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Mental health reform in Brazil: changing hospital-centered paradigm to ensure access to care

Pedro Gabriel Godinho Delgado

Abstract: *Mental health reform in Brazil is a complex process that involves changing the model of care, reallocating funds, downsizing the hospital component, promoting human rights and social inclusion of the mentally ill, extending mental health services to the poorest regions of the country. The objective of this article is to describe and to analyze the changes that took place during the period 2001-2010, and their impact on the increase of the mental health care coverage in the public sector. The selected period corresponds to when the reform process became established as nationwide public policy, affecting all the Brazilian states. It was supported by a strong legislative base (especially Law 10,216, of 2001), a clear financing mechanism, and the cooperation of the public health authorities in the three areas of government (federal, state and municipal). The analysis considers the dimensions of the effectiveness, sustainability, equity of coverage, human rights and quality of life of the users of the system. Some coverage indicators are considered to analyze the impact of the process in facing inequity of access, especially in the smaller cities. The risks and harms of changing a well stablished, although inequal and inneficient, hospital-centered model of care are also considered.*

Keywords: mental health reform; mental health policy; mental health in low and middle income countries

Part 1: Background – Mental health and public policy

1. *Introduction - Mental Health Reforms in the world: replacement of asylums and increase in access to treatment.*

Since the 1960's, national experiments of change in the mental health care model have displayed a coherent background of endeavor to replace large psychiatric hospitals with the provision of community services. These experiments have been increasingly aimed at the primary level of care, the primary care. In the 1960's and the 1970's, the United

Kingdom developed an extensive and successful program of de-hospitalization and the creation of residential services, which were exemplarily monitored by the public health authorities[i]. In the United States, the Kennedy Act inaugurated an attempt to incorporate preventive psychiatry, based in the community[ii]. However, the reduction in hospital beds in the United States did not correspond harmoniously with the extension of the community care, especially due to the restrictions imposed by the absence of the universal coverage of the public health system. In France, the psychiatric sector was unequally developed and not available throughout the country. It competed with the so called institutional psychotherapy, for dominance in the model of asylum replacement. The results, although regionally unequal, displayed a predominance for the primary level of care, and effective actions for the prevention and promotion of mental health must be better evaluated[iii]. In Italy, in 1968, the Basaglia law provided a legal foundation for the profound changes that have occurred in the Emilia-Romagna and the Reggio Emilia regions, although they were spread unequally in the south of the country. Accordingly, in the last 40 years, and especially since the 1980's, reform of the mental health care system has become general policy in diverse and heterogeneous national public health systems and has extended to all the regions of the world.

In Brazil, current studies date the process of reform back to the end of the 1970's, having as main brand the criticism of the abandonment of the large public psychiatric hospitals, the abuse of the rights of the interned patients, the ineffectiveness of the treatment, and the concentration of public resources only in the hospital services area. This criticism was linked with the political process of the re-democratization of the country, which had lived under a military dictatorship for 22 years (1964-1986). It manifested itself in the efforts to increase the coverage and democratization of public health, resulting in the creation, at the National Assembly, of the SUS – the national public health system (called Unified Health System), based upon the principles of universality, equity, users' participation, and decentralization and regionalization of health care[iv].

2. ***Mental Health Reform in Brazil (MHR): a historical outline (1978-2010)***

The 4 periods below are useful as a dynamic description of the political process of the MHR:

I. Asylum critique and the struggle to re-democratize the country (1978-1982)

Serious offences against the human rights of patients, with reports of violence, abandonment, and poor treatment, lead to the origin of the incorporation of the social movement to open up the asylums and the modernization of community care. At the time, the country was experiencing the last cycle of the military dictatorship, and psychiatrists, psychologists, nurses and public opinion, mobilized by the "Mental Health Worker's Movement" (MHWM) fought for the human rights of mental patients alongside the political engine of the process of change. There was intense repression, with the removal of members MHWM in public hospitals. However, the effort to introduce new community

care programs continued, and became associated with the fight for the creation of a public and universal health care system and with the re-democratization of the country. At the end of this period (1981), the country had approximately 110,000 psychiatric beds, both in state hospitals or private hospitals paid by the state, as well as forensic hospitals[v]. Less than 5% of the public budget was allocated to mental health for out-patient care. The model was hospital-centered, asylum based, and highly concentrated. The steep growth in psychiatric hospitals began in 1964/1966 and only stabilized in 1981, because of the financial collapse of health system and social security[vi].

