-social Care Centers (*Centros de Atenção Psicossocial*, or CAPS).

There are several different types of CAPS relating to the population served and the size of population per municipality. The CAPS–I, are located in small towns; the CAPS–II, in medium-sized towns; the CAPSi are for the population of children and young people (the *i* being for *Infanto-juvenil*); the CAPSad, for users of alcohol and other drugs; and the CAPS–III, which are strategic services that offer 24-hour coverage and overnight stay.

Since the passing of Law 10216/01, there has been significant expansion of care services over a wider territory, with reduction in the number of psychiatric hospital beds. Since 2002, 19,109 psychiatric beds have been closed in Brazil, although there are still 198 Psychiatric Hospitals, with a total of 32,284 beds⁶. As a counterpart, 1,742 CAPS have been created: Of these, 822 are CAPS–I, 431 are CAPS–II, 63 are CAPS–III, 272 are CAPSad and 149 are CAPSi. In São Paulo State, in particular, there are 53 Psychiatric Hospitals, with 10,801 beds, and: 282 CAPS, of which 64 are CAPS–I, 79 are CAPS–II, 27 are CAPS–III, 67 are CAPSad, 2 are CAPSad-III and 43 are CAPSi⁶.

In this scenario, consolidation of the services providing overnight stay – a facility of fundamental importance in the process of support for people undergoing psychic suffering when they are at a moment of increased weakness, or when a more intense degree of support is necessary due to an acute mental crisis – is a current challenge. The proposal for widening of the availability of overnight stay, further to what is offered by CAPS–III, includes full-care mental health beds, which should be connected to the Psycho-social Care Network (the *Rede de Atenção Psicossocial*, or RAPS), offering support in articulation with other benchmark services for the user. These are located as support points in General Hospitals, Hospital Emergency Departments, and the reference hospital services for alcohol and other drugs^{7,8}. The 2011 census⁶ recorded 3,910 full healthcare beds, nationwide, in General Hospitals, of which 712 were in São Paulo State. Further, in the point of view and guidelines of the RAPSs, the trend is of expansion of the number of beds in CAPS–IIIs and General Hospitals, components of the RAPS, for the purpose of progressive phasing out of admissions to the Psychiatric Hospitals^{7,8}.

However, in spite of this 'horizon' of de-institutionalization, studies^{9,10,11} indicate that today children and adolescents are still being admitted to Psychiatric Hospitals, and other institutions with similar logic. Bentes⁹ states that admissions by court order have become more frequent, and often

take place without the mental health team of the destination institution being informed; at the moment of leaving the institution, restrictions imposed on procedures for discharge – namely making it conditional upon a court order – perpetuate a situation of institutionalization. According to Scisleski¹⁰, there is a 'circuit' of institutionalizations which results in production of a certain profile of children and adolescents who are repeatedly in this network of hospitalizations. To this situation is added the 'psychiatricization' of social issues in the case of young people who commit offences. In this context, according to Vicentin et al.¹¹, there is at present a conjunction of lines of force, in particular in São Paulo State, which have renewed the notion of a patient being dangerous, 'causing it to acquire connotations that facilitate extension and dissemination of use of the concept, increasingly subordinated to the requirements of civil defense' (p. 161). A fuller understanding of this scenario of hospital admissions is needed.

Objectives and method

This article presents partial results of a survey from an ethnographic perspective that aims to understand the reasons for, and situation of, admission of children and adolescents to a facility with 18 psychiatric beds, located in São Paulo State. The survey was approved by the relevant Research Ethics Committees. It presents details of the children and adolescents admitted over a period of two months (July 12, 2013 to September 12, 2013), and the reasons for admission, using an analysis of the medical records.

The guiding method used was a hermeneutic approach, in which comprehension and criticism can be articulated in the process of interpretation¹². In reading of the data, recourse was had to hermeneutics for understanding of the texts (medical records), seeking to identify both what they had in common – by comparison – and also what was singular in each. A dialectic approach was used to apply a critical attitude to the issues, as a means of interpreting the data, in that dialectics considers 'historical dynamic, antagonistic and contradictory social relationships between classes, groups and cultures' to be 'fundamental in communication'¹² (p. 347).

