SEVEN publicações acadêmicas

From the first asylum of Minas Gerais to the psychiatric reform and its development in the municipality of Diamantina, Brazil

https://doi.org/10.56238/innovhealthknow-034

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ABSTRACT
Psychiatric Reform (PR) emerged in the 18th century as part of a deinstitutionalization movement for psychiatric patients, who were previously subjected to institutionalization and thus excluded from social interaction. The objective of this study was to present the primary experiences of Psychiatric Reform during key historical moments in the development of the Psychosocial Care Network (PCN), even within the municipality of Diamantina, Minas Gerais, Brazil. Methodology: A literature review was conducted across various databases, utilizing the following keywords: Psychiatric Reform, mental health, and psychosocial care. Results: The quest for an understanding of the evolution of Brazilian Psychiatric Reform up to the present time, including its implementation in the municipality of Diamantina, allows for an examination of both the achievements and vulnerabilities in constructing this psychosocial support network.

Keywords: Psychiatric hospitals, Mental health, Deinstitutionalization.

1 INTRODUCTION

According to Foucault (1972), the 17th century witnessed the so-called "great internment," during which the realm of madness became, a world of social exclusion. This era saw the construction of various internment houses across Europe serving as spaces for reception, correction, and confinement. These houses were intended not only for the insane, but also for libertines, magicians, prostitutes, and thieves. Amid political, economic, social, and moral issues, the establishment of these institutions marked the moment when madness was perceived within the context of poverty and the inability to work, thus identifying it as a social problem.

The internment of the insane was a socio-political instrument that was not guided by medical criteria. What united individuals within the "world of inmates" was their inability to contribute to wealth production, circulation, and accumulation (Foucault, 1972).

By the end of the 18th century, the practice of confining individuals, a hallmark of absolutism, had to be abolished in light of the ideals of the French Revolution: "Liberty, Equality, and Fraternity." Nevertheless, there was still a perceived need to segregate the insane to maintain order, a goal achieved through enlightenment ideals of scientificity and the valorization of reason. At this point, madness became the subject of a psychiatric study aimed at isolating "mentally ill" individuals for pure observation. Thus, madness became institutionalized as defined by medical knowledge/power (Amarante, 1998; Cedraz & Dimenstein, 2005).

To create a specific space for madness and the development of psychiatric knowledge, Philippe Pinel, considered the father of psychiatry, proposed a new form of treatment for the insane. He freed them from the chains and transferred them to asylums exclusively for the mentally ill. Pinel's asylum treatment primarily focused on re-educating patients, adhering to norms, and discouraging inappropriate behavior, all under the disciplinary authority of doctors and the asylum. This underscores the moral character attributed to madness (Amstalden & Passos, 2008).

However, Pinel's moral treatment has undergone modifications over time, losing its original ideals. Corrective practices for the behavior and habits of the mentally ill remained, but now as a means of enforcing institutional order and discipline. In the 19th century, treatment for the mentally ill included physical measures, such as showers, cold baths, whippings, rotating machines, and bloodletting (Amstalden & Passos, 2008).

Gradually, with the advancement of organicist theories, what was once considered a moral illness became understood as an organic disease. However, the treatment techniques employed by organicists were the same as those used by the proponents of moral treatment. This means that despite a new understanding of madness stemming from experimental discoveries in neurophysiology and neuroanatomy, the submission of the insane endured and extended into the 20th century (Amstalden & Passos, 2008).

This period set the stage for the contemporary psychiatric reform project, renewing criticism and reform of the asylum institution. Pinel had already emphasized the contradictions between psychiatric practices and institutions of great confinement. Subsequent reforms sought to challenge the role and nature, at times as an asylum institution and at times of psychiatric knowledge, raising new questions on the world's historical stage (Amarante, 1998).

The end of World War II in Europe, as identified by Desviat (1999), marked the emergence of the first challenges to the established model of care in which asylum had become a central element. Similar to the Nazi concentration camps that shocked the world in the 1940s, the conditions in the asylums at the end of World War II caused outrage and were incompatible with democratic projects for the reconstruction of Europe. Moreover, the war caused severe psychological trauma to a significant contingent on young men, whose workforce needed to be rehabilitated (Desviat, 1999).

The historical trajectory of mental health extends beyond a single moment, movement, or period. It involves traversing a path that encompasses various characteristics related to the socio-political and economic context of each era.

Different experiences and models have emerged in France, England, the United States, and Italy. Italy initiated a more radical model influenced by Franco Basaglia, who viewed psychiatric hospitals as threats to humanity (Amstalden & Passos, 2008). According to Costa (1985), Psychiatric Reform movements can be categorized as follows:

a) Reforms limited to psychiatric hospitals: institutional psychotherapy and therapeutic communities.
b) Reforms aimed at integrating extra-hospital services with the hospital: sector psychiatry and preventive psychiatry.
c) Reforms that introduced a rupture with previous ones, questioning both the body of knowledge and the practices of current psychiatry: antipsychiatry and democratic psychiatry.

