



Paths and detours in the trajectory of the Brazilian psychiatric reform

Caminos y desvíos en la trayectoria de la reforma psiquiátrica brasileña

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ABSTRACT This article looks at the principles and guidelines of the Unified Health System as well as the current situation and the limitations and possibilities of Brazilian mental health policy. Based on a review of national and international government documents and the scientific literature from 2015-2020, the study observed positive advances in mental health. However, the psychiatric reform has experienced setbacks, and the balance of mental health care has swung towards hospital-centered treatment. These changes have impeded the implementation of the Psychosocial Care Network, as well as the development of therapeutic practices and strategies focused on the person's experience, their daily life and their relations with the health promotion network. By questioning the supremacy of medical-psychiatric knowledge in the treatment of "mental illness" in the public health care system, the psychiatric reform cleared a path for the construction of new ways of addressing psychological suffering. These gains are currently at risk, making a wider debate on the current trends in mental health care in Brazil essential.

KEY WORDS Mental Health; Deinstitutionalization; Mental Health Services; Psychiatric Reform; Unified Health System; Brazil.

RESUMEN Este artículo aborda los principios y lineamientos del Sistema Único de Salud y revisa la actual política brasileña de salud mental, sus limitaciones y posibilidades. A partir de una revisión de documentos gubernamentales nacionales e internacionales y de la bibliografía científica desde año 2015 hasta 2020, confirmamos avances positivos en el cuidado de la salud mental. Sin embargo, la reforma psiquiátrica se ha retrasado y el equilibrio de la atención de la salud mental se ha desplazado a favor del tratamiento centrado en el hospital. Esto ha frenado la implementación de la Red de Atención Psicosocial, y el desarrollo de prácticas y estrategias terapéuticas enfocadas en la experiencia de la persona, su vida diaria y sus relaciones con la red de promoción de la salud. Al cuestionar la supremacía del conocimiento médico-psiquiátrico en el tratamiento de las "enfermedades mentales" por parte de la atención pública, la reforma psiquiátrica abrió el camino para la creación de nuevas formas de abordar el sufrimiento psicológico. Esto está en riesgo ahora y pedimos un debate más amplio sobre las tendencias actuales en la atención de la salud mental en Brasil.

PALABRAS CLAVES Salud Mental; Desinstitucionalización; Servicios de Salud Mental; Sistema Único de Salud; Brasil.

CONTEXTUALIZATION OF THE STUDY

Brazil is the largest country in South America and the fifth in the world in terms of extension, with an area of 8.5 million square kilometers and a total population of approximately 210 million.⁽¹⁾ It is divided into 27 states, 5,568 municipalities, the Insular District of Fernando de Noronha and the Federal District, characterized by major differences in demographic distribution and social indicators.⁽¹⁾ According to the World Bank⁽²⁾ the population's per capita monthly income is US\$268.90.

Table 1 shows Brazil to be a country with broad geographic borders sociocultural diversity with significant specificities in its population and miscegenation in its five geographical regions, and therefore specific demands in mental health.⁽¹⁾

The Brazilian health system was influenced by the sanitary movement that changed the health promotion paradigm in the 1970s and by the National Movement for re-democratization in the 1980s, which led to

inclusion in health treaties as Brazil became a member country of the World Organization Health (WHO) and the Pan American Health Organization (PAHO).

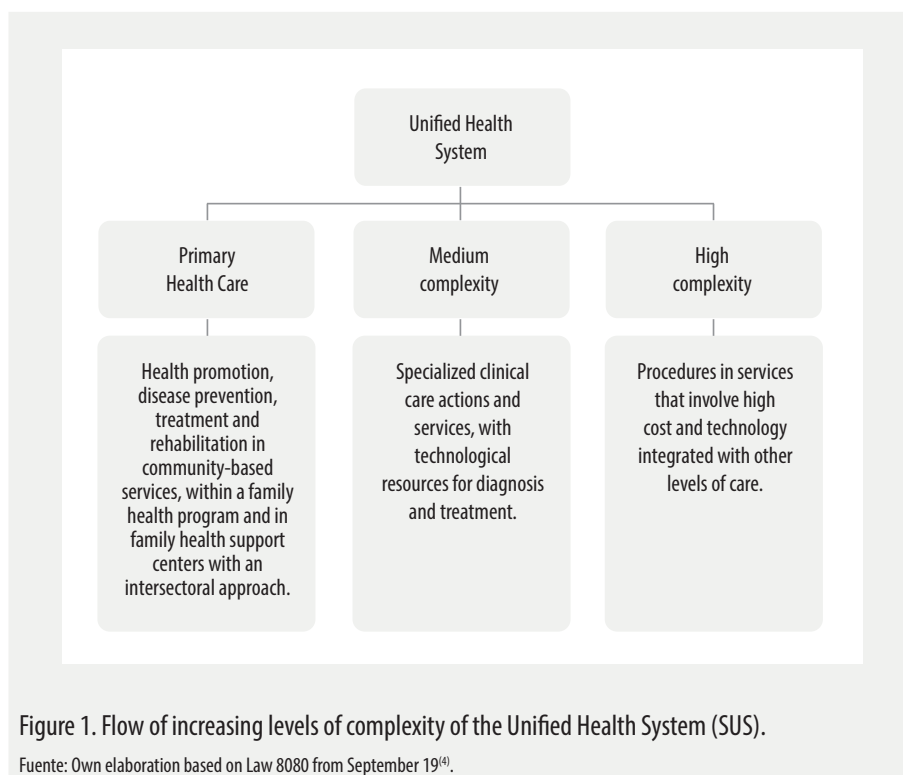
In 1990, the PAHO and the WHO published a document entitled "The restructuring of psychiatric care in Latin America: a new policy for mental health services," known as the Caracas Declaration,⁽³⁾ which had a strong impact on Brazilian psychiatric reform.