The analysis first mapped the decisions that were fundamental in providing a comprehension of the phenomena under consideration – choosing the following documents in the medical records: Medical Records Cover Sheet, Admission/Anamnesis Sheet; and the Hospital Admission Authorization Sheet. In a second stage an effort was made to establish 'the meaning, the internal logic, the projections and the interpretations'¹² in these texts (p. 355). The dimensions of the process of Psychiatric Reform that Amarante³ has described were set as Analytical Categories: the theoretical-conceptual, the legal-political, the technical-assistential and the social-cultural aspects; and Empirical and Operational Categories were created based on the field material: characterization of the subject; characterization of the hospital admission (type, source, subjects involved); and reasons given for the admission (principal complaint and duration; history; symptoms; conditions justifying the admission; and medical diagnosis). Finally, the data were

operationalized: they were ordered by creation of the different groups and sub-groups, and, after a transverse reading of each sub-group and of the totality of the groups, themes/subjects were created which were analyzed. These were: the process – both old and new – of admission to an asylum-type institution; the requirements that are declared today for mental health hospital admissions; and the asylum care practices that are dressed up and disguised as mental health care.

Mapping and characterization of hospital internments of children and adolescents

During the period of the study, 28 children and/or adolescents were admitted to the institution. The admission (internment) was decided by a duty psychiatric doctor, who had the responsibility for making the records in the documents that were studied.

All the subjects were male, aged between 10 and 17. Of their total number, 13 lived in the greater São Paulo area, 14 in towns in the interior of São Paulo state, and one in a city of Minas Gerais state. Of the 28 admissions, one was classified as voluntary; 19 as involuntary; and eight as 'involuntary resulting from a court order'. The persons holding legal responsibility who accompanied these admissions were varied: relations; professionals from Shelter Assistance Homes (*Casas Abrigo*); and professionals from the *CASA* Services (the Adolescents' Social-Educational Service Foundation – *Fundação Centro de Atendimento Socioeducativo ao Adolescente*). As for the places from which they came: four were sent by First Aid units, two from General Hospitals, one from a *Casa Abrigo* Shelter, one from the General Outpatients' service, two from the Health Departments of different municipalities, four from City Halls of various municipalities, three from court bodies, and 11 from various mental health facilities, such as the Psychiatric Infirmary of a General Hospital, an Integrated Mental Health Care Centre (*Centro de Atenção Integrada à Saúde Mental, or CAISM*), a Mental Health Outpatients' Unit, and CAPS's (CAPS–II and CAPSi).

For 23 of these children and adolescents this was their first admission into this service (the documents do not report any admissions into other services of the health services network); for one it was the second time, for three it was the third time, and for one it was the fourth time. One of the subjects was twice discharged and twice re-admitted during the time in which data was collected for this survey; that is to say at the end of this study he was in his fourth admission – three admissions having taken place in a period of two months. The time of admission for those who have left the institution varied between 14 and 77 days, and at the end of the data collection period 15 children and/or adolescents were still in the facility, and one of them had been admitted for a period of exactly 100 days.

Information relating to the reasons for admission was found in two documents: the Admission/Anamnesis Sheet, and the Hospital Admission Authorization Sheet. The Admission/Anamnesis Sheet contains the following information: personal data, principal complaint and duration, current history of the illness, family history, personal prior history, psychological examination, clinical examination and medical diagnosis (by ICD-10 code). The reasons for coming

to the service are deduced from the items stated as: the principal complaint; and the duration and present history of the illness. It is important to point out that in each case the person responding was the person holding the legal responsibility for the subject, or – in the case of subjects coming from institutions – the responsibility for the admission; and that there is no record of information obtained directly from the subjects themselves who were in the process of being admitted. The Hospital Admission Authorization Sheet contains the following information: personal data; principal clinical signs and symptoms; conditions that justify the admission; and medical diagnosis (ICD-10 code). The last three items are of significance for this study. The Hospital Admission Authorization Sheet consulted was exclusively the one issued by the institution that is the scenario of the study, and for this reason the medical diagnosis is the same in the two documents.

In relation to the item 'principal complaint and duration': in some cases clinical symptoms are noted; in others there is a short summary of the history that led the child or the adolescent to the admission; and in others there is no information at all – this was the case for six of the records. In all the other 22 records, more than one complaint was presented, the one most commonly referred to being aggressiveness (against self or other persons).

