



REFLECTIONS ON THE BRAZILIAN PSYCHIATRIC REFORM AND ITS DIMENSIONS

REFLEXÕES SOBRE A REFORMA PSIQUIÁTRICA BRASILEIRA E SUAS DIMENSÕES

REFLEXIONES SOBRE LA REFORMA PSIQUIÁTRICA BRASILEÑA Y SUS DIMENSIONES

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ABSTRACT

Objective: to contextually analyze the faces of the Brazilian Psychiatric Reform by the theoretical-conceptual, technical-assistential, legal-political and socio-cultural dimensions. **Method:** it is a theoretical essay, which makes use of the theoretical benchmark of Hinds, Chaves and Cypress. **Results:** the theoretical-conceptual dimension of the Brazilian Psychiatric Reform is characterized by the set of knowledge about knowledge the psychiatric know/how. The technical-assistential dimension refers to the reorganization of mental health services. The legal-political dimension is a review of the civil, criminal and sanitary legislations of the concepts about mental illness. The socio-cultural dimension corresponds to a set of social practices to transform the concept of mental illness together with society. **Conclusion:** the four dimensions of the Brazilian Psychiatric Reform reveal barriers and challenges in the quest for improvement in care for patients with mental disorders by means of conceptual, legal and operational (re) formulation of the patient and the mental illness. **Descriptors:** Mental Health; Reform of Health Services; Professional Practice; Professional/Family Relationships.

RESUMO

Objetivo: analisar de maneira contextual as faces da Reforma Psiquiátrica Brasileira pelas dimensões teórico-conceitual, técnico-assistencial, jurídico-política e sociocultural. **Método:** ensaio teórico, utilizando-se o referencial teórico de Hinds, Chaves e Cypress. **Resultados:** a dimensão teórico-conceitual da Reforma Psiquiátrica Brasileira caracteriza-se pelo conjunto de conhecimentos sobre o saber/fazer psiquiátrico. A dimensão técnico-assistencial refere-se à reorganização dos serviços de saúde mental. A dimensão jurídico-política consiste em uma revisão das legislações civil, penal e sanitária dos conceitos sobre doença mental. A dimensão sociocultural corresponde ao conjunto de práticas sociais para transformar a concepção de doença mental junto à sociedade. **Conclusão:** as quatro dimensões da Reforma Psiquiátrica Brasileira revelam obstáculos e desafios na busca pela melhoria no atendimento ao portador de transtorno mental pela (re) formulação conceitual, legal e operacional do doente e da doença mental. **Descritores:** Saúde Mental; Reforma dos Serviços de Saúde; Prática Profissional; Relações Profissional/Família.

RESUMEN

Objetivo: analizar de manera contextual las etapas de la Reforma Psiquiátrica Brasileña por las dimensiones teórico-conceptual, técnico-asistencial, jurídico-política y sociocultural. **Método:** ensayo teórico, utilizando el marco teórico de Hinds, Chaves y Cypress. **Resultados:** la dimensión teórico-conceptual de la Reforma Psiquiátrica Brasileña se caracteriza por el conjunto de conocimientos sobre el saber/hacer psiquiátrico. La dimensión técnico-asistencial se refiere a la reorganización de los servicios de salud mental. La dimensión jurídico-política consiste en una revisión de las legislaciones civil, penal y sanitaria de los conceptos sobre la enfermedad mental. La dimensión sociocultural corresponde al conjunto de prácticas sociales para transformar el concepto de enfermedad mental en la sociedad. **Conclusión:** Las cuatro dimensiones de la Reforma Psiquiátrica Brasileña revelan obstáculos y desafíos en la búsqueda de la mejoría en el atendimento al portador de trastorno mental por la (re) formulación conceptual, legal y operacional del enfermo y de la enfermedad mental. **Descriptores:** Salud Mental; Reforma de los Servicios de Salud; Práctica Profesional; Relaciones Profesional/Família.

