Reflections on mental health as a political agenda in Brazil: From the process of enclosure to the restructuring of national policy

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ABSTRACT

The present critical theoretical study aimed to reflect on the process of restructuring mental health in Brazil. As a methodology, the development of a study of theoretical reflection was outlined, with the perspective of discussing the phenomenon of the Brazilian psychiatric reform, taking into account the studies related to the theme, and that would dialogue about such scientific knowledge. The process of psychiatric reform, which began in the 90s, aimed to combat imprisonment through the deinstitutionalization of individuals with a clinical diagnosis of mental illnesses, in the search to bring back to society, as citizens, individuals with mental illnesses, as well as to restructure the psychiatric health model in the country. Such dynamics were based on the ideals of humanization. The expansion of the Psychosocial Care Centers, and consequently, the decrease in the percentage of beds in psychiatric hospitals, accompanied by changes in the labor process, are presented as consequences of this process.

Keywords: Psychiatric Reform, Mental Health Policy, Psychosocial Care, Deinstitutionalization, Mental Health Care.

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INTRODUCTION

State attention to mental health in Brazil is relatively recent, dating back to the beginning of the nineteenth century, when the royal family established the first assistance measures (Fonte, 2012). In this period, the approach was far from humanization, focusing on the removal of the mentally ill from society rather than their well-being. Considered maladequate, they represented a threat to public order in a phase of national consolidation. Thus, the treatment based on confinement was adopted, aiming solely to maintain order, rather than to promote the recovery and inclusion of affected individuals.

More than twenty years later, advocates of a reform in the psychiatric care model fought for what they believed to be the rescue of the dignity and citizenship of people with some type of mental suffering. Thus, they demanded the end of psychiatric hospitalizations in Brazil, a procedure shrouded by contradictions and denunciations of abuse and violations. Although the approved text, unlike the original proposition, did not guide the extinction of these institutions, it nevertheless constituted a new model of treatment for the issue of mental health in the Brazilian territory (Amarante, 1998).

Thus, Law 10.216, enacted on April 6, 2001, marked a historic milestone in the National Mental Health Policy (PNSM) in Brazil, ending a long struggle for a reform in the psychiatric care model (Brasil, 2001; Amarante, 2007; Yasui, 2010; Amarante; Nunes, 2018). Advocates sought to rescue the dignity and citizenship of people with mental disorders, demanding an end to psychiatric hospitalizations due to reports of abuse. Although the law did not eliminate such hospitalizations, it introduced a new treatment model focusing on resources outside hospitals and guaranteed rights to those suffering from mental disorders. This achievement was celebrated by those involved and marked a new phase in the National Mental Health Policy (Amarante, 1998).

Therefore, considering the relevance of the subject and the connection of these researchers to the health area, inserted in the field of public health policies in the country, the present study aimed to develop reflections related to the process of restructuring mental health in Brazil.

INTERNATIONAL POSITIONS ON MENTAL HEALTH AND DEVELOPMENTS IN THE NATIONAL CONTEXT

The consequences of World War II caused major changes in human relations and, consequently, provoked various positions of governmental and non-governmental entities. Among these, the United Nations Organization stands out based on the creation of the Declaration of Human Rights in 1948.

According to Vasconcelos, 1992, this process has driven changes in the perceptions of treatment for people with mental disorders. New paradigms for understanding mental illnesses have

emerged, moving away from the biomedical model focused only on the disease, its symptoms, medications, and hospitalization, to an approach guided by the preventive and community mental health care model**.**

By contextualizing mental health in Brazil, it is possible to verify that this agenda is characterized by disparities in care models. Variations in understandings of madness and mental illness influenced the formation of various care practices. The socio-political and economic context, and the organization of the health system also contributed to the change in institutions and their approaches.

The initial milestone of cloistered care took place in Rio de Janeiro, from the emergence of the Pedro II Hospice in 1841. The idea was to remove from social coexistence those who symbolized intimidation of society, based on hygienist assumptions and private freedom. In this period, the existing asylums had religious and charitable characteristics. As a result, the Pedro II Hospice began to be governed by scientific psychiatry, expanding the medicalizing approach after the Proclamation of the Republic (Messas, 2008; Yasui, 2010).

Although the Psychiatric Reform in Brazil emerged concomitantly with the health movement in the 70s[8], its events presented a singularity that is inserted in the international context of overcoming violence in psychiatric hospitals, in addition to the approval of new laws and norms, as well as changes in government policies and health services (Brasil, 2002).

The Regional Conference for the Restructuring of Psychiatric Care, organized by the Pan American Health Organization, in Caracas, Venezuela, from November 11 to 14, 1990, endorsed the need to review the care related to patients with mental disorders. This event recognized the social incapacity of the asylum based on four axes: ethical-legal, clinical, institutional and sanitary. Therefore, the unfavorable conditions for the human and civil rights of patients were evidenced, as well as inadequate care for the mental health needs of the population and health services.