2 METHODOLOGY

This study constitutes a literature review conducted through an electronic search of various databases. The descriptors used were: Psychiatric Reform, mental health, and psychosocial care. We conducted a survey of manuscripts associated with this theme. The selection was based on the following inclusion criteria: full-text references in Portuguese, regardless of publication date.

3 THEORETICAL REFERENCE

3.1 INSTITUTIONAL PSYCHOTHERAPY AND THERAPEUTIC COMMUNITIES

Institutional psychotherapy originated in France at the end of World War II. It considered psychiatric hospitals to be "ill" and in need of treatment; they should be reformed to become truly therapeutic and capable of reintegrating patients into society. Heavily influenced by psychoanalysis, institutional psychotherapy emphasizes the importance of the therapist-patient relationship in treatment. It aimed to create a collective field within the hospital, helping patients rebuild their connections with people and things. It encourages practices such as workshops, recreational activities, parties, meetings, and more (Minas Gerais, 2006).

Therapeutic communities emerged in England at the same time with the goal of turning psychiatric hospitals into therapeutic spaces. They encourage patients to actively participate in the hospital's administration, their own treatment, and the treatment of others. Special emphasis was placed on holding meetings, assemblies, and other spaces where patients could have an active voice in the institution (Minas Gerais, 2006).

While these two movements had specificities, they shared a common objective: challenging the authoritarian hierarchy in relationships between staff and patients and emphasizing equal and mutually respectful relationships in the treatment of those with mental suffering. However, they faced a limitation: How to democratize the internal functioning of an institution without questioning the authoritarianism and injustices of the society from which they derived? (Minas Gerais, 2006).

Another similarity between institutional psychotherapy and therapeutic communities was their aim to provide dignified and humane treatment to patients, but this support was limited to the period of hospitalization. After discharge, patients lack the support or assistance needed for their return to social life (Minas Gerais, 2006).

3.2 SECTOR PSYCHIATRY AND PREVENTIVE PSYCHIATRY

Sector psychiatry emerged from institutional psychotherapy in France in the 1950s. In this model, the focus of care should shift from the hospital to the extra-hospital space, establishing territorialization of care. The sector is defined as a well-defined geographical area, accompanied by the same Mental Health team, with its own extra-hospital services, such as post-care homes, sheltered workshops, and therapeutic clubs (Minas Gerais, 2006).

In the 1950s, preventive psychiatry began in the United States, promoting three levels of prevention. Primary prevention aims to intervene in individual and environmental conditions that contribute to mental illness formation. Secondary prevention aimed to diagnose these illnesses early, whereas tertiary prevention sought to reintegrate the patient into social life after improvement. Psychiatric hospitalization was only considered when other possibilities were exhausted and for short periods (Minas Gerais, 2006).

These different reform proposals also share common elements. Both sought to reduce the role of psychiatric hospitals and to create community-based treatment alternatives to reduce the number and duration of hospitalizations. However, the psychiatric hospital remained an essential reference, and it seemed inconceivable to envision a care model that could do so without it. Moreover, there has been progress in valuing the psychosocial aspects of mental distress; however, the medicalizing and interventionist stance often overshadows these aspects.

Although the importance of community contributions was emphasized, these proposals were formulated and led by professionals, with little involvement from individuals suffering from mental distress and their families in the development of Mental Health policies (Minas Gerais, 2006).

3.3 ANTIPSYCHIATRY AND DEMOCRATIC PSYCHIATRY

Antipsychiatry emerged in England in the 1960s. It was not a proposal for Psychiatric Reform but rather an entirely new perspective on madness. It originated from bold experiences within

therapeutic communities that ultimately transcended institutional boundaries. Madness was no longer viewed as an illness but as a reaction to family imbalances and social alienation (Minas Gerais, 2006).

Democratic psychiatry emerged in Italy in the 1960s, stemming from the challenges faced in implementing therapeutic community proposals. In the city of Trieste, a large psychiatric hospital was gradually dismantled, concurrently creating opportunities for former inpatients to reintegrate into the society. Mental Health Centers, operating 24 hours a day in an open-door system, began serving all cases that had previously sought the hospital, including, and especially, the most severe cases. They establish opportunities for users in terms of mobility, employment, culture, and leisure within the city (Minas Gerais, 2006).

To achieve this, it was necessary to criticize the medical and psychological appropriation of madness. According to democratic psychiatry, the walls of the asylum symbolize the domination of the words, actions, and decisions of the so-called mad individuals in the name of science. Therefore, the aim was to provide those suffering from mental distress with a real space for citizenship; that is, to offer them a place as protagonists of social transformation, reclaiming their own lives as legitimate city dwellers. This movement prohibited the construction of new psychiatric hospitals in Italy (Minas Gerais, 2006).

