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Psychiatric Reform in Rio de Janeiro: the current situation and future perspectives

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Abstract *This article analyzes the mental health network in the city of Rio de Janeiro. It provides a report on the current status of the implementation of psychiatric reform and identifies progress, limitations and challenges in this area. Documentary research was carried out by examining official documents, ordinances, SUS databases, information that was available at the Superintendency of Mental Health of the city of Rio de Janeiro, and a literature review of Brazilian and international scientific articles. The results point to important advances in the de-institutionalization of care, with a substantial reduction in the numbers of psychiatric beds, and increased community facilities. However, the following significant challenges remain: the need for increased coverage by psychosocial care centers; the implementation of psychiatric beds in general hospitals; the integration of mental health with primary health care; the de-institutionalization of people who remain in hospitals for long periods; the expansion of the number of residential facilities; and an increase in the provision of specific services for people using alcohol and other drugs.*

Key words *De-institutionalization, Mental health, Psychiatric reform, Brazil*

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Introduction

Psychiatric reform in Brazil started towards the end of the 1980s, during the democratic reconstruction of society at the end of the period of military dictatorship, within the context of a general reform of the health sector. The First National Conference on Mental Health, which was held in 1987, can be considered to be the starting point of this reform. Support for such reform had started in the late 1970s, when many segments of society that were linked in the struggle against the military regime organized the National Anti-Asylum Movement, which was designed to seek radical changes in the public healthcare field, an approach to mental health that superseded the asylum model, and a health system that guaranteed universal care[1].

Given the late start of this process in Brazil, there had already been many difficulties, as well as successes, in relation to the reform of psychiatric processes that preceded it, such as the complexity of the care process that created new patients who had previously been hidden behind the walls of asylums, as well as new demands and rights. There was a need for a comprehensive social and health network, and an organization that could meet the needs of people who were outside hospitals, as well as new profiles of chronicity and psychological distress[2].

The de-institutionalization process gained strength in the 1990s, with the incorporation of Psychosocial Care Centers (CAPs) within the structure of the Unified Public Health System (SUS). A process of psychiatric reform was underway in Brazil that was designed to overcome the dominance of the existing care model, which was centered on mental hospitals and which excluded people with mental disorders from the rest of society. This transformation was confirmed by the enactment of Law No. 10,216 on June 4, 2001[3], which redirected the mental health care model toward community care, social integration and the protection of the autonomy of individuals. This was also supported by guideline policies that were issued at the Third Mental Health Conference, which was held in the same year[1].

As a result of this policy, the number of beds in SUS psychiatric hospitals was reduced from 85,000 at the end of the 1980s to less than 26,000 in 2014, with the concurrent deployment of more than 2,200 CAPs and nearly 700 therapeutic homes for long-term patients[4].

Following guidelines established at the national level, mental health policy in the city of Rio de Janeiro has moved towards a gradual diminution in the number of beds in psychiatric hospitals within the city. This hospital structure was partially inherited from the federal government (three municipalized units from 1996) and partly as a result of the intense privatization policy of the 1960s and 1970s.

The issue of mental health was established as an effective municipal policy from 1996, when a census was performed of the inpatients in psychiatric hospitals in the city. This census indicated a significant number of patients in long-term scare and a concentration of resources on hospital equipment[5], which represented a costly and inadequate approach. The realization of the need to change this model resulted in the implementation of the first CAPs in 1996, followed by other community-based services.

The purpose of this article is to assess the implementation of psychiatric reform in the city of Rio de Janeiro and to identify the progress that has been made, as well as the limitations and challenges that still remain in this area. In terms of methodology, the documentary research was carried out by consulting official documents, ordinances, SUS databases, information that was available at the Superintendency of Mental Health Department of the city of Rio de Janeiro, and the results are also discussed in relation to the existing scientific literature on the subject.

