Mental health policies in Brazil

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In the Brazilian Constitution of 1988, in article 196 of the health section, under the title of social order, health is guaranteed as a right of all and a duty of the State. The Constitution also recognizes people's right to universal and equal access to actions and services, aiming at health promotion, protection, and recovery.

Mental health policies have gone through important and significant changes in the last 20 years, as a result of the international movement initiated in the 1950's in countries like England, France, United States, and Italy. These changes were influenced by the proposals of preventive and social medicine and by the concepts about interdisciplinary teams and new health management models.

In Brazil, in addition to these facts, Law 10.216 was issued in April 2001. After 12 years, this Law defined the dispositions about the protection and rights of people with mental disorders and gave a new direction to the mental health care model. Other influential events were the Caracas Declaration of 2000, the sanitary reform in Brazil, and the III National Conference on Mental Health of December 2001, all of which provided the substrates for the mental health policy in recent years.

Integrated to the SUS (the Brazilian public health system) and, according to article 196 of the Constitution of 1988, mental health actions follow guidelines of decentralization, integral service, prioritizing preventive activities, without harming health care services and with the participation of the community.

After guaranteeing the main axes of the rights and duties in the Federal Constitution, it was necessary to create specific and detailed laws, rules and norms about each of the services that became part of the mental health care network for hospitalization, semi-hospitalization, follow-up, emergencies, resocialization, promotion of health and citizenship, and social insertion. It was necessary to define the role and extent of mental health actions in the city, state and country. In addition to the services, with their respective physical facilities and human resources, it was necessary to create conditions for truly recognizing the condition of citizens for patients without a family and lacking the conditions to be reincorporated into the social system, due to long reclusion periods.

It was necessary to open the doors of general hospitals in the basic health network and the other clinical care services to welcome the mental disease, despite the indignation of many health professionals who were not prepared to live with the mental patient and with the mental disease.

In this course of redirecting the former psychiatric policy, which had hospitals (asylums) as the only alternative for patients, tertiary services occupied the base of the health care pyramid. There has been an inversion of the values that placed community services at the base of the pyramid, redirecting secondary and tertiary services.

This reposition does not only affect the direct actions of health professionals, but also rearranges the costs.

Therefore, tertiary services with hospitalization in a psychiatric hospital, psychiatric hospitalization in a general hospital, semi-hospitalizations, emergency services and, more recently, the Psychosocial Care Centers III cover the crisis, symptom remission with medical and psychological evaluation and nursing care, being quick and agile in this clinical task, culminating in the required referrals to community services and returning the patients to their family members.

Follow-up services, outpatient clinics and psychosocial care centers (II, I), as well as mental health care centers offer treatment continuity in an open environment, providing therapy, care and psychosocial rehabilitation. These intermediary care services, between the hospitalization and the basic health network, strengthen the self-esteem of individuals with mental disorders, as well as their family and community bonding.

The primary level comprises the services offered at basic health units, district units, emergency rooms, and the family health program and other many programs for vulnerable groups like the elderly, people with HIV, and others, which are not specialized in mental health but consist of places where individuals with mental disorders circulate.

The health policy defines each of these services with very clear indications about objectives, structural and dynamic characteristics, territorial scope, coverage, necessary teams, and competencies, as well as the expected time of permanence at the services for individuals with mental disorders.

Resizing the service network entails a series of benefits and consequences which are worth highlighting: a) the beneficial consequences are at the ethical and human level, diminishing the stigma, promoting citizenship and social insertion for individuals with mental disorders. Responsible treatments are encouraged to reduce the crises and moments of lack of control, reducing hospitalizations and re-hospitalizations. Increased scientific and technological interest, with new therapeutic options. Greater participation from every segment in the society. b) On the other hand, these changes involve an enormous cost for the family, which is not prepared to take care of that individual, and thus needs support and guidance. Individuals with mental disorders start to participate in every instance of social life (individual and collective), which has triggered the creation of social and

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economic support systems. There has been a need to review the legislation and several social alternatives to welcome the people affected by a mental disease. It is necessary to give a new direction to the formal education of health professionals and to update the professionals who work in the health service network.

In this process, some practices tend to be consolidated (the CAPs), while others are extinguished over time (therapeutic residences).

Though the political definition of mental health care reflects a certain conceptual and theoretical consensus, when put into practice, it remains unsatisfactory. For example, humanization as a policy is present in every instance of the SUS and, therefore, also in mental health. However, many difficulties are faced when attempting to integrate the work processes, as well as in the relations between the different professionals working in the network.

This creates challenges in terms of consolidating the network, constructing therapeutic projects, providing humanization and user embracement, as well as promoting community life, intersectorial actions, and regarding team-related issues, such as interdisciplinarity and qualification.

Finally, it is necessary to increase the dialogue between scientific and political knowledge and the practices they support and guide.

In addition to adopting this or that mental health policy, nurses and other professionals should think about the extent to which it has been possible to embrace, listen, and identify the needs of people with mental disorders, with ethics and responsibility.