II. Social security crisis, asylum reform and increased out-patient specialized care (1982-1990)

The 1980's marked the decline of the military government and the re-democratization in 1986. Large public psychiatric asylums, such as the *Colônia Juliano Moreira*, in Rio de Janeiro (which had 2,500 long term patients at the time), employed young professional staff, who began to internally re-democratize and open the institutions, and improve the treatment, discharging, and social reintegration of the patients. Some states, such as São Paulo and Minas Gerais, introduced psychiatric out-patient services. In 1988, Congress approved the creation of the SUS. The social and political movements in support of the MHR intensified. In 1989, Congress was presented with a legislative bill, supported by the social movement and inspired by the Italian reform, proposing a profound change in the hospital-centered model, with an emphasis on human rights, as in the experience of closure of asylum in the city of Santos, state of Sao Paulo, in the same year. The project took 12 years to be approved[vii].

III. Normative reform, reduction in psychiatric beds, development of the first community mental health centers (1991-2000)

The MHR became an official nationwide policy of the government, from 1990, when the Ministry of Health (MoH) began the process of the standardization and the establishment of general guidelines for the organization of the mental health network in the states and the municipalities. From 1992 onwards, the Facilities or Centers for Psychosocial Care (known by the acronyms NAPS or CAPS) were regulated. These were community services designed mainly for patients with severe mental disturbances. A more effective inspection of psychiatric hospitals was begun, which resulted in a significant reduction in beds and the closure of hospitals operating in precarious conditions. In 1992, the II National Conference of Mental Health included, for the first time, the significant participation of patients and family members, and approved the changes to the care model. During the decade, the social movement intensified for the defense of the rights of patients and family members (especially the branch known as Anti-Asylum Opposition Movement) and for the defense of the reform law, submitted to Congress in 1989. The creation of community services, which still did not have a specific financing mechanism, remained dependent on local political decisions, but these services advanced in several states, including the northeast of Brazil (in the state of Ceará). In 1999, a financing mechanism for essential psychiatric medicines was approved.

IV. Federal Law approval, change in financing, expansion of community services, reduction in psychiatric beds, mental health in the primary care (2001-2010)

In 2001, Law 10,216 was approved, known as the Psychiatric Reform Law. The III National Conference of Mental Health was held, in Brasília, with 1,600 participants and more than 200 patients and family members as formal delegates. The Conference supported the expansion in the network of community services and the reduction in beds. It also proposed the strengthening of several methods of social inclusion, such as residential services and protected work . In 2002, under the support of the new legislation, a specific federal financing mechanism was established for community services (Centers for Psychosocial Care – CAPS). The CAPS care activities were redefined and became more extensive, as well as clear mechanisms of expansion were proposed. Their operation was regulated by new rules, and specific CAPS were created for children and adolescents, and for alcohol and substance abuse[viii]. On the other hand, from 2003, a profound change appeared in the profile of psychiatric hospitals, with a decrease in their size and a reduction in the number of beds. The new national government presents to Congress the Return Home Bill, approved as federal law in the same year[ix]. CAPS expanded throughout the country, reaching the most poor and unprotected regions, such as the north and the northeast of Brazil. Guidelines were established for an alcohol and drugs policy within the Mental Health area in SUS. Another important achievement in the current period of MHR process was the systematic incorporation, albeit incomplete, of family health teams in mental health care.
In the periods III and IV (from 1991 to the present days), MHR effectively became an official nationwide policy of the SUS.

3. Mental Health Reform (MHR) as part of the building of a National Public Health System

MHR cannot be disassociated from the effort of building a National Public Health System and universal health care. The SUS was created by the 1988 Constitution, and regulated in 1990. Its objective is to guarantee access to treatment for all the population. Approximately 70% of the Brazilian population uses the SUS, and 30% uses health plans (mostly, attending SUS for high expensive procedures). Only around 5% uses strictly private services, either directly or through health insurance. The SUS annual budget (federal component) was R$ 67,339 million or US$ 39,600 million in 2010, and there is a serious problem with the under-financing of the system; the annual cost per capita is 210 dollars (federal component, 2010; global cost per capita is approximately US$ 360)[x].