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INTRODUCTION

In Brazil, boosted by the democratization process of the country and criticisms to the hospital-centered model, the therapeutic devices and the medical-psychiatric apparatus, hitherto hegemonic in addressing mental disorders, the Psychiatric Reform Movement was organized based on the assumptions of the Brazilian Sanitary Reform and of the Italian Democratic Psychiatry, by adopting the “deinstitutionalizing” dimension of these movements as its core axis.¹

The deinstitutionalization of mental health care, understood as deconstruction of the constituent medical knowledge of psychiatry,¹ has driven the transformation of character given to the psychiatric hospitalizations, which started to be used with the aim to safeguard the integrity of patients affected by some psychic disease that could endanger their lives and other ones, in a condition or situation of crisis and risk, and it should be only deployed in the impossibility of community monitoring and interrupted after the improvement of the clinical picture of the individual.²

From Basaglia's inspiration, deinstitutionalization finishes political, economic, conceptual, socio- historical and ethical dimensions by reconfiguring spaces uprighted inherited from psychiatric tradition and its practices and powers to the horizontal prospect of practices and skills in mental health focused on person, family and community, through spaces of welcoming, care, sociability and subjectivities.³

The Brazilian Psychiatric Reform (BPR) is a political process of social transformation characterized by the restructuring of work services and processes in psychiatric care with sights to achieve new forms of care more humanized and aimed at the improvement of the quality of life by means of creating spaces for production of social and affective relationships.⁴ This fact means reforming our mindsets, habits and everyday customs intolerant towards the different and the unknown. After being reconfigured, BPR promoted a radical break with the prevailing asylum model through the questioning of its concepts and practices based on positivism and on scientific rationality.

This paper aims:

♦ To contextually analyze the faces of the Brazilian Psychiatric Reform by the theoretical-conceptual, technical-assistential, legal-political and socio-cultural dimensions.

DEVELOPMENT

It is a theoretical essay in which it was used the theoretical benchmark that characterizes the context in four interactive layers - the immediate, the specific, the general and the meta-context.⁵

Such layers are unfolded from the completely individualized meaning to the almost universal meaning, where the researcher describes and analyzes the conceptual aspects through the interpretation of the study outcomes.

Under this perspective, context can be understood as the relationship, the phenomenon and the situation in which it takes place, thus allowing the researcher to get closer to the event to be studied. Approach becomes essential for prediction, explanation and comprehension of the phenomenon.⁵

The immediate context is mainly characterized by the present and is represented by the phenomenon itself⁵ that represents the psychiatric know/how in this study, i.e., the theoretical-conceptual dimension of the Brazilian Psychiatric Reform.

The specific context encompasses the elements in the environment that influence the phenomenon, and it is constituted by the form of organization of mental health services observed in the technical-assistential dimension of the BPR.

The reference frameworks of the subject's life, developed from its interpretations derived from past and current interactions, comprise the general context - this layer explains why the phenomenon takes place in the observed manner.⁵ In this essay, this context is configured in the legal-political dimension of the BPR that addresses the civil, criminal and health legislations of concepts and definitions concerning the patient and the mental illness.

The meta-context reflects and incorporates the past and present, by describing the social vision of the phenomenon shown in the sociocultural dimension of the BPR, which addresses the set of social practices that aim to transform the concept of mental illness along with the social imaginary.

♦ Immediate context: the theoretical-conceptual or epistemological dimension of the BPR

The theoretical-conceptual or epistemological dimension of the BPR is characterized by a set of questions focused on the production of knowledge that underlie the psychiatric know/how. This dimension ranges

from the reflection of the most fundamental concepts of psychiatry, such as mental illness, isolation, normality, abnormality, alienation, healing, among others, to the reconstruction of such concepts and invention of a new theoretical milestone.⁶ It is not just a new way of looking at the same object, but an epistemological break that unveils a subjective, extensive and complex field.

