The trajectory of Mental Health Policies in Argentina and Brazil: why different reform patterns?

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Abstract: Psychiatric reforms in Latin American countries are heterogeneous, although common ideals and objectives. The article analyzes the trajectory of mental health policies in Brazil and Argentina between 1990 and 2020. Under a historical-comparative design, explores political-institutional factors that may explain differences in policies established in these countries. The results point to the importance of the role developed by entrepreneurs of change, with social movements more cohesive in Brazil. The expansion of community rules and services took place especially in the political context of progressive governments, although this is not a sufficient factor to explain it. Federalism has not proved to be an obstacle to this. policies, but in Argentina, national legislative production has suffered more constraints than in the Brazilian case. Psychiatric reform is still a process in dispute in both countries.

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Introduction

The debate on psychiatric reforms in Latin America began back in the 1960s (Alarcón; Aguilar-Gaxiola, 2000). From the 1990s onwards, in the context of transition from authoritarian regimes to democracy in Latin America, mental health care reforms gained momentum (Desviat, 2015; Sosa, 2015).

After three decades, it is possible to evaluate that the implementation of mental health-care alternatives in Latin countries has progressed. The deinstitutionalization of the mentally ill is no longer limited only to hospitals but includes the expansion of services capable of having an impact on society and in the social practices surrounding psychological suffering (Agrest *et al*., 2018; Amorim; Dimenstein, 2009; Caldas de Almeida; Horvitz-Lennon, 2010). There have been plenty of initiatives aimed to imprint mental health care options opposed to the asylum model (Henao *et al*., 2016). However, political and institutional impasses have blocked the consolidation of the various reform experiences, concomitant with the growth in the prevalence and burden of disease in the region (Caldas de Almeida; Horvitz-Lennon, 2010). In addition, there are "multiple implementation patterns" of mental health policies (Agrest *et al*., 2018).

To better understand the reasons for the differences between them, this article seeks to respond to the scarcity of comparative research on the processes of change in the field of mental health care among the countries of the Latin America (Blanco *et al*., 2017), offering findings and reflections that can be compared in other studies (Gerlero *et al*., 2010; Heredia; Barcala, 2017). To this end, it analyzes the trajectory of mental health policies in Brazil and Argentina between 1990 and 2020.

The two countries were pioneers in welcoming new ideas that led to the implementation of psychiatric reforms (Blanco et al., 2017). They managed to establish commitments to restructure the mental health care systems, addressing the violation of rights within asylums, leading to an accumulation of relevant results (Camargo; Preuss, 2017). However, we identified two important dissimilarities: 1) the time for the establishment of national standards, given that Argentina manages to institute a National Law almost 10 years after Brazil; 2) the degree of homogeneity of the institutional arrangements established between the different subnational units under the aegis of a national policy, with Brazil having the larges expansion and homogeneity of the psychosocial network implemented.

Methodology

This is a study with a historical-comparative approach (Mahoney, 2008; Mahoney; Rueschemeyer, 2012). The selection of both cases considered that the countries are presidential republics that play leading roles South America, with similar backgrounds and state's organization.

As far as health policy is concerned, although originally based on corporativist models, there are significant differences. Brazil has managed to establishing health as a constitutionally defined universal right, although with a robust private sector, while Argentina guarantees universal access with strong segmentation of social insurance and diversification in financing.

The time frame is related to the fact that the reforms in mental health care in the Americas gained momentum only after the Caracas Declaration, agreed in 1990 (Desviat, 2015; Sosa, 2015). It also includes a period when both countries were already under democratic rule.

The research combined a documentary analysis complemented with semi-structured interviews. The information analyzed is the result of a narrative review of the literature, from various sources that included the databases SciELO, LILACS and PubMed, as well as laws, bulletins and official documents at national, provincial or state level as well as at local level, using the descriptors: Public Policies, Mental Health, Brazil and Argentina. Thirty-one documents were selected for the analysis of the Argentine case, 37 documents referring to Brazil and a total of 32 official documents (among which can be mentioned the National Mental Health Laws, the ordinances regulating flow and creation of services and subsequent relevant guidelines for expansion or modification of regulations in both countries). In addition, there were included fourteen interviews with key actors in the construction of the national policy of mental health in both countries, whether through social movements or government and service representatives, forming a purposive sample. More information about the identities of the participants have been reserved to protect confidentiality.

