Stakeholder Involvement in Forensic Psychiatry: The Brazilian Experience

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The Brazilian psychiatric reform process has been going on for 28 years. This complex shift in the government-sponsored model of mental health care has its origins in the anti-institutional thinking of Franco Basaglia. It involved replacing psychiatric hospitals, which were the major option for dealing with people with serious mental illnesses in need of care, with systems of community-based services. Beyond the advantages of being more comprehensive and humane, more respectful of human rights, and more hopeful for patients and their loved ones, the major strength of this approach as it evolved in Brazil came from its grassroots construction, as it was discussed and constituted through democratic debates.[1] Having public debates with all stakeholders, including health consumers, health workers, and health care providers, as required by the new regulations, has been paramount in the success of Brazilian psychiatric reform.

The gradual implementation of this new model of care has resulted in a significant reduction in the number of psychiatric beds funded by the federal government and in the implementation of a complex network of mental health services based in the community.[2] Initial opposition from different medical organizations, such as the Brazilian Psychiatric Association and the Brazilian Hospital Association, was unsuccessful in halting this process, much less in reversing it.[3] Having witnessed the successes of Brazilian psychiatric reform first hand, it is my intent in this editorial to consider whether such a debate might still be needed in the United States, even though the U.S. deinstitutionalization movement began much earlier than the Brazilian one (more than a half century ago).

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The Model Before Psychiatric Reform

Until the 1960s, most psychiatric beds in Brazil were in public state psychiatric hospitals. By this time, as was the case in the United States and elsewhere, the conditions inside these hospitals had deteriorated. After the coup of 1964, a military dictatorship took over command of Brazil. Under its rule, there was an impressive surge in the number of privately owned psychiatric hospitals. At the end of the 1970s, roughly 80 percent of the psychiatric hospitals were for-profit, privately owned institutions. The government paid these institutions per service, using money from the social security fund of workers (meaning that only workers contributing to social security had access to these hospitals). Around 15 percent of the federal health budget, through these funds, was designated to pay psychiatric hospitals, which also made up 99.8 percent of all government expenditures in mental health. The privately owned psychiatric hospitals failed to respect basic human rights, but the government psychiatric hospitals, which did not receive money from the social security fund, were, in all aspects, even worse.[4]

The end of the military coup in the beginning of the 1980s offered an opportunity for more open and structured discussions about the health of the popu-

lation and the scope of the government's responsibility. It also created the possibility for discussions among mental health workers. They pointed out, not only the insufficiencies of the mental health model centered on the psychiatric hospital, but also, its oppressiveness and how it segregated those with a mental illness. It was in 1987 that the Basaglia-inspired slogan of "For a society without asylum" was created, marking the beginning of Brazilian psychiatric reform.[4,5]

The Democratic Foundation

The Brazilian Constitution of 1988 stated that all citizens had the right to health care, and it was the responsibility of the government to provide it. This legislation had been the result of several years of organization and mobilization among public health care workers and the general population. Social mobilization, exemplified in the Eighth National Health Conference, which occurred in 1986, with more than 4,000 people debating and voting in its final plenary, was a main reason for congressional approval of the health-related article in the new Constitution.[6,7] It made sense that the social mobilization before the Constitution should now become the social control of government regarding the development of the now so-called Unique System of Health.[6,7] Therefore, the regulation of this new constitutional right not only created mechanisms to increase investments in public health, but also guaranteed the participation of consumers and all stakeholders involved in health care and in decision-making about health care. Government at all levels (federal, state, and municipal) would also submit health budgets for approval by health councils, beyond the standard legislative approval.[8,9]

As a result, two forms of cooperative participation were created: councils that would meet regularly with the executive branch to approve the budget, and conferences that should happen every four years to define the health guidelines for the next four years. Conferences would be held first at the local level, to debate and approve proposals related to their local problems. The local conferences would elect delegates to present proposals to the state conference where decisions about state concerns would also be debated and approved. Finally, state delegates would take their propositions to the federal level. Each state would then present its proposal in a final national conference. Fifty percent of the delegates in all conferences and 50 percent of the members of all health councils must be and represent lay persons who have no connection with health care. The other half would represent health workers (25%) and health care providers and researchers (25%).[6,8,9]