Hence, the formulation of psychiatric knowledge, the manner in which this knowledge is organized before the real suffering of people with mental and behavioral disorders and proposals of the psychiatric reform are directly related. The way in which such relationships are thought can define the positions before those individuals, the mental illness and its treatment form, thus generating different or even opposite opinions. Accordingly, one could state that the personal, social and cultural conceptions on what theoretical and psychiatric field is and how it was built can define the political and assistential strategies of a given society in its relationship with the mad and the madness.⁷

It is noteworthy to emphasize that the historical pathway made by the psychiatric expertise received knowledge contribution coming from the natural sciences and, consequently, by the structuring positivist paradigm of scientific rationality born in the XVI century, which is promoter of rupture between the divine and the human, thus marking the transition from the feudal world to the modern age. The nature ceased to be seen as a set of forces located beyond human comprehension to become an object submitted to the domination of human being through reason.⁸

From the XVIII century, the positivist paradigm imposed itself as a global and totalitarian model, by establishing through it the exclusivist conception of science as the only way to obtain the truth. At the changeover of the XVIII century to the XIX century, hospital was organized as a tool and locus of power and medical knowledge, by giving to the madness a condition of mental illness and instituting hospitalization as a measure of medical nature.⁹

In this context, the psychiatry started to consider mental illness as a “natural object, external to the human being”, thus separating the disease from the individual who experiences it and from the society that permeates it. Accordingly, the psychiatry concerned only the objectivity of the disease and its medical treatment, by guiding actions and practices for clinical pathology in the

uninterrupted pursuit for linearity of the cause and effect relationship of the mental illness, thus forgetting the individuality and subjectivity of subjects.¹⁰

The changes in the political and social conjuncture of the world and of the health sector showed the inadequacy of the positivist paradigm to solve or answer new problems arising from such changes,¹¹ by triggering what Kuhn¹² called paradigmatic crisis. No less different, although with some delay, this panorama of epistemological and paradigmatic conflicts provided the onset of the Brazilian Psychiatric Reform, by promoting a rupture with the theoretical-conceptual model of the classical and rationalist psychiatry, thus redirecting its gaze to the complexity of the experience/ psychic suffering of the subject and its relationship with society through the adoption of the theoretical assumption of the Italian Democratic Psychiatry, inspired by Franco Basaglia, by putting the disease in brackets.¹³

On the one hand, such idea can be understood as a mode of producing knowledge, i.e., an epistemic attitude, since it involves interruption of a certain concept and results in the possibility of new empirical relationships with the phenomenon at stake, because “As the disease is placed between parentheses, it reveals the subjects who were neutralized, invisible and reduced to mere symptoms of an abstract disease”.^{10:67} On the other, it reports the social and political exclusion to what people with mental and/or behavioral disorders are submitted throughout their historicity.

Given these conceptual and structural transformations, there was a greater visibility and appreciation of subjectivity and social inclusion of the subject. The disruption of the disease-mentally ill patient relationship fostered the onset of another important concept of the Psychiatric Reform. This is the concept of deinstitutionalization, which breaks the isolation, by allowing the contact of people with mental and/or behavioral disorders with the possibility of coexisting in the family and society at large through collective spaces, thus turning it into a citizen.¹⁴

Thus, the epistemological dimension of the BPR breaks with the theoretical-practical framework of the classical psychiatry, by redirecting it to new ways of understanding and experiencing psychic suffering, although it coexists with the persistence of the asylum-based logics, which is stigmatizing and segregating and can be seen in some health services, professionals and in the society

itself. It is noteworthy to highlight that the process of replacing the psychiatric hospital by an articulated network of mental health care with psychosocial nature exceeds the simple displacement of spaces to care for a complex change of paradigms and the way of seeing and doing mental health.¹⁵

