WHO-AIMS

WHO-AIMS REPORT ON

MENTAL HEALTH SYSTEM

IN Brazil

World Health Organization

Ministério da Saúde

BRASIL UM PAÍS DE TODOS GOVERNO FEDERAL

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MENTAL HEALTH SYSTEM

IN BRAZIL

A report of the assessment of the mental health system in Brazil using the World Health Organization - Assessment Instrument for Mental Health Systems (WHO-AIMS).

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INTRODUCTION

The country

Brazil is a country with nearly 8.5 million Km^2 and with huge contrasts regarding its demographic distribution and social indicators. Such a contrast is exemplified by the human development index (HDI): Brazil has one of the biggest economies in the world, according to its GDP. Brazil's HDI ranked 79^{th} among the countries studied by UNDP. Based on World Bank criteria (World Bank, 2007), Brazil is a lower middle income group.

From a political-administrative point of view, Brazil has three administrative spheres: Federal, State and Municipal. It has 26 States and 1 capital federal district, which have administrative and legislative autonomy, under the principles set forth by federal laws and the Federal Constitution. There are 5,560 cities, again autonomous units, but subordinated to the laws of the state to which they belong and to the Federal Union.

Brazil has a population of 188,078,227 people (July 2006 est.), with 68.1% being between 15-64 years old. 25.8% are between 0 to 14 and 6.1% are 65 years and over (2006 est.). The Median age is 28.2 years. Portuguese is the official language. Ethnic groups are: 53.7% white, 38.5% mulatto (mixed white and black) and 6.2%, black. 0.9% and the population includes other groups, such as Japanese, Arab, Amerindian, and others. The majority of the population is Roman Catholic (73.6%), and other important religions are Protestant (15.4%), Spiritualist (1.3%) and Santeria (0.3%). Sixty six percent of the population works in services (2003 estimate). The unemployment rate is 9.8% (2005 est.) and 22% of the population live below the poverty line (CIA, 2007).

The total health expenditure per capita is 597 US$ and the proportion of the health budget to GDP is 7.6. Of the total adult population, 0.7% are living with HIV/AIDS (660.000 people). There are 22.5 infants' deaths for each 1,000 births (IBGE 2006).

Organizational structure of the health care system

Before the creation of the National Health System (SUS), in 1990 (Law nº 8.080 of September 19, 1990), the health care was provided by two big financial sources and suppliers:

The National Institute of Health Care of the Welfare System - *Instituto Nacional de Assistência Médica da Previdência Social* (INAMPS) is a result of the fusion of several institutes responsible for allowances and retirement plans of different labor unions organized in the 1960s, which provided a large part of health care services. This system provided care to laborers and their dependents by building big outpatient and hospital care units, as well as by contracting private services in the big urban centers.

The remaining population who could not pay for the private health care were seen by philanthropic institutions, schools providing health care or some initiatives of the Ministry of Health supported by the states and cities. The Ministry of Health programs were mainly promotion and prevention activities, such as vaccination campaigns. (Souza, R.R. (2002).

The guiding principles of the health care reform were as follows (Lobato & Burlandy, 2001):

- All Brazilian citizens acquired the right to health care provided by the state, free of charge, with no discrimination of any kind.
- A single public system to aggregate all health services provided by federal, state, and municipal public institutions through direct and indirect administration, as well as foundations supported by public authorities. The private sector was also allowed to become part of the system under contract; however, public authorities retained the power to rule, control, and inspect the services provided. The Ministry of Health was responsible for monitoring and directing all activities related to health, including medical care, which was no longer under the control of social security.
- Integrated and hierarchical health care. The hierarchy had to operate on referral and counter-referral mechanisms, from the least- to the most-complex level of care, ensuring continuity of care by means of the primary caregiver.
- Decentralization and regionalization. Provision of health services had to become the responsibility of municipal governments, financially aided by the federal government and the states. However, all services had to operate within a unified system, because all levels of services could not be provided at the municipal level (Santos 1997).
- Social control and social participation. Health councils at the federal, state, and municipal levels are created in order to increase the democratic participation to develop and implement health policies. Health conferences, to be regularly held at the national, state, and municipal levels, were also intended to stimulate and guarantee social participation.

EXECUTIVE SUMMARY

The World Health Organization Assessment Instrument for Mental Health Systems (WHO-AIMS) was used to collect information on the mental health system in Brazil. The goal of collecting this information is to improve the mental health system and to provide a baseline for monitoring the change. This will enable Brazil to develop information-based mental health plans with clear base-line information and targets. It will also be useful to monitor progress in implementing reform policies, providing community services, and involving users, families and other stakeholders in mental health promotion, prevention, care and rehabilitation.

The country has started several innovative services and interventions, such as the CAPS, and the Return Home program. In little more than one decade, hundreds of services were established and older services were revised according to general guidelines to maximize limited resources. The revised system includes a mix of mental health outpatient services, day hospitals, and therapeutic workshops. Brazil has sound legislation on mental health and a new mental health policy, which resulted in a major reform of the mental health system. Custodial care is being abolished, and the system is now providing care in the community, allowing free access to a variety of mental health services and essential psychotropic medicines. There are 5259 Psychiatrists, 12377 Psychologists, 11958 Social workers, 3119 Psychiatric nurses and 2661 Occupational Therapists working for the Unified Health System. The number of psychiatric beds is declining, and many acute cases are now being treated in general hospitals, and in the community. However, services are unequally distributed across regions of the country, and the growth of the elderly population (Veras, 1987) is creating an increased gap in mental health care. This gap may get even wider if funding does not increase and mental health services are not expanded in the country. There is no solid data to show the impact of policy change in terms of cost-effectiveness. Moreover, despite some acknowledgement of advances made many hurdles have to be overcome. Some of these hurdles are listed below:

1 Policy and Legislative Framework

Although Brazil has a sound legislation on mental health and a list of documents related to its mental health policy, the country would benefit from an official document, programme or plan for mental health. A policy on child and adolescent mental health, and an annual report with information about trends in mental health services, expenditures, and future actions to be taken by the National Division of Mental Health.

Funding

The federal funding to the Unified Health System (SUS) for 2005 was US$ 15 billions (US$ 82.7 per capita), of which US$ 358 millions (1.95 per capita) was for mental health care. In the last decade, there has been a significant reduction in the allocation to mental hospitals (95.5% to 49.3% of the mental health budget) and a concomitant increase in the budget for community services (from 0.8% to 15%). The

budget for psychotropic medication has increased from 0.1% to 15.5%, and other types of mental health facilities and care (from 3.6% to 20.2%) also increased significantly. The investment in mental health does not match the burden caused by psychiatric illness, (almost 19% of the burden), thus an increase in the percentage of the mental health budget to 5% of the health budget of the SUS is essential to the development of mental health services.

Access to Essential Psychotropic Medicines

Access to basic psychotropic drugs is ensured by the Unified Health System (SUS), but there are organizational problems in distribution. It would be important to determine the percentage of patients under treatment in remote areas who really benefit from this policy. Also it is advisable to improve treatment coverage and to evaluate the effectiveness of dispensation of anti-psychotic medication by general community health workers, so as to reduce relapse and re-admission rates.

Surveillance of Human Rights of the Patients

All mental health services should be regularly visited by committees composed of health and justice technicians and members of the civil society using clear and pre-established criteria to investigate protection of patients' human rights. There is no data available of how patients with a psychosis of mental handicap are in prisons or their ability to access treatment. The Brazilian Center on Human Rights and Mental Health has recently been created. It is composed of universities, government and civil society participants who have an important role in this field. Data about involuntary admissions should be compiled locally and nationally.

2 Mental Health Services

The shift to community care is important and the number of psychiatric beds is declining and the number of CAPS are increasing. However, there is only slightly more care in the community then in the hospital. Therefore, new investment should prioritize the expansion of community services and the development of psychiatric wards in general hospitals for dealing with care. There is room for reducing psychiatric beds as long as Psychosocial Community Services are expanded. Very few psychiatric units were opened in general hospitals in the last years, and day hospital care and intensive care in CAPS have to be further investigated to assess coverage and effectiveness.

There are 66 CAPS directed to infant psychiatry, a number fairly low for the needs of the country. It is very important to expand psychiatric care for infants and adolescents. The percentage of children and adolescents under treatment is very low in all types of mental health facilities.

Community residential facilities, which are funded by SUS (Unified Health System) in Brazil, have been broadly developed and implemented. The federal government finances only patients coming from long-stay admissions (over six months)

in psychiatric hospitals. The number of patients in community residential facilities in 2006 was 2480. Women accounted for 42% of the patients treated in community residential facilities, and children accounted for 2%. The number of residential facilities is expected to increase, and it is important to conduct research in following-up these patients in the community.

3 Mental Health in Primary Health Care

It is important to develop mental health guidelines for primary care health professionals. There are ongoing courses available for training primary care professionals, but it is necessary to expand the mental health component in the curricula of Schools of Medicine and Nursing. Particularly, the training could be intensified for the health teams (general physician, nurse and health workers) acting in the Family Program (PSF) spread throughout the country. It is also important to strength the links between the PSF teams and mental health teams in the community. Training alone is not sufficient to guarantee sustainability of actions, it is important to develop long-term follow-up teams. Some mental health teams do offer supervision for the primary health care workers, but there are teams without this kind of support. Health workers could play an important role in ensuring that those with severe m.d. continue medication programs. This interaction between primary care health workers and the mental health team should facilitate referrals to specialized psychiatric treatments. The National Division of Mental Health of the Ministry of Health in conjunction with universities should develop guidelines for the treatment of common mental disorders by primary care providers.

4 Human Resources

It is necessary to evaluate the curriculum in training programs for health professionals for the diagnosis and treatment of psychiatric disorders. There is a shortage of psychiatric nurses in the country, and there is a need to promote specialization in this field. The number of psychiatrists is still far from the ideal; they are unequally distributed across the country, and the residency positions are concentrated in the wealthier areas of the country. The training should include the exposure to the new community services available. Most of the psychiatrists and specialized mental health workers are concentrated in the capitals. It is important to create incentives to locate mental health professionals in remote areas of the country. There is a shortage of infant psychiatrists and specialized training in areas such as eating disorders, elderly psychiatry and forensic psychiatry.

Mental Health Planners

It is necessary to implement training for Health Managers in the field of mental health. This kind of professional must be knowledgeable in epidemiology, anthropology, biostatistics, health policy, health economy, and planning. A Master of Science for Mental Health Planning could be developed at university level under financial support of

the Ministry of Health. The target would be to train 120 health planners to improve mental health services in terms of coverage, efficiency and resources utilization.

Patient and family associations

Patient and family associations are growing and playing an important role in Brazil, but they should be encouraged to participate in the design of mental health policies, employment projects, health promotion campaigns, and self-help programs. A national organization to bring together all users and family associations should be developed. Governmental financial support for these associations should be available and distributed with equity and according to clear criteria delineated at the National Division of Mental Health.

5 Public Education and Link with Other Sectors

The National Division of Mental Health should have access to local educational, prevention, and health promotion events and should act as facilitator for the exchange of experiences between regions.

It is important to support legislation and financial support for the following topics: a) to establish Legal provisions to encourage employers to hire a certain percentage of employees with severe mental disorders; b) protection from discrimination; and c) giving priority in housing for people with severe mental disorders.

It is necessary to evaluate the mental health activities in several areas: treatment and prevention in primary and secondary schools; actions to promote employment for people with severe mental disorders; the percentage of prisoners with major mental disorders and mental retardation; mental health activities in the criminal justice system; training for judges and police officers; and programs for employment opportunities.