Consequently, these experiences brought about a rupture with previous approaches, particularly Democratic Psychiatry, whose impact has reached a global scale. For the first time, it was asserted that the extinction of a psychiatric hospital was possible and necessary, given the failure of all previous efforts to transform it into a therapeutic space. Additionally, the supposed neutrality of science was questioned, demonstrating that scientific knowledge depends on power relations and takes sides within them (Minas Gerais, 2006).

These changes not only involved Mental Health professionals, but also engaged various stakeholders, sparking debates and mobilizations that encompassed other social segments.

3.4 PSYCHIATRIC REFORM IN BRAZIL

In Brazil, as in other parts of the world, efforts have been made to continue to create new places and new perspectives for caring, treating, and most importantly, reintegrating individuals with mental distress or disorders, including those with psychoactive substance needs. The Brazilian psychiatric reform was based on the Italian movement. The reform in Brazil began in the late 1970s. With the increasing privatization of psychiatric hospital beds in profit-driven hospitals, the institutional and financial crisis of social security, and the fact that public health was essentially assistance-oriented, hospital-centered, and inefficient, it was evident that the country's healthcare system needed reformulation (Amarante, 1994).

The trajectory of the movement was marked by the notion of deinstitutionalization, fitting into a political context of great importance to Brazilian society. The 1980s were characterized by the struggle for a truly democratic state after 20 years of military dictatorship. In this context, the paths of psychiatric reform are closely linked to those of healthcare reform. According to Amarante (1998), the psychiatric reform movement in Brazil was triggered by the crisis of the National Division of Mental Health (DINSAM), a division of the Ministry of Health, and the Mental Health Workers Movement (MTSM). Regarding the MTSM, it is enough to remember that this movement denounced the lack of resources in mental health units and the resulting precarious working conditions, which affected the care provided to the population, with its main focus on labor and humanitarian aspects.

A decisive turning point at that time was the 3rd Minas Gerais Psychiatry Congress held in Belo Horizonte in 1979. With guests, such as Franco Basaglia, and the participation of users and family members, the discussion expanded, reaching the entire country's public opinion. In this context, the Mental Health Workers Movement emerged, and their meeting in Bauru in 1987 coined the famous slogan "For a society without asylums," paving the way for the birth of the anti-asylum struggle (Minas Gerais, 2006).

Despite advancements in Psychiatric Reform, by the late 1980s, Brazil still had 100,000 beds in 313 psychiatric hospitals, with 20% being public and 80% privately affiliated with the Unified Health System (SUS), mainly concentrated in Rio de Janeiro, São Paulo, and Minas Gerais. Public spending on psychiatric hospitalizations ranks second among all expenses paid by the Ministry of Health (Minas Gerais, 2006).

In the path to the Brazilian Sanitary Reform, the 8th National Health Conference in 1986 and the Federal Constitution of 1988 represented the cornerstone for subsequent Psychiatric Reform, defining psychological care without the discrimination that prevailed at the time and healthcare as a right for all (National Health Conference, 1986; Brazil, 1988).

The 1990s represented one of the most remarkable periods in the trajectory of this reform, seeking deinstitutionalization or deconstruction/invention and the consequent construction and implementation of something genuinely new based on humanitarian principles and focused on citizenship (Amarante, 1998). The Brazilian Psychiatric Reform became embedded within the SUS's doctrinal principles, and in 1990, the Caracas Declaration outlined the framework for mental healthcare projects in the Americas (World Health Organization, 1990).

From the 2nd National Mental Health Conference in 1992, guidelines emerged to direct the restructuring of mental health care, proposing an articulated network of substitute services, with a significant focus on the implementation of resources for the first Psychosocial Care Centers (CAPS), ordinances, and incentives for deinstitutionalization (Pitta, 2011).

The Psychosocial Care Centers (CAPS), Psychosocial Care Nuclei (NAPS), Mental Health Reference Centers (CERSAM), and other asylum model substitute services are currently regulated by Ordinance No. 336/GM on February 19, 2002, and are part of the Unified Health System network (Brazil, 2002).

This ordinance recognizes and expands the operation and complexity of CAPS, which aims to provide continuous care to individuals suffering from severe and persistent mental disorders in a given territory, offering clinical care and psychosocial rehabilitation with the aim of replacing the hospital-centered model, avoiding hospitalizations, and promoting the exercise of citizenship and social inclusion for users and their families (Brazil, 2004).

CAPS consists of three service modalities, CAPS I, CAPS II, and CAPS III, defined in increasing order of size/complexity and population coverage. Their characteristics, as specified in Ordinance No. 336 on February 19, 2002 (Brazil, 2002), are described below.

a) CAPS I: All age groups; severe and persistent mental disorders, including psychoactive substance use; serves cities and/or regions with at least 15,000 inhabitants.
b) CAPS II: All age groups; severe and persistent mental disorders, including psychoactive substance use; serves cities and/or regions with at least 70,000 inhabitants.
c) CAPSi: Children and adolescents; severe and persistent mental disorders, including psychoactive substance use; serves cities and/or regions with at least 70,000 inhabitants.
d) CAPS Ad - Alcohol and Drugs: All age groups; specialized in disorders related to alcohol and other drug use; serves cities and/or regions with at least 70,000 inhabitants.
e) CAPS III: Provides overnight shelter and observation for up to five vacancies; all age groups; severe and persistent mental disorders, including psychoactive substance use; serves cities and/or regions with at least 150,000 inhabitants.
f) CAPS Ad III - Alcohol and Drugs: Provides overnight shelter and observation for 8–12 vacancies; operates 24 hours; all age groups; disorders related to alcohol and other drug use; serves cities and/or regions with at least 150,000 inhabitants.