This event made it possible to create a document with the objective of protecting people with mental problems and improving mental health support. This document emphasized the right to consent for treatment, a significant advance in the relationship between health professionals and health service users. Consequently, Brazil adopted these premises through the Mental Health Coordination of the Ministry of Health (PAHO, 1990; Brazil, 2002).

The Paulo Delgado Law sanctioned in 2001, after 12 years of discussion in the National Congress, changed the way mental health care was offered, prioritizing treatment in community services and protecting the rights of people with mental disorders. However, the law did not establish a clear plan to extinguish asylums. The disclosure of Law 10.216 boosted the reform movement in

1. This movement aimed at transformations in management and in the models of care in the field of health, defense of collective health, equality in the supply of services and greater participation of workers and users in the management and production of care technologies (Brasil, 2001).

our country. In the midst of this, the state developed a mental health policy in line with the guidelines of the RPB, creating specific lines of financing for services to be developed to replace the psychiatric hospital.

In the meantime, the III National Conference on Mental Health was created in 2001, which was fundamentally important for the implementation of these changes, as it promoted a dialogue between different actors involved in the sector, including all participating audiences, such as users, family members, health professionals and managers. This broad participation, from managers to users of the system, was essential for the formulation of more inclusive and effective public policies (Brasil, 2001).

According to data from the Ministry of Health, there was an expansion of the mental health care network through care in regions where community mental health care was practically non-existent. The creation of the "Back Home" Program presents itself as a government attempt to deinstitutionalize people who have been hospitalized for a long time. At the same time, a human resources policy linked to the Psychiatric Reform and another to deal with alcohol and drugs was created, including the harm reduction strategy. Subsequently, the first Psychosocial Care Center (CAPS) was started in São Paulo, bringing together about two thousand professionals and patients from the CAPS (Brasil, 2005).

According to Costa-Rosa, 2003, the paradigm of psychosocial care gained materiality through the CAPS in view of the theoretical, technical, ideological and ethical elements to oppose the care model historically constructed by the psychiatric paradigm. Data from the Federal Government indicate the existence of 1,000 CAPS units in 2006. In addition, the amount of financial resources allocated to community services exceeded the amount of what was performed by psychiatric hospitals (Brasil, 2006). In view of the above, it is observed that the RPB created and expanded the number of CAPS in the country.

The restructuring and expansion of the CAPS was highlighted, causing access to the creation of different modalities of care, such as: CAPS-AD (alcohol and drugs), CAPS-II (for more severe cases) and CAPS-AJ (for child and youth care), among others. Thus, these centers were designed with the aim of offering not only an alternative to the hospital model, but also providing a more humane and favorable environment for the recovery and social reintegration of patients into the community (Brasil, 2005). It is worth noting the significant reduction in the number of beds allocated to psychiatry after the BPR after 2008. For Fernandes, 2018, this process brought about the increase in new strategies for care in the community, autonomy and citizenship for individuals in mental suffering.

In 2008, the Family Health Support Centers (NASFs) were designated, with the premise of mental health support for the Family Health Strategy (ESF) teams. That same year, the health

conference was established to provide support to the NASFs, being characterized by advocating for a fairer and more welcoming society, bringing better living conditions to citizens facing mental suffering, integrating the struggle for social equity with the promotion of the psychological well-being of individuals (Andrade and Maluf, 2017; Delgado, 2019).

The reintegration of people with long histories of hospitalization into social life, as well as the reduction of beds in psychiatric hospitals, became a public policy in Brazil from the 90s onwards, gaining momentum in 2002 with norms from the Ministry of Health that established clear, effective and safe mechanisms to reduce the number of beds in these hospitals.

However, in order to assess the pace of this reduction throughout the country, it is necessary to consider the history of implementation of psychiatric hospitals in the states, as well as the adoption of the guidelines of the Psychiatric Reform in each region, since the process of reintegration presupposes cultural and subjective transformations in society, always depending on the cooperation between the three governmental waits. (Brazil, 2005).

THE HOSPITAL SYSTEM FOR PSYCHIATRY

The National Program for the Evaluation of the Hospital System for Psychiatry (PNASHP) is a crucial management instrument for the gradual reduction and closure, planned and agreed, of beds in psychiatric hospitals in Brazil. Established in 2002 by the Ministry of Health, the PNASHP allows managers to assess the quality of care provided by psychiatric hospitals and public hospitals, providing them with criteria for hospital psychiatric care compatible with the standards of the Unified Health System (SUS). This systematic and annual evaluation process also makes it possible to de-accredit hospitals that do not meet the established quality standards (Brasil, 2002).