In the second half of the 1990's, the SUS introduced a strong program of primary care, based on multidisciplinary teams of Family Health and Community Health Agents, reaching 32,000 teams and a coverage of 52,2.% of the population in 2010 [xi]. The management of the system is tripartite, with decisions shared by federal management – the Ministry of Health; state management – the Secretaries of Health of the 27 States -,

and municipal management – the city halls of the 5,565 municipalities[xii].

Part II - Downsizing mental hospitals and addressing social rehabilitation and community care level

In countries like Brazil, with a strong centralization of attendance at the hospital level, the reduction of beds in psychiatric hospitals is a crucial component of the change in the attention model.

Downsizing mental hospitals addresses three principal objectives: 1) to assure the defense and promotion of the human rights of the patients and their psychosocial rehabilitation, reducing asylum spaces, especially in large size hospitals; 2) to redirect, by decentralization, the financial and human resources of the hospital component, allocating them to the community base network; 3) to amplify the access to care, by creating a broader, diversified and community-based entry point close to the location of the lives and home of the patients, capable of attending to all the occasions of the process of mental suffering, and not only the acute crises through the method of admission to mental hospitals or emergency sets.

The psychiatric beds in Brazil can be: state public (large state or federal hospitals), private as contracted by the SUS (approximately 80% of the beds, whose exponential growth was between the period 1966 to 1981) and strictly private beds (small private clinics, in reduced numbers, corresponding to approximately 5% of the beds). There are also about 4,000 beds in forensic mental hospitals (2010).

During the period from 1991 to 2000, a significant reduction in psychiatric beds occurred, especially through the inspection mechanisms that identified serious problems of absence of assistance and low quality of care in psychiatric hospitals. In this first phase of the reduction of beds, the country went from 95,506 beds in 1990, to approximately 63,000 in 1999 (hospital data up to 2000 are approximate). This process was described as “a sanitizing de-hospitalization”, because it principally consisted of closing down of low quality care hospitals, which did not comply with requisite minimum standards. The second reduction stage, due to the enactment of the 2001 federal law, established a plan for the gradual substitution of beds for community services (Table 1).

Table 1 - Reduction of psychiatric beds 2001-2010

Year	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
Beds	52.962	51.393	48.303	45.814	42.076	39.567	37.988	36.797	34.601	32.735

From: Ministry of Health - Mental Health Data 2010

Reduction of beds between 2001 and 2010 and the change in the hospital profile

In 2001, the approval of Law 10216 provided the political tools for the implementation of a planned and gradual strategy for the reduction of beds and the increase in the outpatient network. In 2002, a regulated and systematic mechanism of inspection of hospitals was introduced, PNASH-Psychiatry, which classified the mental hospitals according to the quality of service (including through the evaluation made by users and families) and established the gradual removal of accreditation for those of low quality. In 2004, the new federal government approved, together with the National Council of Health, a national program of change in the size profile of the psychiatric hospitals, with the following components: a) an annual inspection highlighting the hospitals with the best and worst quality of care and compliance with MS regulations, prioritizing the reduction of beds in hospitals with a low score in the PNASH-Psychiatry classification, composed of 20 general items and 100 sub-items; b) the hospitals were divided into sizes, by modules of 40 beds (a division already adopted for the inspection of human resources), and the large size hospitals were prioritized for the reduction of beds, progressively, module by module; c) the financial resources destined for the closed beds were sent to the outpatient network (CAPS and residential services) in the same municipality or region where the hospital was located[xiii].

Change in hospital profile

Despite resistance, in the form of several legal actions (contested by the MS in court) and declarations of dissatisfaction by private contracted hospitals and their owners, the strategy proved to be successful, establishing a clear criteria for the gradual process of the reduction of beds.

Table 1 (above) indicated the annual decrease in beds for the period 2001-2010. In the period, the medium bed coverage rate per 10,000 inhabitants was 4.

Table 2 presents the data that demonstrate the change in the size profile of the mental hospitals in this period, with some significant findings: small size hospitals (up to 160 beds), which corresponded to 24.11% of the beds in 2002, represented almost half (48,67%) of the total of the beds in 2010; macro-hospitals, with over 400 beds, which corresponded to almost one third of the beds (29.43%) in 2002, represented only 11,6% in 2010.