The city of Rio de Janeiro and its health network

The estimated population of the city of Rio de Janeiro in 2015 was 6,476,631 inhabitants in a land area of 1,197,463 square kilometers, giving a population density of 5,265.8 inhabitants/km². The city's Human Development Index in 2011 was 0.799, the equivalent of 45° in the country as a whole and 9º within the capital cities. According to the 2010 census, the city experienced a population growth of 7.9% over 10 years, life expectancy at birth was 75.7 years and 14.9% of the population was elderly. The age pyramid reflected a demographic transition and an aging population[6].

The city of Rio de Janeiro is quite heterogeneous, with different degrees of development and inequality in the distribution and use of health resources. At the administrative level there are 160 districts which are distributed throughout ten planning areas. Non-communicable chronic diseases account for 33.7% of total admissions paid for by the SUS. Psychiatric hospitalizations

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represented the third largest expenditure on admissions twenty years ago; today they are in sixth place. Around 90% of the SUS health network in the city of Rio de Janeiro is under public administration and 84.53% of that group is linked to the municipal administration. Private participation in the SUS within the city is 11.49%. The municipal health network has 29 of its own hospitals, of which three are psychiatric hospitals and there are three psychiatric wards in general hospitals. The city also has a university psychiatric hospital (the Institute of Psychiatry of the Federal University of Rio de Janeiro), a state psychiatric hospital (the Psychiatric Center of Rio de Janeiro) and two psychiatric hospitals contracted to the SUS (Hospital Pedro de Alcântara and the Sanatório Rio de Janeiro). The emergency care network has 14 emergency units and five regional emergency centers[7].

With respect to primary care, in recent years the city has experienced a considerable increase in coverage by the Family Health Strategy, a model that was adopted by the Brazilian Ministry of Health. In 2009, 83% of the municipal budget was spent on hospital expenses and Rio de Janeiro had some of the worst health indicators of Brazilian capital cities. Between 2009 and 2014 primary health care (PHC) coverage increased from 3.3% to 47.16% of the population and during this period there was a significant investment in the expansion and upgrading of PHC in conjunction with considerable administrative and financial decentralization[8].

Like other large Brazilian cities, many people living in Rio de Janeiro have private health plans. In Rio de Janeiro this is equivalent to about 3,400,561 people, representing 52.5 % of the population[9].

Psychosocial Care Centers in the city of Rio de Janeiro

As in the rest of the country, the CAPs are strategic services designed to organize the mental health care network in order to consolidate Brazilian psychiatric reform. Their role follows the guidelines issued by the Ministry of Health, which differentiate services according to the population density of a region or city, the hours of operation, the population served, the capacity to deal with a crisis, as well as the professionals who make up the team.

The CAPs are organized into three different types (CAPs I, II and III) depending on the complexity of services provided and the size of the population served. CAPs I have the operational capacity to serve cities with a population over 20,000 and CAPs II serve cities with a population over 70,000. CAPs III and CAPs III AD (alcohol and drugs) serve cities with a population in excess of 200,000. The latter differ from other CAPs in that they provide continuous 24-hour service, including public holidays and weekends and they also provide beds for evening reception. In addition to these three modes, there are also area-based services for specific clienteles related to alcohol and drug abuse (CAPs AD) for cities with populations over 70,000 people, as well as for children and adolescents (CAPs i) for cities with a population over 150,000[10,11].

In October 2015 there were 29 CAPs in the city of Rio de Janeiro. Most of these were CAPs II (37.9%), followed by CAPs i (27.6%), CAPs AD III (13.8%), CAPs AD II (10.3%) and CAPs III (10.3%) (Table 1). Most CAPs are under the management of the Municipal Secretary of Rio de Janeiro, with the exception one CAP i that is linked to the federal government, as well as one CAP II and one CAP AD II which are under the responsibility of state management.

