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Mental healthcare in Brazil: modest advances and major challenges

REFLECTION

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SUMMARY

This brief article describes the main health indicators of Brazil and gives an overview of psychiatric care. It points out the primary pitfalls of the mental healthcare system and presents some suggestions for the future of mental health in the country.

DECLARATION OF INTEREST

None.

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Demographics and epidemiology

Brazil is an upper-middle-income country located in South America, with a population of about 200 million. Even though living conditions have improved, particularly as a result of the government's social cash transfer programmes (*Bolsa Familia*), Brazil remains among the most unequal countries in the world. Its Gini coefficient, a measure of income or wealth inequality, is 0.55 (0 denotes perfect equality), placing Brazil in the shameful global position of having the 10th highest Gini rating. Table 1 compares social and demographic indicators in Brazil and the UK.

An important demographic change took place in Brazil after the Second World War. The proportion of the population living in urban areas rose from 36% in 1950 to 81% in 2000. This rapid urban population growth was not matched by increased provision of essential public services in education, health and safety. The growth of slums and poor housing lacking even basic services on the outskirts of the great urban centres, combined with social and economic inequality that date back to the abolition of slavery in 1888, has created a vicious environment of drug trafficking and violence. For instance, a recent survey showed that nearly 90% of the population of São Paulo and Rio de Janeiro faced a lifetime exposure to actual or threatened death, with a significant impact on mental health (Ribeiro 2013). In 2010, the homicide rate in Brazil was 21.0 per 100 000 inhabitants (World Bank 2012) and traffic-related mortality was 22.5 per 100 000 inhabitants (World Health Organization 2012a), resulting in around 90 000 deaths in a single year (Reichenheim 2011).

In contrast, a recent cross-sectional population survey carried out in a deprived area of south London, with a high level of violent crime, showed a lifetime prevalence of traumatic events of 78.2% (Frissa 2013). Both homicide and death rates in the UK for 2010 (respectively 1.0 per 100 000, and 3.7 per 100 000) were much lower than those reported for Brazil (World Health Organization 2012a).

Despite the problems imposed by rapid urbanisation and huge social inequalities, there has been economic and political stability over recent years, producing an improvement in general health indicators, with declining fertility rates and increased longevity. As a consequence of this new epidemiological outlook, a decade ago neuropsychiatric disorders overtook cancer and cardiovascular diseases, to account for around 19% of the total burden of diseases (Schramm 2004), a trend very much closer to that experienced in high-income countries (Hyman 2006).

The Unified Health System and psychiatric reform

Brazil's publicly funded Unified Health System (*Sistema Único de Saúde* or SUS) was created in 1988, based on principles of universality, equity and inclusiveness, but nearly 20% of the population have access to private health insurance.

Reform of Brazil's mental healthcare system started in the 1990s with a framework of policies adopted by the Ministry of Health to promote the deinstitutionalisation and humanisation of psychiatric care. Between 1995 and 2005, there

TABLE 1 The social and demographic indicators comparing Brazil and the UK

	Brazil	UK
Gross domestic product (GDP) per capita, US$	11 340	38 514
Health expenditure, total as % of GDP	8.9	9.3
Infant mortality rate per 1000 live births	13	4
Life expectancy at birth, years	73	81
Improved sanitation facilities, % of population with access	81	100
Psychiatrists per 100 000 population	3.26	11
Expenditure on mental health as % of total health budget	2.5	10

Sources: World Health Organization (2005); World Bank (2012).

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was a remarkable 41% reduction in the number of psychiatric beds and a significant increase in the provision of community mental healthcare (Andreoli 2007). By 2006, a total of 848 psychosocial community care centres (*Centros de Atenção Psicossocial* or CAPS) had been set up (0.9 CAPS per 200 000 inhabitants) (Mateus 2008). This number had risen to 1742 CAPS by 2012 (0.72 CAPS per 100 000), although they are unequally distributed across the country (Ministério da Saúde 2012). Psychiatric services are not integrated, there is no communication between different levels of care, and policies are based not on evidence but on political parties' ideologies. There is a belief that out-patient clinics are useless, very much identified with a 'medical model', and the system rarely works within a catchment area. Information systems and cost–benefit assessment are practically non-existent. There is a strong resistance to accepting the balanced care model, where hospital beds, particularly for acute admissions, can coexist with out-patient units and community care (Thornicroft 2010).