Prior to the PNASHP, the systems for control and evaluation of these hospitals intended for psychiatry were restricted, based on hospital supervisions carried out by supervisors of the Unified Health System and on inspections or audits motivated by complaints of malfunction of the units. The implementation of the PNASHP by introducing a comprehensive and periodic evaluation system was fundamental in the process of reorganizing mental health in Brazil. Health now follows a systematic and annual process, carried out by professionals from three complementary areas: the clinic, health surveillance and regulation. This integrated work aims to ensure the quality and safety of health services (Brasil, 2005).

However, psychiatric reform is a complex and multifaceted process that seeks to systematize the Brazilian mental health model, promoting deinstitutionalization and socially including these people who were previously banned from living in the community, because they were mentally ill. One of the pillars of this reform is the idea of deinstitutionalization, which implies not only the closure of asylums, but also the creation of a network of mental health services that offer

comprehensive and comprehensive care, based on the community and the territories where people live. intervention (Rotelli, Leonardis and Mauri, 1990).

Of equal importance, negotiation and agreement between the different management levels, Community Health Councils, and mental health service providers are essential for the effective implementation of the BPR. Understanding with this, that the reform requires an integrated and coordinated approach, which involves the process of transferring resources destined for this purpose. Aiming at respect in the definition of public policies, in the creation of alternative services to asylums and the guarantee of the rights of users of the mental health system. (Deviation, 2015).

The bipartite and tripartite inter-management committees are important spaces for the negotiation and agreement of policies and actions related to the Psychiatric Reform. In these spaces, representatives of the different levels of government and civil society meet to discuss and define strategies, resource allocation and goals to be achieved in the field of health.

The participation of Community Health Councils is crucial, as they represent the voice of the community and can contribute to the formulation of policies that are more appropriate to local needs and that promote the inclusion and participation of users of the mental health system in the decision-making process.

Thus, the RPB is part of a process that requires joint work and articulation between different actors, with the objective of ensuring that people with mental illnesses have access to quality services, based on the community and that respect their rights and dignity, understanding that its main objective is based on the deinstitutionalization of people with mental disorders, with emphasis on those that have been cloistered for a long time.

For each significant reduction in these hospitalization beds, it is necessary to expand the mental health care network based on the needs of each community, this implies knowing how to implement specific actions for the social reintegration of individuals with a history of prolonged hospitalization, as well as implementing strategies such as therapeutic residences and adherence to the Back Home Program (Brazil, 2005).

In this way, it is valid to express that these advances reflect a paradigm shift in the way Brazilian society sees and treats mental health, valuing the humanization of care, the autonomy of individuals and their insertion in the community. The Brazilian Psychiatric Reform continues to be a process in constant evolution, facing challenges and seeking continuous improvements in the care of people who experience mental health problems (Brasil, 2005).

However, the trajectory of the transformation of psychiatric care in our country continues irregularly, with advances and setbacks, not forgetting to mention the tensions in the disputes for power in the nation. Despite the challenges, several studies show that this reform has achieved significant progress, with emphasis on the replacement of hospital care by the expansion of the

community network, even if gradually (Amarante and Nunes, 2018; Clementino *et al*., 2019; Lima, 2018; Onocko-Campos *et al*., 2018).

Notably, the transition period from institutionalized care to the community environment caused a significant increase in the transfer of financial resources to extra-hospital services. The psychiatric reform has experienced significant advances since its creation, although still scarce, in the intensification of its services.

However, the social stigmatization of individuals in mental suffering or with needs resulting from the use of psychoactive substances is still a reality to be overcome, despite the advances with psychiatric reform. Likewise, the reproduction of bureaucratized and rooted practices, as well as the scarce intra- and extra-sectoral junction, are aspects to be faced for the best effectiveness of the reform process.

FINAL CONSIDERATIONS

In view of the above, the advance in mental health policy in Brazil occurred with the implementation of the Psychosocial Care Centers, in the search to replace the hospital-centered model that previously existed. However, there are still assumptions to be overcome, such as the obligation of more investments in research to prove the effectiveness of this model, the training of professionals, the strengthening of intersectoriality and the expansion of the service network.

Thus, the historical stigma in relation to people with mental disorders is a barrier to be faced. This leads to highlighting the importance of addressing these issues to solidify the change in the mental health care model throughout the Brazilian nation. Stabilizing the new services with the traditional model of hospital care is inevitably a challenge to be faced.

Despite the advances with the creation of the Psychosocial Care Centers (CAPS III), which are today the only services effectively focused on the care of patients in crisis, replacing psychiatric hospitals, it is perceived that the vision of comprehensive hospitalization is still seen as a solution to family tensions. Therefore, training and involving family caregivers is essential to consolidate the new care model.

However, a recapitulation of the trajectory of the institutionalization of mental health in Brazil shows that accepting the coexistence of asylums and therapeutic communities with substitutive services contests the principles and objectives of the Brazilian Psychiatric Reform, referring to the model of segregation, incarceration and prejudice. The justification for psychiatric reform is the defense of the right to citizenship and a more equal society, allowing those facing mental health challenges to have their voice and suffering recognized and addressed.

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