6 Monitoring and Research

Mental Health Information Systems

Mental health information systems should be improved. It is paramount to develop a national database to know the number of members of patient associations, the nature and extent of local mental health training programs, or public information programs implemented in the country. Even well-organized and well-supplied data systems such as DATASUS do not compile essential national data, such as the number of outpatients and their diagnoses. The Division of Mental Health should develop standardized epidemiological tools and supervise mental health services in data collection for CAPS, day-hospitals, psychiatric wards in general hospitals, out-patients ambulatories. It would be important to have indicators such as new cases seen in the system, number of persons being served, and so forth. These epidemiological instruments can be developed by universities and should be available for all mental health services in

the country. This information could be gathered at the National Division of Mental Health, and linked to the DATASUS system.

Research in mental health

In the year 2002, the total budget for Health Research was one hundred and one million dollars, and 3.31% was available for mental health research. Nine programs are dedicated to psychiatry, neuropsychiatry, psychobiology and mental health, seven being located in southern states. The investment channeled towards postgraduate and human resource educational programs in Brazil has resulted in a modest contribution to the mental health literature. The National Division of Mental Health and the Brazilian National Council for Scientific and Technological Development (CNPQ) have recently (2005) granted nearly two million dollars for specific mental research projects such as those for violence, minorities, treatment of psychotic patients, and organizational service research. It is highly recommended that this should happen every two years to ensure provision of data within mental health priorities, and the reinforcement of research capability. Research on mental health policies and services organization should be prioritized.

THIS REPORT AIMS TO:

- provide an overview of the context of mental health services in Brazil, its policy changes, the shift to community care, the provision and needs of human resources, and the key areas for future actions;
- underline the steps for formulating and implementing the expansion of the mental health system;
- serve as an advocacy tool to promote the adoption and implementation of the recommended policies, based on consensus, and approved by scientific societies, government and universities;

THIS REPORT WILL BE OF INTEREST TO:

- policy-makers, legislators, general health planners and mental health planners;
- user groups;
- representatives or associations of families and carers of persons with mental disorders;
- advocacy organizations representing the interest of persons with mental disorders and their relatives and families;
- human rights groups working with and on behalf of persons with mental disorders;
- officials in ministries of health, social welfare and justice.

Policy and Legislative Framework

Policy, plans, and legislation

Brazil's mental health policy, initially formulated in 1991 and last revised in 2005[1], does incorporate and follow the Caracas Declaration principles (Caracas Declaration, 1991). There are four main points in the Mental Health Policy: a) to ensure civilian rights for people with mental disorders according to the United Nations Document (1991); b) to overcome the psychiatric hospital as the central unit for treating people with mental disorders; c) to ensure that people with mental disorders are not directed exclusively to the hospitals; and d) to build up a diverse network to maintain the access, efficacy and efficiency for people with mental disorders.

The country's mental health policy is not described in any single official document, but in a series of texts about the mental health programs in operation in the country. The last revision of the national mental health program was in 2005 (Program for social inclusion through employment opportunities). No emergency/disaster preparedness program is available for mental health services. The ongoing mental health programs in Brazil can be summarized as follows:

1. Community residential facilities (2000, Ministry of Health 2004)[2], ;
2. Permanent program of human resources training for the reform of psychiatric care (2001);
3. Program to expand the Psychosocial Community Centers (CAPS) and mental health outpatient facilities (2002)[3];

1 Ministério da Saúde / SAS / DAPE / Coordenação Geral de Saúde Mental, (2005). Psychiatric reform and mental health policy in Brazil (Reforma psiquiátrica e política de saúde mental no Brasil. Conferência Regional de Reforma dos Serviços de Saúde Mental : 15 anos depois de Caracas. OPAS. Brasília, November, 2005).

2 Executive order GM/MS 106 of 2/11/2000 and 246 of 2/17/2005; Ministério da Saúde, Departamento de Ações Programáticas Estratégicas/SAS (2004). Residências Terapêuticas: o que são, para que servem. Brasília. Editora do Ministério da Saúde.

4. Annual program to restructure psychiatric hospital care provided by SUS – Unified Health System (2003)[4], which is related to the PNASH program oriented to monitor mental health hospitals;
5. "Return home" (De Volta para Casa) program (2003)[5];
6. Program for alcohol and drug users (2003)[6] ;
7. Inclusion of mental health care into primary health care (2003)[7];
8. Program of social inclusion through employment opportunities (2005)[8];
9. Program for children and adolescents mental health (2005)[9].

The country does not adopt official documents in the format suggested by the WHO (WHO, 2005) to describe mental health policy, plan or programs and to define all budgets, time frames and specific goals. Such information is available in documents such as the report prepared by the mental health coordinating authority for the 2005 PAHO meeting to celebrate the 15th anniversary of the Declaration of Caracas, the annual report of the mental health coordination authority, and the reports and executive orders issued by the Department of Health concerning the specific action programs listed above.

The latest piece of mental health legislation was Law 10216 of April 6, 2001, which provided for the protection of the rights of persons affected by mental disorders, reoriented the mental health care model to focus on access to mental health care, and addressed issues such as: access to the least restrictive care; rights of mental health service consumers, family members, and other care providers; voluntary and involuntary treatment; and mechanisms to oversee involuntary admission and treatment practices. Procedures and standardized documentation have been developed for all or almost all components of the mental health legislation. Other components, listed below, are provided in the following legal documents:

1. Competency, capacity, and guardianship issues for people with mental illnesses: Federal Constitution; Civil Code;
2. Accreditation of professionals and facilities: more than 60 executive orders regulate the accreditation of health providers and health professionals, among them the PT/GM 1890/97; the PT/GM 3947/98 and the PT/SAS 35/99;

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3 Executive order GM/MS 336 of 2/19/2002; SAS/MS 189 of 3/20/2002; GM/MS 245 of 2/17/2005. Ministério da Saúde, Departamento de Ações Programáticas Estratégicas/SAS (2004). Saúde mental no SUS: Os Centros de Atenção Psicossocial. Brasília. Editora do Ministério da Saúde.

4 Executive order GM/MS 52 of 1/20/2004, attachment.

5 Federal law 10708 of 6/31/2003; Executive order GM/MS 2077 of 10/31/2003. Ministério da Saúde, Departamento de Ações Programáticas Estratégicas/SAS (2003). "De Volta para Casa"- Manual do Programa. Brasília. Editora do Ministério da Saúde.

6 Ministério da Saúde, Departamento de Ações Programáticas Estratégicas/SAS (2004). *A Politica do MS para a Atenção Integral a Usuários de Alcool e outras Drogas.* Brasília. Editora do Ministério da Saúde.

7 Ministério da saúde, departamento de atenção básica/SAS (2003). *Núcleo de atenção básica a família*. Brasília. Editora do Ministério da Saúde.

8 Ministério da Saúde, Departamento de Ações Programáticas Estratégicas/SAS (2005). *Saúde Mental e Economia Solidária: Inclusão Social pelo Trabalho.* Brasília. Editora do Ministério da Saúde.

9 Ministério da Saúde, Departamento de Ações Programáticas Estratégicas/SAS (2005). *Caminhos para uma Política de Saúde mental Infanto-juvenil.* Brasília. Editora do Ministério da Saúde.

3. Mechanisms to implement the provisions of mental health legislation: Health Act of 1990; executive orders issued by the Ministry of Health.

Social participation in mental health policies

Mental health regional and national conferences[10] are remarkable for the interest in the design of mental health policies. There have been three national conferences, in 1987, 1992 and 2001, the latter with the participation of 1,480 official participants. Most of the delegates had been in municipal, regional and state mental health conferences.

The attributions of the Inter-sector Mental Health Commission of the National Health Council (CISM) are set forth in Law 8142/90. The National Health Council considered these issues in formulating health policy: 1) the epidemiological importance of mental disorders and the loss of survival years to those who suffer from such disorders; 2) the need to enlarge and protect the rights of disordered people in accordance with the Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care of UN (1991), and 3) the need of building a diversified and enlarged socio-sanitary network, accessible, effective and efficacious for mental health care". The CISM is composed of representatives of the CONASEMS (National Council of Municipal Health Secretaries); Users; National Health Council; Anti-asylum Movement; CONASS National Council of Health Secretaries; Family members; Brazilian Federation of Hospitals; Human Rights State Bureau of the Department of Justice; Ministry of Health; Brazilian Psychiatric Association; and the Forum of National Institutions of Health Workers.

Financing of mental health services

The Ministry of Health earmarks 2.35% of health care expenditures for mental health. Of all mental health expenditures, 49% are allocated to psychiatric hospitals. The federal funding to the Unified Health System (SUS) for 2005 was US$ 15 billions (US$ 82.7 per capita), of which US$ 358 millions (1.95 per capita) was for mental health care. In the last decade, there has been a significant reduction in the allocation to mental hospitals (95.5% to 49.3% of the mental health budget) and a concomitant increase in the budget for community services (from 0.8% to 15%). The budget for psychotropic medication has increased from 0.1% to 15.5%, and the budget for other types of mental health facilities and care also increased significantly (from 3.6% to 20.2%). The investment in mental health does not match the burden caused by psychiatric illness, (almost 19% of the burden (Escola Nacional de Saúde Pública, 2002)), thus an increase in the percentage of the mental health budget to 5% of the health budget of the SUS is essential to the development of mental health services.

In terms of affordability of mental health services, 100% of the population hypothetically has free access to services and essential psychotropic medicines, but a significant number of those treated in private offices or clinics do not make use of this

[10] Ministério da Saúde, Conselho Nacional de Saúde (2002). *Relatório Final da III Conferencia Nacional de SaúdeMental* . Brasília. Editora do Ministério da Saúde.

benefit. The medicines included in the list of essential medicines are described as follows:

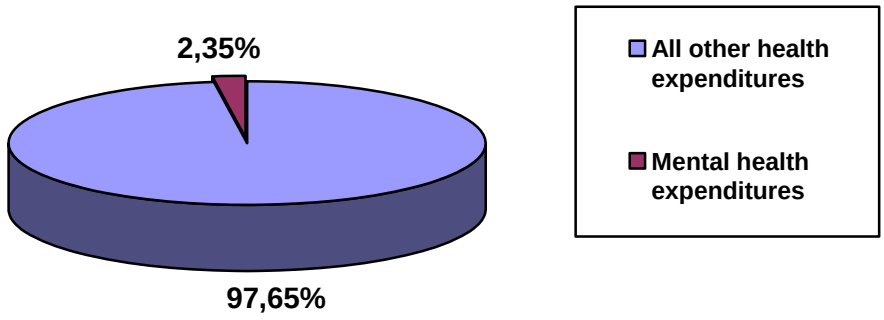
- Antipsychotics - chlorpromazine, fluphenazine, haloperidol;
- Antidepressants - amitriptyline, clomipramine; fluoxetine;
- Mood stabilizers - carbamazepine, lithium carbonate, valproic acid;
- Anxiolytics - diazepam;
- Antiepileptic drugs - phenobarbital, carbamazepine, valproic acid.

For those that pay out of pocket, the cost of antipsychotic and antidepressant medication is: 5% of the daily minimum wage for one day of antipsychotic medication for a user taking the cheapest antipsychotic drug available; and 6% of the daily minimum wage for one day of antidepressant medication for a user taking the cheapest antidepressant drug available.