Table 1. Main complaint declared

Expression that indicates the complaint declared	Number of records in which the expression appears
Aggressiveness (against others/self)	15
Symptoms of hallucinations, delirium	6
Changes in behavior	4
Psychomotor agitation	5
Court order	4
Difficulty of treatment in other services	2
Insomnia	2
Chemical dependency	1
Isolationism	1
Hypersensitivity	1

For the current history of the illness, 28 of the case records report a succession of changes in behavior or in daily routine of the subjects, which the declaring party relates to the process of becoming ill. The history of the illness described in the records in some cases refers to situations that the child and/or adolescent has experienced in his environment, and in some cases describes clinical signs and symptoms. In 16 medical records there are references to referral from other services, and current use of medication. Also in 16 medical records it is highlighted that the declaring party reports a perception or experience of some situation felt to be one of aggression: sometimes express aggression as reported by the declaring party, and sometimes as an already established symptom/diagnosis – as in cases where the expression *heteroaggressiveness* is used. In

nine case records there is a reference to school attendance; and in nine there is information about the use, or not, of drugs; in five, reference is made to a period in the *CASA* Foundation, or small thefts; and in two, a nuclear family has been informed.

As for the principal clinical signs and symptoms, 28 of the medical records contain symptoms from a psychiatric nosography.

Table 2. Clinical signs and symptoms declared.

Expression indicating clinical signs and symptoms	Number of records in which the expression appears
Aggressiveness (against others/self)	19
Behavior disorders and/or antisocial conduct	10
Delirium	9
Psychomotor agitation	9
Hallucinations	5
Use of alcohol and other drugs	3
Perception of persecution	3
Poor insight	3
Suicidal ideas	2
Hyperactivity	2

In the whole group of documents, other symptoms appear, once each, and are described with the following expressions: 'increased appetite'; 'refusal of medication'; 'isolationism'; 'irritability'; 'impulsiveness'; 'depressiveness'; 'disorganization of thought'; 'social ritualizations'; 'challenging'; 'compulsive'; and 'low social participation'. In nine of the documents a diagnosis of mental deficiency is recorded as a symptom; in five, 'resistance to treatment in other services'; referral under court order, in four; the expression 'hard to control', in one; referral from other services, in two; and in a further two 'breakup of the family'.

As for the conditions stated as reasons justifying the admission: five records do not mention this information; the records of four children and/or adolescents contain the expression 'the above', indicating that the principal clinical signs and symptoms comprise the justification for the admission. The records of 10 children and/or adolescents present more than one condition, and those of a further nine present only one condition, making a total of 19 records in which the justification for the admission is stated explicitly.

Table 3. Conditions stated as justifying admission.

Expression indicating conditions that justify admission	Number of records in which the expression appears
Aggressiveness (against others/self)	8
Risk to oneself	7
Risk to others	5
Risk of suicide / risk to physical body	2
Risk of social exposure	2
Inability to take care of oneself	1
"Not taking control"	1

The case records of all the children and/or adolescents contained psychiatric and/or neurological diagnoses, in the range F00 to F99, the category of conditions referred to as mental and behavioral disorders. In eight of the medical records there is a composition of two different diagnoses, and in one, there is a composition of three different diagnoses. Of the 28 subjects and 38 diagnoses, one of the diagnosis was G40 (episodic and paroxysmal disorders), two were in the F00-F09 group (organic, including symptomatic mental disorders), three were in the F10-F19 group (mental or behavioral disorders due to psychoactive substance use), 15 were in F20-F29 (schizophrenia, schizotypal and delusional disorders), the most frequent being F29 (10 children and/or adolescents had this diagnosis); one was in the F30-F39 group (mood disorders); 10 in F70-F79 (mental retardation); two in F60-F69 (disorders of adult personality and behavior); and four in F90-F98 (behavioral and emotional disorders with onset usually occurring in childhood and adolescence).