In the same year as the Caracas Declaration, the Unified Health System [*Sistema Único de Saúde*] (SUS) was regulated by Laws 8080 and 8142, both passed in 1990, which define the array of health actions and services provided by the federal, state, municipal and Federal District public agencies and institutions as well as the administration and foundations maintained directly and indirectly by the government.⁽⁴⁾ The private sector also contributes on a contractual basis with public authorities, who maintain the right to govern, control and inspect services. The Ministry of Health is responsible for monitoring and directing all health care activities, but the provision of health services is the responsibility of municipal governments, while funding

Table 1. Profile of the Brazilian Population (N=209.5 million). Brazil, 2016.

Category	
Life expectancy at birth	Average in years
Women	79.4
Men	72.2
Race/ethnicity	%
Brown (<i>pardo</i>)	46.7
White	44.2
Black	8.2
Asian	0.9
Indigenous	0.3
Population by state (most populated states)	In millions
São Paulo	45.5
Minas Gerais	21.0
Rio de Janeiro	17.1
Bahia	14.8
Rio Grande do Sul	11.3

Source: Instituto Brasileiro de Geografia y Estadística (IBGE)⁽¹⁾.



is provided by the federal government and states. Brazilian citizens have a constitutional right to free medical care provided by the State, without any type of discrimination.⁽⁴⁾

The actions and services of the Brazilian public health system are guided by the principles and guidelines of universality, equity and integrality. SUS services are organized hierarchically and regionally, in levels of increasing complexity, as illustrated in Figure 1.

METHODOLOGICAL ASPECTS

Based on an analysis of national and international government documents recovered from DATASUS and the Brazilian Institute of Geography and Statistics, as well as articles and theses recovered from the Literatura Latinoamericana de Información en Ciencias de la Salud (LILACS), Medline and Scientific Electronic Library Online (SciELO) databases, the aim of this article is to analyze the principles and guidelines of the SUS as well as the

current situation and limitations and possibilities of Brazilian mental health policy.

The mental health policy of the SUS is regulated based on the national public health policy guidelines. It therefore includes strategies and services at the three levels of complexity. A 25-year systematic review study on mental health presented relevant data pertaining to studies and publications on different themes associated with the enactment of the Mental Health Law, as a benchmark for evidence in this field.⁽⁵⁾

In this sense, the psychiatric reform process points to the constitution of a psychosocial model and a psychosocial care network that, while fickle and irregular and with gaps in its effectiveness, has also shown significant gains, such as a valorization of mental health service users' voices. As the model has gained greater relevance, it has put into evidence that the structuring of the field of mental and collective Health in Brazil is closely related to social issues, to citizenship, to confronting inequalities and prejudices – that is, to political issues and democracy.⁽⁵⁾

HISTORICAL MILESTONES OF BRAZILIAN MENTAL HEALTH POLICY

The first Brazilian psychiatric hospitals emerged at the end of the 19th century, with the arrival of the royal family in Brazil. The approach was hygienicist and disciplinary, aimed at people labeled as deviants from the socially established norm. In 1890, under public administration, the so-called Medical-Legal Assistance for the Alienated was created. Its asylum-focused character sustained exclusionary care practices for decades, which formed asylum ghettos in which individuals were confined.

Amarante^(6,7,8) describes four dimensions to Brazilian psychiatric reform: 1) the technical-conceptual dimension, as the technical process of the theory that sustains the psychosocial model; 2) the technical-care dimension as a network of services that replace traditional services, focused on subjectivity and sociability; 3) the legal-political dimension, focused on the reorganization of legislation; and 4) the sociocultural dimension, focused on social practices of inclusion people with social disadvantage.

In this sense, the historical process of Brazilian psychiatric reform is marked by the anti-asylum movement of family members, users and civil society activists, with a de-institutionalization perspective organized in these four dimensions through which Amarante⁽⁶⁾ considers a complex process including cultural, social, economic, political and philosophical contexts.

In the 20th century, during the 1930s, during the Estado Novo period, large hospices were renovated and expanded, becoming the center of all mental health policy. Until the 1950s, large hospitals were nationalized according to State policy.

In the 1960s, a time of military dictatorship, asylum policy underwent great expansion, as private clinics were contracted and funded by Social Security; in the future, this structure would constitute the major problem of Brazil's mental health policy.

The privatization model, not only in mental health but in all areas of health, was considered one of the aspects that caused the institutional and financial crisis that Social Security suffered in the early 1980s. Asylum practices followed the suit of the sanitary reform movement that, in the late 1970s, had begun to outline a form of popular participation in the health sector.

The first attempts to reform this system occurred in the 1970s, with local actions, including small "therapeutic communities" and community-based projects as alternatives to the psychiatric hospital.

With the regulation of the SUS in 1990, a series of changes in mental health policy were introduced based on the Declaration of Caracas and the PAHO. With the main goal of restructuring the psychiatric system, the Ministry of Health gradually redirected resources to an alternative model, reducing hospitals and hospital beds and introducing territory-based services that would guarantee people's civil rights within their social context environment and prioritize voluntary treatment.

According to Amarante,⁽⁶⁾ between 1978 and 1980, the current movement for Brazilian psychiatric reform took shape, with the Mental Health Workers Movement [*Movimento dos Trabalhadores em Saúde Mental*] (MTSM) as its key figure. Mental health policy has historically had as central to its implementation the involvement of workers, users, family members and civil society in national mental health conferences, in which they would debate and come to agreement regarding the program of reform and which, in a major mobilization effort throughout the country, throughout history, has enabled a broad discussion regarding the needs, challenges and perspectives that best correspond to the guidelines of the psychosocial model. In all, four conferences were held with historically relevant themes, as shown in Table 2.