In 2005 (the most recent year for which data are available), there were nearly 6000 psychiatrists working in Brazil, a rate of 3.26 per 100 000 inhabitants. This level is much lower than that observed in high-income countries, where the rate is typically 1.0 psychiatrist per 10 000 inhabitants (World Health Organization 2012b). Mirroring the uneven distribution of wealth in the country, the number of psychiatrists is much higher in the southern states of Brazil (4.55 psychiatrists per 100 000 inhabitants) than in the northern states (less than 1 psychiatrist per 100 000 inhabitants). The number of residency posts is not proportional to the population distribution, and 27% of these posts were not filled in the most recent selection, particularly in the poorest geographical areas of the country, where specialised professionals are more needed (Fernandes 2013).

Child and adolescent mental health

A particular public health concern is related to the children and adolescents living in precarious conditions in the slums on the outskirts of urban centres. They are exposed to numerous risks: being born following an unplanned pregnancy, substance use by the mother during pregnancy, lack of monitoring in pregnancy, perinatal problems, childhood malnutrition, sexual abuse and domestic violence. These are young people who have a greater likelihood of poor school performance, antisocial behaviour and early use of alcohol and drugs. Nonetheless, there is a scarcity of preventive psychosocial interventions and a lack of well-prepared professionals to handle the situation, since few medical schools offer courses in child psychiatry, because of scarcity of professionals trained in the field. This has resulted in a clear imbalance between the mental health needs of these young people and specialised services to meet them (Paula 2007).

The principal service for treating young people (up to 24 years of age) with severe mental illness in Brazil is the psychosocial community care centre for children and adolescents (so-called CAPSi). The number of CAPSi rose from 32 in 2002 to 136 in 2011. But regardless of this substantial increase, there is still only one CAPSi for every 1.3 million young people in the southern region, the wealthiest geographical area in the country, whereas the estimated requirement is one CAPSi per 200 000 young people.

In their recent review, Paula *et al* (2012) recommended four main actions to increase the availability of mental health services for children and adolescents:

- provide specialised training for mental health professionals currently working in the public health system
- improve undergraduate training, particularly for psychologists
- develop career opportunities and offer better salaries for specialised psychologists and psychiatrists
- improve inter-sector collaboration, mostly with the education and justice systems.

Preventive measures are also important, as physical punishment of young people and maternal anxiety and depression both affect the trajectory of mental illness in this population (Fatori 2013). A cross-sectional study was conducted in Embu, a deprived city on the outskirts of São Paulo, to study mental health and risk factors in children aged 6–17 years. It found that 20% of children had suffered severe physical punishment, defined as being hit with an object, being kicked, choked, smothered, burnt, scalded, branded, beaten or threatened with a weapon, in the previous year (Bordin 2009). Physical punishment and maternal minor affective disorders were associated with both internalising and externalising problems in this age group.

Since 1990, children up to 18 years of age have been protected by the Statute of the Child and Adolescent (*Estatuto da Criança e do Adolescente*). If a child is suffering oppression or sexual abuse by a parent or guardian, the legal authority may determine, as a precautionary measure, the removal of the perpetrator from the common residence.

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Mental health research

The local research community is still modest, though fast growing (Bressan 2005), but the impact of data produced is low, owing to the scarcity of well-trained professionals in mental health policy and service planning. However, the increase in research output, the expansion of postgraduate programmes, increased investment in research, and the recent indexing of the *Brazilian Journal of Psychiatry* in the main international literature databases have given recognition to psychiatry as a scientific field of expertise in the country. Today, there is a certain awareness of public health issues emerging among Brazilian psychiatrists. Therefore, it is expected that more and better epidemiological data will become available for planning, implementation and evaluation of mental health policies in the country.

Summary

Custodial psychiatric care is in the process of abolition in Brazil, mental healthcare is now more integrated into primary care and many acute episodes are treated in psychiatric wards of general hospitals. However, the complete picture of progress in the country includes the recognition that few community-based services are available, particularly for children and adolescents, there is a scarcity of professionals in the poorest states of the country, few professionals are trained in service planning, and the capacity to monitor and evaluate services and programmes remains insufficient. The current reality of the small budget for mental healthcare (2.31% of the total healthcare budget; Ministério da Saúde 2012) leads to an array of failures: a chaotic and disorganised mental health system, insufficient supplies of medications, few residential facilities for the mentally ill, lack of cost-effective preventive interventions, and work overload of low-paid mental health professionals.

Forthcoming challenges are enormous: developing effective services, particularly for children and adolescents; expanding training of mental health professionals; prioritising preventive interventions for early identification of psychosis and addictions; and promoting actions to curb violence and thus create a healthier and better educational environment for families and children living in the poor areas of the country.

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