The paradigm of the psychosocial care, or also understood as theoretical milestone, aims to transform the organizational logic of mental health services and create a network of care to substitute the hospital-centered model, with basis on the territorial, humanized and inclusive care towards people with mental and/or behavioral disorders.¹⁰

♦ **Specific context: the technical-assistential dimension of the BPR**

The technical-assistential dimension refers to the construction of new organization of services, by articulating a network of spaces of producing subjectivities, sociability, health care, income generation, social inclusion, housing, work, leisure, finally, production and life improvement. Therefore, it is to (re) formulate places and rooted concepts present in the psychiatry, in order to meet the unique world of each user.⁶

In the history of madness, there are numerous reports of neglect, violence, exclusion and discriminatory practices suffered by patients with mental and/or behavioral disorders admitted to asylums.³ There was no care, but rather a production of silence, neglect and indifference. Thus, it perpetuates the hospital-centered psychiatric model based on dehumanization, isolation, punishment, repression and commercialization of the mental illness. Therefore, the BPR must replace the asylum-based logic by a logic comprised of places for caring, welcoming and promoting social exchange.

The inaugural and paradigmatic milestones to revert the asylum-based model to a new practice of care were associated with the appearance of services considered alternatives to psychiatric hospitals, among them, one could mention the Anchieta Health Center and the Doutor Luis da Rocha Cerqueira Psychosocial Care Center (currently known as CAPS Itapeva), both located in the São Paulo State, and the São Lourenço do Sul Community Mental Health Center, also known as “Nossa Casa”, situated in the Rio Grande do Sul State.¹

Such successful experiences of extra-hospital care in mental health were considered as an intermediate structure between the hospital and the community.

Accordingly, through producing practices and skills from the perspective of psychosocial performance, by requiring changes in the work process in the face of the protagonism that was established, they have contributed to the implantation of a substitute model to the asylum, which is based on non-violence, welcoming, humanization, appreciation of the individual and the processes of community-based works.

It should be highlighted that this process of replacing the psychiatric hospital by a network of mental health care goes beyond the simple displacement of spaces of care, by involving a complex change of paradigms, practices and skills in the mental health field. The changes were organized from conceptual tools considered inseparable parts of the daily life of new services, such as care, territory, accountability and welcoming.¹⁵

Under this new perspective, the act of caring highlights the mental illness, the professional and the family member, each in relationship to the other, as a complex and subjective subject that has needs, feelings, desires, and who also suffers.¹³ This process of caring is deeply related to the concept of territory, which is, in turn, complex and dynamic.¹⁶ It is essentially constituted by the people who inhabit it, with their conflicts, interests, friends, neighbors, family members, institutions and scenarios (church, places of worship, school, work, pubs, among others.).¹⁴

The central axis of the new proposal of psychosocial care searches the capabilities of the territory, i.e., seeks to exert a practice aimed at the formation of a network of services that articulate the different resources available in the health system and in the community, in order to increasingly reinsert the individual in its social context.¹⁰ Accordingly, it requires the accountability on the part of the stakeholders and other social bodies involved in this process, thus constituting one of greatest challenges faced by BPR.

It should be emphasized that the burden by the care to patients with mental and/or behavior disorders is not only a responsibility of the family, nor of the health professionals and of the public spheres of protection, but rather something that requires distribution, delegation and negotiation of responsibility among all these social actors.¹⁷ In light of the foregoing, it shows the relevance of mental health team for the dialogue between the conceptual tools that guide assistential practices and social actors who experience this process, thus requiring professionals with holistic view and able to create opportunities

to build link between mentally ill patient-family-community-health services, by ensuring the organization of the flow of responsibilities between the different strands involved in this process, besides a humanized and resolute care.¹⁸

It should be noted that, if on the one hand and some professionals and services seek to implement the proposals of the BPR, on the other, many professionals and replacement services still remain guided by asylum-based logics, thus preventing the theoretical-practical execution of this reform.