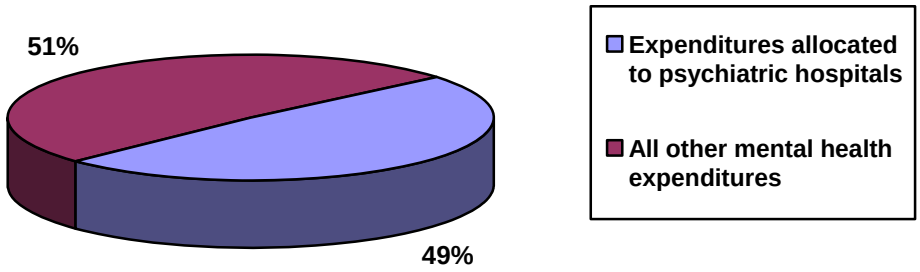
"Exceptional Medications" are high-cost drugs that are administered for long periods, such as drugs for neurological diseases, osteoporosis, hepatitis and transplantations. Each state of the federation is responsible for the procurement and distribution of these medications, which are financed by the Ministry of Health. From a managerial point of view, the control of the supply of these medications improved with the adoption of the High Complexity Discharge Authorization (Autorização para Procedimentos de Alta Complexidade - APAC). This procedure enables the identification of users and provides better control over expenditures, distribution and beneficiaries. Moreover, Clinical Protocols and Therapeutic Guidelines were introduced for each new medication and disease (Negri, 2002). The list of exceptional medications for mental health – 2002 (type of medication and regulated clinical indication) are described below:

- Clozapine – Schizophrenia
- Gabapentin – Epilepsy and epileptic syndromes
- Lamotrigine – Epilepsy and epileptic syndromes
- Olanzapine – Schizophrenia; no organic psychosis not otherwise specified
- Risperidone – Schizophrenia; no organic psychosis not otherwise specified
- Rivastigmine - Alzheimer disease
- Ziprasidone - Schizophrenia

GRAPH 1.1. HEALTH EXPENDITURES ALLOCATED TO MENTAL HEALTH



GRAPH 1.2 MENTAL HEALTH EXPENDITURES ALLOCATED TO PSYCHIATRIC HOSPITALS



As it can be seen in Graph 1.2, for the first time there is now a higher allocation of resources to community services compared to resources for psychiatric hospitals. In 2001 nearly 80% of the expenditure was directed to psychiatric hospital admissions.

Human rights policies

A national human rights review body has the authority to oversee regular inspections of mental health facilities, review involuntary admission and discharge procedures, review investigations of complaints, and impose sanctions (e.g., withdraw accreditation, impose penalties, or close down facilities that persistently violate human rights).

The inter-ministerial executive order 1055/2006 of May 17, 2006, created a working group to prepare the establishment of a Brazilian Center on Human Rights and Mental Health, with the following objectives: to articulate the fields of human rights and mental health; to produce information, studies and research on these fields; to develop mechanisms to monitor institutions that work with people with mental disorders; and to

create ombudsman services to receive and forward demands from people with mental disorders and civil society organizations.

The country does not have inspection mechanisms for the specific protection of human rights of patients, but PNASH/Psychiatry[11] (National Hospital System Assessment Program) was conducted in 2002 and 2003/2004 and inspected, respectively, 244 and 165 psychiatric hospitals associated with the unified health system (SUS). Hospitals were classified according to the quality of facilities and care, and several criteria were used to approach the assurance of human rights. Similar regular inspections have not yet been conducted in community residential facilities. State and municipal mental health committees inspect residential facilities frequently, but do not yet follow unified and systematic criteria.

In Brazil, discussions about human rights in psychiatric hospitals, psychiatric wards in general hospitals or community residential facilities are not regularly promoted in courses or events, but these topics are part of managerial or clinical staff debates. The success of these debates depend, therefore, on the emphasis and importance assigned to this topic by the staff in each mental health group. There is no record of how many work sessions on human rights protection may have been conducted, but best estimates shows that at least 21% of mental hospitals and 100% of inpatient psychiatric units and community facilities discuss patients' human rights issues in the daily work through clinical sessions and community interventions.

The Return Home Program

The Return Home Program is one of the most effective tools for the social reintegration of individuals with long histories of hospitalization. It strongly enhances the emancipation of individuals with mental disorders and the processes of de-institutionalization and reduction of psychiatric beds in states and municipalities. It was created by the Federal Law 10.708 which the President Luiz Inácio Lula da Silva submitted to the Brazilian Congress in 2003, when it was passed and enacted.

The program aims at effectively contributing to the process of social inclusion of individuals with long history of hospitalization in psychiatric hospitals through a monthly rehabilitation benefit (equivalent to about US$ 140) paid directly to those patients when they leave the psychiatric hospital. This financial benefit is transferred to the patient's own bank account.

[11] The National Hospital System Assessment Program (PNASH) of the Department of Health annually conducts the PNASH/psychiatry according to guidelines and rules established in the executive orders GM 799/00 and GM/MS 251/02. In each state and in the Federal District, the inspection team of the PNASH/Psychiatry is composed of 1 representative of the state mental health staff, 1 representative of the state sanitary surveillance staff, and 1 representative of the control and assessment staff; in cities with full management responsibilities, 2 representatives of the mental health staff (1 from the state and 1 from the city), 2 representatives of the sanitary surveillance staff (1 from the state and 1 from the city), 1 representative of the control and assessment staff. The instrument used for assessment has two components: mental health and sanitary surveillance (conditions of health, nourishment, pharmacies, etc).

Beyond the financial support, it has immediate effects on the everyday life of these individuals. The program enhances emancipation and autonomy through the expansion of the users' relationship network and restores civil, political and citizenship rights.

According to the global literature in the field of Psychiatric Reform, this is one of the major tools in the process of psychosocial rehabilitation. Currently, there are 2813 individuals receiving the rehabilitation benefit.

Mental Health Services

Organization of mental health services

The national mental health authority provides advice to the government on mental health policies, legislation, and education to the public and other health professionals. The mental health authority also deals with service planning; service management, coordination and monitoring, and quality assessment of mental health services. Mental health services are organized according to catchments areas.

Outpatient mental health facilities

There are 1086 outpatient mental health facilities in the country, 66 of which are for children and adolescents only. Outpatient services are undergoing intense change, and at the moment there are conventional outpatient mental health services (isolated or as part of outpatient services for several medical specialties) as well as the new Psychosocial Community Centers **(**Centros de Atenção Psicosocial-CAPS). CAPS are specialized mental health services that provide outpatient care or partial hospitalization as day or night treatment. Some CAPS are specialized in the treatment of children and adolescents (66 CAPS in June 2006) or in problems related to alcohol and drug use (109 CAPS, not included in this report). The other CAPS (673 in June 2006) primarily treat severe mental disorders and are classified according to three degrees of complexity, the population served, and the funds allocated.

There is not a good system to monitor the treatment and follow-up cases in the out-patient facilities. These facilities are estimated to treat 1951[12] users per 100,000 inhabitants. Although data on outpatient gender, age and diagnosis are recorded in the services, they are not compiled by region or for the whole country. Of all outpatient facilities, it is expected that near 40% provide follow-up care in the community, and 10% have mobile mental health teams. Estimates indicate that almost 50% of users have

[12] The number of patients treated in outpatient facilities is not available, but the National Public Health System (Sistema Único de Saúde - SUS) recorded 5,130,507 psychiatric visits and 13,866,147 other psychosocial interventions in 2005. Estimates of an average 4 psychiatric visits per patient/year and 6 psychosocial interventions per patient/year add up to a total of 1,282,626 + 2,311,024 = 3,593,650 patients/year.

received more than one psychosocial intervention in the past year[13]. At least one psychotropic medicine from each therapeutic class (antipsychotic, antidepressant, mood stabilizer, anxiolytic, and antiepileptic medicines) should be available at every public outpatient mental health facility or at a nearby pharmacy all year round. However, disruptions in the supply of medicines due to logistic or budgeting problems are still frequent.

Day treatment facilities

Day hospital care is provided by 811 units that are associated with the public network; 66 of these units treat children and adolescents only. Brazil has 72 traditional mental health day hospitals that offer a total of 2513 beds, and 2246 are linked to the Unified Health System (SUS).

The Psychosocial Community Centers (CAPS) provide day hospital care, which are considered intensive care (*acompanhamento intensivo*). In June 2006, there were 739 CAPS registered in Brazil (excluding those specialized in alcohol and drugs, called CAPSad)[14]. The maximum number of day hospital admissions at CAPS varies according to their classification of complexity, but the maximum number paid by SUS may reach 25255 beds/month, if they are all working at their full capacity.

[13] **Questionnaire for qualified informants**: in some items of the WHO-AIMS, the lack of direct data who took account of the country's regional differences led us to use qualified informants, by means of an interview sent by e-mail. The interviewed subjects were selected by means of a contact list of the Mental Health Section of the Ministry of Health, which was composed of: a) 26 state mental health coordinators; b)61 municipal mental health coordinators of state capitals and other cities with more than 300,000 inhabitants; c) 19 consultants of the Mental health coordination. Each of the 106 interviewed subjects have received an email invitating to participate in the study, and received a login and a password to a website in the internet with the questionnaire.We obtained 33 answers (34% of the total).

[14] The number of CAPS is increasing steadily. By December 2006 there were already 1011 CAPS in the country.

Number of CAPS in Brazil, by modality, in June 2006

MODALITY	NUMBER	CHARACTERISTICS
CAPS I	355	Minimum team members: 1 psychiatrist or physician specialized in mental health 1 registered nurse 3 professionals graduated in other areas: psychologist, social worker, occupational therapist, pedagogue or other professionals needed for the therapeutic plan 4 technicians: nursing assistant or technician, administrative technician, educational technician, and artisan.
CAPS II	290	Minimum team members: 1 psychiatrist 1 registered nurse specialized in mental health 4 professionals graduated in other areas: psychologist, social worker, occupational therapist, pedagogue, physical education teacher, or other professionals needed for the therapeutic plan 6 technicians: nursing assistant or technician, administrative technician, educational technician, and artisan.
CAPS III	28	Minimum team members: 2 psychiatrists 1 registered nurse specialized in mental health 5 professionals graduated in other areas: psychologist, social worker, occupational therapist, pedagogue, or other professionals needed for the therapeutic plan 8 technicians: nursing assistant or technician, administrative technician, educational technician, and artisan. Provides 24 hours crisis services with priority to patients participating in one of the therapeutic projects in one of the CAPS, for a maximum of 7 days in a row or a total of 10 days in 30 days.
CAPSi	66	Provides services for children and adolescents Team: 1 psychiatrist or neurologist or pediatrician specialized in mental health. The other professionals are similar to CAPS II.
CAPSad	109	Treatment of problems associated with the consumption of alcohol and other drugs. It needs minimum of 1 psychiatrist, 1 general physician and the other professionals are similar to CAPS II
TOTAL	848	

Source: National Division of Mental Health, Ministry of Health.

These facilities (traditional day hospital and intensive care in CAPS) treat 61 patients per 100,000 inhabitants. Of all patients treated in day treatment facilities, 47% are women and 4% are children or adolescents. Treatment lasts a mean 31.5 days in day treatment facilities.

Community-based psychiatric inpatient units

In Brazil, 105 community-based psychiatric inpatient units provide 2074 beds (1.13 beds per 100,000 inhabitants)[15]. Estimates show that about 2% of these beds are reserved for children and adolescents only. Of all patients admitted to community-based psychiatric inpatient units, 40% are women and 5% are children or adolescents. Admissions to community-based psychiatric inpatient units were primarily classified in the following two diagnostic groups: schizophrenia, schizotypal and delusional disorders (F20-F29), 44%; and mental and behavioral disorders due to psychoactive substance use (F10-F19), 20%[16]. Patient mean length of stay was 14.02 days per discharge. It is estimated that nearly 20% of the patients in community-based psychiatric inpatient units received one or more psychosocial interventions in the last year[17]. At least one psychotropic medicine from each therapeutic class (antipsychotic, antidepressant, mood stabilizer, anxiolytic, and antiepileptic medicines) should be available at every community-based psychiatric inpatient unit at all times. There are 592 general hospitals that offer some psychiatric beds (n=1224 beds, being 1094 linked to SUS and 130 in private institutions) in general wards or emergency-care back-ups, without having a formal psychiatric ward.

