

## Prospects for mental health policy in Brazil

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The November edition of CSP features three articles in the Thematic Section on progress and setbacks in mental health policy in Brazil<sup>1,2,3</sup>. A reading of the three papers in the section provides clear evidence: Brazil was successful in building a wide network of community-based psychosocial care services, spread all across the country, called the Centers for Psychosocial Care (CAPS in Portuguese) with their various modalities and types. There were just 148 in 1998, but by 2014 they had reached 2,209. This network should be a source of pride for every Brazilian, given the country's diversity and continental size. How, we need to ask ourselves if the development of this services network has guaranteed better mental health care in Brazil. Are our patients living better today? In addition to the implementation of services, have we succeeded in changing society's view of individuals with mental disorders, ensuring greater acceptance and their inclusion in our cities' daily lives? In other words, has the Psychiatric Reform also led to the reduction of stigma against users of mental health services?

Judging by the countless stories we hear and collect around the country<sup>4,5,6,7</sup>, yes, without a shadow of a doubt, our psychiatric patients are living better today. But do we really have sufficient information on those who lack access to these services?

Another extremely important element addressed by the three articles and that relates to the opening questions is that despite the initiative's success, we are in the midst of a what amounts to an interrupted process – interrupted before it was strong enough not to run the risk of serious damage.

That is why a Thematic Section on Brazil's mental health policy is so timely and necessary at this juncture in the country's history. We could categorize this section with the three articles in three moments: "what was achieved", "what remains to be achieved, and where we should make progress to achieve what is missing", and "the risks we are facing", emphasizing why the currently impending setback is so dangerous and discouraging, coming as it does under the guise of "reorientation", "resetting the compass", "scientific evidence", etc.

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## What was achieved

The greatest success in the development of this network of community-based mental health services was the implementation of Centers for Psychosocial Care (CAPS), spread all across the country (2,462 as of 2017), although still far short of the real need, especially in relation to the CAPS-III (100 CAPS-III and 106 CAPS-AD-III), which is the modality with day beds and that allows more effective replacement of in-hospital psychiatric services. A significant number of Residential Treatment Services were also implemented (489), but the expansion of these services was even more limited in relation to the need. The other services planned for the network, some created more recently as part of the network of care for patients with disorders resulting from alcohol and other drug use, such as the Outreach Shelters or Unidades de Acolhimento (35) and the Residential Care Services (22), or other even older services such as psychiatric beds in general hospitals, were implemented on an even smaller scale (263 general hospitals with a total of 1,163 beds for psychiatry) <sup>8</sup>.

In order for all of this to happen, a shift was necessary in budget spending on mental health, with community-based services receiving more funds than psychiatric hospitals since 2006, as discussed by Onocko-Campos <sup>1</sup> and Caldas de Almeida <sup>2</sup>, as well as a highly significant decrease in beds in single-purpose psychiatric hospitals, with the closing of many psychiatric hospitals whose quality of care was questionable, to say the least.

In addition to the creation of community mental health services, there was also a growing awareness in society and among the users of mental health services and their families that treatment in the community is the most recommended and most effective, although this process also requires continuity and expansion. As Onocko-Campos <sup>1</sup> (p. 1) emphasizes in her article, *“Although the Reform’s nouvelle familiar emphasizes patients’ and workers’ movements as founding and important movements, they were not successful in spreading across Brazil, so that the Reform was impelled as a public health policy and not as a demand by civil society”*.

Another extremely important element was the huge contingent of mental health professionals who joined mental health care under the new model, even though undergraduate training in the health professions in Brazil are still just beginning their discussion on psychiatric reform and mental health care. In this case, a change in mental health practices induced the training institutions to modify their teaching contents accordingly.

As primary care entered the scene more consistently in Brazil as the portal of entry into the Unified National Health System (SUS), with the Family Health Strategy (FHS) spreading across the country through family health teams in the Basic Health Units, integration of the network of mental health care with the family health teams also became a priority and part of the country’s public health policy. This was done through the Centers to Support Family Health (NASF in Portuguese) and the strategy of joint consultation with the family health teams, or so-called inter-consultation (*matriciamento*). Although the coverage of family health teams by the NASF is still short of the actual needs, it was nevertheless an important strategic step forward in the expansion of patients’ access to care in mental health.

There were many other important strides, such as the program “De Volta para Casa” (Going Home) and the Street Outreach Clinics, discussed in the three articles.

Among all these strides, one in particular should not be overlooked. In a sense, it still ensures possible continuity in Brazil’s psychiatric reform process – the enactment of *Law n. 10,216*, of April 6, 2001, the Psychiatric Reform Law, which *“addresses the protection and rights of persons with mental disorders and redirects the mental health care model”* <sup>9</sup>. What is im-

portant about this law? The law redirects care, organized in the community, and the regulation of voluntary and involuntary psychiatric admissions, allowed only when community care has exhausted its possibilities. With the prevailing law, Brazil has the guidelines for a legally based reform.