Given the above mentioned, it appears that the understanding of the Psychiatric Reform goes beyond mere structural transformation of health services, because, in fact, it is the establishment of a diversity of strategies of care that involve the recognition of the territory and its resources, accountability of health services and of professionals on the demand of this territory, in addition to a strategy of welcoming and creation of bonds between those involved in the care process.

◆General context: legal-political dimension of the BPR

The most significant political milestones are reordered and discussed for the implementation and consolidation of the BPR, which has its origin as a social movement in the late 1970s, organized and strengthened in the years 1980 and transformed into public policy health in the 1990s.

The legal-political dimension of the BPR is configured as a review of the civil, criminal and sanitary legislation about the concepts and definitions that relate the mental illness to irrationality, disability and dangerousness, by proposing changes in social and civil relationships and in terms of citizenship and social and human rights of people with mental and behavioral disorders. This is a political struggle for social transformation, by giving voice to those who do not have rights, who are not considered like citizens, for being hushed and silenced for long periods of time.⁶

The 1940s and 1950s were marked by the consolidation of the public hospital policy as the main therapeutic tool in psychiatry, with the stimulation to the expansion of psychiatric beds through the establishment of agreements between the state governments for building hospitals. During this phase, the psychiatry sought its consolidation as science in Brazilian territory. Hence, it raised the need for the hospital and the creation of new therapeutic techniques that could replace the custodial character, which was initially assigned to the psychiatric hospital.¹⁹

After the Military Coup of 1964, it started the so-called “mercantilization” of madness, promoted by agreements signed with the National Institute of Social Security (INPS), which was created in 1967, by turning mental illness into a lucrative and very profitable business. This trade hid the poor conditions to what numerous patients admitted to Brazilian psychiatric hospitals were submitted.

This framework gave rise to the Mental Health Workers’ Movement (MTSM), regarded as the historical milestone of the BPR, consisting of workers members of the health reform, unionists, associations of families and professionals, with the aim to report the violence in asylums, the hegemony of the private network of care and the consequent industry of madness, as well as the collective construction of criticism towards the psychiatric knowledge and the hospital-centered model.²⁰

It should be emphasized that, over its history, this movement has faced many powerful opponents, such as the owners of private psychiatric hospitals, who did not want to lose their valuable sources of income, as well as most conservative medical organizations, professionals and families that thought that “crazy people” should be kept interned within the hospital.²¹ Thus, it should be noted that the BPR, as a social movement, emerged from the mobilization and articulation of several actors and sectors of the civil society, in the everyday of their institutional practices and in universities, with the aim to politicize the mental health through the intermediary between the struggle against the form of treatment offered by asylums and the quest for new strategies of care to patients with mental and/or behavioral disorders.

The overcoming of the asylum-based model, which is mainly hospital-centered and exclusionary, sought to recover the citizenship of the mentally ill patient, by finding support in health policies in Brazil, raised from the VIII National Health Conference, in 1986, from the First National Conference on Mental Health (CNSM), in 1987, from the II CNSM, in 1992, from the III CNSM, conducted in 2001¹, and the IV Intersectoral-CNSM, occurred in the year 2010.

In the 1990s, there was the occurrence of relevant events to the mental health area, combined with the creation of various laws and ministerial ordinances, especially the Ordinances nº 189/91 and nº 224/92. It should be emphasized that the articulation between the new services created and the several actors and social groups - users, families, and

non-governmental organizations - drove the movement of the BPR to acquire visibility in the Brazilian state apparatus.