The city of Rio de Janeiro has a CAPs coverage ratio of 0.50 per 100,000 inhabitants, which is considered as 'good' according to the parameters of the Ministry of Health. Those parameters consider 'very good' coverage to be above 0.70, 'good' to be between 0.50 and 0.69, and 'average/low' to be between 0.35 to 0.49, always in reference to 100,000 inhabitants. Below these levels, coverage would be low, insufficient or critical. It should be noted that for this indicator the calculation of coverage in terms of the size of the CAPs is used. Thus, CAPs I cover an area incorporating 50,000 inhabitants; CAPs III and CAPs AD III relate to 150,000 inhabitants; and the other CAPs (II, AD and i) relate to 100,000 inhabitants[12].

Table 1. Psychosocial Care Centers in the city of Rio de Janeiro, October 2015.

Types of CAP	Quantity	Percentage
CAPS II	11	37.9%
CAPS III	3	10.3%
CAPSi	8	27.6%
CAPSad II	3	10.3%
CAPSad III	4	13.8%
Total	29	100.0%

Source: CNES/Ministry of Health, October 2015.

Regarding the form of CAPs, it should be noted that almost a quarter are type III (24.1%). This trend started in 2010 when the first CAP III was opened in Rio de Janeiro. Considering their size (beds, night and weekend operation), CAPs III require higher funding requirements. Costa et al. analyzed the implementation of type III CAPs in major Brazilian cities and they found that in 2010 only 17% of cities with more than 200,000 inhabitants had CAPs III operating in their service network[13]. The expansion in the number of CAPs III is vital for providing qualified care to cope with the most serious crises.

The expansion of the coverage of CAPs is essential and it is one of the main challenges facing municipal management. A tangible goal for the next two years could be to increase coverage to 0.64 per 100,000 inhabitants by introducing seven new services (four type III CAPs and three type CAPs II, AD or i).

The care that is provided within the CAPs is developed by the Individual Therapeutic Project, which involves teams, service users, and their families, all of which is designed to ensure longitudinal follow-up in cases[11]. The care process is organized so as to offer therapeutic workshops, community and artistic activities, guidance and monitoring in relation to medication, home visits for service users and their families, individual or group psychotherapy, and matrix support for primary care teams. In addition, it is expected that the CAPs undertake intersectoral coordination in the area that they cover, coordinates the process of de-institutionalization of service users in long-term hospital care, and foster technical support for residential therapeutic programs.

The proper performance of the various duties allocated to the CAPs under the ambit of the Psychosocial Care Networks (RAPS) represents a difficult task. Cavalcanti et al.analyzed the results of a survey conducted in three CAPs in the city of Rio de Janeiro. As well as highlighting the accumulation of the functions that the teams are expected to deal with, they concluded that in a large urban center like Rio de Janeiro it may not be feasible for professionals working within CAPs to be responsible, in a satisfactory manner, for the provision of services to the community[14]. A possible consequence of this difficulty might be the predominance of activities developed to work with service users within the CAPs and a lack of integration with other social and health facilities.

A study of the accessibility of service users to CAPs in the state of Rio de Janeiro highlighted the small number of discharges. The authors considered that a possible explanation for the phenomenon was the profile of some of the service users, who had severe and persistent mental disorders, which require long-term care to prevent relapses and to minimize the loss of autonomy and the ability to perform daily life skills[15]. Further explanations for this phenomenon might be related to the shortage of specialized outpatient clinics in the network or the institutionalization of service users, which means that they eventually become too linked to services and lacking in interests and social ties[16].

With respect to specialized outpatient clinics, this is a limitation of the network within the city of Rio de Janeiro and it represents a challenge for public mental health policies in Brazil, given that these facilities are not recognized as being part of the RAPS[11]. The result has been a reduction in specialized resources at the secondary level for access to the population.

Nascimento and Galvanese[17] analyzed the CAPs in the city of São Paulo and stressed the dependency of the CAPs on the capacity of the municipal health system to provide other reference services. When this did not happen, the CAPs were frequently organized as *synthesis facilities*, where service users would always be assisted regardless of the level of care that they required.