Admission to asylums – then and now, the same profile

There were a significant number of diagnoses of children and/or adolescents with mental deficiency, adult personality and other behavior disorders (for a subject associated with a diagnosis of mental deficiency), and psychoactive substance use (always associated with some other diagnosis). Specifically in relation to the subjects with diagnosis of mental deficiency, referred to as mental retardation in the ICD-10, five were referred from health services, two from court bodies, one from a *Casa Abrigo*, one from a Health Department, and one from a City Hall, three of these being involuntary court-ordered admissions to the institution, and seven being involuntary admissions (of these, two were court orders requiring compliance by the municipality).

This picture may indicate that the admissions are not related to crisis healthcare, because, as well as the high number of subjects with diagnoses of mental deficiency and of behavior disorder, there is a significant number of admissions under court orders. Thus, there are probably

other reasons, likely including fragile social and family links, low coverage by the health services network in certain towns, relationships of violence in the territory.

Having in mind the legal-political and social-cultural dimensions of the Psychiatric Reform, one needs to look at the profile of the population that is being admitted in asylum-type health institutions, as pointed out in Scisleski's study¹⁰. Institutionalization of children with mental deficiency is already known to exist, and is alarming⁴, and considering that the admissions with this diagnosis, as well as those for personality or behavior disorders, take us back to the scenario of admissions prior to the Psychiatric Reform, it must be concluded that there have not been significant changes in the profile of the admitted population.

Further, even if it is considered that all the subjects admitted with the diagnosis of use of psychoactive substances had, at least, one other diagnosis associated, these admissions are significant because the compulsory admissions for abusive use of alcohol and other drugs are a recent scenario, in particular in the major urban centers. These admissions are not justified from the technical-assistential point of view, and can be understood to be 'treatments with the intention of normalizing, and other practices of subordination and annulment of the subject'¹³ (p. 592).

Another important point relates to the eight admissions classified as court-ordered – indicating the existence of a court order addressed to the institution, ordering admission, which is thus compulsory. Also, the number of readmissions is significant: six of the 28 children and/or adolescents had been previously admitted to this service. Law 10216/2001² provides for three modalities of admission: voluntary (with the subject's consent), involuntary (without the subject's consent, at the request of a third party) and compulsory (ordered by the judiciary). Admission to an asylum-type institution is prohibited for all three of these modalities: it may take place only when authorized by a medical professional. Any compulsory admission, in particular, must be ordered by a judge, and must be 'in accordance with the legislation from time to time in force'² (p. 2) – this is a reference to the Penal Code, and means that it is only admissible in a case where the person who is experiencing psychic suffering is an offender against the Law. So it must be deduced that the eight court-involuntary admissions were carried out based on a corrupted interpretation of Law 10216.

Taken together, the three elements: diagnosis; modality of admission; and number of re-admissions, could be indicative of a situation that is in the process of being formed. Even ahead of the moral career¹⁶ that is involved at the time of the admission, there is a process leading up to admission, an admissional career: a path that sets off the mechanism of institutionalization, involving a medical diagnosis, often associated with a question of relationship, a legal action, and/or multiple experiences of admission to the institution.

Vasconcelos⁸ points out that, in the expectation of a rapid implementation of the CAPS-III units, full-time care beds were not given priority, creating a deficit in care in the event of acute mental crisis. This problem is intensified by the use of beds in asylum-type services. This manner of 'internment' is both old and new: it is that in which, in some way, the subject breaks with public

order, receives a medical diagnosis and, sometimes, due to a relationship with the legal system, is placed in reclusion.

The present-day declared demands for mental health admissions

It is significant that the term *aggressiveness* (against others and/or oneself) is the term most frequently used in the description of the three factors that indicate a need for admission (principal clinical signs and symptoms; principal complaint and duration; and conditions that justify admission). It constitutes a symptom, a complaint, and a justification for the admission, and the term can be understood as a simplified explanation of the multiplicity of a case, in a profound reduction of the complexity of the subject's life and needs.

Basaglia¹⁴ indicates that the conflict presented by the subject and translated as aggressiveness (against others/self) takes place in relation to a norm, but this is made into an objective phenomenon of the subject as an ill person. By individualizing the problem, an avenue making it able to be subject to blame is created. In the direction contrary to this simplification, there is a need to understand aggressiveness as an expression of a form of relationship with other private subjects and, in this sense, a need to understand the diversity of aspects that produced a given situation, so as to be able to understand in a contextualized manner what the aggressiveness relationship referred to actually signifies¹⁷. These aspects involve – among other factors – the subject's life history, his or her network of relationships, the territory in which he or she lives, the spaces that he or she moves in, and what is offered to him or her as a possibility of life, and of expression.