Chart 1. Research participants by period of action identified and affiliation institutional.

Interview with (E)	Level - Country	Action period	Institutional affiliation
E 1	Nacional - Argentina	2013 - Current	*Argentine Mental Health Association*
E 2	Nacional - Argentina	2005-2009	*Chamber of Deputies of the Nation*
E 3	Nacional - Argentina	2018 – 2020	National Health Ministry
E 4	National - Brazil	2001 - Current	National Anti-Asylum Movement
E 5	National - Brazil	1991 – 2011	Ministry of Health
E 6	State - Brazil	1990 – 1994	Undersecretariat for Human Rights
E 7	State - Brazil	2005 - Current	Ceará Anti-Asylum Forum
E 8	State - Brazil	1999 – 2000	Brazilian Society of Psychiatry Neurology and mental hygiene
E 9	National - Brazil	1987 - Present	Delegation of supervision of health services
E 10	Nacional - Argentina	2013 - Current	National Mental Health Reviewer
E 11	Nacional - Argentina	2019 - 2021	*Association of Argentine Psychiatrists*
E 12	State - Brazil	1991 - Current	Psychosocial Care Centers
E 13	State - Brazil	1993 - Current	Psychosocial Care Centers
E 14	National - Brazil	2015 - 2021	State Health Council

Source: own elaboration.

For both the analysis of the documentary material and the interviews, there were established categories of analysis derived from the reading of the material collected, aiding the analysis using the Atlas.ti software. The categories defined included: actors involved in the changes, rules and services built and aspects of the institutional or political contexts involved in each of the periods analyzed.

All the ethical principles corresponding to research with human beings have been considered, as well as the assessment by the Ethics Committee (Opinion nº 5.124.298).

Results

Mental health policy in Argentina: advances from the perspective of the provinces

In Argentina, the path to establishing a mental health system with an anti-asylum focus, although it has a distant origin in time, is, in the present, something still far from being achieved. Therefore, during the neoliberal reforms of the 1990s, greater autonomy for provinces in the provision of public services was reinforced in a context of low public financing. This period also experienced further changes in

health system, characterized by the introduction of market competition in the social insurance, known as *Obras Sociales*, and the expansion of private health care options (Machado, 2018).

Paradoxically, in the field of mental health, different attempts to introduce reforms in subnational units were initiated, and as pointed out by the interviewees, one of the greatest achievements corresponds to this era: the reform of Río Negro province, adopting an anti-asylum law in 1991, with Provincial Law No. 2.440. This law was a pioneer in Latin America, regarding de-asylumization, by directing the hospitalization of patients with mental health problems in general hospitals.

These advances are the fundamental basis for further development of the mental health system in Argentina, but they were isolated and unconnected facts, without reaching the expansion of a new health care model throughout the country under central coordination.

During the governments of Néstor Kirchner (2003-2007) and Cristina Fernández (2011-2015), health began to gain greater government interest. For example, the Federal Health Plan 2004-2007 was formulated (Ministerio..., 2004) structured around the strengthening of Primary Health Care. In it the State is presented as the guarantor of health for the population, aiming at equitable access to health and improving the accessibility, effectiveness and quality of services. Increasing support from the Human Rights Movements (which had their origins in the period of democratic recovery) began to be registered in Mental Health, giving impetus to the discussion about reform in the health system in general, and mental health in particular. There is an expansion of specific public programs, such as Plano Nascer and the Remediar program. The agenda for regulating social works and the private sector is also gaining ground (Machado, 2018).

In 2007, some provinces joined in the development of regulations to improve mental health systems. The demands of the human rights movements, which emerged after the last civic-military dictatorship, gained strength during this period, representing support for a national psychiatric reform. The Madres de Plaza de Mayo Association, for example, began to address the issue of mental health (Ardila-Gómez *et al*., 2019).