Another issue that is relevant to the CAPs and outpatient care is the shortage of psychiatrists within the public health network. The low uptake of psychiatrists is obviously related to market forces, but the manner in which they are trained ultimately means that it is unattractive for professionals to work in providing public psychosocial care.

Eight CAPs in the city of Rio de Janeiro deal with children and young people; they regularly monitor more than 2,000 children with severe mental disorders including autism. It is hoped that their capacity to manage crisis situations can be expanded in order to anticipate situations, to redirect the work of teams dealing with urgent / emergency cases, and to act as the first option to provide care at night within CAPs i. In 2014 there were 45 psychiatric hospitalizations of children and adolescents[18].

With respect to their physical structure, and unlike Emergency Care Units (UPAs), the CAPs do not generally have an architectural design that is specially designed for purpose. Over the years, they have been deployed in buildings or public spaces that happened to be available and they have had to adapt their work routine to existing

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physical structures. As a result, some units have inadequate structures to provide the best level of care.

The search for a faster way to procure materials and supplies, the need for flexibility in the selection and hiring of personnel, as well as the adoption of management models focused on results, resulted in the decision to enter into contract with Social Organizations of Health (OSSs) in a shared management process that is regularly monitored by an evaluation committee which analyzes and controls the development of the contract.

The consequences of the adoption of this model still require evaluation over a longer period of time. Barbosa and Elias[19] studied the implementation of OSSs in the state of São Paulo and they found that the direct administration was frequently based on rules that were incompatible with the speed of response required by the public sector, given the demands and needs of the population. There are no available studies evaluating the specificities of mental health in the context of the OSS model. As is well-known, OSSs have a controversial record and they have had to contend with the political arguments of those who are active in the field of public policy; consequently they have become a field of conflicts and clashes.

Mental health actions with the area of primary health care[17]

In Brazil, the SUS considers PHC to be the organizing axis of all health care. Coordination between PHC teams and mental health is essential for comprehensive care to be provided[20].

The remarkable expansion of PHC in the city of Rio de Janeiro was accompanied by investments in organizational and administrative renewal, technology, information management, clinical governance and, above all, expansion in access to services. It has created significant opportunities for the expansion of intervention in the field of mental health.

Berardi et al.(21) have pointed out that in Italy, whose model is often considered as a reference for Brazilian psychiatric reform, the full integration of community mental health centers and PHC care was a desired goal. Among the barriers to integration that were detected in Italy was the lack of training of general practitioners in relation to mental disorders, which was associated with the difficulty of mental health professionals to grasp how mental suffering is expressed in the PHC setting. In Spain, the focus on mental health care is at the secondary level, together with the other medical specialties; joint programs with PHC are the gateway to the health system. The integration between PHC and mental health teams, together with an area-based work network, is considered to be one of the strengths of Spanish psychiatric reform[22].

In the case of the city of Rio de Janeiro, it is hoped that the mental health services within PHC will adopt the model of area-based networks and transversal activities with other specific policies, as well as establishing a service that incorporates creating bonds with service users and providing reception for them. The geographical areas of responsibility of CAPs should follow the guidelines established by the Integrated Territorial Health Care (TEIAS) of Planning Health Areas (AP), in which geographical and population boundaries, as well as a list of actions and services, should be agreed between the services of the local health system in order to avoid barriers to access. It is necessary to deconstruct the logic of routing, which is understood as a failure to assume responsibility for those suffering from mental suffering, and to establish facilities within the ambit of PHC to share the management of cases.

The management of depression and anxiety is a major public health issue that often involves PHC. The increasing use of antidepressant medication has been observed in several countries[23]. Where the consumption of antidepressants is very low the existence of unmet needs should be assessed. However, in other locations, where the consumption of antidepressants is particularly high, it is essential to evaluate the standards for diagnosis and prescription, to define clinical protocols, and to evaluate the possibility of alternative approaches to depression. Some authors consider that there is strong evidence that the diagnosis of depression is over-dimensioned and that the use of antidepressant medication has significant limitations[24]. This situation reinforces the importance of the effective integration of mental health and PHC, as well as the proper use of medication.