It is important to highlight the importance of the progressive participation of all actors involved with mental health in the conferences, with some illustrative events. The first conference upheld the closing of

Table 2. Themes and relevant points of the national conferences on mental health. Brazil, 1987-2022.

Year	Conference	Theme	Relevant points
1987	I	For a society without asylums.	Development of the 8th National Health Conference that established the right to health of all and the State's duty and proposed the SUS.
1992	II	The restructuring of mental health care in Brazil, based on the Italian deinstitutionalization perspective.	Significant participation of service users and of all segments of the health sector.
2001	III	To care for, but not exclude.	Collection of practices and methods focusing on mental health care experiences outside of the hospital.
2010	IV	Mental health, the rights and commitments of all: consolidating advances and facing challenges.	Significant investments in specific policies.
2021 2022	V	May 17-20, 2022 (approved by the National Health Council on September 8, 2021).	In response to the mobilization of non-governmental movements such as associations in response to the central government's counter-reform process in the SUS and the involution of mental health care.

Source: Own elaboration based on the Conselho Nacional de Saúde⁽⁹⁾, Ministério da Saúde⁽¹¹⁾, #susconecta⁽¹⁶⁾.

asylum institutions and the emergence of the first psychosocial care centers, with national repercussions for the possibility of building a care network that effectively replaced the psychiatric hospital. The fourth and at present fifth conferences were instituted due to public mobilization, with the trip of actors in mental health to Brasília in 2009 and the movement of associations with autonomous mental health conferences in 2020, respectively.⁽⁹⁾

This movement incorporated guidelines from the "Alternatives to Psychiatry Network," becoming the Movement for a Society without Asylums. As the tradition initiated by Franco Basaglia resurfaced, the deinstitutionalization process took on on a theoretical-conceptual character, leaving behind the idea of administrative and financial reform.

Between 1992 and 2001, specific strategies for deinstitutionalization were implemented in Brazil, such as stricter controls over new hospitalizations, increased funding

of alternate services, and expansion of the outpatient mental health network.

In 2001, Law 10216,⁽¹⁰⁾ known as Lei Delgado, was passed after twelve years of debate in the Brazilian National Congress, ensuring the protection and rights of people in psychological distress. As a result of this law, in the last two decades there have been significant changes in psychiatric care, with the expansion of new territory-based services, a reduction in the number of psychiatric beds and the assurance of citizenship rights in mental health care.

Law 10216⁽¹⁰⁾ prohibits the construction of new psychiatric hospitals and the hiring of private beds for public use, considering admission to psychiatric units only when extra-hospital resources are shown to be insufficient. Article 4 of this law establishes that hospitalization, in any of its modalities, will only be indicated when extra-hospital resources are insufficient and after a detailed medical report. It established only three

types of psychiatric hospitalization: voluntary, which occurs with the person's consent; involuntary that occurs without the person's consent, but at the request of third parties; and compulsory, where admission is determined by court.

Hospital beds were implemented in general hospitals with a maximum of 10 beds, psychosocial care centers (CAPS III) with an average of 10 beds, general emergency rooms, and hospital referral services for the abuse of alcohol and other drugs. The network of available beds must be integrated in order to replace psychiatric hospitals and long-term hospitalizations.

As a result, there was a 50% reduction in public and private psychiatric beds between 2002 and 2015, as shown in Figure 2.

As of 2015, however, there was a substantial increase in public resources for the private hospital sector, according to national data on hospitalizations in private hospitals in Brazil (Figure 3).

In 2015, following the Lei Delgado,^(10,11) which established a gradual reduction in the number of psychiatric hospital beds, the Ministry of Health specified as the minimum requirement for psychiatric beds the ratio of 1 to every 23,000 inhabitants or 4 beds per 100,000 inhabitants.

Another significant aspect of the psychiatric reform refers to the care provided

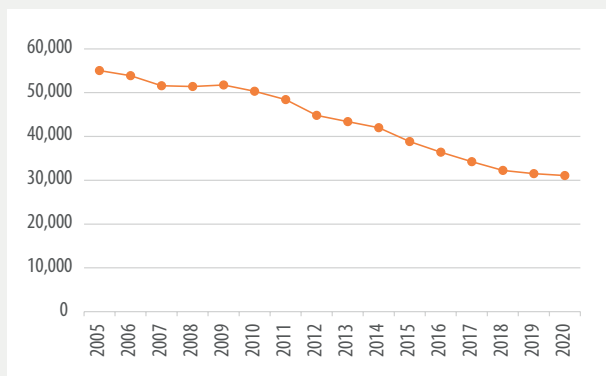


Figure 2. Number of psychiatric beds in public hospitals. Brazil, 2005-2020.

Source: Own elaboration based on data from the Ministério de Saúde, DATASUS⁽¹⁹⁾.