Presented by Congressman Leonardo Gorbacz (*Frente de Todos*), the project in discussion in parliament was in conflict with corporate and private interests. In 2010, the National Mental Health Law was finally passed, No. 26.657, incorporating

a turnaround in the perspective, under which suffering mental health had been addressed until then. For the first time, the nation state established guaranteeing dignified treatment for people suffering from mental illness.

In the following years, several events accompanied the legislation's momentum: in 2011, the *Comisión Nacional Interministerial en Políticas de Salud Mental y Adicciones* (CONISMA) was created, followed by the *Honorary Consultative Council* in 2014. In 2011 there were developed the *"Lineamentos para la atención de la urgencia en salud mental*", regulating the operation of various services: day care centers, health services in general hospitals, *Primary Health Care Centers* (CAPS), among others, with marked community, humanized and interdisciplinary orientation. Years later, standards he minimum requirements for the authorization of mental health establishments and services were defined by Resolution 1484/2015, so as to create the need to adapt of pre-existing establishments to meet the prerequisites required of attention.

Despite the slow progress in the first decade of the 2000s, the testimonies collected from the interviewees converge in pointing out that, during the government of Mauricio Macri (2015-2019), reigned the resistance to the implementation of the Argentine psychiatric reform, already present since the origins of the bill. Thus, the appointment of psychiatrist Andrew Blake as coordinator of the national board was considered a step backwards (Blanco *et al*., 2017), being a figure recognized as a critic of the National Law. The most representative of the measures adopted was the prescription of resolution 1003/2016, repealing resolution 1484/2015 on *Minimum Standards for the Authorization of Establishments and Mental Health Services*, which aimed to encourage the opening of mental health beds in general hospitals.

Under the strong economic crisis of the Macri government, the psychologist Luciano Grasso was convened in 2018 by the newly appointed Minister of Health. Although participating of a government supported by sectors resistant to the implementation of the National Law, Grasso was close to the groups in favor of the community model, which politically were opposed to the government. This change seems to have made it difficult to sign the presidential decree, drawn up by Blake, in which it was agreed that the psychiatric hospitals.

It is possible to think that, to date, little progress has been made in terms of change of the care model at national level. The interviewees' opinion was unanimous: the results expected in plans and regulations over the last twenty

years have not been affected, old-fashioned practices still persist, contradicting the latest laws, preventing the effective implementation of community-oriented services by the human rights paradigm.

Psychiatric Reform in Brazil: despite advances, imminent setbacks

Two sociopolitical movements emerged during Brazil's democratic recovery: the Brazilian Sanitary Movement (MSB), which brought the proposal of the right to health to be guaranteed by the State, and the Movement for Brazilian Psychiatric Reform (MRPB); the movement involved workers, users, family members and activists from the Human Rights to public and private providers, managers, even trade unions and associations (Pitta, 2011).

In line with the reforms in the field of health, which began in Latin America in the end of the last century, a proposal to universalize health care was established in the Brazilian Federal Constitution of 1988. The implementation of the Unified Saúde (SUS) had the participation of different actors, with the relevance of the protagonism of the Ministry of Health and the state and municipal secretariats. Despite the progress made in the 1990s, the neoliberal direction of the governments of the period, imposed limits on the Unified Health System (SUS) (Bravo, 2006; Paim, 2009).

The Brazilian Psychiatric Reform gained ground in the 1990s. Experiences previous institutional arrangements in various municipalities have established new modes of care in mental health. At this time, the recent diaspora of professionals to Brazil as political exiles of the Argentine dictatorship, reinforced the dialog between the two countries and the impact of the Argentine psychoanalysts in the trajectory of Brazilian psychiatric reform (Magaldi, 2018). The Argentine psychiatrists Antonio Lancetti, one of the most famous, deserve to be highlighted. leaders of the closure of the Casa de Saúde Anchieta, and Gregório Baremblitt, one of the founders of the Brazilian Institute of Psychoanalysis, Groups and Institutions (IBRAPSI) (Hur, 2014).

Ministerial Decrees 189/1991 and 224/1992 regulated the Centers of Psychosocial Care (CAPS) and the Psychosocial Care Centers (NAPS), implemented in Brazil as local services, and intermediaries between care outpatient and inpatient services, but without the prospect of substitute services to the hospital model (Amarante, 2020). Between 1992 and 1995, eight Brazilian states passed reform laws.