This context led to the enactment, in 2001, of the Law 10.216, which was a result from the Draft Law nº 3.657/89, also known as the Brazilian Psychiatric Reform Law, proposed by the deputy Paulo Delgado. This law provides for the protection of the rights of people with mental and/or behavioral disorders, with redirection of the assistential model in mental health. It should be highlighted that the above mentioned law does not advocate the phasing-out of asylum beds and neither establishes psychiatric hospitalization in the terms set out in the original Draft Law. It only provides for, among other rights, access to the best treatment of the health system, according to the people's needs; recovery by insertion in the family, work and community; it reaffirms the indication for admission, even when restricting it to situations in which the extra-hospital resources proved to be insufficient; lastly, it establishes the forms of voluntary, involuntary and compulsory admission, thus reaffirming the legislation in force.²²

In 2002, as a result of the III CNSM, a new ordinance was published, the 336/2002, with the aim of proposing a new model of care focused on the Psychosocial Care Centers (CAPS), which were defined as outpatient daily care based on logic of territory; creation of three different types of CAPS, namely: CAPS I, CAPS II and CAPS III. They were defined in ascending order of size/complexity and population coverage.²³

These centers can be defined as articulators of mental health policy in a given territory, by possessing the role of organizing the network of care to people with mental and/or behavioral disorders through daily care shares and use of community resources around them, in order to promote the social (re) insertion of such subjects.²⁴

The IV Intersectoral-CNSM, held in 2010, is added to these historical milestones, which was one of the first Mental Health Conferences with a deliberately intersectoral character. This conference reinforced relevant topics to the mental health field in the perspective of intersectionality, by promoting discussions on the advances and challenges for improving mental health care in the national territory and contemplating the need for intersectoral action for strengthening mental health actions in the current scenario of the BPR.²⁵

It argues about the legal-political dimension of the BPR and shows the trajectory of construction and regulation of the National Policy for Mental Health (PNSM) through the creation and publication of several laws, ordinances, programs, strategies and organization of stakeholders and social groups aiming to provide and ensure the rights to rescue the citizenship of the person with mental and/or behavioral disorder by means of community redirection of care shares, as well as social inclusion in the labor market and in society at large, thus leading to a paradigmatic change in the Brazilian mental health.

♦ **Meta-context: socio-cultural dimension of the BPR**

The sociocultural dimension corresponds to the set of social practices that aim to transform the concept of mental illness along with the social imaginary, thus modifying the relationship between the society and the madness. It refers to the construction of another social space for mental illness in our culture and in our customs.⁶ It means transforming the relationship between society and madness, by inviting it to reflect on its relationship with the difference, with the prejudice, with the unknown, i.e., promoting a true social transformation.

The sociocultural dimension of the BPR promotes the involvement of the society in the discussions on the Psychiatric Reform, in order to stimulate the social imaginary to critically and reflectively analyze the issues of madness, mental illness, exclusion of patients with mental and/or behavioral disorders, psychiatric hospitals, from the cultural and artistic production of the various stakeholders involved, whether they are users, family members or technicians of health services.¹⁰

Popular demonstrations like carnival blocks, radio and television programs, theater groups and various literary, musical and artistic productions have the ability to show the daily lives of mental health services and their users in a playful way to the society, thus deconstructing the archetype of disability and dangerousness associated with the image of the patient with mental and/or behavioral disorder.

From this understanding, it is noteworthy to highlight that the artistic expressions, in addition to being configured as important communication tools between mental health services and society, represent a significant tool in health education, since they make people aware of the importance of recognizing, through differences, the

potentialities and subjectivities of each subject, thus aiding in the disruption of rooted concepts and labeling of the classical psychiatry.¹⁷

It should be emphasized that such disruption is a huge challenge, since the society and some health professionals hold a social repertoire on the madness and the crazy subject inherited from the common sense, as a cultural heritage, characterized by an asylum-based and hospital-centered heritage of medicalization and exclusion of the patient with mental and/or behavioral disorder.²⁶ By thinking about it, on May 18th of the Brazilian calendar was instituted the National Anti-Asylum Day, and this date was chosen due to the date of the National Meeting of Mental Health Workers, held in 1987. On that day, throughout the country, there were cultural, political, academic and sporting activities, among others, to promote debates and instigate society to participate and discuss on the Psychiatric Reform, as a way to raise awareness of society for the prejudice, stigma and social exclusion of people with mental and/or behavioral disorders, by demolishing the walls in the representations, memory and imaginary of the society at large.