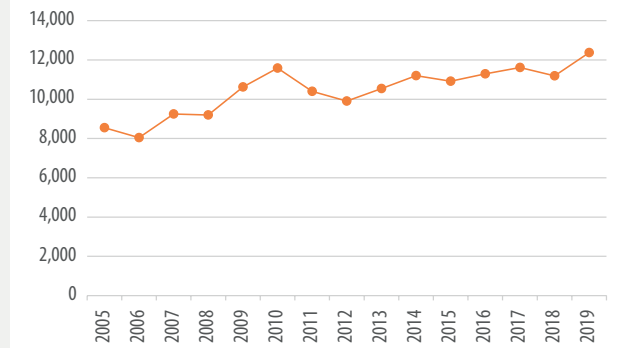


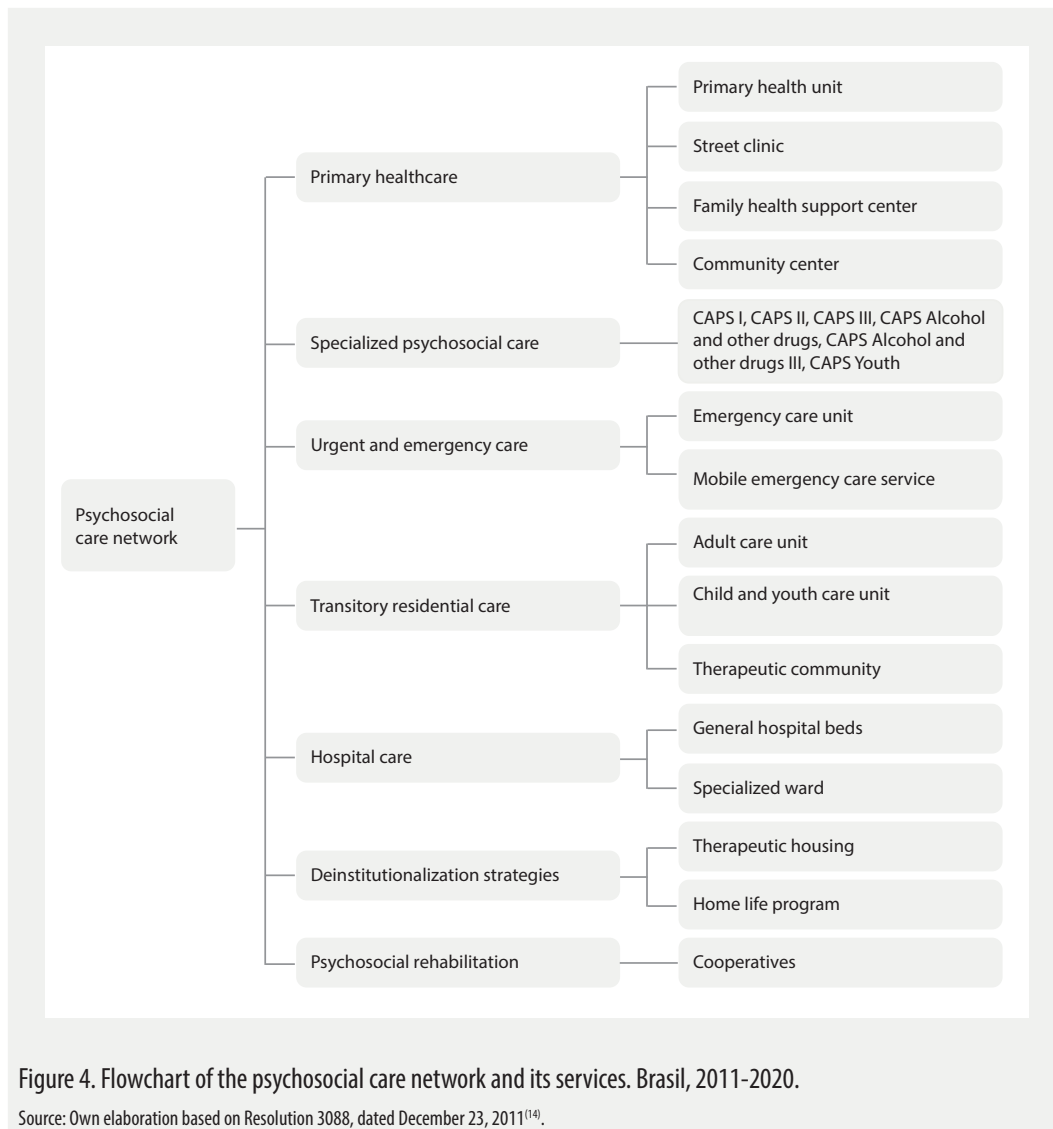
Figure 3. Number of psychiatric beds in private sector hospitals. Brazil, 2005-2020. .

Source: Own elaboration based on data from the Ministério de Saúde, DATASUS⁽¹⁹⁾.

for individuals with abusive use of alcohol and other drugs. Public policies for this target population advanced slowly. In 2006, an important factor for this advance was the inclusion of intersectoral strategies for services that operate in this area. Popular participation has expanded through regional and national forums and Brazilian and international epidemiological reports on drug use.^(7,8,12,13) The current National Drug Policy had been developed in specific areas, such as, for example, the National Policy on Alcohol.

In 2009, the problem of drug use became evident as a worldwide concern with respect to the need to consider new strategies, which resulted in the Emergency Plan to Expand Access to Treatment and Prevention in Alcohol and Other Drugs. As a member of world organizations, Brazil had to respond to the agreed-upon resolutions regarding mental health care, making large investments in this area and expanding treatment strategies.

The program "*Crack, é Possível Vencer!*", was regulated in 2010, and increased investments to several sectors aimed at tackling the issue, with the participation of the Ministry of Health, the Ministry of Social Development, the National Secretariat of Drugs Policies and the Ministry of Justice. The program was organized around three areas – care, prevention and authority – and included significant



investment in training and in the expansion of care services in this sector.⁽¹³⁾

Another milestone in mental health policy was Ordinance 3088,⁽¹⁴⁾ which ten years after Law 10216 consolidated the inclusion of services other than the psychiatric hospital in the care provided for the mentally distressed, creating a Psychosocial Care Network [*Rede de Atenção Psicossocial*] (RAPS) as a model of psychosocial mental health care, by means of the actions of an intersectoral network of services, in which there is no centralization of care, but rather a variety of services and therapeutic strategies that focus on the territory and on the individual's demands. In the

Psychosocial Care Network, services and strategies that replace the hospital model are presented, with care provided according to the psychosocial model centered in primary care, specialized psychosocial care, urgent and emergency units, transitional residential care, deinstitutionalization strategies and psychosocial rehabilitation. Territory and community-based services follow the open doors policy, in which anyone can access these services, located as close as possible to the individual's territory, family and social network.