In the case of the city of Rio de Janeiro, it has been proposed that reference teams should be established for families within a given geographical area, as well as their respective PHC teams, and that they should not be divided by age groups, sub-specialties or diagnosis, but by the service users of the respective areas of coverage, in contrast to the idea of teams of specialists. This strategy would make the field of mental health

more horizontal in approach and put it within the reach of PHC teams and their service users, encompassing all follow-up work with cases involving more severe or acute psychological distress, and offering an alternative to the trend to merely medicate such suffering.

Crisis care and psychiatric hospitals

International studies consider that there is no evidence that a mental health system can do without overnight accommodation for crisis situations; however, this need should be provided by beds in general hospitals or in community services. The number of beds needed in general hospitals is highly conditioned by the quantity of other existing services in the area and it depends on the social, economic and cultural characteristics of each location[25].

The city of Rio de Janeiro has extensively reduced the number of psychiatric beds over the last fifteen years (about 2,400 beds). As a result, admissions were reduced from 42,762 in 2002 to 20,404 in 2012[26]. However, huge numbers of admissions still occur in psychiatric hospitals, showing the limited implementation of community-based facilities with overnight reception and beds located in general hospitals.

Table 2 shows the situation regarding the numbers of beds available for the most serious mental health crises and the overwhelming predominance of beds located in mental psychiatric hospitals in September 2015[27]. Of the total beds within the SUS system still registered in the National Register of Health Facilities (CNES), 1,174 remained active and under continuous supervision by the Municipal Health Secretary of the city of Rio de Janeiro[18].

The main thrust of the de-institutionalization strategy has been to end the cycle of paying for hospital services in private institutions, thereby ending the use of 2,700 beds in eight different hospitals over a period of about 30 years. In relation to the beds that are currently available, a desirable scenario for the coming years would be the complete end of contracted beds and the progressive closure of public beds located in the Philippe Pinel, Nise da Silveira and Juliano Moreira Institutes.

This decision would imply the construction of a care network for the most serious crisis cases in facilities located within general hospitals and community services with beds (type III CAPs). In October 2015, the city network had seven type III CAPs with beds operating 24 hours a day, four for disorders related to alcohol and other drugs, and three for those with other mental disorders. These facilities had 6-9 beds available per night for crisis cases, out of a total of 19 (Table 2).

Table 2. Beds in psychiatric hospitals and Type III CAPs, Municipal Health Secretary of the city of Rio de Janeiro, September 2015.

Location of beds	Quantity	Percentage
Psychiatric hospitals	1,504	95.7%
General hospitals	49	3.1%
CAPs III	19	1.2%
Total	1,572	100.0%

Source: CNES/Ministry of Health, September, 2015.

The integration of mental health with general health can be considered to be one of the main challenges that still need to be overcome. The role of the care that is still provided by the Institutes (structures inherited by the city from the federal government) is still important but it can also be considered to be a factor that constitutes an obstacle to greater progress. There are two emergency facilities located in psychiatric hospitals that have still not been incorporated into the urgent/emergency system of the city. Any future reductions in the numbers of beds in psychiatric hospitals will therefore be limited until this situation is overcome.

On the other hand, of the existing beds that are occupied, there are more than 300 people in long-term care in the Institute Juliano Moreira, who are mostly elderly and with high-dependency care. This situation implies challenges of another kind, as will be discussed below.