3.5 WHERE ARE WE AFTER THE PSYCHIATRIC REFORM

Sixteen years after the enactment of Law No. 10,216 of 2001, which determined the creation of a substitute network following the guidelines of the Psychiatric Reform to overcome the asylum model and guarantee and promote the citizenship rights of people with mental disorders (Brazil, 2001), the landscape of public mental health care in the country has been transforming, with primary care acting as the organizer and director of such care. Therefore, a true theoretical-conceptual revolution is necessary to understand the individuals involved in this broad and complex social process, as well as

an expanded concept of health, clinical care, interdisciplinary and intersectoral work, the notion of a network, and territoriality (Amarante, 2007).

The first Psychosocial Care Center (CAPS) in Brazil was inaugurated in March 1986 and became known as CAPS Itapeva in São Paulo, SP. CAPS was the first substitute service considered as a reference and treatment location for individuals with severe and persistent mental disorders, which justifies the patient's stay in a place of intensive, community-based, personalized, and health-promoting care (Brazil, 2004).

In 2010, the Ministry of Health adopted the strategy of organizing the Unified Health System (SUS) through the creation of healthcare networks, which are organizational arrangements of health actions and services of different technological densities, integrated through technical, logistical, and management support systems, aimed at ensuring comprehensive care (Brazil, 2010).

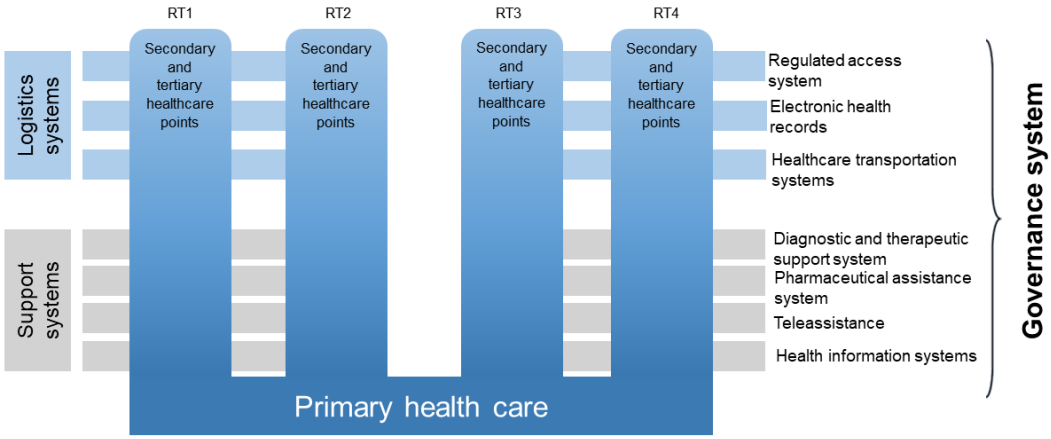
According to Mendes (2010), Health Care Networks are oligarchic organizations of sets of health services linked together by a single mission, common objectives, and cooperative and interdependent action, allowing for continuous and comprehensive care to a specific population, coordinated by Primary Health Care (PHC), provided at the right time, in the right place, at the right cost, with the right quality, in a humanized manner, and with equity, with health and economic responsibilities and generating value for the population.

Healthcare systems operate in a dialectical relationship between contextual factors (population aging, epidemiological transition, scientific and technological advances) and internal factors (organizational culture, resources, incentive systems, organizational structure, leadership style, and management style). Under sectoral governance, contextual factors, which are external to the healthcare system, change more rapidly than internal factors under sectoral governance (Mendes, 2011).

In this context, healthcare systems cannot adapt to contextual changes, especially demographic and epidemiological ones. This is the universal crisis of healthcare systems that was conceived and developed with a presumption of continuity, focused on acute conditions and events, and disregarding the contemporary epidemic of chronic conditions. As a result, we have a 21st-century health situation governed by a 20th-century healthcare system, when acute conditions predominated (Mendes, 2011).

Healthcare networks consist of three elements: population, operational structure, and healthcare model, as illustrated in Figure 1.

Figure 1. Operational structure of health care networks.



Fonte: MENDES (2011). Adapted.