Table 2 – Change in the size profile of mental hospitals during downsizing process - 2002-2010

Hospital size	***Percentage of beds according to the size of the hospital***								
	2002	2003	2004	2005	2006	2007	2008	2009	2010
Up to 160 beds	24,11	29,61	34,09	38,39	42,53	43,98	45,78	45,71	48,67
From 161 to 240 beds	22,01	21,68	21,74	21,72	20,81	19,21	19,6	19,55	21,39
From 241 to 400 beds	24,45	25,83	23,75	21,42	20,54	22,32	20,63	21,59	18,33
More than 400 beds	29,43	22,89	20,42	18,47	16,12	14,49	14	13,15	11,6
Total (%)	100	100	100	100	100	100	100	100	100
Total of beds in each year	51.393	48.303	45.814	42.076	39.567	37.988	36.797	34.601	32.735

From: Ministry of Health - Mental Health Data 2010

Besides the global reduction in the number of beds, there has been a clear change in the configuration of mental hospitals: they have become smaller, with a better score in the evaluation scale, showing a lower proportion of long-stay patients and better articulation with the out-patient services network.

There are few external evaluations with respect to the new configuration of the Brazilian hospital system. Criticisms from some sectors attribute this process of reduction and reconfiguration of hospitals to consequentially leaving patients without care[xiv]. There is no evidence for this kind of statement; however, systematic evaluations of the whole process are still needed.

Part III – The increase and internalization of community based services

The main strategy of scaling up the access to care adopted by the MHR was the creation of effective, open and community-based services, directed towards the priority care of severe and persistent mental disorders (SMD). The function of these services, the Centers of Psychosocial Care (CAPS), is to assure the access to care for the population of a specific geographical area, adopting services of differentiated sizes and complexity for this purpose, according to the enrolled population (see note viii).

The first service designated as CAPS was created in 1987 but still did not present the characteristics of the catchment area population and responsibility by territory. Between 1987 and 1992, the number of these services grew residually, attending local initiatives. From 1992, a first national guideline for their creation was adopted and an important

expansion in services was evidenced. However, it was after the approval of Law 10216, in 2001, specifically at the start of 2002, when more permanent mechanisms of financing, inspection and incentives for municipalities were created. Accordingly, the number of services has expanded, with increasing annual rates after 2002 (Table 3).

Table 3 - Annual growth in the number of Centers for Psychosocial Care (CAPS)

Year	1998	1999	2000	2001*	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011
Total of CAPS	148	179	208	295	424	500	605	738	1010	1155	1326	1467	1620	1742

From: Ministry of Health

(*) 2001 – Federal Law of Mental Health

The creation of community centers for children and adolescents, which did not exist in public health since then, was strategic to expand access to care to youth population suffering from SMD[xv]

Two aspects should be considered and interrogated in this process of expansion. Firstly: has there been a real increase in the coverage of service, with a broadening of access for patients with SMD ? Secondly: has this expansion produced positive changes in the regional and social inequality of the public service in mental health?

The CAPS coverage (calculated according to the population of their catchment areas) has increased from 21% in 2002 to 66% in 2010 (Table 4).

Table 4 - CAPS coverage 2002-2010

	2002	2010
CAPS	295	1620
Coverage	0,21%	0,66%

From: Ministry of Health - Mental Health Data 2010

The CAPS strategy meant also an important way to move services and health workers from its concentration in the richest regions of the country and the big cities towards the hinterland and the small towns, as shown in Table 5.

Table 5 – Internalization of CAPS towards hinterland and small cities - 2002-2010

Population of the cities	2002			2010		
	% population	CAPS	% CAPS	% population	CAPS	% CAPS
Up to 10.000 people	8,03%	3	0,70%	6,78%	16	0,98%
10.001 – 20,000	11,07%	14	3,30%	10,35%	133	8,20%
20.001 – 50,000	16,86%	59	13,90%	16,45%	505	31,18%
50.001 – 100,000	12,47%	90	21,20%	11,68%	293	18,08%
100.001 – 500,000	23,46%	136	32,00%	25,46%	402	24,82%
More than 500,001	28,13%	122	28,70%	29,28%	271	16,73%
Total	100,00%	295	100,00%	100,00%	1620	16,73%

From: Ministry of Health - Mental Health Data 2010; IBGE 2010

Despite the increase in coverage, two important obstacles must be taken into account: 1) the great regional inequality, regarding especially Amazonian and Center-West regions; 2) management difficulties, mainly addressing lack of human resources and of financing. The global amount of financing for mental health services have increased from 2002 to 2009, but resources are still insufficient[xvi].

