Background on national policies on mental health and alcohol and other drugs in brazil from technical note n ° 11/2019

Retrocesso nas políticas nacionais de saúde mental e de álcool e outras drogas no brasil a partir da nota técnica n°11/2019

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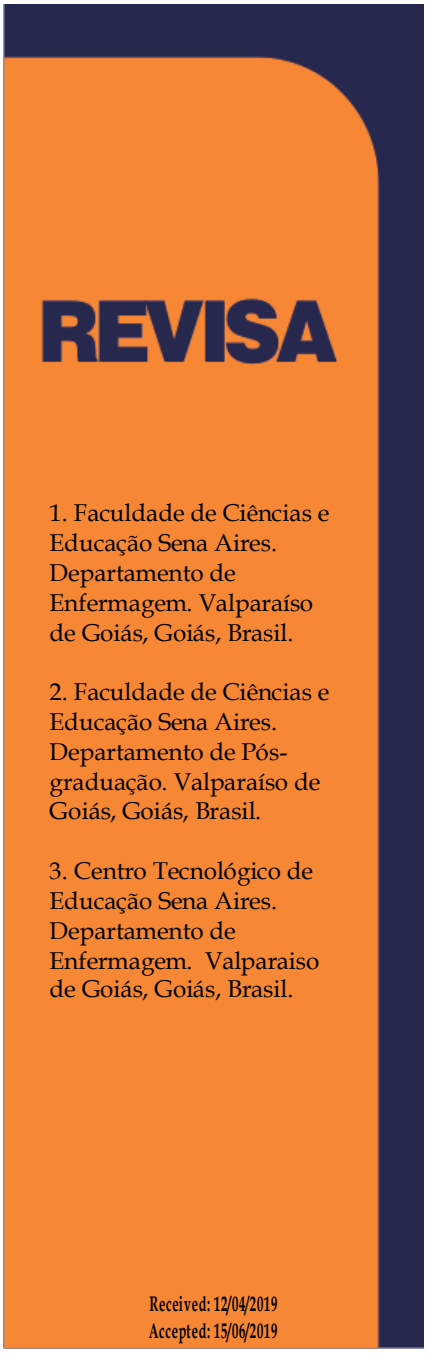
Citation Moraes-Filho IM, Silva JP, Matos AF, Bezerra GS, Negreiros CTF, Guilherme IS. Background on national policies on mental and alcohol and other drugs in brazil from technical note n ° 11/2019. REVISA. 2019; 8(2): 115-8. Doi: https://doi.org/10.36239/revisa.v8.n2.p115a118



The Brazilian Psychiatric Reform is a strong influence of the Italian experience that moves the care of the person with mental disorder from the hospital to the community, showing the political and social dimension of the madness that, from Franco Basaglia in Italy, began to occupy a central place in the field of mental health.[1] In this way there is an understanding of the madness, the ways of caring and the freedom of the person with mental disorder as the central axis, the services created and the questioning of the asylum culture in society are elements that marked and mark the Brazilian Psychiatric Reform.

Thus, the process of Brazilian Psychiatric Reform was based on a great movement to fight for a transformation in the care of people with mental disorders, denouncing abuses, ill-treatment, suppression of civil rights and all irregularities in the asylums that excluded the subject from his family and social life, and treated him only with a focus on his pathology comprising only signs and symptoms inherent in the complaint.[1]

In this sense, the Brazilian Psychiatric Reform has led to numerous advances in understanding and assisting mental health issues in the population, since it is understood as a complex social process and encompasses four dimensions: theoretical-conceptual, technical-assistance, legal-political and sociocultural.[3]

The Ministry of Health, through ordinance 224/92, went on to authorize and finance the construction of Psychosocial Care Centers (PCC), or Centros de Atenção Psicossocial (CAPS) in Brazilian Portuguese, throughout the national territory, services that constitute one of the main strategies for the advancement of the Brazilian Reform Psychiatry.

EDITORIAL

The PCC, or CAPS, are open and community health services of the Unified Health System (UHS), governed by Ordinance 336/2001 and intended for the care of the person with severe and persistent mental disorder that justifies their need for daily care in an "intensive care device, communitarian, personalized and promoter of life".[6]

The new care logic, called the expression of psychosocial care, characterized by the organization of mental health care practices in new bases through open services such as daily care centers, psychosocial care centers, day hospital, territorial base and community.[1]

In this way, the CAPS function under the logic of the territory, in order to seek to integrate the person with mental disorder into a concrete sociocultural environment, in the space of the cities, where their daily lives come from and that of their relatives tripartite.[7] By valuing such services, families are understood as partners, mediators between the person with mental disorder and the society. It is from this new logic that they acquire a fundamental role in the production of community care, starting to share with the surrogate services to the psychiatric hospital the care that was previously carried out almost exclusively by mental hospitals in a subhuman and excluding.[8]