These three elements are characterized as follows by Ordinance No. 4,279/10 (BRASIL, 2010):

a) Population and Health Region: To preserve, recover, and improve people's and community health, Health Care Networks (RAS) must be able to clearly identify the population and geographic area under their responsibility. The health region must be well-defined based on spatial and temporal parameters that ensure that the structures are well-distributed territorially, guaranteeing the necessary response time for care, a better structure/population/territory ratio, and sustainable operational viability.

b) Operational Structure: The operational structure of RAS consists of different healthcare points, that is, institutional places where health services are offered, and the connections that communicate them. The components that structure the RAS include Primary Health Care, communication centers, secondary and tertiary care points, support systems, logistical systems, and the governance system.

c) Health Care Model: The health care model is a logical system that organizes the operation of RAS, uniquely articulating the relationships between the population and its subpopulations stratified by risks, the focus of health care system interventions, and the different types of health interventions. It operates based on the prevailing health vision, demographic and epidemiological situations, and social determinants of health prevailing at a given time and in a given society.

The implementation of RAS requires a change in the current hegemonic care model in the Brazilian Unified Health System (SUS), which requires simultaneous intervention in acute and chronic conditions. The RAS is organized thematically based on the need to address vulnerabilities, diseases, or conditions affecting individuals or populations. They are also cross-cutting themes related to qualification, education, information, regulation, and health promotion and surveillance (BRASIL, 2010).

The following thematic networks are prioritized:

a) Stork Network

b) Urgent and Emergency Care Network

c) Psychosocial Care Network

d) Network for the Care of Chronic Diseases and Conditions

e) Network for the Care of People with Disabilities (BRASIL, 2010).

As of the completion of this work, the national psychosocial care network consists of2,465 Psychosocial Care Centers (CAPS), including 424 specialized in alcohol and drug-related care, 35 Child and Adolescent Shelter Units (UAI), 21 Adult Shelter Units (UAA), 1,163 Mental Health beds in general hospitals, 104 Street Clinics under the responsibility of Primary Health Care, and 493 Therapeutic Residential Services (SRT) for people in vulnerable situations who have been hospitalized in psychiatric or custodial hospitals for an extended period (BRASIL, 2017a).

It can be observed that the RAS has expanded in recent years; for example, between 2014 and 2017, there was a 36% increase in the availability of Mental Health beds in general hospitals. In addition, the Ministry of Health has made significant investments in funding establishments and Street Clinics that make up RAS (BRASIL, 2017a).

It is estimated that 23 million Brazilians have some form of mental disorder, with 5 million in the moderate-to-severe range. This population relies on well-structured RAS for appropriate treatment. However, the Ministry of Health conducted a national survey and identified, among other things, the mismanagement of resources allocated to construction projects, low occupancy of mental health beds in general hospitals, and underreporting in care and production records, thereby compromising the quality and effectiveness of the network (BRASIL, 2017a).

The urgency for RASs across Brazil to function effectively is highlighted when observing a new epidemiological reality for mental health: a significant increase in chemical dependence on crack and other drugs associated with abusive alcohol use and dependence. There has also been an increase in suicide rates, which is the fourth leading cause of death among young people and has a high prevalence among the elderly - 8.9 deaths per 100,000 in the last six years (BRASIL, 2017b).

3.6 HISTORICAL TRAJECTORY OF MENTAL HEALTH IN THE CITY OF DIAMANTINA/MG

It is a fact that the history of the Psychosocial Care Network (RAPS) in Diamantina, Minas Gerais, did not begin after the principles of Psychiatric and Sanitary Reforms. A municipality's mental health network is rich in history, exuberance, gaps, politics, religion, power, charity, treatment, and other characteristics. This is attributed to the presence of Minas Gerais' first asylum in Diamantina, the cornerstone of which was laid in 1888. In the work entitled "Hospício da Diamantina - Madness in the Modern City" by the Diamantina author Maria Claudia Almeida Orlando Magnani, a professor at the

Federal University of Vales do Jequitinhonha and Mucuri (UFVJM), stemming from her master's thesis, she sought to comprehend:

> "What was that asylum, when did it start attending patients, with what objectives, what reality created the need for its existence, who were its patients, and what were its doctors aiming to achieve?" These questions became even more intriguing as the documents and sources proved to be scarce and damaged. Possible answers to these questions are grounded in this dissertation from the perspective of a historical understanding of madness and mental medicine in Europe and Brazil (always considering the peculiarities of Brazilian and Minas Gerais societies in the 19th century). Therefore, I constructed my master's project with the overarching goal of recovering and extracting information from sources as much as possible and attempting to historically understand the metaphorical cries of the asylum, which did not remain silent. The history of the Diamantina Asylum, involving the discourse on madness at the end of the 19th century, has emerged as a borderline object between history and other fields of knowledge, such as sociology. Thus, investigating asylum requires a comprehensive effort to understand the broader social fabric that engendered it from various angles. The construction of the asylum was understood as part of a modernizing process occurring in Diamantina at the end of the 19th century, which, in turn, needed to consider the understanding of the modern city's relationship with the asylum and madness, viewed through a new medical perspective: the perspective of psychiatry, which, as a normative discipline, transformed madness into mental alienation and sought to cure it (Birman, 1978). The understanding of Diamantina Asylum in all its complexities, therefore, demands a broader comprehension of the city of Diamantina concerning the intricacies of its multifaceted urbanity and the medical knowledge that was established alongside it (MAGNANI, 2008).