### **What remains to be achieved, and where we should make progress to achieve what is missing**

Like any process, the Psychiatric Reform is dynamic and continuous. We can identify an initial moment that impelled and defined a direction, but we do not have an end in sight to be achieved. What exists are milestones and principles that orient us on the path and point the direction.

If we could summarize the Brazilian Psychiatric Reform in two phrases, perhaps we would say that, “a place to care for people with mental suffering, whether they are more or less ‘crazy’, is where they feel well”, and “where the way to care for these people is to relate to them”. All the rest could fit into these two phrases. This is the basis: does this process, this orientation, this device put us in closer contact with these people? If so, this is the right path. Or does it alienate them from us? In the latter case we have certainly taken the wrong path.

### **The risks we run**

Psychiatry is a field of very intense and evident disputes. *“Touch the brain, change the mind: here is a modern project rooted in our history and with promises of a beautiful future. Man has always dreamed of transforming man by intervening in his brain. The 20th century armed itself with new technologies, alongside proper scientific concepts referring to the relations between brain and mind. In the West, this project is widespread and has become a social practice that extrapolates mental medicine. Tranquilizers, hypnotics, antidepressants, electroshocks, energizers, vitamins, alcohols, cocaine, heroin, cannabis, coffee, tea, and tobacco, specific diets, even fasting are so many ways at our disposal to physically transform the contemporary individual”* <sup>10</sup> (p. 1). Meanwhile, psychiatry is a field immersed in broader questions that affect human beings: *“a psychiatric condition is not limited to alterations of receptors, calcium channels, and neurotransmitters. Psychiatric conditions have multiple determinants, and when we reduce such conditions to the symptoms, we contribute to individuals’ alienation from their bodies, their minds, and their lives, making them more vulnerable to the market, to authoritarianism, and to psychological suffering”* (Janete Cohen, 2019, personal communication). This promise – “touch the brain, change the mind”, pursued forever by humankind and for more than two centuries by psychiatry, is far from being realized. Even more so when the problems affecting the population we treat and that contribute to many of the conditions we treat extend far beyond the individual’s issue, not to mention the body’s materiality. That is, issues of social misery, violence, and all manner of vulnerabilities. A public policy should thus focus on what affects the majority of the population and what really matters in terms of public health.

And why does the “risk we are facing” relate to these issues that involve the disputes in the field of psychiatry and mental health? Why has the mental health division of the Min-

istry of Health said and repeated that “*the approaches and conducts* [in the field of psychiatry] *should be based on scientific evidence, constantly updated*”<sup>11</sup>, insinuating that the reform process has not been based on scientific evidence in the field of psychiatry and mental health. What is the most consistent scientific evidence in this field?

In an article published in 2004, Thornicroft & Tansella<sup>12</sup> address evidence of what constitutes a modern mental health service. For low and middle-income countries, the evidence suggests that for the low-income nations, it is essential to improve mental health care in primary care, with backup from specialists (the Brazilian inter-consultation model with the NASF), while middle-income nations, in addition to reinforcement in primary care with backup from specialists, should include outpatient units, community-based mental health teams, residential therapeutic services, and creative forms of occupation and employment.

Thus, considering that the resources are finite, what should a public mental health policy invest in?

In another article, this one from 2010, Thornicroft et al.<sup>13</sup> list some key recommendations for the implementation of community mental health. They divide these recommendations into obstacles and challenges, lessons learned, and solutions for five categories: society, government, organization of the local mental health systems, professionals and technicians, users, families, and activists. As for society, the principal obstacles relate to human rights violations, stigma, and acceptance of different behaviors, considered “abnormal”. Obstacles in relation to governments involve inadequate policies, lack of structure and financing, and difficulty with training and retention of health professionals. As for the organization of local mental health systems, the focus is on the system’s design, implementation, and monitoring rather than on the programs’ implementation, sometimes scarcely feasible, the need for inclusion of non-medical services, network collaboration, and shortage of psychoactive medications. In relation to the health professionals, there is the issue of training, burnout, and lack of studies assessing and reporting on the work performed. For users, there is the important need for advocacy, self-help groups, peer support, and shared decisions.

Brazil has one of the world’s most widely cited and admired mental health policies. The implementation of a true network of community mental health services in a continental-sized country like Brazil should be one of our greatest sources of pride, as we highlighted at the beginning of this editorial.

Mental health is an issue of human rights and the civilizing process. As showed in the three articles comprising this section, when democracy is at stake, not only the psychiatric reform is in jeopardy, but society itself is threatened.

## Additional information

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