Difficult First Steps

It was clear in the report from the first National Mental Health Conference that government should concentrate its efforts on nonhospital mental health practices and services, even though the image of Brazilian psychiatric hospitals among the general public in 1987 was not a positive one.[10] On the other hand, it is known that, in 1987, psychiatric hospitals and their emergency rooms were the only public places, for better or worse, that people facing a mental health crisis could rely on and go to for care.[5,11] Government in general, at that time, was not willing to put more money into the health budget, especially into mental health.[11] This reticence meant that any effort to develop new psychiatric services would have to be financed by taking money away from psychiatric hospitals. If we add to this equation the general discrimination against people with a mental illness (principally against those who were inside psychiatric hospitals),[12] we can understand why there was strong resistance to the development and implementation of community-based psychiatric services. The perception was that people inside psychiatric hospitals were essentially dangerous and should be kept locked up.[12]

Psychiatrists who owned and worked in psychiatric hospitals were part of those advocating to maintain the mental health care system as it was. Dangerousness and inevitable deterioration of those with serious mental illness was part of the argument.[3–5,11,12] Again, mobilization of stakeholders (street demonstrations became a standard practice, with May 18 being chosen in 1987 to be the national day of the fight against psychiatric asylums) and debates convinced some mayors to invest in a new model of mental health care.[1] The positive return from these first experiences not only inside the so-called antiasylum movement, but from the population in general, helped build momentum toward psychiatric reform. These experiences became a convincing argument inside city health councils and health and mental health conferences, pushing forward the psychiatric reform agenda.[1]

The Approval of the Brazilian Mental Health Law in 2001

In its early stages, the social movement advocating for Brazilian psychiatric reform proposed a strategy similar to that which had successfully transformed mental health care in Italy.[1] In 1978 in Italy, Law 180 (the so-called Basaglia law) proposed by the Democratic Psychiatry Movement, was approved.[13,14] This law mandated that all psychiatric hospitals be closed and that a web of community-based mental health services and psychiatric beds in general hospitals replace them.

In Brazil, in 1989, a similar law proposed by the mental health social movement entered Congress, but it was halted immediately in its approval process because of opposition from medical institutions such as the Brazilian Hospital Association and the Brazilian Psychiatric Association.[1,15] As psychiatric reform built momentum through the 1990s, becoming the official federal government mental health policy, the government started lobbying in its favor. Through the process in Congress, many amendments were proposed and part of its more radical points were modified, and in 2001 it was finally approved (law 10.216 of 2001).[1,15] It was also rapidly sanctioned by the president. This law reaffirmed several aspects of psychiatric reform; for example, all psychiatric treatment should be based on the patient's living and being treated in the community, outpatient services should be prioritized, and mental health clients should have the right to informed consent about their treatment. Although the law did not propose the closure of all psychiatric hospitals, the judicial system would now be required to regulate all involuntary psychiatric hospitalizations.[16]

In 2014, in its *Guidelines for a Model of Integral Attention in Mental Health in Brazil*, the Brazilian Psychiatric Association, together with the Federal Board of Medicine of Brazil, among other medical institutions, recognized law 10.216 of 2001 as a good law.[17]

Other Outcomes of 28 Years of Psychiatric Reform

There have been six National Health Conferences (every four years since 1986) and four National Mental Health conferences during this period: in 1987, 1992, 2001, and 2010.[7,10,18–26] Each conference involved hundreds of thousands of people in the debates that took place in more than half of all the cities in the country, always culminating in a final National Conference with representatives from all states. In all its stages, and as noted above, it was required that half of the delegates be lay persons representing the general population.[7,10,18–26] Regarding the Mental Health Conferences, except for the first one in 1987, each conference involved more than 45,000 people intensely discussing and debating models of care, needs, and policies related to the mental health field.[10,18–20] Again, half of the delegates in all stages were lay persons from the population, mostly consumers and their family members. It is important to note that all health conferences were supportive of Brazilian psychiatric reform, whenever this topic was discussed. [7,21–26] As one could expect, all mental health conferences supported and proposed advances to Brazilian psychiatric reform.[10,18–20]