The aforementioned author was involved in the construction of the RAPS in Diamantina, MG when she describes, "In this process, accompanying the elaboration of a substitutive mental health service project for the region, I came across the collection of the Santa Casa de Caridade de Diamantina, abandoned in a damp cellar, in a deplorable state of preservation" (MAGNANI, 2008). Mercy's Holy Houses actively participated in providing assistance to the mentally ill in Minas Gerais in the 19th century. Among these, the Santa Casa de Caridade de Diamantina (SCCD) was highlighted by Gonçalves and Goulart as follows:

> "We chose to investigate the participation of the Holy Houses of Mercy in the history of mental health assistance policy in Minas Gerais, based on the paths outlined by the Royal Road. It can be said that this road inaugurated the path of conquest, the path of gold, diamonds, and, above all, power from Colonial Brazil. The Royal Road was built between the late 17th and early 18th centuries, establishing a connection between Rio de Janeiro and the provinces to be explored in Minas Gerais. Among these provinces, two districts stand out, Vila Rica (now Ouro Preto) and Vila do Príncipe/Arraial do Tijuco (currently Serro and Diamantina, respectively). Royal Road has two paths along its trajectory. The old path connected the city of Paraty in Rio de Janeiro to Vila Rica in Minas Gerais, while the new path went from Paraty to Arraial do Tijuco (Diamantina). The new path was constructed after the discovery of diamonds in the Serro region" (GONÇALVES, GOULART, 2015).

Most hospitalizations occurred in the Holy Houses of Mercy in the municipalities of São João Del Rei and Diamantina. In addition to the hospitalizations carried out in the Holy Houses of Mercy within the state, there was a convention established with the Hospital of Rio de Janeiro in 1982, ensuring a specific number of beds for referrals from the state of Minas Gerais (MAGRO FILHO,

1992). The construction of the asylum was part of a process involving economic, social, and political issues, as pointed out by MAGNANI (2008):

> The new reality of the city of Diamantina in the late 19th century, in terms of the creation and complexification of spaces of sociability and the outbreak of industrialization that made it possible to some extent, coexisted with a new medical discourse that extended to the understanding and approach to madness. At the same time, old social relationships coexist with transformation. Strictly speaking, both the aspirations of modernization in the city and the aforementioned industrial outbreak were promises that were not fulfilled. Diamantina did not confirm itself as a significant industrial center in the 20th century, and pre-modern elements seem to me to still be too determinative for a city that aimed to modernize. The decline in diamond mining, which was addressed by the textile industry, was not definitive. Until the almost complete exhaustion of diamond veins in the late 20th century, the city lived from the exploitation, cutting, and trade of diamonds at the mercy of fluctuations in the international precious stone market. If the Diamantina Asylum were, on the one hand, a response to the need to isolate the mentally ill who, wandering the streets, interfered with the city's redevelopment and its need for orderly development; on the other hand, a response to the new needs for treatment and cure imposed by the new medical knowledge that introduced a new conception of madness and normality, it is possible that the specificity of the modernizing process in Diamantina is somewhat linked to the rapid closure of the asylum. Thus, it is possible that the asylum was born alongside the promise of modernizing the city and closed its doors when the promise collapsed before it was fulfilled. Diamantina did not have a sufficiently strong political and economic representation to maintain the state funds earmarked for the asylum for the mentally ill, which, at the beginning of the 20th century, favored the city of Barbacena as the headquarters of a state asylum" (MAGNANI, 2008).

As pointed out by Magro Filho (1992), most hospitalizations occur in the Holy Houses of Mercy in the municipalities of São João Del Rei and Diamantina. In addition to the hospitalizations carried out in the Holy Houses of Mercy within the state, a convention was established with the Hospital of Rio de Janeiro in 1982, ensuring a specific number of beds for referrals from the state of Minas Gerais.

The closure of the Diamantina Asylum took place in 1903, even before it was officially inaugurated. However, the asylum has been active for nearly 20 years despite being an unfinished construction due to a lack of resources and continued to admit patients (MAGNANI, 2008).

> It continues to provide good services; despite being unfinished, the establishment we founded, attached to the Holy House, for the treatment of the exiled reason. The Minas Gerais Congress, which until then had not refused to heed our demands on behalf of the asylum for the mentally ill in Diamantina, bestowed upon it an annual allowance of 2,000$ and in the last fiscal year with 5,000$000, in its recent meeting, when preparing the expenditure law for 1900, left the aforementioned establishment aside and withdrew its subsidy, based on the convenience of reducing the state's burdens; however, it spent only 21 contos on caring for the mentally ill, with 11 contos at the national asylum and five contos each in the asylums of São João Del Rei and Diamantina. With the project to establish a state asylum for the mentally ill, it is believed that this concession will not be reinstated, leaving the work that has cost us so much sacrifice and effort solely to its own resources" (BRANT, 1899, pp. 11-12).