Community residential facilities

Community residential facilities, which are financed by SUS (unified health system) in Brazil, have been intensively implemented. The federal government finances only the housing of patients coming from long-stay admissions (over six months) in psychiatric hospitals. The cities are to finance other cases.

In 2006, there were 476 community residential facilities in the country. Each residence may have up to 8 residents, and, together, these residences provide around 3800 places (2,06 places per 100,000 inhabitants). This figure, however, may be overestimated because many residential facilities operate with less than 8 residents. Of these beds in community residential facilities, 1.2% are reserved for children and adolescents only.

The number of patients in community residential facilities in 2006 was 2480. Women accounted for 42% of the patients treated in community residential facilities, and children, for 2%.

The average number of days in community residential facilities is not available. A trend towards protracted stays (longer than one year) is expected, because patients are transferred from long-stay psychiatric hospitalizations, have severe disabilities and no social support.

Psychiatric hospitals

15 Search of National Registry of Health Facilities (Cadastro Nacional de Estabelecimentos de Saúde-CNES) conducted on June 15, 2006 (CNES:http://cnes.datasus.gov.br).
16 We could not obtain data on the diagnoses of patients admitted to community-based psychiatric units. The figures presented here were estimated from data reported on the National survey of psychiatric units in general hospitals (Botega & Schechtman, 1997, table 6).
17 According to questionnaires applied to mental health coordinators in states and large cities.

Brazil has 228 psychiatric hospitals that are either public or that provide services to the public system. These hospitals offer a total of 42076 beds (22.84 beds per 100,000 inhabitants). Another 4855 private beds are available in psychiatric hospitals that accept private medical insurance payments. There are 3114 private beds in at least 50 fully private psychiatric hospitals[18]. Therefore, the total number of beds in psychiatric hospitals in the country is 50045 (27.17 beds per 100,000 inhabitants). Only a small percentage of the population can afford fully private hospitalization.

Of these facilities, 14% are integrated with outpatient mental health facilities. No data are available about whether any beds in psychiatric hospitals are reserved for children and adolescents only. The number of beds has decreased 27% in the last five years (-18792 beds). Most diagnoses of patients admitted to psychiatric hospitals are classified in the following two groups: schizophrenia, schizotypal and delusional disorders (F20F29), 43%; and mental and behavioral disorders due to psychoactive substance use (F10-F19), 31%. The rate of patients in psychiatric hospitals is 119 per 100.000 inhabitants[19] (the occupancy rate in mental hospitals is 93%). The average length of stay in mental hospitals is 65.29 days: 39% of the patients stay less than one year, 19% stay 1-4 years; 20%, 5-10 years; and 21%, more than 10 years[20]. It is estimated that few (1% to 20%) patients in mental hospitals received one or more psychosocial interventions in the last year. At least one psychotropic medicine from each therapeutic class (antipsychotic, antidepressant, mood stabilizer, anxiolytic, and antiepileptic medicines) should be available at every psychiatric hospital.

Forensic and other residential facilities

In addition to beds in mental health facilities, there are also 3677 beds[21] for persons with mental disorders in forensic inpatient units. Brazil has 25 hospitals for custody and psychiatric treatment, which are psychiatric hospitals kept by the prison system for the exclusive treatment of patients that committed a crime and are suspected to have or actually have a mental disorder that requires specialized treatment. The number of beds in other residential facilities in the country, such as homes for persons with mental retardation, detoxification inpatient facilities and homes for the destitute, is unknown.

Human rights and equity

[18] Data retrieved for the National Registry of Health Facilities (CNES) in June 2006. We believe that there may be a small number of psychiatric hospitals not yet included in this Registry or not correctly registered as psychiatric hospitals.

[19] Initial admissions (does not include repeat admissions after 45 days); more than one admission per patient might have been recorded in the year.

[20] Best estimate. Source: Mental Health Section of the Department of Health. Estimative based in PNASH 2003/2004; "Going home" (De Volta para Casa) program (2003) and Annual program to reform hospital psychiatric care of the SUS (PRH) (2003). Number of patients in mental hospitals on December 31 of the last year: 39.130 = 42.076 beds x 0.93 (Average number of days spent in mental hospitals – item 2.6.9).

[21] This estimate was based on the number of inpatients in hospitals for custody and psychiatric treatment. As there is a probable 100% occupancy of beds, we may suppose that this number is about the same number of beds. Source: Department of Justice, Federal Bureau of Prisons – August 2003.

Although the notification of involuntary admissions to the sanitary authority and the Public Prosecution Service is mandatory, data about such admissions are not yet compiled in Brazil. Seven Brazilian states (Pernambuco, Paraná, Bahia, Rio de Janeiro, Minas Gerais, Rio Grande do Sul and Santa Catarina) have already started a system to record and follow up admissions by means of a partnership with the Public Prosecution Service, but total numbers are not yet available.

Despite the fact that the assessment of psychiatric hospitals takes into account the frequency and the conditions of physical restraint (continuous presence of a health professional during restraint, staff discussion to decide on restraint, and annotation on patient chart), there are no records of the frequency of the use of restraints. The seclusion of patients in locked rooms is a forbidden practice in Brazil (Executive order 251, 2002).

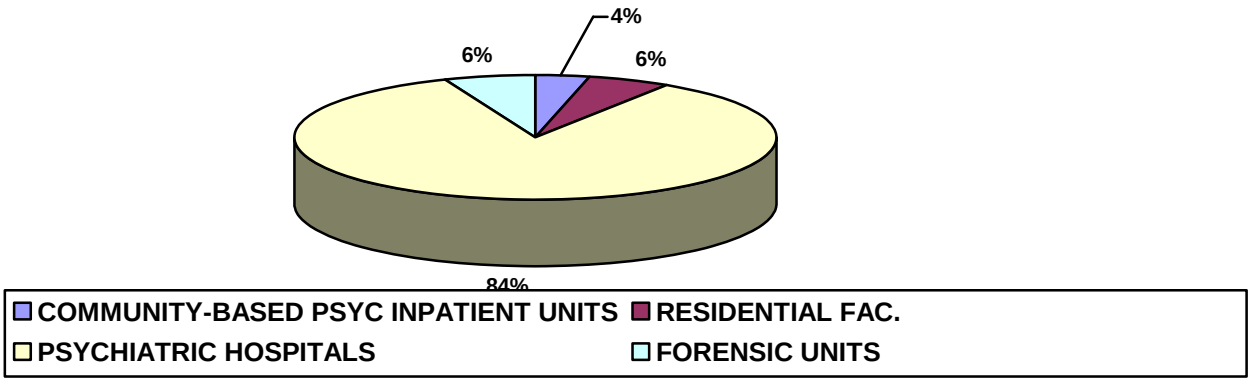
The number of psychiatric hospital beds in only the 16 largest metropolitan areas in the country is 22026 beds for 63,064,612 inhabitants (Census 2000); that is, 36.83 beds for 100,000 inhabitants, 1.36 times greater than the density of beds in psychiatric hospitals in the whole country. The contrast between large cities and the rest of the country shows that equity in health care is not found in a country with the characteristics of Brazil. Large urban areas have poverty pockets where access to treatment may be even more difficult than in rural areas of the most developed states, such as São Paulo or Paraná States. At the same time, the existence of older large psychiatric hospitals still in operation outside large cities may lead to the wrong conclusion that there is a good distribution of beds in the country.

Access to mental health care has improved in the last years. A recent research conducted by the “Instituto Data Folha”, a prestigious daily journal in the State of São Paulo, under the auspices of the Brazilian Psychiatric Association, has found that 9% of the population older than 16 years, have sought mental health care in the last year; 72% of those who sought care were seen in the SUS. 92,3% of those who needed care have been served in the SUS. For those who sought treatment, nearly 45% had a positive assessment of the service. It can be concluded that there is good coverage but there are some problems to be overcome.

Inequity of access to mental health services for other minorities (e.g., linguistic, ethnic, religious minorities) is at least moderate in the country, but the country still lacks studies that investigate the dimension of this problem in the mental health area.

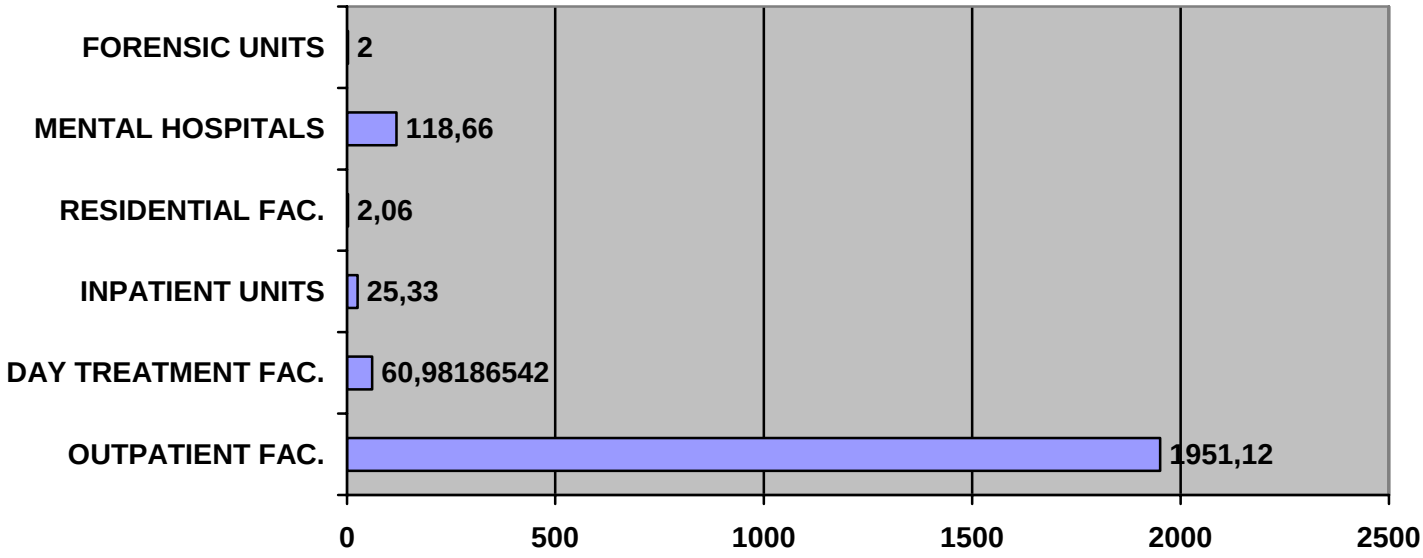
Summary Charts

GRAPH 2.1 - BEDS IN MENTAL HEALTH FACILITIES AND OTHER RESIDENTIAL FACILITIES



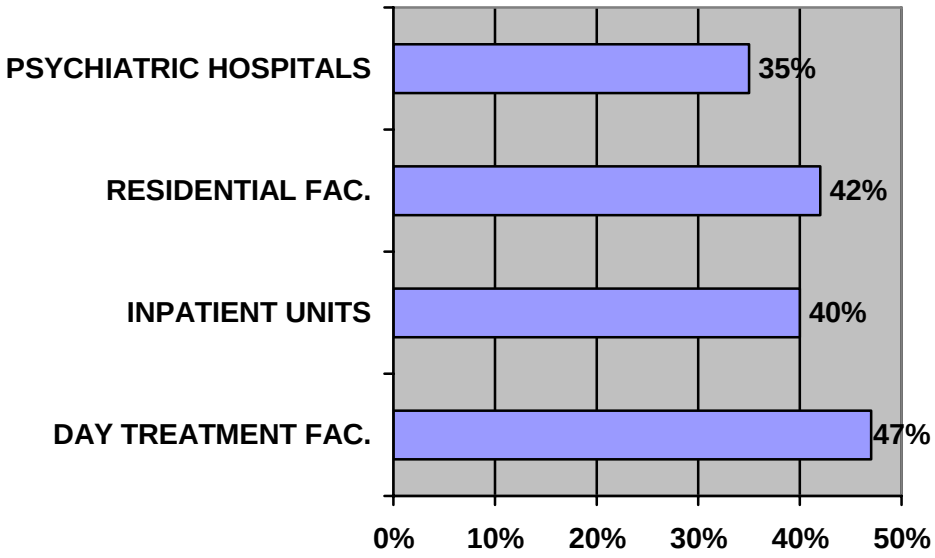
Most beds in the country are available in psychiatric hospitals, followed by residential units and forensic units.