Each Psychosocial Care Network service (Figure 4) must be linked to a variety of community-based organizations, such as

associations, churches, schools, police, primary health units, commerce, sports courts, among others. The services operate in this broader network, in order to promote the well-being and social integration of people with or without psychological distress, ensuring citizenship and the protection of individual rights.

Primary health care units are the first point of contact with the SUS, guided by the principles of universality, equity and integrality, integrating the RAPS as a strategic point of care with several programs (Figure 4). According to the Ministry of Health,⁽¹¹⁾ primary health units have the responsibility of promoting mental health, prevention and care for people with a history of psychological distress, and taking action to minimize the health effects resulting from the misuse of substances, as well as working in close collaboration with other network service components, such as the Family Health Strategy [*Estratégia Saúde da Família*] (ESF) and the Family Health Support Center [*Núcleo Ampliado de Saúde da Família*] (NASF).

The National Mental Health Policy, in the years following 2015, experienced a great decline, culminating in actions such as Ordinance 3588 of December 21, 2017,⁽¹⁵⁾ which modified the Psychosocial Care Network and included new services that led to an increase in number of psychiatric hospital beds. In this sense, the changes that have taken place imply a setback in the psychiatric reform, with the current government arguing in favor of a return to a hospital-centered treatment logic, justified by the scarcity of care, the creation of new hospitals, and the use of modern, efficient and high-quality protocols, reinforcing in the document that, regardless of the inclusion of psychiatric beds, the Federal Government will continue the incentives for deinstitutionalization, verifying that these actions are not contrary to the reform.^(14,15)

The Psychosocial Care Network

National and international documents have highlighted an approach focused on preven-

tion, control, early intervention, treatment, rehabilitation, social reintegration and support services as necessary measures. For the United Nations (UN), the Organization of American States (OAS), the World Health Organization (WHO), the United Nations Children's Fund (UNICEF), the United Nations Office on Drugs and Crime (UNODC) and the Pan American Health Organization (PAHO), psychological distress must be focused upon as a preventable disease, treated with a comprehensive, multifactorial approach and with a variety of interventions, both pharmacological and psychosocial, according to each person's different needs.

The Psychosocial Care Center [*Centros de Atenção Psicossocial*] (CAPS) is a territory-based substitute service tasked with providing clinical care on a daily basis, thus avoiding admissions to psychiatric hospitals, and promoting the social insertion of service users in intersectoral actions. It is therefore the role of the CAPS, *par excellence*, to organize the care network for people with psychological distress in the municipalities. These centers are the strategic articulators of the Psychosocial Care Network and mental health policy in the territory. According to the characterization of the CAPS in Table 3, we can analyze the different types of centers, their target demographic, their territorial coverage, and the composition of their staff.

The CAPS type is determined according to the population coverage index and the study of the health-disease epidemiological profile in the territory. In municipalities with less than 15,000 inhabitants, those experiencing a psychiatric crisis are referred to the nearest city's general hospital emergency room, and subsequently the closest CAPS is contacted. This articulation between municipalities causes a strain to the services. When hospitalization, specialist consults or specific treatment are needed, a person is referred to a city with greater coverage in the Psychosocial Care Network. As shown in Table 3, the territorial coverage of the CAPS is uneven, and in the current context, the psychiatric hospital continues to be an alternative and often the only option for a given municipality.

Table 3. Characterization of the psychosocial care centers. Brail, 2008-2020.

Characteristics	CAPS I	CAPS II	CAPS III	CAPS Youth	CAPS Alcohol and Drugs III
Target demographic	Adults Serious mental distress and use of alcohol and other drugs	Adults Serious mental distress	Adults Serious and persistent mental distress	Children and adolescents Severe and persistent mental distress and use of alcohol and other drugs	Adults, children and adolescents Use of alcohol and other drugs
Coverage	20,000	< 70,000	< 200,000	< 150,000	< 200,000
Working hours	Monday to Friday 8 a.m. to 6 p.m.	Monday to Friday 8 a.m. to 6 p.m.	24 hours a day	Monday to Friday 8 a.m. to 6 p.m.	24 hours a day
Staff	1 doctor 1 nurse 3 higher education professionals 3 technicians	1 psychiatrist 1 nurse 4 higher education professionals 6 technicians	2 psychiatrists 1 nurse 5 higher education professionals 8 technicians	1 psychiatrist or neurologist or mental health pediatrician 1 nurse 4 higher education professionals 5 technicians	1 general practitioner 1 psychiatrist 1 nurse 5 higher education professionals 9 technicians

Source: Own elaboration based on data from the Ministério de Saúde,⁽¹⁷⁾Vasconcelos.⁽¹⁸⁾

There are still significant gaps in the Psychosocial Care Network regarding crisis support, and especially crisis management, as satisfactory community health care services still constitute a challenge in Brazil. The Mobile Emergency Care Service [*Serviço de Atendimento Móvel de Urgência*] (SAMU) and the Emergency Medical Units [*Unidade de Pronto Atendimento*] (UPA) continue to be the main Psychosocial Care Network services in the provision of crisis care even though they are not specialized mental health services.

Of all Brazilian municipalities, about 3% (around 180) have a population greater than 150,000 inhabitants, a specific criterion for

implementing CAPS services (Table 3) that function 24-hours a day, and yet Table 4 shows a reduced number of Caps III in relation to the other types of CAPS. An important factor is the difficulty in establishing institutional partnerships that guarantee continuous care, especially in smaller municipalities: 60% of Brazilian municipalities have a population of less than 15,000 inhabitants, which is the minimum population coverage criterion for the implementation of a type I CAPS, thus hindering the development of primary care actions.