The non-renewal of the National Asylum's agreement with Minas Gerais, along with excessive spending on maintaining the mentally ill from the state in the Holy Houses of Mercy, led to the proposal for the creation of assistance for the mentally ill in 1900. In 1903, the Psychiatric Hospital of Barbacena was inaugurated and was considered one of the largest hospitals in Brazil. At this time, all the resources

previously allocated to the Holy Houses of Mercy in São João Del Rei and Diamantina were directed and centralized solely in Barbacena, without the need for agreements and assistance to other states. In the same period, the first law on the mentally ill was created, as mentioned by Magnani (2008), in which the alienation of rights began to be used as a form of authority, making psychiatry the holder of powers. Consequently, many individuals with mental illnesses never returned to their homes or ended up on the streets, as treatment houses no longer existed.

3.7 THE PSYCHOSOCIAL CARE NETWORK IN DIAMANTINA

The evolution of regionalization and municipalization models has enabled the Brazilian Unified Health System (SUS) to develop a healthcare assistance network in the 2000s, in line with the Antimanicomial Movement. In Diamantina, the efforts of key local health managers, including the Intermunicipal Health Consortium of Alto Jequitinhonha (CISAJE), Municipal Health Secretariat of Diamantina, Regional Health Directorate of Diamantina, and Santa Casa de Caridade de Diamantina, facilitate the establishment of an open and local mental health service.

According to the resolution CIB-SUS/MG No. 1092, dated April 4, 2012, which established the Psychosocial Care Network for individuals with Mental Disorders and needs arising from the use of alcohol, cracks, and other drugs within the scope of the Unified Health System of Minas Gerais/SUS-MG, the Mental Health Network for the municipalities in the microregion of Diamantina-MG was approved (MINAS GERAIS, 2012).

Referring to the commitment spreadsheet for the implementation of the components of the Psychosocial Care Network, conducted on May 10, 2012, at the CIB Micro Diamantina, the following agreements, as presented in Table 1, are mentioned.

Table 1. Composition of RAPS network points in Diamantina-MG (2012).

Components of the RAPS	**Key Focus Areas**	**RAPS Diamantina/MG**	**CIB Micro Diamantina Agreement - May 2012**
Primary health care	Basic health unit; Family health support center; Street clinic; Community and culture centers;	Basic Health Units (UBS/ESF): 8 urban units 3 rural units Nucleus of Support for Family Health (NASF): Not available Street Clinic: Not available Community and Culture Centers: Not available	Maintain the service (ESF), does not have NASF
Strategic psychosocial care	Psychosocial care centers in various modalities;	CAPS II for Mental Disorders CAPS AD for Alcohol and Drug users	Reclassify CAPS II to CAPS III; Requalify CAPS Ad II to CAPS Ad III;

Components of the RAPS	Key Focus Areas	RAPS Diamantina/MG	CIB Micro Diamantina Agreement - May 2012
		Both for users above 18 years old	Open and implement CAPS in 2013;
Urgent and emergency care	Mobile emergency medical service (SAMU 192); Stabilization room; 24-hour urgency care units (UPA) and hospital emergency doors;	SAMU 192: Available Emergency Care Centers: SCCD; HNSS Fire Department	Maintain the service
Transitory residential care	Shelter units; Residential care services;	There is no agreement	Open in 2013, the Child/Youth and Adult Reception Unit; Implement in 2013 Therapeutic Residential Service modality 2 (4 to 10 residents);
Hospital care	Mental health beds in general hospitals (clinics or pediatrics); Specialized wards in general hospitals;	5 beds at SCCD (Santa Casa de Caridade de Diamantina)	Maintain the service
Deinstitutionalization strategies	Therapeutic residential services; Back home program;	2 users enrolled in Back Home Program	2 users enrolled in Back Home Program
Psychosocial rehabilitation strategies	Work and income generation initiatives; Empowerment of users and family members;	Users association	Users association

Fonte: Authors.

Drawing upon the guidelines that constitute the operation of the Brazilian Unified Health System (SUS), the municipality of Diamantina, MG, has shown weakened areas of concern, leading to challenges in delivering care based on SUS principles. According to Luzio and L'Abbate (2006), since the implementation of the SUS, when many municipalities across the country sought to actualize the constitutional rights of users in all healthcare sectors, significant difficulties were observed in implementing both the general guidelines of healthcare reform and psychiatric reform.

The training of health care professionals and their significance in implementing, maintaining, and developing SUS can be considered essential and strategic. During their training, these professionals develop not only skills and knowledge but also the values and attitudes that accompany them in their professional practices.

The current Brazilian political and mental healthcare landscape, with its challenges and prospects, faces issues primarily related to difficulties in service management. These include frequent readmissions, a limited number of available services and equipment, high user demand, disarray in the psychosocial care network, and a shortage of qualified human resources to staff these services (JÚNIOR et al., 2016).