In this perspective, Law 10.216[7] dated 04/06/2001 highlights the shared care between the State, families and society, which is explained in article three of the Law of Psychiatric Reform:

It is the responsibility of the State to develop the mental health policy, to assist and promote health actions to those with mental disorders, with due participation of society and the family, which will be provided in a mental health establishment, institutions or units that offer health care to people with mental disorders.[7]

Technical note Number 11/2019 which provides: Clarification on changes in Mental Health Policy and National Drug Policy Guidelines. Accordingly, Ordinance Number 3588, dated December 21, 2017, amends Consolidation Portions Number 3 and Number 6, dated September 28, 2017, to dispose of the Psychosocial Attention Network (PAN), or Rede de Atenção Psicossocial (RAPS) in Brazilian Portuguese, outlining new guidelines jointly proposed by the Union, States and Municipalities for the strengthening of RAPS.[7,9]

It provides for the reorientation of the guidelines of the National Mental Health Policy, emphasizing practices such as electroconvulsive therapy (ECT), the hospitalization of children in psychiatric hospitals and this is another point that violates Article 4 of Law 10 216, and abstinence for the treatment of users of alcohol and other drugs for the Unified Health System (UHS).[7,9]

This ordinance is characterized as a retrocession because it values hospital-centered practices based on the biomedical model where it protects psychiatric care in an empirical way. Leaving aside the appreciation of the person with mental disorder, as a biopsychosocial being.[10]

The biopsychosocial model is a broad concept that aims to study the cause or progress of diseases using biological, psychological and social integrated factors and adding signs and symptoms in the development of pathologies and diseases. Placing the patient and the family as the protagonist of the unfolding of the effective progress of the treatment by punctuating the triggering factors of

the disease in the health-disease process.[11]

The ECT is accepted as a form of treatment by the Federal Council of Medicine and Brazilian Association of Psychiatry, however, quite controversial and today of restrictive use the psychiatric clinics, and until then not used in the substitutive services in mental health.[12]

The same had been used in the past as a form of punishment, there is a stigma of its use that still predominates in society in general. Unfavorable criticisms are constantly presented by the media, which reinforces the fear of its applicability.[12]

Thus, as the procedure does not lead to cure, but rather to relief of symptoms, many under a scientific eye question its efficacy. More than a technical practice, ECT needs to be discussed as a treatment that generates rejections and that brings a historical framework of punishments and social pain, difficult to forget. If today it has its relevance and has become a judicious and ethical application, it is necessary that without fear or imposition these issues are respectfully faced and discussed in society, and not imposed as a single truth.[12]

Regarding alcohol and drug user assistance, abstinence as the only therapeutic offer is not effective because it did not protect the user's uniqueness in a way that did not reveal the main reason for the use of psychoactive substances.[9,13,14] Ordinance Number 1,028, dated July 1, 2005, *determines actions that aim to reduce social damages and health, resulting from the use of products, substances or drugs that cause addiction*. *Harm reduction is based on* a set of policies and practices aimed at reducing the harm associated with the use of psychoactive drugs in people who can not or do not want to stop using drugs. By definition, harm reduction focuses on preventing harm, rather than preventing drug use; as well as focusing on people who continue to use drugs.[14-15]

The devices to care for users of alcohol and other drugs are: 1 -CAPS AD: Psychosocial care center for users of alcohol and other drugs, which aims to provide care to the population, perform clinical follow-up and social reintegration of users by access to work, leisure, exercise of civil rights and strengthening of family and community ties, 2- The Center of Coexistence, where the patient of mental disorder can socialize with different people applicable to every citizen who needs. 3-The Street Offices: service performed in the streets along with users of alcohol and other drugs aimed at serving the population at risk and social vulnerability, especially children and adolescents. 4- Therapeutic Communities - TCs aim to cure the problems arising from the use of drugs, opportunizing the patient, distance themselves from them and placing it as the main protagonist of his treatment and cure. It is a system of closed regime character structured, with rules, routines, functions, well-defined obligations, clear rules and controlling affects. The structure provides the patient that it feels inserted in a treatment of an intensive and integralist nature, thus, the work is carried out both by the multiprofessional team and by the patients themselves.[14,16]

In this way the hospitalization and application of practices that do not guide the resolution of the real problems of people with mental disorder and users of alcohol and other drugs, will only cause patients a treatment based on signs and symptoms, where it will be momentarily resolved and soon the same when exposed to the initial factors will return to the initial state and may aggravate it.[10,17-18]

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