More than 70 percent of all psychiatric beds contracted by government have been eliminated during the past 28 years. In this period, the total number of psychiatric beds decreased from more than 100,000 in the 1980s to less than 30,000 in 2015.[27] The federal government now spends around 30 percent of its mental health budget on psychiatric hospitals, down from more than 99 percent in the 1980s.[27]

A network of more than 2,000 community-based mental health services has been created in this period, with more than 60 of them available around the clock, with beds for clients who need 24-hour care. It is estimated that almost 70 percent of the population have relatively easy access to mental health care in these services.[2] Also, almost 700 houses for those who were living inside psychiatric hospitals and without a place to go were created.[2] The effectiveness of this program and the improvement in the quality of life of those who are now living in these houses have been reported.[2,28] Another interesting accomplishment in the most recent period was the creation of social enterprises run by consumers as a way to improve income. More than 600 of these enterprises have been created all over the country, with the help of government incentives.[2]

Regarding psychiatric hospitals, there has been great progress in the quality of care and infrastructure, as a much more detailed regulation was imposed by the federal government.[29] The federal gov-

ernment started inspecting the psychiatric hospitals in 2002. This inspection program coincided with the acceptance by the Inter-American Court of Human Rights of a case against the Brazilian government related to the homicide of a patient inside a psychiatric hospital. In 2005, the Inter-American Court of Human rights condemned Brazil for a human rights violation in the murder of Damião Ximenez inside a psychiatric hospital.[30]

Brazilian Forensic Psychiatry in the Context of Psychiatric Reform

Very little has been published about the quality of care inside forensic psychiatric hospitals in Brazil since the late 1980s. Nonetheless, there is not much doubt that there was a sense that quality of life was worse inside forensic psychiatric units, when compared with that in general psychiatric hospitals. Forensic psychiatric units were (and still are) part of the Department of Justice. This arrangement meant that there is less money to pay for their expenses. It was common, until the year 2003, for there to be interruptions in payment for basic needs, such as psychiatric medication.[31,32]

The Italian law 180, which served as a reference for the Brazilian Psychiatric Reform and which required the closure of psychiatric hospitals, did not apply to forensic psychiatric hospitals.[14] Still, this did not present an impediment to inclusion of forensic psychiatric hospitals in the Psychiatric Reform.[19,32] This debate permitted, at least, the correction of some important distortions. Pressure mounted to correlate, when possible, the length of stay in these units with the severity of the crime committed.[31] There was also pressure to match the quality of care inside these units with that in general psychiatric hospitals. For this effort, the health care system was made responsible for paying the health care expenses in these units.[32] These two measures improved substantially the quality of care, and many clients were discharged.[31] Finally, the justice department, adhering to law 10.216, determined that outpatient commitment should be prioritized (as an alternative to the so called "hospitalization security measure" - which meant long term hospital commitment) whenever possible for those who committed a crime and were ruled incompetent to stand trial.[33]

Discussion

Much work remains to be done in Brazil when it comes to improving mental health care.[17,29,34] The Brazilian Psychiatric Association continues to be critical of the continued reduction of psychiatric beds.[17] However, all parties recognize that there have been undeniable advances in mental health care in Brazil in the past 30 years.[1,2,17]

There is evidence that the Brazilian Psychiatric Reform was mainly possible because of the democratic debate of mental health policies in health conferences and in the Health Councils. [1,2,5,6,15] Both institutions hold considerable power, as determined by law; the results of their deliberations become guidelines that must be followed by governments (municipal, state, and federal).[6,8,9] The empowerment of these democratic forums also stimulate consumer organizations to advocate and debate propositions to be defended at the conferences and councils and to make sure that the resolutions from the conferences are implemented in each city.[1,2,5,6,15]

The debate and the resolutions approved in the last health conference and in mental health conferences are indicative of the fact that consumers and family members, mental health workers, and government continue to support the Brazilian Psychiatric Reform process.[20,26] Their consistent backing could be an indication that having democratic forums to decide the guidelines for a model of care is a successful way of building and advancing a health and mental health care system in a sustainable way.