In an article by Wenceslau and Ortega (2015), which offers a theoretical analysis of the integration of mental health into primary care from the perspective of Global Mental Health (GMH) goals and strategies with international perspectives and the Brazilian scenario, the authors point out that individuals with mental disorders require healthcare systems that meet their care needs using the best available scientific foundations.

The academic production gathered by GMH shows that these psychosocial and pharmacological resources are cost-effective and should be accessible worldwide. Achieving this goal in a shorter time frame and in a sustainable manner is only possible through a strong primary care system integrated with an organized mental health network and specialized resources as the cornerstone of mental health care (WENCESLAU and ORTEGA, 2015).

The same authors cite that the international literature affirms that integration is the main global strategy to expand access to mental health services, presenting evidence demonstrating the advantages and feasibility of this model. At the same time, there is a repeated need for more robust and detailed studies on ongoing experiences, particularly demonstrating the epidemiological impact, favorable clinical outcomes, cost-effectiveness, and solutions to the cultural challenges involved.

However, the analysis of the main ordinances and technical guidelines from the Ministry of Health on this topic indicates that the SUS recognizes the fundamental role of primary care in mental healthcare. However, the limits of competence between primary and Psychosocial Care Centers (CAPS) are not clearly established, resulting in a dual entry point in the system for this type of demand. Furthermore, mental health support through the Family Health Support Centers (NASF) is the primary mechanism, better substantiated in ordinances, for qualifying the Family Health Strategy (ESF) for this service. However, this raises doubts about whether this should be the only or even the best way to promote this qualification (WENCESLAU & ORTEGA, 2015).

Eugenio (2010) concluded that there is evidence in the international literature that healthcare networks can improve service quality, health outcomes, user satisfaction, and reduce healthcare system costs when they are integrated. Evidence also suggests that integrating healthcare managers and service providers improves cooperation between them, pays more attention to case management, encourages the use of information technology, and has an impact on healthcare costs, particularly in mental health.

4 FINAL CONSIDERATIONS

The pursuit of understanding the construction of Brazilian Psychiatric Reform to the present day, extending to the municipality of Diamantina, allows us to envision both achievements and weaknesses. Psychiatric Reform is understood to have solidified as a public policy; however, the establishment of the Psychosocial Care Network (RAPS) presents itself as a complex task. For continuous and comprehensive care, it is of utmost importance for professionals to comprehend their

purposes and functionalities. In this manner, we can advance and consolidate psychosocial care, highlighting limited user engagement at the national stage.

ACKNOWLEDGMENT

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REFERENCES

AMARANTE, P. Loucos pela vida: A trajetória da reforma Psiquiátrica no Brasil. Rio de Janeiro: Fiocruz, 1998.

AMARANTE, P. Uma aventura no manicômio: a trajetória de Franco Basaglia. História, Ciências e Saúde. Manguinhos, v. 1, n. 1, p. 61-77, 1994.

AMSTALDEN, A.; PASSOS, E. A reforma psiquiátrica brasileira e a política de saúde mental. Portal do Centro Cultural do ministério da Saúde, Brasília, [2008]. Disponível em: http://www.ccs.saude.gov.br/VPC/reforma.html Acesso em: 15 ago. 2016.

CEDRAZ, A., DIMENSTEIN, M. Oficinas terapêuticas no cenário da Reforma Psiquiátrica: modalidades desinstitucionalizantes ou não? Revista Mal-Estar e Subjetividade. Fortaleza, v. 5, n. 2, p. 300-27, 2005. Disponível em: http://pepsic.bvsalud.org/pdf/malestar/v5n2/06.pdf . Acesso em: 15 ago. 2016.

COSTA, J. F. História da Psiquiatria no Brasil. 4. ed. Rio de Janeiro: Editora Xenon, 1985.

DESVIAT, M. Reforma Psiquiátrica. Rio de Janeiro: Editora Fiocruz, 1999.

FOULCAULT, M. História da Loucura na Idade Clássica. São Paulo: Editora Perspectiva, 1972.

MINAS GERAIS, Secretaria Estadual de Saúde. Atenção em saúde mental: Linha Guia de Saúde Mental. Belo Horizonte: [s.n.], 2006.

BRASIL. Constituição Federal da República Federativa do Brasil: texto constitucional promulgado em 5 de outubro de 1988, com as alterações determinadas pelas Emendas Constitucionais de Revisão nos 1 a 6/94, pelas Emendas Constitucionais nos 1/92 a 91/2016 e pelo Decreto Legislativo no 186/2008. Brasília: Senado Federal, 2016.

ORGANIZAÇÃO MUNDIAL DE SAÚDE. ORGANIZAÇÃO PANAMERICANA DE SAÚDE. Declaração de Caracas. Conferência Regional para a Reestruturação da Atenção Psiquiátrica na América Latina no Contexto dos Sistemas Locais de Saúde (SILOS). Caracas: OMS/OPAS; 14 nov. 1990.