GRAPH 2.2 - PATIENTS TREATED IN MENTAL HEALTH FACILITIES (rate per 100.000 population)



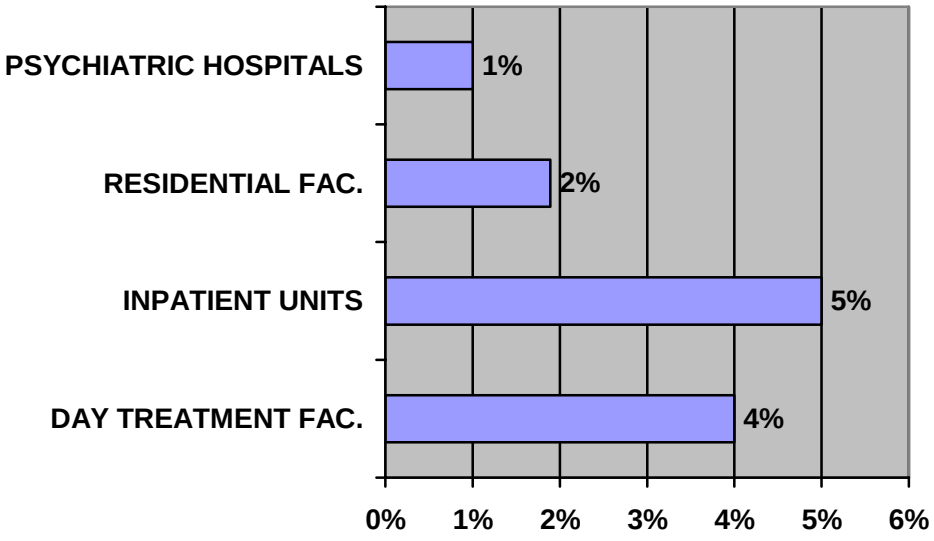
Note: In this graph, the rate of admissions in inpatient units is used as proxy for the rate of patients treated in the units. The number of patients in forensic beds on December 31 is used as proxy for patients treated in forensic units.
Most patients are treated in outpatient facilities and in mental hospitals, while the rate of patients treated in community-based inpatient units and residential facilities is lower.

GRAPH 2.3 - PERCENTAGE OF FEMALE PATIENTS TREATED IN MENTAL HEALTH FACILITIES



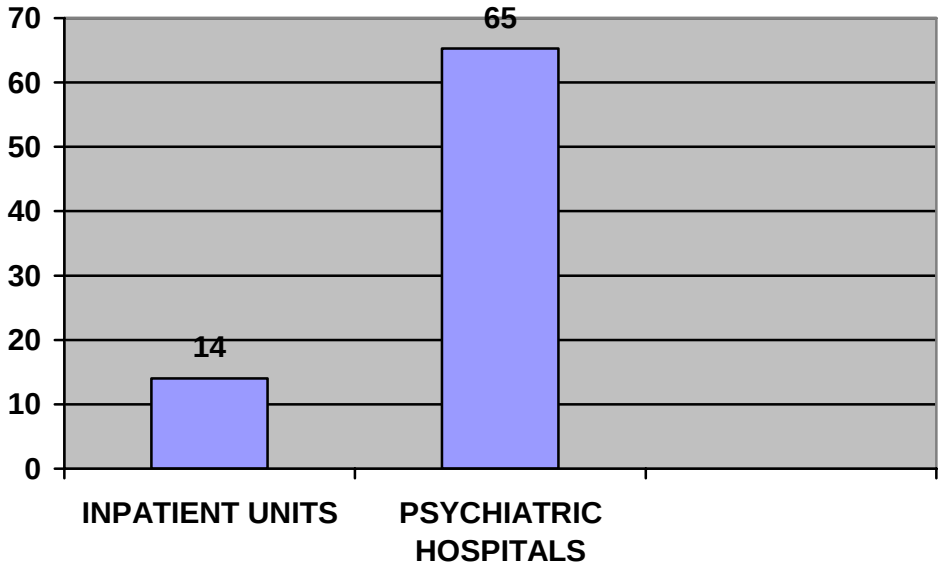
Note: In this graph, the percentage of female patients admitted to inpatient units is used as proxy for the percentage of women treated in the units Female patients are a minority in inpatient units and residential facilities in the country. Data about distribution according to sex in outpatient facilities are not available.

GRAPH 2.4 - PERCENTAGE OF CHILDREN AND ADOLESCENTS TREATED IN MENTAL HEALTH FACILITIES



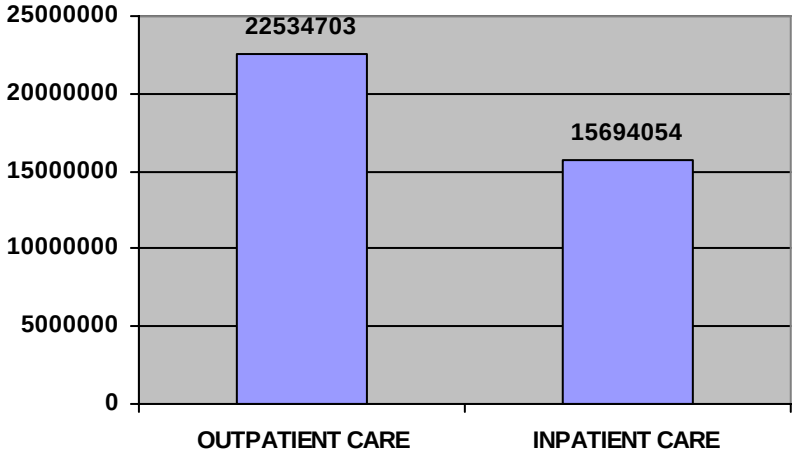
Note: In this graph, the percentage of children and adolescents admitted to inpatient units is used as proxy for the percentage of children and adolescents treated in the units. The percentage of children and adolescents is low in all types of facilities; the percentage of children and adolescents in outpatient facilities is not available.

GRAPH 2.5 - LENGTH OF STAY IN INPATIENT FACILITIES
(days per year)



Note: Patients have a longer stay in psychiatric hospitals; data about length of stay in residential facilities are not available.

GRAPH 2.6 INPATIENT CARE VERSUS OUTPATIENT CARE



Note: The ratio between outpatient/day care contacts and days spent in all the inpatient facilities (psychiatric hospitals, residential facilities and general hospital units) is an indicator of extent of community care: in this country, the ratio is 1.4:1.

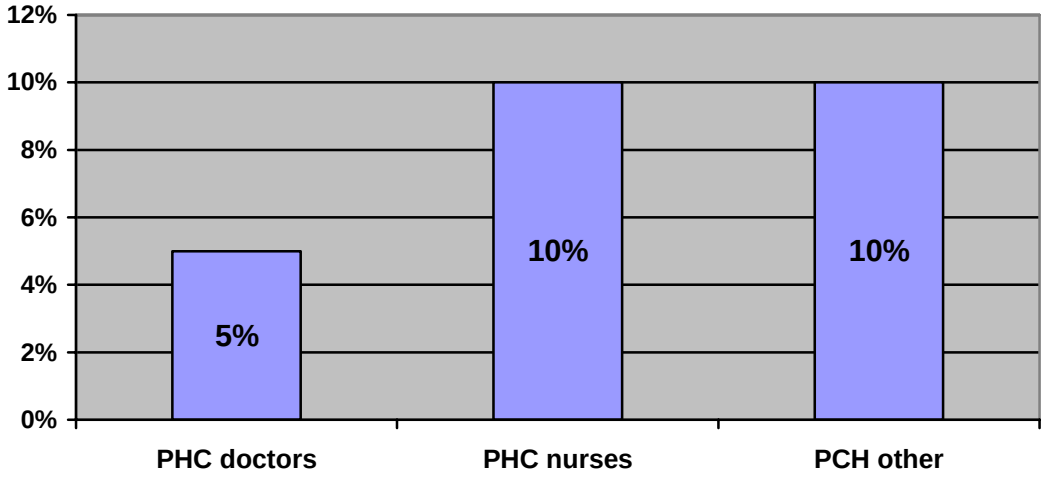
Mental Health in Primary Health Care

Training in mental health care for primary care staff

About 3% of the training of medical doctors is devoted to mental health, in comparison to 7% of the training of nurses. We do not have data about this percentage in the training of non-doctor/non-nurse primary health care workers. We estimate that 5% of primary health care doctors have received at least two days of refresher training in mental health, in comparison with 10% of nurses and 10% of non-doctor/non-nurse primary health care workers. These estimates were based on questionnaires sent to 33 qualified informants.

Primary health care is managed by municipal governments; therefore, training programs are fragmented and the total number of workers trained is not available. Large investments have been made in family health teams in recent years, and thousands of community health agents have received several types of in-service training, which included mental health care, but which was not standardized for the whole country.

GRAPH 3.1 - PERCENTAGE OF PRIMARY HEALTH CARE WORKERS THAT HAD AT LEAST 2 DAYS OF REFRESHER TRAINING IN MENTAL HEALTH IN THE LAST YEAR



Estimates based on responses to questionnaires sent to municipal and state mental health care coordinators.

Mental health in primary health care

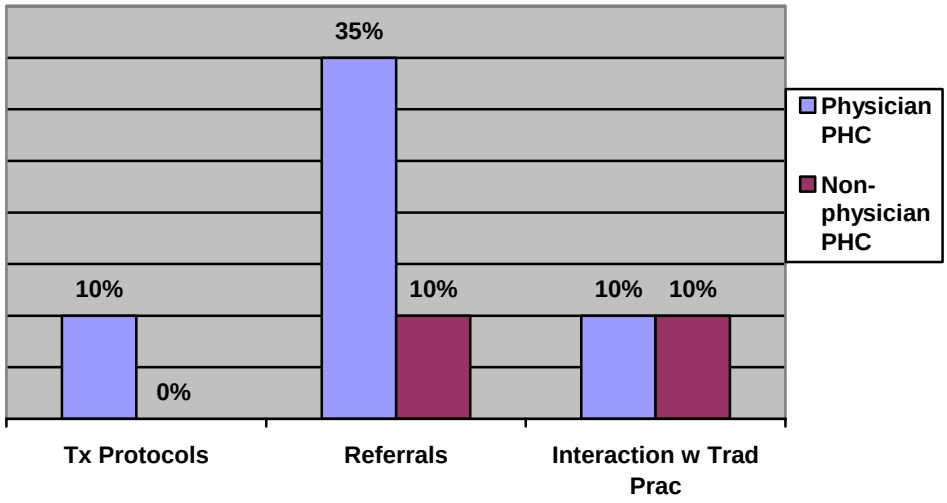
At the primary care level, the supervision and assistance of mental health teams is carried out trough primary care units, as well as by family physicians in the Family Health Program[22] .