Another important aspect to highlight regarding the care for people with comorbidities

Table 4. Regional distribution of the psychosocial care centers. Brazil, 2008-2020.

Type of CAPS	South	Southeast	Midwest	Northeast	North	Total
CAPS I	191	257	74	501	94	1,117
CAPS II	83	193	25	140	33	474
CAPS III	7	54	1	26	6	94
CAPS Youth	42	105	8	45	5	205
CAPS Alcohol and other drugs	67	124	16	84	10	301
CAPS Alcohol and other drugs III	22	27	3	25	7	84

Source: Own elaboration based on data from the Ministério de Saúde, DATASUS⁽¹⁹⁾.

(psychological distress and drug use) is that access to these services is impaired due to social representations that the mentally ill are dangerous and social stigma on the part of the medical professionals responsible for initial care.

From 2006 to 2020, the Ministry of Health⁽²⁰⁾ increased support to states and municipalities in order to expedite their efforts in favor of deinstitutionalization. These actions included: an increase in the number of CAPS; access to urgent and emergency care (SAMU and UPA), with staff specialized in mental health care; the provision of crisis beds in general hospitals linked to the psychosocial network; the regulation of access to the Psychosocial Care Network so as to guarantee the primacy of territory-based services. However, in the last three years there has been a sharp deceleration in the opening of new CAPS, as shown in Figure 5.

Also part of the Psychosocial Care Networks are the therapeutic residential services described that make up transitory residential care (Figure 4), located in urban areas and organized to meet the housing needs of people who have been institutionalized. The number of residents in each facility can vary from one to eight. The therapeutic residential services are aimed at those individuals who have lived many years in psychiatric hospitals and have lost contact with their support network.

Each home has the support of a mental health nursing assistant and an interdisciplinary team, which can be made up of CAPS professionals or professionals from the primary care service. The therapeutic support provided is based on the specific needs of each person and continues even if they change their place of residence. The path of psychosocial rehabilitation offered by the therapeutic residential services seeks to involve the person in the service network and in the social relations of the community, such as the community center.

The therapeutic residential services are located in urban areas and constitute an alternative to prolonged psychiatric hospitalization, for people who have or have not been

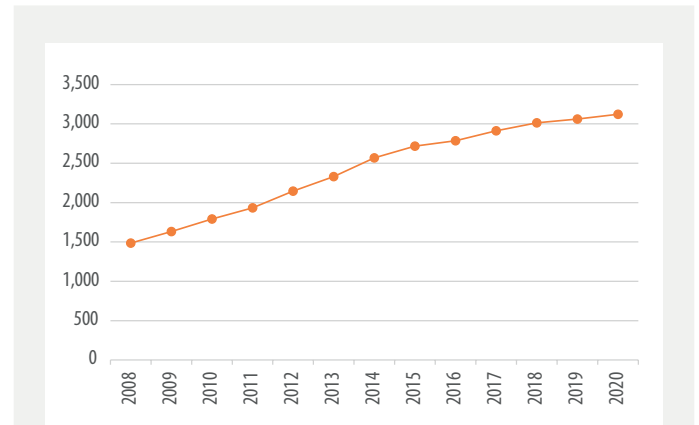


Figure 5. Expansion of territory-based psychosocial care centers. Brazil, 2008-2020.

Source: Own Elaboration based on data from the Ministério de Saúde, DATASUS⁽¹⁹⁾.

institutionalized. With each resident transferred out of the psychiatric hospital, there is a reduction in the number of beds in the hospital of origin and the financial resources which covered the hospitalization costs are reallocated to the budget of the state or municipality responsible for the provision of care. With a refund of R\$9,466 (equivalent to €1,500) from the Ministry of Health, these resources allow funding for the opening of therapeutic residences and the necessary monitoring these entail.

There are other substitute strategies in the Psychosocial Care Network, such as the program *De Volta Pra Casa* [Return Home], which aims to improve, expand and strengthen the out-of-hospital network through financial aid of R\$709.25 paid to the beneficiary for one year (approximately €110/month), which can be renewed if necessary.^(11,15,21) According to the Ministry of Health,⁽¹⁵⁾ at the beginning of 2017, there were 701 municipalities enrolled in *De Volta Pra Casa* throughout Brazil, totaling 4,499 beneficiaries.

For municipalities to formally participate in the program, the Ministry of Health requires a contract of adhesion and inscription. The terms of reference must be indicated for monitoring and follow-up of the program in the municipality. Due to bureaucratic issues and political changes, the program's beneficiaries are still few in comparison to the

demand: in 2011 there were 3,961 beneficiaries, with an increase of just 538 beneficiaries in six years.

The center for community and cooperation aims to promote social inclusion, with special attention to people in psychological distress, respecting diversity in the community, through cultural activities that stimulate new skills and social interaction and connect different groups of people according to their common interests.

According to Alvarez,⁽²²⁾ activities in these community centers are financially dependent on the municipality, since they have no other resources. Thus, the maintenance of existing contracts, the hiring of new professionals, the purchase of materials and supplies depend on financial assistance from another health unit. This situation compromises the expansion and consolidation of the centers. In 2010, the 4th National Intersectoral Conference on Mental Health⁽²³⁾ approved “the implementation and provision of funding for community centers as strategic intersectoral mechanisms of the mental health network.” However, funding remains a challenge and without additional resources it is unlikely that this service will effectively function as an intersectoral mechanism.