The state regulations were in line with elements contained in the Bill, presented by deputy Paulo Delgado, still in 1989, which would become Law No. 10.216/2001 - the Brazilian Psychiatric Reform Law (LRPB). In line with the main international guidelines, the LRPB determined a treatment of and quality, and gave a central place to the participation of society in the approach to mental suffering. Admissions to hospitals with asylums became more common. banned, but there was no obligation to phase out hospital psychiatric.

Moreover, during the government of Fernando Henrique Cardoso (1995-2002), Ordinance No. 2391/2002 regulated the control of involuntary psychiatric hospitalizations, while Ordinance 336/2002 established the guidelines for the operation of the Centers. Psychosocial Care Centers (CAPS). These services are the strategic part of the mental health care network, constituting substitutive services and redirecting psychosocial care in community facilities (Brasil, 2004).

In the first year of Lula's government (2003-2010), the Back to School Program was inaugurated as well as the *Volta a casa* program, aimed at the social reintegration of people with a history of long hospitalization psychiatric. Amarante (2020) points out that ordinances 52/2004 and GM/MS 2644/2009 encouraged the reduction of beds in psychiatric hospitals, based on stimuli with the capacity to induce subnational governments to join. In from 2002 to 2015, 25,405 psychiatric hospital beds were reduced and the number of CAPS in the country has expanded (Brasil/MS, 2015).

The creation of a mental health care network to replace the model hospital-centered, and the progressive and programmed reduction of beds in hospitals psychiatric facilities throughout the country characterize mental health policy the late 1990s and early 2000s (Almeida Filho *et al*., 2015; Pitta, 2011), although under the opposition of some actors such as the Brazilian Federation of Hospitals. On the other hand, the Mental Health Coordination, within the Ministry of Health, brought together various representatives of the RPB from the process of re-democratization. Users and their families were also involved also defending a more humane and effective model at local government level.

The implementation of other services was also encouraged throughout the country. This was the case of Therapeutic Residential Services (TRS): housing for people who have been released from long hospitalizations with broken family and community ties and for dehospitalization and social reintegration (Ordinance 1220/2000 and

complemented by the Ordinance No. 3090/2011). The Psychosocial Care Strategy (EAP) and Evaluation Constant Psychiatric Hospitals were established, through the Program of Evaluation of Hospital Services (PNASH), which sought to inspect all the psychiatric hospitals and beds in psychiatric units with the aim of adapting them to the needs of the population. them to the minimum quality requirements (Almeida Filho *et al*., 2015).

During Dilma Rousseff's government (2011-2016), Ordinance No. 3088 was issued to The Psychosocial Care Network (RAPS) was established with the aim of providing care to through an expanded and articulated network of SUS services. Despite being Considered a significant step forward, RAPS included the Communities Therapeutic Therapies (TC), criticized in the academic and political fields for the use of religious and moralizing aspects to deal with the drug issue, since guiding their practices based on abstinence (Amarante, 2020). The end of this period coincides with strong pressure from groups linked to the interests to contain social spending in the midst of the crisis international economy (Machado, 2018).

The advance of the Brazilian counter-reform began to show signs in 2015. Groups and entities linked to the RPB, such as the Movement of the Anti-Asylum Struggle, manifested themselves against the appointment of the former director of Brazil's largest psychiatric hospital (closed after several complaints), Valencius Wurch Duarte Filho, for the position of Coordinator National Mental Health Commission (Machado, 2018; Pitta; Guljor, 2019), which was ousted on 2016 after the pressure. Despite this, the "tide of directionalization of the policies of counter-reform" continued with the appointment of a representative of the Association Brazilian Psychiatry Association (ABP), which opposes the RPB (Pitta; Guljor, 2019).

After the *impeachment* process of President Rousseff, under the strengthening of conservative and liberal ideals (Machado, 2018), Vice President Michel Temer assumed the presidency of the country (2016-2018), initiating a process of reduction of public spending and social rights, stimulating the expansion of the private sector of health and the dismantling of the welfare state (Pereira, 2020). The Constitutional Amendment No. 95 (EC 95), which established a New Fiscal Regime, limiting public spending on health for 20 years.