According to Basaglia FO¹⁵, asylum-type institutions exercise the relationship of oversight or guardianship by taking over possession of the subject (deprivation of liberty): a situation in which society is defended, to the detriment of the interests of the person being 'overseen' – i.e. to the detriment of one of the sides of the relationship. Also, in this form of 'oversight' there is explicit a certain way of responding to the demand to ensure conditions in which the person who is ill (or whose behavior is deviant), considered to be in some way dangerous, is able neither to harm himself nor others. In fact, the term *aggressiveness* needs to be understood from the point of view of the stigma that a person suffering psychically is 'dangerous'.

The nature of being dangerous, a concept which has its bases in the relationship between psychiatric knowledge and criminal justice, is reputedly related to the possibilities of greater or lesser risk of a breach of public order resulting from exposure of that subject to society^{14,1,16}. It is in relation to the themes of 'protection of the mad person, and defense of society against the excesses of madness', that:

the first legislations set the framework of principles, defining both the canons of so-called 'danger to society' – equivalent to the definition of disease – and also the purposes and the manners of its treatment. On the one side, thus, there are the criteria for recognition of everything that is invalidated as unproductive as representing a danger for social coexistence; on the other, there are rules that justify the reasons for that definition of the quality of being dangerous, and set out plans for the means of its treatment, with their corollaries of separation and control.¹⁴ (p. 301)

The admissions take place around the double subject of aggressiveness–danger, appearing as a demand for admission, aggressiveness being the more frequent principal complaint, the most reported symptom, and the condition justifying admission. Further, in some cases where the expression 'the above' is written in the Hospital Admission Authorization Sheet, the condition that justifies admission is being stated as a synonym of the symptoms. There is a simplifying short-circuit in this system of admissions from which there is no way out, because the other dimensions of the subject's life are not taken into consideration. By this route, the institution carries out its social role of maintaining public order¹⁴.

This relationship between the social role of these institutions – of removing those subjects that breach public order – and the separation of the experience of becoming ill from the complex existence of people is the basis of the category of 'aggressive/dangerous'¹⁴. This social mandate is also evident when court decisions are described as a complaint – in three of the records; and as clinical signs and symptoms, in four records (in fact, the institution received seven admissions by court order). It is worth recording that the term 'behavior disorder', mentioned as a clinical sign and symptom, appears in nine records: 'resistance to treatment', in four; and the description of a person as 'a person who is hard to control', in one.

The complexity of this question points to the statement by Amarante³ that the dimensions of the process of the Psychiatric Reform are always inter-related. A profound transformation is needed in the legal-political, technical-existential, social-cultural and theoretical-conceptual dimensions for this theme to be understood, putting the question of aggressiveness in a context of a legal basis, creating means of providing care in a crisis situation, constructing other viewpoints for looking at psychic suffering, and carrying out studies that make it possible to successfully dominate this subject.

Another feature of the medical records is their indication of the impossibility of social exchanges with these subjects. According to Kinoshita¹⁷, relationships of exchange in a social universe are carried out based on a value attributed to each subject in the social field as a pre-condition for interchanges; and the presumed value of a person is the basis of his or her contractual power, which is defined as 'the conjunction of resources, potentialities (material, psychic, cultural and psychical) that an individual had before participating in the game of exchanges in the social interaction'¹⁷ (p. 72). It is presupposed that a person who is undergoing psychic suffering has low

or zero value for such exchanges, with a contractual power that can be regarded as negative in the sense that it is non-existent: his assets are suspect, his messages are taken to be incomprehensible, and his affects are not in accordance with the rule in force¹⁷.

This presupposition is reproduced in asylum-type institutions, in which the separation of the subject's experience of psychic suffering from his complexity of living converts the illness itself into the only positive aspect of that subject. In the act of admission, the message issued by society is that this subject cannot participate in social exchanges – so much so, indeed, that there is no record of hearing anything from him in the act of admission. The admission is justified by what is referred to as aggressiveness, risk to himself, risk to others and risk of social exposure, in a medical evaluation and, sometimes, backed by the opinion of a judge.