As a strategy for the homeless population, who are in situations of social vulnerability, the Ministry of Health instituted, through Ordinance 122 of 2011, as part of the National Policy of Primary Care, the *consultório na rua* [street clinic], which is integrated with the primary care units, CAPS, urgent and emergency services and other services of the Psychosocial Care Network. It is a mobile and multidisciplinary team that offers medical assistance and support to the homeless. Within the Psychosocial Care Network, the street clinic has the specific responsibility of providing mental health care to this vulnerable population. The staff conducts a general assessment of each homeless person, including health needs, and works in collaboration with other services. These teams receive theoretical and practical training in harm reduction schools to carry out health promotion and prevention with the objective of minimizing the social harm

and damages to health associated with the use of psychoactive substances.

Harm reduction practices seek the political socialization of drug users for them to take the lead, promote healthy self-care, and demand their citizenship rights.⁽²⁴⁾

The Brazilian prison system: intersections between mental health and criminal justice

A major gap in the Brazilian psychiatric reform has to do with the intersection between health and the justice system. Article 26 of the Penal Code establishes that security measures applied to those with severe psychological distress or abusive use of drugs in conflict with the law and considered imputable must be protected by measures that consist of treatment and not punishment. Thus, criteria applied to these people are governed by Law 10.216 from 2001, which establishes hospitalization in Hospitals for Psychiatric Treatment and Custody [*Hospital de Custódia e Tratamento Psiquiátrico*] (HCTP), which provide hospital and custody services in the context of the psychiatric reform. Such security measures are referred to as involuntary or civil commitment. A major contradiction is that these hospitals are part of the penal system and not the health system.

A survey carried out by Professor Debora Diniz⁽²⁵⁾ in 2011 (funded by the Ministry of Justice) evaluated all psychiatric treatment and custody hospitals in Brazil. A total of 23 HCTPs and three psychiatric treatment wards in penitentiary complexes were included. No HCTPs were found in the states of Acre, Amapá, Goiás, Maranhão, Mato Grosso do Sul, Roraima and Tocantins. The three psychiatric treatment wards were located in the Federal District, Mato Grosso and Rondônia. The states of Minas Gerais, Rio de Janeiro and São Paulo have three HCTP units each, and in the other seventeen states there was one HCTP each.

In 2011, the total population of the 26 HCTPs was 3,871 individuals. Of those, 2,838 had already received a court ruling, but 1,033

were awaiting trial, which corresponds to 26% of the population held in custody and psychiatric treatment hospitals.^(26, 27)

The results of this census indicate the vulnerability of this population: one in four individuals should not have been arrested; 47% were incarcerated without a legal or psychiatric basis; 21% were in custody after the stipulated sentence was complete; many were detained for over 30 years, which is the maximum sentence within the Brazilian judicial system. The research did not analyze the physical infrastructure of these institutions or the quality of clinical care, however questions arise concerning to what extent treatment offered is based on the psychiatric reform's principles.

There are some measures underway to modify the current situation, with the aim of providing adequate and humane treatment to offenders with severe psychological distress. The Comprehensive Assistance Program for aggressors with mental health issues was implemented in the State of Minas Gerais in 2000, before the enactment of the Brazilian psychiatric reform law. In 2006, the program was recreated in the state of Goiás. Both programs are guided by the psychiatric reform's principles, promoting access to mental health treatment in the community network.

The program is intersectoral, promoting partnerships with the Judiciary Branch, the Public Prosecution Ministry and the Executive Power. The team consists of psychologists, social workers and law graduates, aptly trained for the job. The team currently manages 243 offenders with mental health issues in 77 Goiás municipalities.

The situation of a patient admitted to a psychiatric hospital leads us to infer that they are, first of all, a person with no rights, subject to the power of the institution, at the mercy, therefore, of the power of society, which removed and excluded them.^(27,28) For people who have a crime associated with their psychological distress, the expropriation of rights and the process of social exclusion are amplified by the power of society. The coordination of public policies in regards to the articulation of mental health and justice

is still a major challenge in a country with so many social inequalities.

It is also important to highlight the specific needs in the Psychosocial Care Network of groups with social vulnerability due to gender, race, and culture, such as indigenous people and the people confined in hospitals for psychiatric treatment and custody, for whom humanized and integral care that responds to their real needs is urgent.

Incompatibilities and challenges in the process of Brazilian mental health policy

In the last few years, diverse measures have been developed and guidelines regarding already approved laws regulating mental health care activities have been implemented – a fact explained by the inclusion of the theme in national government agendas, which sought to develop a mental health model focused on the complexity of people with psychological distress. However, partisan policies, without effective actions to ensure continuity of the established goals and strategies, led mental health services and the psychosocial model in Brazil to management, infrastructure and funding problems.^(29,30,31) Thus, an inconsistency in the structuring of Psychosocial Care Network can be observed, due to a focus on government policy and not state policy.

At present, the latest ordinances illustrate a dismantling of the psychosocial model, with the inclusion and enhancement of hospital spaces in detriment to community spaces. In addition, CAPS have been suffering from an overload in their population coverage and a lack of material and human resources.

A number of studies present difficulties in these services in the articulation among family members and primary care, in the strengthening of the community network and of the strategic therapeutic devices of the Psychosocial Care Network, in coordinating the management and supply of medications and in therapeutic strategies outside of the CAPS, among others.^(27,29,30,31)

Brazil is undergoing significant political and social changes and, in November 2018, the federal government suspended the transfer of R\$77.8 million to mental health. The decision affects 319 services that form part of the Psychosocial Care Network of the SUS, such as CAPS, therapeutic residential services, reception centers and mental health beds in general hospitals.⁽³²⁾ Collective empowerment actions are necessary in order to resist the current regressive policies, driven by economic interests that favor the maintenance of psychiatric hospitals.