[22] Administrative Order nº 1886/GM of, 18 de December 1997

Most primary health care (PHC) services have at least one physician on site or available for referrals; only the most distant regions have non-physician based PHC clinics**.** It is estimated that few physician-based primary health care clinics (1% to 20%) use evaluation and treatment protocols for key mental health conditions, whereas no (0%) non-physician-based primary health care clinics use them. Some (21% to 50%) of the doctors in physician-based primary health units make an average of at least one referral per month to a mental health professional. Few (1% to 20%) doctors in non-physician based primary health care clinics make referrals to higher levels of care. The analysis of professional interaction between primary health care staff and other care providers shows that few (1% to 20%) primary care doctors have interacted with a mental health professional at least once in the last year.

It is estimated that few (1% to 20%) care providers in physician-based PHC facilities had any interaction with a complementary/alternative/traditional practitioner; the same percentage is estimated for non-physician-based PHC clinics and mental health facilities.

GRAPH 3.2 - COMPARISON OF PHYSICIAN-BASED AND NON-PHYSICIAN-BASED PRIMARY HEALTH CARE



Note: Tx protocols = % of PHC clinics with treatment protocols for key mental health conditions; Referrals = % of PHC that made at least one mental health referral per month; Interaction w Trad Prac = % of PHC that interacted with complementary/alternative/traditional practitioners per month.

Estimates based on responses to questionnaires sent to municipal and state health care coordinators.

Prescriptions in primary health care

Nurses and non-doctor/non-nurse primary health care workers are not allowed to prescribe psychotropic medicines in any circumstances. PHC doctors are allowed to

prescribe but with restrictions; they are not allowed to prescribe high-cost medications, such as atypical neuroleptic drugs for schizophrenia refractory to conventional treatment. In some municipal areas only PHC doctors and non-psychiatric doctors that have received refresher training in psychotropic drugs promoted by the government are allowed to prescribe psychotropic drugs provided at no cost for the patient. Psychiatrists are allowed to prescribe all psychotropic medications without restrictions. At least one psychotropic medicine from each therapeutic category (anti-psychotic, antidepressant, mood stabilizer, anxiolytic, and antiepileptic) is available at some (21% to 50%) physician-based PHC clinics, but at no (0%) non-physician-based primary health care clinics.

Human Resources

Number of workers in mental health care

The total number of workers in mental health facilities and private practices per 100,000 inhabitants is distributed as follows:

Worker	Number	Rate per 100,000 inhabitants
1. Psychiatrists[23]	**6003**	3.26
2. Other medical doctors, not specialized in psychiatry[24],	**1065**	0.58
3. Nurses[24]	**3119**	1.69
4. Psychologists[25]	**18763**	10.19
5. Social workers[26]	**1985**	1.08
6. Occupational therapists[27]	**3589**	1.95
7. Other health or mental health workers (including auxiliary staff, non-doctor/non-physician primary health care workers, health assistants, medical assistants, professional and paraprofessional psychosocial counselors) [28]	unknown	
TOTAL	34524	18.74

If psychiatrists that work only in private offices (out of pocket payment, not yet registered in CNES) are not included, it is estimated that 69% of psychiatrists work only for mental health facilities run by the government, 7% work only for NGOs/for-profit mental health facilities/private practices, and 24% work for both public and private sectors. Similarly, and if private practices are not included, 73% of psychologists, social workers, nurses and occupational therapists work only for mental health facilities run by

[23] Psychiatrists in private or public health services; professionals that work only in private practices were not included. Source: tabwin-CNES, December 2005.

[24] The total number of clinicians and nurses working in mental health is not available, but at least 1065 other medical doctors (not specialized in psychiatry) and 3119 nurses are registered in mental health services. In all the services where there are other areas of health care, such as in general hospitals or outpatient services, it is not possible to identify how many doctors or nurses, besides the mental health team, also work with mental health care. Source: tabwin-CNES, December 2005.

[25] Psychologists in private or public health services. Source: tabwin-CNES, December 2005. The number of psychologists in health services does not include those working in private offices. The Federal Psychology Board had records of **125,397** registered psychologists in the country in 2005; 41% of them worked in private practices (full time or part time); 11% worked in companies; and 10% worked in schools (IBOPE, 2004).

[26] There are 14338 social workers in health services. We do not have the number of social workers working exclusively with mental health, but 949 work in psychiatric hospitals and in CAPS, and 1036 work in other outpatient mental health services. Source CNES – TABWIN, Dec 2005.

[27] Occupational therapists in private or public health services; therapists working only in private practices were not included. Source: tabwin-CNES, December 2005.

[28] No estimates are available of the number of other health or mental health workers (including assistants, non-doctor/non-physician primary health care workers, health assistants, medical assistants, professional and paraprofessional psychosocial counselors).

the government, 23% work only for NGOs/for-profit mental health facilities/private practices, and 5% work for both the private and public sectors.

Regarding the workplace, 2425 psychiatrists work in outpatient facilities, 647 in community-based psychiatric inpatient units, and 2603 in psychiatric hospitals. At least 307 other medical doctors, not specialized in mental health, work in outpatient facilities, an unknown number in community-based psychiatric inpatient units, and 758 in psychiatric hospitals. Numbers for nurses show that 1169 work in outpatient facilities, at least 26[29] in community-based psychiatric inpatient units and 1974 in psychiatric hospitals. Of all psychosocial workers (psychologists, social workers[30], and occupational therapists) 5010 work in outpatient facilities, 499 in community-based psychiatric inpatient units and 2908 in psychiatric hospitals.

There are 0.31 psychiatrists per bed in community-based psychiatric inpatient units[31], in comparison to 0.06 psychiatrists per bed in psychiatric hospitals. Also, there are 0.01[16] nurses per bed in community-based psychiatric inpatient units, in comparison to 0.05 nurses per bed in psychiatric hospitals. Finally, of all other mental health care staff (e.g., psychologists, social workers, occupational therapists except other health or mental health workers), there are 0.24 per bed for community-based psychiatric inpatient units, and 0.07 per bed in psychiatric hospitals.

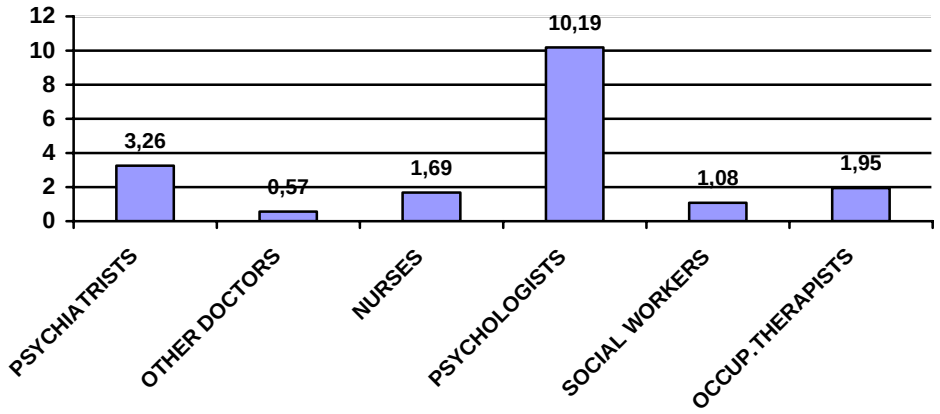
The distribution of human resources between urban and rural areas is disproportionate. The density of psychiatrists in or around the largest city (Metropolitan Sao Paulo) is 1.75 times greater than the density of psychiatrists in the entire country. The same index for psychiatric nurses is not available because there is no survey of the number of non-specialized nurses that work in mental health services.

[29] Psychiatric nurses only; we were not able to separate non-specialized nurses that work in mental health wards from nurses that work in other hospital areas.

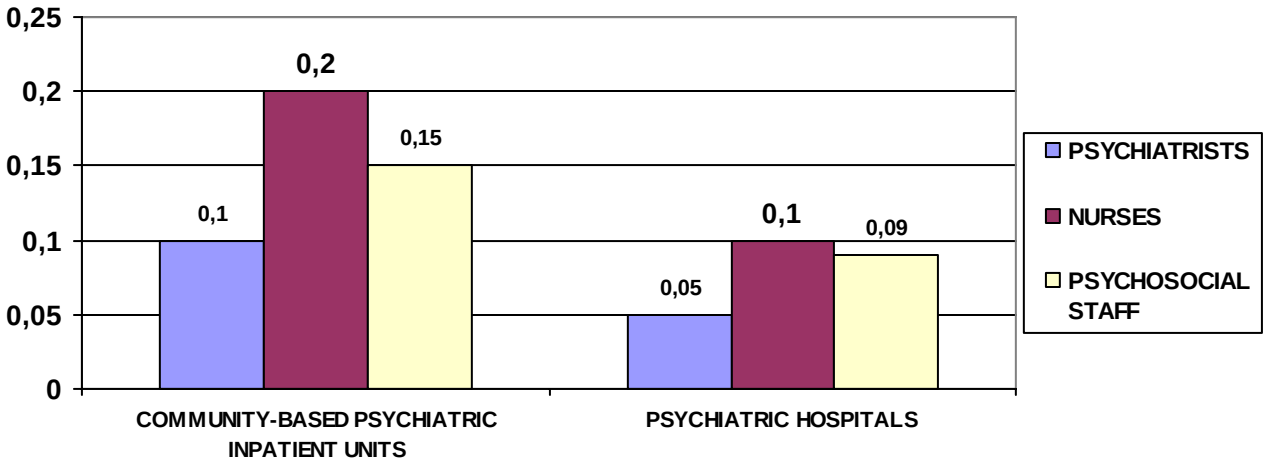
[30] Social workers were not included because most worked for all areas of general or psychiatric hospitals and not exclusively for psychiatric units.

[31] The high number of psychiatrists is explained by the fact that they work some hours in the hospitalization units and the remaining hours in the outpatient service associated with psychiatric units. (Source: tabwin-CNES, Dec 2005).