Patients in long-term care and residential therapeutic services [subtítulo]

In October 2015 there were 613 patients in long-term institutional care (more than a year of psychiatric hospitalization) in public psychiatric hospitals, contracted to the SUS, and in custodial care located in the city or within the state of Rio de Janeiro. Of these, 282 (46%) were aged 41-60 and 176 (29%) were aged over 71. Three hundred patients had been institutionalized for over 10 years and 125 of them had been hospitalized for 1-2 years. The majority were men (61%) distributed in all age groups. Of these, 38.8% had no

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benefits, 35% received no family visits and 86% were hospital residents with no place to stay outside of the unit[18].

The challenge concerning the de-institutionalization of long-stay patients in the psychiatric hospitals of Rio de Janeiro involves a group of people who were institutionalized prior to the implementation of CAPs as part of public mental health policy. Many of them are elderly and have been hospitalized for decades. Patients with this profile are usually highly dependent and have great difficulty leaving hospital. They tend to be in long-stay wards and have a high degree of negative symptoms and severe social disabilities. They usually need the daily care of professionals working for the institution and their family ties have been broken over time. These type of patients normally require high-intensity psychosocial responses, such as residential facilities with supervision and the permanent presence of staff 24-hours a day. Desviat[28] has referred to this group of patients as the hard core which are present in all de-institutionalization processes.

Furtado[29] has written an article on the subject of housing for people with mental disorders in Brazil and has warned about the lack of systematic targeted initiatives for people with no history of long-term psychiatric hospitalization. This creates a bottleneck in access and guaranteed housing for this type of patient, which includes the increasing number of patients with severe mental disorders who are treated within the broad national CAPs network.

Nevertheless, it should be noted that despite decades of de-institutionalization many countries with consolidated mental health systems continue to experience large numbers of patients who end up staying for long periods in acute wards and becoming patients in long-term institutional care. It is often the case that a strong interface is required between hospitals and community services for these types of patients to be able to return to life in society[30].

The main strategy regarding the de-institutionalization of long-term service users lies in residential therapeutic services (SRTs). These facilities are situated in the community and they are designed to care for patients with mental disorders who are leaving long-term permanent stay in psychiatric hospitals or custody and who do not have social support or family ties that can facilitate their social re-integration[31]. They are characterized into Type I and II according to the degree of complexity of the case and depending on the level of need for supervision. The emphasis in these facilities is on building skills for daily living that are related to self-care, food, clothing, hygiene, forms of communication and increasing the conditions for establishing emotional bonds[32].

Factors such as the slow speed of public policy, budget constraints, and the need to expand the psychosocial care network have constituted barriers to the de-institutionalization of hospitalized patients. The health network in the city of Rio de Janeiro includes 62 SRTs which are distributed throughout the city. They currently care for 330 patients who have left long-term hospitalization, 126 (38%) of whom are aged 61-80 and 22 (6.67%) are over 81. Twenty of these patients have been using SRT services for over 11 years. The average number of residents is currently 5.3 per SRT[18]. To give some idea of the magnitude of the challenge that remains, 75 new therapeutic homes would be required to house the approximate 600 people who remain in long-term hospital care (based on eight patients per SRT).

The care process involves monitoring by teams, which is intended to ensure continuity of care and to help to promote the integration of patients into existing resources in the area where they live. For patients to gain access to SRT services it is necessary that they are linked to CAPs, which provide mental health care. The care process within SRTs can be included within the typology proposed by Nelson et al.[33], i.e. supportive housing, where housing and psychosocial rehabilitation are interconnected. Rehabilitation is developed inside the SRTs, often through the work of caregivers, who remain in the SRT for variable periods, depending on the intensity of care required.

One of the powerful mechanisms that can help the processes of de-institutionalization and social re-integration is the allocation of resources to offer guaranteed income directly to patients who leave long-term hospitalization. This funding can be operated by means of scholarships with lifetime monthly payments and it can be paid municipally (Municipal Law No. 3,400 of 17/5/2002) or federally (Federal Law No. 10,708 of 31/7/2003). Patients can also receive financial benefits through the continuing provision of the Organic Law of Social Assistance.