The proposal to change the assistential and psychiatric health model also necessarily implies the transformation of the training process of professionals. The construction of another social place for crazy people shows the need for articulation with the project of elaborating another gaze to the health-disease process, its demands, needs, forms and modes of resolution.²⁷

It is expected a protagonism on the part of the psychiatric reform, because it is not simply a question of transferring patients with mental disorders from hospital to confinement areas at home, under the care of those who can assist them or even being abandoned until death. It seeks to reintegrate the individual to the family and society on the behalf of the rescue or the establishment of the citizenship of the mentally ill subject, by respecting its uniqueness and subjectivity and making it the subject of its own treatment.²⁸

The intense emotional and labor-related burden of the relatives of patients with mental and/or behavioral disorders, mainly due to a zone of conflict and tension generated in family conviviality, can, taking into account the specificities of each case, unleash attitudes of family incomprehension and even rejection, motivated by successive readmissions or permanent admissions. Accordingly, it becomes essential to put the

family unit in a position of co-participant and co-responsible for the care of its members, by making it the agent of changes in various assistential scenarios.¹³

The process of formation of human resources for the mental health area requires a great effort on the part of universities in (re) formulating their perspectives and discussions on the latest issues on mental health, thus building a considerable theoretical production on the topic. Nonetheless, it is recognized that this commitment is still not enough to meet the demand for specific qualification to work within the philosophical perspective of the Psychiatric Reform.²¹

Nursing has revealed new forms of caring in mental health and Psychiatric Reform in its various works on madness, which demonstrates an actual commitment to the essence seized by the care as a social practice, by having a large scientific production on the set of concerns and challenges for the profession.²⁹

The socio-cultural dimension of the BPR exposes the relationship with the other to the extent that there is sharing of events, socializing and human mobility when facing the issue of feelings of rejection and/or tranquility and relief experienced by the family members when there is (re) admission of the relative with a mental and/or behavioral disease.

Therefore, the BPR is a process of deinstitutionalization of the social issue, besides detachment from the institutionalized and rigid forms of life, by showing the need and importance of qualified listening, recognition of subjectivity, as well as the quest for the political, personal, social and cultural emancipation, which allows, among other things, the non-confinement of too many forms of existence banned from the social life, thus providing the tolerant conviviality with differences.

In socio-cultural terms, rather than seek the acceptance of a new assistential policy, the challenge is to turn the madness and the mental suffering into an issue that goes beyond the borders of the technical discourse and the psychiatric knowledge, especially by insisting on the existential and human dimension that easily is hidden behind the medical-psychological jargon and protocols, thus bringing the stakeholders of several social strands to the public debate.

CONCLUSION

From this theoretical essay, we have discussed the four dimensions of the Brazilian Psychiatric Reform, by revealing the obstacles and challenges faced in seeking an improvement in serving people with mental and/or behavioral disorders, through the (re) formulation of several concepts such as, for example, illness and mentally ill patient, review of the civil, criminal and sanitary legislations, construction of a new organization of care services to people with mental disorders and their families, and overcoming the stigma of mental illness, thus modifying the relationships between the society and the madness.

Fortunately, there are, on the one hand, the numerous advances conquered by the Psychiatric Reform from a growing awareness of the society about another kind of care, which is more therapeutic, human and citizen, to be offered to individuals with mental and/or behavioral disorders, thus allowing their reintegration in the family environment and in the society itself. On the other hand, the health workers have also changed their focus of attention of the disease for the individual, by seeking new treatment strategies and informal or formal partnerships.

It should be emphasized that there are still many challenges to overcome, which range from the improvement of resoluteness and the articulation in the network of mental health services, passing through the expansion of psychosocial care services, until the forms of integration and articulation of the mental health with the primary care.

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