In 2017, a "New Policy" began to take shape in the Ministry of Health Mental Health". With the approval of the Tripartite Interagency Commission (CIT), new guidelines for the operation of RAPS were established, among them the inclusion

of psychiatric hospitals and increased payment for hospitalizations. These new guidelines were supported by the ABP, the Federal Council of Medicine (CFM), the Association of friends and relatives of the mentally ill and the federal government, in a way verticalized, without taking into account the broad debate with workers, movements social organizations and researchers in the area (Pereira, 2020).

Government Bolsonaro started in 2019, followed the same "Reasylum trend", which also expresses a societal project of the extreme right (Pereira, 2020). An example of this was the publication of Technical Note No. 11/2019 by the Ministry of Health. This note marks a change in discourse and "the effectiveness of the model in force until 2017 and the direction of a policy based on care community, affirms the need to increase the number of psychiatric beds and repudiates the idea of closing hospitals" (Cruz; Gonçalves; Delgado, 2020, p. 11).

In the same year, the National Drug Policy (PNAD) left the Ministry's purview of Health to be responsible for articulating and coordinating the Ministry of Citizenship and Ministry of Justice and Public Security (Brasil/MS, 2019). The signing of Decree 9761/2019 emphasized the financing of TCs, in a prohibitionist approach (Cruz; Gonçalves; Delgado, 2020). A quote of services outpatient disregarded the coverage of Primary Care teams, specialized actions matrix support in the territory by the NASF and the CAPS themselves. Child and adolescent mental health was only mentioned related to psychiatric hospitalizations concerns. It reappeared in the defense of the electroconvulsive therapy (ECT) technique (Pitta; Guljor, 2019).

Over the course of two and a half decades, Brazil has experienced a progressive and coordinated deinstitutionalization of asylum-based care, process widespread at national level. However, since the second half of the decade, it has witnessed of the 2010s, a dismantling of the advances achieved at the national level by policy mental health, as has been the case with all social rights and with democracy itself, something that has led to an intensification of tensions between projects antagonistic to mental health.

Encounters and divergences along the way

Since the 1960s, social actors in Brazil and Argentina have been pushing for reform psychiatric, with similar ideological references, but there are differences in pace, in the design and scope of national mental health policies.

First of all, it is important to highlight the organization and the role played by the following actors societies in favor of reform. In Brazil, the psychiatric reform movement was reinforced after complaints from mental health workers about the conditions of work and the violation of human rights of people with mental disorders, creating specific and organized movements, which gave strength to the reform psychiatric reform in the context of an expanded health system (Amarante, 2020).

In Argentina, even if the dispute of interests was also strong, especially as a result of corporate struggles between psychologists and psychiatrists. reflected in the debate on the approval of the National Mental Health Law, the collectives of the pro-psychiatric reform struggle seem to have had less cohesion. A health reform mental health in Argentina gained momentum after the inclusion of this issue on the agenda of the human rights movements in the 2000s.

It is important to note that, unlike Brazil, where recently a head of the National Executive exalts memories of the dictatorship and refuses to promote justice to the victims almost fifty years after the military coup, impacting the various policies implemented after the Federal Constitution of 1988, the difficulties of progress in the Argentina are of another order than the retrogression promoted by forces favorable to authoritarianism (Canet; Mazzeo, 2016). In any case today, we have identified the strong presence of actors opposed to the reform in both countries, including hegemonic groups in private medicine, the pharmaceutical industry and, in the case of Argentina, even the judiciary (Alarcón; Aguilar-Gaxiola, 2000; Caldas de Almeida; Horvitz-Lennon, 2010).

However, there were a number of obstacles to the successful formation of a care network in line with the proposal of national laws and regulatory frameworks international: the reduction of the reform to a process of dehospitalization and the complete shift of mental health care to substitute services integrated into the wider health network (Amorim; Dimenstein, 2009), making it necessary to take a critical look at the professionals' work process, at the risk of reproducing the asylum model in their workplaces. segregation provided in the nursing homes of yesteryear (Clementino *et al*., 2019).