Care for service users with problems arising from alcohol and other drugs

In the city of Rio de Janeiro, the network of psychosocial care for people with problems arising from the use of alcohol, crack and other

drugs comprises three CAPs II AD, four CAPs III AD, two adult care units, and seven Street Office teams. Reception units are designed to provide voluntary and continuing care for people with needs arising from the use of crack, alcohol and other drugs, in vulnerable social and family situations, and requiring therapeutic and protective monitoring[34].

For the size of the city this network is still insufficient. Large areas, particularly in the city center, have no coverage. Two Street Office teams function in the center of the city but they have no back-up support Another significant aspect is that the CAPs AD are not necessarily located in the regions where crack is openly used. Although all of these services are intended to be directed at all types of problems, there is certainly a lack of attention to the approach to the use of crack and the care provided for crack users. This network carries out an average of 8,000 calls per month[18].

There is great difficulty in arranging the start and continuation of this type of service, which reflects the specific nature of this type of clientele and the need for flexibility in the approach to practices. Consequently, the Street Offices and the so-called Approach Teams are the major actors in integrated actions with CAPs because they use strategies designed to build links with clients, which is essential at the start of a case and they are offered as devices that are easy to use. The most severe cases are mainly dealt with by the CAPs III AD; many of these patients have clinical morbidities such as pulmonary tuberculosis and syphilis, which means that the beds reserved for crisis cases are always occupied at a rate of around 90-100%. The same applies to the adult reception units, which also have an occupancy close to 100%.

However, the coexistence of a wide network of institutions organized under the premise of long-stay in programs that focus on abstinence, which are maintained by individual contributions or state or federal grants, has a strong appeal for the public and also for the families of drug users. This is a challenging model and although it does not present its results in a clearly visible manner it supports a considerable clientele that gravitates around these institutions, constituting a 'revolving door' scenario.

In a recent article, Ribeiro et al.commented that therapeutic communities in Rio de Janeiro have developed outside the systems of public health and social assistance and that they have low levels of transparency in terms of clinical practice and therapeutic approaches. The aforementioned authors considered that the legal qualifications of these institutions are not clear, at least in terms of the treatments that they claim to practice. Furthermore, the network has a low level of visibility, which is expressed by the fact that only 20.1% of their recorded services are registered with the CNES[25].

The public network has not accurately mapped the capacity of this segment of so-called therapeutic communities; however, the Municipal Health Secretariat in Rio de Janeiro refers to the existence of 45 therapeutic communities in the city[18]. There is a continuing demand for more government subsidies, as well as an ongoing political debate that contaminates the discussion about the decriminalization of the use of psychoactive drugs and turns that issue into a moralizing agenda.

Final Considerations

The analysis of the performance of the psychosocial care network in the city of Rio de Janeiro City provided in this article identifies advances in the de-institutionalization of care, with a progressive reduction in the number of beds in psychiatric hospitals and an increase in the role of community facilities. The current situation points to a number of future challenges, which are summarized in Chart 1.

It is clear that the activities of CAPs in the city of Rio de Janeiro, and in much of Brazil, provide effective longitudinal care of patients with severe and persistent disorders (mainly psychotic disorders); however, there are still difficulties with regard to patients undergoing crisis situations. Campos points out that substitutive services coexist with *psychiatric hospitalization*, to a greater or lesser extent, and that hospitalization often causes breaks in the links with services provided by CAPs, resulting in exposure to new admissions[35].

In the case of the city of Rio de Janeiro, despite a reduction in the number of psychiatric hospitalizations in recent years, there have been a large number of people seeking urgent/emergency psychiatric services. This indicates a weakness in the response of the psychosocial care network in terms of monitoring of cases and also implies a volume of punctual appointments; however, those appointments offer low levels of resolution and are disconnected from individualized therapeutic projects.