Strengthening mental health care in primary care

One of the most striking features of SUS is the strengthening and expansion of primary health care, through the establishment of family health teams (of the PSF - Family Health Program) and community health workers. Started in 1995, this trend of public policy strengthened over the years, in such a way that healthcare coverage (number of PSF teams divided by population) was extended until 52.2 % of coverage, for the whole country, in 2010, with many regions showing coverage percentage next to 90% [xvii]. A tipical team of PSF (formed by the family doctor, nurse and two to three community health workers), is responsible for the care of 600-1000 families of a particular territory, amounting on average to 2000-3000 thousand people benefited.

Until the year 2001, the family health teams were not charged with mental health care, although they had to deal daily with this kind of demand. Since 2002, CAPS was designed to systematically seek coordination with primary care. Training programs in mental health to primary care professionals have become regular from 2003. Although there are still many gaps in technical capacity and insufficient consolidation of clinical

protocols, mental health care is integrated, although not yet thorougly, into primary care routine.

In 2008 special teams, called NASFs (Group for Supporting Primary Care), were created, aimed at strengthening the link between primary care teams and some health areas, such as mental health. An amount of 1,100 of these teams include mental health professionals (psychiatrists or psychologists).

Although still very sparse, the Brazilian scientific production on "mental health in primary care" increased significantly from 2008, reflecting the importance and priority of this issue in the current debate of the psychiatric reform in the country.

The whole network of mental health services created under the MHR process include: CAPS, primary care teams, residential services (620 units in 2010), mental health services in general hospitals, social cooperatives and work initiatives, cultural initiatives, street office for drug consumers, clubs (community leisure centers) and other initiatives. Despite of several difficulties, a large number of new professionals has been incorporated to this diverse group of services each year[xviii].

Conclusions:

The mental health reform in Brazil is strongly supported by some favourable factors: 1) the existence of a nationwide universal system of health, the SUS; 2) a powerful social movement, that unites health workers, users, families and society, in defense of human rights and access to treatment in mental health; 3) the existence of a nationwide legislation with high symbolic approval by the population; 4) the successful of a gradual transition in care model, combining the downsizing of beds to the creation of a strategic community service addressed to people suffering from SMD, the CAPS, whose links with the primary care system are progressively stronger.

As in other low and middle income countries, there are still many problems of life conditions and poverty, and huge obstacles in financing and management of an immense network of mental health services, for a population of 190 million of inhabitants.

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[vii] The Law Project was presented by a congressman of Workers Party (PT), in 1989, and became a federal law in 2001 (Law 10.216, known as Psychiatric Reform or Paulo Delgado Law, for the name of its author).

[viii] There are 5 types of CAPS, according to size, population of catchment area and clinical specificity: CAPS I – up to 50,000 people in catchment area; II – up to 100,000; III – up to 150,000, running day and night; CAPS i – to children and adolescents, up to 150,000; CAPS AD (alcohol & other drugs) – to addiction disorders. BRAZIL. Ministry of Health. Mental health procedure n. 336, February 2002. In 2010, CAPS AD III were also created.

[ix] BRAZIL. Law 40787, approved by Congress in August 2003, creates the Return Home Program and fund.

[x] Ministry of Health budget 2010 = R$ 67,339 million or USD 39,611 million. Expenditure per capita US$ 210 (2010). It is estimated that the whole public health budget (federal plus state plus municipality levels) is almost twice the federal level budget, but data for state and local levels are not precise.

[xi] Source: Ministry of Health (DAB – Primary Care Department - http://dab.saude.gov.br/abnumeros.php).

[xii] See note iv (Lancet Series).

[xiii] Ministry of Health. Ordinance number 32 and PNASH – National Program of Hospital Evaluation. 2004.

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