The informants' statements highlight the predominance of intervention practices that are not in line with the reorganization of the care paradigm in the United States. workers in the area. It can be said, then, that the barriers that presented themselves

were did not correspond to the legislative level, but to the factual level of adaptation of the care practices and care environments to an approach of respect for the human being human rights (Heredia; Barcala, 2017; Rosendo, 2013).

In Argentina, due to the country's specific organizational characteristics, there is a more diverse and asynchronous legislative production, according to the needs of each province. This clearly makes it difficult to secure changes in the Argentine legislature. The anti-asylum movement is beginning to take hold only after the beginning of the 21st century, irregularly throughout the country, only which was unified into a national law in 2010. For this reason, the mental health in the country was incipient. Among other things, the creation of alternative services to the psychiatric hospital, one of the main objectives of the Law, still is far from being achieved, as much as investment in mental health (Gerlero *et al*., 2010).

In the case of Brazil, Ordinance No. 3088/2011 creating the Network of Psychosocial Care (RAPS) as a concrete step in the articulation of services aiming anti-asylum options. However, the interviewees agree that in the nowadays, new regulations are reformulating the design, financing, methodology and evaluation of services and the very clinical orientation of the RAPS. Referred to by interviewed as a "psychiatric counter-reform" movement, it is about support the return to psychiatric hospitals as a relevant therapeutic resource (Cruz; Gonçalves; Delgado, 2020).

On the other hand, despite the expansion of community services with the structuring of a mental health network at various levels of care, a reduction in the number of beds in psychiatric hospitals and greater control of psychiatric hospitalizations, remnants of asylum's practices are notable, as well as obstacles and disputes between one model and another. psychosocial care and nursing homes, especially in recent years (Cruz; Gonçalvez; Delgado, 2020; Pereira, 2020; Pitta; Guljor, 2019). It is also point out that despite Brazil's legislative achievements, and the fact that they have been reflected in practices and services created in recent times, the setback is not only about to do with the closure or suffocation of the budget for these services, but also with the dismantling of regulations and the establishment of new policies against psychiatric reform.

In Argentina (despite the post-law initiatives), the mental health system has yet to has succeeded in improving its services, as can be seen, for example, in the permanence of individual approaches, difficulties in organizing the teams of mental health in care centers and in adapting to the new regulations, lack of articulation between the

services, generating limitations in access and follow-up of the treatments, and lack of prevention and rehabilitation programs perpetuating, models of care based on previous paradigms (Marazina; Paulo, 2011).

With regard to the role of governments, it is possible to observe that although it is important for the reforms, they are not enough. In both countries, the process of the construction of mental health policy has been strained by policies and governments (community vs. hospital model; market interests vs. social interests; neoliberal state versus social democratic state). It is worth remembering that governments usually imply different projects on social policy; therefore, it is different political contexts are expected to represent opportunities or obstacles to changes in public policies (Sátyro; Cunha, 2018) in the case studied, undertaken by actors defending psychiatric reforms.

From the 2000s onwards, which coincides with the advance of the pink wave in the countries of the Latin America, it was possible to expand ideas, regulations and services substitutes for psychiatric hospitals. In Brazil, this represented a major step forward in towards a community-based, anti-asylum health system (Pereira, 2020). In this regard, Argentina has taken an important step in establishing agreements national. However, since 2015, both countries have resumed neoliberal policies translating into an outright setback for Brazilian mental health (Cruz; Gonçalves; Delgado, 2020; Pereira, 2020; Pitta; Guljor, 2019) and addition of obstacles to the (already difficult) progress of these policies in Argentina (Blanco *et al*., 2017).

It is possible to think that making changes to public policies and plans and accompanying legislation is necessary, but not sufficient for effective changes in one direction. It should also be borne in mind that characteristics of the countries' federalism influence the process of change ongoing and that specific policies, such as the case of mental health, are conditioned Thus, in Brazil, the psychiatric reform was strengthened by the concomitant reform which led to the creation of the SUS, in the context of a federalist arrangement (Menicucci, 2017; Soares; Machado, 2020).