In addition, the fact that urgent/emergency

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services remains a gateway to psychiatric services results in a reduced ability to intervene in cases of greater clinical complexity that require the provision of resources for diagnosis and treatment. The implementation of three hospital referral services in general hospitals was a significant improvement in terms of integration with the health sector as a whole and it has been achieved in tandem with a progressive reduction in the dependency of the health network on beds in specialized hospitals. The future planning of municipal mental health policy already indicates the possibility of the closure of psychiatric hospitals over the coming years.

The contrast between a high percentage of people who have private health insurance (52.5% of the population), and who have a care model that is based on individual consultations with psychiatrists and psychologists, and psychiatric hospitalizations with limited community facilities demonstrates the fragile nature of public care and the fact that it is difficult for the population as a whole to have access to services that are efficient and local. It also demonstrates a mismatch between the process of de-institutionalization and the policy of psychiatric reform[36].

Regarding the care provided for people with problems related to alcohol and other drugs, it can be argued that the more effective impact of so-called "therapeutic communities" in the social arena represent an obstacle to the consolidation of the guidelines issued by the Ministry of Health. This has also weakened the position of the stakeholders in psychiatric reform in terms of the control of the agenda regarding the unanticipated, and perhaps underestimated, issue of crack abuse, which has created social demands for institutional and involuntary solutions to this problem. Nevertheless, the low provision of specific services for users of alcohol and other drugs, such as CAPs III AD and reception units, also prevents a more conclusive evaluation of the effectiveness of the current format of the SUS policy on this issue[37].

Despite the efforts made in recent years, the mental health network of the city of Rio de Janeiro still lacks information regarding basic indicators that are required for monitoring, such as the situation regarding access to services and the profile of clients. There also remains a gap between educational institutions and public services, which requires new actions to guarantee the continued training of health professionals within the network, such as master's degrees and new post-graduate *lato sensu* courses. The Integrated Medical internship at the Federal University of Rio de Janeiro, which is being developed in partnership with the Institute of Psychiatry at UFRJ represents a useful initiative in terms of directing the training of family physicians and psychiatrists to have a more integrated approach to patients.

There is still a shortage of evaluative studies that accurately assess the quality and effectiveness of health care in all its dimensions. Thus, it is necessary to promote new initiatives in partnership with research institutions to undertake research that takes into account the specific nature of mental health. Notwithstanding important advances that have been made in terms of knowledge, both in support and in training and research, it remains a challenge for all psychiatric reform processes, including those that are considered to be most successful, that a theoretical,

Chart 1. Psychiatric reform in the city of Rio de Janeiro - crucial issues.

Increased coverage for psychosocial care centers (CAPs)
Conversion of the model of beds in psychiatric hospitals for beds in general hospitals and type III CAPs
Inclusion of care for psychiatric emergencies in the urgent/emergency system of the municipal health network
Expansion of the integration of mental health (and health in general) and the coordination of mental health teams with primary health care
Expansion of the number of residential therapeutic homes
Increase in the provision of specific services for people harmfully using alcohol and other drugs, and a reduction in policy fragmentation
Overcoming the gap between the care models of the supplementary health system and that of the SUS
Psychiatric reform within educational institutions and research institutions.

clinical and care model, which goes beyond the established biopsychosocial model, has still not been sufficiently developed[22].

The lessons identified by monitoring the psychosocial care network in the city of Rio de Janeiro serve as elements that can be used to analyze other municipal experiences in large urban conglomerates that have a mental health network of considerable importance and which seek alternatives to transform their care model.

Despite new and old challenges, it is important to consider the consolidation of the paradigm shift that has occurred in the psychiatric care provided by the city of Rio de Janeiro. This can be witnessed in the everyday lives of de-institutionalized patients, most of whom have spent many years in psychiatric hospitalization in a context of walls and asylum pavilions, who are now able to walk the streets of the city and share their lives alongside their fellow citizens.

Collaborations

HM Fagundes Júnior, M Desviat and PRF Silva participated equally in all stages of preparation of the article.

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