GRAPH 4.1 - HUMAN RESOURCES IN MENTAL HEALTH
(rate per 100,000 inhabitants)



GRAPH 4.3 - AVERAGE NUMBER OF WORKERS PER BED



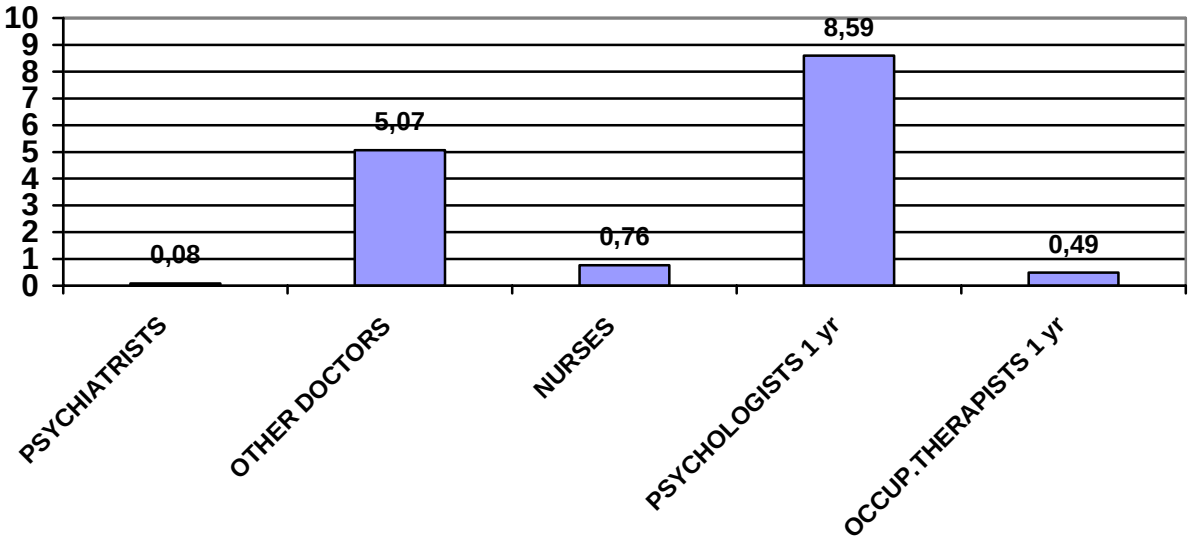
Training professionals in mental health

The rate of professionals graduated last year in academic and educational institutions per 100,000 inhabitants is as follows: medical doctors (not specialized in psychiatry), 5.07[32]; nurses (not specialized in psychiatry), 0.76[33]; psychiatrists, 0.08[34];

[32] Number of physicians that graduated in 2004.
[33] Approximate number for the year 2004.
[34] Data from the Federal Council of Medicine for the year 2005.

psychologists with at least 1 year training in mental health care, 8.59[35]; occupational therapists with at least 1 year training in mental health care, 0.49[23]. The numbers of nurses and social workers with at least 1 year of training in mental health care are unknown. Migration to other countries is not a problem in Brazil: it is estimated that less than **1**% of psychiatrists emigrate within five years of completion of their training.

GRAPH 4.4 - PROFESSIONALS GRADUATED IN MENTAL HEALTH
(rate per 100,000 inhabitants)



Consumer and family associations

Most associations in the country may be classified as mixed organizations because of the participation of mental health service users/consumers, families and mental health workers. It is estimated that at least 3780 users/consumers and 1432 family members belong to these associations. The government provides some economic support for both consumer and family associations.

Although the participation of consumer and family associations in health councils and national health conferences is ensured by law, no survey has calculated the number of participants or associations that have been involved in the formulation or implementation of mental health policies, plans, or legislation in the past two years.

It is estimated that mental health facilities interact with few (1% to 20%) consumer and family associations**.** In addition to consumer and family associations, an unknown number of other NGOs in the country are involved in individual assistance,

[35] Number for the year 2004.

such as counseling, housing, or support groups. However, there is a national policy to stimulate the creation of family and consumer associations in every CAPS. In the National Division of Mental Health it is estimated that near 50% of the CAPS have family and consumer associations acting together with mental health professionals.

Public education and links with other sectors

Public education and awareness campaigns on mental health

A coordinating body led by the National Division of Mental Health of the Ministry of Health, oversees public education and awareness campaigns on mental health and mental disorders. Government agencies, NGOs, professional associations and international agencies have promoted public education and awareness campaigns in the last five years. These campaigns have targeted the general population or children and adolescents. In addition, some public education and awareness campaigns have targeted professional groups, such as health care providers, teachers, social service workers, and other professional groups linked to the health sector. Other campaigns have been conducted in regional or municipal areas, but data are not available to calculate the total number of such events in the country.

Legislative and financial provisions for persons with mental disorders

At the present time, no legislation or financial support is established for the following:

1. Legal provisions establishing a legal obligation for employers to hire a certain percentage of employees that are disabled;
2. Legal provisions ensuring protection from discrimination (dismissal, lower wages) solely on account of mental disorder;
3. Legal or financial provisions establishing priority in state housing and in subsidized housing schemes for people with severe mental disorders;
4. Legal or financial provisions ensuring protection from discrimination in allocation of housing for people with severe mental disorders.

The first clause of Act 10,216 of April 6, 2001 states that: “The rights and the protection of people with mental disorders, provided for by this Act, are assured against any form of discrimination regarding race, color, gender, sexual orientation, religion, political option, nationality, age, family, economic resources and the degree of severity or progression of their disorder, or any other aspects.”

Links with other sectors

In addition to legislation and financial support, there are formal collaboration schemes between the governmental department responsible for mental health and the departments and agencies responsible for:

- Primary health care/community health
- HIV/AIDS

- Reproductive health
- Child and adolescent health
- Child protection
- Education
- Employment
- Housing
- Welfare
- Criminal justice
- The elderly
- Others: Special Bureau of Human Rights; Department of Culture; Public Prosecution Service; Pharmaceutical Assistance; Division of Science and Technology of the Ministry of Health.

Note. Substance abuse: The same department coordinates mental health actions and actions related to the use of alcohol and drugs.

In terms of support for child and adolescent health, the number of primary and secondary schools that have either a part-time or full-time mental health professional[36] is unknown, and few (1% to 20%) primary and secondary schools have school-based activities to promote mental health and prevent mental disorders. Many actions are under way in the area of alcohol and drug abuse, but there are no data on the extent of these actions.

The estimated percentage of prisoners with major mental disorders is 2% to 5%, whereas the percentage of mental retardation in this population is unknown. The analysis of mental health care activities in the criminal justice system showed that most prisons (51% to 80%) have at least one prisoner per month undergoing treatment with a mental health professional. (There is an ongoing study conducted by the Federal University of São Paulo to investigating this situation). The country has a national programme to the health care in the prisoner system with a mental health component[37].

No police officers[38] and few (1% to 20%) judges and lawyers participated in educational activities on mental health in the last five years.

[36] It is estimated that at least 12,500 psychologists work in primary and secondary schools, most as psychopedagogical advisors, according to a 2000 survey of psychologists registered in the Federal Board of Psychology (IBOPE, 2004).

[37] Plano Nacional de Saúde no Sistema Penitenciário (Health to the Criminal Justice System Plan), PT Interministerial nº 1777, September, 2003.

[38] In 2005, 918 police officers (0.14% of 622,261 police officers in the country) took four courses on physical and psychological health of police officers, in which mental health topics were discussed. Source: General Coordination of Personal Development in Public Security of the Department of Justice (*Coordenação Geral de Desenvolvimento de Pessoal em Segurança Publica da Secretaria Nacional de Segurança Publica do Ministerio da Justiça*).

In terms of financial support for patients, few mental health facilities (1% to 20%) have access to external programs that provide outside employment for patients with severe mental disorders.

Finally, 9,8% of people who receive social welfare benefits do so for a mental disability.

Monitoring and Research

All mental health facilities should collect a formally defined list of individual data items.

As shown in table 6.1, the extent of data collection is consistent in public mental health facilities. No compilations of the number of involuntary admissions or of occurrences of patient restraint are available.

The Ministry of Health received data from 100% public services **(**psychiatric hospitals, community-based psychiatric inpatient units, and mental health outpatient facilities) but not from private services. There are some data produced at a regional level that are not compiled for the whole country, mainly for the out-patient facilities. The Annual management report of the Mental Health National Division of the Ministry of Health publishes an estimate of the data available in the country.

The National Division of Mental Health and the Brazilian National Council for Scientific and Technological Development (CNPQ) have recently granted near two million dollars for specific mental research projects such as those for violence, minorities, treatment of psychotic patients, and organizational service research.

In terms of research, 4% of all health publications in the country were on mental health. Research focused on:

1. Epidemiological studies in community samples
2. Epidemiological studies in clinical samples
3. Non-epidemiological clinical/questionnaire assessments of mental disorders
4. Services research
5. Biology and genetics
6. Policy, programs, financing/economics
7. Psychosocial interventions/psychotherapeutic interventions
8. Pharmacological, surgical and electroconvulsive interventions

Table 6.1 - Percentage of mental health facilities that collect and compile data by type of information

TYPE OF INFORMATION COMPILED	**MENTAL HOSPITALS***	**INPATIENT UNITS****	**OUTPATIENT FACILITIES****
No. of beds	100%	100%	NA
No. of inpatient admissions and patients treated in outpatient facilities	82%	100%	UNKNOWN
No. of treatment days and of patient contacts in outpatient facilities.	82%	100%	UNKNOWN
No. of involuntary admissions	UNKNOWN	UNKNOWN	NA
No. of patients restrained	UNKNOWN	UNKNOWN	NA
Diagnoses	82%	100%	UNKNOWN

* Public units or that provide services to the public system (228) + fully private psychiatric hospitals (50)
** Only public units or units that provide services to the public system are related.

Strengths and Weaknesses of the Mental Health System in Brazil

Brazil has sound legislation on mental health and a list of documents which compose the mental health policy. The focus of the legislation is concerned with human rights of the patients, admission and discharges procedures, and monitoring of involuntary admissions. The mental health legislation as well as the policy changes are mainly concerned with the shift from hospital to community care and have been enforced in the last few years. There is a revised version of a publication that regularly updates all norms, executive orders and laws about mental heath.

Access to basic psychotropic drugs is ensured by the Unified Health System (SUS). Moreover, in some large urban centers, some patients with severe mental disorders have free access to high-cost psychotropic medication. The essential medicines are available in all state mental health facilities, though there are some availability, problems in the system. Thus the percentage of the patients under treatment who really benefit from this policy is unknown.

There are mechanisms for the protection of the human rights of patients. The Assessment Program for Psychiatric Hospitals (PNASH) started in 2002, and covered all hospitals funded by SUS. However, most of the mental health community services were not regularly visited by committees composed of health and justice technicians and members of the civil society using clear and pre-established criteria to investigate protection of patients' human rights. There is no data available on how many psychotic patients and mentally handicapped are in prisons and their access to treatment.

Despite great advances in community services in the last years - primarily due to the creation of Psychosocial Community Centers (CAPS) and therapeutic residential facilities for patients transferred from long-stay psychiatric hospitalizations - and a great reduction in the number of beds in psychiatric hospitals, the balance between outpatient and hospital care (1.4:1.0, see page 20 for further details of the index) remains modest in favor of the outpatient care**.** Very few hospitalization units were opened in general hospitals in the last years, and day hospital care and intensive care in CAPS have to be further investigated to assess coverage and effectiveness of the system.

The country has begun to implement innovative services and interventions, such as the CAPS, and the Return Home program. In little more than one decade, hundreds of new services were established in the whole country, and older outpatient services and day hospital programs were revised in order to maximize limited resources. The purpose of CAPS is both to provide for the various needs of patients with serious mental disorders and to act in coordination with the primary care services to treat those mental disorders most prevalent among the population. Assessment of the effectiveness of this model is currently under way, and further studies are necessary to analyze its actual cost-effectiveness, and interaction with the health care network. The same situation is true for the ambitious project to transfer thousands of patients from long-stay psychiatric hospitals to community residential facilities with up to 8 residents. Up to 2006, 2480

patients have already been located, but no long-term studies on the effectiveness of this program have been conducted.

The federal funding to the Unified Health System (SUS) for 2005 was US$ 15 billions (US$ 82.7 per capita), of which US$ 358 millions (1.95 per capita) was for mental health care. In the last decade, there has been a significant reduction in the allocation to mental hospitals (95.5% to 49.3% of the mental health budget) and a concomitant increase in the budget for community services (from 0.8% to 15%). The budget for psychotropic medication has increased from 0.1% to 15.5%, and other types of mental health facilities and care (from 3.6% to 20.2%) also increased significantly.

Another challenge to be faced is the coordination of actions to training mental health professionals to act in mental health in primary care**.** The gigantic national health care system is managed primarily by municipal governments, and mental health has to compete with dozens of other priorities for the needed training and supervision of health workers, particularly doctors, nurses and health agents.