In Argentina, on the other hand, the Union's coordination capacity is more restricted, with the provinces with greater autonomy to legislate and implement policy. In the years following the sanction of the first Latin American anti-asylum law (the 2044 of 1998), many provinces have created laws and provisions that followed the commitment to improving user care, but always with disjointed projects between them and without a national guiding framework. resulted in inefficient, disorganized and profoundly different services in each province (Blanco *et al*., 2017).

These findings converge with the conclusions of Soares and Machado (2020) about the relationship between federalism and social policies in both countries. In none of them have shown federalism to be an obstacle to such policies, but in the Argentina, national legislative production has been more constrained, leaving more room for provincial legislation. This is explained by the fact that the Brazil has a higher degree of jurisdictional centralization, with the Executive being able to national produce constitutional and infra-constitutional legislation with less influence of governors in the National Congress (Soares; Machado, 2020). In Argentina, there seem to be more institutional obstacles to national dissemination of social policies, although in the Brazilian case this becomes a disadvantage under a central government explicitly committed to retrogression. This reinforces findings in which it is observed that political-institutional design can make it viable, or not, the formulation and implementation of national policies. In other words, we start from premise that different federalist arrangements have effects on the conformation and the development of public policies, including the possibility of constraining proposals redistributive and/or universal content (Machado, 2014).

The territorial and political division of the country has consequences for configuration and development of social policies, particularly for those universalist character. But it should be borne in mind that federalism is a phenomenon multiple that depends on the institutional configuration of each country, as well as the context and socioeconomic or political factors that affect the decision-making process and therefore the shaping of public policies (Menicucci, 2017). The characteristics of the distribution of power in Argentina, unlike Brazil, diminish the concentration of legislative power at the national level, promoting the isolation of the experiences (albeit early ones) and the delay in creating national legislation, with support for the implementation of care alternatives throughout the country.

Final considerations

The public health policies analyzed do not operate in a vacuum. They were constituted in a socioeconomic and political context with different governments that condition (Mahoney; Thelen, 1900). It is therefore necessary to understand that despite the similarities between the countries, the peculiar situations of each one redefines the development of the mental health policy process.

As reflected in the work, the characteristics of each period analyzed marked the direction that public policies have taken; therefore, it is necessary to consider taking into account the various factors that affect, enable or hinder implementation of policies, as the characteristics of the groups have been highlighted here societies involved, governments and socio-political, economic and social contexts. in each period. It was also noted that public policies more general impact on specific policies and the particularities of the systems federation of the countries were relevant to achieve a comprehensive understanding of changes in mental health policies.

The struggle for the right to universal access is evident in the trajectory of these countries, to decent health care, with a focus on human rights and quality, has not yet is a definitive victory. On the contrary: in the face of some signs of regression, it becomes it is necessary to (re)establish policies and institutions that reposition progress in towards the psychosocial care model.[1]

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Note

[1] L. B. Pérez: conception of the research design, conduction of methodological procedures, analysis of results and writing of the article. A. Pinheiro: conception of the research design, analysis of results and writing of the article. J. A. Machado: relevant critical review of the intellectual content and final writing. C. E. L. Araújo: conception of the research design and definition of the theoretical framework, analysis of results, writing and approval of the final version.

Resumo

Trajetória das políticas de saúde mental na Argentina e no Brasil: por que diferentes padrões de reforma?

As reformas psiquiátricas nos países da América Latina são heterogêneas, apesar de ideais e com objetivos comuns. O artigo analisa a trajetória das políticas de saúde mental no Brasil e na Argentina entre 1990 e 2020. Sob um desenho histórico-comparativo, explora fatores político-institucionais que podem explicar diferenças nas políticas estabelecidas nestes países. Os resultados apontam para a importância do papel desenvolvido por empreendedores de mudanças, com movimentos sociais mais coesos no Brasil. A expansão de regras e serviços comunitários ocorreu principalmente no contexto político de governos progressistas, embora este não seja um fator suficiente para explicá-la. O federalismo não se mostrou um obstáculo a tais políticas, porém na Argentina, a produção legislativa nacional tem sofrido mais constrangimentos do que no caso brasileiro. A reforma psiquiátrica ainda é um processo em disputa nos dois países.

➤ **Palavras-chave:** Política de Saúde. Reforma dos Serviços de Saúde. Saúde Mental. América Latina.