This is not a matter of negating the suffering that has been undergone by the subject and his surroundings, but rather of questioning the admission as a social response that merely recognizes the problem of public order (only), at the same time making the subject into an object based on the dimension of aggressiveness considered as disease, separating it from people's complex existence^{14,18}. This de-codification of the demand, based on the objectification of the 'other', and enunciated by third parties, needs to be called into question.

Practices of asylum-type institutions that masquerade as mental health care

Places and their practices express means of perception and interaction with phenomena; in this sense the asylum paradigm is a form of relationship with psychic suffering¹⁴. More precisely, it can be perceived that the institution understands aspects that point to a deep objectification of the 'other' as being important/relevant in recognizing a demand for admission. According to Dell'Acqua et al¹⁹ (p. 50), when the institution is 'not able to recognize the subject as a complex entity, the system tends towards reductions and simplifications'. This simplification is evident in the medical records, due to the perception of the subject being an understanding based on the illness, and the perception of the illness being an understanding based, as the key factor, on a reading of the degree of danger. This is not to negate the existence of social, or family, conflicts with the network of services, or with others, but rather of working on the relationships based on recognition of these factors as an expression of the relationship with certain rules, while listening to all those involved¹⁹.

The suffering, itself, needs to be understood as constituting the most important component during an acute mental crisis and; and also as containing in itself the possibilities of change, subordinated to the responses offered and constructed with the subject. However, frequently the response to the crisis is a moment of:

simplification of a relationship in which: on one side, the subject who is showing himself has already, progressively, made a simplification and reduced the complexity of his existence of

suffering to a symptom; and, on the other side, the service, whichever it is, has equipped itself in a detailed, mirror approach to perceive and recognize that same symptom – offering itself as a model of simplification¹⁹ (p. 55).

Among the clinical symptoms in the records are hallucination and delirium. It can be said in response that the problem that the children and adolescents are living through does not refer only to the acts of hallucinating and undergoing delirium, but to not being able to make themselves understood, and not finding a place to share. As already stated, the records do not indicate that the children and adolescents were listened to and supported in their suffering. Indeed it can be said that 27 admissions were not agreed with the subjects, being involuntary or the result of court orders. For one of the sides of the relationship not to be excluded, the professional, in the technical-existential dimension, needs to enter into a relationship with the other, comprehending the dimensions of speech of that subject by recognizing that other as being just as legitimate as he himself. In this scenario, disagreement is possible, but this cannot take the form of exclusion of the other from human relationship^{18,17}.

It is seen that, in the cultural construction of the subject who is undergoing psychic suffering in an acute mental crisis, he is perceived as someone who should be protected from himself and from others – this is explicit in the cases where the justification for admission is the concept that this person offers a risk to himself and to others. However, this creates a paradox, because within the aim to protect the subject and his surroundings, operationally the subject is in fact fenced-in, physically, subjectively and in terms of the subject's affects, by de-legitimizing of the dialog at the moment of crisis, annulling that subject in the relationship.

Precisely, the challenge of the Psychiatric Reform is to build a conjunction of supports consisting of material, subjective and social conditions that make communication possible starting from the basis of conflict¹⁸. For this to happen, the service needs to enter into dialog with the subjects' needs, and assume responsibility for complete care: this premise seeks to overcome the logic of the selection of demand, and of the fragmentation of services, and signifies a new ethical form of relationship between people, operating based on singularization of care, and on the needs of the subjects¹.

Conclusion

The study points to the contemporary contradiction of the Psychiatric Reform, in the coexistence of different logics for care in a crisis situation: admission for overnight stay is planned for, when necessary, in CAPS–III's and in General Hospitals, but admissions to asylum-type institutions are still taking place.

A crisis means a complex existential situation, and the instruments and resources for dealing with this also need to be complex, covering all the dimensions of the Psychiatric Reform. In

Brazilian mental health care there is a need to build strategies and devices that seek to redeem, for the subject, his place as protagonist in the actions that take place, and create a routine way of working in the health services and network that re-inscribes the process of becoming ill as an integral part of life.

Collaborators

Cláudia Pellegrini Braga worked on the conception and writing of the article. Ana Flávia P. L. d'Oliveira contributed to the analysis and worked on the critical revision of the manuscript.

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Translated by James Allen