There are 5259 Psychiatrists, 12377 Psychologists, 11958 Social workers, 3119 Nurses and 2661 Occupational Therapists working for the Unified Health System. There are few nurses oriented to mental health activities though there are sufficient nursery schools in the country. Moreover, social workers specifically trained in mental health are very scarce.

The participation of community members, mental health service users and families in health councils and conferences is ensured by SUS. Consumer and family associations in Brazil have a peculiar characteristic: most are, in fact, mixed associations in which families, users and mental health workers jointly participate. This “mixed association” model seems to be the most appropriate for the Brazilian reality. Considering the size of Brazil, few mutual assistance groups and NGOs participate in the mental health care network. Innovative therapies, such as Community Therapy – groups that work similarly to mutual assistance groups but that are organized by technicians and volunteers trained as primary care agents – have been implemented in several cities, particularly in the Northeast region.

Mental health information systems are one of the aspects that require urgent improvement. A large number of the questions in this report were not addressed more adequately because of the lack of reliable and unified sources of data. We do not know the number of members of patient associations, local training programs, or public information programs implemented in the country. Even well-organized and well-supplied data systems such as DATASUS do not compile essential national data, such as the number of outpatients and their diagnoses. The Division of Mental Health should develop standardized epidemiological tools and supervise mental health services in data collection.

Mental health policy about problems related to alcohol and drug use is integrated in the primary m.h. documents. Improvement of specialized care for children

and adolescents is still greatly needed in the country. According to the WHO ATLAS 2005, Brazil has 2.83 psychiatric beds per 10,000 inhabitants for a Latin American average of 4.66, and 3.26 psychiatrists per 100,000 inhabitants for a Latin American average of 3.91.

Next Steps in Strengthening the Mental Health System

Policy and Legislative Framework

The country would benefit from an official document, programme or plan for mental health including a policy on child and adolescent mental health. The annual national governmental report on mental health care should comprise systematic information on the number of health professionals acting in the public system, a monitoring of trends in mental health services, the expenditure, and future plans. The annual mental health report should be published yearly by the Division of Mental Health. Formal organization of policy, plan and programs and the articulation of objectives for each administrative level, schedules and budgets involved in the format as recommended by the WHO (2003) are welcome.

All mental health services should be regularly visited by committees composed of health and justice technicians and members of the civil society using pre-established criteria set-up by the Brazilian mental health legislation, under the supervision of the National Division of Mental Health of the Ministry of Health, to assure protection of patients' human rights. The National Division of Mental Health should play a more active role to guarantee adequate treatment for mentally handicapped and psychotic patients in prisons. There are ongoing studies to assess the extent of this problem in the country, but additional data on the subject is welcome. The Brazilian Center on Human Rights and Mental Health has recently been created; and it includes universities, government and civil society participants who have an important role in this field.

Unequal distribution and coverage of the community services across regions and the government's ability to fund new investments for mental health care remain major challenges. It is paramount to increase the percentage of the mental health budget in relation to the total health funding to a level of around 5%, as recommended by the WHO.

Mental Health Services

The number of beds has decreased steadily but the system is still heavily based on traditional psychiatric admissions (the balance between outpatient and hospital care 1.4:1.0 should be improved in the direction of outpatient care). There is room for reducing psychiatric beds as long as Psychosocial Community Services are expanded and are able to provide care for people with severe mental disorders. Assessment of the CAPS model should continue to improve its integration with the health care network and

other sectors. Moreover, there is a lack of evidence-based psychosocial interventions to decrease relapse and psychiatric admissions. The hospitalization in general hospitals as an alternative to psychiatric hospitals should be expanded. A cost benefit analysis should be conducted to evaluate admissions at CAPS and residential services. It is important to develop follow-up studies to evaluate the pathways of patients under CAPS and residential facilities and other community services. Research on services organization, policy research, and mental health systems evaluations are strongly recommended in the country.

It is noteworthy that some patients with severe mental disorders go untreated in Brazil. Of those receiving treatment, most are treated with the conventional anti-psychotic agents, afforded by the essential list of medicines. Studies on the coverage, i.e., the percentage of patients who really benefit from this treatment are still missing in the country. In the less privileged areas it is important to improve access of treatment by means of the conventional medicines available in the SUS. It would be advisable to improve coverage of treatment, i.e., to evaluate the effectiveness of dispensation of anti-psychotic medication by general community health workers (such as those involved in the PSF) so as to reduce relapse and admission rates of severe cases.

The number of mental health services are unequally distributed in different regions of the country and this issue needs attention to decrease inequality. However, the number of community services has improved a great deal in the last four years for some states in the northeast region (Sergipe, Paraíba, Alagoas, and Ceará). The special ethnic groups such as indigenous, African descendents, and recent Asian immigrants, should have equal access to mental health services as guaranteed in the constitution, though some data available for health in general show an existing inequality. Studies to ascertain the level of inequality in mental health for minority populations and strategies to overcome stigma and barriers are welcome.

It is also important to develop structured training on human rights for all health professionals acting in mental health. All mental health services should be regularly assessed by committees composed of health and justice technicians and members of the civil society to investigate the protection of patients' human rights according to clear and pre-established criteria delineated by the Brazilian legislation under supervision of the National Division of Mental Health.

Mental Health in Primary Health Care

It is important to develop mental health guidelines for primary care health professionals and training health workers acting in primary care. There are ongoing courses available for training primary care professionals, but it is necessary to expand the mental health component in the curricula of Schools of Medicine and Nursing. Particularly, the training could be intensified for the health teams (general physician, nurse and health workers) acting in the Family Program (PSF) spread out in the country. It is also important to strength the links between the PSF teams and mental health teams

in the community. Some mental health teams do offer supervision for the primary health care workers, but there are teams without this kind of support (data on this subject is welcome). Health workers could play an important role in the delivery of psychotropics and in ensuring medication compliance for patients with severe mental disorder. This interaction between primary care health workers and the mental health team should facilitate referrals to specialized psychiatric treatments. The National Division of Mental Health of the Ministry of Health in conjunction with universities should develop guidelines for treating common mental disorders in primary care.

Human Resources

It is necessary to ascertain the mental health curriculum in health related faculties to prepare health professionals to diagnose and treat psychiatric disorders. There is a shortage of psychiatric nurses in the country, and there is a need to promote specialization in this field. The number of psychiatrists is still far from the ideal and they are unequally distributed across the country. Also the residency positions are concentrated in the wealthier areas of the country. The training should include the exposure to the new community services available (particularly CAPS). Moreover, it is necessary to implement training for Health Managers in the field of mental health. This kind of professional must be knowledgeable in epidemiology, anthropology, biostatistics, health policy, health economy, and planning. A Master Science for Mental Health Planning could be developed at university level under financial support from the Ministry of Health.

There is a need to develop a better registration of professionals who are working in the state, the private sector and private offices. For instance, it is estimated that many psychiatrists and more than 40% of psychologists are working in their private offices. It is important to conduct research to assess the cost-benefit of the activities carried out by the mental health workers in order to evaluate the present policy and determinate future actions. Future studies should investigate the level of training on rational use of psychotropics, psychosocial interventions and child mental health issues.

Patient and family associations are growing and playing an important role in Brazil, but should be motivated to improve participation in the design of mental health policies, employment projects, health promotion campaigns, and self-help programs. A national organization to bring together all users and family associations should be envisaged. Governmental financial support for these associations should be available and distributed with equity and according to clear criteria delineated at the National Division of Mental Health.

Public Education and Link with Other Sectors

The National Division of Mental Health should have access to local educational, prevention, and health promotion events in order to facilitate the exchange of experiences between regions and to prepare material for these actions.

It is important to support legislation and financial support for the following topics: a) the legal provisions to encourage employers to hire a certain percentage of employees with severe mental disorders; b) protection for people with mental disorders from discrimination; and c) giving priority in housing for people with severe mental disorders.

It is necessary to estimate the mental health actions conducted in several areas: treatment and prevention in primary and secondary schools; actions to promote employment for people with severe mental disorders; the percentage of prisoners with major mental disorders and mental retardation; mental health care activities in the criminal justice system; training for judges and police officers; and programs for employment opportunities.

Monitoring and Research

Data about involuntary admissions should be compiled locally and nationally. Similarly, efforts to compile data about outpatient care – number of patients, diagnosis, sex and age of patients – should be a priority in the mental health information system.

Fully private services should also be included in the mental health information system.

In the year 2002, the total budget for Health Research was one hundred and one million dollars with 3.37% of the total available for Mental Health Research. Nine programs are dedicated to psychiatry, neuropsychiatry, psychobiology and mental health, seven were located in southern states. The investment channeled towards postgraduate and human resource educational programs has allowed Brazil to make a modest but continuous contribution to mental health literature. The National Division of Mental Health and the Brazilian National Council for Scientific and Technological Development (CNPQ) have recently (2005) granted near two million dollars for specific mental research projects such as those investigating violence, minorities, treatment of psychotic patients, and the organization of services. It is highly recommended that this sort of activity should occur every two years to ensure provision of mental health data. Research on mental health policies and services organization should be prioritized.

Final Conclusions and Recommendations

The change in policy has resulted in major reform of the mental health system and changes in the delivery of care in Brazil. The system now ensures wider accessibility to essential psychotropic medication, provides care in the community, involves families and the community and provides universal coverage and free access to a network of services. The new national policy also resulted in the development of a larger mental health workforce. The political reforms in Brazil and the commitment of the health professionals to providing care within the primary health care system were the main reasons for its success. Custodial care is being abolished though many patients are still being treated in precarious institutions where abuse and prejudice prevails. The number of psychiatric beds is declining, mental health care is becoming more and more a component of primary health care, and many individuals with acute diagnose are now being treated in general hospitals, and in the community. However, community-based services are still insufficient, mainly for the infants and adolescents, and the capacity to monitor and evaluate services and programs can be improved. Health policy research is very limited, though guidelines for developing appropriated mental health policy are available. The demographic changes in Brazil are driving an increased demand for services which will increase the gap between need and the availability of care. This gap may get even wider if funding does not increase and mental health services are not expanded in the country.

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http://www.who.int/whr/annexes/en/

The World Health Organization Assessment Instrument for Mental Health Systems (WHO-AIMS) was used to collect information on the mental health system in Brazil. This assessment showed there is good mental health legislation and a new mental health policy. The country has started several innovative services and interventions, such as CAPS (Centros de Atenção Psicosocial) and the Return Home program. Over the past decade, hundreds of new services were established and older services were revised. The number of psychiatric beds is declining, and many people with acute needs are now being treated in general hospitals in the community. Custodial care is being phased out. Community mental health care allows free access to a variety of mental health services and essential psychotropic medicines in the community.

There are 5259 Psychiatrists, 12377 Psychologists, 11958 Social workers, 3119 Psychiatric nurses and 2661 Occupational Therapists working for the Unified Health System. However, there is a shortage of psychiatric nurses in the country, and there is a need to promote specialization in this field. The number of psychiatrists is still far from the ideal, they are unequally distributed across the country, and the residency positions are concentrated in the wealthier areas of the country. Training for all professional groups should include exposure to the new community services. Most of the psychiatrists and specialized mental health workers are concentrated in the capitals. There is a shortage of infant psychiatrists, and there is a need for specialized training in areas such as eating disorders, elderly psychiatry, and forensic psychiatry.

Also, services are unequally distributed across regions of the country, and the increase in the number of elderly citizens has increased the gap between need and the availability of services. This gap may get even wider if funding does not increase, and if mental health services are not expanded in the country.