There is a contradiction and a constant struggle between daily clinical practices and legislation. There are few CAPS open twenty-four hours a day. Individuals who experience an acute crisis at night or on weekends are referred to general hospitals, which offer limited services for crisis intervention, thus general hospitals become the gateway to the psychiatric hospital.

There are currently 121 psychiatric hospitals in Brazil distributed across 22 states. This continuing entrenchment of psychiatric hospitals in the mental health system puts at risk the development of community-based mental health services and further hampers the integration of the Psychosocial Care Network. In 2018, only three CAPS were opened, whereas in recent years there has been a significant increase in the number of beds in both public and private hospitals, as we can analyze in Figures 2 and 3. A major challenge today is to advance public policies in line with the psychiatric reform.⁽²⁶⁾

This scenario hinders the Psychosocial Care Network's development of therapeutic practices and strategies focused on the person's experience, on their daily lives and on their relationships with the health promotion network, weakening the effectiveness of the psychosocial model described in Law 10.216 and international agreements.^(27,29,30,33)

One of the many challenges for Brazilian psychiatric reform is human resources. Most of the new professionals present in the network are young people who did not experience the political and ideological process involved in the creation of the anti-asylum

movement, and who did not have the opportunity to engage with emblematic figures of this movement at international level, such as Basaglia, Foucault, Goffman, Rotelli. They grew up during a period in which the political transformation was already history.^(34,35,36)

Psychiatric reform should not be limited to the abolition of psychiatric structures, but should also encompass the construction of new forms of possibilities, in which the actors involved have an active participation in all transformation processes.⁽³³⁾

In the Brazilian context, Ordinance 3588, of December 21, 2017, changed the national mental health policy, increasing the acceptable rate of admissions to psychiatric hospitals from 15% to 20%. The ordinance directly impacted the work of the Psychosocial Care Network, with an expansion of 80% in the occupancy rate of mental health beds in general hospitals as a condition imposed upon institutions to receive financial resources for the services provided. It is worth mentioning that deinstitutionalization is no longer synonymous with the closing of hospitals and psychiatric beds, as they have become part of the Psychosocial Care Network.

According to Sade,⁽²⁹⁾ it is necessary to close psychiatric hospitals in Brazil. As long as psychiatric hospitals remain open, those without a place to go – because their family cannot support them, schools label their behavior, and society classifies them as deviant – will have a single appointed “place,” as only psychiatry has a place for them: the psychiatric hospital. It is only by closing the psychiatric hospital and implementing strong community-based services with best practices that a full and active life can be guaranteed.

CONCLUSION

The psychiatric reform, by questioning the supremacy of medical-psychiatric knowledge in the treatment of “mental illness” in public care, opened the path for the development of new ways of addressing psychological

suffering, enabling different fields of knowledge and practices.

This study, by discussing the milestones of the Brazilian mental health policy and its advances, highlighted the community-based mental health network, centered on a psychosocial approach and whose services focus on the individual and their care needs. However, there is a consensus that, in addition to expanding the community-based mental health care network, it is essential to reflect upon the need to consolidate the paradigm and upon political, cultural and technical sustainability. The Ministry of Health gradually redirected psychiatric care resources to an alternate model, creating community-based mental health services with a territorial scope and implementing criteria of humanization for the specialized hospital network.

Ordinance 3088 of the Ministry of Health established the Psychosocial Care Network, with the goal of promoting service integration and the expanding the mental health service paradigm. The deinstitutionalization process is centered on the emancipation of the individual, the creation of new models and opportunities, demystification of madness and allowing for the exercise of citizenship. The deconstruction of knowledge that supported the foundations of psychiatry since the Enlightenment era, based on the notion of madness as alienation and danger, is replaced by the notions of difference, production of life, and subjectivity.

Law 10216 of the Brazilian psychiatric reform, passed in 2001, established that psychiatric hospitals should gradually be closed. Ordinance 3088, of December 23, 2011, reinforces the determination that psychiatric hospitals should no longer be part of the Psychosocial Care Network. However, the Ministry of Health's current logic, in contrast to the norms, is aligned with traditional psychiatry, emphasizing segregation and medicalization as a major setback for community-based treatment models and for the mental health reform in Brazil.

The World Health Organization points to the importance of expanding the regionalization of community services, improving the coordination mechanisms between primary health care and specialized care, expanding coverage of rehabilitation services, seeking active strategies to combat stigma and implementing training for mental health staff, and permanently assessing the territory's network.

The effectiveness of the model depends on investments in the following dimensions: expansion of CAPS III, service management, continued staff training, the integration of the intersectoral network, evaluation of the services in terms of the users' recuperation of a full life, according to WHO guidelines. Otherwise, the service is ineffectual, which propitiates old practices based on the biomedical model.

However, it is important to note that only actions based on best practices will strengthen the services. Expanding the network is not enough, it is necessary to have health policies integrated with community-based strategies and the conceptual foundations of public health aimed at social protection and, above all, at care in freedom. Freedom is therapeutic. People labeled "mentally ill" have had a long history of psychiatric hospitalization, losing their identity and their right to freedom. The history of psychiatry is a history of closed, isolated and guarded structures. Reflecting on "ways of life," the question is: How do we guide this paradigm so as to recover the lost history of those who have had their lives expropriated by asylum culture?

Far from having been consolidated, the psychiatric reform is a struggle still present in the current Brazilian context, proving itself as essential and a priority due to its potential to drive reflection and change. It is fundamental to build new agreements. It is not enough to simply increase the capacity of services, it is important to broaden connections within the territory, taking care of the community, breaking with the asylum logic of segregation, and enabling the production of life beyond the structures of mental health services.

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CONFLICTO DE INTERESES

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