It is known that the Brazilian Psychiatric Reform would not have advanced without the health and mental health conferences.[10,18–20] It is also understood that the mental health conferences would not have been successful without the participation of consumers and their family members.[10,18–20] This Brazilian experiment makes a case for the active participation of consumers when it comes to debating and deciding which mental health care system a society would like to have. The Brazilian forensic psychiatry system also gained from the open democratic and decision-making process.[32] Better health care and fairer criteria for commitment to a forensic psychiatric hospital are good advances.[31,32] The traditional psychiatric approach to the criminogenic risk of people with a serious mental illness who have com-

mitted crimes continues to be opposed in Italy by those identified with the Democratic Psychiatry movement (a major proponent of Law 180).[14] It would be interesting if this debate gains traction in the democratic setting of the upcoming Brazilian mental health conferences.

The need for more investment in the Brazilian mental health system has been exhaustively reported.[10,17–20,27] However, it should be noted that much has been done in comparison to the amount of resources invested.[2] It could be inferred that another benefit of the democratic process is to optimize investment. On this score, entire chapters about funding have traditionally been part of the final reports of all health and mental health conferences (which means that a fair amount of time in the conferences is dedicated to deciding the best way to allocate the resources).[6,7,10,18–26] According to a government report, about 70 percent of the Brazilian population have relatively easy access to mental health care, if needed.[2]

The United States has also gone a long way in its own mental health care transformation process.[35] On the one hand, this reform effort has achieved significant accomplishments, as is attested to by the existence of excellent services scattered throughout the country. On the other hand, people with mental illness continue to have a greater chance of living in poverty; of being unemployed, homeless, or incarcerated; and of dying younger, which are indicators that the U.S. mental health reform efforts have fallen short,[36,37] not to mention racial and cultural health disparities.[38] The need to advance can also be seen in the lack of continuity of care for some with serious mental illness and in the view that mental health workers are overworked, have low salaries, and are confined to a narrow biological model.[36]

It is not the intention of this editorial to make a direct comparison of psychiatric reform in Brazil and the one in the United States. The structural differences speak for themselves. Not only is there a considerable difference in the amount of research and data available, but also in the amount of resources invested in mental health in each country every year (while it is estimated that Brazil has invested less than $10 per capita in mental health services each year,[17] it has been predicted that the United States spent more than $700 per capita on mental health services in 2014[39]).

The increased access to mental health care has been an interesting accomplishment of the Brazilian Psychiatric Reform.[2] The importance of the contribution of mental health consumers and family members, working and discussing at the democratic decision-making forums to guarantee this accomplishment, should not be underestimated.

The latest Substance Abuse and Mental Health Services Administration reports on Behavioral Health Equity and on Racial/Ethnic Differences point to the idea that difficulty in accessing care is still a very important matter to be addressed when it comes to improving mental health care in the United States.[37,38] Should users/consumers not help in a more systematic way to discuss and propose solutions to this matter? Should they not help decide which is the best model of care?

There is understanding that the way to move forward with U.S. mental health reform is to build therapeutic alliances between consumers and providers, to lead to social integration.[35,36] There is also understanding that it is necessary to strengthen the relationship between consumers and their communities.[35,36] Collective forums, among consumers, their families, members of the community, clinicians, service coordinators, and representatives from governmental mental health agencies could be an interesting means of deciding the best way of achieving these goals. In Brazil, this mechanism has been effective in achieving sustainable advances in the direction of social integration and in bringing to the table parties that initially refused any form of compromise. Could this experience serve as a reference for the United States?

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